Audit and Governance Committee meeting - agenda

Human Fertilisation & Embryology Authority

10 March 2020

Chartered Institute of Arbitrators, Council Chamber - Ground Floor

12 Bloomsbury Square, London, WC1A 2LP.

	Agenda item		Time
1.	Welcome, apologies and declaration of interests		10.00am
2.	Minutes of 3 December 2019 **[AGC (10/03/2020) DO]**	For decision	10.05am
3.	Matters Arising **[AGC (10/03/2020) MA]**	For information	10.10am
4.	Digital Programme Update **[AGC (10/03/2020) DH]**	For information	10.15am
5.	Internal Audit Audit plan, reports and recommendations follow up **[AGC (10/03/2020) TS]**	For information	10.50am
6.	Progress with Audit Recommendations **[AGC (10/03/2020) MA]**	For information	11.05am
7.	External Audit – interim feedback **[AGC (10/03/2020) JH]**	Verbal update	11.15am
8.	Resilience, Business Continuity Management Cyber Security **[AGC (10/03/2020) DH]**	For information	11.20am
9.	Strategic Risk Register **[AGC (10/03/2020) HC]**	For comment	11.30pm
10.	Finance and Resources management **[AGC (10/03/2020) RS]**	For information **(to follow)**	11.40pm
11.	AGC Forward Plan **[AGC (10/03/2020) MA]**	For information	11.50pm
12.	Gifts and Hospitality register **[AGC (10/03/2020) MA]**	For information	12.00pm

13.	Anti-Fraud, Bribery and Corruption policy **[AGC (10/03/2020) RS]**	For decision	12.10pm
14.	Public interest disclosure (Whistle blowing policy) **[AGC (10/03/2020) RS]**	For decision	12.20pm
15.	Contracts and Procurement **[AGC (10/03/2020) MA]**	Verbal update	12.30pm
16.	Regulatory and Register management **[AGC (10/03/2020) RC]**	For discussion	12.40pm
17.	Draft Annual Governance Statement **[AGC (10/03/2020) RS]**	For discussion	12.50pm
18.	Estates Update **[AGC (10/03/2020) RS]**	Verbal update	1.00pm
19.	Any other business		1.15pm
20.	Close (Refreshments & Lunch provided – in the **John Maynard Keynes room**)		1.20pm
	Session for members and auditors only		

Next Meeting: 10am Tuesday, 23 June 2020, Chartered Institute of Arbitrators, 12 Bloomsbury Square, London, WC1A 2LP

Audit and Governance

Committee meeting minutes

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

Details:	
Meeting	Audit and Governance Committee
Agenda item	2
Paper number	AGC (10/03/2020) DO
Meeting date	10 March 2020
Author	Debbie Okutubo, Governance Manager
Output:	
For information or decision?	For decision
Recommendation	Members are asked to confirm the minutes as a true and accurate record of the meeting
Resource implications	
Implementation date	
Communication(s)	
Organisational risk	☒ Low ☐ Medium ☐ High
Annexes	

Audit and Governance Committee meeting minutes

3 December 2019

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

Attendees	Present	Anita Bharucha (Chair) Margaret Gilmore Mark McLaughlin Geoffrey Podger
	Apologies	None
	External advisers	Mike Surman, NAO Jill Hearne, NAO Jeremy Nolan, Internal Auditor – GIAA Tony Stanley, Audit Manager – GIAA
	Observer	Dafni Moschidou, DHSC
	Executives	Peter Thompson, Chief Executive Richard Sydee, Director of Finance and Resources Clare Ettinghausen, Director of Strategy and Corporate Affairs Rachel Cutting, Director of Compliance and Information Morounke Akingbola, Head of Finance Yvonne Akinmodun, Head of Human Resources Dan Howard, Chief Information Officer Paula Robinson, Head of Planning and Governance Helen Crutcher, Risk and Business Planning Manager Debbie Okutubo, Governance Manager

1. Welcome and declarations of Interest

1.1. The Chair welcomed everyone present and gave a special welcome to Rachel Cutting, Director of Compliance and Information as it was her first committee meeting. She also thanked Jeremy Nolan, Internal Auditor as he was retiring in February 2020, which made this meeting his last one.

1.2. There were no declarations of interest.

2. Minutes of the meeting held on 8 October 2019

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

3. Matters arising

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

3.2. Members agreed that 9.10 - the committee to receive monthly updates highlighting any variances and increased risk - would now be removed from matters arising. Likewise, item 3.8 - the Committee Secretary to contact members regarding availability for training after the meeting on 4 December 2018 or 5 March 2019 - should also be removed.

3.3. Following discussion it was agreed that Information security training for Authority members would be moved to the first week in January 2020 and followed up with members after two weeks. This should occur before the Authority meeting on 29 January 2020.

3.4. Members noted the progress updates.

4. Digital programme update

4.1. The Chief Information Officer (CIO) presented the status report to the committee.

4.2. The Chair stated that the committee were aware that staff had been working incredibly hard for a very long period of time with the aim of launching PRISM and the new register in the new year but for assurance purposes needed to understand why the issues identified were unforeseen.

4.3. The key questions were:

- why the slippage had happened?
- how clinics, patients and the Authority could have confidence in the new estimated timescales in light of repeated slippages in the launch date

4.4. The chair confirmed that the committee received monthly updates and the new problem uncovered had never been mentioned or brought to the attention of the committee. It was important to understand why that was the case.

4.5. Officers explained that three issues were identified a week ago:

- Data verification – the checking of imported data into PRISM following a simulated data migration. The source data was correct and the initial testing showed that only 12 out of 17 imported records were fully correct. The trial load process was an iterative process and had taken longer than we expected.
- Data migration – over the last five months we had closed around the same number of data quality issues as we had opened, leaving around 20-25 issues. From 11 November there had been more new issues identified resulting in an additional backlog of 14. The view of the external company we were working with was that this was normal, officers however had not factored the quantity of additional issues into the planning assumptions.

- Data validation – 22 rules were completed with 257 in total remaining of these 160 were high priority for example registration or egg collection.

4.6. The committee asked the following further questions of the CIO

- how the senior management team and other relevant parties had engaged in the programme
- what the wider financial and resource implications were for the rest of the organisation
- what the plan was to manage reputational damage with the sector.

4.7. In light of the external assurance in place, the committee asked why these issues had only been identified at this late stage.

4.8. The CE commented that until very recently we were confident that we would deliver on the previously agreed launch date. The issues uncovered were very recent and we were conscious that this was not the first delay reported to the committee.

4.9. He further commented that delivering PRISM and the new register was our first priority and based on this the governance arrangements and overall ownership of the programme would remain with him so that he could continue to provide oversight on progress.

4.10. The CIO advised the committee that the Programme Manager working on the project had taken the decision to step away from the project (for personal reasons) with immediate effect, which posed a new and immediate risk.

4.11. He further suggested that due to the complexity of issues remaining, an 11 week timescale was now estimated for the completion of the work.

4.12. In response to a question, the CIO stated that following a discussion with data migration experts their opinion was that all issues had now been uncovered.

4.13. Members asked whether it was realistic for the end dates for a number of work programmes to be the same. Officers explained that the different work streams would be carried out in parallel by the different teams, so having similar deadlines was achievable.

4.14. It was also noted that a number of work streams were after the launch date. Officers advised that they were post go-live improvements, they were not major pieces of work and the launch of PRISM and the new register were not dependent on them. Members asked for the workstreams to be reviewed to ensure we do not go live too early as it may be better to include the post go-live improvements in the main release.

4.15. It was noted that communications would be going out to clinics about the revised launch date and that the current system would not be switched off on 20 December 2019 as previously indicated.

4.16. In terms of the budget it was noted that it would be reviewed within two weeks from the date of this meeting.

4.17. With regard the risk to reputational damage it was explained that we would communicate the benefits of the new system, principally that data would be verified automatically on submission into PRISM reducing the need for post data entry checks at the end of the month.

4.18. In response to a question about lost information officers responded that this was not a risk as clinics would hold the patient notes. The issue would be if patients wanted to go to another clinic then the new clinic would need to input the information again.

4.19. It was reiterated that clinics held more data than the Authority therefore if information was not in PRISM it would be at the clinic and in situations where patients went to a different clinic the new clinic would have to take the history again which meant extra work for clinics but no risk to patients.

4.20. Members noted that an imperfect version of PRISM, delivered faster, was not the right aim. It was therefore important to have a timetable that worked and included the planned product functionality. A new Programme Manager might bring useful new ideas to the process of finalising a new plan.

4.21. In terms of data security, members wanted the assurance that this would not be compromised and that the new launch date would allow sufficient time to complete all necessary actions.

4.22. A question was raised about the extra funds requested to continue the programme, and whether it was certain that it would assist in achieving the completed project. A discussion ensued and members requested a full understanding of the costs, including opportunity costs.

4.23. Colleagues from the NAO asked whether the funds requested would be treated as revenue expenditure in the financial statements. Officers confirmed this would be the case.

4.24. The Director of Finance and Resources commented that the funds previously allocated to this project were for the current financial year (2019/20). Next year the HFEA would have the office move and IT related risks, and we would need to look at how these two major pieces of work would co-exist. Running these two projects concurrently in an organisation the size of the HFEA would need to be carefully considered.

4.25. Members sought assurance of delivery and noted that:

- there would be weekly oversight of progress and risks by SMT
- the replacement of the Programme Manager position would commence immediately
- AGC would be briefed in early January 2020 on progress.

Action

4.26. Staff to lay out the options available and preferably get external assurance of the options which could be through a ‘critical friend’ arrangement.

4.27. When laying out the options and timetable, to balance this with other key issues happening in the organisation.

4.28. A paper should be prepared for January Authority, with a realistic timetable and costings for all options.

4.29. Communications with the sector.

4.30. AGC to continue to receive monthly updates.

4.31. Both the AGC Chair and the CE to brief to the Authority Chair on this discussion.

5. Strategy and Corporate affairs update

5.1. It was agreed that this item would be discussed at the next meeting of the AGC due to time constraints at this meeting.

6. Internal audit

6.1. The Internal Auditor provided an update on the progress of the 2019/2020 internal audit plan.

6.2. Five areas were reported on:

- External Information Requests – Members noted that this was originally in the plan as a Q2 audit, but HFEA management requested that this be put back until Q4 due to a number of staff changes which took place over the summer period. It was noted that the fieldwork was planned to start in January 2020.
- Risk Management of Capability Risks – Members were reminded that the final report was issued in October and tabled at the last (8 October 2019) AGC meeting.
- Corporate Governance – The final report was issued on 19 November and was an item to be discussed at this meeting.
- Records Management – It was noted that the scoping meeting had taken place and a draft terms of reference had been issued. The fieldwork was due to start in January 2020.
- Annual Budgeting Process – Members were advised that the fieldwork for this review was nearly complete and a draft report would be issued in December.

6.3. Regarding the recommendations issued by internal audit it was noted that most recommendations had been implemented with evidence provided and marked as closed. However there were seven recommendations that were overdue.

6.4. The final internal audit report on corporate governance was presented to the committee and rated as substantial. Members noted that this was the first of its kind and they were pleased with the report. They further commented that this was evidence that governance structures at HFEA were well defined and controlled.

6.5. The internal auditor agreed and reported that the governance structures in place clearly defined the roles and responsibilities assigned to committees and panels which supported effective decision making.

6.6. The HFEA's organisational structures remained effective in maintaining the high standing of the HFEA in the international community as an exemplar in delivering quality care and guidance.

6.7. The executive put on record their appreciation to the Planning and Governance team through the Head of service.

6.8. Members wanted to know how Authority members who participated in the audit would know the end result. The Chief Executive (CE) suggested that they could be sent the internal audit governance report for information.

6.9. The internal auditors confirmed that they would send the 2020 audit plan to the Director of Finance and Resources.

Action

6.10. The CE to send the internal audit report on governance to Authority members.

7. Progress with audit recommendations

7.1. The Head of Finance presented this item. It was noted that a number of recommendations had now been implemented but those remaining on the schedule as they were still outstanding are:

- business continuity planning
- training around fraud, bribery and corruption
- data loss
- capability – knowledge and skills gap

7.2. Other items had been completed and it was agreed that they would be removed.

7.3. Members noted the progress made with audit recommendations.

Action

7.4. Document to be updated as agreed.

8. External audit planning report

8.1. Mike Surman and Jill Hearne from the NAO presented to the committee and noted the two most significant risks that impacted their audit:

- Presumed risk of management override of controls
- Presumed risk of fraud in revenue recognition.

8.2. The following four areas were identified as the areas of focus for the audit:

- Completion of PRISM project
- Exiting the European union
- Implementation of IFRS 16: Leases
- Office relocation to Stratford.

8.3. The NAO representatives confirmed that they were planning to complete the audit in advance of the summer of 2020 Parliamentary recess.

8.4. In response to a question about how reliant we were on clinics to represent the facts, it was noted that the reporting system had been set up with updated forms so only the facts could be represented.

8.5. Members observed that there was unlikely to be any requirement for disclosure relating to HFEA's role in respect of EU regulations in the accounts. The NAO said they would revisit the wording of the audit response to this area of focus.

Action

8.6. Members considered the inquiries included on page 2 of the NAO's report. They had no matters to bring to the NAO's attention and were content that the risk assessment was complete.

9. Estates update

9.1. The Director of Finance and Resources gave an update to the committee. It was noted that the contract for the Stratford building was expected to be signed by the Department by February 2020 by which time the few elements causing the delay should have been resolved.

9.2. Further conversations will continue to happen with our staff to give them a better understanding of the proposed ways of working and packages available to staff for a transitional period after the move.

9.3. Members noted that a direct consequence of the move was the risk of an adverse impact on staff and turnover. The executive responded that this was part of the ongoing conversation and it would be kept under review.

Action

9.4. Members noted the estates update.

10. Resilience, business continuity management and cyber security

10.1. The CIO presented this item to the committee. It was noted that further Information governance and records management policies and procedures had recently been introduced.

10.2. Windows Defender Advanced Threat Protection (ATP) had also been installed across all laptops as part of the cyber security controls.

10.3. Members were also advised that in February 2020 there would be an upgrade to new security tokens for remote access.

10.4. In response to a question about the impact of these changes as we were relocating to a new office in 2020 it was noted that the kit was cloud based so there would be minimal impact.

10.5. Regarding members and access to the new remote system, officers confirmed that it was a different and an easier new system to implement.

Action

10.6. Members noted the report.

11. Strategic risk register

11.1. The Risk and Business Planning Manager presented an overview of the strategic risk register. It was noted that this was last reviewed by the Authority at their November meeting and two of the six risks were above tolerance.

11.2. It was explained to members that as at November we had a new source of risk relating to Authority member appointments and SMT had viewed this risk as above tolerance. There were currently two vacancies and so far there was no agreement on when a recruitment campaign could begin, which was handled centrally by the Department of Health and Social Care (DHSC). The Chair's term of office expired at the end of March 2020, although the HFEA was waiting to hear if this term had been extended, and there would be two further vacancies in November 2020. Looking further ahead, another seven members' terms of office would expire in 2021. Much therefore would

depend on the Government's policy on reappointment and timescales for recruitment, but the detrimental possible impact on Authority capability and functions was clear.

11.3. Members commented that there remained the need to ensure that the board and its committees were able to continue to function effectively.

11.4. In response to a question on why there has been a DHSC policy change on reappointments, the DHSC representative clarified that there has not been a change in DHSC policy and that appointments continue to take place in line with Cabinet Office guidance, which recommends that '…there is no automatic presumption of reappointment; each case should be considered on its own merit, taking into account a number of factors including, but not restricted to, the diversity of the current board and its balance of skills and experience'. Members were also reminded that the current purdah rules meant that there has been a delay in appointments across Government. The DHSC sponsor and appointments team were aware of the risks to delivery of HFEA key decision-making functions and were taking appropriate action to mitigate these as far as possible.

11.5. Officers suggested that part of the mitigation to be put in place was to have member handover and effective inductions. They would however continue to engage with the DHSC to press for an early decision on appointments and commencement to recruitment.

11.6. Members suggested that in the absence of information from the Department, the Executive should explore the option of approaching members whose terms of office were coming to an end and asking if they would be willing to stay on temporarily. This would enable the HFEA to continue to perform its licensing duties under the Act, as members of the HFEA possessed particular expertise and took quasi-judicial decisions. This approach could enable members to be retained temporarily until the Department was able to formally replace or renew them.

11.7. It was also requested that this risk be escalated to the Department's risk register.

11.8. Following discussion, it was noted that the risk register would be reviewed in relation to financial viability and regulatory effectiveness in the light of changes relating to the digital projects covered earlier in the meeting.

Action

11.9. The AGC noted the latest edition of the risk register and requested that the activity and income forecasting presentation prepared by the Director of Finance and Resources and shared with Authority members in their workshop be circulated to the independent members on the committee.

12. Human Resources report

12.1. The Head of Human Resources presented a report providing a broad overview of work that had taken place in the last six months to help improve employee retention and engagement through the introduction of a new values and behaviours framework and the ongoing preparation to support the move to Stratford in 2020.

12.2. Members noted that in the report the most common reasons identified in exit interviews for staff wishing to leave the organisation were: pay, lack of progression opportunities and poor relationships with line manager/senior managers, which was a new factor.

12.3. The Head of Human Resources stated that she was currently liaising with the Health Leaders Academy regarding developmental opportunities for middle managers as part of the work to upskill

managers to better support their staff. Another way was by providing management development opportunities for middle and senior managers in the new financial year.

People strategy

12.4. It was noted that work was underway to complete the people strategy for the period 2020 – 2023.

12.5. Members were advised that the objectives in the strategy included:

- Improving leadership capability
- Attracting and developing a diverse and high performing workforce
- Building a culture and healthy working environment that promotes collaboration and innovation
- Creating an agile workforce to support the delivery of our strategic goals.

12.6. Members noted that the strategy would be launched in the spring to all staff following sign-off.

Staff turnover

12.7. At the June 2019 AGC meeting members were advised that staff turnover was at 27%. Over the last 6 months turnover has reduced to 20% but this is still above the target maximum of 15%.

12.8. To further reduce turnover members were informed that a new pay and grading system was introduced over the summer. The aim was to reduce variation and make it easier for staff to see a clearer line of sight between their current position and the next level.

Office move

12.9. Members were advised that a staff survey seeking views on the impact of the move to Stratford and what, if anything the organisation could do to alleviate any concerns, was also discussed.

12.10. It was noted that 55 out of 67 staff completed the survey.

- 58% of 55 staff (ie, 33) felt they would incur an increase in cost or longer commute times
- Of that 33, 12% (ie, 4) believed their journey time would increase by longer than an hour
- Of that 33, 35% (ie, 11) believed their journey cost would increase by more than £7.50.

12.11. Members were further advised that staff were also asked what could be done to reduce the impact of the move. 44 people responded and 45% of those (ie,19) said that more opportunities to work from home would help.

12.12. The Chief Executive commented that a final decision was yet to be made but we were considering meeting excess fares for a period of up to 2/3 years following the move probably as an upfront payment as a means of retaining staff. However he commented that if the money was paid upfront it would be conditional on staff remaining with the organisation for a period of time or refunding the money.

12.13. It was noted that further work was ongoing in this area and AGC would be advised of developments.

Values and behaviours framework

12.14. The committee was advised that the current values and behaviours framework was being refreshed.

12.15. It was noted that a small cross section of staff representing all areas of the organisation had worked together to produce a new summary of the values and behaviours which would be shared with all staff at the 9 December 2019 all staff away day.

12.16. Members were advised that the intention was that the new framework would provide greater clarity at all levels across the organisation on what could be expected from leaders and managers.

12.17. It was felt that this would help improve staff engagement through a clearly articulated and shared understanding and commitment to the new values and behaviours.

Action

12.18. Members noted the Human Resources update.

13. Audit and Governance Committee forward plan

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

13.2. It was noted that the Strategy and Corporate Affairs report would be presented to the March 2020 committee meeting.

13.3. Members were advised that the loading of the next agenda would need to be considered after the meeting.

Action

13.4. Members noted the forward plan.

13.5. The Head of Finance was asked to review the next agenda and consider whether all the planned business could be accommodated.

14. Register of gifts and hospitality

14.1. The register of gifts and hospitality was presented to the committee.

14.2. It was noted that there was ongoing work with staff to ensure that they declared all gifts offered (accepted and declined).

Action

14.3. Members noted the entries in the register.

15. Reserves policy

15.1. The Director of Finance and Resources re-presented the reserves policy as the committee had requested that this be brought back to AGC with the exact reserves figure being proposed.

15.2. The revised rationale for our minimum reserve was discussed.

15.3. It was explained that the HFEA from time to time would experience negative cashflow (more payments than receipts) in some months but overall there was a net positive position.

15.4. Members expressed satisfaction with the explanation provided.

15.5. In response to a question raised about carrying funds over from one financial year to the next, staff confirmed that a resolution would be found with the Department at some point although the preferred position was that any excess funds be used to the benefit of patients.

15.6. Members requested that the fees paper be circulated to the non-Authority members on the committee to give them a better understanding of the treatment of fees.

Action

15.7. Members approved the amended policy.

15.8. The fees paper be circulated to the committee.

16. Whistle blowing and fraud – counter fraud progress report

16.1. The Director of Finance and Resources presented the counter fraud progress report to the committee.

16.2. The committee were reminded that in June 2019 we brought to the attention of the committee the Government Functional Standards; Counter Fraud that were introduced in January 2018.

16.3. Part of the requirements from the Cabinet Office was that all government organisations submit evidence of their preparedness to meeting these standards by September 2019. This had been done, although no response has yet been received.

16.4. Notwithstanding this, we have continued to make progress towards completing the actions listed in the strategic action plan.

16.5. It was noted that no other ALB had heard from the Cabinet Office.

Action

16.6. The committee noted the progress made in completing the actions listed in the strategic action plan.

17. Contracts and procurement

17.1. There were no contracts signed for this period.

18. Any other business

18.1. There was no other business to discuss.

19. Chair's signature

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

Signature

Name

Anita Bharucha

Date

10 March 2020

Matters arising from previous AGC meetings

Strategic delivery:	☐Safe, ethical, effective treatment	☒Consistent outcomes and support	☐Improving standards through intelligence
Details:			
Meeting	Audit and Governance Committee		
Agenda item	3		
Paper number	HFEA (10/03/2020) MA		
Meeting date	10 March 2020		
Author	Morounke Akingbola (Head of Finance)		
Output:			
For information or decision?	For information		
Recommendation	To note and comment on the updates shown for each item.		
Resource implications	To be updated and reviewed at each AGC		
Implementation date	2019/20 business year		
Communication(s)			
Organisational risk	☐ Low	X Medium	☐ High

Numerically:

- 4 items carried over from earlier meetings, 1 ongoing
- 7 items added from October 2018 meeting, 1 ongoing
- 10 items added from June 2019 meeting, 4 ongoing
- 9 Items removed: 4.9 (5 Mar-19), 4.20,5.6,6.6,7.7,7.8,7.9,7.11,13.2 (18 June-19)
- Item 9.10 from June 18 combined with 10.6 June 19, item 3.8, 4.10,7.6 (8 Oct-19) removed

ACTION	RESPONSIBILITY	DUE DATE	PROGRESS TO DATE
Matters Arising from the Audit and Governance Committee – actions from 12 June 2018 and 18 June 2019 meeting			
4.7 Committee to be kept updated on the outcome of the meeting with the Cabinet Office – Fraud standards	Director of Finance and Resources	On-going	**Update –** Nothing directly from Cabinet Office. Head of Finance attended Counter Fraud Liaison Group meeting where it was suggested that feedback would happen at the end of March 2020.
10.6 Chief Information Officer to give monthly updates on the progress of the Digital Programme	Chief Information Officer	On-going	**Update –** an item on the agenda
Matters Arising from the Audit and Governance Committee – actions from 8 October 2019 meeting			
5.6 A reminder is to be sent to members about IT security training.	Committee Secretary	Jan-20?	**Update –** Reminder sent. Discussion took place on 29 Jan's Authority. 7/12 Members have completed the training. Remainder yet to respond.
Matters Arising from the Audit and Governance Committee – actions from 3 December 2019 meeting			
4.26 Staff to lay out the options available and preferably get external assurance of the options which could be through a 'critical friend' arrangement	Chief Information Officer	Mar-20	**Update –** An update paper and new plan was provided to aGC in January. Authority was updated in a pre-Board session
4.28 A paper should be prepared for January Authority, with a realistic timetable and costings for all options	Chief Information Officer	Jan-20	
4.29 Communications with the sector	Chief Executive	Jan-20	**Update –** This was done following 29 Jan 20 Authority
4.30 AGC to continue to receive monthly updates	Chief Executive	On-going	**Update -** updates are being provided

4.31 AGC Chair and Chief Executive to brief the Authority Chair on this discussion	AGC Chair/CEO	Jan-20	**Update –** The Authority Chair is regularly updated - *Committee to agree this can be removed.*
6.10 CEO to send internal audit report on governance to Authority members	Chief Executive	Jan-20	**Update –** Reported at the Authority meeting 29 January
11.9 The activity and income forecasting presentation prepared by the Director of Finance and Resources and shared with Authority members in their workshop be circulated to the independent members on the committee.	Director of Finance and Resources	Feb-20	**Update –** This has been done.
13.5 Review the next agenda and consider whether all the planned business could be accommodated	Head of Finance	Feb-20	**Update -** agenda reviewed. Noted that updates from 3 Directors may have a significant impact on the agenda. SMT to agree to defer 2 of the 3.
15.8 Fees paper to be circulated to the committee	Director of Finance and Resources	Feb-20	**Update –** Paper sent to AGC Members on 4/3/2020.

Digital Programme Update – March 2020

Strategic delivery:	☐ Safe, ethical, effective treatment	☒ Consistent outcomes and support	☒ Improving standards through intelligence
Details:			
Meeting	Audit and Governance Committee		
Agenda item	4		
Paper number	AGC (10/03/2020) DH		
Meeting date	10 March 2020		
Author	Dan Howard, Chief Information Officer		
Output:			
For information or decision?	For information		
Recommendation	The committee is asked to: • Note the progress to date and consider whether they have sufficient reassurance to approve spending on PRISM into 2020/21. • Consider when they would next want to have a further 'oversight meeting' to review progress on PRISM and what date that should be? • Consider what approvals they want to make (or see in place) before communicating a launch date to the sector and what interim communications should happen.		
Resource implications			
Implementation date	July 2020		
Communications	None		
Organisational risk	☐ Low	☐ Medium	☒ High
Annexes			

1. Introduction

1.1. The AGC met informally on 27th February 2020 to review programme on PRISM. This paper provides a short update on progress in the 12 days following that meeting.

2. External Assurance

2.1. We previously stated that NHSX had agreed to provide external assurance on the Completion Plan. This work was due to start shortly and the assurance report may be available for the AGC to consider at its 10 March meeting

2.2. Subsequently, all the programme planning documentation surrounding PRISM has been sent to Tim Donohoe, Director of Delivery and Operations at NHSX for his review. We are currently awaiting his feedback.

3. 2020/21 Funding for PRISM Completion

3.1. We previously stated that we had reached an agreement with the DHSC whereby the additional estimated cost of PRISM in 2020/21 (£300k) would be met through additional Grant In Aid. The DHSC contribution would depend on the volatility of treatment income in 2020/21 with the GIA reducing if the HFEA received more income than currently forecast.

4. Progress on delivering the PRISM Completion Plan

General Update for both PRISM Development and Data Migration

4.1. We have just completed week 8 (out of 29 to launch, 22 to final testing) of the Completion Plan.

4.2. As of 6th March 2020, **the Completion Plan is 42% completed (for final testing) with 30% of the contingency used**, as shown in Table 1 below from the weekly SMT progress report:

TABLE 1: 'Overall Plan Performance' as reported to SMT and Programme Board on 6th March 2020

	Week 8 of the Completion Plan	PRISM Development (PD)		Legacy Data Migration (DM)	
Planned	Completion days to date delivered to plan	+5 this wk =	36	+5 this wk =	37
	Planned completion days remaining	+2 this wk =	51	+0 this wk =	26
	% complete until 'ready to test' (Vs 'expected')	('expected' 48%)	**41%**	('expected' 85%)	**59%**
Unplanned	Contingency days used to date	+2 this wk =	8	+0 this wk =	19
	Contingency days remaining		19		36
	% contingency used		**30%**		**35%**

**Workstreams amber lighted if 33% contingency used, red if 66%. 'expected' = original plan / zero contingency*

Note: We show above an 'expected position' for Data Migration (DM) of 85%. However this a forecast based on zero contingency which in DM terms mean 'no new DQRs' which is not a wholly realistic assumption. Moreover on DM we will observe a further divergence between these figures as work progresses and we aim to maximise the pre-launch impact of our expert analyst. Please note 4.8 to 4.11 below for a further explanation of this. **Prism Development (PD) remains the 'critical path' from which overall programme progress should be inferred.**

4.3. As we explained at the last AGC meeting, the performance table tracks planned and unplanned days against the Completion Plan (as they are the 'common currency' across the different programmes of work), and **the key message is that we currently remain on plan to launch PRISM as originally planned at the end of July 2020.**

Also, given PRISM was about 80% built at the start of the Completion Plan, this means that as of today**, the PRISM system is approximately 88% complete in terms of its 'overall build'.**

Update on Forecast Milestones and Deadlines

4.4. The PRISM Completion Plan is not a 'tablet of stone' and we essentially reforecast it every week as we reconcile our overall plan to individual 'workstream sprints'. Our current forecast of when milestones and deadlines will be achieved is as per Table 2 below:

TABLE 2: 'Milestone tracker' as reported to SMT and Programme Board on 6th March 2020

	Milestones and Deadlines *(we will closely track and add an actual date when complete)*	**Original Date**	**Forecast Date**	**Actual Date**
Milestones*	PD: Complete preliminary work on 'CoR' and soft deletion	14th Feb	21st Feb	21st Feb
	PD: Complete all remaining major PRISM functionality	23rd Apr	23rd Apr	
	DM: Complete long fix DQRs in data migration	14th Feb	14th Feb	18th Feb
	DM: Anticipated date for 'zero DQRs'	30th Apr	19th May	
	Transition: Complete 'cut-over plan' for business processes	31st Mar	31st Mar	
Deadlines	**PRISM development complete** and ready for final testing	**5th Jun**	**5th Jun**	
	PRISM completed testing and **ready to launch**	10th Jul	10th Jul	
	PRISM launches to stakeholders	**31st Jul**	**31st Jul**	

** Milestones are with zero contingency applied. If a re-forecast milestone will impact a 'deadline' then this will trigger an alert*

PRISM Development

4.5. Our PRISM development team continue to work through the last remaining items of major PRISM functionality ('change of role', 'soft deletion' and 'donor forms'). They are currently confident of completing these elements of work by the '2nd development milestone' of 23rd April 2020.

4.6. Thereafter, the remaining development work is on areas of lower risk (remaining validation rules, reporting, dashboard development). Therefore, if we successfully hit that second milestone, we will be very confident of then having a launch version of PRISM that is ready to test by the 5th June and ready to launch by 10th July (with an actual launch at the end of July 2020).

4.7. Also, although we have 'amber-lighted' Data Migration (see below), we still categorise the overall programme as 'green' as it the PRISM Development workstream that remains the 'critical path'.

Data Migration

4.8. On Table 1, ACG will note that data migration performance has 'tipped into the amber'. This is because we accounted for new legacy data work identified after the completion of the first data migration milestone, and we have also reduced our contingency by two weeks to account for leave that our expert analyst member of staff is planning to take but has not yet booked.

4.9. As recorded in the original Completion Plan, 'curation of legacy HFEA data' is an ongoing exercise for our expert analyst and he will always have a supply of legacy data quality tasks to address. However only a proportion of these are essential for PRISM launch, although it is often easier to fix quality issues 'in development' rather than after.

4.10. We will therefore be categorising future data migration / data quality tasks (DQRs) between those essential for launch and those which can be completed before or after without compromising use or functionality, and we will be signing off DQR impact assessments at the forthcoming Programme Board in early March.

Thereafter we will sequence the remaining tasks in terms of 'essential for launch' and then 'maximum additional benefit' and we will then rework our data migration plan to ensure our expert analyst maximises his impact in the all the time available before PRISM launch without there being any delay to it.

4.11. In short, once PRISM is built and 'ready to launch', we will not be intending to delay launch to clinics because of data migration DQRs on legacy data that could be addressed afterwards.

Choose a Fertility Clinic (CaFC) Reports

4.12. The last CaFC report was published in October 2019. To ensure regular reports we have investigated how we might publish a further CaFC report in the summer of 2020 using data to December 2019 whilst at the same time ensuring the launch of PRISM. Of course, the risk of running CaFC at this time is that it could cause distraction when focus needs to be on PRISM.

AGC should also note that the following CaFC update will then be derived wholly from PRISM, concerning which there need to be allowance for the writing of new extract reports.

4.13. To mitigate this risk of distraction in the run up to launch, we have conducted detailed feasibility planning to ensure that both can progress in parallel. We have identified a revised 'one-off' process for this report involving contributions from staff less involved in PRISM, and the Programme Board will also want assurance from reconciliation tests on the current progress of data migration before signing off on the commencement of a CaFC process.

4.14. If signed off, as well as ensuring a regular frequency of reporting to the sector, this will also have additional benefits of spreading technical expertise across a wider staff base and helping HFEA in its ambition to move away from being reliant on a handful of people.

5. Communications to the Sector

5.1. On the 27th February AGC discussed the date at which the sector should be advised of a new launch date for PRISM. Such a communication should balance:

- Ensuring we can be certain of any launch date we publish
- Ensuring the sector are given sufficient time for their own launch preparations

5.2. The PRISM programme team would continue to advise that successful completion of the second development milestone (currently 23rd April) would represent for them a step change in their own confidence regarding any predicted launch date.

5.3. Communicating a launch date at the end of April would give the sector a full three months to prepare for any launch of PRISM at the end of July.

5.4. If AGC consider this an acceptable way forward, an interim communication indicating a 'summer' launch may be a way of keeping clinics informed before we communicate an actual launch date.

6. Recommendation

6.1. The committee is asked to:

- Note the progress to date and consider whether they have sufficient reassurance to approve spending on PRISM into 2020/21.
- Consider when they would next want to have a further 'oversight meeting' to review progress on PRISM and what date that should be?
- Consider what approvals they want to make (or see in place) before communicating a launch date to the sector and what interim communications should happen.

Resilience, Business Continuity Management and Cyber Security

Strategic delivery:	☒ Setting standards	☐ Increasing and informing choice	☒ Demonstrating efficiency economy and value
Details:			
Meeting	Audit and Governance Committee (AGC)		
Agenda item	8		
Paper number	AGC (10/03/2020) DH		
Meeting date	10 March 2020		
Author	Dan Howard, Chief Information Officer		
Output:			
For information or decision?	For information		
Recommendation	The Committee is asked to note: • The server power incident on 20 February and our response • The Register incident on 3 February and the investigation • The planned work to improve switchboard and our telephony system over the next three months • The planned work to migrate databases from physical servers into the Microsoft Azure cloud • Details of improved cyber security controls on HFEA laptops, and • The recent improvements to electronic document management		
Resource implications	Within budget		
Implementation date	Ongoing		
Communication(s)	Regular, range of mechanisms		
Organisational risk	☐ Low	☒ Medium	☐ High
Annexes:	None		

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. An incident relating to server room power failure took place on 20 February resulting in server downtime impacting on access to IT services. Further details are below.

1.3. Our Data Protection Officer is investigating the circumstances surrounding a Register enquiry and our response.

1.4. We will be making further improvements to our switchboard, telephony system and wider IT infrastructure ahead of our office move later this year. Further details are available below.

1.5. Improvements are being made to our electronic Document Management System (Content Manager) to include staff engagement, retention schedules, and additional training.

2. Server room incident

2.1. On Thursday 20 February at approximately 10.15pm there was an issue in the server room in Spring Gardens.

2.2. The backup UPS (Uninterruptable Power Supply) provided by NICE activated because a trip switch was triggered. As a result the UPS could not receive mains power and its batteries provided around 30 minutes of power. At around 10.45pm most services running on physical servers went off-line.

2.3. An investigation into the incident started as soon as we were aware of the incident which was at around 7.45am on Friday 21 February.

2.4. This issue affected access to systems on physical servers but more importantly affected network connectivity to staff working in Spring Gardens. There were fewer than 10 people in the office on Friday 21 February who could not access systems such as Epicentre, Content Manager and email for most of the day. Staff working remotely could access major systems such as email, internet, Content Manager (document management system) although some systems (Epicentre, WAP – finance system) were unavailable.

2.5. At around 1pm on Friday 21 February power was restored to the server room. The servers were all restarted and were working again by 4.10pm.

2.6. The third party facilities management supplier for NICE responsible for power and the UPS is investigating to reduce the likelihood of a further issue occurring and we will provide CMG (Corporate Management Group) with a lessons learned and full incident report shortly.

3. Register incident

3.1. On Monday 3 February an information request was received from a local child death review panel to confirm whether or not an individual had received licensed fertility treatment within the UK. We responded confirming that there was no record of treatment. The following day a second request was received from the same requestor. Following an internal review no further information was provided.

3.2. The circumstances surrounding this enquiry are being investigated by our (external) Data Protection Officer at the Human Tissue Authority who will report back in due course.

4. Infrastructure improvements

Telephony

4.1. Our switchboard is due to be upgraded over the next three months. This will provide a better user experience and increased stability.

4.2. Ahead of this taking place (and to support the new switchboard) we will be upgrading our instant messaging and telephony system to Microsoft Teams. CMG will be considering this change at its March meeting, along with the governance relating to its use. Installation, configuration and training for Teams will take place before summer.

4.3. This change aligns to our overall strategy of migrating services away from physical servers ahead of the office move.

Advanced Threat Protection and database migration

4.4. Following the successful deployment of ATP we are continuing to upgrade associated software, such as Microsoft InTune on all laptops. InTune is an upgraded product designed to support the secure management of mobile devices through security policies and configuration settings. ATP is a software security product, provided by Microsoft as part of our Windows 10 license agreement designed to improve cyber security controls.

4.5. We continue to move Microsoft SQL databases from physical servers into the Microsoft Azure cloud ahead of our office move.

5. Information Governance and Document Management

Document Management System (Content Manager)

5.1. Retention Schedule: First quarterly meeting was held with Heads in January 2020 to support the process for reviewing and deleting records. Information Champions have been assigned within each business area to promote good records management within teams. Next quarterly meeting will take place in March 2020.

5.2. Audit logs: Both active and offline audit logs are now active in CM to track any changes made to a record.

5.3. Document Management training: Additional training in Content Manager (for new staff and as a refresher) was provided in February 2020, this included the basic competencies all staff should have. A new IG section on the Intranet was also recently launched.

Audits

5.4. Opening The Register / FOI / PQ and Records Management audits are ongoing and we expect initial feedback shortly.

6. Recommendation

The Committee is asked to note:

- The server power incident on 20 February and our response
- The Register incident on 3 February and the investigation
- The planned work to improve switchboard and our telephony system over the next three months

- The planned work to migrate databases from physical servers into the Microsoft Azure cloud,
- Details of improved cyber security controls on HFEA laptops, and
- The recent improvements to electronic document management

Strategic risk register

Strategic delivery:	☒ Safe, ethical, effective treatment	☒ Consistent outcomes and support	☒ Improving standards through intelligence
Details:			
Meeting	Audit and Governance Committee		
Agenda item	9		
Paper number	AGC (10/03/2020) HC		
Meeting date	10 March 2020		
Author	Helen Crutcher, Risk and Business Planning Manager		
Output:			
For information or decision?	For information and comment		
Recommendation	AGC is asked to note the latest edition of the risk register, set out in the annex.		
Resource implications	In budget.		
Implementation date	Strategic risk register and operational risk monitoring: ongoing. SMT review the strategic risk register monthly. AGC reviews the strategic risk register at every meeting. The Authority reviews the strategic risk register periodically (at least twice per year).		
Communication(s)	Feedback from AGC will inform the next SMT review in March.		
Organisational risk	☐ Low	☒ Medium	☐ High
Annexes	Annex 1: Strategic risk register		

1. Latest reviews

1.1. SMT reviewed the register at its meeting on 19 February. SMT reviewed all risks, controls and scores.

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

1.3. Three of the six risks are above tolerance.

2. New strategic risk register development

2.1. Work is underway to develop a new strategic risk register for the start of the next strategic period in April 2020. This will be aligned to the strategic goals for 2020-2023 and will contain strategic risks as well as core high-level risks which underpin the organisation's ability to operate and deliver both its core functions and strategy.

2.2. The register is still a work in progress, but we would appreciate a conversation with AGC about the new strategic risks identified, which will be presented during the meeting, and the progress made so far.

3. Recommendation

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

Latest review date – 19/02/2020

Strategic risk register 2019/20

Risk summary: high to low residual risks

Risk area	Strategy link*	Residual risk	Status	Trend**
C2: Board capability	Generic risk – whole strategy	**16 – High**	Above tolerance	(New risk Dec) - ⇔⇧
RE1: Regulatory effectiveness	Improving standards through intelligence	**12 – High**	Above tolerance	⇔⇔⇔⇧
FV1: Financial viability	Generic risk – whole strategy	**12 – High**	Above tolerance	⇔⇔⇔⇧
C1: Capability	Generic risk – whole strategy	**12 – High**	At tolerance	⇔⇩⇔⇔
CS1: Cyber security	Generic risk – whole strategy	**9 – Medium**	At tolerance	⇔⇔⇔⇔
LC1: Legal challenge	Generic risk – whole strategy	**8 – Medium**	Below tolerance	⇔⇔⇔⇔
ME1: Effective communications	Safe, ethical effective treatment Consistent outcomes and support	**6 – Medium**	At tolerance	⇔⇔⇔⇔
E1: Relocation of HFEA offices in 2020	Generic risk – whole strategy	**6 – Medium**	Below tolerance	⇔⇔⇔⇔

* Strategic objectives 2017-2020:

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

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

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

Consistent outcomes and support: Improve access to treatment

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

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

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

Recent review points are: AGC 3 December 2019⇨ SMT 11 December 2019 (capability risks only) ⇨ SMT 20 January ⇨ SMT 19 February (with updates to Finance risk in early March)

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

Inherent risk level:			**Residual risk level:**		
Likelihood	Impact	Inherent risk	**Likelihood**	**Impact**	**Residual risk**
5	4	20– High	**4**	**3**	**12 – High**
Tolerance threshold:					**9 - Medium**
Status: **Above tolerance**					

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

Commentary
We are experiencing a drop in treatment volumes. The HFEA is able to meet its financial commitments in this financial year, however, there is uncertainty over future year income which could place budgetary pressures on the organisation in the next financial year. The delays in completing the data migration element of the digital projects increased costs in 2019/20, we are confident that we will be able to absorb these costs. We were provided with an additional £300k from the department for 2020/21. Whilst the project is still incomplete some financial risk remains. In the light of these developments we raised this risk score in March 2020. A licence fee review in 2020/21 and very close scrutiny of both income projections and planned expenditure should allow us to manage to our agreed control totals and reduce this risk in the medium term.

Causes / sources	Mitigations	Timescale / owner
There is uncertainty about the annual recovery of treatment fee income – this may not cover our annual spending. Since the start of Quarter 3, treatment volumes have been below historic trends, and are likely to fall short of our budgeted target for 2019/20.	Heads see quarterly finance figures and would consider what work to deprioritise or reduce should income fall below projected expenditure. We have a model for forecasting treatment fee income, and this reduces the risk of significant variance, by utilising historic data and future population projections. We will refresh this model quarterly internally and review at least annually.	Quarterly, ongoing, with model review at least annually - reviewed by Authority in January 2020- Richard Sydee
Although we have a model for predicting income, recent activity has led to more volatility in our model. This has led to us having	We will ensure there is close monitoring of the next few quarters' activity. If required, we would follow this up with a review of planned work, to reprioritise as required and assess and mitigate the impact on strategic delivery.	Ongoing – Richard Sydee

less confidence in the model for predicting future trends. Should the 'most likely' scenario continue we would have a shortfall in 2020/21.	The 2020/21 business plan includes a review of the licence fee structure, which should address these pressures from 2021/22.	
Our monthly income can vary significantly as: • it is linked directly to level of treatment activity in licensed establishments • we rely on our data submission system to notify us of billable cycles. As at February 2020, some issues with data submission have impacted submission of data from a small number of clinics.	Our reserves policy takes account of monthly fluctuations in treatment activity and we have sufficient cash reserves to function normally for a period of two months if there was a steep drop-off in activity. The reserves policy was reviewed by AGC in December 2018. If clinics were not able to submit data and could not be invoiced for more than three months we would invoice them on historic treatment volumes and reconcile this against actual volumes once the submission issue was resolved and data could be submitted. We intend to take the above approach at year end for those clinics where we have found that data submission is an issue.	Ongoing – Richard Sydee In place – Richard Sydee
Annual budget setting process lacks information from directorates on variable/additional activity that will impact on planned spend.	Annual budgets are agreed in detail between Finance and Directorates with all planning assumptions noted. Quarterly meetings with Directorates flag any shortfall or further funding requirements. All project business cases are approved through CMG, so any financial consequences of approving work are discussed.	Quarterly meetings (on-going) – Morounke Akingbola Ongoing – Richard Sydee
Additional funds have been required for the completion of the data migration work in 2019/20 and this will constrain HFEA finances and may affect other planned and ad hoc work. Looking ahead, we have been granted £300k of additional grant-in-aid funding for completing the work in 2020/21. Should the project not complete as planned, this would put additional pressure on HFEA finances.	Ongoing monitoring and reporting against control totals to ensure we do not overspend. Where possible, costs in 2019/20 were covered by the IT budget, reducing the impact on key delivery teams and other strategic deliverables. Approaching year end, we have reviewed budgets are confident that we will be able to absorb the additional pressure in this financial year, primarily due to underspends in the legal budget. As long as the project completes as planned, there should be no further financial pressures in 2020/21.	Ongoing – Richard Sydee Ongoing – Richard Sydee
Inadequate decision-making leads to incorrect financial forecasting and insufficient budget.	Within the finance team there are a series of formalised checks and reviews, including root and branch analyses of financial models and calculations. The organisation plans effectively to ensure enough time and senior resource for assessing core budget assumptions and subsequent decision making.	In place and ongoing - Richard Sydee Quarterly meetings (on-going) – Morounke Akingbola

Project scope creep leads to increases in costs beyond the levels that have been approved.	Finance staff member present at Programme Board. Periodic review of actual and budgeted spend by Digital Projects Board (formerly IfQ) and monthly budget meetings with finance. Any exceptions to tolerances are discussed at Programme Board and escalated to CMG at monthly meetings, or sooner, via SMT, if the impact is significant or time-critical.	Ongoing – Richard Sydee or Morounke Akingbola Monthly (on-going) – Olaide Kazeem
Failure to comply with Treasury and DHSC spending controls and finance policies and guidance may lead to serious reputational risk and a loss of financial autonomy or goodwill for securing future funding.	The oversight and understanding of the finance team ensures that we do not inadvertently break any rules. The team's professional development is ongoing, and this includes engaging and networking with the wider government finance community. All HFEA finance policies and guidance are compliant with wider government rules. Policies are reviewed annually, or before this if required. Internal oversight of expenditure and approvals provides further assurance (see above mitigations).	Continuous - Richard Sydee Annually and as required – Morounke Akingbola
Risk interdependencies (ALBs / DHSC)	**Control arrangements**	**Owner**
DHSC: Legal costs materially exceed annual budget because of unforeseen litigation.	Use of reserves, up to appropriate contingency level available at this point in the financial year. The final contingency for all our financial risks would be to seek additional cash and/or funding from the Department.	Monthly – Morounke Akingbola
DHSC: GIA funding could be reduced due to changes in Government/policy.	A good relationship with DHSC Sponsors, who are well informed about our work and our funding model.	Quarterly accountability meetings (on-going) – Richard Sydee
	Annual budget has been agreed with DHSC Finance team. GIA funding has been provisionally agreed through to 2021.	December/January annually, – Richard Sydee

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

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

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

Commentary
This risk and the controls are focused on business as usual capability, rather than capacity, though there are obviously some linkages between capability and capacity. For 18/19 turnover was 26.8%. Evidence suggests that the two main drivers of high turnover are the continuing constraints on public sector pay and the relatively few development opportunities in small organisations like the HFEA. In response, we have revised our recruitment strategy using a wider range of national and social media and recruitment agencies to improve the number and quality of applicants. This approach is having some success and we have in recent months attracted several high-quality candidates. We are also taking active steps to improve retention, focussing on things that we can control like learning and development. Turnover in the year to end January 2020 has reduced, to 18.2% AGC receive 6-monthly updates on capability risk to consider our ongoing strategies for the handling of these, to allow them to track progress. Looking further ahead, we need to find ways to tackle the issue of development opportunities, to prevent this risk increasing further. An idea we are keen to explore is whether we can build informal links or networks with other public sector or health bodies, to develop clearer career paths between organisations. We have two Authority member vacancies which create Board capability gaps, these risks are captured in the separate C2 risk, below.

Causes / sources	**Mitigations**	**Timescale / owner**
High turnover, sick leave etc., leading to temporary knowledge loss and capability gaps.	Organisational knowledge captured via documentation, handovers and induction notes, and manager engagement. We have developed corporate guidance for all staff for handovers. A checklist for handovers is circulated to managers when staff hand in their notice. This checklist will reduce the risk of variable handover provision.	In place – Yvonne Akinmodun Checklist in use – Yvonne Akinmodun

	Vacancies are addressed speedily, and any needed changes to ways of working or backfill arrangements receive immediate attention. CMG and managers prioritise work appropriately when workload peaks arise. Contingency: In the event of knowledge gaps we would consider alternative resources such as using agency staff if appropriate.	In place – Yvonne Akinmodun In place – Peter Thompson In place – Relevant Director alongside managers
The Director of Compliance and Information is new in post, there will naturally be a settling in period, meaning that there may be a small continuing resource pressure for a time.	The new postholder has a background in the sector, which will reduce the learning curve and will bring valuable capabilities to the role. A full induction is underway and other staff will be able to support on tasks as required during the induction period.	Underway – Peter Thompson
Poor morale could lead to decreased effectiveness and performance failures.	Communication between managers and staff at regular team and one-to-one meetings allows any morale issues to be identified early and provides an opportunity to determine actions to be taken. The staff intranet enables regular internal communications. Ongoing CMG discussions about wider staff engagement (including surveys) to enable management responses where there are areas of particular concern. Policies and benefits are in place that support staff to balance work and life (such as the buying and selling of annual leave policy and PerkBox) promoting staff to feel positive about the wider package offered by the HFEA. This may boost good morale.	In place, ongoing – Peter Thompson In place – Jo Triggs In Place – Yvonne Akinmodun In place - Peter Thompson
Increased workload either because work takes longer than expected or reactive diversions arise.	Careful planning and prioritisation of both business plan work and business flow through our Committees. Regular oversight by CMG – standing item on planning and resources at monthly meetings.	In place – Paula Robinson
	Oversight of projects by both the monthly Programme Board and CMG meetings, to ensure that projects end through due process (or closed, if necessary). Work is underway to review our interdependencies matrix, which supports the early identification of interdependencies in projects and other work, to allow for effective planning of resources.	In place – Paula Robinson Matrix relaunching 2019/20 – Paula Robinson
	Learning from Agile methodology to ensure we always have a clear ‘definition of done’ in place, and	Partially in place – further work to be

	that we record when products/outputs have met the 'done' criteria and are deemed complete.	done in 2019/20 - Paula Robinson
	Team-level service delivery planning for the next business year, with active involvement of team members. CMG will continue to review planning and delivery. Requirement for this to be in place for each business year.	In place – Paula Robinson
	Planning and prioritising data submission project delivery, and therefore strategy delivery, within our limited resources.	In place until project ends – Dan Howard
We may not be able to find time to implement the People Plan to maximise organisational capability given our small organisational capacity and ongoing delivery of business as usual.	Small focus groups and all staff awaydays have been utilised to make the most of staff time and involve wider staff in developing proposals. The most recent staff awayday was in December 2019 and we engaged external resources to support work on embedding HFEA values and behaviours.	Ongoing – Yvonne Akinmodun
A number of staff are simultaneously new in post. This carries a higher than normal risk of internal incidents and timeline slippages while people learn and teams adapt.	Recognition that a settling in period where staff are inducted and learn, and teams develop new ways of working is necessary. Formal training and development are provided where required. Knowledge management via records management and documentation and clear and effective onboarding methods including handover process in place.	Ongoing – Peter Thompson In place – Yvonne Akinmodun
The future office move, occurring in 2020, may not meet the needs of staff (for instance location), meaning staff decide to leave sooner than this, leading to a significant spike in turnover, resulting in capability gaps.	See separate E1 risk for full assessment of risk causes and controls.	Early engagement with staff and other organisations underway and ongoing – Richard Sydee
Possible capability benefits of colocation with other organisations, arising out of the office move in 2020, such as the ability to create career pathways and closer working may not be realised.	Active engagement with other organisations early on. We are having wider conversations with other relevant regulators to see what more can be done to create career paths and achieve other benefits of working more closely.	Ongoing – Richard Sydee
Risk interdependencies (ALBs / DHSC)	**Control arrangements**	**Owner**
Government/DHSC The UK leaving the EU may have unexpected operational	We continue to work closely with the Department to ensure that we are prepared and can provide detailed guidance to the sector at the earliest	Communications ongoing –

consequences for the HFEA which divert resource and threaten our ability to deliver our strategic aims.	opportunity, to limit any impact on patients. We have provided ongoing updates to the sector. Since December 2018, we have run an EU exit project to ensure that we fully consider implications and are able to build enough knowledge and capability to handle the effects of the UK's exit from the EU. This project includes our role in communicating with the sector on the effects of EU exit, to ensure that clinics are adequately prepared in terms of staffing and access to equipment and materials. We will progress this project through the transition period. We continue to engage with DHSC and clinics to prepare for EU exit. Actions will depend on the progress of the UK/EU talks. Authority and AGC are also updated at their meetings, as appropriate.	Peter Thompson
In-common risk COVID-19 (Coronavirus) may lead to high levels of staff absence leading to capability gaps or need to redeploy staff.	Management discussion of situation as it emerges, to ensure a responsive approach to any developments. We are reviewing our business continuity plan to ensure it is fit for purpose.	Ongoing - Peter Thompson

C2: Failure to appoint new or reappoint current Authority members within an appropriate timescale leads to loss of knowledge and may impact formal decision-making.

Inherent risk level:			**Residual risk level:**		
Likelihood	Impact	Inherent risk	**Likelihood**	**Impact**	**Residual risk**
4	5	20 - Very High	**4**	**4**	**16 - High**
Tolerance threshold:					**4 - Low**
Status: **Above tolerance**					

Risk area	Risk owner	Links to which strategic objectives?	Trend
Estates C2: Board capability	Peter Thompson Chief Executive	Whole strategy.	

Commentary
The HFEA board is unusual as members undertake quasi-judicial decision-making as part of their roles, sitting on licensing and other committees. This means that changes in Board capability and capacity may impact the legal functions of the Authority. We need to maintain sufficient members with sufficient experience to take what can be highly controversial decisions in a robust manner. As such our tolerance threshold for this risk is low. We have two vacancies and the Chair's term expires on 31 March 2020 - recruitment is not yet underway. Two further members' terms end on November 11 2020, bringing the Board membership down to nine – this would pose a significant challenge to robust decision-making. As at the SMT review we had had no further update and we raised the risk score accordingly. We will provide a verbal update at the AGC meeting.

Causes / sources	Mitigations	Timescale / owner
As at January 2020, we have two member vacancies and the Chair's term ends on 31 March 2020. Two further members' terms end on 11 November 2020. This would bring the total Board complement down to nine. While that is still larger than most public boards it would put at risk our ability to meet our statutory responsibilities to licence fertility clinics and research centres and authorise treatment for serious inherited illnesses.	Membership of licensing committees has been actively managed to ensure that formal decision-making can continue unimpeded by the current vacancies. However, there is no guarantee that this would be possible for future vacancies, especially if there were several at once.	Paula Robinson - Ongoing

The uncertainty about Chair reappointment may result in a gap in leadership and direction for the Authority.	Deputy Chair in place and could take the role on a temporary basis, subject to Secretary of State approval. We are maintaining close engagement with the Department to ensure that this can take place. We are ensuring that there is more involvement of the Deputy Chair during the period of uncertainty to reduce the impact on the organisation should this temporary cover be necessary.	Peter Thompson – In progress
Any member recruitment may take some time and therefore give rise to further vacancies and capability gaps. The recruitment process is run by DHSC meaning we have limited power to influence this risk source. Historically, decisions on appointments have taken some time which may create additional challenges for planning. Meanwhile, the annual report from the commission for public appointments suggests appointments take on average five months.	The Chair/CEO are in close contact with the Department to press for an early decision.	Peter Thompson – In progress
A number of current Board members are on their second terms in office, which expire within the same period (8 Members or 2/3 of the Board by mid-July 2021).	We are discussing options with the Department for managing the cycle of appointments, in order to reduce the impact of this.	Peter Thompson – In progress
The induction time of new members (including bespoke legal training), particularly those sitting on licensing committees, may lead to a loss of collective knowledge and potentially an impact on the quality of decision-making. Evidence from current members suggests that it may take up to a year for members to feel fully confident.	The Governance team are reviewing recruitment information and member induction to ensure that this will be as smooth as possible once it starts.	Paula Robinson – In progress
Induction of new members to licensing and other committees, will require a significant amount of resource for internal staff and reduce the ability of the governance and other teams to	We will be mindful of this resource requirement when planning other work, in order to limit the impact of induction on other priorities.	Peter Thompson, Paula Robinson – In progress

support effective decision-making.		
Risk interdependencies (ALBs / DHSC)	**Control arrangements**	**Owner**
Government/DHSC The Department is responsible for our Board recruitment but is bound by Cabinet Office guidelines.	CEO letter to DHSC Permanent Secretary on 10 December to clarify this risk interdependency and recommend that member appointments should be added to Departmental risk register.	Peter Thompson – In progress
Government/DHSC DHSC is responsible for having an effective arm's length body in place to regulate ART. If it does not ensure this by effectively managing HFEA Board recruitment, it will be breaching its own legal responsibilities.	CEO letter to DHSC Permanent Secretary on 10 December to clarify this risk interdependency and recommend that member appointments should be added to Departmental risk register.	Peter Thompson – In progress
Government/DHSC HFEA operates in a sensitive area of public policy, meaning there may be interest from central government in the appointments process. We are unsure of the intended approach of any future government. This may impact any planned approach and risk mitigations and give rise to further risk.	CEO letter to DHSC Permanent Secretary on 10 December to clarify this risk interdependency and recommend that member appointments should be added to Departmental risk register.	Peter Thompson – In progress

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

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

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

Commentary
We have undertaken cyber security (penetration) testing of the new digital systems including PRISM and the Register, to ensure that these remain secure. The results have not revealed any significant issues. Ahead of PRISM go-live later in 2020 we will undertake a final penetration test. The launch of PRISM has been delayed although this poses no increased cyber risk. In 2020 we are introducing additional control measures such as multi-factor authentication to further improve security controls for those who work remotely. A penetration network audit took place in March 2019. We continue to assess and review the level of national cyber security risk and take action as necessary to ensure our security controls are robust and are working effectively.

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

Changes to the digital estate open up potential attack surfaces or new vulnerabilities. Our relationship with clinics is more digital, and patient identifying information or clinic data could therefore be exposed to attack.	The website and Clinic Portal are secure and we have been assured of this. The focus now is on obtaining similar assurance through penetration testing report to the SIRO in relation to the remaining data submission deliverables (PRISM). The final round of penetration testing is underway and there have been no significant issues found so far.	Penetration testing underway throughout development and ongoing – Peter Thompson/ Dan Howard
There is a risk that IT demand could outstrip supply meaning IT support doesn't meet the business requirements of the organisation and so we cannot identify or resolve problems in a timely fashion. We do not currently have a developer in post.	We continually refine the IT support functional model in line with industry standards (ie, ITIL). We undertook an assessment of our ticketing systems and launched a new system in November 2018. Our vision is to have an internal team working in partnership with a third-party software development provider. In May 2018 we awarded a contract for third-party infrastructure and development support. The service is based on the ITIL framework (IT service standard). Our strategy was to recruit to the in-house software development team following a workload review. The workload review has been completed, however during the delay to PRISM and Data Migration work, the funding for the developer post has been used for this ongoing development. Resourcing has now been reviewed and recruitment for the substantive role is underway.	Approved per the ongoing business plan – Dan Howard Third-party support arrangement in place – Dan Howard Recruitment to internal development team underway from January 2020 – Dan Howard
Confidentiality breach of Register or other sensitive data by HFEA staff.	Staff are made aware on induction of the legal requirements relating to Register data. All staff have annual compulsory security training to guard against breaches of confidentiality, updated information risk training was completed by staff during April / May 2019. Relevant and current policies to support staff in ensuring high standards of information security. There are secure working arrangements for all staff both in the office and when working at home (end to end data encryption via the internet, hardware encryption) Further to these mitigations, any malicious actions would be a criminal act.	In place – Peter Thompson A review of current IT policies is ongoing – Dan Howard
There is a risk that technical or system weaknesses lead to loss of, or inability to access, sensitive data, including the Register.	Back-ups of the data held in the warehouse in place to minimise the risk of data loss. Regular monitoring takes place to ensure our data backup regime and controls are effective. We are ensuring that a thorough investigation takes place prior, during, and after moving the Register to the Cloud. This involves the use of	In place – Dan Howard The new Register will be deployed once ongoing

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

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

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

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

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

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

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

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

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

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

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

Inherent risk level:			**Residual risk level:**		
Likelihood	Impact	Inherent risk	**Likelihood**	**Impact**	**Residual risk**
4	4	16 - High	**4**	**3**	**12 – Medium**
Tolerance threshold:					**6 - Medium**
Status: **Above tolerance**					

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

Commentary
We experienced difficulties with migrating Register data since early 2019 and this has delayed the launch of PRISM and the new Register as described under risks above. These issues obviously cause a delay to accessing improved data. Regular updates on this risk are provided to AGC who have oversight over the final stages of this work. PRISM will not be completed in the 2019/20 financial year. These continued delays have led to enhancement work being rescheduled and is having an impact on our ability to take advantage of improvements. We have undertaken to reduce the impact where possible, but in the light of ongoing delays we have raised this risk.

Causes / sources	**Mitigations**	**Timescale / owner**
IfQ has taken longer than planned, and there will be some ongoing development work needed leading to delays in accessing the benefits.	Data submission development work is now largely complete although deployment has been delayed while remaining data migration issues are resolved. Oversight and prioritisation of remaining development work will be through the IT development programme board with oversight from AGC.	Deployment date of data submission system planned for mid- 2020– Peter Thompson
Risks associated with data migration to new structure, compromises record accuracy and data integrity.	Migration of the Register is highly complex. IfQ programme groundwork focused on current state of Register. There is substantial high-level oversight including an agreed migration strategy	Deployment date mid-2020 – Peter Thompson/Dan Howard

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

leading to an increase in outstanding errors	We undertake an audit programme to check information provision and accuracy.	In place – Rachel Cutting
Excessive demand on systems and over-reliance on a few key expert individuals – request overload – leading to errors.	PQs and FOIs have dedicated expert staff to deal with them although they are very reliant on a small number of individuals. We have systems for checking consistency of answers.	In place – Clare Ettinghausen
Since July 2019 there has been a significant increase in the numbers of OTR applications.	There is a dedicated team for responding to OTRs and all processes are documented to ensure information is provided consistently. Since July 2019, increasing demand on the OTR team has been monitored to understand whether this is an ongoing trend. A review of the resource required to put the OTR service on a stable footing will be completed over the summer.	In place – Dan Howard Summer 2020 – Dan Howard
Risk interdependencies (ALBs / DHSC)	**Control arrangements**	**Owner**
None	-	-

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

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

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

Commentary
Authority discussed our communications strategy in January 2020 and received an overview of the positive progress. Communications have been derived from the strategy and aligned with the key organisational objectives. Conversations about messaging and engagement have been central to the development of the new 2020-2023 organisational strategy to ensure that we take a joined-up approach that takes full advantage of our channels and a public affairs approach. We will launch a new communications strategy in April 2020 to accompany this. The update to the data on CaFC at the end of 2019 means that success rates data is now more current, to inform patient choice.

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

Patients and other stakeholders do not receive the correct guidance or information.	Communications strategy in place, including social media and other channels as well as making full use of our new website. Stakeholder meetings with the sector in place to help us to underline key campaign messages. Our publications use HFEA data more fully and makes this more accessible. Policy team ensures guidance is created with appropriate stakeholder engagement and is developed and implemented carefully to ensure it is correct. Ongoing user testing and feedback on information on the website allows us to properly understand user needs. We have internal processes in place which meet The Information Standard (although the assessment and certification scheme is being phased out). External providers are in place for the Donor Conceived Register. The executive facilitated a smooth transition of the service to the new supplier to ensure that effective information and support continued to be in place for donor conceived people.	In place and reviewed periodically (last review Jan 2020) – Jo Triggs Ongoing – Nora Cook-O'Dowd In place – Laura Riley, Jo Triggs In place –Jo Triggs Certification in place – Jo Triggs In place – Dan Howard
We are not able to reach the right people with the right message at the right time.	We have an ongoing partnership with NHS.UK to get information to patients early in their fertility journey and signpost them to HFEA guidance and information. Planning for campaigns and projects includes consideration of communications channels. When developing policies, we ensure that we have strong communication plans in place to reach the appropriate stakeholders. Extended use of social media to get to the right audiences. The communications team analyse the effectiveness of our communications channels at Digital Communications Board meetings, to ensure that they continue to meet our user needs.	In place – Jo Triggs In place and ongoing – Jo Triggs In place - Laura Riley, Jo Triggs In place– Jo Triggs Ongoing – Jo Triggs
Risk that incorrect information is provided in PQs, OTRs or FOIs and this may lead to misinformation and misunderstanding by patients, journalists and others.	PQs and FOIs have dedicated expert staff to manage them and additional staff have been trained to ensure there is not over-reliance on individuals. We have systems for checking consistency of answers and a member of SMT must sign off every PQ response before submission.	In place - Clare Ettinghausen Clare Ettinghausen /SMT - In place

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

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

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

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

Commentary
The Director of Finance and Resources has been involved in discussions with the Department about the office relocation since mid-2018. The physical office build and fit-out is being handled by the British Council and the overall project managing the move of the HFEA and four other organisations is being co-ordinated by the Department of Health and Social Care. An internal project to prepare for the office move is in place to handle the direct impacts of the move on the organisation and ensure that we actively prepare and mitigate associated risks. We have made progress in reviewing working practices and policies and have begun to launch these. All cross-ALB working groups have been established and are actively defining requirements and solutions and these are feeding into the HFEA internal project. In February, we have undertaken a survey of all staff to understand the nature of impacts in different teams and will discuss these findings in order to identify and mitigate any differential risks between teams that may impact effective delivery.

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

We may be unable to recruit staff as they do not see the HFEA as an attractive central London organisation.	We have been advertising the move to Stratford in all job adverts, so that applicants are aware. Monitoring of recruitment data to date suggests that we are not seeing an impact on recruitment, though we will continue to monitor this to enable us to consider whether other mitigations are possible. We will continue to offer desirable staff benefits and policies, such as flexible working, and have begun to evaluate these to ensure that they support staff recruitment and retention. Other civil service and government departments are also being moved out of central London, so this is less likely to impact recruitment of those moving within the public sector.	From July 2019 – Yvonne Akinmodun
Stratford may be a less desirable location for some current staff due to: • Increased commuting costs • Increased commuting times • Preference of staff to continue to work in central London for other reasons, leading to lower morale and lower levels of staff retention as staff choose to leave before the move.	Work underway to review the excess fares policy to define the length of time and mechanism to compensate those who will be paying more following the move to Stratford. Efforts continue to understand the impact on individual staff and discuss their concerns with them via staff survey, 1:1s with managers and all staff meetings. These have fed into discussions about flexible working. Conversely, there will be improvements to the commuting times and costs of some staff, which may improve morale for them and balance the overall effect.	Underway, to complete winter2019/20 – Yvonne Akinmodun, Richard Sydee
The Stratford office may cost more than the current office, once all facilities and shared elements are taken into account, leading to opportunity costs. The Finance and procurement strand of the project has been established and detailed costings should be available by Q1 2020/2021.	Costs for Redman Place (the Stratford building) will be allocated on a usage basis which will ensure that we do not pay for more than we need or use. The longer, ten-year lease at Redman Place will provide greater financial stability, allowing us to forecast costs over a longer period and adjust other expenditure, and if necessary fees, accordingly to ensure that our work and running costs are effectively financed. The accommodation at Redman Place should allow us to reduce some other costs, such as the use of external meeting rooms, as we will have access to larger internal conference space not available at Spring Gardens.	Ongoing - Richard Sydee,
The move to a new office will lead to ways of working changes that we may be unprepared for.	Conversations about ways of working are central to the HFEA project. Policies related to ways of working are being agreed and circulated significantly before the	Ongoing - Richard Sydee,

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

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

Reviews and revisions

SMT review – February 2020

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

- C1 – SMT agreed that Coronavirus should be added as a new risk cause. This risk was being monitored and plans reviewed.
- C2 – SMT noted that no further progress had been made in recruitment for Board members, nor a decision about the Chair. SMT considered that the inherent impact of the risk had increased, since any last-minute changes will have a more significant effect. Given the rapidly shortening proximity of the risk and opportunity for preventative controls the residual likelihood had increased.
- F1 – SMT noted that there may be developments in advance of AGC and requested the Director of Finance and Resources reviews this risk again in the light for these. In the light of that review the Director of Finance and Resources raised the score of this risk.
- RE1 – SMT acknowledged that the ongoing delays to PRISM limited the enhancement work we were able to undertake. The residual impact of this risk had therefore increased. Detailed discussion about risk management in relation to this risk was underway with AGC.

SMT review – January 2020

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

- SMT noted that a discussion with AGC was imminent on the Digital projects, and consequently a more meaningful reassessment of this risk could be taken in the light of the decisions that would be taken.
- FV1 – Director of Finance and Resources to provide an update after the meeting.
- CS1 – Chief information Officer to review and update after the meeting.

Supplementary SMT review – December 2019 (09/12/2019)

SMT met to review the Capability risk only, in the light of the earlier AGC discussion about the impact of Board Member recruitment.

- SMT agreed to establish a separate risk on the register to capture the various causes, mitigations and interdependencies in relation to Board appointments and their impact on capability.
- SMT reviewed the risk sources, mitigations and established the score and tolerance for this new risk. SMT noted that the interdependencies with the overall capability risk should be made clear, but the score of the overarching Capability risk should return to the level it was before adding Board capability risk sources.
- All other aspects of the Register would be reviewed in January 2020.

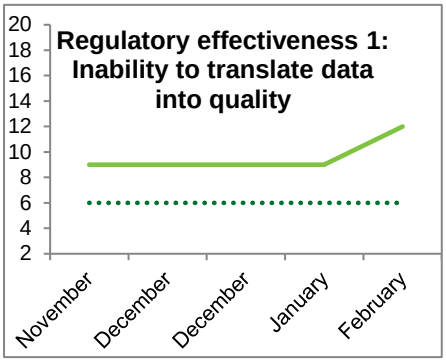
AGC review – December 2019 (03/12/2019)

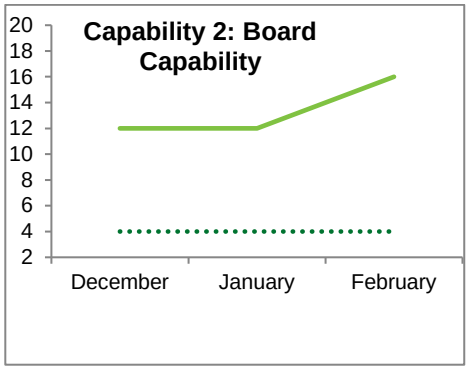
AGC reviewed all risks, controls and scores and made the following points:

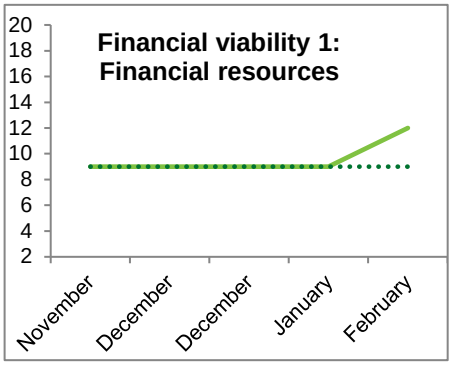
- C1 – AGC discussed at length the newly arising capability risks in relation to member appointments. Members agreed that these should be reflected in the register and that they did pose a significant strategic risk. Members gave a steer to the Chief Executive that he should escalate the risk to the Department and provided useful feedback about possible mitigations for this risk such as the option for temporary extensions to of members terms to cover possible capability gaps.
- FV1 and RE1 – AGC noted that the risk register would be reviewed in relation to financial viability and regulatory effectiveness in the light of changes relating to the digital projects covered earlier in the meeting.

Risk trends

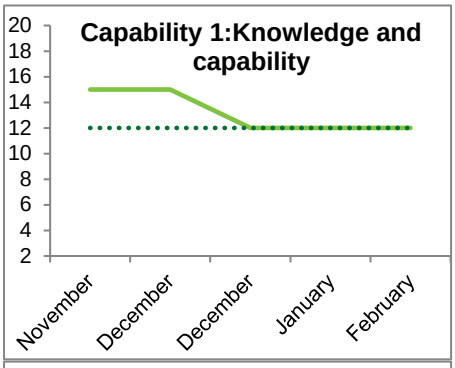
High and above tolerance risks

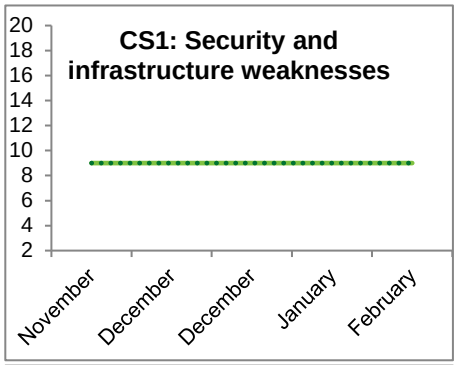


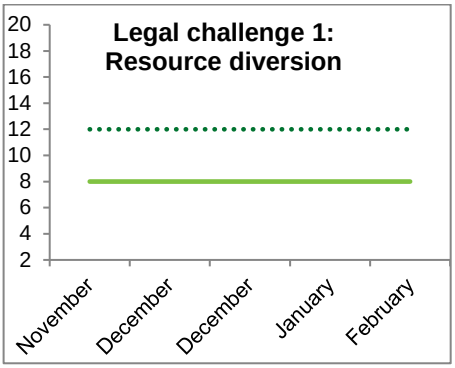


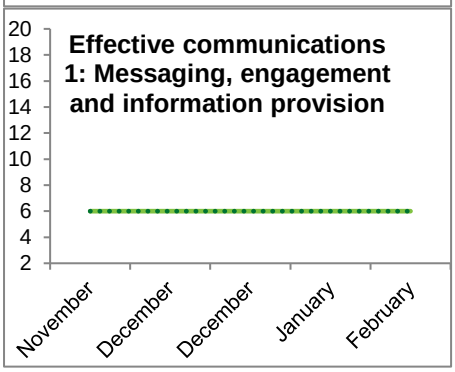


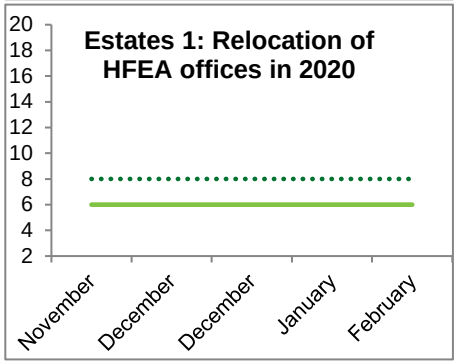
At and below tolerance risks











Criteria for inclusion of risks

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

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

Rank

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

Risk trend

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

Risk scoring system

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

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

Risk scoring matrix

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

Risk Score = Impact x Likelihood

Risk appetite and tolerance

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

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

Assessing inherent risk

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

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

System-wide risk interdependencies

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

Contingency actions

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

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

Audit and Governance Committee Forward Plan

Strategic delivery:	☐Safe, ethical, effective treatment	☐Consistent outcomes and support	☒Improving standards through intelligence
Details:			
Meeting	Audit & Governance Committee Forward Plan		
Agenda item	11		
Paper number	AGC (10/03/2020) MA		
Meeting date	10 March 2020		
Author	Morounke Akingbola, Head of Finance		
Output:			
For information or decision?	Decision		
Recommendation	The Committee is asked to note that the update from the Director of Strategy and Corporate Affairs has been deferred till October and are asked to review and make any further suggestions and comments and agree the Forward Plan		
Resource implications	None		
Implementation date	N/A		
Organisational risk	☒ Low	☐ Medium	☐ High
	Not to have a plan risks incomplete assurance, inadequate coverage or unavailability key officers or information		
Annexes	N/A		

Audit & Governance Committee Forward Plan

AGC Items Date:	3 Dec 2019	10 Mar 2020	23 Jun 2020	6 Oct 2020	TBC
Following Authority Date:	29 Jan 2020	18 Mar 2020	2 July 2020	11 Nov 2020	TBC
Meeting 'Theme/s'	Strategy & Corporate Affairs, AGC review	Finance and Resources	Annual Reports, Information Governance, People	Register and Compliance, Business Continuity	Strategy & Corporate Affairs, AGC review
Reporting Officers	Director of Strategy & Corporate Affairs	Director of Finance & Resources	Director of Finance & Resources	Director of Compliance and Information	Director of Strategy & Corporate Affairs
Strategic Risk Register	Yes	Yes	Yes	Yes	Yes
Digital Programme Update	Yes	Yes	Yes	Yes	Yes
Annual Report & Accounts (inc Annual Governance Statement)		Draft Annual Governance Statement	Yes – For approval		
External audit (NAO) strategy & work	Audit Planning Report	Interim Feedback	Audit Completion Report	Audit Planning Report	Audit Planning Report
Information Assurance & Security			Yes, plus SIRO Report		
Internal Audit Recommendations Follow-up	Yes	Yes	Yes	Yes	Yes
Internal Audit	Update	Update	Results, annual opinion approve draft plan	Update	Update
Whistle Blowing, fraud (report of any incidents)	Update as necessary	Update as necessary	Update as necessary	Update as necessary	Update as necessary
Public Interest Disclosure (Whistleblowing) policy		Reviewed annually thereafter			

AGC Items Date:	3 Dec 2019	10 Mar 2020	23 Jun 2020	6 Oct 2020	TBC
Anti-Fraud, Bribery and Corruption policy		Reviewed and presented annually thereafter GovS: 013 Counter Fraud			
Contracts & Procurement including SLA management	Update as necessary	Update as necessary	Update as necessary	Update as necessary	Update as necessary
HR, People Planning & Processes	Bi-annual HR report		Yes Including bi-annual HR report		Bi-annual HR report
Strategy & Corporate Affairs management	Yes (deferred till future meeting)			Yes (subject to Committee agreement).	Yes
Regulatory & Register management		Yes			
Cyber Security Training				Yes	
Resilience & Business Continuity Management	Yes	Yes	Yes	Yes	Yes
Finance and Resources management		Yes			
Reserves policy				Yes	
Estates	Yes	Yes	Yes	Yes	Yes
Review of AGC activities & effectiveness, terms of reference	Yes				Yes
Legal Risks				Yes	
AGC Forward Plan	Yes	Yes	Yes	Yes	Yes
Session for Members and auditors	Yes	Yes	Yes	Yes	Yes

Register of Gifts and Hospitality

Strategic delivery:	☐ Setting standards	☐ Increasing and informing choice	☐ Demonstrating efficiency economy and value
Details:			
Meeting	AGC		
Agenda item	12		
Paper number	HFEA (10/03/2020) MA		
Meeting date	10 March 2020		
Author	Morounke Akingbola (Head of Finance)		
Output:			
For information or decision?	For information		
Recommendation	Attached is the latest Gifts and Hospitality Register. Since the last meeting only one item has been added. Members are asked to note the new item(s).		
Resource implications			
Implementation date	2019/20 business year		
Communication(s)			
Organisational risk	☐ Low	☒ Medium	☐ High

Register of Gifts / Hospitality Received and Provided/Declined

Version: HFEAG0001
Jul-20

DIVISION / DEPARTMENT: HFEA
FINANCIAL YEAR: 2019/20

	Details of the Gift or Hospitality						Provider Details			Recipient Details	
Type	**Brief Description of Item**	**Reason for Gift or Hospitality**	**Date(s) of provision**	**Value of Item(s)**	**Location where Provided**	**Action on Gifts Received**	**Name of Person or Body**	**Contact Name**	**Relationship to Department**	**Name of Person(s) or Body**	**Contact Name**
Either 'Provision' or 'Receipt'	*Give a brief description of the gift or hospitality recorded*	*Summarize the reason or occasion for the gift or hospitality*	*Give the date(s) on which it was provided or offered*	*Give the known or estimated value - if unknown then state 'unknown' and explain further under the 'Reason for Gift' column.*	*Give the name of the venue or location at which the gift or hospitality was provided*	*For Gifts Received only, specify what happened to the item(s) after it was received*	*Give the name of the individual or organization providing or offering the gift / hospitality*	*Give a contact name if an individual is not specified as the provider - otherwise leave blank*	*Specify the relationship of the provider to the Department (e.g. 'supplier', 'sponsor', etc.) - if the Department is the provider then leave blank*	*Give the name of the individual(s) or organisation receiving the gift / hospitality - if there are multiple recipients, specify each on a separate line*	*Give a contact name if an individual is not specified as the recipient - otherwise leave blank*
Receipt	Lunch invitation	To introduce to Legal Trainers	10/08/2017	£ -	Not known	Lunch accepted	Old Square Chambers	Eleena Misra	Legal Consultancy	HFEA	C Drennan
Receipt	Lunch invitation	Introduce Clients to new lawyers	01/11/2017	£ -	Not known	Lunch accepted	Blackstone Chambers	Catherin Callaghan	Legal Consultancy	HFEA	C Drennan
Receipt	Breakfast invitatoin	Breakfast meeting	08/02/2018	£ -	Not known	Breakfast accepted	Fieldfisher	Mathew Lohn	Legal Consultancy	HFEA	P Thompson
Receipt	Invitation to Silk Party	Informing Clients of a change (to QC)	22/03/2018	£ -	Not known	Invitation accpeted	Blackstone Chambers	Catherin Callaghan	Legal Consultancy	HFEA	C Drennan
Receipt	Lunch provided	Lunch provided prior to a review meeting	24/07/2019	£ 20.00	Not known	Lunch accepted	Alsicent		IT Support supplier	HFEA	D Howard
Receipt	Chocolates	Recruitment agency meeting	16/12/2019	£ -	Not known	Shared in office	Covent garden Bureau	Charlotte Saberter	Recruitment agency	HFEA	J Hegarty
Receipt	Lunch invitation	Interactive Workshops	11/12/2019	£	Central London	Lunch accepted	Interactive Workshop	Anna Beer	Training	HFEA	Y Akinmodun
Receipt	Cheque received	Book Review conducted	14/02/2020	£ 50.00	Not known	Cheque cashed donated to charity	Literary Review		None	HFEA	M Gilmore

Anti-Fraud, Bribery and Corruption Policy

Strategic delivery:	☒ Setting standards	☒ Increasing and informing choice	☒ Demonstrating efficiency economy and value
Details:			
Meeting	Audit and Governance Committee		
Agenda item	13		
Paper number	AGC (10/03/2020) MA		
Meeting date	10 March 2020		
Author	Morounke Akingbola, Head of Finance		
Output:			
For information or decision?	For information		
Recommendation	The Committee is asked to agree the amended policy.		
Resource implications	None		
Implementation date	Ongoing		
Communication(s)	Ongoing		
Organisational risk	☒ Low	☐ Medium	☐ High
Annexes			
Annex A –	Counter Fraud and Anti-Theft Policy		

1. Purpose

1.1. The Counter Fraud and Anti- Theft Policy was implemented to ensure people working for the HFEA are aware that fraud can exist and how to respond if fraud is suspected.

1.2. This paper also confirms that a review of the HFEA Anti-Fraud Policy has been undertaken and to set out the updated policy which includes a few minor amendments for the committee's agreement.

2. Policy

2.1. The policy was shared with the Committee in March 2019 and was shared with staff in May 2019 via the HFEA hub.

2.2. There have been no changes to the policy.

2.3. Any comments or changes the Committee deems necessary are requested.

Counter fraud and anti-theft policy

Introduction

1. This strategy has been produced in order to promote and support the framework within which the HFEA tackles fraud and theft and makes reference to the Bribery Act 2010. It sets out the aim and objectives of the Authority with respect to countering fraud and theft, whether it is committed externally or from within. Awareness of, and involvement in, counter-fraud and anti-theft work should be a general responsibility of all, and the support of all staff is needed. With clear direction from the CEO that there will be a zero-tolerance attitude to fraud within the HFEA.

Aim

2. It is the Authority's aim to generate an anti-fraud and theft culture that promotes honesty, openness, integrity and vigilance in order to minimise fraud and theft and its cost to the Authority.

Objectives

3. In respect of the risk of fraud and theft, the Authority seeks to:

- promote and support an anti-fraud and theft culture;
- deter, prevent and discover fraud and theft effectively;
- carry out prompt investigations of suspected fraud and theft;
- take effective action against individuals committing fraud and theft;
- support the core values and principles set out in the Civil Service Code

Protecting the Authority from the risk of fraud and theft

Promoting and supporting an anti-fraud and theft culture

4. The Authority seeks to foster an anti-fraud and theft culture in which all staff are aware of what fraud and theft are, and what actions constitute fraud and theft. Staff should know how to report suspicions of fraud and theft with the assurance that such suspicions will be appropriately investigated, and any information supplied will be kept in confidence.

5. This policy aims to promote good practice within the HFEA through the following:

- zero tolerance to fraud;
- a culture in which bribery is never accepted;

- any allegations of fraud, anonymous or otherwise, will be investigated;
- consistent handling of cases without regard to position held or length of service
- consideration of whether there have been failures of supervision. Where this has occurred, disciplinary action may be initiated against those responsible;
- any losses resulting from fraud will be recovered, if necessary through civil actions
- publication of the anti-fraud policy on the HFEA intranet site;

all frauds will be reported to the Audit and Risk Assurance Committee.

Deterring, preventing and discovering fraud and theft

6. The preferred way of minimising fraud and theft is to deter individuals from trying to perpetrate a fraud or theft in the first place. An anti-fraud and anti - theft culture whereby such activity is understood as unacceptable, combined with effective controls to minimise the opportunity for fraud and theft, can serve as a powerful deterrent. The main deterrent is often the risk of being caught and the severity of the consequences. One of the most important aspects about deterrence is that it derives from perceived risk and not actual risk.
7. If it is not possible to deter individuals from committing frauds and thefts, then the next preferable course of action is to prevent them from succeeding before there is any loss. Potential/possible frauds and thefts will be identified and investigated through:

- a defined counter-fraud and anti-theft assurance programme addressing the areas where the Authority is most vulnerable to fraud and theft. Any gaps in control or areas where controls are not being applied properly that are identified by this work will be addressed accordingly; and
- routine use of Computer Assisted Audit Techniques (CAATs) as a standard part of the internal auditor's toolkit, to identify transactions warranting further investigation.

8. It is the responsibility of managers to ensure that there are adequate and effective controls in place. Internal Audit will provide assurance on the adequacy and effectiveness of such controls. In addition to the annual programme of internal audits (which provide assurance on the controls identified in the Strategic Risk Register), Internal Audit will also carry out advisory work on request and seek to ensure appropriate controls are built into new systems and processes through its project assurance role.
9. It will not always be possible to prevent frauds and thefts from occurring. Therefore, the Authority must have the means to discover frauds and thefts at the earliest opportunity. All staff should be vigilant and aware of the potential for fraud and theft and report any suspicions in accordance with the Authority's Whistleblowing Policy

Prompt investigation of suspected frauds and thefts

10. All suspected and actual frauds will be investigated promptly in line with the Whistleblowing Policy. The effective investigation of suspected and actual frauds depends upon the capability of the appropriate staff or internal auditors conducting these investigations.
11. All thefts should be reported to the relevant line manager for action to be taken in line with the Authorities policies.

Taking effective action

12. In the case of a proven allegation of fraud or theft, effective action will be taken in respect of those investigated in accordance with the Authority's Disciplinary Policies and Procedures. The Authority will always seek financial redress in cases of losses to fraud and theft and legal action will be taken where appropriate.

Policy Statement

13. The HFEA requires all staff at all times to act honestly and with integrity and to safeguard the public resources for which they are responsible. The Authority will not accept any level of fraud, corruption or theft. Consequently, any suspicion or allegation of fraud or theft will be investigated thoroughly and dealt with appropriately. The Authority is committed to ensuring that opportunities for fraud, corruption or theft are reduced to the lowest possible level.

14. Staff should have regard to related policy and procedures including:

    a. HFEA Standing Financial Instructions and Financial Procedures
    b. HFEA Staff Handbook
    c. Disciplinary and Whistleblowing Policies

15. This Policy applies to all staff including contractors, temporary staff and third parties delivering services to and on behalf of the Authority.

16. The circumstances of individual frauds and thefts will vary. The Authority takes fraud and theft very seriously. All cases of actual or suspected fraud or theft against the Authority will be thoroughly and promptly investigated and appropriate action will be taken.

Definitions of Fraud and Theft, Bribery and Corruption

17. The Fraud Act 2006 created the general offence of fraud which can be committed in three ways. These are by false representation, by failing to disclose information where there is a legal duty to do so, and by abuse of position. It also created offences of obtaining services dishonestly and of possessing, making and supplying articles for use in frauds.

18. A person is guilty of theft if he dishonestly appropriates property belonging to another with the intention of permanently depriving the other of it.

19. A bribe is an inducement or reward offered, promised or provided in order to gain any commercial, contractual, regulatory or personal advantage. The advantage sought or the inducement offered does not have to be financial or remunerative in nature, and may take the form of improper performance of an activity or function.

20. The Bribery Act 2010 includes the offences of:

    a) Section 1 – bribing another person;
    b) Section 2 – offences relating to being bribed.

21. Further guidance is at http://www.justice.gov.uk/downloads/legislation/bribery-act-2010-guidance.pdf

22. Corruption is defined as “The offering, giving, soliciting or acceptance of an inducement or reward which may influence the action of any person”. In addition, “the failure to disclose an interest in order to gain financial or other pecuniary gain”.

23. The HFEA’s responsibilities in relation to fraud are set out in Annex 4.9 of Managing Public Money https://www.gov.uk/government/publications/managing-public-money

Avenues for reporting Fraud and Theft

24. The Authority has a Whistleblowing Policy that sets out how staff should report suspicions of fraud, including the process for reporting thefts. All frauds, thefts, or suspicions of fraud or theft, of whatever type, should be reported in accordance with the Whistleblowing Policy. All matters will be dealt with in confidence and in strict accordance with the terms of the Public Interest Disclosure Act 1998. This statute protects the legitimate personal interests of staff.

Responsibilities

25. The responsibilities of Authority staff in respect of fraud and theft are determined by the Treasury publication "Managing Public Money" (MPM), supplemented by the Authority's policies and procedures for financial and corporate governance. These documents include Standing Financial Instructions, Financial Procedures; Standing Orders, the Financial Memorandum, and the Management Statement

Accounting Officer (Chief Executive)

26. As "Accounting Officer", the Chief Executive is responsible for managing the organisation's risks, including the risks of fraud and theft, from both internal and external sources. The risks of fraud or theft are usually measured by the probability of them occurring and their impact in monetary and reputational terms should they occur. In broad terms, managing the risks of fraud and theft involves:

    a. assessing the organisation's overall vulnerability to fraud and theft;
    b. identifying the areas most vulnerable to fraud and theft;
    c. evaluating the scale of fraud and theft risk;
    d. responding to the fraud and theft risk;
    e. measuring the effectiveness of managing the risk of fraud and theft;
    f. reporting fraud and theft to the Treasury;
    g. In consultation with the Chair, Director of Finance and Resources, and Legal Services, reporting any thefts against the Authority to the police.

27. In addition, the Chief Executive must:

    a. be satisfied that the internal control applied by the Authority conforms to the requirements of regularity, propriety and good financial management;
    b. ensure that adequate internal management and financial controls are maintained by the Authority, including effective measures against fraud and theft.

28. The Chief Executive will be responsible for making a decision as to whether:

    a. an individual who is under suspicion of fraud or theft should be suspended;
    b. criminal or disciplinary action should be taken against an individual who is found to have committed a fraud or theft.

29. Such decisions should be taken in conjunction with the relevant Director, HR Manager and Internal Audit, with advice from Legal Services and Finance where appropriate, to ensure consistency across

the organisation. Should there be any disagreement over the appropriate action to be taken, the Chief Executive will be the final arbiter in deciding whether criminal or disciplinary action should be taken against an individual.

Director of Finance and Resources

30. Responsibility for overseeing the management of fraud and theft risk within the Authority has been delegated to the Director of Finance and Resources, whose responsibilities include:

    b. ensuring that the Authority's use of resources is properly authorised and controlled;

    c. developing fraud and theft risk profiles and undertaking regular reviews of the fraud and theft risks associated with each of the key organisational objectives in order to ensure the Authority can identify, itemise and assess how it might be vulnerable to fraud and theft;

    d. evaluating the possible impact and likelihood of the specific fraud and theft risks the Authority has identified and, from this, deducing a priority order for managing the Authority's fraud and theft risks;

    e. designing an effective control environment to prevent fraud and theft commensurate with the fraud and theft risk profiles. This will be underpinned by a balance of preventive and detective controls to tackle and deter fraud, corruption and theft;

    f. ensuring that appropriate reporting of fraud and theft takes place both within the organisation and to the Audit and Governance Committee, and to the Assurance Control and Risk (ACR) team within H M Treasury, to which any novel or unusual frauds must be reported, as well as preparing the required annual fraud return of the Authority to H M Treasury which also includes a requirement to report actual or attempted thefts;

    g. forward to the Department of Health and Social Care an annual report on fraud and theft suffered by the Authority; notify any unusual or major incidents as soon as possible; and notify any changes to internal audit's terms of appointment, the Audit and Governance Committee's terms of reference or the Authority's Fraud and Anti – Theft Policy.

    h. measuring the effectiveness of actions taken to reduce the risk of fraud and theft. Assurances about these measures will be obtained from Internal Audit, stewardship reporting, control risk self-assessment and monitoring of relevant targets set for the Authority;

    i. establishing the Authority's response to fraud and theft risks including mechanisms for:

        - developing a counter-fraud and anti-theft policy, a fraud response plan and a theft response plan;
        - developing and promoting a counter-fraud and anti-theft culture;
        - allocating responsibilities for the overall management of fraud and theft risks and for the management of specific fraud and theft risks so that these processes are integrated into management generally;
        - establishing cost-effective internal controls to detect and deter fraud and theft, commensurate with the identified risks;
        - developing skills and expertise to manage fraud and theft risk effectively and to respond to fraud and theft effectively when it arises;
        - establishing well publicised avenues for staff and members of the public to report their suspicions of fraud and theft;
        - responding quickly and effectively to fraud and theft when it arises using trained and experienced personnel to investigate where appropriate;
        - establishing systems to monitor the progress of investigations;
        - using Internal Audit to track all fraud cases and drawing on their experience to strengthen control to reduce the risk of recurrence of frauds and thefts;

- reporting thefts to the policy in accordance with the theft response plan;
- seeking to recover losses;
- continuously evaluating the effectiveness of counter-fraud and anti-theft measures in reducing fraud and theft respectively;
- working with stakeholders to tackle fraud and theft through intelligence sharing, joint investigations and so on.

j. as Director of Finance and Resources, enforcing financial compliance across the organisation while guarding against fraud and theft and delivering continuous improvement in financial control.

k. In consultation with the Chief Executive, Chair and legal services, reporting any thefts against the Authority to the police.

Management

31. Managers are responsible for:

a. ensuring that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively, in order to assist in their role of preventing and detecting fraud and theft;

b. assessing the types of risk involved in the operations for which they are responsible;

c. reviewing and testing the control systems for which they are responsible regularly;

d. ensuring that controls are being complied with and their systems continue to operate effectively;

e. implementing new controls to reduce the risk of similar frauds and thefts taking place;

f. ensuring that all expenditure is legal and proper;

g. authorising losses of cash including theft and fraud in accordance with Financial Delegation limits;

h. reporting any fraud, or suspicion of fraud in accordance with the Whistleblowing Policy;

Staff

32. All staff, individually and collectively, are responsible for avoiding loss and for:

a. acting with propriety in the use of official resources and the handling and use of public funds whether they are involved with cash or payments systems, receipts or dealing with suppliers;

b. conducting themselves in accordance with the seven principles of public life set out in the first report of the Nolan Committee “Standards in Public Life”. These are:

- Selflessness: Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends;
- Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties;
- Objectivity: In carrying out public business, including making public appointments or recommending individuals for rewards and benefits, holders of public office should make choices on merit;
- Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;

- Openness: Holders of public office should be as open as possible about all the decisions and action that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it;
- Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest (CCE 4);
- Leadership: Holders of public office should promote and support these principles by leadership and example.

c. being alert to the possibility that unusual events or transactions could be indicators of fraud or theft;

d. reporting details immediately through the appropriate channel if they suspect that a fraud or theft has been committed or see any suspicious acts or events;

e. co-operating fully with whoever is conducting internal checks or reviews, or investigations of fraud or theft.

33. Staff are specifically not responsible for investigating any allegations of fraud or theft. These are to be undertaken in accordance with the Authority's Public Interest Disclosure ("Whistleblowing" Policy).

Board Members

34. The Authority's Board Members have a responsibility to:

a. comply at all times with the code of conduct that is adopted by the Authority and with the rules relating to the use of public funds and to conflicts of interest, and declare any interests which are relevant and material to the board:

b. not misuse information gained in the course of their public service for personal gain or for political profit, nor seek to use the opportunity of public service to promote their private interests or those of connected persons or organisations:

c. comply with the Authority's rules on the acceptance of gifts and hospitality and of business appointments.

Internal Audit

35. Matters in relation to fraud and/or corruption will involve the Authority's Internal Auditors.

Internal Audit's primary responsibilities in relation to fraud are:

a. delivering an opinion to the Chief Executive on the adequacy of arrangements for managing the risk of fraud and ensuring that the Authority promotes an anti-fraud culture;

b. assisting in the deterrence and prevention of fraud by examining and evaluating the effectiveness of control commensurate with the extent of the potential exposure/risk in the various segments of the Authority's operations;

c. ensuring that management has reviewed its risk exposures and identified the possibility of fraud as a risk;

d. assisting management by conducting fraud investigations;

36. Under its approved terms of appointment, the Internal Auditors may be tasked with responsibility for investigating cases of discovered fraud and corruption within, or operated against, the Authority.

Audit and Governance Committee

37. The Audit and Governance Committee is responsible for:

a. Receiving reports on losses and compensations, and overseeing action in response to these;
b. Ensuring that the Authority has in place an appropriate fraud policy and fraud response plan.

Review

38. This policy will be reviewed every two years or when there are changes in the law that significantly affect this policy.

References

Managing Public Money – Chapter 4 and Annex 4.7 (HM Treasury);

Managing the Risk of Fraud (HM Treasury) : www.hm-treasury.gov.uk

Core Values and the Civil Service Code: www.civilservice.gov.uk/about/values/index.aspx

Related Authority Corporate Documents

Financial Memorandum

Management Statement

Standing Financial Instructions

Standing Orders

Disciplinary Policy & Procedure

Whistleblowing Policy

Staff Handbook

Audit and Governance Committee Terms of Reference

Document name	Counter Fraud and Anti-Theft Policy
Release date	May 2019
Author	Head of Finance
Approved by	CMG
Next review date	March 2021
Total pages	14

Version/revision control

Version	Changes	Updated by	Approved by	Release date
2.0	Revisions/update	Head of Finance	CMG	May 2012
2.1	Revision/updates	Head of Finance	AGC	March 2015
2.2	Minor clarification under staff para	Head of Finance		
2.3	Reviewed/re-branded	Head of Finance	CMG/AGC	March 2019
2.3	Agenda item AGC	N/a	N/a	March 2020

Appendix: *(Suggested)* Fraud response plan

Introduction

1. The fraud response plan provides a checklist of actions and a guide to follow in the event that fraud is suspected. Its purpose is to define authority levels, responsibilities for action and reporting lines in the event of suspected fraud, theft or other irregularity. It covers:
   a) notifying suspected fraud;
   b) the investigation process;
   c) liaison with police and external audit;
   d) initiation of recovery action;
   e) reporting process;
   f) communication with the Audit and Risk Assurance Committee.

Notifying suspected fraud

2. It is important that all staff are able to report their concerns without fear of reprisal or victimisation and are aware of the means to do so. The Public Interest Disclosure Act 1998 (the "Whistleblowers Act") provides appropriate protection for those who voice genuine and legitimate concerns through the proper channels.

3. In the first instance, any suspicion of fraud, theft or other irregularity should be reported, as a matter of urgency, to your line manager. If such action would be inappropriate, your concerns should be reported upwards to one of the following:
   a) your head;
   b) your director;
   c) Chief Executive;
   d) Audit and Governance Committee Chair;
   e) Authority Chair.

4. Additionally, all concerns must be reported to the Director of Finance and Resources.

5. Every effort will be made to protect an informant's anonymity if requested. However, the HFEA will always encourage individuals to be identified to add more validity to the accusations and allow further investigations to be more effective. In certain circumstances, anonymity cannot be maintained. This will be advised to the informant prior to release of information.

6. If fraud is suspected of the Chief Executive or Director of Finance and Resources, notification must be made to the Audit and Governance Committee Chair who will use suitable discretion and coordinate all activities in accordance with this response plan, appointing an investigator to act on their behalf.

7. If fraud by an Authority Member is suspected, it should be reported to the Chief Executive and the Director of Finance and Resources who must report it to the Chair to investigate. If fraud by the Chair is suspected, it should be reported to the Chief Executive and Director of Finance and Resources who must report it to the Chair of the Audit and Governance Committee to investigate.

The investigation process

8. Suspected fraud must be investigated in an independent, open-minded and professional manner with the aim of protecting the interests of both the HFEA and the suspected individual(s). Suspicion must not be seen as guilt to be proven.

9. The investigation process will vary according to the circumstances of each case and will be determined by the Chief Executive in consultation with the Director of Finance and Resources. The process is likely to involve the DHSC Anti-Fraud Unit, who have expertise and resources to undertake investigations. An "Investigating Officer" will be appointed to take charge of the investigation on a day-to-day basis.

10. The Investigating Officer will appoint an investigating team. This may, if appropriate, comprise staff from within the Finance Directorate but may be supplemented by others from within the HFEA or from outside.

11. Where initial investigations reveal that there are reasonable grounds for suspicion, and to facilitate the ongoing investigation, it may be appropriate to suspend an employee against whom an accusation has been made. This decision will be taken by the Chief Executive in consultation with the Director of Finance and Resources, the Head of HR and the Investigating Officer. Suspension should not be regarded as disciplinary action nor should it imply guilt. The process will follow the guidelines set out in HFEA Disciplinary policy relating to such action.

12. It is important, from the outset, to ensure that evidence is not contaminated, lost or destroyed. The investigating team will therefore take immediate steps to secure physical assets, including computers and any records thereon, and all other potentially evidential documents. They will also ensure, in consultation with the Director of Finance and Resources, that appropriate controls are introduced in prevent further loss.

13. The Investigating Officer will ensure that a detailed record of the investigation is maintained. This should include chronological files recording details of all telephone conversations, discussions, meetings and interviews (with whom, who else was present and who said what), details of documents reviewed, tests and analyses undertaken, the results and their significance. Everything should be recorded, irrespective of the apparent insignificance at the time.

14. All interviews will be concluded in a fair and proper manner and as rapidly as possible and will include a note-taker.

15. The findings of the investigation will be reported to the Chief Executive and Director of Finance and Resources. Having considered, with the Head of HR, the evidence obtained by the Investigating officer, the Chief Executive and Director of Finance and Resources will determine what further action (if any) should be taken**.**

Liaison with police and external audit

16. Some frauds will lend themselves to automatic reporting to the police (such as theft by a third party). For other frauds the Chief Executive, following consultation with the Director of Finance and Resources and the Investigating Officer will decide if and when to contact the police.

17. The Director of Finance and Resources will report suspected frauds to the police and external auditors at an appropriate time.

18. All staff will co-operate fully with any police or external audit enquiries, which may have to take precedence over any internal investigation or disciplinary process. However, wherever possible, teams will co-ordinate their enquiries to maximize the effective and efficient use of resources and information.

Initiation of recovery action

19. The HFEA will take appropriate steps, including legal action if necessary, to recover any losses arising from fraud, theft or misconduct. This may include action against third parties involved in the fraud or whose negligent actions contributed to the fraud.

Reporting process

20. Throughout any investigation, the Investigating Officer will keep the Chief Executive and the Director of Finance and Resources informed of progress and any developments. These reports may be oral or in writing.

21. On completion of the investigation, the Investigating Officer will prepare a full written report to the Chief Executive and Director of Finance and Resources setting out:
    a) background as to how the investigation arose;
    b) what action was taken in response to the allegations;
    c) the conduct of the investigation;
    d) the facts that came to light and the evidence in support;
    e) recommended action to take against any party where the allegations were proved (see policy on disciplinary action where staff are involved);
    f) recommended action to take to recover any losses;
    g) recommendations and / or action taken by management to reduce further exposure and to minimise any recurrence.

22. In order to provide a deterrent to other staff a brief and anonymous summary of the circumstances will be communicated to staff.

Communication with the Audit and Governance Committee

23. Irrespective of the amount involved, all cases of attempted, suspected or proven fraud must be reported to the Audit and Governance Committee by the Chief Executive or Director of Finance and Resources.

24. The Audit and Governance Committee will notify the Authority.

25. In addition, the Department requires returns of all losses arising from fraud together with details of:
    a) all cases of fraud perpetrated within the HFEA by members of its own staff, including cases where staff acted in collusion with outside parties;
    b) all computer frauds against the HFEA, whether perpetrated by staff or outside parties;
    c) all cases of suspected or proven fraud by contractors arising in connection with contracts placed by the HFEA for the supply of goods and services.

26. The Director of Finance and Resources is responsible for preparation and submission of fraud reports to the Audit and Risk Assurance Committee and the Department.

Public Interest Disclosure ("Whistleblowing") Policy

Strategic delivery:	☐ Setting standards	☐ Increasing and informing choice	☒ Demonstrating efficiency economy and value
Details:			
Meeting	Audit and Governance Committee		
Agenda item	14		
Paper number	AGC (10/03/2020) MA		
Meeting date	10 March 2020		
Author	Morounke Akingbola, Head of Finance		
Output:			
For information or decision?	For information		
Recommendation	The Committee is asked to agree the amended policy.		
Resource implications	None		
Implementation date	Ongoing		
Communication(s)	Ongoing		
Organisational risk	☒ Low	☐ Medium	☐ High
Annexes			
Annex A –	Public interest disclosure Policy		

1. Purpose

1.1. The Public Interest Disclosure Policy generally referred to as the “Whistleblowing” Policy was implemented to ensure people working for the HFEA were aware of the channels available t report inappropriate behaviour.

1.2. This paper also confirms that a review of the HFEA Whistleblowing Policy has been undertaken and to set out the updated policy which includes a few minor amendments for the committee’s agreement.

2. Policy

2.1. The policy was brought to AGC in January 2019. Since then a review has been undertaken to ensure the policy is fit for purpose.

2.2. An addition has been made to the policy see sections 8 and 9 relating to protected disclosures and prescribed persons.

2.3. Any comments or changes the Committee deems necessary are requested.

Public Interest Disclosure ("Whistleblowing") Policy

1. Introduction

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

2. Aim

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

3. Scope

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

4. Responsibility

4.1 The HR department is responsible for ensuring that all staff have access to this policy. Managers and Senior Executives are responsible for ensuring that any public interest disclosure is dealt with immediately, and sensitively, and confidentially.

5. Principles

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

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

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

5.3 It should be noted that disclosures which in themselves constitute an offence are <u>not</u> protected.

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

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

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

6. Legal overview

6.1 Protection for whistleblowers was first introduced in the Public Interests Disclosure Act 1998 the Employment Rights Act 1986 (ERA). This act made it unlawful for an employer to dismiss or subject a worker to detriment on the grounds that they have made a protected disclosure.

7. Procedure

Internal Disclosure

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

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

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

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

- An explanation of how and by whom the concern will be handled
- An estimate of how long the investigation will take
- Where appropriate, the outcome of the investigation

- Details of who he/she should report to if the individual believes that he/she is suffering a detriment for having raised the concern
- Confirmation that the individual is entitled to independent advice.

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

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

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

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

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

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

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

*Via Senior Sponsor at the DHSC (currently Mark Davies, Director, Health Science and Bioethics (tel. 0207 210 6304 / mark.davies@dhsc.gov.uk)

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

7.12 Once investigations and follow up actions as appropriate have been concluded, a written summary of the matter(s) reported and concluding actions taken should be forwarded to the Chair of the Authority (the Chair) for inclusion in the central record of issues reported under this policy. The anonymity of the individual who made the disclosure should be preserved as far as possible.

External Disclosure

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

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

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

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

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

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

7.19 Where matters raised from external disclosure procedures are (as appropriate) subsequently investigated and resolved internally, a written record of the matters raised and actions taken should be forwarded to the Chair for inclusion in the central record of issues referred under this

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

8. Protected disclosures

Certain conditions must be met for a whistleblower to qualify for protection under the Public Interest Disclosure Act 1998 (PIDA), depending on to whom the disclosure is being made and whether it is being made internally or externally.

8.1 Workers are encouraged to raise their concerns with the employer (an internal disclosure) with a view that the employer will then have an opportunity to address the issues raised. If a worker makes a qualifying disclosure internally to an employer (or another reasonable person) they will be protected.

8.2 No worker should submit another worker to a detriment on the grounds of them having made a protected disclosure.

8.3 Any colleague or manager (provided that they and the whistleblower have the legal status of employee / worker) can personally be liable for subjecting the whistleblower to detriment for having made a protected disclosure.

8.4 If a disclosure is made externally, there are certain conditions which must be met before a disclosure will be protected. One of these conditions must be met if a worker is considering making an external disclosure (this does not apply to disclosures made to legal advisors).

8.5 If the disclosure is made to a prescribed person, the worker must reasonably believe that the concern being raised I one which is relevant to the prescribed person.

8.6 A worker can also be protected if they reasonably believe that the disclosure is substantially true, the disclosure is not made for personal gain i.e. is in the public interest, it is reasonable to make the disclosure and one of the following conditions apply:

- At the time the disclosure is made, the worker reasonably believes that s/he will be subjected to a detriment by their employer if the disclosure is made to the employer; or
- The worker reasonably believes that it is likely that evidence relating to the failure/wrongdoing will be concealed or destroyed if the disclosure is made to the employer; or
- The worker has previously made a disclosure to his/her employer.

8.7 Additional conditions apply to other wider disclosures to the police, an MP or the media. These disclosures can be protected if the worker reasonably believes that the disclosure is substantially true, the disclosure is of an exceptionally serious nature, and it is reasonable to make the disclosure.

9. Prescribed persons/organisations

9.1 Special provision is made for disclosures to organisations prescribed under PIDA. Such disclosures will be protected where the whistleblower meets the tests for internal disclosures and additionally, honestly and reasonable believes that the information and any allegation contained in it are substantially true. Contact details can be found here.

The HFEA is not a prescribed organisation under PIDA and as such can only take limited action in relation to whistleblowing concerns in respect of other external organisations.

10. Information held on the HFEA Register

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

11. Notes

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

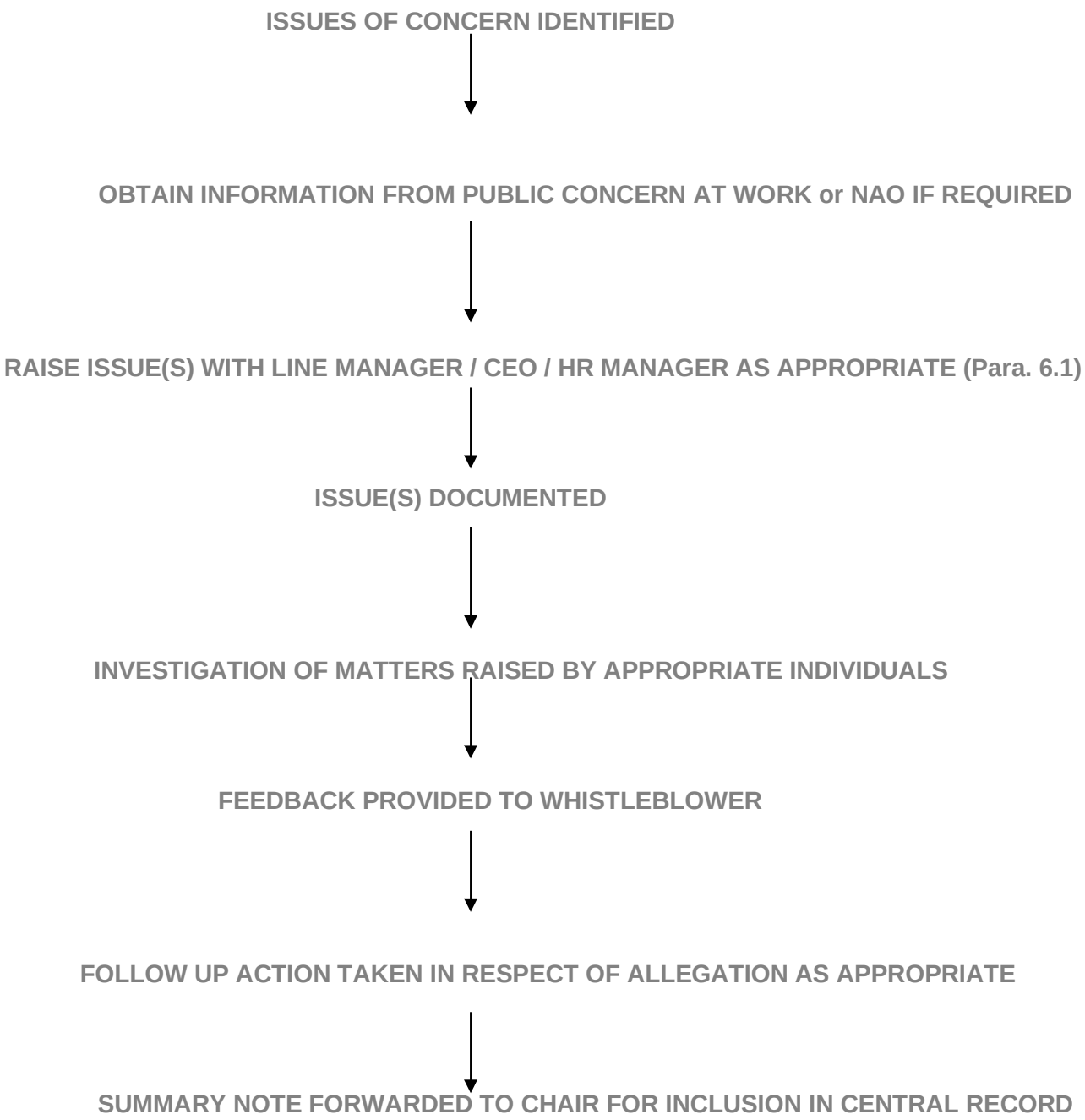
11.2 An anonymised summary of issues raised under this whistleblowing policy and remedial actions taken will be forwarded annually to the Authority for information.

11.3 The role of the HFEA as a regulatory body:

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

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

Procedure Diagram



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

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

Seven Principles of Public Life
(As recommended by the Committee on Standards in Public Life)

Selflessness

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

Integrity

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

Objectivity

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

Accountability

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

Openness

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

Honesty

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

Leadership

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

These principles apply to all aspects of public life.

Document name	Public Interests Disclosure
Doc Ref No.	2014/021228
Release date	January 2019
Author	Head of HR
Approved by	CMG/AGC
Next review date	March 2021
Total pages	10

Version/revision control

Version	Changes	Updated by	Approved by	Release date
0.1	Created	Head of Finance	Head of HR	July 2010
0.2	Revisions and updates	Head of Finance	CMG/AGC/ Staff Forum	May 2012
0.3	Revisions and updated	Head of HR	Staff Forum/CMG/ AGC	December 2014
0.4	Minor clarification in 6.8 omitted at time of (0.3 above)	Head of HR	As above	February 2015
0.5	Reviewed/updated prior to AGC	Head of Finance and Head of HR		*December 2016*
0.6	Reviewed/updated prior to AGC	Head of Finance and Head of HR	N/a	January 2019
0.7	Reviewed/updated prior to AGC	Head of Finance	N/a	March 2020