Audit and Governance Committee meeting

Date: 6 December 2024 – 10.00am to 1.00pm (main meeting) 1.30pm onwards training session for AGC members

Venue: HFEA office, 2 Redman Place, London E20 1JQ

Agenda item	Time
1. Welcome, apologies and declarations of interest	10.00am
2. Minutes of 1 October 2024 (CS) For decision	10.05am
3. Action log (MA) For information	10.10am
4. Internal Audit (JC) For discussion	10.15am
5. Progress with internal audit recommendations (MA) For discussion	10.30am
6. External audit report – audit planning (ND/DG) For discussion	10.55am
7. Risk Update • Strategic Risk Register – for discussion (SQ) • Risk Management Strategy and risk appetite statement for discussion (SQ) • Committee discussion on potential horizon scanning items/items to add to deep dive discussion list (CS)	11.05am
8. Digital projects • PRISM update - for information (KH) • Epicentre replacement (verbal report)- for information (MC)	11.25am
9. Resilience, business continuity management & cyber security (verbal) (MC/NMcC) For information	12.00pm
10. Human Resource bi-annual update 2024 (YA) For information	12.10pm

11. Government functional standards (TS) For information	12.20pm
12. AGC forward plan (CS) For decision	12.30pm
13. Items for noting (verbal update) (TS) • Whistle blowing • Gifts and hospitality • Contracts and Procurement For information	12.35pm
14. Review of AGC effectiveness (PR) For decision	12.40pm
15. Any other business (CS)	12.55pm
16. Session for members and auditors only	
17. Close	

Next Meeting: 4 March 2025 – virtual meeting

Minutes of Audit and Governance Committee meeting 1 October 2024

Details:			
Area(s) of strategy this paper relates to:	The best care – effective and ethical care for everyone The right information – to ensure that people can access the right information at the right time Shaping the future – to embrace and engage with changes in the law, science and society		
Agenda item	2		
Meeting date	6 December 2024		
Author	Alison Margrave, Board Governance Manager		
Output:			
For information or decision?	For decision		
Recommendation	The draft minutes were issued to members on 1 November 2024. The attached minutes incorporate proposed amendments from the auditors. Members are asked to confirm the minutes of the Audit and Governance Committee meeting held on 1 October 2024 as a true record of the meeting		
Resource implications			
Implementation date			
Communication(s)			
Organisational risk	☒ Low	☐ Medium	☐ High
Annexes			

Minutes of the Audit and Governance Committee meeting on 1 October 2024 held virtually (Teams)

Members present	Catharine Seddon, Chair Julia Chain Alex Kafetz, Deputy Chair Anne-Marie Millar
External Advisers	Dean Gibbs, KPMG – External Audit lead Nick Dovan, National Audit Office (NAO) – External Auditor Jo Charlton, Head of Internal Audit (Internal Auditor) – GIAA
Apologies	Steve Pugh, Department of Health and Social Care Farhia Yusuf, Department of Health and Social Care
Observers	Adrian Thompson. Board Apprentice Bernice Ash, Committee Officer
Staff in attendance	Peter Thompson, Chief Executive Tom Skrinar, Director of Finance and Resources Clare Ettinghausen, Director of Strategy and Corporate Affairs Rachel Cuttings, Director of Compliance and Information Morounke Akingbola, Head of Finance Paula Robinson, Head of Planning and Governance Shabbir Qureshi, Risk and Business Planning Manager Martin Cranefield, Head of IT (items 9 and 10) Neil McComb, Head of Information (item 10) Kevin Hudson, PRISM Programme Manager (item 9) Alison Margrave, Board Governance Manager

1. Welcome, apologies and declaration of interest

1.1. The Chair welcomed everyone to the meeting and said that Jo Charlton (Head of Internal Audit GIAA) and Nick Dovan (External Auditor NAO) would be joining later. A warm welcome was extended to the observers.

1.2. Apologies of absence were received from Steve Pugh (DHSC) and Farhia Yusuf (DHSC).

1.3. The Chair asked members if there were any declaration of interest, and none were declared.

2. Minutes of the meeting held on 26 June 2024

2.1. The Chair introduced the minutes from the previous meeting which had been circulated to the members.

2.2. The minutes of the meeting held on 26 June 2024 were agreed as a true record and could be signed by the Chair.

3. Action Log

3.1. The Head of Finance presented this item.

3.2. The Head of Finance informed the committee that the requirement of item 5.18 from October 2023 and item 5.12 from December 2023 regarding formalising more effectively the process to close off audit recommendations could be closed. She referred to the paper submitted to the committee under agenda item 5 regarding guidance to HFEA staff for internal audit relationships and expectations.

3.3. The Head of Finance informed the committee that the requirement of item 5.7 from December 2023 regarding provision of evidence to GIAA regarding KPIs should be kept open as GIAA had not yet managed to review all the evidence that the HFEA had submitted.

3.4. The Head of Finance informed the committee that requirement of items 6.15 and 7.14 from June 2024 could be closed, as the Annual Report and Accounts were laid before recess.

Decision

3.5. Members agreed the proposed amendments to the action log.

Action

3.6. Board Governance Manager to update the action log as agreed by the committee.

4. Internal audit report results and annual opinion

4.1. The Head of Internal Audit – GIAA presented this item and introduced the four papers that were presented to the committee.

4.2. The committee were informed that delivery of the 2024/25 Audit Plan is progressing well, with 40% of the plan now delivered to at least draft report stage, with a further 20% of the plan at planning and scoping stage. It was noted that the planning and scoping work was now in place for the audit on Opening the Register (OTR).

4.3. The Head of Internal Audit stated that there are 27 outstanding audit recommendations and whilst the HFEA had provided additional evidence for some of these, GIAA had raised several questions about this evidence.

4.4. In response to a question the Head of Internal Audit stated that the team at GIAA had been affected by long-term sick leave so the process for reviewing evidence is taking longer than normal. It was noted that the narrative which the HFEA provides when submitting evidence has improved although the scheduling of submitting evidence was concentrated around preparation for these meetings.

4.5. The Head of Planning and Governance commented that the HFEA's ability to provide the required evidence had also been affected by sick leave and annual leave, but for some items there was no further evidence which could be submitted in which case if, after review, GIAA could not agree to closing the recommendation, then the committee would be asked to accept the risk.

4.6. In response to a question about available resources the Chief Executive stated that a number of these recommendation have been outstanding for a period of time, which suggested that the risk

is not critical. The Head of Internal Audit responded that they still related to a risk so it would need to be documented that management are prepared to accept these risks.

4.7. The Head of Internal Audit informed the committee that since its last meeting the final report had been issued on the Data Security and Protection Toolkit (DSPT) audit with a limited assurance. 37% of outstanding audit recommendations relate to DSPT, many from previous years, and the Head of Internal Audit questioned whether the HFEA had a strategy to complete these recommendations and prepare for the next changes to DSPT.

4.8. The Director of Finance and Resources responded that all risks are being managed but that in some cases evidence provided does not completely satisfy the audit recommendation. With the changes to DSPT and eventual replacement by the Cyber Assessment Framework (CAF) the outstanding recommendations may need to be reviewed for relevance, and some accepted at risk.

4.9. In response to the committee expressing disappointment with the overall rating assigned at the conclusion of the audit ~~T~~the Head of Internal Audit commented on the process for completing the DSPT audit which afforded no discretion to the auditor: specific requirements had to be recorded as in place or not.

4.10. The committee reflect that DSPT had been designed for the NHS and had then been implemented for the wider health sector without any consideration for the size or type of the organisations now having to implement it. The committee noted that whilst some NHS trusts have a high DSPT assurance rating they have been subject to data breaches, whereas the HFEA has not been subject to a data breach.

4.11. The Head of Internal Audit commented that NHSE are running various webinars on the changes to DSPT, and it might be beneficial to participate in these so that the HFEA could prepare for the changes in advance.

4.12. In response to a question, the Head of Internal Audit commented on the proposed direction of travel indicators and noted that consideration is being given as to whether these will be implemented in the 2025/26 audit documents.

4.13. The Chair drew the discussion to a close and brought members' attention to the GIAA supplementary pack highlighting the cross-government insights into AI, counter fraud update and resources available to members.

Decision

4.14. Members noted the internal audit update report, DSPT final report and the final annual opinion report 2023/24.

5. Progress with current audit recommendations

5.1. The Head of Finance introduced this agenda item.

5.2. The committee discussed whether the Authority had the appetite or resources to close recommendations.

5.3. The Chair asked that management review all long outstanding recommendations and bring proposals to the next meeting on those that they intend to accept at risk rather than propose to postpone target dates again.

5.4. The Chair further asked that future proposed target dates be aligned with the dates of preparing papers for the Audit and Governance Committee, rather than for the meeting date itself, in order to secure timely closure of all outstanding recommendations.

5.5. In response to a question, the Head of Finance confirmed that it is anticipated that the risks relating to KPIs could be closed before December due to the new evidence submitted to GIAA.

Internal Audit relationships and expectations (Rules of Engagement)

5.6. The Director of Finance and Resources introduced the paper which provides guidance for Directors and Heads undergoing internal audits on rules of engagement with GIAA. He informed the committee that the Head of Internal Audit had attended a recent Corporate Management Group meeting where this paper had been discussed and agreed.

5.7. The Director of Finance and Resources acknowledged that it had been tricky to progress audit recommendations over the summer period due to staff sickness and leave, but suggested that these rules of engagement provide a good basis for the HFEA and GIAA to work together.

5.8. The Head of Internal Audit asked that the following be added to the rules of engagement:

- Regular cycle of submitting evidence which aligns to implementation dates
- The HFEA to recognise how to manage and action ownership changes, so that new owners see previous relevant audit reports.

5.9. The Chair asked that the rules of engagement document should also add clarification of how and where discussions/agreements between the HFEA and GIAA should be recorded.

5.10. The committee were encouraged that the paper should lead to ~~an improved relationship~~ improved ways of working with GIAA in ensuring audit recommendations are closed off in a timely fashion.

Decision

5.11. The committee agreed that management should review all long outstanding recommendations and bring proposals to the next meeting on those that they intend to accept at risk. Future target dates to be aligned with the dates of preparing papers for the Audit and Governance Committee.

5.12. The committee noted the rules of engagement guidance for internal audits with the addition of the extra items agreed at the meeting.

Action

5.13. Management to review outstanding audit recommendations and bring proposals to the December meeting.

6. External audit report

6.1. The External Audit Lead, KPMG, informed the committee that the accounts and annual report were closed and laid in Parliament before recess. Planning work for the preparation of the 2024/25 accounts was underway and would be formally reported to the committee at its next meeting.

6.2. A member commented that the process for the preparation of the accounts and annual report worked well and questioned whether there are any key items of risk which had already been identified in the planning work for the 2024/25 accounts.

6.3. The External Audit Lead, KPMG, responded that PRISM would continue to be a risk that would need to be monitored to consider the level of provision required for duplicate invoices and management's approach to determining this for the year. This could continue to be an area of increased challenge around duplicates and the recognition of revenue in year. The potential need for impairment of PRISM would also continue to be challenged by the auditors.~~impairment would continue to be a risk that would be monitored regarding the level of provision for duplicate invoices.~~

Decision

6.4. The committee noted the verbal report.

7. Strategic risk

Strategic risk register

7.1. The Risk and Business Planning Manager introduced the paper and reminded members that the risk strategy, which was agreed in December 2023, allowed for the strategic risk register to be updated bi-annually in May and December. At other times it could be updated if the risks had been escalated following the process in the strategy.

7.2. The Risk and Business Planning Manager informed the committee of the recent changes to the strategic risk register as identified in the paper.

7.3. Prior to the main review in December, the committee discussed each section:

- Commercial – the committee commented that the risk name does not fully reflect the commentary.
- Governance – no comments.
- Information 1 – the committee questioned whether the definition of this risk is still correct in its current form.
- Information 2 – the committee discussed pace of delivery and whether the rapid increase in direct to consumer DNA testing would pose a significant risk to OTR.
- People 2 – the committee were informed that the four new Authority members would be announced later this month and that the six Authority members whose first term concludes in 2025 would be reappointed.
- Reputational – the committee discussed the HFEA's proactive approach to transparency in its work; and the potential risks from the CQC and Ofsted publications regarding scrutiny of health regulation.
- Security – the committee discussed the capacity of the current team, the increased government reporting requirement and the potential to apply for additional IT funding.

Horizon scanning

7.4. The Chair informed the committee that this agenda item is for members to raise topics which could affect the HFEA in the future but are not yet reflected in the strategic risk register.

7.5. The Chair questioned whether the HFEA was exploring and being mindful of the direction of travel of regulators who are looking at the use of AI. AI could bring both opportunities and risk and she asked whether the HFEA was giving this topic sufficient consideration.

7.6. The Chief Executive responded that the HFEA is doing what it can with the resources it has available to it. A project considering the use of AI in clinics is currently in progress and the horizon scanning function is also monitoring this topic. He commented that the use of AI in clinics as well as more generally in regulation will also be included in the HFEA's next three-year strategy.

7.7. The Director of Strategy and Corporate affairs stated that members of staff regularly attend forums and conferences where this topic is discussed, and she spoke about a recent Institute of Regulation meeting.

7.8. The Director of Finance and Resources stated that the procurement to replace Epicentre will also provide improved infrastructure to support how the HFEA manages its data and spoke about the importance of this to ensure that the HFEA could take advantage of the opportunities which AI might provide in future.

7.9. The Head of Internal Audit GIAA informed the committee that they can put HFEA in touch with colleagues with AIG expertise in GIAA if required. ~~when the HFEA has progressed further in this project they can put them in touch with colleagues with AI expertise in GIAA.~~

7.10. The Chair asked management whether they had been able to consider if there was any connection between whistleblowing reports and non-compliances identified by the HFEA's inspection process and whether external whistleblowing could be a useful deep dive discussion topic for October 2025.

7.11. The Chief Executive stated that each external case of whistleblowing is investigated and that there is not a general connection between whistleblowing and non-compliance.

7.12. The Director of Compliance and Information reiterated that each case of whistleblowing is taken very seriously with a robust procedure led by the Chief Inspector. The committee were informed that a lot of cases are not upheld as they are personnel/HR complaints rather than regulatory non-compliances.

7.13. The Director of Compliance and Information spoke of the openness and transparency of the sector generally and that clinic staff at all levels do approach the HFEA. Members were informed of the whistleblowing cards that each inspector leaves at licensed premises during an inspection and the increase in the number of whistleblowing reports.

7.14. Members discussed that, generally, clinic staff are more confident to whistle blow to regulators when they work for a trustworthy organisation, so members were reassured that the number of whistleblowing incidents to the HFEA is increasing. Members discussed the recently published independent reports on CQC and Ofsted and the wider implications of these reports for health regulators.

7.15. The Chair drew the discussion to a conclusion noting the desire to add this topic to the deep dive list for October 2025.

Decision

7.16. Members noted the strategic risk register and that a deep dive on external whistleblowing reports (both for clinics and for the HFEA's inspection process) should be added to the list for October 2025.

8. Deep Dive discussion – near misses

8.1. The Risk and Business Planning Manager presented the paper and informed members that the HFEA risk management strategy outlines the internal incidents reporting procedure. The aim of the incidents system is to enable the HFEA to understand and learn from reported internal adverse events.

8.2. The Risk and Business Planning Manager explained the reporting procedure stating that an online reporting form is available on the HFEA intranet. In response to a question, he confirmed that the online reporting function has made it easier for staff to report incidents and there is a level of confidence in the reporting system.

8.3. The Risk and Business Planning Manager referred to the table detailing incident reporting since 2019 and stated that the quantity of incidents reported is not large. The process for dealing with lessons learnt from the near misses was explained with members being informed that processes and standard operating procedures were updated quickly, as required, to minimise the reoccurrence of the incident.

8.4. The committee discussed whether it was possible to highlight lessons learnt learning to Whilst accepting that, as a small organisation, it would be important to avoid introducing a blame culture by drawing attention to particular incidents, the committee nonetheless wondered whether there might be ways to highlight broad lessons learnt to staff to ensure continuous engagement with the requirements for reporting incidents. .

8.5. The Risk and Business Planning Manager responded that it was possible to look at themes of incidents and this could be reported on the HFEA intranet once the required page had been set up.

8.6. In response to a question the Director of Strategy and Corporate Affairs confirmed that there had been one incident several years ago which was reported to the Information Commissioner, but it had been rejected as it did not meet their criteria. Members were also informed that the Information Commissioner was complimentary on how the HFEA had handled the incident at the time.

Decision

8.7. The committee noted the paper on near misses and the mitigations in place to reduce the likelihood of near misses.

9. Digital projects

PRISM update

9.1. The Programme Manager presented the paper and informed members of the technical challenges experienced in recent months which impact on the proposed publication dates for CaFC.

9.2. The Programme Manager explained the issues relating to the production of a verification report on thaws as detailed in the paper. Continuing, he stated that for the current report, the missing storage links have been decoupled but that for future reports this will need to be addressed.

9.3. The Programme Manager updated the committee on those clinics on special support noting the positions for both ARGC and CRGH as detailed in the paper.

9.4. The Programme Manager stated that as set out in the paper the team no longer think it possible to publish the 2023 CaFC in 2024. This was obviously disappointing, but he stressed that it is vital

to get the verification reports right, particularly as the HFEA will be relying on these to assure itself of the quality of register data in the future.

9.5. Members were informed that the programme team are currently envisaging a scenario where the 2023 CaFC is finalised during the first half of 2025, but where the 2024 CaFC verification is begun on time in March 2025 with a view to publishing the 2024 CaFC later in 2025.

9.6. In response to a question about resourcing, the Programme Manager stated that it would be a distraction to the team to recruit now to the second data analysist post. That role requires a specific skill set and understanding of the fertility sector, and would require considerable induction, taking time away from the primary data analyst.

9.7. The Chief Executive reiterated that whilst more resources would be an asset to the overall project, it would not assist the resolution of the current phase of work. Once the project has moved on then extra resourcing would be considered.

9.8. In response to a question, the Programme Manager explained the support that had been given to clinics to assist them in progressing the verification of their data.

9.9. The committee discussed the progress of clinics, noting that some are more advanced than others.

9.10. In response to a question, the Director of Finance and Resources stated that the thaw errors do not have an impact on estimated billings. The External Auditor from NAO informed the committee that the auditor's perspective on this risk would be clarified in the audit planning report which would be presented at the next meeting.

9.11. A member questioned whether there would be any reputational risk to the HFEA due to the delay in planned publication and slippage in the overall project timelines.

9.12. The Chief Executive responded that this strategic communication issue had been taken to the Authority the week beforehand and the Authority had decided that given the delay, it would like some text added to the CAFC webpages alerting potential patients to the delay, the work underway to fix the problem and to warn against making treatment decisions on old data. This text is currently being prepared and will be added to the website when finalised.

9.13. A member commented that it was important to keep updating the communication dialogue with those organisations that use the HFEA's data.

9.14. In response to a question, the Programme Manager stated that data entry and accuracy for those clinics using PRISM is very good but there are still some challenges for those clinics using API systems with some pockets of difficulty which need to be resolved.

9.15. The Chair drew the discussion to a conclusion asking that the Programme Manager bring to the December meeting a report detailing contingency plans and options available given the progress made during the period between the two meetings.

Epicentre replacement

9.16. The Head of IT informed members of the work being undertaken with the DHSC procurement team with regards to the epicentre replacement. Over 40 companies had registered to view the tender documents and over 200 clarification questions had been received. Some of these questions had been easy to respond to and others more complex.

9.17. The committee was informed that due to the number of clarification questions received it had been agreed to extend the tender deadline by 4 weeks. The revised timeline and the internal processes which would be used to review all bids received were explained to the committee.

9.18. The Director of Finance and Resources stated that the DHSC Finance Team are aware of the revised timeline and proposed dates for expenditure, and he would continue to liaise with them to ensure that they are kept appraised of the project.

Decision

9.19. The committee noted:

- That the CaFC update has not progressed as hoped.
- Particular challenges around the production of the thaws report, but that a successful outcome for this issue is expected to be available in October.
- The publication of the thaws report will represent publication of 82% of all CaFC exceptions, thereafter there is 5% of PRISM exceptions and 13% of EDI exceptions outstanding.
- The HFEA is providing increased support to clinics for addressing exceptions and this showed results in July but not August.
- The expectation that the 2023 CaFC will complete during the first half of 2025, and that the 2024 CaFC data should be published later that same year.

10. Resilience, cyber security & business continuity

10.1. The Head of IT informed members that due to the changes in DSPT the NHS Cyber Improvement Team had ring-fenced funding which could be made available to health ALBs and the HFEA would be considering applying under this fund.

10.2. Members were informed that the HFEA had participated in the NHSE webinars on the changes to DSPT.

DSPT and GIAA audit 2023/24

10.3. The Head of Information introduced the paper and informed the committee that after submission of the HFEA's improvement plan to NHSE its ranking was raised to 'Approaching standards'. Whilst the GIAA audit of this submission found the HFEA performance to be 'unsatisfactory' and is clearly disappointing, this classification does not take account of the significant improvements made by the HFEA over the past year as detailed in the paper. There are some aspects which cannot be achieved until the Epicentre replacement is in place.

10.4. The HFEA's approach to address only the mandatory requirements was explained, and members were informed that there 108 mandatory requirements for 2023/24. The GIAA audit of the submission looked at 45 different DSPT requirements.

10.5. The Head of Information spoke about the changes to DSPT and eventual replacement by the Cyber Assessment Framework (CAF) and commented that it is not yet clear what this change will mean in terms of workload for the HFEA team. Work has already commenced on identifying key systems for CAF.

10.6. The Chair thanked the Head of Information for this paper which put into context the GIAA DSPT Final Report. It was clear that improvements have been made and the committee was encouraged that early planning work for CAF is being undertaken.

Decision

10.7. The committee noted the report with thanks to the Head of IT and Head of Information.

11. Fraud Risk Assessment

11.1. The Head of Finance introduced the paper and stated that the fraud risk assessment is an additional tool used to identify areas of business susceptible to risk. This register is reviewed quarterly and presented to the Corporate Management Group for review prior to submission to this committee.

11.2. The Head of Finance asked members whether there were any additional risks that they wanted to add to this assessment.

11.3. The committee discussed the risks included in the assessment and concluded that for a small organisation, such as the HFEA, the risks included in the assessment were comprehensive and there was nothing further to add.

11.4. In response to a question the Head of Finance confirmed that some controls, especially those in Finance, are tested regularly and the Fraud Action Plan could be amended to reflect this. It is anticipated that in the future discussions will be held with the other directors regarding the potential of testing controls.

Decision

11.5. Subject to the amendment regarding the testing of Finance Controls (minute 11.4 refers) the committee agreed the Fraud Risk Assessment as presented to the meeting.

12. Reserves Policy

12.1. The Director of Finance and Resources introduced the paper. He informed the committee that there were no fundamental changes to the policy but that a review of the HFEA's annual costs had resulted in increases to the level of contingency required.

12.2. In response to a question the Director of Finance and Resources referred to the management accounts which are issued as part of the performance report to the Authority and published on the HFEA's website.

12.3. In response to a question, the Head of Finance stated that there were no big peaks or troughs in income and as stated in the proposed policy, a cash flow forecast is prepared at the start of the financial year which takes account of when receipts are expected, and payments are to be made. Furthermore, the HFEA's healthy cash reserve levels negate any cashflow risks.

12.4. In response to a question regarding the contingency period the Chair reminded members that this had been raised previously and NAO had confirmed that a contingency of two months' running costs was satisfactory.

Decision

12.5. The committee approved the reserves policy with a revised reserve level of £1.42m which is made up of working capital of £500,000, contingency level of £892,000 and other commitments of £50,000.

13. Governmental Functional Standards (GFS)

13.1. The Director of Finance and Resources informed the committee that the Corporate Management Group had agreed a formal structured approach to monitoring and assuring functional standards, and that all initial assessments (of the 'shall' statements in the core GFS documents) have now been completed. Annual reviews will happen in Q4, and all of the existing self-assessment tools, that are designed to support continuous improvement, will need to be completed and signed off by the relevant Director prior to this review (likely to be in January 2025).

13.2. The Director of Finance and Resources stated that he would present a more detailed update report on the HFEA's GFS approach to the next Audit and Governance Committee meeting.

Decision

13.3. The committee noted the verbal report.

14. AGC forward plan

14.1. The Head of Finance introduced the paper which provides the forward plan for a full year of meetings.

14.2. The Chair asked that a row for "Dear Accounting Officer" letters be added, so that when they are received by the HFEA they are then reported to the committee. The committee noted that the list of horizon scanning topics is to be updated to include whistleblowing with a potential date of October 2025.

Decision

14.3. With these amendments the committee noted the forward plan.

Action

14.4. Board Governance Manager to update the forward plan.

15. Items for noting

15.1. Whistle-blowing

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

15.2. Gifts and Hospitality

- Members noted the updated gifts and hospitality register.

15.3. Contracts and Procurement

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

16. Any other business

16.1. The committee discussed the decision to host this meeting virtually and agreed that it had worked well.

16.2. The Chair reminded the committee that the December meeting would be held in person with a training session in the afternoon. The Chair provided information about the training session on assurance mapping for a small health ALB and thanked GIAA for providing the trainer.

Chair's signature

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

Signature

Chair: Catharine Seddon

Date: 6 December 2024

AGC Action log

Details about this paper

Area(s) of strategy this paper relates to:	The best care – effective and ethical care for everyone The right information – to ensure that people can access the right information at the right time Shaping the future – to embrace and engage with changes in the law, science, and society		
Meeting	Audit and Governance Committee		
Agenda item	3		
Meeting date	6 December 2024		
Author	Morounke Akingbola (Head of Finance)		
Output:			
For information or decision?	For discussion		
Recommendation	To note and comment on the updates shown for each item.		
Resource implications	To be updated and reviewed at each AGC		
Implementation date	2024/25 business year		
Communication(s)			
Organisational risk	☐ Low	☒ Medium	☐ High

Date and item	Action	Responsibility	Due date	Revised due date	Progress to date
7 December 2023 Item 5.7	Decision deferred to June meeting regarding accepting at risk audit recommendations 2.1 and 2.4. If the additional evidence is rejected by GIAA this is to be brought to the June AGC for consideration.	Risk and Business Planning Manager/Head of Finance	June 2024	October 2024	**Update June 2024**: A meeting has been held with GIAA to discuss our various pieces of evidence in relation to all the outstanding audit recommendations. We have agreed to collate and submit some additional evidence. **Update Sept 2024:** Further evidence was submitted following the June meeting, with more sent in July and September. We await the outcome, but staff are satisfied that the risks relating to these recommendations have been well managed and believe that these recommendations (and others) should now be closed. **Update December 2024**: GIAA have agreed to close both 2.1 and 2.4.
1 October 2024 Item 5.13	Management to review outstanding audit recommendations and bring proposals to the December meeting.	Senior Management Team	December 2024		**Update December 2024**: The majority of outstanding recommendations that do not relate to DSPT have been clear or have proposals to risk accept. The approach for DSPT will take a little more time and will need to refer to CAF preparation, therefore we will need to cover this in more detail at the AGC meeting in March
1 October 2024 Item 9.15	Programme Manager to bring to the December meeting a report detailing interim options available given the progress made during the period between the two meetings.	Programme Manger	December 2024		**Update December 2024**: Please see the paper at agenda item 8, Digital projects PRISM update.

Date and item	Action	Responsibility	Due date	Revised due date	Progress to date
1 October 2024 Item 14.4	Board Governance Manager to update the forward plan.	Board Governance Manager	December 20204		**Update December 2024**: Forward plan document updated, this item is now complete and can be closed.

Digital Projects / PRISM Update November 2024

Details about this paper

Area(s) of strategy this paper relates to:	The right information – to ensure that people can access the right information at the right time.
Meeting:	AGC
Agenda item:	8
Meeting date:	6 December 2024
Author:	Kevin Hudson, PRISM programme manager
Annexes	

Output from this paper

For information or decision?	For information
Recommendation:	Following the request from AGC to consider interim options for CaFC, to note the plan for an Interim CaFC to be published as soon as possible in 2025, whilst the Full CaFC will be delivered later in that calendar year. Also to note the launch of automated 10 family limit alerts.
Resource implications:	
Implementation date:	Publication of the Interim CaFC will take place by March 2025. The first Full CaFC is scheduled for June 2025 with the next CaFC (treatments to December 2024) published by December 2025.
Communication(s):	
Organisational risk:	Medium

1. Introduction and recap from last meeting

1.1. PRISM went live on 14th September 2021 for 40 direct entry clinics and API deployment was completed by the end of June 2022 for the other 62 clinics. Since then, 770,960 units of activity have been submitted through PRISM.

1.2. At the October meeting we reported that:

- In July we had undertaken a relaunch of the CaFC verification process, but it had not progressed as fully hoped, particularly due to issues being experienced with producing a verification report on missing thaw linkages.
- This was a material issue in PRISM data. We had identified 12,500 missing thaw linkages for the current CaFC period, and a further 22,500 for earlier periods.
- The thaw report had failed register team testing several times and our data analyst was continuing to work on this challenging area.
- As a result, the programme was forecasting that at best, the 2023 CaFC would not be published until June 2025.
- Consequently, AGC and the HFEA Authority had requested the programme to consider interim options for CaFC should the resolution of the verification issues take even longer than estimated.

1.3. During October and November, the programme has been considering the interim options that will most benefit CaFC delivery, and a plan for an Interim CaFC is outlined in this report.

1.4. This plan is for an interim CaFC to accelerate publication of headline success rates that appear on the clinic front pages of the CaFC website. This will mean that key data is published to the public some months earlier than was previously forecast in the October AGC paper. **Specifically, the latest available live birth success rates (for the year ending 2022) will published by the end of March 2025 instead of the end of June 2005.**

1.5. This paper provides AGC with an outline of how an Interim CaFC process would work, an update on progress with the Full CaFC, and also a briefing on the new automated 10 Family Limit alerts which are due to launch to the sector in December 2024.

2. Plan for an interim CaFC to be published by March 2025

2.1. It is important to recognise that the verification of Register data through the CaFC process serves three purposes:

- To provide patients with performance data on each licenced clinic
- To ensure traceability of all cycles to enable the OTR function to track patients, donors and donor conceived individuals

- To quality control the accuracy of the data held in the Register for the purpose of statistical reporting and in national-level fertility research studies which inform patient care and are based on high quality data.

2.2. Since the last AGC meeting, whilst our data analyst has been continuing on the detailed complex work required to complete a **FULL CaFC** (see section 3 below), the PRISM programme has been considering how to approach an **INTERIM CaFC** which might allow some CaFC related success information to be published before the Full CaFC is complete.

2.3. Two key areas that the programme have discussed with senior management are as follows:

- The challenge of including 2021 data (a hybrid EDI/PRISM year) in the full CaFC as it requires verification of both PRISM and EDI submitted data.
- The fact that we don't yet have any calculated success rates for clinics, as this was originally planned as a stage to be re-established by our data analyst after full verification was finished and before clinics were asked to sign off their data.

2021 data in CaFC

2.4. In the current CaFC plan, data from this year is due to be included in the CaFC for the year ending 2023 but will fall out of the calculation for the CaFC for the year ending 2024, verification of which will start from March 2025. Hence verified data from 2021 will be published for only a few months at best, and therefore will become quickly outdated and be replaced.

2.5. It is therefore proposed that we will not include 2021 data in any future CaFC calculation. However, after HFEA has published the Full CaFC, in order to ensure the accuracy of the register and OTR information, there will need to be a retrospective verification with clinics for data submitted during 2020 and 2021.

2.6. AGC should note that previously advised in October, there are 22,500 missing thaw linkages dating earlier than 2020 in the HFEA register and that in any event, a piece of work would be required to engage with clinics to correct these. Consequently 2020 and 2021 verification can be added on to this existing requirement for retrospective data correction work.

Calculating clinic success rates ahead of a completion of verification

2.7. As an organisation we remain concerned that historically the detailed knowledge of how CaFC is calculated sits just with one person. Therefore, in October, separate to the detailed work of our data analyst, we started to build a calculation model that will attempt to calculate high level success rates from PRISM data which has been partially verified but where there is still some verification steps to complete (see table 1 in section 3.1 below)

2.8. ACG should note that public facing CaFC website has two levels:

- Firstly, the front page, which as its primary statistic, show the headline live birth outcome rate for all embryo transfers and a split for patients above and below the age of 38. The front page also shows births per egg collection as a secondary statistic and also multiple

birth rates for each age category. The primary live birth success rate is also displayed if the CaFC user selects the option to compare clinics.

- Secondly, a drill through a far more detailed set of interrogation options for data from that clinic, including analysis by type of treatment, donor status, and outcome rates based on pregnancy rather than live birth.
- The headline rates currently on the CaFC front page are dated as 2018. Hence, following Authority discussions in September, there is now a message on the website to advise on the limitations of this data.
- It is possible to update the data supporting this front page separate to the data that populates the Full CaFC, and to do so that some clinics can display newer information whilst other clinics are still reporting older previously published data.

2.9. The new calculation model that we have built, has recalculated all headline success rates since 2016 and can calculate for those over or under the age of 38. We have undertaken detailed work internally comparing the impact of this new model success rates across clinics and across years but so far, we have not yet shared this with clinics.

2.10. Moreover, further work is required internally to make sure these new calculations make sense clinically, and also reconcile to other calculations such as the Fertility Trends report.

2.11. Nevertheless, notwithstanding the further reassurance work required, we do believe that this new calculation model is a mechanism by which we can approach most of the clinics in the sector to ask them to sign off interim CaFC figures ahead of the Full CaFC to be published in 2025.

2.12. Figure 1 below, shows a clinic summary of current success rates for a typical clinic as we are currently calculating them from PRISM:

CaFC success rate summary — Year of transfer (covered by the current CaFC) — as of 21/11/2024

start of PRISM

Example Clinic	2019	2020	2021	2022	2023	Average 2016-2018	Average 2021-2022	Movement (percentage points)
All embryo transfers and live birth events (excludes DIs)								
Number of embryos transferred	1868	1096	1553	1377	1287	2277	1465	-55%
Number of live birth events	484	297	379	340	301	518	360	-44%
Births per embryo transferred (current data)	**26%**	**27%**	**24%**	**25%**	23%	**23%**	**25%**	**2%**
Births % (if all missing outcomes included)	26%	29%	27%	26%	26%	23%	26%	3%
Sector average	26%	27%	27%	28%	27%	24%	28%	4%
Maximum rate (med/large clinics)	37%	39%	41%	40%	41%	33%	41%	8%
Minimum rate (med/large clinics)	16%	16%	13%	15%	12%	15%	14%	-1%

Method of Submission: Ideas — Clinic Size: Large — = to be initally published in Interim CaFC

Plan for publishing an Interim CaFC

2.13. If approved by AGC, that interim plan would be as follows:

i. During December, we will undertake work within HFEA with our data team and the intelligence team to ensure there is a consensus on the success rates being calculated through PRISM. The calculated PRISM rates will need to be signed off by the PRISM Programme Board and senior management.

ii. By the end of December, the HFEA Chief Executive will formally write to clinics to advise that clinics will be invited to sign off on an Interim CaFC by the end of March 2025.

iii. During January 2025, through direct emails to PRs and Clinic Focus, we will communicate to the sector on the detail of this process and by the end of February 2025 we will share with all PRs, our calculation of their headline success rates. Specifically, we will share with PRs:

- For all IVF treatments, births per embryo transferred for all patients and also the equivalent rates for patients aged under 38 and those aged 38 and over.
- The multiple birth rates for those categories of treatments.
- For all Donor Insemination treatments, we will publish births per cycle for all patients and also the equivalent rates for patients aged under 38 and those aged 38 and over.

iv. We will disconnect the CaFC front page from the drill through to more detailed information with a message stating why more detailed statistics are not yet available. We will also not publish the secondary rate of births per egg collection. It is felt by the PRISM programme board that this has the potential to distract from the rate which will be most helpful for public – namely births per embryo transferred. This will continue until the Full CaFC is complete at which time those links will be re-established.

v. During February and March, the programme team will liaise with clinics concerning any queries they have on their headline success rates and invite the clinic to confirm they can be published.

vi. Those that sign off their rates, will have their headline success data on the CaFC front page updated from 2018 to 2022. The CaFC front page will be updated at a pre-communicated date with the clinics during March 2025:

- For those clinics that have not agreed their 2022 headline success rates, their existing 2018 headline rates will remain.
- For those clinics that later agree 2022 headline success rates, we will update the CaFC headline tables on a piecemeal basis.

- data which have essentially been brought up to date in a piecemeal fashion as clinics confirm their data, rather than any 'big bang'.

vii. *[The timetable for the Full CaFC is outlined in section 3]*

2.14. AGC should note that the verifications that clinics have already undertaken during 2024 has all helped towards ensuring an accurate headline success rate such as addressing missing live birth outcomes. The verifications that remain are important to ensuring accuracy in the detail of CaFC but will not impact the headline figures.

2.15. In terms of technical resources, the Interim CaFC and the Full CaFC are working in parallel and the Full CaFC will be published at the earliest opportunity in 2025. The current progress on this is described in section 3 below.

2.16. The vast majority of clinics should be in a position to sign off interim success rates. Based on an assessment of the current outstanding verifications, there are only 6 clinics that cannot, or might be unlikely to sign off an interim CaFC at the start of 2025. These are:

- ARGC: 3 clinics, as they have not caught up on data and we cannot calculate a rate.
- 0254 Agora: Missing 2022 outcomes means their rate is currently 9% understated.
- 0316 CARE Cardiff: Missing outcomes means their rate is currently 5% understated.
- 0359 CREATE Manchester: rate currently understated by 8%.

2.17. AGC should note that Figure 1 above (a version of which we will share with each clinic), reports a clinic's current success rates and the projected rate were they to fix all applicable verification issues. This should therefore accelerate those minority of clinics where there is more than 1% discrepancy in these figures.

2.18. Subject to further reassurance work being undertaken (see 2.9 above), we are finding that success rates for clinics calculated from PRISM are generally increasing year on year. This corresponds to the high-level findings of the HFEA fertility trends report. Therefore, this should suggest that clinics will be comfortable in signing off newer information as their older figures are less beneficial for them.

3. Update on progress towards completing the FULL CaFC during 2025.

3.1. Table 1 below, summarises the publication status of current CaFC verification reports, which will reference during this update on progress towards completing the Full CaFC.

CaFC verificaiton reports - summary of publication status of draft reports 19-Nov

Phase		Report No. / Description	Status	Exceptions	% complete	2020	2021	2022	2023
		Total		26,638		5,402	6,547	7,190	7,555
1	98	Cycles missing early outcome details	Published	920	89%	222	481	82	122
1	96	Cycles missing outcome details	Published	2,615	62%	258	251	472	1,702
2	111	Cycles missing any treatment details	Published	4,014	54%	135	762	1,804	1,313
2	97	Duplicate registrations	Complete	458	0%	149	185	86	38
2	104	Thaw cycle errors affecting inventory - Detailed	Current element of work	10,014	0%	1,974	1,851	3,095	3,095
2	105	Cycles missing donor registration records	Analyst still to check	1,265	0%	141	280	464	380
2	114	Patient age at cycle out of bounds	Analyst still to check	1,135	0%	232	283	299	321
3	87	Egg thaw missing link to originating storage	Analyst still to check	2,144	0%	703	844	415	182
3	86	Missing egg donation cycles based on egg batch ID	Analyst still to check	1,290	0%	610	627	46	7
3	101	Missing cycle reason	Analyst still to check	954	0%	395	316	191	52
3	93	Missing donor details based on Gamete source Type	Analyst still to check	564	0%	118	151	146	149
3	99	Cycles missing cycle owner	Analyst still to check	288	0%	62	164	20	42
3	106	Cycles missing fresh egg/embryo donation records	Analyst still to check	256	0%	159	89	4	4
3	107	Cycles showing a fetal pulsation but missing transfer details	Analyst still to check	194	0%	16	26	31	121
3	81	Fresh donated eggs used after 7 days of donation	Analyst still to check	114	0%	78	28	6	2
3	84	IVF cycles where there are no linked registration details (orpl	Analyst still to check	99	0%	33	66	-	-
4		Other draft exception reports		314		117	143	29	25
		Summaries							
		Published		7,549	28%	615	1,494	2,358	3,137
		Complete awaiting publication		458	2%	149	185	86	38
		Checking currently in progress		10,014	38%	1,974	1,851	3,095	3,095
		Remaining Phase 2 (mainly PRISM)		2,400	9%	373	563	763	701
		Remaining Phase 3 (mainly EDI)		5,903	22%	2,174	2,311	859	559
		Other exceptions		314	1%	117	143	29	25

Impact of not including 2021 data in the CaFC calculation

3.2. Table 1 above shows that for phase 3 of the verification process, covering EDI data in 2020 and 2021, up to 9 verification reports and 5,903 exceptions (22% of total exceptions) will be avoided for the current CaFC if detailed verification on these years is deferred.

3.3. The impact of this is that the current Full CaFC through PRISM will cover two years of treatments from 2022 to 2023, and the next Full CaFC, verification of which will commence in March 2025, will cover a full three years from 2022 to 2024.

3.4. As outlined in 2.6 above, detailed verification of 2020 and 2021 data will take place after completion of the Full CaFC at the same time as a retrospective verification for missing thaw linkages.

3.5. However, as can be inferred from Table 1, 2021 and 2022 data are **already verified** in terms of live birth outcomes and cycles missing treatments. The outstanding verification for these years will be in relation to more detailed aspects of the register, particularly missing thaw and donor linkages.

Progress on completing the verification report on missing thaw linkages

3.6. We previously reported to AGC that early drafts of the verification report on missing thaws failed user testing on several occasions.

3.7. As shown in table 1 above, we estimate that there are 6,189 missing thaw linkages for PRISM submissions in 2022 and 2023. Of these, 3,552 (57%) relate to 12 clinics from CARE and 1,826 (30%) relate to 6 Meditex clinics.

3.8. In total, there are only 20 clinics with more than 100 exceptions on this topic – which indicates that whilst this issue is important to solve and affects all clinics for two minority submissions methods (CARE and Meditex), it does not impact those majority of clinics in the sector who submit by different means (e.g. direct entry or IDEAS).

3.9. After previous failed attempts to build a single thaws verification report for all clinics across the sector, we are now approaching this issue by individual clinic and supplier method. This work is detailed and is being complicated by the fact that a solution for one Meditex clinic does not translate to the errors we are identifying for another.

3.10. Nevertheless, this process is progressing to a conclusion which we will launch to the 20 affected clinics when it is complete. This should take place at some stage during January 2025.

3.11. For those Meditex clinics, we have already engaged with 0033 Manchester Fertility, one of the best submitting clinics in the sector, to work through the results of the report to identify the best mechanisms to rectify these issues so that this learning can be spread to other Meditex clinics.

3.12. For those CARE clinics, we have already alerted them to the scale of this issue. They have identified two fixes that they can do their end which will stem current missing thaw linkages and which they will backdate to their historic data. Hence for CARE work on missing thaws linkages is progressing in parallel ‘from their end and ours’.

3.13. The issues with missing thaw linkages for these CARE and Meditex clinics do not affect their reported headline success rates, and so they can be included in the Interim CaFC as detailed in section 2.

Final steps to complete the Full CaFC.

3.14. Given that we are not including 2021 data in the CaFC calculation the final steps to complete the Full CaFC are as follows:

i. Our data analyst to complete the thaws report (report 104).

ii. Our developers to work with Meditex and CARE clinics to implement the required corrections for report 104.

iii. Our data analyst to complete the remaining two phase 2 verification reports (report 105 and 114), totalling 2400 exceptions.

iv. Note, that the requirement to undertake phase 3 of the verification is now removed from the programme (see step x below).

v. In addition, based on feedback from clinic sign off from the Interim CaFC we will gauge whether we need to issue 'full draft data downloads' to sign off the Full CaFC. If clinics are not likely to check them, we will not issue them.

vi. Our data analyst and developer, working together, will build the success rate calculator for the Full CaFC, building on the work already undertaken to build the calculator for the Interim CaFC.

vii. We will calculate detailed CaFC rates for the two years 2022 and 2023, and when during 2025 data quality allows, we will incorporate 2024 data as well.

viii. We will aim to sign off the full CaFC in the same way as we have previously signed off the Interim CaFC – though a summary assurance report and email exchange between the PR and the PRISM programme manager.

ix. We will then populate the detailed tables on the CaFC website, and then re-establish the link between the CaFC front page and detailed data interrogation tool – again on a piecemeal clinic by clinic basis as and when they sign off their data.

x. Once the Full CaFC is published, a retrospective verification of historic missing thaw linkages pre-2020, and 2021 and 2020 EDI data will be undertaken with clinics.

3.15. In terms of timescales for the full CaFC, we previously reported that we expected to publish the Full 2023 CaFC by June 2025 and the Full 2024 CaFC by December 2025. For the majority of clinics, we still expect this to be the case.

3.16. Whether a Full 2023 CaFC for the 20 clinics with large number of missing thaw linkages, particularly CARE and Meditex clinics, will be published by June 2025 will rely on how quickly the clinics concerned are able to fix the missing linkage issues at their end.

3.17. ARGC clinics are also likely to miss publication of the full CaFC. Currently they are only 41.5% complete against 2023 CaFC data and are not projected to complete all data submission until March 2026. More work will be required with ARGC to determine whether one of their clinics can be included in the CaFC calculation rather than the group as a whole.

4. Introduction of automated 10 Family Limit Alerts

4.1. The new PRISM database allows us to interrogate the Register in far greater and in a more systematic way than was possible with EDI.

4.2. Hence, whilst the focus of the technical team has been primarily on CaFC, we have also in recent months been testing an automated alert process that will alert clinics about any donor that is approaching the 10 family limit or has newly registered at a clinic but whom has already hit the limit elsewhere in the sector.

4.3. Whilst it remains the clinic's responsibility to ensure no donor breaches the 10 family limit (and this system does not replace the requirement in the Code of Practice for a primary centre to alert other centres at the 6FL), a number of clinics have requested whether HFEA are able to provide information to help them in this.

4.4. We already provide an anonymised donor usage report in PRISM where a clinic can check how a specific donor has been used across the sector, and since September 2024 we have been running alerts in shadow form to test this functionality.

4.5. We are now ready to bring these to clinics. Figure 2 below shows an example of the alert clinics will receive the morning after information is received which changes the calculated number of families to 9 or more:

Dear Donor coordinator,

We are sending you this email to bring to your attention the following donor(s) at your centre, this data should be used in conjunction with the Anonymised Donor Usage Report.

The following donor(s) relate to the 10 familiy limit recommendation. The trigger point of this email is > = 9 families

Reg No.	Type	This donor has the following confirmed families across the sector	Based on our records this donor has the following embryos in storage at your centre	This donor has the following embryos in storage across the sector
Reg Number	Sperm Donor	10	0	2

- This alert is being sent to the nominated individual within the centre and it is the centre's responsibility to advise of any changes. If there is no nominated individual at the centre then this alert will be sent to the PR.

- PLEASE DONT REPLY TO THIS AUTOMATED EMAIL - THIS IS FOR INFORMATION ONLY -

4.6. We have already asked clinics to nominate their donor co-ordinator emails to whom such alerts should be sent, and we have had a very positive response back from the sector.

4.7. We plan to make the 10 family limit alerts live at the beginning of December 2024.

5. AGC recommendations

5.1. AGC are asked to:

1. Approve the plan for establishing an Interim CaFC and publishing headline success rates for clinics earlier than would otherwise be achieved.

2. Note the ongoing work on the Full CaFC for data to 2023, and that this will be without 2021 data. However, this omission is only temporary as 2021 data will fall out of the calculation when we publish the Full CaFC for data to 2024 later during 2025.
3. Note that HFEA will undertake a retrospective data validation to address EDI errors in 2020 and 2021 and missing thaw linkages earlier that 2020. This is important to ensure an accurate register, particularly for OTR.
4. Note the launch of 10 Family Limit alerts from December 2024.

Human Fertilisation & Embryology Authority

HFEA Staff Survey 2024 overview

Overview of the survey areas

The survey is split into the following themes:

- Overall experience – the extent to which I am committed and enjoy working for the HFEA
- Autonomy
- Enablement
- Reward
- Leadership
- Purpose

- Questions relating to staff views on to return to office working were also explored

Human Fertilisation & Embryology Authority

Comparators

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

- HSIB (Healthcare safety bureau)
- NHS Resolution
- NHSCFA
- GPhC – General pharmaceutical council
- Royal college of surgeons
- Francis Crick Institute
- NHS improvement
- NHS England
- NHS Confederation
- Several local authorities
- NHS supply chain

Human Fertilisation & Embryology Authority

Headline Indicators

- Response rate 87% (83% 2024) (Above sector average of 70%)
- Our engagement scores, i.e. the extent to which staff feel happy at work, stands at 89% – this is above the average for our public sector comparators of 76% and above last year's score of 84%
- There has been a 4% increase in advocacy-based questions, from 85% to 89%. 77% of staff see themselves remaining with the organisation 2 years from now. This is 8% above the average for the sector of 69%, it is also significantly higher than the 65% response rate from last year
- Perception of senior management is higher than last year and stands at 77% compared with 70% last year and is 15% higher than the sector average .
- We have a notably higher favourable response to questions about reward and recognition, 68% which is 7% higher than last year and 7% above the sector average
- While we have seen a 3% positive increase in response to EDI based questions, this is still 8% below the average for public sector.

Human Fertilisation & Embryology Authority

Next steps

What will we do next

- Present findings to staff
- Heads to discuss team level survey results with their teams
- Put together actions and responses from the survey findings
- Share overall results with CMG
- Provide updates on the Hub

Human Fertilisation & Embryology Authority

Audit and Governance Committee Forward Plan

Strategic delivery:	The best care – effective and ethical care for everyone The right information – to ensure that people can access the right information at the right time Shaping the future – to embrace and engage with changes in the law, science, and society
Details:	
Meeting	Audit & Governance Committee Forward Plan
Agenda item	12
Meeting date	6 December 2024
Author	Morounke Akingbola, Head of Finance
Output:	
For information or decision?	Decision
Recommendation	The Committee is asked to review and make any further suggestions and comments and agree the Forward Plan.
Resource implications	None
Implementation date	N/A
Organisational risk	☒ Low ☐ Medium ☐ High Not to have a plan risks incomplete assurance, inadequate coverage or unavailability key officers or information
Annexes	N/A

Audit & Governance Committee Forward Plan

AGC items Date:	6 Dec 2024 *In-person*	4 Mar 2025 *Virtual*	17 June 2025 *In-person*	14 October 2025 *Virtual*	3 Dec 2025 *In-person*
Following Authority Date:	**22 Jan 2025**	**21 Mar 2025**	**2 July 2025**	**19 Nov 2025**	**Jan 2025**
Internal Audit	Update	Approve draft plan	Results, annual opinion	Update	Update
Internal Audit Recommendations Follow-up	Yes	Yes	Yes	Yes	Yes
External audit (NAO) strategy & work	Audit Planning Report	Interim Feedback	Audit Completion Report		
Session for Members and auditors	Yes	Yes	Yes	Yes	Yes
Annual Report & Accounts (including Annual Governance Statement)			Yes, for approval		
Strategic Risk Register	Yes	Yes	Yes	Yes	Yes
Risk Management Policy[1]	Risk management strategy and risk appetite statement				
Horizon scanning committee discussion	Yes	Yes	Yes	Yes	Yes
Deep dives		CaFC			Whistle blowing
Digital Programme Update	Yes	Yes	Yes	Yes	Yes

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

AGC items Date:	6 Dec 2024 *In-person*	4 Mar 2025 *Virtual*	17 June 2025 *In-person*	14 October 2025 *Virtual*	3 Dec 2025 *In-person*
Resilience & Business Continuity Management	Update as necessary	Update as necessary	Update as necessary	Update as necessary	Update as necessary
Information Assurance & Security			Yes, plus SIRO Report		
HR, People Planning & Processes	Bi-annual HR report		Bi-annual HR report		
Contracts & Procurement including SLA management	Update as necessary	Update as necessary	Update as necessary	Update as necessary	Update as necessary
Whistle Blowing, fraud (report of any incidents)	Update as necessary	Update as necessary	Update as necessary	Update as necessary	Update as necessary
Estates			Yes		
Review of AGC effectiveness and terms of reference	Yes			Yes	Yes
Functional standards	Yes	Yes	Yes	Yes	Yes
AGC Forward Plan	Yes	Yes	Yes	Yes	Yes
Accounting policies		Yes (annually)			
Public Interest Disclosure (Whistleblowing) policy		Yes			
Anti-Fraud, Bribery and Corruption policy		Yes			
Counter-fraud Strategy (CFS), Fraud Risk Assessments (FRA) and progress of Action Plan				Yes	

AGC items Date:	6 Dec 2024 *In-person*	4 Mar 2025 *Virtual*	17 June 2025 *In-person*	14 October 2025 *Virtual*	3 Dec 2025 *In-person*
Reserves policy				Yes	Yes
Dear Accounting Officer letters	Update as necessary	Update as necessary	Update as necessary	Update as necessary	Update as necessary
Meeting specific items	Training session on Assurance Mapping				

Training topics

This list below are suggested topics which could be considered for AGC members -note a training session on Assurance Mapping is proposed for December 2024.

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

Suggested deep dive topics

Suggested topic	Date added	Potential meeting to be discussed
CaFC	27 June 2023	4 March 2025
External whistleblowing reports (both for clinics and for the HFEA's inspection process)	1 Oct 2024	14 Oct 2025

Gifts and Hospitality Register

Details about this paper

Area(s) of strategy this paper relates to:	The best care /The right information / Shaping the future
Meeting	AGC
Agenda item	13
Meeting date	06 December 2024
Author	Morounke Akingbola, Head of Finance

Output from this paper

For information or decision?	For information
Recommendation	AGC is invited to note the Gifts and Hospitality Register.
Resource implications	N/a
Implementation date	2024/25 business year
Communication(s)	Na
Organisational risk	Low

Introduction

The Declaration of Interests and Gifts and Hospitality is a standing item on the agenda. In 2021, the Committee agreed that the register at Annex A would only be presented when there were items added.

Update

The register at Annex A contains one new item since the October 2024 meeting.

Annex A

Register of Gifts / Hospitality Received and Provided/Declined

Version: HFEAG0001
Nov-24

DIVISION / DEPARTMENT: HFEA
FINANCIAL YEAR: 2024/25

	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
Receipt	Attended BFI event and film premiere of 'Joy'	Attend premiere of documentary relating to fertility	15/10/2024	£ -	Apricity	Accepted	Apricity	Tim Childs	HFEA Board member	Julie Chain	Julie Chain

Annual Review of Committee Effectiveness

Details about this paper

Area(s) of strategy this paper relates to:	The right information – to ensure that people can access the right information at the right time
Meeting:	AGC
Agenda item:	14
Meeting date:	6 December 2023
Author:	Paula Robinson, Head of Planning and Governance Alison Margrave, Board Governance Manager
Annexes	The template for the review was circulated separately, between meetings.

Output from this paper

For information or decision?	For discussion as part of the annual committee review process.
Recommendation:	AGC is asked to discuss the areas outlined in the NAO's risk review template for Audit Committees.
Resource implications:	In budget
Implementation date:	Ongoing
Communication(s):	Feedback from AGC will be incorporated into the Annual Governance Review, which is presented to the Authority in March every year.
Organisational risk:	Low

1. Introduction

1.1. It is good practice for all our committees to review their effectiveness annually, and this exercise informs an annual governance paper and an annual review of Standing Orders which is presented to the Authority in March.

1.2. For AGC, a different and more specialist form is used, provided by the NAO, and intended specifically for Audit and Risk Assurance Committees. Members and other attendees were asked to complete a copy of the form in advance. This paper summarises the input received in advance of the meeting.

1.3. A table is included in section 4, proposing a range of actions AGC could consider.

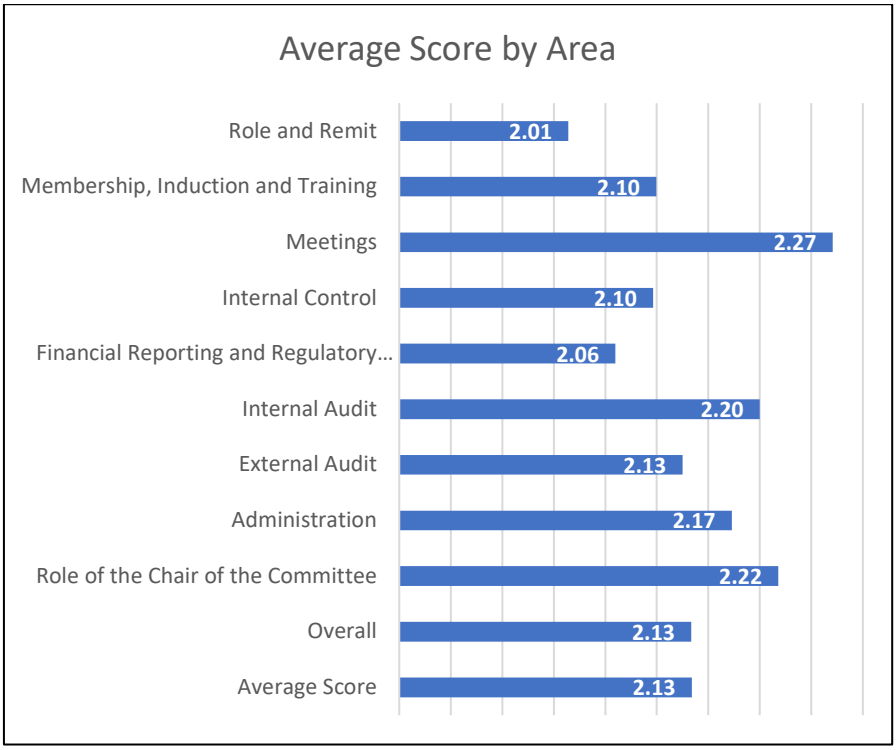
2. Contributors

2.1. All AGC attendees (members, our regular observers and staff) were invited to complete a copy of the form in advance. Further comments are invited at the meeting.

2.2. Nine responses were received before the meeting, and the summary in the next section indicates some areas of focus and areas where we appear to be meeting or exceeding standards.

3. Summary of responses

3.1. The following chart uses the responses received to produce an average rating for each section. The highest possible average rating for each section is 3.00. Not all submissions gave a score for every measure, presumably because some people felt unable to give a rating on some of the factors. Some measures were marked 'need to improve' by some respondents, with no comments provided.



The average score ratings are: improvement needed - up to 1.60; standard met - 1.61 to 2.60 and above standard - 2.61 to 3.00. It is reassuring that the average scores for all questions are standard met.

3.2. Role and Remit.

1	Does the committee have written terms of reference? See SOs, here: standing-orders-from-2024-04-01.pdf (NB these are being updated at the November Authority, so this link may have changed by the time of the AGC meeting.)	2.11
2	Are the terms of reference regularly reviewed? Standing Orders are reviewed annually following each annual committee review.	2.11
3	Do the terms of reference clearly set out the committee's role and are they consistent with the example terms of reference in this ARAC handbook?	2.25
4	Are the terms of reference approved by the committee and the board?	2.11
5	Are the terms of reference made publicly available? They are on the website at the link provided above (all committees' TOR are in Annex 2 of the SOs).	1.67
6	Has the committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?	2.00
7	Do committee members have appropriate authority to require reports on areas of the committee's responsibilities?	1.89
8	Does the organisation's annual report and accounts/Governance Statement mention the committee's existence and its broad purpose?	2.00

The lowest scoring questions in this section relate to whether the committee's terms of reference are made publicly available (5) and whether the committee members have appropriate authority to require reports on areas of the committee's responsibilities (7). Written responses against these questions stated that the respondents were not aware if the terms of reference were published on the website and were unclear when they were last reviewed.

Executive response: the terms of reference are available on the HFEA website in the Standing Orders and these are reviewed each year. They are also updated on an ad hoc basis if needed mid-year. The Standing Orders appear beside the information about the Authority under 'About us – Our Authority, committees and panels'.

In terms of requiring reports, we believe the committee does this as and when the need arises, and the committee's forward workplan is reviewed at each meeting.

3.3. Membership, Induction and training.

9	Has the membership of the committee been formally agreed by the board and/or accounting officer and a quorum set?	2.11
10	Does the committee have at least three members (or the number stated in the agreed terms of reference) who are independent and objective?	2.11
11	Are members appointed for a fixed term?	2.22

12a	Do all members of the committee have a clear understanding of what is expected of them in their role, including: time commitments, the duration of their appointment, training required and how this will be provided?	1.86
12b	Do all members of the committee have a clear understanding of what is expected of them in their role, including: an understanding of the organisation – strategy, operating environment and key risks?	1.89
12c	Do all members of the committee have a clear understanding of what is expected of them in their role, including: role of the board in managing risk and of the committee in supporting the board to provide review and challenge?	1.89
13	Have members received formal appointment letters (setting out their terms of appointment including work required) before their term of office commenced?	1.88
14	Does the committee have the relevant/required range of skills in governance, risk, control, and financial management and is this reviewed on a regular basis?	2.11
15	Does at least one committee member have recent and relevant financial experience?	2.11
16	Is the committee empowered to co-opt members and procure specialist advice to support them when needed?	2.11
17a	Is the Chair a Non-Executive Board member (NEBM) with relevant experience to chair the committee?	2.56
17b	Is at least one other member a NEBM?	2.33
17c	Do governance processes ensure the chair of the board is not a member of the committee?	2.00
18	Are new committee members provided with an appropriate induction, including training to help them understand the public sector accountability framework, if they have not previously worked within central government?	2.13
19a	Does the induction include a programme of engagement with the organisation to help members understand: the organisation, its objectives, business needs, priorities, risk profile and challenges?	2.13
19b	Does the induction include a programme of engagement with the organisation to help members understand: the organisation's vision and purpose?	2.13
19c	Does the induction include a programme of engagement with the organisation to help members understand: the organisation's corporate governance arrangements?	2.13
20	Are regular training and development opportunities (especially for recent developments or emerging risk areas) considered and implemented for committee members?	2.22
21	Has each member formally declared their business interests and/or conflicts of interest and have these been appropriately dealt with?	2.11
22	Are members sufficiently independent of the other key committees of the board?	1.89

23	Has the committee considered the arrangements for assessing the attendance and performance of each member, including the chair?	2.13

The lowest scoring questions in this section relate to whether members have a clear understanding of what is expected of them in their role (12a) and whether members have received formal appointment letters (13). Written responses against these two questions stated that respondents were unable to comment. There was one comment about the range of skills in governance, risk, control and financial management (14), that there continues to be a gap seeking to be filled with finance expertise. There was also one question about whether external members' conflicts of interests are updated regularly (21).

Executive response: The remit of the committee is set out in the terms of reference which are available in our standing orders. External committee members have a formal appointment letter and Authority members have formal correspondence from the Chair (in addition to personal discussions about committee memberships). As the appointment information is very much operational/administrative there is no need for committee members to be particularly aware of the full background work involved, but all (Authority members and external members) should be aware of their own appointment. Authority members typically remain on their allocated committees throughout their term of office as a member, although on occasions committee memberships are rebalanced when new members are appointed to the Authority.

This will be the first meeting since the appointment of new members to the Board. Consideration can be given to filling the remaining available place for an external member, if the committee feels that this is merited.

Since external members' interests are not published on the website, we have not previously updated these between terms of office. We can add that to our annual processes so that we maintain an up-to-date record.

3.4. Meetings

24	Does the committee meet regularly and at least four times a year?	2.22
25	Do the terms of reference set out the frequency?	2.13
26	Does the committee calendar meet the organisation's business and governance needs, as well as the requirements of the financial reporting calendar?	2.22
27	Are members attending meetings on a regular basis and if not, is appropriate action taken?	2.33
28	Does the accounting officer attend all meetings and, if not, are they provided with a record of discussions?	2.33
29	Does the director of finance attend all meetings and, if not, are they provided with a record of discussions?	2.33
30	Does the committee have the benefit of attendance of appropriate officials at its meetings, including representatives from internal audit, external audit, finance and if relevant, the sponsoring/sponsored body?	2.56
31	Does the committee meet privately without any non-members present for all or part of a meeting if considered necessary?	2.33

32	Do committee members or the committee chair meet separately with relevant executives as required (especially the accounting officer and any relevant newly appointed executives soon after their appointment)?	2.33
33a	Is a verbal or written report summarising the business taken by the committee provided to the board after each meeting?	2.13
33b	Does the verbal or written report offer views and advice from the committee on issues that require the board or accounting officer to take action?	2.00

The lowest scoring questions in this section relate to whether the terms of reference set out the frequency of meetings (25) and whether a verbal or written report summarising the business taken by the committee provided to the board after each meeting (33a). Written responses against these two questions stated that the respondent was unable to comment as they had not seen a copy of the terms of reference.

Executive response: The frequency of meetings is set out in the committee's terms of reference and articulated in the committee's forward work plan. At each Authority meeting a written Committee Chairs' report is presented and each Chair has the opportunity to also provide a verbal update to the Authority meeting. As stated above, the terms of office are published as part of the Standing Orders, on our website. A separate copy of the Standing Orders can be provided to members on request.

3.5. Internal Control

34	Does the committee consider the findings of reviews by internal audit and others, on the effectiveness of the arrangements for governance, risk management and control?	2.33
35a	Does the committee: have an understanding of the overall assurances provided within the organisation (by the three lines)?	2.00
35b	Does the committee: consider adequacy of these assurances, especially for outsourced services?	2.11
36	If the Committee does not consider the overall assurance provided to be adequate, does the committee raise these concerns to the executive to commission additional work?	2.00
37a	Does the committee consider how meaningful the Governance Statement is?	2.11
37b	Does the committee consider if all pertinent issues have been included in the Governance Statement from the work the committee has undertaken during the reporting period?	2.11
38	Does the committee satisfy itself that the arrangements for governance, risk management and control have operated effectively throughout the reporting period?	2.11
39	Has the committee undertaken deep dives into significant risks to review and challenge management's actions to manage and mitigate the risk?	2.11
40	Has the committee considered how it should coordinate with other committees that may have responsibility for risk management and corporate governance?	1.75

41	Has the committee satisfied itself that the organisation has adopted appropriate arrangements to counter and deal with fraud, including reporting losses, investigating fraud incidents, and submitting quarterly returns to the Cabinet Office?	2.11
42a	Does the committee receive regular reports on anti-fraud policies?	2.11
42b	Does the committee receive regular reports on whistleblowing processes?	2.11
42c	Does the committee receive regular reports on arrangements for special investigations?	2.13
42d	Does the committee receive regular reports on relevant fraud and whistleblowing cases and near misses?	2.11
43	Has the committee been made aware of the role of risk management in the preparation of the internal audit plan?	2.22
44	Does the committee's terms of reference include oversight of the risk management process to ensure risks are managed and new risks will be identified?	2.13
45	Does the committee review the corporate risk register to ensure it reflects key strategic risks?	2.11
46	Does the committee consider/challenge assurances provided by senior staff on the adequacy and effectiveness of control processes?	2.00
47	Does the committee ensure any significant weaknesses found have been appropriately dealt with?	2.11

The lowest scoring question in this section relate to whether the committee considered how it should coordinate with other committees that may have responsibility for risk management and corporate governance (40).

Executive response: this is not applicable to the HFEA; however there is a section under each of the risks in our strategic risk register for interdependencies on risks, which in our case are mainly with the Department.

3.6. Financial Reporting and Regulatory Matters

48	Is the committee's role in the consideration of the annual report and accounts clearly defined?	2.11
49	Does the committee review the annual report and accounts (including the Governance Statement) and discuss the comprehensiveness, reliability and integrity of assurances in meeting the board and accounting officer's needs?	2.00
50	Does the committee gain an understanding of management's procedures for preparing the organisation's annual report and accounts?	1.89
51a	Does the committee consider, as appropriate: the suitability of accounting policies and treatments and/or changes in accounting treatment?	2.11
51b	Does the committee consider, as appropriate: assurances regarding the financial systems that produce the accounts?	2.11

51c	Does the committee consider, as appropriate: major judgements made (and if specialists were used to help with the judgements)?	2.11
51d	Does the committee consider, as appropriate: large write-offs?	2.11
51e	Does the committee consider, as appropriate: the reasonableness of accounting estimates?	2.11
51f	Does the committee consider, as appropriate: the narrative aspects of reporting?	2.00
51g	Does the committee consider, as appropriate: any differences of opinion between the auditor and executives?	2.11
52	Is a committee meeting scheduled to receive the external auditor's report to those charged with governance including a discussion of proposed adjustments to the accounts and other issues arising from the audit?	2.11
53	Does the committee review management's letter of representation?	2.11
54	Does the committee have a mechanism to keep it aware of topical legal and regulatory issues?	1.89

The lowest scoring questions in this section relate to whether the committee has an understanding of management's procedures for preparing the organisation's annual report and accounts (50) and does the committee have a mechanism to keep it aware of topical legal and regulatory issues (54).

Executive response: The committee receive the draft annual governance statement, including the timeline for the preparation of the annual report and accounts and comments on the draft document. The actual preparation of the annual report and accounts is a very operational and technical task (accomplished mainly with the NAO) which does not sit within the committee's governance remit, although the committee receives updates on progress from both staff and the NAO.

The committee also receives the GIAA supplementary pack which provides additional information to members and receives regular training on topics identified during discussions at meetings. It has also been suggested that we source a quarterly update on legal and regulatory matters, which we will endeavour to do.

3.7. Internal Audit

55	Does the Head of Internal Audit attend meetings of the committee?	2.33
56	Does the committee consider, annually and in detail, the annual internal audit plan (and fee) including consideration of whether the scope of internal audit work addresses the body's significant risks and does not duplicate assurances provided by other lines?	2.33
57	Has the committee considered the internal audit mandate/formal terms of reference/internal audit charter defining internal audit's objectives, responsibilities, authority and reporting lines?	2.22
58	Does internal audit have a direct reporting line, if required, to the committee?	2.22

59	Has the committee considered the information it wishes to receive from internal audit?	2.11
60a	Does the committee receive progress reports from internal audit and review and challenge progress?	2.22
60b	Does the committee review the annual report from the Head of Internal Audit?	2.22
61	Are outputs from follow-up audits by internal audit monitored by the committee and does the committee consider the adequacy of implementation of recommendations?	2.11
62	Does the committee (chair) hold private discussions with the Head of Internal Audit at least once annually?	2.13
63	Is there appropriate co-operation between the internal and external auditors?	2.11
64a	Does the committee review the adequacy of internal audit staffing and other resources?	2.13
64b	Does the committee review internal audit performance measures?	2.22
64c	Does the committee review reports on internal audit quality assurance arrangements?	2.22

The lowest scoring questions in this section relate to whether the committee has considered the information it wishes to receive from internal audit (59), are the outputs from follow-up audit monitored by the committee and does the committee consider the adequacy of implementation of recommendations (61) and is there appropriate co-operation between the internal and external auditors (63). One person queried whether the Chair holds private discussions with the Head of Internal Audit at least once per year (62).

Executive response: The committee has private meeting sessions with the auditors at each meeting. The internal audit plan is developed by GIAA with input from the HFEA's Senior Management Team. As the committee is aware, implementation of audit recommendations and provision of required evidence has been a particular focus throughout this year, and this will continue to be the case. The Chair has a meeting with the Head of Internal Audit a week before each AGC meeting.

3.8. External Audit

65	Does the external audit representative attend meetings of the committee?	2.22
66	Do the external auditors present and discuss their audit plans and strategy with the committee (recognising the statutory duties of external audit)?	2.22
67	Does the committee challenge external audit plans if considered not to cover key risks?	2.11
68	Does the committee (chair) hold periodic (at least annually) private discussions with the external auditor?	2.33
69	Does the committee review the external auditor's annual report to those charged with governance?	2.11

70	Does the committee ensure that executives are monitoring action taken to implement external audit recommendations?	2.00
71	Are reports (including general value for money reports) on the work of external audit presented to the committee?	2.11
72	Does the committee assess the performance of external audit?	1.89
73	Does the committee consider the external audit fee and challenge it if considered inappropriate?	2.13

The lowest scoring questions in the section relate to whether the committee ensure that executives are monitoring action taken to implement external audit recommendations (70) and does the committee assess the performance of external audit (72).

Executive response: The Committee receives regular written and verbal reports from our external auditors, and any matters requiring further resolution are discussed at meetings.

3.9. Administration

74	Does the committee have a designated secretariat and is the secretariat sufficient to deal with the committee's business?	2.33
75	Is a draft forward workplan for the committee agreed at the start of each financial year to adequately cover all areas of the committee's responsibility?	2.22
76	Are agenda papers circulated in advance of meetings to allow adequate preparation by committee members and attendees?	2.22
77	Do reports to the committee communicate relevant information at the right frequency, time, and in a format that is effective?	2.11
78	Does the committee issue guidelines and/or a proforma concerning the format and content of the papers to be presented?	2.00
79	Are minutes prepared and circulated promptly (after review by the chair) to the appropriate people?	2.11
80	Is a report on matters arising from committee meetings presented and/or does the chair raise them at the committee's next meeting?	2.22
81	Do action points indicate the owner and due date?	2.22
82	Does the committee provide an effective annual report on its own activities, which is timed to support the preparation of the Governance Statement?	2.11

The lowest scoring question in this section is whether the committee issues guidelines and/or a proforma concerning the format and content of the papers to be presented (78).

One member also observed that the minutes are not circulated until the papers for the next meeting (79).

Executive response: The HFEA has a template for committee papers and a Standard Operating Protocol (SOP) on how papers should be prepared and finalised in readiness for meetings. The Chair meets with the lead Director and Secretary a month before the meeting to discuss the draft agenda and preparation of papers, and any directions given by the Chair are passed on to the

relevant paper author(s). Minutes are drafted immediately after each meeting, and shared with staff first for minor corrections, before being shared with the Chair. They are then circulated for sign-off by all members with the papers for the next meeting. We follow the same process for Authority minutes.

3.10. Role of the Chair of the Committee

83	Is the Chair involved in the appointment of new committee members and the head of internal audit?	2.29
84	Does the Chair agree the annual core programme of work and agendas for each meeting?	2.25
85a	Does the Chair ensure meetings run effectively and efficiently?	2.25
85b	Does the Chair ensure additional meetings are convened as required?	2.14
85c	Does the Chair ensure the number of meetings held are sufficient to allow the committee to consider all relevant areas?	2.25
86a	Does the Chair ensure committee has access to appropriate resources and support and committee budget is managed?	2.13
86b	Does the Chair ensure members work collaboratively?	2.25
86c	Does the Chair ensure an effectiveness review is undertaken (or an external review is commissioned if considered relevant)?	2.25
86d	Does the Chair ensure internal and external audit have free and confidential access if required?	2.25
86e	Does the Chair ensure governance needs of sponsor/ALB are considered?	2.13

The lowest scoring questions in this section are does the Chair ensure the committee has access to appropriate resources and support and committee budget is managed (86a) and does the Chair ensure the governance needs of sponsor/ALB are considered (86e).

Executive response: The Chair encourages members to sign up and attend the events run by GIAA. Our sponsors are invited as observers to every meeting. If the Chair were to have any concerns about committee resources, support or budget, she would be able to raise this with the Chair or the Chief Executive, or with the Director of Finance and Resources, either during or between meetings.

3.11. Overall

87	Does the committee effectively contribute to the overall control environment of the organisation?	2.13
88	Does the committee seek feedback on its performance from the board and accounting officer?	2.14

There were a few free comments written in this section, and other positive comments, which are summarised below:

- The Committee works well and meetings are well attended by the Executive.
- Induction is good.
- The assurance training in December will be helpful for the committee and staff alike.

- If it is mandatory to do this review each year, could we ask half the committee to do this at a time (so that each individual member only needs to do this every other year)?

4. Potential actions

4.1. Based on the areas for possible improvement, the following table summarises some potential actions AGC could consider. This is not an exhaustive list.

Quick wins	**Actions we can incorporate into already-planned work**	**Other possible future actions**
62 – Chair meeting with Head of Internal Audit. Confirm whether this happens at least annually.	33 a – Board reporting Invite AGC members to observe an Authority meeting.	5 – Committee terms of reference Determine whether there is a way to make Standing Orders appear as a search result on the website (uncertain what this would technically entail).
Overall comments on the review of effectiveness Seek advice from the NAO as to whether a lighter touch approach could be considered, i.e. every other year, or half the committee each year.	21 – Conflicts of interest For external members, we will include an annual update of interests declared whenever we do the annual process each year for Authority members' interests (which are published on the website).	14 – Gaps in expertise To consider whether there is a need to fill the second external member position with (for example) someone with financial expertise.
		54 – Awareness of topical legal and regulatory issues To consider any particular topical issues that arise for future training sessions.
		54 – Topical legal and regulatory issues We will seek an appropriate regular update or free newsletter that covers these topics.
		70 and 72 – External audit implementation and performance To consider scheduling a future discussion for the agenda, to provide greater insight into the process.
Other points have been answered in the executive comments under each section above.		

5. Recommendation

5.1. Members are asked to discuss the committee review, with a particular focus on the tables relating to areas for improvement and potential actions, at paragraph 4.1.