Risk Pooling Schemes for Trusts
Risk Management Standards
Report of Assessment at Level One

Trust Name:	Portsmouth Hospitals NHS Trust		
Trust Contact:	Sheena King	**Trust No:**	T029
Assessor:	Code A	**Date of Visit:**	17 June 2002
Outcome :	Non-compliance	**Date of Report:**	15 August 2002

This report has been prepared to summarise the compliance position of Portsmouth Hospitals NHS Trust in relation to the RPST assessment tool, which represents the level one standard for the NHS Litigation Authority's Risk Pooling Schemes for Trusts. The RPST assessment tool is one of the core standards within the NHS Executive's Controls Assurance Programme. Level one of the assessment tool is principally concerned with ensuring that the organisation has obtained corporate ownership of risk through effective policies and procedures.

Responses to individual controls have been assessed on a yes, no or partial compliance basis where applicable. To obtain level one compliance the trust should obtain a score of 75% or above in each of the eight standards.

We are pleased that Portsmouth Hospitals NHS Trust chose to submit to formal assessment. Unfortunately, the organisation's overall assessment performance has failed to meet the minimum compliance level. The Trust will have a further six weeks from the date of this report to submit further evidence to enable them to achieve a higher score at level one.

Standard	**Compliance**	**Non Compliance**	**Partial Compliance**
1. The Corporate Accountability Arrangements for Risk Management	73%	9%	18%
2. The Risk Management Strategy	69%	31%	0%
3. The Risk Management Organisational Structure	71%	29%	0%
4. The Reporting and Management of Incidents	56%	38%	6%
5. The Reporting and Management of Complaints and Claims	71%	29%	0%
6. The Risk Management Process	26%	74%	0%
7. Risk Management Training	29%	64%	7%
8. Independent Assurance	13%	80%	7%
Overall Results	**51%**	**45%**	**4%**

Executive Summary

The trust is to be thanked for volunteering to come forward for early assessment. The organisation has failed to achieve the minimum compliance level at this stage. The score given reflects the fact that much of the pre-requested evidence was not available to view on the day of assessment. With the 6-week period the organisation should be able to improve their score by submitting further evidence.

Corporate Accountability for Risk Management is the organisations strongest area. There is a good breadth of people involved in the accountability arrangements for risk management. Currently the Risk Management Strategy does not clearly describe the executive responsibility for financial risk, held by the Director of Finance & Information. Furthermore his job description does not clearly reflect this accountability. The responsibilities of all levels of management are very clearly described within the strategy.

The Risk Management Strategy currently stands in draft form and the Board must approve this in the 6-week improvement period. Inserting a description of how the different committees interact with each other to ensure a holistic approach to risk management could strengthen the strategy. Describing the tools that the organisation will use to monitor its risk management performance could further strengthen the strategy.

The organisation could strengthen the organisational structure by regular reporting to the Board from the new Risk Management Committee (RMC) on risk issues. The specialist risk groups need to formally report to the RMC and clear reporting lines must established.

Incident reporting is very important to the overall level of compliance against the standard. This reflects some of the statutory requirements, but also the importance that effective incident reporting has on good risk management. Weaknesses in procedures have a large bearing on overall compliance and it is therefore, important to address the issues highlighted within the body of the report. The recent appointment of a Risk Advisor who will have specific responsibilities for training issues around risk should hopefully address training issues highlighted within the main body of the report. The organisation needs to provide clear guidance on incident investigation for staff to follow to ensure a consistent approach.

The organisation is currently reviewing the Complaints Procedure and the 1996 policy is board approved and therefore is the policy that the organisation can be scored on. However the assessor has also commented concerning the draft Trust Policy and Protocol for the Management of Written and Oral Complaints within the main body of the report. It would improve the score considerably by producing guidance on complaints investigation and detailing this within the procedure. The claims policy is in the final draft stage and is a good document and this should be Board approved within the 6-week improvement period. The title of the claims policy does not currently reflect that it contains guidance concerning PES and LTPS. The assessor suggests that it's made clear that the policy contains guidance on all claims. It would be also useful to contain reference to guidance on claims investigation.

The Risk Management Process is an area of significant weakness for the organisation. The organisation needs to identify, formalise and document the systems, procedures and staff responsible for the identification, assessment and analysis of risk. The low scoring in this area can be attributed to the lack of risks on the register at present. There is a lot of work to be carried out in this area. The organisation should refer to the main body of the report and the guidance available to accompany the tool (available late summer 2002).

There are opportunities for improvement within Risk Management Training. The organisation needs to formalise the system for identifying training needs for staff relating to risk management issues. There also needs to be information regarding attendees and non-attendees at all risk management courses. The organisation needs systems for rectifying non-attendance at statutory and mandatory courses. This needs to be an organisational wide

approach and formalised in a procedure. The organisation has currently purchased a training database that they hope will address many of the issues highlighted in the main body of the report, and will be up and running by Christmas 2002.

Due to inappropriate preparation of the criterion Independent Assurance the assessor was unable to view many of the pre-requested documentation. This lack of preparation is reflected in the score. Independent assurance to the Board for any organisation is an important requirement. Internal Audit should provide an independent opinion on risk management, control and governance.

The organisation has a further 6-week improvement period to provide evidence to improve their score. The assessor suggests writing some action plans in the three weakest areas of scoring.

Action Points

Criterion 1: Corporate Accountability for Risk Management

1.2.2 Accountability is clearly described within the risk management strategy. Where accountability is split (into for example clinical, financial and organisational risk) the strategy includes definitions of these terms and a description of the accountability split.

The organisation currently splits the responsibility between 2 directors. The Director of Finance takes responsibility for finance and the Director of Nursing & Midwifery has responsibility for organisational risk and clinical risk. The Risk Management Strategy describes the responsibility of the Director of Nursing & Midwifery but not that of the Director of Finance. Therefore the organisation was awarded a partial compliance. The Strategy does not currently contain clear definitions of the terms and a description of the accountability split.

1.2.3 Job descriptions reflect Executive accountability for risk management.

The organisation was awarded a partial compliance as the job descriptions for the Director of Nursing & Midwifery and the Director of Finance do not currently detail their responsibilities regarding organisational risk and controls assurance. The job description for the Director of Finance wasn't available to view on the day of assessment.

1.3.2 The risk management strategy describes the relationships between the various committees and summarises terms of reference (including the Audit Committee).

The Strategy appends the terms of reference for the RMC, Risk Management Team and the Audit Committee. There is no explanation of how the different Committees interact with each other therefore the organisation has been awarded a partial compliance. It would strengthen the Strategy to describe the reporting lines of the committees that have involvement in risk management issues.

Criterion 2: The Risk Management Strategy

2.3.1 The strategy describes how the risk management organisational structure functions to ensure a co-ordinated and holistic approach to the management of risk.

The Strategy needs to be clear in regard to how the different committees communicate and their accountability to each other to ensure the holistic approach. Detailing that the RMC has responsibility for the risk register, which encompasses all risks, could strengthen the strategy.

2.4.1 The strategy includes a description of the tools that the organisation will use to review risk management performance.

The tools that the organisation can use to review risk management performance include reviewing incidents, claims and complaints and reviews of performance against controls assurance and CNST standards. These tools need to be clarified and included within the Strategy. Consideration should be given to incorporating a description into the Strategy that pulls together these existing review mechanisms and identifies them as such.

2.7.3 Managers have a clear description of how the strategy is to be communicated within their departments.

The RMS is currently presented at the Divisional Governance Team meetings. Managers are given guidance on how to disseminate the Strategy within their departments, and how to outline staff responsibilities. There was no evidence of the Divisional Governance Team meetings to demonstrate this requirement on the day of assessment.

2.7.4 A full copy of the strategy is made available to all external stakeholders.

The RMS is not currently available to external stakeholders. By placing the Strategy on the Internet and/or making the Strategy available at the local library the organisation will ensure their external stakeholders have access to it.

Criterion 3: Organisational Structure

The RMC has just been introduced to the Trust and has formal terms of reference but has not yet met (meeting September 2002). Therefore the assessor when looking for evidence to demonstrate compliance with criterion 3 looked over minutes from the Controls Assurance Committee (CAC) and the Clinical Governance Committee (CGC) which use to perform the functions that the new RMC will undertake.

3.1.3 Minutes evidence that the Board is receiving minutes and reports from the committee(s) responsible for overseeing risk management. There should be demonstration of co-ordination in the reports.

There was evidence of the CGC reporting to the Board on risk issues but there was no evidence of the CAC reporting to the Board on issues of risk. To enable the Board to make decisions on risk issues it should receive reports detailing all risks within the organisation. The introduction of the RMC that considers all risks may address this issue in the future.

3.6.1 The committee(s) responsible for overseeing risk management issues receive(s) the minutes of the specialist risk management groups which report directly to them.

Currently the reporting lines from the specialist risk management Groups (H & S Advisory Group, Infection Control and the Medical Equipment Services Group) are informal. These reporting lines need to be formalised to ensure continuity of reporting.

3.6.3 Clear terms of reference are established for the specialist risk groups.

The terms of reference for the specialist risk groups (such as the H & S group, Infection Control group and Medical Equipment Services Group) were not available to view on the day of assessment. The terms of reference should detail the committees' responsibilities, accountability, membership and frequency of meetings.

3.7.1 Terms of reference clearly describe the role of the Audit Committee in reviewing and providing verification on the systems in place for risk management.

The terms of reference for the Audit Advisory Group (Finance & Audit Committee) are inserted into the RMS. They are very brief and the organisation should refer to the Audit Committee Handbook 2001 which states that the terms of reference should be reviewed by the Board on an annual basis. The terms of reference should also clearly state the Audit Committees role in reviewing and providing verification on the systems in place for risk management which presently they do not.

Criterion 4: Incident Reporting and Management

4.1.2 A Board minute evidences that the procedure has been Board approved.

Currently the Trust Management Team has approved the Trusts' Policy & Protocol for the Management of Adverse Events and Near Misses. The policy contains a statement outlining the approach towards positive and non-punitive incident reporting. CHI discovered that staff perception of the positive and non-punitive incident reporting varied considerably across the organisation. If the policy has approval of the Board this will demonstrate to staff that the positive and non-punitive approach has the commitment of the Board.

4.3.2 The incident reporting procedure cross-references other significant documentation such as the Whistle-blowing policy.

The current policy does not cross-reference the Whistle-blowing policy. This could be usefully inserted under "6. Reference Documentation" within the policy.

4.5.4 The organisation has a training programme for incident reporting.

The organisation was awarded a partial compliance, as the organisation does not have a training programme for incident reporting that has a structured approach. A talk will be given at induction when requested but this is not a regular slot. The training is reactive rather than pro-active, the organisation will provide training when there is a problem rather than train staff to complete incident forms. There is a desire within the risk management department to develop pro-active training programme for 2002/2003.

4.6.1 The incident reporting procedure requires managers to take immediate actions and the incident form(s) allows for this detail to be recorded.

4.6.2 The incident reporting procedure includes clear guidance on the types of immediate actions that managers may be required to take and is linked to severity grading.

The Adverse Incident Reporting Form allows managers to detail immediate actions taken. The Incident Reporting Procedure does not give authority for managers to take immediate actions following incidents. It would strengthen the procedure to detail what immediate actions the managers should take. Such immediate actions could include risk assessments to be carried out as soon as practicable, referring to other policies that contain references to external agencies, asking advice regarding incidents from specialist advisors, ensuring that injured staff are seen by occupational health and changing working practice. The types of immediate action should also be linked the severity of the incident and this authority of managers should be made clear within the Incident Reporting Procedure.

4.7.3 Training is provided for those responsible for applying gradings.

Currently all staff grade incidents and the onus is on the member of staff to request training if they feel they require it. When all staff are grading incidents it may be quite difficult to ensure an uniformed approach across the organisation. The organisation may like to consider making grading the responsibility of managers as the grading will determine the level of investigation and actions to be taken. A "Risk Advisor" has recently been appointed and the remit of this

role is to feed back regarding training issues. To ensure consistency of grading all staff should be provided with training.

4.8.1 The incident reporting procedure includes clear guidance on incident investigation and root cause analysis.

The organisation does not currently have a protocol for the investigation of all incidents and root cause analysis and therefore has been awarded a partial compliance. The organisation is currently working towards a protocol that it wishes to encompass incidents, complaints and claims. This would enable information to be gathered at every step of the investigation. However, there is guidance contained in the Strategy concerning investigation of clinical incidents but there is no overarching guidance concerning the investigation of all incidents. If the organisation chose to place this advice within the Strategy it should be referred to in the Policy & Protocol for the Management of Adverse Events and Near Misses.

4.8.3 The incident reporting procedure requires incidents to be regraded following investigation.

4.8.4 The guidance requires the level of the investigation to be linked to the incident grading.

The organisation does not currently formally regrade incidents. Presently the Policy & Protocol for the Management of Adverse Events and Near Misses states "Depending on grade of adverse incident, appropriate investigation process invoked" (page 4). It would strengthen the policy to include more detail regarding what is involved in the different types of investigation and to link incident grading to the level of investigation.

4.8.5 The guidance clearly details when external agencies need to be involved in the investigation process.

The Policy & Protocol for the Management of Adverse Events and Near Misses gives clear guidance in Appendix F concerning the notification of external agencies. Including guidance detailing when external agencies need to be involved in the investigation process could strengthen this.

4.9.1 The organisation can demonstrate compliance with CNST Standard 2 (Response to Major Clinical Incidents).

4.9.2 The incident reporting procedure is explicit about responsibilities for informing staff and the public.

4.9.3 The incident reporting procedure requires any information given to staff and the public to be documented.

4.9.4 The incident reporting procedure is explicit that those directly affected by the event must be notified before the media.

The organisation was previously assessed by CNST at Standard 2 and failed to achieve level 1. Appendix E of the Policy & Protocol for the Management of Adverse Events and Near Misses clearly states that the Communications Strategy should be followed before external communication is made. This document was not available to view on the day of assessment.

Appendix E gives no guidance concerning 4.9.2 or 4.9.3 neither did the Hotline Flowchart. Appendix E does detail that patients and the relatives should be informed before the media but does not give guidance regarding any other persons that might be involved in an incident.

4.10.6 The incident form states clearly that when any serious incident including those to patients has occurred, reporting is immediate irrespective of time of day.

The current organisational wide incident report form does not state the above. The new form that is currently being piloted has this detail.

Criterion 5: Complaints and Claims Reporting and Management

The organisation is currently reviewing the Complaints Procedure and the 1996 policy is board approved and therefore is the policy that the organisation can be scored on. However the assessor has commented concerning the draft Trust Policy and Protocol for the Management of Written and Oral Complaints.

5.1.2 The complaints procedure describes the responsibilities of managers and staff in relation to the resolution of complaints.

Neither policy gives clear guidance on the responsibilities that managers have in relation to the resolution of complaints at local level or above. Both policies give clear guidance on what is expected from staff dealing with the complaint.

5.2.2 The complaints procedure lists and summarises the role of the designated individual or individuals responsible for handling complaints.

The current Complaints Policy does not summarise the role of the Complaints Manager. The draft strategy details what the organisation should have under the national guidance (page 3) rather than detailing what they currently have and what the Complaints Managers' responsibilities are.

5.8.1 The organisation has clear guidance on complaints investigation and root cause analysis.

5.8.2 The guidance clearly details who is responsible for complaints investigation and root cause analysis and when.

The organisation does not currently have a protocol for the investigation of complaints and root cause analysis. The organisation is currently working towards a protocol that it wishes to encompass incidents, complaints and claims enabling information to be gathered at every step of the investigation.

5.8.3 The guidance clearly details when external agencies need to be involved in the investigation process.

The assessor recognises that the organisation is currently involving stakeholders in the investigation process, but there was no evidence to support this on the day of assessment. It would strengthen the Policy to detail when external agencies need to be involved in the investigation process.

5.8.4 Training is provided for those responsible for complaints investigation.

Presently no training has been undertaken by those responsible for complaints investigation.

5.10.2 A Board minute evidences that the claims procedure(s) has been Board approved.

The Clinical Negligence and Personal Injury Claims Management Policy & Procedures are currently in draft form. It is strongly recommended that the organisation utilise the 6-week period to Board approve this document.

5.12.1 The organisation has clear guidance on claims investigation and root cause analysis.

The organisation does not currently have a protocol for the investigation of claims and root cause analysis. The responsibilities of the litigation manager listed in the claims procedures are very in-depth but claims investigation should contain more detail. The organisation is currently working towards a protocol that it wishes to encompass incidents, complaints and claims enabling information to be gathered at every step of the investigation.

Criterion 6: The Risk Management Process

6.1.1 The organisation has clearly identified and documented the systems, procedures and staff responsible for the identification of hazards.

6.1.2 The organisation has clearly identified and documented the systems, procedures and staff responsible for the assessment of hazards and risk.

6.1.3 The organisation has clearly identified and documented the systems, procedures and staff responsible for the analysis of hazards and risk.

6.1.4 An action plan is in place to ensure the continual identification, assessment and analysis of risk throughout the organisation.

Discussions with the organisation on the day of assessment indicated that many different methods of risk identification are used. Such systems included looking through the local media, controls assurance, incidents complaints, claims and investigations. The organisation is aware that many of the systems used are reactive and this has been identified as a risk. There was no evidence available on the day to demonstrate that the organisation has documented the systems and procedures that should be followed when identifying hazards and those responsible. The RMC has the responsibility of identifying and developing the assessment systems and procedures that the organisation will use to assess risk. It is important that the organisation is aware of the different assessment tools that individual departments are using to assess risk and bring them all together. The staff responsible for this task should also be clearly documented.

The organisation has recently installed DATIX. They hope to use this database to analyse the information gained from risk assessments. This needs to be formalised and included in the action plan. An action plan needs to be developed to ensure the continuous identification, assessment and analysis of hazards. The action plan needs to state where responsibility lies, when assessments are going to take place and, how identified risks are going to get fed onto the risk register.

6.1.7 The organisation has a system in place to ensure that initial risk ratings can be altered to reflect the results of risk assessment, risk treatment; etc.

The organisation does not currently alter initial risk ratings to reflect the results of risk and treatment assessment.

6.1.8 Minutes evidence that the relevant Board sub-committee(s) responsible for overseeing risk management has/have approved the organisation's risk register and risk identification, assessment and analysis techniques.

The RMC needs to identify the risk identification, assessment and analysis techniques before a complete action plan can be introduced across the organisation.

6.1.10 Strategic risks and underlying hazards are systematically identified, assessed and analysed and included on the organisation's risk register.

The organisations risk register does not currently hold any strategic risks.

6.1.11 There is evidence of the Board regularly reviewing the organisation-wide risk register.

The Board has not yet reviewed the risk register. The RMC hope that the risk register will be reviewed by the Board quarterly.

6.2.1 On the basis of risk evaluation the organisation has produced risk treatment plans for all strategic risks.

6.2.2 There is evidence of the organisation treating strategic risks.

This criterion has not yet been addressed by the organisation. There was no evidence to demonstrate that risk treatment plans had been produced for strategic risks or that strategic risks had been treated.

6.2.3 There is evidence of the risk register being altered to reflect risk treatment.

There are currently no risks detailed on the risk register.

6.3.2 Minutes of the Board evidence that it receives and considers reports on significant risk faced by the organisation.

6.3.3 There is evidence of the Board taking decisions on risk treatment options.

The organisation was unable to provide evidence that that the Board had received any reports regarding significant risks. Dialogue on the day of assessment indicated that the Board would be receiving a report from the RMC regarding a significant risk to the organisation in June 2002 that would contain treatment options. The organisation could use the 6-week period to forward the Board minutes of this discussion.

6.4.3 Evidence demonstrates that external stakeholders are kept informed of significant risks faced by the organisation.

Dialogue on the day of assessment suggested that the report mentioned above would be sent to external stakeholders through the Board papers.

6.5.1 The organisation has identified and developed key indicators capable of showing improvements in management of risk.

The organisation has yet to identify areas in which key indicators can be developed. The key indicators need to be developed quantitatively to ensure that they are capable of measuring improvements in the management of risk.

6.5.2 Any committee with responsibility for defining key indicators has the role defined within its terms of reference.

The terms of reference do not currently reflect that the RMC have the role of defining key indicators.

6.6.1 There is evidence of an annual report on risk management being produced for the Board.

The RMC is charged with the responsibility of producing an annual report on risk management to the Board annually. The organisation could not demonstrate that the Board had received a recent report on risk management.

Criterion 7: Risk Management Training

7.1.1 There is a documented assessment of the risk management training needs of all staff.

The organisation needs to formalise the assessment of training needs for risk management. The assessment should be documented and pulled together centrally. It is hoped that the recent appointment of a "Risk Advisor" will feed back regarding training issues surrounding risk identification, assessment, analysis, reporting, grading and investigation.

7.1.2 The organisation's training prospectus includes details of all risk management courses, highlighting whether they are statutory, mandatory or desirable and who should attend and how often.

The organisation could not produce a training prospectus on the day of assessment.

7.2.1 Records are held of actual and expected attendees of mandatory and statutory training courses, which are correlated to identify non-attendees.

The organisation currently holds records of actual attendees but need to correlate this information with the non-attendees at mandatory and statutory training courses. Discussions on the day of assessment with the Head of Personnel indicated that there has been recent investment in training and record keeping of training. The organisation has purchased a training database that will link up to payroll every two weeks for new starters for induction. The organisation could consider using the database to identify non-attendees of all mandatory and statutory courses.

7.2.2 The organisation has a procedure for rectifying non-attendance at mandatory and statutory training courses and can provide evidence that it is used in practice.

It is the managers' responsibility to rectify non-attendance and the organisation could not evidence which procedures managers use.

7.2.3 Minutes evidence that the Board sub-committee(s) responsible for overseeing risk receive records of attendance at mandatory and statutory training courses on a regular basis.

The RMC does not currently receive any training records. The RMC wishes to utilise the database, when active (Christmas 2002), to receive quarterly reports detailing attendance at mandatory and statutory training courses.

7.2.4 Records of attendance at mandatory and statutory training courses are distributed to managers on a regular basis.

Records of attendance at mandatory and statutory training are not currently distributed to managers. Divisional Human Resources Managers will have access to the database and will be able to download records of attendance. The organisation could consider putting a process in place that ensures managers download records of attendance at least quarterly.

7.3.2 The organisation can demonstrate that the corporate induction includes risk management, complaints and incident reporting.

The induction does not contain a section on complaints or incident reporting & the organisations approach towards positive and non-punitive incident reporting therefore a partial score was awarded.

7.3.3 The organisation can demonstrate that 60% of all staff attend a specific local induction, which includes risk management and is appropriate to the area in which they are working.

Local managers carry out local induction and this is not currently recorded. This information would be usefully included on the training database as the managers have access to it.

7.3.4 The organisation can demonstrate that induction training for new managers and supervisors (including those promoted into this role) includes risk management, which allows them to fulfil their responsibilities as highlighted within the risk management strategy.

The organisation does not currently run any induction training for new managers. It hopes to introduce a "New Managers Course" and "Health & Safety Course" for managers.

7.4.2 Clear measurable objectives are attached to all risk management courses.

Evidence was unavailable on the day to demonstrate that clear measurable objectives are attached to all risk management courses.

Criterion 8: Independent Assurance.

8.1.1 Formal terms of reference exist, which clearly define Internal Audit's objectives, responsibilities, authority and reporting lines.

The terms of reference for internal audit were unavailable to view on the day of assessment.

8.1.2 An appropriate Executive Director is allocated with professional responsibility for the Internal Audit service and this is reflected within their job description.

The Director of Finance and Information is allocated this responsibility but the job description does not reflect this responsibility.

8.1.3 The organisation can demonstrate that there is a direct reporting line between the Head of Internal Audit and the Audit Committee, which is independent of the Chief Executive and other Executive Directors

The organisation was unable to demonstrate this on the day of assessment.

8.2.2 There is evidence that the audit plans are drawn up with full consideration of all risks as detailed within the risk register.

At present the organisation does not have a risk register that contains all risks they can refer to.

7.2.3 Where risks are not reviewed by Internal Audit, the organisation should demonstrate that either suitable alternative arrangements have been made or that they are willing to accept that no review will take place in some areas.

The organisation was unable to demonstrate this on the day of assessment.

8.2.4 There is evidence that the Chief Executive, as accountable officer ensures prompt action is taken in response to concerns raised by both Internal and External Audit.

The organisation was unable to demonstrate this on the day of assessment.

8.3.2 Minutes of the Board and overarching committee(s) responsible for risk evidence that they receive and consider the reports from any reviews carried out by external agencies.

The organisation was unable to demonstrate this on the day of assessment.

8.3.3 There is evidence of the organisation populating the organisation-wide risk register with risks identified from reviews carried out by external agencies.

There are currently no risks detailed on the risk register.

8.4.1 Minutes of the Audit Committee evidence that it is receiving quarterly reports from the Head of Internal Audit summarising Internal Audit activity within the quarter.

The organisation was unable to demonstrate this on the day of assessment.

8.4.2 Minutes of the Audit Committee evidence that it is receiving reports from and reviews carried out by external agencies.

The organisation was unable to demonstrate this on the day of assessment.

8.4.3 There is evidence of the Audit Committee ensuring that follow up audits are conducted to review whether important final report recommendations have been actioned by management.

The organisation was unable to demonstrate this on the day of assessment.

8.4.4 Minutes of the Audit Committee evidence that it is reviewing and providing independent verification on the systems in place for risk management.

The organisation was unable to demonstrate this on the day of assessment.

8.4.5 There is evidence of the Audit Committee reporting to the Board on the systems in place for risk management.

The organisation was unable to demonstrate this on the day of assessment.