KPMG

Clinical Excellence Commission

Quality Systems Assessment Program

Literature Review

March 2007

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Table of Contents

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Introduction

A comprehensive desktop review was performed of literature identified by the Clinical Excellence Commission (CEC) and from our own research. Material was identified from health, financial and other service industries. This assisted in identifying elements valuable in assessing quality, safety and risk management systems and processes that have not previously been utilised in the health industry. Articles were identified either by the CEC, experts from within the project team or expert group or through a search of selected databases, journals and search engines (Pubmed, Medline, MJA, BMJ, Australian Health Review, Google).

The following list provides a brief summary of the scope of articles reviewed:

- Existing approaches in health to patient safety & clinical quality assessment
    - Australia
    - United Kingdom
    - European Union
    - United States
    - Canada
    - New Zealand
- Assessment tools used in various jurisdictions for evaluation of patient safety and clinical qualities
- General patient safety & clinical quality issues including literature and research about safety and quality in health environments
- Reporting and rating methodologies In health related settings
- Other industries

- Petroleum
- Aviation
- Mining
- Finance sector

This document provides a brief outline of some of the key references and summarizes the learnings from the literature for the developing Quality System Assessment (QSA).

Literature from the Health System

A recent Australian example - Victorian Auditor General

In 2003 the Victorian Auditor General was asked to evaluate the patient safety systems of the Victorian public hospitals. In order to do this the Auditor General undertook a survey of 99 hospitals. This survey involved quantitative and qualitative responses based on self assessment. The second component was audit fieldwork at 5 health services. The audit was carried out in two large regional and three large metropolitan health services.

The approach was based on asking four questions about the safety and quality system of the Victorian hospitals and reviewed particular performance areas to answer the questions posed. The four questions are listed in Table 1 and the corresponding areas of assessment are outlined.

Are clinical RM systems rigorous?	**Risk management framework, policies, data & reporting clinical incidents**
Are clinical RM systems effective?	**Incident reporting and response, risk rating**
Are people issues managed effectively?	**Training & policies**
Is performance monitoring and reporting effective?	**Data reporting**

Table 1: Victorian Auditor General questions regarding safety and quality systems and areas of assessment.

The audit was performed in accordance with Australian auditing standards including tests and procedures

The Auditor General recommended the priority development of:

- Consistent definitions of patient safety and clinical quality terms

- Development of minimum datasets relating to adverse events and other indicators of patient safety and clinical quality

- Performance review criteria for safety and quality systems in health care

- Development of information management systems and standards to support the patient safety and quality systems

The report *Managing patient safety in public hospitals* can be found at:

http://www.audit.vic.gov.au/reports_par/agp102cv.html#

United Kingdom: Controls Assurance Standards and NHS Standards for Better Health

This corporate governance based program was the centrepiece of the drive towards improving the standard of health care in the National Health System (NHS) in recent years. The Controls Assurance Standards were used by the Commission for Healthcare Audit and Inspection (CHAI) in their assessment of the quality, safety and overall performance of NHS Trusts. It aimed to provide an integrating mechanism for existing audit and risk management processes and incorporated self-assessment and independent verification of self-assessment within its methodological approach.

Assessment of compliance against individual standards were evaluated using three performance levels

- Minimal

- Moderate

- Expected

The Controls Assurance Standards were deemed to be prescriptive and the criterion too rigid. Evaluation of the Controls Assurance Standards demonstrated that they were not seen to adequately account for difference in organisation type.

The NHS Controls Assurance Standards evolved into the NHS Better Health standards of which there are:

- 24 Core standards that were mandated

- 10 Developmental standards which were used as improvement goals

The Standards specified the methodology for self assessment which was varied and offered a triangulated approach. For example - Workshop with employee teams and management using specialist facilitator to analyse strengths and obstacles and develop an action plan. This was deemed to be an onerous process which was often used as an exercise to identify people to blame – in 1 Trust it took 8 people over a month each to extract and collate evidence required for the assessment process. There was widespread antagonism regarding the CHAI process and the perception amongst staff that the audit process was used to find people to blame and did not support staff in systems improvement.

Information about the NHS Standards for Better Health can be found at:

http://www.healthcarecommission.org.uk/serviceproviderinformation/annualhealthcheck/howitworks/corestandards.cfm

United Kingdom: Clinical Negligence Scheme for Trusts

This is a voluntary program that is run by the NHS Litigation Authority (NHSLA). The NHSLA is a Special Health Authority, responsible for handling negligence claims made against NHS bodies in the UK. In addition to dealing with claims when they arise, they have an active risk management programme to help raise standards of care in the NHS and hence reduce the number of incidents.

Trusts are rewarded for participation in the program with discounts on insurance premiums where they can demonstrate compliance with the Clinical Negligence Scheme for Trusts (CNST) Risk Management Standards.

Trusts are provided with the standards, supporting evidence, verification directions and the scoring system utilised. Standards are assessed progressively at 3 levels:

- Level 1 – Basic elements of Clinical Risk Management framework

- Level 2 – Clinical Risk Management integrated into policies procedures

- Level 3 - Integration of Clinical Risk Management into clinical workplace is monitored

NHS Litigation Authority assessors perform assessment site inspections every 2 years with 1 assessor performing a 2.5 day visit and a pre-assessment visit.

Information about the Clinical Negligence Scheme for Trusts can be found at:

http://www.nhsla.com/Claims/Schemes/CNST/

United States – Agency for Healthcare Research and Quality Patient Safety Indicators

Three sets of health quality indicators are produced by the Agency for Healthcare Research and Quality (AHRQ)

- Prevention quality indicators

- Inpatient quality indicators

- Patient safety indicators

The three sets of indicators are used primarily for quality improvement. Comparative indicator performance reports are published and available for benchmarking on the web. Hospital performance on AHRQ indicators is incorporated into payment schemes by health service purchasers. This is a data driven approach with each indicator defined by supporting technical specifications. Any validity issues and level of evidence is also available to inform assessments. Benchmarked adverse event rates are available and can be accessed by member organisations through the Web.

The Patient Safety indicators focus on screening for adverse events. Indicators occur at two levels with adverse event rates available for benchmarking

- the provider level (20 indicators)
- the area/catchment level indicators (7 indicators)

There are limitations to the utility of the indicators. They rely on the completeness and accuracy of documentation in the medical records and the sensitivity of the coding processes. Also there are varying levels of evidence supporting the validity of indicators with some being more robust than others.

Information about the AHRQ's Patient Safety Indicators can be found at:

http://www.qualityindicators.ahrq.gov/psi_overview.htm

Organisation for Economic Co-Operation and Development (OECD) Patient safety Indicators – Health Systems level

In 2004, as one in a series of technical papers on methodological studies and statistical analysis, the Organisation for Economic Co-Operation and Development (OECD) published a set of 21 patient safety indicators to assist in the drive towards a more standardised approach to measuring various health metrics in OECD countries. The patient safety indicators are listed in Table 2.

Hospital acquired infections	**Ventilator pneumonia** **Wound infection** **Infection due to medical care** **Decubitus ulcer**
Operative and post-operative complications	**Complications of anaesthesia** **Post-op pulmonary embolus (PE) or Deep Vein Thrombosis (DVT)** **Post-op sepsis** **Technical difficulty with**

	procedure
Sentinel events	**Transfusion reaction** **Wrong blood type** **Wrong-site surgery** **Foreign body left in during procedure** **Medical equipment-related adverse events** **Medication errors**
Obstetrics	**Birth trauma** **Obstetric trauma- vaginal and caesarean**
Other care-related adverse events	**Patient falls** **In-hospital hip fracture**

Table 2: OECD Indicators for patient safety

Information about the OECD Patient safety indicators – Health Systems level can be found at:

http://www.oecd.org/dataoecd/53/26/33878001.pdf

United States – Veterans Affairs Assessment for Patient Safety

This is a voluntary self assessment tool which is improvement focussed rather than a compliance model. The tool sits within a well

developed organisational safety management system of which it is one of many components. The system has a very strong no-blame culture and encourages self evaluation.

Elements in the self assessment tool are priority rated to assist organisations to focus on high risk areas. The priority ratings are as follows:

- A = Highest priority impacting fundamental program initiatives
- B = Important to program areas
- C = Strongly recommended

It is anticipated that organisations will follow a program of gradual development and improved performance as they progress further on into the implementation of the program.

The assessment tool incorporates Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards with items being able to be directly translated to selected Standards.

Information about the Veterans Affairs Assessment for Patient Safety can be found at:

http://www.va.gov/ncps/SafetyTopics.html#PSAT

United States – ECRI INsight Program

ECRI (formerly the Emergency Care Research Institute) is a US based not for profit health services research agency whose mission is to improve the safety, quality, and cost-effectiveness of healthcare. It has a range of services, one of which is a Web-based risk assessment tool that assesses risk exposure in healthcare organisations.

This risk-assessment tool provides instant automated, aggregate reports that detail areas needing improvement and provide comparison data suitable for benchmarking. It also produces targeted recommendations including information on the evidence base for recommendations and information on supporting standards that may be of assistance in improvement work.

Participants are provided with performance scores to assist in prioritising areas for improvement. The assessment can be used in hospitals, medical practices and long-term care facilities and can assist organisations to achieve compliance with regulatory requirements. Pricing starts at $US3,500 per facility. Performance assessments may be used by funding bodies to determine levels of payment for services.

Information about the INsight program can be found at:

http://www.ecri.org/Products_and_Services/Services/INsight/Default.aspx

Discussion Paper – National Safety and Quality Accreditation Standards, Australian Commission on Safety and Quality in Healthcare (ACSQH), November 2006.

This paper was prepared by the Australian Commission on Safety and Quality in Healthcare (ACSQH) as a basis for consultation regarding the development of recommendations for a new model of accreditation and Standards for health services in Australia. The Discussion Paper poses a number of questions about standards & accreditation and seeks comments in response. It includes a package of proposals for a new approach to accreditation to stimulate debate on the topic and suggestions for improvement.

Standards

ACSQH identify that standards are developed both to protect the public from harm and to improve the quality of service provision. This discussion paper identifies 23 Standards setting bodies within Australia that are applicable to health care, and a corresponding 22 Accrediting bodies. Some of the Standards setting bodies have up to eight organisations involved in accreditation of the service/organisation. This will inevitably, involve up to eight different methods of accreditation.

Issues identified with mapping health care standards has shown that the complexity of this task is a direct result of the differences in terminology between sets of standards, variance of structure, style, and purpose of the standards. The Commission acknowledges that due to this complexity it is not possible at this stage to identify the extent of duplication in standards, nor the gaps in safety and quality standards that may exist. Further, there are issues around the

proliferation of standards, access to standards, the process of developing standards and the appropriateness of their use in assessment.

Accreditation

The Discussion paper also identifies several issues around accreditation. These include:

- Effectiveness in identifying poor performance;
- Transparency;
- Governance;
- Duplication and Overlap;
- Resource requirements;
- Surveyors; and
- Information to support accreditation.

Proposed Reforms

The Commission proposes an integrated package of reforms to be applied nationally across all sectors in the health care system. The primary focus of these reforms is to avoid overlap and duplication between the Standards and Accreditation processes for health care services, including education and training programs.

The Commission outline 11 reform strategies to address the issues with Standards and Accreditation in Australian health care services. These reforms include:

- developing a register of accrediting bodies
- standardising accreditation language and definitions
- training and competency testing of surveyors
- better use if data for evaluation of health service performance
- system-wide accreditation against safety and quality standards

- introduction of unannounced surveys
- introduction of Tracer methodology in external accreditation reviews
- registration of sets of health care standards
- harmonisation of health service standards
- detailed mapping of standards
- identification of core safety and quality areas.

A copy of the Commission's discussion paper can be found at: http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/whats-new-lp

10 Patient Safety Tips for Hospitals, Agency for Healthcare Research and Quality (AHRQ), February 2007.

This research provides organisations with some helpful hints to improve patient safety and make suggestions as to what protocols have had an impact in similar organisations.

The Agency for Healthcare Research and Quality (AHRQ) has funded more than 100 patient safety projects since 2001. Of these 100 pieces of research according to the AHRQ, ten practical tips can be put into practice in hospitals. These are summarised in the table below:

Practical Tips	Explanation
1 Assess and improve your patient safety culture	The use of staff surveys to assess patient safety and culture using tools developed by the AHRQ. http://www.ahrq.gov/qual/hospculture/
2 Build teamwork	The use of AHRQ toolkits established from evidence-based training techniques for effective communication to improve teamwork within the organisation.

Practical Tips		Explanation
3	Limit shifts for hospital staff	Minimise shifts of more than 16 hours for all health professionals. Studies of two hospitals in the United States showed that eliminating 30-hour shifts by medical staff decreased the number of accidents and injuries.
4	Insert chest tubes safely	The introduction of an easy-to-remember mnemonic (UWET) regarding insertion of chest tubing from a universal protocol developed by the Joint Commission.
5	Prevent central line-related bloodstream infections	Utilising five evidence –based procedures to prevent infections such as these led to a reduction of deadly infections to zero in a study of more than 100 hospitals.
6	Make good use of senior ICU nurses	A study concluded that shifts with the appropriate senior staff cover within ICU led to fewer airway tube complications when they were present than when junior staff were left in the Department.
7	Use reliable decision-support tools at the point of care	"Computerised physician order entry or personal digital assistant-based drug information is available at the point of prescribing of ordering" reduces the potential errors associated with insufficient or incomplete drug information.
8	Set up a safety reporting system	Example of a web-based reporting system in the ICU to help eliminate system failures that lead to errors in healthcare. This aids comparison of near misses to adverse events and examine providers perceptions of the reporting systems.
9	Limit urinary catheter use to 3 days	Introduction of best practice by assessing catheter use within 3 days of insertion and setting up methods to remind clinicians to review and remove as soon as possible to

Practical Tips	Explanation
	minimise urinary tract infections.
10 Minimise unnecessary interruptions	Reduce distractions faced by nursing staff especially when changing shifts. Empower nurses to inform the person interrupting that it is not appropriate to do so at this time. This will reduce errors especially when conducting handover or administering medications.

Table 3: 10 Patient safety tips for hospitals

A copy of the AHRQ's patient safety tips for hospitals can be found at: http://www.ahrq.gov/qual/10tips.pdf

State of Healthcare 2006, Healthcare Commission UK, October 2006.

The Healthcare Commission in the UK is an independent body responsible for reviewing the quality of healthcare and public health in England, with a smaller role in Wales. Part of the Healthcare Commission's role is to assess the performance of healthcare organisations in England, including both the private and public sector.

The performance of the health system is reported through a system called the annual health check. Previously, NHS trusts were provided with a gold star rating, in order to rate their performance. The 2005/6 however, a new health check system was used to provide their annual rating of performance. The information used to develop this rating comes from a range of sources, including both data from the Trust themselves, as well as from other sources, such as the Commission for Social Care Inspection and the Mental Health Act Commission.

The rating given to Trusts has two components:

1. Quality of services available to patients and the public; and

2. Management of finances and other resources[1].

In relation to scoring the quality of service, trusts are assessed against a range of elements. These elements include core standards, national standards, and new national standards. Against each of these standards, trusts are assigned a four point score, which are combined to give them an overall rating for each element. Consideration is also given to independent reviews taken throughout the year, which investigate a specific focus area, such as diagnostic services, or services for children. These reviews also result in the assignment of a rating based on a four point scale. Rules are then used to aggregate the scores a trust received for each element into a total rating for the trust for quality of service. These ratings are again assigned on a four point scale as either weak, fair, good or excellent.

The process used to undertake the health check is based on self assessment. All Trusts submit their self assessment of their compliance against a set of core standards. These self assessments are then verified through inspection of approximately 20% of Trusts. This inspection occurs either randomly or through a risk based process. Approximately half the inspections were targeted in trusts where it was thought there was the greatest risk of a failure being undeclared. During the inspection process, each trust's self assessment is cross checked against a broad range of information, including from national sources, from information provided by other regulators and bodies, and from the Commission's own intelligence.

To follow up on the results of this assessment program, the bottom 10% of trusts are provided with support in order to assist them in improving their performance.

More information about the Healthcare Commission's Annual Health Check process can be found at:
http://annualhealthcheckratings.healthcarecommission.org.uk/annualhealthcheckratings/abouttheannualhealthcheck.cfm

[1] State of Healthcare 2006, Healthcare Commission October 2006 p.7

Public reporting of hospital outcomes based on administrative data: Risks and Opportunities, The Medical Journal of Australia (MJA) 2006; 1854(11): 571-575.

This article counters recommendations made in the Forster inquiry that routinely collected administrative data should be publicly reported to inform the public and promote change in practices by hospital staff.

The authors suggest that while public reporting is worthwhile, it needs to be carefully presented to ensure reports are interpreted accurately.

A number of issues with the public reporting of hospital data are identified and discussed. These include:

- The validity of hospital reports – as a result of issues such as inaccurate/incomplete/insufficient data, failure of analyses to control adequately for differences (e.g. casemix), and difficulties in minimising the effects of random error. Further, the authors question whether differences in outcomes based on administrative data reflect real differences in quality of care, and whether true variation in outcome can be reliably detected for hospitals that are similar.

- Whether the lay public can access, interpret and appropriately act on hospital reports

- The possibility that public reporting provides health services with perverse incentives around care and its quality (e.g. avoidance of high risk patients, inappropriate early discharge, or concentrating efforts on those areas that are performance managed and ignoring those that are not)

This article can be viewed at:
http://www.mja.com.au/public/issues/184_11_050606/sco10085_fm.html

Ready, Set, Survey- Is your facility Prepared for Tracer Methodology? Brenda L. Johnson and Valerie R. Davis (For the Record vol 16 No. 21 Pg 18).

This article discusses a different model of assessing and accrediting an organisation – that of a process which "traces" the patient journey – from point of entry to post discharge and at all points in between. The process is termed "tracer methodology" and has been introduced in America for the former Joint Commission on Accreditation of Healthcare Organisations (JCAHO) to conduct their accreditation processes.

The article acknowledges that sometimes organisations are so used to being assessed that they ensure that they are what Johnson and Davis refer to as "survey ready". Through the use of the tracer methodology, the review team spend more time with patients mapping and exploring their experience of the service, rather than reviewing documentation. This process has been adopted by JCAHO for their accreditation.

Tracer evaluations begin with the surveyors selecting an active patient or recently discharged patient and using that individuals medical notes as a 'road map' to move through the organisation to "assess and evaluate the facility's compliance with selected standards and systems of providing care and services"[2]. Surveyors assess patient care and safety by interviewing the staff in areas that provide the service for the individual. The team follows the patient's treatment path and assesses compliance with Standards. Systems are reviewed for their delivery of safe, quality healthcare.

Surveyors focus on system-level issues within the organisation that arise from tracing individual patients. If appropriate, the surveyors may still ask for permission to speak to a patient.

This methodology requires a healthcare organisation to work as a team as opposed to preparing one particular area for a survey that is independent of the rest of the organisation. This process assesses the interface between departments and assesses the documentation to protect the patient's safety when care is transferred from one provider to another.

Clinicians also find the process meaningful because it looks at the service from the perspective of the patient.

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[2] ibid

This article can be viewed at:
http://www.fortherecordmag.com/archives/ftr_101804p18.shtml

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Managing safety in other industries

Essential Services - Greater London Authority Group

In response to public concerns regarding the performance of peak organisations providing public services in London the Greater London Authority Group implemented a program for assessment of performance of its services which comprises the Greater London Authority, Transport for London, the Metropolitan Police Authority, the London Development Agency and the London Fire Brigade.

Measurement of compliance is via a methodology derived from assessment of financial controls compliance. Organisations perform a self-assessment which includes a review of internal risk controls and self-monitoring mechanisms. This is supported with an external audit process performed by the Audit Commission

The assessment aims to answer the following questions:

- What is the organisation trying to achieve?
- How has the organisation set about delivering its priorities for improvement?
- What improvements has the organisation achieved/not achieved to date?
- In light of what the organisation has learnt so far, what does it plan to do next?

A five point scale performance assessment ranging from 'excellent' (the highest) through 'good', 'fair' and 'weak', to 'poor' (the lowest) is given at the conclusion of the assessment cycle.

More information about the Greater London Authority's performance assessment can be found at: http://www.audit-commission.gov.uk/cpa/gla.asp

Australian Tax Office

The Australian Tax Office (ATO) sets requirements of the tax assessment process through guidelines which accompany the self-assessment forms. Self-assessment is then undertaken by individuals and organisations.

The ATO undertakes a thematic approach to targeting with annual in-depth assessment of different areas of the Tax self-assessment forms. Benchmark performance levels are then established to guide the assessment process and the interpretation of performance.

Outliers are selected for external verification of the self-assessment by ATO officers. A random audit of those within the normal range of performance also supports this process. Where non-compliance with guidelines is identified, an escalation and sanction strategy may be utilised. In some instances of non-compliance or in the event of outlier performance such as fraud, site visits are conducted to view sources of documentation. Training materials and manuals provide comprehensive guidance to ATO officers, covering both the law and likely practical issues when they are accessing information on site as part of verification of self-assessment.

More information about the ATO activity statements and compliance program can be found at: www.ato.gov.au

Australia - National Offshore Petroleum Safety Authority

Companies operating off-shore facilities must comply with safety regulations as set out by the National offshore Petroleum Safety Authority (NOPSA). NOPSA requires assurance of compliance through submission by the operator of a "Safety Case". Safety case describes means by which the operator will ensure adequacy of the design, construction, installation, maintenance or modification of the facility.

NOPSA takes a systems view of safety with operators self-enforcing and self-monitoring compliance. NOPSA works to build a relationship with the operator, with a NOPSA officer working closely with operators within his portfolio to ensure a focus on improvement.

NOPSA must accept a the Safety Case if "there are reasonable grounds" for believing that the operator has complied with the relevant regulation. It also allows for partial or total exemption from some aspects where appropriate.

The NOPSA model has the following overarching set of principles.

- All information will be treated as confidential, within the limits of FOI
- Each assessment will be fair and technically competent
- There will be consistency between different assessments
- Assessment processes will be transparent
- Good project management practices will be applied
- Good quality management practices will be applied
- The detail of assessments will be proportional to the level of risk
- The results of assessment will be presented to relevant stakeholders
- Actions taken in response to findings will be graduated, and proportionate to the risk

More information about the NOPSA safety case approach can be found at: http://www.nopsa.gov.au/safety.asp

Internal Control over Financial Reporting-Guidance for Smaller Public Companies (Committee of Sponsoring Organizations of the Treadway Commission (COSO) 2006).

This document is focussed upon the financial health of an organisation and the issues associated with reporting financial outcomes. Accompanying this document is an *Integrated Framework* which was developed by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in 1992. This Framework has been recognised by executives, board members,

regulators, standards setters, professional organisations and others as an appropriate comprehensive Framework for internal control.[3]

This document provides guidance as to how to apply the Framework. The aim is to use the Framework to design and implement cost-effective internal control over financial reporting.

One of the central themes portrayed in this document is the requirement for appropriate financial reporting objectives. It suggests that appropriate financial reporting objectives result in more effective business activities and subsequently these are reflected in appropriate financial statements and accounts.

Documentation of business processes and procedures is an essential element in tracking the performance of the organisation. This document suggests that effective documentation assists in communicating what is to be done, and how, and creates expectations of performance. Documented business processes and procedures can also be used as a tool for reference and to assist in the training of personnel. Importantly, it also provides evidence which may be used for the process of accreditation or evaluation. The bigger an organisation is, the more important documentation becomes as there is not the intimate knowledge of every single aspect or individual responsibility for the entire process. Instead the process has many stages, and many people can input along this process.

COSO recognises that there may be instances where policies and procedure are informal and not documented. Nevertheless, managers should be able to evidence the use of these policies through other means.

There are five key components of the Framework, which outline 20 basic principles, these are briefly outlined in the following table:

Component	Principle[4]
Control environment	Integrity and ethical values; Understanding and responsibility relating to financial

[3] Internal Control over Financial Reporting – Guidance for Smaller Public Companies, Volume 1: Executive Summary June 2006 p.1.

[4] Adapted from Internal Control over Financial Reporting – Guidance for Smaller Public Companies, Volume 1: Executive Summary June 2006 p.11.

Component	Principle[4]
	reporting and internal control by Board of Directors; Management philosophy and style; Organisational structure; Financial Reporting Competencies; Management and employees are assigned appropriate levels of authority and responsibility; and Effective human resources policies to support financial reporting.
Risk Assessment	Clarity of objectives; Identification of risks; and Appropriate management of risks.
Control Activities	Integration with risk assessment; Development of control activities to mitigate risks; Policies and procedures to support reliable financial reporting; and Information technology to support the achievement of financial reporting objectives.
Information and Communication	Pertinent information is gathered to support the achievement of the financial reporting objectives; and Internal and External communication of the financial reporting objectives.
Monitoring	Evaluations; and Reporting deficiencies.

More information about these financial reporting controls can be found at:

http://www.coso.org/publications.htm

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