Control of Non-conformity and Corrective Action

1. Purpose

To outline the responsibilities and methods for identifying non-conformities in the QMS, its causes, the procedures for initiating corrective actions and performing follow-up activities to ensure that said corrective actions have been effective in addressing the non-conformities in the QMS processes.

2. Scope

This covers the process from receipt of report of non-conformities, to investigating the cause/s of non-conformities, determination of needed actions, implementation of corrective actions and verification of the effectiveness of corrective actions undertaken.

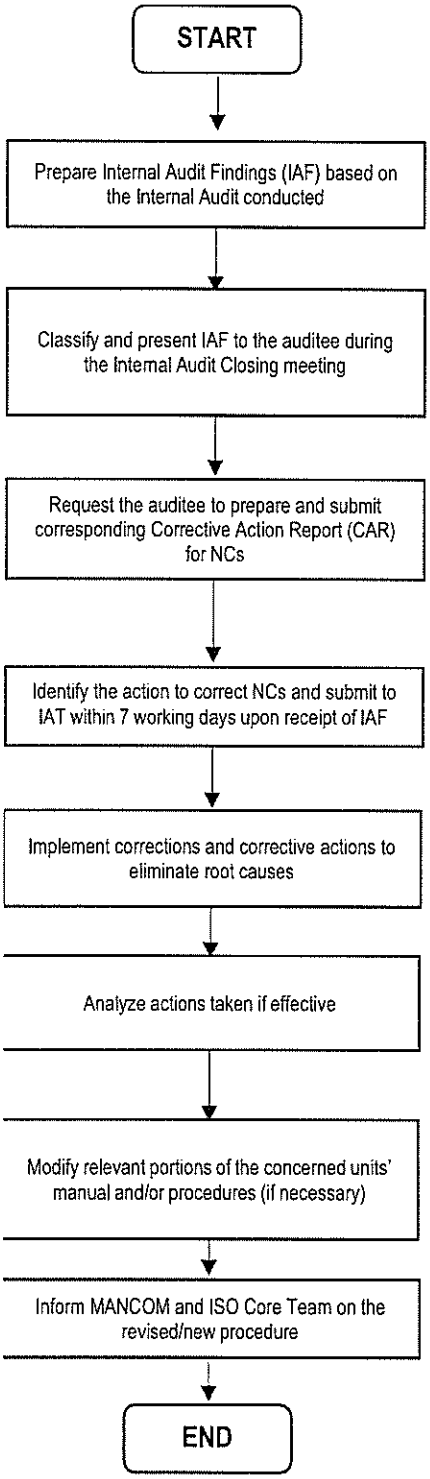
3. Responsibility

The Quality Manager shall be responsible in ensuring the effective implementation of this procedure.

4. Definition

4.1 **Correction.** Immediate solution to address the NC, as applicable
4.2 **Corrective action.** Act of eliminating the root cause of a known non-conformance, or other undesirable situation and to prevent its recurrence.
4.3 **Corrective Action Report.** Form used to report the correction/s and/or corrective action/s, including validation of effectiveness of actions taken, on the audit findings
4.4 **Internal Audit Findings (IAF).** Form used for reporting audit findings.
4.5 **Major Non-conformity**. Total breakdown of the system controlled or procedures failure to conform to the requirements.
4.6 **Minor Non-conformity**. Any non-conformity which does not adversely affect the performance of the QMS.
4.7 **Opportunities for improvement**. A situation where the evidence presented indicates a requirement has been effectively implemented, but based on auditor experience and knowledge, additional effectiveness or robustness might be possible with a modified approach.
4.8 **Positive Findings.** Best practices that can be shared throughout the organization.

5. Procedure



Responsible Person	Applicable Policies / Instruction	Forms Used
Internal Audit Team (IAT)		Internal Audit Findings
IAT	IAFs are classified based on the following categories: 1. Positive Findings 2. Opportunities for improvement 3. Non-conformity (NC)	
IAT		
Service Director and process owner	The following are determined in identifying the action to correct NC: 1. Identified risks if no action is done to correct the NC 2. Results of root cause analysis 3. Correction 4. Corrective Actions 5. Completion date & evidence provided	Corrective Action Report
Service Director and process owner		
Service Director and process owner	Analyze effectiveness of corrections and corrective actions	
Service Director and process owner	Revise affected procedure or create new procedure if necessary	
Service Director	Revisions in the manual and/or procedures are presented during the Management Review	Presentation template issued by the CPDD

Prepared by:	Reviewed by:	Approved by:
CPDD ISO Core Team	Ricardo Benjamin D. Osorio Planning Officer IV	Vilma P. del Rosario Planning Officer V
Date: Oct. 11 , 2022	Date: Oct. 11 , 2022	Date: Oct. 11 , 2022

Internal Audit

1. Purpose

To provide guidelines on the conduct of internal audit to determine the continuing conformance of the PPPC with ISO 9001:2015 standards and other statutory and regulatory requirements and to regularly evaluate the effectiveness of the established Quality Management System (QMS) of the PPPC. Internal audit is also conducted to identify potential improvements on the PPPC's QMS to ensure the delivery of quality service.

2. Scope

a. This procedure covers the programming of the internal audit to the implementation of the audit program and audit plan until closure of non-conformance. The audit program shall cover all functions and services of the PPPC.
b. Internal Audit shall be done at least once a year.

3. Responsibility

The Internal Audit Team shall be responsible for the effective implementation of this procedure.

4. Definition

4.1. Audit. Systematic, independent and documented process for obtaining audit evidence and evaluating it objectively to determine the extent to which the audit criteria are fulfilled.
4.2. Audit criteria. Set of policies, procedures or requirements used as reference against which audit evidence is compared.
4.3. Audit evidence. Records, statements of fact or other information which are relevant to the audit criteria and verifiable.
4.4. Audit findings. Results of the evaluation of the collected audit evidence against audit criteria.
4.5. Auditee. Service, process/procedure or person being audited.
4.6. Audit objective. Purpose or intention of the audit.
4.7. Audit scope. Extent and boundaries of an audit.
4.8. Audit period. Scheduled date of the audit.
4.9. Audit plan. Includes the purpose, scope and, criteria of the audit. This shall also include the audit dates and audit team members.
4.10. Audit program. Set of one or more audits planned for a specific time frame and directed towards a specific purpose.
4.11. Auditor. Person who conducts an audit. A member of the Internal Audit Team.
4.12. Conformity. Fulfillment of a requirement.
4.13. Corrective Action. Act of eliminating the root cause of a known non-conformance, or other undesirable situation and to prevent its recurrence

4.14. **Corrective Action Report (CAR). Form used to report the correction/s** and/or corrective action/s, including validation of effectiveness of actions taken, on the audit findings

4.15. **Correction**. Immediate solution to address the NC, as applicable

4.16. **Internal Audit Findings (IAF).** Form used for reporting audit findings.

4.17. **Lead Auditor**. A member of the Internal Audit Team designated by the Quality Manager to lead and oversee the conduct of the internal audit. The Lead Auditor is responsible for the preparation of the Audit Program, Audit Plan, issuance of the Internal Audit Findings and submission of Internal Audit Report.

4.18. **Management Review.** A formal, structured meeting which involves top management regularly conducted throughout the year to review and evaluate the effectiveness of the PPPC's QMS. This shall also enable all levels of management to be aware of the needed revisions to the system, if any.

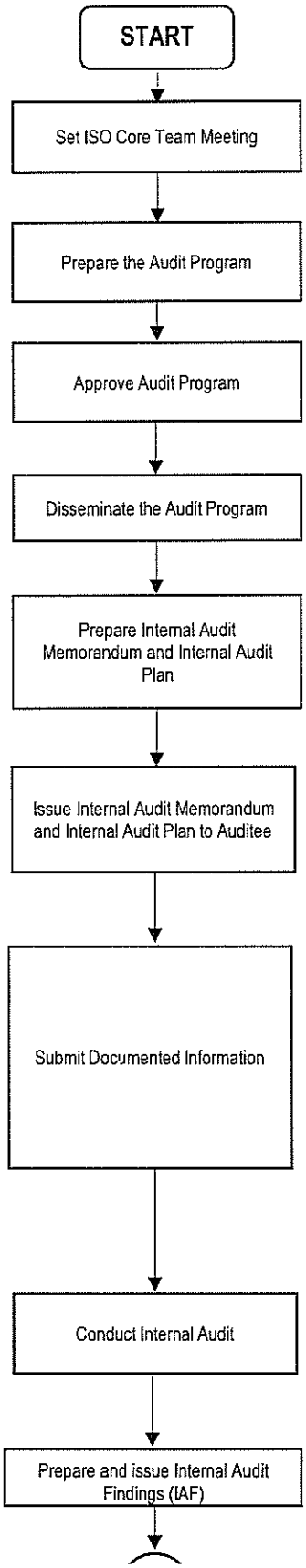
4.19. **Major Non-conformity**. Total breakdown of the system controlled or procedures failure to conform to the requirements.

4.20. **Minor Non-conformity**. Any non-conformity which does not adversely affect the performance of the QMS.

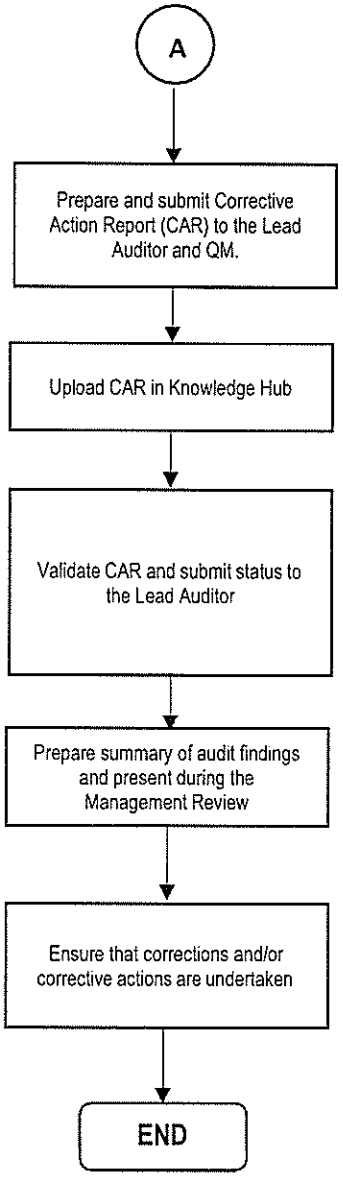
4.21. **Opportunity for Improvement.** A situation where the evidence presented indicates a requirement has been effectively implemented, but based on auditor experience and knowledge, additional effectiveness or robustness might be possible with a modified approach.

4.22. **Quality Manager**. Head of the CPDD, who is responsible for overall development, implementation and maintenance of the PPPC's QMS.

5. Procedure



Responsible Person	Applicable Policies / Instruction	Forms Used
ISO Core Team Secretariat	*(See procedure for the Provision of Secretariat Support to the ISO Steering Committee and ISO Core Team in the CPDD Operations Manual, section 4.8)*	
Internal Audit Team	During the ISO Core Team Meeting, the Quality Manager (QM) should assign a Lead Auditor for the audit cycle among the Internal Auditors. *(See work instruction for preparing an audit program)*	Audit Program
ISO Steering Committee Chairperson		
QM	Disseminate the Audit Program to all PPPC employees via-email, along with a cover memorandum signed by the QM.	
QM, Internal Audit Team, Lead Auditor	Internal Audit Memorandum to be prepared and signed by the QM. Internal Audit Plan to be prepared by the Internal Audit Team and signed by the Lead Auditor. *(See work instruction for preparing an internal audit plan)*	Internal AuditPlan
ISO Core Team Secretariat	Internal Audit Memorandum and Audit Plan to be issued at least ten (10) working days before the scheduled Internal Audit. Send calendar invite to auditee and reserve venue for the opening and closing meetings during the scheduledInternal Audit.	
Auditee	Documented Information to be submitted at least five (5) working days to the Lead Auditor before the scheduled audit. Documented Information includes, but not limited to, the following: ✓ Operational Plans ✓ Operations Manual, Process Flows, Work Instructions ✓ Outsourced Processes ✓ Organizational Chart ✓ List of Documented Information ✓ Risk Assessment Matrix ✓ Results and Analysis of Client Satisfaction and Feedback ✓ CAN and CAR ✓ Work and financial plans ✓ Performance commitment reports (targets) Lead auditor to provide copy of the document information to the audit team.	
Internal Audit Team	Conduct opening meeting to discuss the Audit Plan. Conduct audit based on Audit Criteria; evaluate corrective action/s from previous internal audit, review records, interview process owners, analyze documented information,observe the process in action and suggest opportunities for improvement. Conduct closing meeting to present audit findings. Request comment / feedback from the auditee on how to further improve conduct of audit. Internal Audit Team to request the auditee to accomplish the Client Satisfaction and Feedback Form after the closing meeting. ISO Core Team Secretariat to gather and analyze client satisfaction feedback results	Client Satisfaction andFeedback Form
Internal Audit Team	Issue IAF within three (3) working days after the conduct of audit.	Internal Audit Findings



Responsible Person	Applicable Policies / Instruction	Forms Used
Auditee	Submit CAR for non-conformities within seven (7) working days uponreceipt of IAF.	Corrective Action Report (CAR) Form
Auditee		
Internal Audit Team		
Lead Auditor	Ensure that corrections and/or corrective actions are made to close the findings. Determine the status (open or closed) of the corrections and/or corrective actions based on the action/s taken. For corrections, Internal Audit Team to check the evidence. For corrective actions, the Internal Audit Team to check if the findings will not recur in the next internal audit.	CAR
Lead Auditor	Submit Internal Audit Report at least three (3) working days before the scheduled Management Review.	
Service Directors QM	Ensure thatcorrections and/or corrective actions are made to close the findings, preferably before the next internal audit. Monitor the status of findings in the Internal Audit Report.	

Prepared by:	Reviewed by:	Approved by:
CRDP ISO Core Team	Ricardo Benjamin D. Osorio Planning Officer IV	Vilma P. del Rosario Planning Officer V
Date: Oct. 11 , 2022	Date: Oct. 11 , 2022	Date: Oct. 11 , 2022

6. Managing the Auditor Pool

Before the start of the audit cycle every year, the Quality Manager shall request all Services to nominate representatives for the Internal Audit Team (IAT). The representatives can be selected from the pool of auditors-in-training in the last audit cycle, new nominees meeting the audit competencies, former auditors with audit experience, and current representatives to the IAT.

The selection of auditors based on their competence and performance shall contain the following steps:

1) Determine competence
- The candidate's/auditor's competence shall be determined by considering training programs attended, audit experience, and personal behavior/attributes.

2) Establish evaluation criteria
- The evaluation criteria shall be established for the evaluation of auditors and candidates according to the audit program's objectives and requirements, as well as required competencies of an internal auditor.

3) Set the appropriate evaluation method and conduct the evaluation
- The evaluation shall be conducted by using the following evaluation methods: a) review of records (e.g., training programs attended, relevant experience); b) feedback from auditees and/or principals (e.g., result of client satisfaction survey); and, c) post-audit review (e.g., overall performance of the staff during the audit).
- The Quality Manager and IAT shall evaluate the candidates and auditors through accomplishing the ***Internal Auditor Performance Evaluation Form***. All information gathered and processed which include qualifications of the candidate/auditor, result of client satisfaction survey, and overall performance of the candidate/auditor as technical staff and auditor, shall be compared against the evaluation criteria and required competencies.

Step 1: Determine competence

Selection of representatives for the IAT shall consider the following audit competencies:

1) The **personal attributes** of the auditor, including the following:
   - **Ethical** - fair, truthful, sincere, honest and discreet
   - **Open-minded** - willing to consider alternative ideas or points of view
   - **Diplomatic** - tactful in dealing with people
   - **Observant** - actively aware of physical surroundings and activities
   - **Perceptive** - instinctively aware of and able to understand situations
   - **Versatile** - adjusts readily to different situations
   - **Tenacious** - persistent, focused on achieving objectives

- **Decisive** - reaches timely conclusions based on logical reasoning and analysis
- **Self-reliant** - acts and functions independently while interacting effectively with others

2) **Knowledge** on auditing concepts and methodologies, as well as on the International Organization for Standardization (ISO) 9001:2015, ISO 19011:2018 requirements, and the quality management system (QMS) of the organization; and,

3) **Auditing skills** such as planning, preparing checklists/questions, gathering audit evidence, evaluating audit evidence against audit criteria, preparing audit reports, and monitoring auditee's compliance with the set requirements. The candidate's and auditor's audit experience and performance during audits will be considered in determining his/her competence.

Step 2: Establish evaluation criteria

Each auditor/candidate shall be evaluated based on the audit program's objectives and requirements (e.g., verification of compliance to the requirements set by the Public-Private Partnership (PPP) Center and the ISO 9001:2015, and evaluate the effectiveness of the established QMS of the organization) and required competencies of an internal auditor. The other factors considered in establishing the evaluation criteria include the candidate's/auditor's a) ability to audit complex core processes; and, b) commitment to conduct all assigned internal audits.

Step 3: Set the appropriate evaluation method and conduct the evaluation method

All candidates and auditors including lead auditors shall be evaluated by the Quality Manager and the current Lead Auditor/s through the accomplishment of the ***Internal Auditor Performance Evaluation Form*** as included in this Manual. Said form shall be completed by reviewing records, processing the feedback from auditees and/or principals, and conducting a post-audit review of outputs and performance of the candidate/auditor.

6.1 Designation of members to the IAT

Based on the result of performance evaluation, the Quality Manager shall endorse to the ISO Steering Committee the nominated Lead Auditor/s and the list of IAT members for his/her approval.

Aside from the representatives for the IAT, a new set of auditors-in-training shall also be nominated by all Services to the Quality Manager. The auditors-in-training shall do the following:

i. Prepare notes/highlights of interviews;
ii. Assist the IAT in verifying ISO documentary requirements (e.g., submission of DRFs to the Quality Manager, submission of Operations Manual to the records officer);
iii. Scan/browse ISO documentary requirements and provide questions to the IAT, if possible;
iv. Act as an alternate whenever a member of the audit team is absent; and
v. Does other tasks as deemed necessary by the Quality Manager and/or Lead Auditor/s.

These auditors-in-training can be part of the pool of internal auditors for the next audit cycle of each year.

The competencies and performance of the IAT and auditors-in-training shall be periodically evaluated to identify training and development needs that can further enhance their competencies in the area of auditing and ISO 9001 and ISO 19011 requirements before the start of the audit cycle. The Quality Manager shall identify the training needs and appropriate programs to address the needs of the IAT; and coordinate with the HRD the conduct of the programs.

WORK INSTRUCTIONS

A. INSTRUCTIONS FOR PREPARING AN AUDIT PROGRAM

Step by Step Sequence	Responsible Person	Remarks
1. Determine the following: a) Audit objectives b) Audit risk and opportunities and the actions to address them c) Audit scope d) Audit criteria e) Audit method f) Areas to be audited	Internal Audit Team	
2. Assign internal auditor/s for each area to be audited	Lead Auditor	
3. Schedule of Internal Audit per areas to be audited.	Internal Audit Team	It shall be the responsibility of the ISO Core Team members to ensure alignment of the audit dates with the availability of the Services' which they are representing. Internal Audit shall be done well in advance of the Management Review so correction and/or corrective actions can be determined and/or implemented.

B. INSTRUCTIONS FOR PREPARING AUDIT PLAN

Step by Step Sequence	Responsible Person	Remarks
1. Establish the following: a) Audit Period; b) Organizational unit and processes to be audited; c) Auditor assigned per area to be audited d) Interviewee; and e) Applicable standard chapter per area to be audited	Internal Audit Team	Audit Period reflected in the Audit Plan should be consistent with the dates indicated in the Audit Program. Use the International Standard ISO 9001 as reference in determining the Applicable standard chapter per area to be audited.
2. Set date and time for the following: a) Review of documentation, including review of previous audit findings and verification of actions taken b) Opening meeting; c) Audit proper; and d) Closing meeting	Internal Audit Team	

Management Review

1. Purpose

To determine and evaluate PPPC's QMS performance, need for change and suitability and continued relevance of existing policies and objectives. This is also for the continual improvement of the QMS.

2. Scope

This covers the process from setting schedule of the management review, determination of action plans for the improvement of the QMS until monitoring of action plans.

3. Responsibility

ISO Core Team Head ensures the proper and effective implementation of the management review procedure.

4. Definition

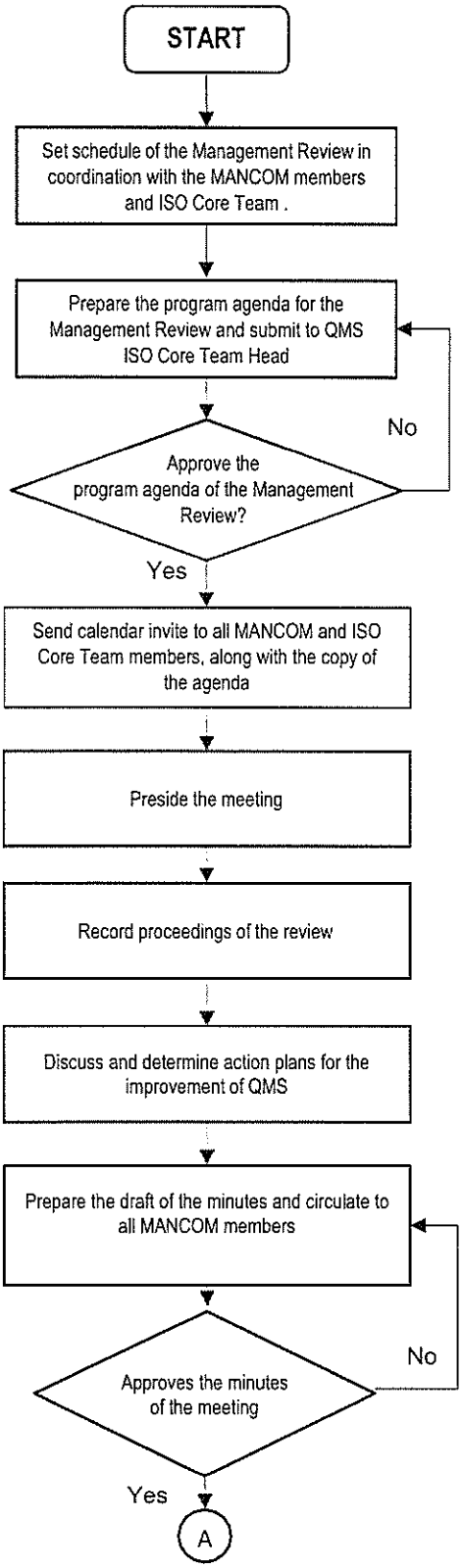
4.1. **MANCOM.** Refers to the PPPC Officials from Director up to the Executive Director.

5. Schedule and Agenda of the Management Review

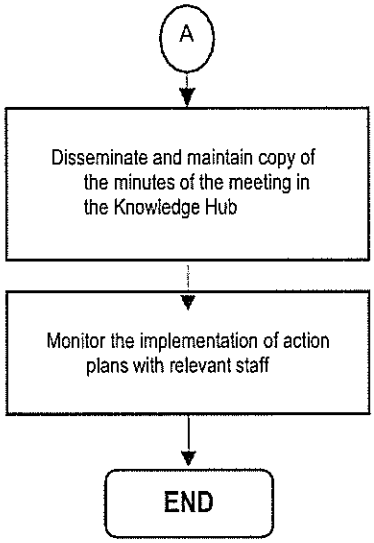
The Management Review of the PPPC' QMS shall be held annually, or as necessary. The following shall be included in the agenda, as applicable:

a. Status of actions from previous management review
b. Results of Internal Audit
c. QMS updates by Service on:
    i. Extent to which quality objectives have been met
    ii. Changes in external and internal issues that are relevant to the QMS
    iii. Updates on Service Risk Assessment Matrix, effectiveness of actions taken to address risk and opportunities
    iv. Summary of Customer Satisfaction and Feedback from Interested Parties
    v. Performance of external providers (if any)
    vi. Resource needs (Human resource / Physical Resource / Financial Resource)

6. Procedure



Responsible Person	Applicable Policies / Instruction	Forms Used
ISO Steering Committee Secretariat	Management Review should be conducted at least once a year, or as necessary.	
ISO Steering Committee Secretariat		
ISO Steering Committee Chairperson		
ISO Steering Committee Secretariat		
ISO Steering Committee Chairperson	Proceedings are recorded and documented by the CPDD	Presentation Materials Template to be issued by CPDD
ISO Steering Committee Secretariat		
ISO Steering Committee		
ISO Steering Committee Secretariat	Minutes to be circulated one (1) week after the activity	PPP Center Official Template for Minutes of Meeting
ISO Steering Committee Chairperson		



Responsible Person	Applicable Policies / Instruction	Forms Used
ISO Steering Committee Secretariat		
ISO Steering Committee		

Prepared by:	Reviewed by:	Approved by:
CPBD ISO Core Team	Ricardo Benjamin D. Osorio Planning Officer IV	Vilma P. del Rosario Planning Officer V
Date: Oct. 11 , 2022	Date: Oct. 11 , 2022	Date: Oct. 11 , 2022

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Risk Assessment

1. Purpose

To set the procedure in identifying, analyzing and evaluating risks at all levels of the organization.

2. Scope

This covers the process of risk identification, risk analysis and risk evaluation.

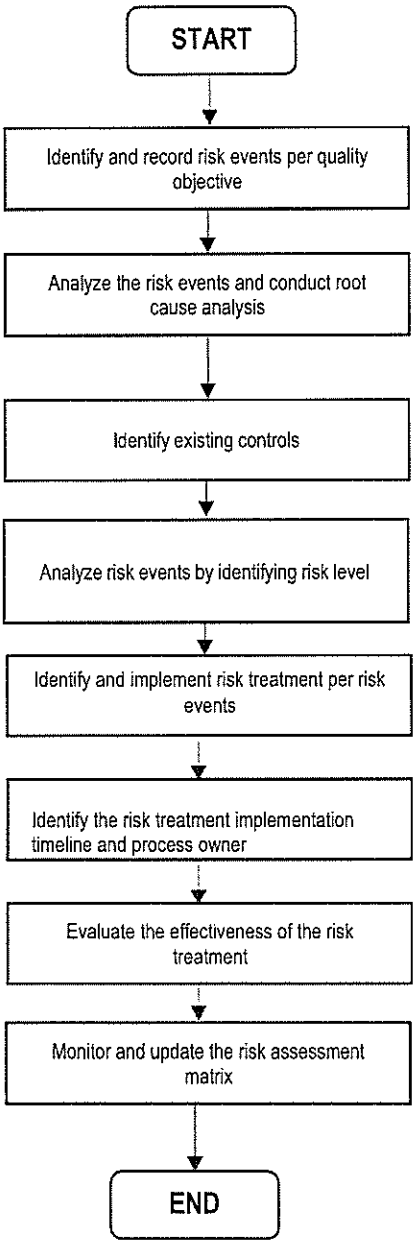
3. Responsibility

The concerned unit heads for Service level risks and the ISO Core Team through shall be responsible in ensuring that the procedure for Risk Assessment are properly implemented.

4. Definition

4.1. Risk event. The possibility of events or activities impeding the achievement of an organization's strategic and operational objectives.
4.2. Existing control. May be policies, people, processes and systems put in place by the organization to reduce risk.
4.3. Risk Assessment Matrix. Compilation of identified risk events, controls and risk treatments of the delivery units and organization.
4.4. Risk Level. Calculated as the product of the likelihood and impact of a potential risk event.
4.5. Risk Treatment. Options and choices available to handle a specific risk.
4.6. Root cause. Factor that caused a nonconformance and should be permanently eliminated through process improvement.
4.7. Root cause analysis. Systematic process for identifying root cause of risk events

5. Procedure



Responsible Person	Applicable Policies / Instruction	Forms Used
Process owner	Identify potential or actual risk events that may affect or is affecting the achievement of the objectives of the organization and continuous function of the system.	Risk Assessment Matrix
Process owner	Assess the risk event to determine what the underlying cause is.	Risk Assessment Matrix
Process owner	Identify measures already being undertaken to prevent the occurrence of the risk event or to manage/mitigate its severity	Risk Assessment Matrix
Process owner	Assess the likelihood and severity of the risk event to determine whether the risk is acceptable or tolerable. The figures here can only range from 1 to 3, with 1 being the lowest figure (e.g., lowest severity) and 3 being the highest. Refer to the Risk Rating Legend as included in the Risk Assessment Matrix template.	Risk Assessment Matrix
Process owner	Identify additional measures that will be undertaken by the Service to prevent the occurrence of the risk event or to manage/mitigate its severity.	Risk Assessment Matrix
Process owner	Determine the period for implementing additional risk treatment measures and responsible process owner	Risk Assessment Matrix
Process owner	Provide the status of the additional risk treatment measures being undertaken and assess its effectiveness, if possible. This can be included in the 'Remarks' column of the Risk Assessment Matrix template.	Risk Assessment Matrix
Process owner	Ensure that the Risk Assessment Matrix is updated periodically to ensure that it reflects the developments in identified risks. It is important that the previous updates are not deleted. If there are significant changes, Services must use a separate tab with the date of review clearly identified to differentiate it from earlier revisions.	Risk Assessment Matrix

Control of Documents

1. Purpose

The purpose of this document is to establish the document control process to ensure that only valid documented information is used.

2. Scope

This covers the document control process for creation, review and approval, revision, registration, distribution and archiving of documents, both electronic and hard copy files, that are related to the implementation of the PPPC's QMS.

These documents refer to the QMS manuals, procedures, and forms.

3. References

3.1.1. Records Keeping Policies and Procedures Handbook
3.1.2. Physical Resources Management and General Services Division Operations Manual
3.1.3. PPPC Special Order No. 46 Series of 2017 – Creation of the PPP Center ISO Steering Committee
3.1.4. PPPC Special Order No. 53 Series of 2018 – Updating SO No. 81 (2012) on the Records Management Improvement Committee (RMIC) and Records andArchives Unit (RAU)
3.1.5. PPPC Special Order No. 32 Series of 2021 – Reconstituting the Members of the RMIC of the PPP Center
3.1.6. PPPC Policy on QMS and ISO Certification initiatives relating to formulation, approval, implementation, and monitoring of unit policies.

4. Definitions

4.1. Document – Information and its supporting medium. The medium can be paper, electronic or optical computer disc, photograph or combination thereof. These include the quality manual, policies, guidelines, procedures, operations manual, process flow and forms indicated in the Document Master List.
4.2. Internal Document – A document generated within the PPPC.
4.3. External Document – A document received by the PPPC from external sources.
4.4. Controlled Copy – A reproduced copy of the original document representing the latest issued document; indicated by "PPP Center Controlled Copy" stamp.
4.5. Uncontrolled Copy – A document copy not subject to further document control after it is issued; indicated by "PPP Center Uncontrolled Copy" stamp.
4.6. Document Master list – A list that identifies the documented information generated by the Services maintained by the Records Officer.
4.7. Originator – Division/Service Head who creates/revises a document.

5. Procedure

Process	Responsible Person	Applicable Policies/Instruction	Forms Used
5.1 Creation of documents	Originator	PPPC Style Guide;PPPC QMS Manual; PPPC Policy on Center's QMS and ISO Certification Initiatives relating to Formulation, Approval, Implementation and Monitoring of Unit Policies	Document Request Form
5.2 Review/ recommending and approval of documents	Division Chiefs, Service Directors, Deputy Executive Directors, Executive Director	PPPC Style Guide;PPPC QMS Manual; PPPC Policy on Center's QMS and ISO Certification Initiatives relating to Formulation, Approval, Implementation and Monitoring of Unit Policies	Routing Slip
5.3 Revision of documents	Concerned Service, ISO Core Team, Quality Manager	PPPC QMS Manual	Document Request Form Document Tracking Form
5.4 Registration of documents	ISO Core Team	N/A	List of Documented Information
5.5 Distribution of documents	ISO Core Team	PPPC QMS Manual	xxx
5.6 Archiving of obsolete master copy	ISO Core Team	PPPC QMS Manual; Records keeping Policy	NAP Form 1 (Records Inventory Form), NAP Form 2 (Records Disposition Schedule), NAP Form 3 (Request for Authority to Dispose Records)
5.7 External Documents	Records Officer	Physical Resources Management and General Services Division Operations Manual; PPPC Records Keeping Policy	

5.1. Creation of Documents

The Document Originator creates the QMS-related document, which shall be in accordance with the Center's Style Guide.

QMS-related documents are formatted with header note as shown below:

REPUBLIC OF THE PHILIPPINES PUBLIC-PRIVATE PARTNERSHIP CENTER	Control No:	
	Revision No: 0	Issue Date:
Title of Document		Page of

For QMS Manuals, it's cover page shall be formatted with footer note as shown below:

Prepared by: **Name** Designation	**Reviewed by:** **Name** Designation	**Approved by:** **Name** Designation
Date:	**Date:**	**Date:**

The following shall be indicated in the foreword of QMS manuals and other QMS-related documents:

The online controlled copy of this document is maintained at the Knowledge Hub. Controlled hard copy is maintained by the Records Officer of the General Services Division (GSD). The reader must ensure that the copy of any other copy of a controlled document is current and complete prior to use. The original copy of this document is with the Records Officer of the GSD. This document is Uncontrolled when downloaded in the Knowledge Hub and when it does not have original "Controlled Copy" stamp.

5.2. Review/Recommending and Approval of Documents

Review/recommending and approval ensures that the documents are appropriate to the needs of the organization in general, and the intended use of the document in particular. The review/recommending and approving authorities depend on the type of document.

For the PPPC QMS Manual, these shall be reviewed by the Quality Manager and approved by the Executive Director.

For other QMS-related documents such as manuals, procedures and forms, approving authorities are delegated through the following:

Type of Policies and Procedures	Recommending	Approving
Division and across divisions within the same service	Chief of Division/s concerned	Service Director
Divisions which do not have their own Service Director (i.e., CPDD)	Assistant Division Chief	Division Chief
Units without a Division Chief (i.e., OED, ODED 1, ODED 2)	Executive Assistant	Deputy Executive Director or Executive Director
Across divisions from different Services supervised by the same Deputy Executive Director	Service Directors concerned	Deputy Executive Director that has jurisdiction over the concerned Service
Across divisions from different Services supervised by the two Deputy Executive Directors	Service Directors concerned	Two Deputy Executive Directors (Endorsement) Executive Director (Approval)

All documented procedures are reviewed every three (3) years to assess their adequacy, suitability, and appropriateness in response to the continual improvement of the QMS. The process owner shall take the lead in the review of their documents.

5.3. Revision of documents

The **Document Request Form (DRF)** is submitted by the concerned service for revision, amendment, removal or restoration of QMS-related documents. This is accomplished by the Document Originator and submitted to the Service Director for approval. This will then be reviewed by the ISO Core Team, approved by the Quality Manager and filed by the ISO Core Team of concerned Service.

The **Document Tracking Form (DTF)** is accomplished to trace the revision history of QMS-related documents. The concerned delivery unit / process owner shall update the Document Tracking Form to keep track of revision.

5.4. Registration of Documents

Internal documents are registered in the List of Documented Information by the ISO Core Team to ensure proper control. For QMS related documents, the control number follows the sequence order below:

Control Number **SER/DIV TYPE YY-XX** where:

SER/DIV	refers to the Service or Division Unique Identification
TYPE	refers to the type of document as described below
YY	refers to the year of creation of the document
XX	refers to the sequence number of the approved QMS document based on the master list of documents of each service

Types of Document:
PRCD – Procedure
MAN – Manual
FORM – Form

5.5. Distribution of Documents

A master copy of QMS related internal documents is retained by the Records Officer until revised. The master copy shall be made available online and accessible through the Knowledge Hub.

Uncontrolled copies of documents are photocopied from master copies. These are then stamped with "PPP Center Uncontrolled Copy" in the first page of the document, prior to distribution to copyholders.

5.6. Archiving of Obsolete Master Copy

When documents are revised, the ISO Core Team upon updating of the Document Request Form and Document Tracking Form shall inform the Records Officer through e-mail to stamp the previous master copy with "Obsolete Copy" in red ink to prevent unintended use.

Refer to Recordkeeping Policies and Procedures Handbook of the PPPC for the retention and disposition schedule.

Other obsolete controlled copies of documents are removed from the Document Master list and archived.

5.7. External Documents

The procedure on the control of externally generated documents is found in the Physical Resources Management and General Services Division Operations Manual. The procedure of registration and distribution of externally generated documents is described in the abovementioned manual.

Feedback and Complaint Mechanism

How to send feedback?	A. Accomplish the Client Feedback and Complaint Form which may be: 1. Submitted directly to the Information Officer (IO); 2. Submitted through ARTC designated drop box in the lobby of PPPC; or 3. Submitted through ARTC dedicated electronic mail (e-mail) address: ARTC@ppp.gov.ph The Client Feedback and Complaint Form may be secured from the PPPC lobby or downloaded through the PPPC website: https://ppp.gov.ph/citizenscharter B. A client may also communicate feedback through contact information number: (632) 8709-4146.
How is feedback processed?	• Every working day, the IO records the received Client Feedback and Complaint Forms: 1. Received directly; and 2. Collected from: a. Drop box, b. PPPC website, c. E-mail, and d. Phone call. • The IO acknowledges receipt of the client's feedback within one (1) day. • Feedback requiring answers are forwarded to the concerned Service. The concerned Service shall answer within three (3) working days from receipt thereof. • The answer is relayed to the client through mail or e-mail. • For inquiries and follow-ups, clients may contact telephone number (632) 8709-4146.
How to file a complaint	A. Accomplish the Client Feedback and Complaint Form which may be: 1. Filed and received personally by IO; 2. Filed through ARTC designated drop box in the lobby of PPPC; or 3. Filed through ARTC dedicated electronic mail (e-mail) address: ARTC@ppp.gov.ph • The Client Feedback and Complaint Form may be secured from the PPPC lobby or downloaded through the PPPC website: https://ppp.gov.ph/citizenscharter B. Complaints may be filed via telephone. Clients will provide the following information: 1. Name of person, Division or PPPC Service subject of complaint; 2. Incident; and 3. Evidence. • IO may require personal information of the client such as client's contact information and preferred mode of communication to relay action on the complaint. • For inquiries and follow-ups, clients may contact the IO through following telephone number: (632) 8709-4146

How complaints are processed	• Every working day, the IO records the received Client Feedback and Complaint Forms: 1. Received directly; and 2. Collected from: a. Drop box, b. PPPC website, c. E-mail, and d. Phone call. • The IO shall acknowledge receipt of the complaint within one (1) day. • The IO shall evaluate completeness of information of the filed complaints and shall record the complaint within the day. • If complete, IO shall forward the complaint to the concerned Service for appropriate action or explanation. • The concerned PPPC Service shall investigate on the complaint and prepare answer or explanation within three (3) working days from receipt thereof. • The PPPC Service shall submit report to the Committee on Anti-Red Tape (CART) Chairperson, for appropriate action. • The IO shall give the feedback to the client through mail or e-mail. • For inquiries and follow-ups, clients may contact the IO through telephone number (632) 8709-4146
Contact Information	Ma. Cynthia C. Hernandez Executive Director, PPP Center **(632) 8709-4146** (loc. 2001) Eleazar E. Ricote Anti-Red Tape Committee (ARTC) Chairperson Deputy Executive Director, PPP Center **(632) 8709-4146** (loc. 2201) **8888**-Presidential Complaints Center **0908-881-6565** -CSC Contact Center ng Bayan **8478-5093**-Anti-Red Tape Authority

Forms:

INTERNAL AUDIT PROGRAM

Date Prepared:	
Audit Objectives:	
Audit Scope:	
Audit Criteria:	
Audit Method:	
Audit Team:	*(Audit Team is composed of representatives of the various Services/Offices who have been trained in QMS and/or Internal Audit)*
Audit Schedule:	

Activity	Schedule	Responsible Party
Audit Planning	At least once a year	Internal Audit Team
Issuance of Internal Audit Memorandum and Audit Plan	At least ten (10) working days before the scheduled audit	Internal Auditor
Submission of Documented Information	At least five (5) working days before the scheduled audit	Auditee
Audit Proper	See attached schedule	
Issuance of Internal Audit Finding (IAF)	At least three (3) working days after the scheduled audit	Internal Auditor
Submission of Corrective Action Report (CAR)	At least seven (7) working days after the receipt of IAF	Auditee
Submission of Internal Audit Report	At least three (3) working days before the scheduled Management Review	Lead Auditor

Prepared by:

[NAME]
Lead Auditor

Reviewed by:

[NAME]
Quality Manager

[YEAR] INTERNAL AUDIT			
Lead Auditor:	**[NAME]**		
AUDIT METHOD	**PROCESSES**	**DATE OF AUDIT**	**AUDIT TEAM**
Remote / Onsite	[List of processes to be audited]	[Proposed date of audit]	[Name of the assigned auditors]
Remote / Onsite	[List of processes to be audited]	[Proposed date of audit]	[Name of the assigned auditors]
Remote / Onsite	[List of processes to be audited]	[Proposed date of audit]	[Name of the assigned auditors]

Prepared by:

[NAME]
Lead Auditor

Approved by:

[NAME]
Chairperson, ISO Steering Committee

INTERNAL AUDIT PLAN
FY [YEAR]

Auditee: [Service / delivery unit]
Audit Type: Internal Audit (ISO 9001:2015)
Audit Objective: Verification of compliance to the requirements set by the Public-Private Partnership Center and the ISO 9001:2015 Standard and evaluate the effectiveness of the established quality management system (QMS) of the PPP Center
Audit Scope: [Process to be audited]
Audit Criteria: ISO 9001:2015 Quality Management Systems Requirements and relevant statutory and regulatory requirements
Audit Period: [Schedule of audit]
Location: [Venue of audit]
Lead Auditor: [Name of the lead auditor]
Audit Team: [Names of the assigned auditors]
Audit Language: English, Filipino

Audit Plan Released: [Date] **Lead Auditor's Signature:** _____

Date / Time	Details	Auditor	Interviewee	Standard Chapter

INTERNAL AUDIT FINDINGS

Auditee:	[Service / delivery unit]
Audit Type:	Internal Audit (ISO 9001:2015)
Audit Objective:	Verification of compliance to the requirements set by the Public-Private Partnership Center and the ISO 9001:2015 Standard and evaluate the effectiveness of the established quality management system (QMS) of the PPP Center
Audit Scope:	[Process to be audited]
Audit Criteria:	ISO 9001:2015 Quality Management Systems Requirements and relevant statutory and regulatory requirements
Audit Period:	[Schedule of audit]
Location:	[Venue of audit]
Lead Auditor:	[Name of the lead auditor]
Audit Team:	[Names of the assigned auditors]
Audit Language:	English, Filipino

AUDIT FINDINGS (Audit Criteria and Evidence)
Positive Findings
Opportunities for Improvement
Non – Conformity
Instructions: 1. If there are NCs, please do Correction/s and/or Corrective Action/s to address it. 2. Prepare the corresponding Corrective Action Report (CAR) for NCs and submit to the Internal Audit Team within seven (7) working days.

Prepared by:	**Noted by:**
Name: Position: Lead Auditor Date:	Name: Position: Quality Manager Date:

CORRECTIVE ACTION REPORT

Process:			**Date:**		
Audit Criteria and Audit Evidence [1]	**Identified Risks if no Action is Done**	**Results of Root Cause Analysis**	**Correction** [2]	**Corrective Action/s** [3]	**Completion Date & Evidence Provided** *(only for NC findings)*
Prepared by: Name: Position: Service/Division: Date:		**Approved by:** Name: Position: Service/Division: Date:		**Received by:** Name: Position: Lead Auditor Date:	

[1] Findings based on Internal Audit Findings (IAF).
[2] Immediate solution to address the Non-Conformity (NC), as applicable. Include target dates and responsible person.
[3] Action to address the root cause of the NC and prevent its recurrence. Include target dates and responsible person.

Internal Auditor Performance Evaluation Form

Internal Auditor/Candidate:
Service/Division:
Audited Services/Divisions (if applicable):
Year of Audit Cycle:

Instructions: Put a check mark (✓) under the Rating column. You can use the 'Remarks' column to further elaborate your rating for each competency.

Competency	Rating					Remarks
	Poor (1)	Unsatisfactory (2)	Satisfactory (3)	Very Satisfactory (4)	Outstanding (5)	
Personal Attributes						
Ethical The auditor is fair, truthful, sincere, honest and discreet						
Open-minded The auditor is willing to consider alternative ideas or points of view						
Diplomatic The auditor is tactful in dealing with people						
Observant The auditor is actively aware of physical surroundings and activities						
Perceptive The auditor is instinctively aware of and able to understand situations						
Versatile The auditor adjusts readily to different situations						
Tenacious The auditor is persistent and focused on achieving objectives						
Decisive The auditor reaches timely conclusions based on logical reasoning and analysis						
Self-Reliant The auditor acts and functions independently while interacting effectively with others						
Knowledge						
The auditor knows about auditing concepts and methodologies						
The auditor knows the requirements of ISO 9001 and						

Competency	Rating					Remarks
	Poor (1)	Unsatisfactory (2)	Satisfactory (3)	Very Satisfactory (4)	Outstanding (5)	
The auditor knows the quality management system of the organization						
Skills						
The auditor demonstrated how to do audit planning						
The auditor demonstrated how to prepare audit checklists/questions						
The auditor demonstrated how to gather audit evidences						
The auditor demonstrated how to evaluate audit evidences against audit criteria						
The auditor demonstrated the ability to prepare an audit report (i.e., internal audit findings)						
The auditor demonstrated regular monitoring of implementation of corrective actions by the auditee.						
Other factors						
The auditor can audit complex core processes.						
The auditor is committed to conduct all assigned internal audits.						
Overall client satisfaction survey result (if applicable)						
Post-audit review rating by the Lead Auditor/s (if applicable)						
					Overall Average Rating	

Evaluation Measure

Overall Average Rating	Interpretation
4.00 – 5.00	The Internal Auditor **exceeds** the expectations of the Quality Manager and Lead Auditor/s in terms of ISO audit competencies. *Caveat: If at least two (2) competencies are rated poor, the interpretation below will apply.*
2.50 – 3.99	The Internal Auditor **met** the expectations of the Quality Manager and Lear Auditor/s in terms of ISO audit competencies. *Caveat: If at least two (2) competencies under <u>each</u> personal attributes, knowledge, skills, and other competency are rated poor, OR if a total of five (5) competencies in all areas are rated poor, the interpretation below will apply.*
2.49 and below	The Internal Auditor **needs improvement** in terms of ISO audit competencies before participating in the next audit cycle.

Other Notable Observations and Areas for Improvement (if applicable):

Evaluated by:

Name
Lead Auditor

Approved by:

Name
Quality Manager

DOCUMENT REQUEST FORM

Service:		DRF No:	

Type of Request: ☐ New ☐ Revision ☐ Restoration ☐ Obsolete

Type of Document: ☐ Form ☐ Manual ☐ Others *(Specify)* _____

Document Control Number:	
Document Title:	
Reason for Change: *(for the preparation, revision, restoration or obsolescence of the document)*	
Details of Proposed Revisions:	
From	**To**

Requested by:	**Date:**
(Name, Designation and Signature)	

Reviewed by:	**Date:**
ISO Core Team Member	

Approved by:	**Date:**
Service Director	

Approved by:	**Date:**
Quality Manager / Chief, CPDD	

DOCUMENT TRACKING FORM

Document Code	
Title of Document	
Service Owner	

Effectivity Date	Revision Number *(old)*	Date of Submission of Document Request Form	Effectivity Date of Revision	Revision Number *(new)*

RISK ASSESSMENT MATRIX

Risk Identification				Risk Analysis			Risk Treatment Required / Opportunities					
Quality Objective	Risk Event	Root Cause	Existing Controls	Likelihood	Impact	Risk Level / Factor (L x I)	Risk Treatment Required	Risk Treatment Implementation Timeline	Owner	Status (Ongoing/ Resolved)	Date Reviewed	Rema