Clinical Audit/Quality Improvement Projects Guidance

For

Professional Competence Scheme

Prepared by Faculty of Public Health Medicine

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KEY POINTS ON AUDIT FOR PUBLIC HEALTH

- This document is produced by the Faculty of Public Health Medicine Ireland (FPHMI) to support and guide participants of the FPHMI Professional Competence Scheme (PCS) to achieve their requirement of completing one clinical audit / quality improvement project each year.

- This document is a guide for doctors practising public health medicine and who are either on the Specialist or General Division of the Register

- All doctors must participate in professional competence

- Each doctor must define his/her scope of practice

- All doctors whose practice include both clinical and non-clinical work should engage in both clinical audit and other quality improvement practices relevant to their scope of practice

- Audit can be at individual, team, departmental or national level

- Each doctor must actively engage in clinical audit / systematic quality improvement activity that relates directly to their practice. 'The Medical Council's Framework for Maintenance of Professional Competence Activities' sets one clinical audit per year as the minimum target. The time spent on completing the audit is accounted for separately from other Continuing Professional Development (CPD) activities. It is estimated that the completion of one clinical audit will take approximately 12 hours of activity.

- The main challenges in undertaking audit in public health practice include
    - Lack of explicit criteria against which to measure audit
    - Timeframes for measuring outcomes which can be prolonged and thus process measures are more readily measured
    - Changing public health work programmes in Departments

- Suggested approaches include
    - Define scope of practice
    - Any clinical work should include clinical audit
    - Use clinical audit methodology to develop quality improvement initiative/project
    - If teaching/training – feedback from clinical supervision, teaching and training;
    - Case review/discussion – can be peer review or multidisciplinary meeting and assessed against national standards or guidelines
    - Guideline development or updating

General Introduction

The Medical Practitioners Act (2007) (under Section 11) places a statutory obligation on all registered Medical Practitioners from 1st May 2011 to maintain their professional competence by participating in recognised Professional Competence Schemes. As a training body accredited by the Medical Council, the Faculty of Public Health Medicine, RCPI has developed a Professional Competence Scheme (PCS), in accordance with Medical Council guidelines. This scheme is designed to promote self-directed and practice-based learning activities.

Principles – who must do audit?

- Doctors who undertake ANY clinical activities must participate in clinical audit.
- Doctors who do not undertake clinical activities that are amenable to clinical audit must participate in other systematic quality improvement activities that are relevant to their practice.
- Doctors whose practice includes both clinical and non-clinical work should engage in both clinical audit and other quality improvement activities that are relevant to their practice.
- Both types of quality improvement activities are treated equitably for the maintenance of professional competence.

Purpose of this document

This document is produced by the Faculty of Public Health Medicine (FPHMI) to support and guide participants of the FPHMI Professional Competence Scheme (either on the Specialist or General Division of the Register) to achieve their requirement of completing one clinical audit / quality improvement project each year. It is important to note that this document represents guidance – it is not exhaustive or prescriptive, and the guidance will evolve as our knowledge and experience with the requirements for professional competence increase.

Doctors working in public health may or may not, depending on their post, provide direct clinical care to patients; however, their practice does influence the health of individuals and populations, and, therefore, needs to be subject to audit. These doctors will have to demonstrate that they engage in systematic quality improvement activities that are relevant to their work.

The Professional Competence Scheme (PCS) of the Faculty of Public Health Medicine

The Faculty of Public Health Medicine has been accredited by the Medical Council to operate Professional Competence Schemes for practitioners on the Specialist and General Divisions of the Register:

- *FPHMI Specialist Division Scheme*

This scheme is for Medical Practitioners who are registered on the Specialist Division of the Medical Council Register in Public Health Medicine.

- *FPHMI General Division Scheme*

This scheme is for Medical Practitioners who are registered on the General Division of the Medical Council Register and who hold one of the following:

- Membership of the Faculty of Public Health Medicine of Ireland (MFPHMI, RCPI)
- Fellowship of the Faculty of Public Health Medicine of Ireland (FFPHMI, RCPI)
- Membership of the Faculty of Public Health, UK (MFPH, RCP UK)
- Fellowship of the Faculty of Public Health, UK (FFPH, RCP UK)
- Masters in Public Health (or equivalent) and at least 50% of practice in Public Health Medicine

While the FPHM operates two professional competence schemes, there is no difference in the processes for either of these schemes or in the requirements for the practitioners enrolled on either scheme. This document therefore applies to both practitioners enrolled on the Specialist Division of the Medical Council Register in Public Health Medicine and those who are registered on the General Division of the Medical Council Register with the above qualifications.

Definition of Public Health

Public health is defined as "The science and art of preventing disease, prolonging life and promoting health through organised efforts of society." (Sir Donald Acheson, 1988)

Definition of Clinical and Healthcare Audit

The Commission on Patient Safety and Quality Assurance (2008) defined clinical audit as:
"..a clinically-led quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and acting to improve care when standards are not met. The process involves the selection of aspects of the structure, processes and outcomes of care which are then systematically evaluated against explicit criteria. If required, improvements should be implemented at an individual, team or organisation level and then the care re-evaluated to confirm improvements."

The HSE document on Healthcare Audit Criteria (2008) states that *"Healthcare audit is audit of current practice against standards in any aspect of healthcare and includes both clinical and non-*

clinical audit." The HSE Quality and Risk Management Standard (2007) states that *"Clinical and Healthcare Audit involves comparing current practice to evidence based best practice in the form of standards, identifying areas for quality improvement and implementing changes to practice to meet the standards".*

Clinical audit is recognised as having three elements (from Professional Competence FAQs, Medical Council):

1) Measurement – measuring a specific element of clinical practice

2) Comparison – comparing results with the recognised standard (in circumstances where comparison is possible)

3) Evaluation – reflecting on outcome of audit and changing practice accordingly

Clinical Audit Methodology

The processes involved in carrying out an audit have been described in the literature. The Draft National Clinical Audit Guidance Document, HSE 2012, following the NICE guidelines, divides these processes into a five step approach:

Stage 1	Planning for audit
Stage 2	Standard / Criteria selection
Stage 3	Measuring performance
Stage 4	Making improvements
Stage 5	Sustaining improvements

Figure 1 The clinical audit cycle (source: Draft HSE guidance, 2012)

Standards are defined as structures and processes needed to identify, assess and manage specified risks in relation to the subject. Criteria provide the detail of what needs to be achieved for the standard to be met. For criteria to be valid and lead to improvements in service user care, they should be consistent with SMART guidance:

- Specific (explicit statements, not open to interpretation)
- Measurable
- Achievable (of a level of acceptable performance agreed with stakeholder)
- Relevant (related to important aspects of care)
- Theoretically sound or Timely (evidence based)

The HSE Clinical Audit Guidance Document provides more detailed information on clinical audit methodology and should be read prior to undertaking clinical audit available at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/Clinicalauditsupportprogramme/clinicalaudit.html

Public Health Medical Audit

All Registered Medical Practitioners must be actively engaged in audit that relates directly to their practice. 'The Medical Council's Framework for Maintenance of Professional Competence Activities' sets one clinical audit per year as the minimum target. The time spent on clinical audit activity is accounted for separately to other CPD activities. The Medical Council guidance suggests that it takes approximately 12 hours to complete this clinical audit activity. This time should not be counted as part of the 50 credits per annum.

Many features of public health medical audit are no different from those of traditional clinical audit; such features include its cyclical nature, the need for systematic and regular audit, a formalised and documented approach, relevance to the quality of medical practice, objective and methodologically sound approaches, the involvement of all doctors, and the need to evaluate the impact of audit – which should ultimately lead to improvement in the health of populations (Bhopal et al, 1993).

Domains of Good Professional Practice

The Medical Council's eight Domains of Good Professional Practice set out the principles on which good practice is founded – see Appendix 1. These principles together describe medical professionalism in action.

Practitioners enrolled on the FPHMI PCS are required, using the Council's eight Domains of Good Professional Practice, to:

- Reflect on their practice
- Identify areas of practice where they are required to stay up to date
- Identify areas of practice they wish to further progress and
- Develop their Professional Development Plan in line with the above

Within the continuous professional development and Clinical Audit framework, practitioners are best placed to choose the activities that reflect their educational needs and are expected to make a judgement on the value of a particular activity. They will also be expected to map their activities against the relevant Domain(s) of Good Professional Practice and ensure that the activities undertaken during the course of a five year cycle encompasses all eight domains.

Challenges to undertaking clinical/ healthcare audit in public health practice

1. **Lack of explicit criteria against which to audit activities**

   Some public health activities are more amenable to the development of criteria, especially those activities that are largely protocol-driven such as the follow-up of communicable disease notifications. Other activities, particularly non-clinical types of work, are more difficult to audit because they are less structured and explicit criteria are more difficult to develop. Also, as much of the work of public health departments is non-routine, this enhances the difficulty of selecting standards for structures, process or outcomes with which to compare practice. This can result in the use of implicit criteria instead of explicit criteria (Kahn et al, 1989). Implicit criteria are where the review of care is undertaken by senior clinicians who rely on their own experience in

judging care. Because of the difficulties of ensuring reliability in the interpretation of information about the care that was given, this method should be avoided where possible (NICE, 2002).

2. **Time frames for measuring outcomes**

   Another barrier to performing public health audit is the long time frame to outcomes which makes it difficult to audit outcomes, with the result that process measures are more readily used (Nuffield, 1992, Johnston et al, 1992).

3. **Changing public health programmes**

   Other difficulties include the fact that completing the audit cycle requires repeating the work to see if improvement has occurred, but due to the changing work programmes of public health departments, this is very difficult for most of the central functions of public health departments (Jacobs & Gabbay, 1994).

Suggested approaches to audit within public health medical practice

The Medical Council, in their guidance document, has considered the alternatives to clinical audit for medical practitioners whose role is entirely comprised of non-patient-facing services, and has stated that the principles of clinical audit should be applied to their professional practice as an improvement project.

A draft document from the Medical Council (2011) re Internal CPD Credits and Audit for PCS for doctors in non-clinical practice states that

' the first step for any person partaking in Professional Competence is to define one's scope of practice as PCS should reflect scope of practice'.

Audit should reflect the scope of one's practice and should be a review of an aspect of one's practice, e.g. if primarily engaged in teaching, a review with students could be undertaken or peer review of teaching skills should be provided . However, if there are ANY clinical component to ones activities the PCS should reflect this very clearly.

An example of using clinical audit methodology in systematic quality improvement projects in public health can be taken from the UK Academy of Medical Royal Colleges draft guidance. They recommend that Case Reviews can be submitted in place of clinical audit -

"If you are unable to provide evidence from clinical audit or clinical outcomes, documented case reviews may be submitted as evidence of the quality of your professional work. You should outline

the (anonymised) case details with reflection against national standards or guidelines and include evidence of discussion with your medical and non-medical colleagues. A number of different approaches will be acceptable, including documented regular discussion at multidisciplinary meetings or morbidity and mortality meetings.

The UK Faculty of Public Health states that it is accepted that traditional clinical audit is not appropriate for many public health specialists. However, they are expected to take part in two case reviews per year. A 'case' may be a project, plan, report or meeting.

Suggested approaches include:

- Define scope of practice
- Any clinical work should include clinical audit
- Use clinical audit methodology to develop quality improvement initiative/project
- If teaching/training – feedback from clinical supervision, teaching and training;
- Case review/discussion – can be peer review or multidisciplinary meeting and assessed against national standards or guidelines
- Guideline development or updating
- Audit can be at individual, team, departmental or national level

Individual, Team, Department and National Audit

Audit can be done at any level from the individual to national level. The quality of clinical audit is considered to be higher when there is a multidisciplinary team approach. Departments of Public Health should facilitate team / department-based public health medical audit. Departments can be based in health services, academic departments or other organisation. Wherever possible, the collective setting of departmental objectives should be a ***prior step*** to auditing the central tasks of public health medicine (FPH UK, 2010). It will assist the design of an audit programme to audit the achievement of those objectives. The FPHMI recommends that each department should outline an annual audit plan.

Examples of audit within public health departments could include the department's annual work programme and regular audit of performance in relation to infectious disease control, clinical effectiveness work and communications (FPH UK, 2010). Risk management techniques can help to identify priorities for action, ensure good documentation (of advice and other work), systematically review complaints, and assess all critical incidents affecting departments. Incidents might include

large outbreaks of communicable disease, environmental health incidents and failures in communication. See Appendix 2 for more detailed examples.

Individual audit is assumed to be both part of the departmental audit process as well as part of the individual's CPD (FPH UK, 2010).

Examples of clinical audit / quality improvement activities for public health medical practitioners are given in the following table. As stated previously this guidance is not meant to be prescriptive or all encompassing, but simply a guidance to public health medical practitioners.

Table 1: Medical Audit Activities adapted from the FPHMI website (Source: Medical Council)

Category	Example Activities	Credits
Public Health Medical Audit *Audit activities should be focused on the practice of the practitioner and not on the processes** **Relating to the individuals own work rather than the processes of the workplace*	• Measurement of individual / departmental compliance with guidelines / protocols (one per year) • Individual practice review • Department audit • Simulator training, e.g. ACLS, table-top exercises for emergency planning, • Self-assessment • Evaluation of individual risk incidents / complaints • Setting standards – guidance development in compliance with best-practice methodology • Skills analysis • Peer review	Minimum 1 audit per year It is estimated that the completion of one clinical audit will take approximately 12 hours of activity.

Key areas for the demonstration of effective public health practice

The FPHMI has defined key areas of public health competence for Specialist Registrars (SpRs) in training. From these key areas public health medical practitioners should identify the key areas of ***personal development most relevant to their own role and aspirations***. The PCS including clinical audit, is designed to demonstrate competence in the role you are currently in.

Table 2: Summary of the key areas for public health competence

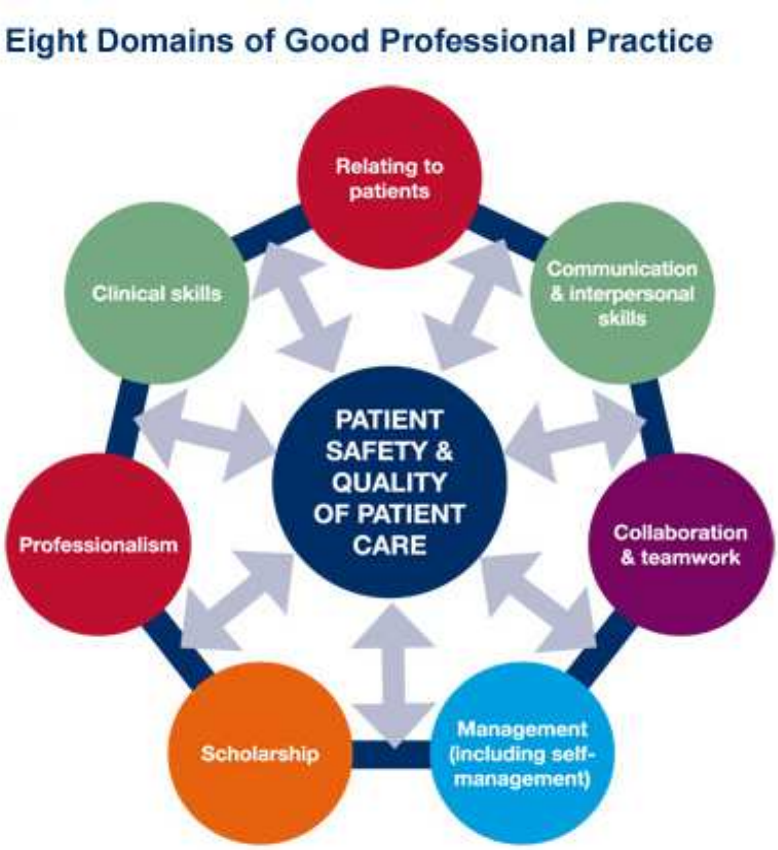
(defined by "FPHMI Forum draft revision 2012 (on behalf FPHMI)")

Key areas of public health competence	
1	Epidemiology & Health Intelligence
2	Research
3	Health Needs Assessment
4	Communicable Disease Prevention, Surveillance & Control
5	Environmental Health
6	Emergency Planning & Response
7	Quality & Risk
	7-A: Governance
	7-B: Evidence-Based Health Care
	7-C: Health Technology Assessment (HTA)
	7-D: Effectiveness & Outcome Assessment
8	Communication (includes teaching/lecturing), Advocacy & Health Improvement
9	Management
10	Professionalism

Conclusion

This is an evolving document, which will be subject to change as more experience is obtained in performing clinical audit and systematic quality improvement activities. Any feedback is welcome, and the draft guidance will be amended on foot of any comments received.

APPENDIX 1



These domains describe a framework of competencies applicable to all doctors across the continuum of professional development from formal medical education and training through to maintenance of professional competence. Since they describe the outcomes which doctors should strive to achieve, doctors should refer to these domains throughout the process of maintaining competence in line with the Standards. For example, the domains can be used to assess needs and plan maintenance of professional competence, and they can be cross-referenced with specific activities for maintenance of professional competence.

Patient Safety and Quality of Patient Care

Patient safety and quality of patient care should be at the core of the health service delivery that a doctor provides. A doctor needs to be accountable to their professional body, to the organisation in which they work, to the Medical Council and to their patients thereby ensuring the patients whom they serve receive the best possible care.

Relating to Patients

Good medical practice is based on a relationship of trust between doctors and society and involves a partnership between patient and doctor that is based on mutual respect, confidentiality, honesty, responsibility and accountability.

Communication and Interpersonal Skills

Medical practitioners must demonstrate effective interpersonal communication skills. This enables the exchange of information, and allows for effective collaboration with patients, their families and also with clinical and non-clinical colleagues and the broader public.

Collaboration and Teamwork

Medical practitioners must co-operate with colleagues and work effectively with healthcare professionals from other disciplines and teams. He/she should ensure that there are clear lines of communication and systems of accountability in place among team members to protect patients.

Management (including Self-Management)

A medical practitioner must understand how working in the health care system, delivering patient care and how other professional and personal activities affect other healthcare professionals, the healthcare system and wider society as a whole.

Scholarship

Medical practitioners must systematically acquire, understand and demonstrate the substantial body of knowledge that is at the forefront of the field of learning in their specialty, as part of a continuum of lifelong learning. They must also search for the best information and evidence to guide their professional practice.

Professionalism

Medical practitioners must demonstrate a commitment to fulfilling professional responsibilities by adhering to the standards specified in the Medical Council's "Guide to Professional Conduct and Ethics for Registered Medical Practitioners".

Clinical Skills

The maintenance of professional competence in the clinical skills domain is clearly specialty-specific and standards should be set by the relevant Postgraduate Training Body according to international benchmarks

APPENDIX 2

TEN KEY AREAS OF PUBLIC HEALTH COMPETENCE

Suggested areas for public health department audits are set out in the attached table, which are cross-referenced to the ten key areas of public health practice.

1. Epidemiology & Health Intelligence

Department
• The Public Health Department carries out surveys of health status and health behaviour. Standard methodology should be used for survey execution. • Compiles and periodically updates a community health profile and / or assessment data. • The Public Health Department has standards protocols for the production, analysis and interpretation of data for comparison. • Data is published in multiple formats for diverse audiences. • Data from the assessment is compared to data from other regions. • The data is used to track changes over time. • There is a communications strategy in place to promote use of the community health profile. • The data is used by the health services to inform health policy and planning decisions.

2. Research

Department
• The Public Health Department promotes research into the gaps in evidence. • The Public Health Department has researchers or access to researchers with the knowledge and skills to design and conduct health-related studies. • Research findings are disseminated to public health colleagues and others e.g. publications in journals, websites.

3. Health Needs Assessment

Department
• Demonstrate how the key determinants of health apply in the local population. • The Public Health Department provides the public, policymakers and stakeholders with information on community health status and health needs in the community, as well as information on policies and programmes that can improve community health. • The Public Health Department assesses the extent to which health services in the region are available and utilised by groups of people who may encounter barriers to care.

4. Communicable Disease Prevention, Surveillance & Control

Department

• Adopting national standards developed for communicable disease control.
• The public health department collects timely notifiable disease information from community health professionals who submit information on possible disease outbreaks.
• There is a system and procedures for the detection and control of communicable disease outbreaks which includes:
  • Protocols for GPs, nurses, physicians etc, regarding the reporting of any unusual clusters or presentations of communicable diseases.
  • Adequacy of reporting level, including stage of outbreak at detection
  • Risk assessment to identify vulnerable populations, considering factors such as poverty, low income, education, quality of housing, access to health care etc
• The Public Health Department has a system and procedures for outbreak investigation and cause identification.

5. Environmental Health

Department

• Perceives and assesses the potential impact of the environment (physical and social) locally.
• The Public Health Department has a system and procedures of control of environmental health controls which includes the:
  • Clear assignment of environmental epidemiological tasks to dedicated PH staff
  • Staff trained in methodology of environmental risk assessment procedures
  • Effective collaboration with EHOs, local authorities, environmental agencies and other relevant parties, including exchange of environmental data

6. Emergency Planning & Response

Department
• Provide a public health response to adverse/serious incidents arising in local services that place the health of the public at risk. • The Public Health Department has developed an emergency plan that defines public health emergencies that might trigger the implementation of the department's emergency plan, describes the departments' responsibilities, and establishes standard operating procedures. • The plan is tested through the staging of one or more simulation exercises and revised as necessary at least every 2 years. • There are written protocols for the immediate investigation of public health threats and emergencies for: • Infectious disease outbreaks, including foodborne and waterborne illness

- Environmental health hazards and emergencies, e.g. lead and asbestosis exposure
- Chemical threats and incidents
- Biological agent threats
- Radiological threats

- The Public Health Department has a named person as Emergency Management lead who:
  - Links with the HSE's Emergency Planning Officer and other emergency response personnel
- The Public Health Department can rapidly respond to emergencies by:
  - Maintaining a current roster of staff trained to respond to emergencies
- The Public Health Department has a communications plan to effectively create and disseminate materials for each stage of a crisis according to recognised theories and methods.
- The Public Health Department evaluates responses to public health emergencies, e.g. by writing up a report
  - Findings from such reports are incorporated into the emergency plans.

7. Quality & Risk

Department
Governance
• Public health governance system in place. • Regular audit meetings held to review performance.
Evidence-Based Health Care
• Ensure that all decisions are based on best current available evidence (annual review of the level of evidence offered by the department in response to priorities and demands), and putting these decisions into the public domain. • Identify effective interventions, including outlining the strength of the evidence, and working with others to implement these.
Effectiveness & Outcome Assessment
• Recommendations of HIQA taken on board. • The Public Health Department evaluates public health services against established criteria for performance, including the extent to which the departments goals are achieved at 3 yearly intervals. • The Public Health Department assesses community satisfaction with the responsiveness to their complaints or concerns regarding public health services

8. Communication (including teaching/lecturing), Advocacy & Health Improvement

Department
Communication
• The Public Health Department has policies and procedures in place to route all media enquiries appropriately
• The Public Health Department has a mechanism in place to document and respond to public enquiries.
• The Public Health Department co-ordinates with local media to develop information or features on health issues.
• The designated spokespersons are adequately trained in providing accurate, timely, and appropriate information on public health issues for different audiences.
• Responding appropriately to public requests about health matters.
• Effective and proactive communication through the media to raise awareness of health and disease locally.
• Effective reactive communication through the media, so that the public receives a clear, accurate and understandable message about actual or potential risks to their health.
• The Public Health Department has policies and procedures in place to ensure rapid flexible response by nominated spokespersons by e.g. having communication templates.
Advocacy
• Identification of inequalities in health.
• Identifying vulnerable sub-groups and proposing interventions.
• Robust system in place to prioritise health issues (within a set of identified principles).
• Anti-discriminatory approach to advocacy.

9. Management

Department
• Providing named people who will liaise and provide input health service planning.
• Regular individual and performance and development reviews.
• Training policy in place.
• The Public Health Department periodically develops, uses and reviews job standards and position descriptions that incorporate specific competency and performance expectations.
• The Public Health Department evaluates members of the department on their demonstration of core public health competencies and those competencies specific to a work function or setting and encourages staff to take advantage of continuing education and training opportunities.
• The Public Health Department identifies education and training needs and encourages opportunities for workforce development, including distance learning and staff cross-training.

10. Professionalism

Department
• Ensuring individuals maintain their skills and expertise through CPD and personal development plans. • Robust system in place to prioritise health issues (within a set of identified principles). • Principles include implementing evidence-based services which impact positively on health. • Regular individual and performance and development reviews. • Training policy in place. • Staff members are in compliance with the certification requirements of their licensing body or with recommended CPD requirements of their discipline. • Maximising the potential of staff to use their skills and abilities to best effect.

APPENDIX 3

Examples of systematic quality improvement activities in education

Practitioners involved in medical education (from UK Academy of Medical Royal Colleges, 2009)

Standards against which audit can be performed include

1. Keep clear, accurate and legible records -

- Maintenance of useful and accurate records of student's work and performance
- Ensure that assessment decisions are recorded and documented accurately and systematically.

2. Audit and monitor the effectiveness of educational programme-
    - Ensure that programmes remain current and valid in light of developing knowledge in the discipline, and practice in its application
    - Evaluate the extent to which the intended learning outcomes are being maintained by students
    - Evaluate the continuing effectiveness of the curriculum and of assessment in relation to the intended learning outcomes
    - Ensure that recommendations for appropriate actions are followed up to remedy any identified shortcomings.
    - Monitor the success of your programme against appropriate internal and/or external indicators and targets.

Methods of audit include formal audit, MSF, student/learner feedback, and review of complaints.

Examples of systematic quality improvement activities for those that give expert advice

Practitioners involved in giving expert advice (UK Academy of Medical Royal Colleges, 2009 and FPH, 2010, Revalidation and Public Health)

Standards against which audit can be performed include

1. Apply knowledge and experience to practice

- Identify and access appropriate bibliographical resources, archives, studies and other sources of relevant information when preparing your opinion or advice (AMRC)
- Adequately assess the patient's or community's conditions (FPH, 2010)
- Provide or arrange advice, investigations or treatment where necessary (FPH, 2010)
- Prescribe drugs or treatment, including repeat prescriptions, safely and appropriately (FPH, 2010)
- Provide effective treatments based on the best available evidence (FPH, 2010)

2. Keep clear, accurate and legible records –

- Ensure that any decisions, opinions or advice you provide are recorded and documented accurately and systematically (AMRC)
- Make records at the same time as the events you are recording or as soon as possible afterwards (FPH, 2010)
- Record clinical findings, decisions, information given to patients, drugs prescribed and other information or treatment (FPH, 2010)

3. Put into effect systems to protect patients and improve care

- Collect, review and , where appropriate, respond to feedback about the effectiveness of your opinion or advice

Methods of audit include formal audit, multi-source feedback, customer feedback, peer review of advice, evidence of compliance with local governance policies and protocols and the Data Protection Act and review of complaints.

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