Implementation of the Recommendations of the Report of the Scoping Inquiry
Progress Report Summary, Q4 2020

Section 1: Establishment of the Process to implement the *Final Report of the Scoping Inquiry into the CervicalCheck Screening Programme* Recommendations

Following publication of the Final Report of the Scoping Inquiry into the CervicalCheck Screening Programme, led by Dr Gabriel Scally, in September 2018, a comprehensive Implementation Plan was developed to support implementation of all 56 recommendations made by the Scoping Inquiry. Dr Scally's laboratory supplementary report was published on 11 June 2019, and contains two additional recommendations bringing the total number to 58. The HSE has developed additional actions against these recommendations.

The Minister for Health is committed to publishing progress reports against the recommendations on a quarterly basis in order to provide details of the work which is underway across the health system to implement all 58 recommendations from the three reports of Dr Gabriel Scally. There has been significant progress made by all parties to date, as demonstrated in the overview below, and this report is a summary of progress made in the period to the end of December 2020 (Q4 2020).

Impact of the COVID 19 Pandemic & the safe recommencement of screening services (Q1-Q4 2020)

There is no doubt that the COVID 19 global pandemic has had a significant impact on the safe provision of screening services, both in Ireland and other countries.

The National Screening Service's (NSS) four national screening programmes BreastCheck, CervicalCheck, BowelScreen and Diabetic RetinaScreen were paused in March 2020. This move was taken on public health advice due to the situation with COVID 19 pandemic. This pause in community testing was put in place to protect patients and staff by complying with social distancing guidelines. In addition, the HSE temporarily redeployed staff and resources to the response to COVID 19. However, clinical staff continued to work within the programmes.

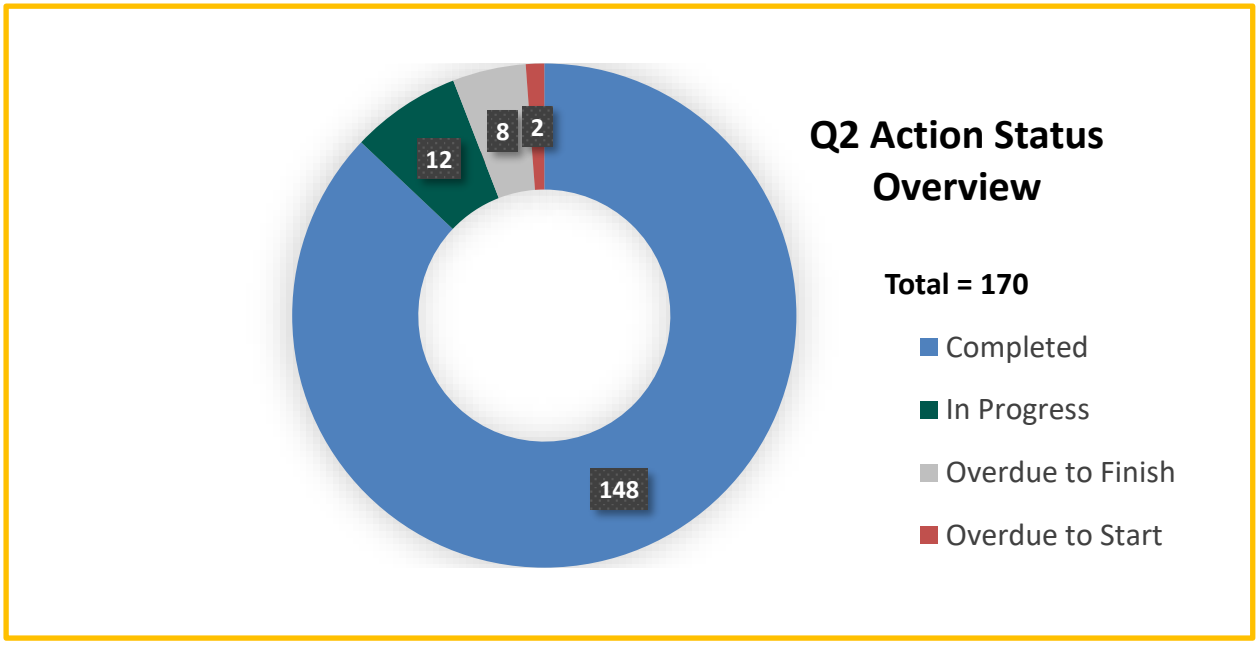
The National Screening Service has a plan in place for and will continue to prioritise the safe and effective reopening of the Screening Programmes, with all four programmes now resumed. In line with Government and Public Health advice, the NSS continues to assess the risks of delivering screening in a COVID environment and advise on and put in place measures to reduce the risk for clients and staff.

As such, to ensure a safe resumption and delivery of screening services in the context of the COVID 19 pandemic, the NSS is taking measures to protect both participants and staff and monitor the delivery of screening services to ensure their continuing safety. This includes ensuring the appropriate infection controls are in place and PPE requirements are identified and made available.

Since COVID 19 was categorised as a national public health emergency, the HSE has continued during Q4 2020 to respond to the situation and many services continue to be affected. Given the challenges that have arisen due to the pandemic, much of the remaining work on the implementation of the recommendations had not progressed within the initial planned timelines, however, some good progress was made during Q4 2020. Plans for a safe return to health services commenced in Q2 2020 in the HSE and continued in Q4 2020 including continued capacity planning for the ongoing delivery of COVID 19 and non COVID 19 care and services side by side. Work on implementing the remaining recommendations was re-prioritised in line with this process and progress with this work continued throughout Q4 2020.

Section 2: Overall summary position at end of Q4 2020

As of the end of Q4 2020, there were 170 actions arising from the 58 recommendations. The number of completed actions is now at 148 with a further 12 in progress, 8 overdue to finish and 2 overdue to start. A breakdown of the status of actions is detailed below.



Section 3: Q4 2020 Progress Report by recommendation theme

There has been significant progress with the implementation of the recommendations to date and some progress has been made in Q4 compared to Q3. The number of completed actions have remained the same, however, 2 actions have now started and are in progress to be completed, with one added to the list of actions being overdue to finish.

Method of Approach

The Department of Health's record management protocol has been updated as per previous reports. A project based approach was adopted to identify areas with potential for improvement and scope requirements. Following research and completion of the project a suitable document management solution was identified. Work is now underway to progress implementation. This is supported by other actions including the roll out of eApplications - ePQS, eSubmissions, eCorrespondence etc. and an exercise to update the Department's record management protocol.

As was reported in the Q1, Q2 and Q3 2020 progress reports, the HSE's Chief Clinical Officer (CCO) commissioned a review of the HSE Healthcare Records Management Policy during 2019 and a first draft of the HSE Healthcare Records Management Practices document was completed in Q1 2020. Subsequently, a programme of work to be overseen by the HSE Audit & Risk Committee and led by the Data Protection Officer has been commenced. This work will include a complete review of all policies, procedures and guidelines in relation to records management (both healthcare and non-healthcare records) throughout the HSE. The scope of work will also include the implementation of recommendations of the audit of access to healthcare records by patients which was undertaken in the HSE in 2019. The work is expected to conclude in early 2021 due to the issues which emerged in repsonse to the COVID 19 pandemic in 2020. Once this has been completed, the HSE Data Protection Officer will ensure that communication and implementation of the policy on best practice for records management is disseminated throughout the system, as per the recommendation.

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Listening to the Voices of the Women and Families Affected

The Department established a Women's Health Taskforce in September 2019, with eight meetings held to date. The Taskforce is co-chaired by the Secretary General of the Department of Health and the Director of the European Institute for Women's Health. It combines internal and external membership, with a strong bias towards involving internal staff, in keeping with Dr Scally's recommendation that the Department improve the consistency, commitment and expertise it applies to women's health issues. Taskforce engagement has included stakeholder workshops, weekly expert presentations through Women's Health Weekly, international learning visits to WHO Geneva, European Parliament, public engagement through a webpage and mailbox and a nationwide "Radical listening" which is currently underway enabling women across the country to share their views and experiences of the health sector and health services.

In its first year, the Taskforce has listened to, engaged with, and worked with more than 1,000 individuals and organisations representing women across the country. Four initial priority areas were selected as the focus for 2020: Improve services for Gynaecological Health, Increase Physical Activity among women and girls, Improve supports for Menopause and An Effective Approach to Mental Health for women and girls.

Following research and consultation, the Taskforce has developed proposals for action under three priority areas: Improving Gynaecological Health for Women and Girls (which includes consideration of endometriosis); Improving Supports for Menopause; and Improving Women and Girls' Physical Activity. A programme of actions under these proposals is currently being finalised. Implementation of actions will be supported by the Budget 2021 allocation of a dedicated €5million 'Women's Health Fund'. This fund will also resource additional priority proposals to be chosen for 2021.

Meetings of the Taskforce and inputs to its work are published regularly on the Women's Health Taskforce website on www.gov.ie/health .

CervicalCheck – Governance and Management

An implementation plan to support the organisational and governance review of the NSS which was completed in late Q2 2019 continued to be progressed by the NSS CEO and management team throughout 2020.

Work continued on enhancing and further strengthening the deployment of professional and public health expertise into the screening services inclusive of collaborating with the HSE Women and Infants Programme to ensure the role of colposcopy is further developed within the screening programmes and in particular through the introduction of HPV primary screening. A Primary Care Advisor is in place within the Cervical Check Programme. The Director of Public Health also continues to ensure public health is positioned strategically and appropriately within NSS structures.
A fulltime Clinical Director was appointed to Cervical Check in Q3 2020.

The NSS Quality Safety & Risk Committee which is independently chaired continues to meet. The membership of this committee is inclusive of patient representatives.

Public Health Expertise

In December 2018, the Department of Health published the Crowe Horwath review on the 'Role, Training, and Career Structures of Public Health Physicians in Ireland'.

In 2019, the Department established an Implementation Oversight Group to oversee the development and implementation of a new model for the delivery of Public Health Medicine in Ireland that reflects the Crowe Horwath review, Dr Gabriel Scally's report on the National Cervical Screening Programme and the need to develop public health medical expertise within the health system in line with Sláintecare.

A dedicated recruitment team has been established to centrally coordinate campaigns and deliver enhanced multidisciplinary teams envisaged as part of the future structures. Campaigns have launched across all job categories. Detailed design and a high level implementation plan, taking account of demands of pandemic response, will be agreed in early Q1 2021, with a view to commencing phased implementation before Q2 2021.

National Screening Advisory Committee

The National Screening Advisory Committee (NSAC), which was established in 2019, held three meetings in 2020 in March, July and October.

The Committee will provide independent expert advice when it comes to considering population-based screening programmes in Ireland. In accordance with best practice and in order to ensure appropriate use of finite resources, the National Screening Advisory Committee will:

- Effectively implement an agreed methodology for accepting applications to consider new or revisions to existing population screening programmes;
- Agree and implement a prioritisation process for the consideration of new or revised population screening programmes;
- Develop and implement a robust and transparent system to evaluate potential population-based screening programmes against a set of internationally recognised criteria;
- Clearly communicate the recommendations and the reasoning to the Department of Health, stakeholders and the public on the outcomes of deliberations.

The Committee will play a significant strategic role in the development of population screening programmes in Ireland. However, it will have no executive function i.e. day to day operational role. Day to day operations will remain the responsibility of the HSE.

Despite the effect of COVID 19 on the operation of the Committee a meeting was convened in July 2020 and a subsequent meeting was held in October. First meeting in 2021 will be held in February.

At its meeting on 15 October the Committee approved the proposed DRS interval change for those with diabetes who have no retinopathy and no non-diabetic eye disease in two annual screens. A formal recommendation has been made to Minster Donnelly which was approved early 2021 and the Programme has been advised of same

The Committee also has a dedicated website http://www.nsacommittee.gov.ie/ which contains information on the Committee.

Risk Management

Following approval by the HSE Board of the report from the review of risk management in the HSE, provision was made in the 2020 National Service Plan for the establishment of an Enterprise Risk Management Programme. It was envisaged that a Chief Risk Officer would be appointed by the HSE in Q1 2020 following a recruitment campaign which commenced in December 2019. This process however was unsuccessful in identifying a suitable candidate.

While due to the demands of the HSE's COVID 19 response there have been delays in appointing a Chief Risk Officer and fully establishing the Enterprise Risk Management Programme, the CEO with the HSE's Executive Management Team have undertaken a fundamental review of the HSE's corporate risk profile and Corporate Risk Register. A second major review was undertaken at the end of Q2 2020 to reflect the impact of COVID 19 on the HSE's risk profile.

A risk development programme with the HSE Board and its committees and the EMT commenced in October 2020. This Programme of work aims to improve the HSE's corporate risk processes.

Incident and risk management continue to be standing agenda items on the Executive Management Team and Senior Management Team meetings of each screening programme.

CervicalCheck Laboratory Services

As reported in previous progress reports, CervicalCheck continues to review its programme standards, inclusive of laboratory standards and the implementation of enhanced quality assurance arrangements and processes has been completed. Updated standards are also being implemented in line with the introduction of HPV primary screening. All recommendations relating to Cervical Check laboratory services were implemented by the end of Q4 2019.

Procurement of Laboratory Services

All actions identified by the HSE in response to the 8 recommendations from the September 2018 report relating to procurement have now been fully implemented. Additionally, a further 4 procurement actions developed by the HSE in response to the supplementary report (June 2019) have been implemented and these actions ensure that future contracts for the provision of cytology and other laboratory services to CervicalCheck will explicitly state each precise locations by the precise company in the written contracts and that measures will be put into place to monitor compliance.

Auditing Cervical Screening

Work concluded on the review and evaluation of clinical audit for interval cancers in three screening programmes during Q3 2020 with final reports presented to the HSE Board. The reports were published on 21 October 2020. Implementation of recommendations from these reports will be led by the National Screening Service over time.

The reports have set out a number of recommendations for the National Screening Service and the Board of the Health Service Executive. Their recommendations will support the NSS in establishing an independent and safe system to support future management of interval cancers. Implementation of recommendations will now commence and progress on implementation will be reported in early 2021.

Open Disclosure

There have been no updates for Q4 2020. As per previous updates, a Government decision approved the publication of the Patient Safety (Notifiable Patient Safety Incidents) Bill 2019 on 3 December 2019. Following publication, the Minister for Health introduced the Bill into Dáil Éireann on the 12 December 2019, completing the second stage with approval to progress to next legislative stage (Committee Stage), with a view to progressing through the legislative process in the Houses of the Oireachtas to enactment.

The Patient Safety (Notifiable Patient Safety Incidents) Bill 2019, for the first time in Irish law, provides a legislative framework for the mandatory open disclosure of patient safety incidents. The Bill is intended to provide a 'future-proofed' legislative framework for mandatory open disclosure of designated notifiable patient safety incidents. In summary it requires a health services provider to ensure that where a notifiable patient safety incident has occurred, a disclosure must be made to the patient and/or their family. This will ensure that patients and their families receive appropriate, timely information in relation to a serious incident that may have occurred concerning their care. Importantly, the Bill provides a dual approach to the designation of notifiable patient safety incidents which are the subject of mandatory open disclosure–

a) the Bill contains a Schedule listing a number of the most serious notifiable patient safety incidents which are subject to mandatory open disclosure. The incidents listed are of a very serious nature, result in unintended or unanticipated death and are preventable;
b) the Bill sets out a process by which the Minister for Health will make regulations expanding the list of notifiable patient safety incidents over time in line with advancements in clinical practice and international developments.

As part of the development of the Patient Safety (Notifiable Patient Safety Incidents) Bill, the Department has been engaging with key stakeholders including HIQA, the HSE, the Mental Health Commission and the State Claims Agency, and other organisations in relation to the progression of the Bill. Requirements to meet this recommendation have been included in the HSE's interim revision of its open disclosure policy.
The Patient Safety (Notifiable Patient Safety Incidents) Bill places an obligation on the health services provider to make a mandatory open disclosure of a notifiable patient safety incident and externally notify to the appropriate regulator. It is an offence (class A fine) to fail to disclose to a patient/relevant person a notifiable patient safety incident or to notify the appropriate regulator of the occurance of a notifiable patient safety incident.

The Independent Patient Safety Council has been established by the Minister for Health and notwithstanding the pandemic, has during Q2 2020 been progressing work on the immediate priority of the Council, namely the review of open disclosure policies, informed by legislation, international best practice and research with a view to standardising and optimising the process of open disclosure to enhance the patient experience and maximise the opportunities for system-wide learning.

The National Open Disclosure Office returned to work on a reduced capacity on 20 July 2020, following a period of redeployment due to COVID 19. Revision of the Open Disclosure National Guidelines continues, including the development of numerous resources to support the guidelines. Training on open disclosure continues, predominantly through e-learning. >23,000 staff have completed Module 1 as at 30 September 2020 (of which 1,486 are medical staff).

The development of Module 2 is in progress and work has commenced on the development of a revised face to face training programme. Open disclosure is included as mandatory on DIME/NER for NCHDs. Intern Networks Executive (INE) confirmed that the open disclosure e-learning module will form part of national intern induction e-learning in July 2021. The RCPI online programme on communication and open disclosure, which is targeted at medical staff, is open for registration and is ready for launch. Work on the annual report is well progressed, with the final first draft ready for submission to the board.

Work progressed during 2019 and 2020 under the leadership of the Chief Clinical Officer in relation to the development of open disclosure and communications skills training programmes with the medical training bodies. The RCPI launched a Gateway to Communications online programme in October 2020.

Cancer Registration

A Memorandum of Understading (MoU) between National Cancer Registry Ireland (NCRI) and National Screening Service was signed in November 2019. This MoU will put in place a structure for collaborative working in 2020 which will involve the formalising of routine data sharing arrangements including the types of data that will be transferred between the two organisations. Revision of the Data Sharing Agreement (DSA) with HSE will incorporate any synchronising required in light of this MoU with NSS.

An MOU is in progress between NCRI, National Cancer Control Programme and Health Intelligence Unit to ensure NCRI data is leveraged in cancer policy and development of services. The Cancer Intelligence Manager in process of following-up with HSE HIU to confirm agreement of text, and with both HIU and NCCP to revised delivery (2021) delivery dates, with a view to signature by end Jan 2021.

Draft Terms of Reference (ToR) for the Peer Review were agreed between the Department of Health and the NCRI Board. These draft ToR were subsequently sent to the International Agency for Research on Cancer (IARC). It was expected that the review would commence before end-May 2020. However, it has been temporarily paused due to Covid 19 pandemic. It is hoped that, in line with evolving public health guidance, it will be possible to progress the Review in 2021.

The NSS/NCRI Strategic Planning Group (SPG) and Operational Delivery group (ODG) had further joint meetings in August and November to scope what data items are available in both systems and how to progress the work. The plan has been to identify the data required and then appraise the available options to ensure timely, safe, legally compliant transfer of data. In addition, the ODG met in September and October to progress the details of the fields required. Work is progressing well but NCRI had been awaiting the publication of the Interval Cancer Reports, which had been delayed, to confirm specific details of what is required. This report was published in late October. At the joint group meeting on 11th November there was a presentation on the implementation planning for the Interval Cancer ERG Report recommendations. This will inform the next steps for the SPG and ODG, and next meeting will be held in January 2021.

Other Screening Programmes

Revised terms of reference and principles of operation for QA committess have been developed across all National Screening Service screening programmes. A steering committee has been established in the NSS to oversee all QA projects and the implementation of a project improvement plan continues to be progressed. All recommendations relating to cross-programme learning in the National Screening Service have been implemented.

Resolution

The CervicalCheck Tribunal Act provides for restoration of trust meetings. The intention behind a restoration of trust meeting is to document experiences, facilitate discussion and provide information to the woman concerned or her family. The Act provides for a Facilitator to accept applications for such meetings. A Facilitator has now taken up the role on an administrative basis to develop arrangements for the meetings and is currently conducting preparatory work necessary to offer the service. The Facilitator will be formally appointed by the Minister to the position of Facilitator once arrangements are in place and they are in a position to accept applications for meetings.

A particular concern is in respect of how the meetings will operate in light of COVID 19. It was envisaged that these meeting would take place face to face and if they cannot now be implemented as intended, it may impact the arrangements for the meetings and their effectiveness. The Facilitator intends to consult with all stakeholders on how the meetings could best be arranged in line with safety measures in place.

As the key arrangements for the CervicalCheck Tribunal were in place it was intended that the Tribunal would be established by the end of March 2020. However, due to the outbreak of COVID 19, in line with the public health measures being taken to control the outbreak of the virus it was decided to delay the establishment of the Tribunal. Issues then arose in respect of the membership of the Tribunal, which were resolved by the nomination by the Minister of Ms Justice Ann Power as chairperson and Mr Justice Tony O'Connor as an ordinary member, in addition to Judge Brian McGovern who was nominated earlier in the year.

The Tribunal was established by the Minister on 27 October 2020. Steps towards full establishment were paused at that time to allow for discussions with the 221+ Patient Representative Group in respect of the Tribunal and CervicalCheck Cases generally. After this pause, nominated members were appointed to the Tribunal with effect from 1 December 2020 and the Tribunal has now begun its work and is in a position to receive claims.