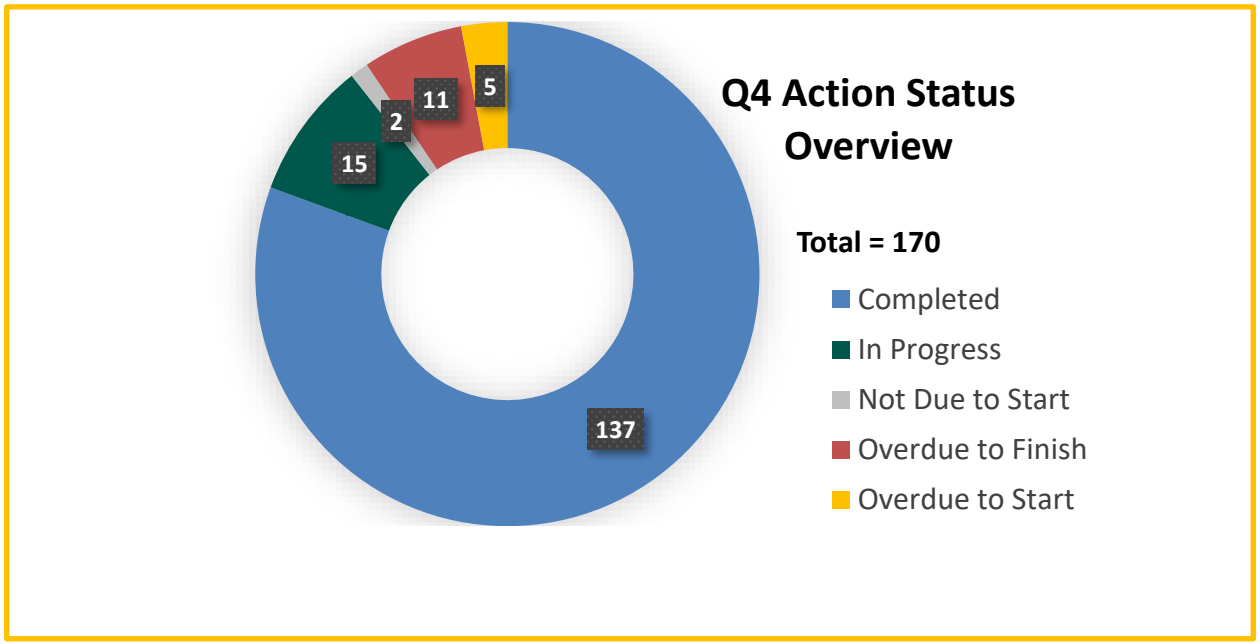
Implementation of the Recommendations of the Report of the Scoping Inquiry
Progress Report Summary, Q4 2019

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 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 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 2019 (Q4 2019).

Overall summary position at end of Q4 2019

As of the end of Q4 2019, there were 170 actions arising from the 58 recommendations. The number of completed actions has increased to 137 with a further 15 in progress, 11 overdue to finish and 5 overdue to start, with 2 not yet due to start. A breakdown of the status of actions is detailed below.



Q4 2019 Progress Report by recommendation theme

Method of Approach

The Department of Health's record management protocol has been updated. 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.

In Q1 2019, the HSE's Chief Clinical Officer (CCO) commissioned a review of the HSE Healthcare Records Management Policy. A process to support the revision of the HSE HCRM Policy continues to be progressed inclusive of a consulation on the existing policy. A working group established and led by the Quality Improvement Division has met on a number of occasions during 2019 and is expected to conclude its work in early 2020.

The National Director of Quality Assurance and Verification has now completed the audit of access to healthcare records which measures compliance with best practice in relation to same. The draft report and recommendations are under consideration by the CCO with a view to planning for implementation in early 2020.

HSE Data Protection Officer is continuing work on developing a policy on best practice for records management in the HSE by the DPO in collaboration with the Chief Information Officer. The work is expected to extend into 2020. Once this has been completed, 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 recommendaton.

Listening to the Voices of the Women and Families Affected

The Department has established a Women's Health Taskforce which met in September, October and December 2019, and will continue to meet every 4 - 6 weeks. The Taskforce is co-chaired by the Secretary General of the Department of Health and the Directory General 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. The Taskforce is currently working through a number of exploratory themes in order to select priority work areas. It is envisaged that priorities will be selected on a rolling basis every quarter. Every meeting of the Taskforce and all inputs to its work are published regularly on the Women's Health Taskforce website on gov.ie/health.

The Women's Health Taskforce has agreed as its first action to initiate a Radical Listening Exercise. Planning is well underway and the exercise will formally commence shortly. In addition, the Taskforce has been seeking direct input into its work programme, into which 500+ women have contributed to date. These inputs are published routinely on the Women's Health Taskforce website.

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. An interim CEO who was appointed to the National Screening Service in Q3 2019 pending the recruitment of a permanent CEO has continued in post. The recruitment campaign for a permanent CEO for the National Screening Service commenced in Q4 2019. The recruitment process for a Deputy Programme Manager for Cervical Check was concluded in Q4 2019 along with other posts across the National Screening Service.

Work continued on enhancing and further strengthening the deployment of professional and public health expertise into the screening services. A Lead Colposcopist was appointed to the Cervical Check Programme in December 2019. Work is continuing in collaboration 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 GP Advisor is in place for the HPV primary screening programme and the recruitment of a Primary Care Advisor to the Cervical Check Programme is progressing The Director of Public Health also continues to ensure public health is positioned strategically and appropriately within NSS structures.

The NSS Quality Safety & Risk Committee which is independently chaired continues to meet every 2 months. 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.

Following successful delivery of Stage 1 of the programme (the development of a 'preferred future model'), Stage 2 of the work is now underway. This phase will utilise enhanced governance structures (including a new Design Authority, comprising senior leadership from the HSE and Department of

Health, include the Sláintecare Office) and wider system involvement to ensure alignment and value. The implementation of the new model is expected to commence in Q3 2020.

National Screening Advisory Committee

The first meeting of the National Screening Advisory Committee took place on 18 November 2019 and the first meeting in 2020 will take place on 5 March.

The National Screening Advisory 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.

The Committee also has a dedicated website http://www.nsacommittee.gov.ie/

Risk Management

Following approval by the HSE Board of the report from the review of risk management structures, provision has been made in the 2020 National Service Plan for the establishment of an Enterprise Risk Management Programme. A Chief Risk Officer will be appointed by the HSE in Q1 2020 following a recruitment campaign which commenced in December 2019.

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

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 will also be 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.

The programme continues to monitor cytology reporting rates by the continued consideration of CYTO1 laboratory returns through the relevant QA structures. A process for monitoring and reviewing laboratory performance has been defined as has the process for escalation of any issues relating to non-conformities. QA site visit inspections to laboratories providing services to the Cervical Check Programme were completed in Q4 2019.
The Cervical Check Annual Report (for 2016 -2017) was published in November 2019 and is available at
https://www.screeningservice.ie/publications/index.html

The QA committee will provide oversight approval for all reports generated from the Cervical Check Programme as they develop inclusive of future potential epidemiological analysis.

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 Cervical Check 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 is continuing on the review and evaluation of clinical audit for interval cancers in three screening programmes. Following the report of the Royal College of Obstetricians and Gynaecologists (RCOG) in December 2019 which made specific recommendations in relation to clinical audit, the reports from the NSS Expert Group are under review to consider these recommendations and therefore extend the conclusion of its work to Q1 2020.

Open Disclosure

The Minister for Health approved the Terms of Reference and membership of the Independent Patient Safety Council. The immediate priority of the Council is to undertake a 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 general scheme of the Patient Safety Bill, approved by Government in July 2018, underwent pre-legislative scrutiny at the Oireachtas Joint Committee on Health on the 26 September 2018. The Report from the Oireachtas Health Committee was issued on 7 December 2018 with 9 recommendations. The Minister for Health responded to all recommendations on the 21 March 2019.

In advance of the publication of the Patient Safety (Notifiable Patient Safety Incidents) Bill, meetings were held with key stakeholders including HIQA, the HSE, the Mental Health Commission and the State Claims Agency 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.

Following the Department of Health meeting with Dr Gabriel Scally on 5 November 2019, further provisions were included in the draft of the Patient Safety (Notifiable Patient Safety Incidents) Bill.

A Government decision (S180/20/20/2008) 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 Department has engaged with, and will continue to progress this issue further with, the Medical Council, so as to enable the requisite strengthening of the guidance for registered medical practitioners.

Training in open disclosure in the HSE continues to be progressed throughout the organisation including ‘train the trainer’ sessions and training against the revised policy for all open disclosure leads. Workshops for open disclosure leads continue to be held across all divisions to ensure the effective implementation approaches to the open disclosure policy and programme at community, hospital group, National Ambulance Service and screening services level.

Work is also continuing with the medical training bodies in relation to the development of a communications and open disclosure skills training programme.

Cancer Registration

The working group established between the HSE and the National Cancer Registry of Ireland (NCRI) to collaborate on the common recommendations in the Scally report continues to meet.

A Memorandum of Understading (MoU) between National Cancer Registry Ireland (NCRI) and National Screening Service (NSS) 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.

The MoU requires the establishment of two groups, a steering group and an operational group that will include members from both organisations as well as a representative from the National Cancer Control Programme. Terms of Reference for both groups have been prepared. The setting up of the groups is in progress.

An MoU is also in progress between NCRI, National Cancer Control Programme (NCCP) and Health Intelligence Unit (HIU) to encure NCRI data is leveraged in cancer policy and development of services. DSAs have been agreed with 1 private hospital group and are in progress with more of the private hospitals and groups. Work is starting on DSAs with voluntary hospitals. Work is ongoing to complete DSAs with all remaining hospitals to complete this action. This work will allow both the NCCP and HIU to undertake analytical work, supporting the planning of services with a coordinated approach and will increase use of the data collected in the NCRI.

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). IARC have made some suggested amendments to the draft ToR and have outlined their views on the way forward. Their proposals are being considered.

Other Screening Programmes

Revised terms of reference and principles of operation for QA committess have been developed across all NSS 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 required legislation to establish the CervicalCheck Tribunal is now in place. In addition to the core function of dealing with claims arising from the CervicalCheck issue, the legislation provides that the Tribunal will facilitate 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 practical arrangements for setting up the Tribunal, including securing premises and staff, are at an advanced stage, and further consultation on 'Meetings to Restore Trust' will take place shortly.

The HSE CCO has engaged with patient representatives to identify any women or families who may wish to meet with their clinicians.