Northern Ireland Cervical Screening Programme

Learning Event Reporting Protocol

Version:	**3.1**
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Approved By:	**Dr Tracy Owen, Lead QA Consultant**
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NORTHERN IRELAND CERVICAL SCREENING PROGRAMME

LEARNING EVENT REPORTING PROTOCOL

Young Person and Adult Screening Team

July 2020

NORTHERN IRELAND CERVICAL SCREENING PROGRAMME

LEARNING EVENT REPORTING PROTOCOL

The rationale of this protocol is to instigate a learning event/incident reporting agreement between all service providers of the NI Cervical Screening Programme (CSP) and the Young Person and Adult Screening Team (YPAST)), PHA. The aim is for providers to alert YPAST at the earliest opportunity of any learning events or potential untoward incidents within the CSP. The definition of an untoward incident is variable, but relates to potential clinical risk to the eligible population, risk to the service, adverse media attention and risk of litigation. ***If in any doubt, it is advisable to report the incident regardless.***

The Service Manager/Lead clinician in the service provider organisation is responsible for adherence to this protocol. This protocol should be used concurrently with local clinical governance policies and early warning schemes as well as existing regional arrangements for reporting Serious Adverse Incidents. .

Initial procedure for informing the YPAST

Service providers should notify YPAST of a learning event as soon as it has been identified. In some cases it may only become apparent that an incident has happened following a number of repeat incidences, e.g. participants calling to say they did not receive an invitation to attend for a smear. Judgment should be used as to when you think it is an incident.

Initially the Service Manager/Lead clinician (or nominated representative) should immediately inform, by telephone, either Amy McAtamney or Ken McInnes at YPAST of any event which adversely impacts on the provision of the cervical screening service. A full list of contact details for YPAST staff is contained in Appendix 1.

The service provider must then complete the YPAST Learning Event Reporting form, Appendix 2, and submit to YPAST within 5 days (screening.cervical@hscni.net). This provides detail on the incident and action taken to date.

Quarterly Reporting

In addition to events and incidents being reported to YPAST as they occur, all service providers must submit a Quarterly Learning Event Reporting Form, Appendix 3. This is for recording purposes and will provide assurance to the PHA that no incidents have occurred. Responsibility for submitting the quarterly report will sit with the Hospital Based Programme Co-ordinator for cervical screening, but should be undertaken in liaison with local colposcopy leads.

What constitutes a learning event?

Suggestions include:

- Failure to invite or recall women for routine screening, early recall or follow up surveillance
- Inadequate failsafe arrangements
- Failure to follow programme guidance (eg minimum training standards)
- Quality control procedures not followed
- Inadequate sample taking
- Inadequate specimen reading
- Inadequate/inappropriate assessment or treatment
- Referral to colposcopy not actioned or inappropriately delayed
- Screening sample/biopsy specimen mix up or loss
- Incorrect results or no results issued (eg owing to communication failures between different organisations involved in the screening process, errors in recording results)
- Patient identities mixed up
- Equipment or IT systems failure
- Breaches of confidentiality (eg loss of screening samples, patient letters mixed up)
- Shortage of staff or resources impacting on service provision
- On-going individual sample taker underperformance
- On-going individual screener underperformance

This list is not exhaustive. The NHS INTERIM Guidelines for managing incidents in the NHS Cervical Screening Programme outlines further examples of the type of events and incidents that can occur.

It must be noted that many problems identified by screening services are isolated events and not systemic throughout the programme posing a serious risk to the eligible population. However, the YPAST should be informed of “near misses” and other minor incidents whatever the perceived importance at the time.

Management of learning events

The process for managing learning events in the CSP is outlined in Appendix 4. This process will be applied in parallel to local protocol for managing incidents. The YPAST and Service Manager/Lead clinician will discuss the likely impact of the reported event. An assessment of the situation will be made with agreed actions between the CSP QA Director, Dr Tracy Owen, and the service provider. If the incident is deemed sufficiently serious, the QA Director will advise as appropriate the Chief Executive of the host organisation, the Director of Public Health, PHA, the Assistant Director of Service Development and Screening, PHA, the Director of Integrated Care, HSCB and the Director of Commissioning, HSCB that an incident should be declared.

The role of YPAST is to work with the provider organisation to investigate and resolve the problem and deal with any consequences. Learning events will be reviewed by the CSP QA Committee and relevant QA Subgroups.

Appendix 1

Northern Ireland YPAST Contacts

QA Reference Centre

Name	Title	Telephone No.	Email
Dr Tracy Owen	QA Director	028 9536 3468	Tracy.owen@hscni.net
Jeni Rosborough	Cancer Screening Programmes Manager	028 9536 1085	Jeni.Rosborough@hscni.net
Amy McAtamney	Cancer Screening Programme Manager (Cervical)	028 9536 1657	Amy.McAtamney@hscni.net
Ken McInnes	Cervical Screening Information Officer	028 9536 1508	Kenneth.McInnes@hscni.net
Gemma Reid	Meetings Administrator	028 9536 1652	gemma.reid@hscni.net

APPENDIX 2

Learning event reporting form – for screening service providers reporting to YPAST, PHA

Organisation	Service concerned	Staff reporting incident to YPAST (and designation)	Date and person reported to in YPAST	Date of incident
	Cervical Screening Programme			
Description of problem				
Action undertaken to date				
Other people/organisations informed				
Further actions planned				

YPAST comments/actions
Escalated to SAI?

APPENDIX 3

NORTHERN IRELAND CERVICAL SCREENING PROGRAMME

QUARTERLY LEARNING EVENT/UNTOWARD EVENT REPORT

To be returned to screening.cervical@hscni.net

Service: ..... **Reported by: .....** **Date: ……..**

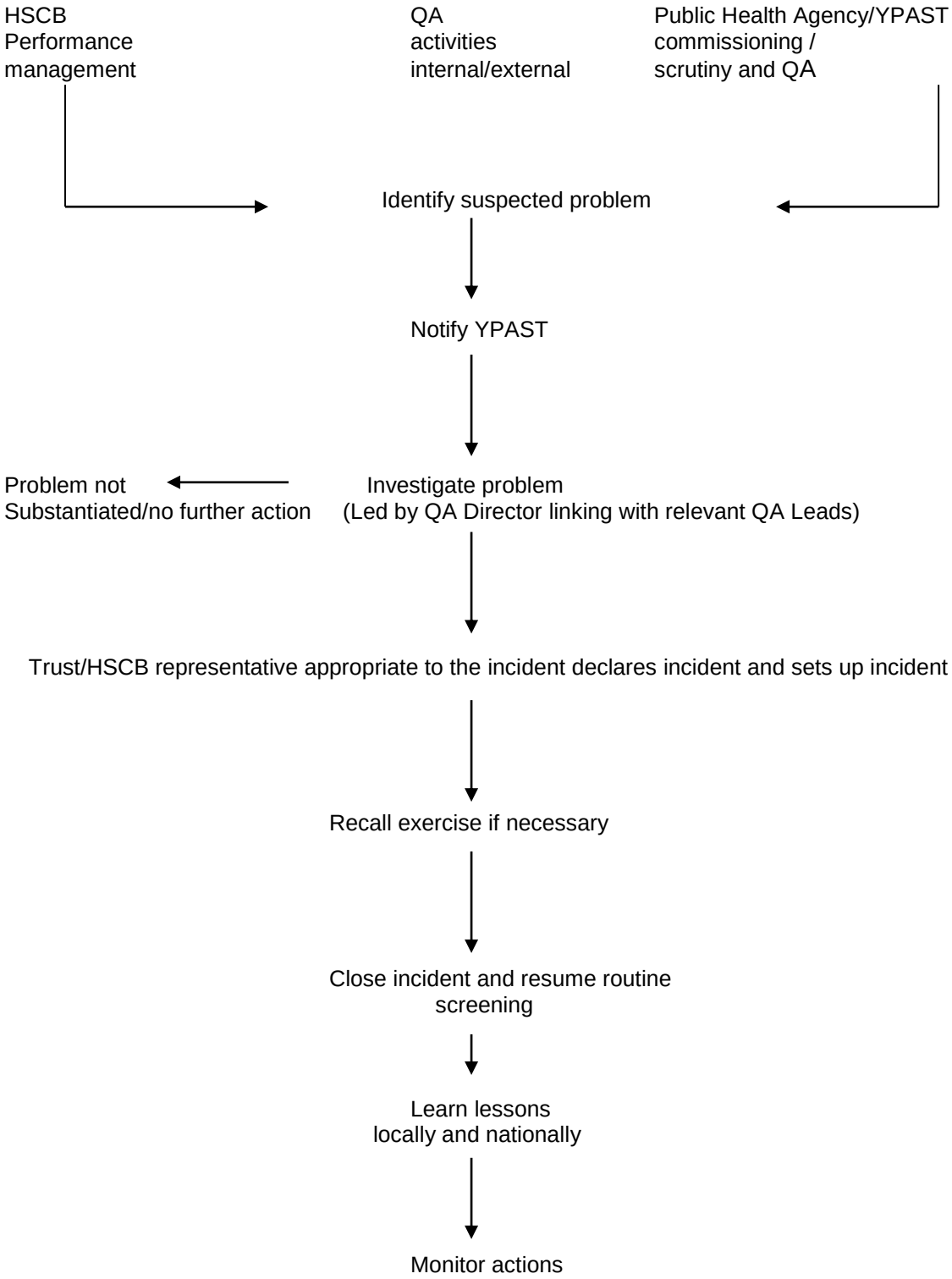
Quarter ……. **No incidents to report** ☐ **(please tick)** **No incidents to report** ☐ **(please tick)**

from colposcopy **from pathology**

Date of Event	Brief description	Involved Parties	Action Undertaken by Unit	YPAST previously advised? Y/N (with dates)	Any Further Action Required?	Shared for learning?	Could the incident occur again?

APPENDIX 4

Guidelines for Managing Learning Events in the Cervical Screening Programme



*****_This process will run in parallel with the Trust Adverse Incident Protocol and SAI process._

Northern Ireland Cervical Screening Programme

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DOCUMENT REVIEW	
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Approved by	**Tracy Owen**
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New Review Date	**December 2021**

SUMMARY OF CHANGES			
Version	**Date**	**Author(s)**	**Notes on Revisions/Modifications**
3.1	July 2020	Amy McAtamney	QA contacts updated to reflect changes in personnel and references to QARC replaced with YPAST.