

Northern Ireland Cervical Screening Programme

Learning Event Reporting Protocol

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| Version: | 4 |
| Author | YPAST Cervical Screening Team |
| Approved By: | Dr Tracy Owen, Lead QA Consultant |
| Date Approved: | 17th April 2024 |
| Review Date: | April 2027 |

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 CSP Programme Manager or Information Officer 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.

If an incident within the cervical screening pathway is identified by a Trust and being managed through the Trust SAI process, YPAST should still be notified of same and kept informed of any outcomes.

Quarterly reminder exercise

In addition to events and incidents being reported to YPAST as they occur, a member of the YPAST team will email the Learning Event reporting form on a quarterly basis as a reminder to report any events from that quarter not previously reported.

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 Consultant Lead, Dr Tracy Owen, and the service provider. If the incident is deemed sufficiently serious, the Consultant Lead will advise as appropriate the Chief Executive of the host organisation, the Director of Public Health, PHA, the Deputy Director of Service Development and Screening, PHA, the Director of Integrated Care, SPPG and the Director of Commissioning, SPGG 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

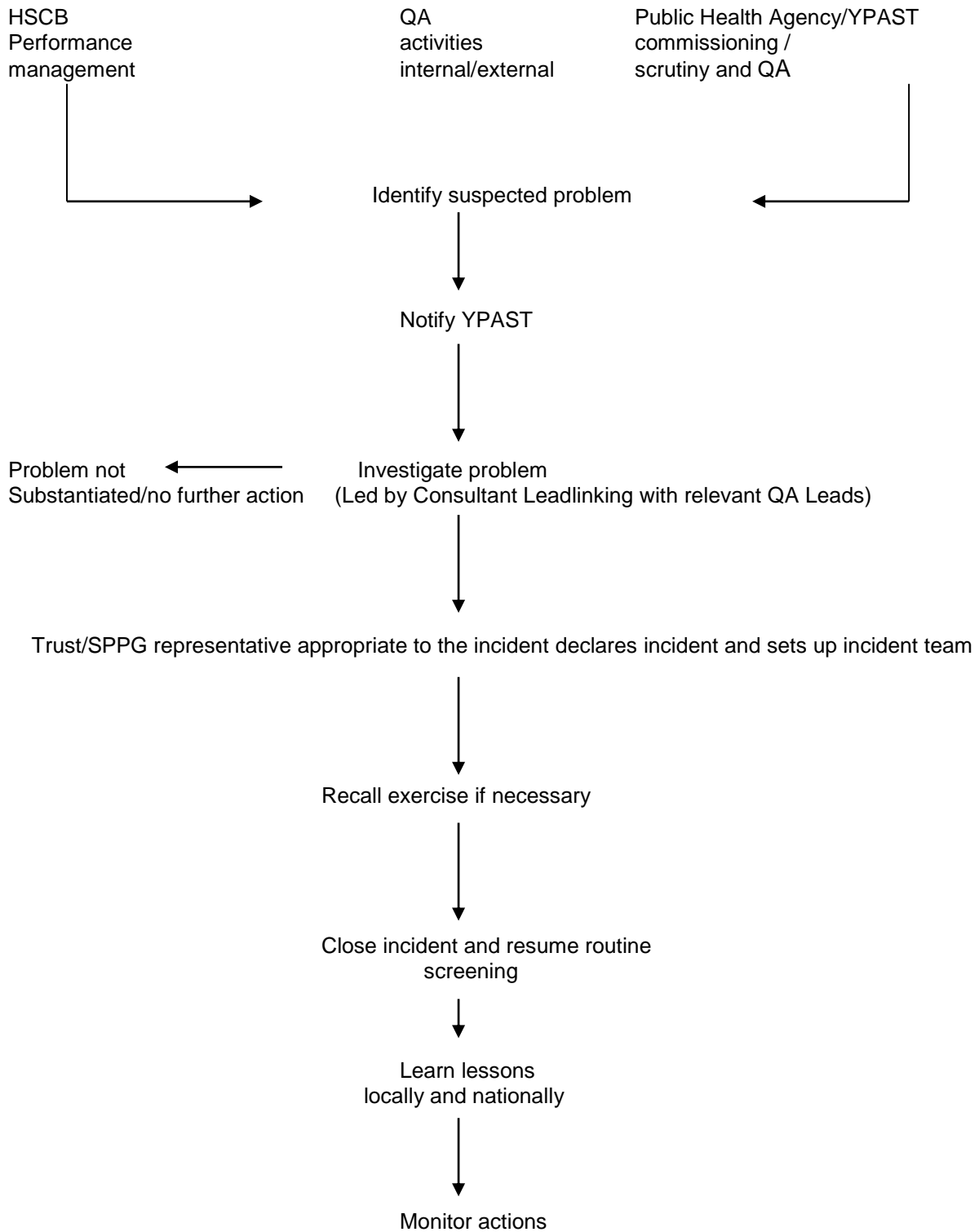
| Name | Title | Telephone No. | Email |
|-----------------|---|----------------------|--|
| Dr Tracy Owen | Consultant Lead/Deputy Director | 028 9536 3468 | Tracy.owen@hscni.net |
| Jeni Rosborough | Cancer Screening Programmes Manager | 028 9536 1085 | Jeni.Rosborough@hscni.net |
| Kelly Bailie | Cancer Screening Programme Manager (Cervical) | 028 9536 0559 | Kelly.bailie@hscni.net |
| Ken McInnes | Cervical Screening Information Officer | 028 9536 1508 | Kenneth.McInnes@hscni.net |
| Amy Harvey | Cancer Screening Programmes Administrativ e Officer (Cervical) | 028 9536 1653 | amy.harvey@hscni.net |
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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 (ie: escalated to SAI/communicated with/shared learning) | | | | |
| Further actions planned to mitigate reoccurrence | | | | |

APPENDIX 3

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
Learning Event Reporting Protocol**

| DOCUMENT REVIEW | |
|------------------------|---------------|
| Version | 4 |
| Review Date | April 2024 |
| Approved by | Tracy Owen |
| Date Approved | 17 April 2024 |
| New Review Date | April 2027 |

| 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. |
| 4.0 | April 2024 | YPAST Cervical Screening Team | YPAST personnel updated to reflect changes in YPAST and job titles amended. Learning event form updated and quarterly process changed. |
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