



An tSeirbhís Náisiúnta Scaghástála  
National Screening Service

**Implementation of the Colposcopy Staff  
Experience of the 2018 Cervical Cancer Audit  
Open Disclosure Process report  
A review by the National Screening Service**



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## Background and context

In 2021/22, the National Screening Service (NSS) consulted with members of 221+ to listen and learn from their experience of receiving interval cancer audit results in 2018. The findings were documented in our [Consultation with 221+ Members Research Report 2022](#).

In July 2022, NSS continued this listening exercise with colposcopy staff. We established a working group to develop a consultation and research process that would enable us to learn from staff's experience of sharing the audit results in 2018.

The purpose of this project was to understand and document the impact of the audit and disclosure processes on staff, and to determine how learning from their experience could improve this process for patients and staff in the future.

The research identified the need to rebuild trust between colposcopy staff and hospital management, CervicalCheck management, and HSE senior management teams. The need to continue to build trust between the population and the HSE's CervicalCheck programme was also identified.

The consultation provided 5 recommendations for our healthcare system. Below we have outlined the recommendations and the National Screening Service's actions to date.

## Recommendations and actions

### Recommendation 1: Communication and education plan on screening

Develop, implement and monitor a communication and education plan that explains the benefits, the limitations, and the complexities of screening to all stakeholders including the media and politicians.

#### Action: National Screening Service Communications strategy

We have developed a communications approach for the National Screening Service as part of our corporate strategy, Choose Screening 2023-27. Our vision is to provide compassionate, accessible and evidence-based communications that empower people to make informed health decisions. We are working to promote equity, improve knowledge and understanding, and continued trust and confidence in our national screening services across all stakeholders.

We are delivering on our strategic communications objectives as follows:

- **Promoting informed choice through health-positive messaging:** Our communications campaigns and stakeholder communications champion proactive, prevention-focused messages that educate and inform people's knowledge of screening to enable informed choice.
- **Strengthening person-centred engagement:** We are embedding the voices of our patients and the public at every stage of message design, delivery and review. We are

working to ensure our communications reflect lived experiences, diverse needs and cultural contexts, and are targeted in areas of need.

- **Maintaining confidence:** We employ open, honest and transparent communication practices, through our press and PR, public affairs and corporate website communications. We share data, report on progress and changes, and convey the diversity of experiences across NSS services. Through our public affairs communication we attend regional health fora and issue updates, education packs and information on the role of screening to TDs to a yearly schedule.
- **Advancing equity and accessibility:** We tailor our communications to reduce barriers and meet the needs of underserved communities, using plain language, multilingual formats, and culturally relevant content.
- **Supporting organisational confidence and collaboration:** We foster internal alignment through our communications toolkit with the NSS tone of voice, principles, and tools. Empower staff with the communications toolkit and opportunities for co-creation.

Through our CervicalCheck Education Strategy we are supporting the education and development of GPs and practice nurse sample takers and staff who are involved in providing our quality-assured cervical screening service. We have worked with the National Women and Infants Hospital Programme to produce guidance for GPs on the management of women with symptoms.

Through our Community Champions education programme we deliver a training programme and provide resources about screening to community health workers to help them support people to take part in screening. Community champions play a vital role in improving equity in screening.

### **Recommendation 2: Cultural change plan**

Develop, implement, and monitor a “Just Culture” for the NSS and wider HSE in response to adverse events and incidents in healthcare. This should accompany implementation of the Patient Safety Act.

**Action 2:** Communicate our learnings from the communication of the first CervicalCheck audit in 2018 to amplify a Just Culture approach within NSS and across the HSE, and establish an NSS project on Just Culture under the leadership of our Quality, Safety and Risk department in 2026.

We are communicating our learnings in designing and implementing personal cervical screening reviews for women who develop cancer after screening. We have presented our colposcopy staff research on communicating review information at webinars, clinical conferences and workshops across the HSE and wider medical community. We are communicating how to foster the key behaviours that influence Just Culture - leadership, open communication, clarity on roles and responsibilities, and maintaining confidence and trust when reviewing a person’s care.

We provide information and resources to staff to support Just Culture in the workplace, through

our incident management, open disclosure training and personal cervical screening review staff training. We have shared our research with the wider HSE to amplify our emphasis on promoting learning over blame, openness over silence, and support over fear in times of crisis, so that patient safety continues to improve and patients and staff are better supported. In 2026, we will continue to strengthen Just Culture within NSS.

We worked within the HSE *Patient Safety Act 2023 Part 5 Implementation Work Stream*, which included patients and public advocates, to ensure our review processes are in line with the requirements of the Patient Safety Act 2023.

### **Recommendation 3: Crisis management plan**

Develop a crisis management plan which guides the NSS/HSE response to future adverse outcomes in collaboration with key stakeholders.

**Action 3:** Build on our collaboration with the WHO on its report, *Best Practices in Cervical Screening Programmes* and incorporate the HSE's Crisis Communications Plan and Open Disclosure policies to create an NSS incident response toolkit that would include:

- A space to discuss potential healthcare service incidents before they happen.
- Guidelines for planning a response to communications of adverse outcomes that is cognisant of patient harm, and involves front-line, patient-facing staff as key stakeholders in planning a response.
- A mechanism for staff and patient supports after adverse outcomes.
- Defining and documenting governance structures and processes, defining roles and responsibilities and ensuring a strong crisis communications plan is in place.
- Clear and informative internal and external communications with a focus on key stakeholder communications to avoid unnecessary media or political crisis.
- Clear communication of crisis management plan to all staff, and regular revision and training in implementation.

### **Recommendation 4: Develop a structure & communications plan for interval cancer reviews**

Develop, implement and monitor an approach to discussion of interval cervical cancer audit results that is uniform, structured and clear.

**Action 4: Personal cervical screening reviews.** In March 2023 we began offering personal cervical screening reviews to women who developed cancer after screening. These reviews are available on request for women who have been diagnosed with cervical cancer and had a CervicalCheck screening test within the 10 years prior to their diagnosis. We developed our review framework with input from women who had had a CervicalCheck screening test and subsequently received a cervical cancer diagnosis. Its implementation was overseen by a multidisciplinary committee which included patient-panel representatives, clinical experts and communications staff.

The aim of the review process is to offer women (or their families) support and answers about how and when their cancer developed, using a restorative and person-centred approach. Each review takes c.18 months. During the process, participants receive a dedicated contact person, may access independent advocacy support, have their screening materials and slides reviewed by external experts, meet with the review team, and receive the final report.

We executed a communications plan to inform stakeholders about the availability of reviews. This includes providing information with every participant invite and result letter, and published information being made available at hse.ie, in our CervicalCheck charter and through our media and stakeholder updates. We provided information on reviews to the gynae-oncology and colposcopy clinical leads who provide diagnosis and treatment to women who develop cervical cancer, for dissemination amongst their relevant clinics. We briefed advocacy groups with the information to enable them to signpost the reviews to women who contact them with questions. We created an information module for our sample taker training programme to raise awareness of the availability of reviews, amongst GPs and practice nurses. We continue to communicate about personal cervical screening reviews as appropriate through press and media, and our stakeholder and training network.

**Recommendation 5: Develop a plan to help all HSE staff communicate transparently and in a trauma-informed way after an adverse outcome.**

The HSE plan should acknowledge that patients experience adverse events as trauma. It should ensure that HSE policies regarding harm in healthcare include communication strategies, and explore how to share with wider HSE staff the experience of colposcopy staff involved in the 2018 disclosure meetings. The plan should provide education and guidance for staff on how to maintain their psychological safety when communicating with patients who have experienced an adverse healthcare outcome. It is important also to consider the impact that fear of litigation has on staff interactions with patients and review the legal framework within which cancer screening operates in Ireland.

**Action 5:** Publication and dissemination amongst stakeholders of **Consultation with 221+ Members Research Report**; Colposcopy Staff Experience of the 2018 Cervical Cancer Audit Open Disclosure Process report; and **Legal Framework Group report on Interval Cancers 2023**.

The 221+ report describes the experience of some of the women who were affected by the cervical-screening audit, with the aim of learning from these experiences and improving future processes. Independent research charity, Quality Matters, conducted interviews and a survey of 221+ members to document these experiences, and map the “patient journey” from screening through to post-disclosure.

The report’s patient-centred recommendations include: The process needs to be transparent: women should get clear, honest information so they understand what’s happening. Communications with patients should be done with empathy, personal contact and care. The system for informing patients should be structured and consistent, so that each step is clear and

patients are supported throughout. Patients should be offered real choices, including about how and when results/review information is conveyed, and provided with follow up information and emotional support. The report informed the development of our personal cervical screening reviews for women who have screening and go on to develop cervical cancer. We have presented the report's findings at national and international healthcare conferences.

The Legal Framework Group Report on Interval Cancers 2023 describes how defensive litigation culture can undermine trauma-informed, person-centred engagement with patients and families at precisely the time when clear, empathetic, trauma-informed communication is needed. The report and its supporting papers examine the legal and ethical framework underpinning Ireland's national population-based cancer screening programmes, with a specific focus on cancers diagnosed despite participation in screening tests. The report examines how the Irish medico-legal environment (with rising litigation and awards) is placing strain on patients, screening programmes, clinical workforce and public trust.

The report recommendations are focused on clarifying terminology, improving communication, safeguarding participants' rights, and reducing adversarial processes. The report also recommends: full discussion of both benefits and harms of screening to participants; standardising audit and review terminology to avoid confusion; enhancing governance and data retention for screening pathways; providing patient-requested reviews for people who develop interval cancers; and reforming pre-action and case-management protocols in negligence claims to reduce cost, delay and harm. A wider public engagement was recommended to engage debate on all aspects of population cancer screening – its benefits, limitations, legal expectations and ethical dimensions, including how interval cancers are understood and addressed.

The report was shared with the Government's 2024 Interdepartmental Working Group on the Rising Cost of Health-Related Claims and is being implemented as part of its recommendations.

Open disclosure is embedded in our work with NSS staff members of the HSE National Open Disclosure Steering Committee. We continue to strengthen corporate oversight, strategic leadership and accountability with the ongoing implementation of the National Open Disclosure framework and HSE Open Disclosure policy through mandatory staff training, staff support and workshops with a focus on screening. In addition, we promote communicating transparently with activities throughout annual Open disclosure awareness week and sharing our knowledge and experience with wider HSE through the OD webinar framework.

The Colposcopy Staff Experience of the 2018 Cervical Cancer Audit Open Disclosure Process report 2023 has been published and we have shared the findings at Patient Safety events nationally and internationally to enhance system wide learning for the future. We will continue to implement and share the report's findings, as described in this implementation report.