Quality Assurance Policy Framework:
Quality Manual for Population Screening Programmes

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1. Purpose and Background

Quality Assurance (QA) is an integral and essential component of any population screening programme. The National Screening Service (NSS) is committed to ensuring a high-quality service is delivered to all those individuals, who avail of the four national population-based screening programmes:

- BreastCheck – The National Breast Screening Programme.
- BowelScreen – The National Bowel Screening Programme.
- CervicalCheck – The National Cervical Screening Programme.
- Diabetic RetinaScreen – The National Diabetic Retinal Screening Programme.

Each programme has their own individual Standards for Quality Assurance as shown in *section 3 legislation/other related policies and documents*. The programme specific Standards for Quality Assurance set best practice standards, monitor the programme, facilitate continuous improvement and promote practice that is up to date, evidence based, effective and consistent. The Standards for Quality Assurance consist of a set of specific, concise statements and related measures of quality that are derived from evidence-based guidance, international scientific research, expert scientific and clinical advisory panels for each programme. The NSS QA framework, structures and processes in place are designed to support and facilitate the programme specific Standards for Quality Assurance. To ensure that these standards are met each programme monitors themselves against these standards to assist in identifying strengths and highlighting areas that may need improvement, while also aiming to demonstrate what safe, high-quality care should look like and what to expect from the service.

This document known as "*the Quality Manual"* is one of a suite of documents under the NSS/S&F-1 QA Policy Framework that support how QA is implemented, monitored and managed across the four programmes.

The Quality Manual sets out the generic HSE/NSS QA structures and processes, which supports the delivery of quality assured population screening programmes and should be read in conjunction with the programme specific Standards for Quality Assurance.

2. Scope

The Quality Manual applies to all NSS population screening programmes and all staff working in the organisation, management, support and delivery of NSS population screening programmes. To support the screening programmes the NSS has different functions/department. The NSS is taken to mean all NSS staff including screening programmes and functions.

3. Legislation/other related policies and documents

3.1 NSS QA Guidelines

- CS/PUB/Q-6 Standards for Quality Assurance in Cervical Screening Quality assurance in programme operation
- CS/PUB/Q-7 Standards for Quality Assurance in Cervical Screening Quality Assurance in Primary Care and Other Cervical Screening Settings
- CS/PUB/Q-8 Standards for Quality Assurance in Cervical Screening Quality Assurance in Laboratories Providing HPV Testing, Cytology and Histopathology Services
- CS/PUB/Q-10 Standards for Quality Assurance in Cervical Screening Standards for Quality Assurance in Colposcopy
- DR/PUB/Q-1 Standards for Quality Assurance in Diabetic Retinopathy Screening
- DR/PUB/T-1 Rev02 DRS Clinical Practice Guidelines for Treatment Clinics
- NCSS/PUB/ Q-4 Guidelines for Quality Assurance in Mammography Screening
- NCSS/PUB/Q-3 National Colorectal Screening Programme International Peer Review Panel Report of Quality Assurance Standards
- NCSS/PUB/Q-2 Rev03 Standards for Quality Assurance in Colorectal Screening

3.2 Other NSS documents

- NSS/S&F-1 Quality Assurance Policy Framework for NSS
- NSS/S&F-6 QA Policy Framework: Standard Setting & Revision Procedure
- NSS/S&F-7 QA Policy Framework: Governance *(under development)*
- NSS/S&F-8 QA Policy Framework: Standardised Language Procedure, *(under development)*
- NSS/S&F - 2 National Screening Service Strategic Plan 2023-2027 - Choose Screening Together we can make a difference.
- NSS Patient and Public Partnership Strategy 2019 -2023
- NSS Improving Equity in Screening – A Strategic Framework 2023-2027
- NSS Stakeholder Engagement Framework
- NSS/SOP/FIN-1 Procedure Guide for Issuance and Closure of Purchase Orders
- NSS/SOP/QSR-2 Incident and Near Miss Identification, Documentation, Rectification, Review and Communication Policy and Procedure
- NSS/SOP/QSR-3 Serious Reportable Event and Serious Incident Identification, Documentation, Rectification, Review and Communication Policy and Procedure
- NSS /SOP/QSR-4 Complaints and Feedback Management Policy and Procedure
- NSS/SOP/QSR-6 Clinical Audit Scheduling and Management
- NSS/SOP/QSR-7 External Audits, Scheduling and Management in the National Screening Service, Policy and Procedure
- NSS/SOP/QSR-8 Internal Quality Audit Scheduling and Management
- NSS/SOP/QSR-9 Quality Improvement Plans Creation and Management

3.3 HSE Policies/ Procedures/ Guidance/ Frameworks relating to Quality

- How to Develop HSE National Policies, Procedures, Protocols and Guidelines - A Practical Guide 2023
- HSE Incident Management Framework 2020
- The Management of Service User Feedback for Comments, Compliments and Complaints HSE Policy 2017
- HSE Enterprise Risk Management Policy and Procedures 2023
- HSE Open Disclosure Policy Communicating with Patients Following Patient Safety Incidents, 2019
- HSE NCCA Clinical Audit Practical Guide 2023

3.4 National and International Legislation/ Regulations/ Guideline Documents

- Cancer screening, diagnosis and care | European Commission Initiative on Breast and Colorectal cancer (europa.eu)
- European Commission Initiative on Breast Cancer | Cancer Screening, Diagnosis and Care (europa.eu)
- European Commission Initiative on Colorectal Cancer | Cancer Screening, Diagnosis and Care (europa.eu)
- European Guidelines for Quality Assurance in colorectal cancer screening and diagnosis, First edition 2010.
- European Guidelines for Quality Assurance in Cervical Cancer Screening. 2nd edition. European Commission. 2008 and European Guidelines for Quality Assurance in Cervical Cancer Screening – Supplements to the 2nd edition. European Commission. 2015
- The Royal College of Pathologists and the Institute of Biomedical Science. The retention and storage of pathological records and specimens (5th edition).
- SNOMED - CT. Systemised Nomenclature of Medicine – Clinical Terms. SNOMED International. http://www.snomed.org/snomed-ct/software-tools
- Dataset for histological reporting of cervical neoplasia (version no 4) March 2021. Royal College of Pathologists document G071
- NHS Cervical Screening Programme: laboratory quality control and assurance for human papillomavirus testing. Updated 25th July, 2019.
- NHS Cervical Screening Programme: laboratory HPV testing and cytology services. Recording and reporting requirements for laboratories in accordance with the primary high risk human papillomavirus (hrHPV) screening pathway. Published 20th September 2019.
- Gov UK publications Cervical Screening Programme and Colposcopy Management providing a Quality Colposcopy Clinic
- Data Protection Act 2018
- General Data Protection Regulation (GDPR)
- Amendment of section 1 of Health (Provision of Information) Act 1997 contained within Data Protection Act 2018. http://www.irishstatutebook.ie/eli/2018/act/7/enacted/en/pdf

- Relevant national and European legislation regarding the use and security of personal information includes: Data Protection Act 1988, Data Protection (Amendment) Act 2003, EU Directive 95/46/EC http://www.irishstatutebook.ie/eli/2003/act/6/enacted/en/pdf
- The Data Protection Directive 1995, EU Directive 2002/58/EC - Directive on privacy and electronic communications, General Data Protection Regulation (GDPR) (effective from 25 May 2018).
- Health Act 2004
- Health Act 2004 (Complaints) Regulations 2006
- HIQA Information Management Standards for National Data Collections, 2017
- HIQA Guidance on a data quality framework for health and social care, 2018
- National Open Disclosure Framework, 2023
- Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023

4. Glossary of Terms, Definitions and Abbreviations

4.1 Glossary of Terms and Definitions

Clinical Audit
A clinically led quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and acting to improve care when standards are not met. The process involves the selection of aspects of the structure, processes and outcomes of care which are then systematically evaluated against explicit criteria. If required, improvements should be implemented at an individual, team, or organisation level and then the care re-evaluated to confirm improvement".
(Report of the Commission on Patient Safety and Quality Assurance. Building a Culture of Patient Safety (2008) [1].

Programmes Evaluation
Evaluation has been defined as 'The systematic collection of information about the activities, characteristics, and outcomes of programmes to make judgments about the programme, improve programme effectiveness, and/or inform decisions about future programme development'. (Center for Disease Control and Prevention, 2011) [2].

Monitoring
"*Monitoring is the process of regularly measuring the outcomes of a screening programme at the national or regional level to ensure that it is meeting its aims. Monitoring should occur regularly, such as annually, and measure outcomes that are derived from the aims of the programme*" (Screening programmes: a short guide Increase effectiveness, maximize benefits and minimize harm (WHO, 2020)[3].

4.2 Abbreviations

CE	Chief Executive
CPD	Continuing Professional Development
EMT	Executive Management Team
EUREF	European Reference Organisation for Quality Assured Breast Screening and Diagnostic Services
GDPR	General Data Protection Regulation
GP	General Practitioner
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
KPI	Key Performance Indicator
MOU	Memorandum of Understanding
NCCA	National Centre for Clinical Audit
NFR	National Financial Regulations
NSAC	National Screening Advisory Committee
NSS	National Screening Service
PPPGs	Policies, Procedures, Protocols and Guidelines
PREMs	Patient Reported Experience Measurements
PROMs	Patients Reported Outcome Measures
QA	Quality Assurance
QIP	Quality Improvement Plan
QMS	Quality Management System
QSRM	Quality, Safety & Risk Management
SLA	Service Level Agreements
WHO	World Health Organisation

5. Procedure

5.1 Commissioning and Contracting

- NSS must follow the *HSE National Financial Regulations (NFR) 1 Purchase to Pay* when purchasing on behalf of respective NSS department.
    - Refer to NSS/SOP/FIN-1 Procedure Guide for Issuance and Closure of Purchase Orders.
- The objectives of procurement are to support service delivery across the health sector; maintain effective governance and compliance with procurement Directives, Legislation, Circulars and other legal requirements; achieve greater value for money to support reinvestment into patient care and service delivery; and facilitate environmental, societal and economic objectives through procurement.

5.2 Communication and Engagement

- The individual screening programmes are to make publicly available their commitments to their participants through the publication of a programme Participant/Patient Charter. The Programme Participant/Patient Charter should;
    - include information regarding screening commitments, ways participants can help through feedback and letting programmes know when details have changed.
    - be reviewed, at a minimum, in line with the review of the Programmes QA

standards and as required.

- The NSS will partner with participants in the design and review of its correspondence and materials.
- The NSS will work with patients and the public across our services to share decision-making power with patients and the public, understand their needs better, engage regarding changes as outlined in NSS Patient and Public Partnership Strategy 2019 -2023.
- The programmes should develop and provide information in appropriate formats to enable the public to make more informed choices in relation to their participation in the programme. Public information materials are to be reviewed on a periodic basis to reflect policy changes and user needs. Reviews will consider materials for appropriateness, accuracy and clarity of content, equity, means of dissemination and new information to be incorporated.
- Channels for the provision of information may include advertisements, promotional materials, information leaflets, digital and social media, and by direct contact (telephone, email, post).
- Information leaflets should accompany invitation (call) letters and letters following results to inform participants about the screening programme and the recommended follow-up steps to be taken. The correct information leaflet should accompany invitation (call) letters and letters following results.
- The programme should provide the means for participants to register, check if they are registered, update their registration details, and check when their next programme test is due through appropriate means, including telephone, email, post and website.
- The NSS will make publicly available their commitment to engaging with stakeholders in the development of its information resources to improve the quality and effectiveness of the information we provide for the public, healthcare professionals and all other stakeholders.
- The NSS will commit to engaging with all our stakeholders through the methods outlined in the NSS Stakeholder Engagement Framework.
- The NSS will publish news and information about our services on our programme websites and on our corporate website on hse.ie. This information will be evaluated on a three-yearly schedule.

5.3 Feedback

- The NSS will:
  - comply with Section 9 of the Health Act 2004 and the associated Regulations 2006 in relation to the roles and responsibilities for managing complaints;
  - comply with the HSE's Your Service Your Say policy and NSS /SOP/QSR-4 Complaints and Feedback Management Policy and Procedure for managing participant feedback including complaints, compliments, comments, and suggestions;
  - comply, where appropriate, with the Ombudsman's Learning to Get Better standards for managing complaints and feedback across the

organisation;
  - comply with the NSS /SOP/QSR-4 Complaints and feedback Management Policy and Procedure to ensure compliance with statutory and national policy obligations;
  - have designated Complaints Officers and Internal Review Officers to investigate and respond to feedback in line with HSE's Your Service Your Say Policy record, track, and monitor feedback on the Quality Management Information System (Q-Pulse and the National Complaints Management System, as applicable), to include data in relation to national mandatory KPIs which are reported to the HSE on a quarterly basis;
  - have effective governance arrangements in place to:
    - ensure that the management arrangements and the roles of all staff in managing feedback are clearly defined;
    - support the timely and effective management of feedback in line with local and national policy and guidelines;
    - commit to and promote a culture of openness, trust, and learning from complaints and feedback;
    - monitor the implementation and evaluate the effectiveness of recommendations made through complaints and feedback.
  - provide suitable channels for participants, and those seeking its services, to provide feedback regarding all aspects of their experience or engagement;
  - contribute feedback casebooks on request from the Complaints & Compliance function for submission to national HSE shared learning forum and the Ombudsman's Quarterly Report.
- Feedback channels should include in person, by telephone, by email, by letter, and via the NSS website.

5.4 Equity

- The programmes should deliver population outcomes equitably across the eligible population in line with equity strategic framework. Inequity can occur at all steps in the pathway.
- The programmes must take steps to ensure all eligible people are invited to attend screening. This includes the requirement to:
  - consider provision for people who may not be included in the Register e.g. people without an address or Personal Public Service (PPS) Number;
  - provide information in accessible formats e.g., EasyRead, plain English, readable documents, large print, etc;
  - have an appointed "access officer" for each programme;
  - ensure provision for people with additional support needs e.g., disability access;
  - use technology as appropriate such as text message reminders and pre-booked appointments;

- Deliver health promotion activities to support equitable uptake and coverage.

5.5 Incident Management

- The NSS will;
    - comply with the HSE Incident Management Framework for identifying incidents, recording incidents, escalating and managing incidents across the whole screening pathway.
    - implement the NSS/SOP/QSR-2 *Incident and Near Miss Identification, Documentation, Rectification, Review and Communication Policy and Procedure* and the NSS/SOP/QSR-3 *Serious Reportable Event and Serious Incident Identification, Documentation, Rectification, Review and Communication Policy and Procedure.*
    - report all incidents via the Quality Management Information System (Q-Pulse) and the National Incident Management System and regulatory bodies as relevant.
    - have effective governance arrangements in place to:
        - ensure that the management arrangements and the roles of all staff in incident management are clearly defined for who is
            - *responsible* for management of incident
            - to whom they are *accountable* to
            - who will be *consulted*
            - who need to be *informed* .
        - support the timely and effective management of incident.
        - commit to and promote a culture of openness, trust, and learning between persons who may be affected by incidents and those delivering and managing the services within which the incident occurs.
        - monitor the implementation and evaluate the effectiveness of actions identified as a consequence of the review of the incident.
        - ensure the mechanisms are in place to implement recommendations and share learning from incident reviews to improve the quality and safety of services.
    - comply with the requirements of the HSE Open Disclosure Policy.
- Incidents, at a minimum, are reviewed quarterly at the relevant Programmes senior management meetings.

5.6 Information Governance

5.6.1 Information Management

- NSS will ensure that they document the data and information they process, and where processing personal data will document this in a Record of Processing Activities that complies with the requirements of Article 30 of the GDPR.
- Systems shall be in place for regular back-ups and secure storage of the personal health information and related data held by the programme.
- NSS will comply with

- Guidance on information governance for health and social care services in Ireland (2012)
- HIQA Information Management Standards for National Data Collections (2017)
- HIQA Guidance on a data quality framework for health and social care, 2018.

5.6.2 Information Governance

- All programmes/functions will identify a liaison person (Data Champion) to engage with the Information Governance programme.
- All staff will complete mandatory training in data protection and information governance.

5.6.3 Data Protection

- All use of personal data within the programme will comply with relevant national and European legislation.
- The NSS will document the technical and organisational measures engaged to safeguard personal data in use by the programme.
- A data processing agreement will be executed wherever a programme engages a data processor, prior to the commencement of processing.
- Personal data will only be shared with third parties where there is a duly executed data sharing agreement in place prior to the commencement of processing.
- Where a programme jointly, along with another data controller, determines the purpose and means of data processing, it will ensure there is a joint controllership agreement in place.
- The NSS will ensure the completion of a Data Protection Impact Assessment for processing activities that require one and will review them whenever there is a change in the nature, scope or scale of the processing activity.
- Personal data will only be transferred or processed in a jurisdiction outside of the European Economic Area where there is a valid transfer mechanism in accordance with Article 46 of the GDPR.
- Programmes will ensure the legal basis of their processing activities are recorded.
- NSS will maintain a Record of Processing Activities.
- All personal data incidents and breaches identified by the programme will be notified to the Information Governance Office within 24 hours.
- NSS will have processes in place to manage subject rights requests.

5.7 Quality Assurance Methodology

A number of activities are undertaken by the NSS to assure themselves of the quality of their Screening programmes. The NSS are committed to participation in formal processes of quality assurance which promotes a quality improvement model to ensure a structured approach.

Each of the screening programmes have a QA committee who report to the NSS Quality, Safety and Risk Management (QSRM) Committee, who in turn, provides assurance to the NSS Chief Executive (CE) that the risks relating to the NSS are being effectively managed. Refer to NSS/S&F-7 QA Policy Framework: Quality Assurance Governance Procedure (under development).

The NSS utilise the following methods:

5.7.1 Accreditation and Licensing

- Required accreditation and licensing, by recognised and approved bodies, will be sought and maintained in line with each programme's specific QA Standards where applicable to programme and or service providers.
- Appropriate professional registration with the relevant professional body must be maintained in line with programme's specific QA Standards, including the required continuing professional development (CPD).
- Where accreditation, licensing and professional registration is not maintained:
  - it is the responsibility of the service provider/person to inform the relevant programme/s in a timely fashion outlining the;
    - current status
    - reason and context regarding the current status
    - the impact on the programme and any mitigant steps required
    - proposed plan and timeline to revert to status in line with programme's specific QA Standards.
  - The relevant programme management team/s will:
    - review the information above
    - assess the impact on the programme
    - make a decision regarding same with ongoing monitoring until the issue is resolved
    - keep the relevant QA committee informed of the issue and eventual resolution.

5.7.2 Audits

- The purpose of audit is to act as an objective assurance activity designed to add value and lead to improved services.
- Audits are conducted to ensure quality in the delivery of services, to identify risks to the participants and to assess if standards are being met.
- Audits are viewed in the context of continuous quality improvement and are used in conjunction with other quality monitoring tools.
- Within the NSS there are four types of audit, as follows: internal quality audits; external quality audits; service provider / supplier audits; clinical audits. These are outlined in turn below.

5.7.2.1 Internal Quality Audits

- Internal quality audits are conducted by internal auditors of the NSS.
- NSS Auditors will receive the appropriate training.
- Internal audits are used to systematically evaluate the quality system of

programme processes against predefined standards and requirements such as those established by policies, procedures, work instructions, training. The benefits of Internal Audits include enabling:
  - preparation for external audits.
  - continuous improvement of the quality of healthcare.
  - the evaluation and improvement of the effectiveness of the quality management system.
  - the promotion of organisational learning.
- Internal Audits focus on programme processes not clinical data or outcomes.
- Each programme will have an annual schedule of audits to assess the performance of their processes against relevant documents. The scope of each audit is outlined in the annual schedule of audits.
- The NSS will implement the NSS/SOP/QSR-8 *Internal Quality Audit Scheduling and Management* to ensure all internal quality audits are approved, scheduled, managed and closed out in a standardised manner.
- Where the audit identifies quality improvement plans, these will be managed in line with the NSS/SOP/QSR-9 *Quality Improvement Plans Creation and Management.*

5.7.2.2 External Quality Audits

- External Quality Audits are audits conducted by external auditors, organisations or commissioned person/group external to NSS (for example HSE Internal Audit Division, HIQA, EUREF etc).
- External Quality Audits can be undertaken on either the NSS, individual programmes within the NSS or its service providers.
- The NSS will implement the NSS/SOP/QSR-7 *External Audits, Scheduling and Management in the National Screening Service, Policy and Procedure.*
- Where the audit identifies Quality improvement Plans, these will be managed in line with the NSS/SOP/QSR-9 *Quality Improvement Plans Creation and Management.*

5.7.2.3 Service Provider/ Supplier Audits

- Service Provider/ Supplier encompasses all services external to the NSS who are contracted to provide services.
- Service Provider/ Supplier Audits assess compliance against the programme standards or supplier contracts / Memorandum of Understanding (MOUs)/ Service Level Agreements (SLAs) etc. and can take the form of:
  - Desktop assessment
    - Is an assessment of compliance against the programmes QA standard and usually involves a review self-assessment questionnaire and the relevant documentation from the service provider / supplier.
    - Can be the precursor for a QA visit or standalone.
  - QA Visit/Service Provider Audit
    - Can be a virtual or onsite visit undertaken by a multidisciplinary Audit team which comprise of the relevant expertise.

- Review
  - Is the examination of a particular aspect of the service provided and may be undertaken following an incident or the identification of a quality concern including but not limited to risk, complaint or compliance with relevant legalisation.

- Each programme undertakes audits of service providers/ suppliers to monitor compliance with the relevant programme Quality standards, NSS Quality Policy Framework and relevant documentation (i.e., contract, SLA, MOU etc).
- Each programme will have an annual schedule of audits which is approved by the programme management team. Additional audit may be required outside of scheduled audits.
- The Programme will ensure audits are managed and closed out in a standardised manner.
- Where the audit identifies;
  - Quality improvement Plans, these will be managed in line with the NSS/SOP/QSR-9 Quality Improvement Plans Creation and Management
  - Recommendations, these will be managed in line with the scope of the audit
- An audit report will be generated by the audit team with fact checking by the service provider/supplier and opportunity for feedback.
- Audit approval is undertaken by the Audit owner/Sponsor and follow up of closing of audit plans and/ or recommendations.

5.7.2.4 Clinical Audit

- Clinical audit, as defined in section 4.1, is about a continuing evaluation and improvement process by health professionals, working towards delivery of safe, high-quality care for patients.
- The programmes will implement the NSS/SOP/QSR-6 Clinical Audit Scheduling and Management Policy and Procedure to ensure all clinical audits are approved, scheduled, managed and closed out in a standardised manner.
- Clinical Audits should be in line with the HSE National Centre for Clinical Audit (NCCA) documents especially HSE NCCA Clinical Audit Practical Guide 2023 [4].
- Any clinical audit undertaken should be given its full descriptive title to ensure clarity of purpose and consistency of understanding. There is considerable risk for misinterpretation and/or misunderstanding of ambiguous language, inconsistent definitions, and use of terminology such as ‘programmatic’. It is critical that a standardised use of language and terminology is applied and aligned with HSE National Centre for Clinical Audit Nomenclature - A Glossary of Terms for Clinical Audit.[5]
- The NSS will learn from clinical audits which are carried out in order to develop on-going quality improvement.
- All clinical audit records are available to relevant staff, involved in the management of the audit, via a centralised system.

- The Executive Management Teams have access to analysis of audit activity.
- Where the audit identifies Quality Improvement Plans, these will be managed in line with the NSS/SOP/QSR-9 Quality Improvement Plans Creation and Management.

5.7.3 Quality Improvement

- QA should ensure that systems are in place to drive continuous quality improvement.
- The Programmes undertake a formal approach to quality improvement and raise and manage all Quality Improvement Plans (QIPs) in a standardised manner in line with the NSS/SOP/QSR-9 Quality Improvement Plans Creation and Management and HSE Quality Improvement toolkit [6].
- QIPs are identified from a number of sources including internal and external quality audits, clinical audits and reviews of KPIs.
- QIPs are plans that outline each risk identified, the proposed action or actions intended to address that risk, a timeline to complete each action and an identified person who will be responsible for ensuring each task is completed.
- QIPs are approved and monitored by Programme management team.

5.7.4 Monitoring and Evaluation

- Monitoring and evaluation, as defined in section 4.1, are about measuring programme performance. This includes analysing and acting, if required, on the information provided. The information is used to determine how the programme is progressing and to allow adjustments to be made as necessary.
- Monitoring may need altering as programmes mature.
- The Programmes uses the regular collation, analysis, and interpretation of data (e.g., KPIs, Quality Improvement Plans) to monitor and evaluate QA adopted as indicators of QA impact/effectiveness.
    - KPI and programme activity is monitored monthly at programmes' specific management team meetings.
        - Refer to the Term of Reference of programmes' Management meetings.
    - For issues identified including underperforming providers/individuals, timely action is taken and followed up until closed. Documentation of same is required.

5.7.5 Quality Management System

- The NSS have a consistent and coordinated approach to managing quality through a Quality Management System (QMS) which is through;
    - Q-Pulse (QMS Software) which encompasses a suite of modules:
        - Document Management
        - Training and People modules
        - Audit
        - Monitoring Analysis and Improvement
        - Suppliers

        - Assets
        - Occurrences
            - Incident
            - Complaints
            - External feedback
            - Data Breach
    - Risk Registers
        - Refer to section 5.8 risk management.
- The Programmes have clear procedures for document management, review and approval.

5.7.6 Survey Methodologies

- The programmes use an array of surveys to get participants and staff feedback.
- For participants feedback, the NSS have access to several survey tools and methodologies licensed through NSS.
- Staff Surveys include both NSS surveys and the HSE Your Opinion Counts Staff Surveys.
- The NSS and individual programmes undertake Participant Surveys e.g. Patient Reported Experience Measurement (PREMs) where these are in place.
- Where the results of surveys identify Quality Improvement Plans, these will be managed in line with the NSS/SOP/QSR-9 Quality Improvement Plans Creation and Management.

5.7.7 Shared Learning

- The NSS have a shared learning culture and have implemented shared learning initiatives to embed the values of care, compassion, trust and learning in everyday practices and to learn from one another's experiences.
- Shared Learning is a standard agenda item on the QSR Shared Learning Forum and the NSS Corporate management team meeting.
- The NSS actively review sources for learning from positive events or events that highlight improvement such as observations from process improvements, audits, day-to-day operations and incidents which are shared on NSS/F/QSR-4 Shared Learning template to share learning.
- The NSS share access to one folder which contains the master copy of shared learning as a forum of communication.

5.8 Risk Management

- The NSS will:
    - comply with the HSE Enterprise Risk Management Policy and Procedures for identifying, recording, and managing risks across the whole screening pathway,
    - adopt a proactive approach to the management of risk and embed risk management into its normal day-to-day activities,
    - clearly outline the governance arrangements for risk management to

include roles and responsibilities for risk management and the process for notification and communication of identified risk/actions from one level of the NSS to another.

- All risks will have clear ownership and the actions identified to minimise a risk will be recorded, assigned to an action owner and have a due date for completion.
- Evidence should be available to describe the identified risks and their assessment and how risk management contributes to quality improvement actions.
- Risk Registers are reviewed quarterly at the relevant senior management meeting and escalated as appropriate.
- Risks are either open, closed or in monitor mode. New risks are added to the Risk Register on an ongoing basis when reviewed and approved by the programmes senior management team.

5.9 Strategy and Planning

5.9.1 National Screening Advisory Committee (NSAC)

- The National Screening Advisory Committee (NSAC) was established in 2019. It acts as an independent advisory committee and advises the Minister and Department of Health on all new proposals for population-based screening programmes and changes to existing programmes.
- The NSS has established a working relationship with the NSAC through the Office of the CEO and the NSS, Department of Public Health.
- Proposed changes to an existing population-based screening programme, must be discussed in advance with the NSS, Department of Public Health who will advise on the necessary processes that will need to be complied with.
- The NSAC conduct an 'Annual Call' over the Nov-Dec period inviting submissions for new programmes or changes to existing programmes.
    - If the NSAC makes a recommendation to the Minister for Health to introduce a new programme it will then fall to the Health Service Executive (HSE) and by extension the NSS to commence the business planning process that will signal the implementation of the new programme.
- Programmes should route any correspondence to or queries for the NSAC via their senior management team through NSAC_Secretariat@health.gov.ie.

5.9.2 NSS Strategy and Implementation

- The National Screening Service Strategy Choose Screening 2023-2027 sets out ambitious but achievable goals. Overall governance for implementation is with the NSS Executive Management Team (EMT). Implementation is broken down on a year-by-year basis and delivery will require the input and expertise from all programmes and functions within NSS and liaison with our external partners.
- The NSS Strategy, Business and Projects function will be the responsible body for the implementation of our strategy. This function will provide co-ordination, oversight and support to key strategic programmes. Furthermore, Strategy, Business and Projects will lead out on the tracking, monitoring, and reporting on

the implementation of the NSS strategy. Implementation progress will be reported on a regular basis to NSS EMT with a progress report developed annually.

5.9.3 Work Force Planning

The NSS is required to develop and maintain a capable and competent workforce across the entire service. The NSS Strategic Workforce Plan developed collaboratively with NSS programmes and department leads, will inform future demand for people and skills across our workforce to enable actional talent management strategies, reducing knowledge and skill gaps. All Functions and programmes ensure:

- Provision of sufficient staff to deliver the service and meet additional HR requirements such as appraisal, study leave, audit and business continuity.
- All staff employed to deliver screening services must be qualified (where required), suitably trained, competent.
- All staff employed to deliver screening services (where required), engage in continued professional development. All staff carry out sufficient procedures to retain the validity of the screening programme.
- Multi-disciplinary learning is supported to enable safe, consistent auditable decisions to be made regarding each service user's pathway which takes into the account the opinions of all involved in their care.
- Staff continuously engage with training and education to keep up to date with changes to policy and practice and to maintain and improve quality.
- Practitioners maintain live annual registration on their professional register as applicable to their post.
- Staff engage in annual Performance Achievement meetings, which includes identifying learning and development needs, with their manager.
- If staff performance falls below an acceptable quality level further training and support, which may include a Performance Improvement Plan, is provided if deemed appropriate.
- Completion of HSE mandatory training is a requirement for all NSS staff.

5.9.4 Business planning

The NSS engages in the HSE annual national service planning process whereby priority actions and service activity are planned and budgeted for a given year. This process requires consideration of:

1. Existing service delivery commitments and any associated changes, e.g. increasing population demographics, changes in referral patterns, inflationary cost increases in service delivery (e.g. consumables/postage)
2. Any new service developments to be undertaken, e.g. extension to a programme's eligible age range, or development of a new IT system.

The Strategy, Business and Projects and Finance teams collaborate with NSS heads of department to determine activity, priorities and funding for each year. Consideration is given to pay and non-pay costs, with business cases for any additional funding

considered by the NSS Chief Executive and senior team. Collaboration takes place across the HSE and with Department of Health colleagues in relation to service activity and priority plans.

Once the National Service Plan and associated budget is agreed, the Strategy, Business and Projects and Finance teams track progress throughout the year to ensure that funding is utilised as intended, in the required timelines and outcomes are reported.

6. Roles and Responsibility

Job Role (and specific Programme)	Responsibilities
All Staff in screening programmes	Adherence to this Quality Manual
Programme & Function Managers	Accountable for the implementation of this procedure
Screening Programmes Quality Assurance Committee(s)	Provide assurance to the Quality, Safety and Risk Management (QSRM) committee and NSS Executive Management Team (EMT) on extent of compliance with this procedure and any quality improvement activities identified to address gaps
NSS Executive Management Team	Ensure consistent implementation across all four NSS programmes

7. Implementation Plan

7.1 Document Development and Approval (See Appendix 1)

7.2 Communication and Dissemination

- This Policy shall be distributed to all NSS staff.
- Distribution to copyholders and acknowledgement shall be via the NSS Quality Management Information System – Q-Pulse. Copyholders shall be required to acknowledge that they have read this document.

7.3 Monitoring, Audit and Evaluation

- A rolling audit programme shall be implemented to determine compliance to this procedure ensuring that all elements are addressed in full within a three-year timeframe. This shall be carried out by the Quality Teams in the individual programmes, in conjunction with the Quality Safety and Risk department.

7.4 Budget and Resource Implication

- No additional budget or resource implication identified outside of existing resourcing of the NSS.

8. Review and Update

- A formal review will be carried out in one year and on a three-yearly basis thereafter unless there is a change informed by legislation, best practice, the Regulator or an EU Directives etc., which would identify the need to update the QA Manual sooner.
- If there are no amendments to the QA Manual following the review process, the date and detail on the version tracking box must still be updated.
- The QA Manual will be kept under review and comments and feedback are welcome to inform this process.

9. References

1. Report of the Commission on Patient Safety and Quality Assurance. Building a Culture of Patient Safety (2008).
2. U.S. Department of Health and Human Services Centers for Disease Control and Prevention. *Introduction to program evaluation for public health programs: A self-study guide*. Atlanta, GA: Centers for Disease Control and Prevention, 2011.
3. Screening programmes: a short guide. Increase effectiveness, maximize benefits and minimize harm (2020. Copenhagen: WHO Regional Office for Europe.
4. HSE NCCA Clinical Audit Practical Guide 2023.
5. HSE National Centre for Clinical Audit Nomenclature - A Glossary of Terms for Clinical Audit.
6. HSE Quality Improvement Toolkit, National Quality Toolkit 2019.

9.1 Additional Reading

- Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.
- Health Information and Quality Authority. National Standards for Safer Better Healthcare. Dublin: HIQA, 2012.
- Screening: Evidence and Practice Oxford second edition
- Amendment of section 1 of Health (Provision of Information) Act 1997 contained within Data Protection Act 2018.
- Relevant national and European legislation regarding the use and security of personal information includes: Data Protection Act 1988, Data Protection (Amendment) Act 2003, EU Directive 95/46/EC.
- The Data Protection Directive 1995, EU Directive 2002/58/EC - Directive on privacy and electronic communications, General Data Protection Regulation (GDPR) (effective from 25 May 2018).

10. Appendices

Appendix 1: Document Development and Approval

Development / Review Team

Name	Title
Colette Brett	Head of Quality, Safety and Risk
Estelle McLaughlin	Public Health Strategy and Development Manager
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Paul Kearney	Quality Assurance Coordinator, BreastCheck
Mairead Duane	Quality Assurance Coordinator, CervicalCheck
Niamh McNamara	Quality Assurance Coordinator, Diabetic RetinaScreen and BowelScreen
Fiona Ness	General Manager of Communications, Engagement and Information Development
Susie Black	Senior Complaints & Feedback Manager
Eimhin Walsh	Information Governance Manager
Patricia Fitzpatrick	Consultant Epidemiologist/Director of Evaluation
Linda Horan	Finance Manager
Grace Turner	Head of Strategy, Business and Projects
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Julie Keegan	Quality, Safety and Risk Co-ordinator

There was no Conflict of Interest in developing of this document.

Approval of Document

Approval responses and digital signatures of approval are recorded in the document record on the NSS Quality Management Information System Q-Pulse.

Chair	Approval Body	Date of Approval
Fiona Murphy	Chair of NSS Executive Management Team	22/03/2024

* NSS Executive Committee members are available on the Terms of Reference and minutes of the date of approval.