Quality Assurance (QA) Policy Framework for the National Screening Services

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Contents

1.0 Introduction

1.1 Policy Statement

National Screening Service (NSS) policy is that all population screening programmes will assure quality in accordance with this policy and the framework described.

1.2 Scope

The policy applies to all NSS population screening programmes and all staff working in the organisation, management and delivery of NSS population screening programmes.

1.3 Purpose of the Quality Assurance Policy Framework

The purpose of this policy is to provide a framework for a standardised cross-programme approach to quality assurance for the national screening programmes. This, in turn will lead to a more objective, consistent and effective approach to QA and ultimately improve outcomes for the participants of national screening programmes. This document will guide the maturation and development of quality assurance operating models in screening programmes over the next three years.

QA is the process of checking that standards are met and encouraging continuous improvement. Assuring and driving up the quality of services is essential if population screening is to achieve the intended benefits to population health, while minimising unintended harms to those taking part. This benefit to harm ratio is especially important given that screening programmes are designed for populations or individuals who do not have any symptoms of the disease in question.

1.4 Terminology & Abbreviations

Item	Definition/abbreviation
Aspects of quality	If various aspects are measured and in agreement, then reasonably secure inferences can be drawn about service quality. Donabedian for example uses the following three approaches to identifying measures: • **Structures** – these define the conditions under which the care is provided and include facilities, equipment, people and culture • **Processes** – these are the activities that constitute healthcare, tests, service user education, analyses etc • **Outcomes** – these are changes which result from the health care whether desirable or undesirable and could be health status, knowledge, behaviour or other changes
Failsafe	Where screening processes carry a higher risk of failure (for example transfer of samples to a testing laboratory and issuing of results) the standards associated with such a process may include the requirement for a failsafe to be in place and measured. For

	example, in the context of the above the following failsafe might be implemented *Outstanding results must be identified if they have not been received within 21 working days from the cervical screening test date and followed-up with the laboratory as appropriate*
Measures of quality (See Figure 1)	In health care generally there are various measures for the expected level of performance against a standard. The term standard itself is sometimes used to denote the level of expected performance. Some standards may be deemed particularly important and monitored as a subset and collectively termed key performance indicators (KPIs). In some cases the term KPI implies the standard and in some cases the target. The terms metric and indicator are sometimes used interchangeably.
Programme QA Operating Model	A programme-specific description of the approach taken to quality assurance in line with this framework
Quality Assurance	The processes used to provide assurance that standards for screening quality are defined and measured
Quality control	An aggregate of detailed processes and activities which monitor and adjust quality
Requirements	Where standards expect a service delivery element to be simply present this cannot be measured quantitatively and these are referred to as requirements in this framework. These are measures of quality which are either be present or absent. These can be structures or processes which must be in place for the screening service to function properly. A requirement may be mandatory or desirable. For example: *Quality assurance standards must be reviewed, updated and published at least once every three years*
Service user	A variety of terms are used to describe the populations and cohorts of affected by screening at some point in each pathway. To enable consistent descriptions, this framework uses the term service user with the following definition taken from a variety of HSE documents written during the last 10 years. A service user is the term used to include:

	• people who use health and social care services as patients; • carers, parents and guardians; • organisations and communities that represent the interests of people who use health and social care services; • members of the public and communities who are potential users of health services and • social care interventions.
Standard	A standard is a clearly described criterion of quality to which a specified measure of quality (quantitative or qualitative) can be applied.
Targets	The term target is used to mean the level of performance expected for a standard which can be measured quantitatively. **Example 1** – a standard with a single target *99% of sample vials and their associated forms must be dispatched to the laboratory within a maximum of five working days of the test being taken.* Here the standard is *'Sample vials and their associated forms must be dispatched to the laboratory within a maximum of five working days of the test being taken'* and the target is *'99%'* **Example 2** – a standard with a target range *Repeating images for technical reasons should be minimised: the minimum standard is <3 per cent and the achievable standard is <1 per cent.* Here the standard is *'Repeating images for technical reasons should be minimised'* and there are minimum and achievable targets set of *'<3% and <1%'*

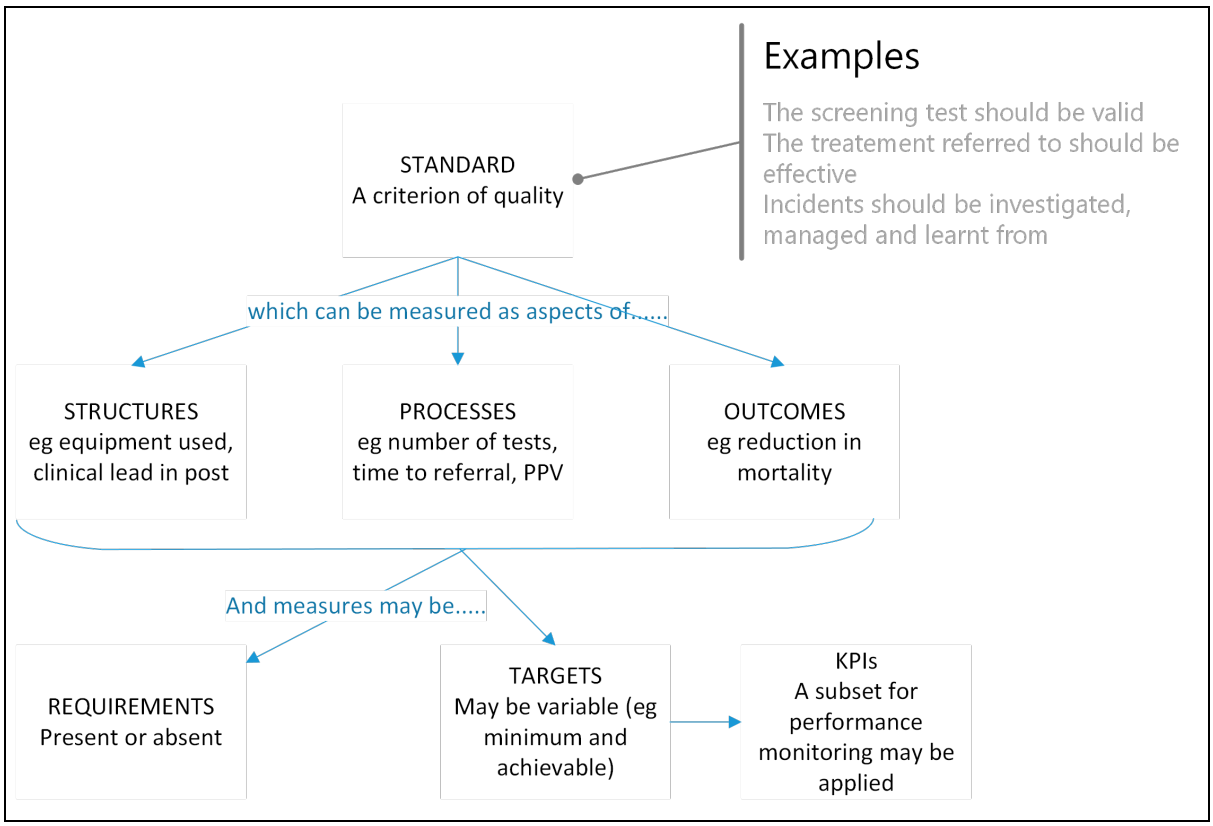

Figure 1: Terminology used in the QA policy framework related to measures of quality

2.0 Context

2.1 Quality Assurance

The National Screening Service, part of the Health Service Executive (HSE), encompasses four national population based screening programmes. These aim to reduce morbidity and mortality in the population through identification of those at risk of the condition or a pre-condition allowing assessment, earlier detection and treatment.

QA is an integral element of the four national population based screening programmes. Each programme has structures and processes in place to put quality and safety at the heart of service delivery. Not surprisingly each screening programme has a unique set of QA objectives, principles and activities specific to their programme. This allows for maximum adherence to and implementation of best national and International practice for the individual condition being screened for.

"*Considering the clinical and technical differences that characterise the different screening programmes, NSS needs to advance its thinking on cross programme learning, external QA, and governance oversight of the QA programme*". (Scoping Inquiry into the CervicalCheck Screening Programme Dr Gabriel Scally Final Report September 2018)

Whilst being mindful of the significant differences in each screening programme and the necessity for their QA Guidelines and QA Committees to meet the specific needs of each

programme, there is merit and benefit in an overarching QA Policy Framework. Standardisation where appropriate and possible will ultimately encourage and strengthen the entire NSS QA process.

It is also necessary to have an overarching NSS QA Policy Framework that can be applied to new screening programmes as/when they come on line as national programmes under the National Screening Service.

There are many documents which already identify how aspects of quality assurance should be enacted within the HSE and the NSS. Refer to section 5.0 Bibliography.

2.2 Quality assurance – what it is and what it is not

Figure 2 describes the processes required to run a high quality screening programme. Each phase does not occur in isolation and quality assurance becomes a continuous and cyclical process.

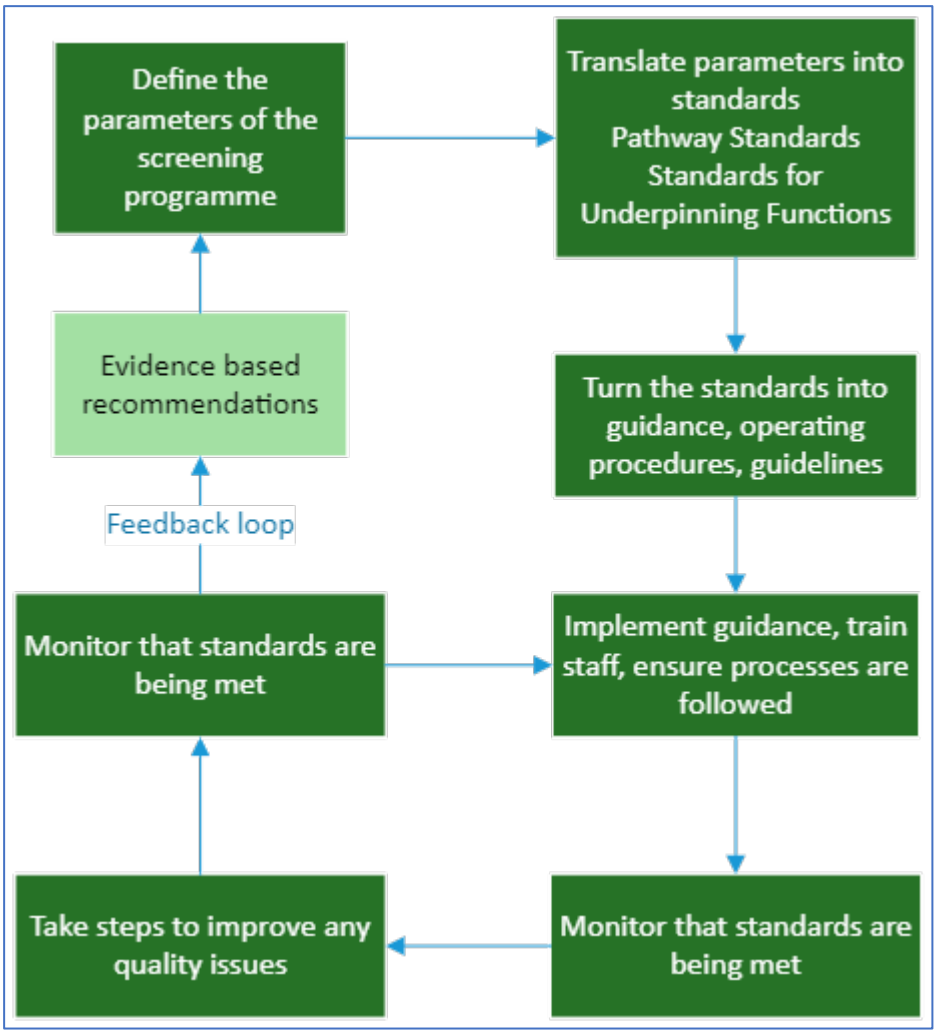

Figure 2: Running a high quality screening programme
Adapted from Screening Programmes, a short guide, WHO 2020)

Three important components can be described:

2.2.1 Defining the aspects of quality which are important

The setting of quality standards may be done by different organisations/groups. However each programme should set out the process by which standards are developed and the measures (targets) are agreed. Quality measures can be set for structures, processes and outcomes and for any aspect of a screening programme which is required to deliver safe and effective population screening.

2.2.2 Measurement

Collecting and analysing information to measure these standards is a critical element of QA. QA will not however directly measure all aspects of safe service delivery. Many of the activities of quality control (QC) are not directly considered to be QA, but programmes QA should take account of standards that they should adhere to. Examples are equipment quality control checks and laboratory quality management systems. Within breast screening for example, the detailed systems required to ensure that mammography is delivered safely and leads to a valid screening test is quality control. QA require these controls to be in place and the resulting test validity measured.

2.2.3 Improvement

QA should ensure that systems are in place to drive continuous quality improvement. Whilst direct quality improvement initiatives remain the responsibility of clinical and operational managers, a programme's QA operating model should ensure these activities occur and are coordinated".

For example the QA operating model for a programme would assure that an incident management system was in place and lessons were being learned, but the investigation and management of incidents would be an operational management responsibility. Likewise, a QA framework would include the requirement to run operational processes consistently but the development and auditing of Standard Operating Procedures (SOPs) would be a management responsibility. As another example, QA would expect there to be systems in place to oversee clinical performance and manage outliers in practice and define the parameters but a clinical leader would be accountable for undertaking this as a leadership task.

The QA operating model for a programme should distinguish between the approach and coordination of improvement activities and their operational delivery (including the business as usual functions required to run a screening programme). An example of this distinction is incident management – the programme QA operating model describes a learning and no blame approach to incident investigation but investigation itself is now a quality assurance activity. QA would, for example, measure the number of incidents, response times, learning disseminated.

2.3 Quality assurance as an over-arching framework

Quality assurance as an overarching framework should:

- Empower staff to act autonomously - where responsibility can be devolved it should be
- Utilise systems already in place and not create bureaucratic systems where none are needed
- Take account of and share current good practice and recommendations already made with the ultimate objective of improving quality and safety
- Take into account justifiable and avoidable differences across programmes
- Apply a QA framework equitably
- Support the development and use of clear and understandable systems and processes
- Drive consistency – where methods can be consistent they should be, as this is likely to improve performance, resilience and reduce risk

3.0 QA Policy Framework Elements

To enable each screening programme to apply this QA Policy Framework, those aspects which are consistent across programmes need to be identified. All programmes describe the screening service in terms of the full pathway from identifying a population to be screened right through to treatment (if required). All programmes will vary in the way in which they measure the accuracy of their screening test, but all programmes should measure it using clearly defined and consistent terminology, such as positive and negative predictive values. All programmes define some aspects of quality which are required across the whole pathway, such as the need for clinical leadership. And all programme use a range of similar methods to measure quality such as audit visits to parts of the service. Figure 3 illustrates how the common elements within this QA Policy Framework can be categorised (blue boxes). Descriptions of these aspects can currently be found in a variety of programme documents including QA guidelines, QA Committee's terms of reference and arrangements with providers such as contracts, service level agreements and memoranda of understanding).

What varies from programme to programme is the content and technical detail within each of these elements as this is entirely dependent on the nature of the clinical pathway.

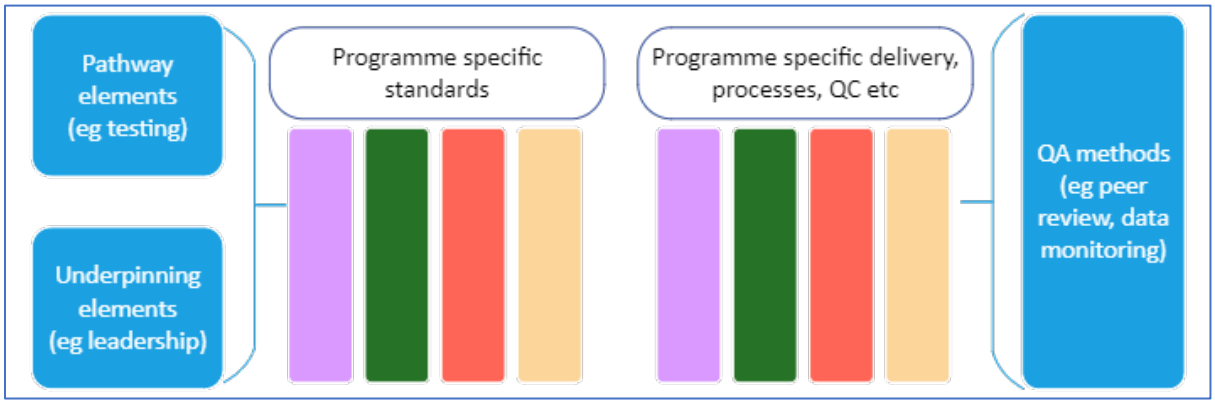

Figure 3: Common and programme specific aspects of the QA framework

This QA Policy Framework therefore aims to specify the common elements where quality could be measured and does not include the detail of the specific measures that each programme would need to apply.

3.1 Assuring the screening pathway

For each screening programme quality needs to be assured at all stages of the screening pathway. The stages of the pathway are inherently consistent across screening programmes and similar approaches to standard setting should apply. Table (a-e) describes these elements and gives examples of how standards are set to measure quality across the pathway.

Failsafe standards fit into any category as they generally aim to ensure the right result is associated with the right client and this assures a valid test at an individual and population level.

Measures for these standards may be quantitative or qualitative and measure aspects of structure, process or outcome.

3.1.1 Cohort Identification

Potential sub-categories of cohort identification standards	**Cohort identification means to:** Identify the eligible group (register) for screening from the population ensuring the correct person identifiable details are sourced/maintained
Register completeness	Identify as many of the true eligible population as possible
Register utility	Capture enough information in the register to ensure data can be utilised in a safe and accurate way to enable screening
Register accuracy	Undertake adequate register accuracy checking and record management
Examples of pathway failures that QA aims to prevent A group of clients is not identified and early disease not picked up. Eg clients moving between GPs do not get included in the cohort or inaccurate demographic information leads to personal information disclosure to non-service users with resulting mortality/morbidity	

Table 1a Screening pathway – Cohort Identification

3.1.2 Invite and Inform

Potential sub-categories of invite and inform standards	**Invite and inform means to:** Invite the full cohort for screening, supplying information tailored appropriately for different groups to enable informed choice to participate

First screen invitation timeliness/interval	Invite the population who become first eligible within evidence-based time parameters
Subsequent screen invitation timeliness/interval	Invite the population who have been screened to a subsequent screen within evidence-based time parameters
Invitation reminders	Use mechanisms to maximise participation such as reminders and monitoring of those who choose not to or fail to attend
Informed consent	Provide sufficient accessible information to enable the eligible population to make an informed choice when consenting to screening and record consent in an auditable manner
Examples of pathway failures that QA aims to prevent Service disruptions or capacity issues result in long intervals between screens or invitation letters are delayed with potential impact on programme effectiveness mortality/morbidity.	

Table 1b: Screening pathway – Invite and Inform

3.1.3 Testing

Potential sub-categories of testing standards	**Testing means to:** Conduct screening test(s) using agreed/recommended methods
Timeliness	Test as soon after invitation as is practicable Transfer samples quickly and securely to a testing location (eg samples to a laboratory, images to a reviewer) Test results are reported to clients and care staff as quickly as possible
Validity	Administer the test in such as way as to maximise its validity (PPV, NPV, false negative and positive rates) *This category of standard is often underpinned by extensive quality control processes to ensure all aspects of the testing are performed technically correctly. This is terms of both the equipment used and the performance of individuals in administering the test.*
Uptake	Maximise the proportion of those offered the test who accept the offer and are tested
Coverage.	Maximise the proportion of the eligible population who accept the offer and are tested
Referral to diagnosis	Refer all presumptive results to appropriate diagnostic services
Examples of pathway failures that QA aims to prevent Testing not carried out in a way so as to identify all positives. e.g. a screening sample is not collected adequately leading to the need for repeated test and client discomfort, disease potentially not identified, incidents logged, professional learning hindered	

Table 1c: Screening Pathway – Testing

3.1.4 Diagnosis

Potential sub-categories of diagnosis standards	**Diagnosis means to:** Diagnose true cases and identify false positives
Timeliness	Administer the diagnostic process as soon after testing as is practicable
Validity	Administer the diagnostic process in such as way as to maximise its validity (PPV, NPV, false negative and positive rates) *This category of standard is often underpinned by extensive quality control processes to ensure all aspects of the diagnosis are performed correctly. This is terms of both the equipment used and the performance of individuals in administering the test.*
Referral to treatment	Refer all presumptive results to appropriate treatment services
Interval diagnoses	In line with nationally agreed principles on open disclosure review those cases diagnosed in the intervals between screening tests and act on the outcomes
Examples of pathway failures that QA aims to prevent Testing not carried out in a way so as to identify all positives. Eg incomplete diagnostic examination leading to clients dissatisfaction/discomfort, disease not identified, incidents logged, professional learning hindered	

Table 1d: Screening pathway – Diagnosis

3.1.5 Treatment/Intervention

Potential sub-categories of treatment/intervention standards	**Treatment/intervention means to:** Intervene/treat cases appropriately
Timeliness	Administer the treatment procedures as soon after diagnosis as is practicable
Procedure effectiveness	Administer the treatment in such a way as to maximise its effectiveness. This category of standard may be underpinned by quality control and/or performance management processes to ensure all aspects of the diagnosis are performed correctly. This is terms of both the equipment used and the performance of individuals in administering the test.
Examples of pathway failures that QA aims to prevent	

Treatment delays occur with potential adverse effects on individual patient outcomes. Treatments are used which have insufficient evidence to have been approved for a screening programme risking reductions in long term mortality gains for a population.

Table 1e: Screening pathway – Treatment/Intervention

3.1.6 Population Outcome

Potential sub-categories of population standards	**Population outcome means to:** Measure the end result of the screening pathway on the disease screened for
Incidence	Reduce the incidence of the disease
Mortality	Reduce deaths from the disease
Morbidity	Reduce the consequences of the disease so as to stop/slow its progression and reduce morbidity
Health equity	Deliver population outcomes equitably across the eligible population Reduce inequalities and improve health
Examples of pathway failures that QA aims to prevent These outcomes are long term and failure to meet anticipated population outcomes is likely to be multifactorial and require investigation across the screening pathway and potential interaction with other social determinants of health	

Table 1f Screening pathway – Population Outcome

3.2 Assuring the Underpinning Elements

For each screening programme quality needs to be assured in all the underpinning and support functions (see Table 2 (a-d). This is often required at a strategic and an operational level to ensure that quality management feeds up into both strategic planning and down and across into individual behaviours. For example, within the underpinning element of leadership and governance, it is critical to have effective pathway-wide governance, as well as clear leadership at each stage of the pathway.

3.2.1 Governance, Leadership and Management

Potential sub-categories of governance and leadership standards	**Governance and leadership means to:** Oversee the service through effective, pathway-wide, clinical and managerial leadership and accountability Maintain effective operational and strategic management with clear escalation mechanisms Have clearly defined roles and responsibilities for those accountable for any aspect of screening
Strategy and planning	Have in place structures and processes to develop, implement, and monitor plans to meet the current and future needs of the screening programme, including responding to changing policy and guidance Maintain effective operational management systems and processes
Operational management	Have in place management structures and process which maintain and can demonstrate day to day service delivery
Risk management	Identify, plan for and mitigate risks to the delivery of the screening programme at strategic and operational levels with effective escalation systems in place in line with HSE policy
Adverse incident management	Identify and respond to screening incidents and near misses. learn from those that occur in line with HSE Incident Management framework
Clinical performance management	Monitor individual clinical performance and act on deviations in an appropriate and proportionate manner
Clinical Leadership	Have in place clinical leadership and process which maintain and can demonstrate day to day service clinical oversight
Quality management system	Have a pathway-wide approach to QMS and specific systems in place appropriate to each screening environment, process or procedure Specify and monitor requirements for any external accreditation
Clinical audit	Develop, implement and learn from regular audit and review
Commissioning and contracting	Procure (or establish a formal non-reimbursed agreement for) and govern any externally provided aspect of screening service delivery so as to achieve value for money, comply with regulations and meet NSS guidance
Examples of failures that QA aims to prevent A long term absence in a key leadership position resulting in failure to escalate a critical impending equipment gap or staffing issue leading to service slow down or temporary cessation Continuity planning or QC checks not undertaken and equipment delivers reduced accuracy affecting the validity of the test Repeated individual errors which are not promptly identified or learnt from potentially leading to a clinical incident, service user harm, reputational and financial damage	

Table 2a Underpinning function – Governance, Leadership And Management

3.2.2 Workforce

Potential sub-categories of workforce standards	**Workforce means to:** Strategically plan and deliver the service with sufficient, trained workforce
Qualified staff	Employ staff who are trained, qualified and registered or accredited appropriately for the role
Training and development	Maintain systems to identify and meet ongoing training needs for all staff Support multi-disciplinary learning Support learning from adverse events identified through governance systems such as performance deficits, incidents, risks
Capacity	Employ sufficient staff to deliver the service and meet additional HR requirements such as appraisal, study leave, audit and business continuity
Workload	Ensure all staff carry out sufficient procedures to retain the validity of the screening programme
Multi-disciplinary working	Make safe, consistent auditable decisions regarding each service user's pathway which take into the account the opinions of all involved in their care
Examples of failures that QA aims to prevent A lack of succession planning leads to insufficient staff in place to deliver the service Undertaking too few procedures or unfamiliarity with administrative practices to maintain high quality practice Poorly documented MDT decisions mean that the evidence of who attended and why a subsequently inappropriate decision was made cannot be retrieved	

Table 2b Underpinning function – Workforce

3.2.3 Data And Intelligence

Potential sub-categories of data and intelligence standards	**Data and intelligence means to:** Manage service user and operational information securely and accurately meeting data protection regulations and legislation
IT	Provide and maintain IT systems which enable service user/client information to be obtained, managed and transferred in line with appropriate governance standards Provide and maintain IT systems which enable the capture and extraction of information required to monitor quality and performance of the screening programme
Data protection	Manage all information in such a way to comply with data protection requirements and good information governance principles
Data quality	Explicitly manage data quality as part of governance systems
Examples of failures that QA aims to prevent Service user identifiable information is not secured and members of the public are able to see confidential information potentially resulting in complaints and reputational damage An IT algorithm is updated inaccurately and a cohort of clients are not invited for screening Data quality checks are not undertaken and clinical information continues to be transcribed inaccurately into service user records by an inadequately trained member of staff	

Table 2c Underpinning function – Data And Intelligence

3.2.4 Service User Engagement/Experience

Potential sub-categories of service user engagement/experience standards	**Service user engagement/experience means to:** Proactively engage with service user, manage complaints, survey service user experience and systematically plan for improvements
Engagement in service governance development	Proactively seek the views of current and prospective service users in service development initiatives Include authentic service user perspectives in service governance
Complaints	Manage complaints in line with HSE guidance
Surveys/feedback	Utilise evidence-based methods to collect, analyse and respond to feedback from service users, staff and other stakeholders
Public reporting	Produce a transparent report of programme quality
Privacy and dignity	Provide a screening environment which meets the needs of service users
Equitable access	Provide a screening environment or option which meets the needs of all service users Deliver health promotion activities to support equitable uptake and coverage and the wider health and wellbeing agenda

Examples of failures that QA aims to prevent
Service delivery locations are not sufficiently accessible and uptake falls Invitation letters do not provide sufficient information and uptake drops Signage and directions are inadequate, clients arrive to a screening service frustrated and staff face complaints and anger No health promotion work is undertaken and hard to reach groups in the eligible population are under-served resulting in inequitable uptake

Table 2d Underpinning function – Service User Engagement/Experience

3.3 Consistency of QA methods

The NSS approach to screening quality assurance recommends appropriate methods to undertaking the quality assurance of pathways and underpinning elements. These methods must meet the following QA principles.:

- Facilitate the identification of quality requirements, their measurement and/or service improvement
- Enable important aspects of quality across pathway stages and underpinning elements to be measured and improved
- Relate to the nature of the standard being assured and be independent to the specific screening programme.
- Roles and responsibilities for all aspects of QA should be clearly defined and QA as an activity is adequately resourced and prioritised
- There should be a clearly defined expectation around the involvement of stakeholders in the development and implementation of QA methods including service users and representatives, service providers and other interested experts or agencies
- Be developed and reviewed in line with HSE's National Framework for developing policies, procedures, protocols and guidelines

Table 3 provides a list of QA methods which should be used in a consistent way across programmes. This list does not imply all methods should be used but rather suggests that where they are used it is reasonable to expect them to be approached consistently.

QA methods	NSS approach to consistency
Feedback into systems which set standards and develop screening pathways	Standards are all set and reviewed to a defined timetable within a clear NSS standard development and review process where the required evidence is consistent in terms of: Standards are measurable consistently over time Standards and targets are consistent with consensus clinical advice Standards are based on the highest level research evidence possible Epidemiological and statistical analysis justifies thresholds and targets
Data collection	Only data that is necessary to answer a high priority clinical question on quality are collected. This helps to ensure that

QA methods	NSS approach to consistency
	data collection is legally justifiable and the burden of data collection is minimised Data dictionaries are used to enable consistency in collection and interpretation
Data monitoring and outlier identification	The identification of unit and individual outliers is based on sound statistical analysis and is clinically relevant There is a consistent and evidence based approach to the investigation and management of outliers Where data used for QA are also used for performance management this should be an explicit overlap and the purpose of the collection transparent to all Key Performance Indicators (KPIs) are identified with a clear rationale
Accreditation	External accreditation is an additional external method to define and measure quality in a screening programme. This helps to ensure programmes meets regulations and international standards set by a recognised, external organization. Going through the accreditation process can streamline operations, improve the quality of care, and build trust with public.
Peer review of screening providers (could be termed visits, reviews or audits)	The objectives of peer review are consistent across programmes and the interval is appropriate for the clinical environment Role descriptions, recruitment and training processes for peers is consistent across programmes Evidence-based prioritisation methods are used to support decision making on the areas of focus for reviews Review planning and logistic approaches are consistent to ensure that providers receive a comparable experience Reporting and recommendations are consistent in the immediate feedback to providers and in formal reporting There is a consistent approach to monitoring action plans produced as a result of visit recommendations Review methods such as case review, MDT observations, clinical observations, peer to peer interviews should all be carried out consistently
Self-assessment	Self assessment tools identify the standards being assessed and the evidence required to meet the standard Self assessment is formally part of the governance of a programme and its use to support external or internal quality assurance is clear Self -assessments which are externally reviewed are done and followed up in a consistent manner
Development and/or delivery of external (EQA) systems to support professional competence (for example test and training diabetic eye image sets, mammography peer review)	Development and delivery of EQA systems is consistent in terms of: Standards and targets used are those required by the programme The identification of unit and individual outliers is based on sound statistical analysis and is clinically relevant There is a consistent and evidence based approach to the investigation and management of outliers

QA methods	NSS approach to consistency
Additional elements required to support quality assurance	
Risk management	Risks are identified, analysed and mitigated in line with HSE risk management guidelines
Oversight of incidents and using the learning to improve quality and safety	Incidents and near misses are analysed, themes are identified and learning occurs within and across programmes
Facilitation of learning and development related to screening standards and quality improvement methodologies	Expert support provided to staff undertaking roles in screening should be needs led and consistent (eg training in incident management)
Quality improvement	There is a pathway wide plan for improving the quality of screening Quality improvement activities are identified based on evidence, are methodologically sound and their impact is evaluated

Table 3: Methods used to measure quality

4.0 Implementation

4.1 Communication and Dissemination

- This Policy Framework 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 Policy Framework.
- This Policy Framework will be made available on the HSE/NSS website

4.2 Roles and Responsibilities

Job Role (and specific Programme)	Responsibilities
All Staff in screening programmes	• Adherence to this QA Policy Framework
Programme Managers	• Support the circulation and implementation of this Policy Framework
Screening Quality Assurance Committees	• Provide assurance to the NSS Executive on extent of compliance with the QA Policy framework and any quality improvement activities identified to address gaps.
NSS Executive Management Team	• Implement across screening programmes, aspects of the policy relating to the consistency of QA methods.

4.3 Monitoring, Audit and Evaluation

- A rolling audit programme shall be implemented to determine compliance to this QA Policy, Framework 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,
- The Quality, Safety and Risk Department will coordinate this action for Policy framework relating to NSS functions. The evaluation shall aim to determine adherence to the process and identify any challenges to implementation.

4.4 Revision/Update

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

4.5 Budget and Resource Implication

- No budget or resource implication identified

5.0 Bibliography

Documents considered in the course of drawing up this policy:

5.1 NSS QA guidelines

- Guidelines for Quality Assurance in Mammography Screening Fourth Edition 2015
- Guidelines for Quality Assurance in Colorectal Screening Second Edition
- Guidelines for Quality Assurance in Cervical Screening Second Edition
- Standards for Quality Assurance in Diabetic Retinopathy Screening First edition Revision 5

5.2 Other NSS documents

- QA committee terms of reference provided in various forms and still in development
- NSS governance structures in development
- National Screening Service - Quality Safety and Risk Committee terms of reference V3
- Quality Assurance and Quality Improvement Workshop Building a cycle of continuous improvement NSS, 12th November 2019
- Information obtained from https://www.screeningservice.ie/
- Scoping Inquiry into the CervicalCheck Screening Programme Dr Gabriel Scally Final Report, September 2018
- Scoping Inquiry into the CervicalCheck Screening Programme –Implementation of Recommendations Status Update 5th September, 2019

5.3 HSE guidance relating to quality

- Quality and Patient Safety Clinical Governance Development; an assurance check for health service providers. An initiative of the Quality and Patient Safety Directorate, Health Service Executive, February 2012
- National Healthcare Charter. What you can expect from your health service and what your health service can expect from you. HSE
- Framework for Improving Quality in our Health Service. HSE 2016
- Incident Management Framework. HSE 2020
- HSE Your service Your Say
- HSE National Framework for developing PPPGs
- HSE Integrated risk Management Policy

5.4 National and international documents

- Developing a conceptual framework for Quality Assurance of screening programmes, Dr Sue Cohen, unpublished
- A Guide to the National Standards for Safer Better Healthcare Health Information and Quality Authority (HIQA) June 2012
- Impact of the Care Quality Commission on provider performance Room for improvement? Kings Fund September 2018
- Screening programmes: a short guide. Increase effectiveness, maximize benefits and minimize harm, WHO Europe, 2020
- Various internal operational documents available to the author with the agreement of the Screening Quality Assurance Service, Public Health England
- An Introduction to Quality Assurance in Health Care, Donabedian 2003
- Screening; evidence and practice. Second edition. Raffle, Mackie and Grey, 2019

6.0 Appendices

Appendix I: Development and Approval

Lead Author/s* v00

Name	Title
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Development Team* v0

The policy was developed in consultation with Screening Programme Managers, Programme Clinical Leads/Directors, Programme Quality Leads & QA Advisors and relevant Function Managers and NSS staff.

Policy and Procedure Development Checklist available upon request from Document owner

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

Approval of Document

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

Approval Body v0

Chair	Approval Body	Date of Approval
Fiona Murphy	NSS Executive Management Team	17-Sept-2021

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