

## INTRODUCTION

After the CervicalCheck audit disclosures in 2018, there was a loss of trust between patients and the healthcare system in Ireland. The subsequent review by Dr Gabriel Scally recommended the development of a process to restore trust, which was formalized in the CervicalCheck Tribunal Act 2019 to involve meetings, the appointment of moderators and a Facilitator. This process was co-designed by 221+ Patient Representatives, the 221+ Manager and individuals from the NSS, CervicalCheck, the HSE and the Department of Health.

## METHODS

This was an entirely new process, developed from a foundation of the needs of those affected.

The initial format was unsuitable as there were no protections in place for 221+ members. Although no predetermined outcome was possible as each member's story and trust process is unique, 221+ felt that a shared foundation must be agreed on as a basis for opening the process to members. The moderator role was to ensure this foundation was adhered to by each stakeholder.

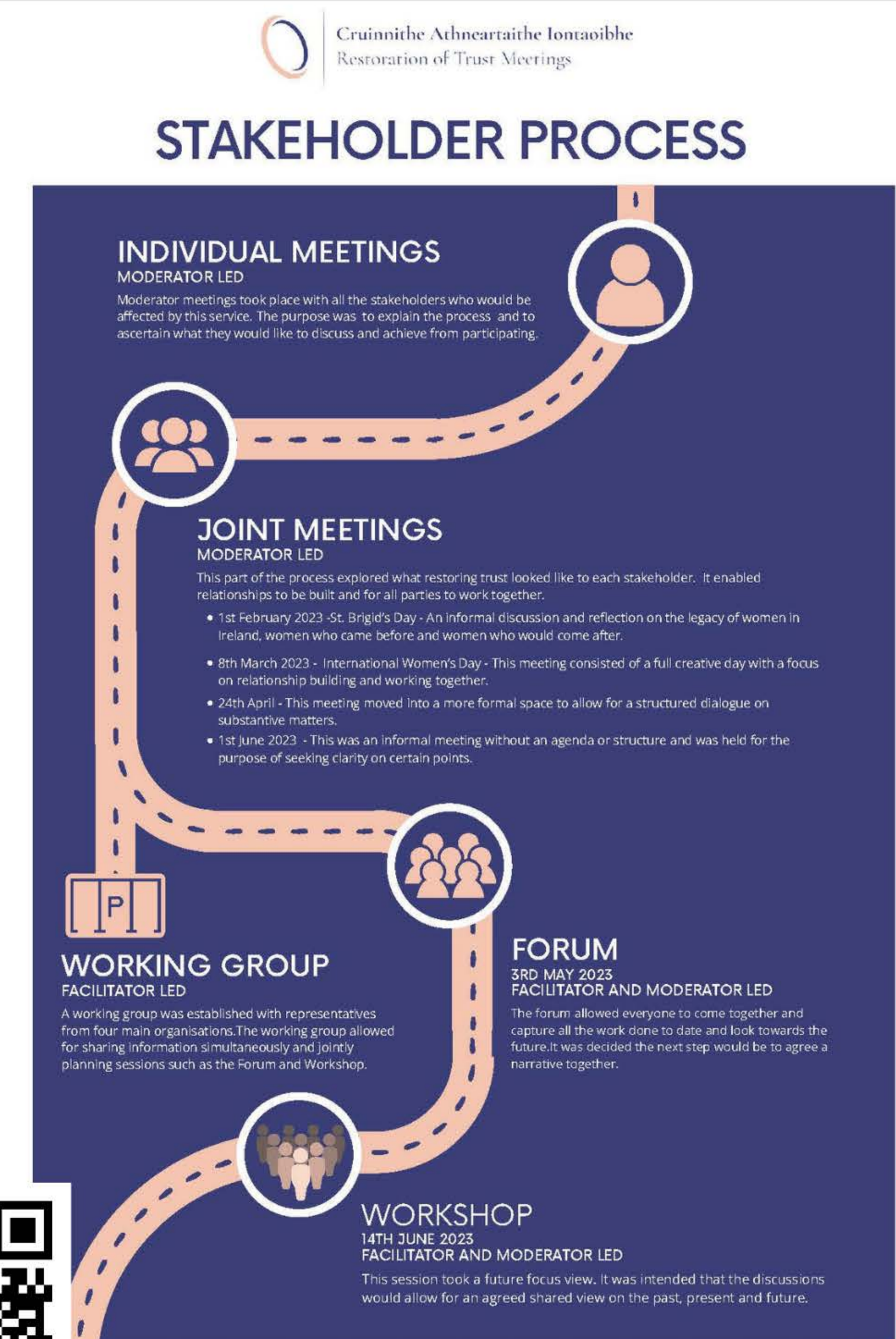
### THE AGREED FOUNDATION:

**Purpose:** to restore the trust of 221+ members – the women and families affected by the CervicalCheck failures, in the cervical screening system and wider health system in Ireland.

**Lens:** future-focused, sensitive and empathetic.

**Objective:** A shared view on the past, present and future

To the right is a flow chart of the process of achieving this baseline.



SCAN QR CODE FOR JOINT STATEMENT

## RESULTS

221+ Patient Representative Lyn Fenton described the process as **“difficult and challenging, but you have the potential to be a part of something that could be huge that could change not only healthcare, but how patients experience their healthcare journey”**.

Ceara Martyn felt that **“There's always so much healing in the process and fighting for something.”**

The outcome is [a joint statement](#) apologizing for and recognizing the harm of the past and agreement to work together towards eliminating cervical cancer. This acknowledgement of accountability is highly significant. Informative meetings with 221+ members have been held and the process is now open to 221+ members.

## CONCLUSION

This process was time-consuming and at times emotionally taxing. Yet it is also an achievement for all involved, who have created a baseline for members who lost trust and want to have a conversation with the individuals involved in their care. It is also a basis to work from to encourage public confidence in screening and the uses for elements of this process may extend far beyond this.

**Lyn Fenton:** despite the emotional toll, **“I still believe in its potential to do good from a restorative point of view. And from a conflict point of view. And I do believe that it could help medical professionals in talking to patients about their care”**.

## KEY TAKEAWAYS FOR RESTORING TRUST

- Really listen to patients
- Engage with patients from the beginning
- Have a process looking at all aspects of the situation and open outcomes
- Create a shared lens to approach restoring trust on an individual basis
- Timeliness
- Education for system change
- When told harm has been caused, “sit back and make a human choice” (Lyn Fenton)