Press Release - Wednesday, 5th March, 2008

Minister Harney publishes reports on Portlaoise Breast Cancer Reviews

‘Patients’ interests will come first in all reviews’

The Minister for Health and Children, Mary Harney, T.D., has today (5 March 2008) published two reports relating to breast cancer services at the Midland Regional Hospital, Portlaoise.

The first, prepared by Ms Ann Doherty (currently Acting Head of the National Hospitals Office at the HSE) was requested by the Department’s Secretary General. It deals with the background to the decision to suspend breast radiology services at Portlaoise in August last year and initiate a clinical review of those services. The second, prepared by the HSE Board on foot of a request from the Minister and with the assistance of Mr John Fitzgerald, examines the management of all events following that decision.

A report, by Dr Ann O’Doherty, on the clinical review of over 3,000 mammograms is being published this afternoon by the HSE, as well as a report on a review of ultrasounds.

The Minister said:

‘The events that were the subject of these reports caused serious concern to many patients and their families in the Midlands. Clearly, the greatest distress was caused to nine patients identified by Dr Ann O’Doherty’s review who had a delay in their diagnosis of cancer. I want to reiterate our apology to those women on my behalf and on behalf of all those involved.

‘I thank Dr O’Doherty, her medical colleagues, nurses and staff who gave expert treatment to those patients, and who also provided assurance tohundreds of other patients.

‘The report prepared for the HSE Board by Mr John Fitzgerald concludes there were serious weaknesses of governance, management and communication in dealing with the situation which arose at Portlaoise. This resulted in unnecessary anxiety for many women. That should never have happened. We are now taking steps to ensure that similar events do not happen again.

Patients’ needs

‘I believe what patients want to know is the following.

1. Is my diagnosis timely and accurate? The best way to ensure this is to build up services at the eight Designated Cancer Centres, with teams of skilled doctors and staff working together for each patient. I am confident our Cancer Control Programme, under Prof. Tom Keane, will achieve this.

2. Will I get the best outcome possible from treatment? We will assure patients of best possible outcomes by making the diagnosis and initial surgical care of patients, as well as follow-on treatment plans, in and from the eight Designated Cancer Centres, with set standards of care. In this regard, I cannot emphasise strongly enough that the fractured arrangement of services in the Midlands could never have allowed us give patients these assurances about their diagnosis and best outcomes, no matter how skilled the individual clinicians were.

3. If there is a need for a review of my case, will I be the first to hear and will it be confidential? Patients' interests will the over-riding priority in managing incidents of this type in future. While we aim to minimise errors, we cannot eliminate them. Where clinical reviews are necessary, patients deserve to hear promptly if they are or might be involved. They deserve to hear this individually in a way which respects their right to patient confidentiality, not through the media or political debates.

4. Will I receive attention and follow up immediately from doctors? Follow up care and treatment, if necessary, will be the first priority. Reviews will be managed with the clinical needs of patients to the fore, from start to finish.

5. Will I get a chance to influence the handling of these issues? The HSE Board has decided that patients should be contacted to allow them to express their feelings about the review process in Portlaoise. I have also asked the HSE to consult with patients' groups about the new serious incident management protocol they are finalising.'

Response at HSE level

The Minister added,

'We need to strengthen the governance and management of serious incidents by the HSE. I welcome the steps already initiated by the Board. These include the preparation and implementation of a new serious incident management protocol and a clear process for managing all aspects of a response to any future serious incident.

'In response to the Fitzgerald report, I have asked the Board to:

- adopt an interim serious incident protocol immediately which incorporates a number of key commitments to patients (see attached document);
- designate one person at national level to ensure that any future reviews are conducted in accordance with the protocol; and
- engage closely with this issue, through its Risk Management Committee, until it is satisfied that serious untoward incidents of this nature are being managed to the required standard.

'I have also asked the Board to consider whether the lessons arising from the systemic weaknesses of governance and management which have been identified in relation to the events at Portlaoise have wider application across the HSE. To this end, the Chairman and I have discussed the need to optimise the HSE's operational capability by addressing issues such as:

- robust governance and management structures, processes and procedures;
- clear reporting relationships and lines of accountability;
- having permanent top level managers in key posts;
- good systems of delegation; and
- a strong sense of corporate identity which permeates all levels of the organisation.

'I recognise that the Board has already been addressing these issues and that progress is being made.'

Response at Departmental level

'I have also asked the Secretary General of my Department, in consultation with the Chief Medical Officer, to review and strengthen the procedures in place within the Department to deal with clinical safety issues, with a view to ensuring that a clinical perspective is brought to these at all stages. I have asked him to submit proposals in this regard to me within the next few weeks. '

Department of Health and Children input to serious incident protocol attached

ENDS

Department of Health & Children input to the HSE's Serious Incident Policy

The draft 'Serious Incident Policy' should be adapted to include the key commitments listed below.

- The interests of the patients shall always be paramount over all other considerations and all matters affecting, or potentially affecting, a patient will be communicated to that patient first before any such information is made available to other organisations, the Oireachtas or the media.
- The lead person for each review will inform all those within the HSE, and others involved in the review, of their respective roles, and all communications will be cleared by them. One point of contact between organisations involved such as the Department will be established at this stage and will apply throughout the process. Numbers of cases under review and associated information will not normally be made public until the patients' interests in the review process have been addressed.
- Immediate consideration will be given to whether a service needs to cease operating in order to prospectively protect patients (pending the outcome of any review), in which circumstances an appropriate contingency must be made to allow patients to access an alternative service.
- There will be a thorough check of whether a health professional over whom sufficient concerns arise worked elsewhere and for what time periods, and a decision made as to whether other locations need to be notified so that a determination can be made on the need for reviewing care in these other locations.

- The Department of Health & Children, HIQA, the Medical Council and/or any other regulatory body, as appropriate, will be advised of the incident and the status of any HSE review.
- An investigation will be undertaken to examine what happened so that 'learnings' (including clinical, managerial and governance) can be identified and applied to all similar care settings. A standard template will be developed that would provide the necessary preparedness for management of serious incidents. It will cover issues such as establishment, terms of reference, procurement of legal advice, communications with patients, professionals and the media and other aspects that would benefit from standardisation.
- Offers of early counselling for patients will be made where appropriate.
- All patients identified who need follow up care, will have it arranged as quickly as possible, outside of regular clinics if necessary. There will be no delay incurred by waiting until there is a cohort of patients.
- First contact with the patient will where possible offer an actual (early) appointment date for the next stage of care.
- Any patient where a fault has been found (e.g. an incorrect test) through a review will be informed of this event (open disclosure) even if it is clinically determined that there has been no impact on their care.
- All reviews will be completed as thoroughly and quickly as possible.

The Reports are at the following links:

http://www.dohc.ie/publications/doherty_report.html

http://www.dohc.ie/publications/fitzgerald_report.html

http://www.dohc.ie/publications/downey_letter.html

http://www.dohc.ie/publications/fitzgerald_letter.html