Public Accounts Committee

Meeting
Thursday 22\textsuperscript{nd} Nov. 2018

Opening Statement
by
Mr. John Connaghan
Director General
Health Service Executive
Good morning Chairman and members of the Committee. Thank you for the invitation to attend the Committee meeting today. I am joined today by my colleagues:

- Dr. Colm Henry, Chief Clinical Officer
- Ms. Michele Tait, Programme Manager, Hep C programme
- Prof. Aiden McCormick, Clinical Lead to the National Hepatitis C Treatment Programme

Chapter 15: Hep C Treatment in Ireland – C and AG report 2017

Firstly let me say that we welcome the C and AG’s report which provides a detailed examination of Hep C treatment in Ireland.

Hepatitis C is a disease of the liver caused by a virus identified in 1989 as the hepatitis C virus. Hepatitis C is a communicable disease that is spread from person to person by contact with infected blood. Over time, hepatitis C can lead to cirrhosis, liver cancer and liver failure. The most common risk factor for becoming infected with hepatitis C is through intravenous drug use where equipment is shared, however, it may also be spread through sexual contact and through receipt of un-screened blood transfusions or blood products. There are estimated to be between 20,000 – 30,000 people infected with hepatitis C in Ireland. Hepatitis C is a notifiable disease since 2004 and at the end of 2017, 14,704 cases of hepatitis C had been notified in Ireland (approximately 650 new cases have been notified per annum since 2015).

In 1994 it was discovered that anti D immunoglobulin (a medication given to certain women during and following a pregnancy) contaminated with the hepatitis C virus had been administered in Ireland between 1977 – 1979 and 1991- 1994. Additionally it was also discovered that certain men, women and children had received contaminated blood and/or blood products in Ireland. In total approximately 1700 people are known to have been infected in Ireland through receipt of known contaminated blood or blood products.

There have been significant developments in the treatments available for hepatitis C since it was identified in 1989. The advent of directly acting antiviral medications (DAAs) for the treatment of hepatitis C and their availability in Ireland since 2012 has offered a cure for most patients from their hepatitis C infection.
All patients infected with hepatitis C through contaminated blood transfusions and other blood products such as Anti D Immunoglobulin have been offered treatment with over 95% rates of cure in those who opted for treatment. Since 2016 hepatitis C has been eradicated in Ireland amongst the haemophilia population through treatment via the national programme. This is an example of micro-elimination in a sub-population.

The National Hepatitis C Treatment Programme is led by a Clinical Lead and a fulltime Programme Manager. It is supported by a Programme Advisory Group which provides oversight and strategic advice to the Programme. The group is representative of key internal and external stakeholders including researchers, public health specialists, clinicians, pharmacists and service planners to ensure successful implementation of the multi annual public health plan for the treatment of Hepatitis C in Ireland over the coming years.

Since 2015 the National Hepatitis C Treatment Programme has provided treatment to almost 3600 patients beginning with those most in critical need. The programme has commenced the extension of hepatitis C treatment away from the traditional hospital based model (where appropriate) and integrating it into community based healthcare within a number of HSE Addiction Treatment Centres. Initial outcomes from these programmes are extremely positive with each patient engaging fully with their treatment and for those who have completed their treatment they have each received a sustained virological response (SVR) i.e. a cure. Additionally the programme is planning a further extension of treatment availability within the community setting outside of Opioid Substitution Treatment (OST) clinics.

The National Hepatitis C Treatment Programme has established a treatment registry which records anonymised data in relation to patients provided with treatment. The registry monitors treatment uptake, activity, prescribing trends and patient outcomes. It also provides a platform for clinicians to register patients whom they intend commencing on treatment.

The Comptroller and Auditor General examination of the treatment of hepatitis C in Ireland recommended the linking of data collected through the notifications of hepatitis C under Infectious Diseases Regulations to the national hepatitis C treatment registry.

The HSE agrees that linking this data is beneficial in terms of planning treatment; however this presents a range of difficulties from a patient consent, data privacy and feasibility perspective. Our division of Public Health is currently looking at the barriers that need to be overcome in relation to linkage.
The HSE is continuing to develop its existing treatment registry to ensure any patients diagnosed with hepatitis C are registered with the national treatment registry. The C&AG report also makes recommendations in relation to the continued planning of treatment and monitoring uptake to ensure patients continue to be identified for treatment and linked to care so that hepatitis C can be a rare disease in Ireland by 2026.

**Management of and learning from Serious Incidents**

I would now like to turn to the management of serious incidents and how we share the learning from these events.

It is the policy of the Health Service Executive that all incidents are identified, reported and reviewed so that learning from events can be shared. In support of this policy and based on us learning from incidents across the health service, the HSE in 2018 published its Incident Management Framework. This Framework sets out elements of the systems required for a responsive and proportionate approach to the prevention of incidents and the management of and learning from incidents which have occurred.

It places considerable emphasis on the importance of learning and the sharing of this learning at all levels in the organisation, nationally and at hospital and community service levels.

When an incident occurs, services are required to carry out a rapid risk assessment and take any immediate actions required to ensure that no other person is harmed. Following a formal review, the findings and the recommendations must then form the basis of the development of an action plan with a focus on the improvements required to reduce the risk of recurrence. The Framework stresses the importance of sharing the outcome and findings of the review with other services.

Cognisant of the criticism that some incidents recur, Step 1 of the incident management process focuses on incident prevention (There are 6 steps in total ranging from prevention and immediate action to improvement planning and review). We know there is a strong link between the need to proactively manage risk and the occurrence of incidents. An example of this would be where a service puts in place a falls prevention strategy and then monitoring the occurrence of preventable falls against this strategy.

The HSE has also recently established a project team to develop a mechanism so that the learning from local reviews can be considered alongside information from a number of other sources, for example, closed claims and complaints which relate to the provision of clinical care.
This team will also consider a range of options for disseminating learning through learning events, learning notices or changes to policies or processes.

Since 2013, the HSE has undertaken an annual review of completed incident reports. This analysis focuses both on the quality of report and the analysis of findings. The findings are themed to identify key areas of weakness.

The National Incident Management System or NIMS for short, hosted by the State Claims Agency, enables services across the HSE and relevant funded agencies to report and manage all safety incidents. As an end-to-end risk management system, it facilitates the management of a safety incident though its lifecycle from initial reporting, through the review process to the tracking of implementation of recommendations, whilst also fulfilling the legal requirement to report incidents to the SCA.

A range of reports are produced from the NIMS at each level of the organisation. These allow services to monitor trends on levels of reporting, timeliness of reporting, the severity, incidents reported, active claims and outstanding liability.

These reports are used as part of the performance management processes and used in conjunction with other measures at local patient safety and quality forums to disseminate information and to set out objective for improvement.

This concludes my statement.

Thank you.