DÁIL ÉIREANN

AN COISTE UM CHUNTAIS PHOIBLÍ

COMMITTEE OF PUBLIC ACCOUNTS

Déardaoin, 22 Samhain 2018

Thursday, 22 November 2018

The Committee met at 9 a.m.

MEMBERS PRESENT:

Deputy Bobby Aylward,	Deputy Alan Kelly,
Deputy Peter Burke,	Deputy Marc MacSharry,
Deputy Shane Cassells,	Deputy Catherine Murphy,
Deputy Catherine Connolly,	Deputy Jonathan O'Brien,
Deputy David Cullinane,	Deputy Kate O'Connell.
Deputy Alan Farrell,	

DEPUTY SEAN FLEMING IN THE CHAIR.

Mr. Seamus McCarthy (*An tArd Reachtaire Cuntas agus Ciste*) called and examined**.**

Business of Committee

Chairman: We are joined by the Comptroller and Auditor General, Mr. Seamus McCarthy, as a permanent witness to the committee. He is joined by Ruth Foley, deputy director of audit. We will have a private session in the afternoon to review a discussion document. I propose that we use a relatively short period to deal with correspondence and then proceed to our engagement with the HSE and the Department of Health. We have received apologies from Deputies Pat Deering and Alan Kelly. We are holding over the minutes and will come back to them shortly. The next item I want to get clearance from the committee in connection with is No. 3, a motion on the second periodic report relating to NAMA. We discussed this at the last meeting. It relates to the terminal surplus and possible consideration of NAMA's activities after its wind-down. We agreed that we have to put a formal motion to the Dáil to discuss this matter. The clerk circulated wording last Friday regarding our recommendation for a Dáil debate on the wind-down of NAMA. The motion is:

> That Dáil Éireann notes the report of the Committee of Public Accounts entitled Periodic Report No.2, November- December 2017, copies of which were laid before Dáil Éireann on 28 March 2018; and, in particular, the Committee's recommendations that the Dáil should debate
>
> - the utilisation of NAMA's projected terminal surplus and
>
> - the orderly wind down of NAMA or the possible consideration of NAMA for other specific purposes

It is in my name as Chairman of the Committee of Public Accounts. Is it agreed to lay that before the Dáil? There will be a debate on it in the Dáil on a Thursday afternoon in the weeks ahead.

Deputy Catherine Murphy: I am okay with that because it is neutral enough. The Taoiseach said in the Dáil yesterday that all of the NAMA surplus will be used to pay Government debt. That is the understanding of Government. I do not think it should be spent that way.

Chairman: This goes back to the report that we issued on 28 March. We recommended that there should be a Dáil debate on the projected terminal surplus of NAMA on the basis that NAMA is so unique that there are no EU rules on it. There is no requirement in EU rules to pay down Government debt. It is a domestic political decision. We cannot prevent the Government from having a view but we did not make a formal decision either way because there could be mixed views on the final surplus. It could be used partially for debt and partially for investment, or whatever. Let us have a debate and present the committee's point of view. There is nothing preventing individual parties from coming back with their own motions but the committee, in our last report in March, did not say anything either way. We said there should be a Dáil debate because we feel that is lacking. We have an announcement from the Taoiseach on his views but there are other views that have not been discussed in the Dáil. This has never been debated on the floor of the Dáil and I think the committee-----

Deputy David Cullinane: We went for a debate in the Dáil because it is a policy matter.

Chairman: It is a future issue. We included it in our report. Let us have a Dáil debate on it. That is as far as the committee can put it. We cannot decide policy.

Deputy Catherine Connolly: I agree with the Chairman totally. There should be a debate on it, especially on the utilisation of any surplus from the orderly wind-down of NAMA or the possible consideration of-----

Chairman: That was our wording.

Deputy Catherine Connolly: We are not recommending that. It is an open discussion on that. The thought that NAMA would be used for other purposes came from other sources. I think it came from the Government. We are not endorsing that but simply saying to discuss it.

Chairman: The committee is the first group saying we should have a Dáil debate.

Deputy Catherine Murphy: Is that in the motion we are suggesting? I do not think one can amend the motion. I am trying to visualise what direction will come from the Dáil from that debate on either of those two things.

Chairman: We cannot determine national policy on this. This is the wording we put in our report six months ago. We are now saying we should discuss the wording. It does not make a particular indication on the future use of NAMA's potential surplus because we have no authority to do so. We are saying that what needs to happen, which has not happened in Irish public life to date, is a Dáil debate on the matter. I might have a different view from the Deputy in the Dáil Chamber on the matter.

Deputy Catherine Murphy: I completely agree.

Chairman: That is what we will achieve.

Deputy David Cullinane: My view of what will happen is that this motion will appear on the Order Paper, the debate will be taken and the Government will have its amendment to it, which will probably say what the Government has already said, that the money will be used to pay down debt. We are all free to table amendments to say it can be done in a different way. There will then be a debate and an amendment will be agreed. I imagine that is how it will play out.

Chairman: This is a motion. All we are calling for is a debate.

Deputy David Cullinane: The amendment to the motion will determine what will happen after the debate.

Chairman: We do not know what that will be yet.

Deputy David Cullinane: It is not for us to decide.

Chairman: It will hardly be squeezed in in the next fortnight before Christmas. I expect this motion will be debated in early January. If the Government tables amendments, while it is going in as a Committee of Public Accounts document, it is a broader issue once it gets to the Dáil Chamber. We will have done our bit by initiating the debate. That is as far as we can take it. The outcome of the debate is for the Dáil to decide, not the Committee of Public Accounts. At least we are getting the matter in there and aired. We will have no problems if different people have different views on it once we get it to the Dáil Chamber. I will present it as is. I

might express a personal view or members might express personal views. Is it agreed to present the motion to the Dáil? Agreed. The clerk will send the motion to the Journal Office with a view to having it added to the Order Paper.

There are three categories of correspondence. The first is category A, briefing documents and opening statements for today's meeting. Nos. 1730A and 1732A are from the HSE, enclosing opening statements and briefing documents, which we will note and publish. Nos. 1735A and 1736A are from the Department of Health for today's meeting and we will note and publish them.

We have a large pile of correspondence which we have been holding over for quite a while due to the sheer volume of it. I want to run through some today. We will not clear it all but I hope that, next week, we will clear anything we have not cleared today. They will be on the screens if members have not brought hard copies.

The first is No. 1482B. In our previous report we included the issue of prepayments and the risk associated with them arising from the lessons learned from the Dublin Institute of Technology which paid upfront for its library services and lost over €700,000. We asked the Department of Public Expenditure and Reform to look at that. It is now recommending that the Government accounting unit of the Department will work with the Office of Government Procurement to clarify the position on upfront payments for procured services as part of general procurement. The current rules did not prevent the current problem from happening but the Department will clarify the position for the future. I know that the issue of upfront payments will come up again. We will note the correspondence and publish the response to it.

The next item is No. 1486 which is a brief note. The correspondence which we will note and publish is from the Department of Education and Skills and concerns the Thorn report on Kildare and Wicklow Education and Training Board. It was received during the summer. It is the intention of the Minister, once he has had an opportunity to consider the report fully, to arrange for its publication. While we have discussed the issue before, we have never noted it. It is an old letter.

Deputy Catherine Murphy: We have talked about this issue before. A file has been sent to the Garda or the Director of Public Prosecutions. How do we separate the two things? We will need to know. Where does it come back in here?

Chairman: Everybody knows that we will be coming back to the third level sector, whether it be the University of Limerick or the Higher Education Authority. It is not coming off our agenda, on which everybody is clear. We will keep it in our work programme and probably check on progress in January.

Deputy Catherine Connolly: It is not my area, but it is particularly significant because so many issues were raised, one of which has been referred to the Director of Public Prosecutions. There is huge learning and the issue should be given priority. For example, somebody asked me a practical question. I understood from the discussion that the minutes of education and training board meetings were to be made public. Am I correct in saying that?

Chairman: Some ETBs were doing so, while some were not. We made a recommendation and the Department has now written to all of the boards asking for it to happen in the future. We will do a check on it.

Deputy Catherine Connolly: Thank you. I just wanted to clarify the position for myself.

Chairman: It was not the procedure in all of the boards.

Deputy Catherine Connolly: It was not happening and the Department has written to all of the ETBs. It is very good that the minutes are to be published. Do we know when that will happen? Is it happening at the Kildare and Wicklow Education and Training Board?

Chairman: We will ask for an update.

Deputy Catherine Connolly: I would have thought it would be one of the first manifestations of a change of culture.

Chairman: We will write to the Department to ask for a schedule for each of the ETBs. Are there 16 or 17 ETBs?

Mr. Seamus McCarthy: There are 16.

Chairman: We will ask for a schedule for each of the 16 ETBs for the publication of the minutes and the date on which it will formally commence.

Deputy Catherine Connolly: I am asking in particular about Kildare and Wicklow Education and Training Board.

Chairman: We will get the full list. We will note and publish the correspondence.

No. 1502 is correspondence received from the Department of Rural and Community Development with a date at the end of July. It concerns a statutory review of the Dormant Accounts Fund, an issue on which we made recommendations. It is an internal review the Department carried out. It was completed in July and covers the general policy in the years 2013 to 2016 and 2017 to 2019. We will note and publish the correspondence in order that anybody who has not seen the document will see it on our website. On page 47 there is a summary of the 15 recommendations made in the review. I will not read all of them. We have completed our review of the Dormant Accounts Fund. There will be a follow-through. We will receive the minutes from the Secretary General of the Department of Public Expenditure and Reform concerning our periodic report. It will make for interesting reading because it was one of the poorest areas in terms of the proper management of grant funding.

Deputy Catherine Connolly: Like the Chairman, I followed up on the matter. I tried, but I found it difficult to read. I welcome the information provided and the review. That is the first point. It is important to try to understand it and explain it to people. The bottom line is that a sum in the millions is sitting in an account. Completely outside the obligation to hold onto a certain amount, there is other money that is not being used. I do not like to use the word "scandal", but it is not acceptable.

Chairman: No, it is not.

Deputy Catherine Connolly: If we could put a timeline on it, I know that we are-----

Chairman: We included the issue in a periodic report. We have recently received a response to a periodic report from the Minister. We cleared two previous ones a couple of weeks ago and will clear this one next week when the topic will be discussed.

Deputy Catherine Connolly: It will be a difficult day for me, but I do not think we will get to it.

Chairman: The topic will be discussed next week.

Deputy Catherine Connolly: Sometime.

Chairman: If not, we can hold over some aspects. We do not have to finalise everything.

Deputy Catherine Connolly: I ask for it to be held over.

Chairman: We will note that request straightaway.

No. 1513 is correspondence received from the State Claims Agency on non-cervical cancer screening. It is an old letter that was received in August. As we have discussed it, we will note and publish it. According to the schedule, it was held over.

No. 1526 is correspondence received from Mr. Ray Mitchell of the HSE providing follow-up information. There is so much in it that I will deal with the items one by one. We will note and publish the correspondence today. It is a voluminous document and I want people to be aware of what is contained in it. I will give a quick outline. At a meeting of the Committee of Public Accounts on 5 July we asked a series of questions to which we have now received written responses. Members should feel free to come back in on them. We could spend a day on this issue, but we will note and publish the correspondence and people can respond to it. I want them to know the issues about which we asked and on which we have received information. They include the cost variation by staff type and the reason agency staff cannot be recruited into the HSE. I will not get into the responses. I am letting people know that the responses contained in the letter will be published.

There is a response to the Hannaway report on HSE properties. Following completion of the Deloitte report on Government arrangements for section 38 and 39 agencies, the letter also includes a breakdown of how each agency was rated. Deloitte stated it was expected that the report would be finished in October 2018, at which stage, it would compile a composite report on the external reviews. We will ask the HSE for a copy as soon as it is available.

There is a note providing up-to-date information on community health organisation 4, about which somebody asked individually. There is also a note on psychiatric services in the south east and bed management and overcrowding in St. Luke's General Hospital in Kilkenny.

The next question we asked concerned the contract entered into with Deloitte to conduct the review. There is a note included on the matter. We also asked about the staffing of the national compliance unit, which is relatively new. There was a staff complement of 12.

There is a note on the number of planned and random audits in HSE agencies in 2018 to date. There were 11 planned audits and three random audits up to the date of receipt of the letter.

The next issue is important in the context of our ongoing work. We asked for a note on the introduction of a mandatory system of retraining and supervision following legal settlements without an admission of liability. It is very much what we are talking about today, that is, medical negligence, which will probably be the subject of a report of the committee in the spring. The first sentence states there is no mandatory retraining and supervision following legal settlements without an admission of liability, although retraining and supervision takes place. Enough has been said for now. It is what we all suspected and has been confirmed in writing.

The correspondence includes a note on the different categories of consultant in non-special-

ist positions who are not on the specialist register. There is a note on the process in respect of the cath lab at University Hospital Waterford.

There is a note on the assessment of needs and the provision of healthcare and plans to take steps to address the issue. Detailed information is given on a region by region basis. There is a detailed breakdown of the €50 million inpatient transport costs by area, including a breakdown of the type of transport used, including taxis, minibuses, private ambulances or other means.

There is a note on whether matters related to procurement compliance were included in the risk register. There is also a note on the section 38 and 39 agencies that have submitted their accounts. Last year 100% of accounts were submitted.

There is a note on whether matters associated with CervicalCheck were placed on the risk register in previous years. We know that they were not. That is something that will come up in discussions on medical negligence. There is a detailed history of the audit related to CervicalCheck with which we are dealing on an ongoing basis. Then there is a note on the number of protected disclosures made to the HSE. It is indicated that 78 were received in 2017 and there is breakdown of the categories of those on page 20 of this 26-page letter. There is a note on the provision of a cardiac cath lab laboratory in Sligo; the figures and trends regarding moneys owed by health insurance companies, which is in the order of €300 million at the end of each calendar year to which we can come back; the different categories of agency staff; and the contract awarded to the private operator in Mount Carmel. I am reading out all these headings because people forget the volume of work we cover. I am not reading to members the responses. There are notes on the sale of a property in respect of Our Lady's Hospice, Harold's Cross, which is the subject to a Garda investigation and is an item on our correspondence list; the position regarding high-risk dental treatment patients; the number of unfilled posts in the HSE; the prompt payment interest and compensation paid during the course of the year; and the patient private property retained interest and where the money goes. We will not discuss the entire detail of this, Deputy Cullinane. I have given a sample of the 29 detailed questions we asked on the day. The responses are now on the public record, and they contain a lot of information. If members want to come back next week on any aspect of this or use this information, they should feel free to do so. They may choose to use it in any event because it is public now.

Deputy David Cullinane: I do not want to refer to any of the detail but some of it relates to CervicalCheck. There is a lot of correspondence there, some of which concerns that issue. Can the Chairman clarify where we are with this? Two weeks ago we had a hearing on it. We dealt with a number of issues, including negligence, so it was wrapped up in that issue. Are we doing a separate report on CervicalCheck or will this be subsumed into a periodic report? My understanding was that we would do a separate report-----

Chairman: Yes, so-----

Deputy David Cullinane: Bear with me. I also understood we would work with the health committee to work out lines of demarcation, that is, what the committee is dealing with and what we are dealing with. I am just concerned this work is scattered at the moment. There is no cohesion to what we are doing.

Chairman: This would be up to the committee to decide, but we need to do a report on the issue of medical negligence, which involves a bill of €2 billion facing the taxpayer. This bill goes up every year and no one pays a blind bit of heed to it. The Deputy will see in the correspondence that there is no mandatory training. CervicalCheck could certainly be a significant

chapter in that report. We may do our own special report distinct from the periodic report on medical negligence after we complete-----

Deputy David Cullinane: My point is more fundamental. When the scandal first broke, we had three or four hearings, and then when the Scally report was published, we had one hearing but we did not get into the report and the issues within it that relate to our work. I had sought a report or some sort of scoping exercise on what we will do and the areas of the Scally report we can deal with and then a comment from a process and procedural perspective or a systems failure perspective. I am a little concerned that we are dealing with the matter here and there but there is no coherence to what we are doing. I would prefer if we knew what we were doing, if there was a clear focus and if a report came through the other end of the process and was not subsumed into a periodic report or a report on negligence. That is part, but only a small part, of the CervicalCheck issue.

Chairman: I will ask the secretariat to write a note because we are gathering information on it and touching on it every other meeting. We probably need an information note that pulls together precisely a suggested roadmap for us for completion of our work on the matter. We will come back and discuss that. I do not know the answer-----

Deputy David Cullinane: We asked that there would be consultation with the health committee, though. Was that done?

Chairman: That was just in respect of the two meetings that have been held in recent weeks in order that we did not overlap. We had touched on the issues previously. The work will be done in consultation with the health committee in order that there is no duplication and everything is covered. We will get that note for the members.

Deputy Catherine Murphy: A couple of issues have been raised. We had been talking about the large contingent liability before the CervicalCheck cancer scandal broke. That was the work we were going to do. In many ways the two issues have become conflated but it has been a useful example to tease out with the likes of the State Claims Agency, SCA, the Department of Health and the HSE in seeking to understand exactly what the process is when a scandal happens. One of the areas we were going to examine was open disclosure and the possibility of reducing the liability by virtue of the fact that part of that liability is a legal cost liability and that if there were a different process, one could well end up with a smaller liability in some cases and still a reasonable outcome for people who have been damaged. By conflating the two, we have taken the focus away from where it should be. These are two very distinct issues.

There are many other issues, and we will deal with one later which is another example. What is obvious - and we have not reached this point - is that if one is damaged and wants to pursue something, one is almost required to go through the SCA. A mediated process is not available. We will never get to the point of open disclosure if the systems are not in place to allow for an alternative dispute resolution to take place. This is an aspect we must set apart from others and do something definitive about. We have to come back to it with the SCA. We have done some useful work on CervicalCheck. Perhaps that should be pulled together so we can see what we have that is distinct from the health committee.

I refer to process and value for money. We must put them into that category so we are properly within the remit of the committee. We wrote to the SCA last week about the "lack of candour", to use the Chairman's term, regarding giving us correct information. I have eight women telling me they still cannot get their slides. We have not received a reply yet. Why

would it take a week to reply?

Chairman: We will have it next week.

Deputy Catherine Murphy: What will happen is the very thing we are trying to avoid. One of the solicitors will go to the High Court and demand the slides, and that will put people through more torture and will do exactly the opposite of what we are trying to achieve, which is the resolution of these issues without having to go the courts for the want of giving us correct information when the SCA comes before this committee. We should, therefore, make sure we receive a reply by next week, but it would not surprise me if the matter was dealt with in court before then.

Chairman: I am guided by what the members want to do. Perhaps we need to have a discussion in private session next week. Let us hope we have that reply in the meantime. Both members are saying that perhaps we need to narrow our focus specifically on this matter. We will discuss that in private session so we know precisely where we are going on this issue rather than it morphing into other issues. The point is taken.

The next correspondence is No. 1528B from Ray Mitchell which was held over from a previous meeting. It is a note on the approach and the protocol in place for the return of the slides to the women affected. This is an historic one, obviously.

Events have moved on since then and that will be very much part of our correspondence. I am only publishing old correspondence whereas we have discussed the reality of it in the meantime. We note that.

Deputy Catherine Murphy: On the protocol, which we have here, Quest Diagnostics is one of the laboratories and it was providing slides until the protocol was put in place. It was told by the HSE to stop providing slides. There was then a dispute over the protocol. We are not getting clear information. A second protocol was to be considered after the engagement with the legal people. When we are looking for the reply, we must note that not only is there a failure to provide slides, but even when they are being provided where there is an urgency - and it is only in those very urgent cases that it is happening - they are not being provided with the laboratory report that should accompany them. It comes back to open disclosure and that piece of work and it will be important in that context. This is an example of that.

Chairman: That is No. 1528. The next correspondence is No. 1530, a follow-up from Mr. Ray Mitchell. We note and publish that.

I refer back to No. 1528, attached to which is a letter dated 24 August 2018 in response to Committee of Public Accounts correspondence No. 1014 with the Department of Health seeking information following the appearance at the committee on 12 July 2018. It deals with a note on the expansion to 7-7 for general adult mental health services, a note on the cost of hiring private investigators, the process and safeguards in place on consultant-compliance contracts. Members might be interested in this. They have asked about the cost of hiring the private investigators and it states on page 2 of that letter that surveillance was a proportionate exercise and not indiscriminate, that three of the lead cases were ultimately the subject of surveillance and that the HSE advised that the cost was €117,853. I am just putting that on the public record as people were interested in the cost.

We also asked for a note on the reasons for the non-disclosure of information in the accounts under No. 62 in respect of legal costs. As a result of our letter and following consideration in

the finalisation of the 2017 appropriation accounts in conjunction with the Comptroller and Auditor General in the context of the raising of the matter at the committee, the Department is now in a position to report in accordance with the relevant circular. It was not publishing legal costs. In the Department of Health in 2017, there were 70 cases totalling €5.699 million and the total in the previous year was €14.655 million for 138 cases. That is in the accounts for 2017. Following us pointing out the Government circular at the committee, information which was not clearly available is now there.

We asked for an explanatory note on the three different schemes available for treatment abroad and people will find that helpful. There is also reference to the European health insurance card and the cross-border directive. The public are a bit confused regarding the cross-border directive. We will recirculate it. I do not have the reference in front of me, but it was dated 24 August 2018 in reference to our correspondence No. 1014 or 1528, I am not sure. It is good to separate the issues as people are confused between the cross-border directive and the treatment abroad scheme. Table 6 is an up-to-date note on the national children's hospital funding and a review of the money owed by insurance companies, which I touched on earlier. We note and publish that.

The next correspondence, No. 1538, is also from the HSE. This is a short letter with a large appendix comprising hundreds of pages. It is a copy of the records relating to the quality assurance visits, to include minutes of discussions and final reports submitted following the tests. That relates to CervicalCheck. We discussed this at our previous meetings but we note formally and publish that substantial document even though we have referred to it before.

Next is No. 1561, correspondence from the Higher Education Authority, HEA, regarding the famous retirement event for the former President of CIT and the fact that the HEA is considering the most appropriate means to recuperate the money from the college, which was not approved. We have discussed this correspondence before but never noted and published it. I have a note that it is held over.

Then there is No. 1672, which is correspondence from Professor O hÓgartaigh of the NUI on the non-competitive procurement of €5.12 million. There is a detailed scheduled on the back of that providing the breakdown. For G4 security, it was €373,000, which was probably a roll-over of a contract. The full breakdown of the €5.12 million is there. There is an issue regarding the severance payment and out-of-office leave payroll costs of €91,000. We note and publish that and members will be free to use the information as best they can.

That is all I have from previous correspondence which we had not published to date and which has been sitting on our desks for the last while. We will try to deal with the last of the unpublished correspondence next week. I turn now to the correspondence received this week, of which there is not too much.

Deputy Catherine Connolly: There is one letter held over for Galway from the Department on the service level agreement.

Chairman: We mentioned that the last day and the Deputy asked to hold it over.

Deputy Catherine Connolly: I did.

Chairman: We will try to deal with it next week, if the Deputy wishes.

Deputy Catherine Connolly: I will deal with it now if the Chairman wants.

Chairman: Please do.

Deputy Catherine Connolly: It is No. 1698. I welcome that we have a service level agreement finally, which was signed on 6 November 2018 between the Department and Galway 2020. I need a little advice on this from the Comptroller and Auditor General, and there are many questions which I will follow up on separately. I will not take up the committee's time on those as they are not relevant to this. However, I will ask various questions about an Irish language officer and a rebranding which resulted in Irish being diminished. I do not know whether the Office of the Comptroller and Auditor General examined the service level agreement, but I have a specific question on monitoring. I say this in a positive manner and welcome the agreement. There is a proposal to have quarterly monitoring meetings, which is positive, but it is proposed that someone from the Department will be on the board of Galway 2020 and then that there will be monitoring of meetings by the Department. How does that work? Where does the loyalty lie for a departmental official on the board of Galway 2020, which is being monitored by the Department? Can the Comptroller and Auditor General tease that out?

Mr. Seamus McCarthy: I do not want to give a definitive view on the specific arrangement in place but the issue has come up previously. It came up in relation to the Dublin Docklands Development Authority where the Department had an assistant secretary on the board. The same person was then overseeing the effective governance and control of the authority. The relevant Department, which is now the Department of Housing, Planning and Local Government, made a change and the person representing it on the board was no longer involved in the oversight on behalf of the Department of the operation of the authority. That has been established as a principle and it was accepted by the Department of Public Expenditure and Reform that it was a better arrangement. I do not have the detail of what has been put in place in respect of Galway 2020 but that is certainly a live issue and a matter of concern.

Deputy Catherine Connolly: It is a welcome change that the same person is not doing it but it does not take away my concern that a Department is providing €15 million - which is very welcome - and then has to monitor that. This is the performance level agreement. It contains all sorts of conditions, which is to be welcomed. I am not sure whether the board of directors is subject to freedom of information legislation. I will have to check that. If somebody here knows I would be grateful for an answer.

Mr. Seamus McCarthy: I do not know offhand.

Deputy Catherine Connolly: There is a person from the Department on that board who, I presume, has a loyalty to the board. I have a difficulty around this. Perhaps the Comptroller and Auditor General might have a chance to look at it. I am not asking him to give a value judgment or anything in this regard but, having learned from the Pálas debacle, this is the first time the Department is putting in place a procedure in Galway, which is welcome. It is the time to do it right. Can we have any input to improve that performance level agreement?

My last point on this is that, interestingly enough, there is a role for the Comptroller and Auditor General mentioned on page 6. I will read the paragraph:

> As the Department reports on all of its expenditure to the Public Accounts Committee and the Department's account is audited by the Comptroller and Auditor General, this agreement reserves the right and entitlement of the Comptroller and Auditor General to examine, query or audit the documentation of the expenditure of these funds at any time up to or after 2021.

That seems to be an open door up to and including 2021. It does not involve looking at something retrospectively. I invite Mr. McCarthy to look at that.

Mr. Seamus McCarthy: It is obviously putting an arrangement in place. The principle that the Comptroller and Auditor General be given access to follow up on the expenditure of public funds if necessary was required in giving grants. It is a general provision. I welcome that it is in this agreement but it does not mean that I will be going down and vetting each decision as it is made.

Deputy Catherine Connolly: I understand that and I am not asking for that. I am raising the fact that we, as a committee, can have an input in due course. I would like clarification on the monitoring arrangement and on where one's loyalty or duty lies as a representative on the board of Galway 2020 and a member of the Department.

Chairman: If one is a member of a board one's fiduciary duty, as loyalty is called, is to the board.

Mr. Seamus McCarthy: A distinction might be made between a director of company arrangement and a body set up with interested parties but without a company law structure behind it.

Deputy Catherine Connolly: I would like that point to be clarified somehow because there is a company and a board of directors on which a representative of the Department sits. It seems to me that the Department should take a hands-off approach, but I am no expert.

Chairman: Should we write to the Department of Public Expenditure and Reform or directly to the Department of Culture, Heritage and the Gaeltacht?

Mr. Seamus McCarthy: If the committee has further queries, points to be clarified, or points of concern in respect of the Department arising from its review of the arrangement which has been put in place they could reasonably be put to the Department. The committee could query what something means or how a certain risk has been dealt with.

Chairman: I will move on to the big question. The Comptroller and Auditor General is mentioned in this performance delivery agreement. If he feels it necessary or feels that there is good reason he has the right to examine documentation, although he would not do it as a matter of course. Does he have that right in the service level agreements between the HSE and section 38 and section 39 bodies?

Mr. Seamus McCarthy: Yes, as they are grant recipients. I might also have that right by virtue of section 8 of the Comptroller and Auditor General (Amendment) Act 1993, which gives me the right of inspection where more than 50% of an organisation's income comes in the form of grants from State bodies.

Chairman: So the Comptroller and Auditor General would have that right in respect of RTÉ.

Mr. Seamus McCarthy: No.

Chairman: Over 50% of its-----

Mr. Seamus McCarthy: There are certain exclusions and RTÉ is one of them.

Chairman: I ask Mr. McCarthy to give us a note on the the right of access because many people felt that this body did not have access under section 38 and section 39 agreements in the past. If the Comptroller and Auditor General does have access it is within the remit of the Committee of Public Accounts to go there. If he goes there, we can go there. I am asking for a note because there has been a certain view generally. It looks as if he can reach into several organisations if he chooses and feels there is a need to do so. Does he know how many service level agreements give his office this right of access? Would he be made aware of each and every one of these as they arise?

Mr. Seamus McCarthy: Yes, it is a standard feature of the HSE's current arrangements. I cannot speak about arrangements made in the past.

Chairman: I am just talking about now. Let us take the sports capital grants for example.

Mr. Seamus McCarthy: That provision was put in as a result of the work done by this committee on SIPTU funding.

Chairman: Let us go to the sports capital grants. If an organisation gets a substantial grant through the Department, is the Comptroller and Auditor General saying that a condition of that grant would be that he could inspect if he feels it necessary?

Mr. Seamus McCarthy: I have a right to inspect if more than 50% of the organisation's funding comes in the form of grants.

Chairman: Okay. It is probably news to many people that he has a greater right of inspection in respect of many organisations that receive public funding, many of which feel they are exclusively in the private sector or outside the public remit.

Mr. Seamus McCarthy: Yes.

Chairman: I am not saying that the Committee of Public Accounts will go there, but the Comptroller and Auditor General has the right to do so.

Mr. Seamus McCarthy: It may be complicated. For instance, if a body is also receiving funding in the form of contracts for which it has competed it does not count toward the 50%.

Chairman: I am talking about grant funding rather than payments for services.

Mr. Seamus McCarthy: It has to be in the form of grant funding.

Chairman: Okay.

Mr. Seamus McCarthy: We can prepare a note for the committee.

Chairman: Mr. McCarthy will send us an explanatory note on that issue in his own time, as soon as he can.

Deputy Catherine Connolly: To be specific, this is called a performance delivery agreement. It is slightly different. It is about monitoring delivery. The Department's role is laid out on page 4 of the agreement, "The Department will appoint a representative of the Minister to serve on the Board". It is under "c" on page 4. Under "d" it is laid out that there will be bilateral meetings. I want to ask the Department to clarify that. Who will be appointed? How does that tie in with the Department's monitoring role?

Chairman: We will write and get clarification on that.

Deputy Catherine Connolly: The final thing for us on this committee is the monitoring. There will be quarterly monitoring reports in respect of the drawdown of the money. Can we ask the Department when the first quarterly monitoring meeting as set out under the agreement will take place? It was to take place within a certain time of the signing of the agreement.

Chairman: Okay. I am moving on to correspondence received in the last seven days. There is not too much of it so it will not take too long. The first item is No. 1715B from the HSE regarding the transfer of properties from religious congregations to the HSE.

Deputy Catherine Murphy: Why are we skipping over No. 1700B? It is on the list here.

Chairman: We are going to deal with that next week. We have cleared about two thirds of the correspondence that has been held over. If the Deputy wants to raise it now she may do so.

Deputy Catherine Murphy: I have concerns that this was not-----

Chairman: The Deputy has an item of correspondence in on this.

Deputy Catherine Murphy: I have, yes.

Chairman: Grand, we will take that now.

Deputy Catherine Murphy: There are some very large amounts of money involved, the largest is nearly €5 million. Other amounts include €2 million and €1.1 million. I am concerned about how procurement was carried out. Was there just a list of contractors from which people were asked to do the work or was there a robust system? Can we write to the OPW, if we have not done so already-----

Chairman: We will.

Deputy Catherine Murphy: -----and specifically ask that because I have a concern that did not happen in all cases?

Chairman: That is fine. The Deputy has sent us a letter, No. 1733 C. We were coming to it shortly. It is specifically about seeking a detailed note regarding the removal of the gates in the Phoenix Park and their repair, restoration and re-erection. It asks whether it had been discussed before it was known that there would be a papal visit. The correspondence also says "in view of the spreadsheet of costs supplied by the OPW, the Deputy wishes to explore the way in which some companies were selected to provide services and infrastructure, were correct tender protocols and procedures adhered to, was the competitiveness of the tendering robust and so on." We will inquire about all of that at the Deputy's request. I will come to the letter in a moment. We will note and publish No. 1700B. We will also note and follow up on Deputy Murphy's request, No. 1733C.

No. 1715B is from Mr. Ray Mitchell, assistant national director, Health Service Executive, and is dated 12 November 2018. It deals with the transfer of properties from religious congregations to the HSE under the various agreements from 2002 and 2009. We are on the case. The Committee of Public Accounts will ensure progress is made. Progress was not made for years. Some of the properties fall under the remit of the HSE, which states that of the 2002 offers, there were two remaining properties, namely, the Sacred Heart centre in Waterford and a property in Cappoquin. The closing documents for the property in Cappoquin were received last

week from the congregation's solicitor and similar documentation for the centre in Waterford is expected soon. It is hoped the transfers will be finalised in the next couple of months. We will ask the HSE to provide an update in January.

In 2009, six properties were offered, of which five were accepted by the HSE, only one of which has transferred. Four properties are outstanding. One is the St. Bernard's Group Homes in Fethard. The correspondence states that the transfer document has been competed and the consent of the Minister and the Charities Regulatory Authority have been received. The property is now being registered. That is fine. The contract documents for the Catherine McAuley centre in Kells have been received and signed, the Minister's consent has been requested and is awaited. The committee will write to the Minister asking that he give that consent as quickly as possible to allow this transfer to proceed.

With regard to a property on Gracepark Road, on 14 June last, the solicitors were advised by the congregation's solicitor that the contracts and title documents would issue shortly. The documents are awaited. The committee will write to the HSE to ask its solicitors to contact the congregation's solicitors forthwith in order that this can proceed.

On the National Rehabilitation Hospital property, the position appears a little complicated. HSE estates say it will reach a transfer and lease-back arrangement for the National Rehabilitation Hospital lands. This will result in a change to the National Rehabilitation Hospital Trust. The original trust owns the land and the new trust will be involved in the sale and lease-back. A due diligence process on the new trust has commenced and will have to be completed before the lands can be transferred. The target date for the completion of this process is the end of 2018. The committee will ask for a note to be provided on this issue in January. We will keep on top of that issue.

No. 1717B is from the Department of Communications, Climate Action and Environment regarding electricity interconnectors, the need for windmills or wind farms to produce surplus energy and what happens to this surplus. Some of it can be exported and the Department advises that in 2017 the rate of curtailment of available wind energy was 4%. The committee will send this detailed response on the utilisation and export of excess wind energy to the correspondent. It has been suggested that this excess is dumped at an uneconomic price to the UK. The reply will be of interest to many.

No. 1718B is from Mr. Seán Ó Foghlú, Secretary General, Department of Education and Skills, dated 12 November 201. It relates to seeking information on the powers of the Minister and the Higher Education Authority, HEA, to carry out different types of investigations. We can note and publish this correspondence, which makes some interesting points. It is the Department's view that the HEA has the power to review compliance with conditions when it is granting funding. The Department states it has received the advice of the Attorney General on this issue and it is being assessed by Department officials. A further update will be provided to the committee members as soon as possible, once the Department has finalised its assessment of the legal advice. That is important and we will monitor that. The letter refers to a timeline for a review of the HEA legislation and the results of a public consultation. The consultation took place during the summer and 14 submissions were received. A consultation forum will be held tomorrow in the Department to provide an update on the HEA legislation. All of those who made submissions are invited. This process will ultimately lead to heads of a Bill.

Deputy David Cullinane: While the questions asked have been partially answered, the issue before the committee, namely, the Waterford Institute of Technology, WIT, report, has not

been dealt with. It is fine that there will be a review of the 1971 Act. That was discussed when the witnesses were before the committee. Mr. Love was concerned about the Act and its limitations in the context of the HEA carrying out reviews. A review of that legislation would be welcome. It seems the Attorney General's advice has been received but we do not know what it is. The WIT report is wrapped up in all of this. There are a number of different options. I was not so much looking for information on what the HEA will do in respect of future reports, examinations and investigations. All future examinations may change as a result of the review of the legislation. There are options regarding the WIT draft report, which is in legal limbo. One option is to modify the existing report. Mr. Love told us it was his intention to publish the report but it may need to be modified. There were concerns as to whether that was possible given the Attorney General's advice and the limitations of the HEA's role in doing these reviews. The other option was a ministerial appointment. It could be the case that the Department would have to wait for an amendment to the Act, before starting again. My question was not less about where the process was that about what would be done with the WIT report. I want to get a response for once and for all because this issue has dragged on. At some point, somebody has to call it and decide what will happen with the draft report. Will the report be modified in some way or will we start again? If the latter is the case, what is the process for starting again? Can we get an answer to that once and for all?

Chairman: We will write to the Department specifically on that issue.

Deputy David Cullinane: I believe the Department is hiding behind the review of the legislation and the Attorney General's advice. While that is all well and good, it does not answer the fundamental question before us. A draft report has been in legal limbo for a year. Separate from that, we have the Comptroller and Auditor General's report which deals with one element of what would have been contained in the HEA report. This committee cannot follow up on that until we have some clarity on this matter.

I asked a question of the clerk, which I also raised at our previous meeting. It is fine that we now have clarity that the Attorney General's advice has been received and the Government intends to change the legislation. That is policy but what is happening with the WIT report?

Chairman: We will write specifically to the Department.

Deputy David Cullinane: Could we get a clear response to that, once and for all, setting out what is being done?

Chairman: The letter will be on one issue, namely, WIT.

No. 1719B is from the Higher Education Authority providing details of the employee assistance help lines, which we will note and publish.

No. 1721B is from the Housing Agency and follows up on our previous meeting. We will note and publish this correspondence, which provides very good information. I thank the agency for supplying it. It gives details, by local authority, of the provision of social housing, the number of offers made by NAMA and the 2,475 housing units that were taken up by local authorities as a result. It also provides details on the €70 million funding the agency has been provided with in respect of local authorities. It sets out details, by local authority, of the 818 houses and apartments that have been completed and bids that are in the process of being accepted. It gives specific information on the 478 units that have been acquired and completed as part of that process, broken down between two, three, four and five bedroom houses and one,

two and three bedroom apartments.

Deputy Catherine Murphy: Which one is that?

Chairman: That is No. 1721B. The Housing Agency has provided a good information note on the regulation of approved housing bodies, which is not statutory. It has also provided a good note on land management on the 600 acres and 83 sites it owns. It gives information on sites transferred and sites progressing where agreement to transfer is in place, and details on the various capital funding schemes to approved housing bodies and local authorities, such as the capital assistance scheme and the capital loan and subsidy scheme. It has technical information on payment and availability agreements to purchase, lease and construct properties and the capital advance leasing facility. For people who are following the housing debate, this is very good information.

Deputy Shane Cassells: That is great information. However, it is a pity the agency did not provide information on the one substantive, negative issue that we raised on the day and that I raised in particular. I asked for the locations and breakdown of the properties that had been offered to local authorities but not taken up. The Chairman alluded to section 2 and the 2,475 units that have been delivered, which is included in the breakdown in tabular form by county. It is a pity the Housing Agency did not provide in tabular form the location of the 2,424 properties which were deemed unsuitable by reference to location or sustainability issues. I consistently pressed the agency on the day on the so-called, to use its word, over-concentration of certain amounts of property which made them unsuitable. What is going on at the moment is a national scandal. It is something for all of us to press with our local authorities. On the day we had representatives of the Housing Agency and the Department here, I had answers from the Minister to parliamentary questions. They were all blaming each other. The Department jumped in to bail out the Housing Agency as well. It is unfortunate that although we have plenty of good information, we do not have it on the issue of the 2,424 properties that the Housing Agency considered unsuitable by reference to location or sustainability based on what it calls "an over-concentration". In some cases it was claimed there was no demand. There are 10,000 homeless but supposedly according to the Housing Agency there is no demand in some of these areas. It is a pity we do not have a table setting out the areas of "no demand" because it would be highly informative. It still rankles with me in terms of the ideological debate that certain phraseology and terms can be used. While I am on that issue, did the committee receive a response from the County and City Managers Association, CCMA, on when it will appear?

Chairman: Not yet.

Deputy Shane Cassells: How many weeks ago did we write to the CCMA seeking an update? Was it three weeks ago?

Chairman: We sent the second letter over two weeks ago. In respect of the Deputy's point about the 2,224 houses referred to under schedule 2, the Housing Agency did not give a breakdown by local authority of those that were considered unsuitable by reference to location and sustainability. We will write back to the agency requesting that list. In addition, when we get that list we will write to the Department for a breakdown by local authority as to the reasons. In my local authority I have gone through the units that were not accepted and there were various issues. The issue could have been financial, for example, the price, or it may have been that it would have taken too long or there was an over-concentration in an area where there was already social housing. There may have been an offer of 50 houses in a local authority area where there was demand for only five houses. Those are the types of issues. We will get the list

by local authority from the Housing Agency. We will ask it to send the list to the Department simultaneously and we want the Department to give us a breakdown. If it is a case of a local authority refusing 47 houses, we want to know where each of them was - there would probably be four or five different locations - and why each offer was rejected. That information is readily available in every local authority and should be readily available in the Department. I have seen it in my local authority and we will get it.

Deputy Shane Cassells: What was key on the day from NAMA's and Mr. McDonagh's point of view was NAMA's willingness to assist local authorities with the completion of housing projects if they had not been finished and so forth. He stressed that it was not a financial issue from NAMA's point of view.

Chairman: We will get that information.

Deputy Catherine Connolly: I support that. We should have got that information. I have read and I welcome the documentation, which was very helpful apart from that. When we get that information we will be able to compare it with the existing policy of local authorities. For instance, in Galway there is a major housing crisis so the council is going back to local authority schemes and building infill houses. It does not see a difficulty with that. I want to see where the inconsistency is in terms of policies. It would be very helpful to have that information.

Chairman: We will get the breakdown. We are asking the Department to get the information from each local authority. The local authorities have it, as I have seen myself, and we want it in here. The information from the Housing Agency was helpful but more is required. We will return to the housing issue. We had the first meeting on it last week. The housing assistance payment, HAP, and all the other issues will come up separately and we are coming-----

Deputy Shane Cassells: Will that be before Christmas?

Chairman: No, probably-----

Deputy Marc MacSharry: After the election.

Chairman: Maybe. We will deal with HAP to some extent next week as we will have representatives from the Departments of Housing, Planning and Local Government with Employment Affairs and Social Protection.

No. 1724B is from NAMA and provides information requested by the committee regarding the geographic location of purchasers of €24 billion of disposals by NAMA. That follows on from a previous letter. It indicates to us that in respect of the €24 billion of secured assets sold by NAMA-----

Deputy Catherine Connolly: I cannot find that on my list.

Chairman: It is No. 1724B. It is only one page. NAMA had given us a breakdown of where the purchasers of NAMA property sold in Ireland were from and we asked for the breakdown of all secured assets worldwide. The letter indicates that the jurisdiction of the purchasers in respect of the €24 billion of secured assets, both Irish and foreign, is as follows: 33% of the purchasers were in Great Britain; 31% were in Ireland; 9% were in the USA; 5% were in Germany; and 22% were from "other", which figure relates to 45 individual purchasers in other countries. We will write back. What surprised me was the figure of only 9% for US companies. We want to know who was the ultimate owner. A US company might have set up a company in

Ireland to buy assets. NAMA is telling us 31% of these assets were sold to Irish-based companies. I want to know if they were part of a group. This does not make sense to me. NAMA is playing games with the committee. It knows what we were looking for. We wanted to know the ultimate owner. The information provided does not tally with anybody's knowledge of these matters. We know many of these companies are controlled by American vulture funds. NAMA says only 9% of its sales are to US companies. There is a lack of candour in the answer and we want a full answer. We want to know the ultimate owners and NAMA has to know that. I am sure Cerberus alone accounts for more than 9% of NAMA sales. We want the full picture of the ultimate owners of the €24 billion of secured assets purchased from NAMA. I am finding that NAMA is not giving full answers. It probably hopes if we give it some information, we will accept that and move on but we will not. We have other correspondence on this.

Deputy Catherine Connolly: The Chairman will give a robust contribution in the Dáil on the motion.

Chairman: Yes, we will have to bring this into that debate as well.

No. 1725B is in respect of information requested by the committee regarding structural assessments carried out in schools constructed by Western Building Systems. People will find this very interesting. It is very detailed information on those schools that have been examined, those that have been reopened and those on which work remains to be done. A second schedule is provided regarding the schools delivered by that company and the overall procurement note. That is helpful. There is a third information note on the oversight and design and build programme, including Western Building Systems projects.

Most interestingly, we asked whether the company that got the projects was always the lowest bidder. I will give credit to the Department for providing us the full information. NAMA could follow its example. We will note and publish this interesting schedule. There are 42 schools. The note lists the top five or six tender prices, with the winning tender highlighted in red on the chart. People can print it off themselves, but it will be noted and published. In many cases, it is clear that the lowest bidder did not get the contract. A second ranking is called "Ranking of winning tenders following an EAT analysis". "EAT" means most economically advantageous tender, which is not necessarily the cheapest tender. It incorporates wider issues such as ability to deliver, track record and access to resources. According to this document, price accounted for approximately 40% of the score, not 60%. Some companies forfeited the job even though they were the lowest tender. Perhaps they had been granted four or five projects but, because they were unable to handle them all, the project fell to the next company on the list. Some companies had tendered for more than they were capable of handling.

We could discuss the 42 schools forever. Everyone has an interest in those in their own constituencies. For example, there is information relating to Portlaoise. We will note and publish the response, which contains good information on the issue. People are free to use the documentation as they see fit.

Deputy David Cullinane: It is good information and I compliment the Department on providing such a comprehensive breakdown. The annexes that it attached are also helpful. We sought this information because so many schools had been affected. The impact on children was the main concern, but process was also an issue. The tendering process was one element of that, with oversight of the design and build programme another. Annex 3 is important from our perspective. It sets out who had oversight of what. It seems that responsibility for compliance with the projects rested with the contractor. Departmental personnel are involved in the

pre-oversight arrangements. That is where we wanted to get under the bonnet. We requested this document in order to establish whether we would pursue and examine this matter. It was not just to get, publish and note the document. We wanted to get the information and then make a decision on whether to examine the tendering process, the design and build process, what compliance checks were in place and so on in order to learn from any mistake that was made. Was that not the reason? Now that we have the document, are we going to make that decision?

Chairman: Now that it has been noted and published, it is out there for everyone to discuss as Deputies, parties and journalists. The committee can discuss it, but I advise people to make their comments. The committee has done its job by getting this amount of information. We can follow it through in further detail, but I expect that members will, based on this information, be raising the issue in their own right outside of today's meeting.

Deputy David Cullinane: I accept that but, with respect, our job is not just to publish information. Our job is to try to understand whether the processes, including compliance systems, work once contracts are signed and contractors start building. It is fine for journalists and us to do what we want with the information that is published, but we sought it for a specific purpose, that being, to allow us to determine whether we would deal with it.

Chairman: When the Department appears before us to discuss its Vote in the new year, we will specifically-----

Deputy David Cullinane: If that is when it is, fine, but-----

Chairman: -----list this as a discussion item for which the Department should prepare.

Deputy David Cullinane: Okay.

Deputy Catherine Murphy: A tendering process is one thing, but there are other processes, for example, signing off. Does that fall within our remit? I do not know to which committee it would be more appropriate.

Chairman: Signing off on a construction contract that costs a great deal of money might be within another committee's remit, but it is certainly within ours. The sign-off on payment for work down is a financial matter, full stop.

Deputy Catherine Murphy: It is about the ability to challenge something that has gone wrong and determining whether the process for signing off needs to be challenged. We probably need to understand the situation. I am led to believe that there were people on site who signed off on the project.

Chairman: We need to examine those matters in further detail.

Deputy Catherine Murphy: We do.

Deputy David Cullinane: Annex 3 deals with the detail of project oversight and the role played by the Department in signing off on compliance with the agreements, which is what we are looking to understand.

Chairman: We will revert to this correspondence, as there is a great deal in it. I have only had a first read of it. Do members wish to revert to it next week?

Deputy David Cullinane: If the Department is coming in anyway-----

Chairman: It will be.

Deputy Catherine Murphy: It would be useful if we had some understanding before it attends.

Chairman: We will write to it.

Deputy Catherine Murphy: We do not want to get the information on the day and not have time to consider it.

Chairman: No. We will make a specific note for this issue to be dealt with in the briefing material that we receive before the meeting.

The next correspondence is No. 1726B from the Department of Education and Skills regarding the transfer of properties from the religious congregations. This is connected with the correspondence from the HSE, which we did not take at the time. This gives a detailed report up to 17 October. The Secretary General writes:

> ... the consent of the Minister for Public Expenditure and Reform has been sought for the acceptance of three properties ... The properties in question are:
>
> - Former primary school in school at Ballyjamesduff ....
>
> - McAuley Centre, Kells ...
>
> - Former St. Patrick's Primary School, Westport ...
>
> It is hoped that the consent of the Minister will be given shortly.

The committee is writing to the Minister asking him to give his consent urgently and not to delay the matter any further. We will follow up on this.

Next is No. 1729B from the Department of Foreign Affairs and Trade relating to our periodic report and a request for information.

Deputy Catherine Connolly: There is no follow-up check on that.

Chairman: We will ensure that there is a nice photograph of the delegation in the report.

We are moving on to correspondence category C. A letter has been received from Deputy Wallace with a further query regarding Project Nantes. We forwarded correspondence received from NAMA to Deputy Wallace and he has reverted with queries. We decided last week to request further details from NAMA and we will include these queries in our request. This is about section 172, which the Deputy says should deal with associated directors of the company. Essentially, he is saying that NAMA's response to us was not broad enough and was too tight. The section requires no debtor involvement, but Deputy Wallace is saying that directors of the purchasing company were associated with the debtor. He believed that the situation should have come under the section 172 declaration. We will forward Deputy Wallace's correspondence to NAMA and ask for specific clarification on the matter.

Deputy David Cullinane: We have received several pieces of correspondence on Project Nantes and we tried to address it when NAMA last appeared before us, but NAMA was not in a position to answer questions on it, or at least the questions that were being put. We are getting information. We cannot take all of it at face value, but many questions are being raised.

We were able to examine Project Eagle because the Comptroller and Auditor General did a special report. What was the genesis of that report? Why was Project Eagle picked out? I would also like to ask about the Comptroller and Auditor General's work in terms of his engagement with NAMA, which he audits. Is Project Nantes something that he has on his radar for future work? We are getting bits and pieces here and there. We do not really know how to handle it. We are going over and back with NAMA. Then we have other people almost acting in between that by telling us we should not believe something else over here. I am trying to work out how we deal with it or do not deal with it. Is the Comptroller and Auditor General across some of these issues?

Mr. Seamus McCarthy: People should note that Project Nantes is a 2012 disposal. Obviously, we audit the financial statements of NAMA each year. We did not examine Project Nantes in the course of the 2012 audit. However, it is certainly on my radar given the issues that have been raised. I have sought information from NAMA. I have not yet got all the information I sought. When I have it, I will consider whether any further work, including a section 9 value for money report, might be done in relation to Project Nantes.

Deputy David Cullinane: Okay.

Mr. Seamus McCarthy: We had intended to include Project Eagle as part of the sample we were examining in the context of the section 226 report, which is a separate legislative requirement. The more we examined it, the more it seemed that there were concerns that needed to be looked at in further detail. I decided to concentrate on that by doing a value for money report on Project Eagle first. It was intended that the process we used in that case would subsequently be used to inform our examination of other loan sales.

Deputy David Cullinane: I would like to follow up on that. When we looked at Project Eagle, we found that many issues arose with deviations from sales practices and the management of conflicts of interest, etc. It would be a bit naive of us to think that such issues did not arise in other loan sales. We are now getting information on a significant loan sale. If it is the case that the Comptroller and Auditor General is across it, that is where it needs to be done and I am happy enough that we may see something coming from that.

Deputy Marc MacSharry: The Comptroller and Auditor General has said he will consider undertaking a potential section 9 report on this matter. For what it is worth, the committee should ask him to undertake such a report. I know it is not within our remit to do so.

Mr. Seamus McCarthy: It is, actually. The committee could ask me to carry out a-----

Deputy Marc MacSharry: That is a matter for the committee. I certainly think we should make such a request, but the other members need to consider the matter too.

Chairman: We will discuss that separately. It is a fair point.

Deputy Catherine Connolly: I would be happy to wait for the Comptroller and Auditor General to come back after he gets further information to see what his viewpoint is at that stage. The committee can certainly have a role. NAMA was set up arising from a failure of governance and of regulation. When representatives of NAMA have come before us, we have expressed the most serious concerns about the lack of governance and so on in some instances. Is it not ironic that we are here in this position all over again now? We are struggling with an organisation that was ostensibly set up to deal with the outfall of the lack of governance, regulation, consensus and thought about things that were being done in a very wrong way. We are

back struggling in a David and Goliath position. I have used that phrase fairly often. We are trying to deal with little bits of information. I do not know anything about Project Nantes other than what we have been told in the correspondence we have received. We are struggling to get something as basic as a section 172 declaration. Then it turns out that what we do get is not relevant and we are left in that position. I will finish on a point that relates to disclosure and upfrontness. There is a duty on NAMA to help us. It was set up as a public body with public duties. There is a bigger issue here for us.

Chairman: Yes, there is. There will be a debate on NAMA's expected terminal surplus. The members of this committee will be able to raise those points in the Chamber as well as at this committee. The Comptroller and Auditor General is seeking information. We have gone back for further information. The Comptroller and Auditor General has raised the whole issue of the section 172 declarations. It does not seem to have been very well policed by NAMA. I will put it as gently as that. We will come back to this issue.

Deputy Catherine Murphy: All of us have concerns about loans that were in NAMA. People seem to be back in control of assets that they have possibly gained by virtue of getting back into a position without appearing to have the ability to do that. That is the genesis of this. It is a concern for me. People were not supposed to be able to buy back their loans-----

Chairman: Buy back their own assets.

Deputy Catherine Murphy: -----unless they could buy something at par value. It may be anecdotal, but it appears that some people have been able to do this. What kind of follow-through is done by NAMA afterwards? There could be people fronting for other people and things like that.

Chairman: The essence of the section 172 declaration is to ensure no person who is connected with the debtor is involved in buying back the same assets. The Comptroller and Auditor General has commented on that. We are back to that section 172-----

Mr. Seamus McCarthy: Which is quite restricted. It refers specifically to the disposal or sale of land or assets. It explicitly does not include the sale of a loan. I think the legal issues that arise in this regard relate to what it means and how enforceable it is.

Chairman: Would it be possible for the Comptroller and Auditor General, if appropriate, to give us a briefing note on section 172, or should we ask the parliamentary legal adviser for a briefing note on it?

Mr. Seamus McCarthy: The committee can certainly look at the section 226 progress report, which is already in the public domain. Perhaps it would be useful to get a legal view on the matter that looks at-----

Chairman: We will ask the parliamentary legal adviser to give us a note on this item, which is cropping up all the time.

Mr. Seamus McCarthy: -----the implications of it in conjunction with what we have presented.

Chairman: We will ask the internal parliamentary legal adviser to clarify the brief. This is an issue. We will try to move on.

The next item on the agenda is the financial statements and accounts that have been received

since the committee met on 15 November last. The only such document to be considered relates to the National University of Ireland. The old NUI is nearly wound up now. Its turnover in the accounting period was just €3 million. Most of the universities are now-----

Mr. Seamus McCarthy: I do not believe it is in a wind-up situation.

Chairman: No.

Mr. Seamus McCarthy: I think it is a continuing body.

Chairman: In a reduced role. It is not over all the universities.

Mr. Seamus McCarthy: It is an umbrella organisation. For example, it maintains the register of graduates of universities for election purposes. It performs other oversight functions.

Chairman: The register for the Seanad elections is something else.

Mr. Seamus McCarthy: Somebody has to do it.

Chairman: It is the greatest book of fiction in Ireland. Anyway, we will come back to that one again.

Deputy Shane Cassells: Is the Chairman referring to the register for the Seanad election?

Mr. Seamus McCarthy: For the NUI constituency.

Chairman: For graduates.

Deputy Shane Cassells: The Chairman is okay. I am on the Seanad reform implementation group. We are working on that. We are going to have it all dickied up.

Chairman: Problem solved. It is over to you.

Deputy Shane Cassells: No problem. We will have a report before Christmas.

Deputy Marc MacSharry: As a former Senator, can I ask that there be no giggling about the Seanad, please?

Chairman: I am only talking about the graduate panels.

Deputy Marc MacSharry: What about the seventh amendment of the Constitution, which was never acted on?

Chairman: That is outside our remit. We will move on. We are behind.

Deputy Marc MacSharry: What is the Committee of Public Accounts doing about that?

Chairman: I do not know anything about it.

Deputy David Cullinane: Everyone could have a vote.

Chairman: We are running a little behind time.

Deputy Marc MacSharry: It is not my fault.

Deputy Alan Farrell: There is collective responsibility.

Chairman: The witnesses are coming in. There is no change in the work programme. We can come back and discuss it next week. Our next meeting will be with representatives of the Department of Employment Affairs and Social Protection. There will be a long agenda. If there are any specific issues that members want to see dealt with in the opening statement or in the briefing material that is to be provided, I ask them to contact the secretariat to give an indication of those issues by tomorrow, if possible, and by Monday at the latest. The work programme is very extensive. It is probable that we will not complete all the chapters on the Department of Employment Affairs and Social Protection and the Vote. There are five chapters on the Department in the Comptroller and Auditor General's report. We will probably have to take a second bite at the Department. In the meantime, anyone who has specific issues to raise in respect of the Department should contact the secretariat to ensure there is as much advance notice as possible. Does anyone else want to come in before I suspend the sitting to allow the witnesses to come in?

Deputy Marc MacSharry: Before we finish up with the work programme, are we going to have a discussion about the person we had in last week in private session?

Chairman: Yes. It will be held in private session. We will reschedule it for next week.

Deputy Marc MacSharry: To decide on our course of action.

Chairman: Yes. We will have a discussion on the issue next week in private session.

Deputy Marc MacSharry: That is fine.

Deputy Alan Farrell: Unfortunately, as I am flitting between committees this morning, my attendance will be sporadic.

Deputy Marc MacSharry: Twenty lashes.

Sitting suspended at 10.40 a.m. and resumed 10.45 a.m.

2017 Annual Report of the Comptroller and Auditor General

Chapter 15: Hepatitis C Treatment in Ireland

Management of Medical Negligence

Mr. Jim Breslin *(Secretary General, Department of Health)* and **Mr. John Conaghan** *(Director General, Health Service Executive)* called and examined.

Chairman: We are dealing with chapter 15 of the 2017 annual report of the Comptroller and Auditor General on hepatitis C treatment in Ireland, on which we will have a discussion with representatives from the Department of Health and the HSE. We will also be looking at the HSE's efforts to prevent medical negligence cases. We had a meeting with the State Claims Agency on the management of medical negligence costs and open disclosure. We have teased out many of the associated issues, to which we should not return today. This meeting is impor-

tant as it gives us an opportunity to review hepatitis C treatment, its implications and whether lessons have been learned. What, if anything, has been learned by the HSE from hepatitis C cases? The State Claims Agency has told us that there is an estimated liability of €2.4 billion arising from active clinical claims and this figure is growing each year. We have discussed with the agency how the figure could be reduced through open disclosure and mediation. However, to quote the old saying, prevention is better than cure. If costs are to be meaningfully reduced, it will only be done by ensuring there is a reduction in the number of serious medical incidents in the first place. We need to focus on what institutional learning has taken place in the HSE and understand the changes that have been implemented as a result of cases such as those involving hepatitis C and CervicalCheck. We need to hear what the HSE has been doing in general to reduce the risk of cases of medical negligence.

I hope what I have said serves to frame the discussion in order that we will not move beyond that issue today with the Department of Health and the HSE. We can come back to other broader HSE-related issues on another day. We are here to discuss hepatitis C treatment, in particular. We are joined by Mr. John Connaghan, director general of the HSE, who is accompanied by Dr. Colm Henry, Ms Michele Tait, Professor Aiden McCormack and Mr. Ray Mitchell. The Department of Health is represented by the Secretary General, Mr. Jim Breslin, and his colleagues, Mr. Michael Conroy, Mr. Finian Judge and Ms Pamela Carter.

By virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by it to cease giving evidence on a particular matter and continue to so do, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the provisions of Standing Order 186 to the effect that the committee should refrain from inquiring into the merits of a policy or policies of the Government or a Minister of the Government or the merits of the objectives of such policies. While we expect witnesses to answer questions put by the committee clearly and with candour, witnesses can and should expect to be treated fairly and with respect at all times in accordance with the witness protocol.

We will take the Comptroller and Auditor General's opening statement and then we will have statements from Mr. Breslin and Mr. Connaghan. I understand that Mr. Breslin cannot attend the committee meeting this afternoon.

Mr. Jim Breslin: I understood the committee has scheduled business for the afternoon.

Chairman: Yes.

Mr. Jim Breslin: I must attend a Cabinet committee on health in the afternoon, but I will stay here as long as the committee needs me.

Chairman: That is fine. Mr. Breslin is free to attend that meeting. In the event that we do not finish before the vote, there might be a brief period when we require his presence in the afternoon after the voting schedule, but we do not know that yet. If we keep the meeting to the precise topic at hand today, we will try to complete it before the vote in order that we can do our private business in the afternoon.

I call Mr. McCarthy to make his opening statement.

Mr. Seamus McCarthy: As members will know, hepatitis C is a disease caused by a virus that infects the liver. The Health Service Executive estimates that between 20,000 and 30,000 people in Ireland may have the hepatitis C virus, many of whom may go on to have significant medical needs if they are not successfully treated. Recent advances in the drugs used to treat hepatitis C have resulted in significantly improved treatment outcomes and the Health Service Executive has set a target to make hepatitis C a rare disease in Ireland by 2026. Each course of treatment is expensive, however, and varies between €23,000 and €92,000 per patient, depending on the strain of the disease.

Approximately 1,700 people, most of whom were women, were infected with the hepatitis C virus through the administration of contaminated blood and blood products during periods in the late 1970s and again in the early 1990s. A number of schemes put in place to compensate and support those affected were subsequently extended to include persons similarly infected with HIV. Expenditure on these schemes is accounted for in a variety of ways. In undertaking this review, I wanted to compile an overview of the expenditure already incurred as a result of the contamination. I also wanted to assess the progress being made by the HSE on its current strategies and plans for treatment of hepatitis C.

The expenditure in 2017 under the schemes to compensate or assist those who contracted diseases due to contaminated blood or blood products totalled €36.4 million. Between 1996 and 2017, a total of just over €1.5 billion was spent. Compensation schemes, including insurance subsidy payments, accounted for €1.18 billion of that total. Almost €300 million has been spent on the provision of hospital and primary care services for those affected.

The HSE published a comprehensive national strategy for dealing with hepatitis C in 2012. It included 36 recommendations covering the areas of surveillance and data collection; education, prevention and communications; screening and testing; and treatment. The implementation of the recommendations has been mixed, with just ten considered to have been fully implemented and most partly implemented. The national strategy noted that a comprehensive programme had been put in place for patients who had acquired hepatitis C through contaminated blood products, but recognised that the needs of those who had acquired the disease through other means had not yet been adequately addressed. The Department of Health published a plan in 2014 for the establishment of a multi-year national hepatitis C treatment programme, which commenced in 2015. It aims to prioritise treatment for those at greatest clinical risk.

Since 2015, the Department has allocated €30 million a year to fund delivery of the treatment programme. In the period 2015 to 2017, more than 2,100 patients completed treatment. As my report was being compiled, information about treatment outcomes was available for 90% of those treated in those years. This indicated that the treatment was successful in clearing the hepatitis C virus in approximately 94% of cases. The majority of the annual budget allocation is used to purchase treatment drugs. Under the terms negotiated with the drug suppliers, a percentage of the purchase price for a course of treatment is subsequently refunded in the form of a rebate. The average cost of treatment, net of the rebate, was just under €28,000 per patient in 2017.

It is a complex challenge to ensure treatment delivery to the maximum number of highest-priority patients in eight main treatment centres, with varying drug costs per virus strain, within a set budget, and this is further complicated by the price rebate arrangement. In 2017, the HSE envisaged the smooth utilisation over the year of the available budget of €30 million. Payments

for treatment accelerated ahead of planned levels in the second quarter, however, resulting in the majority of the available budget having been spent by the end of July. This led to the suspension of the programme in the middle of the year and uncertainty about what would happen thereafter. As indicated in figure 15.7 in the report, significant rebate receipts in the third quarter brought the net spending level back into line. Figure 15.8 indicates the impact this had on treatment delivery, with significant front-loading in the first half of the year and a stop-start pattern in the second half.

The chapter makes a number of recommendations for management of the treatment programme. The HSE indicated it accepted all the recommendations and I am sure the director general will be able to update the committee in this regard.

Chairman: I thank Mr. McCarthy. I invite Mr. Breslin to make his opening statement.

Mr. Jim Breslin: I thank the committee for the opportunity to meet this morning. I am joined by my colleagues, Mr. Michael Conroy of the Department's blood policy unit and Mr. Finian Judge of the community pharmacy policy unit, as well as the HSE director general, Mr. John Connaghan, and colleagues.

The Comptroller and Auditor General's review of hepatitis C treatment in Ireland, set out in chapter 15 of the report, provides a comprehensive overview of this issue. I do not propose to go over that ground in detail, but I will speak to some of the issues examined in it and in particular, the compensation tribunal established for people infected by blood and blood products and the national programme for treatment of people with the hepatitis C virus.

Infection of people through the blood supply was a tragedy of immense proportions, causing great pain and suffering to many people. Approximately 1,700 people in Ireland became infected with hepatitis C or HIV through infected blood products over the period up to 1994. These included women who received anti-D immunoglobulin, people with haemophilia, people who received blood transfusions and people being treated for renal disease. The hepatitis C and HIV compensation tribunal was set up to compensate these individuals. It was established on a non-statutory basis in December 1995 and on a statutory basis in 1997. In 2002, the Hepatitis C Compensation Tribunal Act was amended to extend the tribunal's remit to include HIV and allow for claims by dependants of people who had been infected.

The tribunal is made up of six ordinary members, all of whom are barristers and solicitors, and is chaired by Ms Karen O'Driscoll, who is a senior counsel specialising in medical law and employment law. The compensation tribunal is independent of both the Minister and the Department of Health. It considers cases and makes awards in line with the legislation. Claims are dealt with by an *in camera* oral hearing before at least two members of the tribunal or by an offer of settlement. Claimants are entitled to be legally represented at the hearings. The Department's role is to make payments in line with awards made by the tribunal. The tribunal has heard claims continually since 1996, and it made 3,569 awards up to the end of 2017. Expenditure is approximately €25 million per year and, to the end of 2017, the tribunal had cost a total of €1.18 billion, covering awards, legal fees and administrative costs.

In the years since these infections were discovered, a wide range of actions were taken, based on the recommendations of the Finlay and Lindsay tribunals, to ensure the safety of the blood supply. The Consultative Council on Hepatitis C was established in 1996, while the National Haemophilia Council was established in 2004. Both bodies ensure those most concerned have a say in matters involving hepatitis C and the care of patients with haemophilia and other

bleeding disorders. The Irish Blood Transfusion Service, IBTS, documented a range of policies and procedures covering all aspects of blood transfusion screening and the implementation of these is reviewed by the Health Products Regulatory Authority, HPRA. Ireland has a sophisticated testing regime for screening blood donations, which is kept under continuing review as science and technology develops. The annual HPRA, inspection of the IBTS, a key recommendation of the Finlay tribunal, addresses compliance of its blood-related operations with relevant EU and national legislation. The latest report, from 2017, found that the IBTS was in compliance with legislation. No critical deficiencies which represent a risk to patients and the safety of the blood supply were identified.

On the national hepatitis C treatment programme, hepatitis C is a very serious disease. The public health risk involved is much wider than that pertaining to those who were infected through the blood supply. It is estimated, in line with international data, that more than 30,000 people in Ireland are infected with the hepatitis C virus, with over half of those cases undiagnosed. It is also estimated that over 70% of people with hepatitis C are or were intravenous drug users. In line with the recommendations of a Department of Health advisory group established by the chief medical officer, in 2015 the HSE established a national treatment programme for people with hepatitis C. Although treatment was in place for patients before 2015, it tended to be local and without consistency of approach and outcome measurement was fragmented. The national hepatitis C treatment programme is a multi-annual public health plan to treat all people with hepatitis C in Ireland, irrespective of the source of infection. It is delivered in a range of healthcare settings with a view to making hepatitis C a rare disease in Ireland by 2026 and eventually eliminating it.

The programme has received €30 million in annual funding since 2015. This structured, programmatic clinical approach allowed for the early and timely introduction of very expensive but cost-effective direct-acting anti-viral treatments for very seriously ill citizens, which were new treatments at that time. The treatments are capable of effecting a cure in over 90% of cases. The programme has a programme manager and a clinical lead who are supported by a clinical advisory group and an overall advisory committee. As well as access to anti-viral treatment, it provides a national register to measure treatment plan outcomes; access to treatment based upon agreed clinical prioritisation in line with international criteria; a clear decision pathway for treatment access, involving patient prioritisation, registration and reimbursement approval; treatment for both State-infected and other patients; and that all State-infected patients, clinically prioritised or not, were to be offered treatment by the end of 2017 in conjunction with clinically prioritised patients being treated. I am pleased to state that the latter goal has been met. All State-infected patients identified as suitable for treatment have commenced or been offered treatment. The HSE has advised a 98% success rate in this group of patients.

The HSE has consistently driven down the net cost of treatment per patient and as a result it expects to treat four times as many patients in 2018 within the existing annual budget as it did in 2015. Among the programme's achievements are that nearly 3,000 people have been successfully provided with treatment for hepatitis C since 2015 and hepatitis C was eradicated in the Irish haemophilia population by the end of 2016. Treatment commenced in paediatric patients in 2017. More patients are being treated each year, up from 350 in 2015 to an expected 1,800 in 2018, as the programme achieves better value in drug procurement. Treatment is available to all patients who are clinically prioritised, with no restrictions on availability other than treatment capacity. Treatment is provided outside the hospital setting through HSE addiction treatment centres. This began on a pilot basis in 2017, with plans for additional sites, including prison and homeless services. A treatment registry has been established with the National

Centre for Pharmacoeconomics. The current virus clearance rate at 12 weeks after treatment is over 95%.

The Irish health service is a vast undertaking delivered by people for people. The Department recognises the overriding importance of patient safety and quality in the delivery of health services. By any measure, the planned and programmatic treatment of hepatitis C has been very successful. However, it is time to move to a new phase of identifying and treating at-risk individuals and populations. The Department has received a proposal from the HSE to use some of the savings in the annual €30 million budget to develop treatment capacity, which would enable more people to access services. The Minister has given his agreement in principle to the proposed broadening of the model of care into community-based programmes, subject to details on the deployment of resources being worked out with the HSE. This should lead to an even more comprehensive programme which will include all elements of care including screening, testing and treatment. It will be a significant step forward in realising Irish, European and World Health Organization goals of making hepatitis C a rare disease and eventually eliminating it. When I was before this committee in October 2015, I noted that €30 million had been made available by Government to roll out the hepatitis C treatment programme and that, although we could not undo the damage of the past, it was expected that this would represent a very good use of the State's resources. I am glad that the results have confirmed this to be so and that by any measure the programme has been very successful.

Mr. John Connaghan: I thank the Chairman and members 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 of the hepatitis C programme, and Professor Aiden McCormick, clinical lead to the national hepatitis C treatment programme.

With the permission of the Chair, I will begin part of the way through the provided opening statement in order to avoid repetition. The national hepatitis C treatment programme is led by a clinical lead and a full-time programme manager. It is supported by a programme advisory group which provides oversight and strategic advice. The group is representative of key internal and external stakeholders including researchers, public health specialists, clinicians, pharmacists and service planners and aims 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 some 3,600 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. The initial outcomes from these programmes are extremely positive, with each patient engaging fully with his or her treatment. Those who have completed their treatment have each received a sustained virological response, that is, a cure. The programme is planning a further extension of treatment availability within the community setting outside of these clinics.

The programme has established a treatment registry, which records anonymised data relating to patients provided with treatment. The registry monitors treatment uptake, activity, prescribing trends and patient outcomes. It provides a platform for clinicians to register patients 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 these data is beneficial in planning treatment. How-

ever, it presents a range of difficulties in terms of patient consent, data privacy and feasibility. Our division of public health is examining 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 Comptroller and Auditor General report also makes recommendations regarding the continued planning of treatment and monitoring uptake to ensure patients continue to be identified for treatment and linked to care in order to make hepatitis C a rare disease in Ireland by 2026.

On the management of and learning from serious incidents, it is the policy of the Health Service Executive that all incidents are identified, reported and reviewed in order that learning from events can be shared. In support of this policy and based on us learning from incidents across the health service, in 2018 the HSE published its incident management framework. It 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, including nationally and at hospital and community 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 six steps in total in the framework. We know that there is a strong link between the need to proactively manage risks and the occurrence of incidents. An example would be where a service puts in place a fall prevention strategy and monitors the occurrence of preventable falls against it.

The HSE recently established a project team to develop a mechanism in order that the learning from local reviews could be considered alongside information from a number of other sources, for example, closed claims and complaints related to the provision of clinical care. Since 2013, the HSE has undertaken an annual review of completed incident reports. The analysis focuses on both the quality of reports and the analysis of findings. The findings are themed to identify key areas of weakness.

The national incident management system, NIMS, 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 life cycle, from initial reporting through the review process to the tracking of implementation of recommendations, while also fulfilling the legal requirement to report incidents to the State Claims Agency. A range of reports are produced by the NIMS at each level of the organisation. They allow services to monitor trends in levels of reporting, the timeliness of reporting, the severity of incidents reported, active claims and outstanding liabilities. The reports are used as part of the performance management processes and in conjunction with other measures at local patient safety and quality forums to disseminate information and set out objectives for improvement.

Chairman: I thank Mr. Connaghan. The speakers have indicated in the following sequence: Deputy Kate O'Connell who will have 20 minutes; Deputy David Cullinane who will have 15 minutes; Deputy Catherine Murphy who will have ten minutes; Deputy Jonathan O'Brien who will have ten minutes; Deputy Catherine Connolly who will have ten minutes and Deputy Marc

MacSharry who will have ten minutes. I ask everyone to stick strictly to the allocated time limits in order that we can complete this section of the meeting before the vote that is due to take place at 1 p.m. We do not want to come back in the afternoon. I may cut members short after ten minutes, but perhaps one or two might get a second chance to comment.

Deputy Kate O'Connell: I thank all of the witnesses for coming. I will focus on where we are as opposed to the tragedy of people being infected with blood products.

The United Nations has a target to eliminate hepatitis C by 2030. Our aim is do so by 2026. I am concerned that the low hanging fruit have been targeted in the initial phases, by which I mean people who are more likely to adhere to a medical regime or are easier to reach. Let us estimate that the number of patients is 30,000 and we say we will deal with 18,000 a year. The HSE will not achieve its target of eliminating the disease by 2026 unless we double resources or the HSE doubles its efforts to eliminate it. Hepatitis C is a communicable disease. The medical treatment emerged in 2014 and was licensed for use in Ireland in 2015. There has been a significant price reduction. I compliment the people who negotiated the price reduction. However, I would not give them too much credit as most countries negotiated a significant price reduction.

Do the witnesses know whether tests on students have been conducted or whether the disease burden or load has been eliminated for 3,000 people? Do they have data to show how many more have been infected, either through intravenous drug use or the exchange of bodily fluids or whatever else?

I assume that the lead agency is in charge of reaching targets, but I did not see an annual target included in any of the reports. Therefore, it looks as if the can has been kicked down the road to 2026. The view seems to be that everything will be fixed by then, but I am concerned that no annual targets have been set.

Intravenous drug users are the cohort of patients who are the hardest to reach and make up probably half of the estimated number of patients. They tend to be hard to engage with because they have chaotic lifestyles. In my experience, as a community pharmacist who worked in a methadone service ten years ago, usually one finds when one engages with people such as these - I do not mean to paint everybody with the same brush - that they tend to adhere to regimes and turn up at their community pharmacy. The relationship tends to be strongest between a community pharmacist and the person receiving the methadone treatment. I very much welcome the suggestion treatment be moved to a community setting because I do not see how else we can target that portion of the population. Obviously, the service will involve prescribing doctors. I am sure pharmacists will be anxious to negotiate a very good price for the provision of such treatment.

It was stated each course of treatment cost between €23,000 and €92,000 per patient. I understand the negotiated drug cost is around €10,000 per patient. Can whoever knows the answer explain the difference between the figures of €23,000 and €92,000? Is it the price of administration or doctors' fees? Have I missed something?

I have seen evidence from other countries that there have been deals done with the drug companies whereby €100 million, for example, would be given to treat whatever number of patients, but if we find another 2,000, they must be treated. Have the witnesses come up with innovative actions to get the best value from the drug companies when it comes to dealing with this issue?

I am concerned about the database and confidentiality issues. It seems completely unacceptable that one does not know how many people have hepatitis C, who they are or where they are. As hepatitis C is a communicable disease, it is very important to know the dataset and who has the disease. The approach seems to be *ad hoc*. To tackle an infectious disease one must go at it and include every strain. It looks like the easiest people have been dealt with and that the hardest ones to reach have been left until the end. I find that concerning and do not think we will reach our target.

With reference to intravenous drug users, apparently one out of every three homeless people is hepatitis C positive. That is a big concern if people are living in communal hubs or hostels because I imagine the risk of transmission is extremely high. Do the witnesses have any idea of how many have been reinfected?

Mr. John Connaghan: Most of the questions are probably for the HSE. Perhaps we might start with the first question which will be answered by Professor Aiden McCormick in terms of the forecasted numbers. Ms Tait can then answer the rest of the questions.

Professor Aiden McCormick: In terms of the forecasted numbers, we have actually engaged in a modelling exercise and think the figure is actually closer to 20,000 than 30,000. This finding is very consistent with the findings of the most recent study published by the Health Protection Surveillance Centre, HPSC, which also calculated a figure of about 20,000. Part of the confusion is caused by the notified results. Up until 2012 people who were antibody positive were notified. They included those who had the virus and had cleared it. That gives a figure of 15,000 which includes about 4,000 who have cleared the virus.

I agree entirely with Deputy O'Connell that we have targeted the low hanging fruit, the people who will come to clinics. We have to target people who are in the community and that is exactly what we are doing. We now have four treatment programmes linked with methadone. I share the Deputy's observation that the patients who are on a methadone treatment programme are extremely good and compliant. As the one thing they know about is drugs, they know when to take them and we have had a very positive uptake. We are expanding out to the community and we hope to expand it to level 1 and level 2 GPs and to community pharmacies so the process is ongoing. I do not know if I have answered all the questions.

Mr. John Connaghan: Professor McCormick might want to say something about the target and the position forecast up to 2026.

Professor Aiden McCormick: We have thought about this. We can forecast numbers but we want to find as many people as possible and treat them as quickly as possible. We are telling centres that they do not have a number they have to treat - they should treat as many as they can. If they run into a roadblock, we will give them more resources to treat them. Spending a lot of time on detailed plans is not the right thing to do. These patients are difficult to find and we do not know the exact numbers.

A study was done recently by the Safetynet group into 700 people who were homeless or in hostels. They agreed to be tested for hepatitis C and only 2% tested positive. There is a suggestion that one third of homeless people are positive but it is not fully based on fact. There are a lot but not as many as that.

Deputy Kate O'Connell: It is not ideal having a population carrying hepatitis C in an enclosed communal setting and not knowing about it.

Professor Aiden McCormick: Absolutely. We are in a procurement process to get mobile fibre scans to tell people about their disease. We have tried these in drug treatment centres and when we tell patients that we have a machine that will look at their liver and can tell them how much damage has been done to it, they queue up to be tested. Our plan is to go into hostels and drug treatment centres and test the people there.

Mr. John Connaghan: There was a question about drug costs.

Deputy Kate O'Connell: There are discrepancies in price.

Ms Michele Tait: The published price in the report is the cost price. It is the list price of the medications we use to treat patients and is the price before we apply any rebate we receive from the drug companies. We procure drugs with a public tender, of which there have been two so far. The figure is the cost to the hospital providing the treatment but the HSE has rebate arrangements which we negotiate with the pharmaceutical companies as part of the procurement process.

Deputy Kate O'Connell: When the rebate comes back, where does it go? Does it go into the general hospital budget or back to this particular basket of €30 million?

Ms Michele Tait: It goes into the basket. The primary care reimbursement service, PCRS, is responsible for reimbursing the cost of the drug the hospital purchases to treat the patient and for negotiating the collection of rebates from each of the suppliers based on the commercial terms we that have been agreed. The commercial terms with each supplier are in confidence but we expect the average cost of treatment in 2018 to be below €15,000 per patient.

Deputy Kate O'Connell: Does this include the hospital money or is that simply the cost for the drugs?

Ms Michele Tait: The €15,000 is for the drugs. The hospital will always pay the full list price of the drug directly to the supplier but will have the full cost reimbursed by the PCRS, which will negotiate a rebate from the supplier to get the saving. The €30 million in the PCRS pot is expenditure out of the figure arranged with the suppliers.

Deputy Kate O'Connell: Getting the drug to treat hepatitis was a phenomenal achievement but I compare it with cervical cancer. Australia is heading towards eradicating cervical cancer within ten years. This started in 2004 and we are now in 2018. While the HSE has made good steps, it has been with the low-hanging fruit and good advances in drug treatment. I do not see the same people being successful in eradicating cervical cancer with this approach. If we only deal with the low-hanging fruit and take the easiest options it will not work. If we do not actually know how many people have it or where they are located, it is as if we are making it up as we go along rather than a serious attempt to eliminate the disease.

Ms Michele Tait: The Deputy mentioned the period between 2004 and 2018 but the big advances in treatment have only happened in the last three years, in Ireland and internationally. The programme was established on the basis that we would begin with the patients who were most sick and in most critical need, as well as those infected through State-contaminated products. I cannot comment on the trajectory as regards cervical treatment but the cost of the hepatitis drugs in the first three years was phenomenal and no rebate arrangements were in place. The programme has now reduced the costs, as other countries have done.

It is difficult to capture the number of patients who have hepatitis C and where they are in

the system, but our data are getting much better and there are far more opportunities for people who are infected to be tested and treated. We will have another ten years of treating patients before we get to the eradication of the disease in the Irish setting but we have done what we have set out to do so far. I agree that eradication will not come about if we just set a target for the number of patients to treat every year.

I am pleased that we are moving into settings other than the hospital setting and we will improve screening, which will give us the opportunity to diagnose more of our population. We will also be able to know who they are so that we can link them to care.

Deputy Kate O'Connell: Why have only ten of the 36 recommendations been taken on board when the drug has been on the market for three years now? The recommendations are not overly complicated and do not ask for too much. Why is there inertia in this area?

Ms Michele Tait: The hepatitis strategy was written some time before the national hepatitis C treatment programme was established and in a period when the availability of, and access to, treatment was poor in Ireland. The development of medications to treat hepatitis C has only happened in the past few years. We did not have access to these treatments at the time the strategy was written. The recommendations, which are in the process of being implemented, are in areas across the entire addiction services, such as in education and prevention, and they have to be implemented in tandem with providing the treatment. The work is ongoing and the full implementation of all the recommendations is a work in progress.

Deputy Kate O'Connell: I understand that and the reason for the issue when the report came out before the drug was licensed, but all the same principles of education and prevention still exist. I do not buy the idea that the report is out-of-date, in the sense that it was published before the drug was available, because one could have layered the treatment on top of the existing content and added it as another page. It seems strange that for something that is costing so much money - I do not know the cost of a hospital admission for somebody who is not treated, but I imagine it is significant - not to treat an individual who will end up in an acute hospital with cirrhosis, liver cancer or whatever complications one might have from untreated hepatitis. It seems great value for money, even if it costs between €15,000 to €20,000 per patient because of the impact of treatment on the patient versus hospitalisation.

Chairman: Mr. Breslin had indicated.

Mr. Jim Breslin: It would be useful for me to clarify the mandate that the people were working to because they have done the work against the mandate. When the €30 million was made available the mandate was to do State infected clients. We have done all that and have achieved a 98% success rate. There was a particular rationale for that decision because these people were infected by the negligence of the State and the State owed an extra responsibility to them to get this new drug to them in the first instance. That was the decision at the time.

The second element was based on clinical prioritisation to move beyond that group into the general population, so the priority was to give the drug to those who were sickest first. This was at a time when the drug was at its most expensive level. In fairness people have done that but they have also come back to say that with the drop in the price of the drug they could expand the programme and bring it to the community and mobilise the community to get more and more people involved, which is exactly what Deputy O'Connell is arguing for and where we are now and where we need to be to get to 2026.

Deputy Kate O'Connell: Do we need an updated strategy? Do we get rid of the current strategy?

Mr. Jim Breslin: It is a very different situation now as one is going to an individual and telling him or her that we have an effective treatment that he or she will be able to get through the treatment in a time limited period-----

Deputy Kate O'Connell: Three months.

Mr. Jim Breslin: -----without major side effects. In terms of the people Professor McCormick referenced, the strategy is now completely different from where we were before. That will be part of the programme's roll-out and we will be trying to do that in a way that will get people to mobilise and come on board with the treatment. The indicators from the pilot schemes that have been done in the community setting show this is really successful.

Chairman: Deputy Cullinane has 15 minutes.

Deputy David Cullinane: Go raibh maith agat a Chathaorligh. May I start by stating that the Committee of Public Accounts is not a court, there are no kangaroos here so Mr. Breslin and Mr. Connaghan can rest easy?

How many cases are outstanding to be heard by the Hepatitis C Compensation Tribunal?

Mr. Jim Breslin: I do not have the figures in front of me, but I believe it is of the order of 456. There may be additional cases. For example, if a person dies, the dependant can enter a claim at that stage. It is a moving position but as of today, it is 455.

Deputy David Cullinane: Would it be fair to say that in most of the remaining cases, the adults would have been infected when they were children? Of the profile of the 455 individuals, would it be fair to say that most of these adults were infected when they were children?

Mr. Jim Breslin: It is a combination. Now most of the claims are from the dependants of an individual who was infected. The next category are people who have lost their carer or a consort as a result of their death. Of that figure of 455 individuals there are only 75 primary claimants remaining. The Deputy's question is then whether the majority of these 75 individuals are mostly younger people.

Deputy David Cullinane: Would they be mostly young men?

Mr. Jim Breslin: I do not know.

Deputy David Cullinane: Would Ms Tait know?

Ms Michele Tait: Part of the response to the State infecting patients was to establish a database of State infected patients. The individuals had to consent to their clinical data being used in a research-type database. The data is anonymised and it tracks the disease progression. We capture data such as age, gender and other conditions that they live with as well. I think somewhere between 75% to 78% of patients have consented to their data going into the database. The average age of patients who have consented to the database is 68 years of age and predominately there are more females than males because of the anti-D administration. We publish reports and we have a report that we will publish before the end of this year that details the clinical position of those patients. There are also demographics relating to age and the route of infection would be part of the data we collect.

Deputy David Cullinane: At this point, may I commend Dr. Brian O'Mahony, the chief executive of the Irish Haemophilia Society? I know he has worked with Mr. Breslin and the HSE. The Irish Haemophilia Society has done major work for the people who suffered as a consequence of this medical negligence scandal. I spoke to a number of people who have been through the process and have been compensated, which is the reason I am concerned about those who are still going through the process. It can be complex and difficult to determine a liability because one has to determine loss of earnings, whether there was a loss in terms of a career path. Is that still an issue and part of the complexities of arriving at a settlement for an individual?

Mr. Jim Breslin: Yes, but that is very much done by the tribunal based on individual circumstances. I know I am taking up the Deputy's time, but may I agree with his comments on Dr. Brian O'Mahony and the Irish Haemophilia Society and the hepatitis C communities. A key learning from this case come from an absolutely horrendous place for the country and for the groups affected. We have managed to work with them on the redesign of services, with patients at the heart of them. I refer to the National Haemophilia Council. I first worked with Dr. Brian O'Mahony on the product selection group, where the haemophilia community discusses the procurement process to procure the blood products that are used in Ireland and mostly used by the haemophilia community. That tells the committee members the ownership that they have of this issue. There is a learning for us in all of what we have been through over recent months as to how we involve patients in the work of the health service as a core partner in its service delivery and not after the fact, when things go wrong. We have to do that too, obviously.

Deputy David Cullinane: I thank Mr. Breslin. His response is appreciated.

I will now deal with the report of the Comptroller and Auditor General, which is primarily why we are here. The insurance scheme is referenced in page 165 and the report notes that the HSE does not have a current estimate of future expenditure to be incurred on the scheme. Why is there no estimate?

Ms Michele Tait: Originally, when the hepatitis C insurance scheme was established, the expected cost was in the region of €90 million. That figure of €90 million was based on an evaluation that was done at that time by the then Department of Health and Children. The expenditure on the insurance scheme to date has been around €9 million in the ten or 12 years since it has been established. We do not expect that the costs will be €90 million over the duration of the scheme. We do not have a current estimate of what we think it might be, but we do not believe it will be €90 million.

Deputy David Cullinane: May I interrupt Ms Tait? The Comptroller and Auditor General referred to this in his report. Is he simply noting that there is no current estimate of the cost or is he saying that is a difficulty?

Mr. Seamus McCarthy: The point was made that the figure may not be as high as €90 million but that no figure was expressed.

Deputy David Cullinane: There was no learning from the figure being unavailable. Was Mr. McCarthy noting that there was no estimated cost?

Mr. Seamus McCarthy: Exactly.

Deputy David Cullinane: The report of the Comptroller and Auditor General states that in 2012 the HSE estimates that between 20,000 and 30,000 people were infected by hepatitis C

with around 10,000 individuals living with chronic infection at the end of 2009. Those figures were from nine years ago. Does the HSE have up-to-date figures? Are the figures much the same or have they changed?

Professor Aiden McCormick: The graph at figure 15.3 shows that 1,234 cases were reported in 2011 and that 874 were reported in 2012. That is when it changed from antibody and PCR positive patients to just PCR positive patients. We have made estimate in respect of the positive viraemic patients on the basis of data from the drug treatment centres and the hospitals. We think the figure is 20,000. However, the trouble is that there are unknowns involved and one will not know what is the exact figure until one gets to the end. As stated, we estimate that it is 20,000.

Deputy David Cullinane: Professor McCormick mentioned the modelling study. Was that Europe-wide?

Professor Aiden McCormick: No. This modelling study is us. It is just on the basis of our data.

Deputy David Cullinane: It estimated that 29,500 people were affected.

Professor Aiden McCormick: No, 20,000.

Deputy David Cullinane: No. I am referring to the modelling study. I am looking on page 167 of the-----

Professor Aiden McCormick: That is an international study. Our study, based on our data, shows the number to be 20,000.

Deputy David Cullinane: Therefore, there were two modelling studies.

Professor Aiden McCormick: There was no other modelling study based on our data. There are assumptions - the assumption based on some UK data is that 50% of the people are undiagnosed. They just take the figure of 15,000 reported to the HPSC and double it. We do not believe that figure of 50%. The figure of 14,000 is incorrect because-----

Deputy David Cullinane: Professor McCormick might be able to help me with this. Paragraph 15.26 on page 167 of the Comptroller and Auditor General's report states, "A modelling study in hepatitis C prevalence in 2015 carried out for 28 EU countries estimated the number infected with the hepatitis C virus in Ireland at 29,500."

Professor Aiden McCormick: However, that is not a modelling study using individual data. That is just taking published material from across the European Union and saying, "This is what it is in this country and that is what it is in that country." It is not using our individual data. The study that is published is the one on European epidemiology produced by Dr. Garvey from the HPSC in 2017. That is the most up-to-date one on the basis of virus reference laboratory data. That gives almost exactly the same figure we have come up with. I think it was 20,200 or something.

Deputy David Cullinane: How did the modelling study work? Is that an estimate?

Professor Aiden McCormick: The modelling study in the virus reference laboratory was done on the basis that they took blood samples which had been sent for various studies, but not for hepatitis C, and then tested them on an anonymised basis. So they had thousands of samples

to try and figure out who were the undiagnosed proportion in the country, and using that with the people who have actually been reported giving an estimate in a country. Their figure was 20,000. Our internal figure is 20,000. We think 30,000 is an overestimate.

Deputy David Cullinane: Reference to under-diagnosis and the national screening guideline for hepatitis C is made on page 168 of the Comptroller and Auditor General report. It stated that no national guidance for healthcare providers was developed. Is that still the case?

Ms Michele Tait: No, I do not believe it is. The national screening guideline that the HSE published in 2017 sets out a process whereby anybody who works in any part of the health service and beyond - within the prison service, for example - works to a set of guidelines under which patients are identified on a risk basis and are tested for hepatitis C based on risk. The screening guideline sets out the criteria where patients who may be at risk or who may be identified as having previously been at risk are recommended to be tested for hepatitis C. So there is a national guidance in the form of our national screening guideline that we have produced and published since 2017.

Deputy David Cullinane: The Comptroller and Auditor General might be able to help me with what is meant. Paragraph 15.29 states:

> With regard to reducing under-diagnosis, the HSE in collaboration with the Department of Health published the *National Screening Guideline for Hepatitis C* in 2017. The guidelines acknowledged that while screening for hepatitis C had been ongoing in many settings, national guidance for healthcare providers had not been developed.

I am trying to understand what that means.

Mr. Seamus McCarthy: I would need to go back to source in respect of that. I think this has been in the report. We would have looked for confirmation from the HSE that that was correct.

Deputy David Cullinane: There is a contradiction here between the response Ms Tait has given and what the Comptroller and Auditor General has reported. Either national guidelines were in place for healthcare providers or they were not. It is either a factual observation by the Comptroller and Auditor General or it is wrong.

Ms Michele Tait: It was an observation at the time. The audit was conducted over the period to the end of 2017. At that stage and for quite a significant amount of time prior to us publishing a national screening guideline on hepatitis C, while we had a lot of hepatitis C screening taking place, we did not have a national guideline. The point that is being made in the chapter is that we did not have a national approach to screening, though screening was taking place. Now we do have a national guideline for screening in the form of a screening guideline that was published in 2017.

Deputy David Cullinane: I ask Ms Tait to supply a note on that. The Comptroller and Auditor General may be able to follow up on it and if he is satisfied that is the case, then there is a match. I do not see a match. If there is one, that is fine.

Ms Michele Tait: I think the point was that we did not have a screening guideline and now we do.

Mr. Seamus McCarthy: It went on to recommend the putting in place of that.

Deputy David Cullinane: Therefore, it has been put in place.

Ms Michele Tait: The screening guidelines have been published and are in place.

Deputy David Cullinane: Paragraph 15.31 of the Comptroller and Auditor General's report states:

> A strategy document produced by the then Eastern Regional Health Authority in 2004 set out recommendations to enhance prevention, treatment and surveillance of hepatitis C among infected people in the eastern region. The report was never published and an implementation plan was not developed.

Why was it not published?

Ms Michele Tait: I do not know why it was not published, but I know it was used-----

Deputy David Cullinane: Ms Tait does not know why.

Ms Michele Tait: I do not know why it was not published.

Deputy David Cullinane: Does Mr. Connaghan know?

Mr. John Connaghan: No, I do not know for certain.

Ms Michele Tait: What I would say is that it actually formed the basis for the development of a national hepatitis C strategy. The strategy that is referred to is a strategy that was written for the Eastern Regional Health Authority area; so it was confined to that region. I suppose with the move in 2004 for quite a lot of our services moving on to a national basis, that strategy was then developed into a national strategy.

Deputy David Cullinane: I understand that. It was for one region of the country. However, it was a report that was done. The Comptroller and Auditor General has compiled a special report and he notes and observes a number of issues, one of which is that this report was compiled in 2004 but was never published and no implementation followed. It is an obvious question that was going to be asked. We are following through on his observations. Why was it not published? If Ms Tait cannot answer, surely somebody else, perhaps Mr. Breslin, can do so.

Mr. Jim Breslin: I think Ms Tait's answer is probably the best there is. That organisation was wound up and became part of the HSE. People's responsibilities then moved into national responsibilities. Rather than implementing something in one region, which should be implemented nationally, it then formed the basis of a national approach and a national strategy.

Deputy David Cullinane: That helps us as members of the committee and is a reasonable response. Why is that not in this report? When the Comptroller and Auditor General completes his report, does it go to the HSE for comment?

Mr. Seamus McCarthy: It does, yes.

Deputy David Cullinane: I do not see that response in this.

Mr. Jim Breslin: I think the footnote is indicative of what was happening organisationally at the time.

Deputy David Cullinane: However, the footnote does not explain it. It just states that the

Eastern Regional Health Authority was subsumed. There is a clear observation that a report was done but never published and there was no implementation plan. There were going to be obvious questions as to why it was not done.

Mr. Jim Breslin: Both things are correct. I am not taking issue with the Comptroller and Auditor General's right. A piece of work was done; it was not published and an implementation plan was not drawn up. If people had stayed in place within that organisation I am sure they would have, but when they took on roles in the new national body-----

Deputy David Cullinane: My quarrel is not with Mr. Breslin or even with the Comptroller and Auditor General. I am just saying it would have been more helpful if that had been incorporated into the report. We would have been in a better position to understand that.

Mr. Seamus McCarthy: I produced the report so I need to address that. I think what we were trying to do in this part of the report was to give an overview of how the service had developed and that to a certain extent there was stopping and starting for whatever reason. If one looks at the diagram, there was the Eastern Regional Health Authority report in 2004. The next significant development in terms of a strategy was in 2012. Obviously, there were many reasons that there might have been delays including structural reasons. Probably that is not the only one. I would imagine that other priorities, perhaps, got in the way as the HSE was developing national strategies across many fronts.

Deputy David Cullinane: I have another question. I am nearly finished. The Comptroller and Auditor General makes a number of observations on the national hepatitis C strategy from 2011 to 2014. The first is that there were 34-----

Mr. Seamus McCarthy: It was 36.

Deputy David Cullinane: There were 36 recommendations and some of them have not been implemented. Mr. McCarthy says that the strategy did not set target outputs in terms of overall treatment numbers. I always look to targets being set to ensure we have a sense of what the output will be and we can measure progress. Is that his observation?

Mr. Seamus McCarthy: Yes, that was my concern there.

Deputy David Cullinane: Was that considered then?

Mr. Seamus McCarthy: We would be looking for quantifiable things whereby one could determine the extent to which progress had been made in implementation.

Deputy David Cullinane: Did Mr. McCarthy see that as a weakness in the strategy?

Mr. Seamus McCarthy: Yes. Where it is possible to set a meaningful quantifiable target it should be done.

Deputy David Cullinane: Could that be addressed? First, why was that quantifiable target not made? Second, how many of the 36 recommendations have been implemented? Did Mr. McCarthy deal with that? How many were not implemented?

Mr. Seamus McCarthy: Yes. In the diagram on the screen one can see that one was not implemented at all and then there was partial implementation of the others.

Deputy David Cullinane: Okay.

Chairman: The Deputy will have a second opportunity. Deputy Catherine Murphy is next.

Deputy David Cullinane: The questions were not answered. One was about why there were no targets and the second was about why the recommendations have not been fully implemented.

Deputy Kate O'Connell: I asked that question too and it was not answered.

Mr. John Connaghan: Okay, we can deal with the one that has not been implemented and then have a comment on how far along we are on the amber category, which is partially implemented. Can Professor McCormick deal with the one that is-----

Deputy David Cullinane: Can the witness deal with the absence of setting target outputs as well?

Mr. John Connaghan: We will deal with both. The Deputy might want to relate the answer to that question to where we are with the current model which gives us a better platform to consider the future demand.

Professor Aiden McCormick: There is a difference between an accountant's approach to this and a clinician's approach. Our approach is to treat everybody we can who is in the clinic. That is what we told the institutions. By the end of this year, 1,700 will have been treated. Hopefully it will be more but it will probably be 1,700. There are approximately 1,000 on the books in the hospital. We are probably going to treat 1,800 to 2,500 next year. If they are not around we have to go out and find them. There is no point in us setting a target of 300 for Beaumont Hospital when it only has 200 patients. Our approach has been to treat as many as we can as quickly as we can and to get to the end. Certainly, we can put targets there, but they will be wrong. Is that a useful thing to do? Clinicians just want to eradicate this as quickly as we can. With a bit of luck, the tools the Department has given us and the fact that we are now implementing Sláintecare where we are moving treatment out of the hospitals into the community I believe we will eradicate this before 2026.

Deputy David Cullinane: I will hold Professor McCormick there because this is important in terms of the work Mr. McCarthy does for us. That appears to be a reasonable response. I assume it was communicated to the Comptroller and Auditor General but it is still stated in the report that there was a weakness. Was it not accepted?

Mr. Seamus McCarthy: I do not think it was put in exactly those terms. For me, it is important that targets are set in strategies and plans, particularly where budgets are involved, so one can establish whether one is hitting them. I accept that there has been better performance. If they had set targets they would probably have set them lower. With regard to the delivery of the programme in 2017, my understanding was that the treatment target was 1,600 but that was not achieved in 2017. Everything has changed. The drug type has changed and the cost has dropped so it is time to reset the target. We do not need to have a disagreement about what is important for clinicians as opposed to for accountants. Both perspectives are valuable.

Chairman: Is this a demand-led scheme?

Mr. Jim Breslin: It is at this stage.

Chairman: I understand both points but it is probably difficult to set a target. It is like setting a target for the number of illness benefit claims that will arise next year.

Mr. Jim Breslin: It is probably even a step further from a demand led scheme. One has to create the demand, whereas in many schemes people will apply. The issue here is that we must get out in the community, tell people about it and create awareness that we have a treatment. In doing that we will get more people into the programme. I believe it is possible to construct a middle ground between the two perspectives. The thing is to continually review the targets. This is changing so much so quickly we could set a target that turned out to be under-ambitious and then only meet that target.

Mr. Seamus McCarthy: I do not agree that it is a demand-led service at present. It is budget controlled.

Chairman: One could say capacity and resources.

Mr. Seamus McCarthy: Figure 15.8 shows what happened in 2017. Effectively, the clinicians would appear to have been responding to demand at the beginning of the year but they had to stop in the middle of the year because the budget ran out. There is obviously demand but the critical matter in terms of the control was the budget in 2017.

Deputy David Cullinane: The point is that it is creating demand.

Mr. Jim Breslin: The need is out there and we have to get the people who have a need but do not know it into the scheme. As already stated, we are moving to a stage where we do not have enough people. We have to find them. When I talked about the prioritisation, we had too many people and not enough money. Now we are moving into a new-----

Chairman: Is there enough money to deal with all of the people who have been identified in 2018? I am presuming you are working on the Estimate for next year and that next year will be the same. It will not be like what happened in 2017 when there was a big demand and then a drop.

Mr. Jim Breslin: As Professor McCormick explained, the job next year will be to find more people. If we are successful we might find many more people. The challenge is that we have a list of people and there is capacity to treat more than is on that list. We must find more people to treat.

Chairman: What is the budget for next year?

Mr. Jim Breslin: It is €30 million.

Chairman: What is it for this year?

Mr. Jim Breslin: Also €30 million.

Chairman: What was it for last year?

Mr. Jim Breslin: It was a straight €30 million from the start.

Chairman: Mr. Breslin is stating that the programme is over the hump in terms of numbers. The €30 million was not enough for last year based on the Comptroller and Auditor General's chart but Mr. Breslin is stating that it is enough for this year and next year.

Mr. Jim Breslin: Yes. Two things have happened - the price has come down and we are getting through the backlog of people we already know about.

Chairman: More people can be treated because of the reduced price. We are getting there. That was a useful exchange. Deputy Catherine Murphy can proceed.

Deputy Catherine Murphy: I remember this well because I was one of the people who got the anti-D and was screened in the 1990s. It was a similar crisis to the one we have had with CervicalCheck. People were very scared. I was one of the lucky ones who got a negative result but some of my contemporaries got positive results and the prognosis was awful at the time. There was worry about contamination. Some people were infected in the late 1970s and would have subsequently had more children. They were worried about the children being infected, as well as partners and husbands. It was a crisis at the time. I remember it well because when something affects one personally one does not forget it. When one looked at others who were not as lucky and got a positive result to the test one could see the challenges they faced with fatigue and so forth. The changes as a result of the drug advances are incredibly important from that point of view because it is an awful infection if one does not have the ability to manage it. We have the drug and there are people in that position. Deputy O'Connell made the point that a person will have to be managed in a hospital if the infection is not managed. There is a quantum in that regard if permanent damage is done so one must consider it in terms of how efficient it is to manage this by way of not trying to row back on damage that is already done.

A few things jumped out from the opening statement by Mr. Breslin regarding the people who were infected through the infected blood in the 1970s and 1990s. Obviously, the crisis resulted from infected anti-D serum being administered in transfusions. Haemophiliacs were a particularly badly affected group. The statement notes that some 1,700 people in Ireland were infected, but further on it states that the tribunal had been hearing claims continually since 1996 and made 3,569 awards. What is the reason for the different figures?

Mr. Jim Breslin: A person can be the subject of more than one claim. He or she could have an individual claim which is paid on a provisional basis and subsequently re-enter a claim. The person's dependants could also enter a claim.

Deputy Catherine Murphy: Is a profile available in that regard detailing the rate of infection, family members and so on?

Mr. Jim Breslin: We have a profile distinguishing between primary claimants and others which we can provide that to the committee.

Deputy Catherine Murphy: It would be useful.

Mr. Jim Breslin: In the light of what the Deputy stated and what she went through, it might be of interest to her to know that 16,200 women were given anti-D. Those women were tested and it was found that 1,000 of them had hepatitis C. That was the scale of the issue.

Chairman: I ask Mr. Breslin to go through that again for the non-medics present.

Mr. Jim Breslin: Some 16,200 women were given anti-D over the periods where the issue of contamination arose. Those women were screened for hepatitis C and 1,000 of them were found to have hepatitis C.

Deputy Catherine Murphy: On the drugs that are available, is there any difference in their cost here compared to in other European countries?

Ms Michele Tait: The cost varies. Each of the drug companies negotiates different terms

in different countries. We do not have detailed intelligence on that but we have some limited information. Every country, including Ireland, negotiates a commercial and confidence agreement with a percentage rebate based on sales. Every country negotiates a different agreement. The terms we have reached with the commercial companies operating throughout the EU are quite favourable. In contradistinction to where we were a few years ago, we are getting very good value on drugs for hepatitis C. We may be getting the best value for them, or among the best.

Deputy Catherine Murphy: Although a small number of people were infected, even relative to our small population, do we have a higher rate of hepatitis C infection than other countries because of the contamination or did such events also happen elsewhere?

Ms Michele Tait: Contaminated products were used in certain other countries around the world. Ireland is considered to have a low prevalence of hepatitis C. Including the 1,700 people infected through State products, the rate is in line with that in other countries.

Deputy Catherine Murphy: Some €1.18 billion went to awards and legal fees. There must have been some learning from the scandal. Was a post-mortem conducted to identify what was handled well and what was not? We have a habit of creating problems or crises in the healthcare system and elsewhere and then resolving them. It is something of a national pastime. We do not always learn from the experiences of the past. Was a review conducted to consider what would be done differently if such a problem emerged now and what could have been done to avoid the problem?

Mr. Jim Breslin: Absolutely. Two tribunals separate to the compensation tribunal tried to identify the learning from this case and that has informed subsequent approaches. One learning identified is that while the issue is being considered in terms of how it happened and so on, people will have been affected and need supports. Generally in such situations the first response is to tackle the problem from a patient safety perspective. That did not happen in this case. There was contaminated blood in the blood supply and that continued after the service gained knowledge of it. There is an absolute understanding across the health service of the need for immediate intervention to prevent further harm resulting from a patient safety issue which has an ongoing implication. Another learning is that one must look back to see who was potentially affected by the issue. Another is that while legal processes and other things take their course, those affected will require supports and one should work proactively to put such supports in place. We have recently tried to work with and support affected people on an individual basis. That has been done in various circumstances, including in dealing with women who underwent symphisiotomies in Our Lady of Lourdes Hospital, Drogheda, and those affected by CervicalCheck.

Deputy Catherine Murphy: The management of medical negligence is part of this discussion. It is very welcome that learnings have been identified. There would be something wrong if they had not. As I stated at the committee last week and on a couple of occasions in the Dáil, some things have not been learned. That women are still seeking copies of their CervicalCheck slides indicates that the system is still very legalistic and that the affected person seems secondary, at least in regard to getting medical information.

There was a recent article in *The Sunday Times* on genetic testing in Crumlin hospital. The Minister for Health or his Department has initiated a review of 335 positive BRCA genetic tests. Some 3,500 negative tests remain to be reviewed. This goes back to the issue of problems being foreseen or earlier identified. The 2014 Donnai and Newman report initiated by the HSE

showed serious dysfunctionality in this area. However, a review is now being initiated based on claims published in a Sunday newspaper. This appears to be a very serious issue which may be on a par with Cervical Check and the blood contamination scandal. It strikes me that the early identification of issues, as referenced by Mr. Breslin, is not happening. If serious dysfunctionality was identified in 2014, but now in 2018 no root and branch review on how to deal with that has been carried out, a lot remains to be learned. Some recommendations of the report were never implemented, for example. It falls into the same category as many major issues.

Chairman: I ask the Deputy to conclude as we are under time pressure.

Mr. Jim Breslin: The HSE can comment on the report and the recommendations. I know work is under way on that and on international involvement in that service to bring about improvement. On the specific question about the BRCA test, that was identified as a transcription error and the 300 or so positive tests are being worked through, and that will be completed. As of today, no further errors have been identified. That fits with the principle whereby, as I said, if a single issue is identified, we look to find other cases that might be relevant to that and we do a look-back process through those. It is in line with good practice. There is a serious incident team managing this in Crumlin through the children's hospital. Again, even in a situation where something like this has happened and, again, it is truly wrong and tragic in the individual circumstances, the incident management approach is to look beyond the individual circumstances into any wider risk there might be and to do a look-back through that. That is exactly what is being done in this situation. The findings to date are that it is an isolated error.

Deputy Catherine Murphy: Mr. Breslin is saying - absolutely, categorically - that this is a transcription error.

Mr. Jim Breslin: That is what the findings to date are, namely, in this one case it is a transcription error, and so far no other errors have been found in the positive tests that have been reviewed.

Deputy Catherine Murphy: I have a doubt about that and I have a reason to have a doubt about it. In regard to CervicalCheck, what was the learning from the blood contamination issue in regard to CervicalCheck and working with the person who has been the subject of the problem? Why are we still waiting for these women to get their slides?

Mr. John Connaghan: I will start and Dr. Henry may also come in. We have been requested to provide, on a slide-by-slide basis, the history of when that slide was requested, where it was dispatched to and what the turnaround time was. At a previous evidence session, Mr. McCallion intimated that the average turnaround time was 22 days and the maximum was something of the order of 70-plus days. We are in the process of drawing that together and the committee will get that very shortly. It will show the exact timetable requested. However, perhaps the most recent issue at hand is the one about the observance of a protocol that we have. It is a very simple protocol, which simply asks what is the transport method, where is it going and who is going to be responsible for receipt of those slides. Most requesters of the slides through legal representatives have observed that and are happy to do so. We have had an issue with perhaps one or two latterly, and we are seeking to overcome these issues. However, the committee will very shortly get a full report on the timetable associated with this.

Chairman: I will come back to Deputy Catherine Murphy. Time is tight but we will try to squeeze everyone in.

Deputy Jonathan O'Brien: What is the waiting time between the assessment and the beginning of treatment?

Professor Aiden McCormick: For hepatitis C treatment, it depends on the unit but it is very short. We now have the capacity to treat people and we have taken away barriers, so we do not biopsy people any more and we do not have barriers in terms of alcohol use or drug use. Basically, when someone comes into hospital, it is about the ability to turn up for the appointments. If people turn up for two appointments, they can be treated. For most people who come into the system now, treatment starts within two months.

Deputy Jonathan O'Brien: Would that be longer for people outside a hospital setting, for instance, within the prison service?

Professor Aiden McCormick: We are currently trying to expand services within the Prison Service. The difficulty in the Prison Service is blood testing. The prison nurses are not trained in phlebotomy and, for the hepatitis C nurses who go into the Prison Service, it can be very difficult to get access to the patients because the place can be in lockdown or there are no prison officers to bring them up. We have a major difficulty in that regard. There is now up to a six-week delay in some prisons to get a blood test for hepatitis C. We are working to overcome that and we will have a meeting about it with the Irish Prison Service in two weeks' time. Fifty patients have been initiated into treatment for hepatitis C within the prisons so far this year.

Deputy Jonathan O'Brien: When we identify risk groups and, obviously, intravenous drug users are a high-risk group, how are we targeting those individuals? I presume it is through drug addiction centres but very few intravenous drug users will get to the stage where they are in addiction centres, and some will end up in prison. Therefore, there is a cohort of people who may not engage with services. Are we actively trying to target that group and, if so, how are we doing it and what methods are we using?

Professor Aiden McCormick: The Deputy is right. Ireland is pretty good in terms of opiate substitution therapy, OST, and recent data from across Europe suggest that some 54% of people with active opiate use in Ireland are undergoing OST, which is higher than in most European countries. However, it is very difficult to target the people who are not in opiate substitution, not in hostels and not in prison, and we are trying to target those three areas. Outside of those areas it is very difficult. One could go on the soup run with the Simon Community as a possibility but it is difficult if people are not somehow linked in with therapy. The advantage of opiate substitution is that people will come for their methadone but, if they are chaotic and will not do that, how are we going to treat them with antiviral therapy for eight weeks or 12 weeks? It is very expensive medication and if they take it for a few days and then stop it for a week, there will be resistance and we will not be able to treat them subsequently. The Deputy is right. It is very difficult to see how we are going to get to this very hard-to-reach community when we do not have a good idea of it.

Deputy Jonathan O'Brien: I want to stay on this area. If an intravenous drug user is diagnosed with hepatitis C, and Professor McCormick said we are waiting about two months to begin treatment-----

Professor Aiden McCormick: In the hospital setting.

Deputy Jonathan O'Brien: Yes. What is the issue? I know, not from personal experience but from family experience, that those individuals share needles. How prevalent is that and

how are we trying to address the issue? We have the needle exchange programme running in 120 or 130 pharmacies throughout the State. Although Professor McCormick cannot comment on policy, one of the policy areas that could really bring benefit in this area is in regard to safe injecting centres, which are being proposed for Dublin as a pilot project. While I will not ask him to comment on the policy, I would ask him to share his experience of the international experience of how safe injecting centres can form part of the overall health policy on preventing hepatitis C, particularly for intravenous drug users who are sharing needles.

Professor Aiden McCormick: I think it is fantastic and is the way to go. It is safer for the drug users and safer for the community, certainly if people are using clean needles. I would go further and say that one should give these people the opiates rather than having them buy them on the streets and giving the money to criminals, but that is a different area. If they are in the injecting centres, we have access to them and can go and talk to them and treat them.

Deputy Jonathan O'Brien: Screen them.

Professor Aiden McCormick: Screen them and treat them. These people are the ones who are maintaining the epidemic. We want to get to the people who are chaotic and sharing needles, and treat them to prevent further infections. I think it is an excellent idea.

Chairman: Professor McCormick is speaking personally.

Professor Aiden McCormick: Yes, personally.

Chairman: I do not want to stray into the area of policy. It is a valid point but it is a personal opinion.

Mr. Jim Breslin: I will make a point on the policy position, although I will not go into the issue of the dispensing of the drug. The supervising injecting rooms are policy and the pilot is well advanced. There are 90 drug consumption rooms operating around the world. We have looked at them. Undoubtedly, there is a reduction in blood-borne transmission of diseases in them. It also presents an opportunity to get a public health message across to people, including those who have hepatitis C, about how they could deal with it. It is one of the core rationales for using supervised injection facilities.

Deputy Jonathan O'Brien: I want to highlight it because when we talk about safe injecting centres, which I fully support and would like to see rolled out beyond Dublin, we talk about fatalities and how, internationally, there has never been a fatality in a safe injecting centre. There are other health benefits such as preventing hepatitis C from spreading. I want to put that on the record.

My understanding is there is almost a screening process within the Prison Service when it comes to hepatitis C. Although it is not a statutory screening process, it is as good as one. Is it based on voluntary buy-in by prisoners? Is it, in effect, a screening process within the prison service?

Professor Aiden McCormick: I have not worked in the screening service. What I am told by the nurses who work there and by the Irish Prison Service is that prisoners are offered the option for testing but they have to accept it. It is a civil liberties issue. Getting the blood sample is the problem with that. There have been studies done using saliva or blood spot but getting a blood sample is the way to go.

Deputy Jonathan O'Brien: I have two more brief questions. In cases where a diagnosis has been made, do we have figures for how many people contracted hepatitis C outside the State? I am talking about the immigrant population who may be seeking asylum here or in direct provision who we know have hepatitis C. Do we look at that to try to identify potential risk groups?

Professor Aiden McCormick: We have done estimates using the census figures and international figures in drug prevalence in the various countries the immigrant population comes from. The net figure I came up with was 392 migrants with hepatitis C viremia per year because a lot of migrants come and go. We estimate the net figure is probably about 400 a year.

Deputy Jonathan O'Brien: Do we treat-----

Professor Aiden McCormick: The thing is, when we are talking about migrants, we are talking about people coming from Poland and Romania, for example. They are not known to the health service. They come here and work. If we are talking about migrants who go to the migrant reception centres-----

Deputy Jonathan O'Brien: Direct provision centres.

Professor Aiden McCormick: -----they are offered checking.

Ms Michele Tait: There is a report that has recently been published. We can send it to the committee. The Health Protection Surveillance Centre, HPSC, has just produced it. It looks at the diagnosis of hepatitis C in 2017 in Ireland and gives a breakdown that includes the country of birth because that is recorded for anybody who has a positive diagnosis. We can send a copy of it to the committee. It was published in the last week or so.

Deputy Jonathan O'Brien: If I can-----

Chairman: We have a copy in our briefing notes.

Deputy Jonathan O'Brien: Okay. I obviously did not do my homework.

I will turn to the Comptroller and Auditor General's report. I am not being critical in any way. I am being genuine because I have an interest in the area. In terms of the amber recommendations - there is only one red one, which is positive - which are only partially implemented, most are in the education area. Many concern the provision of resources for addiction centres and residential beds. If we look at the past number of years, we have been through a really tough time economically and have not seen a significant increase in the number of treatment centres. We have seen a bit of an increase in terms of residential beds mainly from the private sector. One issue I keep raising is the adolescent scene; we only have four residential beds for adolescents in the State. Could Mr. Breslin give us a brief comment on where we are in terms of the education recommendations? Are we confident that any of the amber recommendations will turn to green in the next 12, 24 or 36 months? What partnership is there with the HSE on treatment and addiction centres?

Mr. Jim Breslin: I will not talk about all the hepatitis C ones. Some of them are specific to hepatitis C. With regard to the drugs and addiction service and the role it has to play, we have produced the new national drugs strategy, Reducing Harm, Supporting Recovery. We have refreshed the governance and interdepartmental involvement in it. All of the relevant Departments and agencies meet. It is chaired by the Minister of State. Much inter-agency work is

under way. The allocation of resources has started in line with that strategy. I am not here to make a case that we have completed it. We have started it. In 2018, €9 million was made available for a range of initiatives including the supervised injecting room and for addiction services for under 18s. The Deputy spoke about treatment places and beds but it also is about getting people into communities to work on a multidisciplinary basis with children who have addiction and putting in place young people's counsellors, clinical nurse specialists and so on. We have a range of initiatives under way. We could supply details to the committee. They play into making services more accessible but also into prevention and harm reduction. Much of what we are talking about here is harm reduction in order that people who are engaged in a harmful activity understand the implications. We work with them to try to limit it and to try to get them away from behaviour that is harmful to them. That is the core of the national drugs strategy.

Deputy Jonathan O'Brien: I have 30 seconds so I will finish on this. The community provision of services, particularly post release from prison where somebody may have gone through an addiction programme, or from an addiction centre is on a voluntary basis. We give people information on where and how to engage with community-based services. Do we have a register of, or statistics on, the people who engage with those services? Do we have statistics on the people who disengage from the services following an addiction programme? Do we have statistics on how many people relapse in both settings? What is the relapse rate for people who disengage from the service and for people who engage with the service? That kind of information is good information for drug users in particular. When people come out of addiction, those who disengage from the services are far more likely to relapse than those who do not. That is a message we need to be pushing out to that particular community.

Mr. Jim Breslin: It is not an easy area in which to establish reliable information. The Health Research Board, which conduct a drug prevalence study, goes to great lengths because we are trying to establish rates of illicit use. If we just ask people in a shopping centre, they are not going to tell us the answer. A lot of methodology was put behind that in the prevalence study. I do not have them to hand but we can supply them to the Deputy. The biggest drugs that come through that study do not involve the use of needles; they are cannabis, cocaine and so on. We can try to extract out of that relevant information the Deputy might be interested in and supply it to him.

Deputy Jonathan O'Brien: Or we could just legalise it.

Mr. Jim Breslin: There are people making points here, which, as Secretary General of the Department of Health, I am not endorsing in any way.

Deputy Jonathan O'Brien: That was a personal comment. I did not make it on behalf of the Committee of Public Accounts.

Chairman: We are getting interesting personal comments from witnesses and members today.

Deputy Catherine Connolly: Gabhaim buíochas leis na haíonna. Bhí sibh thar a bheith ionraic agus díreach agus thug sibh freagraí.

It is refreshing to have such comprehensive information provided in an open manner. I thank the witnesses for that. Mr. Breslin's comment that the people affected by the State in particular are coming from a horrendous place. That must be borne in mind. The image of the McCole family and a certain Minister at that time will stay in my mind forever.

I welcome Professor McCormick's opening contribution. He said he expects we will meet our target well before 2026. On what is this expectation based?

Professor Aiden McCormick: I hope that we will meet our target before then as we are ramping up. The community treatment programmes that we have established have overperformed rather than underperformed. It is one area of the health service where everyone is trying to help. People are queuing up asking us for access to treatment. We have GPs in Galway, Limerick, Waterford and Cork-----

Deputy Catherine Connolly: That is reassuring but I am looking at a strategy that was set a long time ago. The period of the strategy has passed and the recommendations have not been complied with. At that time, it was recognised that people's lives were chaotic, although I do not like the use of that word. They suffered very chaotic experiences that led them into that. The importance of community was recognised at the start of that strategy. What specific progress has been made in respect of community outreach, given that this was identified back in 2012? There was a pilot project in 2017. Where are we with this? Has it been completed? Have we learned from it? What will we roll out next year?

Professor Aiden McCormick: We have four pilot programmes in the opiate substitution therapy clinics, with one in Dún Laoghaire, one in Castle Street, one in the drug treatment centre and another one that has just started in north Dublin. The therapies are being prescribed and dispensed in the drug treatment centres. They are our community projects. There is also a project in the Mater Hospital where they link with Safetynet. A patient comes to the hospital once and it is then dispensed in the community. There are five community-based projects and one in the Prison Service - in Mountjoy, Wheatfield and another prison. We are trying to ramp up all of these and we are also trying to establish a service in Limerick. We have difficulties in engaging with University Hospital Limerick because it has many challenges, but we are trying to establish a treatment programme in the drug treatment service directly in Limerick and, if necessary, to send a hepatologist down once weekly to see these patients. We are getting mobile fibre scans which will allow us to go out in the community.

Deputy Catherine Connolly: Has the programme analysed communities across Ireland to determine which ones are priorities. Professor McCormick mentioned Dublin.

Professor Aiden McCormick: I mentioned Dublin, Limerick and Galway. However, there is a hole in the midlands and another in the south east and we are trying to fill those.

Deputy Catherine Connolly: From what data or research is the project working? What will be rolled out?

Ms Michele Tait: When the pilot sites were set up it was the first time we had brought hepatitis C treatment outside of hospitals.

Deputy Catherine Connolly: When was that?

Ms Michele Tait: That was in 2017.

Deputy Catherine Connolly: It took some time from the date the strategy was published to roll out a community programme.

Ms Michele Tait: There were patients getting the older treatments. The treatment programme has been using the new directly acting antivirals, with the new curative treatment that

has been up and running since 2015. Prior to that, an older treatment was available mostly through the hospital setting. Very few patients went on that treatment but some did get that treatment in drug treatment centres. One or two programmes were running but they had very small numbers of patients and the outcomes for those patients were not great. It was not a good course of treatment. The pilots for the new, recent curative treatments for hepatitis C were set up to look at the feasibility, accessibility, sustainability and safety of using those treatments in that setting. In the first 15 or 16 months of those pilot programmes, where we have commenced approximately 150 patients, we have learned that it is safe, feasible and acceptable to the people who work in those clinics and their patients and also that the outcomes are the same if not better than for patients in a hospital setting.

Deputy Catherine Connolly: I accept that. This has been going from 2017 and the policy was obviously to treat the sickest people first. However, that did not happen because, as has been pointed out, the budget ran out and, from what I am reading, it was suddenly suspended.

Professor Aiden McCormick: No, the sickest patients were treated first but many other patients were also treated.

Deputy Catherine Connolly: I understood that when the budget ran out the programme was suspended.

Professor Aiden McCormick: It was paused for new patients for about six or eight weeks. Patients who were on treatment continued on treatment.

Deputy Catherine Connolly: Therefore, new patients who may have been chronically ill were not getting treatment during the period the programme was suspended.

Professor Aiden McCormick: Exactly. We did an exercise at that stage to look-----

Deputy Catherine Connolly: No, that happened and that is acknowledged. For a crucial period, people who were very ill, new patients, were not getting treatment because of the budget problems. We now have a new problem now. Professor McCormick is saying that we have plenty of money, which is good, and that he hopes the programme will reach its target well before 2026, which is excellent. However, I am not hearing the evidence for this. Perhaps he will come back to the committee and explain what is being rolled out. The news is very welcome but on what is it based?

Professor Aiden McCormick: We are basing it on the opiate substitution therapy figures for where the people who are on methadone are. We reckon that is where the patients who have hepatitis C are distributed around the country. We have reasonably good data on that. We will roll that out through the big opiate substitution therapy clinics that have a pharmacy on site and then secondarily into the community pharmacies. That is how we are basing our figures for how to spread it out.

Deputy Catherine Connolly: The witnesses' openness is very welcome. If such openness had been shown years ago, we would not be in the position where €54 million and rising has been spent on the area. I do not want to exaggerate the cost of the Finlay and Lindsay tribunals but the figure was high enough. The tribunals cost €47 million and there is also the cost of the compensation for all the heartbreak and the terrible implications of what happened. It amounted to €1.5 billion. According to the document provided, everyone who was infected as a consequence of the State's responsibility was to receive care by 2017. Why was that year chosen?

Mr. Jim Breslin: Initially, the programme was set up in 2015. There had to be a set-up of the programme with a call of people into the programme. People had to come into the programme and take the treatment.

Deputy Catherine Connolly: These were the 1,700 people who were identified as having been infected through State action.

Mr. Jim Breslin: Yes, but that would have involved engagement with their consultants, talking to them about the programme and bringing them on board. It was never envisaged that this could happen over weeks, but would take-----

Deputy Catherine Connolly: This goes back to the 1990s. I am sorry, I am mixed up.

Mr. Jim Breslin: The drug that we are talking about is 2015 and it is a game changer.

Deputy Catherine Connolly: It is a specific drug. They had been under treatment prior to that.

Mr. Jim Breslin: Other drugs before that did not have the same outcomes and they had many more side effects.

Deputy Catherine Connolly: I understand. Hepatitis C has been a notifiable disease since 2004. Two things happened that year. A register was established of those infected as a result of the State and a separate register was established in relation to notifiable diseases. Have these two registers been merged?

Ms Michele Tait: No. The 2004 legislation requires all diagnoses of hepatitis C to be notified, that is, any diagnosis that takes place. On the database to which I referred earlier, which related to State-infected patients, it was recommended that a clinical database to measure their progression through their disease would be established. This is based on the patient's consent.

Deputy Catherine Connolly: I saw that, and there is an uptake of around 80%.

Ms Michele Tait: Yes. There may be patients who are part of that group of State-infected patients who have also been notified to the infectious diseases register, but they are not linked. Incidentally, that register is managed by the Health Protection Surveillance Centre, which collates the notifications from departments of public health. It also manages the database of State-infected patients and produces reports.

Deputy Catherine Connolly: The Comptroller and Auditor General made three recommendations. The HSE accepted them save for one relating to the setting up of a national register, citing data protection issues. Where is the HSE on that recommendation and its related actions?

Ms Michele Tait: The recommendation was on linking the notifiable disease notifications of hepatitis C to the treatment registry, which is a separate entity of the HSE's that tracks any patient who has been prescribed the new drugs. This would link the notification of a patient's diagnosis to the patient's treatment. Those data are not linked currently, but we are considering how such linkages may be developed.

Deputy Catherine Connolly: Was the recommendation in the Comptroller and Auditor General's report reasonable or unreasonable? Is it doable and, if so, when will it-----

Ms Michele Tait: An information interface that brought people from the point of diagnosis and linked them with treatment would greatly assist us. It is part of the bigger picture. There are other considerations to do with surveillance, screening and testing.

Deputy Catherine Connolly: I have read that and I understand those considerations, but when does the HSE see itself overcoming them and what steps is it taking? Is there a process in place to achieve it?

Ms Michele Tait: We have had that recommendation for a couple of months. We are examining it with our colleagues in the department of public health.

Deputy Catherine Connolly: I have one last question.

Mr. John Connaghan: May I say something? I spoke to our head of public health on this recommendation fairly recently. I have asked him to examine it with a reasonable degree of urgency. I expect a report in the early part of 2019 on how we can implement this and what the barriers are. When I say "the early part of 2019", I mean within the first quarter of the year.

Deputy Catherine Connolly: My final question has two completely different parts. One will be for Mr. Connaghan. According to the Comptroller and Auditor General's report, there will be an updated report by the end of the year, as the last update in the database only took us to 2013. Is that on time?

Ms Michele Tait: It is. We will have that before the end of this year.

Deputy Catherine Connolly: That will be published before the end of the year.

Ms Michele Tait: Yes.

Deputy Catherine Connolly: I have a general question on learning. We have gone to great effort and people's lives have been affected. Generally, we sit here every week and try to prevent events from happening and to get our heads around liability. Everyone has a right to go to court, but various incidents lead up to such situations. Coincidentally, we were to discuss and learn from the report on Portiuncula Hospital, Ballinasloe, that was published this year, but I understand that it has been adjourned to another day. What jumped out were the failures to learn and the opportunities to learn that were repeatedly missed. The lack of staff also put them under tremendous pressure.

Is tuberculosis a notifiable disease?

Ms Michele Tait: Yes.

Deputy Catherine Connolly: I am being specific and parochial, but this has major implications for learning. If there is a notifiable disease in Galway, as I have been informed, and staff contract it, and if I then ask a question about it, I will be told that a review will be carried out in the future. I have read the opening statements from Mr. Connaghan and the Department. When an event happens, it should be a case of stopping immediately, protecting people, learning from it and carrying out a review. However, the answer to me is that a review will be carried out. We are now in November, but the event in question happened months ago.

I asked what reviews generally have been carried out in Galway. I made the question simple by only referring to external reviews. What was the cost of those reviews and who carried them out over the past ten years? Extraordinarily, I was told that the HSE did not have that informa-

tion. Following a search for the information I had requested, I was told that the HSE did not have a system to record the number and cost of all external reviews or investigations of patient care at University Hospital Galway. I do not expect Mr. Connaghan to have an answer for me now. I am just drawing his attention to this. There is no database of reviews or their cost even though the matters in question lead to litigation. Regarding my question on a notifiable disease, here we are about to have another review. If Mr. Connaghan could comment, I would appreciate it. If he does not have the details, that is fine.

Mr. John Connaghan: I will make a general comment and follow it up with something more specific. The Deputy's points about prevention rather than cure are enormously important. I started my working career in a quality control department at a point in time when the fashion was to inspect the product as it came off the end of the line and, if found to be defective or the like, reject it.

Deputy Catherine Connolly: We know that. We have sat here every single week. Please, address my specific questions.

Mr. John Connaghan: Prevention must be at the top of our agenda. I need to send the committee something on what we have introduced in 2018 as regards our incident management framework. Claims and safety issues arise through the incidents that occur. The questions were on whether we were capturing these and learning from them and what examples we could provide.

Deputy Catherine Connolly: No, I do not want any more documents. I have read so many documents with my colleagues, I cannot go on half the time. I want to know about implementation. I have cited two specific examples where there are large gaps. We are learning retrospectively after a significant cost, including €54 million for two tribunals not to mention all the others. We do not seem to be learning, which is a point that my colleague made.

Mr. John Connaghan: I will give a specific example of where learning has occurred and what the outcome is.

Deputy Catherine Connolly: I would love it if Mr. Connaghan reverted to me about the two examples I raised.

Mr. John Connaghan: I will indeed.

Deputy Catherine Connolly: I have taken all of my time.

Chairman: We are tight for time, as the Dáil's votes will be starting. Did Deputy MacSharry indicate?

Deputy Marc MacSharry: Yes.

Chairman: Deputy O'Connell also wishes a moment.

Deputy Marc MacSharry: I will be as quick as I can. What is the €25 million per year for?

Professor Aiden McCormick: It is €30 million.

Deputy Marc MacSharry: Sorry. Was there not some-----

Mr. Jim Breslin: There are figures of €25 million and €30 million. The €25 million figure relates to compensation tribunal awards.

Deputy Marc MacSharry: It costs €30 million to run the show.

Mr. Jim Breslin: The budget for drug therapy to remove infection is €30 million per year. People who have been infected with hepatitis C and HIV from the blood supply go to the compensation tribunal. On average, the awards amount to just below €25 million per annum.

Deputy Marc MacSharry: What is the cost of the tribunal itself?

Mr. Jim Breslin: It is €1.18 billion.

Deputy Marc MacSharry: That is the total cost, but I am asking about the annual cost. Obviously, there are legal and administration people in place.

Mr. Jim Breslin: Yes. I can give a breakdown of the costs in terms of compensation, legal fees and administrative costs. We have that. This is the report-----

Deputy Marc MacSharry: Over the 20 years, have we streamlined the process? Have we been able to reduce administrative or legal costs or has it been a one-way trajectory upwards?

Mr. Jim Breslin: Both of those are the case. The tribunal operates independently of the Department, so I do not engage with it on trying to reduce its administrative costs, for example.

Deputy Marc MacSharry: Does anyone?

Mr. Jim Breslin: A chair of the tribunal is in place and manages an effective and efficient operation.

Deputy Marc MacSharry: Does anyone have a role in overseeing that and ensuring that everything is-----

Mr. Jim Breslin: We make the payments. I am not trying to avoid the fact that-----

Deputy Marc MacSharry: I understand that, and I get that Mr. Breslin is not responsible.

Mr. Jim Breslin: The tribunal is audited through the-----

Deputy Marc MacSharry: Does the Comptroller and Auditor General have any role in this?

Mr. Seamus McCarthy: I have some. There is a breakdown of the cumulative spend in the accounts of the tribunal.

Deputy Marc MacSharry: I read those, so I will not hold up the meeting by asking the Comptroller and Auditor General to go through them. I am interested in knowing whether the Comptroller and Auditor General audits the tribunal.

Mr. Seamus McCarthy: Yes, and the audit is submitted to the Oireachtas.

Deputy Marc MacSharry: Have the costs increased?

Mr. Seamus McCarthy: No. In the schedule we have given, the costs have decreased.

Deputy Marc MacSharry: They are pretty static. Have they decreased through efficiencies or a diminishing number of claimants?

Mr. Seamus McCarthy: A diminishing scale, I would imagine.

Deputy Marc MacSharry: Have the legal and administrative costs increased or remained static?

Mr. Seamus McCarthy: I do not have that level of detail here.

Mr. Jim Breslin: During the crash, there was a process to try to moderate legal costs. In line with other bodies, the tribunal moved to-----

Deputy Marc MacSharry: Other tribunals' costs decreased a bit, but then certain heads of tribunals asked that they be increased again. Was this tribunal one of those?

Mr. Jim Breslin: I do not believe so.

Deputy Marc MacSharry: Its costs decreased.

Mr. Jim Breslin: Yes.

Deputy Marc MacSharry: There was an agreement that we would cut them all. Individual tribunals were saying that we needed more money and that was acceded to in some instances. Was this an example?

Mr. Jim Breslin: We would have to look at it.

Deputy Marc MacSharry: It would be good practice when something has been going on for so long and will continue. Where are we with the legal spending?

Mr. Jim Breslin: I can give a breakdown of the overall spending in 2017.

Deputy Marc MacSharry: That would be good.

Mr. Jim Breslin: There was €21.8 million in total. Of that, the tribunal awards are €14.6 million but one has to add €3 million for reparation payments since every award gets a 20% top-up as a reparation.

Deputy Marc MacSharry: That means €17 million or €18 million.

Mr. Jim Breslin: There was €3.7 million in legal costs for claimants, with some €242,000 for the fees of the tribunal chair and members with administrative costs of €207,000.

Deputy Marc MacSharry: That does not sound prohibitive, which is fine. I know we were to focus on the HPV vaccine today but while Mr. Connaghan is here, I have a related question. I asked him a few times previously about claims that are settled without admission of liability. We established that there is not a mandatory monitoring or retraining period for the health professionals involved. I asked the SCA officials as well. They seemed to be agnostic about it. We toed and froed a little bit but the bottom line was that there is no process and we depend on the regulatory bodies. The bottom line is that there is nothing. Have any moves been made in that direction?

Mr. John Connaghan: We have given some thought to that. That exchange was four months ago or so. I ask Dr. Henry to address it. Some decisions were made on that recently.

Dr. Colm Henry: Deputy MacSharry is correct that we do not have a dedicated service and the NHS does. It is called the National Clinical Assessment Service, NCAS, and was estab-

lished in recognition of the fact that the approach to regulation is binary. One is referred and either found guilty or not and fit to practise or not. The focus of the NCAS is on remediation and approaches that can be made short of censuring a doctor. That approach in the UK has been successful in re-educating or retraining doctors on whatever deficits are identified and returning them to the delivery system, bearing in mind our significant recruitment difficulties. We have a recent arrangement with the NCAS to use its services regularly for a small number of cases. We are now going to enter a more substantive agreement with the service to allow for a dedicated Irish phone line assessment service and remediation where appropriate in recognition of the fact that the UK service has been up and running for many years and has developed skills and expertise.

Deputy Marc MacSharry: Will that be optional or mandatory?

Dr. Colm Henry: Unsurprisingly, most will consider it mandatory because the alternative is a regulatory hearing at a Medical Council level.

Deputy Marc MacSharry: Even where it is a case that we have settled without admission of liability? Dr. Henry will be aware the point I am making.

Dr. Colm Henry: I am. The discussion depends on each case and would take place at a hospital level between the clinical director and the clinician concerned. That level is where it should happen and the referral would be from the hospital or a community healthcare organisation to this service which in my view, and that of many people, would be much more fruitful and productive than a more stark direct referral to the Medical Council which will make a judgment based on fitness to practise.

Deputy Marc MacSharry: Will Dr. Henry send us a note on that?

Dr. Colm Henry: Yes.

Deputy Marc MacSharry: It would be good practice to have some kind of mandatory follow-up even if there is no liability on an individual or group of individuals. When there is a settlement in the tribunal, are confidentiality agreements signed by the claimants?

Mr. Jim Breslin: Everything is confidential in the tribunal. Nobody knows the name.

Deputy Marc MacSharry: I am not interested in knowing the names of the people. If I am a claimant, go through the tribunal and get my award and reparation, do I have to sign a confidentiality agreement about that outcome?

Mr. Jim Breslin: I am not aware of that.

Deputy Marc MacSharry: I am interested in getting the answer if possible. If the answer is "Yes"-----

Mr. Jim Breslin: If a person wanted to say he or she had an award of a certain amount, I do not think there is an issue. The tribunal will never say that it has certain people in before it.

Deputy Marc MacSharry: I am not interested in the tribunal but in individuals. Are individuals forced in any way? We have come across this before in other areas.

Mr. Jim Breslin: No. Do not forget that one does not have to go before it to prove negligence. Once a person has received a product and has the disease, then that person is entitled to

the compensation, so that does not apply.

Deputy Marc MacSharry: In his opening statement, Mr. Connaghan talked about rapid risk assessment. It sounds great. In practical terms, what does that mean? How does the HSE manage on 6 January when there are 600 trolleys with sick people?

Mr. John Connaghan: The root of this is in our incident management framework launched in 2018. When we say "rapid," we mean "immediate". It is not optional but a requirement in the framework. We made that quite clear. Certain things need to happen within the first 24 hours and within the first week. The first 24 hours include a rapid assessment. There is guidance in the incident management framework, which is available. A number of people have been trained in this now. More than 1,200 staff have been trained.

Deputy Marc MacSharry: Are there a number in each acute hospital?

Mr. John Connaghan: There are a number in each acute hospital and in each ancillary service, including CHOs.

Deputy Marc MacSharry: With regard to hepatitis C, is there an individual programme manager in each acute hospital?

Dr. Colm Henry: This framework applies to all care delivery organisations and forms part of their performance management. The Royal College of Surgeons in Ireland, RCSI, hospitals, for example, examines all incidents reported and it feeds into their own quality performance. It does not just publish the incidence of complaints, since most pertained at a lower level to falls, though I am not taking away from the seriousness of it, right up to more serious incidents, but hospital groups and CHOs deal with these by recording them through the national incident management system, NIMS, hosted by the SCA. The reports go through to hospital boards and group executives.

Mr. John Connaghan: The Deputy asked if the framework is looking to be effective and if we can see some changes in this. We can look at serious reportable events under this framework, of which the top two are pressure ulcers and falls and trips. Taking pressure ulcers as an example, a lesson from that in the South/South West hospital group shows that we have a 67.5% reduction in the most serious type of pressure ulcers. That is exceptionally good news from this.

Deputy Marc MacSharry: I will give the remainder of my time to Deputy O'Connell.

Chairman: Before people leave, we will be back at 2.30 p.m. to discuss the periodic report in private session.

Deputy Marc MacSharry: I sent my apologies.

Chairman: That is fine. I received them.

Deputy Kate O'Connell: In light of all that has been discussed, I want to make sure that I have not got this wrong. We do not know how many people have hepatitis or how many more new cases there are, so we do not know if we are running at a standstill. There is no database but there are data-sharing issues which the witnesses hope to have dealt with by the first quarter of 2019. As one of my colleagues said, this has been going on since 2004. It appears as if nothing happened until 2017. I refer to the Eastern Health Board report that was never published. I understand that it fed into the national strategy. I found a graph somewhere last night which

I cannot find now. The highest number of cases was in the eastern region under the old health board. Those data would still be useful.

The strategy from 2011 to 2014 is out of date because it is from before the drug came into use. I do not see why it cannot be updated. There are no annual targets. A comment was made about accountancy and clinicians but it all comes down to money at the end of the day and when the money runs out. A clinical decision was made in the frame of accountancy when everything stopped in mid-2017. The two go hand-in-hand. I welcome the move to community care. It is in line with Sláintecare but there is not much connection there apart from it being a good idea. No guidelines were published until 2017, when the pilots started. There was another issue in the report, and I am not sure if someone brought it up when I was outside, which is the treatment centres did not notify the national treatment registry in 2017. What was that breakdown in communication? The drugs cost so much. If the doctors prescribing them are, for whatever reason, whether it is paperwork or because they do not have to, not notifying that they have started person X on it, it does not seem possible to audit outcomes if the centres were not telling us how many people started on the drugs. I am concerned at this entire process. While I concede that moves have been made in the past year - and we have hopes for early 2019 - I would be concerned if this sort of approach was taken to CervicalCheck in the future.

Chairman: I know the Deputy might have to leave in a moment or two, so we will ask Mr Connaghan.

Deputy Kate O'Connell: I have to leave.

Chairman: The Deputy will get the answer in the transcript. We will get the answer when she has left the room.

Deputy Kate O'Connell: I am sorry I have to go.

Chairman: We will be back here at 2.30 p.m. I will finish off in the next few minutes.

Deputy Catherine Connolly: If there is no confidentiality clause, it is amazing because, for the redress board and all the applicants who went forward, it is an offence for their legal team or themselves to disclose what they got. I never accepted that. That is interesting. It is an offence to disclose.

Mr. Jim Breslin: Let me confirm-----

Chairman: I need the Department to clarify-----

Deputy Catherine Connolly: I hope Mr. Breslin is correct.

Mr. Jim Breslin: I will check that.

Deputy Catherine Connolly: I hope he is correct and I hope it what was done to those who went forward under the redress board has not been repeated.

Deputy Catherine Murphy: ----

Chairman: -----

Deputy Catherine Murphy: Is it an ongoing treatment, a cure, or is it a range?

Professor Aiden McCormick: It is a cure.

Ms Michele Tait: Eight to 12 weeks.

Deputy Catherine Murphy: So it is an investment then.

Chairman: Three months.

Professor Aiden McCormick: Three months, and then they have their blood tests done three months later and, if it is clear at that stage, it is gone. They can be reinfected but it is gone.

Chairman: The committee asks the witnesses to put the answers on the record. Even if the members are gone, the answers will be on the record.

Mr. John Connaghan: We note what the Deputy said. She may have a good point about the 2011-14 strategy. We are heading into 2019 and perhaps we need to think again about where we now go because the comments about what we want do to, and how we get there for 2026, are well made.

Chairman: We will see the Deputies later.

I have one or two straightforward questions. How many people have died from the State-infected blood products? I do not know; I am asking an open question.

Ms Michele Tait: The HSE has estimates, which are collated through the database that we set up in 2004. The latest publication will come by the end of this year. There are in the region of 400 patients who have died from the original number. There are currently around about 1,380 people because they also get a Health (Amendment) Act card so they have special access to services, so we have about 1,380 people living at the moment and accessing services.

Chairman: In connection with the compensation or the tribunal, were their cases heard? Was there compensation to the family?

Mr. Jim Breslin: Where there is a death-----

Ms Michele Tait: Yes, if someone is deceased.

Mr. Jim Breslin: -----if one is a dependant, one can enter a claim.

Chairman: Were most of those people next-of-kin?

Mr. Jim Breslin: Yes. It is as-----

Chairman: Would that have been a large portion of the cost of the tribunal? What were the terms of reference in respect of the compensation?

Mr. Jim Breslin: It is a significant, and increasing, portion. Primary claimants will reduce. We are going to have a hepatitis C tribunal for many years yet because when the last person who got hepatitis C or HIV through the blood supply dies, their next-of-kin will enter claims.

Chairman: Why do they not enter a claim for compensation in the meantime?

Mr. Jim Breslin: The primary claimant would be able to say they are not able to work as a result of this and that the family's income is affected, and that would be dealt with in the first claim. The loss of the person when they pass away is also an event that-----

Chairman: It is a secondary-----

Mr. Jim Breslin: Yes.

Chairman: They are probably smaller in terms of money.

Mr. Jim Breslin: They are smaller in terms of the amounts, but the volume will be bigger. The payouts, when this closes, which is a long time away yet, will be for secondary claimants. They will be the final people to be paid and, increasingly, as we go on, most of the payouts on claims will be for that category of person.

Chairman: Are all the primary claims in by now?

Mr. Jim Breslin: There are still some primary claims before the tribunal.

Chairman: But are they all with the tribunal?

Mr. Jim Breslin: Yes.

Chairman: Are there no claims?

Mr. Jim Breslin: One would not think so.

Chairman: How many cases are still with the tribunal?

Mr. Jim Breslin: I had the figures there.

Chairman: How many primary claims?

Mr. Jim Breslin: 450. Just to note-----

Chairman: How many of those are primary versus-----

Mr. Jim Breslin: At the moment, it is 75 primary claimants out of 455.

Chairman: Are the remainder next-of-kin?

Mr. Jim Breslin: Yes. Just to note on that figure of 75, if one got a provisional award, one could subsequently come back, so that is not a static number.

Chairman: Can Mr. Breslin send the committee information on the breakdown of the 75 primary claimants?

Mr. Jim Breslin: Yes. We had agreed-----

Chairman: Will Mr. Breslin how many are first claims and how many are subsequent claims?

Mr. Jim Breslin: We had agreed-----

Chairman: There must be a template.

Mr. Jim Breslin: Sorry, 47 of the 75 are an initial claim and 25 are for further compensation.

Chairman: When was the final initial claim lodged?

Mr. Jim Breslin: The very first claim?

Chairman: No, when was the last of the initial claims lodged?

Ms Michele Tait: It depends. Some people are still-----

Chairman: No, there is a date, a year.

Ms Michele Tait: I do not know, but I know that people are coming to us for services who have been newly diagnosed and the connection between their diagnosis and receipt of a blood transfusion may have only been confirmed-----

Chairman: Even this year?

Ms Michele Tait: Absolutely. There are still some new patients being identified.

Chairman: So there could still be some new first claimants.

Ms Michele Tait: Yes. Very small numbers, but there are still-----

Chairman: The numbers are small at this stage.

Mr. Jim Breslin: The ability to come back if there is a provisional award is available. If the trajectory of the illness was not known at the time, a provisional award would have been made, and the person would have come back if they developed cirrhosis of the liver or further damage.

Chairman: The cost of the tribunal is €25 million. How much of that relates to compensation?

Mr. Jim Breslin: I gave that just a moment ago.

Chairman: Sorry, I missed it.

Mr. Jim Breslin: I was using rough figures but-----

Chairman: Per annum.

Mr. Jim Breslin: -----in 2017, the total was €21.8 million, which comprised €14.6 million for the main awards and €3 million for reparation fund payments. They are a 20% increase on the award.

Chairman: What is the total of the payouts then?

Mr. Jim Breslin: The total is €17.6 million out of €21.8 million.

Chairman: So 15% is for the process and handling the tribunal.

Mr. Jim Breslin: The next biggest is the legal costs of the awards. That is €3.7 million.

Chairman: Mr. Breslin might pass that on to us. Are claimants' costs are included?

Mr. Jim Breslin: Exactly. The €3.7 million are the legal costs attaching to the claimants.

Chairman: Mr. Breslin can send us a briefing note with the information he has.

Somebody mentioned the HSE has some new machine for liver tests. Could Professor McCormick explain that?

Professor Aiden McCormick: That is the fibre scan. We used to do biopsies for either fibrosis or cirrhosis, but this is basically an ultrasound scan. It is put on its side and it basically gives a little knock on the side and the speed of transmission of that wave through the liver is directly related to how stiff the liver is and how much fibrosis there is. It can tell you definitely if a liver is normal, or cirrhotic, or if there is some degree of fibrosis. It gives a number-----

Chairman: In how many locations is that machine?

Professor Aiden McCormick: It is in all the treatment locations and there are two-----

Chairman: In the hospitals and the community?

Professor Aiden McCormick: No, all the hospitals have them. There are two mobile scans and we are in a procurement process at the moment for two more mobile scans and, now that the Department is behind the HSE, we need about six or eight throughout country.

Chairman: Is that just for hepatitis C?

Professor Aiden McCormick: Yes, to treat patients.

Chairman: Could the machines be used for other liver tests?

Professor Aiden McCormick: They can be used for hepatitis B, alcoholic liver disease and fatty liver disease. They are versatile machines, but in proof of principle, they are used for hepatitis C and specifically to decide on treatment, depending on how much scarring there is on the liver.

Chairman: That is fine. I noted on the charts supplied that the numbers of males presenting is now much higher than females. How is that ratio working out?

Ms Michele Tait: We will send the committee the epidemiology report recently published by the health protection surveillance centre, HPSC.

Chairman: I am looking at it now. Perhaps Ms Tait could state the figures for the record. The ratio seems to be nearly 3:1.

Ms Michele Tait: Yes. For 2017, of 620 notifications of hepatitis C, approximately three quarters, that is, 448, were male while 171 were female.

Chairman: I am looking at a chart but perhaps Ms Tait could send the figures to us in numerical form. It also looks as if the number of females presenting is declining, while the number of males has been reasonably static over the past five years.

Ms Michele Tait: We will send the figures in numerical form.

Chairman: On page six of the report there is some information on the different groups that presented. It states that other reported risk factors include tattooing or body piercing and there were nine people who contracted hepatitis C in that way.

Professor Aiden McCormick: These were cases where the risk factor was identified but we cannot say these people got the disease from those sources. Intravenous drug use and blood transfusion are other risk factors.

Ms Michele Tait: There is a risk assessment of each individual patient.

Chairman: It appears that nine people got it through tattooing or body piercing.

Ms Michele Tait: They may have got it from those things.

Chairman: There was a debate in the Oireachtas on this recently. In his opening statement, Mr. Breslin said that in the years since these infections were discovered, a wide range of actions were taken, based on the recommendations of the Finlay and Lindsay tribunals, to ensure the safety of the blood supply. That encapsulates the problem. A problem arises and it is examined to make sure it does not reoccur but I would have liked wider lessons to have been learned from what happened with the blood supply. This is the undercurrent of today's meeting. The issue is dealt with but in a way that is totally divorced from everything else. I do not get the connection in this regard.

At a meeting with the HSE on 5 July this year, we asked a series of questions and we got a reply back dated 16 August 2018, which we read into the record today. The State Claims Agency was before us recently and we asked if it was possible that there were clinicians who were involved in multiple cases. The agency said that if a clinician was listed in legal proceedings, the agency wrote back to say the name of the clinician did not need to be given, on account of the fact that it was the enterprise which was defending the case. It seems the system is geared not to identify cases where learning is needed. The letter we received said the HSE asked for a note on the introduction of a mandatory system of retraining and supervision following legal settlements without admission of liability. It said there was no mandatory retraining and supervision following legal settlements without admission of liability, although retraining and supervision takes place. The letter stated that the HSE talks to the State Claims Agency and looks at the trends the agency has identified but it seems to me that this is not just acting after the horse has bolted - it is acting after the horse is dead and buried. The identification of these issues should be the role of the HSE, not the insurance company which is writing the cheque, which may be years after the event. The last line in the reply states that the office of Dr. Colm Henry, the interim chief clinical officer in the HSE, will have the ultimate responsibility for implementing any necessary retraining and supervision of medical practitioners. We are told that the State Claims Agency sends a report back to each of the institutions but these are landing all over the place. Whose job is it to identify these needs? The State Claims Agency is not picking up on them. The report states that cases can be brought to the medical council but that is not what we are talking about. That is for cases when somebody is judged not fit to be a doctor but that does not solve the problems where a practice is not up to scratch in some way.

This is why we are here. The medical negligence bill is increasing every year. The taxpayers have to pay it and that means less money for everything else. The figure has gone up every year for the past ten years and before that, but we did not get any indication that anyone was really worried about it. There is a demarcation between the HSE and the State Claims Agency. Once a case goes into the latter, the HSE is out of the picture. All it wants to know is what it owes at the end of the quarter. This demarcation does not help the learning process. The HSE should not have to learn anything from the State Claims Agency as the problems happened in the HSE to start with.

In his opening statement, Mr. Connaghan said the HSE had recently established a project team to develop a mechanism so that the learning from local reviews could be considered. He might give us details of that and send them on to us. He went on to say that, since 2013, the HSE had undertaken an annual review of completed incident reports. Are they published? Who is tasked with reducing medical negligence in the organisation when they come into work on a Monday morning? Without this being addressed, it will mean less for patients and lower

budgets for the HSE as a whole.

Mr. Jim Breslin: Dr. Henry, in response to Deputy MacSharry's points, talked about some of the specifics of the points the Chairman has just made. The first question was about what we learned from things going wrong in the blood service. The Finlay and Lindsay tribunals identified a range of specific quality control issues within the blood service. It was vitally important that we re-established confidence in the Irish blood service and a programme of work has been put in place to bring the service to a quality level that compares with international standards.

What the Chairman says, however, is correct. The consequences of what happened in the blood service were defining moments for the Irish health service. Internationally, all health services are dealing with the importance of prevention in achieving patient safety as the complexity of services has increased over the years. At both policy level and operationally within the HSE, we have tried to move that agenda forward. There is nobody saying our work is over and all of us are strong advocates for patient safety because we know the importance of it. The actions that have been taken since then include the establishment of HIQA and the Mental Health Commission to put people who are not in the operating line or the hierarchical structure in to examine services and see how they are operating.

Chairman: How many reports has HIQA done? The Minister has commissioned a report into a hospital. HIQA does not inspect hospitals on a daily basis.

Mr. Jim Breslin: It does.

Chairman: If it did, it would probably close them all.

Mr. Jim Breslin: It has the ability to do that. It can go in and inspect. It has set a standard that has been approved by the Minister. I refer to the national standards for safer and better healthcare. HIQA can go into a hospital and say it wants to examine it under this standard. It can examine things like infection control. It can do targeted inspections.

Chairman: It can inspect on a thematic basis.

Mr. Jim Breslin: That is an important aspect of it. We have put in place the National Patient Safety Office. We have a surveillance programme and a legislative programme. The committee will be aware from our previous engagements of the legislation that is under way in this area. The HSE has put in place a quality and patient safety directorate. There is very much a focus on this at the provider level. Mr. Connaghan has spoken about the serious incident management protocol, which started with maternity hospitals publishing monthly patient safety statements that set out the levels of safety within our hospitals and explain how the risks that exist are managed. All hospitals are now doing that. There is lots of learning.

I would like to mention another learning from the blood service. There is a need for patient involvement and patient advocacy. I have spoken about how the haemophilia and hepatitis C community has come into the design of the service. That is a critical aspect of how we need to operate as a health service in general. In the coming weeks, we will award a national patient advocacy service. When something goes wrong, people lose trust in the health service and need someone to work with them to find answers to their questions. We are going to put in a national patient advocacy service involving skilled people who understand the health service, but are not employees of it, to work with people in such circumstances. I am not telling the committee that we have cracked patient safety in Ireland. It has not been cracked in any healthcare system. We have to work each day to try to improve this. We also have to improve our processes for

mediation and engaging with people when things go wrong. I was in Northern Ireland three or four weeks ago for a conference with colleagues there. They spent €117 million on medical negligence and they have every single issue we have here. We are going to work together on those issues. Dr. Henry has spoken about the work that has been done in England, particularly with regard to mediation. We can learn from others. We have done a lot in this space.

Dr. Colm Henry: At the committee's hearing with the SCA weeks ago, we learned that the number of claims is steady but the amounts are going up. We heard that this is just one element of quality, whether it is of doctors or of services themselves. Some services, such as obstetrics, are more complex and more prone to claims than others. Approximately half of all claims pertain to catastrophic birth injuries, the consequences of which sometimes do not become apparent for many years. I assure the Deputy that there is a great deal of learning going on. The national women and infants health programme is examining the introduction of proxies for catastrophic birth injury. That would involve doing immediate incident reports in cases of neonatal cooling, which happens when there is hypoxia, and also in cases of perinatal events. It is absolutely the case that we want to learn. We do not want to wait for claims to come through four years down the line when cerebral palsy becomes evident. We want to learn from the at-risk cases as they happen. We want to apply that learning to all 19 maternity units in their safety statements and the measurements we provide to them through the Irish maternity indicator system, which is a quality report we give to all 19 units. It is absolutely the case that there is learning.

Chairman: Okay. We will conclude shortly. Mr. Breslin gets the point I am making. I am not just talking about things that have happened while I have been Chairman of this committee. I was a member of the committee in the previous Dáil as well. The feeling I got from the HSE at that time was that when these matters go to the SCA, they are dealt with by the agency. The demarcation line is a bit too strong. There needs to be more collaboration and earlier learning. I know about the costs. We know about mediation. We know all that. I am just saying we are back to prevention and learning. That is the best way of reducing anything.

Mr. Jim Breslin: That is where-----

Chairman: We do not have a sense of that yet at this committee. That is all I am saying.

Mr. Jim Breslin: No. In fairness to the State Claims Agency, it could have taken a very narrow view of its role, which involves the legal management of claims. It introduced the national incident management system to ensure it is upstream when something goes wrong in order to learn from it immediately rather than having to wait for the claim to be lodged. The HSE has a lot of work to do on risk management and patient safety. The claims that are lodged are one element of that. They are a bigger piece of the jigsaw that needs to be done. I would like to mention a statistic that will probably cause the Chairman to take an intake of breath. According to the OECD, 15% of hospital expenditure internationally goes on correcting preventable errors or infections people catch in hospitals.

Chairman: I read that the figure is 25% in parts of the United States. I would like to make a final comment. Mr. Breslin will understand why I am saying this. As Deputy Connolly said, even though this is substantially an historic matter, one of the specific reasons we are here today is the case of the late Brigid McCole. It was just a few weeks ago that we spoke about the case of Emma Mhic Mhathúna in the context of the cervical cancer issue. The public sees a connection when these cases of medical negligence arise. The State had a responsibility 15 years ago and following a tribunal, €1.5 billion in compensation was rightly due to those affected. Fifteen years later, it looks as if we are starting down the exact same road again. All of our successors

who are here in 15 years' will talk about the cost of that. I am worried that some other case will come up at that stage and the wheel will start turning again. That is where broader learning is needed. Every time there is a problem, we try to solve it. We cannot foresee everything that might happen. People have a sense of "Here we go again". I ask Mr. Breslin to make an observation on that. He can understand people feeling that they are not totally disconnected from these issues, even though medically they are. I am sure Mr. Breslin understands the point I am making.

Mr. Jim Breslin: Yes. There are substantial differences between what has happened in this instance and the infection of people through the blood supply at a time it was known that an issue was live and present. The overall challenge and comment is exactly correct. Patients have to be at the centre of the patient safety culture within healthcare. There are many other things we need to do, but that must be the primary focus of all health service practitioners. We need to build systems that support people to make safe decisions as they go about their duties and we need intelligence that spots things before they become a problem. I will give some examples of the scale of this. Every year, we have 3.3 million outpatient attendances, 1.3 million emergency department attendances, 1.6 million admissions to hospital and 20 million GP attendances. It is not enough to get 99% of those right. If we get 1% of them wrong, that has significant implications. That is the culture we need. A great deal of work will be needed in the health service. We will have to bring the community with us as we to try to break down the old-fashioned "doctor knows best" approach and replace it with a partnership with patients.

Chairman: I thank the witnesses from the Department of Health and the HSE for all the materials they have provided. We look forward to receiving the documentation to which we referred during the meeting. I thank the staff of the Office of the Comptroller and Auditor General. The next public meeting of the committee will take place on Thursday, 29 November, when we will meet officials from the Department of Employment Affairs and Social Protection to consider Vote 37, Chapters 11, 12, 13, 14 and 20 and the 2017 Social Insurance Fund. I am now suspending the meeting until 2.30 p.m., when members will meet in private session.

The witnesses withdrew.

Sitting suspended at 1.40 p.m. and resumed in private session at 2.30 p.m.

The committee adjourned at 4.20 p.m until 9 a.m. on Thursday, 29 November 2018.