OVERVIEW OF A HEPATITIS C LOOK – BACK EXERCISE IN WALES – EXERCISE GOLAU

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Financial impact None for Cardiff and vale UHB

Quality, Safety, Patient Experience impact (if applicable)

Healthcare Standard Number 13 Craf Reference Number 5.1

Equality Impact Assessment Completed: No

RECOMMENDATION

The Committee is asked to:

- CONSIDER the actions recommended for the management of a transmission of Hepatitis C from a healthcare worker to a patient and,

- AGREE that they are assured the UHB currently complies with those recommendations which are required to be in place on a day to day basis

SITUATION

The purpose of this report is to provide an overview of the actions taken by Aneurin Bevan Health Board (ABUHB) to manage an incident in which a retired healthcare worker (HCW) who had been tested positive for Hepatitis C had transmitted this to two women. A number of lessons were learned and are outlined within the report.

BACKGROUND

In June 2013, ABUHB notified Welsh Government of a suspected hepatitis C transmission from a doctor to two patients, via the Serious Incident Reporting process.

A healthcare worker who has worked in the field of Obstetrics and Gynaecology but had retired several years prior was found to have Hepatitis C infection (genotype 4). Following a request to the local laboratory to identify all known hepatitis C genotype 4 patients diagnosed in the area, the local Hepatology team became concerned that one of their female patients with genotype 4 infection could possibly have received treatment from the HCW. Phylogenetic analysis of the HCW and patient’s blood was
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February 10th 2015

performed at the UK reference laboratory and this indicated that transmission had occurred.

A second South Wales patient with a similarly close match was identified. It became apparent that she had also been treated by the HCW.

ASSESSMENT

Following advice from the UK Advisory panel on Blood Borne Viruses, a major look-back exercise was commenced, to identify all patients who had received any exposure prone procedures by the HCW over the entire duration of their career in the UK (over 30 years of NHS service). The exercise expanded to include three other Welsh health boards and the Health Administrations of England, Scotland and Northern Ireland.

As of July 2014, the look-back exercise resulted in the identification of 4553 patients, 4053 of whom were invited for testing in Wales. The remaining were either passed to UK health departments or not invited as they were either deceased, had emigrated or were untraceable). 3326 opted for testing.

Of 3326 samples processed by the laboratories:

- 31 samples were referred by ABUHB to the Public Health Wales Virology laboratory, University Hospital Wales, Cardiff for additional testing.
- 3 women were PCR positive for Hepatitis C indicating active infection (one woman was found to have been infected with genotype 4, the other two with other genotypes and had other risk factors)

In addition a further patient with Hepatitis C, genotype 4 was located in a local hepatitis clinic and further testing indicated a likely transmission from the HCW.

28 samples were PCR negative indicating no active infection.

A number of recommendations were made following the look-back exercise. Some are advisory should such a situation require management in the future. These suggest that:

1. Sharing of information between UK nations for the co-ordination and response should be facilitated by joint protocols which clearly outline information governance and confidentiality aspects for all patients affected by the look-back exercise
2. Review of existing patients with similar genotype proved fruitful as did the screening of patients identified that had undergone EPP. A review of the Hepatitis clinic records should be standard in any look-back exercise
3. Legal, Ethical and Information Governance advice should be provided to all members of an Incident Management Group (IMG).
4. IMGs should include a patient advocate in addition to all professional stakeholders.
5. Communication should help the media and public to be realistic in expectations on the time the look-back exercise is likely to take and to bear with those responding to the incident
6. Phased posting of patients ‘invitation to test’ should be in accordance with helpline capacity

7. Early notification of General Practitioner’s, 96 hours before the ‘Go Live’ date, enabled patients with additional factors to be excluded for the mail out and did not result in leakage to the media as details of the incident were not given.

8. Individual appointments with nurse advisors (in special clinics) where patients questions can be answered as well as blood test offered is the ideal and recommended response

9. Positive tests (at any phase) should be communicated verbally to patients by a health care professional initially rather than by letter alone

10. Co-ordination of large scale incidents will require a co-ordination hub to be staffed daily for the first few weeks

11. Database management should be limited to a very few identified individuals under the direction of a data warehouse specialist

12. The closure of an exercise needs careful planning in the same way as the ‘Going Live’ with a Communications Strategy that mirrors that at commencement

The four following recommendations require processes to already be in place. These are:

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<td>Health Boards should ensure that all HCWs performing Exposure Prone Procedures (EPPs) receive enhanced checks for Blood Bourne Viruses. This is particularly important if initial NHS employment in the Health Board occurred before enhanced screening guidance was introduced.</td>
<td>The UHB complies with the Department of Health guidance in regards to the clearance of HCW who undertake EPPs. In order to address those staff members who were in post prior to the guidance being introduced and in response to this incident the UHB also issued a letter asking staff working in EPP roles to contact Occupational Health to check their Hep C status.</td>
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| 14  | Doctors general training should stress the importance around formal notification of infectious diseases to the proper officer of the relevant local authority | Doctors receiving training on all policies and procedures related to infection prevention and control as part of:  
- UHB induction  
- Local departmental induction  
- Specialist core curriculum training as outlined by each Royal College |
| 15  | Hepatitis C patients need detailed employment histories taken and if a new patient is a HCW who has undertaken EPPs, links to other locally registered patients with Hepatitis C should be considered. Genotypes assist in tracing possible individuals of concern | Taking an occupational history is standard practice for patients with hepatitis C (as it is for all patients); the UHB would be aware if one of our patients is a HCW and would be alert to the possibility of possible onward transmission through EPPs. With regards to genotypes – it would be the UHB view that this will rarely be helpful since the vast majority of |
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<td>patients in the UK have either genotype 1 or 3 (roughly 50% each). It was fortuitous in ABUHB incident that the HCW had a genotype (4) which is rare in the UK, so that it was likely that patients identified in the look back with that genotype were likely to have acquired it from him.</td>
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<td>The designation of Foetal Scalp Electrode (FSE) application as an EPP Category 3 means that it now needs to be captured in birth registers with the name of the HCW who applied it</td>
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<td>Currently this information is recorded in the clinical records (rather than the birth register) and FSE’s are applied in about 95% of cases.</td>
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