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Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
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Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/MD/2804/14

David Rees AM
Chair
Health and Social Care Committee

22 September 2014

Dear David

I am writing to provide you with an update on progress since the Welsh Government's response to Health and Social Services Committee's inquiry into Venous Thromboembolism Prevention in Hospitalised Patients in Wales.

Please find attached table and annexes setting out updates on each of the Report's recommendations.

Best wishes

Mark Drakeford.

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Venous Thromboembolism Prevention in Hospitalised Patients in Wales
Welsh Government update against Recommendations

Recommendations	Welsh Government Response	Progress
Recommendation 1: The Welsh Government recognises the importance of reducing the incidence of hospital acquired thrombosis (HAT) in Wales by actively considering whether compliance with the relevant NICE guidance should be included as a tier 1 priority for health boards, against which they will be performance managed. This should be considered alongside revised action through the 1000 Lives campaign. The Committee requests that the Welsh Government reports back to us the outcome of the consideration it gives to including compliance with the NICE guidance as a tier 1 priority and explains the reasons for the conclusion it reaches. This consideration should be given as part of the next review of tier 1 priorities. (p34)	**Accept in principle** • The Welsh Government is committed to reducing the incidence of hospital acquired thrombosis in Wales. • *Together for Health* sets out the Government's vision for better service quality and safety to improve health outcomes. This is described further in our Quality Delivery Plan (QDP) for the NHS: *Achieving Excellence,* where the expectation is on developing a new approach to monitoring NHS performance more focused on measuring clinically appropriate outcomes. • Alongside this, the QDP also acknowledges the need to develop a key set of metrics, described as 'quality triggers'. This will be a focused set of measures as part of routine monitoring of care quality and act as an early warning system to identify services that might give cause for concern. • Metrics to monitor action to prevent hospital acquired thrombosis will be included within the quality triggers. This will facilitate early local action where performance gives cause for concern, whilst providing a mechanism to maintain national oversight and the ability to escalate and intervene in areas of poor progress. This new approach will therefore ensure that any one of our identified core	**Outcome**: **In progress** Significant progress has been made against this recommendation. These actions have already been completed:- 1. The formation of a Steering Group consisting of 'experts' with representation from each Health Board (HB). This is chaired by Dr Simon Noble, a world recognised expert in this field and also includes Prof Beverly Hunt from the Royal College of Physicians. The first meeting was held in May 2013. 2. The Department of Health definition of a hospital-acquired thrombosis has been agreed and adopted. This is "any venous thrombo-embolism arising during a hospital admission and up to 90 days post discharge". 3. A hospital acquired thrombosis (HAT) measure is included (developmental) in this year's Tier 1 measure and each organisation is currently finalising its data collection method. On 2 September a letter and reporting template was issued to HBs for robust and consistent reporting on this measure to Welsh Government. (Annexes 1, 2 and 3).

Recommendations	Welsh Government Response	Progress
	quality indicators 'triggers' action when performance gives cause for concern, generating a 'tier 1' type approach and focus. • Our focus must be on supporting continuous quality improvement for our health services. NHS Wales has made progress in tackling the complexity associated with preventing hospital acquired thrombosis, but it is fully accepted there is still much to do. • The 1000 Lives Plus programme will continue to actively support all NHS organisations in tackling this important area, to ensure the spread and embedding of best practice to reduce the risk of this serious condition.	This has been achieved through empowering NHS Wales clinicians to develop a measure that is directly linked to improving patient outcomes and also 'makes sense' to clinical staff. The measure collects information on: a. Number of suspected Hospital Acquired Thromboses per calendar month of which b. Number of Root Cause Analysis reviews completed to identify numbers of possible avoidable HATS c. A summary of learning and actions, from the Root Cause Analysis process These quality triggers will facilitate early local action and provide a mechanism to maintain national oversight and the ability to escalate and intervene in areas of poor progress. The focus however will be on supporting continuous quality improvement.
Recommendation 2: A standard procedure be implemented to reduce hospital acquired thrombosis (HAT) in Wales, mandating clinicians to	**Accept in principle** • The tools and resources developed through the 1000 Lives Plus collaborative provide NHS organisations in Wales with a clear and systematic	**Outcome: In progress** All clinicians are already required to follow best practice and recommend the best treatment

Recommendations	Welsh Government Response	Progress
risk assess and to consider prescribing appropriate thromboprophylaxis – mechanical or chemical – for all hospitalised patients. (p35)	process for assessing and determining treatment options for those identified at risk of thrombosis. • This, together with a number of measures to help teams test and track the reliability in implementing these interventions, is set out in the 'How to Guide' developed by the 1000 Lives team in partnership with others, notably Lifeblood, the thrombosis charity. The adoption of this approach enables organisations to demonstrate they are providing evidence-based care in line with the NICE guidance for reducing the risk of venous thromboembolism. • The 'Transforming Maternity Services' 1000 Lives Plus collaborative has made significant progress over the past year in developing specific advice and resources tailored to suit the needs of pregnant women. The programme has strong multidisciplinary support and has recently published an updated 'How to Guide' to assist clinicians in Wales in adopting a systematic, all Wales approach. This is being implemented in all maternity units in Wales. • All clinicians are already required to follow best practice and recommend the best treatment options for, and in discussion with, their patients on an individual basis. • As set out in recommendation 1, 1000 Lives Plus will have a renewed focus on supporting health boards and trusts to ensure widespread and	options for, and in discussion with, their patients on an individual basis. The standard procedure already exists in the form of NICE guidance and the 1000 Lives 'How to Guide'. However NICE have recently announced that they will be revising their guidelines in response to new evidence that suggests patients are being 'over treated' with prophylaxis. We await this response to make appropriate changes in Wales. Root Cause Analysis (RCA), following collection, reporting and analysis of suspected HAT incidents, will identify shortcomings in assessment and treatment. This evidence will be used to engage and educate the frontline staff. This will encourage the change of practice needed to further reduce HAT. There is already evidence of improvement reported. Just three examples are: • *An increased focus on re-assessment at ABMU (entered at this year's NHS Wales Awards) which has resulted in an increase in the assessment and re-assessment rate and a decrease in the HAT incidence rate.* • *A pilot development to the All Wales Prescription chart within the Medical Directorate at Cwm Taf. This has resulted in appropriate assessment and treatment for VTE prophylaxis increasing to 98% in the pilot area.*

Recommendations	Welsh Government Response	Progress
	sustainable implementation of this approach.	• *A VTE protocol used by the Trauma & Orthopaedic team in Ysbyty Glan Clwyd that has facilitated a reduction in their HAT incidence.*
Recommendation 3: Health boards should develop a standardised method to demonstrate a hospital acquire thrombosis rate for each hospital in Wales and at a national, all-Wales level. We recommend that health boards learn from the work already undertaken by Betsi Cadwaladr University Health Board and others so that a standard methodology can be rapidly developed and implemented across Wales. (p35)	**Accept** • As the Committee's inquiry has found, making a diagnosis of hospital acquired thrombosis can be difficult and may follow a hospital stay. • The NHS in Wales has demonstrated a strong commitment to develop a standard methodology to enable both a local and a national rate for hospital acquired thrombosis to be measured, despite the complexity involved. Progress has continued in this area. The 1000 Lives Plus programme will coordinate this activity and support the accelerated development and implementation of an agreed all-Wales measure.	**Outcome: Complete** The Steering Group has agreed the principles of the methodology to be used. This has been mandated in the instructions given to all organisations by Welsh Government. Work is being planned to update the All Wales Radiology Management System (RADiS) to automate some data collection therefore simplifying the whole process for the HBs. The Royal College of Radiologists (Wales) has also agreed on terminology that should also help simplify data collection.
Recommendation 4: A root-cause analysis should be undertaken for each case of venous thromboembolism (VTE) at Welsh hospitals, or for patients presenting VTE within 3 months of being discharged from a Welsh hospital, to establish whether they were acquired as a result of hospital treatment. (p35)	**Accept in principle** • It is essential we have mechanisms in place to review and learn from any events which may result in avoidable harm to patients. • Root-cause analysis is an approach already widely used in NHS Wales. However the approach can be very time consuming, so it is essential we develop tools which can easily to be used in practice to drive learning, but without adding too great a burden if the process becomes too time consuming for clinicians – diverting them from direct patient care.	**Outcome: In progress** This has been stipulated as part of the Tier 1 measure reporting and the HBs and Trusts are currently developing plans to put this process into place. The Steering Group has agreed and advised that Root Cause Analysis (RCA) should be a two stage process. All organisations should put in place a process to filter those incidents identified as 'potentially hospital acquired' from the total number of those identified as fitting

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	• Velindre NHS Trust has already developed such a tool which has been shared across Wales through the 1000 Lives Plus collaborative. The 1000 Lives Plus team will facilitate the development of agreed tools for use across different health settings. This is expected to be adopted across Wales for all patients diagnosed with a hospital acquired thrombosis during their hospital stay, or within three months of their discharge.	within the agreed definition. This filter would take the format of two questions: 1. Was a documented risk assessment performed? 2. Did the patient receive appropriate thromboprophylaxis? If the answer to either question 1 or 2 is "no" then the HAT could potentially have been avoided and the standardised Health Board Root Cause Analysis (RCA) process should then follow.
Recommendation 5: The Welsh Government and health boards work together to raise awareness amongst patients and clinicians of the risks of developing hospital acquired thrombosis (HAT). We recommend that this should take the form of a public education campaign to improve understanding of the risks of HAT and the severity of the problem. (p35)	**Accept** • Both NICE guidance and the 1000 Lives Plus 'How to Guide' for reducing hospital acquired thrombosis, describe the need for involving patients. This includes both the need to raise awareness of the symptoms and the risks, as well as providing information on ways to reduce their risk or to act on any concerns or symptoms. In addition, the actions set out in recommendation 2 should lead to an increased awareness amongst clinicians. • However, it is clear much more does need to be done to raise awareness of the risks. Clinicians and organisations need the tools to do this effectively. We have a number of successes to build on and learn from. This includes the previous	**Outcome: Complete** The 1000 Lives Improvement Service, working in collaboration with 'Lifeblood – The Thrombosis Charity' has developed the 'Ask about Clots' campaign that was launched by the Minister for Health and Social Services on April 4th 2014. The campaign draws on two patient stories – one from a survivor of HAT and one from a mother who lost her daughter to HAT. The publicity campaign targets the general public and clinicians. A pack that includes infographics (Annexes 4 and 5), a video and links to a website has been developed and distributed to all health boards. There has been

Recommendations	Welsh Government Response	Progress
	'Clean Your Hands' Campaign, which has been effective at both raising awareness amongst hospital staff, patients and the wider community about the importance of hand washing in helping to combat infections. • More recently, the 1000 Lives Plus S.T.O.P communication campaign, launched earlier this year to reduce the risk of infection by focusing on the better use and management of catheters and cannulas, is already showing great results across Wales in reducing unnecessary use of these devices. We also need to be mindful of the existing work of organisations such as Lifeblood and the important role they have already played in raising awareness, and build on this. • The communications arm of the 1000 Lives Plus team will coordinate this work, in partnership with all key stakeholders. They will review the evidence and look at best practice in this area to put forward proposals for an awareness raising approach across NHS Wales during 2013/14.	a parallel campaign on Twitter and many hospitals are now playing the video in public areas. The campaign was also promoted at the 1000 Lives national learning event in June. To link with World Thrombosis Day (October 13th) 1000 Lives are currently planning an event in Wales to run in parallel to the international event in London. 'Ask about clots' is being promoted at the international event and being offered internationally as a ready-made campaign for engaging the public with the view of reducing the risk (the theme of this year's campaign).

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Cyffredinol a Prif Weithredwr, GIG Cymru

Department for Health and Social Services
Director General and Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

To: Chief Executives, Medical Directors & Nurse Directors
Health Boards

Our Ref: AG/LL/DCL

2 September 2014

Dear Colleague

An Update on Hospital Acquired Thrombosis (HAT)

Developing a fatal condition in a hospital setting is entirely counterintuitive, yet evidence to the HSCC inquiry in 2012 suggests it occurs at a significant rate in the case of Venous Thrombo Embolism (VTE).

The number of people who develop such clots is substantial, and the number of deaths that may have been prevented by improved awareness and treatment was a matter of real concern to the committee. Information received at the inquiry convinced us that there are practical steps available by which this can be achieved and that these actions are within our reach. I know we all believe that more could and should be done to raise the importance of preventing VTEs, and making both professionals and patients more aware of the severity of the problem.

The report, produced following the inquiry, made clear that we must minimise the number of people suffering avoidable hospital-acquired clots and made a number of recommendations, all of which were accepted by Welsh Government and the expectation is that all healthcare organisations would be working towards full implementation of these.

Local mechanisms for the national reporting of HAT incidence must be put in place, together with systems for gaining assurance that healthcare organisations are actively investigating each incidence. The aim being to ensure learning from them, so improvements can be made leading to the reduction in the number of avoidable incidents of HAT.

Therefore all organisations should put in place a process to filter those incidents identified as ‘potentially hospital acquired’ from the total number of those identified as fitting within the agreed definition.

This filter would take the format of two questions:

1. Was a documented risk assessment performed?
2. Did the patient receive appropriate thromboprophylaxis?

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If the answer to either question 1 or 2 is “no” then the HAT could potentially have been avoided and the standardised Health Board Root Cause Analysis (RCA) process should then follow.

All Health Boards and Velindre NHS Trust through their membership on the national steering group have agreed that they have a mechanism in place to collect data on the number of patients who may have had a Hospital Acquired Thrombosis and so the measure to be reported was agreed as:

1. Monthly reporting on the number of suspected Hospital Acquired Thromboses each calendar month
2. Quarterly reporting of the number of potentially avoidable incidents assessed through Root Cause Analysis carried out
3. This quarterly reporting will be supported by a summary of learning and actions

Can I emphasise that reporting of this measure is not to allow comparison of ‘performance’ across Health Boards and NHS Trusts – the specialty mix and details of collection make this invalid. It is a measure for improvement to allow HBs to take ownership of this issue, help them study and improve clinical practice and further reduce the incidence of HAT in Wales. It also allows the government and public to be reassured that this improvement action is receiving high priority.

This is an agreed Tier 1 target that now needs to be implemented. Based on information gathered from the HAT Steering Group, we would expect draft reports to be submitted by end of each month (10 working days) where possible starting end of September for your August data. If you already collect this data you may wish to send your April, May June and July figures at the same time.

Your quarterly report will only be required once you have completed a quarter of data and undertaken the RCA process. We will use this year to work through issues and this will allow us to have a formalised process in place for 2015/16. Proformas for the data collection are enclosed with this letter.

The Minister recently launched the ‘Ask about Clots campaign’, developed by 1000 Lives Improvement, that encourages patients to ask healthcare professionals about their risk of developing a deep vein thrombosis (DVT). Empowered patients, taking an active role in reducing thrombosis, will remind healthcare professionals to be more aware of the risks and ensure that all patients are assessed and treated appropriately.

1000 Lives Improvement are working with all Health Boards and trusts and third sector organisations to raise awareness of the issue with the public and have resources that you can use to make a real difference to patient care.

Further information can be found at www.askaboutclots.co.uk

Yours sincerely

Dr Andrew Goodall
Director General and Chief Executive, NHS Wales

Ruth Hussey
Chief Medical Officer

Enc

Hospital Acquired Thrombosis

Reporting Schedule	**Monthly**
Health Board	
Date of Report	

Completed By	
Contact Number	
E-mail Address	

Reporting Template: The total number of suspected hospital acquired thromboses each calendar month.

Sumbission Date: 10 working days after month end or 14th of the following month.

	April 2014	May 2014	June 2014	July 2014	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Total
Number of suspected hospital acquired thromboses each calendar month													0

Quarter 1 Total	0	**Quarter 2 Total**	0	**Quarter 3 Total**	0	**Quarter 4 Total**	0	

Return form to: Lisa.Phillips@wales.gsi.gov.uk

Hospital Acquired Thrombosis

Reporting Schedule	**Quarter**
Health Board	
Date of Report	

Completed By	
Contact Number	
E-mail Address	

Reporting Template:
> The number of Root Cause Analysis (RCA) completed (based on the quarter's number of suspected HAT).
> The actual number of preventable HATs (detemined from the Root Cause Analysis).
> The number of cases not felt to be HAT
> Summary of learning and actions.

Sumbission Dates:
Quarter 1 2014/15: 14 October 2014 (Data for April to June 2014)
Quarter 2 2014/15: 14 January 2014 (Data for July to September 2014)
Quarter 3 2014/15: 14 April 2015 (Data for October to December 2014)
Quarter 4 2014/15: 14 July 2015 (Data for January to March 2015)

	Q1	Q2	Q3	Q4	Total
Number of suspected hospital acquired thromboses each quarter	0	0	0	0	0
Number of Root Cause Analysis (RCA) completed					0
Actual number of preventable HATs					0
Number felt not to be HAT					0

Summary of lesson learnt to improve delivery	Corrective actions agreed

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GIG CYMRU NHS WALES

Ask about CLOTS

A CLOT IS A BLOCKAGE IN A BLOOD VESSEL.

It can travel to other places in the body.

There are different names for **CLOTS...**

DEEP VEIN THROMBOSIS

A PULMONARY EMBOLISM

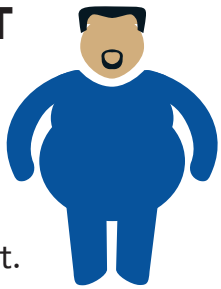
ANYONE CAN GET A CLOT!

1,250 PEOPLE IN **WALES** ARE AT **RISK** OF DEATH **ANNUALLY** FROM BLOOD CLOTS

66% of clots happen in **HOSPITAL** or in the **90 DAYS** following admission.

Some ongoing medical conditions increase the risk of developing a clot.

OVERWEIGHT people have a **200%** higher chance than other people of developing a clot.



A little or very overweight people.

PREGNANT WOMEN have a higher risk of developing a clot.

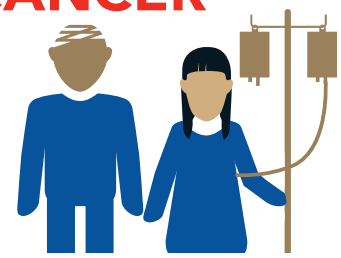
25% people who have **SERIOUS SURGERY** can get clots.

1% of people **aged 80+** develop **CLOTS**

OLDER PEOPLE

People who have **CANCER**

ILLNESS and **POOR HEALTH** increases the risk of a clot



You have a **HIGHER CHANCE** of getting a clot in **HOSPITAL**

Than on an **AEROPLANE!**

Clots can be **AVOIDED!** Ask to be assessed for **YOUR RISK**

EVERYONE SHOULD ASK ABOUT CLOTS

Ask your **DOCTOR, NURSE** or **HEALTH PROFESSIONAL** about **CLOTS.**

www.askaboutclots.co.uk #askaboutclots

1000 LIVES i O FYWYDAU