

Written Response by the Welsh Government to the report of the Health and Social Care Committee; One-day inquiry into venous thromboembolism prevention in hospitalised patients in Wales

November 2012

Executive Statement

Improving the quality and safety of healthcare and ensuring patients receive a good experience of care is a high priority for the Welsh Government. I, therefore, welcome this report and the opportunity to discuss what we are doing to ensure we minimise the number of people who suffer following a thrombosis acquired whilst in hospital. I would also like to put on record my appreciation of the work of the Health and Social Care Committee in collecting the evidence and presenting their findings. This inquiry report can only add to our efforts to raise awareness of the need to identify and manage the risks to prevent venous thromboembolism (VTE) in hospitalised patients in Wales. VTE is a serious and potentially devastating condition and I am committed to continuing and accelerating our efforts to reducing the incidence across Wales.

The open and constructive discussion during this inquiry has helped to identify the challenges to organisations and individual clinicians in tackling the complexity associated with VTE prevention. However, it was clear there is a strong commitment to getting this right and making further improvements. We now need to build on this to ensure any barriers to progress can be removed. We have much to build on and a range of expertise across NHS Wales to ensure the widespread adoption of best practice. The work already in train to develop a national hospital acquired thrombosis rate is just one example of this. I would also like to thank Lifeblood Wales for the support and advice they have provided by working in collaboration with the NHS and the 1000 Lives Plus team. The quality improvement methodology promoted by the 1000 Lives Plus programme has provided a framework and the tools to enable the evidence endorsed by NICE and others to be carried out in practice in a systematic way. This must now become routine, day to day practice to ensure those patients at risk are clearly identified and treated in accordance with their individual need.

The recommendations in this report can only help us take forward and build on the considerable amount of work we have seen to date. My response to each of the recommendations shows work has continued to progress in preventing VTE, but it is coupled with further actions to accelerate our efforts. The 1000 Lives Plus programme will continue to play a key role in driving this work forward.

I have set out below my response to the Report's individual recommendations.

Detailed Responses to the report's recommendations are set out below:

The Committee recommends that:

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.

Response : Accept in principle

I accept this recommendation 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 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.

Financial Implications – None. Any additional costs will be drawn from existing programme budgets.

The Committee recommends that:

Recommendation 2:

A standard procedure be implemented to reduce hospital acquired thrombosis (HAT) in Wales, mandating clinicians to risk assess and to consider prescribing appropriate thromboprophylaxis – mechanical or chemical – for all hospitalised patients.

Response : Accept in principle

I accept this recommendation in principle. The tools and resources developed through the 1000 Lives Plus collaborative, provide NHS organisations in Wales with a clear and systematic 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 sustainable implementation of this approach.

Financial Implications – None.

The Committee recommends that:

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.

Response : Accept

I accept this recommendation. 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.

Financial Implications – None.

The Committee recommends that:

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.

Response : Accept in principle

I accept this recommendation 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. 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. I will expect this 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.

Financial Implications – None. Any additional costs will be drawn from existing programme budgets.

The Committee recommends that:

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.

Response : Accept

I accept this recommendation. 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 '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.

Financial Implications – None. Any additional costs will be drawn from existing programme budgets.