Health and Social Care Committee
One-day inquiry into venous thrombo-embolism prevention
VTE 11 – Cardiff and Vale University Health Board

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4th May 2012

Mark Drakeford AM
Chair of the Health and Social Committee
C/o Committee Clerk,
Health and Social Care Committee,
National Assembly for Wales,
Cardiff Bay,
CF99 1NA

Dear Chair,

Re - Evidence on behalf of Cardiff and Vale UHB for the Health and Social Care Committee – Venous thrombo-embolism (VTE) prevention in hospitalised patients in Wales.

Thank you for inviting evidence on behalf of Cardiff and Vale UHB on this important subject. This has been prepared on behalf of the UHB with written advice from Dr Rachel Rayment (Consultant Haematologist), Vice Chair of the Thrombosis and Anticoagulation Group and Dr Graham Shortland (Executive Medical Director) Chair of the Thrombosis and Anticoagulation Group. Both of us would be agreeable to the presentation of oral evidence.

In 2008 Cardiff and Vale Trust set up a Thrombosis Committee. This was a group of interested clinicians, pharmacists and nurses who were committed to improving the practice across the Trust. The Trust published a thromboprophylaxis policy, demonstrating its commitment to thrombosis prevention at board level. Senior clinicians taught medical students, foundation doctors, and core trainees about the importance of

thromboprophylaxis. The policy was launched, along with standardised risk assessment tools for medicine, surgery and obstetrics, with departmental presentations and a Grand Round presentation.

In 2009 the All Wales Medical Directors Group tasked Dr Simon Noble to chair an All-Wales thromboprophylaxis group, at which Cardiff and Vale were represented by a senior clinician and a pharmacist, to develop an All-Wales risk assessment tool, which was ultimately badged by 1000 lives plus campaign, which had also launched a mini-collaborative to help organisations improve their rates of risk assessment. The risk assessment tools were launched in December 2009.

Simultaneously, in September 2009 the then medical director invited Dr Graham Shortland (then AMD for quality and innovation to chair a thrombosis and anticoagulation group, replacing the existing thrombosis committee), which reported to the Quality and Safety committee. This group was formed in line with guidance from “Lifeblood – The thrombosis charity” and tailored to local needs.

In January 2010 NICE CG92 was published which necessitated some change in the risk assessment tool, this was done locally at Cardiff and Vale UHB. The revised risk assessment tools were launched in the UHB in April 2010 for “general” surgery, obstetrics, elective hip and knee replacement surgery and other elective orthopaedic surgery. The tools were circulated from the Medical Director’s office to divisional directors and clinical directors. Grand round presentations were aimed at engaging senior clinicians and thromboprophylaxis discussed at induction of new junior medical staff.

The UHB has continued to participate in the 1000lives plus mini-collaborative, where there was sharing of approaches/difficulties with the other health

boards in Wales. Clinical audits undertaken in 2011 have demonstrated variable success in the use the risk assessment tool with compliance at its greatest in gynaecology (consistently >80%) and areas of much lower success.

In the past year the UHB has signed up to the maternity mini-collaborative run by 1000 lives plus. One of the issues addressed was VTE prevention (VTE being a leading cause of maternal death for many years). As a consequence, VTE risk assessment has been built into admission bundles for women being admitted to the assessment unit and has to be completed as a criterion for completion of the bundle as a whole. Adopting the PDSA approach has seen a change in the culture with regard to VTE risk assessment in this ward, which we are planning to take to the antenatal ward over the next few months. This initiative by 1000lives plus along with other initiatives from the 1000lives plus programme has helped in the development of tools and improvement methodology to assist in the implementation of NICE guidance. However whilst there are areas that have seen significant change and success, such as gynaecology and obstetrics in Cardiff and Vale UHB, full-scale systems change in our experience has not yet been achieved.

Prevention of hospital acquired thrombosis has been discussed at each division's quality and safety meetings, and it has been suggested that each division has a VTE prevention champion.

We have also tried to adopt a similar approach to that utilised in the hand-washing campaign (i.e. to raise patient awareness) by providing leaflets and providing information on the plasma screens in the hospital waiting areas and on the bedside Patientline screens. Despite these approaches progress continues to be difficult in raising awareness of the risk assessment tool and its use.

Work is under-way, to develop a robust method of measuring the hospital's rate of hospital acquired thrombosis (HAT). This approach needs further work and refinement before being sufficiently robust to publish and use to incentivise clinical staff. However we view this as an important initiative and we would aim to have a HAT rate, which could be published on the UHB "safety dashboard" to help drive the quality and safety agenda, and assist teams who were caring for patients who subsequently developed HAT, so that they may undertake a root cause analysis on why it occurred. **This would allow feedback to the clinicians (who often do not see the patient when they develop this complication) and facilitate a change in practice.** We feel that this is a more useful approach than focussing solely on the rate of completion of risk assessment forms, a process measure.

This leads us to discuss how we might improve the success of implementation of NICE guidance;

> At present we understand each Health Board is working individually to develop their own HAT rate. The method for doing this should be standardised so that Wales can produce a national HAT rate and also be able to compare outcomes between Health Boards and encourage improvement within organisations.
> Welsh Government should work with health boards in Wales to produce a HAT rate. This should include the use of such a rate in Welsh Government "Quality Frameworks" to better focus the issue of VTE prevention, to drive change from a "Board to Ward" level.
> We acknowledge that the development of such a HAT rate is not easy but once again we believe that this would improve implementation of the NICE guidance. Radiology departments would need to provide

standard codes for positive and negative scan (Doppler and V/Q scan) results to help in this process.

We believe that with a greater focus on the development of outcomes would improve the success of implementation of the NICE guidance. A great deal of success has been achieved with Health Care Associated infection (HCAI) rates in Wales, particularly Clostridium Difficile. There is a need to develop similar levels of awareness and measurements throughout the Healthcare Community (from Welsh Government to ward level) of VTE prevention to that which has been achieved with HCAI.

Dr Graham Shortland BM, DCH, FRCPCH.
Medical Director Cardiff and Vale UHB