Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 1 – y Senedd

Dyddiad:
Dydd Iau, 24 Mai 2012

Amser:
09:00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:

Llinos Dafydd
Clerc y Pwyllgor
029 2089 8403
HSCCommittee@wales.gov.uk

Agenda

1. Cyflwyniad, ymddiheuriadau a dirprwyon

2. Ymchwiliad un-dydd i atal thrombo-emboledd gwythiennol – Tystiolaeth lafar (09:00 – 11:30) (Tudalennau 1 – 33)

09:00 – 09:45
HSC(4)-15-12 papur 1 – Lifeblood
Dr Simon Noble
HSC(4)-15-12 papur 2 – Fforwm Thromboproffylacsis y DU
Dr Raza Alikhan

09:45 – 10:30
HSC(4)-15-12 papur 3 – Coleg Brenhinol yr Obstetryddion a'r Gynaecolegwyr
Mr Nigel Davies
HSC(4)-15-12 papur 5 – Coleg Brenhinol y Nyrsys Cymru
Lisa Turnbull, Cynghorydd Polisi a Materion Cyhoeddus
Nicola Davies-Job, Cynghorydd Gofal Aciwt ac Arweinyddiaeth

10:30 – 10:40 Egwyl

10:40 – 11:30
HSC(4)-15-12 papur 4 – Coleg Brenhinol y Ffisigwyr
Prof Beverly Hunt
HSC(4)-15-12 papur 19 – Cymdeithas Orthopedeg Cymru
Dr Andrew Davies

3. Ymchwiliad i ofal preswyl i bobl hŷn - Adborth ar waith ymgysylltu a gyflawnwyd hyd yma (11:30 - 11:50) (Tudalennau 34 - 49)

HSC(4)-15-12 papur 6 – Nodyn ar yr ymweliad â Datblygiad Llys Enfys Linc Care
HSC(4)-15-12 papur 7- Nodyn ar yr ymweliad â Datblygiad Woodcroft Cymorth Hafod
HSC(4)-15-12 papur 8 – Nodyn ar yr ymweliad â Thŷ Bethel
HSC(4)-15-12 papur 9 – Nodyn ar gyfarfod y Grŵp Cyfeirio ar 17 Ebrill 2012

4. Blaenraglen Waith (11:50 - 12:00) (Tudalennau 50 - 53)

HSC(4)-15-12 papur 10

12:00 - 13:00 Cinio

5. Ymchwiliad un-dydd i atal thrombo-emboledd gwythiennol - Tystiolaeth lafar (13:00 - 15:15) (Tudalennau 54 - 98)

13:00 – 13:45

HSC(4)-15-12 papur 11 - 1000 o Fywydau a Mwy / Iechyd Cyhoeddus Cymru
Dr Alan Wilson

13:45 – 14:30

HSC(4)-15-12 papur 12 – Bwrdd Iechyd Aneurin Bevan
Dr Grant Robinson, Cyfarwyddwr Meddygol
HSC(4)-15-12 papur 13 – Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg
Dr Bruce Ferguson, Cyfarwyddwr Meddygol
HSC(4)-15-12 papur 14 – Bwrdd Iechyd Prifysgol Betsi Cadwaladr
Dr Brian Tehan, Cyfarwyddwr Meddygol Cynorthwyol
HSC(4)-15-12 papur 15 – Bwrdd Iechyd Cwm Taf
HSC(4)-15-12 papur 16 – Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
HSC(4)-15-12 papur 17 – Bwrdd Iechyd Hywel Dda

14:30 – 15:15

HSC(4)-15-12 papur 18 – Llywodraeth Cymru
Dr Chris Jones, Cyfarwyddwr Meddygol, GIG Cymru
Grant Duncan, Dirprwy Gyfarwyddwr Gwella Ansawdd, Safonau a Diogelwch

6. Papurau i'w nodi (Tudalennau 99 - 101)

HSC(4)-13-12 cofnodion – Cofnodion y cyfarfod a gynhaliwyd ar 2 Mai

7. Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu eithrio'r cyhoedd o'r cyfarfod ar gyfer eitem 7 (15:15)

8. Ymchwiliad un-dydd i atal thrombo-emboledd gwythiennol - Ystyried y dystiolaeth (15:15 - 15:30)

Health and Social Care Committee
HSC(4)-15-12 paper 1
One-day inquiry into venous thrombo-embolism prevention
- Evidence from Dr Simon Noble

SUBMISSION TO THE NATIONAL ASSEMBLY FOR WALES HEALTH AND SOCIAL COMMITTEE INQUIRY INTO VENOUS THROMBOEMBOLISM PREVENTION IN WALES BY DR SIMON NOBLE

As Medical Director for Wales of Lifeblood: The Thrombosis Charity I am pleased to submit written evidence to the National Assembly for Wales' Health and Social Care Committee Inquiry into venous thromboembolism (VTE) prevention in Wales. I also present this evidence having chaired the All Wales Thrombosis Group, which developed the All Wales Risk Assessment Tools and as 1000 Lives Plus Faculty Lead for the Prevention of Hospital Acquired Thrombosis (HAT). I was also a member of the NICE Guideline Development Group for Clinical Guideline 92: Reducing the Risk of Venous Thromboembolism in Hospitalised Patients.

About VTE

VTE – blood clots – includes both deep vein thrombosis (DVT) and pulmonary embolism (PE). Blood clots form in the veins deep in the leg, usually in the calf or thigh, although occasionally DVT can occur in other veins of the body. A DVT may cause no symptoms at all or it may cause swelling, redness and pain. The majority of deaths from VTE are caused by part of the clot breaking off, travelling around the body and eventually blocking the pulmonary arteries (arteries in the lungs). This is known as a pulmonary embolism (PE). PE can occur suddenly, without warning, and of course can be fatal, though symptoms can include coughing (with blood stained phlegm), chest pain and breathlessness. Patients who survive their PEs are associated with long-term morbidities which can reduce quality of life. In addition up to 30% of people who have suffered a DVT will develop a chronic condition called Post Thrombotic Syndrome (PTS) requiring life long treatment.

Estimates of Hospital Acquired VTE in Wales

In 2005, England's Health Select Committee conducted a similar, one day Inquiry into the prevention of VTE in hospitalised patients[1]. Based on evidence submitted to the Inquiry, the report estimated that without risk assessment and prophylaxis 25,000 avoidable deaths occur every year across the UK. This figure was based on data published in the VITAE study

[1] Available here http://www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/99/99.pdf

which analysed healthcare databases and published research, across six EU countries[2]. From data across a total population of 618 million people, they identified 465,715 cases of DVT, 295,982 cases of PE and 370,012 VTE related deaths. Of these deaths, an estimated 27,473 (7%) were diagnosed as antemortem, 126,145 (34%) were sudden fatal PE and 217,394 (59%) followed undiagnosed PE. All most three quarters of deaths were from Hospital acquired VTE. In addition to these figures highlighting the scope of the problem, it is of interest to note that of all the VTE related deaths, only 7% were identified prior to death. If as these figures suggest, fatal PE is largely asymptomatic (34%) or undiagnosed by clinicians (59%) a strategy to prevent VTE related deaths should focus on their prevention. BAsed on this data, the number of preventable deaths due to hospital acquired thrombosis would be 1250 per annum if risk assessment and thromboprophylaxis were not carries out.

According to data from the Office of National Statistics, the number of deaths due to pulmonary embolus directly or where it is mentioned as an underlying cause are approximately 400 and 800 per annum respectively. However these figures are for all VTE related deaths and not just hospital acquired VTE. Based on Cohen's data where three quarters of all VTE deaths are hospital acquired one could calculate that there are over 300 deaths due to HAT and a further 600 associated with HAT.

Table 1: Number of deaths where deep vein thrombosis or pulmonary embolism was mentioned on the death certificate, Wales, 2006-2010

					Deaths (persons)
Cause of death	**2006**	**2007**	**2008**	**2009**	**2010**
Underlying cause	384	350	367	405	428
Mentioned as underlying or contributory cause	703	697	681	743	799

Even if one were to use these figures to suggest a HAT death rate of 900 per year, this is much lower than the 1250 suggested.
There are several reasons for this:

1. VTE is an under reported phenomenon since death due to VTE is a diagnosis that needs to be made by post mortem. Since Alder Hey, there has been reluctance to request and consent to post mortems and HAT related deaths are likely to be missed.

2. The ICD coding system for diseases does not specify hospital acquired thrombosis and there may be a coding bias which leads to an under reporting.

3. Death due to VTE can only be recorded on the death certificate and hence ONS data, if the cause of death is correctly identified and documented. If only 7% of deaths due to VTE are identified prior to death, it is likely that there is an under reporting of death due to VTE.

[2] Cohen AT et al. Venous thromboembolism (VTE) in Europe. The number of VTE events and associated morbidity and mortality. *Thromb Haemost.* 2007 Oct;98(4):756-64.

The Cost of Hospital Acquired VTE

The cost of Hospital Acquired VTE can be viewed in financial, physical and psychological terms. Lifeblood is contacted on a daily basis by people who have lost loved ones to thromboembolism and those whose lives have been changed by sustaining an thrombosis. It is impossible to quantify the psychological impact VTE has on patients and their families but in addition to recognising the financial cost of VTE we need to appreciate other ways this preventable condition can impact on lives.

Data presented to England's Health Select Committee in 2005 estimated that the hospital acquired VTE costs the NHS in England,Wales and Scotland £640 million per annum.

To view the cost of VTE within Wales one needs to recognise the cost of treating VTE.

The costs of treating DVT range from £499-£1941 depending upon complication and place of management.

The cost of treating a PE is £349-£3618 depending on the level of emergency and complications.

Assuming an incidence of VTE of 1 in 1000, this could lead to an estimated cost of between £1.04 – 1.85 million per annum.

In addition up to 30% of patients experiencing DVT will develop a chronic condition called Post Thrombotic Syndrome (PTS) which requires life long treatment at a current cost of £653 per annum.

Over the past five years there has been an increase in litigation regarding the prevention and diagnosis of VTE. Data from the NHS litigation authority in England shows that £25 million was paid to patients in 2005 and this figure rose to £26 million in 2010. It is estimated that the litigation costs for VTE will have totalled £250 million by 2015.

A cost modelling exercise by NICE calculated that implementing thromboprophylaxis is not only cost effective but also results in net cost savings to the NHS. For every 100,000 risk assessed and given appropriate prophylaxis, this would result in a saving of £12,000.
This figure does not take into account the cost of treating PTS or litigation costs.

About Lifeblood

Lifeblood is a UK based charity whose mission statement is to increase awareness of thrombosis among the public and health professionals, and to raise research funds to improve patient care through improved prevention and treatment of venous thromboembolic disease.

Alongside our active efforts to support research in thrombosis and raise awareness of the condition through our annual public awareness-raising campaign, National Thrombosis Week, we campaign vigorously for Governments across the UK to prioritise VTE prevention in the NHS ('Stop the Clots'), as well as more recently to improve the clinical diagnosis of VTE in the community ('Spot the Clots').

Lifeblood's 'Stop the Clots' campaign

Our ‘Stop the Clots’ campaign aims to ensure that every adult patient admitted to hospital across the UK receives a VTE risk assessment and appropriate prophylaxis in line with national clinical guidelines (SIGN Clinical Guideline 122 in Scotland, and NICE Clinical Guideline 92 in England, Wales and Northern Ireland). The campaign has always been outcomes-focussed. That is, ensuring patients’ risk of VTE, once admitted to hospital, is reduced by receiving appropriate prophylactic treatment if they have been identified as being at risk of VTE through their risk assessment; risk assessment for VTE alone is not enough to prevent hospital acquired VTE.

Lifeblood recognises that each country in the UK presents a different challenge for the national prioritisation of an outcomes-focussed approach to VTE prevention. Lifeblood is determined to continue campaigning vigorously to support each devolved nation implement its own approach to prioritising VTE prevention in a way that that suits their health system, which addresses their individual challenges, and builds on their individual strengths.

Submission

As Medical Director of Lifeblood Wales and Chair of the All-Wales Thrombosis Group (AWTG), I have promoted HAT prevention – Hospital Acquired Thrombosis (the preferred term in Wales) alongside the ‘1000 Lives Campaign’, a national patient safety initiative launched in 2008 aimed at avoiding 1000 avoidable deaths across NHS Wales. This campaign continues under the auspices of ‘1000 Lives Plus’ and Dr Noble remains Faculty Lead for prevention of HAT.

The 1000 Lives campaign comfortably achieved its aim of preventing 1000 avoidable deaths and continues to lead the patient safety agenda in Wales. Many of the successes of 1000 Lives and 1000 Lives plus are clearly evident with marked improvement in safer drugs management, reducing infection rates, pressure sores etc. It is to be congratulated for its achievements in improving patient care and the progress made in VTE prevention. However, the complexity of HAT prevention and the many challenges faced in implementing a sustainable HAT prevention programme means that the successes seen in other health improvement areas have not been realised to the same extent in HAT prevention.

The work of the 1000 Lives and 1000 Lives plus has taken HAT prevention to a point where with appropriate WG support and leadership, a standardised HAT prevention strategy and monitoring programme could be implemented with a system to demonstrate measurable patient benefit.

Lifeblood therefore views this Inquiry as a critical opportunity help shape the national agenda and drive the prioritisation of VTE prevention forward across Wales to ensure all patients receive appropriate prophylaxis when assessed as being at risk of VTE. We recognise that the Health Select Committee Inquiry in England from 2005 acted as a game-changer at the time and continues to be an authoritative source about the scale of avoidable VTE and the simple steps that can be taken to prevent it.

At the end of this submission, Lifeblood lists a number of calls for the Committee which we believe support national leadership on VTE prevention across Wales, with a call for a national focus on outcomes (that is, risk assessment and appropriate prophylaxis), supported by long-term, system-wide structures and approaches to achieve this.

The current status of HAT prevention in Wales

In April 2011 on behalf of the All Wales Thrombosis Group I wrote to the 7 Health Boards and 1 NHS Hospital Trust across Wales asking them to complete the VTE prevention

awareness survey under the provisions of the Freedom of Information Act. We enjoyed a 100% response rate, receiving completed responses from 7 Health Boards and 1 NHS Trust.

Given the impressive response rate, we are confident that we have presented a full account of the challenges faced, and the support required by organisations in implementing best practice guidance at that time. However, one must be mindful that this data reflects the state of play 12 months ago and the evidence submitted by the 7 Health Boards and 1 NHS Trust in Wales will give an up to date overview of progress.

The headline findings are listed below:

Awareness

- **100%** of Health Boards / NHS Trust responded (8 of 8).

- **88%** of organisations were aware of the Welsh Assembly Government's / 1000 Live-Plus monitoring tool for acute stroke (published in June 2010), which includes the requirement to risk assess patients for VTE / HAT?

- **100%** of organisations were aware of the NICE Guideline (published in Jan. 2010) on VTE prevention in patients admitted to hospital.

- **100%** of organisations were aware of the All-Wales Thrombosis Group / 1000 Lives-Plus HAT risk assessment tools, published in September 2010.

- **88%** of organisations had a formal written VTE prevention policy(s) or protocol in place.

Managing HAT Risk

- **100%** of organisations had in place multidisciplinary thrombosis committees, with involvement from doctors and nurses.

- **50%** of organisation's Board members were involved in HAT prevention and management through safety 'walk-rounds', the most common form of involvement.

HAT Risk Assessment

- **88%** of organisations undertook a documented risk assessment for VTE of all hospital inpatients.

- **75%** of organisations routinely reassessed patients for their risk of VTE.

Method and Audit

- **63%** of organisations regularly audited the uptake of risk-assessment for HAT and levels of prescribing of thromboprophylaxis.

- No organisations were able to provide data on the number of patients that were risk assessed for HAT on admission or the level of thromboprophylaxis administered from 2007 to 2009. Only one organisation was able to provide this data from 2009 to 2010.

Education and Information

- **38%** of organisations DID NOT offer patients any information on the risks of HAT on admission.

- **63%** of organisations DID NOT offer patients any information on the risks of HAT on discharge.

- **88%** of organisations DID NOT record instances of HAT on a registry.

Assistance Required

- **88%** of organisations are called for HAT risk assessment to be mandated by Government, with targets set for both documented risk assessment and thromboprophylaxis.

- **63%** of organisations called for mandatory education or training.

Two clear calls for government action emerged from the survey.

1. 88% of organisations called for the Welsh Assembly Government to take steps to **mandate VTE risk assessment**, with Intelligent Targets set for both documented risk assessment and thromboprophylaxis.
A system of national targets has been introduced successful in England through the Commissioning for Quality and Innovation (CQUIN) payment framework, following calls from clinicians themselves for national goals. The fact that clinicians in Wales are also calling for national VTE targets evidences further the significance of VTE prevention to patient safety.

2. Two-thirds of organisations called for the Government to **mandate VTE education and training**, stating it would increase consistent levels of VTE risk assessment and administration of thromboprophylaxis. Increasing professional awareness will be crucial to ensure Board-wide VTE policies are implemented at the ward level.

The challenges of preventing HAT

1. Complexity of HAT

Many of the health improvements bundles that have enjoyed success over the past few years have been in discreet areas of health care where there are clear points of assessment, intervention and evaluation. However, HAT prevention is more complex because:

i. Patients at risk of HAT will enter the healthcare system through different points of entry (elective surgery, emergency surgery, acute medicine, accident and emergency etc)
ii. Different specialties require different interventions; for example surgical patients will need pharmacological and mechanical prophylaxis whilst medical patients only require pharmacological. In addition, elective orthopaedic surgery has the option of using new oral agents to prevent VTE. In short, one size does not fit all.
iii. The risk of HAT may change as the patients condition changes.

As a result, the risk of practice becoming inconsistent across the Prinicipality is significant.

2. Challenges of buy in from all stakeholders

Whilst every health care profession will recognise the importance of handwashing to reduce hospital acquired infection, not everyone fully recognises the importance of HAT prevention. There are several reasons for this:

i. HAT may occur to ninety days after hospital discharge. Therefore the majority will present in the community and not to the hospital team that looked after the patient originally
ii. The majority of HATs will be managed as outpatients and the few that are readmitted to hospital are rarely looked after by their original team (HAT from a surgical procedure will be managed by physicians). Thus there is no formal way to feedback to professionals that their patient has developed HAT. As a result there is a perception amongst some clinician that HAT is not a major problem since they “never see it”.
iii. There is concern within orthopaedic surgery in particular, that by using blood thinning medicines such as heparin or low molecular weight heparin (LMWH) to prevent HAT increases bleeding complications post operatively. The use of anticoagulants has been studies extensively and NICE concluded the side effects of using them are outweighed by the complications of not preventing HAT.

3. Patient empowerment

The success of the national hand washing campaign bears testament to the impact of patient empowerment and buy-in to a health improvement strategy. It is not uncommon for patients to challenge healthcare professionals who have no washed their hands; they have been encouraged to do so and the concept of infections being spread from patient to patient is easily understood. The concept of why HAT occurs is a more complex one to understand since there are many factors which puts someone at risk. Thus it is harder to explain to the public and for them to buy into the importance. In keeping with this, it is more challenging for the media to deliver a successful patient awareness campaign.

4. Prioritisation

Through working with colleagues involved in HAT prevention, there is a strong will to deliver a robust measurable HAT prevention strategy. However there is anecdotal evidence that unless HAT is recognised as priority by the Welsh Government, it is unlikely to have the dedicated attention it needs within each Health Board and Trust.

Data from Betsi Cadwalader University Health Board shows that there is a direct correlation between HAT risk assessment and HAT rates. Interestingly when the risk assessment rate drops off, there is a consequential rise in HAT rate.

Work in England has shown that when risk assessment is prioritised, the risk assessment rate has increased. However, within Wales we have an opportunity to better. Just because someone fills in a risk assessment form does not mean they will get appropriate thromboprophylaxis. Neither can one show in England that the increase in risk assessments has improved patients care. There is an opportunity in Wales to mandate risk assessment PLUS appropriate thromboprophylaxis and directly observe the impact on patient mortality/ morbidity through monitoring the HAT rate for each Health Board.

Further more a HAT rate would allow Health Boards to target patients who have experienced HAT and perform root cause analysis on each case, thereby allowing for learning and improvement.

Conclusion

I am grateful for the opportunity to provide evidence to the committee and would welcome any opportunity to participate in future work within the Principality aimesd at the prevention of HAT.

I respectfully request the Committee for the following in the published Report:

- To recognise the importance of preventing of avoidable hospital acquired VTE in Wales;

- To recognise the cost effective nature of preventing hospital acquired VTE, over and above managing VTE once diagnosed;

- To recognise the comprehensive and up to date nature of NICE Clinical Guideline 92 which sets out best practice in the risk assessment and prevention of hospital acquired VTE;

- To recommend that all adult patients, on admission to hospital, receive a risk assessment for VTE and appropriate prophylaxis in line with NICE Clinical Guideline 92;

- To recommend that the Welsh Assembly recognises VTE prevention as a priority for Welsh Health Boards;

- To recommend that the Welsh Assembly develops an outcomes-focussed approach to preventing VTE across Wales; by developing *Intelligent Targets* for Health Boards across Wales. These could include monthly sample data of a specified size, on both the percentage of adult patients who have received a risk assessment on admission to hospitals, **AND** the percentage of adult patients who have received the appropriate prophylaxis once they have been identified as being at risk

- To recommend that the Welsh Assembly requests all Health Boards and Trust provide an ongoing measure of their HAT rate

- To call on Health Boards to implement a robust system of root cause (RCA) of confirmed cases of hospital acquired VTE, to identify where mistakes have been made in leading to a preventable case of VTE; to recommend that HAT Steering Group shares systems for implementing RCA; and to urge that any learnings from cases of hospital acquired VTE which have been identified as preventable through the RCA are fed back to the responsible clinician and forwarded to the Health Board Medical Director.

- To recognise that professional awareness of hospital acquired VTE remains a challenge; and to recommend that steps are taken across Wales to improve education about preventing VTE amongst health professionals across the disciplines;

Dr Simon Noble
Medical Director (Wales), Lifeblood the Thrombosis Charity
Chair All Wales Thrombosis Group
Faculty Lead for HAT prevention1000 Lives and 1000 Lives Plus

SUBMISSION TO THE NATIONAL ASSEMBLY FOR WALES HEALTH AND SOCIAL COMMITTEE INQUIRY INTO VENOUS THROMBOEMBOLISM PREVENTION IN WALES

BY DR RAZA ALIKHAN: EXECUTIVE COMMITTEE MEMBER: UK THROMBOPROPHYLAXIS FORUM AND CONSULTANT HAEMATOLOGIST UNIVERSITY HOSPITAL OF WALES

As an executive committee member of the UK thromboprophylaxis forum I am pleased to submit written evidence to the National Assembly for Wales' Health and Social Care Committee Inquiry into venous thromboembolism (VTE) prevention in Wales.

The objectives of the UK Thromboprophylaxis Forum are:

- To provide a forum for UK healthcare professionals to meet and exchange views and information on thromboprophylaxis
- To facilitate best practice across the UK
- To identify solutions to problems with implementation of best practice
- To provide information on education initiatives such as thromboprophylaxis courses
- To provide the NHS Implementation Working Group (IWG) and NICE with a forum whereby they can interface with thrombosis committee members and others, thus helping them to achieve their objectives (e.g. development and implementation of the IWG's Risk Assessment Model, RAM)
- To promote local and national audit of thromboprophylaxis
- To raise public awareness of the need for thromboprophylaxis

Deep vein thrombosis (DVT), i.e. blood clots in the veins, and pulmonary embolism (PE), i.e. blood clots that have travelled to the lungs are distinct clinical presentations of the same pathophysiological process: venous thromboembolism (VTE). It is important to recognize that VTE is a significant cause of both morbidity and mortality in patients who have been hospitalized. It is estimated that hospital associated thrombosis (HAT) accounts for 25-50%

of all cases of VTE and that 5-10% of deaths in hospitalized patients occurs as a result of VTE.

Traditionally it was thought that it was patients admitted to hospital for surgery that were at risk of VTE. However, historically it has been known for centuries that pregnancy is associated with DVT and more recently it has become clear that medical patients make up the majority of those diagnosed with VTE.

The risk of VTE is related to the presence or absence of a number of risk factors (table 1) and the risk increases with the presence of increased numbers of risk factors.

Table 1. Risk factors for hospital associated thrombosis

Surgery	Pregnancy	Cancer
Cardiac failure	Respiratory failure	Acute infection
Previous VTE	Inherited thrombophilia	Hormone therapy
BMI > 30	Age > 60	Immobility

Chemical thromboprophylaxis, in particular heparin and low molecular weight heparin, has been shown to safely and effectively reduce the risk of both asymptomatic and symptomatic VTE in surgical and non-surgical patients. To appropriately prescribe thromboprophylaxis a patient must first be assessed for their risk of VTE (table 1).

One of the main recommendations of the Chief Medical Officer's Expert Working Group Report, in April 2007, was that all hospital patients should receive a VTE risk assessment upon admission to hospital. The All Wales Thrombosis Group in collaboration with 1000 Lives are to be commended for producing VTE risk assessment forms for acute medical, acute surgical, elective surgical, acute orthopaedic and elective orthopaedic admissions to hospital http://www.tpforum.co.uk/library/risk-assessment/. These risk assessment forms were produced in advance of the 2010 NICE clinical

guideline (CG92 VTE - reducing the risk) and were universally taken up and adapted by Health Boards across Wales.

Unfortunately, as witnessed in both England and Scotland following their introduction of VTE risk assessment, the use of these forms across Wales has been disappointing. There appears to be varying compliance across Health Boards as well as within individual hospitals, directorates, departments and individual clinicians. To address this issue, England made VTE risk assessment on admission to hospital a mandatory requirement. Scotland has recently also mandated VTE risk assessment on admission to hospital. Having led the way in VTE risk assessment Wales now finds itself following in the wake of both England and Scotland.

It is envisaged that VTE risk assessment and appropriate thromboprophylaxis will become part of the normal admission process, across Wales, associated with hospitalization of a patient. Raising awareness and in particular VTE education are of paramount importance. Since 2011, formal teaching on VTE has been established as part of Year 2 and Final Year medical undergraduate teaching at Cardiff University Medical School. Nursing staff are also central to VTE risk assessment and thromboprophylaxis to prevent HAT and it is therefore important to establish formal VTE teaching as part of the School of Nursing studies in Wales.

The establishment of VTE clinical nurse specialists to provide VTE leadership, promote VTE risk assessment and appropriate thromboprophylaxis, educate medical and nursing colleagues and contribute to audit of HAT are key to reducing HAT. There are a number of VTE nurse consultants as well as a significant number of VTE clinical nurse specialists in England contributing to achieving a reduction in HAT. There are currently no VTE nurse specialists in Wales.

The 1000 Lives campaign as well as the All Wales Thrombosis Group have led the way in Wales in raising the awareness of the scope of the problem as a result of VTE and HAT. Unfortunately, the initial momentum appears to have

faltered and Wales now finds itself falling further behind the progress being made in both England and Scotland.

The UK Thromboprophylaxis Forum would like the Committee to consider the following proposals:

Consider making VTE prevention a Tier 1 Core Delivery Target for NHS Wales, with:

1. Mandatory VTE risk assessment for all patients admitted to hospital in Wales
2. Inclusion of VTE education on the medical and nursing curriculum in Wales
3. Establishment of VTE clinical nurse specialists in each Health Board
4. Establishment of an All Wales HAT collaborative to define the HAT rate for the Principality and use this as a bench mark against which the success of risk assessment and thromboprophylaxis can be measured against

Health and Social Care Committee
HSC(4)-15-12 paper 3
One-day inquiry into venous thrombo-embolism prevention – Evidence from Royal College of Obstetricians and Gynaecologists

Transforming Maternity Services Mini-Collaborative

Venous Thromboembolism (VTE)

Obstetric All Wales DVT Risk Assessment

Part of 1000 Lives Plus, the overall aim of the Transforming Maternity Services Mini-Collaborative is to improve the experience and outcomes for women, babies and their families within Maternity Services. One of the drivers in achieving this aim is to reduce the risk of venous thromboembolism in pregnancy.

Implementation of interventions relating to deep venous thrombosis (DVT) risk assessment should have been straight forward, because the Royal College of Obstetricians and Gynaecologists had published an evidenced based 'green-top guideline' on this subject. Although the guideline summarises the known increased risks of VTE in pregnancy, application of this knowledge to routine pregnancies creates an additional risk of increased morbidity and caesarean section. The level of the evidence has been queried in clinical practice, with the result that there was limited and inconsistent risk assessment taking place in maternity units in Wales.

The Transforming Maternity Services Mini-Collaborative brings together experts, clinicians and managers to effect change at the bedside (from the 'bottom up'). It is endorsed by Welsh Government, all Health Boards in Wales, and the Royal Colleges of Midwives (RCM), and Obstetricians and Gynaecologists (RCOG) in Wales.

The multi-disciplinary and inter-professional nature of the mini-collaborative has seen discussion by maternity staff in Wales with the aim of producing clarity in VTE risk assessment in pregnancy. Feedback from the service demonstrated consensus among clinical staff that the RCOG Green top guideline had several drawbacks, as it may be thought of as 'medicalising' women who would be otherwise regarded as normal. It recommends thromboprophylaxis with low molecular weight heparin (LMWH) for women with a BMI that would result in over 1:4 needing to inject themselves with LMWH during or after pregnancy, for an uncertain benefit, based on trial evidence that is of relatively low quality. There are no data on the clinical or cost-effectiveness of such a strategy.

Following consultation with experts from within Wales and the relevant endorsement committees, consensus has been reached to enable universal VTE risk assessment to be implemented throughout Wales, with two Exemplar DVT Risk Assessment Templates – one relating to the initial 'Booking' visit, which is to be included in the National Hand-Held records and one relating to Antenatal Admission and the puerperium (postnatal period). This has been a significant achievement for the mini-collaborative in a short period of time and is now allowing maternity units to proceed with implementation of the bundles.

All Health boards within Wales are currently implementing these risk assessments following localisation and agreement within their scrutiny committees.

It is recommended that DVT Risk Assessment be carried for pregnant women firstly at their booking appointment (ideally by 12 weeks pregnancy), at each antenatal admission and again following the birth.

Work is also underway to implement a combined antenatal booking and admission risk assessment within gynaecological wards alongside the general DVT risk assessment.

Below are the agreed risk assessments:

Deep Vein Thrombosis Risk Assessment
Booking

All women to be assessed by midwife at first/booking appointment.

Indications for consideration of antenatal thromboprophylaxis

	YES	NO		YES	NO
Previous DVT/PE			**Antithrombin deficiency**		
Systemic lupus erythematosis			**Sickle cell disease**		
Antiphospholipid syndrome			**Myeloproliferative disorder**		
BMI ≥45kg/m^2 **Consider referral to anaesthetist as per local guidance**			**Assessed by** **Date / Signature**		

If one or more Indications (above) present, woman to be referred for obstetric led care and *consideration* of antenatal thromboprophylaxis.

Referred o (if appropriate): **Date:**

Please refer to local guidance re referral timeframes and follow-up.

Obstetrician Review SUMMARY:

Reviewed by: **Date:**

This assessment needs to form part of any further risk assessment following identification of risk factors (and referral) or during any AN hospital admission.

ANTENATAL ADMISSION/POSTNATAL DVT RISK ASSESSMENT

Every woman to be risk assessed at each antenatal admission by locally agreed clinician.
Please refer to Antenatal Booking Risk Assessment (to ensure continuation) prior to completion of this form.
Every woman to be re-assessed postnatally

Addressograph

ANTENATAL ADMISSION

Indications for thromboprophylaxis (TEDS & Clexane) whilst antenatal inpatient.
Indication : One identified indication = Thromboprophylaxis to be considered

Date										
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Ongoing antenatal thromboprophylaxis										
Hyperemesis										
Dehydration with dry tongue / poor urine output										
Booking BMI ≥35kg/m^2										
Varicose veins with phlebitis										
Immobility >3 days bed rest conditions										
Significant medical co-morbidity (such as heart disease, metabolic, endocrine or respiratory pathologies, acute infectious diseases or inflammatory)										
Sepsis										
Active cancer / cancer treatment										
Thromboprophylaxis required										
Booking Weight		**Weight at risk assessment.**								
Signature										

Prescription of Thromboprophylaxis:

Prescribe according to booking weight unless there has been a significant weight gain during the pregnancy of >12kg

Weight (kg)	**Enoxaparin dose (mg)**	**frequency**
<50	20	od
50-100	40	od
101-120	40	bd
>120	60	bd

Contraindications to Enoxaparin (CLEXANE)

1. Birth or spinal or epidural analgesia / anaesthesia anticipated within next 12 hours	5. DIC
2. Wait 6 hours following performing spinal or epidural analgesia / anaesthesia or epidural catheter removal	6. Past history of heparin-induced thrombocytopenia (discuss with haematologist)
3. Do not remove epidural catheter within 12 hours of Clexane administration. (If on > 40mg discuss with anaesthetist)	7. Patient is already receiving other anticoagulants (e.g. warfarin/heparin)
3. Active bleeding	8. Severe liver disease
4. Platelet count < 75 x 10^9/l	9. Severe renal impairment: If eGFR < 30ml/min or evidence of acute renal failure use subcutaneous unfractionated heparin 5000u bd

Consider below knee antiembolism stockings alone if enoxaparin is contraindicated and thromboprophylaxis needed. Avoid stocking if pedal pulses are impalpable, peripheral vascular disease, severe dermatitis, peripheral neuropathy or recent skin graft.

Postnatal (to be completed within locally agreed timeframe)

Ensure thromboprophylaxis (TEDS & Clexane for 5 days) has been prescribed following birth with one or more factor	**Yes**	**No**	**Women receiving thromboprophylaxis during pregnancy should continue treatment for 6 weeks postpartum**
PPH >1500ml			
Red blood cell transfusion or transfusion of coagulation factors			
Caesarean section (elective or emergency)			
Still-birth			
BMI >40kg/m^2			**Signature**
Sepsis			
Complex vaginal delivery (Consider thromboprophylaxis)			
Thromboprophylaxis required			**Date**

Delay commencement until 6 hours following epidural catheter removal or completion of spinal anaesthesia. Encourage early mobilisation, hydration and awareness of symptoms of VTE in all women.
Prescription of postnatal Thromboprophylaxis: As table above. To be calculated using booking weight.

Royal College of Physicians

National Assembly for Wales Health and Social Care Committee: Inquiry into Venous Thromboembolism prevention in Wales

Royal College of Physicians' submission

4 May 2012

1. The Royal College of Physicians (RCP) is pleased to submit written evidence to the National Assembly for Wales' Health and Social Care Committee Inquiry into Venous Thromboembolism (VTE) prevention in Wales.

Introduction

About VTE

2. VTE – blood clots – manifests as both deep vein thrombosis (DVT) and pulmonary embolism (PE). Blood clots form in the veins deep in the leg, usually in the calf or thigh, although occasionally DVT can occur in other veins of the body. A DVT may cause no symptoms at all or may cause swelling, redness and pain.

3. The majority of deaths from VTE are caused by part of the clot breaking off, travelling around the body and eventually blocking the pulmonary arteries (arteries in the lungs). This is known as a pulmonary embolism (PE). PE can occur suddenly and without warning, though symptoms can include coughing (with blood-stained phlegm), chest pain and breathlessness. PE can be fatal.

4. Patients who survive a PE may develop long-term comorbidities, including post-thrombotic syndrome, which consists of chronic swelling and ulceration of the legs. This can significantly impact quality of life.

Estimates of hospital-acquired VTE in Wales

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5. In 2005, the House of Commons Health Select Committee in England conducted a similar, one day Inquiry into the prevention of VTE in hospitalised patients[1]. The subsequent report estimated that 25,000 avoidable deaths occur every year in the UK from hospital-acquired VTE.

6. While there has been some debate in recent years over the accuracy of the 25,000 avoidable deaths figure[2], it is widely agreed that many thousands of deaths occur every year from preventable VTE acquired in hospitals across the UK. Work in England is ongoing to develop up-to-date and accurate statistics about incidence and death from hospital-acquired VTE, though this task entails significant difficulty due to the often clinically silent nature of VTE, and a fall in the number of postmortems in recent years.

Preventing hospital-acquired VTE

7. It is a well-established clinical fact that hospital-acquired VTE can be prevented through a combination of two simple, safe and effective steps: a risk assessment of patients for their VTE and bleeding risk, to identify those at risk of VTE and those for whom preventative treatment is appropriate; and administering preventative treatment for those identified as being at risk of VTE, in the form of pharmacological prophylaxis and / or mechanical prophylaxis.

8. NICE clinical guideline 92, published in January 2010, provides a comprehensive and up to date set of best practice recommendations for VTE prevention applicable across England and Wales. The guideline makes recommendations on assessing and reducing the risk of VTE in patients in hospital, and offers guidance on the most clinically and cost-effective measures for VTE prophylaxis in these patients. The recommendations take into account the potential risks of the various options for prophylaxis and patient preferences[3].

9. VTE prevention, in line with the recommendations contained within NICE clinical guideline 92, is therefore a simple, safe and effective measure which can prevent thousands of avoidable deaths from hospital-acquired VTE every year.

Financial cost of hospital-acquired VTE

10. VTE prevention is undoubtedly a cost effective measure for health boards in Wales to implement. NICE has demonstrated that compliance with NICE clinical guideline 92 to prevent hospital-acquired VTE saves money, over and above the cost of managing VTE once it has developed.

11. Following the publication of NICE clinical guideline 92, NICE placed VTE prevention within its list of top ten cost effective guidelines. NICE estimated that effective VTE prevention would cost the NHS in the UK an additional £21.9 million nationally – but this figure is more than offset by the anticipated reductions in DVT and PE, estimated to save £26.3 million nationally. The costing template published alongside the guidance suggested that, for a population of 100,000, the NHS could expect to generate savings of £11,000.

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[1] Available at http://www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/99/99.pdf

[2] BMJ article and responses available at http://www.bmj.com/content/343/bmj.d6452

[3] P5 http://www.nice.org.uk/nicemedia/live/12695/47195/47195.pdf

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12. In contrast, statistics published by The Office for Healthcare Economics in 1993 estimated that the annual cost of treating patients who developed post-surgical DVT and PE was in the region of £204.7 to £222.8 million in the UK. The total cost (direct and indirect) to the UK of managing VTE is estimated at £640 million (House of Commons Health Select Committee, 2005)[4].

13. These figures clearly demonstrate that compliance with best practice in VTE prevention (that is, risk assessment of patients for VTE on admission and the administration of appropriate prophylaxis) makes financial sense for health boards in Wales at a time when there are significant pressures to manage costs. VTE prevention is a simple, effective, and cost-efficient measure to save lives.

Submission

Building on NHS Wales successes and continuing to improve VTE prevention

14. The medical director of Lifeblood Wales and Chair of the All-Wales Thrombosis Group (AWTG), Dr Simon Noble, has promoted HAT prevention – hospital-acquired thrombosis (the preferred term in Wales) alongside the '1000 Lives Campaign', a national patient safety initiative launched in 2008 aimed at avoiding 1000 avoidable deaths across NHS Wales. This campaign continues under the auspices of '1000 Lives Plus' and Dr Noble remains faculty lead for prevention of HAT.

15. The 1000 Lives campaign achieved its aim of preventing 1000 avoidable deaths and continues to lead the patient safety agenda in Wales. Many of the successes of 1000 Lives and 1000 Lives Plus are clearly evident with marked improvements in safer drugs management, reducing infection rates, pressure sores etc. However, the complexity of HAT prevention and the many challenges faced in implementing a sustainable HAT prevention programme means that the successes seen in other health improvement areas are not as evident in HAT prevention.

16. The work of 1000 Lives and 1000 Lives Plus has taken HAT prevention to a point where, with appropriate Welsh assembly members' and Welsh government support and leadership, a standardised HAT prevention strategy and monitoring programme could be implemented with a system to demonstrate measurable patient benefit.

17. The RCP therefore views this Inquiry as a critical opportunity to help shape the national agenda and drive the prioritisation of VTE prevention forward across Wales to ensure all patients receive appropriate prophylaxis when assessed as being at risk of VTE. We recognise that the Health Select Committee Inquiry in England from 2005 acted as a game-changer at the time and continues to be an authoritative source about the scale of avoidable VTE and the simple steps that can be taken to prevent it.

18. The majority of this submission will focus on broad examples of practice we have learnt from other national approaches to VTE prevention – what has worked well, what we believe falls short in developing an outcomes-focused national approach to VTE prevention, and the opportunity presented by this Inquiry for the Committee to support a robust, comprehensive and national approach to VTE prevention across Wales.

[4] Cited from NICE Clinical Guideline 92 Costing Template, available at http://www.nice.org.uk/nicemedia/live/12695/47234/47234.pdf

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19. In the final part of this submission, we list a number of recommendations for the Committee to consider. We believe these steps will support national leadership on VTE prevention across Wales by highlighting the need for a national focus on outcomes (that is, risk assessment and appropriate prophylaxis), supported by long-term, system-wide structures and approaches to achieve this.

Implementation of NICE clinical guideline 92 in Wales

20. We defer to the submission from the All-Wales Thrombosis Group for evidence on this matter.

Implementation of the 1000 Lives Plus risk assessment tool in Wales

21. We defer to the submission from the All-Wales Thrombosis Group for evidence on this matter.

The adequacy and effectiveness of the 1000 Lives Plus risk assessment tool in preventing venous thromboembolism in hospitalised patients; problems in the implementation and delivery of VTE prevention actions; the effectiveness and utilisation of pharmacological and mechanical prophylaxis for VTE

22. We commend the 1000 Lives Plus team for working with the All-Wales Thrombosis Group to develop robust and comprehensive sets of VTE risk assessment and prophylaxis tools during 2010, and further for supporting health boards to implement these tools locally in the form of the HAT Collaborative last year. The forms are certainly adequate in that they comply with NICE clinical guideline 92, and they provide guidance on both risk assessment ***and*** appropriate prophylaxis for at risk patients. In this respect, the template tools go further than the national VTE risk assessment tool published by the Department of Health in England[5], which, although compliant with NICE clinical guideline 92 in the risk factors for VTE and bleeding for the purposes of risk assessment, do not include guidance on appropriate prophylaxis. The RCP therefore commends the 1000 Lives Plus tools as an adequate template to implement VTE prevention in line with existing, national best practice, at the local level.

23. However, we note that the effectiveness of such tools in practice is limited by their uptake at the ward level. This is turn is driven by, amongst other things, the degree to which health boards require, as part of a local VTE prevention policy, that all patients admitted to hospital receive a VTE risk assessment, and are administered appropriate prophylaxis. Unless health boards stipulate this requirement for every patient admitted to hospital in their local VTE policy – and audit compliance in accordance with this – there is no demand or driver to implement the tools at a local level. In addition, limited professional and commissioner awareness about the scale of hospital-acquired VTE limits the individual responsibility taken by health care professionals to ensure VTE risk assessments are completed.

24. As stated above, we have deferred to the All-Wales Thrombosis Group for evidence about the uptake of the tools at the local level. However, based on experience from England on how the uptake of the national VTE risk assessment tool published by the Department of Health has

[5] Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113355.pdf

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been driven, we strongly believe that the national prioritisation of VTE prevention across NHS Wales is essential if we are to ensure that health boards demand, in local VTE prevention policies, that all patients admitted to hospital have a VTE risk assessment and prophylaxis form completed in line with NICE clinical guideline 92. This must be complemented by the requirement that health boards provide regular audit results to the Welsh government on the percentage of patients who have been risk assessed using the tools, and who have received appropriate prophylaxis treatment. This approach will not only recognise the scale of hospital-acquired VTE and the ease and cost-effectiveness with which it can be prevented across NHS Wales, it will also drive the effective use of the national tools at the local level.

25. Such a national approach has been successful in improving the uptake of the national VTE risk assessment tool in England. VTE prevention has been named a national clinical priority across England since 2010. In the same year, the national commissioning for quality and innovation (CQUIN) scheme was introduced in England. This scheme requires each trust to provide monthly census data to the Department of Health on the percentage of patients who have been risk assessed for VTE; if trusts can demonstrate they has risk assessed 90% of adult admissions for VTE in a month, they receive a financial payment. National prioritisation, coupled with national reporting requirements, has been instrumental in improving risk assessment rates, as we have seen a rise in the percentage of NHS patients risk assessed for VTE on admission climb from under 40% to over 90% in under two years.

26. However, the English approach has been viewed as burdensome by some, due to requirement to report monthly census rather than sample data of patients who have been risk assessed for VTE. In addition, and more importantly, the English approach sees the requirement to report monthly audits of prophylaxis rates left to the local level – there is no national goal for prophylaxis rates supported by a national audit requirement. As such, evidence collected from the All-Party Parliamentary Thrombosis Group during their annual audits of NHS trusts demonstrates that the ongoing, national improvements in VTE risk assessment rates delivered through the national CQUIN goal have not been reflected in improved prophylaxis rates[6]. This is worrying given the fact that the administration of prophylaxis is crucial to preventing hospital-acquired VTE – risk assessment alone is not enough.

27. The RCP therefore emphasises to the Committee that the effective uptake of the 1000 Lives Plus risk assessment tool – focussing on both risk assessment and prophylaxis – must be supported with a national, outcomes-focussed approach to VTE prevention which not only makes risk assessment and prophylaxis compulsory, it also measures health boards' compliance with these requirements.

28. The RCP submits that that Committee should recommend that the Welsh government recognises VTE prevention as a priority for Welsh health boards. We submit that the Committee should recommend that the Welsh government develops an outcomes-focussed approach to preventing VTE across Wales; that the Committee should recognise the impact that the national prioritisation and reporting scheme has had in England in improving risk assessment rates of VTE; and should recommend that the Welsh government adopts its own national approach to VTE prevention. We recommend this go further than England's approach by developing *intelligent targets* for health boards across Wales to provide monthly sample data of a specified size, on both the percentage of adult patients who have received a risk

[6] Available at http://apptg.org.uk/?page_id=58

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assessment on admission to hospital, ***and*** the percentage of adult patients who have received the appropriate prophylaxis once they have been identified as being at risk.

Additional observations to improve the prevention of hospital-acquired VTE across NHS Wales

29. The RCP observes that, in general, professional and commissioner awareness about the scale of hospital-acquired VTE is poor. This limits the individual responsibility taken by health care professionals to ensure VTE risk assessments are completed and prophylaxis administered, even if health board policy stipulates that the forms must be completed. We submit that the Committee recommends that steps are taken across Wales to improve education about preventing VTE amongst health professionals across the disciplines, and to ensure VTE prevention is viewed as an essential standard of quality care.

30. The RCP notes that the Hospital-Acquired Thrombosis (HAT) Steering Group, chaired by Dr Simon Noble, and consisting of the Chairs of Thrombosis Committees from the Health Boards, exists to share practice and experience in preventing VTE at the local level across health boards in Wales. We submit that this Group should be supported to continue its work in supporting health care professionals implement high quality VTE prevention at the local level.

31. The RCP recognises the utility of root cause analysis in learning from mistakes and changing behaviour. While time-consuming, root cause analysis of confirmed cases of hospital-acquired VTE can ensure that hospitals and health boards can identify gaps in practice which can be addressed in order to reduce the incidence of hospital-acquired VTE in future. We therefore submit that the Committee should call on health boards to implement a robust system of root cause analysis (RCA) of confirmed cases of hospital-acquired VTE, to identify where mistakes have been made in leading to a preventable case of VTE; should recommend that the HAT Steering Group shares systems for implementing RCA; and should urge that any learnings from cases of hospital-acquired VTE which have been identified as preventable through RCA are fed back to the responsible clinician and forwarded to the health board medical director. Taken in its entirety, this system of an effective RCA can support an improvement in practice to help prevent of hospital-acquired VTE.

Lifeblood and the RCP's call for the Committee

32. Further to the evidence included within this submission, the RCP calls on the Committee:

    a. To recognise the unacceptably high incidence and death rate of avoidable hospital-acquired VTE in Wales;

    b. To recognise the cost effective nature of preventing hospital-acquired VTE, over and above managing VTE once diagnosed;

    c. To recognise the comprehensive and up-to-date nature of NICE clinical guideline 92 which sets out best practice in the risk assessment and prevention of hospital-acquired VTE;

    d. To recommend that all adult patients, on admission to hospital, receive a risk assessment for VTE **and** appropriate prophylaxis in line with NICE clinical guideline 92;

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e. To recommend that the Welsh government recognises VTE prevention as a priority for Welsh health boards;

f. To recommend that the Welsh government develops an outcomes-focused approach to preventing VTE across Wales; to recognise the impact that the national prioritisation and reporting scheme has had in England in improving risk assessment rates of VTE; to recommend that the Welsh government adopts its own national approach to VTE prevention which goes further than England's approach, by developing *intelligent targets* for health boards across Wales to provide monthly sample data of a specified size, on both the percentage of adult patients who have received a risk assessment on admission to hospitals, **and** the percentage of adult patients who have received the appropriate prophylaxis once they have been identified as being at risk;

g. To recognise that professional awareness of hospital-acquired VTE remains a challenge; and to recommend that steps are taken across Wales to improve education about preventing VTE amongst health professionals across the disciplines;

h. To recognise the ongoing clinical leadership provided by the HAT Steering Group, chaired by Dr Simon Noble, which exists to share practice and experience in preventing VTE at the local level across Health Boards in Wales;

i. To call on health boards to implement a robust system of root cause analysis (RCA) of confirmed cases of hospital-acquired VTE, to identify where mistakes have been made in leading to a preventable case of VTE; to recommend that the HAT Steering Group shares systems for implementing RCA; and to urge that any learnings from cases of hospital-acquired VTE which have been identified as preventable through RCA are fed back to the responsible clinician and forwarded to the health board medical director.

33. The RCP would be more than happy to provide more evidence for the Committee on the matter in writing or verbally during the oral evidence session on 24 May where required.

Professor Beverley J Hunt FRCP, FRCPath, MD
Representative of the Royal College of Physicians

Medical Director, Lifeblood: The Thrombosis Charity

Professor of Thrombosis & Haemostasis, King's College, London
Consultant, Departments of Haematology, Pathology and Lupus & Deputy Director of R&D, Guy's & St Thomas' NHS Foundation Trust

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Health and Social Care Committee
HSC(4)-15-12 paper 5
One-day inquiry into venous thrombo-embolism prevention
– Evidence from RCN Wales

National Assembly for Wales Health and Social Care Committee Inquiry into venous thrombo-embolism prevention in hospitalised patients in Wales: Submission from the Royal College of Nursing in Wales

The 1000 Lives Plus risk assessment tool – the need for national and LHB level monitoring of uptake and performance management

The development of the 1000 Lives Plus risk assessment tool in Wales was a tremendous achievement and justly celebrated. The risk assessment tool was based upon a systematic review, meta analysis and health economic appraisal undertaken by the NICE which was published in Guideline 92: Reducing the Risk of Venous Thromboembolism in Hospitalised Patients.

Unfortunately since its initial launch in 2010 the VTE programme has now a low key maintenance approach. The assessment tool is being used inconsistently across Wales. Some areas are using the tool and many are not. It is important to note that this poor uptake is inconsistent within Local Health Boards and indeed is inconsistent within hospitals.

There does not appear to be any national level monitoring for the use of this assessment tool or incentive for the Local Health Boards to comply with its use.

In England the National Commissioning for Quality and Innovation (CQUIN) department has made huge impact on the rates of hospital acquired thrombosis. CQUIN acted as a lever for driving the implementation of VTE risk assessments by providing financial incentives for organisations to collect 'census' data on all hospitalised patients to demonstrate that they were achieving a target of 90%.

The financial case for this approach was the amount of money paid out was more than compensated for by the financial savings achieved from reducing the number of compensation pay-outs to patients and their families for the incidence of unnecessary VTE. Data from the NHS Ligation authority shows that in 2005 England paid out £21million to patients who experienced avoidable VTE or had the diagnosis missed by doctors, but this rose to more than £26 million in 2010.

A similar financial assessment of the savings in Wales should be made and we would advise the Committee to make enquires of the compensation paid out in Wales.

There is also a need for monitoring of uptake of the risk assessment at a LHB level. We are aware that most, if not all, LHBs have a thrombosis committee but the role and remit of these committees is not clear to our members.

Some Local Health Boards have employed a specialist nurse (often as a part-time aspect of their role) to monitor and promote the uptake of the risk assessment tool and preventative actions. For example a specialist nurse is employed in ABMU LHB and a data analyst (a nurse by background) in Betsi Cadwaladr. A specialist nurse is also employed specifically for Glan Clwyd Hospital but funded by a pharmaceutical company – the funding of which is coming to an end. These nurses are crucial to provide education to healthcare support workers, junior doctors and nurses on the subject.

This approach is clearly inconsistent across Wales. It would make sense to consider the evidence from these posts – including the financial cost-benefit analysis. If the impact of uptake and education can clearly be seen to improve and the rate of VTE reduced the wisdom of securing the future of these posts is clear.

Providing data on the relationship between actions taken and outcome is not something purely of interest to management, where ward staff can clearly see the beneficial outcomes of their work, and its value to the patient and organisation, motivation and participation is high.

Pharmacological and mechanical prophylaxis for VTE

The RCN is aware of a small-scale pilot in the Princess of Wales hospital to develop a high visibility sticker for the drug chart of hospital patients assessed at a high risk of VTE. This pilot scheme is multi-professional in approach with doctors, nurse and pharmacists involved.

Thrombo prophylaxis stockings are ordered to each clinical area in the NHS via the All Wales procurement contract. The selection of the various sizes is good but training on stocking application is patchy and delivered by the contacted company. We would advise that the Committee make enquires as to how this training is funded and delivered e.g. is the company required to deliver this as part of its contract? Who in the LHB can access it? It is worth noting that most LHB have placed a moratorium on nursing staff attending any form of training because they are reluctant to finance the backfill to the posts needed on the ward for even a an hour or so.

Demonstration of Hospital Acquired Thrombosis (HAT) Rate

The incidence of HAT and number of deaths attributable to it are based on large scale European Epidemiological studies. However, the HAT rate for Wales is neither known nor recorded. If each Health Board were required to demonstrate its HAT rate, this would bring several benefits in ensuring safe and standard practice. Firstly, it would provide an accurate picture of the scope of the problem within Wales. Secondly, it would allow Health Boards to identify the key problem areas that need improving. Finally, demonstrating the HAT rate will allow professionals to target cases upon which root cause analysis needs to occur, thus allowing for learning and healthcare improvement for each Health Board

Additional points of interest

Hospitalisation or hospital admission which resulted in a period of lesser mobility may increase the risk of VTE to a patient. However they may develop the condition of symptoms in the community. A GP may then refer the patient for an ultrasound scan. It would be very useful therefore to assign a specific radiology code for this type of referral to better understand the frequency of incident.

The RCN would also recommend consideration of the benefits of a national public awareness campaign on the ways to reduce risk of VTE and promote health following hospital admission. NICE guidelines recommend that patients are given both verbal and written information on discharge from hospital. NICE also recommend re assessment within 24 hours of admission and whenever the clinical situation changes.

VTE risk assessments for expectant mothers are carried out by midwives. The risk assessment implementation has been led successfully by the 1000 lives+ Maternity Collaborative and this initiative is to be strongly welcomed.

Summary of recommended actions

- monitoring and performance management of VTE assessment in hospital at a national and LHB level and development of this model to monitor prevention activity
- consideration of the use of specific posts to champion VTE risk assessment, education and prevention activity including cost-effectiveness
- standardised reporting of positive scans for VTE to enable data capture
- publication of national HAT rate for Wales, mandatory recoding of HAT rate with root cause analysis for all cases of HAT
- primary care referrals for ultrasound scan for suspected VTE to be specifically coded to enable data analysis
- consideration of the benefits of a national public awareness campaign on the ways to reduce risk of VTE and promote health following hospital admission

Health and Social Care Committee
HSC(4)-15-12 paper 19
One-day inquiry into venous thrombo-embolism prevention – Evidence from the Welsh Orthopaedic Society

Welsh Assembly Health and Social Care Committee one-day inquiry: Venous Thromboembolism prevention in hospitalised patients in Wales

Submission from the Welsh Orthopaedic Society

There are two groups of patients under Orthopaedic care; those who have suffered a traumatic injury admitted for the management of bone and soft tissue damage, and those admitted for elective Orthopaedic surgery such as joint replacement.

Venous Thrombosis happens when there is an imbalance in the normal homeostatic mechanisms as a result of blood flow stasis, vessel wall damage and / or activation of the clotting cascade of the patient as a result of injury, surgery or systemic disease.

The incidence of symptomatic Pulmonary Embolus has been shown to be very low in recent series of major elective joint replacement patients[1,2,3]. The incidence of fatal pulmonary embolus is of the order of 0.07%[1] using aspirin as thromboprophylaxis.

Historical data regarding rates of DVT in Orthopaedic patients are of limited applicability to current practice as peri-operative protocols have changed dramatically with regard to early mobilisation of patients following hip and knee replacement, care with maintaining hydration and use of mechanical calf pumps intra-operatively.

Published rates of DVT in Orthopaedic patients are often based on soft end-points such as venographically or ultrasound detected thrombosis in patients who have no symptoms. Patients who have an asymptomatic DVT may not have any long term adverse consequences as patients who underwent major joint replacement in the 1980s and early 1990s (when prolonged bed rest was common) do not have higher rates of venous ulceration in later life than the population averages[4,5]. The significance of a diagnosis of asymptomatic DVT is unknown and treatment in this situation may be unnecessary and potentially even harmful.

Trauma patients have two contradictory conditions with regard to thrombo-embolism as they are often immobilised resulting in blood flow stasis and risk of clot formation but they also have an injury which will predispose to bleeding from damaged soft tissues and broken bones.

In the immediate post-operative period all Orthopaedic and Trauma patients have surgical wounds which can bleed. This can result either in external blood loss requiring replacement or more likely

internal bleeding that can result in haematoma formation. In a number of these patients, deep infection will result with the potential for the loss of implanted metal-work such as fracture fixation or joint replacement prostheses. This will result in poor outcomes for the patient and in extreme cases, loss of the limb itself. The use of drugs that discourage blood clotting in favour of bleeding may therefore have serious unintended consequences for patients suffering such complications. The risk of amputation, loss of soft tissue coverage and loss of the implant is ten times higher for patients who return to theatre with wound problems post-operatively than for those who do not[6]. In addition to the human cost, the cost to the health service of revision surgery for infection is of the order of £30,000 per patient.

There have been a number of guidelines published regarding thromboprophylaxis regimens in Orthopaedic patients, some with conflicting advice. Aspirin has not been recommended for use by many of these documents however analysis of the National Joint Replacement Registry data indicates no difference in outcomes for arthroplasty patients treated with Low Molecular Weight Heparin injections or Aspirin[7,8]. Many guidelines have advocated the routine use of new chemical thromboprophylaxis agents that do not have a long track record in clinical practice.

There have been several clinical studies from both the UK and North America that have shown that adopting a blanket policy of offering all elective arthroplasty patients chemical thromboprophylaxis has resulted in more complications and poorer outcomes for patients than previous regimens that did not include the routine use of such drugs[7,9].

There are a number of new chemical agents available for thromboprophylaxis that report low rates of 'major bleeding' in the published summaries of clinical trials using those drugs. However these trial summaries do not highlight a much larger group of bleeding complications that are termed 'clinically significant non-major bleeds'. These events are reported in small print in the tabulated results sections of those papers [eg10,11]. It is these events that can seriously jeopardise the results of surgery as detailed above.

A small proportion of patients are at increased risk of developing venous thrombosis when compared to the rest of the general population. Many are identifiable in advance of surgery on account of thrombophilia diagnoses such as previous personal or family history of Venous Thromboembolism, Protein S or Protein C deficiency, Factor V Leiden, Antiphospholipid Antibodies etc. Such patients will almost certainly need some form of chemical thromboprophylaxis in addition to the mechanical methods employed for 'standard risk' patients.

Key to the successful management of risk of Thromboembolism in Trauma and Orthopaedic patients is a personal assessment of each patient on admission and a tailored regimen of mechanical and / or chemical thromboprophylaxis. It is important that the risk of DVT be reduced without increasing the risks of poor surgical outcomes as a result of complications caused by the prophylaxis regimen. To this end, latest advice from the American Academy of Orthopaedic Surgeons recommends mechanical and / or chemical thromboprophylaxis[12,13].

The Welsh Orthopaedic Society believes that it is imperative that each patient is assessed pre-operatively for their individual risk of venous thrombosis versus bleeding. These risks together with

the options available for prophylaxis should be discussed with the patient. A decision should then be made on the appropriate thromboprophylaxis regimen. This decision should be based on the balance of benefit versus risk for each individual patient. Once the decision is made it should be recorded in the patient record. We would submit that for 'standard risk' patients that regimen would be based on maintaining hydration, mechanical devices and early mobilisation. Some patients may undoubtedly benefit from additional chemical agents and this should be determined after their individual assessment takes place.

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Y Pwyllgor Iechyd a Gofal Cymdeithasol

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Ymchwiliad i ofal preswyl i bobl hŷn – Ymweliad â Datblygiad Llys Enfys Linc Care (26 Ebrill 2012)

Cefndir

1. Fel rhan o'r ymchwiliad i ofal preswyl i bobl hŷn, bu aelodau'r Pwyllgor Iechyd a Gofal Cymdeithasol ar ymweliad â datblygiad Llys Enfys Linc Care yn Llanisien, Caerdydd (26 Ebrill 2012).

2. Yn ystod yr ymweliad cyfarfu aelodau'r Pwyllgor â chynrychiolwyr o blith staff Llys Enfys a Linc Cymru. Diben yr ymweliad oedd:

    - gweld – a dysgu mwy am – y model byw'n annibynnol a fabwysiadwyd yn Llys Enfys; a

    - dysgu mwy am y cymysgedd o wasanaethau sy'n cael eu darparu drwy ddull tai integredig Llys Enfys, gan gynnwys cymorth a gofal personol, tai gwarchod ar gyfer pobl hŷn, a chymorth a llety arbenigol ar gyfer pobl â dementia ac oedolion ifanc anabl.

3. Bu'r cyfleuster yn Llys Enfys yn weithredol ers 2012. Yn ystod yr ymweliad cyfarfu'r Aelodau a nifer o'r preswylwyr presennol.

4. Mae'r papur hwn yn crynhoi'r pwyntiau allweddol a gododd yn ystod ymweliad y Pwyllgor.

Datblygiad Llys Enfys

Byw'n annibynnol a'r cymysgedd o wasanaethau

5. Eglurodd cynrychiolwyr Linc Cymru wrth yr Aelodau fod cynllun byw'n annibynnol Llys Enfys yn galluogi pobl hŷn i **fyw'n ddiogel ac yn annibynnol yn eu cartrefu eu hunain,** tra'u bod yn elwa o becynnau cymorth a gofal personol ar y safle. Gellir addasu'r holl becynnau gofal a chymorth fel y mae anghenion y preswylwyr yn newid a gellir eu darparu ar eu cyfer yn eu cartrefi eu hunain.

6. Dywedwyd wrth y Pwyllgor fod y cynllun yn cynnwys 102 o **fflatiau annibynnol** , gyda chymysgedd o lety 1 ystafell wely ac, yn bennaf 2 ystafell wely. Mae 124 o breswylwyr yn byw yn Llys Enfys ar hyn o bryd, 60% mewn fflatiau deiliadaeth unigol a'r 40% sy'n weddill mewn fflatiau deiliadaeth ddwbl. Dywedodd staff Llys Enfys wrth y Pwyllgor fod penderfyniad gofalus wedi'i wneud i ddarparu mwy o fflatiau 2 ystafell wely nag o fflatiau 1ystafell wely er mwyn sicrhau y gall teulu ymweld ac aros, ac i barhau i fod yn hyblyg ar gyfer newidiadau demograffig yn y dyfodol (e.e pobl hŷn yn edrych ar ôl rhieni hyd yn oed yn hŷn

neu fel arall). Mae ystafelloedd gwely ar gyfer gwesteion, yn ychwanegol at y rheini yng nghartrefi pobl, hefyd ar gael ar y safle.

7. Cafodd y fflatiau eu cynllunio i **fodloni anghenion yr amrywiol lefelau o gymorth**, gan gynnwys:
    - 60 fflat ar gyfer darpariaeth gofal ychwanegol, 7 o'r rheini wedi'u cynllunio a'u haddasu ar gyfer pobl hŷn sy'n colli'u cof neu sy'n dioddef o dementia ;
    - 8 fflat ar gyfer oedolion ifanc anabl; a
    - 34 fflat ar gael i bobl hŷn eu rhentu.

8. Mae sefydliad penodedig ar gael ar y safle i ddarparu gofal personol i'r rheini sy'n cael eu hasesu ac sy'n bodloni meini prawf cymhwyster y cyngor. Cafodd datblygiad Llys Enfys ei gynllunio er mwyn caniatáu i'r gofal ar y safle gael ei addasu fel y mae anghenion y preswylwyr yn newid. Mae hyn gyda'r bwriad o sicrhau **nad yw newid yn anghenion cymorth a gofal personol yn gorfod golygu o angenrheidrwydd, newid ffordd o fyw neu gyfeiriad preswylwyr**. Mae ystafelloedd ymgynghori hefyd ar gael i'w defnyddio gan weithwyr iechyd proffesiynol a phreswylwyr.

Cyfleusterau a gweithgareddau

9. Ymwelodd yr Aelodau â'r amrywiol gyfleusterau sydd ar gael ar y safle gan gynnwys y siop, y golchdy, y siop trin gwallt a'r lolfa gymunedol, y bwyty a'r ardd. Darperir y cyfleusterau hyn er mwyn sicrhau y gall y preswylwyr gynnal eu hannibyniaeth heb orfod gadael yr adeilad, a gallant ddefnyddio **cymysgedd o wasanaethau** fel y bydd eu hangen.

10. Mae pob llawr yn cynnwys ystafell **weithgaredd** ar gyfer unrhyw breswylwyr sy'n dymuno defnyddio cyfleusterau o'r fath – dangoswyd un ystafell i'r Aelodau lle'r oedd y preswylwyr wedi codi arian i brynu bwrdd pŵl. Dywedwyd wrthym hefyd fod gan Lys Enfys Bwyllgor Cymdeithasol gweithgar sy'n trefnu nifer o ddigwyddiadau rheolaidd. Mae'r preswylwyr hefyd yn weithgar o ran cynllunio a chynnal a chadw'r ardd mewn cydweithrediad â chontractwr garddio penodedig.

11. Dywedwyd wrth yr Aelodau hefyd am y cysylltiadau bywiog y mae Llys Enfys a'i phreswylwyr yn eu cynnal â'r **gymuned leol**. Cynhaliwyd cyfarfodydd ynglŷn â pharc lleol yn ardal gymunedol Llys Enfys, a bu'r preswylwyr yn weithgar iawn gyda'r ymgyrchu dros lwybr bws yn yr ardal. Yn fwy eang, mae Llys Enfys hefyd yn cynnal cyfarfodydd a sgyrsiau ar gyfer nifer o sefydliadau'r trydydd sector gyda'r nod o wella gwybodaeth, ymwybyddiaeth a dealltwriaeth preswylwyr o gyflyrau fel dementia.

Problemau synhwyraidd, cof a symudedd

12. Eglurodd staff Linc Care hefyd fod cydweithio rhwng RNIB Cymru a Chymdeithas Alzheimer's wedi sicrhau bod cynllun a dyluniad yr adeilad yn **ymarferol i denantiaid â phroblemau synhwyraidd, symudedd neu iechyd meddwl**.

13. Dangoswyd i aelodau'r Pwyllgor fod yr holl arwyddion wedi'u darparu mewn Braille ar gyfer preswylwyr â phroblemau golwg, ac roedd gan bob llawr yn yr adeilad thema lliw clir i gyfyngu ar y dryswch i'r rheini â phroblemau synhwyraidd neu gof. I'r rheini â symudedd cyfyngedig, roedd canllawiau ar gael drwy'r adeilad a darperir ystafell bwrpasol i breswylwyr adael eu cadeiriau a'u hoffer symudedd mewn amgylchedd diogel heb aflonyddu ar eu cartrefi eu hunain. Roedd ystafelloedd ymolchi a gynorthwyir hefyd ar gael o fewn Llys Enfys ynghyd â chortyn argyfwng ym mhob ystafell ym mhob fflat rhag ofn bod angen cymorth ar frys.

14. Mae saith o fflatiau o fewn datblygiad Llys Enfys wedi'u cynllunio a'u haddasu ar gyfer pobl hŷn sy'n **colli'u cof neu sy'n dioddef o dementia**. Mae'r rhain yn cynnwys synwyryddion drws a llawr yn ogystal ag offer a all rybuddio staff o ddŵr sy'n gorlifo neu ddigwyddiadau eraill tebyg.

Ailalluogi

15. Dywedwyd wrth y Pwyllgor, o brofiad gwaith Linc Cymru yn Llys Enfys, fod llawer (os nad y rhan fwyaf) o'r preswylwyr yn canfod fod angen llai o ofal a chymorth arnynt, ar ôl iddynt sefydlu yno, nag a fyddai wedi digwydd yn y gymuned. Roedd y staff yn awyddus i bwysleisio nad oedd heneiddio, o angenrheidrwydd, yn golygu mwy o ddibyniaeth, ac y gall unigolion adennill iechyd a gallu, yn ogystal â'u colli.

Staffio a hyfforddi

16. Dywedwyd wrth yr Aelodau fod Llys Enfys yn cael ei reoli gan staff Linc Care tra bod y gwasanaethau gofal yn cael eu darparu drwy ddarparwr penodedig ar y safle.

17. Dywedwyd wrth y Pwyllgor fod staff Linc Care sy'n gweithio ar y safle yn cael **hyfforddiant rheolaidd** gyda rhai'n dilyn hyfforddiant penodol mewn cyflyrau fel dementia.

Ariannu

18. Dywedwyd wrth yr Aelodau fod yr arian cyfalaf ar gyfer datblygiad Llys Enfys wedi'i ddarparu drwy **gyfuniad o grant tai cymdeithasol (56%) a chyllid preifat (44%)**. Mewn perthynas â'r elfen cyllid preifat, roedd 10 o'r 102 fflat wedi'u hariannu gan gronfeydd Linc Care gyda'r gweddill wedi'u codi ar y farchnad.

19. Mae'r **Ffioedd** i breswylwyr yn amrywio, yn dibynnu ar anghenion gwahanol y preswylwyr. Mae trefniant tâl integredig ar waith lle gellir talu cyfran o ffioedd y preswylwyr drwy unrhyw fudd-dal tai neu gyllid awdurdod lleol y gallant fod yn gymwys i'w dderbyn.

20. Gofynnodd yr Aelodau a roddwyd unrhyw ystyriaeth i werthu fflatiau o fewn y cyfadeilad ar y **farchnad agored** debyg i'r model McCarthy & Stone. Dywedodd staff Linc Cymru wrth yr Aelodau, er bod model o'r fath wedi ei ystyried, ni ystyriwyd hyn yn economaidd ymarferol oherwydd y diffyg diddordeb ar y farchnad yn y lleoliad penodol hwnnw.

21. Rhoddwyd terfyn ar ddatblygu **cyfleusterau gofal ychwanegol** newydd o'r natur hwn gan Linc Cymru gan nad yw'r grant tai cymdeithasol bellach ar gael. Dywedodd staff Linc Cymru wrth yr Aelodau pe bai rhagor o grantiau ar gael, byddai rhagor o gyfleusterau o'r math hyn yn ddichonadwy a byddent yn cael eu datblygu gan y sefydliad.

Linc Cymru

22. **Cymdeithas dai ddielw** yw Linc Cymru sy'n arbenigo yn y sectorau tai fforddiadwy, gofal cymdeithasol ac iechyd yng Nghymru.

23. Linc Care yw un o ddau brif faes gwaith Linc Cymru (Linc Homes yw'r llall). Mae Linc Cymru'n darparu **gwasanaethau byw'n annibynnol, gofal nyrsio, tai â chymorth a thai gwarchod**. Mae gan Linc Cymru saith cynllun byw'n annibynnol ar draws Caerdydd, Casnewydd a Blaenau Gwent a thros 330 o fflatiau mewn rheolaeth. Mae gan Linc Care un cartref nyrsio a chynlluniau i ddatblygu dau gyfleuster arall o'r math hyn yn Ne Cymru.

24. Fel sefydliad dielw, mynegodd Linc Cymru'r farn y byddai **llais cryfach i'r sector dielw** – i'w glywed gan Lywodraeth Cymru – yn gwella'r ddarpariaeth o wasanaethau o'r math hyn i bobl hŷn yng Nghymru. Teimlwyd hefyd y byddai llwyfan lle gallent ddod ynghyd, o gymorth i rannu'r arferion gorau yn y maes hwn.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

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Ymchwiliad i ofal preswyl i bobl hŷn – Ymweliad â Datblygiad Woodcroft Cymorth Hafod (8 Chwefror 2012)

Cefndir

1. Fel rhan o'r ymchwiliad i ofal preswyl i bobl hŷn, bu aelodau'r Pwyllgor Iechyd a Gofal Cymdeithasol ar ymweliad â Datblygiad Woodcroft Cymorth Hafod ar 8 Chwefror 2012.

2. Yn ystod yr ymweliad cyfarfu aelodau'r Pwyllgor â chynrychiolwyr o blith staff Cymorth Hafod a'i rhiant-gorff, Hendre Cyf. Diben yr ymweliad oedd:

    - gweld cyfleusterau gofal preswyl newydd sbon – gan gynnwys fflatiau gofal agos a chartref gofal preswyl – cyn iddynt gael eu hagor i breswylwyr; a

    - dysgu mwy am y dull seiliedig ar 'gampws' a fabwysiadwyd gan Gymorth Hafod yn natblygiad Woodcroft.

3. Dewisodd y Pwyllgor ymweld â'r safle cyn agoriad swyddogol y cartref gofal er mwyn sicrhau nad oed presenoldeb yr Aelodau'n amharu ar breifatrwydd y preswylwyr. Bwriedir i'r Aelodau gael cyfle i sgwrsio â phreswylwyr unigol – fel rhan o waith ymgysylltu ehangach y Pwyllgor – yn ystod yr ymchwiliad.

4. Mae'r papur hwn yn crynhoi'r pwyntiau allweddol a gododd yn ystod ymweliad y Pwyllgor.

Hanes safle Woodcroft

5. Dywedwyd wrth y Pwyllgor fod y cartref gofal gwreiddiol ar safle Woodcroft, a adeiladwyd yn yr 1960au, yn cael ei redeg gan Gyngor Sir Caerdydd, gyda chymorth Cymorth Hafod. Mae Hafod bellach wedi cymryd y datblygiad gyda les hirdymor am rent rhad, sydd wedi caniatáu iddi ailddatblygu'r cyfleusterau.

6. Dywedwyd wrth yr Aelodau fod yr ailddatblygiad wedi golygu dymchwel yr adeilad presennol ac adeiladu cartref gofal newydd ar y safle, yn ogystal ag adeiladu nifer o fflatiau 'gofal agos'. Mae'r cartref gofal newydd bellach ar fin cael ei gofrestru a disgwylir iddo gael ei agor yn swyddogol ym mis Ebrill 2012.

Y Datblygiad Woodcroft newydd

Cyfleusterau'r cartref gofal preswyl

7. Eglurodd staff Hafod wrth yr Aelodau fod 60 uned yn y cartref gofal - 24 ar y llawr daear, a 18 ar bob llawr arall. Mae'r llawr daear a hanner y llawr cyntaf ar hyn o bryd wedi'i neilltuo ar gyfer llety i'r henoed bregus eu meddwl . Nid oes gwelyau wedi'u neilltuo ar gyfer gofal nyrsio ar hyn o bryd, er bod yr adeilad wedi'i gynllunio'n bwrpasol er mwyn trefnu ar gyfer hyn yn y dyfodol, os bydd angen.

8. Dywedwyd wrth y Pwyllgor fod y cartref gofal wedi'i rannu'n sawl adain. Mae hyn yn caniatáu defnydd hyblyg o fannau y gellir eu hail-ddyrannu yn ôl yr angen, gan y dywedwyd wrth yr Aelodau fod gofal am yr henoed bregus eu meddwl yn ei gwneud yn ofynnol i ddrysau ar gyfer y mannau sy'n cael eu rhannu fod yn rhai y gellir eu cloi. Hefyd mae cyfyngiad ar faint o fannau agored sydd ar gael.

9. Dywedwyd wrthym fod y cartref gofal wedi costio £4.6 miliwn i'w ddatblygu, sy'n cyfateb i tua £75,000 y gwely. Mae pob ystafell o'r un safon, ac maent i gyd â chyfleusterau en-suite.

10. Eglurodd staff Hafod na roddwyd unrhyw grant tai cymdeithasol ar gyfer datblygu'r cartref gofal, er eu bod yn credu mai ychydig o effaith fyddai hyn wedi'i gael gan fod y costau cyfalaf yn eithaf isel o'u cymharu â gwariant fel costau staffio ac ati.

11. Mae'r Aelodau ar ddeall bod Cyngor Caerdydd wedi gwneud archeb bloc am 24 gwely yn y cartref gofal ar raddfa a gytunwyd. Eglurwyd fod hyn wedi helpu Cymorth Hafod gan ei fod yn sicrhau y bydd rhywfaint o breswylwyr yn y cartref bob amser o leiaf. Dywedwyd wrthym hefyd fod Cyngor Caerdydd yn cau nifer o gartrefi ar draws y ddinas, sydd wedi cynyddu'r galw, ond mae natur gofal preswyl yn newid, gyda phobl yn aros yn eu cartrefi eu hunain yn hwy. Dywedwyd wrthym fod hyn yn effeithio ar ddarparwyr.

Fflatiau 'gofal-agos'

12. Yn ychwanegol at y cartref gofal a ddisgrifir uchod, aeth cynrychiolwyr Cymorth Hafod hefyd ag aelodau'r Pwyllgor i ymweld â'r 15 fflat 'gofal-agos' a adeiladwyd ar yr un safle.

13. Yn wahanol i'r tir ar gyfer y cartref gofal, (a drosglwyddwyd i Gymorth Hafod ar les hirdymor am rent rhad), dywedwyd wrthym fod y tir ar gyfer y fflatiau wedi'i brynu oddi wrth Gyngor Caerdydd gan Gymorth Hafod ar raddfa fasnachol. Eglurodd Cymorth Hafod fod rhywfaint o grant tai cymdeithasol ar gael i ddatblygu'r fflatiau ac mai cyfanswm cost y datblygiad oedd £1.8 miliwn (tua £125,000 y fflat).

14. Eglurodd staff Hafod fod y preswylwyr sy'n byw yn y fflatiau i gyd wedi'u henwebu ar gyfer y cyfleusterau hyn drwy Gyngor Caerdydd.

15. Dywedwyd wrthym fod y fflatiau'n caniatáu i breswylwyr fyw'n annibynnol tra'u bod yn cael systemau cymorth – fel y tîm gofal 24 awr y dydd a'r tîm cymorth tai – os oes angen. Gall preswylwyr y fflatiau hefyd gael mynediad at gyfleusterau fel prydau bwyd a gweithgareddau sy'n cael eu rhedeg yn y cartref pan fyddant yn dewis. Eglurodd y staff fod hyn hefyd yn creu cyswllt â'r cartref os bydd anghenion preswylwyr y fflatiau yn y dyfodol yn golygu y byddant yn dymuno – neu angen – symud i'r lleoliad arall hwnnw yn ddiweddarach yn ystod eu bywyd

Staffio, ariannu a darparu adnoddau ar gyfer y datblygiad

16. Dywedwyd wrth y Pwyllgor y bydd oddeutu 90 o staff yn cael eu cyflogi yn y datblygiad –o'r ardal yn bennaf. Eglurodd ein gwahoddwyr fod llawer o weithwyr yn dewis dod o'r sector preifat, yn enwedig gan fod y sefydliad yn rhedeg rhaglen hyfforddi ac anwytho dda. Yn ychwanegol at gyflogi staff lleol, mae'r sefydliad hefyd yn ceisio cefnogi busnesau lleol a phrynu'n lleol lle mae hynny'n bosibl.

17. Dywedwyd wrthym fod strwythur ffioedd y cartref yn fras, fel a ganlyn:
    - £450 yr wythnos i breswylwyr sylfaenol
    - £530 yr wythnos i gleifion sydd â dementia
    - £700-£750 yr wythnos am ofal nyrsio

18. Eglurodd y staff fod y ffioedd hyn, o'u gwybodaeth hwy, yn ffafriol o'u cymharu â'r sector preifat, sy'n tueddu i godi ffioedd uwch ac sy'n aml yn codi tâl ychwanegol e.e. tâl ychwanegol am deledu. Awgrymodd y staff hefyd, o'i gymharu â'r gost i'r GIG o un noson mewn gwely ysbyty a lle mae hynny'n glinigol briodol, gall costau gofal preswyl gynnig dewis arall sy'n rhoi gwell gwerth am arian.

Model Cymorth Hafod

19. Eglurodd staff Hendre Cyf a Chymorth Hafod:

    - Cymdeithas Tai elusennol yw Cymorth Hafod sy'n darparu amrywiaeth eang o wasanaethau tai a chymorth i dros 1000 o bobl bob blwyddyn ar draws De a Gorllewin Cymru ac mae'n rhan o Grŵp Hendre. Caiff ei redeg fel cwmni dielw.

    - Fel cwmni dielw mae'n creu cronfeydd drwy fenthyg a chreu gwarged. Mae'n ail-fuddsoddi arian gwarged mewn prosiectau newydd a rhai sy'n bodoli eisoes – nid yw unrhyw arian a wneir yn mynd i gyfranddalwyr. Mae ganddynt dargedau gweithredol i greu gwarged, ond ni chaiff yr elw hwn ei wneud ar draul gofal preswylwyr. Bydd datblygiad Woodcroft yn rhedeg ar ddiffyg ariannol am ychydig o flynyddoedd.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

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Y Pwyllgor Iechyd a Gofal Cymdeithasol – Ymweliad â Thŷ Bethel, Dinas Powys (28 Mawrth 2012)

Cefndir

1. Fel rhan o'r ymchwiliad i ofal preswyl ar gyfer pobl hŷn, aeth aelodau'r Pwyllgor Iechyd a Gofal Cymdeithasol ar ymweliad â Thŷ Bethel yn Ninas Powys ar 28 Mawrth 2012.

2. Cyfarfu aelodau'r Pwyllgor â staff a phreswylwyr Tŷ Bethel yn ystod yr ymweliad. Diben yr ymweliad oedd:

    - Ymweld â chartref gofal preswyl sy'n fwy traddodiadol a sefydledig a thrafod â staff pa heriau sy'n eu hwynebu wrth ddarparu gofal preswyl.

3. Gwahoddwyd y Pwyllgor i ymweld â Thŷ Bethel gan Brian West, sef Cadeirydd Cymdeithas Cartrefi Gofal Bro Morgannwg.

4. Mae'r papur hwn yn rhoi crynodeb o'r prif bwyntiau a nodwyd yn ystod ymweliad y Pwyllgor.

Gwybodaeth am Dŷ Bethel

5. Caiff Tŷ Bethel ei redeg o fewn ethos Cristnogol, ac fe'i sefydlwyd fel rhan o ganolfan Neuadd Hebron. Mae lle i 39 o breswylwyr aros yno, ac mae darpariaeth ar gyfer saith gwely i henoed bregus eu meddwl. Nid yw hwn yn gartref sy'n anelu at wneud elw.

6. Daw pobl i'r cartref am amrywiaeth o resymau – er enghraifft, bydd rhai pobl yn dewis y cartref oherwydd eu crefydd, a bydd eraill yn ei ddewis oherwydd ei leoliad.

7. Mae oed cyfartalog y preswylwyr wedi codi dros y blynyddoedd diwethaf; mae'r mwyafrif yn eu nawdegau bellach. Mae perchnogion y cartref wedi sylwi ar dueddiad i annog pobl i aros gartref am gyhyd â phosibl y dyddiau hyn, yn hytrach na chael gofal.

8. Clywodd yr Aelodau sut y bydd Tŷ Bethel yn ceisio mynd i'r afael â'r pryder mewn pobl, sy'n gysylltiedig â symud i ofal preswyl, drwy geisio egluro mai cartref y preswylydd ydyw, ac y dylid ystyried bod yr unigolyn wedi symud tŷ wrth ddod i'r cartref. Mae'r perchnogion yn ymwybodol mai ychydig o bobl sy'n edrych ymlaen at symud i gartref preswyl, ond o'u profiad hwy, unwaith y bydd rhywun wedi setlo yn y cartref, bod tuedd iddynt fod yn llawer hapusach ac iachach am nifer o resymau, er enghraifft byddant yn fwy tebygol o gymryd eu

moddion yn rheolaidd, a bydd ganddynt ragor o gysylltiad rheolaidd gydag amrywiaeth o bobl ynghyd â rhagor o gyfleoedd i gymryd rhan mewn gweithgareddau cymdeithasol.

9. Mae Tŷ Bethel newydd benodi cydgysylltydd gweithgareddau, a fydd yn datblygu'r amrywiaeth o weithgareddau sydd ganddynt yn y cartref ar hyn o bryd, sy'n cynnwys 'munud i feddwl' bob dydd, gwasanaeth ar y Sul, a gweithgareddau crefft. Hefyd, bydd siop leol yn galw yn y cartref yn rheolaidd.

Staffio a hyfforddi

10. Cyflogir 40 o bobl yn y cartref, a byddant yn gweithio shifftiau. Dywedodd perchnogion Tŷ Bethel wrth aelodau'r Pwyllgor nad ydynt wedi cael fawr o broblemau o ran recriwtio a chadw staff, ac maent o'r farn mai'r gyfradd gyflog a gynigir ganddynt, a'r sefyllfa gyflogaeth ar hyn o bryd, sydd i gyfrif am hynny.

11. Bu nifer o ddatblygiadau o ran lefel yr hyfforddiant ar gyfer staff, sydd wedi newid disgwyliadau pobl. Awgrymwyd bod darparu cymwysterau NVQ yn gam da, ond nad oedd pawb a oedd yn gweithio yn y sefyllfa ofal yn awyddus i wneud hyn.
12. Fel rhan o'r ymweliad, bu'r Aelodau'n sgwrsio â Kay, sydd wedi gweithio yn y cartref am 18 mlynedd. Penderfynodd hi ymgymryd â'r proffesiwn gofalu yn dilyn ei phrofiadau o ofalu am ei mam, a'i hawydd i roi'r un gofal i bobl eraill. Roedd hi o'r farn fod hwn yn le gwych i weithio, ac mai dulliau rheoli'r cartref oedd i gyfrif am hyn. Teimlai bod awyrgylch cadarnhaol yn y cartref hefyd, oherwydd bod y preswylwyr yn ofalus o'i gilydd, a'u bod yn ystyried eu bod yn rhan o deulu mawr - er enghraifft, maent yn cynllunio i gynnal parti stryd ar gyfer dathliadau'r jiwbilî diemwnt eleni.

Cofrestru Gofal Preswyl a Gofal Nyrsio ar y Cyd

13. Dywedwyd wrth yr Aelodau, yn Nhŷ Bethel, y nod yw ceisio cadw ffocws ar bobl amser, hyd yn oed pan fydd dementia yn datblygu. I wneud hyn, byddant yn ceisio asesu anghenion gofal preswylwyr ac ystyried yr anghenion hynny wrth ddarparu ar eu cyfer, a byddent yn symud rhywun i gyfleuster arall dim ond os na fyddai dim dewis arall ar gael.

14. Dyweodd perchnogion Tŷ Bethel y byddent yn annog y cam i gofrestru gofal preswyl a gofal nyrsio ar y cyd, er mwyn cynorthwyo i fynd i'r afael a'r problemau sy'n deillio o symud pobl pan fyddant wedi setlo. Dywedasant y gall fod yn anodd iawn gyda chyplau, sy'n cael eu gwahanu yn y diwedd yn aml; ond, yn Nhŷ Bethel byddant yn ceisio cadw cyplau gyda'i gilydd, hyd yn oed os bydd un cymar wedi cael diagnosis o salwch sy'n gofyn am ofal nyrsio.

Ariannu a rheoleiddio

15. Clywodd yr Aelodau y bydd yr Awdurdod Lleol yn ceisio prynu gwasanaethau gofal ar y gyfradd rataf bosibl, a all arwain at frwydr bob blwyddyn i leihau'r gwahaniaeth pris rhwng y gwir gost a'r hyn y bydd yr Awdurdod Lleol yn fodlon

ei dalu. Dim ond saith bunt yw'r gwahaniaeth eleni, a gellir ymdopi â hwn, ond yn y gorffennol bu'r gwahaniaeth gymaint â £30 yr wythnos.

16. Roedd cynrychiolwyr o'r cartref yn sôn sut y dylid ceisio cael rhywfaint o hyblygrwydd o ran rheoliadau, a chanolbwyntio'n well ar y gofal o bobl -er enghraifft, rhaid cael pum ystafell ymolchi yn Nhŷ Bethel, gan fod 40 o breswylwyr yno, ond nid oes ganddynt y lefelau staffio ar gyfer defnyddio'r holl ystafelloedd ymolchi ar yr un pryd beth bynnag.

Y Pwyllgor Iechyd a Gofal Cymdeithasol
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Y PWYLLGOR IECHYD A GOFAL CYMDEITHASOL – YMCHWILIAD I OFAL PRESWYL I BOBL HŶN

CYFARFOD Y GRŴP CYFEIRIO (17 EBRILL 2012)

Cefndir

1. Sefydlodd y Pwyllgor Iechyd a Gofal Cymdeithasol grŵp cyfeirio ar gyfer ei ymchwiliad i ofal preswyl i bobl hŷn yng ngwanwyn 2012. Mae'r grŵp yn cynnwys y rhai sydd wedi cynorthwyo cyfeillion ac aelodau teuluol mewn lleoliadau gofal preswyl, y rhai sy'n gwneud hynny ar hyn o bryd neu sy'n wynebu'r posibilrwydd o wneud hynny yn y dyfodol.

2. Rôl y grŵp cyfeirio allanol yw mynegi barn i'r Pwyllgor ar faterion allweddol sy'n cael eu codi yn ystod yr ymchwiliad. Mae'r materion hyn yn cynnwys y cwestiwn a yw aelodau'r grŵp yn credu bod y wybodaeth sy'n cael ei darparu yn y dystiolaeth yn adlewyrchu eu profiadau personol ac a ydynt yn cytuno â chyfeiriad y polisi presennol o ran darparu gofal preswyl i bobl hŷn.

3. Bydd y grŵp cyfeirio yn cyfarfod yn fisol wrth iddo glywed tystiolaeth lafar, gan ystyried tystiolaeth a glywyd yn barod a chynnig cwestiynau posibl ar gyfer sesiynau tystiolaeth yn y dyfodol. Bydd y grŵp cyfeirio yn cytuno ar gofnodion pob cyfarfod o'r grŵp cyn iddynt gael eu cyhoeddi.

Crynodeb

4. Cyfarfu'r grŵp ar 17 Ebrill 2012 i drafod y prif themâu a gododd o sesiynau tystiolaeth y Pwyllgor Iechyd a Gofal Cymdeithasol ar 23 Chwefror (egluro'r cefndir), 29 Chwefror (defnyddwyr gwasanaethau, eu teuluoedd a'u gofalwyr), 14 Mawrth (byrddau iechyd lleol) a 22 Mawrth (awdurdodau lleol).

5. Roedd y grŵp yn teimlo bod llawer o'r dystiolaeth a gyflwynwyd hyd yn hyn yn dangos synnwyr cyffredin, a gofynnodd pam nad oedd sawl dull a awgrymwyd er mwyn gwella gofal i bobl hŷn wedi cael eu rhoi ar waith yn llawn hyd yma. Roedd y grŵp hefyd yn awyddus i bwysleisio bod llawer o enghreifftiau cadarnhaol o ofal preswyl yn bodoli, a'i fod yn gobeithio na fydd ymchwiliad ac adroddiad y Pwyllgor yn canolbwyntio ar yr agweddau negyddol ar ofal preswyl yn unig.

Prif themâu

6. Cytunodd y grŵp cyfeirio mai'r prif themâu yn deillio o'r sesiynau

tystiolaeth ffurfiol a restrwyd ym mharagraff 4 oedd:

- **Canfyddiad gwael ymhlith y cyhoedd** o ran cartrefi gofal a'r angen i wella'r canfyddiad hwn ymhlith darpar breswylwyr a'r cyhoedd yn ehangach;
- Yr angen am gymorth a **gwybodaeth** well i'r rhai sydd wedi cychwyn ar y siwrnai tuag at ofal preswyl;
- Yr angen i wella prosesau asesu, o ran amseru ac ystyried newid mewn anghenion;
- Yr angen i fynd i'r afael â materion ynghylch **urddas** mewn cartrefi gofal preswyl;
- Yr angen am **gontinwwm gofal**, lle gellir ymateb i anghenion sy'n esblygu ymhlith preswylwyr mewn un lleoliad, yn hytrach na gofyn bod preswylwyr yn symud wrth i'w anghenion newid;
- Pwysigrwydd cefnogi ymyrraeth gynnar ac argaeledd gwasanaethau ataliol, yn ogystal ag amseru asesiadau yn well a gwell opsiynau ar ôl i bobl gael eu rhyddhau o'r ysbyty;
- Hyfforddi a recriwtio **staff** (a mwy o gydnabyddiaeth o ofal cymdeithasol fel gyrfa);
- **Cydweithio integredig** gwell rhwng y rhai sy'n gysylltiedig â darparu gofal preswyl (yn cynnwys gwaith rhwng gofal iechyd a gofal cymdeithasol);
- Pwysigrwydd **gweithgareddau** a symbyliad mewn lleoliadau gofal;
- Yr heriau sy'n codi wrth ddarparu gofal i bobl hŷn mewn ardaloedd gwledig.

7. Cododd nifer o faterion eraill y cytunodd y grŵp y byddai'n eu trafod mewn cyfarfod yn y dyfodol. Y materion hyn oedd **rheoliad ac archwilio** a **chyllido** gofal.

8. Wrth ystyried y prif faterion a'r dystiolaeth a gafwyd, gwnaethpwyd y pwyntiau a ganlyn gan y grŵp:

   - Bod angen gwneud rhywbeth i fynd i'r afael â'r **canfyddiad gwael ymhlith y cyhoedd o fywyd mewn cartrefi gofal a'r staff sy'n gweithio ynddynt**. Roedd y grŵp yn pryderu'n fawr bod gan bobl sy'n mynd i gartrefi ddisgwyliadau isel, ac roedd am sicrhau bod y bobl hyn yn parhau i fwynhau bywydau llawn. Roedd aelodau'r grŵp yn teimlo bod lle mewn cymdeithas ar gyfer gofal preswyl, yn ogystal â modelau eraill ar gyfer darparu gofal, oherwydd gall byw

gartref ar ben eich hun fod yn brofiad unig iawn.

- Roedd **y diffyg cefnogaeth a gwybodaeth sydd ar gael i bobl a'u teuluoedd ar eu siwrnai tuag at ofal cymdeithasol** yn brofiad a rannwyd gan nifer o aelodau'r grŵp o ran dewis cartrefi gofal. Siaradodd aelodau'r grŵp am y diffyg gwybodaeth am gartrefi a oedd ar gael, a'r ffordd nad oeddent yn glir am yr hyn i chwilio amdano wrth fynd drwy'r broses o chwilio am gartref gofal da. Gofynnodd y grŵp beth yw gofal da, yn enwedig beth yw gofal dementia da. Awgrymwyd y byddai pobl sydd wedi bod drwy'r system yn ffynhonnell dda o gymorth a gwybodaeth i'r teuluoedd hynny sydd wedi cychwyn ar y siwrnai tuag at ofal preswyl—gallai hyn fod yn ddefnyddiol oherwydd roedd y grŵp yn teimlo bod angen i'r teuluoedd hyn ddatblygu arbenigedd yng ngofal cymdeithasol yn gyflym iawn, sy'n arbennig o anodd oherwydd y sefyllfaoedd argyfyngus y maent yn aml yn eu hwynebu. Os yw gwybodaeth am fathau o ofal ac yn y blaen ar gael, roedd y grŵp yn teimlo ei bod yn anodd dod o hyd iddi, ac nid yw'n cael ei dangos i'r bobl sydd o bosibl ei hangen.

- Mynegwyd pryder penodol mewn perthynas â'r diffyg gwybodaeth a **chymorth sydd ar gael i bobl sy'n talu am ofal eu hunain**, efallai na fyddent yn cael eu hysgogi i gael mynediad at gymorth gan awdurdodau lleol. Hefyd, nodwyd problemau gyda'r broses o geisio sicrhau cyllid ar gyfer gofal iechyd parhaus drwy'r GIG, yn enwedig ar gyfer pobl sydd â dementia.

- Roedd yr angen am **gontinwwm gofal** yn gysyniad allweddol i'r grŵp. Roedd gan rhai o aelodau'r grŵp brofiad o'r trafferthion sy'n codi pan fo perthnasau'n cael eu trosglwyddo o gartref gofal preswyl i gartref nyrsio a'r cyffro a'r gofid y mae hyn yn ei achosi. Yn benodol, cafodd y trafferthion o ran gorfod ffurfio perthnasau newydd gyda staff a phreswylwyr a'r dewis cyfyngedig o gartrefi gofal eu trafod. Fodd bynnag, pwysleisiodd y grŵp os fyddai cartrefi gofal yn esblygu i ddarparu continwwm gofal o dan un to, byddai angen dulliau diogelu i sicrhau bod niferoedd staff priodol yn cael eu cynnal ar gyfer pob math o ofal yn y lleoliad hwnnw.

- Bu'r grŵp yn trafod y **broses asesu ar gyfer mynediad at ofal preswyl** a'r amser gorau i gynnal asesiad o'r fath. Cytunodd y grŵp nad yw cynnal asesiad tra bod unigolion mewn ysbyty yn ddelfrydol, yn enwedig oherwydd y gallai iechyd unigolion wella unwaith iddynt gael eu rhyddhau o'r ysbyty. Awgrymwyd y gallai asesiadau gwell sy'n cael eu cynnal nes ymlaen ar adeg fwy priodol gynyddu nifer yr opsiynau sydd ar gael i bobl hŷn, gan gynnwys dychwelyd i'w cartrefi eu hunain.

- Darparodd y grŵp nifer o esiamplau o'u perthnasau'n colli eiddo angenrheidiol, gan gynnwys dannedd gosod, cymhorthion clyw a sbectolau tra eu bod yn cael gofal preswyl (ac mewn ysbytai), a thrafferthion dilynol wrth gael mynediad at optegwyr/deintyddion a gweithwyr proffesiynol eraill i gael offer newydd. Cytunodd y grŵp fod cael mynediad at wasanaethau ac offer fel hyn yn hanfodol er mwyn sicrhau **lefel sylfaenol a derbyniol o urddas**. Yn rhannol, roedd y grŵp yn teimlo bod hyn yn gysylltiedig â safon asesiad iechyd y preswylwyr pan roeddent yn dod i'r lleoliad gofal, a bod angen codi ymwybyddiaeth ymhlith staff ynghylch pwysigrwydd cymryd camau i sicrhau bod anghenion synhwyraidd a deintyddol unigolion yn cael eu monitro'n rheolaidd. Roedd y grŵp yn teimlo y gellid gwneud gwelliannau yn y maes hwn.

- Bu'r grŵp yn trafod a allai cartrefi gofal fod mwy fel **canolfannau adnoddau lleol** y gallai gofalwyr fynd iddynt i gyfarfod â'i gilydd, gyda chanolfannau dydd wedi'u hintegreiddio i'r cartref a lle gellid sefydlu cysylltiadau gwell gyda'r gymuned. Mynegwyd rhai pryderon ynghylch dichonolrwydd gwneud hyn o ystyried y strwythurau sy'n bodoli a'r hinsawdd gyfredol o adnoddau prin. Fodd bynnag, roedd y grŵp yn teimlo y gallai'r dull hwn helpu i gynyddu **cyfranogiad y gymuned** a lleihau'r stigma sy'n gysylltiedig â chartrefi gofal.

- Roedd y grŵp yn teimlo y dylid ystyried gofalu fel galwedigaeth debyg i feddygaeth neu ddysgu a mynegodd ei farn bod **angen parhaus i hyfforddi a recriwtio** staff sy'n addas ar gyfer y proffesiwn. Roedd y grŵp yn teimlo ei fod yn ymddangos nad oedd yr hyfforddiant yn trafod urddas sylfaenol a materion yr oedd y grŵp teimlo eu bod yn synnwyr cyffredin, a dadleuodd bod angen cynnwys profiad gwaith yn yr hyfforddiant. Bu'r grŵp yn trafod sut gall gweithio yn y proffesiwn gofalu fod yn werth chweil i'r unigolyn, a bod angen deall hynny os yw'r canfyddiad o weithio yn y maes hwn yn mynd i wella. Cafwyd awgrymiad bod angen i staff gofal preswyl gael tri pheth hanfodol, sef hyfforddiant, amser a natur dda.

- Yn ogystal â hyfforddiant gwell i staff, bu'r grŵp yn trafod **yr angen am gymorth a hyfforddiant i ofalwyr**. Teimlwyd nad oedd pobl yn aml yn disgrifio eu hunain fel gofalwyr, ac felly nid oeddent yn cael y cymorth a oedd angen arnynt.

- Roedd yr angen i wasanaethau sy'n cynnig gofal preswyl, er enghraifft awdurdodau iechyd, awdurdodau lleol a'r trydydd sector, **gydweithio** yn bwysig i'r grŵp. Roedd aelodau'r grŵp yn credu y dylid cael cymysgedd o bobl i gynnig gofal ar y cyd â gweithwyr proffesiynol, fel gwirfoddolwyr yn y gymuned.

Trafodwyd yr angen i gael eglurder o ran gwahanol rolau hefyd, fel gwahanol rolau gweithwyr gofal a gweithwyr cymdeithasol. Roedd y grŵp yn teimlo y gallai gweithio ar y cyd yn well arwain at arbedion.

- Pwysleisiodd y grŵp bwysigrwydd darparu **gweithgareddau a symbyliad priodol** mewn lleoliadau gofal. Cytunodd y grŵp fod gweithgareddau a symbyliad priodol yn hanfodol er mwyn sicrhau safon byw preswylwyr, a bod angen codi ymwybyddiaeth ynghylch yr hyn y mae gweithgareddau a symbyliad priodol yn eu golygu i'r gwahanol bobl mewn gwahanol leoliadau gofal. Nid oedd y grŵp yn teimlo bod digwyddiadau grŵp a drefnwyd ymlaen llawn yn unig yn ddigonol: efallai y byddai'n well gan breswylwyr ddilyn eu diddordebau personol, neu eistedd gydag aelod o staff am bum munud dros baned o de.

- Roedd y grŵp yn credu bod darparu eiriolwyr annibynnol yn bwysig iawn. Ystyriwyd y cyngor a'r cymorth y gallent eu rhoi i'r rhai o fewn y system gofal i fod yn werthfawr iawn. Mynegodd aelodau'r grŵp bryderon nad oedd eiriolwyr yn gallu cael mynediad i rai cartrefi, gan ofyn a allai cymal ar y mater hwn gael ei gynnwys yn adroddiadau AGGCC.

- Cafodd pwysigrwydd ymyrryd yn gynnar ac ail-alluogi eu trafod gan y grŵp. Awgrymwyd y gallai amrywiaeth a maint y gwaith hwn helpu i atal derbyniadau diangen i gartrefi gofal a rhoi mwy o ryddid i bobl benderfynu ar eu gofal eu hunain yn y dyfodol. Fodd bynnag, pwysleisiodd y grŵp bod angen gwneud mwy i sicrhau bod pobl yn ymwybodol o'r opsiynau hyn a'u bod yn gallu cael mynediad atynt.

Cwestiynau ar gyfer sesiynau yn y dyfodol

9. Bu'r grŵp hefyd yn trafod yn fras y cwestiynau allweddol i ofyn i dystion yn y dyfodol, gan awgrymu'r materion a ganlyn:

    - Gofyn i'r trydydd sector beth yw'r cwmpas ar gyfer gweithio ar y cyd yn ehangach gydag awdurdodau iechyd/awdurdodau lleol a chymunedau;

    - Cynnal trafodaethau â chyrff staff ynghylch sut mae mynd i'r afael â natur gwrth-risg rhai cartrefi gofal o ran gwahodd pobl i'w cartrefi [cytunodd y grŵp nad yw hyn yn cynorthwyo'r gwaith o wella dealltwriaeth a chanfyddiadau'r cyhoedd o gartrefi preswyl].

    - Sicrhau bod gan y Pwyllgor gyfle i siarad yn uniongyrchol gyda gweithwyr mewn cartrefi gofal, yn enwedig gan nad oes corff

penodol yn eu cynrychioli.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

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Blaenraglen Waith

PWYLLGOR IECHYD A GOFAL CYMDEITHASOL: BLAENRAGLEN WAITH AC AMSERLEN

Diben

1. Diben y papur hwn yw amlinellu'r busnes a ddisgwylir ar gyfer amserlen y Pwyllgor Iechyd a Gofal Cymdeithasol yn hydref / gaeaf 2012, ac i ofyn am farn Aelodau ar flaenraglen waith y Pwyllgor.

Cefndir

2. Mae'r Pwyllgor Iechyd a Gofal Cymdeithasol yn gyfrifol am archwilio deddfwriaeth a dwyn Llywodraeth Cymru i gyfrif drwy graffu ar faterion gwariant, gweinyddu a pholisi sy'n cynnwys: iechyd corfforol, meddyliol a chyhoeddus pobl Cymru, gan gynnwys y system gofal cymdeithasol.

3. Hyd yma, mae rhaglen y Pwyllgor wedi canolbwyntio ar waith polisi. Gan edrych ar dymor yr hydref a'r gaeaf, mae'n ymddangos y bydd yn gyfnod dwys o ran cyfrifoldebau deddfwriaethol y Pwyllgor.

Busnes a ddisgwylir o Fedi – Rhagfyr 2012

4. Mae nifer o ddarnau o **ddeddfwriaeth** yn debygol o gael eu cyfeirio at y Pwyllgor i'w hystyried yn ffurfiol dros y misoedd nesaf. Ceir manylion pellach am y rhain yn Atodiad A i'r papur hwn. Disgwylir y bydd angen dyrannu'r mwyafrif o amser y Pwyllgor i'r gwaith hwn rhwng Medi a Rhagfyr 2012.

5. Yn ogystal â gwaith deddfwriaethol y Pwyllgor, fe fydd angen iddo ystyried y **gyllideb ddrafft** ar gyfer 2013-14 yn ystod y cyfnod hwn hefyd.

6. O ganlyniad i hyn oll, mae'n anochel y bydd gallu'r Pwyllgor i gyflawnu gwaith **craffu ar bolisi** yn fwy cyfyngedig nag y buodd dros y 12 mis diwethaf. Er hynny, bydd cyfle i wneud darn hyblyg o waith polisi o gwmpas ymrwymiadau ddeddfwriaethol a chyllidebol y Pwyllgor.

Opsiynau

7. O ystyried yr angen i raglen y Pwyllgor ganolbwyntio'n fwy ar ddeddfwriaeth yn nhymor yr hydref, fe fydd angen i unrhyw waith polisi a ddewisir gan Aelodau fod yn ddigon hyblyg i gyd-fynd â'r amserlenni penodedig a osodir ar gyfer craffu ar ddeddfwriaeth a'r gyllideb.

8. Fe gynigir, felly, y dylai'r Pwyllgor ddewis un pwnc polisi i'w ystyried yn nhymor yr hydref / gaeaf. Byddai modd trefnu'r gwaith hwn I gydfynd ag ymrwymiadau deddfwriaethol a chyllidebol y Pwyllgor.

9. Unwaith i'r Pwyllgor ddewis pwnc, fe fydd Ysgrifenyddiaeth y Pwyllgor yn darparu papur cwmpas a chylch gorchwyl drafft er ystyriaeth Aelodau. Awgrymir y dylai'r Pwyllgor lansio ymgynghoriad dros gyfnod yr haf er mwyn cynnig digon o amser i bobl gyflwyno tystiolaeth ysgrifenedig ar gyfer tymor yr hydref.

10. Er gwybodaeth Aelodau, darperir rhestr o bynciau posib a awgrymwyd gan Aelodau a / neu randdeiliaid yn y gorffennol yn Atodiad B 'r papur hwn.

Y cynnig

11. Gwahoddir Aelodau i:

    (i) ystyried yr opsiynau a amlinellir ym mharagraffau 7 – 10;

    (ii) gynnig unrhyw syniadau cychwynnol ar gyfer ymchwiliad.

ATODIAD A – Amserlen posibl deddfwriaeth arfaethedig

Mae'r amserlen isod yn rhoi syniad yn unig ac wedi ei seilio ar wybodaeth a roddwyd gan yr Aelodau sy'n gyfrifol am y ddeddfwriaeth. Mae'n bosibl y caiff y dyddiadau eu newid gan yr Aelodau perthnasol sy'n gyfrifol am y ddeddfwriaeth.

Bil	**Yr aelod sy'n gyfrifol**	**Amseru**
Bil Cynllun Sgorio Hylendid Bwyd (Dangos Gwybodaeth) (Cymru)	Bil Llywodraeth – Lesley Griffiths AC, y Gweinidog Iechyd a Gofal Cymdeithasol	Cyfnod 1: Haf – Hydref 2012 Cyfnod 2: Hydref 2012
Bil Gwasanaethau Cymdeithasol (Cymru)	Bil Llywodraeth – Gwenda Thomas AC, y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol	Cyfnod 1: Hydref – Gaeaf 2012 Cyfnod 2: Gaeaf – Gwanwyn 2013
Bil Rhoi Organau (Cymru)	Bil Llywodraeth – Lesley Griffiths AC, y Gweinidog Iechyd a Gofal Cymdeithasol	Cyfnod 1: Gaeaf 2012 Cyfnod 2: Gwanwyn 2013
Bill Iechyd y Cyhoedd (Cymru)	*Bil Llywodraeth – Lesley Griffiths AC, y Gweinidog Iechyd a Gofal Cymdeithasol*	*Ail hanner tymor 5 mlynedd y Llywodraeth*

Efallai yr hoffai aelodau fod yn ymwybodol hefyd y derbyniodd **Bil Asbestos (Adennill Costau Meddygol)**, a gynigiwyd gan Mick Antoniw AC, ganiatad y Cynulliad i fynd ymlaen. Mae'n debygol y bydd yn dod o dan gylch gwaith y Pwyllgor Iechyd a Gofal Cymdeithasol, ac o ganlyniad, mae'n bosibl y caiff ei gyfeirio at y Pwyllgor i'w ystyried yn ystod Cyfnod 1 a Chyfnod 2 yn hydref a gaeaf 2012.

ATODIAD B – Pynciau ymchwiliadau polisi posib a awgrymwyd hyd yma

Rhestr o bynciau sydd eisoes wedi'u crybwyll gan Aelodau / rhanddeiliaid sydd isod. Nid oes rhaid i Aelodau ddewis o'r rhestr isod – fe'i darparwyd er gwybodaeth yn unig. Gellir darparu rhestr ehangach / mwy o fanylder yn hwyrach yn y tymor, fel bo angen.

- Defnydd Technoleg Gwybodaeth yn y GIG
- Strategaeth / gwasanaethau iechyd meddwl yng Nghymru
- Access to medicines / treatments in Wales
- Gwasanaethau Anabledd Dysgu
- Gofal Iechyd yng Ngharchardai Cymru
- Nyrsys arbenigol a nyrsys ymgynghorol
- Gwasanaethau Cyd-ymatebwyr yng Nghyrmu
- Anghydraddoldebau iechyd
- Anhwylder Straen Wedi Trawma

Health and Social Care Committee
HSC(4)-15-12 paper 11
One-day inquiry into venous thrombo-embolism prevention – Evidence from 1000 Lives + / Public Health Wales

1000 Lives Plus and Public Health Wales

Response to the National Assembly for Wales Health and Social Care Committee: call for evidence on venous thrombo-embolism prevention

This paper is in response to the request for written evidence by the Health and Social Care Committee undertaking the one-day inquiry into venous thrombo-embolism prevention in hospitalised patients in Wales.

The paper focuses upon the national approach taken by 1000 Lives Plus and the actions of the central team. It should be read in conjunction with the individual Health Board and Trust reports.

The following areas are covered in the paper:

1. An introduction to 1000 Lives Plus
2. The case for preventing VTE
3. Reducing Surgical Complications - Preventing VTE
4. Hospital Acquired Thrombosis – mini-collaborative
5. Moving forward
6. Transforming Maternity Care and Preventing VTE
7. Next Steps
8. Appendix 1: Timeline

1. An introduction to1000 Lives Plus

1000 Lives Plus is the national improvement programme, supporting organisations and individuals, to deliver the highest quality and safest healthcare for the people of Wales.
It focuses on three key areas to spread and embed quality improvement:

i. Establishing a common and consistent approach to improvement across all NHS organisations in Wales.
ii. Developing a public and patient-driven NHS.
iii. Establishing a commitment to developing capacity and capability among the NHS workforce.

1000 Lives Plus takes forward the standardised improvement methodology, use of evidence-based interventions and measurement for improvement introduced by the 1000 Lives Campaign and Intelligent Targets work.

Data are used to focus improvement efforts – using measurement for learning and not for judgement, accountability or comparison. Data in the Campaign and within the national programme is collected by organisations and for their own improvement use. Process measures enable organisations to control variation and ensure reliability in their processes. Outcome measures reflect the impact on the patient or system and show the end result of an organisation's improvement work.

The role of 1000 Lives Plus is to support organisations with their improvements, not to performance manage their work. Data is not collected or aggregated by 1000 Lives Plus.

2. The case for preventing VTE

1000 Lives Plus reviewed the evidence for preventing VTE and found a substantial case for evidence-based improvement through small tests of change.

In 2005, the Health Select Committee identified that, in the UK:

- Pulmonary Embolism (PE) following Deep Vein Thrombosis (DVT) in hospitalised patients causes between 25,000 and 32,000 deaths each year.
- PE following DVT is the immediate cause of death in 10% of all patients who die in hospital.
- The total cost (direct and indirect) to the UK of managing VTE is estimated at £640 million.
- VTE in hospitalised patients is largely preventable through the use of thromboprophylaxis during the hospital stay of the patient and, in some cases, continuing after discharge.[1]

In late 2009, Sir Liam Donaldson and John Smith (MP) reaffirmed the priority of preventing hospital acquired thrombosis (HAT), in their foreword in Venous Thromboembolism Prevention (DH 2009) they stated:

> "In 2007 there were 16,670 recorded deaths in England and Wales where Pulmonary Embolism and Deep Vein Thrombosis (VTE) were mentioned on the death certificate (Office of National Statistics).
>
> However, the overall death rate from VTE in hospital and the community is likely to be significantly higher since the condition is often clinically silent and deaths are not being identified due to a reduction in post-mortem examinations.
>
> The emerging picture of death and acute and chronic disability (such as chronic venous insufficiency, venous leg ulcers and pulmonary hypertension) leaves no room for complacency when low-cost effective preventative treatments are available.
>
> VTE prevention is, above all, about saving lives and reducing long term ill health. This is common and often avoidable. We have long known of safe, effective and straightforward methods of prevention and will continue to work towards widespread recognition that VTE prevention is one of the most important new patient safety issues …."[2]

A report by NCEPOD (2009) explored the care of patients who died within four days of admission to NHS and private hospitals in the UK, and found that only 55% of patients admitted under a surgeon and 38% of patients admitted under a physician received venous thromboembolism prophylaxis.[3]

3. Reducing Surgical Complications - Preventing VTE

The 1000 Lives Campaign was launched in April 2008 and took forward a number of actions from the *Healthcare Quality Improvement Plan: Designed to Deliver 2006* (QuIP). It aimed

[1] *House of Commons (2005). House of Commons Health Committee Report on the Prevention of Venous Thromboembolism in Hospitalised Patients.*
[2] *Department of Health, Venous Thromboembolism Prevention: A Patient Safety Priority King's Thrombosis Centre, 2-3.*
[3] *NCEPOD (2009). Caring to the End? A review of the care of patients who died in hospital within four days.*

to save an additional 1000 lives and to avoid up to 50,000 episodes of harm in Welsh healthcare in two years.

The evidence-based content areas were developed by clinicians in Wales, based upon an appraisal by the former NPHS of the evidence base relating to 12 proposed Institute for Health Improvement interventions. Four interventions were prioritised based on their effectiveness and transferability to NHS Wales, including 'Preventing and reducing surgical complications,' and an additional two areas were added.

Within the Reducing Surgical Complications area, three drivers for improvement were identified, including 'Prevent Perioperative Cardiovascular Events.' One of the interventions within this driver was to 'Identify patients at risks, and provide appropriate DVT prophylaxis.'

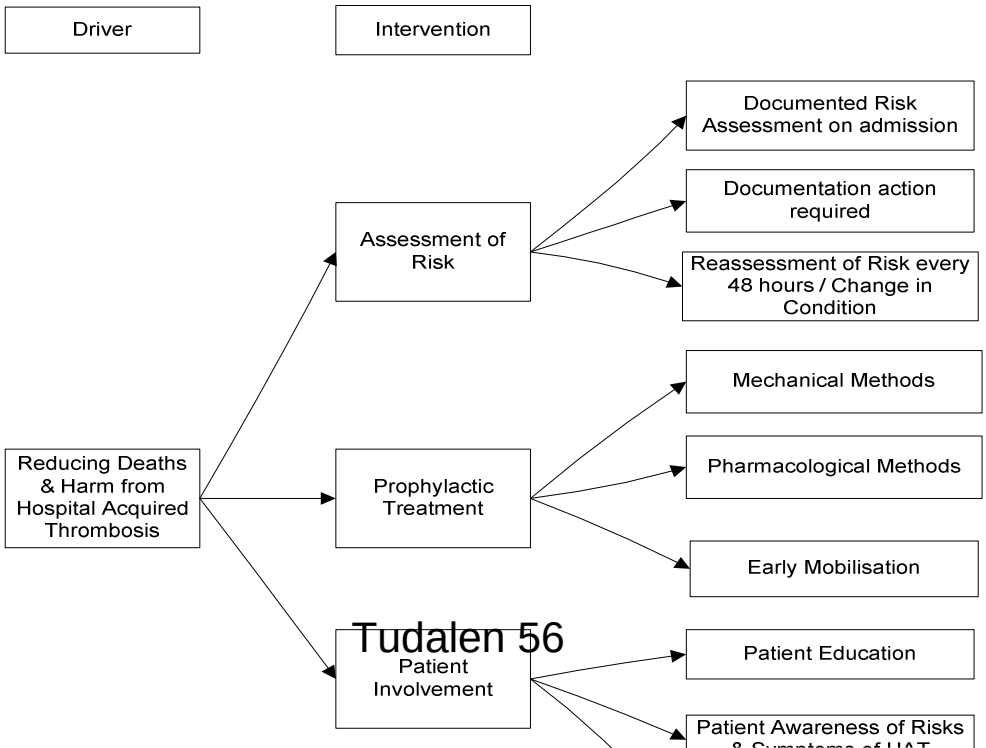
An evidence-based How to Guide was developed for Reducing Surgical Complications and eight Health Boards and Trusts participated in a national mini-collaborative, sharing ideas and knowledge, sharing methodologies for change, implementing proven concepts, and measuring change.

The area proved a challenge to many organisations and it was also delayed by the late introduction of an All Wales Risk Assessment document. All organisations signed up to this area but only three were posting data on risk assessment. Implementation concentrated on pre-assessment clinics for elective surgery was yet to spread to ward areas where patients were admitted directly. Only two organisations were posting data for VTE prophylaxis at this point in time.

4. Hospital Acquired Thrombosis - mini-collaborative

In January 2010, following a review of the evidence available regarding VTE and progress made by organisations, it was agreed to deliver a 12 month mini-collaborative specifically around VTE prevention.

A driver diagram and How to Guide specifically on the area were produced by Dr Simon Noble, Peggy Edwards and Dr Jonathon Gray. Special input was received from Lifeblood: The Thrombosis Charity, the All Party Parliamentary Thrombosis Group, the Department of Health VTE Implementation programme and organisations who contributed case studies.



In this mini-collaborative, the mission of the 1000 Lives Campaign and participating health care organisations was to work together to develop a systematic approach to VTE prevention to reduce avoidable death and harm in hospital patients in Wales. This was to be achieved through the collaborative by the implementation of the All Wales Risk Assessments and appropriate prophylaxis for all in-patients in Wales. Organisations initially focused on a patient population, for example orthopaedic patients; a specific ward; or a specific team.

Goals for participating organisations included:

- Reduce incidents of HAT by 50% in 18 months
- Achieve 100% compliance with risk assessment and prophylactic treatment of in patients by December 2010
- Raise awareness among professionals and the public of HAT prevention and the All Wales Risk Assessment
- Engage with all healthcare professionals, senior managers and doctors in implementing HAT risk assessment in local hospitals and in assessing compliance across the NHS
- Develop better measures and feedback mechanisms on HAT in hospitals
- Raise awareness of HAT prevention in primary care and the community in general.

Organisations completed monthly reports (via the IHI extranet) and considered ways of gathering data monthly such as using risk assessment forms filled out as patients are admitted or follow up inspection of notes.

Process measures:

- Percentage of surgical/ medical patients who have a documented assessment for the risk of developing a HAT.
- Percent of in-patient whose risk assessment is actioned appropriately
- Percent of in-patients whose risk assessment is reviewed at 48 hours and documented

Outcome measures:

- Number of surgical/ medical patients who experience a HAT.

Schedule for the Learning Sessions:

Learning Session 1: 12 January 2010
Learning Session 2: 8 June 2010
Learning Session 3: 16 December 2010

5. Moving forward

At the end of the collaborative in March 2011, there were notable achievements across Health Boards and Trusts. The development of five All Wales Risk Assessment Tools triggered organisations to adopt the all Wales tool, adapt the tool or develop their own bespoke tools. Without the initial prompt for the All Wales Thrombosis Group this work would have been significantly delayed. The work had concentrated upon the implementation of the risk assessment only. The re-assessment of patients on an ongoing basis and ensuring the appropriateness of prophylaxis was identified as a challenge which required support in the service.

The inclusion of the process measure of % patients risk assessed in the Annual Operating Framework from October 2010 helped focus organisations. However, the challenge of the various measures that require data collection across the whole programme was acknowledged as significant for the front line teams.

It was proposed that the Maternity collaborative would continue the work for pregnant women, and Enhanced Recovery After Surgery (ERAS) would pick up surgical patients prophylaxis.

Following the publicity from NHS England in the summer of 2011, the Medical Director for NHS Wales requested a progress update and this was provided by 1000 Lives Plus.

With the ending of the collaborative in March 2011, responsibility for the continuation of the work was passed back to Health Boards and Trusts. 1000 Lives Plus team were approached in the June of 2011 by VTE leads who were concerned at the lack of progress. It was agreed that 1000 Lives Plus would convene a one-off learning event in September 2011 to assess the situation. The event successfully brought together the VTE leads for the seven Health Boards plus Velindre NHS Trust. It was billed as making VTE assessment part of the 'day job'. Three key issues of measurement, clinical engagement and senior management support emerged from the discussions on the day.

The creation of a HAT rate was made the aim for the following six months based on a methodology pioneered in Betsi Cadwaladr University Health Board. It was also agreed that 1000 Lives Plus would arrange a follow-up meeting in March 2012 to assess progress. At that meeting five of the seven Health Boards plus Velindre were able to demonstrate a HAT rate and provide data showing their current performance. The other two Health Boards left with plans in place to do likewise. There is still work to do to evidence the comprehensive nature of risk assessment.

6. Transforming Maternity Care and Preventing VTE

The overall aim of the Transforming Maternity Services Mini-Collaborative is to improve the experience and outcomes for women, babies and their families within Maternity Services. One of the drivers in achieving this aim is to reduce the risk of venous thrombo-embolism in pregnancy. It was launched on 3 March 2011 at the Royal Colleges of Midwives (RCM) annual conference.

The Transforming Maternity Services Mini-Collaborative brings together experts, clinicians and managers to effect change at the bedside (from the 'bottom up'). It is endorsed by Welsh Government, all Health Boards in Wales, the RCM, and Obstetricians and Gynaecologists (RCOG) in Wales.

Learning events have been scheduled as follows to support the all Wales mini-collaborative:

- Learning Session 1: 4 March 2011
- Learning Session 2: 7 June 2011
- Learning Session 3: 24 November 2012
- Learning Session 4: 29 May 2012

Following consultation with experts from within Wales and the relevant endorsement committees, consensus has been reached to enable universal VTE risk assessment to be implemented throughout Wales, with two Exemplar DVT Risk Assessment templates – one relating to the initial 'Booking' visit, which is to be included in the National Hand-Held

records and one relating to Antenatal Admission and the puerperium (postnatal period). This has been a significant achievement for the mini-collaborative in a short period of time and is now allowing maternity units to proceed with implementation of the bundles.

All Health boards within Wales are currently implementing these risk assessments following localisation and agreement within their scrutiny committees.

Work is also underway to implement a combined antenatal booking and admission risk assessment within gynaecological wards alongside the general DVT risk assessment.

7. Next Steps

1000 Lives Plus is working with organisations to develop an outcome measure for the HAT rate. Six out of eight organisations already have a process in place for achieving this and the other two are working on towards this.

Achieving an all-Wales HAT rate is one of the programme's short term ambitions. This is an important step forward and Wales may be the first country to achieve a national HAT rate.

Appendix 1: Timeline

Date	Event
April 2008	1000 Lives Plus Campaign launched and one of the interventions within the Surgical Complications content area is to 'Identify patients at risks, and provide appropriate DVT prophylaxis.'
December 2009	A review of the evidence available regarding VTE and progress made by organisations, led to agreement to deliver a 12 month mini-collaborative specifically around VTE prevention.
12 January 2010	VTE Learning Session 1: 'Count me in to stop the clots.' The session focused upon progress to date, reviewed the improvement methodology and worked with LifeBlood to present the case for change.
8 June 2010	VTE Learning Session 2. This session focused upon risk assessment and prophylaxis, with organisations sharing their feed back on the early stages of testing documentation.
16 December 2010	VTE Learning Session 3. This session focused upon spreading and embedding changes however organisations were still the use of forms in surgical areas, with delays in implementation.
3 March 2011	Maternity mini-collaborative launched at the annual RCM conference by the Chief Nursing Officer for Wales.
4 March 2011	Maternity mini-collaborative Learning Session 1
30 March 2011	VTE mini-collaborative formally ends and responsibility for the continued implementation of the work is passed to organisations.
7 June 2011	Maternity mini-collaborative Learning Session 2
24 November 2011	Maternity mini-collaborative Learning Session 3
July 2011	Report on progress with VTE prevention submitted to Medical Director for NHS Wales.
8 September 2011	Learning event for Health Boards and Trusts at the request of organisations, focussing on making VTE assessment part of the day job.
15 March 2012	Follow up learning event to assess progress by Health Boards and Trusts in demonstrating a HAT rate and provide data showing their current performance.
29 May 2012	Maternity mini-collaborative Learning Session 4

Health and Social Care Committee
HSC(4)-15-12 paper 12
One-day inquiry into venous thrombo-embolism prevention – Evidence from Aneurin Bevan Health Board

National Assembly for Wales' Health and Social Care Committee
Inquiry into Venous Thrombo-Embolism Prevention in Hospitalised Patients

Aneurin Bevan Health Board evidence

Introduction

The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable hospital-acquired venous thromboembolism (VTE) every year. However, in addition to an unacceptable mortality rate due to preventable VTE, it is important not to ignore the effects of *harm* to patients who acquire a preventable venous thrombo-embolism. Reliable Risk Assessment and treatment, also engagement of patients and families in their care is of paramount importance to reduce the risks of mortality and harm due to Hospital Acquired Thrombosis (HAT).

Aneurin Bevan Health Board takes the risks to patients of hospital acquired thrombosis very seriously and has worked hard to implement the recommendations made in NICE Clinical Guidelines 92 and has fully engaged with the 1000 Lives Plus mini-collaborative work to reduce the risk of HAT. The Medical Director is the executive lead for this work and reduction of HAT is expressed as an ABHB priority to improve the safety of patient care through the ABHB Mortality Driver Diagram.

Implementation of NICE Guidance

The ABHB Thrombosis Committee is a multidisciplinary group which has a responsibility for implementing NICE Clinical Guidance 92: reducing the risk of VTE in patients admitted to hospital and the ABHB Haematologist Clinical Lead for this guidance chairs this group. The group's membership includes representation from the 1000 Lives Faculty, consultant staff, pharmacy, pathology, theatres, anticoagulation service and quality improvement. NICE Technology Appraisal recommendations around pharmacological interventions to prevent thrombosis are also discussed at this group. Clinical policies have been implemented including:

- Thromboprophylaxis in Surgical Patients
- ABHB Peri-Operative Anticoagulation in Elective Surgery for Patients on Warfarin
- ABHB Guidance on use of Rivaroxiban
- ABHB Guidelines on the prevention and treatment of thrombosis in pregnancy

In order to understand health board compliance with NICE CG92, the responsibility for audit of compliance with NICE guidance is predominantly held within each division. Recent audits have been carried out in Surgery, Medicine and Pharmacy. However measurement of compliance with Risk Assessment for VTE and thromboprophylaxis is being carried out through the 1000 Lives Plus work.

Implementation of the 1000 Lives Risk Assessment

A 1000 Lives Plus HAT Steering Group was set up to oversee the implementation of HAT prevention drivers which include the HAT Risk Assessment Tools. This multidisciplinary group is led by the consultant Clinical Lead for the All Wales mini-collaborative to reduce harm from VTE. Using the Model for Improvement to implement the Risk Assessment Tools, lead pharmacists in Surgery and Medicine have carried out PDSA cycles to test and alter the All Wales Risk Assessment Tools in pilot

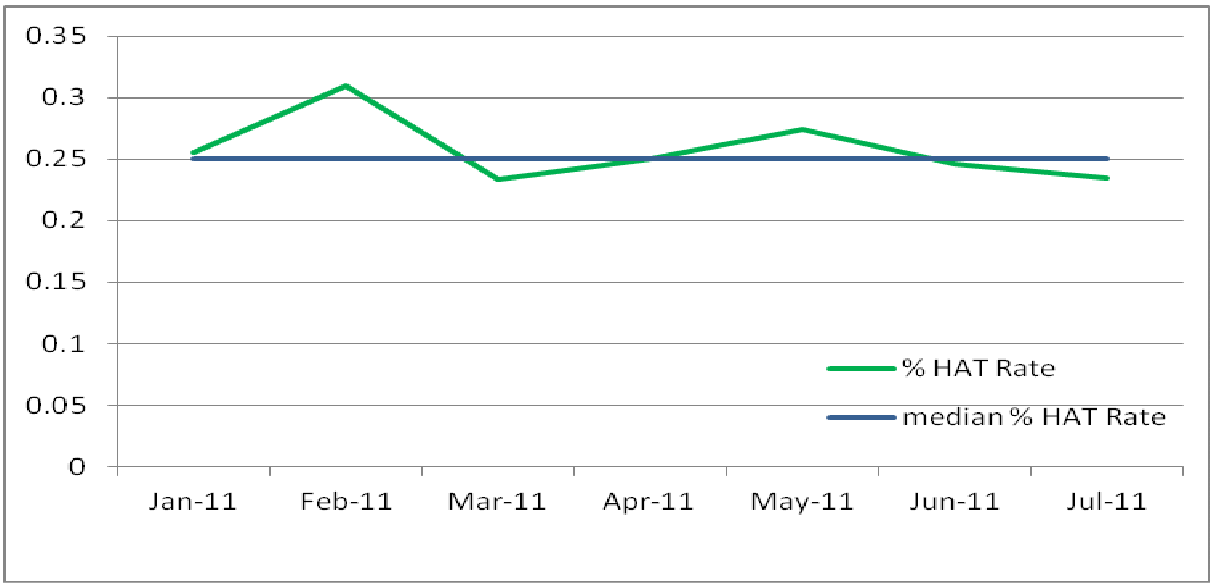
areas. The Risk Assessment Tools for Acute Surgery and Acute Medicine have recently been incorporated into doctors clerking packs. The tools for Acute Trauma and Elective Orthopaedics are being piloted on several wards and the Orthopaedic Surgical Unit. Specific drugs included in the ABHB formulary have been included on the Risk Assessment Tools in order to standardise the use of pharmacological intervention. An All Wales Risk Assessment Tool has been devised for obstetric patients and incorporated into the Admissions Bundle by the All Wales 1000 Lives Maternity Mini-Collaborative. This tool is currently being tested in pilot wards across ABHB who are achieving good compliance. Mental Health Services have also devised a Risk Assessment Tool for Healthcare Acquired Thrombosis which is being piloted and audited.

Ongoing measurement of the process of risk assessment and management of patients at risk of VTE is being carried out in several areas. For patients undergoing surgery this is audited through the ORMIS Theatre Management System. Baseline measurement data is being collected for specific areas across medicine to be followed up with ongoing measurement. Links between this work and that of the Enhanced Recovery After Surgery Programme (ERAS) has been made in the Orthopaedic Surgical Unit because risk assessment for HAT is included in the ERAS bundles. Baseline data in the unit had shown that formal risk assessment for elective knee replacement patients had been around 20% and this has improved to 80% after the risk assessment form had been implemented.

Measurement is a key component of the Model for Improvement used to implement change. Progress has been made to measure the processes of care at ABHB. However, it is important to assess the effect the improvement work is having on outcomes. One of the most important components of this work is to derive a Hospital Acquired Thrombosis Rate (HAT Rate) for the Organisation and to be able to split this rate into specialties and divisions to inform local quality improvement work. The HAT Rate is important not only to assess the progress of improvement work but may be used to engage differing specialties. For instance, often patients admitted under a surgical specialty, who acquire a HAT up to three months following discharge, are either not re-admitted, or re-admission is under a different specialty, eg. medicine. This means that the original staff caring for patients perioperatively may never know that their patient has had a HAT post discharge. Therefore they may not know the effects of not adequately risk assessing and managing patients at risk of HAT. The HAT Rate will enable clinical staff to know the incidence of HAT post-discharge for their patients.

Aneurin Bevan Health Board is currently pulling together data to produce a HAT rate for specialties, divisions and the health board. This is based on a method devised in Betsi Cadwaladr Health Board which has been tailored for use in ABHB. Once validated, this data will be reported each month to the health board. Each case of hospital acquired thrombosis is currently being reviewed by consultant staff leading this work. Root Cause Analysis enables further learning about the care provided for each patient. For instance, if risk assessment tool place, was the risk managed appropriately, was the HAT preventable. Preliminary data, that has not been fully validated through casenote review indicates that the Health Board has a median HAT Rate of 0.25%, and that around half of the cases of HAT were preventable, although it is acknowledged that even with appropriate risk assessment and thromboprophylaxis, HAT may not always be prevented. The run chart below shows the HAT rate between January to July 2011, next steps are to collect ongoing monthly data.

ABHB HAT Rate – January to July 2011



Effectiveness and Utilisation of pharmacological and mechanical prophylaxis for VTE

Mechanical thromboprophylaxis is being used for surgical patients however for medical patients this is not evidence based. Nurses have been trained as per NICE guidelines. For pharmacological thromboprophylaxis there continues to be variation in practice sometimes due to the fact that some clinicians doubt the evidence base. However the drugs recommended by NICE have been incorporated into the Risk Assessment Tool.

Particular Problems in the implementation and delivery of VTE prevention actions

Engagement and Leadership – Despite having strong executive and clinical leadership for this work, in some cases it has been difficult to engage champions within specialties to lead work there. Some clinicians doubt its evidence base, therefore hearts and minds are not behind this change.

Variation in Practice – Different clinicians may use different thromboprophylaxis regimens between directorates or even within directorates despite efforts to standardise practice.

Awareness – The 1000 Lives Plus Programme has achieved a lot to raise the awareness and visibility of the risks to patients of hospital acquired thrombosis. However, many clinicians may not fully understand the importance of prioritising risk assessment of patients.

Conclusions

Staff at Aneurin Bevan Health Board have worked hard to implement the recommendations of NICE CG92 and 1000 Lives Plus drivers for preventing hospital acquired thrombosis. Hospital acquired thrombosis is preventable in many cases therefore it is imperative that health boards provide reliable preventative care. In order to achieve this the health board sees the following as essential:

- Reliable risk assessment for venous thrombo-embolism
- Reliable treatment and management of patients identified as being at risk of HAT

- Ongoing measurement of processes for risk assessment and thromboprophylaxis
- Ongoing measurement of outcomes, more specifically a Hospital Acquired Thrombosis Rate split by specialty, divisional and organisational level
- Root Cause Analysis of each case of Hospital Acquired Thrombosis
- Prevention of HAT to be a national priority

Y Pwyllgor Iechyd a Gofal Cymdeithasol
HSC(4)-15-12 papur 13
Ymchwiliad un-dydd i atal thrombo-emboledd gwythiennol - Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg

Cyfraniad at Ymchwiliad Pwyllgor Iechyd a Gofal Cymdeithasol Cynulliad Cenedlaethol Cymru i Atal Thrombo-emboledd Gwythiennol (VTE) ymhlith Cleifion mewn Ysbytai yng Nghymru (24 Mai 2012)

1. Cefndir

Cynhaliodd Ymddiriedolaeth GIG Abertawe Bro Morgannwg, fel yr oedd yn cael ei adnabod ar y pryd, gyfarfod cyntaf ei Bwyllgor Thromboprophylacsis a Gwrthgeulo ar 12 Ionawr 2009. Lluniwyd Cylch Gorchwyl yn unol ag argymhellion llyfryn Lifeblood: yr Elusen Thrombosis (2008) ynglŷn â sefydlu a rhedeg Pwyllgorau Thrombosis a Thromboprophylacsis. Cadeiriwyd y pwyllgor gan y Cyfarwyddwr Meddygol Cyswllt ar ran y Cyfarwyddwr Meddygol i ddechrau. Mae'r Cyfarwyddwr Meddygol wedi cadeirio'r pwyllgor ers mis Hydref 2010.

Yn dilyn cyhoeddiad Canllaw Clinigol NICE 92 *Thromboemboledd gwythiennol: Lleihau'r risg* ym mis Ionawr 2010, diwygiwyd Cylch Gorchwyl y Pwyllgor Thromboprophylacsis a Gwrthgeulo i adlewyrchu swyddogaeth y pwyllgor o ran rhoi'r canllawiau ar waith a monitro cydymffurfiaeth. Gweithredodd y Pwyllgor hefyd fel y Bwrdd Prosiect ar gyfer Rhaglen Gydweithredol Fach HAT 1000 o Fywydau ac mae'n parhau i arwain a monitro'r gwaith o wneud gwelliannau o ran atal thrombosis a geir yn yr ysbyty (HAT).

2. Mesur canlyniadau

Mae'r Bwrdd Iechyd wedi mabwysiadu proses ar gyfer mesur ei gyfradd fisol o Thrombosis a Geir yn yr Ysbyty yn seiliedig ar fethodoleg a ddatblygwyd gan Fwrdd Iechyd Lleol Betsi Cadwaladr. Mae methodoleg PABM yn dibynnu ar Radiolegwyr yn defnyddio côd penodol i ddynodi sganiau VTE positif. Mae system dechnoleg gwybodaeth yr adran Radioleg wedyn yn cael ei chysylltu at y systemau gwybodaeth am gleifion i dynnu sylw at unrhyw cleifion VTE sydd wedi cael eu derbyn i'r ysbyty o fewn y 12 wythnos flaenorol. Roedd cyfradd HAT y Bwrdd Iechyd ar gyfer mis Chwefror 2012 yn 0.33, sy'n cyfateb i 23 o gleifion. Mae'r gyfradd hon yn amcangyfrif rhy isel gan nad yw'n cynnwys cleifion sy'n datblygu VTE o fewn yr un arhosiad. Mae gwaith yn mynd rhagddo i gynnwys cleifion sy'n datblygu VTE $\geq$48awr ar ôl cael eu derbyn i'r ysbyty, a bydd hyn yn rhoi darlun mwy cynhwysfawr.

Yn y dyfodol, pan canfyddir bod claf wedi cael Thrombosis Gwythïen Ddofn/Emboledd Ysgyfeiniol o ganlyniad i'w arhosiad yn yr ysbyty bydd

hyn yn cael ei gofnodi fel digwyddiad a'i ymchwilio fel rhan o brosesau rheoli risg y Bwrdd Iechyd.

3. Gweithredu Canllawiau NICE/Gweithredu Offer Asesu Risg 1000 o Fywydau a Mwy

Sefydlodd PABM Dîm HAT amlddisgyblaethol i gysylltu â Rhaglen Gydweithredol Fach HAT 1000 o Fywydau. Roedd y tîm yn cynnwys Nyrs Gwrthgeulo, Ymarferydd Nyrsio Llawfeddygol, Fferyllwyr Clinigol sy'n gwasanaethu Derbyniadau Acíwt ac arbenigeddau llawfeddygol, wedi'u cefnogi gan uwch reolwr sy'n aelod o dîm y Cyfarwyddwr Meddygol.

Datblygodd y Rhaglen Gydweithredol 1000 o Fywydau bum offeryn asesu risg ar wahân gan gynnwys offerynnau ar wahân ar gyfer derbyniadau Meddygol Acíwt, Llawfeddygol Acíwt a Thrawma ac Orthopaedeg Acíwt. Ar ôl gwneud profion (cylchredau Cynllunio Gwneud Astudio Gweithredu) datblygwyd un offeryn Derbyniadau Acíwt i'w ddefnyddio ym mhob rhan o PABM. Mabwysiadwyd yr offeryn hwn ynghyd â'r offerynnau Llawfeddygol Dewisol ac Orthopaedeg Dewisol. Cafodd y ddau offeryn dewisol eu profi'n lleol a'u diwygio i gyd-fynd yn well â threfniadau Cyn asesu y Bwrdd Iechyd.

Defnyddiwyd methodoleg gwella i brofi, gweithredu a lledaenu'r offerynnau asesu risg trwy'r sefydliad. Bu rhai llwyddiannau nodedig, yn enwedig wrth asesu cleifion dewisol cyn llawdriniaethau orthopaedig a chyffredinol, lle'r ydym wedi dangos bod 100 y cant o gleifion wedi cael eu hasesu am risg o HAT fel rhan o'r broses asesu cyn llawdriniaethau ers mis Ionawr 2011. Nid yw ail ran yr asesiad risg wedi cael ei gweithredu mor gyson. Fodd bynnag, mae 80 y cant o gleifion orthopaedeg yn Ysbyty Castell-nedd Port Talbot yn cael asesiad risg pan fyddant yn cael eu derbyn i'r ysbyty. Mae casglu data i asesu lefelau cydymffurfiaeth mewn ardaloedd eraill o lawfeddygaeth ddewisol yn cael ei gyflwyno.

Mae rhoi'r offerynnau ar waith yn y mwyafrif o ardaloedd "Meddygol" wedi bod yn her. Lle y bu'n bosib ymgorffori'r offeryn asesu risg o fewn dogfennau a oedd eisoes yn bodoli, mae cydymffurfiaeth wedi bod yn well. Mae Asesiad Risg byrrach ar y siart cyffuriau yn cael ei dreialu ar hyn o bryd mewn ardaloedd Derbyniadau Meddygol. Bydd yr Offeryn Asesu Risg ar gael i feddygon gyfeirio ato wrth iddynt wneud eu hasesiadau er mwyn cefnogi hyn. Mae dulliau o ddarparu'r deunydd cyfeirio yn cael eu harchwilio.

HYFFORDDIANT Mae staff clinigol o fewn PABM yn derbyn hyfforddiant ac yn cael eu dysgu ynglŷn â thromboprophylacsis o lefel cyn cofrestru nes eu bod yn ymgynghorwyr, a hynny gan y Nyrs Glinigol Arbenigol

gwrthgeulo a Fferyllydd. Mae gofyn i fyfyrwyr meddygol cyn cofrestru gwblhau a phasio'r modiwl e-VTE cyn dechrau fel meddygon ym mlwyddyn gyntaf y Rhaglen Sylfaen (FP1). Dylai hyfforddiant o'r fath gael ei wneud yn rhan o raglenni hyfforddi meddygon a nyrsys.

4. Effeithiolrwydd prophylacsis fferyllol a mecanyddol ar gyfer VTE a'r defnydd ohonynt

Mae'r sefyllfa bresennol o fewn Bwrdd Iechyd PABM o ran thromoprophylacsis mecanyddol fel a ganlyn:

Defnyddir pympiau cywasgu yn rheolaidd mewn llawdriniaethau orthopaedig ac yn achlysurol mewn llawdriniaethau cyffredinol gan ddibynnu ar y math o lawdriniaeth a dewis y llawfeddyg.

Defnyddir hosanau gwrth-emboledd ledled y Bwrdd Iechyd a rhoddir lefelau amrywiol o hyfforddiant i staff clinigol. Mae adolygiad o anghenion hyfforddiant yn mynd rhagddo ar hyn o bryd.

Rhoddir dyfeisiau mecanyddol ar y cyd â phrophylacsis fferyllol yn gyffredinol ym maes llawfeddygaeth. Mae'n bosib y bydd dyfeisiau mecanyddol, sef hosanau gwrth emboledd fel arfer, yn cael eu defnyddio gyda chleifion meddygol pan na fydd prophylacsis fferyllol yn addas.

Mewn cleifion meddygol, pan fo'r clinigydd yn ystyried bod yr asesiad risg/budd yn dangos bod angen triniaeth fferyllol, dechreuir rhoi enoxoparin (heparin â phwysau moleciwlaidd isel) ar ddos priodol a'i adolygu ar ôl unrhyw newidiadau clinigol yn y claf.

Mewn cleifion llawfeddygaeth gyffredinol, pan fo'r clinigydd yn ystyried bod yr asesiad risg/budd yn dangos bod angen prophylacsis fferyllol, rhagnodir cwrs o enoxaparin â dos perthnasol.

Mewn cleifion llawfeddygaeth orthopaedig, pan fo'r clinigydd yn ystyried bod yr asesiad risg/budd yn dangos bod angen prophylacsis fferyllol, rhagnodir cwrs o naill ai dabigatran neu rivaroxaban (ar gyfer llawdriniaethau gosod cluniau a phengliniau newydd yn unol ag Arfarniadau Technoleg NICE 157 a 170) neu enoxaparin.

BCUHB response for one day enquiry in to VTE 2012

Implementation of NICE guidance

Implementation has varied across the specialities. This paper will report on each Clinical Programme Group (CPG) and then move to more general issues. DVT risk assessment form completion, the prescription and use of appropriate thromboprophylaxis is assessed in BCU monthly as a rolling audit of a random sample of 50 random case notes.

General Surgery: A risk assessment has been in use within this specialty for several years. The All Wales Risk Assessment has been modified to include an assessment for bleeding risk, with excellent compliance. Patients are offered both pharmacological and mechanical thromboprophylaxis. Within BCUHB Clexane (a type of Heparin) is the pharmacological thromboprophylaxis used. Anti-embolic stockings are currently prescribed for all patients unless contraindicated. Patient information is provided to all patients both verbally and in written form. Stockings are changed every three days to increase their effectiveness. We do not currently reassess after 48 hours, but this is currently being reviewed. Intermittent pneumatic compression pumps are available on the surgical floor for those high risk patients for whom pharmacological thromboprophylaxis is contraindicated. A report, with supporting data is currently being drafted assessing the benefits to extended thromboprophylaxis in major abdominal and pelvic surgery for cancer, and will hopefully be implemented within the near future.

Orthopaedics: Within Nice guidelines all patients are offered both pharmacological and mechanical thromboprophylaxis on admission. As for general surgery patient information concerning anti embolic stockings is available in written form. Intermittent pneumatic compression pumps and foot pumps are regularly used for patients undergoing lower limb surgery. Consistent with NICE guidance, following Hip surgery patients are discharged on extended thromboprophylaxis for 28 days and after knee surgery, two weeks. Work is currently underway, but in the very early stages, to implement the All Wales risk assessment tool. More recently we have progressed to administering thromboprophylaxis to high risk patients, under specific consultants, being managed with a lower limb plaster of Paris.

Gynaecology: Unless contraindicated patients are offered both pharmacological and mechanical forms of thromboprophylaxis. Written information is available concerning the anti-embolic stockings. Cancer patients who had had surgery are sent home on extended thromboprophylaxis for 28 days.

General Medicine: Work within this area has been slow yet steady; this being the area where our team have encountered the greatest difficulty in securing improvement. DVT risk assessment is integrated into the clerking proforma. Unless contraindicated patients are prescribed pharmacological methods of thromboprophylaxis. Mechanical thromboprophylaxis is not currently used. In 2008 – 2009 our Acute Medical Unit (AMU) had a thromboprophylaxis prescription rate of 20 – 30%. With the investment of education and working closely with staff this has increased to 95%. Completion of DVT risk assessment remains low at 45%.

BCUHB Friday, 04 May 2012

Maternity: at present we are implementing the All Wales Risk Assessments tool in our 3 maternity units. In addition we are looking to develop a compliance tool which will capture data on DVT risk assessment. Building on other work within BCU, the team is developing a hospital acquired thrombosis rate for maternity across the three sites. Unless contraindicated all patients undergoing caesarean section delivery are prescribed clexane for 5 days post procedure. Other high risk patients receive the same for up to six weeks post-partum.

A staff education programme is in place at one of the sites, and will be extended to cover all. A patient information leaflet has been successfully piloted which is distributed to all patients, on one of the other sites. Once printed this will be made available in the other two units.

Implementation of the 1000 Lives Plus risk assessment

The implementation and usage of this risk assessment tool across BCUHB has been limited in some specialities like Orthopaedics, where as in others compliance has been excellent with evidence of sustained usage.

As part of the development work to roll out the All Wales Risk assessment across BCUHB a steering group has been set up and has been running now for over 18 months with a multidisciplinary membership from across the board. In two of the three District General Hospitals there are established locality groups with the responsibility to roll out the work to their local teams. These are best placed to deal with local issues and will escalate, where appropriate issues of significance to the main steering group. Each group regularly reviews compliance data for risk assessment and the outcome rates for Hospital acquired thrombosis.

Within Glan Clwyd and Bangor where locality teams have been established, these have demonstrated excellent multidisciplinary working. In Glan Clwyd this is chaired by an Orthopaedic surgeon; in Bangor by a Haematology Consultant. Both are supported by clinicians from other specialities. Having regular outcome data has enabled the team to target Specialities with the highest Rates of Hospital acquired thrombosis and the lowest compliance with risk assessment rates.

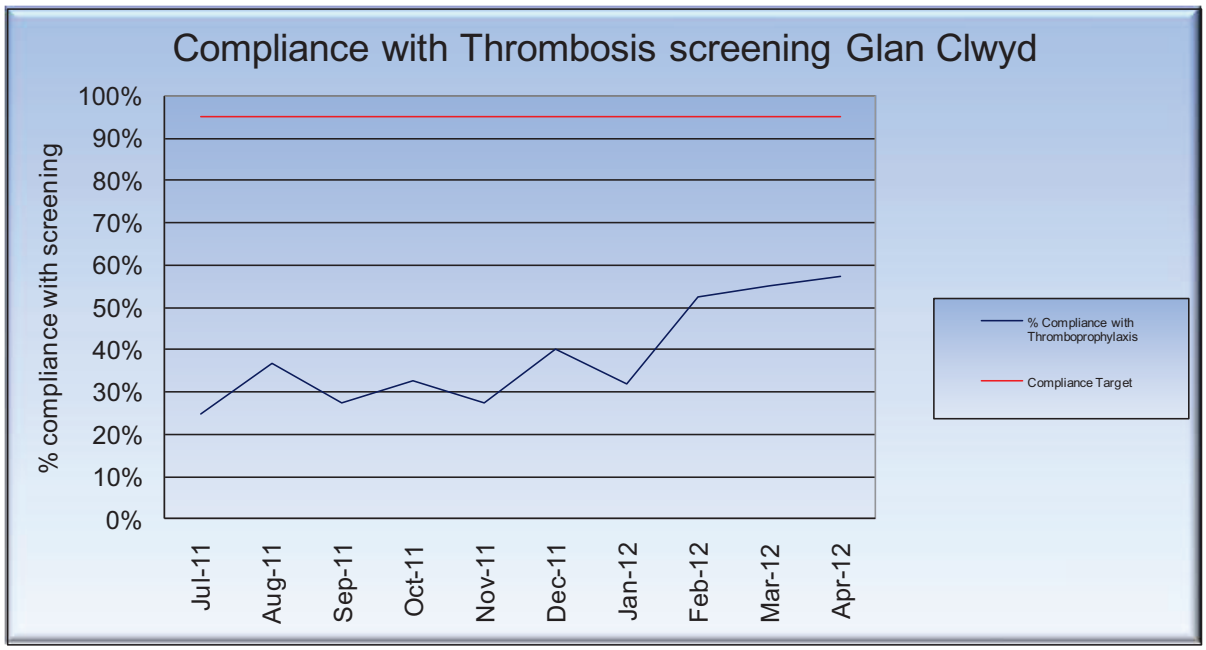
In General Surgery the CPG have now incorporated the risk assessment tool in to their new clerking proforma. This clerking proforma is now in the process of being rolled out across the health board. Before it was introduced in General Surgery at Glan Clwyd, compliance was in the region 50%. Between January and March 2012, with excellent clinical engagement and a ‘must do’ approach, this has risen to, and become consistent at 100%.The BCUHB All Wales risk assessment tools has now been approved and awaiting role out in the following new areas:

- Non ambulatory Medical Patients
- Elective Orthopaedic
- Emergency Orthopaedic
- Maternity

Like General Surgery, Urology has started to incorporate the All Wales risk assessment tool within their clerking proforma. Once finalised and printed they will be used across the whole of BCUHB.

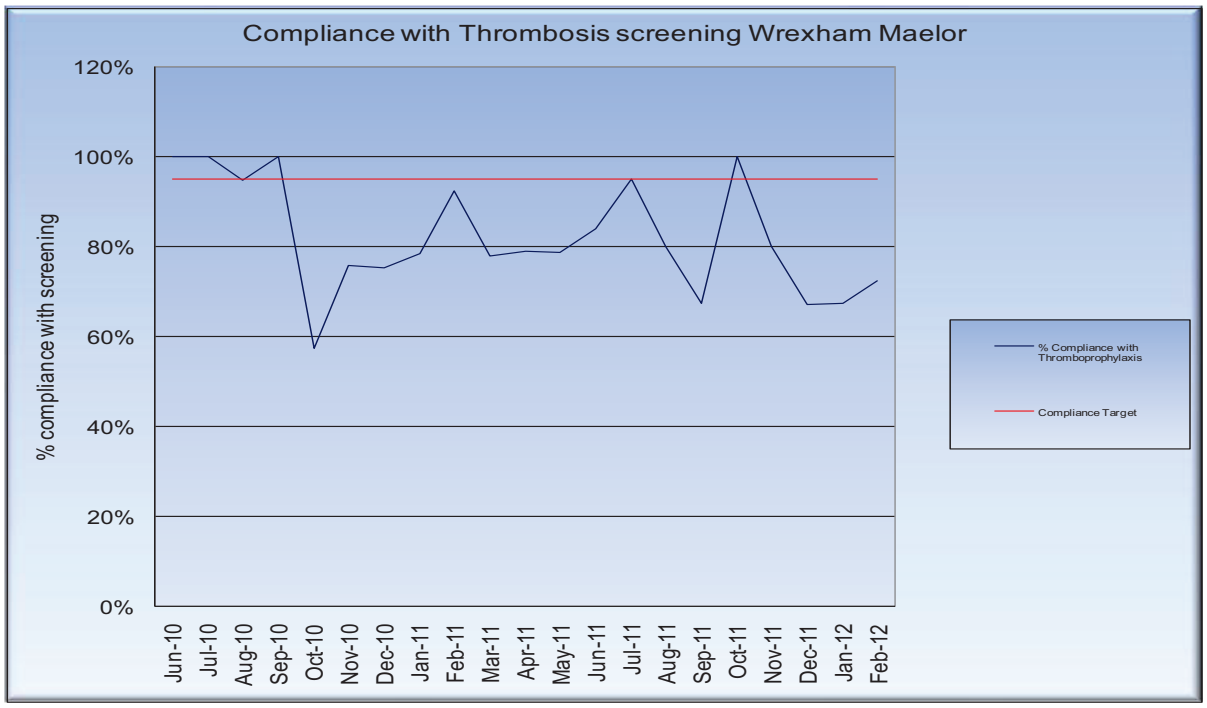
BCUHB Friday, 04 May 2012

Gynaecology is in the very early stages of implementation. The risk assessments have been amended slightly and the all wales maternity risk assessment has been incorporated. Assuming approval it is anticipated it will be implemented at Glan Clwyd on the 1st June, and thereafter to other two sites.



In Wrexham all elective Surgical and Orthopaedic patients are now risk assessed in Pre-operative assessment clinic by a pharmacist achieving a compliance of more than 95%. However, for the rest of the hospital population, a compliance of 73% shows room for improvement. In medicine data collection relies on ward staff and is supplied sporadically. Once again this is an area for further

attention and work.



In summary Current compliance rates for BCUHB are as follows for February 2012:

- Bangor: 33%
- Glan Clwyd: 53%
- Wrexham Maelor: 73%
- **BCUHB compliance with risk assessment= 53%**

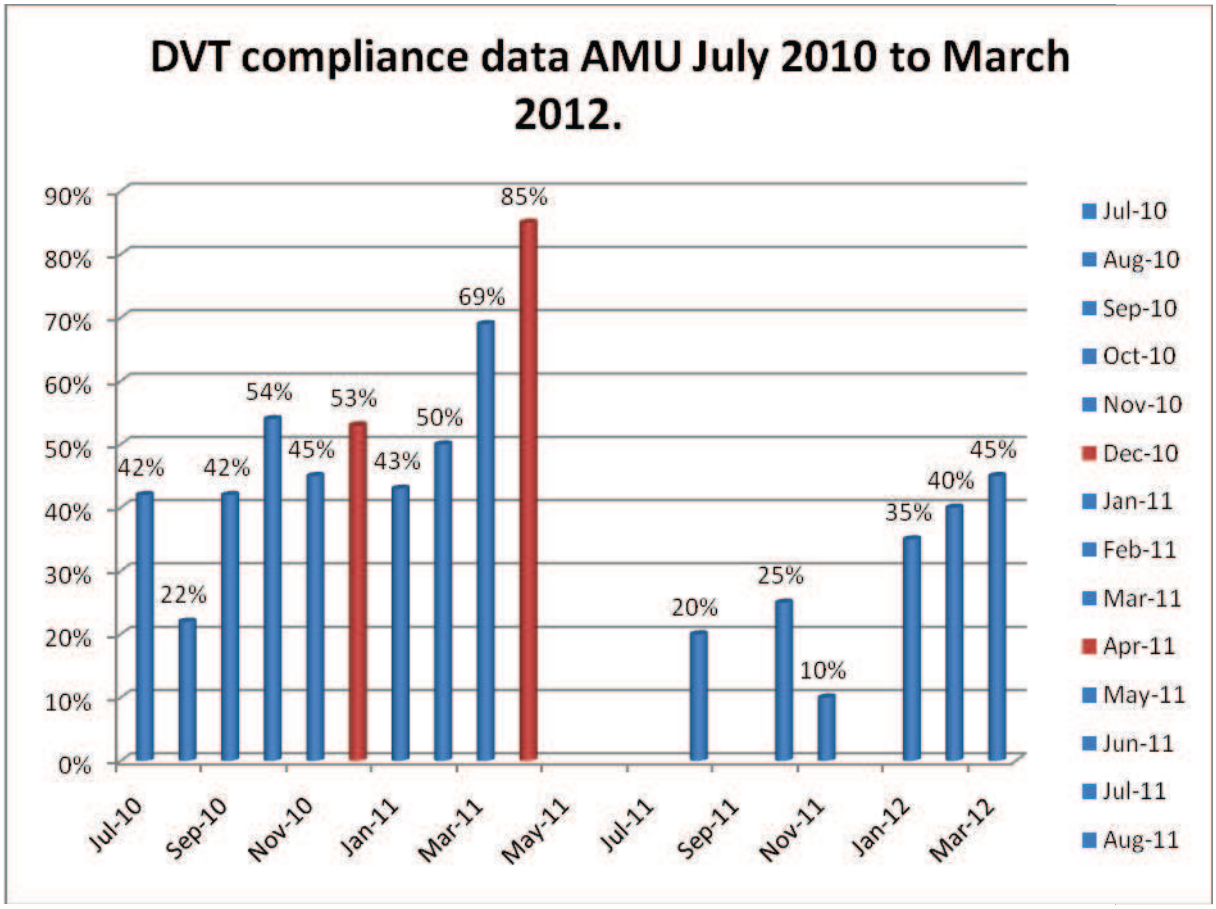
Effectiveness and utilisation of pharmacological and mechanical prophylaxis for VTE

We have observed a difference in compliance in use of the assessment tools and the numbers receiving some form of prophylaxis. Across BCU 80 – 95% of patients receive some form of either mechanical or pharmacological thromboprophylaxis. We are currently performing a retrospective case note audit of all the patients with hospital acquired thrombosis for 2011 to look at the prophylaxis they received.

Particular problems in the implementation and delivery of VTE prevention actions

- ***Day to Day Leadership***

Using commercial sponsorship, BCU have employed a part-time thromboprophylaxis Nurse to assist with this work. With a package of focussed training and support the risk assessment completion rate in one of our AMU increased from 22 to 85% at the beginning of 2011. Unfortunately funding difficulties meant the post ceased to exist in April 2011. This was subsequently reinstated, with further temporary funding. Much of the ground gained was lost and we are still in the process of recovery. Funding runs out this month, with no prospect of further commercial sponsorship. Nevertheless, BCU, recognising its evident value are exploring alternatives, and it would appear likely, though not as yet certain, this will be extended for a further year.



- ***Clinical Engagement*** –
  In general, medical staff do not see this as a priority issue. Nevertheless, developing and providing outcome data has proven of great help.

- ***Consultant Leadership*-**.
  This would appear key. Our success within General Surgery on one of our DGH sites has in no small part been attributable to the leadership and support of an enthusiastic Consultant 'champion'. This individual is also the clinical lead for the Hospital Acquired Thrombosis Collaborative.

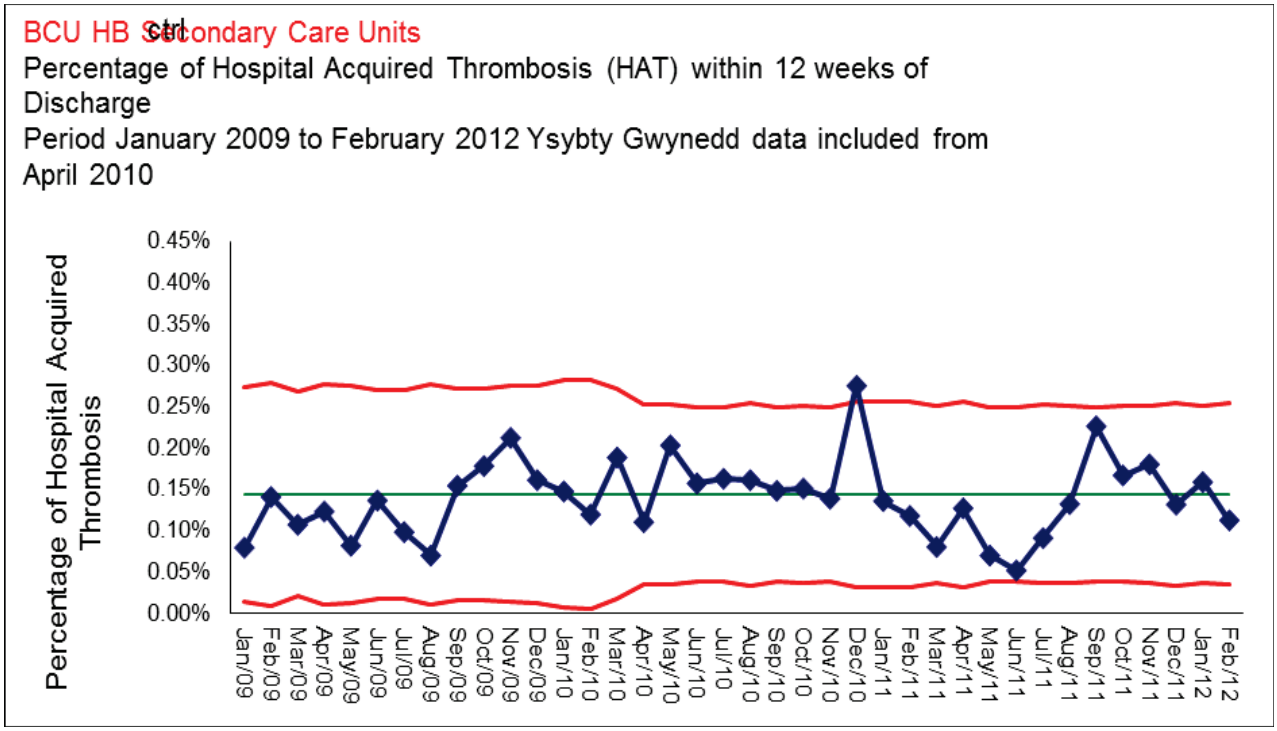
- ***Time to train –***
  Already heavily subscribed it has been difficult to convince postgraduate departments to give time to training in this area. Were this provided at induction, its anticipated this would produce an improvement in use of the assessment tool and prescription of appropriate prophylaxis. With increasing availability of HAT rate and the effect we have noted in general surgery, this should improve.

Hospital acquired thrombosis rate :

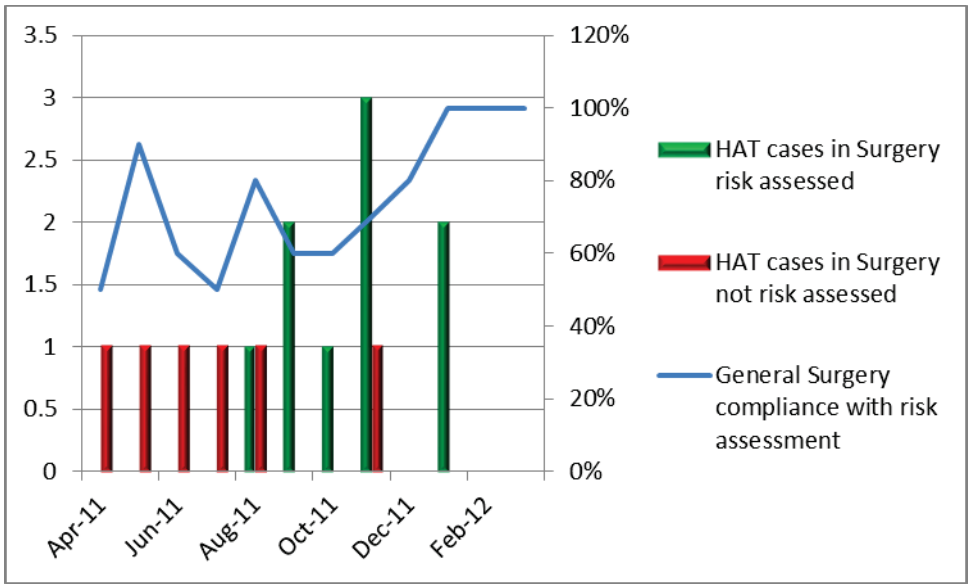
We have determined across BCU, for all Specialities and all methods of admission, there are between 5 and 23 cases per month . From this we have determined a rate using the formula:-

Number of Hospital acquired thrombosis x 100= HAT rate

Number of discharges for the month



Prior to the introduction of this outcome measure, as the majority of HAT is managed in primary care or out-patients, there was limited feedback on HAT. Clinicians were aware of guidance and the advice to provide prophylaxis, but had little to indicate, for their patients, this was a problem meriting their attention. Identifying actual numbers; determining a rate; and bringing this to departmental level has proven a spur to action. The best evidence for this has been in General surgery as below:-



This is early data, in one specialty, on one site, but provides for the first time a link between risk assessment and incidence of HAT.

GIG CYMRU NHS WALES
Bwrdd Iechyd Cwm Taf Health Board

Your ref/eich cyf: AW/JT
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Mark Drakeford AC/ AM
Chair
Health & Social Care Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Dear Mr. Drakeford,

Re: Venous thrombo-embolism prevention in hospitalised patients in Wales.

Thank you for the letter dated 13th March 2012 requesting submissions to the Health & Social Care Committee. Please accept the following information from Cwm Taf Local Health Board.

- There is Executive leadership across Cwm Taf Health Board on the initiatives to reduce the incidence of hospital acquired venous thrombo-embolism. Direction and scrutiny on the implementation of the National Institute for Clinical Excellence (NICE) guidance and the application of the 1,000 Lives Plus risk assessment tool is through the Thrombosis Committee, which is Chaired by the Assistant Medical Director. There is extensive engagement from the Directorates to ensure a collaborative approach to implementation and sharing of audit outcomes for learning across the organisation, with the approach endorsed by the Thrombosis Committee in October 2010.
- Awareness of the risk assessment tool and prevention actions is raised in the induction programmes for all junior doctors and at both the audit meetings and the Integrated Governance meetings in the Directorates. During 2011 awareness raising Directorate sessions have been held to assess the quality standards for the prevention of venous thrombo-embolism.
- There has been extensive audit activity across all relevant Directorates to assess compliance with NICE Clinical Guidance 92 - Venous Thromboembolism : reducing the risk, and NICE Clinical Guidance 46 - VTE in Inpatients undergoing surgery. The outcomes of the audits demonstrate a good awareness of the need to apply the prevention actions but there are opportunities to improve the documentation and record keeping. For example, following

assessment of the patient where the balance of risk demonstrates a risk of bleeding for the patient, the entry in the medical record is not always completed to indicate that an active decision has been taken NOT to instigate pharmacological prophylaxis.

- Audit outcomes demonstrated greater compliance in surgical/orthopaedic/anaesthetics/ENT and obstetric & gynaecology specialities. The roll out of Post - Operative instructions for the application of mechanical prophylaxis is underway with blanket application of TED stockings/calf pumps in some specialities where the risk of VTE is high - trauma/orthopaedics. Audits continue on utilisation and effectiveness of Rivoroxiban, Enoxaprin, Clexane and mechanical prophylaxis.
- Patient information leaflets have been developed and with the roll out of Pre-Operative Assessment patients are being advised of the self care they can engage in during a hospital stay - passive exercise etc. The detailed pre-disposing history is being documented at the pre-operative stage and recorded on the pre-admission check list. In some specialities the Clinical Nurse Specialists and Nurse Practitioners are completing further checks at admission utilising the 1,000 Lives Plus audit tool - this approach is subject to audit to assess the best mechanism to improve compliance across Cwm Taf Health Board.
- To support self care and full engagement by patients and carers in the VTE prevention actions consideration is being given to developing a 'care contract' to be provided at admission which describes the actions patients should take to reduce the risk of development of VTE. The 'care contract' will also contain information for patients on infection prevention & control approaches and general public health information to support a rapid return to normal health.
- Information Technology and Radiological reporting systems are being aligned to provide evidence for the HAT rate. Development of outcome measures to compare incidence prior to and following implementation of thromboprophylaxis is underway and Cwm Taf Health Board is committed to full engagement with the achievement of a National HAT rate.

I do hope the information from Cwm Taf Health Board is useful in the submission to the Health & Social Care Committee.

Yours sincerely,

Allison Williams,
Chief Executive Officer

cc Felicity Barclay, NHS Institute for Innovation & Improvement.
cc Grant Robinson, Medical Director, Aneurin Bevan Health Board

Health and Social Care Committee
HSC(4)-15-12 paper 16
One-day inquiry into venous thrombo-embolism prevention – Evidence from Cardiff and Vale University Health Board

GIG CYMRU NHS WALES
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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

Y Pwyllgor Iechyd a Gofal Cymdeithasol
HSC(4)-15-12 papur 17
Ymchwiliad un-dydd i atal thrombo-emboledd gwythiennol - Bwrdd Iechyd Hywel Dda

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Ymateb Bwrdd Iechyd Hywel Dda i Gynulliad Cenedlaethol Cymru ac Ymchwiliad Un Diwrnod y Pwyllgor Iechyd a Gofal Cymdeithasol i osgoi thrombo-emboledd gwythiennol ("venous thrombo-embolism" - VTE) ar gyfer cleifion yn yr ysbyty yng Nghymru.

Diben y papur hwn
Mae'r papur hwn yn rhoi tystiolaeth i Ymchwiliad Un Diwrnod y Pwyllgor Iechyd a Gofal Cymdeithasol i osgoi thrombo-emboledd gwythiennol ("venous thrombo-embolism" - VTE) ar gyfer cleifion yn yr ysbyty, i ba raddau y mae Bwrdd Iechyd Lleol (BILl) Hywel Dda wedi gweithredu canllawiau'r Sefydliad Cenedlaethol dros Iechyd a Rhagoriaeth Glinigol ("NICE") a dull Asesu Risg 1000 o Fywydau a Mwy.

Cefndir
Mae BILl Hywel Dda wrth wraidd gofal iechyd lleol canolbarth a de orllewin Cymru. Mae'r sefydliad, a ffurfiwyd yn 2009, yn gyfrifol am roi'r gwasanaethau gofal iechyd angenrheidiol yn Sir Gaerfyrddin, Ceredigion a Sir Benfro ac am wella iechyd a lles cyffredinol ei gymuned. Mae'r sefydliad yn dwyn ynghyd wasanaethau gofal cymunedol, sylfaenol ac eilradd ar gyfer tua 375,000 o bobl ledled eu siroedd a'r tu hwnt i hynny.
Mae pedwar ysbyty acíwt:

- Ysbyty Cyffredinol Bronglais, Aberystwyth;
- Ysbyty Tywysog Philip, Llanelli;
- Ysbyty Cyffredinol Glangwili, Caerfyrddin;
- Ysbyty Cyffredinol Llwynhelyg, Hwlffordd.

Mae gwasanaethau acíwt a chymunedol hefyd yn cael eu darparu gan:

- 8 ysbyty cymunedol;
- 15 canolfan iechyd, a mannau eraill.

Caiff gwasanaethau gofal sylfaenol eu rhoi yn bennaf drwy gontractwyr, gan gynnwys:

- 55 meddygfa (prif safleoedd)
- 51 deintyddfa (67 contract deintyddol);
- 99 fferyllfa gymunedol;
- 51 practis optometreg

Mae sawl lleoliad arall sy'n rhoi gwasanaethau Iechyd Meddwl, Anableddau Dysgu, Adfer, Seicotherapi a Niwroseicoleg.

Cyflwyniad

Ystyrir unrhyw VTE sy'n digwydd o fewn 90 diwrnod o dderbyn claf i'r ysbyty yn VTE a gafwyd yn yr ysbyty.

Mae VTE a gafwyd yn yr ysbyty, sy'n amrywio o thrombosis gwythiennau dwfn ("Deep Vein Thrombosis" - DVT) ansympomatig i emboledd anferth yr ysgyfaint ("massive Pulmonary Embulism" - PE), yn gyffredin yn dilyn derbyniad i'r ysbyty ac fe'i hystyrir yn achos sylweddol morbidrwydd a marwolaeth mewn cleifion sydd yn yr ysbyty. Amcangyfrifir y gallai fod 60,000 o farwolaethau o PE yn y DU, er bod Swyddfa Ystadegau Gwladol Lloegr yn cofnodi ffigwr gydnabyddedig o 6,000 yn 2010. Cydnabyddir nad yw nifer sylweddol o farwolaethau o ganlyniad i PE yn cael eu diagnosio ac, ar gyfer pob achos lle nodwyd mai PE oedd achos marwolaeth yn yr ysbyty, fel arfer mae dau glaf arall lle ni wnaed y diagnosis. Roedd 284,000 o farwolaethau yn yr ysbyty yng Nghymru a Lloegr yn 2007, ac amcangyfrifodd astudiaeth VITAE Ewrop fod 12% o'r marwolaethau hyn o ganlyniad i PE. Ond, mae astudiaethau post-mortem yn disgrifio cwymp yn nifer yr achosion o 10% o farwolaethau yn yr ysbyty tua 1980 i tua 2% mewn astudiaethau mwy diweddar. Wrth gwrs, bydd defnyddio thrombobroffylacsis sylfaenol wedi cael effaith ar y cwymp hwn ac mae newidiadau i arferion yn golygu bod cleifion yn cael eu symudedd yn ôl yn gyflym ac yn cael eu hanfon yn ôl yn gynharach, a bydd y rhan fwyaf o farwolaethau o PE yn digwydd ar ôl i'r claf gael ei ryddhau.

Amcangyfrifir bod dau dreian o achosion o PE yn cael eu hachosi yn yr ysgyfaint a bod 70% o farwolaethau'n digwydd ymhlith cleifion meddygol yn hytrach na rhai llawfeddygol. Mae'r risg o VTE ymhlith derbyniadau meddygol yn amrywio o 15% ar gyfer cleifion meddygol cyffredinol i 50% ar gyfer cleifion strôc, tra bod PE a gydnabyddir yn feddygol yn digwydd i 1% o gleifion meddygol cyffredinol.

Cydnabyddir hefyd y gallai risg VTE fodoli am hyd at 90 diwrnod ar ôl derbyn y claf i'r ysbyty, a bydd llawer o VTE yn digwydd ar ôl iddynt gael eu rhyddhau. Hefyd, yn aml, bydd VTE yn glinigol ddistaw, gan nad oes unrhyw arwyddion clinigol mewn 80% o DVT ond gall hyn gynhyrchu goblygiadau hirdymor, sef syndrom ôl-thrombotig.

Gweithredu canllawiau NICE
Roedd polisïau a phrotocolau ar gyfer osgoi thrombo-emboledd gwythiennol ymhlith cleifion mewnol llawfeddygol a meddygol mewn grym yn Ymddiriedolaethau GIG cyfansoddol y GIG BILI Hywel Dda am sawl blwyddyn cyn cyhoeddi canllaw NICE.

Ym mis Ebrill 2007, cyhoeddodd NICE Ganllaw Clinigol 46: 'Reducing the risk of venous thrombo-embolism in in-patients undergoing surgery'. Cafodd y canllaw hwn ei ddiweddaru a'i disodli ym mis Ionawr 2010 gan CG92:

'Reducing the risk of venous thrombo-embolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital'.

Ar ôl i Ganllaw Clinigol 46 gael ei gyhoeddi, cychwynnwyd rhaglen archwilio er mwyn monitro a hwyluso'r broses o roi'r callawiau ar waith o fewn yr arbenigeddau llawfeddygol.

Ym mis Gorffennaf 2009, cynhaliodd Pwyllgor Thrombosis Hywel Dda (sy'n adrodd i'r Grŵp Rheoli Meddygaeth) ei gyfarfod cyntaf. Diben cyffredinol y Pwyllgor Thrombosis yw 'datblygu a goruchwylio'r broses o weithredu'r canllawiau ar gyfer osgoi a rheoli thrombo-emboledd ledled Bwrdd Iechyd Lleol Hywel Dda'.

Ym mis Rhagfyr 2009, lansiodd Grŵp Thrombosis Cymru Gyfan Ddull Asesu Risg Thrombobroffylacsis Cymru Gyfan a gafodd ei fabwysiadu gan BILl Hywel Dda yn dilyn adolygiad a chynnwys nifer gyfyngedig o opsiynau o ran cyffuriau gan Bwyllgor Thrombosis Hywel Dda, gan gychwyn mewn clinigau cyn-asesu llawfeddygol yn gyntaf. Ond, roedd angen trafodaethau pellach ledled BILl Hywel Dda er mwyn symud ymlaen tuag at ddull cyson ar gyfer rhoi cynnyrch ar bresgripsiwn ar gyfer pwysau moleciwlaidd isel, Heparin, a chyfeiriwyd hyn at y Grŵp Rheoli Meddyginiaethau. Achosodd hyn oedi wrth roi ar waith y dulliau Asesu Risg Thrombobroffylacsis ar hyd pob arbenigedd perthnasol.

Nododd Archwiliad a gafodd ei gynnal yn Ysbyty Tywysog Philip yn 2005 fod tua 40% o gleifion yn cael proffylacsis. A nododd archwiliad pellach yn 2010 fod tua 46% o gleifion yn cael proffylacsis.

Gweithredu Dulliau Asesu Risg VTE 1000 o Fywydau a Mwy
Yn dilyn lansiad maes Rhaglen 1000 o Fywydau a Mwy, 'Reducing Harm from Hospital Acquired Thrombosis' ("HAT") ym mis Mai 2010, mae gweithredu HAT wedi dod yn flaenoriaeth sefydliadol ar gyfer BILl Hywel Dda, fel y gwelwyd o benodiad arweinydd gweithredol ar gyfer HAT. Er mwyn parhau â gwaith HAT, cafodd Grŵp Gweithredu HAT Hywel Dda ei sefydlu a roddodd gyfle i feithrin dull sydd wedi'i ganolbwyntio'n well er mwyn parhau â'r elfennau amrywiol sy'n cefnogi'r broses o weithredu HAT yn llwyddiannus ledled y 4 Ysbyty Ardal, o fewn pob arbenigedd.

Dull Asesu Risg VTE: cafodd y Ffurflenni Asesu Risg VTE eu 'lleoleiddio' er mwyn eu defnyddio ledled BILl Hywel Dda, gan gynnwys cyrraedd dull cyson ar gyfer rhoi presgripsiwn ar gyfer pwysau moleciwlaidd isel, Heparin, a thrwy hynny gysoni'r arfer ledled BILl Hywel Dda.

<u>Lansio HAT 1000 o Fywydau a Mwy</u>

Ar 17 Hydref 2011, yn dilyn proses o godi ymwybyddiaeth drwy sawl cyfrwng, fel llythyr gan y Cyfarwyddwr Meddygol, hysbysiad trwy e-bost i'r holl staff, cafodd ffurflenni Asesu Risg VTE eu lansio yn yr ysbytai acíwt ar gyfer pob arbenigedd.

Archwiliad
Gweler: Effeithiolrwydd a defnyddio proffylacsis ffarmacolegol a mecanyddol ar gyfer VTE.

O ystyried y cynnydd rydym wedi'i weld, erbyn hyn mae Grŵp Gweithredu HAT Hywel Dda wedi dod i ben ac mae wedi'i ddisodli gan 4 Grŵp Gweithredu HAT sydd wedi'u seilio yn yr ysbyty. Bydd y rhain yn creu mwy o berchenogaeth leol wrth barhau i weithredu HAT ledled y 4 Ysbyty Ardal. Bydd y 4 Grŵp Gweithredu HAT hyn yn adrodd yn uniongyrchol i'r Pwyllgorau Ansawdd a Diogelwch Sirol yn unol â Grwpiau Cydweithredol eraill 1000 o Fywydau a Mwy yn ogystal ag i Bwyllgor Thrombosis Hywel Dda.

Mae Pwyllgor Thrombosis Hywel Dda yn cyflawni rôl Grŵp Llywio HAT a bydd yn parhau i gefnogi'r gwaith o weithredu HAT ym mhob Ysbyty Ardal drwy fynd i'r afael â materion y sefydliad ehangach, er enghraifft datblygu Polisi Thrombosis, addysgu staff meddygol, monitro/rheoli perfformiad, gan gynnwys datblygu proses ar gyfer cyfrifo cyfradd VTE a systemau gweithredu dibynadwy, taflenni gwybodaeth i gleifion a lledaenu'r gwaith o osgoi HAT ymhellach i'r Ysbytai Cymunedol.

Polisi Thrombosis
Mae'r holl ganllawiau, protocolau a pholisïau sydd mewn grym ar hyn o bryd yn BILI wedi'u coladu a'u hadolygu gan Bwyllgor Thrombosis Hywel Dda. Bydd Polisi Thrombosis cyffredinol yn cael ei ddrafftio a fydd yn cynnwys yr holl ganllawiau, protocolau a pholisïau perthnasol.

Mae Polisi Hosanau Gwrth-Embolig wedi'i gymeradwyo sy'n sicrhau dull cyson wrth ofalu am gleifion sy'n cael eu derbyn i'r ysbyty sydd wedi cael hosanau gwrth-embolig ar bresgripsiwn, yn unol â Rhaglen HAT 1000 o Fywydau a Mwy.

Addysgu Staff Meddygol:
Mae Arweinwyr Clinigol a Hematolegwyr Ymgynghorol ym mhob ardal wedi rhoi addysg i glinigwyr ar gyflwyno a llenwi ffurflenni Asesu Risg VTE. Yn ogystal â hyn, maent hefyd wedi mynychu cyfarfodydd Nyrsys Uwch a chwrdd â thimoedd Anasthetig ac Orthopedig er mwyn hyrwyddo pwysigrwydd osgoi HAT a llenwi ffurflenni Asesu Risg VTE. Ar ben hyn, mae'r Rheolwyr Gwella Ansawdd ym mhob ysbyty ardal a'r Arweinwyr Nyrsio Clinigol yn cynnal gwiriadau ar hap i gadarnhau bod y wardiau'n cydymffurfio, ac yn pwysleisio'r angen i lenwi ffurflenni Asesu Risg VTE.

Er mwyn gwella cydymffurfio, caiff ffurflenni Asesu Risg VTE eu cadw gyda'r siart cyffuriau ar waelod gwely'r claf a bwriedir bod Ymgynghorwyr yn pwysleisio'r angen i Asesu Risg VTE ar y rownd gyntaf ar y ward ar ôl derbyn claf.

Cyflwyno canlyniadau archwiliad ar gydymffurfio ag asesiadau risg VTE mewn Cyfarfodydd Archwilio Clinigol Ysbytai Llawn, cyfrannu at ddysgu staff meddygol ac at waith parhaus i godi ymwybyddiaeth am gynnal asesiadau risg VTE.

Cydnabyddir bod angen addysg ffurfiol barhaus o safbwynt osgoi thrombo-emboledd gwythiennol ("venous thrombo-embolism" - VTE) ymhlith cleifion yn yr ysbyty o ystyried cylchdroadau meddygon iau; bydd yr arweinwyr clinigol a'r hematolegwyr ymgynghorol yn mynd i'r afael â hyn gan ddefnyddio'r slotiau dysgu mewn sesiynau sefydlu meddygon iau.

Monitro/Rheoli Perfformiad/cyfradd VTE:
Mae rhaglen HAT 1000 o Fywydau a Mwy yn nodi mai 'llenwi nifer o asesiadau risg VTE' yw'r unig fesur gorfodol sydd ei angen. Serch hynny, yn ogystal â hyn mae mesurau proses 1000 o Fywydau a Mwy fel a ganlyn:

- % o'r holl gleifion mewnol sy'n oedolion ac sydd wedi cael asesiad risg HAT wrth gael eu derbyn i'r ysbyty gan ddefnyddio dull cenedlaethol.
- % sy'n cael proffylacsis HAT priodol: % o gleifion mewnol sy'n cael y proffylacsis a nodwyd yn eu hasesiad risg.
- % o gleifion mewnol y mae eu hasesiad risg yn cael ei adolygu a'i gofnodi ar ôl 48 awr.
- % o gleifion sydd wedi bod yn yr ysbyty yn ystod y 3 mis diwethaf a ddatblygodd DVT neu PE (y gyfradd VTE)

Rhaid sefydlu prosesau Monitro/Rheoli Perfformiad er mwyn gallu casglu data ac adrodd ar berfformiad o ran canlyniadau a'r mesurau proses, yn enwedig cyfradd VTE BILI Hywel Dda.

Mae gwaith wedi cychwyn ar ddatblygu'r gyfradd VTE yn seiliedig ar ganllawiau 'How to' Mel Baker. Yn dilyn trafodaeth â'r Adrannau Radioleg a Gwybodaeth, daeth i'r amlwg y byddai defnyddio codau Patholeg yn symleiddio'r broses hon a chafodd y rhain eu cyflwyno ar 01/02/2012. Mae data'r 3 mis cyntaf wrthi'n cael ei wirio o ran ansawdd, a bwriedir adrodd ar gyfradd VTE Hywel Dda yn y dyfodol agos.

Taflenni Gwybodaeth i Gleifion:

Mae taflenni gwybodaeth i gleifion, a gynhyrchir gan EIDO Healthcare, yn cael eu rhoi i gleifion mewn clinig cyn-asesu ac mae canllawiau NICE ar gael i unrhyw gleifion sydd am gael gwybodaeth ychwanegol.

Rhoddir gwybodaeth i gleifion hefyd yn unol â pholisi Hosanau Gwrth-Embolig.

Effeithiolrwydd a defnyddio proffylacsis ffarmacolegol a mecanyddol ar gyfer VTE

Roedd archwiliad o ddefnydd ffurflenni Asesu Risg VTE a ph'un a roddwyd thrombobroffylacsis ar bresgripsiwn gyfer cleifion sy'n cael eu derbyn i Uned Derbyniadau Meddygol Acíwt/Uned Penderfyniadau Clinigol yn Ysbyty Tywysog Philip ym mis Tachwedd 2011 yn dangos cynnydd yn y cleifion a oedd yn derbyn proffylacsis priodol. Nododd yr archwiliad fod 61% o gleifion meddygol wedi cael proffylacsis; ond llenwyd ffurflen Asesu Risg VTE ar gyfer 32% o'r cleifion a gafodd eu derbyn. Mae argymhellion yr archwiliad cychwynnol yn cynnwys, felly:

- Bod tystiolaeth o asesiad risg yn perthyn i bob derbyniad, gan ddefnyddio ffurflen thromboproffylacsis.
- Bod Clexane yn cael ei roi ar bresgripsiwn y unrhyw glaf y mae asesiad risg yn nodi bod angen hyn arnynt.
- Bod cleifion nad yw eu harennau'n gweithredu'n arferol yn cael prawf EGFR a bod y dos o Clexane yn cael ei addasu fel y bo'n briodol.
- Bod cofnod yn cael ei wneud o bwysau'r claf ar y ffurflen Asesu Risg VTE.
- Bod y ffurflen Asesu Risg VTE yn cael ei chadw gyda'r siart cyffuriau er mwyn ei hadolygu 48 awr yn ddiweddarach.

Mae cymhariadau ag archwiliadau blaenorol yn dangos bod mwyn o gleifion meddygol yn cael proffylacsis priodol ers cyflwyno ffurflenni Asesu Risg.

- 2005: 40% wedi derbyn proffylacsis priodol
- 2010: 46% wedi derbyn proffylacsis priodol
- 2011: 61% wedi derbyn proffylacsis priodol

Bydd ail-archwiliad yn Ysbyty Tywysog Philip yn cael ei gynnal yn ystod yr wythnos sy'n cychwyn 30/04/2012.

Yn Ysbyty Cyffredinol Glangwili, mae'r archwiliad yn cael ei gynnal ar 9 ward meddygol, ar 9 diwrnod gwahanol yn ystod mis Mai. Mae'r archwiliad yn cynnwys cadarnhau a yw asesiad o risg VTE wedi'i gynnal, gan gynnwys defnyddio'r ffurflen Asesu Risg VTE, a roddwyd thrombobroffylacsis VTE ar bresgripsiwn a, phan na'n cael ei roi ar bresgripsiwn, bod nodyn clir o hyn yn y nodiadau meddygol.

Cafodd y gwaith o weithredu ffurflenni Asesu Risg VTE ar gyfer Derbyniadau Meddygol Acíwt ei fonitro yn ystod mis Medi a mis Hydref yn Ysbyty Cyffredinol Bronglais. Yn ystod mis Hydref, roedd gan 14 o bob 15 (93%) o gleifion ffurflen Asesu Risg VTE wedi'i chynnwys yn eu nodiadau meddygol. Roedd 13% o'r ffurflenni Asesu Risg VTE wedi'u llenwi'n gywir a chafodd 93% o gleifion thrombobroffylacsis. Argymhellwyd rhannu'r data cydymffurfio hwn ag arweinwyr cyd-grwpiau HAT 1000 o Fywydau a Mwy er mwyn ei adolygu, er mwyn gwella, ac er mwyn rhoi tystiolaeth bod y broses o Asesu Risg yn gadarn. Yn ystod mis Ionawr 2012, cynhaliwyd archwiliad ar sampl o holl dderbyniadau Ysbyty Cyffredinol Bronglais. Caiff canlyniadau'r archwiliad hwn eu cyflwyno ar 10 Mai yn Archwiliad Ysbyty Cyfan Ysbyty Bronglais.

Yn ogystal â hyn, rhaid sefydlu archwiliad o arferion llawfeddygol / orthopedig er mwyn cael darlun llawn o waith gweithredu pob arbenigedd a phob ysbyty.

Problemau penodol o ran gweithredu a chynnal camau gweithredu i osgoi VTE

Tra y gall staff nyrsio hwyluso'r broses drwy hyrwyddo ac atgoffa bod ffurflenni Asesu Risg yn cael eu llenwi, y staff meddygol sy'n gyfrifol am asesu cleifion a llenwi ffurflenni Asesu Risg VTE. Gan fod staff meddygol iau yn cael eu newid yn aml, mae angen rhoi addysg barhaus er mwyn gwella dibynadwyedd llenwi ffurflenni Asesu Risg VTE ac, yn bwysicach, bod thrombobroffylacsis priodol yn cael ei roi mewn da bryd i gleifion.

Y brif rôl nyrsio yw hwyluso mesur, cyflenwi a rhoi maint priodol o thrombobroffylacsis meddygol h.y. Hosanau Gwrth-Embolig, yn ogystal â rhoi gofal yn yr ysbyty ac yn y cartref. Bydd staff nyrsio hefyd yn rhoi gwybodaeth i gleifion ac yn rhoi Heparin ar bresgripsiwn ar gyfer pwysau moleciwlaidd isel. Yn olaf, byddant yn sicrhau bod cleifion yn deall y drefn maent yn ei dilyn, a pham.

Casgliad

Mae BILI Hywel Dda wedi cymryd camau positif tuag at leihau risg cleifion mewnol o gael thrombo-emboledd gwythiennol ac felly mae wedi lleihau niwed posibl i gleifion, lleihau amrywiaeth wrth roi gwasanaeth a chanlyniadau clinigol, a lleihau gwastraff drwy osgoi bod cleifion yn datblygu cymhlethdodau. Mae hyn wedi gwella ansawdd y gofal iechyd sy'n cael ei roi, a diogelwch cleifion.

Serch hynny, gall BILI Hywel Dda wella sawl peth er mwyn ymwreiddio'n llawn y broses o Asesu Risg VTE a chydymffurfio'n llawn â'r drefn broffylactig a argymhellir fel rhan o arferion bob dydd yr holl staff ym mhob maes clinigol y BILI.

Kathryn Davies
Cyfarwyddwr Therapiau a Gwyddor Iechyd
Bwrdd Iechyd Hywel Dda

Y Pwyllgor Iechyd a Gofal Cymdeithasol
HSC(4)-15-12 papur 18
Ymchwiliad un-dydd i atal thrombo-emboledd gwythiennol - Llywodraeth Cymru

Diben

1. Mae'r papur hwn yn darparu tystiolaeth ar gyfer ymchwiliad undydd y Pwyllgor Iechyd a Gofal Cymdeithasol i atal thromboemboledd gwythiennol (VTE) mewn cleifion yn yr ysbyty yng Nghymru.

2. Mae'r papur tystiolaeth:

   - yn crynhoi'r holl ganllawiau gan y Sefydliad Cenedlaethol dros Iechyd a Rhagoriaeth Glinigol (NICE) mewn perthynas ag atal VTE.
   - yn edrych ar y ffordd y rhoddir canllawiau NICE ar waith;
   - yn edrych ar yr offeryn asesiad risg 1000 o Fywydau a Mwy ar draws Cymru a pha mor ddigonol ac effeithiol ydyw wrth atal VTE mewn cleifion yn yr ysbyty.

Crynodeb

3. Cyhoeddwyd llawer o dystiolaeth ar beth sydd angen ei wneud i atal VTE yn yr ysbyty. Mae'n cynnwys asesu'n systematig gleifion sydd mewn perygl, triniaeth broffylactig lle bo angen a hefyd addysgu cleifion a'u cael i chwarae eu rhan. Mae'r GIG yng Nghymru, gyda chefnogaeth rhaglen 1000 o Fywydau a Mwy, wedi cymryd camau breision i sicrhau gofal ar sail tystiolaeth a gwella diogelwch cleifion. Roedd hyn yn her ond mae'n dal yn flaenoriaeth wrth i ni geisio sicrhau gofal diogel o'r safon uchaf i gleifion yn yr ysbyty yng Nghymru.

Thromboemboledd Gwythiennol

4. Cyflwr yw VTE lle mae clot gwaed (thrombws) yn ymffurfio mewn gwythïen. Mae'n digwydd amlaf yng ngwythiennau dwfn y coesau; yr enw ar hwn yw thrombosis gwythiennau dwfn. Gall y thrombws symud o'r safle lle mae'n ymffurfio a theithio yn y gwaed – ffenomen o'r enw emboledd.

5. Mae VTE yn ymddangos yn glinigol mewn gwahanol ffurfiau. Yn aml nid yw thrombosis gwythiennol yn dangos symptomau; yn llai aml mae'n achosi i'r goes chwyddo'n boenus. Gall rhan o'r thrombws neu'r cyfan ddod yn rhydd a theithio i'r ysgyfant, sef emboledd ysgyfeiniol, a allai fod yn farwol. Mae thrombosis gwythiennol symptomatig yn creu baich sylweddol o forbidrwydd, gan gynnwys morbidrwydd hirdymor oherwydd diffyg gwythiennol cronig. Gall hyn yn ei dro achosi briwiau gwythiennol a gall aelod ôl-thrombotig ddatblygu (fel rheol gyda phoen gronig, chwyddo a newidiadau i'r croen).

6. Mae VTE yn un o'r prif bethau sy'n achosi i gleifion yn yr ysbyty farw ac mae trin VTE symptomatig nad yw'n farwol a'r morbidrwydd hirdymor cysylltiedig yn gostus iawn i'r gwasanaeth iechyd.

7. Mae'r risg o ddatblygu VTE yn dibynnu ar y cyflwr a/neu'r driniaeth y mae'r claf yn cael ei dderbyn ar ei gyfer ac ar unrhyw ffactorau risg rhagdueddol (megis oed, gordewdra a chyflyrau cydredol).

8. Adroddodd Pwyllgor Iechyd Tŷ'r Cyffredin yn 2005 yr amcangyfrifir bod 25,000 o bobl ym marw bob blwyddyn ym Mhrydain o VTE a gânt yn yr ysbyty ac y gallasid ei atal. Mae hyn yn cynnwys cleifion a dderbynnir i'r ysbyty ar gyfer gofal meddygol a llawfeddygaeth. Mae llawer o adroddiadau bod mesurau proffylactig ar gyfer VTE mewn cleifion yn yr ysbyty yn cael eu rhoi ar waith mewn modd anghyson. Awgrymodd arolwg ledled y DU nad oedd 71% o'r cleifion yr aseswyd eu bod mewn perygl canolig neu uchel o ddatblygu thrombosis gwythiennau dwfn wedi derbyn unrhyw ffurf o broffylacsis mecanyddol na ffarmacolegol ar gyfer VTE.

Canllawiau Clinigol NICE

9. Fis Ionawr 2010, cyhoeddodd NICE ganllawiau clinigol "Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital". Roedd y canllawiau yn diweddaru ac yn disodli canllawiau a gyhoeddwyd gynt gan NICE yn 2007. Disgwylir i bob rhan o'r GIG yng Nghymru ddarparu gofal yn unol â chanllawiau NICE.

10. Mae'r canllawiau yn cynnwys argymhellion o ran asesu'r risg y bydd cleifion mewn ysbytai yn cael VTE a lleihau'r risg hwnnw. Mae'n cynnig canllawiau ar y mesurau mwyaf effeithiol, yn glinigol ac o ran cost, ar gyfer proffylacsis VTE yn y cleifion hyn.

11. Mae'r 'Blaenoriaethau Allweddol' yn y canllawiau i'w gweld isod:

"Asesu risg VTE a gwaedu

- Dylid asesu pob claf wrth ei dderbyn ac adnabod y rhai sydd â risg uwch o VTE.

- Dylid ystyried bod gan gleifion meddygol risg uwch o VTE:

  - os disgwylir i'w symudedd fod yn sylweddol llai am 3 diwrnod neu ragor **neu**
  - os disgwylir i'w symudedd fod yn is yn barhaus na'r hyn sy'n arferol iddynt a bod ganddynt un neu ragor o'r ffactorau risg sydd i'w gweld ym mlwch 1.

- Dylid ystyried bod gan gleifion llawfeddygaeth a chleifion â thrawma risg uwch o VTE os ydynt yn cwrdd ag un o'r meini prawf canlynol:

  - llawfeddygaeth am gyfanswm o amser dan anaesthetig a llawfeddygaeth o fwy na 90 munud, neu 60 munud os yw'r llawfeddygaeth ar y pelfis neu'r goes
  - derbyniad llawfeddygol acíwt gyda chyflwr llidiol neu fewn-abdomenol
  - disgwylir symudedd sylweddol is
  - un neu ragor o'r ffactorau risg sydd i'w gweld ym mlwch 1.

- Dylid asesu pob claf ar gyfer y risg o waedu cyn cynnig proffylacsis ffarmacolegol VTE. Ni ddylid cynnig proffylacsis ffarmacolegol VTE i gleifion sydd ag unrhyw un o'r ffactorau risg ar gyfer gwaedu sydd i'w gweld ym mlwch 2, oni bai fod y risg o VTE yn bwysicach na'r risg o waedu.

- Dylid ailasesu risgiau cleifion o ran gwaedu a VTE cyn pen 24 awr ar ôl eu derbyn a phob tro y mae'r sefyllfa glinigol yn newid, er mwyn:

  - sicrhau bod y dulliau proffylactig a ddefnyddir ar gyfer VTE yn addas
  - sicrhau y defnyddir y proffylacsis ar gyfer VTE yn gywir
  - adnabod digwyddiadau anffafriol sy'n digwydd o ganlyniad i broffylacsis VTE.

Lleihau'r risg o VTE

- Dylid annog cleifion i symud cyn gynted ag y bo modd.

- Dylid cynnig proffylacsis ffarmacolegol ar gyfer VTE i gleifion meddygol yr aseswyd bod ganddynt risg uchel o VTE. Dewiswch unrhyw un o blith:

  - fondaparinux sodium
  - heparin â màs moleciwlaidd isel (LMWH)
  - heparin heb ei ffracsiynu (UFH) (ar gyfer cleifion â methiant yr arennau).

Dylid dechrau proffylacsis ffarmacolegol ar gyfer VTE cyn gynted ag y bo modd ar ôl cwblhau'r asesiad risg. Dylech barhau nes nad oes gan y claf risg uwch o VTE.

Gwybodaeth i gleifion a chynllunio ar gyfer eu rhyddhau

- Cyn dechrau proffylacsis ar gyfer VTE, dylid rhoi gwybodaeth ar lafar ac yn ysgrifenedig i gleifion a/neu eu teuluoedd neu'u gofalwyr am:

  - risgiau a chanlyniadau posibl VTE
  - pwysigrwydd proffylacsis ar gyfer VTE a'i sgil effeithiau posibl
  - sut i ddefnyddio proffylacsis ar gyfer VTE yn gywir (er enghraifft hosanau gwrth-emboledd, dyfeisiau ysgogi'r traed neu ddyfeisiau cywasgu niwmatig ysbeidiol)
  - sut y gall cleifion leihau eu risg o VTE (megis yfed digon ac, os oes modd, ymarfer corff a symud mwy).

- Fel rhan o'r cynllun rhyddhau o'r ysbyty, dylid rhoi gwybodaeth ar lafar ac yn ysgrifenedig i gleifion a/neu eu teuluoedd neu'u gofalwyr am:

  - arwyddion a symptomau thrombosis gwythiennau dwfn ac emboledd ysgyfeiniol
  - sut i ddefnyddio proffylacsis ar gyfer VTE yn gywir gartref ac am ba hyd (os rhoddir proffylacsis iddynt wrth eu rhyddhau)
  - pwysigrwydd defnyddio proffylacsis ar gyfer VTE yn gywir a pharhau gyda'r driniaeth am y cyfnod a argymhellir (os rhoddir proffylacsis iddynt wrth eu rhyddhau)
  - arwyddion a symptomau digwyddiadau anffafriol sy'n gysylltiedig â phroffylacsis ar gyfer VTE (os rhoddir proffylacsis iddynt wrth eu rhyddhau)
  - pwysigrwydd ceisio cymorth a phwy y dylid cysylltu ag ef os bydd ganddynt unrhyw broblemau wrth ddefnyddio'r proffylacsis (os rhoddir proffylacsis iddynt wrth eu rhyddhau)
  - pwysigrwydd ceisio cymorth meddygol a phwy y dylid cysylltu ag ef os ydynt yn amau bod arnynt thrombosis gwythiennau dwfn, emboledd ysgyfeiniol neu ddigwyddiad anffafriol arall.

Blwch 1 Ffactorau risg ar gyfer VTE

- Canser presennol neu driniaeth ar gyfer canser
- Dros 60 mlwydd oed
- Derbyn ar gyfer gofal critigol
- Diffyg hylif
- Thromboffiliau hysbys
- Gordewdra (mynegai màs y corff [BMI] dros 30 kg/m^2)
- Un cyd-forbidrwydd o bwys neu ragor (er enghraifft: clefyd y galon; patholeg metabolig, endocrinaidd neu resbiradol; clefydau heintus acíwt; cyflyrau llidiol)
- Hanes personol neu berthnasau gradd gyntaf sydd â hanes o VTE
- Defnyddio therapi adfer hormonau
- Defnyddio therapi atal cenhedlu sy'n cynnwys oestrogen
- Gwythiennau faricos gyda fflebitis

Blwch 1 Ffactorau risg ar gyfer gwaedu

- Gwaedu presennol
- Anhwylderau gwaedu a gafwyd (megis methiant acíwt yr afu)
- Defnyddio gwrthgeulydd ar yr un pryd y mae'n hysbys eu bod yn cynyddu'r risg o waedu (megis warfarin â chymhareb normaleiddedig ryngwladol [INR] uwch na 2)
- Disgwylir anaesthesia tynnu hylif madruddyn y cefn/epidwral/sbinol cyn pen 12 awr
- Wedi cael anaesthesia tynnu hylif madruddyn y cefn/epidwral/sbinol yn ystod y 4 awr ddiwethaf
- Strôc acíwt
- Thrombocytopenia (platennau llai na 75 x 10^9/l)
- Gorbwysedd systolig heb reolaeth (230/120 mmHg neu uwch)
- Anwylderau gwaedu etifeddol heb eu trin (megis haemoffilia a chlefyd von Willebrand)

Canllawiau eraill perthnasol NICE

12. Yn ogystal â'r Canllawiau Clinigol, mae NICE wedi cynnal yr arfarniadau technoleg canlynol ar gyfer meddyginiaethau mewn perthynas â VTE:

Cyhoeddedig

- Dabigatran etexilate; fe'i hargymhellir fel dewis ar gyfer ataliad cychwynnol o ddigwyddiadau thromboembolig gwythiennol mewn oedolion sydd wedi cael llawfeddygaeth ddethol i gael clun newydd neu ben-glin newydd (TA157 a gyhoeddwyd Medi 2008);

- Rivaroxaban; fe'i hargymhellir fel dewis ar gyfer atal digwyddiadau thromboembolig gwythiennol mewn oedolion sydd am gael llawfeddygaeth ddethol i gael clun newydd neu ben-glin newydd (TA170 a gyhoeddwyd Ebrill 2009);

- Apixaban; fe'i hargymhellir fel dewis ar gyfer atal digwyddiadau thromboembolig gwythiennol mewn oedolion ar ôl llawfeddygaeth ddethol i gael clun newydd neu ben-glin newydd (TA245 a gyhoeddwyd Ionawr 2012).

Mae dyletswydd statudol ar y GIG yng Nghymru i ariannu darparu'r meddyginiaethau hyn, yn unol â chanllawiau NICE.

Wrthi'n cael eu datblygu

- Rivaroxaban ar gyfer trin ac ataliad eilaidd o thromboemboledd gwythiennol (dyddiad cyhoeddi tebygol Gorffennaf 2012);

- Dabigatran etexilate ar gyfer trin digwyddiadau thromboembolig gwythiennol acíwt (dyddiad cyhoeddi i'w gadarnhau);

- Apixaban ar gyfer atal thromboemboledd gwythiennol mewn afiechyd meddygol acíwt (dyddiad cyhoeddi i'w gadarnhau);

- Rivaroxaban ar gyfer atal thromboemboledd gwythiennol mewn pobl sy'n mynd i'r ysbyty oherwydd cyflyrau meddygol acíwt (dyddiad cyhoeddi i'w gadarnhau).

Safon Ansawdd

Mae NICE hefyd wedi cyhoeddi Safon Ansawdd ar Atal VTE yn 2010, gan gynnwys y saith Datganiad Ansawdd canlynol:

Rhif	**Datganiadau Ansawdd**
1	Bydd pob claf, wrth gael ei dderbyn yn cael asesiad o'r risg o VTE a gwaedu gan ddefnyddio'r meini prawf asesiad risg clinigol a ddisgrifir yn yr offeryn cenedlaethol.

2	Cynigir i gleifion/gofalwyr wybodaeth ar lafar ac yn ysgrifenedig ar atal VTE fel rhan o'r broses derbyn.
3	Os rhoddir hosanau gwrth-emboledd i gleifion, cânt eu gosod a'u monitro yn unol â chanllawiau NICE.
4	Ailasesir cleifion cyn pen 24 awr ar ôl cael eu derbyn o ran y risg o VTE a gwaedu.
5	Cynigir i gleifion yr aseswyd eu bod mewn perygl o VTE broffylacsis ar gyfer VTE yn unol â chanllawiau NICE.
6	Cynigir i gleifion/gofalwyr wybodaeth ar lafar ac yn ysgrifenedig am atal VTE fel rhan o'r broses o'u rhyddhau o'r ysbyty.
7	Cynigir i gleifion broffylacsis estynedig (ar ôl gadael yr ysbyty) ar gyfer VTE yn unol â chanllawiau NICE.

Mae Safon Ansawdd bellach, "Rheoli afiechydon thromboembolig gwythiennol" hefyd yn cael ei datblygu a rhagwelir y caiff ei chyhoeddi yn Ebrill 2013.

Gweithredu i atal VTE ar gyfer cleifion yn yr ysbyty yng Nghymru

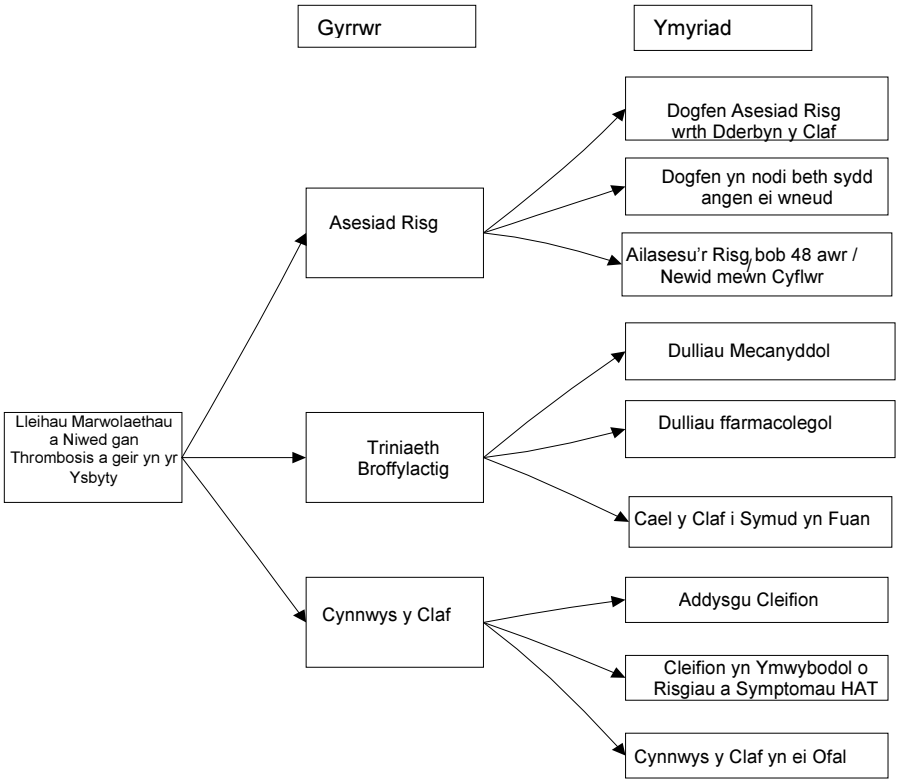
13. Mae gwaith Ymgyrch 1000 o Fywydau ac yn awr Rhaglen 1000 o Fywydau a Mwy, sef y rhaglen wella genedlaethol ar gyfer GIG Cymru, wedi cefnogi'r GIG yng Nghymru wrth iddo roi ar waith beth sydd ei angen i helpu i atal cleifion rhag cael VTE yn yr ysbyty. Mae gwaith 1000 o Fywydau wedi cyflwyno methodoleg safonedig ar gyfer gwella yn GIG Cymru er mwyn cefnogi rhoi ar waith ymyriadau seiliedig ar dystiolaeth mewn modd dibynadwy a chyson. Ei nod yw hwyluso cyflwyno gofal iechyd o'r safon uchaf ac o'r math mwyaf diogel.

14. Lansiwyd Ymgyrch 1000 o Fywydau yn Ebrill 2008 gyda'r nod o arbed 1000 yn rhagor o fywydau ac osgoi hyd at 50,000 digwyddiad o niwed mewn gofal iechyd yng Nghymru mewn dwy flynedd. Cynhwysai ychydig o feysydd (clinigol) seiliedig ar dystiolaeth, yn sgil gwerthusiad o'r dystiolaeth gan y Gwasanaeth Iechyd Cyhoeddus Cenedlaethol fel yr oedd ar y pryd. Roedd hyn yn seiliedig ar waith rhyngwladol a gafodd ei ddyfeisio a'i roi ar waith gan y Sefydliad Gwella Gofal Iechyd yn yr Unol Daleithiau. O ganlyniad, cynhwysai'r ymgyrch yng Nghymru faes ar gyfer 'atal a lleihau cymhlethdodau llawfeddygol'. Un o'r ymyriadau yn y maes hwn oedd adnabod cleifion sydd mewn perygl ac yna darparu proffylacsis priodol ar gyfer DVT.

15. Darparodd Ymgyrch 1000 o Fywydau adnoddau a chefnogodd gyrff yn y GIG trwy raglen gydweithiol i roi mesurau ar waith. Bryd hynny roedd y dull hwn o weithio yn newydd yn y GIG yng Nghymru, gan ddod â thimau clinigol o bob rhan o Gymru ynghyd i rannu syniadau, gwybodaeth a heriau a datblygu dulliau i roi ar waith y gwahanol ymyriadau yr oedd eu hangen, gan gynnwys datblygu offeryn asesiad risg ar gyfer Cymru gyfan.

16. Yn ystod cyfnod Ymgyrch 1000 o Fywydau, daeth rhagor o dystiolaeth i'r fei a chafodd canllawiau NICE eu diweddaru. Felly yn Ionawr 2010, ar ôl adolygiad gan dîm 1000 o Fywydau a Mwy o'r dystiolaeth oedd ar gael o ran VTE a'r cynnydd a wnaed gan gyrff, cytunwyd â Phrif Weithredwr GIG Cymru ar y pryd i roi ar waith brosiect cydweithredol bychan am 12 mis yn ymwneud yn arbennig ag atal VTE fel rhan o Raglen newydd 1000 o Fywydau a Mwy.

17. Gweithiodd tîm 1000 o Fywydau a Mwy mewn partneriaeth ag eraill, gan gynnwys Lifeblood, yr elusen thrombosis, i ddatblygu 'canllawiau sut i'w wneud' a 'diagram gyrrwr' fel sydd i'w gweld isod. Mae'r fethodoleg syml hon yn nodi'r gwahanol weithrediadau, gan gynnwys asesu, trin a chynnwys y claf, y mae angen eu gweithredu mewn dull systematig ar gyfer pob claf sydd mewn perygl er mwyn ceisio ei atal rhag cael VTE yn yr ysbyty.



18. Mae'r dull hwn yn seiliedig ar nifer o fesurau proses i fesur pa mor ddibynadwy yw'r ffordd y rhoddir ymyriadau ar waith. Gyda phrosesau dibynadwy iawn, dylem weld newidiadau a gwelliannau wrth fesur canlyniadau.

19. Mae 1000 o Fywydau a Mwy yn dal i gefnogi cyrff GIG yng Nghymru gyda'r gwaith hwn a'r sialensiau lu y mae wedi'u cynnig. Yn ogystal â rhoi asesiadau risg ar waith, mae gwaith yn parhau i sicrhau bod cleifion yn cael eu hail-asesu'n barhaus ac yn derbyn proffylacsis addas. Ar gyfer cleifion llawfeddygol, mae'r gwaith hwn yn parhau trwy'r rhaglen Gwell Adferiad ar ôl Llawdriniaeth (ERAS).

20. Mae tîm 1000 o Fywydau a Mwy yn gweithio ar hyn o bryd gyda staff arweiniol VTE mewn cyrff GIG i ddatblygu dull mesur canlyniadau ar gyfer y gyfradd thrombosis a gafwyd yn yr ysbyty (HAT). Mae hyn yn adeiladu ar sail gwaith arloesol a wnaed gan Fwrdd Iechyd Prifysgol Betsi Cadwaladr. Erbyn Mawrth 2012, roedd chwech o'r wyth corff wedi sefydlu proses i gyflawni hyn ac mae'r ddau arall yn gweithio tuag ati. Dyma gam pwysig ymlaen yn y gwaith cyffredin i fynd i'r afael â VTE gan ei fod yn anodd asesu'n ddibynadwy pa mor gyffredin yw HAT gyda'r systemau casglu/codio data presennol. Efallai mai Cymru fydd y wlad gyntaf i gael cyfradd genedlaethol ar gyfer HAT.

Trawsnewid Gofal Mamolaeth ac Atal VTE

21. Lansiodd 1000 o Fywydau a Mwy ei raglen gydweithredol Trawsnewid Gwasanaethau Mamolaeth ym Mawrth 2011. Deliodd hyn â'r elfennau penodol ar gyfer atal VTE mewn beichiogrwydd. Nod cyffredinol y rhaglen hon yw gwella'r profiadau a'r canlyniadau ar gyfer menywod, babanod a'u teuluoedd o fewn Gwasanaethau Mamolaeth. Un o'r pethau allweddol i wireddu'r nod hwn yw lleihau'r risg o thromboemboledd gwythiennol mewn beichiogrwydd.

22. Cytunwyd ar asesiad risg VTE cynhwysfawr ar gyfer menywod beichiog. Fe'i cafwyd ar ôl ymgynghori ag arbenigwyr yng Nghymru a'r pwyllgorau cadarnhau. Cafwyd consensws wrth gytuno dau Batrymlun Asesiad Risg DVT enghreifftiol – y naill ar gyfer yr ymweliad 'Bwcio' cychwynnol, a gynhwysir yn y Cofnodion Symudol Cenedlaethol a'r llall ar gyfer Derbyn Cynenedigol a'r pwerperiwm (cyfnod ôl-enedigol). Dyma gyflawniad pwysig ar gyfer y rhaglen gydweithredol fach mewn ychydig o amser. Mae'n dangos arweiniad ac ymgysylltu clinigol cryf yn ogystal â'r ymroddiad sy'n amlwg yn y maes pwysig hwn.

23. Mae pob uned famolaeth yn rhoi'r asesiadau risg hyn ar waith ar hyn o bryd ar ôl eu haddasu ar gyfer y sefyllfa leol a chael eu pwyllgorau craffu i'w cytuno. Mae gwaith ar y gweill hefyd i roi ar waith asesiad risg cyffredin ar gyfer bwcio a derbyn cynenedigol mewn wardiau gynaecolegol ochr yn ochr â'r asesiad risg cyffredinol ar gyfer DVT.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – y Senedd**
Dyddiad:	**Dydd Mercher, 2 Mai 2012**
Amser:	**09:00 – 12:05**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200004_02_05_2012&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**Val Baker, Parkinson's UK Cymru** **Nick Bennett, Cartrefi Cymunedol Cymru** **Richard Davies, Grŵp Tai Gwalia** **Grant Duncan, Llywodraeth Cymru** **Steve Ford, Parkinson's UK Cymru** **Kevin Hughes, Grŵp Tai Pennaf** **Dr Chris Jones, Llywodraeth Cymru** **Rachel Lewis, Cynghrair Henoed Cymru** **Sue Phelpps, Alzheimer's Society** **Chris Quince, Cymdeithas Alzheimer's** **Angela Roberts, Cynghrair Henoed Cymru**
Staff y Pwyllgor:	**Llinos Dafydd (Clerc)** **Meriel Singleton (Clerc)** **Catherine Hunt (Dirprwy Glerc)** **Stephen Boyce (Ymchwilydd)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Ni chafwyd unrhyw ymddiheuriadau na dirprwyon.

2. Ymchwiliad i ofal preswyl i bobl hŷn - tystiolaeth gan sefydliadau a darparwyr y trydydd sector ac ar fodelau amgen

Ymchwiliad i ofal preswyl i bobl hŷn - tystiolaeth gan Gartrefi Cymunedol Cymru

2.1 Atebodd y tystion gwestiynau a ofynnwyd gan Aelodau'r Pwyllgor ynghylch gofal preswyl i bobl hŷn.

2.2 Cytunodd y tystion i ddarparu gwybodaeth am y gyfran o aelodau byrddau grwpiau tai sydd mewn gofal preswyl.

Ymchwiliad i ofal preswyl i bobl hŷn - tystiolaeth gan Gynghrair Henoed Cymru

2.3 Atebodd y tystion gwestiynau a ofynnwyd gan Aelodau'r Pwyllgor ynghylch gofal preswyl i bobl hŷn.

Ymchwiliad i ofal preswyl i bobl hŷn - tystiolaeth gan y Gymdeithas Alzheimer's a Parkinson's UK Cymru

2.4 Atebodd y tystion gwestiynau a ofynnwyd gan Aelodau'r Pwyllgor ynghylch gofal preswyl i bobl hŷn.

3. Papur Gwyn ar Roi Organau - Sesiwn friffio ddilynol gan swyddogion Llywodraeth Cymru

3.1 Atebodd y tystion gwestiynau a ofynnwyd gan Aelodau'r Pwyllgor ynghylch y Papur Gwyn ar Roi Organau.

4. Papurau i'w nodi

Llythyr gan Archwilydd Cyffredinol Cymru - Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru

4.1 Nododd y Pwyllgor y llythyr gan Archwilydd Cyffredinol Cymru.

Goblygiadau iechyd cyhoeddus o ddarpariaeth annigonol o doiledau cyhoeddus - Llythyr gan y Pwyllgor Cymunedau, Cydraddoldeb a Llywodraeth Leol

4.2 Nododd y Pwyllgor y llythyr gan Gadeirydd y Pwyllgor Cymunedau, Cydraddoldeb a Llywodraeth Leol.

Llythyr gan Ysgrifennydd Gwladol Cymru - Confensiwn ar hawliau pobl hŷn

4.3 Nododd y Pwyllgor y llythyr gan Ysgrifennydd Gwladol Cymru a chytunodd i rannu copi â Chomisiynydd Pobl Hŷn Cymru.

4.4 Nododd y Pwyllgor y llythyr gan y Pwyllgor Deisebau.

TRAWSGRIFIAD
Gweld trawsgrifiad o'r cyfarfod.