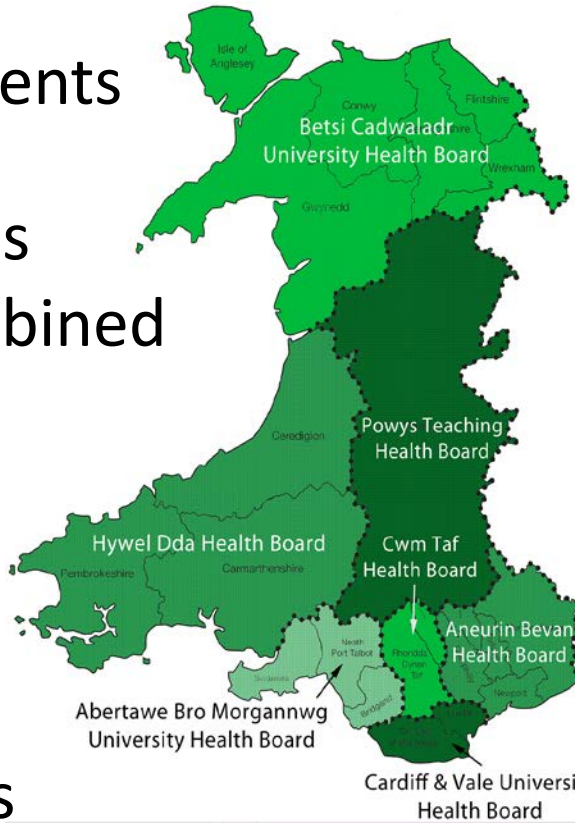
04.05.16

HAT – The current situation in Wales

Mike Fealey, National Programme Manager

Overview

- In the UK between 25,000 and 32,000 patients die as a result of PE following DVT
- Equates to 1,250 avoidable deaths in Wales
- In 2005 this figure was more than the combined deaths from
  - Breast Cancer
  - AIDS
  - RTAs
- 25 times greater than annual MRSA deaths



Health and Social Care Committee

Mark Drakeford (Chair)
Welsh Labour
Cardiff West

Mick Antoniw
Welsh Labour
Pontypridd

Rebecca Evans
Welsh Labour
Mid and West Wales

Vaughan Gething
Welsh Labour
Cardiff South and Penarth

William Graham
Welsh Conservatives
South Wales East

Elin Jones
Plaid Cymru
Ceredigion

Darren Millar
Welsh Conservatives
Clwyd West

Lynne Neagle
Welsh Labour
Torfaen

Lindsay Whittle
Plaid Cymru
South Wales East

Kirsty Williams
Welsh Liberal Democrats
Brecon and Radnorshire

Recommendations

1. Tier 1 priority
2. Mandate risk assessment and thromboprophylaxis in all LHBs
3. Develop standardised HAT measurement
4. Promote ‘Root Cause Analysis’
5. Increase clinician and public awareness

Welsh Government Response

- HAT to become “Tier 1” measure
- Set up Steering Group to advise
- 1000 Lives plus to take the lead
- First step to establish measurable outcomes standards by which to assess performance
- Development of education strategy

The
Ask about Clots campaign

www.holwchamglotiau.co.uk
#holwchamglotiau

www.askaboutclots.co.uk
#askaboutclots

Hospital Acquired Thrombosis

Current situation

- Definition agreed
  - "Any venous thrombo-embolism arising during a hospital admission and up to 90 days post discharge".

- Measures agreed
  - Number of Hospital Acquired Thromboses per calendar month of which
  - Number of Root Cause Analysis completed
  - A summary of learning and actions

Current situation

As from May 2015, NHS organisations are expected to report the following:

Monthly Reporting

- Number of VTE Cases associated with hospital admissions which are possibly HATs per calendar month. These cases are to be validated to determine if they are a HAT.

Quarterly Reporting

- Number of notes missing (unable to validate records)
- Number of root cause analysis completed
- Actual number of potentially preventable HATs
- Number not felt to be HAT or potentially preventable HAT
- Summary of lessons learnt to improve delivery and corrective actions

- This data is not meant for comparison purposes.

Current situation

- **All of the organisations now have a mechanism in place that enables them to report the number of VTE cases associated with a hospital admission which are possibly HAT**.

- **Apart from Aneurin Bevan and Betsi Cadwaladr, all health boards/trusts are reporting the findings of the RCA process for the whole of its organisation.** Aneurin Bevan and Betsi Cadwaladr are working towards meeting this requirement.

Current situation

- From the reported data, there have been **1040 VTE cases associated with a hospital admission and which are potentially HATs** during the first nine months of 2015-16.

- For the organisations that have provided full or partial data, **224 root cause analysis** were completed during quarters 1 and 2 of 2015-16, of which **31 cases were identified as a preventable HAT (13.8%).**

- **168 case notes were missing** which meant that it was not possible to determine whether the VTE case was a preventable HAT or not.

Future work

- When Medical Examiners are in place, develop a system that reports HAT related learning from their role.
- Quantify and understand ‘short-stay’ rate