Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd a Gofal Cymdeithasol
The Health and Social Care Committee

Dydd Iau, 24 Mai 2012
Thursday, 24 May 2012

Cynnwys
Contents

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

Ymchwiliad Un-dydd i Atal Thrombo-emboledd Gwythiennol: Tystiolaeth Lafar
One-day Inquiry into Venous Thrombo-embolism Prevention: Oral Evidence

Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Adborth ar y Gwaith Ymgysylltu a Gyflawnwyd Hyd Yma
Inquiry into Residential Care for Older People—Feedback on the Engagement Work To Date

Blaenraglen Waith
Forward Work Programme

Ymchwiliad Un-dydd i Atal Thrombo-emboledd Gwythiennol: Tystiolaeth Lafar
One-day Inquiry into Venous Thrombo-embolism Prevention: Oral Evidence

Papurau i'w Nodi
Papers to Note

Cynnig o dan Reol Sefydlog 17.42(vi) i Benderfynu Eithrio'r Cyhoedd o'r Cyfarfod ar gyfer Eitem 7
Motion under Standing Order 17.42(vi) to Resolve to Exclude the Public from the Meeting

for Item 7

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mark Drakeford	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rebecca Evans	Llafur Labour
Vaughan Gething	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Mike Hedges	Llafur (yn dirprwyo ar ran Mick Antoniw) Labour (substitute for Mick Antoniw)
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Jenny Rathbone	Llafur (yn dirprwyo ar ran Mick Antoniw) Labour (substitute for Mick Antoniw)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr Raza Alikhan	Fforwm Thromboproffylacsis y DU UK Thromboprophylaxis Forum
Dr Andrew Davies	Cymdeithas Orthopedeg Cymru Welsh Orthopaedic Society
Nicola Davies-Job	Cynghorydd Gofal Aciwt ac Arweinyddiaeth, Coleg Brenhinol Nyrsio Cymru Acute Care and Leadership Adviser, Royal College of Nursing Wales
Nigel Davies	Coleg Brenhinol yr Obstetryddion a'r Gynaecolegwyr Royal College of Obstetricians and Gynaecologists
Grant Duncan	Dirprwy Gyfarwyddwr, Gwella Ansawdd, Safonau a Diogelwch, Llywodraeth Cymru Deputy Director, Quality, Standards and Safety Improvement, Welsh Government
Dr Bruce Ferguson	Cyfarwyddwr Meddygol, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Medical Director, Abertawe Bro Morgannwg University Local Health Board

Yr Athro / Professor Beverley Hunt	Coleg Brenhinol y Ffisigwyr Royal College of Physicians
Dr Chris Jones	Cyfarwyddwr Meddygol, GIG Cymru Medical Director, NHS WAles
Dr Simon Noble	Lifeblood
Dr Grant Robinson	Cyfarwyddwr Meddygol, Bwrdd Iechyd Lleol Aneurin Bevan Medical Director, Aneurin Bevan Local Health Board
Dr Brian Tehan	Cyfarwyddwr Meddygol Cynorthwyol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Assistant Medical Director, Betsi Cadwaladr University Local Health Board
Lisa Turnbull	Cynghorydd Polisi a Materion Cyhoeddus, Coleg Nyrsio Brenhinol Cymru Policy and Public Affairs Adviser, Royal College of Nursing Wales
Dr Alan Willson	1000 o Fywydau a Mwy / Iechyd Cyhoeddus Cymru 1000 Lives Plus / Public Health Wales

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Llinos Dafydd	Clerc Clerk
Catherine Hunt	Clerc Clerk
Mike Lewis	Dirprwy Glerc Deputy Clerk
Victoria Paris	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 9.01 a.m.
The meeting began at 9.01 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Mark Drakeford:** Bore da a chroeso i'r Pwyllgor Iechyd a Gofal Cymdeithasol. Rydym wedi derbyn ymddiheuriadau oddi wrth Mick Antoniw, a bydd Lynne Neagle ychydig yn hwyr yn cyrraedd. Bydd Mike Hedges yma am y bore yn dirprwyo ar ran Mick, felly croeso i Mike. Bydd Jenny Rathbone yn bresennol yn y prynhawn.

Mark Drakeford: Good morning and welcome to the Health and Social Care Committee. We have received apologies from Mick Antoniw, and Lynne Neagle will be here shortly. Mike Hedges will be here this morning substituting for Mick, so welcome, Mike. Jenny Rathbone will be with us this afternoon.

9.01 a.m.

Ymchwiliad Un-dydd i Atal Thrombo-emboledd Gwythiennol: Tystiolaeth Lafar
One-day Inquiry into Venous Thrombo-embolism Prevention: Oral Evidence

[2] **Mark Drakeford:** Mae ein hymchwiliad undydd heddiw yn ymwneud ag

Mark Drakeford: Our one-day inquiry today is in relation to preventing people from

atal cleifion rhag datblygu thrombo-emboledd gwythiennol yn yr ysbyty. Mae'n bleser gennyf gyflwyno ein tystion cyntaf, sef Dr Simon Noble, cyfarwyddwr meddygol Cymru Lifeblood, a Dr Raza Alikhan o'r UK Thromboprophylaxis Forum. Croeso i chi i'r pwyllgor. Diolch yn fawr am ddod heddiw. Rydym wedi derbyn eich tystiolaeth ysgrifenedig cyn y cyfarfod, felly diolch yn fawr am hynny.

developing venous thrombo-embolism in hospital settings. It is a pleasure to introduce our first witnesses for today, Dr Simon Noble, who is the Welsh medical director for Lifeblood, and Dr Raza Alikhan from the UK Thromboprophylaxis Forum. Welcome to this committee. Thank you for joining us today. We have received your written evidence prior to the meeting, so thank you very much for that.

[3] I will begin by asking you whether you have any brief opening remarks that you would like to kick off with, to draw Members' attention to key matters in the evidence that we have received. We will then go to the questions, and, if we are lucky, there may be a couple of minutes before the end when I will come back to you to give you a chance to reinforce any points that you think are of a special importance, or to pick up any points that have not emerged in the session. Simon, are you going to kick off? The microphones will come on automatically.

[4] **Dr Noble:** Thank you, Chair and members of the committee, for inviting us to speak. I will first explain venous thrombo-embolism prevention for those who are not familiar with the concept—it is quite a mouthful to say, let alone understand. All of us have a system in our body by which blood clots, and that is normally there to help heal us. Sometimes, it can work abnormally and it just so happens that an admission to hospital is one of the greatest risk factors. If we have damage to blood vessels, immobility while unwell or just develop sticky blood, we can get blood clots that can develop in our legs. That can slow down blood flow and cause pain, but, at worst, one of those blood clots can dislodge and go on to the lungs, and that is called a pulmonary embolus. It is common—it occurs in one in 1,000 people annually—and it is something that, with appropriate risk assessment and preventative measures, can be reduced by up to 70%.

[5] I want to draw your attention to a review of health improvement methods that was done in 2000 in America when 79 health improvement strategies were reviewed. Among the 79, prevention of hospital-acquired thrombosis was considered the most effective and most cost-effective. We have enough illnesses in the principality that we need to treat; we do not also need to be trying to treat ones that we could have prevented. We know from other countries, England included, that a hospital-acquired thrombosis prevention strategy is possible and cost-effective. Within the principality, we have an opportunity to have a prevention strategy that would be an exemplar around the world. We would like to see a standardised system whereby every health board assesses and, where appropriate, provides preventive measures to every adult patient who comes into hospital. The 1000 Lives and 1000 Lives Plus campaigns have recognised that this is an important issue. It was one of the interventions started right at the beginning of the campaign, and 1000 Lives and 1000 Lives Plus have taken us to a position now where I consider that we have the building blocks to deliver an effective and cost-effective prevention programme.

[6] **Mark Drakeford:** Thank you very much. We will go straight to questions. Vaughan will kick off and then Lindsay will be next.

[7] **Vaughan Gething:** Good morning, and thank you for the evidence you have submitted. I am interested in what you have said and written. In particular, I am interested in the unevenness you describe, not just between different nations within the UK but between different health boards. Can you try to set out for us why you think this unevenness exists within Wales? I understand that there is NICE clinical guidance, so can you explain why you think that is not being implemented evenly, just within Wales to begin with?

[8] **Dr Noble:** To take you back to when 1000 Lives Plus started, prevention of hospital-acquired thrombosis was one of the interventions in reducing surgical complications. The 1000 Lives Plus methodology is to start small and then to deliver and develop and roll out more widely. When it started, every health board was given an opportunity to choose one of the surgical interventions to try first. Those were things such as normothermia, which is ensuring that people do not get cold when they go for an operation, ensuring that shaving areas of the body is done appropriately so that people do not get infections around those areas, and ensuring that blood sugars are kept normal. So, they were given a choice of one of these and what was interesting was that, of all these interventions, three hospitals chose to look at hospital-acquired thrombosis. Those were two hospitals in the Aneurin Bevan LHB area, where I work, so it was something that I was pushing, and one hospital in Betsi Cadwaladr LHB area, which, likewise, had a robust thrombosis committee and which had already been working on thromboprophylaxis.

[9] The message is that people will initially take the path of least resistance. Everyone in healthcare is sold on the idea of hand-washing. They believe that, if they clean their hands, fewer bugs will be transmitted and hospital-associated infection will be reduced. That is an easier task to implement: whenever you see a patient, you wash your hands. Prevention of hospital-acquired thrombosis is more complex, because there are several steps required. One needs to assess whether the patient is a risk, not only of thrombosis, but as a result of the preventive measures we provide. We need to assess whether the person would be at risk if we were to give them anti-embolism stockings or blood-thinning medicines. The question is where you do that in the patient journey. You not only have to carry out that assessment, but implement it and check on it. So it is a several-step process. It is not something you do once and forget about. It is more complex than that.

[10] I think that, when people were first getting used to embracing the 1000 Lives process, they opted for preventive strategies that were more easily achievable, which I do not blame them for. We have seen with 1000 Lives the number of lives saved and the number of episodes of harm that have been prevented. That is one reason. The other reason is that not everyone feels as strongly about hospital-acquired thrombosis prevention as, say, I and Dr Alikhan do. For example, as I mentioned, giving blood-thinning medicines to prevent clots will, by definition, increase your risk of bleeding by a small degree if you have not achieved haemostasis, that is, ensuring that the patient is not bleeding at all and that is is therefore safe to give the drug. If I do nothing but see patients I operate on and I see the complications of bleeding but I do not see the complications of hospital-acquired thrombosis, my mind will be far more focused on bleeding complications than clotting complications. If I were an orthopaedic surgeon, doing bone surgery, I would be focused on the fact that a small bleed into a joint is a major problem for the patient. However, in my practice, I never see the patient with a blood clot either because they are admitted under the medical doctors, the physicians, or because, now, as our treatments have developed so much, they do not even come into hospital but are managed as an out-patient.

[11] Therefore, it is very important to be able to demonstrate truly our hospital-acquired thrombosis rate and to have a feedback system that allows every health professional with patients under their care to see how many of their patients develop hospital-acquired thrombosis. If you do that, you have the opportunity to root-cause analyse each case, and we can ask whether we did the right thing and whether we can learn from this. As an aside, I would say that the bleeding rates we see are very low indeed, and some of the newer agents coming through, particularly in orthopaedics, are now given after the operation so that the surgeon can be happy that haemostasis—blood clotting—has been achieved before they start these measures. So, I believe those concerns are becoming less and less of an issue.

[12] **Vaughan Gething:** I have one follow-up question, Chair. Having heard what you

said, I am not clear whether you are saying that there are guidelines but that people do not necessarily want to follow the guidelines as they exist or that they find other things to do, to put it crudely. I am interested in whether you are really saying that the worry about the risk of a bleed outweighs the worry about the risk of clots and so people just say, 'I'm not doing it'. We heard something similar to this in the stroke inquiry, when we heard different evidence about whether people should be given warfarin or aspirin, and there was a branch of the medical family that was more concerned about the risk of bleeding and therefore did not want to provide preventive treatment. Is that what you are really saying?

[13] **Dr Alikhan:** That is a comment we hear from some of our surgical colleagues, but it is certainly not a concern that is raised in obstetrics, gynaecology or general medicine. Your initial question was why there is poor uptake of these national guidelines. A freedom of information enquiry that Dr Noble made to each health board showed that it was high on the agenda in each health board. It was acknowledged as a health priority. However, when I go to speak to executive members of the health board in Cardiff and the Vale, I am told that the framework that they are working within in the NHS has tier 1 priorities and that they are assessed directly against these tier 1 priorities. One of the priorities is the reduction of mortality, and, in particular, the reduction of stroke and cardiac mortality.

[14] What no-one seems to acknowledge or be aware of is that pulmonary embolisms, blood clots in the lung, are the third biggest cause of cardiovascular mortality. However, without that being stated in your tier 1 framework requirement, it is not being made a requirement to try to reduce mortality from blood clots, and, because it is not a tier 1 priority, it gets put to one side. It is acknowledged across every health board that this is an important thing in which we should all participate, but the health boards are being measured against their tier 1 priorities and not measured against other important factors that are priorities for the health boards. Unless you can clarify that the reduction of mortality by the reduction of thrombosis is an important event, you are going to struggle to get the uptake.

[15] I do not believe that the concerns about bleeding are significant. I do not have conversations with the majority of my colleagues in which they say that they did not provide thromboprophylaxis because they were worried about bleeding. All our risk assessment forms include risks of bleeding, and that is a contra-indication to prophylaxis. Patients are not risk assessed, that is the problem; it is not that they are not receiving adequate thromboprophylaxis. That is the first problem.

9.15 a.m.

[16] **Mark Drakeford:** I do not know whether you have had a chance to see the evidence that we have had from the Welsh Orthopaedic Society. It seems to me that it focuses a great deal on the risk of bleeding.

[17] **Dr Alikhan:** Yes, and I think that we have to acknowledge its concerns. The concerns raised regarding bleeding are genuine concerns, but the risks of bleeding are far lower than the risks of sustaining a blood clot, of dying from a blood clot, and of having chronic problems as a result of a blood clot. You have to weigh up, as we do daily, the risks and benefits to an individual, not to an entire cohort of patients having a joint replaced.

[18] **Mark Drakeford:** Do you think that that evidence gets that balance right?

[19] **Dr Alikhan:** You can look at the evidence and interpret it to support your argument. Unfortunately, sometimes, I feel that orthopaedic colleagues interpret certain pieces of the argument, rather than looking at all of the evidence.

[20] **Mark Drakeford:** Thank you. That is helpful. Lindsay and Rebecca have the next

questions.

[21] **Lindsay Whittle:** I must say that your bedside manner is second to none and fills me with confidence. [*Laughter.*] I should stop there, really.

[22] The evidence submitted to us is written in good, plain, simple, English, and that is vital to get the message across, because it is getting the message across that seems to be important. We are all told, when we go on long plane journeys, or even short plane journeys now, to do ankle exercises and so on. I recall 25 years ago when I was in hospital as a result of quite a nasty car crash, which was my fault, that there was a nurse on the ward who was high-hot on, for example, not lying in bed with your legs crossed. She told all of the patients not to do so, because they might get a blood clot. I did not know that. As patients we were all made aware of that by a pretty vigilant sister. Why is it then, do you think, that other medical professionals cannot get this message across very simply to the patients on the ward?

[23] **Dr Noble:** There are a couple of points that I would like to respond with. First, that nurse who was high-hot on preventing hospital acquired thrombosis is a classic example of where we see areas of excellence through individuals working at the front line. The problem is that when that particular nurse is on leave, we see that these things are not standard practice. There is some evidence that you may have from the Betsi Cadwaladr University Local Health Board that shows that even when the thrombosis nurse was off on leave, the risk-assessment rates went down and the hospital-acquired-thrombosis rates went up. So, unless this is standardised and custom and practice within hospitals, it is unlikely to be sorted.

[24] The other point that you mention that is essential is patient empowerment. I will go on the wards today and a patient will say, 'I will not let you near me if you have not washed your hands'. There is a basin at the end of the ward and in between every patient, and they will watch me and expect me to wash my hands, because they understand the concept of infection.

[25] With hospital-acquired thrombosis, because three different features are required to cause a clot, it is a harder concept to understand. People understand air traveller's thrombosis, because they understand that if you are cramped your blood does not move and you will get a clot. However, understanding exactly why it happens when you go into hospital is difficult, and that is why any strategy to prevent hospital-acquired thrombosis cannot just involve ensuring that the health professionals undertake risk assessments and appropriate thromboprophylaxis.

[26] We must be able to empower patients. Lifeblood: The Thrombosis Charity has done some work on that, and that is one of the reasons why I use the term 'hospital-acquired thrombosis'; it is not necessarily because it is the most accurate term. A more accurate term would be hospital-associated or healthcare-associated thrombosis. However, the general public understands the concept that if you go into hospital you are at risk of having a blood clot.

[27] So, in answer, it is complex. I think that a patient education campaign is required for any strategy. Lifeblood has done some of that. We have patient information leaflets and applications that people can download to learn about it. It is all in plain English. We also have a hospital-acquired thrombosis all-Wales document in English and Welsh, and we even have get-well cards that people can send to their loved ones and say, 'By the way, have you been risk assessed?'. It is just bringing it to the forefront of people's minds. However, we also need to be able to engage the media. Sometimes, to do that, you need patient stories. At present, there is enough litigation going through the system but people are less likely to be recruited to give their story while they are going through legal proceedings for a hospital-acquired thrombosis. Patient buy-in is absolutely essential here.

[28] **Mark Drakeford:** Rebecca's points have been covered for the moment.

[29] **Rebecca Evans:** I will just follow that up, if that is okay. There are particular issues to do with pregnancy and I was just wondering how pregnant women are being informed of the risks that they are facing.

[30] **Dr Alikhan:** We have seen, from the confidential inquiries into maternal death, how important pulmonary embolism is, and, certainly from the work that is being done across England and more recently in Wales, we can look at it as one of the successes in that we have seen a significant reduction in mortality rates as a result of pulmonary embolism. This must be attributed partly to risk-assessing and the appropriate use of prophylaxis. Pregnant patients are far more educated about the risks of blood clots today than they were when I was training. When I was training, I knew that a patient having a surgical procedure was at risk but would not have considered pregnancy in itself to be a risk factor. We have certainly raised awareness among patients or mothers-to-be, as well as midwives, surgeons and nursing staff. It is important, but we have had some success there, which we can look upon and learn from.

[31] **Kirsty Williams:** The paper from Lifeblood makes reference to the introduction in England of set targets via the commissioning for quality and innovation payment framework. Could we hear about your experience across the border? Do you feel that that has made significant differences, and are there any lessons that we could learn in Wales about the implementation of mandatory national targets and procedures for admissions? Do we just need to copy what is happening in England and Scotland, or are there aspects of the experience in England and Scotland on which we could improve if this committee were to recommend to the Minister that there should be mandatory assessment on admission?

[32] **Dr Noble:** I would frame it first by saying that, three years ago, when the chief medical officer accompanied us in launching the all-Wales risk assessment tools, Wales was ahead of the game compared with England. We are behind England now with regard to our thromboprophylaxis—preventing hospital-acquired thrombosis—strategy. In certain ways that is useful, in that we can learn from England. You have to be careful with the targets that you set, or you will miss the point. It is possible—and I hear this anecdotally from colleagues in England—that if the only incentive is based around risk assessment, you will have fantastic figures demonstrating that bits of paper are filled in, but no objective evidence that anyone has acted on the assessment, and therefore no objective evidence that you have improved patient care. So, first and foremost, if there were a recommendation to mandate risk assessment, it needs to be tied in implicitly with Plus-appropriate prophylaxis.

[33] I believe quite strongly and proudly that the work of 1000 Lives Plus and Lifeblood has taken this issue to a point at which we could do better than England, and I would even say make us an exemplar in the world and among the global VTE-prevention forum. That is partly because of the size of the principality, as we are able to do things on an all-Wales basis. If we were able to demonstrate a hospital-acquired thrombosis rate for every health board, and therefore a national hospital-acquired thrombosis rate, that would first give us hard figures on the scope of the problem. Those who say that it is not a big problem will have data either to confirm or to refute that. It will allow us to analyse every case of hospital-acquired thrombosis and see how many were treated appropriately and how many could have been prevented but were missed.

[34] To give you an example, in Aneurin Bevan health board, we are now working on demonstrating our hospital-acquired thrombosis rate. Other health boards are doing this, too. It was started by the Betsi Cadwaladr health board. The evidence that we see is that, of all the hospital-acquired thromboses that occur, 50% were not managed appropriately and, therefore, something could be done differently. However, it is also interesting to see that, of all those

thromboses, 50% received appropriate interventions, and that is why I would also urge the committee to consider that setting hospital-acquired thrombosis as a never-event in health care would not be sensible because we will always have some, despite the best treatment.

[35] Setting targets without intelligent outcomes is not worth doing, so I would not want to take a blanket approach and follow what has happened in England. I recommend taking the advice of Professor Hunt, who will be speaking on behalf of the Royal College of Physicians, because I know that she has worked closely on the English prevention strategy and she may provide another view. However, I think that we can do better than England, and I think that we could be the first to show the true scope of the problem, which would then allow us to focus on the areas that need the most attention.

[36] **William Graham:** Can you explain, for my benefit, and possibly that of the committee, the relevance of the international classification of diseases coding system and why you think that VTE should be specified?

[37] **Dr Alikhan:** The ICD codes will be updated next year. There is a problem with coding in that you rely on someone going through the notes and trying to work out why the patient was in and whether it was a deep-vein thrombosis or a chest infection and so on to pick up all these bits of information. These bits of information are put into the public domain and then we try to interpret them to work out what the rates are of blood clots in the leg and the lung. In a number of health boards, rather than use these codes, we have been looking at patients who presented with blood clots in the leg and the lung, and working backwards, doing a so-called 'root-cause analysis' to work out whether they had been in hospital in the previous 90 days, whether they were risk-assessed and whether we could have prevented those blood clots. Rather than focusing on using ICD-10 codes, personally, I would look to try to define which patients are developing thrombosis and how many of those are hospital acquired. In the new ICD-11 codes, we will not have a hospital-acquired thrombosis code, so if we want to find out what the rates are in Wales, we will have to do it manually.

[38] **William Graham:** Would it not be important to have that specified as an ICD?

[39] **Dr Alikhan:** It is an international system. The concept itself of hospital-acquired thrombosis is a new one. We do not actually have an agreed definition of it across the UK or the world, so we have been working with colleagues on trying to define a hospital-acquired thrombosis. We do not actually know the scope of the problem yet in order to define it as a condition and code it.

9.30 a.m.

[40] **Dr Noble:** If there were a code that we were keen to see, it would be a standardised way of reporting radiologically that someone has a thrombus—either a deep-vein thrombosis or a pulmonary embolus. I will explain why. Currently, the health boards that are trying to demonstrate their hospital-acquired thrombosis rate are cross-referencing two databases: one of hospital admissions and one of radiology. They will cross-reference all the CTPA scans, which are chest scans for blood clots on the lungs, and all the leg scans with every patient who has been admitted in the last 90 days. That will include perhaps 200 patients. On a spreadsheet, there will be 200 reports that someone has to go through manually to see whether there was a positive result for a thrombosis.

[41] In Aneurin Bevan health board, the audit team doing this has been trained to do it, and they will speak to me or to one of my colleagues about any that they are not sure of. There are certain conditions in healthcare that have automatic codes and, therefore, if there were a code every time there was a positive clot, that would save a lot of time and would allow that to be standardised across the principality. So, something like that would allow us to

gain a hospital-acquired thrombosis rate. However, on whether we should have an ICD code for hospital-acquired thrombosis, I think we need to do more work on that. If we are to embark on a hospital-acquired thrombosis prevention strategy, it needs to be robust. We have enough in place to make it robust, but by putting in that code, which is appealing and many colleagues are calling for, we need to be certain that the data being entered are appropriate, and I do not think that we are at that point yet.

[42] **Elin Jones:** Your paper goes into a bit of detail about the cost of hospital-acquired VTE. It also mentions the cost-modelling exercise that the National Institute for Health and Clinical Excellence undertook, which says that if 100,000 patients are risk-assessed and given appropriate treatment, that would result in a saving of £12,000, which is cost-neutral, really. However, have you done any assessment for the Welsh NHS or individual health boards on the likely cost to a health board of introducing the assessment process and then the treatment that follows that?

[43] **Dr Noble:** We have not done any specific cost modelling, but that is recommended as practice anyway, so we would be doing cost modelling on what would happen if something that we are already supposed to be doing were done. Therefore, the costings should already be there. The challenge is that, within a health board, even though it all sits under one budget, those budgets sit within different directorates. For example, in the Aneurin Bevan health board, some of my orthopaedic colleagues will use some of the newer agents, and patients will be on extended prophylaxis, so they go home and take these tablets to prevent blood clots, but that comes out of the orthopaedic directorate's budget. So, for an orthopaedic directorate, it makes financial sense not to prescribe them because its drug bill goes up and the cost of managing hospital-acquired thrombosis will then be in primary care, haematology or vascular surgery. So, that is one of the difficulties when people work in the silos that they are given and are unable to see the whole picture. That is the difficulty because people see how these strategies affect their own area of work, but not necessarily outside that.

[44] **Elin Jones:** Where would the cost of assessment fall? Would it fall on the time costs of nursing staff?

[45] **Dr Noble:** I would suggest that a risk-assessment form, depending on the complexity of the patient, would take minutes to complete and would be a part of your standard clerking. Patients who come in for elective operations have a pre-assessment clinic when that can be done. A patient admitted as an emergency will be clerked and will be reviewed on the post-take consultant ward round. So, there are many times when health professionals come into contact with those patients. Furthermore, ward staff who are looking after the patients will pick these things up. I have to commend the nursing staff—they are hot on this—but the nurses on the ward are not able to prescribe the prophylactic measures, be they anti-embolism stockings or pharmacological measures. They can raise the issue, but if the healthcare professional who is due to prescribe does not agree, they are unable to do it. This really is a team approach, but, at the moment, the onus is ultimately on the consultant, when this is a health board issue.

[46] **Kirsty Williams:** I am interested in your description of what would happen. A nurse would carry out an assessment of a particular patient, issues would be raised because of family history or whatever, and the nurse would say 'This is a person who needs stockings' and so on. What then prevents the nurse, using her professional judgment, from proceeding to treat the patient in an appropriate way? Who needs to give permission?

[47] **Dr Alikhan:** To answer both of your questions, risk assessment does not cost anything; it is part of good nursing and medical care. The cost comes with establishing roles for nursing staff in educating other nursing staff, educating medical staff and educating patients. Following the all-Wales 1000 Lives Plus risk assessment forms, all health boards in

Wales have incorporated risk-assessment strategies into their admission procedures. These can be done by medics, doctors or nurses. The particular issue that you have raised is that if a nurse raises awareness that a patient, in her or his opinion, is at risk of a blood clot, she or he cannot prescribe the medication and, technically speaking, the stockings that are required. That is why you need engagement not just from your nursing staff, who are acting as advocates for patients, but from your clinical staff, such as your orthopaedic surgeons, to prescribe the anticoagulation. We have some very good orthopaedic nurses who raise awareness of the risk for individual patients, but unless the surgeons are prepared to prescribe, the nurses are not empowered to issue these drugs. Unless they have independent prescribing status, they cannot prescribe medication, and there is a limitation there. However, nurses are key to establishing links across wards and educating doctors, rather than doctors educating nurses in this case, and nurses are key to risk assessment.

[48] **Mark Drakeford:** You said that there was a perverse financial issue here, if an orthopaedic surgeon in that position advised that something might be prescribed then thought 'That will come out of my budget, so maybe I won't'.

[49] **Dr Alikhan:** May I quickly come back on one point? You will be hearing from orthopaedic surgeons. Their reason for not wanting to prescribe prophylaxis is not cost, but what we discussed earlier, namely the question mark over bleeding and the perception that, if they give this drug, the patient will bleed, it will be a reflection on their surgery and it will damage the patient's joint and result in morbidity. If you look at all the clinical studies that have been published recently on the prevention of blood clots in orthopaedic patients, you will see that more than half of the patients who received prophylaxis were reported as having a bleed related to the drug, but when they unblinded the drug studies, they found that those patients had bled before they had received any prophylaxis. When you speak to the surgeons in those studies, they blame the drug, yet the patients had been on placebos. So, this perception of bleeding is a false argument.

[50] Like I said, we have excellent orthopaedic nurses in Cardiff and Vale who are doing fantastic work, but unless there is engagement from clinicians, it falls down. That is why risk assessment on its own is not enough. It has to be incorporated with appropriate prophylaxis.

[51] **Lynne Neagle:** In relation to your answer to Kirsty, I can understand what you said about the nurses not being able to prescribe drugs, but I was surprised that they cannot provide stockings. I would have thought that they would have been like bandages. Is that the same across Wales—that nurses cannot provide thromboprophylaxis stockings if they think they are needed?

[52] **Dr Alikhan:** There is potential to do harm as well as good with stockings, and you have to be aware that they are a medicinal product, although you might not take them like a tablet. It is not just a case of a patient being at risk—you need to assess the patient for the suitability of wearing stockings. The nurses can do the assessment and the measurement, and in my opinion, they should be allowed to prescribe them, but I believe that there are requirements from their own representative body that these should be prescribed products. I think that that is a national requirement.

[53] **Mark Drakeford:** I just want to check this one more time, to make sure that I understood what you said about costs. I thought that I heard you say that the system can work perversely in that, sometimes, people will avoid the costs of prevention because those costs might fall into their silo's budget, and because their silo does not have to pick up the cost of failing to prevent, since the costs appear under treatment, and that is in another part of the system. Did I understand that correctly?

[54] **Dr Noble:** I do not think that I made myself clear. The last thing that I would want to

suggest is that any colleague in any profession was not prescribing medicines that could save lives or reduce harm purely on a cost basis. What I am saying is that, in making those decisions, the financial system means that they will be reflected in that particular budget, and at the moment, I would question whether the budgets in each directorate have taken into account the new evidence, and the extent of prophylaxis. A few years ago we were just giving prophylaxis while the patient was in hospital, until they were mobilised. However, evidence has come through and new agents that have been approved by National Institute for Health and Clinical Excellence are now licensed. There is a financial cost to giving them and, likewise, there is a finite financial benefit. Overall, the health boards will benefit from this reduced incidence, but the financial benefit of that reduction will not be seen in the individual directorate. I do not believe that it is actually promoting practice—

[55] **Mark Drakeford:** No—we did not think that you were saying that. It is the system—the way that it is organised means that it can have some perverse outcomes.

[56] **Dr Noble:** I believe so.

[57] **Darren Millar:** The Welsh Orthopaedic Society seems quite resistant to significant changes in the current arrangements. It obviously is a current prescriber of some drugs on some occasions and at certain times for people who have undergone a surgical procedure, but it does not cite the current financial arrangements at all as a reason why it is seeking to maintain the status quo. It does refer to some of the studies that you mentioned, Dr Alikhan. It talks about the increased risk of additional bleeding, for example, in some of the joints. Which of those studies can be dismissed on the basis of the points that you raised regarding the unreliability of the evidence?

[58] **Dr Alikhan:** The evidence that I referred to is from multinational, prospectively collected randomised controlled trials in which there are objective end points and international definitions for bleeding into a joint and not bleeding into a joint. The references that you just mentioned are registries, and whether the data were collected prospectively or retrospectively depends on which study you look at. As I said earlier, it is easy to search through the literature and pick particular studies that can support your argument. The studies that I referred to are all the thromboprophylaxis studies that have been performed over the last decade; I am not picking a particular study. I do not see any point in picking one particular reference and saying that I disagree with it.

9.45 a.m.

[59] The point is that if you give blood-thinning drugs to a patient after they have had surgery, you will increase their risk of bleeding. That is not debated. The risk of bleeding is less the longer you wait after surgery. If you wait six to eight hours or longer and assess your patient after surgery and are happy that they have stopped bleeding, you should start to try to prevent a blood clot. If you just blanketly say, 'No, I am worried about one patient in 1,000 having a bleeding complication' against 50% of patients developing a blood clot, some of whom go on to have blood clots in the lungs and die, then your argument falls down. I do not think that I can just pull apart their references. The argument itself does not stack up.

[60] **Darren Millar:** They refer to specific studies in their paper. I was a recipient of blood-thinning drugs after an ankle operation last year. I think that I had a chat with you about this, Dr Noble. I was given Pradaxa tablets after having a plate put in my leg and they were relatively easy to take, but I was told, on coming back to the UK, that ordinarily I would have been prescribed heparin in the form of self-medicating injections, which put me off a bit, to be honest. To what extent is the difficulty in administering some of these drugs also something that might put patients off taking them and consultants off prescribing them?

[61] **Dr Alikhan:** The use of an oral anticoagulant is preferable for a patient, particularly as we know that if patients' joints are replaced or fixed, they now go home within five days. Historically, and when I was training, patients would spend a couple of weeks in hospital after they had a hip replaced. During those two weeks in hospital, they would have been given injections, because that is all that we had available. Suddenly they are going home and are described as no longer being at risk. It is ludicrous to think that. So, you can still give injections, which are effective, but the problem is that you have to teach patients to do them or have to engage nursing staff in the community to go into patients' houses to give them, which introduces extra costs. If you take a tablet, it prevents a blood clot, is easier to take, is more convenient and you are more likely to get compliance.

[62] **Darren Millar:** However, the drugs are more expensive, are they not—the heparin alternatives, such as aspirin or warfarin?

[63] **Dr Alikhan:** Yes, the new agents are more costly in terms of drug costs, but if they are more effective at preventing a blood clot, the cost-effectiveness in terms of not having patients readmitted to treat their blood clots or not having to treat the complications of those blood clots, such as pulmonary hypertension, or high blood pressure in the lungs, or ulcers in the legs, they pay for themselves. However, we come back to Dr Noble's argument that the cost benefits are not seen within the departments; they are seen within the population and across the health service, but teasing those numbers out is much harder.

[64] **Darren Millar:** I have one final question: why do you think that the Welsh Orthopaedic Association is so resistant to changing the current arrangements, given that it would want the best outcomes for patients?

[65] **Dr Noble:** I cannot speak for them, but I found the submission from the Welsh Orthopaedic Association slightly confusing, because the initial data give me the impression that it does not believe that there is a problem, but later it says that it would support risk assessment in some patients who are at high risk of chemical prophylaxis. So, the beginning says that there is not a problem, but then it recommends risk assessment for what it suggests is a non-problem. I do not want to tear apart the data, but we need to be careful in that it is easy to look at a reference and assume that it is a high-quality study. A randomised controlled trial is a high-quality study, but a retrospective cohort study or registry is not. A study that has been peer reviewed and therefore published in a journal weighs more than a podium presentation at a conference in Derby in April. An editorial is an opinion piece. Our colleagues are the people who are seeing these patients over a particular piece. We have a view; they have a view. Dr Alikhan and I see patients with blood clots, we see people die of blood clots and we see people with complications. We do not get people who have had a bleed into a joint in our clinics. What sticks in the mind—they call it an N of 1 study—is that last patient who had a complication.

[66] **Mark Drakeford:** Thank you very much. This session has been a useful introduction to today's events. We will be able to test some of these propositions with other witnesses as they come in front of us. I am sorry that we have run out of time without being able to offer you a chance to sum up, but if there are points that did not come out strongly enough in the discussion, you are welcome to write a note to us and make sure that we do not lose sight of those things.

[67] **Dr Alikhan:** Thank you for your time and interest.

[68] **Mark Drakeford:** Croeso i Nigel Davies o Goleg Brenhinol yr Obstetryddion a'r Gynaecolegwyr, ac i Lisa Turnbull a Nicola Davies-Job—rydym oll yn gyfarwydd

Mark Drakeford: Welcome to Nigel Davies from the Royal College of Obstetricians and Gynaecologists, and to Lisa Turnbull and Nicola Davies-Job—we are all familiar with

â hwy—o Goleg Nyrsio Brenhinol Cymru. Diolch am ddod yma'r bore yma i'n helpu â'n hymchwiliad undydd. Fel arfer, mae croeso ichi wneud sylwadau agoriadol byr, ac wedyn awn ymlaen at y cwestiynau. Pwy sydd eisiau dechrau?

both of you—from the Royal College of Nursing Wales. Thank you for coming here today to help us with our one-day inquiry. As usual, you are welcome to make brief introductory remarks, and we will then move on to questions. Who wants to start?

[69] **Ms Turnbull:** We would like to echo the comment that you heard from the previous witnesses that, a few years ago, Wales was very much ahead of the game in terms of its performance in the United Kingdom. We think that the time has now come to restart that national direction and push on this issue. Performance, assessment, prevention and the actions following assessments are very inconsistent across Wales, even within the same hospital. That is the important point; they are not only inconsistent on an LHB basis, they are inconsistent in the same hospital. We think that there is an opportunity here for the Welsh Government.

[70] **Mark Drakeford:** Mr Davies, do you want to make any introductory remarks?

[71] **Mr Davies:** The Royal College of Obstetricians and Gynaecologists has been aware of the importance of thrombo-embolic events for more than 15 years. The first guideline looking at reducing the risk of post-caesarean thrombo-embolic events was produced back in the 1990s. There has been a lot of work ongoing for a long time. We are pleased that, in Wales, the 1000 Lives project has picked up on much of the royal college guidance, particularly the most recent guidelines from 2008. Again, we see this as an opportunity to build upon the work that has been done by the 1000 Lives group.

[72] **Mark Drakeford:** Thank you. We will now turn to questions from Members, and we will start with Lynn, and then Kirsty.

[73] **Lynne Neagle:** I have a question for the royal college and another for the RCN. The royal college's paper is interesting, as you say that preventing these incidences should have been a straightforward matter, because you published an evidence-based green-top guideline. You then go on to say that it was not really implemented because it was queried in clinical practice. Could you say more about that? Who was querying it in clinical practice? Was it midwives or other obstetricians? Why did that system that should have worked break down? There is now a new system coming in, and you seem to be more confident that this will work. I just want to press you on that. In view of the problems there have been in the past, are you really confident that this one will work this time and that everyone is on board? I would like to ask a question to the RCN after that.

[74] **Mr Davies:** The green-top guideline produced by the royal college back in 2008 was a document produced by experts. Many of the comments and suggestions in that guideline were expert evidence rather than based upon clinical trials or direct evidence of impact. Although we were aware that some of the risk factors highlighted within that green-top guideline increase the risk of thrombo-embolic events, some of them increase the risk only marginally. Yet, if used in pregnancy, you would then have quite wide-spread use of heparin or other interventions for many pregnant women. For example, the green-top guideline suggests that one of the risk factors in pregnancy would be obesity as measured by a body mass index of greater than 30. In some parts of Wales, that could represent a quarter of the population. You cannot have a risk factor that picks out a quarter of the population. Therefore, with the 1000 Lives project and the tool that we are now introducing, we have increased that to a BMI of 35, which is much more realistic and will identify a slightly smaller population group.

[75] Similarly, smoking was identified as a risk factor in the college's guideline. However, in Wales, we know that 23% of women continue to smoke in pregnancy. So, we have taken

smoking out as a risk factor, partly because it would identify far too many as being at risk and partly because, although it is a risk factor, it is a relatively small additional risk. So, we have taken out some of the risk factors that are possibly more controversial but kept in the strong risk factors, such as varicose veins, dehydration, being admitted to hospital, previous history and family history and so on. However, we have taken out some of the softer ones, which are borderline obesity, maternal age over 35 and pre-eclampsia. That is why we have done it.

[76] With regard to your second question about whether we feel that we now have universal buy-in to the tool that we have now developed, the answer to that would be 'yes'. The Royal College of Midwives in Wales is supportive to the point that it has now been introduced into the all-Wales maternity record, and obstetricians and gynaecologists in Wales, via the RCOG in Wales, and the national specialty advisory group, also accept that this is the right tool with the right measures.

[77] **Lynne Neagle:** I have two questions to the RCN. I do not know whether you heard the evidence of the previous witnesses, but we talked about what they felt the drawbacks were of the fact that nurses cannot prescribe medication in this area. Apparently, they cannot prescribe the stockings either. One witness said that he thought that nurses should be able to prescribe the stockings. I wondered whether you could comment on that.

[78] I also want to pick up one thing from your evidence. You have highlighted problems with the way the stocking issue is managed in hospitals, saying that

[79] '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…an hour or so.'

[80] That is quite a drastic statement. Is that genuinely the case or did you mean it in just this area?

[81] **Ms Turnbull:** No, that is the case in all training areas, and there is a real problem with continuing professional development at the moment. There has been a move, and rightly so, in recent years to try to find different forms of training other than, for example, taking someone out of the ward for a day or two, where often their web-based courses are based on a 15-minute-chunk-type approach. We are finding, as a royal college, that nurses, as a whole, are simply not able to be released, and that is in every area, not just this one. So, it is a very serious problem.

10.00 a.m.

[82] The other problem worth investigation, which we flagged up here with regard to these specific issues, is the contract for training itself. We are not quite clear how that operates. We have been told that it is part of the national procurement project but it is not clear whether that means it is fully funded or how it is drawn down and delivered. We have recommended that as an opportunity for questioning. Yesterday, I spoke to a group of nurses from hospitals across Wales—from north, south and mid Wales. They had all experienced difficulties with getting the right equipment. In some places, for example, the stockings were not available in the hospital at all. One of the nurses described quite an alarming situation where people had been told that they needed to ask the district nurse. That is too late. There were some issues with procurement and training that we would like to see improved. My colleague, Nicola, would be best placed to answer the question on prescribing.

[83] **Ms Davies-Job:** Some nurses can prescribe—they would have to be advanced practitioners. We should not underestimate the role of nurses in assessment, because they are best placed to do things like weighing the patients so that they can have the right

thromboprophylaxis. They would measure the patients for stockings and be with the patient 24/7. They could allay any anxiety that the patients or their families might have and answer their questions. The nurses have a big role—it is not just about badgering the doctor to write something up; they do a lot more than that before that happens.

[84] **Lynne Neagle:** In previous evidence, it has been suggested that something had come down from the royal college to say that they should not be able to do that prescibing: there was a reservation, I think.

[85] **Ms Davies-Job:** If you had an innovative consultant and nurses who were appropriately trained, you could have a wide prescription so patients who were deemed at risk, or at severe risk, would be able to get that prescription automatically. Then again, you need to look at it on an individual basis. So, I am not sure whether that would be such a good idea.

[86] **Ms Turnbull:** The significant point here with nursing, as with any healthcare profession, is that you have a professional requirement to act within your competence. From the RCN's perspective, that could be a fantastic way forward, but in order to make sure that it was delivered properly, you would have to address the issues around education, training and ensuring that the stock was available. If someone is responsible for assessing the situation and providing the right treatment, and the stock is not available, it becomes quite a liability—it would put that person in a dangerous position. That would be a potential way forward.

[87] **Kirsty Williams:** Mr Davies, I would like to come back to the implementation of best practice. I take your point about there not being sufficient buy-in to the previous recommendations, but they were still recommendations from the RCN. Whether people bought into them or not, the assumption should be that that is what they need to do until new evidence comes along and there is a new set of guidelines. Now that you have new practice set out, what steps can be taken to monitor its consistent application? We were told in evidence this morning that, unless something becomes a tier 1 priority that will be used by Ministers to check up on managers, these things fall by the wayside. How can we be sure that these new procedures will be carried out consistently for women across Wales? Do we always have to make things a tier 1 priority for managers to ensure that something happens?

[88] **Mr Davies:** There are two parts to the prevention tool that we have produced. The first part is for women who are booking in for antenatal care who would see their midwife before 12 weeks of pregnancy. We know that that assessment is almost universally done very well because it is part of a much larger assessment tool that assesses the risk of pregnancy, and therefore decides whether a woman books for midwifery-led care, hospital-based care or consultant-led care. We know that that part is done very well, because it is part of a larger assessment that we are used to doing in obstetrics. It is part of the culture.

[89] The second part of the tool is to be used for women who are admitted to hospital while they are pregnant, or for women who are admitted while in labour, or at the time of delivery. The only way that we can know whether it is used as it should be used 100% of the time is to have an adequate audit tool backed up by suitable education for midwives and obstetricians, to ensure that there are reasons for doing it. The risk of having a DVT or pulmonary embolism during pregnancy is about one in 1,000, so there are not lots and lots of these events happening in units across Wales. A typical unit in Wales will deliver 3,000 women per year, and you are therefore looking at two or three events per year. Therefore, many staff members will not have seen a woman with a DVT or a pulmonary embolism related to her pregnancy. Many cases that happen will do so very early in a pregnancy or will happen in women who have risk factors that are flagged up and, where appropriate, treatment is provided. Previous evidence suggested that, when you look back at patients who have had a DVT or pulmonary embolism, the right thing has been done at the right time. It is the same in

pregnancy. While this is a very important problem, it is not a frequent one. Therefore, education is very important, because many members of staff—including many midwives—may not have seen, for many years, a woman with a DVT or a pulmonary embolism related to her pregnancy.

[90] I am afraid, however, that this needs an audit and some form of mandating to ensure that it is used properly. The question is how you do that. Do you mandate the use of the assessment tool? Alternatively, do you work backwards by looking at those women in Wales who have been affected—because there will be 30 to 40 of them each year who will have had a DVT or a pulmonary embolism related to their pregnancy—and do a retrospective audit, examining whether they had the right treatment? I believe that that would be a better way of doing it than mandating the use of the assessment tool. All the latter approach would do is ensure that the assessment tool is used; it would not ensure that the right treatment is given for the right length of time.

[91] **Mark Drakeford:** Is that technique of looking backwards the process that our earlier witnesses referred to as a 'root-cause analysis'?

[92] **Mr Davies:** That is another way of describing it.

[93] **Mark Drakeford:** It is the same thing. Thank you. I will bring Vaughan in now, followed by Darren.

[94] **Vaughan Gething:** I share the general concern about the inconsistent application of what are consistent guidelines unless they are made tier 1 priorities. That is quite a depressing perspective. In particular, I wish to pick up on the RCN's evidence about inconsistent uptake within health boards and inconsistent practice within hospitals.

[95] I know that, in your evidence, you make a number of points about LHB leadership and consistency. However, having heard the evidence this morning, I am particularly interested in your perspective on why there is inconsistent practice within hospitals. Is that about individual management and leadership within hospitals, or is it about different elements of medical practice having different views? I am interested in why you say that inconsistency exists and in how widespread it is.

[96] **Ms Turnbull:** Both of those things are factors. Historically, there have been different approaches in different disciplines. We have seen some very good practice here from colleagues. There is also inconsistent practice even within areas. It is about the LHB setting out a clear and consistent idea of what is expected from the ward areas and using this assessment tool. The two examples that we have included refer to cases where a nurse has been used as a champion to take forward this role. When you look at the evidence that those individuals are collecting, relating to assessments that have been done and action that has been taken, it is obvious that, where they are in place, as lead educators and people who are not only educating but collecting evidence to demonstrate impact, that role clearly works. That is one constructive suggestion we try to put forward, and people should examine the evidence for those. We pointed out the one in Betsi Cadwaladr LHB, and there is one in ABMU LHB. We have seen some of the statistical information collected by these nurses in their roles, and there seems to be clear evidence of their impact in terms of getting improved consistency in approach in the hospital.

[97] **Vaughan Gething:** Given that there is a consistent NICE guideline, I am a bit perplexed about the extent to which we should be judging or recommending how and when politicians should be telling medics to follow the NICE guideline. I do not necessarily want to get into saying that one element of the profession is more to blame than others, but we will obviously hear some interesting evidence later on. I am interested in where you say this needs

to be resolved given that there appears to be a consistent expectation from a policy end.

[98] **Ms Turnbull:** I am sure that the metaphor of it taking a long time to turn a tanker around has been heard before in this committee, and I am sure it will be heard again. With the NHS, you have to look at the role of the Welsh Government and the levers that the Welsh Government has with regard to the management of the LHB, the chief executive and the key performance indicators at that high level, and whether those are the same indicators as the priorities for the clinicians, in terms of their professional perspective. Sometimes, what the professionals and clinically led organisations such as 1000 Lives Plus are coming forward with, which are excellent initiatives with evidence of impact, is not aligned with the performance indicators set by the Welsh Government for the LHBs. My tentative suggestion to the committee is that, if you are looking for areas in which the committee could usefully make recommendations or enquiries, these would not be so much around the professional recommendations and assessment tools—there are some very good examples of work in that regard—but more about the expectation on management that those are supported and that clinicians are supported in using these tools.

[99] **Kirsty Williams:** May I clarify that? Perhaps I am misunderstanding you, but are you saying that the Welsh Government has a set of expectations of managers, which are the things it tells managers are important, but that those sometimes conflict with what clinical staff believe is important? Is it the case that we have a set of expectations on the part of politicians about what is important and how things should be done and that that can conflict with what people on the ground who know about these things think is important, and that that is where you get this mismatch?

[100] **Ms Turnbull:** Yes, although it is not necessarily a case of conflicting. It might be better to say that there is a lack of connection rather than an actual conflict.

[101] **Kirsty Williams:** Ministers are advised by clinical experts in the civil service—they do not randomly decide for themselves what is important and what people should be measured on. What is your analysis of how that situation arises, given that there is clinical expertise in the heart of Government?

[102] **Ms Davies-Job:** I think it is about competing priorities. There are so many things that must be set as priorities, but you cannot do everything as a tier 1 priority—something has to give. Which factor you take as your priority will depend on patient need and your area of professional expertise.

[103] **Ms Turnbull:** To give you an example, one of the points we have identified is that it would be useful to provide education for nurses in some of these areas. That is within the control of management because, to facilitate that, someone has to agree to the release of those members of staff to attend that training, given that they have to agree to the funding of the people who are backfilling. That is a financial management and human resources decision. So, that is an example of what I am talking about.

10.15 a.m.

[104] If you are talking about the collection of statistical information—we emphasised that in our paper and other witnesses have emphasised it as well; it would be useful to have those kinds of national statistics available to demonstrate the uptake of assessment and actions taken—that kind of administrative statistical requirement must be set at management level. So, those are two examples.

[105] **Mark Drakeford:** You are absolutely right when you say that at the heart of all of this is a sense of priority, and not everything can be a tier 1 priority. Part of the basic premise

that has been put to us so far today is that this is an under-prioritised area, and, given what we are told about its impact on patients' health and what could be done about it, it is something that deserves to be moved up the list of priorities. However, when you move something up in the health service, you are also moving something else down. So, do you accept that basic premise that this deserves to be moved up the hierarchy of priorities, bearing in mind that, in saying that, we are implicitly saying that something else will have to give way to allow that to happen?

[106] **Ms Davies-Job:** Yes, I think so; it is important. We are talking about a top-down approach, but we also need to look at a bottom-up approach and at the public becoming more aware of VTE. I am thinking of the 1000 Lives hand-washing campaign, where patients can challenge people on whether they have washed their hands. In the same way, if patients were aware of their risk of VTE, they could challenge the nurse by saying, 'This happened to my mum/dad, it is really important and I am really anxious about it, so please can you escalate it?'

[107] **Kirsty Williams:** The other side of the argument is that, as we have agreed, not everything can be a tier 1 priority. At what stage should we rely on the professionalism of staff, who know what the right thing to do is, and who, regardless of whether the Government says it is a tier 1 priority or not, know what good practice looks like? Should we simply be able to rely on the professionalism of those delivering a service on behalf of patients to say, 'Regardless of whether the Welsh Government is going to give me a hard time if I do this, I am going to do it because it is internationally recognised to be the best thing to do'? Everything cannot be a tier 1 priority, so when can we rely upon professionals to do the best thing, without their being threatened with action by the Welsh Government if they do not?

[108] **Ms Turnbull:** That is an excellent point. To reverse the question, 'When can you not rely on them?' The answer is: if there is an external pressure on the system. One example would be if the equipment was not available—which is a situation that was reported to me yesterday when I was talking with nurses; they wanted to prescribe it, but could not. Another example is when people in a team want the education but cannot access it.

[109] The strategic point I would make about this and about priorities is that, unless the Government has adequate information about the situation out there, it is difficult to make a sensible decision about where it is worth while intervening and where it is not. Many of the recommendations that we have put forward, which are echoed by other witnesses, are around trying to improve the information that is available. Once you have good information, it is going to be easier—it will never be easy—to make educated decisions as to when a Government intervention is necessary and when, as you rightly point out, a set of professional issues needs to be addressed by the profession. Sometimes it will be one and sometimes it will be the other.

[110] **Mark Drakeford:** Mr Davies, do you want to add anything to this?

[111] **Mr Davies:** You are right that this comes down to individuals practising the way that they should and implementing knowledge that is out there. However, it sometimes comes down to education and the concept of having nurse educators in hospitals, namely nurses who go around the hospitals visiting wards, not necessarily taking nurses out of their current role, but speaking to them on the ward, picking up instances where things could have been done better or where things have been done very well, and supporting staff in their roles on a daily ongoing 24/7 basis, but that needs funding. There has to be a reason to fund those roles.

[112] Similarly, as an individual—an individual clinician or a nurse—you may know the right thing to do, but the framework may not be there to allow you to do it. We know that patients should have heparin for five, seven or 10 days after they have had their surgery, but

they will not be in hospital for five, seven or 10 days. Often, they will only be in hospital for two days. How do you then ensure that they get their heparin once they go home? That is sometimes beyond the nurse or the clinician at the bedside. It is more of a structural problem within the organisation, and then it comes down to the organisation needing the push to put those procedures into place. So, it is not always about the individual, but about supporting the individual with education and the right structures to allow them to do the right thing.

[113] **Mark Drakeford:** Darren, this may be the last chance for a question in this round, unless anybody indicates to me.

[114] **Darren Millar:** I just wanted to explore the role of the specialist nurse and the support that the specialist nurse might be able to give. You have referred to Betsi Cadwaladr and Abertawe Bro Morgannwg health boards in the evidence paper. You suggest that one of the posts is funded by a pharmaceutical company. For what reason did the pharmaceutical company feel that it was in its interest to fund such a post? Is it one of the companies that produce the drugs? On what basis—

[115] **Ms Turnbull:** I am sorry, I cannot answer that question. All I know is that it was funded in that way and that that funding is coming to an end, but, as you said, it raises interesting questions about that arrangement. I can put you in touch with or ask that question directly of the LHB.

[116] **Darren Millar:** The answer would be interesting. Was any research undertaken to evaluate the improved outcomes? Our first witnesses suggested that there had been a significant decrease in the number of people acquiring a hospital-acquired thrombosis as a result of interventions from the person in the Betsi Cadwaladr health board area. Were similar improvements seen in the Abertawe Bro Morgannwg health board area?

[117] **Ms Davies-Job:** Yes, and not only with regard to the intervention, but the junior doctor training. When that person took leave and was off sick for a while, the numbers increased.

[118] **Darren Millar:** In this role of supporting a cultural change across a hospital where you have inconsistent practice how important and influential were those nurses? You mentioned in the paper, Lisa, the fact that posts cannot be backfilled while training is ongoing, but some of it might be straightforward, a little nudge here and there, as Nigel has just mentioned. To what extent is that a proportion of their work? Is 50% or 60% of their time spent doing that? Do they spend most of their time on risk assessment?

[119] **Ms Turnbull:** When we were preparing this, the posts seemed extremely effective and there was statistical evidence to demonstrate that. As Nicola has just said, the impact, which was quite interesting to us, on medical education was quite significant. It was a cross-professional approach; it was not just within the nursing profession. So, there was quite significant evidence. On the amount of their time, in one of the posts, it was about a third.

[120] **Ms Davies-Job:** Two days of the nurse in the pharmaceutical-sponsored post's time were spent doing that, namely enabling and educating the ward staff. The other three days were spent back in her substantive role on a ward as a surgical nurse.

[121] **Darren Millar:** So, we are not talking about massive costs here, are we? We are talking about a small number of health boards with a couple of days per week dedicated to this role of trying to get a cultural change across hospital sites and across a health board area.

[122] I would like to ask one final question on ultrasound scans. Is it difficult to get access to an ultrasound scan if someone who has had an operation a few weeks earlier presents at

primary care with the symptoms of a deep-vein thrombosis? How difficult is it to access ultrasound scans? Is it fairly straightforward?

[123] **Mr Davies:** It is very difficult for me to answer that on an all-Wales basis. In Cardiff and the Vale health board area, it is very easy to access an ultrasound scan within the hospitals. So, if the patient comes into hospital, it is very easy to access a scan, certainly Monday to Friday.

[124] **Kirsty Williams:** Not after 5 p.m.

[125] **Darren Millar:** Exactly.

[126] **Mr Davies:** Once you get out of hours, it is difficult and the weekends can be difficult, which can then cause unnecessary admissions or over-treatment. Once again, I could not tell you how easy it is within primary care. I am sorry, but I do not have that information.

[127] **Darren Millar:** It would be interesting to get some evidence on that, in terms of the delay in accessing ultrasounds, particularly from primary care, but also during those weekend and evening periods, as time might be critical if a DVT has been identified.

[128] **Kirsty Williams:** You cannot do it.

[129] **Darren Millar:** Why not?

[130] **Kirsty Williams:** I have had two admissions in the last 12 months, both of which were after 5 p.m., and you just cannot get a scan anywhere in Wales.

[131] **Mark Drakeford:** We have people from the health boards at our meeting this afternoon, so we might be able to pursue that directly with them. Rebecca, you wanted to come in on one of those points.

[132] **Rebecca Evans:** It was an additional point that we have not yet touched upon, if that is okay.

[133] **Mark Drakeford:** Yes, go ahead.

[134] **Rebecca Evans:** In the RCN evidence, you state that you would like the committee to consider the benefits of a national public awareness campaign on ways to reduce the risk of venous thrombo-embolism and promote health following hospital admission. Lifeblood's evidence talked about its Stop the Clots campaign; what is your assessment of the effectiveness of that campaign and what would you like to see a Wales-specific campaign achieve over and above the Stop the Clots campaign?

[135] **Ms Turnbull:** We do not have the answer to that. We certainly have not evaluated that campaign in any way. The point that we were raising goes back to your priority issue: we want the benefits to be considered of a public awareness campaign. My colleague has already alluded to the hand-washing campaign. The other point is how aware the public is of the risk of DVT on long-haul flights. That was a very successful public-awareness-raising exercise. I am not convinced that the public is equally aware of the risks in terms of illness. That is the kind of issue that could usefully be raised so that people are not only aware, as my colleague said, of talking to health professionals about their anxieties, but also of complying with anything that has been suggested. They may not be aware of the significance of the stockings, for example. They may not be aware of the importance of addressing those risks. So, those were the questions that we wanted to ask. We wanted to identify the cost and the benefits and consider what evidence has already been assessed from the campaigns that have been run.

[136] **Mark Drakeford:** Diolch yn fawr iawn ichi am ddod y bore yma.

Mark Drakeford: Thank you very much for coming here this morning.

[137] Thank you very much for that useful session. I am sorry that we have run out of time, but, as I normally say, if there are things that you think have not emerged strongly enough over the last three-quarters of an hour that you think are important for the committee to think about when we come to report, we would be very grateful if you would draw those to our attention. Diolch yn fawr.

[138] Cawn egwyl fach o ryw 10 munud. Ailddechreuwn am 10.40 a.m.

We will have a short break of around 10 minutes. We will resume at 10.40 a.m.

Gohiriwyd y cyfarfod rhwng 10.29 a.m. a 10.42 a.m.
The meeting adjourned between 10.29 a.m. and 10.42 a.m.

[139] **Mark Drakeford:** Croeso yn ôl i'r drydedd sesiwn y bore yma yn ein hymchwiliad undydd. Estynnaf groeso arbennig i'r Athro Beverley Hunt o Goleg Brenhinol y Ffisigwyr a Dr Andrew Davies o Gymdeithas Orthopedeg Cymru. Dechreuwn yn ôl yr arfer drwy ofyn a oes unrhyw ddatganiad agoriadol byr yr hoffech ei wneud. Ar ôl hynny, byddaf yn troi at aelodau'r pwyllgor; rwy'n siŵr y bydd ganddynt lawer o gwestiynau i ofyn i chi.

Mark Drakeford: Welcome back to the third session this morning in our one-day inquiry. I warmly welcome Professor Beverley Hunt of the Royal College of Physicians and Dr Andrew Davies of the Welsh Orthopaedic Society. We will start as usual by asking whether you would like to make a brief opening statement. Following that, I will turn to committee members; I am sure that they will have many questions to ask you.

[140] Are there any brief opening remarks that you would like to make? We have had a chance to look at the written evidence; thank you both for that. We will then move on to questions. Professor Hunt, are you going to lead off?

[141] **Professor Hunt:** It is a great delight to be here today to represent the Royal College of Physicians. I emphasise the importance of this meeting—the Royal College of Physicians recognises its importance. I hope that this is a key turning point for preventing the loss of more than 1,000 lives that are probably lost every year to hospital-acquired clots in Wales. I hope that this committee recognises the size of the problem. You have a chance to lead the world in delivering some form of mandation of appropriate intelligent targets to prevent this very preventable problem. I hope that we will be discussing the mandation of appropriate thromboprophylaxis. We also need to recognise that this is necessary because there is a failure of education among some health professionals.

[142] **Dr Davies:** The Welsh Orthopaedic Society is grateful for the opportunity to submit the document and put across our point of view this morning. I do not doubt that thrombo-embolic disease is a significant issue; I would simply hope that we can establish that in the specific realms of children's orthopaedic surgery, the treatment must not be worse than the disease.

[143] **William Graham:** Do you think that the current National Institute for Health and Clinical Excellence guidelines on VTE are sufficient, particularly with regard to the monitoring of implementation?

10.45 a.m.

[144] **Professor Hunt:** The NICE guidelines are designed to cover about 95% of the

situation. I sat on the guideline-writing committee, along with Dr Simon Noble and a whole host of people with a multidisciplinary background. We went through all of the evidence, as one has to do in NICE. It takes three years to write a guideline. We went through everything meticulously. The statisticians summarised the evidence. I should point out that, when the NICE guidelines were written, for example, for the orthopaedic area, the British Orthopaedic Association sent its members, and the guidelines were approved by the orthopaedic association, and other groups approved areas appropriate to them.

[145] The guidelines are very comprehensive, and they cover all areas of medicine and surgery. They were up to date at the time and there have been very few papers since that will change what they say. So, they set a very good standard of care. They are the best we have, and they are ours: they are British and apply to the British population.

[146] It is not the role of NICE to ensure that they are implemented in every hospital. That is one of the problems with NICE. It is trying to develop ways of helping to deliver the guidelines but it cannot be responsible for ensuring that an individual doctor in an individual ward delivers those guidelines. That is a problem.

[147] **Vaughan Gething:** Returning to some of the evidence that we heard this morning, there is apparent tension between parts of the medical profession and the views expressed by some parts of the orthopaedic branch. There is this point about the call that you made, Professor Hunt, in your opening remarks, about wanting to see mandatory treatment, or at least the consideration of it, with the care following in accordance with the guidelines. That is, essentially, my understanding of what you are saying. Yet, we also have evidence from a range of people of inconstant application of the guidelines and apparent reluctance to implement them. People are pointing the finger at the orthopaedic association. I am interested in your perspective on that. How could we and should we transfer a greater consistency in the application of those guidelines? Where are the problem points? We have heard that the risk of bleeding is one of them.

[148] **Professor Hunt:** The problem is always education. So, the British Society of Haematology has surveyed what medical schools teach about haematology. It is hugely variable across undergraduate education. Some medical schools may just do two days on the subject, and within those two days they might get one lecture on the prevention of clots. If you look at nursing training, there is very little, and if you look at midwifery training, it is not part of the syllabus. So, we have health professionals coming through into practice and the responsibility lies with postgraduate authorities and local education, and it does not always deliver.

[149] The other problem is that a lot of this evidence is very new. So, all of the data on 25,000 deaths are actually from the past 10 years. The other thing coming through, as well as the size of the problem, is where this is happening. If you look at the average orthopaedic patient, they come in and go home within five days, but the average deep-vein thrombosis occurs on day seven, when they are out of hospital. The average pulmonary embolism happens on day 21. We have a problem occurring in the community, although the hospital causes it. The people who were doing the operations do not see it, so they do not perceive that there is a problem.

[150] The real problem is that we do not do post-mortems any more. When I was a junior doctor, at the end of the ward round you would trot down to the mortuary and you would see the mistakes of the past week. Sometimes if you thought that someone had a pulmonary embolism, you were usually right. However, much more commonly, you thought that someone died of something else, but in fact they had died of pulmonary embolism. It is quite a difficult diagnosis to make before someone dies, so we have to provide prevention, because we are so poor at treating it and recognising when it does occur.

[151] **Vaughan Gething:** A lot has been said today about the risk of bleeding. The evidence given to us this morning was very clear that the risk of a bleed is minor compared with the wider risk of venous thrombo-embolism and the health concerns of that. So, I am interested in your perspective on the evidence that we heard and on the call that Lifeblood and the Royal College of Physicians are making for action.

[152] **Dr Davies:** We make the point in our paper that, in terms of the evidence behind these new oral agents that have been introduced, each has a single randomised prospective controlled trial behind it and each was funded by the drug company that has a product to sell. Each was keen to stress a low bleeding rate in the abstract in the paper, or a low major-bleeding rate. The major bleeding was defined in advance of the study in a select way. There is a much larger group of what they then term 'clinically significant non-major bleeds', which are the problems that we see surgically, for example, patients going back to theatre with wound haematomas or with oozing wounds with infections and so on. They are greater in number. On comparing those data, which are prospective controlled trials, performed in strict ways, with the kind of real-world data that we get from registries—I know that one of this morning's witnesses was critical of registry data and felt that those were less important and less reliable—I would put it to you that if we take every patient who has a particular condition in the UK and write them all down and put them in a book and see what happens to them, that would give you a much more accurate reflection of what is real in the UK at any given time.

[153] The analysis of the 2011 data has been criticised because it is a podium presentation, but the data have existed only in the past few weeks, so they have been read at a national meeting and have been accepted for publication; they are not printed yet, but they are that up-to-date. That analysis shows that the outcomes for patients with elective joint replacements are not worse in patients who have not had these new chemical agents given to them. I would not seek for a moment to say that venous thrombo-embolism is not a problem—it is—but the medications that we have to try to prevent it also have their issues, which can cause problems of their own. It is one thing to mandate that the patient is assessed and then make a decision about their relative risk of bleeding and thrombosis—that decision is made on an individual basis, having discussed it with the patient and asked what their view is—and for that policy to be followed for that patient and for each patient to be assessed individually. It is entirely another issue to mandate that every patient must have these drugs, because, as I said at the beginning, the treatment must not be worse than the disease. If you are going to spend a lot of money on various medications and then cause significant harm to a percentage of patients, perhaps that is not the best way forward.

[154] **Professor Hunt:** We are calling for appropriate thromboprophylaxis according to the NICE guidelines. The NICE orthopaedic section was written by five orthopaedic surgeons at the behest of the British Orthopaedic Association. So, it is tied in. I am not quite sure what the Welsh orthopaedic doctors feel fits in with this.

[155] **Kirsty Williams:** That is exactly my point, Dr Davies. Do you have a fundamental disagreement with what NICE has published as to what should happen? If you do not, are you clear that orthopaedic surgeons in Wales are following NICE guidelines? If they are not, is that a concern to you?

[156] **Dr Davies:** I cannot speak for anyone's practice but my own. The guidelines exist. I know that there was widespread disbelief within the UK and English orthopaedic community when the guidelines came out, because there had been huge debate within the BOA in advance of sending representatives up to those meetings. We thought that our position, which was evidence-based, had been agreed, but when the guidelines came out, they seemed to bear little relation to what we thought we had said. I know that Professor Atkins and others from Bristol went up and were involved in that, but when the guidelines came out, they were

something of a surprise to many of us. We are where we are, but again—this point was made earlier—you only have to see one surgical disaster to sway your opinion about what you are going to do for your next patient, regardless of guidelines from elsewhere. If you have done it in your practice and it does not work, you are unlikely to do it again, whatever it is—a particular surgical technique or a particular drug therapy. The guidelines exist, for better or worse, but I think that we all need to defend our own practice individually.

[157] **Kirsty Williams:** When I first became an Assembly Member, a long time ago, a doctor said to me 'We are now doing clinical-based medicine'. That came as a surprise to me, because I thought that that was what medicine was all about. How can clinical-based medicine happen if practitioners are basing their treatment decisions on the basis of what happened to one patient last week rather than three years' worth of expert clinical review of not only one patient but a whole cohort of patients? From a patients' perspective, and as a representative of my constituents, I am worried that we have eminent clinicians like you saying that you do not care what NICE has said, for better or worse, but that you are interested in what happened to the patient you saw last week. I can understand that it must be traumatic if something goes wrong, but we also have many people who are dying of thrombosis, which is equally tragic for the clinicians who are treating them.

[158] **Dr Davies:** I would urge you look at which patients are dying. As we have referenced in the paper, the fatal pulmonary embolism rate in elective orthopaedic surgery is astonishingly low, even if you use aspirin as your chemical thromboprophylaxis; the other drugs have not been around long enough to know what the fatal pulmonary embolism rate is if you use them. However, when you look at established practice that has been going for a long time, using aspirin, the fatal pulmonary embolism rate—if that is the outcome that you want to look at—was less than 0.1%. It was three out of around 4,700. It depends what outcome you want to look for. If you want to look for venographcially diagnosed DVT, we could all have a venogram now and two of us might have a DVT, because we have been sitting here for a little while. Is that a diagnosis worth making? Is that of clinical relevance? Is that important or is it something that happens and goes away again? Are we going to look at symptomatic DVT, where the patient presents with a painful, hot, swollen leg? Is that important? Many of my colleagues say that it is, and others say that it is not. It depends on what you want as your end point. If you want venous ulceration as your end point, that is extremely rare in orthopaedic patients. There is a lot of focus on elective, primary lower-limb joint replacements—hip and knee replacements—as a primary operation, and there is guidance on that. However, that represents a small percentage of patients. There is very little guidance on the vast majority of other operations that go on. There is no guidance on shoulder surgery, elbow surgery, ankle surgery or trauma surgery per se. Half of our practice is trauma patients with broken bones. There is very little guidance on what we should do with those patients. Empirically, we give them treatments—

[159] **Kirsty Williams:** It seems to me that it does not matter whether there is guidance or not; you will go on in your own sweet way, depending on how you see the situation. It does not seem that we should waste any more money producing guidance. I take the point that it takes a strong person to be an orthopaedic trauma surgeon, with the confidence to pick up someone who was torn to pieces, open them up and save their life. I am just concerned that we have guidance that seems to be ignored.

[160] **Mark Drakeford:** I will ask Professor Hunt to come in on this point. Then, I have many people who want to ask questions.

[161] **Professor Hunt:** The NICE guidelines do cover trauma. If you have multiple trauma, your risk of VT is probably the highest in the hospital—about 80%. However, I would like to pull you back from orthopaedics to medical patients, because they account for 70% of all admissions to hospitals. I am speaking on behalf of the Royal College of Physicians, and we

know that thromboprophylaxis is effective in reducing the rate of clots. The argument is won there, and I think that most of the physicians agree about the evidence and agree what we do.

11.00 a.m.

[162] I would like to pull you back to implementation and point out some of the things that are happening in England that you might learn from. I operate in the English system and it is a census system. So, we have to return to our local primary healthcare trust that 90% of all patients admitted have been risk assessed. That means that we have to gather the information, either electronically or on paper, which is hugely time consuming. Probably, a better way forward would be to audit some patient groups monthly rather than make a nurse go round to check that this is happening and collect bits of paper or spend £50,000, as we did in our trust, in setting up an electronic system. So, that is something that would probably be better.

[163] The other problem with the English system, which I would not repeat again if one had an opportunity, is that we are measuring risk assessment, so we are saying that a person is at risk but, actually, what we need to check is that they get appropriate thromboprophylaxis according to the NICE guidelines. That is the point that I would audit; that would be a far more intelligent way to go.

[164] **Mark Drakeford:** That was very helpful. Mike will ask the next question and then Darren.

[165] **Mike Hedges:** Continuing with the NICE guidelines, I came here in ignorance, and I was much happier in that state. [*Laughter.*] I thought that NICE guidelines were created, sent out, and then everyone had to follow them. Listening to people today, it seems to be just optional. What is the point of having NICE guidelines if they go out and they are optional? Is there any way of referring them back if there is a cohort of people who are not happy with them? Is there any means of having a peer discussion about their implementation and whether there needs to be an alteration, so that people who work outside the NICE guidelines, which are agreed by 90% or 95% of people, could be enthused to follow them?

[166] **Professor Hunt:** That is a difficult question. Some hospitals have systems in place, for example, I am in a hospital where I have to account to the hospital clinical governance committee as to whether we are following the NICE guidelines in my area, which is thrombosis and thrombosis prevention. If someone goes against the guidelines, I have to report them to the hospital clinical governance system, and they will go back and perhaps have a chat with them. I do not think that that system operates that well in all hospitals.

[167] **Mark Drakeford:** Dr Davies, I have a question for you about where there are groups of clinicians who do not think that the NICE guidelines are necessarily the best available, is there an iterative process here? Are you able to go back to NICE and have your concerns thought about, at least?

[168] **Dr Davies:** Certainly, the British Association for Surgery of the Knee has made its representations, which goes back to the British Orthopaedic Association, and it then depends whether the BOA goes back to NICE. It is difficult; all we can do is wait for the evidence to accumulate as a result of the change in policy that has been determined and see where that takes us, and that is referenced in the document here. The paper looks at reference 7, the impact of national guidelines for prophylaxis on the complications of arthroplasty, and that takes time to filter through. It takes time for numbers to build up, the reporting to come through and for the real-world implications of the change that has been made to become apparent.

[169] The NICE process allows for these things to be revisited and things to be changed.

Professor Hunt feels that there is not sufficient data that she feels would warrant a change in that practice. Those of us who have felt that the guidelines perhaps went a little bit too far would feel that the evidence that is coming out indicates our view. There is a conflict there. The argument is that I do not see the pulmonary embolism or the DVT present because it happens after the patient has left my care, and the argument is that the haematologist will never see the infected joint replacement and the surgical complication languishing on the ward for weeks and months. We see what we see and we are influenced by it.

[170] To return to your point about guidelines and how I can justify not implementing a guideline, we are faced with what we see in front of us and I am afraid that that does bias your opinion. Dr Hunt's opinion is based on seeing patients in clinics with thromboses and mine is based on seeing patients in operating theatres with problems that have been caused by bleeding. We have to come to a consensus. The document has been written and I am sure that it will be revised in time, either as regards further mandation or rolling back from that to some extent. We will each have our points of view to put across. I have no difficulty with being mandated to assess my patient, or with being mandated to arrive at an appropriate regime for them, based on the risk that I see in front of me. I do have an issue with being mandated to prescribe a chemical in my practice, when the evidence coming back from UK-wide practice is that that chemical can cause at least as many problems as it solves.

[171] **Darren Millar:** Dr Davies, in the first part of this morning's session Dr Noble suggested that there is a perception that there may be resistance to prescribing chemical interventions among practitioners and clinicians like you because of the cost and the way that the cost may fall on your budget because of practice. Do you want to comment on that?

[172] **Dr Davies:** No; I have no concerns about that whatsoever. That is not something that I ought to be thinking about and it is not something that I do think about.

[173] **Darren Millar:** I just wanted to clarify that. Professor Hunt, I noticed that you are involved in Lifeblood: The Thrombosis Charity. I did not get the opportunity to ask where the funding for Lifeblood comes from. Is it funded by pharmaceutical companies at all?

[174] **Professor Hunt:** Lifeblood is mainly funded by donations these days. It receives money from pharmaceutical companies for specific projects and they have no influence on the outcome of the projects. They usually help with patient awareness—for example, they help to fund National Thrombosis Week.

[175] **Darren Millar:** It would be interesting to know what proportion of your funding comes from pharmaceutical companies.

[176] **Professor Hunt:** A total of 60% comes from donations and I suspect that, this year, it will be 80% because we want to be entirely independent. I take no moneys from pharmaceutical companies and neither do any of the other trustees.

[177] **Darren Millar:** I am simply asking the question because we heard earlier that some of the specialist nurse posts had been funded by pharmaceutical companies. The pharmaceutical companies have a clear interest in that they want to make their products more widely available through prescribing.

[178] **Professor Hunt:** Absolutely.

[179] **Darren Millar:** Dr Davies has hinted at the idea that some of the studies that NICE have relied on to produce their guidelines may have been influenced by pharmaceutical companies having paid for those studies, which have come up with data that have been useful to them to present a certain case.

[180] **Professor Hunt:** NICE will choose its evidence on the quality of the evidence; not on who funds it. If it is a randomised controlled study, it should not be influenced by who funds it. If it gets published in *The New England Journal of Medicine,* you can be fairly sure that it was a brilliantly designed study that was executed well and would not have been influenced by the pharmaceutical company that paid for it.

[181] **Elin Jones:** Dr Davies, if NICE guidelines continue as they are, and if at some point risk assessment and mandatory treatment become part of a tier 1 analysis in the Welsh NHS that hospital and LHB management would use to assess performance, do you foresee a situation where your members or your fellow orthopaedic specialists would continue to resist mandatory treatment on an individual basis or on a hospital basis?

[182] **Dr Davies:** Yes. I am probably at the end of the spectrum where I am open to this kind of thing. I read the papers, analyse them, work my way through the issues, understand what the risks and the benefits are and change my practice accordingly. Within any given specialty, there will be a spectrum of individuals, some of whom will be set in their ways and some of whom will be much more flexible and open to change. There will be those who will analyse their own results very carefully, and there will be those who are less enthusiastic about finding out about every outcome for every patient. Those of us who keep outcome data scores for every patient that we operate on make life hard for ourselves. However, we have data for our own practice, and I can say, 'These are my outcomes; this is what happens to my patients, given what I do.' I am then free to be criticised on that basis, but I know what happens to my patients. That cannot be true for every patient and every surgeon.

[183] There is a perception abroad that we are being pushed or perhaps even bullied into doing something that we genuinely believe is not in the best interests of our patients, despite the evidence that we generate in the profession, from the registries, the outcome studies and so on. This very small group of hip and knee replacements is studied ad nauseam, primarily because there is such a well-defined cohort of patients that can be measured against waiting lists and targets derived from waiting times for certain operations and so on. These patients are very well studied, but they represent a very small cohort of our practice. The blunt answer to your question as to whether I perceive that some of my colleagues will be resistant to this is probably 'yes'. I can try to influence my colleagues, as can committees and guidelines. However, you will always find some people who, for their own reasons and perhaps on the basis of good evidence derived from their own practice, will be able to say, 'Look, I do this, and it works. Why are you telling me to change it?'.

[184] **Elin Jones:** We heard earlier that there are litigation cases that are being assessed or are in the pipeline. We did not hear much evidence about what they were, and we were not given any examples. However, if the scenario that you addressed in your answer continues, surely some of those colleagues would be putting themselves at serious risk of challenge, would they not?

[185] **Dr Davies:** At that point, they would have to answer for their own practice. I cannot speak for them about that. I agree that that could be an issue if there is a mandated requirement to do something. This is a part of practice, is it not? We ask why a particular implant has been used, why a particular surgical approach has been used, why a particular technique has been used, and why a certain thromboprophylaxis regime has been used. From the time a patient comes through the door to the time when they shop in Sainsbury's six months later, a number of decisions have been made on various aspects of their care. These include who should do the operation; who should do the anaesthetic; which surgical approach should be used; which implant should be used; should the implant be cemented or uncemented; and what bearing surface should be used

[186] There are dozens of individual decisions that surgeons have to make to care for their patients and get the best outcomes for them. The decision about the DVT prophylaxis regime is one part of this process. I agree with you on the litigation issue. There are registries set up to look for implants that fail. There have been registries set up to look for surgeons who fail. We are looking for all of these things all of the time. I do not deny for a moment that DVT thromboprophylaxis is an important part of that. In the same way, I should not choose a bonkers-looking device that has just been produced by a company that no-one has ever heard of, that says that it might be really good, but there is no evidence for it. Okay, I probably should not use it; I should use a piece of shiny metal and plastic that has been on the market for a very long time, and there is good evidence to support it. I should then look at whether I can let a patient be operated on by a trainee, with me supervising, or whether I have to do the operation and let my trainee learn from watching me. Then, I have to decide which suture material to close with, what rehabilitation regime to follow—whether it is safe to fully weight bear—and then what thromboprophylaxis regime to use.

11.15 a.m.

[187] It is all part of the mix and I agree with you that there will be patients who will sue for one reason or another. There will be patients who sue because there was a complication, and they will argue that the complication was avoidable, whether it was a bleeding complication or a clotting complication. There will always be patients who have poor outcomes one way or another. Some will be very dissatisfied with that. They will feel that they came in to deal with a quality-of-life problem—they had an arthritic knee and could not sleep, do their shopping or enjoy golf any more—they have had the operation and it has all gone horribly wrong and they have ended up losing a joint or a limb. That might be because they got a clot and something went horribly wrong. It might be because they had a bleed and something went horribly wrong.

[188] We walk that tightrope and we have to make decisions based on the evidence we have. That evidence will come from NICE guidance from meetings held elsewhere and evidence taken across the piece and from within your own profession. You go to your society meetings and your colleagues will say that they have analysed all the data that have been collected over the past five, six or seven years from the joint registry and that they point in a particular direction. NICE guidance may point in a different direction, and so you have to make a decision as a clinician on where you place your trust with regard to how to proceed in the best interests of your patient today and your different patient tomorrow and so on every week of every year. Faced with conflicting evidence, people will make different decisions, and I take your point about what the point is of issuing guidance if it is not going to have any influence. How do you proceed? As professionals who keep up to date, we must consider the evidence from our own profession as well as from elsewhere.

[189] **Mark Drakeford:** There are Members who have not had a chance to ask a question at all, so I am going to prioritise them now.

[190] **Darren Millar:** May I just ask a brief question on this issue? From a layman's point of view, guidance is extremely important and people should stick to it. I cannot understand why your profession is so vehemently opposed to the guidance that has been published. Are there international studies or guidance that clearly point in a different direction? Is a different approach being taken in other countries or is just—

[191] **Dr Davies:** America is extremely litigious, and America has been pushed by the American College of Chest Physicians, where a great deal of this force comes from, towards chemical thromboprophylaxis. After that time, which was around 2006 to 2007, there was a rash of papers around 2008 to 2009 with people saying, 'Look, we were pushed for medico-legal reasons to change our practice, which was established and worked for us, by lawyers to

use other drugs, and look what happened: our DVT rate went up, our complication rate went up, the money we spent on drugs and tablets went up and our outcomes went down. So, guess what? We are going back to our old regime based on the evidence that we created in our institution over two decades.' That is referenced in our piece of evidence here. We are just coming to that point in this country now. The NICE guidance came out two or three years ago and, across England, many trusts were pushed to do these things, as they were pushed to change their antibiotic infective prophylaxis regimes. The results of that are just starting to filter through, hence our references. We are faced with conflicting evidence every day.

[192] **Mark Drakeford:** Professor Hunt, I am going to give you a chance to answer that point, and then we are definitely going to have questions from Lindsay and Lynne.

[193] **Professor Hunt:** It is all about the weight of evidence. As an individual, I am very busy. I do not have time to assess the evidence in all the areas I work in. I am reliant on and have to trust guidelines from NICE. I spent three years with a dedicated statistician looking at all the papers on thromboprophylaxis, and I am therefore very confident that the guidelines that were produced were up to date and state of the art. When we weigh evidence, we look at the quality. One of the problems with orthopaedics is that all the quality evidence—the randomised controlled studies—tend not to come from orthopaedic surgeons. You talk about registries. With the greatest of respect, registries do not come high on the list. In a hierarchy of how good various types of studies are, randomised controlled studies are the gold standard, and registries are much lower because people forget to put patients in or do not quite remember what happened to them or the system is not as perfect. It comes down to observation, whereas a randomised controlled study provides hard evidence. It is hard evidence because you are usually giving a placebo versus a drug and you have a statistician working on it. It is really tough stuff.

[194] **Dr Davies:** Many of the studies on the newer agents are not studies of the new drug versus a placebo; they are studies of the new drug versus a low-molecular-weight heparin, which was perceived to be the standard of care in the United States of America and, therefore, it was felt that you could not give a patient no drug. So, the new studies are comparisons of new drugs versus some other drugs. They are not comparisons of new drugs versus aspirin or new drugs versus no drug.

[195] **Lindsay Whittle:** This is fascinating; we could probably go on all day. I am old enough to remember a television programme called *Your Life in Their Hands*—it was in black and white, by the way, which shows how old I am. That is what ordinary people do when they go into hospital: they trust the professionals.

[196] We have had conflicting advice today. I want to ask about your views on the patients' point of view. After all, it is about the patient that you are treating. What I have heard today leads me to think that if I were to have an operation, there could be a 50% chance that I have a pulmonary embolism, unless I took some kind of a drug, or there is a smaller chance that I lose a limb. Well, I would rather lose a limb than lose my life. I appreciate that losing a limb is very traumatic, but losing your life is—well, I would not know about it, but people like you may feel guilty. I have no time for this compensation culture and I think that that should be abolished, but that is another debate. What about the patients' voice in this? Do they get a choice?

[197] **Dr Davies:** As we have set out in our document, we have no difficulty with being mandated to discuss risks and options with our patients or having to make individual decisions for each patient and pursue that course of treatment—mechanical means are the mainstay we advocate. We are certainly not advocating not treating these patients, so please do not hear me saying that.

[198] There are different ways of preventing a thrombosis. The vast majority of thromboses occur in a lower limb. There are mechanical ways of addressing the lower limb in isolation, while the rest of the body is left alone. The thing about a drug is that it goes everywhere; it does not say, 'I am targeted at the veins in the lower limb, so I will go and sit there'. That is not what drugs do; they go throughout you. The thing about mechanical prophylaxis is that is targeted at the area that is most at risk, which is the lower limbs in a patient who is not moving around very much.

[199] So, there are different ways of addressing this problem. Some of it is about maintaining mobility; some of it is about maintaining hydration, so that the patient does not dry out and clotting begins; some of it is about mechanical devices that can keep the blood flowing in the lower limbs and reduce the risk of clots; and some of it is about medication that treats all of the body, which can be useful in some patients. I do not deny that that should be on the agenda and that we should be mandated to consider it.

[200] The evidence within my profession is that orthopaedics accounts for a tiny percentage of the cases that come back with thrombo-embolic disease in our trust. It is not a problem of orthopaedics, because the volumes of patients who have deep-vein thrombosis and pulmonary embolisms are not orthopaedic patients. However, we seem to be the focus of attention all the time. I am sticking my head above the parapet by sitting in front of you and taking a bit of flack this morning, but I want to try to make the point that we understand that this is an issue and we want to treat our patients properly and correctly every day going forward. However, we honestly and truly feel that we can do more harm than good by being mandated to treat every patient with a drug.

[201] **Lindsay Whittle:** So, is physiotherapy and keeping people mobile an answer?

[202] **Dr Davies:** Absolutely, of course. That must be discussed with patients. However, some patients have fixed ideas because they have read something in the *Daily Mail* or they have read something else on the internet or whatever. They say, 'I want this'. They will come to us saying that they want this implant or that technique or this drug. Sometimes, you have to disabuse them of their views because, for example, the implant they want has only been done 10 times in Afghanistan or somewhere and that it is probably a bad idea for them. They will sometimes say, 'My mum had DVT and I am scared about it, so I want treatment', to which I would reply, 'Of course you must be treated'. I do not have any difficulty with that.

[203] **Lynne Neagle:** In view of the answer about your colleagues, who you feel would not all comply with any kind of mandatory assessment regime—

[204] **Dr Davies:** They would not do that out of malice, but out of a genuine belief that that is the right thing to do.

[205] **Lynne Neagle:** I understand that, but, in view of what this committee is trying to do in terms of making recommendations to improve prevention in this area, is there anything that the Welsh Government or NHS management could do that would lead to that kind of compliance? Alternatively, are you saying that, whatever anyone does, some doctors will just do what they want anyway?

[206] **Dr Davies:** I will answer that question by saying that outcomes need to be found for every patient. That is, we need to know what the outcomes are for our patients. If we have problems in one individual or in one unit or principality, then we should address those, based on the evidence of the outcomes for those people. If individuals say that they believe that the guidance is wrong, that they do not have this problem and that their patients do not suffer from DVT/PE rates of whatever and they are therefore justified in not prescribing these agents, then the evidence must be there to support that.

[207] I would have great difficulty in defending colleagues and my profession should they say that they do not believe it. I would be happy to defend them if they say, 'Here are my results: I don't have a DVT/PE problem; I know the outcomes for every patient of mine, so why I am I being mandated to use this stuff?'. I would be happy to stand four-square behind them and say that I am in the same situation, in that I know what my outcomes and what my knee scores are, and what implants I am using, based on the evidence. I feel resistant to being forced to change my practice, knowing what my outcomes are. If you feel that it is necessary to mandate something, then it should be mandating to know what the individual outcomes are for these patients. If there is problem, then we must address it, but if there is not, I would advocate that the status quo continues.

[208] **Professor Hunt:** I feel like we are reinventing the wheel here. I cannot see how individuals who might not agree with the guidelines on the basis of their experience of a few hundred patients, compared with the experience of the people who write the guidelines who have read all of the papers, can override what is proposed. So, I would stick to the fact that you need to provide appropriate thromboprophylaxis treatment, according to the guidelines. That is where we need to go, and there is nothing to argue with on that. However, where the orthopaedic community picks its guidelines is difficult. I can see that the orthopaedic section of the NICE guidelines was written by five orthopaedic surgeons from the British Orthopaedic Association and was approved by the British Orthopaedic Association. So, I have a problem with that this morning.

[209] **Kirsty Williams:** There was a feeling among the committee that we would have a session today where we would all agree that this is a terrible thing, that we need to do more and we could have written the report before we started. So, Dr Davies, you have made this a much more challenging day than we thought it would be at the outset, which is a good thing. [*Laughter*.] It is good thing, because there was a danger that we would all sit here in a cosy consensus, and that it was all going to be mom and apple pie.

[210] I am interested in your answer to Lynne Neagle. It was suggested to the committee this morning that what we need to recommend is that all health boards implement a robust system of root-cause analysis, so that when someone has a VTE, there is a systemised way of looking at the pathway that that patient came through. Is that something that we could usefully recommend?

[211] **Dr Davies:** Yes, absolutely.

[212] **Kirsty Williams:** If that root-cause analysis then demonstrated that there was an issue with whichever doctor in whatever specialty in the hospital, they could go back and robustly challenge that practice, and look to see what—

11.30 a.m.

[213] **Dr Davies:** I think that that is precisely the sensible course. I really do.

[214] **Elin Jones:** May I ask one thing? You referred in the answer just now to the analysis of outcomes and your fellow clinicians' analyses of their outcomes. From ignorance, I wanted to know what you mean by outcomes for a patient. Would you assess that when your patient is leaving your direct care in hospital?

[215] **Dr Davies:** No, the outcome of any operation will not be known for a minimum of six weeks post surgery, and, if you are talking about any kind of fracture fixation or joint replacement, you will be talking about six months as a minimum.

[216] **Elin Jones:** So, what structure is in place for the clinician to assess that outcome?

[217] **Dr Davies:** Out-patient clinic follow-ups. You see every patient who gets an operation at six weeks, six months, a year and, hopefully, more going forward. There are huge pressures on us to reduce the number of times that we see patients in clinics, because it is expensive to pay for me to sit there and review my patients, but, to me, the operation is the beginning of the journey, not the end of it. It is easy to measure the waiting time and the target to get an operation and then say, 'Great, the operation box has been ticked, so episode over', but, as far as I am concerned, as a surgeon, the episode begins when I operate. I want to know where they are in six months' time, in two years and in five years. What are the outcomes for those patients, as individuals? Am I making the right decision on implant, on bearing surface, on cement, or on thromboprophylaxis?

[218] **Elin Jones:** We heard this morning that orthopaedic surgeons may not be fully aware of potential post-hospitalisation onset of VTE, but that is not true, because, at some point, you will know whether someone has died, or whether—

[219] **Dr Davies:** We will all see our patients again. Of course, if they are dead, we will not see them again. That is a given, and the point is well made that what we will not—

[220] **Elin Jones:** Will you know that?

[221] **Dr Davies:** Yes, but, again, the patient who sits in front of you for 15 minutes moaning gets a hell of a lot more of your attention than a letter saying, 'I am sorry to inform you that Mrs X is dead'.

[222] **Mark Drakeford:** We are out of time for this session, but, given the nature of the debate that we have had, I am keen to offer you both a moment or two to sum up. I will go to Professor Hunt first, but Dr Davies, when it comes to your last couple of minutes, I wonder whether you can help us with one last thing. Inevitably, when witnesses are giving evidence, they partly reflect the views of the organisation that they are here to speak for—the Welsh Orthopaedic Society, in your case—but inevitably also their own practice and experience, too. You referred briefly in an earlier answer to where you thought your view sat on the spectrum of views that the society would encompass. If you could say that to us one more time, that would be helpful for us in weighing things up. However, we will go to Professor Hunt first for the last few remarks.

[223] **Professor Hunt:** Thank you for listening. It is exciting to be here. I hope very much that you will make changes that will mean that there will be mandation of appropriate thromboprophylaxis in the principality and that you will introduce root-cause analysis as being absolutely essential, because that will demonstrate individual problems. We also have to realise that there is an education gap in a lot of areas and that that needs to be attended to as well. You have all the tools in place: you have fantastic clinical leadership, guidelines and risk-assessment tools. So, it is all there, but it just needs to be mandated.

[224] **Dr Davies:** On behalf of the Welsh Orthopaedic Society, in answer to your question, I think that I sit at the slightly more academic, pharmaceutically aware end of my professional spectrum. I know that a lot of my colleagues feel that they have been doing this for a long time and it just sort of works, and so why are they being asked to change it? I am also well aware that there are significant issues, and that a lot of people are looking at our particular corner of the profession and studying it in some detail. I am keen that, if it is right for our patients for us to change our practice, we should change our practice, and I should persuade my colleagues to do that and show them that, clinically, their patients are on average better off if we do certain things. The evidence from within the profession in the UK on the changes that have been forced on us so far has not been overwhelmingly positive, and a root-cause

analysis will probably help us going forward. If we have a problem, we will put our hands up and deal with it. However, until we as a group are convinced that we as individuals ought to change, there will be continuing resistance.

[225] **Mark Drakeford:** Diolch yn fawr i chi'ch dau.

Mark Drakeford: Thank you both very much indeed.

[226] It has been a very interesting session, and we will be thinking hard about the conclusions that we will draw from it. Thank you both for the time that you have offered us this morning.

11.35 a.m.

Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Adborth ar y Gwaith Ymgysylltu a Gyflawnwyd Hyd Yma
Inquiry into Residential Care for Older People—Feedback on the Engagement Work To Date

[227] **Mark Drakeford:** Rydym yn bwrw ymlaen yn syth yn awr at eitem 3 ar yr agenda, a mynd yn ôl at yr ymchwiliad i ofal preswyl i bobl hŷn, dim ond am chwarter awr.

Mark Drakeford: We are going to carry straight on now to item 3 on the agenda, and return to the inquiry into residential care for older people, just for a quarter of an hour.

[228] Members will have seen that there are papers to note, which provide written feedback on some of the work that committee members have been doing, such as going out to visit different organisations to look at provision in the field of residential care for older people. There is more to come, because committee members are doing things in June as well. If anybody has so far been out and done anything that is not captured in the notes that we have seen, we have a moment now to get that on the formal record. I will also offer a couple of key observations from the work that has been undertaken. So, I will say a couple of things, and then if anybody else who has been involved wants to add anything, they can do that.

[229] I met with the chair of Cwm Taf Local Health Board, Dr Chris Jones, who is himself a GP and whom many of you will know. We talked through some of the issues that, at that stage, had come in front of the committee. The one key thing that Dr Jones was keen to put to us was his belief that we need to be careful not to ascribe everything that happens to the state of systems and professional practices, but to think hard as well about the difference that the accumulated experience of individuals will make as they face this point in their lives. That is rather a crude summary, but he said that we might be invited to interpret the things that we see as a result of how services are provided and systems work, but that might just be more related to the individual state of mind of someone who has come to that part of their lives. If people have something to look forward to, and they still have families to be interested in, things that they want to achieve, and things that they can see happening to them in the future, their ability to respond to reablement and so on will be at one level, and then there will be other people who, because of what has happened to them in life, or the state of their health and so on, just may not have that sort of motivation. In other words, he was saying that we should not underplay what people bring to the door in all this, as that can make a big difference to the way in which they respond to services. It is not always what the service is doing, but what people themselves bring to it. That was the key message from that discussion.

[230] Elin and I went to Carmarthen and met people involved in what they called a convalescent service, which more generally we have heard called a reablement service, and they provided us with some pretty compelling evidence about the extent to which their new

service has changed outcomes for individuals via the choices that they make. Previously, seven out of 10 people going through their system would go into residential care and three out of 10 did not, but, in the new system, where people go for six weeks to a convalescent home and get an injection of reablement, it is exactly the opposite: seven out of 10 people go home, and three out of 10 go on to other forms of care. Some go on to residential care, and some to palliative care, and not everybody will get better. Some people turn out to be more ill than was first considered. However, the outcomes were pretty compelling.

[231] We also then met senior directors, who reflected many of the things that we have heard elsewhere, and I will do a brief note on that. However, they were keen to convey to us that there is a concerted effort in Carmarthen to reduce the number of people going into residential care whose care is paid for by the public purse, and they have succeeded in bringing those numbers down, partly as a result of the reablement service. However, they number of people for whom they are paying has not gone down at all. That is because a number of people who enter the system are self-funders, but when their resources fall below the threshold the local authority then pays for them. So, although it is reducing the flow on the one hand, its overall bill is not going down. That takes us back to some of what we heard very early on from Professor Bolton, and we will need to return to that as a committee to think about how self-funders can be given the proper advice and assisted in the decisions that they make early in the process.

[232] Would anyone like to add anything about what they have found so far? If not, there will be another chance for us to capture some of this as Members do more of that work. Thank you very much indeed.

[233] I should also just let you know that the reference group is having its third meeting this morning as we speak. It has some particular questions that it wants us to put to the regulators and the inspectors, who we are seeing next week. So, we will ensure that we share those with you before that session. Next week's session will be an interesting one, because it is a different part of the story that we have not captured so far.

11.41 a.m.

Blaenraglen Waith
Forward Work Programme

[234] **Mark Drakeford:** You will see from the papers that, looking ahead to the autumn, it looks as though we will have four sessions at the most to devote to policy work, given the weight of the legislative work that is coming our way. It would be helpful for organisations if we could decide before the summer how we want to use those four sessions. There is a list of potential inquiries that we generated previously, and people may want to add to it. I am not asking people to make that decision today, but I think that we will need to make it next week, in advance of half term. My suggestion to you is that we should think of identifying one that we will definitely aim to do and another as a first reserve, which we can also let people know about, so that we have some flexibility in the programme.

[235] **Elin Jones:** I propose that we consider one of the major pieces of work that the NHS is looking to undertake over the next year, namely its consultation on reconfiguration plans at a local level. My understanding is that there will be three plans now. I think that, at some point—and I do not know when the right point would be, and I apologise that this is not a piece of policy work—this committee should be holding a scrutiny session with each of the local health boards involved, whether individually or together, just to scrutinise them directly on their plans for change in their areas. I do not think that it is appropriate for us to ask the NHS Confederation or the Minister about this at this stage, because both will just say that it is a matter for local delivery, and that will not allow the direct scrutiny that this committee could

usefully undertake of those local health boards.

[236] **Darren Millar:** I certainly second that. It is important that we have some level of scrutiny within the committee of the plans that are coming forward. I think that most of them, or at least the three that Elin is probably referring to, will be published over the summer, so the autumn would be a good time to look at that.

[237] I also support the need for an inquiry into specialist nursing, because there is an opportunity there to improve outcomes for patients but also to reduce costs to the NHS with the use of specialist nurses. I would certainly support an inquiry into that.

[238] **Lynne Neagle:** Mark, are the four sessions that you talked about just in the autumn or over the whole year?

[239] **Mark Drakeford:** They are the sessions that we think that we will have in the autumn, so between the end of September and December.

[240] **Lynne Neagle:** The only thing that I particularly wanted to flag up is mental health, because I understand that the health boards have to submit, in around two weeks' time, their plans on the new procedures and arrangements that have to be in place under the Mental Health (Wales) Measure 2010. I am not sure what would be the appropriate time to look at that, but I wanted to put that into the mix.

11.45 a.m.

[241] **Darren Millar:** The Public Accounts Committee is undertaking follow-up work on some of its mental health work in the past, so we will be passing the buck back to this committee.

[242] **Mark Drakeford:** Yes, you did mention that.

[243] **Kirsty Williams:** On the local health board plans, if we do not consider them, there is not another forum for politicians to look at and question those. There may be issues around not just what are in the plans, but how the consultation has gone and the evidence that has been used. You cannot ask those questions in the Chamber, because, rightly, the Minister will say that it is a matter for the local health boards. I think that the Welsh public would find it strange if there are major changes to local health services in Wales and this committee did not have a role in looking at those. We would have to have a certain amount of self-discipline in the committee about how we handled those sessions, but it would be strange for this committee not to take an interest in what is potentially the biggest single change that people will experience in their local health services for the next 10 years.

[244] **Vaughan Gething:** I assumed that we would look at health board plans, so I do not disagree with anything that has been said on that, but I would like to look at health inequalities at some point. However, I am not sure whether there will be time to do it justice, if we are also going to fit in something else. I am not saying that we will want a nine-month inquiry into it, but perhaps the four sessions will get slimmed down if we look at health boards, and then I am not sure that there would be enough time to consider that, but I would like to return to it.

[245] **Mark Drakeford:** Okay. I would like you to think about one other issue between now and next week, namely that so far—and I have been keen on this myself—we have done everything as a whole committee; we have not done anything on a smaller basis, but we could at least consider whether some of the issues that have been suggested this morning could be considered in two groups rather than in a whole committee. I am not advocating it, but asking

you to think about it in trying to juggle the facts that we will want to do some policy work—and there are organisations out there that are keen to see the committee do some of that—as well as health board scrutiny and that we have a considerable legislative load. Is it worth at least asking ourselves whether we might be able to juggle that by tackling some of it in a slightly different way? It would not mean any extra time for anyone—we would, say, use a Thursday and half of us would look at one topic and the other half look at another and then come back together to discuss those. That is just something for you to think about. We will return to this next week, but any further ideas would be useful.

[246] Finally, before you go, our termly scrutiny session with the Minister is coming up after the half-term recess. Last time, we generated a list of topics that Members were confident that we would want to ask the Minister about. I thought that that worked well. Many issues not included on the list came up in the session and the same will happen next time—it is not an exhaustive list, but is one that gives us an idea of what the committee is likely to concentrate on.

[247] **Kirsty Williams:** I think that it would be useful to look at the key commitments in the manifesto. The Minister says that those are her key commitments, so we should ask what is happening to the over-fifties checks, to extended GP hours and so on—all of the issues that the Minister said were her priorities. It would be interesting to see where we are with those a year down the line.

[248] **Mark Drakeford:** We will probably send an e-mail around, asking people whether they want to add to that list. We will bring whatever we have to committee next week and people can chip in at that point.

[249] **Darren Millar:** I apologise to the committee, but, unfortunately, I cannot be at this afternoon's session to hear the remainder of the evidence. I have a bit of a soft spot for orthopaedics, having had orthopaedic surgery recently and going back in for more—

[250] **Mark Drakeford:** Yes, you do not want to upset them now, Darren. [*Laughter.*]

[251] **Darren Millar:** I was interested in the role of the pharmaceutical companies in funding the organisation; it would be interesting to get more evidence on that.

[252] **Mark Drakeford:** We will ask them for that. We have representatives from Betsi Cadwaladr University Health Board here this afternoon, so we can ask them specifically about the nursing post.

[253] **Lindsay Whittle:** When is your operation, Darren?

[254] **Darren Millar:** On 14 June. You can send me some grapes.

[255] **Mark Drakeford:** We could go en masse to see you. That would really set back your recovery. [*Laughter.*] Thank you, all. Please be back here by 1.00 p.m.

Gohiriwyd y cyfarfod rhwng 11.50 a.m. ac 1.01 p.m.
The meeting adjourned between 11.50 a.m. and 1.01 p.m.

Ymchwiliad Un-dydd i Atal Thrombo-emboledd Gwythiennol: Tystiolaeth Lafar
One-day Inquiry into Venous Thrombo-embolism Prevention: Oral Evidence

[256] **Mark Drakeford:** Prynhawn da. **Mark Drakeford:** Good afternoon. We

Croeso i Dr Alan Willson i'r Pwyllgor Iechyd a Gofal Cymdeithasol. Croeso hefyd i Jenny Rathbone, sy'n dirprwyo ar ran Mick Antoniw y prynhawn yma. Rydym ni'n bwrw ymlaen â'n hymchwiliad un-dydd i atal cleifion rhag datblygu thrombo-emboledd gwythiennol yn yr ysbyty.

welcome Dr Alan Willson to the Health and Social Care Committee. We also welcome Jenny Rathbone, who is substituting for Mick Antoniw this afternoon. We are continuing our one-day inquiry into preventing patients from developing venous thrombo-embolism in hospital.

[257] Bydd Alan yn rhoi tystiolaeth i ni ar ran 1000 o Fywydau a Mwy. Alan yw cyfarwyddwr y rhaglen. Diolch yn fawr iawn am fod yma gyda ni'r prynhawn yma. Mae cyfle i chi wneud datganiad agoriadol byr ar y dechrau ac wedyn byddaf yn troi at aelodau'r pwyllgor i ofyn cwestiynau.

Alan will give evidence to us on behalf of 1000 Lives Plus. Alan is the director of the programme. Thank you very much for being here with us this afternoon. There is an opportunity for you to make a brief opening statement at the beginning and then I will turn to the committee members for them to ask questions.

[258] We will give you a couple of minutes to highlight those points that you think that are particularly important and relevant.

[259] **Dr Willson:** Thank you for inviting us. I am Alan Willson, as you heard, and I am the director of 1000 Lives Plus. I also hold an honorary contract with Public Health Wales.

[260] First, I will outline the role of 1000 Lives Plus. We succeeded the 1000 Lives campaign, and our business is to support the NHS in applying evidence-based practice to care and to achieve reliability. That is about supporting organisations and individual practitioners in their capacity to improve services. We are not performance managers; we do not collect data on the performance of the NHS. We have a teaching role rather than a policing role. As you have heard this morning, Simon Noble, among his many other roles, has a role as our faculty member and has led us in our method and how that is applied.

[261] We have learned a lot about the nature of improving services, and we have learned, along with the NHS, that a just-do-it approach almost never works. So, an instruction from on high that says that something must happen tomorrow is rarely effective, often produces perverse results, and almost never produces sustainable beneficial changes. Our approach is the same approach that we apply to all our work. It is about understanding what the evidence is, adopting and adapting testing, and then achieving reliability and spread.

[262] This challenge is complex. Of all the work that we have done, I would say that changing the experience of Welsh patients with thrombosis is probably one of the most difficult. I know that you have heard some of the reasons for that in the evidence that you have received. One of the problems is that the problem is often silent. The manifestation of the problem is often not in the place where the risk is achieved or experienced. There are many established practices and many opinions about what constitutes best practice. Therefore, as a change and improvement problem, it is quite complex. England has achieved a reported risk assessment rate of above 90%. Our experience would question whether that translates into benefit to patients. I hope that we will have an opportunity to discuss that. We think that our approach in Wales has been intelligent in the way that we have adopted and adapted NICE guidance and supported the service in applying that to practice. We have also developed, in partnership with Betsi Cadwaladr health board, in particular, an approach to outcome measurement, which England does not have, and we are within a very small distance of being able to report a HAT rate for Wales.

[263] I am proud of what we have achieved and what NHS staff are continuing to achieve, but I know that we have a lot more to do. It seems to me that the question for you as a

committee—if I might presume—is: how does one mandate a greater reliability, what should that mandate be, and how should it be achieved? Again, I hope that we have time to discuss that.

[264] **Mark Drakeford:** Thank you. That is a helpful opening. Kirsty will kick off with the questions.

[265] **Kirsty Williams:** Thank you, Mark, and thank you, Dr Willson, for your evidence. You say that part of your role is to disseminate NICE guidance and to make sure that it is widely known and understood in Welsh hospitals and is acted upon. The evidence that we have received this morning is that that has happened in some cases, but that implementation is patchy—within single hospitals as well as within health boards. We have heard about one aspect of surgery—orthopaedics—and those witnesses said that they do not agree with the NICE guidance and ignore it because their practice tells them something different. So, how do you go about doing that and, where you experience resistance, how do you try to overcome it?

[266] **Dr Willson:** As you say, implementation is patchy and in general—this goes right back to the National Confidential Enquiry into Patient Outcome and Death Report—implementation is best where you can protocolise patients' experience. So, if you have an elective episode and, broadly, it runs to a formula, you have an opportunity to apply that formula, including risk assessment. I am not an expert in distilling the huge weight of evidence that there is around hospital-acquired thrombosis. The Chief Medical Officer for Wales commented around two years ago that there needs to be stronger evidence in terms of the epidemiology of thrombosis. The figures of 25,000 and 32,000 are estimates—intelligent estimates, but estimates nonetheless. There needs to be stronger evidence. The other thing that may come into play here is the difference in where risk is experienced. For an orthopaedic surgeon, a very immediate risk is the risk of bleeding during a hospital stay. That will be very apparent and it will cause obvious problems. The risk of silent thrombosis is one that follows hospital stay, by and large, and, with the low PM rate, we may have a very diminished appreciation of it. As I said, I am not an expert in weighing those two cases, but I can see why there is a difficulty.

[267] **Kirsty Williams:** You did say, however, that part of your organisation's role is to see whether guidance is implemented in Welsh hospitals. By your own admission, and according to the evidence that we have had earlier today, that implementation is patchy. So, having identified that, what new methods and actions are you taking to ensure that established NICE guidance is implemented in Welsh hospitals?

[268] **Dr Willson:** There are a number of approaches. The first is that we are particularly focusing on a specialty that has large numbers and where there is a strong consensus, namely maternity services. We have made huge strides in achieving a standardised approach with the acceptance of the profession. The other issue is to prioritise outcome measurements, because they are far more important and meaningful to a surgeon than whether or not they have filled in forms.

[269] **Kirsty Williams:** In your paper, there is a diagram looking at drivers and interventions—the kinds of things that people are doing. One thing that we have been asked to consider as a committee this morning is a robust system of root-cause analysis. As you say, it is outcomes that really motivate people to change practice if they need to. However, there does not seem to be a box on your diagram that looks at outcomes. If outcomes are as important as you say, how do you look at them as part of this particular issue?

[270] **Dr Willson:** Root-cause analysis is one of the methods that we apply to achieve these drivers. These drivers are about the techniques that could and should be used to change patients' experience. The techniques that you then apply to get that right are measurements;

you measure, preferably, what is going on at the left side of the diagram, namely how the outcome is changing, and you also measure what is on the right side, namely how reliably we are doing all of the things that we say are good practice. The techniques that we then teach are how to measure and interpret data, which are not as straightforward as they sound, and how to do root-cause analysis. That is part of the training that we provide on our collaborative days and so on.

[271] **William Graham:** In your answer, you suggested that fewer post-mortem examinations are being carried out. Are you suggesting that if more were carried out, they would demonstrate that there were more fatal embolisms?

[272] **Dr Willson:** They would give a better opportunity to know whether thrombo-embolisms are occurring; we do not know that at the moment.

[273] **William Graham:** Would you argue, therefore, that it would possibly be better to have more post-mortem examinations?

[274] **Dr Willson:** I would; they would give us knowledge that we do not currently have.

[275] **William Graham:** My next question arises from your earlier statement. I agree with what you said about mandatory risk assessments. We had substantial evidence from one party this morning that concurred with that view. I think that the thrust of your evidence is that VTE risk assessment and prevention should be pushed higher up the agenda.

[276] **Dr Willson:** That is my argument.

[277] **Mark Drakeford:** Going back to the first point that William Graham raised with you, we have heard evidence on the number of deaths thought to be caused by this condition every year. We were told that that number exceeds the combined total of deaths from breast cancer, AIDS and traffic accidents. I wish to confirm that what you are saying, Alan, is what we have heard in other evidence, namely that that figure is likely to be understated, because of the fact that it relies on post-mortem examinations to pick up the condition, and that it may not be picked up post mortem. In any case, post-mortem examinations are declining rather than increasing.

[278] **Dr Willson:** Those figures are estimates. The estimates that I have seen are fairly constant. My difficulty is that, when we then look at our observed rate of thrombosis in hospitals—I speak of my experience at Betsi Cadwaladr University Local Health Board, and I am sure that other witnesses would also describe a similar situation—if you take a 90-day period, you are able to pick up something like 10 or 20 cases of hospital-acquired thrombosis per month for a district general hospital. If you start to multiply those numbers for Wales, giving you the detected HAT rate rather than the death rate, the figure does not come anywhere near the projected thrombosis rate for the population. That seems to indicate that there is a silent population that experiences this risk.

1.15 p.m.

[279] **Elin Jones:** I have two questions. Earlier you said that, in developing your work programme, you would look to prioritise maternity care, because there was a large group of women and that there is also medical consensus. Your timeline runs up to 29 May 2012. I was wondering what you are going to do after 29 May 2012 and whether you have any plans to look at an area where there does not seem to be that much medical consensus, such as orthopaedics, and repeating the kind of work that you have done with maternity with the orthopaedic sector.

[280] In your opening remarks you also said that, in England, they have reached a performance level of 90% risk assessments but that you were not convinced that that necessarily related to significant improvement for patient outcomes. Will you expand on what you meant in that analysis?

[281] **Dr Willson:** I will start with your second question. My point is that we have learned how difficult it is to change patients' experience. It is not just about filling in forms. If we declared tomorrow that it was a sacking issue for all chief executives if they did not achieve 90% risk assessment forms, I know, with some certainty, that, pretty quickly, we would have 90% risk assessment form completion. That would not, in itself, have changed the views of the orthopaedic surgeons you heard from this morning, and it would not necessarily connect to a change in process within hospitals. It would give us a result, and England is to be congratulated that they have an aggregated figure for a change in behaviour for the whole country, but much more important is to know that patients are actually at less risk from thrombosis. Therefore, if we are to mandate something, it should be a combination of four things. First is that risk assessment should be in place; secondly, that appropriate thromboprophylaxis is in place; thirdly, that there is a measurement of HAT rate using the method that was introduced by Betsi Cadwaladr University Local Health Board; and fourthly, that there should be root-cause analysis. As a result of the work that we have done, we are not very far away from being able to describe that, should the Welsh Government want to take that on. That would then have the benefit of raising this whole issue in the political agenda, but it would be a more intelligent way than just looking to change one part of the process.

[282] With regard to where we go after maternity, unfortunately, although I am a director of something, I do not get a completely free hand in what we turn our attention to. Our role is to implement things where the evidence is clear. We are not evidence getters; we are there to support the service in implementing something. The reason why maternity is so appropriate is that we know that that evidence exists. The lack of consensus around some of this may dictate how the other priorities are set for us.

[283] **Elin Jones:** So the NICE guidance, in itself, is not enough, in terms of consensus or guidance, for you to have confidence that you could move to the orthopaedic area.

[284] **Dr Willson:** Taking the maternity service as an example, there is the so-called green-top guidance, which was produced by the Royal College of Obstetricians and Gynaecologists, and it was very clear in the way that it assessed evidence and set out guidance. However, we did not simply go about implementing that. We set up a consensus group that drew very widely from all of the relevant professions across Wales. We asked them to consider that guidance and anything else that was relevant on how we should apply it in Wales. That is where our how-to guide comes from. It differs in some respects from the green-top guidance from the Royal College of Obstetricians and Gynaecologists, but we are now not having any discussion with that group about whether we are doing the right thing.

[285] **Rebecca Evans:** I wish to take you back to your comments that deaths due to pulmonary embolisms might be under-reported due to the lack of post-mortem examinations. I apologise if this is an ignorant question but, presumably, you have to give a cause of death, so what is masking potential deaths due to PE?

[286] **Dr Willson:** This is not my specialist area, but I understand from public health colleagues that the certification of death may not be an entirely accurate practice. It may not be very clear at the time of death precisely what the cause was. So, other diagnoses will be put instead of PE. It may not be knowable to the practitioner that the actual cause of the patient's death was thrombosis.

[287] **Rebecca Evans:** So, something like a heart attack, perhaps, might end up on the form

instead.

[288] **Dr Willson:** Exactly.

[289] **Vaughan Gething:** I will just return to the subject that Elin was dealing with. You will have heard the evidence presented this morning, I assume. We had a pretty sharp contrast between the Royal College of Physicians and Professor Hunt, who helped to devise the NICE guidance, and the very honest evidence that we heard from Dr Andrew Davies about the position of orthopaedic surgeons. It was striking to note that, in one sense, the professor was saying that she wanted an education campaign among the medical profession, essentially to persuade them that the NICE guidance is right, so telling them to get on with it and comply. Dr Davies was essentially saying that, until they are persuaded, many of his colleagues will not comply. I am interested in how you get there. On the one hand, Professor Hunt says that they need more education, and the orthopaedic surgeons are essentially saying the same thing but from a very different perspective, by saying, 'We do not believe you', to put it crudely. I am interested in where you go next. Do you see a role in trying to bridge that gap? If the guidance is not real in one sector of the profession, and regarding the points that you make about needing to drive this up the agenda, it does not matter if orthopaedic surgeons are still saying, 'We do not believe you, so we are not doing it'.

[290] **Dr Willson:** That is a very clear statement of the difficulty. I did not hear all of the evidence this morning, but I am not surprised at all by how you summarised it. We are a small resource and we cannot change a mindset that has developed over people's careers and a whole professional ethos. However, we can do better in terms of outcome measurement, because outcome measures are pretty difficult to argue with. If they are there, there is a problem and we need to address it. We can also support medical education, which we are doing, in terms of making sure that improvement methodology, which is specifically about relating outcome to process and how you do that, is incorporated in the medical syllabus, the nursing syllabus, the pharmacy syllabus and the therapy syllabus. We are doing that.

[291] The other way is to increase our experience of success and change. Where we are establishing changes in practice, we make that very apparent. We publicise the achievements that we have in Wales. As we move through the maternity work, we will publicise that. So, it is a matter of trying to change the climate of safety, risk and how we address those things. I also fervently hope that the change in Welsh health structures will help us to build towards that, because we now have responsibility for a whole population. I think that the public health expertise about what the population risk is and what contributes to that, will also start to change the dialogue.

[292] **Lindsay Whittle:** Achieving an all-Wales hospital-acquired thrombosis rate is one of the short-term ambitions and we have heard evidence today that we could be the first country in the world to achieve that. That is a short-term ambition, but what is the long-term ambition? Is it to continue reassessing patients who have left care and may be susceptible to developing thrombosis?

[293] **Dr Willson:** The long-term ambition—and it is a depressingly long-term ambition because these changes take time—is to have that HAT rate, to know what the rate is, and to know that it has come down to an acceptable, unavoidable minimum. We know that none of these interventions will abolish hospital-acquired thrombosis. We know that because we have stable processes. To give you an example, one of the early pieces of work we did in Wales was to set about reducing infections in our intensive care units. Those infections are caused by having long venous access lines, as well as in the lungs. We have world-class outcome data for infections in ICUs. We have stopped measuring whether we are doing the process correctly, because we know that we are getting it right and that it has become part of the way that life is conducted in ICUs. That is a huge achievement—arguably, it is a much simpler

situation in our ICUs because it is a much more confined population. That is the long-term ambition for all of this work. It is about sustainable change. If we simply incentivise a quick, simple change of behaviour and do not think about how that will become sustainable across the system, we will not have achieved anything.

[294] **Kirsty Williams:** I have a practical question. There has been a lot of debate today about whether one of the reasons why orthopaedic surgeons are so resistant is because they do not see patients who go on to develop thrombosis. It was not entirely clear from the answers that we had this morning that an orthopaedic surgeon would even be aware if a patient had died. They would not necessarily be aware of whether a patient had subsequently died, or have a huge amount of time to be interested. What is the process of feeding back? Is it hit and miss, or is there a proper process to let doctors know what has happened to their patients in another aspect of medicine?

[295] **Dr Willson:** As a general point, our information systems do not do that well. We separate episodes, and audits often exclude extraneous factors, so a comparison of orthopaedic performance will seek to exclude external factors. Excellent work is going on with the orthopaedic specialty in Wales right now, whereby we are engaging patients in enhanced recovery after surgery, which is an extended pathway to ensure that the work up to the procedure and following it is understood, measured and managed properly. There have been some stunning changes in practice as a result. It would be wrong to give the impression that orthopaedic surgeons are against change in some way. That is not my experience at all. It is about giving them the appropriate tools and information so that they can take command.

[296] **Kirsty Williams:** I do not think that the witness we saw this morning was being particularly recalcitrant. He obviously felt strongly that his view was right. He was not doing it out of a sense of cussedness—he believed that what they were doing was right.

1.30 p.m.

[297] **Lindsay Whittle:** I did not get the impression that the orthopaedic surgeon who gave evidence this morning would not know that his patients had died. He indicated, it seemed to me, that the initial operation that a surgeon would carry out would almost be the surgeon's first contact with the patient, but that there would then be continual contact with the patient over a period of six months, two years or almost five years. So, with respect, I think that a surgeon probably would have guessed in that period that a patient would have died. Therefore, Kirsty, I did not get the same impression as you, I am sorry to say.

[298] **Mark Drakeford:** To be fair, I do not think that he said that surgeons would not know, necessarily, but rather that the extent to which this impacted on what they did would be much less than it would be for someone who was turning up at the out-patient clinic and complaining about something else.

[299] **Kirsty Williams:** It is understandable. As we have just heard, the systems are not particularly geared up to do that. I am not blaming him personally; I am making a point about the system. That is why I asked the question.

[300] **Dr Willson:** This is a characteristic of the way in which we organise—if that is the right word—our health services. Two weeks ago, there was a report led by Nottingham University that looked at the safety of primary care prescribing. It merely repeated evidence that we have seen over many years. The problem is that, often, the harm that stems from prescribing is seen in a different place to where the prescribing is first done and where the benefits are being measured.

[301] **Elin Jones:** My question is on a similar point. I am trying to understand this analysis

of outcomes better. This morning, the orthopaedic representative certainly said that his fellow consultants would be informed by outcomes. I think that there was some difference in interpretation regarding how those outcomes are currently assessed. However, based on your work in trying to put together a systematic framework for that analysis of outcomes—and I am thinking about the orthopaedic area in particular—how would those outcomes be assessed? Are we talking about outcomes that are six months post operation, or three months post operation? Also, I wish to return briefly to the issue of post-mortems. If there are cardiac deaths—or deaths that are reported to be cardiac deaths—that appear in that three-month, six-month or 12-month period post operation, how would anyone analyse whether there was cause and effect there in any way?

[302] **Dr Willson:** Currently, the Welsh Government is working on a set of outcome indicators for healthcare. I know that that project is ongoing. It is part of the 'Together for Health' initiative, the whole thrust of which is to move towards an outcome focus. I cannot pre-empt precisely how one would do that, and it is not my area of expertise to do so. However, what you are describing is what I would assume to be there. It would be about survival and about patient feedback. The question might be, 'Am I still content with my procedure one year, two years five years hence?' The Government is firmly committed to ensuring that this is the way in which we manage. It is probably very evident that I am signed up to giving clinicians a job that is understandable and that energises them. The better the information they have to act upon, the better their actions will be.

[303] **Mark Drakeford:** I will now ask three separate questions, Alan. Echoing some other evidence, the evidence that we received from the Royal College of Nursing says that the VTE programme in Wales got off to a very good start but has now settled into a low-key maintenance approach. Is that something that you would recognise?

[304] **Dr Willson:** I do not agree with either aspect of that statement, really. The VTE programme got off to a start. Regarding the sign-up that we had, we offered a menu of surgical alternatives in the original 1000 Lives campaign, and most organisations chose not to focus on VTE, which is disappointing. The reason they did that is understandable. If you are trying to mobilise a sensation of change and success, the best place to start is probably with something you know you can succeed with. That dictated most of the choices. The evidence you have received reporting the current situation describes a huge amount of work that is going on and that is successful. My frustration is that we need to up the ante and make it more reliable. Looking at the volume of work and energy going into this now, I do not feel that it is settling in in any way.

[305] **Mark Drakeford:** Professor Hunt was very positive about what had been achieved in England, but I think she was suggesting that there could be better ways to collect the sort of information that would be useful for the future than the mass routine collection of material. There are smarter ways of doing things. Is that reflected in the BCU methodology you talked to us about?

[306] **Dr Willson:** Yes it is. What is described is certainly an aspect of this. What I hope we could mandate across Wales is that we look at appropriate thromboprophylaxis. It does it through an audit, which I think is the right way to do it. You do not need to count every patient; you need a good, randomised way of selecting patients across the board and understanding what is happening. You also need a measure of outcome and, as we have described, a root-cause analysis.

[307] **Mark Drakeford:** Thank you. Some witnesses have suggested to us that it is important to increase the level of patient awareness of all of this because that would create an additional pressure in the system to do things better. People are now very well aware of the risk of DVT on aeroplane journeys, but patients are much less aware of the risk of this as a

hospital-acquired outcome. Do you agree with that? Would that be a useful place to put our energies?

[308] **Dr Willson:** As a principle, I am very impressed by what is achieved when patients are put in the driving seat. We have seen that being done in Sweden to an extent that we generally do not experience in Wales but—and it is a big but—it is not always appropriate. If patients are admitted as emergencies, it is hard to do. With patients who need more care and who need to hand that care to the professionals, it is up to the organisation to be in the driving seat. The evidence you had from Velindre Cancer Centre, for example, shows the very mature and sophisticated way it has assumed the risk. However, with elective patients, who do not want to be medicalised—and maternity services are a great example of that—the answer is 'yes, yes, yes, we should give that information and awareness to patients'.

[309] **Mark Drakeford:** Thank you very much. Are there any final questions? I see that there are none. There are a couple of minutes left, so if there is anything we have not touched on that we ought to have done or if you want to make sure that we take away a particular point, you have a chance to deal with it now.

[310] **Dr Willson:** No, you really have covered the points I hoped you would, so thank you very much for that.

[311] **Mark Drakeford:** Thank you.

[312] Diolch yn fawr am eich help y prynhawn yma. Thank you for your help this afternoon.

[313] Prynhawn da a chroeso i'r Pwyllgor Iechyd a Gofal Cymdeithasol. Rydym yn bwrw ymlaen i glywed gan gynrychiolwyr y byrddau iechyd. Diolch i chi am ddod. Rydym wedi derbyn papurau gan fyrddau iechyd Cwm Taf, Caerdydd a'r Fro a Hywel Dda, ond, gyda ni y prynhawn yma mae Dr Grant Robinson, cyfarwyddwr meddygol Bwrdd Iechyd Lleol Aneurin Bevan, Dr Bruce Ferguson o Fwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg, a Dr Brian Tehan o Fwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr. Croeso i chi oll. Good afternoon and welcome to the Health and Social Care Committee. We are moving on to hear from representatives of the health boards. Thank you for coming. We have received papers from Cwm Taf, Cardiff and Vale and Hywel Dda health boards, but, with us this afternoon are Dr Grant Robinson, medical director of Aneurin Bevan Local Health Board, Dr Bruce Ferguson of Abertawe Bro Morgannwg University Local Health Board, and Dr Brian Tehan of Betsi Cadwaladr University Local Health Board. Welcome to you all.

[314] We will begin as we normally do, by asking all three of you for a brief introduction to the few points that you want to ensure that we have gleaned from your evidence. We have had a chance to look at the written evidence and I thank you for that. Then, we will go to members of the committee who I know will have questions for you. Are we simply going to go down the line? Dr Robinson?

[315] **Dr Robinson:** That works very well for us if that is okay with you. The first thing we want to say is that hospital-acquired thrombosis is definitely on our agenda. We are aware of it and are working to address it. The National Institute for Health and Clinical Excellence's 1992 guidance, which is the subject of this, is a bit complicated to administer. It is worth noting at the outset that there are several different patient groups involved: there are people who come in with medical conditions; people with general surgical conditions; women who are having babies; and people who are having orthopaedic surgery. What you need to do for those groups of patients is a little different and you need to risk-assess each patient. It can be complicated to do.

[316] The good news is we have some very useful tools that have been developed in collaboration with the 1000 Lives team; you have just heard evidence from Alan Willson. Awareness of this issue is improving. It is important to say, and this came up in the evidence that the House of Commons committee took a few years ago, that we do not think that there are any major financial barriers to getting this done. However, there is more that we can do and we have some thoughts about how we can progress this work because we want to move it on. Bruce, I will hand over to you.

[317] **Dr Ferguson:** We recognise that this is a journey. We need to keep the momentum going and speed it up. It is useful to apply pressure. Significant pressure is being generated from the bottom up through the 1000 Lives work. This would be an opportune time to start to develop pressure from other quarters. In the past, the Assembly effectively generated pressure through the annual quality framework process by setting intelligent targets—particularly when the metrics have got to the point of being robust enough to support those targets. There is also an opportunity to learn lessons from how we have begun to manage control-of-infection issues. The mandatory reporting process has been a powerful tool for keeping issues on the agenda of wards and keeping that thread of information running through organisations. Perhaps mandatory reporting of deaths associated with hospital-acquired thrombosis and a root-cause analysis of each case is a way of driving pressure within organisations.

1.45 p.m.

[318] It is important that we get patients more involved somehow. My vision is very much one of the patient demanding the standard of care that they should have because they know about that standard of care. So, it is about improving patient education and perhaps starting to have those difficult conversations when the patient's expectation is driving, sometimes reluctant, clinicians in the right direction.

[319] **Dr Tehan:** We believe that measurement is important. The goal is to decrease the rate of hospital-acquired thrombosis. At present, our starting measurement is around compliance with a screening tool. However, you have to understand that it is what people see for themselves that influences them most in how they behave. Moving to a focus on outcome measures brings us closer to that. It presents to people the consequences of their actions, and that has a major effect on what they do.

[320] We must be careful in that one of the immediate consequences of thromboprophylaxis may be bleeding, which they see immediately, while thrombosis may take as long as three months to appear. Key to this is that we have adequate systems to support us, and the systems at present are in need of development. The other thing is that we would look to develop a standardised approach because doing so would allow us to compare outcomes as a spur to improvement.

[321] **Mark Drakeford:** Thank you for those opening remarks. I am looking to see who would like to begin. Kirsty?

[322] **Kirsty Williams:** There was a suggestion in our evidence session this morning that, sometimes, what the Welsh Government classes as a tier 1 priority, which it measures a board's performance by, is sometimes disconnected from what people in the service believe is really valuable to be measured. There is disconnect between what the Welsh Government is ticking people off on and what the service thinks would add value and drive change if that were being measured. You find yourselves, as both clinicians and managers, trying to straddle both those divides, so do you share that analysis that there is sometimes a lack of connection between the two?

[323] **Dr Ferguson:** There have been times when I would have probably agreed with that. However, we have gone through a change in approach in the past four to five years. I feel more confident that focusing on quality outcomes, and using those quality outcomes and the benchmarking of those outcomes, to set tier 1 priorities is taking the service in an agreed direction. I do not think that any clinician would disagree with a drive that will minimise hospital-acquired thrombosis. There might be some debate about how far you can minimise it, because there was a point in time when I might not have believed that we could abolish ventilator-associated pneumonia, which has happened by taking the right approach. So, as long as we choose the right tools and apply them in the right way that does not create the wrong outcome, we are going in the right direction.

[324] The week before last, we were at a 1000 Lives presentation on the work in England where the CQUIN approach—the commissioning for quality and innovation approach—has been used to push up risk assessments. It was an interesting piece of work to listen to, which clearly showed that risk assessments could be driven to a point at which they were happening, but where the outcome data was not supporting the fact that it was the risk assessment that was changing the outcome. There must be some combination of asking for measurements of the right thing.

[325] There are outcome measures for this area, and if we can find the tools to get those consistently, we will have some hard data at the end to say whether what we are doing is making the right difference. Risk assessments are important, but the next step is even more important. Are we sure that an evidence-based approach is taken towards that individual patient following that risk assessment? Sometimes, that means that three patients with the same risk assessment, who are having different things done to them, might need different approaches. So, your system has to accommodate that.

[326] **Dr Robinson:** I agree with what Bruce has said. The charge that the management framework is disconnected from clinicians bears some weight, but it also feels a little old. In the past, clinicians could fairly say that the management was interested in the money and in access times and not much else, but that has changed over the last few years, as Bruce said. We have seen a refreshing attempt, which has been successful to some degree, to put good-quality measures into those tier 1 priorities in the delivery framework. There is an art to doing that and getting it right and, as Bruce has said, it means that we have to have proper outcome measures in there as well as process measures. Those outcome measures can sometimes be difficult to get. They do not drop out of our IT the way that we would like them to at the moment; they require a little effort, but it is worth making that effort. The great success that we have had recently with things like stroke and Clostridium difficile infections has shown that that approach of top-down pressure by getting something in the tier 1 priorities and bottom-up support from Alan and his 1000 Lives team is a potent combination. We are confident that it is a good way to tackle these kinds of problems.

[327] **Mark Drakeford:** Should mandated action in this field be a tier 1 priority?

[328] **Dr Ferguson:** Yes, as long as it is the right action.

[329] **Mark Drakeford:** I am taking it for granted that we would have to have the right action, but if we did, should it be mandated and should it then be a tier 1 priority? I see that you are nodding.

[330] **Dr Robinson:** I think that we all feel that it would be very helpful.

[331] **Mark Drakeford:** Did you want to come in on this point, Elin?

[332] **Elin Jones:** Yes.

[333] **Mark Drakeford:** Go on then, and then I will call William.

[334] **Elin Jones:** Why does it have to be made a tier 1 priority before health boards in Wales see that the NICE guidance should be implemented for patients in Wales?

[335] **Dr Ferguson:** I would see that more as aiding us to get there quicker than us not getting there. There is no—

[336] **Elin Jones:** You should be a politician; I have no idea what that answer meant. [*Laughter*.]

[337] **Dr Ferguson:** There is an incredible amount of work at present on trying to deliver NICE 92 robustly. There are a lot of barriers, some of which have been broken down, but some still need to be exposed. The use of tier 1 priorities sometimes gets a little more organisational focus into the system. I do not think that everything can be a tier 1 priority. The NHS can only cope with a limited number of tier 1 priorities at any one time, but, in some senses, a tier 1 priority does something to accelerate the process. If none of the work had been done over the last three or four years, it would probably be the wrong time to make this a tier 1 priority. However, because the awareness exists in organisations, because tools are being developed and because there is the beginning of a consensus around how we should measure things, this is the right time for pushing even harder.

[338] **Elin Jones:** Thank you for that.

[339] **Mark Drakeford:** Do you want to add to that?

[340] **Dr Tehan:** Looking at the pressures on the health service and how we direct our activities, one of the things that we do is identify the harms within our system and we have to strategise how we address them. Having an alignment of organisational direction and dealing with those harms—in the wider sense of Wales being aligned in that direction—is of benefit. It is at a macro level, which influences down to the micro level. It is an alignment of those two tiers.

[341] **William Graham:** I have a comment here that may not be prophylactic, but it is certainly prescient from the Aneurin Bevan health board, which I will read for the record:

[342] ‘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.’

[343] Would you care to enlarge on that?

[344] **Dr Robinson:** The real-world experience is that different groups of clinicians have their own culture, and are signed up to some of these initiatives to varying degrees. There can be different reasons for that. Sometimes, the evidence is of a different quality in some areas, and sometimes it is to do with the way in which that group of clinicians works—whether they are very individualistic, or more comfortable with a collective style of decision making. Some groups of clinicians—and I guess that obstetricians would be the obvious example—have taken a corporate approach to this, have got into this work enthusiastically, and are leading it. That makes the work for Bruce, Brian and me much easier. Other groups of clinicians—and this is probably not unique either to Aneurin Bevan health board or, indeed, to Wales—can be a little harder to engage, but it is definitely worth getting into those discussions, and experience shows that, even when it can be difficult, you can generally make progress if you are trying an approach that is right. So, something like hand-washing to get infection under

control is a good example, as you might have had a few barriers to start with, but actually, taking a consistent approach has been effective at making change—and the 1000 Lives campaign team has been good at giving us the right methodologies to engage with people.

[345] **William Graham:** I also want to ask about the part-time thromboprophylaxis nurse that you employed in north Wales. How valuable was that post? I notice that the funding, which was privately funded, now looks a bit uncertain. How valuable was that resource?

[346] **Dr Tehan:** When putting together that paper, it was interesting to see that that post is of great value. There is a persistent theme that comes through in our involvement with the Institute for Healthcare Improvement and the 1000 Lives and the 1000 Lives Plus campaigns, and that is the value of leadership at all levels. This is an example of such leadership. It is a type of front-line leadership that is rather important. This is real life—trying to ensure that we have continuity of such a resource at times when there are lots of calls on our attention and finances. However, there is a determination that we will sort this out. We will sort it out.

[347] **Mark Drakeford:** Our colleague, Darren Millar, who cannot be here this afternoon, would have asked you to help us to understand why the post was funded as it was to begin with.

[348] **Dr Tehan:** It arose from an opportunity from one of the drug companies. That provided us with an easy way to start with the investment into the 1000 Lives campaign and the focus on improving, initially, the use of the screening tool for hospital-acquired thrombosis. That is how it started.

[349] **Mark Drakeford:** Presumably, the company would have an interest in making sure that its products were used in the health service.

[350] **Dr Tehan:** That is correct. It would have had an interest, but there is a balance in everything, is there not? It was of mutual benefit.

[351] **Mark Drakeford:** The evidence that we took from the Welsh Orthopaedic Society this morning suggested that, in this area, drugs are brought a little prematurely to the market, when their proven use has yet to be fully established. Is that a characteristic that you would recognise?

[352] **Dr Ferguson:** It is an interesting perspective. There is a group of drugs that is relatively new, so if somebody asked you whether as much was known about a drug such as dabigatran or rivaroxaban as there is about aspirin or warfarin, the answer would be ‘no’. However, they have been through the appropriate process of licensing and are in use. Will we learn more about them in the next 20 years? Yes.

[353] **Dr Robinson:** I was just going to make the point that the evidence that we have suggests that the chemical methods and the drug methods for preventing thrombosis in the right dose are probably broadly equivalent. Some claims are made that some work better than others, but broadly speaking—and the NICE guidance reflects this—they are equivalent. So, to some extent, the decision to use it can be a practical one based on factors such as how easy it is to give, and cost might come into it. In my experience, in my organisation it has varied from place to place, but it was sometimes easier to get people to use tablets rather than injections because they are easier to administer.

2.00 p.m.

[354] **Vaughan Gething:** My question is not on this point, but I am interested in where we get to and in moving forward. We have all been pretty struck by the clear divide in the

orthopaedic branch and the NICE guidance. The Royal College of Physicians has made a couple of fairly clear recommendations, and I am interested in your perspective on these. One was about conducting a risk assessment in accordance with NICE guidelines prior to admission or at the point of admission. The other recommendation that was of some interest was its call for what it referred to as 'intelligent targets'. It wanted a monthly sample of data with the number of patients who had had the risk assessment, the percentage of those patients who had then gone on to be assessed as potentially needing prophylaxis—we are learning how to say all these big words—and the number who then received it. So, it would not just be a case of doing a risk assessment and noting how many you had done; it would be asking what you had then done as a result of each risk assessment. I am interested in whether you would support those as recommendations that this committee could make. I am also interested to hear where you think you are in relation to that, as you have all talked about unevenness between health boards. Does that just come down to leadership and the different branches within the professions?

[355] **Dr Tehan:** We are in a position where we can demonstrate to you on a monthly basis the proportion of people for whom the screening tool has been completed and who received thromboprophylaxis. They may not be the same. There may be some individuals who have not been screened yet but who have received thromboprophylaxis. We believe that it is important—and there is a consistent theme coming through—that outcomes be seen to be important. The hospital-acquired thrombosis rate is the real issue. I would urge that the entry point should be that everyone should be screened and the outcomes are more important than measuring the thromboprophylaxis rate, because that is determined by the screening tool. So, you have to allow for that. In all this, there is a balance between the interventions that you apply to decrease the risk of thrombosis versus the risk that the individual may bleed. You have to balance that. That is, first of all, a clinical decision, but secondly, the screening tools are not so validated and robust as to be absolute about them.

[356] **Dr Ferguson:** Perhaps I could comment on that. Some of the variance is down to the way in which we are rolling out this programme. Part of the concept of the 1000 Lives campaign is to show that something works on a small scale and then roll it out throughout an organisation. So, I have parts of the organisation where I can quite clearly show through the data that are being collected that the screening tool is being used for 80%, 90% or 100% of the population that comes through on a monthly basis. Then, for the patients who are screened as high risk, I know the number of those receiving thromboprophylaxis.

[357] In some situations, individual clinicians are making a judgment. With the patient, because it is a form of informed consent, they are making a judgment on the risk of giving prophylaxis and the benefit to that patient. So, in some cases, individual decisions will be made for someone who has been through the risk assessment. The risk assessment tool tells me that a clinician, at that point in time, has made a risk assessment to do something or not to do something. You then need a process of audit and a process of outcome data to begin to see whether the right or the wrong decision was made.

[358] This is perhaps a little bit about where orthopaedics finds itself at present. Orthopaedics has some quite large databases, which are historic and which arguably do not always collect the most robust of outcome data. However, at present, if I look in the national joint registry, I can see that 55% of patients in the last three-year cycle received a low-molecular-weight heparin for prophylaxis and another group received aspirin for prophylaxis, but the joint registry cannot tell any difference between those two. I believe that it cannot tell the difference because it does not have robust outcome data. If we can generate local processes that give us robust outcome data, with the process data that we have on how the decisions are made, we can then challenge those decisions based on the outcomes that they produced. That is why it always comes back to having that robust local data. Someone might have operated on a patient three months ago, but what happened to the patient at the point at

which they were out of their care and looked after by others?

[359] **Rebecca Evans:** Returning to your opening remarks, Dr Ferguson, you suggested that there should be mandatory reporting of deaths as a result of thrombosis. However, we have also heard strong evidence this morning that these deaths are underreported because of a lack of post-mortems. I would like to hear your views on that. Do you have the capacity to undertake more post-mortems, and do you think that it would be desirable to do so?

[360] **Dr Ferguson:** That is an interesting question. At present, culturally, fewer hospital post-mortems happen, and, because of that, the outcome data that we have are sometimes based on clinical diagnosis.

[361] There is a strength in the data that we have at present, even though those data might always underrepresent. If I were in a world where I was saying that I was not going to solve this problem until I had post-mortem evidence to give me the absolute rate of pulmonary embolism, I do not think that we would ever get there. The data that we have at present and a constant post-mortem rate will probably give us a surrogate value, which will never be 100% accurate, but which itself can be used to drive this process.

[362] **Dr Robinson:** I have two points. The first is that it is important that we know as often as we can if someone has died from hospital-associated thrombosis. However, death rates are problematic as a tool in this area, and it is difficult to create them as a measure that we can use to feed back to clinical groups that we might wish to influence. If we are going on outcomes, we feel that it is helpful to focus on the thrombosis rate. The other reason for doing that is that it surely must be worth preventing the harm of an avoidable blood clot, regardless of whether it kills you. Some of the evidence based on death rates is debated, and that was reflected in the written evidence that Beverley Hunt gave to the committee.

[363] Secondly, before I became a medical director, I was a director of pathology. My view is that it would be difficult to increase post-mortem rates dramatically. I am a big fan of them. There is lots of evidence to suggest that they are extraordinarily helpful in practice. Since the events at Alder Hey, there has been a big cultural shift away from hospital post-mortems, and the capacity is problematic. In practice, most of the post-mortems that are done nowadays are coroners' post-mortems. It is unusual to find them done outside that context.

[364] **Dr Ferguson:** The reason I was suggesting the mandatory reporting and analysis of deaths is just because that is a fixed point that we already have in the system. I see that nearly as a separate process from outcome measures, because I think that it drives a certain rigour. So, when you know that someone has died from a hospital-acquired thrombosis, at one level, you could say that that is a never-event and should have been prevented. It is about trying to ensure that there is the rigour in the root-cause analysis, the questioning and the challenge to the decision making so that we begin to ask what could have been done differently.

[365] **Rebecca Evans:** Another question that has just occurred to me now is whether there are many legal cases brought against the NHS or health boards because of hospital-acquired thromboses.

[366] **Dr Robinson:** The honest answer is that we would have to go away and find that out, as we do not have it with us. If the committee wanted that information I am sure that we could arrange it. Off the top of my head, I can say that it does happen. Claims are sometimes brought because someone has had a thrombosis and the question arises of whether it was avoidable and whether the right action was taken. However, without going to look for the evidence, I would not be able to tell you what that quantified as. It happens occasionally. It is not very common, but that may reflect the fact that it is not recognised that often.

[367] **Mark Drakeford:** If that information is easily available, it would be useful to see it. We would not want you to embark on a separate piece of work just for that, but, if the information has already been collected and it is just a matter of reporting it, that would be very helpful.

[368] **Dr Robinson:** We are happy to ask.

[369] **Jenny Rathbone:** As a supplementary question to that, it is really about what happens when those investigations occur. Are those then fed back to the clinicians to reflect upon?

[370] **Dr Robinson:** The short answer is 'yes', and that really is the advantage of pursuing the line that Bruce takes on this. If we increase awareness of a death due to thrombosis that may have been precipitated by a hospital stay, that is, where there is a hospital event in the preceding three months, and you create a serious incident process around that—and I think that most of us are reasonably good at doing that now; we have processes to do that—it automatically gets reported to the Welsh Government so that it is visible to colleagues centrally, who can then collate that information. It also involves reaching out to the clinical teams involved. So, the consultant who may have been responsible for the hospital stay would automatically know about it, because they or their team would be a part of that process. So, it provides some loop-closing.

[371] One of the things that we discussed was how practicable that is to do for all thrombosis. It is probably not practicable for all thrombosis, but we would like to think that we would do it for deaths, for sure.

[372] **Lindsay Whittle:** As professionals representing the health board, are you happy that patients are kept mobile in hospital? Is there a case for more physiotherapists? I guess that it is easier to wheel a commode to a patient and then draw a curtain around the bed, as opposed to having two nurses using the limited mobility of that patient and walking him or her down a long corridor to use the loo. Is there a case for that? Would it help in relation to HAT? I do not know.

[373] **Dr Robinson:** The short answer is 'yes'. One of the other programmes that we are involved in with the 1000 Lives team is something called 'enhanced recovery after surgery'. It has come as a fairly recent revelation to healthcare services that we are keeping people in hospital too long after they have had an operation—we are not mobilising them quickly enough. For instance, if you have your hip done, it may have been normal as recently as last year or the year before for you to have stayed in bed for a day or two afterwards, when, in fact, with good pain control, we can probably have you on your feet the same day. There are people who are pushing this forward at the moment, and, of course, physiotherapy is a really important part of that. So, that is another strand of work that we are pursuing. In general, I think that it is an excellent question, and we would all agree that there is room to get people mobilised more rapidly than we have done in the past. Is that fair, Bruce?

[374] **Dr Ferguson:** It is. It will be interesting to see how the ERAS project works for orthopaedics. We now have cohorts of patients who are up within two hours of surgery for knee or hip replacements—they are mobile that day and walking to the toilet, and they are out of hospital the next day. That compares with the patient of five or 10 years ago, who would have been in bed for a week and not allowed to move in case it destabilised their hip. The risks for patients today are quite different, and it will be interesting to see how the ERAS approach of ensuring that the patient is hydrated and dealing with a lot of the risk factors around thrombosis in the perioperative period affects orthopaedics.

[375] **Dr Tehan:** I would just add that the general thrust of surgery in particular has been

towards coming in on the day of admission and shorter lengths of stay—that is one aspect. There has been a relative surge in the day-case rates. The other aspect is around preoperative fasting guidelines. People are being hydrated more aggressively, with clear fluids given up to two hours before surgery. All those things contribute to removing some of the risk.

[376] **Mark Drakeford:** Thank you. I will go to Kirsty next, then to Rebecca.

[377] **Kirsty Williams:** Something that continually surprises members of the committee, as laypeople, is that a lot of time, effort and resource is spent on developing NICE guidelines, which are sent out and then routinely—or so it seems to us sometimes, on this committee—not complied with. Your paper seems to suggest that the responsibility for auditing compliance with NICE guidance is predominantly at a very local level—at a ward level or within a certain discipline. The evidence that we had from Professor Hunt this morning, as a practising clinician, was that she is answerable to her clinical governance committee for her compliance with NICE guidelines. If she does not comply, she has to answer to that committee. Also, if somebody in her service is not doing what NICE says should be done, she said that she has a responsibility to report that person. How do your clinical governance arrangements, at board level, work with regard to compliance with NICE guidelines?

2.15 p.m.

[378] **Dr Robinson:** They probably vary a bit from health board to health board—that is the short answer. Audit against an approach has been helpfully clarified recently by the Welsh Government. It has produced a list of audits for us to do—Bruce has been involved in that work—and some of that is auditing against the kind of territory that NICE covers. So, there is a more consistent approach now, which is being led centrally, which helps.

[379] The other thing that I want to say is that some of the NICE guidance is complicated, so it is not easy to implement. Other brands are available across the United Kingdom. In Scotland, people will follow guidance from the Scottish Intercollegiate Guidelines Network. With the SIGN guidelines, it can sometimes be a little easier to see how you would implement them, whereas the NICE ones sometimes require a little bit of thought and a bit of local tweaking to get them working. I think that I would put hospital-associated thrombosis guidance in that category. I am sure that the committee will have looked at that guidance, and there is quite a lot of it, it varies for different groups, you have to get a risk assessment tool in place, and so on and so forth. So, the kind of work that the 1000 Lives campaign has done around a complicated area such as that to make it more doable is a great help to us in trying to implement it. Other NICE guidance is much more straightforward, and the kind of approach that Beverley advocates—adopt or justify—is very relevant in that kind of situation.

[380] **Dr Ferguson:** Part of the thing with guidelines is that the test is whether you are following the guideline or doing something better. The NICE guidelines are quite complicated, and there are some areas where there is a lot of conflicting information. There has been a very interesting debate in the *BMJ* on the benefit or risk of blanket thromboprophylaxis in acute medical patients. There is also the debate that we have already heard about in orthopaedics. Parts of the processes in the guidelines can be easy to put in. However, other parts of the guidelines depend on judgments being made, and sometimes the issue is getting to the core of those judgments. Quite often, however, you cannot make absolute judgments with individual patients. The advice that I give to my clinicians is that you have to adopt the guidelines—the technology appraised in the guidelines—or justify why you have not done so.

[381] **Dr Tehan:** There is a standard position across the health boards in that we all look to apply and police the guidance, recognising that there is not just NICE guidance; National Patient Safety Agency guidance and other guidance also descends upon us. We have learned

over the years that things imposed from on high do not necessarily work. They often require local tweaking, or there may be reasons why a certain aspect of the guidance is not appropriate in the context that applies to you. That is something that the organisations will manage. As we have already said, the approach is that you should apply the guidance, unless you can argue otherwise and provide evidence for that.

[382] **Kirsty Williams:** The three of you are saying that a top-down approach does not work and it does not win hearts and minds, and the 1000 Lives Plus campaign has said that it has learned that just saying 'do it' does not make people go out and do it. We have also heard today that this has to be made a tier 1 priority, and that that downward pressure would make things move a little faster. If we as a committee were to recommend that mandatory risk assessment, with the appropriate treatment to follow, should be made a tier 1 priority, and that there should be a great deal of emphasis put on root-cause analysis at the other end of the process, would you as medical directors just groan, 'Oh, another set of stuff that we have to deal with', or would you say, 'Yes, this is exactly what we need to drive this forward in our organisations'?

[383] **Dr Tehan:** It is pulling from two directions. A purely top-down approach does not work, but if there is alignment, then it is very powerful.

[384] **Elin Jones:** We should note that the witnesses are all nodding. [*Laughter*.]

[385] **Mark Drakeford:** Yes. It is on the record now.

[386] **Rebecca Evans:** I was really pleased to hear you talk earlier about the importance of leadership at all levels. How do you square that with the evidence we have had from the Royal College of Nursing, which says that:

[387] '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.'?

[388] To show leadership, the nurses would need to have the appropriate training.

[389] **Mark Drakeford:** I see that there are no volunteers to go first on this. [*Laughter*.] You have the default position, Dr Robinson.

[390] **Dr Robinson:** The short answer is that everyone knows that there is some financial pressure on the system. It would be disingenuous to pretend otherwise. At the same time, however, I am certainly not aware of any moratorium on training. Quite the opposite; we would encourage it.

[391] **Mr Tehan:** In relation to our health board, at least, I think that that may refer to the period towards the end of the financial year. One of the actions we took was to suspend training for the last three months of that financial year. However, you have to recognise, as we do, that it is a short-term manoeuvre, and leadership is about the medium to long term. We do recognise that.

[392] **Mark Drakeford:** Dr Tehan, our last witness referred to the development of a HAT rate measurement in Wales under Betsi Cadwaladr health board methodology.

[393] **Dr Tehan:** Thanks. [*Laughter*.]

[394] **Mark Drakeford:** Is there anything that you can share with us on that we would understand?

[395] **Dr Tehan:** You have probably picked up already that the starting premise on this is: what we are we trying to achieve? The line we took was that we are trying to decrease our rate, but where was that rate? When we looked at our systems, we found that there was no easy way to identify those who had had a hospital-acquired thrombosis. Several of my colleagues who have a particular interest in informatics and are medically-based then sought to quiz our system. What we identified is that, if somebody has a hospital-acquired thrombosis, it is usually within three months of the hospital stay, that is, within 84 or 85 days. The problem is, given the turnover in the system, those people do not generally fall back into the care of the clinician of origin. That is a big problem. What we found is happening is that general practitioners would identify it in the community and refer in to our DVT clinic.

[396] So, we have identified that we have a common pathway. We did not assume that that common pathway would incorporate all, but we started off there—maybe it is as near as damn it. It is not just about the clinical diagnosis from the symptomatology and signs that you have DVT or a pulmonary embolus, however; you have to confirm it. You have to clinch it with radiology, and the two things in radiology are ultrasonography of the lower limbs or CTPA. Those are the routes. So, we followed the patients through from the DVT clinic and we quizzed the radiology system to see whether those individuals were diagnosed as having a confirmed hospital-acquired thrombosis. That is the route that we have taken.

[397] We have also quizzed in the opposite direction. We have looked at all the patients who have been diagnosed with a hospital-acquired thrombosis on the radiology systems to check whether one matched the other. That seems to have worked out. The other bit that we fed into our data is information from post-mortems of patients in which there is a diagnosis of pulmonary embolus. It is a bit labour-intensive, and it has to be done monthly; I would argue that I need people around me who are fat, intelligent and lazy, because they will come up with a system that will do it automatically. That is part of the problem; the front-line work is about caring for the patient and anything else on top of that is considered to be additional and takes staff away from direct care. The system needs to be monitoring in the background. Staff can then look over their shoulders and say that this is how they are doing; that is what we aspire to do. At the moment, you could consider it to be labour intensive; we are not there yet on this matter. However, at least we have figures on the chart. We do not know where we ought to be, although it is something that we have discussed. We have a rate; I do not know how good it ought to be, but I suppose that starting from the principles put across to us by 1000 Lives, you start where you start and you look to reduce the rate from there. Talking among ourselves, we found that we have different rates. That does not much matter; what matters is that the trajectory is downward, so that whatever we are doing is improving things. We do not believe that we will get to zero, but we will head in that direction.

[398] **Dr Robinson:** The rate will reflect the patients. You will see in its evidence that Velindre hospital has quite a high rate of around three per 100 people, but that is entirely predictable because it begins with so many people with cancer. For a big health board, it looks as though the rate is somewhere between one and five per 1,000 people. I do not think that any of us has a good enough feel for the data to know for sure at the moment whether we should all be down around that level or below it.

[399] **Dr Ferguson:** One of the challenges is trying to pick a system of measurement that gives us a good enough figure but is also simple. One of the challenges that Brian has not really talked about is the fact that the radiology system is not a coded system. With the radiology system Radis, you enter diagnoses as typed codes. We have adopted the approach used by Betsi Cadwaladr University Local Health Board and we have an information technology programme looking at the radiology system to pluck out the patients for whom the terms ‘pulmonary embolism’ and ‘deep-vein thrombosis’ have been used in diagnosis. We have linked that to the patient administration system to ask whether those patients were in

hospital for the last twelve weeks. This, again, gives us a rate. It is a slightly different rate to Brian's rate—it might be produced for slightly less effort.

[400] **Mark Drakeford:** Is it fair to say that, as this work matures, we are at least on the journey towards being able to have a hospital rate, a board rate and, ultimately, a rate for Wales? That is not a completely distant prospect, is it?

[401] **Dr Ferguson:** No, and I would hope that a specialty rate would be available, which means that you can then have the interesting conversations.

[402] **Dr Robinson:** I cannot leave without making the point that if we were able to beef up the informatics—information systems for healthcare in Wales are centrally managed—it would be enormously helpful in speeding up that process. As Brian has said, some of this is quite labour intensive.

[403] **Kirsty Williams:** On cross-border issues, some Welsh patients receiving their treatment in English hospitals could come back to their communities and end up in a Welsh hospital receiving treatment for DVT. Is the number of such cases so small that it is immaterial? If we are talking about radiology systems talking to each other, then there may be a cohort of patients in completely different hospitals let alone in different episodes of care.

[404] **Dr Tehan:** I could not be assured at the moment that we would not exclude those patients. Our focus is the hospital-acquired thrombosis that we are responsible for, whatever the cause.

[405] **Mark Drakeford:** Thank you all for that interesting session. If it is easy for you to do so, you have agreed to provide some follow-up information to Rebecca's question. If there are points that we have not managed to cover in this session, or points that you think have not come through as strongly as they ought, we would be grateful if you could draw our attention to them; there may not be any, and we may have done everything that we needed to do. When you reflect on the session, you may think that you did not have a chance to mention something, but there is still an opportunity to do so by dropping us a note to alert the committee to those points.

2.30 p.m.

[406] Awn ymlaen at ein sesiwn olaf am heddiw a chroesawu cynrychiolwyr Llywodraeth Cymru. Croesawaf Dr Chris Jones, cyfarwyddwr meddygol GIG Cymru, a Grant Duncan, dirprwy gyfarwyddwr gwella ansawdd, safonau a diogelwch. Rydym eisoes wedi clywed gan dystion eraill ar y pwnc hwn. Felly, dechreuaf drwy ofyn a oes gennych ddatganiad agoriadol byr i'w wneud i'n helpu. Byddwn wedyn yn troi at gwestiynau'r Aelodau.

We will move on to our final session for today and welcome representatives of the Welsh Government. I welcome Dr Chris Jones, medical director of NHS Wales and Grant Duncan, deputy director of quality, standards and safety improvement. We have already heard from other witnesses on this subject. So, I start by asking whether you have a brief opening statement to make in order to help us. We will then turn to Members' questions.

[407] That is the normal drill, Chris, so you will be used to it, even if the headsets are not working. Do you have any opening points to make? We will then go straight to Members' questions.

[408] **Dr Jones:** Thank you for inviting us to give evidence. We welcome your interest in this topic. There is clear evidence to support the use of appropriate thromboprophylaxis to avoid hospital-acquired thromboses. There is no doubt in the evidence; I do not think that

anyone contests the evidence that with appropriate thromboprophylaxis, which could take various forms, we could probably reduce the incidence by 50% to 60%, but I do not think that we would ever eradicate it.

[409] We have been aware of that for several years. There has been quite a strong story of engagement across Wales in the challenge, but, clearly, as you have heard today no doubt, there is more to do. The story from my perspective is that we have known about this for some years. In January 2009, I was the first chair of the thromboprophylaxis and anticoagulation committee at Abertawe Bro Morgannwg University NHS Trust, as was, where the importance of thromboprophylaxis was reflected not only in the name of the committee, but in the work that we did. We saw that as a major challenge. That was before the most recent NICE guidance that reaffirmed the need for this work.

[410] From an all-Wales perspective, the 1000 Lives campaign has been an important factor in that. I should indicate that I am also here as co-chair of the 1000 Lives Plus national programme. I hope that you appreciate that it is a Government-led programme—it is not independent of Government as it may appear from the submission. The reducing surgical complications work stream from the 1000 Lives campaign between 2008 and 2010 included a commitment to appropriate thromboprophylaxis to reduce the rate of thrombosis. That work achieved some traction. It used what we regard as the right approach, which is improvement methodology based on engagement, helping colleagues understand the evidence and helping colleagues feel that they wanted to do this work. It also provided a driver diagram with various measures for local measurements of success and performance.

[411] After that period of time, we then felt that it should be core business. Indeed, in the autumn of 2010, it was one of the measures on the annual operating framework, which was the list of measures or targets at that time that the NHS chief executive used to performance-manage the NHS in Wales. So, it was part of that and was intended to be mandated at that time as core business. That was in late 2010.

[412] We realised last year that despite that, we did not have quite the focus on the topic that we might have had. I asked for an update last August. That showed us that we did not know on an all-Wales basis exactly how we were doing. At that time, I got reports from each of the health boards about their progress, and those were similar to the reports that you have heard today. As a result of that, we have decided to re-establish the thromboprophylaxis collaborative through the 1000 Lives Plus national programme. That is now back in place to wind up the focus on the area through the use of improvement methodology in local clinical services. So, it is an area where there has been quite a lot of attention. There has been some success, and some of that success is reflected in the commitments that you have seen described by the health boards and trusts. I recognise that it is not perfect and there is more to be done.

[413] **Mark Drakeford:** I will look around to see who wants to lead off. We will start with Kirsty.

[414] **Kirsty Williams:** Your paper says that it examines the implementation of the NICE guidance, but it does not really go on to say whether you are satisfied that NICE guidance is being implemented. The fact that you have now said that you have re-established the collective indicates to me, therefore, that you are not satisfied that NICE guidance is being enacted. We have heard today of reasons why, and the reasons are complex and many. I am wondering what approaches, apart from re-establishing the collective, the Welsh Government will take to ensure that implementation according to NICE guidance is more uniform. You also say that you have made this a core business—did you say that?

[415] **Dr Jones:** That was our expectation.

[416] **Kirsty Williams:** Yet, we have heard today that we need to make it a tier 1 priority. Unless it becomes a tier 1 priority, it will not receive the corporate attention that it needs. Could you say whether you have given any consideration to making it a tier 1 priority and why you think that making it a core business measurement has not provided the impetus needed to see the changes that, no doubt, you would like?

[417] **Dr Jones:** I am aware of the feeling that the Welsh Government should somehow mandate this, and there are various things to say. First, as you have heard today, clinicians do not generally do what they are told to do unless they believe that that is what they should be doing. So, the top-down approach does not resonate for clinicians. Also, I do not think that they understand what tier 1 is—it is a performance framework, in a sense, between the executive teams. So, I do not think that that would have great relevance to front-line clinicians. Even if it was a tier 1 measure, it would not alter in any way the nature of the work that had to be done, which is the local and engagement work with colleagues within clinical services. The challenge is in the local measurement. I do not think that it will alter the issues of, 'Why are you not doing this and don't you think that you should?', or 'Why is he doing it when you're not', and so on.

[418] It is mandated in a sense, because it has been previously in the annual operating framework, and it has been a part of the 1000 Lives campaign, and now that 1000 Lives Plus national programme. So, the Welsh Government expects this. There is an issue then about where the mandate should come. I do not see why the health boards do not regard it as a mandatory action. They should, in my view, have it as a mandatory action. If it was a tier 1 measure, how would that work? As I said, I do not think that it will resonate with the clinicians particularly. It may focus the minds of executive teams, but that raises a question about why they need a tier 1 measure to focus their minds, why they are not already there and why it is not already mandated within health boards and trusts.

[419] **Kirsty Williams:** I take your point, and we have had the discussion this morning about why it requires something to be tier 1 before people actually do what is clearly the expectation of them. We have heard today from clinicians on the front line that they want it to be a tier 1 priority. That is exactly what they want. We have just had three medical directors before us and all three of them said that they want it to be a tier 1 priority as they see that as the only way they would be able to apply the top-down pressure, in conjunction with the bottom-up pressure from 1000 Lives Plus, to really make a change. For us, it is quite startling to have you come in to say that that is absolutely what we do not need and that it is not helpful. Why is there such a disparity between your view and the view of three medical directors who have just sat before us as well as the view of eminent medics who have sat here today and said, 'Please, this is exactly what we need you to do'? How can there be such a mismatch?

[420] **Dr Jones:** I do not think I dismissed it out of hand in the way you just described—

[421] **Kirsty Williams:** I think you did.

[422] **Dr Jones:** The tier 1 measures are for the chief executive of the NHS to decide on. I do not think the number of measures that David Sissling expects to use is huge. It could be a tier 1 measure. We also have another approach planned. Last week, we published the quality delivery plan, and part of that commits the NHS in Wales, working over the next few months, to produce a set of quality metrics, which will have to be reported to the public and to the boards, but also to Welsh Government. One would certainly expect this to be one of those quality metrics. That will be a quality-driven process that, to some extent, will run in parallel with the tier 1 delivery framework. It is a means of getting consistent measurement and monitoring in all organisations. I anticipate that that is something that will happen. Of course,

there is an issue about exactly what measure you would want to put in there. Assessment is the easiest thing to measure, but we know that assessment does not always deliver the outcomes we imagine it should.

[423] The week before last, we ran a 1000 Lives Plus day on the business case for quality and heard a very compelling presentation from an exemplar site in Plymouth in England. It achieved very high levels of assessment and was measuring its hospital-acquired thrombosis rates, but it did not demonstrate a change in them. I do not understand quite why that would be, but that was the fact and it probably reflects the complexity of the situation. However, it will be a quality metric for the NHS in Wales when these are all resolved in the autumn. I think that, if you recommended that it should be a tier 1 principle, that would be something for the chief executive to consider.

[424] **Kirsty Williams:** Have you discussed the appropriateness of this being a tier 1 measure with the individual medical directors from the boards? Have you, as the medical director for the NHS for the whole of Wales, had a conversation with your medical director counterparts on the boards?

[425] **Dr Jones:** I cannot recall one.

[426] **Kirsty Williams:** Okay, thank you.

[427] **Mark Drakeford:** Vaughan, I think you wanted to ask something on this. Then I will go to William.

[428] **Vaughan Gething:** When you talk about recommending that 'it' should be a tier 1 principle, to be clear, are we talking about the NICE guidance and that guidance being accurately and consistently implemented? We have heard very clear evidence that it has not been. There has been acknowledgement by a whole range of people that it has not been consistently implemented, so I just want to be clear about that. I do not understand what the quality metrics are. It does not mean anything to me, so I would be really grateful if you could explain what that means and how that would change or drive clinical practice, because we have definitely heard that, in clinical practice, there are real barriers in some of the professions. The orthopaedists got it in the neck, but they are the ones who have been here telling us that, essentially, they do not believe in the NICE guidance, do not think it is appropriate and will therefore not follow it. Perhaps I am deliberately oversimplifying it, but there is a clear problem there.

[429] **Dr Jones:** It is not for me to decide what a tier 1 principle is. Many of my colleagues would want many different measures to be tier 1 measures, and it is for the chief executive of the NHS to consider which should be included. This is one of very many strands of NICE guidance that are mandated; we have a statutory responsibility to deliver NICE recommendations. This is just one of very many. A quality metric is simply a measure of an aspect of quality of care. By producing a set of quality metrics for the NHS as a whole, we will be asking all organisations to monitor those measures, publish them and report them to the boards. We will then see a consistent set of measures across NHS Wales relating to the quality of care.

[430] **Vaughan Gething:** I wish to go back to the point you made earlier about a presentation on a part of England where they have done the risk assessment. I am thinking about the outcome shifting in terms of the level of hospital-acquired thrombosis. When the quality metric is brought in, will it be about both elements, that is, not just whether you are doing the risk assessment, but what its effect might be? One of the recommendations of the Royal College of Physicians was that there should be a monthly sample in relation to compliance in terms of risk assessments, but also outcomes on the level of prophylaxis—the

treatment of people considered to be at risk. Will that be part of the quality metric?

2.45 p.m.

[431] **Dr Jones:** The details of these measures are to be resolved in collaboration between the Welsh Government and colleagues in the NHS. The assessment is the easiest thing to measure, but, in itself, it is simply a process, which is of no particular relevance if it is not followed by appropriate thromboprophylaxis.

[432] **Vaughan Gething:** I understand that.

[433] **Dr Jones:** That is quite a controversial area, as you will have heard. A lot of clinicians in certain specialties do not all agree about what is appropriate thromboprophylaxis and when it is appropriately used. So, we could try to agree some kind of measure there. However, I think that you also heard from the medical directors of the difficulties in measuring consistently the hospital-acquired thrombosis rate. So, to compare those measures across organisations would be troublesome. As one of my colleagues mentioned to you, it makes sense to look at a measure locally and then improve it. The area of measures poses some difficulties, but we want to look at that area, because it should be part of the quality metrics measures.

[434] **Mark Drakeford:** Before I turn to William Graham, I have a point to put to you. You are of course right, Chris, that any number of things could be made tier 1 responsibilities, but the case that we have heard as a committee is that, compared with many other things that the health service could decide to, this is a serious problem that causes many deaths—hospital-acquired thrombosis leads to death in a large number of cases—and we know that something can be done about it in many cases, so what we now need to do is to ensure that what can be done is done. It is not just that it is one of many things that could be done. The first witness we heard from said that, in a ranking exercise of all of the things that could be done to make a health gain, this came out as No. 1 out of 68 different possible things that the health service could decide to prioritise. Do you share the view that there is a sense of urgency about tackling this problem, or is it just one of quite a long list of things in which the health service could decide to take an interest?

[435] **Dr Jones:** It is one of a long list of things. Over the past year or so, all medical directors have been reviewing all deaths in hospitals in Wales. The purpose of that review is to engage all clinicians in a whole-system conversation about quality of care. I am not aware that thromboprophylaxis has been a prominent issue for learning, out of the deaths that have occurred in NHS Wales over the past year. That is surprising, because if the situation is as bad as you have heard, then I would have thought that it would be very prominent—

[436] **Mark Drakeford:** Sorry to hog this conversation, but it depends on what you are measuring, because what we have heard a lot is that the deaths that occur from HAT do not occur in hospital; they occur 85 days later out in primary care and are underreported because of the way that the system operates. So, very often, that information does not make it back to what I think the last witness called the ‘clinician of origin’. So, maybe the reason that it does not emerge as a priority is because we are not looking in the right place for it.

[437] **Kirsty Williams:** We have also had a discussion today that putting something into tier 1 potentially means that something else cannot be a tier 1 priority. I made the assumption that Ministers did not simply pluck issues out of the air and that there was reasoning behind their being tier 1 priorities. You said that that is a matter for the chief executive. Did I understand correctly that you said that you do not have a role in deciding tier 1 priorities? As the Medical Director for Wales, is it really the case that you have no role in deciding and advising the Minister on what a tier 1 priority should be? We have heard that, in the past

couple of years, there has been an improvement in making those tier 1 priorities not about money and simple waiting times, but about quality. People were quite cheered up about that, but now you are telling us, 'It's got nothing to do with me, guv; that's David Sissling and the Minister'. It is quite worrying that you, as Medical Director, have no say in what should be prioritised.

[438] **Mark Drakeford:** Could you explain your part in that?

[439] **Dr Jones:** The tier 1 principles were established just over a year ago and we made a strong representation that tier 1 principles should reflect as many of the different dimensions of quality as possible. Of course, the finances, the efficiency and the timeliness of care are all quality measures. So, we have measures that I would call quality measures, which relate to setting the direction, community care or care that is closer to home and hospital-acquired infections being reported. However, all of my other colleagues in the executive team would have their priorities; maybe my workforce colleague would like some more measures in relation to workforce development, but I do not know. In the end, the chief executive has to resolve all this in conversation with the Minister. However, there is no doubt in my mind that thromboprophylaxis would not appear out of place as a tier 1 principle.

[440] **William Graham:** I share the thanks for your presentation, particularly on the risk factors for VTE and for bleeding, which helps somewhat with the dichotomy that we heard about this morning. May I ask for your opinion on the call for a national HAT rate and the involvement of the Welsh Government in that?

[441] **Dr Jones:** At one level, it would be highly desirable, because we have a publicly affirmed commitment to measuring the outcomes of care and what really matters to people. On that basis, it would be very desirable. We have not required it at present, because, I suppose, we have not required every organisation to report to us their hospital-acquired thrombosis rates. However, that would come about as a result of the quality measures that I have described. This is difficult territory, as I think that you heard earlier. My experience when I was trying to implement this in ABM nearly three years ago was that it is complex, because people turn up in different places, in different circumstances and in different geographical locations. The diagnosis of thrombosis is made by different means, for some, it is post mortem, and we do not routinely get all that fed back into the system. There are different types of scans in different organisations, all of which produce the final measure. In terms of our commitment to outcomes, it would be helpful to know.

[442] **William Graham:** Quite differently, on financial incentives for trusts in England, they demonstrate that they have risk assessed 90% of their admissions. Do you think that that would have a place in Wales?

[443] **Dr Jones:** There are already, in the way that the NHS in Wales works, strong financial drivers to improve the quality of care. There is no doubt that if you avoid the complications and side-effects of hospital care or treatment and if you reduce harm, you will reduce the cost to the NHS. For me, there is a powerful business case around that. We have been emphasising this very much in conversations and meetings with colleagues in the NHS. A Team Wales event in February at which all the executive teams got together for a day was about the business case for quality. The 1000 Lives Plus national learning event that was held about 10 days ago was also about the business case for quality. In that meeting, we had a presentation about thromboprophylaxis.

[444] **Elin Jones:** The point that I was going to raise has been covered, but I was thinking before you came in that we were getting somewhere as a committee, and you have completely thrown where I was, which is probably, you will think, a good thing, although I am not quite so sure. I am a bit demoralised by some of the things that have been said. We heard this

morning that, even though NICE guidance exists, a part of the clinical profession does not agree with it and will not implement it. We have heard you say that it does not matter what you say, clinicians will decide what they want to do or whether they will do something or not. I am slightly demoralised, thinking about all the changes that may be needed in the NHS, that we have clinicians out there who are not doing what management or the Government want them to do and are not even doing what NICE guidance tells them to do or thinks is best to do clinically.

[445] You said that part of the way to persuade clinicians who were reluctant in any area was to look at local challenges and outcomes, and I guess that the quality measures that you have talked about would be one way of providing robust information for clinicians at a local level, and then in a standardised form at national level, for that challenge to be met almost by osmosis. We have heard quite a bit of evidence about outcomes in this area, and I would be keen to make sure that what we have heard from the health boards and clinicians so far on outcomes, on root-cause analysis and all that work, will be related to these quality matrix measures that you are developing now, and will provide that local challenge that you referred to earlier.

[446] **Dr Jones:** I do not want to give you the impression that I do not recognise an important leadership role here for everyone. There is no doubt that leadership is required, and, generally, change has to result from a combination of the right balance between a top-down approach, focused on activity, and a more bottom-up approach through which services actually change. There is a strong leadership role for the Welsh Government, as there is for the executive directors of all the health boards. However, in truth, I think that that is best exercised through mechanisms such as the 1000 Lives Plus campaign, which takes the approach of engaging people to get out there, helping, supporting and challenging. The quality measures will help because, for a whole organisation to report a quality measure, a lot of measures from within that organisation will need to be aggregated, so I anticipate that each clinical unit, or possibly each ward, I suppose, would be asked for its performance on thromboprophylaxis. All that would then have to be brought together in the aggregate for the reporting of the whole organisation. That is the way to do it because, you can go to a ward and see the charts outside demonstrating how long it has been since a patient on the ward had a pressure ulcer or a case of Clostridium difficile, and the staff take pride in that. There is also a certain degree of competitive peer pressure, and that is what drives change. That is what I would expect to be happening in health wards now.

[447] **Elin Jones:** Some of the evidence that we have had has been about outcomes, but the outcome for the patient in this respect could be happening three weeks or six months down the line, and could be not on the ward or anywhere related to the original surgery. Would your quality measures look at the pathway of the patient, or would it just be hospital based?

[448] **Dr Jones:** It is difficult because some of the outcomes also will even be years down the line. My understanding is that most of the trials that demonstrate the benefits of thromboprophylaxis include asymptomatic thrombus as well, so large numbers of patients are scanned until you find evidence of thrombosis and reduce that incidence. That is not apparent as an outcome at the time, but it may be many years later, with leg ulceration and oedema. So, the outcome issue is a difficult one. We would want to get as close to it as we can, and that would require a whole-system approach. There are practical challenges in that.

[449] **Mark Drakeford:** There is one question from me and then I will look around to see whether there are any final questions from anyone else. So far, we have talked about mandation in relation to assessment and then making sure that there is a decision about treatment. However, we have also heard a suggestion that there should be mandation in relation to the reporting of every death that is attributed to this cause, with a root-cause analysis then carried out of each of those reported deaths. Do you think that that would be

useful?

[450] **Dr Jones:** The process that I described is not dissimilar from that at present. You indicated why it is flawed, and I suppose that it is partly for the reason that you described, which is that deaths can be delayed, so you miss them, but also because only a tiny proportion of the overall burden of thrombosis will result in death. There is a question about whether every organisation should be asking clinicians to undertake a root-cause analysis for every case of hospital-acquired thrombosis, because that would then include the post-operative DVT that is recognisable clinically. There would be some value in that, but, once again, it is a question of making the best use of resources, because it is very time consuming to do a full root-cause analysis.

3.00 p.m.

[451] **Mark Drakeford:** The suggestion to us was that to do it in every case would be too big an undertaking, but you could start by doing it for every death from this cause.

[452] **Dr Jones:** We are almost there now, because the medical directors have mechanisms in place to review every death in the health boards at present. That does include, for some of them, deaths in the community.

[453] **Mark Drakeford:** Are there any final questions? I see that there are not. Therefore, I think that we have probably come to the end of this session. We have a moment if there are any final thoughts that you would like to leave with us, or have we covered everything that we ought to have covered?

[454] **Dr Jones:** I just want to thank you for the opportunity to come here. The conversations that we have engaged in on top-down versus bottom-up models are important on many fronts.

[455] **Mark Drakeford:** Diolch yn fawr i chi. Dyna ddiwedd ein sesiynau cymryd tystiolaeth.

Mark Drakeford: Thank you very much. That marks the end of our evidence-taking sessions.

3.01 p.m.

Papurau i'w Nodi
Papers to Note

[456] **Mark Drakeford:** Dim ond un papur sydd i'w nodi, sef cofnodion cyfarfod 2 Mai. A yw pawb yn hapus gyda'r cofnodion? Gwelaf eich bod.

Mark Drakeford: There is only one paper to note, namely the minutes of the meeting on 2 May. Is everyone happy with the minutes? I see that you are.

3.02 p.m.

Cynnig o dan Reol Sefydlog 17.42(vi) i Benderfynu Eithrio'r Cyhoedd o'r Cyfarfod ar gyfer Eitem 7
Motion under Standing Order 17.42(vi) to Resolve to Exclude the Public from the Meeting for Item 7

[457] **Mark Drakeford:** Mae gennym chwarter awr i drafod y dystiolaeth yr ydym wedi ei chlywed heddiw. Byddwn yn mynd i

Mark Drakeford: We have a quarter of an hour to discuss the evidence that we have heard today, and we will go into a private

sesiwn breifat i wneud hynny. Cynigiaf fod

y pwyllgor yn penderfynu eithrio'r cyhoedd o'r cyfarfod am y drafodaeth am eitemau 5 a 6, a hynny yn unol â Rheol Sefydlog Rhif 17.42(vi).

session to do that. I move that

the committee resolves to exclude the public from the meeting for the consideration of items 5 and 6 in accordance with Standing Order No. 17.42(vi).

[458] Gwelaf fod yr Aelodau i gyd yn gytûn.

I see that all the Members are in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 3.02 p.m.
The public part of the meeting ended at 3.02 p.m.