The All-Party Parliamentary Thrombosis Group

"Thrombosis: Awareness, Assessment, Management and Prevention"

THIRD ANNUAL AUDIT OF ACUTE NHS HOSPITAL TRUSTS

November 2009

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ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

November 2009

Dear Colleague,

Welcome to the third annual report of the All-Party Parliamentary Thrombosis Group (APPTG). Here we present the findings of our 2009 survey, which measured the uptake of the Chief Medical Officer's (CMO) recommendations and NICE Clinical Guideline 46 into the prevention of venous thromboembolism (VTE) in hospitalised patients.

In its 2005 report, the Health Select Committee identified that hospital acquired VTE causes 25,000 avoidable deaths a year and is estimated to account for 10% of hospital mortality[1]. In addition to increasing patient safety, VTE prevention delivers demonstrable efficiency savings. Most recently, it was included as one of NICE's top ten most efficient interventions.[2] In the current economic climate, delivering cost saving services while maintaining quality is essential. VTE prevention delivers significant cost savings by reducing costly hospital readmission and lifelong morbidity, while simultaneously increasing the quality of patient care. It is therefore in the interests of both patients and the NHS alike that best practice recommendations are fully and consistently implemented.

Last year, the APPTG was encouraged by the marked improvement of Acute Trusts in developing mandatory risk assessment policies for all hospital inpatients. Within a year of our first survey in 2007, when only one third of Trusts had a policy of risk assessing all inpatients[3], two thirds of Trusts stated this was their policy in last year's survey[4]. This was a considerable and welcome improvement. However, the current lack of an agreed central audit means we are unable to measure the exact extent to which these protocols and best practice are delivered on a ward level.

This was highlighted by the multinational 'ENDORSE' study, published in February 2008, which measured the consistency of risk assessment and subsequent thromboprophylaxis for at-risk patients. The results identified that recommended preventative treatment was only prescribed to 50% of patients identified as being at-risk[5].

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[1] House of Commons Health Committee (2004-05) *The Prevention of Venous Thromboembolism in Hospitalised Patients* (HC 99) p7

[2] NICE, 2009 *Cost Saving Guidance* [online] Available at http://www.nice.org.uk/usingguidance/benefitsofimplementation/costsavingguidance.jsp

[3] All-Party Parliamentary Thrombosis Group (2008) *Second Annual Audit of Acute NHS Hospital Trusts* p9

[4] All-Party Parliamentary Thrombosis Group (2007) *An Annual Audit of Acute NHS Hospital Trusts* p9

[5] Cohen et al (2009) Venous Thromboembolism risk and prophylaxis in acute hospital care (ENDORSE study): a multinational cross-sectional study *The Lancet* 371 (9610)

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The APPTG is therefore concerned that while most Trusts have VTE prevention policies for all inpatients in place, barriers still exist within Trusts which ultimately lead to inconsistent implementation of these procedures at the ward level.

This year's survey therefore attempts to ascertain the level of consistent application of Trust-wide VTE policies, examining also the challenges that Trusts are facing in implementing these. We will communicate these messages, which call for further support and a centrally driven mandate, as necessary steps towards achieving the National VTE Prevention Strategy goal of risk assessment of every inpatient, to the Department of Health.

We have enjoyed a great deal of support from the Department of Health this year in further prioritising VTE prevention. We have welcomed best practice support, including the publication of the VTE best practice resource during our joint event in London this June. In addition, we have been delighted with support for prioritising VTE from the Minister for Health, Ann Keen MP; the CMO, Sir Liam Donaldson; the NHS Chief Executive, David Nicholson; the Care Quality Commission; and the recent assurance that VTE prevention would appear in the 2010 National Operating Framework as a priority for the NHS by Phil Hope MP, Minister for Health[6].

The APPTG is grateful to all Acute NHS Hospital Trusts who have responded to the survey. We are confident our impressive response rate – over 90% – presents an accurate portrayal of the protocols Trusts have in place to reduce the risk of VTE. However, until we have in place a clearly defined system of centralised audit that measures the uptake of VTE prevention initiatives, we will continue to be unable to gauge the true scale of best practice implementation.

Our resolve remains to campaign for every patient to be secure in the knowledge that everything is being done to prevent a blood clot during their stay in hospital. A Parliamentary Question answered by the National Statistician on 5 May this year informed us that the number of recorded deaths from pulmonary embolism alone ranged from 16,000 to 19,000 in each year between 2003 and 2007[7]. Due to the often clinically silent nature of VTE, coupled with the low rate of post mortem examinations being carried out in the UK, we know this number represents just the tip of the iceberg. With the vast size of this problem, coupled with the repeated calls for central government mandation for VTE prevention by the medical and patient community, we are confident our campaign calls remain justified.

We hope the results provide the impetus for continued political, professional and public prioritisation of hospital acquired VTE, a condition that is still resulting in needless and avoidable deaths of thousands of patients each year.

John Smith MP
Chairman, All-Party Parliamentary Thrombosis Group

[6] HC Deb, 291660 ,12 October 2009, c767W
[7] HC Deb 271404, 5 May 2009, c80W

Executive summary

- **94%** of Acute NHS Trusts responded (154 of 164 Trusts).
- **100%** of Trusts are aware of the CMO and NICE Surgical Guideline. **88%** are aware of forthcoming NICE Guidance on VTE prevention, expected in early 2010.
- **94%** of Trusts have in place multidisciplinary thrombosis committees.
- **87%** of Trusts indicated their Boards were already involved with VTE prevention or were developing processes to become involved.
- **85%** of Trusts undertake a documented risk assessment for VTE of all hospital inpatients.
- **24%** of Trusts routinely reassess patients for their risk of VTE.
- **41%** of Trusts were able to provide audit data for documented risk assessments and patients who received appropriate thromboprophylaxis.
- **95%** of Trusts educate their staff on prescribing appropriate thromboprophylaxis.
- **24%** of Trusts do not deliver information to any patients on discharge. **15%** of Trusts do not deliver information to any patients on admission.
- Only a **very small minority** of Trusts were able to provide accurate data on patients developing VTE whilst in hospital, and patients readmitted with VTE following an elective hospital admission.
- **77%** of Trusts called for mandatory risk assessment and thromboprophylaxis targets to be set by government.

Comparison with last year's survey results

There have been some distinct improvements from last year's findings: the majority of Trusts now have protocols in place requiring all inpatients to be risk assessed; almost all Trusts have multidisciplinary VTE committees; and the majority of Trusts have indicated that their Board has some involvement with VTE management. VTE prevention has clearly increased in significance as a hospital-wide patient safety issue.

However, there are key areas that demonstrate limited improvement from last year. Less than a quarter of Trusts routinely reassess patients for their risk of VTE, while the number of Trusts able to provide audit data on the ward-level implementation of VTE protocols continues to be worryingly low.

The results indicate that the focus now needs to turn to implementing VTE best practice. This is reflected in the two strongest calls made by Trusts for government action: mandatory risk assessment and thromboprophylaxis targets, and centralised funding for mandatory education and specialist thromboprophylaxis nurses.

Results

John Smith MP, chairman of the APPTG, wrote to 164 Acute and Specialist NHS Hospital Trusts[8] in August 2009 asking them to complete the VTE survey under the provisions of the Freedom of Information Act. This placed all Trusts under a legal obligation to complete the survey within 20 working days from receipt. We enjoyed a 94% response rate, receiving completed responses from 154 Trusts. Those Trusts that did not respond have been referred to the Information Commissioner.

A small number of Trusts stated that due to time or resource constraints, they were unable to answer some questions requiring numerical data. Where Trusts have not provided a response, they have been coded as 'did not respond' (DNR) throughout the report.

We believe the impressive response rate presents an accurate perception of the extent of Trust awareness and adoption of best practice. We are also confident that we have presented a full account of the challenges faced, and the support required by NHS Hospital Trusts in implementing CMO and NICE Guidance. However, we are aware that a broad survey at Trust level, such as this, will never capture an accurate real-time representation of action at the ward level.

[8] All Trusts with inpatient procedures were targeted

Awareness

1a. Is your NHS Trust aware of the Chief Medical Officer's (CMO) recommendation on the prevention of VTE that all adult patients undergo risk assessment with appropriate prophylaxis?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	154	100
NO	0	0
DNR	0	0

1b. Is your NHS Trust aware of the NICE Clinical Guideline 46: Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in inpatients undergoing surgery published on 19 April 2007?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	154	100
NO	0	0
DNR	0	0

1c. Is your NHS Trust aware of the Department of Health VTE risk assessment tool published on 19 September 2008?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	154	100
NO	0	0
DNR	0	0

As expected, all Trusts are aware of both the CMO's recommendations on the prevention of VTE in hospitalised patients and NICE Guideline 46 on reducing DVT in surgical patients, both published in April 2007. In addition all Trusts are aware of the Department of Health's risk assessment tool, commended for use by the CMO in a 'Dear Colleague' letter in September 2008[9].

[9] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_088222

1d. Is your NHS Trust aware of the WHO surgical safety checklist, adapted for England and Wales, published on 29 January 2009?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	149	97
NO	5	3
DNR	0	0

1e. Is your NHS Trust aware of the draft NICE Guideline on reducing the risk of VTE in patients admitted to hospital, due to be published in early 2010?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	135	88
NO	19	12
DNR	0	0

Almost all Trusts were aware of the WHO surgical safety checklist, which was adapted for England and Wales and identifies VTE prophylaxis as a core action before a surgical intervention. Similarly, most are aware of the forthcoming NICE Guideline on reducing the risk of VTE in patients admitted to hospital. Indeed, some Trusts noted they were looking forward to receiving complete guidelines for both medical and surgical patients in order to bolster their current policies.

2. **Who in your NHS Trust is responsible for ensuring your clinical staff are made aware of these recommendations and guidelines?**

All Trusts were able to state the individual responsible for ensuring clinical staff are made aware of recommendations and guidelines. The majority were named as Trust Medical Directors (43%), Chairs of the VTE Committee (17%), or Consultant Haematologists (14%). In other instances, clinical governance leads, patient safety managers, and Directors of Nursing were also given this responsibility.

3. Does your NHS Trust have a formal written VTE prevention policy(s) or protocol?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	144	94
NO	10	6
DNR	0	0

While 94% of Trusts have a written VTE policy in place, a very small minority still do not. Surprisingly, this figure shows no improvement on last year's findings, despite over two years having elapsed since best practice guidance was released and all Trusts stating they are aware of this. Only two of the ten Trusts without a formal policy in place indicated they had policies in development or would soon be developing them.

Crucially, as later answers will indicate, the extent to which these protocols incorporate best practice guidance, whether or not they are compulsory, and how consistently they are applied, still varies significantly from Trust to Trust.

4. Is your Trust aware of the VTE Exemplar Network as a source of best practice?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	131	85
NO	22	14
DNR	1	1

We are pleased that almost 90% of Trusts are now aware of the VTE Exemplar Centre Network, based at King's College Hospital, as a source of best practice. However, no indication was requested nor given on the extent to which Trusts access materials from the Network, or seek to improve their VTE policies in applying for 'exemplar status'.

Managing VTE risk

5. **Does your Trust have in place a multi-disciplinary thrombosis committee/team responsible for the management of patients with VTE in line with the CMO and NICE recommendations?**

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	145	94
NO	8	5
DNR	1	1

The APPTG is very pleased that 95% of Trusts have in place multidisciplinary thrombosis committees and teams. Moreover, of the eight Trusts without a committee and/or team, three indicated they are in the process of convening one. We would expect this degree of conformity after the Health Select Committee in 2005 identified the introduction of committees and teams in each hospital to be their "most important recommendation"[10].

6a. **If YES, please indicate which staff members are involved in the committee/team:**

All Trusts indicated that, at the very least, the committees comprised of various doctors with nurses and/or pharmacists, along with a member of the clinical governance/risk management/patient safety team. Some Trusts also stated members of their Board and PCT representatives were members of the committee.

6b. **If YES, how often does the committee/team regularly meet?**

There is significant variation in the frequency with which committees and teams meet. Three Trusts stated their teams meet on a weekly basis, while eight indicated their committees meet every six months. The modal responses were quarterly meetings (31%) and bimonthly meetings (23%).

A number of Trusts noted the usefulness of committees in promoting best practice and in carrying out audits. One comment recognised the need for committee meetings to be ongoing for exactly this purpose, while another stated meetings would be more frequent but schedule constraints prevented this.

[10] House of Commons Health Committee (2004-05) The Prevention of Venous Thromboembolism in Hospitalised Patients (HC 99) p3

6c. If your Trust does NOT have a thrombosis committee/team in place, please indicate why:

Of the five Trusts that did not have committees and were not in the process of convening one, three noted that time and schedule constraints prevented the formation of committees and teams. In addition to time constraints, one Trust also identified a lack of internal VTE leadership resulting in little movement on the ground. Only two Trusts of all 154 respondents believed there was no need for a committee, stating that their current committee structures were able to respond adequately to the challenges of VTE prevention and management.

7. Please indicate how your Trust's Board is involved in VTE prevention and management:

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
% OF PATIENTS RISK ASSESSED FEATURES IN QUALITY DASHBOARD	30	19
% PATIENTS PRESCRIBED PROPHYLAXIS FEATURES IN QUALITY DASHBOARD	24	15
SAFETY WALK ROUNDS	57	37
ROOT CAUSE ANALYSIS	44	29
NONE	18	12
OTHER	66	43
DNR	2	1

The APPTG was delighted that, in total, 87% of Trusts indicated their Boards were either already involved with VTE prevention, or were in the process of developing one of the listed methods. A number of Trusts identified additional methods of Board involvement, including:

- Using VTE prevention in the Commissioning for Quality and Innovation (CQUIN) payment framework;
- Regular updates on audits reported back to Board members;
- Trust Quality Dashboard including the numbers of VTE developed post discharge;
- A member of the Board sitting on the Trust's Thrombosis Committee;
- Using VTE prevention as part of the Trust's Quality Account statement.

The NHS Confederation has flagged VTE prevention as being of significant relevance to Trust Boards, by emphasising its fundamental importance to patient safety and quality as well as its cost-effectiveness.

> " There is a strong quality and financial imperative for hospitals to prioritise VTE prevention. "
>
> The NHS Confederation, May 2009[11]

The APPTG believes the support of Trust management can have significant impact, by ensuring that implementation support and resources prioritise VTE prevention.

The level of Board involvement demonstrates that physicians are now well aware of the scale, consequences and manageability of the problem, which the CMO identified was lacking in 2007.

[11] The NHS Confederation (2009) 'Reducing Deaths from Blood Clots in Hospitals: The Role of Hospital Boards' Available at http://www.nhsconfed.org/Publications/Documents/Brieifing_183_Reducing_deaths_from_blood_clots_in_hospitals.pdf

Risk assessment for thrombo-prophylaxis

8. **Does your Trust undertake a documented mandatory risk assessment of all hospital inpatients in line with CMO and NICE recommendations?**

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
ALL HOSPITAL INPATIENTS	131	85
HIGH RISK SURGICAL PATIENTS ONLY	17	11
HIGH RISK MEDICAL PATIENTS ONLY	19	12
NONE	2	1
DNR	2	1

The APPTG is delighted that 85% of Trusts have indicated that they are undertaking a documented mandatory risk assessment for all hospitalised patients, either using an individualised opt in or group specific opt out approach. This is in line with both the CMO's April 2007 recommendations and NICE Clinical Guideline 46.

This result demonstrates a year-on-year improvement since the APPTG began its annual survey. In 2007, one third of Trusts were risk assessing all hospital inpatients[12]. This jumped to two thirds of Trusts in last year's survey[13]. We are greatly encouraged to see this increase again.

9. **If you answered no to any of the groups mentioned in question 8, what do you see as the perceived difficulties of undertaking a documented mandatory risk assessment of every hospital inpatient?**

Of the 15% of Trusts not risk assessing all hospital inpatients, the majority identified staff training as the greatest impediment to implementing risk assessment. This was closely followed by a combination of a lack of staff training and clinical leadership, with many Trusts highlighting the positive impact a thromboprophylaxis nurse could make in implementing the policy.

[12] All-Party Parliamentary Thrombosis Group (2008) Second Annual Audit of Acute NHS Hospital Trusts p9
[13] All-Party Parliamentary Thrombosis Group (2007) An Annual Audit of Acute NHS Hospital Trusts p9

10. Who is responsible for risk assessing hospitalised patients in your Trust?

The majority of Trusts (58%) indicated that risk assessment is the responsibility of both doctors and nurses. 39% of Trusts indicated that only doctors risk assess for VTE, while only 3% stated this is solely the responsibility of nurses.

While some Trusts indicated that doctors and nurses would undertake risk assessments in different situations, a number elaborated further on the division of roles: nurses can play a key role in risk assessing, doctors then prescribe appropriate prophylaxis, nurses then complete the process by administering the prophylaxis. In later statements, where staffing and time issues have been identified as barriers to change, specially trained thromboprophylaxis nurses and expansion of DVT nurse teams have been identified as a key investment/requirement to deliver a more efficient and effective process.

11. Does your Trust utilise an electronic risk assessment tool?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	16	10
NO	138	90

Only a very small proportion of Trusts are using an electronic risk assessment tool; the vast majority carry out paper form assessments. It is not surprising that so few Trusts use an electronic tool. Without such a tool being nationally available, it falls on Trusts themselves to develop their own.

An electronic tool can deliver a number of benefits, including time efficiency, prescription calculation and decision support, and accessible patient information. In recognition of this, the Clinical Safety Team at NHS Connecting for Health is currently developing a national VTE risk assessment tool. Working with the Chief Medical Officer's VTE Implementation Working Group and other partners, the tool is expected to be ready in the near future.

12. Does your Trust routinely reassess hospitalised patients for their risk of VTE (e.g. within 48 hours)?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	37	24
NO	115	75
DNR	2	1

Worryingly, less than a quarter of Trusts are routinely reassessing inpatients for their VTE risk. The CMO emphasises the need for routine reassessment, noting that a patient's risk profile can change during an in-hospital stay.

Some Trusts commented that while they were aware of the need to reassess patients, they would be unable to focus on this policy until the initial policy of risk assessing all inpatients has been realised.

> " It is recommended that all patients are periodically reassessed during inpatient stay as risk may change. Reassessment after at least 48 to 72 hours is recommended."
>
> DH Risk Assessment Tool, September 2008[14]

[14] Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088216.pdf

Method and audit of thrombo-prophylaxis

13a. Does your Trust use any of the following methods of thromboprophylaxis in surgical patients?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
PHARMACOLOGICAL PROPHYLAXIS	153	99
INTERMITTENT PNEUMATIC COMPRESSION DEVICES	139	90
ANTI-EMBOLISM STOCKINGS	149	97
DNR	2	1

NICE Clinical Guideline 46 clearly states that anti-embolism stockings and pharmacological prophylaxis are mandatory for at-risk patients and high-risk patients respectively[15]. It is therefore highly worrying that some Trusts indicated they do not use these. This is in breach of NICE guidance.

13b. Does your Trust use any of the following methods of thromboprophylaxis in medical patients?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
PHARMACOLOGICAL PROPHYLAXIS	148	96
INTERMITTENT PNEUMATIC COMPRESSION DEVICES	17	11
ANTI-EMBOLISM STOCKINGS	125	81
DNR	2	1

CMO recommendations (and the draft NICE Guidelines on Reducing the Risk of VTE), make clear that pharmacological thromboprophylaxis is obligatory for high risk medical patients. It is therefore incredibly concerning that 4% of Trusts are not using pharmacological prophylaxis in medical patients.

The lower usage of mechanical thromboprophylaxis is expected in medical patients, as these are not considered mandatory in best practice guidance.

[15] NICE Clinical Guideline 46:Venous thromboembolism: reducing the risk of venous thromboembolism in inpatients undergoing surgery (2007) p28

14a. Does your Trust regularly audit the uptake of risk assessment for VTE?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	111	72
NO	41	27
DNR	2	1

14b. Does your Trust regularly audit levels of prescribing of thromboprophylaxis?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	121	79
NO	31	20
DNR	2	1

A large number of Trusts do audit both the uptake of VTE risk assessment and the prescription of appropriate thromboprophylaxis for those patients identified as being at-risk. The APPTG is especially pleased to note that many Trusts audit the prescription of appropriate prophylaxis, as this places the emphasis on whether the preventative treatment was indeed administered to at-risk patients.

The audits undertaken by Trusts differ in a number of ways:

- How regularly audits are carried out – a small number of Trusts carried out weekly audits, some carried out monthly, while others carried out quarterly or annual audits;
- The breadth of the audit – some Trusts provided data from different Departments, others gave Trust-wide information;
- The number of patients on whom audits are based – the majority of Trusts stated they used a random sample of medical and surgical patients, while a handful gave a more comprehensive data set.

It is encouraging that of the Trusts not currently auditing risk assessment or patients receiving thromboprophylaxis, 26 indicated this is due to commence over the next 12 months. They stated that new guidelines are being/have been recently introduced and, following a short period of implementation, audit will begin.

Trusts that are not currently undertaking regular audits cited time and staff restraints as the reason for this.

15. **If your Trust audits the uptake of risk assessment for VTE, what percentage of patients was risk assessed on admission in each year 2008/09; 2007/08; and 2006/7?**

16. **If your Trust audits the level of VTE thromboprophylaxis, what percentage of at-risk patients were prescribed appropriate thromboprophylaxis, in each year 2008/09; 2007/08; and 2006/7?**

Despite the majority of Trusts stating they undertake audits for both the uptake of VTE risk assessment and the administration of appropriate prophylaxis, only 41% of Trusts were able to provide data on their audit results for one or more of the years requested. Those Trusts which did not supply data indicated that they were awaiting the results of audits, or due to time limitations were unable to complete the information request.

A number of Trusts called for a mandatory national audit. Not only would this overcome the time and staff restraints highlighted as a barrier to carrying out audits, it would also deliver a systematic and thus comparable audit data set. It is apparent this is not feasible in the current framework where individual Trusts carry out their own audits in individual formats.

VTE education

17a. What format does your Trust offer programmes of education/ CPD to pharmacists, medical and nursing staff and commissioners on VTE risk assessment?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
QUICK REFERENCE	41	27
ELECTRONIC	72	47
WRITTEN	77	50
STUDY / TEACHING SESSIONS	62	40
NONE	10	6
DNR	2	1

17b. What format does your Trust offer programmes of education/ CPD to pharmacists, medical and nursing staff and commissioners on thromboprophylaxis?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
QUICK REFERENCE	42	27
ELECTRONIC	73	47
WRITTEN	78	51
STUDY / TEACHING SESSIONS	64	42
NONE	3	2
DNR	4	3

The figures demonstrate that Hospital Trusts have taken clear steps to ensure relevant staff members are educated about both risk assessment procedures and appropriate thromboprophylaxis. In total, 93% of Trusts indicated they provide a form of education on risk assessment, while 95% stated they educate staff on prescribing appropriate prophylaxis.

A lack of professional awareness of VTE was highlighted by the Health Select Committee as a reason for the low levels of risk assessment in 2005[16]. The progress demonstrated by these figures has no doubt helped contribute to the improvement in risk assessment and prophylaxis rates in Trusts over the past few years.

[16] House of Commons Health Committee (2004-05) The Prevention of Venous Thromboembolism in Hospitalised Patients (HC 99) p18

18a. Is your Trust aware of the VTE Prevention Pathway from the Map of Medicine as an educational tool?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	99	64
NO	51	33
DNR	4	3

18b. Is your Trust aware of the e-VTE modules as an educational tool?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	100	65
NO	50	32
DNR	4	3

The majority of Trusts are aware of both the Map of Medicine's VTE Prevention Pathway[17], and the e-Learning for Healthcare VTE modules[18]. These are both designed to help clinicians deliver the CMO's VTE prevention policy; it is thus pleasing to see so many Trusts aware of guides available to deliver best practice. A number of Trusts indicated that they use the e-VTE modules in their educational programmes, detailed under question 17.

19. Do you offer the following patients information on the risks of VTE on admission?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
ALL HOSPITAL INPATIENTS	66	43
HIGH RISK SURGICAL PATIENTS ONLY	59	38
HIGH RISK MEDICAL PATIENTS ONLY	15	10
OUTPATIENTS	15	10
NONE	23	15
DNR	6	4

20. Do you offer the following patients information on the risks of VTE on discharge?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
ALL HOSPITAL INPATIENTS	40	26
HIGH RISK SURGICAL PATIENTS ONLY	66	43
HIGH RISK MEDICAL PATIENTS ONLY	18	12
OUTPATIENTS	9	6
NONE	37	24
DNR	9	6

[17] Available at http://www.mapofmedicine.com/
[18] Available at http://www.e-lfh.org.uk/projects/vte/index.html

The results this year demonstrate that the majority of Trusts are still not providing counselling to all hospital inpatients on the risk of VTE on admission. Even fewer Trusts are providing information to all inpatients on discharge. Only 43% offer information of VTE on admission, with 26% on discharge.

While these figures are a slight improvement on last year's, they demonstrate a failure to follow the NICE and CMO recommendation that all patients are informed on admission and discharge of the risks of VTE, the effectiveness of prophylaxis, and the implications of not using prophylaxis properly[19].

Some Trusts who do not provide information to all inpatients do target high risk surgical and/or medical patients. These Trusts identified a number of reasons for preferring to target patients at high risk only:

- Excess information can unnecessarily frighten low-risk patients;
- Restrictions on time and money resources mean information must be targeted;
- It should be the role of the Department of Health to deliver a general public awareness programme.

Furthermore, a number of Trusts stated that where information had already been given on admission, there was no need to repeat this on discharge. This may explain why more Trusts delivered no information at all on discharge (24%), than those who delivered no information on admission (15%).

However, that some Trusts are still not delivering information at all to any patients clearly compounds the lack of patient awareness of the scale and seriousness of VTE.

21. If you do offer patients information on admission and/or on discharge, what is your source of information?

Almost all Trusts indicated that the information they give (whether in verbal or written form and regardless of to whom it is aimed), is based on a number of sources and tailored by the Trust in question. Sources of information included:

- ACE: Stop the Clot;
- Lifeblood;
- NICE Guidelines;
- CMO recommendations;
- Pharmaceutical companies' leaflets.

[19] NICE Clinical Guideline 46: Venous thromboembolism: reducing the risk of venous thromboembolism in inpatients undergoing surgery (2007) p29

VTE statistics

22. **How many patients in your Trust have suffered VTE whilst a hospital in-patient and after admission, in each year 2008/09; 2007/08; and 2006/7? (ICD-10 Codes I80.1-I80.3, I80.9, I82.9, I26.0, I26.9)**

The majority of Trusts were unable to respond to this query with accuracy. Most Trusts stated this information was unavailable; some provided data for one or more years but were hesitant about accuracy; others that held the coding data explained it was difficult to distinguish between patients admitted with VTE and patients who developed a VTE diagnosis after admission – and thus provided no information. In the latter case, Trusts explained that information could only be gained by undertaking a detailed clinical audit against every set of case notes where one or more of these codes are identified.

Gathering VTE metrics thus continues to be a challenge for many Trusts and is an issue the Department of Health must address as a priority.

23. **How many patients in your trust were readmitted with VTE following an elective hospital admission in each year 2008/09; 2007/08; and 2006/7? (ICD-10 Codes I80.1-I80.3, I80.9, I82.9, I26.0, I26.9)**

As above, almost all Trusts stated that they were unable to provide this information with sufficient accuracy. Many Trusts that provided data queried its accuracy; most Trusts stated the information was unavailable, explaining coding data is unable to differentiate between readmissions due to hospital acquired VTE and patient readmissions already diagnosed with VTE.

The lack of robust VTE statistics demonstrated by both these questions emphasises the need for a national VTE admissions code. This would enable effective tracking of cases of hospital-acquired VTE at both a local and national level, while building accurate statistics on the prevalence of the condition.

This process would be aided by a specific ICD code for hospital acquired VTE, by solving the coding problems identified by Trusts.

24. Do you record instances of VTE on a venous thromboembolism registry?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
YES	32	21
NO	116	75
DNR	6	4

Only one fifth of Trusts record VTE incidents and deaths from VTE on a register. This is either within their Trust or via contribution to the VERITY database.

The fact that so few Trusts keep this record contributes to confusion over the true prevalence of VTE. Combined with the fall in the number of post mortems in recent years, VTE continues to be underreported. This concern was voiced in a number of responses, and is reflected in the calls for both a national registry and a national audit in later questions.

> " The rates of hospital acquired VTE are inaccurate. The best way to achieve accurate figures would be… via government insistence that this data needs to be collected. "
>
> Acute NHS Trust, East of England SHA

Government policy

24. What Department of Health incentives or assistance would make the risk assessment of all hospital patients more likely to be undertaken?

Response	Number of Acute Hospital Trusts	% of responding Acute Hospital Trusts
MANDATORY RISK ASSESSMENT AND PROPHYLAXIS (TARGETS)	119	77
VTE REGISTRY	51	33
TRAINING / EDUCATION	62	40
PAYMENT INCENTIVES	80	52
OTHER	28	18
DNR	6	4

Over three quarters of Trusts called for VTE risk assessment to be mandated by government, with targets set for both documented risk assessment and thromboprophylaxis. That so many Trusts called for a centrally mandated, minimum acceptable standard proves that clinicians themselves recognise that obligatory compliance is the only way to ensure consistent implementation of VTE prevention policies.

> " The single most effective strategy to improve patient safety and reduce the number of hospital acquired VTE events would be for the Department of Health to mandate VTE risk assessment. "
>
> Acute NHS Trust, South Central SHA

To ensure a mandatory VTE prevention policy is effective and does deliver results, it is essential that compliance with risk assessment and thromboprophylaxis protocols is measured. A number of Trusts highlighted the need for a national audit. This will lead to significant benefits: it will ensure Trust data is in a comparable format so yearly improvements can be tracked between and within hospitals; it will remove pressure from hospital staff already under time and staff restraints; and most importantly, it will drive compliance with mandatory policies and thus help reduce deaths from VTE.

> " The target should be appropriate thromboprophylaxis, not just risk assessment. If provision of appropriate thromboprophylaxis is made mandatory, this should drive hospitals/trusts to make this target a priority. "
>
> Acute NHS Trust, London SHA

More than 50% of Trusts believe payment incentives will drive compliance with risk assessment and thromboprophylaxis policies. The CQUIN payment system is an example which has been proven to work well in North West SHA. For this to be rolled out successfully in more Trusts, guidance is required from the Department of Health on how these processes can be implemented, and compliance monitored.

Mandatory education or training was backed by 40% of Trusts. This reflects the finding that, of the 15% of Trusts not risk assessing all inpatients, staff training was identified as the biggest barrier. Related to this, many Trusts indicated that ring fenced centralised funding for VTE prevention was essential to deliver increased resources, including staff training. The call for funding highlights that clinicians recognise that support is needed at ward level, to ensure those staff members who implement VTE prevention policies are given the support they need.

> " We require funding for appropriate resources, in particular for staff for whom this is a formal part of their role. "
>
> Acute NHS Trust, South East Coast SHA

One third of Trusts support a centralised VTE registry. Such a registry would aid the problems surrounding unclear VTE metrics, and would require a specific ICD code for hospital acquired VTE to develop consistent coding.

Finally, a large number of Trusts suggested the government should deliver a public education programme, to raise awareness of the scale and prevalence of the condition.

> " Knowledge and empowerment of patients to ask clinicians why they are not on thromboprophylaxis is critical. "
>
> Acute NHS Trust, South Central SHA

Conclusion

Two years since best practice guidance was produced by NICE and the CMO, the APPTG is delighted that the majority of Trusts surveyed in England now have policies in place to risk assess all hospitalised inpatients. We are also extremely pleased that the majority of Trust Boards have woken up to the importance of VTE, with 87% of Boards informing us they are involved with VTE management.

However, the lack of audit data which Trusts were able to produce on the level of documented risk assessment and the proportion of patients receiving appropriate thromboprophylaxis, identifies two strong areas for improvement.

An overwhelming majority of Trusts believe that mandatory risk assessment and thromboprophylaxis targets are the best way to ensure proper implementation of VTE policies. Clinicians recognise that time and resource pressures often mean that not all patients will be risk assessed for VTE, nor administered appropriate, potentially life-saving, prophylaxis. A mandatory target will prioritise VTE prevention and ensure policies are delivered at a ward level. An audit to measure compliance with these targets will be essential in tracking yearly improvements between and within hospitals.

Secondly, Trusts have been clear that centralised resources are required on the wards, especially for educating those who risk assess and administer prophylaxis, and to provide financial support for the expansion of VTE nurse teams or for the recruitment of a speciality VTE nurse.

Whilst we welcome the increasing support the Department of Health has given to prioritising VTE prevention in recent years, the challenge now becomes to secure consistent and full implementation of CMO recommendations and NICE Guidelines.

It is only once best practice becomes fully embedded within hospital Trusts, and VTE prevention is viewed as an essential standard of care by all, that we will see the true extent of patient safety and cost saving results that VTE prevention has been proven to deliver.

Further information

'Venous Thromboembolism: Reducing the Risk' – Draft NICE VTE Guideline
http://guidance.nice.org.uk/CG/Wave14/26

e-Learning for Healthcare, e-VTE resource
http://e-lfh.org.uk/projects/vte/launch/

Map of Medicine VTE Prevention Pathway
http://www.mapofmedicine.com/

'Venous Thromboembolism Prevention: A Patient Safety Priority' – DH/APPTG Resource Book
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101397.pdf

'Reducing death from blood clots in hospitals: the role of NHS Boards' – NHS Confederation briefing
http://www.nhsconfed.org/Publications/Documents/Brieifing_183_Reducing_deaths_from_blood_clots_in_hospitals.pdf

CMO Recommendation to Acute Trusts to use the VTE Implementation Working Group's VTE Risk assessment Tool
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_088222report

VTE Implementation Working Group Risk Assessment Tool
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215

'Venous thromboembolism: reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in inpatients undergoing surgery' – NICE Clinical Guideline 46
http://www.nice.org.uk/nicemedia/pdf/VTEFullGuide.pdf

CMO letter announcing the recommendations of the expert working group on the prevention of venous thromboembolism in hospitalised patients
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_073958.pdf

Report of the Independent Working Group on the prevention of venous thromboembolism in hospitalised patients
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073944

Government Response to the House of Commons Health Committee Report on the Prevention of Venous Thromboembolism in Hospitalised Patients
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4116288.pdf

House of Commons Health Committee Report on the Prevention of Venous Thromboembolism in Hospitalised Patients
http://www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/99/99.pdf

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Appendix 1: Letter and survey

ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

19 August 2009

Acute NHS Trust

Dear Medical Director

Audit into Acute NHS Hospital Trusts' Venous Thromboembolism (VTE) Policy

The All-Party Parliamentary Thrombosis Group (APPTG) is conducting its third annual audit into the awareness and uptake of best practice recommendations on the prevention of venous thromboembolism (VTE) in hospitalised patients. This aims to ascertain Acute Trust's adherence to the Chief Medical Officer's (CMO) Expert Working Group's recommendations on the prevention of hospital acquired VTE and those contained in NICE Clinical Guideline 46, both published in April 2007, as well as the Department of Health's VTE risk assessment tool published in September 2008. This audit will form part of a report to Parliament.

Whilst there has been marked improvement in recent years in the way that Acute Trusts are taking steps to prevent VTE in hospitalised patients, the APPTG was concerned that last year over one third of Trusts indicated that they were not following best practice guidelines and undertaking a documented VTE risk assessment for all hospital inpatients. It is estimated that 10% of hospital mortality can be attributed to VTE, but the majority of these deaths could be avoided with appropriate risk assessment, management and preventive treatment.

It is in the interests of both patients and the NHS that these recommendations are fully and consistently implemented. Given this, the APPTG looks forward to learning what progress has been made in the twelve months since our last audit and to continue to advise the Department of Health how it could assist universal uptake of VTE best practice guidelines.

I would be grateful if you would complete the enclosed questionnaire, under the provisions of the Freedom of Information Act, and return it to the APPTG Secretariat by Friday 2 October 2009.

You or a representative from your Trust are invited to the launch of the report which will take place at a half day conference in Parliament on the afternoon of Monday 30 November 2009. An invitation and more details of the structure of the day will follow shortly.

I thank you in advance for your support with this survey which will be invaluable to the campaign to prevent further avoidable deaths from VTE in hospital.

Yours faithfully,

John Smith MP
Chairman, All-Party Parliamentary Thrombosis Group
cc. Chief Executive

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ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

FREEDOM OF INFORMATION REQUEST

Survey into the Uptake of CMO & NICE Guidance into the Prevention of Venous Thromboembolism (VTE) in Hospitalised Patients

August 2009

Please note that the deadline for responses is Friday 2nd October 2009

Name:

Position:

NHS Trust:

Contact Number: **Email:**

An electronic copy of this survey is available on request from the All-Party Parliamentary Thrombosis Group secretariat

Please return the completed survey to the All-Party Parliamentary Thrombosis Group secretariat:

All-Party Parliamentary Thrombosis Group Secretariat
c/o Insight PA
The Garden House
6 Eccleston Place
London
SW1W 9NE

Tel: 020 7824 1867
Fax: 020 7824 1851
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ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

Awareness

1. Is your NHS Trust aware of the following?

a) The Chief Medical Officer's (CMO) recommendation on the prevention of VTE that all adult patients undergo risk assessment with appropriate prophylaxis

☐ Yes ☐ No

b) The NICE Clinical Guideline 46: *Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in inpatients undergoing surgery)* published on 19 April 2007

☐ Yes ☐ No

c) The Department of Health VTE risk-assessment tool published on 19 September 2008

☐ Yes ☐ No

d) The WHO surgical safety checklist, adapted for England and Wales, published on 29 January 2009

☐ Yes ☐ No

e) The draft NICE Guideline on reducing the risk of VTE in patients admitted to hospital, due to be published in early 2010

☐ Yes ☐ No

2. Who in your NHS Trust is responsible for ensuring your clinical staff are made aware of these recommendations and guidelines?

Name: _____

Position: _____

Contact: _____

ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

3. Does your NHS Trust have a formal written VTE prevention policy(s) or protocol?

☐ Yes ☐ No

4. Is your Trust aware of the VTE Exemplar Network as a source of best practice?

☐ Yes ☐ No

Managing VTE Risk

5. Does your Trust have in place a multi-disciplinary thrombosis committee / team responsible for the management of patients with VTE in line with the CMO and NICE recommendations?

☐ Yes ☐ No

6a. If YES, please indicate which staff members are involved in the committee / team:

☐ Doctors

☐ Nurses

☐ Pharmacists

☐ Diagnosticians

☐ Other (please specify) _____

b. If YES, how often do the committee / team regularly meet?

_____

c. If NOT, please indicate why:

☐ Lack of clinical leadership/champion within trust

☐ Lack of managerial support

☐ Time/schedule constraints

☐ Cost

☐ Other (please specify) _____

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7. Please indicate how your Trust's Board is involved in VTE prevention and management:

- ☐ The board's 'quality dashboard' features the percentage of patients risk assessed for VTE on admission to hospital
- ☐ The board's quality dashboard features the percentage of patients receiving appropriate prophylaxis when deemed at risk of VTE
- ☐ Undertake safety 'walk-rounds' to ensure that risk-assessment and prophylaxis are being routinely undertaken
- ☐ Root cause analysis routinely requested following deaths from VTE after discharge or readmission
- ☐ No involvement
- ☐ Other (please specify) _____

Risk assessment for thromboprophylaxis

8. Does your Trust undertake a documented mandatory risk assessment in line with the CMO and NICE recommendations of the following:

a) All hospital in-patients

- ☐ Yes, using an individualised opt-in approach
- ☐ Yes, using a group specific opt-out approach
- ☐ No

b) High risk surgical patients only

- ☐ Yes, using an individualised opt-in approach
- ☐ Yes, using a group specific opt-out approach
- ☐ No

c) High risk medical patients only

- ☐ Yes, using an individualised opt-in approach
- ☐ Yes, using a group specific opt-out approach
- ☐ No

d) Out-patients

- ☐ Yes, using an individualised opt-in approach
- ☐ Yes, using a group specific opt-out approach
- ☐ No

9. If you answered no to any of the groups mentioned in question 8, what do you see as the perceived difficulties of undertaking a documented mandatory risk assessment of every hospital in-patient?

- ☐ Cost
- ☐ Lack of risk-assessment tool
- ☐ Lack of clinical leadership / champion within Trust
- ☐ Staff training
- ☐ Lack of evidence base
- ☐ Other (please specify) _____

10. Who is responsible for risk assessing hospitalised patients in your Trust?

- ☐ Nurse
- ☐ Pharmacist
- ☐ Doctors
- ☐ Anaesthetists
- ☐ Other (please specify) _____

ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

11. Does your Trust utilise an electronic risk-assessment tool?

☐ Yes ☐ No

12. Does your Trust routinely re-assess hospitalised patients for their risk of VTE (e.g. within 48 hours)?

☐ Yes ☐ No

Method and Audit of Thromboprophylaxis

13. Does your Trust use any of the following methods of thromboprophylaxis?

a) Pharmacological prophylaxis

☐ Surgical ☐ Medical

b) Intermittent pneumatic compression devices

☐ Surgical ☐ Medical

c) Anti-embolism stockings

☐ Surgical ☐ Medical

d) Other (please specify) _____

14. Does your Trust regularly audit the following?

a) Uptake of risk-assessment for VTE

☐ Yes ☐ No

If your answer is no, please state why:

_____

_____

b) Levels of prescribing of thromboprophylaxis

☐ Yes ☐ No

If your answer is no, please state why:

_____

_____

15. If your Trust audits the uptake of risk assessment for VTE, what percentage of patients were risk assessed on admission, in each year below?

	2008/09
	2007/08
	2006/07

16. If your Trust audits the level of VTE thromboprophylaxis, what percentage of at-risk patients were prescribed appropriate thromboprophylaxis, in each year below?

	2008/09
	2007/08
	2006/07

ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

VTE Education

17. Does your Trust offer programmes of education / CPD to pharmacists, medical and nursing staff and commissioners?

a) Risk assessment of VTE

- ☐ Quick reference e.g. pocket card
- ☐ Electronic
- ☐ Written
- ☐ Not offered
- ☐ Other (please specify) _____

b) Thromboprophylaxis

- ☐ Quick reference e.g. pocket card
- ☐ Electronic
- ☐ Written
- ☐ Not offered
- ☐ Other (please specify) _____

If your answer is none to either of these, please state why:

_____

_____

18. Is your Trust aware of the following educational tools?

a) VTE Prevention Pathway from the Map of Medicine

☐ Yes ☐ No

b) e-VTE modules

☐ Yes ☐ No

ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

19. Do you offer the following patients information of the risks of VTE on admission:

- ☐ All hospital in-patients
- ☐ High risk surgical patients only
- ☐ High risk medical patients only
- ☐ Out-patients
- ☐ None

If you do not offer all hospital in-patients information on admission please state why:

_____

_____

20. Do you offer the following patients information of the risks of VTE on discharge:

- ☐ All hospital in-patients
- ☐ High risk surgical patients only
- ☐ High risk medical patients only
- ☐ Out-patients
- ☐ None

If you do not offer all hospital in-patients information on discharge please state why:

_____

_____

21. If you do offer patients information on admission and/or on discharge, what is your source of information?

- ☐ Trust-specific leaflet
- ☐ Lifeblood: The Thrombosis Charity
- ☐ ACE / Stop the Clot
- ☐ Other (please specify) _____

ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

VTE Statistics

22. How many patients in your Trust have suffered VTE whilst a hospital in-patient and after admission, in each year? (ICD-10 Codes I80.1-I80.3, I80.9, I82.9, I26.0, I26.9)

☐ 2008/09

☐ 2007/08

☐ 2006/07

23. How many patients in your trust were readmitted with VTE following an elective hospital admission in each year? (ICD-10 Codes I80.1-I80.3, I80.9, I82.9, I26.0, I26.9)

☐ 2008/09

☐ 2007/08

☐ 2006/07

24. Do you record instances of VTE on a venous thromboembolism registry?

☐ Yes ☐ No

ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

Government Policy

25. What Department of Health incentives or assistance would make the risk assessment of all hospital patients more likely to be undertaken?

- ☐ Mandatory risk assessment and prophylaxis / targets (inclusion in the NHS Operating Framework)
- ☐ VTE Registry
- ☐ Training / education
- ☐ Payment incentives (eg The CQUIN payment framework)
- ☐ Other (please specify) _____

Other Comments

26. Please use the space below for any other comments you wish to make:

THANK YOU

Appendix 2

Alphabetical List of Acute NHS Hospital Trusts and whether they responded to the APPTG survey

Acute Hospital Trusts	Response
Aintree University Hospitals NHS Foundation Trust	YES
Airedale NHS Trust	YES
Ashford and St Peter's Hospitals NHS Trust	YES
Barking, Havering and Redbridge Hospitals NHS Trust	YES
Barnet and Chase Farm Hospitals NHS Trust	YES
Barnsley Hospital NHS Foundation Trust	YES
Barts and The London NHS Trust	YES
Basildon and Thurrock University Hospitals NHS Foundation Trust	YES
Basingstoke and North Hampshire NHS Foundation Trust	YES
Bedford Hospital NHS Trust	YES
Birmingham Women's Health Care NHS Foundation Trust	YES
Blackpool, Fylde and Wyre Hospitals NHS Trust	YES
Bradford Teaching Hospitals NHS Foundation Trust	YES
Brighton and Sussex University Hospitals NHS Trust	YES
Buckinghamshire Hospitals NHS Trust	YES
Burton Hospitals NHS Trust	YES
Calderdale and Huddersfield NHS Foundation Trust	YES
Cambridge University Hospitals NHS Foundation Trust	YES
Central Manchester and Manchester Children's University Hospitals NHS Foundation Trust	YES
Chelsea and Westminster Hospital NHS Foundation Trust	YES
Chesterfield Royal Hospital NHS Foundation Trust	YES
City Hospitals Sunderland NHS Foundation Trust	YES
Clatterbridge Centre For Oncology NHS Foundation Trust	YES
Colchester Hospital University NHS Foundation Trust	YES
Countess Of Chester Hospital NHS Foundation Trust	YES
County Durham and Darlington NHS Foundation Trust	YES
Dartford and Gravesham NHS Trust	YES
Derby Hospitals NHS Foundation Trust	YES
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	YES
Dorset County Hospital NHS Foundation Trust	YES
Dudley Group Of Hospitals NHS Trust	YES
Ealing Hospital NHS Trust	NO
East and North Hertfordshire NHS Trust	YES
East Cheshire NHS Trust	YES
East Kent Hospitals NHS Trust	YES
East Lancashire Hospitals NHS Trust	YES
East Sussex Hospitals NHS Trust	YES
Epsom and St Helier University Hospitals NHS Trust	YES

Frimley Park Hospital NHS Foundation Trust	YES
Gateshead Health NHS Foundation Trust	YES
George Eliot Hospital NHS Trust	YES
Gloucestershire Hospitals NHS Foundation Trust	YES
Guy's and St Thomas' NHS Foundation Trust	YES
Hammersmith Hospitals NHS Trust	NO
Harrogate and District NHS Foundation Trust	YES
Heart Of England NHS Foundation Trust	YES
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	YES
Hereford Hospitals NHS Trust	YES
Hinchingbrooke Health Care NHS Trust	YES
Homerton University Hospital NHS Foundation Trust	NO
Hull and East Yorkshire Hospitals NHS Trust	YES
Imperial College Healthcare Trust	YES
Ipswich Hospital NHS Trust	YES
Isle Of Wight NHS PCT	NO
James Paget University Hospitals NHS Foundation Trust	YES
Kettering General Hospital NHS Trust	YES
King's College Hospital NHS Foundation Trust	YES
Kingston Hospital NHS Trust	YES
Lancashire Teaching Hospitals NHS Foundation Trust	YES
Leeds Teaching Hospitals NHS Trust	YES
Liverpool Heart and Chest NHS Trust	YES
Liverpool Women's NHS Foundation Trust	YES
Luton and Dunstable Hospital NHS Foundation Trust	YES
Maidstone and Tunbridge Wells NHS Trust	NO
Mayday Healthcare NHS Trust	NO
Medway NHS Trust	YES
Mid Cheshire Hospitals NHS Trust	YES
Mid Essex Hospital Services NHS Trust	YES
Mid Staffordshire General Hospitals NHS Trust	YES
Mid Yorkshire Hospitals NHS Trust	NO
Milton Keynes General Hospital NHS Trust	YES
Newcastle Upon Tyne Hospitals NHS Foundation Trust	YES
Newham University Hospital NHS Trust	YES
Norfolk and Norwich University Hospital NHS Trust	YES
North Bristol NHS Trust	YES
North Cheshire Hospitals NHS Trust	YES
North Cumbria Acute Hospitals NHS Trust	NO
North Middlesex University Hospital NHS Trust	YES
North Tees and Hartlepool NHS Trust	YES
North West London Hospitals NHS Trust	YES
Northampton General Hospital NHS Trust	YES
Northern Devon Healthcare NHS Trust	YES

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	YES
Northumbria Healthcare NHS Foundation Trust	YES
Nottingham University Hospitals NHS Trust	YES
Nuffield Orthopaedic Centre NHS Trust	YES
Oxford Radcliffe Hospitals NHS Trust	YES
Papworth Hospital NHS Foundation Trust	YES
Pennine Acute Hospitals NHS Trust	YES
Peterborough and Stamford Hospitals NHS Foundation Trust	YES
Plymouth Hospitals NHS Trust	YES
Poole Hospital NHS Trust	YES
Portsmouth Hospitals NHS Trust	YES
Queen Victoria Hospital NHS Foundation Trust	YES
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust	YES
Royal Berkshire NHS Foundation Trust	YES
Royal Bolton Hospitals NHS Trust	YES
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	YES
Royal Brompton and Harefield NHS Trust	YES
Royal Cornwall Hospitals NHS Trust	YES
Royal Devon and Exeter NHS Foundation Trust	YES
Royal Free Hampstead NHS Trust	YES
Royal Liverpool and Broadgreen University Hospitals NHS Trust	YES
Royal National Hospital For Rheumatic Diseases NHS Foundation Trust	YES
Royal National Orthopaedic Hospital NHS Trust	YES
Royal Surrey County Hospital NHS Trust	NO
Royal United Hospital Bath NHS Trust	YES
Royal West Sussex NHS Trust	NO
Salford Royal NHS Trust	YES
Salisbury NHS Foundation Trust	YES
Sandwell and West Birmingham Hospitals NHS Trust	YES
Scarborough and North East Yorkshire Health Care NHS Trust	YES
Sheffield Teaching Hospitals NHS Foundation Trust	NO
Sherwood Forest Hospitals NHS Foundation Trust	YES
South Devon Healthcare NHS Foundation Trust	YES
South London Healthcare NHS Trust	YES
South Tees Hospitals NHS Trust	YES
South Tyneside NHS Foundation Trust	NO
South Warwickshire General Hospitals NHS Trust	YES
Southampton University Hospitals NHS Trust	YES
Southend University Hospital NHS Foundation Trust	YES

Southport and Ormskirk Hospital NHS Trust	YES
St George's Healthcare NHS Trust	YES
St Helens and Knowsley Hospitals NHS Trust	YES
Stockport NHS Foundation Trust	YES
Surrey and Sussex Healthcare NHS Trust	YES
Tameside and Glossop Acute Services NHS Trust	YES
Taunton and Somerset NHS Trust	YES
The Christie Hospital NHS Foundation Trust	YES
The Hillingdon Hospital NHS Trust	YES
The Lewisham Hospital NHS Trust	YES
The Princess Alexandra Hospital NHS Trust	YES
The Queen Elizabeth Hospital King's Lynn NHS Trust	YES
The Rotherham NHS Foundation Trust	YES
The Royal Marsden NHS Foundation Trust	YES
The Royal Orthopaedic Hospital NHS Foundation Trust	YES
The Royal Wolverhampton Hospitals NHS Trust	YES
The Shrewsbury and Telford Hospital NHS Trust	YES
The Whittington Hospital NHS Trust	YES
Trafford Healthcare NHS Trust	YES
United Lincolnshire Hospitals NHS Trust	YES
University College London Hospitals NHS Foundation Trust	YES
University Hospital Birmingham NHS Foundation Trust	YES
University Hospital Of North Staffordshire NHS Trust	YES
University Hospital Of South Manchester NHS Foundation Trust	YES
University Hospitals Bristol NHS Foundation Trust	YES
University Hospitals Coventry and Warwickshire NHS Trust	YES
University Hospitals Of Leicester NHS Trust	YES
University Hospitals Of Morecambe Bay NHS Trust	YES
Walsall Hospitals NHS Trust	YES
Walton Centre For Neurology and Neurosurgery NHS Trust	YES
West Hertfordshire Hospitals NHS Trust	YES
West Middlesex University Hospital NHS Trust	YES
West Suffolk Hospitals NHS Trust	YES
Weston Area Health NHS Trust	NO
Whipps Cross University Hospital NHS Trust	YES
Winchester and Eastleigh Healthcare NHS Trust	YES
Wirral University Teaching Hospital NHS Foundation Trust	YES
Worcestershire Acute Hospitals NHS Trust	YES
Wrightington, Wigan and Leigh NHS Trust	YES
Yeovil District Hospital NHS Foundation Trust	YES
York Hospitals NHS Foundation Trust	YES

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APPTG SECRETARIAT AND FUNDING

This report was undertaken by the APPTG secretariat in consultation with Lifeblood: The Thrombosis Charity.

Insight Public Affairs is employed by sanofi-aventis, Bayer Schering Pharma and Boehringer Ingelheim to provide the secretariat for the APPTG.