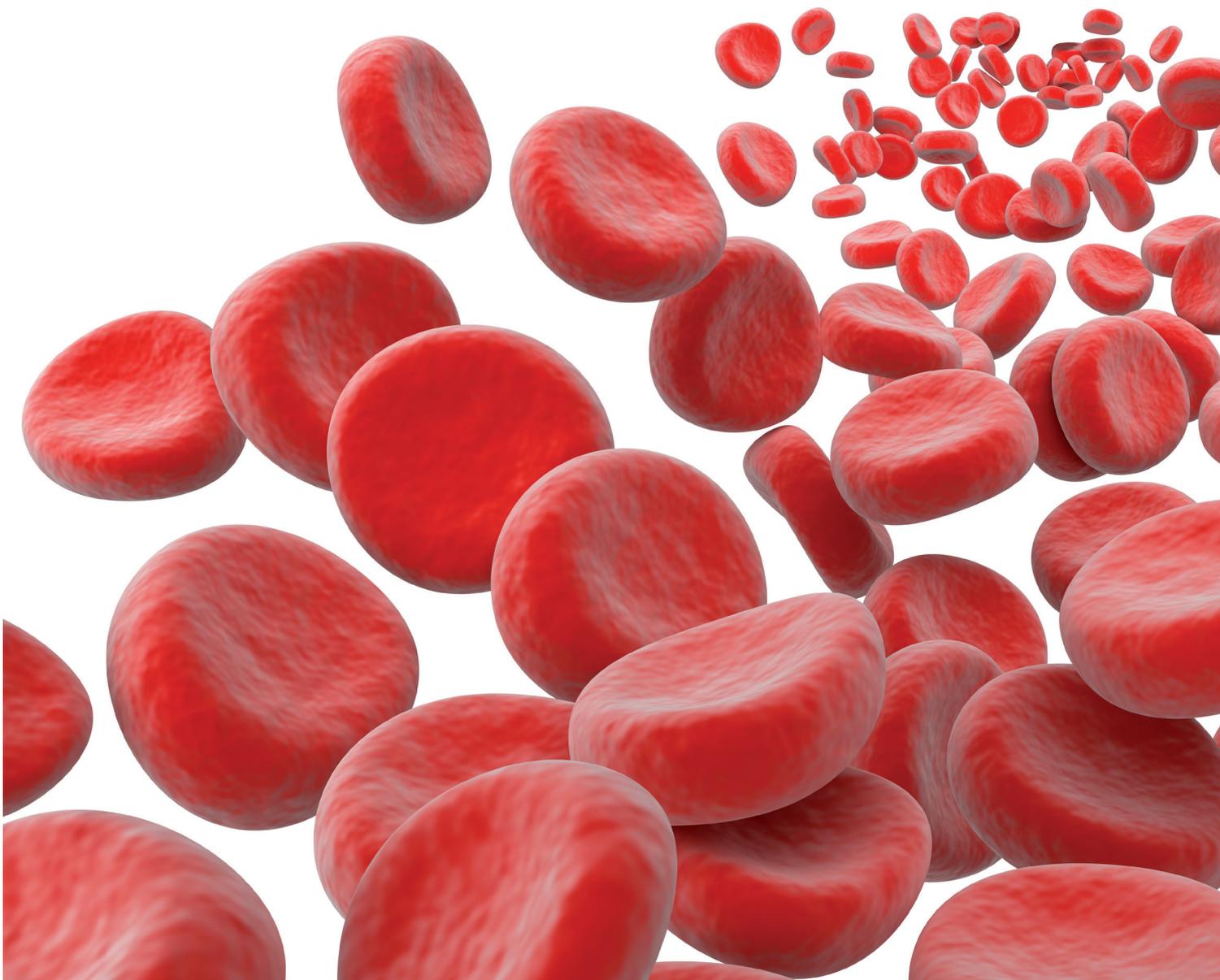




Fourth Annual Audit of Acute NHS Trusts' VTE Policies

November 2010

Launched at a Meeting in the House of Commons
Tuesday 23 November 2010
Hosted by Andrew Gwynne MP







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Foreword



All-Party Parliamentary Thrombosis Group

November 2010



Dear Colleague,

As the new Chair of the All-Party Parliamentary Thrombosis Group (APPTG), I am delighted to launch the findings of the Group's fourth annual report. This report forms the output of a freedom of information survey sent to all NHS Hospital Trusts in August 2010. The survey asked each Trust for evidence of their compliance with national VTE prevention best practice and policy.

2010 has been a hugely significant year for the VTE prevention campaign. We have supported a number of national developments around VTE prevention. England now boasts a comprehensive and up-to-date set of best practice recommendations aimed at preventing hospital-acquired VTE, with the publication of NICE clinical guideline 92 in January 2010 and the NICE quality standard on VTE prevention in June 2010.

On a policy level, the APPTG is delighted that VTE prevention has been recognised at the highest level. The Secretary of State for Health, Rt Hon Andrew Lansley CBE MP, has drawn on the significance of VTE prevention in a number of his speeches since entering office. This follows the announcement of the national goal to reduce the impact of VTE through the Commissioning for Quality and Innovation (CQUIN) payment framework. This framework attaches a financial value to the goal of risk assessing 90% of patients for VTE and bleeding on admission. Combined with the legal requirements to comply with the provisions on prophylaxis rates and root cause analysis contained in the 2010/11 NHS Standard Contract for Acute Services, VTE prevention has been placed at the top of the health agenda for this year.

The prioritisation of VTE prevention in the NHS is necessary. Its importance was accepted by government in 2005, when VTE was estimated by the Health Select Committee to cause in excess of 25,000 avoidable deaths each year, and cost the NHS £640 million a year to manage. The evidence-base behind the prevention of VTE has continued to build since the Committee's 2005 report. Last year, NICE placed the prevention of VTE in its list of top ten cost-saving interventions, whilst this year, figures from the National Statistician have demonstrated that over 60,000 cases of VTE have been recorded in hospitals each year



All-Party Parliamentary Thrombosis Group

between 2005 and 2009. Official statistics this year have also set out that recorded deaths from pulmonary embolism accounted for over 12,000 deaths last year – a figure that represents just the tip of the iceberg of VTE deaths, given that the majority go unreported. The scale and cost of the condition – financially and in terms of long-term morbidity and lives lost – is staggering.

The results contained in this report provide clear evidence that prioritising VTE prevention in the NHS this year has had significant impact on prioritising VTE prevention within Trusts. As such, we are encouraged by reports that the introduction this year of the national CQUIN goal on reducing the impact of VTE has provided the initial impetus to improve VTE prevention across the country. Indeed, the goal has been welcomed by the majority of clinicians in the survey.

However, the responses make clear that there are many teething problems with the framework. Trusts up and down the country are facing wide scale barriers that are preventing them from implementing best practice and policy within their Trusts. These Trusts have called for national guidance and support on a range of issues, and have made clear that VTE prevention needs to be prioritised in the long term if the benefits to patient safety and quality care are to be truly realised.

Based on the calls made by clinicians in the survey, the APPTG has developed a series of recommendations to support clinicians in their efforts to prevent VTE. Some of these recommendations could be delivered by the Department of Health, some by third sector organisations, and others by sites developing exemplary best practice, sharing their resources and systems solutions. Cumulatively, these recommendations will ultimately save lives and money.

I look forward to actively working to build on the successes of the previous APPTG. We will continue to drive forward the campaign until every patient who is admitted to hospital can be safe in the knowledge that every step is being taken to reduce their risk of contracting a blood clot in hospital.

Yours faithfully,

Andrew Gwynne MP
Chair, All-Party Parliamentary Thrombosis Group



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This report outlines the results of the freedom of information request sent to all NHS Acute Trusts in August 2010. With a response rate of over 90% (twelve Trusts did not respond), we are confident our results represent an accurate portrayal of Trusts' compliance with national VTE prevention best practice and policy.

Most Trusts that have VTE prevention policies in place have already updated their protocols in accordance with the latest guidelines from NICE, or are in the process of doing so. Many Trusts are developing their own written patient information on VTE to comply with the recommendation to provide both written and verbal information on admission and discharge. National leadership would clearly avoid duplication of effort and variation of quality in this instance.

Overall, clinicians welcome the national prioritisation of VTE prevention in the NHS, incentivised through the Commissioning for Quality and Innovation (CQUIN) payment framework. However, Trusts are having difficulty demonstrating compliance with the national CQUIN VTE goal. While Trusts' performance improved over the three months of June, July and August, the average return for each month was between 30% and 40% of inpatients risk assessed for VTE – well below the national goal of 90%. There is a need for national guidance on day case procedures and cohorts of patients at low risk of VTE, so these groups can be assessed by cohort rather than individually. Clinicians would prefer an outcomes-focused national CQUIN VTE goal, based on the percentage of at-risk patients receiving prophylaxis.

There is low awareness amongst Trusts of the requirements on VTE prevention and the significance of the legal provisions contained within the 2010/11 NHS Standard Contract for Acute Services. The majority of Trusts were unable to provide monthly data on the percentage of patients at risk of VTE who received appropriate prophylaxis, and reports of root cause analysis undertaken of confirmed cases of hospital acquired VTE – despite both being contractual requirements. Trusts and commissioners require significant guidance on performing acceptable standards of root cause analysis of hospital acquired VTE.

All Trusts stated that they are taking steps to educate staff members on the requirements of the national CQUIN VTE goal, as well as best practice in VTE prevention recommended in NICE clinical guideline 92 and the NICE quality standard on VTE prevention. However, very few Trusts are using electronic tools to facilitate the implementation of VTE risk assessment and data collection. Trusts recognise this is inefficient but compounded by the lack of a standardised NHS IT framework.

Obtaining accurate statistics on incidence and death from hospital acquired VTE continues to be a challenge. A new national code for hospital acquired VTE would be a significant asset in enabling hospital acquired VTE to be distinguished from community acquired VTE.

NHS Trusts support an outcomes-focused, long-term strategy for prioritising VTE prevention in the NHS. Trusts recognise that a variety of measures are needed to aid implementation of VTE prevention at the local level. An electronic VTE risk assessment tool and mandatory education on VTE risk prevention and management for undergraduate and postgraduate health professionals were the most cited recommendations made by the Hospital Trusts surveyed.



Recommendations

Through the findings of our survey and following correspondence with healthcare professionals across the country, the APPTG has developed a series of recommendations to support clinicians in their efforts to prevent hospital acquired VTE.

The APPTG recommends that the Department of Health undertakes the following three actions as a priority in order to deliver improvements in the standard of VTE prevention in the NHS:

- 1. The APPTG recommends as a priority that the national CQUIN goal on reducing the impact of VTE continues in 2011/12, with an outcomes-focussed goal on the percentage of patients at risk of VTE who receive appropriate prophylaxis.**
- 2. The APPTG recommends as a priority that the NHS Outcomes Framework is used to set a minimum standard for VTE prevention, with indicators on the percentage of patients risk assessed for VTE, the percentage of patients at risk of VTE who receive appropriate prophylaxis, and the overall incidence of recorded hospital acquired VTE.**
- 3. The APPTG recommends as a priority that the Department of Health develops a strategy for raising awareness with Trust management and commissioning bodies on the requirements on VTE prevention within the 2010/11 NHS Standard Contract for Acute Services.**

In addition to these three priorities, the APPTG recommends that the Department of Health considers the following:

4. The APPTG recommends that national leadership be provided on the development of authoritative patient information on VTE for use by Trusts on admission and discharge of inpatients. This would reduce duplication of effort and variation of quality.
5. The APPTG recommends that a national, authoritative, clinically-defined list of cohorts agreed to be at low or no risk of VTE is developed by the Academy of Medical Royal Colleges. This would reduce the confusion, duplication of effort, and variation currently within the system.
6. The APPTG recommends that authoritative guidance is provided on performing root cause analysis of cases of hospital acquired VTE. In line with calls from the survey responses, the APPTG recommends guidance is provided on the following:
 - a. Recognising hospital acquired VTE during an inpatient stay and during the three months after a patient has been discharged
 - b. Resource required to perform root cause analysis of cases of hospital acquired VTE
 - c. Best practice in performing root cause analysis of cases of hospital acquired VTE



7. The APPTG recommends that in order to build accurate local and national figures on VTE incidence and death, a national code is developed which specifically applies to hospital acquired VTE.
8. The APPTG recommends that in order to build accurate local and national figures on VTE incidence and death, more post mortems should be performed nationally, where a patient with a recorded sudden death has a recent history of hospitalisation.
9. The APPTG recommends that a CQUIN-compliant electronic VTE risk assessment template is developed for use for clinicians.
10. The APPTG recommends that education on VTE risk assessment and prevention be made mandatory for undergraduate and postgraduate health professionals.
11. The APPTG recommends that a public awareness campaign is delivered nationally about the risks of VTE in hospital, modelled on the successful ‘FAST’ campaign for stroke.
12. The APPTG recommends that GPs be incentivised to manage the ongoing monitoring and prophylaxis of patients discharged with, or at high risk of, VTE.



Results: Section One

Compliance with VTE prevention best practice

(NICE clinical guideline 92 and the NICE quality standard for VTE prevention)

Overview

This section of the survey addressed how closely Trusts' VTE prevention policies follow best practice in line with the recommendations of NICE clinical guideline 92 and the NICE quality standard for VTE prevention.

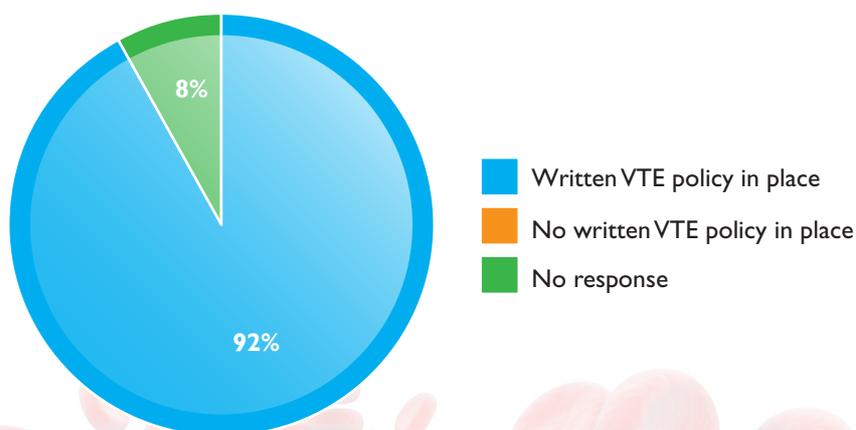
The key findings are as follows:

- Most Trusts that have VTE prevention policies in place have already updated their protocols in accordance with the latest statements of best practice from NICE, or are in the process of doing so.
- Many Trusts are developing their own written patient information on VTE to comply with the recommendation to provide both written and verbal information on admission and discharge. National leadership would avoid duplication of effort and variation of quality.

1) Written VTE Prevention Policies

All Trusts who responded indicated that they have written VTE prevention policies in place. In addition, many Trusts stated that they have already updated their policies in line with the most recent NICE VTE guidelines, or are in the process of doing so.

Figure 1.1: Trusts with a written VTE prevention policy in place



2) Risk assessment of VTE and bleeding risk on admission using the clinical criteria set out in the national tool

As expected, most Trusts indicated that they have already incorporated the VTE risk assessment and bleeding criteria contained within the national VTE risk assessment tool into their local risk assessment forms, for use during inpatient admission.



As such, all Trusts demonstrated compliance with the most recent national policy on VTE risk assessment. Some Trusts stated that this has been achieved by incorporating the tool into their local drugs chart, and that this has proved most useful to increase compliance with VTE risk assessment and prophylaxis best practice.

3) Verbal and written information about VTE prevention for patients/carers on admission

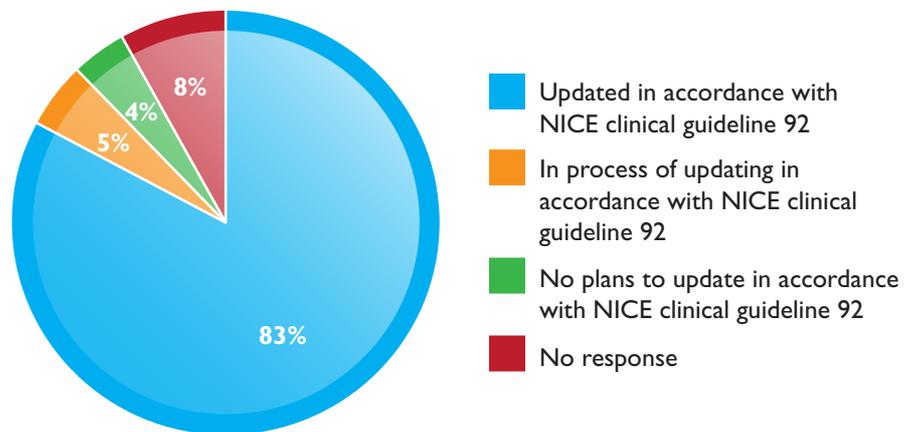
77% of Trusts indicated that their policy requires them to provide both verbal and written information on the risks of VTE as part of the admission process. A further 9% indicated that they are currently in the process of developing and ratifying written information in order to meet this level of best practice.

6% of Trusts stated that their policy requires only one of verbal or written information to be provided. This is at odds with NICE clinical guideline 92 and the NICE quality standard on VTE prevention, which require both.

4) Fitting and monitoring anti-embolism stockings in accordance with NICE clinical guideline 92

88% of Trusts have already updated their VTE prevention policy, or are in the process of updating their policy, on fitting and monitoring anti-embolism stockings in accordance with NICE clinical guideline 92. Worryingly, a minority (4%) indicated that they have no plans to update their policy in line with the most recent best practice – potentially, putting patients at risk.

Figure 1.2: Trusts fitting and monitoring anti-embolism stockings in accordance with NICE clinical guideline 92

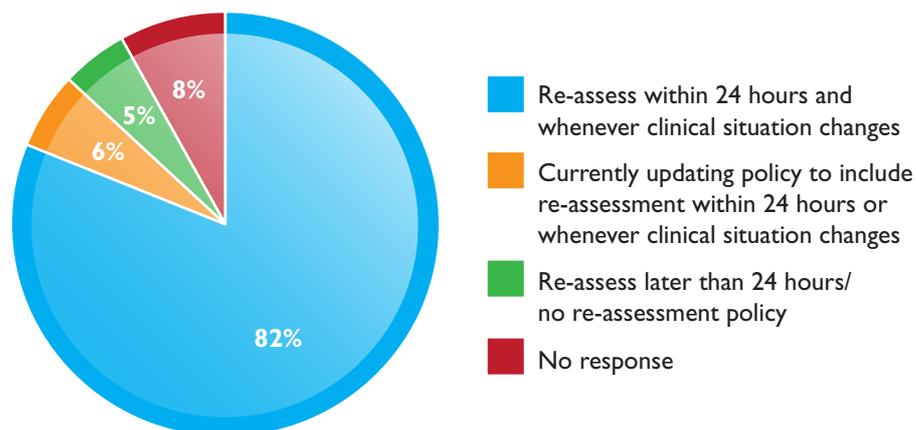


5) Re-assessing patients within 24 hours of admission for risk of VTE and bleeding

82% of Trusts indicated that their policies require patients to be re-assessed 24 hours after admission and whenever the clinical situation changes. This is in line with the latest best practice from NICE on VTE prevention. An additional 6% are updating their policies to include this requirement. Therefore, in stark contrast to last year, when 75% of Trusts indicated that they did not require routine re-assessment, this year only 5% of Trusts are in this position.



Figure 1.3: Trusts re-assessing patients for risk of VTE and bleeding within 24 hours of admission and whenever clinical situation changes

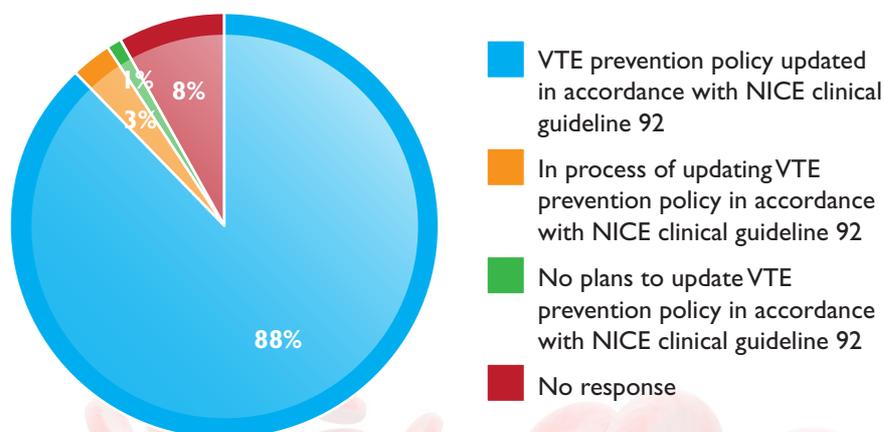


This figure must be viewed in the context of the results in the next section on compliance rates with the national CQUIN VTE goal. Given the figures that Trusts have provided on the percentage of patients being risk assessed for VTE on admission, it suggests similarly low percentages of patients will be re-assessed on the wards in line with their Trust policy.

6) Offering VTE prophylaxis in accordance with NICE clinical guideline 92

Only the smallest minority of Trusts (1%) indicated that they are yet to update their prophylaxis policies in line with the most recent best practice from NICE.

Figure 1.4: Trusts offering VTE prophylaxis in accordance with NICE clinical guideline 92

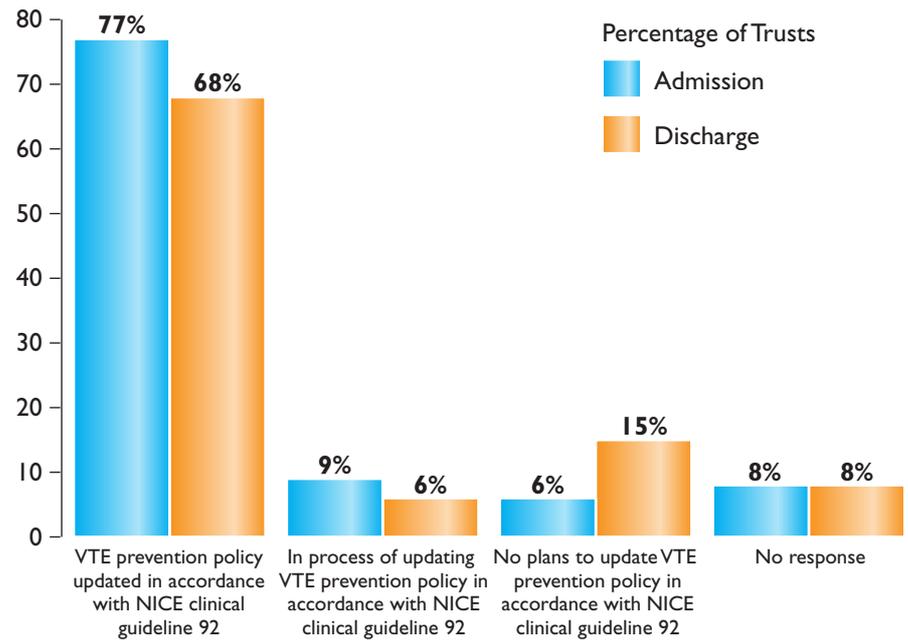


7) Verbal and written information about VTE prevention for patients/carers on discharge

Fewer Trusts require both verbal and written information to be given on discharge than on admission: 74% of Trusts already require or are in the process of providing this on discharge, compared to 86% in the same position on admission. Nevertheless, this does represent a significant increase from last year, when only 26% of Trusts stated they provide both forms of information on discharge.



Figure 1.5: The provision of verbal and written information for patients/carers on both admission and discharge in line with NICE clinical guideline 92



Commenting on why they did not provide both forms of information on discharge, some Trusts stated that information is already given on admission. However, the absence of information provision on discharge contravenes NICE clinical guideline 92, which recognises that additional information must be provided on discharge to that which is given on admission. This additional information includes the importance of using VTE prophylaxis correctly and continuing treatment for the recommended duration, as well as educating patients on the signs and symptoms of VTE. This information is particularly important on discharge given that a large majority of hospital acquired VTE events occur once patients have left hospital.

Given the low level of general awareness about the scale and seriousness of hospital acquired VTE, it is essential that this information is comprehensively provided to patients so that they are aware of the risks of VTE and how the condition can be effectively prevented.

Finally, while some Trusts require both forms of information to be provided on both admission and discharge, whether or not this is delivered on the wards themselves will be determined by numerous factors – including whether or not clinicians, nurses and allied health professionals themselves view VTE prevention as a priority. One respondent referred to this as a ‘hearts and minds’ battle which is yet to be won.

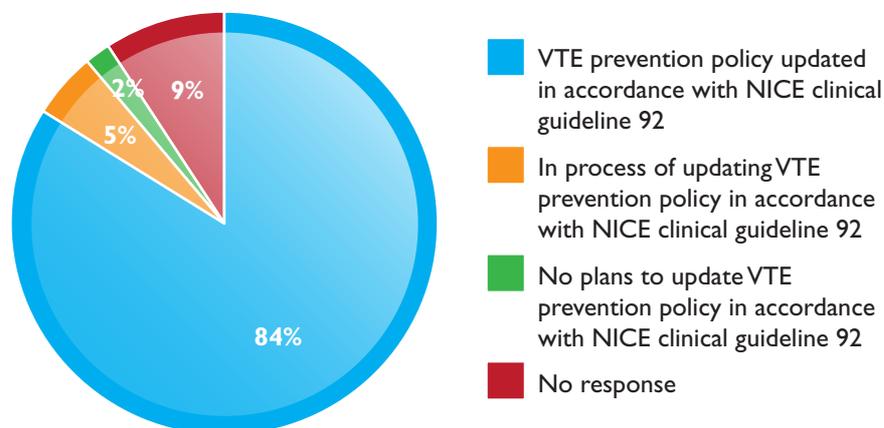
The APPTG recommends that national leadership be provided on the development of authoritative patient information on VTE for use by Trusts on admission and discharge of inpatients. This would reduce duplication of effort and variation of quality.



8) Offering patients extended VTE prophylaxis in accordance with NICE clinical guideline 92

Encouragingly, almost 90% of Trusts have already updated or are in the process of updating their policy on extended prophylaxis in line with NICE clinical guideline 92 and the NICE quality standard on VTE prevention.

Figure 1.6: Trusts with extended prophylaxis policies in line with NICE clinical guideline 92



The NICE quality standard for VTE prevention sets out a set of seven concise statements representing high quality care throughout the patient pathway.

Quality Standard for VTE – prevention

The quality standard for VTE – prevention applies to part of the care pathway for the prevention and management of VTE. Services across the care pathway should be commissioned from and coordinated across all relevant agencies. An integrated approach to provision of services is fundamental to the delivery of high-quality care to patients for preventing and managing VTE.

No. Quality Statements

- 1 All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool.
- 2 Patients/carers are offered verbal and written information on VTE prevention as part of the admission process.
- 3 Patients provided with anti-embolism stockings have them fitted and monitored in accordance with NICE guidance.
- 4 Patients are re-assessed within 24 hours of admission for risk of VTE and bleeding.
- 5 Patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidance.
- 6 Patients/carers are offered verbal and written information on VTE prevention as part of the discharge process.
- 7 Patients are offered extended (post hospital) VTE prophylaxis in accordance with NICE guidance.

SOURCE: National Institute for Health and Clinical Excellence



Results: Section Two

Compliance with the national goal to reduce avoidable death, disability and chronic ill health from VTE in the CQUIN payment framework

Overview

This section of the survey asked Trusts about the progress they are making towards achieving the national CQUIN goal to reduce the impact of VTE. In order to access the CQUIN money related to VTE, this goal requires 90% of patients to be risk assessed for VTE on admission to hospital using the risk factors for VTE and bleeding set out in the national VTE risk assessment tool.

The key findings are as follows:

- Overall, clinicians welcome the national prioritisation of VTE prevention in the NHS through the CQUIN payment framework.
- Trusts are having difficulty demonstrating compliance with the national CQUIN VTE goal. While Trusts' performance improved over the three months of June, July and August, the average return for each month was between 30% and 40% of inpatients risk assessed for VTE - well below the national goal of 90%.
- There is a need for national guidance on day case procedures and cohorts of patients at low risk of VTE, so these groups can be assessed by cohort rather than individually.
- Clinicians would prefer an outcomes-focussed national CQUIN VTE goal, based on the percentage of at-risk patients receiving prophylaxis.

National CQUIN goal to reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)

Achievement of this goal will be measured using the quality indicator:

% of all adult inpatients who have had a VTE risk assessment on admission to hospital, using the national tool

And payment will be triggered by achieving 90% or more.

SOURCE: Department of Health

1) The financial value of CQUIN to Trusts

As would be expected, every Trust indicated that they have agreements in place with their local PCT(s) on the national CQUIN goal on VTE prevention. The value of the national CQUIN VTE goal differs significantly from Trust to Trust. For some Trusts, the value of CQUIN money which is accessed upon achieving the VTE goal was estimated to be in excess of £1 million.

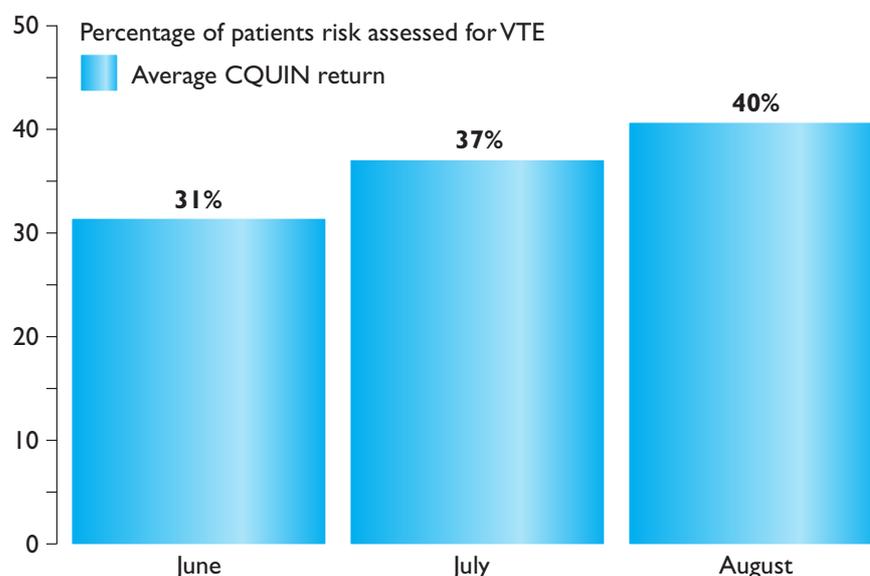


2) Monthly CQUIN returns since 28 July 2011

Only one Trust stated that it has submitted CQUIN returns for June, July and August which all meet the goal to risk assess 90% of patients for VTE and bleeding. The majority reported percentages significantly below this level for each of the three months. The average percentage of patients risk assessed by Trusts for each month of June, July and August fell between 30% and 40%.

While some Trusts were unable to provide results for August (as these were being compiled as the survey responses were being returned), most Trusts did individually demonstrate an increase in the percentage of patients risk assessed for VTE over the period.

Figure 2.1: Average monthly CQUIN VTE returns



3) Clinical and staff groups supporting achievement of the CQUIN VTE goal

All Trusts indicated that more than one clinical or staff group is involved in supporting achievement of the VTE goal.





Figure 2.2: Input of various groups into achieving national CQUIN VTE goal at Trust level

Group Name	Most common use for group
Thrombosis Committee	Designs Trust-wide VTE policy compliant with NICE best practice and Department of Health policy; coordinates training
Risk and Audit Committee	Both groups monitor performance against VTE Trust policy, and are key to collecting and analysing CQUIN returns, local audit data, and confirmed episodes of hospital acquired VTE
Clinical Governance/Patient Safety Team	
Collaboration for Leadership in Applied Health Research and Care (CLAHRC)	Provide expert research, knowledge and development towards implementing effective change
Academic Health Science Centres (AHSCs)	Deliver medical education on VTE prevention
Health and Innovation Education Clusters (HIECs)	Input and publicise innovative VTE prevention strategies
Trust Board/PCT Commissioners/SHA/Quality Committee/Drug and Therapeutics Committee	General oversight and input into VTE prevention policy
IT Department/Coding Team	Specific remits with data collection

4) Respondents’ comments on the CQUIN VTE goal

“The National VTE Prevention Programme and in particular CQUIN has been vital to ensuring that the Trust has prioritised VTE prevention. It has led to a dramatic improvement in awareness, engagement by hospital staff and completion of risk assessments.

Clearly the next step needs to be to develop a similar approach to ensure that appropriate thromboprophylaxis prescribing results from the risk assessment process, as otherwise patients will not benefit.”

Consultant Haematologist and Thrombosis Lead,
 NHS Trust, West Midlands SHA

CQUIN as a payment mechanism

While some respondents questioned the utility of top-slicing an existing budget, suggesting that a true financial incentive would be preferable, the vast majority of Trusts were clear that attaching a financial value to VTE prevention had increased awareness and engagement of the issue at a managerial and Board level – and that this had resulted in a drive to improve standards.



CQUIN as a census-based scheme – data collection

A large number of Trusts commented on the time-intensive nature of the census-based CQUIN data returns.

“Collecting the data for the CQUIN census is a very labour intensive task, and results in underreporting.”

Consultant Haematologist, NHS Foundation Trust, London SHA

Many Trusts expressed a desire for an electronic risk assessment and data collection tool to facilitate the process and effectively capture data.

“We are asking staff on wards to collect data manually and to submit to the Department of Health through UNIFY2. We do not have confidence that [this] measure will provide robust data. An electronic version of the risk assessment form... will enable clinicians to have easy access to the assessment tool whilst providing evidence at patient level that risk assessment has been performed.”

Consultant Haematologist, NHS Trust, South Central SHA

In addition, some Trusts stated that additional resource must be allocated in order to deliver VTE prevention requirements. A number of Trusts stated that ring-fenced funding for a VTE nurse would help drive compliance with the risk assessment tool, while also helping with the data collection requirements of both CQUIN and the audits contained in the 2010/11 NHS Standard Contract for Acute Services.

“These changes are having to be implemented with no extra resources and often with little or belated guidance from the Department of Health, SHA etc. We therefore have not been able to put them in place yet.”

Director of Governance, NHS Foundation Trust,
Yorkshire and the Humber SHA

Low-risk VTE Cohorts

Trusts have welcomed the announcement by the Department of Health for day-case procedures and pre-determined cohorts of patients at low-risk of VTE to be assessed by their cohort, rather than individually, as ‘at low risk of VTE’ for the purposes of data collection. However, establishing a definition of day case procedures and an accepted list of low-risk patient cohorts has given rise to significant challenges.

Different Trusts are using different sources to compile their lists. Some are using guidance from their SHA Medical Director; others have developed their own lists and are awaiting approval from their SHA Medical Director; the remainder are using a mixture of the two.

The lack of national guidance on a day case definition and patient cohorts at low-risk of VTE has required Trusts to devote significant time to developing their individual lists. In the meantime, some Trusts stated that they have returned their



CQUIN data collection forms knowing that, without an established list of cohorts, they are underreporting the percentages of patients who have been risk assessed.

In addition, it is clear from the examples that Trusts gave of the cohorts they are using, that there is nationwide variation in this list.

“It would have been beneficial if prior to implementation of CQUIN, all Royal Colleges provided lists of agreed procedures for patient cohorts at low-risk of VTE and therefore not requiring risk assessment. This would have significantly improved medical engagement and focused attention on higher risk patients.”

Medical Director, NHS Foundation Trust, North West SHA

The APPTG recommends that a national, authoritative, clinically-defined list of cohorts agreed to be at low or no risk of VTE is developed by the Academy of Medical Royal Colleges. This would reduce the confusion, duplication of effort, and variation currently within the system.

The national CQUIN VTE goal

A number of respondents suggested that the national CQUIN VTE goal should become outcomes-focused. It was suggested that the administration of appropriate prophylaxis to patients at risk of VTE is the basis of quality care and safe care – and that VTE risk assessment alone cannot deliver these benefits.

“The introduction of risk assessment as a national standard for CQUIN without including effective implementation of effective prophylaxis is short-sighted, given that effective risk assessment does not necessarily drive appropriate thromboprophylaxis.”

VTE Nurse Specialist, NHS Trust, South West SHA



Results: Section Three

VTE clinical audit data within the 2010/11 NHS Standard Contract for Acute Services

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Overview

This section of the survey asked Trusts about results of their local audits on thromboprophylaxis rates and root cause analysis of hospital acquired VTE, as required in the 2010/11 NHS Standard Contract for Acute Services. Failure to report in accordance with the contract can lead to up to 1% of the monthly contract value being withheld by commissioners until the reports are provided.

The key findings are as follows:

- There is low awareness amongst Trusts of the requirements on VTE prevention and the significance of these legal provisions contained within the 2010/11 NHS Standard Contract for Acute Services.
- The majority of Trusts were unable to provide monthly data on both thromboprophylaxis rates and the percentage of successful root cause analysis undertaken of confirmed cases of hospital acquired VTE.
- Trusts require a significant amount of guidance on performing root cause analysis of hospital acquired VTE.

1) Local audits on the percentage of patients at risk of VTE who receive appropriate prophylaxis

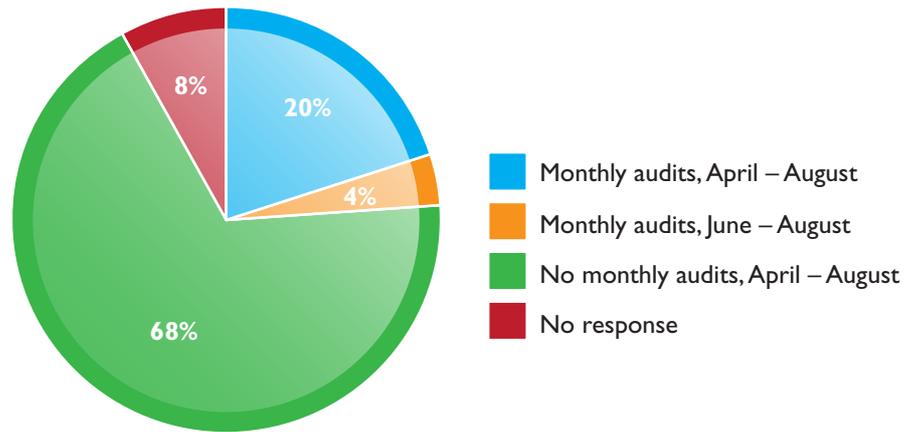
Surprisingly, many Trusts indicated that their current contracts with their commissioning PCTs do not include the VTE prophylaxis clause, as set out in the 2010/11 NHS Standard Contract for Acute Services. While Trusts were able to maintain existing contracts where the expiry date was later than 31st March 2010, it is surprising that so many Trusts stated they are not required to perform clinical audits, given that CQUIN payments are eligible upon moving to the new NHS Standard Contract. The APPTG queries these responses from Trusts and suggests these responses are investigated for their accuracy, as the NHS Standard Contract for Acute Services is decided nationally, and sets a legal requirement which applies nationally.

Where Trusts indicated they are not legally required to report on monthly clinical audits of appropriate prophylaxis to their lead commissioner, they are only required to undertake this audit "in line with good clinical governance", as set out in this year's CQUIN addendum.

One fifth of Trusts were able to provide data on audits between April and August 2010, with a further 4% providing monthly audit results between June and August (in line with the months requiring CQUIN data returns of risk assessment). Those that did not provide any data explained that any local audits on thromboprophylaxis would only be introduced voluntarily once there is a high level of consistency in the current CQUIN reporting of VTE risk assessment.



Figure 3.1: Trusts undertaking monthly audits of patients at risk of VTE who receive appropriate prophylaxis



The results provided by the 24% of Trusts who were able to provide some data showed that a higher percentage of patients received appropriate thromboprophylaxis, than those who were risk assessed as per the CQUIN data collection returns. Results largely ranged between 50% and 90% of patients receiving appropriate prophylaxis. This suggests that patients are continuing to receive prophylaxis without having a documented risk assessment.

The format, method and timeframe in which Trusts provided data varied widely. The APPTG suggests that if a national comparison is to be made, the NHS Standard Contract for Acute Services could provide more guidance on these issues, rather than leaving this to local agreement.

2) Local audits on percentages of confirmed cases of hospital acquired VTE followed up with root cause analysis

As with the audits on appropriate prophylaxis, most Trusts indicated that a monthly report on root cause analysis of inpatient DVTs and PEs was not required under their contractual agreement with their PCTs. As such, for these Trusts, root cause analysis is only an expectation in line with good clinical governance.

However, many Trusts indicated that they recognise the significance of performing root cause analysis, and are taking steps to address this. 20% of Trusts were able to provide monthly reports of root cause analysis on confirmed cases of hospital acquired VTE between April and August 2010. A further 10% of Trusts indicated that they had performed root cause analysis on at least one case of hospital acquired VTE between April and August 2010.

Comments from Trusts highlighted three key barriers to consistently performing root cause analysis:

- 1) The difficulties associated with recognising hospital acquired VTE during an inpatient stay or during the three months after a patient has been discharged;
- 2) The lack of resource within Trusts to perform root cause analysis of cases of hospital acquired VTE;
- 3) The lack of national best practice guidance on performing root cause analysis of cases of hospital acquired VTE.



“A central information resource (registry) would be useful – where individuals could share good practice and solutions. This could be web-based.”

Medical Director and Consultant Gastroenterologist, and
Consultant Haematologist, NHS Foundation Trust, South West SHA

The APPTG recommends as a priority that the Department of Health develops a strategy for raising awareness with Trust management and commissioning bodies on the requirements on VTE prevention within the 2010/11 NHS Standard Contract for Acute Services.

The APPTG recommends that authoritative guidance is provided on performing root cause analysis of cases of hospital acquired VTE. In line with calls from the survey responses, the APPTG recommends guidance is provided on the following:

- a. Recognising hospital acquired VTE during an inpatient stay and during the three months after a patient has been discharged
- b. Resource required to perform root cause analysis of cases of hospital acquired VTE
- c. Best practice in performing root cause analysis of cases of hospital acquired VTE

Requirements on Prophylaxis and Root Cause Analysis in 2010/11 NHS Standard Contract for Acute Services

As part of the National Venous Thromboembolism (VTE) Prevention Programme from 1 April 2010, the NHS Standard Contract for acute services requires providers to:

- Report to their lead commissioner on local audits of the percentage of patients risk-assessed for VTE who receive the appropriate prophylaxis being based on national guidance. (Where appropriate prophylaxis is used but is not based on national guidance, the reasons for this clinical decision will need to be fully documented); and
- undertake and report to their lead commissioner on root cause analysis of all confirmed cases of hospital acquired pulmonary embolism and deep vein thrombosis (including those arising from a current stay or new events arising where there is a history of admission to hospital within the last three months), in accordance with clause 29 and schedule 5 part 2.

Failure to report in accordance with the provisions in the contract is a breach of performance that can lead to a withholding by the commissioners of up to 1% of monthly sums payable under the contract value until the breach is rectified. Where there is a persistent breach the withholding can be retained.

SOURCE: Hansard



Results: Section Four

Management of VTE prevention at Trust level

Overview

This section asked Trusts about their internal management of VTE prevention.

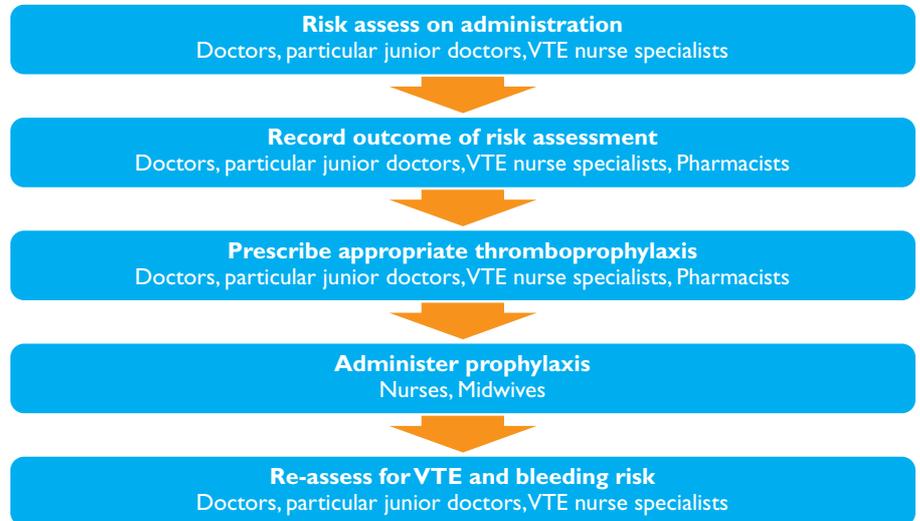
The key findings are as follows:

- Trusts are harnessing the expertise of various professionals to meet the requirements of the national CQUIN goal on reducing the impact of VTE.
- All Trusts are taking steps to educate staff members on the requirements of the national CQUIN VTE goal, as well as best practice in VTE prevention recommended in NICE clinical guideline 92 and the NICE quality standard on VTE prevention.
- Very few Trusts are using electronic tools to facilitate the implementation of VTE risk assessment and data collection.

1) Responsibility for implementing VTE prevention policies

While the majority of Trusts confirmed that doctors are responsible for risk assessing patients and prescribing appropriate thromboprophylaxis, a significant number also indicated that they are drawing on the expertise of VTE nurse specialists and pharmacists during the process.

Figure 4.1: Flow diagram showing responsibilities for VTE risk assessment process

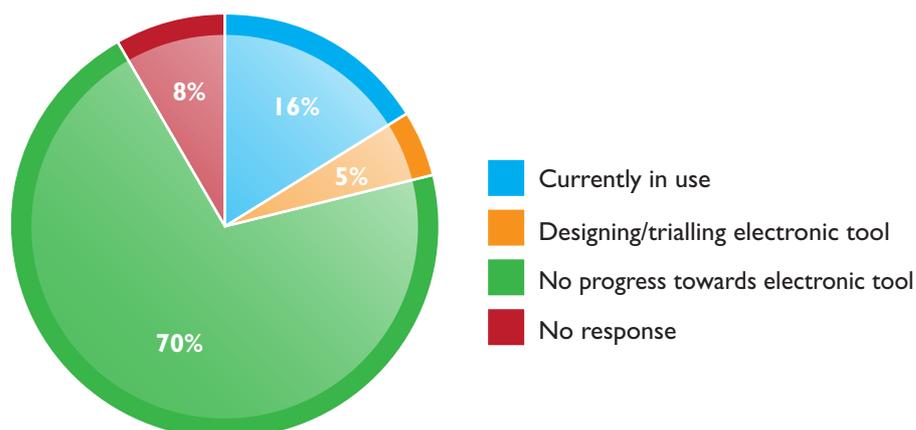


2) Electronic risk assessment tools

Four fifths of Trusts remain paper-based for their VTE risk assessment. Only one fifth of Trusts are currently using, or planning to develop, an electronic risk assessment tool.



Figure 4.2: Trusts using electronic VTE risk assessment tool



Many Trusts stated that given the nature of the CQUIN data collection as a census-based system, the lack of an electronic tool makes the process of data entry and collection burdensome. These concerns reflect the findings in section six, where over two thirds of Trusts ranked an electronic tool as the most useful initiative to improve VTE prevention within their Trust. However, a small number of Trusts indicated that electronic risk assessment mechanisms would only be useful if designed as part of an electronic patient record.

3) Educating staff members about CQUIN VTE requirements and national VTE best practice

All Trusts were able to describe steps they have taken to educate staff members on the requirements of the national CQUIN VTE goal as well the need to risk assess and prescribe appropriate thromboprophylaxis according to NICE clinical guideline 92. Some responses indicated that this is as much an engagement challenge as a training process.

“The hearts and minds battle has not yet been completely won for this initiative... That is needed to ensure commitment amongst very busy and pressured clinicians to additional data recording to fulfil the CQUIN process.”

Director of Medicines Management,
NHS Trust, South East Coast SHA

The following are examples of some of the initiatives described by Trusts about their VTE prevention engagement and training processes:

- Junior doctors – induction training
- Clinicians – e-learning, grand rounds, educational lectures, included in handbook, Trust newsletters, CQUIN and audit results fed back to Clinical Directors and Clinical Leads, Trust-wide ‘league tables’ to compare performance, and VTE information attached to pay slips
- Nursing – training from suppliers, study days
- Pharmacy – bulletins
- Ongoing education campaigns – posters, screen savers and ward manager meetings



Results: Section Five

VTE incidence

Overview

This section asked Trusts about their local statistics on VTE incidence and deaths.

The key findings are as follows:

- Obtaining accurate statistics on incidence and death from hospital acquired VTE continues to be a challenge.
- A new national code for hospital acquired VTE would be a significant asset in enabling hospital acquired VTE to be distinguished from community acquired VTE.

1) Non-fatal DVT or PE arising either as new event during inpatient stay or as a new event following hospital admission in previous three months

(i.e. not including patients admitted to hospital with a confirmed VTE but no history of hospital admission in previous three months)

Obtaining accurate data on VTE incidence continues to be a challenge.

Most Trusts were able to give some statistics on VTE incidence using clinical coding, where VTE appears as either a primary or secondary diagnosis. However, all Trusts that provided this data were unable to confirm whether each incident was truly hospital acquired.

Clinical coding is unable to distinguish between patients admitted with a VTE diagnosis as a pre-existing condition without a prior hospital stay, and VTE episodes acquired either during an inpatient stay or in the three months following discharge from a hospital stay. Trusts stated that performing a clinical audit of patient notes to determine the cause of the VTE would be a time intensive exercise. As such, no Trust was able to provide robust and accurate data on VTE incidence.

2) Fatal PE arising either as new event during inpatient stay or as a new event following hospital admission in previous three months

(i.e. not including patients admitted to hospital with a confirmed VTE but no history of hospital admission in previous three months)

As with statistics on VTE incidence, obtaining accurate data on deaths from VTE continues to be a challenge.

Most Trusts were able to provide statistics on patients who had died with VTE as a diagnosis. However, as these Trusts explained, confirming whether VTE was the cause of death or simply a co-morbidity is impossible without a full review of patient notes. This complication is in addition to that described by Trusts in obtaining data on VTE incidence: the clinical codes for VTE do not themselves determine whether the VTE was hospital acquired.



As some Trusts stated, the difficulty with accurately determining the number of local deaths from VTE is exacerbated by the national fall in post mortems.

“National coding direction is needed on how new onset VTEs should be coded to distinguish between new events acquired from a hospital admission, and established events acquired in the community.”

Medical Director, NHS Trust, North West SHA

The APPTG recommends that in order to build accurate local and national figures on VTE incidence and death, a national code is developed which specifically applies to hospital acquired VTE.

The APPTG recommends that in order to build accurate local and national figures on VTE incidence and death, more post mortems should be performed nationally, where a patient with a recorded sudden death has a recent history of hospitalisation.





Results: Section Six

National action to support implementation of VTE prevention best practice and policy

Overview

This section asked Trusts about initiatives they believe will be useful in helping them implement national policy and best practice on VTE prevention.

The key findings are as follows:

- Trusts support an outcomes-focused, long-term prioritisation of VTE prevention in the NHS.
- Trusts recognise that a variety of measures are needed to aid implementation of VTE prevention at the local level. An electronic VTE risk assessment tool and mandatory education on VTE risk prevention and management for undergraduate and postgraduate health professionals were the most cited recommendations made by the Hospital Trusts surveyed.

1) Types of initiatives supported by Trusts

Most Trusts supported various initiatives to improve the implementation of VTE prevention. These initiatives broadly fall into two types:

- An outcomes-focussed, long-term prioritisation of VTE prevention in the NHS, and
- Action which will increase local compliance with national policy and best practice on VTE prevention.

2) Individual measures supported by Trusts

Electronic risk assessment tool

Supported by 67% of Trusts

Figure 5.1: Measures supported by Trusts to aid implementation of VTE prevention

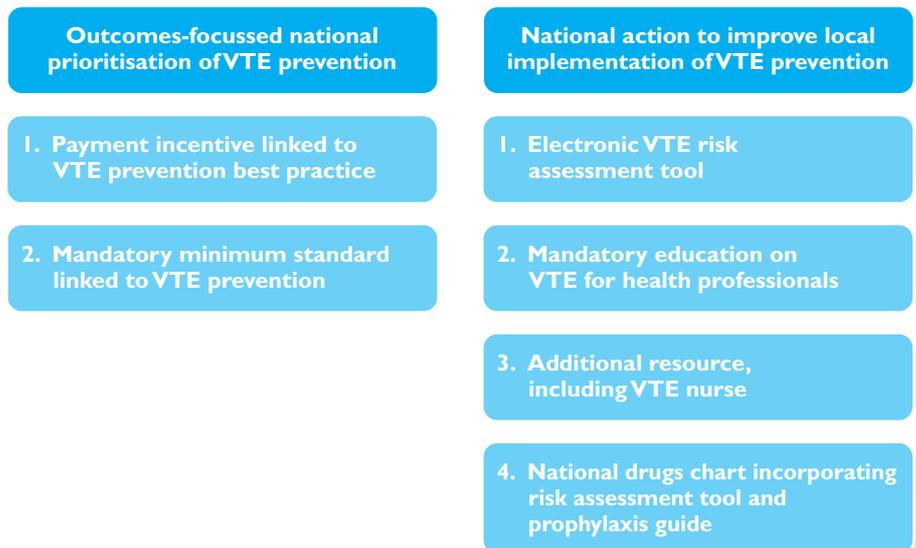
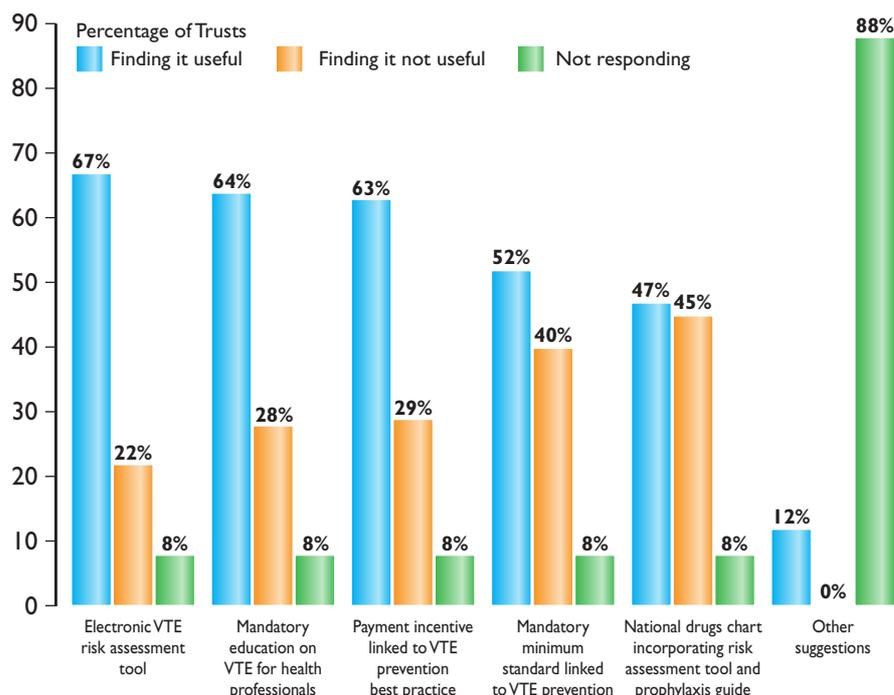




Figure 5.2: Actions ranked as useful by Trusts



Of all the measures supported by Trusts to improve VTE prevention, an electronic risk assessment and data collection tool received the most support, with over two thirds of Trusts expressing a desire for such a tool. This support reflects comments made in section two on the time-intensive nature of data collection for the national CQUIN VTE goal.

“There is a real requirement for a compatible electronic recording assessment system to allow/facilitate data recording and ensure efficient and effective utilisation of clinical time.”

Medical Director, NHS Foundation Trust, North West SHA

Mandatory education on VTE risk assessment and prevention for undergraduate and postgraduate health professionals

Supported by 64% of Trusts

Responses indicated that mandatory postgraduate education on VTE prevention will ensure professionals are up to date with VTE prevention best practice and local protocols. An improved undergraduate education on VTE prevention will increase understanding of the evidence-base in preventing the condition. As such, including a compulsory education piece in undergraduate education on VTE prevention will deliver long-term benefits while postgraduate education will improve current practice.



“To include VTE in undergraduate training for all healthcare professionals is essential if we are to achieve similar success in reducing preventable hospital acquired VTE rates as we did with MRSA. It should also be made mandatory for all Hospital Trusts to provide yearly updates and training sessions for all healthcare professionals. Until this is in place, VTE will always been seen as less of a priority than infection control.”

VTE Nurse Specialist, NHS Trust, South West SHA

It is significant that Trusts are continuing to call for education around VTE prevention given that over five years have passed since the House of Commons Health Select Committee’s Inquiry into VTE prevention recommended that VTE education be given more prominence:

Health Select Committee Recommendation on VTE education, 2005

“We recommend that VTE and its prevention, including the implementation of, and adherence to, guidelines relating to thromboprophylaxis, counselling and risk assessment, be given more prominence in undergraduate medical education, Continuing Professional Development (CPD), and other relevant aspects of medical and paramedical training. We further recommend that the Royal Colleges bring forward proposals to this end as well as to raise awareness of the problems of VTE. In addition, NHS Trusts should ensure that all physicians and surgeons receive training about the subject.”

SOURCE: Health Committee Publications

Payment incentive linked to VTE prevention best practice

Supported by 63% of Trusts

Many Trusts noted the impact the financial attachment to VTE prevention had made on improved standards of VTE prevention. While some Trusts noted a preference for incentives rather than top-slicing of an existing budget, respondents recognised the role that the national CQUIN VTE goal has had in engaging interest in VTE prevention and as such, prioritising the issue within their Trust. Trusts used this opportunity to repeat calls made in section two for an outcomes-focussed goal which focuses on the percentage of patients at risk of VTE who receive the appropriate prophylaxis.

“There is no doubt that payment incentivised VTE risk assessment has been successful in engaging resources to this issue. However to work well in future it needs modification with the use of a validated sampling methodology to establish delivery on indicated thromboprophylaxis. This is a more meaningful outcome.”

Medical Director, NHS Foundation Trust, South East Coast SHA

Mandatory minimum standard on VTE prevention

Supported by 52% of Trusts

It is clear from responses that many Trusts view the CQUIN goal as an expression of a minimum standard. Other Trusts called for a minimum standard with or without the



CQUIN payment scheme attached. These respondents argued that the significance of VTE prevention for patient safety means that the issue should be prioritised, both nationally and within Trusts themselves, with mandatory minimum standards as the mechanism to achieve this.

Those Trusts which called for minimum standards on VTE prevention alongside or separate from the CQUIN scheme recognised the utility of outcomes-focussed minimum standards. The majority focussed on the rates of thromboprophylaxis administered to at-risk patients, while some stated they would find mandatory reporting of VTE rates useful, both nationally and internally within Trusts.

Drugs chart incorporating VTE risk assessment and prophylaxis *Supported by 47% of Trusts*

Opinion was split on the usefulness of a national drugs chart containing the risk assessment form and inbuilt prophylaxis guidelines. Approximately half of Trusts welcomed the idea of a national model for them to adapt locally. Other Trusts stated they had already incorporated this into their own drugs charts. They stated this had been a very successful local initiative and as such did not desire a national chart to be imposed on them.

Ring-fenced resources/national guidance on an effective VTE prevention team *Suggested by 10 respondents*

Many Trusts expressed a need for more resources to deliver national policy and best practice on VTE prevention. This was expressed as either a national funding resource for Trusts, or a mandatory requirement for Trust Chief Executives to hire a senior clinician or nurse specifically to lead on this issue. These suggestions link to comments made about the data collection requirements of CQUIN and the 2010/11 NHS Standard Contract for Acute Services.

"...a recommendation for minimum resources which Trusts should allocate to VTE prevention. For example, a VTE prevention team, specialist nurse(s) and support, who will educate, monitor, perform root cause analysis etc."

Consultant Haematologist, NHS Trust, London SHA

Government-led VTE public awareness campaign *Suggested by 2 respondents*

A couple of Trusts noted that with the continued low general awareness of VTE, more must be done centrally to improve awareness and understanding of the condition amongst the general population.

"National education and support should be a high priority. This should target population awareness and not just healthcare workers."

Patient Safety Project Director and Matron,
NHS Foundation Trust, East of England SHA



A greater role for primary care

Suggested by 2 respondents

A couple of Trusts noted the role primary care in play in delivering a truly joined up, systematic approach to VTE prevention. Respondents called for incentives for GPs to manage the prophylaxis of patients discharged with VTE, where they receive notification that a patient has been discharged with prophylaxis.

The APPTG recommends as a priority that the national CQUIN goal on reducing the impact of VTE continues in 2011/12, with an outcomes-focussed goal on the percentage of patients at risk of VTE who receive appropriate prophylaxis.

The APPTG recommends as a priority that the NHS Outcomes Framework is used to set a minimum standard for VTE prevention, with indicators on the percentage of patients risk assessed for VTE, the percentage of patients at risk of VTE who receive appropriate prophylaxis, and the overall incidence of recorded hospital acquired VTE.

The APPTG recommends that a CQUIN-compliant electronic VTE risk assessment template is developed for use for clinicians.

The APPTG recommends that education on VTE risk assessment and prevention be made mandatory for undergraduate and postgraduate health professionals.

The APPTG recommends that a public awareness campaign is delivered nationally about the risks of VTE in hospital, modelled on the successful ‘FAST’ campaign for stroke.

The APPTG recommends that GPs be incentivised to manage the ongoing monitoring and prophylaxis of patients discharged with, or at high risk of, VTE.



Conclusion

Trusts clearly welcome the national prioritisation of VTE prevention in the NHS. Respondents have recognised that following the announcement of the national goal to reduce the impact of VTE in the 2010/11 CQUIN payment framework, VTE prevention has received a greater focus and importance within Hospital Trusts as a result. Trusts are taking steps to ensure that their written VTE prevention policies are in line with the most recent recommendations of best practice set out in NICE clinical guideline 92, and are carrying out internal training sessions on the requirements of NICE best practice and the CQUIN scheme on VTE prevention. It is essential that this focus continues in the longer-term.

Looking to the future, the results emphasise the appetite for continued guidance on VTE prevention nationally. With processes in place to improve VTE risk assessment of all patients on admission, there is now a real desire to continue the momentum in order to deliver genuine reductions in the rates of hospital acquired VTE in the long-term. Trusts have argued that VTE prevention must remain a national priority under CQUIN, with the national goal shifting focus to the percentage of patients at risk of VTE who receive appropriate prophylaxis (reports of which are currently required in the 2010/11 NHS Standard Contract for Acute Services). Trusts recognise that a financial attachment to an outcomes-focussed goal will drive behaviour change that will ultimately save lives.

Trusts have made clear that practical support is essential if they are to effectively deliver national VTE prevention policy and best practice requirements on a local level. Support is needed within Trusts themselves: there were calls for additional, ring-fenced resources to be allocated in recognition of VTE prevention being a priority within the Trust, and in response to the demands of local audits and root cause analysis. Trusts have also called for guidance and tools to comply with national requirements: Trusts called for a national, clinically-defined list of low-risk cohorts who do not need to be risk assessed individually for VTE on admission, as well as electronic tools to aid risk assessment and data collection. Finally, despite VTE prevention being an essential standard of safe care, there is overwhelming evidence that VTE risk assessment and prevention is not being taught to healthcare professionals at an undergraduate and postgraduate level. Trusts have called for this to be remedied immediately to ensure the risks of VTE are recognised and understood by all professionals.

Ongoing challenges exist around tracking the true scale of hospital acquired VTE. With figures from the National Statistician in November 2010 indicating that over 60,000 cases of DVT were registered as finished consultant episodes last year, a national coding mechanism for hospital acquired VTE is needed in order to establish an accurate number of VTE episodes acquired in hospital. This will help demonstrate the most effective prevention strategies.

Ultimately, the message that Trusts have delivered in this survey is that VTE prevention must be prioritised in the long-term in the NHS, with a focus on outcomes being essential to deliver the improvements in quality, safety and cost efficiency that VTE prevention so clearly offers.

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National Policy

‘Dear Colleague’ letter from NHS Medical Director and National Clinical Lead for VTE clarifying mandatory data collection, May 2010

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_116317

‘Dear Colleague’ letter from Chief Medical Officer and NHS Medical Director on national VTE risk assessment tool, March 2010

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_114570.pdf

National VTE risk assessment tool, March 2010

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215

‘Using the Commissioning for Quality and Innovation (CQUIN) payment framework – an addendum to the 2008 policy guidance for 2010/11’

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110431.pdf

2010/11 NHS Standard Contract for Acute Services

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111203

National Best Practice

NICE quality standard on VTE prevention, Jun2 2010

<http://www.nice.org.uk/aboutnice/qualitystandards/vteprevention/>

‘Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital’ – NICE clinical guideline 92

<http://www.nice.org.uk/CG92>

NICE cost saving guidance

<http://www.nice.org.uk/usingguidance/benefitsofimplementation/costsavingguidance.jsp>

Education and best practice resources

Lifeblood: The Thrombosis Charity

<http://www.thrombosis-charity.org.uk/cms/index.php>

VTE Exemplar Centre Network

<http://www.kingsthrombosiscentre.org.uk/cgi-bin/kings/index.pl>

‘VTE prevention – a guide for delivering the CQUIN goal’, April 2010

<http://www.kingsthrombosiscentre.org.uk/cgi-bin/kings/update.pl>

Academy of Medical Royal Colleges Five-Point Plan on VTE Prevention, April 2010

<http://www.rcseng.ac.uk/news/college-president-backs-academy-venous-thromboembolism-prevention-plan>

Royal College of Nursing VTE e-learning resource

www.rcn.org.uk/vte



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Appendix 1: Freedom of information request and cover letter



All-Party Parliamentary Thrombosis Group

25 August 2010

Acute NHS Trust

Dear Medical Director,

Freedom of Information Request into <NHS Hospital Trust>'s VTE Policy

As you will be aware, the Department of Health has named VTE prevention the top clinical priority for 2010/11. A number of national policy levers have been put in place reflecting this, including VTE being named as one of the first of two national Commissioning for Quality and Innovation (CQUIN) goals. In addition, VTE management has been included in the NHS Standard Acute Provider Contract and, for the first time ever, the Academy of Medical Royal Colleges has been tasked to work with the Department of Health to provide professional leadership in this area. With the publication of the updated NICE VTE Guideline (Clinical Guideline 92) in January 2010, as well as the NICE VTE Quality Standard in June 2010, England is in a unique position demonstrating both clinical and policy leadership on VTE prevention.

The All-Party Parliamentary Thrombosis Group (APPTG) is keen to assess the effectiveness of these significant national developments on VTE prevention that is delivered in hospitals. Our Freedom of Information (Fol) request is therefore designed to measure compliance with national best practice and policy requirements. The aim is to identify the key challenges that Trusts are facing, and to communicate these messages to relevant stakeholders. This will help ensure the national VTE prevention policy is informed by the voice of medics charged with delivering the programme on the ground.

A report detailing the findings will be launched at the APPTG's Annual Conference, this year taking place on Tuesday 23rd November, between 3 and 6pm, where we will be joined by a line up of guest speakers. If you wish to register your place now, or nominate a colleague to do so, please contact Poonam Arora at the APPTG Secretariat, on poonam@insightpa.com.

Please find enclosed a copy of this year's Fol request, which has also been sent to the Trust's Freedom of Information team. I would be grateful if you could arrange for the most appropriate individual to complete the enclosed request, under the provisions of the Freedom of Information Act, and return it to the APPTG Secretariat by the extended deadline of **Friday 1 October 2010**.

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 sincerely,

Andrew Gwynne MP
Chair, All-Party Parliamentary Thrombosis Group

Cc Freedom of information team



FREEDOM OF INFORMATION REQUEST

Fol request into compliance of VTE prevention policies with national VTE best practice and policy

August 2010

Please note that the deadline for responses is Friday 1st October 2010

Name:

Position:

NHS Trust:

Contact Number:

Email:

Please note that a paper copy has been sent to the Medical Director, and an electronic copy has been sent to the Fol team.

Additional paper or electronic copies are available on request from the All-Party Parliamentary Thrombosis Group secretariat.

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

Poonam Arora
All-Party Parliamentary Thrombosis Group Secretariat
c/o Insight PA
52 Grosvenor Gardens
London
SW1W 0AU

Tel: 020 7824 1867
Fax: 020 7824 1851
Email: poonam@insightpa.com



Under the Freedom of Information Act 2000, the All-Party Parliamentary Thrombosis Group writes to request the following information:

SECTION ONE
Compliance with VTE best practice (NICE clinical guideline 92 and NICE VTE quality standard)

- 1) Does your Trust have written VTE prevention policies in place for all groups of adult admissions?

If not, please detail the clinical areas or cohorts of patients in which there are omissions/exemptions.
- 2) Do your VTE prevention policies require that all adult patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria set out in the national tool?
- 3) Do your VTE prevention policies require that patients/carers are offered verbal AND written information on VTE prevention as part of the admission process?

If not, please detail what information, if any, you do provide.
- 4) Do your VTE prevention policies require that patients provided with anti-embolism stockings have them fitted and monitored in accordance with NICE clinical guideline 92?
- 5) Do your VTE prevention policies require that patients are re-assessed within 24 hours of admission for risk of VTE and bleeding?

If not, please detail when, if at all, your policies require re-assessment.
- 6) Do your VTE prevention policies require that patients who are assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE clinical guideline 92?
- 7) Do your VTE prevention policies require that patients/carers are offered verbal AND written information on VTE prevention as part of the discharge process?

If not, please detail what information, if any, you do provide.
- 8) Do your VTE prevention policies require patients to be offered extended VTE prophylaxis in accordance with NICE clinical guideline 92?



SECTION TWO
Compliance with the national VTE Commissioning for Quality and Innovation (CQUIN) payment framework goal

9) Does your CQUIN scheme for 2010/11 include the national goal on reducing avoidable death, disability and chronic ill health from VTE?

If not, please detail why.

10) What is the estimated value to your Trust of CQUIN money related to the VTE goal, payment of which is triggered if your Trust meets the national goal requiring 90% of patients to be risk assessed?

11) What percentage of adult inpatients had a risk assessment on admission to hospital using the clinical risk assessment criteria set out in the national tool, as per the Trust's monthly CQUIN data returns in:

- a. June 2010;
- b. July 2010; and
- c. August 2010?

12) Which of the following groups, if any, will be involved in supporting achievement of the VTE indicator in your Trust, and how?

- a. Thrombosis Committee
- b. Risk and Audit Committee
- c. Clinical Governance/Patient Safety team
- d. Collaboration for Leadership in Applied Health Research and Aare (CLAHRC) partnerships
- e. Academic Health Science Centres (AHSCs)
- f. Health and Innovation Education Clusters (HIECs)
- g. Other (please detail)

SECTION THREE
VTE Clinical Audit Data within Standard Acute Contract

13) As per the NHS Standard Acute Contract (April 2010), what are the results of local audits on the percentage of patients risk assessed for VTE who went on to receive the appropriate prophylaxis, where both the risk assessment criteria and prophylaxis are based on national guidance, for the following months?

- a. April 2010;
- b. May 2010;
- c. June 2010;
- d. July 2010; and
- e. August 2010.

If you are unable to provide results, please detail why.



- 14) As per the NHS Standard Acute Contract (April 2010), what percentage of confirmed cases of hospital acquired pulmonary embolism and deep vein thrombosis were followed up with root cause analysis in the following months?
- April 2010;
 - May 2010;
 - June 2010;
 - July 2010; and
 - August 2010.

(i.e. those arising from a current stay or new events arising where there is a history of admission to hospital within the last three months, but not including patients admitted to hospital with a confirmed VTE with no history of an admission to hospital within the last three months.)

If you are unable to provide results, please detail why.

SECTION FOUR Management of VTE Policy in your Trust

- 15) Who is responsible for routinely risk assessing patients on admission?
- 16) Who is responsible for routinely recording the outcome of the risk assessment?
- 17) Who is responsible for routinely prescribing appropriate prophylaxis?
- 18) Who is responsible for routinely administering prophylaxis to patients?
- 19) Who is responsible for routinely re-assessing patients?
- 20) Does your Trust utilise an electronic risk assessment tool?
- 21) What steps has your Trust taken to educate clinical staff to ensure they understand the CQUIN VTE goal, are able to risk assess patients, record the outcome, prescribe and administer appropriate prophylaxis?



SECTION FIVE VTE Incidence

22) How many patients in your Trust suffered a non-fatal deep vein thrombosis or pulmonary embolism arising EITHER from a current stay, OR as a new event where there is a history of admission to hospital within the last three months, during the year April 2009 – April 2010?

(This does not include patients admitted to hospital with a confirmed VTE but no history of an admission to hospital within the last three months.)

23) How many patients in your Trust suffered a fatal deep vein thrombosis or pulmonary embolism arising EITHER from a current stay, OR as a new event where there is a history of admission to hospital within the last three months, during the year April 2009 – April 2010?

(This does not include patients admitted to hospital with a confirmed VTE but no history of an admission to hospital within the last three months.)

SECTION SIX Implementing VTE Prevention Best Practice and Policies

24) What national action would enable the Trust Medical Director/Thrombosis Committee to more effectively and thoroughly implement VTE prevention best practice? Please rank where more than one of the following may apply:

- a. A mandated minimum standard of VTE risk assessment and thromboprophylaxis
- b. Electronic risk assessment and data collection tool
- c. Payment incentive rewarding risk assessment and thromboprophylaxis (such as continuation of CQUIN payment framework)
- d. Nationally delivered education schemes for health undergraduates and professionals
- e. A national drugs chart including thromboprophylaxis
- f. Other (please detail)

SECTION SEVEN Please use this section if you wish to add any additional comments



Appendix 2: List of respondent and non-respondent Hospital Trusts

NHS ACUTE HOSPITAL TRUST	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 University 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
Blackpool, Fylde and Wyre Hospitals NHS Foundation 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 Foundation Trust	YES
Calderdale and Huddersfield NHS Foundation Trust	YES
Cambridge University Hospitals NHS Foundation Trust	YES
Central Manchester 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
Colchester Hospital University NHS Foundation Trust	NO
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
Ealing Hospital NHS Trust	YES
East and North Hertfordshire NHS Trust	YES
East Cheshire NHS Trust	YES
East Kent Hospitals University NHS Foundation Trust	YES
East Lancashire Hospitals NHS Trust	NO
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
Great Western Hospitals NHS Foundation Trust	YES
Guy’s and St Thomas’ NHS Foundation Trust	YES
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	YES



Hull and East Yorkshire Hospitals NHS Trust	YES
Imperial College Healthcare NHS 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 Foundation Trust	YES
King's College Hospital NHS Foundation Trust	YES
Kingston Hospital NHS Trust	NO
Lancashire Teaching Hospitals NHS Foundation Trust	YES
Leeds Teaching Hospitals NHS Trust	YES
Luton and Dunstable Hospital NHS Foundation Trust	YES
Maidstone and Tunbridge Wells NHS Trust	YES
Mayday Healthcare NHS Trust	YES
Medway NHS Foundation Trust	YES
Mid Cheshire Hospitals NHS Foundation Trust	YES
Mid Essex Hospital Services NHS Trust	YES
Mid Staffordshire NHS Foundation Trust	YES
Milton Keynes Hospital NHS Foundation Trust	YES
Newham University Hospital NHS Trust	YES
Norfolk and Norwich University Hospitals NHS Foundation Trust	YES
North Bristol NHS Trust	YES
North Cumbria University Hospitals NHS Trust	YES
North Middlesex University Hospital NHS Trust	YES
North Tees and Hartlepool NHS Foundation 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
Oxford Radcliffe Hospitals NHS Trust	YES
Papworth Hospital NHS Foundation Trust	YES
Peterborough and Stamford Hospitals NHS Foundation Trust	NO
Plymouth Hospitals NHS Trust	YES
Poole Hospital NHS Foundation Trust	YES
Portsmouth Hospitals NHS Trust	YES
Queen Victoria Hospital NHS Foundation Trust	NO
Royal Berkshire NHS Foundation Trust	YES
Royal Bolton Hospital NHS Foundation Trust	YES
Royal Brompton & Harefield NHS Foundation Trust	YES
Royal Cornwall Hospitals NHS Trust	NO
Royal Devon and Exeter NHS Foundation Trust	YES
Royal Free Hampstead NHS Trust	YES
Royal Liverpool and Broadgreen University Hospitals NHS Trust	NO
Royal Surrey County Hospital NHS Foundation Trust	NO
Royal United Hospital Bath NHS Trust	YES
Salford Royal NHS Foundation Trust	YES
Salisbury NHS Foundation Trust	YES
Sandwell and West Birmingham Hospitals NHS Trust	YES
Scarborough and North East Yorkshire Healthcare NHS Trust	YES
Sheffield Teaching Hospitals NHS Foundation Trust	YES
Sherwood Forest Hospitals NHS Foundation Trust	YES
South Devon Healthcare NHS Foundation Trust	YES
South London Healthcare NHS Trust	YES

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Further Information

Contact Details

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Further Information

Contact Details

Appendix: 2

South Tees Hospitals NHS Foundation Trust	YES
South Tyneside NHS Foundation Trust	YES
South Warwickshire NHS Foundation 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 Teaching Hospitals NHS Trust	YES
Stockport NHS Foundation Trust	YES
Surrey and Sussex Healthcare NHS Trust	NO
Tameside Hospital NHS Foundation Trust	YES
Taunton and Somerset NHS Foundation Trust	YES
The Christie NHS Foundation Trust	YES
The Dudley Group of Hospitals NHS Foundation Trust	YES
The Hillingdon Hospital NHS Trust	YES
The Lewisham Hospital NHS Trust	YES
The Mid Yorkshire Hospitals NHS Trust	YES
The Newcastle upon Tyne Hospitals NHS Foundation Trust	YES
The North West London Hospitals NHS Trust	YES
The Pennine Acute Hospitals 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 Bournemouth and Christchurch Hospitals NHS Foundation Trust	YES
The Royal Marsden 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 of North Staffordshire NHS Trust	YES
University Hospital of South Manchester NHS Foundation Trust	YES
University Hospitals Birmingham 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
Warrington and Halton Hospitals NHS Foundation Trust	YES
West Hertfordshire Hospitals NHS Trust	YES
West Middlesex University Hospital NHS Trust	YES
West Suffolk Hospitals NHS Trust	YES
Western Sussex Hospitals NHS Trust	NO
Weston Area Health NHS Trust	YES
Whipps Cross University Hospital NHS Trust	YES
Winchester and Eastleigh Healthcare NHS Trust	NO
Wirral University Teaching Hospital NHS Foundation Trust	YES
Worcestershire Acute Hospitals NHS Trust	YES
Wrightington, Wigan and Leigh NHS Foundation Trust	YES
Yeovil District Hospital NHS Foundation Trust	YES
York Hospitals NHS Foundation Trust	YES



All-Party Parliamentary Thrombosis Group

“Awareness, Assessment, Management and Prevention”



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