ANNUAL REVIEW

NOVEMBER 2013

ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP
Awareness, Assessment, Management and Prevention

APPTG ANNUAL **SURVEY RESULTS**

www.apptg.org.uk

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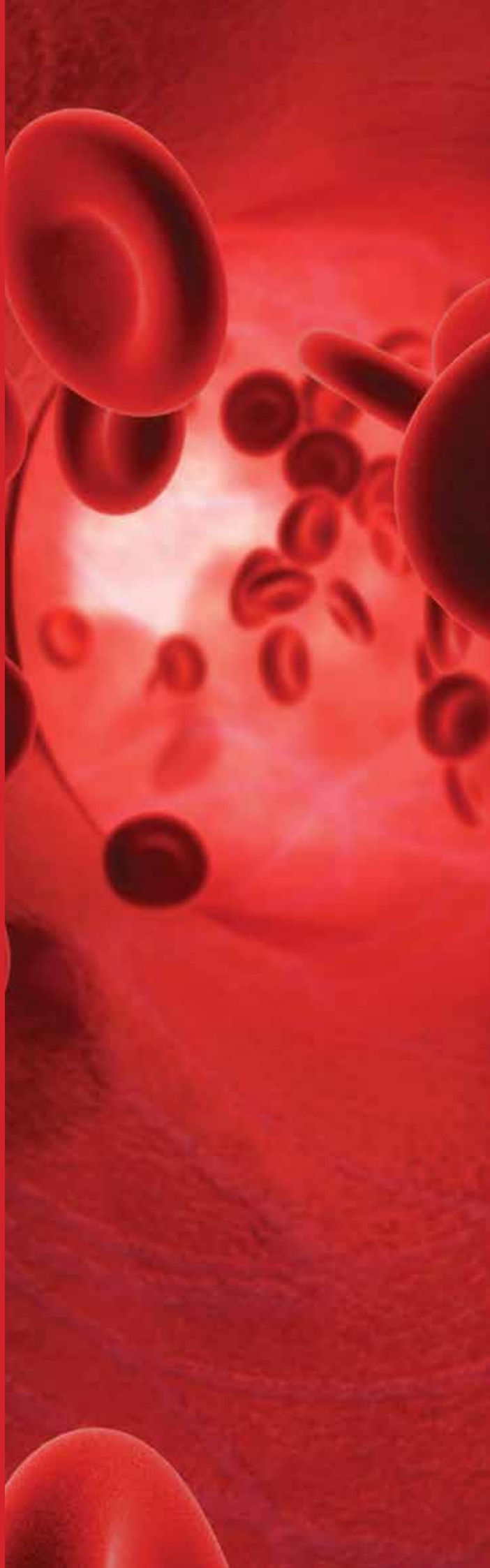
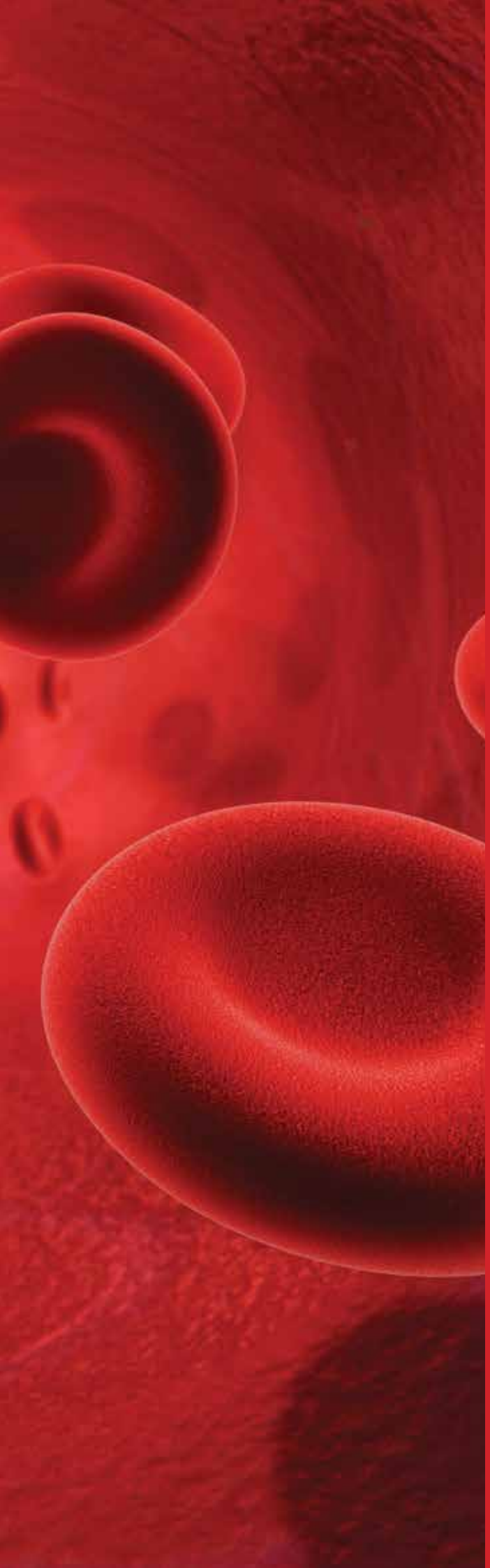




ABOUT VTE

Venous thromboembolism (VTE) is a condition in which a thrombus – a blood clot – forms in a vein. Usually, this occurs in the deep veins of the legs and pelvis and is known as deep vein thrombosis (DVT). The thrombus or its part can break off, travel in the blood system and eventually block an artery in the lung. This is known as a pulmonary embolism (PE). VTE is a collective term for both DVT and PE.

With an estimated incidence rate of 1-2 per 1,000 of the population, VTE is a significant cause of mortality and disability in England with thousands of deaths directly attributed to it each year. One in twenty people will have VTE during their lifetime and more than half of those events are associated with prior hospitalisation. At least two thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and the administration of appropriate thromboprophylaxis.

CHAIR'S FOREWORD

Dear Colleague,

As the Chair of the All-Party Parliamentary Thrombosis Group (APPTG), I am delighted to launch our Annual Review.

Ever since its conception in 2006, the APPTG has produced annual reports to support the implementation of best practice in VTE prevention in the NHS. Drawing on the evidence gathered by our Annual Survey of Acute Trusts, our reports provide: a comprehensive overview of progress in implementing best practice, identify areas for future improvement; and offer a series of recommendations on what more can be done to ensure that NHS services are underpinned by the delivery of high quality VTE prevention and management.

Following the successful introduction of this initiative last year, we are once again complementing our Annual Survey by the production of customised VTE Prevention Scorecards for every Trust that took part in our survey. The scorecards, which are available for download from the APPTG website (www.apptg.org.uk), offer a bespoke collection of local data on Trusts' compliance with best practice in VTE prevention. The Scorecards are intended to allow Trusts to benchmark their performance against the rest of England, to recognise their successes and identify areas that require further attention in the future.

We commend the progress made by Trusts in embedding VTE risk assessment as a standard patient safety practice in our hospitals, with almost 96 per cent of NHS patients having undergone this assessment on admission to hospital in the last reporting period. Nevertheless, we need to recognise that risk assessment forms only one element of best practice in VTE prevention and needs to be followed up by the administration of appropriate thromboprophylaxis for those patients judged to be at risk. As our survey shows, much more could be done to ensure that Trusts carry out root cause analysis of confirmed cases of hospital-associated thrombosis (HAT) and that patients are offered the information they need to understand the risks they face while in hospital and following discharge.

In order to gain a better understanding of the commissioning approaches to VTE prevention adopted by local commissioners, this year's survey also covered Clinical Commissioning Groups (CCGs). Commissioners in the new NHS must recognise that the delivery of high quality VTE prevention should automatically underpin the majority of admissions due to medical illness or surgery as part of providers' duty to deliver care in a safe environment. It was therefore noted with concern that our survey of CCGs indicated that many CCGs have not yet appointed an official charged with quality assurance of the VTE prevention delivered by local providers. As our report shows, commissioners are sometimes not making the most of the opportunities afforded to them by the financial incentives attached to the national VTE CQUIN goal and we would like that to set more aspirational standards for VTE prevention in their areas.

The publication of this Annual Review marks the end of another eventful year for the APPTG. In July, we launched our first ever report into the Management of VTE in the NHS. While we recognise that high quality VTE prevention in our hospitals needs to remain a priority for the NHS, we also know that not all instances of VTE can be avoided. VTE events that take place in the community can be particularly

difficult to prevent. It is therefore important that when VTE does occur, healthcare professionals are aware of what constitutes best practice in its management and are effectively supported to deliver this service in practice.

Given the strong demand for professional education amongst primary care professionals uncovered by our report, the APPTG has called for healthcare commissioners to work together with Health Education England and the Royal College of GPs to deliver formalised, structured education to GPs on best practice in the diagnosis and management of VTE as a matter of urgency.

To help spread awareness of best practice in VTE prevention and management amongst commissioners, the APPTG, in partnership with the National VTE Prevention Programme, has been hosting a series of regional workshops designed specifically for this audience. As a result of the broader NHS reform this year, there are a large number of commissioners new to their posts throughout the NHS. It is therefore imperative that awareness is raised of the commissioning levers available to them when designing services that deliver high quality VTE prevention for populations covered by their commissioning bodies.

Finally, in September the APPTG held an extraordinary meeting entitled VTE Prevention NHS Showcase; an event designed to highlight the significant progress made by the National VTE Prevention Programme in recent years. We were delighted to welcome Professor Sir Bruce Keogh, NHS England National Medical Director, who expressed his support for the work of the National VTE Prevention Programme and the APPTG, describing recent achievements in VTE prevention as "probably the single biggest change programme, conducted in the fastest way, that the NHS has ever seen."

The APPTG takes a lot of encouragement from the kind words of Sir Bruce; however, we recognise that our mission is far from over. We remain committed to working together with NHS leadership, healthcare commissioners and clinicians from secondary and primary care settings to firmly embed best practice in VTE prevention and management into the systems and processes of the new NHS in the long-term.

I hope you find our Annual Review informative and that it inspires you to continue your work in helping to spread awareness of best practice in VTE prevention and management, whatever your role in the health system.

Andrew Gwynne MP
Chair, All-Party Parliamentary Thrombosis Group

SUMMARY OF FINDINGS

Acute Trusts Survey

Only 3% of Trusts taking part in our survey failed, on average, to reach the 90 per cent national VTE CQUIN risk assessment goal for 2012/13

1 in 5 Trusts that responded to our survey indicated that, while they do have a written policy on VTE prevention in place, it does not cover all seven NICE Quality Standard statements.

Only 36% of Trusts indicated that they submit monthly reports on the outcome of all root cause analyses performed pursuant to Service Condition 20 of the NHS Standard Contract 2013/14 and were able to provide details of recent reports to demonstrate this.

Only 28% of Trusts were able to provide evidence to demonstrate that they undertake audits of whether verbal and written information on VTE prevention is offered as part of the admission and discharge processes to patients identified as being at risk of VTE.

46% of Trusts that responded to our survey indicated that they scored Level 1 during their latest assessment by the NHSLA on the VTE risk management standard.

5% The Care Quality Commission found evidence of risk relating to VTE risk assessment in five per cent of Trusts participating in our survey.

Clinical Commissioning Groups Survey

Almost ⅕ of CCGs that took part in our survey indicated that they have not yet appointed a person charged with quality assurance of VTE prevention delivered by local providers.

62% of CCGs indicated that they are choosing not to increase their local CQUIN VTE risk assessment thresholds, despite their local providers already reaching the 95 per cent goal.

36% of CCGs indicated that they set their providers targets of undertaking root cause analysis on all confirmed cases of hospital-associated thrombosis as part of the VTE CQUIN goal.

Over ¼ of CCGs indicated that some of their providers failed to meet the thresholds specified for the VTE risk assessment and RCA elements of the VTE CQUIN goal in at least one of the reporting periods since April 2013.

ACUTE TRUSTS SURVEY

The results of the survey are presented in six sections, examining Trusts' written VTE prevention policies; Commissioning for Quality and Innovation (CQUIN) data returns; approaches to root cause analysis; Care Quality Commission's (CQC) Intelligent Monitoring risk ratings; NHS Litigation Authority (NHSLA) Risk Management Standards; and, approaches to the distribution of patient information. With a response rate of 93 per cent (144 responses) we are confident that our survey results represent an accurate picture of activity within Trusts and their compliance with national VTE best practice and policy.

a) VTE Prevention Policy

The key measures of best practice in VTE prevention are captured in NICE Quality Standard 3, issued in June 2010. The Quality Standard provides specific, concise quality statements to provide patients, clinicians and healthcare commissioners with definitions of high quality care in VTE prevention.

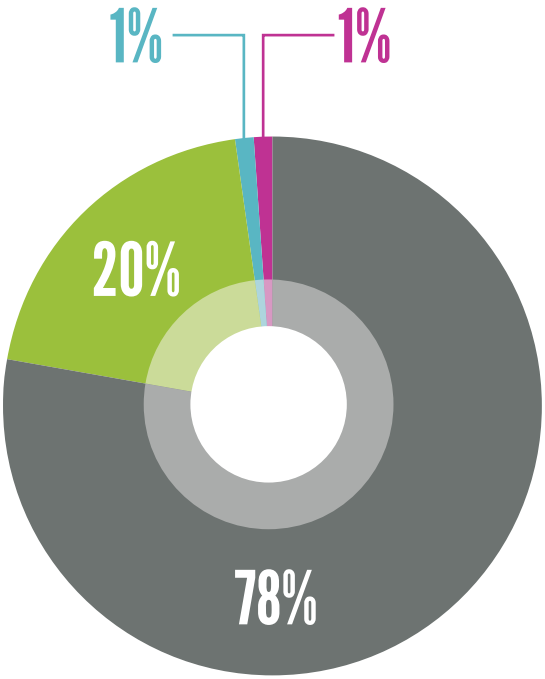
NICE QUALITY STANDARD 3: VTE PREVENTION	
Statement 1	All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool.
Statement 2	Patients/carers are offered verbal and written information on VTE prevention as part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

ACUTE TRUSTS SURVEY

The APPTG has long recommended that all seven statements of the Quality Standard should be incorporated into Trusts' written policies on VTE prevention. Of those Trusts that responded to our survey, 78 per cent indicated that they have in place a written policy for preventing and managing the risks of VTE for adult hospital admissions, and that this policy is in line with all seven principles of best practice contained within the NICE Quality Standard. 20 per cent indicated that, while they do have a written policy on VTE prevention in place, it does not cover all seven NICE Quality Standard statements.

It is worth noting that the proportion of Trusts that indicated having a Quality Standard-based VTE prevention policy in place represents a four per cent drop in comparison with the results captured by last year's survey. The APPTG notes this development with concern and would encourage those Trusts that do not have such a policy in place already to develop it as a matter of urgency. This is especially important as the demonstration of the existence of, and adherence to, a Trust-wide VTE prevention policy is a requirement of the NHSLA Risk Management Standards. The presence and continued compliance with VTE prevention policies based on the NICE Quality Standard should be consistently mandated through service contracts by local commissioners; however, anecdotal evidence suggests that commissioners are not routinely using the Quality Standard to design their local VTE prevention service specification.

VTE Prevention Policy



The Trust indicated that it has in place a written policy for preventing and managing the risks of VTE for adult hospital admissions, and that this policy is in line with all seven principles of best practice contained within the NICE Quality Standard on VTE prevention.

The Trust indicated that it has in place a written policy for preventing and managing the risks of VTE for adult hospital admissions. However, the Trust was unable to indicate that the policy aligns with all seven principles of best practice contained within the NICE Quality Standard on VTE prevention.

The Trust indicated that it does not have in place a written policy for preventing and managing the risks of VTE for adult hospital admissions.

The Trust was unable to indicate whether it has in place a written policy for preventing and managing the risks of VTE for adult hospital admissions.

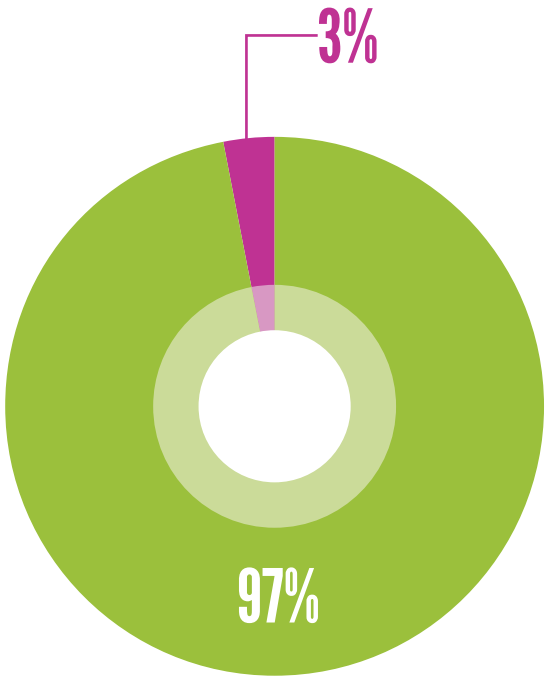
ACUTE TRUSTS SURVEY

b) National CQUIN Data Returns

NHS England recognises the importance of VTE prevention to the delivery of care in a safe environment and VTE-specific indicators are contained in Domain 5 of both the NHS Outcomes Framework and the CCG Outcomes Indicators Set. VTE prevention has also been one of the national CQUIN goals since 2010. As part of the national VTE CQUIN goal in place for 2012/13, Trusts were required to ensure that 90 per cent of all adult inpatients receive a VTE risk assessment on admission to hospital. If this goal was not met, local commissioners had the right to withhold a proportion of the providers' income. Performance against the risk assessment indicator is measured through a nationally mandated monthly Unify2 data collection for all providers of NHS acute services. This data, published on NHS England website, indicates that 97 per cent of Trusts taking part in our survey have, on average, achieved the national goal to risk assess 90 per cent of all adult patients on admission to hospital in 2012/13. Only three per cent of Trusts failed to reach the 90 per cent goal. This represents a significant improvement on last year when 24 per cent of Trusts failed to reach the same target.

In order to gain better understanding of the effect of the VTE CQUIN goal, our survey asked the Trusts to indicate whether they had their CQUIN payment, or a proportion of it, withheld due to non-compliance with the national VTE prevention goal in any of the four financial years since its introduction. The responses indicated that 23 per cent of Trusts that participated in our survey had at a least a part of their income withheld due to failure to reach the VTE risk assessment goal in 2010/11. As the delivery of VTE risk assessment improved across the country in subsequent years, this percentage fell to 15 per cent in 2011/12 and further to 11 per cent in 2012/13.

National CQUIN Data Returns



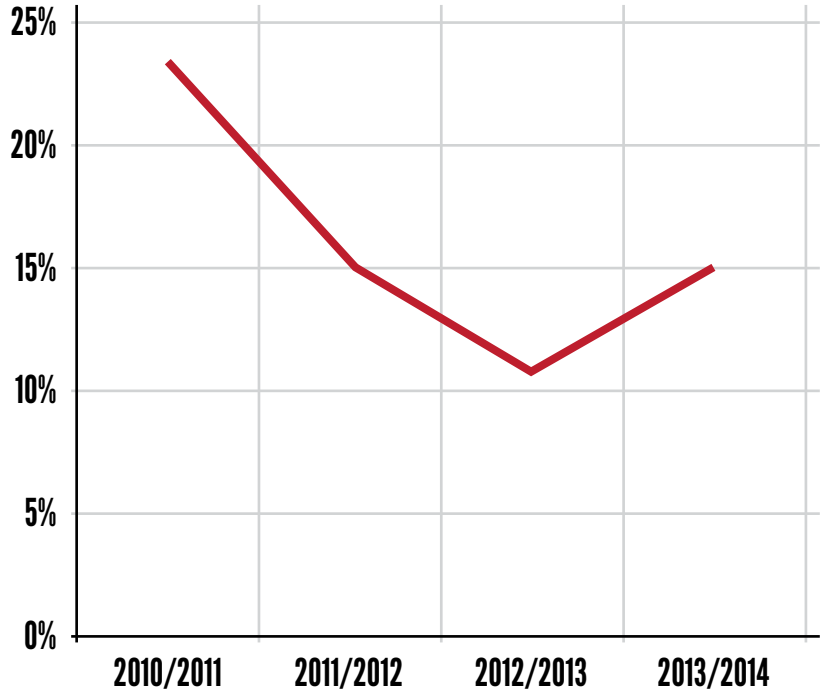
National CQUIN returns indicate that during 2012/13, on average, the Trust achieved the national goal to risk assess 90% of all adult inpatients on admission to hospital for VTE and bleeding.

National CQUIN returns indicate that during 2012/13, on average, the Trust did not achieve the national goal to risk assess 90% of all adult inpatients on admission to hospital for VTE and bleeding.

ACUTE TRUSTS SURVEY

For the financial year 2013/14, the VTE CQUIN goal has been extended, targeting further improvements in care. The current VTE CQUIN goal requires 95 per cent of patients to be risk assessed for VTE on admission as well as the achievement of a locally agreed goal for the number of root cause analyses (RCAs) on confirmed cases of PE and DVT. In part due to the changes to the VTE CQUIN goal for 2013/14, making it more difficult to achieve, the percentage of Trusts which had at least part of their CQUIN income withheld due to their failure to meet the performance thresholds stipulated by the VTE CQUIN goal rose back to 15 per cent. It should, however, be noted that the data for 2013/14 does not cover the entire current financial year and the final proportion of Trusts facing CQUIN penalties could rise by the end of it.

Percentage of Trusts that indicated having their CQUIN payment, or a proportion of it, withheld due to non-compliance with the national VTE prevention CQUIN goal.



2010/2011	23%
2011/2012	15%
2012/2013	11%
2013/2014	15%

The APPTG commends the performance of Trusts across the country in increasing the proportion of patients receiving VTE risk assessment on admission to hospital. The most recent data shows that in August 2013, 95.6 per cent of patients were risk assessed for VTE on admission, compared to only 47 per cent in July 2010 when mandatory data collection was introduced. Such performance establishes the NHS as a world leader in systematic VTE risk assessment; however, it has to be noted that VTE risk assessment represents only one element of an effective VTE prevention strategy and needs to be accompanied by the administration of appropriate thromboprophylaxis in order to deliver optimal benefit to patients. There is no doubt that the introduction of incentives associated with the VTE CQUIN goal played a major part in encouraging the improvement in risk assessment performance seen across the country. The APPTG hopes that the widening of the national CQUIN goal for 2013/14 will deliver similar improvements in the area of RCA.

ACUTE TRUSTS SURVEY

c) Root Cause Analysis (RCA)

Root cause analysis allows Trusts to undertake a structured analysis of the reasons for each case of hospital-associated thrombosis, giving them the opportunity to feed their learnings back into their quality management frameworks. Learning from past shortcomings and adapting local practice accordingly is a major driver of service improvement and is instrumental in instilling a sense of accountability amongst Trusts and local commissioners. RCA will also play an important role in helping Trusts carry out their responsibilities with regard to the newly instituted duty of candour.

According to Service Condition 20 of the NHS Standard Contract 2013/14, the provider must:

"perform root cause analysis of all confirmed cases of pulmonary embolism and deep vein thrombosis acquired by Service Users while in hospital (both arising during a current hospital stay and where there is a history of hospital admission within the last 3 months..."

The provider might then be required to report the results of those RCAs monthly in accordance with the reporting requirements.

Only 36 per cent of responding Trusts indicated that they submit monthly reports on the outcome of all RCAs performed pursuant to Service Condition 20 of the NHS Standard Contract 2013/14 and were able to provide details of recent reports to demonstrate this. This is a disappointing finding and the APPTG would encourage Trusts as well as commissioners to closer observe the relevant clauses in the NHS Standard Contract 2013/14 in order to improve practice at the local level.

From anecdotal evidence available, the APPTG understands practical difficulties remain within Trusts in regularly and thoroughly undertaking RCAs. Support for RCAs in Trusts is essential to inform learning and improve local approaches to VTE prevention. Commissioners must enforce compliance with local contracting provisions on RCA so that appropriate resources are allocated to this process at a Trust level, and to deliver a longer-term impact on quality of care and outcomes.

d) Care Quality Commission (CQC) Intelligent Monitoring

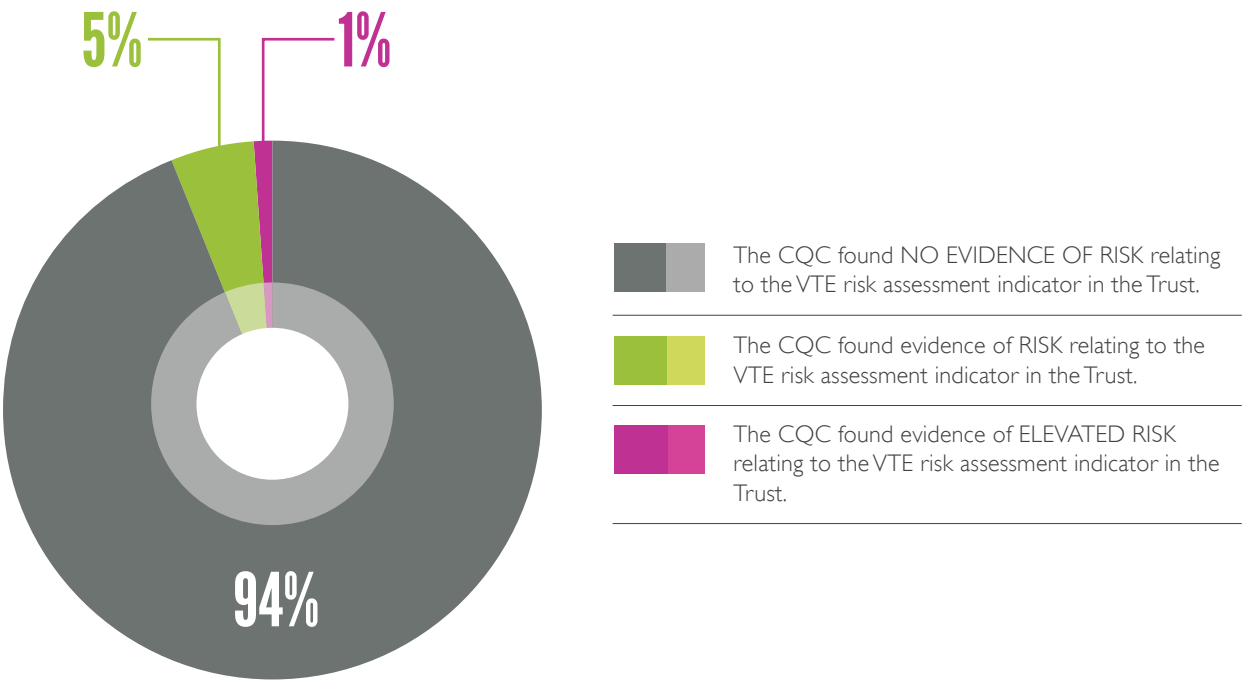
In October 2013, the Care Quality Commission (CQC) published its new Intelligent Monitoring analysis, capturing data on more than 150 indicators encompassing the quality and safety of the Trusts' services as well as patient and staff experience. The CQC will use this analysis to inform its inspections by highlighting areas of care that need to be followed up but will not, on its own, use them to make final judgements. Together with local information from CQC's partners and the public, Intelligent Monitoring will help the CQC decide when, where and what to inspect.

In its 2012 report Addressing the challenges, maintaining the momentum, the APPTG recommended that the Care Quality Commission prioritise VTE prevention as part of its regulatory framework of secondary care services. We have therefore welcomed the fact that one of the indicators used in the CQC's Intelligent Monitoring relates to the proportion of patients risk assessed for VTE. Using the most up-to-date data, the CQC analysed each of the indicators to identify one of the following risk levels for each Trust: 'no evidence of risk', 'risk' or 'elevated risk'.

For 94 per cent of Trusts that participated in our survey, the CQC found no evidence of risk relating to VTE risk assessment indicator in the Trust. Evidence of risk relating to the VTE risk assessment indicator was found in five per cent of Trusts and two Trusts were deemed to be at an elevated risk. The APPTG would encourage Trusts to take note of the CQC's Intelligent Monitoring analysis and use it to identify areas for improvement. The APPTG will be contacting the two Trusts identified as being at an elevated risk for the VTE-specific indicator and offering its support to address any local challenges relating to VTE risk assessment.

ACUTE TRUSTS SURVEY

CQC Intelligent Monitoring



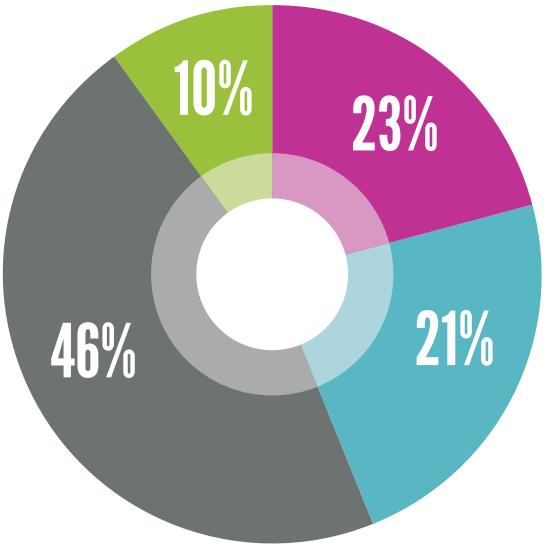
e) NHS Litigation Authority (NHSLA) Risk Management Standards

Acute Trusts are assessed annually against risk management standards developed by the NHSLA. These standards have been designed to reflect the issues which arise most often in the negligence claims reported to the NHSLA. All the NHSLA Standards are divided into three "levels". As NHS organisations achieve higher levels, they receive more favourable premiums on their annual insurance contributions. Failure in any one of the risk management criteria could lead to a failed assessment; passing the annual assessment, however, can lead to discounts of over £1m.

46 per cent of Trusts that responded to our survey indicated that they scored Level 1 during their latest assessment by the NHSLA on the VTE risk management standard. 23 per cent of Trusts scored Level 2 and 21 per cent scored Level 3. This represents an improvement on last year when our survey indicated that only 11 per cent of Trusts achieved Level 3.

ACUTE TRUSTS SURVEY

NHSLA Risk Management Standards



The Trust indicated that during its latest assessment by the NHS Litigation Authority, it scored Level 3 on the VTE risk management standard (Criterion 5.9).

The Trust indicated that during its latest assessment by the NHS Litigation Authority, it scored Level 2 on the VTE risk management standard (Criterion 5.9).

The Trust indicated that during its latest assessment by the NHS Litigation Authority, it scored Level 1 on the VTE risk management standard (Criterion 5.9).

The Trust was unable to indicate its score on the VTE risk management standard during its latest assessment by the NHS Litigation Authority (Criterion 5.9).

f) Patient Information

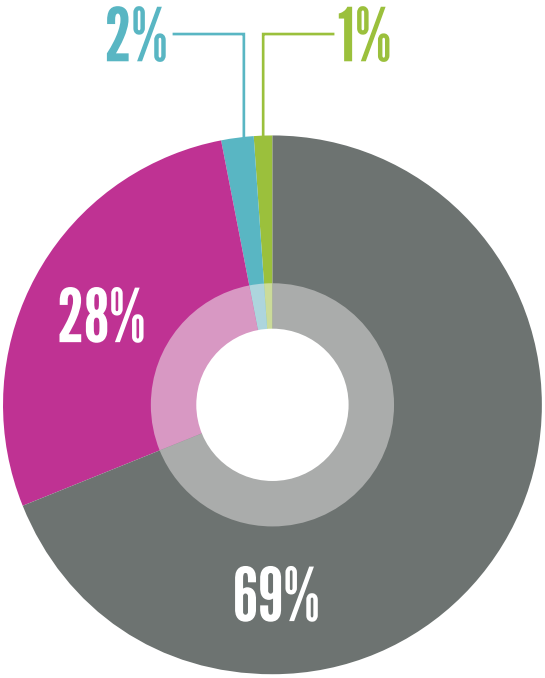
The expert opinion within the NICE Quality Standard on VTE prevention recommends that patients identified as at risk of VTE and requiring thromboprophylaxis should be offered verbal and written information on VTE prevention as part of the admission and discharge processes. The APPTG acknowledges the inherent difficulty of auditing the exchange of verbal information between the clinician and the patient and recognises that it is in part down to the auditing impracticalities that only 28 per cent of Trusts taking part in our survey were able to provide evidence to demonstrate that they undertake audits of whether verbal and written information on VTE prevention is offered as part of the admission and discharge processes to patients identified through VTE risk assessment as being at risk of VTE. The majority of Trusts, 69 per cent, indicated that they do not undertake such an audit.

Patients should be made aware of the VTE risks associated with admission to hospital but also of the increased risk that they face following their discharge. It is known that most cases of HAT occur only after discharge from hospital, with average DVT after surgery occurring on day seven and the average PE on day 21. Furthermore, anecdotal evidence suggests that information about the requirements of patients on extended thromboprophylaxis following their discharge from hospital might not always be clearly communicated to primary care staff, and patients receiving this treatment may be sub-optimally managed upon their return to the community. Information on how to mitigate their risk of VTE following their discharge is therefore of paramount importance to patients.

ACUTE TRUSTS SURVEY

Empowering patients by providing them with information on the risks of hospital-acquired VTE would go a long way to ensuring patient safety following their discharge from hospital. The APPTG would encourage Trusts to closely follow the instructions relating to the dissemination of patient information included in the NICE Quality Standard on VTE prevention and NICE Clinical Guideline 92.

Verbal and written information on discharge and admission



The Trust indicated that it undertakes audit of whether verbal and written information on VTE prevention is offered as part of the admission and discharge processes to patients identified through VTE risk assessment as being at risk of VTE, in line with NICE Clinical Guideline 92. The Trust was able to provide evidence to demonstrate this.

The Trust indicated that it undertakes audit of whether verbal and written information on VTE prevention is offered as part of the admission and discharge processes to patients identified through VTE risk assessment as being at risk of VTE, in line with NICE Clinical Guideline 92. However, the Trust was unable to provide evidence to demonstrate this.

The Trust indicated that it does not undertake audit of whether verbal and written information on VTE prevention is offered as part of the admission and discharge processes to patients identified through VTE risk assessment as being at risk of VTE, in line with NICE Clinical Guideline 92.

The Trust was unable to indicate whether it undertakes audit of whether verbal and written information on VTE prevention is offered as part of the admission and discharge processes to patients identified through VTE risk assessment as being at risk of VTE, in line with NICE Clinical Guideline 92.

CLINICAL COMMISSIONING GROUPS SURVEY

In order to gain a better understanding of the commissioning approaches to VTE prevention employed by local commissioners, the APPTG carried out a national survey of the 211 newly established CCGs. Having received responses from 76 per cent of CCGs (161 responses), we are confident that our survey provides an accurate representation of the national picture.

a) Quality Assurance

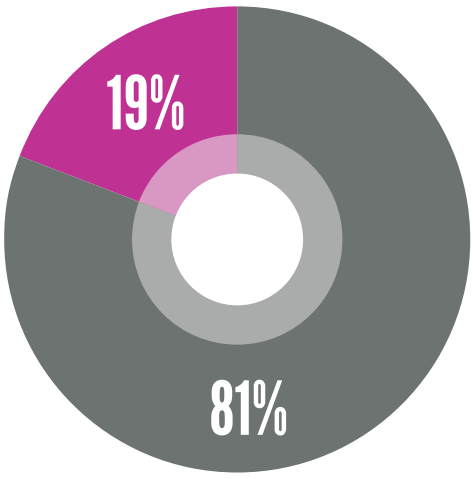
The delivery of high quality VTE prevention should automatically underpin the great majority of admissions due to medical illness or surgery as part of providers' duty to deliver care in a safe environment. Commissioners should ensure that this duty is clearly mandated through local service contracts and consistently monitored.

In order to ensure compliance with best practice in VTE prevention amongst local providers, the APPTG recommends that each CCG appoints a person with responsibility for quality assurance of VTE prevention amongst local healthcare providers. The survey results indicate that out of those CCGs that responded to our survey, 81 per cent have already appointed someone to such a role. The CCGs have a significant degree of autonomy in determining their organisation structure. The job titles of the people charged with quality assurance of VTE prevention therefore varied greatly, with the CCGs providing 68 different job titles across the country. The most common job titles for officials with responsibility for quality assurance of VTE prevention within CCGs were: Head of Quality, Chief Nurse, Executive Nurse and Director of Nursing and Quality.

Given that VTE prevention has been identified as the most important patient safety practice in our hospitals, the fact that one in five (19 per cent) CCGs has not yet appointed a person with responsibility for quality assurance of VTE prevention is cause for concern for the APPTG. A VTE-specific indicator is contained in the CCG Outcomes Indicator Set and by failing to ensure the provision of high quality VTE prevention from their providers these CCGs could put themselves at risk of facing future sanctions by NHS England Area Teams. The VTE indicator contained in the CCG Outcomes Indicator Set is derived from the VTE indicator 5.1 in the NHS Outcomes Framework, relating to deaths from VTE-related events. It is hoped that this indicator will be live from April 2014 and work is being undertaken to identify a suitable way of expressing this data at CCG level.

The APPTG urges those CCGs that have not done so already to urgently appoint a person with responsibility for quality assurance of VTE prevention in local hospitals.

Quality Assurance



The CCG indicated that it appointed a person with responsibility for quality assurance of VTE prevention delivered by local healthcare providers.

The CCG indicated that it has not yet appointed a person with responsibility for quality assurance of VTE prevention delivered by local healthcare providers.

CLINICAL COMMISSIONING GROUPS SURVEY

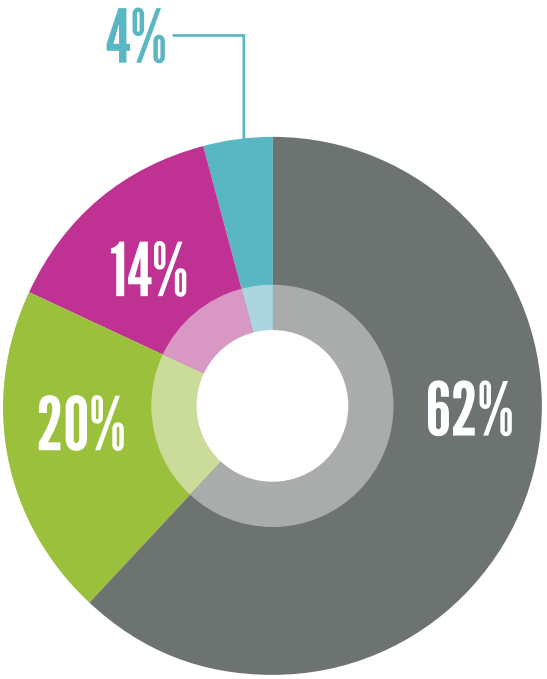
b) National VTE CQUIN Goal: VTE Risk Assessment

0.5 per cent of the value for all healthcare services commissioned through the NHS Standard Contract is linked to the national CQUIN goals. There are four national CQUIN goals for 2013/14, one of which focuses on VTE. As part of this goal, providers must ensure that 95 per cent of patients are risk assessed for VTE on admission and achieve a locally agreed goal for the number of RCAs on confirmed cases of PE and DVT.

Where local providers are already achieving over 95 per cent of all adult inpatients being risk assessed for VTE on admission, local commissioning organisations may choose to set a higher threshold for their providers. According to our survey, only 14 per cent of CCGs have chosen to exercise their right to adopt a higher threshold. The increased VTE CQUIN risk assessment thresholds that were adopted by these CCGs varied from 95.53 per cent to 100 per cent of patients risk assessed for VTE on admission. In some areas, the CCGs adopted thresholds that were progressively rising in each financial quarter.

20 per cent of CCGs that responded to our survey indicated they have not exercised their right to set a higher threshold for their providers because they were not yet reaching the basic 95 per cent threshold. Interestingly, 62 per cent of CCGs that took part in our survey indicated that they are choosing not to increase their local CQUIN VTE risk assessment thresholds, despite their local providers already reaching the 95 per cent goal. In order to capitalise on the potential of the national VTE CQUIN goal to improve local practice, the APPTG recommends that CCGs whose providers are already meeting the 95 per cent VTE risk assessment goal; consider setting new, higher and more aspirational risk assessment goals.

National VTE CQUIN Goal: VTE Risk Assessment



The CCG indicated that it set a higher threshold than 95 per cent for the VTE risk assessment component of the national VTE CQUIN goal 2013/14.

The CCG indicated that it has not set a higher threshold than 95 per cent for the VTE risk assessment component of the national VTE CQUIN goal 2013/14 because local providers were not yet reaching the 95 per cent threshold.

The CCG indicated that it has not set a higher threshold than 95 per cent for the VTE risk assessment component of the national VTE CQUIN goal 2013/14 despite their providers already reaching the 95 per cent threshold.

The CCG was unable to indicate whether it has a higher threshold than 95 per cent for the VTE risk assessment component of the national VTE CQUIN goal 2013/14.

CLINICAL COMMISSIONING GROUPS SURVEY

c) National VTE CQUIN Goal: Root Cause Analysis

The undertaking of RCA on all cases of RCA is central to best practice in VTE prevention. It can help providers to determine the proportion of potentially preventable events; enable learning from individual episodes of HAT; identify common themes; and, promote local and national solutions to cases of inadequate VTE prevention. According to the NHS Standard Contract 2013/14, RCAs should therefore be performed on all cases of hospital-associated thrombosis (HAT), defined as a VTE event occurring while a patient is still in hospital or within three months of discharge. The current VTE CQUIN goal provides a financial incentive to providers to adhere to this obligation by requiring Trusts to achieve a locally agreed quarterly target of root cause analyses.

In order to gain an insight into the nature of local agreements concerning this VTE CQUIN goal component, the survey asked the CCGs to disclose the locally agreed targets for RCAs. Surprisingly, 28 per cent of CCGs that responded to our survey were not able to provide an answer to this specific question, commonly due to the local agreements still being developed.

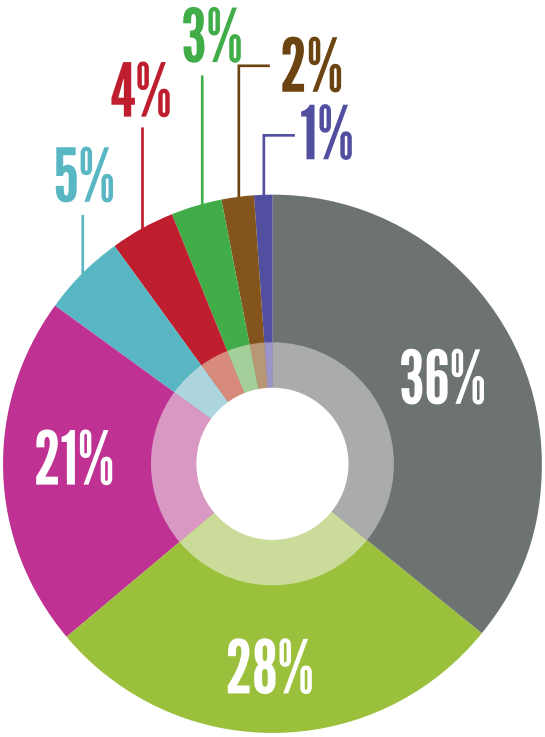
Out of the 116 CCGs that were able to provide an answer, 58 indicated that their local target for RCAs is 100 per cent of HATs. 34 CCGs indicated that their target is between 90 and 99 per cent. Lower number of CCGs indicated to have set their local RCA targets in lower ranges, with seven CCGs setting their targets in the 80-89 per cent range, five in the 70-79 per cent range, three in the 60-69 per cent range and only one in the 50-59 per cent range.* Eight CCGs indicated that they require their providers to deliver a specific number of RCAs every quarter rather than a given percentage of all HATs. These numbers ranged from three to fifteen RCAs per quarter.

RCAs are an essential driver of service improvement and the APPTG would encourage commissioners to use the VTE CQUIN goal to the best of its potential to encourage compliance with best practice in undertaking RCAs amongst their providers.

*VTE CQUIN RCA targets are set quarterly and can therefore vary across the financial year. Where this was the case, the highest quarterly target was used for the purpose of categorising the CCG. Similarly, where the RCA targets varied across local providers, the highest target was used for this analysis.

CLINICAL COMMISSIONING GROUPS SURVEY

National VTE CQUIN Goal: Root Cause Analysis



- The CGG indicated that its locally agreed target for RCAs is 100% of all cases of HAT.
- The CGG indicated that its locally agreed target for RCAs is between 90-99% of all cases of HAT.
- The CGG indicated that its locally agreed target for RCAs is between 80-89% of all cases of HAT.
- The CGG indicated that its locally agreed target for RCAs is between 70-79% of all cases of HAT.
- The CGG indicated that its locally agreed target for RCAs is between 60-69% of all cases of HAT.
- The CGG indicated that its locally agreed target for RCAs is between 50-59% of all cases of HAT.
- The CCG indicated that they require their providers to deliver a specific number of RCAs every quarter rather than a given percentage of all cases of HAT.
- The CCG was unable to indicate its locally agreed target for RCAs.

d) National VTE CQUIN Goal: Use of Financial Incentives

While the 2013/14 VTE CQUIN goal has been in place for only two full quarters, our survey sought to establish whether commissioners appear to be making use of the incentives offered by the VTE CQUIN goal effectively, removing incentives for poor performance in cases where Trusts fail to deliver services in line with the goal's requirements. 26 per cent of CCGs that took part in our survey indicated that some of their providers failed to meet the thresholds specified for the VTE risk assessment and RCA elements of the VTE CQUIN goal in at least one of the reporting periods since April 2013.

The vast majority of CCGs whose providers failed to meet the VTE CQUIN thresholds, 35 out of 42 CCGs, indicated that they have withheld or are planning to withhold a proportion of the CQUIN payment from the provider in question. Surprisingly, four CCGs indicated that while their providers have failed to meet the VTE CQUIN thresholds required to trigger the payment, they have not yet withheld a proportion of the total CQUIN payment from their providers and did not plan to do so. In these cases, the potential of the VTE CQUIN goal in incentivising improvements in VTE prevention is not realised and the CCGs in questions should act fast to administer the set financial penalties where appropriate. The APPTG will be contacting the four CCGs in question to enquire about the details of their local circumstances and will be offering its assistance in order to help them use the CQUIN commissioning lever to its full potential.

CONCLUSION

Significant progress has been made in embedding VTE prevention in NHS care in recent years. Since 2010 the percentage of patients assessed for their risk of VTE on admission to hospital rose from 47 per cent to the current level of over 95 per cent. The National VTE Prevention Programme, supported by the APPTG, has provided exceptional leadership to the efforts to establish high quality VTE prevention as one of the most important patient safety practices in our hospitals. Indeed, Professor Sir Bruce Keogh, NHS England National Medical Director, has recently described the NHS VTE prevention programme as "probably the single biggest change programme, conducted in the fastest way, that the NHS has ever seen."

While the APPTG commends the accomplishments of NHS staff in embedding VTE risk assessment as standard practice in our hospitals, it should be noted that risk assessment forms only one element of best practice in VTE prevention and needs to be followed by the administration of appropriate thromboprophylaxis. As our survey demonstrates, only a minority of providers undertake RCA in line with best practice as mandated by the NHS Standard Contract 2013/14. We were also concerned to find that the Care Quality Commission discovered evidence of risk relating to VTE risk assessment in five per cent of Trusts participating in our survey and call on them to address any possible shortcomings in VTE prevention as a matter of urgency. Moreover, while we acknowledge the inherent difficulty of auditing the exchange of verbal and written information on VTE prevention between healthcare professionals and patients, we urge Trusts to put in place robust systems that would facilitate information sharing, making patients aware of the risk of VTE.

Commissioners in the new NHS must recognise that the delivery of high quality VTE prevention should automatically underpin the majority of admissions due to medical illness or surgery as part of providers' duty to deliver care in a safe environment. As such, commissioners should ensure that this duty is clearly mandated through local service contracts. The APPTG noted with concern that almost one in five CCGs that took part in our survey indicated that they have not yet appointed an official charged with quality assurance of VTE prevention delivered by local providers. Furthermore, our survey results suggest that in many cases commissioners are failing to assure high quality VTE prevention by not making the most of the opportunities afforded to them by the financial incentives attached to the VTE CQUIN goal and choosing not to set more aspirational targets for VTE risk assessment and RCA.

Through its research into management of VTE in primary care undertaken earlier this year, the APPTG established that only a minority of GPs in England claim to be fully aware of what constitutes best practice in diagnosing patients with suspected DVT and are very confident when following this process in practice. Furthermore, our research found that a great majority of GPs have not yet received formalised structured education on best practice in the diagnosis and management of VTE in line with the recently published NICE Clinical Guideline 144 and NICE Quality Standard 29. In view of the high demand for professional education from primary care practitioners, the APPTG calls on healthcare commissioners to work together with Health Education England and the Royal College of GPs to deliver formalised structured education to GPs on best practice in the diagnosis and management of VTE as a priority.

The APPTG remains committed to working with the NHS leadership, healthcare commissioners and clinicians from across the patient pathway to help them tackle the challenges in making sure that NHS care is delivered in the safest possible settings and underpinned by high quality VTE prevention and management.

APPTG RECOMMENDATIONS FOR 2014

Drawing on the evidence gathered through this year's research reports and our interactions with NHS leaders, commissioners and clinicians across the NHS, the APPTG has identified the following recommendations for 2014 and calls on the VTE community to work together to support their delivery:

1. VTE prevention, management and treatment should remain a national clinical priority and should be firmly embedded in the post-Francis / Keogh / Berwick patient safety agenda. The 15 locally-led Patient Safety Improvement Collaborative programmes announced by NHS England in response to the Francis Report should focus on VTE prevention and management as one of the key improvement areas.
2. NHS England should further seek to ensure that the most appropriate metrics are included in the CCG Assurance Framework and the CCG Outcomes Indicator Set, enabling it to hold sub-optimally performing CCGs to account.
3. All Trusts where evidence of risk relating to the VTE risk assessment indicator was found by the CQC need to be urgently supported to adopt best practice in VTE prevention and address any outstanding patient safety concerns as a priority.
4. NHS England should work with the Commissioning Assembly to spread awareness amongst commissioners that high quality VTE prevention should automatically underpin the majority of admissions due to medical illness or surgery as part of providers' duty to deliver care in a safe environment. As such, commissioners should ensure that this duty is clearly mandated through local service contracts.
5. NHS England should continue to collect and publish VTE risk assessment data in the years ahead and consider ways in which Trust-level data on the delivery on requirements regarding RCA could also be made available.
6. Specific guidance on VTE in death reporting should be issued by the Chief Coroner to raise awareness of the importance of accurate coding of VTE in cases of patients with recent hospitalisation in order to better understand the true prevalence of the condition.
7. More formalised structured education needs to be made available to primary care professionals on the diagnosis, management and treatment of patients with VTE in order to satisfy the demand for more professional training.
8. An electronic VTE registry for the collection of RCA data should be rolled out nationally in order to compare and contrast national performance and identify a more comprehensive future outcomes measure.
9. The Quality Standard on VTE prevention should be piloted as a new contractual service specification to be published alongside the NHS Standard Contract 2014/15 in order to make providers contractually obliged to deliver best practice in VTE prevention.

FURTHER INFORMATION

All-Party Parliamentary Thrombosis Group:
http://apptg.org.uk/

National VTE Prevention Programme:
http://www.vteprevention-nhsengland.org.uk/

Commissioning Services That Deliver High Quality VTE Prevention: Guidance for Commissioners:
http://www.england.nhs.uk/wp-content/uploads/2013/05/vte-prev-guide-may2013.pdf

Lifeblood: The Thrombosis Charity
http://www.thrombosis-charity.org.uk/

Care Quality Commission - Intelligent Monitoring Reports
http://www.cqc.org.uk/public/hospital-intelligent-monitoring

NHS England - VTE Risk Assessment Data
http://www.england.nhs.uk/statistics/statistical-work-areas/vte/

VTE Exemplar Centres Network
http://www.vteprevention-nhsengland.org.uk/vte-exemplar-centres

NICE Clinical Guideline 92 - Reducing the risk of VTE in patients admitted to hospital
http://guidance.nice.org.uk/CG92

NICE Clinical Guideline 144 - Venous thromboembolic diseases: the management of venous thromboembolic diseases and the role of thrombophilia testing
http://guidance.nice.org.uk/CG144

NICE Quality Standard 3 – VTE Prevention
http://guidance.nice.org.uk/QS3

NICE Quality Standard 29 - Diagnosis and management of venous thromboembolic diseases
http://guidance.nice.org.uk/QS29

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Awareness, Assessment, Management and Prevention