ANNUAL REVIEW

NOVEMBER 2014

ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

Awareness, Assessment, Management and Prevention

APPTG ANNUAL **SURVEY RESULTS**

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CONTENTS

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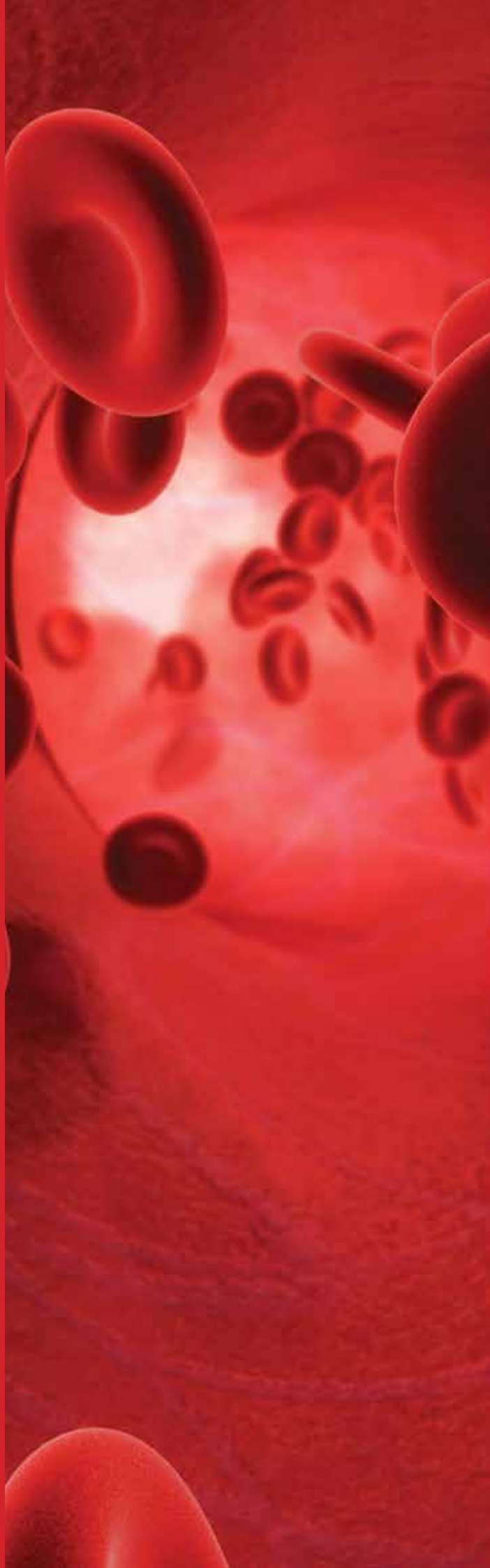
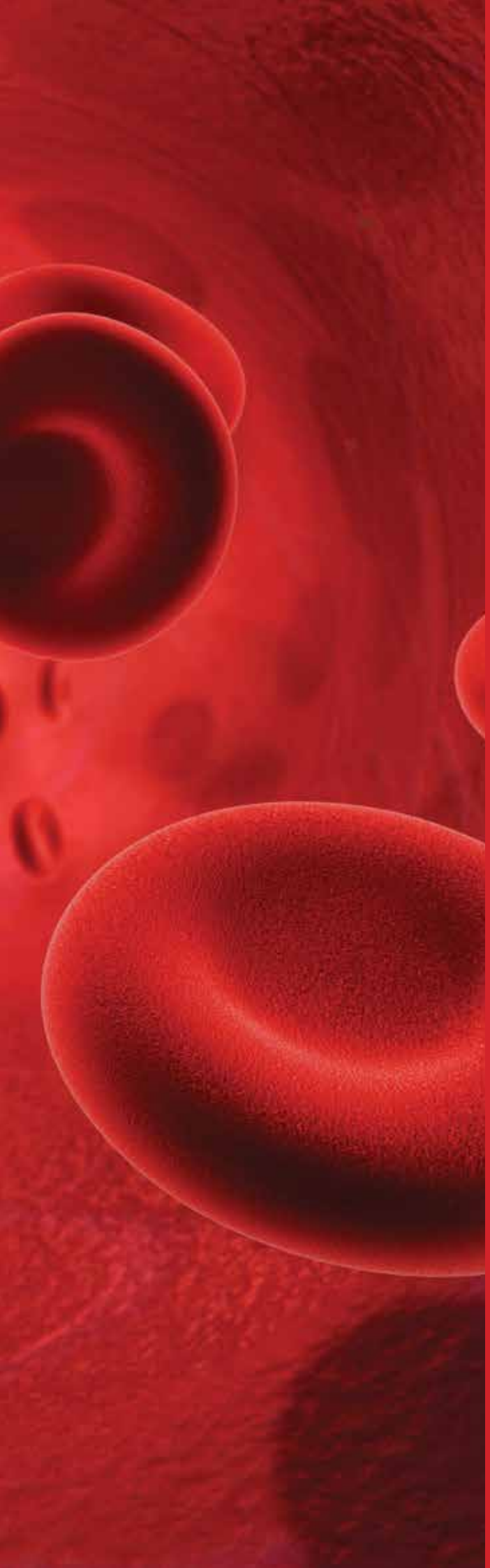




ABOUT VTE

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*.

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 Surveys of Acute Trusts and CCGs, our reports provide a comprehensive overview of progress in implementing best practice; identify areas for future improvement; and offer recommendations on what more can be done to ensure that NHS services are underpinned by high quality VTE prevention and management.

Following the success of the APPTG's VTE prevention scorecards, which offer a bespoke collection of our survey's data on Trusts' compliance with best practice in VTE prevention, the APPTG is this year launching an online e-scorecard atlas. The website will allow Trusts to benchmark their performance against others in England, by searching for data corresponding to a series of key VTE prevention indicators. We hope that the e-scorecard atlas will help Trusts to recognise their successes and identify areas that require further improvement in the future.

The past year has seen NHS England's approach to VTE prevention continue to be recognized on the world stage as a model to emulate. In September, the leaders of the National VTE Prevention Programme were invited to present the outcomes of their work at the 3rd Asia Pacific Forum in Melbourne, Australia. Furthermore, an IPSOS Pulse survey undertaken for the first ever World Thrombosis Day on 13 October 2014 found that the UK leads the world in patient awareness of VTE. The APPTG commends the efforts of all who have worked so tirelessly to elevate VTE prevention to the prominence it now holds in the NHS' patient safety priorities.

The past year has also seen major structural changes in the NHS, with CCGs transitioning into their new roles. With structural change has come change to the VTE policy landscape, most notably with the discontinuation of the national CQUIN goal for VTE prevention. A CQUIN goal setting a minimum threshold for VTE risk assessment of hospital inpatients was first implemented in 2010 following years of campaigning by the APPTG. Over the past four years, it has been an invaluable driver of change, and the percentage of patients risk assessed for VTE has risen from 47 per cent to over 95 per cent. Naturally, the APPTG is concerned that the CQUIN's discontinuation could lead to a loss of momentum in driving best practice.

However, in the absence of a national financial incentive scheme, there are local-level schemes which commissioners can utilise to ensure that momentum is maintained. These include the commissioning sanctions regime for VTE risk assessment outlined in the NHS Standard Contract and the opportunities available for setting local CQUIN goals. The APPTG encourages CCGs and Trusts to work together to take advantage of these opportunities, and has produced a guide for commissioners on the levers available to them to ensure that their providers maintain best practice in VTE prevention. This guide can be downloaded from the APPTG's website. The APPTG also sees an opportunity for the newly created Patient Safety Collaboratives and the Sign up to Safety Campaign to spread understanding of the drivers and incentives available to maintain and enhance best practice locally.

We have an ultimate aim for 2015 and beyond, which is to see primary care clinicians playing an increasing role in the VTE pathway. This includes up-skilling GPs on best practice guidelines for the diagnosis and management of VTE; but equally important is ensuring primary care clinicians and district nurses are fully informed when high risk patients are discharged back into the community, especially if on extended prophylaxis.

This year, the APPTG has reached out to the leads of several primary care DVT services that have demonstrated the substantial cost and efficiency savings that can be made by transferring more responsibility for VTE management from secondary to primary care. We will publish the case studies of these innovative DVT pathways in a report to be launched next year at an APPTG event specifically for GPs and primary care nurses.

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

83%	of Trusts stated that they have in place a written policy for preventing and managing the risks of VTE for adult hospital admissions, and were able to provide a copy of their policy.
Only 43%	of Trusts performed Root Cause Analysis for all confirmed cases of hospital associated thrombosis in every quarter of the period lasting from January 2013 to June 2014.
Over ¼	of Trusts indicated that their local commissioning body has yet to request information on Root Cause Analysis reporting.
Only 39%	of Trusts have agreed a local CQUIN goal with their commissioner to perform Root Cause Analyses on all confirmed cases of hospital associated thrombosis.
Only One	Trust indicated that it has received sanctions, verbal or written warnings from its local commissioning body for failure to comply with the national obligation to perform Root Cause Analysis for all confirmed cases of HAT.
Only 12%	of Trusts indicated that a CQUIN payment (or portion of it) was withheld for non-compliance with the national VTE prevention CQUIN goal for 2013/14.
Over ¼	of Trusts have had a VTE-related negligence claim made against them in each of the last three years, with the single highest VTE related negligence claim reported in our survey settled for **£982,464.**
86%	of Trusts have developed and distribute their own patient information leaflets on VTE prevention.

Clinical Commissioning Groups Survey

93%	of CCGs have appointed a person with responsibility for quality assurance of VTE prevention delivered by local healthcare providers.
9 in 10	CCGs have clearly mandated in their providers' service contracts that failure to comply with best practice in VTE prevention will result in sanctions.
96%	have demanded that their secondary care providers demonstrate that patients are being risk assessed for VTE upon admission.
Less than half	of CCGs indicated that they ensure that their secondary care providers submit Root Cause Analysis reports on a monthly basis.
Only 15%	of CCGs have set a locally agreed CQUIN goal for VTE prevention.

a) VTE Prevention Policy

Introduction

The results of the survey are presented in five sections, examining Trusts' written VTE prevention policies; Root Cause Analysis (RCA) of all confirmed cases of hospital associated thrombosis (HAT); Sanctions and CQUIN penalties for risk assessment; negligence claims relating to VTE; and, approaches to the distribution of patient information. With a response rate of 83 per cent (132 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.

Survey results

Best practice in VTE prevention has been summarised in NICE Quality Standard 3 (Venous Thromboembolism Prevention Quality Standard), which was issued in June 2010. The Quality Standard provides seven 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.

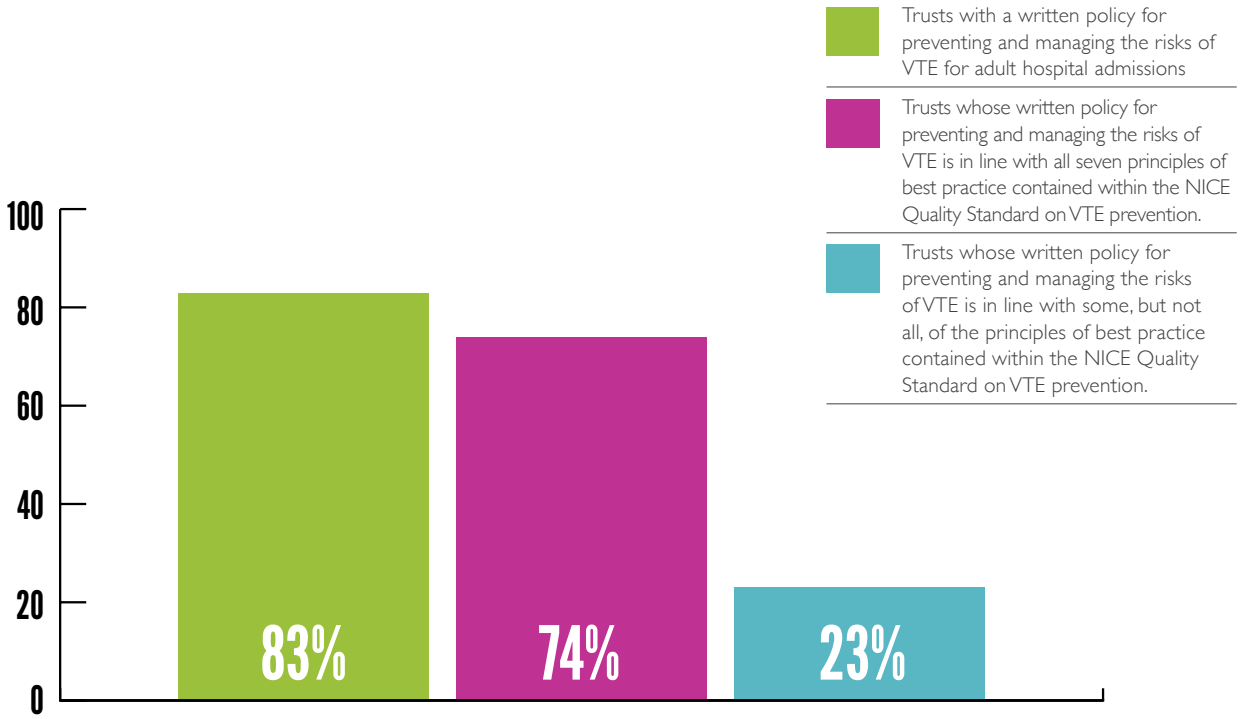
a) VTE Prevention Policy

The APPTG has long recommended that all seven statements of the NICE Quality Standard should be incorporated into Trusts' written policies on VTE prevention. Last year, the APPTG expressed concern when it found that the number of Trusts with a written VTE prevention policy that incorporates all seven statements had dropped by four per cent to 78 per cent of Trusts.

Of the Trusts that responded to this year's survey, 83 per cent stated that they have in place a written policy for preventing and managing the risks of VTE for adult hospital admissions, and provided a copy of their written policy. Of the Trusts with a written policy in place, 74 per cent indicated that their policy includes all seven principles of best practice contained within the NICE Quality Standard, whereas 23 per cent indicated that their policy includes some, but not all seven principles.

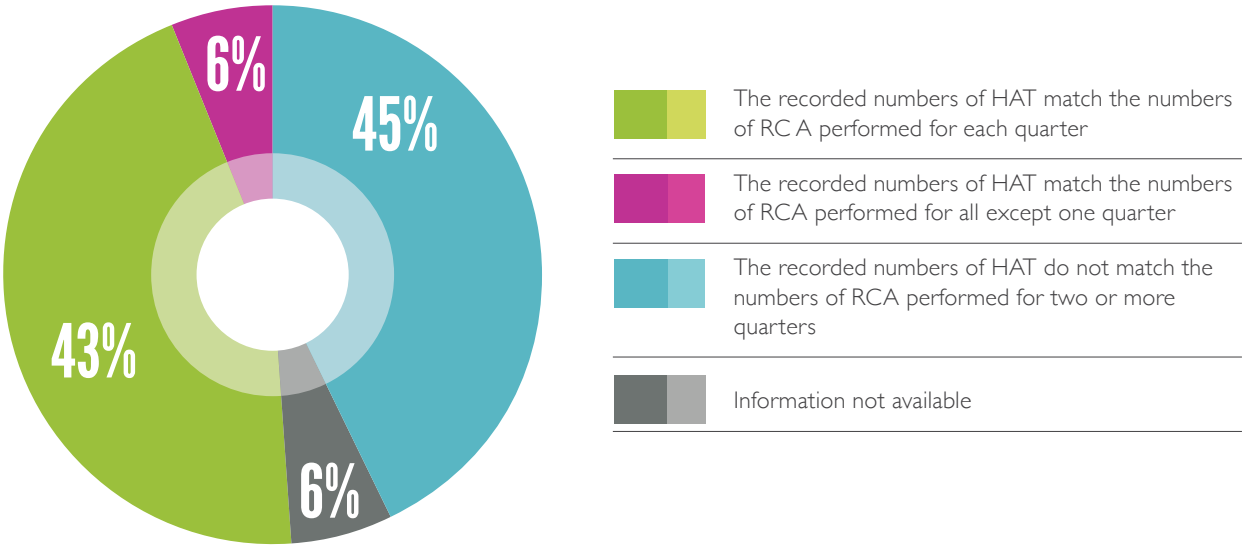
The APPTG finds it encouraging that such a high proportion of Trusts have in place a written policy for VTE prevention, and that the majority of their policies incorporate all of the NICE Quality Standard's seven principles of best practice. However, the APPTG remains concerned that the number of Trusts whose written policy is fully in line with all seven statements has dropped again this year by four per cent, and continues to recommend that Trusts incorporate all of the principles of best practice in NICE Quality Standard 3.

Written VTE Prevention Policy



b) Root Cause Analysis (RCA)

Root Cause Analysis for all confirmed cases of hospital associated thrombosis January 2013 - June 2014



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 to 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 statutory duty of candour which was proposed by the Francis Inquiry into the Mid Staffordshire NHS Trust.

According to Service Condition 20 of the NHS Standard Contract 2014/15, secondary care providers 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, but not in respect of Service Users admitted to hospital with a confirmed venous thromboembolism but no history of an admission to hospital within the previous 3 months..."

b) Root Cause Analysis (RCA)

The APPTG's 2013 survey found that only 36 per cent of Trusts were submitting monthly reports on the outcome of all RCA performed, pursuant to the NHS Standard Contract, and were able to provide details of recent reports. This was a disappointing finding, and the APPTG encouraged Trusts and commissioners to more closely observe the relevant clauses in the NHS Standard Contract to improve practice at the local level.

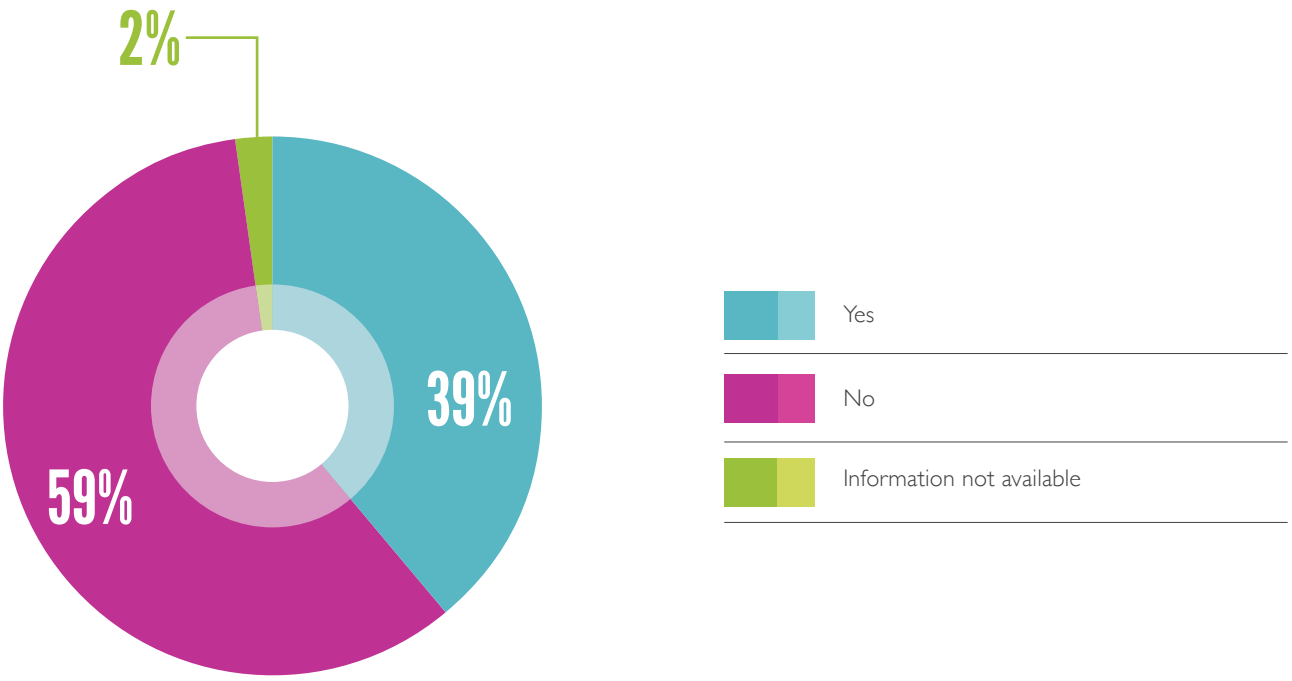
This year's survey sought to establish more objective details on whether Trusts were performing RCA for all confirmed cases of HAT. The survey asked Trusts to list their recorded number of HAT for each quarter from January 2013 to June 2014. It then asked Trusts to list the number of RCA performed for all confirmed cases of HAT in each quarter of the same period.

In order to be compliant with Service Condition 20, the number of recorded HAT and the number of RCA performed should be the same for each quarter. Our survey found this to be true for only 43 per cent of Trusts. For an additional 45 per cent of Trusts, the number of recorded HAT and the number of RCA performed did not match for two or more quarters.

b) Root Cause Analysis (RCA)

The 2013/14 national CQUIN goal for VTE prevention called for a "locally agreed goal for the number of VTE admissions that are reviewed through Root Cause Analysis". The APPTG's survey asked Trusts if they have agreed a local CQUIN goal with their commissioners to perform RCA on all confirmed cases of HAT. Only 39 per cent of Trusts indicated that they have.

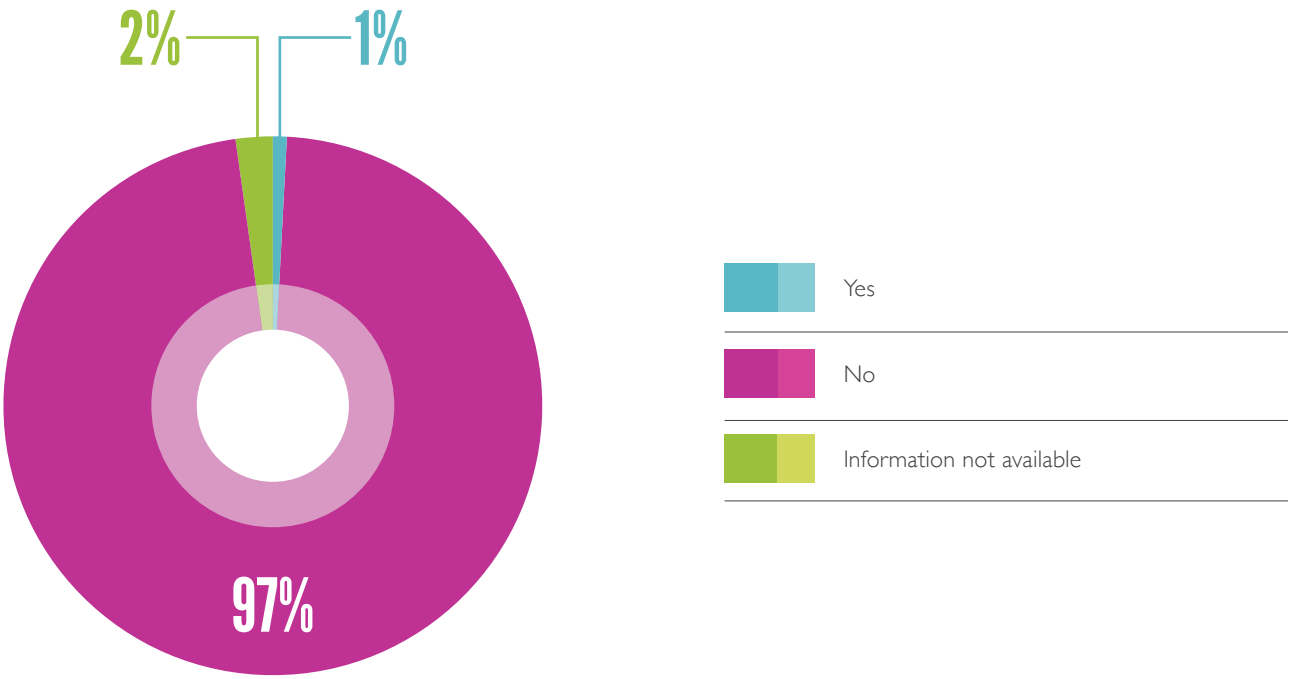
Has your Trust agreed a local CQUIN goal with your local commissioner to perform Root Cause Analyses on all confirmed cases of HAT?



b) Root Cause Analysis (RCA)

Finally, the survey asked Trusts if they have received any sanctions, verbal or written warnings from their local commissioning body for failure to comply with the national obligation to perform RCA for all confirmed cases of HAT. Only one Trust indicated that it had. When this information is considered in light of the finding that only 43 per cent of Trusts performed RCA for all cases of HAT in each quarter from January 2013 to June 2014, it is clear that RCA is not being prioritized. Given that RCA for all confirmed cases of HAT is a service condition of the NHS Standard Contract, commissioners should be holding Trusts to account on RCA reporting to ensure that their providers are compliant with national obligations.

Has your Trust received any sanctions, verbal or written warnings from your local commissioning body for failure to comply with the national obligation to perform Root Cause Analyses of all confirmed cases of HAT?

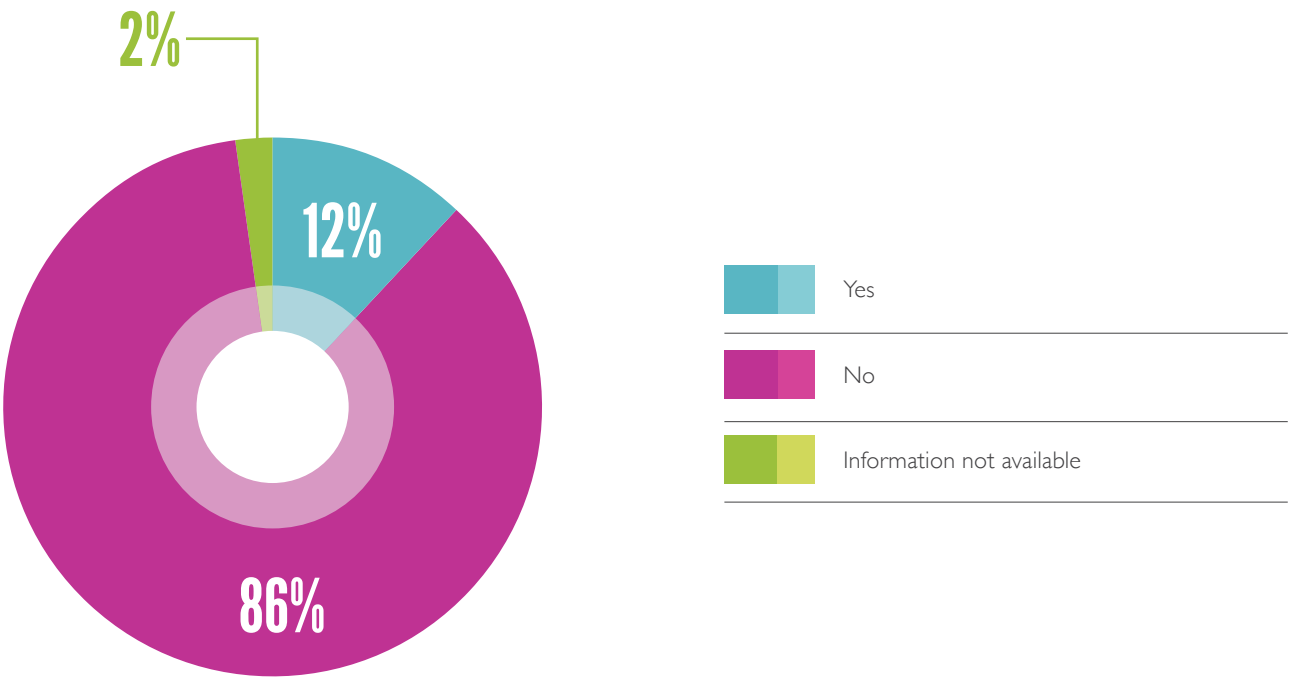


c) Sanctions and CQUIN penalties for risk assessment

As part of the national VTE CQUIN goal in place for 2013/14, Trusts were required to ensure that 95 per cent of all adult inpatients receive a VTE risk assessment on admission to hospital. In addition, this goal required Trusts to achieve a locally agreed quarterly target of Root Cause Analyses to be reported to commissioners. If either of the CQUIN goal components was not met, commissioners had the right to withhold a proportion of the provider's income.

Our survey asked Trusts if a CQUIN payment, or a proportion of it, was withheld due to non-compliance with the national VTE Prevention CQUIN Goal in 2013/14. Only 12 per cent indicated that a payment (or a portion of it) had been withheld.

Was a CQUIN payment (or a proportion of it) withheld from your Trust due to non-compliance with the national VTE prevention CQUIN Goal in 2013/14?



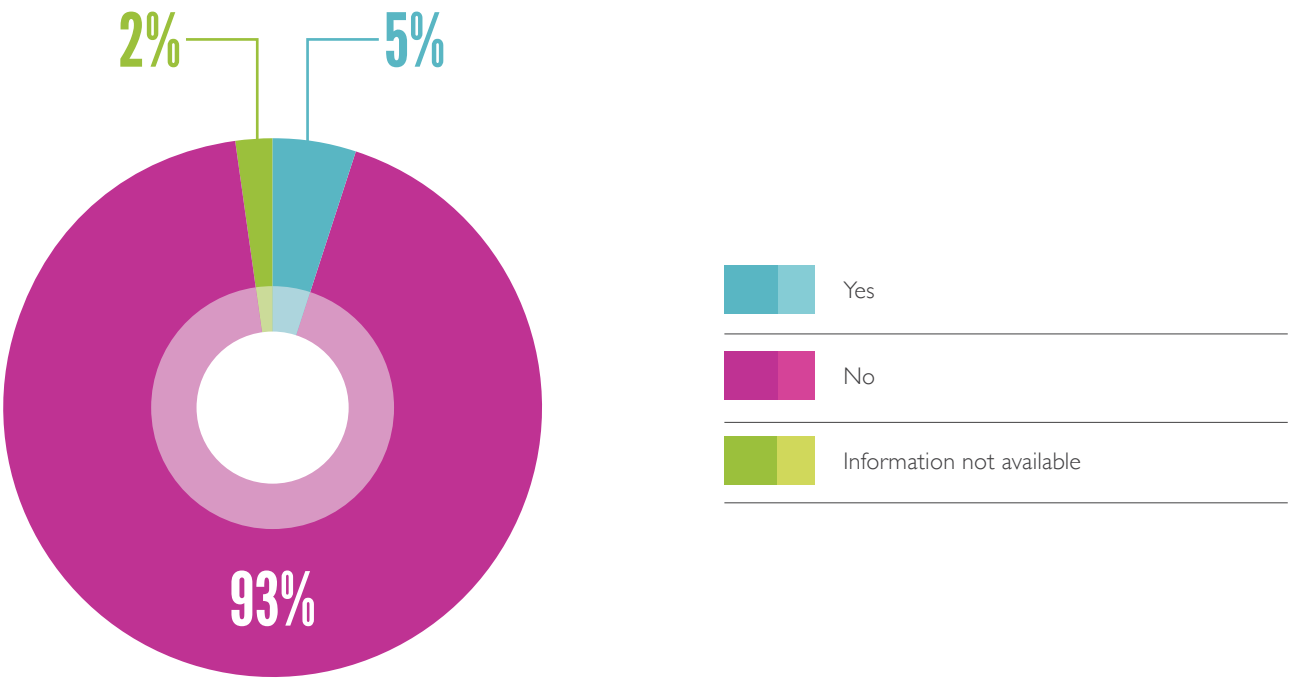
c) Sanctions and CQUIN penalties for risk assessment

Since the national VTE Prevention CQUIN Goal was withdrawn in April, commissioners have alternative means of financially incentivising providers to maintain VTE risk assessment rates above 95 per cent. The VTE risk assessment National Quality Requirement contained within the NHS Standard Contract 2014/15 enables commissioners to impose a £200 sanction on Trusts for every excess breach above the 95 per cent risk assessment threshold.

Our survey asked Trusts if their local commissioning bodies have imposed a sanction on them for failing to deliver the 95 per cent risk assessment threshold. Only five per cent indicated that their commissioners have imposed a sanction.

The low percentage of Trusts that have had CQUIN payments withheld or commissioning sanctions imposed relating to VTE risk assessment reflects the progress that has been made in driving up risk assessment rates. NHS England's latest data on VTE risk assessment, covering the first quarter of 2014/15, found the percentage of admitted patients who are risk assessed to be 96 per cent nationally. The APPTG encourages commissioners to utilise their contractual power to impose sanctions for Trusts' non-compliance with VTE risk assessment, so that risk assessment rates remain at their current high levels following the discontinuation of the national CQUIN goal.

Has your local commissioning body imposed a sanction on your trust for failing to deliver the minimal VTE risk assessment threshold?



d) Negligence claims relating to VTE

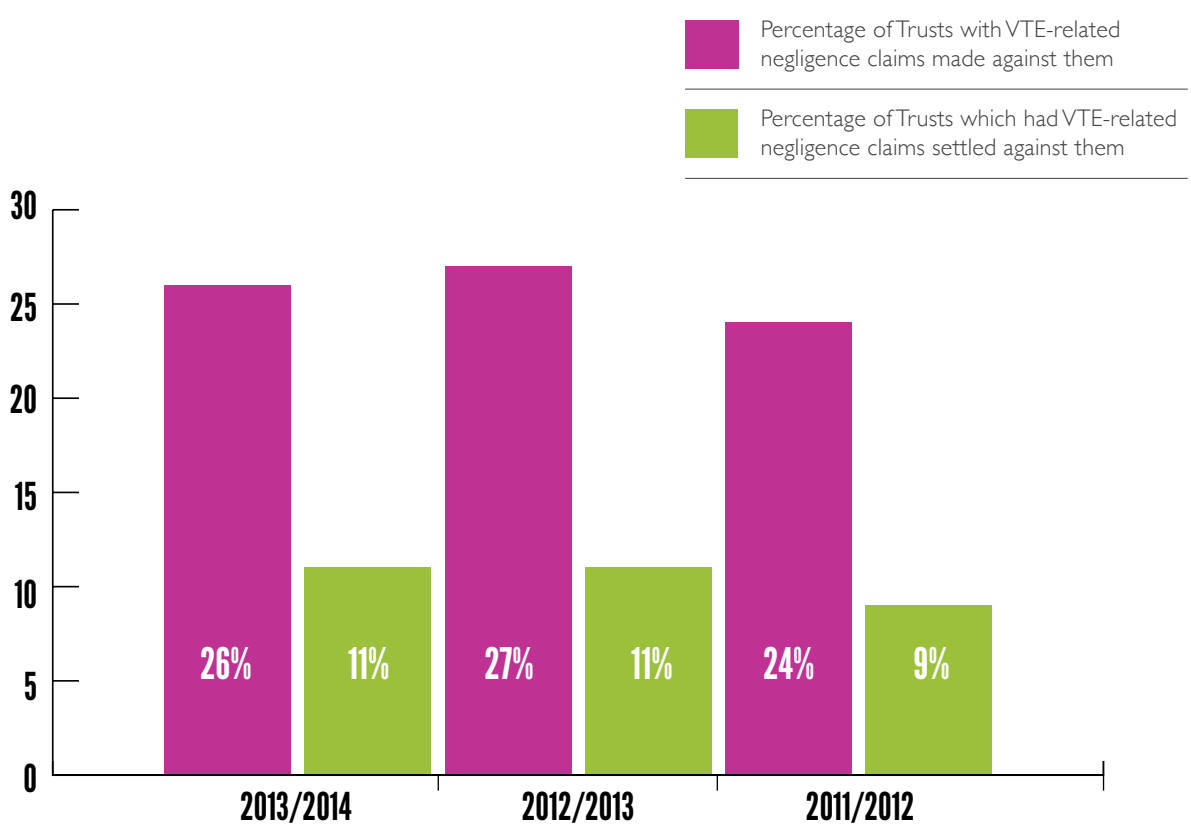
Until their discontinuation in April 2014, Acute Trusts were assessed annually against a set of NHS Litigation Authority (NHSLA) risk management standards. The standards were developed based on the issues that arose most often in negligence claims, and as Trusts achieved higher scores against these standards, they received more favourable premiums on their annual insurance contributions. Risk Management Standard 5.9 required organisations providing acute and community services and non-NHS services to have an approved documented process for the prevention and management of VTE.

The NHSLA now bases insurance premiums on the number and value of successful negligence claims made against an Acute Trust and the risk profile of the services it carries out. In order to determine the cost burden that VTE places on Trusts in terms of negligence claims, our survey asked Trusts to list the number of negligence claims relating to VTE (as defined by ICD-10 codes I80.0-I80.3, I80.8-I80.9, I82.9, O22.2 – O22.3, O87.0 – O87.1, I26.0, and I26.9) made against them in each of the past three years. It then asked Trusts for the number of these claims that have been settled, and the value of the settled claims. On average, over a quarter of Trusts have had a VTE-related negligence claim made against them in each of the past three years, and 10 per cent of Trusts have had a VTE-related negligence claim settled against them in each year of this period. Our survey found the total value of the settled claims for all three years to be £4,447,202.

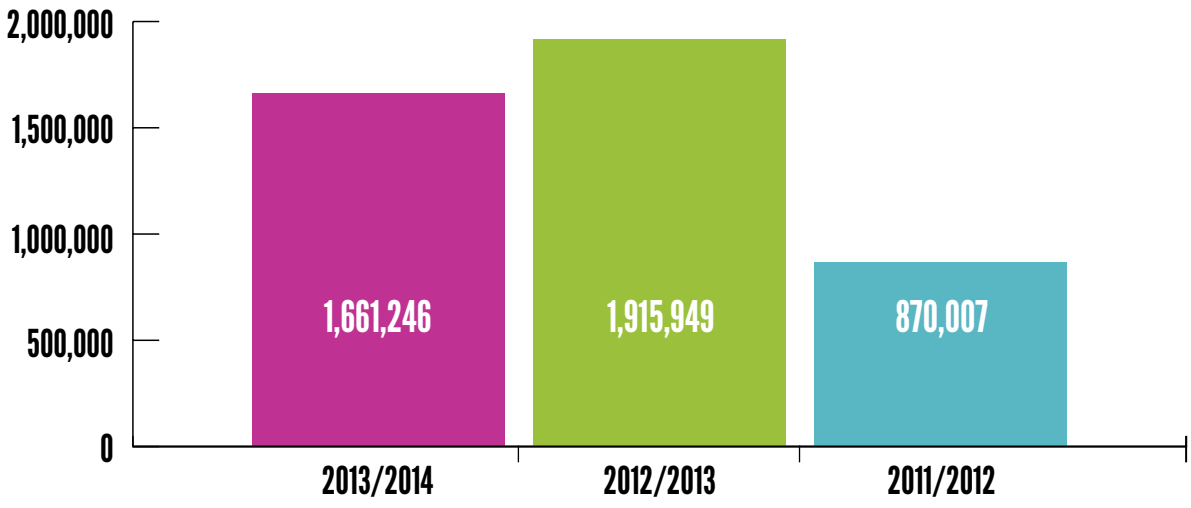
While, on average, most of the VTE-related negligence claims made against Trusts have been successful, VTE represents a significant cost burden on the health system. The single highest VTE related negligence claim reported in our survey was settled for £982,464. With the NHSLA now partly basing premiums on the number and value of negligence claims made against a Trust, it is imperative that Trusts adhere to best practice for VTE prevention in order to keep premium costs down and avoid expensive negligence claims.

d) Negligence claims relating to VTE

VTE-related negligence claims



Total value of settled VTE-related negligence claims (£)



e) Patient Information

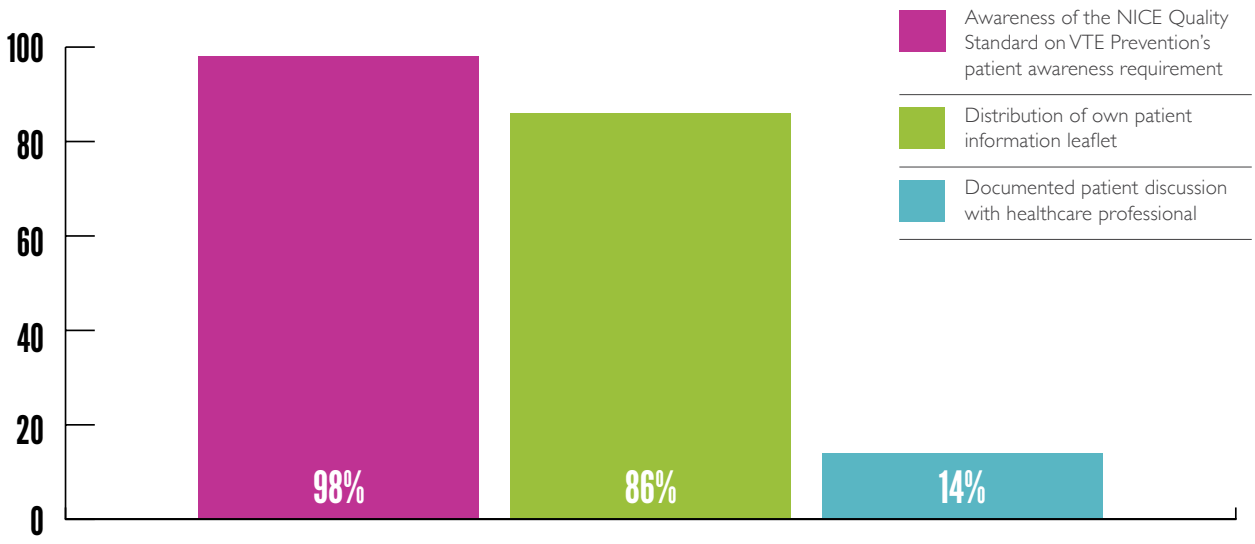
The NICE Quality Standard on VTE prevention recommends that patients identified as at risk of VTE and requiring thromboprophylaxis should be offered verbal and written information on VTE prevention as part of the admission and discharge processes.

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. Most cases of HAT occur only after discharge from hospital, with the average DVT after surgery occurring on day seven and the average pulmonary embolism occurring on day 21. Furthermore, the APPTG has found in previous years that patients on extended thromboprophylaxis may be sub-optimally managed upon their return to the community as a result of their requirements not being communicated clearly to primary care staff. Information on how to mitigate their risk of VTE following discharge is therefore of paramount importance to patients.

The APPTG has always encouraged 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. This year's survey found that 98 per cent of Trusts are aware of the NICE Quality Standard on VTE Prevention's patient awareness requirement, and 86 per cent of Trusts distribute their own patient information leaflet on VTE. However, only 14 per cent of Trusts indicated that a documented discussion takes place between a healthcare professional and the patient.

While the APPTG is pleased that 86 per cent of Trusts have developed and distribute their own patient information leaflets on VTE prevention, it urges Trusts to ensure that their healthcare professionals are having discussions on VTE Prevention with patients. The principles of best practice listed in the NICE Quality Standard on VTE Prevention state that patients should be offered verbal and written information on VTE prevention as part of the admission and discharge process. As most cases of HAT occur after hospital discharge, having a verbal patient discussion is highly important to ensure that any questions the patient may have about their VTE risk can be answered before they are released from hospital.

Trusts' provision of patient information on VTE prevention



a) Quality Assurance

Introduction

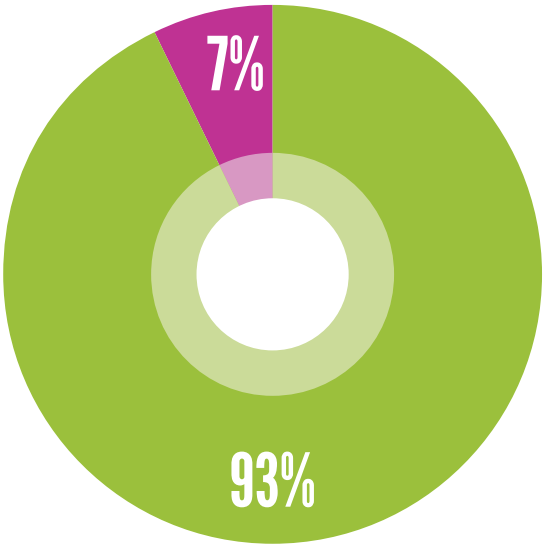
In order to gain a better understanding of the commissioning approaches to VTE prevention employed by local commissioners, the APPTG surveyed all 211 CCGs. Having received responses from 83 per cent of CCGs (175 responses), we are confident that our survey provides an accurate representation of the national picture.

Survey results

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. Our 2013 survey indicated that one in five CCGs had not yet appointed someone with this responsibility. This was a cause of concern for the APPTG, given that VTE prevention has been identified as the most important patient safety practice in our hospitals, and given that the 2013/14 CCG Indicator Set contained a VTE-specific indicator. However, it was acknowledged that many CCGs had not finalised their job appointments at the time of last year's survey.

This year's survey once again asked CCGs to provide the name and job title of the person appointed to be responsible for quality assurance of VTE prevention delivered by local healthcare providers. The results show a marked improvement over the past year, with 93 per cent of CCGs indicating that they have appointed a person with responsibility for quality assurance of VTE prevention. The APPTG continues to encourage all CCGs to appoint a person with this responsibility.

CCG lead for quality assurance of VTE prevention



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

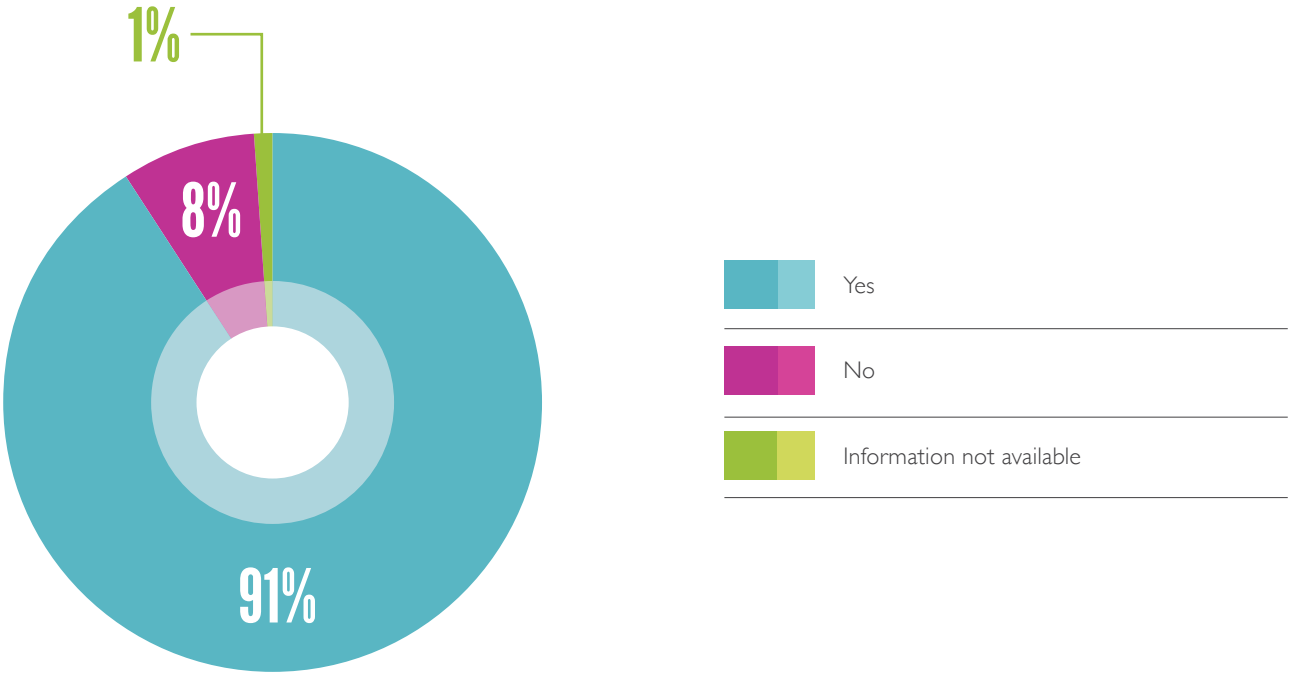
The CCG indicated that it has not yet appointed a person with responsibility for quality assurance of VTE prevention delivered by local healthcare providers.

b) Sanctions for failure to comply with risk assessment

With the national CQUIN goal for VTE prevention discontinued after April 2014, much of the responsibility for financially incentivising providers to maintain best practice in this area lies with CCGs. As discussed in the previous section on the survey of Trusts, the VTE risk assessment National Quality Requirement contained within the NHS Standard Contract 2014/15 enables commissioners to impose a sanction on Trusts for failing to risk assess at least 95 per cent of patients for VTE on admission.

The APPTG found that 91 per cent of the CCGs it surveyed have clearly mandated in their providers' service contracts that failure to comply with best practice in VTE prevention will result in sanctions imposed by the CCG. The APPTG finds this an encouraging sign that CCGs are making it clear to their providers that best practice in VTE prevention is a contractual requirement.

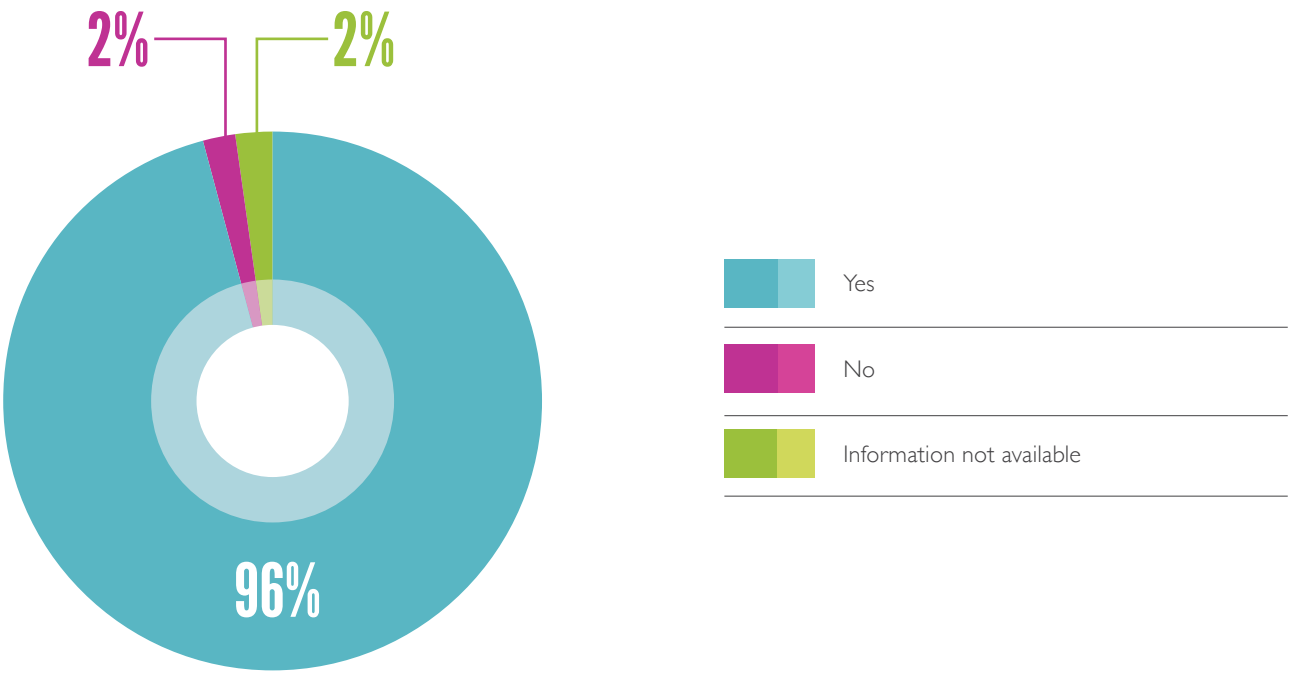
Have you clearly mandated in your providers' service contracts that failure to comply with best practice in VTE prevention will result in sanctions imposed by your CCG?



b) Sanctions for failure to comply with risk assessment

This year's survey also found that 96 per cent of CCGs demand that their secondary care providers demonstrate that patients are being risk assessed for VTE upon admission. The APPTG urges CCGs to follow through on these requirements by using their powers to impose sanctions on Trusts that fail to meet the 95 per cent risk assessment threshold.

Has your CCG demanded its secondary care providers demonstrate that patients are being risk assessed for VTE upon admission?



c) Ensuring RCA reporting

RCA reports 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. For commissioners, RCA reports are therefore a crucial source of information to help guide service improvement. According to Service Condition 20 of the NHS Standard Contract 2014/15, providers must report the results of RCA of all confirmed cases of HAT to the coordinating commissioner "on request". However, the NHS Standard Contract's Reporting Requirements, detailed in Schedule 6B of The Particulars, state that providers should report the outcome of all RCA reports for HAT to commissioners on a monthly basis.

The APPTG's survey found that less than half of CCGs (43 per cent) ensure that their secondary care providers submit RCA reports on a monthly basis. We consider this low percentage to be a reflection of the lack of clarity in the NHS Standard Contract regarding whether RCA reports should be submitted "on request" or on a monthly basis. The APPTG therefore recommends that the wording of Service Condition 20 be strengthened to clarify that RCA should be reported monthly and not solely when a commissioner requests it.

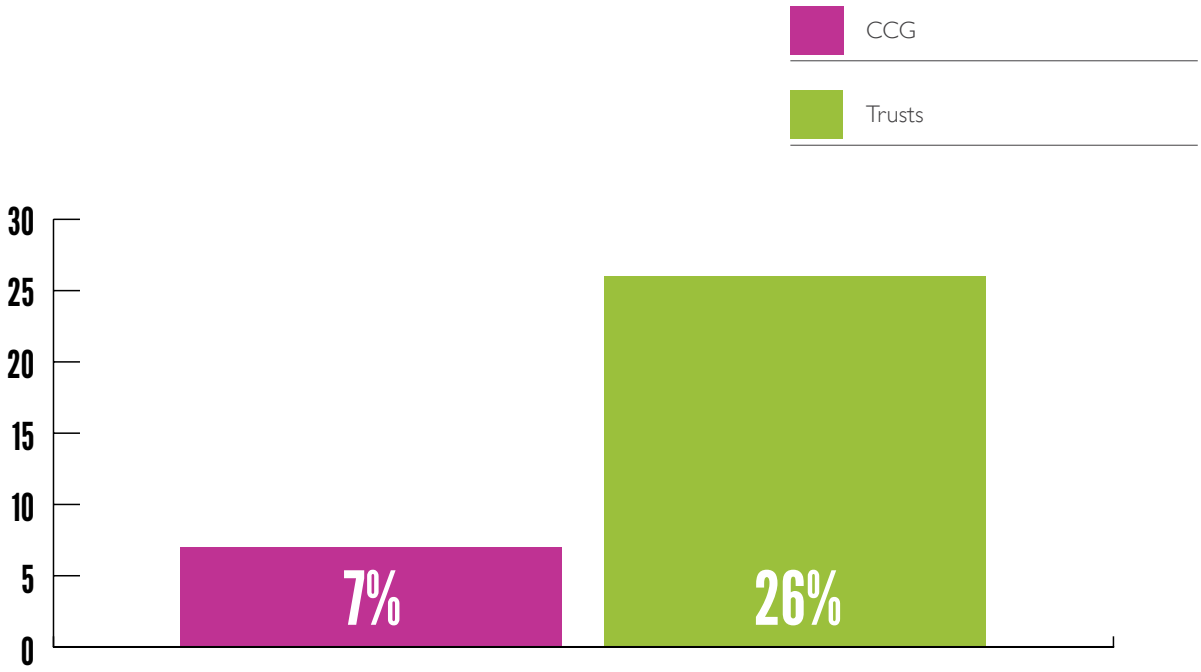
Furthermore, the APPTG's survey found an inconsistency between the responses from CCGs and Trusts on whether commissioners are requesting RCA reports at all. Whereas only seven per cent of CCGs stated that they do not ensure that RCA reports are submitted, 26 per cent of Trusts indicated that their commissioners had yet to request this information. To establish what this inconsistency signifies, the 34 Trusts that indicated having not been asked for information on RCA reporting were cross-referenced with their corresponding CCGs. Only four of these Trusts had a consistent response with their commissioners.

Of the pairings where there was an inconsistency, seven Trusts' corresponding CCGs either did not respond to our survey or left this section blank. An additional seven Trusts' corresponding CCGs indicated that they request RCA information on an irregular basis. However, the most striking finding to emerge from the cross-reference was that for nine of the CCGs which indicated requesting monthly RCA reports, the matching Trusts said that they had never been asked for this information. This figure represents 12 per cent of the CCGs which stated that they ensure their secondary care providers submit RCA reports on a monthly basis.

This finding suggests that in many areas there is a lack of clear communication between Trusts and CCGs on RCA reporting, and a lack of a clear framework specifying the frequency with which this information should be reported. This further highlights the need for the wording of the NHS Standard Contract to be strengthened so that CCGs and Trusts understand that RCA should be reported on a monthly basis.

c) Ensuring RCA reporting

Comparison of answers from CCGs and Trusts on whether information on RCA reporting is requested

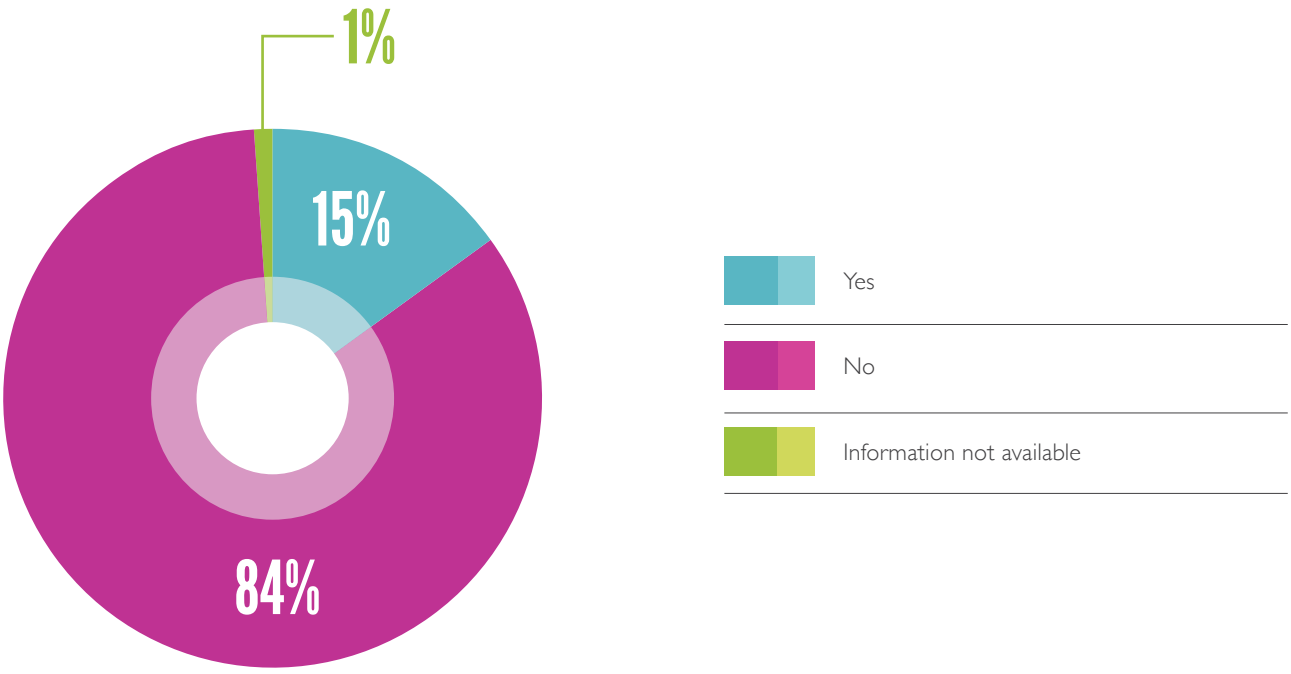


d) Local CQUINs

In the absence of the national CQUIN goal for VTE prevention, the APPTG encourages commissioners to make the most of the opportunities offered by local VTE CQUIN goals. In 2014/15, at least 2 per cent of a provider's total contract outturn is available for local CQUIN schemes, agreed between the commissioner and provider. Our survey asked CCGs if they have set a locally agreed CQUIN goal for VTE prevention. 84 per cent of CCGs indicated that they have not, suggesting that the opportunity to maintain best practice in VTE prevention presented by local CQUIN schemes is not being utilised.

Given that this year's survey also found that the opportunity presented by the commissioning sanctions regime is not yet being fully utilised, the information on local CQUIN schemes adds to concerns that the loss of the national VTE prevention CQUIN goal could result in a drop in best practice. These findings underscore the need for more educational work to be carried out with CCGs so that commissioners are fully aware of and appreciate the importance of using financial incentive schemes to hold providers to high standards on VTE prevention.

Has your CCG set a locally agreed CQUIN goal for VTE prevention?



CONCLUSION

Positive Progress

This year's surveys of Trusts and CCGs found positive signs that VTE prevention is now firmly embedded as a high patient safety priority in the NHS, but also found cause for concern that standards may slip with the discontinuation of the national VTE prevention CQUIN goal. Nearly ten years on from the Health Select Committee report which found that VTE was causing approximately 25,000 deaths in hospitalized patients, almost all Acute Trusts now have a written policy in place for VTE prevention, 86 per cent of Acute Trusts have developed and distribute their own patient information leaflets on VTE prevention, and nine out of 10 CCGs have appointed a person with responsibility for quality assurance of VTE prevention, and have clearly mandated in their providers' service contracts that failure to comply with best practice will result in sanctions. These results are testament to the efforts of all who have worked hard over the past decade to give VTE prevention a high priority on the national agenda.

The results found in this year's surveys are also testament to the effectiveness of having a national financial incentive scheme in place to drive risk assessment. Since 2010, there has been a CQUIN goal setting a minimum threshold for VTE risk assessment. The percentage of patients assessed for their risk of VTE on admission to hospital has subsequently risen from 47 per cent to 96 per cent over the past four years. This year's survey of Trusts found that only 12 per cent of Trusts were penalized for non-compliance with the national VTE prevention CQUIN goal, which required risk assessment of at least 95 per cent of all inpatients in 2013/14.

Building on Progress

However, following the 2013 restructuring of the NHS, more responsibility has been transferred to local bodies to incentivise quality improvements. The findings of the APPTG's surveys suggest that more work is needed to help the newly created CCGs fulfill this role, particularly where Root Cause Analysis of hospital associated thrombosis is concerned. It is disappointing that the majority of Trusts have not agreed a local CQUIN goal for RCA with their commissioners, and it is concerning that only one Trust surveyed by the APPTG has received sanctions, verbal or written warnings from its local commissioning body for failure to perform RCA when our survey simultaneously found that only 43 per cent of Trusts performed RCA for all cases of HAT in each quarter from January 2013 to June 2014.

The reason why the majority of commissioners have not yet utilised their powers to financially incentivise RCA may be due to a lack of information on their providers' RCA reporting. Our surveys indicated that less than half of CCGs ensure that their providers submit RCA reports on a monthly basis and that 26 per cent of Trusts have yet to be asked for information on RCA reporting by their local commissioners. The APPTG thinks that this is a result of unclear wording in the NHS Standard Contract. While the Reporting Requirements outlined in the Particulars list RCA for HAT as information that should be reported to commissioners monthly, Service Condition 20 states that providers should report the outcomes of RCA to commissioners "on request".

Empowering Commissioners

As a priority for 2015, the APPTG would like to see greater education for commissioners to help CCGs fulfill their responsibilities as drivers of patient safety improvements locally. As a first step, the APPTG urges NHS England to strengthen the wording of the NHS Standard Contract to clarify that commissioners should ask their providers for RCA reports on a monthly basis. The APPTG believes that greater provision of educational material and training sessions explaining the incentive schemes available to commissioners, including local CQUINs and commissioning sanctions, will help to ensure that the current high levels of VTE risk assessment are maintained. The APPTG believes that the National VTE Prevention Programme's new e-learning module for commissioners will help to improve commissioners' understanding, and the APPTG has also produced its own guide on commissioning for best practice in VTE prevention. This guide includes a checklist to help commissioners quickly ascertain whether they are fully using the resources available to them to ensure their providers are meeting the national standards of best practice.

APPTG RECOMMENDATIONS FOR 2014

Drawing on the evidence gathered through this year's surveys and our interactions with NHS leaders, commissioners and clinicians across the NHS, the APPTG has identified the following recommendations for 2015 and calls on the VTE community to work together to support their delivery:

1. **The NHS Standard Contract should be strengthened to clarify that Acute Trusts should submit monthly reports of Root Cause Analyses of all confirmed cases of hospital associated thrombosis to their commissioners rather than submit them "on request".**
2. **The new Patient Safety Collaboratives and the Sign up to Safety campaign should be compelled to ascertain the learnings from Root Cause Analyses of individual cases of hospital associated thrombosis, in order to help Trusts build upon these lessons to deliver service improvements.**
3. **The Patient Safety Collaboratives and the Sign up to Safety campaign should work with the NHS England Commissioning Assembly to improve commissioners' knowledge and understanding of the local financial incentive schemes at their disposal for driving best practice in VTE prevention. In particular they could help to signpost commissioners to the National VTE Prevention Programme's e-learning module and the APPTG's commissioning guide VTE: What does it mean for me as a commissioner?**
4. **Primary care should take on greater responsibility for diagnosing and managing VTE when it occurs in the community.**
5. **A patient's VTE risk status should be included prominently in their discharge summary to assist primary care in managing their risk in the community.**
6. **NHS Acute Trusts should ensure that their written policies on VTE prevention incorporate all seven principles of best practice as outlined in NICE Quality Standard 3.**
7. **The Department of Health should publish a white paper containing a route map for primary care, acute services and commissioning that outlines how appropriate anticoagulation and VTE prevention will support the NHS Five Year Forward View.**

FURTHER INFORMATION

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

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

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

AntiCoagulation Europe
http://www.anticoagulationeurope.org/

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

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

NHS England – NHS Standard Contract 2014/15 Service Conditions
http://www.england.nhs.uk/wp-content/uploads/2013/12/sec-b-cond-1415.pdf

NHS England – NHS Standard Contract 2014/15 Particulars
http://www.england.nhs.uk/wp-content/uploads/2013/12/sec-a-part-1415.pdf

NHS England – Sign up to Safety Campaign
http://www.england.nhs.uk/signuptosafety/

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