Gateway reference number 04444

Patient Safety Domain 5
Area 6C Skipton House
80 London Road
London
SE1 4RH

To: CCG Clinical Leaders
CCG Accountable Officers

11 December 2015

Dear Colleagues

Re: Evidence of severe harm and death due to failure to act on measures put in place to reduce the risk of venous thromboembolism (VTE) in hospitalised patients.

A recent patient safety incident has suggested that commissioners' oversight of the reporting and investigation of hospital associated VTE events is not as comprehensive as it could be. Commissioners should be routinely ensuring their providers are complying with contractual requirements in relation to reporting and investigating cases of VTE associated with hospitalisation.

VTE is a significant cause of mortality, chronic ill-health and disability in England and as many as half of all cases are associated with hospitalisation. For this reason there are clear contractual requirements on providers to identify and tackle any deficiencies in their processes for reducing harm from hospital associated VTE. Providers must demonstrate that they are compliant with all of the contractual requirements in the NHS standard contract. Commissioners must hold providers to account for the delivery of acute services that include appropriate VTE prevention.

The information attached in appendix 1 summarises the contractual obligations of providers in relation to VTE and outlines the context in which learning from the investigation of all cases of hospital-associated thrombosis should be applied if we are to continue to improve outcomes for patients and prevent avoidable harm.

Yours faithfully

Dr. Mike Durkin
Director of Patient Safety

Appendix 1

The following table summarises the requirements in national clinical guidance and the NHS Standard Contract with regard to VTE:

Requirement in contract or guidance	Aim and rationale for this requirement	What concerns have been identified in relation to compliance?	Potential questions and local data sources to use for assurance and encouragement of local quality improvement
2015/16 NHS Standard Contract Particulars **Schedule 4 - Quality Requirements** **B. National Quality Requirements** **VTE risk assessment**: All inpatient Service Users undergoing risk assessment for VTE, as defined in contract technical guidance. Threshold: 95%	Risk assessment is a key first step to ensuring patients with indications of VTE risk and/or contra-indications to some types of VTE prophylaxis are correctly identified The threshold was set at 95%, as there will be a small number of patients for whom risk assessment is impractical or inappropriate (e.g. those who die or are discharged or require urgent transfer almost immediately after admission)	Although the vast majority of acute providers submit returns above the 95% threshold, situations have been identified where trust returns may have misunderstood requirements and excluded patient groups or units that should have been included (such as day case units). Risk assessment has to be performed on the basis of individual patient's risk factors, and 'group' risk assessments (e.g. for all patients undergoing a type of procedure) would not meet the requirement. As data collection has been in place long term and on a large scale, there is a risk that the data submitted can become less accurate and robust unless providers and their commissioners have systems in place to routinely check the completeness and accuracy of that which is submitted.	Whilst CCGs will already have systems to monitor and challenge any failure to submit VTE risk assessment data and require action if levels fall below 95%, it is also important that they are assured that the submitted data are complete and accurate. They may therefore wish to seek: • Confirmation that VTE risk assessment completion rates are drawn from all units, services and patient groups to which NICE CG92 applies • Local evidence that the provider is taking steps to assess the accuracy of the data they submit (e.g. independent review of samples of case notes)

2015/16 NHS Standard Contract Service Conditions SC22 Venous Thromboembolism	The provider must: 1. Comply with Guidance (including NICE Guidance) in relation to VTE; 2. Perform root cause analysis of all confirmed cases of VTE acquired in hospital so as to ensure learning is fed back into the system to drive improvement; 3. Perform local audits to identify the percentage of patients receiving appropriate prophylaxis after having been assessed as being at risk of VTE And the provider must report results of RCA and audits to the co-ordinating commissioner (under the Reporting Requirements Schedule)	Risk assessment will only lead to prevention of avoidable harm if risk assessments are fully and correctly completed and acted upon in relation to the prescribing of appropriate prophylaxis. The Annual Report of the All-Party Parliamentary Thrombosis Group (2014) indicated that fewer than half of acute trusts were routinely undertaking root cause analysis for all relevant patients. Commissioners should ensure that they address this issue with their local providers.	Commissioners should use the levers in the Contract, including the processes and sanctions set out in SC22, to ensure that providers submit the required data and reports. Commissioners may wish to consider agreeing local CQUIN or quality requirements to sustain and continue performance improvements.

NICE Quality Standard (QS3) VTE in adults: reducing the risk in hospital	NICE QS3 covers the reduction in risk of VTE in adults admitted to hospital as inpatients or formally admitted to a hospital bed for day-case procedures. It defines a high standard of care with regard to VTE prevention and provides a description of what a high-quality VTE prevention service should look like. Commissioners may wish to consider using quality measures that accompany each of the quality statements in provider contracts as a means of monitoring/rewarding improvement.		
Quality statement on VTE& bleeding risk assessment	Risk assessment will only lead to prevention of avoidable harm if risk assessments are fully and correctly completed. Local audits have identified that risk assessments can sometimes appear complete, but if checked against the patient's case notes and history suggest that important risk factors or contraindications to some forms of VTE prophylaxis have been omitted.	As above	Local evidence of audit cycles that seek to identify that risk assessment is being carried out correctly and all relevant risk factors and potential contraindications to some forms of VTE prophylaxis are documented in the notes of all inpatients to whom NICE CG92 applies.
Quality statements on the need to make verbal & written information about VTE prevention available to patients and carers.	As part of the admission & discharge process, patients and their carers should be informed about the risks of VTE and provided with information (verbal & written) about the steps that can/should be taken to prevent blood clots. This information should include details of who/which organisation to contact if VTE is suspected after leaving hospital.	Safety incidents have been identified where patients have failed to recall being given any information about VTE and the risk associated with hospital admission.	Local evidence of audit cycles that seek to identify that providers make verbal & written information available to patients and their carers.
Quality statement on VTE prophylaxis	The identification of risk will only lead to prevention of avoidable harm from VTE if assessment is documented and followed by the prescribing and administration of the appropriate prophylaxis	There is no national data to show the proportion of patients receiving appropriate thromboprophylaxis following VTE risk assessment.	Judgement on whether appropriate prophylaxis has been prescribed in line with an individual patient's risk of bleeding and/or developing VTE would usually require evidence of clinical audit by medical staff. Therefore we would not recommend CCGs rely on Safety Thermometer data collection by ward nurses for assurance. Monitoring reliable delivery of prescribed treatment is equally

			important. Does the provider have systems in place for measuring and improving levels of compliance? (E.g. data on missed doses, whether antithrombotic stockings are correctly fitted and actually worn?) Routinely collected local provider data, such as expenditure on medication typically used for VTE prophylaxis and on antithrombotic stockings could be used to provide evidence of trends in overall levels of VTE prophylaxis, although these cannot determine if these are appropriate for each individual patient.

Note: Effective treatment when VTE has been diagnosed

Whilst the main emphasis of this communication is on VTE prevention, early diagnosis and effective treatment is vital to recovery and survival if VTE occurs. In November 2015, NICE updated the guideline for the diagnosis and management of VTE in adults www.nice.org/uk/guidance/cg144

The identification of cases of hospital-associated VTE and Root Cause Analysis

Hospital Associated Thrombosis (HAT) is defined as any new episode of VTE (deep vein thrombosis or pulmonary embolism) diagnosed during hospitalisation or within 90 days of discharge following an inpatient stay of at least 24 hours, or following a surgical procedure under general or regional anaesthesia.

Undertaking root cause analysis of all confirmed cases of HAT is a requirement in the NHS standard contract and providers should include details in their monthly Service Quality Performance Report.

In order to identify and learn from any avoidable cases of VTE that are hospital-associated, providers will need to have established systems & processes that systematically identify cases for clinical review. Trusts should have pathways in place to reliably gather this data, since clinical coding is not sufficient for identifying all cases. Pathways should include the regular screening of diagnostic tests (via radiology), the cross checking of episodes of VTE with admission records to identify cases that satisfy the definition of HAT and require investigation through RCA, links with bereavement offices and information from the coroner following autopsy, and contacting the hospital to which the patient was admitted if different from that where the VTE diagnosis was made. It is particularly important to set up reliable alerting mechanisms to support the identification of patients who are readmitted with VTE or who die in the community, so as to avoid a reliance on staff and/or family members recognising and reporting cases.

Monitoring HAT in the local population

Based on data from VTE Exemplar Centres in England, a large acute hospital with 1,000 beds would expect to identify around 250 cases of hospital associated VTE out of a total of 750 new cases of VTE in a year.
CCGs could seek assurance that local systems are comprehensive and check to see if the numbers of cased of hospital-associated thrombosis being reviewed by providers are plausible in relation to these indicative figures.

Questions to consider:

- Has the trust reported any Serious Incidents related to hospital-associated VTE?
- If not, could they be under-recognising or under-reporting cases that meet SI criteria?
- If they have, do investigations meet with all of the requirements of the SI Framework, including involvement of the patient/family?

Leadership for VTE prevention

Preventing avoidable harm from VTE is integral to patient safety. The implementation of effective, evidence-based strategies requires clinical and executive leadership. The NICE Quality Standard sets out what best practice should look like with regard to VTE prevention and forms the basis for the criteria for becoming a **VTE Exemplar Centre** (see appendix 2).

Improvement can only be delivered through continual learning. The VTE Exemplar Centres Network was established to facilitate that and enables the sharing of information and experience. Whilst providers may wish to give thought to joining this network; the criteria for being recognised as a VTE Exemplar Centre can also be used by commissioners to focus discussions about the implementation of best practice.

Useful resources

2015/16 NHS Standard Contract Particulars, Page 47:
www.england.nhs.uk/wp-content/uploads/2015/08/nhs-contrct-partics-v1.pdf

2015/16 NHS Standard Contract Service Conditions; SC22 Venous Thromboembolism Page 17:
www.england.nhs.uk/wp-content/uploads/2015/03/14-nhs-contrct-serv-conditions.pdf

NICE CG92; Venous thromboembolism: reducing the risk for patients in hospital
https://www.nice.org.uk/guidance/cg92

NICE CG144; Venous thromboembolic diseases: diagnosis, management and thrombophilia testing
https://www.nice.org.uk/guidance/cg144

NICE Quality Standard (QS3) VTE in adults: reducing the risk in hospital
www.nice.org.uk/guidance/qs3

The National VTE Prevention Programme on the NHS England website:
https://www.england.nhs.uk/patientsafety/venous-thromb/

NHS Choices
http://www.nhs.uk/Conditions/Thrombosis/Pages/Introduction.aspx

King's Thrombosis Centre (leader of the VTE Exemplar Centre Network):
http://www.kingsthrombosiscentre.org.uk/index.php/vte

Web based VTE educational resources via e-Learning for Healthcare:
http://www.e-lfh.org.uk/programmes/vte/

Appendix 2

VTE Exemplar Centre Criteria

Checklist for organisations considering making an application to become a VTE Exemplar Centre

Tick	**1.**	**VTE STRATEGY**
	a.	Chief Executive endorsement
	b.	Thrombosis committee/VTE Implementation group (or equivalent) established
		• Cross organisation and multidisciplinary representation (evidence to include relevant organisational chart)
	c.	VTE Guidance in place for
		• Clinicians (medicine & surgery)
		• Maternity
		• Extended prophylaxis

Tick	**2.**	**COMPLIANCE & PROCESSES**
	a.	Risk assessment
		• Risk assessment system(s) in place
		• Risk assessment tools utilised
		• Data demonstrating meeting/exceeding National Quality Requirement of achieving 95% threshold for risk assessment for more than 3 consecutive months
	b.	Root cause analysis
		• Process and staff (flow chart demonstrating how RCA is undertaken & how findings drive improvement)
	c.	Audit
		• Audit mechanisms in place and staff to support the process
		• % patients receiving appropriate thromboprophylaxis
		• % patients receiving written information on admission and discharge
	d.	Reporting
		• Clinical governance (trust)
		• Incident reporting
		• Use of league tables (by ward/directorate)
	e.	Commissioning and contracts
		• Inclusion of VTE in acute/community contract service specifications
		• Submission of RCA reports to commissioners

Tick	**3.**	**TRAINING & EDUCATION**
	a.	Evidence of staff having undertaken appropriate thromboprophylaxis training
	b.	Trust/hospital induction programmes includes VTE education
		• New staff
		• Junior doctors
		• Nurses
	c.	E-learning packages available for staff (e.g. King's/VTE Prevention England module)
	d.	Attendance at national learning events and forums

Tick	**4.**	**COMMUNICATIONS**
	a.	Staff
		• VTE Communications strategy in place
		• Evidence of communications undertaken (e.g. campaigns, internal communication such as newsletters, intranet, league tables, use of social media e.g. Twitter
	b.	Patient (evidenced by audit)
		• Written information is offered - Patient Information Leaflet
		• VTE is explained verbally to patients by appropriate member of staff
	c.	Hospital patient group(s) are informed about VTE

Appendix 2

Tick	**5.**	**IMPLEMENTATION**
	a.	Establishment of VTE champions by ward/department/speciality
	b.	Roles and responsibilities of VTE champions
	c.	VTE process diagram (how implementation is applied across the trust, risk assessment, patient information, discharge, community transition)

Tick	**6.**	**PATIENT & COMMUNITY**
	a.	Patient care plans
	b.	Education for self-injection
	c.	Transition to the community
		• Care pathways/protocols established for the transition of patients into community hospitals • Links with primary care (re. extended prophylaxis, on-going management of VTE)