Guidance notes to accompany VTE risk assessment data collection

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Guidance notes to accompany VTE risk assessment data collection

Prepared by VTE analytical resource

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Executive summary

These guidance notes cover the scope of this data collection. The section on ‘general guidance notes’ covers the requirements and purpose of this data collection. Information about how to complete the data collection form is given, and terms of the data collection are defined. In addition, there is a section on Frequently Asked Questions (FAQ’s) that has been further developed in response to helpful questions raised by colleagues in the National Health Service.

General Guidance Notes

Overview of requirements

VTE is a significant international patient safety issue. The first step in preventing death and disability from VTE is to identify those at risk so that preventative treatments can be used. The purpose of this data collection is to quantify for the first time, the numbers of adult hospital admissions who are being risk assessed for Venous Thromboembolism (VTE) to allow appropriate prophylaxis based on national guidance from the National Institute for Health and Clinical Excellence (NICE). Such measures have the potential to save many lives each year. This new data collection commences from June 2010 and is mandatory (RoCR number: ROCR/OR/0276/FT6/000MAND)1.

All providers of NHS funded acute hospital care (including foundation trusts and independent sector providers of acute NHS services) must complete this data collection. Providers of non-acute health services are not asked to complete this data collection, although they should be aware that all patients should be protected from unnecessary risk of VTE.

This data collection is a census of all patients – it is not appropriate to use sampling methodologies to produce estimates.

This data collection also serves as the mechanism to enable providers to demonstrate to their commissioners that they have achieved the national CQUIN goal on VTE in 2010/11[2].

This data collection on VTE risk assessment is intended to embed VTE risk assessment across the NHS and will be critical in evaluating the impact of the National VTE Prevention Programme on improving health outcomes for patients. As a result, we expect to move quickly to focus on audit of appropriate prophylaxis.

Data Collection Summary

What: This data collection will ask for three items of information:

1. Number of adult hospital admissions (ordinary admissions and day cases) admitted in the month risk assessed for VTE on admission to hospital according to the DH/NICE National Tool
2. Total number of adult hospital admissions (ordinary and day cases) admitted in the month
3. Calculated from (1) and (2), the percentage of adult hospital admissions, admitted within the month assessed for risk of VTE on admission

When: The mandatory data collection commences from June 2010 (i.e. relating to admissions in June 2010), the first data collection return[1] must be submitted no later than 28th July 2010. Trusts may submit data before this time on a voluntary basis relating to admissions in April and May 2010.

How often: This return must be submitted each month from June 2010

Data collection terms and specifics will be defined in the following pages.

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[1] We previously stated that the data collection would start in April 2010 but have changed this requirement because of concerns received from NHS colleagues. This is to allow trusts more time to put appropriate systems in place to collect the information. The UNIFY system will still be set up to allow users to submit data relating to April and May 2010 on a voluntary basis.

[2] Ref: **Using the Commissioning for Quality and Innovation (CQUIN) payment framework – an addendum to the 2008 policy guidance for 2010/11** (Department of Health, 2009)

Data collection specifics:

Completion
The "VTE Risk Assessment – Data Collection" must be completed and signed off by Providers. A return is expected for each month starting in June 2010[1].

Submission
Data on VTE risk assessment should be uploaded onto UNIFY2 and signed off no later than 20 working days after the month end e.g. information relating to June 2010 must be submitted no later than 28 July 2010.

Sign off policy
Data collection can be signed off at provider level. Commissioners or Strategic Health Authorities (SHAs) are not required to sign off this collection.

Revisions Policy
- Revisions before the cut off date for submission of data will be allowed, and can be made as many times as necessary. These revisions can be submitted in the normal way through UNIFY2. As stated above, this cut off date will be 20 working days after the month end.
- Revisions after the cut off date can also be made, but these must be done in liaison with Department of Health colleagues.

Clinical guidance developed by NICE

This data collection asks for the number of patients who have been admitted to hospital who receive a risk assessment for VTE on admission. The DH/NICE risk factors for VTE identified in the National VTE Risk Assessment Tool link seamlessly to the risk factors and risk categories in the NICE clinical guidance (CG92);

This NICE guidance can be found at the following link:
http://guidance.nice.org.uk/CG92
The VTE risk assessment can be found at the following link:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215

The scope of the clinical guidance on VTE prevention from NICE covers:
All adults (aged 18 and over) who are admitted to hospital as inpatients (including those admitted for day-case procedures), including:
- surgical inpatients
- inpatients with acute medical illness (for example, myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease)
- trauma inpatients
- patients admitted to intensive care units
- cancer inpatients
- people undergoing long-term rehabilitation in hospital
- patients admitted to a hospital bed for day-case medical or surgical procedures.

The guidance does not cover the care and treatment that should be offered to:
- people under the age of 18
- people attending hospital as outpatients
- people attending emergency departments who are not admitted to hospital
- older people who are cared for at home or in residential care homes
- people who are immobile and are cared for at home or in residential care homes

- people who are admitted to hospital because they have a diagnosis or signs and symptoms of DVT or pulmonary embolism.

The FAQ section at the back of this guidance gives more detail on the scope of this data collection in the context of the published NICE guidelines, in particular;

- the repeated risk assessment of regular day case attendees (FAQ 10)
- Permitted approaches to risk assessment for particular patient groups (FAQ 11)
- increased levels of prophylaxis as a result of increased risk assessment (FAQ 12)

Feedback

The ROCR team is keen to receive feedback on central data collections from colleagues who complete/submit returns. In particular, feedback on the length of time data collection takes to complete as well as any issues regarding data collection, including suggested improvements or duplication of data collections. Feedback can be submitted to ROCR using an online form: http://www.ic.nhs.uk/webfiles/Services/ROCR/Data%20Collection%20Feedback%20Template.xls

Other Sources of Reference:

- Letter from Chief Medical Officer and NHS Medical Director (24th March 2010) on Prevention of Venous Thromboembolism (VTE) in hospitalised patients, http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_114534
- Connecting for Health NHS Data Dictionary/guidance, http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/index_html
- Further information about CQUIN framework, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443
- Further information about the NHS operating framework 2010/11 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107
- Latest NICE guidelines, http://guidance.nice.org.uk/CG92
- VTE risk assessment tool, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215
- Unify2, nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx

CONTACTS/INFORMATION:

VTE mailbox for general queries:
vte@dh.gsi.gov.uk

Data Collection Form

The upload template for data collection will be made available through the Non-DCT collections area of UNIFY2. The 'control panel' will allow the user to specify which provider they are from, for which month they are reporting, and also notifies the user of any validation errors which must be accounted for before uploading to UNIFY2.

Figure 1 below shows the aspect of the upload template that will require providers to enter the information specified – found on the tab 'Frontsheet'. Aspects (i) and (ii) are entered by providers, but (iii) is automatically calculated from items (i) and (ii) and cannot be overwritten.

For further guidance about the definitions that can be used to calculate (i) and (ii) please see the next section 'definitions'.

Figure 1: Data collection form for Non DCT collection:

VTE Risk Assessments on Admission to Hospital		
		Month Actual
i	The number of adult inpatients (ordinary admission and day case) admitted in the month who have been risk assessed for VTE using the National Tool on admission to hospital	0
ii	Total number of adult inpatients (ordinary admission and day case) admitted in the month.	0
iii	Percentage of adult patients admitted in the month assessed for risk of VTE on admission.	0.00%

In addition to the items collected above, there is also a box for supporting or explanatory comments from providers.

The validation checks on this form will not allow uploading of the form if validation errors are present. These validation checks include:

- The number of patients admitted to the trust must be greater than zero
- The number of patients who have received a risk assessment cannot be greater than the number of patients admitted.

Definitions

Adult
A person who is aged 18 or over on the day they are admitted.

The NHS Data Model and Dictionary defines the Age on Admission as 'derived as the number of completed years between the PERSON BIRTH DATE of the PATIENT and the START DATE (HOSPITAL PROVIDER SPELL).'

Admissions
For the purposes of data collection on VTE risk assessments the definition of an admission is subject to local arrangements for admission criteria. However, this collection covers all those patients who, under local definitions, have been admitted to hospital, either for a day case procedure or as an ordinary admission. This data collection is a census of all patients – it is not considered appropriate to use sampling methodologies to produce estimates.

By way of background, the NHS Data Model and Dictionary definition for Hospital Provider Spell is intended to capture all patients who are admitted to hospital under local criteria irrespective of intended management. This definition covers both ordinary admissions (elective and non elective) and day case admissions. This is defined below:

The NHS Data Model and Dictionary definition for Hospital Provider Spell includes the following:
'Hospital Provider Spell is an ACTIVITY GROUP.
The total continuous stay of a PATIENT using a Hospital Bed on premises controlled by a Health Care Provider during which medical care is the responsibility of one or more CONSULTANTS, or the PATIENT is receiving care under one or more Nursing Episodes or Midwife Episodes in a WARD. During Nursing Episodes and Midwife Episodes general medical care is the responsibility of their own GENERAL MEDICAL PRACTITIONER, who is not acting as a CONSULTANT. The Hospital Provider Spell may be as a result of an ELECTIVE ADMISSION LIST ENTRY.
During the Hospital Provider Spell, the PATIENT may be subject to more than one ADMINISTRATIVE CATEGORY PERIODS. The PATIENT may be subject to one or more CRITICAL CARE PERIODS. The Hospital Provider Spell starts when a CONSULTANT, NURSE or MIDWIFE assumes responsibility for care following the DECISION TO ADMIT the PATIENT. This may be before formal admission procedures have been completed and the PATIENT transferred to a WARD. For example, if a PATIENT is brought into hospital as an emergency and dies in the OPERATING THEATRE before being transferred to a WARD, the PATIENT would have started a Hospital Provider Spell.'

The full definition can be found at:
http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/h/hospital_provider_spell_de.asp?shownav=1

The number of Patients reported includes all admissions, irrespective of Intended Management, Admission Method, or Patient Classification. These definitions can be found in the attributes section of the NHS Data Model and Dictionary at:
http://www.datadictionary.nhs.uk/data_dictionary/attributes/attributes.asp?shownav=1

It should be noted that the NHS Data Model and Dictionary also provide a definition of a hospital bed:

A Hospital Bed includes any device that may be used to permit a PATIENT to lie down when the need to do so is as a consequence of the PATIENT's condition rather than the need for active intervention such as examination, diagnostic investigation, manipulation/treatment, or transport. Cots should be included in statistics about Hospital Beds where appropriate.

Specifically:

· A couch or trolley should be considered as a Hospital Bed provided it is used regularly to permit a PATIENT to lie down rather than for merely examination or transport. An example of such an arrangement is a day surgery ward furnished with trolleys

· A PATIENT may need to use a Hospital Bed, couch or trolley whilst attending for a specific short procedure taking an hour or less, such as an endoscopy. If such devices are being used only because of the active intervention and not because of the PATIENT's condition, they should NOT be counted as Hospital Beds for statistical purposes

· A PATIENT needing a lengthy procedure such as renal dialysis may use a Hospital Bed or other means of support such as a couch or special chair. Whatever the device used it should be counted as a Hospital Bed if used regularly for this purpose

· Some procedures require narcosis. If this necessitates the PATIENT to lie down, the Hospital Bed, couch or trolley can be counted as a Hospital Bed if used regularly for this purpose

· A device specifically and solely for the purpose of delivery should not be counted as a Hospital Bed if another device is normally reserved for antenatal and postnatal care. Details of the facilities available for delivery in a maternity ward should be included in a WARD inventory.

Exclusions

There are no exclusions of admitted patient groups from VTE risk assessment. All adult inpatients need to be risk assessed according to the 'National Tool' developed by DH in collaboration with NICE. Although NICE guidelines may differ for particular groups of patients (for example, medical vs surgery), all patients should be protected from avoidable illness or death from VTE.

The FAQ section at the back of this guidance gives more detail on the scope of this data collection in the context of the published NICE guidelines, in particular;

- the repeated risk assessment of regular day case attendees (FAQ 10)
- Permitted approaches to risk assessment for particular patient groups (FAQ 11)
- increased levels of prophylaxis as a result of increased risk assessment (FAQ 12)

Month

The reporting period starts at 00:00 on the first day of each month. The reporting period ends at 23:59 on the last day of each month.

VTE risk assessment

The National Institute of Health and Clinical Excellence (NICE) have produced guidelines referring to the treatment and prevention of VTE. These can be found following the link below:
http://guidance.nice.org.uk/CG92

All patients must be risk assessed according to the DH/NICE National Tool – a risk assessment template that allows clinicians to identify and judge risk factors for venous thromboembolism against bleeding risk.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215

This monthly census through UNIFY2 assumes that all providers will use or incorporate the elements of the National VTE risk assessment tool within local admission procedures. We realise that a number of providers already have VTE risk assessment procedures, but confidence in the mandatory data collection will require that any audit can clearly demonstrate that the clinical risk assessment criteria and exclusion criteria described in the DH/NICE National Tool (as published) are being employed in full. Trust/hospital medical directors are asked to take responsibility for the assurance that local VTE

risk assessment procedures are fully compliant. We will also expect SHA Medical Directors to be fully involved in quality assurance of this national approach. [3]

This data collection on VTE risk assessment is a census of all patients – it is not appropriate to use sampling methodologies to produce estimates of number of patients who have been risk assessed for VTE using the DH/NICE National Tool.

Please see FAQs for further detail.

VTE risk assessment – pre admission

Risk assessments undertaken pre-admission cannot be included in this data collection until the admission of the patient and the continued validity of the risk assessment at the point of admission is subsequently confirmed. At this point the risk assessment does not need to be recorded twice in the data collection (i.e. do not record one admission and two risk assessments). Instead, for the purposes of this collection one patient is admitted and one patient has been risk assessed according to the DH/NICE National Tool and this data is recorded for the month in which the admission occurs.

[3] Ref: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_088222

Frequently Asked Questions (FAQ's)

1. Do Independent Sector Providers need to complete this data collection?

All providers of NHS funded acute hospital care need to risk assess adult patients for VTE using the DH/NICE National Tool. This data collection is mandated for all trusts, including independent sector providers if they are delivering services under the NHS Acute Services Contracts.

2. Will the department be issuing specific OPCS codes to allow providers to determine whether a VTE risk assessment has been carried out at the point when a patient is discharged?

The Department of Health has no plans to issue OPCS codes for the above purpose

3. Why has the start date of the data collection changed?

A number of interrelated measures are being introduced from 1 April 2010 to ensure a comprehensive National VTE Prevention Programme for the NHS in England. . We have delayed the start date for data collection from 1 April 2010 in order to give providers time to develop or modify local systems to enable reporting via UNIFY2. The first data collection return relating to June 2010 must be submitted no later than 28 July 2010.

UNIFY2 will be enabled to support data collection from April 2010 if providers wish to submit data relating to admissions during April and May.

4. Can we carry on using our own risk assessment tool and established procedures?

Guidance about the use of local risk assessment tools is detailed on page 11 in the section 'VTE risk assessment'. We realise that a number of providers already have risk assessment procedures, but confidence in the mandatory data collection will require that any audit can clearly demonstrate that the clinical risk assessment criteria and exclusion criteria described in the DH/NICE National Tool (as published) are being employed in full. We will expect trust/hospital medical directors to be responsible for signing off that the VTE risk assessment being used at a local level is fully compliant with the DH/NICE National Tool. We will also expect SHA Medical Directors to be fully involved in assurance of this national approach.

5. Are there groups of patients who do not need to be risk assessed?

All adult hospital admissions to acute health service providers need to be risk assessed according to the DH/NICE National Tool for VTE. Although NICE guidelines may differ for particular groups of patients (for example medical vs. surgery), all patients should be protected from VTE.

Please see more detail on the scope of this data collection in the context of the published NICE guidelines as follows;

- The repeated risk assessment of regular day case attendees (FAQ 10)
- Permitted approaches to risk assessment for particular patient groups (FAQ 11)

6. What if a patient is transferred from another provider?

It is the responsibility of the provider to ensure that patients are risk assessed using the DH/NICE National Tool, either by verifying a risk assessment undertaken by the transferring provider, or by undertaking a new risk assessment. This data collection should include patients admitted from another provider.

7. What if a patient is transferred to another department within the same trust?

It is the responsibility of the provider to ensure that their patients are appropriately risk assessed. If the patient has been transferred due to a change in their clinical condition then it is likely that another risk assessment would be appropriate in any event. For further information please consult the NICE guidelines (link can be found in General Guidance Notes). However, this data collection does not include repeat risk assessments after the initial assessment on admission.

8. What happens if a patient is risk assessed prior to admission, but also risk assessed on admission – how should this be recorded?

Risk assessments undertaken pre-admission cannot be included in this data collection until the admission of the patient and the continued validity of the risk assessment at the point of admission is subsequently confirmed. At this point, the risk assessment does not need to be recorded twice in the data collection (i.e. do not record one admission and two risk assessments). Instead, for the purposes of this collection, one patient is admitted and one patient has been risk assessed using the DH/NICE National Tool, and this data is recorded for the month in which the admission occurs.

9. Do we have to risk assess patients for VTE if they are regular day cases who are admitted to hospital for treatment frequently?

In the case of regular day case admissions occurring over a period of time for the same clinical condition, local discretion can be applied to the time interval between formal documented risk assessments. Any such local protocols must be agreed with the Trust or hospital medical director (for example using “expiry dates” on documented risk assessments for clarity) and included within local VTE governance policy and audits. However, there are no exemptions for this data collection:

a. Denominator remains "Total number of adult inpatients (ordinary admission and day case) admitted in the month” for all acute providers
b. Numerator will continue to reflect the number of VTE risk assessments completed on admission to hospital

10. What if there is a specific patient cohort deemed to be not at risk of VTE locally – do we still have to risk assess all patients within this cohort on an individual basis at every admission; and if not, how should we count these patients within the data collection?

A ‘cohort approach’ to risk assessment using the DH/NICE National Tool may be considered locally for certain cohorts of patients undergoing certain procedures where the cohort of patients share similar characteristics and are **not at risk of VTE** according to the NICE guidance. A cohort approach to risk assessment can only be used when the Trust Medical Director is satisfied that, when reading the NICE guideline and DH/NICE National Tool together, use of the DH/NICE National Tool among the cohort would always result in the determination that the patient is **not at risk of VTE**, or that under the NICE guideline no pharmacological or mechanical prophylaxis would be appropriate regardless of the risk factors. SHA Medical Directors must also be responsible for assuring this approach.

Any such local protocols must be agreed with the Trust or hospital Medical Director, and included within local VTE governance policy and audits. This approach must be approved by the SHA Medical Director. The Trust/hospital Medical Directors will be responsible for signing off that the VTE risk assessment being used at a local level is fully compliant with the DH/NICE National Tool and all risk factors have been taken into account. SHA Medical Directors will be involved in the assurance of this approach.

For the purpose of this data collection:

a. Denominator remains "Total number of adult hospital admissions (ordinary admission and day case) admitted in the month” for all providers of NHS acute health services

b. Numerator will include all admissions risk assessed under the ‘cohort approach’ and those adult admissions who are risk assessed on an individual basis

11. Will we have to prescribe greater amounts of prophylaxis as a result of this policy?

VTE is a significant patient safety issue. Only those patients assessed to be at risk of VTE on admission to hospital should receive appropriate thromboprophylaxis based on national guidance from NICE. This is in order to reduce the amount of avoidable illness and death caused from hospital acquired VTE. Embedding VTE risk assessment across the NHS is vital to improving patient safety.

This data collection does not measure appropriate prophylaxis, only completed risk assessments. The intention of improving identification of VTE risk is to ensure that all adult patients on admission to hospital receive appropriate thromboprophylaxis. However, some concerns have been raised about increased cost of prophylaxis arising from the comprehensive approach to risk assessment.

The section of the NICE guideline specifically focusing on day surgery patients states that pharmacological VTE prophylaxis is only recommended for those (day-surgery) patients who have a low risk of major bleeding, and only according to clinical judgment. (See Section 1.5.20 of the NICE guidance document, page 29). Mechanical methods are indicated in those with a high VTE risk who are also at risk of bleeding.

The guidance does acknowledge that many day case procedures would not require prophylaxis, and so the following recommendation is included in the guideline: “Do not routinely offer pharmacological or mechanical VTE prophylaxis to patients undergoing a surgical procedure with local anaesthesia by local infiltration with no limitation of mobility”. (See Section 1.5.5, page 20).

As with all of NICE clinical guidance, these recommendations are based on the best available research evidence and expert consensus, and healthcare professionals are expected to take them fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.