THE VTE AWARDS 2023

Thrombosis UK

Awareness • Research • Care

CONTENTS

Thrombosis UK works to increase awareness, understanding and support for all those affected by or at risk of blood clots, also known as 'venous thromboembolism' (VTE) an umbrella term for deep vein thrombosis (DVT) and pulmonary embolism (PE).

Since the charity was founded in 2002, its' work has continually extended to support, inform and update best practice in the prevention and management of thrombosis.
The launch of this first VTE Awards marks a new stage for Thrombosis UK as we reach out to healthcare professionals across secondary, primary and community services to demonstrate and share innovation and excellence in the prevention of avoidable VTE events, and effective management of those diagnosed with venous thromboembolism.

The VTE Awards are also a welcomed opportunity to continue to raise awareness of VTE as a Patient Safety priority, and this is reflected in the work being done by VTE teams across the UK. However, there is still much to achieve in raising increased awareness of VTE, reducing harm and suffering as a result of preventable thrombotic events and tackling variation in care.

We are delighted to welcome representatives from NHS Resolution to the VTE Awards. In March 2023, NHS Resolution published thematic reviews looking at high value and fatality related claims in emergency departments and general practice related claims. VTE featured amongst the most common causes of mortality related to a missed diagnosis in ED and established that VTE is a theme in general practice claims, emphasising the range of clinical settings.

NHS Resolution noted that VTE is a significant cause of mortality, long-term disability and long-lasting ill-health problems – many of which are avoidable. A staggering £23 million pounds had been settled across 411 closed claims between 2012-2022. Their digital resource details how clinicians take preventative action to improve outcomes for patients at risk of VTE.

VTE remains an NHS Patient Safety priority and the VTE Awards celebrate the dedication and achievements of practicing healthcare teams and provide models of practice to inform and inspire others so that together we will advance VTE prevention and management for the benefit of all patients.

Prof Beverley Hunt OBE
Founder and Trustee of Thrombosis UK

Prof Simon Noble
Medical Director and Trustee of Thrombosis UK

WELCOME

Introduction from Lyn Brown MP

As Chair of the All Party Parliamentary Group for Thrombosis (APPGT), I am pleased to welcome the VTE Awards, recognising and celebrating exemplary practice in prevention and management of venous thromboembolism (VTE).

I became Chair because I have personal experience of thrombosis. I know how important good patient care is because I had a DVT in September of 2014. After three weeks of poor care and misinformation, I got lucky and was referred to Professor Beverley Hunt. Beverley has cared for me brilliantly ever since and I genuinely believe she saved my life.

It is positive that we can recognise in Parliament the many individuals and teams across the UK who, like Beverley, are dedicated to preventing harm from VTE. I would like to add my personal congratulations to all those who have participated in these awards and are working to improve patient safety and care.

As we know, the awards reach out to healthcare professionals across all services who are demonstrating innovation and excellence in helping to prevent and treat this devastating form of disease, at all levels of our NHS. I am delighted that even in this first year of these awards there have been very strong applications, and I am grateful to our panel of Judges who gave their time and brought their wealth of experience to the decision-making process.

The VTE Unsung Hero Award was based on peer to peer nominations, showing how much impact individuals can have on improving service, even across a whole department.

I believe that VTE awareness must continue to be a priority for all our communities and across our NHS. I am grateful to Thrombosis UK for all their support with the All Party Parliamentary Group for Thrombosis and the continuing charitable leadership this demonstrates.

This year, alongside our award ceremony, I would like to personally welcome a new patient support resource – the Thrombosis UK VTE patient information app. I know that the app has been designed in collaboration with healthcare professionals, patients, and family members.

So I'm hoping that it will prove an essential new resource, providing information right through the thrombosis pathway – from 'what is a blood clot?' to signs and symptoms, diagnosis and recovery. We all know that many patients need support, as I did, to manage both the physical and psychological impact of blood clots.

I believe that the VTE Awards can represent not just celebration but hope of improving VTE awareness, understanding, prevention and practice. We all know that lives can be saved as a result.

Lyn Brown MP

Chair All Party Parliamentary Group for Thrombosis

AWARD CATEGORIES

VTE AWARD FOR:
Enhancing Patient and Carer Experience about VTE Prevention

VTE AWARD FOR:
Outstanding Patient Resource Sharing Information about VTE Prevention for Patients and Carers

VTE AWARD FOR:
VTE Pathway Award for Improving Timely Diagnosis of Thrombosis

VTE AWARD FOR:
Excellent Quality Improvement Programme Advancing Practice in Thrombosis Prevention or Management

VTE AWARD, PATIENT NOMINATED:
Unsung Hero Award

VTE AWARD, HEALTHCARE PRACTITIONER NOMINATED:
Unsung Hero Award

VTE AWARD

Enhancing Patient and Carer Experience about VTE Prevention

CWM TAF LOCAL HEALTH BOARD, ROYAL GLAMORGAN HOSPITAL

The Royal Glamorgan Hospital (RGH) implemented a referral form to be completed for all patients started on anticoagulation for venous thromboembolism (VTE). This form includes information regarding diagnosis, treatment choice and duration, as well as other clinically relevant information.

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Patients are typically diagnosed with VTE in the Ambulatory Emergency Care Unit (AECU). On diagnosis, patients are provided with verbal and written information by the staff in AECU and the nursing staff are provided with training and resources by the pharmacy anticoagulation team.

The pharmacy anticoagulation team are informed of all patients who are started on oral anticoagulation. They then provide a date the patient will be contacted after starting treatment. A copy of the referral form is given to the patient to give to their GP. Every prescription is reviewed by a specialist anticoagulation pharmacist to ensure correct dose for indication, weight and renal function. It is also screened for any medication interactions.

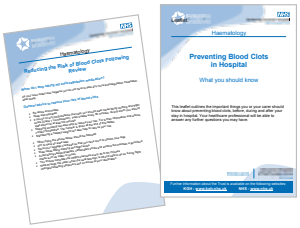
The pharmacy anticoagulation team act as a link between primary and secondary care. Problems often arise when patients are discharged from secondary care and a recent review identified that around 50% of adult patients experience medication errors or unintentional discrepancies following hospital discharge. This can lead to frustration and patients being prescribed inappropriate drugs or doses as well as incorrect durations of treatment.

Patients are contacted by phone on the agreed date. The purpose of this additional follow up phone call is to ensure patients have a chance to discuss their diagnosis and treatment with an anticoagulation specialist. The service aims to ensure patients have access to written and verbal information at several points during their VTE journey.

The service ensures patients are fully informed and supported to get the best outcomes from their treatment and to manage their own condition. The ultimate outcome of the service is that patients on anticoagulants for VTE can be safely and effectively managed in primary care as opposed to requiring hospital management. This has numerous benefits to the patient and NHS.

KETTERING GENERAL HOSPITAL, HAEMOSTASIS AND THROMBOSIS MULTI-DISCIPLINE TEAM (MDT)

The Anticoagulation service is a nurse led service supported by consultant haematologists. We have a team of nine nursing staff with an administrative team of four together with a Domiciliary Phlebotomy team of four phlebotomists. We manage just over 1700 patients prescribed warfarin but also initiate patients onto direct oral anticoagulants following a VTE diagnosis.


Haematology

Reducing the Risk of Blood Clots Following Review

Haematology

Preventing Blood Clots in Hospital

What you should know

We run a Nurse Led Thrombosis Review clinic and all patients diagnosed with VTE event within Kettering General Hospital (KGH) will either have a ward visit completed by anticoagulation nurses during their hospital stay or they will be contacted by the team after being discharged.

All patients are provided with vital anticoagulation leaflets together with a wristband, an alert card, and also the contact numbers to obtain support from the KGH anticoagulation team. The patients are then discussed in a Haemostasis and Thrombosis MDT where an anticoagulation outcome is agreed. At three months the patients are reviewed in either a Nurse Led clinic or Consultant Led clinic where anticoagulation management is discussed and an ongoing treatment plan is agreed, if needed nurses running the clinics can re refer back to MDT to discuss the anticoagulation management plan with a Consultant Haematologist.

VTE AWARD

Outstanding Patient Resource Sharing Information about VTE Prevention for Patients and Carers

KINGS COLLEGE HOSPITAL, LONDON

Launched in October 2022, the development of the animation was funded by a unrestricted educational grant from Thrombosis UK. The animation film was developed in order to redress an identified gap in patient information and intended to be shared with hospitalised patients and their carers to share information about venous thromboembolism.

Meeting NICE guidance [NG89]: Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism, which stipulates:

- Give patients and their family members or carers verbal and written information on the following before offering VTE prophylaxis:
- The person's risks and possible consequences of VTE,
- The importance of VTE prophylaxis and its possible side effects – for example, pharmacological prophylaxis can increase bleeding risk,
- The correct use of VTE prophylaxis – for example, anti-embolism stockings, intermittent pneumatic compression,
- How people can reduce their risk of VTE (such as keeping well hydrated and, if possible, exercising and becoming more mobile).
- The signs and symptoms of deep vein thrombosis (DVT) and pulmonary embolism.
- The importance of seeking help if DVT, pulmonary embolism or other adverse events are suspected.

A film script was developed, and animation designed. It was reviewed by VTE healthcare leads and patient representatives before being launched in October 2022 as part of World Thrombosis Day celebrations.

Following the launch an 'Impact Report', two months post launch reported:

- 63 521 impressions and 18 526 views in the first eight weeks.
- Total watch time 22.4 hours, suggesting that when people clicked, they did watch the entire animation, as opposed to the first 10 seconds.

The results of a survey (July 2023) of how useful and how the animation is being used by the VTE specialists network in the UK and Ireland showed:

- There is growing use of the animation across the UK.
- Most users utilise the animation in a secondary care setting.
- 63% rated the film 'excellent' and 37% 'good.

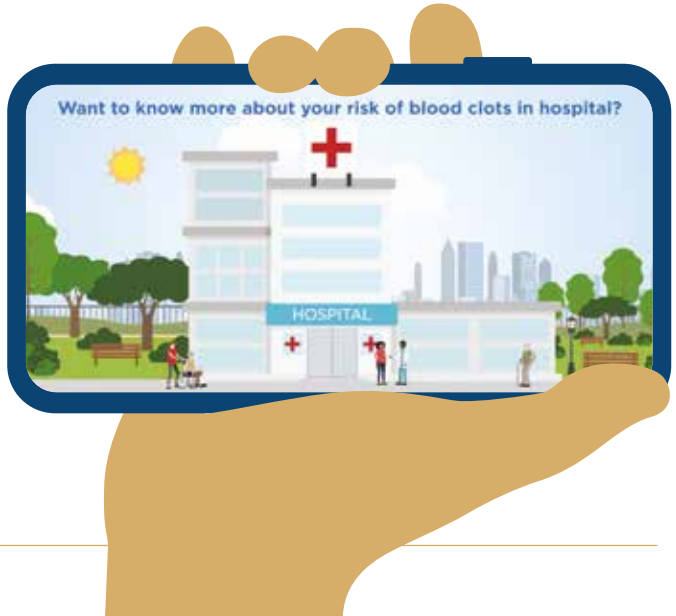
Made available free of charge to NHS hospitals, 20% of the VTE Specialist Network have implemented use of the film in their medical setting, including in, medical inpatients, pre-admission clinic, surgical inpatients and antenatal and postnatal wards.

Feedback received from patients has been extremely positive, with comments including:

- Excellent.
- Information pitched at the right level.
- 67% stating their knowledge of VTE and VTE prevention had increased as a result of watching the animation.

Finally, as awareness of the animation has increased, we have been approached by international organisations to use the animation in their organisation. e.g.:

> "I HAVE DONE SIMILAR PROJECTS IN THE PAST AND KNOW HOW DIFFICULT IT IS TO GET ALL THE POINTS ACROSS SUCCINCTLY IN TERMINOLOGY AND PHRASING THAT THE PATIENT/CARER WILL UNDERSTAND SO HAVE REAL APPRECIATION OF HOW GOOD AND HOW MUCH WORK THIS 2:27 MIN HAS BEEN."



VTE AWARD

VTE Pathway Award for Improving Timely Diagnosis of Thrombosis

UNIVERSITY HOSPITALS PLYMOUTH

The Nurse Led DVT clinic was started in July 2002 to improve experience of patients presenting to hospital with a suspected DVT. Launched in October 2022, the development of the animation individualised care pathway and a totally nurse led service supported by a haematology and medical consultant. In recent years the service has moved to the acute assessment unit [AAU] due to hospital reconfiguration.

Once the service was established, we worked with primary care to ensure referrals for suspected DVT were made through the service, improving the patient pathway.

The service has allowed for a single point of entry for GPs to refer patients to hospital for diagnosis and treatment, with up to six daily dedicated ultrasound slots.

Medication is issued via a patient group directive, with time allocated to explain medication and facilitate patient choice. Furthermore, the link with the acute GP service and AAU has enabled the DVT clinic to refer unwell patients direct to the unit.

The Nurse Led DVT clinic functions well because of close working relationships with Imaging / blood labs/ acute GP service and medical take teams / pharmacist and haematology. The close link with haematology has enabled direct referrals to haematology to make long term decisions around anticoagulation.

Since moving to street access patients no longer have to travel across the hospital for review and then back to another floor for scanning, providing a smoother, easier service for patients.

Audit has evidenced success and informed change, for example around scanning and treating superficial thrombosis. Following patient feedback, we now offer a phone service post diagnosis.

The service continues to adapt and look to how it can improve. It takes part in research studies and has managed to successfully work with intravenous drug users who historically, are a difficult to reach group.

VTE AWARD

Quality Improvement Programme Advancing Practice in Thrombosis Prevention & Management

ALL WALES HOSPITAL ACQUIRED THROMBOSIS (HAT) STEERING GROUP

In 2012 approximately 900 people in Wales were reported as dying from VTE related causes. Not all of these deaths were avoidable, but many may have been. Many survivors of deep vein thrombosis (DVT) suffer long-term physical and psychological effects. Most cases of VTE occur during or following a hospital admission.

The All Wales Hospital Acquired Thrombosis (HAT) Steering Group was set up in 2012 to implement the recommendations made by Welsh Government (WG). The group includes a multidisciplinary membership from all seven health boards and Velindre Cancer Care centre in Wales and also includes clinical trustees and patient representation from Thrombosis UK. The Steering group agreed the definition for HAT and a methodology for collecting potential HAT incidents. As a result, every health board collected and reported potential HAT incidents to WG.

This positive approach by WG and NHS Wales clinicians working collaboratively to improve patient safety has been recognised as good practice.

The group demonstrated standardised practice with the implementation of the amended All Wales medication chart in 2016 which led to an increase in the number of VTE risk assessments undertaken in all Welsh hospitals. The changes made it easier to ascertain whether a patient had been risk-assessed and whether the correct thromboprophylaxis had been prescribed. This is identified as a key process step that can lead to the reduction of HATs. Another example of standardised practice was, that in 2018, following the publication of revised guidance on thromboprophylaxis (NICE NG89), the All Wales HAT Steering Group has led the development and agreement of an All Wales thromboprophylaxis policy. The thrombosis committees of all NHS Wales health boards came together to ratify this policy at the end of 2019.

In October 2021 The NHS Delivery Framework for 2021-2022 did not include the following measure:

- Number of potentially preventable hospital acquired thrombosis.

The loss of reporting the number of potentially preventable hospital acquired thrombosis as a Tier 1 priority and our association with WG was a serious setback.

The Welsh Risk Pool (WRP) was established as a mutual pooling system to reimburse losses to NHS organisations in Wales. In addition, it supported healthcare organisations in establishing systems and processes to manage risk and reduce the incidence of losses.

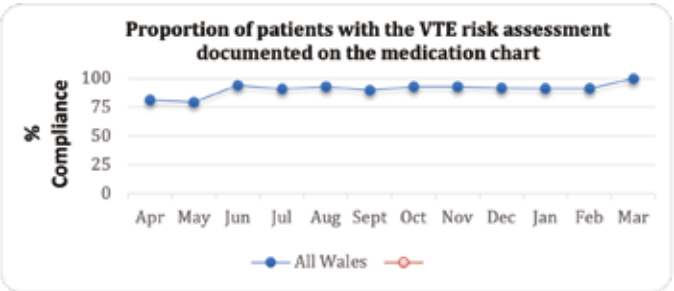
WRP agreed to affiliate with the All Wales HAT Steering group and work together becoming re-affiliated with WG and both achieve the same outcomes;

- Improve Patient Safety.
- Reduce mortality.
- Increase the uptake of a full TP RA.
- Improve TP education in all Welsh health boards.
- Reduce the number of claims associated with VTE.

Our success as a group who meets regularly to share HAT data and a common goal to standardize thromboprophylaxis, Risk Assessment, Treatment, HAT root cause analysis and reporting, education and ultimately the highest provision of patient safety is what maintains and has maintained this unique nationwide collaboration.

The standards set with WG and WRP give us essential governance links at the highest level. It is key to the group that we are involved with the standard setting and do not lose sight of our goals. We have no financial resources only the drive and enthusiasm of the group members and the roll out of the services we have developed:

- All Wales TP Policy.
- All Wales VTE education modules.
- Standard approach to patient information leaflet.
- Standard approach to HAT reporting.
- Sharing best practice.
- Identifying issues causing concern within Wales.
- Everything we do is firstly for the benefit of patients and the way we do it is delivered through a multidisciplinary approach which involves all HCS at the point of care delivery.



VTE AWARD

Quality Improvement Programme that Advanced Practice in Thrombosis Prevention or Management

BETSI CADWALADER HOSPITAL UNIVERSITY HEALTH BOARD

To achieve the recommendations set by the Welsh Risk Pool and to also reduce our preventable Hospital Acquired Thrombosis (HAT) a meeting was held, attended by thromboprophylaxis nurses, clinical leads, pharmacists, HAT group chair and stake-holders. This allowed us to discuss our ideas to change practice and set SMART goals.

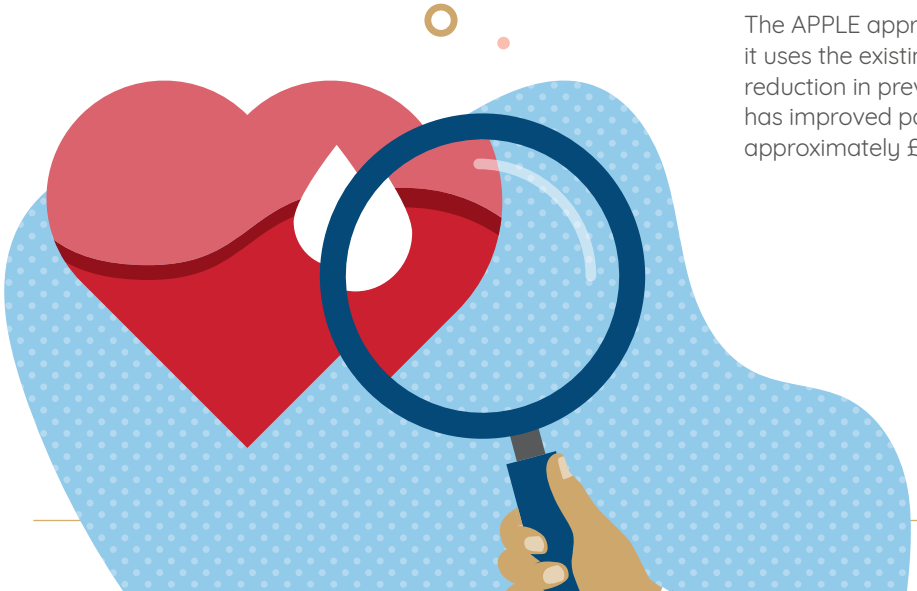
We set the goal

- To increase the compliance in completing thromboprophylaxis risk assessment tool on admission by 30% by January 2023.
- We also set a stretch goal: To reduce preventable HAT rate by 50% by January 2023.

After setting the goals we agreed on the concept of the APPLE approach to be included in our thromboprophylaxis walk around as being the best option for the intervention.

The concept of APPLE is a Multi-Disciplinary-Team (MDT) approach focusing on

Assessment (VTE risk assessment tool).
Peer review (consultants to review thromboprophylaxis on post take round).
Pharmacy check (pharmacists to check thromboprophylaxis prescription is correct).
Leaflet (Nurses to give written and verbal VTE information on admission).
Education (all staff to be educated on the importance of thromboprophylaxis and VTE including risk assessment and missed doses and pass on their learning to colleagues and patients).



This approach enables departments to take ownership and create a culture focused on increasing patient safety.

The outcome of implementing the APPLE approach for thromboprophylaxis was that the goals we set were achieved. On January 2023 audit we had 100% compliance. A secondary outcome was that our number of preventable HATs decreased.

Prior to commencing the APPLE approach our preventable HAT increased to nine in 2020 when the COVID 19 pandemic started, this decreased to seven in 2021. In 2022 when the APPLE project was implemented the preventable HAT cases decreased to three.

Preventable Hospital Acquired Thrombosis are reported to the Welsh Government along with lessons learnt. These preventable HAT's over the last two years were due to either having one missed dose of thromboprophylaxis or having a delay in prescribing thromboprophylaxis. To date in 2023 there has been no preventable HAT's identified, resulting in a culture change towards thromboprophylaxis and VTE by staff and patients. As a result we have seen:

- A dramatic increase in the uptake of education and understanding of prevention of VTE.
- An openness regarding lessons learnt.
- A multi-discipline team approach discipline team approach.
- Reduction in drug errors since the implementation of the APPLE approach.

These improvements have also been seen in the hospital management team, governance leads, patient safety quality groups and clinical effectiveness group and have enabled best practice to be embedded into practice with the focus on patient safety and duty of candour. This in turn has increased patient's knowledge and confidence in their care and an open communication stream between staff, patients and their loved ones to raise and address concerns to work towards Getting It Right First Time.

The APPLE approach was cost neutral to implement as it uses the existing workforce, the improvements and reduction in preventable hospital acquired thrombosis has improved patient safety and saved the health board approximately £500,000.

VTE AWARD

Quality Improvement Programme that Advanced Practice in Thrombosis Prevention or Management

KETTERING GENERAL HOSPITAL

The VTE service at Kettering General Hospital is comprised of a VTE Prevention Nurse and the Lead nurse for Anticoagulation, Ambulatory DVT service and VTE. The Clinical Lead supports the VTE nurse with advice and guidance as required. The VTE service forms part of the wider Anticoagulation service and the Ambulatory DVT (nurse led) service that is provided to all residents of North Northamptonshire.

The VTE Prevention nurse works in conjunction with the specialist nursing teams to provide advice and education to patients within the organisation as well as caring for all patients who are prescribed warfarin within the community and the diagnostic and treatment care for those with a DVT.

The service delivers education and training across the organisation to doctors, nursing staff, healthcare support workers and pre-registration students to engage and develop knowledge and understanding around venous thromboembolism, its prevention, diagnosis and treatment.

The service supports the patients in their knowledge and understanding of preventative measures whilst in hospital and after discharge.

The service works across the organisation and is fluid to the needs of the teams providing acute care and treatment. This support and education are available both formally and informally and the team strive to deliver in whichever setting is most appropriate to the needs identified.

Within the last 12 months we have significantly raised the profile of VTE prevention within the organisation and promoted the guidance set out by NICE within the inpatient setting.

To ensure the effectiveness and provide assurance, the inpatient areas are audited using a harm free care audit using Tendable platform. This allows the organisation to RAG rate each area and identifies actions and improvements that are required, historically the areas were audited by their peers however, it was identified that there was disparity in the quality of the auditing process. In April / May 2023 the VTE team took over the auditing to provide parity in the information gathered and the results available. The team have worked with the practice development team and have RAG rated the audits therefore a Red area <70-% is audited monthly, Amber 70-90% are audited bimonthly and Green >90% every three months. This allowed for concentrated support to be given to the lower scoring areas and a significant improvement was noted.

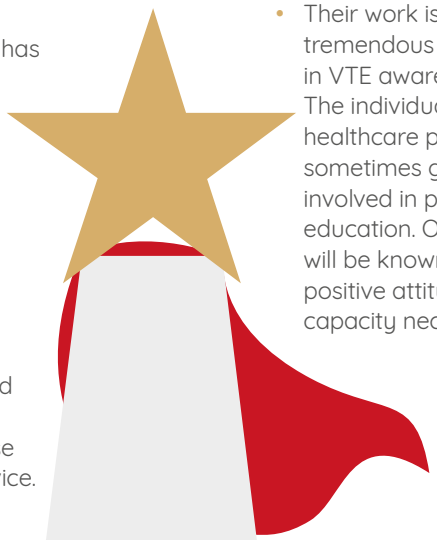
The patients that are admitted into the organisation have benefitted from a dedicated VTE team with cohesive working, visibility and accessibility. This support has reduced the risk of harm from hospital acquired thrombosis events. The learning from events is paramount as too, the ability to be flexible, have the courage to try new approaches to secure reduction of harm sustained by the patients that we care for. VTE and the team are well recognized across the hospital, the number of enquiries has risen over the last 12 months from ward-based clinicians and the knowledge and accessing of readily available resources is evidenced by the number of staff who have completed the online training. The feedback received has only been positive in nature however we consistently strive to maintain current standards and improve the journey for both our patients and staff moving forward.

VTE AWARD, PATIENT NOMINATED

Unsung Hero Award

The Unsung Hero patient nomination has been submited from a member of the public, patients and/or carers who have received care or been aware of a family member/ friend who has received care from a health professional who has gone above and beyond to deliver care that has made a positive difference to the individual, their experience and recovery.

- The award celebrates an individual who has made a significant contribution to the provision of resources and support, which brings benefit to patients accessing the service. Their work has placed emphasis on patient experience, understanding, wellbeing and improved outcomes.
- Has demonstrated innovation and dedication.
- Delivered care in a way that is above and beyond their job specification and has brought considerable benefits to all those benefiting from or involved with the service.



VTE AWARD, HEALTHCARE PRACTITIONER NOMINATED

Unsung Hero Award

Nominated by a fellow health care or allied health care professional, this award recognises an individual who has demonstrated exceptional dedication in going above and beyond to make a difference to VTE awareness, VTE prevention, VTE management, VTE advocacy or VTE patient education and support.

- Their work is often 'behind the scenes' but has had tremendous impact positively influencing improvement in VTE awareness, understanding and shared learning. The individual will have worked across multiple healthcare professional teams at local, national, and sometimes global level. They will also have been involved in policy development, implementation, and education. Over and beyond all of this, the individual will be known as someone who always maintains a positive attitude, a willingness to help in whatever capacity necessary, and a commitment to excellence.

Judges Panel

Sue Bacon
Quality Improvement Nurse and previously Lead VTE Prevention and Anticoagulation Specialist Nurse, North Bristol Trust NHS Trust

Diane Eaton
VTE Awareness Ambassador

Dawne Long
VTE Awareness Ambassedor

Mariana Mascarenhas
Venous Thromboembolism Prevention Specialist Nurse, Buckinghamshire Healthcare

Nusaiba Masnurah
Patient Advocate and Thrombosis UK Trustee

Sophie Millington
Specialist Nurse in Thrombosis & Anticoagulation, Royal United Hospitals Bath NHS Foundation Trust

Janet Morgan
Thrombosis UK Trustee

Clare Prince
Patient Advocate and Thrombosis UK Fundraiser

Rebecca Simpson
Lead Nurse VTE Prevention, Ashford and St Peter's Hospitals NHS Foundation Trust

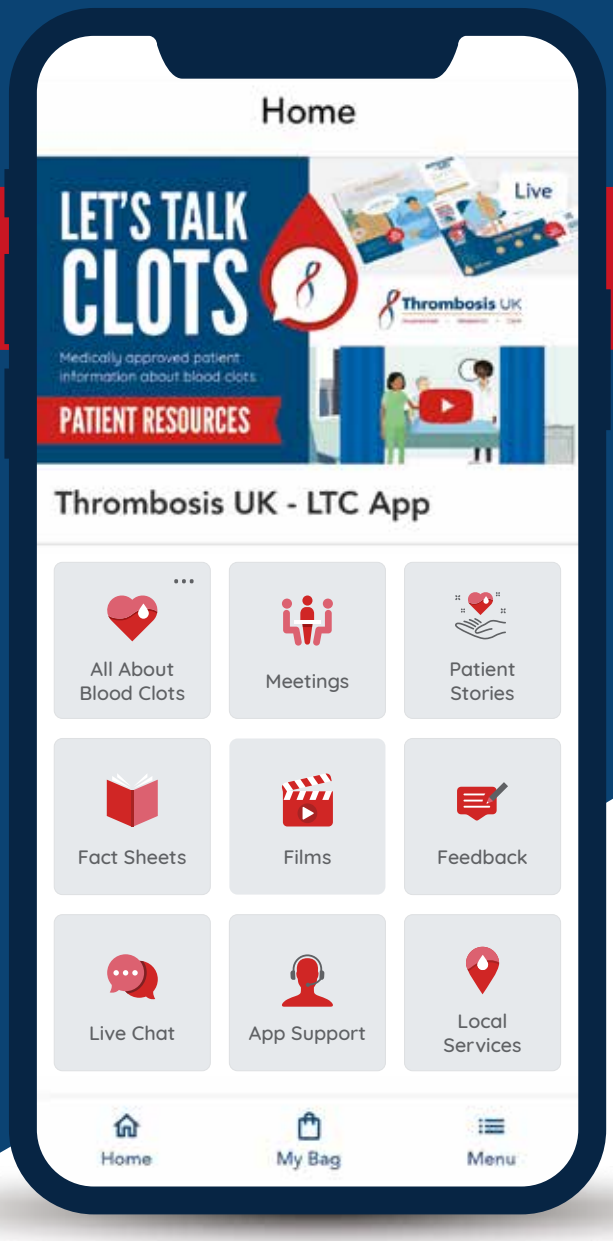
Katherine Stirling
Consultant pharmacist for anticoagulation and thrombosis, Leeds Teaching Hospitals

Thrombosis UK
Awareness • Research • Care

DOWNLOAD OUR NEW APP

LET'S TALK CLOTS

A **FREE** comprehensive one-stop shop for medically approved patient information about blood clots.



What is a blood clot?

Diagnosis, treatment & help

Recovery, what about... & FAQ

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Developed in collaboration with Oxford University Hospitals and UK healthcare and allied professionals and patient advocates

NHS Oxford University Hospitals NHS Foundation Trust

Thrombosis UK is a registered charity in England: 1090540

www.thrombosisuk.org