

# ANNUAL REVIEW

NOVEMBER 2017



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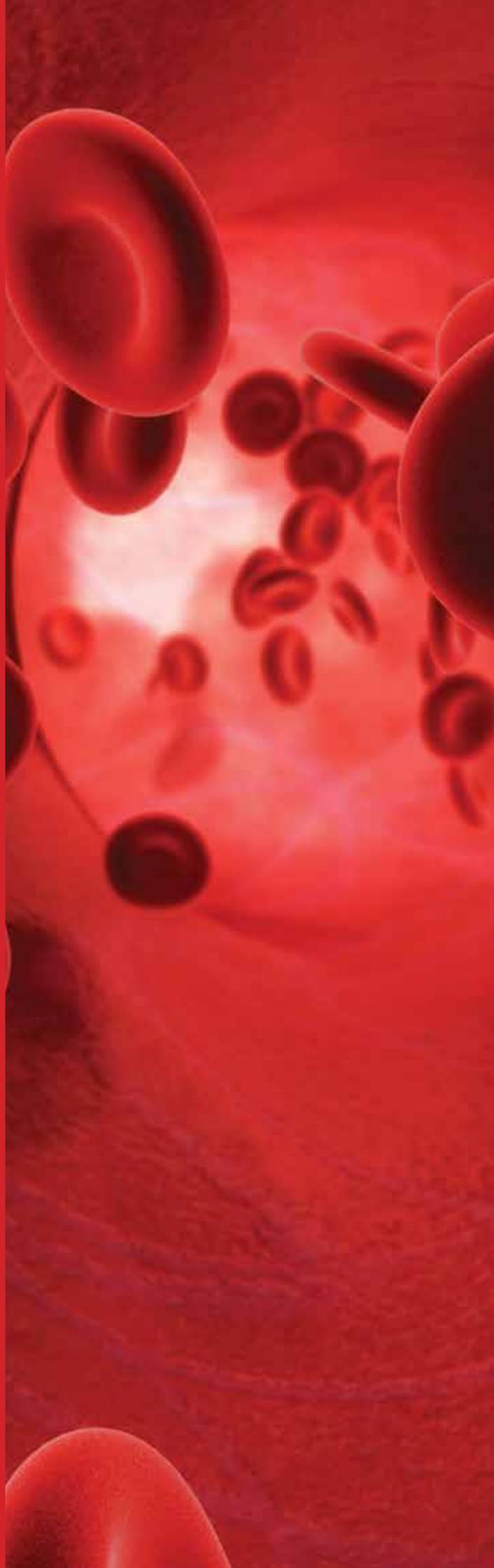
APPTG ANNUAL  
SURVEY RESULTS

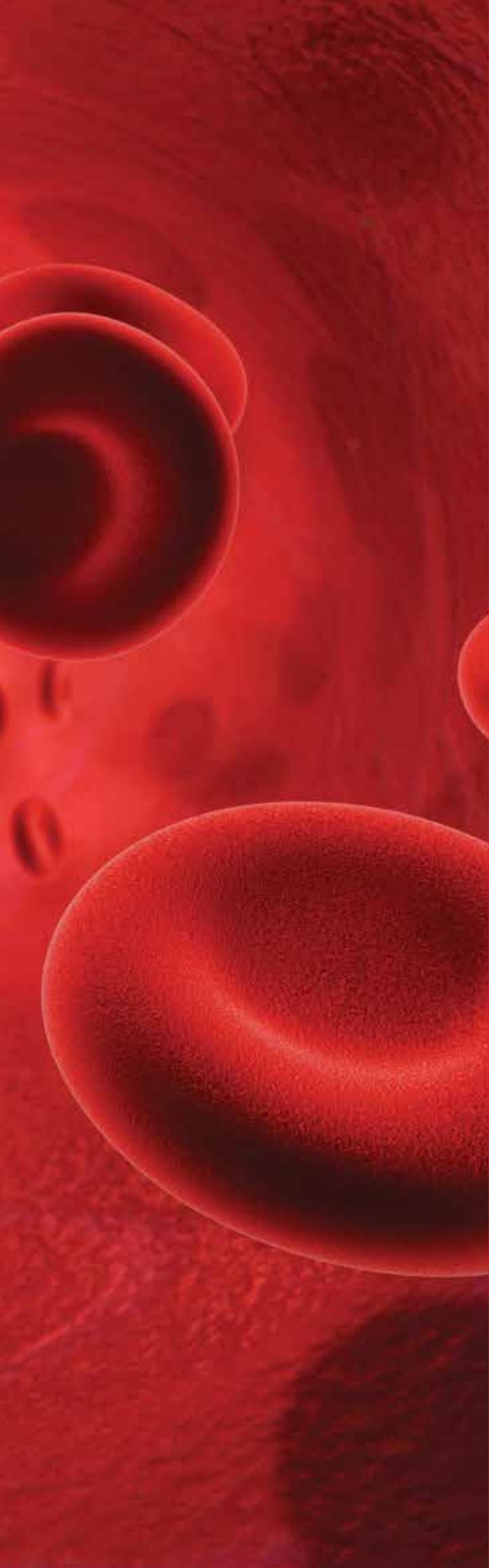
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## ABOUT VTE

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



Next year, the NHS will turn 70 and it is clear that this important milestone comes at a time of unprecedented challenge. Britain's ageing population and the rise in patients with long-term conditions are stretching the capacity of the NHS and social care services, and a difficult funding settlement is creating pressure to do more with less.

As a result, prevention of avoidable illnesses and the associated costs is more important than ever. Since the NHS Five Year Forward View was published in 2014, the NHS has launched several prevention initiatives. NHS England's Next Steps on the NHS Five Year Forward View stated an ambition for the NHS to become the "world's largest learning organisation". This year saw the introduction of a new requirement to publish data on all deaths thought to be linked to care. Managers will also have to identify lessons from these incidents, and actions that can be taken to prevent similar incidents in the future. In parallel with this, the NHS has introduced a new Healthcare Safety Investigations Branch to explore how patient safety can be maximised.

Closer integration between health and social care has rightly become a major priority. NHS England is urging hospitals to collaborate with their local authorities and primary and community services to reduce delayed transfers of care and help free up 2,000-3,000 hospital beds.

Spreading best practice in prevention and management of venous thromboembolism (VTE) is essential to support these priorities for the health service. As we know, VTE is one of the most significant causes of avoidable illness and mortality, and its treatment and management costs the NHS £640 million every year. The NHS still stands out as a world leader in VTE prevention. It is vital that policies continue to adapt to meet new challenges, incorporate new technologies, and adjust to new models of care.

Since its inception, the APPTG has produced annual reports to support the implementation of best practice in VTE prevention and management. This report continues that work by drawing on the evidence gathered by our annual survey of Acute Trusts and CCGs. The aim is to provide a comprehensive overview of the reality of VTE practices in the NHS, and allow us to review progress, identify areas where improvement is needed, and offer recommendations on what more can be done.

This year's survey confirmed that many key national requirements of best practice are firmly embedded in hospitals. On average, Trusts risk assess 96% of adult inpatients for VTE, a higher level than the nationally mandated threshold, and when episodes of hospital-associated thrombosis (HAT) do occur, the vast majority of hospitals are conducting analysis to ascertain the root cause.

However, our survey found that improvement is needed in the steps taken after patients are assessed to be at risk. We found that in one in six cases of HAT, patients had not been receiving preventative care. We also found that the average time from first clinical suspicion of VTE to diagnosis is higher than recommended by NICE. This may be delaying patients' time to treatment.

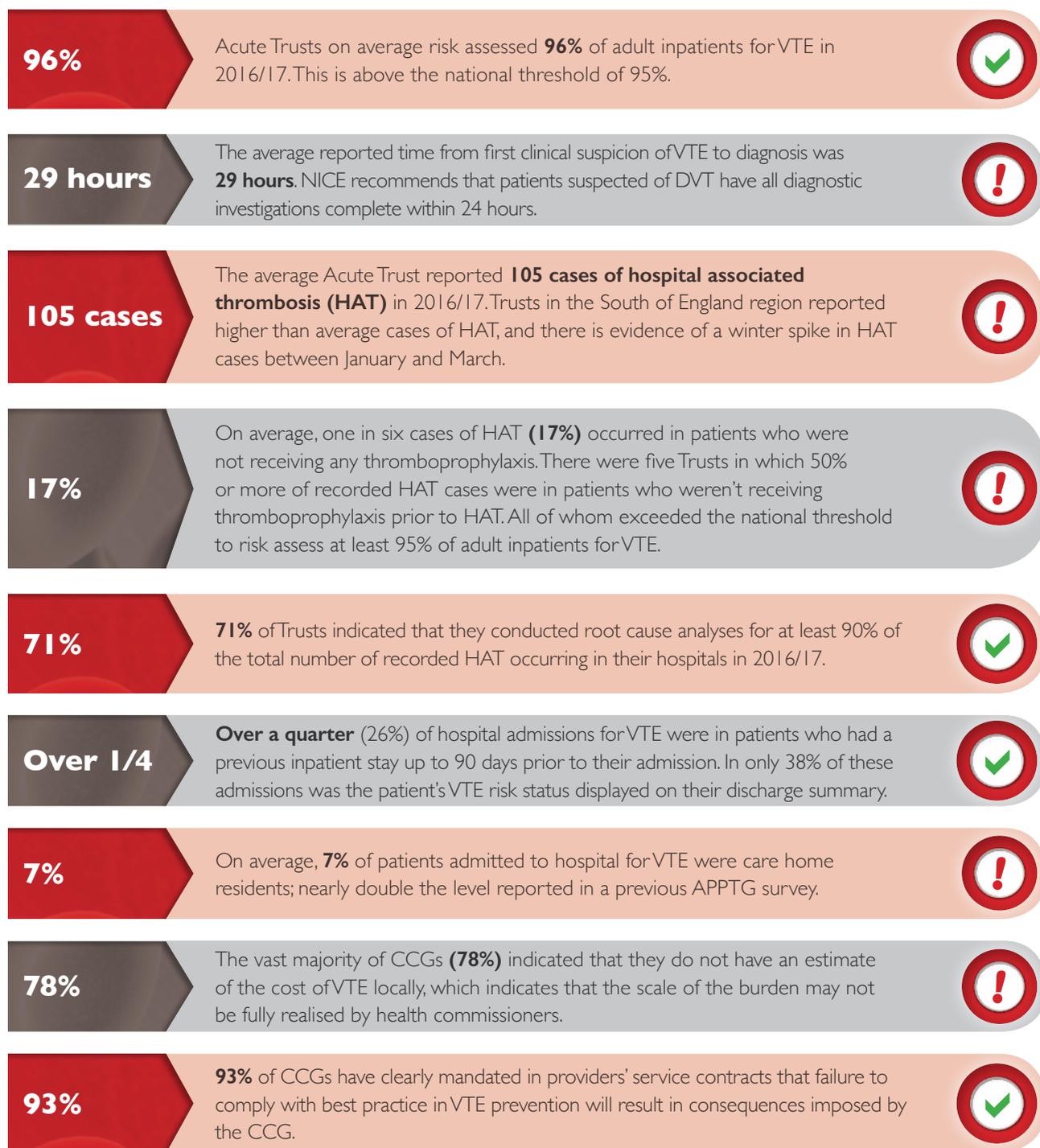
Our survey indicates that while most CCGs have mandated VTE best practice in their providers' service contracts, very few have an estimate of the local cost of VTE. This suggests that it may be omitted from important local discussions. That could include the conversations that are happening on investments in prevention to reduce health and social care costs, and on steps towards integration between secondary, primary and community care.

Overall, our survey evidence suggests that while enormous progress has been made in promoting VTE risk assessment in hospitals, the care pathway that follows a risk diagnosis still needs to be improved. Patients should know that they will be offered the right preventative care, no matter where they are in the country, and that awareness of their needs will flow out from the hospital to other care settings.

I hope this report inspires you to continue to help to embed best practice in VTE prevention and management throughout our NHS.

**Lyn Brown MP,  
Chair,  
All-Party Parliamentary Thrombosis Group**

# SUMMARY OF FINDINGS



The results are presented in five sections, examining VTE risk assessment and diagnosis; hospital associated thrombosis; admission to hospital for VTE; mandating VTE best practice; and, patient information. With a response rate of 104 Trusts and 110 CCGs, we are confident that our survey results represent an accurate picture of activity across England.

# VTE RISK ASSESSMENT, DIAGNOSIS AND MANAGEMENT

## a) VTE risk assessment

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 a definition of high quality care in VTE prevention.

**Statement 1, which covers VTE risk assessment, specifies that:**

*“All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool.”*

This statement was formerly underpinned by a financial incentive. Until April 2014, a National VTE Prevention CQUIN Goal required Trusts to ensure that 95% of all adult inpatients received a VTE risk assessment on admission to hospital. The use of this financial incentive helped to embed VTE risk assessment as standard NHS practice, increasing the average number of patients risk assessed from 53% in 2010 to 96% in 2014.

Following the VTE Prevention CQUIN's discontinuation in 2014, risk assessment continued to be underpinned by a financial incentive in the form of commissioning sanctions. The NHS Standard Contract sets a National Quality Requirement for 95% of inpatients to be risk assessed for VTE. Until 2016/17, if providers failed to hit this minimum threshold, they would be subject to sanctions imposed by their local CCG amounting to £200 for every breach above the 95% risk assessment threshold.

The removal of the financial incentive does not appear to have impacted on risk assessment rates. The Trusts that responded to our survey on average risk assessed 96% of inpatients for VTE in 2016/17. This indicates that VTE risk assessment is now firmly established practice.

This year's survey also asked whether inpatients who are considered to be at risk of VTE are routinely checked for both proximal and distal DVT. The majority of DVTs in inpatients occur above the knee in the proximal veins (approximately 70-80% of DVTs). Distal DVT, also known as calf DVT, accounts for the remaining 20-30% of DVTs in inpatients. The risk of thromboembolic complications from distal DVT is less certain and there is ongoing clinical debate regarding whether this form of DVT warrants diagnosis and treatment.

Our survey found that at present 57% of Trusts routinely check at-risk patients for both proximal and distal DVT and 43% do not. Trust Medical Directors should stay abreast of the latest clinical findings on the risks associated with distal DVTs and ensure treatment practice is in line with the clinical consensus.

## b) VTE diagnosis and management

Best practice in VTE diagnosis and management is summarised by NICE Quality Standard 29 (Venous thromboembolism in adults: diagnosis and management). Quality Standard 29, which was issued in March 2013 and updated in April 2016, includes nine statements of best practice.

**Statement 2 covers the target time from suspicion of DVT to diagnosis. It specifies that:**

*“People with suspected deep vein thrombosis have all diagnostic investigations completed within 24 hours of first clinical suspicion.”*

Our survey asked Trusts what the average time from first clinical suspicion of VTE to diagnosis was for patients diagnosed with VTE between 1 April 2016 and 31 March 2017. This information is not routinely collected by most Trusts, and as such only 39 were able to provide numbers. The average time, rounded to the nearest hour, was 29 hours. This ranged from 1.5 hours in one Trust to 168 hours in another.

Of the Trusts that were over the 24 hour time to diagnosis target set out by NICE, approximately 58% were in the North of England, 25% were in the Midlands and East of England, and 8% each were in London and the South of England respectively. It is important to ensure that diagnostic investigations are completed within 24 hours so that treatment can be initiated promptly if the diagnosis is confirmed and to avoid unnecessary repeat doses of anticoagulants if the diagnosis is excluded.

**Regarding prompt treatment, Statement 1 of NICE Quality Standard 29 states that:**

*“People with suspected deep vein thrombosis are offered an interim therapeutic dose of anticoagulation therapy if diagnostic investigations are expected to take longer than 4 hours from the time of first clinical suspicion.”*

**Likewise, Statement 4 states that:**

*“People with suspected pulmonary embolism are offered an interim therapeutic dose of anticoagulation therapy if diagnostic investigations are expected to take longer than 1 hour from the time of first clinical suspicion.”*

Our survey asked Trusts what the average time from diagnosis to first treatment was for patients diagnosed with VTE between 1 April 2016 and 31 March 2017. Once again, this is not routinely collected information and only 29 Trusts were able to provide specific numbers. Of the Trusts able to provide information, the average time to treatment was 16 hours. This ranged from zero hours – for those that initiate treatment immediately – to 48 hours in one Trust.

Of the Trusts that were above the average, approximately 38% were in the North of England, 25% were in the Midlands and East, 19% each were in London and the South of England respectively. Given that NICE sets targets for prompt interim treatment before VTE is confirmed, it is concerning that the average time from diagnosis to treatment is as high as 16 hours.

## Time to VTE diagnosis and treatment



## HOSPITAL ASSOCIATED THROMBOSIS

### a) Occurrence of hospital associated thrombosis

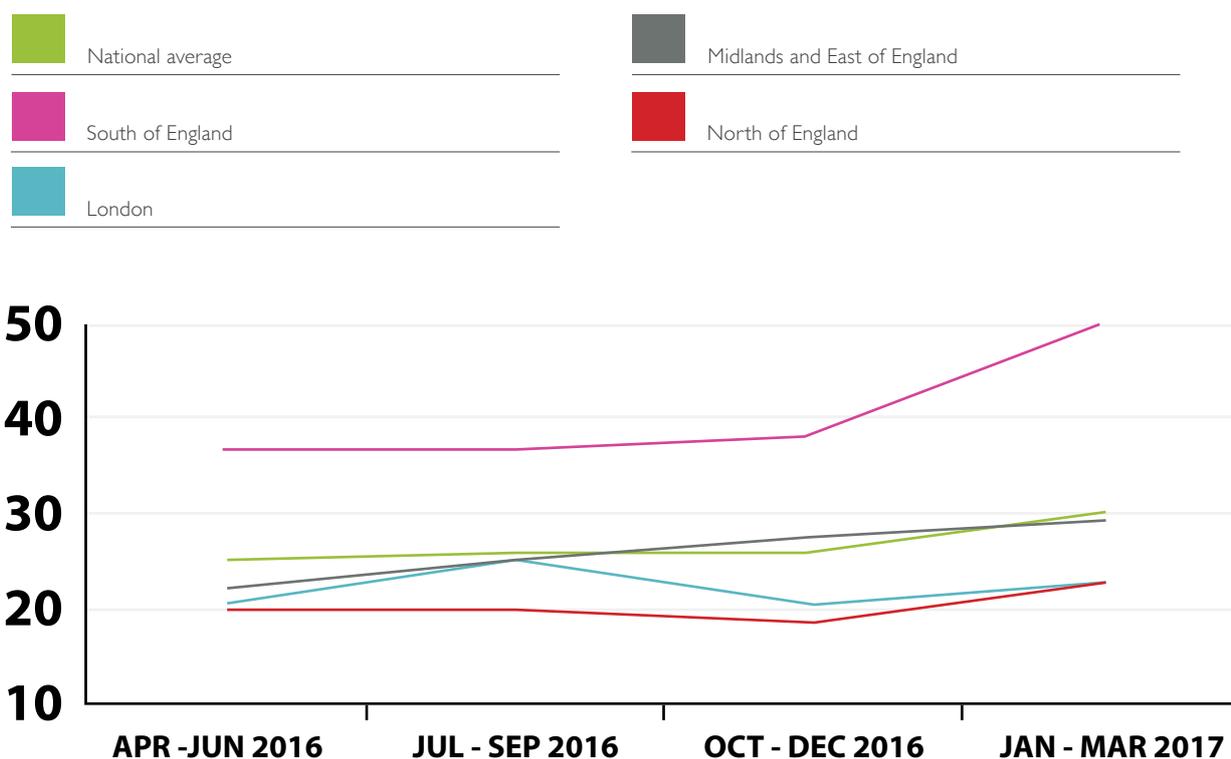
Up to 60% of VTE cases occur during or within 90 days of hospitalisation. Hospital patients are at risk of VTE as a result of decreased mobility due to bedrest or recovery, or blood vessel trauma due to surgery or other serious injury. For this reason, NHS England's National Medical Director made the prevention of hospital associated thrombosis (HAT) a top clinical priority.

In order to gain a clearer picture of the current burden of HAT in hospitals in England, the APPTG asked Trusts to list their number of confirmed HAT for all four quarters of the period between 1 April 2016 and 31 March 2017. Of the Trusts that were able to provide this data, the average number of occurrences of HAT per Trust in 2016/17 was 105. This ranged from as little as 0 occurrences in one Trust to as many as 343 in another.

There is evidence of regional variation in HAT occurrences. Trusts in the South of England averaged 150 cases of HAT in 2016/17, and Trusts in the Midlands and East of England were close to the national average at 101 cases. Trusts in the North of England and London were well below the national average at 82 and 84 cases on average respectively.

There is also evidence of a winter spike in HAT cases, with the average number rising between January and March. This may be a reflection of the increased pressure that hospitals come under during the winter as a result of increased respiratory and cardiovascular illness during cold weather months.

## Average cases of confirmed HAT per quarter by region



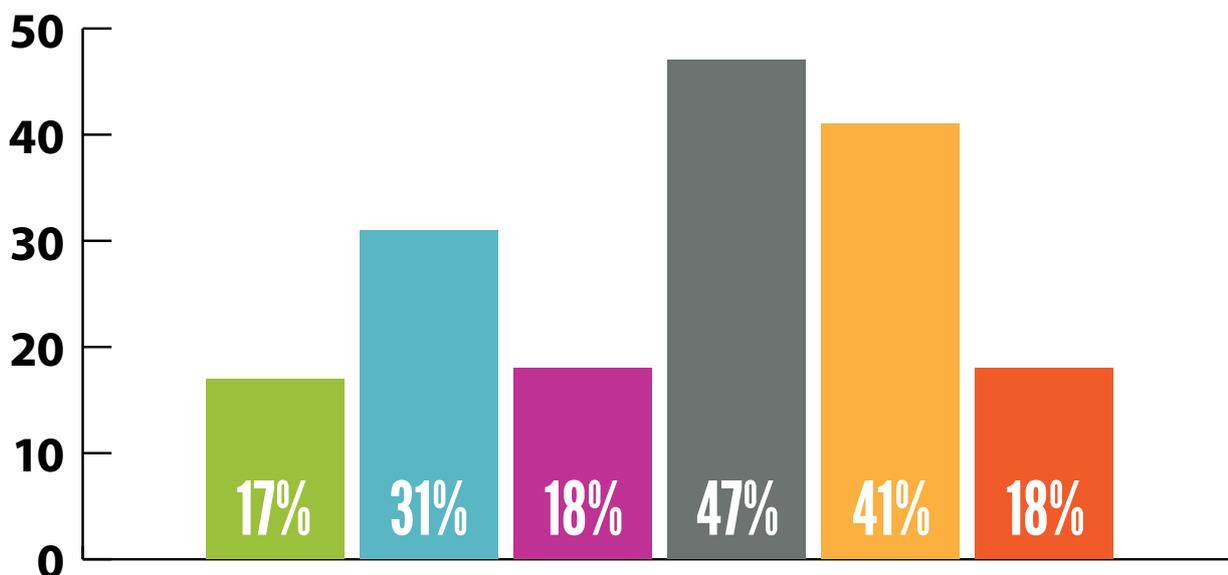
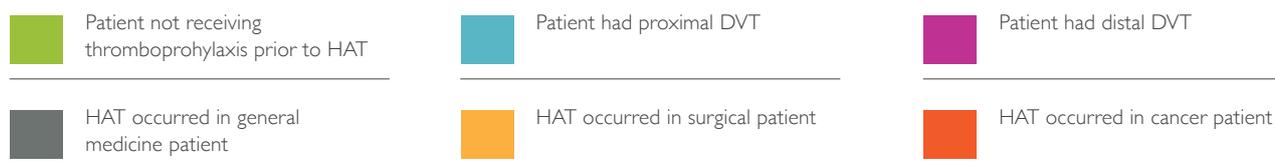
This year's survey also sought further information on the circumstances surrounding occurrences of HAT, in particular, whether patients were receiving thromboprophylaxis prior to HAT occurrence. Data collection on this varies across the country, and as such only 49 Trusts were able to provide figures to this question. The results found that, amongst the responding Trusts, 17% of HAT cases were in patients who were not receiving thromboprophylaxis prior to HAT. The figure ranged from 0 to 88% across Trusts. The regional variation is similar to the variation in average cases of confirmed HAT, with Trusts in the South of England reporting the highest proportion of HAT cases in which patients were not receiving thromboprophylaxis (24%), followed by Trusts in the Midlands and East (18%). Trusts in London and the North of England were below the national average at 13% each.

There were five Trusts which reported that 50% or more cases of HAT were in patients who were not receiving thromboprophylaxis. These Trusts all exceeded the national threshold

to risk assess at least 95% of patients for VTE. This indicates that further work is needed to optimise the process from risk assessment to implementation of preventative measures to reduce the risk of avoidable blood clots.

The survey also sought information on whether HAT occurred in patients with proximal or distal DVT. The results found that nearly twice as many HAT cases involved proximal DVT than distal DVT (31% vs 18%). Additionally, the survey asked Trusts for the percentage of HAT cases occurring in surgical patients, general medicine patients and cancer patients. Of the Trusts able to provide figures, the results indicate that HAT occurs more commonly in general medicine patients than surgical patients (47% of HAT cases vs 41%), which is in line with the APPTG's findings from the previous year. Also, the survey findings indicate that nearly one in five HAT cases occur in cancer patients (18%), which underlines the importance of having firm strategies in place for the prevention of cancer associated thrombosis (CAT).

## Circumstances surrounding HAT occurrences (Average proportions across Trusts)



## b) Root Cause Analysis

Root Cause Analysis (RCA) enables Trusts to conduct a structured analysis of the reasons behind each case of HAT, and allows them the opportunity to feed their learnings back into their quality management frameworks. Drawing lessons from former shortcomings in this way and adapting local practice accordingly is a major driver of service improvement and instrumental to instilling a sense of accountability amongst Trusts and local commissioners. RCA has an important role in helping Trusts conduct their responsibilities in line with the statutory duty of candour.

Service Condition 22 of the NHS Standard Contract 2016/17 outlines that 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). . .”

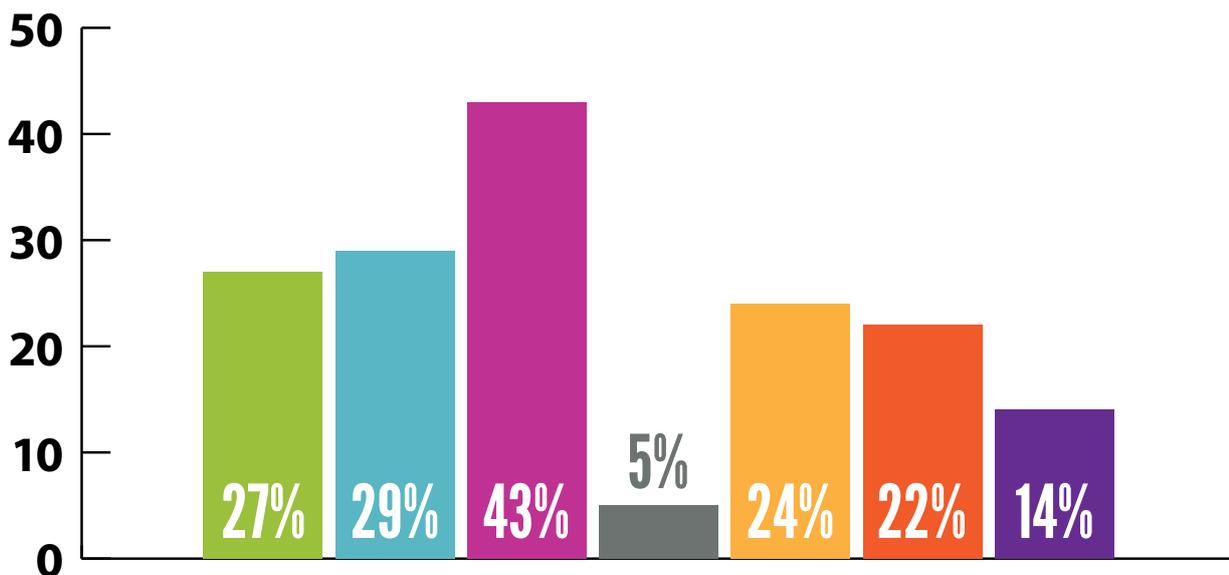
The provider is required to report the results of these RCAs to the coordinating commissioner on a monthly basis. This year’s survey indicated that across responding Trusts, there were RCA reports for 85% of confirmed HAT in 2016/17. Furthermore, 71% of Trusts indicated that the number of RCA performed was at least 90% of the total recorded number of HAT, and only 14% indicated that the number of RCA performed was less than half of the total recorded number of HAT.

It is encouraging to see that for most Trusts, RCA reporting is now firmly embedded practice. RCA reporting improves understanding of the proportion of adverse events that could be prevented; enables lessons to be learned from individual episodes; identifies common themes and promotes solutions for cases of inadequate VTE prevention. For these reasons, RCA reports are particularly relevant to the NHS' current

focus on making efficiencies through prevention of avoidable harm, and it is important that CCGs ensure they are being conducted in a timely manner.

Our survey asked CCGs how they quality assure that providers are complying with the national obligation to perform RCA of all confirmed cases of HAT. The following graph outlines the responses.

### How do you quality assure that your providers are complying with the national obligation to perform Root Cause Analyses of all confirmed cases of HAT?



These results show a notable increase from previous years in the proportion of CCGs that request real-time submission of RCA reports, monthly reports, and face to face meetings. This is a very positive development and may be a reflection of the heightened focus on prevention across the NHS. This year's results also show an increase in the proportion of CCGs that ensure compliance with the RCA requirement by other means.

Stand-out examples include North Cumbria CCG, which holds a monthly Quality Review Group meeting with providers, at which all elements of quality, including VTE, are discussed and assurances sought. Mid Essex CCG noted that senior nurses from the CCG attend VTE meetings at the local Acute Trust. Proactive CCG involvement in VTE prevention, as in these examples, is to be encouraged.

# ADMISSION TO HOSPITAL FOR VTE

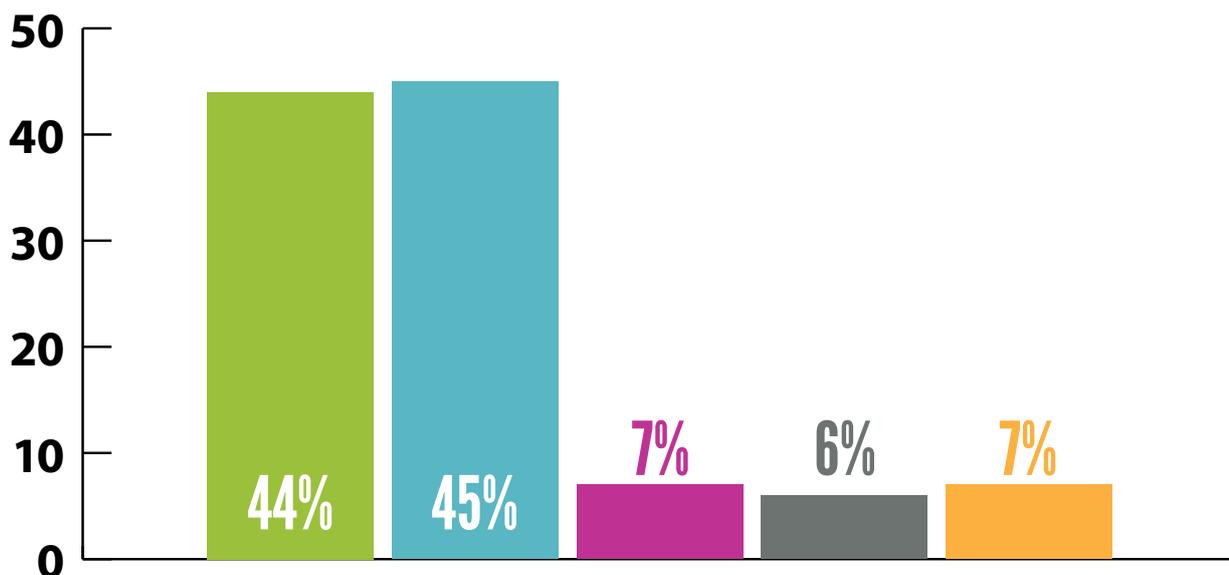
The majority of VTE incidents, including HAT, occur outside of the hospital setting. While high standards have been set for the prevention and management of VTE within hospitals, it is important that equally high standards are in place outside of the hospital setting. This is especially necessary as many of the traditional silos between secondary, primary and community care are broken down to allow for a more integrated health and social care system.

Our survey asked Trusts to provide the number of patient admissions for VTE that occurred outside of a secondary care setting between

1 April 2016 and 31 March 2017. Only 55 Trusts were able to provide this data. Of these, the average number of admissions per Trust was 384, roughly one admission per day. The levels per Trust ranged from 0 to 1,393. Of the Trusts that reported above average admissions for VTE, 39% were in the Midlands and East, 26% were in the South, and 17% each were in the North of England and London.

Demographic information on the patients admitted to hospital for VTE is outlined in the following graph.

## Admission to Hospital for VTE: Demographics



\*The combined percentages of male vs female admissions do not add up to 100% because different numbers of Trusts responded to these questions. The responses however indicate that there is a roughly even gender split in VTE admissions.

The finding that 7% of VTE admissions were in care home residents is nearly double the proportion reported in the APPTG's 2015 Annual Review (4%). This information is not routinely recorded by Trusts, and different lists of Trusts were able to provide figures for the 2017 survey vs the 2015 survey. As such, the 7% finding is not evidence of a rapid increase in VTE admissions from care home residents, but rather an indication that the proportion may be higher than previously estimated. Considering that care home residents comprise approximately 0.5% of the population of England and Wales, a share of VTE admissions between 4-7% is disproportionately high.

Furthermore, our survey found that on average, 26% of patients admitted to hospital for VTE had a previous inpatient stay up to 90 days prior. This indicates that their clots may have been hospital associated. Of this share of admissions, only 38% had their VTE risk status displayed on their discharge summary. Given the current national priority on timely transfer of care to free up hospital bed spaces, it is highly important that patients' VTE risk is clearly communicated to those responsible for their ongoing care after hospital discharge. Discharge notices may be the best mechanism for this, and the APPTG has previously recommended the inclusion of a standard VTE risk section on hospital discharge notices.

The Halton area stood out as a noteworthy example of good communication on VTE risk. Warrington and Halton Hospitals NHS Trust indicated that the outcome of VTE risk assessments is automatically populated onto patients' discharge summaries. The information displayed includes a summary of the risk assessment and its outcome, details on action taken following the assessment and information on whether the patient requires thromboprophylaxis post discharge. Halton CCG also indicated that it provides guidance to nursing care home staff on VTE, and agreed a local CQUIN goal on 'Prevention of avoidable hospital admissions originating from care homes'. Survey responses indicate that this approach may be having an effect on hospital admissions for VTE. Warrington and Halton Hospitals NHS Trust reported that only 5% of its VTE admissions were in patients who had a hospital stay 90 days prior, and only 2.6% of VTE admissions came from care home residents. Both figures are well below the national average.

# MANDATING VTE BEST PRACTICE

## a) Local incentive schemes

As previously discussed, mandatory VTE risk assessment was previously underpinned by a financial incentive (the national VTE prevention CQUIN until 2014 and commissioning sanctions until 2016). The NHS Standard Contract for 2016/17 removed the national sanctions regime for breaching the risk assessment threshold, leaving it up to commissioners to implement their own local system for mandating best practice.

This year's Annual Survey found that 93% of responding CCGs have clearly mandated in their providers' service contracts that failure to comply with best practice in VTE prevention will result in consequences imposed by the CCG. This level is consistent with previous years' findings. However, when asked whether a local penalty has been agreed for failure to comply with the VTE Risk Assessment National Quality Requirement,

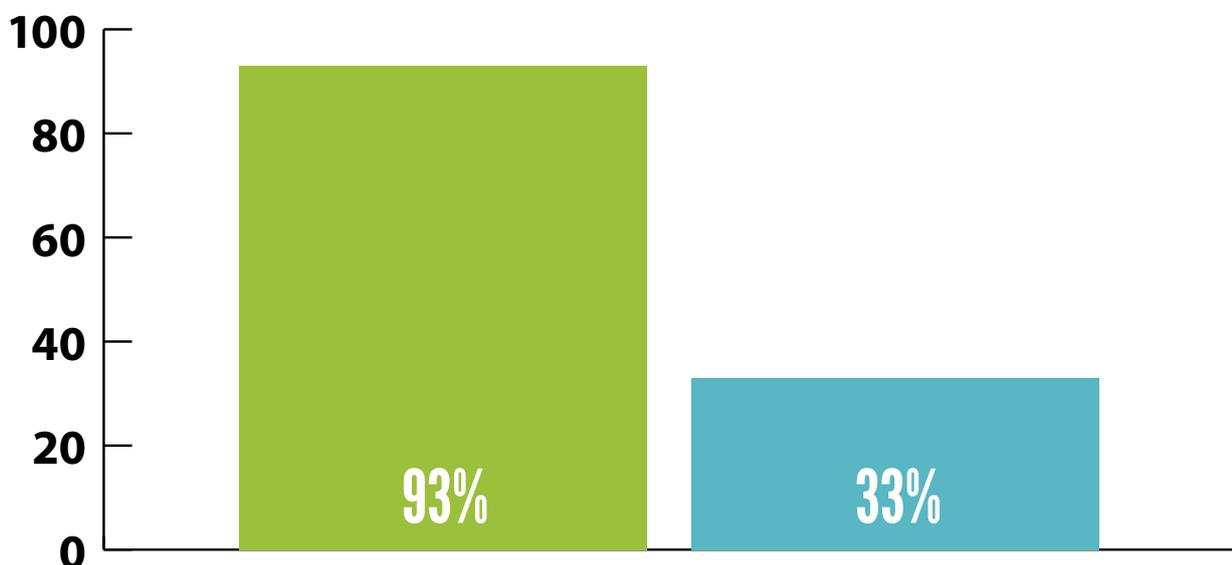
only 33% of CCGs said yes. Of the CCGs that provided details of their local penalty, the majority said that breaches of the National Quality Requirement result in the issuing of a contract performance notice with a remedial action plan.

Some CCGs indicated that they impose a local financial penalty. For example, Somerset, North Tyneside and Northumberland CCGs indicated that a £200 penalty for breaches of the risk assessment requirement is still in place. Solihull CCG indicated that an information breach notice is given with 10 days for the provider to respond. If no response is received, 1% of the monthly contract value is held back per breach up to a maximum of 5%. Financial incentives played an important role in making VTE risk assessment standard clinical practice; more CCGs should develop their own local incentive schemes.

### Mandating VTE Best Practice Locally

CCGs that have clearly mandated in their providers' service contracts that failure to comply with best practice in VTE prevention will result in consequences

CCGs that have agreed a local penalty for failure to comply with the VTE Risk Assessment National Quality Requirement



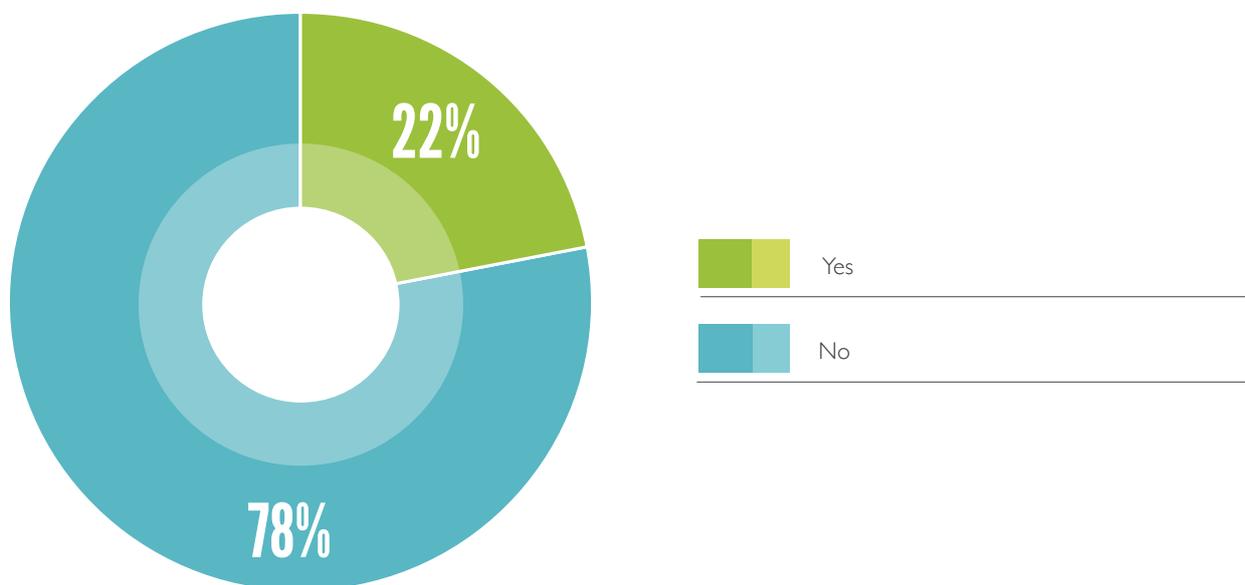
The APPTG's survey also asked Trusts if they received any sanctions, verbal or written warnings from their local commissioning body for failing to deliver the minimal VTE risk assessment threshold in 2016/17. While 20 of the Trusts that responded to our survey fell below the risk assessment threshold, only three of these Trusts indicated that they had received a warning. This indicates that while local consequences for failing to meet best practice may be established, they are not necessarily being enforced.

Likewise, our survey asked Trusts whether they had received sanctions or warnings for failure to perform RCA for all confirmed cases of HAT. Only two Trusts indicated that they had. Considering that 14% of Trusts indicated that the number of RCA performed in 2016/17 was less than half of the total recorded number of HAT that year, there is good cause for commissioners to establish and enforce local incentive schemes for RCA. Luton CCG, for example, indicated that it imposes a £5,000 penalty per quarter for RCA reports not received by six weeks after the end of the month.

## b) Local cost of VTE

The Health Select Committee estimated in 2004 that the treatment and management of VTE costs the NHS approximately £640 million per year. Taking proactive steps to mandate VTE best practice locally could help to reduce this cost burden, however most CCGs appear to be unaware of what VTE is costing locally. Our survey asked CCGs if they have an estimate of the cost of VTE to the NHS locally (including the cost of treatment, hospital bed days, sanctions and any litigation costs) for 2016/17. Only 22% of CCGs indicated that they do.

### Does your CCG have an estimate of the cost of VTE to the NHS locally for 2016/17?



The average local cost quoted was £938,357. Quoted cost estimates ranged from £63,358 in the South Lincolnshire CCG area to over £7 million in the Cambridgeshire and Peterborough CCG area. Of the CCGs able to give an estimate, most based the estimated cost primarily on inpatient spells and excess bed days related to VTE. The higher estimates factored in the cost of drugs for treatment of VTE. Given the inconsistencies in cost calculations between areas, the average costs to the local NHS are therefore likely to be much higher.

# PATIENT INFORMATION

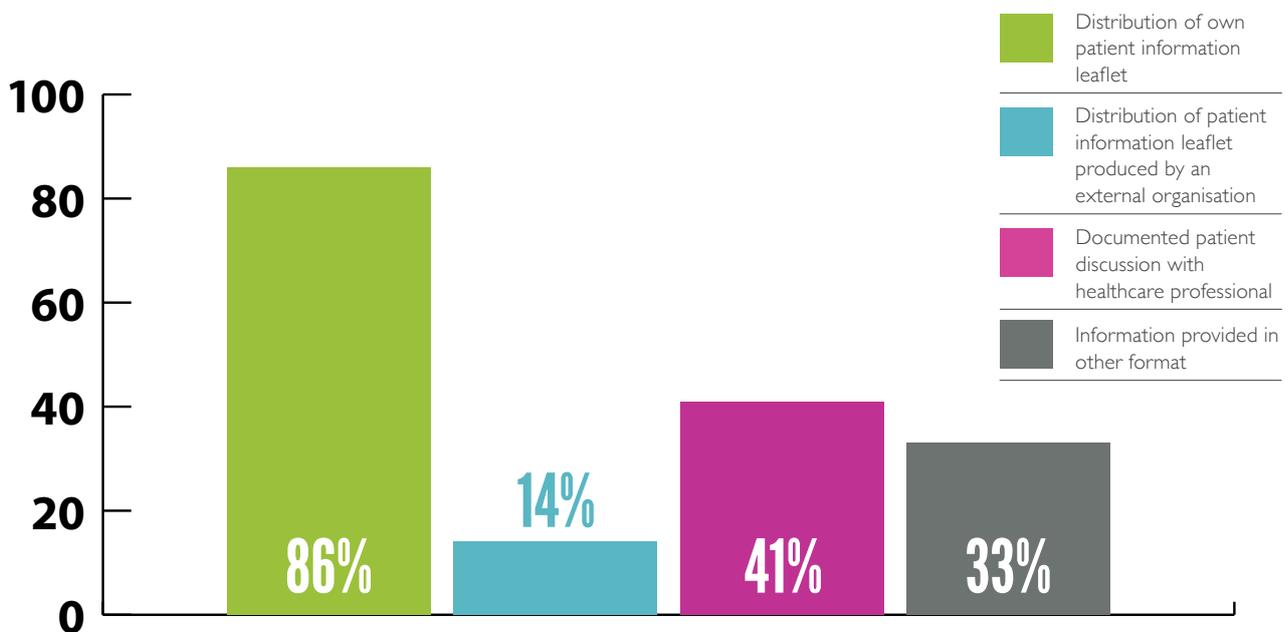
It is equally vital that hospital patients are aware of their own risk of VTE and the steps that they should take should a clot be suspected, both while in hospital and post discharge. Empowered patients are the first line of defence against potentially avoidable blood clots, and their vigilance could possibly lead to the prevention of a later hospital admission for VTE.

The APPTG has consistently encouraged Trusts to follow the instructions in the NICE Quality Standard on VTE Prevention and NICE Clinical Guideline 92 regarding provision of both written and verbal patient information. 86% of Trusts that responded to this year's survey produce and disseminate their own patient information leaflets on VTE prevention. 14% distribute patient information leaflets produced by an external organisation. Cited external organisations include the Thrombosis Research

Institute, patient.co.uk, Thrombosis UK, the Royal College of Anaesthetists, Pfizer and Eido Healthcare.

41% of Trusts indicated that a documented patient discussion takes place with a healthcare professional, and 33% indicate that patient information is provided in another format. Commonly cited formats include posters on display in the hospital, videos on the hospital television screens, and information displayed on the hospital intranet. Particularly innovative examples were cited by Oxford University Hospitals NHS Trust, which directs patients to the VTE prevention smartphone app developed by Incuna Ltd and University Hospitals Birmingham NHS Trust, which directs patients to a video that is also played in local GP surgeries. The latter example demonstrates noteworthy coordination between secondary and primary care on VTE prevention.

Provision of patient information on VTE prevention



Additionally, our survey asked Trusts that provide written information on VTE prevention whether they provide this information in languages other than English. 28% indicated that they do. The

majority of these said that they offer translation on request. Others indicated specific languages; Polish and Arabic were most commonly cited.

# CONCLUSION

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As the NHS seeks to improve prevention of avoidable illness and foster better integration between secondary, primary and community care, best practice in VTE prevention and management is of heightened importance. The APPTG's survey findings indicate that many areas of best practice – VTE risk assessment, RCA of confirmed HAT, and provision of written and verbal patient information – are well established across the country. However, there are clear areas for improvement going forward.

More attention is needed in the actions taken following risk assessment for VTE. The APPTG's survey findings show that merely hitting the national VTE risk assessment target is not enough to prevent HAT. A streamlined diagnosis and treatment process is necessary to ensure that patients assessed to be at risk are given appropriate thromboprophylaxis. As a starting point, it would help if the VTE National Quality Requirement in the NHS Standard Contract set out not only a risk assessment target, but also the diagnosis and treatment targets made by NICE.

Improved information-sharing between regions on best practice approaches would also be helpful. The survey found evidence of regional variation in HAT occurrences along with admissions to hospital for VTE. In both cases, the problem appears to be more prominent in the South of England and Midlands and East of England regions than in London and the North of England. The survey also found many stand-out examples of innovative approaches taken in individual areas in terms of mandating best practice and communicating VTE risk post discharge to ensure smooth transfers of care. Identifying the optimum approach to the latter is particularly important as more care is moved out of the hospital setting to free up bed space and release capacity. There could be a role for NHS RightCare in helping share information on good practice as well as information on the local cost burden of VTE, which our survey found is not well understood by the majority of CCGs.

The survey also found examples of a variety of innovative approaches taken by hospital Trusts in the provision of patient information. Different media for patient information may be more appropriate for different audiences, and for some patients, information is needed in languages other than English. To make it easier for patients and healthcare professionals alike to easily access the most appropriate VTE patient information, it would be helpful to have an online resource acting as single repository for the various leaflets, posters, videos and apps that have been developed by patient advocacy groups, NHS organisations and the private sector alike. This could be an area for NHS Choices to lead on.

More broadly, it is important that the NHS includes VTE in wider strategies to reduce the harm from dangerous blood clots by embracing innovative technology. NHS England this year announced that it will begin commissioning mechanical thrombectomy for stroke in a select number of neuroscience centres. Mechanical thrombectomy is a revolutionary procedure in which stroke-causing blood clots are physically removed from the artery to the brain using a special device. NHS England believes that embracing this technology will help reduce the long-term costs of stroke and make the NHS stand out as a world leader. There have likewise been many technological developments in the prevention and management of VTE in recent years which could help meet unfilled treatment needs and reduce the burden of VTE on the NHS. It is therefore a fitting time for the Department of Health to undertake a review of the costs and harm associated with dangerous clots, including in stroke and VTE, and the costs and benefits of new technology that could reduce the burden in both areas. This could help inform a holistic NHS strategy for tackling the burden of VTE and stroke by harnessing innovation.

# APPTG RECOMMENDATIONS FOR 2018

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Drawing on the evidence gathered through this year's survey, the APPTG has identified the following recommendations for 2018 and calls on the VTE community to work together to support their delivery:

- 1. The VTE National Quality Requirement in the NHS Standard Contract should be expanded to include not only a risk assessment target, but also a target percentage of at-risk patients who receive thromboprophylaxis and time to diagnosis and treatment targets in line with NICE Quality Standard 29.**
- 2. NHS RightCare should produce Commissioning for Value packs on VTE highlighting the incidence, mortality and costs of VTE at CCG level along with examples of innovative approaches to mandating VTE best practice and communicating VTE risk during transfer of care. This will help ensure that commissioners and STP leaders are well informed of the local burden of clots and can develop integrated VTE prevention and management strategies.**
- 3. The CQC should investigate how patients' VTE risk status is communicated post hospital discharge in the eight local health systems it is due to investigate in 2018 regarding transfer of care.**
- 4. NHS Choices should develop a webpage to act as a single source for accessing VTE patient information in various formats and languages developed by NHS organisations, the private and charity sectors.**
- 5. The Department of Health should undertake a review of the long-term costs to the NHS associated with blood clots, and the costs and benefits of new technology available to reduce avoidable harm. This should be used to produce a holistic NHS strategy for harnessing innovation to tackle the burden from both stroke and VTE.**

## FURTHER INFORMATION

All-Party Parliamentary Thrombosis Group

<http://www.apptg.org.uk/>

Anticoagulation UK

<http://www.anticoagulationuk.org/>

Thrombosis UK

<http://www.thrombosisuk.org/>

NHS England - VTE Risk Assessment Data

<http://www.england.nhs.uk/statistics/statistical-work-areas/vte/>

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>

NICE Medical Technologies Guidance 19 - The geko device for reducing the risk of venous thromboembolism

<https://www.nice.org.uk/guidance/mtg19>

Preventing VTE App

<https://itunes.apple.com/gb/app/preventing-vte/id567759012?mt=8>

## CONTACT DETAILS

### All-Party Parliamentary Thrombosis Group Officers

Lyn Brown MP (Chair)

Andrew Gwynne MP (Vice Chair)

Sir David Amess MP (Vice Chair)

Baroness Masham of Ilton (Vice Chair)

Lord Haworth (Secretary)

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