ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

FREEDOM OF INFORMATION REQUEST

FOI request into compliance of Trust Venous Thromboembolism (VTE) prevention policies with national VTE guidance

Position: Consultant Haematologist/ Trust Lead for VTE Prevention

Acute Trust: Oxford University NHS Foundation Trust

Please note that additional paper or electronic copies are available on request from the All-Party Parliamentary Thrombosis Group secretariat

Please return your completed response to the All-Party Parliamentary Thrombosis Group secretariat:

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Under the Freedom of Information Act 2000, the All-Party Parliamentary Thrombosis Group writes to request the following information:

ALL-PARTY PARLIAMENTARY THROMBOSIS GROUP

Venous thromboembolism (VTE) is a collective term referring to deep vein thrombosis (DVT) and pulmonary embolism (PE). VTE is defined by the following ICD-10 codes: I80.0-I80.3, I80.8-I80.9, I82.9, O22.2 – O22.3, O87.0 – O87.1, I26.0, and I26.9.

QUESTION ONE – WRITTEN VTE PREVENTION POLICY

a) Does your Trust have a written policy in place for preventing and managing the risks of VTE for adult hospital admissions? If yes, please attach a copy of the policy. *(Tick one box)*

Yes, the policy is attached.	☑
No	☐

b) If your Trust has a written VTE prevention policy in place, does it include the seven principles of best practice contained within the NICE quality standard on VTE prevention, which are set out below? *(Tick in each box to indicate whether or not the policy includes the principle listed)*

- *Statement 1*: All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool.

Yes	☑
No	☐

- *Statement 2*: Patients/carers are offered verbal and written information on VTE prevention as part of the admission process.

Yes	☑
No	☐

- *Statement 3*: Patients provided with anti-embolism stockings have them fitted and monitored in accordance with NICE guidance.

Yes	☑
No	☐

- *Statement 4*: Patients are re-assessed within 24 hours of admission for risk of VTE and bleeding.

Yes	☑
No	☐

- *Statement 5*: Patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidance.

Yes	☑
No	☐

- *Statement 6*: Patients/carers are offered verbal and written information on VTE prevention as part of the discharge process.

Yes	☑
No	☐

- *Statement 7*: Patients are offered extended (post hospital) VTE prophylaxis in accordance with NICE guidance.

Yes	☑
No	☐

QUESTION TWO – THROMBOPROHYLAXIS

a) Of the in-patients considered to be at risk of VTE in your Trust between 1 April 2015 and 31 March 2016, how many were given thromboprophylaxis?

We have previously carried out Trust-wide audits of VTE prevention against NICE QS every 6 months.
As a new initiative in July 2016 we carried out a pharmacy-led Trust Wide audit of `appropriate thromboprophylaxis` in adult medical & surgical patients. 414 patients were audited from across the Trust. 94% (390) patients were receiving appropriate thromboprophylaxis. Current plans are to repeat this audit every 3 months.

b) Of the above number, how many received 24/7 thromboprohylaxis?

The above audit evaluated whether a patient was prescribed and received appropriate thromboprophylaxis, and whether it was started in a timely manner after admission. Appropriate thromboprophylaxis should be prescribed/administered daily whilst an inpatient (or extended on

discharge if appropriate). The audit did not look at 'missed' doses specifically. 'Missed doses' are reviewed and investigated as necessary when they are picked up through other processes – usually on investigation of HAT, but occasionally flagged up by team on Datix (without HAT).

c) In which care pathways was it not possible to provide 24/7 thromboprophylaxis and what number of patients were associated with this issue?

As above – we aim to provide all patients daily appropriate thromboprophylaxis whilst an inpatient, and extended on discharge if appropriate according to guidelines.

d) Of the in-patients given thromboprohylaxis in your Trust between 1 April 2015 and 31 March 2016, how many were given the following: From the July 2016 Audit

Note:-Information below taken from Trust Wide Audit July 2016

Thromboprophylaxis	**Number**
Anti-embolism stockings And Intermittent Compression device Combined	170/414
Foot impulse device	0/414
Fondaparinux sodium	0/414
Low molecular weight heparin	406/414
Unfractionated heparin	0/414
NOAC	0/414
Other (Please specify)	NB the figures are taken from Jul 2016 audit of 414 patients across the Trust – overall there was 94% appropriate thromboprophylaxis

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QUESTION THREE – ROOT CAUSE ANALYSIS OF HOSPITAL-ASSOCIATED THROMBOSIS

According to Service Condition 22 of the NHS Standard Contract 2015/16, the provider 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 must report the results of those Root Cause Analyses to the co-ordinating commissioner on a monthly basis.

a) How many cases of hospital-associated thrombosis (HAT) were recorded in your Trust in each of the following quarters, and in which care pathways did they occur?

Quarter	Total recorded number of HAT	Care Pathway in which HAT occurred
2015 Q2 (Apr –Jun)	37	Due to low numbers the Trust is unable to provide breakdown to avoid patient re-identification
2015 Q3 (Jul – Sep)	49	As above
2015 Q4 (Oct – Dec)	37	As above
2016 Q1 (Jan – Mar)	60	As above

b) How many Root Cause Analyses of confirmed cases of HAT were performed in each of the following quarters?

Quarter	Number of Root Cause Analyses performed
2015 Q2 (Apr – Jun)	37 (100%)
2015 Q3 (Jul – Sep)	49 (100%)
2015 Q4 (Oct – Dec)	37 (100%)

2016 Q1 (Jan – Mar)	60 (100%)

c) According to the Root Cause Analyses of confirmed HAT in your Trust between 1st April 2015 and 31st March 2016, in how many cases:

Were patients not receiving thromboprophylaxis prior to the episode of HAT?	19 events were reported as potentially preventable HATs
Were patients receiving mechanical thromboprophylaxis prior to the episode of HAT?	Of the potentially preventable HATs, AES & IPC not considered/prescribed/ administered in <5 patients.
Were patients receiving pharmacological thromboprohylaxis prior to the episode of HAT?	Of the potentially preventable HATs, 16 patients were not receiving appropriate pharmacological thromboprophylaxis:
Were patients surgical patients?	10
Were patients general medical patients?	9
Did HAT occur pre-discharge?	Data not readily available
Did HAT occur up to 90 days after discharge?	Yes

d) How does your local commissioner quality assure that as a provider, you are complying with your obligation to perform Root Cause Analyses of all confirmed cases of HAT? (*Tick as many boxes that apply)*

Method	**Tick box as applicable**
Requests real-time submission of Root Cause Analyses on completion	☐

Requests a monthly report of Root Cause Analyses	☐
Requests a quarterly report of Root Cause Analyses	☐
Requests an annual report of Root Cause Analyses	☐
Requests a face-to-face meeting to discuss Root Cause Analyses	☐
Request made by other means not listed. (Please specify)	☑
Commissioners yet to request this information	☐

The number of potentially preventable HATs each month is reported in a 'Quality Report' which goes to our CCG via a Quality Review Meeting agenda and also to Trust Board.
All potentially preventable HATs are discussed at SIRI forum where the level of investigation is decided. Most result in divisional or SIRI investigations, and learning from these investigations is presented at Patient Safety and Clinical Risk Committee and to Clinical Governance Committee which our CCG also attend.

QUESTION FOUR – INCENTIVES AND SANCTIONS

In 2015/16, up to 2.5% of a provider's total contract outturn was available for local Commissioning for Quality and Innovation (CQUIN) schemes to be agreed between commissioners and providers.

a) Has your Trust agreed a local CQUIN goal with your local commissioner to perform Root Cause Analyses on all confirmed cases of HAT? *(Tick one box)*

Yes	☐
No	☑

b) Has your Trust received any sanctions, verbal or written warnings from your local commissioning body between 1 April 2015 and 31 March 2016 for failure to comply with the national obligation to perform Root Cause Analyses of all confirmed cases of HAT? *(Tick one box)*

Yes	☐
No	☑

QUESTION FIVE – VTE RISK ASSESSMENT NATIONAL QUALITY REQUIREMENT

The NHS Standard Contract 2015/16 sets a National Quality Requirement for 95 per cent of inpatient service users to be risk assessed for VTE. Should providers fail to meet the 95 per cent minimum threshold, they will be subject to sanctions imposed by their local commissioning body.

a) Between 1 April 2015 and 31 March 2016, has your local commissioning body imposed a sanction on your Trust for failing to deliver the minimal VTE risk assessment threshold? *(Tick one box)*

Yes	☐
No	☑

b) If you answered 'Yes' above, what is the total value of the sanctions imposed on your Trust for failure to deliver the minimum VTE risk assessment threshold between 1 April 2015 and 31 March 2016?

QUESTION SIX – PATIENT INFORMATION

The NICE Quality Standard on VTE Prevention stipulates that patients/carers should be offered verbal and written information on VTE prevention as part of the admission as well as the discharge processes.

a) What steps does your Trust take to ensure patients are adequately informed about VTE prevention? *(Tick each box that applies)*

Distribution of own patient information leaflet	☑
Distribution of the 'Preventing hospital-acquired blood clots' leaflet produced by the NHS in conjunction with Thrombosis UK (formerly Lifeblood: The Thrombosis Charity)	☐
Documented patient discussion with healthcare professional (If yes, please attach documented evidence that these discussions have taken place)	☐
Other (please specify)	☐

b) Please attach a copy of the written information on VTE prevention that your Trust provides to patients upon admission and discharge.
Leaflet attached

QUESTION SEVEN – ADMISSION TO HOSPITAL FOR VTE

a) How many patients were admitted to your Trust for VTE which occurred outside of a secondary care setting between 1 April 2015 and 31 March 2016? 579

b) Of these patients, how many had a previous inpatient stay in your Trust up to 90 days prior to their admission? 232

183 HATs during this period (ie patients who had an admission within 90 days of VTE diagnosis) – however this figure includes patients who developed a VTE whilst an inpatient – we can not readily provide the separate figures retrospectively (for HATs developing during inpatient stay as opposed to afterwards) but are prospectively collecting this data since April 2016

END

THANK YOU FOR YOUR RESPONSE

AntiCoagulation Europe pays Insight Consulting Group to act as the group's secretariat from grants received from the Pfizer-BMS Alliance, Bayer, Leo Pharmaceuticals and FirstKind Ltd