FREEDOM OF INFORMATION REQUEST

FOI request into Trust Venous Thromboembolism (VTE) prevention and management practices

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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:

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

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 – VTE RISK ASSESSMENT AND DIAGNOSIS

a) Are in-patients who are considered to be at risk of VTE in your Trust routinely checked for <u>both</u> proximal and distal DVT? *(Tick one box)*

Yes	☑
No	☐

b) For in-patients diagnosed with VTE in your Trust between 1 April 2018 and 31 March 2019, what was the average time from first clinical suspicion of VTE to diagnosis?

No formal data available but most patient are diagnosed within 48 hours.

c) For in-patients diagnosed with VTE in your Trust between 1 April 2018 and 31 March 2019, what was the average time from diagnosis to first treatment?

No formal data available but the practice is to commence treatment as soon as the diagnosis of VTE is suspected without waiting for the scan.

QUESTION TWO – ROOT CAUSE ANALYSIS OF HOSPITAL-ASSOCIATED THROMBOSIS

According to Service Condition 22 of the NHS Standard Contract 2017/19, 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?

Quarter	**Total recorded number of HAT**
2018 Q2 (Apr –Jun)	17
2018 Q3 (Jul – Sep)	19
2018 Q4 (Oct – Dec)	23
2019 Q1 (Jan – Mar)	23

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**

2018 Q2 (Apr – Jun)	1
2018 Q3 (Jul – Sep)	3
2018 Q4 (Oct – Dec)	0
2019 Q1 (Jan – Mar)	2

As per agreement with the local CCG we only perform RCA investigations if significant harm is done to the patient. An unavoidable hospital acquired VTE checklist is completed to ascertain whether VTE was avoidable. If avoidable this leads to a full RCA investigation, reporting on STEIS and tracking of actions/ action plans by the Trust's Serious Incident Review Group and the CCG.

c) According to the Root Cause Analyses of confirmed HAT in your Trust between 1 April 2018 and 31 March 2019, in how many cases:

Did patients have distal DVT?	**2**
Did patients have proximal DVT?	**2**
Were patients receiving thromboprophylaxis prior to the episode of HAT?	**Yes & no**
Did HAT occur in surgical patients?	**4**
Did HAT occur in general medicine patients?	**2**
Did HAT occur in cancer patients?	**0**

QUESTION THREE – 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 2018 and 31 March 2019?

179

b) Of these patients, how many:

Had a previous inpatient stay in your Trust up to 90 days prior to their admission?	**65**
Were care home residents?	Unable to provide this information
Were female?	**86**
Were male?	**93**

c) Of the patients admitted to your Trust for VTE occurring between 1 April 2018 and 31 March 2019 who had a previous inpatient stay in your Trust up to 90 days prior to their admission, how many had their VTE risk status recorded in their discharge summary?

We have start recording data electronically on our (Cerner) Electronic Patient Record from May 2018. Since then ALL patients over 18 are assessed for VTE risk as per NHS criteria and our discharge summaries record that they are risk assessed.

d) Please describe how your Trust displays a patient's VTE risk status in its discharge summaries.

The information is provided as below on discharge summaries:

VTE

VTE Risk: Yes
Bleeding Risk: No

QUESTION FOUR – PHARMACOLOGICAL VTE PROPHYLAXIS

a) How many VTE patients who were eligible received pharmacological VTE prophylaxis between 1 April 2018 and 31 March 2019?

All patients over 18 years are assessed for VTE risk and if they are at risk prophylaxis is provided.
Our risk assessment rate is >95%. However exact data for pharmacological VTE prophylaxis is not available. Some patients are not eligible for pharmacological VTE prophylaxis and given other Non-pharmacological prophylaxis (including patients with acute stroke).

b) How many of VTE patients who were eligible received pharmacological VTE prophylaxis within 14 hours of admission between 1 April 2018 and 31 March 2019?

We do not record this data but standard practice is that VTE risk assessment and prescribing happened at the time of admitting the patient.

QUESTION FIVE – VTE AND CANCER

a) How many patients has your Trust treated for cancer (of all types) in each of the past three

years?

2016	2239
2017	2609
2018	2902

b) Of the patients treated for cancer, how many also had a diagnosis of venous thromboembolism (VTE) {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} in each of the past three years?

2016	44
2017	37
2018	46

c) Of the patients treated for cancer who also had a diagnosis of VTE in each of the past three years, how many:

	2016	2017	2018
Were receiving chemotherapy?	4	4	3
Had metastatic disease?	24	26	24
Had localised disease?	20	11	22
Were treated for brain cancer?	0	0	1
Were treated for lung cancer?	7	6	11
Were treated for uterine cancer?	0	0	1
Were treated for bladder cancer?	0	1	1
Were treated for pancreatic cancer?	4	1	4
Were treated for stomach cancer?	0	0	0
Were treated for kidney cancer?	1	0	1

d) In how many patient deaths within your Trust was cancer (of any type) listed as the **primary** cause of death in each of the past three years:

This is not recorded in a data field in eCARE. We do record what are the diagnoses the patient has had made but this in most instances may not directly correlate with the "primary cause of death". Therefore, we are unable to answer (d) and subsets (e) and (f). In other words, we do not have a searchable electronic database of causes of death issued on medical certificates of cause of death.

2016	
2017	
2018	

e) Of the patients who died within your Trust, in how many was VTE **as well** as cancer listed as a cause of death in each of the past three years:

2016	
2017	
2018	

f) Of the patients who died in your Trust who had both VTE **and** cancer listed as a cause of death, how many:

	2016	2017	2018
Were receiving chemotherapy?			
Were treated for brain cancer?			
Were treated for lung cancer?			
Were treated for uterine cancer?			
Were treated for bladder cancer?			
Were treated for pancreatic cancer?			
Were treated for stomach cancer?			
Were treated for kidney cancer?			

g) Are ambulatory cancer patients who are receiving chemotherapy in your Trust routinely risk assessed for their risk of developing CAT/VTE?

All myeloma patients potentially going on thrombotic inducing treatments are routinely assessed for VTE. Other haematological malignancy patients and Oncology patients are not formally assessed but assess them with the slightest indication

Yes	☑
No	☐

h) Are ambulatory cancer patients who are receiving chemotherapy AND deemed at high risk of developing CAT/VTE offered pharmacological thromboprophylaxis with? Please tick/cross all those appropriate.

Low-molecular-weight heparin (LMWH)	**V**
Direct Oral AntiCoagulants (DOAC)	
Aspirin	
Warfarin	
Other	
None	

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 patient information leaflet produced by an external organisation If yes, please specify which organisation(s):	☐
Documented patient discussion with healthcare professional	☐

Information provided in other format (please specify)	☐

b) If your Trust provides written information on VTE prevention, does it provide information in languages other than English? *(Tick each box that applies)*

Yes If yes, please specify which languages:	☐
No	☑

QUESTION SEVEN – COST OF VTE IN YOUR AREA

a) Does your Trust have an estimate of the cost of VTE to the NHS locally (including cost of treatment, hospital bed days and litigation costs) for 2018/19? *(Please tick one box)*

Yes	☐
No	☑

If 'Yes', please specify the estimated cost:

b) Please indicate the cost-estimate for the following areas of VTE management and

care, as well as the corresponding number of VTE hospitalisations/ re-admissions/ treatments that occurred between 1 April 2018 and 31 March 2016.

VTE management and care	Cost-estimate	Corresponding patient numbers
VTE hospitalisations		
VTE re-admissions		
VTE treatments (medical and mechanical thromboprophylaxis)		
VTE litigation/negligence costs		

END

THANK YOU FOR YOUR RESPONSE

Anticoagulation UK is the secretariat for the All Party Parliamentary Thrombosis Group. They employ Four Communications from grants received from the BMS - Pfizer Alliance and Bayer.