

ANNUAL REVIEW

MARCH 2020



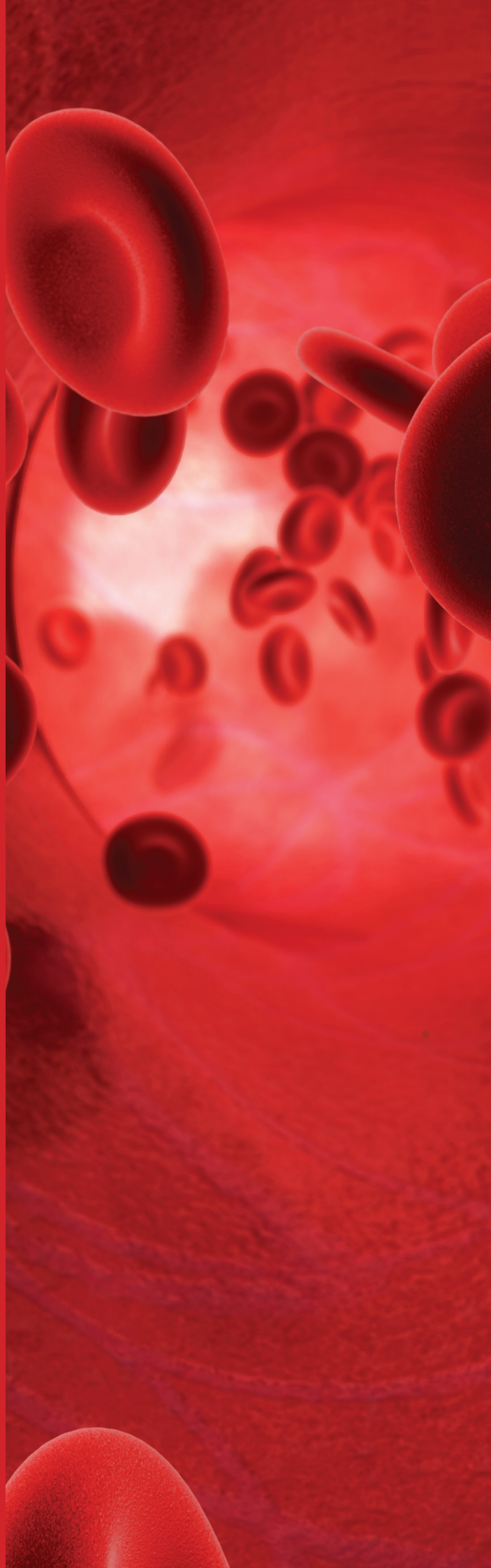
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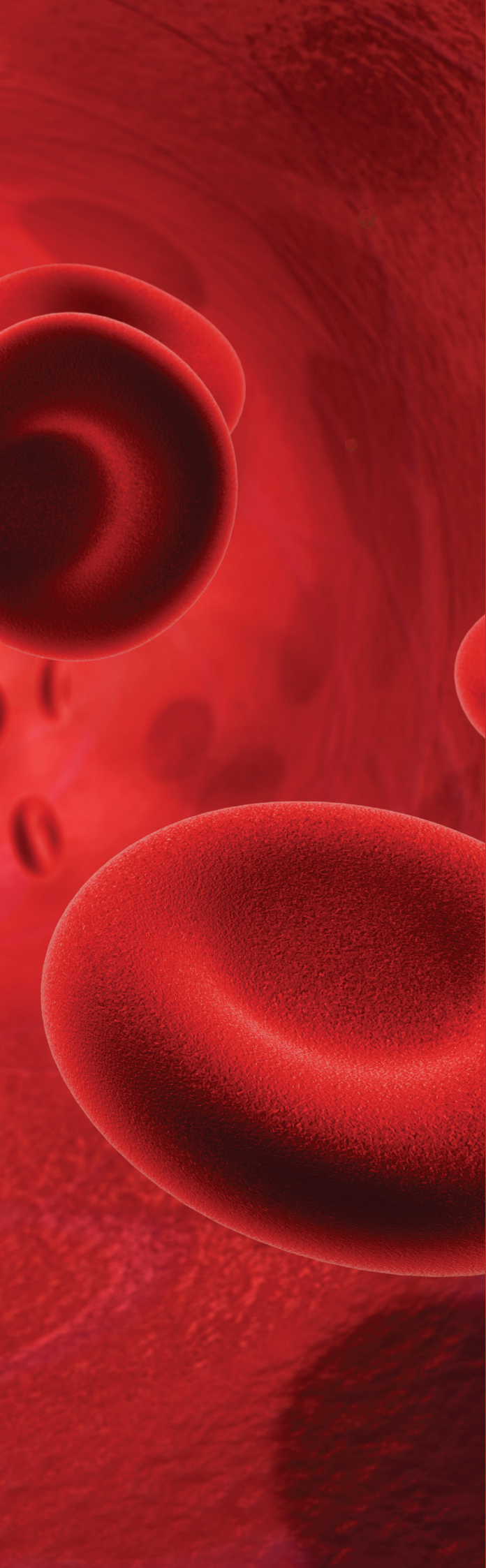
ALL-PARTY PARLIAMENTARY
THROMBOSIS GROUP (APPTG)
SURVEY RESULTS 2019

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ABOUT VTE

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). After that, the clot can break free and travel through the circulatory system towards the lungs. 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, however currently VTE is one of the most common forms of hospital mortality.

CHAIR'S FOREWORD

Dear Colleague,

As Chair of the All-Party Parliamentary Thrombosis Group (APPTG), I am pleased to launch our Annual Review for 2019.

It's great to see that once again, many aspects of VTE best practice have become ingrained in the day-to-day work that you do as clinicians. A good example is that over 90% of NHS trusts now give out patient information leaflets, a simple but effective method for keeping patients informed and in charge of their own health. Elsewhere there has also been a massive fall in the average time from diagnosis of VTE to first treatment, falling to 6.8 hours from 16 hours in 2017/2018. This is a notable improvement and one that goes against trends in other indications across the NHS, where waiting times for treatment are increasing.

However, there are sadly still areas of VTE care and management where standards need to be maintained. Acute trusts on average risk assessed 95% of adult inpatients for VTE in 2018/19, with the majority hitting or exceeding this national threshold. A good result on average, but unfortunately this masks a number of trusts who failed to hit this target, with some slipping to around 70 to 80% of patient risk assessments undertaken. As we know, it is crucial that high standards are maintained, otherwise vulnerable patients will slip through the cracks, won't receive the care they need, and too many will end up with their health or life threatened by a preventable clot.

Maintaining these standards however isn't just about NHS trusts, and NHS England must play its part too. This is why it's worrying to see that VTE risk assessments are currently under review, raising the dire possibility that they may be stopped altogether. While this doesn't mean that trusts would have to follow suit, as we would encourage them to continue to collect their own data, the obligation to do so would be gone. I fear that, with services and trusts under continuing financial pressure, the likelihood of maintaining an optional risk assessment is low.

The report also looks at the number of Hospital Associated Thrombosis (HAT) cases occurring in patients not receiving any thromboprophylaxis. Alarming, this figure has risen substantially since the publication of the last report. Risk assessment isn't enough if the treatment needed to prevent a deadly clot isn't given.

I hope you find the information within this report useful, informative and clear. As always, please continue to provide the exceptional care and support to your patients that you are all known for, and use this resource to help sustain and improve upon the levels of care delivered to patients with VTE.



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

SUMMARY OF FINDINGS

95.5%

Acute trusts on average risk assessed **95.5%** of adult inpatients for VTE in 2017/18. This sits just above the national threshold level of 95%. **This is similar to the figure recorded in 2017/18.**



29.8 hours

The average reported time from first clinical suspicion of VTE to diagnosis was **29.8 hours**. NICE recommends that patients suspected of DVT have all diagnostic investigations complete within 24 hours.



6.8 hours

The average time from diagnosis of VTE to first treatment has fallen by 10 hours to **6.8** compared with last year's report.



122 cases

The average acute trust reported **122 cases of hospital associated thrombosis (HAT)** in 2018/19. A fall of 13 cases compared with data from 2017/2018.



39%

On average, 39% of HAT cases occurred in patients who were not receiving any thromboprophylaxis. A 20% increase on last year's figures. There were 13 trusts in which 50% or more of recorded cases were in patients who were not receiving thromboprophylaxis prior to HAT.



26%

26% of hospital admissions for VTE were in patients who had a previous inpatient stay of up to 90 days prior to their admission. Among these cases, only **21%** included the patient's VTE risk status being displayed on their discharge summary. This is a fall in both cases, but the figure still remains high.



Increasing

The cost of VTE at **CCG** level appears to be **falling**, however at **trust** level it is **increasing**. More research and analysis is required to better understand this variation.



90%

90% of trusts now distribute either their own or an external patient information leaflet regarding VTE treatment and management.



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 responses from 103 trusts and 125 CCGs, we are confident that our survey results represent an accurate picture of activity across England.

VTE RISK ASSESSMENT, DIAGNOSIS AND MANAGEMENT

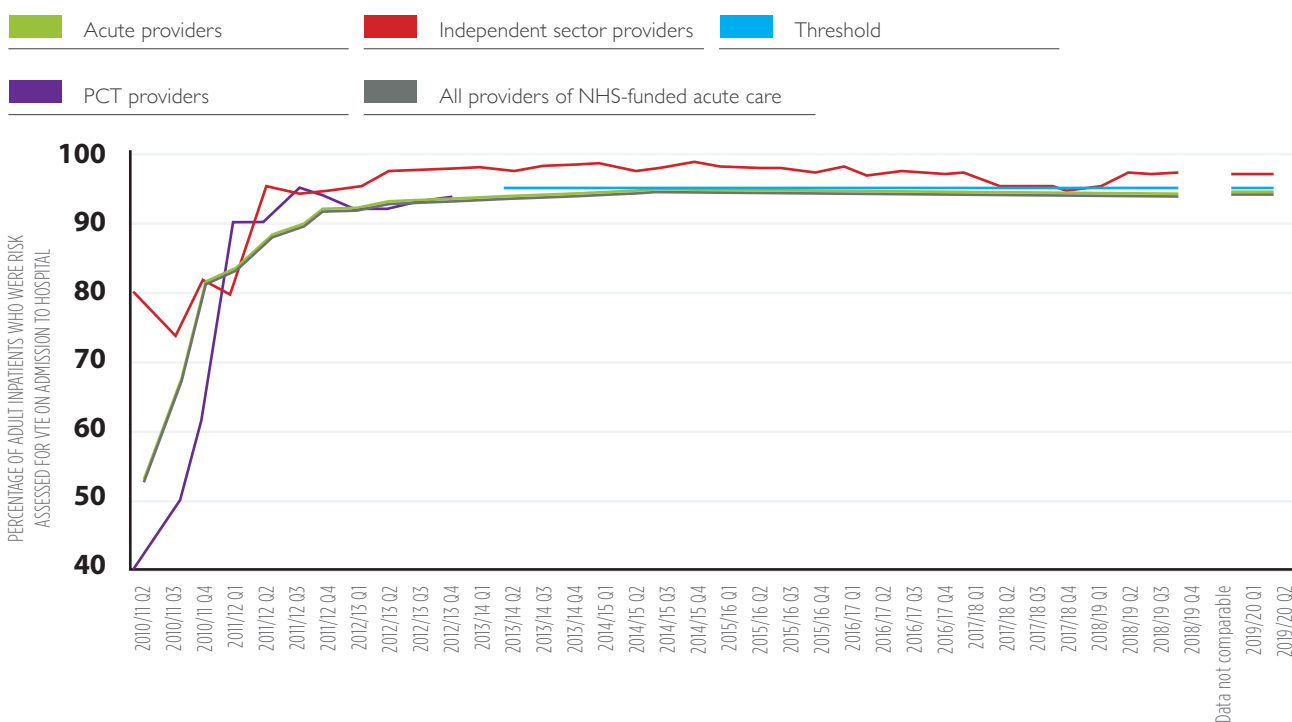
a) VTE risk assessment

In 2014, a national quality requirement, introduced as part of the national VTE CQUIN goal, required healthcare providers to meet and exceed a VTE risk assessment target of 95% each month. This is now a national requirement found in the NHS Standard Contract for 2019/20. Since mandating the VTE risk assessment in the UK, there has been a 15.4% reduction in post-discharge VTE deathsⁱ, with a considerable reduction of death from PE by around 10% to 1% of deaths.ⁱⁱ Continuing this high standard in risk assessment is a crucial part of the overall VTE management and treatment strategy, which is outlined in the NICE guideline - *Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism*.

In 2018/2019 the risk assessment rate has again remained above the 95% target, sitting at 95.5%. However there are concerns that standards are stagnating, with this year's figure similar to 2017/2018's 95.2%. That said, this figure still considerably higher than when risk assessment rates sat at 50% 10 years ago. While it's positive to see that the vast majority of trusts were able to match or surpass the target of 95%, this masked a number of cases at regional level, with some trusts missing the 95% target by a considerable margin, such as Medway NHS Trust who recorded a 77% risk assessment rate in 2018/2019. Overall, on average 42 trusts missed out on the target of 95% from April 2018 to March 2019. A small increase on the 39 trusts who missed the target in 2017/2018.

There are concerns however that the VTE risk assessment could be stopped entirely. NHS England have recently published a notice on the venous thromboembolism (VTE) risk assessment 2019/20 page, outlining that 'The VTE data collection is to continue whilst the review regarding whether to continue the data collection takes place'. It is crucial that data collection is maintained and recorded by trusts and NHS England, particularly given the recent finding from NHS Digital, which has shown that post discharge VTE deaths in England have fallen by 20.8% since 2007/08. The graph below illustrates the changes in risk assessments rates across acute providers and independent sector providers since 2010.ⁱⁱⁱ

How has the rate of venous thromboembolism (VTE) risk assessment changed?



b) VTE diagnosis and management

Best practice in VTE prevention has been summarised in NICE Quality Standard 3 (Venous Thromboembolism Prevention Quality Standard), which was issued in June 2010. Following the publication of the updated NICE guideline on venous thromboembolism in over 16s in March 2018, statements 1, 2 and 4 were updated. 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.

NICE QUALITY STANDARD 3: VTE PREVENTION	
Statement 1	Medical, surgical or trauma patients have their risk of VTE and bleeding assessed using a national tool as soon as possible after admission to hospital.
Statement 2	Patients who are at increased risk of VTE, are given information about VTE prevention on admission to hospital.
Statement 3	Patients provided with anti-embolism stockings have them fitted and monitored in accordance with NICE guidance.
Statement 4	Medical, surgical or trauma patients have their risk of VTE reassessed at consultant review or if their clinical condition changes.
Statement 5	Patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidance.
Statement 6	Patients/carers are offered verbal and written information on VTE prevention as part of the discharge process.
Statement 7	Patients are offered extended (post hospital) VTE prophylaxis in accordance with NICE guidance.

A key element of VTE diagnosis and management is the time taken between first clinical suspicions and admission to hospital; this is reflected by guidelines and quality standards that state that patients should be assessed and reassessed within 24 hours. The NICE guideline - *Venous thromboembolism in over 16s* – outlines that patients should be assessed for VTE and bleeding - ‘as soon as possible after admission to hospital or by the time of the first consultant review’.

The appropriate time taken is also 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 on best practice. Statement 2 covers the target time from suspicion of DVT to diagnosis, specifying:

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

Focusing on this Quality Standard, 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 2018 and 31 March 2019. As with previous years, the data from some trusts was incomplete; however 50 were able to respond. Amongst them, the average reported time from first clinical suspicion of VTE to diagnosis was 29.8 hours. This was the exact same figure as was recorded in last year's report, which in turn also aligned with the Annual Survey in 2017. Unlike previous years however, the variation between clinical suspicion of VTE to diagnosis was not as distinct. As the response rate to this question was low amongst trusts, firm conclusions cannot be drawn from this data. However, 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.

There have been substantial falls elsewhere however, with the average time from diagnosis of VTE to first treatment falling by almost 10 hours to 6.8 compared with the figures from last year's report. This is extremely positive and shows VTE treatment bucking a general trend across the NHS in terms of increasing waiting times.

Time to VTE diagnosis and treatment



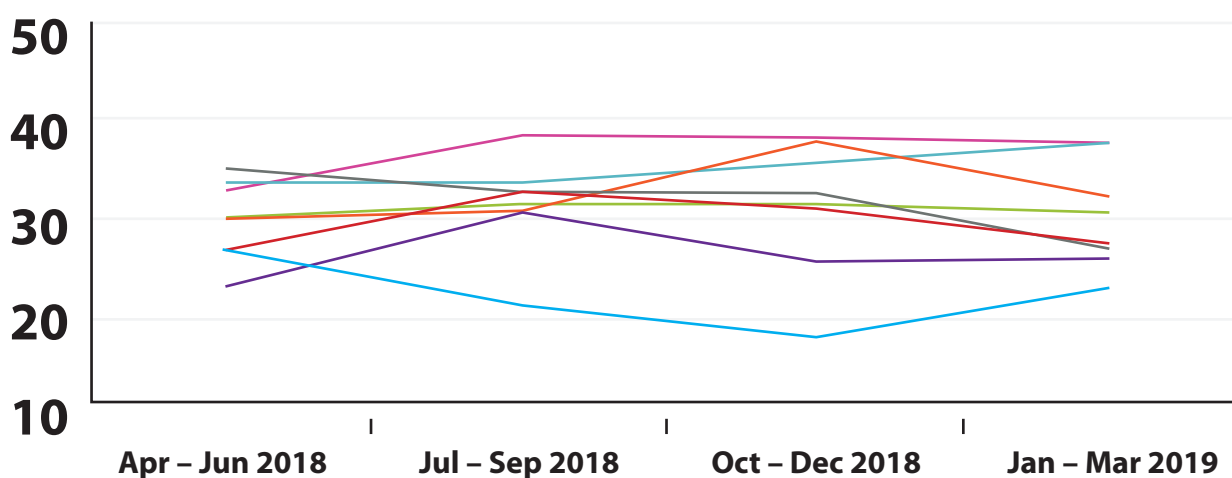
HOSPITAL ASSOCIATED THROMBOSIS

a) Occurrence of hospital associated thrombosis

Hospital associated thrombosis (HAT), defined as any new episode of VTE diagnosed during hospitalisation or within 90 days of discharge following an inpatient stay of at least 24 hours, is one of the leading causes of preventable hospital death. There have been substantial improvements over the last 10 years, which has been led through the UK VTE Exemplar Network of hospitals. However, up to 60% of VTE cases still occur during or within 90 days of hospitalisation^v, and it is estimated that HAT causes 50–60% of VTE.^v

In order to gain a clearer picture of the current burden of HAT in hospitals in England, the APPTG asked trusts to list the number of confirmed HAT cases for all four quarters of the period between 1 April 2018 and 31 March 2019. The average acute trust reported 122 cases of HAT in 2018/19, a decrease of 10 cases compared with 2017/2018. As the table below indicates, trusts in the North East and Yorkshire and the North West had significantly lower HAT occurrences compared with trusts in the South of England, a finding similar to that in 2017/2018.

Average cases of confirmed HAT per quarter by region



On 1st October 2019, Getting It Right First Time (GIRFT) launched the GIRFT Thrombosis Survey. The survey focuses on:

- What proportion of HAT cases are deemed potentially preventable?
- What themes can be identified within cases with potentially preventable HAT?
- Assessing local practice in the prevention of Hospital Acquired Thrombosis.
- Providing data for participating trusts to benchmark themselves against the national average and to drive better scrutiny and investigation of HAT and their causes.

The aim is that the GIRFT Thrombosis Survey will help inform and improve VTE prevention, management and practice that benefits patients, clinicians and efficiency. It is hoped that it will, amongst other things, identify the number of cases of HAT for a period of six months in each hospital, as well as determining the proportion of HAT cases which are deemed potentially preventable.

This is an excellent opportunity for trusts to contribute to the field of VTE treatment and support identifying variation in care, outcomes and cost implications across the NHS. The survey will run until 31st March 2020.

b) Use of pharmacological and mechanical thromboprophylaxis

Venous thromboembolism prophylaxis consists of pharmacological and non-pharmacological measures to diminish the risk of DVT and PE. The updated NICE guidance [NG89] published in 2018, requires a minimum of seven days pharmacological thromboprophylaxis for all medical patients and surgical patients assessed to be at increased risk of VTE. This guidance is intended to support further reduction in the incidence of HAT, as it has often been shown that effective thromboprophylactic measures can reduce the incidence of VTE. Despite national and international guidelines repeatedly recommend thromboprophylaxis for patients admitted to hospital; research has indicated that only 40%-50% of medical patients and 60%-75% of surgical patients are currently receiving adequate thromboprophylaxis.^{vi}

This year's survey found that on average, 39% of HAT cases were in patients who were not receiving thromboprophylaxis prior to developing HAT, a 20% increase on last year's findings. When looking at the regional breakdown of these statistics, the picture was varied, with the North East and Yorkshire reporting the highest proportion of HAT cases in which patients were not receiving thromboprophylaxis (26%), with the East of England (18.7%), London (13%) and the South East (13%) not far behind. The Midlands (8.3%), North West (8.6%) and the South West (6.2%) followed this. Due to the new way the NHS recognises regional areas, a direct comparison cannot be made to last year's results. However, they do indicate that the North East and Yorkshire's levels of patients not receiving thromboprophylaxis is much higher than all other areas.

There were 13 trusts in which 50% or more of recorded HAT cases were in patients who were not receiving thromboprophylaxis prior to HAT, more than double last year's figure. In addition, four of these trusts did not meet the national threshold to risk assess at least 95% of adult inpatients. The regional picture is varied, however trusts from the South East and South West of England featured more predominantly. Elsewhere, the survey also found that on average 31% of HAT cases occur in surgical patients, a 10% fall from last year, while 36% of HAT cases occur in general medicine

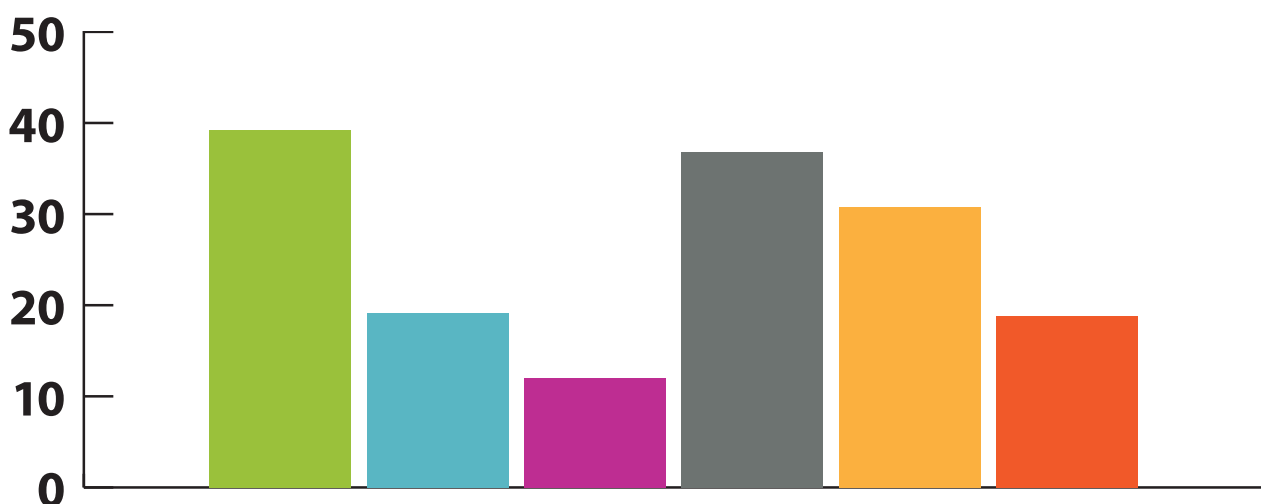
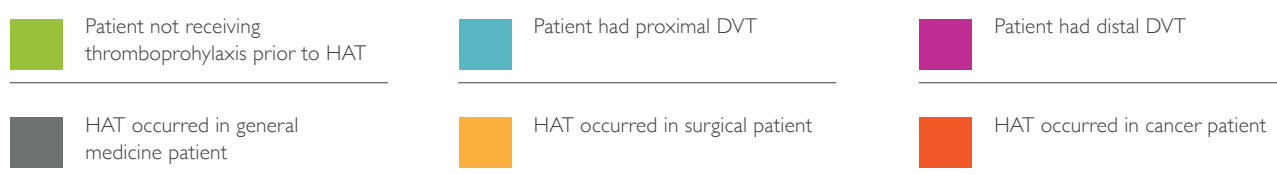
patients, a 20% fall. The number of HAT cases occurring in cancer patients was 18%, the same figure as last year and consistent with levels seen in 2016/17. Again, it is important to ensure that strategies are in place for the prevention of cancer-associated thrombosis (CAT).

Overall, it remains concerning that there are still persistent levels of variation in following guidelines on the use of thromboprophylaxis prior to HAT. 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.

It should be noted, however, that the British Society for Haematology (BSH) outlined that it was 'dismayed' by the current NICE guidance on thromboprophylaxis. Their assessment focuses on two aspects of the guidance - cost and evidence. On cost, they outline that the statement within NG89 - 'we do not expect this update to the guideline to have a significant impact on resources' - is not evidenced based. Instead, BSH estimate that the additional annual cost to NHS England of following this guidance is over £35 million in drug costs alone, which is still over £10 million after allowing for discounted hospital contracts. The BSH also stated that the choice of seven days appears to be arbitrary, rather than based on the evidence available. Overall, they stress that NICE review their recommendation 'in part due to the absence of evidence of benefit and estimated significant cost of full implementation of this part of NG89.'^{vii}

Elsewhere, in an effort to examine how effective risk assessment tools are at identifying patients who require prophylaxis, the National Institute for Health Research (NIHR) has awarded funding to a study looking at 'the cost-effectiveness of venous thromboembolism risk assessment tools for hospital inpatients'. This study is intended to answer NICE's recommendation for research on risk assessment, assessing 'the accuracy of individual risk assessment tools in predicting the risk of VTE and risk of bleeding in people admitted to hospital'. Once complete, the aim is to produce plain language summaries explaining the risks and benefits of thromboprophylaxis using risk-assessment tools that can be used to inform patients and assist shared decision-making.

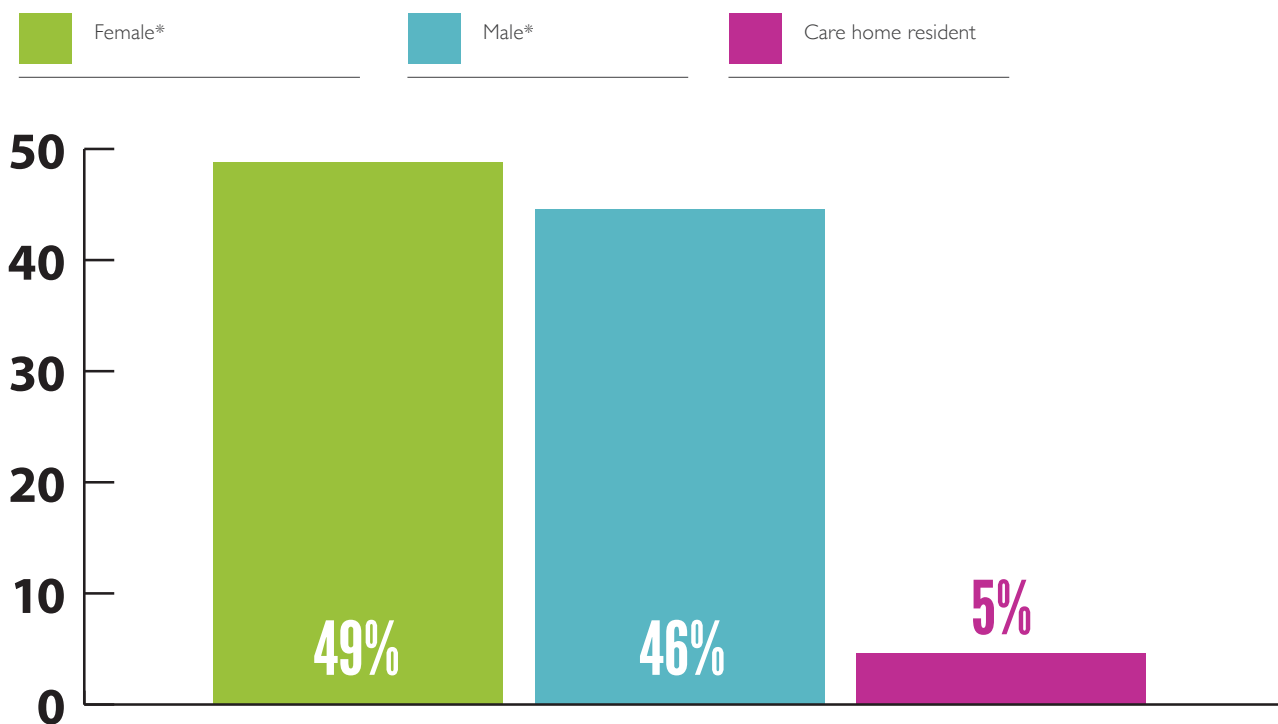
Circumstances surrounding HAT occurrences (average proportions across trusts)



ADMISSION TO HOSPITAL FOR VTE

The majority of VTE incidents, including HAT, occur outside of the hospital setting. Our survey asked trusts to provide the number of patient admissions for VTE that occurred outside of a secondary care setting between 1 April 2018 and 31 March 2019. On average, there were 493 admissions for VTE that occurred outside of a secondary care setting (roughly 1.3 per day) per trust in 2018/19. This is an increase from figures in 2017/18 and ranges from 2 to 1,574 admissions a year. While the increasing number of admissions over the years is concerning, the response rate to this question was particularly low, so firm conclusions cannot be drawn. Unlike last year however, only 26% of VTE admissions had a previous inpatient stay up to 90 days prior to their admission. A fall of 18% from figures in 2017/2018. 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.

We have previously seen a steady increase in the number of VTE admissions from care home residents from 4% in 2015 to 9% in 2018. Given that care home residents comprise an extremely small share of the overall population of England and Wales, a share of VTE admissions between 4 and 9% is disproportionately high. However, this year has seen the first drop in VTE admissions from care home residents, down to 5%. On the surface, this is certainly positive, however the data return from this question is very limited with only eight trusts responding fully to the question. As such, the 5% finding is not a reliable indicator that there has been a rapid decrease in VTE admissions from care

home residents. This area should continue to be monitored given the lack of concrete data and the annual percentage fluctuations.

On average, only 26% of VTE admissions where the patient had a previous stay 90 days prior had their VTE risk status displayed on their discharge summary. This is similar to last year's finding, which has remained low throughout a number of the previous annual reports. Displaying the VTE risk status on discharge summaries is an effective form of communication between staff, patients and hospital patient groups as way of ensuring the better delivery of care, particularly in regards to VTE prevention.

LOCAL COST OF VTE

It is often quoted in healthcare reports and literature that the treatment and management of VTE costs the NHS and the wider economy approximately £640 million per year.^{viii} The Health and Social Care Select Committee reached this figure in 2005; however, since then there has not been an accurate approximation of the cost of VTE to the NHS or the wider economy. The APPTG has taken steps to break down the cost since 2017, asking CCGs and NHS trusts 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).

Year	Average Cost	Estimated cost across all CCGs	Percentage of CCG responses
Clinical Commissioning Groups			
2016/2017	£938,357	£195,178,256	22%
2017/2018	£815,289	£158,981,376	31%
2017/2018*	£602,251	£117,438,945**	64%
2018/2019*	£509,775	£97,367,025	21%
NHS Trusts			
2017/2018*	£1,011,437	£146,658,365**	46%
2018/2019*	£1,138,611	£165,098,595	56%

*Data supplied here is taken from the cost of VTE FOI survey, which specifically focused on the financial implications of VTE management and treatment.

**This data reflects the cost of PE and DVT combined at CCG and Trust level, rather than the combined cost of VTE treatment, hospital bed days, sanctions and any litigation costs.

The responses this year once again indicate that data collection across trusts and CCGs is varied, with a majority indicating that they do not estimate the cost of VTE. This means that firm conclusions cannot be drawn, however the data does help to provide a clearer picture into the financial implications of VTE for CCGs and NHS trusts. It indicates that, once again, costs at trust level are rising, but are falling at CCG level.

This year has seen a £100,000 cost increase across trusts, taking the spending to £1.1m on average and £165m if extrapolated across all trusts. At the same time, spending seems to have fallen across CCGs by around £100,000, which if extrapolated would be around £97m across all CCGs.

In one notable response this year, it was reported to us by Nottingham University Hospitals NHS Trust that their overall estimated spend on treating patients with VTE was £12m. This is the largest estimate we have received since we started asking CCGs and trusts to estimate the cost of VTE. Importantly though, the trust outlined that this estimate includes the total cost to the NHS of the period during which the patient was being treated and when they were diagnosed with their blood clots/s. This includes all cost involved and is not specific to VTE. For example, the overall cost could include those treated for VTE and cancer. Staggeringly, if each acute trust in England also shared this overall cost, then the overall cost to the NHS would be £1.7bn. While this is clearly speculation, what it does indicate is that there is potentially massive variation between how trusts record data and the overall spend on VTE treatment and management.

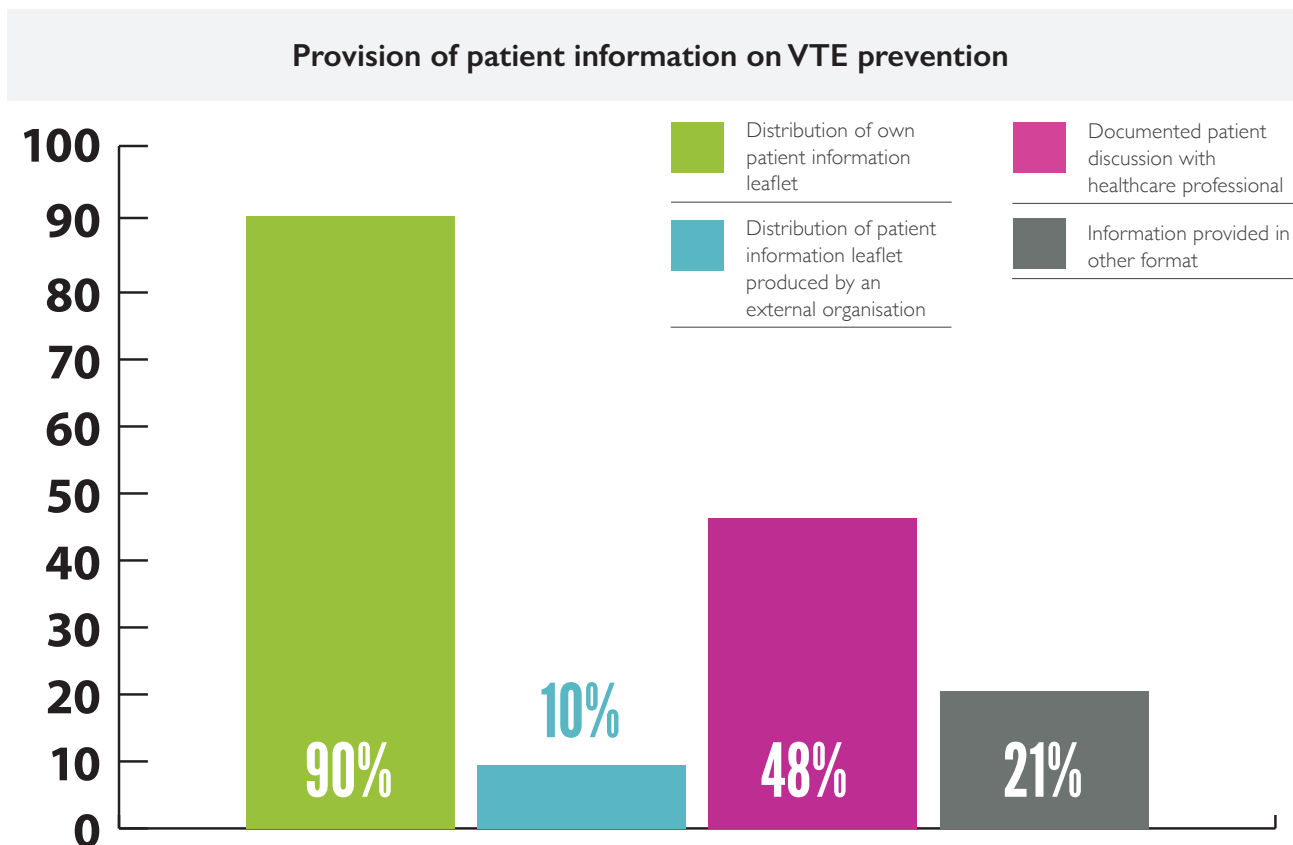
Elsewhere, in December 2018, Thrombosis UK^{ix} sent an FOI to National Services Scotland (Information Services Division), in order to ascertain the cost of DVT and PE to NHS Scotland. From the data gathered, it was estimated that the cost to NHS Scotland for hospital admissions where the initial reason for admission was a DVT or a PE was £14.5 million in 2017/18, while the overall cost from 2011 to 2018 was £99.9 million.

Overall, wider analysis is needed to build a more complete picture of the financial impact of VTE, which could be much larger than current estimates indicate. This is particularly important as there are considerable costs associated with non-fatal symptomatic VTE and related comorbidities.

PATIENT INFORMATION

It is important to keep patients informed about the treatment that they receive. Empowered patients are the first line of defence against potentially avoidable blood clots, and their increased vigilance could possibly lead to the prevention of a later hospital admission for VTE. As such, patient communication is an essential part of effective and long-lasting healthcare. However, patients being discharged from hospital can often face a “disjointed” and “fragmented” process from hospital back to their GP, putting them at risk of harm.

This year it was shown that the vast majority of trusts (90%) indicate that they distribute their own patient information leaflet on VTE; while 48% have a documented discussion with a HCP. These figures have seen increases since last year. It is positive to see that trusts continue to publish or distribute patient information leaflets as the APPTG consistently encourages them to follow NICE Quality Standard 3: VTE Prevention - Quality Statement 6.



CONCLUSION

As we move political discussions on from Brexit, it is important to refocus on the UK's domestic challenges, with healthcare at the forefront. While the NHS is facing a number of pressures across the organisation, including financial constraints and capacity issues, it is crucial that VTE prevention and management remains a key focus for the government and the NHS. This is particularly the case given the increasing rate of admissions, a growing elderly population and increasing waiting list times.

Overall, it is positive to see that there are a number of research projects underway, which look to assess different aspects of the VTE treatment pathway, including the GIRFT Thrombosis Survey and the study into 'the cost-effectiveness of venous thromboembolism risk assessment tools for hospital inpatients'. This ongoing focus on VTE treatment and management is essential in ensuring that NHS England continues to give this area of healthcare the necessary attention it deserves.

Another positive is that patient communication is being maintained and improved upon. 90% of trusts are now disseminating their own patient information leaflets on VTE, which is important as patients who understand their condition and feel comfortable monitoring their own progress are far less likely to be admitted or readmitted to hospital, where further complications can arise. More trusts however, need to start recording the risk of VTE on patients discharge forms.

The last few iterations of this report have highlighted that while many areas of best practice – VTE risk assessment, Root Cause Analysis (RCA) of confirmed HAT, and provision of written and verbal patient information – are well established across the country, standards are still in decline across a number of treatment areas.

Once again, risk assessment rates sit just above the 95% threshold, covering the dates from April 2018 to March 2019, however this masks many individual failings across NHS trusts. This means that tens of thousands of patients are being missed and that many patients may not be receiving appropriate thromboprophylaxis, which, as has been consistently shown, can greatly reduce mortality in patients.

While the annual survey gives a much greater insight into the overall cost of VTE, more work is needed to reduce the levels of variation recorded across the NHS. It is crucial that we have accurate data on the financial implications of treating and managing VTE. Further analysis is needed at trust and CCG level as initial findings from some trusts have shown that the full cost of VTE could be much higher than an average of all trusts would suggest.

APPTG RECOMMENDATIONS FOR 2020

Drawing on the evidence gathered through this year's survey, the APPTG has identified the following recommendations for 2020 and calls on the VTE community to work together to support their delivery:

- 1. Mandatory VTE risk assessment data collection must be maintained, captured and recorded by NHS England. This practice has been vital in reducing unnecessary deaths and costs, which can result from inadequate VTE and bleeding risk assessment.**
- 2. NHS England should expand the VTE National Quality Requirement on risk assessment to include a requirement that data is collected for the percentage of at-risk patients who receive thromboprophylaxis (mechanical and pharmacological) after appropriate risk assessment.**
- 3. HCPs should take part in the GIRFT Thrombosis Survey to ensure that cases of HAT are recorded; common themes within cases of potentially preventable HAT are identified; and that the proportion of HAT cases, which are deemed potentially preventable, are determined.**
- 4. Public Health England should develop a National Public Health profile for VTE, which would highlight areas of variation in healthcare provision across the country and allow commissioners to focus their efforts, in order to improve health and wellbeing and reduce inequalities.**
- 5. There should be further studies undertaken to assess the viability of guideline NG89, to ensure that it continues to remain cost effective and that patient safety is maintained at all times.**
- 6. The Department of Health and Social Care should undertake a comprehensive review of the long-term costs to the NHS associated with VTE in order to ensure that commissioners continue to deliver high-quality VTE prevention services and that variation amongst services is minimised.**

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

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

NHS England – Sign up to Safety Campaign

<http://www.england.nhs.uk/signuptosafety/>

NICE Guideline 89 - Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism

<https://www.nice.org.uk/guidance/ng89>

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 – Venous

thromboembolism in adults: reducing the risk in hospital

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

GIRFT Thrombosis Survey

<https://gettingitrightfirsttime.co.uk/thrombosis-survey/>

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Anticoagulation UK pays Four Health to act as the group's secretariat from grants received from the Pfizer-BMS Alliance and Bayer.

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REFERENCES

- i World Thrombosis Day (2019) 'Data from the World Health Organization Mortality Database Reveal Fewer Deaths from Pulmonary Embolism in the European Region Over the Past 15 Years', available at: <https://www.worldthrombosisday.org/news/post/isth-data-world-health-organization-mortality-database-reveal-fewer-deaths-pulmonary-embolism-european-region-past-15-years-near/> [Accessed: February 2020]
- ii Kopcke, D et al. (2011) Mortality from pulmonary embolism is decreasing in hospital patients. *Journal of the Royal Society of Medicine*, 104(8), 327–331.
- iii Nuffield Trust (2020) <https://www.nuffieldtrust.org.uk/chart/how-has-the-rate-of-venous-thromboembolism-vte-risk-assessment-changed> [Accessed: February 2020]
- iv The Lancet Haematology (2015) 'Thromboembolism: an underappreciated cause of death', available at: [https://www.thelancet.com/journals/lanhae/article/PIIS2352-3026\(15\)00202-1/fulltext](https://www.thelancet.com/journals/lanhae/article/PIIS2352-3026(15)00202-1/fulltext) [Accessed: February 2020]
- v NICE (2019) 'Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism', available at: <https://www.nice.org.uk/guidance/ng89/chapter/Context> [Accessed: February 2020]
- vi BMJ (2020) 'VTE prophylaxis', available at: <https://bestpractice.bmj.com/topics/en-gb/1087> [Accessed: February 2020]
- vii Lester, W et al. (2019) 'NICE NG89 recommendations for extended pharmacological thromboprophylaxis – is it justified and is it cost effective: a rebuttal from the British Society for Haematology', available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/bjh.16007> [Accessed: February 2020]
- viii Health Select Committee (2005) 'Second Report', available at: <https://publications.parliament.uk/pa/cm200405/cmselect/cmhealth/99/9906.htm> [Accessed: February 2020]
- ix Thrombosis UK (2019) 'Thrombosis Statistics', available at: <https://thrombosisuk.org/thrombosis-statistics.php> [Accessed: February 2020]



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