Health and Social Care Committee
One-day inquiry into venous thrombo-embolism prevention
VTE 5 – Royal College of Nursing in Wales

National Assembly for Wales Health and Social Care Committee Inquiry into venous thrombo-embolism prevention in hospitalised patients in Wales: Submission from the Royal College of Nursing in Wales

The 1000 Lives Plus risk assessment tool – the need for national and LHB level monitoring of uptake and performance management

The development of the 1000 Lives Plus risk assessment tool in Wales was a tremendous achievement and justly celebrated. The risk assessment tool was based upon a systematic review, meta analysis and health economic appraisal undertaken by the NICE which was published in Guideline 92: Reducing the Risk of Venous Thromboembolism in Hospitalised Patients.

Unfortunately since its initial launch in 2010 the VTE programme has now a low key maintenance approach. The assessment tool is being used inconsistently across Wales. Some areas are using the tool and many are not. It is important to note that this poor uptake is inconsistent within Local Health Boards and indeed is inconsistent within hospitals.

There does not appear to be any national level monitoring for the use of this assessment tool or incentive for the Local Health Boards to comply with its use.

In England the National Commissioning for Quality and Innovation (CQUIN) department has made huge impact on the rates of hospital acquired thrombosis. CQUIN acted as a lever for driving the implementation of VTE risk assessments by providing financial incentives for organisations to collect 'census' data on all hospitalised patients to demonstrate that they were achieving a target of 90%.

The financial case for this approach was the amount of money paid out was more than compensated for by the financial savings achieved from reducing the number of compensation pay-outs to patients and their families for the incidence of unnecessary VTE. Data from the NHS Ligation authority shows that in 2005 England paid out £21million to patients who experienced avoidable VTE or had the diagnosis missed by doctors, but this rose to more than £26 million in 2010.

A similar financial assessment of the savings in Wales should be made and we would advise the Committee to make enquires of the compensation paid out in Wales.

There is also a need for monitoring of uptake of the risk assessment at a LHB level. We are aware that most, if not all, LHBs have a thrombosis committee but the role and remit of these committees is not clear to our members.

Some Local Health Boards have employed a specialist nurse (often as a part-time aspect of their role) to monitor and promote the uptake of the risk assessment tool and preventative actions. For example a specialist nurse is employed in ABMU LHB and a data analyst (a nurse by background) in Betsi Cadwaladr. A specialist nurse is also employed specifically for Glan Clwyd Hospital but funded by a pharmaceutical company – the funding of which is coming to an end. These nurses are crucial to provide education to healthcare support workers, junior doctors and nurses on the subject.

This approach is clearly inconsistent across Wales. It would make sense to consider the evidence from these posts – including the financial cost-benefit analysis. If the impact of uptake and education can clearly be seen to improve and the rate of VTE reduced the wisdom of securing the future of these posts is clear.

Providing data on the relationship between actions taken and outcome is not something purely of interest to management, where ward staff can clearly see the beneficial outcomes of their work, and its value to the patient and organisation, motivation and participation is high.

Pharmacological and mechanical prophylaxis for VTE

The RCN is aware of a small-scale pilot in the Princess of Wales hospital to develop a high visibility sticker for the drug chart of hospital patients assessed at a high risk of VTE. This pilot scheme is multi-professional in approach with doctors, nurse and pharmacists involved.

Thrombo prophylaxis stockings are ordered to each clinical area in the NHS via the All Wales procurement contract. The selection of the various sizes is good but training on stocking application is patchy and delivered by the contacted company. We would advise that the Committee make enquires as to how this training is funded and delivered e.g. is the company required to deliver this as part of its contract? Who in the LHB can access it? It is worth noting that most LHB have placed a moratorium on nursing staff attending any form of training because they are reluctant to finance the backfill to the posts needed on the ward for even a an hour or so.

Demonstration of Hospital Acquired Thrombosis (HAT) Rate

The incidence of HAT and number of deaths attributable to it are based on large scale European Epidemiological studies. However, the HAT rate for Wales is neither known nor recorded. If each Health Board were required to demonstrate its HAT rate, this would bring several benefits in ensuring safe and standard practice. Firstly, it would provide an accurate picture of the scope of the problem within Wales. Secondly, it would allow Health Boards to identify the key problem areas that need improving. Finally, demonstrating the HAT rate will allow professionals to target cases upon which root cause analysis needs to occur, thus allowing for learning and healthcare improvement for each Health Board

Additional points of interest

Hospitalisation or hospital admission which resulted in a period of lesser mobility may increase the risk of VTE to a patient. However they may develop the condition of symptoms in the community. A GP may then refer the patient for an ultrasound scan. It would be very useful therefore to assign a specific radiology code for this type of referral to better understand the frequency of incident.

The RCN would also recommend consideration of the benefits of a national public awareness campaign on the ways to reduce risk of VTE and promote health following hospital admission. NICE guidelines recommend that patients are given both verbal and written information on discharge from hospital. NICE also recommend re assessment within 24 hours of admission and whenever the clinical situation changes.

VTE risk assessments for expectant mothers are carried out by midwives. The risk assessment implementation has been led successfully by the 1000 lives+ Maternity Collaborative and this initiative is to be strongly welcomed.

Summary of recommended actions

- monitoring and performance management of VTE assessment in hospital at a national and LHB level and development of this model to monitor prevention activity
- consideration of the use of specific posts to champion VTE risk assessment, education and prevention activity including cost-effectiveness
- standardised reporting of positive scans for VTE to enable data capture
- publication of national HAT rate for Wales, mandatory recoding of HAT rate with root cause analysis for all cases of HAT
- primary care referrals for ultrasound scan for suspected VTE to be specifically coded to enable data analysis
- consideration of the benefits of a national public awareness campaign on the ways to reduce risk of VTE and promote health following hospital admission