Health and Social Care Committee

One-day inquiry into venous thrombo-embolism prevention

VTE 9 – Royal Pharmaceutical Society

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2nd May 2012

Dear Chair and Committee Members

One Day Inquiry into Venous Thrombo-embolism Prevention in Hospitalised Patients in Wales

The Royal Pharmaceutical Society (RPS) welcomes the opportunity to contribute to the Health and Social Care Committee's one day inquiry into Venous Thrombo-embolism (VTE) Prevention in Hospitalised Patients in Wales.

Key Points from the Royal Pharmaceutical Society

We are pleased to see that this issue is being addressed by the Committee. It is estimated that 25,000 people in the UK die from hospital-acquired venous thromboembolism (VTE) every year[1] despite the fact that it is a preventable condition. We recognise the need for a structured approach to minimising the risk of VTE for hospitalised patients including robust risk assessment processes which are consistently applied whether in emergency or elective care.

We acknowledge the 2010 NICE guidelines on reducing the risk of VTE and the 1000 Lives Plus Risk Assessment Tool in Wales as structured guidelines for reducing VTE. Our membership with specialised experience in the pharmacological aspects of preventing VTE have also noted the importance of these guidelines and support tools but have expressed concerns about their implementation in hospitals across Wales.

[1] House of Commons Health Committee (2005) *The prevention of venous thromboembolism in hospitalised patients.* London: The Stationery Office.

We have been made aware from one of our members in particular who has substantial experience in this area that there is a significant gap between policy intentions and practice in the implementation of measures to reduce the risks of VTE in hospitalised patients in Wales. While we lack the hard evidence to substantiate this with complete confidence, we believe the anecdotal evidence presented at Appendix 1 is important and can help paint a picture to the Committee of some of the key problems that have been experienced by our membership who specialise in this area.

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About the Royal Pharmaceutical Society (RPS)

The RPS the professional body for pharmacists in Wales and across Great Britain.

RPS is the only body that represents all sectors of pharmacy. We promote and protect the health and well-being of the public through the professional leadership and development of the pharmacy profession. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

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Appendix 1

Health and Social Care Committee One-Day Inquiry into Venous Thrombo-embolism Prevention in Hospitalised Patients in Wales

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Views from a Welsh Hospital Pharmacist

Venous Thromboembolism (VTE) presents a significant health burden and has resulted in an increased public awareness following the publication of the NICE recommendations in 2010. It is estimated that without risk assessment and appropriate thromboprophylaxis there could be 25-30,000 deaths per year as a result of hospital acquired DVT. This is more than the total deaths per year of road traffic accidents, breast cancer and HIV together. It is also more than twenty five times greater than the deaths attributed to MRSA.

This huge public health burden is often preventable with thromboprophylaxis, but despite established effective treatments, there is currently a shortfall in the use of these treatments across Wales.

It is well known that despite good evidence that thromboprophylaxis can reduce the risk of VTE, there is a significant shortfall in the number of patients that are given appropriate treatment. Orthopaedic surgery is one of the highest risk procedures with almost 40% of patients developing a DVT without any form of thromboprophylaxis. Up to 20% of general surgical patients are also likely to develop a VTE without preventative treatment.

The resultant development of VTE results in a major economic burden on the health service in general. There is strong evidence that appropriate assessment of a patient at risk of developing a VTE reduces morbidity and mortality. The use of a risk assessment tool also ensures that patients are treated appropriately with pharmacological thromboprophylaxis. The All Wales Thromboprophylaxis Risk Assessments Tools (RAT) that were produced through 1000 Lives collaborative, recommended which drug should be prescribed according to evidence. Whilst implementing these there is still marked variation between each Health Board and even variation between directorates.

For example – in a pool of 13 different consultants, there may be 6-7 different regimens for prescribing thromboprophylaxis, some of these may even be off license and some not evidence based. This poses problems for pharmacists within Medicines Management. Experience from other colleagues appears to be several key areas which account for unstandardised practice.

- **Education and Awareness**

Although 1000 Lives has raised awareness of the importance of preventing hospital acquired thrombosis (HAT) and facilitated the prevention strategy,

there has still been a lack of education amongst all health care professionals in risk assessing all patients on admittance to hospital. This has been difficult to achieve with a lack of dedicated staff time to implement the strategy.

- **Prioritisation**

HAT appears to be low on the checklist of prioritisation. Other targets for health care professionals are being prioritised above the need for risk assessment of HAT.

- **Visibility**

There is a challenge in winning hearts and minds of people perhaps because staffs do not directly see the consequence of not carrying out a risk assessment. This will remain the case until every Health Board is able to demonstrate the HAT rate. This will provide the evidence that HAT is a problem and can be taken to each directorate to show the rate for their patients.

- **Responsibility**

Due to the complexity of the risk assessment process there has been some debate over who is directly responsible for completion of the risk assessment tool. Opinion varies between nurses and doctors.

- **Documentation**

The All Wales RAT tools allowed standardisation amongst all Health Boards in Wales for an appropriate tool. To try and implement this into different specialities has been difficult as documentation is inconsistent. Where wards use clerking proformas, the documentation has been easier to include the RAT, but this varies between different specialities. It is difficult for staff to know where to look to find the appropriate forms.

- **Patient Empowerment**

Being a complex issue HAT is not as simple as hand washing, a concept easily understood by patients who thus feel empowered to challenge Health Care Professionals about their practice. There is therefore a challenge in engaging patient partners in VTE awareness and the importance of risk assessment and appropriate thromboprophylaxis.

- **Engagement**

Although there has been engagement for this from executive level, sometimes there is no lead for HAT or a responsibility attached to executive level. Several team members within our Health Board have been recognised for their VTE prevention work. All the work and policies are in place but the

people enforcing it have no real teeth to ensure the process becomes mandatory.

The real successes in some hospitals have been those that can demonstrate the HAT rate. This enables each individual case to have a root cause analysis. This provides information and learning for the Health Board and reassures public and Health Care Professionals are receiving appropriate training. This allows us to learn from our mistakes and increases awareness.

This is a multi-professional issue that requires engagement from all grades of staff in all specialities for it to become implemented. A solution to this needs to come from all members.

If risk assessment and appropriate thromboprophylaxis became mandatory then HAT, which is a largely preventable disease, would become less of a financial burden and offer financial savings to the NHS.

Conclusion and Recommendations

HAT is a serious problem facing Health Boards in Wales. Not only is it preventable, there are cost benefits to the NHS if hospitalised patients are risk assessed and on the basis of the risk assessment receive appropriate thromboprophylaxis.

Inconsistent practice across Health Boards or even within Health Boards poses challenges to those involved in Medicines Management and a system by which practice was standardised would help reduce waste, variation and harm.

The following initiatives are strongly recommended:

- The risk assessment and appropriate thromboprophylaxis of all hospitalised patients becomes mandatory.
- All Health Boards are able to demonstrate their hospital acquired thrombosis rate.
- All cases of hospitalised thrombosis undergo root cause analysis to ensure best practice has occurred and to provide opportunities for learning and improvement.
- Health Boards be required to demonstrate their rate of risk assessment and thromboprophylaxis.
- A campaign to increase awareness of HAT amongst healthcare practitioners and patient partners.