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TO:
Medical Directors in all Primary Care Trusts in England
Medical Directors in all NHS Trusts in England
Medical Directors in all NHS Foundation Trusts in England
Medical Directors in all Strategic Health Authorities in England

CC:
Care Quality Commission, Monitor

Dear Colleagues,

Prevention of Venous Thromboembolism (VTE) in Hospitalised Patients

On 24 March 2010 the Chief Executives of all acute providers were asked to ensure the introduction of procedures to support the forthcoming data collection relating to VTE risk assessment: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_114570.pdf.

Further clarification on the data collection
We are aware that provider organisations have been developing or modifying local systems to enable reporting via UNIFY2.

Draft guidance to support the data collection has been available on the UNIFY2 system for some time, and prompted some very helpful comments from providers and healthcare professionals. As a result, the guidance has been revised and we hope that it now deals with all the main areas of concern raised by correspondents. This revised version is available through UNIFY2 and the Department of Health website.

We have become aware that there are some local protocols in use influencing definitions of what constitutes a hospital admission. We are not seeking to interfere with these through this data collection. But we do want to stress that there are no exceptions in principle to the policy of all adult patients receiving a risk assessment for VTE on admission (ordinary and day case) to hospital. This is because VTE risk assessment provides the necessary springboard to ensure appropriate prophylaxis for every patient at risk of VTE in hospital.

Even so, we have become aware that for some regular day case admissions and specific cohorts of patients it may be possible to forecast the results of the risk assessment with confidence. The guidance now clarifies that some local flexibility is possible around what constitutes delivery of the risk assessment in such cases, if this is agreed with provider Medical Directors. SHA Medical Directors must be responsible for assuring any locally agreed approach as suggested in the guidance.

Finally, we would like to take this opportunity to welcome the announcement by the Academy of Medical Royal Colleges on 15 April 2010, that all Colleges and Faculties have agreed to:

1. Bring to the attention of all their Fellows and Members the importance of risk assessment and appropriate prophylaxis for venous thromboembolism in all patients admitted to hospital. This includes the assessment of risk in primary care at the time of referral to hospital.

2. Emphasise that all Fellows and Members should ensure that their clinical unit has systems in place to ensure all patients are assessed for VTE prophylaxis and that the reasons for the resulting decision are documented and appropriate therapy given. This may be achieved through modifying drug charts, for example.

3. Ensure Fellows and Members participate in regular audit of the percentage of patients risk-assessed for VTE. In some specialties this is suitable for becoming a mandatory standard for revalidation.

4. Produce specialty-specific guidance where needed.

5. Continue emphasis of the importance of VTE in undergraduate and postgraduate curricula and training programmes, and promotion through various e-learning initiatives

We look forward to continuing to work with colleagues across the healthcare community in this important work on reducing avoidable death, long term disability and chronic ill health from VTE.

Yours sincerely,

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NHS Medical Director

Dr Anita Thomas OBE
National Clinical Lead for VTE