

**Health and Social Care Committee  
One-day inquiry into venous thrombo-embolism prevention  
VTE 15 - UK thromboprophylaxis forum**

**SUBMISSION TO THE NATIONAL ASSEMBLY FOR WALES  
HEALTH AND SOCIAL COMMITTEE INQUIRY INTO VENOUS  
THROMBOEMBOLISM PREVENTION IN WALES  
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As an executive committee member of the UK thromboprophylaxis forum I am pleased to submit written evidence to the National Assembly for Wales' Health and Social Care Committee Inquiry into venous thromboembolism (VTE) prevention in Wales.

The objectives of the UK Thromboprophylaxis Forum are:

- To provide a forum for UK healthcare professionals to meet and exchange views and information on thromboprophylaxis
- To facilitate best practice across the UK
- To identify solutions to problems with implementation of best practice
- To provide information on education initiatives such as thromboprophylaxis courses
- To provide the NHS Implementation Working Group (IWG) and NICE with a forum whereby they can interface with thrombosis committee members and others, thus helping them to achieve their objectives (e.g. development and implementation of the IWG's Risk Assessment Model, RAM)
- To promote local and national audit of thromboprophylaxis
- To raise public awareness of the need for thromboprophylaxis

Deep vein thrombosis (DVT), i.e. blood clots in the veins, and pulmonary embolism (PE), i.e. blood clots that have travelled to the lungs are distinct clinical presentations of the same pathophysiological process: venous thromboembolism (VTE). It is important to recognize that VTE is a significant cause of both morbidity and mortality in patients who have been hospitalized. It is estimated that hospital associated thrombosis (HAT) accounts for 25-50%

of all cases of VTE and that 5-10% of deaths in hospitalized patients occurs as a result of VTE.

Traditionally it was thought that it was patients admitted to hospital for surgery that were at risk of VTE. However, historically it has been known for centuries that pregnancy is associated with DVT and more recently it has become clear that medical patients make up the majority of those diagnosed with VTE.

The risk of VTE is related to the presence or absence of a number of risk factors (table 1) and the risk increases with the presence of increased numbers of risk factors.

Table 1. Risk factors for hospital associated thrombosis

Surgery	Pregnancy	Cancer
Cardiac failure	Respiratory failure	Acute infection
Previous VTE	Inherited thrombophilia	Hormone therapy
BMI > 30	Age > 60	Immobility

Chemical thromboprophylaxis, in particular heparin and low molecular weight heparin, has been shown to safely and effectively reduce the risk of both asymptomatic and symptomatic VTE in surgical and non-surgical patients. To appropriately prescribe thromboprophylaxis a patient must first be assessed for their risk of VTE (table 1).

One of the main recommendations of the Chief Medical Officer's Expert Working Group Report, in April 2007, was that all hospital patients should receive a VTE risk assessment upon admission to hospital. The All Wales Thrombosis Group in collaboration with 1000 Lives are to be commended for producing VTE risk assessment forms for acute medical, acute surgical, elective surgical, acute orthopaedic and elective orthopaedic admissions to hospital <http://www.tpforum.co.uk/library/risk-assessment/>. These risk assessment forms were produced in advance of the 2010 NICE clinical

guideline (CG92 VTE - reducing the risk) and were universally taken up and adapted by Health Boards across Wales.

Unfortunately, as witnessed in both England and Scotland following their introduction of VTE risk assessment, the use of these forms across Wales has been disappointing. There appears to be varying compliance across Health Boards as well as within individual hospitals, directorates, departments and individual clinicians. To address this issue, England made VTE risk assessment on admission to hospital a mandatory requirement. Scotland has recently also mandated VTE risk assessment on admission to hospital. Having led the way in VTE risk assessment Wales now finds itself following in the wake of both England and Scotland.

It is envisaged that VTE risk assessment and appropriate thromboprophylaxis will become part of the normal admission process, across Wales, associated with hospitalization of a patient. Raising awareness and in particular VTE education are of paramount importance. Since 2011, formal teaching on VTE has been established as part of Year 2 and Final Year medical undergraduate teaching at Cardiff University Medical School. Nursing staff are also central to VTE risk assessment and thromboprophylaxis to prevent HAT and it is therefore important to establish formal VTE teaching as part of the School of Nursing studies in Wales.

The establishment of VTE clinical nurse specialists to provide VTE leadership, promote VTE risk assessment and appropriate thromboprophylaxis, educate medical and nursing colleagues and contribute to audit of HAT are key to reducing HAT. There are a number of VTE nurse consultants as well as a significant number of VTE clinical nurse specialists in England contributing to achieving a reduction in HAT. There are currently no VTE nurse specialists in Wales.

The 1000 Lives campaign as well as the All Wales Thrombosis Group have led the way in Wales in raising the awareness of the scope of the problem as a result of VTE and HAT. Unfortunately, the initial momentum appears to have

faltered and Wales now finds itself falling further behind the progress being made in both England and Scotland.

The UK Thromboprophylaxis Forum would like the Committee to consider the following proposals:

Consider making VTE prevention a Tier 1 Core Delivery Target for NHS

Wales, with:

1. Mandatory VTE risk assessment for all patients admitted to hospital in Wales
2. Inclusion of VTE education on the medical and nursing curriculum in Wales
3. Establishment of VTE clinical nurse specialists in each Health Board
4. Establishment of an All Wales HAT collaborative to define the HAT rate for the Principality and use this as a bench mark against which the success of risk assessment and thromboprophylaxis can be measured against