Department of Health

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Chief Operating Officer

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Ms J Lake
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11 May 2015

Dear Ms Lake

Thank you for providing the Department with a copy of your Regulation 28 Report following the inquest into the death of Nicola Tweedy. I was very sorry to hear of Mrs Tweedy's death and wish to extend my sincere condolences to her family.

I understand that you found that Mrs Tweedy died following a rare but recognised risk of surgery for varicose veins. You draw attention to several serious issues that arose during Mrs Tweedy's stay in hospital which, if addressed, could prevent future deaths from occurring.

I note that you have sent your report to the Norfolk and Norwich University Hospital NHS Foundation Trust. My officials have liaised with the Foundation Trust about your report and I understand that it has fully considered and responded to each of your concerns relating to the care of Mrs Tweedy. I can report that a recent independent external inspection found that the Foundation Trust had implemented an Action Plan, to address the issues raised by this case, and that this demonstrated that learning and improvement had taken place.

I am aware that you sent our Department a copy of your report for interest and were not expecting a direct response. Nevertheless, I would like to take this opportunity to respond to some of the issues that your report raises. I have sought views from officials at NHS England to enable me to do this.

The Department is aware of the importance of reducing the risk of venous thromboembolism (VTE) in hospital patients and the need for all nurses and health care assistants to understand VTE prevention procedures, and the reasons for these procedures. This is why the Department recommends use of a risk assessment checklist and published a VTE risk assessment tool in 2010:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113355.pdf

This tool helps to ensure that assessments take place for every patient, and that results are closely monitored in order to reduce preventable deaths from VTE.

In addition, The National Institute for Health and Care Excellence (NICE) published guidelines in 2010, Venous thromboembolism: reducing the risk. Clinical guideline 92, which offers best

practice advice on reducing the risk of VTE in patients admitted to hospital. The guidelines recommend that all patients, including those admitted for day medical or surgical procedures should be individually assessed for risk of VTE and that the risks and benefits of prophylaxis should be discussed with the patient.

VTE prevention has been recognised as a clinical priority for the NHS by the National Quality Board and the NHS Leadership Team. It has been identified as the most important patient safety practice in our hospitals, and VTE-specific indicators feature in both the NHS Outcomes Framework and the Clinical Commissioning Group Outcomes Indicator Set.

NHS commissioners are required to undertake root cause analysis of all cases of hospital-acquired VTE, in line with the National CQUIN (Commissioning for Quality and Innovation) goal 2013/14, to enable commissioners to address gaps in service provision.

There are a number of levers available to commissioners to ensure that their providers' maintain patient safety practices in relation to VTE prevention. First and foremost, local commissioners should make certain that they fully utilise the provider payment incentives provided by the national VTE CQUIN Goal 2013/14. There are two indicators that must be met in order to qualify for a single provider payment:-

1) Proportion of all adult inpatients that have been assessed for risk of VTE on admission to hospital must be at least 95%. The commissioners can access quarterly data on the number and proportion of VTE risk assessments carried out by providers and can withhold payment if the threshold is not met; and
2) Root cause analysis should be carried out on all cases of hospital-acquired VTE. The proportion of cases subject to root cause analysis necessary to trigger the CQUIN payment is to be determined locally.

The National VTE Prevention Programme (http://www.vteprevention-nhsengland.org.uk/) publishes data, from NHS England's data collection, on the number of inpatients admitted monthly that have been risk assessed for VTE on admission to hospital, using the criteria in the National VTE Risk Assessment Tool.

Data for VTE Risk Assessment Quarter 4, 2013/14 (January to March 2014) (revised July 2014), shows that the Norfolk and Norwich University Hospitals NHS Foundation Trust, risk-assessed 98.29% of admitted patients for VTE in March 2014.

As a result of this case NHS England has agreed to look at the potential for national learning at the next meeting of the VTE Programme Board. NHS England has also been in direct contact with [redacted] to reaffirm its commitment to doing everything it can to prevent hospital-associated thrombosis, through the efforts of the National VTE Prevention Programme. It will also update [redacted] as national initiatives progress.

Lastly, as some of the actions of medical and nursing staff are subject to criticism in your report, I wish to take this opportunity to remind you of the role of the professional regulatory bodies and their fitness-to-practise processes.

As you may be aware, Doctors must register with the General Medical Council (GMC) and Nurses must register with the Nursing and Midwifery Council (NMC) and meet set professional standards to work in the UK and be fit for practise. If an allegation is made about a registrant, who may not meet the professional standards required in the UK, the relevant regulatory body has a duty to investigate and, where necessary, take action to safeguard the

health and well-being of the public. The Department cannot get involved with or comment on individual cases.

I will ensure that a copy of your report and our response is sent to the Care Quality Commission.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Mrs Tweedy's death to my attention.

Yours sincerely

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