NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Venous thromboembolism in adults (update)

NICE quality standard

Draft for consultation

|  |
| --- |
| **This quality standard covers** reducing the risk of venous thromboembolism (VTE) in people aged 16 and over who are in hospital. It also covers diagnosing and treating VTE in all people aged 18 and over. It describes high-quality care in priority areas for improvement. **It is for** commissioners, service providers, healthcare practitioners and the public.This quality standard will replace the existing quality standards on [Venous thromboembolism in adults: reducing the risk in hospital](https://www.nice.org.uk/guidance/qs3) (published June 2010) and [Venous thromboembolism in adults: diagnosis and management](https://www.nice.org.uk/guidance/qs29) (published March 2013). For more information see [update information](http://www.nice.org.uk/guidance/qsXXX/chapter/Update-information)We’ve produced [new guidance on reducing the risk of venous thromboembolism in over 16s with COVID-19](https://www.nice.org.uk/guidance/conditions-and-diseases/respiratory-conditions/covid19/products?ProductType=Guidance&Status=Published). This is relevant to statement 1 in this quality standard.This is the draft quality standard for consultation (from 20 November to 18 December 2020). The final quality standard is expected to publish in April 2021. |

# Quality statements

[Statement 1](#_Quality_statement_1:) People aged 16 and over who are in hospital and assessed as needing pharmacological VTE prophylaxis start it as soon as possible and within 14 hours of hospital admission. **[2010, updated 2021]**

[Statement 2](#_Quality_statement_[X]) People aged 16 and over who are in hospital and assessed as needing anti-embolism stockings are supported to wear them correctly and have their use monitored. **[2010, updated 2021]**

[Statement 3](#_Quality_statement_2:) People aged 18 and over with a deep vein thrombosis (DVT) Wells score of 2 points or more have a proximal leg vein ultrasound scan within 4 hours of it being requested. **[2013, updated 2021]**

[Statement 4](#_Quality_statement_X) People aged 18 and over taking anticoagulation treatment after a VTE have a review after 3 months and then at least once a year if they continue to take it long-term. **[2013, updated 2021]**

[Statement 5](#_Quality_statement_[X]) People aged 18 and over having outpatient treatment for suspected or confirmed low-risk pulmonary embolism (PE) have an agreed plan for monitoring and follow-up. **[new 2021]**

In 2020 this quality standard was updated and statements prioritised in 2010 and 2013 were updated (2010 or 2013, updated 2021) or replaced (new 2021). For more information, see [update information](#_Update_information_2).

Statements from the [2010 Venous thromboembolism in adults: reducing the risk in hospital](https://www.nice.org.uk/guidance/qs3) quality standard that are still supported by the evidence may still be useful at a local level.

Statements from the [2013 Venous thromboembolism in adults: diagnosis and management](https://www.nice.org.uk/guidance/qs29) quality standard that are still supported by the evidence may still be useful at a local level.

|  |
| --- |
| NICE has developed guidance and a quality standard on people’s experiences using adult NHS services and adult mental health services (see the [NICE Pathway on patient experience in adult NHS services](https://pathways.nice.org.uk/pathways/patient-experience-in-adult-nhs-services) and [service user experience in adult mental health services](https://pathways.nice.org.uk/pathways/service-user-experience-in-adult-mental-health-services)).Other quality standards that should be considered when commissioning or providing services for venous thromboembolic disease services include:* [Stroke in adults](https://www.nice.org.uk/guidance/qs2). NICE quality standard 2
* [Medicines optimisation](https://www.nice.org.uk/guidance/qs120). NICE quality standard 120

A full list of NICE quality standards is available from the [quality standards topic library](http://www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards-/Quality-standards-topic-library). |

|  |
| --- |
| Questions for consultation Questions about the quality standard**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?**Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.**Question 4** For draft quality statement 3: Are requests for proximal leg vein ultrasound scans usually made in a timely manner, or are delays experienced?Local practice case studies**Question 5** Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form |

# Quality statement 1: Timing of pharmacological VTE prophylaxis

## Quality statement

People aged 16 and over who are in hospital and assessed as needing pharmacological VTE prophylaxis start it as soon as possible and within 14 hours of hospital admission. **[2010, updated 2021]**

## Rationale

If people need pharmacological prophylaxis after a VTE risk assessment, it should be given in a timely manner to reduce the risk of VTE. VTE risk assessments are carried out for most hospital patients, but the results are not always acted on promptly, meaning that pharmacological prophylaxis can be delayed and the risk of hospital‑acquired thrombosis increased. Ensuring that prophylaxis is started within 14 hours of hospital admission for medical, surgical and trauma patients will reduce the chance of VTE.

## Quality measures

### Structure

a) Evidence of written clinical protocols to ensure that people aged 16 and over who are in hospital and assessed as needing pharmacological VTE prophylaxis start it as soon as possible and within 14 hours of hospital admission.

**Data source:** Local data collection, for example service protocols.

b) Evidence of prescribing systems so that people aged 16 and over who are in hospital and assessed as needing pharmacological VTE prophylaxis start it as soon as possible and within 14 hours of hospital admission.

**Data source:** Local data collection, for example service specifications.

### Process

Proportion of people aged 16 and over who are in hospital and assessed as needing pharmacological VTE prophylaxis who start it within 14 hours of hospital admission.

Numerator – the number in the denominator who start pharmacological VTE prophylaxis within 14 hours of hospital admission.

Denominator – the number of people aged 16 and over who are in hospital and assessed as needing pharmacological VTE prophylaxis.

**Data source:** Local data collection, for example local audit of patient records.

### Outcome

Rates of hospital-acquired thrombosis (HAT).

**Data source:**The [Royal National Orthopaedic Hospital, NHS England and NHS Improvement’s GIRFT Thrombosis Survey](https://www.gettingitrightfirsttime.co.uk/thrombosis-survey/) and the [All-Party Parliamentary Thrombosis Group (APPTG) Annual Review](https://thrombosisuk.org/downloads/APPTG%20Annual%20Review%202019%20100320.pdf) include the number of HAT cases.

## What the quality statement means for different audiences

**Service providers** (secondary care services) ensure that written clinical protocols are in place so that people aged 16 and over who are in hospital and assessed as needing pharmacological VTE prophylaxis start it as soon as possible and within 14 hours of hospital admission. They also ensure that they have prescribing systems and healthcare professionals available to carry out the assessment to ensure that prophylaxis, if needed, is started within this timeframe.

**Healthcare professionals** (such as pharmacists, advanced nurse practitioners and doctors) prescribe pharmacological VTE prophylaxis to people aged 16 and over who are in hospital and an assessment of their risk of VTE and bleeding has shown that they need it. They make sure that they give people verbal and written information on the possible side effects, and that they start treatment as soon as possible and within 14 hours of hospital admission.

**Commissioners** (clinical commissioning groups) ensure that services have written clinical protocols in place for pharmacological VTE prophylaxis to start as soon as possible and within 14 hours of hospital admission when needed. They also ensure that services have prescribing systems and healthcare professionals available to carry out the assessment to ensure that prophylaxis, if needed, is started within this timeframe.

**People** **aged 16 and over who are in hospital and who need medicine to prevent blood clots** are given the medicine within 14 hours of being admitted to hospital. They are given verbal and written information about the medicine.

## Source guidance

[Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism](https://www.nice.org.uk/guidance/ng89). NICE guideline NG89 (2018), recommendations 1.1.4 and 1.1.7.

## Definition of terms used in this quality statement

### People aged 16 and over who are in hospital

This includes medical, surgical and trauma patients. [NICE’s guideline on venous thromboembolism in over 16s](https://www.nice.org.uk/guidance/NG89), sections 1.4 to 1.15 should be referred to for population-specific recommendations that include different timings for pharmacological VTE prophylaxis. [[NICE’s guideline on venous thromboembolism in over 16s](https://www.nice.org.uk/guidance/NG89), recommendations 1.1.4, 1.1.6 and 1.1.7]

# Equality and diversity considerations

Statement 1 highlights that people are given verbal and written information on the possible side effects of VTE prophylaxis, and that they start treatment as soon as possible and within 14 hours of hospital admission. For people with additional needs related to a disability, impairment or sensory loss, information should also be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/).

# Quality statement 2: Anti-embolism stockings for VTE prophylaxis

## Quality statement

People aged 16 and over who are in hospital and assessed as needing anti‑embolism stockings are supported to wear them correctly and have their use monitored. **[2010, updated 2021]**

## Rationale

The use of anti‑embolism (compression) stockings to prevent VTE is common practice. However, stockings need to be used correctly and only when they are recommended for the person. Incorrect or inappropriate use of anti‑embolism stockings can lead to adverse events such as skin damage, inadequate protection against thrombosis development and unnecessary costs.

## Quality measures

### Structure

Evidence of written clinical protocols to ensure that people aged 16 and over who are admitted to hospital and assessed as needing anti‑embolism stockings are supported to wear them correctly and have their use monitored.

**Data source:** Local data collection, for example, from service protocols.

### Process

Proportion of people aged 16 and over who are in hospital and assessed as needing anti‑embolism stockings who are supported to wear them correctly and have their use monitored.

Numerator – the number in the denominator who are shown how to use anti‑embolism stockings correctly and have their use monitored.

Denominator – the number of people aged 16 and over who are in hospital and assessed as needing anti‑embolism stockings.

**Data source:** Local data collection, for example, local audit of patient records.

### Outcome

Proportion of people aged 16 and over in hospital who use anti‑embolism stockings to prevent VTE and are satisfied with the support they receive to wear them.

Numerator – the number in the denominator who are satisfied with the support they receive to wear anti‑embolism stockings.

Denominator – the number of people aged 16 and over who are in hospital who use anti‑embolism stockings to prevent VTE.

**Data source:**Local data collection, for example, local audits of patient records and patient surveys.

## What the quality statement means for different audiences

**Service providers** (such as secondary care services) ensure that written clinical protocols are in place so that people aged 16 and over who are in hospital and assessed as needing anti‑embolism stockings are supported to wear them correctly and have their use monitored.

**Healthcare professionals** (such as specialists and nurses) assess people aged 16 and over who are in hospital to decide whether they need anti‑embolism stockings. If they do, they measure the person’s legs to ensure they have the correct size of stocking, show the person how to use them, encourage them to wear the stockings day and night until they no longer have significantly reduced mobility, monitor their use and offer help if the stockings are not being worn correctly.

**Commissioners** (clinical commissioning groups) ensure that services have written clinical protocols in place so that people aged 16 and over who are in hospital and assessed as needing anti‑embolism stockings are supported to wear them correctly and have their use monitored.

**People aged 16 and over who are in hospital and are given compression stockings to prevent blood clots** are shown how to use the stockings correctly, and offered help if they have difficulty.

## Source guidance

[Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism](https://www.nice.org.uk/guidance/ng89). NICE guideline NG89 (2018), recommendations 1.3.2, 1.3.6 and 1.3.8.

## Definitions of terms used in this quality statement

### People aged 16 and over who are in hospital

This includes medical, surgical and trauma patients.[[NICE’s guideline on venous thromboembolism in over 16s](https://www.nice.org.uk/guidance/NG89), recommendations 1.1.1, 1.1.2 and 1.1.5]

### Assessed as needing anti-embolism stockings

Anti‑embolism stockings are recommended as an option for mechanical VTE prophylaxis for people:

* having elective spinal surgery
* having cranial surgery
* with spinal injury
* having abdominal surgery who are at increased risk of VTE
* having bariatric surgery
* having thoracic surgery who are at increased risk of VTE
* having cardiac surgery who are at increased risk of VTE.

[[NICE’s guideline on venous thromboembolism in over 16s](https://www.nice.org.uk/guidance/NG89), recommendations 1.12.1, 1.12.6, 1.12.11, 1.14.2, 1.14.6, 1.14.9, 1.15.1 and terms used in this guideline]

### Supported to wear them correctly and have their use monitored

People who need anti‑embolism stockings should have their legs measured so that they are given the correct size of stocking. Stockings should be fitted and people shown how to use them. People should be encouraged to wear their anti‑embolism stockings day and night until they no longer have significantly reduced mobility. Use of anti‑embolism stockings should be monitored and assistance offered if they are not being worn correctly.[[NICE’s guideline on venous thromboembolism in over 16s](https://www.nice.org.uk/guidance/NG89), recommendations 1.3.2, 1.3.6 and 1.3.8]

# Quality statement 3: Proximal leg vein ultrasound scan for a likely DVT Wells score

## Quality statement

People aged 18 and over with a deep vein thrombosis (DVT) Wells score of 2 points or more have a proximal leg vein ultrasound scan within 4 hours of it being requested. **[2013, updated 2021]**

## Rationale

People aged 18 and over with a suspected DVT need interim therapeutic anticoagulation if they have to wait more than 4 hours for a proximal leg vein ultrasound scan. In some cases, unnecessary interim anticoagulation treatment continues for up to a week before a scan rules out DVT. If a scan is performed within 4 hours, unnecessary interim anticoagulation treatment is avoided and, if DVT is ruled out, alternative diagnoses can be investigated promptly.

## Quality measures

### Structure

Evidence of the availability of staff to perform proximal leg vein ultrasound scans for people aged 18 and over with a DVT Wells score of 2 points or more within 4 hours of it being requested.

**Data source:** Local data collection, for example staff rotas.

### Process

Proportion of people aged 18 and over with a DVT Wells score of 2 points or more who have a proximal leg vein ultrasound scan within 4 hours of it being requested.

Numerator – the number in the denominator who have a proximal leg vein ultrasound scan within 4 hours of it being requested.

Denominator – the number of people aged 18 and over with a DVT Wells score of 2 points or more.

**Data source:** Local data collection, for example, local audit of patient records.

### Outcomes

a) Time from risk assessment to diagnosis of DVT.

**Data source:** Local data collection, for example local audit of patient records.

b) Prescribing rates of interim therapeutic anticoagulation to prevent DVT.

**Data source:** Local data collection, for example local audit of patient records.

## What the quality statement means for different audiences

**Service providers** (such as secondary care services) ensure that ultrasound scanning equipment and staff are available to perform proximal leg vein ultrasound scans for people aged 18 and over with a DVT Wells score of 2 points or more within 4 hours of the scan being requested.

**Healthcare professionals** (such as GPs, specialists and nurses) are aware of referral pathways for proximal leg vein ultrasound scans, and refer people aged 18 and over with a DVT Wells score of 2 points or more to have this imaging. If it is not possible to obtain the scan result within 4 hours, they offer a D-dimer test, then interim therapeutic anticoagulation.

**Commissioners** (such as clinical commissioning groups) ensure that services have referral pathways so that people aged 18 and over with a DVT Wells score of 2 points or more can have a proximal leg vein ultrasound scan within 4 hours of it being requested. They also ensure that services have the equipment and capacity to perform this imaging within this timeframe.

**People aged 18 and over who have signs and symptoms of a deep vein thrombosis (blood clot)** and whose doctor requests an ultrasound scan are given the scan within 4 hours of the doctor requesting it. If this is not possible, they are given the scan within 24 hours and offered a D-dimer test and an anticoagulant (medicine to treat blood clots) to take while waiting for the scan.

## Source guidance

[Venous thromboembolic diseases: diagnosis, management and thrombophilia testing](https://www.nice.org.uk/guidance/ng158). NICE guideline NG158 (2020), recommendations 1.1.3 and 1.1.4.

## Definition of terms used in this quality statement

### DVT Wells score of 2 points or more

A likely DVT Wells score, which is a score that predicts the probability of DVT for people with suspected DVT, estimated using the Wells clinical prediction rule:

Two-level DVT Wells score

|  |  |
| --- | --- |
| Clinical feature | Points |
| Active cancer (treatment ongoing, within 6 months, or palliative) | 1 |
| Paralysis, paresis or recent plaster immobilisation of the lower extremities | 1 |
| Recently bedridden for 3 days or more, or major surgery within 12 weeks requiring general or regional anaesthesia | 1 |
| Localised tenderness along the distribution of the deep venous system | 1 |
| Entire leg swollen | 1 |
| Calf swelling at least 3 cm larger than asymptomatic side | 1 |
| Pitting oedema confined to the symptomatic leg | 1 |
| Collateral superficial veins (non-varicose) | 1 |
| Previously documented DVT | 1 |
| An alternative diagnosis is at least as likely as DVT | -2 |
| Clinical probability simplified score | Points |
| DVT likely | 2 points or more |
| DVT unlikely | 1 point or less |

[[NICE’s guideline on venous thromboembolic diseases](https://www.nice.org.uk/guidance/NG158), recommendation 1.1.2]

## Equality and diversity considerations

[NICE’s guideline on venous thromboembolic diseases](https://www.nice.org.uk/guidance/NG158) covers people aged 18 and over as the evidence for the recommendations focused on this age group. This statement applies to people aged 18 and over, but clinical judgement should be used when treating people aged under 18 for suspected DVT.

# Quality statement 4: VTE anticoagulation review

## Quality statement

People aged 18 and over taking anticoagulation treatment after a VTE have a review after 3 months and then at least once a year if they continue to take it long-term. **[2013, updated 2021]**

## Rationale

The benefits of anticoagulation treatment for VTE prevention become less certain over time, and after 3 months treatment needs to be reviewed and a decision made about whether to continue or stop treatment. Reviewing long-term anticoagulation treatment for people who decide to continue it beyond 3 months ensures that treatment is guided by the person's changing balance of benefits and risks, and changes in their preferences over time.

## Quality measures

### Structure

a) Evidence of local systems to identify and invite people aged 18 and over taking anticoagulation treatment after a VTE for a review after 3 months.

**Data source:** Local data collection, for example service specifications.

b) Evidence of local systems to identify and invite people aged 18 and over taking long-term anticoagulation treatment after a VTE for a review at least once a year.

**Data source:** Local data collection, for example service specifications.

### Process

a) Proportion of people aged 18 and over taking anticoagulation treatment for 3 months after a VTE who have a review.

Numerator – the number in the denominator who have a review after 3 months.

Denominator – the number of people aged 18 and over taking anticoagulation treatment after a VTE.

**Data source:** Local data collection, for example local audit of patient records.

b) Proportion of people aged 18 and over taking long-term anticoagulation treatment for secondary prevention of VTE who have a review at least once a year.

Numerator – the number in the denominator who had a review in the previous year.

Denominator – the number of people aged 18 and over taking long-term anticoagulation treatment for secondary prevention of VTE.

**Data source:** Local data collection, for example local audit of patient records.

### Outcome

Rates of adherence to VTE anticoagulation treatment.

**Data source:** Local data collection, for example local audit of patient records.

## What the quality statement means for different audiences

**Service providers** (such as GP practices and secondary care services) ensure that local systems are in place to identify and invite people aged 18 and over taking anticoagulation treatment after a VTE for a review at 3 months and then at least once a year. They also ensure that staff have the time to carry out the reviews.

**Healthcare professionals** (such as GPs, specialists and nurses) carry out a review for people aged 18 and over taking anticoagulation treatment after a VTE after 3 months of treatment to discuss the benefits and risks of continuing, stopping or changing the anticoagulant. They give people information about when their anticoagulation will be reviewed. They also carry out a review for people taking long-term anticoagulation treatment for secondary prevention of VTE at least once a year to review general health, risk of VTE recurrence, bleeding risk, adherence, side effects and treatment preferences.

**Commissioners** (such as clinical commissioning groups and NHS England) ensure that services have local systems in place to identify and invite for review people aged 18 and over taking anticoagulation treatment after a VTE 3 months after starting treatment and adults taking long-term anticoagulation treatment for secondary prevention of VTE. They also ensure that services have the capacity to carry out the reviews.

**People aged 18 and over who have had a blood clot and are taking an anticoagulant (medicine to prevent another blood clot)** have a review after 3 months to discuss whether to continue or stop taking the anticoagulant, or change to a different anticoagulant. If they continue the anticoagulant, they have a review at least once a year. They are given information about when their treatment reviews will be scheduled.

## Source guidance

[Venous thromboembolic diseases: diagnosis, management and thrombophilia testing](https://www.nice.org.uk/guidance/ng158). NICE guideline NG158 (2020), recommendations 1.4.1 and 1.4.12.

## Definitions of terms used in this quality statement

### Review after 3 months

A review after 3 months of anticoagulation treatment to assess and discuss the benefits and risks of continuing, stopping or changing the anticoagulant with the person having treatment. [[NICE’s guideline on venous thromboembolic diseases](https://www.nice.org.uk/guidance/NG158), recommendation 1.4.1]

### Review at least once a year

A review of general health, risk of VTE recurrence, bleeding risk and treatment preferences for people taking long-term anticoagulation treatment. [[NICE’s guideline on venous thromboembolic diseases](https://www.nice.org.uk/guidance/NG158), recommendation 1.4.12]

## Equality and diversity considerations

[NICE’s guideline on venous thromboembolic diseases](https://www.nice.org.uk/guidance/NG158) covers people aged 18 and over as the evidence for the recommendations focused on this age group. This statement applies to people aged 18 and over, but clinical judgement should be used when treating people aged under 18 taking anticoagulation treatment after a VTE.

Heparins are a type of anticoagulant used to treat VTE. They are of animal origin and this may be of concern to some people because of religious or ethical beliefs. The suitability, advantages and disadvantages of alternatives to heparin should be discussed with the person.

# Quality statement 5: Follow-up for outpatients with low-risk pulmonary embolism

## Quality statement

People aged 18 and over having outpatient treatment for suspected or confirmed low-risk pulmonary embolism (PE) have an agreed plan for monitoring and follow-up. **[new 2021]**

## Rationale

Clear arrangements for monitoring and follow-up for outpatients ensures that they receive the same quality of care as patients in hospital. Specialist services with expertise in thrombosis are not available at all times, so it is important that people aged 18 and over with PE know who they can contact if they need advice outside normal service hours. Understanding signs to look out for and how and when to get help when needed can ensure that outpatients act in a timely manner before things worsen, and that they contact the appropriate service.

## Quality measures

### Structure

a) Evidence of local arrangements to ensure that people aged 18 and over having outpatient treatment for suspected or confirmed low-risk PE have an agreed plan for monitoring and follow-up.

**Data source:** Local data collection, for example service specifications or local protocols.

b) Evidence that information is available for people aged 18 and over having outpatient treatment for suspected or confirmed low-risk PE on symptoms and signs to look out for, and contact information for healthcare professionals they can discuss concerns with.

**Data source:** Local data collection, for example information leaflets.

### Process

Proportion of people aged 18 and over having outpatient treatment for suspected or confirmed low-risk PE who have an agreed plan for monitoring and follow-up.

Numerator – the number in the denominator who have an agreed plan for monitoring and follow-up.

Denominator – the number of people aged 18 and over having outpatient treatment for suspected or confirmed low-risk PE.

**Data source:** Local data collection, for example local audit of patient records.

### Outcome

Rates of emergency admissions to hospital for people aged 18 and over having outpatient treatment for PE.

**Data source:** Local data collection, for example audit of case records.

## What the quality statement means for different audiences

**Service providers** (such as secondary care services) ensure that healthcare professionals have the time and resources to discuss and agree a plan for monitoring and follow-up with people having outpatient treatment for suspected or confirmed low-risk PE.

**Healthcare professionals** (such as specialists and nurses) discuss and agree a plan for monitoring and follow-up with people having outpatient treatment for suspected or confirmed low-risk PE. They provide them with written information on symptoms and signs to look out for, direct contact details of a healthcare professional or team with expertise in thrombosis to discuss concerns with, and information about out-of-hours services they can contact when their healthcare team is not available. They should provide adequate information to enable people to make an informed decision about outpatient management.

**Commissioners** (such as clinical commissioning groups) ensure that services have the capacity and resources to discuss and agree a plan for monitoring and follow-up with people having outpatient treatment for suspected or confirmed low-risk PE.

**People who are having outpatient treatment for a pulmonary embolism** are given written information on signs and symptoms they should look out for and who to contact if they need help or advice, including out-of-hours services.

## Source guidance

[Venous thromboembolic diseases: diagnosis, management and thrombophilia testing](https://www.nice.org.uk/guidance/ng158). NICE guideline NG158 (2020), recommendation 1.2.4.

## Definition of terms used in this quality statement

### Agreed plan for follow-up

A plan for follow-up that is agreed with the person having outpatient treatment for suspected or confirmed low-risk PE. They should be given:

* written information on symptoms and signs to look out for, including the potential complications of thrombosis and of treatment
* direct contact details of a healthcare professional or team with expertise in thrombosis who can discuss any new symptoms or signs, or other concerns
* information about out-of-hours services they can contact when their healthcare team is not available.

[[NICE’s guideline on venous thromboembolic diseases](https://www.nice.org.uk/guidance/NG158), recommendation 1.2.4]

## Equality and diversity considerations

[NICE’s guideline on venous thromboembolic diseases](https://www.nice.org.uk/guidance/NG158) covers people aged 18 and over as the evidence for the recommendations focused on this age group. This statement applies to people aged 18 and over, but clinical judgement should be used when treating people aged under 18 having outpatient treatment for suspected or confirmed low-risk PE.

# Update information

**April 2021:** This quality standard was updated and statements prioritised in 2010 and 2013 were replaced.

Statements are marked as:

* **[new 2021]** if the statement covers a new area for quality improvement
* **[2010 or 2013, updated 2021]** if the statement covers an area for quality improvement included in the 2010 or 2013 quality standard and has been updated.

Statements numbered 3 and 5 in the 2010 version have been updated and are included in the updated quality standard, marked as **[2010, updated 2021]**.

Statements numbered 2 and 8 in the 2013 version have been updated and are included in the updated quality standard, marked as **[2013, updated 2021]**.

Statements from the 2010 quality standard that are still supported by the evidence may still be useful at a local level, and can be found [here](https://www.nice.org.uk/guidance/qs3).

Statements from the 2013 quality standard that are still supported by the evidence may still be useful at a local level, and can be found [here](https://www.nice.org.uk/guidance/qs29).

# About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See our [webpage on quality standard advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10142/documents).

This quality standard has been included in the [NICE Pathway on venous thromboembolism](https://pathways.nice.org.uk/pathways/venous-thromboembolism), which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

* hospital-acquired thrombosis
* hospital readmissions for people with suspected or confirmed VTE
* deaths from VTE related events within 90 days post discharge from hospital
* quality of life of people with venous thromboembolism
* rates of patient safety incidents.

It is also expected to support delivery of the following national framework:

* [NHS outcomes framework](https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework).

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the source guidance to help estimate local costs:

* [resource impact statement for NICE’s guideline on venous thromboembolism in over 16s](https://www.nice.org.uk/guidance/ng89/resources)
* [resource impact template and report for NICE’s guideline on venous thromboembolic diseases](https://www.nice.org.uk/guidance/ng158/resources).

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10142/documents) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

ISBN:

© NICE 2020. All rights reserved. Subject to [Notice of rights](https://www.nice.org.uk/terms-and-conditions#notice-of-rights).