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The Scottish Government

PE1056/R

Franck David
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Your ref: Petition PE1056
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Dear Franck,

CONSIDERATION OF PETITION PE1056 (DEEP VEIN THROMBOSIS)

Thank you for your letter of 25 March 2011, in which you asked for a response to the points raised during the discussion of the Petition and in particular to the following specific questions:

- **What is your response to the points made by Trish Godman during the discussion?**

The Committee will recall that *The Venous Thromboembolism Challenge in Scotland: A Report into VTE Prevention in Scottish Health Boards,* published by Lifeblood, the thrombosis charity, called on the Scottish Government to ask each of the territorial NHS Boards to set up a VTE committee, suggesting, on the basis of experience in England, that the advantages these would bring include: promoting best practice; adapting local protocols and providing local audit of thromboprophylactic practice; and acting as a source of education and training for all staff.

The Cabinet Secretary for Health, Wellbeing & Cities Strategy, therefore asked the Chief Medical Officer (CMO) to raise the possibility of setting up VTE Committees with NHS Board Medical Directors. The Scottish Association of Medical Directors will consider this at their next meeting and will provide its views on whether setting up VTE committees is the best way to deliver the perceived benefits, or whether there is a more appropriate solution now that SIGN Guideline 122 on the prevention and management of VTE has been published. The Association expects to reply to CMO by September.

VTE risk assessment and family history were also mentioned during the Committee's last discussion and I would like to emphasise that the issue of VTE prophylaxis is one which the Scottish Government takes very seriously. This is underlined by the enthusiasm with which the Scottish Patient Safety Programme (SPSP) is now taking the issue forward, in particular

through the extension of assessment of VTE risk to medical, as well as surgical, inpatients. Following the SPSP VTE Learning event on 17 November 2010, all NHS Boards are developing a risk assessment tool which will help achieve a consensus on prophylaxis. The Scottish Government are organising a further meeting to be held in September for NHS Boards to share their work on this. The SPSP, Scottish Government and the Quality Improvement Hub will also be involved in this meeting which will aim to develop a measurement strategy for VTE. The measurement strategy is about ensuring all patients in Scotland have a risk assessment and receive VTE prophylaxis where appropriate.

In terms of family history, SIGN Guideline 122 on the prevention and management of VTE highlights that a family history of VTE (of a first degree relative under the age of 50 or more than one first degree relative of any age) is an indicator of increased risk of first VTE. Part 16 of the Guideline covers the provision of information and clearly states that, at initial presentation or assessment, it should be explained to the patient/carer what VTE is and what causes it. There should also be a discussion with the patient/carer about the risk factors for VTE, including family history, and it should be explained to patients who have tested positive for VTE (especially if unprovoked) that the thrombotic tendency may run in the family in some cases. Discussions about family history also forms part of the Grampian risk assessment tool which is provided as an example of an algorithm for assessing the risk of VTE, at Annex 2 of the Guideline. SIGN Guideline 122 also notes that heritable thrombophilia further increases VTE risk in those on combined oral contraceptives, but that the risk of recurrent VTE is not increased in patients with Factor V Leiden. The Guideline also notes that all women should be assessed for risk factors for VTE when booking for antenatal care and at each subsequent maternity contact. Women should also be asked about a personal and family history of VTE and whether an objective diagnosis was made.

SIGN Guideline 36, on anti-thrombotic therapy, is also being revised, and we understand that the new version is expected to be published later this summer.

The SPSP continues to working closely with SIGN on implementation of the Guideline. An important step in its implementation is gaining an understanding of current clinical practice, and the guideline recommends that the rate of healthcare-associated VTE should be recorded and monitored routinely to identify areas where the risk assessment policy may need to be reviewed.

Ms Godman also raised the issue of the availability of appropriate codes for recording VTE. She wrote to the Cabinet Secretary on 20 September 2010, regarding this matter, highlighting the good work underway in Ninewells Hospital in adopting good practice in VTE risk assessment and prevention for patients coming into hospital. Ms Godman also advised that members of staff have experienced problems in attempting to audit the number of hospital acquired VTEs to provide information on the success of their prophylaxis due to the lack of a specific code for hospital acquired VTE. The Cabinet Secretary's has therefore asked that that we investigate the issue with the Information Services Division of NHS National Services Scotland (ISD). Work has already begun and a coding solution is being actively pursued.

- **What impacts have the new leaflets, information and SIGN Guideline had on the assessment of the diagnosis of DVT?**

We have welcomed the work that SIGN has already done to develop a Guideline implementation plan and in our previous reply to the Committee of 14 December 2010, I provided an outline of the range of activity currently being taken forward. This work is still in its early stages and it is therefore too soon to determine the long term impact of the guideline

on the assessment and diagnosis of DVT. In the interim I would like to draw the Committee's attention to some of the good progress made to date.

As an aid to standardising the provision of patient information throughout NHSScotland, SIGN has included the text of the model patient advice leaflets sent to all NHS Boards by the Chief Medical Officer on 26 January 2008, as appendices in the Guideline. In addition, the information leaflet on DVT for the general public has been available for download from the SIGN website since April 2011. Distribution of paper copies will be led by the SIGN Patient Involvement Officer and will take place by the end of June 2011. This work should promote continuity as well as consistency of message.

SIGN is continuing to work with its partners to embed the Guideline's recommendations into general practice decision-making software, and has been working with an IT company to develop decision support screens for GP IT systems. The first of these was developed for asthma and has been piloted in a number of GP surgeries. VTE is one of the next guidelines that SIGN is keen to develop such tools for. SIGN is awaiting the outcome of the evaluation report for the asthma guideline screens before it commissions the next batch.

SIGN is now part of the eForms group run by the Scottish Government eHealth team. SIGN will be supporting eForms developers to create tools based on SIGN guidelines, and Guideline 122 will be one of these when this work commences. However SIGN has advised that a start date has yet to be agreed.

The Guideline acknowledges the importance of auditing current practice as part of their training. All junior doctors must carry out an audit and so to encourage them to focus on VTE prophylaxis, SIGN has now made audit tools for junior doctors available to download from the SIGN website.

An iPhone application is also now available on the SIGN website, and it is expected that an Android application will be available by the end of June 2011.

I trust that the information in this letter, the terms of which have been cleared by the Minister for Public Health, will be of assistance to the Committee in its further consideration of the Petition.

Yours sincerely,

Craig Bell