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Franck David
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Your ref: Petition PE1056
14 December 2010

Dear Franck,

CONSIDERATION OF PETITION PE1056 (DEEP VEIN THROMBOSIS)

Thank you for your email of 8 December 2010, in which you asked for a response about the impact the revised version of SIGN Guideline 62 on the prophylaxis of venous thromboembolism (VTE) is expected to have on the issues raised in this Petition.

As the Committee will be aware, Scottish Intercollegiate Guidelines Network (SIGN) Guideline 122 on the prevention and management of VTE was launched on 10 December 2010. It sets out the latest evidence on the subject.

Guideline 122 recommends that:

- all patients admitted to hospital, or presenting acutely to hospital should be individually assessed for risk of VTE and bleeding, and the risks, and benefits, of prophylaxis must be discussed with the patient;
- a risk assessment method checklist should be used for this purpose;
- the assessment should be repeated regularly and at least every 48 hours;
- all patients should be assessed for their individual risk of thrombosis versus increased risk of bleeding with pharmacological prophylaxis; and
- the risk assessment should be shared with the patient/carer and the outcome of that discussion formally recorded as part of the routine process of informed consent to treatment.

We made very clear at the Guideline launch event on 10 December that we want to take maximum advantage of the opportunity presented by the new Guideline to achieve a real change in our approach to VTE prophylaxis in Scotland. We therefore welcome the work that SIGN has already been doing to develop an implementation plan.
SIGN is now working with its partners to embed the Guideline's recommendations fully into general practice decision-making software. This is an extremely significant

development, as it will enable GPs to refer readily to the key recommendations in the Guideline as part of their day-to-day management of patients. SIGN expects this to happen within 6 months of the date of publication of the new Guideline.

As an aid to standardising the provision of patient information, SIGN has included as Appendices in Guideline 122 the text of the advice leaflet on the prevention of DVT for patients admitted to hospital and the generic patient information leaflet on DVT, both of which were attached to the letter of 26 January 2008 issued by the Chief Medical Officer and the then Chair of NHS Quality Improvement Scotland. These are expected to be available for download from the SIGN website from spring 2011. This should promote continuity as well as consistency of message.

The Guideline also acknowledges that an important step in its implementation is gaining an understanding of current clinical practice. As part of their training, all junior doctors must carry out an audit, and SIGN is encouraging them to make VTE prophylaxis their chosen topic. To encourage this, an audit tool will be made available for download from the SIGN website, and SIGN will put in place arrangements to collate individual audit results. This will help to give a much clearer picture of what is happening at ward level. SIGN is also developing an iPhone application based on the Guideline, again primarily as an aid for junior doctors, and that should be ready within 3 months of the launch of the Guideline.

The Scottish Patient Safety Programme's (SPSP) peri-operative work stream has developed the target that 95% of eligible surgical patients are assessed and receive appropriate VTE prophylaxis. At the moment, 29 surgical teams or areas are reporting data, and are on average achieving reliability in 98% of patients. We have encouraged the SPSP to build on this achievement by extending its approach to cover medical as well as surgical patients. The Programme has embraced this suggestion enthusiastically, and wants to incorporate the lessons learned from the work of the South West Special Health Authority, by common consent one of the exemplars south of the border.

In order to give added momentum to the SPSP work, we have encouraged the Scottish Medical and Scientific Advisory Committee to focus on VTE assessment and prophylaxis as an ideal context in which to further its work in promoting the concept of clinical leadership. As a result, SMASAC, and the wider circle of the Chief Medical Officer's specialty advisers, who cover all of the more than 50 branches of medicine, will develop a strategy, in consultation with the leaders of the SPSP, to accelerate the changes required.

The Petitioners have also expressed concerns about lack of awareness of thrombophilias such as Factor V Leiden. These are clearly highlighted as a risk factor for VTE in Guideline 122. It 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.

SIGN Guideline 36, on anti-thrombotic therapy, is also being revised, and we understand that the new version is expected to be published in January 2011.
I trust that the information in this letter will be of assistance to the Committee in its further consideration of the Petition.

Yours sincerely,

W S SCOTT