NHS
East Lancashire
Clinical Commissioning Group

Agenda Item No: 6.5

REPORT TO:	**PRIMARY CARE COMMITTEE**		
MEETING DATE:	**13 September 2017**		
REPORT TITLE:	**East Lancashire DVT Local Enhanced Services (LES)**		
SUMMARY OF REPORT:	The paper provides an overview of the current pathways for DVT and a recommendation to implement a DVT LES across East Lancashire.		
REPORT RECOMMENDATIONS:	Implementation of an East Lancashire DVT LES.		
FINANCIAL IMPLICATIONS:	DVT LES - £100 per patient Budget allocation - £43,000 Funding already allocated to DVT LES via the previous LES's as noted in the paper.		
REPORT CATEGORY:			**Tick**
	Formally Receipt		X
	Action the recommendations outlined in the report.		X
	Debate the content of the report		X
	Receive the report for information		
AUTHOR:	**Kirsty Hamer, Ribblesdale Locality Manager** **Samantha Jones, Senior Commissioning Manager, BwD CCG**		
	Report supported & approved by your Senior Lead		**Y**
PRESENTED BY:	**Kirsty Hamer** **Locality Manager**		
OTHER COMMITTEES/ GROUPS CONSULTED:	A DVT Service Review was submitted to the Sustainability Performance Group. The DVT LES has also been submitted to the LMC for consideration, it will be presented for Chairs' actions and ratified at the LMC Board at the end of September.		
EQUALITY IMPACT ANALYSIS (EIA) :	Has an EIA been completed in respect of this report?		**N**
	If yes, please attach	If no, please provide reason below To follow as part of the full DVT review.	
RISKS:	Have any risks been identified / assessed		**N**
CONFLICT OF INTEREST:	Is there a conflict of interest associated with this report?		**N**
CLINICAL ENGAGEMENT:	Has any clinical engagement/involvement taken place as part of the proposal being presented.		**Y**
PATIENT ENGAGEMENT:	Has there been any patient engagement associated with this report?		**N**
PRIVACY STATUS OF THE REPORT:	Can the document be shared?		**Y**

Which Strategic Objective does the report relate to		**Tick**
1	Commission the right services for patients to be seen at the right time, in the right place, by the right professional.	**X**
2	Optimise appropriate use of resources and remove inefficiencies.	**X**
3	Improve access, quality and choice of service provision within Primary Care	**X**
4	Work with colleagues from Secondary Care and Local Authorities to develop seamless care pathways	

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NHS EL CCG Primary Care Committee
13th September 2017

East Lancashire DVT Local Enhanced Service

1. Introduction

1.1 This paper outlines the current provision for treatment of Deep Vein Thrombosis (DVT) in East Lancashire, and the recommendation for the implementation of a DVT LES across East Lancashire.

2. Purpose / Background

2.1 Treatment of DVT, in the main, is provided by East Lancashire Hospitals Trust (ELHT). There are two referral pathways in place. The first is that GP's can ring the radiology department directly and book patients in for a scan (they will get an appointment within 24 hours as this is in line with their NOUS contract and NICE guidance). The GP is responsible for prescribing and overall patient management.

2.2 The second referral pathway is the referral via the Elective Care Centre at Burnley General Hospital (which used to be known as Ward 28). Overall patient management is the responsibility of ELHT but scanning and prescribing capacity is limited.

2.3 Until February 2017 there was a LES 1 and LES 2 within Primary Care. LES 1 required Practices to clinically assess patients using the wells scoring system and where indicated D-Dimer testing, this was to identify a suspected DVT in the community and referral onto secondary care as appropriate. LES 2 required Practices to complete the clinical assessments as identified in LES 1 plus to maintain overall clinical responsibility for the patient, arranging the ultrasound and managing the treatment of DVT as per the local treatment pathway and prescribing guidance. These enhanced services were ceased following a recall on the D-Dimer/POC tests due to a quality issue.

2.4 A change has been made by East Lancashire Hospitals Trust to DVT treatment at Burnley General Hospital. When the Elective Care Centre was launched in 2016 they increased the number of scan slots and expanded the scope and capacity within the wards so that they could concentrate on managing other patients conditions as well as DVT. This has meant a reduced offer for direct GP referrals. There was no consultation regarding this change with Primary Care or East Lancashire/Blackburn with Darwen CCG.

2.5 The impact of this change has been exacerbated by the requirement to end the LES 1 and LES 2 contracts due to quality issues. The end of the contracts means that Primary Care are currently providing an enhanced level of service without the additional funding to support. There is also confusion with regards to the current pathway and the most efficient and effective for patient care.

2.6 Informal feedback from practices has identified the pathways as confusing and difficult to navigate.

2.7 As a result of the above a clinical pathway has been developed and a new LES for DVT to provide resource to Practices to support the first pathway noted in 2.1. The DVT LES (appendix A) is available for all Practices to sign up to deliver, as well as offering to deliver the service on behalf of neighbouring GP Practices who do not wish to sign up to delivering the LES.

2.8 Due to the issues experienced above, it has become apparent that a full review of DVT services and pathways needs to be addressed and therefore the DVT LES is an interim arrangement whilst a more permanent solution is considered. A workshop is being held on the 19th September 2017 to take this work forward.

3. Conclusion

3.1 As noted in the report, the current DVT pathways are not fit for purpose. The implementation of the DVT LES will enable us to address some of the above issues whilst we work to develop a more permanent solution.

3.2 Commissioners will work with localities to look at opportunities within each Neighbourhood / Locality to promote the uptake of the DVT LES and offer support to Practices to establish processes to provide the scheme to patients at neighbouring Practices where there is the option to do so.

4. Recommendations

4.1 To consider the report and approve the implementation of the DVT LES

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Appendix A

Service Specification No.	**1**
Service	**Deep Vein Thrombosis Diagnosis and Management**
Commissioner Lead	**NHS East Lancashire Clinical Commissioning Group (CCG)**
Provider Lead	
Period	**1st April 2017 – 31st March 2018**
Date of Review	**July 2017**

1. Population Needs

1.1 National/local context and evidence base

Deep venous thrombosis (DVT) is the formation of a blood clot in a vein that is deep inside a part of the body, usually the legs. DVT mainly affects the large veins in the lower leg and thigh. The clot can block blood flow and cause swelling and pain. If the clot dislodges and travels in the blood to the pulmonary arteries this can result in a sometimes fatal pulmonary embolism.

National prevalence of Deep Vein Thrombosis (DVT) suggests an incidence of 1:1000 per annum. This is a crude rate and makes no allowance for DVTs occurring whilst in hospital. Whilst accurate figures for DVTs presenting in primary care are difficult to find, studies of referral of swollen leg/suspect DVT have shown conversion rates from suspicion to proven of between 50% and 33%. Thus there are clearly many more legs needing assessment than actual DVTs.

Traditionally, patients with suspected DVT have been diagnosed and managed in Secondary Care. Assessment tools for DVT diagnosis can now be managed in Primary Care and as a result lead to a more safe and effective way of excluding this condition in the community in patients with a low probability of the condition.

Patients presenting with an acutely swollen leg constitute a significant number of referrals to secondary care for further assessment. A validated assessment scoring method (Wells score – Appendix 3) can enable Primary Care physicians to select with confidence those patients that do NOT need onward referral to Secondary Care.

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients and those of other patients (upon request/agreement). This LIS contract service specification for the diagnosis and management of DVT outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patients, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

This agreement provides funding for the practice to provide all required routine referral, care and treatment of suspected and proven DVT's in line with the locally agreed Primary Care and Secondary Care DVT pathways (see appendix 1 and 2).

References:

- Department of Health, 'Our Health, Our Care, Our Say', (2006)
- The British Committee for Standards in Haematology. 'The diagnosis of deep vein thrombosis

in symptomatic outpatients and the potential for clinical assessment and D-dimer assays to reduced the need for diagnostic imaging'. (2004) Blackwell Publishing Ltd, British Journal of Haematology, 124, 15-25

- Wells, P.S. et al. (1997) 'Value of assessment of pretest probability of deep-vein thrombosis in clinical management'. Lancet 350 (9094), 1795-1798

- Map of Medicine, NHS Institute for Innovation and Improvement, 29.10.2010, Suspected Deep Vein Thrombosis (DVT) link: http://app.mapofmedicine.com/mom/1/page.html?department-id=8&specialty-id=1040&pathway-id=14339&page-id=14341&history=clear&history=clear

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health following injury**	
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Local defined outcomes

- A reduction in referrals to secondary care for suspected DVT (based on national conversion rates it is expected that this will be a reduction of approximately 20% of total referrals per year).

- To ensure care is delivered in a timely manner and in a convenient location closer to the patient's home

- Improved and streamlined patient experience

The practice will manage all cases of suspected and subsequently proven DVT where clinical judgement suggest community management is safe, desirable and appropriate.

3. Scope

3.1 Aims and objectives of service

The aims of the service are to:

- Improve patients' experiences by seeing and diagnosing patients in community settings and avoiding inappropriate referrals to Secondary Care

- Increase patient safety by enabling more accurate early diagnosis.

- To improve standards of care and accessibility to the patient.

- Maximise clinical skills in General Practice

- Improved and streamlined patient experience which is consistent with patient safety and high quality care

The delivery of the service will be discussed at locality level with discussions with primary care on how the service can be delivered on a neighbourhood basis. So that Single GP Practices can see practices from other locality practice patients.

3.2 Service description/care pathway

The GP retains clinical responsibility for the patient throughout this pathway unless it is agreed that a lead neighbourhood practice will manage the patient on their behalf.

The pathway for this service is shown in **Appendix 1**. The service will be carried out in GP surgeries by either GPs or practice nurses. Patients with suspected DVT will be scored against the Wells Diagnostic Algorithm. The GP is responsible for the initiation of the anticoagulant, blood sample and referral for ultrasound scan if necessary as part of the practices own protocol for the management of suspected DVT patients. This should be based on current accepted practice, cover identification of possible patients, how any diagnosis is to be established and what treatments are to be used. It must cover initial dosing regimes and how patients are to be transferred to longer duration treatments where appropriate (in line with locally agreed pathways).

The default position for those patients with criteria listed above, or for any patient that a clinician and or the patient feels is not suitable to follow this care pathway, is immediate referral to Secondary Care services.

- Active cancer within 6 months - consider for LMWH e.g. tinzaparin. (When considering LMWH, primary care clinician to ensure that treatment is in accordance with the NPSA advice 'Reducing treatment dose errors with low molecular weight heparins (July 2010) and local prescribing guidance.
  See http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=75208 Note - The prescribing of LMWH under a shared care agreement with a specialist is outside the scope of this LIS. Use of low molecular weight heparin in this manner is unlicensed).

- Patients should be managed in line with relevant NICE Clinical Guidelines and Technology Appraisals.

1. Diagnostics and initiation

Participating GP Practice is required to confirm availability of Doppler ultrasound via direct referral to the Radiology Department at Royal Blackburn Hospital or via the Elective Care Centre. See ELHT DVT pathway for GP ultrasound referrals (**Appendix 2**).

- If a proximal ultrasound scan is **available** within 4 hours, GP Practice to refer to direct access service immediately.

- If a scan is **not available** within 4 hours:

  - GP Practice to **initiate anticoagulant** as per current local Treatment Pathway & Prescribing Guidance, available on the Medicines Management website **(www.elmmb.nhs.uk).**
  - GP Practice to refer immediately for proximal ultrasound scan which will be available within 24 hours of request.

- Results will be communicated to GP practice by direct access ultrasound service (currently Radiology Dept at ELHT) within 24 hours

2. Ultrasound Scan outcome:

If Doppler ultrasound scan is **positive**:

- GP confirms diagnosis of DVT and manages patient as per current local Treatment Pathway & Prescribing Guidance, available on the medicines management website **(www.elmmb.nhs.uk).**

- **GP to consider investigations for cancer**

  - For patients aged over 40 years with a first unprovoked VTE – after carrying out a physical examination (guided by the patient's full history), a chest X-ray, blood tests (full blood count, serum calcium and liver function tests) and urinalysis – consider further investigations for cancer with:

  - an abdomino-pelvic CT scan **and** sputum cytology **and**

  - a mammogram for women.

If Doppler ultrasound scan is **negative**:

- And the Wells score was 'UNLIKELY', advise the patient it is not likely they have DVT, stop anticoagulant (if applicable) and consider alternative diagnoses within 24 hours

- The Wells score was 'LIKELY', and the d-dimer test was positive, repeat scan within 6-8 days to either confirm or exclude diagnosis of DVT

Exclusion Criteria

The service will be accessible for any patient from both their own or as agreed within another neighbouring GP practice presenting with suspected DVT with the application of the following exclusion criteria:

- Unsuitable for treatment with a new oral anticoagulant licensed and locally approved for the treatment of DVT (such as rivaroxaban) – these criteria will be specified in the Treatment Pathway as guided by the relevant SPC for that product

- Pregnant or breastfeeding/post-partum

- Aged <18 years

- Currently on an anticoagulant or a low molecular weight heparin (LMWH e.g. tinzaparin)

- Symptoms of pulmonary embolism

- Potential bleeding lesions

- Systolic BP >180 or diastolic BP >115

- Congenital or acquired bleeding disorders

- Severe renal impairment (CKD stage 5) eGFR <15 ml/min/1.73 m^2

- Known thrombocytopenia (Platelets <90 x 109/L)
- Known liver failure

This specification outlines the service to be provided during core and agreed extended hours where these are provided by a practice.

Patient transport arrangements do not form part of this service specification. Patients will be expected to make their own transport arrangements. Those patients who are entitled to assistance with transport under existing NHS arrangements will be able to access this through their GP Practice as per local arrangements.

3.3 Population covered

The service provided shall be for eligible patients who are registered with a practice in the NHS East Lancashire CCG geographical boundaries.

3.4 Any acceptance and exclusion criteria

The service will be accessible for any patient presenting with suspected DVT. The following criteria apply:-

- Not Pregnant or breastfeeding
- No history of recurrent DVT/PE

3.5 Interdependencies with other services

- NHS East Lancashire CCG
- Primary Care
- Local Acute Trusts (Secondary Care Consultants)
- PALS
- Independent and Voluntary Sector as appropriate

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The delivery of the commissioned service is underpinned by the appropriate standards, including but not limited to:

- Care Quality Commission Standards
- Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance
- Relevant safeguarding standards.
- Rules of Professional Conduct http://www.gmc-uk.org/guidance/index.asp

4.2 Applicable standards set out in Guidance and/or issued by a competent body

As per the NHS Standard Contract.

4.3 Applicable local standards

The Service is responsible for ensuring that staff undertaking diagnostic tests and assessments are adequately trained and supervised, where required, to do so. **The service provider must provide evidence to the CCG that their healthcare professionals have the appropriate knowledge, skills, experience, qualification and competency to provide the service. This must include but would not be limited to the following requirements:**

Accreditation/Competencies/Continuing Professional Development

- GP signing up to provide the LES will be required to complete DVT Education/training, as part of the requirement of the Enhanced Service contract, and must apply the competencies found in Appendix A.
- Staff undertaking diagnosis tests, assessments and initiating and administering treatment must be adequately trained and supervised as determined by the practice.
- Staff must ensure recording of adequate data for the safe transfer of follow-up, that there is provision of patient held information, which contains information on the need for anticoagulation and possible side effects.
- Staff must implement risk minimisation strategies for the co-prescribing and monitoring of non-steroidal anti-inflammatories and other interacting medicines, to include gastroprotection with PPIs for example where appropriate.

Infection Control

- The provider will have access and adhere to national and local guidance in relation to infection prevention and control principles and protocols.
- The provider will ensure that up to date infection prevention and control policies are written, reviewed and adhered to by all staff.
- The environment must be clean, clutter free and sterile items stored appropriately i.e. not on the floor. A cleaning schedule will be in place and monitored by the provider.
- All clinical staff will adhere to standard precautions. Personal protective equipment must be available and clinical staff to don appropriate personal protective equipment in accordance with national guidance.
- Staff must attend infection prevention and control training annually. Training manual to be available.
- Infection prevention and control audit or a self-assessment will be undertaken by the provider annually. This will be disseminated to the Infection Control Lead at the PCT.
- Sharps will be stored, handled and disposed of at the point of source in accordance with national guidance. This process will be monitored by the provider.
- All needlestick injuries will be treated as a significant event and will be investigated by the provider. The report will be disseminated to the Infection Control Lead at the PCT.

Premises and Equipment

- The provider will ensure that the premises used for the provision of the service are:
    - suitable for the delivery of those services; and
    - sufficient to meet the reasonable needs of the patients.
- The provider shall provide all of the required clinical equipment. This equipment shall be maintained in accordance with manufacturers' guidance and best practice and, where appropriate, recalibrated annually.

Business Continuity

- The provider must ensure that adequate arrangements are in place for continuity of the service in the event of staffing shortages, facilities and system failures appropriate to the service.

Record Keeping and Information Requirements

- All providers of NHS commissioned care should use the latest NHS Information Governance Toolkit to assist in implementation and assessment of compliance with policy and legal requirements.
- Full records of all procedures, screening and test should be maintained in such a way that aggregated data and details of individual patients are readily accessible. Practices should regularly audit and peer review outcomes.
- Practices must ensure that details of the patient's monitoring are included in his or her lifelong record. If the patient is not registered with the practice, then the practice must send this information to the patient's registered practice for inclusion in the patient notes.

Significant Events

- The Department of Health emphasizes the importance of collected incidents nationally to ensure that lessons are learned across the NHS. A proactive approach to the prevention of recurrence is fundamental to making improvements in patient safety.
- The provider must have systems in place for documenting and learning from significant events, including reporting to the PCT, as appropriate.
- The provider should be aware of the various reporting systems, such as:
    a. the National Patient Safety Agency National Reporting and Learning System
    b. the Medicines and Healthcare Products Regulatory Agency reporting systems for adverse reactions to medication (yellow card system) and accidents involving medical devices
    c. the legal obligation to report certain incidents to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
- In addition to their statutory obligations, the provider should give notification, within 72 hours of the information becoming known to him/her, of all emergency admissions or deaths of any patient treated by the provider under this enhanced service, where such admission or death is, or may be due, to the providers treatment of the relevant underlying medical condition covered by this specification.

Termination of Agreement

- This agreement will be reviewed. If the provider/commissioner wishes to terminate this

agreement before this date then they are required to give six month notice of termination in writing. The provider should submit this notice to at the CCG.

The CCG has the right to terminate this agreement if a serious breach occurs.

Monitoring and Reporting

A contract monitoring pro-forma (**Appendix 4**) must be completed to record each patient contact on a monthly basis which will be submitted to enhancedserviceslcsu@nhs.net .

A quality schedule which outlines the key standards and requirements to deliver the contract (**Appendix 5**) is to be completed and monitored on a monthly basis.

Practices will also be required to submit anonymised data on patients managed within this service on a quarterly basis.

Practices will be required to participate in an annual CCG audit to look at the following:

- Patients with negative D-dimer who are diverted from secondary care
- The rate of conversion from suspected to positive DVT
- Patients referred to Secondary Care for DVT exclusion without Wells assessment.

The participating practices must adhere to the agreed assessment tool (Modified Wells Score). Each episode must also be recorded in the life long patient record.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

The provider will receive a payment of £100.00 per patients following receipt of completed monthly contract monitoring and quality reports. **Current tariff is £75 per patient so I have proposed an 25% increase on this due to the increase in time taken to book the patient for a scan/prescription.**

The above payment is to cover:

- All staffing times involved in providing this service
- Disposable/consumables associated with providing this service
- The payment is exclusive of any prescribing/medicine costs
- All sterilisation/maintenance/calibration/serviing/repair/replacement and insurance of equipment.

Appendix 1

Appendix 1 V2.docx

Appendix 2

Appendix 2 ELHT DVT PATHWAY.DOCX

Appendix 3

appendix 3.docx

Appendix 4

Appendix 5

Appendix 5 DVT 2017-18 Quality Stan

Appendix A

Initiating anticoagulant therapy – Competencies

- Read the patient's notes and prescription, and identify any special instructions, investigations (including abnormal blood test results), or issues for which you need to seek advice.
- Assess the appropriateness of the intended treatment against the patient's current health and social status, medication, other treatment and the patient's preferences.
- Determine the appropriate dose regimen for the patient, which drugs to prescribe, the dosage and the frequency of administration. Document the indication for use, duration of treatment and monitoring plan in the patient's notes. Order baseline blood tests prior to the administration of the first dose of anticoagulant where indicated.
- Ensure that the patient receives verbal and written information concerning their anticoagulant therapy prior to the first dose of anticoagulant.
- Prescribe the anticoagulant treatment according to legislation, national and local prescribing guidelines and relevant clinical information to ensure safe and optimal delivery of treatment.
- Include in the prescription:
    - the approved name of anticoagulant drug(s);
    - dose, route, method and duration of administration;
- Prescribe legibly, ensuring your intention for treatment and monitoring is clear, accurate and complete and that there are no ambiguities.
- Review the anticoagulant prescription in accordance with the monitoring plan.
- When transferring the care of the patient to another healthcare team ensure that the new team is sent information concerning the clinical indication for use, intended duration of therapy, current prescription and recent laboratory test results.