Transforming the treatment of DVT

Historically, most patients in Bradford who were suspected of having a deep vein thrombosis (DVT) required hospital admission for diagnosis and initiation of treatment. Treatment involved a low molecular weight heparin and warfarin - therefore management by a hospital anticoagulant clinic. The problems with this model were:

- Poor adherence to care pathways by clinicians
- Significant inconvenience for patients
- The risks associated with warfarin dosing
- High cost for commissioners

Following the recommendation by NICE that rivaroxaban should be made available to treat DVTs, an opportunity to redesign the DVT care pathway was identified. With the help of direct-access diagnostics, a blood test and rivaroxaban, the condition can now be diagnosed and managed in primary care. The change has led to lower cost and better patient experience, and is expected to deliver improved health outcomes.

How we started

A draft pathway was written - based on that established in the EINSTEIN study (New England Journal of Medicine 2010;363:2499–510). The draft underwent consultation with GPs in two clinical commissioning groups - to identify any practical issues. At the same time, consultation with secondary care clinicians - particularly from radiology, haematology and acute medicine - took place.

The consultation process confirmed widespread support for the pathway, with some measured caution regarding potential risks. The feedback led to a draft pathway being written.

This article is continued on the last page of PCPA Spotlight

Get in touch

If you would like to contribute to a future issue of SPOTLIGHT or have a specific issue you would like to see us cover please contact our Communications Director Michelle Kaulbach on 01483 211092 or email michelle@pcpa.org.uk

The PRIMARY CARE PHARMACISTS’ ASSOCIATION is the only professional association exclusively for pharmacists working in primary care and NHS commissioning structures.

From the editor

When NICE produced its positive technology appraisal on rivaroxaban to treat deep vein thrombosis, there were probably concerns up and down the country about where the money was going to come from. In Bradford, they saw the bigger picture. The arrival of a simpler, albeit more expensive, anticoagulant created an opportunity to redesign the DVT care pathway. Patients who suffer a DVT can now be treated entirely in primary care. As a result, the local commissioners need not worry how to pay for the drug since, overall, they are saving. Pharmacists from Bradford CCG share their experiences in this issue of Spotlight.

Also sharing her experiences is Michelle Cossey. She led the development of the shared decision making programme in North Yorkshire and Humberside (think: “no decision about me without me”). She offers suggestions for others on where to start, what barriers need to be overcome and what help is available.

Finally, GP Adrian Penney shares with us his view on the work done by primary care pharmacists. On the whole, he is pro-pharmacy; although he understands how tensions can develop between pharmacists and GPs. For those struggling to get GPs to engage, he offers constructive suggestions on how to develop a symbiotic relationship with your local practitioners.

Enjoy!

Gareth Malson
Editor, Spotlight

Ever wondered whether it would be beneficial to make a pharmacist a partner in a GP practice? A practice in Croydon has done just that. Rena Amin, the pharmacist in question, describes the benefits of her role in an article in the Pharmaceutical Journal.

If you have an interesting role that you think other pharmacists might like to hear about, let us know.
No decision about me without me

So goes the NHS mantra on patient involvement in healthcare. In theory, it’s a no-brainer: why shouldn’t patients be involved in decisions about their care? Historically though, in practice, most patients have been silent partners when decisions were made. Given the lack of engagement patients have with these potentially lifestyle-changing decisions, is it any wonder that half of them are not able to take their medicines as instructed?

Times are changing however. The Government wants the NHS to deliver the best healthcare outcomes. This can only be realised by involving patients fully in their own care, with decisions made in partnership with clinicians.

Spotlight talks to Michele Cossey, former associate director for pharmacy and prescribing for NHS North Yorkshire and the Humber, about her experiences in leading the regional shared decision making (SDM) programme.

What is shared decision making?

SDM is far more than just obtaining patients’ informed consent, or giving them a choice of healthcare provider. It is an interaction where both patient and clinician are equal partners and can voice their opinions, and where an agreement is reached on the most appropriate treatment option or intervention for that patient. One of the aims of the national SDM programme is to move away from the traditional, paternalistic clinician-patient relationship.

It’s not to say that we should ignore the knowledge and experience of clinicians. They still:

• Make the diagnosis
• Provide understanding of the disease aetiology and prognosis
• Present the treatment options and the probability of treatment outcomes, and any associated side effects

However, different patients will have different experiences of illness, social circumstances, attitudes to risk, values and preferences. We have to allow these factors to be incorporated when deciding which treatment or intervention is best.

As part of the SDM process, conversations need to be clearly documented so that earlier decisions can be understood at future appointments.

SDM should also be applied to wider aspects of care. Greater patient consultation and involvement should be sought whenever care pathways are reviewed or changed.

What are the benefits of shared decision making?

Evidence suggests that where SDM is properly implemented, patients are more likely to achieve better outcomes from treatment and be more compliant or engaged with it. They also tend to have stronger, more open relationships with their clinician, are less likely to change their mind about treatment and less likely to complain about their care.

What needs to happen to implement shared decision making?

First and foremost, an agreement needs to be reached among all health professionals that SDM should become part of day-to-day practice. For those involved in planning and delivering healthcare pathways, greater awareness of the tools and techniques available to better deliver SDM is important.

Changing NHS culture is probably the most challenging aspect of implementing SDM. Better education and training for clinicians is necessary at both undergraduate and postgraduate level.

Raising patient awareness is equally important. Awareness campaigns, including the use of leaflets and posters is one approach, as is the use of social media. Patients also need access to easy-to-understand, quality information to help them evaluate the choices available to them. This may need to be available in several formats.

What barriers are there to implementation, and how can they be overcome?

Extra time is needed - both to have the discussions necessary for SDM to take place and to document them. Consultation styles and patterns may need to be re-thought. Using the wider healthcare team may enable SDM discussions at key “decision points” in care pathways.

There can be professional reticence towards the concept: some practitioners feel it isn’t something that patients want, others will think they are already doing it - but they are not.

Patient confidence and better engagement is another barrier. Patients and the public need confidence to ask questions and query the options they may have. They shouldn’t feel like they are being led towards one option, as different patients may choose different options for the same condition. SDM won’t be for everyone; but it should be available to all.

It may be possible to financially incentivise clinicians to implement SDM. This can be done by using local quality premia, such as CQUIN payments, through QIPP targets or by building a requirement into service contracts.

What tools are available to enable implementation?

There are 38 patient decision aids currently available on the NHS Shared Decision Making website: (http://sdm.rightcare.nhs.uk) These cover a range of interventions and treatment options for several common conditions. Patients can use the aids to work through the treatment options available to them, incorporate their own views, weigh up the pros and cons of each option and then make a decision. A summary can then be printed. The aids are available online, in paper format and through an app compatible with Android or Apple smart phones.

There are several resources and tools for clinicians, commissioners and providers available on the SDM section of the NHS RightCare website (www.rightcare.nhs.uk). These range from patient engagement tools to examples of how SDM can be embedded into care pathways and commissioning processes.

Michele Cossey is Director of Independent Health Partner Limited

E: mcossey@independenthealthpartner.co.uk
From the PCPA

Membership survey

During the summer the PCPA conducted a survey of its members to find out more about what they want from the PCPA in terms of training and resources. Well over a hundred of you responded - thank you for taking the time to do this; your feedback is invaluable.

Your key priorities for the PCPA were that it enabled you to share best practice, promoted the role of primary care pharmacists and provided networking opportunities and training. Our activities over the next 12 months will continue to reflect these priorities.

Your top two training priorities were medicines management for patients recently discharged from hospital, and polypharmacy and prescribing. We are planning two workshop days in early 2014 focusing on ‘Polypharmacy and medicines optimisation in older people’, and will be in touch shortly with further information on these.

Networking

The PCPA continues to network on our members behalf. In addition to our recent involvement at the Clinical Pharmacy Congress and the Commissioning Show, our chair Duncan Petty was involved in a keynote theatre debate entitled “Is pharmacy fit for purpose - the primary care view” at the Pharmacy Show, which took place on 30 September in Birmingham. We hope you were able to join in the debate.

Competency Framework

We are progressing our work with the Royal Pharmaceutical Society to develop a competency framework for primary care pharmacists. Thank you to all who forwarded us their job descriptions to assist us in this activity - if you still wish to do so, please email a copy to michelle@pcpa.org.uk

We will be uploading some of these onto our website to assist members. Any uploaded job descriptions will be anonymised.

Resources

Our regular Medicines Matters newsletter, providing a round up of highlights from member’s local CCG newsletters, has continued to be produced. In addition, two new resources have recently been developed - these are an update on the new NICE medicines and prescribing (MPC) associates and a document put together by our chair, Duncan Petty, detailing key learning points for primary care pharmacists from the Commissioning Show. All of these resources can be found under the members section of our website: www.pcpa.org.uk

Medicines optimisation update

The Royal Pharmaceutical Society is continuing to push forward the medicines optimisation (MO) agenda and has been working closely with NHS England and the ABPI. Any pharmacists wanting to contribute to this work, or share successes and ideas relating to MO, are encouraged to contact Liz Butterfield, MO lead for the RPS English Board: lizbutterfield@wood-field.co.uk. She welcomes the opportunity to visit areas that have demonstrated success.

For those keen to develop their understanding of MO, or to integrate it into services they provide or commission, the RPS has produced:

- A guide for patients on making the most of their medicines: http://www.rpharms.com/promoting-pharmacy-pdfs/patients-making-the-most-of-medicines.pdf

More guidance on specific therapeutic areas, starting with diabetes, cardiovascular, respiratory and mental health, will be published in January 2014.

The English Board has also set up a commission to develop practical ideas about how future models of care can be delivered through pharmacy: http://www.rpharms.com/leading-on-nhs-reforms-for-pharmacy/models-of-care.asp

The commission will bring together expertise from across pharmacy, other healthcare professions, patients and the public. The final report will be published on 5th November 2013. Pharmacists are encouraged to ensure the positive messages within this report reach the attention of their local clinical commissioning groups.
In the first of a series of articles, GP Adrian Penney reflects on the challenges facing general practice and how pharmacists can help to shape the future

The NHS has undergone one of the biggest reforms in its history. This has meant great change for the healthcare professionals that work within it. For most, there has been a profound difference in the way they work. This is particularly true for pharmacists working in primary care.

Pharmacists can no longer do what they have always done and expect it to work. They need to think differently and adapt quickly to a rapidly changing environment. In his book “The age of unreason”, Charles Handy claims that if you put a frog in water and slowly heat it, the frog will let itself be boiled to death. Handy claims that humans, if not careful, can respond to change similarly.

I have had variable experiences working with pharmacists over the years; the most productive relationships are where there is true respect, practical visible outcomes, simplification of work-flows and shared learning.

**Historical context**

In the early 1990s, changes began to occur that caused GPs to move from being autonomous to having to quantify their service provision.

In 2004, the new GP contract introduced a greater demand for information about the activity of GPs. Data gathering became more formal and computerised analyses of ‘quality’ markers were done. However, GPs had a limited respect for the data and how it was interpreted.

These changes were the first overt review of activity and often were handled with a confrontational and top-down approach. Many GPs felt this challenged their rights and responsibilities to act as independent professionals. This belief, and the self-employed nature of GPs, influences their response to the changes within the NHS.

**Present challenges and the role of pharmacists**

There are several challenges facing general practice today. There is a sense among GPs of being expected to take increasing risks and responsibilities for patients despite increasing restrictions and lack of support for our clinical experience and integrity. This can create difficulties for pharmacists if they subsequently receive unenthusiastic or hostile reactions to the work they are commissioned to do.

This need not be the case if both sides can find common goals and work together to achieve them. The key issues, and potential opportunities, are summarised below:

- **GP referrals, admissions and A&E use is being scrutinised heavily and we are being asked to reduce this in a more structured way than previously. Pharmacists can help GPs to identify and review patients who are likely to have unplanned hospital admissions - eg, older people on 4 or more medicines, patients with kidney disease and those taking high-risk drugs (eg, DMARDs)**
- **GP are being asked to provide considerable amounts of (often irrelevant) evidence for our clinical activity to satisfy the Quality and Outcomes Framework and the Care Quality Commission. Few GPs have any interest in writing reports or audits, nor do they have the skills to do so. If pharmacists are performing prescribing audits, consider how this could link to the practices QoF targets. It will probably provide evidence for standard 9 of the essential QoF targets. Do this, and GPs will be more receptive to your work.**
- **GPs are required to record evidence of reflection for both peer appraisal and revalidation, although many will admit that they struggle to do so. If, having conducted an audit, pharmacists can present the results in a structured reflective template, it can provide evidence of reflection for the GP’s appraisal**
- **GPs are required to manage patients with increasingly complex medical, social and psychological needs. Pharmacists can bring valuable expertise to the medicines management of these patients. They are also valuable at building bridges between primary care and secondary care because they can navigate prescribing systems effectively.**
- **A major skills gap is developing in general practice that will worsen over the coming years. GPs from the baby boomer generation, who have always worked full time, are retiring and the new generation seem to prefer a work-life balance and part-time hours. For pharmacists, however, this creates a growing opportunity for those who are independent prescribers to take responsibility for chronic disease supervision**
- **GPs are often isolated and can stop thinking pragmatically and with perspective. Pharmacists can offer a valuable external perspective and challenge their thinking. However, this can only occur where there is a mutual trust and respect - which takes time to develop**

In my view, general practice is the best job in the world. I think that, in the future, pharmacists should be a recognised part of that.

In the next article we will discuss practical ways in which pharmacists can collaborate with GPs on common goals.
Transforming the treatment of DVT
(article continued from the front page)

to several useful amendments that made the pathway more readily adoptable in primary care.

The new pathway

GPs faced with a patient with a possible DVT assess its likelihood using the Wells scoring system and a D-dimer test - the results of which are usually available on the same day. Where these assessments suggest a DVT is likely, the patient is referred for an urgent ultrasound at the local acute trust. This test confirms the presence (or not) of a DVT.

Patients with a suspected DVT are initiated on rivaroxaban by the GP. If the ultrasound is negative, patients are advised to stop treatment. If positive, they are advised to continue. Complex or high-risk patients can still be sent to the medical admissions unit for management, if necessary.

The pathway has also been adopted by the local A&E department. They discharge patients with DVTs to their GP for ongoing management - only admitting those at high risk.

Financial planning

In addition to clinical agreement on the pathway, it was necessary to ensure that the changing nature of workflow was reflected in contracts with providers. There was a need to ensure that the income flow into secondary care reflected the work done by the different departments - in effect, moving income into radiology from A&E and the admissions unit.

Also, patients diagnosed with a DVT require review by haematology. This occurs in an outpatient clinic where a consultant haematologist and clinical pharmacist determine any underlying causes for the DVT and the duration of treatment required. This requires the clinic to access the patient’s primary care record. In Bradford, all GP practices use TPP SystmOne - which the hospital can access.

Outcomes

Locally, there is strong clinical consensus that the new pathway is of high quality, safe and more convenient than its predecessor. Given the higher levels of compliance with a simpler pathway and ‘easier’ treatment, better clinical outcomes and reduced medicines waste are anticipated.

Initial feedback from patients is that it works for them and their families, with patients avoiding hospital admission. During the first 18 weeks of the pathway, 269 patients underwent over 400 scans. All patients were managed by their GP and 33 patients tested positive for a DVT. After taking account of the costs of ultrasound scanning and prescribing, a £51,000 saving has been generated.

A full clinical audit of the impact of the changed pathway is underway.

Financial implication

We estimate a need for 1,900 D-dimer tests per year, with approximately 1,300 patients being referred to radiology for an urgent scan. Our estimate of the net cost of diagnostics is £77,500.

Of this, we estimate 446 patients will be diagnosed with a DVT and the increased cost of prescribing rivaroxaban will be £150,000. Thus the additional costs associated with operating the new pathway, in a population of 440,000, is £227,500.

However, by treating patients in primary care, we expect to save £140,000 that was previously spent on anticoagulant clinics and £600,000 on avoiding hospital admissions. Therefore, we predict that implementing this pathway will, overall, save £512,500 per year.

Future developments

We plan to establish a financially sustainable means of community D-dimer testing. This is not currently available without pathology support. We are exploring the use of community hubs to enable point-of-care testing without the need to send samples to a laboratory.

We also plan to develop the pathway for low risk patients with suspected pulmonary embolisms.

Want to know more?

This work can be replicated elsewhere easily and readily. The pathway would simply need to be localised, obtain clinical agreement and ensure that contracts reflect workflow.

For more information, contact Clare Smart, Head of Service Improvement at Bradford Districts and City CCGs.

E: Clare.Smart@bradford.nhs.uk

QIPP update

The NHS Improvement website (www.improvement.nhs.uk) the Department of Health’s website dedicated to the QIPP programme, has now closed down. Instead, NHS England has created NHS Improving Quality (www.nhsig.nhs.uk) to facilitate “successful improvement programmes” and provide a domain to share best practice. It promises to learn from the experiences of the various former national improvement teams (eg, National Cancer Action Team, NHS Diabetes and Kidney Care, NHS Improvement). NHS Improving Quality’s objectives centre around five domains:

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

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