Support for commissioning for varicose veins in the legs

Support for commissioning
Published: 14 August 2014
nice.org.uk

Overview and resources

This resource helps with quality improvement by providing information on key clinical, cost and service-related issues to consider during the commissioning process and signposting other implementation support tools.

More information about NICE support for commissioning.

Use the NICE pathway on varicose veins in the legs for fast access to NICE guidance and implementation resources to support commissioning for this condition.

Why the quality standard on varicose veins in the legs is needed.

Who is responsible for commissioning for varicose veins in the legs?

- Clinical commissioning groups (CCGs) all services for people with varicose veins in the legs.

Who should CCGs work with?

- CCGs should work in partnership with GPs and secondary care providers to improve the quality of care for people with varicose veins in the legs. Secondary care providers are anticipated to be local hospitals.
CCGs may find the Royal College of Surgeons' NICE-accredited commissioning guide on varicose veins helpful in reviewing their commissioning. The guide is designed to help CCGs make decisions about appropriate healthcare for specific clinical circumstances.

More information about using NICE quality standards to improve practice.

The quality statements and their commissioning and resource implications

Quality statement 1: Referral to a vascular service

People with varicose veins that are causing symptoms or complications (including ulceration) are referred to a vascular service.

Rationale

If left untreated, varicose veins will continue to cause symptoms that affect quality of life, and may progress to bleeding, skin damage and ulceration. Referral to a vascular service is a first step to interventional treatment for varicose veins that can relieve symptoms and slow disease progression, thus improving people's quality of life. In some localities interventional treatment for varicose veins has been wrongly identified as being of low clinical value and this has resulted in constrained and highly variable local referral criteria. These commissioning constraints, along with an absence of national evidence-based guidance, have led to variation in referral patterns across the country.

Commissioner and provider actions

- CCGs and local secondary care providers should ensure that GPs have a pathway for referral to local vascular services so that people with varicose veins that are causing symptoms or complications are referred and people with bleeding varicose veins are referred immediately.

- CCGs and local vascular services should work together to ensure that there is sufficient capacity commissioned and available to refer people with varicose veins that are causing symptoms or complications to a vascular service.

- CCGs should monitor levels of referrals to local vascular services for varicose veins and associated waiting times.

- The costing report developed alongside NICE clinical guideline 168 forecast that referrals and procedures would increase by up to 25%. CCGs may wish to review local referrals and procedures in light of this forecast and review local progress on anticipated change in referrals.
CCGs may need to adjust financial plans for an increase in the number of referrals and associated procedures depending on progress made.

Estimated resource impact

The costing report developed alongside NICE clinical guideline 168 estimated an additional cost of £9000 per year per 100,000 population. This is due to expected increases in the first and follow-up outpatient appointments within vascular services, and due to the expected increase in the number of interventional procedures carried out to treat varicose veins, as a result of this standard.

Quality statement 2: Duplex ultrasound

People with varicose veins who are seen by a vascular service are assessed with duplex ultrasound.

Rationale

Duplex ultrasound is a non-invasive scan used to image the blood vessels of the body. It provides detailed information that helps to confirm the diagnosis and pattern of venous disease and determine which type of treatment will be most clinically and cost effective (see quality statement 3). The handheld doppler is still used in some services, but is outdated and does not provide the detailed, accurate information produced by duplex ultrasound.

Commissioner and provider actions

- CGGs should specify that people with varicose veins who are seen by a vascular service have their diagnosis and type of treatment confirmed with duplex ultrasound.
- Local vascular services should confirm diagnosis and type of treatment with duplex ultrasound for people with varicose veins in the leg.
- Local vascular services may wish to use the clinical audit tool developed alongside NICE clinical guideline 168 to assure CCGs that people with varicose veins who are seen by a vascular service are assessed with duplex ultrasound.

Estimated resource impact

The use of duplex ultrasound is not anticipated to have a significant cost impact. The economic analysis in NICE clinical guideline 168 full guideline (page 86) indicated that the cost of a scan using
handheld doppler was £25 compared with £53 for duplex ultrasound. Expert opinion suggests this equipment is available however is not always used.

**Quality statement 3: Treatment of varicose veins**

People with confirmed varicose veins and truncal reflux are offered a suitable treatment in this order: endothermal ablation, ultrasound-guided foam sclerotherapy, surgery, compression hosiery.

**Rationale**

Historically, surgery and compression therapy were the only treatments available to people with varicose veins, but in recent years other treatments, including endothermal ablation and ultrasound-guided foam sclerotherapy, have been developed. These newer treatments are less invasive than surgery, promote faster recovery and involve shorter hospital stays. Not all treatments are suitable for all people and therefore it is important that the person’s needs and preferences are also considered when deciding which is the most suitable treatment.

**Commissioner and provider actions**

- CCGs should ensure that vascular services have a full range of services so that people with varicose veins are offered the most suitable treatment, taking account of the person’s needs and preferences and clinical condition.

- CCGs and vascular services should work together to ensure that endothermal ablation, ultrasound-guided foam sclerotherapy and surgery are available and offered as set out in quality statement 3, taking account of the person’s needs and preferences and clinical condition. Compression hosiery should be offered only if these treatments are not suitable or are declined by the person.

- The costing report developed alongside NICE clinical guideline 168 estimated that procedures would be undertaken in the following proportions: endothermal ablation (70%), ultrasound-guided foam sclerotherapy (25%) and surgery (5%). CCGs may wish to review local services in light of this estimation.

- Local vascular services may wish to use the clinical audit tool developed alongside NICE clinical guideline 168 to assure CCGs that people with confirmed varicose veins and truncal reflux are offered treatments as set out in quality statement 3.
Estimated resource impact

The Payment by Results national tariff price is the same for each of the 3 procedures, because all 3 procedures currently map to the same Healthcare Resource Group. However, the health economics model in NICE clinical guideline 168 full guideline (section 9) showed variations in the cost of each procedure.

Using this economic analysis, the costing report developed alongside NICE clinical guideline 168 estimated there would be a saving of £7800 per year per 100,000 population.

Savings are achieved because endothermal ablation and ultrasound-guided foam sclerotherapy are less invasive than surgery, promote faster recovery and involve shorter hospital stays.

Commissioners and providers may wish to discuss at a local level how savings and benefits from this change in practice are used.

Disclaimer

This resource provides support for the local use of NICE quality standards. It does not constitute formal NICE guidance. Each resource should therefore be used in conjunction with the relevant NICE quality standard and current national guidance on commissioning.

Copyright

© National Institute for Health and Care Excellence 2014. All rights reserved. NICE copyright material can be downloaded for private research and study, and may be reproduced for educational and not-for-profit purposes. No reproduction by or for commercial organisations, or for commercial purposes, is allowed without the written permission of NICE.