

### Written evidence from Neil Munro

In the South East Coast our strategy has been to reverse the poor state of neurology. The primary problem is that the hub and spoke model is out-dated. Too few resources are distributed unfairly. Only 11% of neurological conditions have a care plan. Few patients admitted with a neurological disease are admitted under the care of a neurologist; most DGHs do not have dedicated inpatient beds. Even in regional neuroscience centres and those few DGH's that do have dedicated beds there are not enough beds so most patients are not admitted under the care of a neurologist.

| Number of sites                        | Total    | With specialist registrars at site | With dedicated neurology beds |
|--|----------|------------------------------------|-------------------------------|
| Neuroscience Centre                    | 31 (16%) | 31 (100%)                          | 31 (100%)                     |
| Neurology Centre                       | 19 (10%) | 18 (95%)                           | 14 (74%)                      |
| DGH with neurologists based at them    | 69 (35%) | 24 (35%)                           | 9 (13%)                       |
| DGH with no neurologists based at them | 76 (39%) | 2 (3%)                             | 0                             |
| Total                                  | 195      | 75 (38%)                           | 54 (28%)                      |

Good neurological care is only available in 16% of our hospitals and even in those hospitals there are so few beds that most neurological inpatients are still under the care of "general physicians" (ie respiratory physicians, gastroenterologists, cardiologists and geriatricians who do acute medical take). Access to these neuroscience centres is poor.

It is well appreciated that access is poor but less well appreciated that the status quo is highly inefficient and costly. There is no understanding of even the relevance of queuing theory, so demand capacity ratios are so poor that most patients spend their time waiting: waiting for admission, waiting to see doctors, waiting for tests, and waiting to go home. The ward visiting model, means that patients may wait days for a visit from a neurologist, then days for tests, days for review. In an inpatient neurology ward this cycle can be reduced from days to hours.

We know that the dramatic reduction in stroke mortality was achieved not through thrombolysis but by putting stroke patients on stroke wards. So having patients strung out in various hospital ward, under different specialists, reviewed by different neurologists leads to poorly organised care.

The model we propose is,

1. Close cooperation with stroke medicine
2. Put neurology beds in DGHs adjacent to HASUs which will reduce LOS and enable the 5yfv to be implemented with outreach nurses and seamless primary/secondary care via networks. The nidus of neurologists associated with an inpatient unit forms an important node on the LTC network.
3. Economies of scale achieved by sharing neurology-stroke on-call/acute neurology take with stroke physicians
4. Only modest numbers of additional neurologists are required but some additional nurses are required

This can be driven by 4 national CQuINs/PbR

1. Premium for having neurology patients under a neuro-expert on a neuro ward (ie neurologist or stroke physician)
2. CQuIN for care plans for neuro LTCs (of appropriate standard with clinically responsible coordinator – usually specialist nurse)
  - a. This will drive the recruitment of recommended numbers of specialist nurses which we know reduce admissions
  - b. It will drive the development of LTC networks
3. There should be a CQuIN on urgent neuro outpatients. For example a CQuIN demanding 30% (or a given number per capita) should be seen within 2 weeks. (The reality is that nearly everyone is seen just in time to meet 18 week target – but there are real concerns of the data validity on when a patient is treated). This means putting neurologists into TIA clinics and renaming them acute neurology clinics – which is what they are. This would enable first seizures to be seen within NICE guideline of 2 weeks – of which only 14% of Trust meet. Because waiting times are so poor, patients get seen by a non-neuro consultant (or worse admitted) before being referred onto a neurologist.
4. A CQuIN on standards for correspondence – a 4-6 week wait to get correspondence out is dangerous and highly inefficient.

For SEC pop 5m) about £75m is spent on ~ 70,000 inpatients with neurological disease: 1/3 primary and 2/3 mentioned as a second diagnosis. The second category often have illnesses like infections that may reflect the neurological disease and potentially preventable by better LTC networks. It's hard to be certain but an investment of ~£12m has the potential to save much more than this on acute admissions and elevate the care in the community.

The South East Coast, SCN for neurology has been disbanded (possibly temporarily) due to lack of funds.

*Consultant Neurologist*

*Formerly SCN lead Acute Neurology for South East Coast, NHS England*

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## **Annex A**

[http://www.secsn.nhs.uk/files/6014/4171/2203/Reccomendations\\_for\\_improving\\_neurology\\_care\\_in\\_the\\_south\\_east - August 2015.pdf](http://www.secsn.nhs.uk/files/6014/4171/2203/Reccomendations_for_improving_neurology_care_in_the_south_east_-_August_2015.pdf)

## Annex B

We agree with Dr. Morrish's analysis of the parlous state of British Neurology. Too few resources are distributed unfairly. Only 11% of neurological conditions have a care plan<sup>1</sup>. Few patients admitted with a neurological disease are admitted under the care of a neurologist; most DGHs do not have dedicated inpatient beds. Even in regional neuroscience centres and those few DGH's that do have dedicated beds there are not enough beds so most patients are not admitted under the care of a neurologist.

Dr. Morrish may be correct that there should be an enquiry but that should not delay taking action now.

There have already been a number of reports clearly setting out the problems. In 1996, the RCP "*The district general hospital as a resource for the provision of neurological services*"<sup>2</sup>, was followed by two further reports in 2002 and 2003 from the Association of British Neurologists.<sup>3,4</sup> We have had the National Service Framework for long-term conditions<sup>5</sup>, a report from the All Party Parliamentary Group on Epilepsy. "*The human and economic cost of epilepsy in England*" (subtitled – "wasted lives wasted money"),<sup>6</sup> a report from House of Commons Committee of Public Accounts committee,<sup>7</sup> and follow-up from the National Audit Office<sup>2</sup>, several NICE guidelines including guidelines on multiple sclerosis, epilepsy, and Parkinson's disease. There has been another comprehensive report from the Royal College of Physicians: "*Local adult neurology services for the next decade: Report of a working party*".<sup>8</sup> There have been a number of excellent reports from the patients' representative charity, the Neurological Alliance most recently: "*The invisible patients. Revealing the state of neurology services.*"<sup>9</sup>

Of these documents, the report from the RCP sets out clearly *what* should be done and now two further reports on the NHS, Keogh<sup>10</sup> and the 5yfv<sup>11</sup> indicate *how* it should be done.

For the purposes of comparison with Europe, there are now about 950 consultants with neurological expertise "neuro-experts", 746 neurologists<sup>12</sup> and about 200 stroke physicians<sup>13</sup>. The latter group manage 75% of acute stroke and support 7day "TIA clinics" where only about 30% of patients have TIAs. This represents 1: 67,000, compared to 1:15,000 in Europe. Keogh has cited the advances in stroke care in London by having HASUs support a population of ~1m, so that 7-day working is possible. In more rural districts, the requirements of a short symptom to needle time for thrombolysis is likely to make HASUs supplying a population of 500,000 to 700,000 more realistic implying about 100 HASUs in the UK. 200 stroke physicians cannot provide 7 day working on 100 HASUs even if the, currently, 50 vacant posts are filled. The logic of this is that, like in most regional

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<sup>1</sup> Department of Health and NHS England: Services for people with neurological conditions: progress review JULY 2015

<sup>2</sup> Royal College Physicians. *The district general hospital as a resource for the provision of neurological services*. London: RCP, 1996.

<sup>3</sup> Association of British Neurologists. *Acute neurological emergencies in adults*. London: ABN, 2002.

<sup>4</sup> Association of British Neurologists. *UK neurology – the next ten years*. London: ABN, 2003.

<sup>5</sup> Department of Health. *The National Service Framework for long-term conditions*. London: DH, 2005

<sup>6</sup> The All Party Parliamentary Group on Epilepsy. *The human and economic cost of epilepsy in England*. London: Joint Epilepsy Council of the UK and Ireland, 2007.

<sup>7</sup> House of Commons Committee of Public Accounts. *Services for people with neurological conditions*. 72nd report of session 2010–12.

<sup>8</sup> RCP and ABN: *Local adult neurology services for the next decade: Report of a working party*, 2011

<sup>9</sup> Neurological Alliance. *The invisible patients. Revealing the state of neurology services*. 2015..

<sup>10</sup> *Transforming urgent and emergency care services in England, Urgent and Emergency Care Review* Keogh 2013

<sup>11</sup> *NHS Five Year Forward View*

<sup>12</sup> *RCP Census of Consultant Physicians and Higher Specialty Trainees: Neurology 2013-14*

<sup>13</sup> *RCP Census of Consultant Physicians and Higher Specialty Trainees: Stroke Medicine 2013-14*

neuroscience centres, neurologists in the DGHs must share in the care of stroke patients and that there will need to continue to be an expansion in consultant numbers.

The introduction of thrombolysis galvanised the radical reform of stroke care in the UK but it has not been the introduction of thrombolysis, per se, that has been the major factor in reducing stroke mortality. Rather it is the caring of stroke patients by expert doctors, expert nurses in Stroke wards, managing complications and risk factors that has improved care. So it must be in non-stroke neurology. The report : *“Local adult neurology services for the next decade”* recommends:

*R3 The DGH should have an acute neurology ward area, led by a consultant neurologist with specialist staff. Consideration should be given to locating this ward next to the acute stroke unit to allow for the sharing of specialist medical staff, nurses and allied health professionals.*

Unsurprisingly, evidence does support the contention that when patients are managed by those trained in their disease, diagnosis is more accurate. Aside from this we are reminded in 5yfv, that care is centred on the patient and patients want to be managed by those trained to manage their disease. The alternative to a neurology ward is the status quo: a 7 day ward referral service in only 8 out of 164 (6%) DGHs (hospitals that are not one of the 31 designated Neuroscience centres) and 3 or fewer days for ward referrals in 38% of all hospitals<sup>14</sup>. The treating team is usually not present during these consultations and there is no data on how many patients receive return visits. There are compelling reasons to suppose that when patients are managed by a consultant doing daily, 7 day, ward rounds, with good and quick access to investigations, on a specialist unit with expert nurses and MDT clinical decisions will be better and faster, and length of stay reduced. Because we have few DGHs have neurology wards which function with appropriate resources, evidence is sparse but anecdotal evidence from Plymouth suggests a 7 day reduction in LOS from 13 days is possible<sup>15</sup>. 5yfv proposes a number of elements which address the failures in neurological service.

- Empowerment of patients with services that are integrated around the patient.
- networks and systems of care with an emphasis of out-of-hospital care and prevention
- Community involvement
- New ways of working including Information Technology
- Emphasis on efficiency and cost effectiveness

The patient is the master of the care plan. It is the contract that ensures good care in the community and pivotal to patient centred care. The named coordinator of the care plan works with the patient to support every aspect of their life and is responsible for meeting care-plan standards. Delivery of care in the community is dependent on well-designed networks led by specialists. Only the rudiments of these networks exist with only 11% of patients with LTCs having care plans. Few Trusts have the recommended number of specialist nurses and opportunities to coordinate and link networks with generic nurses with community involvement. Consultant led inpatient units provide the platform for the development of these networks with models that include outreach nurses to coordinate more ambulatory care and intensive “hospital-at-home” treatment and monitoring facilitating early discharge.

Implementing this now will save money. In the South East Coast, for example, population 4.9m, in 2013-14 there were 66,000 admissions citing one of the top ten neurological diagnoses. This cost £72m of which £22m was for a primary neurological diagnosis, where the neurological diagnosis was the main reason for admission, and £50m for secondary diagnoses. Where the neurological diagnosis was secondary, the primary diagnosis was often, urinary or respiratory infections, falls or collapses and therefore attributable to the secondary diagnosis and potentially preventable from good community care. For primary diagnoses, avoiding admission or reducing the length of stay by

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<sup>14</sup> Association of British Neurology. ABN acute neurology report. 2014.

<sup>15</sup> Steven Allder: My cure for the NHS, Daily Telegraph May 2013.

5 days would save ~£10m. Preventing avoidable admissions in, say, a quarter of secondary admissions would save a further £12.5m.

To achieve this, in the South East Coast, the number of consultant neurologists would need to be increased from 1:110,000 to 1:70,000 – about 30 neurologists, which with 30 secretaries, and on-costs would cost about £4.5m. A full complement of specialist nurses to support effective community networks would need to be increased from the existing 50 nurses, to 200 nurses at an annual cost of £8.5m. So for an increased annual expenditure of around £13m, there are potential savings of £22.5m

| <b>Nurses</b>            | <b>Per<br/>100,000</b> |
|--------------------------|------------------------|
| <b>PD nurse</b>          | <b>0.6</b>             |
| <b>MS nurse</b>          | <b>0.6</b>             |
| <b>Epilepsy nurse</b>    | <b>1.8</b>             |
| <b>Generic neurology</b> | <b>0.4</b>             |
| <b>Headache</b>          | <b>0.6</b>             |
| <b>Inreach/outreach</b>  | <b>0.3</b>             |
|                          | <b>4.3</b>             |

To fire this process up, two national initiatives are required. First, there needs to be a national CQINS requiring all patients with a neurological LTC to have a high quality care plan, with appropriate rigorous governance and supporting database. Meeting this target could only be achievable with the recommended number of specialist nurses. Second, like stroke patients admitted to stroke wards there needs to be a national PbR (perhaps coupled with a national CQINS) to ensure all patients admitted with a primary neurological diagnosis are admitted to a neurological ward with a “neuro-expert’s” name above the bed.