

Separating Diagnostic Neurology from Management of Long-Term Neurological Conditions: A new concept of service delivery



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Imagine admitting a 22-year-old with a stroke. After the initial management, would you prefer to refer him to the local stroke unit or to the neurological rehabilitation unit? Some will prefer the stroke unit where protocols for investigations and assessment are in place. Other clinicians would say that a neurological rehabilitation unit will have more appropriate expertise to meet the needs of a young person with a neurological insult.

The opinions will show the traditional dilemma: should we manage the patient according to his pathology or according to his needs? Many people would feel that the key determinant is the stage of the neurological condition. In the early stage, the focus is on accurate diagnosis, medical stability and interventions that may improve the outcome for scenarios such as thrombolysis for stroke or immunoglobulins for Guillain Barré Syndrome. This necessitates a pathology orientated service provision. The longer the duration of the condition, the more the emphasis shifts to a rehabilitation emphasis with clinical, emotional, social and vocational needs taking centre stage.

This argument begs the question: Is it in the best interest of the patient to have a pathology focused service provision such as Stroke service, Multiple Sclerosis service etc where diagnosis, early interventions and long-term management are combined or is it more appropriate to separate the diagnostic/early intervention service where rapid access, sophisticated investigations and prompt interventions are priorities from long-term management where concepts such as case management, interdisciplinary work and care plans should prevail?

Bolton: Catalysts for change

Royal Bolton Hospital (RBH) is the provider of secondary care for 265,000 Bolton residents. It used to contract consultant neurologists sessions from the regional neuroscience centre based in Salford, 10 miles to the south.

In 2005-2006 the UK government adopted two new strategies to improve the quality and productivity of the health services. These were 'targets-driven service delivery'¹ and adoption of the market forces in health economy using Adam Smith's invisible hand² to improve productivity and efficiency.

RBH struggled to meet the new target of a maximum of 16 weeks waiting for new clinic appointments for neurology patients. They had to postpone or cancel many follow up appointments to meet this target. Unfortunately, this led to huge problems for patients with long-term neurological conditions such as epilepsy, Parkinson's disease (PD) or multiple sclerosis (MS) who needed regular follow ups or occasional prompt consulta-

tions. The community based neurological rehabilitation service found it difficult to access specialist neurology opinion for their patients.

To respond to the government's second drive to encourage health market economy, the regional neuroscience service based in Salford launched a new Centre for Assessment and Treatment (CATS) primarily for Salford patients. This new service integrated the work of the neurologists, neurosurgeons and neuroradiologists enabling them to have a standard patient's journey between GP referral and diagnosis of only few weeks.

The unacceptable delays for neurology follow up appointments galvanised Bolton PCT to rethink the whole ethos of service delivery. After wide consultation with the key stakeholders, Bolton PCT decided to commission the diagnostic neurological services to the Centre for Assessment and Treatment (CATS) based in Salford. Management of long-term neurological conditions moved to a new purpose-built community centre where all the members of the neurological rehabilitation team are based, including the medical team of consultant physicians and specialist nurses (Figure 1).

Implementation

Bolton neurological community team was recognised as the largest in the region, which provided a strong foundation on which to build. Bolton PCT took the opportunity, as it configured the whole service, to address other long standing issues, such as an inappropriate working environment and lack of neuropsychology support. The team moved to a new purpose made building (Figure 2) in 2009. This new physical environment provided adequate office space, excellent gym facilities and modern clinic spaces within the same building. A clinical neuropsychologist was also recruited in the same year.

Negotiations with regional neuroscience to purchase consultant neurology clinic time were successful. The three consultant neurologists doing a minimum of four clinics a week only for patients with long-term conditions, were more than the original neurological input provided in secondary care. Clinical time is also available to the neurologists to meet other members of the team or provide supervision to the specialist nurses. The consultant neurologist clinics were started in 2008.

A part time consultant in rehabilitation medicine has worked with therapists in joint clinics since 2002. These clinics were mainly for patients with complex disabilities or needing single specialist interventions such as chemodenervations. This joint clinic offered the therapists a chance to inform the medical assessment, and the manage-

Figure 1.

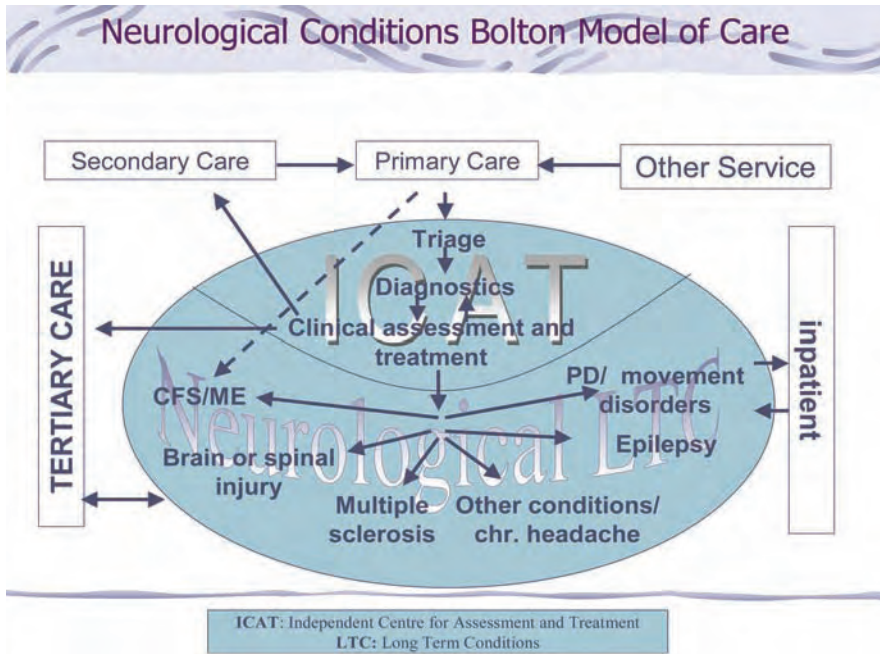


Figure 2.



Parkinson's Society, developed Bolton Neuro Voices (BNV) to act as a partner and supervisory body ensuring an effective way to communicate patients' views and experiences to commissioners and providers. BNV canvasses the views of patients and communicate them to the clinical teams during regular joint meetings.

Impact

We believe that our new model of service delivery for patients with long-term neurological conditions is leading to a significant improvement in quality and efficiency. Unfortunately, we will never be able to verify the amount of monetary savings as the traditional model was so chaotic that knowing the amount of money spent in the past was almost impossible.

However, our main objective was and still is to improve the quality of care. Formal audits showed improvements in Did Not Attend (DNA) rates (6.3% in December 2010) and patient satisfaction (100% score service as good or very good). The neurology clinics waiting lists were cut to a maximum of nine weeks.

Our service now complies with most of the quality requirements of the National Service Framework for Long-Term Condition (NSF/LTC) quality requirement 1.³ Concepts such as case management, one point of contact, care plans and patient involvement are integral to our service model.

The service model has also allowed for the development of several care pathways (Figure 3) which facilitated monitoring and audit on one hand and on the other hand minimised duplication and unnecessary referrals.

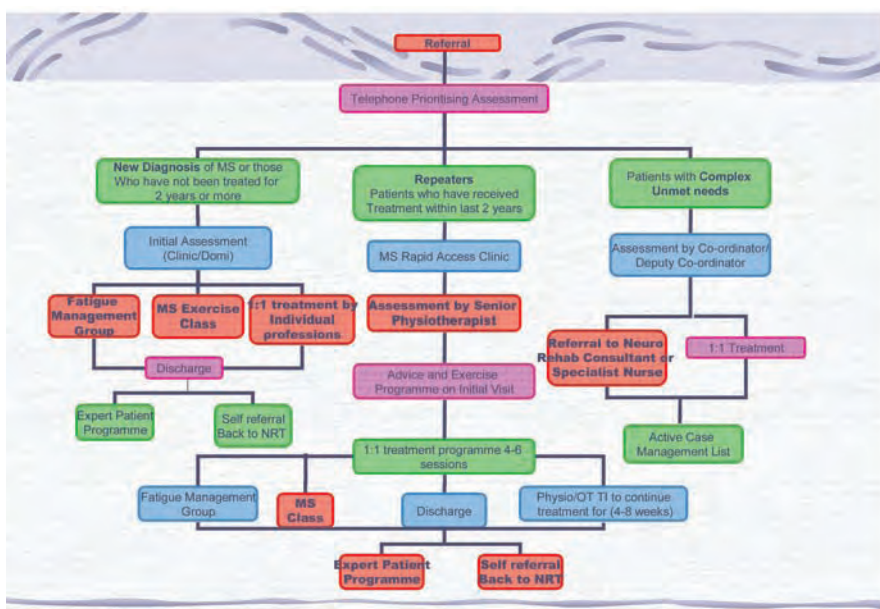
The future

Following the government advice to separate commissioning from provider arms, NHS Bolton the provider arm of Bolton PCT joined Royal Bolton Hospital Foundation Trust. Our new employer has expressed their commitment to our service and their desire to expand our model to cover the neighbouring districts. ♦

REFERENCES

1. Yong KK, Heymann T. Target centred medicine: targets can seriously damage your health. *BMJ* 2003; 327 (7416): 20
2. Adam Smith. *The wealth of nations: Inquiry into the nature and causes of the wealth of nations*. Hackett publishing company Inc. London. Abridged edition 1993
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Figure 3.



Condition	Suitable case manager
Brain injury	OT
MS	MS specialist nurse
Epilepsy	Epilepsy sp. nurse
Parkinson's disease	Parkinson's sp. nurse
CFS/ME	OT
Guillain-Barre Syndrome	Physiotherapist
School leaver's (cerebral palsy)	Physiotherapist / OT

ment plan is usually jointly formulated.

The key component of the service however was based on the concept of case management, which is provided by either specialist nurses for conditions such as MS, epilepsy, and Parkinson's disease, or OTs for brain injury (Table 1).

This team of specialist nurses / case managers is in the forefront of patient care. Their case load is between 600-1000 per nurse. Their case load is between 600-1000 per nurse. Easy access to specialist consultant advice or therapist opinion is the main factor enabling the case managers to cope with such a high case load. The concept of case managers also saved significant consultants' time as duplication of efforts was kept to a minimum.

The close relationship between the local services and the local patients' support groups was initially instrumental in recognising the scale of the problem. Representatives from the support groups, especially the Neurological Alliance and