Association of British Neurologists

ABN Advisory: Service Reconfiguration In Peri-Covid Period

Services and Quality Committee Recommendations
During the COVID pandemic, neurological services were profoundly altered. The ABN Services and Quality Committees gathered information during May and June 2020 in order to understand those changes, the areas of challenge and the opportunities to enhance services in the future.

On the basis of our findings, we make recommendations below for neurology services following recent events. The intention of these recommendations is to support our ABN members in local discussions. Where appropriate, we provide links to more detailed information, guidelines and evidence. We have aligned this work with the Neurological Alliance to ensure patient experience is central to reshaping services.

We recognise that the challenges to neurology services will change in the coming months. We will continue to assess progress and evolve the guidance accordingly.

This should therefore be read as a “live” document and comments are welcome.

The information in these recommendations is based on:

- Regional reports from all ABN Services representatives.
- ABN Services & Quality Committees joint meeting on service reconfiguration
- Clinical snapshot survey of a sample of neurology representatives

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<th>Version</th>
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## Recommendations

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<th>Outpatient</th>
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| **Advice and Guidance and enhanced triage systems should be developed** | - Consultant-led triage with tiered system  
- Full range of consultation options should be offered at triage  
- Dedicated consultant time job planned | - Triage to A&G, TC, video, F2F initially  
- Rapid phone review with GP where uncertain – GP hotline  
- Clear process and escalation pathway required |
| **Outpatient services should be tiered to fit the patient and the disease** | - Remote consultation offers advantages, but not appropriate for all patients  
- Higher risk for non-F2F needs active management  
- Provision for clinically vulnerable patients who need F2F appointments  
- Patient initiated follow up appropriate for select groups | - Consider individual patient, disease and clinician factors in triage arrangements  
- Clinician experience will alter risk profiles as will duration of pandemic and longer-term structural changes |
| **Clear escalation pathways are necessary** | - Phone-based triage at start, followed by appropriate escalation to other modalities where patient, disease or clinician factors suggest  
- Rapid escalation to F2F wherever needed  
- New and follow-up patients have differing requirements | - Phone-based triage to identify those patients requiring investigations  
- Some subspecialties will need mainly F2F appointments  
- Follow-up appointments may require mix of remote and in-person assessment depending on patient, disease and clinician factors |
| **Preserve enhanced communication with community care providers and patients** | - Hotline and virtual clinics with GPs  
- Ensure sufficient CNS/AHPs to staff triage and help lines  
- Responsive admin system to enable flexible timing if escalation appointment required | - Clarify referral purpose and urgency to improve quality, education and reduce risk of late presentation  
- Enhance ability of patients to contact service rapidly, reducing admissions |
| **Sufficient time required for appointments** | - Remote consultations need adequate time and generally no quicker than F2F appointments  
- Significant variation across patients, disease and technology | - Assign adequate time to set up video appointments pre-appointment  
- Learning curve for clinicians and patients  
- If appointment unsuccessful, need to be able to rapidly escalate to F2F |
| **Provide adequate service support** | - Access to hospital information systems required to access notes and investigations  
- Adequate video technology  
- Appropriate space (including access to the above) to conduct the clinic | - Sufficient information to manage patient expectations necessary  
- Improved booking systems needed to allow appointment flexibility in modality and timing, given escalation pathways |
| **Range of appointment types need to be maintained** | **MDT environment an essential part of clinical care**<br>Provision for linked specialty assessment important | **Utilise possibilities for enhanced consultation with video (remote family members, GP, other specialists)**<br>MDT clinic facilitated by video linkage |
| **Outcome monitoring essential** | Risk involved in rapid change without measurement of outcome | Should measure clinical safety and patient-based experience at a minimum |
| **Inpatient** | Use virtual consultation as adjunct to ward care<br>Maximise opportunity for facilitated discharge with closer integration social care and health care | Embed models with general medicine, palliative care |
| **Preserve enhanced multidisciplinary working and cross-specialty collaboration** | Attending system to AMU/A+E<br>Consultant-led hot clinics in A+E with one-stop investigations | Review tariff structure to resource acute inpatient work<br>Closer working with related disciplines beneficial |

Abbreviations:<br>A+E – Accident & Emergency, A&G – Advice and Guidance, AHP – Allied Health Professional, AMU – Acute Medical Unit, CNS – Clinical Nurse Specialist, F2F – Face-to-face consultation, GP – General Practitioner, MDT – Multidisciplinary Team, TC – Telephone consultation