Managing chronic conditions (epilepsy, Parkinson's, MS, NMD)

NHS South London Specialised Services Delegation Programme

There is significant post-code lottery, with community therapy teams having variable roles – e.g. different workforces, acceptance criteria. The pilot is aiming to address this through creating standard service specifications.

Examples of case management breaking down barriers include:

- Primary care epilepsy nurses that support GPs in prescribing specialist drugs locally, linking to tertiary care. Reduces unnecessary travel of patients to the Neurosciences Centre and direct medication advice for patients.
- Specialist care advisors identify deteriorating patients and escalate urgent cases for review, bypass barriers to facilitate rapid access to specialist input.
- Specialist care advisors work directly with community therapy teams - joint consultations, educate on rare conditions and management advice.

1. Specialised neurology is defined as activity delivered in a Neurosciences Centre (NC). This includes inpatient care, day cases, C2C OP attendances and prescribing high cost drugs.

2. Many Neurologists have a joint appointment at the NC and a DGH This provides DGH with super-specialist expertise, but due to commissioning arrangements they cannot provide a full range of services at all sites. They may review a patient in the DGH clinic and need to refer to themselves at the NC for treatment.

3. This causes delays to care, repeat appointments, unnecessary travel and pathway inefficiencies

4. This can be addressed through derogating these therapies to DGH sites, allowing them to deliver certain therapies

5. Resulting in more streamlined, efficient pathways and the right care at the right time and place.

6. These conditions involve complex treatment pathways where early identification and escalation of care can reduce disability, improve outcomes and reduce health system costs.

7. Patients require complex MDT management, and significant community input.

8. GPs direct the patient into the pathway, and ultimately the GP holds the patient and manages their care. These pathways are complex and **GPs need support to do this.**

9. Case managers support by navigating the primary - community – tertiary boundaries, making them seamless and avoiding unnecessary layers

Derogation will be supported by appropriate governance and standards, including: specialist MDTs, subsspeciality specific common standards and governance frameworks, strategic community-based roles that link primary, community, secondary and tertiary care. These principles have been tested within SWL/Surrey system. E.g. Kingston Hospital and St George's Hospital, for prescribing high-cost MS drugs via SLAs - improves patient experience but SLAs are a large administrative barrier. Other examples include Deep Brain Stimulation optimisation – the device will be implanted at the NC (SGH) but reprogramming clinics could be offered in DGHs.

It is important to support patients with community based case managers. We know this approach reduces preventable admissions, as evidenced in the case for change. Where this is not provided, there are a greater number of non-elective admissions e.g. estimated £345,000 avoidable admissions for NMD alone for SWL. NMD care advisors have been piloted with Surrey Heartlands in 2020 and this pilot aims to roll out this model across multiple conditions and pathways.