Establishing a regional FND service

NHS South London Specialised Services Delegation Programme

Functional Neurological Disorder is a common and disabling condition. Patients with FND find it difficult to get a diagnosis and may have numerous primary care and OP attendances and multiple short acute admissions through acute medical units, often discharged without a diagnosis. FND occupies a borderland between neurology and psychiatry with neither group taking long-term responsibility. This leads patients to present to different hospitals, searching for an answer to their symptoms.

Although it is relatively easy for a neurologist to diagnose FND, in many DGHs they aren't consulted. This is evident in the case for change data, with significantly higher levels of FND diagnosed at SGH compared with DGHs.

A study of FND patients at one Trust in south London estimated 340 patients seen per year. The average LOS was 70hrs at an estimated cost of £750 per patient or £300k per year.

In one subtype of FND – Non-epileptic attack disorder, studies suggest clear communication and antiepileptic drug withdrawal associated with up to 80% reduction in admissions.

Neurologists do not feel supported to care for patients with FND, and for GPs this condition is uncommon, unfamiliar and complex. Neurologists and GPs need support to co-manage these patients with community and tertiary teams.

Patients with more complex FND can be admitted acutely to hospital and cannot then be discharged due to their disability and need for rehabilitation (which typically cannot be accessed in general hospital settings). This impacts on both patient outcomes and patient flow across the sector.

Across SWL and Surrey Heartlands, and more broadly England, there is a challenge with the provision of appropriate FND rehabilitation services that meet the needs of this patient cohort. Typically, rehabilitation is delivered in a level 1 inpatient rehab bed (spec comm), over the course of 6-12 weeks. There is currently a waiting list of over a year for this service.

As with other chronic neurological conditions, patients are best supported using specialist care advisors. Care advisors can provide community based support that facilitates localisation and de-escalation of care through providing support for patients and GPs, and providing rapid access to super-specialist input when a patient is deteriorating. This model is patient centred and identifies complex problems earlier, bypassing lengthy over-burdened referral pathways.

SGH is a national and international leader in clinical service provision and research. A key part of our service is the provision of specialist multidisciplinary rehabilitation.

We are proposing to pilot an outpatient / virtual multidisciplinary rehabilitation service for FND patients where we can provide intensive specialist multidisciplinary assessment and rehabilitation (face-to-face and virtual) and a wider regional system of care for this neglected patient group

This will enable improved access, better patient outcomes, and improve the interface with community services for longer term care.

Case vignette: A 20 year old woman was under the care of at least 13 clinicians across multiple trusts for functional symptoms at time of referral. She was bed bound with 24 hr care. She underwent assessment and treatment by the MDT through a pilot virtual rehabilitation programme. She made significant gains with reduction in tremors, improved strength and coordination; translating into functional gains such as improved sitting. Medications and medical appointments were rationalised and reduced at the point of discharge.