**‘Delay Phase’ COVID-19 Pandemic**

**Management of Patients within the Specialised Neurobehavioural (Level 1c) and Neuropsychiatry Pathways**

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| 1. What are the key pathways of care likely to be impacted?   There are three key service pathways in London:   * Cognitive & Neurobehavioural Rehabilitation (Level 1c) for patients with acute and post-acute acquired neurodisability and neuropsychiatric symptoms, e.g. traumatic brain injury and stroke; * Specialised Neuropsychiatry Pathways for patients with neurological disorders and associated or comorbid mental illness; * Functional Neurology Pathways for patients with functional neurological symptoms. |
| 1. What changes do you propose during the ‘Delay Phase’ of COVID-19:   **During the Covid-19 pandemic, the main role of specialised neurobehavioural and neuropsychiatry units will be to help ease the pressure on acute services by transferring appropriate patients from acute beds to increase bed capacity for acute medical patients.**  To facilitate this during the delay phase we recommend the following changes:  **General**   1. All patients who can be managed at home or in a placement on the basis of medical or psychiatric risk are discharged or transferred as soon as possible to increase acute (medical) bed capacity and also acute and post-acute rehabilitation capacity; 2. Outpatient assessment and follow-up is conducted virtually through telemedicine; 3. Specialised neuropsychiatric and therapy advice for London primary care; acute physical and mental illness secondary care pathways be made available for: 4. Patients with acquired brain injury facilitated through a single point of access to the cognitive and neurobehavioural rehabilitation services (Lishman Unit, Thames Brain Injury Unit (Blackheath), Wolfson Neurorehabilitation Services (St George’s)). 5. Patients with neurological disorders and associated or comorbid mental illness and patients with functional neurological symptoms facilitated through single points of access at centres determined by traditional geographical catchment areas in Greater London (South London & Maudsley NHS FT; National Hospital for Neurology & Neurosurgery and, South West London & St George’s NHS Trust)   **Inpatients**  All patients in neurosciences beds be RAG-rated to establish their needs during the pandemic and have their neuropsychiatric needs included in the definitions below:   1. **Red**: ongoing medical need that is a barrier to discharge. This would include psychiatric symptoms that have high levels of distress, risk, or burden of care that cannot be met outside of a specialised inpatient setting because it is dangerous, unstable or subject to high levels of daily medical supervision that would not be able to be delivered elsewhere; 2. **Amber**: ongoing need that is a barrier to discharge but can potentially be managed in another setting once appropriate biopsychosocial interventions are in place either at home or in a placement; 3. **Green**: (i) no medical or psychosocial need that cannot be met at home, (ii) the patient has suitable placement and their needs have been addressed with a suitable package of care or can be transferred for Discharge for Assessment pathway. Essentially ready for discharge or transfer.   All green patients will be discharged as soon as possible. All amber patients will receive appropriate input from neurosciences including neuropsychiatry and therapies as well as social care to affect a discharge or transfer, as soon as possible to home or a placement. Social care will need to use Discharge for Assessment pathways to facilitate continuing care assessments away from hospital.  All red patients will be reviewed by their local team together with liaison psychiatry where possible. Those who are deemed physically and psychologically fit for discharge will be identified and transfer arrangements from acute neurosciences be expedited. These would include the following local transfer arrangements where at all possible:   1. Acute mental illness inpatient services (with gatekeeping through crisis home treatment services) where the primary need is psychiatric treatment and care (often those needing admission under The Mental Health Act or with high levels of risk to self or others); 2. Specialist nursing home placement where the primary need is neurobehavioural with low medical or psychiatric need, but high therapy needs including neuropsychology where rehabilitation is likely to exceed 6 months (i.e. slow stream specialist nursing home placements); 3. Stroke patients where rehabilitation can be delivered on a stroke unit with the assistance of liaison psychiatry, and then potential early supported discharge input with the support of community mental illness pathways. This is not a complete pathway but some access to rehabilitation is ensured and can be integrated with appropriate support and advice from mental illness services. Non stroke patients have no access to rehabilitation other than specialised services.   Those who still require ongoing specialised neurobehavioural rehabilitation despite consideration of the above, will be referred to L1c pathways through BadgerNet to The Lishman Unit (SLAM); Thames Brain Injury Unit (Blackheath) and The Wolfson Neurorehabilitation Services (St George’s). Each of these services has subspecialised expertise in particular groups of patients and referrals are triaged for assessment to the most appropriate service. **During the Covid-19 pandemic, the main role of specialised neurobehavioural and neuropsychiatry units will be to help ease the pressure on acute services by transferring appropriate patients from acute beds to increase bed capacity for acute medical patients. It is therefore essential that all appropriate medical and therapy information is provided to allow for a quick triage and assessment as the priority will be to expedite transfer out of acute medical and surgical beds, and lack of information will slow down assessment.**  Red patients with all other neurological conditions and neuropsychiatric need that require ongoing admission for neuropsychiatric management that cannot be managed in local mental illness pathways because their mental illness and neurological condition cannot be managed outside of hospital but who don’t necessarily require neurobehavioural rehabilitation, should be referred to either Hughling’s Jackson Ward (The National Hospital) or The Lishman Unit (SLAM).  **Admissions**  We will continue to provide pathways to patients in London and outside of London who do not have access to specialised expertise and whose assessment or treatment cannot be provided in local non-specialised services with the following provisos:   1. All patients with functional neurological disorder waiting for elective inpatient rehabilitation are deferred during the pandemic; 2. Where possible local arrangements for admission to community-based neurorehabilitation (CNRT) and mental illness (CMHT) pathways are prioritized over admissions to neuropsychiatry beds and that where at all possible those community services work together in managing patients collaboratively; 3. Opportunities for co-working between specialised services are maximized and supported by a weekly teleconference between providers to consider assessments, flow, declined referrals to continue (with additional partners as necessary)   All assessments for admission will be provided virtually by telemedicine. The assessing team will need to speak with the referring doctor, a therapist and where possible the patient or a family member and staff should make themselves available to do this in order to expedite assessment. All relevant neuroimaging and investigation results, and information to support this assessment will need to be provided with the referral.  This has two purposes:   1. Reduced patient and clinician movement from one trust to another for assessment, and therefore reducing risk of spread of potential COVID19; 2. Supports the discharge from the acute site to free up beds quicker with a greater number of potential assessments due to decreases in travelling time.   A number of referrals where the benefit of admission vs transfer to the community is not apparent will result in discussions with referrers that the patient has not been accepted and will need to be discharged to the community either home or a placement. To facilitate this, providers in L1c, neuropsychiatry and representatives from specialist nursing home provision will discuss cases as appropriate and give a unified opinion on suitability and recommendations for discharge. This will also maintain flow out of acute beds (into Discharge for Assessment pathways) and out of specialised neurobehavioural and neuropsychiatric beds facilitating transfer of those who will more likely benefit from those services.  Close working with social services will be essential in facilitating flows out of acute neurosciences beds and also specialised neurobehavioural and neuropsychiatric beds and there will need to be clear lines of communication between local CCG/ICS/STP’s and Social Care.  In order to provide specialised advice and opinion on referrals and discharges out of services a Single Point of Access advice service should be provided to London that can be accessed by GP’s, Community Services (Neuro/Mental Illness), and Secondary Care (Neuro/Mental Illness) who need specific neuropsychiatric advice that they have not been able to access in their local provision of services (also see above under ‘General’ above). In the first instance local advice from existing services should be taken but where this is unavailable or where there is uncertainty about the best approach to take, neuropsychiatric and/or therapy expertise will be available on a daily basis to provide such advice.   * 1. Increase critical care, ambulance services and other key resources by, for example, differential triage, differential utilisation, differential resource deployment   None   * 1. What are the clinical implications for patients requiring input from:  |  |  |  | | --- | --- | --- | | London Ambulance Service | Critical Care | Non-Critical Care | | None | None | Patients from hospitals without rehab services will need to facilitate their own discharges and work along side community teams to provide ongoing care. | |  |  |  | |  |  |  | |  |  |  |  * 1. What are the principles used to inform your proposed changes? * Public health guidelines for vulnerable staff to work from home. * Public health guidelines to self-isolate if fever or cough, which is a very low threshold. * Shortage of beds in acute hospital relative to the expected demand as COVID progresses. * Likelihood of therapy staff in neuropsychiatry/neurobehavioural rehabilitation be redeployed to support acute physical or mental health services * Increasing access to specialised advice to facilitate transfers and discharge * Providing rehabilitation to a highly complex patient group who need to be transferred out of acute medical settings often urgently in order to subsequently expedite their discharge   2.5 Please highlight benefits and risks for proposed changes:   |  |  | | --- | --- | | Benefits  Reducing patient movement  Reducing staff movement  Improving patient flow through acute beds  Keeping patients out of hospital  Decreasing burden of care of a highly complex patient group on acute medical pathways | Risks  Patients unable to receive appropriate services  Increased care burden in the long term for patients | |
| 1. What are the workforce implications of new proposals?   Workforce numbers likely to drop regardless of proposals.  Where there is sickness of consultant neuropsychiatrists, essential medical expertise may not be available to pathways that is essential to make clinical decisions and maintain flow out of acute medical settings.  Consideration of consultant neuropsychiatrists working in clinical areas and in organisations where they have not previously worked will need to be considered in this event. Priority to maintain neuropsychiatry specialised pathway so as not to impede flow out of acute medical beds is highlighted as these skills are provided through an extremely small workforce but have very significant impact on neuroscience and medical beds through risk, behaviour that challenges, aggression and neurobehavioural needs. These needs will not decrease during the pandemic and will prove extremely challenging to acute medical settings and there will need to be facility for transfer out of acute settings where the appropriate skills and expertise are available to manage neuropsychiatric needs.  Potential for consultant neuropsychiatrists in mental health trusts to be mobilized into acute mental illness pathways and the neurobehavioural/neuropsychiatry pathway to no longer able to provide medical staffing unless a robust approach is taken to the provision of these pathways. The result would be highly challenging patients remaining in acute medical settings and impacting resources there unnecessarily. |
| 1. What partners have you worked with to develop the new proposals (organisation, names & roles)?   Dr Michael Dilley, Consultant Neuropsychiatrist, St George’s, Neurosciences CRG, Chair-Elect RCPSych Faculty of Neuropsychiatry, CD Neurosciences ODN  Dr Nick Medford, Consultant Neuropsychiatrist, Maudsley, Vice-Chair RCPsych Faculty of Neuropsychiatry  Prof Eileen Joyce, Consultant Neuropsychiatrist, NHNN, Chair, RCPsych Faculty of Neuropsychiatry  Dr David Okai, Consultant Neuropsychiatrist, Maudsley, CD Neuropsychiatry SLaM  Dr Panayiota Petrochilos, Consultant Neuropsychiatrist, NHNN, Clinical Lead Neuropsychiatry NHNN  Dr Stefania Bruno, Consultant Neuropsychiatrist, Huntercombe (Blackheath)  Dr Chris Symeon, Consultant Neuropsychiatrist, St George’s  Dr Shai Betteridge, Consultant Neuropsychologist, St George’s, Division of Neuropsychology, BPS  Dr Richard Irwin, Consultant Neuropsychologist, Royal Hospital for Neurodisability, Clinical Lead, RHN (Putney)  Gill Cluckie, CD London Stroke Network  Dr Sancho Wong, Consultant in Rehabilitation Medicine, St George’s  Dr Emer McGilloway, Consultant in Rehabilitation, King’s College Hospital |
| 1. What other stakeholders do you still need to work with? |
| 1. Does the new proposal require staff to work outside their scope of practice? If so, how has this been addressed?   If therapy staff are moved to acute side; if consultant psychiatrists are redeployed in to acute medical or psychiatric areas. Training and support will need to be provided and needs further consideration. |
| 1. Recommendations that you would like approved from the London Clinical Advisory Group? 2. All patients with functional neurological disorder waiting for elective inpatient rehabilitation are deferred during the pandemic; 3. All patients who can be managed at home or in a placement on the basis of medical or psychiatric risk are discharged or transferred as soon as possible to increase acute (medical) bed capacity and also acute and post-acute rehabilitation capacity; 4. All inpatient assessment for admission is conducted virtually through telemedicine; 5. All outpatient assessment and follow-up is conducted virtually through telemedicine; 6. Where possible local arrangements for admission to community-based neurorehabilitation (CNRT) and mental illness (CMHT) pathways are prioritized over admission to neuropsychiatry beds and opportunities for co-working between pathways are maximized and supported; 7. That access to neuropsychiatric and specialised therapy expertise for advice is facilitated through a single point of access for London primary care, community neurorehabilitation and mental health pathways, and secondary care acute physical and mental illness pathways. 8. Weekly teleconference between providers to consider assessments, flow, declined referrals to continue (with additional partners as necessary). 9. Communication of these recommendations to provider organisation Clinical Directors and Executive Boards |
| Please attach any flowcharts to demonstrate the proposed changes to the clinical pathway |