Health Innovation
Oxford & Thames Valley

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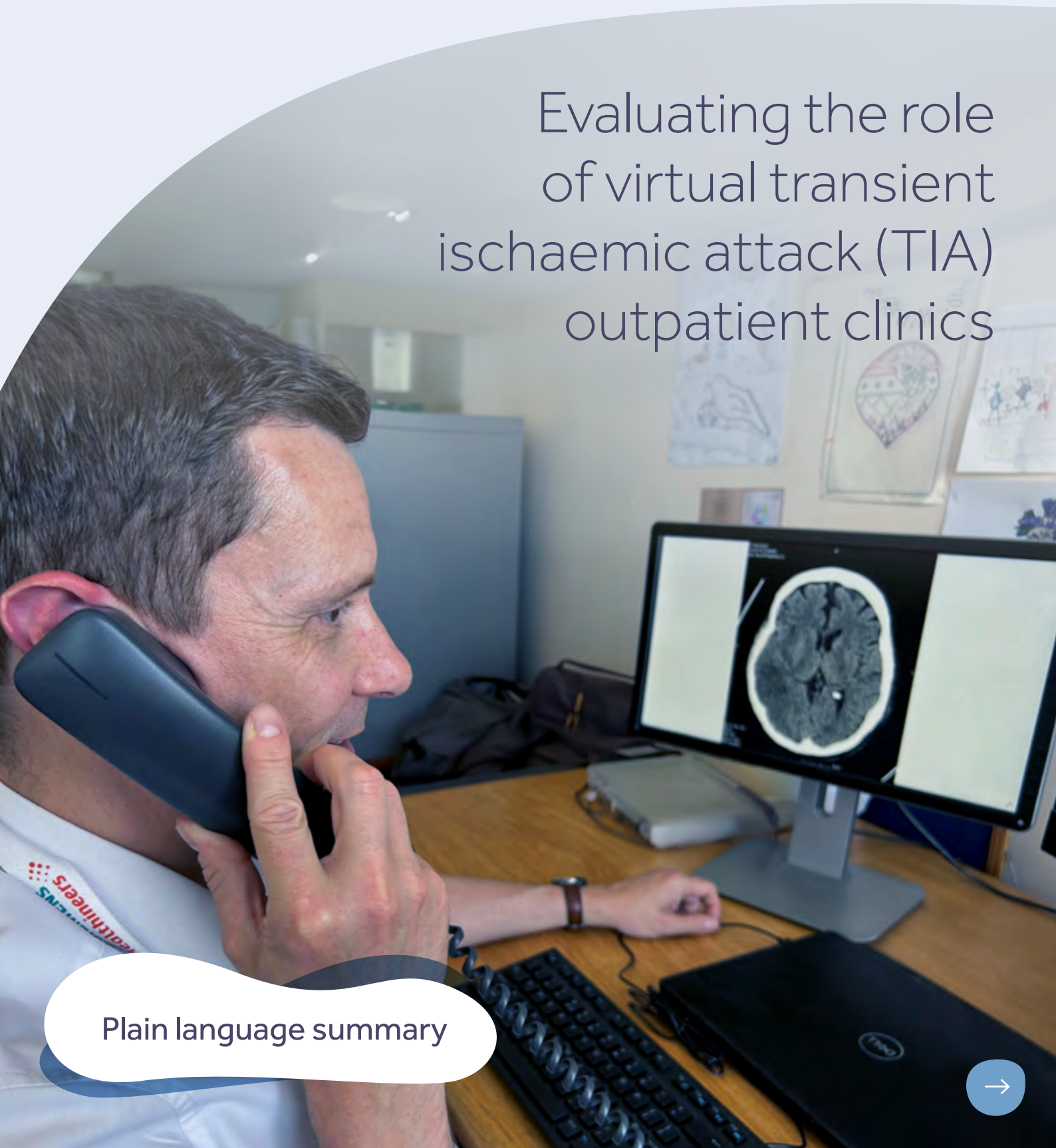
Evaluating the role of virtual transient ischaemic attack (TIA) outpatient clinics



Plain language summary

What is the topic?

During the COVID-19 pandemic most NHS trusts changed the way they provided appointments for safety reasons, minimising face-to-face contact between healthcare professionals and patients. Many TIA services switched to a telephone-based 'virtual' approach (most patients' appointments and consultations are carried out remotely; patients attend hospital for investigations such as scans and blood tests). Some have continued to run this way; others have returned to face-to-face clinics or now offer a hybrid approach (mixed approach of face-to-face and virtual, dependent on patient and service need). There has been limited research into whether these virtual clinics are effective, or into the experience of patients using them and the staff running them.

What did we do?

We carried out an evaluation between November 2021 and May 2023. We took a detailed look at 14 clinics across the South East of England by producing a visual diagram (pathway map) of the different steps/ activities involved for each model, from a patient being referred to discharged. We interviewed 15 patients and 12 healthcare professionals to gather their views and experiences of the different models. Also, we considered costs, environmental factors and how all these may impact on existing health inequalities (avoidable and unjust differences in people's health).

The evaluation was a collaborative effort between the Oxford Academic Health Science Network, the National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) Oxford and Thames Valley and the Nuffield Department of Primary Care Health Sciences at the University of Oxford. In addition, two public members, both former patients with first-hand experience of TIA, were involved in the project from the start, to ensure the patient perspective was always considered. We also worked closely with the clinical lead for stroke at NHS Getting It Right First Time (GIRFT).

What did we find?

There were two main findings.:

1) There is wide variation across services, even when the same model is used (face-to-face, virtual or hybrid). This meant it wasn't possible to define what a good service model looks like for each approach.
2) Services were designed around the availability of diagnostic imaging, particularly for MRI (magnetic resonance imaging - a type of scan which helps diagnose a TIA).

Benefits of the virtual model for patients included time-saving due to fewer journeys to appointments. This was important to those caring for others and/ or who also had one or more long-term conditions or difficulties accessing transport. For healthcare professionals, the virtual model provided greater flexibility to manage TIA services around other clinical demands and supported them to progress patients more quickly through the various steps of investigation and care delivery.

Challenges of the virtual model included a lack of clear information for patients on how their care would be delivered and that this would be as good as seeing a healthcare professional face-to-face. Some patients and healthcare professionals found it more difficult to build a clinician/ patient relationship and patients said they had fewer opportunities to ask questions, particularly at the time they were diagnosed with a TIA. They would accept the inconvenience of having to make travel and care arrangements if it meant they could be seen in person.

Why is this important?

Ensuring prompt and rapid access to TIA services is important in reducing the risk of potential future strokes through early treatment. We have four key recommendations:

1) Setting common standards for TIA outpatient clinics, including when virtual consultations are appropriate and or preferred.
2) Improving the referral and triage system to help manage unpredictable demand. Triaging is where a health professional reviews a referral and decides the best way to provide care, both for individual patients and for the service.
3) Improving patient information on how care is delivered, particularly for the hybrid and virtual models.
4) Adopting a hybrid model could maximise benefits for both patients and healthcare professionals.

In summary

There is potential to use virtual consultations for some patients referred to TIA services. Developing a framework to support how services are provided is key. It is essential that patients can contribute to this. We will work with the GIRFT stroke team and regional stroke networks to support these changes.

Acknowledgments

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Contact:

Sarah Brown
Project Manager
sarah.brown@healthinnovationoxford.org
info@healthinnovationoxford.org

Further information:

More detailed information on the results and recommendations can be found in our main evaluation report, available on our project website **https://bit.ly/HealthOxTIA**