liaison point with medical teams and can help provide prompt review even with rising referral numbers. Indeed, from January to July 2017, after introduction of the neurology clinical fellow, only 5.1% of patients were not seen on the day a referral was received. In contrast in 2015 and 2016 10.2% and 10.9% reviews were delayed for referrals in the first half of the year.

For such a position to succeed considerable input from consultants is needed, particularly given the fellow's possible lack of experience in neurology. The consequences of inadequate supervision have been highlighted elsewhere.[2] The fellow may not have the administrative skills of a neurology nurse co-ordinator but they bring other attributes.

Nitkunan *et al* found that siting their hyperacute neurology team close to the acute medical unit allowed an approachable referral system to be created. A hospital's layout may make this difficult, and we instead have a computerised referral system which also avoids a formal referral approach. Designing acute neurology care may require different solutions across the NHS. ■

Conflicts of interest

No conflicts of interest to declare.

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References

1 Nitkunan A, MacDonald B, Boodhoo A *et al.* A hyperacute neurology team – transforming emergency care. *Clin Med* 2017;17:298–302.
2 Yogarajah M, Mirfenderesky M, Ahmed T, Schon F. Consultant supervision of trainees seeing inpatient ward referrals – a cause for concern? *Clin Med* 2014;14:268–73.

Response

Editor – Both letters above raise issues about the place of non-consultant staff.

We agree that different units will, no doubt, develop different models depending on their needs. It is key to collect and publish data with similar outcome measures so that genuine comparisons of efficacy can be made.

Whatever the layout of the hospital, almost all now have 'acute admission units' with acute physicians closely linked to emergency departments. That is where the person leading the acute neurology team should be based; in our case it is the acute neurology nurse.

The model we report is based on using exclusively senior staff: consultant neurologists, a band 8 nurse triaging patients and band 7 epilepsy nurses. Acute neurology requires two critical decisions:

- which patients are safe for early discharge
- what sort of follow up arrangements do these 'early discharge' patients require.

These decisions are difficult, require vast experience and are fraught with potential medico-legal pitfalls.

We strongly believe in providing both a high quality clinical service as well as training but that these two aspects require different approaches.

Supervision of trainees nationally is problematic as highlighted in our recent paper.[1] In our experience supervising trainees properly requires great time and commitment. Neurology trainees are disproportionately based in tertiary centres but would benefit enormously from time in DGHs like ours where there is a major commitment to service and training. Approximately half of funding for trainees is derived from Health Education England via the Local Education and Training Board and half is from the trust itself. With neurology inpatient beds (and therefore income generated) at tertiary centres, it is difficult for DGHs to fund neurology juniors. Changes envisaged in the Shape of Training could feed into this debate. ■

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1 Yogarajah M, Mirfenderesky M, Ahmed T, Schon F. Consultant supervision of trainees seeing inpatient ward referrals – a cause for concern? *Clin Med* 2014;14:268–73.