NEUROLOGICAL CONDITIONS
LOCAL DELIVERY PLAN
2016 / 17

February 2016
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1. BACKGROUND AND CONTEXT

“Together for Health – a Neurological Conditions Delivery Plan” was published in April 2014 and provides a framework for action by health boards and NHS trusts working together with their partners. It sets out the Welsh Government’s expectations for the planning and delivery of high-quality person-centred care for anyone affected by a neurological condition. It focuses on meeting population need, tackling variation in access to services and reducing inequalities across seven themes:

- Raising awareness of neurological conditions
- Timely diagnosis of neurological conditions
- Fast and effective care
- Living with a neurological condition
- Children and young people
- Improving information
- Targeting research

For each theme it sets out:

- Delivery expectations for the management of neurological conditions
- Specific priorities for 2013-17
- Responsibility to develop and deliver actions to achieve the specific priorities
- Potential assurance measures

These complement the quality requirements endorsed in the report of the task and finish group on care pathways for long term neurological conditions, which must be delivered alongside the delivery plan.

The Vision

Our vision is for people with a neurological condition in Wales to have access to high-quality care, wherever they live, whatever their underlying neurological condition and regardless of their personal situation.

The Drivers

Neurological conditions range from relatively common to rare, such as mitochondrial diseases or Wilson’s disease, and taken together, affect many people. For example, eight million people in the UK have migraine and around half a million have epilepsy.
Altogether, approximately 10 million people of all ages across the UK have a neurological condition. These account for up to 20 per cent of acute hospital admissions and are the third most common reason for seeing a GP\(^1\). Around 17 people in a population of 100,000 are likely to be newly diagnosed per year with Parkinson’s disease, and two people in a population of 100,000 experience a traumatic spinal injury every year. An estimated 350,000 people across the UK need help with daily living because of a neurological condition and 850,000 people care for someone with a neurological condition\(^2\).

Annually, about 200,000 people in the UK are admitted to hospital with head injury. Of these, one-fifth have features suggesting skull fracture or have evidence of brain damage\(^3\).

It is estimated there are more than 500,000 people in Wales affected by a neurological condition and of these, 100,000 will have a long-term neurological condition (LTNC). An LTNC results from disease of, injury or damage to the body’s nervous system (i.e the brain, spinal cord and/or their peripheral nerve connections), which will affect the individual and their family in one way or another for the rest of their life.

It has been estimated that between two and three per cent of the child population will have some level of disability leading to additional health and educational needs. The vast majority of child disabilities are neurological in origin with paediatric epilepsy the most common neurological disorder affecting about 0.7 per cent of all children\(^4\). Neurological conditions* can be broadly categorised as follows:

- **Sudden onset conditions**, for example acquired brain injury or spinal cord injury, followed by a partial recovery.

- **Intermittent and unpredictable conditions**, for example epilepsy, certain types of headache or early multiple sclerosis, where relapses and remissions lead to marked variation in the care needed.

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\(^2\) Neuro Numbers, Neurological Alliance www.neural.org.uk/store/assets/files/20/original/NeuroNumbers.pdf

\(^3\) NICE Clinical Guideline CG176 Head Injury, http://guidance.nice.org.uk/CG176


* not all neurological conditions covered by this plan are contained within the list
• **Progressive conditions** for example motor neurone disease (MND), Parkinson’s disease or later stages of multiple sclerosis (MS), where there is progressive deterioration in neurological function. For some conditions (e.g. MND) deterioration can be rapid.

• **Stable neurological conditions**, but with changing needs due to ageing, for example post-polio syndrome or cerebral palsy in adults.

• **Congenital and developmental neurological conditions**, for example cerebral palsy, spina bifida or Duchenne muscular dystrophy, which may be present at birth or develop during early childhood. Some of these may be associated with varying degrees of learning disability.

**What do we want to achieve?**

The all-Wales delivery plan sets out action to improve outcomes between now and 2017. These actions are grouped under seven delivery themes:

• **Delivery theme one: Raising awareness of neurological conditions** - Increased awareness of neurological conditions and their symptoms

• **Delivery theme two: Timely diagnosis of neurological conditions** - Neurological conditions are detected quickly, allowing timely progress to care and treatment

• **Delivery theme three: Fast and effective care** - People with a neurological condition should receive fast, effective care and treatment

• **Delivery theme four: Living with a neurological condition** - Whether in the community or in hospital, people are placed at the centre of care with their individual needs identified and met so they feel well supported and informed and able to manage the effects of their neurological condition

• **Delivery theme five: Children and young people** - Children and young people with neurological conditions receive appropriate care
• **Delivery theme six: Improving information** - Information systems to support high-quality care, clinical audit and to drive service improvement

• **Delivery theme seven: Targeting research** - A commitment to research, delivering improved diagnosis, management, treatment options and outcomes

### 2. DEVELOPMENT OF CWM TAF UNIVERSITY HEALTH BOARD’S DELIVERY PLAN FOR NEUROLOGICAL CONDITIONS

This Local Delivery Plan is a refresh of the 2014/15 plan. It identifies progress made against the previous plan and outlines the priorities for the coming year.

In response to the “Together for Health – A Neurological Conditions Delivery Plan” (2014), Health Boards are required, together with their partners, to produce and publish a detailed local service delivery plan to identify, monitor and evaluate action needed within timescales. Health boards are required to report progress formally to their Boards and publish the annual reports on their websites annually.

This Local Delivery Plan has been developed by a multi-disciplinary group from Cwm Taf UHB, led by the Medical Director, in conjunction with partners in the Welsh Health Specialised Services Committee (WHSCC), Cardiff & Vale UHB and the third sector.

### 3. ORGANISATIONAL PROFILE – CWM TAF UNIVERSITY HEALTH BOARD

**Organisational Overview**

Cwm Taf Local Health Board was established in 2009 and in July 2013 was awarded University Health Board (UHB) status.

The UHB is responsible for the provision of services to the 289,400 residents of Merthyr Tydfil and Rhondda Cynon Taf. Almost 81% of the population live in Rhondda Cynon Taf Local Authority and the remaining 19% in Merthyr Tydfil. The UHB’s catchment population increases to 330,000 when including patient flow from the Upper Rhymney Valley, South Powys, North Cardiff and the Western Vale.
The UHB provides a comprehensive full range of hospital and community based services to its resident population. The vast majority of health and care needs are met in local communities by primary care and community services. Such care is provide by GP Practices, Dental Practices, Optometry Practices and Community Pharmacies, Community Health Teams, in health centres and our flagship Keir Hardie Health Park, in partnership with local authorities and the third sector. In line with ‘Setting the Direction’ (2009), there has been an increased focus over recent years on integrated care provision within localities. Inpatient care is provided in our two major District General Hospitals – the Royal Glamorgan and Prince Charles Hospitals – and in a number of smaller community hospitals.

As well as delivering services to its local population, the UHB provides patient care services to the populations of other health boards. Aneurin Bevan University Health Board is the largest external commissioner of services from Cwm Taf and this reflects the patient flow from the Upper Rhymney Valley. Approximately one third of admissions to Prince Charles Hospital are residents Aneurin Bevan and Powys health boards.

The UHB is responsible for making arrangements for the residents of Rhondda Cynon Taf and Merthyr Tydfil to access health services where these are not provided within Cwm Taf. Where we are unable to provide services locally, usually for more specialist or tertiary services including neurology, the University Health Board makes arrangements with other health boards (largely Cardiff & Vale) or trusts to provide these services on its behalf. In addition, the WHSCC commissions highly specialised services on behalf of all the Welsh Health Boards.

**Overview of Local Health Need and Challenges**

Overall the health of our population is improving however, within the UHB we have areas of significant deprivation and poor health, many of the causes of which are difficult to tackle. Cwm Taf is an economically deprived area, with low levels of employment and educational attainment. These factors, along with other aspects of the physical environment, impact on the lifestyles of people living in the Cwm Taf University Health Board area.

Within the UHB boundaries there are well recognised areas of deprivation, particularly in the post industrial areas such as in the Rhondda and Cynon Valleys and Merthyr Tydfil. 34% of the resident population live in the most deprived areas of Wales as determined by the Welsh Index of Multiple Deprivation. The
University Health Board has the highest proportion of LSOA’s* in the most deprived fifth in Wales. *(Lower Super Output Area (LSOA) is a statistical geography designed by the Office for National Statistics to improve the reporting of small area statistics and have a mean population of 1500).

The association between deprivation and health is clearly apparent with the differences in the mortality rates demonstrated between our most deprived communities and least deprived areas. There are consistently higher proportions of people reporting key illnesses in Cwm Taf compared to across Wales. For many of the lifestyles and key illnesses included in the Welsh Health Survey and the GMS Quality and Outcomes Framework, Cwm Taf is statistically significantly worse than Wales. In Cwm Taf the healthy life expectancy for women is 60.6 years, the lowest in Wales and statistically significantly shorter than all other Health Board areas. For Cwm Taf males the equivalent is just 60 years, again the lowest in Wales and statistically significantly shorter than all other Health Board areas.

Cancers and circulatory disease were consistently the major causes of premature mortality in Cwm Taf between 1998 and 2008. Most notable is the significant difference between the two main causes of death in the under 75 year olds and all the other causes.

By 2033 the population growth in Cwm Taf is projected to result in a 59% increase in the number of residents over 75 years of age. The increase in elderly population is likely to result in an increase in prevalence of dementia, chronic conditions such as cardiovascular, respiratory diseases and cancers.

**Neurological conditions and services in Cwm Taf**

In 2012, Public Health Wales Observatory produced a Neurology Needs Assessment which included the following estimated prevalence of neurological diseases within the population of Cwm Taf, based on Office of National Statistics (ONS) mid-year population estimates 2010, and using a variety of condition specific data sources. It is likely that these are an under-estimate of actual prevalence and a key national priority is to undertake a more detailed needs assessment during 2015:

**Parkinson’s Disease**

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5 Public Health Wales Observatory. Neurology needs assessment: all-Wales prevalence and inpatient tables 2012
<table>
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<tr>
<th>Condition</th>
<th>Prevalence</th>
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People with a neurological condition in Cwm Taf receive health services from their GP and primary care team as well as specialist secondary care teams based at both Cwm Taf and Cardiff & Vale University Health Boards. Neurology services are provided on a network basis by Cardiff & Vale UHB including outreach consultant sessions at the Royal Glamorgan and Prince Charles Hospitals. All neurosurgery is undertaken at the University Hospital of Wales.

Neurology Services provided by Cardiff & Vale UHB for Cwm Taf include specialist services for secondary and tertiary neurology and specialist MS, epilepsy, neurophysiology, neuromuscular conditions, dystonia, Huntington’s disease, neurorehabilitation (including the Community Brain Injury team), spinal injuries, neuroradiology, early onset dementia, movement disorders, headache, non-epileptic attack, non-organic illness neuropsychology, learning disability and neuro-ophthalmology.
Acute and general physicians also play a key role in the care of patients with acute neurological illness, as approximately 20% of acute medical admissions have a significant neurological problem\(^6\). Our physicians are currently able to refer patients for urgent neurological assessment by the visiting neurologists on their afternoon ward rounds, or for less urgent assessment via their neurology outpatient clinics.

Neurologists also receive a high volume of referrals for people with non-organic illness, for example, non-epileptic attack disorder (NEAD), which evidence suggests account for around a third of new general neurology outpatient referrals\(^7,8\). These conditions are normally diagnosed by a neurologist and often require detailed further investigation to confidently exclude other diseases. Cwm Taf has been heavily dependant on the NEAD service in Cardiff and Vale UHB for these patients. Psychological support can be very helpful for people with these conditions but is not readily available.

In order to address current waiting time issues, Cardiff & Vale UHB undertook a Waiting List Initiative with the aim of reducing the backlog. There is also a need to review patient flow arrangements between neighbouring Health Boards, as out-of-area (eg. Rhymney Valley) patients accessing Prince Charles Hospital should be referred to Aneurin Bevan UHB Neurologists rather than to Cardiff & Vale UHB.

Highly specialised in-patient neuro-rehabilitation services for adults are provided by Cardiff & Vale UHB. Cwm Taf provides limited on-going in-patient rehabilitation and discharge planning in Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda hospitals. Whilst there are a small number of specialist therapists the service is primarily delivered by generalist staff.

A significant number of people with neurological conditions do not require in-patient rehabilitation. Specialist advice from Cardiff & Vale UHB is available for some conditions such as MS and Motor Neuron Disease with rehabilitation programmes and long-term management delivered by generic therapists. There are pockets of specialist neurological therapists e.g. Speech and Language and


physiotherapy who operate uni-professionally in the community. However this is a very small resource and spread extremely thinly. There is a Community Brain Injury Team which is a discrete community service is shared by Cardiff & Vale and Cwm Taf UHBs. It provides primarily psychological support and physical advice to adults with acquired brain injury at home. In addition it delivers behavioural therapy classes from Rookwood and can support limited training and discharge planning advice from community hospitals. Children and young people with a neurological condition will be under the care of a consultant paediatrician, with GP involvement for regular prescribing and access to a visiting specialist paediatric neurologist from Cardiff & Vale UHB. Any urgent cases will be seen promptly in Cardiff.

**Specialised and Tertiary Services**

The planning and commissioning of specialised and tertiary services for patients with neurological conditions is currently delegated by Health Boards in Wales to the Welsh Health Specialised Services Committee (WHSSC). These include:

- Neurosurgery including Stereotactic Radiosurgery
- Interventional Neuroradiology
- Specialised Neuro-rehabilitation
- Spinal Cord Injury Rehabilitation
- Neuropsychiatry
- Posture and Mobility Services

WHSSC has developed a work programme for 2014-17 and action plan for the coming year. These focus on addressing the following key challenges:

- Long waiting times for neurosurgery for patients in South Wales
- Long waiting times for complex wheelchairs – adult and paediatric
- Sustainability of current medical model for the Welsh Spinal Injuries Centre
- Lack of provision for paediatric neuro-rehabilitation in South Wales and limited uptake of out of area referrals

Since 2010, the planning and commissioning of neurology, neurophysiology and non-tertiary diagnostic neuroradiology was to have passed to health boards, however WHSSC continues to pay for the neurology element of the Cardiff & Vale UHB contract via the established contracting mechanisms and collects the income for these from the relevant commissioning health boards. An urgent priority for Cwm Taf UHB is to achieve the Transfer of Services for
specialised neurology from WHSSC during 2015. In order for this to take place, there needs to be a clear and mutual understanding of all activity to ensure the appropriate resources are transferred.

There are no local specialist inpatient or community neuro-rehabilitation teams for people with long term neurological conditions who have the potential of making a recovery and increasing their independence. Neuro rehabilitation services have in the past been provided by a regional specialist services in Cardiff & Vale UHB. However, in recent years there has been a move to repatriate patients back to the local services. This has presented a major challenge in terms of the lack of local specialist resource or expertise.

Cwm Taf UHB recognise the need to support people with neurological conditions and their families/carer throughout the whole of a person’s life and to be responsive to need as symptoms change. The UHB is committed to improving and developing services for Neurological Conditions across the Cwm Taf area.

4. Progress to Date

Cwm Taf UHB has made excellent progress over the last twelve months in establishing a baseline for improvement of services for Neurological Conditions across Cwm Taf and some of the key achievements include:

- Cwm Taf UHB has established a multi-disciplinary implementation/delivery group and led by the Medical Director, in conjunction with partners from WHSSC and Cardiff & Vale UHB. Meetings have been planned for the duration of 2016/17 to ensure the implementation of the Local Delivery Plan (LDP).
- We have demonstrated good stakeholder engagement by holding a stakeholder Focus Group in January 2015 to engage on priorities within the Local Delivery Plan for Neurological Conditions.
- A service model has been developed for a Multidisciplinary Community Neuro-rehabilitation team within Cwm Taf.

Implementation of the proposed Service Model was subject to obtaining additional funding. Cwm Taf UHB submitted a proposal for funding application in 2015 to the Welsh Government’s Neuro- and Stroke Rehabilitation Fund, the total bid was for £187,671, and the total funding awarded to Cwm Taf UHB was £117,000 (recurring).
The proposed Service Model will now require review to ensure that funding awarded to Cwm Taf is allocated appropriately for the development of a Neurological Community Rehabilitation Service across Cwm Taf.

- Funding was also secured from Welsh Government and Welsh Health Specialist Services Committee (WHSSC) to establish a tertiary paediatric neurological rehabilitation team.
- Reviewed and improved the literature available to the public in outpatient clinic areas.
- Agreement has been made with WHSSC to facilitate a transfer of commissioning responsibility back to Cwm Taf UHB by the end of 2015/2016. WHSSC transfer of services group has been established and first meeting was held October 2015 where neurology transfer was identified as a priority area for transfer.
- The waiting list initiatives put on by Cardiff and Vale UHB cleared the backlog of new outpatients. Work has progressed with Cardiff and Vale UHB to understanding the commissioning pathway and responsibilities and no further Cwm Taf specific issue are expected going forward.

Our Specialist Nurse for Parkinson’s disease has undertaken numerous educational events over the last twelve months for example:

- Attendance at multiple care homes and residential home to raise awareness of Parkinson’s disease in the form of educational sessions.
- Run multiple awareness sessions of the Parkinson’s disease and the service available to numerous social groups’ e.g. Church groups, Women’s Institutes.
- Undertook, the “training partnership” with social services and other agencies such as privately run care homes.
- Made training available within the Health Board for all members of staff which is provided by the Parkinson’s Clinical Nurse Specialist.
- There are plans to undertake ‘road shows’ within Health Board (the educators will be a consultant, Clinical Nurse Specialist for Parkinson’s Disease and a patient representative)

5. National/Local Priorities

National Priorities
This delivery plan takes into account the national priorities identified by the Welsh Government’s Neurological Condition Implementation group which are as follows:

- Developing a co-productive approach to increasing awareness of neurological conditions
- Delivering clear and consistent patient information
- Delivering access to neurology services, for patients of all ages, consistently throughout Wales
- Developing consistent and coherent neuro-rehabilitation services for patients of all ages
- Developing and responding to patient experience and outcome measures

The Cwm Taf Neurological Conditions Delivery Group, having reviewed the current provision of neurological services across the area, has developed this local Delivery Plan which includes actions against each of the 2017 milestones within the Welsh Government’s Neurological Conditions Delivery Plan (2014).

Local Priorities

Delivery Theme 1: Raising awareness of neurological conditions

For people with a neurological condition, stigma and discrimination often result from a lack of public and professional awareness of the condition and symptoms. This can hinder people from seeking help and being able to take an active role in managing their condition.

Our key challenges for raising awareness are:

- **Reducing stigma** - to reduce the stigma and discrimination associated with neurological conditions, by improving general public awareness.
- **Staff awareness** - to ensure that our staff in primary and secondary care, including accident and emergency departments, have an awareness of neurological conditions and the symptoms, are able to provide written information regarding their condition to patients and families, and are able to refer on or signpost to the relevant services and community support groups and other resources.

Our priorities for raising awareness for 2016 – 17 are:

- to promote national public awareness raising campaigns on neurological conditions via the UHB website, social media and other media.
• to establish a rolling programme of general and targeted staff awareness raising on neurological conditions, particularly GPs, Acute Physicians, A&E and general medical and ward staff.
• to check what written information is available for all neurological conditions, including that from third sector organisations, and ensuring the availability of appropriate online and written information materials for patients and families.

Delivery Theme 2: Timely diagnosis of neurological conditions

The first point in the patient pathway for someone presenting with neurological symptoms is usually their GP. Timely diagnosis can help reduce distress and anxiety when symptoms first present and can lead to earlier treatment and effective management. We therefore need to ensure that all GPs have a knowledge and awareness of neurological conditions, are able to manage certain conditions. When needed, they should have timely access to a range of diagnostic tests and procedures and specialist advice.

Those with acute neurological conditions may present to A&E, and patients who have sustained traumatic injuries to the brain in road traffic accidents, falls or assaults are often treated for their orthopaedic injuries with little consideration for the often significant and potentially devastating impact of neurological and cognitive symptoms.

Our key challenges for ensuring timely diagnosis are:
• **GP access to advice** – ensuring availability and GP awareness of the regional neurology on-call service through which advice can be sought.
• **Demand management** – ensuring that patients are managed in the most appropriate setting whether that be in primary or secondary care, and that patient expectations are appropriately managed.
• **Referral pathways** – there are various referral routes for patients with a neurological condition including to Care of the Elderly and Acute Medical services as well as Neurology. These pathways need to be clarified to ensure that patients are referred via the appropriate pathway. Referral processes also need improving and made more efficient, such as the use of e-referral.
• **Access to diagnostics** – the waiting time for CT is currently under 2 weeks for urgent cases and under 8 weeks for routine cases; the waiting time for MRI is currently up to 4 weeks for
urgent cases but up to 20 weeks for routine cases. These waiting times can hamper timely diagnosis and have led to high levels of private referrals. Cwm Taf does not have a visiting neuro-radiologist to interpret scans, unlike the other health boards in the region, and this is acknowledged as a deficit.

- **MDT assessment** – There is a lack of clinicians with expertise in neurological conditions, who can assess symptoms and functioning in order to get a correct diagnosis and prognosis. Many patients need access to a clinical psychologist with a specialism in neuropsychology who can carry out a comprehensive assessment particularly for more complex cognitive presentations and those with severe acquired brain injury, to receive a correct diagnosis and advice on treatment and rehabilitation. There is currently no clinical psychologist or therapy team with sufficient expertise available to see these patients in Cwm Taf UHB, although this service was provided by Cardiff & Vale UHB in the past.

Our priorities for ensuring timely diagnosis for 2016 – 17 are:

- to support our GPs to manage patients when appropriate within primary care and how to access specialist advice via telephone or email when needed.
- to review referral pathways and protocols to neurological services with clarity around when and how to refer to Care of the Elderly, Acute Medicine or Specialist Neurology services.
- to introduce a primary care referral pathway for headache.
- to explore the introduction of electronic referral systems.
- to achieve Referral to Treatment (RTT) targets.
- to reduce waiting times for diagnostics including scans, particularly MRI, and neurophysiology, in line with agreed improvement trajectories.
- to develop a business case for 2 days of neuro-radiologist input to Cwm Taf UHB.
- to have access to prompt assessment and advice from clinical psychologist and therapists with expertise in neurological conditions, to contribute to diagnosis and care planning.
- To develop robust information management systems between tertiary and local services to ensure that the patient pathway is seamless.
- To ensure that robust administration and notes management are in place to support the above.

**Delivery Theme 3: Fast and effective care**
Once diagnosed with a neurological condition, patients should receive fast and effective care and treatment, in line with clinical guidelines.

Most patients attending the Royal Glamorgan or Prince Charles Hospital with a neurological condition are firstly seen by an acute or general physician who can then refer for specialist assessment by the visiting neurologist in Clinical Decision Unit/Medical Assessment Unit or on their afternoon ward round.

Following the waiting list initiative undertaken in recent months it is essential that the waiting times are monitored to prevent a reoccurring problem.

Some patients needing urgent secondary or tertiary neurology inpatient support are transferred to the Neurology ward at University Hospital of Wales.

The group of patients, who have been diagnosed with an acquired brain injury, including traumatic brain injury, subarachnoid haemorrhage, hypoxic brain injury and encephalitis, often miss out on specialist neuro-rehabilitation and appropriate care due to a lack of expertise and no senior clinician or physician with a special interest in this area. Access to services and specialist advice in Cardiff & Vale UHB is very limited and there is a lack of pathways and clear referral route for people with acquired brain injury. This group often have complex cognitive, behavioural and psychosocial needs and without prompt specialist assessment there are numerous risks to their health and psychological well being.

For young people transferring from paediatric to adult neurological services there should be a seamless transition of care, however there are acknowledged challenges in achieving this across Wales given the differences in the way paediatric and adult services are organised. Cwm Taf UHB is implementing a new policy and procedure for transition to adult services, including the development of a patient-held record to aid communication and continuity of care. However there are still issues around the management of young people aged over 16 with neuro-disability and complex needs. Paediatrics in Cwm Taf keep these patients under their care until the age of 20 plus however the paediatric ward is not an appropriate care environment for this client group. The Cardiff & Vale UHB adult learning disability team take a significant number of these cases. The importance of multidisciplinary and inter-agency support at this crucial time is recognised.
People in the later stages of long-term and progressive neurological conditions will receive access to co-ordinated, effective and compassionate palliative and end of life care, in line with our End of Life Care Local Delivery Plan. Such care is provided by, or with the advice of, our specialist palliative care team who provide care and specialist support within the community and in hospital settings.

Neuro-rehabilitation is a process of assessment, treatment and management by which the individual (and their family / carer) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living. Patient goals for rehabilitation vary according to the recovery trajectory and stage of their condition. Specialist rehabilitation is delivered by a multi-professional team who have undergone recognised specialist training in rehabilitation.

Following illness or injury, the majority of patients requiring rehabilitation will progress with the support of a local specialist community rehabilitation service. Those with more complex needs may require referral to their local specialist rehabilitation service. A small number of patients with highly complex needs require the staff expertise and facilities of tertiary specialised rehabilitation services.

Tertiary specialised services have highlighted concerns that under resourced community services have led to delays in discharge and therefore increased length of stays when benchmarked against equivalent centres.

There are a number of examples of individual patient commissioning being utilised on an adhoc basis to commission specialist rehabilitation services from the private sector at a high cost where services are not available locally.

Our key challenges for ensuring fast and effective care are:

- **Timely and equitable access** to specialist neurological services and an urgent need to tackle lengthy waiting lists.
- **Access to specialist advice within 24 hours for A&E departments and inpatient wards** – access to specialist advice from the on-call neurologist is currently available within 24 hours, 7 days a week via the telephone or tele-stroke service, or urgent transfer to Cardiff if clinically necessary. Providing face-to-face 24/7 access would require a significant increase in resources and would represent a key challenge to services.
- **Access to brain injury services** – which are currently limited.
• **Cost pressures** – advances in drug treatments and technologies are a positive development for patients but have significant cost implications for service commissioners and providers. This poses a major challenge in the ability of the service to support treatment regimes, an in providing equitable access to treatment across health boards.

Our priorities for ensuring fast and effective care for 2014 – 17 are:

- To work with Cardiff & Vale UHB to review current service provision, demand and capacity.
- To review the adequacy and appropriateness of the current 24 hour access to on-call specialist advice for those admitted to hospital with a primary or suspected neurological condition.
- To seek ways to establish care pathways and local expertise, such as a physician with a specialist interest, for people with acquired brain injury, so that timely assessment can be carried out and referral on to the right care setting take place.
- To review compliance with NICE guidelines on drugs and treatments for neurological conditions.
- To develop a Community Neuro Rehabilitation service designed to meet the needs of the population of Cwm Taf.

**The Community Neuro-rehabilitation Service Development**

A significant development within Cwm Taf has been to secure funding for a Community Neuro-rehabilitation service. The aim of the project is to develop a Neurological Community Rehabilitation Service inline with the funding awarded to Cwm Taf UHB. The project will ensure that the funding is allocated appropriately to facilitate service improvement for the treatment of patients with neurological conditions across Cwm Taf.

Implementation of the proposed Service Model was subject to obtaining additional funding. Cwm Taf UHB submitted a proposal for funding application in 2015 to the Welsh Government’s Neuro and Stroke Rehabilitation Fund, the total bid was for £187,671, and the total funding awarded to the UHB was £117,000 (recurring).

The project will be split into three phases:

**Phase 1** - Establish the Project Management Framework, to include the establishment of a Working Group.

**Phase 2** - Development of Documentation Detailing All Current Neurological Services Provided Across Cwm Taf.
Phase 3 - Development of Documentation Detailing Future Development of a Community Neurological Rehabilitation Service.

The objectives of the project are as follows:

Phase 1 - Establish the Project Management Framework, to include the Establishment of a Working Group:

- Agree Project remit, process and reporting mechanisms.
- Develop and finalise the Project Initiation Document, to include the Communication Plan for agreement by the Project Board.
- Establish a Working Group - identify key individuals who are critical to achieving the projects aim and objectives defined.

Phase 2 - Development of Documentation Detailing All Current Neurological Services Provided Across Cwm Taf:

- Scope the work which needs to be undertaken to resource map all current services for Community Neurological Rehabilitation across Cwm Taf.
- Identification of neurological services currently provided across Cwm Taf.
- Complete the resource mapping exercise of all current neurological services across Cwm Taf.
- Scope the work which needs to be undertaken to map the development of the service.
- Gather patient experiences via feedback, complaints, serious incidents and patient and staff satisfaction surveys to help identify underlying causes, themes and trends to identify possible gaps in service.
- Identify gaps in current service provision to inform the development of the Community Neurological Rehabilitation Service.

Phase 3 - Development of Documentation Detailing Future Development of a Community Neurological Rehabilitation Service:

To produce recommendations for the proposed Development of a Community Neurological Rehabilitation Service that is within the constraints of the funding allocation and approved by the Project Board.

The constraints of the project are:

- A challenging timescale.
• Limited amount of funding available for the development of a Community Neurological Rehabilitation Service across Cwm Taf.
• Limited staff resource capacity.
• Delayed product outputs from the Project Team and/or Working group will impact on the project timeline for completion of the project.
• Multiple stakeholders.
• Managing expectations of stakeholders.
• The proposal for the development of a neurological rehabilitation service must be clinically and financially sustainable.
• Risks and issues that are currently not described but are identified as the project develops.

**Delivery Theme 4: Living with a neurological condition**

People with neurological conditions often need a wide range of services from statutory and third sector agencies to meet their ongoing physical, psychological and social needs. These services need to be well co-ordinated and patient-centred, with an emphasis on promoting independence and self-care as much as possible and appropriate.

The context for commissioning, planning and delivering services to people with Long Term Conditions is changing as Setting the Direction is implemented within the new framework of Cluster Network Development and the 2014-2017 GMS Contract. The Health Board has prepared a draft strategy for Long Term Conditions with a model that can be adapted to each Long Term Condition. One component is to raise standards by education and support for every general practice team to deliver appropriate services that every patient should expect. The second component is to think about those with more complex conditions or less common conditions who will be supported by specialist ‘lead’ practice nurses and general practitioners within each Locality. Those with very complex or rare conditions will be supported by ‘lead’ clinicians at Health Board or Regional level.

Condition specific services currently available:

• **Motor Neurone Disease** (MND) – the South Wales MND Care Network provides consultant-led multi-disciplinary clinics, care co-ordination and support to people with MND and their carers, along with education opportunities for staff. Established in December 2011, the network has been mainly funded by the MND Association for a period of 4 years, after
which time the participating health boards will contribute to the funding on a tapered basis from 2016.

- **Parkinson’s Disease** – Cwm Taf provides a consultant-led multi-disciplinary Parkinson’s service, supported by a Parkinson’s Clinical Nurse Specialist. In 2014 the Clinical Nurse Specialist won a Cwm Taf UHB staff recognition award for her work in improving the lives of patients with Parkinson’s Disease. Working in partnership with the independent sector, she planned and delivered a rolling programme of structured education to health care professionals in care home settings which aimed to address the specific care needs of those with Parkinson’s. To date 60 care home staff have been trained, with positive changes made to working practice, including effective medicines management.

- **Multiple Sclerosis (MS)** –
  - The close link Cwm Taf UHB maintains with the multi-disciplinary MS team in Cardiff & Vale UHB, is facilitated by 2 of the 3 MS specialists for South East Wales already providing a general neurology service to Cwm Taf UHB. A two way dialogue enables local specialist staff to seek advice from and deliver services to patients in response to tertiary consultations. The 2 dedicated MS nurses for Cwm Taf provide direct services to patients including information and training on self-management, access to Disease Modifying Drugs and symptom management treatments and case coordination.
  - Meanwhile MS Enhanced Services have been introduced in ten GP Practices in Cwm Taf. Enhanced Services are specialist services provided in addition to a practice’s essential services. The aim of the scheme is to address proactively the physical health care needs of patients with MS, by ensuring they receive rounded health care and support. Where appropriate, the scheme should encourage the primary care team to work closely with the patient’s carer(s), and to encourage closer interaction with other support services.

- **Epilepsy** –
  - An Adult Epilepsy service has been set up at the Royal Glamorgan Hospital by one of the visiting Neurologists, however there is no adult epilepsy specialist nurse in Cwm Taf UHB which is an area of risk and inequality, given that all other Health Boards do offer such support. There are also limitations in prescribing as some drugs, e.g. perampanel are only available in hospital as local primary care services do not currently prescribe this and
the visiting neurologist is unable to offer repeat prescriptions.

- The visiting Neurologist ensures that patients with complex epilepsy surgical needs are linked into the epilepsy surgical programme in Cardiff and Vale UHB.

The Physiotherapy department in Cwm Taf UHB has a specialist out patient neurology team. Services include hydrotherapy and the provision of Functional Electrical Stimulation (FES). FES was previously delivered by Cardiff and Vale UHB, however, repatriation of this service enables timely intervention of FES for people who are experiencing difficulties walking.

With the exception of Parkinson’s, there are no local specialist inpatient or community neuro-rehabilitation teams for people with long term neurological conditions or acquired brain injuries, who have the potential of making a recovery and increasing their independence. Neuro-rehabilitation services have in the past been provided by a regional specialist service in Cardiff & Vale UHB. However in recent years there has been a move to repatriate patients back to local services and many patients are unable to access a bed in Cardiff & Vale UHB in a timely manner. This has presented a major challenge in terms of local specialist resource availability. Individuals with an acquired brain or spinal cord injury are most often younger and of working age with a normal life expectancy, resulting in ongoing high costs for NHS and social services as their symptoms remain untreated with high reliance on care. As described previously in this plan progress has been made to develop a Community Neuro-rehab service within Cwm Taf.

Symptoms in neurological conditions are frequently diverse and variable in nature with many patients presenting with complex, life-long disability including physical, cognitive, communication and behavioural. The management of profound disability is challenging for families, carers and support services such as social services or residential/nursing homes. Cwm Taf UHB recognise the need to support people with neurological conditions and their families/carers throughout the whole of a person’s life and to be responsive to need as symptoms change. There is robust evidence to show that multidisciplinary intervention can improve the experience of living with a neurological condition (Khan et al., 2007⁹; Turner-Stokes et al., 2005¹⁰).

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⁹ Khan et al., 2007 available @ http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006036.pub2/full

¹⁰ Turner-Stokes et al., 2005 available @ http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004170.pub2/full
Neurological conditions have major implications for many individuals’ psychological well being and often result in mental health problems, adjustment disorders, Post Traumatic Stress Disorder (PTSD) and complex psychological reactions in carers, which have an impact on health and quality of life. Patients with complex psychological difficulties require the service of a clinical psychologist who can carry out assessment of neuropsychological needs, and provide consultation and supervision to colleagues. Psychological care should also be provided through collaboration with the Third Sector and self-management initiatives.

Advances in technology and equipment can significantly reduce dependency and improve the quality of life for both for people living with neurological condition and their carers. For example Functional Electrical Stimulation (FES) and laser canes in aiding people to walk; standing frames, tilt tables and specialist exercise equipment to allow people to experience standing and exercise safely; communication aids and digital technology to support communication; as well as life supporting breathing machines. In addition to the physical benefits and greater access to the community that equipment brings, there are many psychological gains associated with the independence technology can deliver. For some people technology and equipment are key to self-management strategies.

Cwm Taf UHB recognises the benefits of equipment and technology however, understands the challenges that funding often expensive, specialist equipment poses. A decision is awaited from Welsh Government on the possibility of central funding arrangements for communication aids, which would improve equity of access across Wales.

Third sector provision – the third sector is active in our localities including the Wales Neurological Alliance, Parkinson’s UK, MND Association, MS Society, Epilepsy Action, Headway, Alzheimer’s Society and others. All provide a varying degree of direct care and support and advice through support workers, user groups, websites, help lines and information leaflets.

There is an increasing focus on integrated working across health and social care and the third sector. There are three linked work streams in Primary and Community Care relevant here:

- Community co-ordinators have been appointed as a part of the Integrated Care Fund to identify all third sector and other activities and groups in each Locality. The Coordinators have
already met with Cwm Taf general practice managers and are now engaging with each Locality and with general practice teams to maximise the links between Primary Care Teams and people who can support patients, families and carers.

- We are exploring the possibilities of linking this work to the role of the Carer’s Champions that have been appointed in most Cwm Taf general practices.
- Links with Communities First and their programmes are being made as a component of both the Inequalities / Inverse Care Law Initiative and of the Cluster Network Development domain of QOF and the 2014-2017 GMS Contract. These links will ensure that people with Long Term Conditions and their families and carers who could benefit from Communities First activities will be signposted appropriately.

Our key challenges for living with a neurological condition are:

- **Local condition specific services** – ensuring that appropriate specialist condition based services and support is available locally, eg dedicated first seizure service with expert epilepsy input.
- **Local neuro-rehabilitation services** – providing a specialist inpatient and community multidisciplinary neuro-rehabilitation services locally including services to preserve function and manage complex symptoms.
- **Co-ordinating services** – ensuring services are joined up and patient centred with effective communication and information sharing about the patient’s needs and care plan
- **Provision of equipment** – providing specialist equipment or technology to support quality of life and promote independence and self-management.

Our priorities for living with a neurological condition for 2016 – 17 are:

- Review and develop local condition specific services that support the ongoing needs of patients with a neurological condition and their families, including the potential for reinstating the Epilepsy Clinical Nurse Specialist post.
- Review current services and develop plans for specialist neuro-rehabilitation services in the community.
- Develop a business case for an Epilepsy Specialist Nurse to work with the Consultant. This business case will need to reflect the model of care to be provided and identify the interface with Primary and Secondary care services.
- Work closely with Cardiff and the Vale UHB to ensure that the same principles are used when developing this new service.
- Ensuring patients have individualised care plans which are accessible to all who may be involved in their care.
• Ensuring that services provide psychological care to facilitate long-term adjustment for patients and their carers. This is particularly important in such common conditions as non-epileptic attack disorder.
• Work proactively with third sector and other organisations to promote access to their community based services.
• Promote access to patient and carer support groups and programmes such as Education Programmes for Patients (EPP) and condition specific programmes.
• To review current equipment/technology provision in Cwm Taf UHB. Cwm Taf did receive some one off funding from Welsh Government during 2015 to purchase specialised equipment so there has been some progress in this area.

Delivery Theme 5: Children and young people

Healthcare for children and young people with a neurological condition in Wales is guided by the All Wales Neurosciences Standards (2009)\textsuperscript{11}, the National Service Framework\textsuperscript{12} and the Children and Young People’s Continuing Care Guidance\textsuperscript{13}. All children with significant neurological conditions are looked after by a Paediatrician and this works well.

Tertiary services are organised at a national level as per the above document. All Paediatricians have good access to a tertiary neurologist.

For Epilepsy there are two lead Paediatricians, one for the North and one for the South of the Health Board, who give advice and take on the more complex epilepsy cases, and also do joint clinics with a tertiary neurologist.

Our key challenges for children and young people are:
• **Transition** - planning and managing the transition of care for young people from paediatric to adult services is not well co-ordinated. This is not unique to Cwm Taf and there are discussions at national level looking at better models of care.

\textsuperscript{11} All Wales Neuroscience Standards for Children and Young People’s Specialised Healthcare Services

\textsuperscript{12} National Service Framework for Children, Young People and Maternity Services in Wales
http://www.wales.nhs.uk/sites3/home.cfm?OrgID=441

\textsuperscript{13} Continuing Care Guidance for Children
http://wales.gov.uk/topics/childrenyoungpeople/publications/care/?lang=en
• **Transition of children with epilepsy** – transition of services work well when the child has a Learning Disability or difficult to control epilepsy, as these children are taken on by adult secondary care. Things do not work so well for most other children who have to be transferred to primary care. Most adult patients are looked after by GPs and it can be a culture change for young patients to move from close secondary supervision to GP led care. There is need for GP involvement of the care of these children before transfer, and an epilepsy transition service has recently been set up by Dr Ann Johnston.

• **Multi-Disciplinary Team (MDT) assessment** - we are unable to provide MDT assessment due to lack of medical and administrative capacity.

• **CAMHS** - there are diagnostic challenges when neurological conditions such as epilepsy present with associated behavioural problems or a psychiatric disorder. Psychogenic seizures are very common and can mimic epileptic seizures, and if not carefully diagnosed it can lead to unnecessary usage of anti epileptic as well as psychotropic medications. Also uncontrolled epilepsy can have an impact on the psychological well being of the child.

• **Neuro – developmental services** – currently, neuro-developmental services for children and young people with conditions such as ADHD, Tourette’s Syndrome and Autistic Spectrum Disorder, are provided by CAMHS services. There is a need to develop specialist multi-agency Neuro-developmental services for these clients.

• **Intellectual disability** - with regard to the Neurological conditions that accompany Intellectual disability we find an increase in challenging behaviour and aggression that can lead to stress, interrupted education and sometimes to placement breakdown. All these factors add to the burden/stress and act as triggers for co morbid psychiatric conditions. There is a new Learning disability CAHMS service with joint clinics with Paediatricians and this is addressing some of the above problems. This is an excellent service but there are still significant capacity issues that need to be looked at.

Our priorities for children and young people for 2016 – 17 are:

• To consider the implications of the outcome of the South Wales Programme on paediatric neurological services.

• To continue to work with colleagues in adult services and primary care to improve the transition from paediatric to adult services, particularly for those with acquired brain injury and epilepsy.
• Develop plans for a multi-agency neuro – developmental service for Cwm Taf

Delivery Theme 6: Improving information

Information is used in a variety of ways to support patients and carers in understanding and living with their neurological condition; to enable more co-ordinated care for individuals across organisational boundaries; and to inform service and performance improvement. The current processes in place for managing patients across the boundaries of Cwm Taf and Cardiff & Vale UHB’s needs to be strengthened providing robust governance in relation to notes management and data capture.

Our key challenges for improving information are:
• **Commissioning arrangements** – specialist neurology services are currently commissioned on Cwm Taf’s behalf by WHSSC.
• **Information for planning, commissioning and performance management** – there are differences across Cwm Taf in the way that activity data for neurology services is administered, which makes it difficult to monitor and manage the service effectively.
• **Information systems** – although services are provided on a network basis, clinicians from different health boards cannot obtain access to patient records, investigation results etc.
• **Information for patients** - how to provide patients and carers with easy access to information on their condition and services available.
• **Patient feedback** – how to obtain and act on feedback from service users and carers.

Our priorities for improving information for 2016 – 17 are:
• To secure the transfer of commissioning responsibility from WHSSC to Cwm Taf UHB.
• To clarify and standardise the management of activity information on neurology services provided to Cwm Taf patients.
• Work with partners to develop an improved IT infrastructure enabling clinicians fast, safe and secure access to the information needed to care for patients.
• Review current patient information leaflets and other sources of information including Health Board and third sector websites, liaising with national Neurological Conditions Implementation Group colleagues to ensure a consistent all Wales approach.
• Seek feedback from service users and carers on the services provided and ideas for improvement.
• Participate in audits and peer review.
• Review admin support to ensure robust data input and notes management.

**Delivery Theme 7: Improving Research**

Achieving University Health Board status in 2013 has afforded Cwm Taf an exciting opportunity to extend its research and educational profile.

Our key challenges are:
• To maximise the opportunities for involvement in formal research activity and service innovation.
• To improve our understanding of our patient profile and opportunities for continuous improvement.

Our priorities for 2016–17 are:
• To support and encourage protected research and teaching time for clinical staff, including consultant SPA time and nurse specialist time for teaching.
• To explore the development of a patient database, in line with that developed by Cardiff & Vale UHB.

### 6. PERFORMANCE MEASURES / MANAGEMENT

Implementation of this Delivery Plan will be overseen by the Cwm Taf UHB’s Neurological Conditions Delivery Group, and sub groups relating to each theme. Actions will be assigned to sub groups whose leads who will report progress to the Delivery Group on a quarterly basis.

The Welsh Government’s Neurological Conditions Delivery Plan (2014) contained some potential assurance measures against which delivery of the plan will be assessed. These measures are currently being discussed and refined by the all Wales Neurological Conditions Implementation Group.

Progress against these NHS outcomes and assurance measures will form the basis of each health board’s annual report on neurological services. They will be calculated on behalf of the NHS annually at both a national and local population level.

Cwm Taf Health UHB’s delivery plans and their milestones will be reviewed and updated annually in accordance with agreed timeframes.
### Delivery Theme 1: Raising awareness of neurological conditions

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<tr>
<th>Priority</th>
<th>Actions</th>
<th>Expected outcome</th>
<th>Risks to delivery</th>
<th>Timescales</th>
<th>Lead</th>
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</thead>
<tbody>
<tr>
<td>1.1 Raise public awareness of neurological conditions</td>
<td>Promote national public awareness raising campaigns via the UHB website, social media and other media..</td>
<td>Increased public awareness. Earlier presentation to health services Reduced stigma</td>
<td>Reliance on national awareness raising to link into</td>
<td>March 2016 and ongoing</td>
<td>Raising Awareness Sub Group</td>
</tr>
<tr>
<td>1.2 Improve staff awareness and understanding of neurological conditions</td>
<td>Establish a rolling programme of general and targeted staff awareness raising on neurological conditions.</td>
<td>Increased staff awareness. Improved patient / carer satisfaction Earlier diagnosis</td>
<td>Ability to release staff for training</td>
<td>2016 and ongoing</td>
<td>Raising Awareness Sub Group</td>
</tr>
<tr>
<td>1.3 Ensuring the availability of comprehensive information materials</td>
<td>Source and ensure availability of hard copy and on-line information leaflets and materials from relevant support organisations</td>
<td>More informed public, patients and staff</td>
<td>Financial constraints</td>
<td>2016 and ongoing</td>
<td>Raising Awareness Sub Group</td>
</tr>
</tbody>
</table>
### Delivery Theme 2: Timely diagnosis of neurological conditions

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<tr>
<th>Priority</th>
<th>Actions</th>
<th>Expected outcome</th>
<th>Risks to delivery</th>
<th>Timescales</th>
<th>Lead</th>
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</table>
| 2.1 to support our GPs to manage patients when appropriate within primary care, and in accessing specialist advice when needed. | a. Review the conditions which may be appropriately managed within primary care and support GPs to do so  
   b. Introduce a primary care referral pathway for headache  
   c. Improve access for GPs to specialist telephone or email advice | GPs feel confident in managing appropriate neurological conditions how to access specialist advice when needed  
   Appropriate management of headache  
   Patient and carer satisfaction | Engagement of GPs | 2016 and ongoing | Referral / Diagnosis Sub Group |
| 2.2 clarify referral pathways | a. Review referral pathways and protocols to neurological services with clarity around when and how to refer to Care of the Elderly, Acute Medicine or Specialist Neurology services | Greater shared clarity amongst referrers and providers of the correct pathways  
   More timely and effective referral | Failure to referral agree pathways  
   Funding for electronic referral systems | By September 2016 and ongoing | Referral / Diagnosis Sub Group |
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<tr>
<th>Priority</th>
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<th>Risks to delivery</th>
<th>Timescales</th>
<th>Lead</th>
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</thead>
<tbody>
<tr>
<td>2.3 to achieve Referral to Treatment (RTT) targets</td>
<td>Work with Cardiff &amp; Vale UHB on a Waiting List Initiative for Neurology</td>
<td>Waiting list managed to within required timeframes. Need to monitor closely to ensure this remains the case</td>
<td>Information management / sharing between health boards, Financial constraints</td>
<td>Ongoing monitoring</td>
<td>Referral / Diagnosis Sub Group</td>
</tr>
<tr>
<td>2.4 to reduce waiting times for diagnostic scans and neurophysiology</td>
<td>Implement plan to meet agreed improvement trajectories Work with the directorate of radiology to ensure demand and capacity plans accurately reflect the service</td>
<td>More timely diagnosis Financial constraints Access to neuroradiology and neurophysiology</td>
<td>Ongoing</td>
<td>Referral / Diagnosis Sub Group</td>
<td></td>
</tr>
<tr>
<td>2.5 to have access to prompt</td>
<td>Review current service and develop business</td>
<td>Improved access to MDT assessment Financial constraints</td>
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specialist multi-disciplinary assessment and advice, to contribute to diagnosis and care planning

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<th>Expected outcome</th>
<th>Risks to delivery</th>
<th>Timescales</th>
<th>Lead</th>
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</thead>
<tbody>
<tr>
<td>3.1 Review current service with C&amp;VUHB</td>
<td>Work with Cardiff &amp; Vale UHB to review current service provision, demand and capacity</td>
<td>Reduced waiting times</td>
<td>Inter-organisational co-operation</td>
<td>During 2016</td>
<td>Fast and Effective Care Sub Group</td>
</tr>
<tr>
<td>3.2 Seek ways to improve access to timely acute neurological advice</td>
<td>To review the adequacy and appropriateness of the current 24 hour access to on-call specialist advice for those admitted to hospital with a primary or suspected neurological condition</td>
<td>More timely diagnosis and effective care</td>
<td>Financial constraints</td>
<td>During 2016</td>
<td>Fast and Effective Care Sub Group</td>
</tr>
<tr>
<td>3.3 Review and develop services for people with acquired brain</td>
<td>Seek ways to establish care pathways and local expertise for people with acquired brain injury, so</td>
<td>Improved services for people with ABI</td>
<td>Financial constraints</td>
<td>During 2016</td>
<td>Fast and Effective Care Sub Group</td>
</tr>
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</table>
that timely assessment can be carried out and referral on to the right care setting take place

3.5 To implement the project outcomes in order to deliver the Community Neuro Rehab service.

Implement and project manage the rehab programme according to the project plan

To provide a local rehab service for patients with Neurological conditions

Limited model due to financial constraints

During 2016

Fast and Effective Care Sub Group

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<tr>
<th>Priority</th>
<th>Actions</th>
<th>Expected outcome</th>
<th>Risks to delivery</th>
<th>Timescales</th>
<th>Lead</th>
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<tbody>
<tr>
<td>4.1 Review and develop local services that support the ongoing needs of patients with a neurological condition and their families</td>
<td>Review current service provision and identify priorities for improvement</td>
<td>Improved continuity of care</td>
<td>Financial constraints</td>
<td>By Sept 2016</td>
<td>Living with Neuro Conditions Sub Group</td>
</tr>
<tr>
<td></td>
<td>Consider potential for reinstating the Epilepsy CNS post</td>
<td>Improved patient and carer satisfaction</td>
<td></td>
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<tr>
<td>4.2 Review and develop specialist</td>
<td>Review current service provision and develop a</td>
<td>Improved local care provision</td>
<td>Financial constraints</td>
<td>Model agreed</td>
<td>Living with Neuro</td>
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<tr>
<td>Local neuro-rehabilitation services</td>
<td>Business case for specialist neuro-rehabilitation team in the community</td>
<td>December 2015. Partial funding received. Further scoping/stakeholder engagement/priority setting planned for March 2016.</td>
<td>Conditions Sub Group</td>
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<tr>
<td>4.3 Ensure patients have individualised care plans which are accessible to all who may be involved in their care</td>
<td>Review current care planning processes and documentation and identify priorities for improvement</td>
<td>Patient centred care</td>
<td>Financial constraints</td>
<td>Sept 2016</td>
<td>Living with Neuro Conditions Sub Group</td>
</tr>
<tr>
<td>4.4 Review how services provide psychological care to facilitate long-term adjustment for patients and their carers</td>
<td>Review current access to psychological care for people with a neurological condition</td>
<td>Understanding of current provision and gaps</td>
<td>Financial constraints</td>
<td>Dec 2016</td>
<td>Living with Neuro Conditions Sub Group</td>
</tr>
<tr>
<td>4.5</td>
<td>Ensure effective partnership working with third sector organisations</td>
<td>Work proactively with third sector and other organisations to promote access to their community based services</td>
<td>Improved support for patients and carers</td>
<td>Availability of third sector services</td>
<td>Commenced 2015 and ongoing</td>
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<td>4.6</td>
<td>Encourage patient self management and peer / carer support</td>
<td>Promote access to patient and carer support groups and programmes such as Education Programmes for Patients (EPP) and condition specific programmes</td>
<td>Improved patient and carer engagement and satisfaction</td>
<td>Engagement of patients</td>
<td>Commenced 2015 and ongoing</td>
</tr>
<tr>
<td>4.7</td>
<td>providing specialist equipment or technology to support quality of life and promote independence and self-management</td>
<td>Undertake audit of equipment availability</td>
<td>Improved assess to equipment required</td>
<td>Financial constraints</td>
<td>Capital money received from WG December 2015. Equipment ordered/delivery by March 2016. Ongoing</td>
</tr>
<tr>
<td>4.8</td>
<td>review the potential to employ a epilepsy specialist nurse.</td>
<td>Develop a business case to identify need.</td>
<td>Access to specialist nursing services</td>
<td>Financial constraints</td>
<td>During 2016</td>
</tr>
<tr>
<td>Priority</td>
<td>Actions</td>
<td>Expected outcome</td>
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<td>Lead</td>
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<tr>
<td>5.1 Consider the implications of the outcome of the SW Programme on paediatric neurological services</td>
<td>Paediatric sub group to convene and report on any implications and actions required</td>
<td>Clarity on implications for services</td>
<td>Medical staffing availability</td>
<td>Ongoing</td>
<td>CYP Sub Group</td>
</tr>
<tr>
<td>5.2 Improve the transition of care from paediatric to adult services for young people with a neurological condition</td>
<td>Review the current transition arrangements for each condition, and develop and action plan for improvement</td>
<td>Improved patient and family satisfaction levels. Improved continuity of care</td>
<td>Resource implications</td>
<td>March 2016</td>
<td>CYP Sub Group</td>
</tr>
<tr>
<td>5.3 Improve services for children and young people with neuro-developmental disorders</td>
<td>Develop plans for a multi-agency neuro-developmental service for Cwm Taf</td>
<td>Improved multi-agency support for children and families CAMHS able to focus more on core service</td>
<td>Resource implications</td>
<td>September 2016</td>
<td>CAMHS</td>
</tr>
<tr>
<td>Priority</td>
<td>Actions</td>
<td>Expected outcome</td>
<td>Risks to delivery</td>
<td>Timescales</td>
<td>Lead</td>
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<tr>
<td>6.1 Transfer commissioning responsibility</td>
<td>Work with WHSSC to secure the transfer of commissioning responsibility from WHSSC to Cwm Taf UHB</td>
<td>Cwm Taf responsibility for commissioning</td>
<td>Resource implications</td>
<td>2016</td>
<td>Information Sub Group</td>
</tr>
<tr>
<td>6.2 Improve information management arrangements</td>
<td>Work with Cardiff &amp; Vale UHB and WHSSC to clarify and standardise activity information on neurology services provided to Cwm Taf patients</td>
<td>Improved joint understanding of activity, information sharing, and demand, waiting times and issues to be addressed</td>
<td>Reliance on C&amp;VUHB for information provision</td>
<td>September 2016</td>
<td>Information Sub Group</td>
</tr>
<tr>
<td>6.3 Improve IT infrastructure</td>
<td>Work with partners to develop an improved IT infrastructure enabling clinicians fast, safe and secure access to the information needed to care for patients</td>
<td>Improved coordination of care for individuals</td>
<td>Funding for IT developments</td>
<td>March 2016</td>
<td>Information Sub Group</td>
</tr>
<tr>
<td>6.4 Participate in audits and peer review</td>
<td>Identify any relevant audits and peer review opportunities to enable the measurement and benchmarking of our</td>
<td>Improved understanding of how our services can be improved</td>
<td>Funding and time constraints</td>
<td>Ongoing</td>
<td>Information Sub Group</td>
</tr>
</tbody>
</table>
services with a view to continuous improvement

### 6.5 Review patient and carer information

<table>
<thead>
<tr>
<th>Services</th>
<th>Improvement and Awareness Sub Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review patient information leaflets and information provided, both hard copies and online</td>
<td>Improved public and user awareness</td>
</tr>
<tr>
<td></td>
<td>Funding and time constraints</td>
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<tr>
<td></td>
<td>Ongoing updates</td>
</tr>
</tbody>
</table>

### 6.6 Seek patient and carer feedback

<table>
<thead>
<tr>
<th>Services</th>
<th>Improvement and Awareness Sub Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish mechanism to obtain regular feedback from service users and carers on the services provided and ideas for improvement</td>
<td>Improved understanding of how our services can be improved</td>
</tr>
<tr>
<td></td>
<td>Funding and time constraints</td>
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<tr>
<td></td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

### Review administrative functions across the service to ensure robust pathway management

<table>
<thead>
<tr>
<th>Services</th>
<th>Improvement and Awareness Sub Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure that all patient activity is recorded appropriately, notes management is according to governance arrangements and clinics are supported robustly.</td>
<td>Improved information systems. Improved patient confidentiality</td>
</tr>
<tr>
<td></td>
<td>Funding and time constraints</td>
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<td></td>
<td>During 2016</td>
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<td></td>
<td>Directorate management team</td>
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</tbody>
</table>

### Delivery Theme 7: Targeting research

<table>
<thead>
<tr>
<th>Priority</th>
<th>Actions</th>
<th>Expected outcome</th>
<th>Risks to delivery</th>
<th>Timescales</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 To support and encourage</td>
<td>Identify neurology related research projects in which</td>
<td>Increase in number of</td>
<td>Funding and time constraints</td>
<td>June 2016</td>
<td>Medical Director</td>
</tr>
<tr>
<td>neurology related research and innovation</td>
<td>CTUHB is participating research trials</td>
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<tr>
<td>7.2 make arrangements for protected research and teaching time for clinical staff</td>
<td>Protect consultant SPA and nurse specialist time for research and teaching</td>
<td>Increased time available for research and teaching</td>
<td>Operational pressures</td>
<td>Dec 2016</td>
<td>Medical Director</td>
</tr>
</tbody>
</table>