THREE YEAR
INTEGRATED MEDIUM TERM PLAN
2020 – 2023 Draft November 2019

Local Annexes: Book ___
Together for Health Delivery Plans
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1. INTRODUCTION

2. STROKE SERVICES

Key Strategic Drivers

The initial “Together for Health – Stroke Delivery Plan” was published by Welsh Government in December 2011 and provided a framework for action by Local Health Boards and NHS Trusts working together with their partners. It set out the Welsh government’s expectation of the NHS in Wales to tackle stroke in people of all ages, wherever they live in Wales and whatever their circumstances. The plan was designed to enable the NHS to meet the needs of people at risk of a stroke or affected by a stroke. This Plan was refreshed in February 2019 and sets out the vision for stroke care across Wales up to 2020.

Progress during 2019/2020

Stroke Prevention

Cwm Taf Morgannwg UHB’s vision is to be recognised as a population well-being organisation. Work is underway to roll out a model of population health management based on segmentation and risk stratification, linking and analysing primary and secondary care data in order to segment the cluster population and allow targeted anticipatory care.

The intention is to develop an integrated chronic disease programme which has a key focus on an evidence based approach to prevention and early intervention, increased collaborative working between primary and secondary care and improved equity of access. Development would be based on the principle of patient centred care particularly in the presence of multimorbidity.

The Health Board is committed establishing ‘Making Every Contact Count’ across the organisation with a focus on disease prevention through a range of programmes to address modifiable lifestyle risk factors including expansion of smoking cessation services.

Making Every Contact Count (MECC) is an approach to behaviour change that supports staff to more routinely and effectively incorporate health behaviour change conversations into their interactions with other people. These conversations, based on brief advice and brief intervention methodology help support individuals to make positive changes to their lifestyle by empowering them to consider; the changes that they want to make as well as how they may achieve them. As part of this individuals are signposted and referred to avenues of local support. A large proportion of staff within stroke services have been trained which also allows a strong focus on secondary prevention.

The Health Check Programme, seeks to improve the health and wellbeing of adults aged 40-74 years through promoting the early identification and management of individual behavioural and physiological risk factors for cardiovascular disease and other conditions associated with these risk factors.
Practice based assessments are undertaken by trained Health Care Support Workers (HCSWs) using the menu driven software. Appointments include measuring blood pressure, pulse, height and weight, blood testing, patient history and assessment of lifestyle factors. Based on this information, a revised “heart age” and risk of developing CVD over the following 10 years are calculated and explained to the patient. Using brief intervention techniques, patients are encouraged to consider potential lifestyle changes to reduce their risk, provided with individualised information regarding their risk and where appropriate, referral/signposting to other services for ongoing support is made. Patients with abnormal results are referred back into the normal practice system for further clinical assessment and management.

The current development of Primary care cluster IMTPs will allow a further focus on tackling behavioural and clinical risk factors in particular hypertension and atrial fibrillation.

The Identification of individuals with Atrial Fibrillation (AF)

During 2018 the National SIG provided £15,000 for a project to undertake a collaborative approach to optimise the management of patients with atrial fibrillation to reduce stroke risk in the then Cwm Taf University Health Board (UHB). Phase one of the project was to identify pilot practices (in Tonypandy) who would be supported by the clinical lead, a pharmacist and secondary care specialist to enable the assessment of all those identify to optimise their management including anticoagulation.

Primary Care practices was supported to utilise the new Dashboard on Audit-plus to ascertain the number of people with known AF that are not currently anticoagulated. The aim was to roll this practice out across Cwm Taf Morgannwg UHB. The project also developed a pathway to facilitate the assessment and management of people identified with AF in the Health-Check pilot.

During 2019/20 the National Stroke Implementation Group have continued to support Cwm Taf Morgannwg UHB by allocating £75,000 to further deliver the Stop a Stroke Campaign across the UHB, building on the experiences from Cardiff and the Vale UHB. The Stop a Stroke Campaign is a multi-level intervention, influencing at cluster level, working directly with health professionals and encouraging patient education on AF through multimedia as illustrated in Figure 1.
Progress on this project will continue to be monitored and evaluated throughout 2019/20.

Reconfiguration of stroke services in Wales

The then Cwm Taf UHB redesigned its stroke services back in 2015. This redesign was driven by the need to improve the quality of services in line with ever-challenging national clinical standards. March 2015 saw the culmination of a comprehensive redesign which incorporated a creation of a new community-based rehabilitation service enabling Early Supported Discharge for stroke patients, centralisation of longer term inpatient stroke rehabilitation services at Ysbyty Cwm Rhondda and centralisation of hyper-acute, acute stroke and early stroke rehabilitation services at Prince Charles Hospital (PCH). Since the reconfiguration Cwm Taf Morgannwg UHB have continued to strive to improve stroke pathways to order to improve services for patients as well as improve performance against Quality Improvement Measures.

Clearly with the Bridgend boundary change, we will be looking to refresh our approach to stroke service improvement to include these services and staff and working with our partners, we will be looking to how we can further improve our stroke services to the communities we will serve. The SIG have committed to assisting us with this work, by sharing best practice, lessons learnt and progress undertaken in neighbouring health boards which received funding for taking forward HASU projects.

Community Neuro/Stroke Rehabilitation:

An update in terms of progress made during 2019/2020 relating to the Community Neuro/Stroke Rehabilitation services is included under Section 3.

Responding to patient experience and outcome measures

In terms of patient experience and outcome measures we can report the following progress:

- As part of the work funded and facilitated by both the neurological and Stroke implementation groups we have actively been involved with the development and implementation of a Patient Reported Outcome Measure (PROM). The UHB is
involved in a research study with Aneurin Bevan UHB on PROM/PREMs for stroke patients. This is being done using quality of life measures as part of the 6 month follow up review. This is being undertaken by comparing doing this face to face, via telephone and on-line. The stroke team at PCH are achieving 100% in the 6/12 review target, as monitored by SSNAP, consistently and are amongst the top performers in the UK against this target. A number of our therapist are represented on the National Implementation Group which is auditing the implementation of the PEOMS/PREMS work.

- Within Prince Charles Hospital a specific stroke patient satisfaction survey is undertaken both in acute and rehabilitation. This is being done using Survey Monkey using electronic devices.
- Within our Community Neuro/Stroke Rehabilitation service, service users have had an active part in developing media resources and ‘starring’ in educational videos which will be available to clinicians and the public via inter and intranet sites. http://cwntaf.wales/services/community-neuro-service/
- The production of a digital story by a service user is under way, to feature the voice and story of someone who has benefitted from the neurorehabilitation provided.
- The ESD Service Patient satisfaction rates are consistently high and the team are confident we are capturing and reflecting the views of the majority of our patients with a current 69% return rate to our questionnaires.

Continue stroke improvement work and improvement in performance against QIMs including a shift to 7 day working (nursing, medical and therapy) should resources become available.

- A business case has been produced for both PCH and POW which outlines to options, from a medical, nursing and therapy perspective, for moving to a 7 day stroke service. This case will be submitted again this year into the organisations IMTP prioritisation process for consideration.
- The National Stroke Implementation group have provided funding to implement 7 day working within therapies as a pilot project. This project also aimed to implement the Bridges Training methodology. It involved goal setting with patient and relatives aiming to improve family/patient participation, ownership supporting therapy plans and self-management. This project enabled therapy based inventions to be delivered on Saturdays and Sundays at PCH, where families can come to the hospital and be involved in the rehabilitation process, improving quality of care for patients as well as improvement against performance measures. This pilot strengthens the business case for 7 day working which has been developed as it demonstrates clear positive outcomes for patients and carers. Members of the stroke team in POW have also undertaken Bridges Training however there have been some issues relating to resources such as books and training materials.

National Priorities for 2020/2021

The National Stroke Implementation Group (SIG) have reviewed priorities for 2020/2021 which are as follows:
• Workforce planning to address patient flow through the whole stroke pathway, from HASU to community rehabilitation, ensuring a prudent workforce model.
  - Ensuring that each Health Board has a staffing model to deliver services across their whole stroke pathway with a focus on the medical staff and SpR posts for HASU standards; and also addressing the benchmarking gaps of Speech and Language Therapists, Physiotherapists, Occupational therapists and nursing staff.
  - Support the development of rehab assistant roles to support the prudent workforce model and a 7 day rehabilitation model.
  - Ensure that staffing for rehabilitation and community settings offer a sustainable resource model that enables efficient and effective flow through the stroke pathway.

• Progress to implement HASU implementation plans.
  SIG has made some progress nationally in achieving HASU plans agreed by SIG previously. There remains work to be done to implement HASU models across Wales with the right staffing 24/7. Such plans much also ensure the best possible access to hyper acute care for the population in remote areas. The key elements of a HASU are the staffing which will need to be sustainable and a whole pathway approach.

• Primary Stroke Risk Reduction
  The aim is to prioritise primary stroke risk reduction at all points of contact with a proactive approach. Hypertension is present in around 54% of stroke admissions, atrial fibrillation is present in 21% of stroke admission with only 12.4% being on anticoagulation (figures from annual SSNAP data report for UK).

Local Priorities for 2020/21

During 2019 the Stroke Delivery and Planning Group reformed and became a Cwm Taf Morgannwg wide group following the Bridgend boundary change. Clearly with the boundary change, we will be looking to refresh our approach to stroke service improvement, focusing on how we can further improve our stroke services to the communities we serve. There is a plan to produce a new Cwm Taf Morgannwg Stroke Improvement plan by January 2020. To date the group have determined what the key challenges are across stroke services, which will inform the priorities within the Improvement plan. The main challenges identified are as follows:

• Specific challenges within Speech and Language Therapy which impact on MDT working. Our recent challenges had had an impact on our SSNAP score this year and the Quality Improvement Measures.
• Both stroke units currently run a 5 day service. There are real challenges to being able to consistently delivery high compliance for assessment by a consultant within 24 hours across the organisation, given that there is 2.6 WTE Stroke Consultants at PCH and 2.0 WTE at POWH, with very limited middle grade cover. There are also challenges in delivering a 7 day service for nursing and therapy provision due to current staffing numbers.
• Thrombolysis rates and door to needle times continue to be a challenge and is an area of focus for further improvement.
• Both stroke units have a specific challenge around achieving the 4 hour target for admission to the stroke unit. Significant patient flow issues and pressures across both
site have a direct impact on stroke service provision. This is a key priority areas to focus on in service of service improvement over the next 12 months.

- Within Prince Charles Hospital there is a Community Stroke/Neuro Rehabilitation service which is currently funded out of National Stroke/Neurological funded on a non recurring basis. There is also a Early Supported Discharge Service which is funded currently funded out of Intermediate Care Funds. With POWH there is no stroke/neuro rehabilitation service or an Early Supported Discharge Service the development for which will be a priority within our Stroke Improvement Plan going forward.

Considering the challenges described and the recent Bridgend boundary change and the drive nationally to have fewer centres for stroke care provision, to enable the development of centres of excellence we will be looking to refresh our approach to stroke service improvement. A bid will be submitted to the National Stroke Implementation Group for support to undertake scoping work in relation to the development of a Hyperacute Stroke Unit.

**Links to Workforce Plan**

The workforce implications of the development of a seven day stroke service have already been set out within a business case within each respective DGH stroke units. However, should funding be approved from the National Stroke Group scoping work for the development of a HASU will provide significant detail in terms of the workforce requirements.

**Links to Finance Plan**

Financial implications in relation to the development of a HASU will be scoped out as part of the work outlined above.

There is financial risk relating to the funding of the Early Supported Discharge Service and Community Neuro Rehabilitation Service operating within what was the old Cwm Taf UHB. There are no such services running within the POWH area which is a significant gap in provision.

**Links to Performance**

**Performance is monitored and reported against:**

- Welsh Government Quality Improvement Measures – monthly
- Royal College of Physicians Stroke Sentinel National Audit (SSNAP) – clinical audit reported quarterly
- Royal College of Physician’ Organisational Audit – annually.

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**Cancer Services**

**National Priorities**

The Cancer Implementation Group led by Welsh Government has agreed a set of priorities as follows:

- Health boards and Velindre NHS Trust to implement the single cancer pathway, including pathway standardisation and detecting cancer early programme.
• Health boards and Public Health Wales NHS Trust to focus on improving bowel cancer outcomes by optimisation of the bowel screening programme and the development of sustainable endoscopy services.

Implementation of the national Cancer Delivery Plan and the Health Board’s progress in delivering against its agreed set of local priorities is overseen by the Health Board’s Cancer Programme board.

Outcome measures
The Health Board’s work programme will be assessed against the following key outcome measures:
• Incidence and prevalence of cancer.
• One year and five year survival rates.
• Premature mortality related to cancer.
• Stage of diagnosis.
• Local screening uptake.
• Referral to treatment time
• Single Cancer Pathway performance
• 30-day mortality post treatment.
• Number of patients with a key worker and care plan.
• Completion of holistic needs assessment (HNA).

Local Priorities
The Health Board is playing a key role in delivering a number of national priorities in relation to early cancer diagnosis, diagnostics and the single cancer pathway.

Our key priorities include:
• Early Cancer Diagnosis Programme:
  o Embedding and evolving the Rapid Diagnostic Clinic as a mainstream service following its’ successful pilot.
  o USC pathway improvement which seeks to develop a one-stop approach to diagnostics, resulting in diagnostics being undertaken earlier in the pathway thereby reducing time to diagnosis. Current areas of focus include haematuria, prostate, gynaecology, colorectal and lung pathways.
  o Improving screening uptake across our communities (Ongoing).
  o A programme of community engagement to address barriers to early presentation.
  o Continued engagement with Primary Care to actively participate with the Macmillan primary care Toolkit

• Single Cancer Pathway:
  o Continue with the demand and capacity analysis to inform strategy for delivering the Single Cancer Pathway
  o Increasing and strengthening the diagnostic capacity of the HB to facilitate the delivery of the Single Cancer Pathway
  o Developing additional resource and expertise to clinical and directorate services, to enable them to deliver the National optimal pathways
Work to be undertaken with POW to enable effective data reporting

- **Cancer workforce sustainability and succession planning:**
  - Succession planning for Cancer Nurse Specialist posts and effective use of specialist workforce (Ongoing).
  - Role of Band 4 navigators to support the CNS workforce to be implemented
  - Identify Lead Therapist for Cwm Taf
  - Address shortage of Cancer AHPs and impact on single cancer pathway agenda, pre-habilitation, optimisation and rehabilitation.
  - Identify shortages for other specialities within the HB such as Radiology, endoscopy, oncologists

- **Meeting People’s Needs:**
  - Improve patient handovers between tertiary and local services (Ongoing).
  - Improved communication between primary and secondary care (Ongoing)
  - Continued roll out of the Macmillan recovery package (Ongoing).
  - Implementation of the actions required within the Health Board in response to the cancer patient experience survey released in July 2017 (Ongoing).

- **Peer Review**
  - Maintain high level of Peer Review Compliance. A robust reporting mechanism will be put in place to ensure that each clinical directorate is working towards the peer review action plan and that cancer services are aware of the work that is being undertaken.

- **Engagement with the Transforming Cancer Services Programme:**
  - Work with Velindre NHS Trust to capitalise on opportunities to develop more integrated services with the aim of improving quality and patient experience (Ongoing as programme has been delayed).

The Health Board’s Cancer Programme Board chaired by the Executive lead for Cancer monitors progress against our priorities on a bi-monthly basis.

**Key Challenges**

Some of the Health Board’s key challenges for 2020/2021 include:

- High incidence of cancer and low one and five year survival rates.
- Successfully addressing cultural attitudes and beliefs of our local communities in relation to cancer to reduce the number of patients presenting with late stage disease.
- Delivery of the Single Cancer Pathway. In particular this includes managing the interface between our local services and tertiary providers particularly in relation to ensuring patients requiring treatment in another Health Board receive this in accordance with the agreed pathways. There is also a large resource required across diagnostics in order to provide the needed capacity for delivery.
- Cancer Nurse Specialist workforce. The challenges for the Health Board are two-fold in relation to capacity within some of our services and ability to recruit to vacant posts. We have a number of site specific teams who are single handed and 8 CNS’ due to retire in
the next 5 years. Succession planning is a fundamental to manage the risks for the organisation around service delivery and meeting of the single cancer pathway targets.

**Liver disease**

Hospital admissions because of liver disease are increasing with the majority of these patients admitted with end-stage disease, liver cirrhosis or liver failure. The prevalence of key risk factors such as alcohol, obesity and IVDU associated with liver disease and its outcomes are linked to social deprivation and inequality.

Obesity is an increasing challenge in all age groups and there is concern that this will become a main cause for liver disease in the future.

The Cwm Taf Local Public Health Team has completed a Liver Disease Population Needs Profile which shows:

- Cwm Taf has the highest chronic liver disease premature mortality rate in Wales
- Cwm Taf had the highest level of hospital admissions for liver disease in Wales.
- Cwm Taf has the highest alcohol related illness, mortality, admission and percentage drinking above guidelines in Wales.

The Together for Health – Liver Disease Delivery Plan, published by the Welsh Government in 2015, provides a framework for action by Health Boards and NHS Trusts working together with their partners to develop and improve services for people with liver disease. It focuses on how to prevent the disease in the first instance and also, where necessary, to ensure people have access to excellent care, reaching across the following themes:

- Preventing liver disease
- Timely detection of liver disease
- Fast and effective care
- Living with liver disease
- Improving Information
- Targeting research

**National Priorities for 2020/21**

1. Further develop the opportunistic assessment of alcohol in different settings and develop secondary care-based alcohol care teams to provide timely interventions as appropriate.

2. Taking forward the implementation of Welsh Health Circular 048 2017 ‘Attaining the WHO targets for eliminating hepatitis (B and C) as a significant threat to public health’.

3. Improve the provision of assessment, testing and treatment of those at highest risk of developing liver disease.
Local Priorities for 2020/21

The Cwm Taf Morgannwg local Delivery Plan focuses on the following priorities:

Preventing Liver Disease

1) Ensure the full engagement across the HB on the management of pathways for the management of obesity. (2019/20 progress: adult weight management services has developed a business case. Liver Disease planning support is present on the working group).

2) To raise awareness of alcohol as a risk factor for liver disease and promote opportunities for screening and brief intervention amongst our population, including opportunistic screening in less traditional settings (pre-assessment clinic for elective surgery etc). (2019/20 progress: Audit C soon to be sighted on Nursing Initial Assessment Forms. On-going links with Drink Wise age Well Services and Third sector)

Timely detection of liver disease

3) To ensure GPs are aware of the pathways and what tests should be done prior to referral (Clinical leads currently in discussion with AMD for primary care regarding standardising referral criteria and minimal requirements as part of OPD transformation)

4) Non-invasive risk assessment of liver disease – Fibroscan machine. Our own abnormal LFT pathway (both locally and All Wales) as well as recent national guidelines have identified ways of detecting patients at risk of liver disease. This requires subsequent assessment in the majority of cases with non-invasive tools. This relies on Fibroscan but our current service is limited by only occupying one fibroscan machine. In able to provide timely assessment to patients referred from our primary care pathways, increased capacity and ability to deliver this assessment has to be created. (2019/20 progress: Business case currently being developed and considered for additional fibroscanner)

5) Strengthen Alcohol Liaison nurse services across the UHB. (2019/20 progress: Alcohol Liaison service evaluation and business completed, and long term funded gained through APB. Alcohol liaison Champions soon to be present on each ward).

6) Improve local transplant referral pathway to support the increased number of patients needing transplant. This should include a dedicated high intensity nutritional services and “prehabilitation” programme with dedicated dietician and physiotherapy involvement (2019/20 progress: Pre-transplant check list completed, transplant pathway in progress; Business case for handgrip strength measurement devices being developed; clinical leads to meet with dietetics and physiotherapy departments to discuss further).
7) Continue working with all tiers of substance services to ensure Dry Blood Spot Testing (DBST) of clients injecting drugs. (2019/20 progress: on-going, referrals being monitored by APB)

8) Provide training for cluster liver disease champions and develop community cluster diagnostic clinics, including the use of portable fibroscan machines. (2019/20 progress: currently no champions in Wales. Clinical Lead currently in discussions with Primary Care to develop cluster liver disease champions.)

9) Improving Quality in Liver Services (IQILS) accreditation (2019/20 progress: local working group set up. Action plan developed in line with level 1 accreditation)

Fast and effective care

10) Identify time for lead clinicians to develop and implement robust pathways across the health community designed to deliver a consistent approach to liver disease management (2019/20 progress: Clinical leads engaging with colleagues in POW to ensure transition and standardisation of pathways where appropriate; Ongoing)

11) Continue with engagement at the All Wales BBV network meetings. (2019/20 progress: priority completed, engagement in place. Clinical lead attends networking meetings)

12) BBV leads have an agreed standard supporting the implementation of prescribing appropriate treatments in line with NICE and AWMSG guidance from the management of viral hepatitis. This needs to be agreed on a national level. (2019/20 progress: action completed)

13) Hepatocellular carcinoma (HCC) Cwm Taf currently utilises both local upper GI cancer MDT services as well as a regional HCC MDT (unfunded component of HPB MDT) to discuss and offer treatment to patients with HCC. The clinical lead for HCC is currently attending the MDT on a weekly basis and is engaged in discussions to streamline the services and improve timely discussion, diagnosis and treatment (2019/20 progress: Clinical lead now attending weekly meeting. Discussions in progress with radiology colleagues to offer TACE and RFA therapy locally within CTUHB)

Living with Liver Disease

14) Continue with & review the outcomes of the Cirrhosis Surveillance Clinics – to include patient feedback and develop PROMs (2019/20 progress: evidence based quality of life questionnaires currently being reviewed and patient satisfactory survey being drafted and finalised)
15) Develop a peer support network and patient support group for patients and relatives of patients living with liver disease (2019/20 progress: Discussions in progress to develop a monthly patient support group with support from external charities).

16) Ensure palliative care is available and offered to patients at an appropriate time (2019/20 progress: Clinical Lead engagement with Palliative Care Team. Palliative care pathway in development with other non-cancer teams).

17) Improve the provision of psychiatric liaison nurses to provide intensive input for patients with advanced liver disease and alcohol related brain impairment. (2019/20 progress: referral pathway established for difficult ARDB patients. Pathway in development).

Improving Information

18) Establish links to local and national charities. (2019/20 progress: on-going links made with British Liver Trust and PBC foundation)

19) Develop a performance dashboard specifically for liver disease and the priorities identified within this plan. (2019/20 progress: links to developments within IQILS)

Our priorities have taken into consideration the following:

- **Well-being**: Ensuring an over-arching focus on the reduction of health inequalities. An example of this – Drink Wise, Age Well.
- **Care closer to home**: Planning and delivering the majority of care closer to home – an example is shown how the heard board has strengthened links between statutory (i.e. the Health Board’s Community Drug and Alcohol Team) and third sector delivery of substance misuse services with a unified governance structure. The local planning and delivery group also now has a third sector representative present within the group.
- **Acute Care**: Ensuring the provision of safe and sustainable secondary care services - an example the recently developed alcohol liaison service, whereby national evidence suggests that this service helps to reduce re-admissions.

Links to well being and futures generations act

Our priorities for liver disease contribute to the well-being goals and ways of working:

- We will ensure that all services provided are safe and sustainable and provide good value for money.
- Working collaboratively with third sector groups, local authority and other directorates in the local planning and delivery group to take programmes forwards holistically.
- A focus on the preventative agenda – such as the Early Detection of Liver Disease Pathway.
- Working closely with charities promoting a more globally reasonable Wales.
- Evidence-based decisions informed by sound science and the principles of value-based health and prudent healthcare.
Links to Prudent Healthcare

Recently the local planning and delivery group has recently extended. We now have representatives from the third sector, local authority, palliative care and primary care. This has allowed a more holistic approach to the delivery of more prudent health care.

Prudent initiatives include: Early Detection of reversible Liver Disease, Nurse led clinics - Cirrhosis Surveillance Clinics, Alcohol Liaison Service and links with third sector.

Links to Performance

Regular reporting on progress will be reported up to the National Liver Disease Implementation Group.

Links to the Financial and Workforce Plans

A business case is currently being develop for re-submission to obtain additional fibroscanners for the liver service. The importance of these pieces of equipment on achieving the aims of multiple priorities cannot be under-estimated as without them patients will potentially be mis-diagnosed or not identified until they present with symptomatic, advanced liver disease and decompensation. This was have significant financial implications and increase the burden on in-patient services and bad occupancy, as well as impacting on the quality of life of patients. Work is ongoing at identifying novel funding options including links with primary care and other departments with common patients cohorts (substance misuse, diabetes and endocrinology).

3. Neurology

Key Strategic Drivers

“Together for Health – a Neurological Conditions Delivery Plan” was published in April 2014 and provided a framework for action by Health Boards and NHS Trusts working together with their partners. I set out the Welsh Government’s expectation for the planning and delivery of high quality person centred care for anyone affected by a neurological condition. The Plan was refreshed in February 2017 and sets out the vision for neurological care across Wales up to 2020.

Progress during 2019/2020

Annual update from the Community Neuro/Stroke (CNS) Rehabilitation Service

In 2016/17 the then Cwm Taf UHB received funding (£117,000) for improvement of neurorehabilitation services. The funding was utilised to develop a small community neuro/stroke rehabilitation team, which would work according to a multi-agency co-production model with a holistic intervention programme working in collaboration with other agencies utilising existing resources and expertise. The outcome of stakeholder consultations clearly indicated the need to develop provision of psychological support to increase adjustment and resilience of people who life with life-long neuro-conditions.

The service was launched in February 2017 and the team consists of a clinical psychologist, occupational therapist and assistant psychologist. The service has developed community
activities and projects and support groups, such as emotional well-being and fatigue management courses, woodwork classes and carer and family support group. The clinicians have been able to offer specialist neuro-assessments and education and consultation to service users, carers and staff groups in generalist services. There is no community neuro/stroke rehabilitation team within Prince of Wales Hospital (POW), however there is a Community Rehabilitation Team which is a general service and is time limited in terms of intervention.

The aim of the service is to increase condition/symptom awareness and self-management, and enable service users to participate in communities, find purpose and increased quality of life. The enclosed report below provides details of the progress this service has made over that 12 months:

In June 2019 the Chairs of the Neurological and Stroke Implementation Groups requested UHBs to consider the impact on these service in the event that the funding is withdrawn either in part of in its entirety from April 2021 onwards. Our Community Neuro/Stroke Rehabilitation Service is funded solely by the funding from these National Implementation Groups therefore the impact will be significant should this funding cease. This will be a consideration within our Integrated and Medium Term Plan (IMTP) as a service risk

*To seek agreement to transfer the commission of secondary care neurology services within C&V from WHSSC to Cwm Taf UHB.*

Up until 1st April 2019 a key challenge for the then Cwm Taf UHB was the commissioning arrangements for neurology services as the arrangement was via WHSSC. This presented the UHB with limitations to develop the service further in line with emerging local needs and priorities. However, progress has been made with the transfer of the commissioning process to the UHB from 1st April 2019. With regards to the Princess of Wales Hospital there is a commissioning arrangement established with Swansea Bay for the provision of services. Cwm Taf Morgannwg have now identified the need to undertake a service review across the new organisation which will feed into the development of a CTMUHB Neurological Strategy which has been included in the list of key local priorities.

*Princess of Wales – Parkinson’s Disease Service*

The Parkinson’s Disease service has been developed over many years and provides care and treatment for patients generally referred by GPs for diagnosis through to end of life care. The service is provided across the whole of Bridgend and Western Vale in community and hospital settings.

The work of the team has been recognised nationally and last year the team hosted the European Parkinsons Disease Nursing Society. This was a great opportunity to share knowledge and skills between professionals working in the field across Wales and beyond. The Services are provided from the hospital and community venues as described in the progress report document attached above.

*Patient Knows Best – co-production with patients*
In the last 12 months an addition service option for patients has been introduced through the Patient Knows Best development in Wales. BBC described the development referring specifically to our use supporting patients with Parkinson’s disease in a broadcast last year

https://vimeo.com/285905475

For some patients this service options has proved to be valuable and we will review the outcomes of the trial.

*Parkinson's Disease Society*

The team work well with this third sector group and recognise the excellent support and information provided to many patients. There was a meeting held recently to explore future work and developments.

**Local Service Challenges**

*Challenges from the CNS Service*

The main challenges for this period have related to staffing, with the OT being on maternity leave from December 2018, and no cover being provided, as well as a vacant clinical psychologist post. This has somewhat affected the momentum of service provision and the consistent evaluation of the service. Also until recently there was no administrative input, which meant that staff had to dedicate more time to data entry, sending letter etc. taking them away from their clinical work.

There are on-going challenges is the nature of delivering interventions in communities where transport and sociodemographic factors make it difficult to get attendance and critical mass for all activities.

To date there has been a low response rate for our outcome measures, and would aspire to have a greater numbers in terms of our returned PREMS and PROMS, in order to have more robust data on how the interventions benefit the service users.

The biggest challenge for the CNS is that long term funding for the service needs to be identified. The CNS was launched in February 2017 with £117,000 funding from the National Neurological and Stroke groups, this funding has continued since then however there is a risk to whether this funding will continue after 2020. This has been identified within the IMTP process within the health board and has been identified as a priority area for 2010/20.

*Challenges in relation to services provided to patient diagnosed with Epilepsy*

The current neurology service within CTMUHB does not currently comply with NICE guidelines which state that every person with epilepsy should have access to a specialist nurse. A specialist nurse is a key member of the multi-disciplinary team and can help to reshape the current service providing the opportunity to develop rapid access to specialist services for patients who have a diagnosis of, or who are awaiting investigations for epilepsy.

The epilepsy specialist nurse (ESN) provides a valuable link between primary, secondary and tertiary care services. The benefits would include the development and co-ordination of care for patients with epilepsy within Cwm Taf, helping to meet the clinical, educational and holistic needs of people living with epilepsy. This development would support health care professionals through the use of care pathways supported by locally agreed protocols. The
lack of an Epilepsy CNS service across the UHB continues to be a challenge and has been included in our top three local priorities for this coming year.

**Neurophysiology**

The waiting times within neurophysiology continues to be a problems across what was the Cwm Taf catchment population. This service is commissioned from Cardiff and Vale. For the Princess of Wales Hospital this service is commissioned by Swansea Bay. Recently some vacancies there have been filled and the waiting times for Bridgend are getting back on target. Due to the current waiting times for the service provided by Cardiff and Vale it has been agreed to include the improvement in neurophysiology waiting times as a priority for the coming year.

**Succession planning and development of Professional interest and expertise**

The Parkinson’s disease Service in the Princess of Wales needs to commence succession planning as there are several key staff that will be finishing in the next few years

**Parkinson’s Disease Service – Future Planning**

We feel that to develop and improve the experience for people with Parkinson’s Disease across the CTM Health Board there will need to be work undertaken and there will also need to be consideration given to:

- Joint working with Old age and adult psychiatry
- Scoping of Parkinson’s disease dementia and Lewy body dementia with Parkinsonism and complex patients across the health board to quantify their need and how best to deliver
- Joint audit
- Joint research
- Joint MDT meeting discussing difficult cases regularly
- Funding for and recruitment of an adult Neuro Psychologist
- Developing Physiotherapist interested in PD across health board especially in the community setting
- Ongoing education sessions in University of South Wales for student nurses by PDNS to inspire nurses of the future
- Succession planning for the future workforce with expertise and passion

**Local Priorities for 2020/2021**

The local priorities for 2020/21 areas identified to address local challenges are as follows:

**Local Priority 1**: Development of an Epilepsy Specialist Nursing Service

This development will improve service delivery and quality by reducing outpatient follow-up time, increasing access to specialist epilepsy services and enhancing patient experience. This local priority is consistent with the priority area of work identified within the national group and the development of a national “seizures sub group” to take forward this work. CTMUHB has nominated representation on this group which will ensure there is good communication flow in terms of the national and local developments around epilepsy and seizures.
**Local Priority 2:** Ensuring secured funding for the Community Neuro-Rehabilitation Service

The CNS was launched in February 2017 with £117,000 funding from the National Neurological and Stroke groups, this funding has continued since then however there is a risk to whether this funding will continue after 2020. This has been identified within the IMTP process within the health board and has been identified as a priority area for 2019/20.

**Local Priority 3:** Development of a Cwm Taf Morgannwg Neurological Strategy

A local priority areas identified for 2019/20 within the then Cwm Taf UHB was to seek agreement between Cwm Taf, Cardiff and Vale and WHSSC to transfer the responsibility and funding for the commissioning of secondary care neurological services to Cwm Taf. The majority of services were commissioned by WHSSC from Cardiff and Vale on our behalf, therefore were limitations in terms of being able to commission services in line with local priorities and needs.

From the 1st April 2019 we saw the boundary change and the formation of the new Cwm Taf Morgannwg UHB which includes the service provision at the Princess of Wales Hospital. Again there is a commissioning arrangement in place with services being provided by Swansea Bay UHB.

In line with our priority the UHB has been recently notified that the commissioning arrangement for neurology has now been transferred from WHSSC to CTMUHB. Therefore there is now an opportunity to review the provision across the health board and to develop a long term strategy based on local need for population of CTMUHB.

**Local Priority 4:** To improve neurophysiology waiting times

As described under the local challenges section.

**Local Priority 5:** To manage the SLA’s between CTM UHB and Swansea Bay UHB

There are SLAs in place but it will be important to understand if they are sufficient to meet the needs of patients and whether there may be a case for the development of a service within and across CTM UHB.

**Links to Workforce**

A service review has been undertaken for what was the old Cwm Taf service provision which identified that there may be opportunities for improve service quality and efficiency through the employment of specialist nurses in key areas such as epilepsy, as well as the scope for realigning investment in key areas at a local level.

**Links to Finance**

The biggest challenge for the CNS is that long term funding for the service needs to be identified. The CNS was launched in February 2017 with £117,000 funding from the National Neurological and Stroke groups, this funding has continued since then however there is a risk to whether this funding will continue after 2020. This has been identified within the IMTP process within the health board and has been identified as a priority area for 2010/20.

**Links to Performance**
Annual reports on the Community Neurological Service are presented to the all Wales Implementation Group. With the transfer of commissioning arrangements from WHSSC to the UHB a greater emphasis on evaluation and monitoring the service will be required during 2020/2021 and beyond.

RARE DISEASES

Welsh Government published its first Implementation Plan for Rare Diseases in February 2015. The plan confirms the strong commitment to improve services for those who live with rare diseases. The Plan provides a framework for action by Welsh Government, Health Boards, NHS Trusts and their partners in Local Government and third sector. It sets out the Welsh Governments expectation of the NHS in Wales to tackle rare diseases for people of all ages, wherever they live in Wales and whatever their circumstances. The Plan is designed to enable the NHS to delivery on its responsibility to meet the needs of people at risk of affected by such conditions.

The Work in Wales will continue to be in coordination with the UK Rare Diseases Advisory Group and UK-wide Stakeholder Forum, which will monitor and report on progress in the four countries.

The action to be undertaken to deliver this Plan will focus on the following five areas:

- Theme 1: Empowering those affected by rare diseases.
- Theme 2: Identifying and preventing rare diseases.
- Theme 3: Diagnosis and early intervention.
- Theme 4: Co-ordination of care.
- Theme 5: The role of research.

The National Implementation Group has been established and the Health Board has been represented and fully engaged with the work undertaken by this group during 2016/17. The purpose of this group is to oversee and ensure implementation of the Plan, to monitor progress and to escalate issues through performance processes where necessary. The group will also agree yearly national priorities.

The national priorities identified by the Rare Disease Implementation Group for 2020/21 are:

- Identify and improve the pathway for patients with unknown or delayed diagnosis;
- Ensure better use of patient feedback, best practice and evidence to improve pathways for primary, secondary and specialist services;
- Improve reporting of rare disease information including epidemiology, significant event analysis and shared learning.

During 2019/20 priorities are outlined below:

- Identify and improve the pathway for patients with unknown or delayed diagnosis;
- Ensure better use of patient feedback, best practice and evidence to improve pathways for primary, secondary and specialist services.
Progress 2019/20: Medical case studies undertaken. Common themes established aid the improvement of patient pathways across primary, secondary and specialist services. Continued strong links with patient experience team.

Given national priorities are unchanged, our 20/21 local priorities will remain as outlined for 2019/20.

**Links to the Financial and Workforce Plans**

There is not currently any direct Welsh government funding to support the delivery of “Rare diseases” services within the health board. It is also estimated that over 200 new forms are identified each year. As a health board we are proud of the developments we have made to date, within current resource.

**Diabetes & Endocrinology**

Local 2020-21 priorities and progress for our Diabetes Planning and Delivery Group is outlined below:

<table>
<thead>
<tr>
<th>Children and young people</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>April 2016 – September 2019 Achieved</strong></td>
</tr>
<tr>
<td><strong>Peer review</strong></td>
</tr>
<tr>
<td>0.9 WTE dietitian appointed</td>
</tr>
<tr>
<td>Two 0.5 WTE DSN appointed</td>
</tr>
<tr>
<td>Achieving high quality performance in National Paediatric Diabetes audit. NPDA feeds directly into Paediatric sub-group</td>
</tr>
<tr>
<td>SEREN education tool implemented</td>
</tr>
<tr>
<td><strong>Transition</strong></td>
</tr>
<tr>
<td>CTUHB wide guideline, including checklist and proforma, developed and implemented</td>
</tr>
<tr>
<td><strong>Technology</strong></td>
</tr>
<tr>
<td>Medtronic (Carelink) and Roche (360) CSII downloading software installed across HB</td>
</tr>
<tr>
<td>CSII issued based on NICE guidance – 75.5% PCH and 55.2% RGH on CSII (2018 audit)</td>
</tr>
<tr>
<td>DIASEND (downloads glucose monitoring data live and virtually) installed across HB</td>
</tr>
<tr>
<td>Twinkle (Paediatric IT diabetes system installed) across HB</td>
</tr>
<tr>
<td>Freestyle Libre available to children based on HB guidelines</td>
</tr>
</tbody>
</table>

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### Preventing diabetes and detecting diabetes quickly

#### April 2016 – September 2019 Achieved

**Pocket medic links**

Have been sent out twice to all GP practices (GP and PN) and practice managers in Cynon, Merthyr, Rhondda and Taf-Ely localities.

They are also available to be dispensed opportunistically to patients in secondary care clinics / inpatients.

Pocket medic available on NUMED practice system across primary care.

**Screening**

Cardiovascular risk screening established 2016


**Pocket medic links**

Exploring dispensing pocket medic links via pharmacies.

GP practices encouraged to text relevant pocket medic links to their diabetic patients. Has been trialled in Taf-Ely, need to encourage additional practices to adopt process.

Pocket medic videos available to play in diabetes centre in RGH and PCH, however compatible audio and visual equipment required.

**Dispense pre-diabetes booklet**

**Local obesity pathway**

**Diabetes prevention Diabetes regression services.**

Strategy for CTUHB agreed, planned and partly initiated. A pre-requisite is the ability to clearly identify individuals at high risk of diabetes and to instigate regression services and supportive strategies to reduce this risk, including clear signposting to lifestyle change / support activities by locality based community co-ordinators, which can
be accessed by any HCP managing people at risk of diabetes whether in Primary, Community or Secondary care.
Explore opportunities to engage with Education for Patients Programme (EPP) to deliver aspects of diabetes prevention strategy

<table>
<thead>
<tr>
<th>Making our services as effective as possible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>April 2016 – September 2019 Achieved</strong></td>
</tr>
<tr>
<td><strong>Antenatal</strong></td>
</tr>
<tr>
<td>Designated pre-conception clinic / service in RGH &amp; PCH</td>
</tr>
<tr>
<td>NPID feeding into antenatal sub-group</td>
</tr>
<tr>
<td>Pocket medic prescribed at initial review</td>
</tr>
<tr>
<td>All Wales GDM strategy implemented – embedded into Antenatal clinic policy – needs auditing</td>
</tr>
<tr>
<td><strong>Feet</strong></td>
</tr>
<tr>
<td>Inpatient screening tool developed and piloted.</td>
</tr>
<tr>
<td>Medical high risk foot clinic established in PCH and RGH</td>
</tr>
<tr>
<td>Provision of emergency slots for “foot attack” established in PCH and RGH</td>
</tr>
<tr>
<td>National foot audit feeds into foot sub-group</td>
</tr>
<tr>
<td><strong>Education</strong></td>
</tr>
<tr>
<td>Menu approach adopted to patient education which includes Structured and non-structured education:</td>
</tr>
<tr>
<td>DAFNE</td>
</tr>
<tr>
<td>X-PERT</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>DAS</td>
</tr>
<tr>
<td>Peer support / EPP</td>
</tr>
<tr>
<td>Pocket medic</td>
</tr>
<tr>
<td>Newly diagnosed booklet (orange books)</td>
</tr>
<tr>
<td>HCP one to one</td>
</tr>
<tr>
<td>Community hospital staff education – established and ongoing</td>
</tr>
<tr>
<td><strong>Social services</strong> - diabetes awareness sessions established. Further dates planned for core agencies 2019.</td>
</tr>
<tr>
<td><strong>District Nurses (DN)</strong> Education sessions established. All DN have completed FRAME education module (feet)</td>
</tr>
</tbody>
</table>

| **Health Care Support Workers (HCSW)** To date 2 of HCSW on DN team taught to administer insulin and monitor Capillary blood glucose (CBG) - ongoing. |
| HCSW in General Practice are being educated to examine feet |
| **Care home staff education** - piloted and being evaluated |

<table>
<thead>
<tr>
<th><strong>Integrated Care</strong></th>
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<tbody>
<tr>
<td><strong>Personalised email / telephone support</strong> established RGH</td>
</tr>
<tr>
<td><strong>Community diabetes clinics</strong> established RGH</td>
</tr>
<tr>
<td><strong>Personalised referral service</strong> established RGH</td>
</tr>
<tr>
<td><strong>Hub pilot</strong> established in Cynon – positive outcomes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Integrated Care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCP education</strong> Facilitated by joint community clinics – ongoing</td>
</tr>
<tr>
<td><strong>PCH</strong> - establish personalised email / telephone support; Community diabetes clinics; Personalised referral service</td>
</tr>
<tr>
<td><strong>Locality hubs</strong> – to be rolled out across 4 localities</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong> - Work with mental health team to develop and submit a business case and employ Psychology services for adults with diabetes</td>
</tr>
<tr>
<td><strong>Mental Health and COTE services</strong> – establish education (HCP and carer) on management of PWD and dementia</td>
</tr>
<tr>
<td><strong>Locality hubs</strong> – establish across 4 localities, will require recruitment of dedicated work force (WF)</td>
</tr>
<tr>
<td><strong>Bridgend</strong> – work with Princess of Wales diabetes team, community and primary care team to understand their diabetes service provision and clinical priorities. Work collectively to develop, and where required and desired, align clinical services</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Technology</strong></th>
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<table>
<thead>
<tr>
<th><strong>Technology</strong></th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Multi-disciplinary CSII and CGMS teams established across in PCH and RGH</td>
</tr>
<tr>
<td>Weekly CSII/CGMS clinic provision – face to face and virtual</td>
</tr>
<tr>
<td>Wireless POCT testing equipment agreed</td>
</tr>
</tbody>
</table>

| Think Glucose | Think Glucose |
| **Charts** – developed and implemented: | **Charts** - under development: |
| DKA management chart | HHS |
| CBG monitoring chart | PWD undergoing surgery or elective procedures |
| SC/VRII management chart | **HCP Education** |
| **HCP education** | General diabetes and sub-specialised Oncology, A&E and midwifery education courses prepared, however difficulty releasing staff to attend and DSNs to deliver. Need additional diabetes staff as per workforce plan (WF) |
| Accredited diabetes diploma course established (University of Glamorgan) | On line diabetes modules need to become part of core learning on ESR |
| Knowledge and skills of inpatient staff audited – will need regular cycles | **Diabetes Eye Screening Wales (DESW)** |
| Diabetes inpatient team established but inadequately staffed (WF) | **Diabetes Eye Screening Wales (DESW)** |
| Think glucose inpatient note stickers developed and introduced | Review: RTT for DESW referrals to ophthalmology outpatients; ophthalmology outpatient follow up, and discharge to DESW from ophthalmology |
| Foot education posters developed and disseminated | **Peer Review T1DM** |
| Digitisation of DSN data – awaiting WISDM pilot PCH; implement with DIAMOND initially RGH | Participate in T1DM peer review |
| **Diabetes Eye Screening Wales (DESW)** | **Primary Care - DES** |
| Additional fixed site opportunities for DESW provided | Promote uptake of DES in primary care |
| Representation to the DESW Governance Programme Board provided | |
### Supporting living with diabetes

<table>
<thead>
<tr>
<th><strong>April 2016 – September 2019 Achieved</strong></th>
<th><strong>Diabetes &amp; Endocrinology - 2020/21.</strong> On-going priorities.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td><strong>Education</strong></td>
</tr>
<tr>
<td><em>SDE:</em></td>
<td><em>X-PERT</em> – additional sessions required. Additional dietetic time required (WF)*</td>
</tr>
<tr>
<td><em>DAFNE</em> established 2004 – available across HB</td>
<td><em>X-PERT insulin – 4 DSNs trained. Will require additional sessions (WF)</em></td>
</tr>
<tr>
<td><em>X-PERT</em> established 2010 – available across HB. Additional administrative support recruited 2017</td>
<td><em>DAFNE</em> – additional staff required to deliver required training including clinic follow up appointments and DAFNE update sessions (WF)*</td>
</tr>
<tr>
<td><strong>Non-SDE:</strong></td>
<td><strong>Pocket medic</strong></td>
</tr>
<tr>
<td>Diabetes awareness sessions (DAS)</td>
<td>Exploring dispensing pocket medic links via pharmacies.</td>
</tr>
<tr>
<td>Peer support / EPP</td>
<td>GP practices encouraged to text relevant pocket medic link to their diabetic patients. Has been trialled in Taf-Ely, need to encourage additional practices to adopt process</td>
</tr>
<tr>
<td>Pocket medic</td>
<td>Pocket medic videos available to play in diabetes centre in RGH and PCH, however compatible audio and visual equipment required.</td>
</tr>
<tr>
<td>Newly diagnosed booklet (orange books)</td>
<td><strong>Information prescriptions</strong> – available on GP computer systems but underutilised – need to raise awareness of their availability and effectiveness</td>
</tr>
<tr>
<td>HCP one to one</td>
<td><strong>Engagement with PWD</strong> – improve engagement and ensure all localities represented by patient reference groups. Work with PWD to establish groups where they don’t exist and establish their priorities for the service</td>
</tr>
<tr>
<td><strong>Pocket medic</strong> links dispensed to patients during appointments in:</td>
<td><strong>DUK</strong> – work with DUK to develop literature on how to eat well on a limited budget</td>
</tr>
<tr>
<td>- secondary care clinics</td>
<td></td>
</tr>
<tr>
<td>- joint community clinics (also circulated to GP practice at time of community clinics)</td>
<td></td>
</tr>
<tr>
<td><strong>Support for PWD</strong></td>
<td><strong>Support for PWD</strong></td>
</tr>
<tr>
<td>Patients support groups</td>
<td>Continue to raise awareness of local support groups and patient reference groups and increase availability where not established</td>
</tr>
<tr>
<td>Patient reference groups</td>
<td></td>
</tr>
</tbody>
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Respiratory disease

Respiratory disease is the cause of one in seven all-cause deaths in Wales; the third largest cause of death for both women and men in Wales. At the same time, one in seven adults in Wales reports being treated for a respiratory condition. Respiratory disease is a very common cause of severe acute illness, A&E attendance and a major cause of emergency hospital admissions. COPD is generally the most frequent cause of an emergency admission to hospital.

As with a number of other health conditions, lifestyle factors can increase the risk of getting a respiratory disease. Whilst diet and weight are contributory factors, smoking continues to be the main risk factor. We continue to help make people aware of these risks in their own lives, and encourage individuals to take responsibility for the actions which they can take to shape their own health, and reduce the risks of respiratory disease.

Occupational factors such as the historical mining industry have a large effect on the respiratory disease in our cohort of patients. Although the mines have gone the sufferers still remain. There are also new occupational lung diseases and the diagnosis of these is poor but our patients suffer with occupational asthma, occupational Interstitial lung disease (ILD) and asbestos related cancers. All these diseases affect our deprived community more than more affluent communities.

To achieve the best possible outcomes for patients with a respiratory condition, each individual needs to be fully involved in their care; be that a child and their family managing a new diagnosis of asthma, or an elderly patient with a terminal diagnosis considering options for palliative care. Patient education and co-production of care needs to be part of the patient’s care pathway to achieve the best for the patient.

The first national Respiratory Delivery Plan for Wales was published in April 2014. In December 2017 the re-fresh version was published. Our work programme focusses on three national themes embedded the national delivery plan document:

- Preventing respiratory disease
- Early diagnosis, fast effective care
- Children and younger persons

**Key Respiratory Priorities 2020-2021**

1. Health Boards to focus on improving COPD outcomes by encouraging participation in the primary care QI platform linked to national clinical audit to address the 25% of patients without a secure diagnosis of COPD and optimising the care and record keeping of those with COPD.

2. Health Boards to adopt the use of the national prescribing guidelines for the management of COPD and asthma and the accompanying National Welsh Standard competency programme to standardise basic COPD and asthma care across Wales to improve the accuracy of diagnosis, increase utilisation of high value interventions and reduce admissions to hospital.
3. Health Boards to work with WAST on alternative pathways of care to reduce avoidable admissions and review specialist nursing provision for managing patients with COPD and asthma, particularly to reduce avoidable admissions to hospital and to prevent re-admissions following exacerbation.

**Local Priorities**

As a local planning and delivery group it has been agreed that the seven priorities will be focused on in **2020/21** are as follows:

### Preventing respiratory disease

1) Increase the number of smokers who are motivated to quit using NHS support
   a. Consolidate in-house cessation services delivered across Cwm Taf Morgannwg at PoW, RGH and PCH.
   b. Review existing service protocols, and align.
   c. Implement support for staff.
   d. Implement to support mental health patients.
   e. Introduce Help Me Quit minimum service standards, and review compliance.
   f. Agree and monitor key performance indicators, e.g. for contacts, treated smokers and CO validated quits.

   **Progress 19 20**: *Business case completed and long term funding granted August 2019.*

2) To implement evidence based pulmonary rehabilitation service across the whole of Cwm Taf UHB linked with a specific piece of work around the effective use of respiratory medicines. To set up a pulmonary rehabilitation service using the savings from medicines management invest to save project.

   **Progress 19 20**: *business case completed to support service expansion.*

   *Medicines management recruited staff and commended invest to save project.*

### Early diagnosis, fast effective care

3) Acute non-invasive ventilation (NIV) service improvement. Ensure Quality Standard for acute NIV (non-invasive ventilation) service following information from recent NCEPOD audit, including funding for adequate NIV machines, workforce and dedicated area and including those who may need chronic NIV

4) A. Enhance the existing model for the training and education of health care professionals working within GP Practices, Community services and Community Hospitals by:
   - Implementation of an accredited ARTP (Association of Respiratory Physiologists and Technologists) module for Spirometry practice.
     Priority completed.
     This training is now undertaken on a National level by the Institute of Clinical Science & Technology. There is currently still funding for all clinicians including Bridgend to undertake directly
   - Implementation of the 3 day course “Introduction to Asthma and COPD care & management” for “new to post” Practice Nurses and District Nurses.
     Priority completed.
Ongoing programme and will be extended to Bridgend.

- Development of an Asthma and COPD competency based workbook for Practice Nurses.
  Progress 19 20: Work books in use in former Cwm Taf and in progress of being rolled out on an All Wales basis. Bridgend will have access to workbooks but no capacity at present to mentor nurses in Bridgend to sign off competencies

- Implementation of the “shared care” model to facilitate the mentoring/supervision of “new to post” Practice Nurses in relation to Asthma and COPD competencies. No capacity at present to mentor nurses in Bridgend

- Pilot newly designed templates to facilitate the annual reviews undertaken by the Practice Nurse (for those patients with a diagnosis of Asthma and COPD). Progress 19 20: Pilot complete and ready for rollout. Bridgend can be included in rollout of templates but no capacity to support clinicians.

- Implementation of the Respiratory Network meeting which provides Continuing Professional Development sessions targeting Community Pharmacists, District Nurses and Practice Nurses. Priority completed. Invitation to attend will be extended to Bridgend

- Implementation of educational sessions for care home staff via the Social Care Workforce Development partnership. Progress 19 20: In place but no Capacity to deliver sessions in Bridgend with existing workforce.

- Exploring the feasibility of District Nursing staff being skilled up to undertake annual reviews (COPD) of those patients who are unable to attend GP Practice. Progress 19 20: Work ongoing as a pilot.

- Implementation of weekly ward based clinical teaching which provides a framework for structured training and education across the community hospital sites. Progress 19 20: Ongoing programme but no capacity to extend to Bridgend with existing workforce.

4 B. Undertake a scoping exercise to inform resource required to support Bridgend area for this priority. Ensure parity of services across all CTM localities

5) Launch prescribing guidelines to promote cost effect use of inhalers

6) A. Roll out recommendations from the COPD Rhondda Cluster Hub Community service evaluation report to roll out service to Merthyr Tydfil and Cynon

   B. Undertake a scoping exercise to ensure parity of services across all CTM localities

**Children and younger persons**

7) To increase asthma awareness and improve outcomes for children and Young People with Asthma within Cwm Taf.
   - To undertake an audit of asthma management in C&YP in A&E departments to identify any improvement work needed (PCH & RGH).
Progress 19 20: priority now complete

- To work in partnership with other Health Boards as part of the South Wales Paediatric Respiratory Network to create a unified Asthma pathway and shared documentation for management of Asthma across South Wales.
- To continue close working relationships with Practice Nurses & GP’s to strengthen asthma management in C&YP in Primary Care. To identify a Lead for GP practice to identify priorities in this area.
- To establish closer working with pharmacies to identify a flagging system for C&YP with problematic asthma.
- To consider a “train the trainer” model for asthma awareness in schools.
- To continue to refer parents who smoke to the range of smoking cessation services available in Cwm Taf.

Our priorities have taken into consideration the following:

- **Well-being**: Ensuring an over-arching focus on the reduction of health inequalities. 2018/19 the health board has prioritised the development of an evidence based pulmonary rehabilitation service. There are over 8,000 patients within our population who have COPD and currently 224 class places can be offered to patients in the service as it stands today. This investment will enable a greater proportion of our population going through an evidence based programme that will aid in the management of their condition.

- **Care closer to home**: Planning and delivering the majority of care closer to home – an example of this is the implementation of the COPD pilot project and also prioritising the development of an evidence based pulmonary rehabilitation service.

- **Acute Care**: Ensuring the provision of safe and sustainable secondary care services - an example of this is prioritising the developing our NIV services across the health board.

- **Tertiary and Specialised Services**: The second stage of the COPD pilot project will be looking at working more closely with WAST, in relation to COPD re-admission rates.

**Links to Prudent Healthcare**

The Respiratory Planning and Delivery Group are applying the principles of Prudent Healthcare across their work programme. In particular, in the development of cluster hub service provision in the Rhondda Valleys to support practices and patients within the community with COPD who are post discharge. The service is a co-production model which will support patients for the first six weeks after a discharge from hospital, when they report their limiting factor on returning home being their anxiety about managing their condition, due to a lack of confidence following acute exacerbation. This co-production model is key if this service is to work allowing patients to manage their own care and take measured risks with support. A robust service evaluation has recently been completed. It was evident that the data analysed in relation to the Supported Discharge Scheme part of the project highlighted:

- A reduction in re-admissions
- Reduction in A&E attendances
- Reduction in out of hours contacts
• Reduction in GP contacts
• Increased capacity in secondary care clinics

In addition, the local planning and delivery group will focus on value-based medicine approaches in new priorities in the life of the plan.

Links to the Well-being of Future Generations Act

Our priorities for respiratory contribute to the well-being goals in the following ways:

• We will ensure that all services provided are safe and sustainable and provide good value for money.
• Engaging with patient representative and third sector groups in the local planning and delivery group to take programmes forwards holistically.
• The local planning and delivery group promotes value-based medicine approaches, this allows the health board to reach more of our population in the most prudent way possible.

Links to Performance

The plan and its associated actions will form the work programme for the Respiratory Planning and Delivery Group, progress against which will be monitored on a quarterly basis and reported to the Executive Board and Board annually.

Links to Workforce Plan

The workforce requirements have been identified as part of the development of the NIV service health board wide and also the development of the pulmonary rehabilitation team.

Links to Finance Plan

Investment needs to be identified as part the development of the NIV service health board wide and also the development of the pulmonary rehabilitation team.

### MYALGIC ENCEPHALOPATHY (ME), CHRONIC FATIGUE SYNDROME (CFS) AND FIBROMYALGIA

In 2013, a ME-CFS and Fibromyalgia Task and Finish Group was reconvened by Welsh Government to focus on the practical means of improving NHS services and patient experience. Cwm Taf have had robust representation at this All Wales Group since that time and we have welcomed the support the group have given us in the development of our local pathways. It must be noted that these conditions are complex and although there is good practice in Wales, challenges exist in accessing appropriate care and services.

During 2017, the Health Board produced an action plan to take forward the recommendations of the National Task and Finish Group and this plan has been refreshed on an annual basis. Progress made 2019/20 is outlined below:

• The development of paediatric pathways for CF/ME/FM – progress: seamless process – patients are transferred to Bath for assessment and treatment.
• Continued engagement at national level
• Internal agreement of the CFS/ME Pathway
Whilst no national priorities have been determined our Local Action Plan identified a number of local priorities for 2019/20 and progress noted is outlined below:

- The identification and collaborative working with Consultant/other UHB with an interest in ME by undertaking a scoping exercise to explore possibilities
- Finalise the Implementation of the fibromyalgia and CFS/ME Pathways
- The development flowchart to illustrate paediatric pathways for CF/ME/FM
- The development of a psychology support service for patients with CF/ME/FM – Engagement with the Mental Health Service has commenced. Further work to be undertaken from March 2019 but the development is dependent on funding.

**Links to Prudent Health Care**
The ongoing development of the pathways for ME/CFS/ME is consistent with the principles of prudent healthcare as the vision is to provide holistic and person centred community based support, which will aid people with these conditions to self-manage symptoms and improve psycho-social well-being.

**Links to Performance**
There are no specific performance outcomes relating to ME/CFS/ME other than Referral to Treatment Times monitoring and reporting within rheumatology services.

**Links to Workforce**
The pathway development work has identified the lack of psychological support which will need to be a consideration within the Health Board for the future. Establish whether the UHB can take a collaborative approach to developing a business case for a psychologist.

**End of Life Care**

**Key Strategic Drivers**

In Wales, around 32,000 people die each year, of these almost two-thirds are aged 75 and over. The majority of deaths follow a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. There is a high prevalence of such diseases amongst our local population. It is estimated that 75% of people dying have some form of palliative care need.

Welsh Government’s Delivery Plan “Together for Health – Delivering End of Life Care” was last refreshed in 2017 and provides the strategic context for improving end of life care services in Wales. The key themes remain as follows:

1. Supporting living and dying well.
2. Detecting and identifying patients early.
3. Delivering fast, effective care.
4. Reducing the distress of terminal illness for patients and their families.
Local End of Life Care Delivery Plan

Palliative and End of Life Care in Cwm Taf Morgannwg is provided by a wide range of healthcare professionals across primary, community and secondary care. This includes care provided by GPs, District Nurses, care home staff and hospital staff as well as the Specialist Palliative Care team, depending on the complexity of the individual’s need:

Where more intensive, specialised care and treatment is required, this is provided by the multi-disciplinary Specialist Palliative Care Team (SPCT), which works in the three localities of Bridgend; Merthyr Tydfil/Cynon Valley; and Rhondda/Taff Ely.

The Cwm Taf Specialist Palliative Care Team provides:

- Inpatient based care, specialist day centre care and palliative medicine outpatient clinics at Y Bwthyn (Royal Glamorgan), Y Bwthyn Newydd (Princess of Wales Hospital) and Ward 6 Ysbyty Cwm Cynon.
- Specialist support to general hospital teams.
- Specialist community care in patients’ own homes including care homes.

Through our local Cwm Taf Morgannwg End of Life Care Delivery Plan we have made significant progress against the key themes set out by the national Delivery Plan:

**Advance Care Planning** – our Advance Care Planning (ACP) CNS, originally funded by Macmillan, has now become an integral part of our @Home service and has been embedding ACP practice across our services. She has also been helping to skill up nursing home staff to undertake advance care planning and to understand where to access support. This additional education support is also now being offered to residential homes, enabling care home staff to become skilled in undertaking advance care planning. The ACP nurse is also more available to troubleshoot and support the teams with provision of specialist advice. There has been an increase in referrals for ACP / RBID from both residential care homes and nursing homes.

**Hospice @Home** - £80k funding from the EOLB is being used to develop two District Nurse champions in each of the DN teams, with an enhanced knowledge base and skill set in terms of palliative care and symptom management, to support people to be cared for at home. The DN champions are more highly skilled and form the on-going link with the specialist palliative care team. They have an increased understanding of the role and responsibilities of the SPCT including the purpose and function of our palliative care in-patient beds. This is
helping facilitate enhanced communication between the two services and is mutually beneficial for patients and staff alike.

Funding from the EOLB is also being used to increase capacity in our Hospice @Home service, by increasing ad hoc capacity through our contract with Marie Curie and also additional bank nursing shifts to support our district nurses who provided the majority of the hands on care to this client group.

**Bwy Nawr** – The Health Board has now become affiliated with Bwy Nawr. Various events were held across Cwm Taf during Dying Matters Week 2018 in order to promote the importance of enjoying life but planning ahead for the inevitable, e.g. making a will, telling loved ones your wishes, registering as an organ donor, recording funeral wishes, and planning end of life care and support preferences..

**WAST rapid transport service** – The Health Board was the first of the areas involved in the piloting of an End of Life Care Rapid Transport Ambulance scheme, which has now been rolled out to other areas. This enables the timely transfer of palliative care patients back home, or to a hospital or hospice, when required, and was recognised in the NHS Wales Awards 2019 as the winner of the Person Centred Services award.

**Modernisation of the specialist palliative care service** – following extensive work undertaken to review and develop a service specification for our specialist palliative care service, the process is now being replicated for services in the Bridgend locality, to ensure improved alignment and consistency across the health board footprint. Macmillan are continuing to fund an EOLC Modernisation Manager post to help with this ongoing work.

**Y Bwthyn NGS Macmillan Specialist Palliative Care unit** – September 2019 saw the opening of the new ‘Y Bwthyn’ Unit at the Royal Glamorgan Hospital, enabling the transfer of the current service from Pontypridd Cottage Hospital. This purpose designed facility provides a light, spacious and fitting environment for palliative care patients and their families, and has already proved clinically beneficial in terms of facilitating on-site access to acute specialists for treatments and symptom management. Work on the corridor linking the unit to the main hospital is due for completion in February 2020, enabling easier access to and from other wards and departments.

**Medication** – Various community pharmacies across Cwm Taf Morgannwg hold an agreed list of palliative care medicines that can be accessed out of hours to support patients to be cared for at home. Just in Case boxes are also used to ensure medication is available and can be administered without undue delay.

**Bereavement services** – our Macmillan End of Life Care Modernisation Manager has compiled a list of organisations and services available to help people during bereavement. A gap analysis has also been undertaken to assess the standards of bereavement support provided in our hospitals, and includes reviewing practice and procedures on the wards, the mortuary and the role of the chaplaincy. Macmillan have supported the upgrading of the mortuary viewing area at the Royal Glamorgan to improve the experience for relatives.

**Pre-discharge checklist** – a checklist was successfully piloted and adopted in specialist palliative care ensuring all aspects of a patient’s palliative care needs are considered prior to discharge home. This includes ensuring that families/carers are taught the basic principles of care including mobility, lifting, continence, dietary and fluid needs, pressure relief, mouth
care and how to access support when needed. Feedback from staff confirms that people have found the checklist and training very helpful, and it will be re-evaluated in 2020/21.

**Therapies Audit** – our Therapies Directorate designed and undertook their own audit against the domains within the National Standards for Specialist Palliative Cancer Care. The audit found that therapists of all disciplines within the Palliative Care Team are providing expert holistic care spanning numerous aspects of the domains of care. This ensures patients get high quality specialist care whoever they see within the team. As a result of the audit it was decided to design and pilot a SPCT Therapists Holistic Needs Assessment to minimise duplication, ensure sharing of information and enable them to document all aspects of domains of care outside their own speciality. To address gaps identified, they have now sourced training for staff on how to advise patients on sex/intimacy issues and spirituality, as well as information on complementary therapies available.

**NACEL** – The Health Board participated in the 2018 National Audit for Care at the End of Life (NACEL). This was an extensive audit requiring significant clinical and administrative input. The outcomes have highlighted key areas where further improvements would be beneficial, and these have been incorporated into an action plan which is being overseen by the EOLC Delivery Group. Key actions include:

- Implementation of the Care Decisions Tool for the Last Days of Life
- Review or development of policies, procedures and guidelines such as Bereavement Policy; EOL Care for people with a learning disability or mental health needs
- EOLC training and education
- Communication with and support for carers during their loved ones end of life and in bereavement.

**Staff Education and Training** – Various education and training courses have been provided to the Macmillan / Specialist Palliative Care Team and to generalist staff with a role in end of life care. Training has been arranged for staff in Connected Advanced Communication Skills and Serious Illness Conversations, and an End of Life Care Framework for Education is being developed enabling courses to be administered on-line and linked to individual electronic staff records.

**Links to Prudent Healthcare**

Through Advance Care Planning we are involving people and their families in making informed choices in advance about their treatment and care at end of life. This can help in the difficult and sensitive decision making process around starting or stopping potentially life prolonging treatment which may only serve to prolong the dying process or cause the patient unnecessary distress. This includes consideration of whether the patient wishes to invoke the ‘Do Not Attempt CPR’ (DNACPR) process, and ensuring that patients’ wishes and decisions about CPR, made in partnership with their clinician and close family where appropriate, are effectively communicated and respectfully adhered to.

**Links to Workforce Plan**

- It is already acknowledged that there is a need for succession planning within the specialist medical team as two members are approaching retirement age, and consideration of how the service can be made less fragile in the event of vacancies or extended absence.
The education of staff in good end of life care planning and provision is a key priority across the Health Board and care homes, and continues to be led by specialists from the Palliative Care service.

**Links to Financial Plan**
The Hospice @Home service has received £80k funding annually from the End of Life Care Board Delivery Plan £1m funding. The sustainability of this service would be at risk if the Delivery plan funding is discontinued.

**Links to Performance**
Implementation of our local End of Life Care Delivery Plan is overseen by the multi-agency Cwm Taf Palliative and End of Life Care Delivery Group, chaired by the Executive Director of Primary, Community and Mental Health. Work is ongoing at both a national and local level on the development of outcome measures for palliative care.

**Estates/Capital Requirements**
- Whilst the Y Bwthyn palliative care service has now transferred from the Pontypridd and District Cottage Hospital in September 2019, the Tonteg Older People’s Mental Health Day Unit, some Mental Health services and office accommodation will remain on the site until alternative provision is made, mainly linked to the phase 2 Dewi Sant Health Park development. Only at this stage, potentially 2021, will the Pontypridd and District Cottage Hospital site be able to be released.
- Alternative accommodation is being identified to enable relocation of the services currently based at Pontypridd Cottage Hospital: the Tonteg EMI Day Centre is earmarked for relocation to the Maritime Centre in Pontypridd; the Mental Health Outreach and Recovery Team is earmarked for relocation to the Dewi Sant Health Park; and various Therapies and community management offices for which alternative accommodation will be identified as part of the wider review of estate utilisation across Cwm Taf.

### Heart Disease

**Vision / Key Strategic Drivers**
The Welsh Government’s Heart Disease Delivery Plan provides the strategic context for the delivery of services to those patients with a heart related condition. The Health Board is committed to preventing avoidable heart disease and delivering well-coordinated services, where specialised care is well connected to local services, providing better patient experience and outcomes. Historically, some cardiology and all cardiac surgery services have been provided by other Health Boards. Our vision is to repatriate these services as locally as possible using a hub and spoke model, developing local expertise and ensuring our patients receive services as close to home as possible. The repatriation of PCI services is a key priority for 2020/21.

To support this, the Health Board has:
• Analysed the gap between current provision and the standard of service described in the NSF and in Together for Health – a Heart Disease Delivery Plan, and developed a plan to close the gap.
• Developed a plan to repatriate PCI services
• Demonstrated through regular reporting, improved outcomes for patients, with an emphasis on reducing health inequalities.

Priorities
To support implementation of the national delivery plan, the Heart Disease National Implementation Group has identified the following priorities for 2020/21 as follows:
• To build on the development of all Wales clinical pathways to deliver Value-based healthcare and to implement the Heart Failure, Atrial Fibrillation and Acute Coronary Syndrome
• To implement the Out of Hospital Cardiac Arrest Plan for Wales
• To improve the cardiac informatics roadmap

In terms of the services we provide across primary and secondary care and commission from tertiary providers, our proposed priorities for 2020/21, pending internal approval by our local implementation group, mirror those identified by the national implementation group and include:
• Achieving Referral to Treatment (RTT) component waiting times, including outpatients, diagnostics and treatment pathways.
• Remodelling of the chest pain pathway and implementation of the Heartflow system. This will include expansion of the Cardiac Catheter Lab at Royal Glamorgan Hospital and Pacing Theatre Prince Charles Hospital sessional capacity to facilitate the repatriation of complex devices and PCI from Cardiff and Vale UHB. Repatriation would help to reduce outpatient waiting times and inpatient bed day waits for patients awaiting transfer to neighbouring health boards.
• Review of our local cardiac physiology service to include a demand and capacity analysis, workforce review and development of an agreed service model
• Review of the heart failure pathway including benchmarking against national requirements and implementation of recommendations within the NCEPOD report
• Participation in Cardiac Peer Review and NCAP Audit
• Participation in the AWACI project, to include electronic test requesting and digitisation of notes

Outcomes
The Health Board’s heart disease work programme will be evaluated against the following key outcome indicators as identified within the national heart disease delivery plan:
• Prevalence of coronary heart disease.
• Circulatory disease mortality rate for those aged 75 and under.
• Referral to treatment time
• Percentage of patients requiring Primary Percutaneous Coronary Intervention admitted to a coronary intervention centre.
• Survival following out of hospital cardiac arrest.
• Risk adjusted: outcome at 30 days after procedure.
• Antenatal diagnosis of congenital heart disease.

**Progress**

Significant progress has been made against a number of the delivery themes and national priorities referred to above, some of which are included below:

• Successful pilot of the Welsh Patient Referral Service for electronic prioritisation of referrals. Hospital to Hospital referrals will be piloted in early 2020.
• A robust assessment of the heart failure service using the NCEPOD toolkit
• Approval of a revised chest pain pathway
• Continuation of the Community Cardiology Model
• Extension of Cardiac CT capacity to 2 lists per week.
• Management Board approval for the repatriation of PCI, to include the expansion of the Cardiac Catheter Lab and CT service.

**Key challenges**

Whilst good progress has been made in the previous twelve months there remain a number of challenges for the organisation including:

• Outpatient capacity of general and sub specialty clinics.
• Diagnostic capacity (MRI, CT, Echocardiography, and coronary angiography).
• Increasing demand for new outpatients (and an associated impact on demand for diagnostics).
• Capacity at the tertiary centre for investigations and treatments.
• National shortage of qualified physiologists and radiographers which has a significant impact on recruitment and retention.
• Limited informatics support due to issues with staff recruitment and retention. This has also impacted on the development of a demand and capacity plan for diagnostics.
• Delay of the RGH site development programme
• Adopting a system-wide approach to reducing the burden of cardiovascular disease through greater emphasis and proportionate spend on prevention; this includes making effective use of partnership opportunities afforded by the Well-being of Future Generations (Wales) Act and Public Services Board.

**Links to Prudent Healthcare**

Improving the capacity of the RTT pathway and implicitly improving the speed of diagnosis and treatment will lead to fewer unscheduled admissions to hospital and improved patient morbidity and mortality. In line with the principles of Prudent Health Care, re-organising and improving the capacity of the RTT pathway will ensure that the patient sees the right person first time, and is able to receive the most appropriate investigation and treatment in an appropriate timescale. The investment required to achieve the RTT targets will reduce the cost of unscheduled care, social care, and improve the health of the local population.

Investing in the PCH pacing service will ensure patients receive the most appropriate treatment in the right place in a clinically acceptable timeframe rather than continue to wait longer than is clinically acceptable and suffer increased complications as result of delays in treatment. The development of CT Coronary Angiography (CTCA) service in the Health Board would improve our ability to assess, treat and discharge low to intermediate risk patients in
line with NICE guidance. It will improve the choice of available investigations and avoid unnecessary alternative investigations.

**Links to Workforce Plan**
The demand and capacity plan for Cardiology will inform Directorate workforce plans where a shortfall in consultants, specialised cardiac nurses and physiologists to meet the delivery requirements set by the Welsh Government is identified. The full extent of this is being developed in the next stages of our action and workforce plans and will require service redesign and prioritisation.

Further expansion of the Cath Lab would require workforce redesign as well as additional staffing resource.

**Links to Financial Plan**
Welsh Government investment has been identified for the Community Cardiology pilot. The repatriation of PCI activity will also have an impact on income generation for the health board.

**Links to Performance**
The Heart Disease Implementation Group is responsible for overseeing delivery and reporting progress to the Executive Board. The Health Board has increased the number of heart disease related indicators that are reported as part of our Integrated Quality and Performance Dashboard to Board. This includes the shadow reporting of component waiting times and the Cardiology outpatient waiting list profile ensuring greater visibility at Board level of the key issues affecting performance of these services.

**Capital/ Estates Requirements**
Our work programme for the period of the IMTP requires associated investment in our estate/equipment. This includes:
- Expansion of outpatient accommodation to facilitate the increased general and specialised outpatient clinics
- Expansion of diagnostic equipment and accommodation to achieve the target of reducing diagnostic waiting times for both primary care direct access investigations and secondary care investigations.
- Investment in storage accommodation for equipment for interventional Cath lab
- Office accommodation and IT equipment for new members of staff.

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**Critical Care**

**Key Strategic Drivers**
In February 2017, the Welsh Government published a refreshed Delivery Plan for the Critically Ill. The refreshed delivery plan, reaffirms the Welsh Government’s commitment to ensuring everyone who is critically ill has access to timely, effective and safe services.

**Priorities**
The priorities of the Critical Illness National Implementation Group for 2019/20 have been identified as:
• Implement the priorities/actions identified by the task and finish group. Currently the health board has Critical Care staff contributing to the implementation of the priorities/actions identified by the task and finish group and the work is still ongoing.
• Procure and commission the Clinical Information System for Wales

The current work programme of the Health Board’s Critically Ill Delivery Group aligns to each of the themes within the national Delivery Plan. The Health Board has made significant progress in developing services for the critically ill and has demonstrated this year on year in the annual progress reports to Welsh Government. The Health Board is compliant with a number of the actions within the plan; those listed below identify the key priorities for delivery during the course of the updated IMTP.

**Delivery Theme 1: Delivering Appropriate, Effective Ward Based Care**
• Ensure all acute admissions are assessed for the risk of developing acute kidney injury.
• Ensure all acutely unwell patients are screened for sepsis and appropriate care pathway delivered where indicated.
• Put in place a process to ensure all patients requiring general surgery have their mortality risk calculated - those with a score of predicted mortality greater than 10% will require assessment for post-operative critical care admission. NELA laparotomy audit results have shown significant improvements over both health board sites.

**Delivery Theme 2: Timely Admissions to Critical Care**
• Allocate critical care units as appropriate, aligning with Service Redesign / South Wales Plan. Unit capacity within the health board will be reviewed as it has been identified that units are currently are running over the agreed level of bed utilisation.

**Delivery Theme 3: Effective Critical Care Provision and Utilisation**
• Ensure that critical care patients are managed by dedicated critical care consultants and middle tier doctors.
• Deliver effective and efficient care of critically ill patients; including increasing provision or enhancing services to care for Level 1 patients outside of critical care where appropriate.
• Align critical care delivery with Service Reviews whilst continuing to ensure patient safety of unselected admissions.

**Delivery Theme 4: Timely Discharge from Critical Care**
• Prioritise critical care discharges.
• Develop mechanisms to undertake ongoing assessment of impact of DToCs:
  - To patients whose discharge is delayed.
  - To those who are prevented from accessing critical care due to the lack of a critical care bed.

We continue to make good progress on the delivery of our local plan, and in particular our performance against the Welsh Government Assurance Measures demonstrates our performance is improving in a number of key areas and that we compare favourably to the rest of Wales, particularly in relation to delayed transfers of care.
Some of our key achievements over the last twelve months include:

- The progression of ICIP for electronic prescribing is in the process of being developed. The project is now well established and will be implemented in the current financial year.
- NICE 83 Rehabilitation Clinics are now established in Royal Glamorgan Hospital. The clinics started in Prince Charles Hospital in September 2016. The role of these clinics is to follow up patients post ITU discharge. Cwm Taf is the first Intensive Care department in Wales to establish this service. Funding was approved for twelve months to employ a clinical psychologist at 15 hours per week to support the clinics. Recruitment is currently in progress.
- The Critical Care outreach teams at the Royal Glamorgan and Prince Charles Hospitals have now been given computer tablets so they can collect data on the patients who have sepsis. This data was previously collected manually via a triplicate pad system. The new process of recording data electronically has proved far more efficient. The outreach team in RGH has been a 24 hour service the first in Wales for 18 months.
- Critical Care Network funding has been received for the expansion of Outreach services. We are currently in the process of recruiting Band 7 nurses to enable a 24/7 service across sites.

Links to Prudent Healthcare
A prudent approach to the delivery of services for the critically ill can be evidenced by the following:

- As referred to above the Critical Care Outreach Team (CCOT) are supporting the roll-out of SEPSIS 6 and are working with ward staff to ensure all patients are screened for Sepsis.
- Local evidence demonstrates that early intervention by the CCOT has prevented admissions to critical care.

Links to Performance
- Analysis of our performance against key Welsh Government measures shows that our performance is improving in a number of key areas and that we compare favourably to the rest of Wales. This is outlined in detail in our most recent progress report as well as local and national reporting through the Critically Ill Scorecard and the Intensive Care National Audit and Research Centre (ICNARC).

Links to Workforce Plan
- Opportunities to train Anaesthetic Critical Care Practitioners such as Band 7 Nurses, or ODP staff to take on some of these responsibilities will be given further consideration.

Links to Financial Plan
- The Health Board has received funding from the Critical Care Network to facilitate a 24/7 Outreach service across all sites. A phased implementation plan is currently development as part of this process.

Capital/Estates Requirements
- Ongoing Estates work programme at the Royal Glamorgan Hospital which includes the establishment of an isolation room within the current template.
Key Strategic Drivers

In July 2018, Welsh Government published ‘A Healthier Wales: The Oral Health and Dental Services Response’ document that provided detail on the contribution oral health and dental services can make in achieving the vision of a whole system change, focused on health and wellbeing and a preventive approach to care set out in ‘A Healthier Wales’.

Health Board’s previously based their Local Oral Health Plans on the National Oral Health Plan [2013-18]. The Healthier Wales documentation emerged from ‘Together for Health: A National Oral Health Plan for Wales’ and seeks to develop on the improvements already made to oral health through previous oral health plans and looks to overcome existing challenges by providing more focus on dental services which promote an increase in prevention, provision of dental services fit for future generations and developing skill mix within dental teams.

There are 5 key priorities set within the plan for 2018-21:

1. sustained and whole system change underpinned by contract reform;
2. teams that are trained, supported and delivering value-based quality care;
3. oral health intelligence and evidence driving improvement; and
4. improved population health and wellbeing.
5. Timely access to prevention focused NHS care

Welsh Government, seeks to achieve some of these objectives by instigating a complete change to the way general dental practitioners provide [and are remunerated] for the care provided within dental practice, though the development and implementation of National Contract Reform Programme.

A new Oral Health Plan is currently being developed within CTM UHB in line with WGs dental response to ‘A Healthier Wales’ policy documentation. The local plan will look to support the roll out of the contract reform programme across the Health Boards footprint, review of existing pathways to improve efficiencies and patient care, integration of dental services and increase the provision of intermediate care services within primary care service. Additional priorities have also been identified and will be included in the plan as a result of the Bridgend boundary change.

Sharp differences remain between individuals with the best and worst oral health in Wales; in Cwm Taf Morgannwg our performance lags behind similar areas in some important aspects. Prevention is at the core of the plan and reducing the risk factors that lead to oral disease is only possible if the delivery of dental services and oral health improvement programmes are oriented towards primary health care and prevention.

We recognise the benefits of Dental Contract Reform and will continue to promote and encourage practices to engage in the scheme. Contract reform encourages practices to assess the patient’s dental, medical and social history and make an assessment based on their level of risk, it supports the use of skill mix within teams and co-production of care with patients. CTM UHB already has 36% of all practices engaged in the programme and have 2 practices
already engaged in phase 2 of the programme. In 2019/20 CTM UHB has one of the highest percentages of practices engaged on the programme and was the first Health Board to have a dental practice move into phase 2.

Priorities
We aim to deliver the actions outlined within the new oral health plan. One of our major goals must be to help people take responsibility for ensuring their own good oral health. By working together, we believe we can make a real and sustainable difference to the oral health of our population.

Improvement of children’s oral health is a national as well as local priority. Reducing the level of tooth decay in children (5 year olds) is one of the indicators included in the 2020 Child Poverty Targets, Early Year’s Outcome Framework and Public Health Outcome Framework. The results of the latest epidemiology surveys showing the levels of dental caries in children showed that the dental health of children in Cwm Taf Morgannwg is poor with 56.5% of Merthyr Tydfil children, 45% of Rhondda Cynon Taf and 33.9% of Bridgend children with experience of tooth decay.

Whilst the dental health of 5 year-old children in Wales and some Health Boards has significantly improved since the previous survey in 2007/08, dental health of Cwm Taf Morgannwg children has not significantly improved. A survey of 3 year-old children showed that 21% of Cwm Taf Morgannwg 3 year olds had tooth decay compared to the Wales average of 14.5%. The end of year dental activity data for 2016/17 showed that approximately 40% of children under the age of 5 years of age had not visited a dentist in the previous two years.

The Health Board has identified the following local priorities for 2020/23:
1. Implement the agreed set of actions to focus on targeting children and their parents to start oral health promotion and prevention early in a child’s life. This includes the expansion of the Baby Teeth DO Matter initiative across RCT and Bridgend.
2. Maintain the provision of Minor Oral Surgery (MOS) in Primary Care with appropriate service specification and contract arrangement.
3. Continue to explore the range of services [including intermediate care services] that can be delivered from the Dental Teaching Unit (DTU) building on the successful introduction of the MOS and sedation services.
4. Explore development of GDP attachments with local restorative /OMFS consultants to upskill the GDP workforce and seek to reduce the high number of referrals into secondary care.
5. Following the transfer and amalgamation of the of the Community Dental Service (CDS) transferred from Cardiff and Vale UHB and Swansea Bay (Bridgend) on 1 April 2018, continue the ongoing review of core services to ensure service delivery is integrated, streamlined and improved [where appropriate]
6. Implementation of the recommendations from the completed Designed to Smile (D2S) service review
7. Repatriation of healthy children from CDS into GDS to release capacity within the service to enable compliance with WHC 2019-021.
8. Review and cease [where appropriate] the SLAs currently in place with Swansea Bay and reallocate funding streams for these services into the CTM UHB primary care budget ie:
a) Paediatric GA service - repatriate Bridgend patients into CTM UHB pathway, additional GAA sessions to be identified within CDS and additional GA lists within RGH by March 2020.

b) Ty Newydd and Caswell Clinic - review of current SLA and remuneration allocated to service.

c) Domiciliary Service - develop new service model for domiciliary care and cease GDS provision currently provided through Swansea Bay

9. Support the implementation of phase two of the dental e-referral system [phase 1 implemented July 2019]

10. Continue to roll out contract reform in line with WG expectations of Health Boards and ensure practices are fully engaged with support via HEIW to support effective delivery within practice.

11. Ensure WG innovation funding is allocated to practices and monitored within primary care

12. 111 service redesign of dental call handling and review of current service to streamline urgent dental care service across the health board footprint.

13. Continue to raise awareness of oral cancer and its risks, working with GDPs, GPs and the cancer network to improve outcomes.

Links to Workforce Plan
Workforce issues identified in local plans include:
- The requirement for an additional consultant in restorative dentistry to support the Bridgend population.
- Upskilling of GDPs with development of GDP attachment programme.

Links to Financial Plan
- The Oral Health Plan highlights that the majority of the actions will be taken forward by making the best use of the current resource whether that is a staff, facility or financial resource.
- Identify any financial risks associated with the expansion of Dental Contract Reform.
- To end current SLAs with Swansea Bay and utilise associated costs to fund priorities identified within new oral health plan.

Links to Performance
The Plan and the associated actions will form the work programme for the Oral Health Advisory Group (OHAG) and progress will be monitored through the quarterly meetings with reports presented to the Executive Board as appropriate.

Eye Health

Key Strategic Drivers
The vision set out in the Eye Health Care Delivery Plan which extended to 2020 is being evaluated by Welsh Government and we await decisions on the new direction for service development. However, high quality, patient focused, integrated services which improve the eye health for the population will remain the priority, along with ensuring those who develop sight impairment receive appropriate care, support and rehabilitation.
The key priorities are:

- Preventing avoidable sight loss and improving eye health (this includes ensuring wider public health messaging on the impact of obesity, smoking cessation and immunisation is conveyed at every available opportunity)
- Early identification of poor eye health and sight problems (including school screening)
- Providing high quality, efficient, accessible services.
- Ensuring integration of services and patient focussed delivery.
- Providing care and support for people living with sight / dual sensory impairment.

The Welsh Governments’ current 10 priority areas will continue to be incorporated in the Local Eye Care Plan along with greater emphasis on prudent practice and value based healthcare.

Under the priority theme of raising awareness of eye health and the need for regular sight tests:

**Action 1)** Work with Public Health Wales and other partners, including third sector, to develop a plan to raise awareness of eye health and the need for regular sight tests to detect and prevent sight loss especially to groups of people who have a high risk of eye disease.

Under the priority theme of early detection of poor eye health and sight problems, targeted for people at risk:

**Action 2)** Deliver quality assured vision screening service to children in mainstream schools on school entry and a service that provides an annual sight test to children with special educational needs in schools.

The mainstream screening service is delivered to all children aged 4-5 years. These results are reported annually to WG. The HB awaits the results and recommendations of WG regarding screening for children with special educational needs.

**Action 3)** Work with key stakeholders and clusters to ensure good quality eye care is provided to frail older people, those with dementia and to people in care homes and residential care.

*The optometric advisor is working with primary care providers to ensure services are available to this cohort.*

**Action 4)** Ensure all optometrists practising in Wales are providing the enhanced Eye Health Examination Wales service to enable more people to be managed closer to home.

Under the priority theme of providing access to high quality, integrated services and support:

**Action 5)** Work with Medical Directors and patients to revise targets for hospital ophthalmology services to incorporate measures for all patients (new and follow-up) based on clinical need and risk of irreversible sight loss.
This includes transformation of retinal and glaucoma services as a priority. Plans will include additional multidisciplinary staffing and adequate training resource. Cataract pathway reconfiguration and other sub specialties will be reviewed to provide sustainable value based service across HB sites as appropriate.

The appointment of a specialist glaucoma consultant on all sites is a priority to allow sustainable multidisciplinary teams to practice across secondary and primary care. Sufficient resource is required to ensure patients can be managed equitably according to national guidelines.

Pathway transformation, as outlined above will require additional imaging and administrative support, which medium term will become cost neutral as current higher banded staff retire. The Health Board will develop a screening programme for Hydroxychloroquine retinal toxicity.

*Action 6) Support integrated, efficient working and improve the safe communication of information by rolling out electronic optometry referrals and their prioritisation in hospitals across Wales, starting from January 2017. Alongside this, we will appraise the options for an Electronic Patient Record to roll out across Wales.

The HB will support this development with upgrading of IT infrastructure and specific ophthalmology technical equipment in line with national EPR requirements.

*Action 7) Implement the priority actions of the Wales Ophthalmic Planned Care Plan including that National Cataract Audit

The HB will support POWH to provide this data in line with other HB sites.

*Action 8) Develop workforce plans and identify training needs to support good standards of care and ensure education and training is available to support developments in eye care nationally across Wales; develop multi-disciplinary teams and care closer to people’s homes

The HB will support staff training in the most appropriate and prudent form. HCSW will be trained using nationally accredited Agored packages and registered staff will utilise the ophthalmology Common Core Curriculum framework with additional higher education qualifications being supported where essential.

Action 9) Work to ensure that everyone entitled is offered certification as sight impaired

Action 10) Work with local authorities and Regional Partnership Boards to support the implementation of the Social Services and Well-being (Wales) Act

Key to this is the provision of rehabilitation and habilitation services in every authority that prevent loss of independence, loss of mobility, falls, isolation and depression in people with sight loss/impairment.
The role of the Eye Clinic Liaison Officers (ECLOs) is key in the delivery of 9 and 10 and the UHB will continue to develop this role to support patients with sight loss.

The Diabetes Implementation Group has also identified two actions from the Eye Care Plan that it is prioritising. The eye health care community will take a lead from them and work with them and other stakeholders to implement these actions:

- To raise awareness of the need for regular diabetic screening amongst high risk groups.
- To deliver fast, effective ophthalmic treatment for people with diabetic eye disease.

As identified above, an essential element for all of these priorities is an electronic patient record (EPR) for eye care to facilitate shared care between community optometrists and the hospital eye services.

**Links to Prudent Healthcare**

Promoting the importance of regular eye tests is key in maintaining good eye healthcare and the Health Board will work with all of the relevant stakeholders to achieve this. Our strategy is to ensure that patients’ eye healthcare is delivered in the most appropriate setting by the most appropriate practitioner working to the top of their licence.

Examples of how this is achieved are:
- Post-operative cataract care performed by primary care optometrists.
- Diagnosis and monitoring of patients with Glaucoma or Ocular Hypertension by multidisciplinary teams working in both hospital and community setting utilising virtual working practices to maximise resource.
- Orthoptic led Botulinum toxin service

We will continue to deliver these schemes into 2020/21 and beyond and will also explore other opportunities to develop services in community settings. We will continue to promote the use of the Eye Health Examination Wales (EHEW) scheme, to prevent unnecessary attendances in secondary care, and promote the Low Vision Wales Service (LVWS) for patients with sight impairment.

In addition, we will continue to reconfigure multidisciplinary teams to optimise the use of Ophthalmic Diagnostic and Treatment Centres (ODTC) and primary care services for patients with glaucoma and ocular hypertension. We will further develop use of telemedicine to assess patients presenting with ocular plastic conditions and to virtually review referrals from Diabetes Eye Screening Wales, some additional technical workforce will be required to maximise efficiency in these areas.

**Links to Performance**

We anticipate the developments described above will support a reduction in new and follow up waiting times together with a reduction in the number of patients awaiting an appointment past their planned follow up date.

**Links to Workforce Plan**
Additional staff are required to support the redesigned ophthalmology service model including:
Hospital based optometrists and orthoptists
Ophthalmic technicians and health care support workers
Administrative and clerical support.

Links to Finance Plan
Investment has been identified to support the implementation of our Eye Care Plan including priorities such as:
Development of glaucoma assessment service.
Promoting the use of the Low Vision Wales Service.
Re-designed ophthalmology service model.
Development of a service to undertake eye examinations in Special Schools

Pain Management

Key Strategic Drivers
Chronic non-malignant pain is a common pain disorder causing physical and psychological distress to patients and can occur due to conditions involving inflammatory and neurological pathways. An increasing number of patients are seeking help for persistent pain.

In April 2019 the Welsh Government issued guidance on ‘Living with persistent pain’ to provide advice on the management of pain services and optimal approaches. Within Cwm Taf Morgannwg, our aim has been to develop new, more accurate ways of assessing and treating types of chronic non-malignant pain and provide guidance about when patients should be referred to the chronic pain service. This will allow patients in both primary care and hospital services to be referred to the most appropriate specialists for their needs. This should ultimately mean they are treated more effectively and quickly.

Links to Prudent Healthcare
- Cwm Taf Morgannwg’s chronic pain service, in conjunction with pharmacy, has developed an evidence-based guideline to direct primary and secondary care clinicians in the correct assessment of chronic pain, selection of cost-effective therapies and appropriate referral to the chronic pain service.
- Adherence to the guidelines will result in improved medication management of chronic pain conditions and has the potential for significant cost-savings. The guidelines are available on the SharePoint site and should be referred to by all non-specialist clinicians managing chronic pain conditions.
- New guidelines are also being introduced to improve services, with a group led by specialist pain clinicians and the medicines management pain lead. This will develop further advice which will ensure patients are getting consistent and effective treatment.

Links to Performance
The key performance indicator for the chronic pain service is delivery of the 36 week referral to treatment time (RTT) target. However our ambition for the forthcoming years will be to reduce this waiting time closer to 26 weeks.
Links to Finance Plan
Further investment in the chronic pain and associated workforce is required to meet the growing demand on these services.

Links to Workforce Plan
- Workforce challenges include limited nursing levels and lack of clinical psychology support. The following workforce priorities have been identified:
- Continuation of succession planning for specialist pain nurses.
- Opportunities to introduce clinical psychology support to patients with chronic pain.
- SAS Doctors are currently being trained to support the chronic pain service.
- Development of anaesthetic roles with an interest in pain management to support the relocation of palliative care services to the Royal Glamorgan Hospital.
- Closer working with primary care and potential development of extended roles.