

Transforming neurology: A system-wide approach

The South West London and Surrey Neurosciences Network's transformation pilot is revolutionising neurology care.

By adopting a networked approach and investing in key roles, we're:





Improving patient experience

Reducing waiting times, increasing access to specialist care, and enhancing patient outcomes.

Increasing efficiency

Streamlining processes, reducing unnecessary referrals, and avoiding hospital admissions.





Optimising resource allocation

Ensuring that resources are used effectively to deliver the best possible care.

Our system wide approach:

- Focusses on the needs of our patients and the health system
- Uses high quality data to optimise performance and reduce health inequalities
- Shares benefits and risk across trusts







Transforming neurology: The impact of system wide roles



The South West London and Surrey Neurosciences Network's transformation pilot is revolutionising neurology care.

Our system wide pilot roles are delivering tangible results:



These roles support service transformation though:

- Complex case management and care coordination
- MDT facilitation
- Network support



Improved patient outcomes

Better quality of life and increased patient satisfaction.

Reduced hospital admissions

Fewer unnecessary hospitalisations, leading to cost savings.





Enhanced efficiency

Streamlined processes and reduced administrative burden.

System wide roles

- Collaboration manager
- **Epilepsy**: Regional MDT coordinator
- Functional neurological disorder: Care advisor
- Motor neurone disorder: Care advisor
- Multiple sclerosis: Advanced champion
- Myasthenia gravis: Clinical nurse specialist
- Parkinson's: Clinical network manager



The South West London and Surrey
Neurosciences Network's transformation pilot is
revolutionising neurology care. By investing in
innovative roles and improving collaboration,
we're delivering better patient outcomes and
optimising resource allocation.





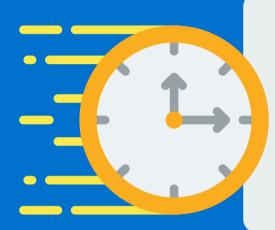
Transforming neurology: Data driven insights



The South West London and Surrey Neurosciences Network's transformation pilot is revolutionising neurology care.

By harnessing the power of data, we're driving continuous improvement in neurology care:





Reduced waiting times

Shorter wait times for appointments and treatments.

Increased access to specialist care

More patients receiving timely access to specialist services.





Improved patient satisfaction

Higher levels of patient satisfaction and positive feedback.

About the pilot

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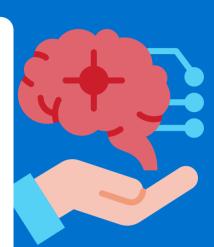


Regional Epilepsy MDT Coordinator



The South West London and Surrey Neurosciences Network's transformation pilot is revolutionising neurology care.

Through key system wide roles, we're improving access, outcomes, and experience for our patients.



Our Regional Epilepsy MDT Coordinator extends the Epilepsy MDT to all regional consultants. This will better distribute specialised care to local hospitals, ensuring the best treatment for patients.



Increasing capacity

Increased neurologist and specialist nurse capacity for clinical work.

Improving patient experience

Reduced patient travel and quicker access to specialised treatment, leading to better symptom management.

Patients able to access to specific medications, like Valproate, without living near a tertiary centre.

Greater access



Reduced need for further appointments at tertiary centres



1 year in post

- 10 MDTs held
- 26 patients discussed
- 16 complex cases, 10 surgical cases
- 11 referrals from external hospitals
- 18 patients started on appropriate medications



Roles and responsibilities

- MDT support and outcome documentation
- Diagnostics and prescribing clinic arrangements
- Blood and ECG monitoring
- Patient database maintenance
- Patient communication and letters
- Data and equipment related to vagus nerve stimulation (VNS) equipment









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Our Myasthenia Gravis CNS serves as a point of contact for patients, increasing access, assessment, and treatment for those with MG. This will ensure equity of access to specialist myasthenia care across the region.



Increasing capacity

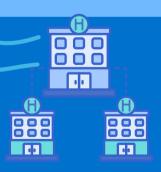
Reduced workload for neurologists.

Improving patient experience

Direct access to a specialist nurse for advice and support.

Equity of access

Active monitoring of patients across the region.



Better value for money

Avoided hospital admissions and reduced length of stay.

7 months in post

- Care for 76 patients
- Support 33 patients on steroid therapy
- Monitor blood for those staring on steroid sparing agents
- Identify patients appropriate for theymectomy

Roles and responsibilities

- Direct point of contact for patients
- Review stable patients and advise on managing their condition
- Flag deterioration of patients to consultants for rescue therapy / hospital admission avoidance
- Work up patients on novel disease modifying drugs (organisation, infusion, monitoring)



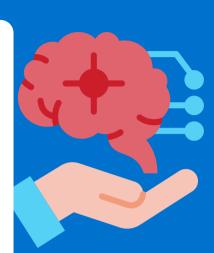


Parkinson's Clinical Network Manager



The South West London and Surrey
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neurology care.

Through key system wide roles, we're improving access, outcomes, and experience for our patients.



Our Parkinson's Clinical Network Manager is creating a networked approach to Parkinson's care.

This will better distribute specialised care to local hospitals, ensuring the best treatment for patients.



Increasing capacity

Facilitating knowledge sharing and reducing administrative burden.

Improving patient outcomes

Quicker access to specialist MDT discussions and better treatment outcomes.

1 year in post

- Connect regional consultants and Parkinson's nurses / practitioners
- Map local services
- Investigate catchment areas, referrals, caseloads
- Create MDT processes

Better value for money

Reducing ED attendances and hospital admissions through improved access to advanced therapies.



Roles and responsibilities

- Facilitate integration of MDT teams across primary, secondary, and community care
- Map services across the region
- Explore acute admission / discharge pathways and community links
- Establish a non oral therapies pathways
- Initiate an ongoing regional MDT







Motor Neurone Disease Care Advisor



The South West London and Surrey
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Through key system wide roles, we're improving access, outcomes, and experience for our patients.



Our Motor Neurone Disease (MND) Care Advisor provides clinical practice, education, and pathway expertise. This builds collaborative links and expert guidance for both patients with MND and healthcare professionals.

Increasing capacity

Reduced workload for other healthcare professionals.

Improving patient experience

Personalised care and timely access to specialist advice.



Equity of access

Standardised care for MND patients across the region.

Better value for money

Reduced length of stay and avoided hospital admissions.





7 months in post

- 17,500+ minutes of contact with patients and carers
- 3 hospital admissions avoided
- 6 complex discharges from inpatient setting
- 110 referrals to community

Roles and responsibilities

- Provide highly developed assessments of complex clinical situations in acute and community settings
- Community settingsPractical and emotional support to patients and
- families
- Multi-professional targeted education
- Pathways that align to local service provision and optimal care

Outreach and home visits for those with NMD







Functional Neurological Disorder Care Advisor

The South West London and Surrey
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Through key system wide roles, we're improving access, outcomes, and experience for our patients.



Our Functional Neurological Disorder (FND) Care Advisor supports patients in the region with complex FND in accessing and navigating care. This ensures that patients are better informed on their condition and care plan.



Increasing capacity

Reduced workload for clinicians.

Improving patient experience

Increased support and guidance for those managing FND.



Equity of access

Ensuring access to specialist advice for all patients with FND.

Better value for money

Reduced ambulance callouts, ED attendances, and hospital admissions.



Roles and responsibilities

- Link patient care across multiple services
- Improve experience and outcomes for people with FND
- Promote self management skills of people living with FND
- Facilitate specialist management plans
- management plansSupport development of

emergency care plans

6 months in post

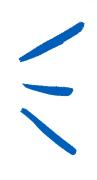
- 416 patient actions
- 17 outreach visits
- 110 referrals to community
- 16 inpatient in-reach sessions for complex admissions
- 90 meetings with healthcare professionals
- 13 in service training sessions to teams and networks





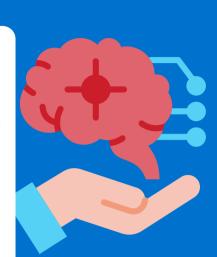






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Our Advanced Multiple Sclerosis (MS) Champion plans, delivers and coordinates complex care for people with advanced MS. This ensures that patients and their carers are best served in all settings.



Increasing capacity

Reduced workload for healthcare teams.



Personalised care and home visits.



Equity of access

Access to specialist advice for patients who might otherwise struggle to attend hospital appointments.

Better value for money

Avoided hospital admissions and early detection of UTIs.





- 33 home visits
- 23 clinic appointments
- 7 hospital admissions avoided
- 80+ referrals to community
- 1 safeguarding issue raised

Roles and responsibilities

- Organise MS MDTs and ensure timely referrals
- Coordinate care across health and social care to deliver a joined up care plan
- Attend home visits
- Reengage patients with essential care
- Support carers in symptom management, increasing knowledge and confidence
- Provide practical advice, eg accessing Personal Independence Payment (PIP)