Saolta
Grúpa Ollscoile Cúram Sláinte
University Health Care Group

Neurology Services Review 2024
Saolta University Health Care Group

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Medicine MCAN

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Version Control

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V1.'s	Version 1.0 & V1.1 are for original drafts	GC drafts	Closed
V2.'s	V2.0 & V2.1 TOB edits V2.2 & V2.3 GC revised draft	GC /TOB	Complete 22/02
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V5.0		GC/TOB/MH	10/10 Finalised for publication

1.0 Addendum 2 added with Activity & Resourcing data - 09/08/2024.

09/08 Steering Group initial meeting decisions.

1. Agreed to add this 'Addendum 2' to the document. Section 1.1 shows the additional activity that could be generated by resourcing the recommendations of this review. Section 1.2 shows the revised resources table, as presented in Addendum 1, page 6
2. The Implementation plan for new services in LUH & MUH, should be conducted on a 2 Phase basis. Phase 1 should start with the implementation of 1 X Consultant led service and team and Phase 2 should incorporate the 2nd Consultant led team. Both phases need to align with agreed transitional plan(s) and clinically led governance arrangements with the Hub hospitals. There needs to be active engagement and collaboration arrangements agreed with the Clinicians and Services in SUH and GUH

1.1 There are both quantitative and qualitative benefits accruing to the organisation by investing in the resources needed to deliver on this strategy.

The two activity tables 1A and 1B has been added to this document to demonstrate the additional activity that can be generated by resourcing the new and existing Services as recommended by this review.

Key Points on interpreting the tables 1A & 1B:

- The projections are based on the HPVP data for the Model 4 Hospital in Galway during 2023
- For 2023, the sum total of appointments was 6546
- Appointments per WTE Consultant was 1451
- The Saolta New: Review ratio for 2024 is 1:2.2 with the current target being 1:2

New : Review ratio for Neurology patients – National Clinical Programme comments
There is no recommended ratio for Neurology patients. The Model of Care did look at this but found very big differences between hospitals and sites. Neurology look after people with chronic diseases who need frequently monitoring. Need to see reviews more often and get to discharge less due to advancement with treatments. GPs not in a position to take back patients e.g. cannot discharge people with controlled epilepsy anymore.

- Proposed activity for the Neurology implementation is based on these parameters
- Nursing activity is based on the average patients being seen in SUH as is the New:Review ratios from 2023 ANP clinics
- The proposed / projected activity is based on <u>full teams being in place on each site</u>
- The Nursing additionally for Galway and Sligo is based on the reinstatement of funding for the ANPs
- The Consultant additionality for SUH is based on the repatriation of the current resources allocated to LUH.

Table 1A Proposed activity by hospital summary:

Site	New	Review	Total OPD	Site Totals
PUH	243	1,308	1,551	1,551
LUH	972	5,230	6,202	6,202
MUH	972	5,230	6,202	6,202
SUH	343	3,075	3,418	3,418
GUH	275	2,925	2,475	2,475
	2,805	17,769	19,848	19,848

Table 1B Details of proposed activity by hospital:

	Site	Resources	No's	Planned Activity	Total OPD	Ratio's	New	Review	Total OPD	Site Totals
New	PUH	Consultant (0.5)	0.5	1,451	726	01:02.2	227	499	726	1,551
		ANPs / CNS	1	825	825	01:50	16	809	825	
	LUH	Consultants (2) & team (2)	2	1,451	2,902	01:02.2	907	1,995	2,902	6,202
		ANPs / CNS	4	825	3,300	01:50	65	3,235	3,300	
	MUH	Consultants (2) & team (2)	2	1,451	2,902	01:02.2	907	1,995	2,902	6,202
		ANPs / CNS	4	825	3,300	01:50	65	3,235	3,300	
Add	SUH	Consultants & team	0.65	1,451	943	01:02.2	295	648	943	3,418
		ANPs / CNS	3	825	2,475	01:50	49	2,426	2,475	
	GUH	Consultants & team	0.0	1,451	0	01:02.2	0.0	0.0	0	2,475
		ANPs / CNS	3	825	2,475	01:50	49	2,426	2,475	
Team resources - HSCP and Admin Grade 4 resources are part of team activity										
TOTAL (New & additional) activity					**19,847**		**2,578**	**17,270**	**19,848**	**19,848**

1.2 The Resourcing table has been amended to include the Nursing & HSCP requirements for SUH & GUH, as follows:

- The Nursing requirements need to reflect the vacant posts which have had their funding withdrawn during 2024 and which were not included as part of the NSP 2024.
- HSCP allocations for Neurology currently need to be provided for and aligned to the LUH resourcing model. This has been estimated by the review team as there are no HSCP benchmarking numbers available at this time.

Both sites need these Nursing and HSCP resources to be prioritised and included in the overall submission for funding, which stands at 30.0 – see below for details.

By way of note - the 'Medicine MCAN' have included the total Neurology Resource requirements, as part of the Estimates process. As the Estimates process progressed the individual sites will need to prioritise their requirements for Neurology and include in their 2025 Hospital / Saolta Estimates planning and submissions.

Resource Requirements to implement the recommendations – updated 04/07/2024

Resources	GUH	PUH	MUH	SUH	LUH	Totals
Consultants	0.0	**0.5**	**2.0**	0.0	**2.0**	**4.5**
Registrar	0.0	0.0	**1.0**	0.0	**1.0**	**2.0**
SHO	0.0	0.0	**1.0**	0.0	**1.0**	**2.0**
Advanced Nurse Practitioner	**1.0**	**1.0**	0.0	0.0	0.0	**2.0**
Clinical Nurse Specialist	**2.0**	0.0	**4.0**	**3.0**	**4.0**	**13.0**
Physiotherapist	**0.5**	**0.5**	**1.5**	**0.5**	**1.5**	**4.5**
Occupational Therapist	**0.5**	**0.5**	**1.0**	**0.5**	**1.0**	**3.5**
Speech & Language Therapist	0.0	0.0	0.0	0.0	0.0	**0.0**
Medical Social Worker	0.0	0.0	0.0	0.0	0.0	**0.0**
Grade IV	0.0	**0.5**	**1.0**	0.0	**1.0**	**2.5**
Totals for Hospitals	**4.0**	**3.0**	**11.5**	**4.0**	**11.5**	**34.0**
Implementation team **1 X Senior Project lead (Grade 8) & 0.5 admin support (Grade 5)**						**1.5**
Total resources required						**35.5**

04/07 Updated Notes to table:

SUH Nursing & HSCP. - *Recommended by DON & GM in SUH*

- Funding for posts in MCP programme was withdrawn in March 2024 and needed to be prioritised and resourced for SUH Nursing. Both sites need these Nursing resources prioritised in order to sustain and support the current level of services being delivered. These nursing vacancies are in different stages of the recruitment process (see table on nursing resources on page 34) included in the overall submission for funding.
- The SUH GM has identified the gap in HSCP allocations for Neurology currently and has requested that the HSCP resourcing to be aligned to the LUH resourcing model. This has been estimated by the review team as there are no HSCP benchmarking numbers available at this time.

Addendum 1 for Exec Council 05/06, to be added to Implementation Plan page 22

Resource Requirements to implement the recommendations

Resources	GUH	PUH	MUH	SUH	LUH	Totals
Consultants	0.0	**0.5**	**2.0**	0.0	**2.0**	**4.5**
Registrar	0.0	0.0	**1.0**	0.0	**1.0**	**2.0**
SHO	0.0	0.0	**1.0**	0.0	**1.0**	**2.0**
Advanced Nurse Practitioner	0.0	**1.0**	0.0	0.0	0.0	**1.0**
Clinical Nurse Specialist	0.0	0.0	**4.0**	0.0	**4.0**	**8.0**
Physiotherapist	0.0	**0.5**	**1.5**	0.0	**1.5**	**3.5**
Occupational Therapist	0.0	**0.5**	**1.0**	0.0	**1.0**	**2.5**
Speech & Language Therapist	0.0	0.0	0.0	0.0	0.0	**0.0**
Medical Social Worker	0.0	0.0	0.0	0.0	0.0	**0.0**
Grade IV	0.0	**0.5**	**1.0**	0.0	**1.0**	**2.5**
Totals	0.0	**3.0**	**11.5**	0.0	**11.5**	**26.0**
Implementation team **1 X Senior Project lead (Grade 8) & 0.5 admin support (Grade 5) = 1.5**						

Notes to table:

1. **Consultants.** **-** *Recommended by Group Specialty lead, MH*
   - For new services in MUH & LUH, there needs to be 2 new Consultants.
   - PUH will be providing an ambulatory service and needs 0.5 new for PUH. The shared 0.5 will be provided by GUH from within existing resources.
   - PUH services can be commenced in advance of MUH & LUH and so resources can be costed from 2025, depending on estimates and approvals.
   - MUH & LUH fall into 'difficult to fill posts' and will need special measures as proposed by Michael Hennessy, Group Specialty Lead. *Special Measures* will include Academic, Admission rights, close communication etc, to secure close working relationships with the existing / developed sites
   - These will take minimum of 2 years following CAAC processes and could be factored in from Jan 2027.
2. **NCHDs**. - *Recommended by Group Specialty lead, MH*
   - Recommended 1 Registrar and 1 SHO for the new services in MUH & LUH
   - PUH will be managed by an ANP and does not require any NCHDs
3. **Nursing -** *Recommended by Group Specialty lead, MH & agreed by DON Medicine MCAN, LQ*
   - For PUH 0.5 ambulatory service, it is recommended to resource with 1 X ANP on that site
   - 2 CNSs per Consultant on the MUH & LUH sites
   - Unfilled posts on the GUH & SUH sites need to be derogated and filled for optimum levels on both sites
4. **HSCPs –** *Compared to MOC & discussed with HSCP leads in GUH & SUH.*
   - Physio and OT numbers have been based on OPD & inpatient services being developed in MUH & LUH
     - For OPD that equates to *0.5 OT* & *0.5 Physio*.
     - *0.5 OT* and *1.0 Physio* additionality has been added for inpatients up to 10 beds.
   - Allocated beds need to be ring-fenced on all sites and developed in MUH & LUH. None needed for PUH
   - Social workers and SLTs will be shared resources. Will need to be calculated on each site with HOSs
5. **Administrative Support –** *recommended by Group Specialty lead MH & review findings, GC*
   - Adequate administrative support on each site is fundamental to success for Consultants, Specialist Nurses Clinics and for PA support.
   - Senior Project Manager should have a clinical background to support the Group Specialty lead.

Contributors

Authors: Ms Gráinne Cawley & Prof Tim O'Brien with significant input from Dr Michael Hennessy, Group Specialty Lead and Administrative Support provided by Ms Rachael Keady, MCAN.

Thanks to all the site teams who met with the Medicine MCAN team at review meetings during 2023 and January 2024.

- Site review meetings with MUH, SUH, GUH & LUH
    - Led by Ms Gráinne Cawley, Ms Lorna Quinn, Ms Ann Dooley and Ms Rachael Keady in the Medicine MCAN
    - ACDs, Hospital Managers, DONs and ADONs
- Input from PUH & RUH
- Input from the National Clinical Programme for Neurology – Ms Dervla Kenny, Programme Manager and Prof Sinead Murphy, Clinical Lead
- Ms Magdalen Rogers, Executive Director, Neurological Alliance Ireland

Version input, clarifications and comments received by many, with a special thanks to:

- Medicine MCAN team
- Activity reporting personnel in SUH, LUH & Ms Ann Dooley for GUH
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Part A

1.0 Introduction

The Saolta Strategy 2018 – 2023 provided the Medicine specialties of Saolta with a first opportunity to develop a clinical strategy for their specialties, enabling them to create their vision, highlight key critical issues and make recommendations for their specialty based on clinical needs of their population and aligned to National Programmes and Sláintecare principles. The rollout of the RHAs or Health Regions (HR's) which align with the Saolta Hospitals area will impact the services being delivered and how they will be delivered going into the future. The decision was made by Saolta to do an addendum for 2024 while we await the new governance structures for these HR's.

During 2023 the Medicine MCAN was launched and one of their key strategic priorities is to conduct a 'Deep Dive' review of 2 priority areas of regional services and to continue with the addendum for the other 12 specialties. Both Pat Nash, Chief Clinical Director and Tim O'Brien, Director of Medicine MCAN agreed to prioritise Neurology and Dermatology services. This report contains the Neurology element of the reviews.

Preparatory works for the review commenced in April 2023 and the Project charter was completed by CCD office. This initial Project Charter was drafted to define the problems and agree associated activities needed to be conducted for these reviews with proposed timelines during 2023.

Under the original charter the site meetings were due to take place during April / May 2023 but the timelines were pushed out to Qtr4, 2023. The charter has been updated with these revised dates and with some changes to scope.

From May to December 2023, Medicine MCAN team set up these review meetings with key stakeholders on the hospital sites where Neurology services are being delivered and where commitment has been made to deliver these services. The Medicine MCAN team has met ACDs, Group Specialty lead, Clinicians, Hospital Directors of Nursing and General Managers, or their representatives in conducting the activities for this review. We would like to thank all of the contributors for their support and input which have also given greater insight into the issues and challenges facing these services on the ground.

We believe it is a good reflection of the current 'As is' and we have made recommendations as relevant to our findings. We also reviewed the Saolta Strategy recommendations and tracked some progress since 2017. It is important to note that the landscape of 2017 was different to our current state and this is reflected in the report as the basis for change with some unintended consequences arising from COVID, Health Service reform and the availability of skilled specialised staff. Current expenditure restrictions and the recruitment embargo are also impacting on securing suitable resources to our services.

The Recommendations of the review is divided into two sections of (1) short term / responsive actions, needed to be taken now and (2) medium to long term recommendations that require business cases and some lengthy processes to implement.

2.0 Executive Summary

The current provision and delivery of Neurological services for the NW and Western regions of the Saolta HG are being provided by GUH for the Western region (W) and by SUH, in the North West (NW) of the Saolta HG.

It should also be noted that there are extensive overlaps between Neurology and other specialties such as Geriatrics, Stroke Medicine, Psychiatry and Rehabilitation Medicine which will be managed by group Specialty Leads

This deep dive has examined the Regional services delivery model in the Western region and the Hub and spoke model of delivery in the North West and has made recommendations on resourcing these models

The need to deliver neurology care to the dispersed geographic Saolta region with a service provision population of 830,000 has been a key determinant of the recommendations. It should also be noted that this population and its age demographics will increase in the coming decades. We highlight the relative health and social deprivation of the region.
A hub and spoke model is challenging to deliver in such an environment. We are also mindful of the international recommendation from the Association of British Neurologists that 1 consultant neurologist is needed for every 70,000 people, although these population ratios vary significantly across European countries.

In the Western Region it is recommended that a Hub & Spoke, consultant led model, be extended to PUH with an apportionment of visiting consultant's time along with the supporting team of NCHD, Nursing, HSCP and Administration staff. Consultant commitment of 0.5 wte will be provided by GUH team in a 50:50 share with PUH.
We recommended that MUH will develop their own Neurology service on-site as is warranted by the population numbers and which will improve access for patients in the catchment area.
The National model states that there should be no units with a single neurologist and MUH will need 2.0 additional consultants, and appropriate levels of NCHDs, Nursing, HSCP and Administration staff to provide these services. Access to diagnostics will need to be considered as part of implementation planning.
This will enable GUH to improve access for their catchment areas, reduce numbers waiting on their lists so that neurology patients can access and receive the continued care required for their chronic conditions. This will facilitate the hospital to grow their sub – specialisms within the Model 4 hospital.

In the NW, there is a need to develop the services on-site in LUH as the Hub and Spoke model has not worked for the NW area. This will require 2 new posts in LUH, along with the appropriate NCHD, Nursing, HSCP and Administration staff. This would allow the existing team in SUH to improve access and manage the chronic nature of their patients for the Sligo / Leitrim area, in the right place at the right time, as set out in the Sláintecare programme for the reform of our services.

Resourcing the Neurology services need to provide for adequate NCHD, Nursing, HSCP and Administrative resources. While specialist nursing resources have been funded in 2023, the level of current vacant posts is concerning and needs to be to escalated and prioritised as recommended by this review.
The current gap in HSCP dedicated allocations for neurology services is impacting on the current service delivery model.
Insufficient administrative resources for current services and the need for additional administrative supports for developing services requires special attention and needs to be resourced for a full MDT approach.

All Hospital sites are experiencing significant challenges with OPD Clinic space and allocation of slots appropriate to the work loads of OPD teams. This is a whole of team issue, from Consultant to ANP delivered clinics.

The Medicine MCAN team was asked to develop an 'As is' of current services and conduct a deep dive into the challenges, issues and opportunities across the Saolta Hospital sites. Part of this was a review of capacity, current demands, activity and waiting lists.

One of our key priorities in Saolta is to reduce the time waiting and to improve overall access to our services. The Group are now using DPS / Procured frameworks to help reduce and manage these lists in the short term. It is important that we find Long term sustainable solutions to capacity and access for our patients.

The recommendations are broken into short term and the Medium / longer term actions. Some of the short term recommendations and actions can commence now and it is important to identify those actions that *we can do now with what we have in place*. Some of the longer term recommendations will need significant resourcing over the next 3 – 5 years and a programmatic approach should be implemented to deliver the whole system of reform needed for the Neurology Services and Model of Care being delivered across the Saolta Hospitals. Following approval, the key elements/ recommendations and Plan can move onto the next stages. Funding will follow.

While the Saolta Strategy 2018 – 2023 was a first step in identifying and drafting the strategic priorities and challenges for the Neurology Clinical Services, it did not progress sufficiently since then, mainly due to resourcing deficits and an implementation plan to drive this change. Some of these challenges remain the same.
In order to progress, we need to ensure that the Recommendations are used to design a programmatic approach to Neurology services reform across Saolta and Area F, led by Saolta leadership with a clear stakeholder working group in support.
The National Clinical Programme for Neurology have met with Medicine MCAN and have provided comments and feedback in support the review recommendations and will provide guidance and support, where possible.

There is an old saying which goes something like '*Don't start from here, start from a better place'*. It is better to commence the improvement plan and subsequent programme of reform from a better starting point with a clear mandate of improvement aligned to the National model of Care and supported by the allocation of the necessary resources.

3.0 Summary Findings

The provision and delivery of **Neurological services** for the NW and Western regions of the Saolta HG are being provided by GUH for the Western region and by SUH, in the North West (NW) of the Saolta HG. The Western region service is provided by the Model 4 Hospital, GUH across the Galway, Mayo and Roscommon counties. In the NW, the Model 3 hospital, SUH provides out-reach OPD clinics to LUH under the Hub and Spoke Model.

Additional Consultant and specialised Nursing resources have been added in recent years but the current services **remain under resourced** in line with the National clinical Programme / Model of Care, population norms and the Saolta Strategy recommendations 2018 – 2023.

In the North West part of the Saolta Hospital Group region, the **Hub and spoke model** of delivery of Neurology Services is not working well and is suboptimal in SUH and LUH. While the commitment of the Sligo consultants is recognised and commended, the model is not sustainable and will increase the risk of physician burnout in the coming years. There are insufficient resources / numbers of consultants to cover this geographical area and the developing specialist needs of the NW. This is also compounded by the difficulty of filling Consultant posts in LUH, as currently being experienced by the Hospital. We suggest that 2 additional consultant neurologists should be appointed to LUH and these will complement the existing 3 consultant neurologists in Sligo University Hospital, giving a total of 5 Consultants covering the North West Region. There will be the usual challenges of recruiting these specialty posts for Letterkenny and every effort needs to be made to encourage and support the recruitment and retention of key specialty staff across the North West.

As SUH consultants transition back to SUH service delivery, there will be a need to reduce and cease sessions in LUH. There will continue to be administrative, education and research interactions. Work plans will need to be updated and the transition needs careful planning and addressed in the impact assessments for SUH & LUH. Some similar transition planning needs to take place in GUH and MUH. The recommended additionality for PUH will be managed by GUH and can commence in the initial stages of transition. Again, work plans and commitments will need to be updated and a process agreed to ensure that agreed commitments are met.

In the Western Region of the Saolta Group, GUH provide all the regional services on the Model 4 site, which some fragmented **support to the MUH, PUH Model 3 and RUH Model 2 hospitals in the region**. There was a historical consultant commitment of 0.24 from GUH to MUH which has not been provided by GUH consultants due to service pressures and inadequate consultant numbers.

In the western region we would suggest that **2 consultant neurologists** are appointed to MUH and patients from this catchment area can now travel to their nearest model 3 hospital for their care. The National model states that there should be no units with a single neurologist.

These additional posts would bring the total number of Consultants in Saolta to 14.5 Consultants, which is in keeping with population planning, internationally recommended numbers and the Model of Care

We further recommend that services to Portiuncula and Roscommon would be provided by the Galway-based neurologists. This would enable rotation of teams from GUH and more appropriate point of delivery, while providing Clinical Governance and collegiality from GUH. This practice in PUH is primarily based on the hub & spoke model but differs in that GUH currently own all the Western Region waiting lists. As PUH is connected to Galway by a motorway, it is felt that a hub and spoke model will work for this site, once there is adequate consultant staff appointed to the group.

For NCHDs resourcing, the overall recommended ratio for trainer to trainee (Consultant to NCHDs) is 1:1.3 but can range to 1:1.5 for all NCHDs. So an estimate of NCHD workforce might be 15 per 10 consultants and needs to be considered as part of the whole resourcing plan for Neurology.

This model would ensure added capacity to the region and may be challenged by infrastructural deficits for clinics at sites. All elements of the process, across sites would need to be agreed and optimal in order to ensure that the benefits can be realised for patients and staff across the region.

It is also noted that there are consultant appointments approved for Galway which will have beneficial impacts on service delivery e.g. waiting list initiative post with current post holder on maternity leave, Professor of Neurology/Consultant Neurologist. There is another 0.5 WTE approved post which could be merged with a future retirement to create a 7 full time posts, one of which will be an 50/50 Professorship in partnership with the University of Galway). That will result in 6.5 WTE clinical consultant in Galway and 0.5 WTE academic. One of these posts is part of the consultant staff complement for the Regional Specialist Memory Centre along with consultants in Geriatrics and Psychiatry of Later Life. These post holders will interact with the MASS services throughout the group to ensure delivery of the Dementia Model of care. The academic post which has been approved and is due to be interviewed, will ensure that the education and research elements of the model of care will be delivered. A consultant in Clinical Neurophysiology has also recently been appointed to GUH and SUH, and these will be the 2 centres from which neurophysiology services will be delivered.

The involvement of additional RANPs / cANPs and CNS / cCNS will bring an added dimension to clinical care. They will need to be closely integrated into the services provided alongside the Consultants. A number of posts have been approved but not all are filled due to the embargo.

Advanced Nurse Practitioners have the capacity to independently plan, co-ordinate and deliver increasingly complex care, fulfil the potential as primary care givers to the full extent of their education, training and licence. This covers all steps from patient assessment to discharge. They are autonomous practitioners and work in close partnership with consultants and the wider MDT team.

CNSs possess specially focussed knowledge and skills in a defined area of nursing. This involves assessment, planning and initiating care and treatment within agreed inter-disciplinary protocols to achieve patient centred outcomes. They assist with the discharge process.

A plan will be needed to optimally manage difference between these grades in the best use of these specialised resources whilst also being mindful of succession planning for the existing staff as well additional recruitment. There are many options that could be explored here and these can be evaluated by the working group and built into the programme plan. The role of Clinical Neurophysiology CNS can be considered as an option for optimal resourcing and skill mix. There is a Clinical Care Training Programme for CNS being established to incorporate (approx. 3-5 trainees at a time in a 5 year programme). This needs to be incorporated into the overall plan for optimal Neurology services resourcing

New challenges are presenting for Hospital DONs with the increased numbers and roles for candidate ANPs and CNSs. Additional governance and educational teaching elements need to be considered as part of workforce planning and impacts on existing services being provided by nursing staff.

The collaborative work of these posts with consultants will be designed in keeping with the National Model of Care, emphasising the need for Nurse Led clinics.

The need for the development of specialist HSCP services throughout Saolta needs to be referenced here. The Neurology Programme strongly recommends that all neurology services have access to a dedicated MDT, with competencies & experience in neurological conditions, to support and enhance their outpatient activity.

It should also be noted that there are extensive overlaps between Neurology and other specialties such as Geriatrics, Stroke Medicine, Psychiatry and Rehabilitation Medicine which will be managed by group Specialty Leads.

Clinic space for OPD clinics and infrastructural deficits continue to pose significant challenges for all the sites. These deficits are being progressed by Hospitals via Capital planning and site DCPs on an annualised basis. The analysis of OPD data and activity statistics for the sites varies but does demonstrate what can and is being done with/within current capacity. We need to note the impact of additional requirements on these spaces arising from additional resources and new services being developed on-sites.

Additional funding has been granted to support Nurse led clinics in Neurology for ANPs and the hospitals have recruited some specialties in both GUH and SUH. Some posts are caught up in the embargo and will need to be prioritised as soon as derogation or BAU resumes.
In the past few years this additionality has allowed the specialties break out into Consultant and Nurse led clinics, thereby optimising the focus on review and chronic patients according to clinical need. These resources have allowed more patients to be seen and continue their care in both GUH and SUH hospitals. Space for these clinics is an ongoing issue and the hospitals are continuously trying to do more with what they have. Continuous efforts are

being made to re-organise in the context of poor and old infrastructures. Every effort should be made to provide space for new consultants and new Nurse led clinics, whether face-to-face or virtual. The special needs of the Neurology patient' will be factored into the planning.

In the short term, the additional allocation of evening and weekend clinics will significantly improve the outcomes for long waiters and allow more new patients into the system. For a longer term, more sustainable solution, there needs to be a review of available spaces in the hospitals and off-site, with allocation to meet the needs of the services, which includes an element of future proofing. Appropriate admin support and IT/ clinical systems need to be wrapped around these OPD services.

Neurology has long waiters and the Group are now using DPS / Procured frameworks to help reduce and manage these lists. In the short-term additional sources of non-recurring and MCP Funding is being allocated to GUH and SUH to help reduce these lists. It is important that we find sustainable solutions to capacity and access for our patients and this review document offers recommendations and a system wide plan of action over the next 3 – 5 years.

New funding streams are very welcome and have significantly improved and strengthened the services in the Saolta HG. The National Clinical Programme provide a strong model of Care and continuous guidance and oversight. Neurology has strong advocacy, voluntary and sub specialty groups throughout Ireland, who are continuously advocating on behalf of their patients and their families for better access and improved services to be delivered as close to home as possible. These groups and forums should be included in future planning and represented on the Working Group implementing the review recommendations. There will be significant patient involvement in rolling out this strategy with representation on the implementation group.

Administration support continues to be a big issue for all specialties, from Clinics to discharge and all the supports in between. Adequate support, including Business support needs to be factored into the resourcing model in order to get the best synergies for the specialty. It is noted that new funding streams do not include adequate Admin support and have limited non pay allocations. Reporting and setting up new services processes, systems inputting and metric collection are best dealt with by administration personnel and this role needs to be resourced appropriately and needs to remove any wastage associated with using clinical and Nursing resources for these activities. It is important to reform this way of funding allocation as the gap is always met by hospital sites, who are extremely stretched as is.

The review Summary and recommendations recognise the significant contributions made by Hospital ACDs and the working relationship between ACDs, Specialty Leads and Hospital Managers is a key enabler for good governance and provides a conduit for the Medicine MCAN to manage Risks and Issues and further progress Medicine priorities. Business supports need to be available to Clinicians in Management and we need to ensure that this can be provided across the MCAN and a level which supports service development, helps achieve strategic priorities without the normal operational challenges facing sites.

The need for a Neurology Group Specialty lead is evident as these roles enhance the network and help reduce silo-based operations. The Group Specialty lead needs to continuously engage with the National Clinical Programmes, Voluntary Groups and links with Funders of Service developments. The Group lead needs to work closely with colleagues and Hospital Management in planning service requirements. This role will have protected time in the job plan to accomplish these roles.

Under the Saolta Strategy 2018 – 2023 development, Neurology developed a group wide strategy for the next 5 years. We have used this strategy document as a baseline to compare the current 'As is' and this review. This Saolta Strategy provided a cohesive approach for Neurology and a strategic direction for Saolta. On reflection, it did not agree a process to progress actions or mechanisms to follow up on recommendations, and/or any QIPs to continue highlighting the recommendations of the Saolta Strategy. To ensure success, there needs to be a clear plan with accountability and this review recommends that an Action plan and accountable persons are put in place to drive and report on these recommendations, as and when approved by the Saolta Executive Committee.

It is important to recognise the considerable transformation underway under Sláintecare and this review needs to recognise the changing Organisational structures for Area F in the new Health Region structures. The recommendations of this review will line up to the proposed HRs while supporting the current and proposed governance & operational arrangements.

COVID is getting a brief mention here, as the impact of COVID on our hospitals has changed some of the way we deliver our services and conduct our business, with a greater use of virtual and community outreach services. COVID, Health Service reform and the availability of skilled specialised staff continues to impact our ability to recruit and retain skilled caring staff.

When numbers of consultants on the POCC contract are increased extended days, weekend cover and a regional on call system should be implemented. Currently there is no out of hours on call system for neurology but ad hoc arrangements with the input of consultant neurologists do exist.

The plans for community neuro-rehabilitation will also beneficially impact neurology patient care and the Medicine MCAN is working with the Rehabilitation Medicine National Lead on a proposal for rehabilitation needs for the Saolta region. A pilot scheme has been approved for implementation in Galway/Mayo/Roscommon but all 13 posts are subject to the recruitment embargo (the 3 county region needs 26 staff and the 13 proposed is a pilot with a plan to extend to the required numbers and also to extend to the Northwest.

There should be a tiered approach to delivery of rehabilitation services. The community neuro-rehab team will address the needs of some of the population at a particular point in their rehabilitation journey, depending on the complexity of their needs. However we need to plan for rehabilitation of all levels of complexity. GUH currently provides specialist rehab services and complex specialist rehab services as reflected by the Rehabilitation Complexity

scores of patients currently under our care. The pilot scheme will deliver a 12 week programme requiring at least 2 disciplines for patients selected based on likely benefit. It should be noted that there are currently no consultants in rehabilitation medicine in the Saolta group.

3.1 Population

The population statistics available to this review are based on 2022 census. Our recommendations are based on planning for the 2022 populations and not the projected populations. See appendix 1.

Saolta totals (2022)	2022 data	1 : 70, 000	Recommending	Pop ratio
NW totals	273,686	4	5.0	1 : 54,700
Western totals	485,966	7	9.0*	1 : 54,000
Saolta totals	**759,652**	11	14.0	1 : 54,300
Saolta current 'working population stats'	**830,000**	**12**	**14.0**	**1 : 54,300**

(9.0*clinical posts and 0.5 University of Galway)

In order to incorporate other counties that drift into the Saolta Hospital Group, we use the working figure of 830, 000. These above working figures at a 1:70k ration confirm the need for 12 consultants to support the Saolta region.

It will be important to get quantification of the current numbers and projections from population health in order to future proof Neurology services across the region. This needs to reflect the appropriate resourcing for the catchment areas, taking into consideration the demographics, new IHAs in the region and patient needs for the WNW region.

Rationale for 14.0 posts in NW and Western regions of Saolta

- GUH currently have 6.5 clinical posts and 0.5 academic post approved. This will increase by 0.5 for PUH and will bring the total GUH compliment up to 7.5 (**7.0 clinical** and 0.5 NUIG). This revised number of consultants would facilitate the development of an on-call rota for Neurology.
- MUH will need **2** new Consultants and will develop the Neurology services on the Castlebar site.
- As part of patients and services transitioning to PUH and MUH, the GUH consultants will be seeing reduced numbers on the Galway site and will be able to focus on greater specialisation on-site.
- This will bring the Western region total **to 9.0** (plus 0.5 NUIG).
- MUH will require 2 consultants as their population was at that threshold in 2022 (138K) and the MOC requires no single handed services in our hospitals. The additional 0.5 in GUH will support outreach services to Ballinasloe which improve capacity and reduce waiting lists in county Galway.

In relation to the NW, the population of Sligo, Leitrim, Donegal and West Cavan requires 4 Consultants in the NW. There are 3 consultants already in SUH and additional 2 for LUH would exceed these stats. However, it is necessary for 3 to remain in the strong SUH Neurology team as they provide services to Sligo, Leitrim, West Cavan area, as well as North Roscommon & North Mayo. The Roscommon & Mayo population stats are not factored into the calculations above. SUH is one of the 4 centres of Excellence for epilepsy, along with strong developed sub specialties for the NW area.

Based on the population in Donegal, this warrants 2 Consultants which would provide a strong on-site service. This is strongly supported by the challenges of the geographical spread in Donegal and the distance from SUH to LUH, for consultants in travelling to provide the outreach services to LUH. The area of Donegal has 4 CHNs and this would support greater integration for Neurology services for these hubs and to support GPs and their patients and families across the county. It is easier to attract 2 X consultant rather than single handed posts. Past evidence shows that single handed Neurology services is far from optimal. It should also be noted that that single neurologist sites are not in keeping with the national Clinical Programme and MOC. The provision of undifferentiated acute care to Donegal needs the presence of on-site neurologists.

The population statistics available to this review are based on 2022 census. Our recommendations are based on planning for the 2022 populations and not the projected populations.

Geographic Area Pop. (2022) Hospital(s) No. of CHNs

Geographic Area	Pop. (2022)	Hospital(s)	No. of CHNs
Donegal	159,227	M3	4
Sligo, Leitrim, South Donegal & West Cavan	114,459	M3	2
NW totals	**273,686**		
Mayo	137,970	M3	3
Galway & Roscommon	347,996	M4+M3+M2	6
Western totals	**485,966**		
Saolta totals	**759,652**		

Notes

- North Roscommon is closer to Sligo and are more likely to travel there for acute care.
- Variance in population between counties do not reflect geographical dispersion and how services are structured in urban and rural areas
- Sligo is the nearest acute Model 3 hospital for 95.8% of the population of the North Roscommon & North East Galway CHN.

The current review recommendations will probably line up to the proposed IHAs and should not disrupt current and proposed governance & operational arrangements. This is a positive for the new Health Regions being developed and implemented across Ireland under the Sláintecare programme.

4.0 Recommendations & Implementation Plan

This review team are proposing short term and Medium to longer term recommendations as part of an overall system reform approach. Some actions will be resource dependant and will take longer to get approvals and generated funding streams in place. Others can commence now, either in-tandem with some projects underway or as part of the newly constituted Neurology implementation group, with accountability and governance arrangements to carry out immediate and agreed actions.

4.1 Short-term Actions & Recommendations

No	Recommendation	Action Plan
SR1.0	GUH site issues & move to MPUH TOB to sit on Phase 1 Project moves & escalate issues of Office space and team dispersal between GUH & MPUH when clinics move to the Merlin site.	W.I.P.
SR2.0	Strengthen the ACDs and Group Specialty lead roles with adequate allocated time and Admin support	Approved. Needs to be implemented
SR3.0	Continue to prioritise and implement MCPs and additional funding streams to secure the specialist services for GUH	Ongoing
SR4.0	Continue to support and develop specific funding streams and processes to reduce waiting lists for GUH and SUH / LUH	Ongoing
SR5.0	Seek approval to proceed with the filling of the consultant posts in Galway, Letterkenny and Mayo as part of MR4.0	May / June Exec council with 3-5 years for delivery on recruitment (MR4.0)
SR6.0	Continue to escalate and proceed to fill the approved nursing roles when embargo allows this to happen.	Ongoing – Hospital DONs
SR7.0	Recruit the community neuro-rehab posts as currently approved for pilot CHW region.	Not commenced yet due to embargo. TOB is Co-Chair of Steering Group.
SR8.0	Structured Saturday work should be commenced when POCC contract holders are at an appropriate number.	Not commenced yet.
SR9.0	Continue working with Saolta Scheduled Care Group to implement the Neurology Waiting List Action Plan for 2024	Ongoing – Hospital Managers & Medicine CD. See section 8.0
SR10.0	Neurology will review the current integrated clinical governance structures and arrangements, and align with the Medicine MCAN model.	Ongoing with CD and site ACDs
SR11.0	It is important to monitor the high DNA rates at both new and review clinics and learnings need to be applied across the specialties.	Ongoing – Hospital Managers & specialty
SR12.0	Funding streams now come with targets and the need to collect metrics. Hospitals and specialties need to work with BIU to develop this process, going forward.	Ongoing – Hospital Managers & BIU

4.2 Medium / Long-term Recommendations

No	Recommendation	Actions & Plans
MR1.0	Seek approval of the 2 new consultant posts in LUH (include transitional arrangements for patients moving and services set up)	Need Business Case & approval from Saolta Exec to proceed. We would be seeking approval of the LUH new posts and need to consider how consultant approvals aligns with processes. Design action plan to reflect this
MR2.0	Seek approval of the 2 new consultant posts in MUH (include transitional arrangements for patients moving and services set up)	Need Business Case & approval from Saolta Exec to proceed. We would be seeking approval of the MUH new posts and need to consider how consultant approvals align with processes. Design action plan to reflect this
MR3.0	Seek approval of 0.5 additional consultant for PUH in a GUH 0.5 share to provide neurology support from Galway consultants to PUH and incorporate support for Roscommon. GUH will provide 0.5 from existing compliment.	Need Business Case & approval from Saolta Exec to proceed. We would be seeking approval of the additional GUH PUH shared post and need to consider how consultant approvals aligns with processes. Design action plan to reflect this
MR4.0	Seek approval and recruit the NCHD compliment for the additional consultants.	Need Business Case & approval from Exec. Build into Plan of Action
MR5.0	Seek approval and recruit the Nursing resources required for the additional consultant post.	Need Business Case & approval from Exec. Build into Plan of Action
MR6.0	Seek approval and recruit the Administrative support compliment for the additional consultants.	Need Business Case & approval from Exec. Build into Plan of Action
MR7.0	In nursing, the overall plan for improvement will need to recognise and manage the different skillsets and roles of CNSs and ANPs in the best use of these specialised resources.	Needs further scoping with DONs for sites.
MR8.0	Nursing to review & match caseloads of specialists in line with available resources	Needs further scoping with LQ and DONs/ADONs and existing Neuro Nursing workforce

No	Recommendation	Actions & Plans
MR9.0	There needs to be clearer and additional designated HSCP supports as needed for MDTs and improved clinical decision-making. There should be dedicated HSCP support integrated into the neurology teams and a business plan will need to be prepared.	HSCPs need to be included as key stakeholders in defining these requirements and developing the action plan
MR 10.0	Appropriate radiology resources including MRI, CT, PET CT, Radiographers and Radiology Consultants with special interest in neuroradiology and MDM support will be needed and the implementation group will need to engage with the Radiology MCAN.	Needs further scoping with Radiology MCAN
MR11.0	Modernise administrative support processes to include digital technologies	Needs further scoping with project team
MR12.0	Implement rehabilitation medicine report (being drafted) which will include community and hospital rehabilitation for the whole region.	Needs further scoping with VJ and I.T. departments. Need to ensure that key stakeholders are included in scoping exercise.
MR13.0	Expedite the electronic health records to support optimal record management.	Needs consultation with VJ and I.T. departments
MR14.1	The Implementation Working Group will conduct an audit of existing spaces for OPD clinics and review against current needs for GUH/Merlin Park, SUH and LUH. Needs to include all options	Needs further scoping with Hospital managers and working group / project team
MR14.2	In Line with M14.1 above, there needs to be Neurology or MCAN representation on the project team overseeing the move of OPD clinics from UHG to Merlin Park, to recognize current and planned footfall for resources and Office arrangements.	W.I.P. ongoing representation on GUH project team
MR15.0	An Education and training plan and research objectives need to be scoped with the Academic office, CAO and Medical School.	Needs further scoping with Prof Anto O'Regan and Medical School. See Academic section for further details

4.3 Implementation Plan

(As updated by addendums 1 & 2 on pages 3 to 6)

The recommendations are broken into short term and the Medium / longer term actions. Some of the short term recommendations and actions can commence now and it is important to identify those actions that *we can do now within current resources.*

Some of the longer term recommendations will need significant resourcing over the next 3 – 5 years and a programmatic approach should be implemented to deliver the whole system of reform needed for the Neurology Services and Model of Care being delivered across the Saolta Hospitals.

While the Saolta Strategy 2018 – 2023 was a first step in identifying and drafting the strategic priorities and challenges for the Neurology Clinic Services, some of these challenges remain the same.

The review team recommend that the Recommendations are used to design a programmatic approach to Neurology services reform across Saolta and Area F, led by Saolta leadership with a clear stakeholder implementation group.

The National Clinical Programme for Neurology have met with Medicine MCAN and have provided comments and feedback in support of the review recommendations and will provide guidance and support, where possible.

There needs to be a Strategic / programmatic approach and plan to support. The Medicine MCAN will help with developing the high level indicative plan, based on the outcomes of Executive Council decisions and will make recommendations on scoping and deliverables for this strategic plan. There needs to be clear Project governance with key stakeholder input into the scoping of the implementation plan and consideration needs to be given to membership of the Implementation group. The Neurology needs to be adopted as a key strategic priority for Saolta and the Medicine MCAN.

High level principles of the design plan will include:

- Project needs to be aligned to the National model of Care and supported by the allocation of the necessary resources
- Will need to have all key stakeholder inputs, including National, Voluntary and User Groups.
- Agreed process for funding applications and resourcing
- Impact assessments need to be done on
    - new services and the impact on their sites
    - Existing services and the collaboration needed with developing sites.
- Plan needs to cater for phases of implementation, to include
    - Strengthening current services
    - Transition arrangements for MUH & LUH.
    - Repatriating patients & services to new sites
    - Due diligence and handover to Hospitals
    - Organisational changes in the community and Area F.

- Each category of staff will need to be scoped-out with key groups and every effort needs to be made to make posts and services attractive to would-be employees.
- Plan should be formal and accepted by organisation, with clear accountability, governance ad performance reporting.

As part of the Implementation process, the Implementation Group need to complete an Impact assessment of the existing and new sites. This will help to identify issues and challenges associated with implementation and will give greater clarity for planning and costings.

Benefits should be identified at this stage.
Examples for MUH new service would include:

- Greater Access for Mayo patients for:
    - inpatients, OPD and specialist consults
    - improved long term management of the chronic conditions
    - reduced waiting times
    - closer to home
- GUH consultants can get a better specialist Versus generalist mix

After the impact assessment has been completed, the IG can measure this impact using the following suggested tool:

Ease of implementation (subjective) - high **Moderate**			Mild	17.0 to 25.0
	Rate / 5		Moderate	8.5 to 16.5
Proximity	2.0	5	Significant	2.5 to 8.0
Recruitment ability	2.0	5		
Funding process / applications	2.5	5		
GUH readiness	3.5	5		
PUH readiness	2.5	5		
	12.5	**25.0**		

The suggested framework for measuring implementation is presented on the next page. Each template needs to be populated by the working group as part of planning and has been populated using MUH as an example -

- MUH example will need 2 additional consultants and team.
- This will be a Medium / Long term action and may require phasing and/or transitional arrangements with GUH
- currently all Mayo and catchment area patients are referred to GUH for OPD/Waiting Lists
- All consults / queries are dealt via the phone support system of 1 X Registrar in GUH – fragmented currently and impact of MUH having own service.

The model 3 hospitals providing the broad range of undifferentiated emergency care need access to on site neurology.

Sample Impact Assessment Framework Form

MUH additional new 2.0 consultant & team							
			MUH		**Costs**	**Recc Ref**	**Comments**
Resources							
Consultant	Consultant		2.0				MUH to take over catchment area patients from GUH.
NCHD			3.0				Assume additional 0.5 SHO / 0.5 Intern
Nursing	ANPs		3.0		€248,821.02		Need to agree appropriate number / specialty / category os Nursing staff
HSCPs							Need to agree supports needed and revsed impact on existing
Admin	Grade 4		1.5				
Infrastructure							
Clinic spaces							Need to discuss with GMs
Admin support*					€80,297.57		included above
Diagnostics							
MRI							Need to assess impact on additional Radiology on sites
Specialist							Need to assess impact on additional Radiology on sites
Laboratory							Should be little impact / additionality
Metrics							
New OP activity		200					Need to assess repatriation and new Mayo patients numbers
Review +/ repatriated patients from GUH							Need to assess repatriation and new Mayo patients numbers
Nursing to take 10-20% physician review							Nursing to demonstrate Physician reviews for 2 new consultants

Part B

5.0 Neurology Services in Saolta & Model of Care

5.1 The Vision

To provide state of the art Specialist Neurology Services across the Saolta HG integrated with education, training and research which meets the needs of the regional population and which are provided by skilled, caring staff. The services provided should be based on best practice and aligned to the National Model of Care and associated strategies.

Specific to Saolta is the need for the Model 4 Neurology services to strengthen the access to consult and specialist services to the Model 3 & Model 2 hospitals in the region. Equally in the NW, the two Model 3 hospitals need to have neurology services on-site which meets the needs of their catchment areas and which will provide the associated emergency care consults.

It is important to note that approx. 98% of Neurology services are assessed and treated within the region. Spinal surgery is carried out on the GUH site but spinal cord monitoring is available and the related diagnostic monitoring is outsourced to an external Vendor.. Neurosurgery support is provided by Beaumont Hospital.

Underpinning this is the need to provide Neurology services across the region which

- Develop a service which places the needs of patients as the paramount consideration
- Supports staff satisfaction, career development needs and wellbeing
- Meets the unique needs of the catchment area
- Develops the neurology specialisms that are impacting people in the region
- Based on the National Model of Care
- Closely integrated multispecialty model of care with expanded roles for nurses and dedicated HSCPs in systems of excellent clinical governance
- Has clear governance and accountability structures
- Improves access for patients
- Aligns to Sláintecare principles of 'Right care in the right place at the right time'
- Need to focus on patients care / waiting in our Hospitals and waiting on our lists.
- The development of Neuro rehabilitation for the West and North West Region, in conjunction with the National Rehabilitation Programme

The Neurology Programme strongly recommends that all neurology services have access to a dedicated MDT, with competencies & experience in neurological conditions, to support and enhance their outpatient activity."

- Each Neurologist should be supported by a full multidisciplinary team at inpatient and outpatient level"
- "The needs of patients with neurological conditions can be varied and extensive, with many requiring a high intensity of therapeutic input, both in terms of range of HSCP

interventions, and number of treating therapists. This level of dependency needs to be acknowledged and provided for with respect to HSCP intervention”

Services delivered across Saolta

GUH as the model 4 Hospital provides a regional service to Galway, Mayo & Roscommon. While there is a nominal consultant commitment to MUH, there is no Consultant presence on either MUH or PUH Hospital sites.

GUH provides an ANP/CNS & Medical contact team for phone queries from RUH.
In addition, there is a dedicated Registrar rota (rotating Specialist registrar & General Registrar) for OPD queries in RUH, PUH & MUH. This outreach service will be strengthened in PUH by providing a 0.5 Consultant presence on site.

The Regional Memory Service is being developed in GUH in collaboration with the Community and this will provide an integrated service across the catchment area.

In the North West of the Group, SUH consultants deliver these services to LUH in a Hub & Spoke model in the agreed commitment. The current 3 consultants travel to LUH and conduct clinics in the OPD setting. They also provide telephone consults to the Medical Consultants in LUH and there is good access to colleagues across both sites.

The 2 clinical leads for MASS in Sligo work with the ECC programme and with Neurology input from Consultant Neurologist and Neuroradiology. There is funding for 0.2 Neurologist and currently 0.1 is being provided and works well. Since 2017 a complex case cognitive MDM meeting with Geriatric Med Neurology and Psychiatry of Old Age occurs to review difficult to diagnose cases including radiology review.

Services are currently delivered across Saolta by GUH and SUH and in the following settings:

A. Outpatients clinics / OPD
B. Inpatients
C. Diagnostics
D. Tele-healthcare / tele-consults predominately Nurses Used by patients / GPs & PHNs. To formalise & resources this intensive

Women with Epilepsy in Pregnancy

Women with Epilepsy have particular issues in relation to cyclical impact on seizures, contraceptive choices, medication options and foetal development, pregnancy complications and adverse menopausal impact; such that Women with Epilepsy should receive care from informed health professionals who can minimise the risks faced by these women and their children.

Epilepsy is one of the most common neurological disorders in pregnancy with a prevalence of 0.3-0.7%. Although most women with epilepsy (WWE) have straightforward pregnancies and healthy babies, *there is an increased risk of complications*.

In the UK and Ireland twice as many women with epilepsy (twenty- two), died due to sudden unexpected death in epilepsy (SUDEP) during or up to a year after the end of the pregnancy in the MBRRACE report from 2016- 2018 compared to 13 women between 2013-2015.These cases may be partly due to anti-seizure medication (ASM) adherence and dose optimisation.

The recognised standard of care is that women with epilepsy in pregnancy should be managed in a *joint obstetric/neurology setting, by a named neurologist/epilepsy specialist nurse, community midwife and consultant obstetrician*. This approach will ensure that Women with Epilepsy would achieve optimal seizure control and support prior to pregnancy and during the antenatal period, labour and birth, and postnatal period.

In the region currently the model of care is being broadly achieved in Sligo and UHG with women having access to the combined care of neurology, including specialist Nursing and Maternity services. *There is no service provision in LUH, MUH and PUH for women with epilepsy in pregnancy. Further collaboration between W&C MCAN and the Neurology service is required to develop appropriate pathways for women with epilepsy in pregnancy.*

5.2 Governance

In SUH there is no designated Neurology specialty coordinator.
In GUH the Neurology specialty operates its' own governance and has the site and group specialty leads on the GUH site.
Since the rollout of the Medicine MCAN in 2023, there is a more focussed approach on specialties operating an integrated clinical governance approach across the Medicine specialties in the Hospitals reporting into the site ACDs and upwards across the Saolta network, reporting into the MCAN Director. This extends to developing community integration as we move into the new Health Regions in 2024.

Neurology teams need to review and develop integrated clinical governance structures and arrangements,

- aligned with the Medicine MCAN model which provides
  - Clinical leadership and Improved clinical integrated governance across region
  - Strengthening the roles of site ACDs and Group Specialty Leads
  - Dedicated DON to strengthen and develop nursing in Neurology in collaboration with Hospital DONs and specialty ADONS.
  - Dedicated General Manager to strengthen the network with Hospitals and build business capacity for Medicine specialties.
- Working with the National Clinical Programme & strategies
- Conduit for Business Case development, Additional funding mechanisms and voluntary groups
- Patient engagement and communication processes

5.3 Diagnostics

- EEG - Brain
- EMG – Nerves & Muscles

This was a fragmented service until recently with the permanent appointment in December 2023. While this is very good news we need to ensure that this service is sustainable and supported into the future and will need further resource requirements reviewed.

Clinical Neurophysiology at GUH 2024

1. Clinical Neurophysiology is a branch of Clinical Neurology Medicine. Thus, whether investigations are carried out by or under the supervision of Consultant Clinical Neurophysiologists (CCN) or by suitably qualified Clinical Physiologists (Neurophysiology) (CP), the same duty of patient care applies.
2. Clinical Neurophysiological procedures and reports should only be carried out by medical and physiological staff who have undertaken the necessary training and having received due recognition as competent by their relevant professional body following competence-based assessments.
3. Neurophysiological assessments should always be carried out in safe circumstances, and therefore where possible the presence of staff within the department where tests are carried out is desirable both for medical emergencies and for supervision.

4. EEG is an invaluable resource for neuro-diagnostics for organic and functional neurological disorders in adult and as an aid in clinical neuro-prognostication in critical care unit (ICU) and Paediatric patients

The Neurophysiological Investigation is only part of the process that begins with a referral. Referrals to Clinical Neurophysiology Dept for EEG's for both inpatient and Outpatients come from Neurology and many other specialities both in GUH and other hospitals MUH PUH RUH.

There are only **2 WTE Clinical Physiologists (CP)** working in GUH. This has been the case for 2 decades. The department is primarily involved in clinical EEG for adults and ICU and paediatrics and NICU with an extensive workload including Neurology inpatient Epilepsy monitoring unit – VTEEG (R308 St Ann's). Due to the pressure on beds at UHG accessing this room for planned admissions for Neurology patients is an ongoing challenge. There are 2 Clinical monitoring rooms located in MRI-1 wait area used for both outpatients and inpatients.
A vacant senior post is currently on hold due to HSE embargo. Two previous applicants were offered a post following interview stage but did not take up the position.
Due to lack of staff resources further expansion is not sustainable unless additional clinical Physiologist staff are employed and a properly developed Clinical Department which need to be addressed with the imminent appointment of a Consultant Neurophysiologist (CCN).
Similar Neurophysiology Departments in 500 bed + hospitals (UK) have Chief /Head of Department with 4 Clinical Physiologists at Senior Grade and 4 at Basic Grade and 1 HCA and Administration/secretarial support staff.
A self-contained Neurophysiology department including 3 recording rooms, an administrative and reporting room and two (additional) dedicated video EEG beds which would be situated in the Neurology ward and additional clinical and support staff are needed.

Appropriate radiology resources including MRI, CT, PET CT, Radiographers and Radiology Consultants with special interest in neuroradiology and MDM support will be needed and the implementation group will need to engage with the Radiology MCAN.

Activity – GUH perform over 8,000 MRI Brains and CT Brains per year as well as over 11,000 MRI Spines per year.
Radiology support for Neuroradiology MDMs is imperative.
There is a busy Stroke service in GUH that will necessitate in house CT radiographers.
The demand for radiology services with specialist neuroradiology expertise will continue to increase with increase in aging patient population, Memory Clinic and Dementia services.

Currently there is no Radiology Consultant in Model 4 GUH with specialist interest in Neuroradiology. There was 0.2wte funding from MASS and Dementia Program but this has been held up in current embargo.
Based on the current and projected workload ***there should be three Consultant Radiologists in GUH with special interest in neuroradiology.*** While strictly not within the scope of this review a combined radiology medicine collaboration will be needed to define the

neuroradiology requirements for the group. This needs to incorporate the future requirements for new services based at MUH and LUH.
While there was no activity data received from SUH for this review, a review needs to be done for SUH and appropriate / similar recommendations will need to be made for SUH by the Radiology Lead in SUH and the Radiology Directorate.

5.4 IT Systems & Communication

Feedback from sites is that each area has their own IT infrastructure and associated challenges. The need for standardisation of IPMS has been completed and there now needs to be an expediting of electronic health records to support optimal record management.

5.5 National Clinical Programme for Neurology Model of Care

The model of care document for Neurology was led out and developed by the National Clinical Programme in collaboration with all key stakeholders. When the MOC was written, there was only one Neurologist in all of the NW of Ireland. Galway had more developed neurological services but with inadequate resources. While there have been significant resources invested in the NW and West of the region, there remains an underlying deficit and insufficient resources to deliver the services for the catchment areas, in line with the MOC and population norms.

''The focus of the Neurology Programme is to improve access for patients to both outpatient and inpatient care which will lead to earlier diagnosis, earlier treatment, improved outcome and consequent improved quality of life. This will ultimately decrease cost to the State by decreasing disability.

.. this Model of Care document can be used to rapidly improve neurological services nationally by providing dedicated space for outpatient and day ward and inpatient care; increase the number of consultants, NCHDs, nurse specialists, therapists and social care professionals; fund and resource highly effective medications and therapies so that disability and death can be decreased and support the development of academic clinical neuroscience in the country by the appointment of full professors of clinical neuroscience ''

The review team have targeted the areas of space, numbers of consultants, Nurse Specialists, HSCPs and other groups for discussion. Summarily, it finds that funding has improved the numbers since the MOC was written but there needs to be a further investment of Consultants (and MDT teams) to adequately resource the services across Saolta.

There is a much greater reliance on virtual clinics since the MOC was written, which is being optimised by the Nursing teams on-sites with increasing attendances year on year. The investment of ANPs into the GUH & SUH sites has brought significant benefits in terms of sub speciality clinics and freeing up space for Consultants to specialise in their areas and provide more consults hospital wide.

Overall investment has facilitated supported services and our ability to attract more skilled and professional staff.

''Proper support for these busy consultants is needed to avoid physician burnout which is prevalent in the speciality of neurology internationally.''

It is important to recognise the current deficits and maximise this ability to attract more consultants and specialists into our hospitals. The Medicine MCAN aims to look at burnout within its consultant workforce and implement initiatives to address this. A properly resourced workforce would go a long way to help improve morale and burnout.

The 'New:Review' patient ratios for consultants and nurse led clinics, varies across sites. Ratios can vary across sites depending on Consultant workloads, Nurse led clinic types and population requirements. It is important to capture trends and analysis of data for site ratios which will help inform planning and control for Neurology patients in the Hospital.

Interdisciplinary Services:

A framework of interdisciplinary services will need to provide the appropriate continuum of care across Community Health Organisations, acute hospitals and post-acute rehabilitation services. The service design framework will need to recognise the valuable contribution of the interdisciplinary teams at each level of service delivery. Services will be determined and needs will be informed by clear assessment, referral and service protocols. These policies and protocols will identify the assessment, treatment and care that can be provided to an individual and the clinicians/professionals who will deliver this care in the various settings outlined below. The provision of services is intended to ensure equity of access to high-quality, reliable, person-centred care, delivered as close to the home as possible.

- **Acute hospital**
- **Complex specialist rehabilitation services**
- **Post acute specialist inpatient rehabilitation services**
- **Community based specialist rehabilitation services**
- **Primary care**
- **Voluntary Organisations**

The multi-tier model of levels of complexity of need (figure 3.0) forms the basis for the provision of specialist rehabilitation services in the UK. It is a model that translates well into the Irish context.

Fig.3.0; Levels of specialism as per Model of Care for Rehabilitation Medicine

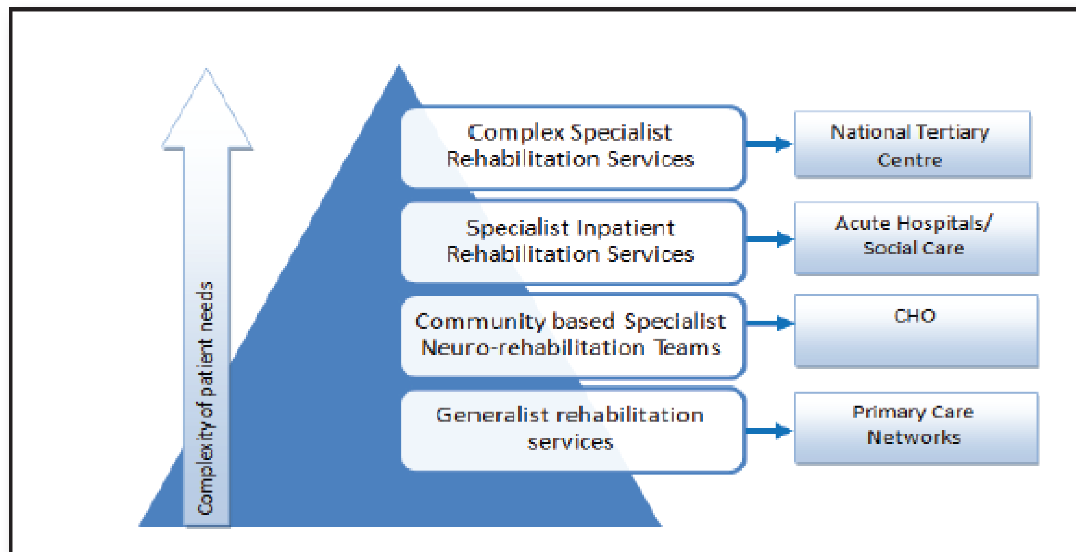


Fig.3.0; Levels of specialism as per Model of Care for Rehabilitation Medicine

6.0 Staffing & Resources

Table of Neurology approved resources in Saolta

Resources	GUH	SUH	LUH	Saolta	NUIG	TOTAL WTE	Comments
Consultants	6.0	2.35	0.65	9.0	0.5	9.5	**7 in post**
NCHD's*	7.0	5.00		12.0		12.0	
Nursing	10.5	8.00	0.00	18.5		18.5	**9.5 in post**
HSCPs							**No dedicated**
Other							
Total Saolta	**23.5**	**15.35**	**0.65**	**39.5**	**0.5**	**40.0**	

6.1 NCHDs

NCHD's *
GUH has 2 X SPRs (Specialist Registrars), 1 X Registrar, 1 X Clinical Lecturer, 2 X General Medicine SHO and 1 X Intern = 7

- SPRs are doing their training programmes on Fridays and are not available to the services 1 day per week.
- The 2 X SHOs are general medicine and are in the basic Medical training scheme.

SUH has 3 X Registrars, 1 X SHO and 1 X Intern = 5

6.2 Consultants

Table 1 Saolta Regional Summary – current & proposed

Consultants	WTE	GUH	NUIG	PUH	MUH	SUH	LUH	Funded	New
Consultants Western Region	7.0	6.5	0.5	0	0	0	0	7.0	0.0
Consultants NW Region	3.0	0	0	0	0	2.35	0.65	3.0	0.0
Totals Saolta Region	**10.0**	**6.5**	**0.5**	**0**	**0**	**2.35**	**0.65**	**10.0**	**0.0**
Proposed additionality	4.5	0.0	0.0	0.5	2.0	0.65	1.35	0.0	4.5
Revised Regional WTE's	**14.5**	**6.5**	**0.5**	**0.5**	**2.0**	**3.00**	**2.00**	**10.0**	**4.5**

Table above shows the current consultant compliments and proposals.

- Each Neurologist should be supported by a full multidisciplinary team at inpatient and outpatient level. To note, for each consultant post there should be resourced along with CNS', designated HSCP resources and Admin support as relevant.
- PUH 0.5 will be a new additional resource / post request and the GUH 0.5 share will be facilitated from within the GUH resources.

GUH Consultants

Consultants	WTE	GUH clinical	NUIG	PUH	MUH	Funded	New
Consultant 1	1.0	1.0				1.0	
Consultant 2	1.0	1.0				1.0	
Consultant 3	1.0	1.0				1.0	
Consultant 4	0.5	0.5				0.5	
Consultant 5 Professor	1.0	0.5	0.5			1.0	
Consultant 6 Waiting List	1.0	1.0				1.0	
Consultant 7	0.5	0.5				0.5	
Consultant 8 RSMC	1.0	1.0				1.0	
Current funded total	**7.0**	**6.5**	**0.5**	**0**	**0**	**7.0**	**0.0**
Review Proposal							
PUH 50:50 with GUH	*0.5*			*0.5*			*0.5*
MUH	*2.0*				*2.0*		*2.0*
Total additionality	***2.5***	***0.0***	***0.0***	***0.5***	***2.0***	***0.0***	***2.5***
Long term WTEs	**9.5**	**6.5**	**0.5**	**0.5**	**2.0**	**7.0**	**2.5**

- Currently there are 7.0 Consultants working in GUH with 6.5 commitment to the Hospital and 0.5 to NUIG - this is including the 2023 additional funding for the Dementia post (RSMC) and Waiting lists.
- They provide OPD services to the Western region on-site
- Inpatient services and patient consults are provided to GUH patients
- Some fragmented external communication is resourced by a Registrar for MUH & RUH access to consultants.
- Historically there was a 0.24 commitment to MUH but this does not happen in practice.
- 1 of the consultants will be working on the Cognitive Dementia strategy and this post will be filled from an existing panel.
- Another Physician does 1½ days per week in Botox clinic and seeing AMU patients This is included above
- Total clinical funded posts in GUH is now 7.0 WTEs including 0.5 WTE for the academic post. The 50:50 share with PUH will be facilitated within this compliment. As there are 1.5 vacant posts, it is proposed to recruit the 2WTE's to the GUH for current vacancies and to cover 0.5 to PUH
- On-call, GUH would need 7 for the rota and currently no on-call is provided within the current compliments. This can be achieved in the new proposal.
- Cover is being provided to the Acute Stroke service along with the geriatricians/stroke physicians.

SUH Consultants

Consultants	WTE	SUH	LUH		Funded	New
Consultant 1	1.0	0.78	0.22		1.0	
Consultant 2	1.0	0.81	0.19		1.0	
Consultant 3	1.0	0.76	0.24		1.0	
Current total	**3.0**	**2.35**	**0.65**		**3.0**	**0.0**
Review Proposal						
LUH additional posts	*2.0*		*2.00*		*0.0*	*2.0*
SUH reformatting	*0.0*	*0.65*	*-0.65*		*0.0*	*0.0*
Total	***2.0***	***0.65***	***1.35***		***0.0***	***2.0***
Long term WTEs	**5.0**	**3.00**	**2.00**		**3.0**	**2.0**

SUH consultants provide a **H**ub and **S**poke model of care for Sligo, Leitrim, West Cavan and Donegal catchment areas, with the hub in SUH and the spoke services being provided in LUH.

SUH provide OPD clinics, Inpatient, day case, transfusion and consult services on-site. The 3 consultants travel to LUH to provide OPD and consult services there. Arrangements for how these visits operate is changing from January 2024 onwards to 3 days per week, every 3rd week. The SUH team (Consultants & NCHDs) will travel down the evening before clinic days, stay overnight in Letterkenny and will do full day clinics.

Following site engagement with LUH Management team and Medicine consultants, it was advised that Letterkenny requires consultant presence on-site and while the support / access to the SUH consultants is very good, it does not meet the needs of the LUH Model 3 hospital which provides emergency undifferentiated medicine care in a remote area. This model is unsafe and LUH general physicians need access to a neurology service on a daily basis for both in patient and pout patient consultations. LUH needs to have the Neurology Specialty on-site, in order to meet the requirements of the ageing population and demographics associated with Donegal.

As with other Regional specialties, the visited site takes the burden of travel time, thereby reducing the amount of clinic time on-site. Travel time to regional sites is agreed in the Work plans for consultants and usually the hub site has the travel time included in the consultant committed hours. This continues to be raised by Hospitals for regional services but was not a major issue for LUH. In fact access to SUH consultants was not an issue and there is evidence of very good relations between the SUH Consultants and site based consultants.

In essence, the Hub & Spoke model is not optimal for Donegal and catchment area. Because of the population needs and as evidenced by activity levels in LUH, the site would require 2 on-site Neurologists and associated Nursing and admin resources to deliver the services in-hours

6.3 Nursing

Summary of Neurology Nursing posts

Location	Grade	WTE	In post	Specialty	Status at Dec 2023
GUH	cANP	1.0	1.0		In post
GUH	CNS Neurology	3.5	3.5		In post
GUH	cCNS Neurology Headache	2.0	1.0		1 in post for last year & other needs to be re-advertised as there was no applicants
GUH	cANP, General	1.0	0	Huntington's Disease	Advertised & paused
GUH	CNS General	1.0	0	Multiple Sclerosis	Interviewed & candidate. On pause with embargo
GUH	CNS General	1.0	0	Parkinson's Disease	Interviewed & candidate. On pause with embargo
GUH	cANP, General	1.0	0	Access to Care OPD	Interviewed & candidate & paused
GUH	**TOTAL**	**10.5**	**5.5**		
SUH	CNS	2.0	2.0	1 MS 1 General Neurology	In post
SUH	ANPs	2.0	2.0	Epilepsy	Both in post. Movement disorders
SUH	CNS General	1.0	0.0	Headache	Job advertised no applicants Re-advertised as candidate CNS –Unable to re-advertise again due to HSE embargo
SUH	CNS General	1.0	0.0	Epilepsy	Job advertised no applicants Re-advertised as candidate CNS – no applicants Unable to re-advertise again due to HSE embargo
SUH	CNS General	1.0	0.0	Parkinson's Disease	Job advertised as movement disorder CNS – no applicants. Re-advertised as Parkinson's CNS –unsuccessful recruitment campaign Unable to re-advertise due to embargo
SUH	CNS General	1.0	0.0	Multiple Sclerosis	Successfully recruited
SUH	**TOTAL**	**8.0**	**4.0**		

	GUH	SUH	LUH	Saolta	
Nursing approved	10.5	8.00	0.00	18.5	
Total Saolta filled	**5.5**	**4.0**			**9.5 in post**
% posts filled	52%	50%		51%	

SUH & GUH Nursing Notes

In SUH:

- Medical 5 has a mixed cohort of patients – general medical patients, Neurology and Nephrology patients
- The Infusion suite is specifically for Neurology patients

In GUH

- Historical compliment was 5.86 WTEs
- Increased by 5 with total WTEs of 10.86
- There are no cohorted neurology beds in GUH resulting in safari rounds. The usual number of in patients in GUH neurology is 9
- Additional funding streams like MCPs and the Regional Specialist Memory Clinic will increase the numbers of funded nursing posts in GUH – See Appendix 2

ADON GUH nursing issues:- No current cohorted ward for neurology due to the fact they have on average only 12 admitted patients under there care on any given day in the hospital
Current nursing issues as identified during the review-

- Lack of clinic space lack of admin support—nurse led clinics no org numbers specific to ANP roles
- cANP take at least 2 years to develop roles into autonomous practitioners so don’t have a direct impact on numbers straight away.
- No standardised reporting of previous or current data and day case activity under the nursing umbrella
- no integrated programme in the community setting (due to the lack of consultant clinical lead) to roll out national model of care programme for neurology

The Nursing Vision
Neurology nurses have a very significant impact on patients, increasing accessibility of healthcare and improving management of their condition. The nursing profession provides valuable supports to Consultants in the treatment and management of Neurology patients. Key to this relationship is the training, recruitment and retention of specialist nursing staff to resource these services.

The Patients Deserve Better campaign addresses Ireland's shortage of over 100 neurological nurses. There are currently 42 neurological nurses in Ireland. International recommendations state that Ireland should have 142 such nurses.
A very successful pre budget campaign led to 23 additional nurses being announced in the budget for 2024. These additional nurses will cover conditions including multiple sclerosis, Parkinson’s disease, epilepsy and rare neurological conditions; and will be assigned by the National Clinical Programme in Neurology all across Ireland in response to local needs.

When a consultant post is recommended in a service the logical next step is to support that post with two CNS’ and as time goes on an uplift can be applied for an Advance Practice Nurse. The reasoning behind this is as well as saving bed days, admission avoidance and having reduced length of stay.

Succession planning needs to be considered as part of this review.

Specialists Nursing:
ANPs and CNSs are ideally placed for chronic disease management in Neurology.
Caseloads for sub specialties differ in quantity and this needs to be matched with appropriate resources.
Candidate ANPs and CNSs take 2 years to train up. Hospitals need to take into account the time it takes to train candidates.

Table outlining roles of specialist nurses.

Clinical Nurse specialist(CNS)	Advanced Nurse Practitioner(ANP)
CNS is a career pathway incorporating professional development within a speciality area of practice. This specialised practice encompasses a major clinical focus of care to patients and their families in hospital, community and OPD settings. The CNS will work within an inter-professional team structure (NMBI)	ANP is a career pathway for registered nurses, committed to continuing professional development and clinical supervision, to practice at a higher advanced level of capability as independent, autonomous and accountable practitioners (NMBI 2017)

6.3.1 Recommendations

- Current embargo affecting nursing recruitment & retention – needs to obtain derogations for specialist nursing specialties impacting the sub specialties.
- DONs and ADONs need to review & match caseloads of specialists in line with available resources. This can be scoped out with the MCAN DON and site DONs & ADONs.
- For every new consultant recruited as part of this review, it is recommended to strategically aim for 2x CNS posts per consultant. This will take time and careful planning by the implementation group to ensure that each service area / site will have the optimal number and specialty to support their patient base.

6.4 Admin Supports

Admin supports

Feedback from all sites clearly stated the need for greater admin supports to the clinical services.

Consultant clinics are supported by appointments and Medical records staff but Nursing led clinics have not been allocated similar resources. There is an immediate and urgent requirement for Nurse led clinics to be supported by Admin, in order to free up the time spent by Specialist Nurses / ANPs on administrative processes and follow ups. There is significant activity in Nurse led clinics and this needs to be reviewed in the context of value added.

Because of the size and workload of Neurology we are recommending that some form of senior administrative support is allocated to the specialties on both sites. This could be part of a bigger Medicine MCAN Business support on each site. Initially this would be needed in GUH & SUH and would be instrumental in leading and supporting the Programme of change across the whole system of Neurology in Saolta. This support would be able to analyse and disseminate all the rich activity and waiting list data available to the specialty and which would help with awareness, profiling and planning future activities.

New technologies such as T-Pro may allow reassignment of duties to limit the requirement for extra FTE approval.

6.4.1 Recommendations

Recommendations:

- Provide support for all OPD clinic activity, nursing and consultant led.
- Review overall supports to the MDT in line with reporting and other admin processes
- Allocate business support to develop governance and support Medicine ACDs on-sites

6.5 HSCPs

There are no dedicated HSCPs allocated to Neurology in GUH or SUH. Resources are shared with other specialties, resulting in:

- Shared arrangements for Speech Therapists, Physiotherapists and Occupational Therapists.
- No Dietician or Sessional Social Worker allocated to Neurology Services.
- Precarious and insecure allocations which can be dependent on staff resources from other services areas. It is essential that resourcing is provided to secure the appropriate clinical expertise to support the increasing number and complexity of neurology patients.

The Neurology Programme strongly recommends that all neurology services have access to a dedicated MDT, with competencies & experience in neurological conditions, to support and enhance their outpatient activity

HSCPS and the Neurology Service:
The needs of patients with neurological conditions can be complex, with many requiring a high intensity of therapy input, both in terms of the range of HSCP needed, and the number of treating therapists. This level of dependency needs to be acknowledged in staffing and workforce planning for HSCPs. All neurologists require the support of a multidisciplinary team and specialist nursing (Model of Care, 2016). The Neurology Programme recognises the need for full multidisciplinary intervention for patients, both at an acute hospital level, and for rehabilitation of cognitive, physical and emotional symptoms of neurological conditions.

Occupational Therapy for Out-Patient neurology services:
The Neurology Programme Model of Care (2106) strongly recommends that all neurology services have access to a dedicated MDT including Occupational Therapy, with competencies & experience in neurological conditions, to support and enhance their outpatient activity.

A major gap is in patients in the early stages of disability or with minimum disability being able to access HSCP services. Investment of resources attached to Neurology OPD for this patient group may avoid unnecessary 'crisis' interventions at a later stage or reduce need for admissions for assessment and intervention/ rehabilitation. It may also support the patient to maintain independence and stay in employment (Model of Care, 2016). In the NAI 2019 report 'Living with a Neurological Condition in Ireland', only 11% had access to an Occupational Therapist.

10 OTs are necessary per million of the population for community specialty neurology services for those living with neurological conditions. Galway County alone would require 2.75 WTE and the whole Saolta region would require 8.3 WTE in total. A skill mix of Clinical Specialists, seniors and Staff Grades would be required. Advanced Practice posts should also be planned for with therapy led clinics in areas like spasticity management an option. The pilot Community Neuro-rehabilitation programme will provide some OT support for Galway/Mayo/Roscommon.
Access to space is an issue on all sites.

The Model of Care (2016) suggests that “the current prioritisation system in community services does not support the needs of many patients with neurological conditions. HSCP interventions through PCCC teams are often short term with minimal opportunity for follow-up. It is also recognised that therapists in the community may not have specific specialist expertise or experience in managing the complex needs of patients with neurological conditions. Appropriate measures need to be implemented to support HSCP’s and ensure that all HSCPs are adequately resourced and supported in terms of upskilling, opportunities for continuing professional development (CPD) and for professional clinical supervision”.

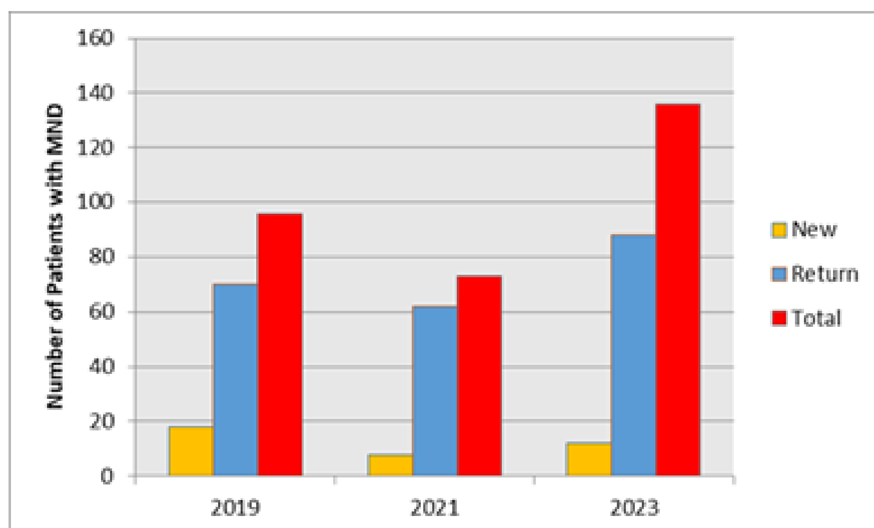
Occupational Therapy for In-Patient neurology services:
In-patient beds are often required to coordinate multidisciplinary care for patients with complex neurological conditions as it remains difficult to both source and secure this level of specialist MDT support in a community setting in the absence of dedicated supports for patients with neurological disorders.

The current OT staffing levels for inpatients do not allow for a comprehensive rehabilitation services to be offered on our Hospital sites A ratio of 4 OTs: 20 beds is cited in the Model of Care for the complex nature of the cases presenting. The argument is made in the Model of Care document that all interventions of HSCP’s, including OT within Neurology are rehabilitative in nature.

Required: Each Hospital should have 1 dedicated Clinical Specialist OT and 1 Staff Grade OT for neurology in-patients, where Consultant led services are being delivered. This includes existing GUH and SUH sites and needs to plan for new sites at LUH and MUH

Physiotherapy for Neurology services:
The physiotherapy service are currently being provided on sites without a dedicated neurology post, resulting in:

- Inpatient neurology patients are under the care of medical rehab physiotherapy team from their admission (shared resources with all other medical specialties requiring inpatient rehabilitation).
- As part of an ANP led MND clinic, physiotherapy regularly attend MND clinic twice per month. As a result, staff grade physiotherapists within the medical rehabilitation service are unsupported for inpatients during these time-points.
- No capacity to attend any other OPD activity including MS clinics, Parkinson’s clinics etc.



Speech and Language Therapy in Neurology Services:

- Some sites have dedicated SLT resources for Neurology.
- SLTs provide a key role in MDT management of MND patients at MND OPD Clinic - especially in Team decision regarding oral feeding / Enteral Feeding options & timing of same to ensure safe routs for nutrition / hydration & medication in neurologically-impaired patients with deteriorating swallow function
- Close liaison with Community SLT, especially in relation to the need for voce banking in patients with deteriorating speech & voice
- Key role in Assessment for & provision of alternative communication options / assistive technology for patients with progressive neurogenic communication disorders
- Given the expansion of the Neurology Service since 2003, and anticipated future expansion, recommends additional SLTs within a structure of specialist & advanced Practice roles, appropriate to the site.

Medical Social Workers:

There is no ring fenced funding for a dedicated neurology MSW. This impacts on the ability to provide a sufficient service to outpatient cohorts, particularly those with chronic needs as a result of their diagnosis – see below, benefits of having such a resource to the service.

Neurological disorders are the leading cause of disability and the second leading cause of death worldwide. Global burden of disease data over the past 20 years shows a large and growing burden of death and disability caused by neurological diagnoses. Neurological disorders contribute significantly to a global disability, often leading to severe physical, cognitive and psychosocial limitations. Neurological disorders constitute 6.3% of the global burden.

A significant number of neurology patients belong to middle age (35–45 years), lower and middle socioeconomic status, and urban domicile. Fear, anxiety, sadness, shock, and pre-occupation about the future is a common reaction of a person diagnosed with a neurology condition and their family.

Living with a neurological condition affects the person and the wider family. Access to a dedicated neurology social worker can provide support and referral on to other organisations for all family members. The neurology social worker can provide advice and support on diverse personal, emotional and practical issues, including:

- Psychosocial counselling and support
- Signposting to relevant agencies for specific information / advice
- Care at home
- Family support
- Welfare benefits and finances
- Housing related matters
- Grant applications
- Carer support and linking with specialist agencies
- Hospital discharge planning
- Continuing Healthcare applications

Living with a neurological condition can present ongoing challenges and problems as conditions change and progress. It is imperative that access to a dedicated social worker is provided within neurology multidisciplinary teams on each site.

During a number of RCPI SpR visits, it was identified that there was no Social Worker assigned to Neurology. In relation to a regional service these should be at least a Senior and Basic Grade as this is a complex service with patient have complex often life changing needs that require support and counselling and this grade for this service is equally important as other AHPs.

Recommendations:

The overall plan for HSCP resourcing needs to start with 'dedicated resourcing' on the GUH and SUH sites, in the short term. As part of overall HSCP resource planning, the implementation team will need to engage with all sites (existing and planned), in order to assess and incorporate reasonable resource requirements for existing and new sites, based on patient / population needs and aligned to the Model of Care for Neurology. This will be a significant task and will need to be transitioned in line with new sites being developed.

Ratio of HSCP for In-patient Specialist Rehabilitation Service for every 20 beds	
Physiotherapy	4 WTE
Occupational Therapy	4 WTE
Speech & Language Therapy	1.5-2.5 WTE (depending on whether patients with tracheostomy are accepted)
Clinical Psychologist	1.5-2 WTE
Social Worker	1-1.5 WTE
Dietitian	0.5-0.75 WTE. (These ratios are for medically stable patients for more acute care, dietitian staffing should be more reflective of the AFRM 2011 standards 1.0 WTE per 10 patients)

7.0 Activity & Data From 2023

7.1 Outpatient OPD Clinics

7.1.1 Analysis of GUH Clinics

GUH OUT PATIENT ATTENDANCES 2023

Type	New	Review	Total	DNAs new	DNAs review	DNAs Total	CNAs	Total scheduled
Consultant	2051	3958	6009	326	451	777	274	7060
Nursing	106	202	308	20	4	24	37	369
Total 2023	**2157**	**4160**	**6317**	**346**	**455**	**801**	**311**	**7429**
% of non-attendance / DNAs				**14.00%**	**10.00%**			
New : Review clinics ratios		**1 : 1.78**						

GUH OUT PATIENT ATTENDANCES 2022

Type	New	Review	Total	DNAs new	DNAs review	DNAs Total	CNAs	Total scheduled
Consultant	2174	4036	6210	471	408	879	421	7510
Nursing	99	37	136	13	2	15	24	175
Total 2022	**2273**	**4073**	**6346**	**484**	**410**	**894**	**445**	**7685**
% of non-attendance / DNAs				**18.0%**	**9.0%**			
New : Review clinics ratios		**1 : 1.60**						

Notes:

1. Total number of attendances n 2023 is almost the same as 2022. Clinic attendances remain fairly constant at 6.3k attendances per annum, albeit with a reduction in the ratio of new to review clinics. This could be due to extra Waiting list initiatives performed in 2023.
2. A closer scrutiny of the 2023 data shows the consultant led clinics range varies with the clinic types e.g. one consultant runs Botox clinics for review patients only and another does all new from the AMU.
   The average ratio of 'new : review' for consultants is 1:5.5.
3. The ratio of new to review patients for Nursing is running at 1:1.3 compared with 1:0.37 in 2022 where the number of new patients exceeded reviews. Again, this could have been decided by the specialty or happened as a result of the sub-specialties becoming resourced by ANPs.
4. The number of DNAs for 2023 has been 93 patients which is mostly reflected in the new patient cohort. There was a 4% reduction of new patients DNAs in 2023. Again, this could have been impacted by additional W/L sessions or additional resources developing the sub-specialities.
5. The Nurse led clinics in GUH are understated and this needs clarification.
6. DNA (Did not attends) are reviewed by consultant at end of clinic for decision re outcome /follow up. It is important to monitor the high DNA rates.
7. CNA means the number of patients that cancelled appointments. Patients would normally be rescheduled with another appointment but this would be at the discretion of each consultant.

7.1.2 Analysis of SUH Clinics

SUH OUT PATIENT ATTENDANCES 2023

Type	New	Review	Total	DNAs new	DNAs review	DNAs Total	CNAs	Total scheduled
Consultant	367	2308	2675	80	500	580	272	3527
Nursing	60	3255	3315	2	738	740	8	2583
Total 2023	**427**	**5563**	**5990**	**82**	**1238**	**1320**	**289**	**7599**
% of non-attendance				16.11%	18.20%	18.06%	**3.80%**	
New : Review clinics	1	13						

SUH OUT PATIENT ATTENDANCES 2022

Type	New	Review	Total	DNAs new	DNAs review	DNAs Total	CNAs	Total scheduled
Consultant	532	1931	2463	173	241	414	180	3057
Nursing	31	3502	3533	2	716	718	143	4394
Total 2022	**563**	**5433**	**5996**	**175**	**957**	**1132**	**323**	**7451**
% of non-attendance				**2.35%**	**12.84%**	**15.88%**	**4.33%**	
New : Review clinics	1	9.7						

Notes:

1. Total number of attendances n 2023 is almost the same as 2022. Clinic attendances remain fairly constant at 5.9k attendances per annum, with a slight change in the ratio of new to review clinics.
2. The ratio of new to review patients being called to OPD clinics in 2023 has dramatically changed in ratio – see below.
3. The level of DNAs for the OPD clinics has increased by 2.18% in 2023, from 15.9% in 2022 to 18.06% in 2023.
4. The Nurse led chronic patients have very few DNA's & CNAs.
5. DNA (Did not attends) are reviewed by consultant at end of clinic for decision re outcome /follow up. It is important to monitor the high DNA rates.
6. CNA means the number of patients that cancelled appointments. Patients would normally be rescheduled with another appointment but this would be at the discretion of each consultant.

Nursing & Consultant New:Review Ratios

Clinic type	2023	2022	Comments
Consultants	1 : 6.3	1 : 3.6	1 clinic had a 1:40 in 2023 compared to 1:7 in 2022, arising from a change in scheduling of urgent review patients.
Nurse Led	1 : 54.3	1 : 113	These are for chronic patients but note 2023 had more new.
Total	1 : 13	1 : 9.7	

7.1.3 Analysis of LUH Clinics

LUH OUT PATIENT ATTENDANCES 2023

Type	New	Review	Total	DNAs new	DNAs review	DNAs Total	CNA new	CNA review	Total scheduled
Consultant	204	548	**752**	22	66	**88**	33	136	1009
Nursing									
Total 2023	**204**	**548**	**752**	**22**	**66**	**88**	**33**	**136**	**1009**
% of non-attendance				**9.7%**	**10.7%**				
New : Review clinics	**1**	**2.9**							

LUH OUT PATIENT ATTENDANCES 2022

Type	New	Review	Total	DNAs new	DNAs review	DNAs Total	CNA new	CNA review	Total scheduled
Consultant	143	561	**704**	17	78	**95**	36	172	1007
Nursing									
Total 2023	143	561	**704**	17	78	**95**	36	172	1007
% of non-attendance				**10.6%**	**12.2%**				
New : Review clinics	**1**	**4.14**							

Notes:

- Improved performance in 2023 compared to 2022
- Lower levels of DNAs in 2023
- New : review patients reduced in 2023
- All LUH nurse led clinics are done virtually by SUH.
- Changes in frequency of Consultant led Clinics should show greater performance in 2024.

7.1.4 Space & Infrastructure

Space & Infrastructure – OPD clinics

The current demand for OPD clinic spaces is not being met on any site. This is mainly due to insufficient capacity within the hospitals arising from increased demand and poor infrastructure which was never created with a plan to meet the growing demands of service delivery.

Any surplus clinic spaces arising from clinics being held in community (under the ECC programme) could be identified and reallocated to priority areas like Neurology.

This has been identified as the 2nd biggest issue affecting the services as articulated during this process and it is recommended that an immediate review of clinic spaces in the 3 Hospitals where Clinics are currently being conducted is undertaken. A core part of good governance in the integrated networks and integrated services is to recognise the integrity of the sites, ensuring that these reviews and plans need to be done in partnership with Hospital Managers.

The review needs to start immediately as the lack of capacity is having a significant negative impact on clinics and patients on waiting lists.

In the NW services are delivered via the Hub & Spoke model with agreed clinic days in SUH & LUH. Like all hospitals, SUH are experiencing challenges on their site to accommodate the current compliment of staff. Similarly, the SUH visiting team are also having difficulties in getting adequate clinic spaces in LUH. Because of the complexities and chronic conditions of Neurological patients, there is an increased demand from Donegal patients to be seen on-site and virtually during the SUH clinic slots and this is impacting numbers that can be seen locally.

Going forward, it is important to factor in the additional requirement for space and slots on both site as SUH return to full time staff on-site and as LUH develop and grow their teams.

It is noted that GUH Neurology OPD clinics are moving to the Merlin Park site. Currently there is a project team in place overseeing these moves to the Merlin site. The requirements of the Neurology OPD services need to be aligned and reflected in this project deliverables for the current compliment of staff and needs to phase in additionality for the increase workload when the additional teams have been recruited.

HSCPS will lose one of their 2 dedicated neurology OPD rooms in the move to the Merlin Park site.

New OPD services will be developed in PUH & MUH as the recommended consultants come into post. Therefore, it is important to identify and plan for these needs in the medium term. PUH and MUH will have to provide space for these new services. Agreement will have to be reached with the GUH consultants, Specialty lead, ACDs and Hospital Managers on the number of clinics, consults and inpatients activities and this needs to be incorporated into

the work plan. The current GUH support in place for external hospitals can be reviewed and amended in this context, 'as and when' services are developed on the other two sites.

Core to seeing Neurology out-patients is the demand for

- Appropriate facilities and number of clinic spaces for consultants, for face-to-face sessions
- Facilities for virtual clinics
- Appropriately staffed
- Clerical support, to include appointments, Medical records and follow up.
- Access to I.T. and clinical systems

7.1.5 Recommendations

- As part of the implantation plan, the Implementation Group need to conduct a review and Plan of Action (POA) of existing clinic spaces in GUH/Merlin Park, SUH and LUH.
    - Planning needs to commence with the management in MUH & PUH for clinic space on their sites for additional neurology services.
    - The scope of the review and plan needs to cover the following:
    - Numbers of clinics to meet current demand and surplus required to clear Waiting Lists
    - Mix of Consultant and nurse led clinics needs to be reviewed by the clinicians based on Best Practice & MOC
    - admin support for Clinics, to include support for nurse led clinics
    - Identify any other S/T and M/T deliverables

- It is important to monitor the high DNA rates at both new and review clinics and learnings need to be applied across the special

7.2 Inpatients

7.2.1 Analysis of GUH

GUH Dedicated beds (10 – 12) in GUH

GUH IN-PATIENT ATTENDANCES 2023 & 2022

Years	Type	Day cases	Inpatient - planned	Total Patients		Total Admissions	Total Discharges	ALOS
2023	Consultants	1,166	223	1,389		1,387	1,383	13.04
2022	Consultants	1,005	193	1,198		1,196	1,196	11.57

Breakdown of planned Inpatients

Years	Elective –W/L	Elective – planned	Emergency	Total Patients
2023	23	158	42	223
2022	20	141	32	193

7.2.1 Analysis of SUH

SUH IN-PATIENT ATTENDANCES 2023 & 2022

Years	Type	Day cases	Inpatient - planned	Total discharged				ALOS	
2023	**Consultants**	1453	183	1636				15.37*	
2022	**Consultants**	1253	203	1456				9.47	

SUH Dedicated beds
SUH have an agreement that the medical 5 ward is shared between Medical and Neurology. Occasionally, the Neurology consultant will advise patients at OPD clinic that they will be seen for infusions on medical 5 ward.

Notes:

1. Bulk of Admissions are Day Cases at 84%.
2. It is difficult to track infusions for Neurology patients – tracked by Medical 5 here.
3. Some MS patients come in for Lumbar Puncture and the activity needs to be recorded.
4. ALOS for 2023 =15.37* because one or two with long LOS (one patient 488 days)
   ALOS for 2022 =9.47

8.0 Waiting Lists

Scheduled care needs OPD clinics and Waiting lists to be viewed together. OPD clinics have been reviewed above and some recommendations have been made regarding (1) ratios, (2) DNAs, (3) Clinic slots, (4) additional resources, (5) profile of clinics (Consultant to Nursing), (6) changes to the model of care (as delivered in the NW) and (7) infrastructure. All positive changes to these recommendations will have a resulting impact on Waiting Lists.

Additional funding continues to be allocated for long waiters and these measures will improve waiting lists in the Medium term. As new patients are seen, there will be an ongoing need to review and manage the chronic conditions of neurological patients. As the number of overall of resources and clinics increase, this will improve capacity which will be able to meet the demand for services in the longer term. This will also facilitate better patient and staff outcomes. See page 49 with details of the 2024 W/L Action Plan for Neurology.

Snapshot - See numbers on Galway GUH Waiting list by county - New OPD services will be developed in PUH & MUH as the 2.5 consultants come into posts. See table below for numbers waiting in Mayo and county Galway, which would support the need for OPD clinics in PUH & MUH.

Patients with no appts		Patient with appts		Total W/L	% W/L
Galway (City)	550	Galway (City)	26	576	18.9%
Galway (County)	1058	Galway (County)	63	1121	36.7%
Mayo	686	Mayo	30	716	23.4%
Roscommon	253	Roscommon	11	264	8.6%
Sligo	27			27	0.9%
Leitrim	13			13	0.4%
Donegal	39	Donegal	2	41	1.3%
Cavan	1			1	0.0%
N.Ireland	1			1	0.0%
Westmeath	118	Westmeath	5	123	4.0%
Clare	56	Clare	8	64	2.1%
Offaly	27	Offaly	1	28	0.9%
Longford	24	Longford	1	25	0.8%
Exception	25	Except + Dublin 15	3	28	0.9%
Limerick	8			8	0.3%
Tipperary (North)	7			7	0.2%
Tipperary (South)	2			2	0.1%
Waterford	2			2	0.1%
Kilkenny	2			2	0.1%
Laois	2			2	0.1%
Wexford	1			1	0.0%
Carlow	1			1	0.0%
Cork	1			1	0.0%
Total	**2904**		**150**	**3054**	100.0%

Neurology and the 2024 Waiting List Action Plan

While short-term interventions have delivered improvements across waiting lists nationally, lasting and meaningful reductions in the number of people waiting for care and associated waiting times is dependent on an integrated and broader reform of the scheduled care system. The Minister for Health, along with the Access Team in Acute Operations first initiated a Waiting List Action Plan (WLAP) in 2021. This is multi-annual approach to sustainably reduce and reform hospital waiting lists and waiting times. A further annual WLAP has been developed this year and has the following high level priorities for all specialties:

1. Total Waiting List

There is a continued focus on reducing the total number of patients waiting for care, this will require a significant amount of additional activity due as additions to the waiting list are forecast to continue to increase

Neurology	OPD		
Hospital	Dec 2023 Waiting List	Apr 2024 Waiting List	YTD (%) Change
Galway University Hospital	3,102	3,111	0%
Letterkenny University Hospital	748	772	3%
Sligo University Hospital	727	830	14%
Total	4,577	4,713	3%
Neurology	IPDC		
Hospital	Dec 2023 Waiting List	Apr 2024 Waiting List	YTD (%) Change
Galway University Hospital	48	67	40%
Sligo University Hospital	27	39	44%
Total	75	106	41%

2. Reduction in patients waiting over 3 years

There is a targeted **90% reduction** in number of patients at risk of/ waiting over 3 years for access to care

Neurology	OPD (> 3 Years)		
Hospital	Dec 2023 Waiting List	Apr 2024 Waiting List	YTD (%) Change
Galway University Hospital	281	159	-43%
Letterkenny University Hospital	6	8	33%
Sligo University Hospital	28	131	368%
Total	315	298	-5%
Neurology	IPDC (> 3 Years)		
Hospital	Dec 2023 Waiting List	Apr 2024 Waiting List	YTD (%) Change
Galway University Hospital	2	2	0%
Total	2	2	0%

3. <u>% of patients meeting NSP Maximum Wait Time targets</u>

In 2024, NSP Max Wait Time Targets remain the same as 2023:

- OPD: 90% of patients waiting less than 15 months
- IPDC: 90% of patients waiting less than 9 months
- GI Scope: 95% of patients waiting less than 9 months

Neurology	*OPD (> 15 Months)*		
Hospital	*Dec 2023 Waiting List*	*Apr 2024 Waiting List*	*YTD (%) Change*
Galway University Hospital	1,058	976	-8%
Letterkenny University Hospital	290	302	4%
Sligo University Hospital	197	285	45%
Total	1,545	1,563	1%
Neurology	*IPDC (> 9 Months)*		
Hospital	*Dec 2023 Waiting List*	*Apr 2024 Waiting List*	*YTD (%) Change*
Galway University Hospital	12	13	8%
Sligo University Hospital	1	4	300%
Total	13	17	31%

West & North West Waiting list > 9/15 Months NSP Targets December closing and current state percentage change

4. <u>Reduction in volume of patients breaching Sláintecare Access Targets</u>

- There is a continued focus on reducing the volume of patients waiting more than the Sláintecare access targets:
- OPD: waiting less than 10 weeks
- IPDC: waiting less than 12 weeks

Neurology	*OPD (10 Weeks)*		
Hospital	*Dec 2023 Waiting List*	*Apr 2024 Waiting List*	*YTD (%) Change*
Galway University Hospital	2,534	2,622	3%
Letterkenny University Hospital	843	820	-3%
Sligo University Hospital	841	821	-2%
Total	4,218	4,263	1%
Neurology	*IPDC (12 Weeks)*		
Hospital	*Dec 2023 Waiting List*	*Apr 2024 Waiting List*	*YTD (%) Change*
Galway University Hospital	25	35	40%
Sligo University Hospital	41	23	-44%
Total	66	58	-12%

The Plan is focused on three key areas outlined below which RHA West North West have focused on in 2023 and which we will continue to focus and build upon in **2024.**

Delivering Capacity

The delivery of capacity is essential to ensure that the progress on waiting lists that has been achieved over recent years, through the implementation of the WLAP approach, continues in 2024. The improvements in waiting lists achieved to date are as a result of, in part, delivering capacity throughout the health system. There are 6 WLAP actions associated with delivering capacity;

1. Capacity optimisation to deliver 5% more activity in IPDC and GI scope than the full 2023 outturn as well as 8% on the OPD 2023 outturn. This is a collated increase on both core activity as well as additional insourcing activity. This will be achieved by clear and focused communication on quarterly target achievement measured against activity to ensure all sites are maximising core capacity as well as continuing additional insourcing sessions funded through the NTPF and HSE Access to Care.
2. Capacity Optimisation by expanding on insourcing pathways across all hospitals within the region. Expand upon the transfer of suitable patient cohorts (low acuity patients) from the model 4 site (GUH) out to the model 3 hospitals potentially.
3. Outsourcing usage to maximise all available capacity in the private sector for OPD full packages of care. There is no available capacity within the republic of Ireland however, Neurology has availed of available capacity in Kingsbridge Derry and Belfast. Patients are triaged to see if they are suitable to be sent to the North to receive a full package of care (Consultation, MRI, CT, EEG, EMG) and discharge post.
4. NTPF Validation cycles will continue to occur for all patients on OP and IPDC waiting lists waiting greater than 3 months. This is an already well established process within the group and will continue this year.
5. NTPF Triage and Clinical Validation has primarily happened for Endoscopy referrals and waiting lists. However there is potential to expanding this model to neurology services in order to control demand and stream patients onto the most appropriate pathway.
6. Work is progressing on creating additional OPD capacity in MPUH, PUH and MUH.
7. Increasing activity associated with consultants on the new contract.

Reforming Scheduled Care

Reform actions under WLAP 2024 will align with the newly established Productivity and Savings Taskforce, the aim of which is to ensure that the maximum amount of patient care is delivered for the funding available. There are 6 WLAP actions associated with delivering reform in which all specialties should engage:

1. Modernised Care Pathways. The overarching aim of the Neurology Programme under the Clinical Strategy and Programme Division is to;
   a) Improve safety and quality in the delivery of patient centered care
   b) Improve access to appropriate services
   c) Improve cost effectiveness of services delivered.
2. Productivity and Efficiency. The focus this year is on implementation of Patient Initiated Review across all suitable cohorts in specialties and hospital. This reform

aims to reduce review appointments scheduled across the system, to those who need it most. This will improve patient experience, maximise throughput whilst also feeding in to the Did Not Attend (DNA) strategy.

The second aspect is establish a Central Referrals approach across all specialties and hospital sites. There has been significant work already done in this space which we will build upon to achieve the target of 25% of all hospitals and specialties by end Q2, 50% by end Q3 and 100% end of Q4. We also continue to focus on chronological scheduling percentage attainment to ensure all longest waiting routine patients receive access across the board.

Enabling Scheduled Care

This 2024 WLAP is underpinned by a number of key process/policy and technology/data enablers. Full implementation of these enablers is critical to support the whole of-system reform required to improve access to scheduled care and achieve sustained waiting list reductions and maximum wait times.

1. IPMS e –referrals, SMS text messaging and correct capture of ECC activity. All specialties should engage with these enablers.
2. IIS and HPVP: Further promote and embed the use of waiting list management protocols, training and development programmes, ICT infrastructure as well as Health performance Visualisation Platform (HPVP) and IIS dashboards to provide data insights and improve operational efficiencies.
3. Mobilise Robotic Process Automation: GUH are the first site to pilot the use of RPA for batch suspensions and removals of waiting list entries. This technology has endless opportunities to support access delivery across all specialties.
4. Further expand virtual patient engagements to enable timely access to scheduled care.

9.0 In-patient Consults

Analysis of **GUH** Consults' activity

Consults	**2022**	**2023**
Requests	1,649	1,775
Responses	1,628	1,736
Cancellations	83	109
Specialties Top 5		
General Medicine / AMU	30.7%	23.8%
Geriatric Medicine	10.7%	9.0%
Gastroenterology	8.8%	9.0%
Respiratory Medicine	7.8%	8.4%
Endocrinology	6.1%	8.0%

Breakdown of total requests by MCAN for 2023

2023		
MCAN	**Total requests**	**%**
Medicine	1403	79.0%
Peri Op	197	11.1%
Cancer	110	6.2%
W&C	55	3.1%
Psychiatry	10	0.6%
	1775	100.0%

10.0 Academics – Education & Training

(Delivered by Anto O'Regan, CAO, Saolta and University of Galway)

From a training and Education perspective the following is worthy of consideration:

1. Presently there are a total of 12 NCHDs allocated to neurology of which 5 are rotating SHO NCHDs in internal medicine (2 NST trainees) and 2 interns. The national proposal from the NCHD taskforce is to reduce or eliminate standalone non training scheme NCHDs and expand training posts. The overall proposed NCHD to Consultant ratio is 1.3-1.5.
2. The Neurology Programme should work with the Chief Academic Office and educational leads to ensure the development of accredited programme which are nationally and internationally recognised as high quality.
3. The objective for regional neurology would be:
    a. Appoint a regional training lead for Neurology who will
        i. Act as the Regional representation on national specialty training scheme supported by educational training leads on each site.
        ii. Develop a strategic plan to increase SPR posts in accordance with population need and clinical expertise (target minimum 4 SpRs)
        iii. Deliver neurology training according to outcome based curriculum including clinical simulation and access to virtual and in person national meetings. A clear annual training plan should be developed by June for the next academic year.
    b. Ensure all non-training posts have appropriate support, supervision, and career guidance.
    c. Advise on the expansion of the multidisciplinary team to develop strategically in a manner that enhances doctor training and planning with a focus on multidisciplinary training.
4. Support CPD and academic advancement for multidisciplinary neurology team. Neurology has a well-established, and will continue to evolve, a multidisciplinary team approach to clinical care. The regional strategy should ensure that there is a regional inter-professional training and education focus that supports access to relevant CPD for all disciplines. There should be an education and training committee with nursing, doctor, HSCP, and neurophysiology representation with a clear terms of reference to oversee and support education and training for all disciplines across the region.

University of Galway is an important partner in regional academic affairs for neurology. There are established leaders in academic neurology in the University of Galway in both adult and paediatric disciplines. The regional programme should work with University academic leads, in conjunction with research and development structures (i.e. Chief Academic Officers), to develop neurology research and innovation across the region. A key aim will be to develop national and internationally recognised academic reputation in neurology. There is an excellent neuroscience cluster in the University and this research area is a priority for CURAM and REMEDI. The overall interaction between hospital and University needs to be strengthened and the new Professorship will be charged with this.

Part C

Appendix 1 - Project Charter & Conduct Review

Objectives & Scope

Problem

Lack of personnel to deliver services leading to extensive waiting lists and inequality of access to services across the Saolta population.

Objectives

To complete a review of the service, with comparative analysis against national model of care and previous service review, to identify key resource and/or additional requirements to develop a sustainable service for both specialties within Saolta.

Key Activities

- As part of as-is individual engagement with each site was undertaken with as-is to include Current workforce – Consultant, NCHD, ANP/CNS, HSCP; Activity & KPIs – outpatient/inpatient; Waiting list – OPD & Issues, risks identified
- Complete comparative analysis of as is against national model of care/ recommendations (population based) and previous reviews completed in 2017
- Identify and make recommendations on resource requirements for delivery of sustainable service
- Review of other options to address waiting list (access to care, care pathways, DPS etc)
- Other considerations including HSE transformation into RHAs and any associated impact on the services
- Engagement with national clinical programmes – advocate for support with resource gaps, implementation of model of care etc
- Need to include a review of the provision of emergency care for these specialties.

Key Milestones and Deliverables

- End December 2023: meetings with all sites scheduled; Preliminary consultant staffing review complete; meetings with all sites complete
- End January 2024: All activity/ waiting list/ KPI data requirements collated and analysis complete
- End June 2024: comparative analysis and review reports complete report **Needed Qtr1 2024**

Conducting the Review Meetings

The reviews were to be carried out with all key stakeholders input and each site needed to be given opportunity to provide their input.

It is noted that the input from the Clinicians has both given clarity around the Hub and Spoke model and in turn have provided some possible solutions and suggestions.

A key learning for the MCANs and group networks is the need to adequately communicate and actively engage with the Medicine specialties across the group.

Appendix 2 - Additional Funding Streams 2023

1. MCPs

Pathways, Neurology - Headache Pathway funded **€266,205.49**

Hosp	Grade		Status	WTE	Full Year OP New Activity	Full Year OP Review Activity
GUH	Clinical Nurse Specialist (General)	Nursing	Permanent	1.00	150	Reduced physician review by 20%
SUH	Clinical Nurse Specialist (General)	Nursing	Permanent	1.00	100	Reduced physician review by 20%
SUH	Psychologist, Clinical	Medical	Permanent	0.50		
SUH	Grade IV	Admin	Permanent	1.00		
				3.50		

2. National Dementia Strategy GUH

National Dementia Strategy	Regional Specialist Memory Clinic	Galway University
Staff Category	**Grade**	**Job Status**
Nursing & Midwifery	Advanced Nurse Practitioner (General)	Onboarded
Nursing & Midwifery	Advanced Nurse Practitioner (General)	Onboarded
Nursing & Midwifery	Advanced Nurse Practitioner (General)	Onboarded
Medical & Dental	Consultant Neurologist	Campaign to be assigned
Health & Social Care Professionals	Dietitian, Senior	Stopped Temporarily
Management & Administrative	Grade IV	Post approved
Health & Social Care Professionals	Occupational Therapist, Clinical Specialist	Onboarded
Health & Social Care Professionals	Psychologist, Senior Clinical	Onboarded
Medical & Dental	Registrar, Specialist	Onboarded
Health & Social Care Professionals	Social Worker, Senior Medical	Onboarded
Health & Social Care Professionals	Speech & Language Therapist, Clinical Specialist	Onboarded

3. Neuro-Disability Nursing Posts

NSP2023 – **Neuro-Disability Nursing Posts** for GUH and SUH has been approved for the provision of an additional 6 WTE's to be provided in 2023.

Location	Initiative	Grade	WTE	Specialty & Grade
SUH	Specialist Neurology Services	Clinical Nurse Specialist General	1.0	**Epilepsy** CNS General
SUH	Specialist Neurology Services	Clinical Nurse Specialist General	1.0	**Parkinson's Disease** CNS General
SUH	Specialist Neurology Services	Clinical Nurse Specialist General	1.0	**Multiple Sclerosis** CNS General
GUH	Specialist Neurology Services	Candidate Advanced Nurse Practitioner, General	1.0	**Huntington's Disease** cANP General
GUH	Specialist Neurology Services	Clinical Nurse Specialist General	1.0	**Multiple Sclerosis** CNS General
GUH	Specialist Neurology Services	Clinical Nurse Specialist General	1.0	**Parkinsons Disease** CNS General

Notes on Funding streams:
Most funding comes without the full team Pay Costs and usually No Non-pay allocations.
The lack of funding for Admin supports is always an issue.

Additional space will not have been factored in.
Hospitals usually have to allow for this additionality within limited resources and space available to them.

National Funding streams now require the collection of metrics and targets to demonstrate the value for money for funded posts. It is important that specialties and hospitals build this reporting processes into their business. The BIU at COO level can support this.

Appendix 3 Saolta Strategy 2018 – 2023 Neurology Recommendations extract for NW

Extracted from the strategy for comparative purposes.

Future Service Development Priorities (2018)

Executive Summary for North West Neurology Service – SUH & LUH					
Summary of resources for North West Neurology - SUH & LUH		**WTE**	**Total**	**2017 / 2018 status**	**2023 status**
	Consultant Neurologists	**2**	**3**	SUH immediate need for 3rd consultant	3rd in post
	CNS/cANP/ANP Epilepsy Nurse	**1**	**3**	3rd needed	Funded
	MS CNS / cANP / ANP nurse	**1**	**2**	2nd needed	Funded
	Headache CNS / cANP / ANP	**1**	**1**		Funded
	Parkinson's CNS / cANP / ANP	**1**	**1**		Funded
	Neuropsychologist for the N.W.	**1**	**1**		In place 2 X 0.5
	Consultant Neurophysiologist	**1**	**1**		
	dedicated Neurology Physiotherapist	**1.5**	**1.5**		Still an issue – have re-recommended
	dedicated Neurology Occupational Therapist	**1**	**1**		Still an issue – have re-recommended
	dedicated Neurology SALT Therapist	**1**	**1**		Still an issue – have re-recommended
	dedicated Neurology Dietician	**0.5**	**0.5**		Still an issue – have re-recommended
	Appropriate administrative support for the above proposals				Still an issue – have re-recommended
	Total	**13**			
The development of Neuro rehabilitation for the North West Region, in conjunction with the National Rehabilitation Programme. CHW has been approved but currently effected by embargo					Need to clarify

Appendix 5 – Response from National Clinical Programme for Neurology

Feedback from the National Clinical Programme Neurology on Saolta's Draft Neurology Services Review.

March 2024

On behalf of the National Clinical Programme Neurology (NCPN), we would like to thank you for sharing this draft for our review and consultation.

Service development and growth in Neurology is always welcomed and particularly the longstanding under resourced area of the West and Northwest. Even despite investment in recent years in consultant and nursing posts in GUH and SUH, both continue operating with less than optimal no. of Neurologists, nursing staff and HSCPs, which long term is not sustainable.

For the purposes of the feedback on the report, we will provide feedback in bullet points in the following section:

General Feedback:

- The Model of Care for Neurology (2016) recommends the development of neurology services within Model 3 and Model 4 hospitals.
- NCPN supports the expansion of Neurology services to include MUH and LUH. Due to geographic distances, a 'hub and spoke' type model is challenging with reference to LUH and MUH. However, to ensure these posts will be attractive to potential applicants, it would be important to ensure formal ties and linkages exist between these Neurology services and those in the larger 'Hub' sites at GUH and SUH, e.g. via a rotating departmental lead across sites, consideration of remote MDTs/CPD activity etc.
- With respect to the service development in MUH, a full complement of dedicated neurology staff should be provided to include NCHDs, administrative support, nursing and HSCPs as well as dedicated clinic space, access to telemedicine and day ward beds, with links to GUH for teaching, education, case reviews and so on. Please refer to Table 1, 2 and 3 for detail on staffing for nursing and HSCPs.
- The current model of consultants in SGH providing outreach to LUH on a weekly basis and having to stay in hotels is not sustainable, risking burnout and impacting quality of life of staff. With respect to the service expansion in LUH, a full complement of dedicated neurology staff should be provided to include NCHDs, administrative support, nursing and HSCPs as well as dedicated clinic space, access to telemedicine and day ward beds, with links to SUH for teaching, education, case reviews and so on. Please refer to Table 1, 2 and 3 for detail on staffing for nursing and HSCPs.
- The Model of Care for Neurology (2016) has been a good reference point in the development of this document. However, although still very relevant the MOC (2016) is now eight years old, and the landscape of Neurology has changed significantly over those years as well as population growth, ageing population and so on. In 2011, The Royal College of Physicians (UK) advised that the recommended ratio for Neurologist to population was 1:70,000. This figure, although still aspirational in an Irish context where the ratio is much higher, likely under-represents what is required now and into the future. The European average is now 1:10,000 while Ireland still has the lowest ratio of the WHO European countries (Bassetti et al, 2022). To plan for an ageing population, with higher complexity of disease and developments in treatments (e.g. incoming Alzheimer's disease therapies, multiple new genetic therapies for neurological disease etc) alongside population growth, we recommend aiming towards a much higher ratio.
- PUH is a Model 3 hospital that also provides a maternity service. The Model of Care recommends that each hospital with a neurology service should have a minimum of 3 Neurologists covering that service. A single 0.5 post in PUH with 0.5 in GUH is therefore not recommended as this leaves the post holder working in isolation in PUH, and no cover at all during periods of leave. Whilst the road network between CUH and PUH is good, the hospitals remain 60km apart. We therefore recommend at least

three posts be linked to Portiuncula to allow sufficient cover; these should be linked to GUH in a 'hub and spoke' type model.

- The MOC (2016) recommends a minimum of 3 Neurologists per site and no Neurologist should be working in isolation. If planning new services, such as that in MUH, LUH and PUH then that should be the documented standard to work towards.
- Off-site clinics are not unreasonable if a suitable clinic space is identified and available. This model is used successfully in other hospitals providing Neurology services around the country. However, the size of the service and the location of the off-site clinic must be considered to ensure sufficient cover for patients on the main hospital site. i.e. is the off-site clinic 5-minute walk from the acute hospital or a 30-minute drive, where parking and distance from the acute service in the case of an emergency maybe an issue etc.
- Regional recruitment imbalances historically exist in Neurology. Posts in more rural settings, outside of the primary city hubs are frequently more difficult to recruit into and retain. Ensuring new posts in areas such as MUH, PUH and LUH have formal links to a larger unit in GUH and SUH will be very important – in terms of training; CPD etc. Recruitment and retention may be improved if the service is well staffed and has dedicated clinic space and HSCP/admin resources.
- Neurophysiology is a separate speciality to Neurology and, although many clinicians are dual trained in both Neurology and Clinical Neurophysiology, the day-to-day work is very different. If a post is identified as a Clinical Neurophysiology post it should not form part of the headcount within Neurology. It is however, recommended that within any efficiently operating Neurology department, Neurology teams would have access to Clinical Neurophysiology services. It is also important with respect to the proposed OPD move from GUH to MPUH to recognise that Neurophysiology services are required on site in GUH to allow neurophysiological assessment of in-patients who cannot and should not travel off site for tests (e.g. ITU/unstable patients).
- Paediatric Neurology functions completely separately to adult Neurology services, except for an overlap as young people transition from child services to adult services. Paediatric Neurologists should not be counted as headcount in adult Neurology services, neither should adult neurologists be expected to prove a service for paediatric patients with neurological problems.
- Establishing effective links between neurology and other specialisms as required for the management of neurological conditions should be noted in the document. Formal documented referral pathways for Palliative care, Access to Managed Clinical Rehabilitation networks; Dementia care, Psychiatry, voluntary organisations, and Mental health should be considered.
- If a Neurologist post is being sought (e.g. MUH/LUH/PUH) then the necessary clinic and day ward space should be identified and NCHD, administrative support; nursing support and HSCP support provided to ensure the Neurology service runs effectively and efficiently and offers a holistic approach to patient care.
- There is no documented recommended New:Return ratio specific to Neurology as may be the case with other medical specialities. Variances can exist, based on the complexity of patients presenting, the nature of chronic disease management and given the nature of some of the treatment and medication patients will be on.
- For GUH, a two-site service is not recommended currently, as within a small department of 4 WTE as is currently in operation, it is not sustainable and does not lend itself to an efficiently running service. Although plans are afoot to increase this WTE, funding has not yet been provided and recruitment not progressed, so until such time as GUH has a greater dedicated neurology WTE, the two-site model is not recommended.
- If there are to be additional clinics to support long waiters, then the corresponding additional staffing needs to be approved and recruited and additional clinics should not be expected within the current cohort of staffing in SUH or GUH.
- Dedicated administrative staff for Neurology for both existing sites and future sites may have a positive impact on the recorded high DNA rates in Neurology clinics and should be considered. Access to dedicated administrative staff has been reportedly a long-standing concern for clinicians in Neurology, indicating to date the cover has been insufficient.

- For more holistic Neurological care, and to improve outcomes, the provision of dedicated Neurology HSCPs per site is recommended. We note there is an absence of dedicated HSCP in GUH and SUH. Please refer to table 2 and 3 below.
- Consideration about heightened linkages with hospital business managers and neurology administrators for data collection and monitoring is recommended. Digital technologies to allow for ease of access to data will assist in developing neurological services going forward.
- Although there are a significant number of nursing posts approved for SUH and GUH, many of these posts remain unfilled. We recommend every effort be made to fill these posts given the impact of neurology nurses on quality of patient care, assistance with managing return waiting lists and monitoring of therapies. Consideration should also be given to Table 1 below which outlines the international and HSE's Neurology and Epilepsy's Model of Care (MOC) recommendations for nurse specialists in Neurology. Current disease specific waiting lists per hospital site (if available) would give an indication of the no. of nurses required.

Table 1: International and HSE Model of Care Recommendations for Nurse Specialist Staffing in Neurology

Disease Area	Recommendation	No. of Nurses	Source
Multiple Sclerosis	1 nurse per 315 patients	29	MS Specialist Nursing in the UK (2018) Results from the 2018 MS Nurse Mapping Survey
Headache	1 nurse per 140,000 population	36	Neurology Model of Care for Ireland (2016) page 164
Epilepsy	1 nurse per 140,000 population	36	Epilepsy Model Of Care for Ireland (2016) page 22
Parkinson's Disease	1 nurse per 300 patients	31	NICE Guideline and Neurology Model of Care for Ireland (2016)
Rare Diseases	1 nurse per 500,000 population	10	Local Adult Neurology Services for the Next Decade (Royal College Physicians, Association of British Neurologists June 2011)
Total		142	

Table 1: International and NCP Neurology, NCP Epilepsy Recommendations for nurse specialist staffing in Neurology

- Determining appropriate staffing levels for HSCPs within Neurology can be a challenge, in that patients present in many ways i.e. through emergency departments, through primary care services etc. A patient's level of acuity not only depends on the diagnosis, but also on the stage of illness, response to treatment, treatment modalities available for the specific Neurological condition, premorbid function, and support at home. (NCPN MOC, 2016). NCP MOC (2016) suggests that if we consider a definition of rehabilitation to be "*a process of assessment, treatment and management by which the individual is supported to achieve their maximum potential for physical cognitive, social and psychological function, participation in society and quality of living*", then it could be suggested that all interventions of HSCPs within Neurology are rehabilitative in nature. Should that be the case then the following tables (table 2 & table 3) should apply to inpatient services

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Ratio of HSCP for In-patient Specialist Rehabilitation Service for every 20 beds	
Physiotherapy	4 WTE
Occupational Therapy	4 WTE
Speech & Language Therapy	1.5-2.5 WTE (depending on whether patients with tracheostomy are accepted)
Clinical Psychologist	1.5-2 WTE
Social Worker	1-1.5 WTE
Dietitian	0.5-0.75 WTE. (These ratios are for medically stable patients for more acute care, dietitian staffing should be more reflective of the AFRM 2011 standards 1.0 WTE per 10 patients)

Table2: Ratio of HSCP for inpatient rehabilitation services

Minimum HSCP provision for community specialist rehabilitation services to support people with Long Term Neurological Conditions (population 1 million)	
Physiotherapists	6
Occupational Therapists	10
Speech & Language Therapists	4
Clinical Psychologists	4
Social Workers	8
Dietitian	2

Table 3: Ratio of HSCP for community-based rehabilitation services for patients with long term neurological conditions.

Please get in touch with NCPN, should you have any additional queries.

Prof Sinead Murphy Clinical Lead NCPN

Dervla Kenny Programme Manager NCPN

Appendix 6 – Response from Neurological Alliance of Ireland

Coleraine House, Coleraine St., Dublin 7
T: 01 8724120 E: mrogers@nai.ie W: www.nai.ie

1st March 2024

cc Dr Michael Hennessey, Consultant Neurologist, UCHG

Dear Ms Cawley,

I wish to thank you for the opportunity to receive the draft review of Neurology Services for the Saolta Hospital group and to submit any comments.

The Neurological Alliance of Ireland, the national umbrella represents over thirty patient organisations throughout Ireland that work to support people with neurological conditions and their families. Our umbrella organisation is committed to ensuring that these patients have access to the vital services they need to ensure prompt diagnosis and treatment and long-term management of their neurological condition.

We work closely in partnership with the National Clinical Programme in Neurology as well as neurology departments in hospitals throughout the country to improve access to neurological care services. Where we see gaps across the spectrum of service needs, we undertake proactive campaigns to highlight and define the requirement and engage both the health service and political systems to resource the necessary service developments.

We understand the opportunities that the move to Regional Areas in the HSE will bring to more fully network neurology services and bring them closer to patients. We also understand that the development of outreach services needs resourcing to achieve these aims.

We welcome the recommendations of the review that additional Consultant Neurologists are appointed to both Mayo and Letterkenny hospitals. Our own work with neurological patients in both of these regions has highlighted the significant ongoing impact on patients of travelling long distances for care and the value of having dedicated outpatient neurology services in both of these regional hospitals.

Prior to receiving this report, we had already written in early February to both hospitals, and to the CEO of Saolta group, outlining our intention to launch an advocacy initiative on March 12th to coincide with National Brain Awareness Week which, together with the support of twenty three national patient organisations, will highlight the need for dedicated neurology services in both Letterkenny and Mayo hospitals.

This report provides further support for the testimony and experience of neurological patients and patient organisations locally and is welcomed by the Neurological Alliance.

Board: Tom Scott, Chair; Magdalen Rogers, Executive Director; Sonya Gallaher; Aoife Kirwan; Catherine Lacy; Barry McGinn; Gillián Murphy; Dr Kieran O'Driscoll; Dr Niall Pender; Emma Rogan; Tara Smith; Jimmy Smyth.

The NAI is a company limited by guarantee and was incorporated in 2003 (CRO number 366603) CHY number: 14889 Registered Charity Number 20049829. The registered office is Coleraine House, Coleraine Street, Dublin 7.

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I want to thank you for sharing the draft report and If you have any queries about the Neurological Alliance and our work, at mrogers@nai.ie or 086 1216957

Magdalen Rogers.

Magdalen Rogers
Executive Director
Neurological Alliance of Ireland (mrogers@nai.ie) Phone 086 1216957

Board: Tom Scott, Chair; Magdalen Rogers, Executive Director; Sonya Gallaher; Aoife Kirwan; Catherine Lacy; Barry McGinn; Gillian Murphy; Dr Kieran O'Driscoll; Dr Niall Pender; Emma Rogan; Tara Smith; Jimmy Smyth.

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