Department of Health
An Roinn Sláinte
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Regional Review of Neurology Services – Final Report

Consultation Questionnaire

May 2025

Responding to the Consultation

This consultation seeks views on the final report of the Regional Review of Neurology Services. You can provide your views by completing this questionnaire and submitting to the Department of Health (DoH) either by e-mail or by returning a hard copy to the address below. Please read the consultation document before completing this questionnaire.

Email address:

Neurology.Review@health-ni.gov.uk

By post:

Regional Health Services Transformation Directorate
Neurology Review – Consultation
Department of Health
Annexe 3
Castle Buildings
Stormont Estate
Belfast BT4 3SQ

You can also let us know your views by completing the online consultation questionnaire via (https://consultations2.nidirect.gov.uk/doh-1/regional-review-of-neurology-services).

The DoH is committed to protecting your privacy. For more information about how we process your information please see the privacy notice at **Annex A.**

Please note the deadline for responses is 5.00pm on 06 August 2025.

Section 1: About you

When completing this section, you only need to answer the questions that are relevant to you.

Personal details	
Name:	**Dr Julie Anderson, Chair Royal College of Psychiatrists in Northern Ireland & Vice President Royal College of Psychiatrists**
Email address:	**thomas.mckeever@rcpsych.ac.uk**
First part of postcode (e.g. BT25)	**BT18**

Are you responding as an individual or on behalf of an organisation:

Individual (general public)	☐
Individual (Service user)	☐
Individual (Family / carer)	☐
Organisation	**X**

If replying as an individual, please indicate if you do not wish for your identity to be made public:

Yes	☐
No	☐

If you selected organisation, please provide the details of the organisation you represent.

Royal College of Psychiatrists in Northern Ireland

Whilst not essential, it would assist the Department in analysing responses if responding on behalf of an organisation, you could provide details of who your organisation represents and, where applicable, how the views of members were assembled?

The Royal College of Psychiatrists (RCPsych) is the statutory body responsible for the supervision of the training and accreditation of Psychiatrists in the UK and for providing guidelines and advice regarding the treatment, care, and prevention of mental and behavioural disorders. Among its principal aims are to improve the outcomes for those with mental illness and to improve the mental health of individuals, families and communities.

The College has approximately 450 Members in Northern Ireland (including Resident Doctors pursuing specialist training in Psychiatry) who provide the backbone of the local Psychiatric service, offering acute and community treatment, as well as specialist care and consultation across a large range of settings.

This response is submitted on behalf of the Devolved Council of the Royal College of Psychiatrists in Northern Ireland.

Finally, we would welcome ongoing and direct engagement with us as the recommendations of the review are progressed.

Dated: 1st August 2025

Dr Julie Anderson Chair RCPsych in Northern Ireland & Vice President RCPsych
- on behalf of RCPsych in Northern Ireland

Contact Email: thomas.mckeever@rcpsych.ac.uk

Section 2: Consultation Questions

These questions should be read in conjunction with the accompanying consultation document.

Questions	
Q 1	**To what extent do you agree or disagree with the extent of the challenges within neurology services identified by the analysis undertaken by the Review?**
	Strongly Agree **X** Agree ☐ Neither Agree nor Disagree ☐ Disagree ☐ Strongly Disagree ☐
	Do you have further comments? *[yes/no with free text, max 250 words]*

	We note that the remit of this Review excludes, for example, Traumatic Brain Injury and Paediatric Services, both of which have significant unmet mental health needs in terms of their incidence and the patient's transition from Paediatric to Adult services - including the increasing presentation of Functional Neurological Disorder (FND) in Child & Adolescent mental health services. These areas also need urgent development and commissioning attention. **Therefore, whilst our response herein will of necessity also not include reference to these cohorts, we would wish to stress at the outset that we would seek a separate opportunity to represent the mental health needs of both cohorts and their need for additional service development, to the Department. We would make the point strongly that there is a need for Neuropsychiatric services which is much broader than this Consultation allows and it would be essential to ensure that all such services are first of all commissioned and immediately thereafter fully integrated with the outcome of the Neurology Review in order to avoid siloed services.** **The work on the Strategy for Paediatric Health Care and the separate proposed work on services for Myalgic Encephalitis and Chronic Fatigue Syndrome are further examples of where integration of services with the outcome of the Neurology Review will be required following commissioning.** **Similarly, while alcohol-related brain damage (ARBD) falls outside the direct remit of this review of neurology services, it is important to highlight, given the multiple interfaces the condition crosses, the significant and ongoing gaps in service provision for this patient group in Northern Ireland. ARBD is a prevalent condition, affecting up to 30% of individuals with chronic alcohol dependence. It is typically resource-intensive, contributing substantially to prolonged hospital admissions and delayed discharges.** **Currently, outcomes for individuals with ARBD in Northern Ireland are suboptimal due to limited appropriate placements, limited access to rehabilitative treatments, absence of designated services and defined roles and the nonexistence of formal care pathways. These deficiencies place additional strain on multiple areas of the health service and lead to fragmented care. With the correct treatment ARBD can be reversible in 75%, fully so in 25% of patients.** **The Royal College of Psychiatrists' 2018 report Alcohol-Related Brain Damage: Treatment, Not Just Care, along with further guidance from the Royal College Report CR185, outline successful models for ARBD service development and multidisciplinary team structures. These models have demonstrated strong investment to save outcomes as well as excellent patient recovery outcomes in other parts of the UK and provide a clear direction for service planning and implementation.** **It is essential that services for ARBD are commissioned and appropriately funded. The Royal College of Psychiatrists is clear that**

	existing resources across mental health and neurology services are insufficient to meet the specific needs of this complex patient group. **ARBD spans several specialties including general adult psychiatry, general medicine, brain injury, addiction services and old age psychiatry and more. At present, there is no clear consensus on where responsibility for ARBD services should reside, which further hampers coordinated care delivery. This structural gap must be addressed to ensure that individuals with ARBD in Northern Ireland receive equitable, effective care comparable to provision elsewhere in the UK.** **The degree and complexity of mental illness comorbidity with neurological disorder has evolved considerably but services have not been commissioned or developed for many years across adult, old age, learning disability services.** **The broad categorization of neurological disorders (page 21) into four groups is useful but the few examples for each group include some rare neurological conditions – whereas more common conditions such as dementia, early onset dementia and neurological deficits resulting from cerebro-vascular disorders are not mentioned. It needs to be referenced where these patients are envisaged to be seen within the HSC Services, what the role of neurology will be and what is the interface with the recommendations from this Review. Our interest is the prevalence of mental illness within these disorders and seeking to ensure that these additional service development needs also receive attention in terms of commissioning and subsequent integration.** **Page 52 does recognise the need for improved interfaces between Care of the Elderly, Psychiatry of Old Age and neurology services, which is to be welcomed, but there is no guidance or recommendation as to how this will move forward.** **Within Northern Ireland in 2025, there is a prevalence of 1,800 people living with early onset dementia, who are often diagnosed between the fourth and sixth decade of life. Early onset dementia is significantly more likely to have a rarer aetiology and to present with associated neurological symptoms. This is particularly common in dementia related to Frontotemporal dementia, Parkinson's disease and Huntington's disease. A strategy for diagnosis and management of these complex conditions is currently a significant unmet need within Northern Ireland and investment in specialist neurology services to facilitate timely investigation, management and diagnosis for this cohort of patients is much required.** **(It would be good to know the broad breakdown of the neurological disorders that the 11,000 patients have, who have been on the waiting list for over a year in comparision to the prevalence in the community of these neurological disorders and similar figures in England and Wales.)**

	With regard to the analysis of Neuro-psychiatry and the recommendation for 4 WTE consultant neuropsychiatrists, now that we have seen this Review document and the totality of what is proposed in terms of increases in both inpatient beds and Neurologist numbers, we feel that the number of additional Neuropsychiatrists should be 6 – being 1 for each Trust and 2 for Belfast. This is because we readily foresee that the projected increase in both beds and Neurologists will add to the need for Neuropsychiatry input in Belfast with increased need for Liaison Psychiatry across all the Trusts.The proposed increase in inpatient neurology beds in RVH will increase need for mental health liaison service to RVH. We expect the demands for neuropsychiatry services to be greatest in BHSCT. **We recognise the enormous need for the development of a training programme for neuropsychiatrist resident doctors in conjunction with NIMDTA, with appropriate funding to meet the service development needs. This would include provision for an increased number of training posts and attachments at specialist centres outside Northern Ireland.** **<u>ADDITIONAL INFORMATION ON CHILD & ADOLESCENT MENTAL HEALTH & LEARNING DISABILITY</u>:** **Two key areas, which are mentioned in the review but not explored in any depth, will require attention from the neurology delivery team:** • **Needs of adults with learning disability and neurological disorders** • **Transition from child to adult services.** **Specific areas to consider are as follows:** **<u>Needs of adults with learning disability and neurological disorders:</u>** **The increased rates of epilepsy amongst people with learning disability are recognised, but not the increased rates of various other neurological conditions including movement disorders, headaches, and cerebral palsy. These conditions are often under-recognised and sub-optimally managed. Migraines, for example, can be very debilitating for people with learning disability, yet they may not even receive first-line treatment from their GP. Similarly, tic disorders can be chronic and severe, but with no clear pathways to treatments (with neurologists often not seeing this as within their role). Rates of cerebral palsy are much higher in people with learning disability – about half of people with cerebral palsy have a learning disability. Access to specialist neuro-disability services is often non-existent, and many people with learning disability are living with chronic pain because of poor outcomes from their cerebral palsy. Creation of the role of specialist learning disability physicians would help meet some of the workforce challenges; they could help manage less complex, long-term neurological conditions.** **Epilepsy often has a devastating effect on the lives of people with learning disability. They are more likely to have epilepsy, epilepsy with**

	multiple co-morbidities and difficult-to-treat epilepsy. The risk of sudden death in epilepsy (SUDEP) is significantly higher in those with learning disability than those without. Among people known to learning disabilty services in the UK, the prevalence of epilepsy is about 20–30%. Two-thirds of people with learning disability and epilepsy are considered to show a poor response to anti-epileptic medication. This can be related to underlying genetic disorders and rare diseases. We need improved access to genetic and rare diseases clinics, perhaps on a supra-regional basis. Behavioural and psychiatric conditions associated with epilepsy are more common, however, often these are attributed to the learning disability and very poorly understood. We support the need for access to neuropsychiatry and neuropsychology services across the region, and people with learning disability should have equal access to these services alongside specialist learning disability services. There is a role for learning disability nurses with additional specialist expertise in epilepsy, embedded within neurology services. **People with learning disability need to be able to access specialist care pathways across the range of neurological conditions. This also requires availability of reasonable adjustments to allow people with learning disability to have equal access to outpatient appointments, investigations and inpatient care when needed. Often people cannot co-operate with outpatient appointments, investigations such as EEG or MRI, or being in hospital. There are a range of best practice approaches which improve these e.g. longer appointments and adapted environments, support from learning disability liaison nurses, communication/hospital passports, involvement of family carers, use of new technologies to allow easier EEG recording (such as at home recording and wearables for long-term EEG monitoring) and use of AI cameras.** **We commend the College document, "Good Psychiatric Practice CR203 Management of epilepsy in adults with intellectual disability" to the review team. This highlights that "poorer outcomes are often associated with late diagnosis, misdiagnosis, variations in access to appropriate investigations and treatment, and lack of robust implementation of reasonable adjustments". This document should be fully considered in respect of workforce challenges because it "offers an important step towards clarifying the role of the psychiatrist in ID in the management of epilepsy. The proposed tiered system of professional competency gives psychiatrists the option to identify their role in care provision and ensures a framework for training. It provides a structure from which a competency evaluation can be developed. The vision should be for all psychiatrists working with people with ID to have training and certification to one of the three levels of competency (Bronze, Silver and Gold)". This is briefly illustrated here:**

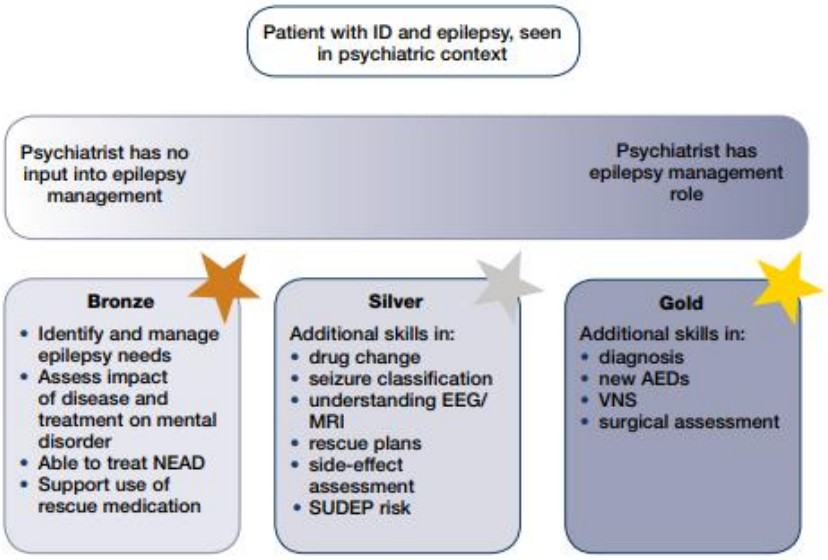

Fig. 2 The psychiatrist's role in epilepsy service delivery. AED, anti-epileptic drugs; EEG, electroencephalogram; ID, intellectual disability; MRI, magnetic resonance imaging; NEAD, non-epileptic attack disorder; SUDEP, sudden unexpected death in epilepsy; VNS, vagus nerve surgery. Figure adapted with permission from *Epilepsy in People with ID: Can we Redu the Burden of Disease?* Keynote presentation by Professor Mike Kerr at the Faculty of Psychiatry of Intellectual Disability Annual Conference, 26–27 September 2013.

Implementation of such a model would have major workforce and training implications in Northern Ireland. There is evidence that a bespoke service, which considers current good practice for supporting people with learning disability and amalgamates it with good practice for managing epilepsy, can reduce deaths in learning disability.

The Step Together guidance from Epilepsy Action describes what good quality integrated services for people with a learning disability and epilepsy should look like. This guidance is highly recommended. 1 in 5 people needing an epilepsy service will have a learning disability, so services should be designed to meet their needs.

Transition from child to adult services:

This only gets one dedicated paragraph but is an area requiring significant attention. The report recommends "Specialist multidisciplinary transition clinics should be available for adolescents moving from paediatric to adult care". The current reality is far from this. Adolescents are discharged from paediatric services at any stage from 14-years onwards and go on a waiting list for adult neurology. This can create a hiatus of 1 -2 years where they have no access to specialist care.

The Inbetweeners Report is a review of the barriers and facilitators in the process of the transition of children and young people with complex chronic health conditions into adult health services and was published by the National Confidential Enquiry into Patient Outcome and Death in 2023. 4 out of the 12 conditions in this report are relevant to neurology (epilepsy, cerebral palsy, a brain tumour, Rett syndrome) and the report

may allow some further analysis/recommendations to be made in respect of transitions. Northern Ireland was included in the original study and several Trusts have committed to implementing the recommendations as a priority. It is supportive of transition clinics.

NICE recommendations about transition in NG217 are outlined below. These specific recommendations are about epilepsy, but good transition supports should be available for children with all neurological conditions. There is a clear role for mental health / learning disability practitioners within specialist transition clinics.

Involve young people with epilepsy in planning for their transition from children's to adult epilepsy services in line with the NICE guideline on transition from children's to adults' services for young people using health or social care services.

Ensure transition from children's to adults' epilepsy services is individually tailored to the young person with epilepsy.

Begin planning transition early for young people who have complex or additional health and social care needs, for example young people whose seizures are not yet controlled or those with learning disabilities.

During transition of young people with epilepsy to adult services, the paediatric and adult multidisciplinary teams should jointly review the person's diagnosis and management plan, taking a person-centred approach that involves the young person, and their family or carers as appropriate, in planning and decisions about their care.

Ensure that information about the young person's management plan and support for transition to adult services is discussed with the young person with epilepsy and shared in an accessible format that meets their needs and uses language they understand. Repeat this information at different time points to establish that the young person understands their care plan and the support that will be provided.

When discussing transition to adult epilepsy services with the young person, cover any issues of concern to the person, including, but not limited to, the following:

- activities of daily living, including driving and sports
- adherence to antiseizure medication
- comorbidities, such as low mood or impaired memory
- continuing in education or work
- emotional health and psychological wellbeing
- living independently

	• possible effects of epilepsy and antiseizure medication on neurodevelopment, cognition and behaviour • risks associated with alcohol and illicit drugs • safety and risk (including sudden unexpected death in epilepsy [SUDEP]) • reproductive health, including contraception, pregnancy and teratogenicity • sleep disturbance • social aspects of epilepsy, including considering if or when to disclose epilepsy status and managing the impact of possible assumed limitations • stigmatisation of epilepsy.
Q 2	**To what extent do you agree or disagree with the vision of the Review that future neurology services should be person centred, joined-up, responsive, evidence-based and suitably resourced to meet the needs of people with neurological conditions in NI?**
	Strongly Agree **X** Agree ☐ Neither Agree nor Disagree ☐ Disagree ☐ Strongly Disagree ☐
	Do you have further comments? *[yes/no with free text, max 250 words]*
	We welcome the broad vision as described in this Review. However, the Principles as outlined for this Review (Pages 28/29) should include recognition of the role and needs of Carers/Family/ Supporters of patients. **The paragraph on Carers (page 32) focuses on the importance of their role in supporting patients with a neurological disorder and the support and information they need in exercising this role. We support this. Additionally however, the impact on Carers can have an effect on their own physical and mental well-being and the need for this type of specific support for Carers in this area must be recognised.**

Q3(a)	**To what extent do you agree or disagree with the person-centred approach as set out under priority one in the report?**
	Strongly Agree ☐ Agree **X** Neither Agree nor Disagree ☐ Disagree ☐ Strongly Disagree ☐
	Do you have further comments? *[free text, max 250 words]*
	We agree with the approach to person-centred care and support efforts to empower patients to access self-care for mental health components of their neurological disorder. This may include the development of the Recovery College model within mental health services. **Those with more complex mental health will require assessment and triage of their mental health needs to ensure referral to the most appropriate service for an individual patient at a particular time. We encourage the development of a tiered model for mental health care from services provided within community and voluntary sector through to generic mental health services through to development of enhanced "Mental health for neurology" teams.** **We welcome the House of Care Model provided this is built on foundations of improved capacity for service provision and workforce within mental health, training of healthcare professionals on the mental health needs of patients for early identification of mental illness and importantly development of robust organisational structures for multidisciplinary working between neurology, neuropsychology, AHP and psychiatry/ community mental health.**
Q3(b)	**To what extent do you agree or disagree with the recommended actions set out to achieve priority one?**
	Strongly Agree ☐ Agree **X** Neither Agree nor Disagree ☐ Disagree ☐ Strongly Disagree ☐

	Do you have further comments? *[free text, max 250 words]*
	There should be recognition that for some patients, the nature of their mental disorder may prevent or limit their ability to engage in self-directed care, despite possible agreement to do so. **Given both the chronic and fluctuant nature of several neurological conditions, there will be periods of increased complexity and mental ill health. During such periods there will be a need for close or joint key-working between the mental health and neurology key-workers, to optimise person-centred care, avoid duplication of roles and support prompt access to more acute care if required.** **Those with complex needs will require an AHP keyworker within the mental health team. To deliver this will require protected funding for development of mental health for neurology teams in each Trust with a consultant neuropsychiatrist. This will require workforce development and training.** **HSC professionals should have some understanding of the structure and provision of mental health services or know where such advice can be accessed. This is to facilitate appropriate referrals and avoid delays in the assessment process – eg: Trust catchment-based provision of services, referrals to acute crisis services, addictions services. Trusts should ensure such information is available to professionals.** **We welcome training on neurological conditions to improve understanding and delivery of mental health care to patients. Recurrent training systems to support this are also welcomed considering the relatively frequent changes of staff within community mental services.** **1(b) and 1(c) should include ensuring the physical and mental wellbeing of carers/supporters.**

Q4(a)	**To what extent do you agree or disagree with the need to develop additional workforce capacity in neurology services as set out under priority two in the report?**
	Strongly Agree **X** Agree ☐ Neither Agree nor Disagree ☐ Disagree ☐ Strongly Disagree ☐
	Do you have further comments? *[free text, max 250 words]*
	In considering changes to workforce in neurology and neuropsychology we emphasise such changes will increase identification of mental illness, referral and demand for mental health services. The need for Neuropsychiatry input increases in parallel with the various developments and demand from greater numbers of Neurologists for Neuropsychiatric input. **With regard to the analysis of Neuro-psychiatry and the recommendation for 4 WTE consultant neuropsychiatrists, now that we have seen this Review document and the totality of what is proposed in terms of increases in both inpatient beds and Neurologist numbers, we feel that the number of additional Neuropsychiatrists should be 6 – being 1 for each Trust and 2 for Belfast. This is because we readily foresee that the projected increase in both beds and Neurologists will add to the need for Neuropsychiatry input in Belfast with increased need for Liaison Psychiatry across all the Trusts.The proposed increase in inpatient neurology beds in RVH will increase need for mental health liaison service to RVH. We expect the demands for neuropsychiatry services to be greatest in BHSCT.** **We welcome development of structures for multidisciplinary discussion of cases to support care planning between disciplines and to avoid duplication of roles.** **We recognise the enormous need for the development of a training programme for neuropsychiatrist resident doctors in conjunction with NIMDTA, with appropriate funding to meet the service development needs. This would include provision for an increased number of training posts and attachments at specialist centres outside Northern Ireland.** **Psychiatry is part of the medical workforce and we highlight this to the Review when approaches are made to NIMDTA for training of future medical professionals in this area. Given the 6-8 year time needed for training, urgent engagement will be required between DoH and**

	NIMDTA to develop the necessary type of training and numbers for training in order to realise the Action Plan targets and Recommendations for Neuropsychiatry set out on page 80.
Q4(b)	**To what extent do you agree or disagree with the recommended actions set out to achieve priority two?**
	Strongly Agree ☐ Agree **X** Neither Agree nor Disagree ☐ Disagree ☐ Strongly Disagree ☐
	Do you have further comments? *[free text, max 250 words]*
	Workforce capacity in mental health for neurology is in crisis with one stand-alone LTFT Consultant Psychiatrist in neuropsychiatry in BHSCT providing community care, liaison service to RVH neurology, neurosurgery, RABIU and neurology MPH. There is no community mental health team for neuropsychiatry. **With regard to the analysis of Neuro-psychiatry and the recommendation for 4 WTE consultant neuropsychiatrists, now that we have seen this Review document and the totality of what is proposed in terms of increases in both inpatient beds and Neurologist numbers, we feel that the number of additional Neuropsychiatrists should be 6 – being 1 for each Trust and 2 for Belfast. This is because we readily foresee that the projected increase in both beds and Neurologists will add to the need for Neuropsychiatry input in Belfast with increased need for Liaison Psychiatry across all the Trusts.The proposed increase in inpatient neurology beds in RVH will increase need for mental health liaison service to RVH. We expect the demands for neuropsychiatry services to be greatest in BHSCT.** **We advocate development of "Mental Health for Neurology" community teams to work in community and mental health liaison settings: to deliver care to more complex patients, support implementation of self-care models, address interfaces with neurology, collaborate with specialist neurology nurses and contribute to training of colleagues within other community mental health teams. Such teams will require CBT, community mental health nurse, social worker, occupational therapist, speech and language therapist, neuro-physiotherapist and neuropsychiatrist input. In particular we welcome detail on how mental health and neuropsychology services can be integrated to ensure patients can have equitable access to the most**

	appropriate professional at the correct time. This should include the identification of roles of neuropsychology and psychiatry within patient care pathways to support flexibility. **We suggest neuropsychiatry has a training action plan, similar to that proposed by neurology. This is a high priority as we are unlikely to recruit outside Northern Ireland, are mindful of the current vacancy rate in Consultant Psychiatrists (25% vacancy) and time required for training (6 to 8 years). Presently there is no speciality training post in neuropsychiatry and such a post will require funding to access training opportunities outside of Northern Ireland.**

Q5(a)	**To what extent do you agree or disagree with the need to address gaps in the current neurology service as set out under priority three in the report?**
	Strongly Agree ☐ Agree ☐ Neither Agree nor Disagree **X** Disagree ☐ Strongly Disagree ☐
	Do you have further comments? *[free text, max 250 words]*
	The complexity and nature of mental illness in neurological conditions often necessitates prescription of psychiatric medication in addition to or instead of psychological intervention. e.g. antipsychotics in Parkinson's psychosis, antidepressants in MS, antipsychotics in TIC disorders. At other times the action of a mental health social worker can address psychosocial problems contributing to the mental disorder or CBT therapist can deliver therapy. So, the fluctuating and chronic nature of the mental illness requires a flexible, multidisciplinary approach and this cannot be achieved with any discipline in isolation. We want to avoid the development of parallel services for mental health and support integration to ensure patients do not fall between teams. **Specifically in relation to Functional Neurological Disorder (FND), on Page 68 it is stated: "Effective management of some neurological conditions such as FND are particularly reliant on services which sit outside of neurology specialty including…mental health services.… During the course of the Review, we have identified barriers to accessing these services for patients with FND in particular. We need to be cognisant going forward that all Trusts ensure that patients living with FND are able to access the appropriate services to help manage their condition."** **We wish to highlight that services for FND have not been commissioned within mental health as they should be. Given the prevalence and complexity of this, we believe that a consistent agreed Regional approach to service development and commissioning for this should be implemented across Trusts. Presently many patients are unable to access psychological services and are defaulting to community mental health teams. Such teams can only address some of the patient needs but are unable to access the required psychological input or physiotherapy. There must be integrated service delivery for FND.**

	FND should be very much engaged with Neurology Services and not confined within general mental health services. FND is at the interface and requires Neuropsychiatric and Neuropsychological service input. Psychiatry needs to be involved in treating FND, but FND requires a multidisciplinary approach and cannot be confined to Psychiatry alone.
Q5(b)	**To what extent do you agree or disagree with the recommended actions set out to achieve priority three?**
	Strongly Agree ☐ Agree ☐ Neither Agree nor Disagree **X** Disagree ☐ Strongly Disagree ☐
	Do you have further comments? *[free text, max 250 words]*
	The increase in in-patient neurology beds in RVH will increase demands on mental health liaison services. If this is not resourced, delayed assessments could potentially contribute to prolonged length of in-patient stay. **We note the statement arising at various points in the document regarding access to general mental health services for Neurology Patients – eg: "Trusts must ensure barriers to accessing general mental health services for neurology patients regardless of diagnosis are addressed." We would point out that such access difficulties are often related to the lack of commissioning of appropriate services rather than any intentional barriers**. **We know that a significant number of patients with neurological illness currently access mental health services. Data on this and the patient experience would be welcomed for review and consideration. It goes without saying that mental health services must be accessible to all.** **Gaps in service provision due to the absence of commissioned services should not be conflated and confused with barriers to access. We urge the review to take a Regional approach and ring-fenced funding will also be required.** **At present individuals fulfilling criteria for more specialist services, but in the absence of such services, are referred on to generic CMHTs**

	which are unable to address the entirety of need for the individual patient.

Q6(a)	**To what extent do you agree or disagree with the need to use current resources more effectively as set out under priority four in the report?**
	Strongly Agree ☐ Agree **X** Neither Agree nor Disagree ☐ Disagree ☐ Strongly Disagree ☐
	Do you have further comments? *[free text, max 250 words]*
	NI data on mental illness comorbidity is required to inform service development. **We welcome cooperation between the Trusts and the community and voluntary sector.** **There are issues with access to appropriate clinical environments, including suitable space and privacy for psychiatry assessments for inpatients in neurology and accessible outpatient accommodation in mental health.** **We welcome patient initiated follow-ups when adequate systems and resources are in place.** **With suitably resourced community services, we would hope that prompt escalation within mental health services for assessment would be offered and if required, referral to acute community care in place of admission to mental health inpatient services.** **We would be keen to be involved by DoH in the development of condition specific pathways (page 81).**

Q6(b)	**To what extent do you agree or disagree with the recommended actions set out to achieve priority four?**
	Strongly Agree ☐ Agree **X** Neither Agree nor Disagree ☐ Disagree ☐ Strongly Disagree ☐
	Do you have further comments? *[free text, max 250 words]*
	In the absence of raw data, Clinicians inform us that there is a significant unmet need in patients with Neurological disorders and those attempting to access. **There is a need to capture comprehensive NI data to inform service development, referral and prescribing data across all areas of mental health – eg:** **General Adult** **Old Age Psychiatry** **Learning Disability** **Self-harm Services** **Unscheduled Care and Liaison Services** **Addiction Services** **Child & Adolescent Mental Health Services – and in particular the transition to Adult Mental Health Services**

Q7	**To what extent do you agree or disagree with the proposed next steps for the Review as set out in the report?**
	Strongly Agree ☐ Agree **X** Neither Agree nor Disagree ☐ Disagree ☐ Strongly Disagree ☐
	Do you have further comments? *[free text, max 250 words]*
	We have already referred to several Recommendations in our response. These are additional comments: **2e Action plan is required to develop training programme in neuropsychiatry to fulfil required consultant workforce and support specialist interests of other psychiatry trainees e.g. Old Age Psychiatry and Learning Disability.** **2j Priority for recruitment of AHP within community services to establish mental health for neurology services, especially CPN, SW CBT, OT and physio sessions.** **2l Suggested 4 WTE neuropsychiatrists is only for current provision not the proposed expanded services, which are likely to increase recognition of mental illness.** **3d We welcome development of condition specific pathways.** **3f - See earlier comments on barriers to accessing mental health services**

Section 3 – Equality and Human Rights

Section 75 of the NI Act 1998 requires departments in carrying out their functions relating to NI to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between person with a disability and persons without; and
- between persons with dependants and persons without.

You may wish to refer to the Equality Screening, Disability Duties and Human Rights Assessment template at https://www.health-ni.gov.uk/consultations

<table>
<tr><td rowspan="3">Q8</td><td rowspan="2">Are any of the recommendations set out in the consultation document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the 1998 Act? (Please Tick)</td><td>Yes</td><td></td></tr>
<tr><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please state the group(s) and provide comment on how these adverse impacts could be reduced or alleviated in the proposals:</td></tr>
<tr><td rowspan="3">Q9</td><td rowspan="2">Are you aware of any indication or evidence – qualitative or quantitative – that any of the recommendations set out in the consultation document may have an adverse impact on equality of opportunity or on good relations? (Please Tick)</td><td>Yes</td><td></td></tr>
<tr><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact:</td></tr>
</table>

Q10	**Is there an opportunity to better promote equality of opportunity or good relations? (Please Tick)**	**Yes**	
		No	
	If yes, please give details as to how:		
Q11	**Are there any aspects of the proposals in the consultation where potential human rights violations may occur? (Please Tick)**	**Yes**	
		No	
	If yes, please give details as to how:		

Section 4 – Rural Impact

The Rural Needs Act (NI) 2016 became operational on the 1 June 2017 and places a duty on public authorities, including government departments, to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services. A draft rural needs impact assessment has been prepared against these policy proposals.

<table>
<tr><td rowspan="3">Q12</td><td rowspan="2">Are the actions/proposals set out in this consultation document likely to have an adverse impact on rural areas? (Please Tick)</td><td>Yes</td><td></td></tr>
<tr><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please provide comment on how these adverse impacts could be reduced or alleviated:</td></tr>
</table>

Thank you for your comments.

Annex A

Privacy Notice

Data Protection Officer Name: Charlene Maher

Email: DPO@health-ni.gov.uk

Being transparent and providing accessible information to individuals about how we may use personal data is a key element of the Data Protection Act (DPA) the EU General Data Protection Regulation (GDPR). The Department of Health (DoH) is committed to building trust and confidence in our ability to process your personal information and protect your privacy.

Purpose for processing
While we are not seeking to process personal data as part of this consultation and would encourage you to be mindful of the information you disclose as part of your responses, if you disclose any personal data, we will ensure we process this according to the requirements of Data Protection law. We will process any data provided in response to consultations for the purpose of informing the development of our policy, guidance, or other regulatory work in the subject area of the request for views. We will publish a summary of the consultation responses and, in some cases, the responses themselves but these will not contain any personal data. We will not publish the names or contact details of respondents but will include the names of organisations responding.

Lawful basis for processing
The lawful basis we are relying on to process your personal data is Article 6(1) (e) of the GDPR, which allows us to process personal data when this is necessary for the performance of our public tasks in our capacity as a Government Department. We will only process any special category personal data you provide, which reveals racial or ethnic origin, political opinions, religious belief, health or sexual life/orientation when it is necessary for reasons of substantial public interest under Article 9(2)(g) of the GDPR, in the exercise of the function of the department, and to monitor equality.

How will your information be used and shared
We process the information internally for the above stated purpose. We don't intend to share your personal data with any third party. Any specific requests from a third party for us to share your personal data with them will be dealt with in accordance the provisions of the data protection laws.

How long will we keep your information

We will retain consultation response information until our work on the subject matter of the consultation is complete, and in line with the Department's approved Retention and Disposal Schedule Good Management, Good Records (GMGR) Good management, good records | Department of Health.

What are your rights?

- You have the right to obtain confirmation that your data is being processed, and access to your personal data
- You are entitled to have personal data rectified if it is inaccurate or incomplete
- You have a right to have personal data erased and to prevent processing, in specific circumstances
- You have the right to 'block' or suppress processing of personal data, in specific circumstances
- You have the right to data portability, in specific circumstances
- You have the right to object to the processing, in specific circumstances
- You have rights in relation to automated decision making and profiling.

How to complain if you are not happy with how we process your personal information

If you wish to request access, object or raise a complaint about how we have handled your data, you can contact our Data Protection Officer using the details above. If you are not satisfied with our response or believe we are not processing your personal data in accordance with the law, you can complain to the Information Commissioner at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF
casework@ico.org.uk