**Examples of executive summaries**

**Downbanding**

“Changing the role of the MS specialist nurse to a neurology specialist nurse will have an adverse impact on safe, high quality patient care, creating longer waiting lists for neurologists and for out patients appointments, risking breaches of the 18 week referral to treatment target.

 It will increase the risk of emergency admissions by 20% and raise the risk of emergency readmissions within 28 days by 50%.

Management of high cost disease modifying drugs (DMDs) requires specialist nurse input as this is a highly complex and fast developing area of practice with the potential for severe adverse events including death if not managed effectively. This aspect of the MS service will be severely impacted resulting in unsafe practice or the need to stop prescribing DMDs.

The specialist nurse's caseload will rise to 1,200 patients, so the majority cannot be offered annual reviews in clinic including symptom management and medication reviews: this will lead to increased pharmacy costs, and avoidable admissions for patients poorly managed in primary care.

The specialist nurse will no longer be able to offer support to inpatients, risking increased readmissions within 28 days and significantly delayed discharges, as well as poorer medication adherence.

 Additionally, the education requirements of the post-holder will rise in order to ensure safe practice, particularly in prescribing, at a time of rapid change in neurological medications. This has implications for study leave costs as well as for covering clinics.”

**Redundancy**

"We recommend retaining the role of MS specialist nurse in its current form. Making the MS specialist nurse role redundant will have an adverse impact on safe, high quality patient care, creating longer waiting lists for neurologists and for out patient appointments, risking breaches of the 18 week referral to treatment target and severely impacting on safe prescribing and management of high cost disease modifying drugs (DMDs).

 It will increase the risk of emergency admissions by 20% and raise the risk of emergency readmissions within 28 days by 50%. Without an MS specialist nurse service, all annual reviews and monitoring (including DMD monitoring) will have to be undertaken by neurologists, whose caseload will prevent them from offering annual reviews in clinic. Therefore all symptom management and medication reviews will pass to primary care where there is no specialist knowledge. This may create an increase in complications such as avoidable UTIs and falls, leading to a rise in avoidable admissions. Since the specialist nurse will no longer be able to offer support to inpatients, many of whom have limited mobility and may present with pressure ulcers – requiring intensive nursing and therapy input - a risk of increased readmissions within 28 days and significantly delayed discharges, as well as poorer medication adherence is anticipated.

Management of high cost disease modifying drugs (DMDs) requires specialist nurse input as this is a highly complex and fast developing area of practice with the potential for severe adverse events including death if not managed effectively. This aspect of the MS service will be severely impacted resulting in unsafe practice or the need to stop prescribing DMDs."

**Despecialisation**

“We recommend retaining the role of MS specialist nurse in its current form.

Changing the role of the MS specialist nurse to a neurology specialist nurse will have an adverse impact on safe, high quality patient care, creating longer waiting lists for neurologists and for out patients appointments, risking breaches of the 18 week referral to treatment target and unsafe management of high cost disease modifying drugs (DMDs).

 It will increase the risk of emergency admissions by 20% and raise the risk of emergency readmissions within 28 days by 50%. The specialist nurse's caseload will rise to 1,200 patients, so the majority cannot be offered annual reviews in clinic including symptom management and medication reviews: this will lead to increased pharmacy costs, and avoidable admissions for patients poorly managed in primary care.

Management of high cost disease modifying drugs (DMDs) requires specialist nurse input as this is a highly complex and fast developing area of practice with the potential for severe adverse events including death if not managed effectively. This aspect of the MS service will be severely impacted resulting in unsafe practice or the need to stop prescribing DMDs.

The specialist nurse will no longer be able to offer support to inpatients, risking increased readmissions within 28 days and significantly delayed discharges, as well as poorer medication adherence. Additionally, the education requirements of the post-holder will rise in order to ensure safe practice, particularly in prescribing, at a time of rapid change in neurological medications. This has implications for study leave costs as well as for covering clinics.”

**Redeployment**

“We recommend retaining the role of MS specialist nurse in its current form.

Redeploying the MS specialist nurse so that 0.2 FTE of time is spent managing the neurological ward will have an adverse impact on safe, high quality patient care, both for inpatients and outpatients, will create longer waiting lists for neurologists and for out patient appointments, risking breaches of the 18 week referral to treatment target. It will increase the risk of emergency admissions by 20% and raise the risk of emergency readmissions within 28 days by 50%. The specialist nurse's caseload will not change, but fewer clinical hours will lead to a reduction in service including clinic cancellations, so the majority will not be offered annual reviews including symptom management and medication reviews: this will lead to increased pharmacy costs, and avoidable admissions for patients poorly managed in primary care.

The specialist nurse will be able to offer much less support to inpatients, risking increased readmissions within 28 days and significantly delayed discharges, as well as poorer medication adherence.

 It is likely that the specialist nurse will no longer be able to offer as much clinical supervision, education and training to non-specialists. Additionally, the education requirements of the post-holder will rise in order to ensure safe practice whilst working on the wards, particularly in relation to medicines management, manual handling, and staff management. This has implications for study leave time and costs.”

**Impending vacancy**

"We recommend replacing the specialist nurse as soon as possible. We recommend advertising for a full-time Band 7 specialist nurse role.

Leaving the current specialist nurse role vacant will have an adverse impact on safe, high quality patient care, both for inpatients and outpatients. It risks creating longer waiting lists for neurologists and for out patient appointments, potentially breaching the 18 week referral to treatment target. And will adversely impact on the prescribing and effective management of high cost disease modifying drugs (DMDs).

 It will increase the risk of emergency admissions and raise the risk of emergency readmissions within 28 days. Without specialist nursing input to the wards, and to aid with discharge, increased length of stay for admitted patients seems likely.

Management of high cost disease modifying drugs (DMDs) requires specialist nurse input as this is a highly complex and fast developing area of practice with the potential for severe adverse events including death if not managed effectively. This aspect of the MS service will be severely impacted resulting in unsafe practice or the need to stop prescribing DMDs.

The remaining MS specialist nurse(s) will not have capacity to offer regular symptom management, via telephone and nurse-led clinic, nor will annual reviews be available: this will lead to increased pharmacy costs and avoidable admissions for patients poorly managed in primary care.

 Without a specialist nurse in post, clinical supervision will need to be rearranged for her supervisees, and the current education programmes of patient self-management and a basic grounding in the condition for GPs and community nurses and therapists will no longer be available."