

Mental Health, Dementia, Neurological  
Conditions, Learning Disability and Autism  
(MHDNL) Strategic Clinical Network  
(SCN) East of England

Epilepsy Event Evaluation Report  
26th June 2014

The Weston Business Centre, Stansted



# NHS England

**Mental Health, Dementia, Neurological Conditions, Learning Disability and Autism  
(MHDNL) Strategic Clinical Network (East of England)**

**Epilepsy Event 26<sup>th</sup> June 2014**

**Evaluation report v1**

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**Prepared by Victoria Doyle**

## Contents

1. <b>Purpose</b> .....	4
2. <b>Key points</b> .....	4
3. <b>Next steps/forward planning</b> .....	6
Appendix A – Feedback form responses	
Appendix B – Morning workshop Epilepsy Pathway feedback	
Appendix C – Afternoon workshop discussion feedback	
Appendix D – Delegate contact list	

## 1. Purpose

1.1 The purposes of the epilepsy event were;

1.1.1 To bring together interested stakeholders from across the East of England to hear about local and national projects to improve the care of patients with epilepsy so that these can be utilised within the region.

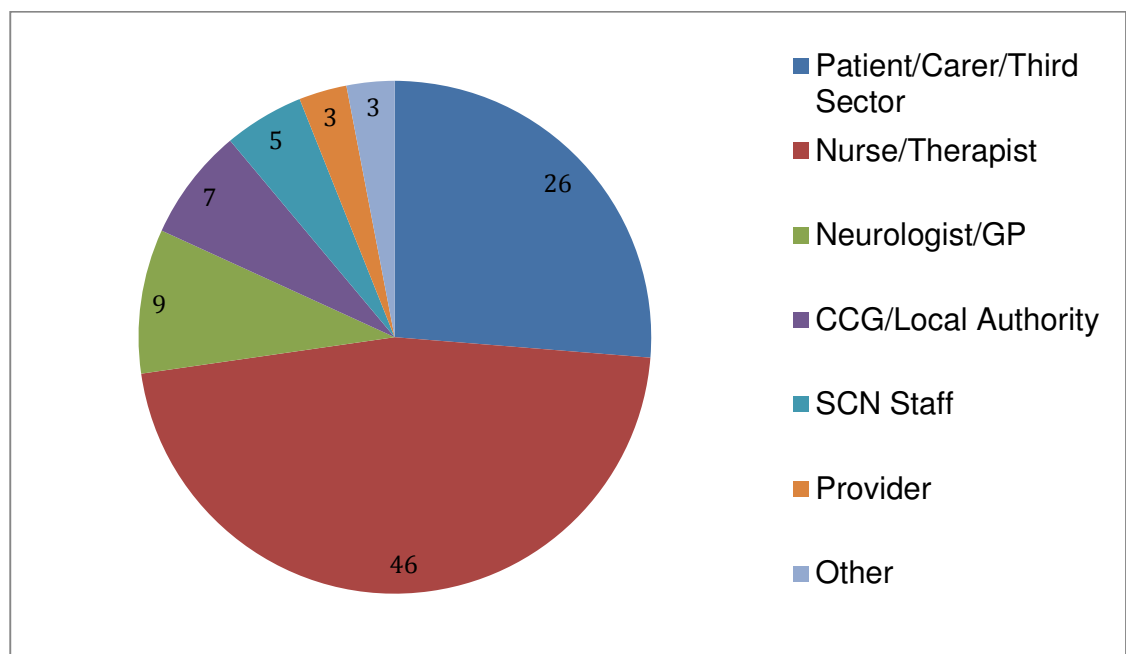
1.1.2 To start work on an aspirational epilepsy pathway which the SCN will develop further.

1.1.3 To understand what was currently working well within the region, what needed to improve and how, in order to develop the work programme of the SCN.

1.1.4 To raise the profile of epilepsy and to inspire the delegates to develop projects of their own to improve the care of patients with epilepsy and to forge new contacts within the region to help with this work.

## 2. Key Points

2.1.1 A total of 99 delegates attended the epilepsy event out of 112 who had registered to attend. The breakdown of attendees is depicted in graph 1.



Graph 1: Breakdown of the delegates attending the epilepsy event

- 2.1.2 The graph shows a strong representation from nurses, therapists, third sector and patients/carers. Commissioners, local authority, clinicians and providers continue to engage with the work of the Strategic Clinical Network (SCN).
- 2.2 Fifty two delegates completed the feedback forms. There was a high level of interest in all of the presentations. A full breakdown of feedback responses and some key comments can be found in **Appendix A**.
- 2.2.1 Dr David Bateman the NHS England National Clinical Director for Neurology gave an insightful presentation into commissioning a better epilepsy service and introduced the launch of the Neurology Intelligence Network <http://www.yhpho.org.uk/mhdnln>.
- 2.2.2 Dr Tejal Mitchell gave an inspiring talk on the NASH2 data and how this could be used to support a business case. Dr Max Damian introduced an interesting telecare pilot between Addenbrookes and Ipswich Hospitals to improve the care of patients presenting in A&E in status epilepticus, which will start in September.
- 2.2.3 Vicki Raphael, Christian Raphael and Matt Clarke gave a thought provoking presentation from the patients and carer perspective which the delegates found very important.
- 2.2.4 Juliet Aston and Sarah Vibert introduced a potentially extremely useful commissioning tool which they are developing to support the role of epilepsy specialist nurses by demonstrating the positive impact they have.
- 2.2.5 In the afternoon Dr Greg Rogers gave a motivating talk on the role of primary care in managing epileptic patients which captured the interest of the delegates.
- 2.2.6 Dr Mark Manford brought the comedy touch to his presentation on a new anti-epileptic drug shared care protocol they have developed at Addenbrookes, which was well received by the delegates.
- 2.3 There was a moderate to high level of interest in the workshop sessions with the majority of delegates finding them highly useful. A full breakdown

of feedback responses and some key comments can be found in **Appendix A**.

2.3.1 In the morning delegates worked on the epilepsy pathway either from first seizure, through diagnosis and treatment or for long term or poorly controlled epileptic patients. **Appendix B** contains the pathways drawn out by the groups and any points/comments they raised as there was not enough time for all of the groups to provide detailed feedback on the day.

2.3.2 In the afternoon delegates brainstormed the link between primary and secondary care for patients with epilepsy focussing on what was going well, what wasn't going well and how this could be improved. This generated some interesting ideas to be taken forward which have been captured in **Appendix C**.

### 3. Next Steps and Forward Planning

3.1 Delegate contact list to be shared for continuation of networking opportunities with key stakeholders. See **Appendix D**.

3.2 The East of England Strategic Neurology Advisory Group (SNAG) was set up in June 2014 to develop and steer the work of the neurological conditions part of the SCN. There is strong representation from patients, third sector, neurologists, general practitioners, specialist nurses and commissioners on the group.

3.2.1 Members of the SNAG have been asked to work on;

3.2.1.1 An alert system for patients admitted into secondary care so that the specialist neurology team is alerted to the admission. The aim is to ensure that the patient is well supported during the admission to reduce complications and length of stay.

3.2.1.2 A series of neurology GP education sessions culminating in referral guidelines to assist GPs with managing neurological patients.

3.2.1.3 A business model for commissioning acquired brain injury rehabilitation beds.

- 3.3 In September the SCN is also launching a pilot project linking Addenbrookes and Ipswich Hospitals to improve the care of patients presenting to the A&E departments in status epilepticus.
- 3.4 The SCN is working on regional guidelines for patients presenting to A&E after a seizure as well as medicines optimisation in primary and secondary care.
- 3.5 The SCN links closely with the National SCN work streams which include epilepsy, headache and neurological rehabilitation.
- 3.6 The SCN is also working closely with the work of the East of England Citizens Senate who are working on a project involving equality of access for patients with epilepsy.
- 3.7 The SCN is in partnership with the National Development Team for Inclusion (NDTi) on a two year project to embed meaningful co-production to all of the SCN work streams. There will also be two series of Action Learning Sets over a 12 month period for commissioners, providers and patient representatives to work on co-producing specific projects. Two in depth CCG sites will be supported by the SCN and NDTi to undertake a large scale co-produced project over 12 months. All of the work will be fully evaluated to facilitate embedding co-production more widely across the East of England.

## **Appendix A - Feedback Form Responses.**

- Total responses received – 52
- Total delegates - 99

### **Presentations**

#### **1. Commissioning a Better Epilepsy Service by Dr David Bateman**

	High Level of Interest	Moderate Level of Interest	Low Level of Interest	Highly Useful	Moderately Useful	Less Useful
Rating	26	15	0	26	13	2

#### **Key Comments**

- Will be going away to investigate the data further
- Good overview particularly highlighting some of the variances and suggesting some further analysis required and some possible solutions
- Very informative and interesting presentation. Data very useful for supporting un-met needs analysis
- Good points on epilepsy pathway and standards
- No mention of family/carer involvement! How many admissions were due to carer breakdown? Carer involvement in discharge planning and long term management. Will definitely look at NICE – commissioning and budgeting tool for adults to see if carer support is identified.

#### **2. NASH2 Report – East of England/ National Perspective by Dr Tejal Mitchell and Dr Max Damian**

	High Level of Interest	Moderate Level of Interest	Low Level of Interest	Highly Useful	Moderately Useful	Less Useful
Rating	36	7	0	31	12	0

#### **Key Comments**

- Excellent NASH explanation and how data can be used to promote a business case
- Very interesting and informative and great to see such enthusiasm and helpful to know how data was used to inform business plan



### 3. The Patient and Carer Perspective by Vicki and Christian Raphael and Matthew Clarke

	High Level of Interest	Moderate Level of Interest	Low Level of Interest	Highly Useful	Moderately Useful	Less Useful
Rating	40	8	0	31	6	2

#### Key Comments

- Really good to hear about personalised care/holistic approach
- Very positive session and listen to carers
- Excellent to have a patients/carers perspective. It is very important that your views are central to future development.
- Excellent to hear the impact of Epilepsy Society wider (non-medical context). The highlighting of transition services were brilliant and the way in which patients can be actively involved in devising content and delivering training.
- As a commissioner about to redesign neurology services, hearing from the patient/carers was invaluable.

### 4. Epilepsy pathway and Commissioning Tool by Juliet Ashton and Sarah Vibert

	High Level of Interest	Moderate Level of Interest	Low Level of Interest	Highly Useful	Moderately Useful	Less Useful
Rating	33	10	2	26	14	1

#### Key Comments

- Excellent session – appropriate, relevant to today’s epilepsy event
- Interesting presentation on epilepsy pathway
- Again a very useful presentation with very useful data which was explained in a clear way
- Good presentation of work undertaken to date and plans going forward
- Interesting facts-shocking! Good introductions to morning workshop.

## 5. Primary Care Services for Epilepsy by Dr Greg Rogers

	High Level of Interest	Moderate Level of Interest	Low Level of Interest	Highly Useful	Moderately Useful	Less Useful
Rating	37	5	0	30	8	1

### Key Comments

- Will lead to further reading and investigation
- Excellent, relevant and appropriate
- Great to hear from a real GP
- Excellent presentation – clear and inspirational. Be great to see more GPwSI in East of England
- Good overview of how GP and primary care services can provide effective epilepsy services and good presentation of GP services. Would like to see evaluation of model developed in Kent
- More information about how to manage clients currently in primary care would be good as well as just what would be ideal.

## 6. Shared Decision Making for New AEDs between Primary and Secondary Care by Dr Mark Manford

	High Level of Interest	Moderate Level of Interest	Low Level of Interest	Highly Useful	Moderately Useful	Less Useful
Rating	36	4	1	28	7	1

### Key Comments

- Interested in investigating the Addenbrookes model
- Really interesting and fun presentation
- Helpful insight into consultant's view/perspective and frustrations. Interesting quick overview of development of AEDs.
- Very clear explanation and information displayed in an accessible way. I enjoyed the use of humour in the slides which made the point extremely well
- Perhaps a national directive regarding shared care would assist GPs who are not confident in prescribing. Prevents individual with epilepsy being stuck in the middle.

## Workshops

### 1. Epilepsy pathway – What should the epilepsy pathway look like?

	High Level of Interest	Moderate Level of Interest	Low Level of Interest	Highly Useful	Moderately Useful	Less Useful	Well Facilitated	Moderately Well facilitated	Less well Facilitated
Rating	24	14	2	29	8	1	25	7	2

#### Key Comments

- Good to share experiences between service users and commissioners
- Good to start working on a gold standard over and above NICE
- Good communication between everyone
- Group work bouncing ideas off one another. Group facilitator was very helpful.
- Really useful to hear all the good ideas and share experiences around the room. Good opportunity to meet/network with key others
- Activity was very organised and useful
- Good to hear a range of policies and procedures from different teams.

### 2. How can primary and secondary care work more effectively together?

	High Level of Interest	Moderate Level of Interest	Low Level of Interest	Highly Useful	Moderately Useful	Less Useful	Well Facilitated	Moderately Well facilitated	Less well Facilitated
Rating	28	12	0	24	9	0	21	11	1

#### Key Comments

- Good to brainstorm and make us think about ways to improve services
- Good to look at alternative solutions
- Awareness of each other's services and joint working
- Good to have the opportunity to engage in discussion with others on this topic
- Activity was very useful in giving opportunity to discuss/share experiences across the region

## **Appendix B – Morning Workshop Feedback Session**

### **The Epilepsy pathway**

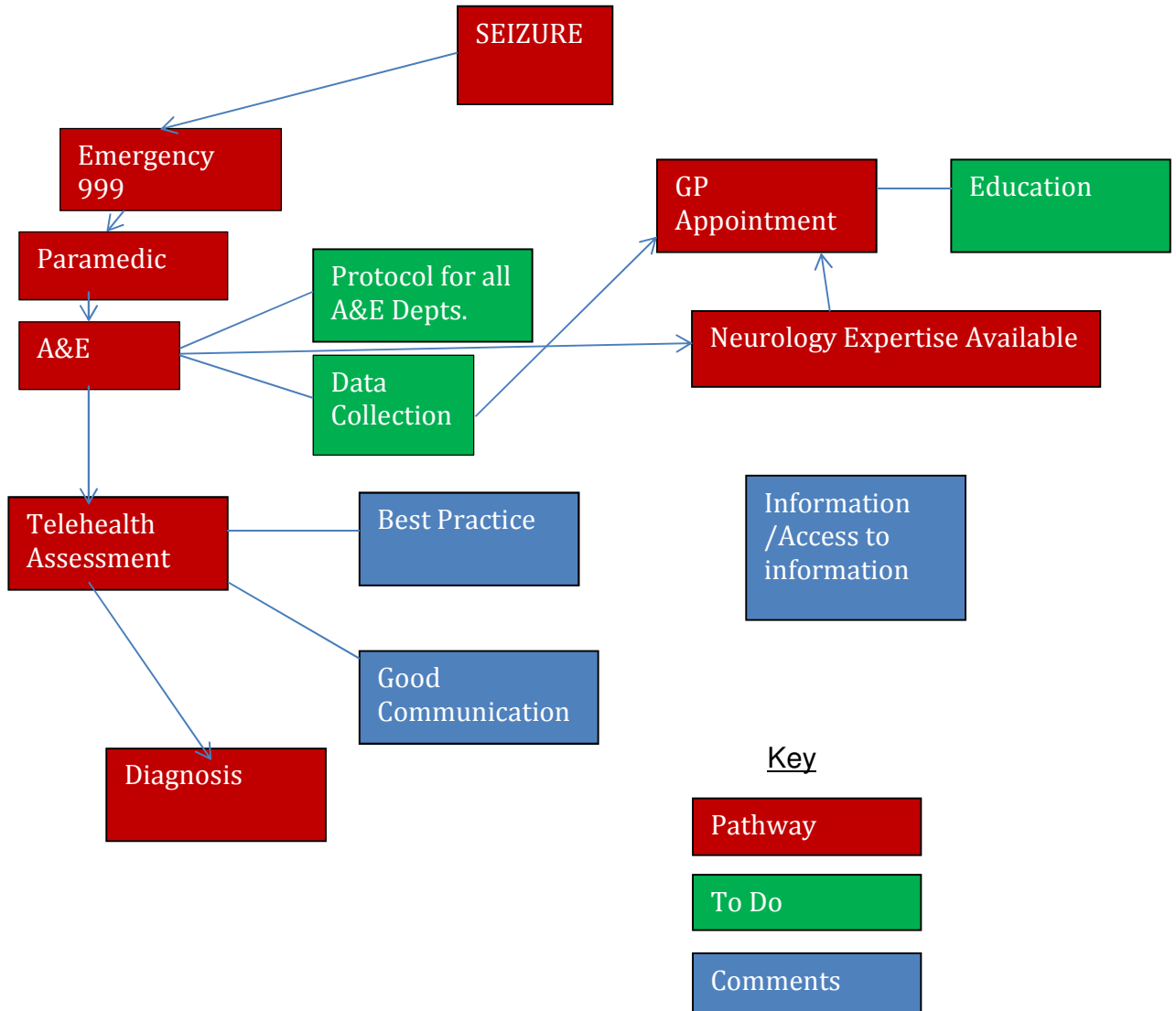
- What should the epilepsy pathway look like?
  - First seizure, diagnosis and treatment
  - Poorly controlled and long term management

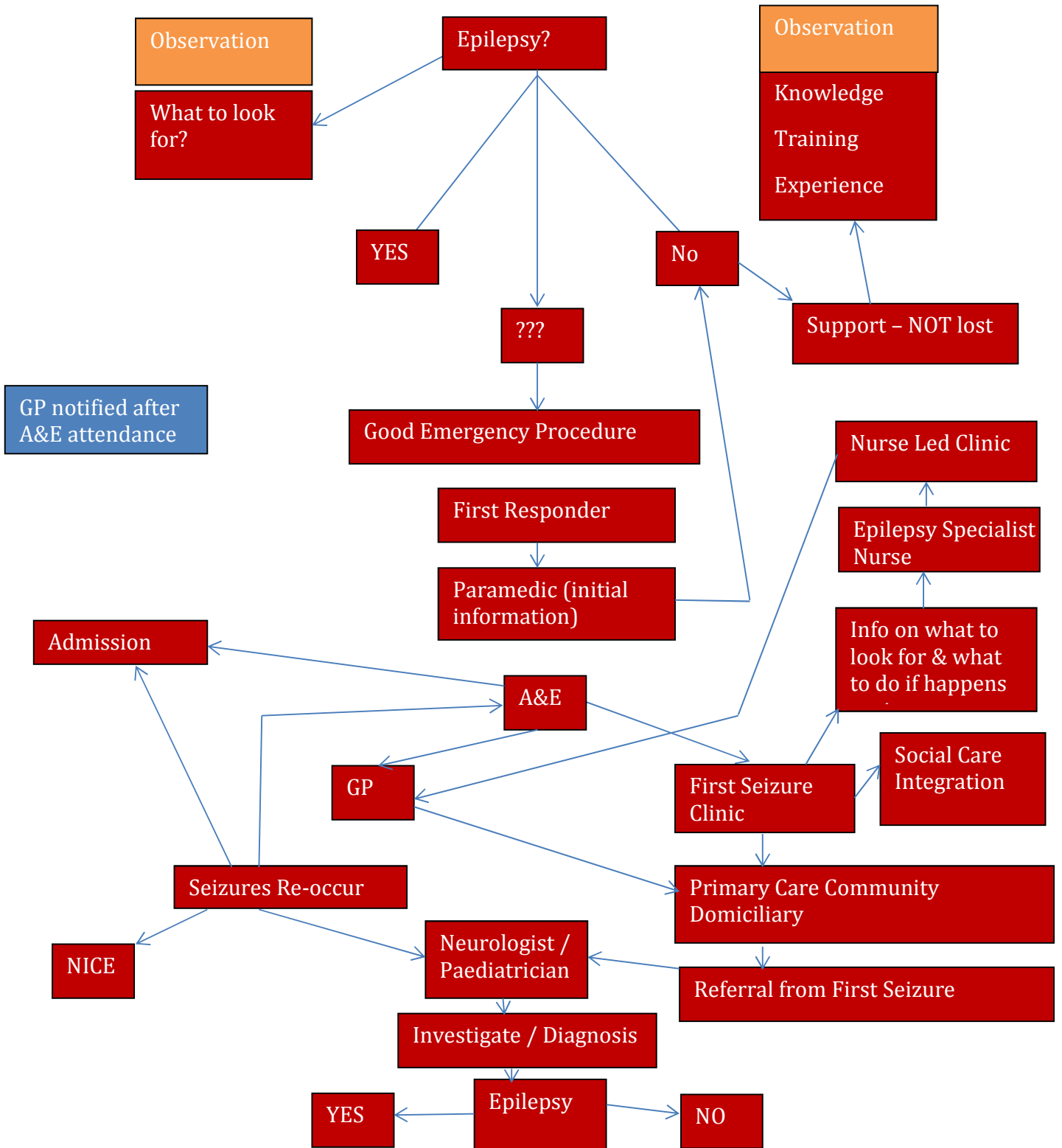
As part of the workshop delegates were asked to draw out the epilepsy pathway. Some tables chose to put theirs in point format. The pathways and comments have been included below. Each page represents feedback from a table.

### **Points fed back to the Room - First seizure, diagnosis to initial treatment and monitoring (Groups A-G)**

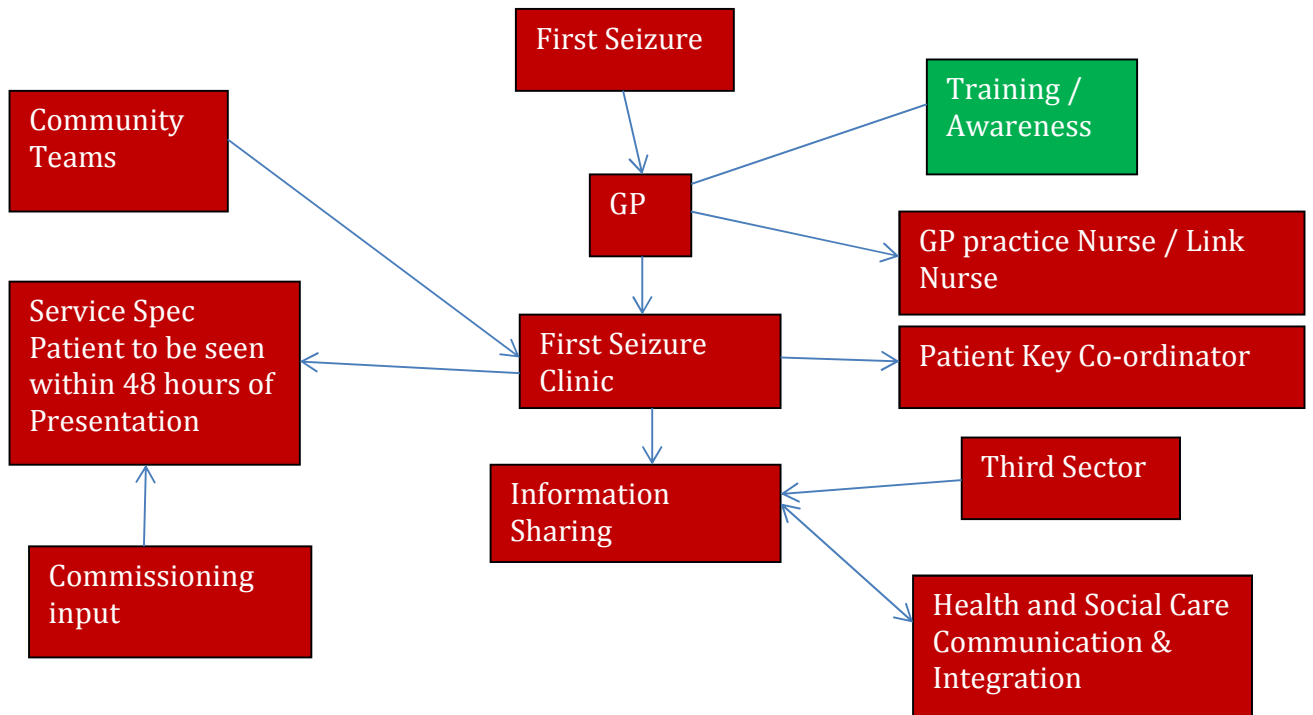
- Joined hub at first seizure/ clinic for assessment/ signposting
- Referral and assignment of “care-coordinator”
- Commissioners’ service-specification for what should be provided
- Timely diagnosis
- Every contact counts and knowledge of key workers.
- GP and A&E/ ambulance/ paramedic protocols required
- Information and support available across pathway from pre-diagnosis
- Diagnostic timely access
- Hospital admissions and awareness of epilepsy diagnosis
- New diagnosis pack – reduce stigma and recognition of disability
- TIA referral form as a template
- Witness checklist and education of paramedics needs to be taken into consideration
- Ambulance capacity to refer and follow-up mechanism
- Public education (TV advertisements)

**First Seizure, Diagnosis and Treatment**





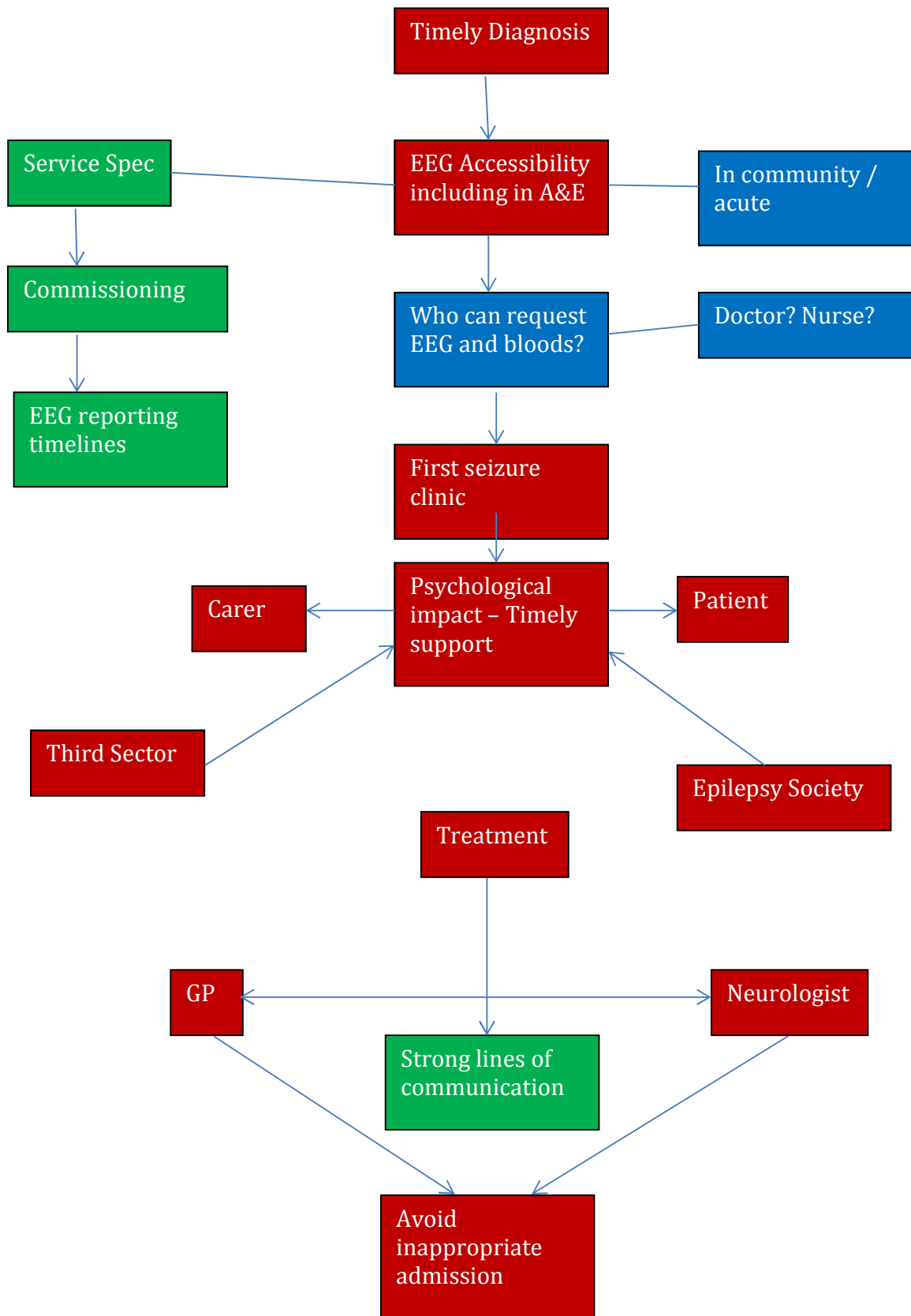
GP notified after A&E attendance



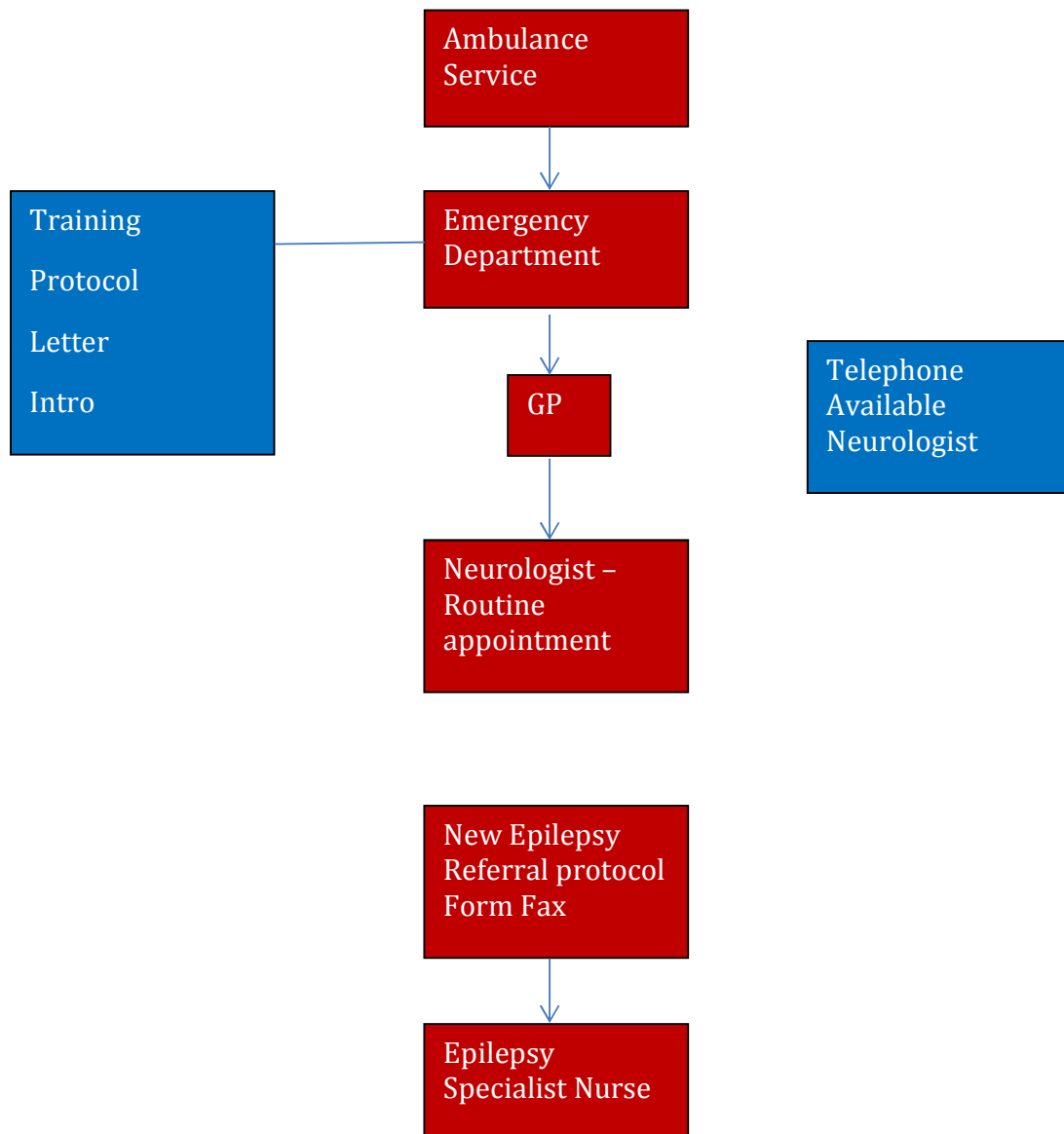
Acute Teams in A&E - ? Pre-Reg

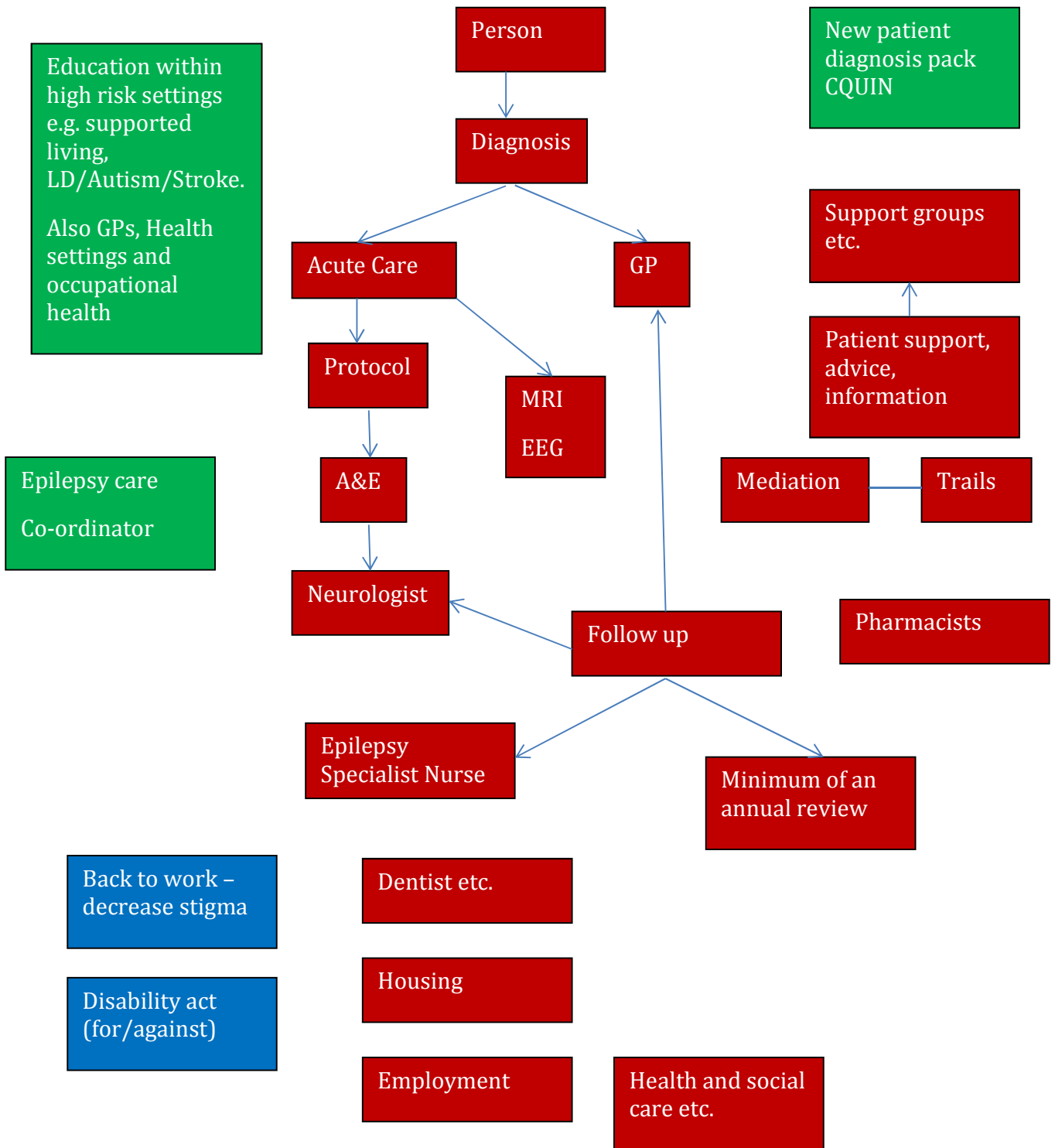
Generalised training and awareness for health and social care workforce

Every contact counts

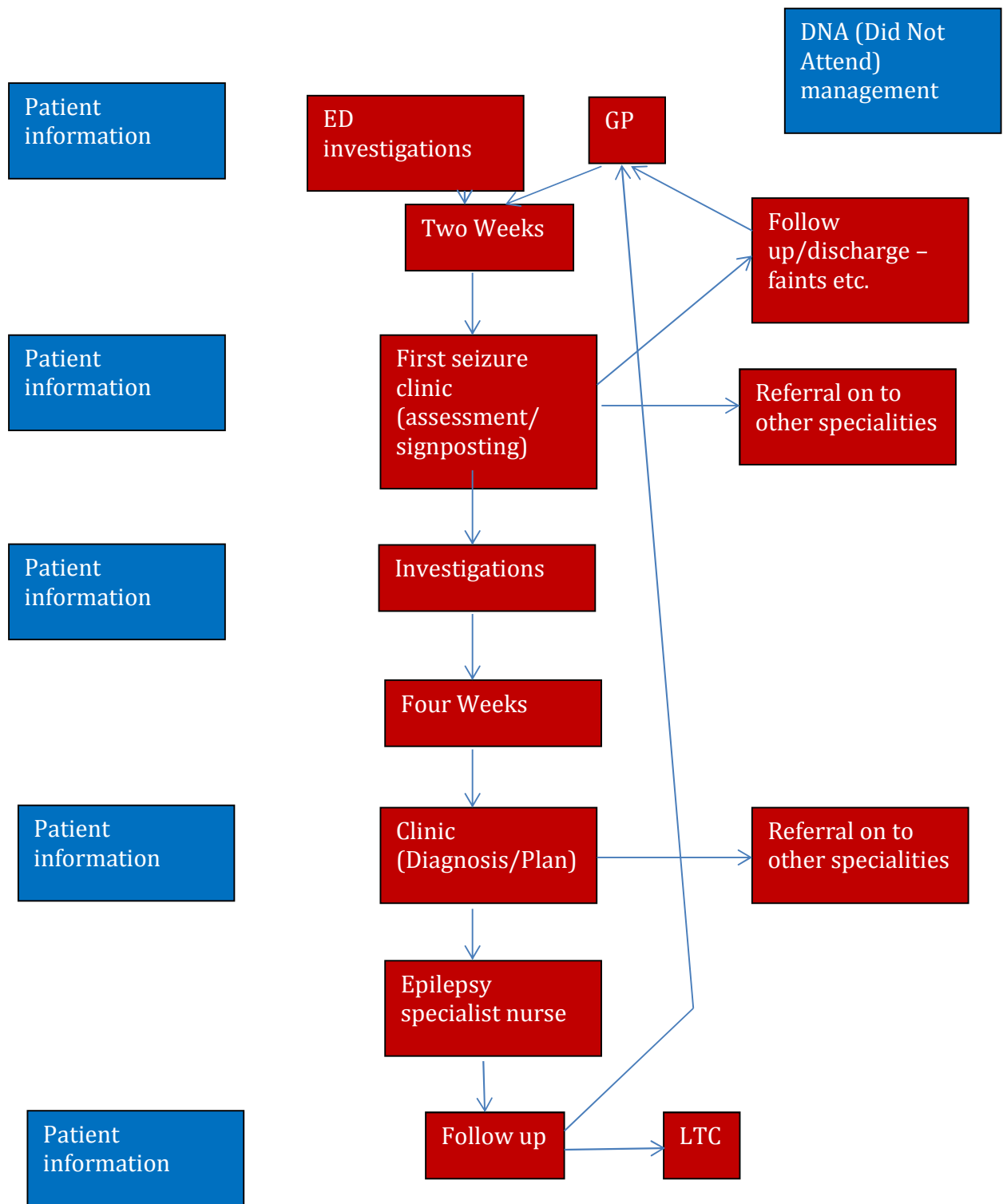




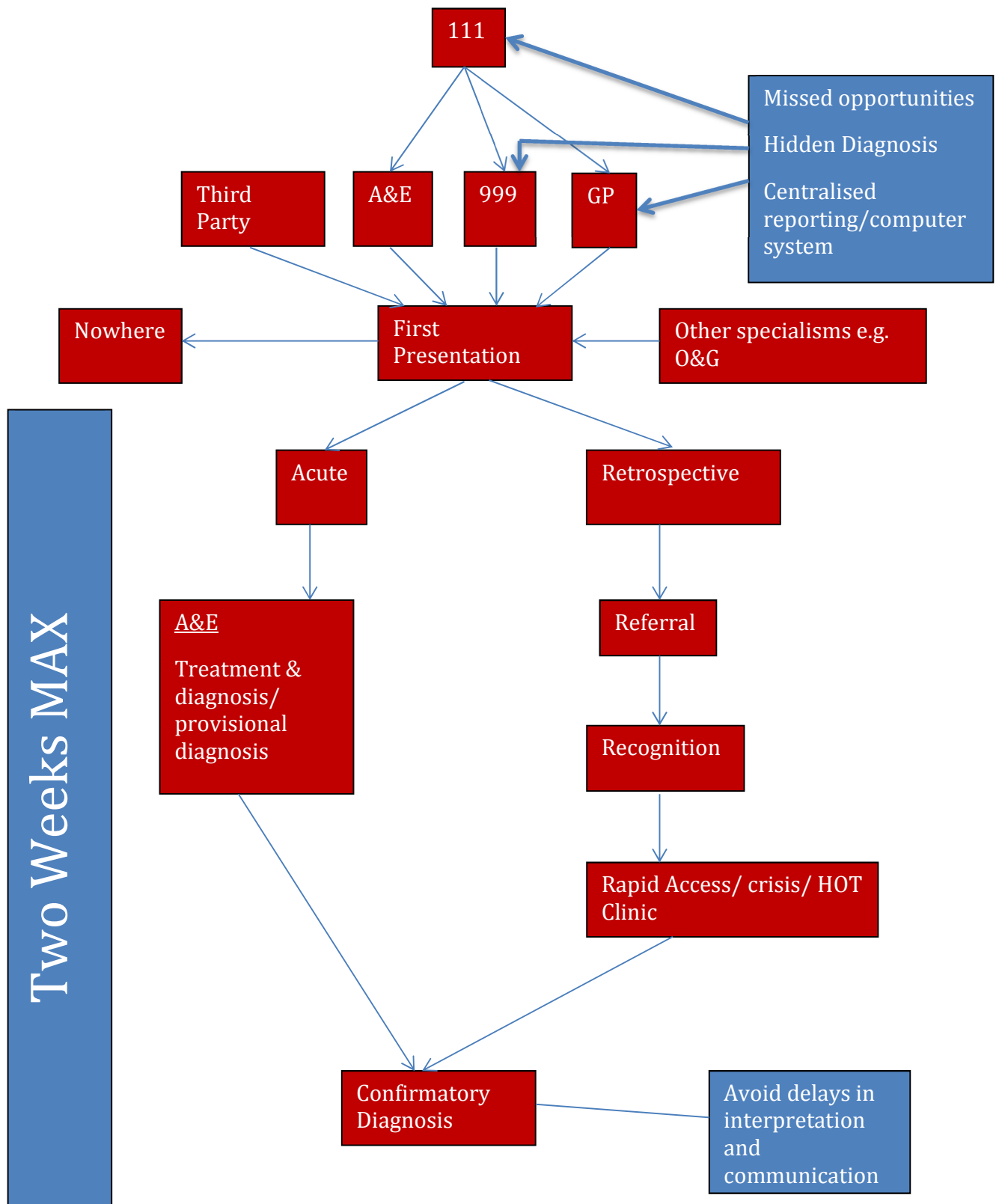












### **First Seizure Points to Consider**

- What happens at the first point of clinical contact
  - Is it the first episode
  - Did the patients/carer know what the signs were
  - ? Patient/public education
- Accurate diagnosis / Presence of a witness / Collaborative history
  - Syncope pathway vs neurology pathway
- Ambulance service
  - Extending ability to refer (such as in falls)
  - Extending access to rapid EEG and diagnostics
  - Refusal of transfer / ambulance attendance rates
- Epilepsy Nurses/ Champions in each area for early;
  - Specialist support
  - Medication advice
  - Recruitment and retention?
- CCG Concern
  - Non elective costs vs elective costs
- Under diagnosis and DNA problems?
  - Quick appointments and diagnostics
  - Minimising number of appointments
  - 'HOT' week where everything 'gets done'

## **First Seizure Pathway - Organisations and Points to Consider**

- Template developed in Norfolk
- Transition workers flag as people come through
  - Transition should have a plan in place for transfer over
- Children's specialist nurse
- Pharmacists
- Ambulance service
  - May attend but not bring the patients in but they should inform the GP
- GPs
  - GPs don't always know about the LD team and services
  - Medication change and prescriptions
  - 10 minute GP appointment don't raise epilepsy
- Voluntary organisations
- Letter from A&E
- Epilepsy Specialist Nurse
  - Epilepsy diagnosis – gives guidance to other health care professionals
  - Initiates link
  - See in between neurologist appointments
  - Epilepsy assessment – poorly controlled
  - Associated LD liaison
- LD - Annual health checks for LD
- Mental health teams – need better relationship
- Neurologist
  - Known refractory epileptic patients should have a longer appointment in the clinic
- Care plan
  - Person centred
  - Copy to all health care professionals who should read it!
- Information not always read
- Letter before appointments
  - Record seizures
  - Meds
  - Diagnosis
  - Health issues
- Parallel systems
  - Not all GPs use Systm1
  - Cant access consultation notes
  - Information sharing
- Knowing how many have epilepsy, LD –inefficient
- Social care knowledge for professionals
  - Quick turn around
- Education/information
- Pregnancy / Elderly
- Poorly controlled because of lifestyle choice
  - SUDEP
  - Medication adherence
- ID cards
- SUDEP – Neurologists and epilepsy specialist nurses to bring up



## **Poorly Controlled Epilepsy and Long Term Management**

### **Points Fed Back to the Room - Long term treatment, refractory epilepsy and emergency admissions for known epileptics (Groups H-M)**

- Medication reviews to ensure treatment effective and supporting medication changes
- Quality of annual health checks
- Pathway – proactive and flexible
- Effective independent advocacy
- Improving/ sharing communication/information
- Link into Children and Families Act for 16-25 better integration
- Accessing personal health budgets
- Aspirations for living
- Co-production
- Person-centred and better communication with carers/families
- Listening to and acting on patient feedback
- Passport care-plans and named point of contact
- Single point of contact and shared patient record
- Nurse prescribing and specialist pharmacists/ review lead
- Epilepsy Nurse – coordinating, monitoring of LTC with community focus
- Local support groups for help and information
- Patient-centred, joined-up primary care approach and good access back into services when needed
- Primary care training and information to increase awareness

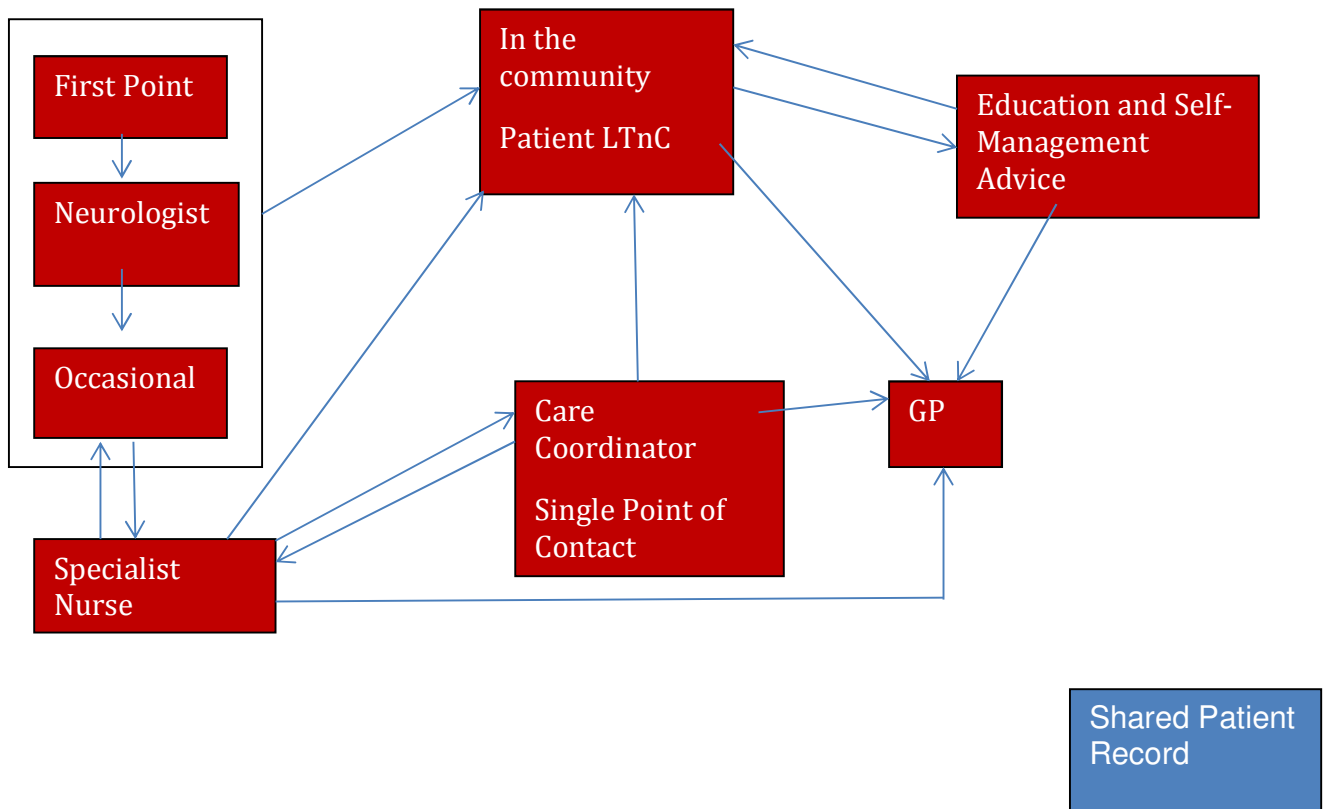
## **Poorly Controlled Epilepsy and Long Term Management**

### Key Points

- CO-ORDINATION
- COMMUNICATION
- PERSON CENTRED APPROACH

### Other Points

- Regular reviews – GP and Neurologist
- Support from epilepsy nurse / prescriber
- Named specialist / co-ordinator
- Speedy and good communication
- Holistic approach
- Education about treatments / options
- Social care involvement
- Quality of life / inclusivity
- Counselling support / IAPT



### **Long Term and Poor Control – Key Principles**

- Point of contact – Epilepsy specialist nurse or community nurse, Practice nurse or GP
  - Annual reviews given to all
- Improved communication between professionals/client/carers/family involved. Passports, linked systems.
- Identify first point of contact in a crisis
  - Ask patients
- Learn from other long term conditions / areas involved around the country
- Try to be realistic about what information you can capture
- Patient feedback to influence pathway
- More epilepsy specialist nurses in post

## **Long Term Management Points**

- Neurological condition-related (i.e. dementia)
- Non-compliant
- Diagnostic overshadowing (mistaking seizure for other cause i.e. behaviour)
- Learning disability
- Drug refractory epilepsy
- ABI
- Never accesses services but have long term problems
- Substance misuse
- Co-morbidity
- Impact on epilepsy
  
- Patient centred
- Joined up services
- Primary care led – GP with specialist interest
- Long term conditions team involvement
- Multidisciplinary appraisal – raising understanding of epilepsy, ongoing training
- Epilepsy nurse specialist team
- Specialist LD community teams – joint health and social
- Appropriate specialist services i.e. drug and alcohol
- Psychology
  
- Family/carer involvement
- Individual H&S – Holistic Plan – Seizure free
- Confident self-management
- Training/information giving/support
  - Families, service users, support staff
  - Work advice, socialising
  
- How to get back into the system again? Via GP?
- GOOD FULL LIFE
- Accessing support services for ongoing advice, review or informal support
- Fully utilise third sector services

## **Long Term and Poorly Controlled Epilepsy Points**

- GPs aware of pathways
- Why the epilepsy is poorly controlled?
  - Wide range of poorly controlled
  - Options for poorly controlled
  - Survey with them
  - Practice nurses in survey
- Communicate
- Non-medical areas
- Access to patients and carers
- GP
- Meds review
- Neurologist
- GP A&E pharmacists
- Transition
- Computer systems
- Psychological
- Care plans and history needed
- Hospital passport
- Person with epilepsy
- Everyone has opportunities for review
- Ability to move if not
- NEAD
- Transient populations
- Pathway for people post diagnosis
- Not reinvent the wheel
- More epilepsy specialist nurses
- Terminology
- Non-compliance of medication

## **Appendix C – Feedback from the afternoon workshop**

### **How can primary and secondary care work more effectively together?**

- What is working well?
- What isn't working well?
- How can we improve it?

### **Key Themes:**

- Joint commissioning, health and social care.
- "Patient delivered care."
- Specialist nurses – as link worker/ care coordinator.
- Cross-over for CYP to adult pathways to ensure smooth transition.
- Joint management clinic (nurse/consultant led).
- Procurement to encourage integration, not competition.
- A&E and neuro alert systems – joined-up working.

### **Feedback - What is working well?**

- Epilepsy specialist nurses
- Closer links between learning disability teams and GP practices
- Integrated team working in learning disability (including social care)
- Community based specialist epilepsy nurse service in Norfolk with good links between GP and consultant
- Ensuring GPs aware of services
- GPs printout/ front sheet with medication/diagnosis
- Good links with GPs in Cambridgeshire
- Learning disability liaison nurses
- Learning disability nurses in hospital
- EPNs – where they exist
- Annual Reviews (especially for learning disability), better uptake for annual health checks and medication reviews but more work needed
- Joint funding for learning disability
- Good links with individual professionals (though not consistent)
- Nurses linking with each other/ networking
- Sharing information
- Hospital passports to highlight patients' needs
- Hospital to community referral
- Third sector involvement
- Transition team
- Some good practice in referrals from acute to community rehab – but its patchy and down to individuals

- Children's epilepsy pathway between primary and secondary care
- Paediatric specialist epilepsy nurse at IHT

### **What is not working so well?**

- Epilepsy nurse role is very secondary care focused
- Access to neurologist – multiple seizures before
- Not sharing information between electronic systems
- Different electronic systems
- Information taking time to get to all involved or lack of, inconsistency
- Joined-up A&E and neurology
- A&E changing medication without consultation with community teams
- Newer or generic prescribing rather than particular brand of medication
- Communication from secondary care to primary care – e.g. medication changes not seen or actioned by GPs
- Community to hospital referral
- Lack of clarity for pathway and lack of funding
- Lack of specialist EPNs
- Communication and data
- Lack of engagement
- Lack of integration
- Disconnected and disjointed commissioning leads to silo working
- Lack of pathway
- Not commissioning service for epilepsy patients
- Time gap between appointments
- Transition – child to adult (waiting list for adult services)
- Access to respite facilities
- Missed appointments (often due to memory issues/ seizures) – especially when leading to discharge

### **How can things be improved?**

- A&E emergency protocol to be introduced
- Better support to A&E staff
- A&E practitioner with special interest in neurology/ alert system to neurologist/ CNS
- A&E: video link to neurologist, referral system into epilepsy nurse of seizure break through, emergency care plan flag on patient name 111, ambulance/ paramedic to contact hospital if on alert system
- Better maternity primary/ secondary support for women with epilepsy
- Time gap: education/ wide availability of diagnostics – give GPs rapid access to EEG/MRI for 'seizure protocol'



- Uncouple diagnostics from first outpatients
- More EPNs within community and responsive to need
- Community neurology provision
- Empathy
- Strong advocacy and advocacy for vulnerable groups to ensure voices being heard
- “Expert patients”
- Patient and families at the centre:
  - Continual service improvement
  - Patient experience led
  - Feedback
  - Outcome focused based on patient feedback and refocus resources
  - Expert patient and families
- Good relationship with neurologist
- Integration with social care
- Quality standards in epilepsy care, throughout the country rather than just a few areas of excellence – develop hospital protocol
- Implement South Thanet model
- More investment in specialist nurses
- Raise profile of epilepsy to increase awareness – public promotion through adverts/campaigns, schools?
- More epilepsy training – tiered, e-learning package, training delivered by those with epilepsy, include carers/care homes
- More opportunities to network and share good practice
- Collate best practice to share
- More joined up training days to understand pressures and build links thus improving services
- Use GP education training events to promote other services and share learning
- CCG/national register of GPs with special interests
- Care co-ordinator (most relevant professional to primary need)/ more epilepsy specialist nurses
- Holistic/ integrated model of care
- Single point of contact with triage need
- Named lead in each GP surgery for neurology
- Clear pathways – map of whole pathway:
  - Who does what?
  - Who and how to refer
  - Names and contacts
  - kept updated

- Carer/support groups in GP practices to link between GP and community and raise awareness
- Patient forums to strengthen patients' voice (such as Epilepsy Action Group in Stanford)
- Shared care and community pharmacists – increase awareness of branding implications for medication
- Continuity in prescription when a person goes into hospital
- Shared person-centred care records
- Communication:
  - ? Champion in each locality
  - Relevant clinicians at commissioning meetings
  - attaching students to services at early stage
- Incentivise service to help free up time/ broaden experience
- Remove access criteria that are restrictive
- Electronic communication for primary/secondary interface – letters via email
- One electronic system
- Missed appointments: phone/tele-comms/home visits and outreach and reminders for appointments – consideration of personal circumstances
- Local audits to look at when management plans reviewed, when medications reviewed and when rescue medications have been used
- Increased awareness & referrals and less capacity emphasises need for new services (80-85% capacity)
- Lobby for funding needs (using same approach as dementia/COPD/cancer)
- Collaborative working to plan strategically for more prevention of items such as COPD, cancer, CVD, to allow more resource available for smaller, less preventative areas like epilepsy
- Engaging CCG quality teams – monitoring against epilepsy standards, primary/secondary care
- Find ways to commission that encourage join working
- Funding streams for providers
- Incentivising discharge from provider to community services
- Improve perception:
  - time to spend to go through everything, look at whole picture
  - take time to listen
  - build up trust
  - introduce to nurse by neurologist
  - transition with/from consultant to nurse
- Transition clinic – paediatric nurses and adult – nurse led, prepare documentation ahead of clinic – before seeing consultants
- Consistency around transition ages and handover times
- Consider national work on transition and incorporate into SCN work on epilepsy

## **Appendix D – Delegate Contact List**

<b>Surname</b>	<b>First Name</b>	<b>Job Title</b>	<b>Company</b>	<b>Email</b>
Anderson	Tracy	Parent Carer	Patient Representative	tracyanderson70@virginmedia.com
Anderton	Shelley		Anglia Community Enterprise	sanderton@nhs.net
Ashton	Juliet	Sapphire Nurse Consultant for Epilepsy Commissioning	Neurological Commissioning Support	juliet.ashton@csupport.org.uk
Baker	Sheila	Vice Chair	Epilepsy Action Colchester	sheilabaker1963@yahoo.co.uk
Bateman	David	National Clinical Director, Neurology	NHS England	
Baxter	Naomi	Epilepsy Specialist Nurse	The Ipswich Hospital NHS Trust	naomi.baxter@ipswichhospital.nhs.uk
Bigg	Karen	Volunteer	Epilepsy Society	
Bindemann	Neil	Executive Director	Primary Care Neurology Society	neil.bindemann@p-cns.org.uk
Bradshaw	Jane	Lead Nurse Specialist in Neurology	Norfolk Community Health & Care NHS Trust	Jane.Bradshaw@nchc.nhs.uk
Brindle	Theresa	Community Occupational Therapist	South Essex Partnership University NHS Foundation Trust	theresa.brindle@sept.nhr.uk
Brittain	Janet	Primary Care Family Carer Adviser	Suffolk Family Carers	Janet.Brittain@suffolkfamilycarers.org
Burton	Wendy	Epilepsy Specialist Nurse	The Ipswich Hospital NHS Trust	wendy.burton@ipswichhospital.nhs.uk
Casey	Rachel	Associate GP	West Suffolk Clinical Commissioning Group	rachel.casey@nhs.net
Catchpole	Jill	Commissioning Development Manager	Herts Valley/East and North Herts CCG	gillian.catchpole@enhertscg.nhs.uk
Chapman	Kadie	service user/carers	Patient Representative	kadie@dial.pipex.com
Cheeseman	Mark	Specialist Pharmacist	Cambridgeshire and Peterborough CCG	mark.cheeseman@nhs.net
Clarke	Matt	PA to Christian Raphael	Inclusion East CIC	matthew.clark70@ntlworld.com
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Collins	Margaret	Parent carer	Patient Representative	

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