Manchester, Lancashire and South Cumbria
Strategic Clinical Networks and Senate

Mental Health, Dementia
Neurological Conditions Summit

Report with Emerging Priorities

Thursday 26 September 2013
De Vere Whites Hotel, Reebok Stadium, Bolton, BL6 6SF


Contents:



Executive Summary

The Summit provided an opportunty for our partners, patients, carers and members of the public to come together and help us to set our priorities for the next three years. The three national directors: Dr Geraldine Strathdee (Mental Health), Professor Alistair Burns (Dementia) and Dr David Bateman (Neurological Conditions) outlined the national priorities. The SCN clinical leads led on the round table discussions with the delegates to identify issues, challenges and ambitions and emerging priorities. These include:

Issues, challenges and ambitions

Mental Health

- Inspire staff working in mental health services to have good clinically integrated pathways that are mainstreamed into NHS systems and in partnership with different sectors, including the voluntary sector, patients and carers acting as a seamless process.
- Improve early diagnosis identification and prevention at primary care level - treating mental health problems at an early stage can help prevent physical problems by counselling, support groups or signposting to other services or agencies.
- Need more evidence based treatments e.g. psychological therapies
- Opportunity for SCN to prioritise work on CAMHS to tackle unacceptable variations in access; to develop alternatives to in-patient care; develop care pathways throughout the CAMHS services .

Dementia:

- Develop dementia friendly communities where people of all ages with dementia are looked after and cared for when they need it. This would include planning ahead, working with care home liaison teams which need to be expanded across the footprint,
- Provide continuing support with the help of charitable and voluntary organisations.
- Identify people with dementia and where they are, e.g. own home, care home, hospital
- Lack of pathway makes it difficult for staff to secure services that the patient needs including the provision of experienced/dedicated staff.
- Engaging with people where they are. For example the needs of BME individuals don't always fit with care pathways.
- Support people with comorbid illness and avoid the compartmentalisation that occurs within/across services

Neurological Conditions:

- Develop the system as holistic model e.g. using a specialist nurse model within the supporting structure.
- Timely review / on-going support – link to decision on discharging of patients from services. Doesn't have to be medical support.
- Funding streams make it difficult to integrate services and priorities. Need ownership by lead clinicians.
- Requires a strategic partnership working to stop the pull between DGHs and specialist services and a buy-in from all key partners. Need to involve local authorities, third sector providers and charitable organisations.

Learning Disabilities:

- All care pathways should be tested to ascertain if they are fit for LD patients. This practice could benefit general population.
- 'LD condition' seems to override any existing pathways of care – "patients seen as different therefore do not get optimal care". Need to make reasonable adjustments for LD.
- Lack of continuity e.g. local interpretation of 'health passports'.
- Physical Intervention – lack of guidance no sharing of good practice. Lack of preventative measures before physical intervention is used.
- East Lancashire has good links with IAPT but difficulty with single point of access.
- Having meaningful data on an Area Team level on mental health, dementia and neurological conditions was a cross cutting theme.
- The ambition to have a single point of access for data and information.

Emerging priorities and themes

Emerging prioities for the SCN have been allocated into themes to be considered along with national prioirites and data available for the footprint. There was an overarching theme focusing on values (dignity and respect for all) that the delegates wanted the SCN to abide by. These included:

- SCN work is underpinned by enhancing the quality of life for patients and carers.

- Carers and patients be respected and involved in the work of SCN.
- The SCN promote the value to their partners including joint partnership work with other networks and agencies working towards integrating the physical and mental health pathways.
- SCN and partners work towards ensuring that everyone enjoys physical safety and feels secure: free from physical and emotional abuse, harassment, neglect and self-harm; protected from avoidable harm, disease and injuries.

Mental Health Pathways:

Develop pathway for acute, unplanned and emergency care; suicide prevention, develop integrated pathways from primary through to tertiary care; develop integrated pathway for people with schizophrenia, psychosis and personality disorder; review implementation and impact of IAPT; support early diagnosis of mental health and develop integrated pathway for people with anorexia.

Dementia Pathways:

Access to accurate and timely diagnosis with post-diagnostic support; develop prevention strategies and screening programmes; review access to services for younger people with dementia; improve crisis management to avoid unnecessary hospital admission; develop care home staff and visiting healthcare staff to enable optimum care for people with dementia; monitor and reduce the use of anti-psychotics for people with dementia.

Neurological Conditions Pathway:

Improve access to specialist care and investigations, for people presenting at DGH to avoid unnecessary admission and reduce LOS; improving management of epilepsy; develop a neurosciences strategy which facilitates the development of integrated pathways; improve access to and quality of neuro-rehabilitation and re-ablement including return to work; supporting people to manage their neurological condition to avoid crisis; review and develop co-ordinated pain management services.

Learning Disabilities Pathways:

Reducing premature death in people with a learning disability; monitor and reduce where possible the use of anti-psychotics for people with LD; review current practice and pathways around the use of physical and / or chemical restraint; ensure that people with LD have equitable access to health and social care services in line with general population; review access to psychology services; people with LD have an accurate and timely diagnosis of their condition.

Cross Cutting Priorities and Themes

Coordinate/produce accessible information and data on mental health, dementia, learning disabilities and neurological conditions that is understandable over the footprint and Area Teams so that it can be used to improve patient care and improvement in measuring user led outcomes leading to changes in the service provision; achieve parity of esteem between mental health and physical health care needs; promote and contribute to creating friendly communities (dementia, mental health, Neurological conditions & LD); review access to services for prisoners focusing on offender health; establish data systems to understand mortality and activity and raising awareness, promoting well-being and improving access to services in partnership with public health.

Please note: SCN Clinical Director , Clinical Leads and Area Team Medical Directors will advise the SCN on the ranking (low, medium and high) and which of the emerging priorities will be taken forward in the first, second and third year.

Introduction
Dr Peter Elton, SCN Clinical Director

Dr Peter Elton welcomed the delegates to the Summit and emphasised the important role of clinical leads to help colleagues and partners to set priorities with SCN partners. The SCN purpose is to improve clinical areas of work within mental health, dementia, learning disabilities and neurological conditions through the development of policy, structure and culture. This would build on major changes in the past such as the transfer of much mental health provision from institutional care to community care accompanied by partnership working including clinicians. For dementia, there has been a drive to reduce anti-psychotic prescribing. For neurological conditions, there have been a number of new treatments.

The new network offers an opportunity to bring together clinicians and other stakeholders to make a difference to patients and people within the SCN footprint. He stated that the Summit is a good opportunity for everyone to debate ideas, explore issues, challenges and ambitions including setting out what they feel are the priorities the SCN should embark on in the coming years. Dr Elton introduced the delegates to the new clinical leads: Dr Arokia Antonysamy for Mental Health; Dr Kenneth Wood for Dementia; Dr Mark Kellett for neurological conditions and Dr Sandeep Ranote for CAHMS.

There are a lot of issues that relate to individual specialties and priorities in individual areas plus cross cutting areas which relate to all conditions or many conditions. Some of these are covered in other parts of the Network from cardiovascular to maternity. Dr Elton indicated that he was pleased that all three of the national NHS England Clinical Directors were speaking and thanked them in advance for their time. He introduced the speakers: Janet Ratcliffe, Professor Alistair Burns, Dr David Bateman and Dr Geraldine Strathdee, OBE.

Setting the scene:
Janet Ratcliffe, Associate Director, SCN and Senate.

Janet started by passionately sharing her own personal experience of her family. She reminded the delegates the importance of the NHS and at some stage of our lives we will be dependent on the services and highlighted the importance of working together to improve outcomes for patients. Janet went on to highlight the following in her presentation:

The SCN and Senate are led by a Clinical Director and three Medical Directors. They are supported by a small team, with strong involvement from patients, carers and members of the public. The SCN and Senate contribute towards the delivery of the *NHS England Mandate* and *NHS Outcomes Framework* domains and cross cutting areas of work.

SCN aim is to improve quality, improve health outcomes and address unacceptable variations in health and care services. This will be achieved by providing strategic direction, enabling clinical leadership and bringing the voice of service users, carer's and the public to shape evidence based pathways and models of integrated care for our populations.

The SCN can help commissioners and providers to meet national and local priorities by:

- providing support and leadership through clinical consensus to reduce unwarranted variations in services in relation to mental health, dementia and neurological conditions; coordinating the expertise of commissioners, providers, academic health science networks, health and wellbeing boards to overcome challenges faced and highlighted in the outcomes framework domain areas;
- encouraging innovation and spreading best practice;
- offering support and assurance to commissioners to support their core purpose of quality improvement as outlined in the mandate and outcomes framework;
- meaningful engagement with local patients, carers and members of the public affected by mental health, dementia, neurological conditions and by advancing equality and tackling health inequalities.

Janet went on to outline the Senate aim which is to be the conscience and guiding intelligence for strategic service change across Greater Manchester, Lancashire and South Cumbria. The Senate will:

- Take an overview of the totality of health and care across the region and support commissioners by

providing a source of clinical leadership and strategic advice on how services should be designed to provide the best overall care and outcomes for patients.

- Prioritise large scale reconfiguration for example, regional change programmes, hospital reconfiguration and redesign of services that impact upon a number of providers and that span a wide geographical area.
- Comprise of a Senate Assembly and Senate Council, led by an independent Senate Chair. The Assembly will be called upon to consider topics that are defined by commissioners to provide advice, expertise and information. The Council will perform business functions; taking the views and perspectives of the Assembly and formulating advice, recommendations, guidelines and statements of best practice.

Professor Alistair Burns
National Clinical Director for Dementia

Professor Burns went through his PowerPoint presentation highlighting the drivers from the dementia area work timeline which included: National Dementia Strategy (Feb 2009); Antipsychotics Report "Time for Action" (Nov 2009); Public Accounts Committee (Jan 2010); National Clinical Director (NCD) appointed (DH) in Feb 2010. He further added the important events such as the General Election May 2010; Prime Minister's Challenge March 2012 and the NHS England launched in April 2013. Professor Burns went on to explain the dementia "I" statements from a patient perspective. For example

- I was diagnosed in a timely way
- I know what I can do to help myself and who else can help me
- Those around me are well supported and are in good health
- I get the treatment and support, which are best for my dementia, and my life
- I feel included as part of society
- I understand so I make good decisions and provide for future decision making
- I am treated with dignity and respect
- I am confident my end of life wishes will be respected.
- I can expect a good death.
- I know how to participate in research

Professor Burns outlined some of the current issues that the SCN may wish to undertake. For example:

- Awareness of dementia is at its highest
- Diagnosis rate
- Early vs. timely diagnosis: benefits
- Support is the key: need a way of measuring it
- Recast dementia as a Long term condition managed in primary care
- Population screening not appropriate
- Primary care in charge
- Dementia rarely travels alone
- Primary care memory services
- Read codes
- Brain Imaging
- Prevention

He went on to state that the focus should be on post diagnostic support and the numbers will follow. He encouraged people and the SCN to work with others to design and implement a comprehensive improvement plan, which aims to:

- improve access promote timely diagnosis
- improve pathways to support people seeking help, and for post-diagnosis support
- improve systems to capture diagnosis and to follow up after diagnosis

"Professor Burns – as usual very inspiring; Dr Strathdee – thought provoking and inspiring; Dr Bateman – again thought provoking need to work closer with Mental Health services" (Brigid Flanagan, CMHT Manager, Pennine Care NHS Foundation Trust)

He explained ways to improve access covering the following areas: timely diagnosis through communication strategy and nurturing 'dementia champions' and experts in General Practice; improve pathways, to support people seeking help, and for post-diagnosis support focusing on reviewing standards of access; pathways and patient experience; to capture diagnosis, and to follow up after diagnosis by understanding local prevalence and establishing realistic trajectories for improvement, using Dementia Prevalence Calculator and encouraged delegates to use system levers such as DES, LES, CQUIN.

Dr David Bateman
National Clinical Director for Neurological Conditions

Dr Bateman started his presentation by explaining why neurology was important and provided the delegates with some neurology statistics:

- 80,000 in 500k (1in 6) are affected by neurology
- 8000 disabled by their neuro condition
- 3000 require help with ADL
- Neurological conditions are the most common causes of serious disability and have a major, but often unrecognised, impact on health and social services.

Dr Bateman went on to set the scene of where professionals were and made reference to two main reports: Services for People with Neurological Conditions (National Audit Office) and Local Adult Neurology Services for the Next Decade (Royal College of Physicians). The reports suggested:

- Expansion of local DGH services
- Change in emphasis from scheduled to emergency care
- Better organised care for LTC
- Better local planning using a network approach
- 31% increase in neurology admissions
- 32% increase in emergency neurology admissions
- 14 % PD, MS & MND patients readmitted within 28 days
- Variability in admission rates for same conditions 5x

Dr Bateman stated that there were a number of problems associated with neurology:

- Poor care
- Poor access to care
- Poor value for money
- Lack of expert staff
- Lack of clear pathways of care

He went on to outline a number of issues highlighted by the NAO report: that the local commissioners were not held to account; quality of care has worsened since NSF; Poor access to diagnosis; emergencies do not get specialised care and specialist nurses poorly appreciated.

Dr Bateman also took the opportunity to refer to the findings of the PAC Committee report including lack of national & local leadership; lack of data to measure outcomes; variable quality of care; poor integration of health & social care; poor coordination of individual care and NICE will not cover all neurology conditions. The Committee recommended that there should be:

- Clear accountability
- Outcomes
- Standards
- Collaborative CCG commissioning
- Specific reference to SCN role

Involving patients was also highlighted by Dr Bateman. He stated that patients basically wanted a local service, quick and accurate diagnosis, rapid access to expert support, support to self-manage their condition and reduced admissions and LOS.

Dr Bateman indicated that acute neurology services were under the radar. For example:

- 1 : 10 admissions – Neurological
- 3rd most frequent specialty after cardiology & respiratory
- Current process : triage to general physician
- Inappropriate care due to unavailability of local neurologist
- Delay in referral & misdiagnosis
- Increased LOS
- Inappropriate use of investigations
- Great concern but no champion! (charity or GP)
- 41% DGH no policy for acute seizure care
- 35% DGH no policy for status epilepticus
- 10% mortality
- 48% DGH no policy of further referral
- 66% known epilepsy
- 3.5% admitted to a neurology ward

"All speakers were very interesting and informative. More information on next steps would have been welcome (Catherine Tickle, Joint Commissioning Manager, NHS Bury CCG)"

Dr Geraldine Strathdee, OBE
National Clinical Director for Mental Health

Dr Strathdee outlined the outcomes the NHS was trying to achieve and what the national priorities are. She provided a background to mental health, outlining the national strategy "No Health Without Mental Health"; NHS Mandate and emerging priorities across the country. She was very keen to find out how she could help and what can her and the other national directors learn from the delegates. She stated that the national directors needed the leadership, expertise and the drive from people within the room.

Dr Strathdee highlighted the mental health conditions in: children stating that one in five children is affected by mental health and 50 per cent are bullied which often leads to depression, low self-esteem and suicide. With regards to the workforce: one in six workers at one time are affected and 5.6 million workdays are lost a year due to mental health.

Dementia in senior citizens is very common (5 per cent over 65's ten to 20 per cent over 80). She also highlighted the challenges facing different cultures and communities in the way they see patients with mental health. For example there are over 300 spoken languages in the UK and we know there is over representation of black people in acute inpatient and forensic care.

> "incredibly impressive event both in terms of the quality of speakers and the depth and breadth of delegates (Warren Heppolette, Director of Operations & Delivery)"
> NHS England (Greater Manchester)

She mentioned primary and acute care (30 to 50 per cent of their work load due to mental health) with ICD conditions such as depression and anxiety, substance misuse and children's conditions with an impact of premature mortality: 15-25 years; quality of life in LTCs; recovery from illness, patient safety and patient experience are having an impact. The other prevalence she mentioned were: prisoners and offenders with ADHD, ASD, depression, substance misuse and PD leading to premature mortality. On specialist mental health services prevalence she mentioned psychosis, neuro-developmental, personality disorders and complex multi axial. The impact due to these conditions included premature mortality, recovery from illness, quality of life, patient experience and safety.

She went on to highlight the issues around depression and the importance of early intervention and prevention. Dr Strathdee outlined the importance of partnership work with the patients to achieve positive outcomes. She highlighted that patients wanted to be safe; everything that we do needed to be effective for the patient and patients having a good experience through accessibility to information and treatment.

In addition to the above she also highlighted: the importance of parity and what it meant in practice via two examples:

1) The economic impact and how mental health loses out in the NHS (document from London School of Economics).

2) How mental health has among the most clinically and cost effective treatments of any sector but access is low and a post code lottery.

Dr Strathdee stated the following emerging system priorities based on value, equalities and shared learning.

1.	CCG building capacity and capability in mental health leadership
2.	Primary Care Mental Health
3.	Care of people with psychosis: "industrialising" improvement
4.	The acute care pathway and suicide prevention
5.	Integrated physical and mental health pathway
6.	Mental health intelligence informatics network programme.

Dr Strathdee concluded by highlighting the CCG GP mental health leadership programme, route map for mental health strategy and stating economical and financial benefits as well as the benefits for the patients.

Mr Maqsood Ahmad OBE Patients, Carers and Public Engagement

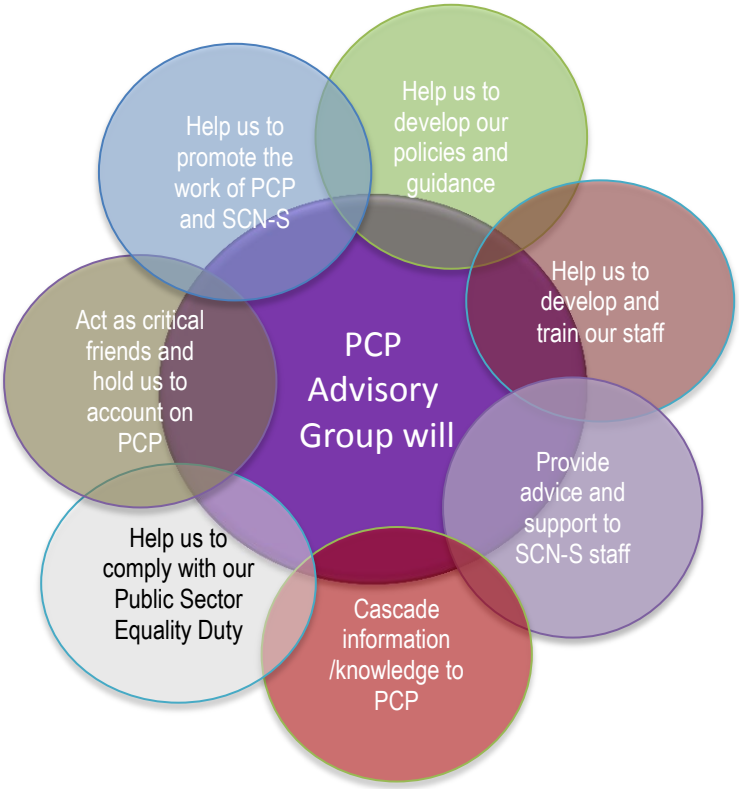
Mr Ahmad started his presentation by providing delegates the SCN and Senate commitment to meaningful involvement of patients, carers and member of the public. He went on to outline the progress made since the establishment of SCN in April 2013:

- Mapped out the patient, carers and voluntary sector organisations within our footprint.
- Established a PCP Involvement Advisory Group. First meeting held on 8 July 2013.
- Established staff PCP Involvement Champions Network - meet on a monthly basis and link to national SCN PCP Networks and PCP Advisory Group.
- Working with Advisory group to develop our PCP Engagement Policy and staff development day.
- Adopted and started to implement our four key commitments on PCP involvement in areas of work.

Mr Ahmad explained the role of the SCN Advisory Group (outlined in diagram opposite) and explained that the advisory group is part of SCN and senate overall engagement policy. The PCP Advisory group will help the SCN and Senate staff to embed PCP into all the SCN areas of work including within the new structure which are currently being developed.

"Excellent opportunity to network, all at the table were included and contributed. Thank you for the opportunity to shape future provision. I look forward to further work and information (Gillian Drummond, Dementia Quality Lead, Greater Manchester Mental Health NHS Foundation Trust)"

The PCP Advisory Group has suggested that the SCN and Senate: place "carers" as part of their work; undertake partnership approach between SCN staff /clinicians, patients, carers and voluntary sector when developing projects/pathways; reminded the SCN not to work in silos.



Mr Ahmad covered the four SCN and senate commitments which they have developed and started to implement with the help of their partners, patients, carers and members of the public.

He also went on to highlight number of challenges such as involving young people, people with learning disabilities and visible minority groups. He informed the delegates they will be involving people with learning disabilities and young people from the footprint to ask them on how they would like to be involved in the work of SCN and Senate.

Progress has been made on involving visible minority groups and he was pleased with the number of carers and patients in attendance today but recognised a lot more is still needed to be done to ensure we have a good representation from all the protected characteristics under the Equality Act 2010 involved in SCN and Senate work.

Identifying issues, challenges, ambitions & priorities



Kenneth Wood Arokia Antonysamy Mark Kellett

The SCN clinical leads: Dr Kenneth Wood (Dementia), Dr Arokia Antonysamy (Mental Health) and Dr Mark Kellett (Neurological Conditions) led on the round table discussions and provided delegates with their own observations and thoughts in the afternoon session.

Dr Kenneth Wood introduced the first round table discussions by outlining how the SCN has over the last few months gathered information based on national priorities set by the national directors, data and meetings with local commissioners and providers. He indicated that this was another opportunity to hear the delegate's views and what they saw as priorities for the footprint. He asked delegates to identify issues, challenges and ambition from their perspective in mental health, dementia, neurological conditions and learning disabilities.

Mental Health: issues, challenges and ambitions in additions to the ones highlighted in the summary section include:

- Opportunity to work in partnership with public health and develop education processes for carers and patients.
- Opportunity to share and learn from good practice from others within the footprint and beyond Network including promoting and championing innovation and roll out of best practice.
- Ambition should be to get everyone involved and have a shared vision for the whole of MH and build a culture where we have greater input from service users to monitor progress.
- Opportunity to work with charitable and third sector and overcome perception that the "Third Sector seen as cheap solution". An opportunity to work in partnership across the footprint to have a common definition and understanding of what we mean by a "mental health patient".
- Opportunity to work with partners to promote MH issues via education and training across the footprint for all those working on mental health. For example raising awareness in schools, communities etc
- CAMHS: strategic clinical networks are able to prioritise work on CAMHS clinical and service pathways? There are unacceptable variations around access; alternatives to in-patient care are generally not available; there is a need to further develop care pathways throughout the CAMHS framework, and across agencies, in particular, the transition from tier 3 to tier 4.
- Equity of access to information for non-English speaking groups using CAMHS services.

- Opportunity to work with GP's to educate and increase their awareness and the importance of identifying problems early and move away from a tablet giving culture as a solution to everything.
- Leadership or capacity in the system is a challenge and experience in developing outcomes.
- Opportunity to work together with NHS partners to provide better information to support the commissioning agenda including tackling social inequalities in mental health.
- Opportunity to tap into good practice already within the footprint – "don't reinvent the wheel".
- Opportunity to understand the need for engagement of patients and members of the public and the importance of them being valued.
- The challenge to capture the views and experience of 'hard to reach groups who perhaps don't ask for help".
- Learn from other countries and good practice, for example new innovative approaches for suicide (nudge method in Netherlands).

> Excellent idea to have themed tables. All the discussion was useful and relevant. Excellent facilitator kept us on track. From Janet Bott, Director of Clinical Services, David Lewis

- There needs to be parity across the areas: "some services have not been the "sexy" services and these have not done as well as i.e. IAPT, EIP"

- Opportunity to involve the voluntary sector more, ensure they receive relevant information and support. Any information provided should be simple and easy to read so that it can be understood.
- Organisations and individuals "are working too much in silos" more integration is needed. Clinicians, voluntary sector and social care staff all need to work together
- Challenge for the various and different organisations is how do they "build a structure" that can enable them to move forward"
- There seems to be too much focus on the clinical aspects of mental health, not enough on community services.
- Opportunity for the SCN with other partners to look into "pathways and find out why people fall through the cracks." Including tackling the issue of why people with a lower mental health need are not able to access support as easily as those with high level MH need and marketing of pathways in relation to point of entry.

Dementia: issues, challenges and ambitions:

- Education and training programmes that meet the needs of the broader workforce, competence based training. Emphasis on care homes in particular
- Public health model, in terms of awareness raising, healthier lifestyles and a preventative approach. Better use of evidence and research to inform patients, carers and members for the public.
- Working in partnership to develop Dementia Champions within CCG's and NHS organisations within the footprint.
- Housing provision tailored toward people with dementia
- Public health campaign to educate the public on what dementia is and to reduce the fear associated with Dementia and what it means for individuals and their carers
- Opportunity to involve seldom groups and communities. Example, the taboo/stigma associated with Dementia, and in particular within the BME community, which impacts on access to appropriate and timely services. This tends to reinforce social isolation from the wider community and end up "suffering in silence".
- Potential to standardise/procure centrally dementia–friendly signage for hospitals. Also differences in logs – butterflies vs. forget-me-nots
- All hospital staff need to be better trained in dementia awareness.

"Really enjoyed being actively involved in the discussions with like minded people with shared practice (Carri McMenamy, 5 Boroughs Partnership NHS Foundation Trust)"

- Due to cultural reasons some South Asian GPs are less likely to refer patients with suspected dementia. This needs to be explored further. There isn't a word for dementia is some South Asian languages and awareness is not high within BME communities.
- Dementia needs to be non-mediatized and seen as a long term condition, not a mental illness.
- Opportunity to work in partnership to develop dementia friendly communities and organisations. These would include staff working in NHS and education. Greatly underestimated prevalence of dementia in Salford.
- Recognise and support good practice with excluded groups such as the Rochdale Service for people with Dementia and their carers (Allotment/farm)
- Work towards having a dementia friendly footprint, Increase the number of Dementia Cafes that are very positive and supportive work with local communities.
- Consider having "young onset dementia team as in Pennine Care". Explore the possibility of employing dementia patients.
- Timely access to services, for example, Memory Assessment Services (MAS)
- Dementia cafes and be-friending serves are not appropriate for BME groups.
- Dementia patients need services that assist them in eating and meal times.
- More extensive use of voluntary sector for e.g. day-care which is so valuable and now being cut or limited in some areas.
- Link nurses between GP's & memory services need to be developed. Memory nurses to go out to care homes with diagnosis and management
- Holistic care of dementia patients need to be provided between health and social care.
- One stop shop for people with dementia to provide the integrated care involving the 3rd sector

- Need for only one care plan (similar to a maternity pack) which starts in the community and follows the patient through their entire pathway.
- Implement the 'I's in Alistair Burn's presentation
- Out of hours services need to be primary care led.
- Managing risk within the community. Social risk v medical risk and lack of assessment is a concern.
- Remember demography, populations, rural communities, technology usage, regional diversity
- Opportunity to tackle dementia in younger people, (30-60 years). This seems to be falling between services.
- Resource challenges of memory services not recognised. Plus services tended to be 'cobbled together' rather than commissioned. Service models don't account for contingency.
- Services are still working in silos. Lack of link up with the pathway & services. Gaps in provision – "not our responsibility". "Not commissioned to do this".
- Opportunity to involve and support carers: establish a Carers Peer Support Network that provides 'problem solving' and drop in sessions to support patients with early diagnosis.
- Needs to be better support for carers of dementia patients to be able to stay in work.
- Improving referral processes and access to diagnosis and support services
- Timely and accurate diagnosis.
- Not enough support for patients under the age of 55 and it is extremely difficult to get a diagnosis at an early age.

- Dementia projections can cause panic/services to stand-still and not develop due to overwhelming task ahead.
- Lack of equity of services, e.g. equipment availability
- Lack of standardisation in use of assessment tools – event within some organisations
- Research to explore prevention agenda. Links between Healthy Heart & Healthy Brain not fully understood
- Issues around sharing of information and knowing who the key stakeholders are
- Need better data - without diagnosis there is no data.

Neurological Conditions: Issues, challenges and ambitions

- Local areas working to separate out stroke & neuro conditions rather than joining/integrating the services.
- There is some cross over between the needs of people with mental health problems, dementia and neurological conditions but it is difficult to refer patients between services.
- More specialist nursing and AHPs to prevent admission
- Access to neurologists – availability of urgent access clinics would decrease the number of avoidable admissions
  and the need for neurologists to be on site at DGHs 24/7
- There should be a smooth seam-free journey where patients have responsibilities and control of their own journey.
- Need for clear accountability process i.e. needs accountable clinician/neurologist
- RAPA – rapid access patient alerts – used in cancer to alert CNS when their patient comes in through A&E so the nurse knows to ring the ward. This would be great for neuro patients.
- Inequality in access to specialist nurses and pathways to services
- NHS reorganisations leading to some services lost in transition
- Lack of neuro in CCG community plans
- Recognition most neuro is not specialised commissioning
- Referrals into acute trusts for patients that can be managed within general practice.
- Lack of early supported discharge in neuro teams
- Lack of whole pathway integration. Often the blocks are shifted down the pathway, rather than a whole system solution.
- Lack of vocational & social inclusion type services. Traditionally sat with a number of charity organisations but funding to these have ceased.
- Inequity in longer term neurological rehabilitation.
- UK ROC initiative categorizing patients up to 6 months. Those with longer term rehabilitation needs become problem for placement & reporting change
- Rehab needs to be given the same level of priority as acute care.
- Targets for stroke rehab means that other neuro patients are often left on waiting lists for longer to allow for stroke and trauma patients to be seen.

- Pathway says 6 weeks for rehab, then discharge. However this doesn't work for neuro LTC. Some patients need two weeks, some need three months.
- Consultant via attendance at MDTs and involvement in the major trauma network. Issues for the service:
  - Patients referred who do not meet the service criteria e.g. those with stroke
  - Patients aged 16 – 18 years – unclear where they should be managed
  - Patients in low awareness states – unclear which assessments should be used i.e. WHIM or SMART.
- Better knowledge/clinicians primary care and therapy services

- Commission properly & provide properly. Stop covering gaps in provision, thereby diluting efficient & effective care.
- Educate ward staff so they understand the impact of delays in medicine for PD patients and understand moving and handling issues for neuro patients.
- Educate family and carers to care for the patient and manage condition peaks and troughs – avoid admission when possible.
- No focus (policies) at DGH level
- Community care is missed off the national engagement process, making reference to secondary care & primary care but not community care. Community care & primary care are not the same. Patients now have to reapply for benefits. This causes a great deal of stress and can be detrimental to their mental health.
- Rapid / timely access to diagnosis
- Mapping of diagnostic pathways if the patient is seen in out-patients rather than being admitted to MAU
- Expertise & timely assessments of patients.
- Triage / self-management for Parkinson'
- Lack of DGH neuro services at a local level
- Not enough access to neuro rehab facilities across the entire footprint. There is a massive variance in the time it takes for patients to get an appointment, in some places 18-20 weeks. In that time patients can deteriorate greatly.
- South Manchester has no neuro rehab and patients have to be housebound before they get help.
- South Cumbria is a large geographical area with limited neurological services e.g. out-patient services are provided at Lancaster and Barrow but these are general neurology clinics with access to a specialist nurse in epilepsy only. This is compared to other areas e.g. Cambridge where all clinics had relevant specialist nurses with volunteers to offer patient support.
- The increase in demand creates income for the acute trust which is in conflict with clinicians making best use of the pathways & rejecting referrals
- Lack of availability of specialist consultants in neurology & neuro-rehabilitation for recruitment
- Lack of commissioning clarity locally against national picture. For example, specialist commissioning in NW for neurology not CCGs.
- Need to look at the infrastructure of services e.g. ability to man phone lines for advice services
- Whatever a service looks like it should have the right capacity and staff with the right competencies.
- Lack of sharing of information to enable others to learn from projects etc. across the strategic clinical network footprint.
- Need standards for referrals and pathways
- Epilepsy services can teach us a lot about transition for 16 – 18 year olds. This is important as teenagers with epilepsy and young people with MS often struggle with the diagnosis and drop out of school.
- Issues around safeguarding for people in the 16 – 18 year old category. Also expectations are different - greater numbers of paediatricians raise expectations about treatment and support which aren't maintained within adult services.

Learning Disabilities: Issues, challenges and ambitions

- Physical intervention monitoring and quality measures. National approach to 'positive behavioural support'.
- LD not to be considered as an 'add on' and addressed appropriately by SCN
- Lack of understanding of what is required despite available resources
- Premature death due to access to mainstream services e.g. screening and cancer.
- Number of LD people in criminal justice system – lack of understanding of LD.
- Seen as specialist service so difficult to access other services e.g. mental health
- Meeting needs in a crisis to enable people to stay at home – not able to access MH crisis intervention teams. Variable experiences across GM.

- East Lancashire has good links with IAPT but difficulty with single point of access.
- All care pathways should be tested to ascertain if fit for LD patients. If useful for LD patients will be useful for population in general.
- 'LD condition' overrides any existing pathways of care – patients seen as different therefore do not get optimal care. Need to make reasonable adjustments for LD.
- Lack of continuity e.g. local interpretation of 'health passports'
- Physical Intervention – lack of regulation no sharing of good practice. Lack of preventative measures before physical intervention is used.
- Lack of support services e.g. day centres.
- Reduction in packages of care.

Learning disabilities cut across several of the conditions dealt with. It would have been / will be a good idea to bring in the National Clinical Director for LD to link in. Third sector / Patient groups on this context should bring in patient experience – not that of intermedicines or those who only represent a small group for that condition with limited approaches (Mike Harnor, Trustee/Executive, Greater Manchester Neurological Alliance)
Please note the national director for learning disabilities had not been appointed at the time of organising the conference.

Emerging Priorities

Dr Antonysamy thanked everyone for their contribution in the first round table session and introduced the second session. The second session focused on the way forward and exploring priorities across the footprint in relation to mental health, dementia, neurological conditions and learning disabilities.

The table in Appendix "A" outlines the issues/priorities as identified by delegates during the table discussions. The themes have been placed into themes and we have also suggested a way forward in how they could be implemented through projects/programmes. The next stage will be for clinical leads to decide which one of the projects and programmes will be made a low, medium and high priority in year one, two and three.

Dr Raj Patel
Medical Director, Greater Manchester Area Team
Concluding Remarks

Dr Patel concluded the summit by thanking everyone for a very productive day and was pleased so many delegates stayed behind to participate in the round table discussions that an excellent sign of quality of debate and commitment from our partners. SCN and Senate footprint is probably the most challenging geographically and one of the most diverse and difficult boundaries. He thanked the three national key note speakers: Geraldine, Alistair and David for setting national priorities. The themes that were emerging from the round table discussions were partnership - strong word to hold on to and strong concept - we are very guilty of talking about health service and social care in silos – we are more likely to consider a joined up service if we were recipient.

The clinical leads: Ken, Sammy and Mark's observations reminded us that whatever we do as priorities they must be doable and not come up with a wish list from a large number of delegates. Maqsood outlined the importance of placing the patient, carers and members of the public at the centre of everything we do and the importance of their involvement.

Dr Patel shared with the delegates his own personal experience of what is it like to be a patient and as a member of the community and stated that it was not always more resources or more money that was needed to provide effective services to patients but a change in culture and way we communicate - partnership and people working together is the way forward. A report on the summit with emerging priorities will be written and circulated to all the delegates and wider. He thanked the SCN mental health, dementia and neurological conditions team and the clinical leads for the hard work that went into organising the summit.

"good and informative, learnt quite a bit from speakers and those around the table (Thaira Qureshi, Project Coordinator, Health and Care Together, Bolton CVS)"

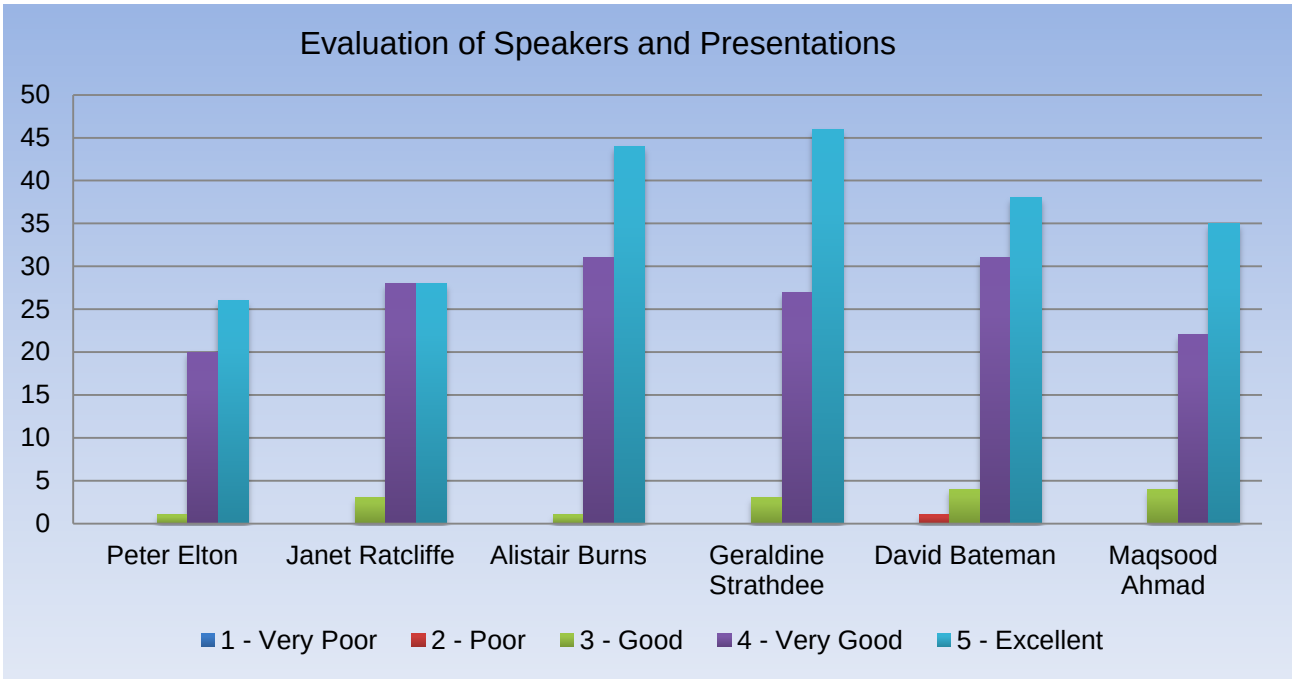
Area	Ranking: National / SCN	Priority	Theme	Domain
MH & D	Local	Raising awareness to reduce stigma, promoting well-being and improving access to services	Public health	1 & 2
MH, NC & LD	Local	Working with the children’s network to improve transition	Transition	2
MH, D, NC & LD	National / SCN	Achieve parity of esteem between mental health and physical health care needs (No Health without Mental Health)	Improving physical & mental well-being	1 & 2
MH & D	Local	Work with the mental health intelligence network	Information and data	1 & 2
NC & LD	Local	Establish data systems to understand mortality and activity	Information and data	1 & 2
MH, D, NC & LD	National / SCN	Develop education and training programmes related to MH, D, NC and LD	Leadership, workforce and education	1 to 5
MH, D, NC & LD	Local	Review access to services for prisoners - offender health	Pathways	1, 2 & 3
MH	National / SCN	Develop pathway for acute, unplanned , emergency care	Pathways	1, 2 & 3
MH	National / SCN	Suicide prevention	Pathways	1
MH	National / SCN	Develop integrated pathways from primary through to tertiary care	Pathways	2 & 3
MH	National / SCN	Develop integrated pathway for people with schizophrenia, psychosis and personality disorder	Pathways	2 & 3
MH	National / SCN	Review implementation and impact IAPT (No Health without Mental Health)	Pathways	2 & 3

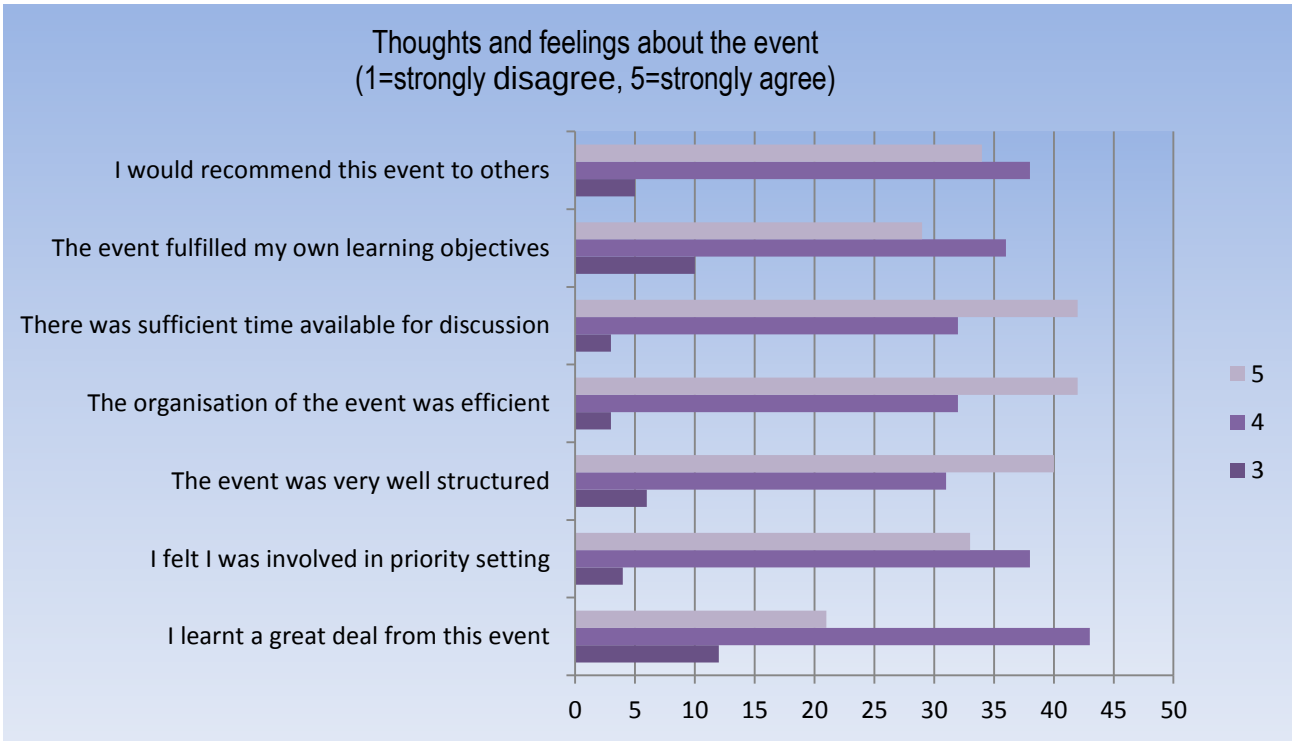
Area	Ranking: National / SCN	Priority	Theme	Domain
MH	National / SCN	Support early diagnosis of mental illness	Pathways	2 & 3
MH	Local	Develop integrated pathway for people with eating disorders	Pathways	2 & 3
D	National / SCN	Promote Dementia Friendly communities e.g. dementia	Improving physical & mental well-being	1 & 2
D	National / SCN	People with dementia have an accurate and timely diagnosis with post-diagnostic support e.g. use of dementia assessment toolbox	Pathways	2 & 3
D	National / SCN	Develop prevention strategies and screening programmes	Pathways	2 & 3
D	Local	Review access to services for younger people with dementia	Pathways	2 & 3
D	Local	Ensure links with other relevant service areas e.g., neurology and cardiology	Pathways	2 & 3
D	Local	Improve crisis management to avoid unnecessary hospital admissions including management of delirium	Pathways	3
D	National / SCN	Improve and shorten hospital admission via medicines management, discharge planning, patient passports, Butterfly system	Pathways	3
D	National / SCN	Develop care home staff and visiting healthcare staff to enable optimum care for people with dementia	Pathways	2
D	National / SCN	Monitor and reduce where possible the use of anti-psychotics for people with dementia	Pathways	2 & 3
D	Local	Promote the use of non-pharmacological treatment interventions for people with dementia e.g. memory services	Pathways	2 & 3
D	Local	Improve access to respite for carers	Pathways	2

Area	Ranking: National / SCN	Priority	Theme	Domain
D	Local	Develop integrated pathways which facilitate self-management and longer-term support	Pathways	2
D	Local	Review use of safeguarding and mental capacity act for people with dementia	Pathways	5
NC	National / SCN	Improve access to specialist care and investigations, for people presenting at DGH to avoid unnecessary admission and reduce LOS	Pathways	3
NC	National / SCN	Improve appropriate access to neurological opinion through better referral management e.g. back pain toolkit	Pathways	2 & 3
NC	National / SCN	Improving management of epilepsy - utilisation of GM strategy	Pathways	2 & 3
NC	Local	Develop a neurosciences strategy which facilitates the development of integrated pathways	Pathways	2 & 3
NC	Local	Develop pathways which support timely diagnosis in line with NICE guidelines and avoid misdiagnosis	Pathways	1, 2 & 3
NC	Local	Improve access to and quality of neuro-rehabilitation and re-ablement including return to work	Pathways	2 & 3
NC	Local	Supporting people to manage their neurological condition to avoid crisis	Pathways	2 & 3
NC	Local	Review and develop co-ordinated pain management services	Pathways	2
NC	Local	Review access to psychology services including memory services as part of an MDT approach	Pathways	2 & 3
NC	Local	Scope capacity of neurological expertise	Leadership, workforce and education	2 & 3
LD	National / SCN	Reducing premature death in people with a learning disability (Winterbourne)	Pathways	1

Area	Ranking: National / SCN	Priority	Theme	Domain
LD	National / SCN	Review current practice and pathways around the use of physical and / or chemical restraint (Winterbourne)	Pathways	2 & 3
LD	Local	Develop pathways for crisis management including use of OOH and step-down facilities	Pathways	3
LD	Local	Monitor and reduce where possible the use of anti-psychotics for people with LD	Pathways	2 & 3
LD	Local	Ensure that people with LD have equitable access to health and social care services in line with general population	Pathways	2 & 3
LD	Local	Supporting people to self-manage where possible	Pathways	2
LD	Local	Review access to psychology services	Pathways	2 & 3
LD	Local	People with LD have an accurate and timely diagnosis of their condition	Pathways	2 & 3

Legend	Key: Domain areas
MH: Mental Health D: Dementia NC: Neurological Conditions LD: Learning Disabilities	1. Preventing People from dying prematurely 2. Enhancing Quality of Life for people with long term conditions 3. Helping people recover from episodes of ill health or following injury 4. Ensuring that people have a positive experience of care 5. Treating and caring for people in a safe environment and protecting them from avoidable harm


Evaluation of Speakers and Presentations
50
45
40
35
30
25
20
15
10
5
0
Peter Elton
Janet Ratcliffe
Alistair Burns
Geraldine Strathdee
David Bateman
Maqsood Ahmad
1 - Very Poor
2 - Poor
3 - Good
4 - Very Good
5 - Excellent


Thoughts and feelings about the event
(1=strongly disagree, 5=strongly agree)
I would recommend this event to others
The event fulfilled my own learning objectives
There was sufficient time available for discussion
The organisation of the event was efficient
The event was very well structured
I felt I was involved in priority setting
I learnt a great deal from this event
0
5
10
15
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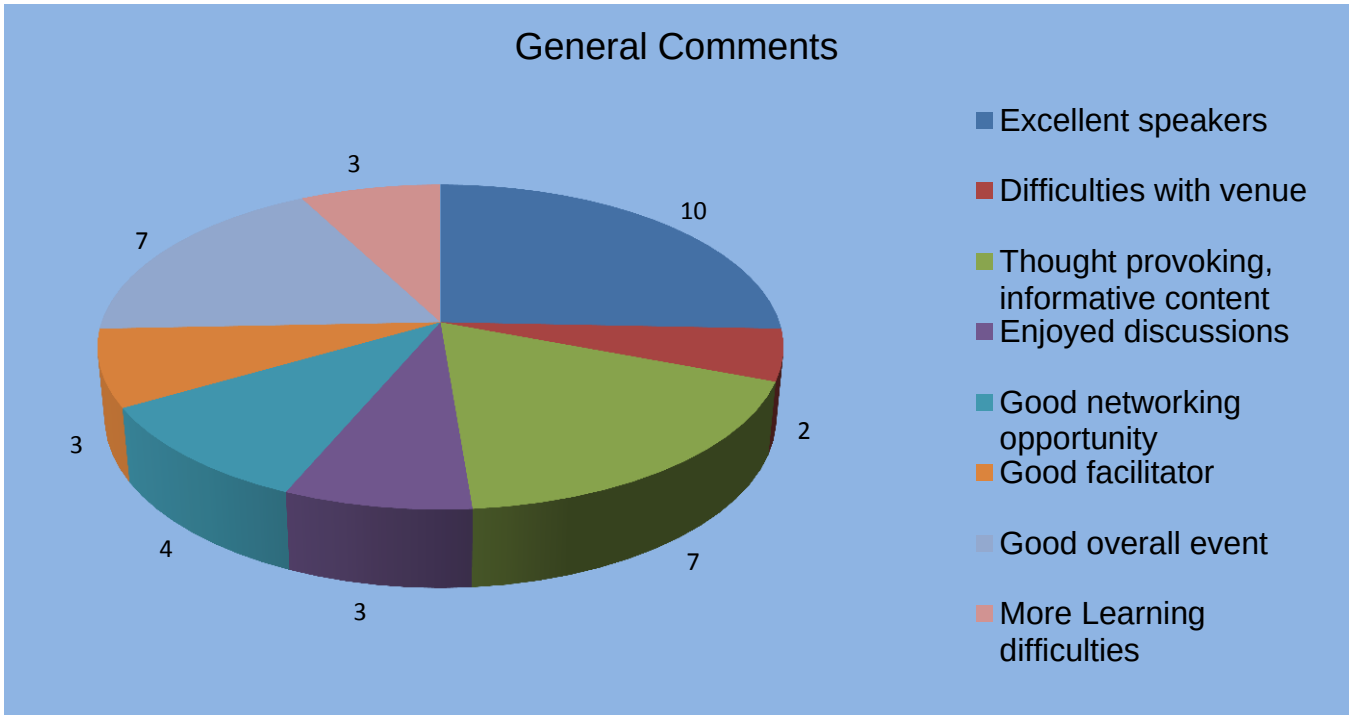
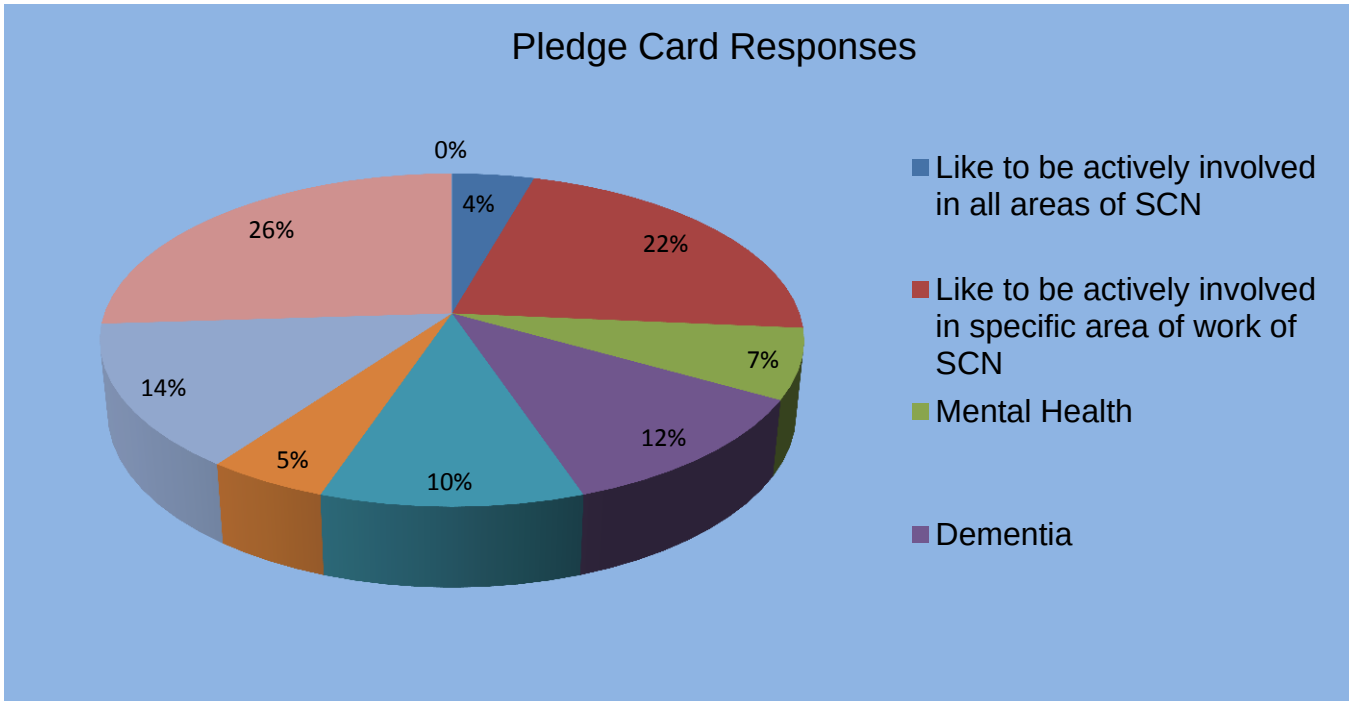
5
4
3


General Comments
10
2
7
3
4
3
7
3
Excellent speakers
Difficulties with venue
Thought provoking, informative content
Enjoyed discussions
Good networking opportunity
Good facilitator
Good overall event
More Learning difficulties


Pledge Card Responses
0%
4%
22%
7%
12%
10%
5%
14%
26%
Like to be actively involved in all areas of SCN
Like to be actively involved in specific area of work of SCN
Mental Health
Dementia

DELEGATE LIST

Name	Title	Organisation
Maqsood Ahmad OBE	Strategic Clinical Network Manager	GML&SC Strategic Clinical Network & Senate
Ann Aindow	Ambassador for SUDEP Action	SUDEP
Joe Aindow	Ambassadors for SUDEP Action	SUDEP
Helen Al-Nufoury	Head of Speech and Language Therapy	Lancashire Teaching Hospitals NHS FT
Kanwal Ambereen		Asian Women's Forum Chorley
Abdul Amin	Quality Improvement Manager	GML&SC Strategic Clinical Network & Senate
Dr A Antonysamy	Clinical Lead – Mental Health	GML&SC Strategic Clinical Network and Senate
Norma Armston	Patient/Carer Representative	Greater Manchester
Joy Arrandale	MH & LD Commissioning Manager	East Lancashire CCG
Debbie Ashforth	Commissioning Manager	NHS Tameside & Glossop CCG
Khalid Bashir	Community Engagement Lead	BME Health Matters
David Bateman	National Clinical Director for Neurological Conditions	
Sarah Beattie	Senior Commissioning Manager	Fylde & Wyre CCG
Claire Benjamin	Head of Communities	National Museums
Sandy Bering	Lead Commissioner	NHS Trafford CCG / GM Networks
Michele Bering	Consultant Nurse Learning Disabilities	Cheshire and Wirral Partnership Trust
Kathy Blacker	Assistant Director – Clinical Strategy	NHS England (Lancashire Area Team)
Bushara Bostan	Domain Team – Support Manager	NHS England – Leeds
Janet Bott	Director of Clinical Services	David Lewis
Melvin Bradley	Manager	MhIST
Julie Brown	Team Lead Occupational Therapist	Lancashire Teaching Hospitals NHS FT
Alistair Burns	National Clinical Director for Dementia	
Andrew Burridge	Policy Manager	AGMA
Anne Cairns	Parkinson's Disease Specialist Nurse	Pennine Care NHS FT
Julia Charnock	Quality Improvement Manager	GML&SC Strategic Clinical Network & Senate
Julie Cheetham	Strategic Clinical Network Manager	GML&SC Strategic Clinical Network & Senate
Dr Elaine Church	Consultant Public Health Medicine	IPMHC

DELEGATE LIST

Name	Title	Organisation
Melanie Close	CEO	Disability Equality NW
Dr Tracy Collins	Lecturer in Occupational Therapy	University of Salford
Dr Shanu Datta	Consultant Psychiatrist	Pennine Care NHS FT
Catherine Davies	SLT Clinical Lead	Pennine Acute Hospitals NHS FT
Elaine Day	Quality Improvement Manager	GML&SC Strategic Clinical Network & Senate
Michelle Devine	Clinical Services Manager	Priory Highbank Centre
Paul Doherty	Senior Physio Assistant	CWP Community Rehab
Rachel Douglas-Clark	Senior Project Manager, Service Redesign Unit	Greater Manchester Commissioning Support Unit
Beverly Drake	Quality Improvement Manager	GML&SC Strategic Clinical Network & Senate
Gillian Drummond	Dementia Quality Lead	Greater Manchester West NHS Mental Health FT
Sue Dyke	Network Assistant	GML&SC Strategic Clinical Network & Senate
Philip Dylak	Director of Innovation, Nursing & AHPs/Deputy MD	NW Coast Academic Health Science Network
Peter Elton	Clinical Director	GML&SC Strategic Clinical Network & Senate
Hedley Emsley	Consultant Neurologist	Lancashire Teaching Hospitals NHS FT
Gina Evans	Joint Commissioning Lead	NHS Stockport CCG
Macaila Finch	Programme Manager - Workforce	Health Education NW Strategy
Brigid Flanagan	Community Mental Health Team Manager	Pennine Care NHS FT
Martyn Fletcher	Clinical Lead – Mental Health	NHS Bolton CCG
Debra Foster	Service Manager Neurophysiology	Lancashire Teaching Hospitals NHS FT
John Fox	Service Manager	Alzheimer's Society – South Cumbria
Katherine French	Influence and Service Development Officer	Parkinsons UK
Anna Fryer	Consultant Older Adult Liaison	Pennine Care NHS FT Psychiatrist
Olwyn Fuller	Occupational Therapist / Memory Clinic Manager	Pennine Care NHS FT
Mandy Galling	Specialist Speech & Language Therapist	East Lancashire Hospitals NHS Trust
Ruksana Ghoas	Post Grad Social Work Student	MMU
Joy Gibbon	Occupational Therapist	Bolton Hospitals NHS FT
Karen Gibbons	Quality Improvement Manager	GML&SC Strategic Clinical Network & Senate

DELEGATE LIST

Name	Title	Organisation
Jason Gladwin	Data Analyst	GML&SC Strategic Clinical Network & Senate
Paula Grange	Supplier Manager Specialised Commissioning	NHS England – Cheshire, Warrington & Wirral AT
William Greenwood	Network Manager	Cheshire and Merseyside Strategic Clinical Network
Sonia Grimshaw	Occupational Therapy Team Leader	East Lancashire Hospitals NHS Trust
Sue Grumley	Therapy Manager	5 Boroughs Partnership NHS FT
Paul Hackett	iNetwork NHS Engagement Lead	iNetwork, Tameside MB Council
Dr Jim Hacking		NHS Cumbria CCG
Lesley Hadley	Directorate Manager/Head of Therapy Services	Wrightington, Wigan & Leigh NHS FT
Marianne Hare	Lead Research Nurse	DeNDRoN (Dementia Neuro-degenerative Diseases Network)
Mike Harnor	Trustee/Executive	Greater Manchester Neurological Alliance
Craig Harris	Executive Nurse & Director	Citywide Commissioning & Quality
Andy Harrison	Project Manager	Healthwatch Blackburn with Darwen
Glenn Harrison	Patient Experience Manager	NHS England (Lancashire Area Team)
Katie Harrison	Occupational Therapist	East Lancashire Hospitals NHS Trust
Peter Harrison	Head of Commissioning - Mental Health and non NHS contracts	NHS Wigan Borough CCG
Suzette Harrison	Associate General Manager, Renal & Neurology	Lancashire Teaching Hospitals NHS FT
Shona Harvey	Speech and Language Therapist	Mersey Care NHS Trust
Ali Hassoon	Consultant in Neurorehabilitation	Salford Royal NHS FT
Warren Heppolette	Director of Operations and Delivery	NHS England (GM Area Team)
Dr Sue Hooper	Counselling Psychologist	Community Neuro Rehab Team
Beverly Hopcutt	Therapy Services Manager	Neuro Rehab CMFT
Dr Kevin Hope	Honorary Professor and Associate	Dementia Services, Development Centre, University of Stirling
Doug Hopkins	Director	5050 Partnership
Helena Hounslow	Service Redesign Officer	Lancashire CSU
Gaye Jackson	Head of Continuing Personal Development & Education Partnerships	Health Education NW
Dr Keith Jeffery	Clinical Director for Mental Health	Oldham CCG
Louise Jenkins	Interim Service Specialist	Specialised Commissioning

DELEGATE LIST

Name	Title	Organisation
Dr Nicola Jervis	Clinical Psychologist	Manchester Learning Disability Partnership
Nicola Johnson	Dementia Nurse Specialist	Central Manchester University Hospitals NHS FT
Clive Johnstone	Managing Director	Medical Management Services
Stephanie Jones	Quality Improvement Manager	GML&SC Strategic Clinical Network & Senate
Jane Keep	Associate	Health Services, Management Centre, University of Birmingham
Mark Kellett	Clinical Lead – Neurological Conditions	GML&SC Strategic Clinical Network & Senate
Louise Kelso	Community Physiotherapist	Pennine Care NHS FT
Zara Khan		Asian Women's Forum Chorley
Julianne Kinch	Therapy Services Manager	Priory Highbank Centre
Jacqueline Kindell	Specialist Speech & Language Therapist/Clinical Research Fellow	Pennine Care NHS FT/University of Manchester
Penny Kirk	Quality Improvement Lead	Yorkshire & Humber Strategic Clinical Network
Ashleigh Knowles	Senior Clinical Specialist & Clinical Lead Neuro-rehabilitation	Pennine Care NHS FT
Juliette Kumar	Senate Manager	GML&SC Strategic Clinical Network & Senate
Joanne Langton	Quality Improvement Manager	GML&SC Strategic Clinical Network & Senate
Dr Iracema Leroi	Consultant Psychiatrist Dementia Director	MMHSCT DeNDRON Northwest
Gareth Lord	Quality Improvement Manager	GML&SC Strategic Clinical Network & Senate
Magie Low	Treasurer	The Dystonia Society
Stewart Lucas	CEO	Lancashire Mind Ltd
Christine Lynch	RCDA	MND Association GMNA
Charlotte McAllister	Business Information Analyst	West Lancashire CCG
Janice McGrory	Lead Nurse	Salford Royal NHS FT
Verna McLean	Personal and Professional Consultant and Trainer	POWER Training Development Coach, Consultants
Carri McMenamy	Advanced Physiotherapist	5 Boroughs Partnership NHS FT
Kate McNulty	Vice Chair	Kidney Patients Association (Greater Manchester)
Glenys Marriott	Chairman	Headway South Cumbria
Andy Milburn	Occupational Therapy Clinical Lead	Cumbria Partnership NHS FT

DELEGATE LIST

Name	Title	Organisation
Shahid Mohammed	Project Development Officer	BME Health Matters
Andy Morgan	Councillor	Bolton Council (H&WB)
Stephen Morris	Physiotherapist	Pennine Care NHS FT
Julie Mugarza	Snr Research Nurse	C&M CLRN central team
Alison Napier	Consultant Psychiatrist	Lancashire Care NHS FT
Sue Neilson	Interim Dementia Partnership Coordinator	Oldham CCG
Philip Owen	Senior Occupational Therapist	East Lancashire Hospitals NHS Trust
Marie Oxtoby	Chair	Bolton Neuro Voices
Stephen Parry	Specialist Occupational Therapist Neuro Rehab	Pennine Care NHS FT
Dr Raj Patel	Medical Director	NHS England (Greater Manchester)
Jane Pattinson	Commissioning Support Manager	Lancashire North CCG
Kathryn Powell	Physiotherapist	Cheshire and Wirral Partnership Trust
Ellen Juliet Prady	Specialist Neuro Rehab Liaison	Tameside and Glossop Community Health Care
Joanne Preston	Network Delivery Manager	NE Strategic Clinical Network
Janet Priest	Neurology LTC service Lead	Bolton FT Breightmet HC
Jennifer Prole	CPN Memory Assessment Service	Pennine Care NHS FT
Thaira Qureshi	Project Co-ordinator	Bolton CVS
Dr Sandeep Ranote	Consultant Child & Adolescent Psychiatrist / Associate MD	5 Boroughs Partnership NHS FT
Safina Rashid	BME Mental Health & Dementia Coordinator	South Asian Mental Health Cluster
Dr David Ratcliffe	Deputy Medical Director	North West Ambulance Service
Janet Ratcliffe	Associate Director	GML&SC Strategic Clinical Network & Senate
Abdul Razzaq	Director of Public Health	Trafford Council
Sara Renwick	Lead Nurse for Quality, Medicine and Community Services	Central Manchester University Hospitals NHS FT
Julie Rigby	Quality Improvement Programme Lead	GML&SC Strategic Clinical Network & Senate
Kate Ritchie	Quality Improvement Manager	GML&SC Strategic Clinical Network & Senate
Ian Roberts	Head of Procurement & Contracting	Greater Preston CCG
Angela Robinson	Commissioning Officer	NHS Cumbria CCG

DELEGATE LIST

Name	Title	Organisation
Sara Robson	Specialist AHP, Brain and CNS Rehabilitation	Christie NHS FT / Salford Tumour Royal FT NHS FT
Carol Rogers	Executive Director Education	National Museums
Marion Rogers	Regional Manager North West	Parkinsons UK
Carol Rushton	CPN	Pennine Care NHS FT
Shakil Salam	Carers Development Worker	Carers Contact
Lisa Sanders	Speech and Language Therapist	Lancashire Teaching Hospitals NHS FT
Mohammed Sarwar	Chief Executive	Multicultural Arts Media Centre
Dr Sonu G Sharma	Consultant Psychiatrist – Group Medical Director	Priory Hospital Cheadle Royal
Judd Skelton	Integrated Commissioning Manager – Mental Health	NHS Salford CCG/Salford City Council
John Spark	Volunteer - North West	Epilepsy Society
Liz Stafford	National Clinical Lead / Lancs LPN	Rowlands Pharmacy / Lancs Area Team
Geraldine Strathdee	National Clinical Director for Mental Health	
Amanda Thornton	Clinical Director	Lancashire Care NHS FT
Catherine Tickle	Joint Commissioning Manager	NHS Bury CCG
Julie Treadgold	Matron	Trafford Hospitals
Karen Vernon	Multiple Sclerosis Nurse Consultant	Salford Royal NHS FT
Caroline Waddington	Service Redesign Specialist	Lancashire CSU
Alex Walker	Senior Operating Officer	East Lancashire CCG
Catherine Walsh	Learning Disabilities Physiotherapist	Pennine Care NHS FT
Jo Ward	Carer	
Kerry Ward	Research Nurse	DeNDRoN (Dementia and Neuro-degenerative Diseases Network)
Amanda Wardle	Team Leader Neuro Rehab Team	Bolton NHS FT
Annette Weatherley	Head of Nursing, Medicine and Community Services	Central Manchester University Hospitals NHS FT
Derek Whitehead	Stroke Carer	Greater Manchester
Lisa Wilkins	Consultant in Public Health Medicine	Oldham Council
Kenneth Wood	Clinical Lead - Dementia	GML&SC Strategic Clinical Network & Senate

DELEGATE LIST

Name	Title	Organisation
Jo Worswick	Deputy Chief Officer	NHS West Lancashire CCG
Mark Worthington	Higher trainee (ST6) in Old Age Psychiatry	Pennine Care NHS FT
Karenjo Worthington	Clinical Team Manager	Blackpool Teaching Hospitals FT
Kim Wrigley	Quality Improvement Programme Lead	GML&SC Strategic Clinical Network & Senate
Janice Wycherley	NW Health Equalities Group, Health programme coordinator	North West Training Development Team /Pathways CIC Associates
Anjum Zulfiqar	Finance Manager	NHS England (Greater Manchester)