the antibodies may have altered excitatory neurotransmission as this could mimic better in vivo conditions. Local pathological inflammation may also contribute to excitability in vivo. A localised immune response with the subsequent release of cytokines and a possible element of complement activation might further impact onto local neuronal signalling pathways. Activated microglia and reactive astrocytes may alter the balance between excitation and inhibition in the milieu and may affect neuronal wiring through the formation of a glial scar.\textsuperscript{14}

Blood-brain barrier integrity could be affected through cytokine-activated receptors on endothelial cells, leading to a further recruitment of immune cells to the CNS. Thus, the effects mediated by pathogenic antibodies against inhibitory channels calls for the need to develop comprehensive in vivo human studies and animal models to determine autoantibody-mediated pathogenicity on a molecular, network and more global level. Understanding how autoantibodies can cause specific symptoms would help us understand not only disease but also brain function.\textsuperscript{7} Clinicians should be guided by the neuropsychiatric symptoms to identify whether an autoimmune cause should be ruled out mainly because the immunotherapy provides clinical improvements. The findings of Ohkawa et al\textsuperscript{8} extend the clinical spectrum of autoimmune encephalitis. The immunotherapy provides clinical improvements. The findings of whether an autoimmune cause should be ruled out mainly because the immunotherapy provides clinical improvements. The findings of Ohkawa et al\textsuperscript{8} extend the clinical spectrum of autoimmune encephalitis.

REFERENCES


5. Petit-Pedrol M, Armangue T, Peng X, Bataller L, Cellucci T, Davis R, McCracken J. Autoantibodies with anti-NMDAR receptor encephalitis: a case series, characterisation of the antibody and a analysis of the effects of antibo-


14. Each of the twelve Strategic Clinical Networks (SCNs) have been tasked to improve services for people with neurological conditions. Services for people with epilepsy have been identified as a priority by all of the SCNs which is reinforced by the decision of the Royal College of GPs to highlight epilepsy as one of its clinical priorities for 2013 -16.

The East of England SCN certainly lived up to its shared values of “Creating a shared purpose for transformational change” and “Putting patients, clinicians and carers at the heart of decision making” at the Epilepsy Event on June 26th. Over 100 delegates attended the event made up of service users, families, carers, Voluntary sector organisations (Epilepsy Action and Epilepsy Society). The National Development Team for Inclusion, Epilepsy Specialist nurses, Learning Disability nurses, Health Facilitator teams, Ntiologists, Commissioners, Social care staff and GPs, to name but a few. The aim was to gather information from all the delegates across the network, sharing examples of good practice, coming together in workshops to identify what people with epilepsy want from their services and what matters most to them. This is the first event I have attended where there has been such a strong voice from the people with epilepsy. I believe the points raised will get listened to by the SCN and taken forward into positive actions.

The day commenced with an introduction and welcome from the morning chair, Dr Max Damian, SCN Clinical Lead, explaining one of the rationale for SCNs was ‘To improve quality and outcomes through connecting services and efficiently using resources’. Dr Damian described the objectives for the day as: bringing together key interest groups involved in epilepsy care and highlighting their perspectives; to outline the elements of a pathway towards a better, more equitable service across the East of England and to identify how we can ensure strong collaboration between those involved in improving services.

This was followed by Dr David Bateman, National Clinical Director for Neurology, who discussed commissioning a better epilepsy service and highlighted the headline figures for the East,

- 16000 people with epilepsy in the East of England 1000 people of which admitted with an unplanned admission (6.25%)
- $400 000 cost minimum?
- 17% are managed by neurologist
- Total bed days per year $7500

What is needed to address these figures are local services, an accurate initial diagnosis, good initial advice and support and appropriate long term care. Dr Bateman, demonstrated the new Public Health England Neurology Intelligenc Network http://www.yhpho.org.uk/ mhdrn, which provides indicators about risk factors, prevalence, access to services, outcomes and finance, and includes profiling tools in particular for epilepsy.

Dr Tejal Mitchell, Neurologist in Peterborough, gave an East of England and National perspective of the second National Audit
of ‘Seizure management in Hospital’. She detailed the findings of poor policies for management of first seizures (62%), status epilepticus (68%) and onward care of seizure patients (56%).

Only half of people experiencing a first seizure were referred on to first seizure or epilepsy clinics. 54% of patients had access to Epilepsy nurses and under 50% had seen an ‘epilepsy specialist’ in the previous 12 months.

Dr Mitchell concluded that there is a need for a planned epilepsy pathway, to improve quality of care and clinical outcomes for patients, whilst increasing efficiency. She has also been working with the clinical commissioning group (CCG) on a business case for two band 7 ESN posts both of which have been appointed.

Vicki and Christian Raphael from Inclusion East and Matt Clark, Christian’s personal assistant, talked about how to live a full life with epilepsy and a learning disability and what their expectations of the health team are, from the perspective both the patient and the carer. Christian is central in planning his own care and communicating what he likes and wants to do and his team support him completely. Their expectations are that if Christian is admitted to hospital, the health care professionals responsible for his medical care will communicate with other clinical teams so that everyone is aware of his needs. Christian, with support from his PA Matt, deliver training based on his personal experience of living with epilepsy, across the country. Vicki is a co-director of Inclusion East, which is an organisation made up of families with similar experiences who provide a circle of support for each other. They also campaign for equality and social inclusion for people with learning disabilities and their families, with a focus on people who have complex needs. It was an inspirational and very well delivered presentation.

With a tough act to follow, Sarah Vibert and I, Epilepsy Society, discussed a new epilepsy commissioning tool being set up by a steering group involving, the Royal College of GPs, Epilepsy Society, Epilepsy Action, SUDEP Action, NICE, NHS England and pharma partners. We are pulling together a compendium of good practice across the UK as well as data on unplanned emergency admissions for people with epilepsy. This information is going to be discussed at a round table event with CCGs on November 20th.

Everyone assembled for the first workshop to address what the epilepsy pathway should look like, particularly at first seizure, diagnosis and long term management stages. Each group was balanced with a representative allocation of the delegates described above, the facilitators ensuring that everyone had an equal opportunity to voice their opinions, in particular the people with epilepsy. All the tables provided feedback on key points, with some great examples of good practice, in particular prompt access to a neurologist for accurate diagnosis, an epilepsy specialist nurse to act as a sign post and the ability to see patients in a setting which suits the individual person with epilepsy.

Dr Alex Smallwood, GP and Bedfordshire CCG, chaired the afternoon session, introducing a fellow GP and RCGP Epilepsy Champion, Dr Greg Rogers, talking about the primary care element of services for epilepsy. Dr Rogers highlighted some statistics from a survey, Critical Times, conducted by Epilepsy Action in 2013, in which 34% of CCGs have a plan or intend to produce a plan for epilepsy and 17% of CCGs have appointed someone to lead on epilepsy. 34% of hospital trusts do not offer adults access to epilepsy specialist doctors and only 46% offer access to specialist nurses. Epilepsy Action have repeated the survey and are in the process of collating the results. It will be interesting to see if these statistics have changed and what has driven the change. He went onto illustrate how epilepsy is the fifth highest cause of emergency admissions amongst neurological long term conditions, arguing that now is the time to address epilepsy services across secondary and primary care. He went through the nine NICE epilepsy quality standards and asked how capacity could be increased to meet these standards? A suggestion is devolution of appropriate care to Practice nurses, GPs and Pharmacists with a special interest in epilepsy. For example perhaps GPs could review everyone who has required unscheduled care for epilepsy, within 2 weeks, to see if a remediable cause is identifiable?

Dr Mark Manford, Neurologist from Cambridge University Hospital, discussed shared decision making for new anti-epileptic drugs (AEDs) between primary and secondary care. He explained shared decision making should do exactly what it says, involving the neurologist, GP, person with epilepsy and their family if appropriate. He went on to say that the CCGs have a role in supporting GPs in deciding whether or not to accept clinical responsibility for prescribing and supporting trusts to resolve issues that may arise as a result of shared care.

I was very impressed with the quality of the speakers, their obvious interest and motivation to improve services and their commitment to keep people with epilepsy at the heart of decision making.

ECTRIMS Joint meeting with ACTRIMS, Boston 2014

Conference details: 10-13 September, 2014; Boston, USA. Report by: Alasdair Coles, University Lecturer in Neuroimmunology, Cambridge University.

“A bit thin this year,” said my friend as she left. And I had to agree. No blockbuster news. No big trials. Rather a quiet ECTRIMS this year. The only record was the attendance: 9000 delegates from 70 countries. After due consideration, the committee-of-one has awarded this years’ ACNR ECTRIMS prizes.

ACNR prize for the Most Motivating Presentation: the skipper of the yacht ‘Sailing Sclerosis’

The yacht ‘Sailing Sclerosis’ sailed from Copenhagen in June to arrive in Boston a few days before the ECTRIMS meeting, crewed entirely by people with multiple sclerosis. The plan is to circumnavigate the world. The skipper, a Neurologist, described how he had been inspired by talking to a man with progressive multiple sclerosis; this blacksmith was depressed because he thought that he would never sail the world in the boat he had built. The Neurologist hit him across the back and told him to get sailing again. (Hopefully the Danish GMC did not hear that bit.) The skipper’s reflections on their journey so far were challenging, touching and humble. They promise to arrive in Barcelona in time for ECTRIMS next year. Well done to Biogen for sponsoring them.

ACNR prize for The Best Plenary Talk: David Hafler, Yale

David Hafler, one of the rock stars of multiple sclerosis biology, often gives the impression that the only work that is any good comes from his group. That is clearly not correct but annoyingly, it is not completely wrong. The new data he reported at this meeting was that

- Next generation sequencing of T cells from the periphery and brain of people with multiple sclerosis suggests that the common ancestral founders originates in the periphery, found in cervical lymph nodes (Stem Sci Trans Med 2014). So, Hafler says this proves that multiple sclerosis is triggered in the periphery first and does not arise because of a primary brain problem, like oligodendrocyte death. I am not sure you can be so sure. But the data is impressive.
- Eating at a fast food restaurant increases the proportion of CD4 T cells that are Th17.