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INDICATOR DEVELOPMENT PROGRAMME

Feedback report on piloted indicators

Topic area: Epilepsy

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Output: Findings from qualitative pilot to contribute towards
recommendations for NICE indicator menu

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Summary of pilot findings

Indicator 1: Annual review - all adults receiving drug treatment for epilepsy

The percentage of adults receiving drug treatment for epilepsy who had a structured review in the preceding 12 months.

Acceptability assessment

Most survey respondents agreed that indicator 1 would improve the quality of care for patients (79%, 30/38). Practice interviewees were largely supportive of inclusion but some raised concerns regarding potential duplication with reviews conducted in secondary care, and there was variability between practices in views on how the review could be implemented. Mostly, these views concerned the potential risk of it becoming a 'tick-box exercise', with more guidance suggested on what the review should contain. Conversely, a minority of views were concerned about the term 'structured' review. Interviewees did not support narrowing the review to only those patients on drug treatment known to produce side effects or interactions, and there were mixed views on whether to narrow the review to only those aged under or over 65.

Implementation assessment

Minor problems with implementation were highlighted, as summarised in the table below, with mitigations possible for some issues.

Issues to be resolved prior to implementation

Issue	Detail	Mitigating activity
Review setting (primary care or secondary care?)	Potential duplication with reviews being conducted in secondary care.	Allow those already reviewed in secondary care to count in the indicator and for primary care to not have to re-review. Or further define type/content of 'holistic' primary care review.
Review content	Potential variation in level of review conducted – 'tick-box' exercise or a more comprehensive review.	Standardisation. Templates. Detail in guidance.
Coding	Notifications from secondary care may be delayed/difficult to code.	Consider integration of templates/clinical systems between primary and secondary care?

Indicator 2: Annual review (adults with a learning disability and epilepsy)

The percentage of adults with epilepsy and a learning disability who had a structured review in the preceding 12 months.

Acceptability assessment

The majority of survey respondents (71%, 27/38) agreed that this indicator would improve the quality of care for patients. Practices interviewed were generally in favour of the inclusion of this indicator, with many noting that an annual review already took place for patients with a learning disability. Where practices noted there was overlap with existing indicators, this was seen as positive as it would support completion of this indicator (rather than being seen as duplication). The potential to identify patients with a learning disability and a diagnosis of epilepsy, even if not on the epilepsy register (due to not being on drug treatment, for those who thought this was possible) was also seen as a potential benefit of this indicator in addition to indicator 1. It was also noted by a few that it can be difficult to engage patients with a learning disability to attend reviews, so it would be useful to conduct the epilepsy review at the same time as other reviews particularly for this patient group.

Implementation assessment

No substantial issues with implementation were highlighted. A few concerns need to be taken into consideration, as outlined in the table below.

Issues to be resolved prior to implementation

Issue	Detail	Mitigating activity
Relationship of this review to existing annual reviews	Practice views mainly supported the review for this indicator being included in the learning disability review for the existing Primary Care Network (PCN) DES Indicator HI-01.	Incorporate the epilepsy review with the learning disability review. To consider: use of an integrated template for LD and epilepsy review in support of a combined review.
Patient engagement	It can be challenging to engage patients to attend reviews/health checks.	Review epilepsy within the learning disability health check, rather than a separate review.

Indicator 3: Annual review (adults with a mental health condition and epilepsy)

The percentage of adults with epilepsy and a mental health condition who had a structured review in the preceding 12 months.

Acceptability assessment

Two thirds of respondents to the survey (66%, 25/38) agreed this indicator could improve the quality of care for patients. There were mixed views from practices on the inclusion of this indicator. A few questioned the value of the indicator given the small number of patients likely to be involved. Interviewees held mixed views regarding the appropriateness of including a discussion of epilepsy within existing mental health reviews, with some concerns raised over the role of different healthcare professionals and current focus of the mental health review. There were also mixed views on whether the QOF mental health register (SMI register¹) is sufficient to identify patients with a 'complex mental health problem', with some interviewees proposing an amended indicator definition to include other mental health diagnoses.

Implementation assessment

Some problems with implementation were discussed, as summarised in the table below, with some mitigations available.

Issues to be resolved prior to implementation

Issue	Detail	Mitigating activity
Expertise of healthcare professional if this review were to be included in existing annual reviews	Combined or separate review to existing MH reviews? Which healthcare professional would conduct the review?	Training of healthcare professionals undertaking the review.
Identification of patients	Mixed views on whether the QOF mental health register is sufficient to identify patients with a 'complex mental health problem'.	Consider extending the indicator denominator to include more patients beyond the QOF mental health register.
Small number of patients	Value of indicator questioned by a few on this basis.	Propose as a PCN-level indicator.

¹ The QOF mental health register may also be referred to as the severe mental illness (SMI) register

Background

As part of the NICE indicator development process, all clinical and health improvement indicators for general practice proposed for inclusion in the NICE Indicator Menu are piloted, using an agreed methodology, in a representative sample of GP practices across England.

The aim of piloting is to test whether indicators work in practice, have any unintended consequences and are fit for purpose.

The full background to the inclusion of this topic in the pilot, including a list of piloted indicators, is presented in Appendix A along with a description of the method and approach to piloting.

Practice recruitment

More detail on the general practice recruitment methodology is shown in Appendix B.

In summary:

Number of practices initially recruited	27
Final number of practices in the pilot (January 2022)	16
Number of practices participating in feedback	16

Feedback was obtained via interviews and an online survey, and individuals were able to participate in both the survey and the interviews. At least one survey was completed by each of the 16 participating practices. The quantitative responses to the online survey for all piloted topics are shown in Appendix F. The table below indicates the practice participation in the pilot specifically for the epilepsy topic.

Feedback participation by role and method (epilepsy topic)

Staff role	Interviews - number of participants	Survey - number of respondents
GP	7	17
Practice manager	2	6
Other senior management	3	2
Pharmacist	1	2
Practice Nurse	1	4
Practice administrative staff	1	5
Other clinical staff	0	2
Number of participants	15 From 11 practices # *	38**

As described in Appendix A, not all interviews covered all topics and only 11 out of the 16 practices were asked questions about epilepsy in their interviews.

*Only 9 practices were able to provide interview feedback about indicators 2 and 3.

**Not all respondents completed all of the epilepsy-related indicator survey questions (see Appendix A).

Assessment of clarity, feasibility, reliability and acceptability

Clarity

There were no significant problems with ambiguity for any of the three indicators, although greater clarity on the definition of those with a 'mental health condition' in the guidance was suggested for indicator 3. A few specific amendments to indicator wording were suggested in the survey feedback (for detail see p21).

Feasibility and reliability

No significant issues were raised by the pilot practices regarding identifying patients for indicators 1 and 2, with one specifically noting the cohort for indicator 1 would be 'easy to define'.

There were mixed views as to whether the mental health QOF register would adequately capture the appropriate patients for indicator 3. The accuracy of the register was also highlighted as a potential issue by a few practices (see p19).

The ability to accurately capture information or notifications in a timely manner from secondary care was raised as a possible issue by some practices (see p20).

Acceptability

This section summarises practice views from the interviews and the survey on the acceptability of the topic; on the potential impact on quality of care; the importance of the issues covered by the indicators for patients and families; the role of financial incentivisation; and, separately for each indicator, any specific acceptability issues identified.

Topic feedback

Most practices interviewed were supportive of an annual review for all adults receiving drug treatment for epilepsy (indicator 1) and three practices commented that it would improve patient safety (for example, through improved medication compliance). One GP noted that patients with epilepsy are already reviewed in their practice every year.

“I think straight off we'd say we can see the value in it, I think, from a patient perspective it's a very useful thing to do, and certainly hopefully improve their confidence in terms of their use of their medications.” [Pharmacist, Interview]

“In a clinical practice you meet quite a few patients who have challenges with medication, and I think it is important that we are adequately resourced to do that and (...) it will help enormously from a safety profile because (...) then this patient will come on the radar and won't slip through the net.” [GP, Interview]

However, one GP questioned the value of this indicator (indicator 1), asserting that because patients with epilepsy are referred and managed within secondary care, particularly for medication reviews/changes, the indicator would be better placed in secondary care:

“I am not a big fan of this, and the reason why is because – fine, you have reviewed these patients, they have got side effects, they get seizures from it – what are you going to do as a GP? You just end up referring anyway – you are just basically a middleman here. This really needs to be done from secondary care.” [GP, Interview]

Many other practices also highlighted the potential overlap with reviews of patients with epilepsy being conducted by staff in secondary care emphasising that they would not want to have to re-review these patients (see p13).

Interviewees generally agreed that indicators 2 and 3 are acceptable, with practices noting that existing reviews are conducted with these patient groups regarding their learning disability and/or mental health condition. However, views on whether an epilepsy review would be included in these existing reviews varied between practices, particularly for indicator 3 (see p18 for detail). In contrast, and due to these existing reviews, one practice questioned the value of creating subsets of patients for these indicators and suggested that only indicator 1 is retained.

“I would suggest that you drop indicators 2 and 3 because they add nothing because we are doing learning disabilities' health checks every year, we are getting battered with them and you have got the severe mental health indicators that do all the mental health patients. Forget 2 and 3 but do 1.” [Practice Manager, Interview]

A further practice also initially shared this view, but after further reflection during the interview, the GP from this practice thought indicators 2 and 3 were important to ensure that these subgroups of patients are not missed by only including indicator 1:

“I'm going to contradict myself now because the problem is that with indicator 1, there's likely to be percentage parameters for performance and you can end up with

these small cohorts of difficult to reach being indicators two and three. So, if they're not sub-setted, they become the ones who become ignored because you hit your QOF targets and pressure goes. So, I guess high targets on the subsets. Maybe there is some merit." [GP, Interview]

Whilst there was support in general for indicators 2 and 3, some issues were noted: the small cohort of patients (particularly for indicator 3), the difficulty of incorporating a review of epilepsy within existing mental health reviews (indicator 3), and the potential to miss appropriate patients (indicator 3). See indicator-level feedback for indicators 2 and 3 for further detail.

Indicator-level feedback

Quality of care

The views of survey respondents about the impact of the epilepsy-related indicators on the quality of care for patients were obtained. Across all three indicators, no respondents predicted the indicators could 'worsen' the quality of care for patients (Table 1).

Table 1: Views on the impact of quality of care of epilepsy-related indicators (survey)

What impact do you think the following indicators could have on the quality of care for patients?				
	Improve	No change	Worsen	Total
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	30 (78.9%)	8 (21.1%)	0 (0.0%)	38
Indicator 2: Annual review of adults with a learning disability and epilepsy	27 (71.1%)	11 (28.9%)	0 (0.0%)	38
Indicator 3: Annual review of adults with a mental health condition and epilepsy	25 (65.8%)	13 (34.2%)	0 (0.0%)	38

Most respondents (78.9%, 30/38) agreed that an annual review of all adults receiving drug treatment for epilepsy (indicator 1) could improve the quality of care for patients. Compared with indicator 1, slightly fewer respondents thought that indicators 2 and 3 could improve the quality of care for patients. However, the majority (71.1%, 27/38) still agreed that an annual review of adults with a learning disability and epilepsy (indicator 2) would improve care quality. Similarly, 25 of the 38 respondents (65.8%) thought an annual review of adults with a mental health

condition and epilepsy (indicator 3) could improve the patients' quality of care, with around one third (13/38, 34.2%) reporting there would be 'no change'.

As discussed previously, the interviews with practices revealed a general agreement that the indicators could improve the quality of care for patients in terms of medication compliance and ensuring patients do not 'slip through the net'.

"We thought this was a useful indicator [Indicator 1] that would improve quality of care for this group." [GP, Interview]

Value to patients

There was general agreement by the survey respondents that the epilepsy indicators represent what is important to patients, families, and carers (Table 2).

A slightly larger number of respondents (73.7%, 28/38) thought an annual review of adults with a learning disability and epilepsy (indicator 2) was important to patients, families and carers when compared with indicator 1 (65.8%, 25/38) and Indicator 3 (68.4%, 26/38). Seven respondents (18.4%) were unsure whether indicators 1 and 3 represent an issue that is important to patients, families and carers, with 4 respondents (10.5%) reporting such uncertainty for indicator 2 (Table 2).

Table 2: Views on the importance of the epilepsy-related indicators to patients, families and carers (survey)

Do you think the following indicators represent an issue that is important for patients, families and carers?				
	Yes	No	Unsure	Total
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	25 (65.8%)	6 (15.8%)	7 (18.4%)	38
Indicator 2: Annual review of adults with a learning disability and epilepsy	28 (73.7%)	6 (15.8%)	4 (10.5%)	38
Indicator 3: Annual review of adults with a mental health condition and epilepsy	26 (68.4%)	5 (13.2%)	7 (18.4%)	38

Four practices were asked in the interviews whether patients with epilepsy would value an annual review. Although they had not received direct feedback from their patients, it was felt patients would be likely to appreciate a review. When discussing indicator 2, one practice noted that patients with a learning disability value their current annual review:

"I think they value it actually. We have got (...) a member of our team who specialises in this area in some ways and is very good at getting the patients in, so I think we try and provide a continuous service where we are very flexible [and] offer appointments at certain times. I think it works quite well really" [GP, Interview]

However, in relation to indicator 1, two practices did caution that patients would not value a review if they were unable to see what benefit it would provide:

"...we did do this a few years ago, and it was one of those indicators where you thought, 'What quite are we doing here?' It can feel rather like you're extracting data from a patient. 'Are you seizure free?', 'Yippee', or, 'How many seizures have you had?' So, I'm not sure how useful it felt to the patients when we were doing it before and any indicator that sort of gives that result feels a bit cynical to deliver as a doctor and might feel a bit cynical and un-engaging to a patient. So, I think that's worth just considering." [GP, Interview]

Financial incentivisation

Most respondents to the survey were supportive of financial incentives for the epilepsy-related indicators.

The proportion of respondents who agreed the indicators should be financially incentivised varied between each indicator (Table 3). Whilst a high proportion (80.6%, 29/36) thought the annual review of all adults receiving drug treatment for epilepsy (indicator 1) should be financially incentivised, there was slightly less support for incentivising indicators 2 and 3 (75.0% and 69.4%, respectively). Five respondents (13.9%) did not think the annual review of adults with a mental health condition and epilepsy (indicator 3) should be financially incentivised, and a further six respondents (16.7%) were unsure.

Table 3: Views on financial incentivisation of epilepsy-related indicators (survey)

Do you think the following indicators should be financially incentivised?				
	Yes	No	Unsure	Total
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	29 (80.6%)	2 (5.6%)	5 (13.9%)	36
Indicator 2: Annual review of adults with a learning disability and epilepsy	27 (75.0%)	3 (8.3%)	6 (16.7%)	36
Indicator 3: Annual review of adults with a mental health condition and epilepsy	25 (69.4%)	5 (13.9%)	6 (16.7%)	36

As noted previously, one of the practices interviewed cautioned that if only indicator 1 was implemented in QOF, there is a risk that the harder to reach subgroups associated with indicators 2 and 3 may be overlooked once the target parameters for indicator 1 had been achieved.

Quality improvement

The survey showed mixed views as to whether the epilepsy-related indicators could be suitable for quality improvement without incentivisation.

Approximately half of respondents thought the indicators were suitable for quality improvement without incentivisation; 52.8% (19/36) reported this was the case for indicators 1 and 3, with a slightly higher proportion (58.3%, 21/36) agreeing indicator 2 was suitable for quality improvement (Table 4). Around one quarter of respondents did not feel the indicators were suitable for quality improvement without incentivisation, with the remaining respondents being unsure (Table 4).

Table 4: Views on suitability of epilepsy-related indicators for quality improvement (survey)

Do you think the following indicators could be suitable for quality improvement, without financial incentive?				
	Yes	No	Unsure	Total
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	19 (52.8%)	8 (22.2%)	9 (25.0%)	36
Indicator 2: Annual review of adults with a learning disability and epilepsy	21 (58.3%)	9 (25.0%)	6 (16.7%)	36
Indicator 3: Annual review of adults with a mental health condition and epilepsy	19 (52.8%)	10 (27.8%)	7 (19.4%)	36

Indicator 1 – Annual review (all adults receiving drug treatment for epilepsy)– specific issues identified in interviews and survey

Review setting

As noted previously, one practice interviewed was not in favour of this indicator due to the limited involvement (in their view) that GPs have in managing medication for patients with epilepsy and believed it should take place in specialist settings:

“I am not a big fan of this, and the reason why is because – fine, you have reviewed these patients, they have got side effects, they get seizures from it – what are you

going to do as a GP? You just end up referring anyway – you are just basically a middleman here.” [GP, Interview]

One respondent from a different practice corroborated this view in the survey:

“Too much crossover duplication with the epilepsy ones and most patients under secondary care anyway.” [Practice Manager, Survey]

“I don't feel there is much use for epilepsy reviews as we are powerless to alter the patient's medications. Referring to neurology when there is a problem is additional work for the GP. Therefore, it is preferable for 2o care or epilepsy nurses to do them” [GP, Survey].

The potential overlap with secondary care was also highlighted as an issue by a few other practices interviewed with practices emphasising, on the whole, that they would not want to re-review the patient if they had already been reviewed in secondary care:

“I suppose what I'm concerned we had was around the relationship with secondary care. A lot of epileptic patients will have been assessed by neurologists and a lot of them will have their review done by their neurologist, so are we duplicating slightly what's been done by secondary care if this was going to be an indicator? Would the neurologists' review stand instead of what we do in primary care, or would we be then reviewing the patient in primary care?” [Pharmacist, Interview]

Some of the practices interviewed stated that GPs are not involved in altering patients' anti-epileptic medications. However, this varied between practices with some stating that they were able to make changes. In summary, the interviews revealed variation between practices in how epilepsy patients are managed. A few practices explained that most patients are discharged to primary care from their local neurology team, with one practice noting that their neurology service was “non-existent” in their area. In other areas patients with epilepsy appear to be largely under the care of a specialist epilepsy team.

Implication of reviews being conducted in secondary care

There were mixed views on the value of the indicator if the review was conducted in secondary care, with GP practices recording this information in their clinical system. Many practices thought it should be acceptable to simply record that the review had taken place in specialist care to fulfil this indicator, with one GP noting that it would

be 'irritating' if they were required to conduct an additional review when this was already being completed by a specialist.

"...it feels very tick box-y if somebody else is doing a review and we're being asked to do a face-to-face review of somebody who we know is having a review under a specialist. That feels very tick box-y and is a bit irritating. If it's adequate to say, 'This patient is under active epilepsy clinic review and that that meets the indicator,' I think that enhances the indicator rather than detracts from it, given that one would expect an epilepsy clinic to manage effectiveness and tolerability." [GP, Interview]

"Quite a few of these patients are under the epilepsy service, so a review by the epilepsy service should count as a review – it doesn't have to be additional work. If the professional epilepsy service is doing the review – fine – tick the box." [Practice manager, Interview]

"I think ultimately the outcome for the patient would be similar if they've still got an assessment every twelve months, it doesn't really matter where that's done. Arguably, there might be more value in their assessment coming from the neurologist perhaps, because they have a specialist interest in that field." [Pharmacist, Interview]

When discussing the potential duplication with reviews being carried out in secondary care, one practice suggested that some of their practice members thought it could be important for an additional review to be conducted in primary care which was more 'holistic' in nature although this view was contested

"We did wonder about whether there will be some duplication for people in secondary care, who are having their medication reviews in secondary care. Then we wondered whether, actually, what we would do would be a more holistic review than some of our secondary care colleagues and actually, it might be important that we should review them as well. So there was some difference of opinion in the group there as to whether there should be a code for an annual secondary care review that would take people out of this or not." [GP, Interview]

Notifications from secondary care

If the review was carried out in secondary care there was a shared view that practices would be notified, although one practice said there could be a delay in receiving this information. Further, another practice noted that the letters can be of poor quality, making it difficult to record the information in their clinical system. It was implied by one interviewed practice that the notification of reviews conducted in secondary care would depend on the quality of the local specialist service:

“We have actually got quite a good epilepsy team in our area with a very good epilepsy nurse specialist so I suppose it will depend on what’s available to each of the primary care teams across the country, but we are quite lucky” [GP, Interview]

It was also highlighted by one practice that it can be difficult to know the quality and content of a review that has been conducted in secondary care:

“I think that it's difficult for primary care to necessarily quality assure what's going on in secondary care. So, you know, if there's a code associated with a secondary care review it will just be added when the letter comes in from secondary care on a regular basis. So we don't necessarily know that everything that should be in that structured review is going to be done.” [GP, Interview].

Content of review

Concern was expressed by a few practices that there could be variation in the level of review conducted, with some practices just ‘ticking the box’ and others completing a more extensive review. One practice suggested that more information in the supporting guidance would help mitigate this issue.

Effectiveness and tolerability were identified by some practices as key topics to include in the content of the review. One practice argued that it was ‘quite straightforward’ what needed to be included in the review, stating “It’s last fit, contraception, driving, and mental health.” [GP, Interview]

Indicator 2 – Annual review (adults with a learning disability and epilepsy) – specific issues identified in interviews and survey

Learning disability reviews

There was agreement amongst those interviewed that this indicator could be fulfilled by incorporating a review of patients’ epilepsy within the existing learning disability annual reviews/health checks. Many practices noted how existing full reviews with this group of patients already include a discussion of their epilepsy:

“We actually already currently do this under the learning disability health check. Our nurses identified that they didn't feel that they could do the full check for the learning disability if they were epileptic without discussing it in detail anyway. So, as far as we're concerned, that's something we fully support, because it won't be any change to us.” [Data Quality Staff Member, Interview]

“It is already being done (...) obviously they have a full review with the nurse and with the GP. So, there wouldn't be much change, really.” [Deputy Practice Manager, Interview]

One GP said it would be straightforward for the epilepsy review to be part of the learning disability review as a ‘tick box’ exercise, but felt it was important for the learning disability review to be of high quality through greater investment:

“I thought it was already being done in the learning disability reviews. We thought that it would be a box-tick, potentially, that a review is done as part of the learning disability and you could make an extra box to tick on that, it would be easy to do. But what's actually important in this population is thinking about control of epilepsy and side-effects, and actually that if you amended what goes on in the learning disability review and put some money into it rather than ticking boxes, actually getting better quality reviews done and then that actually might be a better way to invest that.” [GP, Interview]

Practices' views on expanding the existing Primary Care Network (PCN) DES indicator are outlined in the later relevant section (see p36).

Difficulty engaging patients

It was noted by two interviewed practices and one survey respondent that it can be difficult to engage with patients with learning disabilities so including a review of their epilepsy within the learning disability health check, rather than a separate review, was considered important.

“We are already struggling to get patients to attend their LD reviews - it often takes as many as 4 or 5 invites with hours of clinical time lost.” [Other Senior Management, Survey].

“I think it is crucial to do that within primary care really as part of that disability review (...) because often when you arrange these disability reviews you have got the carers coming in, you have got the parents, you have got whoever and I think it is an ideal time to, again do a one stop shop for that patient really, because it is quite hard getting these patients in sometimes.” [GP, Interview]

Indicator 3 – Annual review (adults with a mental health condition and epilepsy) – specific issues identified in interviews and survey

Small patient cohort

During the interviews, a few practices questioned the value of this indicator given the small number of patients that would be both on the epilepsy register and the mental health QOF register.

“I think there's only five patients on both the mental health register and the epilepsy register, that wouldn't really be much more work (...) so, I can't see that needs to be an indicator, in its, like, own right, kind of thing.” [Data Quality Staff Member, Interview]

“It's not going to be very helpful. It's going to throw up a few people because they're both relatively small registers. So, there might be one or two people in a huge practice who you may or may not be able to chase down.” [GP, Interview]

However, one practice interviewed implied that the small numbers involved would make the indicator more achievable but that it should be done at PCN level.

“So, patients on the severe mental health illness, there isn't a big register on those so that would be doable ... and only a small proportion of those will have epilepsy. So, the numbers are quite small there so you can do it as a PCN level.” [GP, Interview]

Related mental health indicator

Practices noted that they already conduct comprehensive reviews of people with a mental health condition who are on the mental health QOF register.

There were mixed views on whether existing mental health indicators could be expanded to include a discussion of epilepsy. At least four practices thought it would be acceptable to incorporate a discussion of epilepsy within the existing mental health reviews, with one explicitly stating that epilepsy would already be covered in this discussion. In contrast, two other practices did not agree with this suggestion; one GP felt the focus of the care plan review is not compatible with a discussion of epilepsy and one practice emphasised that the healthcare professional conducting a mental health review may not have the necessary knowledge of epilepsy as their focus is on mental health rather than neurology. It was suggested that a separate review (or split review with different professionals) would be required:

“...I think the care plan review certainly feels like it's more about recognising deterioration in their mental health rather than dealing with their other co-morbidities (...) so I think this would sit better as indicator three under epilepsy than it would as a component of the mental health care review even if it was a subset under that. I suspect it would sit better in a separate epilepsy [review].” [GP, Interview]

“so this one [mental health review] is done by a mental health facilitator... obviously the epilepsy wouldn't be mentioned during that, because it's not something you would be able to help with. So, that would require a completely different review (...) so, for us it would be two separate appointments.” [Deputy Practice Manager, Interview]

One of the practices warned that the process of splitting the review (or conducting separate reviews) would have negative implications.

“You can't put indicators that require two different things and two different skill sets and then split the work to five different people. It's not efficient money-wise, it's not good for the patient.” [Deputy Practice Manager, Interview]

Due to variability between practices of the skills in the team and how they run their systems, the GP quoted in connection to the use of a separate review suggested that individual practices should decide on how best to conduct the review:

“I would think, and probably best left, the practices, to decide how they do them. I mean, I guess if you're ultimately organised as a practice, you make it all one review with the right person who has the set of skills to deal with it all, or a, sort of, split review. So, an appointment with one, followed by a finishing off appointment with someone else, and if you're in a less coordinated practice you might find yourself thinking, 'Okay, well we'll do the epilepsy review in March, and then we'll contact them for their diabetic review in August,' but I think that would just vary so much about how practices run their systems.” [GP, Interview]

Identifying patients

There were mixed views as to whether patients on the mental health QOF register would adequately capture appropriate patients for this indicator i.e. patients with a 'complex mental health problem'. One practice noted that many patients who have a complex 'mental health problem' “would be missed” as they are not on the register:

“The vast majority of that patient group aren't on the SMI register, of course (...) Huge, huge numbers would be missed (...) There will be personality disorders, there'll be chronic depressions, recurrent depressions, anxiety depressions, PTSDs, all of those. Although, you know, the severe and enduring mental illness register is

psychosis and bipolar disorder. So, all of those chronic, complex mental health patients aren't on the SMI register." [GP, Interview]

Similarly, another GP commented that there are patients with mental illnesses who may not be captured within the QOF register, noting the importance of using indicator 1 to ensure patients are not missed:

"I think if you didn't have Indicator 1, then it would be concerning because [of] the fact that there are a lot of patients with mental health conditions that don't quite fit the theory of mental illness. So, if you had Indicator 1 as well, I would be reassured." [GP, Interview]

This view was supported by another GP who when asked if any patients would be missed by using the existing QOF mental health register for the indicator population responded by saying "Any patients that are missed are still covered by indicator one."

Views on the accuracy of the mental health register varied between practices. One practice explained that their mental health register is up-to-date as it was reviewed last year, but prior to this some people were missed due to incorrect coding. A different practice noted that conducting a search of patients who are on medication for a mental health problem via the care plan should be accurate, but other patients (who are not on medication) would not be on the register as their social circumstances are more of a clinical judgement.

The interviews revealed that, if the review was not conducted in primary care, capturing information from secondary care is another potential issue for this indicator. Whilst one practice said they would expect to receive information from secondary care around what had been done or discussed with the patients, another practice highlighted that in their area capturing such information would be difficult:

"The only thing I would say is if it isn't done in primary care, the data coming back for mental health is really poor in our area. So, capturing that data would be difficult." [Practice Manager, Interview]

Suggested amendments to indicator definitions and/or wording

Feedback regarding the indicator wording, definitions and associated guidance were provided from the interviews and the survey.

Indicator 1 – Annual review of all adults receiving drug treatment for epilepsy

Only 2 of the 33 survey respondents (6.1%) thought the wording for this indicator should be changed. Both respondents thought the word 'structured' should be removed due to the implication this is associated with numerous requirements.

“For the epilepsy [indicators] I would remove the word 'structured'. It indicates a lot of questions to ask.” [GP, Survey]

“Less is more! The epilepsy ones use the amorphous term structured review - this could hold a multitude of requirements.” [Practice Manager, Survey]

Practices were asked whether this indicator should be limited to patients with epilepsy receiving certain anti-seizure medications associated with long-term side effects or drug interactions (rather than all patients on the epilepsy register i.e. all patients receiving drug treatment for epilepsy), and/or whether they should focus on adults aged 65 and over receiving drug treatment for epilepsy.

Overall, the interviewed practices agreed that the indicators should not be limited to subgroups based on the patients' type of medication and/or age. It was noted by a pharmacist that for equality reasons all patients should be given a review. Other practices mentioned the importance of reviewing all patients to check on compliance and tolerability, and that by creating subgroups there was a risk that some patients could be missed.

“I'm fine with keeping with just the register, personally, partly around the issue of equality. If they've been diagnosed with epilepsy, I think they're entitled to a review.” [Pharmacist, Interview]

“I just think with this condition (...) everybody should have that review. I think it is really important and compliance, side effects, contraception – all of those things, they all tie in with it (...) I didn't like the idea of sub-groups.” [GP, Interview]

“So I think the more you subset things, the more difficult they get to manage to get the right people. So, I mean, for everyone, they need effectiveness. Some drugs may have more tolerability problems but trying to divide that-, I would keep it simple and say all patients with epilepsy.” [GP, Interview]

When discussing the potential age groups for restricting the indicators, one GP advised that those aged over 65 typically report fewer side effects and generally adhere to prescriptions, suggesting therefore that those aged 20-40 years should be prioritised. In contrast, while a GP from a different practice agreed that those aged over 65 are less likely to have continued seizures, they noted that older patients are more susceptible to side effects and toxicity from other medications (polypharmacy), so it is important to review everyone. This view was supported by another GP who highlighted that as people age their bodies change and they are more likely to be given other medications which may have side effects.

The same GP suggested that an alternative indicator for those patients aged 65 and over, where a different type of review could be conducted, would allow for a consideration of anti-epileptic medication's side effects. However, they added that, rather than sub-grouping the indicator, the guidance could instead state that the practice could vary the focus of the review depending on the age of the patient:

“If what you’re doing is looking for side effects, you could focus on the over-65, you could have that as an alternative indicator ... The other thing you could do is you could specify in the guidance a different type of review or a different focus to the review depending on the age of the patient and leave it up to the practice to actually do two types of reviews to two ages of patients. But you could achieve some of those outcomes without actually counting it and just be able to trust practices to do two different reviews depending on age and the guidance.” [GP, interview]

This view was not limited to older people, another practice made a similar suggestion regarding sub-grouping by medication:

“I think having an epilepsy register and just saying those are the people who are going to be reviewed and then the nature of their treatment determines the nature of the review, would be my perspective.” [Pharmacist, Interview]

The same GP quoted above highlighted that if focusing on the side effects of anti-epileptic drugs is the intention of indicator 1, the indicator should be extended to include all patients prescribed such medication (such as for those with facial pain or bipolar disorder), rather than just patients on the epilepsy register.

Whilst a different GP suggested that it may be important to include all epilepsy patients in indicator 1 irrespective of whether or not they are on medication, both to avoid ‘search questions’ (in the clinical system) and in case patients had got a stock

pile of medication and, as such, subsequently got missed off the register despite still taking medication.

“... or all patients with epilepsy rather than sub-setting it because I think that makes for search questions and, you know, if they've got a stock pile of a drug so they've ordered it and now that drug hasn't appeared, they don't appear in the list so they get missed off.” [GP, Interview]

Indicator 2 – Annual review of all adults with a learning disability and epilepsy

Three respondents (9.1%, 3/33) agreed the wording of this indicator should be changed. Two were the same respondents who noted the issue with the word 'structured' review (in regard to indicator 1); the third respondent suggested specifying the wording for the indicator to adults (18 and over) on the Learning Disability register receiving drug treatment.

When discussing this indicator, practices were asked to consider a wider definition of patients with epilepsy to include those who may not currently be on medication.

There was variation between the practices interviewed on whether there would be any patients who have a clinical code for epilepsy but who are not on the QOF epilepsy register because they are not currently on medication. One practice explicitly confirmed there are patients with an epilepsy clinical code who are not currently on medication:

“I know we've got patients logged as epilepsy and they're not on medication. It needs checking and reviewing. There are also quite a lot who have had it changed to 'history of epilepsy', whether that code would have got included I don't know. But it would definitely need some sort of data validation I think.” [Practice Manager, Interview]

However, two practices considered it unlikely that there would be patients with an epilepsy code who were not on medication and therefore on the epilepsy register.

“I think it is highly unlikely that we have got patients with epilepsy who aren't on medication.” [GP, Interview]

It was noted by one of these practices that there is a potential for some patients to be coded incorrectly as having epilepsy due to unclear letters provided by specialist care, with the coding being completed by non-medically trained staff.

“... it's very unusual to see people with epilepsy who aren't on medication, unless they were actually a solitary seizure and coded in a way that isn't actually correct.”

But then, we do often get quite unclear letters from secondary care and then coding is of course done, often, by non-medically trained staff. They're very good but a letter that says, 'This patient has had two seizures, two years apart, they may have epilepsy,' that could get coded as epilepsy, but it draws one's focus into tidying up registers, I think." [GP, Interview]

Five practices were asked directly if they could identify patients with epilepsy, who were not on medication, from their clinical systems. Two practices confirmed it would be possible to identify this group of patients, with one noting it would be recorded within the learning disability review.

"Anyone who has epilepsy, who are not on medication, we can identify those cohorts – yes that would be easy to find." [GP, interview]

However, one practice thought identifying this cohort could depend on the quality of coding within the clinical system and suggested the indicator should include patients with a learning disability with either a diagnosis of epilepsy or those who are on antiepileptic drugs. At least one practice appeared to be confused about the eligibility for the QOF epilepsy register (which requires drug treatment for epilepsy, not just a diagnosis of epilepsy):

"I think it depends on the coding. I think that I'm confident in our coding that if someone has got a diagnosis of epilepsy, they are on our QOF register because I'm confident that our code is-, we'll have picked that up from hospital letters and we'll have added it. I don't know if every practice is that good (...)" [GP, Interview]

The need for data validation was also noted by another practice (see later in this section) in relation to including those with epilepsy irrespective of whether or not they are on medication.

Finally in relation to this area of questioning, one practice highlighted that those patients with epilepsy, who are not taking anti-epileptic medication, would be captured regardless if the learning disability health check was extended to include a review of their epilepsy. The value of a review being conducted with a patient who was no longer taking medication for epilepsy was questioned by two practices.

"If you make it [indicator 2] an 'all are on anti-epileptic medication' (...) then you would pick up the vast majority of those. There would be a few who have had a few fits twenty years ago and then not had any more fits and then not been on any medication for the last ten years. But what's the value in doing the review for them anymore?" [GP, Interview]

In contrast, a different practice appeared to suggest they would still conduct a review with epilepsy patients even if they were no longer taking medication:

Practice Nurse: "... patients that (...) have got epilepsy and they have come off the medication because it's resolved but they will still have that code on their records.....

GP (from same practice):and we will still be doing a review with them."

Indicator 3 – Annual review (adults with a mental health condition and epilepsy)

Four survey respondents (4/33, 12.1%) reported the wording of this indicator should be changed. The word 'structured' review was noted as problematic by two respondents (as per indicators 1 and 2). A third suggested the wording should be amended to "*only those receiving drug treatment and on[ly] those eligible for MH Care Plan*". A fourth respondent suggested greater clarity was needed for defining a mental health condition:

"Clarity is needed when defining mental health condition – e.g. serious mental illness rather than a broad brush-stroke to cover all possible mental health conditions." [GP, Survey]

The need for further definition of patients with a 'complex mental health problem' was also discussed during the interviews with practices (see p19).

Practices were not asked to consider any changes to the scope of indicator 3.

Practices' views on implementation issues and impact

This section covers practices' views on: training requirements; workload, resource utilisation (including which healthcare professionals would be involved) and costs (including impact on appointment times); any changes required to practice organisation (e.g. setting up and use of clinical system protocols, recall systems and templates); any barriers to implementation; assessment of overlap with and/or impact on existing QOF indicators or local schemes; and any other overall views on implementation of the indicators (including unintended consequences).

Training requirements

Practices in the survey and interviews were asked whether staff would need any additional training or guidance to implement the epilepsy-related indicators. Almost

two thirds of respondents to the survey (63.3%, 19/30) thought that clinical staff would need to undertake additional training if the epilepsy indicators were introduced, with fewer respondents (43.3%, 13/30) reporting this was the case for administrative staff.

It was highlighted by some practices interviewed that the level of training would be dependent on the type of review required and the health professional conducting it. In contrast to the survey findings, interviewed practices generally agreed that unless GPs will be required to manage patients' medication (such as being given authorisation to amend their anti-epileptic medication), no further training or guidance would be necessary:

"I don't think there is much [training or guidance required] – unless you give authorisation for a GP to be – to fiddle around with their anti-epileptic medications" [GP, Interview]

"...it depends slightly on what the outcome is going to be from these reviews (...) The way I'm reading this is we're talking about a review rather than necessarily a comprehensive clinical intervention. This could well trigger a referral into secondary care, and I think if we're managing it that way, that's what we're trying to achieve, then that's fine. I think in terms of additional training, if we were taking it a step further and saying, 'We're going to be managing epileptic patients in primary care,' then that would require additional input." [Pharmacist, Interview]

"...usually epilepsy is, sort of, a lifelong thing with people with learning disabilities. So, I've never had to start over (...) So, to answer your question, I don't think any new training would be necessary." [GP, Interview]

Whilst one GP said they were comfortable with conducting a review for patients with epilepsy, they thought the guidance contained useful advice that could be drawn upon in the review and that some further training of nursing staff may be required. Another GP thought the use of a template might be useful for indicator 2.

"Specify what should take place, making, you know any sort of paperwork or templates available and easy to use. And, like, 'tick this box if you've done this package of care for this patient'." [GP, Interview]

Templates were also mentioned by a couple of the other practices, specifically in relation to either indicator 2 and/or indicator 3. However, practices emphasised the importance of merging the templates with existing templates to avoid significant implications on workload:

“So, I think it’s just locally how do they ensure that it’s all in one template, so that’s a learning disability template, if there is a section on there about if this patient also suffers with epilepsy, then complete that part rather than switching and changing and completing ...” [Deputy Practice Manager, Interview]

Only a small number of survey respondents thought the indicator guidance in the pilot handbook (Appendix A) could be improved: 3/33 respondents (9.1%) for indicators 1 and 2 and 4/33 respondents (12.1%) for indicator 3. Their free text comments centred on the rationale or focus of the indicators rather than the guidance, with only one respondent noting that more practical solutions are needed:

“All too "ivory tower". Need more practical solutions rather than a cut & paste from NICE. Just put a link to NICE. I'm capable of finding the detail on their website if I want it.” [GP, Survey]

Workload, resource utilisation and costs

As with training requirements, the perceived workload associated with the indicators was regarded by interviewees to be dependent on the type/extent of review conducted. Greater clarity on the expected review content may be required prior to implementation, to better understand the implications of the indicators for clinical and administrative workload. One GP felt that specifying which type of health professional should conduct the review is “too formulaic” but specifying what should be covered – effectiveness and tolerability – should be included.

Clinical workload

Just over half of the survey respondents (17/31, 54.8%) said indicator 1 would ‘definitely’ create additional clinical workload, with a further 9 respondents (29.0%) saying it would ‘to some extent’ (Table 5). The proportion of respondents who thought indicators 2 and 3 would ‘definitely’ generate additional clinical work was lower than for indicator 1 (11/31, 35.5%).

Table 5: Views on additional clinical workload generated by each indicator (survey)

Will the requirements relating to each indicator generate additional clinical workload?					
	Yes, definitely	Yes, to some extent	No	Unsure	Total
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	17 (54.8%)	9 (29.0%)	3 (9.7%)	2 (6.5%)	31
Indicator 2: Annual review of adults with a learning disability and epilepsy	11 (35.5%)	9 (29.0%)	7 (22.6%)	4 (12.9%)	31
Indicator 3: Annual review of adults with a mental health condition and epilepsy	11 (35.5%)	10 (32.3%)	7 (22.6%)	3 (9.7%)	31

Most survey respondents thought the indicators would create additional workload. In contrast, some practices interviewed noted that if a comprehensive review was carried out in secondary care (indicator 1), the workload for primary care would be minimal, as long as practices were able to simply code that a review had been undertaken in secondary care and, as such, not have to re-review the patient.

One GP from another practice suggested that a text questionnaire could be used to identify and review those patients with epilepsy that are experiencing seizures and/or medication side effects.

“How [do] you define what takes place in that structured review, is it something that could be done as simple as a text questionnaire to try and pull out some people who have got side effects or poor control (...) Those are the two key things to (...) take some action on (...) a few have said that a text review or a short questionnaire is completely suitable for this (...) You don't have to inconvenience and put off large numbers of well-controlled, completely happy patients in order to achieve the quality payment.” [GP, Interview]

A similar view was expressed by another practice who emphasised that the review should not have to be conducted face-to-face:

“Any reviews that are specified as face-to-face ... tend to feel more burdensome and it feels a bit more formulaic if you are insisting on face-to-face when in fact it really is just a conversation, so why not do it on the phone? So, I would feel that this would be once that certainly shouldn't be face-to-face.” [GP, Interview]

However, another practice cautioned that unless the supporting guidance provides greater clarity on what is expected within a review, there will be variability between practices in how the indicator is fulfilled:

“I think you'll get a two-tier system. Those practices that'll just tick the box without, you know, doing the full review that you would expect us to do. So, I think you would need more information as part of that indicator to make sure it was all covered.” [Practice Manager, Interview]

The survey showed variation in views on whether the requirements of indicator 2 would generate additional clinical workload (Table 5). The interviews revealed differences between practices in how the learning disability health checks are currently conducted, which may explain some of this variation (given a general agreement that the epilepsy review would be covered within the existing learning disability health checks). For instance, one of the practices interviewed noted that the learning disability health checks are carried out by specialists in the PCN, whereas another practice reported that their own staff conduct them.

It was noted by a few practices that, due to the small number of patients with both epilepsy and a learning disability, or both epilepsy and on the mental health register, the increase in workload for implementing indicators 2 and 3 would not be significant. One GP recognised indicator 2 as a ‘high-value’ indicator; due to the small cohort of patients, completing the epilepsy review within the learning disability review would not be too demanding.

“One would probably recognise indicator two as potentially quite a high-value indicator, because if you've only got a small number of patients and you've got a high percentage to meet, to hit, it's not a big job to make sure that that's done at their learning disability review. So, I think it would sort of be self-fulfilling in a way.” [GP, Interview]

The difference in opinions among the practices interviewed on whether the epilepsy review (indicator 3) could be incorporated within the existing mental health review has implications for workload and resources. If a separate review was required, this could potentially increase the workload to a greater extent and may require input from more than one type of healthcare professional.

Healthcare professionals' role

The survey showed varying views as to which staff groups would be most affected by the clinical requirements of the epilepsy indicators.

Over half of survey respondents reported that ‘Pharmacists’ (23/31, 74.2%) and ‘GPs’ (17/31, 54.8%) would be most affected by the clinical requirements of indicator 1 (Table 6). For indicators 2 and 3, whilst a slightly higher proportion of survey

respondents indicated GPs would be most affected by the clinical requirements, similar proportions also reported that other staff groups (nursing and pharmacist) could be most affected (Table 6).

Table 6: Views on staff groups affected by the clinical requirements (survey n=31*)

Which staff group(s) would be most affected by the clinical requirements of the epilepsy indicators?						
	GP	Nursing	Pharmacist	Other Clinical	Unsure	Total respondents*
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	17 (54.8%)	11 (35.5%)	23 (74.2%)	3 (9.7%)	1 (3.2%)	31
Indicator 2: Annual review of adults with a learning disability and epilepsy	19 (61.3%)	18 (58.1%)	13 (41.9%)	6 (19.4%)	1 (3.2%)	31
Indicator 3: Annual review of adults with a mental health condition and epilepsy	20 (64.5%)	13 (41.9%)	15 (48.4%)	5 (16.1%)	2 (6.5%)	31

* This is a multiple response question, so the number of responses per indicator/row totals more than 31, as respondents could select more than one response

The interviews showed variation between both practices and indicators regarding the healthcare professional role required to undertake the annual review. It was also noted that the staff groups(s) involved would depend on the type of review required.

When asked about which healthcare professionals would be involved in conducting the reviews and whether or not this would be burdensome for the practice, one practice referred to the Additional Roles Reimbursement scheme and the use of these funds to get the staff they need.

“I think particularly with the growth of the ARRS team, I think it’s people who-, if they’re not already there, there are options for them to be already there, according to your priorities and how you spend your ARRS money.” [GP, Interview]

Administrative workload

There were mixed responses to the survey question on whether the indicators would create additional administrative workload, although most responded that the indicators would increase administrative workload either ‘definitely’ or ‘to some extent’ (Table 7).

Table 7: Views on additional administrative workload generated by each indicator (survey)

Will the requirements relating to each indicator generate additional administrative workload?					
	Yes, definitely	Yes, to some extent	No	Unsure	Total
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	12 (37.5%)	14 (43.8%)	4 (12.5%)	2 (6.3%)	32
Indicator 2: Annual review of adults with a learning disability and epilepsy	10 (31.3%)	15 (46.9%)	5 (15.6%)	2 (6.3%)	32
Indicator 3: Annual review of adults with a mental health condition and epilepsy	11 (34.4%)	14 (43.8%)	5 (15.6%)	2 (6.3%)	32

To minimise the administrative workload associated with implementing the indicators, a few practices interviewed suggested that an integrated template should be used to capture the information from an epilepsy review if incorporated into a learning disability or mental health review.

“...ensure that QOF review templates for Epilepsy review, LD check and MH review are all integrated - otherwise we potentially need to complete 3 different templates following a single review.” [Other Senior Management, Survey]

“I think the only comment that we'd have about this indicator [indicator 2] and the next one [indicator 3] is that it's all (...) mostly been done already. It's just a case of that means another template, the increase would be in work, as in actually admin work, than the actual clinical work, as it already being done. So, I think it's just locally how do they ensure that it's all in one template (...) rather than switching and changing and completing, you get another template just for the sake of doing the same amount of work.” [Deputy Practice Manager, Interview]

Similarly, when discussing indicator 1, the Deputy Practice Manager quoted above suggested that if the epilepsy review is conducted in secondary care, an integrated system would reduce administrative workload and prevent primary care staff from being ‘data entry clerks’:

“If they're already being reviewed in secondary care, then leave it as it is. If they have to copy information over, I think our time is utilised better, why do we have to become data entry clerks? So, if you want to collect data, make sure that we're all integrated system and we all use the same clinical system and then coping and pasting, because there's absolutely no value to it whatsoever.” [Deputy Practice Manager, Interview]

Time pressure, appointment capacity and appointment type/length

Overall, there were mixed responses to the survey on whether the introduction of the indicators would be associated with any time pressure issues (Table 8), appointment capacity issues (Table 9) or changes needed to the appointment type or length (Table 10). Such varied opinions may reflect the previously noted differences between practices in how existing learning disability and/or mental health reviews are conducted (including variation in existing appointment times), in addition to different views on the type/extent of the epilepsy review to be introduced.

In the interviews, there were differences reported between practices in terms of the existing appointment length for a learning disability review/health check, ranging between 30 and 60 minutes.

One GP thought the epilepsy review should be kept simple and the appointment would not need to be extended:

“I think if you are going to do an epilepsy review for a learning disability patient, it has got to be kept really simple, because we can’t do much for these patients and it would literally be the case of ‘Are you having any seizures? Are you taking your medication regularly?’ Those are the two things that I see relevant in asking (...) I don’t think you need to extend the appointments any longer.” [GP, Interview]

However, other practices thought some additional time would need to be added to the existing learning disability review to cover epilepsy.

“I think perhaps the person doing the review just needs an extra five minutes in the time slot to do it, to cover it. Because I think they should be covering it anyway. Maybe they’re not covering it in a structured enough way, as in Indicator 1 I suppose. You know, and it should be.” [Practice Manager, Interview]

As shown in Tables 8 and 9, a slightly higher proportion of survey respondents anticipated time pressure issues and appointment capacity issues relating to indicator 1, when compared with indicators 2 and 3. This may reflect that for indicators 2 and 3, some respondents considered that a review of patients with epilepsy could be/was already incorporated within existing learning disability and mental health reviews/health checks.

Table 8: Views on time pressure issues in the practice relating to the indicators (survey)

Can you foresee any other time pressure issues in the practice relating to the indicators				
	Yes	No	Unsure	Total
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	14 (46.7%)	13 (43.3%)	3 (10.0%)	30
Indicator 2: Annual review of adults with a learning disability and epilepsy	11 (36.7%)	15 (50.0%)	4 (13.3%)	30
Indicator 3: Annual review of adults with a mental health condition and epilepsy	12 (40.0%)	13 (43.3%)	5 (16.7%)	30

Table 9: Views on potential capacity issues in the practice relating to the indicators (survey)

Can you foresee any appointment capacity issues in the practice relating to the indicators?				
	Yes	No	Unsure	Total
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	18 (58.1%)	12 (38.7%)	1 (3.2%)	31
Indicator 2: Annual review of adults with a learning disability and epilepsy	13 (41.9%)	17 (54.8%)	1 (3.2%)	31
Indicator 3: Annual review of adults with a mental health condition and epilepsy	14 (45.2%)	15 (48.4%)	2 (6.5%)	31

There was a split view from survey respondents regarding appointment type across all 3 indicators, with just over 40% stating changes would need to be made, and a similar proportion said no changes were needed, with the remaining respondents being unsure (Table 10). A higher proportion of survey respondents reported there would need to be changes to the appointment length for implementing indicator 2 (60.0%, 18/30) and indicator 3 (63.3%, 19/30), when compared with indicator 1 (46.7%, 14/30) (Table 10).

Indicators 2 and 3 could be incorporated within existing reviews for these patient groups, with many of the practices interviewed stating that epilepsy would already be covered in relation to the learning disability review. However, additional time may need to be added.

“So for a learning disability review, quite a long time as in possibly an hour or two half hours. For an epilepsy medication review, it's probably likely to be a ten minute.” [GP, Interview]

“Somebody with epilepsy and with other chronic illness would be done by a nurse in the chronic illness review. We'd have to make a call on what the size of the population with epilepsy and no other chronic illness who currently wouldn't be getting any sort of review. And what we'd do for them, we would probably end up giving them a ten-minute doctor appointment I would have thought.” [GP, Interview]

In contrast, some interviewees commented that indicator 1 could be fulfilled in a straightforward review, thereby not needing to extend the appointment time.

Table 10: Views on any changes needed to appointment type/length relating to the indicators (survey)

Do you think there would need to be any changes to appointment TYPE for the following indicators?				
	Yes	No	Unsure	Total
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	14 (46.7%)	12 (40.0%)	4 (13.3%)	30
Indicator 2: Annual review of adults with a learning disability and epilepsy	11 (36.7%)	14 (46.7%)	5 (16.7%)	30
Indicator 3: Annual review of adults with a mental health condition and epilepsy	13 (43.3%)	13 (43.3%)	4 (13.3%)	30
Do you think there would need to be any changes to appointment LENGTH for the following indicators?				
	Yes	No	Unsure	Total
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	14 (46.7%)	13 (43.3%)	3 (10.0%)	30
Indicator 2: Annual review of adults with a learning disability and epilepsy	18 (60.0%)	10 (33.3%)	2 (6.7%)	30
Indicator 3: Annual review of adults with a mental health condition and epilepsy	19 (63.3%)	8 (26.7%)	3 (10.0%)	30

Changes in practice organisation

From the interviews, it is difficult to identify the impact on practice organisation if the indicators were introduced, due to the variability reported between practices in current procedures and views on the perceived content/process of an annual review for adults with epilepsy. However, one practice explicitly stated that indicator 3 would

directly impact the way their practice operates if included as part of the mental health review as currently it is mental health facilitators who conduct patient reviews, and these facilitators would not be able to help with the patient's epilepsy.

The interviews revealed variation between practices in how epilepsy patients are currently managed – whether primarily in primary or secondary care – and also in how existing annual reviews/health checks are conducted, including by which healthcare professional.

Barriers to implementation

Practices were asked in the survey if there were issues that would need to be resolved, or barriers that would need to be addressed, to enable the indicators to succeed. Only two respondents wrote a comment in relation to the epilepsy-related indicators. A Practice Manager noted:

- there is too much duplication across the three indicators;
- most patients are managed in secondary care.

A Senior Manager from a different practice stated that:

- review templates need to be integrated;
- they are already struggling to get patients to attend their learning disability reviews.

From the interviews with practices, other potential barriers to implementation appeared to be:

- staff and/or patients not recognising the value of an annual review with it feeling like a 'tick-box' exercise (see p14-15);
- staff conducting the mental health reviews may not have the required skills/knowledge about epilepsy (see p18);
- receiving timely and clear information/notifications from secondary care (see p15-16).

Assessment of Personalised Care Adjustment reporting rates

No issues were mentioned by practices.

Assessment of overlap with and/or impact on existing QOF indicators or local schemes

There was general agreement by practices interviewed that the review of patients with epilepsy and a learning disability (indicator 2) could be/already was incorporated within the existing annual Learning Disability Health Check. Four practices were specifically asked whether they thought the indicator could be made a PCN indicator as opposed to a general practice indicator or whether the existing PCN DES Indicator HI-01² could be expanded to incorporate a conversation about epilepsy. Three practices were supportive of this suggestion, but the fourth practice did not agree, noting that because their practice reviews every person with a learning disability it did not need to be made a PCN level indicator.

Moderator: "...it could be done at, sort of, PCN level because the size of the denominator in some practices could be quite small."

Practice Manager: "I'm not sure I'd agree with that to be honest, because we are hopefully seeing every person with a learning disability. So, it would just easily be incorporated into that review. So, no, I wouldn't agree with that one." [Practice Manager, Interview].

To identify eligible patients for indicator 3, the QOF indicator MH001³ is of relevance. However, a few practices highlighted that some patients with a 'complex mental health problem' would not be captured from this register alone (see sub-section 'indicator 3' of indicator-level feedback, p19).

As outlined in a previous section, practices had differing views on whether it would be appropriate for the current QOF mental health indicator MH002⁴ to be expanded to include a discussion of epilepsy.

² PCN DES IIF indicator (21/22 onwards): HI-01 Percentage of patients on the QOF Learning Disability register aged 14 or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan.

³ MH001 The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy.

⁴ MH002 The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate.

Other overall views on implementation of the indicators (including unintended consequences)

Most survey respondents were either unsure or did not think there would be any unintended consequences if the epilepsy-related indicators were introduced (Table 11). Of the minority who did report there could be some unintended consequences, most thought they would be positive (Table 11).

Table 11: Views on potential unintended consequences relating to the indicators (survey)

Are there any unintended positive or negative consequences that you can think of that could be experienced locally if these indicators were introduced nationally?					
	Yes, positive	Yes, negative	No	Unsure	Total
Indicator 1: Annual review of all adults receiving drug treatment for epilepsy	7 (23.3%)	2 (6.7%)	11 (36.7%)	10 (33.3%)	30
Indicator 2: Annual review of adults with a learning disability and epilepsy	8 (26.7%)	2 (6.7%)	12 (40.0%)	8 (26.7%)	30
Indicator 3: Annual review of adults with a mental health condition and epilepsy	7 (23.3%)	2 (6.7%)	12 (40.0%)	9 (30.0%)	30

Not all respondents provided an explanation for their response, but those who predicted positive consequences referred in free text comments to indicators improving quality of care:

“A positive consequence for epilepsy is that it will improve concordance and reduce hospitalisation.” [GP, Survey]

“All indicators are reasonable and feel like they should be already routinely added into current reviews, but this structure would help to ensure the work is completed regularly and focused on the targets.” [Practice Manager, Survey]

Only two respondents (2/30, 6.7%) expected there to be negative unintended consequences of introducing each of the three indicators. These related to the perceived value of the indicators or the potential duplication of financial payment due to the overlap between indicators:

“I don't feel there is much use for epilepsy reviews as we are powerless to alter the patient's medications. Referring to neurology when there is a problem is additional work for the GP. Therefore, it is preferable for 2o care or epilepsy nurses to do them.” [GP, Survey]

“Crossover issues could mean double funding accusations.” [Practice Manager, Survey]

Practices interviewed did not discuss any unintended consequences of the indicators, although it was highlighted by one GP that the indicators could raise dilemmas around the management of patients with epilepsy between primary and secondary care. It was noted, however, that this should not necessarily be seen as a negative consequence and could help align patient treatment with current clinical aims:

“If a specialist feels like they've optimised treatment and are accepting periodic, if not quite frequent seizures, you can sort of get into this historical thing where they were reviewed last five years ago and nothing has really changed but they seem to have monthly seizures and you think, 'Well, I would have thought you're aiming for no seizures, but clearly the specialist five years ago didn't think that, and you're not quite sure then when they should be referred back (...) this [indicator] (...) brings up a set of dilemmas about management but it's probably better to have those dilemmas than just not know.” [GP, Interview]

One practice also mentioned that, to avoid unintended consequences of indicator 1, all patients on anti-epileptic medication should be included.