Epilepsy service provision in the National Health Service in England in 2012

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ABSTRACT

Purpose: The National Health Service in the United Kingdom compares favourably on many international measures of quality and cost-effectiveness. It has many centres of excellence for epilepsy care and in some areas is a world-leader. However, for over twenty years there have been concerns that the provision of good quality care is variable and in many areas major improvements are required. We report the results of the latest major survey into the quality of epilepsy care in the NHS.

Methods: Four target groups were sent questionnaires: acute hospital trusts, Clinical Commissioning Groups, local authorities and patients. Each questionnaire was specifically designed by Epilepsy Action after reviewing national guidance and quality standards.

Results: We present the key results of the survey and we discuss them in the context of the latest national guidelines, quality standards, the organisational structure of the NHS and the research literature.

Conclusion: Although there are some examples of excellent services for people with epilepsy these results show that overall there has been little improvement in recent years and there continues to be significant geographical variability in quality with many areas offering sub-optimal care.

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1. Introduction

1.1. Epilepsy services in the United Kingdom National Health Service

The National Health Service in the United Kingdom compares favourably on many international measures of quality and cost-effectiveness [1]. Despite frequent and ongoing reforms, the United Kingdoms’ National Health Service (NHS) is intended to be a comprehensive service, available to all, in which access is based clinical need and not an individual’s ability to pay. The NHS “aspires to the highest standards of excellence and professionalism” and to “put(ting) patients at the heart of everything it does” [2].

Just over 20 years ago, the Clinical Standards Advisory Group, an expert group established to advise United Kingdom (UK) health ministers, published their report into epilepsy and highlighted infrequent routine monitoring, a lack of coordination and poor communication between primary and secondary care. They emphasised that General Practitioners (GPs) need help and support with the clinical management of more complex aspects of epilepsy care [3]. The Epilepsy Needs Documents were published in 1993 [4] and 1998 [5], and since then, many published reports by governmental and non-governmental organisations and research studies have compared the clinical and social reality with the aspirations expressed in these official documents and suggested how services for people with epilepsy could be developed to match them better.

In 2002 the National Sentinel Audit of Epilepsy-Related Deaths [6] highlighted the mortality associated with uncontrolled epilepsy and that systemic inadequacies in the delivery of care meant that many of these deaths were potentially preventable. In response to this report, the Department of Health (DoH) published
its action plan Improving Services for People with Epilepsy [7,8] which made specific recommendations including the decision to focus the National Service Framework (NSF) for long-term conditions on neurological conditions [9]. The DoH also provided additional funding of £1.12 million (€1.52/$1.93 million) [10]. The NSF consists of eleven quality requirements (QRs). QR2 for example, refers to “early recognition, prompt diagnosis and treatment”. This QR stipulates that “people suspected of having a neurological condition are to have prompt access to specialist neurological expertise for an accurate diagnosis and treatment as close to home as possible”. The eleven QRs are due to be fully implemented in 2015 via Clinical Neuroscience Networks led by Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs).

In the same year as the DoH’s action plan (2002), the Scottish Intercollegiate Guidelines Network (SIGN) published their first clinical guideline on Diagnosis and Management of Epilepsy in Adults [11], followed in 2004 by the guideline of the National Institute for Clinical Excellence [12]. Both sets of guidelines were intended to provide evidence-based advice on the optimal treatment of epilepsy in NHS settings. Epilepsy also became part of the Quality Outcomes Framework for GPs, a system under which GP practices receive additional income for specified activities (such as carrying out annual reviews of patients with epilepsy) [13]. In 2005, the Action on Neurology Programme [14], which arose as a response to the challenge of delivering the NSF’s QRs, illustrated some national examples of best practice. A proposal to develop a competency framework for GPs and other health care professionals with a special interest in epilepsy was published in 2007 [15]. In the same year the All Party Parliamentary Group on Epilepsy published The Human and Economic Cost of Epilepsy [16]. In 2009 Epilepsy Action published Time for Change [17] and in 2011 the Royal College of Physicians and the Association of British Neurologists published Local Adult Neurology Services for the Next Decade – all making specific recommendations, many already included in previous reports. The latest major reports into epilepsy care in the NHS are the National Audits of Seizure Management in Hospitals (NASH) [18,19] which highlighted highly variable care in emergency departments (EDs) when patients present with seizures.

1.2. Current organisation of the NHS in England

The NHS in the UK is organised differently in each of the constituent nations (England, Scotland, Wales and Northern Ireland). In England it is run by NHS England which is an independent organisation funded from tax revenue by the Department of Health in England. Its remit is to improve health outcomes and deliver high-quality care for people in England. This is achieved by direct commissioning of specialised services such as neurology and by funding and overseeing Clinical Commissioning Groups (CCGs) which are clinically-led organisations which commission services for local populations. There are 211 CCGs in England with a mean population of 251,693 (range 61,607–863,433) [20] and an average size of 618 km² per CCG [21]. CCGs replaced Primary Care Trusts (PCTs) which were previously responsible for commissioning local services, in April 2013.

In England, in-patient and most specialist outpatient services (including almost all outpatient epilepsy services) are currently provided by 160 acute hospital trusts. Emergency hospital care relating to epilepsy is commissioned by local CCGs, specialist care (which currently includes neurological outpatient care) is commissioned centrally by NHS England. Acute trusts differ considerably in size, and although they mainly serve their local population, they do not have geographical boundaries and are required to treat patients from any area. The Office for National Statistics mid-2013 population estimate for England was 53,865,800, therefore each of England’s 160 acute trusts serves a nominal 336,661 people.

Local government in England also has responsibility for health. Local authorities are required to host Health and Well Being Boards (HWBBs) which must produce a Joint Strategic Needs Assessment (JSNAs) to inform the strategy of the local authority and the local CCG. HWBBs consist of representatives of the authority, the CCG, social services, children’s services, public health, patients and other invited members. Their remit is to plan the best way to meet the needs of their local population and reduce inequalities in health.

1.3. A Critical Time

In January 2013 Epilepsy Action published their report entitled A Critical Time for Epilepsy in England. It was a survey of patients and organisations responsible for epilepsy service provision in England (the other devolved nations of the UK were not included). It was based on the responses of four target groups: acute hospital trusts, CCGs/PCTs, local authorities and patients. This paper is intended to present the key results of this snapshot of epilepsy care and to disseminate the findings of the survey to a wider audience national and internationally. We discuss the context of the results and draw conclusions about the quality of current epilepsy service provision in England.

2. Methods

Four separate questionnaires were designed for each of the target groups by Epilepsy Action, the largest membership-lead epilepsy organisation in the UK. The surveys were lead by their Policy and Campaigns team. Initial drafts were drawn-up after review of up-to-date national guidance including NICE Clinical Guidance, the National Service Framework for long-term conditions and in anticipation of the NICE quality standards which were at that time due to be published imminently. The Medical Advisory Board of Epilepsy Action reviewed and provided feedback on all four questionnaires. In addition to this, the patient survey was reviewed and user tested by six people with epilepsy. This process took place between February and May 2012.

2.1. Target groups

2.1.1. Acute hospital trusts

A list of the relevant acute hospital trusts in England was compiled from the NHS Choices website (specialised trusts that were known not to provide epilepsy care or treatments were not contacted). The initial requests were entered under Freedom of Information requests by email to Information Governance teams, on 4 May 2012. The trusts were given the option of supplying the data online or by email or by post. Two reminders were sent. A total of 152 trusts were contacted. 10/152 (6.6%) responded stating that they did not provide epilepsy services and 62/152 (40.1%) did not respond (or responded after the deadline). A total of 80/152 (53%) trusts responded with completed questionnaires.

2.2. Primary Care Trusts and Clinical Commissioning Groups

CCGs were set up by the Health and Social Care Act 2012. They began operating in shadow form in 2012 before taking on their full legal responsibilities in April 2013. The survey was therefore conducted during the transition period over which responsibility transferred from PCTs to CCGs. A list of the 208 CCGs was purchased from Specialist Info, a company who specialise in maintaining databases of doctors and health care providers. A total of 158/208 (75.9%) of the CCGs contacted responded to the survey.
2.3. **Local authorities**

A list of local authorities was compiled by Epilepsy Action from [www.gov.uk](http://www.gov.uk), totalling 149. The initial request was also entered under Freedom of Information requests by email to Information Governance teams in May 2012. Again, data could be supplied via an online form or returned by email or post. Two reminders were sent. 113/149 (75.8%) local authorities responded.

2.4. **Patients**

The patient questionnaire was available through a link on the Epilepsy Action website ([www.epilepsy.org.uk](http://www.epilepsy.org.uk)). All stakeholders of the charity were invited to complete a questionnaire. An email promoting the survey was sent to 3,876 members of the organisation, based in England, for whom the charity had an email address aalthough non-members were not specifically contacted, they were welcome to take part. The survey was promoted via Twitter (5311 followers at the time) and Facebook (17,450 members at the time). The questionnaire was live from 31 May 2012 to 7 August 2012. 1086 responses were received.

3. **Results**

3.1. **Acute hospital trusts**

3.1.1. **In-patient and out-patient services**

The large majority of trusts provided diagnostic services (73/80, 91.3%) and/or outpatient treatment (79/80, 98.8%) but only 15% (12/80) offered surgical treatment. The vast majority of trusts (76/79, 96.2%) had referred to tertiary centres at some point for diagnosis, treatment or ongoing care. **Table 1** shows the availability of out-patient clinics for patients with epilepsy.

The majority of adult in-patient management of epilepsy problems is done by neurologists (31/66, 47.0%), or general physicians with input from neurologists or epilepsy specialist nurses (25/66, 42%). However, 15% (10/66) of respondents stated in-patient management was purely from general physicians. For children, the majority of in-patient management comes from general paediatricians (52/68, 76%) with only 4% (3/68) of respondents describing management by paediatric neurologists. General paediatricians with input from paediatric neurologists or epilepsy specialist nurses managed the remaining 19% (13/68). **Table 2** shows the mean number of epilepsy specialists that are employed within acute trusts.

3.2. **Waiting times**

The mean of reported “average” waiting times for adults with suspected epilepsy to see an epilepsy specialist for an initial assessment was 37 days (range 3–84). Recognising fluctuations in waiting times, respondents were encouraged to report minimum and maximum waiting times for initial appointments. The mean of reported maximum waiting times was 60 days (range 13–154 days). The waiting time data for adults to see non-epilepsy specialists was very similar as were the equivalent data for children. The median number of epilepsy nurse specialists in each trust was 1 (range 0–8) for adults, 0 (range 0–9) for children and 1 (range 0–8) for people with learning disabilities.

3.3. **Access to investigations**

**Table 3** shows the percentage of acute hospitals with access to specific investigations and the mean of the reported average waiting time for these tests.

3.4. **Care planning**

Care plans were offered routinely to patients with epilepsy in 48.8% (39/80) of trusts.

3.5. **Emergency care**

98.8% (79/80) of trusts operate an Emergency Department (ED). 72.7% (56/77) of trusts have a protocol for someone presenting to the ED after a suspected first seizure. 66.2% (51/77) can refer directly to a first seizure clinic from ED and 57.1% (44/77) have a protocol for the management of seizures in patients with epilepsy. The mean number of ED attendances with seizures, or suspected seizures, reported by responding trusts per year in adults was 653. These represented a mean of 17% of ED attendances for ambulatory care sensitive conditions (ACSCs) [22]. ACSCs are defined as clinical conditions for which the risk of emergency hospital admission can be reduced by timely and effective ambulatory care (primary care, community services and outpatient care) [23]. An average of 43% attending ED with seizures were admitted, 12% were referred to first seizure clinics and 24% were referred back to primary care.

The mean reported number of epilepsy-related attendances per year in children was 205. Such admissions represented 18% of ED attendances for ambulatory care sensitive conditions. An average of 49% of these ED attendances led to admissions, 16% were referred to first seizure clinics and 21% were referred back to primary care.

3.6. **Clinical Commissioning Groups and Primary Care Trusts**

Most CCGs were working independently to commission services for their patients but a significant minority (27.2%) (43/158) were working in confederations. 20.9% (33/158) had appointed a clinical lead for neurology, and 17.1% (27/158) for epilepsy. The clinicians to whom a GP can refer patients with epilepsy (expressed as percentages of all CCGs) were as follows: epilepsy specialist consultant 55.7%, general adult neurologist 78.5%, GP with a special interest in epilepsy 10.1%, paediatric neurologist 48.7% and general paediatrician 62.0%. **Table 4** summarises the services that CCGs declared that they intended to offer to people with epilepsy.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Availability of epilepsy clinics. Percentage of trusts offering clinics at designated intervals. NA: not available.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Every week</td>
</tr>
<tr>
<td>General neurology clinics</td>
<td>96.3%</td>
</tr>
<tr>
<td>General epilepsy clinics</td>
<td>65.0%</td>
</tr>
<tr>
<td>First seizure clinics</td>
<td>36.3%</td>
</tr>
<tr>
<td>Paediatric transition clinics to adult care</td>
<td>1.3%</td>
</tr>
<tr>
<td>Adult transition clinics to geriatrics</td>
<td>1.3%</td>
</tr>
<tr>
<td>Pre-surgical clinics</td>
<td>7.5%</td>
</tr>
<tr>
<td>Pre-conception clinics</td>
<td>16.5%</td>
</tr>
</tbody>
</table>
3.7. Local authorities

99/113 (87.6%) of the authorities that responded had a JSNA for 2012–13. The JSNA is the key document which informs the strategy of the local authority and the local CCG. Of these, only 74.7% (74/99) had a section on neurology and only 27.3% (27/99) had a section on epilepsy. Of those with a JSNA 84.8% (84/99) consulted with patients. The most common methods of consulting were existing structures such Healthwatch (66/84, 78.6%), surveys (40/84, 47.6%) and public meetings (35/84, 41.7%).

4. Patients

4.1. Demographics

1086 patients (or their carers) completed the online questionnaire. 35.8% were male and 63.9% were female. 9.2% were under 12 years old, 7.1% were 13–18, 78.2% were 19–65 and 4.5% were over 65.

4.2. Seizure control

Only 28.8% (313/1086) were seizure free. Fig. 1 shows the frequency of seizures amongst the other 773 patients who were not seizure free. Those who were not seizure free were asked how long have your seizures been uncontrolled. 21.5% (166/773) had been uncontrolled for less than a year, 13.7% (106/773) for 1–2 years, 48% (372/773) for 2–10 years and 16.7% (129/773) for over 20 years.

4.2.1. Anti-Epileptic Drugs (AEDs)

94.8% (1029/1086) were taking AEDs. The majority (80.7%) (830/1029) were taking 1–2 AEDs but the remaining 19.4% (199/1029) patients were taking more, some more than five.

Table 3

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Yes – elsewhere</th>
<th>No</th>
<th>Waiting time (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EEG</td>
<td>71.3%</td>
<td>27.5%</td>
<td>1.3%</td>
<td>29 (0–200)</td>
</tr>
<tr>
<td>Ambulatory EEG</td>
<td>48.8%</td>
<td>46.3%</td>
<td>5.0%</td>
<td>39 (0–200)</td>
</tr>
<tr>
<td>MRI</td>
<td>100%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>28 (0–84)</td>
</tr>
<tr>
<td>CT</td>
<td>98.8%</td>
<td>1.3%</td>
<td>0.0%</td>
<td>22 (0–64)</td>
</tr>
<tr>
<td>Video telemetry</td>
<td>23.8%</td>
<td>67.5%</td>
<td>8.8%</td>
<td>64 (0–200)</td>
</tr>
</tbody>
</table>

4.2.2. Waiting times for investigations

Of those patients that had had an MRI scan in the last two years, 47.4% (239/504) waited longer than four weeks and some patients waited longer than eight months. Of those patients that had had an EEG within the last two years, 43.5% (253/581) had waited longer than four weeks and, as with MRI, some patients waited longer than eight months.

4.3. Ongoing care

The main health care professional reported as looking after patients’ seizure disorder varied but the majority either stated that they were under the care of an epilepsy specialist consultant (27.3%) (296/1083), a GP (24.0%) (260/1083) or a general neurologist (22.0%) (238/1083). 66% (676/1030) had received an invitation for an annual review. Annual reviews were most frequently carried out by adult/paediatric epilepsy specialist consultants (34.1%) (244/657), general neurology consultants (20.2%) (133/657), GPs (19.9%) (131/657) or epilepsy specialist

Table 4

<table>
<thead>
<tr>
<th>Percentage of CCGs offering specific epilepsy services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>An outpatient clinic service</td>
</tr>
<tr>
<td>Epilepsy specialist nurse</td>
</tr>
<tr>
<td>A diagnostic pathway</td>
</tr>
<tr>
<td>An A&amp;E attendance protocol</td>
</tr>
<tr>
<td>A care planning service</td>
</tr>
<tr>
<td>A first seizure clinic</td>
</tr>
<tr>
<td>Support groups for people with epilepsy</td>
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<tr>
<td>An epilepsy information service</td>
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<tr>
<td>A surgical pathway</td>
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<tr>
<td>A transition service</td>
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<tr>
<td>A shared electronic care plan</td>
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<tr>
<td>An epilepsy expert patient programme</td>
</tr>
<tr>
<td>A GPwSPa epilepsy led service</td>
</tr>
<tr>
<td>A telemedicine service</td>
</tr>
</tbody>
</table>

*GP with a special interest in epilepsy.

Table 2

The mean number of healthcare professionals that are employed within acute trusts listed in descending order.

<table>
<thead>
<tr>
<th></th>
<th>Median (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatricians</td>
<td>9 (0–32)</td>
</tr>
<tr>
<td>Geriatricians</td>
<td>5 (0–23)</td>
</tr>
<tr>
<td>Neurologists</td>
<td>3 (0–25)</td>
</tr>
<tr>
<td>Adult epilepsy specialists*</td>
<td>1 (0–10)</td>
</tr>
<tr>
<td>Epilepsy nurse specialists (adults)</td>
<td>1 (0–8)</td>
</tr>
<tr>
<td>Epilepsy nurse specialists (adults with LDs)</td>
<td>1 (0–8)</td>
</tr>
<tr>
<td>Paediatric epilepsy specialists</td>
<td>1 (0–7)</td>
</tr>
<tr>
<td>Neurosurgeons</td>
<td>0 (0–16)</td>
</tr>
<tr>
<td>Neuropsychologists</td>
<td>0 (0–9)</td>
</tr>
<tr>
<td>Epilepsy nurse specialists (children)</td>
<td>0 (0–9)</td>
</tr>
<tr>
<td>Paediatric neurologists</td>
<td>0 (0–6)</td>
</tr>
<tr>
<td>Neuropsychiatrists</td>
<td>0 (0–5)</td>
</tr>
</tbody>
</table>

* Adult epilepsy specialist is a consultant with expertise in epilepsy as demonstrated by training and continuing education in epilepsy, peer review and regular audit of diagnosis. Epilepsy must be a significant part of their clinical workload (equivalent to at least one half-a-day a week).

Fig. 1. Seizure frequency amongst the 773/1086 who were not seizure free.
nurses (12.9%) (85/657). The review resulted in no changes in 50.0% (326/652), treatment changes in 41.6% (271/652), referral to a consultant 7.4% (48/652) and referral to an epilepsy specialist nurse in 2.1% (14/652). Only 51.8% (561/1082) had ever been referred to an epilepsy specialist nurse and only 13.7% (149/1084) had a written care plan.

Only 13% (141/1086) of patients could remember a healthcare professional discussing bone health with them. Less than 50% of patients recalled ever being provided with information about key medical, social and psychological aspects of living with epilepsy such as family planning and contraception, epilepsy related death and driving. Nevertheless, the majority of patients felt they were well informed about their epilepsy (63.8%) (693/1086) and the majority trusted their doctor to make choices about their epilepsy treatment (55.4%) (602/1086).

Discussion

4.4. Summary

This paper presents the results of four recent complementary surveys of epilepsy services in the NHS in England. It shows a mixed picture but overall there has been little improvement since 2008, when Time for Change [17] was published. Some commissioners, providers and local authorities have adopted best practice standards and provide proactive and high quality services for people with epilepsy. However, there is significant variability and many CCGs offer suboptimal care which does not meet NICE’s Quality Standards [24,25].

Overall, commissioning of epilepsy services seems to have a very low priority despite the relatively high prevalence of epilepsy. Estimates vary but approximately 1% of the UK population have epilepsy [26]. Epilepsy is an ambulatory care sensitive condition. With optimum antiepileptic drug therapy (AED) 70% of people will become seizure free [27] but actual seizure freedom rates in the UK are likely to be much lower at around 50%. Recurrent seizures cause morbidity, mortality and increase health costs. Unscheduled care (hospital treatment and admission) accounts for the majority of costs associated with uncontrolled epilepsy [28]. Despite this many patients receiving treatment for epilepsy have never received advice from an epilepsy specialist which leads to misdiagnosis, sub-optimal treatment and inadequate provision of advice [29].

Epilepsy does not feature in most JSNAs, the key document which informs the strategy of the local authority and the local CCG, and many key features of a high quality epilepsy service, such as ED protocols, are not commissioned by CCGs. Many CCGs have no appointed lead for neurology. There remain long waiting times for out-patient clinics (including first fit clinics) for the management of epilepsy. These clinics are often not run by epilepsy specialists (general neurologists and general physicians) who often do not have access to epilepsy specialist nurses especially in paediatric services. Although the evidence-base could be stronger, epilepsy specialists nurses are considered a key part of the epilepsy team in many centres where they have diverse roles and have been shown to improve the quality of care for people with epilepsy [30]. There are long waiting times for investigations such as MRI and EEG, care plans are rarely put in place, dedicated transition clinics are available only in a small minority of CCGs.

4.5. Limitations of the study

Much of the information required to assess the quality of epilepsy services in England is not in the public domain and the questionnaires did not capture all the key metrics of good quality epilepsy care. It was important to balance collecting as much good quality data as possible with the time requirement for completing the questionnaire. Too many questions were likely to adversely affect the response rate from organisations and so the final questionnaires were a pragmatic balance of these two priorities. Data collection for A Critical Time required the use of significant resources by Epilepsy Action, a major UK charity, through freedom of information requests. The quality of the data was dependent on diligent and accurate recording by organisations and in some areas this was lacking and data quality was poor. Many organisations (trusts, CCGs and local authorities) were slow in making returns, which resulted in follow-up requests from EA, but despite this some did not submit a return at all. Some organisations submitted returns which contained gaps in the data i.e. no entry for one or more of the variables. The denominator is included for each percentage cited in this paper so that readers can see how frequently this occurred for each variable. Finally, making comparisons between hospital trusts is difficult. Acute hospital trusts are required to treat all patients that present or are referred to them and as such do not have populations which would be the obvious denominator when, for example, comparing staffing levels. Other denominators are either unsatisfactory or not in the public domain.

All data was manually inspected by JMD and returns that were deemed to be inaccurate, non-representative or misleading were excluded. This process of exclusions was separate to the analysis undertaken by EA and so figures in this paper and the official 2013 report may vary slightly. In the interests of brevity, analysis of some variables from the original questionnaires are not included in this paper; the main reasons for not including variables were that the variable was deemed of less interest or that the data quality was poor. Full-length versions of the questionnaires are available as additional on-line content.

The respondents contributing to the patient survey described here are unlikely to be fully representative of individuals with epilepsy living in England, indeed given the self-reporting of epilepsy, it is possible some may not truly have epilepsy. The proportions of patients reporting uncontrolled seizures and the proportion of patients stating that they received their epilepsy health care in specialist settings was higher than expected [31]. However, the fact that most respondents to this survey were being treated by epilepsy experts and that most had uncontrolled seizures means that the low number of patients who reported having a care plan is particularly disconcerting (given that the provision of a care plan, agreed between health care professional and patient) has been clearly recommended as a feature of good epilepsy care since the publication of the NICE guidelines in 2004. Regardless of sampling bias, the result of the patient questionnaires (especially when considered together with the other findings of this study) are consistent with an overall impression that a large proportion of England’s estimated 495,000 [32] people with epilepsy are not being optimally treated [33]. Finally, the report did not include questions about the provision of services for people with non-epileptic attack disorder (NEAD) which was beyond the scope of this report, but who nevertheless make-up a significant proportion of patients seen in epilepsy clinics and for whom service provision is equally variable [34].

5. Conclusions

Despite its’ limitations this report contains the most up-to-date data available on epilepsy services in England and we hope it is helpful for people trying to improve these services. The recent reorganisation of the NHS has created huge challenges but the recent five-year plan from NHS England has created a unique opportunity for the NHS to respond to the needs of people with epilepsy. It emphasises empowering patients, new models of care
including multi-speciality community providers, more integration of acute and emergency care, diverse solutions and local leadership. Epilepsy Action made a series of recommendations in A Critical Time for improving epilepsy care in England many of which would be in keeping with the aspirations of the new NHS. Time will tell whether the NHS can respond to the challenges highlighted in this report.

Conflicts of interest

None.

Acknowledgement

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at http://dx.doi.org/10.1016/j.seizure.2015.05.009.

References