Commissioning better headache services!

DE Bateman NCD Neurology 21/10/15
The financial burden of headache!

- Direct cost to the NHS: £1 billion per year (Ridsdale 2007)
- GP consults and medications: £468 p.p per year
- Gross under-estimate as frequent comorbidity with anxiety/depression
- 160/100,000 acute admissions for primary headache disorders per year England average
- Commonest neurological reason for A&E attendance
- 1 in 5 headache patients in Neurology O/P have attended A&E in last 6 months (Gahir et al. 2006)
Whose problem? Neglected & overlooked

- Lack of ownership
  - Primary care?
  - Secondary care?
  - Tertiary care?
- Lack of interest
- Lack of expertise
- Not a problem!
Answers

• What do the patients want?

• What do the GPs want?

• What do the neurologists want?
Guidance

- NICE
- Map of medicine
- Protocols
The answers

- Medical school education
- Mandatory headache competency for VTS
- SCN initiatives
Headache SCN Working Group

Aims:
• Better understand headache patient experiences
• Identify and agree the core principles in the pathway

• Agree principles for clinical algorithms
• Agree structures, patient flows and tools required to deliver best quality care
• Establish standards (Quality Improvement Programme)
• Identify the ways in which a headache service could be delivered
Headache patient behaviour

Poly-pharmacy is common
46% used OTC Analgesics to try to control headaches

Identified an intervention opportunity at local Pharmacy
How long after first going to your GP about headaches has it taken until you received....

Question 15.1: A headache diagnosis
Question 15.2: A treatment plan for your headaches
Question 15.3: An effective treatment

- Less than 2 weeks
- 2 weeks - 1 month
- 2 - 3 months
- 4 - 5 months
- More than 5 months
- No diagnosis yet
An integrated headache service

• Most patients will be supported to self-manage

• Pharmacist (also opticians) can be a key support in the community

• GPs will be main source of medical management

• To support and enable the above, we will establish a multidisciplinary team working across primary and secondary care (the headache service)
  • Network of GPwSI
  • Consultant Neurologist with community clinic sessions to run joint clinics with GPwSI
  • Headache specialist nurse to offer follow-up clinics in the hospital and community
  • Access to psychological support for chronic pain management (repeat A/E attenders; MUS comorbidities)
GPwSI Pilot

- 72 referrals were triaged to BK. Two patients (3%) declined to be seen by a GPwSI (one of whom was himself a GP), 5 (7%) cancelled, 8 (11%) DNA’d, leaving 56 (78%) patients seen

- *Cost Savings:* There was a 33% saving in costs per head in the pilot clinic vs. NHS reference costs for a Neurology OPA (£141 vs. £209).

- MRI only half as often compared to Registrar-clinic

- 73.5% were discharged after consultation (vs. 60% in the JR OP1).

- *Initial Clinical Outcomes*
  - There was a near 75% increase in the number of patients who felt able to manage their headache after the consult (15% pre-consult vs. 84.9% post consult).

Oxfordshire CCG now looking to commission a community headache clinic
Supporting Self-Management

• Patient education meetings

• Work with pharmacists and opticians to have consistent management advice

• Websites, webportals and connected devices for information; monitoring symptoms, supporting clinical decisions
a platform for self-management
Hello, you're about to take

Headache daily questionnaire

INSTRUCTIONS

Please answer the following questions about any headache that you have experienced today.

Let's get started
Wessex SCN

- Decision support tool
- Web based
- Management guidance
- Direct access for imaging
Acute headache

- NIN data 158/100,000 (72-300) admissions
- NCEPOD findings 43% overlooked in GP
- 25% outcome affected adversely
- ED & AMU protocols
- Hot clinics 59% reduction in admissions for acute headache.
- Problem organisation of neurology!!
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<th>Upper CI</th>
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<td>-</td>
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<td>NHS Darlington CCG</td>
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<td>219.5</td>
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<td>235.4</td>
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<td>NHS North Durham CCG</td>
<td>171.8</td>
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<tr>
<td>NHS Sunderland CCG</td>
<td>79.4</td>
<td>67.7</td>
<td>92.5</td>
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Source: Health and Social Care Information Centre (HSCIC)
Solutions

- CCG commissioning of headache services
- Variety of models
- Must have one!
- CN to facilitate & organise
- Pathway for acute & chronic
- Outcomes!
Headache

Leone Ridsdale

Professor of Neurology & GP
Consultant Neurologist
King’s College Hospital
Relationship between episodes of symptoms recorded in health diaries and symptoms presented at consultations. (From Banks et al., 1975. By permission of Oxford University Press.)
HA pathway

- 50% adults report 1 + HA pa
- 10% adults report migraine pa
- 4% adults consult GP for HA pa (2 million)
- 90% of GP HA consulter have migraine
- GP diagnose 30% as migraine
GP Diagnosis of HA & referral

- 30% GP HA consulters for HA have anxiety/depression, but no screening
- 30% GP consulters report HA on 15+ days pm
- GPs do not record HA days 15+ (chronic migraine)
- 15/30+ days of HA risk of depression analgesic overuse
How is frequent HA different from infrequent HA?

50% with headache frequency >14 pm had co-morbidity requiring daily medication.

Wiendels et al Cephalalgia 2007
97% of HA patients managed by GP with no referral

2% HA patients referred to neurologists

More likely to report

- other symptoms
- worry about their headaches
- headache makes them anxious
- cost more £200 to see a specialist

Ridsdale et al BJGP 2007
GPs views- why they refer
‘everyone feels they need a scan — as soon as they’ve got a headache they feel they need a scan’
Morgan et al BJGP 2007

Patients views-
‘I got so worried because it had gone on for so long …, I suppose you get stressed which makes the headache worse they said we’ll send you for a scan for peace of mind,…which showed it was all right. I relaxed a bit
Ridsdale et al JNN 1014
New developments

• GPSI service satisfies patients more

• GPwSI service cheaper £150 vs £200

  Ridsdale et al BJGP 2008

• Training GPwSI in HA recommended in all districts

  RCP 2011

• GP open-access MRI
CBT

Similar reduction of migraine to preventive drugs can be achieved by:

- Relaxation
- CBT

For patients who:
want less drug side-effects +
accept psycho-social issues affect their HA +
willing to work actively with therapist

Holroyd et al 2010, Power 2013, NICE 2015
CBT in Headache: patients relate symptoms, thoughts, feelings + behaviours

<table>
<thead>
<tr>
<th>Body Symptoms</th>
<th>Thoughts</th>
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<tbody>
<tr>
<td>• Blurry vision</td>
<td>• “I’m dying”</td>
</tr>
<tr>
<td>• Dizziness</td>
<td>• “I’m going mental”</td>
</tr>
<tr>
<td>• Nausea</td>
<td>• “I’ve got a brain tumour”</td>
</tr>
<tr>
<td>• Slurry speech</td>
<td>• “I can’t cope today”</td>
</tr>
<tr>
<td>• Tiredness</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Feelings</th>
<th>Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sad</td>
<td>• Go to room and sit down</td>
</tr>
<tr>
<td>• Anxious</td>
<td>• Tell people to be quiet</td>
</tr>
<tr>
<td>• Angry</td>
<td>• Stop in the middle of doing an activity</td>
</tr>
<tr>
<td>• Stressed</td>
<td>• Sleep</td>
</tr>
</tbody>
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Treatment Structure

Week no.

1
- **Session 1**
  - Expectations of treatment
  - Brief assessment
  - What is CBT?
  - Introduction of
    - Thought and headache diaries
    - Relaxation techniques

2
- **Session 2**
  - Telephone follow-up - Reviews progress, offer support

3
- **Session 2**
  - Review of headache/thought diaries and progress with relaxation techniques
  - Introduction of **problem solving** and **cognitive restructuring**

4
- **Session 3**
  - Telephone follow-up - Reviews progress, offer support

5
- **Session 3**
  - Review - progress with relaxation/cognitive restructuring techniques (using headache/thought diaries)
  - Problem solving
  - Ways to maintain improvement
Patients’ views of therapy

• “…if I get to a level where I’m rushing around or stressed, I think, OK let’s do a ten seconds of breathing and bring myself down and that does help.”

• “Sometimes when I have that migraine, you often get anxious about something as well, the pain and the anxiety get mixed up. I think having the CBT helps those moments.”
Future hopes

- GPs Dx Migraine x 2-3
- Migraine > 4 days/mo offered prophylaxis Propranolol/Topiramate
- patients with HA-related-anxiety -> CBT/IAPT
- GPs use Dx Chronic migraine >14 days/mo + screen for co-morbid depression
Future hopes

• Diagnosis of pain-killer overuse/addiction >2 days per week → stop pain-killers

• Migraine + anxiety about a brain tumour
  Reassurance +/- Brain Imaging +/- Stress management course MBSR

• Migraine + depression
  Medication for both +/- CBT

• Migraine + unexplained medical symptoms, e.g. Chronic Fatigue / Irritable Bowel Syndrome
  Psychological referral + CBT