Developing a General Practitioner with a Special Interest in Headache Service

Support for Commissioners and Clinicians

Exeter NHS Headache Clinic 2013

The burden of headache

The economic, social and personal burden of headache in the community is substantial.[1] Migraine alone affects 7.6% of males and 18.3% of females in England.[2] Measures of health-related quality of life are similar to patients with other chronic conditions such as arthritis and diabetes [3] and worse than those with asthma.[4] One in three migraine sufferers believe that their problem controls their life [5] and the impact extends to family and friends.[6]

There are also significant economic consequences. Indirect costs of migraine in the UK due to work loss have been estimated as approximately £I billion a year.[7] Setting this in an NHS context, two studies have reported from hospital settings. A study in an NHS hospital in Hull, found that 20% of respondents experienced disabling headaches with an average of 16 migraine attacks a year. The average loss of work was two days a year. There was considerable reduced efficiency at work with an estimated annual financial cost to the Trust of over £110,000.[8] A study in a Liverpool NHS Hospital[9] found that 21% of respondents had migraine and lost 3 days of work a year.

Current patient pathways

In the U.K. the annual primary care consultation rate for headache is 4.4 per 100 patients. The majority of headaches that present to the GP do not reach a diagnostic threshold[10] and when a diagnosis is made, treatment is often inadequate. Ongoing education for GPs in the diagnosis and management of headache is an important first step. Headache GPwSI can support this development.

Although only 3% are referred to secondary care, headache is the most common cause of neurological referral[11]. Typically 25-35% of neurology referrals are for headache and many referrals are inappropriate for a secondary care setting. There is no difference in headache impact between neurology headache referrals and patients managed in primary care but referred patients consult more frequently and have higher levels of headache related anxiety[12]. Apart from reassurance that no serious pathology is present, inevitably with an inappropriate brain scan (secondary care imaging rates are as high as 60%[13]), in many cases the needs of headache sufferers remain unmet. Where GPs have direct access to neuroradiological investigation reported significant findings are between 1.2-5.3%[14] with similar diagnostic yields to hospital specialists. Three studies have reported on the impact on secondary care referrals when GPs have access to investigations. A randomised trial reported neurology referral rates of 23% for treatment as usual or 1.3% when GPs had access to MRI, a referral reduction of over 90%;[15] a prospective study with CT showed a referral reduction of 86%[16]; a retrospectively study of MRI showed that referral was avoided in 41% of patients[17].

Headache is becoming an increasing reason for attendance in Accident and Emergency departments. 22% of patients with headache seen in general neurology outpatient clinics reported prior attendance at an emergency department because of their headache and 9% of the headache cohort had been admitted to hospital. All had primary headache[18].

Developing a GPwSI service

The British Association for the Study of Headache has proposed that intermediate care headache clinics staffed by general practitioners with a special interest should support GP colleagues who would continue to provide first-line headache care.[19] This development is in line with NHS policy where the hope is that intermediate care will provide more effective and efficient service delivery in local settings.[20] The suitability of this model for headache care has also been recently endorsed by the Royal College of Physicians and the Association of British Neurologists[21].

The difficulties in obtaining a rigorous and generalisable evidence base to address the expansion of GPwSI services are recognised.[22] [23] Service developments will also depend on the context of the local health economy and the relationships between local stakeholders. There is only one study on the cost effectiveness of headache care delivered in an intermediate care setting.[24] It was found that a GPwSI headache service can satisfy patients with similar headache impact as those seen in secondary care at lower cost.

A possible referral pathway for headache patients is shown in appendix 1.

Some practical points to consider:

- GPwSI setting and administrative support – community or hospital based?
- Telephone or e mail advice to GPs as an option?
- Training, re validation and annual appraisal. See Appendix 2 for suggested framework.
- Objective of clinic – ongoing care with follow up or assessment and comprehensive management plan to GP/minimum follow up?
- Relationship with secondary care/mentorship?
- Governance framework. See Lambeth, Scarborough and Bradford PCT reports for extensive guidance and detailed description of service use. www.exeterheadacheclinic.org.uk (support for commissioners)

The Exeter Headache website contains an extensive range of support material for commissioners and clinicians.

If you want additional advice please contact david.kernick@nhs.net

APPENDIX 1

Suggested Referral Pathways for Headache in Adults

This pathway is not inclusive of all headache types.

IMMEDIATE assessment required: Ref Hospital	
Thunder clap headache (including orgasmic headache) Exclude subarachnoid haemorrhage	• Severe headache rising to maximum crescendo within a minute • Worst ever headache
Headache associated with possible Meningo/encephalitis	
Malignant hypertension	• Retinal changes • BP > 200 systolic, 120 diastolic
Significant head injury	
URGENT assessment required Urgent investigation or urgent neurology referral	
Temporal arteritis Check inflammatory markers	• Always consider in patients over 50 years • Inflammatory markers are normal in 5% of cases • May need urgent biopsy to confirm

Exercise headache
(including pre-orgasmic headache)

iNeed image/scan

- 10% will have a secondary cause

Carbon monoxide poisoning

Measure CO-haemoglobin

- Non-specific headache
- Enquire re heating devices

Space occupying lesion

Red flags (risk >1%)

Image/scan or refer neurologist

- Associated relevant neurological signs
- Associated with new onset seizure

Orange flags (risk >0.1%-1%)

Need careful monitoring and low threshold for Image/scan or referral to GPwSI or neurologist

- Significant unexplained change in headache character
- Migraine aura >1 hour
- Headache precipitated by Valsalva manoeuvre
- New headache in a patient older than 50 years
- Headache that wakes from sleep (not migraine or cluster)
- Headache where diagnosis can not be made 8 weeks from presentation
- Primary cancer elsewhere
- Immunosuppressed or HIV

Diagnose Primary Headache

Exclude medication overuse headache

If treatment resistant refer to GPwSI

- Any analgesia including Triptans taken on more than 3 days of the week on a regular basis
- Non specific headache with a history of a prior primary headache
- Can obscure diagnosis of primary headache

Cluster Refer to GPwSI. All new cases will need MRI. (Can be relaxed if stable cluster present for some time)	• Excruciating unilateral peri-orbital pain lasting up to 3 hours – the cluster attack • Unilateral autonomic features • Number of cluster attacks in a cluster period – classically 6-8 weeks • 10% are chronic
Migraine Refer to GPwSI if: • Difficult to manage • Chronic migraine • Uncertain diagnosis	• Recurrent severe, unilateral (30%) or bilateral pain with (30%) or without aura lasting 4-72 hours (can be longer). • May be associated with nausea • May be associated with phonophobia, photophobia or movement sensitivity • Two out of three positive has high sensitivity: three months recurrent headache; associated with nausea; light sensitivity more pronounced with headache.
Tension type headache Refer to GPwSI: • Difficult to manage • Uncertain diagnosis	• Dull, featureless, bilateral pain • Cause unknown but often associated with anxiety/depression • Reassurance and amitriptyline

APPENDIX 2

i) BASH recommended GPwSI Headache Accreditation for new service

Date of assessment_____

Name	
Address	
GMC Number	
Current post and sessions per week	
Registered on Performers List	
Name of Clinical Mentor	

Criteria	Evidence	Signature of assessor
Involvement with local headache specialist service and/or local neurology service	Brief description of role, log of clinics/sessions per week, log of relevant meetings with PCO/PCP/PCT in developing the service:	

Criteria	Evidence	Signature of assessor

Training under direct supervision • A minimum of normally 6 months, 1 session per week or equivalent • Relevant department eg GP-led headache clinic, neurology clinic		
Assessment of history taking skills	• Mini-Clinical Eamination x 3 or equivalent • Case Based Discussion x 3	
Assessment of neurological examination	• Mini-Clinical examination x1 or equivalent • Directly observed proceedures (eg fundoscopy)	
Academic teaching course	• Minimum of 1 event	
Peer support network eg BASH or local neurology network	• Evidence of attendance at meetings/ significant engagement	
Reflective reading	• E-portfolio or equivalent record to be assessed • Show evidence of critical appraisal	
Demonstration of adequate exposure to cases	• Log book (reflecting competences in Appendix 2 of RCGP Document *Guidance and Competences for the Provision of Services using Practitioners with Special Interest (Headache)*	
Quality Appraisal Activity	• Evidence of 1 audit/ data collection eg patient satisfaction questionnaire	
Medical Indemnity to cover GPwSI role	• Certificate of indemnity	

BASH = British Association for the Study of Headache

Links to assessment tools can be found on the RCGP website www.rcgp.org.uk

References

1. Implementing care closer to home: Convenient quality care for patients Part 3: The accreditation of GPs and Pharmacists with Special Interests. *Department Of Health 2007*
2. Guidelines for the appointment of General Practitioners with Special Interests in the Delivery of Clinical Services: Headaches. *DOH 2003*
3. Core Curriculum on Headache for Neurologists. *International Headache Society Education Committee, November 2011*
4. Guidance and Competences for the Provision of Services using Practitioners with Special Interest (PwSIs): Headache. *Royal College of General Practitioners, Department Of Health, Royal Pharmaceutical Society of Great Britain*

ii) BASH recommended Re-Accreditation every 5 years

Date of assessment_____

Suggested by BASH group to reaccredit every 5 years in line with revalidation.
Commissioners may wish to do three yearly revalidation

The evidence collected for re-accreditation will normally have been presented at annual appraisals, so ideally this form would be used in conjunction with appraisal form

Name	
Address	
GMC Number	
Current post and sessions per week	
Name of Assessor	

Criteria	Evidence	Assessor's signature
GPwSI actively involved in headache service	Statistical summary of service provided	
Quality Appraisal Activity	Completed audit cycle	
Patients involved with the service	Eg one of	

	• Patient satisfaction questionnaire • Significant event analysis • Comments/ compliments/ complaints • Patient information evening	
Critical re-appraisal of the role	Discussion with relevant party, usually PCT/Health Board/Trust	
Improving quality of service for the next accreditation term	Discussed through Personal Development Plan	
Any additional training requirements	Agreed at accreditation assessment if required	

Reference

Implementing care closer to home: Convenient quality care for patients Part 3: The accreditation of GPs and Pharmacists with Special Interests*. Department Of Health 2007*

iii) BASH GPwSI Headache Appraisal (part of GP annual appraisal)

Date of assessment_____

Name	
Address	
GMC Number	
Current post and sessions per week	
Registered on Performers List	
Appraiser Details	

Criteria	Evidence	Signature of assessor
Involvement with local headache specialist service and/or local neurology service	Brief description of role, log of clinics/sessions per week, log of relevant meetings with PCO/PCP/PCT in developing the service:	
Evidence of monitoring the service	For example • Audit • Significant Event Analysis • Patient Satisfaction Questionnaire • Feedback from colleagues	
Membership of professional body	Membership certificate or receipt for subscription	
Evidence of continual professional development (15 hours recommended by RCGP)	For example • Attendance at courses • Reflective learning • Journal or e-learning	
Evidence of ongoing communication and involvement with others involved in the care of headache	For example • Joint clinics • Case-based discussion • Use of care pathways	
Education of others	For example • GP Education (peers, GP trainees) • Patient information Leaflet • Patient Participation Groups	
Medical Indemnity to cover GPwSI work	Certificate or letter of proof	
Review of complaints and compliments		

The examples given in the "Evidence" column are a guide. The GPwSI is not required to provide all of these

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