# HEADACHE SERVICES IN ENGLAND

FAYYAZ AHMED
CONSULTANT NEUROLOGIST
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

# HEADACHE DISORDERS ARE UBIQUITOUS, PREVALENT, DISABLING AND LARGELY TREATABLE, BUT UNDER-RECOGNISED, UNDER-DIAGNOSED AND UNDER-TREATED

**Steiner et al J Headache Pain 12(5);501**

# YOUNG OR OLD

# HEADACHE DISORDERS IN ENGLAND

- Population 51.5 million (Adult 16-65 = 33.5 million)[1]

- Headache in general[2] 90%
- Migraine[3] 15% (M=7.6 F=18.3)
  80% disabling
- Chronic Daily Headaches[4] 1.5-4%

OR

- 5.02 m adult migraineurs of which 4.06 disabling
- 1.38 m adults with Chronic Daily Headache
- 5.44 m in need of headache care

***1. Census 2008 2. Latinovic, 2006 3. Steiner, 2008 4. Lipton 2002***

# BURDEN OF HEADACHE DISORDERS

- 1 IN 10 GP CONSULTATIONS[1]
- 30% OF ALL NEUROLOGY REFERRALS[2]
- 20% OF ALL ACUTE NEUROLOGY ADMISSIONS[3]
- IN THE TOP TEN CAUSES OF DISABILITY[4]
- IMPACT SIMILAR TO ARTHRITIS, DIABETES[5] WORSE THAN ASTHMA[6]
- MORE YEARS LIVED WITH DISABILITY WORLD-WIDE THAN EPILEPSY[4]

*1. ABN 2011 2. Sending J, 2004 3. Weatherall, 2006 4. WHO, 2001*
*5. Solomon, 1989 6. Terwindt et al, 2000*

# IMPACT OF HEADACHE DISORDERS

**PATIENTS**

- 160,000 attacks / day[3]
- 75% can't function during an attack[1]
- 50% need help from others[1]
- 50% impacts on social life[1]
- 33% headache controls their life[2]
- 15% cant get promotion at work[3]

**ECONOMY (indirect)[3]**

- 83,000 miss work or school every day
- 20 million lost days / yr
- £ 2 billion / yr
- 95,000 DALY

**(direct)[3]**

- £ 125 million for migraine
- £ 210 million for all headache disorders

*1. Clarke CE, 1996 2. Lipton, 2003*
*3. Steiner TJ, 2003*

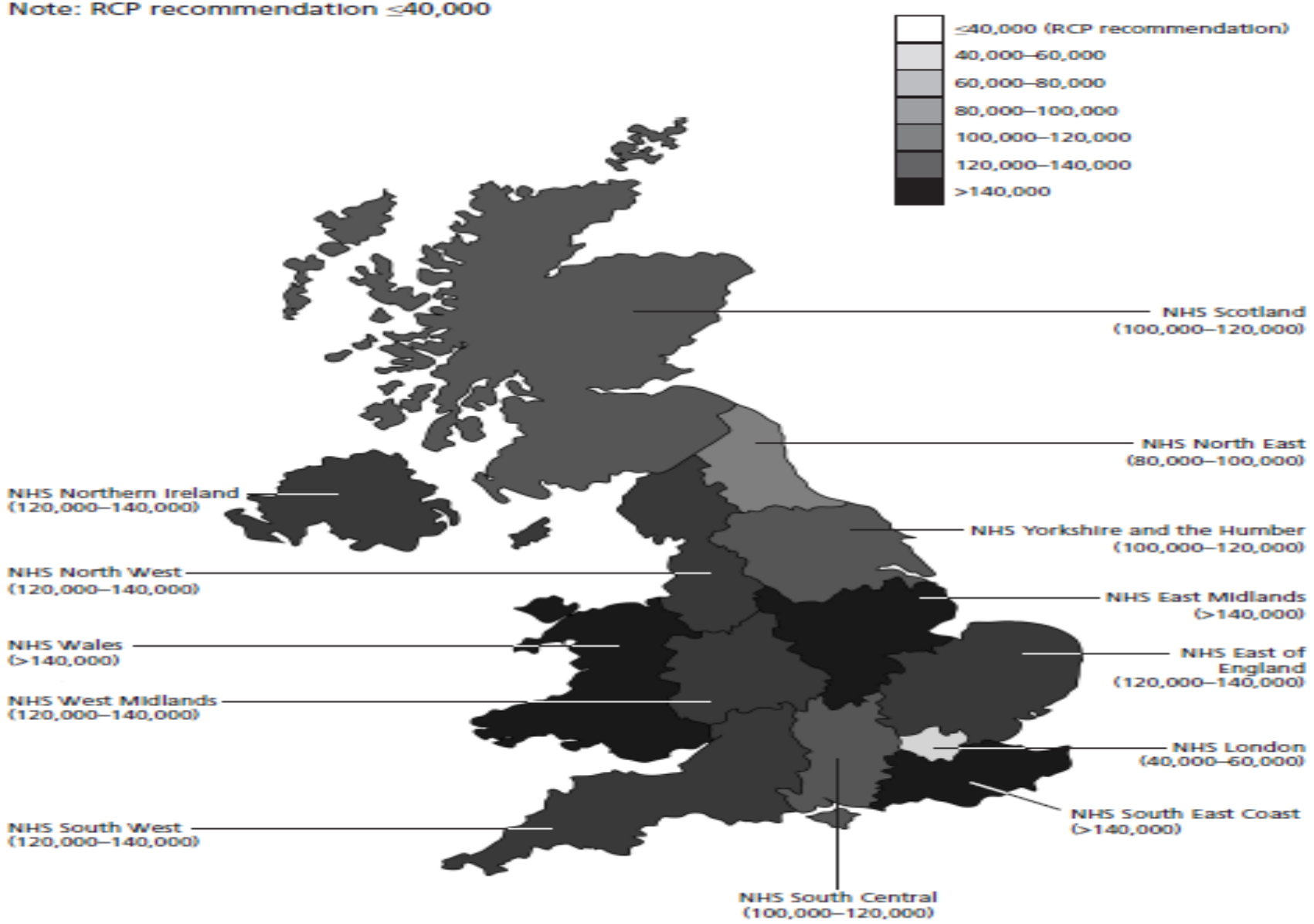
# NEUROLOGICAL SERVICES IN ENGLAND

- A Neurologist / 117,000 (514) [Holland 1 in 20,000][1]
- Acute Neurology seen by Non-Neurologists
- Services based on out-of-date 'Hub and Spoke' model
- Commissioning only for scheduled services
- Unrestricted and Unregulated OP referral system
- Lack of Expansion
  - Difficult to recruit
  - Changes in immigration rule
- Next decade; call for
  - Expansion mainly in DGH's
  - Commissioning for Unscheduled services

***1. ABN; Neurology for next decade, June 2011***

Census 2009

**Neurology:**
**Population served by each whole-time equivalent consultant**
Note: RCP recommendation ≤40,000



# HEADACHE SERVICES; WHERE WE ARE?

- 50% Headache sufferers do not consult[1]
  - 'it is too inconvenient to see a doctor' (53%)
  - 'there is nothing a doctor could do' (22%)
- 9% of those seen in primary care get referred[2]
  - Vast Majority seen by General Neurologists
  - Many are discharged with reassurance 'there is nothing serious'
- 31 Dedicated Headache / Migraine Clinics
  - Mainly at the Regional Centre
  - Neurologist with training in headache
  - General Practitioner with Special Interest
  - Headache Specialist Nurse

***1. Steiner and Fontebasso 2002*** ***2. Laughey et al 1999***

# MIGRAINE CLINICS IN THE UK

# HEADACHE SERVICES; THE UNMET NEEDS

- The services are inefficient, inequitable, inadequate
- No local or national targets for headache management
- Lack of awareness and headache education among Public & Healthcare Professionals
- Lack of undergraduate training in headache
- Post-graduate education in headache is driven by the Pharmaceutical Industry
- Too many referrals to secondary care (Unregulated)
- Unnecessary investigations (wasted resources)
- Lack of Specialist Nurses and Therapists

# HEADACHE SERVICES; WHERE WE WANT TO BE?

- A shift to Primary Care
  - Care closer to home
  - In line with the current Policy (intermediate care)
  - Better patient satisfaction[1]
  - Reduced secondary care referrals[2]
- GPwSI
  - Expert Generalists[3]
  - More complete care in a therapeutic field
- Headache Specialist Nurse
  - Integrating primary and secondary care
  - Cost effective

***1. Ridsdale et al BJGP 2008  2. Thomas et al, BJGP 2010  3. Baker, 2002***

# HEADACHE SERVICES; PROPOSED MODEL[1]

- **Level 1;** Primary Care Physician (90%) /35,000
  - Diagnose and Manage Migraine and Tension Headache
  - Recognise and refer secondary headaches to level 2
  - Theoretical postgraduate headache training
- **Level 2;** GPwSI (9%) / 200,000
  - Diagnose and Manage more difficult but not rare headaches
  - Refer the rare ones and those requiring in-patient care to level 3
  - Affiliated with a headache clinic for sometime
- **Level 3;** Headache Specialist (1%) /2 million
  - **Neurologist with training in headache**
  - **In-patient facilities**

1. ***Steiner et al J Headache Pain 2011***

# HEADACHE SERVICES; HOW DO WE GET THERE?

- Education
  - Public and Professional meetings
  - Undergraduate headache education
- Resource Allocation (re-allocation)
  - Set up and training costs
  - Specialist Nurses freeing up Physicians' time
  - Reduced mismanagement and secondary referrals
  - Reduced economic burden (indirect cost)
- Governance
  - Evaluation process
  - Integrated arrangements
  - Stakeholders engagement

# HEADACHE SERVICES; OUTCOME MEASURES

- Reduced referrals to secondary care
- Timely access to service
- Equitable service based on need
- Increased patient satisfaction
- Cost savings
- Reduced burden of headache in general

# HEADACHE SERVICES; LIMITATIONS

- ADDITIONAL RESOURCES
  - Low overhead cost in primary care but more GP's required
- CHANGE RESISTANCE
  - Patients' perception of specialist
  - Savings mainly indirect
  - Lack of gold standard model of care
- RECRUITMENT
  - Interested General Practitioners
  - Specialist Nurses