**HEALTH SCRUTINY PANEL**

A meeting of the Health Scrutiny Panel was held on 25 January 2011.

**PRESENT:** Councillor Dryden (Chair); Councillors Carter, Cole, Junier, Lancaster, Purvis and P Rogers.

**OFFICERS:** J Bennington and J Ord.

**PRESENT BY INVITATION:** Councillor Brunton (Chair of the Overview and Scrutiny Board)

Prof. Charles Greenough, Consultant Orthopaedic and Spinal Surgeon Director, Regional Spinal Cord Injuries Centre, James Cook University Hospital
Margaret Murray, Specialist Nurse Practitioner, South Tees Hospitals NHS Foundation Trust.

**** DECLARATIONS OF INTEREST**

No declarations of interest were made at this point of the meeting.

**** MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 7 January 2011 were taken as read and approved as a correct record.

**REGIONAL SPINAL CORD INJURIES CENTRE – JAMES COOK UNIVERSITY HOSPITAL**

Further to the Panel's expression of interest in considering the topic of back pain and how the local health and social care economy dealt with such conditions the Scrutiny Support Officer submitted a report the purpose of which was to introduce senior representation from the Regional Spinal Cord Injuries Centre at James Cook University Hospital to provide a briefing on the specialised Unit.

By way of background information it was noted that NHS Choices stated that: -

'Back pain is a very common condition and can affect adults of all ages. It is estimated that one in five people will visit their GP in any given year because of back pain. And 80% of adults will experience at least one episode of back pain at some point in their life.

Chronic back pain is less common than acute back pain, but it is still very widespread. In England, chronic back pain is the second most common cause of long-term disability (after arthritis). After stress, it is the leading cause of long-term work-related absence. A recent study found that one in every 10 people reported having some degree of chronic back pain.'

The Chair welcomed Prof. Greenough and Margaret Murray to the meeting who gave a presentation and amplified the key areas of the current model of service and identified areas for improvement. In order to improve the overall service there was an overriding need for one health community solution, which provided early triage for back pain and swift access to specialist care for non-specialised surgery.

The James Cook University Hospital was one of Europe's most modern hospitals and the site was the largest of its type with a wide range of services as outlined including spinal injuries.

The Panel was advised that whilst there were a number of patients who would benefit from surgery there were many patients with axial (spinal) pain who needed effective management rather than surgery. It was acknowledged that spinal pain was very common and a major health care challenge with 40% of the population having back pain in any one year. Primary Care Trusts spent £2.2 million per 250,000 population.

Current arrangements for non-specialised surgery involved a four-fold wait of: -

- Referral to out patients;
- Out patients to investigation;
- Investigation to review;
- Review to surgery.

The existing secondary care service based at the Spinal Assessment Clinic (SAC) was set up to triage low back pain. It was Nurse Practitioner based for the management of non-specific low back pain and there was provision for surgical FAST TRACK for those who required surgery. Statistical information was provided which demonstrated that after a one year follow up of 90 patients, 96% patients had been satisfied with the clinical assessment and 67% satisfied with rehabilitation. Such information also showed that after one year following a SAC consultation there had been 81% less visits to a GP for lower back pain and 45% fewer patients receiving repeat painkiller prescriptions.

In terms of the impact on waiting times until surgery from GP referral it was noted that this had reduced from at one time in 1991 to be 62 weeks to 16 weeks for the first post operation. In relation to the impact on the service it was pointed that 72% had been directed to the SAC, 11% to Neurosurgery, 9% Orthopaedics, 7% Rheumatology and 45 to the Pain Clinic. Other information demonstrated only 4% of patients with a re-referral to a GP within two years.

The Panel was advised of the importance of the service progressing to a seamless service focussing on two areas namely, spinal pain and non-specialised surgery. The principals of moving forward to a seamless service involved maximising the opportunity of undertaking any required management within primary care but at the same time maintaining equity of access and management across the Region. In order to achieve this it would be necessary to have a seamless interface between primary and secondary care whilst maintaining quality.

Within primary care it was suggested that it should be specialist nurse led by the Triage and Treat Practitioner involved with extended Scope Practitioner, development of existing roles, Nurse Practitioner or Physiotherapist, and extended competencies and training. There needed to be a unified evidence based approach across the region.

An indication was given of the proposed overall process starting with the initial point of presentation by a patient with acute axial pain to a GP, Community Physiotherapist or Triage and Treat Practitioner. A patient with spinal pain for a longer period of time would be referred to a Triage and Treat Practitioner at the discretion of the initial health care professional and at the latest at six weeks if not able to resume normal activities. The triage would be undertaken on a protocol drive basis and would allow patients with unusual presentations to obtain secondary care opinion.

A flowchart was presented which demonstrated the proposed various stages within primary and secondary care which in terms of the re-assessment of mechanical back pain was in accordance with the NICE guidelines.

The management of simple axial pain involved such methods of altering exercise and activities of daily living; class based cognitive behavioural management rather than one to ones with a health professional; manual therapy; and advice on recommended local groups. It was considered that more could be done before the process started in terms of community education by changing attitudes to axial pain by encouraging self help, manage expectations and develop further web based information. It was felt that there was much confusion and it was important to promote a consistent message and information.

If the back pain was not resolved after 12 weeks it was suggested that there should be a Combined Physical and Psychological Programme or (Functional Restoration Program) which had been identified as a major service gap in the 2009 NICE guidelines. A programme would involve such actions as the availability of appropriate information and advice in community premises; referral from Triage and Treat Practitioner; various activities such as aerobic training

and gyms; and pain management skills. Such a process was seen as reducing waiting times and should be completed before consideration of surgical management of axial pain.

An indication was given of the referral process of triaged patients on evidence based protocols in respect of non-specialised surgery and spinal surgical pathway. In terms of the discharge arrangements the Triage and Treat Practitioner would co-ordinate post-operative care following surgeons protocols and organise complex discharges with community matrons.

In terms of training specific reference was made to two programmes; a broad based refresher programme to ensure consistency of diagnosis and advice across the region; and a specific modular programme for new skills and for new practitioners. In relation to support it was considered that this would be from two sources a named GP with a special interest and a close relationship with secondary care by means of a Senior Nurse Practitioner and with robust audit and governance arrangements.

In order for the service to improve and progress to a seamless service it was considered that there were currently three main obstacles to implementing such a service. It was considered that the creation of Triage and Treat Practitioners in Primary Care would make a significant difference and an integrated pathway from primary to secondary care was essential. A Functional Restoration Programme was required as reflected in the 2009 NICE guidelines as there was currently no such programme in Teesside and patients requiring such a programme had to be referred to Newcastle upon Tyne.

In discussing the potential benefits of a Functional Restoration Programme it was noted that the current approximate costs were £4,000 per patient which although a new service there was potential for reducing the need for surgery in certain cases. Whilst such a programme had been the subject of much discussion with Primary Care Trusts and had received support a lack of funding had hindered the implementation of such a service in Teesside.

In response to Members' questions the barriers between primary and secondary care were amplified and the potential for developing the service in primary care with Triage and Treat Practitioners whether based in GP practices on specified days/times or in the community to allow patients to be nearer to home were outlined. Although surgery was regarded as a last resort to many patients they required support and needed to be informed of the alternatives available to them. The role of a Nurse Practitioner with specialised training would be to triage patients and refer to a GP, the SAC or to some other appropriate service or local group.

The possible impact of Government proposals in particular the setting up of GP Consortia the number of which had yet to be determined across Teesside was referred to. It was considered important that measures were in place to ensure consistency and that patients received the same service and/or treatment.

**AGREED** as follows: -

1. That the representatives from the Regional Spinal Unit at James Cook University Hospital be thanked for the information provided which was noted.

2. That the Panel receives further information and evidence with particular regard as to how back pain services could be developed in the future.

**OVERVIEW AND SCRUTINY UPDATE**

In a report of the Chair of the Health Scrutiny Panel, Members were advised of the key matters considered and action taken arising from the meeting of the Overview and Scrutiny Board held on 11 January 2011.

NOTED

**ANY OTHER BUSINESS – WINTER PRESSURES – SOUTH TEES HOSPITALS NHS FOUNDATION TRUST**

With the approval of the Chair and the Panel it was agreed that a briefing note outlining the latest position with regard to winter pressures in respect of the South Tees Hospitals NHS Foundation Trust be added to the agenda for consideration at this meeting.

The report stated that preparations for winter 2010-2011 had commenced following guidance, which had been issued in Autumn 2010. An assurance was given that the Trust's approach to managing a surge in demand was to focus primarily on patient safety and to ensure that those who needed access to acute care were able to receive it in a timely and effective way.

It was acknowledged that the adverse weather conditions in December 2010 had affected both patients and staff in getting to the hospital. During such a period a number of planned operations had been cancelled mainly as a result of patients being unable to get to the hospital. In addition, orthopaedic consultants had been diverted from their routine work to manage the high number of fractures that were admitted as a result of accidents in the snow and ice. Consequently, a backlog of waiting list cases had developed going into the Christmas and New Year holiday period.

The Panel was advised that the period between Christmas and New Year had been exceptionally busy and when the hospitals returned to normal business on 4 January 2011 the hospital was running at 98% occupancy. The impact of this had been to restrict the ability of the Trust to admit patients who needed admission overnight for routine surgery.

In response to the demand the medical teams had put in place a number of service improvements. Like all critical care units across the North East and the rest of the UK the Trust had experienced very high demand for its critical care facilities. In accordance with guidance from the NESHA a daily critical care control group had been established and was working with units across the North East Critical Care Network to ensure that those patients most in need of critical care received it.

It was anticipated that from the week commencing 17 January the normal workload would be reinstated. Clinical teams were working on plans to recover the work lost over the past six weeks and to ensure patients were admitted in a timely manner.

**AGREED** that the information provided be noted.