SPINE MATTERS

UKSSB Triannual eBulletin – October 2017

www.UKSSB.com

www.BritSpine.com

Twitter: @UKSpineSB

TABLE OF CONTENTS

CONCEPT AND PURPOSE OF THIS BULLETIN

This is an attempt to inform and thereby empower the spinal services community. It is designed to:

- Provide an immediate overview of the several work-streams which currently, or in the near future, will directly affect spinal services both within and without the NHS; and which organisations and individuals are contributing to these.
- Share knowledge of the different societies' news and developments that may be of relevance without those societies themselves. (It is not intended to replace or duplicate the content of individual societies' newsletters).
- Provide a précis of the continuing work of advisory bodies which impact on our subject (NICE, Acute Oncology Measures, etc)
- Provide a notice board for:
    - Spinal and other relevant society events
    - Non-clinical posts of professional interest (RCS, JCST, BOA Board of Examiners, NICE, GMC, etc)

It is not intended that this eBulletin will be exhaustive, rather a rapid digest to inform and point to more detailed resources (as e-links, where available, or to relevant websites).

Suggestions for improvements are very welcome. Please send these to ukssb@boa.ac.uk

EDITORIAL

Alistair Stirling - UKSSB Chair

Diagnostic and therapeutic nihilism?

It may be apocryphal but at approximately the time of my appointment as a consultant it was suggested that a Department of Health definition of a consultant was somebody capable of dealing with non- protocol events.

This now seems relevant given the increasing numbers of MRI –based triage clinics. Also that numbers of colleagues are suggesting that they will only see patients who have had an MRI scan and that this demonstrates some surgically treatable abnormality.

As will be familiar the national back and radicular pain pathway describes MRI scans should only be used in specific circumstances. For example if more significant underlying pathology is suspected or alternatively when symptoms suggest neural compression causing significant disability that is not settling with conservative measures. When the findings on the MRI are concordant with the presenting symptoms and signs this is clearly within protocol, and decision-making is usually straightforward and well within the capability of specialised spinal triage practitioners(SSTPs) albeit requiring surgical endorsement if intervention is thought justifiable.

By contrast when symptoms are clearly of neurological type and MRI is non –confirmatory more careful assessment may be necessary to consider whether vertical MRI scan may reveal dynamic root compromise or that symptoms represent a peripheral entrapment neuropathy or a non-surgical neurological condition . Also in recent years
I have had many patients referred from arthroplasty colleagues suggesting symptoms particularly in the anterior thigh are of mid lumbar origin rather than indicative of prosthetic loosening which has more usually been the case; although in many instances it has proven to be both and, rather than either or .

It is certainly recognised that in many patients their appendicular pain is of somatic referred origin rather than neural compromise. This does not however infer that this should not be defined, conclusion reached and appropriate advice given. Similarly there are a group of patients with a definite organic basis for their symptoms that is not spinal but in some way mimicking this.

As is well recognised there is a high-frequency of multiple "degenerative (ab)normalities" in asymptomatic individuals. The presence of these "abnormalities "relayed to the patient often reinforces medicalisation of normal episodes of self-limiting back pain.
In addition analysis suggests that not only do MRI results change patient but also medical behaviour.

How then to avoid unconscious bias and its consequences?
I suggest (albeit recognisably a counsel of perfection) that certainly in training and to develop adequate discriminative abilities that symptoms, signs and clinical conclusion in terms of diagnosis and recommended management are defined before the MRI scan report or imaging is looked at .
Also to ensure that both the imaging itself and the report is looked at, a simple system is in correspondence to include the phrase "I have reviewed the imaging and agree with the reported interpretation of this."

The real concern now is who has the necessary skill set and has organised their clinical work to allow some necessary focus on those patients who present a diagnostic and management non-protocol conundrum. They may be significantly disabled by their symptoms and the present system (MRI based triage) may not provide adequate assessment to enable a solution to be found which may often be straightforward.

There is a tension therefore between the requirement to triage the large numbers of patients presenting and our ability to deal with them. Logistically in most areas we simply do not have the necessary spinal surgical manpower to be able to assess all ourselves; nor given high quality assessment by SSTPs should this be necessary. Providing SSTPs have close working relationships with spinal surgical colleagues, are familiar with our thresholds and have ready access for discussion and if necessary review, this should provide adequate safeguard not to miss important and treatable conditions. As yet however in many areas there is still a shortage of fully trained SSTPs (recommended competencies are listed in the Improving Spinal Care section of the UKSSB website which is one of the aspects it is hoped the National Back Pain-Clinical Network (NBP-CN) will seek to address. It is also unclear whether this necessary skill level and close working relationship with surgeons is currently the case in areas where (MSK and) Spinal triage is being commissioned through AQPs.

I suggest through our training, including familiarity with the varying and often combined presentations of appendicular and spinal pathology we are perhaps the only group likely to provide what both the patient and their referring GP require to enable them to move on.
Notwithstanding current pressures perhaps we need to assess our practice on the basis of the standard of assessment and clinical recommendations we would wish for ourselves and families. We have the training but as consultants are we presently resolving non-protocol events or engaging in diagnostic and consequently at times, therapeutic nihilism?

National Back Pain – Clinical Network (NBP-CN)

Elaine Buchanan, Henry Dodds (UKSSB Exec Assistant) and faculty are to be congratulated on a very successful first meeting of this group attended by 130 AHPs (mainly physiotherapists 70% of whom have relevant higher degrees) Her assessment of the first meeting of this group, the output from the workshops at the meeting and the current plans for development follow below. The next meeting is on Tuesday, March 20 preceding BritSpine (please see www.BritSpine.com for details of how to register) Please encourage Physiotherapists and also other AHPs working in Spinal care to attend.

BritSpine 21st -23rd March 2018

As reported by Almas Khan in the section below, preparations are now well underway for this exciting event in Leeds. Registration is now open at www.BritSpine.com with Early Bird rates ending 31 January 2018.

Best Wishes,
Alistair Stirling

NEW MEMBERS OF THE UKSSB EXECUTIVE BOARD

We thank Linda Pollard to whom we are most grateful for her work as foundation chair in setting up the PLG in the first instance.

We are very pleased to welcome Paula Wray as the new Chair who has kindly written an introduction about herself below:

"Everyone has an experience to share and my wish is to support people to recognise the value of these experiences and not only communicate them but also to value the knowledge of those around them. I work with members of the public, researchers and staff to provide confidence and guidance in enabling multiple perspectives shape a project, team, activity or organisation. I am currently a Senior Public Involvement Manager at INVOLVE, leading on Diversity and Inclusion and the development of National Standards for Public Involvement. I have a neuroscience PhD and previously I held public involvement leadership roles in the voluntary sector and with the National Institute of Health Research Collaboration in Applied Health Research and Care and Research Design Service in the East Midlands. I have built comprehensive networks both nationally and internationally and utilise my own experiences as a researcher, spinal patient and parent to provide leadership, appropriate resources and support for others." **– Paula Wray**

OFFICE MATTERS

Henry Dodds – UKSSB Executive Assistant

Websites

www.ukssb.com – This website is currently being reviewed and a new website should be online on this domain by the end of the November. Feedback is always welcome on how this can be improved to help support the Spinal Community, so if you have any comments or queries regarding the site, please send an email to ukssb@boa.ac.uk with subject line "UKSSB Website Feedback"

www.britspine.com is now being redirected to the new events page. Here you will be able to find all the information for BritSpine 2018, which will take place at Leeds University – 21-23 March 2018. Information includes registration, pre-conference courses, event programme, accommodation, social events, location and directions.

www.spinesurgeons.ac.uk – The British Association of Spine Surgeons (BASS) Executive have been working behind the scenes to re-launch this website, which has been developed in partnership with developers at netdreams.co.uk. This should be live shortly, with the BASS Executive notifying all BASS members when this takes place.

Abstract Management System for Conferences

Firebird Systems have been contracted to for **BritSpine 2018** and **BSS 2017** for abstract management. It is envisaged that this system will also be used for **BASS 2019** and all future BritSpine and BSS Conferences. The benefit of an abstract management system means that you will require only one login for all the events and you can also make changes to your submissions up until the set deadlines. This online automation will provide a better service for those submitting, as previously this has been a manual process via the administrator for each event. This also gives us the ability to remind those who have incomplete submissions and notify submitters who have been successful for poster or podium presentations.

FINANCES

Nick Birch – UKSSB Treasurer

At the board meeting of the UKSSB in December 2016 it was unanimously agreed that the status of the organisation should change from a company limited by guarantee to that of an Association. To achieve this a number of different actions needed to be completed including:

Filing of the full 2016 accounts at Companies House

Agreement on the final form of the UKSSB amended constitution

Winding up of UKSSB Ltd with transfer of all the existing funds to the new organisation

To date, the accounts have been completed and filed at Companies House and the amended constitution has been agreed by the members of the Board.

New banking arrangements are now in place and Association status is confirmed.

UKSSB Ltd will be formally wound up in December 2017 after the mandatory 3 month non-trading period.

SECRETARY'S REPORT

Lee Breakwell – UKSSB Secretary

Most of the issues are covered elsewhere in this document. The website is coming on, Henry has done a tremendous job of updating and modernising the look, whilst transposing the huge amount of useful content we have collected.

We are looking to link the UKSSB, BASS and BSS sites more, as Henry will be aiding the admin and update of these sites regularly. The hope is to offer an obvious source for the info you require, and a portal for your questions and concerns.

Planning for BritSpine 2018 progresses well, and I look forward to seeing you all in Yorkshire in the spring. The aim of BritSpine is to offer as much as we can to all spinal professionals, and to link the professions as best we can. One manner of achieving this is to have an overarching theme to the meeting that draws on the expertise and experience of our community. The theme for 2018 is "Back pain: Cradle to Grave", with sessions starting out on genetics, through inflammatory spinal conditions and leading to oncology management.

Planning is well under way for BritSpine 2020, with the thematic view of neurological compromise.

The UKSSB will be all change after BritSpine, with the current Chair and Treasurer making way for new incumbents. It will be a shock for me to see both Alistair and Nick go, who have both been a pleasure to work with, and have transformed the workings of the spinal community over the last few years. It will be great however to have new colleagues in Patrick Statham (Chair) and Neil Orpen (Treasurer), and I wish them all well.

BRITSPINE 2018

Almas Khan – BritSpine 2018 Host and Nick Birch – UKSSB Treasurer

BritSpine 2018 will be hosted at Leeds University, in the diverse and vibrant cultural city of Leeds, located in the heart of the UK, fifth on Lonely Planet's list of the 10 best places to visit in Europe in 2017.

Tuesday 20th March pre-meeting courses and meetings:
- Trainees' Cadaver Lab at Leeds Medical School
- Multi-Disciplinary Team event focusing on Decision Making in Common Complex Spine Problems
- National Back Pain Clinical Network
- Patient Liaison Group meeting

Wednesday 21st to Friday 23rd March Main Meeting will include:
- A session on the interface between spine problems and their genetic basis, and where new genetic advances are taking us.
- A must-attend session on GIRFT and Spinal surgery;
- A number of important and politically charged discussions regarding funding of healthcare and in particular, surgery of the spine in the UK and around the world.

- A session on inflammatory conditions of the spine, and the complexity it brings to surgery.
- A not-to be missed debate on surgery for non-specific back pain with arguments from either side of the pond.
- A session on spinal oncology, and an introduction to some of the cutting-edge oncology therapies soon to be available in the UK.
- Paper sessions and Debates

The Conference Dinner will be held at the Royal Armouries Museum located at Leeds dock with a 3-course evening meal and entertainment with the 'Spinal Chords'

The local hosts at the Leeds Organising Committee lead by Almas Khan, supported by the United Kingdom Spine Societies Board (UKSSB). They look forward to welcoming you to a stimulating, thought-provoking and enjoyable meeting in Leeds in March 2018.

UKSSB FUNDING APPLICATIONS

The Board of the UKSSB welcomes applications from its constituent societies for financial support in the delivery of Research, Education and Administrative activities.

Applications must be on the attached form, and submitted with the supporting information to the Executive Assistant of the Board for consideration. (UKSSB@boa.ac.uk)

Funding Applications - Link to UKSSB Funding Application Form

UPDATES

SPINAL SERVICES CLINICAL REFERENCE GROUP

Ashley Cole – September 2017

There is some concern regarding the NHSE Commissioning approach to Specialised Spinal Services in some Trusts. A meeting is planned to discuss this soon.

There is increasing activity around the work plan for 2017/8:

- Revision of the Specialised Spinal Surgery Service Specification has started.
- Revision of the Spinal Cord Injuries Service Specification is also in progress.
- Production of a Quality Dashboard for Spinal Surgery
    - Replies are being collated from stakeholders to select the most meaningful measures for the dashboard.
- A provisional policy proposal has been submitted to NHS for vertebral body tethering in scoliosis.
- Spinal Cord Injuries service and peer reviews (see BASCIS Report).

IMPROVING SPINAL CARE PROJECT

Ashley Cole – September 2017

The first meeting for those involved in delivery and commissioning of Specialist Spinal Triage services for back and radicular pain took place on 6 September and was centred around the National Back and Radicular Pain Pathway which has now been endorsed by NICE: http://www.ukssb.com/pages/Improving-Spinal-Care-Project/National-Backpain-Pathway.html* *(*website link due to change in November)*

The Regional Spinal Networks continue to progress and a meeting is planned for the Clinical Leads and Commissioners at the end of November.

IMPLEMENTING THE NATIONAL BACK & RADICULAR PAIN PATHWAY AS PART OF MSK TRANSFORMATION

David Cumming

In many parts of the country musculoskeletal services are undergoing a transformation project. The primary focus by commissioners at this time is to reduce inappropriate secondary care referrals. The transformation projects fit in well with the focus on the National Back and Radicular Pain Pathway.

In Ipswich and East Suffolk commissioners, primary care and secondary care clinicians have worked closely together to deliver a new system to ensure rapid access to the most appropriate health care professional at the right time. This has involved working across boundaries and ensuring we are all seen as equal partners in the care of patients with musculoskeletal conditions. The transformation project has encompassed Trauma & Orthopaedics, Spinal Surgery, Rheumatology, Pain Management and Surgical Podiatric Services.

The re-design has focused on a single point of access through an electronic pathway. All referrals are triaged by the primary care team. Urgent / red flag referrals are passed onto secondary care with immediate effect. All other referrals including self-referral are assessed by the most appropriate health care professional in primary care. All diagnostics are organised by the specialists in primary care.

Close links between the clinicians, including regular MDTs, ensures the appropriate patients are referred into secondary care when required.

The system in the first 6 months has reduced the number of referrals into secondary care by 28%. This allows all patients to be seen rapidly by the most appropriate health care professional.

UKSSB WORKING GROUPS

TRAINING AND EDUCATION

Niall Eames

STIG

The STIG process is now entering, hopefully, its final stage before it is launched. Bill Allum (Chair JCST) and David Wilkinson (HEEngland) are now helping me steer the proposal through the various regulatory loops it needs to go through, to achieve GMC recognition. A meeting is being held in December of the relevant bodies and I will continue to drive our proposal forwards as fast as possible.

The next step will be to ask for expressions of interest from units to host a STIG Fellow. I would ask units to begin thinking if they would be in a position to host such a post. The proposal is available on the UKSSB site. A few things require reiterating. These are pre CCT Fellows. They will require supervision and training. They will be allocated centrally to units by a STIG Committee. At the start there will only be a few centres hosting STIGs. Centres will need to provide both neurosurgical and orthopaedic input into the fellowship. Remember, this is to train a day one consultant spinal surgeon, not a specialised spine surgeon in a particular aspect of our specialty.

No new funding is available, so the money for the fellowship will have to come from local sources – either from pre-existing monies in local centres already allocated for fellows, or diversion of already funded local training posts to a STIG Fellow. This latter option requires the support of the local deanery. We are seeking this support at the moment and hopefully can go live with a letter asking for expressions of interest in hosting the fellows in the very near future.

The regulatory phase of this project is however crucial to ensuring it is correctly set up and whilst I am impatient to launch the scheme, we are all cognisant of the need for this stage to be performed with due diligence.

Curriculum Alignment

As an exercise in uniformity, I have compared the physiotherapy curriculum (MSC module) and our spinal surgical curriculum. I am delighted to say there is 100% correlation, with every aspect of the physiotherapy curriculum present in our own. Clearly, the surgical curriculum details areas regarding surgery which are not taught on the physiotherapy side, but it is good to know that such a strong overlap exists at this stage. With the establishment of the NLBRP pathway, this can only be good news.

European Diploma

A meeting of the European Group looking at establishing a European Diploma was held at the recent Eurospine meeting in Dublin. Neil Orpen (UKSSB Secretary Elect) kindly represented us at this meeting. They are proposing a modular education process quite similar to our own and plan to look into the requirements for a centres to host a surgeon. Various levels of Diploma are envisaged either for basic or more complex surgery. We will continue to engage with this group to endeavour to make sure that no matter what consequences Brexit has, UK training and European training are not on differing paths. There are still concerns over various aspects of the European model - assessment of competencies being one, as well as worries regarding validity and independence of the proposed program. We will continue to interact with this group.

UKSSB/BSS/BASS/BOA

The recent BOA spinal updates, revalidation sessions and boot camp sessions in Liverpool were extremely well received. I am extremely grateful to the faculty, who came from all the spinal societies and gave of their time to help run this event. With so much happening at the moment, the very close cooperation between all the spinal societies on education is proving hugely beneficial for us all.

Mr Niall Eames
MD FRCS Orth Tr - Consultant Spinal Surgeon
Regional Lead Clinician Spinal Surgery NI

JOINED UP SPINAL THINKING (JUST)

Alistair Stirling

In the course of preparations for the NBP-CN meeting it became apparent that there are multiple parties all endeavouring to improve various aspects of care for spinal patients. Also that as members of the Spinal societies some of us are not aware of the existence or activities, past, current and future of the other contributory groups listed below
It seems rational in the initial instance to become aware of the relevant parties , their lead personnel and their focus of activity This might then enable synthesis to avoid duplication and optimise process This has now been discussed with a majority of those listed below although not all as yet . There seems to be a common view that it would be worthwhile mapping the landscape and establishing lines of communication
To that end the following is in process:

- That each of the parties put together a brief description of their organisation and the above items. These follow below
- That this is circulated through Spine Matters and contact links put on the UKSSB website
- That an initial meeting of the relevant parties is arranged
- If agreed as worthwhile this might then be continued on an annual basis to generate ongoing spinal harmony
- That a representative from each of these groups be invited to the possible NBP-CN implementation meetings on the days preceding BritSpine/ BASS in subsequent years. The next being prior to BritSpine on 20th March 2018 in Leeds

It it intended this Group will include:
NHSE National Clinical Director - MSK
NHSE Spinal Services CRG
NHSE ISCP – Project manager
NBP-CN – Lead
NICE – Lead
AHPs - Lead
Spine Societies Education Leads
Right care - Primary care
Spinal GIRFT
Chartered Society of Physiotherapists -
UKSSB – Chair (includes SBPR, BASS, BSS, and BASCIS with representation from BOA and SBNS)
RCGP - Lead

Allied Health Professions into Action

'AHPs into Action', published in January 2017, describes how AHPs can support the delivery of Sustainability and Transformation Plans (STPs) and the pursuit of the triple aim in the Five Year Forward View. It is a resource to inform and inspire AHPs, leaders and decision makers across the health and care system, offering:

- A clear view of the potential of AHPs
- 53 examples of innovative AHP practice
- A framework to help develop local delivery plans.

'AHPs into Action' defines how AHPs can support the delivery of the triple aim by describing how England would be different if AHPs were genuinely used effectively (part one) and what they need to stop, start or do differently to make this happen (part two). It describes the:

- Impact of the effective and efficient use of AHPs for people
- Commitment to the way services are delivered
- Priorities to meet the challenges of changing care needs.

Allied Health Professions into Action brings together the views of the third largest workforce in the health and care system. This includes Art Therapists, Drama Therapists, Music Therapists, Podiatrists, Dietitians, Occupational Therapists, Occupational Therapists, Prosthetists and Orthotists, Paramedics, Physiotherapists, Diagnostic and Therapeutic, Radiographers and Speech and Language Therapists.

Aimed at leaders and decision makers, this document will help them understand the potential and role of AHPs within the health, social and wider care system.

For more information: https://www.england.nhs.uk/ourwork/qual-clin-lead/ahp/

NHS RightCare

NHS RightCare is a national NHS England supported programme committed to delivering the best care to patients, making the NHS's money go as far as possible and improving patient outcomes.

Ensuring people access the right care, in the right place at the right time means the NHS can treat more people effectively, now and in the future. It's unacceptable to see unwarranted differences across the country around the type of care patients receive. NHS RightCare's work is core to ensuring the best possible care is delivered everywhere.

Using leading edge medical evidence and practical support helps local health economies understand how money is spent to deliver the best care in different parts of the country.

Through the use of data, including local health economies' spend data, patient admissions and prescribing data - along with other evidence - NHS RightCare Intelligence shines a light on variation and performance. This data identifies areas of greatest opportunity and support for quality improvement. Working with relevant partners this information is translated into a range of comprehensive data packs, tools and other resources to act as a source of insight which support local health economies to have local discussions to agree a starting point for change.

The Intelligence programme also provides support for the three phases of the NHS RightCare approach (see diagram below). The approach begins with a review of indicative data to highlight the top priorities or opportunities for transformation and improvement: *Where to Look.* Value opportunities exist where a health economy is an outlier and will most likely yield the greatest improvement to clinical pathways and policies. Phases two and three then move on to explore *What to Change* and *How to Change* where we work with health economies and stakeholders to identify optimal pathways and design.

For more information about NHS RightCare please visit https://www.england.nhs.uk/rightcare/ or email rightcare@nhs.net.

The Arthritis and Musculoskeletal Alliance

The Arthritis and Musculoskeletal Alliance (ARMA) is the umbrella body for the arthritis and musculoskeletal community in the UK, and our mission is to transform the quality of life of people with musculoskeletal conditions. We have 33 member organisations ranging from specialised support groups for rare diseases to major research charities and national professional bodies.

We work in partnership with our members to shape policy and guidance; identify and disseminate best practice; and work constructively with decision-makers in the NHS and public health throughout the UK.

ARMA co-ordinates work on issues of common concern to ARMA members. Current examples include a focus on back pain pathways and the access to joint replacement surgery.

The ARMA knowledge hub is currently in development. This will be an on-line portal signposting to information on a range of resources relevant to MSK including a discussion forum.

Working in partnership with NHS England, our clinical networks project aims to improve healthcare for people with MSK conditions through multidisciplinary working.

Chief Executive: Sue Brown

Website: arma.uk.net

Contact: projects@arma.uk.net phone: 0203 856 1978

SOCIETY/REGISTRY REPORTS

BRITISH ASSOCIATION OF SPINE SURGEONS (BASS)

Stuart Blagg and David Cumming – September 2017

BASS continues to work to produce best practice guidance for its members. On a monthly basis the educational booklets on spinal procedures and conditions are being updated. These information leaflets are an important part of the consent process. The booklets should be used alongside the recently amended procedure specific consent forms.

Further best practice guidance on ensuring correct level surgery & management of spinal infections will be produced over the next few months.

The BASS Boot Camp for senior trainees and junior consultants took place in June of this year. This educational event discussed clinical scenarios & complications as well as guidance in other areas that are essential as a new consultant.

BASS continues to work with all spinal societies to ensure that all spinal surgeons are supported and are able to provide best quality care for all spinal surgical patients.

The next BASS executive meeting will be taking place on the 15th September. This meeting is essential in discussing our future priorities and how the executive will deliver for the members.

BRITISH SCOLIOSIS SOCIETY (BSS)

www.britscoliosissoc.org.uk

James Wilson-Macdonald and Elnasri Ahmed – September 2017

- BSS was asked to be involved in a trust investigation by NHS England. Mr James Wilson McDonald (President) and Mr Vinay Jasani are to help in the investigation.
- BSS to assist in establishing centres to start a national trial on Vertebral Body Tethering (VBT). (CRG is leading in this.)
- Research:
    - **Vitamin D study -** Sheffield team to lead on the project

- **ASD Guideline project**
  steering group will meet on 29 Sept.
  First draft is to be presented in next BSS meeting in November, Birmingham.

- **Future meetings**

- 2017 Birmingham
- 2018 Belfast
- India Spine Society (January 2018) (waiting to hear from the Indian spine Society)
- 2019 Anglo- French joint meeting or Cardiff.
-

SOCIETY FOR BACK PAIN RESEARCH (SPBR)

www.sbpr.info

Nadine Foster and Steve Vogel

No report for this edition

BRITISH ASSOCIATION OF SPINAL CORD INJURY SPECIALISTS (BASCIS)

www.bascis.org.uk

Ali Jamous – President
Nigel Henderson –UKSSB BASCIS representative

1. The Spinal Cord Injury Working Group of the CRG has been established and is meeting regularly. A face to face meeting was held on 29 June and a recent phone conference on 30th Aug 17. The membership includes a representative of each SCI Centre and the workstream leads of the SCI Service Review.

2. The NHS England Specialised Commissioning Review of SCI Services in England is complete. This is progressing through to the Specialised Commissioning Oversight Group and will hopefully go to public consultation soon.

3. The Peer Review of spinal cord injury centres (NHS England Quality Surveillance Team) has now been published to individual Centres for them to make progress with recommendations. The national report is still awaited.

4. Having recently agreed a new curriculum for training BASCIS is concerned to learn that the the SAC in rehabilitation medicine is now to review this again.

5. The spinal cord injury referral portal, which includes a useful and informative document resource, is available on www.spinalcordinjury.nhs.uk.

SOCIETY OF BRITISH NEUROLOGICAL SURGEONS (SBNS)

http://www.sbns.org.uk/

SBNS Vice-President – Mr Tom Cadoux-Hudson

SBNS lead for Spine Surgery – Mr Aprajay Golash

No report for this edition

BRITISH ORTHOPAEDIC ASSOCIATION (BOA)

www.boa.ac.uk

Lee Breakwell – BOA Representative

I am pleased to report that the BOA Congress in Liverpool was a most successful meeting. The attendance was a new record, and the variety and content in the sessions was second to none.

Thanks to all my spinal colleagues who helped with the Spine educations sessions. This year they comprised the Bootcamp style rapid fire small group tutorials on a multitude of relevant spinal topics. The feedback was simply, more of the same please!

The revalidation sessions were also well received from the audience with good coverage of the breadth of practice for a generalist practitioner of orthopaedics and trauma.

The instant updates are breath-taking short bursts of the most up-to-date details on common areas of concern, such as cauda equina, spinal tumours and infection. Again, the feedback was that this serves a purpose for the non-specialist spinal surgeon.

A general theme of the Congress was around a just culture, and that we must ensure all members of our team are adequately supported and encouraged to perform as well as they can.

Revalidation looms large for all doctors, and the congress intends to prepare as many for this process as possible.

The BOA is working closely with BASS and the BSS to deliver elective care reviews of spinal departments as required. This is due to start for arthroplasty units very soon, based on NJR data of persistent outlier status. The BOA will select a team of relevant experts to review and support the unit to address the underlying barriers to progress. The plan is to provide the same system for spinal units if required, and that the experts will come from the specialist societies dependent upon the issues at hand, and the BOA will aid in the administration and support of the team.

In the interest of improved dialogue with respect to our interface specialty, the BOA has extended the offer of a representative of the SBNS Council to have direct access to the BOA Council, and to join sub-committees as required for greater influence and understanding.

BRITISH SPINE REGISTRY (BSR)

http://www.britishspineregistry.com/

Mike Hutton

No report for this edition

NATIONAL BACK PAIN CARE PATHWAY CLINICAL NETWORK (NBP-CN)

Elaine Buchanan – October 2017

Inaugural Meeting of NBP-CN - Birmingham 6 September 2017

The NBP-CN got off to a good start attracting 128 delegates. It was great to see a mix of professions including; physiotherapists, surgeons, commissioners, nurses and chiropractors. With a focus on the organisation and commissioning of services, 33 faculty delivered a range of topics including; the national direction of spinal care, an update on the implementation of the National Back Pain Pathway, commissioning of spinal services, governance, data and outcomes, advanced practice and academic approval. There were clinical sessions focusing on; the Radicular Pathway, Multi-disciplinary Comprehensive Combined Physical & Psychological Programmes, Red Flags, Cauda Equina Syndrome and Metastatic Spinal Cord Compression.

Link to the presentations: https://goo.gl/gz3iPp

The feedback from the meeting was good; 88% were satisfied with the event and 97% would recommend the NBP-CN to others.

Thank you to all those who contributed and for the enthusiastic participation of the delegates.

Next Steps for the NBP-CN:

- A call for nominations for the National Backpain-Clinical Network Committee has been sent out (closing date 27/10/17). 3 executive officers and 9 members will be appointed shortly following this.
- The NBP-CN will have non-voting representation at the UKSSB.
- Date of **next meeting Tuesday** 20th March 2018, University of Leeds
    - The programme for the day is in development.
    - Suggestions for the March programme are welcomed (elaine.buchanan@ouh.nhs.uk)

50 UKSSB bursaries for BritSpine will be available to delegates attending the NBP-CN meeting on the 20th March. Applications will be linked to the NBP-CN/BritSpine registration process once it is live.

Below are summaries from the various workshop sessions from the day:

1. **National Backpain Clinical Network Workshop - Elaine Buchanan, Louise White**

Twenty four delegates participated in the NBP-CN workshop, exploring the future structure, function and benefits of the NBP-CN. The proposed object and objectives of the NBP-CN were reviewed with the whole group. Four subgroups were formed and each asked to consider one pre-set question (see below). Key points from each subgroup were conferred to the full group. Further discussion concluded the session. There was a good deal of support for continuation of the Network.

Proposed Object:

- To promote the implementation and advancement of the National Low Back Pain Pathway (NBPP) through a clinical network for the benefit of people in the UK with back pain.

Proposed Objectives:

- To foster and encourage sharing of best practice in the management of back pain across the UK.
- To promote and share best models of organisational practice in the delivery of back pain services.
- To facilitate dissemination of clinical guidelines and standards of care relevant to the management of back pain.
- To reduce variation in the management of Back Pain in the UK.
- To share implementation & delivery plans relevant to the NBPP
- To hold network meetings entitled "Improving Spinal Care" at least once per year
- To promote the NBPP and disseminate best models of care at BritSpine.
- To contribute to the work of the UKSSB
- To foster collaboration between the NBP-CN and Regional Spinal Networks.

Group 1: Who should be the officers of the NBP-CN?

- 12 committee members
- Regional Spinal network gains representation from across the country
- Geographically diverse
- Different professions
- Community as well as acute trusts
- Commissioners
- Research
- Charity

Group 2: How do we finance the network?

- The Committee need to be clear about how much money the NBP-CN want/need
- Define and be clear about the NBP-CN market
- Take account of the numbers in the network
- Define the Unique Selling Point of NBP-CN. What is different from other organisations?
- Market the NBP-CN
    - Communicate the benefits of membership
        - Learning
        - Access to UKSSB
        - Closer links between AHP's and spinal surgeons

- Linked networks

Group 3: What contribution can we make to the UKSSB?

- Need to ensure people understand the value of being associated with UKSSB
- Promote non-surgical management
- Representation of AHP's in the back pain pathway
- Contribute to developing a national
  - library of information for patients
  - Standards of care
- Sharing challenges & lessons learnt related to service delivery
- Sharing what non surgeons "are doing" and "can do"
- Contributing to spinal education, E-Spine content.

Group 4: What contribution can NBP-CN make to BritSpine?

- Specialist Spinal Triage Practitioners(SSTP) are the glue between surgery/pain/core therapies.
- Evidence what AHP's contribute
- Debate models of care
- Sharing promoting AHP skills.
- Promoting shared decision making
- Promoting best practice in patient communication.
- Feedback successful models of service delivery
- Service evaluations: what works well & what didn't
- Demonstrate evidence and outcomes of what we do.
- Demonstrate SSTP governance

2. Advanced Practice & Education Workshop Feedback - Frances Arnall & Niall Eames

Many thanks to all those who contributed to the workshop, these are your collective responses to the questions posed.

Question 1a: What are the additional skills required for the SSTP role above those for general MSK?

Amongst participants there was consensus around themes on clinical reasoning skills, judgement especially around risk balance, correlating spinal images with symptoms, skills in shared decision making, as being necessary key skills.

There was discussion as to the 'ideal skill requirement'; the additional skills required being person dependent: there should be identification of the key skills which clinicians already demonstrate & those where additional training maybe required.

1b: What learning would you have found most beneficial when you were new to the role?

There was a discussion on the value & format of having a buddy/mentor; a number of participants felt that this would have been especially helpful. Other points raised included having a greater working knowledge of what other members of the team could offer in patient management. For primary care clinicians; having some colocation working with secondary care.

Question 2: How should learning be assessed & by whom?

Time prohibited a consensus on this question; However, themes raised & discussed included peer review, Self-reflection, 360 feedback, Academic status, Work based assessments & exams at Masters level. There was range of thoughts as to who should be the assessors from another person in a similar role to mechanisms which align to GP or other Health Professionals.

Question 3: How should SSTP's learn & at what level

There was unanimous agreement that this should be Masters level as SSTP's needed to have good critical thinking skills.

The group is a need for a range of learning opportunities from in house training, peer learning to more spine specific taught Masters programmes. Areas of most training need were discussed with radiology, Psychology/ CBT/ behavioural change skills and governance knowledge.

3. NBRPP – Implementation Report - David Cumming

The following issues / questions were suggested to the group.

- The Referral Process
  - Self-Referral
  - GP Referral
  - Who does the paper triage?
  - How to onward refer for red flags?

This was discussed at length. It was agreed that there are several models across the UK. A single point of access was felt to be the most appropriate as part of a MSK referral pathway. Administrative triage to ensure forms completed and then a senior treat and triage practitioner to clinically triage the e-referrals.

- The Role of the Treat & Triage Practitioner.
  - What is the role of the Treat & Triage practitioner?
  - Should the "T & T" do both parts?
  - 'Pathfinder' suggests Triage & Treat practitioners should be band 8a and 1 per 80,000 population – Is this realistic? Can existing services adapt fulfil the role of Triage and Treat?

Discussion based around the role of the treat & triage practitioner. Most people felt the role was to direct the patient to the appropriate health care professional for treatment. The practitioner would clinically assess appropriate patients, organise diagnostics and inform the patient of diagnosis and management plan. Close links with consultants was felt to be important.

- The Role of the MDT
  - How should Spine MDTs function? – What is the role of Triage & Treat practitioners in MDTs?
  - How should Triage & Treat practitioners link with consultants (Pain /Spinal)?
  - What should be the onward referral process to secondary care?
  - Who and how is the MDT funded?

The role of an MDT was discussed. This is seen as a place for the practitioners to bringing cases to discuss with consultants, pain & spinal. The MDT was felt to be an important area for governance and oversight of the system.

Funding was not discussed in detail. There are several models that need to be discussed with commissioners.

- The Role of Community Physio
  - See the patient first and then refer to T&T
  - T&T first then physiotherapy if required?
  - Cost implication.

The role of physiotherapy was discussed. This is an essential area for patients to be referred to for further treatment. Some felt that treatment by physiotherapy was most appropriate Time may be an issue for T&T practitioners to complete both roles.

4. M-CPPP Workshop - Leila Heelas and David Rogers

Participants were invited to consider questions related to implementation of M-CPPP or to raise any points for discussion of their own.

Feedback from participants was as follows:

- There was a lack of clarity about how to identify a patient that is more appropriate for an LI-CPPP versus an M-CPPP and there is no evidence-based guidance to support this decision-making. Language and physical barriers need to be considered as well as fear of group work.

- There were questions about how the content of LI-CPPP and M-CPPP would differ and a risk of duplication if patients were following the pathway and progressing from an LI-CPPP to an M-CPPP. It may be better to select patients for the correct level of intervention rather than progress though different programmes. Additional criteria for M-CPPP may be an aim to return to work or a greater level of functional impairment.

- Clinicians delivering LI-CPPP in primary care noted that it is more difficult to manage patients with distress and depression as a lone clinician and they would value stronger links with either secondary care or specialist pain management services.

- In one area there was access to LI-CPPP, M-CPPP and highly specialist PMP, thus the NBP could be aligned with existing provision. Some areas had no access at all and were uncertain where to start with developing new services. LI-CPPP can be developed with existing resources.

- Commissioning of back pain specific rehabilitation services and introduction of new terminology used in the NBP versus language used by The British Pain Society, may create confusion for commissioners and managers. Other clinicians felt that mixing patients with spinal and other types of pain might be confusing, although this model is used in PMPs.

- If patients are not ready for group programmes, review clinics can be useful for increasing readiness for treatment. If there are barriers to treatment, a multi-disciplinary discussion is helpful, which may result in further assessment, preparation work or treatment being deferred. Rationale for decisions would be explained to the patient with a letter to the GP, suggesting that re-referrals could be made should circumstances change. In some instances patients attend for treatment in mental health services and are re-referred later or are offered individual treatment if working in groups is not indicated / desired.

- If patients re-consult following a flare up, a flare-up plan can be sent to the GP that can be worked through in primary care. Some provide an 'emergency' card to patients for this purpose.

5. <u>Screening Workshop</u> - Dr Sue Greenhalgh

Twenty one delegates attended the screening workshop and were split into two groups; one considering Cauda Equina Syndrome (CES), the second spinal malignancy. The groups were asked to consider the five most important items in screening for;

group 1: CES,

group 2: malignancy

The two groups were self selecting having chosen the screening workshop and then a specific group. A qualitative methodology was employed using a short version of Nominal Group Technique (NGT). The NGT approach was chosen to generate themes for further consideration in study and education relating to screening for serious spinal conditions and is particularly useful when interogating a concept in a short period of time. The first stage required delegates to complete blank post cards with their top five items for screening for either CES or spinal malignancy. During this first stage delegates were not allowed to communicate with one another and worked in silence. The second stage involved all delegates in their specific group, volunteering one of their top five items in turn until all had delivered all documented items. Facilitators recorded each item on a flip chart. Items were often repeated by delegates which was recorded by the facilitator to illustrate a weighting or level of agreement.

Following the NGT the facilitators of the workshops collaboratively conducted an informal analysis of the findings.

Group 1; Five most important items in screening for CES;

The focus of items was surrounding Red Flags and well known Red Flags were offered with ease and incidence. Very quickly it became clear that 80% of items were in the subjective history. Of the 55 items generated, only 4 were relating to sexual dysfunction. The findings are in-keeping with current literature; subjective questioning and safety netting those at risk is key. Sexual dysfunction is said to be less likely to be explored and documented and to reflect this did not appear often in the top five items

The findings illustrate the importance of clear communication

- Using patient language in subjective questioning and safety netting
- Good listening skills

Group 2: Five most important items in screening for spinal malignancy

Once again, the focus of items was surrounding Red Flags with well-known Red Flags offered with same ease and regularity. However, the Red Flags in the top five were of advanced disease suggesting cord compression e.g. Unwell, weight loss, abnormal neurology, bladder and bowel dysfunction (a late stage disease manifestation)

These findings highlight the need for dissemination of early Red Flags suggestive of serious disease e.g. band –like pain, escalating pain, funny feelings in legs, difficulty lying flat to enable impending cord compression to be identified more readily rather than at the compressive stage.

Acknowledgements

Thank you for the invitation to lead this informative workshop, to the facilitators and all of those who took part engaging enthusiastically, readily sharing their valuable knowledge.

6. Back Pain Pathway Data Collection and Outcomes - Andrew Coxon

Due to the current financial constraints the NHS is experiencing, it is proving more important than ever that activity can be readily demonstrated, and also shown to be of benefit to the patient. Unfortunately the collection of this data and the process of turning it into usable information can be expensive both in obtaining the data collection tool and providing the staff to input the data; the last point being amplified if clinical staff members are used. Appropriate data collection strategies can offset this cost.

Data collection methods range (in order of increasing efficiency) from a clinician manually entering data onto a spreadsheet (or sometimes even paper), an internally designed database with designated data entry staff, an externally designed database, and an externally designed database created for a service across multiple sites. Internal development is now rare due to the costs of employing full time software developers as opposed to contracting an external company for the duration of the project.

The purpose of any data system is to provide information and so a suitably designed database is a necessity, and if suitably constructed it can provide the facility for efficient and accurate data entry and information extraction.

For the Back Pain Pathway, the proposed activity data collection would be: Percentage of population referred onto the pathway; Number of referrals that DNA; Time from Booked Date to Appointment; Number of attendees that only have an Initial Appointment; Number of patients sent for MRI; Number of patients referred to Core Therapies; Number of patients referred to Pain Services; Number of patients referred to Surgery.

The proposed outcomes data would be: Average EQ5D improvement from Initial to Discharge; Average EQ5D improvement from Pre to Post Core Therapies.

These data systems should also allow a clinician easy access to their own data, be it via a reporting system or a flat file download option for more advanced users.

Ideally activity data should be derived from direct links from sources such as SystmOne or EMIS, and outcome measures gathered remotely via smartphone apps or e-mailed weblinks. Direct entry methods could still be provided for those patients unable/unwilling to enter their outcomes remotely. These methods negate the requirements for multiple entry of the same data, increasing accuracy and reducing cost.

7. Commissioning Workshop - David Stockdale

The workshop began with an informal question and answer session. Several delegates wished to receive details of how to access Rightcare data and Getting It Right First Time data and reports.

There was also a good deal of interest in acquiring the NEQOS/GIRFT data which mapped surgery and injection rates to CCG populations.

The need for a reasonably senior project manager was raised and supported by the group. It was considered essential for ensuring a commitment to introducing the pathway was followed through from inception to the new pathway becoming operational.

There was an example where the commissioner was not keen to host the employment of the project manager but getting one of the other parties to provide that support was problematic for that health economy.

Many of the clinicians were aware of local groups of CCGs maintaining lists of Procedures of Limited Clinical Effectiveness. Some already contained procedures for lower back pain, including injections. Others did not and could offer a route to discussing the whole pathway with CCGs.

The workshop also discussed how to approach CCGs, to promote the pathway. The group concluded it was essential to find an appropriate contact within a CCG. A fairly slick promotion of the pathway was needed; identifying the cost savings and benefits to patients (and very bust GPs!). Whoever approached the CCG needed to know the facts; local and national. It was also

important to highlight what elements of the pathway were already in place – the CCG may not know. The person approaching the CCG would need to devote time for further contact and involvement.

8. Governance - Lee Breakwell and Louise Hailey

Within the workshop the group discussed aspects of governance in relation to implementing the National Low Back and Radicular Pain Pathway and issues relevant to Specialist Spinal Triage practitioners. It was accepted that it is essential to establish a strong framework of clinical governance. This process must begin within the setting of Primary Care, but at the same time must extend into Secondary and Tertiary Care in order to ensure that the most appropriate care is delivered in the best possible setting by a team of suitability skilled clinicians.

In the discussion it was recognised that there are different systems across the United Kingdom that deliver services that have developed in response to local needs. There are small as well as large services and each has varying degrees of expertise. The clinical governance structures are also varied. In order to develop sustainable, efficient, high value triage services, work needs to be done to create more uniformity, particularly in relation to clinical governance structures. The widely accepted concept of the 7 pillars of clinical governance (clinical effectiveness, audit, risk, education, patient and public involvement, using information, staff management) need to be implemented in all services and supported both locally and nationally. The discussion covered issues related to organisational culture, team work, individual responsibilities, peer review and metrics to monitor both individuals and services. With the adoption of a standardised approach to clinical governance, which would align with the clinical governance structures within most Trusts, significant progress would be made in establishing the National Low Back and Radicular Pain Pathway.

Communication between the different groups was recognised as an important factor in supporting individuals and promoting the development of competencies. Good communication, together with the provision of adequate local and national resources, are the basic requirements for the establishment of a database on which professional and organisational metrics could be based - an important tool in a cycle of continuous improvement.

EVENTS AND MEETINGS

North American Spine Society - NASS 2017 – Orlando, FL, USA
Wednesday 25 - Saturday 28 October 2017
www.nassannualmeeting.org

SBPR Annual Meeting 2017, Northampton
Thurs 2-Fri 3rd November 2017
www.sbpr.info/meetings

Metastatic Spinal Cord Compression (MSCC)
Tuesday 21st November 2017
Information Here

BSS Annual Meeting 2017, ICC Birmingham
Wed 29th Nov-Fri 1 Dec 2017
www.britscoliosissoc.org.uk / http://www.cvent.com/d/35qq52

BritSpine 2018, University of Leeds
Wed 21-Fri 23rd Mar 2018
www.britspine.com

COURSES

BOA INSTRUCTIONAL COURSE 2018

6-7 January, MacDonald Hotel Manchester

The BOA's Instructional Course is an outstanding opportunity for surgical trainees not only to gain a number of CBDs in a range of topics but also to network and attend lectures delivered by expert clinicians. This course brings together trauma and orthopaedic trainees at all stages of their postgraduate training, to prepare for their FRCS examination. The Case Based Discussions (CBDs) for 2018 will include the following; Foot and Ankle, Pelvic and Acetabular, **Spine**, Sarcoma and Trauma. This course brings together trauma and orthopaedic trainees at all stages of their postgraduate training, to prepare for their FRCS examination.

The BOA are pleased to confirm that Nigel Rossiter, Hiro Tanaka, David Limb and Ananda Nanu will be delivering the plenary lectures at the Instructional Course. Please see the full list of confirmed faculty at www.boa.ac.uk/events/instructional-course.

Registration is now open, but please be aware places are limited so register early to guarantee your spot on the course. For more information on how to register and details of the provisional programme please visit the BOA website: www.boa.ac.uk/events/instructional-course

ARTICLES AND NEWSLETTERS

HIGHLIGHTED ARTICLE – RCS "THE BULLETIN" VOLUME 99, ISSUE 7

Implications of the Ian Paterson case for the private hospital sector

http://publishing.rcseng.ac.uk/doi/10.1308/rcsbull.2017.252

After the breast surgeon was sentenced to 15 years for performing unnecessary operations on cancer patients, Colin Leys considers what the inevitable inquiry could mean for private hospitals.

REGULATION 28 – LETTER FROM BASS PRESIDENT – STUART BLAGG

https://goo.gl/y3HNyN

RULES FOR NHS COMPENSATION ARE TO CHANGE AGAIN AFTER COSTS SPIRAL

Author: Clare Dyer
https://doi.org/10.1136/bmj.j4209

THE EXTENDED SURGICAL TEAM

How hospitals around the UK are using the extended surgical team to improve patient care.
http://publishing.rcseng.ac.uk/doi/pdf/10.1308/rcsbull.2017.264

NASS NEWSLETTER

NASS 2017 – Orlando, FL – 25-28 October
Join your colleagues at NASS 2017 in Orlando, Florida. The premier meeting in spine features an extensive and challenging multidisciplinary educational program that includes symposia, specialty section sessions, abstract presentations, ePosters, innovative technology presentations, world-renowned guest speakers and a technical exhibition featuring the industry's largest display of spine care products and services. It is a meeting not to be missed.

View the Preliminary Program
Learn more about NASS 2017 at www.nassannualmeeting.org

EUROSPINE NEWSLETTER

- **EUROSPINE Newsletter Ed 9 / 2017**
  Includes information on Research & Education, Annual Report and upcoming events

EUROSPINE Spring Speciality Meeting 2018 - Vienna waits for you!

EuroSpine are proud to announce the 2018 Spring Speciality Meeting which will take place in Vienna, Austria from 26-27 April 2018

Find out more about the programme **here**.

Be an early bird and save up to €150 by **registering** before Wednesday, 18 October 2017.

VACANCIES

There are no current vacancies on the UKSSB Board

NOTICES

For more information on many of the topics detailed in this eBulletin, please visit the UKSSB website, along with each of the constituent society websites. BASS, BSS, SBPR and BASCIS.

LINKS

Useful Spine Society Website Links

- UK Spines Societies Board (UKSSB) Website
- BritSpine Event Website
- British Association of Spine Surgeons (BASS) Website
- British Scoliosis Society (BSS) Website
- Society for Back Pain Research (SBPR) Website
- British Association of Spinal Cord Injury Specialists (BASCIS) Website
- The Society of British Neurological Surgeons (SBNS) Website
- British Orthopaedic Association (BOA) Website
- Spine Societies of Europe (SSE) Website
- North American Spine Society (NASS) Website
- Scoliosis Research Society (SRS) Website

Links to external websites are being provided as a convenience and for informational purposes only; they do not constitute an endorsement or an approval by the UK Spine Societies Board (UKSSB) of any of the products, services or opinions of the corporation or organization or individual. The UKSSB bears no responsibility for the accuracy, legality or content of the external site or for that of subsequent links. Contact the external site for answers to questions regarding its content.