SPINE MATTERS

UKSSB Quarterly eBulletin - September 2015

Introduction

Alistair Stirling (UKSSB Chair)

This is a time of unparalleled change on many fronts not least in Spinal Services. In an attempt to inform and thereby empower the spinal services community, this is the first of a continuing series of quarterly eBulletins designed to:

- Provide an immediate overview of the several workstreams 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 society newsletters).
- Provide a précis of the continuing work of advisory bodies which bear on our subject (NICE, Acute Oncology Measures, etc)
- Provide a notice board for:
  a. Spinal and other relevant society events
  b. Non-clinical posts of professional interest (RCS, JCST, BOA Board of Examiners, NICE, GMC, etc)
- In future it may include invited articles and debate relevant to professional, rather than clinical practice which is already well covered elsewhere.

It is acknowledged that whilst some of the changes now current will be welcomed by some, others may find these at least challenging and some potentially threatening. It is hoped that through being aware, many will choose to engage and influence this evolving process both nationally and locally. As Ashley Cole makes clear in his article, the spinal surgical community is being offered a unique opportunity to engage with this with DH investment to assist in spinal service improvement.

It is not intended that this eBulletin will be exhaustive, rather a rapid digest to inform and point to more detailed resources (as elinks, where available, or to relevant websites). The UKSSB website now has a reference document section to which additions will be made as they evolve.

Please recognise that some initial teething problems are inevitable with this, the first edition, and hopefully will be overcome shortly. Suggestions for improvement would be welcome

The front page below lists the contents of this eBulletin and each section will open when clicked on.

Welcome

This is also an opportunity to extend a very warm welcome to the newly appointed Chair of our Patient Liaison Group, Linda Pollard (please see Nick Birch's brief biopic).

Updates

Charles Greenough (National Clinical Director for Spinal Disorders)

- Spinal Transformation Project including GIRFT

  I am delighted to be able to inform you that the Pathfinder Pathway for Low Back Pain and Radicular Pain has been taken up in the new Spinal Transformation Project which is being funded by NHS England. As some will be aware there has been a very disappointing delay between the completion of this work by the clinical group (which included representatives from all spinal societies) and any movement on implementation.

  The Spinal Transformation Project encompasses three separate pieces of work, which in actual fact have very great synergies and interactions. In addition to the Pathway, the second piece of work is on Spinal Networks (see Ashley Cole's article below). This is another recommendation of the Spinal Taskforce report in 2013; and under Sir Bruce Keogh pilot spinal networks have been running in four Centres in England. The spinal networks will be based on a spinal hub, where the majority of specialised spinal surgery is undertaken. Spinal hubs will often be co-located with major trauma centres or with neurosurgical centres, or will be in other major spinal surgical centres such as the Royal Orthopaedic Hospital, Birmingham or the Royal National Orthopaedic Hospital. Each of these hubs will have a geographical network of partner hospitals which will be district general hospitals.

  The network is designed to provide audit, governance and support for surgeons in partner hospitals via implementation of regional multi-disciplinary meetings of the surgeons in the network. This will provide increased quality of care as the networks develop. The Pathfinder Project will essentially provide each surgical centre with its own network within primary care to manage back pain and radicular pain. The Pathfinder Pathway will also have the function of expediting appropriate referrals and reducing inappropriate referrals for low back pain to the spinal surgeons by implementing a coherent and comprehensive management pathway within primary care.

  The third element is the result of a task and finish group of NHS England which produced a spinal tool kit. This is designed to address the significant 18 week backlog in spinal surgery in collaboration between commissioners and provider trusts. Alison Tonge, Regional Director, North made several proposals to NHS England and this has resulted in the appointment of a senior manager and a project manager to implement the Spinal Transformation Project. (The text of this paper is on the UKSSB website). The appointments are due to be made over the course of the summer and implementation plans will be drawn up in early autumn. This will be undertaken through a collaborative commissioning route.

  In addition, the "Get It Right First Time" (GIRFT) initiative, headed by Tim Briggs at the BOA, will be a partner in the Spinal Transformation Project. The GIRFT team will provide some funded sessions for the appointed clinical champions to aid implementation. Spinal GIRFT will produce a detailed analysis of all hospital based spinal activity throughout England and enable comparison of rates and costs of interventions. With progressive adoption of the BSR, it is anticipated outcomes will rapidly become an intrinsic part of what will become an annual report.

  The methods of implementation are necessarily undecided at this point, but one plank of the implementation will probably be a number of "roadshows" around the country, addressing both CCG commissioners and the local commissioners from NHS England in the regions.

  I am delighted that finally we have got some progress towards an actual implementation of all the hard work that the pathfinder and related groups have put in. This will transform management in primary care and, in my belief, will transform the prognosis for patients presenting with simple low back pain. The construction of an implementation vehicle will also allow the management of low back pain and radicular pain to remain up-to-date in the future, as when new evidence becomes available, changes may be made to the pathway which will then have a direct route of implementation. I will keep you informed and up-to-date as to developments over the next few months. If you have any suggestions or comments, I would

be very pleased to hear them.

- Spinal Pathfinder document

- Letter to Trust CEOs
  Letter of 22nd July 2015 to Trust Chief Executives requesting support for the British Spinal Registry (including administrative support) which should now have been received by all relevant Trusts.

Regional Spinal Networks (RSN) Proposal

Ashley Cole (Complex Spinal Surgery Clinical Reference Group Chair)

Introduction

Over the last 2 years there have been dramatic changes in the way Spinal Services are commissioned with the formation of CCGs commissioning 'non-specialised' spinal procedures and NHS England (through Local Area Teams) commissioning 'specialised' procedures. A group of clinicians including representation from all the Spinal Societies were asked to defined which spinal procedures are non-specialised' and which are 'specialised'. Initially, providers of specialised services were supposed to provide services for 1 million population. This largely guided the split between specialised and non-specialised with a maximum of 50-60 providers of specialised services. The initial consensus was to make as much specialised as possible within the rules as it was perceived that one commissioning body would be easier to deal with than the 210 CCGs. Over time, there has been a proposal to reduce the number of centres providing specialised services to 15-20. Despite efforts to date, spinal services continue to cause problems both as a high cost specialised service and achieving the 18 week target.

There remain concerns that many centres currently providing specialised services might be de-commissioned and services centralised. The Regional Networks Proposal was initially recommended in the Spinal Task Force Report of 2013 and is the number one recommendation:

'NETWORKS: All commissioners of spinal services should ensure that comprehensive spinal networks are established to facilitate integrated care pathways. Clinical commissioning groups and specialist commissioning must interface along these pathways. The networks for general spinal work (including primary care) must be co-ordinated with the individual and sometimes differing networks for trauma and cancer.'

These networks were to establish safe, efficient and effective pathways for both elective spinal services and emergency care.

The intention is that Regions will propose their own Network Structure based on a 'flexible template'. This proposal will be reviewed to ensure it meets the core objectives and then commissioned. This proposal has obtained support from NHS England which is keen to support spinal services and to allow clinicians to shape the way we deliver care to our patients. During a time where doctors seem to have reducing influence on their working environment, this is a unique opportunity for spinal surgery to shape its own future. The Regional Networks will collaborate to define and achieve shared goals in areas such as education and research. The proposed 'Core Principles' for each Regional Network are:

1. Excellent care for patients
2. Supported audit and research
3. Sustainable and motivated working practice for all staff
4. Education for all staff
5. Future workforce provision

Sir Bruce Keogh authorised implementation of the networks and four pilot sites were established in November 2014. The pilots were Bristol, Liverpool, Middlesbrough and Sheffield. This document is based on the combined experience of these pilots.

A. Regional Spinal Network (RSN) – Initial Planning

1. Define the Spinal Hub(s): The Hospital Network comprises a spinal hub(s) and a number of partner hospitals. The Spinal Hub is where the 24/7 emergency spinal service is located but not necessarily where all the emergency work is done. The spinal hub of the pilot networks was a major spinal centre: The Bristol Royal Infirmary, The Walton Centre, The James Cook University Hospital and The Northern General Hospital. These centres undertook specialised surgery with 24/7 availability of spinal surgeons and appropriate investigations. Three of these spinal centres had a neurosurgical presence and all were co-located with major trauma centres. Appropriate paediatric support was available to Centres undertaking paediatric deformity surgery. It is anticipated that a region may have more than one Spinal Hub.

2. Spinal Hubs will have integrated relationships with a number of partner hospitals which will in general be Trauma Units and District General Hospitals. Within the pilots were three types of partner hospitals:
    a. Hospitals where there is a group of three or more spinal surgeons undertaking a varied caseload which might include some specialised spinal surgery, commissioned by the relevant area team or by the CCG. Some had their own internal MDT meetings. These were orthopaedic surgeons by back ground.
    b. Hospitals where one or two surgeons were involved in spinal surgery on a part time or special interest basis undertaking non-specialised spine surgery commissioned by local CCGs. These were orthopaedic surgeons by back ground.
    c. Hospitals with an emergency department but without any surgeons undertaking spinal surgery on site.

    The configuration of networks will be locally determined. In some areas Partner hospitals will potentially have a choice between two hubs, and this will be a local decision. The MDT is a professional body, and local considerations will determine the configuration anticipated to achieve the most effective function.

3. Once the Regional Network has been defined, activity needs to be defined:
    a. Number of Spinal Consultants and WTE in each hospital
    b. Services provided in each hospital: Emergency on-call, Emergency surgery, Specialised surgery, non-specialised surgery, paediatric surgery
    c. Current MRI availability in each hospital with an Emergency Department
    d. Current and future operational relationships between the component units.

B. Emergency Care

The Spinal Hub(s) will provide 24/7 Consultant Spinal on-call for emergencies. Partner Hospitals may provide partial on-call services (eg, 8-8 weekdays) or may provide a service for some or all spinal emergencies where urgent but not emergency surgery is required. Consideration must be given to local resources especially where more complex surgery is required.

Spinal pathways and management protocols need to be agreed between the spinal hub and the partner hospitals for the assessment, triage and appropriate management of spinal emergencies. All acute primary care referrals should be assessed and admitted (if necessary) by the orthopaedic team at the patient's nearest acute unit, and that all ED referrals in partner hospitals should also first be assessed and admitted (if necessary) by the local orthopaedic team. If specialist spinal input is deemed necessary this should be initiated and referrals received by at least SpR grade clinicians.

The precise arrangement will depend on the experience and capacity of the spinal surgeons available in the partner hospital together with supporting infrastructure. Written protocols were agreed in Sheffield for the management of common presentations (Appendix 1).

For hospitals with no spinal presence, the objective is to provide a system of advice and support to allow patients to be safely treated as close as possible to their own homes and to support orthopaedic teams in achieving this objective. Continued advice as management progresses was an integral part of this protocol.

For the effective management of emergency care an electronic referral and response system is essential. This is because:

- Response to telephone referrals are often subject to delays if staff are unavailable immediately (eg, in theatre)
- Discontinuity if staff change over during the referral process
- Degradation of information if the receiving surgeon needs to seek further opinion and provides no written record of the information received or advice given
- If further advice is required there may be no written notes to refer to and then the process may have to start from scratch

There are three such systems available at present: Refer-a-patient, Orion and NORSE. The purpose of the system is to facilitate communication between the hub and the partner hospital, to provide on-going communication where patient management is continued in the partner hospital and to provide a permanent record of the information contained within the referral and responses. The system must fulfil some basic requirements:

- The referring clinician must provide a written synopsis of the clinical situation, which may be proforma driven or in free text.
- Provide a list of imaging sent with the referral through Image Exchange Portal (IEP)
- Allow clarification of any points of the presentation
- Allow updates in the light of further investigations or change in clinical condition
- Allow written advice to be received and up-dated in the light of further information, or consultation with senior opinion.
- Record the identity of staff involved and their seniority.
- Provide an audit trail.
- Allow analysis of referrals patterns and workload.
- If possible linkage to the British Spine Registry (BSR) for admitted patients would be desirable
- It should also have the facility to generate a summary letter to the referring agency to be sent the day following referral irrespective of whether the patient attended for assessment.

This is a potential QIPP as recent litigation has included cases in which although a patient never attended for assessment advice was given but no record or inadequate record of advice given was kept and subsequently disputed.

Imaging in the Partner Hospitals requires careful planning. The first principle of care is that it should normally be provided in the facility closest to the patient's home. It is unacceptable for a patient who arrived at a partner hospital during hours when the imaging service was running to be subsequently transferred simply to obtain imaging. Elective imaging lists must have protocols to allow interruption or extension for emergency referrals. This must apply to weekend sessions as well as weekday sessions. NICE guidance for metastatic spinal cord compression (CG75) indicates that emergency scanning in partner hospitals is most cost effective if scanning is available from 8 until 8 on weekdays and from 9 until 3 at weekends.

Partner Hospitals should provide prompt and uncomplicated repatriation of patients requiring rehabilitation (with the exception of spinal cord injury) or when surgery is not required. In addition to

being better for patients and their relatives, this often allows easier access to any required local services. There should be an escalation policy for occasions where this system fails to work.

C. Elective Care

1. Regional MDT

The regional MDT will be established for all surgeons undertaking spinal surgery both in the hub and in partner hospitals. Core membership will be every surgeon undertaking spinal surgery together with a musculo-skeletal or neuroradiologist to provide advice on imaging. Other members to be locally agreed and who may attend less frequently might include an oncologist, infection control, consultant in linked spinal cord injury centre, representatives from community services for back pain and radicular pain. Core membership should attend (75 percent) of meetings.

The centre of the clinical functioning of the Spinal Network is the Regional multi-disciplinary meeting. This will be a meeting involving surgeons from all of the hospitals in the network to be held on a regular basis. The location and frequency of these meetings will be determined by the particular needs of each individual network, but it is envisaged that meetings might be held on a monthly basis or possibly every fortnight. Meetings may be face to face, or in networks with a large geographical spread might alternate with virtual meetings.

The way the Regional MDT operates will be determined by the experience and capacity of the partner hospital involved but would form an overarching governance structure and should be considered a partnership between hospitals in the Network. The primary function would be to provide a larger critical mass of surgical opinion and expertise to improve audit governance and quality control. Prospective data collection would be mandatory (see below). Necessary prerequisites for Hospitals to be commissioned to undertake specialised spinal surgery are satisfactory audit and governance including attendance at the regional MDT, proven quality control and appropriate facilities, rehabilitation support and integrated discharge arrangements with local services.

For the Spinal Hub and partner hospitals where specialised surgery is undertaken, the purpose of the MDT will be to provide audit and governance for more complex cases and to allow surgeons undertaking specialised spinal surgery to join in larger groups for peer review, clinical advice and quality assurance. In these circumstances the MDT may comprise of a discussion of individual cases for specialised spinal surgical procedures and presentation of audit of practice[1] and of particular procedures. It would not be anticipated that all cases be discussed. The data from the referral system will be a part of the information reviewed. Complications must be recorded with formal internal review at least on a monthly basis. Specialised spinal surgery will be given some priority but the function of the MDT is to provide audit and governance for both specialised and non-specialised surgery (Appendix 2 shows suggested cases for MDT discussion).

For centres undertaking only non-specialised spinal surgery, most value may be obtained by considering the results of audits of practice over the previous year, to include audits of specific surgical procedures together with outcome measures and discussion of individual cases of a more complex nature. The benefits of the MDT will in this case be to provide support to surgeons who may be single handed or working as a pair from a larger group through discussion and for governance.

For hospitals with no spinal presence, audit of referrals and of management pathways might form a significant component.

Pilot sites have identified that support of each Trust in job planning, administrative support and travel time is essential. The biggest barrier to establishment is lack of this support.

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[1] *Audit would include indications for surgery, complications and surgical outcomes including PROMs and PREMs.*

The MDT is not a disciplinary venue. If commissioners have substantial concerns about the practice of an individual surgeon or Trust then commissioners must initiate an investigation out-with the MDT structure. Clinicians will naturally try to assist with provision of advice, but in some cases it is recognised that advice from outside the Network may be required to allow maintenance of the normal Network functioning.

Further work is required to provide a working template for these Regional Networks in the different Regions.

2. Local MDT

The Spinal Hub and Partner Hospitals will still continue to have their regular local MDT meeting when the Regional MDT is not scheduled. This could include discussion of emergency cases, routine elective cases, complex cases, complications, audits and other educational activities. The frequency of these, who attends and documentation should be discussed by the local team and agreed with the Regional Spinal Network. It would be expected that Spinal Hubs and Partner Hospitals performing specialised surgery will have weekly MDT meetings.

3. Inter Hospital Co-operation

In elective practice the network may also make provision in appropriate circumstances for surgeons from partner hospitals to undertake specialised procedures in the hub to take advantage of facilities or surgical support. This has a number of associated financial and capacity issues which would need to be resolved.

Consideration should be given to mechanisms to ensure that all hospitals within the RSN have approximately equal waiting times.

None of the pilots have as yet addressed this network functionality in practice.

4. Back Pain and Referrals from Primary Care

All the hospitals in the network will have a role in the management of referrals from primary care and the audit and governance of these referrals. Effective and timely primary care pathways will reduce disability, reduce inappropriate referrals and expedite referral of patients with surgically remediable conditions. Implementation of the Pathfinder Project will involve co-operation of CCGs, all regional hospitals, spinal Consultants and established triage and treat services.

5. Other Providers

In some networks active NHS Elective Centres may exist which will provide an effective platform for non-specialist surgery. Independent providers who undertake Any Qualified Provider (AQP) work will be integrated into this hospital network to provide more transparent audit and governance and provide professional support. Surgeons in these independent hospitals, who may not have formal NHS appointment, will be brought into the network to ensure a more robust local delivery and quality assurance.

D. British Spine Registry (BSR)

For those Centres undertaking specialised spine surgery the use of the BSR is mandatory[2]. It is strongly recommended that the BSR is also used for non-specialised spinal surgery to provide the audit and outcome data which is essential for a quality control and effective governance.

The registry may be used by the network to monitor the number and location procedures and ensure that patient outcomes and experience (PROMs and PREMs) are recorded.

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[2] *Spine Tango is a suitable alternative for existing users of this system. Data will be transferred into the BSR.*

E. CQUIN

The Trauma Programme of Care has supported a CQUIN for the Regional MDT for 2015/2016, which is now available. Uptake has been variable in the pilot sites, in one case due to reluctance by the Trust, and in another by difficulties establishing the regional MDT. There has been some confusion within Trusts as to how this CQUIN will function.

To maximise uptake with the new implementation it is suggested that the CQUIN be rolled over to 16/17.

F. Research/Audit

The RSN must establish a plan for spinal research and audit. Time must be considered in job planning to allow this.

G. Training

Spinal networks will also improve spinal training by providing postings for trainees at a level appropriate to their experience. In the future it is anticipated that all trainee spinal surgeons will spend time within the spinal hub(s) in both neurosurgery and orthopaedic surgery whilst spinal surgery evolves to its own speciality.

H. Resources

- When established the Networks will require some overall funding, which may come from Participating Trusts and Commissioners.
- Participating surgeons and other professionals will need PA allowance in their job plan to attend required MDTs. On call PAs may need adjusting for increased referrals and record keeping. Referrals may be complex, eg, spinal oncology and a time allowance with administrative support is required.
- Funding for Network Management
- Virtual Clinics: These are volume reviews of patient records acquired from initial assessment in triage clinics and imaging by senior clinicians with the assessing AHP. This determines the next step in patient management and provides excellent support and tuition to the triage profession(s). It is an efficient use of Consultant time but needs a mechanism for remuneration.
- Administrative support will be required for the MDT, and for surgeons attending from partner hospitals.
- Data manager for BSR.
- Arrangements for commissioning of any cross working arrangements between hospitals.

I. Frequency Asked Questions

Attendance at the Regional MDT will involve travel time and time from what is already a busy clinical practice. How will this be funded?

The CQUIN for 2015/16 for spinal networks will provide funding for the attendance at the Regional MDT.

The Regional MDT will take time and in some areas travel time may be significant. In some Centres multi-disciplinary meetings between sites are already undertaken by video linkage using a twin screen approach with image on one screen and participants on the other. In the future this might save considerable travelling.

Does every case for specialised spinal surgery need to be discussed?

This is a decision for each individual network and will depend on the surgical expertise and the capacity of the partner hospitals. In some circumstances a mixture of case discussions and review of indications and audit of complications and measured outcomes may be employed. The intention is to provide quality assurance of practice within the network.

Some of our specialised cases, for example intradural surgery or cord vascular problems, have already been discussed in a specialised MDT. Do these need to be presented again at the Regional MDT?

If cases have been discussed in an appropriate MDT setting then the network may decide that presentation at the Regional MDT would be unnecessary. Policy decisions of this sort should be recorded by the Regional network.

Our centre undertakes some specialised spinal surgery commissioned by CCGs. Will this continue?
In the new arrangements for NHS England, it is intended that all specialised services should be commissioned by NHS England Specialised Commissioning. However, there is a considerable legacy of CCG commissioned specialised services and undoubtedly it will take some time to work through this.

Do the Spinal Networks have any role in where spinal services are commissioned?
It is wholly the responsibility of the Regional Teams for specialised surgery and the CCGs for non-specialised surgery to determine where and under what circumstances services are commissioned. The spinal networks have no role in this decision. The Regional MDT is a clinical structure based on a collaboration, co-operation and clinical support. Commissioners may request the support of the Regional MDT to provide evidence of appropriate quality assurance, audit and governance for the procedures that they are commissioning and providers may similarly use the MDT to assure themselves of the quality and governance of their practice.

J. Members of the Spinal Network Working Party

Prof	Charles	Greenough	Chair	Chair
Mr	David	Stockdale	Commissioner	Trauma Programme of Care
Mr	Paul	May	Consultant Neurosurgeon	Trauma Programme of Care
Mr	Ashley	Cole	Consultant Orthopaedic Spinal Surgeon	Chair of Specialised Spinal Surgery CRG
Mr	Stephen	Morris	Consultant Orthopaedic Spinal Surgeon	Lead – Bristol Pilot Site
Mr	Martin	Wilby	Consultant Neurosurgeon	Lead – Liverpool Pilot Site
Mr	Simon	Tizzard	Consultant Neurosurgeon	Lead – Middlesbrough Pilot Site
Mr	Neil	Chiverton	Consultant Orthopaedic Spinal Surgeon	Lead – Sheffield Pilot Site
Mrs	Glynis	Peat	Centre Manager	Representative Spinal Hub
Mr	Vivek	Panikkar	Consultant Orthopaedic Surgeon	Representative Partner Hospital
Mr	Alistair	Stirling	Consultant Orthopaedic Spinal Surgeon	Chair United Kingdom Spine Societies Board (UKSSB)

UKSSB Working Groups

Professional Practice Issues

Harshad Dabke (Chair – UKSSB Private Practice Advisory Group (PPAG))

Established in June 2015 with representatives from BASS, SBNS and BSS.

Harshad	Dabke	BASS	Chair
Rodney	Laing	SBNS	
James	Wilson-McDonald	BSS	
Nick	Birch	BASS	
Ben	Taylor	BASS	
Alistair	Stirling	Ex-officio	UKSSB Chair & BOA Liaison

- The PPAG supports good medical practice by implementation of robust clinical governance measures and aims to review all current PMI schemes using following criteria:
  - Adherence to Good Medical Practice and Good Surgical practice

- Adherence to whole practice appraisal and revalidation
- Engagement with national and local audit (but not exclusively BSR)
- Compliance with CMA recommendations regarding fess and commercial interests
- Compliance with best practice relating to the management of, in particular, complex spinal surgery
- Declaration of commercial and professional interests

- The first meeting - 7th August 2015
  Current situation with regards different initiatives put forth by PMIs was discussed and it was agreed that a unified response via UKSSB is required.

  - Regulations
    Work done by FIPO, PHIN and CMA (including the latter's 11 hospital and consultant specific performance indicators) was discussed.
  - BSR
    Agreed BSR to be used as the default option by all spine surgeons in the UK, to record outcomes and performance. It was recognised that some centres which had used non-UK based registries for a long time would be unlikely to suddenly change to BSR. It was also felt that hospitals should register patients on BSR and ensure that the questionnaires were completed. Consultants would be responsible for clinical data describing treatment.
  - Data Collection
    The responsibility for collection and collation of data would require defining in conjunction with the provider hospitals and ensuring that appropriate mechanisms are in place for this.
  - MDT
    Should be used for both NHS and private patients to drive quality and implementation of evidence based, peer reviewed treatments. MDT, constitution could be decided by individual surgeons/groups, depending on factors like case-mix, skill, etc. It was felt that Medical Directors of PMIs and private hospital groups should be approached to facilitate this process.
  - Surgeon networks in private practice
    Some PMIs have suggested this option and it was felt that while there were some advantages to it, the group would not support formation of "cartels" or commercial groups.
  - Fees
  - SBNS expressed opposition to any negotiation about on fees but others felt that fees should be discussed. It was agreed that fees should be discussed but the main focus should be on quality, however advice would be taken from the CMA on this matter.
  - Commercial interests
    It was agreed that surgeons should declare commercial and professional interests in NHS and private sectors, which would help in improving quality of clinical care.

  - Recognition of surgeons
    It was agreed that PMIs should not be allowed to "recognise" or "derecognise" spinal surgeons. It was felt that PMI's should grant approval on the basis of quality and not fees and that patient choice should be maintained.

- Advice has been obtained from FIPO, BOA, PHIN and CMA.

- The Chair of PPAG (currently Harshad Dabke) has been co-opted to UKSSB to provide a summary to the Board on a regular basis and to BritSpine.

- Members of PPAG will be meeting a representative from CMA on 25th September and details of future strategy will be decided.

- A letter addressed to Medical Directors of Private Hospital Groups and PMIs has already been drafted, inviting them to send their response to this initiative. This letter will be sent in early October, after a final strategy has been decided.

- After analysing responses from Private Hospital Groups and PMIs, a face-to-face meeting with them will be arranged early next year to establish a common platform to drive this initiative forward.

Training and Education

- **Spinal Surgery Training Interface Group (SSTIG)**
  The JCST has been reconfiguring the framework for official peri-CCT Fellowships and this will be completed later this autumn. Further discussions have occurred with Lisa Hadfield-Law to act as an educational adviser. Representatives have been nominated by all societies and a Doodle poll for dates for a first meeting of SSTIG is being circulated.

- **BASS/BSS Presidents' Travelling Fellowship**
  The British Association of Spinal Surgeons (BASS) and the British Scoliosis Society (BSS) offer senior residents, spinal fellows and junior consultants a chance to have extensive exposure to complex spinal procedures at established spinal units over 2 weeks.

  The Fellowship programme includes mandatory attendance at the following BASS/BSS meetings.

  The programme rotates between established orthopaedic and neurosurgical spinal centres allowing significant contact between fellows and leaders in the field.

  The Fellowship will take place in late February/early March 2016 around spinal centres in the north of the United Kingdom between Glasgow, Edinburgh and Newcastle, culminating at the President's institute in Norwich.

  The Fellowship is funded by the United Kingdom Spine Societies Board (UKSSB) which represents BASS, BSS and the Society of Back Pain Research (SBPR).

  Further details can be obtained from Mr Iqroop Singh Chopra, BASS Education and Training Chair at ichopra@doctors.org.uk.

  Application Process:
  1. To apply, please submit your CV, along with a personal statement describing your career pathway, interests and future plans.
  2. Please submit a letter of recommendation from your supervising consultant/clinical lead.
  3. Your application should be sent to Julia Bloomfield at j.bloomfield@boa.ac.uk by 15th October 2015. Selected candidates will be informed in early December 2015.

  Eligibility Criteria:
  1. Applicants should be members of BASS or BSS or BOA or SBNS or local spine society.
  2. Applicants should be post-FRCS exam senior residents, clinical spinal fellows or junior consultants in the first 2 years of their appointment.
  3. Previously unsuccessful applicants can re-apply.
  4. Fellowships cannot be awarded retrospectively.

  The Fellowship:
  1. BASS/BSS will reimburse travelling expenses up to £1,000. Claims must be submitted within 6 months of the Fellowship. Detailed financial arrangements will be provided to successful candidates.
  2. International fellows will be required to pay for their flights to the UK.

3. By accepting the Fellowship, all awardees agree not to partake in any activities that will bring BASS/BSS and/or sponsors into disrepute. BASS/BSS accept no liability for the actions of the candidates whilst on the Fellowship or for activities related to it.
4. Each Fellow is required to submit a report of approximately 500 words within 6 weeks of completion of the Fellowship. This may be published on the BASS and/or BSS websites.

Society/Registry Reports

- British Association of Spine Surgeons (BASS)
  www.spinesurgeons.ac.uk
  President – *Am Rai*

1. Guidelines for Cauda Equina Syndrome are being developed (awaiting SBNS approval) which we hope to send to all emergency and radiology departments to allow us to collect data to understand and improve the care of CES.
2. We are developing generic spinal consents which will be available for BritSpine 2016. We ask for general comment on our discussion forum and will discuss this in the medico- legal forum at BritSpine.
3. We would like to improve the uptake of the British Spinal Registry to 60% of membership (see BSR section.
4. We invite suitably qualified trainees to apply to apply for the BASS/BSS President's Travelling Fellowship (please see BASS website via UKSSB link).

- British Scoliosis Society (BSS)
  www.britscoliosissoc.org.uk
  President – *Bob Crawford*

  - BSR
    A mandatory dataset for complex spinal surgery cases to be entered into the BSR/Tango has been compiled which fulfils the requirements of the NHSE D14 contract and will be published soon. Charles Greenough has written to the Chief Executives of Trusts to point in out the requirement under this contract to enter complex spine cases on one of these databases so we may anticipate some pressure (and hopefully help) from Trust CEOs in due course.

  - ASD Guidelines
    A thorough literature review is under way with a 3-stage sieving process of about 5,000 papers from year 2000 onwards currently in progress. An ASD guidelines panel will then do a structured review of the selected papers after which the Delphi consensus process will be applied to establish current norms and guidelines in the management of ASD.

  - MAGEC Rod
    Audit of this device continues.

  - Website
    The new BSS website goes live in October with an increased membership to include a society subscription to the SRS journal "Spine Deformity".

  - EUSSAB and affiliated membership for BSS
    There seems no reason for the BSS not to affiliate with EUSSAB and hence the Spine Society of Europe. It may enable us to promote better representation for spine deformity in the Europe-wide spine surgery educational structure which is being developed.

- Society for Back Pain Research (SBPR)

www.sbpr.info
President – *Lisa Roberts*

The annual meeting 'Biological factors in non-specific back pain' is taking place at the Anglo-European College of Chiropractic, Bournemouth on 5th-6th November 2015. The keynote sessions are:

- 'The biopsychosocial model: Time for a new back pain revolution?' Professor Maurits van Tulder
- 'Challenges in researching the importance of biology in back pain' Professor Mark Hancock
- 'Back pain - too many degrees of freedom?' Dr Judith Meakin
- 'Disc degeneration: The how and why' Professor Sally Roberts

We are also eagerly anticipating the outcome of the debate: 'Non-specific low back pain is a valid concept' with Professor Charles Greenough and Mrs Elaine Buchanan speaking for the motion and Professor Wim Dankaerts and Mr Nick Birch against. It promises to be a lively debate!

For further details about registration please see the website www.sbpr.info.

- Society of British Neurological Surgeons (SBNS)
  www.sbns.org.uk

Officers				
President	Mr	Richard	Kerr	Sep 2014-Sep 2016
President-Elect	Mr	Paul	May	Sep 2015-Sep 2016
Past-President	Mr	Richard	Nelson	Sep 2014-Sep 2015
Hon Treasurer	Mr	Alistair	Jenkins	Oct 2013-Oct 2017
Hon Secretary	Mr	John	Thorne	Sep 2015-Sep 2019
Meetings	Mr	Christos	Tolios	Sep 2014-Sep 2018
Neurosurgical National Audit Programme				www.hed.nhs.uk/sbns
Meetings				
9-11 Sep 2015	York			
20-22 Apr 2016	Newcastle			
21-23 Sep 2016	Telford			
Administration	Suzanne Murray			admin@sbns.org.uk
	Alix Gordon			admin2@sbns.org.uk
	Carole Turner (Research)			clt29@medschl.cam.ac.uk

- British Orthopaedic Association (BOA)
  www.boa.ac.uk
  Alistair Stirling

PMI/Private Provider Engagement
Following agreement that initial contact needed to be with private providers rather than the PMI in order to gain a better appreciation meetings are being arranged for the President/and or another member of the Executive with the following organisations:
- BMI, Circle Health, Nuffield Health, Spire

News from American Orthopedic Association
- Bundled care payment system
  Combines payment for primary joint replacement and any necessary revision sharing any financial gains between purchaser and provider to act as incentivisation. *?potential role in spinal surgery*
- ESPs and Physician Assistants
  A full session was devoted to extended scope practitioners and physicians assistants who appear to fill the same role, but from different backgrounds and working best as a hybrid system. *?UK*

application

FSSA Proceedings

- ?British Surgical Association
  Discussion of possible "surgical" BMA. Following the recent BSA survey, over 1,400 responses had been received, 90% of which were in favour of a new society. This information relayed to the BMA.

FIPO

The FSSA expressed concern over effectiveness of FIPO given recent PHIN and other private practice developments. The FSSA website was becoming more active, and the 'Doctors in Difficulty' report and the response to the 7 day working had been uploaded.

GIRFT

Implementation guidance, including guidance on a unit approach to optimum volumes of procedures is currently in development with leadership from BOA Executive and in consultation with the BOA Specialist Societies.

Monitor Optimum Elective Care Workshop

The aim of the project is to identify what the optimum care models look like through reviewing international and national models. It was clear that the project would provide useful support for ring fenced beds.

Procurement

Implant procurement is an ongoing issue with vast variation in prices paid. Pricing data is available in the NJR which will act as a useful monitoring tool.

GMC Fitness to Practice

The BOA will be responding to a GMC consultation on the adjudication of fitness to practice cases.

ARMA Clinical Networks Project

The ARMA Clinical Networks Project has been re-focused and will now deliver a knowledge network allowing commissioners and clinicians to share best practice.

ARUK

- Working with MSK Conference
- The recent ARUK working with MSK Conference was largely focused on RA patients despite ARUK's otherwise growing attention to OA. It was time to refocus the BOA's contribution to ARUK's Research Strategy by means of a refresh of our membership of their Scientific Strategy Committee.

Shape of Training

To help implement SHoT, the RCSEng Committee to improve surgical training, is developing ideas for BootCamps, cadaveric workshops and simulation to improve training at CT. The BOA Education Board will propose an expansion to T and O to allow training to be faster.

BOA Clinical Leaders Programme

The programme now has 20+ confirmed names and we are expecting more to be confirmed in the coming weeks

- British Spine Registry (BSR)
  www.spineregistry.co.uk (Data Input)
  http://bsrcentre.org.uk (Information Website)
  Mike Hutton

  The British Spine Registry has undergone a number of changes and is about to undergo more.
  There is a new look user interface and I would encourage those that have looked at the registry before to take another look.

  There is a move to make use of the registry mandatory for all spinal surgical cases with payment being withheld by CCGs and NHS England respectively.

  I would, therefore, implore units to get themselves up and running as soon as possible.

  Any unit needing assistance in doing so can contact me at audit@spinesurgeons.ac.uk to arrange a team registry visit, providing a free and independent report on 'how to set up the registry for your unit' or to work uploading existing data onto the registry again.

UKSSB Patient Liaison Group (PLG)

Linda Pollard
by Nick Birch - Treasurer

The UK Spine Societies Board (UKSSB) is pleased to announce that Linda Pollard, CBE, JP, DL has accepted the position of Chair of the newly formed Patient Liaison Group (PLG).

Linda has very wide experience in the UK Healthcare sector, commerce, academia and the Criminal Justice Service.

Currently she is the Chair of the Leeds Teaching Hospitals NHS Trust, having previously chaired the Bradford NHS Foundation Trust, the West Yorkshire SHA, Bradford Care Trust and the Leeds/Bradford/Airedale PCT. She is also a Board Trustee of the Leeds Hospitals Charity Foundation.

Until 2014 she was the Chairman/Pro-Chancellor of the University of Leeds and was honoured by the University with the award of Doctor of Law in 2013.

Linda is the National Chairman of *An Inspirational Journey* and the national *Two Percent Club* - an organisation that professionally supports women in the corporate world. She was previously Deputy Chair of Yorkshire Forward (the Regional Development Agency).

She is an experienced business entrepreneur having held several directorships and has extensive corporate understanding and was the Regional Chair of Coutts Bank for six years until 2014.

The PLG will reflect the very successful model created by the BOA (www.boa.ac.uk/patient-information/a-brief-history-of-the-plg/). Its primary aims, like those of the BOA PLG, will be to introduce lay

representatives to the work of the UKSSB and, through their advice, support the patient-doctor relationships that are key to the delivery of spinal care in the UK. With the current significant political pressures within the NHS, particularly in our specialty, this has never been more important. Lay input is now an integral part of the development of guidelines, patient pathways and commissioning. With Linda's guidance and assistance, the UKSSB will join the BOA and similar organisations leading the drive for enhanced public/professional healthcare co-operation and development.

BritSpine 2016 – Nottingham – 6th-8th April

Nas Quraishi

The BritSpine programme is progressing well.

- Tuesday
  Anatomy training day and masterclass Complications in Spinal Surgery: Prevention and Treatment Strategies

- Wednesday
  Keynote Lecture 1 - SBPR
  Medico-legal session on Consent
  Keynote Lecture 2 - Changing the laws of patient consent: The Montgomery ruling
  Spine Care Strategy 2020
  Grandmasters of Spine Session

- Thursday
  Scoliosis Research Society (SRS)
  Combined Paper Session BASS (6), SBPR (6)
  British Spinal Registry session
  Instructional Lectures (SRS)
  SBPR Papers
  Keynote Lecture 3: BSS
  Special Guest Speakers
  Best of Show Papers (6)

- Friday
  Infection/Tumour (6)
  Special Poster Sessions (12)
  Keynote Lecture 4 - Diagnosis and Treatment of Spinal Infections
  Trauma/Tumour (6)
  Special Poster Sessions (12)
  Keynote lecture
  Spinal Pathfinder group meeting
  Patients' Afternoon – Patient Liaison Group

NICE updates and related matters

Clinical Guidelines

Following publication these are reviewed on a 2-yearly cycle and consideration given to revision if, after consultation with relevant clinicians, it is felt there is sufficient new evidence. If there is little change, guidance may be placed on the static list and thereafter reviewed 5-yearly or before, if required, due to interval developments.

- Metastatic Spinal Cord Compression
  See NICE website CG75 (2008) and Quality Standard QS56 (2013)
  - This is due for review in 2018. Whether there is sufficient new evidence to justify review before this will be considered at the 7th annual MSCC meeting (11th November 2015 - Holiday Inn Birmingham) and representations subsequently made to NICE.
  - Acute Oncology Measures (including MSCC) was updated in May 2015.

- LBP
  See NICE website CG88 (2009)
  - This is currently being revised and the GDG anticipate that this may be published in February 2016.

- Major Trauma (Spinal Injury Assessment)
  This is currently out to consultation. UKSSB has responded with comments prepared by Nigel Henderson and Charles Greenough.

- NICE Technology Appraisals (in process)
  ELF
  John O'Dowd/Naffis Anjarwalla

  IDET
  Mike Grevitt

  AxiaLIF
  Andrew Quaile

Other Clinical Items

- Spinal Oncology Meeting and Development

Notices

- Meeting Dates
  Please see UKSSB website www.ukssb.com which links to BASS, BSS and SBPR websites with details of the societies and other meetings.

- The BOA Instructional Course 2016 is filling up fast. The focus of the 2016 Instructional Course will be paediatrics and trauma with the opportunity to obtain clinical case based discussions (CBDs) in the following areas:
  - Neurovascular injuries
  - Painful hip in a child
  - Painful spine in a child
  - Necrotising fasciitis
  - Open fractures

Vacancies

- BOA Regional Advisers/RCSEng Regional Specialty Professional Advisers
  The BOA is still considering applications for two RCSEng Regional Specialty Professional Adviser/BOA Regional Adviser vacancies. The vacancies will cover the following regions:
  - South West England - 1 vacancy
  - Northern Ireland - 1 vacancy

  These roles are crucial for enabling the BOA and the College to connect with members at a local level and are a key aspect of the partnership between the BOA and the College in creating a unified voice for surgery. The RSPAs/RAs sit on the local RCS Professional Affairs Board. The deadline for applications is 11th September 2015; please visit our website for more information on the role and how to apply.

- RCS , JCST, BOA/SBNS committees, NICE, etc (under development) Julia we need to ask all of these for updates on vacancies for each edition

- Sporadic - Other related