eBulletin

SPINE MATTERS

UKSSB Quarterly eBulletin
March 2017

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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 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 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). The UKSSB website now has a reference document section to which additions will be made as they evolve.

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

Editorial

Alistair Stirling - UKSSB Chair

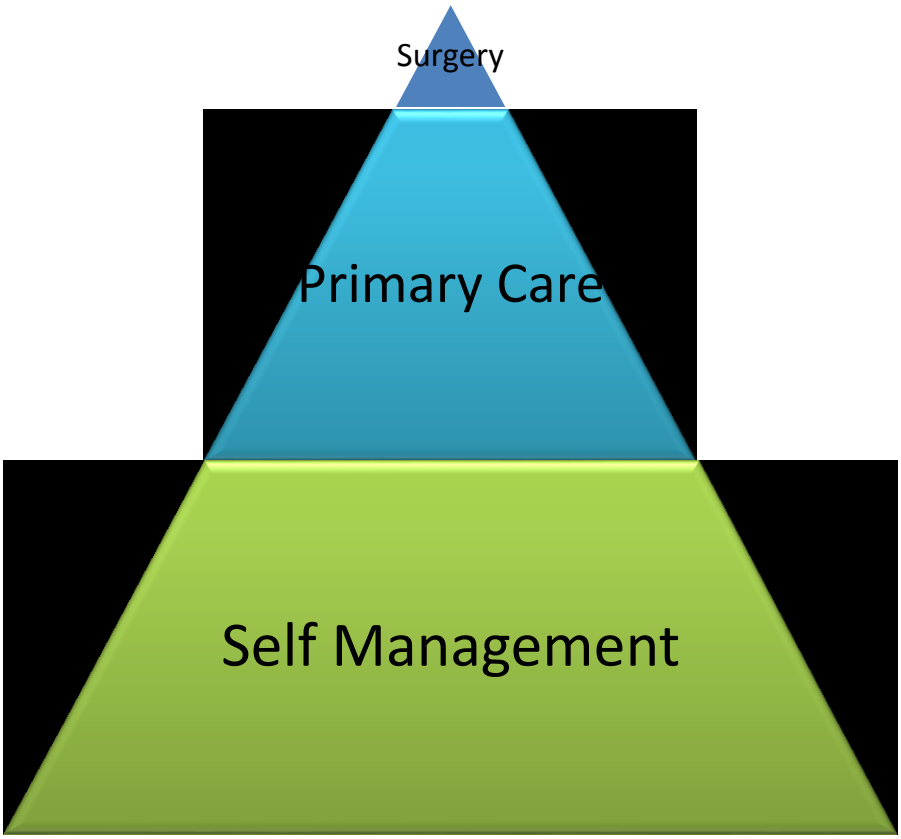
Improving Spinal Care Project

NBRPP

Since 2008 at the request of the NHS Medical Director there has been a continuing focus on improvement in the provision of spinal care in recognition of the very significant costs and currently inadequate provision. For those unfamiliar this has included 2 DH spinal taskforce reports, (2010, 2013) 3 NICE guidelines (2008 MSCC, 2009, 2016- this including radicular pain) and 2 National Low back Pain Pathway documents (2013, 2017). These are all on the UKSSB website (open access) for reference.

The latter document NBRPP 2017 is supported by the 31 stakeholders enlisted by Charles Greenough and includes all the spinal societies. This recommends significant changes in both patient assessment pathways and subsequent treatment. It will be the basis of commissioning of Spinal Services by CCGS (non-specialised) and NHS England through local area teams (Specialised services). This will be overseen by the Spinal Services Clinical Reference Group chaired by Ashley Cole who has kindly written an explanatory article below. The composition of the CRG and your relevant local and Society representatives are listed on the website under Dramatis Personae. For many of us some of the changes in the Pathway will require modification of current ways of working and the use of treatments that will continue to be funded.

To provide perspective David Cumming on behalf of the 3 clinical champions (Others - Elaine Buchanan (NBRPP Pathway editor following Charles retirement) and Tim Piggott) has kindly written the article below. Elaine Buchanan's diagram correctly reminds of the relative place of surgery in spinal care



NBRPP will be discussed both in the plenary and ESP sessions at the forthcoming BASS meeting. There are undoubtedly significant challenges posed by some of the recommendations and inevitably these will not be welcomed by all. For many interventions however we still have a case to prove and until this is done funding is likely to remain limited and for some procedures withdrawn.

The pathway places the Spinal Specialist Triage Practitioner at the centre of the spinal patient pathway and they are now forming a network (and considering a professional body National Back Pain Pathway: Clinical network (NBP-CN) to support the Pathway and to assist their professional evolution. It is hoped the spinal surgical community will enable this important development. This should ensure earlier and more appropriate attention for those with potential surgical requirement.

UKSSB

Constitution In recent time there has been discussion about the relative roles of the Spinal Societies and UKSSB. For clarification the constitution has been redrafted and supported by an all society working group lead by Lee Breakwell and David Cumming. This is now in final draft and it is intended this will be signed off at the next UKSS Board meeting in May. In the interim UKSSB has revoked its previous limited company status and reverted to the status of a society.

Finances For complete clarity and transparency Nick Birch has kindly laid out below the finances and thinking underpinning the present arrangements .A criticism has been that a majority of money raised at BritSpine is from the surgical instrument companies and subsequently goes to UKSSB rather than the

surgical societies. It was one of the initial altruistic intentions behind UKSSB that cross subsidy should enable research and education , both of which are now occurring . A formal process for application for funding is now available for these and potentially other purposes. The application form is on the website under 'News & Information' here.

Some information about application for SBPR (10 pa) may be found here (further details from Deb McStrafick here, and UKSSB/BOA clinical leadership fellowships (3 pa) here.

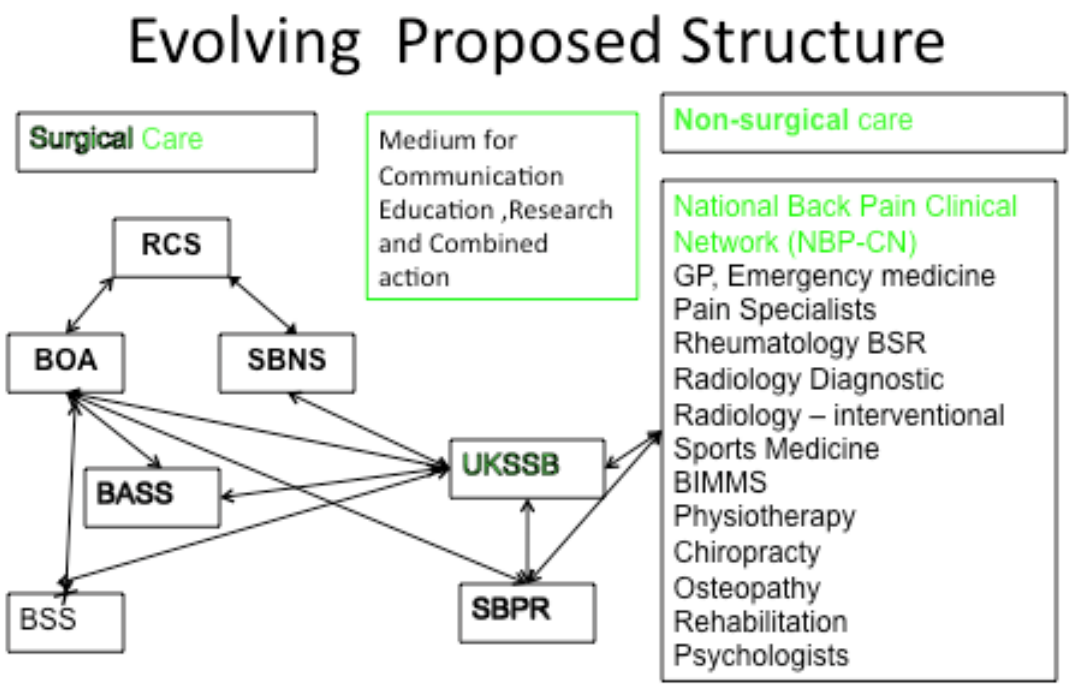
Education After advertisement and formal interview Niall Eames has been appointed as the UKSSB /BOA education representative. He also sits on the BASS education committee headed by Aprajay Golash who in turn is the SBNS Spinal representative. This should enable necessary synthesis and coordinated working in implementation of the excellent educational strategy outlined by Niall below.

Succession Planning

After BritSpine in March 2018 both Nick Birch as Treasurer and myself as Chair will have served our terms of office. The job descriptions, selection process and application forms for our successors are on the website. The appointees will be invited to attend UKSSB meetings over the coming year for familiarisation with process. Please consider applying. Interviews will be on the 3rd May 2017

Future view

There should be an exciting period of development to come in hopefully progressing the emergence of an integrated multi-disciplinary spinal profession which will better serve the needs of our patients and thereby (probably more than most other branches of medicine or surgery) the economy. I believe that it is by bringing our constituent professions **together** through the medium of UKSSB that we will serve our patients optimally. Please see the diagram below



Articles (Anchor)

The morale maze: what's to be done to improve workforce morale?

28 Oct 2016, Clare Marx

The NHS is struggling with the increasing realisation that the allocated money over the next few years will not be enough to pay for the demands being placed upon it. We have also heard that there is unlikely to be any more money, despite the significant inflationary shock that may follow the recent currency devaluation. Yet less attention has been given to a potentially greater problem: the inter-related problems of workforce shortages and poor morale.

The junior doctors' dispute shone a light on the issue, but there has been growing concern and signs that a sense of detachment and demoralisation is creeping its way through the workforce. This threatens to undermine the huge change programme required to deliver the savings that are needed and the Five Year Forward View. How can we expect staff to champion far-reaching changes to transform care if they are demotivated and disaffected?

In the latest survey of staff only 42% were satisfied with the extent to which their work was valued by their organisation, while 57% said they were unable to meet the conflicting demands made on them. The Nuffield Trust's most recent survey of 100 health leaders found almost 60% thought that morale had deteriorated at their organisation, with workload cited as the main factor, closely followed by the financial position of the organisation and the NHS more generally.

So what can we do about it? At this year's political party conferences the Nuffield Trust and Royal College of Surgeons brought together leading politicians, trade unions, doctors, nurses, allied health professionals, and employers for roundtable discussions about those extra-contractual issues that, if addressed, might boost morale and make NHS staff feel valued at work.

Two broad types of solution were identified: those within the power of NHS staff to change and those outside of our immediate control and require action from those in more senior positions in the health system.

Actions within our local control

Recognising that NHS activity is unlikely to become less intense we cannot just wait for a top down solution to improve morale. So what can individuals working on the frontline do to champion positive behaviour and improve morale?

- #HelloMyNameIs has been a great success for patients, partly through its simplicity, in raising awareness about the problems with clinician-patient communication. Some attendees felt we now need a similar campaign for the workforce. Busy hospital staff under pressure sometimes don't take the time to properly introduce themselves or say hello to a fellow member of staff. Being polite at work does not cost more money.

- Doctors at our events felt there was a particular need for consultants to show more leadership, being positive about careers in medicine, and mentoring and supporting those in training. Senior clinicians also have a role in stamping out poor workplace culture including undermining behaviour and bullying.

- While there has been an emphasis on improving care at nights and the weekends, there has been less importance placed on providing better out-of-hours support for staff at work at these times. Weekend availability of canteens or crèches is very variable. If we expect staff to work at weekends, it was argued, then it is only fair to provide access to these services as well.

- Attention to the detail of how staff are treated is important. For example, some hospitals have been poor at providing sufficient notice of rotas. Better advanced planning in the age of technology and the Doodle poll does not cost anything and would make a huge difference.

- For the medics, recruitment into training programmes does not feel personal and therefore the opportunity to make initial and lasting mentoring relationships is often missed. Induction, especially for junior doctors but also for midwives and nurses, can be repetitive and poorly organised. Yet when done well it can be very important for helping orientation and communicating an organisation's values. NHS Trusts should therefore be thinking more carefully about the structure of these sessions and whether they are making the most of inducting new members of staff appropriately.

- Schwartz rounds are seen as very beneficial to morale, helping teams to have a sense of community and to discuss their concerns.

Action for national leaders

- The pressures of the wider system, the focus on finance and performance management in particular, play their part in impacting morale – not least through rising workloads and declining staff numbers. It's hard to see how the current performance pressures are conducive to encouraging a caring culture in our health service. Ultimately these wider issues still need addressing.

- Providers with good morale tend to be those who invest in personal development and training. In this context it is concerning that professional development budgets in the NHS have been cut. This is particularly relevant as the NHS is looking to develop more non-medical roles to support the current workforce. Equally more support needs to be given to developing clinical management opportunities and skills.

- Low morale, as well as bullying, affects trust chief executives as much as frontline staff. Those at the top play a vital part in establishing the culture of their own organisations. If they are being pressured and harshly performance managed by system leaders, this poor culture risks trickling down, infecting the wider system. With the turnover of chief executives resembling the short tenures of Premier League football managers, more needs to be done to provide support for our organisations' leaders.

- Due to the nature of system-wide decisions in the NHS, NHS staff can sometimes feel the locus of control is far removed from them. A recent example are Sustainability and Transformation Plans. If more is not done to engage clinicians and patients in significant changes to the health service there is a risk of further demotivating staff.

There were a number of other issues identified that need further reflection. Doctors working in acute specialties such as surgery often support a nostalgic return to a 'firm structure' of apprenticeship style working. Whilst team working is common, the lack of regular senior mentoring opportunities is what is missing from the current structures. Other specialties have questioned whether "the firm" is a realistic model for the modern NHS and it does not apply as well in general practice, or to nursing or other health professions. Nonetheless, the mentoring opportunities or lack of them apply across the profession.

Consideration also needs to be given to the experiences of different groups of staff. Black and minority ethnic staff report much worse concerns, for example. The NHS Staff Survey and the General Medical Council's trainee doctors' survey need to be more widely studied by the NHS to monitor areas for improvement in morale. There is also a vast workplace psychology literature that needs to be better explored and further options presented.

One way or another, it is absolutely clear that workforce morale requires much greater priority. Let's try some simple things now – they may make a difference.

Clare Marx is President of the Royal College of Surgeons and Nigel Edwards is Chief Executive of the Nuffield Trust.

Legacy

By Mr Peter Lees

Aneurin Bevan said: "Illness is neither an indulgence for which people have to pay, nor an offence for which they should be penalised but a misfortune, the cost of which should be shared by the community."

Politically, 2016 was easily the most extraordinary year in my lifetime. For the iconoclast there was undoubted pleasure seeing armchair pundits proved so very wrong, so many times. Consequently, 2017 offers unprecedented uncertainties, the potential perils of which will hopefully make us all think a little more deeply. Being shaken out of our complacency is long overdue and it will be interesting to see how right the prophets of doom are this time.

Reflection should include being clearer about what we must fight for in the future, before it slips irretrievably through our fingers. The NHS is a case in point. I confess to blind faith in the principles of the NHS borne of many factors, both overt and subliminal. I do not remember life before the NHS, but I was brought up by the generation who do recall what Bevan's book so aptly calls In place of fear. I am moving gradually into the recipient phase and will be increasingly at the mercy of generations who, quite rightly, will challenge the principles of the NHS which I have so blindly followed, but only time will tell if they dispatch the baby with the bathwater. And what have we done to debate with later generations that which so many of us blindly hold so dear?

There are unparalleled benefits to the UK public in having a largely free health service, but do we, as healthcare professionals, fully acknowledge the privilege of treating most people without counting the cost? Picture a consultation in which you face a patient who must sell all their hard-earned assets to pay for the treatment you recommend – does that not make you shudder? In our rush across the Atlantic in the quest for better ways of running healthcare, we might do well to study in depth the experiment of implementing and almost immediately unravelling Obamacare. What does being a loser in that melee actually mean? Thankfully there is still no translation of the term medical bankruptcy in the UK, but how far off are we? Certainly the refrain about funding seems to be gathering a respectable number of hitherto moderate voices to oppose a seemingly unmoved government.

The call for more funding has gone on at least since 1975 when I graduated, but we are relatively silent on the other side of the balance sheet – unless we are complaining about 'cuts'. Wales and Scotland have taken brave and imaginative steps to address this. Prudent Healthcare (Wales) talks of doing "only what is needed, no more, no less; and do no harm", and to "reduce inappropriate variation using evidence based practices consistently and transparently." Scotland's Realistic Medicine is equally aspirational and has a

number of similarities. The Academy of Medical Royal Colleges has also pioneered Choosing Wisely as part of a global initiative.

There are serious sums involved and much to be gained from prudence – if Lord Carter is right it is close to five per cent of the NHS budget in England. These are global challenges but the UK has so many outstanding organisations, systems and tools which, fully harnessed, would surely contribute to a risk-reduced approach to easing much pressured budgets. For example, we have NICE, the envy of the world, and the Academy of Medical Royal Colleges. We also have HQIP and NHS Digital and academic healthcare institutions developing big data to improve patient outcomes and reduce costs, which appear to be delivering where they are applied.

As well as looking to learn from outside and across our internal borders we should look far harder at what we already have access to and go boldly, not blindly, with the faith that we have the expertise, data and resources; we now need to lead and apply the best in the system. This is a medical leadership challenge, enshrined in the FMLM Leadership and Management Standards for Medical Professionals. Governments rarely have the longevity to tackle such tricky systemic issues but medical leadership lasts a lot longer – what a legacy we could create by making a phoenix of the ashes dealt to us by the global financial crisis!

The impact of complications and errors on surgeons

Do surgeons need support – and, if so, what kind?

K Turner Consultant Urologist
C Johnson Postgraduate Researcher
K Thomas Senior Lecturer in Psychology
H Bolderston Lecturer in Psychology and
Chartered Clinical Psychologist
S McDougall Professor of Psychology

Royal Bournemouth and Christchurch
Hospitals NHS Foundation Trust
2Bournemouth University

Office Matters

It is with regret that I have to announce that after a very successful first six months Jo Wilson has been given a financial offer she feels she cannot refuse in her preferred and previous university sector. She leaves with profound thanks from all the Spinal Societies and the BOA and with our best wishes for her future. Interviews for her successor are imminent.

A note from Jo: Thank you all for your support in my role on the UKSSB and I know you will give my successor the same warm welcome. As there will be an unavoidable gap in cover over the next couple of weeks, and the new executive officer will need some time to get to grips with the post, I do ask for your patience over that time.

New Members of the UKSSB Executive Board

Paul May President of the SBNS
Am Rai will demit from the BASS Presidency on 17th March and will be succeeded by Stuart Blagg
Almas Khan is the Local Host for the Leeds BritSpine meeting in 2018
Niall Eames Education lead for the BOA

Finances

Nick Birch

UKSSB Treasurer's Summary Report

Nick presents a breakdown and analysis of the UKSSB income and expenditure and the relative benefits to the constituent member societies

Introduction

This summary report has been prepared for the UKSSB Board meeting of 9 February 2017 in response to criticisms made of the financial behaviour of the Board by members of the executive committee of BASS.

This report provides information that underpins the comprehensive reconfiguration of the UKSSB structure initiated by the Chair and members of the Board in March 2016.

All of the financial documentation contained within this report has previously been circulated to members of the Board in a timely way ahead of the relevant Board meetings that have taken place since 2012. As a result, members of all of the constituent Societies and Specialty Associations have had access to the complete dataset through the executive members who have sat on the Board whether they attended the meetings or not.

BASS Executive Committee Allegations

Allegation 1: There is lack of financial transparency of the UKSSB.

The complete financial dataset has been made sequentially available to the incumbent Presidents and Secretaries of BASS from mid-2012 when I took over from Robin Pillay as Treasurer of the UKSSB. If members of the BASS executive committee and ordinary members of the Society have not had this dataset passed onto them it is not the fault of the UKSSB or its Treasurer.

Therefore the allegation of a lack of transparency is refuted.

Allegation 2: BASS is denied the financial benefit of an annual meeting every other year, unlike the other Spine Societies, because its annual meeting is subsumed within BritSpine which is organised by UKSSB. As a result it is alleged there is a significant financial penalty to BASS and the UKSSB is withholding funds that should by right be transfered to BASS.

The body of this report addresses this allegation and makes it clear that it is unfounded.

Methodology

In preparing this summary report I have analysed all the financial records of the UKSSB from June 2012 to December 2016. This period covers two full "BritSpine Cycles" 2012 – 2014 and 2014 – 2106.

All of the information has been submitted to the Board's accountants (SB Patel Ltd) and formal accounts have been prepared and relevant abbreviated accounts have been presented to Companies House annually. The abbreviated accounts have been available in the public domain on the Companies House website from 1 October each year.

The main analysis includes summaries of income and expenditure in each financial year and across the BritSpine cycles. In preparing this analysis I have recognised that BritSpine is greater than the sum of its parts and that the annual meetings of individual societies would not have the same "Pulling power" of a combined meeting. Evidence that this is the case comes from my term of office as honorary Treasurer of BASS. I was fully conversant with the financial details of the 2013 and 2015 BASS annual meetings and worked very closely with Archer Yates Associates to maximise the income in 2015. Both annual meetings made in the region of a £30k surplus. As the BritSpine analysis shows, since my direct involvement with the organisation of the conferences, surpluses have been more than £250k on each occasion, proportionately a much greater sum than a single BASS annual meeting would generate. However, the methodology recognises that the majority of income from the BritSpine conferences is derived from involvement with companies manufacturing and distributing surgical implants. Therefore the two surgical societies are responsible for much more of the income then the SBPR. I have accounted for this by allocating on a notional basis 76% of the relevant income to BASS, 16% to BSS and 8% to SBPR.

The proceeds of BritSpine are used to run the organisation that is the UKSSB and provide specific funding for projects submitted to the Board by the members on behalf of their constituent societies. On this basis there is a much more equitable split of expenses than income and therefore I have allocated 50% of the UKSSB running expenses to BASS and 25% each to the BSS and and SBPR. This takes into consideration the involvement of the UKSSB Executive Assistant in organising the BASS annual meeting thus the additional notional cost of organising the BASS annual meeting component of BritSpine.

Results

Table 1: UKSSB Cash position

Peak Bank Balance	
Post BritSpine 2012	247089
Post BritSpine 2014	374714
Post BritSpine 2016	400397

The cash position of the UKSSB has improved during each of the last two BritSpine cycles. This allows a healthy reserve to be maintained as working capital and a hedge against potential losses from a poorly executed and attended BritSpine conference.

Table 2: Absolute and Notional Proportional BritSpine Surpluses

Income		**BASS**	**BSS**	**SBPR**
	Surplus	76%	16%	8%
BritSpine 2012	100436	76331	16070	8035
BritSpine 2014	266821	202784	42691	21346
BritSpine 2016	255745	194366	40919	20460

The surplus from BritSpine conferences is held by the UKSSB to fund the organisation and its work over a 2 year cycle. There is a proportionate amount that can be notionally attributed to each Society calculated by analysis of the sums raised from the various trade exhibitors at each conference according to the budgetary records.

Table 3: Outgoings BritSpine 2014 Cycle

	Total	**BASS**	**BSS**	**SBPR**
		50%	25%	25%
Accountant	1560	780	390	390
EA/Board	68369	34185	17072	17072
Web/Media	6990	3495	1748	1748

	BritSpine	330519	165260	82630	82630
	Education	10280 *	8280	2000	
	Europe / BOA	2367 ^	1642	725	
Total		420085	213642	104565	101840

* eSpine and BASS / BSS Presidents Travelling Fellows (no SBPR expenditure)

^ BASS and BSS members attending SSE and EFFORT plus UKSSB Surgical Fellowships Report (no SBPR expenditure)

Table 4: Outgoings BritSpine 2016 Cycle

	Total	**BASS**	**BSS**	**SBPR**
		50%	25%	25%
Accountant	1530	765	382	382
EA/Board	109401	54701	27350	27350
Web/Media	20131	11361*	4385	4385
BritSpine	353155	176578	88289	88289
Education	27596	14186	3410	10000
Europe / BOA	1773	887	443	443
Total	513586	258478	124259	130849

* Includes UKSSB financing of BASS costs from April 2014 – January 2015

Outgoings of the UKSSB have been grouped into a number of cost centres including Accountancy, Executive Assistant and Board expenses, Website and Media, BritSpine costs, Educational activities and involvement with specialty organisations and spine societies in Europe and the USA.

Table 5: Notional Net Benefit to BASS from UKSSB Financial Activity

BritSpine Cycle	Proportionate Benefit / (Loss)
2014	137311
2016	55694
Mean Annual Notional Net Benefit	48251

There is a notional net benefit to BASS from BritSpine conferences because the Society gives up an annual meeting on alternate years. That annual notional benefit is greater than, but similar in magnitude to, the surplus made from the 2013 and 2015 BASS annual meetings.

Table 6: Notional Retained Surplus (Net bank balance at beginning and end of cycle)

BritSpine Cycle	Total	BASS	BSS	SBPR
2014	127625	96995	20420	10210
2016	153308	116514	24529	12265

The UKSSB maintains a cash surplus at the end of each BritSpine cycle to act as working capital for the next cycle and as a hedge for "conference failure" should it occur. The proportionate retained surplus at the end of the BritSpine 2016 cycle that could be attributed to BASS of over £116k is similar to the sum BASS holds in its deposit account that was designated for the same purpose during my time as BASS treasurer.

Summary

There has been complete transparency of all financial activity of the UKSSB from mid-2012 to the present, the term of my office. The Presidents and Secretaries of all of the Spine Societies of the UK have been provided with timely, accurate and approved accounts on a very regular basis. Any failure to transmit that information to Society executive committees or Society members is not a result of any lack of openness by the UKSSB and its executive officers.

All three Spine Societies benefit from BritSpine academically, socially and politically. The ability to run the centralised infrastructure of the UKSSB and from that provide finances for educational and inter-Society projects allows activity that individual Societies would struggle to replicate. All the Societies have benefited financially from BritSpine and specifically the notional net benefit accrued to BASS has been somewhat greater than, but of a similar magnitude to, the surpluses generated from its biennial stand-alone meetings.

Secretary's Report

Lee Breakwell

The proposed new constitution of the UKSSB follows. This clarifies the role and structure of the body, and the mechanisms for electing new Officers.

This also includes the newly devised process for application by the societies to the UKSSB for funds to support educational, research or administrative activities.

Comments are welcomed, and voting on the constitution will take place at the next UKSSB Meeting in May.

Proposed Constitution

United Kingdom Spine Societies Board

British Orthopaedic Association

at The Royal College of Surgeons of England

35-43 Lincoln's Inn Fields, London WC2A 3PE

CONSTITUTION and Bye Laws

1. **NAME**

1.1 The United Kingdom Spine Societies Board is composed of representatives from:

- Society for Back Pain Research (hereafter SBPR)
- British Scoliosis Society (hereafter BSS)
- British Association of Spine Surgeons (hereafter BASS)
- British Association of Spinal Cord Injury Specialists (hereafter BASCIS)
- British Orthopaedic Association (hereafter BOA)
- Society of British Neurological Surgeons (hereafter SBNS)

1.2 The Board includes representatives of the Patient Liaison Group (hereafter PLG)

1.3 The Board will include co-opted members as decided when appropriate to inform the society on relevant matters.

2. **OBJECT**

The UKSSB is a federated body with the stated objective to facilitate collaborative working between the spinal societies for the benefit of the UK population.

3. **OBJECTIVES**

To hold a scientific meeting entitled "BritSpine" every 2 years with an agreed educational content for spinal surgeons and allied health members.

3.2 To maintain accurate mailing lists of:

- the total membership of the SBPR, BSS, BASS and BASCIS.
- individuals with an interest in spinal disorders.
- national and international professional organisations with an interest in spinal disorders.
- industry and other commercial organisations with an interest in the spine.

3.3 To encourage and facilitate the dissemination of information on spinal disorders, including meetings, courses, research and national publications of interest to the spinal societies.

3.4 To facilitate collaborative working on research and education between national spinal and related organisations for the benefit of the UK population.

3.5 To act as a liaison and conduit between spinal societies to ensure collaborative working.

3.6 To act as a liaison and conduit between the Spinal Societies and relevant statutory and national bodies

3.7 To maintain and publish a Register of Board Members Interests related to spinal matters.

4.0 **MEMBERSHIP OF UKSSB**

Officers of the Board of UKSSB are the Chair, Secretary, Treasurer and two nominated Officers from each of the constituent national societies or specialty associations as well as the Chair of the PLG.

5.0 **FINANCE**

5.1 UKSSB will be a Not For Profit Association. No income or money of any sort received by UKSSB will be used for the pecuniary benefit of any individual member of the Board of the Association. Actual expenses and reasonable compensation for services rendered may be paid to a member who may incur such an expense or render such services.

5.2 UKSSB will be funded by the income from BritSpine. UKSSB will receive no funding from the Member Societies.

5.3 No individual member of the Board of UKSSB, either the executive officers (the Chair, the Secretary and the Treasurer) or other members, will be liable for any debts of the Association. Any debts or shortfalls of funds will solely be the responsibility of the Association.

5.4 Spinal societies and specialty associations represented on the Board of the Association are not individually or collectively responsible for the debts of the Association. Debts are exclusively guaranteed by the assets of UKSSB. UKSSB is not responsible for the debts of it's constituent UK spinal societies and specialty associations.

5.5 The UKSSB Board will consider funding requests from it's constituent Board and/or Society members to support education, research, or other relevant activities in pursuance of the above Objectives

5.6 UKSSB will consider funding requests from it's constituent Board and/or Society members to provide administrative support in relation to membership.

5.7 The business of UKSSB will be conducted in, and the financial accounts will be made up to, a year ending on 31st December.

5.8 The income and property of UKSSB will be applied solely towards the promotion of the objectives of the Association. No portion thereof will be paid or transferred, directly or indirectly, by way of dividend bonus, or otherwise by way of profit to the members of the Board of the Association provided that nothing will prevent the payment in good faith of reasonable and proper remuneration and out-of-pocket expenses to any Officer or servant of the Association or to any member of the Board of UKSSB in return for any services actually rendered to the Association. Nor will this prevent the payment of interest at a rate not exceeding 3% above the prevailing Bank of England Base Rate per annum on money lent, or reasonable and proper rent for premises let by any member of the Board of the Association.

5.9 The UKSSB accounts will be prepared by a qualified accountant and verified each year by an independent examiner, not being a member of Board of UKSSB, appointed by the Board and confirmed at the General Meeting held during BritSpine. The report of the independent examiner will be published with the Association's annual report and statement of accounts.

5.10 The Treasurer will keep account of all monies received and expended on account of the Association. A bank account will be maintained in the name of UKSSB. Cheques drawn upon the said account will require to be signed by an authorised member of the Board.

6.0 GOVERNING BODY

The affairs of UKSSB will be managed by its Board

7.0 OFFICERS

- Chair
- Secretary
- Treasurer
- Two representatives of each of the four Constituent United Kingdom Spine Societies (SBPR, BSS, BASS, BASCIS).
- Up to two representatives each from BOA and SBNS.
- One representative from PLG

No Board member can be in a post for more than 3 years unless their official role within a member society is for a longer period, but not more than 5 years.

7.2 Chair

The Chair will be appointed for a three year term. The post will be advertised 12 months before the date of demission. Suitable candidates will be sought via the Constituent Societies

and short-listed for interview by the Board. Outcome of the interview will be made available to the Board, and appointment will be via an election of the Board Officers.

If not already an existing Board member, the Chair-Elect once appointed will be a co-opted member of the Board until succeeding the incumbent Chair on demission.

The demitting Chair may be invited at the Board's discretion to remain in an advisory capacity as a co-opted member for 12 months from the date of demission.

The Chair, or in his/her absence, an Officer elected by the meeting, will preside at Committee meetings and will have a casting vote.

Other Officers will support the Chair in the execution of his/her duties and responsibilities and will act for the Chair in his/her absence or disability.

7.3 **Secretary to the Board**

The Secretary to the Board will be appointed for a three-year term. The post will be advertised 12 months before the date of demission. Suitable candidates will be sought via the Constituent Societies and short-listed for interview by the Board. Outcome of the interview will be made available to the Board, and appointment will be via an election of the Board Officers

7.4 **Treasurer**

The Treasurer will be appointed by the Board for an initial term of up to 3 years. This will be renewable once. The post will be advertised 12 months before the date of demission. Suitable candidates will be sought via the Constituent Societies and short-listed for interview by the Board. Outcome of the interview will be made available to the Board, and appointment will be via an election of the Board Officers

Any member of the Board who ceases to be a member of either BASS, BSS, SBPR or BASCIS will automatically cease to hold office.

8.0 **BOARD**

8.1 The Board will comprise the following:

Chair, Secretary and Treasurer each of whom will have one vote.

Two representatives of each of the four Constituent UK Spine Societies (SBPR, BSS, BASS,BASCIS) each of whom will have one vote.

Two representatives each from BOA and SBNS each of whom will have one vote.

One representative from the PLG, who will have one vote.

Co-opted members of the Board but will not have voting rights

No Society will be permitted more than three votes at any one time

8.2 The Board will meet on at least 2 occasions each year either physically or electronically.

8.3 The agenda for meetings of the Board will be compiled by the Chair or his/her deputy.

8.4 Review of the Register of Board Members Interests relating to any Association matters and declaration of Conflicts of Interest will be the first Standing Item on the agenda at each meeting.

9 GENERAL MEETINGS

9.1 A General Meeting of the Association will be held on every occasion of BritSpine. A quorum will be 4 Board members and 30 other members of BASS, BSS, SBPR and BASCIS. Every attending Society member present will be eligible to a non-binding vote. Notice of General Meetings will be advertised on the UKSSB website at least three months in advance

9.2 An Extraordinary General Meeting may be called by any member of the Board, in exceptional circumstances. The petition must state the reasons for the meeting and be signed by the petitioner. The quorum at such a meeting will be 4 Board members and the Chair in attendance and 30 other members of BASS, BSS, SBPR and BASCIS. Following discussion at the EGM the Board will vote on the petition.

9.3 The business of the General Meeting will be:

9.3.1 To receive apologies for absence

9.3.2 To receive notification of conflicts of interest from the Board and members

9.3.3 To review and agree the contents of the minutes of the previous General Meeting

9.3.4 To receive a report from the Chair of the Board

9.3.5 To receive written reports with relevant information to other spine societies from BASS, BSS, BASCIS, BOA, SBPR & SBNS.

9.3.6 To receive results of elections of Board members, Chairs of sub-committees and Representatives

9.3.7 To receive a financial report and the accounts of the company by the Treasurer

9.3.8 To confirm the appointment of accountants to the company

9.3.9 To consider Constitutional Amendments submitted

9.3.10 Such other business as the Board will decide appropriate to the role of the society.

10.0 SCIENTIFIC MEETINGS

10.1 A Scientific Meeting will be held every 2 years. The site of the meeting will be determined at a board meeting following the submission of an outline business case from potential hosts. The successful hosts will be informed and announced at the BritSpine meeting 4 years in advance. The principle organiser of the meeting will be responsible to the Board of UKSSB and will attend planning and board meetings as a co-opted member.

10.2 Additional Scientific Meetings will be held at the discretion of the Board. They may be arranged in conjunction with other organisations and may be held in countries other than the

United Kingdom. These will only be approved for funding by the board after submission of a business case and due consideration.

10.3 The business transacted at Scientific Meetings will include scientific communications and/or clinical case or other demonstrations as well as other matters of interest to the members of the UK spine societies.

10.4 The dates of all scientific meetings for the ensuing year will be notified to all members at each Scientific Meeting and through the UKSSB website.

10.5 A draft programme for BritSpine will be sent to members of the UK spine societies at least 12 weeks before the scheduled date of the meeting.

11.0 **ADDRESS**

United Kingdom Spine Societies Board
British Orthopaedic Association
at The Royal College of Surgeons of England
35-43 Lincoln's Inn Fields, London WC2A 3PE
Direct: 020 7406 1746
Tel: 020 7405 6507 Ext 244
Fax: 020 7831 2676

12.0 **CONSTITUTION**

12.1 The Constitution and Bye Laws of the company cannot be amended, repealed or extended, except by giving notice of motion of such a proposal to the board.

12.2 Such a motion must be properly tabled and seconded. It will be circulated to all Board members for consideration.

12.3 To be adopted, the motion must contain no alteration to the Byelaws which will cause UKSSB to cease to be lawful and must receive the votes of 75 % or more of the Board members. If carried the Byelaws will be considered to be amended as from the time of the vote.

12.4 In the event of dissolution of UKSSB, any assets remaining, after payment of any debts and liabilities, will be transferred to the Constituent United Kingdom Spine Societies under the prevailing profit distribution model.

UKSSB Funding Applications

Funding Applications

Link to UKSSB Funding Application Form

Updates

National Low back and Radicular Pain Pathway

Ashley Cole

Since Charles' retirement at the end of 2016, I have taken on the role as Clinical Lead for this project. The National Back and Radicular Pain Pathway is in the final stages of updating in light of the revised NICE Guidelines (published Nov 2016) – after review by the 30 members of the stakeholder group and with particular thanks to Elaine Buchanan and Charles Greenough. Implementation continues and will be supported by full day sessions at the BASS and Britspine meetings in alternate years. For further details please contact David Waddingham – d.waddingham@nhs.net

For the CCGs adopting the National Pathway, it is important to monitor the process and outcome. It is therefore important that there is a single point of entry and that ALL GP referrals are managed according to the Pathway with no 'back-door' referrals to other providers. To help with a unified approach, as of 1 April 2017, non-specialised spinal surgery will be paid by the CCG whether performed by Neurosurgery or Orthopaedics. For definition of non-specialised and specialised spinal surgery please see Service Specification D14 (https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-d/d03/). It is suggested that spinal surgeons should confirm local arrangements with employers and referring CCGs.

Development of Regional Spinal Networks is progressing with many Regions agreeing Terms of Reference and a Network Clinical Lead. Strong regional groups which demonstrate good governance and collection of outcome measures are more likely to resist the impact of reduced funding.

Improving Spinal Care Project

Elaine Buchanan AHP Clinical Champion

NHS England

Back pain remains the largest single cause of disability in the UK. Despite the development of many back pain pathways and guidelines, successful national implementation was not achieved.

Over the last year the ISC project team has been working with commissioning groups to promote and support investment in and implementation of the national back pain pathway.

THE NATIONAL BACK PAIN PATHWAY

Representatives from 30 stakeholders reviewed existing UK back pain pathways and guidelines and agreed on a generic pathway for use in England.

The new NICE Guidelines will be implemented through the National Back Pain Pathway.

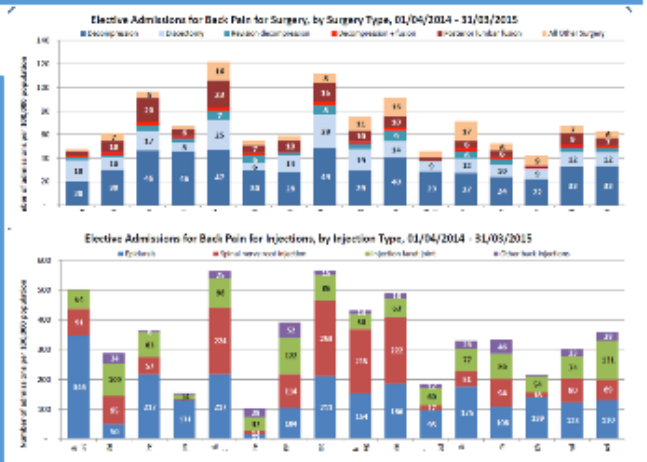
You will find lots of useful material embedded in the document:

- Referral timelines and thresholds
- Key clinical skills & competencies
- Imaging guidance
- Red flag guidance

www.ukssb.com

Variations in CCG spending on high cost low value treatments

Spinal Fusion for LBP, Facet Injections, Emergency Admission for LBP



How is your area performing? Have a look and use the data to support commissioning of the National Back Pain Pathway in your locality.

www.neqos.nhs.uk/article_page/back-pain/

The most frequent **comment made by patients about the current system for back pain is the feeling that nobody appears to be in charge of their treatment and that there is no apparent coherent plan.**

The Solution

Triage and Treat Practitioners at the Core of the National Back Pain Pathway

- Highly skilled
- Directs the pathway
- Provides continuity

Job Description available at www.ukssb.com/pages/Improving-Spinal-Care-Project/National-Backpain-Pathway.html

Evidence of Successful Commissioning & Implementation:

South Tees and Hambleton, Richmondshire & Whitby CCG Regions.

Read the Report: www.ukssb.com/assets/PDFs/2016/August/24th/NEQOS-Evaluation-of-Back-Pain-Pathway-2-August-2016-Final-Version.pdf

NHS England: Trauma Programme of Care

National Pathway of Care for Low Back and Radicular Pain

2017 Update: Summary

With thanks for the contributions from the representatives of 31 Stakeholder organisations

Change of Chair

Prof Charles Greenough has now retired. Mr Ashley Cole has now taken up the role of chair.

Implementation Guide

A new section has been added, outlining the outputs from the NHS England Improving Spinal Care Project:

- Implementation of the National Back Pain Pathway though commissioning
- Roll out of Regional Spinal Networks
- Evaluation of the North East Back Pain Pathway Implementation by the NEQOS
- Development of a database providing transactional and patient outcome data.

Change of Terminology

- Triage & Treat changed to Specialist Triage
- CPPP changed to Comprehensive Multidisciplinary CPPP

New Box: Medial Branch Block +/- Radiofrequency Denervation

An approved intervention later in the pathway for people with mod-severe chronic back pain with clinical features suggestive of a facet joint component, who have had insufficient improvement with comprehensive conservative management.
Guidance is provided on the entry/exclusion criteria, referral information, clinical skills and competencies, and outcome measures.

Rewrite: Comprehensive Multi-Disciplinary Combined Physical and Psychological Programme

The overview of CPPP has been rewritten to reflect the NICE NG59 discussion and to differentiate between the comprehensive multi-disciplinary CPPP & the low-intensity CPPP (delivered in the core therapy box). The entry criteria, content of programmes and clinician skills/competencies have also been updated.

Promoting Best Value for Managing Back Pain & Radicular Pain

- Defining appropriate and timely access throughout the pathway.
- Defining the skills and competencies of clinicians at different stages of the pathway.
- Promoting the commissioning of treatment recommended by NICE (NG59) 2016
- Backing de-commissioning of treatments which are recommended against by NICE (NG59) 2016

The Future of the National Low Back Pain & Radicular Pain Pathway

Implementation will continue as a national programme overseen by NHS England TPoC and the Spinal Services CRG. The Chair of the pathway and the accountable commissioner, will work with the STP's to ensure that CCG's can see the benefits. Work is underway to implement effective monitoring of the pathway to determine its value.

Develop National Back Pain Pathway Clinical Networks: NBP-Clinical Network

NBP-Clinical Network:

The UKSSB have supported the introduction of a new national clinical network for key players (clinicians and commissioners) who have responsibility for the implementation & development of their local back pain pathway.

- **Travel fellowships**
- **Annual meeting (to include implementation and outcomes)**
- **Links to the Regional Spinal Networks**
- **Representation to the UKSSB**

If you would like to join this network please send your contact details to **elaine.buchanan@ouh.nhs.uk**.

Incorporation of the NICE NG59 recommendations

The NBPP stakeholders agreed to adopt all of the NG59 recommendations:

NICE	Back pain +/- Sciatica:	Box in Pathway
1	Consider using risk Stratification from STarT Back Tool	2/3
2	Based on risk stratification: a) less intensive support if low risk b) more intensive support if high risk	4/10/12
4	Explain to patients imaging may not be needed in specialist setting	2/3
5	Consider imaging in specialist setting if it is likely to change management	8/9/11/13
6	Consider alternative diagnoses: new/changed symptoms/exclude specific causes	2/3/6/7/9
7	Provide advice & information to help self-management & encourage normal activities	All
8	Consider group exercise	10
13	Manual therapy as part of a treatment package including exercise +/- psychological therapy	10
19	Consider CBT psychological therapies as part of a treatment package including exercises	10
30	Consider a Combined Physical and Psychological Programme (CPPP)	12
31	Promote and facilitate return to work and normal activities of daily living	2/3/9
21-23	Consider oral NSAIDs: with assessment, monitoring & gastro-protection, lowest effective dose & shortest time	1/2/3
24	Consider weak opioids +/- paracetamol (acute LBP only if NSAID not possible or ineffective)	2/3
33	Consider radiofrequency denervation if non-surgical treatments ineffective in chronic LBP	13
34	Consider radiofrequency denervation only if positive medial branch block	17
	Sciatica:	
20	For recommendations on neuropathic pharmacology see CG 173	2
36	Epidural injections of local anaesthetic and steroid for acute and severe sciatica	22
38	Refer for surgical opinion regardless of: BMI, smoking status, psychological distress	8
41	Consider spinal decompression if non-surgical treatment has not improved pain or function	21
	Back pain +/- Sciatica: Do not offer	
3	Routine imaging in a non-specialist setting	2/3
9-11	Belts, corsets, foot orthotics, rocker sole shoes	10/18
12	Traction	10/18

14	Acupuncture	10/18
15	Ultrasound	10/18
16-17	PENS or TENS	10/18
18	Interferential therapy	10/18
	Back Pain: <u>Do not offer</u>	
25	Paracetamol alone	2/3
26	Routine opioids for acute LBP	2/3
27	Opioids for chronic LBP	2/3
28	Selective serotonin, serotonin-norepinephrine or tricyclic antidepressants	2/3
29	Anticonvulsants	2/3
32	Spinal Injections	16
35	Imaging as a prerequisite for radiofrequency denervation	13/17
39	Disc replacement	15
40	Spinal fusion (**unless part of a RCT**)	15
	Neurogenic Claudication:	
37	Do not use epidural injections for neurogenic claudication with central spinal stenosis	22/16

Mr Ashley Cole
National Back Pain Pathway Chair

Elaine Buchanan
National Back Pain Pathway Editor

Spinal Services Clinical Reference Group

Ashley Cole

The new NHS England Spinal Services CRG is responsible for advising NHSE on Spinal Cord Injuries and Spinal Surgery. The Committee has met face-to-face in November and meets by teleconference every 2 months. It is composed of:

Chair (Ashley Cole)

2 Members from each Region (1 member from Spinal Cord Injuries and 1 member from Spinal Surgery)

North (Charles Greenough & John Leach)

Midlands and East (Aheed Osman & David Cumming)

London (Angela Gall & James Allibone)

South (Chalil Vinod & Nigel Henderson)

Representatives from BASS (Stuart Blagg), BSS (Vinay Jasani), SBNS (Paul May) and MASCIP (Dorothy Trussler)

3 patient representatives

Accountable Commissioner (David Stockdale)

Public Health England representative

The CRG has proposed a Work Plan for 2017/18 to NHSE and are awaiting approval. Plans include:

A review of the Service Specification for Spinal Cord Injuries and Specialised Spinal Surgery

Produce a Quality Dashboard for Spinal Surgery and review the Spinal Injuries dashboard

Policy for growth modulating procedures in scoliosis

Implement the approved recommendations of the Spinal Cord Injuries Service and Peer Reviews

Implement the new National Pathway for Back and Radicular Pain

Continue implementation of Regional Spinal Networks

The CRG is also active in the cross-CRG working groups for NICE, NIHR, Data and Improving Value. We are hoping to work with BASS and SBPR to propose national RCTs for spinal fusion in axial back pain.

UKSSB Working Groups

Training and Education

Niall Eames

Training and education are critical to us all. But they are different in many ways, not least in the way they are provided.

STIG (Spinal training interface group)
An exciting proposal has been put forward regarding a spinal training interface group.

In some surgical disciplines where two specialities overlap, training interface groups have been successfully developed with common goals. Examples include hand surgery and oncoplastic breast surgery. The combination of orthopaedic and neurosurgical specialties in a training post for spines seems an obvious amalgamation.

The proposal is that a combined spinal training interface group (STIG) would be developed. The result would be a combined specialty spinal fellowship for pre CCT trainees in suitable U.K. centres. The aim is very much to provide a consistent and comprehensive baseline level of understanding in the practice of spinal surgery focused at the level of a day one spinal consultant. Trainees may decide to undertake a STIG fellowship in addition to a subsequent more highly specialised period of fellowship training, overseas for example.

How a training interface group is established is legislated by the JCST and follows various designated steps (see JCST TIG final report March 2016). As part of the process a working group, composed of representatives from the BOA and the spinal societies both orthopaedic and neurosurgical, met in December in order to agree a draft curriculum for the STIG program. The curriculum is an amalgamation of the spinal component parts of the orthopaedic and neurosurgical syllabus. Subsequently, the proposal and

curriculum has been presented to the combined SACs and the Training Programme Directors as the next step in the process and has received the support of both these groups.

In order to advance, funding needs to be secured. I have been asked to advance this further and am in the process of approaching Health Education England (HEE) . If successful the next stages would be:

Appointment of a chair (in the gift of the Post Graduate Dean nationally responsible for hosting TIGs and the Chair of the Interface Training Oversight Group) ,

Appointing a TIG committee with relevant multi-society representation

Defining the anticipated content of the fellowship

Defining the criteria for the hosting centres and trainers

Obtaining approval of relevant stakeholders and subsequently the GMC

Inviting applications to become, and selecting host centres

Appointing Fellows

A process that is anticipated to take approximately 18 months

UKSSB and education.

STIG is very clearly a training issue, under the auspices of the combined SACs of orthopaedics and neurosurgery and the JCST. It is being advanced by these bodies.

In contrast, the UKSSB has no role in the statutory training of surgeons. The role of the UKSSB is in education for the wider spinal family.

In order to advance this important role, an educational strategy for the UKSSB has been drafted, with the aim of optimising the understanding of spinal care through education. The purpose of the strategy is to allow UKSSB to plan and coordinate educational components of for example the BOA annual congress, on a rolling cyclical basis.

This year, we will be focusing on the new NICE low back pain guidelines, the national back and radicular pain pathway (NBRPP) and spinal trauma. The highly successful model of update, revalidation and boot camp sessions will be repeated. This will provide insight into these important areas for the wider orthopaedic surgical community.

Also as part of this strategy, the UKSSB will continue to reach out to allied health care professionals by providing educational opportunities for them and the wider spinal community. The majority of spinal conditions are treated in the community without requiring either spinal surgical opinion or intervention and the hope is that a combined strategy for the educational needs of these practitioners will lead to both enhanced uniformity and an overall improvement in the standard of care for our patients.

Society/Registry Reports

British Association of Spine Surgeons (BASS)

The final stages are being planned for the BASS meeting in Manchester on the 14th – 17th March. The meeting has been planned to cater for all. In addition to the main programme there will be a masterclass, cadaver course, allied health meeting and anaesthetic session. The meeting has received a record number of abstract submissions and currently has in the region of 200 delegates registered per day.

The membership of BASS continues to grow with 395 consultants and 111 trainees.

Stuart Blagg will be taking over from Am Rai as President from March 2017.

The BASS executive will be looking for applicants in setting up education, research and audit/registry sub-committees.

British Scoliosis Society (BSS)

Society for Back Pain Research (SPBR)

Steve Vogel

President: **Nadine Foster**
President Elect: **Naffis Anjawalla**
2016 Annual meeting summary
The annual meeting successfully took place in Preston in November 2016. There were 32 platform presentations and 5 invited keynote speakers:

- Dr Lisa Roberts, University of Southampton: 'New trends in communication: Improving the consultation experience'
- Dr Julia Wade, University of Bristol: 'Consent in Research'
- Dr Nick Hacking, Lancashire Teaching Hospitals, Preston: 'New Direction in Pain Management'
- Professor Justin Cobb, Imperial College London: 'Role of 3D printing in Orthopaedic Surgery'
- Dr Frances Williams, Kings College, London: 'The anatomical basis for low back pain.

Several of the society's travel fellow from the 2014-15 cycle presented an overview of their fellowships. Successful fellows from the 2016-17 cycle were announced:

- Janet Deane, Dept of Surgery & Cancer, Imperial College, London - Lumbar disc disease, symptomatic non symptomatic, shape modelling.
- Sarah Harrison, Arthritis Research UK Primary Care Sciences Centre at Keel University - The epidemiology of neuropathic pain.
- Kevin Brownhill, The British School of Osteopathy - Video fluoroscopy, kinematic chains.

- Alex Breen, Anglo-European College of Chiropractic - Low back and lower limb prosthesis mechanics.

The next meeting is planned for 2nd November 2017 - 3rd November 2017 at the Park Inn by Radisson Hotel, Northampton.

Society of British Neurological Surgeons (SBNS)

British Orthopaedic Association (BOA)

Lee Breakwell

I have now taken up my seat at BOA council as an elected trustee. Many thanks to those BOA members who voted for me. This gives the Spinal world central access to the legislative body for training and policy. I will therefore be able to represent our needs, and feedback the results

Here is a letter from the current President Ian Winson

The atmosphere and culture in which we work remains difficult and at times confrontational, yet there are some signs of a wind of change.

The Chair of the Public Administration and Constitutional Affairs Committee of the House of Commons said in January this year:

"There is an acute need for the Government to follow through on its commitment to turn the NHS in England into a learning organisation; an organisation where staff can feel safe to identify mistakes and incidents without fearing the finger of blame."

This is music to my ears. For too long now many surgeons (me included) have been confronted with enforced outcome publication, together with a regime of outlier management that sounds punitive and – ultimately – the intimidating prospect of an IRM: no other profession is subjected to this degree of intrusive scrutiny. The whole outlier lexicon, with its system of alerts, alarms and heavy regulation, smacks of guilty unless proven otherwise. The greatest shame is that, inevitably perhaps, the NJR is perceived by many within our speciality to be partially responsible for this when it is quite rightly acknowledged by the profession internationally as a jewel in the global crown of orthopaedic registries. The value to our patients is huge but could be even greater if the learning organisation principles are applied.

Progressively we have not been idle on this front. A year ago my predecessor, Tim Wilton, argued the case strongly with HQIP (the operators of the NJR) that the categorisation of individual surgeons as outliers was entirely counterproductive: not only did it stigmatise unnecessarily, but it also impacted psychologically on the individuals concerned and, importantly, acted as a most unhelpful barrier to the wider development of new registries focused on quality improvement. He proposed a more positive, balanced and supportive approach.

Interestingly, Tim's views ultimately prevailed. At a Clinical Outcome Programme (COP) leadership seminar last May the National Medical Director for NHS England – Sir Bruce Keogh - said that:

The whole emphasis of the COP should shift from one of rooting out poor performance to celebrating success.

Outcome publication for all future audits should be unit or team based.

And that rather than concentrating largely on the negatives, all audits should in future highlight the positives.

More recently, I, Martyn Porter (the NJR Medical Director) and others met with Bruce Keogh and secured his agreement that the NJR would not publish individual surgeon revision rates. In addition, Bruce acknowledged that the NJR's outcome reporting language and culture would change to focus on the positive aspects of joint replacement surgery that transforms orthopaedic patients' lives. As a direct consequence, the NJR Surgeon Outlier Committee will be renamed the Surgeon Performance Committee and, while there will still be a requirement to publish individual surgeon outcomes, the NJR and the profession have the discretion to determine what is put out there. Bruce also noted that the BOA will offer supportive Elective Care QI Reviews when requested by units.

This was also music to my ears. Why? Because although it took a year to achieve not only does it demonstrate the extent of our influence at a high level, but it also aligns exactly with the BOA's position on Quality Improvement. Our view is that it is part of our professional skills to reflect on our practices and develop insight by reviewing our results in comparison to our peers. Where registries are available to support this reflection with observational science, then we have a professional duty to make use of them and the insight that they can provide. In addition, important enabling processes such as GIRFT can provide alternative sources of data with which to inform reflection and review. All individual reflection should of necessity focus on the positives as well as any areas where there appears to be scope for improvement. Comprehensive assessment of our individual practice by each of us - as an individual - means that it is then possible to discuss our results with an appraiser, and to contribute to unit reviews of performance. This has to be in our patients' interests. It is also vital that the total context of this data is considered: it is intrinsically true that being a good surgeon in a struggling unit does not make you a better surgeon. Having the resources to look at the data can only add power to your quality improvement efforts. The simple statement 'no data no argument' will always catch us out. The more we have clinically insightful data the more we can push and control positive change. To help when units run up against problems that they are unable to solve, the BOA as your professional body, in conjunction with all the affiliated Specialist Societies, will assist with a supportive review. Here we intend to build on our extensive trauma experience of multi-disciplinary hip fracture service reviews, which have been well received by those units that have requested them.

This is what we mean by the Just Culture and it is one that has been widely adopted by the aviation industry with which we are so frequently compared. In a just culture it is important always to take a balanced and objective view: taking variation as an example, as Colin Howie so often says 'variation can be good or bad, but we do need to understand it'. In this way we avoid jumping to an over-hasty or ill thought through conclusion and use the full spectrum of available evidence to inform our decision making. Similarly, in a just culture the focus will always be first and foremost on learning from mistakes, errors of judgement and untoward incidents, rather than pointing the finger of blame. In this way we avoid the unnecessary spread of risk aversion and understand the essentials of and rationale for good practice. To be sure, if a surgeon is reckless and ignores the evidence without good cause, then there will be a case to answer, but those instances are rare in our specialty. Finally, in a just culture it is entirely professional to seek the support and advice of a fellow professional: while I appreciate this is instinctive to many, it is not always the case for some and is something to be positively encouraged.

So the key ingredients of a just culture are, as the name suggests, evidence based objectivity, a positive frame of mind, a quest for learning with which to promote further quality improvement, and supportive professionalism. As your professional body, it is the BOA's role to promote these principles. This accords entirely with our strapline of Caring for Patients; Supporting Surgeons, and I would hope that we could all subscribe to them. In closing, I would strongly encourage you all, if you have not already done so, to familiarise yourselves with our GIRFT implementation guidance and our statement on transparency, all of which can be found here. These documents spell out the detail of our quality improvement intentions. I will be in touch shortly with further details of our Elective Care QI Reviews.

Kind regards,

Ian Winson FRCS

BOA President

British Spine Registry (BSR)

Lee Breakwell

A recent update has added some improved functionality in the reporting section, and tidied up some of the issues around the mandatory fields

The BSR is a central part of the Spinal GIRFT, and will become a requirement for full payment under the 2017-19 Tariff

British Association of Spinal Cord Injury Specialists (BASCIS)

Ali Jamous - President
Nigel Henderson –UKSSB BASCIS representative

1. The CRGs for spinal cord injury (SCI) and for complex spinal surgery are now merged to form the new Spinal Services CRG. The membership is noted in the report by Ashley Cole the Chair of the CRG. The details of the working relationships and the workplan will follow the first meeting in November.
2. The NHS England Specialised Commissioning Review of SCI services in England is almost complete. The workstreams have been: Access to Services, Specification of Services, Performance of Services, Quality of Services, Patient Experience and Rehabilitation into the Community, and Measurement and Research. Following a stakeholder meeting on 23rd September the final draft is now in preparation covering Service Model, Gap Analysis, and Option Appraisal and is supported by chapters from the workstreams.
3. The planned Peer Review of spinal cord injury centres (NHS England Quality Surveillance Team) has published draft Quality Indicators concerning compliance with specifications focusing on quality, patient pathway and experience. A preliminary review and visit to one centre has taken place and the remainder are due in November.
4. A Meeting of BASCIS took place hosted by the Midlands Centre for Spinal Injuries in Oswestry on Thursday 23rd June. Among many agenda items particular concern was expressed about the difficulties in workforce recruitment as there are significant vacancies at every level. This meeting was followed the next day by the Annual Multidisciplinary Guttmann scientific meeting which was a great success.
5. The spinal cord injury referral portal, which includes a useful and informative document resource, is available on www.spinalcordinjury.nhs.uk.

The Spine Society of Europe (SSE)

Here is your monthly update from EUROSPINE. Enjoy reading!

Kind regards,
EUROSPINE, the Spine Society of Europe

EUROSPINE Research

Register now: EUROSPINE TFR Course 2017: 13-17 March 2017, Munich, Germany

Come for direct exchange with leading spine experts, take advantage of the very interactive and intimate course format to create your very own research project which can then be submitted as abstract for EUROSPINE 2017!

Read further reasons for attending EUROSPINE TFR Course 2017

Register NOW online

EUROSPINE Meetings

EUROSPINE 2017: 5 Top Reasons to Submit Your Abstract

Uncertain about your submission?

Read the 5 top reasons to submit your abstract

You have not yet submitted your abstract for EUROSPINE 2017?

Get started NOW - submission deadline is approaching: **1 March 2017**

Submit your abstract online

EUROSPINE Spring Speciality Meeting 2018: Preliminary Programme online

For the first time EUROSPINE will organise a meeting with focus on Prevention of Disability in Spine Disorders, an international multidisciplinary conference to raise the awareness of the global burden of spine disability.

Follow this link to read the preliminary programme online

EUROSPINE Education

Registration is now open for EUROSPINE Education Week 2017, 19-23 June 2017 in Strasbourg, France

Space is limited and fills up quickly – register now to reserve your spot!

Click here for online registration

The first EUROSPINE Advanced Course was a great success

Join us for the next EUROSPINE Advanced Course, 16-18 October 2017 in IRCAD, Strasbourg, France.

Get more information and save the date

education@eurospine.org

Patient Line

Writing Competition: 'What every patient should know before surgery'

EUROSPINE young members are invited to submit an evidence-based, up to date text written in patient-friendly English and submitted to Karen McRae, belrae84@gmail.com, until **1 March 2017**

Of course, there is a prize for you in store: the winner will receive a free registration to EUROSPINE 2017 in Dublin!

Find more information on the writing competition online

EUROSPINE in the Press

Text neck – the global disease of new generations

Read EUROSPINE's latest press release on the topic of text neck - the pain and possible damage sustained from constantly looking down at a mobile phone, tablet, or other wireless devices for an extended period of time.

Please feel free to share or redistribute!

Click here for the full text

BritSpine 2018

Almas Khan

On behalf of the UKSSB and the local organising committee in Leeds, I have great pleasure in inviting you to the 10th BritSpine congress to be held in March 2018 at Leeds University.

The first BritSpine was held in Manchester in 1999, with a philosophy of providing an opportunity for all practitioners involved in the treatment of spinal pathology to have a chance to network and experience some of the latest research in the field.

The UKSSB BritSpine 2018 planning committee had its first meeting at the end of September. As usual, the plans for the conference are to hold the main presentation days over the Wednesday to Friday (21st to 23rd of March 2018). Over the last few occasions, the masterclass and cadaver courses have been hugely popular, becoming booked up well in advance. These will be held on Tuesday 20th.

Given the broad remit covered by the conference, for this year we have decided to concentrate on selected areas. Future meetings will cover the complementary subject areas over the next few years, hopefully developing into a 6 yearly cycle, enabling us all to give better coverage in greater depth and perhaps improving the scientific content, and also to be able to be able to provide appropriate background for improving spine care in the UK with a robust evidence base.

For this meeting, the UKSSB BritSpine steering committee has selected the main themes as Genetics, Inflammatory and oncology spinal conditions to cover spine problems affecting people throughout their lifetime, and we have had confirmation from some eminent speakers in these areas.

We hope to open the abstract submission is aimed to run between 1/7/17 and 30/9/17, and a priority will be given to papers submitted in line with the subject content at this meeting. Posters will be electronically displayed, and there will be a requirement for all authors to attend the conference.

Cadaver course: Aimed at senior trainees and fellows, we are fortunate in Leeds to have an outstanding cadaver facility. We use Thiel preserved cadavers, where the cadavers are preserved in appearance similar to an almost fresh state, maintaining flexibility through the joints and the colours of the tissues, yet without the need for freezing.

Masterclasses: We are hoping to hold four masterclass sessions, each accommodating approximately 20 delegates on the Tuesday.

Wednesday will be dedicated to genetic conditions of the spine, with themed papers rather than according to society subspecialty.

Thursday will be for Inflammatory conditions of the spine, and speakers will include Dr Chris Bono, Dr Todd Wetzel, and Professor Paul Emery from Leeds

The Gala Dinner will be held at the Royal Armouries in Leeds, on the Thursday and I am sure that those who have visited there before will agree that it promises to be a spectacular venue for the dinner.

Friday morning is dedicated to oncology affecting the spine, and the Medtronic Prize session, drawing the meeting to a close at lunchtime, leaving plenty of time to get home.

I hope that has given you a flavour of what to expect next year.

Best wishes from the UKSSB BritSpine Planning Team

See you at BASS next week.

Events and Meetings

BASS 2017, Manchester
Wed 15-Fri 17th March 2017
British Association of Spine Surgeons Meeting
REGISTRATION OPEN
Manchester (Lowrie, Salford Quays)

AOSpine Principles Course in Sheffield
AOSpine Principles Course—Controversies in spinal trauma
Date: 20-21 March 2017
Sheffield, Holiday Inn Royal Victoria

Eurospine 2017
Registration for Eurospine 2017 in Dublin on 11-13 October 2017 is open here.
Abstracts invited until March 2017 here.

SBNS, Spring Meeting 2017, Oxford
Wed 29-Fri 31st March 2017
Society of British Neurological Surgeons Spring Meeting
REGISTER NOW
Oxford

International Phillip Zorab Symposium 2017 (BSRF)
Thurs 15-Fri 16th June 2017
British Scoliosis Research Foundation
London

Early Onset Scoliosis Meeting

Wed 13-Thurs 24th September 2017
Details and registration: www.oxfordscoliosis.org

BOA Annual Congress 2017, Liverpool
Tue 19-Fri 22nd September 2017
BOA Annual Congress
INFORMATION
ACC Liverpool

Eurospine 2017, Dublin
Registration for Eurospine 2017 in Dublin on 11-13 October 2017 is now open here.

SBPR Annual Meeting 2017, Northampton
Thurs 2-Fri 3rd November 2017
Society for Back Pain Research Annual Meeting
REGISTRATION OPEN, ABSTRACTS TO BE INVITED

BSS Annual Meeting 2017, ICC Birmingham
Wed 29th Nov-Fri 1 Dec 2017
British Scoliosis Society Annual Meeting
DETAILS TO COME

BritSpine 2018, University of Leeds
Wed 21-Fri 23rd Mar 2018
BritSpine 2018
DETAILS TO COME

Courses

TFR Course (Eurospine/EuSSAB)
13–17 March 2017 in Munich, Germany
The course is open to all clinicians interested in gaining a basic understanding of clinical research. It will provide clinicians with an overview of the methodology used to conduct clinical research. The purpose of the course is to provide clinicians with the fundamental concepts and tools to design clinical studies.

Notices

Please see UKSSB website, which links to BASS website, BSS website, SBPR website.

Fellowships

UKSSB SBPR Fellowships
The Society for Back Pain Research Travel Fellowships 2017
please see Travelling Fellowships SBPR.

UKSSB BOA Clinical Leadership Programme Fellowships

UKSSB sponsors applications for members of SBPR, BASS, or BSS with a minimum of one per constituent society (subject to application) and depending on the quality of application consideration may be given to a second place. Membership of the BOA is a normal requirement for eligibility. SBNS members can also apply but require to join BOA as affiliate members at a low cost. For more information, please see UKSSB/BOA Fellowships.

The CLP offers further educational support with a specific focus on developing leadership within Trauma and Orthopaedics and related fields.

Dramatis Personae

NHS Chain of Command, GIRFT Team and Improving Spinal Care Team

BASS Website
BSS Website
SBPR Website
SBNS Website
BOA Website