

## TR3 Spinal Surgery: Networks, Data, MDT Oversight

Scheme Name	TR3 Spinal surgery: networks, data, Multi-Disciplinary Team (MDT) Oversight
QIPP Reference	16-17 S5-Trauma
Eligible Providers	All c.35 spinal centres, providers of specialised spinal surgery
Duration	April 2016 to March 2019.
Scheme Payment (% of CQUIN-applicable contract value available for this scheme)	<p>CQUIN payment proportion [Locally Determined] should achieve payment of c. £50,000 for each MDT network, plus £150 times the expected number of patients scheduled for PSS IR defined spinal surgery expected to receive an MDT for that network (capped in agreement with the commissioner), to be distributed across host and contributing centres.</p> <p>Target Value:     Add locally CQUIN %:           Add locally</p>
<b>Scheme Description</b>	
<p>Establishment and operation of regional spinal surgery networks, data flows and MDT for surgery patients. The scheme aims to promote the better management of spinal surgery by creating and supporting a regional network of a hub centre and partner providers that will ensure data is collected to enable evaluation of practice effectiveness and that elective surgery only takes place following MDT review.</p> <p>All spinal surgery hubs have several hospitals in their vicinity that tertiary-refer patients for possible treatment. Additionally, some partner hospitals provide a spinal surgical service. (There are currently no formal arrangements to provide a regional spinal MDT.) One of the principal benefits of a network is that a single or double handed service in a DGH has opportunity to discuss elective cases prior to treatment, determine if their practice mirrors those in other providers and the ability to compare outcomes.</p> <p>Closer collaboration also helps with the management of emergency patients. Cases of late diagnosed cauda equina and spinal cord compression can lead to permanent damage (with a typical litigation claim costing many hundreds of thousands of pounds). Many such cases could be avoided by closer working between hospitals, and a network helps produce the closer ties necessary to ensure patient safety is maximised.</p> <p>Further support would be given to four existing pilots and other providers as and when they are ready to develop a network.</p> <p>The target payment per network should be derived as indicated, £50,000 plus the expected flow of MDT cases, i.e. the number of patients scheduled for PSS IR defined spinal surgery expected to receive an MDT. (This averaged 117 patients per centre in the year to September 2015) A ceiling beneath this number may be agreed with the commissioner, or a higher number may be agreed for example to clear a backlog: for providers with a significant backlog, it may be appropriate to schedule MDTs sufficient to clear the backlog over an agreed period – with the expectation that surgery rates will</p>	

decline through this process, but without removing the scope for affordability gains. Division of the targeted sum across the members of each of the 35 networks is for local determination by the commissioner in consultation with the providers.

### **Measures & Payment Triggers**

The CQUIN scheme has three elements

- (1) Regional Spinal MDT: (a) establish a regional spinal MDT with core members of all Spinal Consultants in the Region and at least one Radiology Consultant, with input from consultant in Pain management and physiotherapist (to advise on alternatives to surgery). (b) Attendance for all core members must be documented; (c) Meetings must be minuted including the time of the MDT; (d) Regional Policy to manage spinal emergencies including transfer; (e) Regional Policy for emergency imaging.
- (2) All specialised and non-specialised spinal surgery will be entered on the British Spine Registry or Spine Tango.
- (3) All elective specialised spinal surgery taking place within the network should have the agreement of the regional MDT either by individual case or mandatory audit (including meeting inclusion/exclusion criteria and complications) at the agreement of the MDT and Commissioners.

The payment triggers are therefore:

- (1) Achieve 1(a) to 1(e) above. Number of regional MDT meetings attended by each Spinal Consultant.
- (2) Entry of specialised and non-specialised spinal surgery activity in the spinal network on to the British Spine Registry or Spine Tango.
- (3) Discussion of elective specialised surgery in the spinal network at the regional MDT. Audit of specialised surgery every 2 quarters to be completed and presented at the Regional MDT.

### **Definitions**

### **Partial Achievement Rules**

Payment is proportional to the proportion of patients receiving MDT assessment for whom triggers 1-3 are achieved relative to that upon which the payment amount was agreed, capped at 100%.

### **In Year Payment Phasing & Profiling**

Quarterly payment with end year reconciliation.

### **Rationale for Inclusion**

The aim is to ensure that the regional spinal surgery network operates efficiently, ensuring that patient selection for specialised surgery is carefully discussed and the optimum treatment option is chosen in all cases.

As well as benefiting patients clinically the challenges of meeting 18 week RTT targets are best served by a network approach.

Better patient selection will minimise surgical intervention where not clinically warranted, accumulating considerable savings.

**Data Sources, Frequency and responsibility for collection and reporting**

Each provider must provide evidence quarterly of achievement of the three measures for its patients.

Information should be submitted to the commissioner drawn from submission to British Spine Registry/Spine Tango.

Host provider should confirm MDT attendance.

All providers should supply the list of spinal consultants. Providers should immediately notify the MDT Host if a consultant leaves or joins their spinal surgery service and if a consultant is on a period of extended leave.

Relevant data should be entered onto BSR/Spine Tango daily.

MDT attendance should be submitted monthly.

BSR/Spine Tango. This data is not yet available for contract monitoring. In the absence of flow from the registries, providers will need to provide a report regarding the flow of data.

Baseline period/ date & Value	N/A
Final indicator period/date (on which payment is based) & Value	As above.
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
<b>CQUIN Exit Route</b> <i>How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?</i>	A three year CQUIN is proposed to allow the costs of MDTs to feed through into reference costs and to Tariffs and local prices as a routine element in the cost of providing this service.

**Supporting Guidance and References**

Administrative overhead of organising MDTs, and clinical expert time in participating: for the latter the cancer MDT reference cost collection gives an indicative cost – of some £110 per patient reviewed. For a spinal MDT it would be important to have input from consultant in Pain management and physiotherapist to consider alternatives to surgery. (Note these MDTs are do not require patient attendance)

One of the spinal network pilot sites reviewed 92 long waiting patients and concluded only 30 required surgery. This ensured that patients received appropriate care and saved about £70,000 of surgery. (The cost of the avoided surgery varies greatly: many cases will be of fairly low value e.g. £700 to £1,500, with average of £1,100.) The most expensive surgery may cost more than £40,000. Some cases will have

less than an hour of surgical time, others a full day. If this example was a proxy for England, the surgical savings would be £140m.