

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

<b>Scheme Name</b>	<b>TR3 Spinal surgery: networks, data, Multi-Disciplinary Team (MDT) Oversight</b>
QIPP Reference	16-17 S5-Trauma [Add 17/18 local QIPP reference]
Eligible Providers	All c.35-40 spinal centres, providers of specialised spinal surgery and neuro-surgery
Duration	April 2016 to March 2019.
Scheme Payment (% of CQUIN-applicable contract value available for this scheme)	<p>CQUIN payment proportion should achieve payment of c. £60,000 for each MDT network, plus £180 times the expected number of patients scheduled for PSS IR defined spinal surgery or neuro-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>2017/18 Target Value:     Add locally</p> <p>2018/19 Target Value:     Add locally</p>

### Scheme Description

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.

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.

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.

The target payment per network should be derived as indicated, £60,000 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 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. The payment will go to where the contract is held (usually the hub); it is the responsibility of the hub to ensure that the scheme is delivered, and this may involve defraying costs of partners.

### **Measures & Payment Triggers**

Trigger 1. Regional Spinal Network: (a) Agree Terms of Reference for and establish a Regional Network Board, Regional Meeting and Sub-Network Clinical Governance Bodies. Appoint a Regional Network Administrator. (b) Commence 4-6 monthly Regional Network Board Meetings and appoint a Clinical Lead. Minutes to be available and must follow the National template. (c) Establish a Sub-Network Clinical Governance Group with meetings every 2-4 months. Minutes to be available and must follow the National Template (d) Regional Policy to manage spinal emergencies including transfer; (e) Regional Policy for emergency imaging.

Trigger 2. Data. All specialised and non-specialised spinal surgery will be entered on the British Spine Registry or Spine Tango. Administrative support for clinicians must be available.

Trigger 3. MDT Governance. All elective specialised spinal surgery taking place within the network should have the agreement of the Local MDT (if more than 2 Spinal Surgeons) or Sub-Regional Clinical Governance Group 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, for each year:

- (1) Achieve 1(a) to 1(e) above. Minutes to be available and reviewed by Spinal Services CRG.
- (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 Sub-Network Clinical Governance Body.

### **Definitions**

1. Spinal Surgery. Spinal surgery is undertaken by neurosurgeons and orthopaedic surgeons. Of the 35 providers, 24 are neurosurgical centres. Some of the neurosurgery providers also have orthopaedic spinal surgeons. Very often they are performing the same procedures and the only point of difference is that the neurosurgery activity is coded to specialty code 150 and the orthopaedic activity to 110. Some Trusts use the bespoke spinal surgery code. Both neurosurgeons and orthopaedic surgeons can be and are spinal surgeons.
2. Spinal Hub(s): The Spinal Hub is where the 24/7 emergency spinal service is located but not necessarily where all the emergency work is done. A region may have more than one Spinal Hub. A minimum of 6 Consultants are required for a 24/7 emergency spinal service. The Spinal Hub(s) will often but not always be the Major Trauma Centre(s)
3. Spinal Partner Hospitals: Spinal Hubs will have relationships with a number of partner hospitals which will in general be Trauma Units and District General Hospitals. Spinal Partner Hospitals will have Spinal Consultants offering 'non-specialised' +/- 'specialised' spinal surgery and may offer an emergency service without a 24/7 emergency on-call.
4. Non-Spinal Partner Hospital: Hospitals with an emergency department but without any

surgeons undertaking spinal surgery on site.

5. Regional Spinal Network (RSN): An Operational Delivery Network (ODN) with geographical boundaries decided by local and national consultation to be consistent with Trust/CCG and Commissioning boundaries.
6. Sub-Regional Network: One Spinal Hub and affiliated partner hospitals and AQPs.
7. Regional Network Board: Board responsible for Monitoring the delivery and strategy of the Regional Spinal Service. Template for Terms of Reference available from Spinal Service CRG Chair.
8. Sub-Network Clinical Governance Body: A meeting of the Spinal Hub, Spinal Partner and Spinal AQP providers for a given Spinal Hub. They will decide pathways, policies and guidelines for the Sub-Regional Network and monitor clinical governance issues. They will report to the Regional Network Board. There will usually be 2-3 Sub-Regional Networks within one Regional Network. Template for Terms of Reference available from Spinal Services CRG Chair.

#### **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.

The Regional Network Board and Sub-Regional Clinical Governance Bodies should submit minutes of their meetings which will include information on pathways, policies, guidelines, clinical governance issues, service evaluations, audits, education, research, risk register, workforce planning, objectives and work plan.

All providers should supply the list of spinal consultants. Providers should immediately notify the Regional Network Board 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.

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 input from consultant in Pain management and physiotherapist to consider alternatives to surgery. (Note: these MDTs do not require patient attendance)

One of the spinal network pilot sites reviewed 92 long waiting patients and concluded that 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.