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NHS England

Spinal Services Clinical Network Specification

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Contents

Executive Summary

Spinal Services Clinical Networks aim to improve access to excellent care for patients presenting with spinal conditions via an elective pathway or as an emergency, and to reduce variation in clinical practice between providers within the network. They do this by helping define standards, pathways and standard operating procedures (SOPs) aimed at improving access and care for patients presenting with spinal conditions via an elective or emergency care pathway.

1. Clinical Networks

Specialised services Clinical Networks[1] are a vehicle for specialty level collaboration between patients, providers and commissioners. They should have a clear line of accountability to Integrated Care Boards (ICBs), and NHS England (NHSE) Regional Teams, to ensure local ownership, alignment and a local mandate.

All networks have an important role in delivering the triple aim, supporting:

- better health and wellbeing of everyone
- the quality of care for all patients, and
- the sustainable use of NHS resources

This specification sets out the appropriate scope for the work of Spinal Services Clinical Networks. This will inform the development of the annual work plan developed in conjunction with the network's commissioners. No network will, or could, focus on all aspects of the scope described, at one time.

In describing the appropriate scope for networks, these specifications refer to the work of the network board and the network's members, supported by the network team. Networks are not expected to assume the legitimate accountabilities and responsibilities of providers who are accountable for meeting the needs of the Service Specification. However, network responsibilities inevitably overlap with those of providers, because networks aim to improve the ways in which services are delivered operationally and shape how they develop and because providers are members of networks.

[1] While some specialised services Clinical Networks have previously been described as Operational Delivery Networks (ODNs), the range of activity undertaken is now significantly beyond that envisaged for ODNs, reaching into non-specialised services, and in some cases primary and community care and prevention. Some are jointly funded as part of national transformation programmes and have accountabilities outside as well as within specialised services. As a result, as a group they are now referred to as specialised services 'Clinical Networks'.

2. Spinal Services Strategic Context

2.1 Getting it Right First Time (GIRFT)

GIRFT considered that a good spinal service is 'not just about the provision of spinal procedures but about looking at a patient's journey from first presentation with a spinal problem, to exploring how to achieve the best possible outcome for a patient in the most cost-effective way'. 'A good service has a robust governance structure with clinicians meeting regularly locally and within a wider geographical network to discuss difficult clinical problems.'

GIRFT recognised that the establishment of Spinal Services Clinical Networks was important and recommended that all providers, including Independent Sector providers, should be part of a network. Further, clinicians, both spinal and neurosurgical, including allied health care practitioners[2], should actively engage in the relevant spinal services clinical network(s).

This specification has been developed taking into account the Spinal Services GIRFT Programme National Specialty Report[3].

2.2 Establishing Spinal Networks

Spinal services are provided in a hub and partner model. Each hub centre must run a 24/7 on-call service for all spinal emergencies including complex reconstruction for tumour, trauma and infection when required. The hub centres also provide care for non-specialised low complexity high volume procedures as well as low volume high complexity procedures.

Close collaboration between the hub and partners ensures the early diagnosis and management of spinal emergencies. The close working also allows the partner hospitals to work closely in elective care and ensure that appropriate cases are discussed at an MDT and that patients receive appropriate high-quality care.

2.3 Transform Clinical Reference Group

The Transform CRG for Neurosurgery and Spinal Surgery[4] provides clinical leadership and expert advice to a national programme of transformation including:

- Fulfilling a key role in the overall strategic leadership and clinical governance for the programme including assurance, check and challenge to the products and outputs of the programme.
- Working collaboratively with a broad network of clinical leaders and clinical stakeholders of the programme, ensuring there is a shared purpose and broad clinical endorsement for the programme's vision and outputs.
- Supporting delivery of the programme and providing clinical subject matter expertise.

[2] While GIRFT, in its report, specifically cites AHPs, the expectation is that all clinical professions involved in spinal care should be involved in the network.
[3] Spinal Services National Report, GIRFT, 2019 available at https://gettingitrightfirsttime.co.uk/wp-content/uploads/2022/09/Spinal-Services-Report-July19-N.pdf
[4] See https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-d/spinal-services/

3. Network Scope

3.1 Scope

Spinal services are coordinated through 14 Spinal Networks that coordinate all levels of care from referring centres into a Specialist Spinal Surgery Centre (hub). All specialised spinal surgical procedures are provided by spinal surgical 'hub' centres, of which there are between one and three in each network.

Spinal care is delivered via a hub and partner service model that includes all providers. The care delivered to all spinal patients (adults and children) within the geographical area covered is in scope for the Spinal Network. All parts of the pathway are in scope. This will include pre-hospital services, other hospitals receiving acute admissions, as well as those only delivering elective care and rehabilitation services.

Spinal conditions and surgery that can only performed within one of the neurosciences centres in England will be managed and discussed within the established neurosurgical networks. All other spinal surgery will be considered by and managed within the spinal clinical networks.

Close collaboration and joint working will be required between spinal and neurosurgery clinical networks to ensure consistency and to facilitate joint working.

Care for children and young people between 0 and 16 years will often be within children's services, but arrangements vary for young people over 16 years. Each network should work with the relevant providers within their network footprint to agree a policy on developmentally appropriate care arrangements for children and young people aged 16-18 (and beyond 18 years where this is appropriate, for example those with learning disabilities) cared for outside a specific child or young person's service. The network should also have an agreed transition protocol which includes these issues, in line with NICE guidance[5], Transition from children's to adults' services for young people using health or social care services.

Specialised spinal services are described in detail in the Service Specifications:

- Complex Spinal Surgery Services (All ages) (URN 1738)

Not in Scope

Spinal Cord Injury Rehabilitation

3.2 Population Covered

All providers of spinal care in England are required to be part of one of 14 clinical networks which cover the country. The networks are:

NORTH EAST AND YORKSHIRE

North East and North Cumbria
Yorkshire and Humber

NORTH WEST
North West

MIDLANDS

[5] Guideline NG43 Transition from children's to adults' services for young people using health or social care services, NICE, 2016 available here: https://www.nice.org.uk/guidance/ng43

East Midlands
West Midlands

EAST OF ENGLAND
East of England

LONDON
North East London
North West London

LONDON with SOUTH EAST
South East London and Kent
South West London, Surrey and Sussex

SOUTH EAST
Thames Valley
Wessex

SOUTH WEST
Severn
Peninsula

Wales, Scotland, Northern Ireland & Crown Dependencies

While residents in these geographies may receive specialised care within England, referring services in these geographies are not part of spinal services networks.

4. Network Aims and Objectives

4.1 Network Vision and Aims

The aim of Spinal Services Clinical Networks is to improve access to excellent care for patients presenting with spinal conditions via an elective pathway or as an emergency, and to reduce variation in clinical practice between providers within the network.

To achieve this aim, spinal patients should receive the highest levels of patient-centred, multi-disciplinary care in the most appropriate environment.

Spinal Services Clinical Networks provide professional and clinical leadership. Members will work collaboratively to share learning, experiences, knowledge, skills and best practice for the benefit of everyone within that specialist environment.

4.2 Network Objectives

The objectives for Spinal Services Clinical Networks are:

- To implement national and regional policies and pathways (including the National Back & Radicular Pain Pathway).
- To define network standards, pathways and standard operating procedures (SOPs) to improve access and care for patients presenting with spinal conditions electively and in emergency situations.
- To work collaboratively as a whole system to ensure the delivery of safe and effective services across the patient pathway.
- To increase the involvement of allied health professionals and other non-medical clinicians in spinal care.

- To agree and implement consistent standards, provider guidance and service to ensure a consistent, positive, patient experience.
- To undertake comparative benchmarking and auditing of services, through the British Spine Registry (BSR), to improve service quality and effectiveness.
- To provide assurance of service quality to commissioners of all aspects of quality, undertaking service evaluation and audit.
- To coordinate providers to secure the best outcomes for patients across the network.
- To support the development of a flexible, skilled, resilient workforce though workforce planning for future service provision, training and development.
- To support providers in restoring services and reducing long waits.

4.3 Network Functions

Service delivery: *the network's role in planning and managing capacity and demand*

- Support restoration and recovery planning and delivery.
- Ensure specialised procedures only being performed in designated hospitals
- Co-ordinate patient pathways between providers over a wide area to ensure access to specialist spinal care.
- Embed best practice models.
- Close working with spinal cord injury (SCI) services to support rehabilitation of spinal patients.
- Undertake capacity planning and activity monitoring to ensure service capacity matches demand requirements, for both elective and emergency patients, identifying and resolving gaps and blockages in services.
- Develop, agree and implement common referral, care and transfer pathways and other policies, protocols, and procedures across the network, to reduce variation in service delivery, with an initial focus on:
    - National Back and Radicular Pain Pathway
    - High Volume Low Complexity GIRFT pathways
    - Emergency pathways and standards of care
    - Repatriation policies
    - Spinal Cord Injury pathways as per national rehabilitation guidelines
    - National Suspected Cauda Equina Syndrome (CES) Pathway
    - Improving Access to 24/7 MRI
    - Assuring access to emergency input in spinal services
    - A standardised multidisciplinary team (MDT) proforma to be used by each unit to ensure there is clinical consensus on specialised procedures.
    - Agreeing transfer policies between centres.
    - Implementing out-patient change in line with GIRFT guidance.
    - Implementing of theatre efficiency in line with GIRFT guidance

Resources: *the network's role in stewardship of resources across whole pathway and minimising unwarranted variation*

- Develop an approach to optimising efficient use of resources across whole pathway.
- Reduce unwarranted variation in pathways and processes that lead to inefficiencies.

- Support consistent, network-wide implementation of new approaches to outpatient care e.g. phone/video OP clinics, patient-initiated follow-up.
- Work with other related networks, flexing use of resources to find efficiencies, target resources for best effect and share insight and experience.
- Support the work of the Clinical Reference Group by implementing national commissioning products.

Workforce: *the network's role in ensuring flexible, skilled, resilient staffing*

- Assess future workforce needs for provision of spinal services across the network taking into account projected demand.
- Support providers to develop and implement innovative and extended roles for non-medical staff groups, through training and development and network wide policies and procedures.
- Assess training needs for the network (including baseline skills audit and network maturity assessment) and networked services.
- Develop and agree a network training plan that meets the needs of the network both in the delivery of care and in the functioning of the network.
- Agree with commissioners and providers how the planned training will be resourced and delivered.
- Monitor delivery and assess the effectiveness of the agreed training.
- Promote workforce resilience through:
  - mutual aid agreements;
  - health and wellbeing support for staff.

Quality: *the network's role in improving quality, safety, experience & outcomes*

- Establish and maintain systems for the collection, analysis and reporting of key indicators of outcomes, quality of care and patient experience.
- Monitor compliance of British Spine Registry in line with Best Practice Tariff, and promote entry of all cases onto the British Spine Registry, ensuring there is sufficient administrative support for clinicians to facilitate this.
- Improve quality through comparative benchmarking and audit across the network through the British Spine Registry, Model Hospital and NCIP.
- Reduce avoidable harm and potential litigation in the population of patients who have spinal conditions.
- Provide commissioners with local information, data and intelligence to support performance monitoring of the network.
- Manage risks to the delivery of the network's annual work programme.
- Identify service issues and risks and ensure they are managed through regional and system quality structures following agreed escalation processes. Providers or commissioners may ask networks to facilitate the response to risks, but providers and commissioners remain accountable for their services' risks.
- Ensure the provision of high-quality information for patients, families, staff and commissioners, standardised across the network.
- Network level clinical governance based on:
  - Effective British Spine Registry (BSR) data collection
- Comparative benchmarking and audit of services, through BSR, including PROMS, PREMS and complications) to improve service quality, experience and effectiveness. Network Morbidity and Mortality (M&M) reviews of operative deaths

and complications; return to theatre; negligence cases, DoC, serious incidents and never events.

Collaboration: *the network's role in promoting working together across organisations at local, system and national level*

- Develop close collaboration and joint working with other spinal and neurosurgery clinical networks to ensure consistency and to facilitate joint working.
- Engage with all relevant partners to foster a culture of collaboration and promote the development of provider collaborations across the network.
- Develop a network data sharing agreement between network partners. Engage with patients and third sector organisations.
- Link with Local Education and Training Boards (LETBs) to ensure spinal education provision is supported.
- Link with adjacent Spinal Services Clinical Networks.
- Link with other related networks such as Major Trauma, Cancer, and rehabilitation.
- Link with the Neurosurgery and Spinal Surgery Clinical Reference Group.

Transformation: *the network's role in planning sustainable services that meet the needs of all patients*

- Regularly review network configuration, capacity and compliance with standards, advising and agreeing a plan with commissioners to assure sustainable services that meet the needs of all patients.
- Review network wide low volume high complexity procedures and centralise to most appropriate centres.
- Apply improvement and redesign methodologies to all aspects of the network's work to deliver ongoing quality and service improvement.
- Work in partnership with ICBs to develop a strategic approach to improving spinal pathways, including the delivery of an optimal configuration of spinal services within the geography.
- Adopt a network agreed research strategy including access and participation in clinical trials.
- Participate in national, regional, and local research and audit across all clinical disciplines and share findings.
- Support the early and systematic adoption of innovation and research across the network.
- Participation in relevant national policy or guideline development such as NICE for development of spinal related clinical guidelines.

Population health: *the network's role in assessing need, improving inequalities in health, access, experience and outcomes*

- Work with commissioners to improve equity of access to spinal services.
- Ensure network wide access to education for the prevention of spinal related conditions.
- Work with all health care professionals within the network to create public information for the public to improve spinal health.
- Provide robust professional clinical leadership to ensure population health is the key emphasis across the network geography.

- Identify health service needs of patients and review service provision across the network against identified need and identify gaps.
- Plan and deliver improvements to network services to address identified gaps.
- Leverage wider programmes of work to identify and address unwarranted variation and drive and monitor plans to address areas of inequity and populations who are at highest risk, but not optimally treated.

4.4 Annual workplan

The network board will agree an annual workplan with its commissioners (usually through the joint strategic commissioning committee). This will reflect national, regional and local priorities, taking account of the resources available to support delivery. The workplan will describe its expected deliverables and benefits.

The network board will publish an annual report detailing its activities, accounts and delivery against the agreed annual plan.

5. Governance

5.1 Accountability

Hosting

Each Spinal Services Clinical Networks will be hosted by a named lead provider from within the network determined by the network's commissioners,, but will operate at arm's length, for the benefit of the network and not the host organisation.

Accountability and responsibility

Network footprints reflect patient flows, provider scale and catchments so will often cut across commissioner boundaries (ICB and regional). Governance arrangements must provide clear accountability to commissioners at system level (with links to all relevant ICSs) and region as appropriate for both network delivery and commissioning responsibilities. Local arrangements to achieve this should be clearly documented within the network's terms of reference.

Networks will be responsible to ICBs for the management of local pathways and delivery of locally agreed targets. This should be set out in memoranda of understanding between ICBs, providers and the network.

The network will be accountable to the regional team of NHSE via the appropriate board within the Region including any multi-ICB decision bodies established.

A single network plan and deliverables should be agreed with all ICBs within the network's geography and signed off by the region. Networks will be expected to provide regular reports and have regular reviews with their commissioners.

The network's authority to act on behalf of its commissioners and members will be set out clearly within the network memorandum of understanding and where necessary clarified within the agreed annual plan.

5.2 Network governance and architecture

Members and stakeholders

Networks are required to have a formally constituted governing body or board, which is accountable to the network's commissioners for delivery of the network's agreed programme, with a line of sight to all ICBs whose patients use the services of providers within the network.

Network boards should include balanced representation from member organisations and other relevant stakeholders, including patient representatives and third sector organisations.

Representation on the spinal network board will include clinical representation from each trust undertaking spinal work in the region (including IS providers where relevant), management support from the hub centres, regional allied health professional representatives and other specialties as required such as major trauma, spinal cord injury, rehabilitation, oncology and radiology.

Clinical representation should cover the whole multi-disciplinary team and pathway of care.

The network should develop an approach to working with patients and families that ensures patient views inform its whole work programme and ensure optimal service provision for patients.

The Board

The board should meet on a regular basis and operate under the oversight of a suitable chair with agreed terms of reference.

The chair will be an appropriately experienced, impartial leader who is credible across the whole network and will be appointed through a fair and open process.

- The chair should not be the network clinical lead, and ideally should not have the same main employer as the Network Clinical Lead in order to mitigate the risk of (real or perceived) conflicts of interest.
- They could be a board member or senior clinician from one of the providers or commissioner organisations in the network (ideally not the host, to underpin the collective nature of these arrangements) or a patient representative where a suitable candidate is available.

5.3 Risk Management and risk sharing

Networks do not manage risk independently but within a system of national, regional and system level arrangements. Networks support risk identification, assessment, mitigation and may facilitate any agreed response.

Specific local risk management arrangements and governance processes should be managed locally through MOUs/ SOPs etc which are clear and signed off. Escalation processes for risks within a system should be clear and explicit, with any quality concerns escalated through agreed systems and regional processes.

5.4 Interdependent Relationships

Spinal Services work alongside many other services and are dependent upon working relationships with:

- Major Trauma Networks

- Critical Care Networks (adult and paediatric)
- Spinal Cord Injury services
- Neurosurgery
- Neurology
- Imaging / Diagnostics
- Pain Management
- Physiotherapy
- Rehabilitation
- Primary care MSK services
- Microbiology
- Cancer Networks
- Children's Strategic Forum (CSF) or equivalent

6. Resources

Network funding provided to the host is ring-fenced for the network programme of work.

Each network should have a team to support its work that provides clinical leadership, management and administrative support. Networks should also have arrangements for analytical and business intelligence support. Commissioners must ensure as part of the annual planning process that the scale of resource made available to networks is sufficient to support the agreed programme of work. The capacity of the network to deliver its programme of work does not reside solely in the network team but also in the support of all network members including its commissioners. As part of the annual planning process, commissioners must ensure that:

- the scale of resource made available to networks is sufficient to support the agreed programme of work
- networks have access to the data they need and the analytical capacity and capability to turn this into actionable improvement programmes

Roles such as administration, network management and analytical support may be appropriately combined across networks, with further opportunities to increase the value from these investments, share learning across networks and improve the sustainability of networks through the provision of a pool of staff to support specialised services Clinical Networks across a region.

7. Deliverables, Service Indicators & Outcomes

Indicators and metrics of network performance come from three principal sources:

1. Generic indicators of a well set up, well-functioning network

- There is an appropriate network management team in post with the skills to deliver the specification
- There are IT facilities in place that enable communication across the network, supporting image transfer and remote participation in the MDT.
- There is an annual workplan agreed with the network's commissioners
- There is an agreed plan for patient and public voice engagement

- There is an analysis of the service needs of the population served by the network, a gap analysis and a plan, agreed with the network's commissioners to meet those needs
- There are network agreed patient pathways, procedures and protocols
- There is an analysis of workforce requirements and a plan, agreed with network members to meet these requirements
- There are arrangements (for example passporting) that enable workforce flexibility between providers within the network.
- There is an analysis of training needs, and an annual network training plan agreed with network members
- There are appropriate data sharing agreements between network partners in place
- There is an analysis of the networks data and information needs and a plan, agreed with network members to meet these requirements
- There is a network agreed research strategy including access and participation in clinical trials
- The annual workplan includes at least one quality improvement initiative
- An annual report is produced, summarising the work of the network and its outcomes. The report includes a financial statement
- The network participates in the national network of networks

2. Nationally agreed indicators and outcomes

Networks will need access to provider data that allows them oversight and assurance of progress. The core data set is described in Appendix 1 below.

3. The network's individual locally agreed annual workplan, which should build in metrics and indicators for each element

The network board will agree an annual workplan with its commissioners which will include the expected in year deliverables along with the indicators that will demonstrate effective network operation.

8. Further support and information

GIRFT report on spinal surgery available here: https://gettingitrightfirsttime.co.uk/wp-content/uploads/2019/01/Spinal-Services-Report-Mar19-L1.pdf

Complex spinal surgery services (all ages): Service Specification – available here: https://www.england.nhs.uk/wp-content/uploads/2021/03/1738-Service-specification-FINAL.pdf

The full suite of materials covering what clinical networks do, commissioning of specialised services clinical networks and the clinical networks operating model together with model materials for use by networks and their commissioners can be found on the Future NHS website here:
https://future.nhs.uk/NationalSpecialisedCommissioning/view?objectID=34094320

Access requires membership of the site and permission to access the workspace. This is straightforward for all NHS employees.

APPENDIX 1: Nationally agreed indicators

ELECTIVE

British Spine Registry

- % procedure Forms (BSR / HES Data)
- % 6/52 EQ5D (BSR / HES Data)
- % 1 year EQ5D (BSR / HES Data)

Pathway Data

- Waiting time to 1st Appointment
- % conversion to procedure at 1st appointment
- % discharged at 1st Appointment.
- Number of follow ups following procedure

Model Hospital - HVLC

- Length of stay - anterior cervical surgery
- Length of stay - lumbar decompression / discectomy
- Length of stay - Lumbar fusion
- Re-admission 30 days anterior cervical surgery
- Re-admission 30 days lumbar decompression / discectomy
- Re-admission 30 days lumbar fusion
- Revision surgery within 1 year anterior cervical surgery
- Revision surgery within 1 year lumbar decompression / discectomy
- Revision surgery within 1 year lumbar fusion

LVHC

- Number of thoracic discectomy in last year
- Number of adult degenerative deformity correction in last year
- Number of anterior lumbar fusion in last year
- Number of occipital - cervical fusion in last year
- Re-admission 30 days for all LVHC procedures
- Revision surgery within 1 year for all LVHC procedures

NON-ELECTIVE

Cauda Equina

- Number of Transfers between hospitals for MRI scan
- Percentage of MRI scans within 4 hours of request
- Time to start of surgery from scan request
- Number of patients referred to SCI centre

Spinal Infection

- Number of referrals to hub centres
- Number of operations for spinal infection
- Number of patients referred to SCI centre

Metastatic Spinal Cord Compression

- Number of referrals to hub centres

- Number of operations for MSCC