**NAME Spinal Network**

**REGIONAL SPINAL NETWORK: STRUCTURE AND TERMS OF REFERENCE**

Document Control:

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| --- | --- |
| Organisation | NAME Spinal Network |
| Document Purpose | Guidance for Network Board, Regional Meeting, Clinical Governance Group and Local MDT |
| Author | Ashley Cole |
| Date and Version | 08 October 2016, Version 1.2 |
| Linkages | Regional Spinal Network Objectives  Regional Spinal Network Work Plan |
| Circulation | Network Board |
| Description | This document confirms the structure and terms of reference for the Regional Spinal Network |
| Point of Contact |  |
| Contact Details |  |
| Review Date | October 2017 |

**THIS DOCUMENT IS A TEMPLATE ONLY. REGIONAL SPINAL NETWORKS WILL SET THEIR OWN STRUCTURE WITHIN THE GUIDANCE OF THIS DOCUMENT AND SIMILARLY, THE SUGGESTED MEETING AGENDAS ARE ONLY GUIDES ALTHOUGH IT IS EXPECTED THAT THE MEETINGS WOULD EVOLVE TO INCLUDE ALL HEADINGS.**

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# Regional Spinal Network

Clinical Commissioning Groups

Specialised Commissioning Group

Spinal Services

Clinical Reference Group

Adjacent Regional Spinal Network Boards

**Regional Spinal Network Board**

**SELKaM Spinal Network**

Spinal Partners:

St Thomas’

The William Harvey – Ashford

The Tunbridge Wells Trauma Unit

Medway Maritime Hospital

Hub:

King’s College London

**Non- Spinal Partners:**

Lewisham Hospital

Queen Elizabeth Hospital

Princes Royal University Hospital

Darent Valley

Margate

**AQPs:**

**Spinal Sub-network**

**Stakeholders**

**Spinal Injuries:**

? Stanmore

**Triage & Treat Service**

**Spinal Injection Only Providers not already listed:**

**Hub Management Boards**

**Definitions**

1. Spinal Hub(s): The RSN comprises a spinal hub(s) and a number of partner hospitals. The Spinal Hub is where the 24/7 emergency spinal service is located but not necessarily where all the emergency work is done. 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)
2. 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.
3. Non-Spinal Partner Hospital: Hospitals with an emergency department but without any surgeons undertaking spinal surgery on site.
4. 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.

**Clinical Structure of Regional Spinal Network**

* Local MDTs: Clinical meeting of spinal sub-network or spinal hub or larger Spinal Partner Hospital with more than 2 Spinal Surgeons. Partner hospitals and AQPs may attend some or all of these subject to local agreement. This is mainly to discuss direct clinical management.
* Regional Meeting: Clinical meeting of all the Regional Spinal Consultants every 2-4 months. In regions where there are no sub-networks, this will be the Clinical Governance Group.

# Regional Structure

## Regional Spinal Network Board

1. Membership
   1. Network Clinical Lead (Chair). Elected from the Clinical Governance Group Leads.
   2. Clinical Representative from each Spinal Hub and Spinal Partner Hospital in the Region.
   3. Management Representative from each Spinal Hub. Spinal Partner Hospital will have optional Management input.
   4. PPI representation.
   5. Representative from specialised commissioning.
   6. Representative from each CCG or Commissioning Support Unit.
   7. Network Manager.
   8. Where required other Stakeholders can be invited to attend the Network Board Meeting: Spinal Injuries, Rehabilitation, Radiology, Emergency Medicine, AQPs and Transport services.
2. Purpose
   1. To define and implement the strategy for the Regional Spinal Network. This strategic role will include dealing with local and regional Commissioning Bodies and monitoring standards.
   2. The Network Board has no statutory rights and any decisions will be advisory.
3. Operating Principles, Responsibilities and Duties
   1. Implementation of Pathways, Guidelines and Policies from the Clinical Governance Group and national organisations: Spinal Services CRG, NICE, Spinal Societies.
   2. Produce a ‘directory’ of Pathways, Guidelines and Policies for the Region. These should be made available nationally.
   3. Ensure resources are available to collect the Network Monitoring Data; review the Monitoring Data and produce a plan to implement any changes; collate the Monitoring Data for national review and feedback to the Regional Network Meeting.
   4. Review clinical governance issues (deaths, serious untoward incidents, never events, duties of candour, root cause analysis and risk management issues) discussed by the Regional Network Meeting. Implement any lessons learnt or changes which are not under the direct control of the Regional Network Meeting. Collate for national review.
   5. Keep a record of any audits, service evaluations or research presented at the Regional Network Meeting with any changes to clinical practice or service delivery. Ensure these changes have been implemented.
   6. Identify areas for service improvement and ensure spread of good practice throughout the Network.
   7. Review educational and research opportunities although these will be set by the Regional Network Meeting.
   8. Review activity data and targets, working with Commissioners to ensure equality of access across the region.
   9. Keep a record of the Spinal workforce and services in the region. These will include Triage Services, availability of MRI imaging, Spinal Consultants, AQPs. Anticipate and plan for potential problems which may affect service delivery.
   10. Review the Network Objectives and Work Plan.
   11. Compile a Network Risk Register and review.
   12. Report functioning of the Clinical Governance Groups
4. Success Criteria
   1. Evidence for achieving the ‘Operating Principles, Responsibilities and Duties’ above.
5. Reporting Mechanisms
   1. Minutes of meetings.
   2. Network Objective and Work Plan.
   3. Network Risk Register.
   4. National Spinal Network Monitoring.
6. Links to Other Groups and Stakeholders
   1. The Clinical Lead will have responsibility to feedback to the wider clinical group through the Regional Network Meeting.
   2. Clinical and Managerial representatives will feedback at Directorate and Executive level to their Trusts.
7. Operational Process
   1. Frequency of Meetings: Every 4 months initially but may reduce to every 6 months
   2. Declaration of Interests: At every meeting
   3. Matters Arising Between Meetings: To be reviewed by the Network Manager who will involve the Network Clinical Lead as required.
   4. Review of Terms of Reference: Next review – October 2017

## Regional Network Meeting (Clinical Governance Group)

Meeting of all the Spinal Consultants in the Region (Hub, Partner, AQP). This is the Clinical Governance Group in regions where it has been decided not to have sub-networks.

1. Membership
   1. The nominated Clinical Lead or agreed Deputy will Chair the meeting.
   2. All Spinal Consultants in the Region.
   3. Spinal Consultant from each AQPs.
   4. Radiologist from the hosting Spinal Sub-Network.
   5. Network Administrator.
   6. Spinal Hub Management Representative for non-clinical issues.
   7. Possible representation from Infectious Diseases, Microbiology, Cancer Services, Pain Management, Emergency Department, Triage and Treat Services, Spinal Injuries.
2. Purpose
   1. Responsible for governance of the Network.
   2. Advise the Regional Network Board on clinical matters.
3. Operating Principles, Responsibilities and duties
   1. Discussion of complex spinal cases to produce a plan for future management. Routine clinical cases at the Hub would be discussed in the Local MDT. Consultants from Spinal Partner Hospitals (especially those who do not have their own local MDT) and AQPs should discuss cases which should be submitted to the MDT co-ordinator in advance so imaging can be transferred. Clinical details should be presented by the Consultant. These case should be required to:
      1. Need a management decision from the wider clinical group.
      2. Illustrate a clinical governance issue.
      3. Illustrate a need to develop a new guideline or policy.
   2. Service evaluations and audits including complications, PROMS and PREMS. Summaries must be reported to the Regional Network Board. Suggestions for service evaluations and audits at the next meeting should be agreed.
   3. To produce pathways of care, guidelines and policies for managing emergency and elective spinal patients. This may involve setting up working groups to engage all stakeholders and should be reported to the Regional Network Board.
   4. Confirm that all Spinal Consultants are entering all cases on the British Spine Registry.
   5. A review of complications from each hospital since the previous meeting. Individual cases may be discussed if felt important but infection rates must be discussed. Any issues where service change is considered should be reported to the Regional Network Board.
   6. Presentation and discussion of clinical risk management issues since the last Regional Network Meeting including the Spinal Hub Risk Register. These should be summarised and reported to the Regional Network Board. These should include all:
      1. Deaths
      2. Serious Untoward Incidents
      3. Never Events
      4. Duties of Candour
      5. Root Cause Analysis
      6. A summary of the Network Risk Register with patient identifiers removed should be submitted to the Regional Network Board.
   7. Collation and presentation annually the regional spinal Consultant workforce including AQPs. Also, potential workforce or service delivery issues. A report to be submitted to the Regional Network Board.
   8. Documentation of Objectives and a Work Plan. This should be submitted to the Regional Network Board.
   9. Plan a research and educational programme to submit to the Regional Network Board with suggestions for implementation.
4. Success Criteria
   1. Evidence for achieving the ‘Operating Principles, Responsibilities and Duties’ above.
5. Reporting Mechanism
   1. Minutes of meetings.
   2. Regional Network Board to be informed as described above.
   3. Objectives, Work Plan and Network Risk Register
6. Links to Other Groups and Stakeholders
   1. The Spinal Consultants will have responsibility to feedback to the wider clinical group.
   2. Clinical and Managerial representatives will feedback at Directorate and Executive level to their Trusts.
7. Operational Process
   1. Frequency of Meetings: Every 4-6 months
   2. Matters Arising Between Meetings: To be reviewed by the Network Administrator who will involve the Network Clinical Lead as required.
   3. Review of Terms of Reference: Next review – October 2017

## Local MDT

All Spinal Hubs and any Spinal Partner Hospital with more than 2 Spinal Consultants must have a weekly spinal MDT.

1. Membership
   1. All Spinal Consultants in the Spinal Hub and Spinal Partner Hospitals.
   2. Partner Hospital and AQP Spinal Consultants may attend some or all of these meetings as agreed.
   3. At least one Consultant Radiologist from the Spinal Hub.
   4. Representation from Infectious Diseases, Microbiology, Cancer Services, Pain Management, Emergency Department, Triage and Treat Services, Spinal Injuries.
   5. Spinal Co-ordinator
   6. Theatre and Ward staff as required
   7. Hub Hospital Spinal Administrator
   8. Spinal Hub Management Representative for non-clinical issues
2. Purpose
   1. A clinical and logistics meeting of the Spinal Consultants in the Hub, Partner Hospitals and AQPs.
3. Operating Principles, Responsibilities and Duties
   1. Discussion of spinal cases to produce a plan for management. Consultants from Spinal Partner Hospitals and AQPs should discuss cases which should be submitted to the MDT co-ordinator in advance so imaging can be transferred. Clinical details should be presented by the Consultant.
   2. Consideration to monthly meetings to discuss specific patient groups should be considered and clinicians from involved specialities invited. For example, a Spinal Infection MDT with representatives from Infectious Diseases and Microbiology.
   3. Review of complications which may be summarised monthly.
   4. A summary of any clinical risk management issues will be documented in the Spinal Hub Risk Register:
      1. Deaths
      2. Serious Untoward Incidents
      3. Never Events
      4. Duties of Candour
      5. Root Cause Analysis
      6. Risk Management issues
   5. An education programme should be delivered including presentation of service evaluations, audits and important papers or national guidelines.
4. Success Criteria
   1. Evidence for achieving the ‘Operating Principles, Responsibilities and Duties’ above.
5. Reporting Mechanisms
   1. Minutes of meetings.
   2. Spinal Hub Risk Register
6. Operational Process
   1. Frequency of Meetings: Weekly
   2. Review of Terms of Reference: Next review – October 2017

## Appendix 1: Template Meeting Agendas

**THE SUGGESTED MEETING AGENDAS ARE ONLY GUIDES ALTHOUGH IT IS EXPECTED THAT THE MEETINGS WOULD EVOLVE TO INCLUDE ALL HEADINGS.**

### Regional Network Board

* Apologies.
* Declaration of Interests.
* Minutes of last Board Meeting.
* Pathways / Guidelines / Policies from Regional Spinal Meeting (Clinical Governance Group):
* National Guidelines / Policies from CRG, NICE, NHSE, Spinal Societies.
* Network Data Review.
* Review of Clinical Governance Issues reported from Regional Network Meeting
* Review of Spinal Hub Risk Registers.
* Review of Service Evaluations and Audits by Provider including learning points and implementation.
* Suggestions for future Service Evaluations and Audits.
* Service Improvements.
* Education Plan for Network.
* Research Plan for Network.
* Spinal Workforce Review.
* Review of Network Objectives and Work Plan.
* Review and Update Network Risk Register.
* Issues with Regional Network Meeting, Local MDTs.
* AOB.
* Date of Next Meeting.

### Regional Network Meeting

* Apologies.
* Declaration of Interests.
* Minutes of last Board Meeting.
* Discussion of clinical cases.
* ***Pathways / Guidelines / Policies:***
  + ***Review draft proposals.***
  + ***Review of National Guidelines / Policies from CRG, NICE, NHSE, Spinal Societies.***
  + ***Delegate action for new issues (may be a work group).***
  + ***Sign off of Final proposals sent to Network Board.***
* ***Confirm all Consultants are entering all cases into the British Spine Registry noting any clerical issues.***
* ***Summary of Clinical Governance Issues (Complications, Deaths, Serious Untoward Incidents, Never Events, Duties of Candour, Root Cause Analyses, Risk Management Issues) from each provider:***
  + ***Spinal Hub.***
  + ***Spinal Partner.***
  + ***AQPs.***
* ***Network Data Review including waiting lists.***
* ***Review of Service Evaluations and Audits by Provider including learning points and implementation.***
* ***Suggestions for future Service Evaluations and Audits.***
* ***Spinal Workforce Review.***
* ***Education Plan for Sub-Network.***
* ***Research Plan for Sub-Network.***
* ***Review of Network Objectives and Work Plan.***
* ***Review and Update Network Risk Register.***
* AOB.
* Date of Next Meeting.

Items in bold & italics need to be submitted to the Regional Network Board

### Local MDT

* Apologies.
* Minutes of last Meeting.
* Discussion of Clinical cases.
  + Current in-patients and new emergency admissions.
  + Cases for surgery – local rules to determine which cases.
  + Instrumented cases since previous local MDT.
  + Complex cases for management decisions.
* Specific issues which may be discussed monthly:
  + Spinal Infection.
  + Spinal Tumour.
  + Pain Management.
  + Complications (these must be discussed at least monthly and summarised for the Regional Network Meeting).
  + Journal Club, Service Evaluations and Audits.
* Summary of Clinical Governance Issues (Complications, Deaths, Serious Untoward Incidents, Never Events, Duties of Candour, Root Cause Analyses, Risk Management Issues).
* AOB
* Date of Next Meeting