**NAME SPINAL NETWORK**

**Objectives and Work Plan 2017-19**

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**June 2017**

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| Organisation | Regional Spinal Networks |
| Document Purpose | Guidance |
| Title | NAME Spinal Network Objectives and Work Plan 2017-19 |
| Author | Modified by Ashley Cole – Original by Sue Shepherd, Network Director, East Midlands Spinal Network |
| Date and Version | June 2017, Version 2.1 |
| Linkages | Network Terms of ReferenceNetwork Governance Framework Toolkit |
| Circulation | Network constituent member Provider/Acute Trusts Network constituent member Commissioner organisations Regional Chief Executives’ |
| Description | This document provides the NAME Spinal Network Objectives and underpinning Work Plan to illustrate the activities of the Network with key outputs and measures to be achieved for the period July 2017 – March 2019. It contains a brief outline of the evolvement of the Network to an Operational Delivery Network.  |
| Point of Contact | INSERT NAME OF RSN MANAGERINSERT NAME OF RSN CLINICAL LEAD |
| Contact Details | NAMEADDRESSEMAIL  |
|  | This document is subject to ratification by the Regional Spinal Network Board |

**THIS DOCUMENT CONTAINS SUGGESTIONS FOR INITIAL OBJECTIVES AND WORK PLAN FOR A REGIONAL SPINAL NETWORK. THIS IS ONLY A TEMPLATE AND CAN BE MODIFIED.**

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# Background

The prime aim of the Network is to ensure that all patients within the Network who require spinal care receive the best care possible, in the most appropriate environment, at the most appropriate time. This document contains the Network Objectives (Appendix 1) and underpinning Work Plan (Appendix 2) highlighting the activities of the Network with key outputs and measures to be achieved within the given time (Appendix 2 and 3).

The Network Risk Register included at Appendix 4 provides an outline of current risks identified in the Network with regular updates being provided to the Network Board.

# Development of the Network

The NAME Spinal Network was formally established as a clinical network in DATE to ensure equitable access and improve outcome and experience for spinal patients within the INSERT REGION region. Spinal services are provided for patients from INSERT COUNTIES. More specifically, the Network vision is to improve spinal care in the region and deliver evidence-based treatments in a timely manner in a location most appropriate to the needs of the patient. The Network provides an environment where clinicians can work together to share best practice and promote best quality care to continually improve spinal services.

Membership of the Network consists of provider (clinical and managerial) and commissioner organisations within the region with firm links to independent sector organisations.

# Network Objectives and Work Plan 2017-19

This paper outlines the Network Objectives and underpinning Work Plan for 2017-2019. As the Network continues to evolve, the Work Plan will be adapted.

As the Network develops, a set of strategic objectives have been identified in line with the QIPP agenda. The Network vision is:

*“Our vision is to ensure safe, equitable access to the best spinal care in the most suitable environment including timely transfer to regional specialist providers.”*

To achieve this vision, the Network will create an environment where clinicians can work together to share best practice and promote best quality care to continually improve spinal services.

As the Network Board agrees the Network objectives, it is anticipated that each constituent member organisation will adopt them as part of their local delivery plans, thus enhancing spinal services for all patients within our Network region.

The annual Network Work Plan outlines key areas of work to be undertaken in the Network against a set of measures. A progress report is delivered on a bi-yearly basis to the Network Board to evidence progress against the plan and identify any areas of concern.

The Network Objectives for the period 1 July 2017 – 31 March 2019 are included at Appendix 1 and the Network Work Plan for the same period is included at Appendix 2.

Additionally, the Network maintains a Risk Register and this is included at Appendix 4.

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**NAME + TITLE + EMAIL OF NETWORK CO-ORDINATOR**

**NAME + TITLE + EMAIL OF NETWORK CLINICAL LEAD**

## Appendix 1 - Network Objectives April 2017 to March 2019

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| Quality Strategic Objective: To improve the quality of spinal services and outcomes for spinal patients throughout the INSERT REGION region |
| Specific Objectives: |
| 1. To identify Network boundaries and agree the Network Structure within the Region (with or without sub-networks).
 |
| 1. To agree Terms of Reference using the National Templates.
 |
| 1. To appoint a Network Clinical Lead, form a Regional Spinal Network Board and organise a meeting schedule with agenda items
 |
| 1. To secure the engagement of Network member organisations to work together.
 |
| 5. To set up Clinical Governance Groups or Regional Network Meeting depending on agreed Network Structure to act as clinical advisors to the Network Board. To agree a meeting schedule with agenda items |
| 6. To ensure that local spinal MDTs are functioning with core membership and are minuted. Define meetings for inviting AQPs and ‘specialised’ areas eg infection and tumour’ |
| 7. To involve patients in planning and decision making processes for spinal services in the region so that patients access the right facilities in a timely and appropriate manner. |

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| Innovation Strategic Objective: To promote developments in spinal care pathways to spread best practice throughout the Network |
| Specific Objectives: |
| 8. To agree a Network data set for the sharing of best practice and audit of care across the Network and identify an agreed set of Network benchmarking measures to identify common areas for service improvement and further development of the service: See Appendix 3 |
| 9. To ensure that the Network complies with recommendations from national documents and standards for the further development of spinal services |

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| Productivity Strategic Objective: To maximize the availability of spinal care resource and minimize delays in access to spinal care to improve the experience and outcomes for patients across the Network |
| Specific Objectives: |
| 10. To document Regional Work Force |
| 11. To develop common standards and clinical pathways and protocols for patient transfer |
| 12. To develop a Network repatriation policy so that once a patient’s need to be in a Spinal Centre is resolved, that their re-enablement occurs as close to home as possible |
| 13. To assess MRI capacity for emergency spinal patients and develop a plan to ensure these patients are scanned in the hospital to which they present in a timely manner avoiding transfer as often as possible |

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| Prevention Strategic Objective: To minimize the requirement for spinal care  |
| Specific Objectives: |
| 14. To seek opportunities to identify common education and training opportunities across the Network |
| 15. To consider research and audit opportunities and objectives |

## Appendix 2 - Network Work Plan April 2017 to March 2018

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| Quality Strategic Objective: To improve the quality of spinal services and outcomes for spinal patients throughout the NAME’ region |
| Key/Team Objective | **Measurement** | **Work to be done/progress** | **Owner/Lead** | Timescale |
| 1. To identify Network boundaries and agree the Network Structure within the Region (with or without sub-networks). | * Define Spinal Hub(s), Spinal Partners and Non-spinal Partners within the RSN.
* Define any AQPs.
* Define other stakeholders – Triage and Treat services, spinal cord injury services, pain management services.
* Agree Network Name.
* Agree Network structure i.e. with/without sub-networks.
 | * Initial meeting to define Network, stakeholders and structures – invite all clinical leads and management representative from Hospitals offering spinal services (hubs and partners, may include AQPs).
* Circulate two NHSE templates for RSN Terms of Reference.

At meeting:* Define Spinal Hubs
* Define Spinal Partners
* Define Non-spinal Partners
* Define AQPs
* Define other stakeholders – triage and treat services, spinal cord injuries services, pain management services
* Agree RSN boundaries and identify synergies with adjacent RSNs
* Agree Network name and structure (with or without sub-networks – see NHSE Terms of Reference).
 | Clinical Leads from each Hub and Spinal Partner Hospitals with Trust Management and Commissioning Hub Spinal Specialist | January to March 2017 |
| 2. To agree Terms of Reference using the National Templates. | * Agree Terms of Reference from National Templates.
* Which services will be provided by which provider – split by emergency, specialised and non-specialised.
 | * Modify (if needed) and agree Terms of Reference from National Templates.
* Define which providers will provide:
	+ Emergency surgery
	+ Specialised spinal surgery
* Define scope of non-specialised surgery for each provider
 | Clinical Leads from each Hub and Spinal Partner Hospitals with Trust Management and Commissioning Hub Spinal Specialist | January to March 2017 |
| 3. To appoint a Network Clinical Lead, form a Regional Spinal Network Board and organise a meeting schedule with agenda items. | * Appoint RSN Clinical Lead.
* Define other members of the Regional Spinal Network Board
* RSN Board meeting schedule for first 12 months
* Agenda items for RSN Board
 | * Appoint RSN Clinical Lead
* Agree other members of the RSN Board
* Develop Network organisational structure including Network Meeting or Clinical Governance Groups (see Terms of Reference)
* Develop programme of RSN Board and Clinical Governance Group meetings for first 12 months
* Work with clinical and management leads across Network to agree current and future priorities for Spinal in the region
* Agree Network wide assessment/reporting schedule
 | Clinical Leads from each Hub and Spinal Partner Hospitals with Trust Management and Commissioning Hub Spinal Specialist | January to March 2017 |
| 4. To secure the engagement of Network member organisations to work together. | * Confirm all Trusts in the Region are aware of the RSN and its function
* Secure sustainable funding stream
* Report Network measures with National Project through Spinal Services CRG
 | * Ensure all Trusts within the region are aware of the RSN and its function.
* Engage stakeholders and agree sustained and prospective funding sources.
* Establish regular communications and information from the Spinal Services CRG.
* Generate common metrics of performance with other national spinal networks.
* Link with other spinal networks through the Clinical Leads especially adjacent Regions.
* Set annual meeting of RSN Clinical Leads
* Open invitation to CRG chair and Transformation Project Lead
* Share outcomes across the Network via appropriate forums
* Provide appropriate forums for sharing of best practice in line with Network developments
* Identify national work programmes relevant to Spinal and undertake analysis as appropriate
* Identify economies of scale in terms of procurement and the sharing of best practice
* Identify opportunities to share the work of the Network on a local, regional and national basis
* Develop a mechanism to Network data to evidence “Best Practice” and demonstrate value for money
* Encourage Network staff to share best practice through a range of media e.g. e-mail, letter and presentations
* Identify and agree areas for service development / improvement and innovation through the Network Groups, including prevention, ensuring the effective collaboration with commissioners
* Identify barriers to implementation and assist Units in developing a plan for implementation
 | Co-ordinated by RSN Clinical Lead. Clinical Leads from each Hub and Spinal Partner Hospitals with Trust Management and Commissioning Hub Spinal Specialist | April to July 20017 |
| 5. To set up Clinical Governance Groups or Regional Network Meeting depending on agreed Network Structure to act as clinical advisors to the Network Board.  | * Clinical Governance Group / Regional Network meeting schedule for first 12 months
* Define composition of each Clinical Governance Group or the Regional Meeting
* Agenda for meetings
 | * Agree Clinical Governance Group / Regional Network meeting composition, schedule and agenda.
 | Co-ordinated by RSN Clinical Lead. Clinical Leads from each Hub and Spinal Partner Hospitals with Trust Management and Commissioning Hub Spinal Specialist | April to July 20017 |
| 6. To ensure that local spinal MDTs are functioning. | * Confirm which Hospitals have weekly spinal MDT meetings
 | * Minuted, weekly spinal MDT meetings to continue in Spinal Hub and Partner Hospitals with 2 or more spinal surgeons
 | Clinical Leads from each Hub and Spinal Partner Hospitals  | April to July 20017 |
| 7. To involve patients in planning and decision making processes for spinal services in the region so that patients access the right facilities in a timely and appropriate manner. | * Appoint 1-2 patient representatives to RSN Board
* Patient feedback from involvement in process
 | * Invite patient representatives to sit on the RSN Board
 |  | April to July 20017 |
| Innovation Strategic Objective: To promote developments in spinal care pathways to spread best practice throughout the Network  |
| Key/Team Objective | **Measurement** | **Work to be done/progress** | **Owner/Lead** | Timescale |
| 8. To agree a Network data set for the sharing of best practice and audit of care across the Network and identify an agreed set of Network benchmarking measures to identify common areas for service improvement and further development of the service | * See Appendix 3
* National dataset in preparation
 | * Agree any additional data items
 | RSN Board | April to July 20017 |
| 9. To ensure that the Network complies with recommendations from national documents and standards for the further development of spinal services | * Insert into Assessment Tool for RSN (see Appendix 3)
 | * CRG will feedback issues as they arise to all the Networks
 | RSN Clinical Lead | As required |
| Productivity Strategic Objective: To maximize the availability of spinal care resource and minimize delays in access to spinal care to improve the experience and outcomes for patients across the Network |
| Key/Team Objective | **Measurement** | **Work to be done/progress** | **Owner/Lead** | Timescale |
| 10. To document Regional Work Force  | * WTE Spinal Consultants in each Hospital and anticipated retirement
* AQP Providers including capacity and casemix
 | * WTE Spinal Consultants in each Hospital and anticipated retirement
* AQP Providers including capacity and casemix
 | Clinical Governance Groups to RSN Board | April to July 2017 |
| 11. To develop common standards and clinical pathways and protocols for patient transfer | * Policy for transfer of emergency spinal patients including electronic referral system
* Define referral pathways for patients requiring emergency or specialised spinal surgery
 | * Define indications and process for transfer of emergency spinal patients including electronic referral system
* Define referral pathways for patients requiring emergency or specialised spinal surgery.
* Communication strategy to stakeholders and partner hospitals
* Define priorities of relevant conditions & pathologies
* Establish working groups around specific pathways
 | Clinical Governance Groups to RSN Board | April to July 2017 |
| 12. To develop a Network repatriation policy so that once a patient’s need to be in a Spinal Centre is resolved, that their re-enablement occurs as close to home as is feasible | * Network Policy for repatriation of spinal patients
 | * Construct policy for re-patriation of spinal patients within the RSN
* Audit of delayed discharge from principle spinal providers
* Modelling of impact of likely repatriation policy & feasibility of proposed changes
* Enactment of policy and monitoring of compliance
 | Clinical Governance Groups to RSN Board | April to July 2017 |
| 13. To assess MRI capacity for emergency spinal patients | * MRI scanning times for each Hospital (routine scanning + availability for emergency scanning)
* Policy for MRI scanning of emergency spinal patients
 | * MRI scanning times for each Hospital (routine scanning + availability for emergency scanning)
* Construct policy for MRI of emergency spinal patients
 | Clinical Governance Groups to RSN Board | April to July 2017 |
| Prevention Strategic Objective: To minimize the requirement for spinal care |
| Key/Team Objective | **Measurement** | **Work to be done/progress** | **Owner/Lead** | Timescale |
| 14. To seek opportunities to identify common education and training opportunities across the Network   | * Record of Spinal Fellowships in the Region
 | * Record of Spinal Fellowships in the Region
* Training of Specialist Spinal Triage Practitioners
 | Clinical Governance Groups to RSN Board | April to December 2017 |
| 14. Once Spinal Training Interface Group Fellows are approved, each RSN should have one STIG Fellow | * Appointment of STIG Fellow to RSN at National Selection
 | * Evaluate training options within the Region and formulate a plan to accommodate training of a STIG Fellow.
 | Network Board | Unsure at present |
| 15. To consider research and audit opportunities and objectives | * Document agreed audits for all or specific providers
* Any proposed multi-centre research projects
 | * Document agreed audits for all or specific providers
* Any proposed multi-centre research projects
 | Clinical Governance Groups to RSN Board | April to December 2017 |

## Appendix 3: Assessment Tool for RSN

On initial set-up of the RSN, the ‘Measurements’ in Appendix 2 should be completed (copy the table as a template).

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| **Criteria** | **Evidence** | **Assessment** | **Identified Gaps** | **Comments** |
| R | A | G |  |  |
| Waiting times | Average time to outpatients by each hospital / AQP. Number of 18, 26,52 week breaches for each provider |  |  |  |  |  |
| Electronic Referral System | Introduce electronic referral system in each spinal hub and any other hospital offering an on-call service for all non-GP referrals |  |  |  |  |  |
| Repatriation | Record the number of patients and days for each partner hospital where repatriation is delayed |  |  |  |  |  |
| British Spine Registry (BSR) | Confirm use of the BSR for all non-injection procedures. |  |  |  |  |  |
| British Spine Registry (BSR) | Confirm number of WTE BSR data managers |  |  |  |  |  |
| Local MDT Audit | Each case discussed at the local spinal MDT and regional meeting should be documented as:* Plan made before discussion: y/n
* If yes: decision of meeting proceed as planned / no surgery / smaller surgery than planned / larger surgery than planned
 |  |  |  |  |  |
| RSN Manager and Clinical Lead | Confirm presence of a Spinal RSN Manager and a Clinical Lead (0.5PAs) |  |  |  |  |  |
| Risk Management | Evidence of recording all risk management issues in the RSN Risk Register:* Deaths
* Serious Untoward Incidents
* Never Events
* Duties of Candour
* Root Cause Analysis
* Risk Management issues
 |  |  |  |  |  |
| RSN work plan | Show evidence of a RSN work plan for at least 24 months. The initial plan should also include a short report as to what immediate changes have resulted from setting up the RSN and any potential savings |  |  |  |  |  |

## Appendix 4 - Network Risk Register as at December 2016

**Risk Register**

 **Introduction**

This Register is a management tool that provides a list of current risks identified within the NAME Spinal Network. Risks can be identified by any Network Group, Participant Member Organisation or Participant Member. The Director of the Network will be responsible for maintain the register and identifying any new Risks or any areas of concern to the Network Board on a quarterly basis.

**Risk Rating**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |   | **Impact** |
|  | **Likelihood** | Negligible 1  | Minor2  |  Moderate3  | Major4  | Catastrophic5 |
| 5 | Almost Certain | Medium | High | Extreme | Extreme | Extreme |
| 4 | Likely | Medium | High | High | Extreme | Extreme |
| 3 | Possible | Low | Medium | High | High | Extreme |
| 2 | Unlikely  | Low | Medium | Medium | High | High |
| 1 | Rare | Low | Low | Low | Medium | Medium |

 |   | 1 - | 3 | Low Risk |  | No action (re-assess if any changes) |  |

Example of Risk Register:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Risk Number | Date Registered | Identified by | Description | Score before mitigation | Mitigation | Mitigation lead | Score post mitigation | Outcome | Date last reviewed |
| SN/01 | 22nd March 2016 | Network | RTT 18 weeks | **9** | Hub and spoke centres to work together |  | **8** | Likely to be ongoing 18 week issue |  |
| SN/02 | 22nd March 2016 | Network | PROMS Data Collection – requirement for data collectors | **7** | Network to develop business case for hub centres | Chair | **5** | Improvement in data collection with some centres not collecting any data |  |
| SN/03 | 22nd March 2016 | Network | Electronic emergency referral system to improve referral process | **8** | Contact and business cases to be developed for refer-a-patient | Chair | **5** | Two hub centres in negotiations |  |
| SN/04 | 22nd March 2016 | Network | Ongoing issue with respect to delay in transfer of spinal cord injuries to SCC | **9** | Engagement with SCC & improvement in local services |  | **8** | Likely to continue, but to develop local network to improve local training |  |
| SN/05 | 22nd March 2016 | Network | Access to 24/7 spinal surgeon for emergency spinal surgery  | **9** |  |  | **8** | No definitive plan submitted by local trusts |  |