Manchester University
NHS Foundation Trust

Trust Response to the Spinal Safety Look Back Review

23 February 2024

Response

Manchester University NHS Foundation Trust (MFT) welcomes and accepts in full the publication of Royal Manchester Children's Hospital's review into the quality of care, safety and experience received by patients operated on by Spinal Surgeon A between 1 January 2006 and 31 December 2011.

The review in Royal Manchester Children's Hospital (RMCH) was commissioned by their senior leadership team in November 2022 following concerns being raised by the Northern Care Alliance (NCA) that an external expert review of 4 cases had identified considerable concerns about Spinal Surgeon A's practice during the period he operated at Salford Royal Hospital (now within the NCA) and RMCH (now within MFT).

The internal RMCH team who conducted this review were assisted by two experienced Consultant Paediatric Spinal Surgeons from UK Children's Hospitals. Neither of the experts has been employed by or worked in RMCH. One of the experts had experience of supporting the Northern Care Alliance spinal review which was published in 2023.

A total of 182 possible patients for review of care were identified from MFT data searches and other sources (including NCA, direct patient contact and legal claims, incidents and complaints). Following administrative and primary reviews, the records of 56 patients were determined to require secondary review. 43 of these patients were not found to have suffered harm, and 13 patients were found to have suffered mild, moderate or severe harm. All patients/families involved in the review were contacted and kept informed of progress of the review throughout the process.

Firstly, we apologise unreservedly to the patients and their families who experienced harm and further interventions as a result of Surgeon A's practice, and for the distress that this has caused. We also apologise to those patients and their families who, whilst there may have been no harm identified in relation to their care, have experienced anxiety due to their inclusion in this review.

The review found some evidence of good outcomes, some in very complex cases. Many families expressed their gratitude for the service they received and praised the medical and nursing teams involved in their treatment.

We thank those who supported our review with descriptions of their care as this has helped us to provide important answers to our patients and their families. The review has allowed us to assess the way we measure and monitor the quality and safety of our services, and we are committed to implementing improvements moving forwards.

Effective communication and engagement

We have learnt that we did not engage effectively with our patients and their families as decisions were being made about their care and treatment. Decisions were often based on what was deemed to be in the best interest of the patient, even for those who had the capacity to make decisions for themselves. The review also found that decisions were not made in a collaborative way, which compromised the quality of patient consent.

Our approach to engaging with patients and families is now very different, with shared decision making and informed consent fundamental to the care we provide – enabling joint decisions about care and treatment to be reached. We are now able to demonstrate improvement in this area, having achieved NHS England's Shared Decision-Making standard in both 2022/23 and 2023/24. Our improved approach has also seen patient decision tools embedded in our electronic patient record, which is supporting patients to make more informed decisions around their care.

The way we share information is much improved, with our recently launched patient portal MyMFT providing patients with fast and secure access to their health information. Carers can also use MyMFT to schedule appointments, view test results and communicate with the clinician on behalf of a loved one.

We are committed to ensuring that we implement national consent principles across all our services, and have proactively engaged with patients and staff to develop initiatives that support good consent practice. An example of this good practice is providing patients with access to our library of approximately 400 treatment-specific informed patient consent documents. This library, which is endorsed by the Royal College of Surgeons of England, helps to ensure that our patients are fully informed of the benefits, risks and alternatives to treatment in an accessible format.

Electronic consent forms are now in use, which has allowed for more detail to be included on the risks of a procedure and has allowed for more tailored discussions to be had with patients and family members. These discussions are also detailed in physical letters sent to patients to remind them of the risks and potential consequences.

Responding to patient and family concerns

We recognise and deeply regret that we did not always respond to patient and family concerns in a compassionate and responsive way. Moving forward, we are committed to putting transparent and accessible processes in place to allow for concerns to be raised and responded to in a timely manner.

The contact details of our established Patient Advice and Liaison Service (PALS) are readily available to both patients and staff, and we are currently reviewing the effectiveness of our responses to those who raise concerns around their care and treatment.

We are also making significant changes in how we engage with patients and their families once concerns are raised. A new national framework is being implemented, part of which places more focus on the patient's experience, and we are working closely with key stakeholders to identify further opportunities for change and improvement.

Recognising and responding to patient safety events

We recognise that at the time period covered by this review we did not have a transparent and consistent approach to monitoring and evaluating complication rates within the spinal service, with few attempts made to understand the impact of complications on individual patients.

Now, we actively seek to understand the impact of any procedure complications on a patient-by-patient basis and report all recognised complications that result in notifiable harm as 'patient safety events'. A multi-disciplinary approach is in place to identify any opportunities for improvement in a patient's care, and we are exploring with other Specialist Children's Hospitals a dual-operating model in spinal surgery, whereby two senior surgeons will perform surgery together in particularly complex cases.

All of our spinal surgeons already voluntarily submit their outcome data to the British Spinal Registry, and submission will be a condition of practice at RMCH for all future appointments to this team. Through this and other sources of performance data, we can review patient outcomes and the complication rates of individual surgeons, enabling us to quickly identify potential issues.

Since 2011 we have significantly improved how we monitor our work, and our revised clinical governance framework based on the NHS Patient Safety Incident Response Framework (2022) provides greater assurance to ourselves, our commissioners and our regulators. We actively monitor the effectiveness, including complication rates, of our services Trust-wide, benchmarking our outcomes against other hospitals and our compliance with national quality improvement programmes.

The Responsible Officer Role

We recognise that many surgeons and other doctors work within more than one NHS hospital (as the case was with Spinal Surgeon A) and may also conduct private practice. The Responsible Officer legislation which came into force in 2011 now gives us visibility on a doctor's performance across the full scope of their practice, allowing us to act accordingly.

In addition, we escalate any urgent patient safety concerns to the General Medical Council's (GMC) Employer Liaison Advisor (ELA), who ensures that the doctor has informed the Trust of everywhere they have worked. We also hold quarterly meetings with the GMC's ELA to review any concerns and discuss an approach to handling them.

Summary

Since the time period covered by this review, we have made significant improvements to the care we provide, as well as the way in which we monitor, measure and provide assurance on the quality and safety of our services.

We recognise that there are further opportunities to develop the quality of care we provide to patients and their families, and we will work to implement further improvements moving forward. In addition, we recognise that there may be patients and their families who were not included in the review because they did not fulfil one of the inclusion criteria, and who may wish to discuss with the Trust the care they received from the Surgeon in question. We would welcome any such discussion and our contact details are published in our statement on the website.