Spinal Surgery

Independent Patient Safety Investigation

- Phase One, Diagnostic review of concerns raised

Final report V1

April 2026

Contents

Final report – April 2026

This Final Report has been written in line with the terms of reference as set out in Appendix 1 of this report, the development of which has been supported by Niche Health and Social Care Consulting. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out of date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

This is an independent report which has been prepared for NHS England and has been written for the purposes of publication. No other party may place any reliability whatsoever on this report because it has not been written for their contractual purposes.

Different versions of this report may exist in both hard copy and electronic formats and therefore only the final signed version of this report should be regarded as definitive.

Chapter 1: Introduction

Background to this review

1.1 On 8 December 2021, a group of staff in the Northern Care Alliance NHS Foundation Trust ('the NCA') raised concerns with the new CEO about Consultant Surgeon A, a consultant spinal surgeon, who had been dismissed from one of the Trust's legacy organisations, Salford Royal NHS Foundation Trust (SRFT) in 2015. Their concerns were about the standard of his surgery and resulting harm to patients, his leadership style, and the culture that he had created in the department, where staff had felt bullied and afraid to speak up.

1.2 The new CEO commissioned two investigations, one into the care of patients (the Spinal Patient Safety Look Back Review (SPSLBR)) and another into the non-clinical matters raised by staff (the Breen Report). These investigations had several aims, including to enable lessons to be learned that would prevent the same things happening in the future.

1.3 Consultant Surgeon A also worked at the Royal Manchester Children's Hospital (RMCH), and the Spire Hospital Manchester. These organisations also undertook look back / recall exercises. The findings from the RMCH review are published on the Manchester University NHS Foundation Trust (MFT) website.

1.4 However, several patients and staff still had concerns, feeling that these reviews had not been comprehensive enough. They wanted all patients who had been under the care of Consultant Surgeon A to be recalled. They were so concerned that they raised the issues with their local MPs, who in turn raised a question in Parliament to the Health Minister.

1.5 In March 2025, the Health Minister wrote to the then Chief Executive of NHS England to request a full recall of patients who had been under the care of Consultant Surgeon A. This was to include patients who had received care from Consultant Surgeon A at Salford Royal Hospital and the RMCH.

1.6 At this request, NHS England North West region commissioned a comprehensive diagnostic review. This was based on previous reports having been commissioned by the individual organisations into patients who had undergone instrumented surgery[1] carried out by Consultant Surgeon A. The findings from this review are set out in this report.

Terms of reference

1.7 The terms of reference for this review define what the review team (referred to as 'we' throughout this report) was asked to assess. Our full terms of reference are provided in Appendix 1. The key tasks from the terms of reference were:

- "*Using appreciative enquiry to actively engage with patients, their families and stakeholders including, but not limited to, patients, MPs and spinal experts to understand their concerns about the reviews already undertaken and their further request for a look back in more detail*". These reports are:

[1] For the purpose of this report, by 'instrumented surgery' we mean procedures involving the insertion of metalwork, which was the agreed upon definition which emerged during our fieldwork.

  - A report for the Northern Care Alliance NHS Foundation Trust Spinal Patient Safety Look Back Review ("SPSLBR") and its follow-up addendum, dated September 2025 and not yet published
  - Royal Manchester Children's Hospital Spinal Safety Look Back Review (RMCH SPSLBR)
  - The Spire Spinal Safety Look Back Review (Interim Report), March 2024, (Spire PNE), unpublished
  - Investigation report on behalf of the Northern Care Alliance NHS Foundation Trust (NCA) (known as The Breen Report)

- "*To review the previous terms of reference, reviewing the consistency of application of previously agreed definitions e.g. instrumental/implantable surgery and the methodology and timelines from existing reviews for the purpose of identification of any new cohorts of patients to be reviewed clinically or to have an alternative look back process*".
- "*Review, triangulate and thematically review the recommendations from all four previous reviews undertaken so far to establish if any new recommendations emerge*".
- "*Determine the level of assurance for each provider organisation on the delivery and governance associated with the recommendations*".
- "*Develop terms of reference for any future reviews/look backs needed, including any identification of further patient cohorts*".

Review team

1.8 The review was independently chaired by Dr Yvette Oade. Dr Oade is a paediatrician by background and has spent most of her career working in the north of England. She has held various medical director roles in acute provider organisations. After retiring from the NHS, she spent two years as the interim Regional Medical Director for NHS England North East and Yorkshire.

1.9 Dr Oade appointed an experienced spinal surgeon to support her in her work. Professor Sashin Ahuja is an experienced consultant orthopaedic spinal surgeon who practices in Cardiff. He is the former president of the British Association of Spine Surgeons, a professor at Cardiff University and chair of the United Kingdom Spine Societies Board.

1.10 Support, investigative and governance expertise was provided to the review team by Niche Health and Social Care Consulting.[2] Niche is an employee-owned trust and a B-Corp,[3] which specialises in providing independent patient safety reviews and investigations for the NHS and private providers of healthcare.

Method

1.11 Our approach to delivering the terms of reference and understanding the concerns of patients, families and staff was to identify, collect, collate and review qualitative information from a range of sources.

[2] Niche Health & Social Care Consulting (2025) Who Are We?

[3] "*Certified B Corporations are businesses that meet the highest standards of verified social and environmental performance, public transparency, and legal accountability to balance profit and purpose*". Cultivating Capital (accessed 2025) What is a B Corporation? Everything You Need to Know.

1.12 The range of key documents we reviewed included Trust and independent hospital commissioned reports and their terms of reference, recommendations and action plans. We also reviewed a range of documents to help us to assess progress made against the recommendations and actions from the previous reviews.

1.13 We held meetings, interviews and focus groups to speak to a wide range of people affected by Consultant Surgeon A's care and treatment. This included patients and their families, current and past staff, managers, senior medical and other leaders, authors and reviewers of past reports and other key stakeholders. In total between May and September 2025 we conducted 21 one-to-one interviews with current and past staff from each of the three organisations where Consultant Surgeon A had worked.

1.14 In October 2025, we carried out a site visit to the spinal service at Salford Royal Hospital, where we observed a spinal surgery multidisciplinary team (MDT) meeting and a morbidity and mortality (M&M) meeting. During the visit, we visited key clinical areas and spoke to current staff and held two focus groups (attended by 17 staff members).

Involvement of patients and their families

1.15 Following revelations made in a Sunday Times report in Summer 2022, a number of affected patients, families and some staff members formed a support group, which now has around 30 members. The group is currently in touch with around 50 people, which includes those treated by Consultant Surgeon A at each of the three organisations involved and who have been negatively impacted by these events.

1.16 We worked closely with the affected patients and family group to understand their experiences. We met with the group organisers on several occasions and attended face-to-face meetings. We held one face-to-face and two virtual (online) focus groups to hear the concerns and opinions of group members. Sixteen people attended the focus groups.

1.17 We also offered anyone affected the opportunity to complete a survey which would capture their experiences of treatment by Consultant Surgeon A and their subsequent experiences, such as during the look back reviews and any other interactions with the healthcare organisations involved. Ten people completed the survey. Some people submitted both online and hard copies, so they may be counted twice.

1.18 We must note that we only spoke to a very small number of those Consultant Surgeon A operated on over his career and so we cannot claim that this is a representative sample of those affected. However, it was reassuring that the second NCA look back review (dated September 2025), which also recorded feedback from patients on their overall experiences of their care and treatment by Consultant Surgeon A, identified many of the same issues and concerns raised during our review.

Involvement of Consultant Surgeon A

1.19 We invited Consultant Surgeon A, through his legal team, to contribute to the review, but were told that he did not wish to be involved. We understand that this is consistent with other review processes that have been completed.

1.20 From our perspective, not being able to hear the views of the person at the centre of this investigation means there is a gap in our findings, and it is important to highlight this. However, we respect the wishes of this individual and have not contacted them as part of our work.

Timeline of key events

1.21 Before presenting our findings, we have included the timeline to show the sequence of key events. **Dates in turquoise** show when relevant guidance, frameworks and policies were introduced in England.

1991	Consultant Surgeon A was employed by Salford Royal Hospital NHS Foundation Trust (SRFT) as a spinal surgeon.
December 2003	Maintaining high professional standards (MHPS) framework was first published.
2005	Two deaths in theatre At Salford Royal Hospital. They were linked to blocked anaesthetic equipment, prompting a joint police and hospital investigation.
February 2007	Death of Catherine O'Connor at age 17.
2011	Consultant Surgeon A was appointed head of division for neurosciences and renal medicine
2011	Consultant Surgeon A operates for the last time at RMCH.
December 2012	Medical revalidation was introduced in England, requiring doctors to have an annual appraisal and a fitness to practice recommendation every five years.
2013	Consultant Surgeon A operates for the last time at Spire Manchester.
October 2014	Duty of candour was introduced in England, requiring healthcare organisations to be open and honest with patients after a notifiable patient safety incident
3 March 2015	Salford Royal Hospital was rated outstanding. Surgery was rated as requiring improvement.
March 2015	Montgomery v Lanarkshire Health Board (2015) established a more patient-centred approach to consent: Doctors must now inform patients of any "*material risk*" associated with a recommended treatment and any reasonable alternative treatments.
2015	Consultant Surgeon A was dismissed by SRFT for non-clinical reasons.
December 2015	The Royal College of Surgeons invited review of the Trust's spinal surgery service and clinical review of 10 patients took place.
March 2017	National Guidance on Learning from Deaths was published by the National Quality Board.
1 October 2017	The RMCH becomes part of the newly established MFT.
August 2018	Salford Royal Hospital was rated outstanding. Surgery was upgraded to a good rating.
October 2020	Dr Catherine Cale was appointed group medical director of Spire Healthcare.
2021	A multiprofessional group raised concerns under the Freedom to Speak Up (FTSU) process about Consultant Surgeon A to the NCA CEO.
1 October 2021	NCA was established and incorporated the Salford Royal Hospital.

1 November 2021	Dr Owen Williams OBE was appointed CEO of NCA.
January 2022	NCA commissioned the SPSLBR, overseen by the NCA chief medical officer (CMO).
Between February 2022 and March 2023	The SPSLBR investigation group met to oversee the look back review.
February 2022	Spire was informed of the look back review by NCA.
March 2022	Consultant surgeon A's practising privileges were withdrawn from Spire for commercial reasons.
June 2022	The Sunday Times ran a story on Consultant Surgeon A, which included details of the SPSLBR.
November 2022	Spire initiated a patient recall.
December 2022	The NCA CMO retired and the interim CMO took oversight of the SPSLBR.
November 2022 to March 2023	SPSLBR MDT round-table reviews took place.
December 2022	Care Quality Commission (CQC) report into NCA was published. The NCA received an overall requires improvement rating. Safe and well-led domains were also rated as requiring improvement.
February 2023	Dr Rafik Bedair joined the NCA as CMO
22 May 2023	MFT started the RMCH SPSLBR.
31 July 2023	NCA published the SPSLBR.
7 March 2024	The Breen Report was published.
June 2024	RMCH SPSLBR was issued to the MFT Trust Quality and Safety Committee.
1 September 2025	An addendum report was issued by the NCA as a follow-up review of additional patients who came forward after the SPSLBR had been published.

Chapter 2: Executive summary

Overview

2.1 Consultant Surgeon A was dismissed from the SRFT for matters relating to their conduct in 2015. Before this date, it appears that their colleagues had been raising concerns about their practice for some time. Formal reviews were not started until early 2022, but they had a domino effect, triggering look back activity across all the organisations Consultant Surgeon A had operated in. Additional previous reviews into their practice also emerged.

2.2 This matter has been reviewed extensively in various forms over many years, with varying levels of patient and staff engagement, different purposes and with variable clarity of output. Despite all this review activity, patients and their loved ones, former staff and some stakeholders still have several concerns. The extent of these concerns varies across the reports in question.

2.3 In many cases, the reviews already completed (both those within our scope to review and those that came to light later) did not answer important questions. The ways these matters were investigated have, in some cases, made the trauma which some patients have experienced, worse. This is especially true for the family of Catherine O'Connor, a former patient of Consultant Surgeon A who sadly died during a planned operation in 2007.

2.4 Through this diagnostic review, we have sought to understand the concerns with the reviews undertaken so far. We did not investigate the events themselves or pass judgement on Consultant Surgeon A's practice or conduct. We have engaged with patients and their families, current and former staff in the service and other stakeholders to understand their concerns with the previous reviews and what further questions need to be answered. For patients who have been affected, this process is crucial for their healing and closure, as far as possible.

2.5 All the stakeholder groups above commented that the reviews carried out to date had (to different degrees across each of the organisations):

- been impaired in their methods, relying as they did on clinical notes which are believed to have been unreliable
- failed to tell the stories of affected patients well - in some cases, they failed to even try to do so
- not reviewed a large enough sample of cases (with the exception of the Spire), which led to perceptions that they were only doing the "bare minimum" or were trying to "cover up" issues raised about earlier cases
- in the case of the NCA specifically, did not sufficiently answer key questions about organisational governance, leadership and culture which allowed for these events to occur and recur

2.6 Chapter 4 details how the lives of the patients we spoke to have been significantly impacted by their condition and/or experience. They believe the treatment they received made their situation worse and they have not been able to accept the answers given to them by the organisations involved. The manner in which some of the review work was carried out has exacerbated this feeling. Some are left with the belief that failings have been covered up, which has further compounded their suffering. On meeting patients and their families, it became clear that some also hold a heavy burden of responsibility, worrying about patients who may not be aware of the concerns about Consultant Surgeon A's practice and as a result, worry that their safety may be at risk.

2.7 There is also a small number of current and former staff who worked closely with Consultant Surgeon A, who feel that the reviews carried out so far have not sufficiently revealed the scale of

the issues they believe took place. This has seriously eroded their trust in the NCA and continues to cast a shadow over the department today. A small number told us that their mental health and wellbeing has been seriously impacted by these events.

2.8 More than 10 years have passed since Consultant Surgeon A left the NCA. Since that time, the organisation has changed materially, and it has become one of the largest NHS organisations in the country. Its Board members were not in post at the time of these events, and most are new to the organisation. Governance, leadership and operational structures have changed significantly. These continue to evolve at the time of writing, for example, through the introduction of a new Clinical Leadership Model, work on safety culture and antiracism initiatives. Many of the surgeons and staff working there today have never known or worked with Consultant Surgeon A, and they struggle to understand why these issues continue to surface. Nonetheless, a high degree of interest in the service persists and it is possible that a second inquest into the death of Catherine O'Connor will be opened in 2026.

2.9 We heard repeatedly that staff are working hard to move the service forward and deliver an excellent service for Greater Manchester. All acknowledged how much the service has progressed in the past 10 years and were saddened by the reputational damage these events have caused.

2.10 In our opinion, the look back work carried out to date (in the NCA SPSLBR, the RMCH look back review, the Spire PNE and the Breen Report) has been carried out in good faith. It is clear that the leaders of the organisations involved have invested significant resource and effort into investigating these matters. This is particularly the case for the NCA, which initiated the reviews, and commissioned an additional, detailed piece of work from an experienced employment legal specialist to understand colleagues' wider concerns (outwith clinical practice) around these matters.

2.11 The organisations who commissioned each of these reports set out to do so to manage risks to patient safety and, where possible, to find answers to patients' questions. We recognise that this work was often completed in challenging circumstances, which varied depending on the context of each organisation. However, in several cases, some of the approaches and / or methods taken compromised the quality of the resulting report and there is important learning to be taken from them. This is explored at Chapter 5. In some cases this has been recognised by those who oversaw the work.

NCA SPSLBR

2.12 The NCA SPSLBR was the first look back review to be commissioned. Recognising the scale of work undertaken in very challenging circumstances, there are however several concerns with this report.

2.13 Patient engagement in the process was limited and reactive and did not meet the standards set out in national guidance for conducting a patient recall[4]. Patients found out about the review through national media coverage about Consultant Surgeon A, which mentioned the look back review. The Trust has sought to learn from this and there is a section in the second look back report (dated September 2025) which seeks to describe the impacts of "*surgery as a traumatic event impacting life course*" and recognises the difficulties for patients in revisiting these events. In our opinion, this significantly strengthened the second report.

2.14 Once the first review began, patients were only told their care had been reviewed if the desktop review found potential evidence of harm. Again, the Trust sought to learn from this process and

[4] National Quality Board (2022) National Patient Recall Framework.

more patient engagement took place for the subsequent review of 40 patients, who asked for their care to be reviewed after the initial report had been published.

2.15 However, patients repeatedly told us that the methodology of the look back process is inherently flawed, relying as it does on the review of notes which (we were told) have been found to be unreliable.

2.16 A second and significant proportion of the dissatisfaction with the (first) report comes from the sample of cases reviewed, which covered a five-year period from 2009 to 2014. Staff involved in the review felt that they had been promised a look back at earlier practice, but that this has since been rescinded. We were told that expectations regarding the purpose of the review, the report's authorship and sign-off controls throughout were not aligned. It also appears that the review quickly became fraught with mistrust and perceptions of conflicts of interest. Consultant Surgeon A was a senior clinical leader who oversaw the department involved and was also well known in the specialism externally, which added a level of complexity to the process at the NCA.

2.17 We understand that it was very challenging to find an external reviewer whose independence could be assured; therefore internal resource had to be used to progress the reviews at a reasonable pace. However, this meant relying on the expertise of surgeons in the department that had formally raised concerns about Consultant Surgeon A to support the review. It must be acknowledged that this was a difficult position for all involved to find themselves in.

2.18 While those overseeing the review sought to manage these potential conflicts, some were later accused by staff of having covered up that they were aware of some of the issues much earlier. There were also several legal processes associated with these matters within the NCA. From our perspective, despite the best efforts of those involved, the disagreements on these elements compromised the overall quality and clarity of the work.

2.19 An important example is the lack of agreement and clarity about the amount of and the levels of harm. The report does not distinguish between harms attributed to Consultant Surgeon A's practice and other harms, whereas the RMCH and Spire reports separated them out. It is unclear how harm and levels of harm were assigned in the SPSLBR, or if a recognised framework was used to support this (Spire and RMCH reports referenced which guidance had been used). The report describes differences in opinion among the Trust's spinal surgeons about some of these levels of harm. In addition, included in the number of those harmed were deceased patients and those who did not want to be involved in the recall. It is unclear how these opined harms were validated.

2.20 Linked to these issues, the report did not include the use of benchmarking to form judgements about, for example, recognised complication rates, nor did it describe any use of weighting for case mix complexity.

2.21 It was not always clear how guidance had been applied, and therefore what the overall purpose of the review was. The recommendations made were transactional in nature, and did not consider the overall safety system staff were working in. Equally, the lessons learned and recommendations had little bearing on surgical practices or the concerns that had prompted the look back exercise. It was difficult to identify the flow of the report: from findings to recommendations and then to a clear action plan.

2.22 We were told that some key staff working in the department did not receive the action plan until late 2024, and that some surgeons felt aggrieved that what they believed should have been a review of one clinician's practice had instead led to calls for service-wide changes. Recent updates on the action plan highlighted a lack of engagement in the action plan by consultants in the service and the

pace of putting some of the actions in place has been slow. A clear process for the tracking of these actions is now in place and traction is being made.

2.23 The joint (orthopaedic and neurosurgery complex spines) MDT is still at a relatively early stage and job plans for neurosurgeons have not yet been arranged to allow for their full attendance. But it should be noted that a huge amount of highly skilled, expensive clinical time is being used in this forum, so it is essential that the cases discussed involve decision-making for complex patients and provide learning opportunities for attendees.

2.24 Despite the challenges outlined, we found that the neurosciences division had been proactive in making positive changes in the service, additional to the recommendations made in the SPSLBR and Breen Report; processes for pre-operative planning, consent and MDT working have been much improved since the time of the cases reviewed. Since 2024, the service has also been recognised as a European Spinal Centre of Excellence.[5] It remains a concern that, despite recommendations from the national Getting it Right First Time (GIRFT) lead for spinal surgery, the service still has not adopted use of the British Spine Registry (BSR). The Trust, more widely, has and continues to invite peer reviews across its services, which suggests an openness to external scrutiny and a willingness to learn.

2.25 Staff we spoke to in the service were committed to providing an excellent service for their patients and for Greater Manchester. There was a clear desire to move forward from these matters and to look to the future.

Breen Report

2.26 At the same time as the SPSLBR, the NCA commissioned a separate independent report to focus on the referral of Consultant Surgeon A to the General Medical Council (GMC) and to seek staff views on these matters; therefore, being more employment-orientated.

2.27 This was a complex investigation, incorporating evidence over a 15 year timeline. This included speaking to a wide range of people, including bereaved families and affected staff and patients. This was a significant investment on the part of the NCA and, again, we were told that securing a reviewer who would be seen as sufficiently independent was challenging.

2.28 Due to this complex scope, the resulting report is extensive and detailed. Given that the author was a barrister, it is natural the report would take a legal approach and tone. We were frequently told by patients and their families that the report was not accessible or easy to understand, and left several patients and staff members unclear about its conclusions. That said, we are also aware that at the time of its publication, several of those who contributed to the work fed back that it was a detailed, credible and helpful piece of work.

2.29 Some of the confusion we heard from people (over a year following the publication of the Breen Report) seemed to come from differing expectations about the review's scope and purpose. Several patients, families and staff involved expected the report to provide firmer conclusions and make recommendations about governance, leadership and cultural matters, including racism. However, the report concluded that there was insufficient evidence in some of these areas. It was also explicit about matters that were outside of the review scope, including whether bullying took place.

2.30 The organisation has taken the oversight of the Breen report seriously, and a board-level, non-executive attended committee has been established to oversee the resulting action plan. This group

[5] The Surgical Spine Centres of Excellence is a voluntary certification programme that aims to audit and certify the implementation of services that advance spine surgery and spine care. The criteria for certification is detailed in EUROSPINE Task Force Surgical Spine Centre of Excellence (SSCoE) Guidelines.

includes members who are affected patients and/or affected family members. The CEO has also sought to engage with each member of the bullied staff group (BSG) who is currently employed by the Trust.

2.31 Our review of the report found that its recommendations lacked clarity. A recommendations chapter is included, but the degree to which they are recommendations written in a style recognisable to the NHS is debatable. As already outlined, the author was an independent a barrister, not employed by the NHS, and was not instructed to use particular NHS guidance or frameworks in undertaking their work. Many of the 36 paragraphs in this section are the author's reflections or updates on practice the author became aware of during the writing of the report. Where recommendations are definitively made, they are lengthy and the desired outcome is not always clear. Staff working in the service echoed this point, telling us that they had had to "*interpret the action and outcome required*". In our view, this has limited the impact of the oversight work.

2.32 Whilst the Breen report is long and for some was difficult to interpret, it raised important issues for the NCA, which through the BROG they have started to address. Positively, the Trust has taken the opportunity to consider the context of the Breen observations more broadly and in several instances, actions have been developed to address improvements in areas not directly addressed by the report, for example in relation to MDT working. Work is also ongoing to seek to implement a clinical leadership model across the organisation, and an independent review of the Trust's quality governance arrangements is also underway.

RMCH look back review

2.33 Both the RMCH and the Spire's look back reviews were modelled on the methodology developed by the NCA for the SPSLBR, therefore some of the critique of the SPSLBR also applies to these reports, particularly the reliance on a desktop review of Consultant Surgeon A's notes.

2.34 We were told no reports of cultural issues had been made in the RMCH spinal surgery team. As a result, the process appears to have run more smoothly, and the purpose of the work was clearer. That said, some of the patients and families we spoke to pointed out that:

"There hasn't been a Breen Report at the Children's Hospital and Spire … we don't know what we don't know."

2.35 The increased amount of family engagement in this work, appears to have mitigated the reliance on clinical records. The review team (which included two independent and external spinal surgeons) sought to benchmark complication rates and to consider the risks of the procedures under review. Including supporting data or references would have strengthened the findings in these areas.

2.36 As in the Breen Report and the SPSLBR, the recommendations made in the RMCH review were also somewhat transactional and did not specify what outcomes were needed to improve patient safety. Some of the findings in the report have not been translated explicitly into recommendations, posing a risk that the review action plan is incomplete.

2.37 We were told that organisational change within MFT has impacted the embedding of governance structures, and that changes in divisional leadership have meant that governance meetings at this level have only recently been fully implemented. Actions taken to ensure appropriate oversight of spinal services need to be confirmed to ensure a clear line of sight from departmental level through to the Trust Board.

2.38 Where actions have been defined, good progress has been made in several areas; however (linked to the above) given their relatively transactional nature, it seems unlikely they will have a material impact on patient safety.

2.39 There are two significant actions outstanding at RMCH: a) consultant capacity in job plans remains insufficient to enable them to attend M&M and MDT meetings, and b) work is still ongoing to develop benchmarking data (such as dual surgeon operations and capacity and demand on the service). The service has recently started submitting data to the British Spine Registry (BSR) to support this. These are key safety controls that should now be progressed at pace. We were also told that incident reporting in the Spinal Surgery department remains low, and the reasons for this need to be better understood.

Spire patient notification exercise (PNE)

2.40 The Spire's PNE followed its internal policy on conducting a patient recall, which in turn links to national guidance in this area. Like at RMCH, we were told no reports of the cultural and behavioural issues reported at the NCA had been made. In our view, these two factors led to the PNE report having a clearer purpose and outcomes.

2.41 All of Consultant Surgeon A's patients were reviewed by the Spire and key dates, such as the death of Catherine O'Connor, were factored into the decision-making around the recall scope.

2.42 We found that the description and breakdown of harms in this (interim) report was clearer than in those described above, and that 'inconclusive' and 'unquantifiable' harms were described in more detail than in the first report.

2.43 Because this was explicitly a recall exercise, no action plan was developed (for clarity, we do not view this as a weakness). Instead, findings from the PNE have been drawn into the Spire's existing improvement work. A thematic review of PNEs is completed every three years; feedback is taken from staff who have been involved in PNEs, and the outcomes of the reviews are shared with staff at learning events.

2.44 The most recent thematic review was finalised in July 2025. It outlines 19 themes from PNEs which had concluded or were still underway at the time of this report. Acknowledging that the PNEs reviewed may have been historic, we noted that several of these are relevant to findings discussed throughout our report in relation to the Consultant Surgeon A case. It is important that the Spire continually reviews the impact of improvement actions to ensure that they have had the desired impact and to reduce the risk of similar events recurring.

2.45 We reviewed a sample of evidence of the changes the Spire told us they had made that were relevant to this case. We noted a significant number of changes to the practices that had been in place at the time that Consultant Surgeon A was operating, including, for example, the process for raising concerns, oversight of individual consultant's performance, and how much audit activity takes place. In the future, it will be important for the Spire to continue to monitor the impact and embeddedness of these improvement actions.

Next steps

2.46 From our findings outlined in this summary, we make a series of recommendations, aimed at:

- completing and evidencing the impact of recommendations already made
- addressing the findings in previous reports where formal recommendations were not made
- addressing a small number of further recommendations identified by this work

2.47 Our recommendations are provided in full in Chapter 9.

2.48 We were also asked to recommend any further review/recall/look back activities required. We have concluded that, for at least a three-year period, any previous patient of Consultant Surgeon A who requests a review of their care should be offered an in-person consultation, even if no harm has been identified by previous reviews. This should be available to any patient who has had surgery performed by Consultant Surgeon A at any of the three organisations where he worked. Chapter 6 describes how we reached this conclusion.

2.49 There are those we spoke to who will believe this recommendation should go further, yet all the surgical opinions we received (both internal and external to the NCA) were consistent in the view that patients in need of further intervention would have come forward by now, either through re-referral to the service, through follow-up appointments or by presenting at neighbouring hospital services. When we asked current and former staff about this matter directly, only one person felt there was any patient safety value in recalling more patients or risk of not doing so.

2.50 Significant concerns were shared about the possibility of extending the recall because of the lack of available information. We note here that the unavailability of clinical records mentioned in each report was more pronounced the more historic a case was. We are aware that only one patient has been recommended to consider further surgery as a result of the look back reviews.

2.51 There are also calls for a phase 2 review to focus on the outstanding questions not covered by the look back work completed to date. These are:

- How would a similar issue be handled in each department today to ensure patient safety?
- Within the NCA/SRFT, what was known about these matters historically, and at what key points could different action have been taken?

2.52 Since previous reports have not been able to fully answer the latter, a feasibility study would be required to understand the availability of the key information needed to carry out this work. A draft terms of reference for this work is provided in Appendix 5.

Chapter 3: Context and history of spinal surgery in England

History and current context

3.1 Complex spinal surgery in the NHS has undergone significant changes over the past three decades. Spinal surgery has become a formal subspecialty, with both orthopaedic and neurosurgical disciplines contributing. Today, spinal procedures make up 14% of orthopaedic and 60% of neurosurgical practice. Most spinal surgery in the NHS is delivered in specialist centres which provide both regional services for complex planned and emergency spinal surgery, in addition to local services for patients with more common spinal conditions.

3.2 The demand for these services is huge, with back pain being the second most common presenting complaint in primary care, often resulting in onward referrals for further opinion and imaging. Information from the BSR shows the significant growth in recorded patient pathways: the number of patients recorded on the deformity pathway rose from just 138 in 2012 to over 6,600 in 2021. NHS England now mandates that data on spinal surgery is entered into the BSR.

3.3 The increase in demand for these services is being driven by an ageing population with more degenerative conditions, and by technical advances in the specialty, anaesthetics and critical care, enabling more patients to benefit from surgery. This, along with a significant proportion of major trauma patients who have associated spinal injury, has led to an increased workload in spinal surgery centres. Many of these acute conditions are time critical from a neurological point of view, as any delay in treatment could lead to lifelong health issues for the patient. This can have a significant impact on the patient's quality of life, affecting their work and earnings, day-to-day functioning and their relationships.

3.4 Surgeons from either an orthopaedic or neurosurgery background perform spinal surgical procedures. Most are carried out by surgeons from either training background, but generally neurosurgeons perform the intradural work, while orthopaedic spine surgeons perform paediatric spine deformity surgery.

3.5 Training for surgeons has improved in recent years; it is now standard for surgeons nearing the end of their specialty training (whether it be in orthopaedics or neurosurgery) to join spinal fellowship programmes in specialist spinal centres. They provide opportunities for surgeons to get more operative experience and to receive mentorship in spinal surgery before taking on the responsibilities of a consultant post and expose surgeons to both orthopaedic and neurosurgical disciplines.

The use of the multidisciplinary team (MDT)

3.6 Like many other specialities, spinal surgeons rely heavily on collaborative working with colleagues from, for example, radiology, infectious diseases, oncology, specialist physiotherapists, spinal nurses and others. The main platform for this collaboration is the MDT meeting, which over the years has come to be an integral part of consultant job plans. Over the last decade, MDTs nationally have developed into a more formal process, with their structures, composition and documentation becoming increasingly standardised.

3.7 MDT meetings provide a forum to discuss a patient's clinical presentation, any uncertainties about the treatment plan, nuances of clinical presentation, patient-related factors, radiological findings, management options and risks. The final decision in relation to a patient's clinical management is based on the group's shared experience and the current evidence base. Usually, a consensus

opinion is reached by the MDT, which in turn should help to inform shared decision-making with the patient.

Common risks associated with spinal surgery

3.8 Most adult elective spine conditions can be treated non-operatively with physiotherapy or injections. If conservative management fails, for the correct indication, surgery usually has very good outcomes. In about 10 to 20% of patients surgery may be required. Among adults, elective spinal surgery is usually performed:

- To treat neural issues, such as nerve compression or spinal cord compression (via discectomy or spinal decompression)
- To treat instability (i.e. excessive movement between vertebrae causing mechanical issues requiring stabilisation)
- To correct spinal deformity, which can be associated with the above issues i.e. nerve related issues, instability or progressive deformity with associated cosmetic issues.

3.9 There have been significant advances in spinal surgery, such as in the instrumentation used, the development of minimally invasive procedures, and navigation as just a few examples. Spinal deformity correction surgery has also progressed over the past 30 years, resulting in improved outcomes thanks to better surgical techniques, the introduction of enabling technology, improved spine monitoring technology and data tracking. These factors, along with robust MDT discussion as outlined above, and shared decision making have helped improve outcomes in spinal surgery.

3.10 However spinal surgery procedures are associated with several risks. Some of these can be catastrophic, leading to lifelong conditions. While extremely rare, some risks can be fatal. Adverse events are slightly more common with complex spine procedures. To mitigate this risk in 2008 the British Scoliosis Society (BSS) made recommendations[6]

"*that complex paediatric and adult spine deformity procedures should be performed as dual surgeon procedures which allows there to be the expertise of two surgeons to help minimise complications*".

This has become the norm in most centres that perform complex spine surgical procedures. Sharing options and risk information with patients and giving them the time and support to understand it so they can make an informed decision about surgery is vital.

3.11 The complication most commonly experienced by patients is post-operative infection (1-4%) in paediatric deformity surgery. Any spinal surgical procedure has a significant risk of neurological complications, which is higher in spine deformity correction. These include weakness in the limbs, paralysis, altered sensation (tingling, numbness) and bladder or bowel related issues. The use of minimally invasive surgery over the past decade, along with navigation and improvement in magnification (either by using microscope or loops), has helped mitigate this risk in routine spinal surgery procedures, such as discectomies, nerve decompression and stabilisation. From a spine deformity point of view, intra-operative spinal cord monitoring is now a mandatory requirement for the correction of scoliosis to prevent neurological complications. This has been the standard for over 20 years. The risk of neurological complications is 0.5-1%.

3.12 Spinal implant-related problems can occur after spinal stabilisation and spine deformity correction surgery, with malposition of the screws being the most common implant-related problem. A misplaced pedicle screw can cause neurological or vascular problems. In patients with scoliosis, the

[6] BSS (2008) Recommended Standards of Care for Patients with Spinal Deformity

curvature of the spine presents significant challenges to implanting a pedicle screw. This difficulty is greater in paediatric cases, due to the smaller size of the bones in the spine (vertebrae).

3.13 In paediatric deformity surgery various studies have shown that 5-20% of pedicle screws are malpositioned (Amaral et al, 2021, Mun Keong Kwan et al, 2017, Yin Wei Chang and Mun Keong Kwan 2017, Lehman Jr et al 2007), with most breaching the lateral wall of the pedicle (that is, the outer part, which is away from the spinal cord). This does not usually cause any significant neurological issues.

3.14 The standard technique for implanting pedicle screws is a free-hand technique, relying on anatomical landmarks to implant the screws. Some surgeons use x-ray guidance while implanting the pedicle screws free-hand, but this increases the radiation exposure for the patient and the wider operating team.

3.15 In the past 5 to 10 years, advances in enabling technologies such as computerised tomography (CT) navigation, robotic navigation or patient specific spine jigs (guides) have mitigated the risk of screw malposition. These technologies support the safe and accurate implantation of screws, lowering the risk of malpositioning, which in turn reduces the risk of neurological injury. However, it should be noted that these enabling technologies carry a high financial cost and are currently only used in a few paediatric spinal centres. This means that free-hand pedicle screw placement is still the most commonly used technique.

3.16 A further major risk of paediatric scoliosis surgery is blood loss resulting from the need to expose the spinal column from the muscles and bones. This can lead to excessive bleeding throughout the operation, which can increase towards the end of the procedure. The team should anticipate this and plan for it in advance of the surgery.

3.17 A number of techniques have been introduced over the years to mitigate the risk of blood loss, including hypotensive anaesthesia[7], drugs such as tranexamic acid to reduce blood loss, and cell salvage[8]. Dual surgeon operating (two surgeons working together in a single procedure) also helps reduce blood loss. Having the expertise of two experienced surgeons to expose the spine and handle the tissue can also reduce the length of the surgery.

3.18 Although less common in deformity cases, minimally invasive approaches are emerging for select patients, reducing recovery time and blood loss.

Concluding words

3.19 Spinal surgery is often a high-risk activity. It can be an emotionally charged and difficult decision for patients and their families to make. While it can offer life-changing benefits, it also carries a small but significant risk of devastating consequences.

3.20 Informed consent processes for patients and safe environments for clinical teams to work in are key to mitigating these risks.

[7] This means maintaining a relatively low blood pressure under careful monitoring.
[8] In which blood is collected from the wound by suction during the surgery and is then filtered and transfused back to the patient.

Chapter 4: The voice of patients, families and carers

> *"I used to think that I was unlucky the way things had turned out, but now I know that what has happened needn't have … Things could have been so different."*

Introduction

4.1 There is no doubt that some patients operated on by Consultant Surgeon A have been harmed. Despite their shortcomings, the look back reviews that started in 2022 identified that a minority of patients were harmed by the substandard surgical care, including planning and aftercare, they received from Consultant Surgeon A.

4.2 Some of the impacts on these patients are described in clinical terms in these reports, but the patients and family group members also told us about the significant negative impacts on their everyday lives they have been experiencing since their operations.

4.3 As detailed in the method section, it was important for us to give recognition to those whose voices had not been heard sufficiently in the review processes to date. We engaged with affected patients and their families in a variety of ways, in the hope of encouraging and supporting as many as possible to share their views and experiences with us. Using appreciative enquiry, we have recorded the stories of patients and their families in this chapter. We were not commissioned to investigate their experiences further. We also note that some of these people have brought legal cases to the providers of their care.

4.4 Because of the patient cohort we spoke to (those involved with or known to the patient group), the feedback about Consultant Surgeon A was overwhelmingly negative about the care and treatment patients had received and also his "*manner*" with patients and families. We were not able to talk to people who felt their care had been good and their outcomes positive, although we did meet one individual who felt that their surgery had changed their life for the better. We want to make clear that it is likely that if we had talked to a more representative sample we may have heard more positive stories of this nature.

4.5 We were not commissioned to provide a clinical opinion on the concerns raised to us through this work.

4.6 Each person we spoke to shared details of how these failings in their care affected their lives and the lives of their families, including the physical, psychological and functional impacts. In many cases, this was compounded in the years since their treatment by the lack of openness, compassion and support from the organisations where Consultant Surgeon A worked, as well as their struggles to find information that would help them understand the full extent of what happened to them.

Key concerns

4.7 We heard from people who had walked into the operating theatre and never walked again, who have been left in permanent pain, who had been left unable to work again or to live the life they had hoped for. We also heard from the family and friends of Catherine, the young girl who tragically died on the operating table during surgery by Consultant Surgeon A.

4.8 We recognise that revisiting and retelling their experiences of such stressful times carries its own emotional burden, which should not be underestimated. We are very grateful to the patients and their families for sharing their experiences with us. Many continue to experience physical pain and/or have significant disabilities that require ongoing care.

4.9 The look back reviews identified key deficits in the care, treatment and service offered to patients by Consultant Surgeon A including:

- poor surgical technique
- poorly planned surgery
- high blood loss
- poor communications with patients and their families
- failures to be open and honest
- poor consent processes, including not sharing risks with patients
- poor documentation, often inaccurate or inconsistent with the records of other healthcare professionals
- unprofessional behaviours

4.10 The accounts we heard made real the impact of these shortcomings. The people we spoke with reported experiencing a range of serious complications immediately after their surgery, many of which were either minimised or not recorded in their notes[9]. They also told us of a range of chronic, ongoing and longer-term complications and negative impacts caused or made worse by their surgery and emphasised the enduring impact these have had on their lives.

4.11 We heard from people living with physical impacts, such as constant debilitating pain, chronic headaches, fatigue and lack of mobility, who described how their lives, relationships, hopes and expectations had been impacted. They described how this had resulted in numerous losses, including time with family, missed education, loss of income, relationships and career opportunities. It has left many people fearful about their futures and mourning the effect on family members, their relationships and more. It also left many distrustful of health services and afraid of the future surgeries they are likely to need.

4.12 Below is a selection of individual stories, as told to us by affected patients and families. The review team has not investigated these accounts.

> Patient B had surgery in 2005 which had to be abandoned. She was told her left side had been temporarily paralysed. She described how she walked into the hospital but never walked unaided again. No explanation was given to her as to why the surgery had to be abandoned. She was called in for a review three years ago and told that Consultant Surgeon A had placed the screws incorrectly and caused severe nerve damage. She explained that she was an active person before the surgery but now needs a wheelchair most of the time.

[9] The review team was not commissioned to and has not investigated these matters.

Patient C had an operation in May 2013. The operation had to be halted after she lost a significant amount of blood, requiring a transfusion of over 17 units of various blood products and had to be transferred to the intensive care unit. While there, the staff tried to get hold of Consultant Surgeon A for advice in the early hours of the morning due to their concerns with the continuation of extensive blood loss, but they were unable to contact him. Patient C was taken back to theatre for the surgery to be completed 10 days later. Since the operations she has lived with severe pain and has intermittent periods of back spasms that can leave her bed- or chair-bound for weeks at a time. She has lost five inches in height since the operation, and her breathing is now affected. The look back review found that she had suffered low harm
Patient D had an operation to straighten her spine at Salford Royal Hospital in 2007. Her parents were given no indication that it was a high-risk operation. She died on the operating table, aged just 17, after losing a large amount of blood. When Consultant Surgeon A met with the parents afterwards, he told them "*she just bled to death*". They were not aware of any concerns about Consultant Surgeon A's practice until senior staff from the Trust arrived unannounced at their house just before the Sunday Times article was published.
Patient K had an operation in 2014 to stabilise her spine following a traumatic spinal fracture. She was told that the operation went well, although her husband noted that it took two hours longer than anticipated. She later found out that Consultant Surgeon A had become angry, thrown a surgical instrument across the theatre and walked out of theatre in the middle of her operation, leaving her on the operating table. Once the operation was completed, a nurse phoned her husband and told him the operation had gone well and there was no mention of the time she was left on the operating table with an open wound.
Patient Q had an operation for scoliosis in 1994 at RMCH. She did not experience any major complications after the operation. When she heard that other patients had been harmed by Consultant Surgeon A, she tried to find out information about her own case. However, her notes were missing and RMCH were not able to provide any reassurance. She remains worried that she may have been affected without knowing.
Patient S had multiple operations at both RMCH and Salford Royal Hospital between 1998 and 2012. Each operation was performed after either an infection or the failure of the previous operation. She suffered multiple post-operative issues including metalwork sticking out of her skin and severe infections, including sepsis, which required long stays in hospital and invasive treatment. She has since found out that she lost a lot of blood during her first operation. She remains in constant pain, which is exhausting. She has post-sepsis syndrome and remains in a wheelchair.
Patient T had unsuccessful surgery at Salford Royal Hospital in 2009 when a cage was inserted. Patient T had to undergo further surgery in 2010 as the cage was unstable. She was told that the operation had been a success, but instead of easing, the pain increased. After two years of suffering she was told that the screws Consultant A had used were too big and had been misplaced. One screw was touching a major artery, significantly increasing her chance of rupture and putting her at severe risk of harm. This resulted in her having to undergo a difficult third surgery to replace the misplaced screw with the correct sized screw, which again put her life at risk. She underwent this surgery in October 2012. Consultant A was advised that a vascular surgeon should be present at this surgery because of the proximity of the screw to the artery, but he refused.

Patient W had an operation in 2009 at the Spire. She was initially told that the surgery had been successful, but she was in severe pain afterwards. Her Mum refused to take her home until the pain was better controlled. Unfortunately, it got worse over the next few months, necessitating high doses of opioids and other painkillers. Consultant Surgeon A continually dismissed her concerns, even though she was on very high levels of painkillers. Six months after the operation it was found that her pelvis had been broken during or just after the operation. She continues to live with chronic pain.

Patient A had an operation at RMCH in 2006 for kyphosis and scoliosis. Spinal rods were inserted. Consultant Surgeon A said it was a "*textbook operation*", but two hours later she was paralysed. She was taken back to theatre to remove the rods, and six weeks later she returned to have them reinserted. She remained in hospital for 14 months. The paralysis never went away. She now needs full-time care, which is provided by her family plus overnight carers.

4.13 Impacts described in the words of patients and their families:

"*She lost a good active physical life through the multiple spinal operations not through the general effects of spina bifida*".

"*Because of the pain, I had to give up a job I had worked so hard for … and in doing so, essentially had nothing worth living for*".

"*The damage from these surgeries has resulted in me suffering from constant chronic pain and limited mobility for which I have had to take a cocktail of opiate based medication for over 15 years now*".

"*I walked into the hospital but after surgery I never walked unaided again*".

"*Having to retire at the age of 42 was a particularly dark time for me. I felt that I had lost my independence, lost my confidence and I started to suffer from anxiety and depression and withdrew from friends and family. I have worked hard to try to overcome these feelings, but they have re-emerged recently with the trauma of having to relive my experience. As a coping mechanism, I told myself that I was just one of the unlucky ones and to move forward as best I could. A feeling I have heard many times since from other patients affected by [Consultant Surgeon A]…*".

"*I enjoyed work, it was important for my wellbeing - but after the surgery I was unable to work again*".

"*Two hours after the operation, I was paralysed. I will never be able to live independently*".

"*After every operation, Consultant Surgeon A told us it had gone well despite multiple complications … and requiring multiple further surgeries … when the registrar told Consultant Surgeon A that the metalwork was coming through her skin, he refused to believe them*".

"*It's ruined-our life on an ongoing basis. We live in mental pain*".

Distress caused by conduct

4.14 Understandably, the impact of Consultant Surgeon A's substandard clinical care has been the main area of concern, but we also heard a lot of anger about the way Consultant Surgeon A conducted himself and communicated with patients and families. Patients and families feel that there has not been enough recognition of the harm done by Consultant Surgeon A's behaviour and the way he treated patients and families.

4.15 It has previously been documented (for example in the Breen Report) that Consultant Surgeon A behaved in an inappropriate and sexualised way with some patients and some staff members. Several examples were shared with us. Again, the review team has not investigated these matters:

- One patient told us how nursing staff had warned her about Consultant Surgeon A, saying "*watch him he's a ladies' man*". She also described an incident where he put his hand under the covers to "*play with*" her feet and toes on one occasion, which made her feel extremely uncomfortable.
- Another told us how Consultant Surgeon A would make her undress completely at every appointment and would examine her with his hands.
- A third person told us how on the day of her admission, Consultant Surgeon A, took her into a toilet cubicle, unchaperoned, to mark her back for surgery, instead of waiting for an available clinical cubicle. She told us "*nursing staff witnessed me and Consultant Surgeon A exiting the toilet cubicle in disbelief and later asked if I wanted to make a formal complaint. I didn't make a complaint, as I was still under Consultant Surgeon A's care and didn't want it to interfere with my treatment.*"

4.16 Many patients and family members described Consultant Surgeon A's manner in dealing with them in very negative terms, using words such as "*pompous*", "*arrogant*" *and* "*full of his own importance*". Several described his approach as "*callous*".

4.17 We also heard repeatedly from patients and family members how Consultant Surgeon A dismissed their concerns and questions about the risks of the operations which he planned to carry out. One said "*he made me feel stupid and worthless. His having power and control was more important than doing the best by his patients … it was as though he was doing me a huge favour seeing me and I should be grateful and not question him*".

4.18 They also described how other staff were scared of him, and some had heard him shouting at other staff members.

4.19 The other issue on which there was widespread agreement, was that after operations had taken place, Consultant Surgeon A consistently and persistently told patients that they had gone well, even when this contradicted their experiences.

"*Following insertion of the rods and screws I was in an immense amount of pain. X-rays were performed and I was told they were satisfactory. I have since learned that they were far from satisfactory. No scans were performed at the time. I was told that the pain would settle down in time, my pain relief was increased, and I was discharged after 10 days*".

4.20 Clinicians who carried out look back reviews concluded that Consultant Surgeon A's post-operative notes were often very brief. One of them told us that they "*invariably stated that everything had gone very well*."

Impact on patients' families

4.21 It is not just patients who have been affected. Family members have also been negatively impacted by the emotional trauma of supporting their loved ones through such difficult times and the immense mental and physical challenges caused. People we spoke to described what they have been through as emotionally and physically exhausting, impacting on key relationships, jobs, income, family dynamics and much more.

4.22 The impact and harm families have experienced has been, and remains, significant in many cases, yet it has not been fully recognised or acknowledged in previous reviews, although the follow-up NCA report has sought to address it more.

We were told of the distress they experienced in seeing their loved ones suffer and change. Some constantly relive the day of the surgery and struggle to move on from it, even years later. Some, especially parents, feel guilt that they "*allowed*" their loved one to have surgery, believing it would help them, only to see it do the very opposite. "*If only we'd known then what we know now we would not have allowed the operation to go ahead*".

4.23 Losing a loved one or managing the daily realities of supporting a loved one who is significantly disabled and/or in chronic pain has been compounded by the pain of finding out that this was not just a case of bad luck but happened because of substandard medical treatment by someone they trusted.

4.24 Despite everything, both patients and family members have shown great integrity and strength, with the group determined to try to make a positive change for others as well as for themselves.

Patients' and families' experiences of the look backs

4.25 In addition to the harm and distress caused by the procedures and how the patients and family members were treated; additional distress has been caused by the way the organisations handled matters. For example, patients being made aware of issues through the Sunday Times article, and the lack of engagement in some of the review work.

4.26 One person explained to us that, after so many years they had "*put their concerns to bed*" but the newspaper article and look back reviews brought their concerns back to the surface and their feelings felt "*raw again*". Another said, "*it was a complete and utter shock to hear that story about what happened during her surgery … we all have PTSD … its visceral*".

4.27 There was consensus that the reviews conducted to date had not been particularly helpful for many of the patients cared for by Consultant Surgeon A, for a variety of reasons. The main reason was that they had a narrow focus and that the patients themselves, their views, experiences and their current conditions, were not at the centre of the process. Chapter 5 explores this in more detail and concludes that some of the reviews did this better than others.

4.28 Many of the patients we spoke to had already been reviewed as part of the look back reviews. However, their experiences of the process and its impact on them differed significantly. Approaches differed in relation to what they were told, how things were communicated to them (or not) and what, if any, resolution or support was offered.

4.29 In many cases the conclusions did not chime with the lived experience of the patients and families concerned. For example, some of the operations deemed "*successful*" or causing "*no harm*" in the review had resulted in a person becoming paralysed, living with chronic pain or with significantly reduced functionality and mobility. The patients living with these outcomes would not classify the operations in this way.

4.30 Patients and families expressed concerns that:

- only patients seen during a specific five-year period had had their care reviewed, this left patients operated on outside this period, unreviewed, "*in the dark*" and potentially at risk of serious harm
- reviews were based on notes that were often poorly written, incomplete and biased towards Consultant Surgeon A's view of events, rather than the patient experience

- when no notes were available, no review was carried out, which patients and families found unsatisfactory and believed that in such cases patients should be called in for clinical review to ensure they had not been harmed and to provide assurance
- many reviews did not take into account a patient's current condition, experiences and, often, their deterioration since their discharge from hospital
- reviews were conducted by surgeons who knew or worked with Consultant Surgeon A and patients and families felt this could introduce bias

4.31 There was a fair degree of consensus among past patients and their families about what they would like to see in future reviews. They wanted the look back reviews to continue and a recall which:

- reaches out to as many former patients as possible
- enables individual patients to find out exactly what happened to them, to support them to fully understand it, to be able to identify whether they had been harmed by Consultant Surgeon A but also, where evidence is not available (for example, because of poor or lost clinical notes) that they could still find answers to these questions

  "*Most people want a review based on their clinical condition now, not based on a poorly written, or incomplete set of notes from 10 or more years ago*"
- offers a face-to-face review with a knowledgeable clinician if they wish
- is delivered compassionately and provides patients and families with an acknowledgement of the long-term damage caused by Consultant Surgeon A's treatment and of the emotional and psychological burden caused.
- offers immediate referral to further treatment (surgical or otherwise) or support (psychological or otherwise) where required
- provides information at a level each patient or family wants - there was a recognition that, while some people want all the technical detail, others do not and just want reassurance or a chance for their current condition to be reviewed in a timely manner

4.32 Accessibility, both physical and otherwise, must be considered in any future review or approach. The organisations involved must work together to ensure that approaches taken are based on what is easiest for patients and their families.

4.33 Organisations also need to carefully consider the language they use when communicating with patients. This is something that has already caused further distress to some patients and their families. In particular, for some, being referred to as "*complex cases*" has come across as an attempt by the organisations involved to undermine and minimise the suffering of individuals and they have found the term unhelpful.

4.34 Our engagement with affected patients and families clearly showed that there is no typical patient or family and that any future reviews need to be based on this understanding to promote fairness, respect, compassion and inclusivity and to ensure that those affected get what they need from the process.

Chapter 5: Terms of reference for previous reviews

Overview

5.1 In this chapter we review the terms of reference and approach of the four reports available that fall within our scope. These are:

- A report for the Northern Care Alliance NHS Foundation Trust Spinal Patient Safety Look Back Review ("SPSLBR") and its follow-up addendum, dated September 2025 and not yet published
- Royal Manchester Children's Hospital Spinal Safety Look Back Review (RMCH SPSLBR)
- The Spire Spinal Safety Look Back Review (Interim Report), March 2024, (Spire PNE), unpublished
- Investigation report on behalf of the Northern Care Alliance NHS Foundation Trust (NCA) (known as The Breen Report)

5.2 Other reviews linked to these matters have been undertaken, including by the Royal College of Surgeons and an NCA internally produced report in 2016. These fall outside our scope.

5.3 Our terms of reference in this area required us to

"*review the previous Terms of Reference, reviewing the consistency of application of previously agreed definitions e.g. instrumental/ implantable surgery and the methodology and timelines from existing reviews for the purpose of identification of any new cohorts of patients to be reviewed clinically or to have an alternative look back process*".

5.4 In this chapter we analyse each of the reports in turn against these areas and triangulate this with our findings from our desktop review and with the concerns raised with us through our engagement work. The purpose of this is to identify any further look back processes needed. We used the outputs of this analysis to inform the options appraisal for a further look back, which is presented at the end of this chapter.

Application of previously agreed definitions

5.5 Our terms of reference asked us to review the consistency of agreed definitions, including 'instrumented' and 'non-instrumented'. Our reviews of the terms of reference and the resulting reports did not find any issues in this area, particularly as both the RMCH and Spire followed the methodology initially set by the NCA.

5.6 We tested several spinal surgeons' understanding of 'instrumented/instrumental' in our interviews; all were clear that this meant procedures involving the insertion of metalwork.

5.7 We did not identify any other relevant technical terms that needed investigation for consistency of understanding in the reviews carried out to date.

Analysis of these reports

NCA look back review

Patients in scope

5.8 This review focused on identifying patients who:

- had instrumental surgery under Consultant Surgeon A between August 2009 and September 2014
- were identified to have:
    - had subsequent surgery
    - new information
    - subsequently been seen in clinic
    - self-identified
    - brought litigation action
    - brought a complaint
    - had an inquest
    - had subsequent adverse incident reports

5.9 The report does not state why the time frame was selected.

5.10 The report outlines that some of the staff group involved felt that all patients seen by Consultant Surgeon A should have a full clinical review to ensure their safety. However, the report concluded that:

- additional learning themes were unlikely to be identified from such a process
- securing records going further back than August 2009 would be difficult and that most images before 2005 would be unavailable for review
- in a patient group treated before August 2009, fewer patients would be available for recall due to death or emigration
- witness statements become more unreliable and challenging to obtain over time

5.11 When we interviewed consultants who had been closely involved in these matters, only one person, when asked directly, felt there was a need for a full look back review of Consultant Surgeon A's practice. We explore this further in Chapter 6.

Methods used

5.12 The NCA review was initially intended to be carried out wholly independently. The expert chosen was a consultant adult and paediatric orthopaedic spinal surgeon working outside the Manchester health system, who had no identified conflicts with Consultant Surgeon A. We were told that, given the high profile of Consultant Surgeon A in the specialism, sourcing this independence presented significant challenges. A key comment was "*the spinal surgery world is so small that it would be impossible not to know of Consultant Surgeon A*".

5.13 Over time, due to the volume of cases identified for review, it became necessary for the workload to be shared across the Trust's spinal surgeons, so that the work could progress at a reasonable pace.

5.14 We understand that the Trust reported on the SPSLBR process to NHS England, the ICB, the CQC and NHS Resolution's Significant Concerns Group. No concerns about the planned methodology were raised with the Trust. The following methods were used:

- The Trust's clinical coding team searched for patients who were operated on by Consultant Surgeon A in the defined time frame. They used the operating theatre management system and admitted patient care episode data. The list of patients was manually cleansed to remove duplicates and non-instrumented cases. It was then refined to identify the patients who met the

scope requirements. This included searching the current and former incident management systems.

- Initially, the independent expert reviewer undertook a priority review of five cases where there were known concerns and that had been identified through the FTSU process. These were selected by some of the Trust's spinal surgeons and anaesthetists.
- A desktop review process of the cases identified then took place. For each patient, a structured case review using a defined proforma was applied. The purpose of this was to:
    - exclude cases where there was sufficient evidence to exclude harm, complication, return to theatre or a negative surgical outcome
    - exclude cases where there was no evidence of a disagreement of recorded facts
    - identify patients who required a clinical recall appointment with an NCA spinal surgeon
- A round-table MDT approach to reviewing cases, including the Trust's spinal surgeons. Cases where concerns were identified were presented by the reviewing surgeon to the independent expert, including the scan images and notes used for discussion and to agree next steps.
- Letters were sent to patients where harm was identified.
- Clinical recall appointments were made where required, using a structured case review method.
- A thematic review of the outcomes of recall appointments was produced for learning and to inform actions.

5.15 Following the publication of the NCA SPSLBR in July 2023 and the publication of the Breen Report, in March 2024, it was agreed that any patients who came forward with concerns about their care would also be reviewed by the NCA. Forty additional patients came forward, but clinical notes were only available for 37 of them. Of the 37 patients, clinical concerns were identified in six cases. No new themes or learning were identified in the resulting addendum report.

5.16 For the additional 37 patients, learning was taken from the previous look back exercise, and:

- any patient expressing concern was reviewed, they did not need to meet the criteria at 5.4
- all cases were reviewed by independent reviewers
- harm levels were assessed using a national policy[10]
- any patient or family requesting a meeting with the Trust had one

5.17 The approach to identifying the patient cohort in scope, as well as the review methods described above, were largely the same across the three organisations (NCA, RMCH/MFT and the Spire). We were told by the respective chief medical officers and medical directors that this was intentional to ensure consistency and to help with the interpretation of outcomes.

5.18 However, there were some notable differences in terms of how the methods were applied, which had a material impact on patient and stakeholders' satisfaction with the resulting reports. These include approaches taken to engaging with patients and the timeframes used (described at 5.79).

5.19 A consistent concern in all three clinical reports (NCA, RMCH, Spire) is the first-stage reliance on documented notes, given that all organisations found weaknesses in the quality of Consultant Surgeon A's note taking. As outlined in Chapter 4, some patients also told us that their clinical

[10] NHS England (updated 2024) Policy Guidance on Recording Patient Safety Events and Levels of Harm.

record did not align with what they told Consultant Surgeon A during appointments. This has led to a lack of faith among some stakeholders in the quality of the outcomes of the reviews, particularly where patient engagement approaches have also been insufficient to supplement and balance the clinical record account of events.

Patient engagement

5.20 As outlined in Chapter 4, patients and the public became aware of the NCA look back review when an article was published in The Sunday Times newspaper in June 2022. We understand that prior to this, Duty of Candour meetings had been planned with affected patients and their families, and psychological support funded by the Trust had also been arranged. However, it appears that confidential medical information regarding a deceased patient had been left outside their family's home, and provided to the Sunday Times, prompting the article (we understand that despite extensive investigations, the Trust has been unable to identify which employee leaked this information). In response to the Trust becoming aware about this, the CEO set up a hotline for affected patients to contact the Trust and a statement was uploaded to the Trust website about the review. The planned Duty of Candour meeting then had to take place with this particular family immediately. This unfortunate sequencing of events damaged trust and compounded the trauma some of the affected patients feel.

5.21 We were told by senior NCA leaders that, at the time of commissioning both the look back review and the Breen Report, some patients and families felt so damaged by their involvement with the NCA that they wanted nothing to do with either process.

5.22 Patients were only told that their care had been reviewed if the desktop review found potential evidence of harm. Where patients were identified for clinical recall, they were contacted by the spinal services department at the Trust. Where contact was not possible by telephone, details were re-checked. Letters were also sent to patients asking them to make contact by telephone or email.

5.23 A telephone hotline was set up for patients to contact the service, which remains open.

5.24 As outlined in 5.16, greater emphasis was placed on patient engagement in the Trust's review of additional patients.

Review purpose

5.25 The SPSLBR, as its name suggests, was intended to be a safety focused exercise. The report states that the review purpose was to:

- ascertain whether patients' care was appropriate, whether any harm is identified that requires further assessment
- to identify whether there are any concerns regarding Consultant Surgeon A's probity
- to identify whether there were shortcomings in duty of candour that need to be rectified.

5.26 In reality, we found that the purpose of this review became more confused over time, as members of the MDT, the BSG, the patient group and those who oversaw the work articulated different ideas about what the review was meant to achieve. This led to frustrations with its outputs and, from our perspective, appears to have exacerbated the pre-existing distress and tension related to these matters. This was particularly so when differences of opinions emerged about a) the need for further look back work, and b) the final content, sign-off and sharing of the report.

5.27 The divergence of views in this area included:

- Colleagues in the BSG expected the work to highlight concerns about Consultant Surgeon A's practice and conduct. When recommendations about practice in the department more broadly emerged, we were told some staff saw this as "*retaliation*" for speaking up. This theme recurred repeatedly, and we saw that it led to disengagement with the action plans developed as part of the review.
- Several staff members wanted their views on the department's culture over the years, and Consultant Surgeon A's role in shaping it, to be heard. The terms of reference of the SPSLBR did not include this.
- There was a drive from the Trust for the work to look at themes, and to take a systems-based approach, in line with the Patient Safety Incident Response Framework (PSIRF), which was being implemented at the time.
- Many staff, patients and their families wanted the review to explain more about oversight of the department and how concerns did not come to light sooner. The Breen Report was commissioned in response to this feedback.

5.28 Due to a lack of internal resources, including specialist governance expertise, the Trust's lawyers facilitated the look back review process (alternative providers were sought but unavailable at this time). Several legal processes linked to these matters were also live at this time, including staff and patient claims, a coronial process, a police investigation, and consistent Freedom of Information requests.

Findings

5.29 Our review of the report, its terms of reference and the methods used, identified seven further concerns, which we discuss in turn in this section, namely:

- guidance applied and extent of systems-based tools used
- benchmarking
- reference to historic standards
- MDT round table membership
- links to evidence
- harms
- findings, recommendations and actions

5.30 Although the report may not clearly state it, we have been assured that none of the patients who were recalled required further surgical intervention or remedial surgery as a result of the review/recall process.

5.31 **Guidance applied and extent of systems-based tools used.** Given the breadth of opinion about the purpose of this review, it is unclear what guidance should have been used. The PSIRF had not been fully implemented by the NCA at the time, but the report states that the review applied a PSIRF methodology. It is unclear what this was. Some themes have been identified from the recall process, which is positive and reflective of PSIRF, however a systems-based approach to understanding what took place has not been used. These would have been particularly useful to explore, for example:

- patients lost to follow-up

- equipment failings
- delays
- World Health Organisation (WHO) checklist compliance
- pre-operative planning and risk management

Safety problems in these areas are often safety systems issues, however, the report only examines the role of the individual. If the purpose of the review was to confirm or rule out transgressive practice, PSIRF may not have been the right tool. It is unclear how PSIRF methods were to be used alongside the structured judgement review methods in this case.

5.32 **Benchmarking.** We were told throughout our work (and see also Chapter 3) that spinal surgery is often high risk and that reliably determining "*normal complications*" and "*higher than normal complication rates can be challenging*". Unlike the other two reports, the SPSLBR does not reference case complexity or attempt to compare outcomes with the internal and/or external benchmark for comparable procedures. This is not to excuse or minimise poor practice; complications and subsequent failings are evident. However, without weighting for case complexity and expected complication rates, it is difficult to know the extent to which it was directly related to poor surgical technique.

At the time (and still today) the team does not submit data to the British Spinal Registry. This is likely to hinder benchmarking exercises and recently an urgent recommendation has been made after the Getting It Right First Time (GIRFT)[11] visit in August 2025.

5.33 **Reference to historic standards.** The cases went back to 2009, which was 14 years before the look back review. The report does not consistently benchmark findings with expected policy and practice in place at the time. There is a risk that, in some areas, historic practice has been reviewed against contemporary standards. See also the timeline at 1.21.

5.34 **MDT (round table) membership.** Some members of the round table MDT have been candid about their poor and, in some cases, distressing experiences of working with Consultant Surgeon A. This work was undertaken in part by colleagues who had made active whistleblowing allegations against Consultant Surgeon A. It is difficult to see how this would not have created a degree of bias (nor, arguably, would it be reasonable to expect otherwise). It is clear from reading the report that some members felt the findings could have been more critical, leading them to withdraw from the process.

The Trust sought to mitigate this risk through the input of an external reviewer, facilitation of the meetings by the Trust's lawyers, using a structured review method and ensuring that the ultimate report writing process was undertaken separately.

5.35 **Links to evidence.** The report contains references to issues, such as safeguarding, child protection and visiting consultant contracts which do not clearly link to the findings set out in the report, making it unclear how conclusions were reached. We were told that this is because they came from the individual case reviews. Other examples include an operation causing a chest infection and an incomplete consent directly contributing to the incident.

5.36 Several references to culture are made throughout but it is unclear where they came from if the report relied on, what we have been told were, scant notes and historic oral account.

[11] GIRFT is a programme of reviews led by NHS England that is aimed at improving patient care by assessing services and using benchmarking data to make positive changes.

5.37 **Harms.** Unlike in the RMCH and Spire reports, the harms identified were not disaggregated into those directly related to Consultant Surgeon A's care and those that were avoidable or other types of harm.

5.38 **Findings, recommendations and actions.** The lessons to be learned and recommendations cited have little bearing on surgical practice. This is surprising given the nature of concerns initially raised, and which generated the SPSLBR.

RMCH look back review

Patients in scope

5.39 As mentioned above, the methodology used was the same as that employed at the NCA. As such, the RMCH reviewed patients:

- who had instrumental spinal surgery under Consultant Surgeon A between 1 January 2006 and 31 December 2011
- who fell outside this time period but were identified as potentially having concerns because:
  - they had been included in the NCA review and were identified as also having been operated on at RMCH
  - RMCH spinal surgeons raised concerns about specific cases
  - they had contacted patient advice and liaison service (PALS) and made formal complaints
  - they had made legal claims
  - they had reported incidents

5.40 This time frame was selected:

- "*with acknowledgement that reviewing care pre-2006 would be limited due to records availability*
- *to include the years covering the majority of the concerns identified from the NCA report*
- *to include the final years of employment of [Consultant] Surgeon A at RMCH*".

Methods used

5.41 The investigation team included two paediatric spinal surgeons from UK children's hospitals who were external to RMCH. The following approach was taken:

- **Patient identification:** admitted patient care episodes, theatre and coding systems were used to identify the patients in scope, alongside risk management systems. A longlist was cleansed to ensure that patients met the review criteria. Some patients could not be reviewed (the number was unquantified) due to their notes having been lost or destroyed. Seven patients were excluded because their notes were limited, or notes and / or x-rays were unavailable.
- **Primary review (RMCH-led):** the case notes of patients who were in scope were given to RMCH spinal surgeons for an initial internal primary review. This included reviewing medical case notes, images and any information held on clinical systems. Any clinical concerns were noted and the case proceeded to the next stage of the process, which was external scrutiny (a secondary desktop review). Cases in which pre-existing concerns had been raised by any route were automatically passed to the second stage review.

- **Secondary desktop review (external scrutiny):** the secondary desktop reviews were a series of MDT meetings including an independent external expert to review each patient's care in detail. This included feedback from families and patients and other available intelligence such as claims. These reviews and their templates used a structured judgement approach, with assessments of each patient's care reviewed against a series of themes. Harm was determined through this process.
- **Patient feedback:** for all cases that underwent secondary desktop review, a final letter was sent to the patient detailing the outcome of the review and offering to meet with the patient and their family to discuss the findings.
- **Clinical recall:** patients identified as having potential clinical concerns have been given a recall appointment, unless a planned follow-up had already been scheduled.

Patient engagement

Letters were sent to all patients and families during the process to let them know that their care either did not need to be reviewed further or to update them on the review process. For all cases that underwent secondary desktop review, a letter was sent outlining the outcome of their review and offering a meeting to discuss the findings. RMCH also offered all families a meeting, and this took place with all families who accepted this offer. We heard that RMCH met with one family several times to answer their questions.

Review purpose

5.42 The purpose of this review was to identify patients for clinical recall. We were told that there had not been any reports of issues relating to culture or dynamics involving Consultant Surgeon A at RMCH, although this was difficult for present leaders to corroborate given the natural churn in staff since 2011, when Consultant Surgeon A left the organisation. From our perspective, the report therefore feels clearer in terms of its focus on clinical safety. There is no reference to the PSIRF, although the Trust was implementing this at the time of the look back review.

Findings

5.43 Other areas identified through our review of the report, which we discuss in turn below, were:

- family engagement
- benchmarking
- incident reporting

5.44 **Family engagement**. The report clearly states that is has limitations because it is relying on historic case records and because of the lack of capacity to meet each and every family to hear their experience. That said, the team appears to have made concerted efforts to keep affected and/or worried families updated about the review's progress and their particular outcomes. It is positive that all families were offered meetings to hear feedback and share their experiences.

We were told that progress in starting the review was slow, which we understand was because of resource constraints until full-time administrative support was identified within the Clinical Governance team.

The report recognises the distress these matters cause families, for example, where harm is not identified but patients continue to live with pain and impacts on their quality of life as a result of "*expected complications*".

5.45 **Benchmarking**. Where harm has been identified, the report sought to clarify where this was an expected complication or risk, and to disaggregate these from harms identified. The report found that "*The majority of the issues and complications experienced by patients including those causing harm were recognised risks of surgery.*" It would have been helpful to include the data or references in the report to support these findings.

5.46 **Incident reporting.** Despite some severe harms, there was no evidence of incidents being reported at the time linked to these cases. We were told that incident reporting in the Spinal Surgery department at the RMCH remains low. This is discussed in more detail in Chapter 8.

5.47 Feedback about the NCA SPSLBR's reliance on partial and incomplete records and the short timeline also applies to this report.

5.48 Although the report does not clearly state it, we have been assured that none of the patients recalled required further surgical intervention or remedial surgery as a result of the review/recall process.

Spire look back review (patient notification exercise)

Patients in scope

5.49 For consistency, Spire used the same definition of cases to be included used by the NCA. It was a review of patients who:

- had instrumental surgery by Consultant Surgeon A in the 5-year period between March 2008 and February 2013
- had died within two years of surgery
- self-presented (including the family of deceased patients)
- brought litigation action
- brought a complaint
- have had an inquest
- had an adverse clinical incident logged in the incident management system at the time
- were identified by the Trust as having requested a review for a specific period

5.50 Having considered the date of Catherine O'Connor's death in 2007, they extended the review and ultimately decided to review all of Consultant Surgeon A's instrumented cases undertaken at the Spire Manchester.

5.51 Across the initial, and later extended, scope, the Spire reviewed a total of 211 patients. Of these, 67 did not respond to recall letters. The Spire sent these patients two letters advising them of the recall and seeking their involvement.

Methods used

5.52 The following methods were used:

- Patients were identified using a series of defined clinical codes.

- An engagement pack was sent to each patient to inform them of the review to explain the PNE process, to ask for feedback on their care and to seek their consent. A hotline was set up for patients to call. This remains open at the time of writing.
- A questionnaire was to be completed by the patient to identify any concerns they had, asking about their experience of care and about any complications following their surgery, or if subsequent surgery had been required.
- A desktop review of identified patient records was completed by individual spinal clinicians. Seven patient safety focused questions were used to guide the reviews. Where no notes were available, patients were asked if they had concerns, sent a feedback form and a clinical review was offered
- Discussion and decision-making by the clinical advisory group (CAG) which was set up to assess levels of harm.
- Clinical assessment (recall) of patients if indicated by the clinicians, including updated imaging.
- Feedback to patient.

5.53 Reviews were inconclusive for 13 patients where medical records were unavailable. Some of these patients were able to provide additional information and, for some, this enabled a CAG review and conclusion, or patients were offered a clinical review. However, for some patients the review remained inconclusive. All of the patients in this group received an outcome letter, and the reasons for this were explained to them. We were told that it was common practice for consultants in private practice at this time to retain their patients' clinical records.

Extended review

5.54 The extended (Phase 2) review went back to 1998. All 141 patients were written to twice, and just over 50% of these responded. Of the patients who responded, an initial triage took place. Once clinical information was available, 60% went onto have a face-to-face clinical review in a Spire Hospital outside of Manchester. Of these patients, two (3%) had suffered harm

Patient engagement

5.55 All patients in scope were contacted about the review when it began. Patients were contacted twice to offer engagement in the process (if no response was received after the first attempt).

5.56 All patients received an outcome letter, which included contact details for further discussion. One patient had several questions, and they were offered an appointment with one of the CAG spinal surgeons.

5.57 Any patients where harm was opined received a phone call before the letter, and a discussion of findings, including the duty of candour process. All patients included in the PNE were offered counselling. Eight patients accepted this offer. Twenty-eight patients were under the age of 18 at the time of the surgery; Some of their parents were also offered counselling, but this offer was not taken up.

Review purpose

5.58 The Spire's interim report (March 2024) was prepared at the end of the first phase of the organisation's PNE. The report was written for the Spire as a summary of the review outcomes to date, to support assurance and learning, and to engage with the GMC.

5.59 The purpose of this Interim report is clear and it is aligned with a coherent policy that reflects national guidance[12] on conducting a recall. As with RMCH, we were told there had not been any cultural and dynamic issues involving Consultant Surgeon A at the Spire, although this would have been difficult for present leaders to corroborate given the natural churn in staff since 2013, when Consultant Surgeon A had last operated at the Spire Manchester.

Findings

5.60 The purpose of the Spire report is clear and its methodology conforms with that set out in internal policy and with the national guidance in this area.

5.61 It is positive that the Spire reviewed all of Consultant Surgeon A's patients and that key dates (such as Catherine O'Connor's death) were factors in this decision-making. However, it is likely that the total number of cases at the Spire was much smaller than the number of Consultant Surgeon A's procedures at Salford Royal Hospital.

5.62 The breakdown of harms identified is more comprehensive than in the other reports, with inconclusive/unquantifiable and unavoidable harms described in detail. However, it would have been helpful to more explicitly quantify which harms were severe and which were moderate (they have been merged and/or reported as percentages at different parts of the report).

5.63 The CAG did not include members from outside the organisation, which would have helped ensure objectivity (including any perception of conflicts). However, none of the consultants on the CAG had practising privileges at Spire Manchester, they were from outside of the region and undertook documented conflict of interest declarations.

5.64 The feedback we were given about the NCA SPSLBR and RMCH LBR reliance on partial and incomplete records also applies to this report.

Breen Report

Review purpose

5.65 The purpose of the Breen Report was different to the other reports that had supported patient recall activities. The CEO of the NCA commissioned this work.

5.66 The purpose of the Breen Report was to:

- review the case material supplied to the GMC about Consultant Surgeon A and assess whether the subsequent findings warranted a re-referral
    - as part of this, the findings from the SPSLBR were to be included
- interview representatives of the BSG, informed by the case material for the GMC referral and the SPSLBR

5.67 The introduction to the report includes extensive background information taken from FTSU intelligence. Allegations include bullying, manipulation of governance, sexual harassment, a workplace affair and collusion in these events by very senior managers in Salford Royal Hospital Foundation Trust.

5.68 During our interviews, we were consistently told that the scope of the Breen Report was to look at the governance and culture concerns about Consultant Surgeon A and how the concerns had been

[12] NHS England (June 2022) National Quality Board: Recall Framework.

managed. We note that this does not align neatly with the purpose stated in the report but understand that this developed over time, and many of its findings related to these areas.

5.69 In light of this and given that our reviews of previous reports were aimed at identifying any further look back work required, we have not reviewed this report in the same way. However, the report's findings about leadership, management, governance and culture, have a material impact on patient safety.

Patients in scope

5.70 An appendix to the report includes reviews of the care of five patients. These reviews were commissioned separately, as part of the SPSLBR, and were all carried out by an external independent spinal surgeon. These appear to have been included because of the requirement "As part of the consideration of any GMC re-referral, to have regard to the findings from the first phase of the current "Spinal Patient Safety Look Back Review."

Methods used

5.71 No terms of reference for the review are included in the report, which is unusual for an NHS-commissioned report. The report refers to "*instructions received*" which we believe is common practice in legal reports.

5.72 There is no clear statement in the report of the methods used by the author to arrive at their conclusions, although we do not doubt that their fieldwork was extensive. On reading the report, it is evident that a vast range of evidence was reviewed and many interviews carried out (the register of names appendix suggests it was in the region of 80). We note that some people were interviewed on two or three occasions.

Patient engagement

5.73 We were told by senior NCA leaders that when this review and the SPSLBR were commissioned, some patients and families felt so damaged by their involvement with the NCA that they wanted nothing to do with either process.

5.74 A small number said they would have liked to see more patient stories included and pointed out that the appendices were redacted so patients could only see their own account (however this was to comply with information governance legislation).

5.75 Some patients were disappointed that the report focuses solely on the NCA/SRFT and there is no equivalent for the RMCH. This was beyond the review scope.

Findings

5.76 In our view, it is positive that this work was commissioned by the NCA to address the gaps the SPSLBR was unable to answer, such as those about governance, leadership and cultural matters. We recognise that this was a significant piece of work that attempted to answer important questions posed by patients and staff.

5.77 Given its focus, independence in carrying out the work was key. We were told that finding a suitable independent reviewer proved challenging, in part because of pre-existing relationships in the Manchester healthcare system, but also because trust with the spinal surgeons had been damaged. Clear assurances around impartiality were required. This, in part, led to the appointment of an independent barrister to carry out the work. Several members of the BSG were consulted in the appointment of the independent reviewer.

5.78 Clearly the report has been approached in a legal manner, and this is reflected in its content and tone. The author describes the approaches used to arrive at conclusions and is explicit in several cases where this was not possible. For example:

"*At my discretion I have omitted certain comments made to me either because they can't be verified, or because I attach no weight to them, or because they cannot be verified and are damaging. Certain comments have been included even though it has not been possible to verify the same, on the basis that it is relevant evidence and that it is appropriate that it be included in my report. If this is the case, the weight attached to it is limited*".

We understand that the author himself sought independent legal advice on the language used in the report. This was due to the potentially damaging nature of some of their findings, and the need to apply the 'balance of probabilities' test[13].

5.79 Examples of where the author is clear that conclusions could not be reached, either because it is outside of their scope or because of a lack of available evidence include:

- "*manipulation*" of governance processes
- whether bullying or intimidation occurred
- whether there is still "*systemic*" bullying in middle management within the NCA
- whether aspects of Consultant Surgeon A's practice (such as blood loss) was poorer than that of their colleagues
- what actions were taken by colleagues relating to the incident report resulting from the death of Catherine O'Connor

5.80 Several patients and some staff we spoke to felt strongly that the review remit did not "*allow*" the author to comment on matters like these. We heard several times that "*the report could have said more*". The review author and sponsor assured us this was not the case; rather, evidence was simply not there to draw negative conclusions in these areas.

5.81 The report is very long, at 1,139 pages. Some of this is unavoidable, given that full appendices are provided, some of which are themselves long documents (such as the SPSLBR). However, the main body of the report extends to almost 500 pages. Some stakeholders felt that the length, breadth and legalistic style of the report make it difficult to draw out the key messages and identify any areas of concern.

5.82 Finally, there is a section in the report called recommendations. They are structured around seven headings and there are 37 numbered paragraphs under the theme headings. However, not all are recommendations, many are reflections, a re-emphasis of points previously made or updates on findings the author has become aware of since the time of their review. We understand that the report author included these (key) points within this section so that they were given sufficient prominence, and not lost in a long and detailed report.

5.83 It is difficult to quickly or reliably determine which points are recommendations and the intended outcome of any recommended action. This is discussed further in Chapter 7.

[13] In English law, the "balance of probabilities" is the standard of proof for civil cases, meaning a claim is proven if the event is more likely than not to have occurred.

Timeframes in scope

5.84 One of the key concerns among patients, families and affected staff has been the timeline of these reviews. Of particular concern has been the five-year time frame used in the SPSLBR.

	NCA SPSLBR	RMCH look back review	Spire
When did Consultant Surgeon A practice within this organisation?	1991 - 2015	1991 - 2011	Practising privileges held 1992 - March 2022, although last procedure performed in February 2013
Time frame included in the look back	August 2009 - September 2014	January 2006 - December 2011	Phase 1: March 2008 - February 2013 Phase 2 (extended review)1998 to February 2013
Cases in scope in this time frame	178	56	70
Concerns with time frame	Catherine O'Connor death was in 2007, which some feel indicates there will be more harms around this period. Some people feel that a further review was "*promised*". Some patients feel that a full recall of all Consultant Surgeon A's patients is needed.	Some patients feel that a full recall of all Consultant Surgeon A's patients is needed.	None. A full review of all Consultant Surgeon A's cases was undertaken

Harms identified within this cohort

5.85 There were differences in the categories of harm used in the existing reports and in how these were disaggregated. For the NCA column, the two figures in each box (x + x) represent the numbers in both the first look back report, and its later addendum).

5.86 It is a concern that the SPSLBR report does not disaggregate harms attributed to Consultant Surgeon A's practice and other harms. The RMCH and Spire reports separated these out. It is unclear how harm and levels of harm were assigned in the SPSLBR, or if a recognised framework was used to support this. The report describes differences in opinion among the Trust's spinal

surgeons about some of these levels of harm. Furthermore, the numbers include deceased patients and those who did not wish to be seen, whereas the RMCH and Spire reports disaggregated these cases for clarity.

	NCA	RMCH	Spire
Catastrophic	Definition not used in NCA	0	Definition not used in Spire
Severe	(7+1) 8	3	5
Moderate	(13+4) 17	6	7
Low	8	4	-
No	(36+2) 38	43	36
Unquantifiable	2	-	-
Under review	-	-	7
Inconclusive	-	Not quantified	13
Unavoidable	-	-	2
Additional notes	'Inconclusive' was due to a lack of medical records. Unquantifiable harm includes psychological harm in this report.		Definition of harm was guided by the PNE policy, which includes a harm assessment tool. 'Inconclusive' was due to a lack of medical records.
TOTAL	(66+7) = 73	56	70

5.87 We used our findings from the analysis in this chapter to inform our recommendations for any further look back activity required. This is set out in the following chapter.

Chapter 6: Recommendation for further look back activity

Overview

6.1 Our terms of reference require us to recommend if any further look back activity of Consultant Surgeon A patients is required. Stakeholder views on this varied significantly. To assess this, we completed an options appraisal. This involved identifying several options proposed to us and scoring them based on the views we heard and our own assessments against several criteria.

6.2 These criteria were based on a) people's concerns with the review work carried out so far, as described in this chapter, and b) what we were told needs to be addressed and/or considered through any further review/recall work.

Defining the scoring criteria

6.3 Patients, families and staff told us the key reasons for their concerns with the original reports were:

- **Lack of patient voice:** in particular, the look back reviews (to different extents) did not sufficiently hear affected patients' accounts of their care by Consultant Surgeon A, nor how their care has affected them in the years following their operation(s). In most cases, this led to them feeling discounted and dismissed and it has compromised the credibility of the review work carried out.
- **Size of cohort review:** some felt that they were "*promised*" a historic look back review. The lack of this has undermined their trust in the senior leadership of the organisations. There are also specific concerns that Consultant Surgeon A's practice at key points in time, such as when Catherine passed away in 2007, has not been systematically reviewed.
- **Methodology:** in addition to the radiological images, the look back reviews relied on the medical records, which these same reviews criticised for their poor quality. This has fundamentally called into question the resulting reliability of the reports for the patients, families and affected staff.

6.4 We also asked the people we spoke with what any future reviews should seek to address and take into account. We used the key considerations put forward to define the following criteria:

- **Closure for patients.** Does this option promote restorative justice? Does it give people answers? Does it promote healing?
- **Staff experience.** A minority of staff (past and present) told us the events traumatised them and they still feel the impacts today. Staff currently working in the service may never have met Consultant Surgeon A and yet they also feel the impact of the repeated reviews. Many are frustrated and saddened that the service is still seen in this way.
- **Patient safety and scope for further learning.** Does it provide greater assurance of patient safety than the reviews undertaken so far? Are further and material learning themes likely to be identified that would improve service quality?
- **Feasibility.** How achievable is this option based on the availability of images, notes and records?
- **Impact on current service running.** What would the likely impact be on existing service running? Spinal surgery has some of the longest waiting lists in the country. We need to be clear that those waiting are typically in pain and that their quality of life is affected. Could the option lead to further risk of harm to these patients caused by longer waits?

Options available

6.5 Through our conversations with patients, staff, stakeholders and independent experts, we identified six options for review/recall activity:

1. no further clinical recall or other review activity
2. offer a review to all recalled patients who have been found to be harmed
3. offer a review to all patients who request one, even if no harm has been identified
4. complete a further look back review of patients who had instrumented surgery during the five-year period from August 2004 - September 2009
5. complete a further look back review of patients who have had instrumented and non-instrumented surgery since 1991, when Consultant Surgeon A started working at Salford Hospital
6. recall all former patients of Consultant Surgeon A for a full clinical review

Caveats

6.6 There are two important things to note in reading this options appraisal discussed below.

Acknowledging the diversity of views heard

6.7 We sought to include the whole spectrum of stakeholder views we gathered. This means that we must acknowledge the diversity of opinion, even within groups of stakeholders. In particular:

- **Patients:** healing, closure and justice means different things to different patients. This is to be expected because people's lives have been impacted in different ways by these events. Some patients are actively engaged in the patient group and are campaigning for further look back reviews, others may only be interested in their own case and others have declined involvement with any further review activity.
- **Staff:** we have also included a staff experience criterion. As outlined above, staff (past and present) have been affected by these events. They have different views about the value and impact of any further recalls, and their views on our recommendation are likely to diverge; existing staff in the service may feel that this work has already been done, while a small number of former staff will feel that the option does not go far enough

Challenges of further recalls

6.8 Any further recall activity will involve logistical challenges that become more acute as cases become older. From the review work undertaken to date, we know that:

- the availability of records will be an issue, especially for patients seen earlier and for the time before the implementation of electronic patient records
- Consultant Surgeon A's record-keeping was frequently poor and the reliability of these notes has been questioned
- a new image archiving system was introduced in Salford in 2005, we understand that images taken before this date are not available for review - similar challenges were found by RMCH and the Spire

- there have been challenges in contacting patients treated further back in time, this has been attributed to possible emigration or death
- witness testimony taken in the present day, about events which happened prior to 2009 may have issues with reliability, due to the significant time elapsed

Conclusion

6.9 The full scoring matrix is provided at page 45.

6.10 Options 1 to 3 all returned a total score of 16. Options 2 and 3 scored a 3 for quality, however, we gave a heavier weighting to criterion 1 (closure for patients) based on how frequently and strongly the need for this was communicated to us by patients and the strength of feeling that their voice has not been heard in previous reviews.

6.11 **We have concluded that face-to-face reviews should be available to all patients who request one for a minimum of three years, even if no harm has been identified by previous reviews. This should be open to any patient who has had surgery by Consultant Surgeon A at any time, at one or more of the three organisations where he worked.**

6.12 These reviews must:

- focus on the patient's current concerns about their condition and how it impacts their daily life. To understand the impacts, patients should be spoken with directly. Each request could be triaged and it could be a spinal specialist nurse, physiotherapist or surgeon who carries out the initial consultation.
- offer a historic review of the involvement of Consultant Surgeon A in their instrumented surgery if it is requested and is feasible.
- be delivered compassionately and acknowledge any suffering caused to patients and families.
- take into account accessibility, physical and otherwise, to ensure that approaches taken are based on what is easiest for patients and their families. This might include offering video and telephone options for the initial triage.
- meet all the requirements of the NHS England Recall Framework.[14]

The NCA and MFT will need to communicate the offer to ensure that all Consultant Surgeon A's patients are informed and are aware that they have a three-year window to request a review.

6.13 We scored this as the preferred option because:

- it offers an opportunity for closure and, in some cases, healing for patients who remain concerned if the recall appointment is done sensitively and is person-centred
- there is limited scope for further learning. All the reviews carried out so far (including those of patients who self-referred after the SPSLBR) have returned very similar findings. The review team, the independent experts we spoke to and spinal surgeons all agreed that it is very unlikely there is new learning to be identified from a more expansive recall.
- all staff working in the service today, along with the three independent experts we asked, agreed that if there had been any harm caused or safety issues among former patients of Consultant Surgeon A's, they would have presented to the service by now.

[14] National Quality Board (2022) National Patient Recall Framework.

- it is likely that this option is feasible. Where patients have self-referred, records and images have mostly been available.
- this option will likely have a minor impact on the running of the departments involved. It is critical that this is considered, given the long waits in place and the impacts on the quality of life on all patients waiting for spinal surgery. The risks of harms while waiting must also be considered.

6.14 This option must remain open to patients for at least three years because, in many cases, the conditions are chronic and enduring. In addition, each organisation involved should make GPs aware of this offer, so they can signpost past patients of Consultant Surgeon A who present to them with ongoing issues for a review, if desired.

6.15 It is critical that this review is carried out in a compassionate and supportive way by the service and focuses on what matters to the patient. Some want imaging, but others want a more person-centred assessment. The key question is what can be done for this patient today to help their quality of life? This may involve facilitating referrals to other services, such as psychological support, social prescribers or social care assessments. Some pathway mapping may be required to support this and a longer appointment than usual for follow-up may be needed. Appointments may not always need to be arranged with a spinal surgeon, they could be made with specialist nurses or spinal physiotherapists, for example.

6.16 The service needs to consider the impact on some patients who were deemed to have experienced "*no harm*". Some feel psychologically harmed by the events and their lack of involvement in previous reviews has compounded this. The service needs to keep this at the forefront of their minds when planning how it implements this further review activity.

6.17 A risk assessment of this option is provided in Appendix 4.

Scoring these options

6.18 In the matrix below, we have scored each option 1 - 5 against the five criteria. This returned an overall score for each option. The scores are defined, from best to worst:

5 - optimal impact

4 - positive impact

3 - neutral impact

2 - negative impact

1 - highly undesirable impact

Options appraisal matrix

Options appraisal matrix						
	Criterion 1	Criterion 2	Criterion 3	Criterion 5	Criterion 6	
Options	Closure for patients	Staff experience	Patient safety and scope for further learning	Feasibility	Impact on current service running	Score
1. No further clinical recall or other review activity	2	3	2	5	4	**16**
2. Offer a review to all recalled patients who have been found to be harmed	3	3	3	5	2	**16**
3. Offer a review to all patients who request one, even if no harm has been identified	4	2	3	5	2	**16**
4. Complete a further look back review of patients who had instrumented surgery during the five-year period from August 2004 - September 2009	5	3	4	1	1	**14**

5. Complete a further look back review of patients who have had instrumented and non-instrumented surgery since 1991, when Consultant Surgeon A started working at Salford Hospital	3	2	2	1	1	**9**
6. Recall all former patients of Consultant Surgeon A for a full clinical review	2	2	2	1	1	**8**

Chapter 7: Thematic review of recommendations made

Introduction

7.1 We were asked to review the recommendations made in the four existing reports: identifying the themes that emerged and highlighting any gaps compared to our fieldwork findings. Specifically, we were asked to assess what the concerns of patients, families and staff are and whether the existing recommendations address them.

7.2 We did this by reviewing and triangulating all the recommendations made in the reports that were in our scope. As outlined elsewhere, the Spire's interim PNE report does not make recommendations and therefore the findings below do not include this work.

7.3 As an overarching finding, we noted that the three organisations do not seem to have looked at the recommendations in the other reports to assess their relevance to their own organisation. This is a missed opportunity to ensure that all relevant learning is taken from this case.

7.4 The approaches taken in each of these reports have been described in detail in Chapter 5.

Findings

7.5 The key themes from the look back reviews were largely about the deficits in Consultant Surgeon A's clinical practice. These included:

- poor surgical technique
- poorly planned surgery
- high blood loss
- poor communications with patients and their families
- failures to be open and honest
- poor consenting processes, including not sharing risks with patients
- poor documentation, often inaccurate or inconsistent with the records of other healthcare professionals
- unprofessional behaviours

7.6 The reviews also identified a small number of failings at departmental level including:

- poor culture of incident reporting
- suboptimal governance practices

7.7 The Breen Report identified a range of failings predominantly with the management culture, custom and practice, but also in related areas such as human resources (HR) management, governance and record-keeping practices.

7.8 In total 35 recommendations are listed in these reports. The full list is included in Appendix 2 of this report. Split by report, there were:

SPSLBR	9 recommendations

RMCH LBR	10 recommendations
Breen Report	16 recommendations
Spire PNE	0 recommendations

7.9 We examined these recommendations and assigned them to thematic categories as shown in the table below.

Theme or area covered by the recommendation	Number of recommendations	Additional comments
HR processes	6	All from the Breen report.
Clinical processes	5	One on dual surgeon operating and four on clinical follow up or review.
Sharing findings from reports	5	These related to sharing findings with staff or other organisations.
Record keeping	5	These related to recording of information from MDT, M&M meetings and meetings with families. All were from the Breen report.
Sharing patient outcome reports (with patients)	3	
Incident and risk reporting	2	
Clinical governance	2	
M&M review processes	2	
PSIRF[15]	2	
Apologies	1	
Corporate governance	1	
Duty of candour	1	
Racism	1	

7.10 The recommendations made were overwhelmingly task/input-oriented and did not specify the improvements needed in most cases.

[15] NHS England (accessed 2025) Patient Safety Incident Response Framework.

7.11 We have a number of observations on the recommendations from the Breen Report and NCA SPSLBR specifically, detailed below.

Breen Report recommendations

7.12 The Breen Report was required to only focus on practice at the NCA, which means that the issues reviewed such as management culture and governance have not been reviewed at the other two providers. This was perhaps a missed opportunity.

7.13 The lack of clarity in some recommendations meant the Trust had to come to their own interpretation of what they meant. The report author has confirmed that the Trust did not ask them to clarify the recommendations at any stage.

7.14 The recommendations made in the report do not address the full range of findings, leaving a number of residual recommendations - or areas where recommendations should have been developed but are absent. However, in their absence, in many cases the department has identified and progressed work around these themes.

7.15 In addition, the Breen Report explicitly stated that there were areas of concern on which the author could not reach a conclusion, either because they were outside the scope of the review or there was insufficient evidence to support them. These included:

- "*manipulation*" of governance processes
- whether bullying or intimidation occurred
- whether there is still "*systemic*" bullying in middle management within the NCA
- whether aspects of Consultant Surgeon A's practice (such as blood loss) was poorer than that of their colleagues
- what actions were taken by colleagues relating to the incident report resulting from the death of Catherine O'Connor

7.16 For several people that we spoke to, these questions remain critical and they were raised during our interviews as unanswered to date. We suggest that further work is required to explore these questions. See Chapter 9.

NCA SPSLBR report recommendations

7.17 The SPSLBR identified a range of clinical concerns, as listed above, but there are no associated recommendations for most of them. For example, there are no specific recommendations about surgical technique and practice, blood loss, patient consenting practice or the quality of clinical documentation, all of which were key areas of concern.

7.18 As above, we note that in spite of this, the NCA spinal surgery department has progressed work in these areas.

7.19 We identified the following residual recommendations from the NCA look back report.

- **Consenting system.** To improve consenting processes for patients the Trust should introduce a digital system that can be incorporated into the electronic patient record.
- **Introducing new procedures, and approving surgeons to carry these out.** Through innovation and advancement of treatment, new procedures will be introduced into the service. The report suggested a need for more rigour around the oversight of these.

Gaps in recommendations in all four reports

7.20 Other gaps in recommendations in all four reports include:

- The need to regularly benchmark a range of clinical indicators in spinal surgery, such as surgical site infections, metalwork failure rates, misplaced screws and post-operative neurological deficits, as well as metrics of patient satisfaction and feedback. This information should be visible to all staff delivering the service so they can see how well the service is performing.
- Improved post-operative consultant (and other medical) follow up of patients. This includes patients in hospital, during ward rounds, dealing with own complications, giving explanations to patients about their procedures, and post-discharge follow-up care and rehabilitation through outpatients and handover to GP care.

Chapter 8: Delivery and oversight of existing recommendations

Introduction

8.1 In this chapter, we assess the progress made on the recommendations in the existing reports. Specifically, our terms of reference in this area required us to:

"*Determine the level of assurance for each provider organisation on the delivery and governance associated with the recommendations.*"

8.2 Each organisation submitted their action plans and evidence of progress. Given the Spire's review was a patient recall exercise rather than any other form of investigation, no action plan was developed. Instead, they have identified improvement themes from the interim recall report, and we requested a sample of evidence linked to these to review.

8.3 Where needed, we held clarification meetings to determine what actions have taken place. Where possible, we cross-referenced our findings with other sources, such as our site visit to the NCA in September 2025.

8.4 Key commentary from our review is provided in this chapter. The supporting detail used to underpin these findings is provided in Appendix 3.

NCA SPSLBR action plan

Key findings

8.5 The SPSLBR report sets out nine overarching recommendations and 11 actions.

8.6 Key leaders responsible for the management of the service told us that, until late 2024, they had not seen or been involved in developing the action plan. It appears that oversight of this work took place more tangentially, through the monitoring of actions from the Breen Report through the Breen Recommendations Oversight Group (BROG). This will likely have reduced local engagement in the changes and their overall impact. The action plan is now monitored by the local clinical governance lead and at the divisional governance meeting.

8.7 Overall, we found that the recommendations and associated actions tended to be transactional/input-oriented, lacking clearly defined outcomes. This lack of clarity can result in actions being closed before they have had the intended outcome. As previously outlined, many of the nine recommendations focus on communicating the report to various stakeholders and regulators.

8.8 There is some overlap with the Breen Report recommendations, for example, those made about MDT working, but assurance processes in the two reports have not been combined. We understand that this was so that the BROG and Quality Committee respectively could focus on overseeing these actions through their respective scopes. A joint approach may prove helpful; A single oversight forum, such as the BROG, could provide assurance that actions have been completed and remove any duplicated effort.

8.9 In our review, we tried to track the report's findings and the recommendations that came from each one, and, finally, the actions that could be tracked. This was challenging for several reasons, which has implications for their effective monitoring. In particular:

- Some of the stated actions are more like statements of fact or descriptions of work already carried out. This makes it difficult to understand what needs to be done, when it needs to be done by, who needs to do it and what the goal is.
- For some of the items on the action plan it is noted that they have been "undertaken since 2007". The status of these actions appears to have just been accepted and not systematically tracked, even given the time elapsed, and with no formal oversight/assurance gathering in place.
- Not all the recommendations have associated actions, so it is not always clear how these areas are being progressed.
- The referencing system in place is confusing and made it difficult for us to track the report recommendations into the action plan, and then later action plan updates (the latter also using Datix reference numbers).
- Some of the actions in the Trust's action plan update do not come from the SPSLBR report recommendations and actions. This may suggest that the service felt there were gaps in the report that have been addressed through the action planning process.

Headline views of progress made

8.10 To summarise our findings, we have grouped similar action areas from the report into a series of themes. Given the high-level and input-focused nature of the recommendations made, the associated actions tend to be transactional in nature and do not lend themselves to ongoing monitoring in several cases.

More detailed analysis of the actions taken and the evidence provided by the Trust is set out in Appendix 3.

Area of concern 1: Incident investigation and governance
Evidence of actions linked to governance was limited. We understand that a significant review of the Trust's quality governance arrangements is currently underway, which covers relevant issues, including learning from adverse events and safety culture. The PSIRF was implemented across the Trust in April 2024, in line with NHS national guidance. A policy, procedures and further guidance have been made available to staff. Monitoring requirements are set out in the policy document, but evidence of this was not provided for review. The Trust's patient safety incident response plan (PSIRP) for 2024/25 shows that incidents involving implantable devices are a local priority (we did not see the PSIRP for 2025/26). We would add that for all Trusts nationally, significant culture change is required to successfully implement the PSIRF and that this is likely to take some time. Concerns were highlighted in the SPSLBR report about there being a poor patient safety incident reporting culture in the spinal service. Datix incident reports from 2019 to March 2025 have been examined and show an increase in the number of incidents reported. This may indicate an improved reporting culture, although during our site visit we were told that the process is laborious, which often deters consultants from using Datix. In addition, we heard that feedback on incidents that have been reported is often missing or else takes a long time. This means that staff do not always see the learning value in reporting incidents. No evidence was provided for incident reporting trends or levels of harm. The service M&M meeting seeks to share learning, although it is mostly attended by consultants, and it was not always clear how learning for other professions is shared so that relevant changes

in practice can be made. During our observation of this forum we found positive discussion, several examples of healthy challenge and a willingness to share questions. Time during this forum could be better used by starting the meeting with the more complex cases. We also found that cases can take a very long time (sometimes 12 months) to get to the M&M meeting for discussion. It was unclear why this was the case.

No reference was made in the action plan update to an audit of contemporaneous surgical record-keeping, which was required.

The action plan also refers to the monitoring of duty of candour processes through relevant patient safety forums and processes but did not provide evidence of any such monitoring.

The executive summary of the report had been shared with patients and families involved in the review and it is published on the Trust's website, which is positive and demonstrates a commitment to being transparent.

Area of concern 2: Multidisciplinary team (MDT)

The Trust has undertaken significant work to ensure that MDT processes in the spinal service work effectively and consistently. This has included the development of a standard operating procedure (SOP), the establishment of an MDT coordinator role and an ongoing audit to ensure complex cases are discussed pre-operatively. Our observation of the MDT meetings saw several areas of good practice, including good attendance levels, good levels of engagement, respectful dialogue and healthy challenge about the cases presented.

Engaging neurosurgeons in this meeting ('joint MDT') remains an area for development that the service is still working on and which NHS England has urged the Trust to progress. We understood that job planning arrangements and some changes to working norms are needed for this to become fully implemented.

Audit of the effectiveness of the MDT operation was last carried out in early 2025 and showed that outcomes had improved compared to an audit in 2023.

The actions about MDT working were also covered by the Breen Report action plan.

Area of concern 3: Patients lost to follow-up and patients outside the scope of the SPSLBR

The Trust carried out further work for three patients that had been identified as lost to follow-up in Phase 1 of the SPSLBR. They found no issues because these patients had in fact been followed up or discharged. The further and later review of 40 patients did not identify any concerns in this regard.

Ongoing oversight of the patient pathway is provided through the waiting list safety group and incidents relating to the timely management of patients with implantable devices was a local priority in the PSIRP for 2024/25.

The Trust determined that any patients coming forward after the SPSLBR and Breen Report were published would also be reviewed. An update was provided to relevant governance forums in August 2025 and advised that of this group of 40 patients, five cases of patient harm were identified with learning themes consistent with the findings of the SPSLBR. Duty of candour processes had been followed where applicable.

Area of concern 4: Pre-operative surgical planning

Formal discussions take place each week where cases on the theatre list are discussed and actions taken to ensure every preparation is made for each case. Completing the WHO checklist and having a team brief before surgery provides a final safety check. However, no evidence of an audit of the completion of the checklist or the team brief process was provided.

Review of the audit of the anaesthetic pre-operative assessments is not directly referenced in the action plan update, so we are unable to confirm that this audit has taken place and whether the outcomes have been reported and reviewed.

Area of concern 5: Informed consent

The Trust's consent policy was reviewed and updated in September 2022 and sets out a requirement for audit at least annually. A specific audit on consent in the complex spinal surgery service, reported in June 2025, showed 100% compliance in the recording of patient consent in medical records. All audits have highlighted a need for the integration of consent processes with digital systems across the Trust. There was no evidence of a wider review of processes and system infrastructure across the Trust as required in the action.

An external audit on consent did not cover complex spinal surgery cases. Deficiencies in compliance processes were found across the NCA specialities selected for audit (it included a sample of lumbar micro-decompression patients only). An update to the action plan dated March 2025 indicated that most of the external audit recommendations had been completed, although specific evidence of this was not provided. One of the recommendations for a protocol relating to anaesthetic consent did not feature on the action plan update, so it is unclear whether this was actioned.

The SPSLBR referred to training on consent but we did not receive evidence in relation to this.

Area of concern 6: Audit of anaesthetic charts for blood loss recording

The Trust identified this as a specific audit requirement because of concerns about blood loss identified in the SPSLBR report. The recent audit carried out highlighted that there are still weaknesses in recording blood loss. Documentation to guide compliance is being introduced by the Trust following which a reaudit will take place.

Pre-operative planning improvements at MDT meetings (including blood loss) were noted elsewhere in the evidence provided and a process for the activation of a major haemorrhage protocol has been introduced. The audit found that all patients' records had evidence of appropriate pre-operative planning for blood transfusion in the event of blood loss.

Breen Report action plan (NCA)

Completion of actions and quality of the evidence provided

8.11 Our review of the Breen Report itself (Chapter 5) identified potential gaps in recommendations and further actions that may be required. Our assurance review of progress on the recommendations is solely focused on the actions identified by the Trust in its action plan.

8.12 Oversight of this action plan has taken place through the BROG. The BROG is a committee of the board of the NCA, which was established specifically for this function. It is chaired by an executive director and includes membership from affected patients and families and a non-executive director. In our view, it is positive that this level of attention and resource has been given to these important matters, although several actions are currently reported as being off-track.

8.13 The version of the action plan provided by the Trust for review was a draft and unratified (dated July 2024). This assurance review used the evidence that was provided with this action plan and the BROG update from September 2025. We noted that the update paper makes reference to tasks that are "*to be completed*" even when the action is recorded on the update as "*closed*", which is confusing.

8.14 As outlined earlier, recommendations made in the Breen Report were in fact more like overarching observations. They have often needed further interpretation by the Trust to understand what actions were required. For clarity, we have mapped them in Appendix 2.

8.15 As a general observation, we note that the majority of the actions are input/task-focused and are not therefore outcome-oriented. In some instances, the actions are statements of fact or tasks done. This means that further work will be required by the Trust to monitor the impact of actions carried out to provide ongoing assurance that required changes are embedded and have resulted in improvements, for example through staff survey results.

8.16 Positively, the Trust has taken the opportunity to consider the context of the Breen observations more broadly and in several instances, actions have been developed to address areas not directly referenced by the Breen report, for example in relation to MDT working.

8.17 The summary below sets out for each area of concern identified in the Breen Report and our assessment of the actions taken so far by the Trust to address the key issues raised. A full assessment of the evidence provided is set out in Appendix 3.

1. Area of concern: Bullied staffing group
The action plan focuses on engagement with affected staff in the spinal surgery department during 2025 through individual and team meetings with Trust senior management. No information was provided on attendance at and content of these meetings, although we understand that the CEO has met with all staff who accepted a meeting invitation and written apologies have been sent to affected staff. It was unclear why the group meeting for staff was dependent on the outcome of the culture work given that the Breen Report identified multiple failures affecting this group of staff, of which culture was only one factor. For example, the processes to allow staff to raise concerns and be listened to had failed and staff wanted to understand why this had happened and be assured that better processes are now in place.

This area of the Trust's action plan did not appear to capture some key Breen Report findings, for example:

- failure of FTSU and disciplinary procedures, including communicating with staff that their concerns have been heard and acted upon
- delays in taking action on staff concerns

2. Area of concern: Governance

The Trust has standardised the operation of M&M meetings and a central storage solution for documentation is being developed.

The service has carried out considerable work to improve the effectiveness of its MDT meetings. This was not a direct recommendation of the Breen Report, although it was a focus of the SPSLBR, which the Breen Report referenced. The Trust has audited the revised procedure.

Progress on the governance actions has encountered some barriers caused by changes in leadership at the Trust and the need for alignment with governance processes across the organisation.

As outlined elsewhere, an independent governance review is currently underway as of October 2025. This has delayed some actions, including those on incident reporting and associated training and audit, as well as future Datix system requirements.

3. Area of concern: Senior leadership and appointments

The Trust has carried out a review of the recruitment process for medical leaders and is seeking to embed the Trust's leader pledge into the recruitment and development of leaders. A revised framework has been developed for the recruitment of medical leaders under the new clinical leadership model. Regular updates have been provided to the people and education committee about this area, although an audit in 2024 highlighted inconsistencies in the application of the framework and policy. A further audit is planned.

The evidence provided did not specifically address the raising of concerns and the reporting of incidents, nor did it cover the reluctance of staff to report when the issue involves senior divisional leadership, which was a particular challenge identified by the Breen Report.

A 360-degree appraisal system is already in place at the Trust, but it is not mandated. Once cultural issues have been identified, the Trust is considering making it a mandatory process for clinical leaders and extending the remit of the appraisal process to cover broader performance areas.

No reference was made to considering whether appraisals of senior leaders should be independent of the division concerned.

4. Area of concern: Patients and family members

Letters were issued to affected patients and families and this action was marked as complete by April 2025. We did not see the content of these letters because of confidentiality considerations and we cannot comment on whether this has been completed.

Feedback from patients and families indicated that they needed more regular communication on the progress being made by the Trust on the Breen recommendations. This has been addressed

through the BROG, which has two patient/family representatives. Updates from this meeting are available to the public through its reports to the Trust Board.

The Trust has made some progress in managing queries raised by patients and families through the introduction of a single point of contact. However further work is needed to ensure communication with patients and families is appropriate and further resource is needed to support this work.

5. Area of concern: Investigations

The Trust has standardised its approach to disciplinary investigations. The training material sets out that such investigations should be carried out in line with policies and with the just culture principles. It highlights the involvement of HR expertise in the process to support commissioning managers and investigating officers. Investigation training and education sessions have been rolled out across the organisation. A register of attendance shows that 60 staff had attended by May 2025.

The Trust has reviewed and updated its Tackling Workplace Bullying and Harassment Policy and it was approved in June 2025. It clearly sets out the processes to be followed, provides guidance for staff and details the specific roles and responsibilities of commissioning managers, the HR team and investigating officers.

6. Area of concern: Concerns relating to race discrimination

The Trust has analysed various data sources to understand the extent of concerns about allegations of racism, this includes equality data, Datix incidents, complaints and staff survey data. The resulting report has been used as the basis for staff engagement work and facilitated sessions were held with the spinal surgery department during 2025 to discuss the findings. There were indications that some staff still felt that a racist culture remained, although some minority ethnic staff we spoke to during our service visit spoke positively about the Trust, saying it felt like an equitable place to work.

The actions in the report itself were limited to the consideration and sharing of findings from the report with relevant stakeholders and the development of an action plan, which we believe has not yet been developed. We recommend a single, combined action plan for the spinal surgery department elsewhere in this report.

The Trust progresses its anti-racism work through their involvement in the North West NHS BAME (Black, Asian and Minority Ethnic) Assembly and received a bronze level of attainment in October 2024 for their work in implementing the associated framework.

We note that the Trust has analysed compliance with the NHS Workforce Disability Equality Standard requirements in the spinal surgery department, which is supplementary to the required actions of the Breen Report.

7. Area of concern: Reflection
The Breen report also recommended that the individuals involved reflect on their actions or inaction. Notes from these meetings have been shared with the review team. We note that these do not tend to focus on individuals' reflections (about their actions/inactions, per the recommendation) and rather are discussions about the Breen report more widely.

RMCH look back review

Key findings

8.18 The action plan has seven recommendations with associated actions from the look back review. We were told that due to changes being made to organisational governance across MFT, oversight of this action plan at divisional level has been inconsistent.

8.19 As with the action plans described above, several of the recommendations in this report were task-oriented/transactional. Clearer definition of the intended outputs of actions would be beneficial for future patient safety reviews and recall exercises.

8.20 Some recommendations (such as that relating to clinical governance) are high level and have not been translated into the different facets needed to ensure their delivery in the action plan. For example, the look back review found key issues with consent, information sharing, pre-operative discussion, incident reporting, duty of candour and peer scrutiny of practice. Some of these specific elements do not appear to be in the action plan, so it is unclear if they have been addressed, although we understand that there plans to audit consent practice moving forward.

8.21 The summary below sets out our assessment against each area. Our detailed analysis of the evidence provided by the Trust is set out in Appendix 3.

Recommendation 1: Communication with patients and families
Communication with affected patients and families was comprehensive both during and after the case reviews. A formal communications plan set out the requirements in detail. For those cases where a full review was required, the outcome was documented in a letter to patients and families along with the offer of a meeting, thus fulfilling duty of candour responsibilities. The governance team has completed a final check to ensure all the letters had reached their intended recipients. The progress of communications with patients and families following the report was reported in routine updates to the specialist hospitals care group (SHCG), the quality and safety committee and the senior leadership team.

Recommendation 2: Communication with external stakeholders
The Trust developed a comprehensive communication plan that detailed how the report would be shared with relevant external stakeholders before or on the day of publication of the report in February 2024. The report was also shared on MFT's website on the day of its publication. The Trust had engaged with NHS Resolution[16] throughout the review.

[16] NHS Resolution provides advice to the NHS on resolving disputes, concerns and claims.

Recommendation 3: Opportunity for further learning

The Trust has taken steps to consider whether patients need reviews outside the time period of the terms of reference for the look back review (2006 to 2011). However, internal searches outside the timescale were limited because of issues locating archived paper records before the introduction of electronic records systems.

The Trust maintained a log of patient and family contacts after the report was published to identify potential further cases. This resulted in two contacts in 2024 that involved additional queries from patients and families. These were addressed and no clinical concerns were identified.

Some potential legal claims (16) were raised after the report was published. Some of these cases had been part of the review, while others were new. These should be reflected on by the Trust, to understand how the claims arose without a previous incident or concern/complaint having been raised, and what learning can be taken from this.

Recommendation 4: Shared learning

A summary of the review findings was presented to relevant quality and safety governance forums in March and June 2024. A further update was shared in May 2025 with the SHCG senior leadership team meeting. The papers only provide assurance on action completion. The detailed assurance plan, which captures all the recommendations and actions from the review, was not shared at these committees. Trust oversight of the actions from the review may therefore be limited.

No detail was provided on how the learning themes from the review would be shared across RMCH, the Trust and to other stakeholders.

Recommendation 5: Governance processes across the spinal service

Overall, this recommendation is high level. The actions cover some aspects of clinical governance, including the establishment of a divisional quality and safety forum, a weekly review of incidents, the implementation of the PSIRF requirements, data submission compliance for the BSR and the monitoring of surgical outcomes.

We made the following observations about the evidence provided for our assurance review:

- The divisional quality and safety forum needs formal terms of reference that includes oversight of the action plan from this review in the spinal surgery department. Analysis of incidents in the escalation report made to this forum shows it does not drill down to specialty level.
- It was highlighted that consultant capacity in job plans does not currently enable their attendance at M&M and MDT meetings. This is a weakness in service governance, particularly considering findings from the NCA SPSLBR in this area.

- A Trust-wide review of PSIRF implementation is currently underway. Following this, speciality and service level improvement priorities may be identified, but it is too soon to say what these may be in Spinal Surgery.

Other aspects of clinical governance were referenced in the report but are not included in the action plan. These include issues with consent, information sharing, pre-operative discussion, incident reporting, duty of candour and peer scrutiny of practice. A standard operating procedure for consent has now been developed, but is not yet being audited.

Recommendation 6: Use of data to determine effectiveness and safety across the service.

This action remains open. The Trust is exploring the use of dual consultant operations in the spinal service and is examining capacity and demand data to inform a business case. Benchmarking work is underway with Alder Hey Children's Hospital and the Evelina London Children's Hospital.

We were told that the service started to submit data in full to the BSR in early 2025, and that there is a process in place for ongoing data submission. There are intentions to use this data in local governance meetings, but this has not yet been established.

No evidence of the work done to date or reference to oversight by the relevant governance forum was provided.

Recommendation 7: Further review of research relating to clinical trial identified as part of the review.

The director of research governance and quality at RMCH carried out a comprehensive investigation into the conduct of the clinical trial and reported their findings in June 2024. The investigation found challenges in locating records that the principal investigator (Spinal Surgeon A) should have retained.

As additional assurance, the Trust provided a summary of the controls in place to ensure that research leads understand their responsibilities during clinical trials and that good clinical practice is maintained. These include a specific policy for principal investigators, associated SOP, training and certification.

Spire approach

8.22 As outlined in this report, the Spire's review was a patient recall exercise aimed at identify patients who needed a review to assure their safety. No specific action plan was produced from this work.

8.23 To help our understanding of how the recall exercise of Consultant Surgeon A's cases had informed the organisation's improvement work, the group medical director shared with us a presentation given to staff at the Spire Manchester in July 2025.

8.24 This event shared the learning from the PNE, outlining the purpose of the review, how it had been undertaken and overseen, and what the PNE had found. Findings shared with staff included:

- levels and types of harms identified

- incidental findings (e.g. quality of documentation, quality of GP correspondence)
- high-level findings from the NCA and RMCH reviews

8.25 The presentation then focused on actions the Spire had taken to improve care, either in the years since these historic cases or more recently. Helpfully, these were linked to the Systems Engineering Initiative for Patient Safety (SEIPS) model,[17] which is used to holistically review the systems in which safety incidents often take place and the multitude of factors that can limit patient safety. Around 30 changes are noted, including:

- raising concerns policy and processes
- formalised MDTs
- daily safety huddles
- reviews of relevant policies and procedures
- oversight of individual consultant performance
- new audit programmes
- pre-operative assessment, which has been in place for all inpatient and day-case surgery since 2016

8.26 Some of the actions noted are difficult to assess from an assurance perspective (such as "*more of an open door culture*" and "*culture change in hospitals*") although we acknowledge that the presentation was written for staff engagement purposes and is deliberately high level.

8.27 Positively, a thematic review of PNEs, summarising the learning from all PNEs undertaken since 2022, was reported in July 2025. Debriefs are also held at the end of each PNE with clinical panel members. We have seen a sample of feedback from these clinicians who have commented favourably on the fairness and clarity of the process.

8.28 This work outlined 19 themes from PNEs which had concluded or were still underway at the time of this report. Several of these are relevant to findings discussed throughout our report in relation to the Consultant Surgeon A case, such as:

- quality of consent processes, including discussion of all available treatment options and the extent of joint decision-making with the patient
- not sending patients for the appropriate investigations before surgery to confirm a diagnosis
- extent of discussion with MDT before surgery
- poor clinical decision-making about which procedure to perform
- spinal screw placement and placement of other implants
- complex surgery being performed by a single surgeon
- surgical technique
- how patient concerns are treated
- post-operative follow up

[17] NHS England (2022) SEIPS Quick Reference Guide and Work System Explorer.

- consultant behaviour
- quality of notes

8.29 We requested a sample of evidence of some of the changes described at 8.25, to carry out a high-level assessment of progress made in these areas. Our analysis from this work is provided in Appendix 3. Because a formal action plan was not developed after the Consultant Surgeon A recall, we could not approach this in the same way as for the three action plans in scope. For clarity, we do not view this approach as a weakness on the Spire's part because:

- their review was explicitly focused on patient recall
- the Spire sought to draw out themes from its PNE activity to understand the extent to which recurrent factors are a factor and to inform its improvement work

8.30 Key areas of development that are also of relevance to the findings from the Consultant Surgeon A PNE have been:

- a significant focus on consultant review, with strengthened processes for reviewing practising privileges
- greater focus on culture and behaviours, including their consideration in the biennial appraisal process for consultants
- a rigorous quarterly audit programme, including consultant documentation, consenting processes and pre-operative assessment
- processes to support speaking up
- staff engagement

8.31 However, the latest thematic review of PNEs from 2022 - 25 noted very similar findings to those identified in the reports within our scope linked to Consultant Surgeon A's practice. Acknowledging that the PNEs reviewed may also have been historic, it is important that the Spire continually reviews the impact of improvement actions to ensure that they have had the desired impact and to reduce the risk of similar events recurring.

Chapter 9: Conclusion and next steps

Summary

9.1 In our opinion, the look back work carried out so far (in the NCA SPSLBR, the RMCH look back review, the Spire PNE and the Breen Report) has been carried out in good faith. We have reviewed the previous reports and their recommendations in detail and found that while the investigation aims were well intentioned, some of the approaches taken led to recommendations and actions which have been incomplete, difficult to interpret and therefore implement and assure.

9.2 In this section we summarise the next steps, including our recommendations, our view on what further clinical review activity is needed and a suggested approach for a phase 2 review.

Recommendations

9.3 Based on our findings, we have made recommendations aimed at:

1. completing and evidencing the impact of recommendations *already made*
2. addressing the findings in previous reports *where formal recommendations were not made*
3. addressing a small number of *further recommendations* that this work has identified

9.4 We make six specific recommendations:

1. Develop an overarching, combined action plan for spinal surgery

Finding: Each organisation's spinal surgery departments have been reviewed by different bodies, leading to different action plans (e.g. look back reviews, CQC, GIRFT and now this review). To date, the impact of the actions taken has not received enough attention. There is a risk of losing oversight of all the disparate strands of improvement work underway.

Recommendation 1: All three organisations should develop a single and combined action plan that incorporates all the learning from previous review work (e.g. look back reviews, CQC, GIRFT).

There must now be a clear focus on the impact of actions taken, driven by defined measurement strategies for each action. Clear assurance reporting routes must also be agreed.

Consider whether project support is needed to drive these plans forward.

2. Ensure learning from all reviews is shared across all three organisations

Finding: Although many of the areas of concern about Consultant Surgeon As practice and the oversight of it appeared similar at each of the providers involved, the nature and extent of action planning differed substantially. Each site could benefit and learn from the action plans of the other two sites.

Recommendation 2: Once each organisation has developed a combined action plan, it should be shared with the other providers to ensure that each plan is complete, with all relevant learning and improvement ideas are captured.

3. Completing and evidencing the impact of recommendations already made

Finding: Our assurance review found that some recommendations from previous reviews had not been implemented. Where action had been taken, it had rarely been reviewed to ensure that it had achieved the desired impact.

Recommendation 3: The NCA and RMCH must review all actions from their respective reports to a) ensure that all have been delivered in full and, b) that their impact has been measured and embedded. If recommendations remain open they should be transferred to the combined action plan recommended above.

4. Closing down residual recommendations

Finding: Our review of the Breen Report and the NCA SPSLBR found some findings that had not been made into formal recommendations.

Recommendation 4: The NCA should review any potential gaps in recommendations from the Breen Report and the SPSLBR (see page 49) to assess whether further action is required. If it is determined that no further action is necessary, the reasons must be formally documented and shared at the forums responsible for overseeing the action plans.

5. Ensuring action plans reflect current concerns

Finding: During our fieldwork, staff raised several current concerns that had not been covered in the four previous reviews. These included, post-operative inpatient follow-up by the responsible surgeon, ward round effectiveness (including communication between medical staff, nursing colleagues and other staff), inconsistent reporting of serious incidents, the monitoring of key clinical indicators for spinal surgery and outpatient support after spinal surgery.

Recommendation 5: When developing a combined action plan, include actions to improve the processes for:

- **post-operative inpatient follow-up by the responsible surgeon**
- **ward round effectiveness (including communication between medical staff, nursing colleagues and allied health professionals)**
- **outpatient support after spinal surgery**
- **the quality of incident reporting**

6. Ongoing monitoring of key clinical indicators for spinal surgery

Finding: Because of the risks associated with spinal surgery and the historic concerns in the departments, there is a need for a joined-up picture of the current safety of each service.

Recommendation 6: Introduce a spinal surgery quality and safety dashboard in each organisation to regularly benchmark performance on, for example, surgical site infections, metalwork failure rates, misplaced screws, post-operative neurological deficits, and metrics of patient satisfaction and feedback. This information should be visible to all staff delivering the service so they can see how well the service is performing.

Further clinical reviews required

9.5 We were also asked to recommend any further review, recall or look back activity that may be needed. To assess this, we conducted an appraisal to analyse the different recall options available

against a set of criteria taken from our discussions with patients, staff and stakeholders. This options appraisal is detailed in Chapter 6.

We have concluded that, for at least a three-year period, any previous patient of Consultant Surgeon A who requests a review of their care should be offered an in-person consultation, even if no harm has been identified by previous reviews. This should be available to any patient who has had surgery performed by Consultant Surgeon A at any of the three organisations where he worked.

These reviews must:

1. focus on the patient's current concerns about their condition and how it impacts their daily life. To understand the impacts, patients should be spoken with directly. Each request could be triaged and it could be a specialist nurse, physiotherapist or surgeon who carries out the initial consultation.

2. offer a historic review of the involvement of Consultant Surgeon A in their instrumented surgery if this is requested and is feasible.

3. be delivered compassionately and acknowledge any suffering caused to patients and families.

4. take into account accessibility, physical and otherwise, to ensure that approaches taken are based on what is easiest for patients and their families. This might include offering video and telephone options for initial triage.

5. meet all the requirements of the NHS England Recall Framework.

We recommend that the NCA and MFT, with support from the ICB, communicate and advertise this offer (e.g. to GPs, on Trust websites and with relevant charities and national bodies such as the BSS) to ensure that Consultant Surgeon A's patients are aware they have a three-year window to request a review.

The need for additional investigative review work/phase 2 review

9.6 Much of the distress for patients (and staff) who were treated at SRFT and the NCA is less about the care they received, which some have made their peace with, and more about the overall governance of the service. As outlined at the start of this section, patients believe there have been cover ups about what was known about these events. They believe that if issues had been dealt with appropriately, outcomes for them or others may have been different.

9.7 Understandably, some of these patients, and also staff, have lost trust in the NCA. Our experience of speaking with NCA executives and leaders found a real desire to understand what happened - even when this is uncomfortable - and to unequivocally learn from this. The CEO in particular was proactive throughout in sharing information that would help our work, but this is not always being felt by patients, families and staff, who feel too bruised by their experiences.

9.8 As such, there are clear calls for a phase 2 review focusing on the outstanding questions:

Within the NCA and SRFT, what was known about these matters historically, and at what key points could different action have been taken? For the concerns about the clinical practice and behaviour of Consultant Surgeon A:

- what information was available?
- what was done with this information?
- how did this action compare with expected policy and practice?
- at what points could different action have been taken to change outcomes?

9.9 It is important to note that fully answering these questions may not be achievable. We were repeatedly told that in the reviews completed so far, changes in electronic systems, the Trust merger, poor documentation and inconsistent recollections of events had frustrated efforts to understand what had happened historically.

9.10 For this reason, we recommend that an independent feasibility study is completed to:

- define what information is required to satisfactorily answer these questions
- determine the availability of this information
- conclude whether a meaningful investigation into these matters can progress

9.11 This is necessary to prevent public money being wasted on further review work that will not return clear answers. Where answers cannot be provided, it needs to be clear what information was sought, how it was sought, and why it was unavailable or insufficient to arrive at a balanced view. The final terms of reference must reflect the voice of patients and staff so there is no room for misaligned expectations. It is crucial that any further reviews and recall activity about Consultant Surgeon A and associated matters put patients first and fully answer outstanding questions (or are explicit about why this cannot be done) so that proper remedial action can be taken and patients, families and staff affected can find closure, as far as possible.

9.12 If this feasibility study concludes that the required information can be secured, a phase 2 review should provide a clear timeline of events, so that patients have all the available facts, presented in a way that is accessible to them and that is validated independently.

9.13 Finally, while staff and leaders in the NCA have worked hard to drive the service forward, we believe the quality of recommendations from previous reports has been inadequate to meaningfully prevent similar issues from recurring. In any further review work, it is key to focus on the quality and safety of the service provided today. Many years have passed since Consultant Surgeon A left each of these organisations and it is essential to maintain a sufficient focus on the here and now, to provide assurance to the public that these issues are now in the past.

9.14 We recommend that an efficient independent current controls review is completed in each of the three spinal surgery departments, focusing on the current oversight of quality and safety. This work should objectively answer the question of how a similar issue would be handled in each department today to ensure patient safety.

9.15 The draft terms of reference for this review (both the feasibility study and current controls work) are set out in Appendix 5. If further work is commissioned, the final terms of reference will be refined with patient and stakeholder engagement.

Appendices

Appendix 1: Terms of Reference for this review

A retrospective lookback review of patients who underwent spinal surgery provided by Index Consultant A in hospitals across the North West

Introduction and background

Consultant Spinal Surgeon A has been under investigation following whistle blowing concerns initiated by colleagues. Concerns related to behaviour, conduct, probity and capability. Consultant A worked at:

- Salford Royal NHS Foundation Trust (now part of the Northern Care Alliance NCA) to 2015
- Royal Manchester Children's Hospital (part of Manchester Foundation Trust) between 2006 to 2011
- Consultant A provided additional private services at Manchester Spire and BUPA Hospital from 1991

Current state

To date there have been four reviews into the surgical activity undertaken by 'Consultant A'.

- NCA - INTERNAL INVESTIGATION - Spinal Patient Safety Look Back Review (SPSLBR)
- MFT - Internal investigation
- Spire - Internal investigation
- NCA - External investigation

Scope of the investigation

The initial phase includes*:*

1. Using appreciative enquiry to actively engage with patients, their families and stakeholders including, but not limited to, patients, MPs and spinal experts to understand their concerns about the reviews already undertaken and their further request for a look back in more detail.
2. To review the previous Terms of Reference, reviewing the consistency of application of previously agreed definitions e.g. instrumental/implantable surgery and the methodology and timelines from existing reviews for the purpose of identification of any new cohorts of patients to be reviewed clinically or to have an alternative look back process.
3. Review, triangulate and thematically review the recommendations from all four previous reviews undertaken so far to establish if any new recommendations emerge.
4. Determine the level of assurance for each provider organisation on the delivery and governance associated with the recommendations.
5. Develop Terms of Reference for any future reviews/look backs needed, including any identification of further patient cohorts.

Out of scope of the investigation

The purpose of an independent patient safety investigation (IPSI) is to capture insight to inform improvement through investigation and exploration of the care, treatment and healthcare systems and processes for one or more patients at any level of the healthcare system.

They support the NHS to:

- be open and transparent about what happened and how it happened
- identify areas for improvement to reduce the possibility of a reoccurrence of similar events
- make recommendations for the improved delivery of health services in the future which can then be acted upon by relevant organisations with the power to make appropriate changes

IPSIs are only commissioned in limited circumstances, where it is considered appropriate to dedicate additional resources to the generation of insight due to the nature of the events in question.

An NHS England-commissioned IPSI does not apportion blame or liability. They do not hold people to account nor are they concerned with fitness to practice, criminal or other issues. However, the commissioning of an IPSI may occur alongside such processes.

Governance

1. This Independent Patient Safety Investigation (IPSI) will be a nationally commissioned, regionally led review with support from the National Patient Safety Investigation Team (NPSIT).
2. The Senior Responsible Officer (SRO), Dr Michael Gregory, will be supported by the Regional Independent Investigations Team (RIIT).
3. Immediate patient safety concerns should be raised with the RIIT to be escalated to the SRO.
4. The North West Independent Investigation Review Group function is to provide governance and oversight of Patient Safety Incident Investigations (PSII) and their progression. The NPSIT will be invited to these meetings where there is decision making, discussion regarding escalation of concerns, and to review the progress of the IPSI.

Timescale of the investigation

The initial phase of this review should be completed by the end of October 2025.

Expected outputs / intended outcomes

1. Written report, following engagement with all the relevant stakeholders to include recommendations for restorative action, that are clear and explicit.
2. Written report to include the triangulation of the recommendations from all four reports undertaken and include any new recommendations that emerge from the thematic review.
3. Written report that captures the quality and integrity of assurance for each provider organisation on the delivery and governance associated with the recommendations.
4. Provide NHS England NW with a ‘Terms of Reference’ for any future review/look back.

Appendix 2: Recommendations from the four reviews within scope

Recommendations from the Breen report

Recommendation from the Breen report		Theme
1	1137. Members of this group feel aggrieved and disappointed with the manner in which they have been dealt with by the Trust. Some of the individuals have attempted to speak out about concerns for themselves or others and have been met with resistance and inaction.	Not a recommendation
2	1138. Various individuals have raised multiple concerns, as set out in the whistleblowing letters and indeed as part of the disciplinary process. Taken globally, and considering all the accounts I have been given, there is merit in their belief that they have been failed.	Not a recommendation
3	1139. Members of staff and surgeons were not informed of the basis of the dismissal of Doctor F until 2021, some six years after their departure.	Not a recommendation
4	1140. Because of the lack of information being shared surrounding Doctor F's dismissal, members came to their own conclusion, and believed that Doctor F had been "paid off". This is in the context of a group of individuals who had felt bullied and mistreated by Doctor F, it therefore strengthened their perception that they were "untouchable". There was a perception that Doctor F was being "'protected'" by senior management.	Not a recommendation
5	1141. I have considered suggestions that governance had been manipulated by Doctor F and or Manager A. Whilst I have not seen specific and clear evidence of this, as a result of interviews of various staff members, there is certainly an inference of manipulation and an inference that complications, DATIX and concerns were not progressed as they perhaps should have been. Independent Expert A has commented on this aspect in their reports and has raised concerns. Furthermore, there was a clear perception that Doctor F was being protected by Manager A, and that they together either bullied staff, or as above, manipulated governance processes. This was not investigated by the Trust, at the time. The culture that existed in my view eroded the trust and confidence of staff in this division.	Not a recommendation
6	1142. I cannot see what became of the review conducted by Manager C in the latter part of 2015 and May of 2016. Members of the BSG provided lists of patients that they believed warranted further consideration. They reported concerns they held about Doctor F and their practice, one of which appear to have progressed further until November 2021.	Not a recommendation
7	1143. Taking these and other factors into account, it is little wonder that members of the BSG felt let down and believed that Doctor F was being protected.	Not a recommendation
8	1144. I remind myself of the split in the 2014 investigation that led to the disciplinary proceedings and the ultimate dismissal of Doctor F. I have	Not a recommendation

Recommendation from the Breen report		Theme
	recorded my views on the inadequacies and failings of this exercise earlier. It is another example of how the members of the BSG feel that they were not listened to.	
9	1145. Members of the BSG were not advised that they had been listened to, there was no opportunity to discuss concerns, nor were they given any reassurance that the concerns would be dealt with. The Freedom to Speak Up process failed them.	Not a recommendation
10	1146. The recent observations by the CQC, set out above, are a cause for concern.	Not a recommendation
11	1147. The above examples support the view held by the BSG that they had been failed. Left without clear information and/or support, it is understandable the feelings of disappointment, upset, anger and apathy have fostered negative beliefs. For this, I believe that they are owed an explanation and apology.	Bullied Staff Group
12	1148. I have listened carefully to the concerns raised regarding the systems and measures that were and are in place at the Trust. I have considered evidence of DATIX, Adverse Incident Report and serious untoward incidents and how they are recorded and the various forms in which concerns can be raised and/or investigated. As set out above however, my remit does not include a consideration of governance manipulation. I limit my observations to the governance processes in place within the Trust.	Not a recommendation
13	1149. Doctor H has provided me with some insight as to how a given division/directorate operates in practice and the hierarchy of each division/specialty.	Not a recommendation
14	1150. Leader D, Leader C, Leader E and Manager C have all provided information on various management roles and general structure.	Not a recommendation
15	1151. Leader A has helpfully provided me with a detailed picture of the organisation and functions of the Trust.	Not a recommendation
16	1152. Reflecting on all of the accounts, information, opinion, and evidence provided to me, I make the following observations.	Not a recommendation
17	1153. I understand that the DATIX system has evolved and now tracks actions and input from individuals. Taking into the account the concerns voiced by Doctor H, users would benefit from comprehensive guidance about the channels and steps that determine what should and should not be filed using the DATIX system. From the examples that I have seen, the information contained can be somewhat limited and it can be difficult to follow the chain of events.	Datix

Recommendation from the Breen report		Theme
18	1154. I am told that, for example, in the case of Patient A there is no record of a multidisciplinary team meeting or what was agreed and discussed there. This is something that should be readily available.	Record keeping - MDT
19	1155. I am aware of the function of the Morbidity and Mortality meeting and the Rapid Review process. However, as I understand it, none of this is recorded centrally.	Record keeping - M&M and RR notes
20	1156. I am told that while letters and notes of meetings with family members dealing with duty of candour etc. may be stored in some capacity, there is no uniform approach, and they are not centrally recorded.	Record keeping - meetings with families
21	1157. I believe that the digital systems that are in place have the capacity to capture and store all of the relevant information, documents and reports. Use of the central storage of all relevant material, does not appear to be demonstrated.	Record keeping - reports and other information
22	1158. There is a need for a robust recording system, with the function to record who made changes and why. The Trust should put in place a system that allows and keeps records of all discussions and documents including Rapid Reviews (currently not in the DATIX system) and multidisciplinary team meetings. Where DATIX are downgraded, the reason for this and who made that decision, needs to be recorded. This also applies to any form of patient review in relation to a particular surgeon. For example, had Doctor I's work for Manager C been recorded in a central system, it could have been viewed in 2016 by multiple individuals, which could then have impacted upon the Trust taking action earlier.	Record keeping - for rapid reviews and Datix grading decisions
23	1159. The contents of Morbidity and Mortality meetings should be recorded in the same system to allow easy access and recovery of data when and if required in later years. If adherence to such a system was strictly enforced, then there would not be a situation as in the case of Patient A and Patient C that Morbidity and Mortality meeting notes were not stored.	Clinical governance/M&M meetings
24	1160. Of course, the completion and adherence to protocol would require supervision and oversight.	Clinical governance/M&M meetings
25	1161. Whilst there is no specific evidence, certain individuals have described to me what amounts to an undercurrent of cronyism.	Not a recommendation
26	1162. I am told individuals are being placed in roles as a result of the grace and favour of close colleagues. An example of which that was reported to me is that Doctor F appointed Doctor L as their Deputy when Doctor G was the more senior member. I have not confirmed if this is accurate, and this allegation is therefore unverified.	Not a recommendation
27	1163. The Trust should ensure that the senior leadership appointments process should be an open, transparent, and competitive process, with an	HR processes - leadership

Recommendation from the Breen report		Theme
	objective assessment as to competency for the role. There is a perception that the appointments process is not transparent. The views as expressed to me in a letter from Doctor X on 3 January 2023, set out above, need to be taken into consideration.	appointments processes
28	1164. It may be desirable for the Trust to set out a description as to the roles of the leadership team within each division, providing job descriptions. The Trust should consider undertaking regular appraisals, including 360-degree appraisals of the leadership team. Perhaps appraisals of senior leaders could be conducted by someone outside of the division to allow for a degree of independence.	HR processes - regular and independent appraisals of leaders
29	1165. When considering the specific Division of Spinal Surgery, the fact that the Chair of Division was also a surgeon in that speciality, made it difficult for staff to raise concerns (filing DATIX) specifically about Doctor F or their practice, knowing that this would be seen by Doctor F. The approach taken by Doctor H is more favourable, in that a Chair of Division should not also be a surgeon in that same division, but from a different specialty.	HR processes - arrangements for divisional chairs
30	1166. This perceived cronyism resulted in legitimate and real concerns not being raised due to a perceived lack of independence and accountability. Any measure afforded to the staff to 'speak up' was met with mistrust and suspicion. Systems need to be put in place to ensure transparency, and that any appointment made is done so on merit.	HR processes - systems to appoint leaders on merit
31	1167. I have considered the worrying opinions and commentary, in particular of Doctor H, Doctor I and Independent Expert A, in relation to the clinical and surgical practice of Doctor F, and the findings and conclusions of the Spinal Patient Safety Look Back Review. I rely on the expertise of these individuals and particularly the expert opinion of Independent Expert A, whose opinions I adopt.	Not a recommendation
32	1168. Throughout the various 'patient lists', reviews and Doctor H's "dip dive" it is clear that there is evidence that certain patients have at worse suffered avoidable harm and at best received substandard care.	Not a recommendation
33	1169. In each of the cases mentioned, they and or their families should receive a full and transparent explanation and an apology for the level of care they received from Doctor F and the Trust. In relation to Patient A, I understand that the family have now at very long last been provided with a finalised serious untoward incident investigation report, and an explanation has been provided to them, 16 years after Patient A's unfortunate death.	Full report and explanation to each patient with apology
34	1170. In my view disciplinary investigations require the expert input of Human Resources.	HR processes - HR input to disciplinary investigations

Recommendation from the Breen report		Theme
35	1172. My understanding is that Doctor F has been referred again to the GMC.	Not a recommendation
36	1173. It has been reported to me that certain members of staff believe that there was, at the time of Doctor F's tenure, an undercurrent of racism. There is also a perception that a racist culture continues to exist. My remit was not to investigate if this was correct, and I have not done so. In my view, however, the Trust needs to explore with colleagues why concerns have arisen and what the Trust can do to restore confidence. This is an issue which must be dealt with.	Racism

Recommendations from the NCA look back review

Recommendation from the NCA look back review		Theme
1	10.1. Where severe harm has been identified and externally validated by the Independent External Reviewer, a separate datix will be raised and linked to the SPSLBR datix serious incident.	Raise datix reports
2	10.2. The Trust should implement a patient safety framework in line with national requirements following implementation of a PSIRF by Autumn 2023.	Implement PSIRF
3	10.3. In light of multiple significant contradictions identified in the Royal College of Surgeons' clinical review of 10 patients under the care of Consultant Spinal Surgeon A and the SPSLBR findings having reviewed 9 of these patients, the Trust should share such findings with the Royal College of Surgeons.	Share findings with RCS
4	10.4 A copy of the SPSLBR report should be shared with interested external stakeholders including: a) Consultant Spinal Surgeon A b) Consultant Spinal Surgeon A's Responsible Officer c) NHS Resolution's Significant Concerns Group d) Spire Manchester e) MFT f) Care Quality Commission g) Integrated Care Board, and h) National professional bodies such as Royal College of Surgeons and the British Scoliosis Society.	Share findings with stakeholders
5	10.5. Given the nature of the serious and frequently occurring significant professional issues identified, the Trust should share a copy of this report and any associated concerns within Appendix Q regarding conduct, probity and capability with the General Medical Council.	Share report with GMC
6	10.6. A copy of Appendix A (Executive Summary) to the SPSLBR should be shared with patients who fall within the scope of the SPSLBR and relevant internal stakeholders, if requested.	Create summary of report for patients
7	10.7. In respect of recommendations 10.4, 10.5 and 10.6, consideration should be given to the sequence in which a copy of this report is shared with the interested external stakeholders identified.	Share report

Recommendation from the NCA look back review		Theme
8	10.8. A deep dive review should take place of the patients who were noted to be lost to follow up to identify whether there were any other drivers that may have caused the issue and to identify any areas of learning.	Review lost to follow up
9	10.9. It is recommended that the Trust considers whether patients falling outside the scope of SPSLBR require separate review. The SPSLBR Investigation Group considers that there are three options in this regard and recommends option: a) Take no further action; b) Adopt a risk stratified approach that may take the form of i. Invite all patients seen by Consultant Spinal Surgeon A whilst employed at the Trust for a review of their care, if the patient wishes; ii. Following any likely media publication of the outcomes of the SPSLBR, issue a media invitation for a desktop review to any patients who have concerns. c) Complete a full review according to the Terms of Reference and methods within the SPSLBR for every patient who has been seen by Consultant Spinal Surgeon A since they began working for the Trust in 1991.	Further review

Recommendations from the RMCH look back review

Recommendation from the RMCH look back review		Theme
1	RMCH will review the clinical governance structure and processes within the paediatric spinal service and ensure that they are aligned to the recently implemented National Patient Safety Incident Response Framework (PSIRF); and assurance provided to the RMCH Quality and Safety Committee and Group Quality and Performance Scrutiny Committee.	PSIRF
2	RMCH will review the potential indications for, and implications of, dual consultant operating by spinal surgeons and benchmark current practice against other UK children's hospitals and any national standards.	Clinical recommendation - use of dual surgeons and benchmark
3	RMCH will review the clinical governance structure and processes within the paediatric spinal service and ensure that they are aligned to the recently implemented National Patient Safety Incident Response Framework (PSIRF); and assurance provided to the RMCH Quality and Safety Committee and Group Quality and Performance Scrutiny Committee.	Review clinical governance and implement PSIRF
4	All patients and families have been sent summary letters outlining the outcome of their reviews.	Outcome letters to patients
5	The Group Research Governance Committee will oversee and carry out further investigation into the clinical trial identified as part of this review, and the associated research governance.	Review clinical trial governance processes
6	A summary of the review and its findings will be presented at relevant RMCH and MFT Quality and Safety meetings to ensure learning from the issues	Corporate governance

Recommendation from the RMCH look back review		Theme
	highlighted by the report; and assurance provided that all actions have been completed to the Board-level Quality and Performance Scrutiny Committee.	
7	Clinical follow up has been arranged if required.	Clinical follow up
8	MFT, along with the review team, will consider if any further reviews are required for other patients who have received care under Spinal Surgeon A outside of the time period reviewed, particularly if concerns come to light from other patients and families.	Further clinical review
9	A copy of this report will be shared where appropriate with external stakeholders including the NCA, NHSR, the GMC, Spire Manchester Hospital (private provider where Spinal Surgeon A had practised), Spinal Surgeon A and their Responsible Officer.	Share report with stakeholders
10	Duty of candour letters have been sent to patients and families for whom there have been findings of moderate or severe harm, and meetings offered to discuss the findings in more detail.	Duty of candour

Appendix 3: Evidence of progress against recommendations made

NCA look back review action plan progress

Recommendation 1: Where severe harm has been identified and externally validated by the Independent External Reviewer, a separate datix will be raised and linked to the SPSLBR datix serious incident (report ref. 10.1).	
This recommendation tracks to original action 7 on the Trust's action plan update (action 6 in SPSLBR report). The action plan update shows that this work was completed ahead of deadline in March 2025; individual Datix records could not be provided in the evidence due to patient confidentiality.	
Evidence submitted	**Review team analysis**
Action plan update (not dated).	The action plan update indicates that this action (original action 7) was closed on 2 March 2025 (deadline date was end of May 2025). The individual Datix records are not provided in the evidence as these contain patient identifiable information.
Recommendation 2: The Trust should implement a patient safety framework in line with national requirements following implementation of a PSIRF (Patient Safety Incident Response Framework) by Autumn 2023 (report ref. 10.2).	
This recommendation tracks to original action 6 on the Trust's action plan update (action 5 in the SPSLBR report). The PSIRF was implemented across the NCA in April 2024 in line with NHS national guidance. A policy, procedures and guidance for staff have been developed and made available on the Trust's intranet. The policy sets out the monitoring arrangements for oversight of the effectiveness of the policy but no evidence of monitoring of implementation was provided. The Trust's Patient Safety Incident Response Plan for 2024/25 shows that incidents relating to implantable devices are a local priority.	
Evidence submitted	**Review team analysis**
Action plan update (not dated).	The action plan update states that the PSIRF was implemented Trust-wide in April 2024. The NCA's policy and associated documents are available to staff on the intranet. The action plan states that PSIRF local priorities and learning from PSIIs are routinely monitored by the Patient Safety Group and Quality and Performance Committee. No additional information was provided as evidence of monitoring application of the PSIRF.
Patient Safety Incident Response Policy, March 2024	The Trust's PSIRF policy was approved by the Quality and Performance Committee on 18 March 2024.
Patient Safety Incident Response Plan, April 2024	This document sets out the Trust's Patient Safety Incident Response Plan in line with PSIRF requirements and was approved in March 2024. This shows that a local priority is 'implantable related incidents.'
NCA PSIRF intranet resource, not dated.	This document provides a link to the PSIRF policy on the Trust's intranet.

Patient Safety Incident Investigation, Colleague information (File: NCAPS010 _Colleague information), not dated.	This document provides further guidance to staff to support implementation of the PSIRF. This covers: • what to expect during a PSII; • staff involvement in PSIIs; and • how staff can access further support.
Recommendation 3: In light of multiple significant contradictions identified in the Royal College of Surgeons' clinical review of 10 patients under the care of Consultant Spinal Surgeon A and the SPSLBR findings having reviewed 99 of these patients, the Trust should share such findings with the Royal College of Surgeons (report ref. 10.3).	
This recommendation is restated in action 7 in the SPSLBR report. The report was shared with the RCS.	
Evidence submitted	**Review team analysis**
Action plan update (not dated)	No reference to this recommendation in the action plan update.
Recommendation 4: A copy of the SPSLBR report should be shared with interested external stakeholders including: a) Consultant Spinal Surgeon A, b) Consultant Spinal Surgeon A's Responsible Officer, c) NHS Resolution's Significant Concerns Group, d) Spire Manchester, e) MFT, Care Quality Commission, Integrated Care Board, and h) National professional bodies such as Royal College of Surgeons and the British Scoliosis Society (report ref 10.4).	
This recommendation is restated in action 9 in the SPSLBR report. The report was shared with: The RCS, the GMC, the British Scoliosis Society, as well as with wider stakeholders.	
Recommendation 5: Given the nature of the serious and frequently occurring significant professional issues identified, the Trust should share a copy of this report and any associated concerns within Appendix Q regarding conduct, probity and capability with the General Medical Council (report ref 10.5).	
This recommendation is not captured in the SPSLBR report actions. The report was shared with the GMC.	
Recommendation 6: A copy of Appendix A (Executive Summary) to the SPSLBR should be shared with patients who fall within the scope of the SPSLBR and relevant internal stakeholders, if requested (report ref 10.6).	
This recommendation is not captured in the SPSLBR report actions but tracks to original action 16 on the Trust's action plan update. The action plan update shows that the sharing of Appendix A with patients/families was completed ahead of deadline in December 2023; individual Datix records could not be provided in the evidence due to patient confidentiality. The action plan does not refer to the sharing of the Executive Summary internally or if there were any requests for this by staff.	

Evidence submitted	Review team analysis
Action plan update (not dated)	The action plan marks this action (Datix 43481) as complete on 29 December 2023 and states that all associated Duty of Candour information has been uploaded to Datix. The individual Datix records are not provided in the evidence as these contain personal identifiable information.
Recommendation 7: In respect of recommendations 10.4, 10.5 and 10.6, consideration should be given to the sequence in which a copy of this report is shared with the interested external stakeholders identified. (report ref 10.7).	
This recommendation is restated in action 8 in the SPSLBR report but there is no reference to this action in the action plan update, so we are unable to give assurance that this action was completed.	
Evidence submitted	**Review team analysis**
Action plan update (not dated)	No reference to this recommendation in the action plan update.
Recommendation 8: A deep dive review should take place of the patients who were noted to be lost to follow up to identify whether there were any other drivers that may have caused the issue and to identify any areas of learning. (report ref 10.8).	
This recommendation is restated in action 10 in the SPSLBR report and tracks to action 10 on the Trust's action plan. The Trust has undertaken further work for three patients identified as lost to follow up in Phase 1 of the SPSLBR and found no issues as these patients were in fact followed up or discharged. In addition, the Phase 2 work did not identify any concerns in this regard. Ongoing oversight is provided through the Waiting List Safety Group with waiting list management as a PSIRF priority.	
Evidence submitted	**Review team analysis**
Action plan update (not dated)	The action plan marks this action as complete on 29 November 2024. It states that three patients were identified as lost to follow up from the original review and that these cases were reviewed to establish if there were any further issues apparent (not already known). Upon review, it was found that these patients were followed up or were discharged. The action plan update also states that there were no lost to follow up issues identified in Phase 2 of the review. It is highlighted that waiting list management is a PSIRF priority (with a focus on implantables) with assurance through a Waiting List Safety Group. Evidence of inclusion in the Patient Safety Incident Response Plan was not provided.
Patient Safety Incident Response Plan, April 2024	This document sets out the Trust's Patient Safety Incident Response Plan (PSIRP) for 2024/25 in line with PSIRF requirements and was approved in March 2024. This shows that a local priority is 'implantable related incidents' including the timely management of these patients.

Recommendation 9: It is recommended that the Trust considers whether patients falling outside the scope of SPSLBR require separate review. The SPSLBR Investigation Group considers that there are three options in this regard and recommends option 10.9 (b):

a) Take no further action;

b) Adopt a risk stratified approach that may take the form of:

i. Invite all patients seen by Consultant Spinal Surgeon A whilst employed at the Trust for a review of their care, if the patient wishes;

ii. Following any likely media publication of the outcomes of the SPSLBR, issue a media invitation for a desktop review to any patients who have concerns.

c) Complete a full review according to the Terms of Reference and methods within the SPSLBR for every patient who has been seen by Consultant Spinal Surgeon A since they began working for the Trust in 1991.

(Report ref 10.9)

This recommendation is restated in action 11 in the SPSLBR report and tracks to action 15 on the Trust's action plan. The Trust has considered the options for the review of patients which did not fall within the scope of the SPSLBR and determined that any patients coming forward following publication of the SPSLBR and Breen reports would be reviewed as part of the Phase 2 work. Progress is being monitored via reporting to the Patient Safety Group and Quality and Performance Committee, an update was given in August 2025 and identified that out of the cohort of 40 patients in Phase 2, five cases of patient harm were identified with learning themes consistent with the findings of Phase 1. Duty of Candour processes had been enacted where applicable. The Phase 2 report is not yet available.

Evidence submitted	Review team analysis
Action plan update (not dated)	The action plan marks this action as complete on 29 November 2024 (action ref. 43480) as the Trust has considered review of patients falling outside the scope of the SPSLBR and determined a way forward through the SPSLBR Phase 2. The Trust's decision was to review any self-identified patients with concerns following publication of the Phase 1 report and Breen Report. A full recall was not deemed necessary as unlikely to generate further learning. The commentary refers to 40 patients being reviewed as part of Phase 2 and that the report was in progress. The action plan states that no new learning themes were identified.
Paper to the Patient Safety Group and Quality and Performance Committee, 20 August 2025 Spinal Service Update - Patient Reviews	This paper provides an update to the Committee on the progress of the review of 40 patients as part of the Phase 2 work. It highlights that: • five cases of patient harm were identified (4 moderate, 1 severe) from the patient cohort; • the learning themes identified related to surgical planning, clinical documentation and inadequate consent which were consistent with previous findings from Phase 1; and

	• patients were being informed of the findings with Duty of Candour processes where applicable and an offer to meet with the Deputy Chief Medical Officer (eight meetings requested to date had taken place). Following this meeting, we understand that the SPSBLBR addendum report was approved at the Trust's Quality Committee and has been the subject of a Triple A Board Report (November 2025).

These are the actions referenced in the SPSLBR report (section 11) which are not clearly linked to the overarching recommendations. Those actions in section 11 which are duplicated from the overarching recommendations are considered above.

This section of the report was unclear on the actions remaining to be undertaken as it refers to actions and learning from the 2007 investigation for the index case, statements of reassurance on actions undertaken as well as what was deemed to remain as outstanding actions.

In our analysis below, we highlight those actions (including those referenced in the index case) where further assurance may be required to demonstrate that actions are embedded as limited evidence in relation to some of these actions was provided in the action plan update.

Action 1: MDT (multi-disciplinary team) process. Confirm governance processes are fit for purpose within Spinal MDT:

- **Terms of Reference to be drafted for the MDT.**
- **By September 2023, the Spinal Clinical Governance Team will complete an audit of Morbidity & Mortality, MDT and governance minutes; and triangulation with theatre listings, team brief and WHO checklist.**

The overarching action on governance processes within Spinal MDT translates directly to action reference 11 on the action plan update. This states that the Spinal team have regular M&M meetings, clinical governance meetings and operational meetings; evidence of these meetings was not provided.

The Trust has undertaken significant work to ensure that MDT processes in the Spinal Service work effectively and consistently including the development of a Standard Operating Procedure, the establishment of an MDT coordinator role and ongoing audit to ensure complex cases are discussed pre-operatively.

An audit of the effectiveness of the MDT operation was last undertaken in early 2025 and showed an improvement in outcomes compared to an audit in 2023 (over 90% (47 patients) in the 2024/25 audit compared to 55% in 2023 compared to the target of 100% of cases referred to MDT being achieved).

It is unclear why the Trust has not undertaken triangulation of outputs from governance meetings with theatre listings, team brief and the WHO checklist (this action is also referenced below in Action 2); no evidence was provided for this part of the action.

Action 1, bullet 1 corresponds to action reference 3 on the action plan update. Action 1, bullet 2 corresponds to action reference 1 on the action plan update.

Additional observations where more assurance may be required:

Note that these actions are set out in the report under the MDT section and do not directly relate to the operation of the MDT.

Action 1 (section 11 of the SPSLBR) refers to learning from incidents and states as follows:

- "*Any matter where there is joint learning across surgery and anaesthesia are shared between the governance leads to discuss at their governance meetings.*" No evidence was provided to demonstrate that this joint governance of learning is effective.
- "*Clinical incidents are discussed at Spinal Morbidity and Mortality meetings as well as clinical governance meetings.*"

With regards to learning from the 2007 investigation, the following actions are noted as complete with no evidence provided to this review to confirm this:

- Mandatory child protection and safeguarding training for anaesthetists and surgeons.
- Visiting surgeons involved in direct care or interventions now have honorary contracts where necessary.

Evidence submitted	Review team analysis
Action plan update (not dated)	The action plan update states that the Spinal team have established quarterly combined M&M and governance meetings as well as monthly operational meetings for discussion of incidents and audit. The action plan refers to evidence of these meetings being available through minutes, but these have not been provided (noting that redaction will be required).
Local Standard Operating Procedure (SOP): Spinal Surgery Multi-Disciplinary Team Meeting, 5 February 2025	The SOP was approved in February 2025 and sets out how the weekly MDT should operate with attendance by relevant professionals to discuss the management of complex spinal cases. It describes roles and responsibilities, MDT referral process and how MDT meetings are organised (purpose, attendance, frequency) and documented, thereby providing a terms of reference for the meetings. The SOP refers to a quarterly audit by the MDT Clinical Lead to ensure that cases referred to the MDT have been managed or discussed appropriately.
Action plan update (not dated)	The audit and triangulation actions relating to M&M, MDT and governance meetings were marked as complete as at the end of May 2025 in the action plan update. The action plan update states that this work focused on the quality, clarity and reliability of the MDT discussion and that the initial audit (see below in 2023) did not provide satisfactory assurance that all complex cases were reviewed. A reaudit with a clear terms of reference was undertaken in 2025 (see below) with improved results, and this would be undertaken on an annual basis. The action plan states that the action on triangulation with M&M and governance meeting discussions has not been undertaken "*as not feasible clear action…*" We are unclear as to the meaning and intention of this statement.
Spinal MDT Audit, November 2023	This document is a presentation on the MDT audit undertaken in 2023 to assess how many instrumented elective spinal surgical cases are discussed at the complex spinal MDT prior to surgery (target of 100% of cases). The audit covered 31 cases in May and June 2023 of which 55% had been discussed in MDT prior to their surgery. The audit observed that the poor result appeared to be due to a lack of coordination across surgery rather than any lack of intention to discuss cases pre-operatively.

	The recommendations from the audit were for an MDT coordinator role to be put in place with guidelines for patients to be discussed at MDT.
Review of revised MDT process, 25 April 2025	This document reports on the most recent audit undertaken to evaluate the adherence to Complex Spinal MDT SOP to determine if all cases referred to the MDT were reviewed and if the outcome was documented and filed. The audit covered the period from mid-December 2024 to the end of February 2025. 81% of cases (42/52) referred were reviewed at the MDT with appropriate documentation available in all of the cases reviewed. The ten cases not discussed were investigated and in five cases there was a logical reason why they had not come to the MDT meeting, e.g. under the care of a different specialty or not fit for surgery. For the five patients who had been missed, three had not had surgery and would be discussed pre-operatively, two appeared not to have been discussed as there was no documented record of this. The audit recommended further investigation for the five missed patients and annual reaudit.
Meeting Summary: Spinal Directorate, 7 May 2025	Notes of this meeting showed that the audit results from the April 2025 audit were shared with the team.
Action 2: Pre-operative surgical planning. By September 2023, the Spinal Clinical Governance Team will complete: • **Triangulation of theatre WHO checklists with MDT outcomes and theatre listings.** • **Review of the audit of the anaesthetic pre-operative assessments, which was identified in the 2007 investigation.**	
Action 2, bullet 1 is duplicated in Action 1 - as stated above it is unclear why this has not been completed. Action 2, bullet 2 is not directly referenced in the action plan update so we are unable to confirm that this audit has taken place and whether the outcomes have been reviewed.	
Action 3: Surgical team brief. • **Formalise discussion between the theatre MDT on the morning of the surgery.** • **By September 2023, the Spinal Clinical Governance Team will complete: Triangulation of theatre WHO checklists with MDT outcomes and theatre listings.**	
Action 3, bullet 1 relates to original actions 12 and 13 in the action plan update and is marked as complete as of February 2024. There are several meetings each week where cases on the theatre list are discussed and actions taken to ensure all preparation is made for each case. The completion of the WHO checklist and team brief prior to surgery provides a final safety check. No evidence of audit of completion of the checklist and team brief process was provided in the evidence. Action 3, bullet 2 is duplicated in Action 1 - as stated above it is unclear why this has not been completed.	

Evidence submitted	Review team analysis
Action plan update (not dated)	The action plan update states that this action had been closed as improvements had been made following standardisation of the theatre listing process and that the WHO checklist and team brief processes provide a final safety check which are subject to continuous audit at specialty level. It also highlights that the improvements made to the operation of the Spinal MDT for complex cases before surgery (see Action 1).
Surgical listings process - Spinal Surgery	This document sets out the detailed procedure for listing patients for surgery and references discussion at the Wednesday Spinal MDT meeting. It states that all lists within a two-week period are also discussed every Monday at the Manchester Centre for Clinical Neurosciences (MCCN) listings meeting which ensures actions are taken for any additional requirements for particular cases, for example scans or equipment. These actions are then followed up at the weekly '6-4-2' meetings on Thursdays.

Action 4: Informed consent:

- **MIAA (Mersey Internal Audit Agency) independent consent audit to be completed in the 3rd quarter of 2022/2023. The outcomes from this will be actioned.**
- **A wider review of consent processes will take place, ensuring this is in line with best practice and is integrated in digital systems, when this becomes available.**

Action 4, bullet 1 corresponds to action references 4 and 14 in the action plan update.

The Trust policy for consent was reviewed and updated in September 2022 and this set out a requirement for audit at least annually. All audits undertaken have highlighted a need for integration of consent processes with digital systems across the Trust but there was no evidence of a wider review of processes.

The MIAA audit on consent did not cover complex spinal surgery cases; there were deficiencies found in compliance with processes across the NCA specialities selected for audit (it included a sample of lumbar micro decompression patients only). An update to the action plan dated March 2025 indicated that most of the MIAA recommendations had been completed although specific evidence of this was not provided. One of the MIAA recommendations for a protocol relating to anaesthetic consent for the provision of information to patients in pre-operative clinics did not feature on the MIAA action plan update so it is unclear whether this was actioned.

Additional observations where more assurance may be required:

Action 4 (section 11 of the SPSLBR) refers to the following actions for which no evidence is provided to this review:

- Formal consent training is now part of junior doctor induction.
- Regional consent training session completed.

With regards to learning from the 2007 investigation, the following action is noted as complete with no evidence provided to this review to confirm this: "*Development of the elective surgical pathway. This is still in use and was last updated in 2021.*" It is unclear if this is in relation to the consent process.

Evidence submitted	Review team analysis

Action plan update (not dated)	The two associated actions are marked as completed as at the end of February and November 2024. The action plan refers to the MIAA audit undertaken and further audit undertaken specific to spinal surgery. It also refers to annual audit being undertaken. The action plan states: "*The embedded process for informed consent ensures that the risks associated with surgery are discussed and documented in the clinical patient record and this is subject to regular audit see MIAA and CAT [Clinical Audit Team] activity. Policy updated. As additional measure this was included in MDT pathway audit showing good compliance specific to spines. The main area for development is documentation of written information shared with patients. This was discussed at recent GIRFT visit beginning of August and requires adoption of electronic consent module for robust and consistent documentation of this.*"
Consent for Examination or Treatment - Adults and Young People over the Age of 16, September 2022	This policy was updated in September 2022 (next review due 2027) following approval by the Quality & Patient Experience and Clinical Effectiveness Committees. The policy sets out the monitoring requirements with the aim of achieving 100% compliance with the policy which include clinical audit of patient notes and checks of clinician's training records to ensure suitably trained to obtain consent. Audit is to be undertaken no less than annually and to be reported to each Care Organisation's Quality & Patient Experience and Clinical Effectiveness Committees and the Executive Quality Committee.
Patient Consent Final Report, MIAA, 2022/23	MIAA undertook an audit of patient consenting processes during 2022/23 across the NCA. The scope of this audit was across several specialty areas Trust-wide and **did not** cover instrumented cases for complex spinal surgery. The audit sample did include cases of lumbar microdiscectomy (numbers not stated). The audit found that Trust-wide, there were: • weaknesses in compliance with patient consent documentation; • information on surgery and risks was not always provided to patients; and • anaesthetic consent forms were not always available. Ongoing audit was a recommendation of the report.
Consent Action Plan Update, March 2025	This document records the completion of the actions following the 2022/23 MIAA audit on consent. No evidence of completion of these actions is provided. Actions marked as complete were: • Quarterly consent audit focussing on elective procedures per division. • Patient 'empowerment' to provide guidance on the questions to ask and a text reminder system. • Revision of the consent policy to include 'one-stop' clinics. It is unclear from the update whether the actions relating to anaesthetic consent have been completed as follows:

	• Add URL link and/or QR code (to the relevant anaesthetic information from Royal College of Anaesthetics) into pre-op clinic information to ensure it is shared with all patients. • Ensure a non-digital route is developed to share information to ensure those unable to get info online are not disadvantaged. There was a third action relating to consent for anaesthesia which does not feature on the action plan update' "*Develop pre-op clinic SOP to ensure all information provided is recorded.*"
2024 264 - Review of Patient Pathway, 25 June 2025	This audit covered various aspects of the patient pathway in the Complex Spinal Surgery Service including consent. Out of a sample of 27 cases (period of review not stated), 100% of patients had consent recorded in the medical record. Specifically: • All forms contained the name of the intended procedure / treatment, benefits, and serious risks. • In all cases, the health professional signed and dated the confirmation section. • All forms had been signed by the patient and 97% were dated. • 100% compliance achieved for the recording of patient demographics. Required improvements were: recording of clinicians' names and job titles on the forms and a lack of evidence of written information / recordings being given to patients (noting the requirement for a digital solution across the NCA). The outcome of the audit was shared with the Spinal Surgery Governance meeting in June 2025.
Consent & Operation Note Documentation Audit (Emergency Procedures) 2024 015cS, report not dated	This was an audit of compliance with the consent policy across the Salford Care Organisation for emergency procedures only. This included assessment of whether the information documented on the consent form is the same as information documented within the operation notes and case notes. The audit assessed 91 emergency consent procedures and operation notes from July 2024. Ten of these cases were in Spinal Surgery. This audit found similar findings across the Care Organisation sample as in the Spinal Services audit undertaken subsequently in June 2025.
Action 5: Incident investigation and governance • **Learning from this investigation through the sharing of findings via governance cascade in Salford Care Organisation and across the NCA to include a reminder to be circulated to emphasise the importance of completing surgical records contemporaneously, followed up by a notes audit to ascertain the time lag between surgery and notes entered.** • **Implementation of the Patient Safety Incident Response Framework (PSIRF) by Autumn 2023 in line with national requirements.**	
Action 5, bullet 1 corresponds to action reference 5 in the action plan update. Dissemination of learning has taken place through specific events and meetings but the process for sharing of findings through governance structures was not referenced. The action remains open as the Trust is planning for wider learning events relating to the findings of the reviews.	

No information was provided on the content of the learning communications, so we are unable to comment on whether contemporaneous surgical record keeping was referenced. There was no evidence provided of a notes audit in this regard.

Action 5, bullet 2 is duplicated and addressed in recommendation 2.

Additional observations where more assurance may be required:

Action 5 (section 11 of the SPSLBR) refers to the following action for which no evidence is provided to this review:

- "*Duty of Candour is monitored at the following patient safety forums to ensure this duty is executed in a timely manner: M&M reviews of adverse patient outcomes; Care Quality Review, Structured Judgement Reviews or internal mortality review; Medical Examiner's office review; inquest processes and outcomes; and complaints, PALS [Patient Advice and Liaison Service] and claims.*"

With regards to learning from the 2007 investigation, the following comment requires explanation and potentially evidence for assurance: "*The incident investigation findings and action plan followed governance processes, with prompt actions to improve safety in relation to management of major haemorrhage. There is, however, no evidence that the findings were shared with the patient's family.*"

Evidence submitted	Review team analysis
Action plan update (not dated)	The update states: "*Sharing of initial reports was conducted at Chief Medical Officer Roadshow events, discussion via the Safety Summit and discussion with Chairs of division.*" This action remains open to allow wider briefings to be undertaken across the Salford Care Organisation on the major learning themes including information from recent audits. A learning summary briefing was to be circulated by the end of August 2025. A presentation has been proposed for a learning senate/summit, the date for which was to be agreed by the end of September 2025. The learning summary and plan for the learning senate were not provided for our review, so we are unable to comment on the target audience for the learning senate or whether the content of the briefings refer to the issues identified (completion of surgical records contemporaneously and audit).

Part 3: Supplementary actions

These are actions referenced in the action plan update which are not clearly linked to the recommendations or actions set out in the SPSLBR report (section 11).

Action Plan reference 43467 (original action 2): Audit of anaesthetic charts will be undertaken for the recording of blood loss, to ensure contemporaneous recording of bleeding.
This action is specific to the recording of blood loss in theatre. The recent audit undertaken highlighted that weaknesses remain in blood loss recording. Documentation to ensure compliance is being launched following which reaudit will take place. We note that Action 1 in the SPSLBR report refers to pre-operative planning improvements at MDT (including blood loss) and that a process for activation of major haemorrhage protocol was introduced. The audit found that all patients' records had evidence of appropriate pre-operative planning for blood transfusion in the event of blood loss.

Evidence submitted	Review team analysis
Action plan update (not dated)	The action plan states: "*This was pulled out as a distinct audit action due to concerns re blood loss preparation in original cases. This was not routinely audited.*" It refers to a recent audit which has been undertaken (see below) and the poor results noting that: "*Absence of recording may denote no excessive blood loss issues but this needs to be consistently recorded. This has been discussed across spinal and anaesthetic colleagues and is unlikely isolated to spinal surgery practice. Categorical recording of blood loss is conducted in other teams e.g. emergency laparotomy (0-100, 101-500, 501-1000, >1001ml) and this practice is proposed to be adopted in spines with further re-audit. Closure is pending an agreed standard template for op note completion to prompt this categorical recording.*" Closure of the action was anticipated at the end of September 2025 when documentation was launched with reaudit to be undertaken three months post implementation.
2024 264 - Review of Patient Pathway, June 2025	This clinical audit of the elective surgical pathway for patients undergoing instrumented spinal surgery within the Complex Spinal Service included blood loss documentation compliance. The audit found that blood loss was documented in only 13 out of 27 cases (47%). In the pre-operative assessment, all patients' records had an evidence of blood transfusion agreement documented, as evidence of pre-operative planning for blood loss.
Action Plan reference 43473 (original action 8): Evidence of reporting culture improvements in the Spinal Service to be reported to GRAC.	
Concerns were highlighted in the SPSLBR report regarding a poor patient safety incident reporting culture in the Spinal Service and reference made to systems in place across the NCA in Action 5 (section 11). This action is specific to the Spinal Service and was due for completion by the end of March 2025. Datix incident reporting numbers since 2019 to March 2025 have been examined and reported to the MCCN Divisional Governance Meeting and show an increase in the number of incidents reported over this time period in the Spinal Service which could indicate an improved reporting culture. The Trust's report on claims of a racist culture in the Spinal Surgery provides an analysis of incidents reported relating to racial discrimination. There was no evidence provided of reporting on incident trends. *We note that the action was included in the tabular action plan at the end of the report under 'incident investigation and governance' but was not referenced in the narrative action plan.*	
Action plan update (not dated)	The action plan states: "*Team perceived high reporting culture. Spinal Datix Review completed December 2023 to confirm team perceptions and presented to action group. Presented later as report to division (17/04/2025) and SCO safety summit (06/05/2025). Agreed to close in combination with Breen culture report and sharing of same with directorate.*"

Spinal Surgery Incident Reporting Culture, report to the MCCN Divisional Governance Meeting, not dated.	The subject of this paper relates specifically to the delivery of this action. The report includes an examination of Datix data since March 2019 which indicates a consistent use of DATIX to report issues and an increase in the number of incidents reported. The analysis shows the breakdown of incidents reported by staff group and incident type. The report concludes: "*Overall, evidence taken from the DATIX system is considered to show an acceptable and reasonable appetite and practice for incident reporting via this mechanism within the service, and the increase in number of incidents reported per month may indicate an improved appetite to report incidents over time.*"
Review of claims of racism and racist culture detailed in Breen report, May 25	In response to the Breen report, the Trust has further examined the issues reported of a perception of racism within the Spinal Service. The report provides an analysis of incidents reported relating to racial discrimination.

Action Plan Reference 43475 original action 9: Strategy for assurance that clinical standards in the spinal service meet national standards to be reported to GRAC.

This action was included in the tabular action plan at the end of the SPSLBR report under 'incident investigation and governance' but was not referenced in the narrative action plan in the report.

The Trust has not provided a documented strategy for assurance on clinical standards or evidence of reporting to this forum [GRAC]. Evidence included some reports evidencing consideration of clinical standards including a GIRFT review from 2020 and European accreditation as a Spinal Surgery Centre of Excellence (awarded in 2024).

A further GIRFT review was undertaken in 2025, with other recommendations made. The Trust's response to this is not yet available.

A task and finish group has been set up to oversee the transfer to the British Spine Registry.

Evidence submitted	Review team analysis
Action plan update (not dated)	The action plan update states that this is an ongoing action and makes reference to: • a previous GIRFT review in 2020 (see below); • European accreditation as a centre of excellence; and • the Breen cultural review. The action plan notes a very recent GIRFT review. Feedback had been received from GIRFT at the visit that the British Spine Registry and the National Consultant Information Programme were the preferred solution for recording of data for monitoring of performance and benchmarking purposes and the Trust was examining this and developing a transition plan to move to this, away from the Eurospine Spine Tango Registry.
Interview with the Operational Manager for ENT, major trauma and	We were told that the recent GIRFT visit has good attendance from the spinal team with positive engagement and constructive conversations, including recognition of improvements.

spinal services, 26 July 2025	
GIRFT, NCA NHS FT, Spinal Surgery Observation notes, 1 August 2025	The recommendations made from this GIRFT visit were: • *There must be a move from submitting data to Spine Tango to the BSR. Provide an action plan with a timeline of 3 months on how the change will be implemented.* • *All consultants should review their own NCIP data to ensure that patients and procedures are appropriately attributed. They should understand and discuss significant variation.* • *Ensure the new pathway around emergency admissions for back pain is implemented across the trust rather than at individual hospitals; there must be a consistent approach.* • *The team hope to have a SPOA implemented by the end of September with a standardised pathway.* • *A network approach to an electronic consenting process would be beneficial.* • *Ensure repeat facet joint injections are not happening going forward across the organisation.* *It was noted that the elective hub at Rochdale is underutilised. HVLC activity at the Rochdale elective hub must be maximised. The benefits will be:* *Increased spine activity.* *Reduced wait times for patients.* *Increased capacity for complex cases (including adolescent scoliosis) at the Salford acute site.* *We were concerned at the discussions about peri-operative responsibility for significant surgical complications. The expectation is that the usual professional responsibility to patients remains, and either the operating consultant or a suitable named alternative senior decision maker is available for advice and review as needed. This should not be delegated to the busy Salford acute site consultant on call unless the senior review, usually face-to-face, of the patient mandates transfer to the acute site for urgent investigation/treatment.* • *Review MRI access for out of hours availability across the organisation.* • *There should be a discussion with the ERAS service to establish what is needed for the patients and how it can be effectively reinstated.* • *AIS Consider moving 16- to 18-year-olds to the adult pathway for over 17's. This should be presented as a choice to the patient, and they will most likely choose the adult service as they will be treated quicker. Note that, the 16 to 18s do not need a critical care bed. There are side rooms and scoliosis nurses already predominantly in place and these are unlikely to be large volumes of patients.*

	• *Ensure that 2 straightforward AIS patients are on a list. Removing the dependency on critical care beds will help this move to 2 on a list as there will no longer be a wait for a bed.* • *Develop a plan for providing mutual aid to the children's hospital in Manchester. These patients are on a transfer of pathway which means the RTT does not reset to 0.* • *Use the spinal paediatric Further Faster handbook if not already.* • *Review pain implants used (spinal cord stimulation and ablation probes) to establish the variation in use and cost.* • *Discuss litigation in governance meetings. Individual claim details will be held by the trust legal department and should be easy to access for discussion, learning and improvement.* ***GIRFT Actions:*** • *Provide a forum for introducing the anaesthetists at NCAs elective hub to those in Devons nightingale hospital spinal team. (Particularly whether there really is a need for Group & Save for lumbar decompression/discectomy)* • *Share the Getting Spine Ready document for elective surgical hubs with the team. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2025/06/250605-Getting-Spine-Ready-v2.pdf* • *Provide a procurement report based on current expenditure and information on the variation of implants being used within the unit.* We have not seen the action plan resulting from this visit.
Spinal Surgery GIRFT Review 2020, report to the Clinical Effectiveness Committee in June 2021	This is a report to the Salford Care Organisation's Clinical Effectiveness Committee to summarise the key findings from the GIRFT review undertaken in 2020. It provides benchmarking analysis on key performance metrics for Spinal Services (noting that analysis was somewhat limited as based on out-of-date data since 2015/16) including time to surgery from spinal cord injury, admission rates, day case rates for lumbar discectomy, lengths of stay for specific procedures and emergency readmissions. The key area for improvement noted was cancellation rates for elective procedures and actions were noted to improve performance in this area.
Presentation on the Eurospine Society accreditation audit, not dated	Accreditation as a Surgical Spine Centre of Excellence was awarded to the Trust on 9 February 2024 following an audit undertaken in October 2023. Positive feedback was given on: • clinical governance through Morbidity & Mortality meetings; • infection control - quality and data available to clinicians; • volume of patients and complexity of cases; • the high number of emergency referrals managed; • urgency list; and • ability to provide multidisciplinary care across all pathology groups.

	Areas for improvement were the departmental webpage, research output and waiting times for surgery and review.
Interview with the Operational Manager for ENT, major trauma and spinal services, 26 July 2025	We were told that a task and finish group is overseeing the transfer to the use of the British Spine Registry.

The Breen Report action plan progress

1. Area of concern/recommendation: Bullied staffing group (BSG)
Breen Report, paragraphs 1137/47 state: "*Members of this group feel aggrieved and disappointed with the manner in which they have been dealt with by the Trust. Some of the individuals have attempted to speak out about concerns for themselves or others and have been met with resistance and inaction.* *Various individuals have raised multiple concerns, as set out in the whistleblowing letters and indeed as part of the disciplinary process. Taken globally, and considering all the accounts I have been given, there is merit in their belief that they have been failed…* *Members of staff and surgeons were not informed of the basis of the dismissal of Doctor F until 2021, some six years after their departure. Because of the lack of information being shared surrounding Doctor F's dismissal, members came to their own conclusion and believed that Doctor F had been 'paid off.'…* *I remind myself of the split in the 2014 investigation that led to the disciplinary proceedings and the ultimate dismissal of Doctor F. I have recorded my views on the inadequacies and failings of this exercise earlier. It is another example of how the members of the BSG feel that they were not listened to.* [We note that the Trust's action plan restates this finding as follows: "*Further, the split in the investigations of Doctor F between sexual allegations (for which Doctor F was subject to disciplinary proceedings and dismissed) and concerns around patient care is another example of how the BSG felt they were not listened to, given they had repeatedly, and futilely, blown the whistle on such issues….* *Members of the BSG were not advised that they had been listened to, there was no opportunity to discuss concerns, nor were they given any reassurance that the concerns would be dealt with. The Freedom to Speak Up process failed them.* *The recent observations by the CQC, set out above, are a cause for concern.* *The above examples support the view held by the BSG that they had been failed. Left without clear information and/or support, it is understandable the feelings of disappointment, upset, anger and apathy have fostered negative beliefs. For this, I believe that they are owed an explanation and apology.*"
Action 1: Group meeting with speciality to be planned as soon as the culture work is completed (Breen Action Plan ref. 37.1).
The action plan update to the BROG states that a first meeting with the department was held on 2 July 2025 (we understand that this was with the Trust's Chief Medical Officer) with a follow-up meeting held with the Clinical Director and Service Manager on 20 August 2025. The action was due for completion by June 2025 so only marginally delayed; the group meeting was held after one-to-one meetings with the

Chief Executive had taken place. The cultural diagnostic work had commenced with a survey having been undertaken in January 2025.

The action plan indicates that the cultural diagnostic work is ongoing, but it is unclear why the meeting with staff was dependent on the outcome of the culture work given the Breen Report findings that this group of staff had been failed from multiple perspectives of which culture was one contributory factor. For example, processes in place to allow staff to raise concerns and be listened to had failed and staff wanted to understand why this had happened and gain assurance that processes are in place to ensure a robust patient safety environment with regards to raising concerns.

At the time of writing, a meeting is being organised for the Deputy CMO to share the findings from the SPSLBR addendum report with the service, and to offer an apology.

Evidence submitted	Review team analysis
BROG papers, September 2025	The action plan update to the BROG states that a first meeting with the department was held on 2 July 2025 with a follow-up meeting with the Clinical Director and Service Manager on 20 August 2025. A cultural survey had been undertaken in January 2025 to inform further cultural diagnostic work for the department. The indicated planned date for completion of this work was 30 June 2025, and the action plan update indicates this is ongoing.
IPSI_BREEN-ACTIONPLAN UPDATE_ UNRATIFIED_ DRAFT_V1_2 30725	Action plan states: "*Date of meeting to be scheduled now survey in action 43.1 below complete…An update on the work that has taken place will be delivered and an action plan embedded by the end of June 2026.*" The update to the action plan of September 2025 indicates the deadline for this work is June 2025.

Action 2: The Chief Executive continues to meet on an individual basis with affected colleagues (Breen Action Plan ref. 37).

This action was due for completion by 30 April 2025; some individual meetings were held after this date but before the group meeting (see action 1). The action is marked as complete and refers to written apologies being given to all affected staff (date not recorded).

It is unclear from the evidence provided how soon individual meetings commenced after receipt of the Breen Report (March 2024) and whether staff were provided with interim support pending their one-to-one meetings.

Evidence submitted	Review team analysis
BROG papers, September 2025	The Action Plan states: "*Chief Executive has had individual meetings with all members of the group that accepted an invitation to one. All members have received written apologies.*"

2. Area of concern/recommendation: Governance

Breen Report, paragraphs 1153 -1160 state:

"*I understand that the DATIX system has evolved and now tracks actions and input from individuals. Taking into account the concerns voiced, users would benefit from comprehensive guidance about the channels and steps that determine what should and should not be filed using the DATIX system. From*

the examples that I have seen, the information contained in the system can be somewhat limited and it can be difficult to follow the chain of events.

I believe that the digital systems that are in place have the capacity to capture and store all the relevant information, documents, and reports. Use of the central storage of all relevant material, does not appear to be demonstrated. I am told that while letters and notes of meetings with family members dealing with, for example, the duty of candour, may be stored in some capacity, there is no uniform approach and they are not centrally recorded.

I am told that, for example, in the case of Patient A there is no record of a multidisciplinary team meeting or what was agreed and discussed there. This is something that should be readily available.

There is a need for a robust recording system, with the function to record who made changes and why. The Trust should put in place a system that allows and keeps records of all discussions and documents including Rapid Reviews (currently not in the DATIX system) and multidisciplinary team meetings. Where DATIX are downgraded, the reason for this and who made that decision, needs to be recorded. This also applies to any form of patient review in relation to a particular surgeon. For example, had Doctor I's work for Manager C been recorded in a central system, it could have been viewed in 2016 by multiple individuals, which could then have impacted upon the Trust taking action earlier.

The contents of Morbidity and Mortality meetings should be recorded in the same system to allow easy access and recovery of data when and if required in later years. If adherence to such a system was strictly enforced, then there would not be a situation as in the case of Patient A and Patient C that Morbidity and Mortality meeting notes were not stored.

Of course, the completion and adherence to protocol would require supervision and oversight."

Action 3: To review the incident reporting training and develop an audit schedule associated with alterations. (Breen Action Plan ref. 38.1)

This action was due for completion by 31 July 25 and is reported as not on track because of the need to be aligned with a broader NCA governance review. The action plan indicates that an audit tool has been developed but there is no reference to any updates to incident reporting training.

Minutes of the BROG in June indicate that progress on governance actions has been hindered by a change in leadership responsibility (no further details are provided).

Evidence submitted	Review team analysis
BROG papers, September 2025	The action plan update indicates that this action is behind schedule. There is reference to the Incident Management System Task and Finish Group Progress Report signed off by Senior Management Team (SMT) in November 2024. This report was not provided as evidence but would indicate that work was ongoing to review the incident management system. There is no reference in the action plan to a review of associated training provision. The action plan states that an audit tool has been developed but evidence of this was not shared.
BROG minutes, 3 June 2025	The minutes state that there are key gaps in the governance actions required due to a handover of leadership responsibility. No further detail is provided.

Action 4: Report of documentation upload process in Datix. Audit of documentation uploaded to be undertaken (Breen Action Plan ref. 38.2)	
Guidance is available to NCA staff on how to upload documents to Datix, however it does not specify which documents are required to be uploaded; additional guidance on this is required to meet the requirements of the Breen recommendations. The Trust's Patient Safety Incident Response Policy also makes general references to effective document management and mentions specifically audit being undertaken to ensure Rapid Reviews and Duty of Candour forms are available in the system. However, this policy was updated in March 2024 so was not in response to the Breen Report. The specific audit required of documentation upload is marked as overdue; it was due for completion by 31 July 2025. As highlighted above, progress on governance actions has been hindered by a change in leadership responsibility.	
Evidence submitted	**Review team analysis**
BROG papers, September 2025	The Action Plan update states that guidance has been produced for staff relating to documentation upload in Datix (see below).
Help guide to Completing an Investigation in Datix (Refs. BEB3780D/ EDQ008 Supp4 V3)	This provides detailed guidance for NCA staff on fields to be completed, how actions and communications are tracked and refers to the upload of documents and templates: "*The investigator can add any relevant documents to this section, such as statements, operating procedures, policies etc. by clicking 'Attach a new document' and attach as you would a document to an email.*" The guidance does not however clarify which documents must be uploaded relating to an incident, for example notes of Morbidity and Mortality meetings. The document is not dated and appears to be a draft version.
Patient Safety Incident Response Policy, 18 March 2024	The policy for the management of patient safety incidents was updated in March 2024 to reflect PSIRF requirements. It makes some references to effective document management, communications, recording and tracking in Datix. The policy monitoring section refers to weekly monitoring through PSIRF Assurance Group to ensure Rapid Reviews are accessible and appropriate templates for Duty of Candour are used.
Action 5: Understanding of whether there has been an evaluation of MDT in spinal surgery. Align separate spinal MDTs. Review of MDT-FIT as an evaluation tool for MDT meetings (Breen Action Plan ref. 38.3).	
This action does not directly focus on the Breen recommendation on governance, which was a reference only to ready access to, and centralised storage of MDT meeting notes, but rather, it appears to address the general operation of MDT meetings which is a helpful addition for added assurance. We have assessed the evidence in terms of the Breen recommendation regarding MDT documentation only. This action is substantially complete. The SOP for Spinal Surgery Multi-Disciplinary Team Meeting was updated in February 2025 for complex spinal cases. It sets out the requirements for central storage of MDT meeting documentation and outcome letters. The Trust plans to align the separate SOP for general spinal surgery to the requirements of this SOP for complex spinal surgery. The audit plan for the SOP includes review of MDT documentation and the action plan indicates that an audit was completed in July 2025. Evidence of outcomes was not provided. There is no reference in the	

action plan to the consideration of MDT-FIT as an evaluation tool (this is a tool designed to evaluate the effectiveness of cancer MDTs).	
Evidence submitted	**Review team analysis**
BROG papers, September 2025	The action was due for completion by 31 July 2025. The Spinal MDT SOP was signed off by the directorate on 5 February 2025 and approved by the Managing Director of the Manchester Centre for Clinical Neurosciences (relevant division at the NCA which includes Spinal Surgery). Audit of MDT processes is marked as complete on 23 July 2025. The action plan update highlights that there are two separate SOPs for general and complex spinal cases and that the two documents will be aligned once plans for joint MDT meetings have been agreed.
Local Standard Operating Procedure (SOP): Spinal Surgery Multi-Disciplinary Team Meeting, 5 February 2025	This document is the SOP for MDTs for complex spinal surgery and sets out the requirements for document storage relating to MDT meetings and states: "*MDT outcome document will be created in MediSec and will be available in the Letters Section of EPR [electronic patient record] clearly titled in a proforma which also documents the clinical details provided at the time of the referral. Process is tracked through the MDT Sharepoint.*" The SOP refers to quarterly audit to be undertaken by the MDT Clinical Lead of cases discussed to provide assurance on compliance with processes.
Clinical Audit Team - Project Proposal, not dated.	This document sets out the plans for audit of the revised MDT process as set out in the SOP above. The audit was planned to be undertaken over the period from 27 January 2025 to 31 March 2025. The audit was to cover all elective cases involving instrumentation over the period from December 2024 to December 2025 and required assessment against a compliance target of 100% for documentation of MDT outcome in the MediSec system for storage of documentation and in the relevant section of the electronic patient record (EPR) system.
Action 6: Table of governance changes made to Datix since 2016 and gap analysis. Future system requirements to be discussed (Breen ref. 38.4)	
Significant progress has been made in terms of establishing Datix system requirements and a re-procurement is planned by March 2026. It is unclear from the evidence provided whether the developments on Datix and the revised specification will address the issues raised by Breen regarding the upload of key documents such as Rapid Reviews and Morbidity and Mortality Reviews. This action was due for completion by 31 July 25 and is reported as not on track because of the need to be aligned with a broader NCA governance review.	
Evidence submitted	**Review team analysis**
BROG papers, September 2025	The action plan states that a Datix System Specification Group is established; it also refers to a table of changes made to Datix since 2016 (see further below) and a gap

	analysis having been completed. It refers to the Datix system being upgraded to take account of the PSIRF requirements and re-procurement of the system by March 2026. Datix changes are being overseen by the Incident Management System Task and Finish Group.
Governance changes since 2016	This is a spreadsheet which refers to new national guidance and changes made to governance including the functionality of the Datix system over the period from December 2016 to 2024. These are not described in detail but are summarised as follows: • Incidents - changes were made to Datix in 2023 and 2024 covering PSIRF and compliance with the national NHS Learn from Patient Safety Events Service (LFPSE) requirements. An NCA executive-led panel for the sign-off of patient safety incident investigations was established in July 2024. • Legal and Mortality - changes to implement guidance relating to Learning from Deaths; the most recent changes relate to the establishment of an executive-led Learning from Deaths Group and use of the Mortality Screening Tool to identify cases for review. • Complaints - a Freedom to Speak Up module in 2022/23 and an update to the complaints' module in 2023. • Various dashboards were developed in 2023/24 to improve governance compliance tracking (including for PSIRF) and the corporate risk register and action recording was put onto Datix. • Risk - in 2023 a new risk management strategy and policy was launched, the Board Assurance Framework and Corporate Risk Register were developed and an NCA executive-led Risk Management Group was established. As there is no further detail, we are unable to ascertain whether the Breen requirements on functionality to upload key documents such as Rapid Reviews and Morbidity and Mortality Reviews have been covered.
Patient Safety Incident Response Policy, 18 March 2024	The policy for the management of patient safety incidents was updated in March 2024 to reflect PSIRF requirements. It makes some references to effective document management, communications, recording and tracking in Datix. The policy monitoring section refers to weekly monitoring through the PSIRF Assurance Group to ensure Rapid Reviews are accessible and appropriate templates for Duty of Candour are used.
Action 7: Changes to morbidity process to be discussed at 'Medical Directors'. One side describing current <u>morbidity</u> process which addresses the recommendation. Description of changes needed for the morbidity process to share with medical colleagues. One side describing current <u>mortality</u> process which addresses the recommendation. Description of changes needed for the mortality process to share with medical colleagues (Breen ref. 38.5).	
This action relates to the Breen recommendation on centralised storage of documentation from M&M meetings. The Trust has taken the opportunity to standardise the operation of M&M meetings operate across the Trust and a central storage solution for all associated documentation is being developed on SharePoint (timeframe for completion is not indicated). The Trust has made good progress on the actions (due for completion April 2025) but the action plan states not on track due to the need to align with a broader NCA governance review.	

Evidence submitted	Review team analysis
BROG papers, September 2025	The action plan states that: • M&M meetings (47 across the Trust) have been reviewed and standardised documentation has been developed - terms of reference, agenda, register of attendance, case presentation template and minutes template. • A centralised repository on SharePoint is being built for the storage of all M&M documentation and as a facility to share learning. Once complete, the revised standardised process will be communicated to M&M leads across the Trust for adoption. The action plan does not provide a revised timescale for completion of these actions.
Action 8: To audit the use of the updated protocol via adherence to recording contents of Morbidity and Mortality meetings in the same system to allow easy access and recovery of data when and if required in later years (Breen ref./ 38.6).	
This action cannot be progressed until implementation of the SharePoint solution referenced above for the storage of documentation from M&M meetings.	
Evidence submitted	**Review team analysis**
BROG papers, September 2025	The action was due for completion by 31 May 2025 and the action plan update references that it is overdue.
3. Area of concern/recommendation: Senior leadership and appointments	
Breen Report, paragraphs 1161 -1160 state: *The Trust should ensure that the senior leadership appointments process should be an open, transparent, and competitive process, with an objective assessment as to competency for the role. There is a perception that the appointments process is not transparent. The views as expressed to me in a letter from Doctor X on 3 January 2023, set out above, need to be taken into consideration.* *It may be desirable for the Trust to set out a description as to the roles of the leadership team within each division, providing job descriptions. The Trust should consider undertaking regular appraisals, including 360-degree appraisals of the leadership team. Perhaps appraisals of senior leaders could be conducted by someone outside of the division to allow for a degree of independence.* *When considering the specific Division of Spinal Surgery, the fact that the Chair of Division was also a surgeon in that speciality, made it difficult for staff to raise concerns (filing DATIX) specifically about Doctor F or their practice, knowing that this would be seen by Doctor F. The approach taken by Doctor H is more favourable, in that a Chair of Division should not also be a surgeon in that same division, but from a different specialty.* *… Systems need to be put in place to ensure transparency, and that any appointment made is done so on merit.*"	
Action 9: Review and audit of appointment process for Clinical Directors (Breen ref. 39.1).	

The Trust has undertaken a comprehensive review of the recruitment process for medical leaders and undertaken an audit of compliance with policy requirements and implemented the resulting agreed action plan. A revised framework has been developed for the recruitment of medical leaders under the Trust's clinically-led model and regular updates have been provided to the People and Education Committee. Audit has highlighted inconsistencies in terms of the application of the framework and policy with continued annual audit planned.

The action is marked as complete as of 4 June 2025 on the action plan update of September 2025 (ahead of the deadline date of the end of July 2025).

The evidence provided does not specifically consider the raising of concerns and reporting of incidents and reluctance to report by staff when the issue involves senior divisional leadership.

Evidence submitted	Review team analysis
BROG papers, September 2025	The action plan update refers to the following actions having been completed: • A standardised approach to medical recruitment had been implemented in July 2023 (prior to the Breen Report, not seen). • An audit was undertaken in July 2024 to assess compliance and found inconsistencies (see paper to the People and Education Committee (PEC) in November 2024 below). • An action plan was developed and agreed with the Chief Medical Officer (not seen). • Leadership recruitment principles were developed and agreed as part of the development of the clinically-led model. • An advisory paper following audit was shared with the Group Joint Local Negotiation Committee and the General Medical Council in March 2025 (not seen).
Clinical Director Recruitment Audit, paper dated 20 November 2024	A paper to the PEC in November 2024 sets out the findings from the audit undertaken in July 2024 of adherence to standardised guidance on the recruitment of medical leaders (which was introduced in July 2023). The paper refers to the Breen Report findings and the risk of cronyism undermining trust in leadership and recruitment processes. An audit of eight medical leadership appointments between August 2023 and July 2024 was undertaken. The audit found that assessment processes were rigorous however, other findings were: • low application numbers; • one appointment was undertaken outside of the Trust's recruitment management system (TRAC); and • the specified panel composition was not consistently followed and cultural ambassadors were not always present on panels. The paper made recommendations to ensure an open and inclusive process which included: • ensuring the recruitment process requirements were effectively communicated across the Trust; • greater involvement of the HR team in the process;

	• recruitment training; • the involvement of cultural ambassadors on all recruitment panels for medical leadership roles; and • a new leadership recruitment framework was to be developed. The PEC were asked to support the recommendations in the report and referred to a follow-up paper to be presented to the PEC (see Action 9 below).
Evidence submitted	**Review team analysis**
Medical Leadership Recruitment, paper to the PEC, April 2025	This paper provides an update to PEC following the audit in November 2024 of actions taken: • An action plan was shared with the Chief Medical Officer (not seen in evidence). • A communication plan was agreed and shared with Medical Directors and Clinical Directors to reinforce the need for rigour in medical leadership appointments. A letter set out the need for: - all medical leadership roles to be advertised on the Trac recruitment system; - all opportunities to be shared internally with eligible candidates to ensure transparency; - appropriate HR representatives to be involved in all aspects of the recruitment process; - a Cultural Ambassador on interview panels; and - Chairs of medical leadership recruitment panels to complete the updated Recruitment & Selection training. • The findings of the audit were shared with the Joint Local Negotiation Committee and the General Medical Council in March 2025. Additional planned actions were: • a review of job descriptions for clinical leadership roles; • a possible dedicated web page to encourage greater diversity in applications for clinical leadership roles; • development of a new leadership recruitment framework to ensure recruitment is in line with the Trust's required values and behaviours; and • annual audit by the recruitment team of adherence to processes.
Recruiting to the new Clinically Led Model, not dated.	This paper sets out a recruitment framework for leadership positions under the clinically-led model (Band 8c and above) across the NCA. This document is not dated. It clearly sets out the principles for recruitment to these positions to ensure equity, transparency and fairness including: • clear job descriptions and person specifications; • opportunities to be openly advertised; • assessment of standard leadership competencies;

	• interview panels to be appropriately representative and to have received recruitment training; • the panel to include a member from outside of the relevant service; and • candidates to be assessed on merit and, "*should not be treated more or less advantageously because of their previous or current activities, affiliations, or the employment of their friends, partner or family members.*" There is no reference in this document to the governance arrangements around the application of the framework.

Action 10: The Trust should consider undertaking regular appraisals of the leadership team, including '360 degree' appraisals (whereby junior colleagues review the performance of their senior colleagues). Perhaps appraisals of senior leaders could be conducted by someone outside of the division to allow for a degree of independence (Breen ref. 39.2).

The action is marked as complete as at April 2025. A 360-degree appraisal system is already in place at the Trust but this is not mandated; the Trust is considering making this a mandatory process for clinical leaders when cultural issues have been identified and extending the remit of the appraisal process to cover broader performance areas. There was no reference to considering whether appraisals of senior leaders should be undertaken independently of the division concerned.

Evidence submitted	Review team analysis
BROG papers, September 2025	The action plan states that: • 360-degree reports are available to all leaders currently on a "*self-select basis*" other than when advised by HR & OD. For 2025/26, 180-degree (line manager and leader) feedback is being considered for clinical leaders' appraisals to assess performance and behaviours against the Trust's Leader Pledge (see below). • Clinical leadership job descriptions include reference to the Leader Pledge which is part of Accelerated Leadership Development (ALD) for medical leaders (attendance at ALD is mandated for clinical leaders). • A team culture survey is available to all Trust teams for anonymous feedback and is used when cultural concerns are evident. This has been used for the Spinal Service and a report collated by HR & OD (report not seen). • A proposal to PEC on medical engagement was presented in June 2025 (not seen). • A paper regarding 180-degree feedback was planned for the end of July 2025 (not seen). Further actions planned by the Trust include: • extending the appraisal process for medical leaders to cover non-medical aspects of performance; • considering reporting and effectiveness on leader appraisal compliance; • reporting on 360-degree feedback for leaders and mandating 360-degree feedback when cultural issues are identified; and

	• monitoring and reporting on attendance on ALD by clinical leaders in the Spinal Service.
Leader Pledge, not dated	This document sets out a vision for leadership across the organisation ('Leadership by All; Development for All') which aligns with the NCA's culture and values. It sets out ten core responsibilities and behaviours as pledges which include elements relating to culture and wellbeing, inclusivity, team cohesion and development of teams and individuals. The document states that these leadership behaviours will be assessed as part of the recruitment process.

Action 11: Audit of adherence to the recruitment approach for clinical leadership appointments (Breen ref. 39.3).

An audit was undertaken in July 2024 of adherence to required recruitment processes for medical appointments. There was no evidence provided of an audit having been undertaken in 2025 in line with the recommendations made to the People and Education Committee in April 2025. The action is marked as complete by the deadline date of the end of May 2025 but an annual audit cycle is required.

Note: this is a duplication of the action required under Action 7.

Evidence submitted	Review team analysis
Clinical Director Recruitment Audit, paper dated 20 November 2024	An audit was undertaken in July 2024 of adherence to required recruitment processes for such appointments (see detail under Action 7).
Medical Leadership Recruitment, paper dated 23 April 2025.	A paper to the PEC in April 2025, provided an update on actions following the audit of July 2024 (see Action 7). The paper referred to next steps which included annual audit of adherence to recruitment guidelines by the Recruitment team.

Action 12: The decision about whether a chair of a division should be from outside the profession/specialty would need to be considered organisation wide (Breen ref. 39.4).

This action was marked as complete on the action plan with reference to having considered and discussed this approach. No evidence was provided of the discussion and decisions made.

Reference to the appointments process being made more robust to embed the culture and values embedded in the Leadership Pledge (see above) does not directly reference this specific issue but promotes leadership behaviours to ensure team cohesion.

Evidence submitted	Review team analysis
BROG papers, September 2025	The update to the action plan refers to this issue having been discussed by the Trust and refers to a more robust approach to the appointment of clinical leaders to ensure a fair and transparent process which is aligned with Trust values.

4. Area of concern/recommendation: Patients and family members

Breen Report, paragraphs 1168 -1169 state:

"*It is clear that there is evidence that certain patients have, at worst, suffered avoidable harm and, at best, received substandard care.*

In each of the cases mentioned, the patients and/or their families should receive a full and transparent explanation and an apology for the level of care they received from Doctor F and the Trust…In relation to Patient A, I understand that the family have now at very long last been provided with the RSUI [Reportable Serious Untoward Incident] Report and an explanation has been provided to them, 16 years after their tragic death."

Action 13: Meet and discuss clinical review process for affected patients (Breen ref. 40.1).

A meeting was held in February 2025, and the action is marked as complete on the update in September 2025. The Trust should confirm that the planned May 2025 meeting took place.

Evidence submitted	Review team analysis
BROG papers, September 2025	The action plan refers to a meeting between the Trust Chair, Chief Medical Officer and Chief Nursing Officer with patient and family representatives for those patients who had come forward on 12 February 2025; this included discussion of the approach to the clinical review process for patients. Minutes are available of this meeting (not seen). The action plan refers to a further meeting with the wider patient group being scheduled in May 2025, but the September update does not indicate whether this meeting took place.

Action 14: Establish oversight group for implementation of the Breen recommendations (Breen ref. 40.1).

Feedback from patients and families indicated that they required more regular communication on progress being made by the Trust on the Breen recommendations; this has been addressed through the BROG. There are two patient/family representatives on the BROG. The Group is a sub-committee of the Board and is chaired by an executive director with papers being available to the public.

Evidence submitted	Review team analysis
BROG papers, September 2025	The action plan update of September 2025 refers to the establishment of the BROG; there are two patient representatives on this group. Separately there is a monthly meeting of the Patient and Family Members Group, although we heard that Trust attendance at this meeting is sporadic, and expectations in this area do not appear to be explicit.
BROG Summary Report to the Trust Board, 31 October 2024, 7 January 2025 and 27 March 2025	Reports to the BROG were provided as evidence of the implementation of this oversight group. Feedback from patients/families indicated that they required more regular communications on progress made against the Breen recommendations.

<table>
<tr><td colspan="2">Action 15: In each of the cases mentioned, the patients and/or their families should receive a full and transparent explanation and an apology for the level of care they received (Breen ref. 40.2/40.3).</td></tr>
<tr><td colspan="2">Letters were issued to affected patients/families. The action plan does not indicate over what period the letters were issued but the action is marked as complete by April 2025. No information was provided on the generic content of the letters; the individual letters could not be shared due to confidentiality reasons.</td></tr>
<tr><th>Evidence submitted</th><th>Review team analysis</th></tr>
<tr><td>BROG papers, September 2025</td><td>The action plan states that letters were sent to all patients who were part of the SPSLBR and found to have been impacted by moderate or severe harm.</td></tr>
<tr><td colspan="2">Action 16: From the first meeting with the spinal patient group, clarification was sought on the list of patients cited in the report and the process around patients initially reviewed in the SPSLBR.

Not being heard or acknowledged was shared and despite sending regular emails one of those present advised they had not had a response or acknowledgement and shared they do not feel supported by the organisation. The Chief Nursing Officer (CNO) asked for clarification to whom emails had been sent… was advised emails had been sent to PALS (Patient Advice and Liaison Service) and copied to her. The CNO advised she would investigate this as a matter of urgency (Breen ref. 40.4).</td></tr>
<tr><td colspan="2">As referenced above (action 15), all affected patients/families were contacted by the Trust. See also action 18 below which refers to providing report reference information provided to patients.

Progress has been made with regards to the ongoing management by the Trust of queries raised by patients/families through a single point of contact The action was due for completion in July 2025 but is marked as not on track as there is a need for further work to ensure communication with patients/families meets their needs through the single point of contact and is appropriate; further resource is needed to support this work.</td></tr>
<tr><th>Evidence submitted</th><th>Review team analysis</th></tr>
<tr><td>BROG papers, September 2025</td><td>The action plan states that:
The Chief Nursing Officer has liaised with PALS and the governance team to establish a single point of contact for patients/families to address communication issues.
Correspondence sent to PALS by patients/families who had not received a response had been followed up and meetings arranged with eight individuals; particular queries for these individuals were being ascertained before meetings could take place.
The update recognises that further work is needed to ensure prompt and appropriate communication with patients/families. A SOP was in development for a single point of contact and further resources were to be committed to the exercise (before the end of April 2025). The update and evidence provide no further reference to progression of these elements.</td></tr>
</table>

Action 17: Identify single point of contact for Spinal, SPSLBR and Breen communication (Breen ref. 40.5).	
See action 16 above regarding the establishment of a single point of contact for affected patients and families.	
Evidence submitted	**Review team analysis**
BROG papers, September 2025	See comments above regarding establishment of single point of contact with work underway to develop a standard operating procedure and a need for more resource to be allocated to the engagement activity.
Action 18: Share individually the legend to the Breen report (Breen ref. 40.6).	
Evidence submitted	**Review team analysis**
BROG papers, September 2025	The action plan states that: "*Each of the patients referenced in the Breen report have received an individual email providing them with their reference information.*"
5. Area of concern/recommendation: Investigations	
Breen Report, paragraphs 1170 -1171 state: "*In my view disciplinary investigations require the expert input of Human Resources.* *It is imperative that the Trust's own policies are complied with, and that allegations are fully investigated, particularly if they fall within bullying, whistleblowing or the staff charter. Any individual who is appointed to be a case manager or investigator needs to be trained on how to conduct such a role and be guided by Human Resources on the framework of the investigation, and the relevant policies. In my view, the investigation should be led by Human Resources.* *My understanding is that Doctor F has been referred again to the GMC.*"	
Action 19: Investigation training complete for anybody who may be involved. In process of agreeing approach to allocating cases - there will be a pool of investigators who undertake training - and refresher training. Delivered train the trainer sessions (Breen ref. 41.1).	
The Trust has standardised the approach to disciplinary investigations. The training material sets out how such investigations should be undertaken in line with policies and the Just Culture Framework. It highlights the involvement of HR expertise in the process to support commissioning managers and investigating officers. The action plan updates refer to formal training and education sessions having been rolled out across the organisation for investigation training; at May 2025 a register of attendance showed that 60 people had attended the training.	
Evidence submitted	**Review team analysis**
BROG papers, September 2025	The action plan states that: • the approach to investigations and training was developed at Salford Care Organisation level for application across the NCA;

	• an NCA-wide Just Culture framework workshop has been developed following engagement with staff-side representatives; • the Director of Attraction and Retention has undertaken a review of behavioural standards and values; and • an externally delivered session on learning from employment tribunal cases was held in January 2025. With regards to training delivery, the action plan refers to: • training on the standardised approach to investigations for all investigating officers provided as face-to-face sessions with virtual training for commissioning managers and chairs of panels; • training sessions were delivered to HR Business Partners and the training schedule for 2025 was completed by each care organisation team and available as virtual training for managers; • continuing professional development for HR teams to ensure their expert input to investigations and case management; • further quarterly training sessions on supporting panel decisions for commissioning managers; • standardised terms of reference (see evidence below) and investigation report documents have been implemented; and • further formal training for case managers for Maintaining High Professional Standards (MHPS) cases was to be undertaken during 2025. The action plan also refers to an improvement action plan being submitted to the PEC in March and May 2025 (not provided in evidence).
Completing an effective investigation, roles and responsibilities, not dated.	This is a PowerPoint presentation of the training content delivered across the NCA. This sets out how to conduct efficient and effective disciplinary investigations in line with Trust policies (disciplinary policy and the Just Culture framework). It sets out roles and responsibilities highlighting the requirement for input and guidance from HR to support the investigating officer. The presentation does not refer to the level of seniority of the investigating officer or the training provided to investigation officers. It does refer to the requirement for independence from the issues being investigated, for example an investigating officer may be from a different division. The training content includes the templates for the standardised terms of reference and report from an investigation. We noted that the template for the terms of reference was not consistent with the separate Terms of Reference document referenced below.
Register of trained investigators	This is a spreadsheet provided by the Trust to show who has attended the investigation training and date of attendance (during 2024 and 2025). There had been 60 attendees on the training as at May 2025.
Investigations training screenshot	This is a screenshot showing how staff enrol for training on disciplinary investigations. The module is titled ‘Formal Investigation, Report Writing & Presenting Evidence (Disciplinary, Grievance, Bullying & Harassment.’
Disciplinary training screenshot	This is a screenshot showing how staff enrol for training on disciplinary processes. The module is titled ‘What to Expect at Formal Disciplinary Hearing and Appeals.’

Terms of Reference	This is a standardised template for the terms of reference for a formal investigation. It requires completion of a field to confirm that the investigating officer has received investigation training as well as whether they are independent and have capacity to undertake the investigation. It also requires named HR support to the commissioning manager and the investigating officer to be stated.

Action 20: Develop / update a bullying and harassment policy (Breen ref. 41.2)

The Trust has reviewed and updated its Tackling Workplace Bullying and Harassment Policy and this was approved by the Group Joint Local Negotiation Committee in June 2025. It clearly sets out the processes to be followed and guidance for staff as well as the specific roles and responsibilities of commissioning managers, the HR team and investigating officers.

Evidence submitted	Review team analysis
BROG papers, September 2025	The action plan update refers to the development of the policy with amendments made following feedback from staff-side representatives followed by approval by staff-side via the Group Negotiating and Consultation Committee Group Joint Local Negotiation Committee in June 2025.
Tackling Workplace Bullying and Harassment Policy, July 2025	This policy was reviewed, updated and approved in July 2025 by the Group Joint Local Negotiation Committee. The policy was authored by the Director of HR following consultation with relevant stakeholders for implementation across the NCA. The policy was disseminated via HR teams with presentations at Team Briefs and the 'Inform' newsletter, signposting to training and support for managers. The policy clearly sets out roles and responsibilities and the process to be followed whether informal resolution of concerns or formal investigation process. The responsibilities of the HR team and investigating officers are described with HR acting as advisors and support to commissioning managers, investigating officers and employees involved. The policy sets out monitoring arrangements for compliance with the processes set out by the HR team with a quarterly report to the PEC and annual report to the Group Negotiating and Consultation Committee and the Group Joint Local Negotiation Committee.

Action 21: Doctor F to be referred to the GMC (General Medical Council) (Breen ref. 41.3)

The Trust has made a referral to the GMC on 19 July 2023 for the individual concerned.

Evidence submitted	Review team analysis
BROG papers, September 2025	The action plan refers to a referral letter on 19 July 2023 from the relevant Trust officer to the GMC for the doctor concerned. The letter was included in the evidence to the BROG in September 2025.

6. Area of concern/recommendation: Concerns relating to race discrimination

Breen Report, paragraphs 1173 states:

"*It has been reported to me that certain members of staff believe that there was, at the time of Doctor F's tenure, an undercurrent of racism. There is also a perception that a racist culture continues to exist. My remit was not to investigate if this was correct, and I have not done so. In my view, however, the Trust*

needs to explore with colleagues why concerns have arisen and what the Trust can do to restore confidence. This is an issue which must be dealt with."
Action 22: **Deep dive review of access to training aligned to Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) within the Spinal Service** **Deep dive analysis of WRES and WDES data specifically in relation to Spinal Service.** **Deep dive review of National Staff Survey data.** **Deep dive to review career progression within service.** **Deep dive to consider review of Datix within service.** **Deep dive into PALS complaints relating to racist incidents in relation to service (Breen ref. 42.1).**
The action is marked as complete as at 23 June 2025. The Trust has undertaken analyses of various data sources to understand the extent of concerns regarding allegations of racism (for example Datix incidents, complaints, staff survey). The resulting report of May 2025 was provided. The actions noted in the report itself were limited to the consideration and sharing of findings from the report with relevant stakeholders and the development of an action plan. A detailed action plan was developed from this work and shared as evidence; the majority of actions were noted as in development. We note that the Trust has undertaken reviews relating to compliance with the WDES requirements within the Spinal Service which is supplementary to the required actions of the Breen Report.

Evidence submitted	Review team analysis
BROG papers, September 2025	The action plan refers to a report 'Review of claims of racism and racist culture detailed in Breen report' of May 2025; this report was provided (see further below). The September 2025 update to the action plan states that the following actions were completed to identify areas of concern: • WRES/WDES data for Spinal Services reviewed (although limited due to low numbers and confidentiality threshold). • Deep dive of NHS staff survey data for Spinal Services for 2023 and 2024. • PALS and complaints data reviewed: "*… covering a 2-year period. 89 complaints in total, of which one categorised as discrimination, which was partially upheld.*" • Culture survey completed at the end of February 2025 and feedback was reviewed. The findings form the basis of interviews and focus group sessions in the Spinal Service which were planned to begin in April 2025; it is unclear if these sessions have commenced and to whom delivered. • Datix incident data reviewed over the period from January 2022 to December 2024: "*348 recorded. 3 of which recorded as staff on staff and one accusation of racism from patient against SCO [Salford Care Organisation.*" • Equality, Equity & Inclusion Action Plan (see below) (including identification of demographic characteristics for concerns raised via PALS and the Freedom To Speak Up process). The September 2025 update to the action plan refers to the Trust's anti-racism work through their involvement in the North West NHS BAME Assembly, noting that the NCA

	received a 'bronze' level of attainment in October 2024 for their work to date in implementing the associated framework.
Review of claims of racism and racist culture detailed in Breen report, May 25	In response to the Breen report, the Trust has examined the issues reported of a perception of racism within the Spinal Service. This report was provided as evidence to one of the actions assessed under Action Plan 2 relating to the SPSLBR report (see further below) so we have taken this into account as evidence for this action. The report includes the data collated to understand: • Workforce Race Equality and Workforce Disability Equality Standards data for the Spinal Service and the NCA in relation to other Trusts in Greater Manchester; • National staff survey data for the Spinal Service in 2024 (all questions); • Datix incidents reported relating to racial discrimination for the Spinal Service (January 2022 to December 2024); • PALS and complaints data relating to concerns of discrimination (January 2022 to December 2024); • culture survey results for the Spinal Service (which includes one question relating diversity and inclusivity - 80% of staff responded positively to this question); the document was not dated so it is unclear when this survey was undertaken; and • the Trust's Ethnicity Pay Gap Report for 2023.
Equality, Equity and Inclusion Objective Tracker 25-26	This is a detailed action plan for 2025/26 following the Trust's culture survey work. Section 2 contains the actions relating to race discrimination. The majority of actions are marked as 'in development.' There is one completed action relating to a revised Cultural Ambassador process.
Action 23: Concerns relating to BAME employees - report and recommendations to be provided on data gathering and focus groups (Breen ref. 42.2).	
A report and recommendations have been generated as a result of the analytical work undertaken to understand the extent of concerns about racism; the plan was to use this report as the basis for staff engagement work on this topic. Two facilitated staff engagement sessions were held in April and May 2025 to discuss the findings which indicated that staff felt that a racist culture remained. An action plan was to be developed from this report but this has not been provided as evidence. We found that the report strayed into analysis of other areas of culture and performance and did not focus solely on racism; this limited somewhat the visibility of the conclusions with regards to discrimination.	
Evidence submitted	**Review team analysis**
BROG papers, September 2025	A report has been produced to summarise the work undertaken as described above (action 22), 'Review of claims of racism and racist culture detailed in Breen report', May 2025. The report states that two online discussion group sessions were held in April and May 2025 to provide an opportunity to discuss the findings of the report. The sessions were led by the Head of Equality, Equity and Inclusion and an Organisational Development Consultant. All Spinal Service staff were invited to attend a session with 19 staff attending.

	The action plan highlights that the report was used to inform staff engagement sessions undertaken by the Chief Medical Officer and Chief Nursing Officer (no detail was provided on the dates of these sessions or attendance). Discussion at these sessions indicated that staff felt a racist culture still existed. The action plan refers to an action plan developed by the end of June 2025. A detailed action plan following this report was not provided
Area of concern/recommendation: Reflection	
Breen Report, paragraphs 1173 states: "*Lessons need to be learnt from these unfortunate events. Those involved who have been criticised should reflect upon their actions or inactions. The Recommendations of the SPSLBR needs to be robustly adopted.*"	
Action 24: Those involved who have been criticised should reflect upon their actions or inactions (Breen ref. 43-45).	
This action is marked as outstanding on the September 2025 update to the BROG and the planned actions do not directly reflect the intention of the Breen recommendation for individuals to reflect on their actions or inaction; we are therefore unable to assess whether this individual reflection has taken place. The recommendations of the SPSLBR are considered in the assurance review of the separate action plan relating to this review (see below Action Plan 2).	
BROG papers, September 2025	The action plan update refers to a review to identify whether there has been a positive change in the culture of the Spinal Service. A cultural survey took place in January 2025 to inform this work which was to be followed by discussions with the Spinal Service team.

RMCH Look Back Review action plan progress

Recommendation 1: Communication with patients and families	
Action 1: All patients and families will be sent summary letters outlining the outcome of their reviews.	
RMCH's Look Back Review report and communications plan sets out the communications issued to patients and families both during and after their case reviews, as applicable. For those cases where a full review was required, the outcome was documented in a letter with the offer of a meeting, fulfilling duty of candour responsibilities. The Governance team undertook a further check to ensure all letters had reached their intended recipients. Reporting on the progress with communications with patients and families following the report has been provided in routine updates to the Senior Leadership Team and the SHCG Quality and Safety Committee. This action is complete.	
Evidence submitted	**Review team analysis**
Spinal Safety Look Back Review, Royal Manchester Children's Hospital, February 2024	'Secondary desktop reviews' were undertaken for any case identified where clinical concerns or concerns regarding patient harm or experience were raised. The report refers to communication undertaken throughout and after the review with patients and families:

	"*For each patient identified from the initial searches of medical records and other sources, an initial advisory letter was sent…to inform them that a review was taking place…*" "*Follow up letters were sent to patients and families during the review process to either provide reassurance that their care did not require further review, or to keep in touch and inform them that their case was still moving through the review process.*" "*For all cases that underwent secondary desktop review, a final letter was sent detailing the outcome of the review and offering a meeting with the patients and families to further discuss the findings.*" "*In cases where harm has been identified appropriate NHS and MFT duty of candour processes have been followed to ensure any concerns highlighted by the review have been shared openly and honestly with patients and families.*"
Evidence submitted	**Review team analysis**
RMCH Spinal Safety Look Back Review, Communications Update Updated Version: 29 February 2024 - 14:00	The communications plan (final version) indicates that the final letters to patients/families were sent on 19 February 2024. There was a query on the plan regarding delivery of letters where email addresses were needed (previous correspondence had been by post). The Trust advised that there were some delays in the letters reaching some patients/families due to issues such as incorrect email addresses or patients/families having moved address. The Trust has undertaken a further review of the records and confirmed that all letters were present and had reached their intended recipients.
Email 29 February 2024	The final communications plan was shared with the Trust Executive Team noting changes to timescales and process to be followed.
RMCH Spinal Safety Lookback Review Update to the SHCG Quality and Safety Committee, June 2024	This update to the SHCG Quality and Safety Committee confirmed that all patients and families had been sent summary letters outlining the outcome of their review including a contact number and email should they wish to discuss further.
Report of the RMCH Spinal Surgery Lookback Review Team to the SHCG Quality and Safety Committee, 20 June 2024	This progress report to the SHCG Quality and Safety Committee in June 2024 provides an update on the status of patient communications since report publication and states: "*All patients and families have been sent summary letters outlining the outcome of their review including contact number and email if they wish to discuss further. Clinical follow up was arranged as required.*"
Spinal Safety Lookback Review Update, May 2025 (also provided as evidence for Action 4).	This summary paper by the Associate Medical Director, Quality and Safety was shared at the Senior Leadership Team meeting for the SHCG on 2 May 2025 and previously to the SHCG Quality and Safety Committees (see below). It states that: "*All patients were notified of their review outcomes and follow up letters and*

	meetings were provided in response to patient and family questions." The paper refers to an associated complaint due to a patient not receiving the outcome of their review and that this had been resolved. The paper states that there are no outstanding queries or questions from patients relating to the review which would also indicate that the letter delivery issues referred to above were resolved.
Recommendation 2: Communication with external stakeholders	
Action 2: A copy of this report will be shared where appropriate with external stakeholders including the NCA, NHS Resolution (NHSR), the General Medical Council (GMC), Spire Manchester Hospital (private provider where Spinal Surgeon A had practised), Spinal Surgeon A and their Responsible Officer.	
MFT provided a comprehensive communication plan which shows that the report was shared with relevant external stakeholders prior to or on the day of publication of the report. The report was shared on MFT's website on 29 February 2024. This action is complete.	
Evidence submitted	**Review team analysis**
https://mft.nhs.uk/rmch/spinalreview/	On 29 February 2024, MFT published on its website RMCH's report on the Spinal Safety Look Back Review into historic treatment at RMCH. This was accompanied by the Trust's response to the review which provided a summary of key findings.
RMCH Spinal Safety Look Back Review, Communications Update Updated Version: 29 February 2024 - 14:00	A detailed communications plan is set out in Appendix 1 to this document and sets out the plan for publication, briefings to a wide range of relevant external stakeholders and sharing of the report. The report was to be shared in advance of publication with the solicitors of Spinal Surgeon A. On the day of publication, the plan showed that email briefings with a link to the report on the website were to be sent to: • the Regional Director and Medical Director of NHSE NW; • the Chair, CEO and CMO of GMICB; • the Mayor of Greater Manchester; • the CEO of Manchester City Council and the Executive Member for Healthy Manchester and Adult Social Care and the CEO of Trafford Council; • the Director of Quality at the Royal College of Surgeons; • the NCA Medical Director; • the Medical Director for Spire; and • the General Medical Council.

	Shortly after publication, the plan shows that the report was to be shared widely with other relevant stakeholders including the CQC, relevant Healthwatch organisations, other hospitals in the Shelford Group and the University of Manchester. NHSR was not referenced in the list of stakeholders, and we confirmed with the Trust that this was an omission on the list in the plan and that the report was shared. The Trust also confirmed that NHSR had been regularly engaged throughout the review with meetings held on a number of occasions; their involvement was overseen by the Director of Governance at the time and the Head of Legal Services. The Trust advised that as the surgeon was no longer working at the Trust at the time of publication of the report, a Responsible Officer was not in place with whom to share the report.
Spinal Safety Look Back Review, Royal Manchester Children's Hospital, February 2024	The review report itself states: "*Contact was made with NHSR prior to starting the review to ensure they were fully aware that RMCH would be conducting such a review, and to establish regular contact to ensure transparency with the findings of the patient reviews.*" "*NHSR have been kept up to date regarding the commissioning of the RMCH review and progress during the review. Findings will be appropriately shared with them following appropriate communication with patients and families.*"
Email 29 February 2024	The final communications plan was shared with the Trust Executive Team.
Report of the RMCH Spinal Surgery Lookback Review Team to the Group Quality and Safety Committee, 20 June 2024	This progress report to the SHCG Quality and Safety Committee in June 2024 provides an update on the status of communications since report publication and states that the report was shared with relevant stakeholders.
Recommendation 3: Opportunity for further learning	
Action 3: The Trust, along with the review team, will consider if any further reviews are required for other patients who have received care under Spinal Surgeon A outside of the time period reviewed, particularly if concerns come to light from other patients and families.	
The Trust logged two further patient/family contacts in 2024 following report publication; these queries were responded to, and no clinical concerns were identified. The terms of reference for the Look Back Review included identifying additional patients outside of the time period (2006 to 2011) via internal search mechanisms such as concerns, complaints, incidents and claims; however, these searches were limited due to issues with locating archived paper records before this period. It was reported to the RMCH Quality and Safety Committee in May 2025 that some legal claims had been made which had not been captured as part of the review. Further investigation by the Trust found that the majority of the claims were not at a formal stage and had arisen following publication or had been part of the review. However, there were some new cases identified which may not have been	

investigated previously and these should be examined further by the Trust to understand how the claims may have arisen without a previous incident or complaint having been raised.	
Evidence submitted	**Review team analysis**
Spinal Safety Look Back Review, Royal Manchester Children's Hospital, February 2024	The review report highlights that the original terms of reference covered the period from 1 January 2006 to 31 December 2011. Additional patients outside of this time period were also to be identified through various mechanisms, including contacts from patients/families, internal departmental concerns, concerns/ complaints, incidents and legal claims. However, the Trust confirmed that these additional searches were limited as incident and complaint records prior to 2007 and imaging records prior to 2006 were not available due to the change to electronic systems and physical moves of archived paper records. The report acknowledged that whilst recognising the limitations of incomplete records before 2006, further reviews may need to be undertaken outside of the time period should further information materialise.
Patient Contact List - Spinal Review, not dated	This document is a log of contacts from patients and families involved in the review or new patients/families who contacted the Trust following report publication, and actions taken. It shows that the Trust logged two further contacts; the dates of contact and clinical care episode are not recorded on the log. These were follow-up queries from patients/families which were responded to and (August 2024 indicated) no clinical concerns were identified.
Spinal Safety Lookback Review Update, May 2025	This paper by the Associate Medical Director, Quality and Safety, was shared with the Senior Leadership Team meeting for the SHCG at MFT on 2 May 2025. It indicates that the paper had previously been presented to the SHCG and RMCH Quality and Safety Committees. It refers to the additional two contacts from patients, that reviews were undertaken and that no harm was identified. The paper refers to 16 associated legal claims stating that: "*Around half of these were cases reviewed as part of the RMCH review, and the others appear to be new patients not within the scope of the review.*" The Trust has looked into the status of these claims and confirmed that a number of these legal claims are at pre-claim stage rather than having been notified as formal claims and that these arose following publication of the review. Many were part of the review, but some cases are new and the Trust advised may not have been previously investigated. One of the claims which was part of the review had previously gone to court and the final outcome is awaited.

RMCH Spinal Safety Look Back Review - Assurance Plan Update, June 25	With reference to the contacts log, the note on the action plan update states: "*No further reviews required as a result of this contact.*" We confirmed with the Trust that this comment is referring to no further reviews being required after the two additional cases referenced to above.

Recommendation 4: Shared learning

Action 4: A summary of the review and its findings will be presented at relevant RMCH and MFT Quality and Safety meetings to ensure learning from the issues highlighted by the report; and assurance provided that all actions have been completed to the Board-level Quality and Performance Scrutiny Committee.

A summary of the review findings has been presented to quality and safety forums as follows: the RMCH/SHCG Quality and Safety Committees on 7 March 2024 and June 2024. A further update was shared in May 2025 with the SHCG Senior Leadership Team meeting. The papers shared provide reassurance only on action completion and no detail on how the learning themes from the review would be disseminated across RMCH, the Trust and to other stakeholders.

The detailed action plan capturing all the recommendations and actions from the review was not shared at these committees. Central oversight of the actions from the review and the subsequent actions identified (as referenced in the committee papers) is therefore unclear.

No papers were provided from the Trust's Quality and Performance Scrutiny Committee to provide assurance on the completion of the actions.

Evidence submitted	Review team analysis
RMCH Quality and Safety Committee, minutes of meeting held on 7 March 2024.	A summary of the report scope and findings were shared verbally with the RMCH Quality and Safety Committee and minuted in detail (the report had been published in February 2024, and the Committee were advised to read the report in full). The summary set out the findings in terms of harm and the key themes found: inadequate consent; misplaced screws; consent to research work (subject to a separate investigation); and duty of candour issues. Actions were summarised as: • review of the governance processes in the spinal department and assurance received that there are adequate safeguards and benchmarking in place; and • work had started on how procedures with a higher risk for complications could be more effectively recorded and how it can be identified if a particular complication is happening more frequently or more severely with a particular surgeon or team. The committee was also signposted to an additional report on findings relating to hospital culture which were a contributory factor to the issues raised by the review. The full action plan relating to the review was not provided as evidence for assurance to this committee (see further below).

RMCH Spinal Safety Lookback Review Update Paper to the SHCG Quality and Safety Committee, June 2024	This paper was shared with the SHCG Quality and Safety Committee on 20 June 2024 to provide an update highlighting that the review was complete and ongoing activity following its completion. It provides a summary update on actions taken with regards to the review recommendations but does not provide the full action plan for assurance.
Spinal Safety Lookback Review Update, May 2025	This paper was shared with the Senior Leadership Team meeting for the SHCG on 2 May 2025. It indicates that the paper had previously been presented to the SHCG and RMCH Quality and Safety Committees. The paper provides a summary of the review and its findings, including the status of actions from recommendations and next steps required, including action taken in relation to further patient/family contacts and legal claims (existing and new). The learning from the review is set out as in the review report as the main themes arising from the case reviews themselves and from discussions with patients and families. In addition to the concerns raised with aspects of Spinal Surgeon A's practice, there were some key issues relating to consent, information sharing, pre-operative discussion, incident reporting, duty of candour and peer scrutiny of practice. This paper does not provide assurance on the dissemination of learning from this review. There is an update on action status within this paper, however this is not the detailed action plan with evidence of completion, responsibility and completion dates against the plan. The update provides reassurance only on the actions.
Recommendation 5: Governance processes across spinal service	
Action 5: RMCH will review the clinical governance structure and processes within the paediatric spinal service and ensure that they are aligned to the recently implemented National Patient Safety Incident Response Framework (PSIRF); and assurance provided to the RMCH Quality and Safety Committee and Group Quality and Performance Scrutiny Committee.	
The actions undertaken cover some aspects of clinical governance structure and processes including the establishment of a Divisional Quality and Safety forum, weekly review of incidents, implementation of the PSIRF requirements, data submission compliance for the British Spine Registry and monitoring of surgical outcomes. The detailed implementation plan for the PSIRF across RMCH was provided; this did not drill down to actions required at specialty level and therefore for the spinal service specifically. The Divisional Quality and Safety forum requires a formal terms of reference to include oversight of the action plan resulting from this review in the spinal service. Analysis of incidents in the escalation report to this forum does not drill down to specialty level. It was highlighted that currently consultant capacity in job plans is insufficient to facilitate attendance at Morbidity and Mortality and MDT meetings.	

Overall, this recommendation is high level and has not been translated into the multiple facets of clinical governance and processes that may need to be considered. The Trust has interpreted this recommendation into the actions below, but we are unable to provide assurance that all the required aspects of clinical governance within the spinal service have been addressed, for example the report findings reference issues around consent, information sharing, pre-operative discussion, incident reporting, duty of candour and peer scrutiny of practice. We note that consent around clinical trials is considered in Action No papers were provided from the Trust's Quality and Performance Scrutiny Committee to provide assurance on the completion of the actions.	
Evidence submitted	**Review team analysis**
RMCH Spinal Safety Look Back Review - Assurance Plan Update, June 25	The update states that the following aspects of this action are complete: • Divisional Quality and Safety monthly meetings in place since October 2024. The Trust has advised that the Divisional Quality and Safety meeting does not yet have a formal terms of reference but is supported by the governance lead and minuted. It was established in October 2024 following changes in divisional leadership. It has not had responsibility for formal oversight of the review, and it is recognised that it would be appropriate for this forum to have this role to "*ensure responsibility for risk and safety from a governance perspective, not just to review incidents.*" • Governance Lead review of all incidents on a weekly basis with Governance facilitator. The Governance Lead confirmed that incidents are reviewed weekly and themes examined with escalation to the divisional level via the Escalation and Assurance Report (see below). • Divisional alignment to PSIRF principles, undertaken in line with RMCH wide approach to governance/safety. The Trust has provided a detailed implementation plan on PSIRF (see below). • Individual and departmental surgical outcomes are uploaded and discussed within annual appraisal. The Trust confirmed that incidents reported relating to spinal surgery are automatically pulled through from the incident reporting system (Ulysses) to the appraisal and revalidation system (SARD) if staff are named in an incident. Actions relating to oversight of the British Spine Registry completion compliance have been implemented (see further below). In addition, there was an action referring to twice-yearly presentation of BSR data at the divisional audit day (ACE) and sharing of the audit data at the Children's Clinical Audit Committee. The Trust confirmed that BSR data for 2024/5 will be scheduled for discussion at the Clinical Audit Committee in November/ December 2025. The Trust noted that the Audit

	Committee structure is under review due to ongoing organisational changes. The Trust confirmed that job plan review is underway to support attendance at Morbidity and Mortality (M&M), MDT and departmental meetings. However, it has been identified that additional capacity will need to be found as job plans do not currently reflect what is needed for M&M and MDT meetings.
Evidence submitted	**Review team analysis**
Escalation and Assurance Report RMCH Quality and Safety Committee, 3 April 2025	This is an example of the report from the Division of Surgery and Theatres which has been shared at the Divisional Quality and Safety Committee and through to the RMCH Quality and Safety Committee. The report provides an analysis of incidents and risk commentary but does not drill down to specialty level.
Escalation and Assurance Report RMCH Quality and Safety Committee, 10 July 2025	The escalation and assurance report for July 2025 from the Division of Surgery and Theatres is provided. This reports on progress on compliance with data completeness for the BSR - see further below.
Paediatric Spinal Surgery - BSR (British Spine Registry) Patient Audit and Oversight	This document shows the tracker in place to monitor compliance with the requirements of the BSR patient audit. The document shows cases recorded and audited from April 2024 to July 2025.
Interview with the Operational Manager for ENT, major trauma and spinal services, 26 July 2025	We were told that a task and finish group is overseeing the transfer to the use of the British Spine Registry.
RMCH Quality and Safety Committee Notes, 7 March 2024	These notes state: "*Spinal department governance processes reviewed and benchmarked.*" This provides reassurance only to the Committee rather than assurance based on evidence of actions undertaken.
Spinal Safety Lookback Review Update, May 2025	This report to relevant Quality and Safety Committees (QSCs) states: "*The clinical governance structure and processes within the paediatric spinal service and paediatric surgery division were reviewed and are in line with the Patient Safety Incident Response Framework.*" This provides reassurance only to the QSCs for RMCH and the Care Group rather than assurance based on evidence of actions undertaken.
Patient Safety Incident Response Plan, 2022-2025	The Trust has adopted the PSIRF and provided the Patient Safety Incident Response Plan. This sets out the Trust's local priorities for incident monitoring; these are generic categories applicable Trust-wide and include: patient care monitoring and review, communication failure, documentation.

PSIRP Implementation, May 2023	This is a detailed presentation setting out the approach and actions required for the implementation of the PSIRF and PSIRP across RMCH.
RMCH PSIRP Action Plan, May 2023	This shows the action plan status from the implementation of PSIRF at May 2023. More recent evidence of the status of the action plan and where this is overseen was not provided.
'Safety Differently' RMCH ACE Day, September 2023	This is a presentation pack used as training material at an audit day (ACE) by the governance team for sessions on the implementation of the PSIRF. Information was not provided on how many training sessions have been delivered and attendance. The Trust has advised that specific training for the spinal service team is planned.

Recommendation 6: Use of data to determine effectiveness and safety across the service.

Action 6: RMCH will review the potential indications for, and implications of, dual consultant operating by spinal surgeons and benchmark current practice against other UK children's hospitals and any national standards.

The Trust has commenced work to look at dual consultant operations in the spinal service and is examining capacity/demand data with a view to informing a business case. Benchmarking work is underway with Alder Hey Children's Hospital and the Evelina London Children's Hospital.

No documentary evidence was provided of the work to date or reference to oversight through the relevant governance forum.

Evidence submitted	Review team analysis
RMCH Spinal Safety Look Back Review - Assurance Plan Update, June 25	The action plan update states that the following aspects of this action are ongoing: • Review of the number of dual operations and support from Salford underway. The Trust confirmed that data is now available from Salford which will be used to inform a business case. • A request was made to the performance team for in-depth capacity and demand data by the Director of Operations on 20 June 2025. The Trust has confirmed that a capacity and demand model has been provided, and this requires further refinement which is underway. • Benchmarking with Alder Hey Children's Hospital and Great Ormond Street Hospital is to commence in the week commencing 23 June 2025. The Trust has advised that work is in progress with Alder Hey and the Evelina London Children's Hospital.

Recommendation 7: Further review of research relating to clinical trial identified as part of the review.

Action 7: The Group Research Governance Committee will oversee and carry out further investigation into the clinical trial identified as part of this review, and the associated research governance.	
The Director of Research Governance and Quality at RMCH undertook a detailed investigation of the conduct of the clinical trial and reported the findings in June 2024.This action was completed by the required deadline of July 2024. The investigation found that there had been challenges in locating records which should have been retained by Spinal Surgeon A. Attempts to contact the Clinical Research Organisation managing the trial were made regarding the records and the findings of the review, but an appropriate senior contact could not be reached. The Trust provided a comprehensive summary of the controls in place to ensure that research leads understand their responsibilities with regards to clinical trials and that good clinical practice is maintained. These include a specific policy for Principal Investigators, associated standard operating procedures, training and certification.	
Evidence submitted	**Review team analysis**
Spinal Safety Look Back Review, Royal Manchester Children's Hospital, February 2024	The Look Back Review identified concerns regarding consent and documentation for patients involved in a clinical research trial using novel metalwork in their surgery (the Expedium Memory Spinal System). Specifically: • some patients did not have a consent form in their case notes, and consent forms found did not always detail the potential risks; • there was a lack of evidence that a patient information leaflet had been given to patients and families in some cases; and • two patients required additional surgery due to a break in the metalwork.
Summary of Spinal trial review 07.06.2024 final	This report by the Director of Research Governance and Quality details the findings of a research governance review of the participation of RMCH in the Expedium study between 2009 and 2012. The report's findings and our observations are as follows: • The trial was set-up with appropriate documentation (listed in the report) for approval. We confirmed with the Trust that R&D approval had been given by the relevant Trust (Central Manchester University Hospitals NHS Trust) on 28 May 2009 via its Research Office. • A signed contract was put in place on 27 May 2009, indicating that the contract was signed a day before R&D approval. There were then some changes to the contract and this was updated and signed by the Divisional Director for Research and Innovation on 9 July. • A Research Ethics Committee (REC) annual report on 20 June 2010 referred to the start date of the study as 22 January 2010 noting that seven patients had been involved and there had been one serious adverse event. The report does not

	state if the adverse event was for RMCH or at another organisation ('Nottingham') and whether this was investigated and communicated to stakeholders in the trial. • A letter was sent to Spinal Surgeon A on 16 March 2012 by the Head of the Research Office which raised concerns about the follow-up of some participants in the study and that although this required medical input, a Spinal Specialist Nurse was being asked to do these. The letter recommended that this was addressed with named clinicians having such duties under the research protocol. The report states that there was no evidence of a response from Spinal Surgeon A on this issue. • A site file for the trial (including patient information such as consent forms and case reports) could not be found at RMCH. This should have been retained and was the responsibility of Spinal Surgeon A. The Clinical Research Organisation managing the trial were contacted regarding records, but no response was received. Upon further investigation the NCA located an archive box for the trial at Salford Royal Hospital (the main base for Spinal Surgeon A). The Trust further clarified that "*the documentation in the (limited) site file archived at NCA was insufficient to confirm who followed up the participants. Current R&I [Research and Innovation] staff did not request medical records at either MFT or NCA to verify medical involvement. Access to medical records at NCA was not requested by R&I, only access to the study site file. It was the understanding that medical records were being reviewed by other parties contributing to the report.*" • Upon examination of the contents, documentation was found relating to the trial but there were no consent forms, case record forms (although correspondence in the file indicates they were completed) or adverse event forms. The serious adverse events which occurred under the trial were reported in the final report to the REC (date not indicated). The REC report did not indicate if the adverse events related to RMCH or a different site and work has since been undertaken to link this information to patient records with a file being securely held in the Trust's Research Office. The Trust has advised that the Chief Medical Officer made a separate request to the team to attempt to make contact with the trial sponsor to notify them of the findings. The team have explored contacts but have not been able to identify an appropriate senior contact.
Extract of minutes from the Research Governance Committee, May 2024	The report was discussed at the May 2024 meeting of the Trust's Research Governance Committee as agenda item 5.3, Spinal Surgeon Report Notification.

	It was recorded that further information had been requested in relation to the research study. The original report would be updated for this and would be shared with the relevant RMCH lead and the Group Joint Medical Director.
Update from the Trust on the action plan, 30 September 2025	The Trust provided a comprehensive written update to the action plan with regards to this area to explain the controls in place for research work as follows: • "*The Trust has a policy for Principal Investigators which describes their responsibilities, what is expected of them and about medical oversight of a study.* • *All Trust-wide R&I policies and SOPs [standard operating procedures] once created, or updated, and placed on the Trust intranet, are circulated in the monthly R&I communication "Research Update" which includes all R&I staff and researchers on the distribution list.* • *All investigators are required to provide Good Clinical Practice (GCP) certificates when starting a study and these are renewed every 3 years while the investigator is part of an active study. A process is in place to remind researchers and obtain new certificates when due. Maintaining appropriate records for a trial is central to GCP principles (data integrity).* • *Other SOPs are available on the intranet which cover source data, site file maintenance and archiving. These are covered when any study is audited or monitored by a research sponsor, or the Research Office.* • *The Research Office runs 'Research Support Clinics' for new researchers, part of this is signposting SOPs/policies which are relevant to their responsibilities. (R&I also runs Clinical Trial Management training aimed at R&I research delivery staff, but open to others, which includes records management sessions. This means the wider research team also understand appropriate record management.)*"

Spire improvement actions

Evidence submitted	Review team analysis
Consent policy and documentation	The Consent Policy was issued in September 2023 and includes links to relevant guidance from the Department of Health and the General Medical Council. It sets out the meaning of consent and provides guidance on patients who lack the capacity to consent, the process for obtaining consent, documentation requirements, responsibilities, treatment considerations, special circumstances and training.

Evidence submitted	Review team analysis
	The policy explains that when a patient formally gives their consent to a particular intervention, this is only the endpoint of the consent process. The whole process of information provision, discussion and decision-making is part of 'seeking consent' and the provision of information is central to the process. Patients require comprehensible and comprehensive information about their condition, possible treatments, risks, benefits and comparative risks with other procedures before coming to a decision about their treatment. The policy outlines both a single-stage and a multi-stage consent process. Where the standard process is not followed, a clear explanation for the deviation must be documented. For significant procedures, health professionals are required to clearly document both the patient's agreement to the intervention and the discussions that led to that decision.
Raising Concerns policy, May 2024	This policy is to support anyone who works at Spire and includes any healthcare professionals (including consultants) to raise concerns about risks to patient safety, malpractice, wrongdoing or other matters of concern. It outlines clear pathways for raising concerns, including speaking to line managers, Freedom to Speak Up Guardians (FTSUGs) and FTSU Ambassadors which are being established in every hospital as an additional channel for consultants and resident doctors to raise concerns, using the Datix incident reporting system, contacting the Corporate Concerns Officer or escalating to external regulators and prescribed bodies if needed. It distinguishes between employment issues (which should be managed through HR processes) and whistleblowing concerns, which are protected. Where an individual is dissatisfied with how their concern has been managed or with the outcome of the process, the matter will be reviewed in line with the organisation's Grievance Policy. While the policy applies to all individuals working with Spire, including consultants (employed or self-employed). There is also a separate policy for how concerns about consultants are to be investigated and managed..
Summary of any anonymised speak-ups from Manchester Hospital spinal team (last three years)	Between 1 July 2022 and 1 July 2025, a total of 20 concerns were raised via the FTSU Datix system. Of these, two were submitted anonymously, and none were related to the spinal service or team. The anonymous concerns were as follows: • In November 2023, a concern was raised regarding the working environment within the Outpatient Department. A HR investigation was undertaken and all actions arising from the report have been completed. A senior leader was appointed as interim manager to support the department's operations. Following this, the concern was closed. • In August 2024, a concern was raised regarding the management of confidential information on a shared drive. The issue was referred to the DPO team for review and advice was provided to the line manager regarding transferring the information to a confidential drive. Following this, the concern was closed.
FTSU mandatory training package	The organisation told us that they recognise that fostering a positive speak-up culture is fundamental to ensuring patient safety and high-quality care. To

Evidence submitted	Review team analysis
and compliance rates	strengthen this culture and embed best practice, the National Guardian's Office e-learning modules were made mandatory for all staff, tailored to their role. The training was launched in Quarter 3 of 2023 and comprises the following modules: • **Speak Up** - This is module is undertaken by all staff to build understanding of how to raise concerns in line with the Raising Concerns Policy. The module covers what speaking up is, why it matters, understanding how to speak up and what to expect when one does speak up. • **Listen Up** - This module is undertaken by all managers to develop the skills required to respond appropriately when concerns are raised. This training focuses on listening and the barriers to speaking up. • **Follow Up** - This training is undertaken by senior managers to strengthen understanding of how to provide effective feedback and close the loop. The training helps senior leaders understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement. Niche did not receive example of the training modules but was instead provided with a narrative description outlining the content of each module. Completion compliance for all three modules is monitored by the Learning and Development Digital Team. As at September 2025, year-to-date compliance for this training (within Spire Manchester) was 94% overall, however, training compliance was lower for the modules which are mandatory for more senior managers (Listen Up and Follow Up).
Summary of 'soft intelligence processes' now implemented	As part of the Consultant Practicing Privileges Review and Practicing Privileges and Appraisal Policy, soft intelligence is formally incorporated. The Medical Governance Lead gathers information from key staff across the hospital, including Theatre, Ward and Outpatient Managers, as well as from other colleagues and other Spire hospitals where the consultant practices. This information may include information relating to ongoing investigations or 'softer' concerns that have not met the threshold for formal incident reporting or whistleblowing. In circumstances where individuals require their performance to be reviewed in more detail by the relevant speciality representative will advise the Registered Manager. A face-to-face meeting between the Practitioner and the Registered Manager (and/or the Director of Clinical Services) will be arranged. The circumstances in which meeting will be arranged are listed and include: "*Where soft intelligence identifies concerns e.g. from staff, colleagues or MAC members. This should include concerns raised by Whistleblowing reports and incidents raised through the Freedom to Speak up Guardian.*"
Pre-operative assessment audits	**A Pre-Operative Assessment Documentation** audit is conducted quarterly to provide assurance that patients have been prepared for their procedure in line with the standards outlined in the relevant policy. The audit reviews a sample of 30 patient notes who are undergoing general or regional anaesthesia who have

Evidence submitted	Review team analysis
	attended for pre-operative assessment. There are 16 questions, with guidance provided for the auditor. The audit requires that all charts and notes are drawn from inpatients or day-case patients who have undergone anaesthesia and attended pre-operative assessment. Auditors are expected to use the same patient episode consistently across all questions. Where any clinical concerns are identified, these must be escalated for resolution outside of the audit process, and documented to ensure that action is taken. **The Routine Preoperative Testing audit** is conducted quarterly to provide assurance that patients attending Spire for pre-operative assessment have undergone pre-operative testing in line with NICE guideline NG45. The audit reviews a sample of 30 patient notes comprising of six minor surgery notes, 12 intermediate surgery notes and 12 major or complex surgery notes as defined by NICE NG45. There are 16 questions, with guidance provided for some. The audit requires that all charts and notes are drawn from patients who have undergone pre-operative assessment by Spire-employed staff. Auditors are expected to use the same patient episode consistently across all questions. Where any clinical concerns are identified, a Datix is to be completed so this can be addressed outside of the audit, and this is to be recorded in the action taken. The **HMS (Hospital Management System) Admin audit** is conducted quarterly to ensure that the relevant process is being followed and that patients are progressing through the HMS system as expected. The audit requires checking of the completion of the system dashboard and is to be completed by the Admin Manager or pre-operative assessment lead. There are 11 questions, with guidance provided for some. If compliance is below 95% for any of the audits above, an action plan should be created, considering what actions will be effective in improving compliance, assigning actions to a relevant individual including a timescale for completion. We have not seen the results from recent audits in these areas.
PSIRF plan for 2025, Reflections on our implementation **PSIRF Implementation at Spire**	This document outlines the Spire Group's PSIRF plan for 2025, highlighting the organisation's key patient safety priorities and associated processes: 1. Management of Deteriorating Patients 2. Post-Operative Complications 3. Injuries Sustained During Surgery 4. Inpatient Falls 5. Blood Transfusion 6. Near Miss / Never Events Each priority includes example Incidents, response type and anticipated learning routes. The SEIPS model is included, along with a mapping diagram, to support systematic analysis and improvement.

Evidence submitted	Review team analysis
Healthcare report by the National Deputy Director of Quality Governance, July 2025 **Patient Safety Incident Response Framework (PSIRF) Policy April 2025**	The report states that PSIRF has been fully implemented across all Spire hospitals, and is described as 'a "step change" in the culture and approach to patient safety and response. The implementation followed a structured, phased model from planning (August 2023) through to full implementation (January to April 2024). It uses multiple enhanced investigation methods, including PSIIs, After Action Reviews, MDT meetings and SWARM huddles. The SEIPS systems-based model guides investigations, focusing on systems rather than individual blame, supporting sustainable improvements. This is supported by training resources and dashboards on DCIQ. Local and central thematic analysis of trends from incidents, including near-misses and low-harm events, informs quarterly campaigns. Dashboards and structured reporting are used to monitor incident types, severity, and recurrence across sites. Reports generated show how near-miss and low-harm incidents are increasingly reported and analysed to detect early signals and inform decision-making for further deep dive analysis. Spire has introduced a new patient experience framework alongside PSIRF, which includes a toolkit for hospitals to listen to patients more effectively. This framework supports the identification of themes and early warning signs by capturing patient feedback and integrating it with incident data. The approach is designed to ensure that learning from incidents is embedded into everyday practice and that systemic issues are addressed proactively The PSIRF policy outlines Spire Healthcare's approach to patient safety incident reporting and response, emphasising learning, transparency, and fairness. Spire Healthcare's safety culture are defined under the following categories: • Leadership commitment • Open communication • Reporting and learning • Training and education • Continuous improvement • Patient involvement • Safety is a priority Within the policy it details Just Culture as a principle promotes a blame-free environment where staff feel confident to report errors or near misses without fear of reprisal. It recognises that incidents typically result from multiple factors, including human error, system failures, and organisational influences. A Spire Healthcare Just Culture Managers Step-by-Step Guide is included in the Appendices. Psychological safety is explained that it is cultivated in an environment of trust and openness, allowing team members to take risks, raise concerns, and learn from mistakes.

Evidence submitted	Review team analysis
	The Patient Safety Incident Response Group (PSIRG) reviews and approves every PSII within five working days, recommending national actions such as policy changes, training or care pathway updates.
Theme and trend analysis by the Governance Team - latest report	Refer to 8.28.
Manchester Spire Hospital, Meeting Minutes - Clinical Governance Committee, March 2025	Standing agenda items include: • Review of Incidents and near misses, including harm levels and learning • Audit compliance • Local Intelligence Network (LIN) reports • Unplanned transfers • Unplanned returns to theatre (including any outlying surgeons) • Surgical site infections • Regulatory updates • Clinical risk • Patient experience • Learning from deaths The committee also reviews escalations from hospital committees, policies and procedures
Consultant documentation audit and Outpatient Consultant Documentation audit results	The Consultant Documentation audit is conducted quarterly to assess consent, daily visit and documentation standards in accordance with Clinical Policy 78, Clinical Policy 15 and relevant professional standards including GMC Record Keeping Standards and the Records Management Code of Practice for Health and Social Care. The audit reviews a sample of 30 surgical inpatients with a selection 10 different Consultants included. There are 41 questions, with guidance provided for some questions. Auditors are expected to use the same patient episode consistently across all questions. Consultant GMC and patient identifier numbers must be recorded for each submission, and the Hospital Director and Director of Clinical Services are accountable for the audit. The Outpatient Consultant Documentation audit is conducted quarterly to assess documentation standards in accordance with MED02 and relevant professional standards including GMC Record Keeping Standards and the Records Management Code of Practice for Health and Social Care. The audit reviews a sample of 20 medical records, with the sample including a selection of the top 10 consultants. There are 27 questions, with guidance provided for some questions.

Evidence submitted	Review team analysis
	Auditors are expected to use the same patient episode consistently across all questions. And Consultant GMC and Patient SAP numbers must be recorded for each submission. If audit compliance is below 95%, an action plan should be created, considering what actions will be effective in improving compliance, assigning actions to a relevant individual including a timescale for completion. Manchester hospital audit results for CON01 - Consultant Documentation and CON02 - Outpatient Consultant Documentation, July 2025: • CON01 compliance over the last two periods is 96% and 96.8% respectively, with three overdue actions. • CON02 compliance over the last period is 99.6%, with no overdue actions. Compliance for other periods was not provided or available.
Proforma for daily safety huddle	**This safety huddle template is designed for Spire Manchester Hospital to provide a comprehensive overview of daily operations, patient safety and departmental updates.** **Daily inputs include:** • Hospital safety information including information on the SMT on call, FTSUG on site, clinical on call, safeguarding lead and nurse in charge. There is an additional section to capture feedback from the on-call team, 48 hour flash/drug alerts and supply issues. • Ward information including admissions, overnight patients and staffing levels. • Pre-Operative Assessment information including number of appointments and patients awaiting triage. • Departmental updates from CYP, Physio, Radiology, Theatre, Critical Care, Outpatients, Pharmacy and other departments including Housekeeping and Admin. • Bank, agency, and overtime staff in each department. • Other sections including visitors, meetings, resus/training/test results and upcoming meetings. There is a section for complaints and poor experience alerts, call-back requests, as well as all open/overdue datix incidents and key operational matters (e.g. staffing). Niche did not receive any evidence of monitoring that these daily safety huddles take place.
Example of Complex Spinal MDT Outcome form	**This is an example of a Complex Spinal Multidisciplinary Team (MDT) outcome document. Included in the form is information regarding:** • Patient details. • Clinical details of the patient including relevant medical history and current clinical presentation.

Evidence submitted	Review team analysis
	• Specific clinical questions or issues to be addressed during the MDT are clearly documented. • Imaging and other relevant investigations reviewed are included. • The outcome section includes the date of the MDT, Consultants present, including spinal surgeons, neurosurgeons, and neuroradiologists, names of all other attendees and detailed MDT outcome based on the question to that was noted to be addressed.
Consultant Practicing Privileges Application Management form	As part of the practising privileges application process, consultants are required to complete this form, which requests that Consultants provide details of their current NHS post, NHS Trust, type of contract and details of any other hospitals where they have held practising privileges. Information entered on the form should reflect the full scope of the doctor's practice, both within and outside the NHS. Consultants are required to submit the following evidence of practice: • A completed spreadsheet (provided separately by the Hospital Director) outlining, by specialty, the procedures the consultant intends to undertake at the Spire Healthcare Hospital. • A reference from the consultants Responsible Officer or Clinical Director. For Consultants employed by the NHS, any requests to undertake clinical procedures that do not form part of their standard NHS practice are considered on a case-by-case basis. In these instances, the consultant must demonstrate: • A satisfactory level of training. • A satisfactory level of competence. • Evidence that these additional undertakings have been considered at the latest annual whole practice appraisal.
Practicing Privileges and Appraisal Policy, 2024	Practitioners will have a review of their practicing privileges carried out after 1 year of practice with Spire Healthcare. Following this, the practitioner will drop into the routine biennial review cycle (or remain in annual review if they meet set criteria). The appraisal looks at: • Evidence of continuing professional development including mandatory training. • Quality improvement activity including audits. • Serious Incidents Requiring Investigation (never including events) • Feedback from colleagues (at least once every five years). • Feedback from patients where applicable (at least once every five years). • Complaints and compliments. The biennial review process must comprehensively consider all hospitals that the practicing privileges are held at. Appraisals are ratified by the Medical Advisory Committee

Evidence submitted	Review team analysis
	The appendices to this policy were not available to us.
Mandatory training	**Mandatory documentation compliance, July 2025:** Mandatory documentation compliance is monitored through a weekly report covering the five mandatory documents linked to practising privileges. Spire is currently transitioning from a 10-year to a 3-year validity period for DBS checks, with a deadline for completion by 31 December 2025. As a result, current DBS compliance figures are below 100%, reflecting the number of consultants who have already moved to the new 3-year requirement. All consultants continue to hold a valid DBS, and the National Consultant Practice lead is monitoring the position across the group. Compliance scores for the five mandatory documents: • Manchester - 93.4% • Network average - 86.0% Appraisal compliance: • Manchester - 100% • Network average - 99.9% Biennial compliance: • Manchester - 100% • Network average - 99.9%
Surgical Safety Guardian job description	The Surgical Safety Guardian job description details that the purpose of this role includes establishing a culture of surgical safety, to advise on safety concerns and promote the role of surgical safety ambassadors. The role responsibilities include: • Empowering staff to speak up, challenge actions and behaviours that undermine safety. • Ensuring effective information flow across individual sites and the Surgical Safety Guardians forums. • Establishing and leading regular surgical safety meetings and feeding back to national group including audit findings and soft intelligence. The postholder should demonstrate a proven ability to work collaboratively with consultants to explore and challenge existing practices while maintaining and enhancing service quality and clinical standards. Key indicators of success include increased reporting of near misses, a reduction in never events and improved safety scores and staff satisfaction scores at departmental level. The role reports directly to the Director of Clinical Services (DoCS).

Evidence submitted	Review team analysis
Staff survey action plan, February 2025	The highest scoring questions or questions with the highest increase in score were that staff are aware of their FTSUG , understand their work expectations, are aware of Spire's Raising Concerns policy, respect their line managers and would be confident in the standard of care provided by Spire for a friend or relative. Key factors supporting this include the visibility of FTSUGs , an increased number of trained FTSU Guardians and FTSUGs visibility is discussed as part of induction. A clear set of employee expectations and personal development plans and regular one-to-one meetings. The improvements included: • Continued professional development opportunities and clear development structure, Education and training access additional to mandatory training. • Communicating action taken via meetings, Leadership forums, Staff Forums and Weekly emails from the Hospital Director. • Interdepartmental recognition and praise from SMT using Inspiring People Awards and 'thank you Thursdays'. Regular huddles, weekly emails, and meetings to communicate and celebrate achievements, with consideration of using departmental budgets for staff recognition. The SMT will continue to acknowledge successes through local events • Improvement to the patient record systems for improving workload. • Increasing visibility and communication from the SMT to staff. Manchester Colleague Survey results 2024 (survey ran in November to December 2024): • 69% of staff feel able to speak up without fear, this is a 4% increase compared to 2023. • 77% are proud to work for Spire, this is a 3% increase compared to 2023. • 76% have the opportunity to do their best, this is a 6% increase compared to 2023. • 60% feel meaningful action has been taken since the last survey. • 78% of colleagues completed the survey, this is a 10% decrease compared to 2023.

Appendix 4: Risk assessment of recommendation option for further lookback

Domain	Risk description	Considerations	Mitigating actions	RAG RRR*
Patient Safety	Without a full recall there is a risk that some harmed patients may not be identified.	• Many patients will have presented to their GP, hospital spinal services for further advice. • Reliably assessing whether symptoms are the result of the intervention is difficult. • We are aware that medical note keeping is said to be poor which can create an unreliable view on harms. • Only one patient has been recommended to consider further surgery as a result of the look back reviews undertaken. • The clinical reviews undertaken to date indicate a higher proportion of harms sit within governance, conduct and culture than • Spire has undertaken an extensive look back and confirmed relatively low incidence of overall harm	• The further reviews that have taken place have not found any new patient safety learning themes. • In some cases it has been hard to differentiate between recognised complications and actual harm, due to the complexity of case mix. Further work to consider national benchmarks such as published complication rates is needed. • Increase review awareness of available recall and review via GP. • Publish this offer on provider websites to raise awareness.	
Patient Engagement	Families may not feel they have sufficient closure if a complete look back does not occur.	• The review may cause distress to patients by approaching people who were not aware that there is an issue and who are well (i.e. some patients told us the lookback reviews did this). • There needs to be a balance between achieving a historic view and a safe today assessment. • A proportional approach must be applied given the extent of resource and cost already applied to reviewing Consultant Surgeon A.	• Patients should be included in ensuring that definitions of ‘harm’ are sufficient for their unique needs in any future recall appointments. • For patients who have mobility or pain issues access to outreach services should be available • People have three years to register their wish for a review this should be sufficient time for them to request an investigation into their case	

Current staffing and resource requirement	Staff may become demoralised and intolerant of repeated reviews and a failure to draw a line underneath these issues, even with this proportional option.	• There may be an onward impact on patient care and patient safety because of diverted resource. • Notes retrieval, case reviews, pre-recall checks (i.e. deceased patients) is a resource intensive activity. • There is an opportunity cost in relation to resources required to do a recall and the benefit of doing other significant analysis.	• Compassionate staff engagement must occur from organisational leaders • Highly organised approaches must be prioritised through interviews and information requests. • There is a new operating model within spinal surgery (NCA) and assurance on current governance is needed as part of this work as this is actionable today.	
General risks				
Regulation	Regulators will not receive sufficient assurance if residual questions remain because the scope has been insufficient to form a comprehensive view of what happened as well as an assessment of the likelihood of it happening again.	• This will occur if there is insufficient stakeholder and regulator engagement. • Feedback and inputs from regulator. • NHS England is going through a transitional phase and so central oversight of this extensive case must be retained.	• Engagement with regulators. • Sufficiently clear scope. • The feasibility study approach limits the risk of wasted public funds and duplicative review work. • Supporting evidence will be fully documented. • Ensuring the desired outcomes for the review are clearly articulated from the outset.	
Value for money (VFM) (public).	Risk of improper use of public funds if the review does not provide sufficient insight into the events and also that it does not draw a definitive line under the historic events and impacts.	• Insufficient breadth of scope will not deliver the desired outcomes. • Sufficient learning will not occur if the scope is not sufficient to extract all available understanding.	• Sufficiently worked up scope. • Clearly defined accountabilities. • Monitoring of risk. • The feasibility study approach limits the risk of wasted public funds and duplicative review work. • Recommendations which are actionable and lead to sustainable improvements must be prioritised. • Action planning support must also be provided via this review.	

Extended timescales	Any issues with culture or safety today may not be identified until the end of the review.	• Patients and some staff have waited a long time to have answers to these matters. • There must a balance achieved between looking backwards and providing a contemporary assessment of the work done today.	• The focus on safety oversight today will prioritise identifying any immediate risks, so that action can be taken promptly if needed. • A feasibility assessment (part 2) is needed to reduce the risk that patients wait for many months for answers to their questions which may not be achievable; it is key that expectations are managed with honesty and clarity.	

Residual Risk Rating (RRR) scoring key:

	Even when the mitigation is applied this may still present as a significant risk.		The mitigation applied means the risk is minimised.
	When the mitigation is applied the risks are materially reduced.		

Appendix 5: Draft terms of reference for Phase 2 review

Background

These terms of reference relate to a 'Phase 2' review, following the diagnostic work undertaken by Dr Yvette Oade alongside Niche Health and Social Care Consulting (NHSCC), which comprised an assessment of the lookback work undertaken in relation to Consultant Surgeon A. The purpose of this work was to identify any further lookback work required, and any residual recommendations which needed to be put in place. The outputs of this work can be found at [link to published report].

The review team was also asked to make recommendations for any other types of review work required (a Phase 2). They concluded that:

There should now be a focus on the existing safety oversight arrangements within the three providers at which Consultant Surgeon A practiced; and

There is a clear appetite for a fuller investigation into how concerns relating to Consultant Surgeon A were handled within Salford Royal NHS FT and the Northern Care Alliance NHS FT. Previous reviews have not been able to fully answer patient and staff's questions into these matters. There are concerns that given the length of time passed, changes to systems, the organisational merger and other reasons, information may not be available to investigate these questions in a meaningful way.

Review objectives

This Phase 2 review will therefore focus on:

1. Assessing the current levels of safety oversight within each department, with a view to surfacing any key risks; and

2. Assessing the feasibility of a fuller investigation into the organisational handling of concerns about Consultant Surgeon A.

<u>Part 1: Existing safety oversight arrangements</u>

a) The objectives of part one are to assess how similar issues (relating to the Consultant Surgeon A case) would be handled by each organisation today. Specifically the review team will:

b) Undertake a rapid review of departmental risk to identify the risk profile of each service. This will inform the need for any early safety actions required, while the broader review is ongoing.

c) Assess, from service to board, the governance, reporting and escalation structures in place, to understand the 'line of sight' each Board has into these services.

d) Assess culture (including safety culture) within each service, and the extent to which this enables high quality care to be delivered.

e) Identify any risks in relation to workforce. This will include staffing, training, turnover, sickness and any formal HR processes which may have an impact on patient safety.

f) Assess compliance with clinical guidelines, and how audit is being used to drive clinical effectiveness

g) Assess the use of information, including benchmarking, to support patient safety.

h) Assess how incidents, complaints, claims and other sources of patient experience intelligence are used, and what current performance in this area suggests about each service.

i) Assess how regulatory compliance is determined, and identify any risks in relation to this.

j) Assess the rigour of the combined action plan recommended in Phase 1; its completeness, oversight and accountability arrangements.

k) Identify good practice and areas for inclusion in the combined action plan.

l) The review team will evaluate each of these areas and provide a scored assessment on the current controls in place. In doing so, they will consider:

m) Whether all risks have been identified by the department;

n) Whether appropriate mitigations and decisions are made in relation to managing those risks; and

o) Whether risks, when placed together and made 'compound' impact greater than each individual risk.

Part 2: Feasibility assessment: Investigating the outstanding questions about the handling of concerns relating to Consultant Surgeon A

The objectives of part 2 are to:

a) Map out the known questions which remain unanswered in this area for patients, staff and stakeholders. At a high level, we understand these to be:

b) With regard to the clinical and behavioural concerns relating to Consultant Surgeon A:

c) What information was available, when, and what was done with this information?

d) How did these actions compare to existing policies in place at the time?

e) At what points could other actions have been taken to address the issues sooner?

f) Undertake a gap analysis with the existing reports to confirm that this information has not already been fully investigated with answers provided elsewhere (or to identify where it has).

g) Identify what an information request would comprise in order to fully answer these questions.

h) Identify who the review team would need to interview to fully answer these questions.

i) To investigate the availability of all required information and how this would be provided.

j) To make a recommendation about whether a Phase 3 (investigation) into these matters should proceed.

Review scope

For part one, the orthopaedic (complex) spinal surgery department for the Northern Care Alliance NHS FT, the Royal Manchester Children's Hospital and the Spire Manchester Hospital is within the review scope.

For part one, the review team is tasked with assessing current-day performance and arrangements.

For part two, the Northern Care Alliance NHS FT is within the review scope.

For part two, the review team will be seeking to assess the availability of information from 2007 to the point at which the Spinal Patient Safety Lookback Review was commissioned.

Review approach

The review team must ensure that patient experience is central to their investigations. Acknowledging the scale of review work already undertaken and time elapsed since these matters surfaced, trauma-informed approaches must be used.

Proportionality must be considered, acknowledging that these matters have already been reviewed extensively. Wherever possible the review team should seek to use work already undertaken, if this is deemed reliable.

For part 2, a further investigation must not be recommended unless there is sufficient evidence deemed to be available to fully answer the outstanding questions in relation to these matters. It is key that any further review work provides as much closure as possible to the patients and staff involved. Public funds should not be used if this work will not provide meaningful or reliable answers.

Review governance

This review will be regionally led as an Independent Patient Safety Investigation (IPSI).

The review will be independently Chaired and supported by an independent Programme Management Office, (The Review Team).

Immediate patient safety concerns will be escalated to the SRO and Regional Independent Investigations Team (RIIT).

Regular meetings will be held between the RIIT and the review team and monthly updates will be provided.

Data Processing Agreements will be put in place for any and all information sharing.

Outputs and deliverables

A report (in both draft and final versions, following factual inaccuracy and legal review) which answers the review scope and objectives as set out in this terms of reference.

For Part 1, the report will make recommendations for inclusion in each service's combined action plan.

For Part 2, a recommendation will be made about the feasibility of a third phase Governance Investigation. If this is recommended, draft terms of reference must be provided in the report.

Timescales

A draft report will be issued within six months of this work commencing.

Appendix 6: Glossary of terms used

Term used	Definition
ALD	Accelerated Leadership Development
BAME	Black, Asian and minority ethnic
BROG	Breen Recommendations Oversight Group
BSG	Bullied Staff Group (a group of staff from the NCA who came together to raise concerns about the behaviour of Consultant Surgeon A during and after his tenure)
BSR	British Spine Registry
BSS	The British Scoliosis Society
CAG	Clinical Advisory Group
CAT	Clinical Audit Team
CEO	Chief Executive Officer
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CQC	Care Quality Commission
CT	Computer tomography - a medical imaging procedure that uses X-rays and a computer to create detailed, cross-sectional images of the inside of the body.
CYP	Children and young people
Datix	This is a software system which stores and can analyse information about complaints, patient safety incidents and related information.
DBS	Disclosure and Barring Service
Dciq	DatixCloudIQ (DCIQ) is a centralised risk management system
DGH	District General Hospital
DoCS	Director of Clinical Services
DofC	Duty of Candour The duty of candour is a principle in UK healthcare requiring professionals and organisations to be open and honest with patients and their families when a care incident results in harm, or has the potential to cause it. It mandates clear communication, apology, explanation, and support when something goes wrong.
DPO	Data Protection Officer
ENT	Ear, Nose and Throat
EPR	Electronic Patient Record
FT	Foundation Trust
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
GCP	Good Clinical Practice
GIRFT	Getting It Right First Time

Term used	Definition
GMC	The **General Medical Council (GMC)** is the independent regulatory body in the UK for doctors, physician associates (PAs), and anaesthesia associates (AAs). Its primary role is to protect patient safety and improve medical education and practice across the country. The GMC sets standards for medical professionals, maintains a register of qualified individuals, oversees education and training, and investigates concerns raised about patient safety or professional conduct.
GMICB	Greater Manchester Integrated Care Board
GP	General Practitioner
HMS	Hospital Management System
HR	Human Resources
HR & OD	Human Resources and Organisational Development
ICB	Integrated Care Board
Implantable device	Implantable devices in spinal surgery serve to alleviate pain, restore height and stability, and stabilize the spine by introducing devices like spacers for stenosis, spinal cord stimulators for pain, or interspinous implants and mechanical devices such as rods or cages for stability.
IPSI	Independent Patient Safety Investigation
Kyphosis	Kyphosis is curvature of the spine that causes the top of the back to appear more rounded than normal. If it is severe it can cause pain, difficulties with eating and breathing and can require surgery to correct it.
LBR	Look back review - A ‘ look-back review ’ is “a retrospective review of the care provided to patients to determine if advice or treatment given was correct and safe, and whether further advice, investigation or treatment is required in response to any shortcomings identified during an investigation.”
LFPSE	Learn from Patient Safety Events
LIN	Local Intelligence Network
M&M	A morbidity and mortality (M&M) meeting is a structured forum for healthcare professionals to review patient cases involving complications (morbidity) and deaths (mortality) to improve patient safety, quality of care, and professional education. These meetings aim to identify system and process failures, encourage a culture of learning rather than blame, and implement changes to prevent similar adverse outcomes in the future.
MAC	Medical Advisory Committee
MCCN	Manchester Centre for Clinical Neurosciences
MDT	Multi-disciplinary team
MDT-FIT	Multi-disciplinary Team Feedback for Improving Teamwork
MFT	Manchester University NHS Foundation Trust (who now manage the Royal Manchester Children’s Hospital)
MHPS	MHPS (Maintaining High Professional Standards) is an NHS framework for assessing doctors' and dentists' performance to improve patient care, while the broader NHS Patient Safety Strategy focuses on systemic

Term used	Definition
	changes, patient involvement, and learning from incidents to create a just and safe culture. These initiatives aim to reduce harm by fostering collaboration, promoting continuous improvement, and implementing systems and processes that prevent errors and learn from them
MIAA	Mersey Internal Audit Agency
MP	Member of Parliament
NCA	Northern Care Alliance NHS Foundation Trust (this includes Salford Royal Hospital)
NHS	National Health Service
NHSE NW	NHS England North West
NHSR	NHS Resolution
NICE	National Institute for Health and Care Excellence
NPSIT	National Patient Safety Investigation Team
OBE	Officer of the Order of the British Empire
PALS	Patient Advice and Liaison Service
PEC	People and Education Committee
PNE	Patient notification exercise. This is a term used by the Spire to describe their look back reviews of individual patients.
PSII	Patient Safety Incident Investigation
PSIRF	PSIRF stands for the Patient Safety Incident Response Framework. It is a mandatory framework for the NHS in England that establishes a revised approach to responding to, learning from, and improving patient safety incidents, replacing the older Serious Incident Framework. Key elements of PSIRF include compassionate engagement with affected individuals, a proportionate response to incidents, and focusing on understanding how incidents occur rather than blaming individuals. It was introduced in 2023/24.
PSIRG	Patient Safety Incident Response Group
PSIRP	Patient Safety Incident Response Plan
PTSD	post-traumatic stress disorder
QSC	Quality and Safety Committee
R&D	Research and Development
R&I	Research and Innovation
RCS	Royal College of Surgeons
REC	Research Ethics Committee
RIIT	Regional Independent Investigations Team
RMCH	Royal Manchester Children's Hospital (formed by amalgamating Pendlebury and Booth Hall Children's Hospitals)
RRR	Residual Risk Rating
RSUI	Reportable Serious Untoward Incident

Term used	Definition
SCO	Salford Care Organisation
Scoliosis	Scoliosis is where the spine twists and curves to the side. It can affect people of any age, from babies to adults, but most often starts in children aged 10 to 15.
SHCG	Specialist Hospitals Care Group
SMT	Senior Management Team
SOP	Standard Operating Procedure
Spire	Spire Independent Hospital
SPSLBR	Spinal Surgeon Look Back Review (conducted by NCA)
SRFT	Salford Royal Hospital NHS Foundation Trust
SRO	Senior Responsible Officer
SWARM	A ‘swarm huddle’ is a quick gathering after a patient safety incident to analyse what happened and how, and to decide what to do to reduce risk.
TRAC	Trust’s recruitment management system
Ulysses	Incident reporting system
UMFT	University of Manchester NHS Foundation Trust (which includes RMCH)
VFM	Value for money
WDES	Workforce Disability Equality Standard
WHO	World Health Organisation
WRES	Workplace Race Equality Standard

Appendix 7: References

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