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IMPROVEMENT THROUGH INVESTIGATION

Independent review of the governance arrangements at Spire Parkway and Little Aston hospitals in light of concerns raised about the surgical practice of Mr Ian Paterson

Executive summary and recommendations

A report for
Spire Healthcare

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Executive summary and recommendations

1.1 Mr Ian Paterson, a consultant breast surgeon employed by the Heart of England NHS Foundation Trust (HEFT), had practising privileges at Spire Parkway since 1998 and Spire Little Aston since 1993.

1.2 The chief executive of HEFT told the hospital director at Parkway in December 2007, and the hospital director at Little Aston in May 2008, that Mr Paterson had been performing a *“surgical technique known as cleavage sparing mastectomy and shavings with mastectomy”* on patients with breast cancer. HEFT had told Mr Paterson to stop performing this technique which was in effect an incomplete mastectomy. Spire did the same and cooperated with HEFT’s audit and investigation into his practice.

1.3 In the middle of May 2011, HEFT notified the Spire hospitals that Mr Paterson was to be excluded from the NHS for two weeks pending a wider investigation involving the recall of his mastectomy patients. At the end of the month, HEFT notified them that it was excluding him for a further four weeks.

1.4 Managers at Parkway and Little Aston began an immediate investigation into Mr Paterson’s practice subsequently restricting his practising privileges in June 2011, suspending them in August 2011 and withdrawing them in August 2012.

1.5 In early July 2011, supported by a team of independent consultant breast surgeons, the Spire hospitals reviewed patients on whom Mr Paterson had performed a mastectomy since 2007.

1.6 The same month, The General Medical Council imposed restrictions on Mr Paterson’s breast practice for 18 months.

1.7 By October 2011 a number of concerns had been raised about Mr Paterson’s clinical practice in addition to him carrying out incomplete mastectomies:

- carrying out unnecessary surgery when there was no evidence of malignancy
- giving misleading information about pathology reports to his patients and their GPs
- using cancer codes for non-cancer treatments
- following up patients with more frequent imaging than was accepted as normal

- carrying out procedures for which patients had not given consent
- conducting Spire breast multidisciplinary team (MDT) meetings without a radiologist or histopathologist present, and in which only he and his breast care nurse, Bethan Lloyd Owen, had access to pathology reports.

1.8 The hospital directors of Parkway and Little Aston extended their investigation of Mr Paterson's practice with a series of patient reviews and recalls.

1.9 In April 2013 Dr JJ de Gorter, group medical director for Spire, on behalf of the executive management team, commissioned this review into how its hospitals had responded to concerns regarding Mr Paterson in the context of the governance systems in place at the time.

1.10 While focusing on Spire, the matters considered in this report are common to, and of relevance to, many independent healthcare providers particularly with regard to the work of medical advisory committees, the granting and maintenance of practising privileges, the monitoring of consultants' performance generally, and consultant appraisals.

Missed opportunities and key dates

1.11 We developed a detailed chronology relating to Mr Paterson's clinical practice and behaviour which enabled us to identify missed opportunities and key dates. These are set out below.

December 2007/January 2008

1.12 The chief executive of HEFT writes to Ruth Paulin, hospital director at Parkway, on 20 December 2007 to tell her that the trust is investigating Mr Paterson's practice, specifically "*cleavage sparing mastectomies and shaves with mastectomy*", and that he has been told to stop carrying out this procedure. Ruth Paulin instructs Mr Paterson to stop performing the procedure in early January 2008. She confirms the instruction in writing on 14 January and copies the letter to the chairman of the Parkway Medical Advisory Committee (MAC).

1.13 We found no evidence that Ruth Paulin notified a wider audience of HEFT's review and the fact that Mr Paterson had been instructed to stop performing incomplete mastectomies. Nor did she make any arrangements to monitor Mr Paterson's clinical practice to see if he was complying with her instruction.

1.14 If more people had been told that Mr Paterson's practice was under review in January 2008 and systems put in place to monitor his performance, it would have been harder for him to continue to carry out inappropriate treatment.

7 January 2008

1.15 The MAC chairman at Parkway writes to Mr Paterson to tell him to stop performing colonoscopies because he did not carry out this procedure in the NHS and his appraisal did not include it. Mr Paterson ignores the instruction and continues to carry out colonoscopies despite repeated requests from the MAC chairman and Ruth Paulin.

1.16 The failure to tackle his persistent non-compliance sent the wrong signal to both Mr Paterson and his colleagues, and is illustrative of a collective failure to manage him.

9 September 2008

1.17 Two GPs from the same practice complain about Mr Paterson's treatment of a patient, in particular that he gave misleading information about pathology reports, was over treating patients and disregarded the multidisciplinary team meeting process. Will Knights, hospital director at Parkway, asks the MAC chairman to investigate the complaint.

1.18 Mr Paterson claims that there had been a misunderstanding about histopathology results which he blamed on the breast care nurses accepting results over the phone. The MAC chairman largely accepts Mr Paterson's version of events and responds to the complaint accordingly.

1.19 The GPs ask Will Knights to commission an independent audit conducted by a breast surgeon. As far as we know this was never commissioned. Instead, an audit that was

generally reassuring was produced by breast care nurse Bethan Lloyd Owen, Mr Paterson's closest associate at Spire, and presented to the GPs.

1.20 Given that Mr Paterson's practice was under review by HEFT, and that he had a history of challenging Spire's policies and processes, we consider that the GPs' complaint should have been taken much more seriously and an independent audit commissioned. This might have identified issues that are only now coming to light.

11 June 2009

1.21 Having told Mr Paterson on numerous occasions to stop performing colonoscopies at Parkway, Ruth Paulin discovers that he continues to do them at Little Aston. She writes to Mr Paterson instructing him to stop performing colonoscopies at Little Aston and notifies Will Knights at Parkway.

1.22 Both hospital directors viewed Mr Paterson's refusal to stop performing surgery outside his scope of practice as no more than him being a difficult consultant. There is certainly no evidence that they thought him to be a serious risk to patients. We believe that at this point, if not before, they had good grounds to consider withdrawing his practising privileges but we found no evidence to suggest that they did so.

7 September 2009

1.23 HEFT's medical director writes to Ruth Paulin to tell her that West Midlands Cancer Intelligence audit found that the five-year recurrence rates for invasive cancer for Mr Paterson's patients were within acceptable limits. At the time these findings were accepted by Spire as assurance that Mr Paterson's practice was safe.

1.24 In Sir Ian Kennedy's *Review of the response of HEFT to concerns about Mr Ian Paterson's surgical practice* (2013) he reported that HEFT's medical director had been advised by the director of the West Midlands Cancer Intelligence Unit (WMCIU) on a number of occasions before 2009 that Mr Paterson's rates of recurrence were not accurate because the WMCIU did not have all of Mr Paterson's data. The director of the WMCIU also told HEFT's medical director on a number of occasions that the three to five per cent parameters

proposed by the Association of Breast Surgery had no scientific basis. HEFT's medical director was therefore aware that the information he was providing to Spire was not complete and was therefore unreliable.

15 December 2009

1.25 Patient A first raises concerns about her treatment with Mr Paterson in August 2009. This escalates over the next few months, culminating in the patient making a formal complaint to Mr Paterson on 15 December 2009 which she forwarded to Ruth Paulin on 5 March 2010. The patient complains about:

- having a general anaesthetic against her wishes
- being given misleading information
- Mr Paterson's bullying approach
- Mr Paterson's proposal on how to get around having her breast reconstruction carried out by a surgeon who at that time was not registered with her insurance company.

1.26 We found that the benefit of doubt was given to Mr Paterson. No action was taken.

16 December 2010

1.27 The General Medical Council (GMC) notifies Ruth Paulin and Will Knights about a complaint it had received from one of Mr Paterson's NHS patients who had had an incomplete mastectomy in May 2006. This was the first of four GMC complaints.

1.28 Despite the mounting evidence that there were serious concerns about Mr Paterson's practice, no measures were in place to monitor his performance at Parkway or Little Aston.

6 January 2011

1.29 HEFT's acting medical director writes to Will Knights to inform him that a patient reviewed at the trust is believed to have had an incomplete mastectomy at Parkway hospital in January 2009 after Mr Paterson was told to stop in January 2008. He asks Will Knights to investigate the matter. There is no evidence that he does so, or that he tells Ruth Paulin at Little Aston about the allegation.

1.30 In the same month HEFT starts to investigate whether Mr Paterson carried out incomplete mastectomies at the trust after 20 December 2007.

1.31 By this time the warning signs were clear that there were serious issues that needed to be investigated, but checks were not in place to see if Mr Paterson was complying with the restrictions on his practice that were already in place at Parkway and Little Aston.

2 February 2011

1.32 The GMC notifies the hospital directors about a complaint it has received from one of Mr Paterson's patients.

7 February 2011

1.33 The GMC notifies Will Knights that it has received a complaint from one of Mr Paterson's patients who alleged that she had had an incomplete mastectomy at Spire Parkway in 2009. At this point Spire has sufficient information to realise that there were serious concerns about Mr Paterson's practice.

May to June 2011

1.34 HEFT excludes Mr Paterson for two weeks from 13 May while it carries out further investigation into his practice. Mr Paterson was allowed to practice as normal at Parkway and Little Aston for a week after being excluded from HEFT. We think that Spire should have suspended him on 13 May. Instead he was allowed to continue working at Parkway and Little

Aston and although he was instructed to limit his practice and not perform surgery he continued to perform breast surgery until 31 May and general surgery until 8 June 2011.

8 July 2011

1.35 The GMC notified Spire that it had placed restrictions on Mr Paterson's breast practice.

12 August 2011

1.36 Mr Paterson's last outpatient clinic was on 12 August 2011. The same day Will Knights and Ruth Paulin confirmed to insurers that his practising privileges had been suspended.

1.37 We believe that if these missed opportunities had been taken there could have been a difference to the outturn of events. At the very least there would have been a heightened awareness of the need to monitor Mr Paterson's practise and behaviour. However, in most instances we cannot quantify *what* difference as there is not always an obvious cause and effect between actions and consequences.

1.38 Nonetheless, what we can be certain of, concerns Mr Paterson's practising privileges. Had consideration been given to withdrawing them in September 2009 and had - after consideration - they actually been withdrawn, then events beyond that date would have been avoided.

1.39 We are also clear that if Spire had suspended Mr Paterson's practising privileges on 13 May 2011, when he was excluded by HEFT, he would not have been able to operate at Little Aston until 6 June and Parkway until 8 June.

Communication with HEFT

1.40 Between December 2007 and 30 June 2009, and 7 September 2009 and 6 January 2011, there were long periods in which there was no communication between HEFT and Spire about Mr Paterson. We would have expected managers at the Spire hospitals to keep in contact with HEFT about investigations into such serious allegations about a consultant's practice.

1.41 The Kennedy report makes it clear that very few people at HEFT knew about the investigation into Mr Paterson's practice between 2007 and 2011 because of its decision to conduct it as a confidential HR investigation.

1.42 HEFT was not explicit about the reasons it excluded Mr Paterson in 2011. HEFT refused to share the terms of reference of its internal investigation with Spire. This lack of communication certainly played a part in the delay between HEFT excluding Mr Paterson in May 2011 and Spire suspending his practising privileges in August 2011. However despite HEFT not being totally transparent it was clear from its communications with Spire that it was seriously concerned about Mr Paterson's practice. The fact that Mr Paterson was excluded from the trust should have been sufficient cause for Spire to suspend his practising privileges immediately.

Spire Healthcare

1.43 Spire has a flat management structure and the hospitals have devolved autonomy, much of which is vested in the hospital director. Spire Healthcare is therefore highly reliant on its hospital directors making the right judgements and decisions and knowing when - and from whom - to seek advice. The corporate risks associated with making the wrong decision at hospital level can therefore be high.

1.44 Although recognising that patients are the ultimate customer, consultants are promoted corporately as a primary customer. This approach sits alongside the continuing need within the hospitals to enquire and challenge consultants across a range of performance issues. This requires an empowerment culture locally, which is supported and reinforced by Spire HQ.

1.45 The hospital director's job description places a heavy emphasis on business imperatives and other than in a general reference, it says little about the hospital director's responsibility for patient safety. Specifically, the job description makes no reference to the hospital director's crucial role in the granting and withdrawal of consultants' practising privileges and for ensuring that there is a robust system in place for reviewing consultants' performance. Neither does it refer to the hospital director's responsibilities as a registered manager or their role in ensuring that they have a medical advisory committee in place which works effectively.

1.46 The job description for matrons is particularly onerous. Although it listed 95 responsibilities, it makes no mention of the matron's role in granting and reviewing consultants' practising privileges and the performance of the MAC.

Medical advisory committees

1.47 Parkway and Little Aston MACs were both well attended by the consultants and senior hospital managers.

1.48 In general the MACs discussed an appropriate range of issues in support of their primary role of advising the hospital directors "*on any matter relating to the proper, safe, efficient and ethical medical and dental use of the hospital.*" However they lacked organisation and purpose. In particular they were poor at recording whether they had followed up and closed down matters previously discussed.

1.49 The MACs also lacked a system for ensuring that they received regular structured reports from their various subcommittees. This was contrary to Spire's corporate policy as set out in the *Consultants' handbook*. For instance, the Parkway Clinical Governance Committee, while comprising the MAC chairman, did not keep minutes and we do not therefore know what, if any, matters discussed at this committee were reported to the full MAC.

1.50 Meanwhile, the Little Aston Clinical Governance Committee was disconnected from both the MAC and the hospital director with no formal reporting mechanism in place. While the hospital director was instructing Mr Paterson to stop performing colonoscopies, the committee was reporting that there were no issues concerning his scope of practice.

1.51 The various reviews into Mr Paterson's clinical practice were not discussed at the MAC meetings. The Parkway MAC chairman commendably dealt with two significant issues concerning Mr Paterson - colonoscopies and a complaint from GPs - but they were not shared with the full MAC.

1.52 HEFT's investigation into his practice was not mentioned in the Parkway MAC minutes until 3.5 years after it had started; the fact that Mr Paterson was under investigation was only noted in the Little Aston MAC minutes when the extraordinary combined MAC meeting with Parkway took place on 5 August 2011.

Practising privileges

1.53 Overall, MAC arrangements for considering applications from new consultants who wish to have practising privileges work well at Parkway and Little Aston.

1.54 However, the arrangements for reviewing the practising privileges of existing consultants are weak and the hospitals have not complied with Spire policy. The Parkway MAC never carried out a biennial review of consultants while the Little Aston MAC appeared to carry out such a review but never documented the discussion.

1.55 To ensure that each consultant biennial review is meaningful, it must be fully informed by all of the clinical activity and performance data captured on site about individuals, including adverse clinical events, complaints, appraisal information, scope of NHS practice, and any documented areas of concern. Some of this might be in the form of 'soft' information. Such information should be held in a central practising privileges file for each consultant.

1.56 Mr Paterson's practising privileges files at Parkway and Little Aston fell short of this requirement because the information contained in them was incomplete. As such, they were of limited use.

1.57 Parkway and Little Aston do not have a system for monitoring consultants' scope of practice in the NHS. They rely on consultants to tell them what procedures they carry out

in the NHS and to all intents and purposes they are therefore allowed to regulate themselves.

1.58 Mr Paterson's clinical practice at Spire Parkway and Little Aston did not mirror his practice in the NHS. The issue was focused around his performance of colonoscopies at the hospitals when he no longer performed the surgery in the NHS. Hospital managers attempted to rein back his colonoscopy practice on successive occasions but were unsuccessful. The issue of colonoscopies was raised with Mr Paterson on nine occasions (that we know of) between 2004 and 2009 at Parkway and Little Aston. In 2008 and 2009 he was formally asked to stop performing them on five occasions.

1.59 Mr Paterson was asked to stop performing colonoscopies at Parkway in 2008 when Ruth Paulin was the hospital director. By 2009 she had become hospital director at Little Aston and had to again ask him to stop performing colonoscopies. He had performed eight at Little Aston in 2008 and nine in 2009.

1.60 In light of the fact that Mr Paterson continually breached Spire's policy on practising privileges by working outside of his NHS practice the management at both hospitals had sufficient reason to consider withdrawing his practising privileges in 2009. These breaches should have been a warning to the hospitals' management that Mr Paterson had shown himself unwilling to comply with Spire's policy.

1.61 Specialist equipment and trained staff are required in order to perform colonoscopies. At Little Aston there is a separate endoscopy suite. Mr Paterson would therefore have needed help from Spire staff to conduct colonoscopies. We have seen no evidence that the hospital management ever informed the theatre staff that they had instructed Mr Paterson not to perform colonoscopies. In our view they should have done so because - unless hospital staff had conspired to ignore this instruction - this was the certain way to ensure that Mr Paterson did indeed stop performing such a procedure.

1.62 Dr de Gorter, group medical director, has been working towards JAG (Joint Advisory Group) accreditation for endoscopy services for the last three years. This will involve quality assurance of the services, and ensure that only surgeons with suitable experience will conduct endoscopies at Spire hospitals.

1.63 During the time that Mr Paterson worked at the hospitals, there was growing evidence of his non-compliant behaviour and practice but the various sources of information were not pieced together to form a whole picture. Had all the information been in one place and had it been reviewed as part of the biennial review of practising privileges the hospital directors may have been alerted to the issues with Mr Paterson's practice sooner.

Appraisals

1.64 Spire's policy on 'whole-practice' appraisal is clear and follows national guidance. The policy makes it clear that if a consultant does not provide evidence of 'whole-practice' appraisal on a yearly basis, practising privileges may be withdrawn. Despite this, both Parkway and Little Aston still have problems with consultants not supplying up-to-date appraisals.

1.65 Little Aston documents show that the management threatened to suspend consultants who did not comply with appraisal policy on a number of occasions. This was not followed through and only 50 per cent of consultants are compliant with the policy.

1.66 Contrary to Spire policy Mr Paterson did not provide appraisal documentation to Spire Parkway and Little Aston every year. On occasions he had not submitted it for two years.

1.67 Mr Paterson only ever provided a letter from his appraiser stating that he had had a satisfactory appraisal. The letters did not confirm that he had been appraised for his work in the private sector. This issue was raised with him by Spire on three occasions but we have seen no evidence that it was ever followed up.

1.68 None of Mr Paterson's appraisal letters refer to the HEFT investigation into his surgical practice and he was always given a satisfactory appraisal. The hospitals, perhaps not unreasonably, trusted that the appraisals were an accurate reflection of his clinical performance.

1.69 However, in light of the HEFT investigation into Mr Paterson's practice we consider that it would have been appropriate for the hospital directors to probe more and to ask for

more detailed information about both his appraisal and the ongoing investigation. We accept that HEFT failed to share information about Mr Paterson, but at the very least this approach may have prompted it to reconsider its position which would have given Spire an earlier insight into the issues with his practice in the NHS.

Clinical outcomes

1.70 There is a corporate emphasis on a specific set of consultant clinical outcome data that is collected routinely and effectively at Spire Parkway and Little Aston and reported to the Spire Board on a quarterly basis.

1.71 Neither hospital complied with Spire's policy on practising privileges as set out in the *Consultants' handbook*, which is clear that consultant outcome data should be reviewed as part of the biennial review of practising privileges in line with national best practice.

1.72 The clinical governance committees and MACs at both hospitals discuss trends in clinical outcome data. However there is no record that they had any meaningful discussion in terms of an individual consultant's performance.

1.73 The Parkway MAC considers only anonymised consultant data and therefore it is difficult for it to monitor effectively a consultant's performance and identify when there is a cause for concern. We believe that this lack of transparency should be addressed as a matter of priority.

1.74 There is no record in any of the minutes we have seen that Mr Paterson's clinical outcomes data were discussed at either of the clinical governance committees or MACs at Parkway or Little Aston. However as Mr Paterson's data did not show any cause for concern, discussion about them would not necessarily have resulted in greater scrutiny of his practise.

1.75 JJ de Gorter has shown us plans he has for Spire to explore using data more effectively including "*exploring the value of tracking intervention ratios e.g. new appointments to theatre episodes to follow up appointments*" and producing "*risk adjusted performance indicators for individual consultants with flags identifying outliers*". We think this is a good step towards Spire being able to identify consultants who might be over treating patients.

1.76 The *Consultants' handbook* makes no mention of collecting 'soft' information about consultants' personal conduct, attitudes or behaviour. In our opinion this information is as valuable as clinical data and should be collected and considered as part of the biennial review. In the case of Mr Paterson there is ample evidence that he was difficult to manage with a reputation for pushing the boundaries and overriding colleagues. A review of this information may have helped managers see a fuller picture of his practice and behaviour.

Clinical adverse events

1.77 Before 2012 actions following adverse events at Parkway were recorded in the Clinical Governance Committee minutes but were referred to as ongoing for many months before they stopped appearing without apparently being resolved or closed. This may indicate that the hospital did not adequately report adverse events and the associated learning.

1.78 Since the introduction of Datix in 2012 the hospitals are responsible for keeping accurate records of adverse events and monitoring and reporting have improved. However the minutes of the Clinical Effectiveness Committee and the MAC at Parkway do not record discussions of the same adverse events. The MAC only considers adverse events that have been anonymised¹ and are therefore not attributable to individual consultants. The MAC is therefore not able to identify any trends or whether consultants have a greater than expected number of adverse events. The information about adverse events is not used effectively as a means of identifying consultants who might be a cause for concern at Parkway.

1.79 At Little Aston serious adverse events are discussed at the Clinical Governance Committee and at the MAC. The minutes record that the same adverse events are discussed at both. However incidents are not attributable to specific consultants in the minutes.

1.80 We do not know whether consultants' adverse events are discussed as part of biennial review of practising privileges at Little Aston as there are no records. Similarly, we do not know whether information about adverse events is used as a means of monitoring

¹ We were told that the MAC voted to anonymise reporting of adverse events.

consultants' performance at Little Aston due to lack of consultant identifiable documentation.

1.81 Although the hospitals reviewed adverse incident data for consultants as a group - they did not review them for individual consultants as part of the biennial review of practising privileges. Neither hospital therefore complied with guidance in the *Consultants' handbook*.

1.82 There is no record that Mr Paterson's adverse events were discussed at the Governance Committees or MAC at Parkway or Little Aston.

Complaints and concerns

1.83 The minutes of the Parkway Clinical Effectiveness Committee show that complaints are reviewed but actions remain the same for months and cases are closed often without an adequate record of the outcome. The MAC discusses complaints data but complaints are not attributable to consultants in the minutes. There does not appear to be any meaningful discussion about complaints as part of assessing a consultant's performance at Parkway.

1.84 The Little Aston Clinical Governance Committee and MAC minutes do not record any detailed discussion of complaints or concerns raised about Mr Paterson. The complaints and concerns were not, for the most part, recorded in Mr Paterson's practising privileges files at Parkway or Little Aston. The information did not appear to be shared between hospitals.

1.85 None of the complaints or concerns raised about Mr Paterson triggered any action against him. He was allowed to carry on as normal with no checks or restrictions in place.

The breast care service and multidisciplinary team

1.86 The *Parkway hospital breast pathway - diagnosis process* and *Breast care surgical process* in place at both Parkway and Little Aston before 2012 were created by the breast care team. The relationship between the processes described in the two documents is not clear, and it is likely that they simply reflect Mr Paterson's practice.

1.87 Significantly *Parkway hospital breast pathway - diagnosis process* does not mention the role of the MDT in the diagnosis of breast disease and is therefore not in line with national guidance. The *Breast care surgical process* includes an MDT discussion but not until after lumpectomy surgery has been carried out. This is not in line with national guidance. There was no policy governing how the MDT operated.

1.88 Mr Paterson was the only breast surgeon at Spire Parkway, which meant that Spire staff were unable to compare him with his peers and made it harder for them to identify unusual aspects of his practice.

1.89 We have seen evidence from MDT minutes and patient notes that MDT meetings often took place only after patients had been operated on. This was contrary to best practice that is clear that MDT meetings should take place both before and after surgery.

1.90 We have heard from interviewees and seen documentary evidence that there was no radiologist and histopathologist present at MDT meetings and that Mr Paterson was usually the only breast surgeon in attendance. This was contrary to best practice and did not allow Mr Paterson's patients to be debated in an open forum with an appropriate range and number of healthcare professionals.

1.91 On balance we think that given that the other breast surgeons at Little Aston refused to attend the private MDT, the management at Little Aston should have looked more closely at how it operated and whether it provided adequate peer review and challenge to the way Mr Paterson's treated his patients.

1.92 *Spire cancer standards* - introduced in July 2012 - stipulates that the treatment plan for all cancer patients must be discussed at MDT and the MDT's recommendations documented in the patient's medical notes. It is also clear that a radiologist and histopathologist should be present at MDT meetings where Spire patients are discussed.

1.93 At Little Aston in 2012 a high proportion of cancer patients were still not discussed at the MDT. A consultant told us that it is still up to the consultant to ensure their cancer patients are discussed at MDT.

1.94 Spire is putting a number of measures in place to improve MDT processes including piloting the use of an electronic MDT workflow at a number of Spire hospitals across the UK and developing a template for discussion of private patients at NHS MDTs.

Patient review and recall programme

1.95 In July 2011, Spire started a patient review and recall programme that evolved as Mr Paterson's practice gradually became known. We found it difficult to piece together the arrangements Spire put in place to review patient notes and recall patients from contemporaneous documents.

1.96 The fact that patients told us that they were confused about whether or not they should have been recalled was in keeping with our own experience of piecing together the various stages of the recall programme.

1.97 The decision to identify patients for recall on the basis of their treatment code added another layer of confusion: some patients have been recalled more than once (we spoke to one woman who had been recalled three times) whilst others who were eligible were not recalled at all because Mr Paterson had miscoded their treatment.

1.98 The patients we spoke to were very critical of the recall process. Many raised the same concerns:

- a lack of explanation about the recall process and what they should expect
- difficulty in obtaining information about their own treatment, with specific questions going unanswered
- difficulty in obtaining medical notes
- an inconsistent approach to imaging
- lack of support and counselling
- an ineffectual helpline.

1.99 Once the concerns about Mr Paterson's practice were publicised in the media, the onus was on Spire to identify as quickly as possible the patients who may have had inappropriate or unnecessary surgery or both.

1.100 Given the size of the task, Spire was right to prioritise patients who were most at risk. Using treatment codes was one way of doing this, but it was not 100 per cent reliable and resulted in some patients being recalled more than once while others were missed. Patients told us that repeated recall appointments increased their anxiety.

1.101 It is now over two and a half years since the review and recall programme started, and it is not yet finished. We have seen no evidence that Spire has reflected on how it could speed it up.

1.102 We welcome Spire's decision to review the notes of Mr Paterson's breast patients who have not yet been reviewed or recalled. We believe that this more holistic approach should have been considered earlier when the full extent of Mr Paterson's practice became apparent.

1.103 The majority of the evidence that we reviewed for this section related to Mr Paterson's breast patients. However, we have heard concerns about Mr Paterson's general practice including one man who had 14 colonoscopies, 13 of which were unnecessary. We therefore welcome Spire's decision to review his general surgery patients. We assume that Spire has assured itself that the initial sample is representative, as there is already evidence of unnecessary operations and no evidence to suggest that Mr Paterson would restrict practices such as unnecessary follow-up and miscoding to his breast patients.

Recommendations

R1 The chief operations officer for Spire, in conjunction with the group medical director, should review the job descriptions for the hospital director and matron/head of clinical services. This is to ensure that they clearly reflect their responsibilities for granting, reviewing and withdrawing practising privileges, the review of consultants' performance generally and their role on the medical advisory committees.

R2 The executive management team should assure itself that there is a shared understanding between the hospitals and HQ regarding the matters that need to be reported to Spire HQ. This will enable hospital directors to seek and receive corporate guidance and support.

R3 The hospital directors at Spire Parkway and Little Aston hospitals should ensure that:

- discussions of both the full medical advisory committee and any subcommittees are properly recorded in the minutes
- there is a system in place to ensure that the various subcommittees regularly report to the full committee
- agreed actions are confirmed as followed up and closed down and documented in subsequent meeting minutes
- in conjunction with the medical advisory committee chairman, any formal investigation or review concerning a consultant with practising privileges is properly shared with the full committee
- any information concerning consultant performance is presented at the medical advisory committee in a non-anonymised form. This is to enable informed discussions regarding the management and appraisal of individuals. This requirement should be outlined in Spire's *Consultants' handbook*.

R4 The hospital directors at Spire Parkway and Little Aston hospitals, with the support of the medical advisory committee chairs, should ensure compliance with Spire's policy regarding biennial review of consultants with practising privileges. For Parkway, this means improving the system of reviews for all consultants with practising privileges; at Little Aston, it means continuing to carry out such reviews but documenting the discussion at the relevant medical advisory committee.

R5 For ensuring effective biennial review, the hospital matrons/heads of clinical services should hold the range of information available on site about consultants in individual practising privileges files. As a minimum, each file should contain adverse clinical events, complaints, evidence of satisfactory appraisal in line with sector guidelines, scope of practice and any documented areas of concern. The information should be kept up to date, be stored securely and be readily available including (with the exception of confidential file notes and correspondence) to the consultant.

R6 The Spire group medical director should consider developing objective criteria - for inclusion in the *Consultants' handbook* - setting out the requirements for maintaining practising privileges, and the scenarios that may result in their suspension or withdrawal.

This would be useful guidance for the hospital directors and members of medical advisory committees.

R7 The medical advisory committee's standing agenda item on practising privileges should be in two parts: a) new applications for practising privileges, and b) the biennial review of practising privileges for existing consultants. The minutes should reflect these two separate issues where relevant and record the names of the individuals considered and the decisions made.

R8 The hospital directors and their medical advisory committee chairs at Spire Parkway and Little Aston hospitals should consider how best to tighten the systems in place for knowing about and monitoring a consultant's scope of practice.

R9 The hospital directors at Spire Parkway and Little Aston should assure themselves that all consultants with practising privileges are appraised in line with Spire's appraisal policy.

R10 The Spire group medical director should continue to look at the value of comparing intervention ratios (i.e. the ratio of new appointments to theatre episodes to follow up appointments) within specialties across Spire hospitals (and ideally with surgeons in the NHS) as a possible way of identifying consultants that are over treating.

R11 Matrons/heads of clinical services at Spire Parkway and Little Aston hospitals should ensure that information on individual adverse events:

- is recorded in consultant practising privileges files
- forms part of the information the hospitals make available to the NHS appraiser as part of whole practice appraisal
- is reviewed by the medical advisory specialty representative before making their recommendation to the hospital director as part of the biennial review of practising privileges.

R12 The hospital directors at Spire Parkway and Little Aston hospitals should ensure that consultant surgeons operate only on patients with breast cancer when there is evidence that they have undergone 'triple assessment' and been discussed at an appropriate multidisciplinary team meeting.

R13 In order for Spire breast cancer patients to have access to an effective multidisciplinary team, the hospital directors should either:

- formalise arrangements with NHS trusts so that Spire patients are discussed at trust multidisciplinary team meetings
- set up a private multidisciplinary team in line with published standards for multidisciplinary team meetings i.e. including the involvement of a radiologist and histopathologist.

R14 The Spire Group should consider its arrangements for reviewing and recalling Mr Paterson's remaining breast patients and his general surgery patients in order to ensure that it has processes and resources in place to establish as quickly as possible whether or not they have had appropriate treatment. It should set a deadline for the work.

R15 The hospital directors at Parkway and Little Aston should ensure that senior members of staff and members of the medical advisory committee are informed if a consultant is under investigation either by a NHS trust or by the hospital itself. In addition they should inform theatre managers immediately whenever a consultant has been restricted from performing certain surgical procedures.