Universiy Hospitals of Morecambe Bay NHS FT

Invited Clinical Records Review (Trauma and Orthopaedics)

By

The Royal College of Surgeons

(Redacted Report)

draft report received: 29th September 2021
final report received: 11th November 2021

Subnitted on behalf of: Deborah Turner – Clinical Quality Director (NHSE/I- NW)
Dr Damian Riley- Associate Medical Director

18/11/2021

Contents

Please note: this is a REDACTED summary document of the Invited Clinical Records Review (Trauma and Orthopaedics) received from The Royal College of Surgeons:

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Both the Seious Incident Framework and the RCS's invited review process envisage the sharing of an investigation's findings. However, this does require a balancing of openness and transparency against duties of confidentiality.

The RCS has an expectation that the healthcare organisation commissioning a review should publicise and make available to the public a clear summary of the review that has taken place and the steps the healthcare organisation is taking to address the issues themselves and the recommendations applicable to them. The healthcare organisation's summary should include clear information on:

a. The reasons for the invited review
b. Its terms of reference, conclusions and recommendations
c. The actions taken by the healthcare organisation to address the issues identified by the review and the recommendations applicable to them.

Rationale for redaction: there is a substantial quantity of sensitive/confidential personal information within the report relating to individuals/patients. The recommendations do not require a reader (member of the public) to know all of the patient information included within the Report.

The UNREDACTED version of the report will be received by the UHMB trust PRIVATE board on the 24th November 2021

1. Introduction

1.1 On 16 March 2021, the Chief Executive for University Hospitals for Morecambe Bay NHS Foundation Trust (referred to hereafter as “UHMBT”) wrote to the Royal College of Surgeons of England (RCS England) Chair of the Invited Review Mechanism (IRM) to request an invited review of the Trauma and Orthopaedic (T&O) surgery service including a number of clinical records. The request noted that the invited review was to be commissioned jointly by UHMBT and NHS England and NHS Improvement (referred to hereafter as “NHSE/I”).

1.2 The request highlighted that concerns had been raised by UHMBT staff in March 2018 about the clinical care provided in a number of cases, and that, following a number of internal and external investigations and/or reviews during 2019, concerns remained and were subsequently outlined both to the Chief Executive of UHMBT and NHSE/I in December 2020.

1.3 The request subsequently made to the RCS England was considered by the Chair of the IRM and a representative of the British Orthopaedic Association (BOA) and it was agreed that an invited clinical record review would take place of forty-six T&O cases.

1.4 A review team was appointed and an invited review of the cases was arranged for 28 and 29 July 2021. The review team considered the care provided to the forty-six records agreed by UHMBT and NHSE/I to be put forward for the invited review. This included the review of the clinical records of these forty-six cases and supporting information provided to the review team by UHMBT and NHSE/I.

2.0 Background

2.1 UHMBT commissioned an external orthopaedic surgeon to undertake an independent review of the orthopaedic department during November and December 2019 and the report was produced in January 2020. The scope of the review was to include addressing: (i) concerns raised in an email from two UHMBT orthopaedic surgeons to the UHMBT Chief Executive, and (ii) seventeen questions outlined in a separate email to the UHMBT Chief Executive.

2.2 The report subsequent to the external independent review, from reviewing background documents provided and twenty two interviews undertaken with "key staff," included: (i) observations "regarding cultural and operational challenges facing the service; (ii) responses to the seventeen questions raised with the UHMBT Chief Executive and (iii) recommendations.

2.3 This report is referred to here as relevant background information and to provide context to this RCS England clinical record review. It is noted that any comments made on the observations, findings and recommendations in the external independent review report of January 2020 will be included only in so far as they relate directly to the forty-six sets of clinical records reviewed and the agreed terms of reference for this review.

2.4 It was understood that the forty-six cases put forward for the RCS England invited clinical record review, included cases about which concerns had been raised, and cases which had been part of previous internal and external investigations and reviews. The majority of the forty-six cases appeared to be under the care of one orthopaedic surgeon.

3. Terms of Reference

3.1 The review team were to consider the standard, quality and safety of care provided to patients in 46 cases where concerns had been raised including:

- Clinical assessment and investigations
  - History taking, examination and diagnosis
  - The timeliness and appropriateness of investigations and imaging undertaken
- The patient pathway of treatment (operation or procedure) provided
  - Clinical decision making and assessment, including all relevant X-rays
  - Case selection and threshold for surgical intervention/decision to operate
  - Potential effectiveness of treatment based on best available evidence/compatibility of treatment with other treatments the patient was receiving
  - Perioperative care, pre-operative, intra-operative and post-operative (including discharge planning) and any complication
- Team working
  - MDT discussion
  - Appropriate communication, consultation and discussion with colleagues
- Communication with the patient, the patient's family and GP
  - Including the consent process
  - Respect for the patients right to seek a second opinion
- The appropriateness of the care provided by the surgery team including:
  - If those involved in providing care were working within the limits of their competence
  - Adequacy of oversight and/or supervision by consultant surgeons of non- consultant grade surgeons

- Whether any avoidable complications or patient harm occurred, and, if considered as such, the appropriateness of the action taken
    - This should include where relevant responsibilities in respect of duty of candour
- The clarity, accuracy and legibility of the clinical records and operation notes.

4. Conclusions and Recommendations

4.1 The review team highlighted the context of the conclusions made in section three of the unredacted report; in respect of the recommendations made relating to the clinical records put forward for the forty-six cases reviewed. The review team also noted that the recommendations made are in the context of Surgeon X not operating independently.

4.2 **Urgent recommendations to address patient safety risks-** The recommendations below are considered to be highly important actions for the healthcare organisation to take to ensure patient safety is protected.

1. A review of <<<redacted>> clinical activity in performing unicompartmental knee replacements is required given the review may indicate an insufficient number of these procedures being undertaken to maintain the appropriate skill set required for the techniques involved.
2. Assure evidence of <<<redacted>> training in anterior approach surgery before further anterior approach hip replacements are performed.
3. In respect of more complex cases, more effective utilisation of MDT to:
   (i) Improve governance in respect of clear decision making, transfer/handover of care documentation.
   (ii) Ensure appropriate consultant surgeon involvement.
4. The consent pro-forma should ensure that the potential risks of the planned surgery are clearly documented for the patient to assimilate and space to record that these have been explained to the patient.

4.3 Recommendations for improvement

The following recommendations are considered important actions to be taken by the healthcare organisation to improve the service.

5. <<<redacted>> may benefit as part of learning to reflect upon and discuss with colleagues case AXX in particular, possible reasons for the femoral notch (which was not documented in the operation note) occurring.
6. The Trust should take steps to improve the continuity of care for patients through their pre-operative, intra-operative and post-operative care pathway. This may include, but is not limited to, listing patients, wherever possible, on the operating surgeon clinic list.

4.4 Additional recommendations for consideration

The following recommendations are for the healthcare organisation to consider as part of its future development of the service.

7. If the Trust identifies primary concerns about an individual surgeon, then a formal review of their clinical practice is recommended. If the Trust identifies concerns associated with the surgical service then a review of the service is recommended.

Appendix A - Clinical record review notes

The following notes were made by the clinical reviewers with regard to the cases under review.

<<<<redacted as contains patient sensitive data>>>>

Appendix B – Documents received during the review

The following items of documentation were provided to the review team before, during or after the review visit.

1. External Review Orthopaedic Department: January 2020.
2. Lancaster Review: 27th August 2018, Consultant Orthopaedic Hip and Knee Surgeon.
3. Patient list cross matched to thematic review and seven external review cases.