Review of patients who underwent Laparoscopic Ventral Mesh Rectopexy at Spire Bristol Hospital by Mr A Dixon

Summary Report

Background

Mr Anthony Dixon, a colorectal surgeon at North Bristol NHS Trust (and its precursor), had practising privileges (PPs) granted at Spire Bristol (known as The Glen at that time) in October 1996. As a result of concerns raised, his PPs were withdrawn by Spire Healthcare in 2017.

We referred Mr Dixon to the General Medical Council (GMC) and the GMC's investigation into care provided by Mr Dixon led to a tribunal hearing of the Medical Practitioners Tribunal Service (MPTS), which commenced in September 2023.

In November 2017, Spire Healthcare began a review of patients who had had Laparoscopic Ventral Mesh Rectopexy (LVMR) performed by Mr Dixon. This review is now complete.

Throughout this comprehensive process, Spire has endeavoured to be compassionate with patients and transparent with all stakeholders and regulators. We have worked closely with the NHS Trust and co-operated fully with the GMC. A helpline remains open for patients.

We have apologised and provided support to all patients and their families who received a poor standard of care from Mr Dixon.

A summary of our initial findings was shared with Mr Dixon. He did not agree with our conclusions.

Review of patients

Spire Healthcare has reviewed the care of all known patients who underwent LVMR procedures throughout the whole period of Mr Dixon's practice at Spire Bristol (1996 to 2017).

Spire Healthcare is also reviewing an additional small cohort of patients who underwent other procedures with Mr Dixon, to ensure that they received an appropriate standard of care, and all these patients have been contacted.

Methodology

Although the methodology used varied during the course of the review, in all cases the patients' records were reviewed by senior Consultants with relevant expertise and from 2019 using a clinical advisory group approach where a panel of consultants discussed each patient's care.

All patients received a letter detailing any concerns identified with their care. We also provided telephone and clinical consultations, and offered patients access to counselling.

Summary of findings

A total of 544 patients were reviewed who had seen Mr Dixon over a 20-year period (1996 to 2017).

Of these, harm was opined in the case of 259 of the patients. 285 were deemed not to have been harmed or the cases were inconclusive or not able to be reviewed.

The majority of harm was in three main areas: the failure to adequately investigate patients prior to offering LVMR; the failure to adequately offer alternative treatments (including more conservative treatments); and poor consent with risks and benefits of the procedure not adequately discussed.

Duty of Candour, in line with CQC requirements, has been undertaken for all patients where harm was opined.

Actions taken to improve governance, safety and oversight of consultants

Our aim is to ensure that, where concerns arise, they are appropriately acted upon in a timely manner. We had already begun to evolve our governance and oversight processes before the suspension of Mr Dixon in 2017. We have continued to develop these since the suspension of Mr Dixon's practising privileges, assisted by the learnings from this review, as set out below.

Strengthening our governance and patient safety processes

- Patient safety is our highest priority, and we have consistent safety standards in all our hospitals.
- When concerns are raised about patient treatment or safety, we listen and investigate thoroughly and have robust processes in place to ensure that lessons are learnt.
- Our policies and procedures are aligned with the Medical Practitioners Assurance Framework[1], which is the framework for medical governance adopted by the independent sector through our industry association, the Independent Healthcare Providers Network. This includes a robust approach to the granting of practising privileges, and every consultant practising with us has their practice reviewed thoroughly at least every two years and annually if they do not also work in the NHS.
- We take a proactive approach to quality improvement through our Quality Improvement Strategy and have a strong ward-to-board governance framework. This ensures that we maintain the highest standards and that each hospital is focused on safety and quality.
- Since 2018, we have enhanced clinical leadership with clinicians on the Board and Executive Committee – all with extensive NHS experience.
- Since 2020, we have invested significantly in the Medical Director's team, so there is an increased level of support to hospitals when concerns are raised about a consultant's practice.

[1] Medical Practitioners Assurance Framework 2022

- We have developed an open and honest culture, with colleagues encouraged to speak up and raise concerns.
    - In 2018, we led the independent sector in adopting Freedom to Speak Up Guardians at all of our hospitals and extended these to non-clinical sites in 2019, as well as adopting surgical safety champions in our theatres.
- We now gather and use much more data than in the past, to help monitor performance and use data to give us insight into potential over-treatment by individual consultants.
- We have been a pro-active adopter of the new Patient Safety Incident Response Framework (PSIRF). Although PSIRF is only mandatory in England and when treating NHS patients, we have implemented this across our 39 hospitals in England, Wales and Scotland for both NHS and private patients.
- We recognise the importance of patient feedback and have significantly strengthened our collection and use of patient feedback. We engage with patients before, during and after their treatment and use this feedback to make improvements and identify if there are any concerns about the standard of care provided.

Regulatory ratings

- The NHS and the independent sector have common regulators, the Care Quality Commission (CQC) in England, Healthcare Inspectorate Wales and Healthcare Improvement Scotland and are held to the same standards of care.
- 98% of our inspected locations, including Spire Bristol Hospital, are rated 'Good, 'Outstanding' or the equivalent by regulators in England, Scotland and Wales – above the industry average.

More details on our governance processes can be found on our website.

Conduct of a patient recall

- At the time this review started, there was no national published process or pathway to undertake a patient recall, which meant that patients experienced different pathways and delays between being notified of a recall and hearing the outcome.
- In early 2021, Spire introduced a Patient Notification Exercise Standard Operating Procedure (SOP). Spire made a significant contribution to the development of the National Quality Board Framework for patient recalls, published in July 2022.
- We worked with the Patients Association to understand the impact on patients of being part of a recall and amended our SOP to reflect their findings. We are grateful to the Patients Association and the patients and families for their input.
- We undertook a learning event with colleagues at Spire Bristol to share the findings of our review and to understand the impact on them.

Conclusion

Following this extensive review of Mr Dixon's patients, we would like to take this opportunity again to apologise sincerely to those patients affected. We would like to reassure patients that we have substantially strengthened our procedures to monitor consultant practice and

outcomes. Addressing any concerns promptly is a top priority and we are committed to monitoring learning continuously in everything we do.

Our helpline remains open (0800 783 8163) and we will continue to review the cases of any patients who contact us with concerns about their care.

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