Review of patients who underwent specific spinal procedures at Spire Manchester by Mr John Bradley Williamson

Summary Report

Background

Mr John Bradley Williamson was granted practising privileges at Spire Manchester in 1992. He was employed by Salford Royal Hospital NHS Foundation Trust (now Northern Care Alliance) and Royal Manchester's Children's Hospital (now part of Manchester University NHS Foundation Trust). Mr Williamson last operated at Spire Manchester in 2013.

NCA informed Spire of its spinal patient safety look-back review in February 2022, Spire commenced its own patient review in November 2022, which aligned with the scope of the NCA's look-back review. Spire has worked closely with the NHS throughout the course of its review, sharing findings and learnings.

All patients contacted as part of Spire's review have been informed of the outcome of their review. We have apologised and provided support to all patients who received a poor standard of care from Mr Williamson. Our helpline remains open (see below) and we will continue to review the cases of any patients of Mr Williamson who contact us with concerns about their care.

When considering the content of this report it should be noted that Mr Williamson has not provided comment on the outcome of our review.

Review of patients

Spire carried out its review in two phases:

1. The initial review was into patients who underwent specific spinal procedures between March 2008 and February 2013 and reflected the scope of the Trust's review.
2. In May 2024, Spire extended its review to include patients who underwent specific spinal procedures from 1998.

How the review was undertaken

Spire's review of patients was conducted in accordance with NHS England's National Patient Recall Framework, and Spire's own policy on patient reviews. The review team worked to ensure that all information was shared with patients in a transparent, timely and compassionate manner. Patients were contacted and asked for their views on their care. Where sufficient medical notes or radiology were not available, patients received new imaging and a clinical review.

A clinical advisory group (CAG) approach was used where together a panel of independent consultants discussed each patient's care. The CAG was chaired by a Spire Associate Medical Director. The independent consultants who participated in CAGs had relevant expertise, no conflicts of interest and did not work in the same geographical region as Mr Williamson.

All patients whose care was reviewed received a letter detailing the outcome of the CAG's consideration of the standard of care they received by Mr Williamson. All patients who were

deemed to have been harmed were contacted by telephone, provided with clinical consultations if required and offered access to counselling.

The review aimed to ascertain whether:

- patients followed the appropriate clinical pathway in line with available national guidance and accepted standards of practice.
- surgical procedures were clinically indicated.
- consent was completed satisfactorily.
- surgery was completed to expected standards.
- comprehensive documentation was included in patients' medical records.
- probity and candour were demonstrated.

Patients were deemed to have been harmed if standards of care fell below that expected of a consultant surgeon, taking into account standards of care at the time of the procedure. The levels of harm were assigned according to Spire's policy that is aligned with NHS England's definitions of harm.

For any surgical procedure, some patients may experience a poor outcome which is not due to any issues with the care provided but is the result of a recognised clinical complication. Such patients would not be deemed to have been harmed in a review of this type.

It should be noted that if a patient was deemed as having been harmed in the course of their care, which did not necessarily equate to a poor clinical outcome for the patient. Harm could result from, for example, poor evidence in relation to the decision-making process, meaning that the review team could not confirm if the patient had received adequate information on which to base their decision to proceed with their surgery.

Summary of findings

A total of 211 patients, who had undergone specific spinal procedures, were contacted.

109 patients were deemed not to have been harmed and 17 patients (8%) were deemed to have been harmed at the low (1 patient), moderate (11 patients, 2%) or severe (5 patients, 2%) level. 17 (8%) patients' cases were inconclusive, mainly due to lack of records.

Duty of candour, in line with professional and CQC requirements, was undertaken.

Governance and safety in Spire hospitals

Patient safety is our highest priority, and we have consistent safety standards in all our hospitals. We continue to review our processes and make incremental changes to ensure we continue to enhance the governance and safety processes in our hospitals.

More details on quality and patient safety at Spire can be found on our website, with some key points highlighted below:

- 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. We share learnings across all our hospitals via quarterly learning reports.

- 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 pro-active 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
- We have an open and honest culture, with colleagues encouraged to raise concerns and, since 2018, have had Freedom to Speak Up Guardians in all our hospitals.
- Our data collection strategy helps us to monitor performance and identify outliers and variations in consultant practice.
- 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 all our 38 hospitals in England, Wales and Scotland for both NHS and private patients
- It is our practice to collect and use 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 their care.
- We have updated our policy around consent and carry out training and audits to ensure the policy is followed.
- For consultant biennial reviews, we triangulate soft intelligence along with data relating to complaints, incidents, activity and interventional ratios to ensure that we review a consultant's whole scope of work in order to identify any trends that may need further exploration.
- We share a report with consultants who are connected to NHS and other providers which contains data relating to their last 12 months' practice at Spire, including their activity, incidents and complaints. This supports their whole practice appraisal.
- We have introduced a national New Procedures and Research Committee to enhance the existing approval process for new techniques.

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.

- Since 2022, 98% of our inspected locations have been rated 'Good or 'Outstanding' or the equivalent by regulators in England, Scotland and Wales and Spire Manchester is rated 'Outstanding' by the Quality Care Commission.

Conclusion

Following Spire's extensive patient review we again apologise sincerely to those patients affected.

Addressing concerns promptly is a top priority at Spire Healthcare. We are committed to listening to concerns when they are raised and to continuously learning and improving everything we do. We

[1] Medical Practitioners Assurance Framework 2022

have made, and continue to make, improvements in the way we monitor clinical outcomes for patients and consultants.

Our helpline remains open (0800 028 7418 between 8.30am and 5.30pm Monday to Friday or email **spirepne@spirehealthcare.com**) and we will continue to review the cases of any patients of Mr Williamson who contact us with concerns about their care.

May 2026