Surrey and Sussex NHS Healthcare NHS Trust

TRUST BOARD IN PUBLIC	**Date: 30th October 2014** **Agenda Item: 2.1**	
REPORT TITLE:	UROLOGY REVIEW REPORT	
EXECUTIVE SPONSOR:	Des Holden Medical Director	
REPORT AUTHOR:	Des Holden Medical Director	
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	N/A	
Action Required:		
Approval	**Discussion**	**Assurance (√)**

Summary of Key Issues

A look-back and re-call of patients affected by prostate and/or bladder cancer as mandated by Royal College of Surgeons Invited Clinical review.

A review of the care of 1200 patients with either cancer of the prostate or cancer of the bladder was initiated as a consequence of an invited review by the Royal College of Surgeons. The review focussed on patients seen by Mr Paul Miller, consultant urologist at SaSH, since 2006. An SI was declared.

An external clinical advisory group was convened and has reported 28 patients have come to harm as a consequence of their management, with 6 patients in this group having died. A further 22 patients were judged to have had sub-optimal care though no consequent harm could be demonstrated by the CAG at health record review.

The trust has received just under 200 phone calls from patients, their families and GPs. As a consequence we are arranging to see 30 extra patients in the near future to review their care. At present the trust has received a small number of contacts from patients / families initiating compensation claims. A number of appointments have been made with next of kin for deceased patients.

Relationship to Trust Strategic Objectives & Assurance Framework:

SO5: Well – led

Corporate Impact Assessment:	
Legal and regulatory implications	Probability of litigation/ NHSLA., TDA, commissioners + CQC aware
Financial implications	Some cost for additional time of clinical review
Patient Experience/Engagement	Impact on affected and unaffected patient experience and view of trust
Risk & Performance Management	Identifies possible future strategic risks which the Board should consider
NHS Constitution/Equality & Diversity/Communication	Active communications campaign

TRUST BOARD REPORT – 30th October 2014
UROLOGY REVIEW REPORT

Two separate clinical concerns were raised by a urology consultant and by a specialist urology cancer nurse about another urology consultant (Mr Paul Miller) late in 2013. As a consequence of the seriousness of the concerns PM was excluded from the trust in December and asked to agree to a Royal College of Surgeons professional review. PM agreed to this and the college identified its reviewers and lay representation and attended the trust on 1-2 April to conduct their review. This was based on case note review and a series of interviews with PM, and other relevant doctors, nurses and other key staff including the chief of surgery and me.

At the end of the two day review the panel gave verbal feedback in which they stated they had serious concerns about PM clinical activity and also concerns about his probity from the evidence given by interviews. They suggested that the trust would need to review certain categories of patient who had received care from PM and not been handed on to other members of the urology team. This verbal advice was supported by an immediate review letter received a week later and the formal report which the trust received at the end of June 2014 confirming serious concerns about clinical care and other aspects of professional practice, and again requiring a recall/ review of certain patients with prostate and bladder cancer treated since 2006.

After taking advice from the NHS TDA the trust set up an operational group, to run the review and recall process (beginning in second week April), an external clinical advisory group (CAG) to review patients thought to be at risk or harmed, and gives assurance that the look back had been performed robustly, and a system oversight group with membership drawn from stakeholders (including commissioners, NHSE, Deanery, TDA). These stakeholders and also the CQC were informed of the RCS recommendations.

Approximately 1200 patients were identified and had their notes reviewed. All the patients where concern was identified by internal notes review were seen in clinic by the urology team (consultant and cancer nurse specialist) and where necessary had their care discussed and in some instances changed on the basis of new discussion at the MDT. The CAG looked at approximately 60 sets of notes where it was thought patients had been managed sub-optimally and a 5% sample of notes where there were thought to be no concerns. 28 patients have been written to stating that the trust believes they were managed sub-optimally and as a consequence have been harmed. The nature of the harm differs but includes permanent side effects from treatment through to disease progression. We are grateful to both the NHSLA and also Healthwatch for help in wording these letters and also the letters that went to patients where no harm was found and those patients who had been reviewed at notes level but were not thought to have received sub-optimal care. We have written to the next of kin of patients in all three groups where the patient themselves is deceased.

At the present time about 200 contacts through the trust help line have been taken through the comms team and forwarded through to the urology department. This has resulted in approximately 30 additional clinic appointments being made to review patients where concerns could not be dealt with by telephone.

The Royal College of Surgeons review also recommended investigating aspects of the urologist in questions conduct and probity and as a consequence of this investigation a disciplinary panel was held on 3rd October and Mr Miller was subsequently dismissed on 7th October 2014.