

Getting it Right First Time, Urology, Southern Trust



Southern HSC Trust Getting it Right First Time Urology

Southern Trust Recommendations Action plan updated 6th March 2024

RAG rating	No. of actions
	7 (39%)
	9 (50%)
Both regional	2 (11%)

Getting it Right First Time, Urology, Southern Trust

WORKFORCE					
RECOMMENDATION 1					
The Trust should continue to address barriers to recruitment, where these are within their control. A middle grade rota can comprise an					
Developing areas of sub-specialist practice can also aid recruitment and retention of staff.					
Original Findings	Responsible Person	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
The medical workforce remains reliant on locum appointments and has difficulty recruiting to substantive posts. This is a recognised problem nationally across the UK due to unfilled consultant posts and a lack of National Training Number's (NTN's) accredited each year.	Cathrine Reid / Mark Haynes	Since the GIRFT Visit in March 2023 the Urology Team have advertised for the following medical staff: • Specialty Doctor – Commenced Aug 2024 Temp initially until recurrent funding is secured • International recruitment – successfully appointed 3 Urology Consultants. Commencing 1 x Feb 24 and 2 x April 24 • Physician Associate – advertised, offered and declined. Back out to advertise. Temp initially until recurrent funding is secured • Urology CNS – non-recurrent funding received for 1.8wte, 0.8wte in post. Recurrent funding in IPT We will continue with one Locum Consultant until all Substantive Consultant posts are filled.	Complete		

Getting it Right First Time, Urology, Southern Trust
RECOMMENDATION 2

The Training Programme Director (TPD) for urology should continue to work with individual units to ensure that trainees are allocated to departments in line with the trainees' educational needs and that areas of particular training value are utilised well.

Original Findings	Responsible Person	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
The unit receives 3 NTN's per year; there is an unequal distribution of trainee numbers across Northern Ireland.	Mr Tony Glackin	Southern Trust trainees get appropriate learning experiences in SHSCT as evidenced at ARCP and national training survey. The Urology consultants insist on the trainees following a defined job plan. Additional national trainee numbers were created. At this time a process was undertaken by NIMDT where by proposed additional SPR placement proposals from each Trust were objectively accessed and ranked in order to determine the placement of the additional numbers. Wider recommendation than the Southern Trust	complete		

Getting it Right First Time, Urology, Southern Trust

Facilities including HLVC Site					
RECOMMENDATION 3					
Subject to funding, the Trust needs to urgently re-establish the UIU. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work					
Original Findings	Responsible Director	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
While outpatient facilities for consulting, diagnostic procedures and therapeutic interventions are adequate, much of the Urology Investigation Unit (UIU) is currently occupied by other services if there is an outpatient room available. Urology has primary use of the outpatient rooms in Thorndale, it is only utilised by other services if the rooms are not utilised	Cathrine Reid / Lynn Lappin / Wendy Clayton	The Thorndale Urology Unit is specifically for the Urology Services. It comprises of 9 consultation rooms and 2 treatment rooms. All consultation rooms are flexible to allow procedures such as bladder scanning/difficult catheter changes/ Haem clinics etc Treatment rooms are available for TP Biopsies and Urodynamic Clinics. Post covid there were 2 specialities outside of urology using the outpatient rooms as these were not occupied due to medical vacancies. However, since recruitment the Thorndale Unit is occupied solely by Urology Services In addition we have created 2 additional outpatient rooms just outside Thorndale Unit for overflow of outpatient clinics if required	Complete		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 4					
Trust management should ensure that Trusts are optimising their theatre capacity in order that each urologist has, as a minimum, 2					
Original Findings	Responsible Director	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
Theatre capacity has not been restored following the pandemic and the consultants no longer have access to an all-day theatre list.	Cathrine Reid / Declan	The Urology surgeons from August 2023 have their job planned theatre sessions per week, the service is back to full funded sessions We are delivering the full Urology funded theatre sessions by Urology Consultants from other Trusts backfilling if theatre is available In addition ST provide 2 theatre sessions in Lagan Valley Hospital All Urology Consultants deliver Urologist of Week which is 35 weeks of clinical activity. With 7 consultants and staff grade; as well Belfast Trust using theatres in ST the urology team aim to deliver 11 theatres per week	Aug 2023		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 5					
The Lagan Valley facility is a key component of elective recovery. The Southern Trust needs to ensure that the facility is used to maximum effect by its clinicians, aiming for maximum utilisation of available lists and unnecessary cancellations at short notice due to annual leave					
Original Findings	Responsible Director	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
The protected elective capacity at Lagan Valley Hospital is an impressive development, led by the South Eastern Trust but also utilised by Southern and Belfast teams. It has enhanced the daycase opportunities and created a hub for a regional bladder outlet service, enabling significant progress on recovering the waiting list. The unit is highly efficient and appears to be working well.	Mark Haynes / Wendy Clayton	The Southern Trust does send an operator to Lagan Valley Hospital each Wednesday approx 48 weeks of the year	Complete		

Getting it Right First Time, Urology, Southern Trust

Outpatients and diagnostics					
RECOMMENDATION 6					
There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.					
	Responsible Director	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	Cathrine Reid / Barry Conway / Lynn Lappin / Mark Haynes/ Wendy Clayton	Suspected Prostate cancer pathway is currently being reviewed regionally as part of NICAN and also being considered along with the Regional Diagnostic Centre (RDC) project There is a meeting arranged Wed 10 Jan 24 between Cancer, Radiology and Urology team to discuss and consider a Prostate RDC pathway Commissioning assistance will be required to achieve this recommendation However, Southern trust would welcome discussion regarding haematuria and whether imaging prior to flex cyst is more efficient from a provision perspective than imaging at the time of attendance	Est. Dec 2024		

Getting it Right First Time, Urology, Southern Trust

		Encourage pathways by using Physician Associates ie imaging prior to flex cyst. To be discussed through Regional PIG meeting			
--	--	--	--	--	--

RECOMMENDATION 7

Further efforts must be made to reduce the delays in access to and reporting of imaging and pathology.

Original Findings	Responsible Director	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
Turnaround times for MRI scans and reporting delays in biopsy results mean that the suspected prostate cancer pathway is significant delayed.	Barry Conway/ Denise Newell / Geoff Kennedy	12/12/23 Prostate pathway snapshot Date for MRI scan – decision to biopsy = 14 days MRI imaging is included in the pathway streamlining process in Recommendation 6 Currently there are 57 MRI prostates on the waiting list – 24 of these are prioritised as red flag – all of these are appointed with the exception of 1 and only one is currently waiting over the 2 weeks.	Completed		

Getting it Right First Time, Urology, Southern Trust

		From a reporting perspective on average 40.5% of red flag and urgent examinations are reported within 2 days. There are additional radiologists that have been trained up to report in this area however, with ongoing demands across the system it is difficult to increase this at the moment.			
--	--	--	--	--	--

Oncology					
RECOMMENDATION 8					
Original Findings	Responsible Director	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
Up to 25% of patients currently admitted for a transurethral resection of bladder tumour (TURBT) or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	Mark Haynes / Wendy Clayton	Funding has been received from SPPG and 1 xTULA equipment ordered Outpatient Sister has advised that the TULA has arrived and waiting on estates asset ID label. They have been emailed again last week about it. Currently waiting on the delivery of accessories to go with the TULA 2 x CNS's are going to a training session in January 2024 in London – flights were cancelled due to storm	April 2024		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 9					
The day case TURBT pathway for Craigavon Area Hospital should be developed further at Lagan Valley Hospital and Daisy Hill Hospital for stable ASA 3 patients and below and become the default pathway for patients who are suitable for a day case approach.					
Original Findings	Responsible Director	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	Mark Haynes / Helena Murray	Urology moved to DHH theatres during COVID and remains there present day Previously, Urology services were in CAH main theatres only and would not have operated in DHH. Therefore, theatres nursing team will require training and protocols drawn up Initial start-up will be DHH day surgery theatres. Meeting to be arranged with MDH and Theatre management (estimated 19/1/24)	Est April 2024		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 10					
In theatre Mitomycin-C should be the default option for suitable patients, irrespective of the facility in which the procedure is performed.					
Original Findings	Responsible Director	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
Current provision of Mitomycin-C is problematic	Declan McClements / Helena Murray	See recommendation 9 Initial start-up will be DHH day surgery theatres. Meeting to be arranged with MDH and Theatre management (estimated 19/1/24)	April 2024		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 11					
The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in Northern Ireland. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a single-					
Original Findings	Responsible Director	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
Radical nephrectomy is provided by two surgeons at Craigavon Area Hospital. Patients requiring partial nephrectomy are referred to Belfast City Hospital using an in-reach model	Mark Haynes	This is a regional recommendation. From a Southern Trust perspective 2 substantive Urology Consultants provide radical nephrectomy and from Sept 2023 patients have been transferred from Belfast to Southern Trust waiting list due to long waiting times in Belfast Trust for robotic procedures. To provide capacity in Belfast for robotic take radical nephrectomy from Belfast to Southern Trust A renal cancer project had been initiated in early 2023 with the support from NICAN A regional meeting took place in October 2023 where region wide	Regional timescale re single MDT implementation		Green – 3 surgeons in Craigavon providing radical nephrectomy from Sept 2023 (Surgeons – AJ Glackin, M Evans and MD Haynes) Amber – no single MDT at present

Getting it Right First Time, Urology, Southern Trust

		agreement for a single region waiting time was agreed This subsequently has been discussed through the PIG group with the view to implementation over the next 3 months			
--	--	--	--	--	--

Urgent and Emergency Care					
RECOMMENDATION 12					
The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy at Lagan Valley Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed across Urology departments in NI.					
Original Findings	Responsible Person	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
Further improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute extra-corporeal shockwave lithotripsy (ESWL).	Cathrine Reid / Lynn Lappin / Wendy Clayton / Mark Haynes	Regional recommendation: Regionally to look at capacity and demand for ureteroscopy patients to establish if LVH Pilot Southern Trust for book and return (Ambulatory 'hot' ureteroscopy patients)	Est April 2024		

Getting it Right First Time, Urology, Southern Trust

		Once established Southern Trust would be happy to utilise and partake in delivery There is a regional access to the Southern Trust Regional ESWL service (elective and emergency)			
--	--	---	--	--	--

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 13					
The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the BOO surgery at the Lagan Valley					
Original Findings	Responsible Person	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	Mark Haynes / Wendy Clayton	There is currently an agreed route for patients from ED into the outpatient urology service for trial removal of catheter and subsequent through the Lower urinary tract symptoms (LUTS) / Bladder outlet obstruction (BOO) nurse specialist service which already dovetails with the available daycase bladder outlet surgical options in NI. The pathway could be improved and discussions have commenced with ED with a view to improving the pathway, however, the biggest challenge to delivering a timely service is capacity	June 2024		No issue in the Southern Trust. Patients have catheter removed within timeframe following procedure

Getting it Right First Time, Urology, Southern Trust

Specialist services					
RECOMMENDATION 14					
It has been agreed that Extra-Corporeal Shock Wave Lithotripsy (ESWL) and Percutaneous Nephrolithotomy (PCNL) surgery will be centralised at Craigavon Area Hospital. This will require the provision of 42 all day lists per year (2 procedures per list). There will need to be additional capacity for other types of					
Original Findings	Responsible Person	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
Stone service.	Cathrine Reid / Lynn Lappin / Declan McClements Mark Haynes / Wendy Clayton	The Southern Trust has submitted an IPT for the ESWL and is finalising an IPT for PCNL service ESWL – regional service has commenced, including both elective and emergency ESWL procedures region wide. PCNL – the regional PCNL surgery sessions have commenced in the Craigavon Hospital but using Southern Trust core sessions. 2 consultants from Belfast Trust come to CAH to undertake long waiting PCNL surgery First international recruit Urology Consultant will be running PCNL theatre sessions once through induction	August 2024		Green – ESWL is established Amber – plans in place, local waits of PCNL have been stabilised.

Getting it Right First Time, Urology, Southern Trust

		From next summer operators will increase once by potentially a further 2 PCNL operators			
--	--	---	--	--	--

RECOMMENDATION 15					
The facilities for the delivery of ESWL will need to be upgraded to facilitate the delivery of 4-5 patients for ESWL per half-day list.					
Original Findings	Responsible Person	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
ESWL.	Cathrine Reid / Lynn Lappin / Barry Conway	The ESWL currently has 4 patients AM and 3 patients PM per session When radiographers are recruited this will increase to 4-5 patients per session Interviewing Dec 2024 with estimated start date of March 2024 Allowing 1 slot per day for emergency 5 AM slots – one for emergency 4 PM slots Cancellation is usually a 2nd treatment	April 24		

Getting it Right First Time, Urology, Southern Trust

RECOMMENDATION 16					
Given the regionalisation of this service in WHSCT the trust should consider disinvesting in the provision of benign andrology. There are now good examples nationally of delivering andrology surgery in 'cold' elective sites. Clinicians with expertise in this area should work as					
Original Findings	Responsible Person	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
There is currently under-provision of benign andrology surgery across NI.	Mark Haynes	The Southern Trust agree that benign andrology should be a specialist service undertaken by a small team as a regional service, ideally co-located with the penile cancer service, and utilising regional day case facilities where appropriate. Penile straightening surgery for example, has not been undertaken by any of the Southern Trust team for a number of years and none of the team are in a position to be able to offer this surgery. There are currently a number of patients on the waiting list for this surgery and we have no means of providing this surgery at present. This includes many of the trusts longest waiters.	Regional		

Getting it Right First Time, Urology, Southern Trust

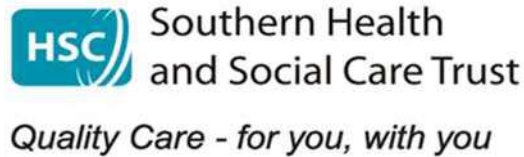
RECOMMENDATION 17					
Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.					
Original Findings	Responsible Person	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
Pathways for female and functional urological treatments need to be clearly agreed and described.	SPPG	Action to be discussed at the Regional Urology PIG meetings Feeds into Gynae GIRFT recommendations			

Getting it Right First Time, Urology, Southern Trust

Outpatient Care					
RECOMMENDATION 18					
Original Findings	Responsible Person	Action(s) Required to Deliver Recommendation(s)	Timescale	Status RAG	Evidence of Completion
The DoH should ensure that Trusts review their outpatient practice with a view to reducing the number of unnecessary review appointments, aspiring to a new to follow-up ratio of 1:2.		The Southern Trust are participating in the Regional Outpatient Modernisation Project. Mr Haynes has volunteered for the Enhanced Clinical Triage and Patient Initiated Follow up (PIFU) Task & Finish Groups. Meeting scheduled for Mon 15/1/24 (Led by SPPG) As per Southern Trust sharepoint Urology New : Review ratio at the end of Nov 23 is 1:5 average. This is not a true reflection as there are more review clinics than new clinics due to priority of MDM reviews. Assurance the Southern Trust consultants are following the appropriate follow up for the patient to maximise the efficiency of time i.e	Ongoing		

Getting it Right First Time, Urology, Southern Trust

		PIFU, discharge back to GP, virtual, enhance triage and scan first, use of nurse specialist Regional group is established to work through			
--	--	--	--	--	--



SOUTHERN HEALTH & SOCIAL CARE TRUST

UROLOGY LOOKBACK REVIEW

Activity and Interim Outcomes Report Cohort 1

9 August 2023

CONTENTS

SECTION 1: INTRODUCTION

1.1	Purpose.....	3
1.2	Background and Context.....	3
1.3	What is a Lookback Review?.....	3
1.4	Methodology for the Southern Trust Lookback Review.....	5

SECTION 2: ACTIVITY & OUTCOMES

2.1	Stage 1: Immediate Action/Risk Assessment.....	5
2.2	Stage 2: Review.....	10
2.3	Stage 3: Recall/Lookback Review Clinics.....	12
2.3.1	Changes to Clinical Management Plan:	
	➤ Diagnostics.....	14
	➤ Medication.....	15
	➤ Treatment.....	16
	➤ Referral.....	19
2.3.2	No Change to Clinical Management Plan.....	20
2.4	Stage 4: Closure.....	21

SECTION 3: NEXT STEPS

3.1	Extension to the Urology Lookback Review.....	22
-----	---	----

APPENDICES

Appendix 1	Chart 6: Flow Summary of Cohort 1	23
Appendix 2	Patient Review Form	24
Appendix 3	Change of Management Plan - Categories and Subcategories..	27

1.0 INTRODUCTION

1.1 PURPOSE

The purpose of a Lookback Review is to ensure patients have received / are receiving the care and treatment they required and if not, remedy care where possible.

The purpose of this report is to outline the activity undertaken as part of the Southern Health and Social Care Trust Urology Lookback Review and describe the outcomes for Cohort 1 of this process.

1.2 BACKGROUND AND CONTEXT

In June 2020, the Trust became aware of a potential issue regarding patients under the care of Mr Aidan O'Brien, Consultant Urologist. On investigation, it appeared that a number of patients who required surgery to remove renal stenting might not have been added to an inpatient / day case waiting list as expected.

This was considered a serious concern because these patients were at risk of not receiving the necessary treatment and potentially suffering serious side effects as a consequence. Based on the clinical risk identified the Southern Trust deemed it necessary to undertake further investigations to determine the outcome for the patients identified, to establish if other patients under Mr O'Brien's care were similarly affected and to consider the implications for other patients and the wider service.

A subsequent administrative review undertaken by the Service Manager, and shared with a senior Trust Consultant Urologist, led to the identification of further potential issues in other elements of Mr O'Brien's work. Namely: delays or absence of reports and/or investigations; lack of / poor communication; incorrect treatment; and un-actioned outcomes following cancer multidisciplinary team meetings including for example, onward referrals and planned reviews.

In considering the outcomes of the audit, the Southern Trust determined that, due to the nature of the findings a Lookback Review would be appropriate.

1.3 WHAT IS A LOOKBACK REVIEW?

A Lookback Review Process is implemented where “...a number of people have been exposed/potentially exposed to a specific hazard in order to identify if any of those exposed have been harmed and to identify the necessary steps to ameliorate the harm

e.g. repeat diagnostic test/ investigation/ referral to relevant clinical service, change treatment pathway, etc”.¹

¹ Department of Health, 2021 *Policy for Implementing a Lookback Review Process* [doh-pol-implement-lookback-review.pdf](https://www.health-ni.gov.uk/publications/doh-pol-implement-lookback-review.pdf) (health-ni.gov.uk)

A Lookback Review is a formal process underpinned by a regional Department of Health Policy and supporting guidance² and normally consists of four stages:

- ❖ *Stage 1:* Immediate action and preliminary investigation and risk assessment to scope the extent, nature and complexity of the incident/concern/issue;
- ❖ *Stage 2:* Identifying and tracing service users at risk;
- ❖ *Stage 3:* Service User Recall;
- ❖ *Stage 4:* Closing, Evaluating and Reporting on the Lookback Review Process.

Lookback Review exercises are by nature high volume, high-complexity and as described above they involve multiple stages which can lead to logistical challenges and cumulative delays. For this reason, there must be a methodical, systematic approach to undertaking the exercise with clear lines of management and accountability to ensure it is delivered effectively.

As previously referenced, the primary objective of a Lookback Review is to remedy care for patients when required, and where possible. However, it also provides an opportunity to elicit learning in order to take action and prevent the situation from reoccurring in the same or a different speciality.

² Department of Health, 2021 *Regional Guidance for Implementing a Lookback Review Process*. [doh-reg-guide-lookback-reveiw.pdf \(health-ni.gov.uk\)](https://www.health-ni.gov.uk/publications/doh-reg-guide-lookback-reveiw.pdf)

1.4 METHODOLOGY FOR THE SOUTHERN TRUST UROLOGY LOOKBACK REVIEW

Using the Department of Health's, *Regional Guidance for Implementing a Lookback Review Process* as a framework the Southern Trust Urology Lookback Review, was carried out in four stages as defined and described in further below:

SOUTHERN TRUST UROLOGY LOOKBACK REVIEW – COHORT 1		Stages 2 – 4 ran concurrently for patients in Cohort 1
STAGE: 1	IMMEDIATE ACTION and PRELIMINARY INVESTIGATION and RISK ASSESSMENT to scope the extent, nature and complexity of the incident/ concern/issue, to confirm the scope and number of patients in the Lookback Review (Cohort 1).	
STAGE: 2	The Patient REVIEW including the completion of Patient Review Forms to establish if there were concerns / no concerns to decide which patients should progress to a Lookback Clinic (Recall of patients).	
STAGE: 3	The RECALL of patients, for whom there was concern from stage 2, to a Lookback Clinic. This included face-to-face or telephone communication with patients to complete a clinical assessment and a change to treatment plans as required.	
STAGE: 4	CLOSURE a) Closing individual cases on the database - Each Patient reviewed at Stage 2 and Stage 3 received a letter to confirm the outcome of the review of their case; b) Production of a Cohort 1 Outcomes and Activity Report; c) Dissemination of a Cohort 1 Outcomes and Activity Report, including next steps, and closure of the Cohort 1 Lookback Review Exercise.	

2.0 ACTIVITY & OUTCOMES

2.1 STAGE 1: IMMEDIATE ACTION / RISK ASSESSMENT

The Regional Lookback Review guidance indicated that the first stage of a Lookback Review process is to take immediate action, including a risk assessment in terms of the presenting issue and establish the cohort of patients to be reviewed as a part of the Lookback exercise.

As referenced, concerns about this situation initially came about when the Trust became aware that patients under Mr O'Brien, who required a surgical procedure,

appeared not to have been added to the waiting list for this procedure. This presented a concern that there might have been patients missed and may not have received the required treatment and care.

There was sufficient concern that an audit was undertaken by the Service Manager which led to the identification of further issues with Mr O'Brien's work including potential issues with prescribing practices and onward referral, etc.

A formal risk assessment of the situation was undertaken using the Regional Risk Matrix (HSCB, 2016)³. The risk that patients may not have received the correct care was graded as "extreme". This was calculated as follows:

Likelihood - 5 (Almost Certain) x Consequence - 4 (Major) = 20 (Extreme).

On this basis, the Trust considered that patients would need to be recalled to establish if their care was appropriate. This was essentially a Lookback Review situation.

As per the Regional Lookback Review guidance, when a situation is determined to require a Lookback, it is necessary to establish the cohort of patients who may have been exposed to harm.

Therefore, in July 2020, the Trust embarked on a process of identifying patients that may require a review and **Recall** with regard to the care they received. As the purpose of a Lookback Review is to remedy care for patients when required and where possible, the timeframe of **1 January 2019 to 30 June 2020** was selected as a starting point.

June 2020 was selected as the end date for this Cohort of patients because this is when Mr O'Brien retired from the Trust.

The reason **January 2019** was selected as the starting point was because clinical advice indicated that a patient who had a renal stent in place should have that stent removed within 18 months (i.e. 18 months prior to June 2020).

To identify the total number of patients in this cohort, the Trust gathered details of the Mr O'Brien's patients from the following sources. Reports were extracted from a number of hospital systems for the review time period of **January 2019 to June 2020** and cross-referenced to remove duplicate entries. The following systems were interrogated and a composite database developed to record all **2112** patients in the Lookback Review:

- Patient Administration System (PAS);
- Cancer Patient Pathway System (CaPPS);
- Northern Ireland Electronic Care Record (NIECR);
- Theatre Management System (TMS);
- Radiology Information System (SECTRA).

³ Health & Social Care Board (2016) *Procedure for the Reporting and Follow up of Serious Adverse Incidents*.
Appendix 16

A summary of the information is tabled below:

Urology Patients Under Mr O'Brien - January 2019 – June 2020			
Category	Numbers		Rolling Total
	Added	Minus	
1. Emergency Urology Patients (TMS)	160		160
2. Theatre Elective (TMS)	352		512
3. Oncology Review Backlog (PAS)	236		748
4. Pathology Results (NIECR)	168		916
5. Radiology Results (NIECR and checked on SECTRA)	1536		2452
6. Urology MDM (CaPPS)	271		2723
SUB-TOTAL			2723
Duplicate Patients - patients in more than one of the groups above		377	2346
New patients initially coded to AOB but not seen by him – seen by different consultant (PAS)		234	2112
FINAL NUMBER IN COHORT 1			2112

These lists were validated to confirm the total number of patients who remained under Mr O'Brien and had not been transferred to a different consultant. This resulted in **2112 patients** being included in the first cohort of patients for the Lookback Review.

A high-level summary of the outcomes for this group of patients is included as **Appendix 1**.

Demographic Data

The demographic detail of the patients in the first cohort of the Lookback Review at the commencement of the process (i.e. 1 July 2021 when the Review Stage formally commenced).

Gender:

- Male – 1539 (73%);
- Female – 573 (27%).

Age:

- The mean age 69 years (including patients' age at death i.e. if a patient had deceased before the lookback process had completed, the patients age at their time of death was used in the analysis).
- Range from 3 months to 98 years.

Status:

- Living patients – 1797 (85%)
- Deceased patients – 315 (15%)

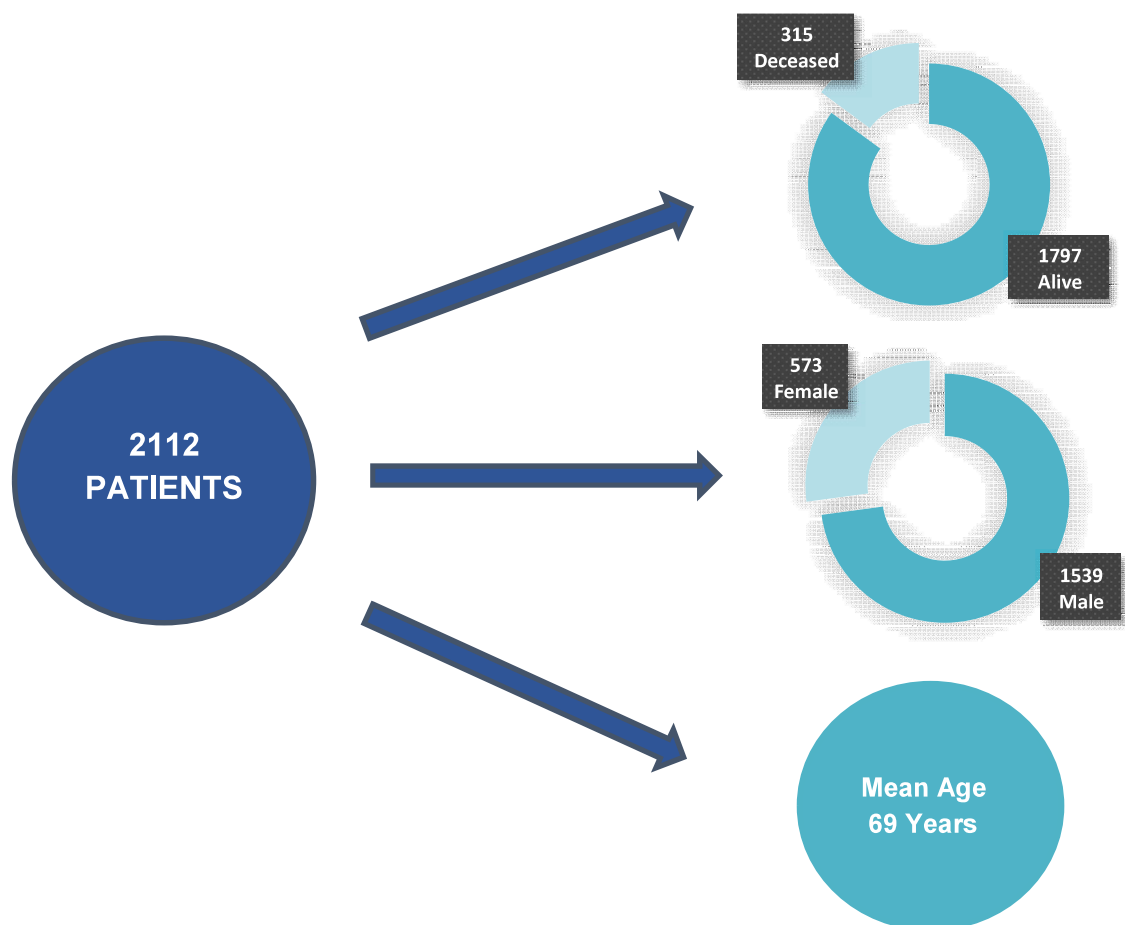


Chart 1: Summary of demographic make-up of Urology Lookback Review Cohort 1

Clinical Conditions

Of these **2112** patients identified, **560** patients had either an active urological cancer diagnosis or, had been treated for a urological cancer in the past and remained under review with Mr O'Brien.

The remaining **1552** patients had a non-cancer condition.

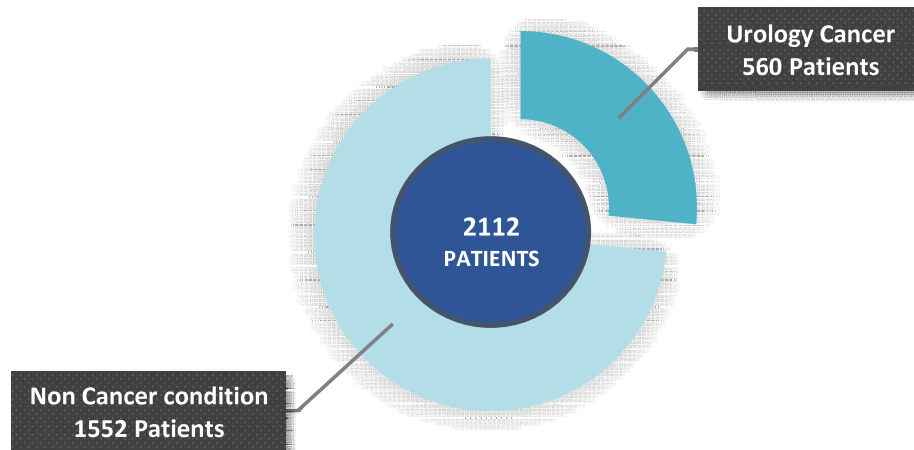
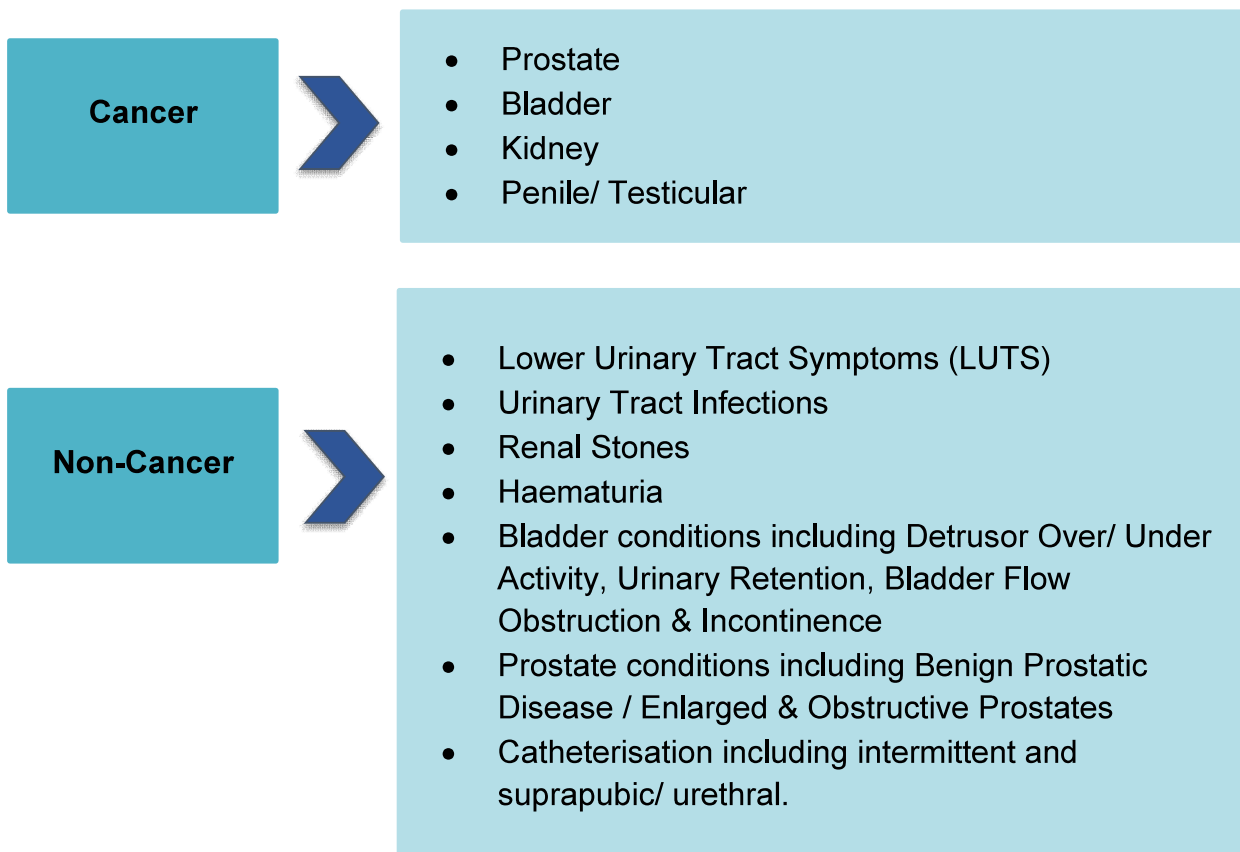


Chart 2: Cancer versus non-cancer conditions

The actual urological conditions, both cancer and non-cancer related, associated with patients within this cohort includes the following:



2.2 STAGE 2 – REVIEW

Within the Trust’s Urology Lookback Exercise, the purpose of the **REVIEW** stage was to identify which of the **2112** patients required a Lookback / **Recall** appointment.

A Patient Review Form was developed to capture information for the review stage of the Lookback. The Patient Review Form was used to capture the clinical aspects of this review. A copy of this form is included as **Appendix 2**. The review stage, including the completion of the Patient Review Forms, commenced in July 2021.

To complete the Patient Review Form process, all patients in Cohort 1 had either a face-to-face or telephone review undertaken by one of the Consultant Urologists in the Southern Trust, or their case notes were reviewed virtually by an external urologist using the Northern Ireland Electronic Care Record (NIECR). A number of factors were considered when determining if the patient required face to face or telephone review i.e. need to physically assess the patient, mobility and accessibility of the patient.

When populated by the consultant with patient specific information, the Patient Review Form was triaged to assist with the decision on whether or not a patient would progress to the **Recall** stage of the process. This triage was essentially a “sorting” process to establish if there were concerns or issues with the care received by patients and if these necessitated the patient being recalled and seen in an outpatient setting by a senior urologist from the Trust.

All Patient Review Forms were reviewed and triaged into one of three categories i.e.:

1. No clinical concerns	No clinical issues / concerns identified in Patient Review Form.
2. Concerns but not clinical in nature	Issues / concerns identified in Patient Review Form, which <u>did not</u> have a clinical impact on the patient.
3. Clinical concerns	Issues / concerns identified in the Patient Review Form, which <u>could</u> have a clinical impact on the patient.

Determinations Following Triage of Patient Review Forms

The result of this triage exercise for the **2112** patients highlighted the following:

TRIAGE RESULT		ACTION
1. No concerns with care received	1696 Patients (80.3%)	Closed to the Lookback Review**
2. Concerns but not clinical in nature	176 Patients (8.3%)	Further review in Lookback / Recall Clinic
3. Clinical Concerns	240 Patients (11.4%)	Further review in Lookback / Recall Clinic

Patients triaged into Category 1, received a letter from the Trust advising their care had been reviewed and no concerns were identified. For the purpose of the Lookback Review process, these patients were subsequently closed on the Urology Lookback database.

Of the **1696 patients in Category 1, **111** patients were being actively treated for cancer at the time. Whilst there were no concerns identified with the treatment and care of these patients were receiving, a decision was taken by the team that all active cancer patients would receive a face-to-face appointment in a clinic setting to ensure they continued on the correct patient pathway.

It was determined that patients triaged into Categories 2 and 3, required further assessment therefore were progressed to the **Recall** stage of the Lookback. These patients were advised as such and a Lookback appointment was made with a Southern Trust Consultant Urologist.

In summary, 527 patients from the Review stage progressed to a Lookback clinic at the **Recall** stage of the process.

Summary of Patients Progressing to the Recall Stage of Lookback	
Determined Category	Number of Patients
Patients determined as 'clinical concerns'	240
Patients determined as 'concerns but not clinical in nature'	176
Cancer patients with 'no concerns'	111
Total Number of Patients Recalled	527

2.3 STAGE 3 – RECALL / LOOKBACK REVIEW CLINICS

The purpose of the **Recall** element of the Urology Lookback Review is to establish if a patient's diagnosis and treatment is correct and, if not, what amendments were required to the patient's clinical pathway.

The **Recall** stage of the Lookback process commenced in July 2021 and was managed alongside the review phase. Patients were recalled according to their clinical need.

RECALL

The Urology Lookback Review **Recall** appointments took place with a Trust Consultant Urologist either face-to-face in an outpatient setting or virtually via video or telephone. Following the patient's appointment, the consultant dictated an outcomes letter, which was shared with the patient and their GP.

In order to ascertain the outcomes of the **Recall** aspect of the Lookback Review, senior nurses in the Lookback team scrutinised the clinic letter, which was generated by the consultant after each appointment. This was to establish if Mr O'Brien had placed the patient on the correct management plan or if a change was required to the clinical management plan and if so, what this change was.

For the purpose of this exercise, "Change" was considered to be: *"The ceasing and / or amending of the clinical management plan put in place by Mr O'Brien"*.

The outcome of the senior nurses' analysis are described below.

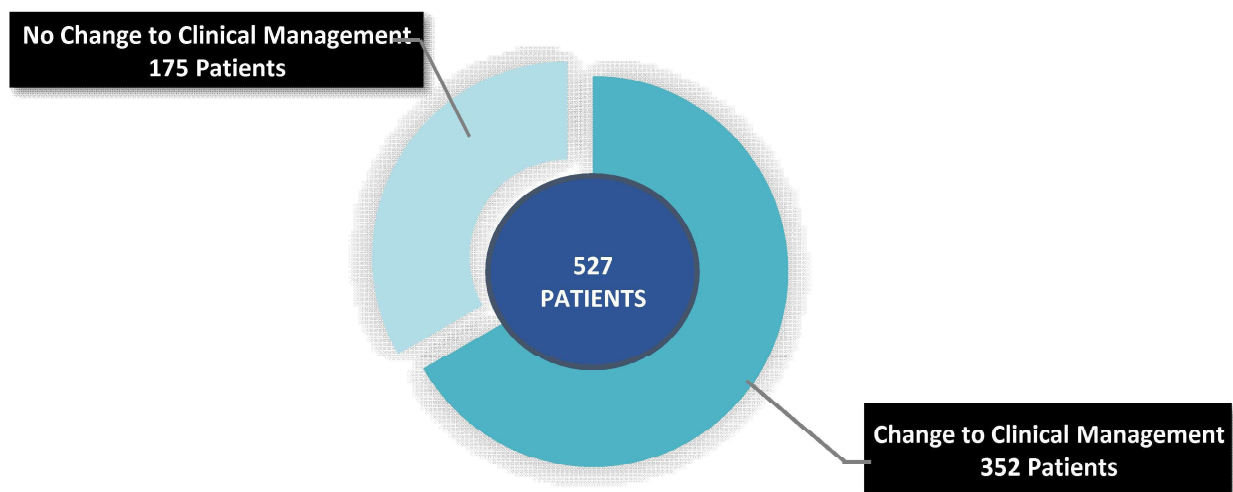


Chart 3: Breakdown of "change" versus "no change" in clinical management plan following **Recall** appointment

Of the **527** Lookback **Recall** appointments completed:

- **352** of patients (67%) required at least one change to their clinical management plan. **92** patients out of this **352** (26%), were Urological Cancer patients; and
- A total of **175** (33%) of the **527** patients who attended a Lookback **Recall** appointment did have a change to their clinical management plan however they did receive information regarding the Lookback Review as well as advice and reassurance as required.

Further detail of this is provided in **Sections 2.3.1 and 2.3.2** below.

2.3.1 Changes to Clinical Management Plan

The analysis undertaken by the senior nurses relating to changes in management plan was grouped into 4 categories:

1. **Diagnostics** – this includes the requesting of new or repeat diagnostic examinations, blood tests;
2. **Medication** - this includes the stopping, increasing or decreasing of dosage of current medication or the starting of new medication;
3. **Treatment** - this includes providing new treatment or the adding of a patient to a surgical waiting list or the removal or suspension of a patient from an existing surgical waiting list;
4. **Referral** - this includes referral to Oncology, Multidisciplinary Meeting (MDM), a specialist Urology Unit or Specialist Urology/ Cancer Nurses or to another Specialist Team outside of Urology.

Each of these categories had a number of subcategories. The categories and sub-categories are detailed in **Appendix 3**.

The chart below details the changes to the clinical management plan for the **352** patients who required a change to their clinical management plan.

To note, some patients required more than one change therefore the total number of patients in each category below is greater than **352** i.e. the number of patients who had an appointment.

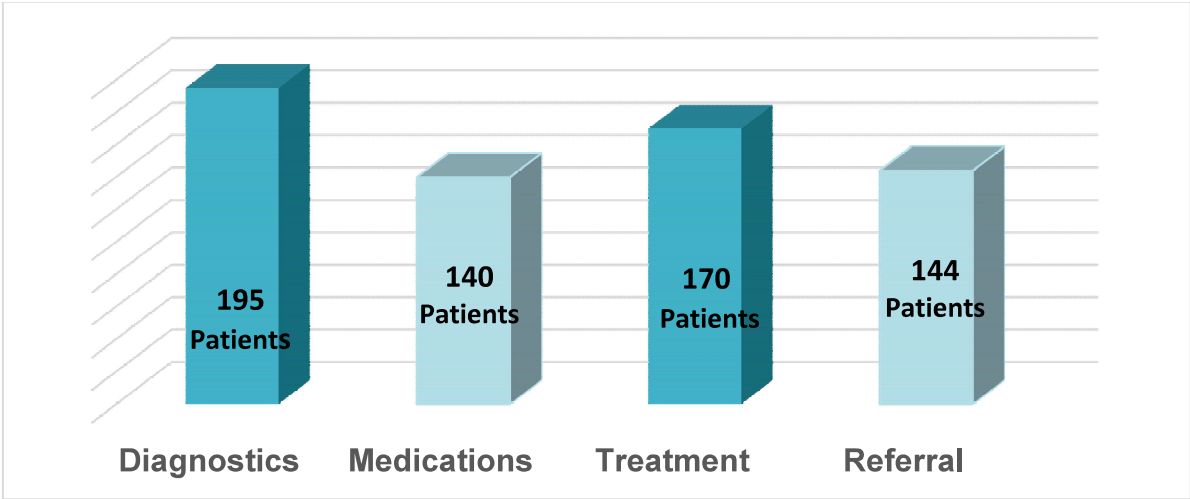
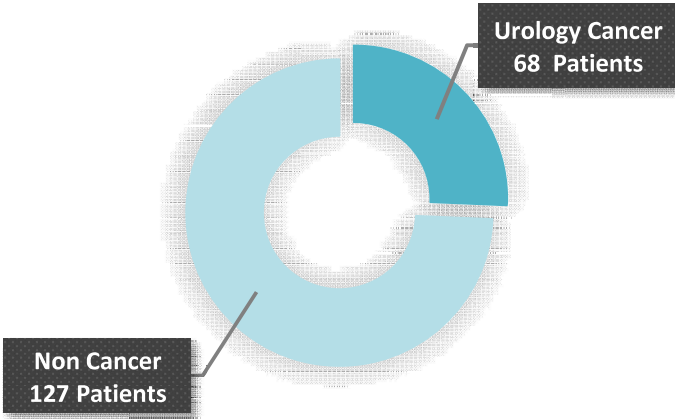


Chart 4: Patients with a Change in Clinical Management N=352

Diagnostics

The most prevalent change was found in the category of diagnostics. A total of **195** patients required a diagnostic action. The cancer / non-cancer split of these patients was:



Of these **195** patients, the “change” was as follows:

Breakdown of Required Diagnostic Changes	No. of Patients	%
➤ Repeat diagnostic tests e.g. CT or MRI scanning	87	45%
➤ New / additional diagnostic tests e.g. Scanning or urodynamics	68	35%
➤ Place on blood testing surveillance (PSA monitoring all prostate cancer disease) ⁴	40	20%

⁴ This change in clinical pathway coincided with the discontinuation hormone medication i.e. Bicalutamide (detailed below in “medication”) and moving the patient to an appropriate surveillance pathway.

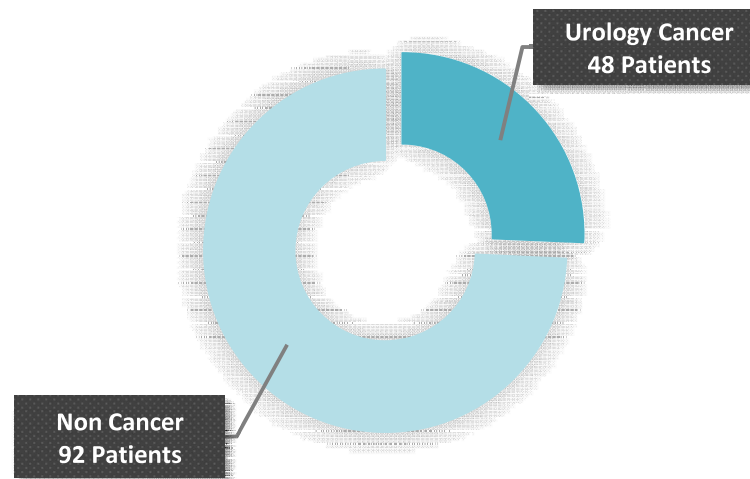
Of the **127** patients with non-cancerous urological conditions, **26** patients had renal stone disease treated with or without ureteric stenting (21%). For these patients, the diagnostic analysis identified the need to request either new or repeated investigations to assess renal stone disease or confirm the presence of ureteric stents.

The Lookback Team considered the renal stone disease findings to be significant given the potential effect on patients with untreated stone disease and ureteric stents.

The subsequent action taken following diagnostics for these patients is reflected in the “*treatment*” section on page 16.

Medication

A change in medication was required for **140** patients seen at Lookback **Recall** clinic. The cancer / non-cancer split of these patients was:



For the **48** patients with cancer, the medication issue focused entirely on prescribing Bicalutamide medication (hormone therapy) that was not in line with recognised standard clinical practice. This is specific to male patients with a diagnosis of prostate cancer. Issues with Bicalutamide prescribing were two-fold:

- i. The unlicensed prescribing of low dose Bicalutamide 50mg, as a monotherapy when the patient's clinical pathway should have been surveillance (**23** patients); and
- ii. Prolonged prescribing of Bicalutamide either before, or instead of, referral to Oncology, as would have been standard treatment and practice (**25** patients).

All **48** patients required the prescribing of Bicalutamide to be stopped.

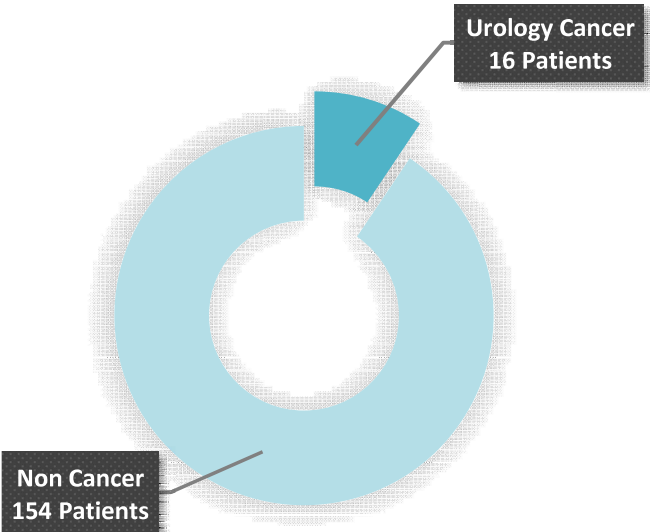
In addition to the medication being stopped **19** of these patients were discussed at MDM for treatment planning and were referred to Oncology. The remaining **29** patients were placed on a surveillance pathway with regular checking of their PSA.

For the **93** patients with a non-cancerous urological condition the following medication changes were required:

Breakdown of Medication Changes Required	No. of Patients	%
➤ Antibiotics stopped (these had been prescribed indefinitely or had continued as a result of patient not being reviewed)	19	20%
➤ Other medication stopped (as it was determined to not be of benefit to the patient)	18	19%
➤ New medication commenced	50	54%
➤ Current medication doses increased	6	7%

Treatment

In relation to “change in treatment” category, a total of **170** patients either had a procedure which was not clinically indicated, or were on a waiting list for a procedure which, when reviewed, was not required. The cancer / non-cancer split of these **170** patients is:



Breakdown of Treatment Changes Required	No. of Patients	Cancer	Non-Cancer
Had a procedure which was not clinically indicated	47	5	42
On a waiting list for a procedure which when reviewed was not required	123	11	112

Procedure Performed Not Clinically Indicated

Of the **47** patients who had a procedure that was not clinically indicated, **5** patients had a Cancer and **42** patients had a non-cancerous urological condition.

An example of the procedures, which were considered not required, include:

- Transurethral Resection of Prostate (TURP)
- Ureteroscopy/ Urethrotomy
- Hydrodistension/ Bladder Distension
- Testicular/ Scrotal Exploration
- Epididymectomy
- Cystoplasty/ Pyeloplasty
- Other procedures such as penile implants, upsizing of catheter & self-catheterisation, intravesical Botox treatment and Urodynamics

Waiting List Adjustment

There were **123** patients who were on a waiting list for a procedure who, following the Lookback **Recall** Clinic did not require that procedure.

The following changes to the waiting lists took place:

Changes to Waiting List	No. of Patients	%
Removed from the Waiting List – other follow up required	66	54%
Removed – assessed and deemed suitable to manage with simple lifestyle changes	10	8%
Suspended from the Waiting List with trial of lifestyle changes (noted the need for surgical intervention was highly unlikely)	21	21%
Removed from one waiting list and added to another waiting list for a different procedure.	26	17%

It should be noted that patients were not adversely impacted by changes to waiting lists i.e. if removed from one waiting list and added to another waiting list for a different procedure they were backdated so effectively they waited the same amount of time.

A total of **76** patients were either removed from the waiting list (**66** patients), or suspended from the waiting list (**10** patients). The chart below demonstrates the procedure sites for which they had been listed for surgery:

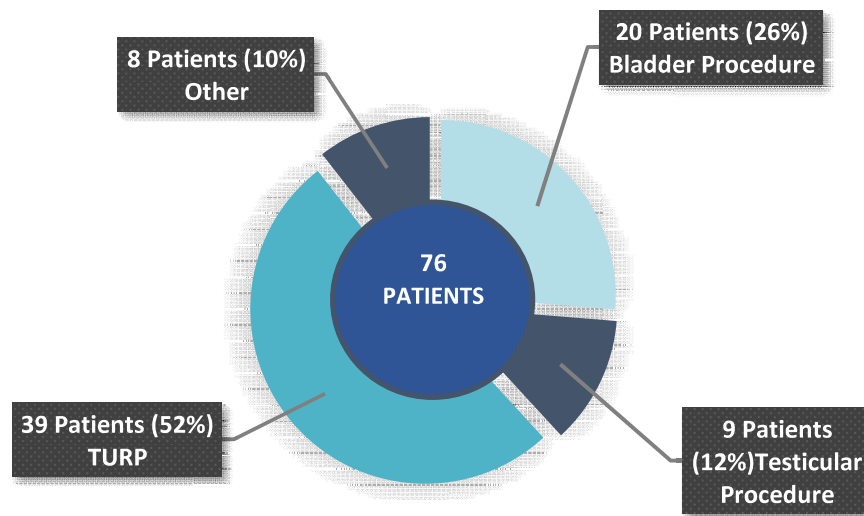


Chart 5: Patient Removed from Waiting List

**Category of "other" includes Penile Procedures, complex procedures of Mitrofanoff, Ileal Conduit and Urinary Diversion and Revision of Nephrectomy Wound.*

Prostate related procedures were greater in number with **39** patients requiring a change in the management plan decided upon by Mr O'Brien. The following findings were noted as the reason for change of pathway:

- First line treatment including lifestyle changes and medications to manage symptoms had not been offered;
- Diagnostics performed did not support the need for TURP;
- Diagnostics had not been performed/were missing from records;
- Alternative options were available but not offered to the patient;
- Co-morbidities made the patient high risk for surgery, which was known prior to adding to the waiting list for a TURP procedure; and
- Patient age - either too young or too old for the associated risks and potential side effects.

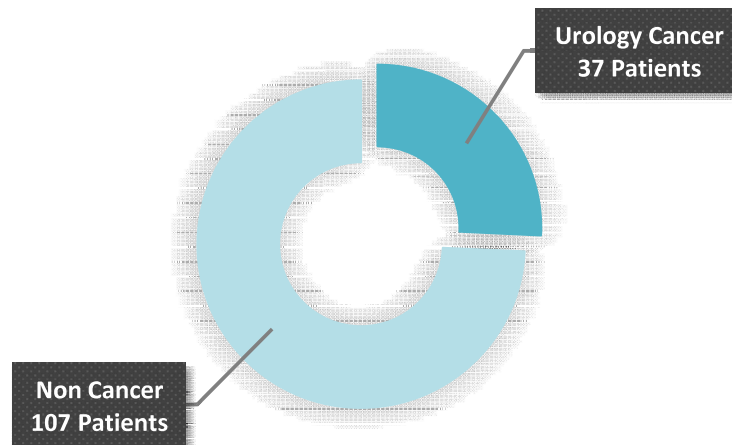
As detailed in "*diagnostics*" section on page 15, **26** patients, with renal stone disease treated with or without ureteric stenting, required further treatment following diagnostic follow up. The treatment changes for these patients include the following:

- Requiring either stone treatment surgery or had an ureteric stent identified as still being in situ which required either removal or replacement;
- Onward referral to the Stone Treatment Centre for lifestyle advice and placed onto surveillance;
- Annual surveillance; and
- Discharged to their GP with advice on fluid intake, dietary considerations and symptoms of recurrence of stone formation;

As a benign disease, given the potential effect on patients with untreated stone disease and encrusted ureteric stents, this condition needs to be specifically included in any extension of the current Lookback Review.

Referral

Change required in relation to “Referral” was noted for **144** patients. The cancer / non-cancer split of these patients is:



Of the 37 patients with a urological cancer, the following referrals were actioned:

Changes to Referral Required for Patients with Urological Cancer	No. of Patients	No. of Referrals
➤ Referred to the Lower Urinary Tract Symptoms (LUTS) Clinic for assessment and management of symptoms associated with cancer diagnosis	16	16
➤ Referred to Cancer Nurse Specialists	6	7
➤ Referred to Oncology/Specialist Urology Unit to commence Cancer Treatment	6	7
➤ Required discussion at the Urology Multidisciplinary Team Meeting (MDT) for treatment plan recommendation	5	6
➤ Referred to another speciality	4	4
Total Number of patients / referrals	37	40

This applies to 37 patients however, 40 referrals were made in total as 3 patients had 2 referrals each.

Of the **107** patients with a non-cancerous Urological Condition requiring referral actions, the following referrals were actioned:

Changes to Referral for Patients with Non-Urological Cancer	No. of Patients
➤ Referred to the Lower Urinary Tract Symptoms (LUTS) Clinic for assessment and management of urinary symptoms	52
➤ Referred to Specialist Urology Units or Practitioner	20
➤ Referred to another Speciality for example Gynaecology	14
➤ Referred to another Trust Urologist with a speciality / MDT in specific Urological conditions for example renal stone disease	10
➤ Referred to others e.g., physio, Continence Nurses	11
Total Number of patients	107

Reflecting the findings in “*diagnostics*” in relation to patients with renal stone disease, with or without the use of ureteric stents (i.e. non-urological cancer patients), of the **107** patients requiring referral action, **13** patients had a diagnosis of stone disease and required onward referral for treatment.

2.3.2 No Change to Clinical Management Plan

A total of **175** patients (33% of patients) who had a Lookback appointment did not have any change in their clinical management plan.

All of these patients were informed about the Lookback Review and were provided with the detail of the specific issues identified with the treatment they received while under the care of Mr O'Brien.

Where patients had deceased during the period since the commencement of the review, their Next of Kin were informed of the findings in writing. In addition, they were offered the opportunity to meet with a Senior Urology Consultant to discuss the issues and have an opportunity to have questions addressed.

2.4 STAGE 4 – CLOSURE

Stage 4 of the Regional Lookback Review Guidance focuses on Closing, Evaluating and Reporting on the Lookback process.

The Lookback of each individual patient's case is considered to be complete and closed when they or their next of kin have received a final written communication from the Lookback Team detailing the outcomes of their review.

Where there were concerns with a patient's care and their case was subject of deeper analysis to establish learning opportunities for the Trust, these patients, or next of kin for deceased patients, have been provided with correspondence detailing the learning identified.

At the time of publishing this report, **2029** individual cases have been closed on the Lookback database. The Lookback cannot be closed for an outstanding 83 patients. This is because the patients are deceased and despite extensive efforts the Lookback Team were unable to identify the next of kin details for these patients. Consequently, the Trust has not been able to write and advise these relatives of the outcomes of the Lookback with regard to their family member.

The protracted time interval between the commencement of the Lookback Review and the publication of this report is recognised, however it has been necessary to ensure robust completion of the following actions:

- Identifying the patients to be reviewed and ensure a robust database of all patients affected;
- The subsequent large volume of patients identified to be reviewed and progress through each stage of the Lookback process;
- The limited clinical resource available to undertake the different elements of the Lookback Review methodology;
- Arranging **Recall** clinic appointments with the one consultant available to undertake this work; and
- Completing a report for each patient to be shared with them/their next of kin detailing the outcome of their Review i.e. any findings/shortcomings with their care.

As previously referenced, patients were managed through this process according to clinical priority.

At a patient level, all of the urology patients in the Lookback Review received individual letters to advise of the outcome of the review as soon as possible after their review was complete. Nevertheless, the length of time to complete the full Lookback Review for all 2112 patients has been prolonged and it is recognised that a timelier conclusion of the process would be preferable for any further cohorts.

3.0 NEXT STEPS

3.1 Extension of the Urology Lookback Review

This report provides high-level outcome data for people who were under the care of Mr O'Brien's from January 2019 until June 2020.

As a result of the findings from Cohort 1, it is recognised that a further cohort of individuals (Cohort 2) will need to be further analysed and reviewed.

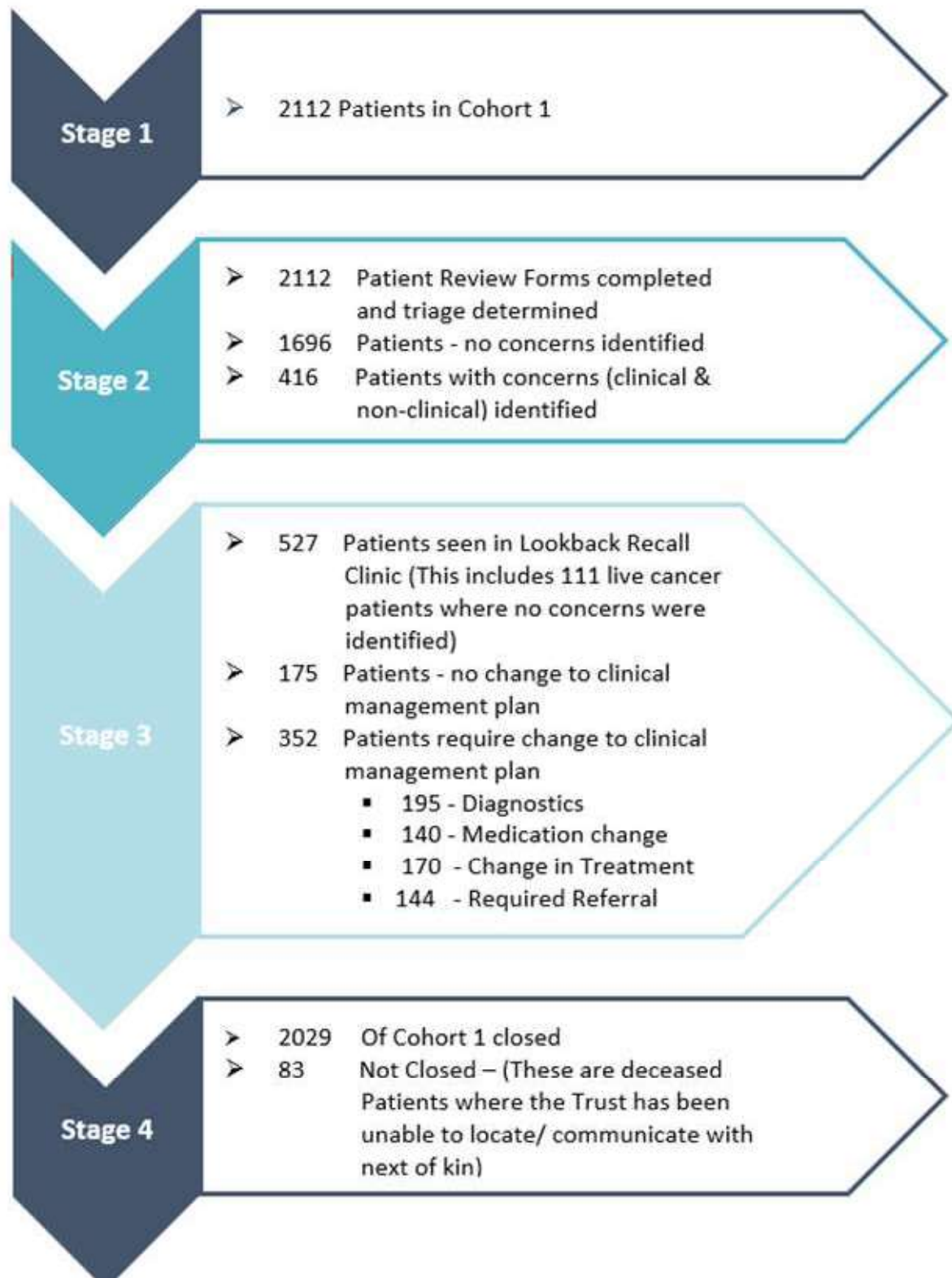
In identifying this group of patients the Trust determined that they are patient groups where there would be a greater opportunity to change their clinical management pathway for a more positive outcome. This includes patients with Urological Cancer and patients who were diagnosed with renal stones, who were treated with or without ureteric stents and any patient who continues to have an "open" episode of care and has yet to be discharged or their care taken over by another Trust urologist.

In addition, a concern has been raised that Mr O'Brien may have seen and treated patients privately in his own home. Due to the ongoing difficulties in gaining access to Mr O'Brien's private patients, it is the intention of Southern Trust to include in Cohort 2 any private patients, who wish to have a review. Patients who fall into this category will be invited to come forward and make contact with the Trust directly.

In summary, the Urology Lookback Review will be extended to a second cohort of patients to include:

1. Patients diagnosed with a Urological Cancer (prostate, penile, bladder and kidney tumour groups) diagnosed from 1 April 2010 (this is when Cancer MDM's became functional in Southern Trust) who are currently alive;
2. Patients with Renal Stone Disease, which may or may not have been treated with Ureteric Stenting and any patient who continues to have an "open" episode of care; and
3. Any patient who was seen and treated privately by Mr O'Brien and wishes to be included in this Cohort.

The Trust expects that when this second cohort of patients have progressed through the Trust's Lookback Review, all of Mr O'Brien's patients, for whom there may have been a requirement to change or adjust their ongoing clinical management plan, will have been reviewed. Therefore, there is no expectation that review of a third cohort will be required. However, this situation will be kept under review.

Appendix 1: Summary of Activity & Outcomes of Cohort 1**Chart 6: Hi-Level Lookback Review Summary for Cohort 1**

Appendix 2: Patient Review Form Template

UROLOGY LOOKBACK REVIEW
PATIENT REVIEW FORM

This form is to be used to review the care of the patient identified below as part of the Urology Lookback Review.

- Each question must be completed using a response from the “drop down” options i.e. Yes / No / Unable to Determine
- The “Details” section is for free text if more information is required to supplement the Yes / No / Unable to Determine answer
- The reviewer’s details and date must be recorded in the final section.

Please refer to the User Guide to ensure the correct format of saving and upload is followed on completion of this review form.

Patient Details

Name	
H&C Number	
Date of Birth (DD/MM/YYYY)	

Clinical Details

Patient Clinical Summary	
--------------------------	--

Regarding the patients current care

	Question	Yes / No / Unable to Determine (UTB)	Details
1	Is the present diagnosis / diagnoses reasonable? (‘Reasonable’ to consider if <i>diagnosis / diagnoses is consistent with investigations and examinations carried out to date, is there a requirement for further investigations / examinations to confirm diagnosis / diagnoses?</i>)		

2	Are the current medications prescribed appropriate? (‘Appropriate’ to consider if prescribing is consistent with current best evidence based practice, are any deviations from guidance recorded and rationale fully noted?)		
3	Is a secure clinical management plan currently in place? (‘Secure Clinical Management Plan’ to consider if the current patient treatment pathway is optimal and in line with current best evidence based practice and guidance)		
4	If there is not a secure clinical management plan in place please document immediate actions required to be taken		

Regarding the Patient’s Historical Care.

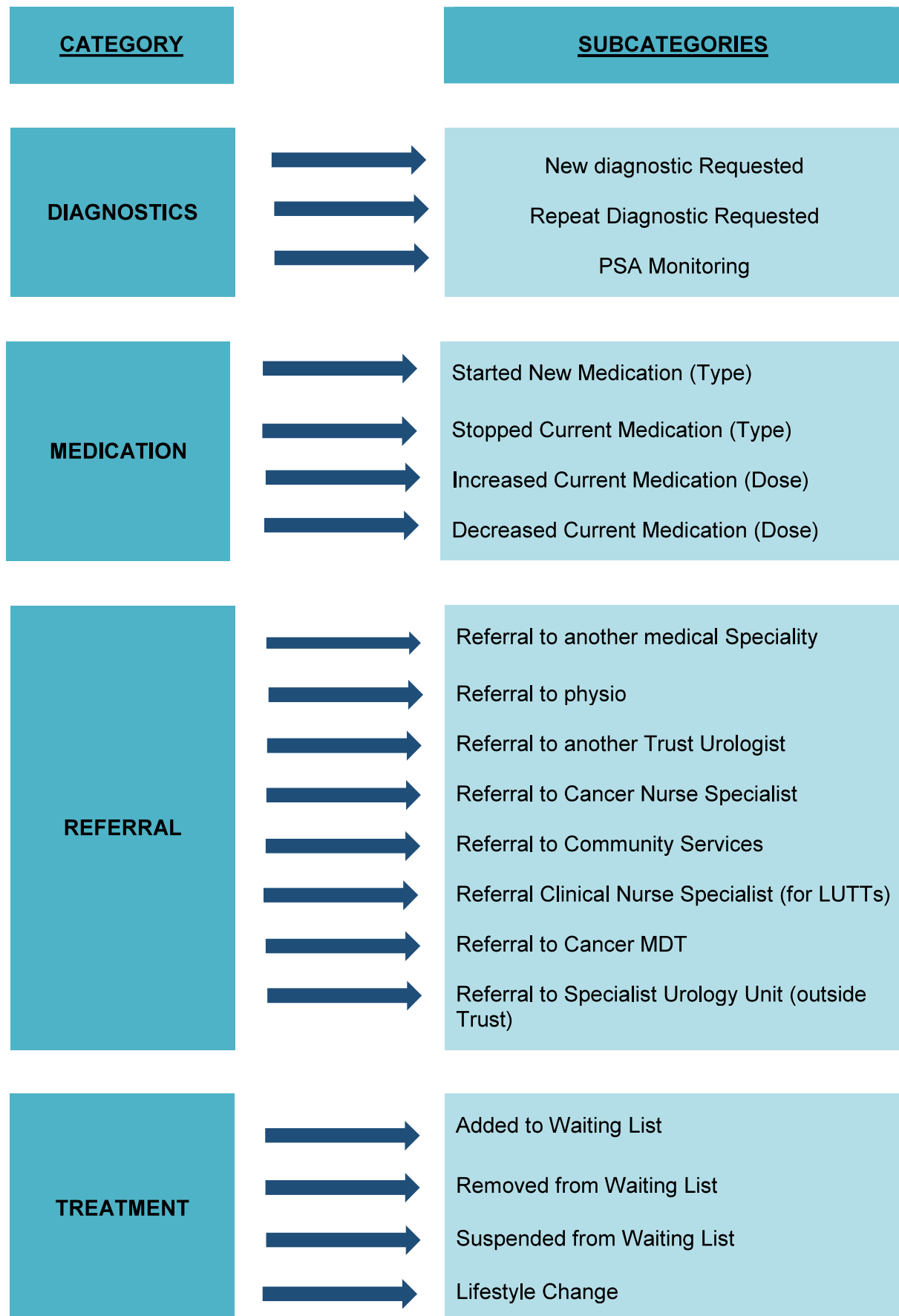
No.	Question	Y / N / Unable to Determine	Details
5	Were appropriate and complete investigations carried out for all relevant conditions? (‘Appropriate’ to consider if investigations consistent with current best evidence based practice at the time of review, are deviations from guidance recorded and rationale fully noted?)		
6	Were the medications prescribed appropriate? (‘Appropriate’ to consider if prescribing was consistent with current best evidence based practice at the time of previous review, are deviations from guidance recorded and rationale fully noted?)		
7	Was the diagnosis / diagnoses reasonable?		

	<i>(‘Reasonable’ to consider if diagnosis / diagnoses is consistent with investigations and examinations carried at the time of review, was there a requirement for further investigations / examinations to confirm diagnosis / diagnoses?)</i>		
8	Was the clinical management approach taken reasonable? <i>(‘Reasonable’ to consider if clinical management plan if the patient treatment pathway at the time was optimal and in line with best evidence based practice and guidance available at that time.)</i>		
9	Were there unreasonable delays within the Consultants control with any aspect of care (reviews, prescribing, diagnostics, dictation etc?) <i>(‘Unreasonable Delays’ to consider if diagnosis required more urgent treatment / intervention that was received based on best evidence based practice and guidance available at that time. The Southern Trust will consider any delays in treatment highlighted to assess if these were within the Consultants control or due to systematic issues e.g. length of waiting lists)</i>		
10	On balance - was the patient’s care: Optimal Suboptimal Unable to Determined		

Clinical Professional Reviewing Care

Name	
Title	
Date of Casenote Review (DD/MM/YYYY)	

Appendix 3: Change of Management Plan - Categories and Subcategories



Clinical Record Review Report



Royal College
of Surgeons
of England
ADVANCING SURGICAL CARE

Report on 100 clinical records relating to the urology service on behalf of Southern Health and Social Care Trust

Report issued: 29 September 2022

A clinical record review on behalf of:

The Royal College of Surgeons of England

British Association of Urological Surgeons

Review team:

Mr David Jones FRCS

Mr Jonathan Glass FRCS

Mr Mark Speakman FRCS

Mr Brian Birch FRCS

PRIVATE AND CONFIDENTIAL

The Royal College of Surgeons of England
38-43 Lincoln's Inn Fields
London WC2A 3PE
T: 020 7869 6222
E: irm@rcseng.ac.uk
W: www.rcseng.ac.uk/irm

Registered Charity No. 212808

Contents

1.	Introduction and background	3
2.	Terms of reference for the review	4
3.	Conclusions.....	5
3.1.	Assessment including history taking, examination and diagnosis.....	5
3.2.	Investigations and imaging undertaken.....	6
3.3.	Treatment including clinical decision-making, case-selection, operation or procedures and prescribing practices	7
3.4.	Evidence of compliance with best clinical practice guidance available at the time of care given, including NICE guidance.....	9
3.5.	Communication with the patient, their family and general practitioner(s), and patient consent	10
3.6.	Team working including communication with other members of the care team, MDT discussions and working with colleagues	12
3.7.	Follow-up action on the patient care	13
3.8.	Actions taken by the consultant as a result of Multidisciplinary Team (MDT) Meeting recommendations.....	14
3.9.	Completeness of patient records in connection to the patients episodes of care.....	15
3.10.	Identifying instances where harm may have occurred.....	18
3.11.	Identifying if any harm that has occurred is such that might be expected from any consultant surgeon working in similar circumstances	19
3.12.	Identifying patients that may require further follow up by the Trust.....	19
4.	Recommendations	21
4.1.	Urgent recommendations to address patient safety risks.....	21
4.2.	Recommendations for service improvement	22
5.	Guidance for the healthcare organisation	24
5.1.	Responsibilities in relation to this report.....	24
5.2.	Further contact with the Royal College of Surgeons of England	24
	Appendix A - Clinical record review notes	25
	Appendix D – Royal College review team	119

1. Introduction and background

On 9 November 2020, Dr Maria O’Kane, Medical Director for the Southern Health and Social Care Trust (“the Trust”), wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited clinical record review of 100 urology cases. In particular, the request highlighted concerns regarding delays in treatment and surgery of patients who were under the care of a Trust employed Consultant Urologist (Surgeon 1). The Trust undertook an internal review of the Consultant’s practice to ascertain if there were wider service impacts. The internal review was held over a 17 month period (period 1st January 2019 - 31st May 2020) and identified deficiencies in patient care provided and which potentially had an impact on patient prognosis.

This request was considered by the Chair of the RCS England IRM and a representative of the British Association of Urological Surgeons (BAUS) and it was agreed that an invited clinical record review would take place.

A review team was appointed and an invited review of the 100 cases was arranged. The review team considered the care provided to the 100 patients put forward by the Trust between June 2021 and February 2022. This included the review of the clinical records, and supporting information provided to the review team by the Trust. The appendix to this report lists the members of the review team. This clinical record review was carried out with the purpose of meeting the terms of reference outlined in section two, and drew conclusions from the information provided in relation to the clinical record review only.

The review team conclusions are based on the information provided to them, which are outlined in section three. The notes made by the clinical reviewers with regard to the individual cases are detailed in Appendix A. These represent their initial views on each case while looking at them individually and do not necessarily reflect their final conclusions. The conclusions section of this report contains the review team’s views on the care provided to these patients, and recommendations based on these conclusions are outlined in section four.

2. Terms of reference for the review

The following terms of reference for this review were agreed prior to the review being undertaken between the RCS England and Southern Health and Social Care Trust.

Review

The review will involve:

- A clinical record review of up to 100 cases who were under the care of the consultant between the period January 2015 – December 2015 put forward by the Southern Health and Social Care Trust¹.

Terms of Reference

In conducting the review, the review team will consider the standard of care demonstrated in the clinical records provided by the Southern Health and Social Care Trust including with specific reference to:

- Assessment including history taking, examination and diagnosis;
- Investigations and imaging undertaken;
- Treatment including clinical decision-making, case-selection, operation or procedures and prescribing practices;
- Evidence of compliance with best clinical practice guidance available at the time of care given, including NICE guidance;
- Communication with the patient, their family and general practitioner(s), and patient consent;
- Team working including communication with other members of the care team, MDT discussions and working with colleagues;
- Follow-up action on the patient care (for example, ordering diagnosis/onward referral to other specialties (oncology etc.).
- Actions taken by the consultant as a result of Multidisciplinary Team (MDT) Meeting recommendations
- Completeness of patient records in connection to the patients episodes of care;
- Identifying instances where harm may have occurred – if so whether this was serious or moderate harm;
- Identifying if any harm that has occurred is such that might be expected from any consultant surgeon working in similar circumstances;
- Identifying patients that may require further follow up by the Trust.

Conclusions and recommendations

The review team will, where appropriate:

- Raise any immediate patient safety issues that are identified during the course of the engagement with the Medical Director of Southern Health and Social Care Trust
- Form conclusions as to the standard of care provided and whether there is a basis for concern in light of the findings of the review.
- May make recommendations for the consideration to the Medical Director of Southern Health and Social Care Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

The above terms of reference were agreed by the College, the healthcare organisation and the review team on 12 April 2021.

¹ It was noted by the review team that they were provided clinical records that extend beyond the timeframe stated.

3. Conclusions

The following conclusions are based on the information provided to the review team from the clinical records reviewed and any other supplementary information provided. These are overall conclusions based on the cases provided and focused on highlighting areas of concern or improvement.

It should be noted that this section highlights a number of conclusions and comments and provides a summary of these. Further and more specific details in respect of the review team comments and conclusions are included in [Appendix A](#) under each case.

There were 4 clinical records which indicated that Surgeon 1 was not involved in any part of the patients' clinical journey, therefore, the review team did not review these patients' records any further and no detailed comments were provided for the following:

- i. In **Case A18**, the review team found only two entries in the patient's record in relation to urology.
- ii. In **Case A60**, Surgeon 1's name only appeared in the patient's waiting list card and there was very limited information provided to draw any further conclusions on the care of the patient.
- iii. The review team noted that in **Case A61**, there was only one record relevant to Surgeon 1 and the subsequent presentation and patient management were not relevant to this review. The review team regarded that there was sparse information available regarding the clinic visit, however, the limited information provided suggested that appropriate management took place.
- iv. The review team were unable to comment on the patient's standard of care in **Case A100** due to lack of information provided for review.

3.1. Assessment including history taking, examination and diagnosis

The review team considered that this aspect of patient care was acceptable in the majority of the cases reviewed and it appeared that the appropriate assessment checks had been undertaken for 80 cases.

The review team concluded that there were, in some of the cases, areas which indicated that there was room for improvement. The review team made the following observations regarding the following cases:

- a) In **Case A42**, it was noted by the review team that the patient's history was not fully documented in their record. The patient's notes only mentioned their urinary symptoms and the digital rectal exam (DRE²) undertaken.
- b) In **Cases A64** and **A65**, it was documented that Surgeon 1 managed the patients' initial referrals. The review team considered that the assessment records for both cases were brief and did not include the patients' family history and the fact that the patients were smokers.
- c) In **Case A82**, the review team found that the assessment notes did not include a record of the examination undertaken and therefore, it was difficult to fully comment on whether the patient had been adequately assessed.

² A digital rectal examination (DRE) is a test that examines a person's lower rectum, pelvis, and lower belly. This test can help your doctor check for cancer and other health problems, including prostate cancer in men.

From the cases reviewed, the review team identified 6 cases where the patient's assessment was deemed unacceptable and as a consequence, the patient's standard of care was of significant concern. The review team's conclusions for those cases are covered at [Appendix A](#) of the report.

The review team made the following observations regarding the following cases:

- d) In **Cases A3 and A13**, it was difficult for the review team to consider whether these patients were adequately assessed due to lack of information, however, from the inpatient and outpatient notes available for review, the review team concluded that the assessment was unsatisfactory.
- e) In **Case A63**, it was concerning to the review team that the patient was initially assessed as not suitable for radiotherapy (RT) as their prostate was considered to be too large. In the opinion of the review team, this was not the correct decision, unless the patient had been considered for brachytherapy alone. The review team highlighted their concern that the patient had sustained significant comorbidities by the time they were referred for haematuria.
- f) In **Case A83**, the review team found it unacceptable that there was no record of any prostate assessment by way of a DRE and that the patient's PSA³ was not documented in their clinical record.
- g) In **Case A85**, it was noted by the review team that there was no detailed record of the patient's history, physical examination or a simple assessment of lower urinary tract symptoms (LUTS) bother undertaken. The patient's urinary tract infection (UTI) and orchitis⁴ were also not mentioned in their records.
- h) In **Case A86**, the review team found no detailed record of any examination of the patient.

3.2. Investigations and imaging undertaken

The review team found that this aspect of patient care was acceptable in the majority of the cases reviewed and it appeared that the appropriate investigations and imaging had been undertaken for 83 cases, which were considered to be suitable to the patients' needs.

The review team were not able to draw any conclusions on the investigations undertaken on two specific cases⁵ based on the limited information and lack of imaging provided. However, the review team considered that from the documentation that was made available, the management of these patients appeared satisfactory.

The review team did not consider investigations and imaging to be applicable on two specific cases⁶, therefore, no comments were made regarding these areas.

The review team made the following observations with regard to the cases⁷ reviewed which were identified as either unacceptable or requiring improvement and, as a consequence, the patient's standard of care was of concern:

- i. In **Case A4**, the review team considered it unacceptable that there were delays in the investigation of the patient, although, it was not directly attributed to the urology team. It

³ The PSA test is a blood test used primarily to screen for prostate cancer. The test measures the amount of prostate-specific antigen (PSA) in your blood. PSA is a protein produced by both cancerous and noncancerous tissue in the prostate, a small gland that sits below the bladder in males.

⁴ A condition characterised by inflammation of one or both the testicles.

⁵ Cases A19 and A20

⁶ Cases A78 and A88

⁷ Cases A4, A24, A42, A72, A82, A85 and A86

was unclear to the review team why a DMSA⁸ scan was required as the patient's renal function was considered normal at the time of the assessment. It was noted by the review team that the eGFR⁹ information relating to this decision was not provided in the clinical record, only a CT scan indicating a normal contralateral kidney was included.

- ii. In **Case A42**, the review team questioned that whilst an ultrasound (US) scan and PSA¹⁰ tests were undertaken, these were not subsequently acted upon. There was no information available to account for the lack of action following the results being received.
- iii. In **Case A72**, it was of concern to the review team that there were delays in undertaking scans for this patient and there were no reasons indicated in the clinical record to account for these delays.
- iv. In **Case A82**, it was noted by the review team that there was no record of examinations undertaken for this patient, making it difficult to ascertain the adequacy of the investigation in this case.
- v. In **Case A85**, it was the review team's view that the patient's bladder function should have been investigated at an early stage as it would have provided substantial information regarding the patient's bladder management.
- vi. In **Case A86**, it was of concern to the review team to find no record of any examination undertaken with this patient before transurethral resection of the prostate (TURP) was decided. In the review team's view, the patient's PSA had risen in the past, and so another investigation of the PSA should have been considered prior to TURP.

3.3. Treatment including clinical decision-making, case-selection, operation or procedures and prescribing practices

The review team considered that clinical decision making and the treatment provided was acceptable in 69 of the cases reviewed. The review team considered that the treatment undertaken in these cases had been appropriate and noted the positive outcomes for the patients.

From the clinical records reviewed, there were 5 cases¹¹ where the review team noted that the patients appeared to not have had any surgical intervention or treatment undertaken. Therefore, the review team made no further comments in respect of these cases.

The review team considered that, in 17 of the cases¹² reviewed, there were areas in which the notes indicated that there was room for improvement:

- 1) In **Case A4**, the patient was reviewed by the urology team in June 2015 and was not operated on until two months later, in August 2015. It appeared that the surgery was delayed due to a cardiac investigation, a delay which the review team regarded as unsatisfactory.
- 2) In **Case A14**, the review team considered that the clinical decision for the patient to have Botox was inappropriate. The review team were of the opinion that Botox should only have been given if there was no improvement following TURP.
- 3) In **Case A15**, although the review team acknowledged that the patient's treatment was effective (in prescribing Bicalutamide), they noted that a more common treatment for

⁸ A DMSA scan is a radionuclide scan that uses dimercaptosuccinic acid (DMSA) in assessing renal morphology, structure and function.

⁹ eGFR or estimated glomerular filtration rate measures kidney function. A GFR measurement is the gold standard in detecting changes in kidney status but it is a complicated procedure. Therefore, an eGFR is often used instead. The measurement is based on blood creatinine levels.

¹⁰ The PSA test is a blood test used primarily to screen for prostate cancer. The test measures the amount of prostate-specific antigen (PSA) in your blood. PSA is a protein produced by both cancerous and noncancerous tissue in the prostate, a small gland that sits below the bladder in males.

¹¹ Cases A78, A79, A88, A96 and A97

¹² Cases A3, A4, A14, A15, A24, A46, A49, A54, A64, A65, A76, A82, A85, A86, A89, A98 and A99

Gleason Score 7 non-metastatic prostate cancer would have been a luteinising hormone-releasing hormone (LHRH) analogue.

- 4) In **Case A49**, when another surgeon took over the patient's care, the review team questioned why radical cystectomy was not considered in 2015 and whether treating the patient with Mitomycin C intravesically was due to a known world shortage of Bacillus Calmette-Guerin (BCG) during that period of care.
- 5) In **Case A64**, the review team considered it unnecessary for the patient to have undergone a repeat flexible cystoscopy instead of reporting if their urinary flow had worsened. In the review team's view, this would have been less invasive for a patient with LUTS that did not appeared to have been bothersome.
- 6) In **Case A65**, in the review team's opinion, Surgeon 1's decision to undertake a repeat flexible cystoscopy in three months to see if a stricture had recurred, was unnecessary, as the patient could have been told to report if their urinary flow was getting worse. This would have been less invasive than a second flexible cystoscopy, prevented more urethral trauma and was a more appropriate management for a patient whose LUTS reportedly did not bother him unduly.
- 7) In **Case A82**, although the review team considered that the treatment was reasonable, in their opinion it would have been preferable to increase the dose of Sildenafil rather than prescribing the patient Tadalafil in addition to the ongoing Tamsulosin and Sildenafil.
- 8) In **Case A85**, it was of concern to the review team that the planned urodynamics¹³ testing for this patient was cancelled. In the review team's view, knowing the bladder function at this stage would have provided valuable information for future advice and bladder management.
- 9) In **Case A89**, the review team considered that the patient's prophylactic antibiotics medication was continued in 2017 despite several negative mid-stream urine (MSU) sample results. However, the review team recognised that Surgeon 1 accounted for this in his clinic letter written in December 2019.
- 10) In **Case A98**, the review team were of the opinion that Nephrology intervention would have benefited the patient at an earlier stage. The review team also highlighted that the dosage of Vardenafil prescribed by Surgeon 1 should have been 20 mgs instead of 50mgs.
- 11) In **Case A99**, the review team considered that it was an unusual decision to use a three month course of Nitrofurantoin to cover the extracorporeal shock wave lithotripsy (ESWL) treatment.

The treatment of patients in 5 cases¹⁴ in respect of clinical decision making, surgical procedures and prescribing practices were of significant concern and considered not to be appropriate by the review team. The review team provided the following comments in this respect:

- 12) In **Case A13**, the review team were unclear whether the Bicalutamide medication was the cause of the interstitial lung disease as it was a rare complication of Bicalutamide use. Furthermore, the review team questioned why a simultaneous TURP was also carried out when the transurethral resection of a bladder tumour (TURBT¹⁵) was performed, as there was no indication given in the clinical record.
- 13) In **Case A28**, despite the patient being first seen on 31 January 2015, the flexible cystoscopy was not undertaken until 10 April 2015, over two months later. Whilst a plan appeared to be in place after the initial appointment, the reason for the two month delay was unclear to the review team. They considered whether there was a possibility that this unexplainable delay contributed to the poor clinical outcome in this case.

¹³ Urodynamic testing is any procedure that looks at how well the bladder, sphincters, and urethra are storing and releasing urine. Most urodynamic tests focus on the bladder's ability to hold urine and empty steadily and completely.

¹⁴ Cases A13, A28, A29, A63 and A90.

¹⁵ Transurethral resection of bladder tumour (TURBT) is a medical procedure that is used to remove tumours from the inner surface of the bladder wall.

- 14) In **Case A29**, it was of significant concern to the review team that there was a delay in undergoing the planned surgery between February and December 2014, by which time the patient's disease had progressed from superficial to muscle invasive cancer, of which the patient subsequently sadly died. Due to this delay, it was the review team's opinion that this patient had experienced significant harm.
- 15) In **Case A63**, the review team noted that the flexible cystoscopy was performed with no evidence of a CTU¹⁶ being requested. It would appear that Surgeon 1 recorded that urodynamics showed bladder outlet obstruction (BOO), however, in the review team's opinion, this was ambiguous as the patient's Pdet@Qmax¹⁷ was only 33 cms H2O. Furthermore, the review team were concerned that Surgeon 1 prescribed Oxybutynin for LUTS which was not an appropriate choice of medication for a patient with Parkinson's disease.
- 16) In **Case A90**, the review team were strongly of the opinion that the treatment of this patient was unacceptable, given that the patient was on a waiting list for surgical procedures for five years. This prompted the review team to consider whether it was possible that he had not been initially entered onto the waiting list, and if this contributed to the delay in his care and treatment.

3.4. Evidence of compliance with best clinical practice guidance available at the time of care given, including NICE guidance

The review team concluded that it was not possible to make detailed comments relating to this area for most of the cases reviewed due to the very limited information provided.

However from the limited information provided the review team considered that this aspect of patient care appeared to have been acceptable in the majority of the cases reviewed and they did not identify any major concerns in respect of compliance with national standards.

The review team identified some areas for improvement in a small number of the cases as follows:

- a) In **Case A8**, whilst the review team considered that the steps taken up until the patient's surgical procedure were appropriate, the absence of any records on the NIECR¹⁸ was of concern.
- b) In **Case A28**, the review team noted that the clinical decisions made during MDT meetings were not carried out, although the review team considered that this may have been due to administrative errors rather than individual practice of the surgeons involved. Furthermore, the patient was informed in writing of a flexible cystoscopy arranged, the day before the procedure was scheduled. It was concerning to the review team that there was no safeguards in place to identify priority clinical decisions that required escalations, which would have prevented such delay from having occurred.
- c) In **Case A29**, it was of concern to the review team that they found the MDT records lacking certain information, such as the patient undergoing a flexible cystoscopy in February 2014 and his placement on the waiting list for a GA cystoscopy¹⁹. It prompted the review team to question the sufficiency of waiting list processes. The review team considered, when the patient was listed for the GA cystoscopy what priority was given to this procedure and how waiting lists were monitored, and what the criteria was for assigning priority to operations.

¹⁶ CT Urography is a sophisticated radiological examination designed to evaluate the urinary tract (kidneys, ureters and bladder) using computed tomography (CT). CT urography or CT-IVU has now largely replaced traditional IVU in imaging the genitourinary tract. It gives both anatomical and functional information, albeit with a relatively higher dose of radiation.

¹⁷ The detrusor pressure reached during maximum urinary flow (PdetQmax) is a crucial measurement in the assessment of bladder function during pressure-flow studies.

¹⁸ The Northern Ireland Electronic Care Record (**NIECR**) is a computer system that health and social care staff can use to get information about your medical history.

¹⁹ Rigid cystoscopy under general anaesthetic

The review team considered whether procedures went onto waiting lists for individual surgeons, or shared lists for all surgeons working within the urological service.

3.5. Communication with the patient, their family and general practitioner(s), and patient consent

The review team considered that communication with the patient, their family and/or carers was acceptable in 54 of the cases reviewed.

There were a small number of cases²⁰ where patient consent was not applicable as no surgical procedures were performed on those patients. Therefore, the review team did not make any detailed comment regarding this specific terms of reference on those cases.

The review team noted that in some cases²¹, documentation of patient consent for the surgery was not seen and it was not possible to ascertain if it had been documented and not provided for this review or if it had not been documented.

The process of obtaining consent observed in this sample of cases was of significant concern to the review team, with a number not having a documented consent process to the standard that would be expected by the review team. It was very concerning to the review team to see examples where not all reasonable options had been discussed with patients, and examples where the implications of treatment had not been explained, or at least these were not documented to an acceptable standard.

The review team made the following observations on these particular cases:

- I. In **Case A3**, the review team noted that there was no evidence of patient discussion regarding fertility, future parenthood, sperm banking and prosthesis, pre-operatively (although prosthesis insertion was discussed post-operatively and was declined by the patient).
- II. In **Case A8**, although there were some notes recorded by Surgeon 1 of clinic visits which took place in March and April 2015, these were not followed up by correspondence with the patient's GP. Furthermore, the review team were uncertain how well informed the patient was of any possible complications prior to the surgical procedure.
- III. In **Case A9**, the review team regarded that the patient was not made aware of the possibility of incontinence as complication of TURP, when the consent was obtained.
- IV. In **Case A13**, the review team considered that the consent form had insufficient information relating to the TURP and TURBT and only Surgeon 1 and the patient's signature were included.
- V. In **Case A14**, the review team noted that patient consent was taken for the flexible cystoscopy. However, the consent form only contained the signatures of the doctor and the patient.
- VI. In **Case A15**, it was of concern to the review team that there was nothing to indicate that the risk of complications were explained to the patient. It was also noted by the review team that there was no information to indicate that the patient was offered a choice in terms of treatment. Furthermore, there were delays in corresponding with the patient's GP following either a clinical visit or the patient not attending an appointment.
- VII. In **Case A22**, in the review team's view, the consent form provided for the flexible cystoscopy before the TURBT was inadequate, as the form omitted to outline the procedure and only contained the patient's signature.
- VIII. In **Case A24**, although there was a consent form for the TURP undertaken in March 2010, the review team found that it was illegible. The review team noted that there was no

²⁰ Cases A41, A79, A82 and A97

²¹ Cases A10, A16, A19, A23, A26, A28, A45, A46, A49, A59, A63, A90 and A98

consent form for the flexible cystoscopy performed in June 2015. Furthermore, the consent form recorded by Surgeon 1 in September 2015 stated TURBT as the procedure, however, it did not mention the benefits and risks of the operation and why this operation had been suggested.

- IX. In **Case A26**, the review team did not find any evidence of discussions with the patient and consent was only provided for two cases: the flexible cystoscopy (01 September 2017) where the patient had not dated the consent form and the TURBT on 21 August 2015, where the intended benefits were not recorded. There also were no consent forms available for the procedures specifically where Surgeon 1 operated on the patient.
- X. In **Case A28**, it was concerning to the review team that the patient was seen at an outpatient's appointment in January 2015 (which was likely to have been a private sector appointment, although this could not be confirmed) and this was not followed up until a letter was sent to the patient's home address on 09 April 2015, which informed her of the flexible cystoscopy being arranged for the following day (10 April 2015).
- XI. In **Case A37**, the review team found that the consent form, prior to cystoscopy and Botox injection, did not list the possible complications of urinary retention and the inability to pass urine.
- XII. In **Case A46**, the review team noted that discussions with the patient and their family were not fully documented and lacked detail in the clinical records.
- XIII. In **Case A57**, the review team noted that Surgeon 1 had not mentioned the complications and risks on the consent form relating to the flexible cystoscopy in May 2015.
- XIV. In **Case A58**, although the patient was informed that recurrence of the problem was a recognised complication, the consent form omitted to list possible further complications from the surgery.
- XV. In **Case A62**, the review team found that the consent for the flexible cystoscopy (from 30 June 2016) only contained the doctor's signature and there was no patient signature on the form.
- XVI. In **Cases A64** and **A65**, the review team highlighted that patient consent in both cases were obtained by a specialist nurse rather than Surgeon 1 and the forms were also undated.
- XVII. In **Case A66**, the review team considered that there was no information of any discussion with the patient, nor a record of potential problems with the prescribed medication discussed with them. Furthermore, in the review team's opinion, the consent forms were deemed unacceptable, as what had been provided was insufficient to represent adequate consent for a flexible cystoscopy.
- XVIII. In **Case A68**, the review team regarded that the consent form for the first flexible cystoscopy in May 2015 did not record the intended benefits and there was also no evidence that the serious or frequently occurring risks were explained to the patient.
- XIX. In **Case A83**, it was concerning to the review team that there was no history of advice or discussion with the patient on the treatment provided. In the review team's opinion, there should have been advice provided to the patient about their lifestyle as the records only detailed that they went straight to drug treatment and that no operation was needed.
- XX. In **Case A86**, the review team did not find any documented patient discussion of treatment options other than the TURP. The review team considered that the consent for TURP was generally adequate, however, it should have been signed by surgeon as well as a record of discussion with the patient.
- XXI. In **Case A95**, the review team were concerned that the consent form obtained in 2019 had no description of harm or potential harm documented.
- XXII. In **Case A95**, the review team noted that whilst the patient had a consultation in September 2015, the letter was not written until December 2016, some 15 months later, which delayed communication with the patient's GP.

3.6. Team working including communication with other members of the care team, MDT discussions and working with colleagues

The review team considered that team working including communication with other members of the care team, MDT discussions and working with colleagues was acceptable in 76 of the cases reviewed.

There were a small number of cases²² where team working including communication with other members of the care team, MDT discussions and working with colleagues was not applicable. Therefore, the review team did not make any detailed comment regarding this specific terms of reference on those cases.

The review team were not able to draw any conclusions on the care of the patients in **Cases A20, A90 and A94** based on the limited information provided in relation to this specific terms of reference.

The review team considered there to be examples of inadequate team working and MDT communication in some cases. The review team noted that MDT discussion was not documented in some of them so it was unclear if this had taken place or had taken place but was not documented. In the opinion of the review team, team working and MDT communication in these cases were considered as requiring improvement or unacceptable and, as a consequence, the patient's standard of care was of concern. The review team's detailed conclusions for each of these cases are covered at [Appendix A](#) of the report.

The review team made the following observations on some of these particular cases:

- a. In **Case A3**, the review team were unable to determine if the documented MDT discussion was at a urology specialist MDT, as it should have been, and if so, why issues like sperm banking had not been discussed.
- b. In **Case A4**, the review team were unclear why, at the MDT discussion, for which Surgeon 1 was present and chaired the meeting, a decision for open partial nephrectomy (PN) had been taken, rather than consideration of the appropriateness of laparoscopic surgery. It was not clear to the review team, from the MDT records provided, whether there was laparoscopic PN experience available locally, or if an opinion was sought elsewhere. It was unclear to the review team if the case had been discussed at a urology specialist MDT (as it should have) or just the local MDT.
- c. In **Case A26**, it was not known to the review team whether the patient's case was discussed at a regional MDT.
- d. In **Case A28**, the review team questioned whether there were sufficient safeguards in place to monitor clinical decisions made at MDT meetings and to ensure that recommendations were appropriately carried out. In this particular case, 6 Mitomycin C instillations were arranged following an MDT meeting, two of these were correctly given to the patient, however, this was recorded incorrectly by the nursing staff.
- e. In **Case A29**, it was of concern to the review team that there were omissions from the MDT reports for this patient which did not mention the patient undergoing a flexible cystoscopy in February 2014 and his placement on the waiting list for a GA cystoscopy. The review team highlighted that Surgeon 1 appeared to have chaired the meeting in April 2015.
- f. In **Case A31**, given the progression of the patient's cancer, the review team had concerns regarding some of the recommendations made during MDT meetings and their consequent impact on the patient's care and treatment. Specifically, the review team questioned the recommendation of continuing the BCG treatment after 2013, when it was identified that the cancer was recurrent. Furthermore, the review team was concerned that the decision

²² Cases A41, A69, A79, A80, A82 and A83

to undertake a cystectomy was not discussed at an earlier stage, given the progression of the cancer, and the procedure was not performed until 2015, which was too late.

- g. In **Case A63**, the review team noted that Surgeon 1 prescribed the patient with Bicalutamide monotherapy which did not appear to have been discussed at MDT. In addition, the review team considered that the patient had significant comorbidities and they should have been referred to clinical oncology or discussed at the specialist urology MDT. It was also unclear from the records whether the new consultant urologist considered radiotherapy (RT).
- h. In **Case A90**, the review team were concerned that there were no MDT meetings where this patient's care appeared to have been discussed.
- i. In **Case A98**, the review team were unable to comment on the actions taken as a result of the MDT meeting and whether the recommendations were appropriate as there were no MDT records provided for this case. The review team speculated that there might have been a 'Stone MDT'²³ however, there was no information to verify if this was the case.

3.7. Follow-up action on the patient care

The review team considered that follow-up action on the patient care had been acceptable in the majority of the cases reviewed.

It was noted by the review team that there were 5 cases²⁴ where follow up action on the patients' care was not applicable. Therefore, the review team did not make any detailed comment regarding this specific terms of reference on those cases.

The review team identified some areas for improvement in a number of the cases as follows:

- 1. In **Case A22**, the review team were unclear why the patient was discharged after a relatively short follow up.
- 2. In **Case A25**, although the patient did not attend (DNA) an outpatients department (OPD) appointment in October 2014, in the review team's view, a reappointment should have been arranged considering the patient's subsequent medical history.
- 3. In **Case A36**, there was no record of the follow up conducted in 2021 for this patient.
- 4. In **Case A54**, the review team were concerned to note that there was considerable delay with the patient's follow up care from June 2015 to 2017.
- 5. In **Case A72**, the review team noted that there were delays in follow up prior to the patient being referred to the Enuresis service. It was unclear to the review team what caused these delays.
- 6. In **Case A75**, it was of concern to the review team that there was no indication that follow up occurred, although the patient appeared to have been seen by other services. It was documented that the patient was seen in 2015 and at a follow up appointment in 2017. It was unclear to the review team why there was no indication to suggest that the patient was seen in urology during their follow up.
- 7. In **Case A76**, the review team considered that the patient was not followed up initially and there was no prescribed medication confirmed in their clinical record.
- 8. In **Case A83**, the review team were unclear on whether the patient had been lost to follow up and had not been asked to return to OPD or whether they had failed to re-attend their appointment.
- 9. In **Case A84**, the review team had no information regarding further OPD review after 11 June 2018.

²³ Stone MDT is an MDT dealing with patients who have urinary tract stones. Many larger hospitals have MDT meetings where difficult cases such as renal stone disease are discussed.

²⁴ Cases A78, A79, A80, A82 and A97

10. In **Case A92**, the review team were deeply concerned with the delays in follow up that spanned between 2015, 2017 and 2021. The reasons for the severe delays were unclear to the review team.

From the cases reviewed, the review team found 7 cases²⁵ where follow up action was considered unacceptable and as a consequence the patient's standard of care was of concern. The review team made the following observations with regard to these cases reviewed:

11. In **Case A13**, it was unclear to the review team whether the patient had any follow ups at three different stages of their clinical journey which was of significant concern considering their medical history.
12. In **Case A29**, it was the review team's opinion that the patient received poor follow up action considering the severe delay in their planned surgery which took several months to undertake.
13. In **Case A55**, the review team were deeply concerned that there was a two year delay between the patient's diagnosis to their surgery.
14. In **Case A58**, the review team considered that clinical follow up with the patient was required to review her original cancer diagnosis and the status of the stoma.
15. In **Case A82**, it was of concern to the review team that there had been large gaps in the patient's follow up although the reasons for these were not known.
16. In **Case A85**, the review team were concerned that there was no consideration for further, long-term clinical follow up of this patient who was known to have abnormally large bladder capacity.
17. In **Case A86**, in the review team's view, there should have been a planned clinical follow up with the patient, with urology or a urology nurse specialist, given the diagnosis of low risk and low volume prostate cancer.

3.8. Actions taken by the consultant as a result of Multidisciplinary Team (MDT) Meeting recommendations

The review team concluded that there were, in some of the cases, areas in which the notes indicated that the subsequent actions taken as a result of MDT meetings left room for improvement. Some of these were mentioned in [Section 3.6](#).

The review team highlighted the following in support of this conclusion:

- i. In **Case A4**, the review team questioned why laparoscopic surgery was not considered at the MDT meeting which was chaired by Surgeon 1. In the review team's opinion, this would have been the appropriate treatment for this patient although the review team were unsure if a second opinion was sought.
- ii. In **Case A28**, the review team considered that the recommendations made at MDT meetings for this case were appropriate. However, the actions involving the Mitomycin C installations were unsatisfactory. In addition, the patient was scheduled to undertake flexible cystoscopy but was not informed of this plan until the day before the surgery. Although the reasons for the delay was unclear, the review team queried if there were safeguards in place to identify priority clinical decisions made at MDT meetings which needed to be escalated.
- iii. In **Case A63**, it was of concern to the review team that during the MDT of 08 June 2017, it was advised that medication options should be discussed with the patient, however, there was no evidence that was done by Surgeon 1 at the outpatient clinic on 17 July 2017. Furthermore, the patient medication was initiated by Surgeon 1 with Bicalutamide monotherapy, however, there was no evidence that this had been discussed with the patient. It also appeared that there was no consent form for the

²⁵ Cases A13, A29, A55, A58, A82, A85 and A86

TURP whilst the consent for the flexible cystoscopy was signed by a specialist nurse and not Surgeon 1 who had performed the procedure.

3.9. Completeness of patient records in connection to the patients episodes of care

The review team considered that the documentation from initial consultation, surgical procedure to discharge was acceptable in the majority of the cases reviewed and it appeared that the appropriate information had been included in the clinical record for 58 cases.

In some of the cases, the standard of record-keeping in the clinical records reviewed was below the standard expected. The pre-operative correspondence and documentation was inadequate in some of the cases and the review team were concerned that this could indicate insufficient time spent preparing patients for major, and sometimes life-changing, operations.

In a number of the records, the operation note was brief or difficult to read. Some patient records appeared to be incomplete and particularly lacking detailed information on the examinations undertaken and the impacts of treatment options and aftercare requirements.

The review team made the following observations in regards to these particular cases:

1. In **Case A3**, the review team considered that the operation note was brief, with no mention of incision, findings or post-operative instructions.
2. In **Case A4**, the review team noted that the out-patient department and the post-operative notes were not detailed and lacked sufficient information.
3. In **Case A8**, the absence of any records on the NIECR was of concern to the review team. Although there were some notes recorded by Surgeon 1 of clinic visits which took place in March and April 2015, it did not appear that these visits were appropriately followed up by correspondence with the patient's GP.
4. In **Case A10**, the review team noted that there was no operation note for the TURP surgery in 2002 and consent forms were not included for both procedures undertaken on the patient in 2002 and 2015. It was unclear whether consent was obtained prior to surgery or whether the forms were not filed in the patient's record.
5. In **Case A13**, in the opinion of the review team, there was inadequate consent for the TURP and TURBT procedures and the operation notes were brief.
6. In **Case A14**, the review team found there was no record of any MDT discussion following the TURP on 29 April 2015.
7. In **Case A15**, it was of concern to the review team that there were occasions where subsequent correspondence was either missing or there was a significant delay in it being sent to the patient's GP following either a clinical visit or the patient not attending an appointment. The review team considered whether these were recurring issues within the electronic patient record system, and whether there were sufficient safeguards for administrative staff to identify and escalate missing correspondence.
8. In **Case A16**, the review team noted that, within the electronic records made available, there did not appear to be a consent form obtained from the patient. Furthermore, the review team noted that in a letter dated 9 January 2017, there was reference to the patient having last been seen in January 2016, however, within the documentation provided to the review team, there was no subsequent letter to follow up such a visit. This was of concern to the review team, and they considered whether there were safeguards in place to monitor decisions, and to identify and escalate such missing correspondence from outpatient clinics.
9. In **Case A22**, in the review team's view, the consent form provided for the flexible cystoscopy pre-TURBT omitted to outline the procedure and only contained the patient's signature. Furthermore, the operation note did not mark the location of the tumour on the bladder map.

10. In **Case A23**, the review team were unable to comment on the consent or appropriateness of the operation notes for the surgery performed by Surgeon 1 as they were not provided within the patient's clinical record. Furthermore, there was no record of the extent of pre-operative counselling that the patient may have received prior to their radical cystectomy.
11. In **Case A28**, the review team noted that 6 Mitomycin C instillations were appropriately arranged after an MDT meeting, and that whilst two of these were correctly given to the patient, this was recorded incorrectly by the nursing staff.
12. In **Case A29**, it was of concern to the review team to find that there were omissions within the records of the MDT meetings where this case was discussed, specifically, there was no mention of the flexible cystoscopy undertaken in February 2014. Furthermore, the review team questioned the adequacy of clinical correspondence, following clinical decisions being made, and whether they were checked and followed up to ensure actions were carried out.
13. In **Case A32**, the review team were concerned that there was a delay in documenting the patient's clinical journey until information was summarised in a letter dated 11 March 2016 and again in a letter dated 05 April 2019. The assessment and investigations undertaken in 2015 were not documented until nearly a year later.
14. In **Case A42**, the review team noted that there was little history of the patient's case documented.
15. In **Case A44**, the review team were concerned that there were brief notes from the out-patient reviews which did not cover what discussions were held with the patient or the decision making process. The review team particularly noted that records were poor, as there were no operation or consent forms included in the patient's clinical records.
16. In **Case A46**, the review team noted that discussions with the patient and their family lacked detail in the records and there was no consent information provided. In addition, the operation notes for the TURP conducted in June 2016 were very brief.
17. In **Case A47**, a clinic letter dated 21 July 2017 referred to seeing the patient in February 2015 and April 2016, however there were no records of correspondence during those time periods included in the patient's clinical record.
18. In **Case A64**, during the initial referral managed by Surgeon 1, the review team found the assessment records were brief and omitted factors such as smoking and family history. The review team also considered that the operation notes did not note a distal penile urethral stricture and obstructive prostate nor mention the dilation (that was performed) or bladder (which was the focus of the investigation).
19. In **Case A65**, the review team considered that the patient history notes were brief and did not include factors such as smoking and family history. The review team also noted that the operating notes did not record all findings and did not mention the bladder, which was the focus of the investigation.
20. In **Case A66**, the review team found the clinical record lacked sufficient details as there was no information of discussion with the patient, nor a record of potential problems with the prescribed medication. The consent forms were deemed unacceptable by the review team as what had been provided was insufficient to represent appropriate consent for a flexible cystoscopy.
21. In **Case A76**, there was no letter included in the patient's record pertaining to their admission in 2015 and there was no medication confirmed in their clinical record, which the review team found to be inadequate.
22. In **Case A82**, the review team found that the assessment notes did not provide a record of the examination. In addition, the review team noted that there had been follow up with the patient planned but the clinical records ended in June 2021.
23. In **Case A84**, the review team found that there had been no discussion with the patient noted until June 2018 despite being assessed several times in the previous years and no information regarding further OPD review was documented after June 2018.
24. In **Case A91**, the review team noted several examples of clinical appointments which were referred to in subsequent correspondence, however these appointments had not been followed up with letters in a timely manner or, on some occasions, at all.

25. In **Case A94**, the review team were unclear what occurred after the patient was seen by Surgeon 1 in August 2015 and the clinic letter was missing from the patient's clinical record.
26. In **Case A98**, the review team found that some of the consent forms were either missing or incomplete.
27. In **Case A99**, the review team noted that after the patient was seen on 01 December 2015 the follow up letter was not dictated until 17 December 2015. The handwritten records made available to the review team were also of poor quality with multiple blank sheets included.
28. In **Case 100**, the review team considered that there was no clinic letters included in the patient's record, nor was there any follow up documented in the patient's notes.

From the clinical records reviewed, the review team identified 9 cases²⁶ where the standard of documentation and record keeping was considered unacceptable and as a consequence the patient's standard of care was of concern. The review team's detailed conclusions for those cases are covered in [Appendix A](#) of the report.

The review team highlighted a number of significant points in respect of the clinical records reviewed, including:

29. In **Case A24**, the review team noted that the outpatient records lacked details of what the patient was advised, and inadequate consent was obtained by Surgeon 1.
30. In **Case A48**, it was noted by the review team that the patient was seen on 19 February 2016, however a follow up letter from this visit was not recorded until 07 December 2016, which the review team considered to be unacceptable record keeping.
31. In **Case A63**, the review team identified that the MDT discussion of 20 April 2017, which was chaired by Surgeon 1, recorded the prostate biopsy histology incorrectly. Furthermore, there was no information provided on patient consent for TURP.
32. In **Case A69**, the review team were concerned that whilst the patient was seen on 05 May 2015, the subsequent letter to her GP was not sent until 22 April 2016, almost a year later.
33. In **Case A70**, the review team noted that the patient was seen and assessed on 10 March 2015, however, the subsequent letter to the patient was not sent until 29 December 2016, and to the patient's GP until 04 January 2017, eleven months later.
34. In **Case A83**, it was of concern to the review team that there was no history of advice or discussion with the patient on the treatment provided. There was also no record of any prostate assessment by DRE and no PSA was recorded.
35. In **Case A85**, there was no proper record of the patient's history, physical examination or a simple assessment of LUTS bother (e.g. mild/moderate/severe) which was unacceptable to the review team. When the patient was seen again in July 2017, there also was no mention of UTI/orchitis from July/August 2015 in their clinical record.
36. In **Case A86**, it was of significant concern to the review team that the only OPD record available was for the TURP and there was no detailed record of any examination of the patient or discussion of treatment options other than the TURP. The review team found it unacceptable that the record of the TURP pathway was unclear and inadequately recorded.
37. In **Case A90**, the review team were uncertain where waiting lists were held in the system, and considered whether it was possible that the patient was placed on the waiting list, or whether there were occasions when, despite being on that waiting list, he had been missed.

²⁶ Cases A24, A48, A63, A69, A70, A83, A85, A86 and A90

3.10. Identifying instances where harm may have occurred

The review team did not consider there to be significant concerns arising in respect of patient harm in 90 of the cases reviewed. It was the review team's view that clinical management of these patients was considered to be acceptable and had not led to any harm.

The review team highlighted some areas for improvement in a number of the cases²⁷ as follows:

- 1) In **Case A28**, it was acknowledged by the review team that management of this case was difficult for all involved. However, it caused great concern to the review team that the recommendations made at MDT meetings were recorded and carried out incorrectly. In addition, having seen the patient in January 2015, no follow up correspondence was written until April 2015, some three months later, where the patient was informed of the flexible cystoscopy arranged, giving them one days' notice of the surgery. The review team were unable to find the reason for this delay, and they considered that this significant interval may possibly have contributed to the poor clinical outcome in this case.
- 2) In **Case A31**, in the review team's opinion, the decision to undertake a cystectomy could have been taken at an earlier stage (as the patient was assessed to be fit for surgery in 2015), and the review team considered that this may have resulted in a better outcome for the patient. However, the review team noted the patient's cancer progressed in a recognised manner and the review team acknowledged that it was entirely possible that other urological surgeons would have managed the patient's care in the same manner.
- 3) In **Case A63**, the review team were uncertain whether the patient had come to any harm due to the number of errors in the patient's treatment as stated in [Section 3.3](#). The review team considered that an opportunity for RT treatment with curative intent was possibly missed in June 2017 and the patient should have been referred to clinical oncology for an opinion or discussed at the specialist urology MDT.
- 4) In **Case A65**, the review team considered Surgeon 1's decision to undertake repeat flexible cystoscopy to see if a stricture had recurred, to be unnecessary. In the review team's view, the patient could have been told to report if their urinary flow was getting worse. The review team considered that this would have been less invasive than a second flexible cystoscopy, it would have prevented more urethral trauma and was a more appropriate management for a patient whose LUTS was not bothersome.

The review team identified 3 cases where the quality and safety of the patients' care was deemed unacceptable and as a consequence these patients' standard of care was of concern. The review team made the following observations with regard to these cases:

- 5) In **Case A13**, it was unclear to the review team whether the patient's Bicalutamide medication was the cause of the interstitial lung disease that the patient developed. Furthermore, it was of serious concern to the review team that the patient appeared not to have had any follow up care following TURP and TURBT procedures being undertaken as well as specific follow up for their prostate cancer for several months prior to the patient's death.
- 6) In **Case A29**, it was of significant concern to the review team that there was a delay in undergoing the planned surgery between February and December 2014, by which time the patient's disease had progressed from superficial to muscle invasive cancer, of which the patient sadly subsequently died. It was the review team's opinion that this patient had experienced significant harm, due to this delay.
- 7) In **Case A55**, the review team concluded that moderate harm occurred in this case due to the prolonged patient symptoms for two years. The review team were deeply concerned

²⁷ Cases A28, A31, A63 and A65

that there was a two year delay between the patient's diagnosis to their surgery being undertaken.

3.11. Identifying if any harm that has occurred is such that might be expected from any consultant surgeon working in similar circumstances

Whilst the review team did not identify substantial concerns in the majority of the cases reviewed, they made the following comments:

- a.) In **Case A31**, the review team acknowledged that as the patient's cancer progressed as expected, it was entirely possible other urological surgeons would have managed the patient's care in the same manner.
- b.) In **Case A86**, it was concerning to the review team that the TURP was delayed for one year without any explanation as to why this happened. The review team also considered that a 5ARI²⁸ could have been added to any alpha blocker treatment and a further Trial without Catheter (TWOC²⁹) should have been arranged during the interim period.
- c.) In **Case A89**, the review team considered that, the use of a cystectomy for chronic interstitial cystitis/chronic pelvic pain was relatively rare, however, they acknowledged that this was utilised by other urologists. It was also noted by the review team that the patient's prophylactic antibiotics medication was continued in 2017 despite several negative mid-stream urine (MSU) sample results. Having said that, the review team recognised that Surgeon 1 accounted for this in his clinic letter written in December 2019.

3.12. Identifying patients that may require further follow up by the Trust

The review team considered that there were 7³⁰ cases in the sample they reviewed where there was a need for the patients to receive clinical follow-up to ensure their safety. The review team noted that some of these patients may have received clinical follow-up, or have follow-up planned, but considered it important to highlight potential patients requiring follow-up to ensure that none were overlooked. The review team's findings are detailed in their comments under each case in Appendix A.

The review team made a number of specific follow up comments regarding these cases:

- I. In **Case A58**, the review team recommended that clinical follow up with the patient was required to review her original cancer diagnosis and the status of the stoma.
- II. In **Case A63**, the review team recommended clinical follow up with the patient should continue for their prostate cancer.
- III. In **Case A83**, the review team considered that patient might require clinical follow up by urology team to see if they remained symptomatic and to check their PSA.
- IV. In **Case A84**, the review team considered that further clinical follow up was required to be satisfied that the patient treatment in 2019 had been effective and appropriate.
- V. In **Case A85**, the review team were concerned there was not a decision for further, long-term clinical follow up of this patient who was known to have abnormally large bladder capacity. Further clinical follow up with the patient was recommended to prevent future issues.

²⁸ 5 alpha-reductase inhibitor (5ARI) and alpha-blockers are one of the standard interventions in symptomatic benign prostatic hyperplasia (BPH) especially where the prostate is large.

²⁹ A Trial without Catheter (TWOC) is when the catheter (the tube inserted into the bladder to drain urine) is removed from the bladder for a trial period to determine whether the patient can pass urine without it. There will also be a scan of the patient's bladder as part of the trial.

³⁰ Cases A58, A63, A83, A84, A85, A86 & A98

- VI. In **Case A86**, the review team considered that there should be clinical follow up with the patient, with urology or a urology nurse specialist, given the diagnosis of low risk and low volume prostate cancer. In addition, the review team recommended follow up of the patient to see if their LUTS could be optimised and the ongoing nocturia investigated in case there was any underlying condition, such as nocturnal polyuria.
- VII. In **Case A98**, the review team recommended that clinical (medical and surgical) follow up of the patient was required because of the ongoing stone problems despite the medical treatment.

4. Recommendations

4.1. 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. The Trust should review the comments made in this report, alongside the local information it holds, and determine if the patient records contain the information they would expect for the patient episode(s). The Trust should ensure that the current practice meet the agreed standards as set out in the *RCS England Surgical Care Team Guidance Framework*³¹.
2. The Trust should consider the conclusions of this report, as well as the other information it holds, and on this basis, provide further follow-up of any patients for which it considers this to be required, in particular those patients identified in [Section 3.12](#) of this report. This should protect patient safety and ensure that patients or their families have received communication in line with the responsibilities set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009³².
3. The Trust should review the consent-taking practices within the urology service to ensure appropriate discussion of risks, complications, benefits and alternatives of treatment takes place and is legibly documented and signed by the surgeon and the patient. Clinical records should clearly detail the giving of information and the decisions made by the patient. It should ensure that consent practices are compliant with the Montgomery ruling³³.

The RCS England good practice guide³⁴ may be of assistance in this process.

4. In addition to recommendation 3, the Trust should review this sample of records and ensure that there was appropriate informed consent obtained for each procedure or operation.
5. The Trust should share this report with the wider urological team for the 96³⁵ cases reviewed and discuss its contents with them. They should be given the opportunity to reflect on the contents of the report and consider how they can learn from it.
6. The Trust should review the MDT arrangements within the urology service to ensure that there is appropriate MDT input into the decision-making for every patient. All MDT decisions and communication should be adequately documented in each patient's record.
7. It was unclear to the review team whether the MDT meetings that Surgeon 1 attended and chaired, were local urology MDT or specialist urology MDT. The Trust should ensure that complex cancer cases, especially those where major surgery are being considered,

³¹ <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/surgical-care-team-guidance/>

³² <https://www.legislation.gov.uk/nia/2009/1/contents?msclid=27a3d90eac5511ecaa04663a30c9797a>

³³ The 2015 Supreme Court decision on Montgomery vs NHS Lanarkshire <https://www.supremecourt.uk/cases/uksc-2013-0136.html>

³⁴ <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/consent/>

³⁵ Surgeon 1 was not involved in 4 of the cases reviewed.

should always be discussed at a specialist MDT. In the review team's opinion, these decisions should not be made on a purely local basis.

8. In addition to recommendations 6 and 7, the Trust should consider whether there are sufficient safeguards in place to monitor clinical decisions made at MDT meetings and to ensure that recommendations are appropriately carried out.
9. The Trust should consider whether there are sufficient safeguards in place within the electronic system to identify priority clinical decisions which needs escalation.
10. The Trust should review the adequacy of clinical correspondence following clinical decisions being made, and whether they are checked and followed up to ensure actions are subsequently carried out.
11. The Trust should review the sufficiency of waiting list processes, ensuring that waiting lists are monitored and ideally shared by all consultants who do the same procedures. In addition, the Trust should review what priority is given to certain procedures, who checks waiting lists, and what the criteria is for assigning priority to operations.
12. The Trust should ensure immediate recognition amongst management and clinicians that no patient should wait for longer than a pre-agreed period for surgery and follow up. The management of each case should be consistent with the surgeon's own standards for how they would like to be treated.

4.2. Recommendations for service improvement

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

13. The Trust should improve the quality of record keeping in clinical records. This should include but is not limited to:
 - (i) Information about patient's history, assessments and examinations;
 - (ii) Descriptions of imaging investigations and reports during pre and post operations;
 - (iii) More detail in clinic notes and letters, which should document the reasoning and evidence for clinical decisions. This should include details of MDT discussions;
 - (iv) Descriptions of discussions with patients regarding diagnosis, options for treatment, risks of treatments and of non-treatment;
 - (v) More detailed information in operation notes;
 - (vi) Details of discharge planning and care plans;
 - (vii) Clinical correspondence, radiology reports and investigation results.
14. The Trust should audit the standard of clinical documentation to ensure there are contemporaneous and comprehensive notes of patient care at each stage of the surgical pathway.
15. The Trust should consider whether there are recurring issues within the electronic patient record system, and whether there are sufficient safeguards for administrative staff to identify and escalate missing correspondence.

16. The Trust should ensure there are safeguards in place to monitor decisions made during follow-up appointments and to identify and escalate missing correspondence from outpatient clinics.
17. The Trust should ensure there are systems in place to monitor that letters are written and sent out to patients and their GPs after each clinic visit.

5. Guidance for the healthcare organisation

5.1. Responsibilities in relation to this report

This report has been prepared by the Royal College of Surgeons of England and the British Association of Urological Surgeons under the IRM for submission to the healthcare organisation which commissioned the invited review. It is an advisory document and it is for the healthcare organisation concerned to consider any conclusions and recommendations reached and to determine subsequent action.

It is also the responsibility of the healthcare organisation to review the content of this report and in the light of these contents take any action that is considered appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009.³⁶

5.2. Further contact with the Royal College of Surgeons of England

Where recommendations have been made that relate to patient safety issues, the Royal College of Surgeons of England will follow up with the healthcare organisation to request confirmation that timely action has been taken to address these recommendations.

If further support is required the College may be able to facilitate this. Additionally, if it is considered that a further review would help to assess improvements that have been made the College's Invited Review service may be able to undertake this.

³⁶ <https://www.legislation.gov.uk/nia/2009/1/contents?msclid=27a3d90eac5511ecaa04663a30c9797a>

Appendix A - Clinical record review notes

The following notes were made by the clinical reviewers with regard to the one hundred cases under review. These represent their initial views on each case while looking at them individually and do not necessarily reflect their final conclusions. The conclusions section of this report contains the review team's definitive view on the cases reviewed.

Case A1

Description

This male patient, whose age was unknown, underwent a penectomy for penile cancer.

The patient presented with a phimosis and was noted to have a probable squamous cell cancer on the prepuce and glans penis. The lesion was biopsied and a circumcision was carried out.

The histology was discussed at an MDT and subsequent surgery was carried out as per the MDT recommendations.

At a subsequent MDT follow up, one year on from surgery, the patient was identified to have a malignant inguinal node. A lymph node dissection was carried out as per MDT decision and a single malignant node was identified.

On 16 May 2017, there was a letter from Surgeon 1 to the patient stating that all was clear and follow up would be continued.

Comments

The review team considered, from the clinical records provided, that the assessment, investigations, treatment, team working including MDT working, consent and communication with the GP and patient's family/carers were acceptable in this case. In addition, the review team highlighted that the record keeping was excellent.

In conclusion, the review team did not recommend specific follow up with the patient because it was noted, from the letter of 12 May 2017, that follow up with the patient would be arranged, which was appropriate. In the review team's view, regular follow up of a case such as this should take place for at least 10 years.

Case A2

Description

This patient was a 65 year old male, with a history of Type 2 diabetes, alcoholic pancreatitis and previous admissions with acute kidney injury (AKI) and dehydration.

The patient was initially referred by physicians with a paraphimosis. This was reduced and a lesion on the glans penis was identified and the patient subsequently had a biopsy. The patient was diagnosed with a moderately differentiated squamous cell cancer. This was further investigated and discussed at MDT and a partial penectomy was recommended. There was a two month delay with treatment due to the unfitness of the patient and he needed to improve his health prior to surgery. The patient underwent a partial penectomy for penile cancer on 30 December 2015.

Follow up occurred on 13 April 2016 when, at a CT, the chest, abdomen and pelvis were recorded as showing no metastases.

Comments

The review team considered, from the clinical records provided, that the assessment, investigations, treatment, team working including MDT working, consent and communication with the GP and patient's family/carer were reasonable in this case. In particular, the review team noted that the two month delay from staging to definitive treatment was as a result of the relative unfitness of the patient and the need to optimise his health. However, in the review team's view, from the time of referral to subsequent follow up, patient management appeared appropriate.

In conclusion the review team did not recommend specific follow up with the patient as, noted in the letter of 13 April 2016, this was already in progress. In the review team's view, regular follow up of a case such as this should take place for at least 10 years.

Case A3

Description

This 32 year old male patient was seen in accident and emergency (A&E) on 11 May 2015 with swelling of the right testis following blunt trauma whilst playing football. An ultrasound scan (US) indicated a mass on their right testis and the patient was flagged for urology referral, which the patient was informed about. The urologist subsequently arranged a repeat US.

On 14 May 2015, the patient was seen in clinic by Surgeon 1. The US taken showed a mass on their right testis and there was a concern for malignancy, therefore, Alpha-fetoprotein (AFP³⁷) and Beta-HCG³⁸ tests were arranged and a referral for radical orchidectomy³⁹ was made. There was no record of any patient discussion regarding options of sperm banking.

On 16 and 17 May 2015, the patient was again seen by Surgeon 1 and the outcomes of AFP and Beta-HCG were discussed. The additional option of radical orchidectomy was also discussed with the patient. The consent was obtained by an ST4⁴⁰.

Another CT scan was undertaken on 26 May 2015 and showed there were no metastasis above or below the diaphragm.

On 31 May 2015, the patient was seen by the oncology team and began surveillance for a stage 1 testicular non-seminomatous germ cell tumour (NSGCT). The chest X-ray (CXR) and tumour markers were normal. The patient exhibited no symptoms of hypogonadism⁴¹.

On 04 June 2015, the patient was discussed at MDT. The patient was then seen at outpatient clinic for review by Surgeon 1 before referral to another clinician.

On 15 June 2015, the patient was seen by Surgeon 1 and the patient's wound was noted to be healing well. The possibility of a testicular prosthesis was discussed with the patient, which he declined. It was documented that Oncology would provide active surveillance for the next five

³⁷ Alpha-fetoprotein (AFP) is a glycoprotein (molecular weight 69.000 Dalton, 4% carbohydrates) with great similarity to albumin. It is produced in the embryonic liver, intestine and yolk sac. AFP is not produced after birth. In healthy adults, alpha-fetoprotein is detected only in low concentrations. It can be raised in testicular cancer.

³⁸ Beta-hCG (β-hCG) is a test that measures the amount of human chorionic gonadotropin (hCG) in the blood. It can be raised in testicular cancer.

³⁹ Testicle removal

⁴⁰ Specialist Trainee doctors at this stage of training take on much more responsibility in the medical team. They are often the most senior doctor on site for that specialty, particularly on nights and weekends.

⁴¹ Condition where the body does not produce enough testosterone.

years and in July 2020 the patient was well and tumour markers were normal (beta-HCG <0.1 and AFP 1.3). A completion of a CXR was arranged.

On 21 August 2020, the CXR was noted to be normal and the patient was discharged with no evidence of disease (NED).

Comments

The review team considered, from the clinical records provided, that the speed of treatment of the patient's testis cancer was commendable, having first been seen in A&E on 11 May 2015 and with the patient's operation on 16 May 2015.

However, the review team were concerned that the patient records lacked detail as there was no evidence of patient discussion regarding fertility, future parenthood, sperm banking and prosthesis pre-operatively (although prosthesis insertion was discussed post-operatively and was declined by the patient). The review team also found that the operation note was brief with no mention of incision, findings or post-operative instructions. Therefore, the review team found that the record keeping was unacceptable.

The review team considered that the MDT discussion was adequate, although they were unable to determine if this was a urology specialist MDT discussion, as it should have been, and, if so, why had issues like sperm banking not been discussed.

Nonetheless, the review team noted that the cancer outcome was excellent and that the patient had been discharged from oncology follow up with no evidence of disease (NED).

Case A4

Description

This male patient, whose age was unknown, was seen by Surgeon 1 on 29 January 2015 with LUTS⁴², testicular pain, erectile dysfunction and low testosterone. A testicular US taken on 12 February 2015 showed an inter alia, a cyst in the mid pole of the right kidney. A further CT scan on 22 March 2015 showed a solid lesion on the upper pole of the right kidney consistent with renal cell carcinoma (RCC) and confirmed by the US on 21 May 2015.

The patient was referred to the urology team on 3 June 2015. On 11 June 2015, a MDT review took place and the case was referred to Surgeon 1 to discuss staging and partial nephrectomy (PN).

Surgeon 1 saw the patient on 19 June 2015 where a CT and bone scan were obtained and a cardiology review sought. On 23 June 2015, the CT scan of the patient's chest revealed a non-specific nodule in the right middle lobe. A DMSA scan on 02 July 2015 showed the patient's split renal function to be 54% on the right.

An MDT review was undertaken on 23 July 2015 and it was suggested that the patient undergo a right partial nephrectomy when the cardiology assessment was completed.

On 24 July 2015, the patient was seen by Surgeon 1 and the right partial nephrectomy was planned for 26 August 2015.

On 26 August 2015, the patient underwent a right partial nephrectomy operation where a ureteric stent was inserted. It was documented that the Warm Ischemia Time (WIT) was 7 minutes.

⁴² Lower urinary tract symptoms

The clinical records indicated that there was a post-operative ileus and an unexpected decrease in eGFR to 29 (this later recovered to >60). The patient was discharged on 01 September 2015.

On 10 September 2015, a further MDT review occurred and the patient's T1a chromophobe R0⁴³ RCC⁴⁴ was discussed. The previously placed right JJ stent⁴⁵ was removed on 30 September 2015.

On 04 December 2015, the patient was readmitted with obstructive jaundice and weight loss.

In February 2016, the patient underwent a Whipple's procedure to remove the cancerous tumour of the pancreas. The diagnosis was of malignant stricture of the common bile duct (CBD). The histology records indicated a pT3N1R1 pancreatic ductal cancer. The patient then developed liver metastasis prior to discharge and undertook palliative chemotherapy.

The patient sadly died on Personal Information redacted by the USI due to metastatic cancer of the pancreas.

Description

The review team considered, from the limited clinical records provided, that the assessment, consent and communication with the GP and patient's family/carer, team working and follow up actions were acceptable in this case.

However, the review team were concerned that there were some delays (although not specifically related to the urological team) in the investigation of the patient's health, which they considered unacceptable. The review team particularly questioned why a DMSA scan was required if the patient's renal function appeared to be satisfactory at pre-operative staging. The review team were also not provided with the eGFR information relating to this, to confirm this decision, however they had been provided with the CT scan which showed the contralateral kidney to be normal.

The review team were unclear why at the MDT discussion, for which Surgeon 1 was present and chaired the meeting, a decision for open PN had been taken, rather than consideration of the appropriateness of laparoscopic surgery. It was not clear to the review team, from the MDT records provided, whether there was laparoscopic PN experience available locally, or if an opinion was sought elsewhere. It was unclear to the review team if the case had been discussed at a urology specialist MDT (as it should have) or just the local MDT.

In addition, the review team viewed that there was room for improvement with respect to the treatment for this patient. The review team noted that the patient had been seen by the urology team on 29 June 2015 and was operated on 26 August 2015 with some delay due to a cardiac investigation prior to surgery.

The review team considered that the OPD and the post-operative notes were not detailed and lacked sufficient information.

Despite these concerns, the review team did not have any significant concerns about the urological treatment of this patient. The review team considered that Surgeon 1 was working within his capabilities, similar to what might be expected from any consultant surgeon working in similar circumstances.

⁴³ R0, pronounced "R naught," refers to the margin status of the specimen. R0 means the margins were clear of disease.

⁴⁴ Chromophobe renal cell carcinoma – rare form of kidney cancer

⁴⁵ A percutaneous nephrostomy or JJ stent is used to drain the kidney to prevent a urine leak from the kidney post-operatively.

Case A5

Description

The patient was an 80 year old female with a pacemaker since 2011. The patient had drainage of abscess in February 2014. An ultrasound scan was undertaken on 16 December 2015 which was followed by a renal biopsy.

MDT discussions were documented in the patient's clinical record.

The patient was offered conservative management or nephrectomy. Patient consent was obtained for the operation and on 22 April 2016, the patient had laparoscopic nephrectomy. The patient's histopathology was recorded with TIA⁴⁶ RCC.

The patient was subsequently referred for local follow up. The clinical records stated that the patient was seen in follow up until 2020 where it was noted that there were no adverse sequelae⁴⁷.

Comments

The review team considered that this case had difficult diagnostics and that the patient presented with abscess within the iliopsoas⁴⁸ muscle.

The review team noted that subsequent imaging indicated that the patient had RCC which was confirmed on the biopsy undertaken. In the review team's view, this patient had appropriate imaging and assessment. The review team noted that the patient was then referred for laparoscopic nephrectomy.

In the review team's opinion, the patient had appropriate follow up until 2020, four years after surgery, and no harm occurred during the patient's treatment.

The review team also highlighted that there were excellent notes and letters included in the patient's clinical records.

Case A6

Description

This male patient, whose age was unknown, presented with chest symptoms and had an incidental finding of a small renal lesion following a scan. On 18 September 2015, the patient had the renal lesion removed.

On 30 September 2015, a CT scan indicated upper side renal cell carcinoma.

During a MDT meeting on 15 October 2015, biopsy was advised.

At a MDT review on 15 January 2016, it was advised that the patient undertake a RF laparoscopic partial nephrectomy⁴⁹.

⁴⁶ A transient ischaemic attack or TIA (also known as a mini-stroke) is the same as a stroke, except that the symptoms last for a short amount of time.

⁴⁷ A morbid condition following or occurring as a consequence of another condition or event.

⁴⁸ The iliopsoas muscle is the main flexor of the hip joint.

⁴⁹ A laparoscopic partial nephrectomy is a minimally invasive technique to remove a portion of the kidney. This technique is usually used to treat primary renal tumours.

On 01 February 2016, the patient had RF laparoscopic partial nephrectomy surgery.

It was documented that the patient was in follow up until February 2021 and no recurrence was noted in the clinical records.

Comments

The review team noted that the initial assessment undertaken in this case was excellent. In the review team's view, the investigation was timely and appropriate despite a very slight delay after the biopsy.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted and a second opinion was obtained. The review team highlighted that there were appropriate MDT discussions and actions that took place, leading to the referral for laparoscopic partial nephrectomy.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care.

The review team found communication with the patient /their family and or carers appeared to be appropriate in this case. The review team considered that there was good and timely communication.

The review team noted that the clinical record entries were clear, accurate and legible to an acceptable standard.

It was concluded by the review team that this patient had prompt management and appropriate follow up and no harm occurred during their treatment.

Case A7

Description

This 66 year old female patient was diagnosed with endometrial cancer.

The CT and MRI scans obtained in October 2014 showed an incidental 3-4cm upper pole renal mass. An open partial nephrectomy was performed in October 2015. Post-operatively, there were some reported complications (infection and delayed incisional hernia).

The patient was first seen by Surgeon 1 in the out-patients department on 31 October 2014, which was subsequently followed up by a letter to the patient's GP.

The patient was then reviewed at the MDT meeting on 30 October 2014. With the endometrial cancer being the priority to treat urgently, a decision was made to delay the surgery for the renal tumour, until the completion of gynaecological surgery.

Comments

The review team considered that the patient was adequately assessed and the diagnosis was deemed acceptable. In the review team's view, the investigations undertaken were suitable to the patient's needs and were considered satisfactory. The review team noted that patient was investigated with both CT and MRI scans.

Overall, the review team considered that a correct decision was made for the patient to have an open procedure, as opposed to a laparoscopic partial nephrectomy, given the patient had previously undergone gynaecological surgery, and the position of the renal tumour.

Although there was a 12 month delay in treating the patient, the review team considered that this was acceptable, due to the incidental finding of the endometrial cancer, and the more

serious gynaecological malignancy to deal with as a priority. The review team noted that there were some post-operative complications (infection and delayed incisional hernia⁵⁰), however, in the review team's view, these are recognised complications of this type of surgery, and the review team considered that they were managed appropriately. In the review team's opinion, the appropriate guidelines were followed in the treatment of this patient.

Although the review team considered that the clinic letters described a thorough conversation with the patient, there was no evidence to suggest that these letters were sent to the patient in following up on those conversations. However, the review team accepted that, whilst this would have been preferable, it was not a national requirement at the time. The review team made this assessment based on the Northern Ireland Electronic Care Record (NIECR), however, the review team did not have access to the handwritten clinical records. The review team considered that the standard of correspondence which was sent to the patient's GP and obstetrics and gynaecology consultants in late 2014 and early 2015 was acceptable.

The review team considered that MDT meetings were appropriately utilised, and that recommendations from those meetings were carried out sufficiently. The review team noted that there were no requests for a second opinion documented in the patient's clinical record.

The review team viewed that the follow up action taken on the patient care was appropriate. The review team noted that the histology revealed a benign oncocytoma⁵¹, which was subsequently followed up with general surgery for a mesh incisional hernia repair⁵². The review team therefore did not consider that the patient required clinical follow up to ensure their safety.

In considering whether the patient came to harm, the review team were of the opinion that in this case recognised post-operative complications materialised and they were appropriately managed. The review team highlighted that it was possible that the same sequence of events could have occurred for any other consultant surgeon working under similar circumstances.

The review team considered that the standard of record keeping had room for improvement. Whilst the written letters were of a high standard, there was evidence to suggest that there were some appointments which were not followed up with written correspondence, for events which were referred to in subsequent documentation several months later.

Case A8

Description

This male patient, whose age was unknown, presented in March 2015 with right loin pain and urinary frequency. The patient's ultrasound scan suggested a possible mass in the right upper pole and a possible hydronephrosis⁵³.

A subsequent renogram⁵⁴ revealed no obstruction, however, a CT scan in March 2015 confirmed a 4.5cm right mid-renal mass which was suitable for a partial nephrectomy⁵⁵.

⁵⁰ Incisional hernias can develop after 15-20% of abdominal operations involving incisions, most noticeably, they involve a bulge near the incision site.

⁵¹ A renal oncocytoma is non-cancerous (benign) mass in one or both of the kidneys.

⁵² Open repairing of an incisional hernia with mesh involves re-opening the old incision, to allow dissection and reduction of the hernia sac.

⁵³ Hydronephrosis is a condition where one or both kidneys become stretched and swollen as the result of a build up of urine inside them.

⁵⁴ A renogram is a nuclear medicine test of the kidneys, used to see how well each of the kidneys are working, and whether urine can pass into the bladder without obstruction.

⁵⁵ A partial nephrectomy is the removal of part of the kidney, usually because of a tumour, whilst sparing the remainder of the kidney from damage or removal.

An index operation was carried out on the patient on 06 May 2015.

Comments

The review team considered that the patient was adequately assessed and their diagnosis was deemed acceptable. In the review team's view, the investigations undertaken were suitable to the patients' needs and were considered satisfactory. The review team noted that the ultrasound, renogram, CT and bone scans were carried out very efficiently.

The review team considered that there was sound clinical decision making in this case, highlighting that the referral of the patient to partial nephrectomy, in less than two months, was commendable.

Whilst the review team considered that the steps taken up until the patient's surgical procedure were appropriate, the absence of any records on the NIECR was of concern. Although there were some notes recorded by Surgeon 1 of clinic visits which took place on 24 March 2015 and 17 April 2015, it did not appear that these visits were appropriately followed up by correspondence with the patient's GP. Whilst the review team considered that obtaining consent and communicating with the patient was likely to have been reasonable, the review team was unable to fully comment, given the absence of information in the documentation provided. Furthermore, the review team were uncertain how well informed the patient was of any possible complications prior to the surgical procedure.

The review team considered that this patient's case was appropriately discussed and recorded, both pre-operatively and post-operatively, during the MDT meetings held on 9 April 2015 and 28 May 2015 respectively. The review team highlighted that colleagues were consulted with appropriately, when needed.

The review team noted that complications occurred after the partial nephrectomy, however, these were appropriately managed with interventional radiology and subsequently followed up. Furthermore, the review team noted that the patient suffered a significant post-operative bleed and chronic wound pain after the procedure. Whilst this was a relatively rare complication, the review team accepted that it was a recognised one. The review team therefore did not consider that the patient required clinical follow up to ensure their safety.

Case A9

Description

This patient, a 67 year old male, underwent a transurethral resection of the prostate (TURP) for prostate cancer on 07 September 2011.

The patient initially presented with chronic retention and back pressure nephropathy, raised creatinine and reduced eGFR and had a PSA⁵⁶ level of 57.8 on 04 August 2011. The patient also had previous abdominal perineal resection (APR) surgery, therefore, a digital rectal exam (DRE) was not possible.

The patient was treated with catheterisation and investigated with bone scan and MRI. There was T3c⁵⁷ tumour indicated on the MRI, however, the bone scan result was negative.

⁵⁶ PSA (prostate-specific antigen) is a small protein molecule which is released from the prostate gland into the bloodstream.

⁵⁷ T3: tumour invades through the muscularis propria into the subserosa or into non-peritonealised perirectal tissues; T3c: tumour extends 5-15 mm beyond muscularis propria 4.

Following TURP in September 2011, the patient commenced with hormones on Day One. Histology records showed that the patient had a poorly differentiated prostate cancer Gleason score⁵⁸ of 4+5.

It was noted at the post-operative review dated 28 September 2011, that the patient had stress incontinence likely due to sphincter deficiency (from the previous APR). The possibility of incontinence did not feature during the consent for TURP undertaken by the urology registrar, although a full range of possible complications were documented to have been discussed with the patient.

A subsequent urodynamics test showed detrusor instability. The patient underwent a cystoscopy and Botox injections performed by Surgeon 1. Consent for these procedures were taken by a ST4.

The last clinical record available was dated 09 October 2012.

Comments

The review team considered, from the clinical records provided, that the assessment, investigations, treatment, team working including MDT working, consent and communication with the GP and patient's family/carer were satisfactory and the management of this patient appeared to be in line with accepted practice.

However, the review team noted that the patient was not made aware of the possibility of incontinence as complication of TURP, when consent was obtained.

In conclusion, the review team did not recommend follow up with the patient, other than the expected long term follow up either by the Urology department (doctors or nurse specialists) or by GPs required post-surgery.

Case A10

Description

The patient, a 68 year old male, underwent a TURP surgery performed by Surgeon 1 in 2002.

There were detailed in-patient and outpatient notes seen, but no operation note for the TURP surgery or consent available for review. The clinical records were dated from 12 June 2012 to 18 September 2015.

A flexible cystoscopy was carried out by Surgeon 1 on 18 September 2015. A detailed operation note was included in the patient's clinical record, however, no consent form was available.

Comments

The review team considered, from the limited clinical records provided, that the assessment, investigations, treatment, team working including MDT working, patient communication with the GP and patient's family/carer were appropriate in this case. The review team highlighted that the patient's clinical records (with the exception of the operation note for the TURP surgery and consent forms) were detailed and all letters sent to the patient and their GP were fully explanatory.

The review team noted that there was no operation note for the TURP surgery in 2002 and consent forms were not included for both procedures undertaken by the patient in 2002 and

⁵⁸ The Gleason score is the most common system doctors use to grade prostate cancer. The grade of a cancer tells you how much the cancer cells look like normal cells. This gives your doctor an idea of how the cancer might behave and what treatment you need.

2015. It was unclear whether consent was obtained prior to surgery or whether the forms were not filed in the patient's record. The review team considered that there was room for improvement in regards to patient consent and completeness of record keeping.

In conclusion, the review team did not recommend a further follow up with the patient, other than the standard follow up required post-surgery.

Case A11

Description

The patient was an 85 year old male who had acute urinary retention⁵⁹ and a failed Trial without Catheter (TWOC) on 18 March 2015.

The patient underwent circumcision and TURP surgery on 27 May 2015 and was subsequently discharged on 31 May 2015 with prescribed Warfarin⁶⁰.

During a follow up appointment on 16 June 2015, it was indicated that the review was satisfactory. The patient was not reassessed until two years later, on 12 July 2017, where all appeared well. It was noted that the patient had low grade cancer of prostate (CAP), albeit, no medications were prescribed.

Comments

The review team considered that the patient was assessed excellently and their diagnosis was deemed acceptable. The review team highlighted that the admission was timely and there was good communication between staff throughout the patient's treatment.

In the review team's view, the consent obtained for the circumcision and TURP was appropriate and the operation notes were satisfactory. In the opinion of the review team, record keeping was commendable for this case as the clinical notes contained excellent accounts of events.

It was noted by the review team that the follow up on the ward, with a nurse initially, then the consultant, appeared sufficient and correctly managed. The review team found that the patient was provided with an excellent medication plan.

Case A12

Description

This male patient, whose age was unknown, presented in 2005 with a high grade prostate cancer and prostate-specific antigen (PSA) of 131 in his blood.

From the documentation provided, onward investigations were conducted by an oncologist in the unit and the patient had progressive care and follow ups since.

The patient had other symptoms detected in 2015 and consent for TURP surgery was obtained by a Registrar. The patient subsequently had TURP in 2015 and was still under care in 2016.

⁵⁹ Acute urinary retention is defined as a new onset inability to pass urine*, which subsequently leads to pain and discomfort, with significant residual volumes.

⁶⁰ Warfarin is an anticoagulant (blood thinner). Warfarin reduces the formation of blood clots. Warfarin is used to treat or prevent blood clots in veins or arteries, which can reduce the risk of stroke, heart attack, or other serious conditions.

Comments

The review team considered that the patient was adequately assessed and their diagnosis was deemed acceptable. It was noted by the review team that the patient consent obtained was appropriate.

It would appear that the patient had regular follow up and care by an oncologist, which in the review team's view demonstrated good team working between MDT and the oncologist. The review team were of the opinion that the follow up was appropriate with onward care provided over 10 years.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard. In the review team's opinion, the MDT episodes were recorded and completely documented.

The review team concluded that there was no evidence of harm found in this case.

Case A13

Description

This 92 year old male patient was referred for transurethral resection of a bladder tumour (TURBT) having had a past history of prostate cancer.

On 13 August 2014, the patient was seen by the urology team with PSA level of 16 and an abnormal DRE. Prostate biopsies were performed and the patient was prescribed Bicalutamide⁶¹. Further follow up was arranged and MDT review was organised.

The patient was again seen by the urology team on 28 August 2014 and the histology indicated that the patient had an aggressive prostate cancer with Gleason Score 5+4 disease. The patient was prescribed Bicalutamide and Tamoxifen⁶², and referred for a further CT and bone scan.

On 03 September 2014, the CT scan revealed subtle sclerotic changes and the bone scan results of 05 September 2014 did not show any significant results. On 19 September 2014, the patient's Bicalutamide medication was increased to 150mgs, once daily.

The patient was an in-patient on 06 and 12 November 2014, as their condition appeared to be worsening. A CT scan showed changes consistent with interstitial fibrosis and sclerotic metastasis as T8. Bicalutamide medication was stopped and Decapeptyl⁶³ treatment commenced.

The patient had further PSA monitoring from April 2015 and it was documented that on 01 July 2015 the PSA result was 4.86 and on 17 August 2015, the PSA result was 10.22. The patient was recorded as having had an increase of LUTS and haematuria (blood in the urine).

On 25 August 2015, the patient was noted to have severe shortness of breath (SOB) with imaging suggesting a bladder tumour (BT) on the left side of the bladder wall. A cystoscopy was therefore arranged (date of surgery was unknown) and results indicated an occlusive prostate and a BT on the left bladder wall.

⁶¹ Bicalutamide is a cancer treatment drug and is also known by its brand name, Casodex. It is a treatment for prostate cancer.

⁶² Tamoxifen is a hormone therapy used to reduce the chances of breast swelling in men with prostate cancer who are on bicalutamide.

⁶³ In men, Decapeptyl injections are given to treat prostate cancer. They act by lowering levels of testosterone.

Between 09 and 12 September 2015, the patient was an in-patient (IP) and a TURP and TURBT were carried out. Only Surgeon 1 and the patient's signature were included on the consent form.

The clinical notes documented bladder outlet obstruction with bladder neck hypertrophy and a bladder tumour (BT) on the left bladder wall. A TURBT was performed, however, there was no indication given as to why a simultaneous TURP was also carried out. It would appear that the patient pulled their catheter out post-operation, and this had to be replaced. A TWOC undertaken on 12 September 2015 was considered to be successful.

On 04 February 2016, the patient was admitted to accident and emergency (A&E) due to deterioration in their condition. The patient was taken to the geriatric ward with right lower lobe (RLL) and middle lobe (ML) pneumonia and sadly died on Personal Information redacted by the USI.

Comments

The review team were concerned that there was limited information in the patient's clinical record to satisfactorily conclude that the patient's treatment was appropriate. The review team noted that it was unclear whether the Bicalutamide medication was the cause of the interstitial lung disease (as CXR on 28 August 2014 showed underlying interstitial lung disease before medication was started) and it was a rare (<0.1%) complication of Bicalutamide use.

In addition, it was unclear to the review team if the patient had:

- a.) Any follow up after TURP/TURBT;
- b.) Any specific follow up for his prostate cancer between 16 June 2015 until the patient's death on Personal Information redacted by the USI and
- c.) Follow up for his bladder cancer after his TURBT on 09 September 2015.

In the opinion of the review team, there was inadequate consent for the TURP and TURBT procedures (the consent form had insufficient information relating to the TURP and TURBT and only Surgeon 1 and the patient's signature were included) and the operation notes were brief.

Whilst there were some areas of minor concern to the review team, notably the investigations and imaging undertaken and actions taken by the consultant following the MDT discussions, the review team concluded that the overall management of this case was unacceptable due to the reasons described above.

Case A14

Description

This 68 year old male patient underwent endoscopic resection of the prostate.

On 31 January 2006, the patient was seen by Surgeon 1 with raised PSA of 91.1. A good medical history was taken by Surgeon 1 and it was noted that the patient awaited prostate Bx⁶⁴ and had already been started on Bicalutamide medication for a presumptive diagnosis of prostate cancer.

On 22 February 2006, the patient was again seen by Surgeon 1. It was noted that the patient had an aggressive prostate cancer Gleason score (GS) 9 in 3/3 biopsies from the left side with

⁶⁴ Biopsy

evidence of perineural invasion (PNI⁶⁵) and lymphovascular invasion (LVI⁶⁶). The patient's Bicalutamide medication was increased to 150mgs once daily and the patient was referred for an ultrasound scan, bone scan and an MRI scan of their prostate.

On 07 July 2006, the patient was reviewed by Surgeon 1 and appeared 'very well'. The patient had a PSA of 0.8 and their MRI report was requested.

On 25 July 2006, the patient was seen by Surgeon 1 for review of their bone scan and MRI scan. The results of the bone scan showed there were no metastases, whilst the ultrasound scan (dated 28 June 2006) indicated a RU 15 cc and sludge in the bladder. The MRI (dated 05 July 2006) had no evidence of spread of prostate cancer outside of the prostate gland. A flexible cystoscopy (dated 25 July 2006) appeared normal.

From the documentation provided, it would appear that patient consent was taken for the flexible cystoscopy. However, this only contained the signatures of the doctor and the patient. It was documented that a private review would be arranged.

On 26 March 2015, the patient was referred from medical Oncology to Urology regarding the LUTS.

At a review on 02 April 2015, it was decided to optimise the patient's LUTS prior to chemotherapy and request an MDT review.

On 10 April 2015, the patient was seen by Surgeon 1 for the management of LUTS and arrangements were made to have a cystometrogram⁶⁷ (CMG). The patient was also referred for TURP and possibly for Botox. The results of the CMG showed both detrusor overactivity (DO) and bladder outlet obstruction (BOO).

On 29 April 2015, the patient underwent endoscopic surgery where 500 units of Botox and a standard TURP were performed. The patient consented to these procedures and the paperwork relating to this appeared satisfactory. Post-operatively, the patient experienced retention and a later TWOC was arranged. The patient was discharged on 02 May 2015.

Histology of the resected prostate showed a possible neuro-endocrine tumour and the plan was for this to be discussed at MDT.

On 29 April 2016, the patient was referred for palliative care during the last weeks of their life.

Comments

The review team considered, from the clinical records provided, that the general management of the patient's care was acceptable. In the review team's view, the onward referral after adequate investigation, the prescribed medication and the MDT review were satisfactory.

However, the consent for flexible cystoscopy obtained on 25 July 2006 was considered inadequate by the review team. The consent form left room for improvement as it only contained the words "Flexi cyst" and had two signatures (of the doctor and the patient). The review team found it lacked detailed risks and reasons for the procedure.

⁶⁵ PNI or perineural invasion shows that prostate cancer cells are beginning to spread to nerves from where they can metastasise or spread to parts of the body. It is associated with a poorer prognosis.

⁶⁶ Lymphovascular invasion (LVI) has recently emerged as possible new predictor of prostate cancer recurrence. Lymphovascular invasion is the movement of cancer cells into either a blood or lymphatic vessel. Once cancer cells are within a blood or lymphatic vessel, they have the ability to spread to other parts of the body.

⁶⁷ a test which measures bladder function

The review team also questioned the decision for the patient to have Botox being appropriate. In their opinion, the DO was likely secondary to BOO and the review team considered that there should have been improvement following TURP and Botox should only have been given if there was no improvement post-operatively. There was no record of any MDT discussion following the TURP on 29 April 2015.

Despite such concerns, the review team considered that the team working and actions taken by the consultant following the MDT discussions and follow up with the patient by the Urology team was adequate. The review team also noted that the OPD notes were clear and had detailed plans recorded.

Case A15

Description

This 60 year old male patient had three instances of urological care under Surgeon 1 in 2013, 2015 and 2019

The patient initially presented in 2015 with LUTS, upon which it was presumed this was secondary to prostate enlargement.

The patient underwent TURP operations on 29 April 2015, and was subsequently diagnosed with prostate cancer. The operation note was documented, however, the consent form had no intended benefits, risks and complications recorded.

The patient did not attend clinic on 19 June 2015 and a letter was sent to their GP on the same day.

The patient did not attend clinic on 28 October 2016 and a letter was dictated by Surgeon 1 on 29 December 2016 and typed on 04 January 2017.

Surgeon 1 assessed the patient in clinic on 27 September 2019 and a letter was recorded on 21 November 2019.

The patient's cancer was managed with hormone blockade treatment and subsequent radical radiotherapy, and the patient received routine follow ups. The outcome of the patient's treatment was poor, which was likely due to his living with mental health difficulties and a possible alcohol dependency.

Comments

The review team considered that appropriate assessment, investigations and imaging of the patient were undertaken. The review team noted that after the initial history and examination of the patient was undertaken in 2015, MRI, CT and bone scans were performed in order to investigate and diagnose the prostate cancer.

The review team considered that the team working was sufficient, with appropriate use of MDT meetings and involvement of the radiotherapy department in ongoing treatment. The review team considered that an appropriate MDT meeting was held on 14 May 2015, during which the patient's reported G7 prostate cancer was discussed. The review team also considered that appropriate action was taken as a result of recommendations made during MDT meetings, with the patient being appropriately referred to Belfast for radiotherapy.

Whilst the operation notes dated 10 April 2015 were sufficient, the review team considered that the recording of the consent process left room for improvement, as there was nothing to indicate that the risk of complications were explained to the patient. Furthermore, there was an absence of information to indicate that the patient was offered a choice in terms of treatment.

The review team considered that there were examples of good communication with the patient. When the patient did not attend an appointment on 19 June 2015, this was promptly followed up on the same day with a letter to the patient's GP. However, there were occasions where subsequent correspondence was either missing or there was a significant delay in it being sent to the GP following either a clinical visit or the patient not attending an appointment.

For example, the patient did not attend an appointment on 28 October 2016. The subsequent letter was not dictated by Surgeon 1 until 29 December 2016. Furthermore, on the same date, a detailed letter was sent to the patient's GP, stating that his last correspondence had been in June 2015, despite reference being made in the letter to another clinic visit in July 2015 from which there was no correspondence. Given such examples, the review team considered that the record keeping left room for improvement. This prompted the review team to consider whether these were recurring issues within the electronic patient record system, and whether there were sufficient safeguards for administrative staff to identify and escalate missing correspondence.

The review team accepted that this may have been a difficult case of patient care to manage, given the patient's mental health difficulties and a possible underlying alcohol dependency. This may have contributed to some of the issues that were identified in relation to the missing and/or delayed correspondence following clinical appointments which were not attended by the patient.

The review team considered that the patient's treatment (Bicalutamide 150mg once per day in January 2013, reduced to 50mg in 2017 after radiotherapy) was effective. However, the review team noted that this was not a widely recognised treatment for Gleason Score 7 non-metastatic prostate cancer; a more common treatment would have been the luteinising hormone-releasing hormone (LHRH).

The review team concluded that appropriate follow up of the patient took place. The review team did not consider that specific harm materialised, and therefore did not consider that a clinical follow up was required to ensure the safety of the patient.

Case A16

Description

This 86 year old male patient was referred in September 2014 with a visible haematuria. The patient underwent a flexible cystoscopy in October 2014, which revealed a lateral bladder tumour and an enlarged prostate.

On 26 November 2014 the patient was diagnosed with a pTa G2 tumour at TURBT. The patient sustained post-operative blood clot retention. The patient underwent a subsequent TURP procedure, which revealed a score of G 3+4=7 prostate cancer.

By 10 February 2017, the prostate cancer had progressed to recurrent transitional cell cancer. The patient suffered a myocardial infarction (MI)⁶⁸ on 19 February 2017.

On Personal Information
redacted by the USI, the patient sadly died of an unrelated intracerebral haemorrhage, which was most likely due to known comorbidities, and unrelated to the urological treatment he received.

Comments

In respect of assessment of the patient, the review team considered that appropriate history, examination and diagnosis of the patient were undertaken. Given the patient's presentation with visible blood in his urine, the review team considered that this was appropriately investigated and imaging was undertaken, with the flexible cystoscopy being performed. The review team

⁶⁸ A myocardial infarction (MI), commonly known as a heart attack, occurs when blood flow decreases or stops to the coronary artery of the heart, causing damage to the heart muscle.

considered that the investigation of the bladder cancer, through the TURBT and subsequent TURP procedure, which identified the prostate cancer, was also acceptable.

In the opinion of the review team, there was appropriate use of MDT meetings, with sufficient actions taken as a result of the recommendations made during those meetings.

The review team considered that the consent process and communication with the patient, and consequently, the record keeping in this case, left room for improvement. The review team noted that within the electronic records made available, there was nothing recorded to suggest consent had been obtained from the patient. The review team did not receive copies of handwritten records either, which indicated that this had not been undertaken.

Furthermore, the review team noted that in a letter dated 9 January 2017, there was reference to the patient having last been seen in January 2016, however, within the documentation provided to the review team, there was no subsequent letter to follow up such a visit. This was of concern to the review team, and they considered whether there were safeguards in place to monitor decisions, and to identify and escalate such missing correspondence from outpatient clinics.

The review team considered that there was appropriate treatment of the patient's bladder tumours and the subsequent enlarged prostate. In the review team's view, the patient was provided with appropriate post-operative care, noting that the blood clot retention, following the TURBT procedure, was a recognised complication. The review team were also of the view that appropriate follow up action was taken for this patient, in respect of both the bladder and prostate cancers.

Case A17

Description

This 55 year old male patient presented to Surgeon 1 in January 2015 with a number of medical problems including learning disabilities, a history of alcohol abuse and had previously undergone brachytherapy in Belfast for organ confined prostate cancer (CaP) in 2009. The patient had a strong family history of prostate cancer. The patient was also noted to have LUTS, which had worsened since the brachytherapy and erectile dysfunction which had developed after the brachytherapy.

The Oncology team referred the patient to Surgeon 1 and he was seen in clinic on 13 and 26 January 2015 for assessment and treatment of erectile dysfunction. A thyroid problem was also identified at the time and Surgeon 1 referred the patient to an endocrinologist. There were further records of the patient attending clinic visits with Surgeon 1 in June 2018 and August 2019, the latter of which Surgeon 1 listed the patient for cystoscopy and intra vesical Botox injections.

Comments

The review team considered that the assessment, investigations, treatment, consent and communication with the GP and patient's family/carer were acceptable in this case.

The review team highlighted that there were numerous documents provided for this patient, however, very few of which were relevant to this review. Nevertheless, the review team found that the assessment and management of LUTS and erectile dysfunction appeared satisfactory.

The review team concluded that follow up was not required for this patient.

Case A18

Description

This 80 year old male patient was treated due to possible erectile dysfunction and bladder outflow obstruction, although this was unclear from the clinical records provided.

A GP letter mentioned Tadalafil⁶⁹ being prescribed to the patient in 2015. However, there were no further details available regarding this.

A second letter dated 01 June 2018 was from a locum consultant urologist to Surgeon 1 and the GP with details regarding urodynamic investigations showing bladder outflow obstruction and listing the patient for a TURP. The patient's complex medical history was commented on.

Comments

The review team was unable to make specific comments on this case as there were only two entries relevant to urology.

From the documentation provided, the patient did not appear to have been assessed or treated by Surgeon 1. The review team did not review this patient's record further and no further comments were provided on this case.

Case A19

Description

This 50 year old male patient was referred by his GP to urology with erectile deformity presumed Peyronie's disease. A clinic note written by Surgeon 1 on 23 June 2015 outlined a plan for frenuloplasty. This was followed up in a letter from Surgeon 1 to the patient's GP confirming the patient's Peyronie's with pain and deformity and he was put on waiting list for surgical correction.

A waiting list card written by Surgeon 1 on 27 July 2016 noted the correction of the Peyronie's.

Comments

The review team considered, from the clinical records provided, that the assessment, treatment and team working including MDT discussion was acceptable. However, due to limited information for this case, the review team did not make any specific comment on the investigations/imaging, consent and communication with the GP and patient's family/carer. The review team were content from the information supplied, that the management of the patient appeared to be satisfactory. Therefore, the review team did not recommend follow up with the patient, other than the standard follow up after the surgery.

Case A20

Description

This 20 year old male patient was referred with foreskin frenular problems. On 23 June 2015, the patient was seen by Surgeon 1 in the OPD. The documentation included a full clinic note and a letter to the patient's GP regarding the frenuloplasty.

On 22 December 2015, the patient underwent a frenuloplasty as a day case. Consent was obtained and a full operation note was written by Surgeon 1. The clinical record showed that Surgeon 1 provided a comprehensive case letter to the patient's GP.

⁶⁹ Medication to treat erectile dysfunction/impotence.

Comments

The review team considered, from the clinical records provided, that the assessment, treatment, consent and communication with the GP and patient's family/carer was acceptable in this case. The review team did not comment on the investigation/imaging and team working including MDT discussion due to lack of sufficient information.

From the information provided, the review team considered the management of the patient was appropriate. Therefore, no clinical follow up with the patient was recommended other than the standard follow up post-surgery.

Case A21

Description

The patient, a 61 year old man, with multiple sclerosis and erectile dysfunction was investigated and treated as an outpatient by Surgeon 1.

Detailed clinic notes and letters were provided between 10 February 2015 and 27 October 2018. The patient was eventually discharged on 27 October 2018 following a telephone consultation at which time all possible treatment options had been used and were ineffective. The patient accepted the situation.

Comments

The review team considered, from the clinical records provided, that the assessment, investigations, treatment, team working including MDT working, consent and communication with the GP and patient's family/carer was appropriate in this case. The review team specifically highlighted that the investigations and treatments were entirely in keeping with standard practice and full explanations of rationale for treatment options were provided in the clinic notes and letters to the patient and their GP.

The review team did not consider that follow up was required as the patient had been discharged which was considered to be appropriate.

Case A22

Description

This female patient, whose age was unknown, had surgery for invasive bladder cancer.

On 21 July 2015, the patient was seen in the outpatient clinic by Surgeon 1 for painless haematuria and was referred for flexible cystoscopy. Based on the ultrasound obtained, the patient's kidneys and bladder appeared satisfactory and bladder emptying was complete.

The CT scan dated 29 July 2015 indicated that there was no upper tract or renal malignancy.

On 26 August 2015, the patient was referred for TURBT. There were no details of consent taken and no operation notes were included in the patient's clinical record, however, there was a note of an MDT discussion regarding inadvertent resection of right ureteric orifice (RUO). The post-operation records appeared satisfactory. Subsequent examination of the resected bladder tumour showed a G1/2 pTa or non-aggressive bladder cancer with a very good prognosis.

An intravenous urogram (IVU⁷⁰) on 28 August 2015 showed a degree of right hydronephrosis, most likely related to the previously noted resection of the RUO (see above), but no urine leak was detected.

On 29 August 2015, the patient was subsequently discharged shortly after their TURBT.

The patient's case was discussed at MDT on 03 September 2015 and it was suggested that the patient have a flexible cystoscopy in three months' time and a repeat IVU.

On 11 September 2015, the patient was seen by Surgeon 1 and was deemed to be doing well. An IVU was planned for November 2015 and a subsequent flexible cystoscopy in December 2015.

The patient underwent IVU on 05 November 2015. There was mild fullness on their right kidney collecting system but with no evidence of obstruction as noted by complete drainage of the ureter.

On 04 December 2015, the patient was referred for flexible cystoscopy. There was no sign of recurrent bladder cancer and the right ureteric orifice had healed. A further flexible cystoscopy was arranged for nine months' time.

On 02 September 2016, the patient underwent another flexible cystoscopy. Once again, there was no evidence of bladder cancer recurrence. The patient was subsequently discharged from further follow up.

Comments

The review team considered, from the limited clinical records provided, there was overall adequate management of a straightforward case of low risk bladder cancer.

However, the review team flagged two main areas of concern regarding the consent and operation records. In the review team's view, the consent form provided for the flexible cystoscopy pre-TURBT was inadequate as the form omitted to outline the procedure and only contained the patient's signature. Furthermore, the operation note did not mark the location of the tumour on the bladder map. Nonetheless, the review team were satisfied there was inadvertent resection of the RUO at the time of the TURBT that can be seen especially with tumours close to UOs and usually there were no sequelae from this.

The review team were unclear why the patient was discharged after a relatively short follow up and what safety netting there was in relation to this.

Case A23

Description

This 83 year old male patient underwent surgery for an invasive bladder tumour.

On 06 September 2012, the patient was referred to a haematuria clinic with blood in his urine and results indicated that there was a polyp⁷¹ in the bladder. Following a CT scan, a flexible bladder tumour was found in the dome/ant wall.

⁷⁰ An intravenous urogram (IVU) uses an intravenous dye to look at the whole of the urinary system.

⁷¹ A polyp is a growth that forms on a mucous membrane or other surface inside your body. Polyps can develop in many different organs, including your bladder. Bladder polyps are growths in the lining of your bladder. They may or may not be cancerous.

On 09 October 2012, urine cytology suggested the presence of a malignant tumour in the bladder and a CTU showed both a left renal stone and filling defect in the superior wall of the bladder.

The patient underwent a TURBT on 31 October 2012. There was no consent form or associated operation notes included in the patient's clinical record. Histology showed a high risk non-muscle invasive bladder cancer stage G3pTa.

It was documented that an MDT discussion took place on 08 November 2012 where it was suggested that the patient underwent repeat flexible cystoscopy in February 2013 to check for tumour recurrence.

On 26 November 2012, the patient attended an outpatient clinic where their diagnosis was discussed.

On 01 February 2013, the patient underwent a flexible cystoscopy which showed multifocal tumour recurrence. Arrangements were made for TURBT and the patient was advised to stop aspirin seven days pre-operation.

Surgeon 1 performed the TURBT on 05 June 2013. Histology showed a high risk non-muscle invasive bladder cancer stage G3pT1.

During an MDT discussion on 13 June 2013, the patient was referred for intravesical BCG treatment for their bladder cancer, a repeat CT scan planned for September 2013 and cystoscopy in October 2013.

On 08 July 2013, the patient was seen at the outpatient clinic and was advised of the operation and the MDT's plan was enacted.

On 26 March 2014, Surgeon 1 performed a TURBT for recurrent bladder cancer on the posterior bladder wall. Histology of the resected specimen once again showed a high risk non-muscle invasive bladder cancer stage G3pTa.

Following a CT scan on 01 April 2014, the patient appeared to have a filling defect on the post wall, together with a left renal stone and small pulmonary nodules in the right and left upper lobes and foci in their liver.

On 03 April 2014, a MDT discussion took place and the patient was planned to have an ultrasound (US) of the liver, a repeat BCG⁷² treatment (i.e. 6 treatments at weekly intervals of intravesical BCG) and a cystoscopy in July 2014.

On 10 April 2014, the patient was seen in the outpatient clinic and was told of the diagnosis and the MDT plan was enacted.

Surgeon 1 performed TURBT of the recurrent bladder cancer on the posterior wall on 03 June 2015. Histology showed further high risk non-muscle invasive bladder cancer stage G3pTa together with carcinoma in situ (or CIS).

⁷² Bacillus Calmette-Guerin (BCG) is the main intravesical immunotherapy for high risk non muscle invasive bladder cancer.

On 18 June 2015, a further MDT took place. The patient was seen for review of the staging of the tumour and was offered the options of MMC⁷³ or radical cystectomy.

On 08 September 2015, the patient was seen at the outpatient clinic and the records outlined that the patient had cardiac stents and a pacemaker, although otherwise was very fit. A radical cystectomy (removal of the bladder and prostate in men) with urinary diversion by means of an ileal conduit or neobladder reconstruction were also discussed with the patient. The patient was keen for the surgical option.

The patient was discussed at MDT on 17 September 2015, and the patient was again seen where consent was obtained for radical cystectomy (RC).

On 30 September 2015, the patient underwent the RC and ileal conduit urinary diversion and on 12 November 2015, the radical cystectomy histology was discussed at MDT. It showed G3pTcis and G3pt1; with no involvement of the removed lymph nodes (N0) and no involvement of the surgical resection margins (R0). An incidental prostate cancer was also found. This was staged as GS 3+4 Pt2C N0 R0 disease and localised to the prostate with evidence of spread elsewhere.

On 20 February 2017, the patient was seen as an outpatient. The patient was described as doing well, however, they were referred for a further CT and blood tests in April 2017.

A consultant letter dated 08 May 2017 outlined that the CT taken showed no sign of recurrent disease.

On 26 January 2018, the patient attended the outpatient clinic where they were noted to be well and referred for further CT and blood tests in April 2018.

On 14 May 2018, a consultant discussed the latest CT scan (showing no sign of recurrent disease) with the patient and recommended follow up in a year's time.

The patient attended the outpatient clinic on 17 July 2019 and awaited the outcome of CT and blood tests results.

On 29 August 2019, the patient attended the outpatient clinic where the CT scan was noted as showing no sign of recurrent disease.

On 11 January 2021, the patient was seen in the outpatient clinic where the PSA result of 10 December 2020 at <0.01 was discussed. It was documented that the patient was well, their urinary stoma and bag appeared satisfactory and another CT scan was planned.

On 17 February 2021, the patient was seen in the outpatient clinic and the CT scan obtained on 13 February 2021 was discussed as showing no sign of recurrent disease. The patient was again referred for follow up in outpatient in 9 months.

Comments

The review team considered, from the limited clinical records provided, that the overall management of patient's bladder cancer appeared adequate. The review team was unable to comment on the consent or appropriateness of the operation notes for the surgery performed by Surgeon 1 as they were not provided with the patient's clinical record.

⁷³Mitomycin is a chemotherapy drug used to treat different cancers including breast, bladder, stomach, pancreatic, anal and lung cancers. For bladder cancer you have mitomycin C directly into your bladder.

Furthermore, there was no record of the extent of pre-operative counselling that the patient may have received prior to their radical cystectomy.

The review team regarded that follow up with the patient was continuous and at the latest review, the patient was noted to be well and had no recurrence of the disease.

Case A24

Description

This 88 year old male patient, with significant comorbidities, was treated for invasive bladder cancer.

On 03 October 2008, the patient was seen in clinic for LUTS. The patient's PSA⁷⁴ was recorded as 14.31 and the ultrasound of the patient's kidneys was recorded as normal but with a possible bladder stone. The patient was subsequently referred for TURP.

On 14 November 2008, the patient was seen by a consultant and their LUTS were again discussed. The patient's PSA on this occasion was 12.5. The patient was referred for a repeat PSA and flexible cystoscopy with TRUS⁷⁵ biopsy.

The patient underwent a TRUS biopsy and provided consent on 18 December 2008. Histology of this showed aggressive prostate cancer with a Gleason score of 8 in 6 out of 11 biopsies.

On 19 January 2009, the patient had a rectal exam. The left lobe of the prostate felt hard, which was consistent with the patients' known prostate cancer. At this time, the patient denied having significant LUTS. The patient was referred for a CT and bone scan.

In May 2009, the patient was advised that the bone scan result was negative. The CT results showed no spread of disease to the lymph nodes. The patient's flexible cystoscopy showed an occlusive prostate with mild trabeculation of the bladder and an outpatient review was recommended in the near future.

On 22 May 2009, the patient was referred for ADT⁷⁶ with Casodex⁷⁷ and Prostav⁷⁸ injections.

On 19 November 2009, the patient was seen in clinic where the use of Prostav for his prostate cancer was discussed. His LUTS were noted to be satisfactory. The patient was offered TURP.

The patient was referred for TURP on 30 March 2010. There was a consent form provided for this procedure.

On 04 May 2010, the patient was seen in clinic having had his TURP four weeks previously. The patient was noted to have developed sudden incontinence and was provided with a catheter. The patient was subsequently discharged with a planned clinic follow up review.

⁷⁴ The PSA test is a blood test used primarily to screen for prostate cancer. The test measures the amount of prostate-specific antigen (PSA) in the blood.

⁷⁵ A TRUS biopsy (transrectal ultrasound biopsy) can be used to produce detailed images of the prostate gland and surrounding tissues and allows for them to be biopsied. This provides tissue for laboratory analysis to see if cancer is present.

⁷⁶ Androgen deprivation therapy (ADT), also called androgen suppression therapy, is an antihormone therapy whose main use is in treating prostate cancer. Prostate cancer cells usually require androgen hormones, such as testosterone, to grow.

⁷⁷ Casodex (bicalutamide) is an anti-androgen. It works in the body by preventing the actions of androgens (male hormones). Casodex is used to treat prostate cancer that has spread to other parts of the body (metastatic).

⁷⁸ Prostav injection (leuporelin) is a hormone therapy for prostate cancer, breast cancer, fibroids and endometriosis.

On 10 May 2010, the patient was referred for a TWOC which was scheduled on 14 May 2010.

On 11 June 2010, the patient was still noted to have incontinence and was referred for an ultrasound, blood tests and a return to clinic. The patient's PSA on 11 June 2010 was noted as 0.06.

The patient attended clinic on 09 March 2012, having last been seen in June 2010. The ultrasound scan indicated complete bladder emptying and the patient was noted to be wearing a pad to manage urinary leakage. No PSA results were available so the patient was referred for a PSA blood test and flexible cystoscopy.

On 01 February 2013, the results of the flexible cystoscopy in July 2012 indicated that the prostate was open and there was no bothersome LUTS. The patient's PSA from 09 March 2012 was recorded as 0.03. The patient's PSA on 01 February 2013 was noted as 0.06 and the PSA on 25 June 2015 was 0.11. The patient was referred for review in six months.

The patient was referred to the haematuria clinic on 24 June 2015 with a complaint of blood in the urine. A flexible cystoscopy indicated there to be a bladder tumour (BT) present and a bladder biopsy showed an aggressive G3 bladder cancer. There was no consent included in the patient's clinical record.

On 26 June 2015, the patient was an inpatient with haematuria post cystoscopy. The patient was referred for irrigation, a CT scan and further review.

On 02 July 2015, the CT scan showed a 20 x 18mm lesion on the lung right upper lobe (primary lung cancer or possibly a secondary from elsewhere) and a BT in the left bladder wall. There was also a lesion (35 x 32mm) in the right kidney.

The patient's case was discussed at MDT on 06 July 2015 where the bladder and right kidney lesions were noted. The patient was referred for a CT scan on 22 July 2015 and a further review by Surgeon 1.

On 22 July 2015, the CT scan showed a right lower pole lesion in the kidney and the patient was referred for follow up in six months. The following day, the case was discussed at MDT and the patient was referred for review by Surgeon 1 to assess their fitness for TURBT.

On 31 July 2015, the patient was seen by Surgeon 1 and was referred for TURBT on 09 September 2015.

Between 09 September and 11 September 2015, the TURBT was managed by Surgeon 1. The clinical record noted a large solid tumour on the left lateral wall.

The consent recorded by Surgeon 1 stated TURBT as the procedure, however it did not mention the benefits and risks of the operation and why this operation had been suggested.

The operation note stated that the tumour resection was incomplete and that this was to be discussed at MDT on 17 September 2015.

On 24 September 2015, the patient's case was discussed at MDT. Bladder tumour histology showed high risk non-muscle invasive bladder cancer and the patient was referred for an MRI of their pelvis and a CT scan on their chest by Surgeon 1 and for MDT review.

On 09 October 2015, the patient was seen by Surgeon 1 for imaging as advised at MDT. However, no MRI was undertaken as the patient had a pacemaker.

On 16 October 2015, the patient's CT results indicated a 19mm lesion lung in the right upper lobe (or RUL), a 3cm complex mass on their right kidney and a 2cm lesion on their left bladder wall.

Between 11 and 14 November 2015, the patient was in hospital having a TURBT. The consent was completed by another surgeon. The operation note stated that there was no sign of tumour recurrence at the previous resection site other than tumour protruding from a diverticulum. An incomplete TURBT was performed.

The bone scan of 13 November 2015 showed no metastasis.

On 18 December 2015, the patient was seen by Surgeon 1 and was awaiting a PET CT scan. The patient was referred for review after and was discussed at a lung MDT (no notes were available for these).

An MDT meeting on the 19 November 2015 suggested referral to the central MDT for discussion but there were no notes relating to this.

The patient's PET CT scan result on 27 January 2016 indicated a possible lung cancer.

On 22 February 2016, the patient had a CT guided lung biopsy. The histology results showed no cancer.

On 22 June 2016, the patient attended an outpatient clinic with a fracture of the left proximal humerus.

Between 08 June 2016 and 02 July 2016, the patient suffered a fall, contracted a hospital acquired pneumonia and sadly died on Personal Information
redacted by the USI.

Comments

The review team considered from the clinical records provided that patient communication and consent as well as the patient documentation and record keeping were of an unacceptable standard. There was a consent form provided for the TURP in March 2010, however it was difficult for the review team to read. There was no consent form included in the patient's clinical record for the flexible cystoscopy in June 2015. The consent form recorded by Surgeon 1 in September 2015 stated TURBT as the procedure, however, it did not mention the benefits and risks of the operation and why this operation had been suggested. The review team particularly noted that the outpatient records lacked details of what the patient was advised and inadequate consent was obtained by Surgeon 1 as it did not record patient discussion.

The review team also noted there was room for improvement regarding the patient's assessment, the investigations undertaken, the treatment provided and team working. An MDT meeting in November 2015 suggested referral to the central MDT for discussion, however, there were no notes relating to this in the patient's clinical record. There was no record of the specialist MDT decision.

Despite these concerns, the review team viewed that the follow up of the patient was acceptable given that they had multiple comorbidities and as such, was unlikely to be a candidate for curative treatment. In addition, the review team concluded that the actions taken by the surgeon would not be comparatively different overall, albeit the individual stages of treatment may have been quicker. In general, the review team found the MDT records to be excellent.

Case A25

Description

This 89 year old female patient with vascular dementia was treated for invasive bladder cancer.

The clinical record included a letter dated 03 October 2014 from a consultant to the patient's GP which indicated a referral for recurring UTI.

On 22 October 2014, it was documented that the patient did not attend (DNA) an appointment and was subsequently discharged.

On 24 August 2015, the patient was referred to a gynaecologist and the ultrasound obtained was normal and the vaginal examination (VE) was also normal. The patient's urinary catheter was noted to be draining bloody urine and the cytology result was positive indicating the presence of a bladder cancer. The patient was referred to a urologist and was seen by Surgeon 1.

The patient was admitted to a ward on 07 September 2015 and on 09 September a CT scan showed that the patient had a left bladder wall malignancy; a moderate left Hydronephrosis or kidney swelling secondary to obstructed drainage; bilateral adnexal masses likely nodal metastatic disease and pulmonary nodules.

At operation, there was a large tumour of the posterior bladder wall with surrounding cystitis or possible Carcinoma in situ (CIS). No palpable mass was felt and partial TURBT was carried out. Post-TURBT, irrigation was arranged for the patient before they were discharged on 11 September 2015.

On 17 September 2015, an MDT discussion took place. 13g of bladder tissue showed poorly differentiated transitional cell carcinoma (TCC), focal intestinal metaplasia and also foci of squamous metaplasia. It was noted that the tumour infiltrated into the muscularis propria of the bladder – so the disease stage was at least pT2a. A decision was made for symptomatic care only for the patient.

The patient subsequently was admitted with delirium and sadly died on Personal Information redacted by the USI.

Comments

The review team considered from the clinical records provided that the overall management of this patient was acceptable. In the review team's opinion, it was always going to be difficult to manage bladder cancer in an elderly patient with dementia.

It was of concern to the review team that the patient did not attend an OPD appointment in October 2014 and was then discharged. Given the patient's problems, the review team wondered whether a reappointment could have been sent to the patient as she may have had TCC at this time given her subsequent history.

Case A26

Description

This 94 year old female patient had treatment for invasive bladder.

Between 23 June 2015 and 06 July 2015, the patient was noted to have vaginal bleeding due to endometrial cancer and an ultrasound scan showed an 8cm mass in their bladder.

The clinical record indicated that, on 24 June 2015, the patient's cytology result was positive suggesting that the bladder mass was malignant.

On 26 June 2015, the patient had a flexible cystectomy which showed a large solid tumour.

On 30 June 2015, a CT scan showed a large bladder mass and bilateral kidney stones, however, there was no evidence of metastasis.

The patient's case was discussed at MDT on 17 July 2015 and the patient was referred for TURBT.

On 17 July 2015, the patient was seen by Surgeon 1 and was admitted on 26 July 2015 for intravenous gentamicin (as she had a UTI) and had 2 units of packed RBC⁷⁹ transfusion.

The TURBT was performed by Surgeon 1 on 29 July 2015, however, it was an incomplete resection. The histology showed a high risk non muscle invasive G2-3 pTa bladder cancer.

It was noted at an MDT discussion on 06 August 2015 that the patient was a high risk non-muscle-invasive (NMI) TCC. This was reviewed by Surgeon 1 and further TUR was undertaken.

On 21 August 2015, another TURBT was performed on the patient by a different consultant surgeon.

On 03 September 2015, it was documented during an MDT discussion that the patient had recurrent high risk NMI bladder cancer (stage G3pT1). Surgeon 1 was tasked with arranging surveillance of the patient's condition and requesting treatment with an induction course of intravesical BCG if deemed appropriate.

The patient was seen by Surgeon 1 on 11 September 2015 and it was noted that the patient had pain in their right thigh, which increased with weight bearing.

A bone scan showed no evidence of metastatic disease and a further TURBT was performed on 4 November 2015.

An MDT on 12 November 2015 reviewed the histology, which again showed high risk non-muscle invasive bladder cancer. However, at the age of 87, it was deemed that the patient was not a candidate for radical curative surgery.

The patient was seen by surgeon 1 on 04 December 2015 and was noted to be well and an induction course of intravesical BCG immunotherapy was arranged for January 2016 with a cystoscopy planned for April 2016.

Further TURBT was carried out on 24 August 2016 with the histology showing G1-2pTa bladder cancer which was a slight improvement on previous results.

An MDT review on 01 September 2016 confirmed this and suggested maintenance BCG bladder instillations and continued bladder surveillance together with an up to date CT scan.

An induction course of BCG was completed on 14 December 2016 and a subsequent CT scan (23 January 2017) showed no sign of recurrent disease.

The cystoscopy on 24 February 2017 showed no recurrent disease within the bladder, however, a flexible cystoscopy on 01 September 2017 showed recurrent bladder cancer on the right bladder wall.

On 11 October 2017 the patient was admitted with haematuria and abdominal pain. A CXR was reported as normal and a further TURBT was performed on 19 October 2017. The histology showed aggressive muscle invasive bladder cancer (G2-3pT2).

A CT scan (24 October 2017) showed metastatic bladder cancer and following discussions with the patient's family, the patient was started on a palliative care pathway.

⁷⁹ Packed Red Blood Cell (Red Cell Concentrate) Transfusion Packed red blood cell (PRBCs) transfusions are used to improve blood oxygen-carrying capacity and restore blood volume.

The patient sadly died of metastatic bladder cancer on Personal Information redacted by the USI.

Comments

The review team considered from the limited clinical records provided that there was room for improvement regarding the patient's assessment, communication and consent and the record keeping in this case.

The review team noted that this was a patient with a high risk NMI bladder cancer and the management of her care had pivoted around the decision as to whether she would be a candidate for radical cystectomy or not, especially taking into account her age.

The review team could not find any evidence of discussions with the patient and consent was only provided for two cases: the flexible cystoscopy (01 September 2017) where the patient had not dated the consent form and the TURBT on 21 August 2015, where the intended benefits were not recorded. There also were no consent forms available for the procedures specifically where Surgeon 1 operated on the patient. It was also not known to the review team whether the patient's case was discussed at a regional MDT.

Despite the above concerns, the review team considered the overall management of the patient's care appeared to be satisfactory. The decision to re-resect the large tumour in >1 procedure was appropriate given the patient was not going to be a candidate for radical cystectomy.

Case A27

Description

This 76 year old male patient was referred by his GP on 07 October 2015 for haematuria.

A CT scan was carried out on 20 October 2015.

The patient underwent a flexible cystoscopy on 29 October 2015, and a subsequent TURBT procedure on 25 November 2015, which established T1G3 bladder cancer.

On 29 January 2016, the patient was referred by Surgeon 1 to a urologist for a radical cystoscopy, which was performed on 07 April 2016.

Comments

The review team considered that this was a well-managed case, across all areas of patient care.

In relation to assessment, investigations and imaging taken, the review team considered that these were appropriate and promptly carried out. The review team noted that this patient was initially managed under the care of Surgeon 1, and a CT scan and flexible cystoscopy was undertaken. This led to a TURBT procedure being undertaken, and subsequently both MRI and bone scans were performed. The patient was appropriately referred by Surgeon 1 to a urologist for a radical cystoscopy, which was performed on 07 April 2016.

The review team considered that there were detailed discussions of this patient's case at the MDT meetings held on 03 December 2015, 21 January 2016 and 28 January 2016, and that following these meetings appropriate discussions were held with the patient and sufficient actions were undertaken. In particular, the review team noted that the patient's case was discussed at the MDT meeting held on 21 January 2016. As a result, on 29 January 2016, Surgeon 1 appropriately referred the patient to the care of a urologist.

The review team wished to highlight what it considered to be very honest discussions with the patient after the initial TURBT, as well as at the stage where major surgery was required. The review team considered that the process of obtaining the patient's consent was appropriate,

noting that the consent form recorded all the risks and benefits of undergoing the procedure, which had been explained to the patient.

The review team considered that the patient received appropriate treatment. The review team were of the opinion that the patient was satisfactorily reviewed and discussed at MDT meetings and there was clear consultation with the patient up until the point of him undergoing major surgery.

The review team did not consider any concerns arose in respect of the record keeping. The review team noted examples of best practice in respect of recording all of the follow up actions. The review team also noted that the MDT meetings held on 03 December 2015, 21 January 2016 and 28 January 2016 were subsequently recorded in an appropriate manner.

The review team considered that correct follow up action was taken, with the patient being referred to the tertiary care centre. The review team did not consider there to be significant concerns arising in respect of patient harm, and therefore did not consider that clinical follow up was required in order to ensure the safety of the patient.

Case A28

Description

This 57 year old female patient was referred in January 2015 and was initially seen on 31 January 2015. There was some delay before she underwent a flexible cystoscopy on 09 April 2015.

The flexible cystoscopy revealed superficial tumours. The patient underwent a TURBT procedure on 06 May 2015, which revealed T1G2 bladder cancer.

The patient's case was regularly reviewed and discussed at MDT meetings. She was treated with Mitomycin C⁸⁰ for intravesical chemotherapy⁸¹.

The patient sadly died of bladder cancer on Personal Information
redacted by the USI.

Comments

Overall, whilst accepting that this was a difficult case to manage, the review team considered that many aspects of this patient's care were unacceptable or left room for improvement.

The review team considered that the early assessment, investigations and imaging taken in respect of the patient were appropriate.

The review team considered that there was appropriate use of MDT meetings on 14 May 2015 and 18 June 2015. Whilst the recommendations made at those meetings were appropriate, the subsequent actions taken left room for improvement. This prompted the review team to consider whether there were sufficient safeguards in place to monitor clinical decisions made at MDT meetings and to ensure that recommendations were appropriately carried out subsequently (albeit the review team considered this likely arose due to administrative issues, rather than individual practice of surgeons). For example, the review team noted that 6 Mitomycin C

⁸⁰ Mitomycin C is a type of chemotherapy drug. You might have it as a treatment for a number of different types of cancer. Mitomycin C works by interfering with the development of the genetic material in a cell, the DNA. This stops it from dividing into 2 new cells and kills it. So it destroys quickly dividing cells, such as cancer cells.

⁸¹ Intravesical chemotherapy involves injecting chemotherapy medication directly into the bladder to treat cancerous tumours. "Intravesical" means "within the bladder." Intravesical chemotherapy refers to chemotherapy treatment a healthcare professional applies directly into a person's bladder to treat bladder cancer.

instillations were appropriately arranged after an MDT meeting and that whilst two of these were correctly given to the patient, this was recorded incorrectly by the nursing staff.

The review team considered that the consent process, communication with the patient and consequently the record keeping in this case left room for improvement. The review team noted that there was nothing recorded on the electronic system or within the handwritten records made available to indicate that the patient's consent had been obtained. The records and correspondence indicated that the patient was seen at an outpatient's appointment on 31 January 2015 (which was likely to have been a private sector appointment, although this could not be confirmed). Whilst there was a plan in place following this visit, this was not followed up until a letter was sent to the patient's home address on 09 April 2015, which informed her of the flexible cystoscopy being arranged for the following day (10 April 2015). The reasons for the delay were unclear, and it prompted the review team to consider whether there were sufficient safeguards in place within the electronic system to identify priority clinical decisions which needed to be escalated. The review team considered it likely that these issues, across many aspects of patient care, arose as a result of administrative issues, rather than the errors of individual clinicians.

The review team considered that the treatment of this patient was unacceptable, noting that despite being first seen at her appointment on 31 January 2015, her flexible cystoscopy was not performed until 10 April 2015, over two months later. Whilst a plan appeared to be in place after the initial appointment, the reason for the two month delay was unclear to the review team. The review team accepted that the rapid progression of the patient's cancer from superficial to metastatic made this a difficult case to manage. However, they considered whether there was a possibility that this unexplainable delay contributed to the poor clinical outcome.

The review team considered that appropriate follow up action was taken in respect of the patient, with the second TURBT being performed on 09 June 2015.

Case A29

Description

This male patient, whose age was unknown, had an initial diagnosis of superficial Ta⁸² TCC bladder cancer. This progressed to T2 muscle invasive TCC.

The patient underwent two early TURBT resections.

A flexible cystoscopy was undertaken on 07 February 2014.

On 31 December 2014 a general anaesthetic (GA) cystoscopy and biopsy were undertaken.

The disease had advanced by the time of the TURBT procedure which was undertaken on 31 December 2014. The patient sadly died on Personal Information redacted by the USI.

Comments

Based on the patient's initial presentation, the review team considered that the early assessment, investigations and imaging undertaken were appropriate.

The review team noted a lengthy report of the MDT review which took place on 16 April 2015, which recorded the patient's rectal cancer, the need for an AP resection and radiotherapy in 2006, the subsequent diagnosis of probable bladder cancer, after haematuria, in 2013, the resection of a further tumour and CT scan on 13 December 2013. However, within this MDT report, there was no mention on the patient undergoing a flexible cystoscopy on 07 February 2014, or his placement on the waiting list for a GA cystoscopy. The next comment in this report

⁸² Ta is superficial tumour just in the mucosa

referred to the TURBT undertaken on 31 December 2014. The review team noted that this MDT report was signed by Surgeon 1, as the chair of the meeting.

The review team noted that a previous MDT report from 5 March 2015 did record the clinical details for 13 January 2014, and the patient seeing the continence nurse at an outpatient's appointment in June 2014, however again, there was no reference to the flexible cystoscopy performed on 07 February 2014.

The review team noted another MDT report from 29 January 2015, which made reference to a plan to review the patient on 13 January 2014, and that the patient was advised to have a flexible cystoscopy.

The review team considered that the actions taken as a result of MDT meeting recommendations were acceptable, given the patient was subsequently and appropriately referred to the palliative care team for advice. However, given the omissions within the records of the MDT meetings, the review team considered the MDT working to be overall unacceptable.

The review team considered that consent was taken appropriately from the patient before a TURBT was performed in December 2014. However, given the continence nurse noted on 02 June 2014 that the patient was on the waiting list for a GA cystoscopy, but this did not result in action to ensure the patient underwent this procedure as a priority, the review team considered that there was room for improvement with regard to communication with the patient.

The review team noted that after the early TURBT, the flexible cystoscopy undertaken on 07 February 2014 showed recurrent disease. The fact that the patient was listed for a GA cystoscopy and biopsies/resection, but this did not occur until 31 December 2014, made the review team form the opinion that the treatment of this patient was unacceptable. It was for the same reason, the review team considered that poor follow up action was taken in respect of this patient. There was a delay in undergoing the planned surgery between February and December 2014, by which time the disease had progressed from superficial to muscle invasive, the patient sadly subsequently died.

Having regard to the delays which occurred between February and December 2014, despite certain entries being made in the patient's clinical records, as well as the omissions within the MDT reports, the review team considered that the record keeping in this case was unacceptable. It prompted the review team to question the sufficiency of waiting list processes. The review team considered when the patient was listed for the GA cystoscopy, what priority was given to this procedure, and more broadly, who checked waiting lists and what the criteria was for assigning priority to operations. The review team considered whether procedures went onto waiting lists for individual surgeons, or shared lists for all surgeons working within the urological service. Furthermore, the review team questioned the adequacy of clinical correspondence, following clinical decisions being made, and whether they were checked and followed up to ensure actions were carried out.

The review team considered that the patient had experienced significant harm, because of the delay between February and December 2014. At this point, his disease had progressed to a muscle invasive cancer, and he sadly died a year later.

Case A30

Description

This 65 year old male patient had non-muscle invasive superficial bladder cancer. He was cared for and his bladder cancer was managed between 2014 and 2021 with multiple flexible cystoscopies and repeated treatments for recurrent superficial disease. The patient was treated with Mitomycin C intravesical chemotherapy and BCG instillations.

Comments

Overall, the review team considered that the patient received appropriate care and treatment, and they did not have any specific concerns. The review team considered that assessment, investigations and imaging were acceptable, with appropriate history taken and investigations performed.

The review team identified no concerns with the MDT and team working in this case, with the involvement of a number of individuals in the care of the patient. The review team considered that the actions taken as a result of MDT meeting recommendations were acceptable. The review team noted that the patient was initially managed under the care of one surgeon, who said that if the procedure was to be performed sooner, it should be done by a colleague, and therefore Surgeon 1 took over the patient's care and performed the procedure. This prompted the review team to consider whether each surgeon held their own waiting list, or whether this was a shared waiting list amongst the service, but overall the review team found acceptable use of the MDT and team working in this case.

The review team noted that patient consent was not recorded on the electronic records available to the review team, and they did not have sight of hard copies of such documentation. However, from the information available, the review team considered that the correspondence appeared appropriate and that the patient was kept well informed.

The review team considered that prompt and appropriate treatments were delivered to the patient, as well as acceptable follow up action being taken by clinicians within the service.

The review team did not identify substantial issues with the record keeping in this case.

The review team did not consider that this patient came to significant harm, and did not consider that clinical follow up was required to ensure the patient's safety.

Case A31

Description

This 70 year old male patient was treated for recurrent bladder cancer over a period of five years. The patient's comorbidities included a cardiac history, having had a stenting in 2015 and iliac artery aneurysm.

In March 2011 the patient was diagnosed with T1G3 superficial non-muscle invasive bladder. Between March 2011 and December 2013, the grading varied from T1G3, to TaG3, and then back to T1G3. By 2014, carcinoma in situ (CIS) had developed.

Once the grade of the cancer had progressed, the patient was treated with intravesical BCG.

The patient had a TURP on 03 April 2013.

The cancer had progressed to T2 muscle invasive in July 2015.

A nephrostomy was undertaken on 06 August 2015 to treat the patient's left renal obstruction.

The cancer became metastatic by late 2015/early 2016.

The patient sadly died in Personal information redacted by the USI.

Comments

The review team considered there was appropriate first line management, investigations and testing. They considered that overall the assessment, investigations and imaging taken were acceptable.

In respect of MDT and team working, the review team noted that the patient's care and treatment was regularly reviewed and discussed at MDT meetings, and agreed recommendations were actioned appropriately following those meetings. However, given the progression of the cancer, the review team had concerns regarding how appropriate some of the recommendations made during those meetings were and the consequent impact on the patient's care and treatment. The review team considered it appropriate at initial stages that the MDT decided on offering the patient BCG treatment, in 2011 and 2013. However, when it was identified that the cancer was recurrent in 2013 (and the progression to T1G3, as well as the rec CIS developing in July 2014), the review team questioned the recommendation of continuing the BCG treatment.

Furthermore, the review team considered that the decision to undertake a cystectomy should have been discussed at an earlier stage given the progression of the cancer. They noted the patient was not referred for consideration and this procedure was not performed until 2015, at which stage the cancer was T4N2, which was too late. Given these matters, the review team considered there was room for improvement in respect of MDT working, and consequently actions taken as a result of recommendations made during MDT meetings.

The review team considered that the patient was kept informed appropriately throughout the period of his care and treatment. They considered that the benefits and risks of undergoing the TURBT and the two nephrostomy procedures were sufficiently explained to the patient, and the consent process and communication with the patient appeared acceptable.

The review team considered that the patient received appropriate treatment, including the required BCG for the T1G3 disease.

The review team considered that there was acceptable follow up action in respect of this patient over a five year period.

The review team considered that the record keeping, which included documentation for the investigations, treatments, adjuvant treatments and MDT meetings, were acceptable. Whilst the hard copies of the clinical records were difficult to assess, the electronic records were clear and accurate in respect of the relevant areas of the patient's care and treatment.

In respect of patient harm, the review team considered that the decision to undertake a cystectomy could have been taken earlier, and this may have resulted in a better outcome. However, the patient's cancer progressed in a recognised manner and it was entirely possible other urological surgeons would have managed the patient's care in the same manner. The review team further noted the patient's cardiac history, however, he was assessed as fit enough to undergo a cystectomy in 2015.

Case A32

Description

This male patient, whose age was unknown, had MRI and biopsy twice in 2014. Results from both scans appeared satisfactory.

On 22 April 2015, the patient had LUTS with a rising PSA and the patient was prescribed Ciprofloxacin.

On 16 October 2015, it was recorded that the patient's PSA was down to 4.98 from 9.15mg.

In December 2015, the patient's LUTS appeared settled.

On 11 March 2016, an MRI scan showed no evidence of CAP. A letter documented the assessment and investigations undertaken, summarising all information.

On 30 September 2016, the patient's PSA was stable at 5.8 mg.

It was documented that the patient had follow up until April 2016, when the patient subsequently moved to Glasgow, Scotland.

Comments

The review team considered that the patient was adequately assessed and his diagnosis was deemed acceptable.

In the review team's view, the investigations undertaken were suitable to the patient's needs and were considered satisfactory as PSA's were obtained.

The review team noted that there were three MDT meetings in 2014 however, no further MDT discussions were indicated after this time.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care. However, the review team were concerned that there was a delay in documenting the patient's clinical journey until information was summarised in a letter dated 11 March 2016 and again in a letter dated 05 April 2019. Therefore, the review team considered that record keeping in this case was below the standard expected and had room for improvement.

Case A33

Description

This male patient, whose age was unknown, was referred in November 2015 due to a painful epididymal swelling, which was initially thought to be an infection. The patient was seen in clinic on 01 December 2015. The patient was found to have a lump in their right epididymis and was prescribed Ciprofloxacin and Ibuprofen.

Ultrasound scans were obtained on 06 November 2015, 23 June 2016, 04 October 2016 and 09 June 2017. It was documented that no procedure was required for this patient.

At a follow up appointment, it was indicated that the patient showed likely bilateral epididymal cysts.

Comments

The review team considered that the patient was adequately assessed and his diagnosis was deemed acceptable.

In the review team's view, the investigations undertaken were suitable to the patient's needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment of non-surgery and received appropriate follow up.

The review team found that the clinical record entries and letters were clear, accurate and legible to an acceptable standard.

Case A34

Description

This male patient, whose age was unknown, was referred by general surgery for LUTS on 16 July 2011 with an elevated PSA.

On 25 October 2011, the patient had a TURP biopsy after a clinical appointment. During an MDT discussion on 03 November 2011, the patient was referred for radical radiotherapy with a follow up by an oncologist.

The patient underwent radical radiotherapy in July 2012.

At a telephone consultation on 06 October 2014, it was documented that the patient undertook radiotherapy for prostate cancer (CAP) and the patient was referred on to oncology

The patient was referred back to their GP on 24 November 2015.

Comments

The review team considered that the patient was adequately assessed and their diagnosis was deemed acceptable. The review team observed that the patient was discussed at MDT after diagnostics and that there was appropriate management between oncology nurse specialists.

The review team noted that there was patient involvement with the decisions made and there was good guidance to the patient's GP when the patient was re-referred.

It was the opinion of the review team that there were appropriate written notes and very detailed letters included in the patient's clinical record.

The review team concluded that no surgical follow up was required for this patient. In the review team's view, oncology follow up should be ongoing in this case.

Case A35

Description

This 44 year old male patient was seen in clinic on 24 November 2015 with an elevated PSA and LUTS. Flexible cystoscopy was conducted on the same day. The patient provided verbal consent for the examination and written consent for the flexible cystoscopy was obtained.

On 23 May 2016 the patient was reviewed in clinic.

In February 2020, the patient's PSA was recorded as stable and the patient was noted to still be experiencing LUTS. An interpreter was present at first consultation where verbal consent was mentioned for examination. The patient was prescribed Ciprofloxacin⁸³ and Solifenacin⁸⁴ indefinitely.

Comments

In the review team's opinion, it was unusual for the patient to be prescribed Ciprofloxacin for an indefinite period.

⁸³ Ciprofloxacin is a broad-spectrum antibiotic that is used to treat a wide range of infections, especially respiratory and urinary tract infections. Ciprofloxacin is not used as often as some other antibiotics because of the risk of serious side effects.

⁸⁴ **Solifenacin** is a medicine used to treat symptoms of an overactive bladder.

The review team noted that this patient had excellent recording of their clinical journey and full details of the decision-making are documented in their patient record.

It was the review team's view that this patient had a marginal call for an MRI and that the clinical evaluation was not necessary. However, the review team concluded that there was no evidence of harm found in this case and therefore there was no follow up required.

Case A36

Description

This 78 year old male patient was referred on 29 December 2015. A letter dated 06 January 2016 documented that the patient had LUTS and an elevated but fluctuating PSA.

There was no cause for concern from the subsequent follow up and re-referral. The patient was put in a follow up programme.

Comments

In the review team's opinion, appropriate care and advice was provided to this patient. There was excellent initial assessment and care plan conducted and the investigations were timely and prompt.

It was the review team's view that clinical management of this patient was acceptable and the patient was discharged appropriately after initial consultation.

The patient was re-referred in 2019 and it was documented that follow up was conducted in 2021 with no sequelae recorded.

Case A37

Description

This 60 year old male patient was diagnosed with organ confined prostate cancer. A full investigation took place and he was then treated (as per MDT recommendation) with brachytherapy and neo-adjuvant hormones. However, there were subsequent problems with bladder instability, which was fully investigated and treated with Botox.

Detailed notes were provided by Surgeon 1 and other clinicians between 11 September 2015 and 14 March 2017.

There was a delay in definitive treatment (i.e. brachytherapy) at the patient's request (as he was a butcher and farmer and did not want time off in the lead up to Christmas).

Comments

The review team considered from the clinical records provided that the assessment, investigations, treatment and team working including MDT working, were acceptable. However, the review team considered that there was room for improvement regarding patient communication as the consent form, prior to cystoscopy and Botox injection, did not list the possible complication of urinary retention and the inability to pass urine.

Despite this concern, the review team noted that specific clinical follow up with the patient was not required as it was presumed the patient would be followed up in the long term either by urology, oncology or their GP, or a combination of the three depending on the local protocols.

Case A38Description

This 90 year old male patient presented with prostate cancer and was referred by his GP in December 2014. The patient was seen by Surgeon 1 in January 2015. The patient was treated with hormones.

Comments

The review team considered from the clinical records provided that the assessment, investigations, treatment, team working, patient consent and communication with the GP and patient's family/carer were acceptable in this case. The review team also described the record keeping as very detailed.

The review team noted that the patient's care was followed up by their GP as appropriate and in line with the local protocols.

Case A39Description

This 58 year old male patient presented with a mildly raised PSA and was seen by Surgeon 1 between 12 January 2015 and 05 January 2017. The patient was discharged back to his GP with appropriate advice regarding PSA follow up.

Prostate cancer was not diagnosed.

Comments

The review team considered from the clinical records provided that the assessment, investigations, treatment, patient consent and communication with the GP and patient's family/carer were acceptable in this case.

The review team did not make any recommendation for clinical follow up, noting that the GP follow up regarding the PSA monitoring had been arranged which was considered appropriate.

Case A40Description

This 69 year old male patient was referred by his GP in January 2015 with a raised PSA. He was seen by Surgeon 1 in clinic on 23 February 2015 and referred for a hernia and truss⁸⁵ and prostate biopsy. The biopsy result showed no cancer, however, it indicated some prostatic intraepithelial neoplasia (PIN)⁸⁶. A repeat biopsy was carried out on 01 July 2015 as per MDT recommendation. This biopsy result was completely negative.

Comments

The review team considered from the clinical records provided that the assessment, investigations, treatment, team working including MDT working, patient consent and communication with the GP and patient's family/carer were appropriate in this case.

⁸⁵ A surgical appliance worn to support a hernia, typically a padded belt

⁸⁶ Changes to cells in the prostate.

The review team did not make any recommendation for clinical follow up, noting that Surgeon 1 had advised the patient's GP of PSA follow up which was considered appropriate.

Case A41

Description

This 74 year old male patient was seen by a urologist in November 2014 with LUTS, haemospermia and a PSA of 7.2. The patient was prescribed Ciprofloxacin at that time and was reviewed in clinic in April 2015 by Surgeon 1, who noted that the haemospermia had resolved, the patient's PSA reduced to 6.8, and the prostate was enlarged and felt benign.

The patient was again seen again by Surgeon 1 on 21 July 2017 when the LUTS had worsened slightly. The patient was prescribed Finasteride⁸⁷ in addition to Tamsulosin⁸⁸ and was listed for TURP.

There was a presumed waiting list check on 02 August 2019 where it was recorded that the patient stated that, as he had had no symptoms from his medication, he no longer wished to proceed with the surgery.

The patient presented in mid-2020 with malaise, fatigue, a malignant feeling prostate and a PSA of 370. A bone scan showed multiple bone metastases. The patient commenced hormone therapy.

The last note available was by an oncology nurse stating the patient had a PSA of 0.68 and that he was on Abiraterone⁸⁹ and Prednisolone⁹⁰ medication and felt well.

Comments

The review team considered from the clinical records provided that the assessment, investigations and treatment were entirely appropriate in this case.

The review team did not consider that team working/MDT discussion or consent was applicable in this case.

The review team regarded that Surgeon 1's outpatient management was satisfactory. The review team, however, considered that some urologists would possibly investigate a PSA of 6.8 in a 75 year old man as he had been presented to Surgeon 1. However, the review team were of the opinion that the course of action taken by Surgeon 1 mirrored that of the majority of urologists caring for a patient with in an enlarged benign prostate and demonstrated resolution of symptoms.

Case A42

Description

This 65 year old male patient was referred due to a raised PSA.

⁸⁷ Finasteride (Proscar) is used to treat symptoms of benign prostatic hyperplasia (BPH) in men with an enlarged prostate. Finasteride is for use in men only.

⁸⁸ Tamsulosin (Flomax) is an alpha-blocker that relaxes the muscles in the prostate and bladder neck, making it easier to urinate. Tamsulosin is used to improve urination in men with benign prostatic hyperplasia (enlarged prostate).

⁸⁹ Abiraterone is a treatment for advanced prostate cancer. It is most commonly offered to men whose cancer has stopped responding to other types of hormone therapy.

⁹⁰ Prednisolone is a steroid medication used to treat certain types of allergies, inflammatory conditions, autoimmune disorders, and cancers.

On 19 October 2015, the patient was seen by Surgeon 1 for LUTS with hesitancy, poor flow, PMD⁹¹, Nocturia⁹² and urge. The patient was referred for a PSA, blood test, ultrasound and his LUTS were treated with Xatral XL.

The patient's PSA came back raised at 9.7 and a further review was planned in February 2016 (there were no notes relating to this review included in the patient's clinical record, so it was difficult to know whether it took place or not).

There were no concerns raised from the ultrasound scan obtained on 02 November 2015.

A GP referred the patient on 11 August 2017 due to raised PSA at 8.2, EtOH⁹³ dependency syndrome and palpitations. The patient was on Omeprazole⁹⁴ and an ex-smoker of eight years.

It was documented that the patient DNA their OPD appointments on 18 September and 11 October 2017.

On 01 November 2017, the patient was seen for LUTS which started two years previously. It was recorded that the patient's IPSS⁹⁵ was 6, their QoL⁹⁶ score was 1 and that the patient had two brothers with BPH⁹⁷ diagnosed on prostate biopsy. The results of the patient's examination was noted as normal and on a rectal exam, a large benign prostate was felt. The patient was referred for MRI and for follow up review.

On 26 November 2017, the MRI result was recorded as showing 65 cc prostate and indicated no lesion of PIRADS⁹⁸ 3 or greater.

The MRI results were explained to the patient on 13 December 2017.

The patient's PSA on 20 July 2018 was recorded as 10.7 and the PSA trend was noted to be increasing. It was agreed to continue monitoring the patient and/or further review.

On 19 September 2018, the patient attended clinic and opted for continued monitoring rather than have a prostate biopsy.

The patient's PSA on 23 January 2019 was noted as 6.4 which was the lowest result recorded in the last five years. The patient was discharged to their GP for annual PSA review (with an alert noted if their PSA score went over 10 on two occasions).

On 29 January 2020, the patient attended clinic with LUTS including decreased flow, hesitancy and nocturia. However, the patient was reluctant to take an alpha blocker of 5ARI and

⁹¹ Post Micturition Dribble (PMD), or after dribble, is the name given to the problem when men experience an involuntary loss of urine immediately after they have finished passing urine, usually after leaving the toilet.

⁹² Nocturia is a condition characterized by the need to awaken ≥ 1 times per night to void. Although nocturia is a multifactorial condition that can coexist with other lower urinary tract symptoms, the most common causal factor is night time overproduction of urine.

⁹³ Ethanol (EtOH) or alcohol is a chemical added to various beverages to enhance its flavour and provide a relaxing feeling.

⁹⁴ Omeprazole is used to treat excess stomach acid in conditions such as non-cancerous stomach ulcers, gastroesophageal reflux disease (GORD), active duodenal ulcer, Zollinger-Ellison syndrome and erosive esophagitis.

⁹⁵ This International Prostate Symptom Score (IPSS) evaluates the severity of urinary symptoms due to prostate enlargement in BPH.

⁹⁶ Quality of Life measure specific to urinary problems that can be used to assess the impact of urinary problems and their treatment.

⁹⁷ Benign prostatic hyperplasia (BPH) is when the prostate and surrounding tissue expands.

⁹⁸ Prostate Imaging Reporting and Data System (PIRADS) was developed in order to standardize the reporting of mp MRI and to establish clear guidelines for the characterization of suspect lesions in the prostate. By assigning a score from 1 to 5, the PIRADS shows the probability of every lesion to harbour clinically significant prostate cancer.

arrangements were made for him to be taught clean intermittent self-catheterisation (or CIC⁹⁹). No further records were available.

Comments

The review team considered from the clinical records reviewed, that there was room for improvement in relation to the assessment, investigations and the associated record-keeping for this patient's case. The review team particularly noted that there was little history of the patient's case documented, other than the record of the patient's urinary Sx¹⁰⁰ and DRE. The review team queried that, whilst the ultrasound and PSA were undertaken, these were not acted on and this might have been because of the patient's lifestyle being a contributory factor.

Despite such concerns, the review team concluded that the patient's treatment was acceptable and there was no patient harm caused despite the two-year gap between October 2015 and August 2017 when the patient should have been followed up but was not seen. However, there may be patient related factors for this too, given the history of out-patient DNAs and EtOH dependency.

The review team viewed that another consultant in similar circumstances potentially would have acted on the raised PSA to ensure patient follow up was not missed. As such, the review team considered that a repeat MRI would be recommended at an appropriate stage.

Case A43

Description

This 67 year old male patient was treated for a raised PSA.

On 27 July 2011, the patient had a normal flexible cystoscopy.

On 14 August 2011, the patient's IVP¹⁰¹ was recorded as having no abnormalities detected (NAD).

On 16 November 2011, the patient attended clinic and it was noted that the patient had suspicious urine cytology and a long history of microscopic haematuria. The results of the flexible cystoscopy and IVP were recorded as NAD. It was documented that repeat cytology¹⁰² was required.

The cytology result appeared satisfactory and therefore the patient was discharged on 28 November 2011.

On 23 January 2015, the patient's GP made a referral as the patient's PSA was recorded as 5.7 and the patient also had LUTS and nonvisible haematuria.

On 28 January 2015, a consultant referred the patient for urgent MSU¹⁰³, medication for any UTI and a repeat PSA.

⁹⁹ Clean intermittent catheterisation (CIC) is a simple procedure to empty the bladder. It involves passing a small tube called a catheter up the urethra (water pipe) into the bladder to allow the urine to empty.

¹⁰⁰ Symptoms

¹⁰¹ An intravenous pyelogram (IVP) is a type of x-ray that provides images of the urinary tract.

¹⁰² In a urine cytology exam, a doctor looks at cells collected from a urine specimen to see how they look and function. The test commonly checks for infection, inflammatory disease of the urinary tract, cancer, or precancerous conditions.

¹⁰³ A midstream specimen of urine (MSU) is tested to look for infection.

The patient was seen by Surgeon 1 on 09 March 2015 following the result of their PSA of 4.0 taken on 06 March 2015. The patient was also recorded as having microhaematuria, LUTS with nocturia and a DRE showing large prostate. It was documented that the patient had been on Tamsulosin since February 2015. The patient was referred for an ultrasound scan and CTU.

On 20 March 2015, the ultrasound scan and CTU were noted as having no significant concerns.

On 29 December 2016, the patient was seen by Surgeon 1. It was documented that the patient was on Tamsulosin and his LUTS were not considered to be problematic at that stage. The patient's PSA from 30 September 2016 was 4.5 which was satisfactory, given the volume of the prostate (77mls). A repeat ultrasound was recommended to assess voiding.

The outcome of the ultrasound (27 January 2017) was unremarkable showing a prostate volume of 77mls and a residual; urine of 77mls.

On 13 August 2018, Surgeon 1 reviewed the patient. The patient reported LUTS including nocturia x2-4. The patient was noted to have low back pain with sciatica and was concerned about the possibility of metastasis from the prostate. The patient's DRE showed a benign enlarged prostate (or BEP) and his PSA was 7.4. The patient was referred for US, MRI of the spine, and a bone scan. In the interim, the patient was treated with Baclofen, Finasteride, paracetamol, Ibuprofen and a follow up review was scheduled for December 2018.

On 07 September 2018, the bone scan result was noted as normal with no metastasis.

The patient attended orthopaedic out-patients on 15 October 2018 and it was considered that the left hip pain was due to osteoarthritis (OA).

On 22 November 2018, a CT scan showed increased volume of the prostate.

On 23 November 2018, the ultrasound scan results were satisfactory but showed an enlarged prostate of 88mls.

The patient was referred back to urology on 07 January 2019 due to fluctuating PSA levels since 2015. It was documented that the patient had been taking Tamsulosin since February 2016. The patient's DRE showed a large BEP and he was referred for a prostate MRI.

On 14 January 2019, the results of the MRI showed a 75 mls prostate and a tiny PIRADS 3 lesion of the left peripheral zone which was discussed at MDT (although no record of this was available).

On 22 January 2020, the patient was seen in clinic as the PSA was 6.5. The patient was therefore referred for LUTS assessment and an up to date PSA.

On 10 February 2020, the patient was advised that their repeat PSA was 5.6. This had been stable for some years. Given this and the MRI results from a year prior, the patient was referred back to his GP to monitor PSA every six months and for urology follow up review in one year.

On 17 March 2020, the patient was seen at Accident and Emergency for urinary retention and was catheterised.

According to records from 18 July 2020, the patient's catheter was in situ and the patient was noted as having haematuria.

On 18 August 2020, the patient was seen in clinic and a previous TWOC was noted as being unsuccessful with a residual urine of 650mls. Therefore, the patient was referred for urology review.

On 02 October 2020, the patient was seen by a consultant and TURP was discussed due to the refractory urinary retention and several failed TWOCs.

A pre-assessment took place on 06 October 2020 and TURP was arranged for 19 October 2020. No consent form was provided.

TURP was performed on 19 October 2020.

On 23 October 2020, the patient was seen to review their condition post operation. It was noted that the TWOC had been successful and so the patient was taken off Tamsulosin and Finasteride.

During the patient's review in clinic on 05 November 2020, the histology records showed acute inflammation of the prostate and benign prostatic hyperplasia but no cancer was detected. The patient was advised a review of their PSA should be undertaken in six months' time.

On 03 June 2021, the patient's health was recorded as satisfactory since the TURP and the PSA result of 07 March 2021 had reduced to 1.85. The histology recorded a diagnosis of BPH and the patient was subsequently discharged.

Comments

The review team concluded from the clinical records provided that the patient's management was acceptable in this case.

The review team considered that the patient was adequately assessed and the diagnosis was deemed acceptable.

In the review team's view, the investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care.

The review team considered that no patient harm had occurred and, as such, the patient did not require further clinical follow up.

Case A44

Description

This 87 year old male patient was treated for a raised PSA.

The review team noted that Surgeon 1 was only involved with a small part of the patient's care throughout their clinical journey.

The patient's treatment pathway was therefore grouped together by theme as shown below:

The patient was initially seen by Surgeon 1 on 26 May 1998 regarding LUTS and the patient was prescribed Finasteride. The patient was referred for an US scan, blood tests, an MSU and flexible cystoscopy.

The patient was seen by two different consultants on 03 December 1998 and 02 March 1999, during which time the patient's medication was changed from Proscar (Finasteride) to Flomax

(Tamsulosin). There was a notable improvement to the patient's LUTS due to the Flomax. The patient was also given MUSE¹⁰⁴ 250mcg to treat their erectile dysfunction (ED).

Surgeon 1 reviewed the patient on 31 August 1999 and noted that Flomax was ensuring a better 'flow' (of urine). However, there was some PMD¹⁰⁵ and nocturia x2 noted. The patient was placed on the waiting list for TURP.

The patient was not seen again by Surgeon 1 until 16 October 2001 who arranged for the TURP admission. In the intervening period the patient was reviewed by three different consultants about the LUTS and was referred for PSA and MSU, and it was recommended that the TURP operation was expedited.

The patient was in hospital from 11 December to 16 December 2002 for their TURP (no consent form had been provided). The patient's histology was recorded as benign.

Between 30 December 2002 and 06 July 2004, the patient was reviewed by a number of consultants following the TURP operation. The patient appeared to show some improvement in their condition, apart from some pain in their upper left leg/groin area which turned out to be due to a hernia. The patient was referred for a hernia operation.

On 12 June 2007, a consultant referred the patient to the prostate assessment clinic given reports of the patient's testicular discomfort. The patient's PSA of 04 June 2007 was recorded as 3.1. The outcome of tests conducted were satisfactory although the prostate could not be felt on a DRE. The patient was referred for a testis ultrasound scan.

On 24 October 2007, the patient attended clinic and it was noted that the patient still had pain in their testis, although the ultrasound scan was normal and there was no complaint of LUTS. It was documented that there were no hernias or abdominal masses. The patient was again referred for a PSA and MSU, with further review in three months' time.

The clinical record showed that on 13 June 2008 the patient's PSA result was 3.5. There was some occasional pain in the patient's left groin and the prostate was not palpable on a DRE. The patient was referred for PSA, US scan, blood tests and a flexible cystoscopy.

On 30 October 2008, the patient was reviewed following the flexible cystoscopy which showed that the urethra was normal, however, there was some prostate regrowth and the bladder was unremarkable.

This was revisited by Surgeon 1 on 12 June 2012. In the intervening period, the patient was seen by a number of consultants relating to PSA and urinalysis tests. No blood was detected in the patient's urine although testicular pain was still reported by the patient. Further examination of the testes was undertaken, no LUTS were reported and the patient's PSA outcomes were of no concern at this point.

On 26 January 2011, a consultant reviewed the patient and recommended that he could be discharged depending on the outcome of his next PSA. This was 3.28.

However, the patient was referred by their GP on 12 June 2012 to Surgeon 1 given the patient's PSA of 04 April 2012 which had increased to 6.88. A scrotal ultrasound scan of 01 June 2012 was unremarkable. The patient was referred for an ultrasound scan of their urinary tract.

¹⁰⁴ MUSE is a treatment for erectile dysfunction. The treatment consists of a urethral stick containing alprostadil which is then inserted into the urethra. MUSE treatment works by helping to relax the muscles in the blood vessel wall which will allow blood to flow more freely into the penis.

¹⁰⁵ Post Micturition Dribble (PMD), or after dribble, is the name given to the problem when men experience an involuntary loss of urine immediately after they have finished passing urine, usually after leaving the toilet.

The patient was seen by Surgeon 1 on 16 June 2012 and 15 June 2013 respectively for LUTS and review of PSA. It was determined that Oxybutynin had helped the patient's LUTS. The PSA on 31 May 2013 was 5.31 correcting to 10.62 allowing for the effect of Finasteride. Given that on DRE the right base of the prostate felt firm, this raised the possibility of prostate cancer being present. The patient was referred for a prostate biopsy.

This patient's case was discussed at MDT on 11 July 2013. Since the patient had been seen on 16 June 2012, there had been a notable deterioration in their LUTS. The prostate biopsies showed prostate cancer in 6 out of 10 biopsies with aggressive Gleason score 9 disease. The plan was for the patient to be reviewed by Surgeon 1 so that they could arrange a bone scan and MRI scan, with the results to be discussed at the next MDT.

The patient's case was again reviewed on 22 August 2013 by the MDT. The BS on 09 August 2013 revealed no metastasis and the MRI results on 21 August 2013 showed T3N0 prostate cancer localised to the prostate. Surgeon 1 was to review the patient and consider radiotherapy as a treatment option.

On 09 September 2013, the patient's Bicalutamide was stopped and changed to injections of Goserelin and the patient was referred for radiotherapy (RT) in December 2013.

Between January and February 2014, the patient's prostate RT was completed.

On 22 February 2014, the patient was seen by Surgeon 1 regarding LUTS which appeared to have worsened post-RT. The patient was on Oxybutynin and PSA results from November 2013 was at 0.24. On 22 February 2014 it was 0.16 which showed a slight decrease.

On 31 May 2014, it was noted that the patient's recent morbidities included MI¹⁰⁶, pneumonia, AF¹⁰⁷ and CCF¹⁰⁸. However, the patient's LUTS appeared 'better'. The patient's Tamsulosin and Finasteride were stopped and the Oxybutynin medication was increased by 5mgs. A further review was scheduled for September 2014.

On 06 September 2014, it was noted by Surgeon 1 that the patient's LUTS had improved due to the Oxybutynin and the patient was advised to remain on their medication, which included Bicalutamide (150mg). The patient's PSA was now down to 0.054 and their eGFR (47) was stable.

However, by January 2015, there was a significant deterioration in the patient's LUTS. Surgeon 1 noted that the patient complained of nocturia x 3 together with urge and mixed incontinence. The patient's PSA was 0.04. The patient was scheduled for flexible cystoscopy and urodynamics on 17 February 2015.

Urodynamics showed the bladder appeared stable with low voiding pressures and there was no evidence of BOO. The flexible cystoscopy appeared to show bulbar prostatic urethritis possibly due to infection or the result of previous RT. The patient was therefore given a six week course of the antibiotic Ciprofloxacin to see if this would settle things down.

¹⁰⁶ myocardial infarction (MI) death of the cells of an area of the heart muscle (myocardium) as a result of oxygen deprivation, which in turn is caused by obstruction of the blood supply; commonly referred to as a "heart attack."

¹⁰⁷ Atrial fibrillation (AF) is a common abnormal heart rhythm that happens when electrical impulses fire off from different places in the atria (the top chambers of the heart) in a disorganised way. This causes the atria to twitch, and is felt as an irregular heartbeat or pulse. Atrial fibrillation is a major cause of stroke.

¹⁰⁸ Heart failure, sometimes called congestive cardiac failure (CCF), is a condition in which the heart muscle is weakened and can't pump as well as it usually does.

The patient returned to see Surgeon 1 on 02 May 2015 due to blood in their urine. The PSA result was recorded as 0.05 and the MSU also showed E.coli which was treated by the patient's GP. The patient was advised to reduce their Warfarin medication by 1mg daily and Bicalutamide to 50mgs once daily. The patient was then referred for a CT scan on 11 May 2015, which showed no evidence of upper tract pathology.

Surgeon 1 reviewed the patient on 23 May 2015 and it was noted that the blood in their urine had persisted though the severity had reduced. A cystoscopy and TURP was arranged for June 2015.

Between 09 and 15 June 2015, the patient was admitted and underwent cystoscopy and TURP. The histology results showed no sign of cancer. There was no consent form or operation note provided.

The patient's medical history was then discussed at MDT on 18 June 2015 and the patient was again referred to Surgeon 1 on 27 July 2015 due to their stress incontinence and nocturia. Pyuria with bacteria was detected on microscopy. The patient's PSA remained low at 0.1 and an eGFR stable at 49.

In September 2015, the patient was seen by Surgeon 1 as there was a record of blood in their urine. A flexible cystoscopy showed bleeding from the TURP surface (there was minimal operation information provided and no associated consent form). The patient was then referred for TURP on 23 September 2015. The histology records showed inflammation and necrosis.

The patient's case was discussed at MDT on 01 October 2015 where it was noted that the results from April 2015 indicated that the INR¹⁰⁹ was too high and that there was ongoing significant NVH¹¹⁰. The CT showed no upper tract (kidney and ureters) pathology and the cystoscopy of 09 June 2015 showed prostatic urethritis. Following the TURP, the histology showed no prostate cancer or PIN¹¹¹. The patient's case was again referred to Surgeon 1 for review.

On 16 October 2015, the patient was noted to have a little blood in their urine, together with stress and urge incontinence and nocturia x2-3.

The patient was seen by Surgeon 1 on 20 May 2016. There was no blood detected in the urine, however, the patient had stress leak and was using up to two pads per day. The patient's PSA from January 2016 was noted to be 0.12. The patient was recorded as taking Fesoterodine and ADT (Goserelin). The patient was referred for a PSA test with review in December 2016.

From 27 April 2017 to 04 October 2018, the patient was reviewed on multiple occasions by the oncology team in the OPD.

On 23 July 2019, the patient was being seen by a care at home team. The patient was diagnosed with a UTI and was prescribed IV gentamicin.

On 28 November 2019, the patient was seen by the out of hour's service and was noted to be semi-conscious. The patient was given palliative care for metastatic prostate cancer. On Pers
onal Personal Information redacted by the USI, the patient sadly died following breathing difficulties.

¹⁰⁹ The **international normalised ratio** (INR) is a laboratory measurement of how long it takes blood to form a clot.

¹¹⁰ Non-visible haematuria (NVH), also known as microhaematuria, is the presence of three or more red blood cells (RBCs) per high-power microscope field on a midstream, clean-catch urine sample.

¹¹¹ PIN stands for prostatic intraepithelial neoplasia. It involves changes to the cells in the prostate. The cells may grow in a different way to normal prostate cells.

Comments

The review team concluded from the clinical records provided, that the treatment, investigation (particularly the management of raised PSA and subsequent prostate cancer), team working and MDT discussions and follow up with the patient were all adequate.

However, the review team were concerned that there were brief notes from the out-patient reviews which did not cover what discussions were held with the patient or the decision making process. The review team particularly noted that records were poor, as there were no operation or consent forms included in the patient's clinical records. Therefore it was difficult to tell what information had been imparted to the patient to explain the rationales for treatment, be this surgical or medical.

Despite these concerns, the review team did not consider that the treatment of the patient had led to any harm. Sadly the patient died of cancer of the prostate and associated co-morbidities on Personal Information redacted by the U.S.I..

Case A45

Description

This 84 year old male patient was referred by their GP for raised PSA on 23 September 2015.

The patient was seen by Surgeon 1 on 01 December 2015. It was recorded that the patient's PSA was raised (12.57) but falling. There was no complaint of LUTS and the DRE showed a suspicious right lateral lobe of the prostate on palpation. The patient's US scan showed bilateral renal cysts. It was documented that the patient also had significant comorbidities such as severe COPD¹¹², T2DM¹¹³, diverticular disease (DD) and CKD¹¹⁴. Surgeon 1 discussed the merits of prostate biopsy with the patient who decided in favour of this.

On 08 December 2015, the patient underwent a TRUS biopsy of the prostate. No consent form was provided for the procedure.

All six biopsies from the right side of the prostate showed aggressive prostate cancer with a Gleason score 9 with associated perineural invasion.

A bone scan from 19 January 2016 showed no metastasis and an MRI on 21 January 2016 showed T3a N0 disease confined (but only just) to the prostate gland.

The patient was seen by Surgeon 1 on 08 December 2015. The results were explained to the patient together with MDT suggested options of watchful waiting (WW) versus androgen deprivation therapy (ADT). There were no records of this MDT meeting included in the clinical records provided. The patient was referred for ADT and was prescribed Bicalutamide.

¹¹² Chronic obstructive pulmonary disease, commonly referred to as COPD, is a group of progressive lung diseases. The most common of these diseases are emphysema and chronic bronchitis. Many people with COPD have both of these conditions.

¹¹³ Type 2 diabetes mellitus

¹¹⁴ Chronic kidney disease (CKD) is a long-term condition where the kidneys don't work as well as they should. It's a common condition often associated with getting older.

The patient was reviewed by Surgeon 1 on 07 March 2016 as their PSA score was 3.5 and their serum testosterone was recorded as 22.4. The patient was advised to remain on Bicalutamide and start injections of the GnRH¹¹⁵ analogue preparation Leuprorelin.

On 09 April 2016, the patient was noted as having diarrhoea and was taken off Bicalutamide and advised to remain on Leuprorelin.

On 22 August 2016, Surgeon 1 noted that the patient's PSA (from May 2016) was down to 0.4. The patient was also noted as having sweats and nocturia x1. The patient was started on medroxyprogesterone acetate (or MPA) to help his hot flushes and was advised to continue the Leuprorelin injections.

The patient was an in-patient under the respiratory team on 12 May 2017. Sadly the patient died on Personal Information redacted by the USI of type 1 respiratory failure due to a persistent right pneumothorax.

Comments

The review team considered from the clinical records provided, that the overall management of the case was acceptable. However, the review team were unable to make an assessment of the adequacy of the consent process due to the information being unavailable. Nonetheless, the review team did not consider that the handling of the case had resulted in patient harm.

The patient sadly died of non-prostate cancer related causes on Personal Information redacted by the USI. The MDT meeting notes were unavailable for review.

Case A46

Description

The patient was a 93 year old male.

On 29 June 2016, Surgeon 1 performed a TURP on the patient.

This patient was seen by Surgeon 1 on 16 August 2016. The patient's prostate histology documented intermediate risk prostate cancer Gleason score 7 (4+3) and their PSA was 22.22 (from March 2015). An OPD review was arranged for September 2016 with a repeat PSA.

The patient's case was reviewed at MDT on 29 September 2016. The histology result was noted. The patient was noted to be unable to pass urine (PU) post TURP and there had been two failed TWOC. It was recorded that the patient had had an IDC¹¹⁶ since 2012. The patient had experienced recent UTIs with collapse in 2013 and 2015. The patient's eGFR (taken in June 2016) appeared reduced but stable at 45. The endoscopy showed a large obstructive prostate. The PSA taken in August 2016 was 5.52 and by September 2016, this had decreased to 5.2. The patient was booked for further review by Surgeon 1 with a PSA review in December 2016.

On 20 January 2017, the patient attended clinic where their eGFR was recorded as 44. Examination of the abdomen was normal as was examination of the external genitalia. Rectal exam showed a small and firm left Lateral lobe. The patient was advised to continue with his IDC and a further PSA review was planned in six months' time.

¹¹⁵ The gonadotropin releasing hormone (GnRH) agonists and antagonists are short peptide analogues of GnRH that cause a profound inhibition of oestrogen and androgen synthesis and are used predominantly as androgen deprivation therapy of advanced prostate cancer.

¹¹⁶ Indwelling Urinary Catheter (IDC): A catheter which is inserted into the bladder, via the urethra and remains in situ to drain urine.

On 09 January 2018, the GP referred the patient. There was now a history of emotional change and headache with concerns about the possibility of a brain secondary. The patient's medical history (PMH) included AF, IHD, dementia, ischaemic colitis and raised BP.

Between 15 January 2018 and 17 January 2018, the patient was an in-patient (IP) with haematuria, clot retention and confusion. The patient was prescribed medication for a UTI. An ultrasound scan showed that the patient had cysts in their left kidney. The patient was subsequently discharged.

The patient was reviewed by Surgeon 1 on 16 February 2018 and was noted to be doing well. The patient's PSA in October 2017 was recorded at 9.9, however this had increased to 16.18 by February 2018. The patient's eGFR was noted as 58. The patient was therefore booked for OPD in August 2018 with a PSA review.

In mid-April 2019, the patient was reported to be well, albeit with increasing memory problems. The patient's PSA was noted to be 13.3 and the patient was discharged back to their GP for yearly PSA review.

On 02 April 2020, a DNACPR¹¹⁷ form was signed as the patient was noted as being frail with multiple co-morbidities. On 26 June 2020, a DOLS¹¹⁸ document was signed.

On 29 July 2020, the patient was reviewed and the decision was made to provide acute care at home. This followed from the patient having had a fall with head injury although a brain CT showed no acute injury. The patient was noted to have an acute kidney injury (or AKI) and increased CRP¹¹⁹. The patient was referred for community physiotherapy on 27 August 2020. The patient sadly died on [Personal Information redacted by the USI] with bronchopneumonia being the primary cause of death.

Comments

The review team considered from the limited records provided, that there was room for improvement in relation to the assessment and treatment of this patient. In particular, the review team noted that discussions with the patient and their family lacked detail in the records and there was no consent information provided. The operation notes for the TURP conducted in June 2016 were very brief and no consent form was included in the clinical record.

Nonetheless, the review team did not consider that the patient had come to harm. The patient sadly died of non-related causes on [Personal Information redacted by the USI].

Case A47

Description

This 57 year old male patient was seen in 2012 with an enlarged prostate and elevated PSA levels. Biopsies were taken which ruled out prostate cancer. Between 2012 and 2021 the patient received ongoing PSA monitoring for the enlarged prostate (90cm).

The patient was seen for further appointments in February 2015 and April 2016.

¹¹⁷ Do not attempt cardiopulmonary resuscitation (DNACPR)

¹¹⁸ The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

¹¹⁹ C-reactive protein (CRP) is a blood test marker for inflammation in the body

The patient was put on a waiting list for a TURP in late 2017.

The referral for a TURP was expedited in 2020 and the patient underwent the TURP in 2021.

Comments

The review team considered that the early assessment was appropriate. In the review team's view, the first line investigations and imaging were appropriate, with the PSA testing, transrectal ultrasound and prostate biopsies, and the subsequent flow rate testing and bladder cancer.

The review team found the MDT working was acceptable in this case, with collaboration and good team working between colleagues. The review team considered that an appropriate MDT meeting was held in 2012 after the biopsies were undertaken, and the recommendations made during that meeting were sufficiently actioned.

In the opinion of the review team, communication with the patient and the consent process was acceptable, with clear explanations given to the patient.

The review team considered that the patient received appropriate treatment, and subsequent ongoing monitoring and follow up over an eight year period.

The review team considered that there was room for improvement in respect of the record keeping. They had sight of a clinic letter dated 21 July 2017 which referred to seeing the patient in February 2015 and April 2016, however there were no records of correspondence during those time periods.

The review team also noted that the patient was placed on a waiting list for TURP in 2017, this had to be expedited in 2020, and the patient had the procedure in 2021. Although the review team had no clinical concerns in respect of the patient's care and treatment, they did question whether there was a system in place for monitoring the waiting list, as well as the absence of correspondence relating to clinical appointments.

The review team did not consider that this patient requires clinical follow up in order to ensure their safety.

Case A48

Description

This male patient, whose age was unknown, was seen in 2012, with raised PSA levels associated with a UTI. His PSA levels were reduced from 10.8 to 8, and he was discharged.

The patient was seen again in 2015 with raised PSA levels (13). Biopsies were undertaken, and the patient was diagnosed with Gleason 3+4+7 prostate cancer. The patient also had LUTS.

A plan was put in place for ongoing monitoring, with multiple clinical visits between 2012 and 2017, and treatment arranged accordingly.

Comments

Overall, the review team did not have any clinical concerns regarding this patient's care and treatment. They noted that the patient was monitored between 2012 and 2017, with more focused care and treatment in 2015 following the prostate cancer diagnosis.

The review team considered that the initial assessment in 2012, and when the patient again presented with elevated PSA levels in 2015, were appropriate, and his care was evaluated properly, with appropriate tests, investigations and imaging carried out.

The review team considered that there was good team working between colleagues, and appropriate discussions during MDT meetings, including consideration given to complex investigations, which were appropriately actioned.

The review team considered that the consent process and communication with the patient was acceptable. With the information available (although this did not include hard copies of the patient notes), the review team considered there were appropriate discussions with the patient and his wife.

The review team considered that the patient received appropriate treatments in 2012 and between 2015 and 2016. The review team considered whether the patient's treatment in 2017 with 50mg of Bicalutamide and Tamoxifen was appropriate, although there was no evidence that the patient came to harm.

The review team considered that the patient received satisfactory follow up action between 2012 and 2017.

It was noted that the patient was seen on 19 February 2016, however a follow up letter from this visit was not recorded until 07 December 2016, which the review team considered to be unacceptable record keeping.

The review team concluded that this patient does not require clinical follow up to ensure their safety.

Case A49

Description

This 67 year old male patient had bladder cancer which progressed from superficial to muscle invasive between 2015 and 2017.

BCG treatment was not available during some time periods in 2015, due to a worldwide shortage, and the patient was treated with Mitomycin C intravesically.

The patient's care and treatment was discussed regularly during MDT meetings between 2015 and 2017, with recommendations followed. The patient was initially under the care of Surgeon 1 in 2015, and his care was transferred to another surgeon in early 2016.

The patient sadly died on Personal Information
redacted by the USI.

Comments

The review team considered that the early management of the patient's superficial bladder cancer was appropriate, with correct assessment, investigations and imaging being undertaken.

The review team considered that the patient's care was managed collaboratively between colleagues. His care and treatment was discussed regularly at MDT meetings in March and April 2015, January 2016 and April 2017, and recommendations made during those meetings were subsequently actioned appropriately. The review team therefore considered that the MDT and team working was acceptable.

The review team considered that detailed letters were sent to the patient following discussions held with him during clinical visits. However, the review team did not see any evidence of written consent within the documentation available. The review team therefore considered that there was room for improvement in respect of the consent process and communication with the patient.

The review team considered that the superficial bladder cancer was treated appropriately with biopsies and TURBT resections being undertaken. They noted that the patient's care was

discussed at MDT meetings in 2015, noting the T1G3 disease, and a repeat cystoscopy and biopsy being undertaken, but no disease being found. After this, the patient's care was taken over by another surgeon. The review team did question whether there was a missed opportunity to consider a radical cystectomy in 2015, given the patient would only have been 67 at that time. The review team also noted that there was a worldwide shortage of BCG at the time, and therefore the patient was treated with Mitomycin C intravesically. Whilst respecting this was the decision of the MDT, the review team considered this could be regarded as a sub-optimal treatment. The review team therefore considered that there was room for improvement in respect of this patient's treatment.

The review team noted that the patient was referred to oncology to consider chemotherapy, once the cancer had progressed to become metastatic. The review team considered that appropriate follow up action was taken in respect of this patient.

The review team considered that the records appeared complete, and therefore the record keeping was acceptable.

The review team considered that there was no evidence of harm when the patient was under the care of Surgeon 1. They noted that that the patient sadly died of metastatic bladder cancer, after the progression from superficial to muscle invasive disease. BCG treatment, whilst preferable, was not used due to a worldwide shortage. Subsequent follow up of the patient in 2016 appeared to show an absence of the disease, and the progression to metastatic appeared not to be evident until February 2017.

Case A50

Description

This 50 year old male patient was referred in October 2015 with haematuria. The patient's comorbidities included diabetes, obesity and taking Clopidogrel medication.

The patient was seen by Surgeon 1 on 03 November 2015, presenting with LUTS and foreskin paraphimosis¹²⁰.

A flexible cystoscopy was undertaken on 03 November 2015.

The patient's comorbidities included being diabetic, obesity and taking Clopidogrel medication.

Comments

Overall, this was a short episode of urological care, and the review team had no clinical concerns in respect of the care and treatment the patient received.

The review team considered that appropriate assessment, investigations and imaging were undertaken, including a flexible cystoscopy being undertaken, and urgent investigation of the LUTS.

There appeared to be no need for the patient's care to be discussed at MDT meetings and recommendations made, therefore the review team had no concerns in respect of MDT and team working in this case.

The review team noted that the intended benefits and risks of the flexible cystoscopy undertaken on 03 November 2015 were explained to the patient. This discussion and the patient's consent

¹²⁰ Paraphimosis is a condition that only affects uncircumcised males. It develops when the foreskin can no longer be pulled forward over the tip of the penis. This causes the foreskin to become swollen and stuck, which may slow or stop the flow of blood to the tip of the penis. The condition can lead to serious complications if it isn't treated.

was clearly documented. The review team considered that the consent process and communication with the patient was acceptable.

Having regard to the flexible cystoscopy being performed, the review team considered that treatment of the patient was acceptable.

The review team considered that follow up action was acceptable, however they noted no further documentation after paraphimosis being mentioned in the operation note from the flexible cystoscopy procedure, and therefore it was unclear whether the patient moved location and/or sought treatment elsewhere.

The review team considered that the record keeping was acceptable. The review team noted a lack of records after November 2015. However, this was not necessarily an error, it could have been that the patient was not seen again and he may have been treated elsewhere.

There was no evidence of patient harm in this case. They noted the patient was seen subsequently for diabetes care in 2020. The review team did not consider that clinical follow up is required to ensure the safety of the patient.

Case A51

Description

This 42 year old female patient was referred by rheumatology with a non-visible haematuria (NVH). This was investigated with an ultrasound scan.

The patient was a non-smoker, and therefore at lower risk of developing bladder cancer.

Given the patient was of childbearing age, no CT scan was performed.

After thorough discussion with the patient, no flexible cystoscopy was undertaken.

The patient subsequently remained under the care of the rheumatology team, and she was considered for biological treatment for her psoriasis/rheumatoid arthritis.

Comments

Overall, the review team considered all aspects of this patient's care and treatment were appropriate.

The review team considered that appropriate investigation for the NVH took place, with ultrasound scans being undertaken. They noted that no CT scan was performed, given the patient was of child bearing age. The review team therefore considered that the assessment, investigations and imaging were acceptable.

The review team noted that there was no requirement to consult the MDT for this particular patient, and they identified no concerns in respect of team working from the information that was considered.

The review team considered that consent was obtained appropriately, and that communication with the patient was acceptable, with the patient deciding not to undergo a flexible cystoscopy after thorough discussion of this option with her.

The review team considered that there was appropriate clinical decision making, with no active urological treatment required, and the patient being referred back to rheumatology. For the same reasons, the review team considered that the follow up action taken was also acceptable.

The review team noted that the record keeping was limited but considered it to be appropriate.

The review team considered that there was no evidence of patient harm and did not consider that clinical follow up is required to ensure the safety of this patient.

Case A52Description

This female patient was referred on 28 April 2015 with microscopic haematuria according to a letter dated 17 July 2015.

A rapid review was conducted and no LUTS were recorded. An ultrasound scan obtained in October 2014 was normal and the patient was discharged with no other action needed. There was no follow up indicated in the patient's clinical record.

Comments

The review team considered that the patient was adequately assessed and in the review team's view, the investigations undertaken were suitable to the patients' needs and were considered satisfactory.

The review team found communication with the patient appeared to be timely and appropriate in this case.

The review team considered that there was no evidence of patient harm, and did not consider that clinical follow up is required to ensure the safety of this patient.

Case A53Description

This male patient was admitted on 24 November 2015 with microscopic haematuria.

On 29 December 2015, the patient underwent flexible cystoscopy¹²¹ which was uneventful and appropriate consent was obtained for this procedure. The ultrasound scan taken on the same day indicated that the patient had renal cyst. The patient had LUTS and minimal other symptoms. Flow rate and PSA were noted in the patient's record. It was documented that the patient commenced an alpha-blocker.

At a follow up appointment on 04 March 2016, it was noted that the patient's symptoms had settled and the patient was subsequently discharged.

Comments

The review team highlighted that there was limited access to clinical notes on the system to enable a thorough review of this case. With the minimal information seen, it was the review team's view that adequate evaluation and assessment were undertaken.

There were no issues found with the consent obtain for the flexible cystoscopy and in the opinion of the review team there was adequate recording of the patient's care. However, no letters were included in the patient's clinical record.

The review team concluded that no harm was identified in this case and the patient did not require follow up.

¹²¹ A flexible cystoscopy is a procedure to check for any problems in your bladder using a flexible telescope (cystoscope).

Case A54

Description

This female patient was seen on 03 July 2015. There was no referral letter included in their clinical record to ascertain the patient's medical history.

The patient was diagnosed with anal verge carcinoma¹²² which was treated with radiation therapy (RT). It was documented that this has now resulted to radiation cystitis.

On 09 February 2017, the patient underwent flexible cystoscopy.

The patient was seen for incontinence assessment on 09 April 2019.

On 16 February 2021, the patient attended clinic due to urgency incontinence and had radiation cystitis. New medication was commenced and the ultrasound scan result noted NAD.

It was documented that the patient had ongoing care and was last seen in clinic in June 2021. On 04 June 2021 commenced Mirabegron.

The patient had ongoing follow up in urology.

Comments

The review team noted that there were limited records from the patient's first presentation, however, it appeared that cystoscopy was performed to make the diagnosis.

The review team acknowledged that this patient's case was difficult to manage. The review team noted that other teams were involved in the patient's care – the incontinence service, gynaecology team and general surgery. It was unclear to the review team what initial treatment was started.

The review team were concerned to note that there was considerable delay with follow up from June 2015 to 2017. However, no evidence of harm was found.

In the review team's opinion, record keeping appeared satisfactory, apart from the first letter not being available.

Case A55

Description

The patient was a 32 year old male who was referred with haematuria on 24 June 2015.

The patient was seen in clinic on 06 July 2015 with tight phimosis and it was planned that the patient would undergo circumcision. The patient was subsequently diagnosed with phimosis with pinhole meatus.

The operation occurred on 08 August 2017 and the patient was reviewed by a nurse practitioner on 06 October 2017.

Follow up by telephone was conducted in 2018 where it was noted that the patient was satisfied and was subsequently discharged on 22 October 2018.

¹²² Anal cancer refers to a malignant growth of cells in the anal canal or verge. Cancer of the verge is sometimes called perianal skin cancer.

Comments

The review team considered that the patient was adequately assessed and their diagnosis was deemed acceptable.

In the review team's view, the investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with sufficient treatment albeit it was significantly delayed. The review team were concerned that there was a two year delay between diagnosis to surgery. The review team found appropriate consent was obtained for the procedure.

The review team noted that record keeping had room for improvement as the apology regarding the severe delay was not clearly justified from the notes although there was an admission of disappointment in the delays stated in a letter.

The review team concluded that moderate harm was identified in this case due to the prolonged patient symptoms for two years.

Case A56

Description

This 81 year old, blind male patient initially presented in 2009 with CaP. The patient was referred back for assessment in April 2015. The patient was seen in clinic on 28 September 2015 and it was noted that there was a minor rise in his PSA. The patient was advised by a nurse to have further biopsy which was halted by Surgeon 1.

An MRI scan obtained in October 2015 showed widespread intraprostatic disease. The patient was advised to see an oncologist, however, the patient refused. The patient was given options for treatment in which hormones was chosen.

During a follow up appointment with Surgeon 1 in 2016, the patient was found to have lung cancer in the same year. The patient subsequently sadly died of lung cancer.

Comments

The review team considered that the patient was adequately assessed and their diagnosis was deemed acceptable. In the review team's view, the investigations undertaken were suitable to the patient's needs and were considered satisfactory. The review team considered that further biopsy was not needed in this case.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted as multiple teams were involved with the patient's care. In the opinion of the review team, the patient was provided with prompt and sufficient treatment and there were no issues with consent. The review team also considered that the patient was seen in urology repeatedly, and was discussed with oncology regarding the lung cancer. The review team highlighted that options of treatment for CaP was given to the patient.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard. It was noted that there was complete history taking and recording of the patient's care.

The review team noted that the patient had appropriate follow up, which was recorded as ongoing. The patient subsequently sadly died.

Case A57Description

This 68 year old male patient presented to Surgeon 1 with a single episode of haematuria, LUTS and a PSA of 0.47 in early 2015. An examination result indicated that the patient had an enlarged benign prostate. The patient had a history of cardiovascular problems and was on Clopidogrel medication.

Surgeon 1 investigated the patient's urinary tract via an US scan which appeared normal.

The patient underwent flexible cystoscopy in May 2015 which was also normal. The consent was obtained by Surgeon 1.

On 14 March 2019 the patient was seen again in clinic by another consultant with a further episode of haematuria. Normal CTU and flexible cystoscopy results were documented.

Comments

The review team considered from the clinical records provided that the assessment, investigations and record keeping was acceptable.

However, the review team considered that there was room for improvement relating to the consent process. The review team noted that Surgeon 1 had not mentioned the complications/risks on the consent form relating to the flexible cystoscopy in May 2015.

Despite the review team's concern about consent, they did not recommend that clinical follow up was required with the patient.

Case A58Description

This 59 year old female patient underwent cystectomy and ileal conduit formation in 2006 and left nephrectomy in 2009.

The patient was seen in outpatient clinic by Surgeon 1 with stoma problems. The GP's letter explained the need to assess the stoma. On 18 October 2017, an endoscopic and fluoroscopic assessment were undertaken by Surgeon 1. The full operation note and full consent form were included in the patient's clinical record.

On 01 April 2019, the patient was reviewed by Surgeon 1 and was advised of a further stoma revision. This was carried out on 03 July 2019 by Surgeon 1. The review team were provided copies of full consent, the operation and post-operation notes.

The patient was seen in clinic for recurrent urinary infections and stomal stenosis. Surgeon 1 advised further surgery in the form of transposition of stoma which was carried out on 12 February 2020.

A discharge summary of 15 February 2020 detailed the patient's stay in hospital and arranged OPD follow up. There were no further details available.

Comments

In the review team's opinion, the assessment, investigations, treatment and record keeping were of an acceptable standard in this case. The review team considered that stoma problems were difficult and prone to recurrence, however, there was no information from 2016 available

for review. In the review team's view, the subsequent presentation with stoma problems and the endoscopic assessment were appropriate, including the decision to refashion the stoma.

The review team considered that was room for improvement regarding consent and communication with the GP and patient's family/carer. Although the patient was informed that recurrence of the problem was a recognised complication, the consent form omitted to list possible further complications from this surgery.

In conclusion, the review team recommended clinical follow up with the patient was required to review her original cancer diagnosis and the status of the stoma.

Case A59

Description

This 89 year old female patient was referred by their GP with haematuria.

The patient was seen in clinic by Surgeon 1 on 13 April 2015 with a plan for investigation by undertaking CTU and cystoscopy. A fully detailed clinic note and letter to the GP was included in the patient's record. The CTU showed a right hydronephrosis secondary to PUJO¹²³ and nothing else. The clinical record mentioned possible chest abnormalities and an urgent CT of the patient's chest was requested, however, it did not show any worrying features.

The patient underwent a subsequent cystoscopy and retrograde ureterogram on 06 May 2015 which showed no bladder abnormality and confirmed the PUJO. A detailed operation note was provided.

The patient was subsequently discharged on 08 May 2015. The discharge letter explained that no further investigation or follow up was needed unless the haematuria recurred. Surgery for the PUJO was not advised in view of the age of the patient.

Comments

The review team considered that the patient was adequately assessed and their diagnosis was deemed acceptable.

In the review team's view, the investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care.

The review team considered from the clinical records provided, that the assessment, investigations, treatment, team working including MDT working were appropriate in this case. The review team noted that the consent form for the cystoscopy was not provided however, this did not detract from the view that the overall management of the case which appeared satisfactory. As such, the review team did not recommend that clinical follow up with the patient was required, other than the expected clinical follow up post-surgery.

Case A60

Description

This 80 year old male patient appeared to have a complex medical history with multiple comorbidities.

¹²³ Pelviureteric junction obstruction (PUJO) is a restriction to the flow of urine from the renal pelvis to the ureter, which if left uncorrected, may lead to progressive renal deterioration.

There was only one record of the patient's involvement with Surgeon 1, which was a waiting list card dated 25 June 2015, and the card listed the patient for an urgent left ureteroscopic lithotripsy. There were records from cardiology noting that an urgent opinion was necessary prior to any surgery because of his cardiac problems.

There were other urological entries on 23 June 2015 when an operation note for cystoscopy described a stone at the left vesico-ureteric junction written by another consultant and for which presumably led to the waiting list card.

On 04 December 2019, there were entries from another urologist, (the consent for cystoscopy, a letter to the patient's GP and the operation note for cystoscopy) all of which appeared satisfactory.

Comments

The review team were not able to draw any further conclusions on the care of this patient based on the limited information provided. The review team highlighted that the only relevant record involving Surgeon 1 was the waiting list card.

Case A61

Description

This 72 year old male patient was seen in clinic on 30 October 2015 by Surgeon 1. There were no clinic notes available, however, a letter to the GP indicated that the patient had LUTS and was arranged to undertake TURP.

Subsequent records showed the patient was under the care of another consultant urologist in 2017 who carried out the bladder/ureteric cancer surgery.

Comments

The review team considered that there was sparse information available regarding the clinic visit, however, the limited information provided suggested that appropriate management took place.

The review team noted that there was only one record relevant to Surgeon 1 and the subsequent presentation and patient management was not relevant to this review. The review team were not able to draw any further conclusions on the care of this patient based on the limited information provided.

Case A62

Description

This 88 year old male patient was seen by the out of hours (OOH) team on 25 February 2015 with lower abdominal pain and possible UTI. The patient's temperature was noted to be 38.8°C and it documented that their urine was concentrated with a strong odour. The patient's abdominal pain was later reduced. The patient was referred for Urine Microscopy, Culture and Sensitivity (MC+S), and for necessary treatment.

Between 10 November 2015 and 04 December 2015, the patient was an in-patient under the medical team with community acquired pneumonia, UTI and AKI. The patient had haematuria during the admission and underwent a traumatic urethral catheterisation whilst on Aspirin and Ticagrelor. The patient was referred for a CT Urogram and urology OPD review with a PSA blood test to be taken in five weeks.

On 12 November 2015, the patient had an US scan of their kidneys which was recorded as normal. It was noted that the patient had an indwelling catheter.

The CTU was cancelled on 26 November 2015, as it did not meet local guidelines and the patient was therefore advised to wait for a cystoscopy.

A letter by one of Surgeon 1's trainees was written after they had been asked to review the patient on 03 December 2015. The letter stated that the patient MSU showed microscopic traces of blood in the urine. It was further noted that the patient had been catheterised and noted visible haematuria (VH) afterwards. It was mentioned that the patient had a history of LUTS with hesitancy, poor flow and occasional urge with urinary incontinence (UI). However, there was no blood detected in the patient's urine. The patient's abdomen was noted as soft and non-tender, and there was no palpable bladder. The ultrasound result from 12 November 2015 was noted. The VH was deemed consistent with traumatic catheterisation, BPH and the fact that the patient was on anti-platelet medication.

On 08 January 2016, the patient had CTU and the result indicated that the patient's kidneys were normal and their bladder had multiple diverticula with a large one at 7cms.

On 19 May 2016, the patient was seen for LUTS review. The patient was referred for cystoscopy and a repeat PSA when their urine had cleared. It was agreed that if the patient's flow rate (FR) and bladder emptying (BE) were poor, to consider medical treatment with a 5ARI and alpha-blocker.

On 23 June 2016, the patient was seen in the clinical nurse specialist (CNS) clinic. Due to a UTI, the planned flexible cystoscopy was rearranged. The flexible cystoscopy was conducted on 30 June 2016 and showed an enlarged prostate and trabeculated bladder with multiple diverticula. The plan was to start the patient on the combined 5ARI and alpha-blocker drug Combodart, the antibiotic Cephalexin on a continuous dose at night (to prevent infection or UTI) with OPD review in four months.

Between 02 July 2016 and 15 July 2016, the patient was seen by a number of different clinicians regarding their treatment, including an admission for urosepsis after flexible cystoscopy. The patient had been fitted a catheter on 15 July 2016 and was referred for TWOC in the community and for their renal function blood tests to be periodically monitored.

On 29 October 2016, the patient was seen by the OOH team. The patient appeared confused, thought to be due to a urine infection and was prescribed the antibiotic Nitrofurantoin.

On 31 October 2016, Surgeon 1 contacted another consultant regarding a planned LUTS review in January 2017. The patient had US scans pre and post catheterisation to check if the diverticulum seen on US emptied completely. The initial diagnosis was chronic urinary retention. Urinalysis was positive and the patient was therefore prescribed 200mgs of Pivmecillinam once daily for an indefinite period and CIC once a day with urine testing once per month. OPD review was arranged for January 2017.

Between 17 and 29 November 2016, the patient's treatment for UTI and bladder was reviewed. The patient's bladder was noted on ultrasound as having RU¹²⁴ of 75mls. The patient was referred for an echocardiogram with blood tests suggesting heart failure.

During March 2017, the patient was assessed by the community continence team to monitor their RU and it was approved that the patient should receive antibiotics for symptomatic UTIs

¹²⁴ Residual urine

only. At out-of-hours team visits, it was noted that the patient generally appeared to be very sleepy, with a low blood pressure (BP).

On 03 June 2017, the OOH team noted that the patient was 'very drowsy', with their BP recorded as 76/48. The patient was taken off Bisoprolol (a medication to lower BP).

On 20 July 2017, the patient was seen with shortness of breath (SOB) and an unrecordable BP by the acute care at home team. An ECG showed elevated ST¹²⁵ segments compatible with a heart attack and the patient was given intravenous fluids and 100 O2 % with GTN¹²⁶. The patient was transferred by ambulance to hospital.

The patient sadly died on Personal Information
redacted by the USI in hospital due to Acute pulmonary oedema which was the result of a heart attack (myocardial infarction).

Comments

The review team considered from the clinical records provided, that there was room for improvement in relation to patient consent and communication with the GP, and team working. In particular, the review team noted that the consent for the flexible cystoscopy (from 30 June 2016) only contained the doctor's signature and there was no patient signature on the form. The patient appeared to have been seen by multiple members of the urological team and the review team noted there were no obvious management issues other than unreasonable concern regarding the PSA, which should have been considered unremarkable for an elderly patient with significant comorbidities. However, the review team were of the opinion that an earlier plan could have been considered for non-antibiotic management of the UTIs.

The review team considered that the assessment (including history taking, examination and diagnosis), investigations and imaging undertaken, treatment and follow-up action on the patient care appeared acceptable.

The review team therefore did not consider that the patient had come to harm as result of urological management. The review team considered that the cause of the patient's death was not related to haematuria, UTIs or their investigation/management.

Case A63

Description

This 80 year old male patient was seen for both haematuria and a raised PSA.

Between 09 May 2008 and 03 June 2008, the patient was seen by two separate consultants regarding his PSA (which was recorded as 5.22 in May 2008). A DRE was undertaken and the result was satisfactory apart from a slightly firm right prostate lobe. The diagnosis was discussed with the patient and he was counselled regarding a biopsy.

The biopsy results were shared with the patient on 03 June 2008. They showed evidence of an intermediate risk prostate cancer Gleason score 6-7 with no adverse features. Arrangements were made for a staging bone scan and prostate MRI.

The results were shared with the patient on 20 October 2008. The MRI showed T2a N0 prostate cancer and the bone scan was normal. The treatment options of active surveillance (AS),

¹²⁵ The ST segment is the flat, isoelectric section of the ECG between the end of the S wave (the J point) and the beginning of the T wave. The ST Segment represents the interval between ventricular depolarization and repolarization.

¹²⁶ Glyceryl trinitrate, or GTN, is a type of medicine called a nitrate. Nitrates are used to treat angina. Angina is chest pain that happens when not enough blood gets to the muscles of the heart.

radiotherapy (RT) and radical prostatectomy (RRP) were discussed with the patient. There was no plan for RT as the patient's prostate was considered as being too large. RRP was considered more risky than RT but could help reduce the patient's LUTS. The patient opted for AS.

The patient's PSA was monitored and noted as remaining static until 04 January 2010 when the PSA increased to 12.9. The DRE result was not suspicious and a plan was made for repeat Bx.

On 17 February 2010, the patient was seen in clinic for prostate biopsy. A repeat PSA was noted as 7.0 so the biopsy was cancelled and OPD review was booked in three months.

The patient's PSA was reviewed between 06 August 2010 and 22 October 2010. It was noted as being 7.41 in July 2010 and had increased to 8.4 in October 2010, although the patient's LUTS were not troublesome and there was no palpable bladder. A DRE revealed a smooth prostate.

There was no change to the prostate in January 2011 and a repeat prostate biopsy was arranged for February 2011.

The patient's case was then discussed at MDT in February 2011. The prostate biopsy showed low risk Gleason score 6 disease in 3 of 10 biopsies. A MRI and BS were arranged.

An MDT meeting on 08 April 2021 reviewed the results and suggested the patient remain on AS for their prostate cancer. Alternative treatment options were discussed with the patient in OPD on 16 May 2011 and the patient elected to stay on AS.

On 18 July 2012, the patient was reviewed having had a TURP six weeks earlier. The histology revealed BPH (19g) and the patient was noted as 'voiding well' since the operation. However, the patient was documented to have slightly tender testes. Therefore, an MSU sample was taken, the patient prescribed with Ciprofloxacin 500mgs bd¹²⁷ and referred for a testicular ultrasound.

On 13 August 2012, the patient was seen regarding their recent treatment for epididymo-orchitis post TURP. It was noted that US taken showed small bilateral hydrocoeles. OPD review for 6 months with a repeat PSA was arranged.

On 12 March 2013, the patient's urinary flow was noted as better, their PSA was 7.2 and nocturia was x2-3. The patient's PSA was scheduled for review in a year's time.

Between 17 September 2014 and 24 April 2015, the patient's PSA was monitored (as of September 2014 it was stable at 8), until 14 August 2015 when the patient's GP referred the patient for a cystoscopy and ultrasound because of a history of blood in the urine. The patient's comorbidities were noted as T2DM¹²⁸, COPD, CaP¹²⁹, hypertension, ischaemic heart disease, angina, ankylosing spondylitis and Parkinson's disease.

Between 25 August 2015 and 10 March 2017, the patient was reviewed by Surgeon 1 regarding their LUTS and haematuria, and consent was obtained from the patient for a flexible cystectomy. The patient was then started on Finasteride and a prostate MRI was arranged.

On 10 March 2017, the patient was again seen by Surgeon 1, having been referred previously with VH in August 2015. The ultrasound for LUTS showed that the kidneys and voiding were now satisfactory and the prostate was very enlarged at 115mls. However, the flexible cystoscopy showed an enlarged prostate for which the patient was prescribed Finasteride. The PSA results of June 2016 were down to 3.03 (the corrected value – as patient was on Finasteride

¹²⁷ Twice a day

¹²⁸ Type 2 diabetes mellitus

¹²⁹ Prostate cancer

– being 6.06) and it was noted that the patient had a complete loss of libido and erectile dysfunction since his TURP procedure. A digital rectal examination (DRE) showed a firm prostate that was symmetrical and especially malignant. The patient was therefore referred for further blood tests, biopsies and a plan for MDT discussion.

Between 04 April 2017 and 08 June 2017 there were further reviews of the patient's care by various consultants (including Surgeon 1) and MDT discussions at certain points in the pathway. Prostate biopsy showed prostate cancer that was intermediate in aggression (Gleason score 4+3). This was reviewed at MDT on 20 April 2017 and a plan was made for a clinic review and a bone scan with a later MDT review.

Surgeon 1 reviewed the patient on 28 April 2017 and discussed the biopsy result with the patient. The plan was to repeat blood tests and start the patient on Bicalutamide monotherapy as he considered that the patient's prostate cancer would inevitably progress.

An MDT review on 08 June 2017 reviewed bone scan and MRI scan findings. Grade progression of the prostate cancer was noted but the disease still remained localised to the prostate. The plan was for an OPD review by Surgeon 1 with a discussion of treatment option.

Further tests and review of the patient continued between June and October 2017. As the patient's LUTS appeared to have worsened and the flexible cystoscopy showed prostate regrowth post-TURP; the patient's Bicalutamide dose was increased from 50mgs to 150mgs. Surgeon 1 arranged investigations which he interpreted as showing prostate obstruction and so the patient was scheduled for TURP.

Between 31 January 2019 and 02 February 2019, the patient underwent another TURP procedure. The Finasteride medication was stopped.

At MDT, on 07 March 2019, it was discussed that the patient's LUTS had continued despite the PSA result in July 2017 being down to 0.45. It was agreed that the patient should continue with their current medication. This was to be reviewed by Surgeon 1 at a future date.

The patient was reviewed by Surgeon 1 on 08 March 2019. The patient's TURP histology detailed no prostate cancer and BPH only (15g), with a PSA of 0.05. The patient was prescribed Oxybutynin for severe urinary frequency.

Surgeon 1 reviewed the patient again on 17 May 2019 when it was noted that the patient's LUTS had improved and their PSA was down to 0.07. The patient's Oxybutynin medication was therefore increased to 5mgs bd.

Surgeon 1 retired in February 2021 and the patient's care was then managed between 19 February 2021 and 28 July 2021 by another consultant, during which time the patient's PSA was monitored. The patient was then referred for RT which, according to the records, was a procedure not seemingly offered whilst under the care of Surgeon 1. On 28 July 2021, it was noted that a recent bone scan did not show metastatic disease. An MRI was arranged but no notes were available after this time.

Comments

The review team considered from the clinical records provided, that the assessment, treatment, team working and record keeping were unacceptable in this case. The review team were concerned that the patient was initially assessed as not being suitable for RT due to their prostate being too large. In the review team's opinion, this was an incorrect course of action, unless the patient had been considered for brachytherapy alone. In addition, the review team noted that by the time the patient had been referred for haematuria in August 2015, he had already sustained significant comorbidities.

The review team highlighted a number of errors in the patient's treatment, notably:

- 17) The flexible cystoscopy was performed with no evidence of a CTU being requested to complete Ix¹³⁰ unless this was done elsewhere;
- 18) The MDT discussion of 20 April 2017 recorded the prostate biopsy histology incorrectly and the GS 4+4 component would make this a high risk disease (it was noted by the review team that Surgeon 1 was chairing the MDT at that time);
- 19) During the MDT of 08 June 2017 it was advised that medication options should be discussed with the patient, however, there was no indication that was done by Surgeon 1 at the outpatient clinic on 17 July 2017;
- 20) The patient medication was initiated by Surgeon 1 with Bicalutamide monotherapy, however, there was no indication that this had been discussed with the patient or at MDT;
- 21) Surgeon 1 recorded urodynamics as showing BOO but this was considered to be equivocal at best especially as Pdet@Qmax was only 33 cms H2O;
- 22) Surgeon 1 prescribed Oxybutynin for LUTS which was not an appropriate choice of medication for a patient with Parkinson's disease.

In addition to the concerns highlighted above, the review team were unable to comment on the appropriateness of the consent process as there was no information provided on patient consent for TURP. The only consent provided was for the flexible cystoscopy which was signed by a specialist nurse and not Surgeon 1 who had performed the procedure. In view of this, the review team considered that record-keeping in the patient's records was unacceptable.

However the review team did not have any concerns regarding the investigations which had been prompt and appropriate.

The review team could not be wholly certain whether the patient had come to any harm. The review team noted that an opportunity for RT treatment with curative intent was possibly missed in June 2017. However, as aforementioned, the patient had significant comorbidities and, in the review team's opinion, should have been referred to clinical oncology for an opinion or discussed at the specialist urology MDT. It was also unclear from the records whether the new consultant urologist was considering RT. In view of this, the review team recommended clinical follow up with the patient should continue for their prostate cancer.

Case A64

Description

This 77 year old male patient had haematuria and prostate cancer.

The patient was seen by multiple consultants between August 2013 and June 2014 regarding their PSA results.

On both 04 February and 08 June 2004, the patient was referred for TRUS biopsy. The procedure took place on 16 November 2004 and the patient was reviewed on 29 January 2005. There was no cancer detected and a review was planned in three months' time.

On 23 September 2005, the patient was noted as having 'atypical glands' in their previous biopsy and their PSA was 11.5. The patient was referred for a repeat biopsy. This was undertaken on 31 January 2006.

The patient attended clinic on 13 February 2006 for 8 biopsies. It was noted in their clinical record that there was 'no CaP' and therefore the patient was referred to the outpatient clinic for PSA review in three months' time.

¹³⁰ investigation

The patient's condition was reviewed by multiple surgeons between 12 May 2006 and 14 August 2006. On 25 August 2006, the patient's PSA was noted to have dropped from 15.3 to 13.2 and the patient was therefore referred for MRI and further review.

On 01 June 2007, it was noted from the MRI result that there were no nodules or lesion to target and the rectal exam showed the prostate to be moderate and smooth. It was arranged for the patient's PSA to be reviewed in six months' time.

On 03 August 2009, the patient was seen in a prostate assessment clinic. It was documented in the patient's clinical record that their LUTS were minimal and urinalysis indicated no problems while the US scan showed the kidneys appeared 'normal'. However, due to the DRE showing an irregular left lateral sulcus of the prostate, the patient was referred for TRUS biopsy which was performed on 27 August 2009. Consent was obtained for the procedure.

The patient was reviewed by various consultants between 07 September 2009 and 20 August 2010 where their PSA was monitored and the patient had MRI scans.

At a review on 07 September 2009, the biopsy results were discussed with the patient. They showed prostate cancer in 2 biopsies with peri-neural invasion. The plan was for a bone scan and further prostate MRI to be taken.

An MRI taken on 21 December 2009 showed T2 disease. The patient was given information about prostate cancer and the plan was for review in one month.

At a review on 25 January 2010, it was noted that the patient had read the information given to them and decided that active surveillance was how they wanted their prostate cancer to be managed. The plan was for OPD review in two months.

The patient's PSA remained stable.

At review on 17 November 2010, it was noted that a TWOC for urinary retention had failed. The plan was for the patient to be taught CIC to drain the bladder with OPD review in 2-3 months.

On 10 December 2010 it was noted that patient had a catheter in situ and an OPD appointment was arranged to discuss TURP.

On 07 January 2011, it was noted that the patient wanted further TWOC. The patient was prescribed an alpha-blocker (Tamsulosin) and 5ARI (Finasteride) and a plan for TWOC in a months' time was made. However, on 02 July 2011, it was noted that a further TWOC had failed and the patient was therefore referred for TURP.

Between 14 and 16 November 2011, the patient had TURP. Consent was obtained for the procedure. Histology was recorded as BPH 14g.

On 12 December 2011, the patient's condition was noted to have improved. The patient was therefore discharged to their GP with a review of PSA planned in January and July 2012.

On 05 May 2015, the patient was seen by Surgeon 1 with visible haematuria and US showed bilateral kidney cysts and an 88mls prostate. Flexible cystoscopy showed a large prostate. Consent was obtained for the procedure. The patient was referred for another MRI and MDT review.

The MRI taken on 13 August 2015 did not reveal any prostate tumour but showed an indeterminate nodule on the left lung and a possible haemangioma of the liver. The patient was referred for a CT of their chest and an MRI of their liver.

At an MDT on 03 September 2015, it was documented that the MRI scan suggested an organ confined CaP. There seemed to be multi focal lesions in the spine and sacrum together with liver lesions. An MRI of the spine with a CT and bone scan were requested.

The patient undertook a TRUS Bx x21 on 18 September 2015 and consent was obtained. The histology documented included CaP in 5/28 cores: 3 cores GS 3+3 and 2 cores GS 3+4.

The spine MRI showed intermediate lesion in 3 vertebrae, which were thought unlikely to be metastatic. The bone scan from 29 September 2015 was normal.

A review by Surgeon 1 was done on 09 October 2015 and a plan was made for review in January 2016.

An MDT review on 01 October 2015 considered the results of the previous investigations and seemed uncertain as to whether the patient should be offered treatment with curative intent or not, given the difficulty in interpreting some of the results.

The patient was not reviewed then until 03 February 2017 when it was decided that further investigations should be organised and then reviewed at MDT.

An MDT review on 09 March 2017 noted there seemed to be no evidence of disease outside of the prostate gland and so restaging MRI and spinal scans were arranged.

The patient was seen by Surgeon 1 on 02 November 2018 and was noted to be well with a PSA of 16.71. Surgeon 1 stated that <30 would be normal for 119mls prostate. As such the patient was happy with continued PSA monitoring.

The patient then received no further follow up until 2021.

On 19 March 2021, the patient was referred from their GP with painless VH.

A CT (18 March 2021) showed no significant concerns. It was noted that the patient had an enlarged prostate but had no evidence of metastasis. It was recorded that the patient's PSA was 18.8 in November 2020. The patient was referred for flexible cystoscopy.

On 19 April 2021, the flexible cystoscopy results showed evidence of regrowth of a vascular prostate. A PSA was arranged for the patient in six months' time.

Between 08 and 11 May 2021, the patient was admitted for clot retention and cystoscopy with BWO¹³¹ under GA¹³² was arranged. Patient consent was obtained for the procedure. The patient was started on Tamsulosin and Finasteride medication. The TWOC was planned in two weeks. A letter indicated that the patient might need a redo TURP in the future.

On 28 May 2021, the TWOC was recorded as successful. There were no plans for further urology nurse specialist review.

Comments

The review team considered from the clinical records provided, that there were room for improvement on the assessment, treatment, patient consent and communication with the GP, the patient and/or the patient's family and the follow up of the patient in this case.

The review team noted that this was a straightforward case of visible haematuria. During the initial referral managed by Surgeon 1, the review team found the assessment records were brief and omitted factors such as smoking and family history. The review team considered that the operation notes did not note a distal penile urethral stricture and obstructive prostate nor mention the dilation (that was performed) or bladder (which was the focus of the investigation). The review team also highlighted that the consent was obtained by a specialist nurse rather than Surgeon 1 and it was also undated.

¹³¹ Bladder washout

¹³² General anaesthetic

The review team noted that the patient was seen by Surgeon 1 on 02 November 2018 a PSA of 16.71 was recorded. Surgeon 1 stated that <30 would be normal for 119mls prostate which, in the review team's opinion, was incorrect.

The review team were also concerned that it was unnecessary for the patient to have undergone a repeat flexible cystoscopy as they could have been told to report if urinary flow worsened and this would have been less invasive in a patient whose LUTS did not appear to bother him unduly.

The review team, however, considered that the investigations and imaging undertaken were acceptable, noting that there was appropriate CTU done prior to review.

Despite concerns above, the review team considered that the patient had not come to harm as standard protocols (apart from the request for follow up for flexible cystoscopy mentioned) had been appropriate. The review team therefore considered that the patient did not require clinical follow up.

Case A65

Description

This 79 year old male patient was referred by their GP with haematuria and a PSA of 0.9 on 06 August 2015. It was recorded that the patient had a past history of TURP and their blood tests result were normal. An US was requested which showed no significant findings other than an enlarged prostate.

On 11 August 2015, the patient had a CTU which noted normal kidneys. However, it was documented that there might have been a possible thickening of their anterior bladder wall.

The patient was reviewed on 25 August 2015 by Surgeon 1. The clinical record stated that the patient had LUTS with reduced flow and a DRE showed a moderate enlarged prostate. It was noted that the patient was on Finasteride and Clopidogrel medications. The patient's PSA was noted as 0.9 (corrected value 1.8) with an eGFR>60. The patient was referred for MSSU¹³³ and cystoscopy. On the same day, the MSSU result came back with no issues and flexible cystoscopy was undertaken. Consent was obtained by a specialist nurse, which the patient had signed. However, the consent form was not dated. The operation notes stated there was a minimal distal penile urethral stricture (which was dilated under local anaesthesia, however, it was not mentioned in the operation note). It was also noted that the patient had an obstructive prostate. The patient was put forward for a flexible cystoscopy in November 2015 to check for stricture recurrence.

On 06 November 2015, the consent obtained did not mention the risk of UTI. It was noted that the patient had sub-meatal stricture which was dilated with an 18Fr¹³⁴ catheter. The remainder of the urethra was normal. It was documented that there was a large occlusive prostate with a large intravesical median lobe and that the patient's bladder was trabeculated.

The patient was again referred by their GP on 27 September 2018 with haematuria and with their PSA recorded as 0.9. An US taken on 01 October 2018 was normal and the patient was noted to have an enlarged prostate.

On 13 November 2018, the patient was reviewed and it was documented that their LUTS were stable on Finasteride medication and the flexible cystoscopy showed a large median lobe. The

¹³³ Mid-stream specimen urine. A MSSU is the middle part of your urine stream, passed in a single urination, which is required for testing.

¹³⁴ That "Fr" is the unit of measurement for the French Scale measurement system, and it's responsible for how catheters are sized. Commonly referred to as simply "French size," the French Scale system is how all modern catheters are measured. All urinary catheters are made in French sizes, and these sizes are the same for every brand and manufacturer.

findings were discussed with the patient and who was subsequently discharged following the appointment.

Comments

The review team considered this was a straightforward case of visible haematuria referred on two occasions. The initial referral (06 August 2015) was managed by Surgeon 1. The review team found the patient history notes were brief and did not include factors such as smoking and family history and on this basis was judged as having room for improvement.

The review team considered that appropriate investigations had been done prior to review.

The review team considered that the consent procedures needed attention and strengthening as consent for flexible cystoscopy was obtained by a specialist nurse (not Surgeon 1) and was not dated by the patient.

The review team considered the operating notes minimal and there was room for improvement as they did not record all findings and did not mention the bladder (which was the focus of the investigation).

The review team considered Surgeon 1's plan for repeat flexible cystoscopy in three months to see if a stricture had recurred to be unnecessary, as the patient could have been told to report if their urinary flow was getting worse. This would have been less invasive than a second flexible cystoscopy with another dilation, prevented more urethral trauma and would have been more appropriate management for a patient whose LUTS did not bother them unduly anyway. With respect to clinical decision making this was considered as having room for improvement.

The review team did not consider that further follow up of the patient was required.

Case A66

Description

This 68 year old female patient was referred by her GP on 05 February 2015 for visible haematuria (VH).

On 10 February 2015, an ultrasound of the patient's kidney revealed some cortical scarring but was otherwise normal.

The patient's consent for flexible cystoscopy was then sought (date unknown). Surgeon 1 appeared to have been responsible for the patient's hospital care plan notes, however, the notes were undated and did not mention the risks and benefits of the procedure and had no patient signature.

The patient was reviewed by Surgeon 1 on 17 February 2005 for their recent VH and UTIs. The patient's LUTS were noted as including post-micturition dribble (PMD), and nocturia x0-1 (which was normal). The US findings were noted and the outcome of the flexible cystoscopy was normal. The patient was referred for blood tests, treatment with prophylactic antibiotics (nitrofurantoin 50mgs od for 6/12) and a CTU.

The outcome of CTU, dated 31 March 2005, showed no upper tract pathology and was otherwise normal.

The patient was reviewed on 31 December 2016. The patient had been given a pessary for pelvic floor prolapse which had significantly improved her LUTS and urinary control was also good.

As there were no concerns on CT, the US and flexible cystoscopy were normal and the patient described minimal LUTS she was therefore discharged to her GP.

On 13 October 2018, the patient was seen by the OOH service with a possible UTI and a diagnosis of cystitis for which they were prescribed the antibiotic Nitrofurantoin.

Comments

The review team were unable to make a full assessment of the patient's case given the limited clinical records available. However, the review team considered that from the clinical records reviewed that there was room for improvement as the records lacked sufficient details, notably there was no information of discussion with the patient, nor a record of potential problems with the prescribed medication. The consent forms were deemed unacceptable as what had been provided was insufficient to represent consent for a flexible cystoscopy.

The review team had no concerns with the investigations undertaken and considered that the team working or follow action with the patient were not relevant in this case. The review team noted that the patient was under the care of the GP which was appropriate.

Case A67

Description

This 68 year old male patient was referred on 13 May 2015 with a NVH. The patient had been investigated for a similar problem previously in 2012.

A CT scan was performed on 19 May 2015, which indicated a chest nodule, however, no other clinical issues were raised.

The patient was seen by Surgeon 1 on 26 May 2015 and was referred to the chest team for other symptoms. A flexible cystoscopy was not performed.

The patient remained well until December 2018. There were no further information since.

Comments

The review team considered that all aspects of this patient's care and treatment were appropriate.

In the review team's view, there was appropriate assessment and investigation of the patient, through the taking of his history and the CT scans undertaken.

The review team considered that the MDT and team working was acceptable, with appropriate onward referral of the patient to the chest team. They noted that there were no recommendations made during MDT meetings in respect of this particular patient.

The review team considered that the consent process and communication with the patient was acceptable, with a thorough discussion and explanation being given to the patient.

In the review team's opinion, the patient's treatment was appropriate. They noted that some urologists may consider that a flexible cystoscopy should have been performed. However, the review team considered that it was reasonable not to perform this procedure after the CT scan showed no abnormalities. The review team considered that the patient was appropriately referred to chest physicians for other symptoms.

The review team considered that there was acceptable follow up action, with a repeat CT scan being arranged for November 2015.

The review team found that the records appeared complete and acceptable.

The review team considered that overall there were no clinical concerns and the patient came to no harm. They did not consider that this patient required clinical follow up to ensure their safety.

Case A68Description

This 65 year old male patient was referred with a visible haematuria. The patient had developed cardiac disease in 2012.

An ultrasound and CT scan were undertaken, which identified a tumour.

A flexible cystoscopy was performed on 12 May 2015.

A TURBT resection of the tumour was performed on 27 May 2015, which indicated a Ta G2 superficial bladder tumour. A repeat resection was carried out in July 2015.

The patient was regularly reviewed during MDT meetings and received follow up care for the tumour.

The patient remained well. The patient subsequently was referred back in 2020 with LUTS.

A further flexible cystoscopy was undertaken on 25 September 2020.

Comments

The review team considered that this patient's superficial bladder cancer was appropriately managed.

In the review team's opinion, there was acceptable assessment of both the haematuria and the patient's LUTS, with good use of ultrasound and CT scanning at an early stage. They noted that a flexible cystoscopy was performed on 12 May 2015. The review team therefore considered that the assessment, investigations and imaging undertaken were acceptable.

The review team considered that the MDT and team working was acceptable. They noted that during an MDT meeting on 04 June 2015, a repeat resection was recommended, which was carried out in July 2015. The review team considered that all colleague's involved in this patient's care worked well together, with appropriate use of MDT meetings, and decisions made during those meetings subsequently followed appropriately.

In respect of the consent process and communication with the patient, the review team noted the detailed records after seeing the patient on 12 May 2015, which indicated that the patient appeared to be well informed. They noted that following the flexible cystoscopy, the patient was given appropriate information, and this was recorded in detail. The review team found that the appropriate waiting list card was completed and recorded, as well as consent being appropriately taken and recorded for the subsequent flexible cystoscopy undertaken on 25 September 2020. Where the review team noted room for improvement was the consent form for the first flexible cystoscopy on 12 May 2015, which did not record the intended benefits as well as serious or frequently occurring risks as being explained to the patient.

The review team considered that the patient received appropriate treatment and follow up, with the further flexible cystoscopy performed on 25 September 2020, which was well documented.

The review team considered that the record keeping was acceptable, although this assessment was mainly of handwritten records, as opposed to electronic patient records.

The review team considered that no patient harm was apparent with appropriate follow up. They did not consider that this patient requires follow up to ensure their safety.

Case A69Description

This 68 year old female patient had known chronic renal dysfunction and was referred with LUTS.

The patient was seen on 05 May 2015, and her renal function was checked.

The patient was regularly followed up, and her kidney function appeared stable when checked in 2016, 2017, 2019 and February 2021.

Comments

The review team considered that the patient was initially evaluated and assessed correctly, with appropriate investigations and check of her renal function, with Creatinine and eGFR.

In respect of the MDT and team working, the review team found that there was no specific requirement for MDT involvement for this patient.

The review team noted that specific consent was not required, given there was no need for direct treatment. The subsequent letter sent to the patient's GP on 22 April 2016 suggested that the patient was aware of the investigations and their results. The review team considered that communication with the patient appeared acceptable.

There was no requirement for direct treatment for this particular patient, and the review team identified no concerns in respect of clinical decision making.

The review team considered that appropriate follow up to check the patient's renal function was carried out between 2016 and February 2021.

The review team noted that, whilst the patient was seen on 05 May 2015, the subsequent letter to her GP was not sent until 22 April 2016.

There was no evidence of patient harm as a direct result of the delayed correspondence, and the review team identified no clinical concerns in respect of this patient's care. The review team did not consider that this patient requires clinical follow up to ensure their safety.

Case A70Description

This 17 year old female patient had longstanding right renal impairment since childhood. She was referred with LUTS in 2014.

The patient was treated for pyelonephritis in November 2014.

She was seen on 10 March 2015, and an ultrasound and intravenous urogram (IVU) was undertaken. Her renal function was checked.

The patient was treated for a UTI in September 2016.

She was referred to the gynaecological team in 2016, and was seen on 04 January 2017.

The patient was followed up in April 2021, with her renal function being regularly checked and appearing stable.

Comments

The review team considered that there was appropriate assessment of the patient in 2014 and 2015, as well as acceptable investigations and imaging, with an ultrasound and IVU being undertaken.

The review team considered that the team working was acceptable, with the patient being referred to the gynaecological team in 2016 when required, and seen by that team on 04 January 2017. The review team noted the patient did not specifically require the input of the urological MDT, and her care was not discussed, nor any recommendations made, at those MDT meetings.

There was no requirement for specific consent to be obtained from the patient. The detailed letter sent to the patient's GP on 04 January 2017, although delayed, indicated that the patient was well informed, and therefore the review team considered that communication with the patient was acceptable.

The review team considered that the treatment was appropriate, with the patient receiving treatment for pyelonephritis in November 2014 and treatment for a UTI in September 2016.

In the review team's view, the follow up action was acceptable, with the patient's renal function appearing stable, in spite of the long standing right kidney abnormality, up until April 2021.

The review team found that the record keeping was unacceptable. They noted that the patient was seen and assessed on 10 March 2015, however, the subsequent letter to the patient was not sent until 29 December 2016, and not to the patient's GP until 04 January 2017, eleven months later. This prompted the review team to ask whether there were safeguards within the electronic patient record system to identify and escalate such administrative errors.

There was no evidence of patient harm as a result of the delayed correspondence, and the review team did not consider that this patient requires clinical follow up in order to ensure their safety, given that she has been receiving ongoing monitoring.

Case A71

Description

This 77 year old female patient was referred on 18 March 2015 with LUTS, a NVH and recurrent UTIs.

The patient underwent a right hemicolectomy for bowel cancer in June 2014. She had known stage three chronic kidney disease.

In April 2014, the patient's CT chest scan appeared normal, as did her ultrasound in November 2014.

An ultrasound was performed on 12 May 2015. A flexible cystoscopy was arranged.

Outpatient's appointments were arranged for 06 and 21 July 2015.

The patient was treated with low dose antibiotics for chronic cystitis.

Comments

The review team had limited clinical records available for review and were therefore unable to comment on the patient's care and treatment in great detail. They noted that the referral was

downgraded from red flag to consultant clinic urgent, with a plan made for the same day for a flexible cystoscopy. From the limited information available, there did not appear to be evidence of any obvious clinical harm.

Case A72

Description

This young female patient whose age was unknown, suffered from enuresis¹³⁵, and was seen by a registrar on 29 September 2015 and was referred to the Enuresis service. There were no letters from the Enuresis service included in the patient's clinical record.

The patient's ultrasound scan obtained on 28 June 2017 showed normal results.

The patient was reviewed by Surgeon 1 on 09 April 2018 and was prescribed Nitrofurantoin.

A letter dated 25 September 2018 noted that there was "complete reduction of all symptoms" and the patient was subsequently discharged.

Comments

The review team noted that there were delays in undertaking scans and follow up prior to the patient being referred to the Enuresis service. It was unclear to the review team what caused these delays.

The review team highlighted that Surgeon 1 did not see the patient during the first clinic visit and only reviewed the patient at a follow up appointment in 2018.

The review team considered that the patient record appeared to be acceptable overall, albeit the registrar's notes during the first visit were difficult to read.

In the review team's opinion, there was no evidence of harm found in this case.

Case A73

Description

This 92 year old female patient, on Warfarin medication, was diagnosed with haematuria in 2013. The patient was referred back in January 2015 due to UTI and haematuria.

A flexible cystoscopy was performed on 06 January 2015. There was no indication that the patient required follow up after surgery.

Comments

The review team considered that the patient was assessed twice and appeared to have had acceptable examinations on both occasions.

In the review team's view, appropriate investigations were conducted in 2013, 2014 and 2015.

The review team found that there was no treatment indicated and subsequent follow up with cardiology team/department appeared to have been undertaken.

The review team considered that no patient consent was needed, other than for the flexible cystoscopy.

¹³⁵ **Enuresis** is the medical term for bedwetting. Also known as: night time incontinence.

In the opinion of the review team, there was good evidence of record of events and there was no evidence of harm that occurred in this case.

Case A74Description

This female patient, whose age was unknown, was referred in 2015 for an initial ultrasound scan prior to being seen by Surgeon 1.

On 23 September 2016, the patient was seen by Surgeon 1 having had a hysterectomy and posterior repair in 2015.

The patient was seen in clinic on 03 December 2015 due to repeated UTI and was prescribed with Ciprofloxacin.

No surgery was undertaken other than a flexible cystoscopy and urodynamics. The patient was recommended Nitrofurantoin.

The patient was referred for physiotherapy and to a gynaecologist for anterior repair and was subsequently discharged.

Comments

The review team noted that appropriate urological investigations and referral to urogynaecology¹³⁶ were undertaken.

It was the review team's view that the clinic letters, by way of referral, were comprehensive, with lots of detail included. However, it was noted by the review team that one letter in December 2015 was not available for review.

In the opinion of the review team, appropriate treatment was instigated and the patient's referral was acceptable. The flexible cystoscopy and urodynamics were undertaken appropriately.

The review team considered that discharge to gynaecology appeared appropriate.

The review team concluded that there was no harm identified in this case.

Case A75Description

This 50 year old female patient with recurrent UTI was seen in November 2015 and a CT scan was requested. There was no letter provided in the clinical record pertaining to this admission.

From the clinical record, it appeared that an initial medication was instigated, however there was no operation indicated that had been performed on the patient.

The patient was seen on 21 July 2017 and a letter documented the events in 2015. The patient was reviewed and was planned for follow up. However, there was no follow up that occurred after 2017.

¹³⁶ Urogynaecology is a sub specialty of Gynaecology. It covers services that provide assessment, investigations and treatment for women with urinary incontinence, vaginal prolapse, recurrent urinary tract infections, bladder pain and pelvic floor injury after childbirth including faecal incontinence.

From the documentation provided, it appeared that multiple investigations were organised for this patient between 2011 and 2021. It was noted that the patient was seen by gynaecology and general surgery teams.

Comments

The review team noted that there was no indication that urology follow up occurred, however, the patient appeared to have been subsequently seen by other services. It was documented that the patient was seen in 2015 and at a follow up appointment in 2017. It was unclear to the review team why there was no evidence to suggest that the patient was seen in urology during their follow up.

The review team considered that multiple repeat imaging was obtained and no abnormalities were indicated. The review team also noted that appropriate urology investigations were undertaken.

In the review team's view, an appropriate follow up plan was put in place, albeit the patient appeared lost to urological follow up. The review team concluded that there was no evidence of harm found in this case.

Case A76

Description

This female patient, whose age was unknown, had a history of recurrent UTI's and was diagnosed with LUTS on 12 May 2015. An ultrasound was requested, however, there was no letter included in the patient's clinical record pertaining to their admission.

The patient did not attend follow up appointments in January and February 2017 and was subsequently discharged.

Comments

From the clinical notes provided, it appeared that this patient had adequate initial assessment. The review team noted that there was no clinic letter regarding the 2015 admission.

The review team did not find the ultrasound scan arranged in 2015.

The review team were concerned that this patient was not followed up initially and there was no medication confirmed in their clinical record.

In the review team's opinion, there was no indication of harm identified in this case, however, the patient appeared lost to follow up. The review team considered that it was unlikely that this patient need further follow up at this stage.

Case A77

Description

The patient, a 73 year old woman (at the time when seen by Surgeon 1), with complex medical problems, was diagnosed with locally advanced lung cancer in 2018 and was treated with palliative radiotherapy.

The patient was initially seen by another consultant urologist in August 2010 with LUTS and diagnosed with possible interstitial cystitis.

On 16 July 2012, the patient was seen by another consultant urologist for the LUTS and was prescribed Amitriptyline and had urodynamics at that time.

The patient was reviewed on 14 April 2015, however, the LUTS remained unchanged. The patient was prescribed Nitrofurantoin and had urodynamics. The patient was reviewed on 08 May 2015, after urodynamics, which showed bladder hypersensitivity. However, the LUTS were documented to have improved.

The patient was then discharged from clinic with the advice to continue on a low dose Nitrofurantoin.

Comments

The review team considered from the clinical records provided, that the assessment, investigations, treatment, team working, consent and communication with the GP and patient's family/carer were acceptable in this case.

The review team did not recommend that clinical follow up with the patient was required, other than the expected clinical follow up post-surgery.

Case A78

Description

The patient, a 55 year old woman, was referred by her GP with urinary frequency.

On 23 May 2016, the patient was seen in clinic by Surgeon 1 and there was a full letter to their GP explaining the need for urodynamics.

A letter was exchanged between the GP and a consultant colleague on 03 June 2016 regarding the urodynamics and requesting a second opinion.

Comments

The review team considered from the clinical records provided that the assessment, team working, consent and communication with the GP and patient's family/carer and record keeping were acceptable in this case.

The review team did not consider investigations, treatment and the follow up action to be applicable, therefore no comments were made regarding these areas.

Case A79

Description

The patient, a 31 year old woman, was referred by her GP with loin pain. The renal ultrasound and urinalysis obtained were noted as being normal.

The patient was seen in clinic on 12 May 2015 by Surgeon 1. The examination appeared normal apart from the patient being noted as obese. The patient was referred back to their GP with no urological cause for the loin pain and with the suggestion of weight loss.

Comments

The review team considered from the clinical records provided, that there was appropriate management in this case. The review team noted that the treatment, communication/consent with the GP and patient, team working and the follow up action were not applicable in this case.

Case A80Description

This 67 year old male patient presented with LUTS on 27 October 2015 and was seen in clinic by a clinical fellow who listed him for TURP after discussion with Surgeon 1. It was not known if Surgeon 1 had seen the patient at that time.

The review team were provided with the patient's history, examination, IPSS, flow rate and an US of their urinary tract. No further records were available.

Comments

The review team considered from the clinical records provided that there was appropriate management of the patient's LUTS. The review team found the clinic notes and letter to the patient's GP were very detailed.

The review team noted that the treatment, communication/consent with the GP and patient, team working and the follow up action were not applicable in this case.

Case A81Description

The patient, a 64 year old man, with a history of alcohol abuse presented after referral from their GP due to a raised PSA. He was seen in clinic by Surgeon 1 on 06 July 2015 and underwent TRUS¹³⁷ and a prostatic biopsy on 19 August 2015.

The patient's case was then discussed at MDT on 27 August 2015 after a small volume CaP was found (3+3=6). The patient was seen in clinic by Surgeon 1 on 18 September 2015.

On 01 October 2015, staging MRI suggested an anterior prostate tumour which may not have been sampled at the original biopsy. This was further discussed at MDT on 08 October 2015 and repeat biopsies were advised. The patient was then seen by Surgeon 1 on 19 October 2015 and a microcytic anaemia had been noted so an urgent CT was requested by Surgeon 1.

The scan (dated 22 October 2015) showed a probable caecal cancer which led to a referral to colorectal surgeons and necessitated a laparoscopic right hemicolectomy on 26 January 2016 for a pT3 poorly differentiated adenocarcinoma with nodes. The patient was noted to have previously had surgery for perforated diverticular disease.

The prostate biopsies showed CaP 3+4=7 in 5/29 cores and were discussed at an MDT on 19 November 2015 where curative treatment or cautious active surveillance (AS) was suggested.

Following the bowel surgery, adjuvant chemotherapy was commenced on March 2016 and there were delays in urology follow up because of alcohol relapse, hospital admissions with dehydration, UTI and DNA at clinics.

The patient was discussed at MDT on 04 August 2016 where it was advised that the patient should have an ongoing review by Surgeon 1 and treatment with androgen blockade.

There were numerous letters from Surgeon 1 to the patient and their GP following clinic visits, the last of which was on 23 March 2019.

¹³⁷ A TRUS biopsy (transrectal ultrasound biopsy) can be used to produce detailed images of the prostate gland and surrounding tissues. This test is often used to help diagnose prostate cancer, as well as other conditions, such as an enlarged prostate gland or male infertility.

Comments

The review team considered from the clinical records provided that the assessment, investigations, treatment, team working including MDT working, consent and communication with the GP and patient's family/carer, follow up and record-keeping were appropriate.

Case A82

Description

This 72 year old male patient was reviewed on 22 October 2021 for chronic testicular pain. The pain was noted as being bilateral and had been present for the previous four years with a severity of 6/10 daily.

The patient had no LUTS and an ultrasound, taken on 31 July 2012, had shown a small cyst in the lower pole of the right testis, a slight left varicocoele and microlithiasis (L > R). Testicular tumour markers were negative. Following review and examination, the patient was reassured and discharged.

On 08 January 2015, the patient's PSA was noted to be 0.42 which was normal.

On 27 April 2015, the patient underwent an ultrasound of their testes. The report noted a 4.4mm cyst in the lower pole right testis and a left varicocoele (as in the US from 2012). The patient was referred by their GP with a history of LUTS, chronic testicular pain and erectile dysfunction.

The patient was noted to have testis pain that was intermittent with no aggravating or relieving factors, and was not better with antibiotic treatment. Some penile tip pain was noted. LUTS included weak stream, hesitancy, terminal dribbling (TD) and reduced bladder emptying. However, there was no urge or frequency and no history of UTIs. The patient also complained of erectile dysfunction despite having received treatment with Sildenafil (Viagra). On examination, the abdomen was normal and the scrotum was hypersensitive. The penis and testes were normal to palpation. A rectal examination indicated significant tenderness. The IPSS score was recorded as 23 and QOL score was noted as 6. The patient was prescribed Tamsulosin for their LUTS, was referred to a pain specialist and had a testosterone blood test organised together with a Doppler ultrasound for the penis to check blood flow.

On 29 September 2015, the patient's testosterone level returned at 15.6 (normal).

There were no further records relating to the results of the above investigations and no follow up review was recorded.

Several years later, on 15 July 2017, the patient was reviewed by Surgeon 1. It was noted that the patient's previously prescribed Tamsulosin medication had significantly helped the patients LUTS and their erectile dysfunction had responded to Sildenafil 50mgs. However, the patient felt this response could be better. The patient was therefore prescribed Tadalafil 5mgs once daily (a Viagra like drug) for their LUTS and erectile dysfunction. The patient was asked to continue with their Tamsulosin and Sildenafil medication. The patient was to be reviewed further in October 2017.

The patient was seen on 08 May 2021. The patient had not been reviewed by urology since 2017. It was noted that there had been an improvement in their LUTS and their testicular pain was now much better. However, erectile dysfunction remained a problem despite daily Tadalafil and Sildenafil as required. The patient was keen for treatment. The patient was advised to try Vitaros cream and arrangements were made to check testosterone levels.

On 09 January 2019, an ultrasound revealed the kidneys were normal and bladder emptying was satisfactory. A follow up letter on 16 June 2021 informed the patient that their testosterone

was normal and if the Vitaros cream was not working, to consider intracavernosal injections as an alternative and ring for an appointment.

Comments

The review team considered from the clinical records provided that there was room for improvement of the assessment, investigations and treatment including the clinical decision-making in this case. The review team considered that this was a relatively common case with the patient exhibiting a combination of symptoms. The review team viewed that the assessment notes did not provide a record of the examination and so it was difficult to fully comment on whether the patient had been adequately assessed. However, the review team did not think that the treatment was unreasonable, although considered that increasing the dose of Sildenafil initially may have been preferable to adding in daily Tadalafil.

The review team did not consider that comments regarding consent and team working were applicable in this case. However, there had been large gaps in the patient's follow up although the reasons for these were not mentioned.

The review team viewed that there was appropriate management of the patient and that he had not come to harm. The review team noted that there had been follow up with the patient planned but the clinical records ended at 16 June 2021 so they were unable to comment further.

Case A83

Description

This 24 year old male patient was referred for lower UTI and LUTS by their GP on 25 November 2014.

The patient was seen by Surgeon 1 on 11 May 2015. Surgeon 1's notes detailed that the patient had reduced flow and unsatisfactory voiding with nocturia x2. On examination, the genitalia were noted to be normal. Arrangements were made for the patient to have a urine test or MSU. Treatment was commenced with Oxybutynin (a drug to reduce urinary frequency) with a review in August 2015.

On 11 May 2015 the MSU result was noted as not available as the specimen had been spilt in transit.

The ultrasound of 10 July 2015 was normal and showed a pre-micturition bladder volume of 304mls and a post micturition volume of just 24mls.

There was no further follow-up records provided beyond this point.

Comments

The review team considered from the limited clinical records provided that the assessment and record keeping were unacceptable, notably that there was no history of advice or discussion with the patient for the treatment provided. There was no record of any prostate assessment by DRE and no PSA was recorded.

Despite the issues with the record keeping and inadequate clinical records, the treatment was considered to be adequate. The review team viewed that there should have been mention of advice provided to the patient about their lifestyle as the records only detailed that they went straight to drug treatment and that no operation was needed.

The review team considered that the investigations and imaging requested were acceptable and had been prompt and suitable for the patient's needs. The review did not consider that consent or team working was applicable in this case.

Given the lack of information provided, it was difficult for the review team to fully determine whether the patient had “fallen through the net” and had not been asked to return to OPD or whether they had just failed to re-attend. Therefore, the review team considered that patient might require clinical follow up by the urology team to see if they remained symptomatic and to check their PSA.

Case A84

Description

This 56 year old male patient was originally seen on 10 January 2007 requesting vasectomy. The patient had a complex past history with retrograde ejaculation and the need to use assisted reproduction techniques to allow him and his partner to start a family.

The patient and their partner were reviewed the following month on 23 February 2007 where the patient's partner wanted to have the future option of having more children and so the patient was discharged with no further action planned.

In October 2010, the patient was reviewed again having requested a vasectomy. He was counselled and referred for surgery.

On 23 December 2011 vasectomy was performed under a general anaesthetic.

On 02 April 2014, the patient was referred by their GP with a history of proven UTIs since Christmas. The patient also complained of nocturia (2 hourly).

The patient was reviewed by Surgeon 1 on 19 April 2014. The patient's PSA from 24 March 2014 was 5.71. It was noted that they experienced LUTS even in the absence of infection. The patient had a past history of surgery to the bladder neck with subsequent retrograde ejaculation. On examination, the patient's abdomen and rectal exam were noted to be normal. A repeat PSA from April 2014 was 4.73.

Arrangements were made for the patient to have a urinalysis (MSU) and ultrasound. They were also prescribed the antibiotic Cephalexin for the next two weeks and further review was organised.

On 19 April 2014, the patient's MSU was reported as showing no evidence of infection.

It was noted from the ultrasound on 22 May 2014, that the right kidney was reduced in size, with reduced flow on Doppler US. The prostate volume was measured at 51cc, with the bladder volume before voiding being 399mls and post-voiding being 55mls.

The patient was again seen by Surgeon 1 on 24 February 2015 for LUTS present even in the absence of UTIs and including nocturia x2-4. The patient's renal function was normal and the PSA was measured at 3.83. The patient's MSU grew E-coli and so they were prescribed Nitrofurantoin 50mgs bd and a CT was arranged.

The CTU on 23 June 2015 showed reduced size right kidney with calcification and a complete duplex, with one of the ureters dilated near the bladder but without any proximal dilation.

On 05 December 2015, Surgeon 1 reviewed the patient. The patient was noted to have been on Nitrofurantoin 50mgs bd since February 2015. The patient was referred for a micturating cystourethrogram (or MCUG to assess urine reflux to the kidneys) and a nuclear medicine DMSA scan to check for scarring and renal function.

The results of the DMSA scan of 23 February 2016 showed severely reduced right renal function at just 11%.

The MCUG of 11 April 2016 showed no reflux, however, it did show a bladder diverticulum with incomplete emptying.

On 23 February 2017, the patient was reviewed relating to their LUTS and nocturia x2-3. The patient stopped Oxybutynin but continued Nitrofurantoin 50mgs at night. It was noted that the patient had a fairly good flow of urine with complete emptying on double voiding. The patient's case was discussed at the uro-radiology MDT together with the option of removal of the right kidney given its poor function.

Surgeon 1 reviewed the patient on 11 June 2018. The patient thought that removal of the right kidney would resolve their hypertension. Another surgeon was of the opinion that the right kidney was responsible for the recurrent UTIs. Surgeon 1 did not appreciate any urinary retention. He considered that the patient should continue treatment for hypertension and continue antibiotic treatment. He did not consider that they should undergo right nephrectomy.

Arrangements were made for the patient to be reviewed in September 2018 to discuss further investigation by means of flexible cystoscopy and urodynamics.

On 16 May 2019, it was noted that the patient's MSU was negative but there were no further OPD reports beyond this point.

Comments

The review team considered from the clinical records provided that the assessment, investigations, treatment - including clinical decision making, case selection, operation or procedures and prescribing practices were acceptable.

Team working including communication with other members of the care team, MDT discussions and working with colleagues and the record keeping/completeness of patient records in connection to the patient's episodes of care were acceptable.

The review team commented that there had been no discussion with the patient noted until 11 June 2018 but otherwise did not consider consent and communication with the GP, the patient and/or the patient's family to be applicable in this case.

The review team considered there to be appropriate management of the patient's case overall, with antibiotic prophylaxis and the advice to control BP. The review team considered that the correct decision was made by clinicians to defer right nephrectomy.

The review team, however, had no information regarding further OPD review after 19 May 2019. Therefore the review team considered that further clinical follow up was required to be satisfied that the patient treatment had been effective and appropriate.

Case A85

Description

The patient, a 45 year old male, was referred with LUTS. His PSA result was 0.4 on 14 November 2014.

On 15 January 2015, it was noted that the patient had no evidence of STDs.

A GP referral on 30 January 2015 was made as the patient continued to complain of dysuria (painful passing of urine). He had had similar symptoms 13 years prior with negative investigations. Although the patient had had several courses of antibiotics, these had made no difference to his symptoms. A PSA and US were reported as normal.

The patient was reviewed by Surgeon 1 on 13 April 2015 where LUTS was noted, including PMD, frequency and nocturia x1-2. Urinalysis was performed (MSU) and the patient was prescribed Tamsulosin with a further review scheduled for July.

On 14 April 2015 the MSU report came back showing no evidence of infection.

On 05 July 2015, the patient was seen with pain in right testis and a temperature of 36C. On examination, the patient was noted to have a high riding right testis, swollen scrotum and pain increased with testicular elevation. An ultrasound from 06 July 2015 noted a mild right varicocele however, the kidneys appeared normal.

The patient was prescribed Ciprofloxacin and Analgesia and was discharged on 06 July 2015.

On 01 August 2015 it was noted that the patient's testicular pain was the same. However, there was no entry as to what action(s) were taken as a result of this.

The PSA was noted as 0.4 on 07 May 2016.

The patient was noted as not being reviewed by Surgeon 1 until 21 July 2017. The patient's condition had not improved despite Tamsulosin. The patient was noted as having poor and intermittent flow together with nocturia x1-3. It was noted that Vesicare (an oral medication to reduce bladder contractions) provided some help. The patient was referred for flexible cystoscopy and urodynamics.

On 10 August 2018, the patient was reviewed by Surgeon 1 and another surgeon. The patient's PSA of 10 August 2018 was noted as 0.36. Having had urodynamics, free flow showed a very large voided volume of 1253 mls; a maximum urinary flow rate (Qmax) of 36.3 mls/sec and a small residual urine of 56 mls.

Surgeon 1 noted that the patient's LUTS were much better with Vesomni and that the potential existed to increase the dose of Solifenacin in future if required. The patient was therefore discharge to their own GP.

Comments

The review team considered from the clinical records reviewed, that the assessment of the patient was unacceptable because there was not a proper record of the patient's history, physical examination or a simple assessment of LUTS bother (e.g. mild/moderate/severe). When the patient was seen again in July 2017, there also was no mention of UTI and orchitis from July/August 2015.

In the opinion of the review team, there was room for improvement regarding the investigations, treatment, patient consent and communication and follow up action on the patient's care. In particular, the review team were concerned there was not a decision for further, long-term clinical follow up of this patient who was known to have abnormally large bladder capacity. The review team viewed that the urodynamics should not have been cancelled and that the bladder function at this stage would have provided valuable information for future advice and bladder management.

The review team did not identify the patient had come to harm at the point of the review based on the information provided. In light of this, further clinical follow up with the patient was recommended to prevent future issues.

Case A86

Description

This 83 year old male patient was referred for lower UTI and was seen on 29 November 2007 with LUTS. It was noted that the patient had nocturia x2-4, with urge and urge incontinence. A

flow study suggested an obstruction, as the patient only managed to pass 87mls of urine. The patient's PSA in May 2007 was noted as 5.9, which had been stable since 2005. The patient was referred for a further PSA check and started on alpha-blocker medication.

On 10 April 2008, the patient was reviewed and the patient's LUTS were noted to be better with the alpha-blocker. The flow study was also better with a maximum flow rate of 15.1 mls/sec on a voided volume of 144mls and a residual urine of <20mls. The urology SHO carried out a DRE showing BPH and a further PSA check was organised.

Several years later, on 08 January 2015, the patient's GP referred them with acute urinary retention and failure of a TWOC. The patient's medical history was noted to include COPD and Parkinson's disease.

The patient was seen by Surgeon 1 on 10 March 2015 where an entry stated for TURP (planned for 15 April 2015), however no other information was recorded, including a discussion with the patient.

An ultrasound of the patient's kidneys on 25 March 2015 showed that the kidneys were normal and that the bladder had a catheter in situ. The prostate was noted as large.

Surgeon 1 reviewed the patient on 15 April 2015 and noted that the patient had evidence of infection with rigors. The patient was admitted for treatment and their planned TURP was deferred.

The patient was admitted for TURP on 13 April 2016. The consent form was adequate (though not done by Surgeon 1). The operating note was very brief and post-operative care was satisfactory.

Histology showed a low risk Gleason score 6 prostate cancer with no unfavourable features.

The patient was discussed at MDT on 19 May 2016, where it was considered that the incidental prostate cancer was low volume and low risk. It was recommended that the patient was reviewed by Surgeon 1 and managed with ongoing surveillance.

On 20 June 2016, Surgeon 1 reviewed the patient where the diagnosis was discussed. The patient was noted as having ongoing LUTS with a weak flow, urgency and urge incontinence together with nocturia. A PSA on 20 June 2016 was noted as 3.1. Arrangements were made for the patient to have a prostate MRI and a review in September 2016.

The MRI of 09 August 2016 showed BPH only, with no evidence of cancer.

Surgeon 1 further reviewed the patient on 01 November 2016 and the MRI findings were noted. It was documented that storage LUTS were still persistent, however, they were less severe. The patient's PSA on 01 November 2016 was recorded as 3.39. The patient was therefore prescribed Oxybutynin MR to be taken at night.

At a review on 07 August 2017, it was noted that the patient's LUTS persisted with nocturia x2-3 with occasional bed wetting. The case was referred to MDT who advised observation for the known prostate cancer with a PSA every six months and OPD review in one year.

There was no record of further OPD review by urology, only PSA results which were noted as: 07 August 2017 = 5.26, 11 February 2019 = 6.1 and 25 June 2021 = 7.09.

Comments

The review team considered from the clinical records reviewed that the assessment and record-keeping were unacceptable because the only OPD record available was for the TURP and there

was no detailed record of any examination of the patient or discussion of treatment options other than the TURP.

The review team also considered that there was room for improvement regarding the investigations, treatment, patient consent and communication. In particular, the review team noted that there was no investigation undertaken prior to the decision for immediate TURP especially in light of the patient's known history of Parkinson's disease (which can affect urinary function).

In the review team's view, the patient's PSA had risen in the past, and so another investigation of the PSA should have been considered prior to TURP. It was of concern to the review team that the surgery was delayed for one year without any explanation as to why this happened.

The review team considered that a 5ARI could have been added to any alpha blocker treatment and a further TWOC arranged during the interim period. The review team considered that the consent for TURP was generally adequate, however, it was not signed by the surgeon and a record of the discussion with the patient was not included.

The review team did not have any concerns with the team working and actions taken by Surgeon 1 as a result of MDT discussions, noting that the management of the incidental prostate cancer was fine and the MDT decision for observation appeared appropriate.

The review team therefore did not consider that the patient had come to any harm, apart from the record of the TURP pathway being unclear and inadequately recorded.

The review team considered that there should be clinical follow up with the patient, with urology or a urology nurse specialist, given the diagnosis of low risk and low volume prostate cancer. In addition, the review team recommended follow up of the patient to see if their LUTS could be optimised and the ongoing nocturia investigated in case there was any underlying condition, such as nocturnal polyuria.

Case A87

Description

This 58 year old male patient was referred by his GP on 09 April 2015 with LUTS.

The patient underwent an ultrasound, the results of which were normal.

The patient was seen at an out-patient appointment by Surgeon 1 on 13 October 2013.

The patient was prescribed Tamsulosin and Tadalafil.

A plan was put in place to review the patient again in January 2016.

The patient was seen on 21 March 2017. It was noted that his LUTS had improved through taking the Tamsulosin.

Comments

The review team concluded that all aspects of this patient's care and treatment, which was managed by three consultant urological surgeons, appeared appropriate with no clinical concerns.

The review team noted that the patient received appropriate evaluation at an early stage, as well as correct investigation and imaging with the ultrasound, flow rate testing and post-void bladder scan.

The review team considered that the team working was acceptable, with Surgeon 1 working collaboratively with his colleagues. There was no specific requirement for involvement of the MDT for this patient.

The review team considered that the consent process and communication with the patient was acceptable. The review team noted that the investigation and treatment was explained to the patient during appointments, and this was appropriately followed up with written correspondence.

The review team noted that the patient received appropriate and effective drug treatment, in line with the latest European guidelines available at the time.

The review team considered that appropriate follow up action was performed, which revealed that the treatment was effective.

The review team considered that record keeping was acceptable.

There was no indication of patient harm and the review team did not consider that this patient requires clinical follow up in order to ensure his safety.

Case A88

Description

This 55 year old male patient was referred by his GP with LUTS.

The patient was seen and assessed on 24 November 2015. The patient underwent a rectal examination. It was noted that the patient had normal PSA levels (1.29). The patient had a benign feeling prostate, which was recorded as 60cc, and a small residual volume in the bladder after voiding.

The patient was discharged back to the care of his GP.

Comments

The review team considered that all aspects of this patient's care for LUTS were appropriately managed.

The review team considered that the assessment of the patient was acceptable, noting that there was no requirement for imaging to be undertaken.

This patient did not require surgical intervention or treatment, and there was nothing for the review team to comment in respect of team working and wider MDT involvement, which was not required for this patient, given the issue was benign.

The review team found that communication with the patient was acceptable. Given he did not undergo treatment, there was no requirement to obtain consent, although the management of his care was explained well, and followed up appropriately with a detailed letter to his GP.

The review team concluded that there was acceptable follow up action, with the patient being discharged back to the care of his GP.

The review team considered that the record keeping was appropriate, albeit limited.

There was no indication this patient came to harm and the review team did not consider that this patient requires clinical follow up in order to ensure his safety.

Case A89Description

This 37 year old male patient was seen between 2004 and 2005, when he was evaluated and treated for chronic interstitial cystitis, with a cystectomy, and an orthotropic bladder in September 2005.

The patient was later seen in 2008 when he had LUTS and undertook urodynamics.

In 2016 the patient was treated for a renal tract obstruction with bilateral nephrostomies, a laparotomy and bilateral ureteric re-implantation.

The patient's care and treatment was monitored and followed up with appointments in 2017 and 2019.

Comments

The review team noted this was a relatively complex case, with the involvement of Surgeon 1 and other colleagues on multiple occasions over a 12 year period, between 2005 and 2017.

The review team considered that the early assessment of the patient was thorough and detailed, and appropriate investigations were utilised.

The review team considered that the team working was acceptable, with many colleagues involved, particularly after the patient underwent surgery. The review team noted that there was no requirement for MDT involvement for this patient.

The review team were unable to comment on the consent process and communication with the patient as there was insufficient information within the electronic patient records provided.

The review team considered that there was room for improvement in respect of the patient's treatment. The review team noted from the patient records that there was criticism from the pharmacy department's antibiotic stewardship programme as ongoing prophylactic antibiotics had been continued in 2017, despite the seven negative mid-stream urine (MSU) sample results. However, they noted that this was taken on board by Surgeon 1, by reference to a clinic letter from 17 December 2019, in which he stated that he would prefer to avoid antibiotic prophylaxis, after the patient's neobladder surgery and intermittent catheterisation.

The review team considered that appropriate follow up action took place over a twelve year period, which was well documented.

The review team also considered that adequate record keeping took place over the twelve year period.

There was no evidence of patient harm and the review team did not consider that this patient requires clinical follow up in order to ensure his safety.

Case A90Description

This 58 year old male patient was referred in May 2015 with right loin pain. Ultrasound and CT of the kidneys, ureters and bladder (KUB¹³⁸) was carried out on 24 June 2015.

¹³⁸ KUB refers to a diagnostic medical imaging technique of the abdomen and stands for Kidneys, Ureters, and Bladder

The patient was seen by Surgeon 1 on 25 August 2015.

The patient was put on a waiting list for a flexible ureteroscopy and laser fragmentation of kidney stones from 2015 to 2020. He underwent surgery in 2020.

A CT scan had been taken in January 2021, which showed a small increase in kidney stone size.

Comments

The review team considered that the treatment of this patient was unacceptable, given he appeared to be on a waiting list for surgical procedures for five years. This prompted the review team to consider whether it was possible he had not been initially entered onto the waiting list, and if this contributed to delay in his care and treatment.

The review team considered that the patient received a correct initial assessment, and had appropriate investigations and imaging, with an ultrasound and CT of the kidneys, ureters and bladder on 24 June 2015.

In respect of team working, the review team noted that the patient was initially seen and assessed by Surgeon 1, and he was subsequently cared for by another urologist. The review team noted there were no MDT meetings where this patient's care was discussed.

In respect of the consent process and communication with the patient, the review team considered that the patient was informed of his treatment plans, however, it appeared that no actual consent was taken.

The review team considered that the follow up was acceptable. They noted that a further CT scan was taken in January 2021, which showed a small increase in kidney stone size. In the notes for this appointment, the review team found reference to this patient having been on the waiting list since 2015.

Given the patient appeared to be on a five year waiting list for treatment, the review team considered that the record keeping was unacceptable. The review team were uncertain where waiting lists were held in the system, and considered whether it was possible that he was placed on the waiting list, or whether there were occasions when despite being on that waiting list, he had been missed.

The review team noted that there was no obvious patient harm, however, the patient had been experiencing some flank pain since 2015. The CT scans only showed a small increase in the kidney stone size over five years. The review team did not consider that this patient requires clinical follow up in order to ensure his safety.

Case A91

Description

This 57 year old male patient was referred in February 2015 with suspected ureteric colic with right loin pain. He was seen in clinic on 09 March 2015. He was found to have bladder stones which were treated by laser treatment in November 2015.

The patient had a separate referral in 2019. His care was managed until 2021, during which time the patient appeared to be clinically well.

Between 2015 and 2021 the patient's care and treatment was managed by several clinicians, including Surgeon 1. The patient underwent open bladder stone removal in September 2019, treatment with a stent for sepsis in March 2020 and a TURP later that same month. A ureteroscopy and stent removal was performed in January 2021.

Comments

In the review team's view, the patient received appropriate care with no clinical concerns, however, there were several examples of letters from follow up appointments being sent either very late, or not at all, for events which had been referred to in subsequent correspondence.

The review team considered that the assessment, investigations and imaging were acceptable.

The review team considered that the team working was acceptable, with the patient treated by multiple clinicians over the six year period. They noted there was no specific requirement for MDT meetings to discuss this patient's care.

The review team were unable to comment on the consent process, as they did not receive handwritten records, including consent forms for review. In respect of communication with the patient and their GP, the review team noted several examples of clinical appointments which were referred to in subsequent correspondence, however these appointments had not been followed up with letters in a timely manner, or on some occasions at all. For example, in a letter dated 19 October 2015, there was reference to seeing the patient on 09 March 2015, however, there was no letter following up such an appointment. A letter dated 14 July 2020 referred to the patient last being written to in February 2020, although there was no such letter present from this time period, in the information made available to the review team. Whilst there was no clinical harm arising from letters being sent late or not at all, there was certainly room for improvement in respect of the record keeping.

The review team noted that the patient received multiple treatments under the care of several clinicians, including Surgeon 1, and no significant concerns arose in respect of the treatment.

The review team considered that the follow up action was acceptable, with the patient being monitored on an ongoing basis as appropriate with relevant clinicians.

The review team did not identify any patient harm and did not consider that this patient requires clinical follow up in order to ensure his safety other than that already ongoing.

Case A92

Description

This 60 year old male patient was initially seen in clinic by a registrar in 2013. Another consultant saw the patient on 29 September 2015 with a rising PSA between 3.5-5.1 and borderline PUJO on their right side with no loss of function.

The patient was reviewed again in February 2017 with LUTS and their PSA was noted as down to 4.37.

The patient attended occasional follow ups in 2015, 2017 and was reviewed in 2021.

Comments

The review team considered that the patient had a good initial assessment with the consultant and that appropriate initial imaging was taken. The review team therefore considered that the assessment, investigations and team working were acceptable.

The review team had no comment to make in respect of the consent process and communication with the patient as there was no consent needed as no surgical procedure was being considered.

The review team considered there to be no clinical indication for surgical intervention, with medication commenced as needed. The review team considered that the patient's treatment was acceptable.

However, the review team were deeply concerned with the delays in follow up that spanned between 2015, 2017 and 2021. The reasons for the severe delays were unclear to the review team, and they considered this left room for improvement.

The review team considered that there was good recording of information, although the review team found the record keeping had room for improvement due to the delays with follow up.

The review team noted that the patient was reviewed in 2021, with no indication that harm had occurred. The review team did not consider that this patient requires clinical follow up in order to ensure his safety, having regard to the follow up action which had taken place.

Case A93

Description

This male patient, whose age was unknown, initially presented in July 2014 with haematuria.

On 07 July 2015 the patient was diagnosed with metastatic oesophageal cancer and underwent chemotherapy and oesophagectomy.

On 07 August 2015 the patient was seen in clinic due to pain caused by his kidney stones. The patient was booked for ESWL on 24 September 2015 after returning from his holiday.

During a follow up appointment on 28 September 2015, it was noted that all stones had passed on the imaging taken.

The patient sadly died in Personal Information redacted by the USI of oesophageal cancer.

Comments

The review team considered that the patient had timely treatment of stone disease.

The review team considered that the patient was rapidly assessed, and he had rapid and responsive investigations. They therefore found the assessment, investigations and imaging to be acceptable.

The review team had found the MDT and team working to be appropriate.

The review team did not identify any concerns with the consent process and communication with the patient.

The review team concluded that the patient received appropriate treatment, and rapid and acceptable follow up action was taken.

The review team considered that there were good records for all of the care and treatment provide to the patient, and therefore the record keeping was acceptable.

The review team noted that the patient sadly died in Personal Information redacted by the USI of an unrelated cause (oesophageal cancer).

Case A94Description

This female patient, whose age was unknown, attended clinic in June 2015 where stones were seen in the lower pole of her right kidney.

The patient was seen by Surgeon 1 on 24 August 2015 and a flexible ureteroscopy (URS) was planned. There was no clinic letter included in the patient's record.

On 26 November 2016, the patient was referred from A&E and was booked for ureteroscopy¹³⁹ on 14 December 2016.

On 09 January 2017, the patient underwent ureteroscopy and stone fragmentation using a helium laser.

Comments

In the review team's opinion, from the clinical records provided, the patient's initial assessment appeared to be appropriate.

The review team were unclear what occurred after the patient was seen by Surgeon 1 on 24 August 2015 and the clinic letter was missing from the patient's clinical record. They noted that the patient was seen again on 26 November 2016 and her treatment was expedited.

The review team considered that the follow up treatment was equivalent to the original planned treatment.

The review team did not consider that this patient requires further clinical follow up in order to ensure her safety.

Case A95Description

This male patient who presented with haematuria was documented to have incontinence since 2008 and appeared to have been seen by Surgeon 1 in May 2015 where ISC¹⁴⁰ was started (based on a letter written by a nurse specialist dated 28 April 2016).

It was documented that renal stone was identified on 24 July 2019 and the patient undertook the procedure on 04 September 2019 where the stent was removed by Surgeon 1.

A CT scan taken on 19 April 2021 showed a sizable stone and the patient underwent flexible ureteroscopy and stent placement on 25 May 2021. The stent was removed on 02 June 2021.

Comments

In the opinion of the review team, from the clinical records provided, the patient's initial assessment, investigations and MDT team working appeared to be appropriate.

¹³⁹ It is a procedure in which a small scope (like a flexible telescope) is inserted into the bladder and ureter and it is used to diagnose and treat a variety of problems in the urinary tract.

¹⁴⁰ Intermittent self-catheterisation (ISC) is a term used to describe the process of regular catheterisation which you carry out yourself to remove urine from the bladder.

The review team noted that the patient had recurrent stone disease. In the review team's view, from the clinical records provided, the patient had adequate and responsive treatment and timely stent removal.

The review team considered that there were very comprehensive letters included in the patient's clinical record.

However, the review team were concerned that the consent form obtained in 2019 had no description of harm or potential harm documented. The review team concluded that despite this omission on the consent form, the patient did not appear to have come to any harm and no further follow up was required.

Case A96

Description

This male patient, whose age was unknown, was referred in August 2015 and was seen in clinic on 08 September 2015. A CT IVU was taken, which was noted as normal. The patient's PSA levels were measured at 0.58ng/ml. A flexible cystoscopy was also undertaken at the initial assessment, which appeared normal. It was documented that the patient had renal stones.

A letter dated 10 December 2016 confirming a telephone consultation with the patient was included in their clinical record. No other letter was seen from the date of the initial consultation.

Comments

The review team considered that this patient was assessed and investigated in a timely manner, with a CT IVU, PSA and flexible cystoscopy being undertaken rapidly. The review team therefore considered that the assessment, investigations and imaging were acceptable.

The review team did not comment on team working and the MDT. However, the review team noted that whilst the patient had a consultation on 08 September 2015, the letter was not written until 10 December 2016, some 15 months later, which delayed communication with the patient's GP. The review team therefore considered there was room for improvement in respect of communication with the patient and their GP.

The review team noted that after the investigations and imaging were undertaken, which appeared normal, the patient did not require treatment.

There was no need for follow up action and the patient was subsequently telephoned and discharged.

Whilst noting the significant delay in communicating with the patient's GP, the review team did not consider that the patient came to harm, or that he required clinical follow up in order to ensure his safety.

Case A97

Description

The patient, a 60 year old woman, was referred to Surgeon 1 by their GP with urinary incontinence. The patient had a previous history of urinary stones which was treated with lasertripsy between 2013 and 2014.

The patient was seen by Surgeon 1 in clinic and urodynamics requested. There was a delay (on the part of the patient) before urodynamics were performed on 15 July 2019 which showed significant detrusor instability, however, no stress incontinence was found.

No further records were provided to the review team.

Comments

The review team considered from the clinical records provided, that there was appropriate assessment, investigations, team working and record-keeping in this case.

The review team noted the delay before urodynamics were performed however noted that this was on the part of the patient and not the Trust's actions. The review team considered that the treatment provided was acceptable.

The review team noted that the communication/consent with the GP and patient and the follow up action was not applicable in this case.

Case A98

Description

This 70 year old male patient was referred with ureteric colic and LUTS (complex case).

Initially, the patient was an inpatient between 12 January 2006 and 17 January 2006 for TURP which was performed by Surgeon 1. This patient's clinical records did not include a consent form or operation notes.

The patient was reviewed on 23 February 2006. The prostate histology showed no evidence of cancer, no concerns were noted and the patient was referred for OPD review on 03 December 2006.

However, on 09 May 2006, the patient was reviewed and it was noted that post TURP, the patient was not doing well. It was documented that the patient had nocturia x4 with urgency and spraying and it was noted that a pre-operative CMG showed BOO and detrusor instability (DI), meaning that the bladder was overactive. The patient was therefore booked for flexible cystoscopy and prescribed the antispasmodic Oxybutynin 5mgs once daily.

The flexible cystoscopy was performed on 01 December 2006 and it was noted that there was tight external meatus, which was dilated.

On 21 August 2007, the patient was reviewed and it was noted that there was mild improvement with their LUTS, post urethral dilation. The patient was prescribed Vesicare 10mgs (another bladder antispasmodic drug) and another flexible cystoscopy was scheduled. The patient also complained of erectile dysfunction and was prescribed Vardenafil (a Viagra like drug) for this.

Between 12 February 2008 and 12 January 2009 the patient's condition was further investigated and reviewed by various consultants, including Surgeon 1.

On 12 January 2009 Surgeon 1 and another surgeon carried out a cystoscopy and bladder distension. It was noted that there was no stricture or obstruction and that the capacity was 700mls.

By July 2010, it was noted that the patient's LUTS had worsened, with nocturia x5, reduced flow with frequency and urge, together with the passing of tiny yellow stones. The patient was noted to have bilateral flank pain. On examination, the abdomen appeared normal, as were the external genitals. The patient was referred for a flexible cystoscopy, CT scan and for stone analysis (this was not done as the specimen was not labelled correctly).

The patient underwent further investigations and treatment between 02 September 2010 and 23 April 2014. Imaging studies showed a staghorn calculus in the right kidney and a stone in

the left ureter managed by left ureteroscopy and lasertripsy in 21 April 2014. The right kidney was noted to be atrophic and non-functional.

On 18 June 2014, Surgeon 1 and another surgeon reviewed the patient, who was due for stent removal and endoscopic assessment. The operating notes appeared satisfactory, however, the consent form was difficult to read. The patient was discharged home with plans for a DMSA scan with an OPD review.

Between 08 August 2014 and 04 June 2015, the patient was further reviewed for complex urological problems (including cystinuria), bilateral flank pain and LUTS with urinary frequency.

Surgeon 1 reviewed the patient on 03 November 2015 and the patient was noted as having LUTS and passing stones. The patient was therefore referred for CT and US scans with a planned review in December 2015.

The CT scan on 09 December 2015 noted a small right kidney, however, there were no stones on either side nor any obstruction found.

The GP referred the patient on 04 November 2016 due to LUTS with difficulty passing urine.

Between 30 January 2017 and 16 August 2017, the patient underwent further treatment and investigations. It was documented that there were no stones in the kidneys.

However, on 23 August 2017, the patient was reviewed and it was noted that they were having severe dysuria and the feeling of stone at the bladder neck. A flexible cystoscopy showed a 1cm stone in the prostatic urethra which was pushed back into the bladder and a catheter was inserted. The patient's eGFR on 14 August 2017 was noted as 58. A note was made of the DMSA scan from Aug 2014 showing the right kidney to have 17% function. The patient was prescribed Ciprofloxacin for two weeks and was referred for cystolitholapaxy (to remove the bladder stone).

Between 29 August 2017 and 30 October 2017, the patient was reviewed and it was noted that the patient's LUTS were better following cystolitholapaxy on 24 August 2017.

In October 2017, the patient passed a left ureteric stone and was therefore referred for follow up at a stone clinic.

Between 31 October 2017 and 02 November 2017, the patient was reviewed as they had been admitted for recently passing a stone and as a result, were experiencing left flank discomfort. The patient was later discharged.

It was not until two years later, in March 2019 that the GP referred the patient due to complaints of bilateral flank pain and reduced flow with poor bladder emptying.

Further investigations of the patient's condition were carried out between 15 May 2019 and 01 July 2019. The patient passed some small stones which were sent for analysis (showing cysteine stones) and a referral to a stone clinic was made for 06 December 2019.

On 03 July 2019, it was recorded that the patient's urine was positive for cysteine. A DMSA scan from 25 July 2019 was noted as showing the right kidney as having 17% function.

The patient was then reviewed by the Nephrology team between 01 October 2019 and 28 October 2019. The patient was started on potassium citrate 10mls three times a day to try to reduce stone formation.

It was noted that in OPD on 06 December 2019, the patient had passed several small stones and had increasing LUTS. A flexible cystoscopy was therefore arranged together with further nephrology input.

On 14 January 2020, the patient was again reviewed by the Nephrology team, with recent right flank pain. On ultrasound, it was noted that the right hydronephrosis had increased and the patient was referred for an urgent urology opinion.

The patient was seen in urology on 21 January 2020. A flexible cystoscopy was unremarkable. The consent form for this procedure did not mention any of the benefits of surgery.

There were further investigations and treatment of the patient's condition in the ensuing months and the patient was trialled on Tiopronin (16 February 2021) for the stones. However, it was noted on 16 February 2021 by the Nephrology team that the CT of 06 December 2020 showed stones in the distal right ureter which were awaiting intervention by urology.

On 10 March 2021, the Nephrology team reviewed the patient and noted a diagnosis of aortic stenosis from 18 February 2021. The patient was noted to have problems with headache and fatigue which may have been due to their Tiopronin medication and the patient was advised to stop medication for two days and, if the headaches abated, to restart at a half dose.

The Nephrology team reviewed the patient on 15 June 2021 and noted that they had frequent flank pain and also continued to form stones. The patient was taken off Tiopronin due to intolerance and was prescribed Penicillamine and Pyridoxine.

Comments

The review team considered from the clinical records provided, that the assessment, investigations, team working including communication with other members of the care team and the follow-up action of the patient care were acceptable.

The review team noted that this was a complex case involving congenital stone disease, LUTS, erectile dysfunction (ED) and it was appropriate for there to be multiple intervention by medical and surgical teams, including the Nephrology team for stone management. Although the management was acceptable, the review team viewed that Nephrology intervention may have been beneficial at an earlier stage which no urology consultant had appeared to consider.

The review team considered that there was room for improvement in respect of the consent and communication as some of the consent forms were either missing or incomplete (this was not unique to Surgeon 1). It was therefore difficult for the review team to know what information was given to the patient. The operating notes and the consent form for the cystoscopy and bladder distension appeared adequate. Overall, the review team considered that the record keeping required improvement.

The review team were unable to comment whether actions taken by Surgeon 1 as a result of MDT recommendations were appropriate as there were no MDTs records provided for this case. The review team speculated that there might have been a 'Stone MDT' but there was no information to verify if this was the case.

The review team did not consider there was patient harm in this case, although noted that there was an obvious error by Surgeon 1 relating to the dose of Vardenafil given, as this should have been 20mgs, rather than 50mgs.

The review team recommended that clinical (medical and surgical) follow up of the patient was required because of the ongoing stone problems despite the medical treatment.

Case A99

Description

This 40 year old female patient was referred by her GP on 11 August 2015 with loin pain.

On 18 August 2015 a CT KUB was arranged, which revealed two renal stones and left hydronephrosis. An MAG3¹⁴¹ renogram was organised, which appeared normal and was not obstructed.

The patient was seen by Surgeon 1 at an out-patient's appointment on 01 December 2015. All treatment options were explained to the patient including ESWL, ureteroscopy or percutaneous nephrolithotomy (PCNL). The patient was subsequently referred for ESWL treatment. The patient received a three month course of 50mg Nitrofurantoin to take twice daily to cover the ESWL treatment.

The patient was seen on 27 February 2017, and arrangements were made for her to undergo a flexible ureteroscopy.

When the patient was reviewed on 09 October 2017, she had completed the second course of ESWL treatment. It was noted that one of the stones had reduced in size, and the other had disappeared completely. There was therefore no requirement to perform the flexible ureteroscopy.

The patient received metabolic follow up. When she was reviewed on 20 February 2019, the stones and symptoms had cleared.

Comments

The review team considered that the patient's assessment, care and treatment by three clinicians, including Surgeon 1, appeared acceptable. The review team considered that there was appropriate assessment, investigations and imaging at an early stage, and the patient correctly had a CT KUB as well as a dynamic MAG3 renogram.

The review team considered that the team working was acceptable, with the patient's care being jointly managed by three urologists, including Surgeon 1, with no concerns identified. The review team noted there was no requirement for MDT input in this patient's care.

The review team noted that the patient was kept well informed, and the consent for the ESWL was properly documented, and therefore they considered that the consent process and communication with the patient was acceptable. The review team considered there were thorough discussions with the patient about all of her treatment options, and subsequently ESWL treatment was appropriately completed in February, June and September 2016. The review team noted that the patient was listed for a flexible ureteroscopy and laser treatment on 27 February 2017, but ultimately this treatment was not required. The review team considered that it was an unusual decision to use a three month course of Nitrofurantoin to cover the ESWL treatment, which was potentially an area for improvement.

The review team had access to the records of the clinical visits and the ESWL treatments being given to the patient which appeared satisfactory. When clinical appointments and treatment had been appropriately followed up with written letters, the review team considered their quality to be above average. However, they noted that after the patient was seen on 01 December 2015, the follow up letter was not dictated until 17 December 2015. The handwritten records made available to the review team were also of poor quality, with multiple blank sheets included. The review team therefore considered that there was room for improvement in respect of the record keeping.

The review team considered that the patient received appropriate follow up until 2019.

¹⁴¹ A renogram, which may also be known as a MAG3 scan, allows a nuclear medicine physician or a radiologist to visualize the kidneys and learn more about how they are functioning. MAG3 is an acronym for mercapto acetyl tri glycine, a compound that is chelated with a radioactive element – technetium-99m.

The review team did not identify any patient harm and did not consider that this patient requires follow up in order to ensure her safety.

Case A100Description

This female patient, whose age was unknown, was seen by Surgeon 1 on 08 September 2015.

It was documented that the patient had previously had an episode of ureteric colic on 02 December 2013.

A CT scan was obtained on 03 November 2015 as requested by Surgeon 1.

There were no letters included in the patient's clinical record.

Comments

The review team were unable to comment on the care and treatment provided to this patient in any detail, as no relevant information were provided in the patient's clinical records. They noted that there were no clinic letters included in the patient's record, nor was there any follow up documented in the patient's notes.

In the review team's view, there was no indication of patient harm from the information provided, and the review team did not consider that this patient requires clinical follow up to ensure her safety as the CT scans two years following the incident appeared satisfactory.