	Over 4 month period was a saving of 166 bed days Martina and Wendy need to be involved in this from community perspective CDCC – how much floor space will they have to actually cope with this demand? Shift from in-patient to day case to ambulatory care Pathway construction Is there enough resources to take this forward? Need to set out what the requirements are to make this work Need to establish what consultants happy to send to this area. Need to calculate the nursing hours to make it work and build a case around that.	Jerome Marley	
Urodynamic service	Asked to take this out of 2 south Medicine moving in this week. Cannot move into Thorndale until	Shirley Tedford Jenny McMahon Mr Young Mr O'Brien Mr Akhtar	Mid-December

	agreement from where slots into timetable for consultant support. What about in-patient urodynamics? Children after procedure? ??treatment room in 3 south for this? Need to know how many in-patients are affected. ??CDCC for this and arrangement made for these patients there – 2 medical ??STC – if room for equipment. Available Tuesday, Wednesday PM, Thursday and Friday ??Does urodynamics have to be carried out in Thorndale or is this an opportunity to look at changing location for the service entirely.	Martina Corrigan	
REVIEW BACKLOG	Consultant Review Backlog is: MY – CAH = 889 - ACH = 172 - BBH = 116 Total = 1177 AOB – CAH = 508 - ACH = 165	Sharon Glenny Martina Corrigan	End November for plan to be submitted.

	- BBH = 129 Total = 802 MA – CAH = 128 A lot of effort has been put in already from MA to reduce his backlog of reviews. Philip Rogers sessions now increased to have two dedicated sessions for review backlog work. Tues pm for AOB Fri pm for MY MY sessions already in place AOB sessions still to commence. Review backlog case submitted to SDU and allocation of funding given and this can only be drawn down as clinics happen. Options were discussed and Sharon will meet individually to agree a way forward in relation to backlog		
THORNDALE	Location – short on OP consulting rooms, 2 large procedure rooms which are excellent.	Martina Corrigan Sharon Glenny Judith Anderson	

	Emergency access difficult – traditionally 999 call. Now link corridor in place. No disabled parking. Staff now using car parks since paying car parks in place. Swing doors on unit, could do with automatic doors. Air conditioning for unit – Colin Spiers to carry out assessment Fax and photocopier – multifunctional devices – Siobhan Hanna Smell out of toilets – Health and Well being – Director of Estates Waiting Room Area – not enough space for all the patients and their families when attending clinic. Staff – more reception cover now. Need to think about what their duties actually are. Need constant support. No cover over lunch time. – Judith Medical support – not sufficient to cover all the clinics – Mr Young Thorndale staff – isolated. Access to	I	

	senior staff difficult. Need built into timetable. ICATS – set up pre-targets. WLI not sustainable long-term. Harder to continue with week on week. With lack of registrars will be hit harder than ever. LUTS – 1:2 reviews – chronicity of patients would lead to think that these are being seen more often. TRUS – demand from red flags is high, but should all patients be red flag for this service? Always requires additional clinics D4 never set up in the original SDM. Needs this for the patient journey Needs looked at under the guidelines of NICAN and need to conform to these. Biopsy infection rates – nothing done yet regarding this. Antibiotics have changed and there may be an increase in admission rates. Decontamination of probes has	LUTS (Workstream) Jenny McMahon Sharon Glenny Judith Anderson TRUS (Workstream) Martina Corrigan Sharon Glenny Kate O'Neill Alison Porter Judith Anderson Information Team	

	commenced in accordance with decontamination policy. Haematuria – need to think about what is red flag. Current waiting list is 7 weeks. Service needs overhauled. Do all patients need all of the investigations. There is regional and global variations. Need to think about what we want for our service. Link corridor – will this improve service. Who is the best person to do the cystoscopy? What about the decontamination of scopes? Where will this be done? Minimal data set for referral letters is not being met, but referral letters is not being returned. One member of Thorndale staff moves with the patients to have the 4 procedures carried out in DSU on Friday afternoon 1. Quantity required each week – actual referral letters received. Diagnosed by day 31 and treatment in 62 days. If need treatment in Belfast need diagnosed and staged by day 28. 2. Process to get done on one day	Haematuria (Workstream) Martina Corrigan Mary McGeough Alison Porter Jenny McMahon Sharon Glenny	

	Upper tract imaging for NICAN. Doesn't go down to level of detail to say IVP Andrology – ED, scrotal swellings and lumps Ideally split into purely ED clinic. Takes a few clinics before get to end point. At least 2 – 3 reviews for each. Lack of time for patients. Jerome more frustrated with his role. Need to look at what Jerome can do/able to do at the clinic. Is he covered to do the things he is or could do? If Jerome stand alone would double the amount of patients seen, but then space becomes a problem. Jerome doing bloods and injection therapies. From clinical governance can he do more? Non-ED patients – USS access, eg testes. Would be more ideal to have this at the time of clinic. Could be facilitated if split by referral criteria. 1. clarify the patient types attending the clinic 2. consequences to the clinic accommodation if this happens 3. what if the patient requires surgery – can Philip consent 4. Need protocols to drive the way forward	Andrology (Workstream) Mr Young Mr O'Brien Mr Akhtar Jerome Marley Philip Rogers Alexis Davidson Martina Corrigan Sharon Glenny	

	GPwSI – 10 patients was too many. Now reduced to 8 . Uro-Oncology clinic – should only be used for patients with stable prostate disease. Opportunity for patients on consultants review backlog to be referred into this clinic. Walk-ins/Virtual clinics – Not actually being recorded anyway, but an amount of time is being spent each day/time to deal with these patients. Patient advice line lost with ward reconfiguration – may have had an affect on the Thorndale staff. Patient Choice – offered where possible, however, on instances this can not be accommodated, eg, gentleman attending 2 types of clinic on one day. Future needs : MDM Regional Review – satellite clinics Female Urology – never got off the ground Day 4 TRUS – need to find a way to see these patients in the Thorndale Unit, regardless of funding	Philip Rogers Sharon Glenny Future Needs (Workstream) Mr Young Mr O'Brien Mr Akhtar Jenny McMahon Kate O'Neill Jerome Marley Philip Rogers	

		Martina Corrigan Sharon Glenny	
ONCOLOGY	MDT – CAPPS Thursday PM MDT meeting. Letter from H Mullen mid June requesting that Trusts move to Thurs PM MDT meeting. Start date 01.01.10 using link to Belfast or going to Belfast. Involves the whole urology team – all cons, radiologist, pathologist, nurse specialists, Jerome, Philip. Team approach to delivery all integrating to discuss cancer cases. All complex pathology will be discussed by video link with Belfast. Clinical Governance and quality/standards. Number of cases will require the whole afternoon. Each consultant would like to present their own cases. Will not detract from the Thurs morning x-ray meeting. May require 1.5 – 2 sessions per week for preparatory work and subsequent action Affects to out-reach clinics needs to be quantified and consideration given to locations of these in the future. In a 5 cons model, only 3 may still continue with oncology work – therefore outreach clinics still continue with	Resolution to accommodation and backfill to be found Mr Young Mr O'Brien Mr Akhtar Sharon Glenny Martina Corrigan Alison Porter Paula Tally	Meeting on 12th November

	remaining consultants. Each consultant must attend 66% of meetings in order to retain presenting rights. Existing Thurs PM sessions need to be reallocated to other clinical sessions if available? Or How do the existing sessions get covered, eg, locum? Or 2 consultants present to discuss on behalf all 3, and so that we continue with the outreach clinics		
CAPPS	Presence in theatre 2, ICATS room, DSU, STH, consultant rooms in all clinics is required. Hardware required to run the software. If not available through own IT department, could this be included in Regional review?	Let Martina know where equipment required and then raise with IT/Alison. For outreach can be raised with Connie Connolly. Mr Young Mr O'Brien Mr Akhtar Sharon Glenny Martina Corrigan Alison Porter Paula Tally	
Nurse Specialists	5 being made available across 3 areas for	Mr Young	

	oncology	Mr O'Brien Mr Akhtar Sharon Glenny Martina Corrigan Alison Porter Paula Tally Sandra Wadell Bid required from SHSCT	
RED FLAGS	1. Carry on as normal 2. Establish how many urgent cases need to be assessed (as opposed to non-cancer cases) Do you run the risk of swamping the system with "red flags". Need to have the capacity to deal with these, therefore need true figure. Any patient triaged as TRUSA or HAEM should automatically become a red flag patient? – not current practice. Only if GPs marked as RF or if consultant upgrades as RF do they form path of the cancer pathway.	Consensus that the patients who are triaged for TRUS and HAEM should be regarded as requiring an urgent appointment/RF. Quantum analysis is required. Further discussion on 12th November 2009. Also at departmental meeting. Mr Young Mr O'Brien Mr Akhtar Sharon Glenny Martina Corrigan Alison Porter	

TEAM JOB PLAN	Implement the recommendations of the Regional Urology review. Looking at demand into service and how can meet the demand. – this would require an additional cons urologist. Devoted to the consultant led service only. 3 urological centres with one at SHSCT, includes Southern Region of Western Trust. Overview: 20 per week after ROTT, 1040 per year. Conversion to review Chronicity Open registrations on PAS from 05 Consultant Initiated referral 52 week model 27 new and 95 review per week DTA from Opts, other sources, eg, A&E, private work, consultant referrals 42% in-patients 58% day cases 23 in-patients per week 22 day cases per week	Mr Young Mr O'Brien Mr Akhtar Sharon Glenny Martina Corrigan Heather Trouton Paula Tally	

	Looked at what would then be acceptable across a 5 consultant model – MY provided info. 9 ins and 4 day sessions per week 6 – 7 out-patient sessions per week 5 day case sessions per week (per MY model) Depends on how many junior doctors are available and location of clinics.		

DEPARTMENTAL MEETING 22nd SEPTEMBER 2016

Chair: Mr Young

Present: Mr Glackin, Mr O'Brien, Mr Suresh, Mr O'Donoghue, Pamela Johnston, Theatre Manager & Sr. England

Apologies: Mr Haynes , Mrs Corrigan

TOPIC: SALINE RESECTION

The specifications for the saline resectoscope system were presented. Mr Young outlined the history behind the move to the saline resection, also explaining that the last year had been spent trialling the various resectoscopes. Mr Young asked the forum if they had regarded enough time had been given to each of the resectoscope providing companies so that an adequate assessment could be made for each of the scopes. The unanimous decision was that the trial period for each of the resectoscopes was adequate to make an opinion.

We all agreed that the appraisal form used was of a good standard and certainly adequate to make a surgeons' assessment of each scope. The overall assessment looked at scope quality, ease of use, product design and effectiveness of the core principal of diathermy and resection of tissue. Second component to be evaluated were costs of generators and disposables. Thirdly was the topic of CSSD and backup. Scoring was undertaken from the feedback forms with the result that the WOLF system was the poorest and was not fit for purchase. In third place was the TONTARRA system which was described as having a variable performance with regards to the resection loop activity. The STORZ and the OLYMPUS system scored virtually equally on the various points with an overall equal score. It was recorded that there was no cystoscope present on the OLYMPUS resectoscope tray for evaluation but we generally felt that this was not an issue to take into account. There was general record of a fairly good ease of use and that the vaporisation module component was good. Several negative points related to the working element of inflow/outflow not being ideal; there were some comments on excessive bubble formation on the resectoscope loop as well as some other comments relating to slow resection. Overall however this was a system that could be purchased. With regards to the STORZS system, it was felt that the cutting modality of the resectoscope loop was excellent. Overall the scope components were easily constructed and there was a generalised good ease of use. Comments with regards to consistency and haemostasis had been positive. One of the major points in its favour was that the STORZ system could be easily changed if required on an urgent basis to the use of glycine. This in the current climate of change from one system to another in association with the range of urologists within the unit was a more suitable system for the team in Craigavon Area Hospital. The STORZ system certainly was a system that could be purchased.

Purely on the ease of use principal, excluding other criteria (i.e. cost and CSSD), the option came down to either STORZ or the OLYMPUS system, the other two being excluded. Four surgeons voted for the STORZ, one electing for the OLYMPUS. Mr Haynes was not present for this vote but on subsequent conversation later in the day, Mr Young put the same question to Mr Haynes asking for his comments on ease of use and again he had no particular preference and was happy to run with the global opinion.

On reviewing the various costs, it was noted that the disposables did have a variable range. It was accepted that loop quality did vary and that loops could be purchased from different sources. We all felt that this was not a particularly focused point for making a decision (namely cost of loop).

The price of the individual resectoscope systems was recorded noting that the OLYMPUS system was significantly more expensive in totality. The OLYMPUS system would have to be purchased completely whereas the STORZ system could be involve both new scopes and modification of current sets. (The costs set out for this meeting were significantly in favour of the STORZ system but it was appreciated that if a STORZ completely new systems was to be included that this information was to be presented to the forum before a final decision was made).

A further significant contributor to decision making was the generator needed for the electrical input. Although the OLYMPUS company was going to offer a free £40,000 generator, we did record that we may need up to three generators in view of the amount of urology sessions occurring at the same time. (The forum did not know if the company would supply three free generators. They felt it unlikely but enquiries would be made). The current generator system available within the Trust is multifunctional and therefore would already suit the STORZ system more appropriately. Even with the OLYMPUS generator system, this would result in increased machinery parking within the theatre environment. Overall this was regarded as a fairly substantive pointer in favour of the STORZ system.

CONCLUSION

In concluding, the vote on several aspects namely ease of use, cost, generator type were all in favour of the STORZ system. All the urologists have backed this decision with a unanimous vote.

This decision was based on the information supplied with a final decision pending the outstanding enquiries, namely the cost of a completely new STORZ resectoscope system and the cost of the OLYMPUS cystoscope. This would give a truly like for like comparison. The additional enquiry related to the OLYMPUS generator issue.

Mr Young will add an addendum to this document when the above information becomes available before final sign off.

The paperwork with regards to this has been forwarded to the Service Administrator, Martina Corrigan and to Pamela Johnston, Theatre Manager.

M Young
22nd September 2016
Chair of Session

ADDENDUDEM to outstanding information in relation to Saline resection Systems

1/ Full cost specification for STORZ and OLYMPUS resectoscope systems (excluding generator) have now been supplied and presented by the Theatre management. This is included on the updated evaluation sheet. (see enclose document)

(*The conclusion of the forum group remains the same – namely that STORZ is less expensive*)

2/ OLYMPUS will only supply one free generator

This information is to be presented at the next Departmental meeting for ratification

M Young

12th October 2016

Urology Departmental Meeting
18 June 2015

AGENDA

1. New OP
2. Review OP
3. Dashboard
4. Elective – IN's/Days – Urgents
5. Urodynamics
6. Cancer performance paper
7. Peer Review
8. Red Flag capacity over July (escalation email from Mandeville)
9. Workshop on 26 June 2015
10. Future dates for workshops
11. AOB

Southern Health and Social Care Trust

Quality Care - for you, with you

Meeting with Kate, Jenny and Martina
Friday 3rd April 2015
Thorndale Unit
11.30am

Present: **Martina Corrigan, Kate O'Neill, Jenny McMahon**

Ref	Issue	Discussion	Owner/Date
1.	**Precarious Liability**	Letter to be done for Kate and Jenny in respect of Removal of Stents/Prostate and Flexi's	Martina
2.		Access to A&E for ill patients	Kate and Mary Burke
3.	**Governance**	We discussed the format and Martina to see if a previous format is still used within SEC	Martina
		Trus Biopsies/Urodynamic/Flexi SOP's and what information is needed from the patient including – clinical obs, NEWS charts to be completed etc…..	Jenny
		Jenny to email specific questions…..	Martina
		Latex free policy how long latex free environment – Advise needed.	Martina/Kate/Jenny
		Look at all documentation with Dawn Connolly Control of documents and are they still ok.	Martina/Kate/Jenny
		Standard Operational Policies within the unit are done but some will need changed whilst others need done, at the moment none are signed off but this will be part of the new process.	

Ref	Issue	Discussion	Owner/Date
4.	**Operational** **Staffing**	It was agreed that we would take one policy at a time – starting with Urodynamics and work thorough and then discuss with Consultant and get their signature that they are happy with them. Scopes issues to continue to work on getting this resolved Clarification of an outpatients with procedure and what should be recorded as a Day case • Radiology Biopsies – the future management of these • How are the biopsies captured Martina advised that she was not in a position to extend the temporary staff beyond April as the meeting with HSCB has not taken place, but she will keep them informed and once funding is in place the jobs will be advertised on a permanent basis **Date and Time of Next Meeting: no meeting next Friday 10th and next meeting will be at 11:30pm with Katherine Robinson/Sharon Glenny to discuss Nurse-led clinics**	Martina

MINUTES OF UROLOGY / PRIMARY CARE MEETING
17TH JUNE 2010

Present	Apologies
Mr Young	Mr O'Brien
Mr Akhtar	
Dr Beckett	
Dr Rankin	
Mrs Trouton	

1) Management of Review Backlog

It was agreed after discussion that Cancer patient required secondary care review.

Other non- cancer patients could be discharged with a management plan . Others may require secondary care review due to the nature of the clinical condition.

Patients with a raised PSA could be managed by the GP with Clinical Protocol agreed.

Non Consultant staff who support Outpatient Clinics will be required to have an action plan for the patient having a justifiable reason for bringing the patient back for review. These patient management plans will be monitored by Consultant staff on a regular basis to support junior staff in clinical decision making.

It was accepted that although many patients feel that it is comforting to remain under review by a consultant, irrespective of clinical need, that it may be more appropriate for such patients to be discharged back to their GP for re referral should a clinical problem re occur as waiting times for a new outpatient appointment are much shorter than for a routine review. Mr Young agreed that Clinicians would be more mindful of this despite pressure to review that can often come from patients.

Dr Beckett felt that the majority of GP's would prefer to see a patient discharged back to them with a clear management plan rather than have patients given unrealistic expectations regarding a review appointment in secondary care. In effect this often means that patients repeatedly contact their GP enquiring re late review appointments and often necessitate repeated referrals / letters into the secondary care system.

2) Patient Pathways

My Young and Mr Akhtar described the following patient care pathways that were either in place or could be adopted.

a) Stable Prostate Clinics

LUTS clinic is a one stop clinic. It generally has a 1:1 new to review ration and then the patients are dischared.

b) Prostate Diagnostic Clinic

If the patient is diagnosed with cancer they remain in secondary care for treatment and management.

If the diagnosis is non cancer – the patient is phoned with their biopsy result ie negative. This patient could then be discharged back to the GP for onward review as per agreed protocol.

c) Haematuria Service

The current New to review ration is 1:1.5. It is anticipated that at 6 months the patient could be discharged back to the GP for Dip Stick Urines as per agreed protocol.

d) Andrology Service

This is currently managed by Dr Rodgers and Mr Marley. It is agreed that there is currently a high rate of review which will be reviewed by the Consultant team and written protocols adopted to streamline the patient pathway.

With regard to Erectile Dysfunction, it was agreed that guidance would be given to Dr Rodgers that patients would be discharged to the GP if the medication was working, only to be referred back if problems reoccurred.

e) Vasectomy Service

With regard to the Outcomes measurement of the procedure. It was agreed that the patient would submit samples as requested to the lab. The results would go to the GP and the patient would contact the GP for the results before resuming unprotected sexual relations .

f) Urodymics.

Nurse Led service.

g) Stone Service.

There was some discussion regarding the management of patients with suspected or previously confirmed stones.

For suspected calculi, it was agreed that it would be reasonable (under guidance and protocol) for a GP to request a plain film x-ray and Ultrasound before referring to Secondary care.

The review of a patient with a history of calculi should remain in Secondary care for early detection of a re occurrence. There will be a high new to review ratio for these patients. However the service would like to develop a Specialist Stone Nurse who could participate in the review and management of these patients.

h) Female Urology

This is currently managed in Urology ICATS by Dr Rodgers. It is anticipated that this is one area were a considerable amount of patients could be discharged back to GP 's with management plans. Protocols to be worked up in conjunction with the ICATS team.

3) Prevention of Review Back log building.

Mr Young and Mr Akhtar agreed that the Urology team as a whole would be more proactive in discharging patients back to their GP (appropriately) with a management plan.

Regarding re referral letters being triaged, if the Consultant considers that the patient does not necessarily need to be seen at a clinic, he will write back to the GP with a management plan to be followed, either in the meantime until a review appointment can be secured or indeed discharged with the plan.

Pilot Pathways will be created by the Urology Team commencing with those for Lumps and Bumps and for the Prostate Assessment Clinic.

The proposed pathways will be discussed among a Urologist and a small group of GP's and agreement of a pilot pathway reached for implementation. – Mr Akhtar has agreed that he will lead on this piece of work.

It was agreed that Pathway work , including protocols for safe and appropriate discharge to GP's would commence as a priority considering the current review backlog numbers. Meetings with GP's should be arranged as soon as possible.

Other Issues.

Mr Young suggested that a Locum Consultant be recruited to support the service . It would be anticipated that the Locum would continue to see New outpatients, perform flexible cystoscopy, day cases etc to free up the core consultant team to perform review backlog clinics for those patients requiring an urgent review.

In the meantime, Lead Urology Nurses are working with the Consultant team to review patient centre letters of patients waiting on a Urology review, to identify those that require an urgent review, those who it may be appropriate to discharge and of course those who are on the review list due to an administrative error only.
The patient centre letter review is essential for the following reasons:-

1) To Cleanse the list from admin error to ensure that appointments are not given to those who should not be on the list.
2) To ensure that those patients who require urgent review are prioritised and are seen urgently.
3) To ensure that precious patient review slots are utilised for those patients whose clinical need is evident and that those who no longer require a review can be identified for safe discharge.

Virtual Clinics which occur in Consultant Offices need to be captured on PAS and counted as valid Outpatient activity. Sharon Glenny and Martina Corrigan to set up .

Southern Health and Social Care Trust

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Preparation/Advance information:

- Most recent HCAI bundle indicators (hand hygiene audits etc.)
- HCAI incidence information/time since last HCAI
- Any recent RQIA/other external audits/reports
- Briefing from Director/AD on any current issues
- Complaints/Incident analysis (when available)
- Other?

Name:	Roberta Brownlee
Visit To:	Ward 3 South, Craigavon Area Hospital
Date and time of visit:	10 am 12/10/11
Accompanied By:	Sister Shirley Tedford

**** Please note: you may not wish to complete all questions during your visit – the following are suggested questions.***

1.

a. What works well for you?

Good team work. Well skilled staff. Good staff voice who contribute actively in staff meetings. The measures board is well displayed. 'Dot comments' from staff with suggestions as well as criticism.

b. What doesn't work well?

Patient flow coordinators – ensuring they understand when Ward Staff says there are no empty beds – why? Only staffed for 31 patients despite having 36 beds – willing to take 36 patients but must have staff for safe and effective care (hard to reason with at times). Ward admin staff would like to see no paper results of tests – all on the computer why do we need duplicate of paper results?

2.

a. What would you like to change or see different?

Ward Managers allowed to get on with managing their ward – with less interference. Chasing after 'medical outlying patients' and getting consultants to see.

No issues when Ward Sister on duty. Issues arose when no Sister on duty – meeting arranged for 16th January to address these issues:

Medical Outliers – trying to be proactive in getting medical outliers seen through patient flow.

b. What challenges do you face?

Some staff owe the Trust hours due to new harmonization of duty. Not able to get this easily corrected. Ward Sisters have put forward suggestions how to resolve at her ward level but to date these have not been accepted, as the object of the shift harmonization was to all wards starting and finishing shifts at the same time.

S/Ns expressed concerns in this area too.

Harmonisation – all wards working same shifts. There will be + ve/- ve hours per week but staff not allowed to finish when it suits them due to WTD – already D/W Lead Nurse and A/D re: same.

c. Have you any ideas for improvement?

Continued work on the 'releasing time to care'. Increase the bed capacity to 36 and staff accordingly. Could possibly reduce beds to 25 at weekends.

d. Have you made any improvements you are particularly proud of?

Cultural change of the team to acknowledge that Urology and ENT (3S) all one ward not two separate.

Good progress and saving on 'releasing time to care'.

3.

a. **How many commendations have you received in the past 3 months?**

20-25 per month average. Good display.

b. **How many complaints have you received in the past 3 months?**

1 complaint since March which has been resolved.

c. **What were these about/how were complaints resolved?**

Local resolution worked well.

d. What are you doing to respond to/learn from the issues raised?

Regular staff meetings and sharing the learning at measure board meetings.

4. How do you engage with users?

As a Ward Sister I see my patients dally when on duty. Speak frequently with families when needs Indicate.

15. Any other comments? (*Record any additional information noted during visit*)

Excellent visit. Very open, honest and informative visit. Ward Manager highly capable and competent in role. Six staff spoken to. Spoke to patient flow coordinator (DMcC). Twelve patients spoken to – all very commendable of care provided, food served, communication and high standards of attitude and behavior from staff. Extremely busy ward with very well informed staff.

Ward waiting for 4 months for a much needed microwave

Signature 

Date 2/11/11.

**** This report should be completed within 7 days of your visit and shared with the Chair as well as the person(s) who conducted/assisted in your walk-around e.g. Ward Managers/Team leader etc.***

Southern Health and Social Care Trust

Quality Care - for you, with you

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Geraldine Donaghy. NED
Visit To:	Thorndale Unit (Urology) Craigavon Area Hospital
Date and time of visit:	Monday 5th March at 11.30am
Accompanied By:	Jenny McMahon Urology Nurse Specialist

Key Issues:

- **Ongoing development of services**
- **Ongoing development of nursing skills**
- **Challenges of meeting cancer targets**
- **Equipment needs (enhance training potential)**

Director's Response:

**** Please note: you may not wish to complete all questions during your visit – the following are suggested questions.***

1.

a. What works well for you?

I visited the Unit on Mon 5th March and was accompanied by Urology Nurse Specialist Jenny McMahon. [redacted] Personal Information redacted by USI .

Thorndale Unit is now located within the main hospital block which has removed the isolation felt when the unit was located at the back of the hospital. The Unit has been designed to allow the smooth running of one stop assessment and review clinics with 5 consultation rooms and 2 treatment rooms. CAH is the only hospital within the region to offer a service whereby when appropriate patients may have USS scanning and procedures completed in one visit. Delegates from the DOH and other Trusts have visited the unit to explore if they could replicate this service design. From speaking with the Nursing, Admin and one of the Consultants, it was evident that there was an excellent team spirit in the Unit with openness to cooperate in all areas of the service delivery. Excellent systems of communication have been developed and in evidence including efforts to keep patients informed throughout their attendance at the clinic (which often stretched over a whole day).

b. What doesn't work well?

The staff were conscious of the distress for patients when difficulty was experienced in getting patients admitted as an emergency in a timely manner due to bed pressures. In general when theatre lists are cancelled or reduced, this often results in a noticeable increase in the volume of calls from patients / carers expressing anxiety regarding delays to treatment. This problem was sympathetically managed by staff who maintained good communication with patients when these situations arise.
As a small nursing team and while sickness episodes are not common, they have significant impact on the ability to cover both Thorndale Unit and the Stone Treatment Centre which the Unit has management responsibility for.
Workforce issues are generally stable although with an ever increasing workload, additional staff are needed. Increased incidences in Prostate & Renal Cancers have resulted in a case being made for an additional nurse to do follow up and the Unit is hopeful this will happen. Currently there is a Consultant Urologist vacancy and ongoing dependency on Locum Consultants continues.

2.

a. What would you like to change or see different?

- With the support of the management structure we continue to discuss further opportunities for nursing staff development in the provision of new services e.g. Prostate cancer review, Erectile Dysfunction clinics, Renal cancer follow up
- Improved flexible cystoscopy equipment to allow further training for nurse endoscopy
- Improve succession planning for the future of the service

b. What challenges do you face?

- Difficulties remain in meeting the cancer targets for first appointment and first definitive treatment
- Lengthy waiting time for what are considered to be non-urgent urological surgery, however many of these patient are experiencing significant impact on their quality of life while awaiting procedures

Concerns were expressed by both nursing and medical staff on these challenges. In some cases Non urgent waiting times extended to a 4 year wait. It was suggested that proposed new guidelines due to be rolled out on treating prostate cancers would create added pressures on waiting times for non urgent cases.

c. Have you any ideas for improvement?

- Ongoing support for staff development
- Further development of nurse provided services
- Additional equipment & suitable equipment to facilitate training & additional work .

The Unit noted a clear need for additional equipment/scopes & Videoscopes in particular which would facilitate improved diagnosis and staff training due to staff in training being able to observe the site of the problem on video. The Line Manager I was informed was actively pursuing funds. I mentioned the E&G Funds as a possibility to pursue?

d. Have you made any improvements you are particularly proud of?

Since the last visit to Thorndale Unit (in 2012) the team has seen significant improvements with:

- Continued development and improvements at new clinic progress
- Improved patient information available/designated key worker for all patients with a cancer diagnosis
- Appointment of 2 Band 6 staff (development of competencies/specialization ongoing)
- Development of a Trial Removal of Catheter Service
- One Band 7 & one Band 6 undertaking Non Medical Prescribing course this year
- Band 7 leading the prostate biopsy service
- Appointment of an Admin Staff Member which has proved invaluable
- The team were delighted to receive the Overall Trust Excellence Award in 2016

3.

a. How many commendations have you received in the past 3 months?

- Patients continue to be very complimentary of the new clinic design and recognize that while their clinic visit may take several hours, much is achieved in one visit thus avoiding unnecessary repeat trips by patients.
- Patients who attend the clinic for benign & cancer bladder treatments are impressed at the personalized service which they receive from the Band 5 in charge
- Gifts of sweets/cakes/thank you cards on a weekly basis

b. How many complaints have you received in the past 3 months?

None

c. What were these about/how were complaints resolved?

If any patient shows any sign of dissatisfaction whilst attending Thorndale Unit, staff endeavour to resolve the issue locally.

The staff are very engaging with the patients due to the invasive nature of the procedures performed plus patients are usually there for a few hours so there is ample opportunity available to discuss any concerns.

Nice little touch in the Unit that patients are offered Tea/Coffee during their attendance.

d. What have you done with the learning from the issues raised?

Staff meetings are used as an opportunity to share issues with staff as well as compliment them on their achievements.

4. How do you get feedback from patients, services users and families and how do you use this feedback?

Staff engaged with service users when designing the floor plan and painting of the new unit.

The service has been involved in Peer Review for several years now. Several patient satisfaction audits / questionnaires have been completed regarding local and regional services for those affected by urology cancers.

The Unit proactively seeks to involve patients in their treatment plans. A new N.I.C.E. decision aid is used to outline treatment options, outcomes for each options, benefits/side effects etc so that the patient can make informed choices. Also a key worker is allocated to each patient throughout their treatment who they can call for advice.

5. Do you have regular team meetings?

a. What's on your team meeting agenda and do team members contribute to the agenda?

We have a formal annual team meeting for nursing staff but regular informal meetings occur on audit days.

Items we cover include:

- Unit management/human resources
- Cancer/Benign services
- Training/Professional Development
- NMC revalidation
- Audit
- Equipment
- Governance
- Correspondence
- Supervision
- Clinical issues
- Any other business

6. Any staffing issues?

- As indicated above, two Band 6's have been appointed to allow the Band 7's expand their service delivery
- Review of all service provision is ongoing
- The Stone Treatment Centre for which Thorndale has staffing responsibility has undergone significant service development over the last 12 months with further plans proposed – this may require further training for nursing staff and potentially appointment of a member of clerical staff.

7. Is your Team's mandatory training up-to-date?

- We negotiate Basic Life Support to be provided within the unit once a year – if a member of staff cannot attend it is their responsibility to organize a further date
- Manual Handling is also negotiated within the unit every other year- if a member of staff cannot attend it is their responsibility to organize a further date
- There are nominated Link Nurses for eg. Infection Control/Dementia care
- All trained staff attend Nominated Fire Officer Training Annually
- Provision is made to allow all staff necessary time to complete on line training through e-learning

8. Do you have arrangements in place for regular supervision?

Previously one Band 7 took responsibility for Clinical Supervision and another for KSF.

Both Band 6's have attended training for the above and now have a plan in place to achieve regular supervision and KSF. Appraisal meetings conducted twice per annum. This is essential to allow Revalidation to occur.

The Unit has established a comprehensive e mail communication system which aids staff support.

9. Tell me about your safety audits (on dashboard/other)

Bedpan/fridge/hand hygiene audits are completed – learning outcomes shared with staff and displayed in the patient waiting area.

Cystoscopy storage cabinet checks are completed daily and weekly
Any issues are shared and dealt with immediately.

10. Is there a good understanding of when and how to report an incident/error?

All staff are aware of how to complete a Datix. Incidents / errors are occasional occurrences and the outcome/learning is shared with all staff

11. What areas of risk are you concerned about in your ward/facility/team?

The decontamination process for cleaning of probes used for prostate biopsy is quite lengthy – however recent developments with the Decontamination Team has seen the purchase of new advanced equipment for probe decontamination and it is expected that this service will be implemented soon.
The equipment is in place and the majority of the staff have received their training.

The cystoscopy storage cabinet has been included on the SEC risk register as staff have difficulty accessing the low level shelving in order to clean the cabinet properly and there is risk of injury. This issue is recognized throughout the Trust with this equipment. Also the chemicals used in the disinfectant process are currently under review as to the safety for staff inhaling potential vapours.

12. When you escalate risks that are beyond your control, do you get a timely response?

The management team is supportive of any concerns raised.

13. Are you getting the support you need to manage risks that you are accountable for to enable you to fulfil your role and responsibilities?

Yes – no concerns

14. Do you have any problems with infection control (if applicable)? (Non Executive Directors to comment on environment and general observation for infection control)

None reported by staff. I was given a conducted tour of the facility including surgical rooms, decontamination unit and consultation rooms. All were clean and tidy and I observed staff preparing the room for a procedure in a clinical environment. The importance of infection control was raised by Urology Nurse Specialist Jenny throughout my discussion and visit.

15. When had you last an MRSA; MSSA; C. Diff or other problem?

No problems in past 3/4 years.
Patients with an infection control issue are booked at the end of the clinic and when a patient attends the unit with a history of any of the above, a terminal clean is requested immediately and the room is not used until the clean is completed.

16. How well do you feel the 'Smoke Free' policy is being adhered to and how do you feel staff are managing?

No staff smoke within the team, however it would appear throughout the hospital that the Smoke Free policy is being adhered to quite well.

The only issue commented on is cigarettes continue to be disposed of outside the main doors of the hospital and maternity department.

17. Any other comments? (*Record any additional information noted during visit*)

The fact that the staff are actively involved in service development is reflected in their work ethic and progression of skills. Medical, nursing and clerical staff work collectively and this is reflected in the enhanced patient experience.

It was clear that all staff working here are committed to and passionate about the work they do. This Unit is a pioneering clinic where nurses undertake many procedures including biopsies which are normally not undertaken by nurses. This speeds up patient diagnosis and treatment plans and makes for an overall more efficient service.

Signature Geraldine Donaghy **Date** 5th March 2018

**** This report should be completed within 14 days of your visit and returned to the Chair's Office. The Chair's PA will then forward to the Chief Executive and person(s) who conducted/assisted in your walk-around.***

Southern Health and Social Care Trust

LEADERSHIP WALK – GUIDANCE TOOL FOR NON EXECUTIVE DIRECTORS

Name:	Roberta Brownlee
Visit To:	Thorndale Unit (Urology), Craigavon Area Hospital
Date and time of visit:	23 May 2012 at 10.30 am
Accompanied By:	Kate O'Neill, Urology Specialist Nurse

**** Please note: you may not wish to complete all questions during your visit – the following are suggested questions.***

1.

a. What works well for you?

Small select unit. Very personalised for patients. We engage well with the patients. Many patients afraid – need a lot of reassurance. Small effective team and very adaptable. Highly skilled and competent team. Specific nurses who lead in different areas and development opportunities are available and accepted. Good communication. Good flexible and responsive staff. Supportive Consultants.

b. What doesn't work well?

Short of middle grade doctors for support (Registrar level). *There is a recognised shortage of middle grade doctors nationally within Urology. The Trust has advertised on a number of occasions without success. However we have recently advertised and we have had three applicants – interviews due to take place mid-August and we are hopeful that we will be successful in appointing. Also last year we only were successful in getting one registrar through training but from August 2012 we are getting 2 Registrars which will assist with this support. Last week we were advised that the Trust had secured funding from Board Liaison Group for an additional Specialty Doctor and we are hopeful that we will appoint another doctor from the interviews in August.*
Limitations of the size of the building. *These limitations have been recognised and there are plans being put in place to move the 'Thorndale Team' to main outpatients.*
Small team so if one staff member off sick impacts greatly. *As part of the Review of Adult Urology there is funding for a further 2 Specialty Nurses and we have been involved in discussions on how best to utilise this funding. Also the Unit depends on the General Practitioner with Specialist Interest (GPwSI) and when he is off sick this impacts on the activity. However it is hoped to address this through the appointment of more Specialty Doctors.* **Two patients and staff raised concerns of no car parking spaces. The length of walk for older patients and their family members**. *It is anticipated that both these points will be addressed through the move from the current location to main outpatients.*

2.

a. What would you like to change or see different?

Expansion of the team *this is in process with the additional 2 new Consultants and 1 replacement Consultant commencing 1 August, 1 September and 1 October. Also the appointment of the 2 new Specialty Doctors, 2 Specialty Nurses and the successful securement of 2 Registrars*
***Non-stock and requisitions – the process i.e. consumables – e.g. can these be stock items to enable more cost effective purchasing? I have asked for this to be looked at on several occasions – to date no response.** *This is currently with Head of Purchasing and Supplies. Although we have been advised that the items alluded to can only be moved to stock items once they have gone through the tendering process which is governed by BSO. A list and appropriate documentation has been completed in preparation of this tendering process.*

b. What challenges do you face?

Expansion of the area 'South'. Limited medical cover. Not always a medical member available in this unit. *As per above this will be addressed with the additional medical staff (Consultants, Specialty Doctors, Registrars) that are coming to the Trust. The plan is that one or more of these will be based each day in Thorndale Unit.*

****Access to the main hospital for emergencies is not possible – what we have to do is call 999 to get Emergency Department. Needs to be noted for future reference. The present link corridor not passable**** *the corridor was planned to link the Thorndale Unit with the main hospital but the only access was through the Paediatric Outpatients area which has security risks in that only staff can use this when paediatric outpatients is not taking place. Also part of the corridor is open so therefore not suitable if accessible for patients during inclement weather. This issue will be addressed when the Unit is incorporated in main outpatients.*

c. Have you any ideas for improvement?

Privacy at reception – for phone calls. *This will be addressed when the Unit moves to main outpatients as they will have a 'closed in' reception area*. **Formalisation of link corridor – how to use – great corridor but of no benefit.** *It has been very difficult to progress the use of this corridor due to child protection issues. We have been able to use it for moving equipment through from main hospital to Thorndale Unit.*

d. Have you made any improvements you are particularly proud of?

- One stop clinic - Haematuria and prostate diagnosis – these patients seen within 1 or 2 weeks and offered biopsy on the day of visit. Most flexible cystoscopy done on same day of clinic.
- Decontamination purposes – used to only have one probe now bought 4 and formalised a protocol for decontamination– excellent outcomes – Band 7 lead the MDT approach to safe practice, completing this task is nursing auxiliary.
- Harmonisation of prostate biopsy service – Band 7 used the opportunity of her post graduate diploma in specialist nursing to standardize all patients to get appropriate local analgesia.

3.

a. How many commendations have you received in the past 3 months?

Feedback from community services very good and have many commendations. Staff impressed with high levels of satisfaction. Could patient satisfaction survey and the questionnaires be completed at this unit?

b. How many complaints have you received in the past 3 months?

None.

c. What are you doing to respond to/learn from the issues raised?

If any complaints I would share locally and listen and learn. Engage with all staff.

4. How do you engage with users?

We do 1:1- we have used service users to improve haematuria documentation. Daily engagement with all patients and ask for feedback before they leave the clinic. Open honest 1:1. Availability of documentation used.

5. Do you have regular team meetings?

a. What's on your team meeting agenda?

Band 7 goes to Sisters meeting weekly – I find this excellent. Good links with the wards. I bring back and share information weekly. Formal meetings 2-3 times per year. We look at Assistant Director meeting outcomes, HR, Training, Governance and Infection Prevention Control.

6. Any staffing issues?

Only middle grade doctors. *As per response to 1 (b).* No other staffing issues.

7. Is your Team's mandatory training up-to-date?

Basic life support up-to-date.
M&H – 100%
Fire Awareness – all staff booked for May 12 – all previously trained.
Infection Control – annual – 100% up-to-date. Excellent and up-to-date. Good opportunity for development.

8. Do you have arrangements in place for regular supervision?

I do this twice yearly with staff (one Band 7 responsible for this) and KSF completed by other Band 7.

9. Tell me about your safety audits (on dashboard/other)

Bedpan/fridge/hand hygiene audits – learning outcomes shared with staff for display in patient waiting area.

10. Is there a good understanding of when and how to report an incident/error?

Good understanding by staff. Sharing Datix report/process to all other staff.

11. What areas of risk are you concerned about in your ward/facility/team?

None raised but highlighted isolation from main hospital. Could have two collapses per month and have to go via 999 call. *This is a recognised concern and one of the reasons to having Thorndale relocated to main outpatients.*

12. When you escalate risks that are beyond your control, do you get a timely response?

No concerns – can raise concerns and gets a timely response.

13. Are you getting the support you need to manage risks that you are accountable for?

Yes – no issues.

14. Do you have any problems with infection control (if applicable)? (Non Executive Directors to comment on environment and general observation for infection control)

None. Fresh and new unit. Extremely clean. Spoke to three patients and all very complimentary of the service provided. Commended staff's friendliness, helpfulness and privacy.

15. When had you last an MRSA; MSSA; C. Diff or other problem?

None.

16. Any other comments? (*Record any additional information noted during visit*)

This is an excellent facility. Very person centred. Patients like the privacy. Spoke to two S/Ns and audio typist. Both S/Ns highly skilled nurses – no concerns raised. Confirmed the high quality outcomes. Phone area very open and poor privacy. *To be addressed and to be taken into account when Thorndale is relocated.* Staff have had 'other teams' come to look at Thorndale as it appears Urology may move from this Unit. *The discussions about a potential move were only at a very early initial stage and had been tentatively discussed with the Urologists and Specialty Nurses and nothing had been agreed or that there would be a definite move. However, the other team that have been provisionally told that there may be a potential for them to move to Thorndale if Urology moved went to visit the Unit without notifying, Assistant Director/Head of Service and arrived unannounced. However, Head of Service addressed this immediately with the Staff in Thorndale.* Staff not really aware of any planned changes. Staff need to be kept informed and involved in the planning e.g. Urodynamics Room – extremely hot and no air conditioning. If Urology moving to another area the name 'Thorndale Unit' needs to go with this specialty because of how and why it was named this. It's important that this request is noted at this stage please. *The proposed move has been discussed with Consultants and Specialty Nurses and they all had been given an opportunity to advise on any areas that they wanted to have included. This is still only at the planning stage and it will not be progressed without their involvement including a clinical room suitable for urodynamics/biopsies etc. We have also noted the request to keep the Thorndale name for the area when it is relocated.*

Signature _____ **Date** _____

**** This report should be completed within 7 days of your visit and returned to the Chair's Office. The Chair's PA will then forward to the Chief Executive and person(s) who conducted/assisted in your walk-around.***

Corrigan, Martina

From:	Corrigan, Martina
Sent:	23 January 2013 16:15
To:	Connolly, David; Glackin, Anthony; O'Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc:	Trouton, Heather; Conway, Maria; Glenny, Sharon; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; McCorry, Monica; Troughton, Elizabeth
Subject:	****URGENT NEED A RESPONSE****Patients requiring to be seen by end of March in order to meet backstop targets
Attachments:	Inpatients MY PCNL 23 jan 13.xlsx; daycases AOB 23 jan 13.xlsx; daycases MA 23 jan 13.xlsx; daycases MY 23 jan 13.xlsx; Inpatients AOB 23 jan 13.xlsx; Inpatients MA 23 jan 13.xlsx; Inpatients MY 23 jan 13.xlsx; IEAP letter to DIR of Performance.pdf; SUMMARY ACUTE DIRECTORATE CNA DNA.docx
Importance:	High
Follow Up Flag:	Follow up
Due By:	28 January 2013 14:00
Flag Status:	Flagged

Dear all

Please see attached PTL's lists for the total patients that must be seen before end of March to meet the following backstops:

Inpatients patients should not be waiting any longer than 21 weeks Daycases – patients should not be waiting any longer than 21 weeks Flexis – patients should not be waiting any longer than 9 weeks

There are 9 weeks left until end of March2013 so I have to have a plan for these patients and need to know what will be on the lists until then, in order to follow the IEAP (I've attached a copy of correspondence received from Dean Sullivan relating to this and our summary of this) these patients will need to be contacted within the next few weeks with a date and if they do not accept then they can be reset as long as they get 3 week's notice and this will validate these lists in that it may not suit all these patients to come in before end of March or indeed they may not be fit or may no longer want this surgery.

The Board are really focusing on these long waiters so I will really appreciate if you can give me your update and could please let me know before Monday of what your plans are for these patients.

I am happy to discuss

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

Admission Reason	Intended Primary Procedure Code	Casenote	Consultant Name	Original Date	Actual Weeks Waiting (Rounded Up)
PCNL DIABETIC/TABLETS ON WARFARIN - PROSTHETIC VALVE	M09.9	[redacted]	Young M Mr	18/07/2011	78.57142857
LEFT PCNL (NEPHROSTOMY IN SITU)	M09.9	Personal Information redacted by USI	Young M Mr	27/08/2011	72.85714286
LEFT PCNL	M09.9	Personal Information redacted by USI	Young M Mr	31/08/2011	72.28571429
URETHROTOMY & LEFT PCNL	M79.4	Personal Information redacted by USI	Young M Mr	15/09/2011	70.14285714
RIGHT PCNL - TCI DB4 FOR IVI/IVA -CANC BY PRE-OP - 24HR TAPE	M09.9	Personal Information redacted by USI	Young M Mr	04/07/2011	66
LEFT PCNL PT WISHES MR YOUNG TO DO	M09.9	Personal Information redacted by USI	Young M Mr	14/11/2011	61.57142857
PCNL	M09.9	Personal Information redacted by USI	Young M Mr	28/11/2011	59.57142857
LEFT PCNL	M09.9	Personal Information redacted by USI	Young M Mr	19/12/2011	56.57142857
RIGHT PCNL UTA 29.03.11 - WISHES SFA AUGUST 2011	M09.9	Personal Information redacted by USI	Young M Mr	12/04/2010	53.42857143
LEFT PCNL +/- INSERTION SPC WHEELCHAIR BOUND TCI DB4	M09.9	Personal Information redacted by USI	Young M Mr	14/01/2012	52.85714286
RIGHT PCNL/NEPHRECTOMY (LAP)	M09.9	Personal Information redacted by USI	Young M Mr	13/02/2012	48.57142857
URGENT PCNL (ADMIT FOR PRE-OP NEPHROSTOMY)	M09.9	Personal Information redacted by USI	Young M Mr	17/02/2012	48
LEFT PCNL DIABETIC-TABLET CONTROLLED	M09.9	Personal Information redacted by USI	Young M Mr	21/02/2011	45.42857143
RIGHT PCNL (AOB PATIENT)	M09.9	Personal Information redacted by USI	Young M Mr	30/03/2012	42
RIGHT PCNL (LETTER IN B/F)	M09.9	Personal Information redacted by USI	Young M Mr	29/08/2012	20.28571429
PCNL (NEEDS PRE-OP NEPHROSTOMY)	M09.9	Personal Information redacted by USI	Young M Mr	03/09/2012	19.57142857
LEFT PCNL (?ADMIT EARLY? PRE-OP NEPHROSTOMY) CEREBRAL PALSY	M09.9	Personal Information redacted by USI	Young M Mr	17/09/2012	17.57142857
PCNL	M09.9	Personal Information redacted by USI	Young M Mr	04/10/2012	15.14285714
RIGHT PCNL	M09.9	Personal Information redacted by USI	Young M Mr	08/10/2012	14.57142857
LEFT PCNL	M09.9	Personal Information redacted by USI	Young M Mr	08/10/2012	14.57142857

Admission Reason	Intended Primary Procedure Code	Casenote	Consultant Name	Original Date	Actual Weeks Waiting (Rounded Up)
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	O'Brien A Mr	05/04/2011	50
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	O'Brien A Mr	03/06/2011	47
DIVISION OF PREPUTIAL ADHESIONS +/- CIRCUMCISION	N30.2	Personal Information redacted by USI	O'Brien A Mr	27/03/2012	42.42857143
CIRCUMCISION GA	N30.3	Personal Information redacted by USI	O'Brien A Mr	03/04/2012	41.42857143
CYSTOSCOPY ? TURBT	M45.9	Personal Information redacted by USI	O'Brien A Mr	04/05/2012	37
CYSTOSCOPY, HYDROSTATIC DILATATION OF BLADDER	M45.9	Personal Information redacted by USI	O'Brien A Mr	18/05/2012	21.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	O'Brien A Mr	20/08/2012	21.57142857
RIGHT EPIDIDYMAN CYSTECTOMY	M34.3	Personal Information redacted by USI	O'Brien A Mr	14/09/2012	18
INTRADETRUSOR INJECTION BOTULINUM TOXIN	M43.4	Personal Information redacted by USI	O'Brien A Mr	15/09/2012	17.85714286
EXCISION RIGHT EPIDIDYMAL CYST	N15.3	Personal Information redacted by USI	O'Brien A Mr	18/09/2012	17.42857143
CYSTOSCOPY & HYDRODISTENSION OF BLADDER	M45.8	Personal Information redacted by USI	O'Brien A Mr	05/03/2012	16.85714286
LIGATION OF VARICOCELE	N19.1	Personal Information redacted by USI	O'Brien A Mr	25/09/2012	16.42857143
RIGHT INGUINAL EXPLORATION AND LEFT ORCHIOPEXY		Personal Information redacted by USI	O'Brien A Mr	25/09/2012	16.42857143
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	O'Brien A Mr	01/10/2012	15.57142857
FLEXIBLE CYSTOSCOPY DA	M45.9	Personal Information redacted by USI	O'Brien A Mr	04/10/2012	15.14285714
INTRADETRUSOR BOTULINUM TOXIN 500 UNITS	M43.4	Personal Information redacted by USI	O'Brien A Mr	05/10/2012	15
TROC U/S ? TURP	M47.3	Personal Information redacted by USI	O'Brien A Mr	06/10/2012	14.85714286
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	O'Brien A Mr	09/10/2012	14.42857143
CIRCUMCISION FOR BXO REQUIRES POLISH INTERPRETER	N30.3	Personal Information redacted by USI	O'Brien A Mr	10/10/2012	14.28571429
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	O'Brien A Mr	15/10/2012	13.57142857
GA VASECTOMY	N17.1	Personal Information redacted by USI	O'Brien A Mr	25/09/2012	13.28571429
FLEXIBLE CYSTOSOCPY	M45.9	Personal Information redacted by USI	O'Brien A Mr	24/10/2012	12.28571429
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	O'Brien A Mr	24/10/2012	12.28571429
FLEXIBLE CYSTOSCOPY LA	M45.9	Personal Information redacted by USI	O'Brien A Mr	30/10/2012	11.42857143
INTRADETRUSOR BOTOX GA	M43.4	Personal Information redacted by USI	O'Brien A Mr	30/10/2012	11.42857143

Admission Reason	Intended Primary Procedure Code	Casenote	Consultant Name	Original Date	Actual Weeks Waiting (Rounded Up)
FLEIXBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	06/08/2012	23.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information	Akhtar M Mr	06/08/2012	23.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	10/08/2012	23
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	14/08/2012	22.42857143
FLEXIBLE CYSTOSCOPY & UPPER TRACT IMAGING	M35.9	Personal Information redacted by USI	Akhtar M Mr	14/08/2012	22.42857143
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	22/08/2012	21.28571429
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	15/08/2012	19.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	10/09/2012	18.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	11/09/2012	18.42857143
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	14/09/2012	18
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	17/09/2012	17.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	17/09/2012	17.57142857
FLEXIBLE CYSTOSCOPY ajg	M45.9	Personal Information redacted by USI	Akhtar M Mr	17/09/2012	17.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	17/09/2012	17.57142857
LAPAROSCOPIC DEROOFING OF RIGHT RENAL CYST	M04.1	Personal Information redacted by USI	Akhtar M Mr	18/09/2012	17.42857143
FLEXIBLE CYSTOSCOPY	M45.9	[redacted]	Akhtar M Mr	18/09/2012	17.42857143
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	19/09/2012	17.28571429
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	24/09/2012	16.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	24/09/2012	16.57142857
FLEXIBLE CYSTOSCOPY - SOUTH TYRONE HOSPITAL	M45.9	Personal Information redacted by USI	Akhtar M Mr	25/09/2012	16.42857143
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	25/09/2012	16.42857143
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	25/09/2012	16.42857143
FLEXIBLE CYSTOSCOPY STH	M45.9	Personal Information redacted by USI	Akhtar M Mr	26/09/2012	16.28571429
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	28/09/2012	16
FLEXIBLE CYSTOSCOPY (OCT 13)	M45.9	Personal Information redacted by USI	Akhtar M Mr	28/09/2012	16
FLEXIBLE CYSTOSCOPY cah	M45.9	Personal Information redacted by USI	Akhtar M Mr	28/09/2012	16
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	08/05/2012	16
EXCISION OF URETHRAL CARUNCLE	M72.8	Personal Information redacted by USI	Akhtar M Mr	01/10/2012	15.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	01/10/2012	15.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	01/10/2012	15.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	01/10/2012	15.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	02/10/2012	15.42857143

FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	02/10/2012	15.42857143
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	03/10/2012	15.28571429
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	03/10/2012	15.28571429
FLEXIBLE CYSTOSCOPY STH IF POSS	M45.9	Personal Information redacted by USI	Akhtar M Mr	03/10/2012	15.28571429
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	04/10/2012	15.14285714
FLEXIBLE CYSTOSCOPY UNDER LA	M45.9	Personal Information redacted by USI	Akhtar M Mr	08/10/2012	14.57142857
FLEXIBLE CYSTOSCOPY STH	M45.9	Personal Information redacted by USI	Akhtar M Mr	09/10/2012	14.42857143
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	09/10/2012	14.42857143
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	10/10/2012	14.28571429
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	10/10/2012	14.28571429
FLEXIBLE CYSTOSCOPY AJG	M45.9	Personal Information redacted by USI	Akhtar M Mr	10/10/2012	14.28571429
FLEXIBLE CYSTOSCOPY AJG	M45.9	Personal Information redacted by USI	Akhtar M Mr	10/10/2012	14.28571429
VASECTOMY UNDER LA	N17.1	Personal Information redacted by USI	Akhtar M Mr	10/10/2012	14.28571429
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	15/10/2012	13.57142857
FLEXIBLE CYSTOSCOPY MR CONNOLLY	M45.9	Personal Information redacted by USI	Akhtar M Mr	15/10/2012	13.57142857
CYSTOSCOPY & BOTOX (FEB 2013)	M45.9	Personal Information redacted by USI	Akhtar M Mr	11/09/2012	13.42857143
CIRCUMCISION (LA) diabetic and co-morbidities	N30.3	Personal Information redacted by USI	Akhtar M Mr	20/10/2012	12.85714286
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	20/10/2012	12.85714286
FLEXIBLE CYSTOSCOPY AJG	M45.9	Personal Information redacted by USI	Akhtar M Mr	20/10/2012	12.85714286
FLEXIBLE CYSTOSCOPY AJG	M45.9	Personal Information redacted by USI	Akhtar M Mr	22/10/2012	12.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	22/10/2012	12.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	22/10/2012	12.57142857
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	23/10/2012	12.42857143
REDO VASECTOMY AJG TO DO ONLY	N17.1	Personal Information redacted by USI	Akhtar M Mr	24/10/2012	12.28571429
FLEXIBLE CYSTOSCOPY	M45.9	Personal Information redacted by USI	Akhtar M Mr	24/10/2012	12.28571429
FLEXIBLE CYSTOSOCPY AJG PATIENT	M45.9	Personal Information redacted by USI	Akhtar M Mr	26/10/2012	12
CIRCUMCISIION AJG PATIENT	N30.3	Personal Information redacted by USI	Akhtar M Mr	29/10/2012	11.57142857
FLEXIBLE CYSTOSCOPY LA	M45.9	Personal Information redacted by USI	Akhtar M Mr	29/10/2012	11.57142857
RIGHT HYDROCOELE REPAIR		Personal Information redacted by USI	Akhtar M Mr	29/10/2012	11.57142857
FLEXIBLE CYSTOSCOPY AJG PATIENT	M45.9	Personal Information redacted by USI	Akhtar M Mr	30/10/2012	11.42857143
FLEXIBLE CYSTOSCOPY AJG PATIENT	M45.9	Personal Information redacted by USI	Akhtar M Mr	30/10/2012	11.42857143
FLEXIBLE CYSTOSCOPY LA	M45.9	[redacted]	Akhtar M Mr	29/10/2012	11.57142857
RIGHT HYDROCOELE REPAIR		Personal Information redacted by USI	Akhtar M Mr	29/10/2012	11.57142857
FLEXIBLE CYSTOSCOPY AJG PATIENT	M45.9	Personal Information redacted by USI	Akhtar M Mr	30/10/2012	11.42857143
FLEXIBLE CYSTOSCOPY AJG PATIENT	M45.9	Personal Information redacted by USI	Akhtar M Mr	30/10/2012	11.42857143

Admission Reason	Intended Primary Procedure Code	Casenote	Consultant Name	Original Date	Actual Weeks Waiting (Rounded Up)
CYSTOSCOPY & HYDROSTATIC DILATATION OF BLADDER/NEEDS INPT	M45.9	Personal Information redacted by USI	Young M Mr	25/11/2011	60
INSERTION OF LEFT TESTICULAR PROSTHESIS	N10.1		Young M Mr	22/12/2011	56.14285714
RT FLEX URETEROSCOPIC LASERTRIPSY	M30.9		Young M Mr	30/01/2012	50.57142857
LT FLEX URETEROSCOPY & LASERTRIPSY	M30.9		Young M Mr	30/01/2012	50.57142857
APRIL 2012 URETEROSCOPY	M30.9		Young M Mr	08/02/2012	49.28571429
END MARCH 12 PCNL PRIVATE PATIENT LTR IN B/F	M09.9		Young M Mr	17/02/2012	48
NESBITTS PROCEDURE	N28.8		Young M Mr	02/03/2012	46
FLEXIBLE URETEROSCOPY	M30.9		Young M Mr	07/03/2012	45.28571429
RIGID URETHROSCOPY&LASERABLATION	M17.9		Young M Mr	16/03/2012	44
RT FLEX URETEROSCOPY & LASERTRIPSY	M30.9		Young M Mr	19/03/2012	43.57142857
1/12 FLEXIBLE CYSTOSCOPY & LASER TO BLADDER STONE	M45.9		Young M Mr	21/09/2010	43.14285714
NESBITT'S PROCEDURE	N28.8		Young M Mr	29/03/2012	42.14285714
RT FLEX URETEROSCOPY & LASERTRIPSY ON WARFARIN TILL JAN 13	M30.9		Young M Mr	30/04/2012	37.57142857
LT FLEX URETEROSCOPY & LASERTRISPY	M30.9		Young M Mr	30/04/2012	37.57142857
CYSTOSOCPY,LT URETEROSCOPY +/- RT URETEROGRAM	M45.9		Young M Mr	30/04/2012	37.57142857
LEFT FLEXIBLE URETEROSCOPY & CYSTOSCOPY	M30.9		Young M Mr	26/03/2012	37.42857143
RIGHT URETEROSCOPIC LASERTRIPSY	M30.9		Young M Mr	28/05/2012	33.57142857
GA CYSTOSCOPY	M45.9		Young M Mr	01/06/2012	33
cystolitholapaxy	M44.1		Young M Mr	22/06/2012	30
LEFT URETEROSCOPY & LASERTRIPSY	M30.9		Young M Mr	25/06/2012	29.57142857
LEFT FLEXIBLE URETEROSCOPIC LASERTRIPSY	M30.9		Young M Mr	25/06/2012	29.57142857
INSERTION SUPRAPUBIC CATHETER LOCAL ANAESTHETIC	M38.8		Young M Mr	16/07/2012	26.57142857
FEBRUARY 2013 CHECK CYSTOSCOPY & STENT CHANGE (FRANK HAEM)	M29.8		Young M Mr	25/07/2012	25.28571429
SEPTEMBER 2012 FLEXIBLE URETEROSCOPIC LASERTRIPSY	M30.9		Young M Mr	01/08/2012	24.28571429
LEFT URETEROSCOPIC LASERTRIPSY	M30.9		Young M Mr	06/08/2012	23.57142857
LEFT FLEXIBLE URETEROSCOPY & LITHOTRIPSY	M30.9		Young M Mr	06/08/2012	23.57142857
MID AUG 12 REPEAT CIRCUMCISION	N30.3		Young M Mr	01/06/2012	21.85714286
CYSTOSCOPY	M45.9		Young M Mr	25/06/2012	21
FLEXIBLE CYSTOSCOPY	M45.9		Young M Mr	29/08/2012	20.28571429
MEATAL/URETHRAL DILATATION	M81.4		Young M Mr	31/08/2012	20
LEFT FLEXIBLE URETEROSCOPIC LASERTRIPSY	M30.9		Young M Mr	03/09/2012	19.57142857
LEFT FLEXIBLE URETEROSCOPIC LASERTRIPSY	M30.9		Young M Mr	03/09/2012	19.57142857

LEFT FLEXIBLE URETEROSCOPIC LASERTRIPSY	M30.9	Personal Information redacted by USI	Young M Mr	03/09/2012	19.57142857
BOTOX - need inpt per anaesthetist due to cardiac hx	M43.4		Young M Mr	07/09/2012	19
LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M30.9		Young M Mr	10/09/2012	18.57142857
FLEXIBLE CYSTOSCOPY	M45.9		Young M Mr	18/09/2012	17.42857143
RIGHT URETEROSCOPY & LASERTRIPSY (NOV/DEC 12) - LTR IN B/F	M30.9		Young M Mr	23/09/2012	16.71428571
CYST & RESECTION OF LATERAL LOBE OF PROSTATE	M44.1		Young M Mr	30/03/2012	16.42857143
FLEXIBLE CYSTOSCOPY (LETTER IN B/F)	M45.9		Young M Mr	26/09/2012	16.28571429
REVERSAL OF VASECTOMY	N18.1		Young M Mr	26/09/2012	16.28571429
URETEROSCOPY & LASERTRIPSY OBSTRUCTION	M30.9		Young M Mr	28/09/2012	16
URETEROSCOPY & LASERTRIPSY	M30.9		Young M Mr	28/09/2012	16
YEFT URETERORENOSCOPY & LASERTRIPSY ON ASPIRIN 75MGS	M30.9		Young M Mr	02/04/2012	15.57142857
LEFT FLEXIBLE URETEROSCOPY & LASERTRIPSY	M30.9		Young M Mr	01/10/2012	15.57142857
FLEXIBLE CYSTOSCOPY	M45.9		Young M Mr	01/10/2012	15.57142857
GIVE DATE 2/3 WK NOV 12 RIGHT FLEXIBLE URETEROSCOPY & LASER	M30.9		Young M Mr	01/10/2012	15.57142857
TUR PROSTATE CAT 2	M65.3		Young M Mr	05/10/2012	15
TURP CATHETER IN SITU - FAILED TROC 08/11/12	M65.3		Young M Mr	05/10/2012	15
CIRCUMCISION & EPIDIDYMAL CYST EXCISION +/- HERNIA REPAIR	N30.3		Young M Mr	11/05/2012	14.57142857
LEFT RIGID URETEROSCOPIC LASERTRIPSY	M30.9		Young M Mr	08/10/2012	14.57142857
FLEXIBLE CYSTOSCOPY	M45.9		Young M Mr	08/10/2012	14.57142857
optical urethrotomy	M76.3		Young M Mr	20/07/2012	14.57142857
BILATERAL FLEXIBLE URETEROSCOPIC LASERTRIPSY	M30.9		Young M Mr	08/10/2012	14.57142857
BOTOX	M43.4		Young M Mr	09/10/2012	14.42857143
CYSTOSCOPY & HYDROSTATIC & BIOPSY MR YOUNG TO DO LTR B/F	M45.9		Young M Mr	12/10/2012	14
Internal visual urethrotomy	M79.4		Young M Mr	12/10/2012	14
2-3/52 FLEXIBLE URETEROSCOPY (NOT BEFORE 04/11/12 -18TH BIRT	M30.9		Young M Mr	14/10/2012	13.71428571
FLEXIBLE CYSTOSCOPY	M45.9		Young M Mr	15/10/2012	13.57142857
GIVE DATE DIAGNOSTIC RIGHT URETEROSCOPY ? MID NOV 12	M30.9		Young M Mr	15/10/2012	13.57142857
BLADDER LITHOPAXY & SUPRAPUBIC CATHETER INSERTION	M44.1		Young M Mr	15/10/2012	13.57142857
TUR PROSTATE	M65.3		Young M Mr	15/10/2012	13.57142857
flexible cystoscopy	M45.9		Young M Mr	19/10/2012	13
flexible cystoscopy	M45.9		Young M Mr	19/10/2012	13
FLEXIBLE CYSTOSCOPY	M45.9		Young M Mr	20/10/2012	12.85714286
FLEXIBLE CYSTOSCOPY	M45.9		Young M Mr	22/10/2012	12.57142857
JAN 2013 REPEAT URETEROSCOPY POLISH INTERP PLAVIX	M30.9		Young M Mr	24/10/2012	12.28571429
RIGHT URETEROSCOPY & RETROGRADE	M30.9		Young M Mr	25/10/2012	12.14285714

CYSTOSCOPY & HYDROSTATIC DILATATION MR YOUNG TO DO	M45.9	Personal Information redacted by USI	Young M Mr	25/10/2012	12.14285714
LEFT URETEROSCOPY & LITHOTRIPSY STENT IN SITU	M30.9		Young M Mr	26/10/2012	12
OPTICAL URETHROTOMY	M76.3		Young M Mr	26/10/2012	12
ESWL (FEB 13 AS IN AUSTRALIA UNTIL END JAN 13)	M14.1		Young M Mr	29/10/2012	11.57142857
INSERTION OF SUPRAPUBIC CATHETER	M49.8		Young M Mr	30/10/2012	11.42857143
8/52 REPEAT LEFT URETEROSCOPY & LASER STENT IN SITU	M30.9		Young M Mr	30/10/2012	11.42857143
SUBCAPSULAR ORCHIDECTOMY INPATIENT DAYCASE	N06.1		Young M Mr	01/11/2012	11.14285714
CYSTOSCOPY	M45.9		Young M Mr	02/11/2012	11
CYSTOSCOPY & PROSTATIC MASSAGE	M45.9		Young M Mr	10/08/2012	11
FLEXIBLE CYSTOSCOPY	M45.9		Young M Mr	02/11/2012	11
GA CYSTOSCOPY	M45.9		Young M Mr	02/11/2012	11
GA CYSTOSCOPY & HYDROSTATIC DILATATION	M45.9		Young M Mr	02/11/2012	11

Admission Reason	Intended Primary Procedure Code	Casenote	Consultant Name	Original Date	Actual Weeks Waiting (Rounded Up)
RESITING OF UROSTOMY	M83.9	Personal Information redacted by USI	O'Brien A Mr	08/11/2011	62.42857143
CORRECTION OF PENILE ERECTILE DEFORMITY	X23.9		O'Brien A Mr	08/11/2011	62.42857143
URETHROTOMY/URETHROPLASTY	M79.4		O'Brien A Mr	04/02/2012	49.85714286
LEFT SELECTIVE RENAL EMBOLISATION	L43.3		O'Brien A Mr	07/02/2012	49.42857143
BLADDER DIVERTICULECTOMY (WARFARIN)	M35.1		O'Brien A Mr	13/02/2012	48.57142857
BILATERAL URETEROGRAPHY, URETEROSCOPY ?URETERIC STENTING	M30.1		O'Brien A Mr	14/03/2012	44.28571429
CIRCUMCISION	N30.3		O'Brien A Mr	14/03/2012	44.28571429
RIGHT ? BILATERAL ORCHIDOPEXY GA	N09.3		O'Brien A Mr	14/03/2012	44.28571429
LEFT URETEROGRAPHY AND URETEROSCOPY	M30.1		O'Brien A Mr	14/02/2012	43.57142857
INCISIONAL HERNIORRHAPHY	T25.9		O'Brien A Mr	27/03/2012	42.42857143
RIGHT ORCHIOPEXY			O'Brien A Mr	27/03/2012	42.42857143
LEFT URETEROGRAPHY URETEROSCOPY ? flexible a			O'Brien A Mr	03/04/2012	41.42857143
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN	M49.5		O'Brien A Mr	27/04/2012	38
CIRCUMCISION			O'Brien A Mr	30/04/2012	37.57142857
CYSTOLITHOLAPAXY +/- BNI DIABETIC	M44.1		O'Brien A Mr	03/05/2012	37.14285714
RIGHT ORCHIDOPEXY GA	N09.3		O'Brien A Mr	08/05/2012	36.42857143
RIGHT INGUINAL HERNIORRHAPHY DAY CASE - GA	T20.1		O'Brien A Mr	08/05/2012	36.42857143
TURP	M65.3		O'Brien A Mr	18/05/2012	35
TROC U/S CYSTOSCOPY ? TURP ? TURBT	M45.9		O'Brien A Mr	22/05/2012	34.42857143
INTERNAL URETHROTOMY	M79.4		O'Brien A Mr	25/05/2012	34
RIGID CYSTOSCOPY + BLADDER BIOPSY + EUA	M45.5		O'Brien A Mr	29/05/2012	33.42857143
CYSTOSCOPY AND HYDROSTATIC DILATATION BLADDER	M45.9		O'Brien A Mr	29/05/2012	33.42857143
CYSTOSCOPY AND URETHRAL DILATATION	M45.9		O'Brien A Mr	29/05/2012	33.42857143
TURP	M65.3		O'Brien A Mr	15/06/2012	31
CYSTOSCOPY ? BLADDER NECK INCISION OR DILATATION	M45.9		O'Brien A Mr	15/06/2012	31
TURP			O'Brien A Mr	18/06/2012	30.57142857
TURP	M65.3		O'Brien A Mr	19/06/2012	30.42857143
CYSTOSCOPY ? URETHROTOMY ? hydrostatic dilatation			O'Brien A Mr	22/06/2012	30
REMOVAL OF STENT LEFT URETEROGRAPHY URETEROSCOPY AND ?	M27.5		O'Brien A Mr	25/06/2012	29.57142857
BLADDER NECK INCISION/TURP	M65.3		O'Brien A Mr	25/06/2012	29.57142857
TURP			O'Brien A Mr	26/06/2012	29.42857143
DIVISION PREPUTIAL ADHESIONS ? CIRCUMCISION			O'Brien A Mr	27/06/2012	29.28571429

CIRCUMCISION	N30.3	Personal Information redacted by USI	O'Brien A Mr	27/06/2012	29.28571429
GA CYSTOSCOPY AND RETROGRADE STUDIES			O'Brien A Mr	28/06/2012	29.14285714
TURP (SUPRAPUBIC CATHETER)	M65.3		O'Brien A Mr	01/07/2012	28.71428571
TURP			O'Brien A Mr	10/07/2012	27.42857143
CYSTOSCOPY, RIGHT URETEROSCOPY AND ? STENTING	M45.9		O'Brien A Mr	11/07/2012	27.28571429
CIRCUMCISION (catheter in situ)			O'Brien A Mr	11/07/2012	27.28571429
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN	A01.1		O'Brien A Mr	11/07/2012	27.28571429
(WAFARIN) CYSTOSCOPY/BLADDER BIOPSY/CYSTODIATHERMY - GA	M45.9		O'Brien A Mr	13/07/2012	27
TURP	M65.3		O'Brien A Mr	13/07/2012	27
TURP	M65.3		O'Brien A Mr	13/07/2012	27
RED FLAG REMOVAL OF STENT R URETEROGRAPH AND URETEROSCOPY	M27.5		O'Brien A Mr	16/07/2012	26.57142857
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN	M13.4		O'Brien A Mr	23/07/2012	25.57142857
HYDROSTATIC AND URETHRAL DILATATION			O'Brien A Mr	23/07/2012	25.57142857
CYSTOSCOPY AND SUPRAPUBIC CATHETERISATION	M45.9		O'Brien A Mr	24/07/2012	25.42857143
TURP	M65.3		O'Brien A Mr	25/07/2012	25.28571429
TURP	M65.3		O'Brien A Mr	25/07/2012	25.28571429
RIGHT URETEROGRAPHY AND URETEROSCOPY			O'Brien A Mr	26/07/2012	25.14285714
CYSTOSCOPY,BILATERAL RETROGRADE STUDIES & URETERIC WASHINGS	M45.8		O'Brien A Mr	26/07/2012	25.14285714
TURP			O'Brien A Mr	27/07/2012	25
RED FLAG CYSTOSCOPY GA	M45.9		O'Brien A Mr	27/07/2012	25
BLADDER NECK INCISION/TURP			O'Brien A Mr	27/07/2012	25
TURP	M65.3		O'Brien A Mr	27/07/2012	25
TURP (CATHETER)			O'Brien A Mr	10/08/2012	23
ORCHIDOPEXY	N09.2		O'Brien A Mr	14/08/2012	22.42857143
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN			O'Brien A Mr	17/08/2012	22
TURP/BLADDER NECK INCISION			O'Brien A Mr	17/08/2012	22
HYDROSTATIC DILATATION OF BLADDER			O'Brien A Mr	28/08/2012	20.42857143
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN 750 UNITS	M43.4		O'Brien A Mr	31/08/2012	20
TURP GA	M65.3		O'Brien A Mr	04/09/2012	19.42857143
CIRCUMCISION GA	N30.3		O'Brien A Mr	04/09/2012	19.42857143
TURP	M65.3		O'Brien A Mr	11/09/2012	18.42857143
RIGHT ORCHIDOPEXY GA	N09.3		O'Brien A Mr	11/09/2012	18.42857143
CYSTOSCOPY AND HYDROSTATIC DILATATION OF BLADDER	M45.9		O'Brien A Mr	11/09/2012	18.42857143
TURP	M65.3		O'Brien A Mr	11/09/2012	18.42857143
VASECTOMY (DIABETES)	N17.1		O'Brien A Mr	11/09/2012	18.42857143

BILATERAL ORCHIOPEXY		Personal Information redacted by USI	O'Brien A Mr	12/09/2012	18.28571429
REMOVAL OF URETERIC STENTS AND BILATERAL URETEROGRPAHY	M27.5		O'Brien A Mr	13/09/2012	18.14285714
TURP AND?TURBT AFTER CHRISTMAS 2012 PLEASE	M65.3		O'Brien A Mr	14/09/2012	18
HYDROSTATIC DILATATION OF BLADDER	M43.2		O'Brien A Mr	14/09/2012	18
TURP Would prefer to be called January 2013	M65.3		O'Brien A Mr	15/09/2012	17.85714286
TURP	M65.3		O'Brien A Mr	15/09/2012	17.85714286
TURP	M65.3		O'Brien A Mr	15/09/2012	17.85714286
RIGHT URETEROSCOPY	M30.4		O'Brien A Mr	25/09/2012	16.42857143
TROC U/S ? TURP - JULY 2013	M65.3		O'Brien A Mr	25/09/2012	16.42857143
CYSTOSCOPY AND MCUG	M45.9		O'Brien A Mr	27/09/2012	16.14285714
FLEXIBLE CYSTOSOCPY PT REQUESTS ANAESTHETIC	M45.9		O'Brien A Mr	28/09/2012	16
RIGHT HYDROCELE REPAIR	N11.8		O'Brien A Mr	28/09/2012	16
TURP	M65.3		O'Brien A Mr	28/09/2012	16
REMOVAL OF STENT AND LEFT URETEROGRAPHY			O'Brien A Mr	29/09/2012	15.85714286
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN			O'Brien A Mr	29/09/2012	15.85714286
TURP (WARFARIN)	M65.3		O'Brien A Mr	01/10/2012	15.57142857
INSERTION OF URODYNAMIC CATHETER GA AND URODYNAMICS	M38.8		O'Brien A Mr	02/10/2012	15.42857143
TURP GA	M65.3		O'Brien A Mr	02/10/2012	15.42857143
TURP - MUST BE A SATURDAY LIST AS PER FERANDO			O'Brien A Mr	03/10/2012	15.28571429
NESBITTS PROCEDURE ON CLOPIDOGREL, ASPIRIN, SIMVASTATIN	N32.8		O'Brien A Mr	03/10/2012	15.28571429
RED FLAG TURBT	M42.1		O'Brien A Mr	05/10/2012	15
CIRCUMCISION & FLEXIBLE CYSTOSCOPY (diabetes)	N30.3		O'Brien A Mr	05/10/2012	15
CIRCUMCISION & FLEXIBLE CYSTOSCOPY	N30.3		O'Brien A Mr	08/10/2012	14.57142857
TURP (CATHETER)	M65.3		O'Brien A Mr	09/10/2012	14.42857143
RIGHT URETEROGRAPHY AND URETEROSCOPY	M30.4		O'Brien A Mr	09/10/2012	14.42857143
RED FLAG TURBT GA	M42.1		O'Brien A Mr	12/10/2012	14
GA URETHRAL DILATATION	M47.1		O'Brien A Mr	12/10/2012	14
TURP	M65.3		O'Brien A Mr	12/10/2012	14
FLEXIBLE CYSTOSCOPY	M45.9		O'Brien A Mr	13/10/2012	13.85714286
TURP	M65.3		O'Brien A Mr	16/10/2012	13.42857143
CIRCUMCISION AND BILATERAL ORCHIOPEXY			O'Brien A Mr	23/10/2012	12.42857143
CYSTOSCOPY & URETHRAL DILATATION	M45.9		O'Brien A Mr	23/10/2012	12.42857143
TURP SATURDAY LIST IF POSSIBLE	M65.3		O'Brien A Mr	24/10/2012	12.28571429
TURP -(SATURDAY LIST IF POSSIBLE)	M65.3		O'Brien A Mr	24/10/2012	12.28571429
MEATAL DILATATION AND CATHETERISATION OF MITROFANOFF CONDUIT			O'Brien A Mr	24/10/2012	12.28571429

INTRADETRUSOR INJECTION OF BOTULINUM TOXIN		Personal Information redacted by USI	O'Brien A Mr	24/10/2012	12.28571429
CYSTOSCOPY AND SUPRAPUBIC CATHETERISATION			O'Brien A Mr	24/10/2012	12.28571429
CYSTOSCOPY ? TURP	M45.9		O'Brien A Mr	26/10/2012	12
HYDROSTATIC DILATATION OF BLADDER	M43.2		O'Brien A Mr	26/10/2012	12
CIRCUMCISION			O'Brien A Mr	27/10/2012	11.85714286
HYDROSTATIC DILATATION OF BLADDER	M43.2		O'Brien A Mr	27/10/2012	11.85714286
TURP	M65.3		O'Brien A Mr	29/10/2012	11.57142857
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN			O'Brien A Mr	30/10/2012	11.42857143
FLEXIBLE CYSTOSCOPY UNDER GA	M45.9		O'Brien A Mr	30/10/2012	11.42857143
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN	M13.4		O'Brien A Mr	30/10/2012	11.42857143
TURP	M65.3		O'Brien A Mr	30/10/2012	11.42857143
TURP TCI WEEKEND	M65.3		O'Brien A Mr	31/10/2012	11.28571429
TURP - HEARING IMPAIRED-TCI WEEKEND	M65.3		O'Brien A Mr	31/10/2012	11.28571429
BLADDER LITHOTRIPSY	M14.1		O'Brien A Mr	01/11/2012	11.14285714
CYSTOSCOPY AND CHANGE OF SUPRAPUBIC CATHETER	M45.9		O'Brien A Mr	01/11/2012	11.14285714
BLADDER NECK INCISION/TURP	M65.3		O'Brien A Mr	02/11/2012	11

Admission Reason	Intended Primary Procedure Code	Casenote	Consultant Name	Original Date	Actual Weeks Waiting (Rounded Up)
GA CYSTOSCOPY +/-URETHROTOMY +/- RENDEZVOUS	M45.9	Personal Information redacted by USI	Akhtar M Mr	07/02/2012	49.42857143
INSERTION OF INFLATABLE PENILE IMPLANT	M26.4		Akhtar M Mr	17/02/2012	48
CIRCUMCISION	N30.3		Akhtar M Mr	13/03/2012	44.42857143
CIRCUMCISION	N30.3		Akhtar M Mr	13/03/2012	44.42857143
LEFT NEPHRECTOMY	M02.5		Akhtar M Mr	13/07/2012	27
TURP pacemaker in situ	M65.3		Akhtar M Mr	08/08/2012	23.28571429
GA CYSTOSCOPY AND HYDRODISTENSION	M45.9		Akhtar M Mr	14/09/2012	18
TURP	M65.3		Akhtar M Mr	17/09/2012	17.57142857
TURP PACEMAKER INSITU	M65.3		Akhtar M Mr	19/09/2012	17.28571429
REDO HYDROCELE REPAIR	N11.1		Akhtar M Mr	02/10/2012	15.42857143
REDO LEFT HYDROCELE REPAIR	N11.1		Akhtar M Mr	02/10/2012	15.42857143
LAPAROSCOPIC +/- OPEN RIGHT NEPHRECTOMY	M05.3		Akhtar M Mr	02/10/2012	15.42857143
CYSTOSCOPY & HYDRODISTENSION OF BLADDER TRICYYCLIC ANTIDEPP	M43.3		Akhtar M Mr	10/10/2012	14.28571429
TURP	M65.3		Akhtar M Mr	10/10/2012	14.28571429
NESBITTS PROCEDURE	N32.8		Akhtar M Mr	15/10/2012	13.57142857
TURP MR CONNOLLY	M65.3		Akhtar M Mr	15/10/2012	13.57142857
LA CIRCUMCISION - IP ONLY PER PRE-OP FIT(14.11.12)CD	N30.3		Akhtar M Mr	17/10/2012	13.28571429
RIGHT LAPAROSCOPIC PYELOPLASTY	M10.2		Akhtar M Mr	24/10/2012	12.28571429

Admission Reason	Intended Primary Procedure Code	Casenote	Consultant Name	Original Date	Actual Weeks Waiting (Rounded Up)
NEPHROURETERECTOMY-NEPHROSTOMY TUBE IN SITU	M02.2	Personal Information redacted by USI	Young M Mr	10/02/2011	67.85714286
TURP AAA (4.3cm) - stable	M65.3		Young M Mr	15/08/2011	66.14285714
PARASTOMA HERNIA REPAIR & BLADDER LAVAG			Young M Mr	23/09/2011	57.14285714
LEFT NEPHRECTOMY	M02.5		Young M Mr	21/12/2011	56.28571429
LEFT LAPAROSCOPIC NEPHRECTOMY-pt phon ? date not suitable IS	M02.5		Young M Mr	30/01/2012	50.57142857
LEFT NEPHRECTOMY LITHUANIAN INTERPRETER	M02.5		Young M Mr	06/02/2012	45.71428571
IP CIRCUMCISION DIABETIC & ON PLAVIX	N30.3		Young M Mr	28/02/2012	41
INSERTION OF SPC	M49.8		Young M Mr	21/05/2012	34.57142857
CYSTOSCOPY-NOT SUITABLE FOR IS	M45.9		Young M Mr	22/05/2012	34.42857143
CYSTOSCOPY	M45.9		Young M Mr	08/06/2012	32
RIGHT URETEROSCOPY HIGH BMI	M30.9		Young M Mr	23/01/2012	30.57142857
9-12/12 CHANGE OF STENT	M29.8		Young M Mr	20/06/2012	30.28571429
RIGID CYSTOSCOPY BLADDER WASHOUT	M45.9		Young M Mr	29/06/2012	29
GA CIRCUMCISION & LEFT VARICOCELECTOMY CHILD	N30.3		Young M Mr	29/06/2012	29
URETEROGRAM (LETTER IN B/F)	M30.1		Young M Mr	07/07/2012	27.85714286
JANUARY 2013 CHECK GA CYSTOSCOPY +/- TURBT	M45.9		Young M Mr	19/07/2012	26.14285714
CIRCUMCISION & FLEXIBLE CYSTOSCOPY DIABETIC/ASPIRIN	N30.3		Young M Mr	20/07/2012	26
REPEAT L FLEXI URETEROS & LASERTRIPSY	M30.9		Young M Mr	03/06/2012	26
GA CYSTOSCOPY +/- IVU +/- TURP	M45.9		Young M Mr	23/07/2012	25.57142857
OPTICAL URETHROTOMY	M76.3		Young M Mr	20/04/2012	25
OPEN PYELOPLASTY	M05.1		Young M Mr	27/07/2012	25
TURP	M65.1		Young M Mr	27/07/2012	25
OCTOBER 2012 URETEROSCOPIC LITHOTRIPSY & STENT CHANGE	M30.9		Young M Mr	28/07/2012	24.85714286
JANUARY 13 CHANGE OF STENT	M29.8		Young M Mr	31/07/2012	24.42857143
LEFT LOBE TURP MR YOUNG TO DO WIFE PHON ? DATE 13.12.12	M65.3		Young M Mr	03/08/2012	24
CIRCUMCISION AS INPATIENT ON WARFARIN	N30.3		Young M Mr	07/08/2012	23.42857143
TURP (TCI DB4) PT PHON 14/12/12 ? DATE WILL CANC	M65.3		Young M Mr	08/08/2012	23.28571429
TURP ON CLOPIDOGREL FOR CAROTID ARTERY STENOSIS	M65.3		Young M Mr	09/08/2012	23.14285714
CYSTOSCOPY & HYDRODISTENTION (NOT SUITABLE DSU)	M45.9		Young M Mr	15/08/2012	22.28571429
CYSTOSCOPY & URETHRAL MEATAL DILATATION ON WARFARIN	M45.8		Young M Mr	20/08/2012	21.57142857
TURP	M65.3		Young M Mr	20/08/2012	21.57142857
LEFT URETEROSCOPY & LASER FRAGMENTATION (PUJ OBSTRUCTION)	M30.9		Young M Mr	22/08/2012	21.28571429

TURP	M65.3	Personal Information redacted by USI	Young M Mr	24/08/2012	21
BLADDER NECK INCISION	M66.2		Young M Mr	24/08/2012	21
LEFT SIDED URETEROSCOPIC LASER LITHOTRIPSY REMOVAL OF STONE	M30.9		Young M Mr	28/08/2012	20.42857143
REDO PREPUTIOPLASTY	N30.1		Young M Mr	07/09/2012	19
GA CYSTOSCOPY & MILD OPTICAL URETHROTOMY	M45.9		Young M Mr	14/09/2012	18
CYSTOURETHROSCOPY MEATAL DILATATION GEN/ANEAS DIABETIC	M45.9		Young M Mr	14/09/2012	18
RIGHT FLEXIBLE URETEROSCOPIC LASERTRIPSY	M27.1		Young M Mr	17/09/2012	17.57142857
TUR PROSTATE DIABETIC & WARFARIN	M65.3		Young M Mr	17/09/2012	17.57142857
TURP +/- TRUS BIOPSY OF PROSTATE	M65.3		Young M Mr	24/09/2012	16.57142857
TURP	M65.3		Young M Mr	27/09/2012	16.14285714
TURP	M65.3		Young M Mr	08/12/2011	16
BLADDER NECK INCISION	M66.2		Young M Mr	04/05/2012	16
cystoscopy & bladder lavage WHEELCHAIR USER - NEEDS HOISTED	M45.9		Young M Mr	05/10/2012	15
CIRCUMCISION - pt on wrong WL (needs inpt - changed 290612)	N30.3		Young M Mr	04/04/2012	14.28571429
CIRCUMCISION & TURP +/- TRUS BIOPSY OF PROSTATE WARFARIN	N30.3		Young M Mr	15/10/2012	13.57142857
RIGHT URETEROSCOPIC LASERTRIPSY DEC 2012	M30.9		Young M Mr	15/10/2012	13.57142857
JAN 13 CHECK GA CYSTOSCOPY +/- TURBT	M45.9		Young M Mr	18/10/2012	13.14285714
TURP	M65.3		Young M Mr	29/10/2012	11.57142857
TURP	M65.3		Young M Mr	29/10/2012	11.57142857
GA CYSTOSCOPY INSERTION OF SPC +/- TU RP	M45.9		Young M Mr	30/11/2011	11.42857143
RED FLAG TURP & TRUS BIOPSY OF PROSTATE	M65.3		Young M Mr	09/07/2012	10.85714286

Health and Social Care Board

Commissioning Directorate
Health & Social Care Board
12-22 Linenhall Street
BELFAST BT2 8BS

Tel : Personal Information redacted by USI
Fax : Personal Information redacted by USI
Web Site : www.hscboard.hscni.net

To Trust Directors of Performance

7 January 2013

Dear Colleague,

Integrated Elective Access Policy (IEAP) Implementation

I refer to my letter of 10 October 2012 regarding the application of the IEAP for the effective management of all outpatient, diagnostics and inpatient waiting lists. I would like to reiterate that a reasonable offer is defined as set out below and Trusts are required to ensure the following key actions:

- patients must be given a minimum of three weeks' notice of the date of their assessment and or treatment; and
- at least one offer must be within Northern Ireland except for a small number of regional specialties where there are no alternative providers in Northern Ireland.

In relation to outpatients offered an appointment within Northern Ireland, if a reasonable offer is made and a patient cancels their appointment the patient should be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date. If a second reasonable offer is cancelled by the patient, which may be at the same or a different hospital site, the patient will not normally be offered a third opportunity. In this case the patient will be referred back to their referring clinician.

In relation to inpatient/day case treatment, patients who refuse a reasonable offer of treatment, or fail to attend an offer of admission, will have their waiting time reset to the date the hospital was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs).

Please do not hesitate to contact Beth Malloy, AD Service Improvement if you need to clarify any points in relation to the implementation of IEAP.

Yours sincerely

Personal information redacted by USI

Dean Sullivan
Director of Commissioning

cc Owen Harkin
Michael Bloomfield
Beth Malloy
Jill Young
Peter McLaughlin

Acute Directorate
CNA and DNA Policy
Out-Patients and Elective Admissions
Summary of Key Points

Reasonable Offer for outpatients

A reasonable offer is an offer of appointment, irrespective of provider, that gives the patient a **minimum of three weeks' notice and two appointments**. If the patient refuses a reasonable offer, the waiting time will be recalculated from the date the reasonable offer was refused

Management of Patients Who Cancel their Appointment (CNA)

If a patient cancels their appointment the following process must be implemented:

- The patient will be given a second opportunity to book an appointment which should be within six weeks of the original appointment date.

- If a second appointment is cancelled by the patient, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

Management of Patients Who Did Not Attend their Appointment (DNA)

Where the patient has agreed the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked. And agreed with the patient.

Inpatient and Day Case Active Waiting Lists

Patients who are added to the active waiting list must be **clinically and socially ready for admission on the day of the decision to admit**, i.e., if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in.

Reasonable Offer

Patients should be made reasonable offers to come in on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of patient's chronological wait.

The Trust uses a fixed appointment system for inpatient and day cases therefore patients will be given two opportunities to attend.

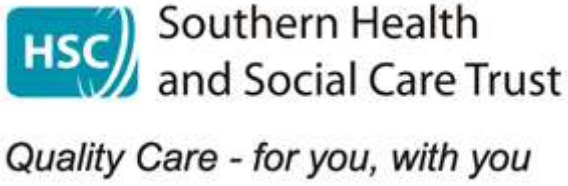
Management of Patients Who Cancel their Admission (CNA)

Patients who cancel a reasonable offer will be given a second opportunity to book an admission, which should be within six weeks of the original admission date. If the second admission is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

Management of Patients Who Did Not Attend their Admission (DNA)

If a patient DNAs their first admission date where they previously agreed the date and time of their admission, they will not normally be offered a second admission date.

Under exceptional circumstances a clinician may decide that a patient should be offered a second admission. The second admission date must be agreed with the patient.



ADEPT PROJECT
Southern Trust
Stone Treatment Centre

Matthew Tyson
ST7 Urology/ADEPT Fellow

Project

1. To meet the demand for the Extra Corporal Shockwave Lithotripsy (ESWL) service for elective and emergency renal and ureteric stone treatment for the Southern Trust

2. Provide stone treatments recommended by NICE, BAUS and EAU

3. Provide patients with informed choice

To meet the demand for the Extra Corporal Shockwave Lithotripsy (ESWL) service for elective and emergency renal and ureteric stone treatment for the Southern Trust

- On-site ESWL

- Southern Trust 372926
- Stone service 472000
- + Referrals from South Eastern, Northern

Aims

- Decrease waiting list times for elective ESWL treatment to 2 weeks
- To provide emergency ESWL provision for upper and distal ureteric stones
- To decrease the cost of renal and ureteric stone treatment

Change of Practice 2017

- Referral pathway agreed (Urology/Radiology/A+E)
- Urology MDT since December 2017
- Decreased Nursing paperwork
- Improved treatment safety and effectiveness
- Improved pain relief
- E-discharge
- Improved patient follow-up pathway
- Data collection to demonstrate improvement
- Audit/ research and development

ESWL Day of Treatment

- Radiographer and Nurse led
- Currently 3 treatment a session
- 3 sessions a week
- 9 patients a week

Waiting List

- ESWL 233 PATIENTS JAN 2018
  - 108 Patients Jan 2017
  - **116% increase in 1 year!!**

- Ureteroscopy and laser to Stone 174 (December 2017)

URS

Craigavon Urology Theatre **for elective ureteroscopy**

- As an elective day case £1608
- As an elective case with average inpatient stay £2747

Craigavon Urology Theatre for **emergency ureteroscopy**

- Long stay inpatient £2862 per patient
- Short stay inpatient £2376 per patient

ESWL

Craigavon Stone Treatment Centre for **elective ESWL**

- **£363** per **elective outpatient** patient, as of February 2017.
- **This is based on a morning session with 3 patients, giving a total session cost of £1092**
- A time and motion study conducted at the Stone Treatment Center, December 2016, noted a possible 4 patients could be treated in the same time period, thus lowering the cost further per sessions and per patient.
- **Inpatient ESWL** £627 per patient as of February 2017

Compare

One session of elective ureteroscopy with no stay is equivalent to 4.4 sessions of ESWL.

One session of emergency ureteroscopy with a short stay is equivalent to 3.9 sessions of ESWL

Costs ESWL Waiting List

With the new pathway followed:

- If 233 patients needed on average 1.5 treatments then 318 treatments needed.

- Cost of £126868

Costs ESWL Waiting List

- Currently 9 patients per week treated
- If sessions increased to 9 per week, 3x9=21patients/per week
- Therefore 16.6 weeks need to clear waiting list
- Funded for 2.5 sessions per week currently, therefore **£81675** needed to over run and clear excessive waiting list.

MDM

- If 233 patients on waiting list had been discussed at MDM, placed on a current treatment and imaging follow-up pathway then a **new and follow-up OPD might be saved**

OPD COST OF 233 PATIENTS =

- 233 X (250 (NEW) + 170 (Follow-up) = £97860

- Note: £81675, is required to potentially clear the list

Waiting List- All adult patients

- 108 Patients Jan 2017
- 233 Patients Jan 2018 (116% INCREASE)

Per month added to waiting list

- June 32 patients
- July 22 patients
- August 20 patients
- September 37 patients
- October 37 patients
- November 43 patients
- December 26 patients

Waiting time

- Currently booked patients for elective ESWL for January 2018, from patients booked May 2017.

- **8 month wait**

Emergency Stone Guidelines

‘For symptomatic ureteric stones, primary treatment of the stone should be the goal (LE 1b) and should be undertaken within 48h of the decision to intervene’

British Association of Urological Surgeons standards for management of acute ureteric colic
A. Tsiotras, R Daron Smith, I Pearce, K O’Flynn, O Wiseman
Journal of Clinical Urology 2018. Vol. 11 (1) 58-61

Projected Session (All adult patients)

- Once waiting list cleared:
- 217 Patients added June to December 2017
- Average of 31 patients per month
- Average of 8 (7.75) patients per week

ESWL session multiplier of x1.5

- Therefore 12 (11.6) patients per week
- Therefore 12/3 = 4 sessions per week

If multiplier of x2

- Therefore 16 patients per week
- Therefore 16/3 = 6 (5.3) average sessions per week (range 5 – 7 sessions per week)

South Eastern patients

- 49 patients in 7 months
- 49 X2 treatment multiplier = 98
- Therefore 14 patients per month
- Average of 3.3 patients per week
- Therefore 1 sessions per week to meet demand, with no Southern Trust emergency patients treated, with x4 patients per session

Projected week

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
am	ESWL	ESWL (South Eastern Trust)	ESWL	MDM	ESWL
pm		ESWL	ESWL	ESWL	

Current funding for x2.5 sessions per week (7.5 patients)
Southern Trust need 5 sessions per week (3 patients per sessions)
South Eastern Trust x1 session per week (4 patients per session)
Need x6 sessions
Waiting list likely to increase when waiting list time decreases, patients may move over from URS list to ESWL. Extra sessions therefore add to account for this possibility, mindful extra session in future needed as population increases, age and obesity rises as will stone presentations.
Therefore x7 sessions needed, extra funding for x4.5 per week needed (with the South Eastern paying for x1)
(x2.5 funded at present)

Staffing

- Session needs,
  - X1 Staff nurse, Health Care Assistant, Radiographer

  - Based on 7 sessions, dedicated staff to unit,
  - Sister dedicated to Stone Treatment Centre
  - X2 Staff Nurse (flexible to work in Thorndale unit)
  - X2 Health Care Assistant (flexible to work in Thorndale unit)
  - X 1 dedicated radiographer to Stone treatment Centre

  And continued rotation of x3 radiographers as required

  Or x2 dedicated radiographers

Future

- Stone Treatment Centre
- ESWL waiting time of 2 weeks elective and daily (mon-fri) emergency ESWL available
- Dedicated nursing staff to the unit
- Nurse specialist for long term follow-up/high risk stone formers
- Dietician clinic for high risk formers and dietary modification

Future

- Sessions available for dedicated trust use other then the Southern Trust, with payment to the Southern Trust
- Cross border working
- Dedicated team to the Stone Treatment Centre, with teaching, training and research opportunities, giving a **Highly skilled and dedicated staff, providing highly effective ESWL treatment and follow-up to renal and ureteric stone patient.**

Many thanks

This is a team project,

Involving:

Mr Young and Consultant Team

Martina Corrigan, Laura McAuley, Paulette Dignam,

Hazel McBurney, Bronagh OShea, Bernadette Mohan, Wayne Heatrick

Nuala Mulholland, Mairead Leonard, Justin McCormick, Kate McCreesh, Martina O'Neil

UROLOGY PLANNING AND IMPLEMENTATION GROUP – ACTIONS/ISSUES REGISTER – 26 JUNE 2015

	MATTERS ARISING	LEAD
1.	**Terms of Reference** **Issue:** Board submitted terms of reference to the Group for comment or approval.	
	Terms of Reference accepted by the Group with no amendments made.	
2.	**Excess Patients Waits** **Issue:** The HSCB delivered presentation on excess patient waits including: new outpatients, review outpatients, and in patients day cases. Dean Sullivan sought the views of the Consultant Urologists present in relation to the clinical priority of the different cohort of long waiting patients. It was agreed that the following groups should be addressed as a priority; • resection of outlet of male bladder • review waiting list backlog	
	<u>New Outpatients</u> **Issue:** There are currently 1,117 patients waiting over 12 months for a new outpatient appointment. South Eastern Trust and Southern Trust advised admin and clinical waiting list validation has been undertaken. Belfast Trust advised admin validation has been completed and agreed to now undertake clinical validation. The group discussed the potential implications of recently published NICE guidance which relates to macroscopic and microscopic haematuria. This may result in a reduction of red flag urology referrals. SET advised that an audit of OP waiting lists showed that a significant number of long waiting patients had vasectomy or	

	circumcision as reason for referral. Dr McKenna, representing Primary Care, highlighted lack of information regarding waiting times as an issue for GPs when referring patients. The group discussed the potential benefits of one stop clinics, the concept of one visit clinics was also presented by SHSCT who have implemented this model. Physical space and decontamination requirements were discussed as being some of the potential barriers to implementing these models. Dean Sullivan asked that each Trust should ensure that, given the clinical risk associated with long waiting times for cystoscopies, the development of one stop/visit clinics should be discussed at Director level in each Trust.	
	Action: - Each Trust to ensure that their outpatient waiting list is validated (both administratively and clinically); - Each Trust to assess how many patients there currently were on the outpatient waiting list with an indication of referral being for vasectomy or circumcision; - Each Trust to bring forward definitive proposals and timelines for implementation of one stop/visit model. Where infrastructure constraints do not currently allow for a one stop/visit model, Trusts should advise on alternative models to improve the pathway for flexi cystoscopy procedures.	**Trusts**
	<u>Review Outpatients</u> **Issue:** There are currently 1,135 patients waiting longer than 15 months beyond their clinically indicated date and approximately 3,100 waiting longer than 6 months. Following discussion with Trust clinical and service representatives the following was agreed: • administrative and clinical validation to be carried out if it had not already been undertaken. • the review backlog would be best managed by the Trust in which the waiting list was held. Models of outpatient review pathways, such as telephone review and mega clinics in Belfast Trust and nurse led review in clinically appropriate cohorts in the Western Trust, were discussed. Dr McKenna suggested that there may be clinically appropriate roles for the GP in review of urology patients in primary care and	

	the group agreed that this should be considered in any future reform work relating to review pathways. Each Trust to identify the actions required to reduce outpatient review waiting times to no patient waiting longer than 3 months past their clinically indicated date for review. It was recognised that this would be over a period of time and should be done in parallel, and in consideration with, plans for reform.	
	Action: - South Eastern Trust and Southern Trust to each submit an action plan to address the cohort of patients waiting longer than 15 months past their clinically indicated review date; - Each Trust to consider actions required to reduce outpatient review waiting times to have no patients waiting longer than three months past their clinically indicated date for review.	**Trusts**
	<u>IPDCs</u> **Issue:** There are currently 879 patients waiting longer than 12 months for their elective treatment. The waiting list comprised of 300 cystoscopies, 200 vasectomies, 114 resection of outlet of bladder, 77 operation on prepuce and 186 other operations. *Vasectomies and Circumcisions* The group discussed the commissioning of vasectomies and circumcisions and noted that due to clinical risk associated with other urology referrals that they are not being offered treatment dates at present. It was agreed that an Independent Sector solution should be explored for treatment of vasectomies and circumcisions. *Flexible Cystoscopy* Current waiting times for flexible cystoscopies were reviewed. In recognition of the prolonged waiting times it was agreed by all that both administrative and clinical validation was essential as a first step where this had not already been carried out. Potential solutions to address were discussed and it was agreed that a regional approach with contribution from as many operators as possible and all day operating would be the most effective way of addressing this backlog. It was noted however, that this may result in more patients being listed for IPDC treatments and this should be considered as part of the planning. It was recognised that there would be a requirement for HSCB and Trusts to work together to identify physical and clinical (medical and nursing) capacity to	

	facilitate WL reduction. *Resection of outlet of male bladder* The group discussed the bed and nursing support required to address those patients waiting greater than 12 months for resection of outlet of male bladder. It was acknowledged that these patients would be best managed in units where there was a urology presence and experienced support staff. It was suggested that the Causeway Hospital would be suitable for potential weekend use.	
	Action: - HSCB to take the lead on exploring the option of an IS solution for vasectomies and circumcisions; - Belfast, South Eastern and Southern Trusts to undertake an administrative and clinical validation of all patients waiting longer 12 months for their procedure; - Each Trust to confirm what operator capacity would be available to support a regional waiting list initiative; - HSCB to discuss potential for utilising staff and physical resources in Causeway.	**HSCB & Trusts**
3.	**Opportunities for Integrated Working** The opportunities presented by technology, for example, GP referral to Consultant for advice was recognised. It was agreed that the potential for a project echo model and collaborative working between Urologists & GPs (such as that currently underway in neurology) should be explored further in pathway work. The HSCB referred to the development of regional referral guidance which would sit on the CCG urology banner page. It was advised that this would be best developed on a regional basis would input from both consultants and GPs.	
	Action: - Each Trust to provide nominations for a working group (membership of the group to include GPs and Consultants) which will focus on CCG both in terms of referral for advice and the development of CCG banner guidance.	**HSCB, GPC & Trusts**

4.	**Workforce Planning** Board advised that it requires a sub group including medical representation from the PHA in order to: • update 2014 stocktake workforce position; • review middle grade support across the region; • explore extended roles of nursing.	
	Action: - Each Trust to advise HSCB of nominated medical and managerial representative to sit on this group.	**Trusts**
5.	**Urological Cover for Acute Sites** David McCormick presented data relating to in-hours & out of hours non elective admissions and sought views on providing cover to sites with no urology presence. Current models were discussed with input from Belfast and Western Trusts regarding cover to Northern Trust. The group agreed that current processes in place to provide cover for urology emergency presentations were in place but it was acknowledged that they should be formalised and therefore written protocols should be developed which reflect these arrangements.	
	Action: - The development of a written protocol for staff requiring urology advice on sites where there is no urology presence to be taken forward by the Workforce Planning Group. This should be taken forward by Belfast and Western Trusts.	**Belfast and Western Trusts**
6.	**Elimination of Pathway Variations** It was agreed that NICaN should review the current cancer pathways and bring any revisions to these pathways to the implementation group for review/discussion.	
	Action: - NICaN to review relevant urology cancer pathways.	**NICaN**

7.	**Procedure Based Service and Budget Agreements** It was agreed that there was a need to review the current urology SBA currencies and move to a procedure based SBA in line with agreed pathways.	
	Action: - Each Trust to advise the HSCB of nominated medical and managerial representative to sit on this group.	**HSCB & Trusts**
8.	**Boundary Arrangements for Urology Referrals** Lynne Charlton referred to the interim arrangement for the redirection of urology referrals from the Northern Trust. It was agreed that the HSCB should write formally to GPs to clarify the current interim referral arrangements. Colin Mulholland highlighted the risk of using two booking systems and advised that urology referrals would be best managed through one centre.	
	Action: - HSCB to write formally to GPs in the Northern LCG advising of the interim referral arrangements; - Current booking processes in Western and Northern Trusts to be reviewed.	**HSCB & Western & Northern Trusts**
9.	**Regional Solutions** • **Reconstruction (AUS and urethroplasty)** • **prostatectomies** The South Eastern Trust explained that clinicians across Trusts were already meeting regularly to discuss urology reconstruction cases. It was agreed that further work was required to understand the activity volumes, skill mix and theatre capacity required to support this service. Chris Hagan explained that training for radical prostatectomies is gradually moving to robotic which will have a significant impact on service provision. He explained that approximately 300 patients per annum (gynaecology and urology) could utilise the robot and therefore this would be a cost effective option.	

	The Trust also referred to the potential investment from Men Against Cancer for robotic equipment. The Trust enquired if the current cost of sending patients via ECR (Extra Contractual Referrals) could be used to offset the running costs of the robot.	
	Action: - Each Trust to advise the HSCB of nominated medical representative to sit on the reconstruction group; - The Belfast Trust to write formally to HSCB detailing the business need for robotic prostatectomies.	**HSCB, PHA & Trusts** **Belfast Trust**
10.	**AOB** <u>Peer Review</u> Board advised it will consider formal feedback from peer review once it is received.	
	<u>Date of Next Meeting</u> Board recommends using time allocated on **28 July 2015** for sub group workstreams and advised next Planning and Implementation Group meeting will be held on **Wednesday, 26 August 2015 at 10.00am, CR2 & CR3 Linenhall Street**	

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 11 September 2019 13:30
To: Corrigan, Martina; Haynes, Mark
Subject: Urology PIG
Attachments: Urology PIG Meeting - 7 August 2019 (10.3 KB); Urology PIG Meeting - 11 Sept 19 (8.51 KB)

Subject: Urology PIG
Location: Bracken Suite, Dunsilly Hotel, Antrim
Categories: Urology
Importance: Normal
Start: 2019-09-11 12:30:00Z
End: 2019-09-11 16:00:00Z
Body:

<html> <head> <meta http-equiv="Content-Type" content="text/html; charset=utf-8"> <meta name="Generator" content="Microsoft Exchange Server"> <!-- converted from rtf --> <style><!-- .EmailQuote { margin-left: 1pt; padding-left: 4pt; border-left: #800000 2px solid; } --></style> </head> <body>   </body> </html>

Corrigan, Martina

From: AD Scheduled Care PA [redacted]
Sent: 27 June 2019 11:32
To: Alex McCleod; Allison McCrea; Brian Duggan; Caroline Cullen; Catherine Coyle (Public Health Consultant); Christine Allam (SEHSCT); Chris Hagan; Chris Thomas; Colin Mullholland; David Connolly; David McCormick; Frances O'Hagan; Franz Schattka; [redacted]; Linda Millar; Lisa McWilliams; Lynne Charlton; Haynes, Mark; Corrigan, Martina; Mary Jo Thompson; Brian McAleer (HSCB); Young, Michael; Miriam McCarthy; Nicola Scott; Ronan Carroll; Sam Gray; Stephen Boyd; Tracey McDaid; OKane, Hugh [redacted]; [redacted]; [redacted]
Subject: Urology PIG Meeting - 7 August 2019

"This email is covered by the disclaimer found at the end of the message."

Dear All

A Urology PIG meeting will take place as outlined below. I would be grateful if you could confirm if you can attend. Lunch will be provided.

Date **Wednesday 7 August**
Time **1.30pm**
Venue **Masareene Room, Clotworthy House, Antrim Castle Gardens**

Many Thanks

Kirsty

Corrigan, Martina

From: AD Scheduled Care PA [redacted]
Sent: 19 July 2019 12:05
To: Alex McCleod; Allison McCrea; Brian Duggan; Caroline Cullen; Catherine Coyle (Public Health Consultant); Christine Allam (SEHSCT); Chris Hagan; Chris Thomas; Colin Mullholland; David Connolly; David McCormick; Frances O'Hagan; Franz Schattka; [redacted]; Linda Millar; Lisa McWilliams; Lynne Charlton; Haynes, Mark; Corrigan, Martina; Mary Jo Thompson; Brian McAleer (HSCB); Young, Michael; Miriam McCarthy; Ronan Carroll; Sam Gray; Stephen Boyd; Tracey McDaid; OKane, Hugh; [redacted]; [redacted] Carroll, Ronan; [redacted] [redacted] Patricia Grimley
Subject: Urology PIG Meeting - 11 Sept 19

"This email is covered by the disclaimer found at the end of the message."

Dear All

Due to the high number of apologies received for previous dates circulated, I can confirm the Urology PIG meeting will now take place as outlined below. Please remove any holds you have in the diary for previous dates. I would be grateful if you could confirm if you can attend. Lunch will be provided.

Date **Wednesday 11 September 2019**
Time **1.30pm**
Venue **Bracken Suite, Dunsilly Hotel, Antrim**

Many Thanks

Kirsty

Corrigan, Martina

From: Harrison, Eric [redacted]
Sent: 07 December 2020 10:19
To: Elliott, Joanne; [redacted] 'Mark Haynes'; [redacted] 'Connolly, David'; 'Michael Young'; [redacted] David McCormick; 'Brian Duggan'; 'Chris Thomas'; 'Colin Mullholland'; Martina Corrigan; [redacted] Ronan Carroll; 'Sam Gray'; Stephen Boyd; [redacted] 'Sloan, Samanthaa'; 'OKane, Hugh'; 'Maggie Parks'; 'Allam, Christine'; Turbitt, Andrea; Cathy Gillan; Christine McMaster; Magwood, Aldrina; 'Robinson, David'; [redacted] Radovana Juhazyova; [redacted] 'Hogg, Rosemary'; Rachel Deyermond
Subject: Urology PIG meeting agenda
Attachments: Agenda - Urology PIG meeting - 9 December 2020 at 2pm.docx

Please see attached agenda for the Urology PIG meeting on Wednesday @2pm.

Join Zoom Meeting
https://us02web.zoom.us/j/87038846456?pwd=TlBwb0lCd28yQUsreXBrbEM3KzNjdz09

Thanks,

Eric Harrison
Hospital Services Reform Directorate
Department of Health

Urology PIG Meeting

9 December 2020 at 2pm

Agenda

1. Welcome
2. Stones pathway update – Michael Young
3. Bladder outflow procedures pathway update – Ajay Pahuja
4. Daycase TURP protocol and outcomes – Alex MacLeod
5. Update on TURBT – Mark Haynes
6. Day Procedure - Anaesthetics update – Rachel Deyermond
7. Utilisation of IS for urology – David McCormick
8. Pyeloplasty provision – David McCormick
9. Regional penile cancer and andrology implant service – Alex MacLeod
10. Rezum treatment for BPH - David McCormick
11. Recruitment update – all Trusts to advise
12. AOB
13. Date of Next Meeting

Stone Treatment Centre

- Increase Stone Treatments from 2 to 6 weekly sessions (increase 8 patients to 24 patients)
- Additional staffing requirements:

  1 x Band 6 Staff Nurse
  1 x Band 5 Staff Nurse
  1 x Band 3 HCA
  1 x Band 7 Radiographer
  1 x Band 4 Administration

- Current waiting list for treatments is 66 weeks
- Total on waiting list is 186 patients

Total cost = £150,000 please note that this is a very high level cost and detail can be submitted if approved

Health and Social Care Board

REGIONAL REVIEW OF ADULT UROLOGY SERVICES

Consultation Response Questionnaire

September 2009

CONSULTATION RESPONSE QUESTIONNAIRE

You can respond to the consultation document by e-mail, letter or fax.

Before you submit your response, please read Appendix 1 about the effect of the Freedom of Information Act 2000 on the confidentiality of responses to public consultation exercises.

Responses should be sent to:

E-mail: urology.consultation@hscni.net

Written: Laura Molloy, Project Officer
Health and Social Care Board
Performance Management and Service Improvement Directorate
Templeton House, 411 Holywood Road
Belfast BT4 2LP

Fax: Personal Information redacted by USI

Responses must be received no later than Friday 18th December at 5.00pm

I am responding: as an individual ☐ on behalf of an organisation ☐

(please tick a box)

Name:	Mrs Mairead McAlinden
Job Title:	Acting Chief Executive
Organisation:	Southern Health and Social Care Trust
Address:	Trust Headquarters, Craigavon Area Hospital,
	68 Lurgan Road, Portadown, Craigavon, BT63 5QQ
Tel:	Personal Information redacted by USI
Fax:	Personal Information redacted by USI
e-mail:	Personal Information redacted by USI

Q1. This document makes a total of 26 Recommendations, 17 of which are set out in Table 1 below. Please indicate whether you agree or disagree with each of the recommendations. If you disagree with any of the recommendations please provide, in the space provided, detail of your reasons. We would also ask that you provide detail of any additional suggestions you may wish to make.

Recommendation	**Y/N**
3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with specialist Primary Care and NICE Guidance. (Section 2 – Introduction and Context, pg 5) *Additional Comment:* *Required service pathways from Primary Care to both Urology and Gynae services also needs to be taken into account.*	**Y**
7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit. (Section 3 –Current Service Profile, pg 5) Additional comment: *The Southern Trust would suggest that these protocols and care pathways need also to be developed for Hospitals with Acute Urology Units to ensure clarity of roles and responsibilities*	**Y**
8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit. (Section 3 –Current Service Profile, pg 5)	**Y**
9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week. (Section 3 –Current Service Profile, pg 5)	**Y**
10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home. (Section 3 –Current Service Profile, pg 5)	**Y**

Recommendation		Y/N
12.	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients. (Section 5 – Performance Measures, pg 6)	**Y**
14.	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients. (Section 5 – Performance Measures, pg 6)	**Y**
15.	Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery. (Section 5 – Performance Measures, pg 6)	**Y**
18.	The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG. (Section 7 – Urological Cancers, pg 6) *Additional comment: The Southern Trust are currently working towards the arrangements for this starting on 1 January 2010. While the Trust support the need to have appropriate arrangements in place for cancer pathways, there are significant implications for available capacity at local units with the introduction of these arrangements. In SHSCT approx 3 sessions per week of consultant capacity will be required to implement the NICAN recommendations. It is unclear if this impact has been factored into the resource assumptions in the review or will need to be considered in the business case process.*	**Y**
19.	By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties. (Section 7 – Urological Cancers, pg 6)	**Y**
20.	Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).(Section 7 – Urological Cancers, pg 6)	**Y**

21.	To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte. (Section 8 – Clinical Workforce Requirements, pg 6)	**Y**
22.	Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans. (Section 8 – Clinical Workforce Requirements, pg 6)	**Y**
23.	At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010. (Section 8 – Clinical Workforce Requirements, pg 6)	**Y**
24.	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability. (Section 9 – Service Configuration Model, pg 7)	**Y**
25.	Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements. (Section 9 – Service Configuration Model, pg 7)	**Y**
26.	Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served. (Section 9 – Service Configuration Model, pg 7) Additional comments: *: It is expected that there will be a Regional Structure put in place for arrangements for the service delivery and that the Southern Trust will be involved in this. Within the Southern Trust there will be a Project Team established which will include representation from the Western Trust. There will be an implementation plan drawn up to implement all the recommendations from the review.*	**Y**

If you disagree with any of the above recommendations, please explain.

Please continue on an additional page if necessary

THANK YOU FOR YOUR COMMENTS.

Appendix 1

FREEDOM OF INFORMATION ACT 2000 – CONFIDENTIALITY OF CONSULTATIONS

The Board will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The Board can only refuse to disclose information in exceptional circumstances. **Before** you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the Board in this case. This right of access to information includes information provided in response to a consultation. The Board cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

the Board should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Board's functions and it would not otherwise be provided
the Board should not agree to hold information received from third parties "in confidence" which is not confidential in nature
acceptance by the Board of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner

For further information about confidentiality of responses please contact the Information Commissioner's Office (or see web site at: **http://www.informationcommissioner.gov.uk/**). For further information about this particular consultation please contact Laura Molloy (contact details are shown on page 1).

Produced by:
Performance Management and Service Improvement Directorate
Templeton House, Belfast BT4 2lp

Telephone Personal Information redacted by the USI

www.dhsspsni.gov.uk

September 2009

Mr John Compton
Chief Executive
Health and Social Care Board
12-22 Linenhall Street
BELFAST BT2 8BS

Dear Mr Compton,

Re: Regional Review of Adult Urology Services

I refer to the above and your correspondence of 23 September 2009 which you invited responses to a questionnaire regarding the Public Consultation of the above Review.

Please find attached the completed questionnaire from the Southern Health and Social Care Trust. The Trust are in agreement with the 17 recommendations as set out in the questionnaire and we have added some additional comments into the questionnaire.

The Trust also support the recommendation that the Urology Services should be reconfigured into a 3 team model with the Southern Trust being team South and we look forward to being involved in the implementation of the recommendations.

Yours sincerely

Mrs Mairead McAlinden
Acting Chief Executive

Corrigan, Martina

From: Trouton, Heather [redacted]
Sent: 05 March 2010 14:37
To: Corrigan, Martina
Subject: FW: Summary of the Urology Review Responses
Attachments: Consultation paper for Urology - SUMMARY.doc

-----Original Message-----
From: Rankin, Gillian
Sent: 01 March 2010 18:43
To: Clarke, Paula; Trouton, Heather
Subject: FW: Summary of the Urology Review Responses

Dear Paula and Heather,
Thought you would wish to see this statement of responses,

Gillian

-----Original Message-----
From: Beth Malloy [mailto[redacted]
Sent: 23 February 2010 17:27
To: Seamus.McGoran setrust; Welsh, Jennifer; Rankin, Gillian; Dickson, Michael; Jackson, Valerie
Cc: Hugh Mullen; McNicholl, Catherine
Subject: Summary of the Urology Review Responses

"This email is covered by the disclaimer found at the end of the message."

Dear all

Please find attached a copy of all the responses the Board received in relation to the Urology Review.

Please do not hesitate to contact me if you have any further questions.

Thanks

Beth

Mrs Beth Malloy

Assistant Director, Scheduled Services

Performance Management and Service Improvement Directorate

Health and Social Care Board

Templeton House

411 Holywood Road

Belfast

BT4 2LP

Tel Personal Information redacted by USI

Fax Personal Information redacted by USI

Mobile Personal Information redacted by USI

Personal Information redacted by USI

Health and Social Care Board

REVIEW OF ADULT UROLOGY SERVICES IN NORTHERN IRELAND

SUMMARY OF THE RESPONSES TO THE CONSULTATION ONLY

JANUARY 2009

1. Summary of Responses

In general, there were very few comments on the review. A table showing each of the respondents is shown below; this also indicates if their overall comments were for/supportive, against or neutral in relation to the recommendations in the review.

Table 1: Summary of Responses

	External Bodies/Charities/Voluntary Sector	For	Against	Neutral
1	Royal College of Surgeons (Edinburgh)			
2	Royal College of Nursing (Northern Ireland)			
3	Press Enquiry - BBC Radio Foyle			
4	Disability Action			
5	Cancer Registry			
6	The Prostate Cancer Charity			
7	Cancer Choices			
	Political Parties	**For**	**Against**	**Neutral**
8	Councillor D Barbour			
9	DUP - Mr Philip Weir			
10	Gregory Campbell MP/MLA			
	Trust Management/Exec Directors	**For**	**Against**	**Neutral**
11	Southern Trust			
12	South Eastern Trust			
13	Belfast Trust			
14	Northern Trust			
	Urologists	**For**	**Against**	**Neutral**
15	Southern Trust - Mr M Young			
16	Northern Trust - Mr P Downey			
17	Northern Trust - Mr R Fiala			
	Northern Trust Staff	**For**	**Against**	**Neutral**
18	Urology Specialist Nurse - D Butler			
19	Urology Specialist Nurse - R Kane			
20	Consultant Surgeon - Mr M Whiteside			
21	Consultant Rheumatologist - Dr E Whitehead			
22	Consultant Gynaecologist - Dr R Ashe			
23	Consultant Gynaecologist - Dr F Stewart			
24	Consultant Paediatrician - Dr J McAloon			
25	Consultant Haematologist - Dr A Kyle			
26	Consultant Nephrologists - Dr C Harron			
27	Consultant Neonatologist - Dr S Ball			

1. ADULT UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Section 4 – Capacity, Demand and Activity

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Section 8 – Clinical Workforce Requirements

21. **To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.**

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Section 9 – Service Configuration Model

24. **Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.**

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in

place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Comprehensive Consultation Responses:

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
1	Mr John D Orr; President Royal College of Surgeons of Edinburgh Nicholson Street EH8 9DW Personal Information redacted by USI Personal Information redacted by USI Date of receipt of response: 2/10/2009	**Recommendation 20:** These numbers are too small. Complications following (laparoscopic) radical prostatectomy are much lower in higher volume centres. The population of Northern Ireland would indicate that there should be a single centre for radical pelvic surgery. This recommendation contradicts recommendation 19.	✓		
2	Debra Mae Butler Northern Trust Urology Nurse Specialist Causeway Hospital 5 Thorndale, Limavady, Londonderry BT49 0ST Personal Information redacted by USI	**Recommendation 9:** There is no dedicated urology ward/unit within the Northern Board. All services currently offered/ provided at causeway. The service is provided from 2 general surgical wards, not ideal if this is to be 1 of 3 units in Northern Ireland. **A SEPERATE UROLOGY UNIT IS ESSENTIAL TO COPE WITH THE WORK LOAD AND TO ENSURE SPECIALISED UROLOGICAL NURSING CARE**. This is a long way for patients to travel from Carrickfergus/ Whiteabbey. **Recommendation 10:** Three specialist Urology Nurses in the causeway hospital which currently provides ALL the urology care for the Northern Trust		✓	

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
	Date of receipt of response: 19/10/2009	have been told that funding provided by ICATS to date is being withdrawn. They have no jobs in march 2010, for this reason I have reservations of anything linked to ICATS. There needs to be stability within Urology services, if funding can be withdrawn so suddenly without little or no consultation then I have grave reservations regarding any care provided under the umbrella of ICATS. **Recommendation 23:** I am sure a large amount of these specialist cancer nurses workload will consist of Mytomycin and BCG therapies. Will any money be diverted from the current cancer site BCH to the other 2 sites in order fund these activities locally? There are often issues around funding this care.			
3	Response to BBC Radio Foyle media enquiry by HSCB – Northern Office	**In response to media enquiry** A consultation on the review of adult urology services in Northern Ireland was launched by the Health and Social Care Board and endorsed by the Health Minister, Michael McGimpsey on 23 September 2009. The recommendations of the review are set to improve capacity for the delivery of urology services and have been developed in partnership with Trusts and the four former Boards. Hospital consultants and nursing staff were members of the steering group. Included in the proposals is the design of a 3 team service model; Team North, Team South and Team East. Proposals for Team North include approximately 7 elective beds for minor			✓

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		and intermediate cases; day surgery and outpatients in Causeway Hospital. There are therefore no plans to change the current acute hospital services including the number of beds, consultants and other support. The proposals actually recommend an enhanced service with increased provision for out of hours. No final decisions will be taken until after the close of consultation, 18 December 2009 when the proposals will be taken to the January meeting of the Health and Social Care Board. The report will then be forwarded to the Minister for final approval. - ENDS - For further information contact: Elizabeth Owen/ Nataleen Surgenor, Public Relations, Health and Social Care Board on Tel: Personal Information redacted by USI / Out of Hours Pager: Personal Information redacted by USI.			
4	Councillor Mr David Barbour 44 Castlewood Avenue Coleraine BT52 1JR Personal Information redacted by USI Date of receipt of response: 23/11/2009	1.It was helpful that the review team had Health Service representatives from the main population area. 2. Although the review team in some measure reaches out to lay understanding, it nevertheless assumes a lot of previous knowledge and is heavily laden with professional peer language and description. I just wonder how many laity had time and courage to delve into such a volume and how effective this consultation has been. 3. Understanding tables and their deductions assumes additional knowledge, for example Table 3, assumes drift from North to East, which I am aware of as a former employee working in the NHSSB however, there is no commentary how this is arrived at. Explanation of the context within would be helpful.		✓	

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		4. Whilst it is necessary to have a wide range of medical opinion; the work of statisticians in population profiles would be helpful. It is a comparatively simple act to lop of two-thirds of the North and West and total them as a mass figure but that does not show the population distribution of those deemed most at risk and projections of possible future demand in certain areas. 5. Discussion on geographical terrain and infrastructural difficulties for people requiring access would be helpful as well as clarification on catchment areas and how the referral will be managed between catchment areas used by the project team. 6. The review team considered and scored several models and subsequently made a recommendation of three Urology teams. Whilst it is essential and important to include the values/standards held by professional healthcare groups in assembling criteria, I wonder if consultation was conducted with non-healthcare professionals to consider if the inclusion of other criterion would be of benefit. I am not saying that the team of three is unacceptable, I just wonder if other professional opinion was sought on the influence of outcome. 7. In relation to Northern and Western, explanation how one team intends to operate between two centres, Altnagevin and Coleraine while comment is necessary on what conditions have to be met in Causeway. 8. Comment should have been made on what impact changes would mean for the ring fenced budget of £642 for ICATS in Causeway as the largest budget in the cluster for this purpose. 9. Comment should have been made on why Causeway was not previously intended for development and why having been built up it is embarked for a reduced role. 10. I accept that change is required to allow a specialist service to develop			

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		resulting in higher levels of care. However I contend that Causeway must be included in a substantial partnership role.			
5	Rosemarie O'Kane Urology Nurse Specialist Northern Trust Causeway Hospital Coleraine [redacted] [redacted] Date of receipt of response: 3/12/2009	**Recommendation 9:** Who is going to manage this service and who is going to deal with queries? **Recommendation 10**: I am currently working in Causeway Hospital as an Urology Specialist Nurse, from next March 2010 ICATS are withdrawing funding for my post including my two colleagues, at present their is no plan for funding after March 2010. We have been told that we do not fit in to the ICATS model as we see cancer patients and our activity did not reflect a working model. **Recommendation 12:** This is an ideal proposal but at present we can not get funding for our existing clinics on a regular basis it seems unlikely that a dedicated unit would work if these resources are not in place. At present we are using annual leave slots for adhoc clinics. We carry out various clinics which include Flowmetry, Urodynamics, Intermittent Catheterisation, Intravesical Chemotherapy, Bladder Instillation, ESWL and Trial Without Catheter. These clinics are vital for the assessment of urological problems and subsequently for the planning of treatment and surgery. **Recommendation 15:** How can this happen without extra facilities.		✓	

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		Recommendation 18: The funding for Bladder Cancer adjuvant treatment went to the BCH, I would hope that this funding would be shared regionally to create equality and not a post code lottery. **Recommendation 21:** This is not possible in Causeway as the funding for the 3 Urology Nurse Specialists is being withdrawn March 2010. **Recommendation 22:** As funding is being withdrawn March 2010 I do not see that this plan can proceed at Causeway. **Recommendation 24:** Causeway Hospital covers a large demographic area, elderly patients will have to travel long distances. Currently in Northern Trust there are no on call facilities. There will be resource and staffing issues (No ICATS) as of March and we have been told that staff grades for Urology will also go as there is no funding for these posts.			
6	Mr Michael Whiteside Consultant Surgeon Antrim Area Hospital Northern Health and Social Care Trust Personal Information redacted by USI Tel Personal Information redacted by USI Date of receipt of	I do not believe it is reasonable for a major hospital like Antrim to be left without an in-house urology service. This hospital is a cancer unit with a large colorectal practice, urogynaecology service along with a gynae cancer service. It also has a renal dialysis unit. It is the only large hospital in NI without a Urology service and I believe this is to the detriment of the patients we serve. I do not believe it will be possible to set up an equitable service for patients admitted to Antrim with urological problems or indeed those patients in the		✓	

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	response: 4/12/2009	Hospital for other reasons that develop urological problems without a proper robust in-house service. My medical colleagues tell me that the majority of their referrals for a surgical consultation for medical inpatients is for a urological problem. The reading of the recommendations for 'Team East' in the review does not inspire confidence for a robust service to Antrim Hospital which should be on a par with the service provided at the Ulster Hospital and Craigavon.			
7	Dr Esme Whitehead Consultant Rheumatologist Antrim Area Hospital Northern Trust Personal Information redacted by USI Personal Information redacted by USI Date of receipt of response: 10/12/2009	Patients with Gynaecological malignancies which may have spread to involve the Ureters or patients in whom a Ureter is inadvertently damaged at Surgery for another reason, and patients who have had Urological surgery with Acute problems. These patients, like the Oncology patients, are admitted to their nearest DGH when ill, not sent to their original treatment area. The admitting hospital has no details of the patient's past medical or surgical history, making management more difficult and less safe. Again, this might be considered to be obvious that patients with Urology problems should be transferred immediately and by protocol, but sick patients are not so easy to classify. They may require IV fluids and antibiotics, and urgent radiology before the problem can be defined and they need to move hospital. I do not think it is safe, nor good practice to separate the specialities of Urological and general surgery completely and to remove Urologists from being personally on site in general hospitals where there is extensive general and Gynaecological surgery. I would urge you to look at this wider picture and seek consultation with Surgeons, Gynaecologists, and A&E staff, who are individuals at the Cold face and whose care for ill patients could be significantly compromised by the		✓	

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		plans envisaged. I can appreciate the reasons for centralising a service, but I think the planning is suboptimal if it does not allow for the physical presence of a Urologist on site in the busiest of DGHs on a daily basis. I feel sure that some planning on the basis of a Hub and Spoke principle could mean that the Surgeons travel to do outpatient clinics on several sites and concentrate their planned surgery in certain centres, but who would then be on site to assess sick patients and for advice. I do note that the group constituted to advise the Minister is a group with wide experience and expertise comprising of Urologists, Public, Health Physicians, GPs, ICATS representatives and specialist Nurses. I do not see any representatives from other Surgical disciplines that represent a user group who need Urology services intermittently but very acutely. I can foresee problems where patients, probably in one of the groups referred to above, suffer increased morbidity or maybe even mortality as a result of planning that does not see the necessity for integrated acute surgical services. In general hospitals doing a lot of general surgery.			
8	Dr Robin G Ashe Consultant Gynaecologist Antrim Hospital Northern Trust BT41 2 RL Personal Information redacted by USI	**Recommendation 3: Statement 2.18** is inaccurate and will not be appreciated by Urogynaecology colleagues throughout Northern Ireland who have established services incorporating Consultants/Continence advisers/ Physiotherapists and follow NICE guidelines. Within my own service in the Northern Trust we conduct bimonthly meetings of the Continence Care Team. Weekly Urogynaecology clinics incorporate the Continence adviser and Urodynamic investigation. Other services in BCH, Lagan Valley, Altnagelvin,		✓	

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
	Personal Information redacted by USI Date of receipt of response: 10/12/2009	Daisy Hill, CAH work along the same principle. Of course, you are not to know this without a gynaecologist or a Continence Adviser on the panel. The personnel included in the Urology review group are incomplete. An Uro gynaecologist would provide perspective on the female service – the make up of the panel is hugely weighted towards the male patient! Representations to Parliament have been made by the patron of our multidisciplinary Society (Ulster Gynae Urology Society), Baroness May Blood, recommending a review of continence services several years ago! Certainly I would welcome assistance and even better coordination of services. Many services are working to NICE Guidelines and this can be improved upon and widened to other services with DOH assistance. I recommend you delete the sentence 'current services in NI are fragmented, disparate and not managed in accordance with NICE Guidelines – Urinary Incontinence: The management of Urinary Incontinence in Women (2006)'. With respect I am of the opinion that the panel could not make such a judgement without Urogynaecological representation. **Recommendation 7:** I have no confidence in Urologists as a group to develop clear protocols. My evidence for this is that I am part of a service in the Northern Trust where for the past 5 years, since the retirement of Surgeons with a Urology interest; urologists within the Trust have failed to engage with clinicians in other specialities to develop pathways of care. My own contact with individual Urologists has always been amicable and this			

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		is not a personal issue – the speciality just seems to have problems when they come together as a group. I recommend that pathways of care are developed within the confines of an implementation group driven by DOH with major contributions from Urologists/General surgeons/ A & E colleagues. **Recommendation 8:** the principles outlined above also apply to this recommendation. **Recommendation 9:** My remarks relate to my own hospital, Antrim Area, which requires an on site Consultant Urologist with an inpatient list and Outpatient clinic, within your proposed three network structure. The hospital is too large with too many specialities to have otherwise. My confidence in the Northern Trust is shaken 'to proactively manage and provide equitable care to those admitted under general surgery (and Medicine, Intensive Care, Nephrology, Gynaecological Oncology) in Hospitals without Urology. Within my remit as Medical Staff Chairman I have addressed 3 Chief Executive and 3 Directors of Acute Services on behalf of Clinicians about inequitable care and poor access to Urology services since the retirement of two Consultant Surgeons with an interest in Urology from Antrim Hospital. I was unsuccessful. This has been enormously frustrating for Clinicians within this hospital. What exactly has changed since the last review in 2000 to warrant a move of Urology from the busiest Hospital in the Trust to Causeway? In fact, Antrim Hospital is now larger since the closure of Mid Ulster O & G/Surgery units in			

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		addition to Whiteabbey surgical unit and the expansion of the Nephrology service / A&E, ICU! My own sub speciality (Urogynae) is setting up a Subspec. Training Programme with BCH and linked TO Oxford (John Radcliffe) which will see further complex Pelvic surgery undertaken. The panel requires to rethink the strategy whereby Antrim is a hospital without an Urology Unit (or a Consultant Urology presence 9-5 during the week). It is a gaping fault in an otherwise satisfactory document. My particular concern relates to Intensive Care, Gynaecological Oncology, Nephrology (the Renal unit has expanded in recent years), General surgery (now 4 Colorectal and 2 Laparoscopic Surgeons) and A&E (60,000 patients seen yearly). All have had difficulties in recent years accessing prompt, or any, Urology services. This would be resolved overnight with an assigned Urologist with sessions shared with BCH attending Antrim. Recommendation 19: I am uncertain what is meant by 'radical pelvic surgery'. If this refers to Cancer Surgery, well and good. Urogynaecologists undertake complex PELVIC Surgery which may be referred to as 'radical'. This term needs to be clearly defined by the panel to avoid confusion.			
9	Mr Seamus McGoran Director of Acute Services South Eastern Health and Social Care Trust Second Floor Thompson House Hospital	With regard to the twenty six arrangements I can confirm the South Eastern Trust's support of these. There are however some points following on from the Recommendations which we wish to raise. The opportunity to discuss these further would be welcomed. • We would seek agreement on the 'Team East' population	✓		

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
	19-21 Magheralave Road Lisburn BT28 3BP Personal Information redacted by USI Date of receipt of response: 12/12/2009	• We require clarification regarding Junior Doctors support as they are not mentioned in the review. **Diagnostics** • The report refers to Diagnostic enhancement but there is no mention of additional investment. **Theatre Lists** • The report recommends up to at least four lists per week per Consultant. The Trust is unclear if this is reflected fully in the costs. **Nurse Staffing** • The report recommends at least five Clinical Nurse Specialists. Clarity is sought regarding funding of these. These five only relate to Cancer related posts. With regard to the non Cancer posts i.e. Specialist Nurses for Urology – how is funding to be agreed? Is there a requirement for this to be negotiated via ICATS? This requires further discussion and clarification. • The South Eastern Trust bid for a Urology ICATS Nurse Specialist was withdrawn by the commissioner pending the Review outcome. Clarification with regards to ICATS investment with South Eastern Trust is required. **Consultant Out of Hours Arrangements** • This will require agreement regarding number and location of Inpatient sites in 'Team East'.			

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		We would welcome further discussion regarding the implementation of this Report. This, of course, will require close communication between the South Eastern Trust, Belfast Trust and the Commissioner. It will be important to agree the funding allocations and the staging of implementation early, especially within the current financial climate. You will be aware that we have recruited a Consultant in November 2009, without funding to help sustain the service. We would appreciate a meeting early in the New Year to discuss this further. Perhaps it would be beneficial to have a joint meeting with Belfast. We will be happy to accommodate whichever is though appropriate.			
10	Dr Frances Stewart Consultant Obstetrician and Gynaecologist Northern Trust Antrim Area Hospital Bush Road Antrim Personal Information redacted by USI Personal Information redacted by USI 12/12/2009	Disagrees with **Recommendation 20**: My main concern is that Antrim Area Hospital should have an onsite Consultant Urologist, 9-5, with a Clinical load consisting of out patient and Surgical list. Antrim runs a busy A&E department with 60 000 attendances per annum. Antrim provides Gynae Oncology Service which undertakes complex surgical techniques which may require Urology input, both in medical and surgical management. Antrim provides one of the most extensive Urogynaecological services in the region, this sub speciality should be complimented by on site Urology services, enhancing care for patients and training for both specialities. In emergency situations it is very difficult to get patients seen or transferred to Urology service, resulting in impaired quality of care. Even though Antrim			

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		provides secondary care to a significant population we do not provide GP access to Urology within our area.			
11	Ms Monica Wilson Chief Executive Portside Business Park 189 Airport Road West Belfast BT3 9ED Personal information redacted by USI [redacted] Date of receipt of response: 15/12/2009	Disability Action has no views on the review but advised on their policy regarding the accessibility of Consultation documents.			✓
12	Dr Jarlath McAloon Consultant Paediatrician Antrim Hospital 45 Bush Road Antrim, BT41 2RL Personal information redacted by USI [redacted] Date of receipt of	The volume of patients and the specialty services provided at Antrim Hospital clearly indicates that the presence of an onsite urology service for both inpatients and outpatients is required. The absence of this service on the main NHSCT hospital site has caused difficulties in accessing the service to an acceptable standard as identified by those Antrim clinicians e.g. surgeons and gynaecologists responsible for the care of these patients in Antrim.		✓	

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	response: 15/12/2009				
13	Dr Anne Kyle Consultant Haematologist and Lead Cancer Clinician Northern Trust Dept of Haematology Antrim Hospital 45 Bush Road Antrim BT41 2RL Personal Information redacted by USI Personal Information redacted by USI Date of receipt of response: 15/12/2009	There are serious implementation issues with the 3 team model. The configuration appears to suit Urological Surgeons rather than patients. Geographical lines will have to be drawn across Northern and Western Trusts. In Northern Trust acute Urological cases from the Southern third will travel to Belfast Trust and those from slightly further North will presumably have to travel all the way to Altnagelvin for an acute Urology bed (elective beds only at Causeway). This appears very inequitable. Robust service agreements between Northern Trust and Belfast Trust could support specialities that require rapid access to Urological services, but this is hardly an optimal arrangement. This also leaves the Northern Trust funding in house Urological services at Causeway but getting quite a limited service in return. The current lack of onsite acute Urology at Antrim Hospital causes great concern among Clinicians from A&E, other Surgical specialities and renal medicine. The Urological Cancer Patient Pathways will have to be very clear and unambiguous to avoid confusion and delay particularly in the Northern Trust. There will need to be great clarity around referral routes.		✓	
14	Dr Sanjeev Ball FRCPCH MRCP MBchB BSChons Dip Hssm	As chair of the medical staff in Antrim. NHSCT and on behalf of the Consultants based here, I wish to express major concerns regarding the new model and service reconfiguration of Urology services in N Ireland.		✓	

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	Consultant Neonatologist Chair Medical Staff Antrim Hospital 45 Bush Road Personal Information redacted by USI Personal Information redacted by USI Date of receipt of response: 16/12/2009	Antrim Hospital is a large District Hospital with no Urologists on site. It is imperative that the new model have on site Urologist and absolutely clear out of hours arrangements. At present there are major concerns regarding this, particularly out of hours for emergency Urology assessment and management by Urology Specialists affecting adult patients in surgery, Gynaecology, A&E, Nephrology and Cancer Services. This is a major patient safety and clinical governance issue. As per the new modelling proposed, Antrim Hospital appears to have been overlooked entirely. This is based on 1. Busy A&E department. 2. Busy Gynae/Gynae Oncology service undertaking complex surgery. 3. Substantial Urogynaecology Service. 4. Difficulties in transfer of patients to specialist Urology in Belfast and Causeway Hospital. The Urology modelling must include a substantial Urology team presence in Antrim Hospital and clear robust arrangements for out of hours arrangements			
15 & 16	Mr Paul Downey & Mr Richard Fiala MD FEBU Consultant Urologist Causeway Hospital 5 Thorndale, Limavady, Londonderry BT49 0st	This review of Urology services has identified shortfalls in manpower and physical resources, however, it has in our opinion failed to deliver the correct solutions to these issues. It is fragmented and in parts incomplete. It does not address all aspects of Urology service provision [e.g. continence services / endourology], is inconsistent in its recommendations for emergency cover and has not provided adequate detail in relation to the proposed models of service delivery. It has ignored concerns over a potential destabilisation of Surgical services which it may produce if it is implemented and has made assumptions in relation to the provision of emergency services by General Surgeons without		✓	

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
	Personal Information redacted by USI Date of receipt of response: 16/12/2009	any discussion with them. It would appear to have been preoccupied with delivering a "centralisation of services" agenda proposing a model of health care delivery which would be suitable for an urban population but totally unsuitable in the rural community particularly in the North/Northwest where transportation issues will leave patients severely disadvantaged in terms of access to emergency and elective services. The proposed model thus enhances any "post code lottery effect" which may already exist and flies in the face of the "closer to home" agenda which it was tasked to deliver. The development of three teams is a concern and we believe important detail in relation to them in missing. There is little detail of where/how services will be provided and there appears to have been no consideration given to options for the teams. This is particularly true for Team North which would be the most complex to organise/set up. There is no clear view of where emergency and elective in-patient services will be provided. There is no clear view on what financial resources will be available to deliver this model and no account has been taken of how much the service would cost depending on where it is based. Problems with transportation/infrastructure would make it very difficult for patients from Antrim to access services should they be based in Altnagelvin and this would especially true if they require a period of hospitalisation when visiting could involve 3-4 hours travelling. This effect would be most severe in the Winter months. Availability of ambulances could also be a major issue and this would affect the elderly most. These issues have not been addressed adequately and concerns in relation to them appear to have been ignored. The review enables expansion in the number of Consultant Urologists but			

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		does not place them where they are needed most. Whilst we support the need for a Regional Cancer Centre with transfer of appropriate complex cases to specialist surgeons working in it we do not see why these specialists perform small numbers of complex cancer procedures spending up to 50% of their time performing core urology procedures and on account of this are apportioned additional consultants. Expansion in consultant numbers is required more outside of Belfast on account of increasing demand, transfer of N code activity and geographical area to be covered. This affects Team North more than any other yet this team receives the least additional support in terms of consultant expansion. This leaves us perplexed. Paul Downey MD FRCS [Urol] Richard Fiala MD FEBU Consultant Urologist			
17	Dr Anna Gavin Director N. Ireland Cancer Registry, QUB School of Medicine, Dentistry & Biomedical Sciences Mulhouse Building Grosvenor Road Belfast BT12 6BJ Tel: Personal Information redacted by USI Fax: Personal Information redacted by USI	The N. Ireland Cancer Registry (NICR) has undertaken audits of the process and outcome of care for prostate cancer for patients diagnosed 1996, 2001 and 2006 and collects data annually on all urological cancers. It is in that context and also as a member of the Urology NICaN Group that I am responding on behalf of NICR to Urology Review. 1. I welcome the proposed specialisation and formal links with MDTS, also the development of protocols and care pathways. 2. I support the aspiration for Equality for Patients presenting to non urological units. The recent Prostate Cancer Audit demonstrated some geographical differences in access to diagnostic services and investigations. 3. I welcome that all radical pelvic surgery will be located at the Cancer Centre with an annual minimum of 5 cases per year. Radical Pelvic Surgery	✓		

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	web: www.qub.ac.uk/nicr Date of receipt of response: 17/12/2009	however, applies to Rectal & Ovarian Cancer procedures and I wonder is there some overlap with these. 4. The proposed appointment of clinical nurse specialists is to be welcomed. I presume there will be geographical equity in their location. 5. There needs to be a mechanism to ensure good communication between the three proposed teams to ensure equality and consistency of approach. The N. Ireland Cancer Registry using the Cancer Patient Pathway System, CAPPS, will have a role in evaluation of the impact of these changes on patient care. Congratulations on an excellent document. I look forward to its implementation.			
18	Mr Philip Weir Democratic Unionist Party HQ 91 Dundela Avenue Belfast BT4 3BU Northern Ireland, United Kingdom. Tel: Personal Information redacted by USI Fax: Personal Information redacted by USI Email: Personal Information redacted by USI	In response to the DHSSPS consultation on the Review of Urology Services, the DUP recognises the increasing demand for Urology services in Northern Ireland. We want to see the public having timely access to high-quality services across the province. We note the recommendation to reconfigure services into a three team model. In the Northern area for example Causeway Hospital already has three urology surgeons, more in fact than at Altnagelvin Hospital currently. The service provided in Coleraine is highly regarded by the local community and the DUP shares the view expressed widely in that area that Urology services should continue to be offered at the Causeway Hospital.		✓	

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	Date of receipt of response: 17/12/2009				
19	Mr M RA Young, MD FRCS (Urol) Consultant Urologist Craigavon Area Hospital Southern Trust 68 Lurgan Road Portadown BT63 5QQ Personal Information redacted by USI Date of receipt of response: 17/12/2009	I am writing to you as chair of the Urology Steering Group to express my concern about the proposed alteration in how the urology services are going to be changed. I, like I suspect others, feel that the Department of Health has not fully grasped the potential consequences of this action. My interpretation is that the Department is endeavouring to downgrade the scope of urological service provision in all facilities outside of one unit in Belfast. It is appreciated that the Department of Health has focused on pelvic cancer work as defined by IOG guidelines. Others may quote that there is no strong evidence to back this approach. We are all encouraged to perform audit but this appears to be disregarded for this particular project. I however would like to take a different angle on this point. Urological Surgeons provide a service to their own patients as well as being part of a larger team to help with urological emergencies and difficulties that our General Surgical and Gynaecological colleagues may have. Training and competencies in this field take time to accumulate and to be maintained. There is a significant crossover of surgical technique that is applicable, however if pelvic surgery is to be removed from the current Cancer Units there will be a significant knock on effect. This dogmatic approach to a population base has not been taken in other areas within the UK where unit size of four to five hundred thousand still has a viable oncology approach. With the uncertainty of population boundaries for Health Service provision I feel that it is unwise to take the "all eggs in one		✓	

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		basket" approach. I would regard that there is the capabilities of having three significant urology units to cover the vast majority of the urological spectrum with the rare and low volume workload being provided in a central unit or indeed if at such a low quantity may have to be on a supra regional basis. I do not regard pelvic oncology as falling into this spectrum. Unit manpower and size is critical to cover the population's total need. Eventually there will be a loss of experience and this will lead to a further shift in the expected patient pathway. Recent review by your Department has obviously defined the need for three units in Northern Ireland for Trauma and Orthopaedics. Their needs are probably not far from our own. If however the Department is going to instigate IOG guidelines then there are indeed certain conditions which even our local regional centre will not be able to provide and such cases will have to be transferred to the mainland for their therapy. I appreciate that some may say that close links can be taken in such instances however if the IOG guidelines are to be implemented, this you will have to regard as insufficient. If the Department however does instigate a complete centralisation of services then I would suggest that there are four subsidiary peripheral units, as I regard that the principles of treatment closer to home is important. I would urge that IOG guidelines, although focused on one precise area for this review will have immense detrimental knock-on effects that they should be taken with significant regard.			
20	Mr Gregory Campbell MP MLA 25 Bushmills Road Coleraine Co. Londonderry	In response to the DHSSPS consultation on the Review of Urology Services, I recognise the increasing demand for Urology services in Northern Ireland. I want to see the public having timely access to high-quality services across the province. I note the recommendation to reconfigure services into a three team model.		✓	

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	BT52 2BP Date of receipt of response: 17/12/2009	In the Northern area for example Causeway Hospital already has three urology surgeons, more in fact than at Altnagelvin Hospital currently. The service provided in Coleraine is highly regarded by the local community and I share the view expressed widely in that area that Urology services should continue to be offered at the Causeway Hospital.			
21	Dr Camille Harron Consultant Nephrologist and Lead Clinician Renal Unit Antrim Area Hospital Northern Trust Personal Information redacted by USI Personal Information redacted by USI Date of receipt of response: 17/12/2009	Recommendation 24: The Nephrology consultants at Antrim would like to raise concerns regarding the lack of proposals for a robust Urology service at Antrim. Antrim is one of the busiest receiving hospitals in Northern Ireland and the Renal Unit is the busiest one outside of the regional centre at Belfast City Hospital. We require Urological input to our patient population in a number of settings which include patients presenting with acute or acute on chronic renal failure where Urinary tract obstruction is a factor, outpatients with Urological symptoms and patients with complex Urological histories who have developed renal failure. All these patients would be best served by access to integrated clinical care with both an emergency and elective Urology service on the same site as their renal care. We have personal experience of the problems with the current lack of Urology on this site. Patients with acute renal failure secondary to obstruction can wait for days for a bed in BCH to have appropriate intervention – there is a risk that they will have permanent kidney damage as a result may require dialysis support (which is associated with increased mortality risk) – the patients can also expect explanations from the local team for delays over which Antrim Physicians have no control. Outpatients are sometimes reluctant to travel elsewhere for their Urology opinions – from experience some patients may be unwilling to travel to Causeway due to the distance involved and older or frail patients can have concerns about travelling to Belfast. There are also practical difficulties with arranging dialysis for chronic patients with		✓	

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		established renal failure if they need to travel to another hospital for an Urological procedure or operation – there is no Renal service at present on the Causeway site. It would appear that the current recommendations regarding Antrim are not patient centred. In addition we would support other concerns raised by our colleagues at Antrim that there should be an onsite Urology Consultant service to support; 1. The business of the A & E department (60 000 attendances per annum are likely to rise further as the configuration of acute Hospitals in the Northern Area changes in the future). 2. The Urogynaecology service (which also interferes with the renal service). 3. The Gynae-oncology unit 4. The large numbers of male medical inpatients whose average age is increasing and who develop acute Urological issues during the course of admission with other illnesses.			
22	Ms Katie Scott Policy Manager The Prostate Cancer Charity First Floor, Cambridge House 100 Cambridge Grove London W6 0LE DD Tel: Personal Information redacted by USI Fax: Personal Information redacted by USI	The Prostate Cancer Charity also makes the following specific recommendations. Continence services The Charity welcomes Recommendation 3 - that a separate review of continence services should be undertaken, with a view to developing an integrated service in line with NICE clinical? guidance. NICE guidelines clearly state that all men who experience urinary symptoms or incontinence should be given information about local continence services and referred to specialist continence services such as a continence nurse for assessment and treatment.	✓		

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
	Helpline: 0800 074 8383 Date of receipt of response: 18/12/2009	Urinary incontinence is one of the most common side effects and serious side effects affecting men who receive surgery, radiotherapy, brachytherapy, HIFI or cryotherapy treatment for prostate cancer. The Charity recommends that both urology and continence services in Northern Ireland are designed to ensure that all men who receive these treatments have their needs assessed by a healthcare professional following treatment and that this assessment includes a review of any continence support that they may require. Appropriate referral processes should also be put in place to ensure that, following assessment, men are able to access the continence services they need. Radical Pelvic Surgery The Prostate Cancer Charity welcomes the recognition within Recommendations 19 and 20 that radical pelvic surgery should be carried out by surgeons with specialist experience in this area and that to facilitate this all radical pelvic surgery should be undertaken by on a single site in Belfast City Hospital. These Recommendations are in line with the recommendations set out in the NICE Improving Outcomes in Urological Cancers guidance, which state that radical prostatectomies should not be carried out by teams that carry out fewer than 50 radical operations (prostatectomies and cystectomies) for prostate or bladder cancers per year and recommends the centralisation of services to help achieve this. The Charity recommends that the Health and Social Care Board fully implements the Improving Outcomes in Urological Cancers guidance and			

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		strengthens the recommendations regarding radical pelvic surgery. Radical prostatectomies should only be carried out by teams that perform at least 50 radical operations to treat prostate or bladder cancers. Evidence shows that where teams carry out 50 or more of these operations a year, the risk of serious complications following surgery is significantly reduced and the recommendations need to make this clear. Clinical Nurse Specialists Clinical Nurse Specialists (CNS) have been widely acknowledged as central to improving the patient experience of people diagnosed with cancer. It has been proven through the work of The Prostate Cancer Charity and elsewhere that when men with prostate cancer have access to a CNS their needs are more likely to be met. , The importance of the CNS role is emphasised in the NICE Improving Outcomes Guidance on Urological Cancers (2002) which recommends that all patients with urological cancers, including prostate cancer, should have access to a specialist nurse from the time of diagnosis. On average, Uro-oncology CNS's across the UK have far larger case-loads than CNS's specialising in other common cancers. A recent census of CNS roles found that in Northern Ireland there are only four Uro-Oncology Nurse Specialists compared to 14 breast care nurses. This means that, on average, each Uro-Oncology nurse specialist will manage 229 new cases of prostate cancer each year , which is higher than the national average of 203 new cases per Uro-oncology Nurse Specialist each year. In comparison, breast care nurses in Northern Ireland will manage 82 new cases.			

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		Survival from prostate cancer in Northern Ireland is high, leading to a high prevalence of men living with or beyond the disease – there were 3,391 men in Northern Ireland diagnosed in 1994-2004 with prostate cancer who were still alive at the end of 2004. Many of these men may need to be followed up for many years, are in active treatment for advanced cancer and/or may have needs for many years after diagnosis, for example through side effects or late effects of treatment. Therefore a CNS will often be caring for these men in addition to new cases. Men with prostate cancer should have equal access to a CNS - this access should be equal in two ways: 1. Each man with prostate cancer should have equal access to a CNS, when compared with other men with prostate cancer 2. and, men with prostate cancer should have access to a CNS, when compared to people with other cancers Equity of access will be affected by the caseloads of CNS's, which can affect the time a CNS has to spend meeting the needs of each patient. The optimum caseload for a CNS working in urological cancers has not yet been identified, despite the recommendation by The Prostate Cancer Charter for Action (of which The Prostate Cancer Charity is a member) for this to be identified. However, this should not prevent the Health and Social Care Board from reviewing the provision of Uro-oncology Nurse Specialists to ensure that men with prostate cancer receive the same quality of care as people with other common cancers, such as breast cancer. Therefore, the final recommendations for improved urology services in			

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		Northern Ireland should include the need to review CNS provision in Northern Ireland to ensure that provision of Uro-oncology Nurse Specialists is equitable when compared to the provision of CNS's for other common cancers and to take remedial action where inequalities are identified. If you have any questions about The Prostate Cancer Charity's response to this consultation please do not hesitate to contact me.			
23	Mr John Knapp Head of Communications, Policy & Marketing RCN Northern Ireland 17 Windsor Avenue Belfast BT9 6EE Telephone: Personal Information redacted by USI Personal Information redacted by USI Date of receipt of response: 18/12/2009	In respect of question 3, the review of urinary continence services needs to encompass an integrated team approach and needs to be undertaken urgently. In addition to the specialist nurses leading continence services, there needs to be involvement from primary care managers, district nurses, health visitors and GPs, as well as from the acute sector. Continence services span a broad range of programmes of care, including adults, children, learning disability, physical disability and mental health. Some teams provide diagnostic services, such as urodynamics for the acute sector. Increases in hospital consultants can, in turn, increase demands upon urodynamics. The service needs to focus investment upon treatment rather than containment; the cost of disposal of continence pads in landfill sites cost the service around £700,000 per annum and referral rates can be as high as 20%. With regard to question 10, this could be GPSi managed away from the acute sector and could be a focus for local commissioning with appropriate nursing involvement and leadership. The RCN welcomes, in principle, the projected deployment of at least five clinical nurse specialists but urges the need to ensure that they have a robust	✓		

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		role that reflects a holistic approach to urological conditions. We also question whether the focus of these posts upon cancer is too narrow and how the broad volume of urology work that it not cancer-related will be effectively resourced and addressed. The appropriate banding of these posts is also critical and should be at least at AfC Band 7. We would like to see a commitment to securing an increase in specialist urology nurses, rather than cancer nurses, and to the deployment of at least one nurse consultant (at AfC band 8a-d) in each of the new teams. Further to question 24, the area served by Team East appears geographically vast, particularly from the perspective of the on-call consultant. The same observation would apply to question 25. We accept the need to ensure that the new teams are sustainable but question whether on-call and out-of-hours arrangements can effectively cover such large areas. In general terms, the RCN supports the proposals outlined in this review but urges the DHSSPS and the HSCB to ensure that appropriate investment is made in securing the right numbers of specialist urology nurses and nurse consultants to drive the new service vision, commissioning and delivery. In this respect, we commend to the DHSSPS and the HSCB the work of Angela Patterson, lead clinical nurse specialist in bladder and bowel dysfunction at the Ulster Hospital, who was runner-up in the RCN Northern Ireland Nurse of the Year Awards 2009. The evidence-based guidelines devised and implemented by Angela in 2007 have reduced incidences of urinary problems amongst women who have given birth, eliminated incidences of urinary retention, promoted the early identification of potential problems, improved communication between acute and primary care and, most importantly, significantly improved the care of women. The project has received a number			

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		of professional awards and the guidance has been shared with other health care providers			
24	Mrs Jennifer Welsh Director of Specialist Services Belfast Health and Social Care Trust Trust Headquarters Roe Villa Knockbracken Healthcare Park Saintfield Road Belfast BT8 8BH Tel: Personal Information redacted by USI Date of receipt of response: 18/12/2009	Firstly, the Belfast Trust is very pleased with the progress that has been made over the last eighteen months in redesigning and remodelling Urology Services within Northern Ireland and I can confirm that the Belfast Trust supports all 26 high level recommendations. However there are a number of other issues following on from the high level recommendations, and I would welcome the opportunity for further discussions and clarification. These issues were previously highlighted in a 26 March 2009 letter to Catherine McNicholl, formerly Associate Director, Service Delivery Unit. • The Report states that 6 additional consultants will be appointed, with theatre lists but without any additional inpatient beds. The Trust would welcome a discussion about our respective understandings of the number of beds and budget currently available to the Urology Service, and the ability to then manage the expected change in activity. • The Report acknowledges that Diagnostics need to be enhanced; however no additional investment seems to be earmarked. • There would appear to be no additional investment for Urology ICATS within Belfast Trust, which is a concern regarding the implementation across Team East. Then there are other specific areas, which will require more detailed discussion. These are:	✓		

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		• Agreement on Team East Population size • Agreement on Boundary Management and referrals from outside Team East. • Theatre lists - The report suggests that each Urologist should have 4 Theatre lists per week, whereas the investment profile would suggest only 3 lists per week. • Cases per Theatre List – There will need to be understanding and agreement in respect of the number of cases per list, depending on which procedure. This is important for Team East in the context of the balance of complex cases and core local urology lists. • Demand for complex Reconstruction Services – There is concern that the unknown demand for complex Reconstruction Services will not be met. • Reasonable workload per Consultant • Understanding of funding for Specialist Nurse posts, particularly those non-cancer posts. The key to this excellent Report is obviously its implementation. We are very aware of the difficult financial situation within the current CSR period and beyond, both for revenue and capital funding. Therefore, collectively we will need to have a pragmatic approach to the implementation. A discussion is required regarding the funding which is available, what the priority order is in terms of implementation and then what can be delivered at each stage. We would like to meet with you as soon as possible to enable a more detailed discussion.			
25	Mrs Mairead McAlinden	The Trust are in agreement with the 17 recommendations as set out in the questionnaire and we have added some additional comments into the	✓		

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
	Acting Chief Executive Southern Health and Social CareTrust Trust Headquarters, Craigavon Area Hospital 68 Lurgan Road, Portadown Craigavon BT63 5QQ Personal Information redacted by USI Personal Information redacted by USI Date of receipt of response: 04/01/2010	questionnaire. The Trust also support the recommendation that the Urology Services should be reconfigured into a 3 team model with the Southern Trust being Team South and we look forward to being involved in the implementation of the recommendations. **Recommendation 3:** Required service pathways from Primary Care to both Urology and Gynae services also needs to be taken into account. **Recommendation 7:** The Southern Trust would suggest that these protocols and care pathways need also to be developed for Hospitals with Acute Urology Units to ensure clarity of roles and responsibilities. **Recommendation 18:** The Southern Trust are currently working towards the arrangements for this starting on 1 January 2010. While the Trust support the need to have appropriate arrangements in place for Cancer pathways, there are significant implications for available capacity at local units with the introduction of thee arrangements. In SHSCT approx 3 sessions per week of consultant capacity will be required to implement the NICAN recommendations. It is unclear if this impact has been factored into the resource assumptions in the review or will need to be considered in the business case process. **Recommendation 26:** It is expected that there will be a regional structure put in place for arrangements for the service delivery and that the Southern Trust will be involved in this. Within the Southern Trust there will be a project team established which will include representation from the Western Trust. There			

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		will be an implementation plan drawn up to implement all the recommendations from the review.			
26	Ms Madeline Mulgrew Line Manager Cancer Choices Kylemore Cottage 29 Carland Road Dungannon BT71 4AA Personal Information redacted by USI Date of receipt of response: 05/01/2010	Agreed with all recommendations	✓		
27	Mrs Margaret O'Hagan Assistant Director, Acute Hospital Services Northern H&SC Trust Bretten Hall Antrim Hospital Tie Line: Personal Information redacted by USI Phone: Personal Information redacted by USI Email:	The Northern Trust apologises for the late response to the Urology review. This was an over sight. We hope this response will be considered as an addendum to the complete report which is being presented to the Board of the RHSCB. Comments on the report are presented under the section numbers. Section 3 - Current Seminar Provision 3.1 The Trust have no issue with the recommendations 7-10 however the basis of current service provision on which these is fundamentally flawed as the complete service at all levels is not described.	✓		

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
	Personal Information redacted by USI Date of receipt of response: 13/01/10	In presenting a description of the service the Review Team did not consider the infrastructure to which it refers. The Northern Trust has a 3 consultant surgeon team only. There is no middle grade or more junior speciality doctors or training grades at any level. This is a vital infrastructure to provide clinically safe service in any speciality regardless of the number of consultants. In Urology there is high volume out patient and inpatient work as well highly complex surgical interventions and treatments. Having no junior staff to support ward work, in particular, pre & post operatively as first responder when consultant as in clinics, theatre, DPU etc. puts pressure on medical and nursing staff as well as create disruption for core elective work. In theatre more experience junior staff are required to assist with complex surgery. Without these staff other consultant urologists are used as assistant. This is not a good use of clinical expertise and unproductive from a performance perspective. 3.2 The NT Urology service is not recognised as a urology training service. This means there are no Special Registrar posts nor are there any junior specialist post formally known as specialist SHO post. This underscores the lack of “hands” medical support for this service and the issues described above. 3.3 The NT recognises this lack of infrastructure as a clinical risk and well as performance risk and have logged it on the risk register. Subsequently 2 locum staff grade have been employed over the past year with no identified funding. Additionally the cost of this is 75% greater that having substantive posts in place there does not prove good value for the Trust. 3.4 In this section the review panel describe the “specialist nurse service”. At			

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		the time of the review the Northern Trust had 1 x nurse specialist Band 7 and 2 x nurse practitioners Band 6. The current position is 2 nurse specialist and 1 nurse Practitioner. 3.5 These nurses were employed to substantive posts using ICATS funding. Currently an average of 1/3 of their work is assessment/diagnostic in nature. The other 2/3 support core activity and cancer work. Because the nurses are not following the Urology ICATS model the Northern Office of the RHSCB is withdrawing the ICATS funding (approx 650K) including the 180K for these nurses at the end of this financial year. With the withdrawal of funding the Trust has no option but to redeploy these nurses. This will have devastating effect on the current service provision. This compounded the lack of medical infrastructure could create a situation were a urology service may be unstainable in the Northern Trust. 3.6 The Trust at this stage does not have the information to challenge the figures presented in the paper in general. However at the time of the review was ongoing a NT representative heavily contested information data and did not support their inclusion in the document. 3.7 The report highlights Causeway Hospital has a mobile lithotripter on sessional basis. It fails to report this is a service put in place a couple of years ago as a pilot and never ceased. It is currently unfunded and as such will only continue if supported in the Trust and in a new service reconfiguration if funded by the Commissioner. 3.24 As mentioned previously ICATS within Urology in the Northern Trust has not develop as planned. The recurrent funding for this service has been			

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		withdrawn from the Trust. By far the biggest impact of this will be on the diagnostic and treatment and review service provide by the specialist nurses in the Trust. Additionally significant funding had been identified for diagnostic support – labs and radiological. Staff were also employed substantively at the outset. These staff will also be redeployed to address of volumes of work. This again will have a significant impact of the suitability of the urology core work. 3.25 Recommendation 10 suggests further developing ICATS to include other urological referrals. The Trust maintain that with the cross region variance and challenges of this ICATS and the future reprofiling of the Urology services the new urology teams should focus on establishing a Team (in our situation Team North) ICATS service with current scope of referrals to create a stable base before developing pathways for new areas within the speciality. Section 4 – Capacity Demand and Activity 4.6 See Section 3.4 – 3.8 regarding the Trust inability to validate these figures. Section 5 – Performance Measures 5.1 – 5.11 As indicated earlier the infrastructure beneath the Consultant Urologist has a great bearing on the level of service provided. Performance in out patients, in patients and day case in both cancer and non-cancer is affected by the lack of middle grade support. It is unlikely to improve unless this is addressed within the Trust and / or in the future urology cross-trust teams.			

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		Section 6 – Challenges and Opportunities 6.2 Some challenges are clearly identified however do not include consultant only teams with no junior support despite this being articulated clearly by the Northern Trust staff at the time of the review. Bullet point 4 attempts to articulate this but fails as it makes no reference to the clinical risk within the service in this situation. Section 8 – Clinical Workforce Requirements 8.13 This point makes reference to average in-patient/day case activity for "a Consultant Urological Surgeon and his Team". The Northern Trust would like to reiterate that their Consultant Urologists have has no medical team below them and rely solely on general surgery F1 and F2 doctors who are covering the general surgical specialities. Therefore this statement of activity cannot be applied to the Northern Trust service. 8.16 This point indicates efficiency should be found in the Northern Trust service to realise a greater workload as compared to their peers. Again, the Trust reiterates the lack of medical team infrastructure to support this and maintain comparators can only be made when one compares like with like. 8.19 The review identifies the initial and expanding to roles of specialist nurses and practitioners within and, importantly, out with ICATS. The NT urology specialist nursing service straddles these functions and also has a vital role in cancer care i.e. attendance at MDM, deliver chemotherapy for bladder cancer (lifelong treatment) ,support and counselling patients, etc yet this role is not recognised by the commissioner as funding is being withdrawn. The Trust acknowledges funding this was for a specific service i.e. ICATS but maintain the source of funding should be changed not			

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		withdrawn. Section 9 - Reconfiguration Model 9.6 The Trust acknowledges reconfiguration needs to take place and see merit in a 3 team model. However it wishes to point there are a number of historically unfunded elements to the urology service in the NT which needs addressed before the new team come into being. An example of the unfunded elements includes: Unfunded Service Approx Cost Lithotripsy £1200 and ¼ PA per month Staff Grades x 2 £180k per annum Specialist Nurses x 3 £180 per annum Radiological support Now funding removed Laboratory support Now funding removed Good and services To be confirmed A more comprehensive breakdown of these services can be provided by finance in the Northern Trust if requested by the Board. 9.6 In reference to Table 14 the Trust maintains it should be the responsibility of the Northern and Western Trust urology clinical and managerial staff in collaboration with the commissioner to agree the best fit for the new service. In particular what needs decided is location of outpatients, inpatients and day services taking into account current trust profiles future service profiles and any outstanding issues in each Trust. 9.8 The Report acknowledges the commitment / contribution of the consultant urologist to an out-of-hours service. Clearly this is not going to be a resident			

	Name & Contact Details Date of Receipt	Issues/Concerns	For	Against	Neutral
		on-call commitment. However, it is concluded from this paragraph and the subsequent recommendation No25 that there needs to be an out-of-hour's arrangement escalating to on-call consultant as required. On Call in a speciality of this size and complexity must be provided in a compliant rota by a tier of juniors with knowledge and experience in urology. This needs addressed as a matter of urgency because the Northern Trust will not be able to contribute funded posts to this rota in any future model.			

Regional Urology Review

Team South Steering Group Meeting

A meeting of the Steering Group was held on Thursday 13th May 2010

Attendees:

Dr G Rankin, SHSCT (Chair)
Mrs P Clarke, SHSCT
Mr D McLoughlin, WHSCT
Ms B Malloy, Service Delivery Unit
Mr M Fordham, Royal Liverpool Hospital
Mrs C Cullen, Southern Office, HSCB
Mr M Akhtar, SHSCT
Mr E Mackle, SHSCT
Mr M Young, SHSCT
Mrs H Trouton, SHSCT,
Mrs M Corrigan, SHSCT
Mrs H Walker, SHSCT
Mrs C Cassells, SHSCT
Mrs S Waddell, SHSCT

1.0 Welcome and Introductions

Dr Rankin welcomed everyone to the meeting.

2.0 Minister's Endorsement of Urology Review Recommendations

Ms Malloy reported that the review and associated revenue funding had been endorsed by the Minister prior to the election. The aim now is to implement recurrent solutions throughout the region as quickly as possible.

Mr Young asked about the availability of funding for additional equipment as basic equipment such as scopes and theatre instrumentation would be required to support expansion of the current service. Ms Malloy said that no specific funding had been allocated for equipment. She agreed to raise this issue with Mr Cole's department on behalf of the region.

3.0 Update on Project Management Arrangements for Team South

The Project Initiation Document which had been circulated with the agenda was discussed. A number of amendments were agreed:

- A Southern LCG representative to be added to the Steering Group (Mrs Cullen will confirm the representative);
- A Western LCG representative to be added to the Steering Group (Mr P Cavanagh to be asked to nominate the representative);
- SHSCT Finance representative on the Steering Group will be Ms H O'Neill, and Mrs C Cassells on the Project Team;
- Consultant Urologist representatives are to be added to the Demand/Capacity and Human Resources sub groups.

The PID is to be updated and circulated to members of the Steering Group.

Funding has been identified to enable the appointment of a Project Manager for a 1 year period.

4.0 Update on Progress with Recommendations

An update on progress was circulated and discussed.

A visit to the Erne Hospital is to be arranged as soon as possible. One or more of the Southern Trust's Urologists will meet with the General Surgeons, and if possible a GP representative to discuss patient pathways and the nature of the services to be provided at the Erne Hospital.

The current ICATS service was discussed at length and the potential to take the entire service to the West when clinics were being held at the Erne. Mr Fordham advised that this may not be the best use of limited resources and that it would be important to process map the service and identify what it is feasible to provide on the various sites.

The concept of a medical/diagnostic urologist was discussed and the potential to appoint this type of consultant in Northern Ireland.

Mr Young asked if the Trust had to appoint the staff specified in the 'Estimated Team Costs' which accompanied the letter from Mr H Mullen to Trusts dated 27 April 10. Ms Malloy/Mr Fordham advised that it would be necessary to describe in detail how the Trust's service model would work and each team member's contribution. This should include trainee doctors. Mr Young felt that the current number of junior doctors would be insufficient to support an expanded team. Ms Malloy advised that there were no plans to increase the current number.

The importance of benchmarking the current service and building improvements in day case rates, new to review ratios and lengths of stay into the new service model were emphasised.

The requirement to refer radical pelvic surgery cases on to Belfast Trust was re-affirmed by Ms Malloy/Mr Fordham. It was confirmed that the Board would no longer provide funding for this type of surgery to be undertaken outside Belfast Trust.

Mr Akhtar said that that Multi Disciplinary Team meetings have been established at the SHSCT and are progressing well. However no Oncology input from Belfast Trust has been provided as yet. Ms Malloy agreed to raise this issue.

5.0 Key Patient Pathways and Protocols

It was agreed that both patient flow and clinical pathways will need to be developed/documented. Mr Young expressed concern that these could not all be completed by 11th June. It was agreed that the patient flow pathways along with a number of the most common clinical pathways would be focused on initially.

6.0 Next Steps and Timetable

It was agreed that development of the implementation plan will present a significant piece of work for the team. It was agreed that a draft plan will be completed for **11th June 2010.** Following review of this draft plan a timescale for submission of the business case will be confirmed.

7.0 Any Other Business

No further business was raised.

8.0 Date and Time of Next Meeting

The next meeting will take place on:

Thursday 10th June at **2.30pm** in **The Meeting Room, Ground Floor, Trust Headquarters, Craigavon Hospital site**

Southern Health and Social Care Trust

REVIEW OF ADULT UROLOGY SERVICES

PROJECT INITIATION DOCUMENT

Version	Draft 0.4
Date	21-May-10

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1.0 Introduction & Background

1.1 Introduction

This document outlines the key objectives and project management structure for taking forward the recommendations arising from the Review of Urology Services in Northern Ireland.

1.2 Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, is recommended. All core urology will be undertaken and the following special interest areas are suggested:

- Uro-oncology (2 consultants);
- Stones/endourology (2 consultants);
- Functional/female urology (1 consultant).

It is proposed that the main acute elective and non elective inpatient unit will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, Daisy Hill and the Erne Hospitals. Outpatient clinics will be held at Craigavon, South Tyrone, Daisy Hill, Banbridge, the Erne and Armagh.

The Minister has endorsed the recommendations and Trusts have been asked to develop business cases and implementation plans to take forward the recommended team model and to secure the necessary investment.

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2.0 Objectives and Constraints

The key objectives of the project are to:

- *Carry out a baseline assessment of the Trust's urology service;*
- *Agree patient pathways;*
- *Develop an implementation plan for urology services based on the recommendations set out in the regional review (for submission to the Regional HSC Board by 11 June 2010);*
- *Establish bed requirements;*
- *Review the demand for the service;*
- *Identify staffing required for the new model of care;*
- *Identify training needs required for the new model of care;*
- *Identify additional equipment needs;*
- *Prepare a business case.*

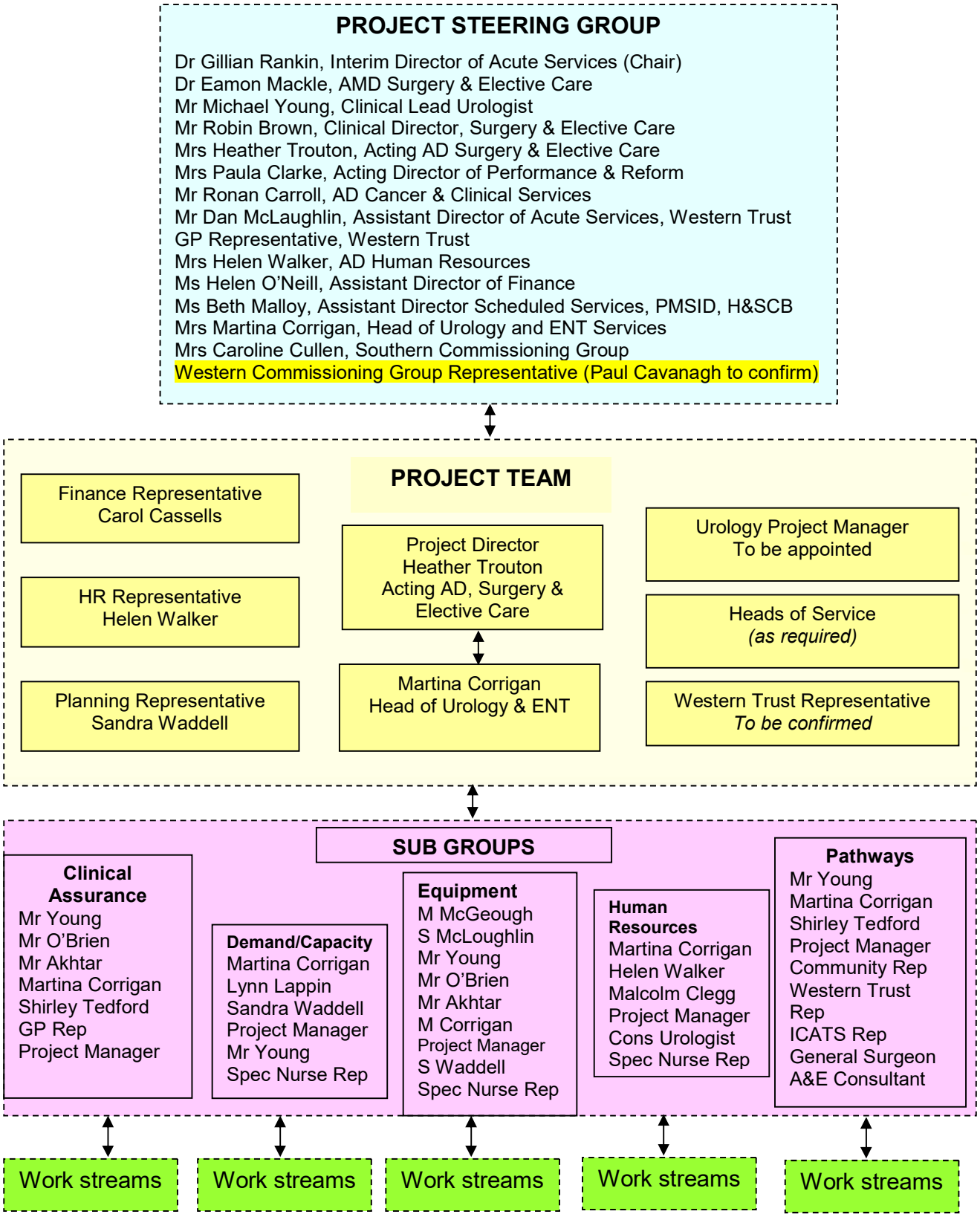
The key constraint to the project is:

- Limited funding for the project - both revenue and capital (for equipment). It is unclear how equipment will be funded and whether this will need to come from Trust general capital.

3.0 Project Management Structure

A project management structure based on PRINCE 2 methodology for project management is given overleaf. It identifies the key stakeholders and interfaces throughout the lifespan of this project.

Review of Urology Services



3.1 Sub Groups/ Work Packages

Many of the deliverables relate directly to recommendations arising out of the regional review. Where this is the case the recommendation number is noted in brackets.

3.1.1 Clinical Assurance

Key tasks for the Clinical Assurance Group include the following:

- Develop an implementation plan for the delivery of the key elements of the Elective Reform Programme including admission on the day of surgery, pre-operative assessment and increasing day surgery rates (Rec 11, 13 & 15);
- Develop an implementation plan for the delivery of a single visit for suspected urological cancer patients (Rec 12);
- Undertake benchmarking and agree target lengths of stay for specified urological conditions/procedures (Rec 14);
- Undertake a review of outpatient review practice with a view to reducing new: review ratios to the level of peer colleagues (Rec 16);
- Undertake a review of outpatient clinic templates and booking practices (Rec 17);
- Quality assure/approve clinical pathways developed by the Clinical Pathways Sub Group.

3.1.2 Demand/Capacity

The key tasks for the Demand/Capacity sub group include the following:

- Undertake an assessment of the current service;
- Review the demand/capacity analysis;
- Establish bed requirements for the service.

3.1.3 Human Resources

The key tasks for the Human Resources sub group include the following:

- Develop team job plans and job descriptions for medical staff (Rec 6, 21 & 22);

- Developing job plans and job descriptions for Clinical Nurse Specialists (Rec 23);
- Quantify the support staff required to deliver the projected activity levels;
- Identify training needs.

The Human Resources sub group will develop an implementation plan for the appointment of additional staff including timescales.

3.1.4 Patient Flow and Clinical Pathways

The Pathways sub group will develop patient flow pathways for elective and non elective patients requiring access to the service and also clinical pathways for a range of conditions. These pathways will include:

- Non elective patients requiring admission who present at Daisy Hill, the Erne and Craigavon Hospital (Rec 7, 8 & 9);
- Elective patients ;
- Clinical pathways - initial focus to be on the 10 most common conditions eg erectile dysfunction, benign prostatic disease, LUTS and renal colic (Rec 3 & 10).

3.1.5 Equipment

The Equipment sub group will identify additional equipment requirements and prepare equipment specifications if required.

4.0 Project Timescales

A draft implementation plan with timescales will be completed for presentation to the Steering Group by **10-Jun-10**

A business case will be completed by **30-Jun-10**

Corrigan, Martina

From: Waddell, Sandra [redacted]
Sent: 19 May 2010 08:27
To: Cullen, Caroline
Cc: Corrigan, Martina
Subject: RE: Urology Project Board
Attachments: image001.jpg

This is great, thank you. You are quite correct. The next meeting of the Steering Group is indeed the 10th June. I think the Monday meetings are more for us to try to keep things pushing forward internally. Would it be appropriate for Martina and I to meet with Diane and yourself on 7th June to provide an update? I am happy to provide you with information on demand etc before that as it becomes available. I realise that Diane has a lot of calls on her time and if you are holding some time in her diary it might be a good opportunity to meet with you both. You can let me know what you think.

Sandra
Sandra Waddell
Head of Acute Planning
Directorate of Performance & Reform
Southern Health & Social Care Trust
1st Floor, The Rowans
Craigavon Area Hospital
[redacted] Direct Line [redacted]
Email: [redacted]
Mobile: [redacted]
Fax: [redacted]

From: Cullen, Caroline [redacted]
Sent: 18 May 2010 10:39
To: Waddell, Sandra
Subject: Urology Project Board

"This e-mail is covered by the disclaimer found at the end of the message."

Hi Sandra

Apologies should have contacted you yesterday!

I have spoken with Lyn and agreed that it should be me as the SLCG rep to the Urology Project Board.

I have also agreed with both Diane and Lyn to keep them fully updated with all the papers/outcomes etc. I have scheduled some time with Diane on the 7th June so that I will have had an opportunity to discuss the proposed implementation plan.

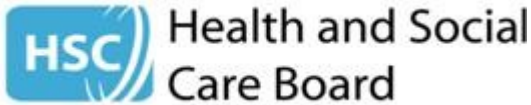
In terms of the actual business case wasn't it agreed that between Beth and the SLCG that we would look at the full business case after the work was completed for the 4 week deadline on the implementation plan.

Plus keep me right – the next meeting which I have to attend is the 10th June at 2.30. There was some chat with Martina about 5pm Monday meetings which would be decision meetings – do I need to attend these?

Hope all is well

Regards

Caroline Cullen
Senior Contracts Manager
Contracts Department
Tower Hill
ARMAGH
BT61 9DR
Personal Information redacted by USI
Direct Line: Personal Information redacted by USI



Urology Action Plan v0.1 17 May 10 - DUE DATES FOR DISCUSSION & AGREEEMENT

		Responsible	Due Date	Progress	% Complete	Outstanding Issues
Agree Demand & Capacity						
	Update demand for Southern Area	Martina/ Sandra/ Lynn	24-May-10	Information Department est approx 19 May. L Lappin will then update model.		
	Factor in demand for Fermanagh	Dan	24-May-10			Need Fermanagh demand by 19th.
	Use currently available figures to progress other tasks					
	Agree capacity for existing consultants/non consultant medical staff/specialist nurses	Martina/ Sandra/ Michael	21-May-10			Needs to reflect review recommendations (set up meeting with Mr Young)
	- new : review ratio					
	- average cases session					
	- produce current/historic activity			look at zipped files		
	- compare current activity by consultant with review recommendations/peer levels					
	- compare current activity with funded (SBA) levels					
	- identify resources and sessions funded for Mr Akhtar's post	*Martina/ Sandra/ Carol*	21-May-10	Have list of staff now, awaiting cost centres.		
Agree service model (based on demand)						
	? Surgeon of the Week ? How will back fill work	Michael/ Eamon	To be agreed			
	Determine job plans	Michael/ Eamon/ Malcolm	To be agreed			
	Numbers/frequency/location/personnel for OPD clinics	Martina/ Sandra/ Michael	To be agreed			
	Numbers/frequency/location/personnel for theatre sessions	Martina/ Sandra/ Michael	To be agreed			
	Numbers/frequency/location/personnel for day case sessions	Martina/ Sandra/ Michael	To be agreed			

Urology Action Plan v0.1 17 May 10 - DUE DATES FOR DISCUSSION & AGREEEMENT

		Responsible	Due Date	Progress	% Complete	Outstanding Issues
	Agree demand/capacity & service model with SLCG	Martina/ Sandra/ Michael/Dan/ LCGs rep	To be agreed			
Attach resources to service model						
	Staffing	HR Group	To be agreed			
	Goods and services		To be agreed			
	Equipment	Equipment Group	To be agreed			
	- identification of funding source for equipment					
	- identification of equipment requirements					
	- preparation of equipment specifications where appropriate					
	- order equipment					
Progress Recruitment of Staff						
	Consultant Urologists					
	- Draft Job Plans					
	- Agree job plans internally					
	- Agree shortlisting panel					
	- Forward job plan/job description to Specialty Advisor					
	- Agree interview date & set up panel					
	- Complete e-requisition & forward to HR					
	- Process requistion job plan through SMT/Scrutiny					
	- Schedule interviews					
	- Agree start date with successful candidates					
Progress Patient Flow & Clinical Pathways						
	Agree 'top 10 - 15' clinical pathways (include the ones specified.	Cons/ Martina	21-May-10			
	Initial draft of pathways	Martina/ Shirley	01-Jun-10			

Urology Action Plan v0.1 17 May 10 - DUE DATES FOR DISCUSSION & AGREEEMENT

		Responsible	Due Date	Progress	% Complete	Outstanding Issues
	Sign off of pathways	Clinical Assurance Group	04-Jun-10			

Corrigan, Martina

From: Waddell, Sandra Personal Information redacted by USI
Sent: 25 May 2010 15:16
To: Corrigan, Martina
Subject: Notes of Project Team Meeting
Attachments: Action Notet Urology Team Meeting 24 May 10.doc

Martina

I need your help with some names under 'Visit to the Erne' please. Please modify/add anything that you feel is appropriate.

Sandra

Sandra Waddell
Head of Acute Planning
Directorate of Performance & Reform
Southern Health & Social Care Trust
1st Floor, The Rowans
Craigavon Area Hospital
Personal Information Direct Line Personal Information redacted by USI
Email: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Fax: Personal Information redacted by USI

ACTION NOTE FROM PROJECT MEETING

Project:	Urology Review Team Meeting 24-May-10
Date of Meeting:	24th May 2010
Attendance:	Mrs Heather Trouton, Mrs Martina Corrigan, Mr Aidan O'Brien, Mr Eamon Mackle, Mr Michael Young, Mr Ronan Carroll, Mr Malcolm Clegg, Mrs Sandra Waddell.
Apologies:	Dr Gillian Rankin, Mrs Paula Clarke, Mrs Carol Cassells, Mr Mehmood Akhtar, Mrs Helen Walker.

	Responsibility
Project Initiation Document (PID) The agreed changes have been made, including inclusion of the Specialist Nurses on all of the sub groups. Mrs Caroline Cullen will be the Southern LCG representative on the Steering Group and it is likely that Dr Michael Smyth will be the Western GP representative. The Western Commissioning Group representative is still to be confirmed. **The updated PID is to be circulated to the Steering Group.**	**Martina/Sandra**
Implementation Plan Beth Malloy has sent draft guidance for the implementation plan to Sandra Waddell for comment. It includes a section for each of the Regional Review's recommendations and requests a significant level of detail including: • Daily triage of 'red flag' referrals; • Current levels of pre-op assessment, admission on the day of surgery, day surgery rates by consultant and cancelled operations, along with actions to improve these; • Existing job plans for all clinical staff and the new consultant team job plans.	
Visit to the Erne The visit to the Erne took place on Thursday 20th May. Mr Young and Mrs Corrigan had a very positive	

meeting with Mr Ghareeb, Consultant Surgeon, Dan McLaughlin, AD for Surgery and Ms Mary Melley, Outpatient Manager. It is likely that 'N' code work will remain with the surgeons at the Western Trust with 'M' code procedures transferring. Mr Ghareeb is to attend the next meeting of the local GP forum to explain the changes to the urology service. Mrs Sarah Groogan, the Director of Performance at the Western Trust is to write to Dr Michael Smyth to ask him to be the local GP representative on the Steering Group and to attend the next meeting on the 10th June.	
Action Plan V0.2 of the action plan was circulated. This had been updated in light of the draft guidance on the implementation plan. Preliminary discussions have taken place regarding the service model and consultant job plans with Mr Mackle and Mr Young. Actual activity for 2009/10, uplifted for anticipated flows from Fermanagh, was circulated and discussed. This will be used to calculate the numbers of sessions required, prior to revised demand and activity analysis being made available later in the week. Junior cover and the impact on activity levels was discussed at length. An existing registrar post will convert to an SHO post in August, reducing the non consultant grade cover to 1 registrar, 2 trust grades and an SHO. This will effectively reduce the middle grade rota to 3, thereby impacting on the number of nights when consultants will be first on call (assuming no available funding to provide locum cover) and also the availability of junior staff to contribute to elective sessions. The potential to appoint one or more staff grades from the available funding was discussed. Ronan Carroll had provided details of available theatre sessions. The only free sessions in CAH main theatres are on Friday afternoons, and there is already an inpatient urology list on Friday afternoon. It was agreed that the introduction of a 3 session operating day would be explored further. Martina and Sandra are meeting with Mary McGeough on Wednesday and will discuss the implications of this. The difficulties surrounding fitting day 4 red flag patient consultations and also covering inpatient	**Martina/Sandra**

emergencies when consultants are holding clinics on other sites was raised. Mr Mackle suggested that he would do some work on draft job plans for discussion with the consultants and that he would reflect the discussion around these issues.	**Eamon/Martina/Sandra**
Patient Flow and Clinical Pathways Draft pathways for suspected renal colic, urinary retention and recurrent UTIs which had been prepared by Shirley Tedford were circulated for comment.	**Clinical staff to comment**
Date and Time of Next Meeting **TUESDAY** 1st June at [redacted] in the Meeting Room, Administration Floor, Craigavon Area Hospital.	**All members to note date and time of meeting**

Investment Proposal Template (IPT3)
Revenue funding > £500,000 < £1,500,000
(unless in exceptional circumstances and approved by Commissioner for >£1,500,000)
Commissioner's Statement

Reference Number	
Commissioner Representative	**Mrs Lyn Donnelly**
Title	**Assistant Director of Commissioning for the SLCG**
Contact Tele No. & Email	Personal Information redacted by USI
Date	**December 2011**

1. **Strategic Context – (if provider requires to add any further information for strategic context this should be added to box 14 in the main proposal attached)**
Outline of Strategic Context within which the Commissioner is seeking service proposals. Reference should be made as appropriate to:
   - Priorities for Action.
   - HWIP.
   - Strategy, Policy or Service Review documents, Local, Regional, National.
   - Compliance with NICE, SMC and other appropriate recognised guidance on effectiveness.
   - Likely Board/LCG service shares.
   - Legislative/Statutory requirements.

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet Cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. The overall purpose of the review was to develop a modern, fit for purpose in the 21st century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN)

The review made a wide range of recommendations that are required to be implemented (see appendix A). A number of the key recommendations have been highlighted below.

- Acute services should be reconfigured into a 3 team model, to achieve long term stability and viability. The three teams are as follows:
  - Team East comprising of the catchment area of Belfast HSCT, SET and the southern sector of the Northern HSCT. Team increasing from 11 consultants to 12 consultants.
  - Team Northwest comprising of the catchment area of northern sector of the Northern HSCT and the catchment area of Altnagelvin hospital and Tyrone County Hospital in the Western HSCT. Team increasing from 5 consultants to 6 consultants.
  - Team South comprising of the catchment area of the Southern HSCT and the Erne Hospital catchment in the Western HSCT. Team increasing from 3 consultants to 5 consultants.
- Radical surgery for prostate and bladder cancer should be provided by teams typically serving populations of one million or more and carrying out a cumulative total of at least 50 such operations per annum. Surgeons carrying out small numbers of either operation should make arrangements within their network to pass this work on to more specialist colleagues.
- To modernise and redesign outpatient clinic templates and administrative booking processes to maximise capacity for new and review patients.
- The requirement to redesign and enhance capacity to provide single visit outpatient

and assessment for suspected urological cancer patients.

The formation of a Team South ensures that patients receive safe and effective care within clinically recommended timeframes and PfA targets. It will also ensure that staff are equipped and motivated to adopt innovative and efficient ways of working.

The recommendations are in line with the regional strategy, *Developing Better Services* (2002). It also reflects the Southern Trust's commitment to localise services where possible, protect elective services and reduce any unnecessary duplication of services.

2. **Description of Services - (if provider requires to add any further information for strategic context this should be added to box 14 in the main proposal attached)**

The current service model is an integrated consultant led and ICATS model. The service base is at Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are General Surgery inpatient beds at Daisy Hill Hospital, Newry and at the Erne Hospital.

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the Urology team also undertakes some Urology outpatient and day case work.

Network Development

A Urology Review Project Implementation Board has been established consisting of clinical representation from all Trusts. This group meets regularly to agree the key actions required to deliver the review recommendations.

Activity Assumptions

New indicative activity levels have been agreed with Team South and work is underway to finalise these volumes.

Table 1 below details the full year effect of the outpatient and finished consultant episode activity for each team.

FYE Team South Outpatients		
	New	Review
MY	504	756
AOB	504	756
MA	504	756
Cons4	504	756
Cons5	504	756
Total	2520	3780
Less Travel Impact	192	99
Total	2328	3681
ICATS	1620	1724
Overall Total	**3948**	**5405**

Team South Proposed FCE Activity		
	DC	**Admissions**
MY	877	248
AOB	877	248
MA	877	248
Cons4	877	248
Cons5	877	248
Total	4385	1240
Less Travel Impact		40
Overall Total	**4385**	**1200**

Pathway Development

The Urology Review Implementation Project Board has discussed and is finalising the details of patient pathways for the following areas:

- Diagnosis and management of an acutely obstructed kidney with sepsis
- Diagnosis and management if acute urinary retention
- Diagnosis and management of suspected renal colic
- Haematuria Single Visit Pathway
- Lower Urinary Tract Symptoms (LUTS) Pathway
- Prostate Pathway
- Scrotal lumps or swelling (in discussion)

Performance Indicators

The HSCB PMSI directorate is working with Trust management and clinicans across each of the Trusts concerned to agree a range of service quality indicators and clinical quality indicators which will help all stakeholders to measure the quality of the urology service and the long term benefits and outcome for patients.

Objectives

- Implement recommendations of Urology Review
- Deliver agreed volumes of activity
- Establish Team South – to be based at the Southern Trust and to treat patients from the southern area and also the lower third of the western area (Fermanagh)
- To increase from a 3 consultant team to a 5 Consultant team plus two nurse specialists
- Meet PfA target for outpatients (within 9 weeks) and IPDC (within 13 weeks)

3. **Funding -**Summary of sources and amounts of available funding including:
   - Recurrent and/or non recurrent funding from commissioners (detailed by LCGs as appropriate)
   - Potential recurrent/non-recurrent funding from other agencies e.g. Supporting People monies from NIHE.
   - Capital funding where appropriate.

The HSCB has confirmed to the Trust that an additional £1.233m uplifted for 2011/12 is available to fund the full year impact of the new 5 Consultant team known as Team South and the associated activity. This funding also covers the support staff costs including radiology, theatre staff, anaesthetics, nurse specialists, secretarial, administration and goods and services associated with each new consultant appointments.

The Trust is asked to submit a Business Case outlining all capital and recurrent costs concerning the development of Team South.

4. **Timescale and process for submitting**
Timescale within which providers should submit the completed investment decision making proformas to commissioners.
Timescales which providers will be advised of the commissioner's decision.
Arrangements for submitting completed documents.

Trusts must submit the completed IPT by 31 January 2012 to allow for HSCB approval in the final quarter of 2011/12and ensure that the service is fully operational by 1st April 2012.

Completed proposals should be submitted to Mrs Lyn Donnelly, SLCG, Tower Hill Armagh BT61 9DR

PROVIDER SECTIONS

Provider	Southern Health and Social Care Trust	Submission date	**06 Feb 12**
Scheme Title	Urology Team South Business Case **FINAL V1.0 (Approved SMT 08 Feb 12)**		
Responsible Officer - including title	Mrs Heather Trouton, Assistant Director of Acute Services, Surgery and Elective Care		
Contact Details – Tele no. & Email	Personal Information redacted by USI Personal Information redacted by USI		

- This business case should be prepared in line with the Green Book and NIGEAE Guidance
- Please complete this template with proportional effort, i.e. detail provided should be commensurate with the size of the bid.

1a) Explain how this proposal specifically meets the needs for this investment (linked directly to the Commissioner statement)

Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended. The Team South share of the available funding to implement the review has been estimated at £1.233m.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans and business cases to take forward the recommended team model.

The Trust's preferred option which is described in more detail later in this document is to appoint the necessary staff to enable the recommendations made in the regional review to be implemented for the population of Armagh and Dungannon, Craigavon and Banbridge, Newry and Mourne and Fermanagh.

1b Describe how this proposal will reduce inequalities in Health and Wellbeing

The specialty of urology predominantly covers the care of urogenital conditions involving diseases of the kidneys, bladder, prostate, penis, testes and scrotum. Bladder dysfunction, male and female continence surgery and paediatric peno-scrotal conditions are also included. The proportion of the male population over 50 years old has risen by approximately 20% over the last 20 years and referrals to secondary care have been rising at 5-10% per year[1].

Prostate cancer is the most common cancer in men. Each year in the UK about 36,000 men are diagnosed with prostate cancer. It accounts for 25% of all newly diagnosed cases of cancer in men. The chances of developing prostate cancer increase with age. Most cases develop in men aged 70 or older. The causes of prostate cancer are largely unknown.[2]

This proposal will enable the Trust to provide an equitable service to residents of the Southern area and Fermanagh. Reduced waiting times for outpatient assessment and inpatient and day case treatment will be facilitated.

2a) Objective(s) of this development - these will be examined in more detail in section 10 and 11)
Please complete the list below - please note that this list is not exhaustive but is a ***minimum requirement***

OBJECTIVES	DATE/ACTIVITY	EXPLANATORY TEXT IF REQUIRED
Development implemented by what date?	End of August 2012	The Trust expects to have the new consultants in post by August 2012
Target met by what date?	March 2013	Compliance with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits longer than 36 weeks for treatment by the end of March 2013.
Provide the total capacity (agreed with the HSCB) within the integrated urology service on completion of the project -	March 2014 3,948 new outpatient appts 5,405 review outpatient appts 4,385 day cases/23 hour stays 1,200 inpatients	The first full fiscal year for delivery of the increased volume of activity will be 2013/14
Facilitate the establishment of Team South as specified in the regional review	End of August 2012	The Trust expects to have the new consultants in post by August 2012
Provide an accessible service across the Team South	March 2013	The first full year for delivery of the enhanced service will be 2012/13

[1], [2] British Association of Urological Surgeons

catchment area		

2b) What are the Constraints of the Project?

Availability of staff, recruitment difficulties, Constraints in, space, time and funding etc.

- Availability of Consultant staff
- Funding for equipment
- Access to additional theatre & outpatient sessions

Current Service Model

The current service model is an integrated model comprising a consultant led outpatient, day case and inpatient service supported by a range of outpatient clinics delivered by a GP with special interest in urology (GPwSI), a nurse practitioner and two specialist nurses. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The GPwSI/specialist nurse services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital. Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2012 and one post is currently vacant),
- 2 Trust Grade Doctors (2 posts are currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either a GPwSI, specialist nurse or consultant led clinic by the outpatient booking centre. Red Flag referrals are managed within the Cancer Services Team. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided by the GPwSI and specialist nurses:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics
- Andrology
- Uro-oncology
- General urology clinic
- Haematuria Assessment and Diagnostics
- Histology Clinics
- Urodynamics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

GPwSI & Specialist Nurse	**Weekly**
Prostate Assessment	1.5
Prostate Biopsy	1
Prostate Histology	1.5
LUTS	3
Haematuria	2
Andrology	2.5
General Urology/Uro Oncology	2.5
	14

Main Theatres (CAH)	**Weekly**	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly	1 monthly
Flexible Cystoscopy	1.5 weekly[2]	
Lithotripsy	2 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) 2 lists/1 list on alternate weeks

Current Activity

Activity for 2010/11 for the service is shown in Table 2. Core activity and in house additionality have been included in the table

Table 2: 2010/11 Actual Activity for the Urology Service

		Core Activity	IHA	Totals
2010/11	**New OP Activity**			
	Consultant Led	1086	375	1461
	GPwSI	475		475
	Specialist Nurse Led	825		825
	Total New OPs	**2386**	**375**	**2761**
	Review OPs			
	Consultant Led	2843	90	2933
	GPwSI	971		971
	Specialist Nurse Led	571		571
	Total Review OPs	**4385**	**90**	**4475**
	Day Cases	1589	152	1741
	Elective FCEs	1021	61	1082
	Non Elective FCEs	613	0	613

The current service is unable to meet the demands of the Southern area and a significant amount of in house additionality was required in 2010/11 to meet agreed back stop access targets for outpatients and inpatients/day cases.

A 9 week waiting time for new outpatient appointments is currently being achieved but only with a high level of in house additionality, which is not sustainable. The waiting time for routine inpatient procedures has risen to 56 weeks and for day cases to 62 weeks. The Trust is striving to reduce these waiting times to 36 weeks by the end of the fiscal year.

3) Option one: Status Quo or Base Case

Option 1 involves continuing to provide the current level of core activity as shown in Table 1.

Advantages

There would be no requirement for additional recurrent investment (although if the Trust continued to provide in house additionality non recurrent funding would be required to support this).

Disadvantages

The Trust would be unable to comply with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits

longer than 36 weeks for treatment by the end of March 2013.

The recommendations set out in the regional review could not be implemented eg:

- 2 additional consultants and associated support staff would not be appointed;
- The service would not be expanded to encompass patients from the Fermanagh area;
- The 62 day cancer target would not be achievable for all patients.

The Trust would be unable to deliver the annual levels of service which are expected by the HSCB:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

The additional investment required to enable the Trust to move forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases, would not be provided.

4) Option Two – Expand the Service to Facilitate Treatment of All Southern Area Patients and Fermanagh Patients

Option 2 involves expanding the current service in line with the recommendations of the regional view to meet the demand from the Southern and Fermanagh areas.

Advantages

The Trust would be able to comply with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits longer than 36 weeks for treatment by the end of March 2013.

The recommendations set out in the regional review could be implemented eg:

- 2 additional consultants and associated support staff would be appointed;
- The service would be expanded to encompass patients from the Fermanagh area;
- The 62 day cancer target would be achieved.

The Trust would be able to deliver the annual levels of service which are expected by the HSCB:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

A sustainable service model would be facilitated and the Trust would be able to move forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases, where appropriate.

Disadvantages

Additional recurrent revenue investment will be required.

5) Option Three - Provide the Current Level of Service within the Trust and Supplement with Independent Sector Provision.

Option 3 involves continuing to provide the current level of core activity and supplementing this with independent sector provision to meet the demand from the Southern and Fermanagh areas.

Advantages

There would be the potential for the Trust to be able to comply with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits longer than 36 weeks for treatment by the end of March 2013.

Some, though not all of the recommendations set out in the regional review could be implemented eg:

- The service would be expanded to encompass patients from the Fermanagh area;

The Trust may be able to deliver the annual levels of service which are expected by the HSCB by using IS provision:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

Disadvantages

Additional non recurrent revenue investment will be required.

A sustainable service model would not be facilitated and the Trust would be unable to move forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases.

The service would be difficult to manage and the current 3 consultant model would not enable any outreach services to the Fermanagh area. The service would therefore not be an equitable service.

Not all of the recommendations set out in the regional review could be implemented eg:

- 2 additional consultants and associated support staff would not be appointed;
- The service provided to patients from the Fermanagh area would be limited.
- Compliance with the 62 day cancer target for all patients would be a challenge within the current staffing levels.

Independent sector provision is comparatively expensive and this option would therefore not represent good value for money.

7) Identify and evaluate the overall benefits of all of the options

Consider costs and benefits to other parts of the public and private sectors

PLEASE LIST & SCORE BENEFITS THEN SHOW RANK OF OPTIONS

			1 Base case		**2** Expand Service - Create Team South		**3** Current Service + IS	
	Criterion	**Weight**	Score	Score x Weight	Score	Score x Weight	Score	Score x Weight
1	Implement Regional Review recommendations	45	6	270	9	405	7	315
2	Provide agreed capacity	20	6	120	10	200	9	180
3	Compliance with targets	20	6	120	9	180	9	180
4	Accessible service across Team South area	15	7	105	9	135	8	120
	Totals	**100**		**615**		**920**		**795**
RANKING				**3**		**1**		**2**

Robustness/Bias Test (Sensitivity Analysis)	If benefits are not delivered as expected above would the ranking change? There is a considerable difference between the total scores of options 2 and 3 which suggests that the ranking is relatively robust. The biggest risk to the scores achieved by the preferred option is around the ability to appoint one or more of the consultant urologists (this risk is addressed in more detail in section 13 below). However, it is the Trust's view that any detrimental effect on the benefits would be short term – ie if both consultant posts cannot be filled immediately, they will be able to be filled later. How much would costs increase before VFM (Ref Box 9 is impacted?

8) Financial Quantification of chosen option

Express Costing in total rather than incremental terms to expose full resource consequences

Please note which option is the preferred option -

OPTION NUMBER AS ABOVE	Option Name	Total £ (Rec)	Total £ (Non-Rec)
BASE CASE		£1,346,611	
OPTION 2		£1,494,081	
OPTION 3			
OPTION 4			
Additional Cost (Marginal Increase: Preferred Option less Status Quo Option		**£147,470**	

Note: Detail to be contained in costing appendix.

The estimated funding indicated in the *'Review of Urology Services in NI, A Modernisation & Investment Plan',* uplifted for 2011/12 pay and prices has been stated at £1.233m. The staffing identified in the modernisation and investment plan has been replicated in Appendix 2. However as Appendix 2 indicates, if these are re-costed at HSCB rates (yellow columns), then the total recurrent funding is £1,346,611 (ie an additional £113,611). This figure has been used as the base case revenue cost above.

Appendix 1 provides the Trust's required staffing levels and associated costs for the Team South model detailed in option 2. The Trust's staffing and costs are shown in the first two (grey) columns. For ease of comparison the second two (pink) columns show the staffing and costs given in the urology review investment plan and the third two (orange) columns show these costs uplifted to HSCB rates.

The main areas of deficit have been denoted with a red bar. The following notes apply to the Trust's costs:

Notes:-

1. Cons Urologist costed at 11 pa's and Cat A 1:5 to 1:8 rota (5%)
2. Cons Anaesthetist costed at 10 pa's and Cat A 1:9 rota or less (3%)
3. Cons Radiologist costed at 10 pa's and Cat A 1:9 rota or less (3%)
4. Outpatient attendances costed at marginal goods and services rate using 10-11 TFR (unit cost of £51)
5. Day Case/23 hr stays costed at marginal goods and services rate using TFR 10-11 Day Case rate (unit cost of £100)
6. FCE net off costed on same basis as Day Cases.
7. CSSD staff costed at unsocial hrs rates from HSCB 11-12 costing schedule.

The consultant urologist posts have been costed at 11 PAs as 11 PA contracts will maximise the amount of direct clinical PAs. If these are reduced to 10 PAs there will be an associated reduction in activity. The Trust also wishes to highlight the fact that no staff were included in the review investment plan for either Labs or Pharmacy. Both of these support services will be impacted upon by the increase in urology activity.

9) Value for Money

A) Efficiency Savings (Where applicable)

- Provide an accurate costing of any savings. Are these savings to be cash released or redeployed? If redeployed please provide full details of redeployment (cost, activity, outcomes etc).

It is not anticipated that this proposal will generate efficiency savings.

B) Further demonstrate overall Value for Money by including benchmarking evidence

B1) Breakdown the elements of the option and compare cost and activity to Status Quo option and benchmarking statistics eg Community Statistical Indicators, Reference Costs, Specialty Costs, HRGs etc.

B2 *Please explain the reason for any positive or negative variances that exist when the preferred option is compared to B1 above.*

Positive Variances: eg Better working practices, more efficient use of resources etc. These will indicate VFM.

Negative Variances: eg Increased complexity of services etc. These will not initially indicate VFM – More information required below in B3.

B3) *If there are negative variances shown in B2 above explain how are these offset by, for example Qualitative benefits and the context of the project.*

10) Preferred Option (Insert option number)

Please rank costs and benefits and summarise reasons for selection.

	Current Funded Position	**1** Base case	**2** Expand Service - Create Team South	**3** Current Service + IS
Benefit Appraisal Weighted Score	-	615	920	795
Ranking	-	3	1	2
Revenue				
Ranking				

Option 2 - Expand the Service to Facilitate Treatment of All Southern Area Patients and Fermanagh Patients is the Trust's preferred option.

Option 2 will enable the Trust to implement the recommendations set out in the regional review of urology services and will facilitate the delivery of the annual levels of service which are expected by the HSCB.

The urology service will be able to comply with the 2011/12 PfA access targets by the end of March 2013 and a sustainable service model would be facilitated.

11) What are the Specific Outcomes of the preferred option
Quality, Timescales, Quantity (detailed in box 11)

The recommendations set out in the regional review of urology service could be implemented.

A sustainable service model for the urology service would be facilitated forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases, where appropriate.

2 additional consultants and associated support staff would be appointed;

The service would be expanded to encompass patients from the Fermanagh area;

The 62 day cancer target would be achieved for all patients.

The Trust would be able to deliver the annual levels of service which are expected by the HSCB:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

12) Activity Outcomes
Activity, contacts, placements, procedures etc, please identify

SBA Activity

	New OP[1]	Review OP[2]	FCEs	Day Cases/ 23 Hour Stays
Original Baseline Activity	1,014	2,390	1,596	1,239
Additional Baseline Activity	2,934	3,015	- 396	3,146
New Baseline Activity	3,948	5,405	1,200	4,385

1) New outpatient appointments comprise 2328 slots at consultant led clinics & 1,620 at support staff clinics.
2) Review outpatient appointments comprise 3,681 slots at consultant led clinics & 1,724 at support staff clinics.

If approved, activity will be added to Indicative volumes in Organisation's Service and Budget Agreement (if applicable)

The above table must be completed for each discreet element of the service in question, please replicate as required. If activity is for more than one LCG please detail separately.

13) Assess Risks and Uncertainties
Identify the main risks associated with the proposal and how can these be mitigated – these should be scored using the Providers recognized risk scoring method

The following main risks have been identified in relation to this project:

- Inability to appoint consultant urologists
- Inability to appoint other key staff
- Activity projections are not achieved

These have been assessed using the Trust's scoring methodology:

Consequence		Likelihood	
1	Insignificant	**1**	Rare
2	Minor	**2**	Unlikely
3	Moderate	**3**	Possible
4	Major	**4**	Likely
5	Catastrophic	**5**	Almost certain

The consequence and likelihood are combined to provide a risk rating

Risk Rating

H	Red Risk - High = 20 - 25
M	Amber Risk - Moderate = 12 -19
L	Yellow Risk - Low = 6 - 11
VL	Green Risk - Very Low = 1 - 5

Description of Risk	Consequence	Likelihood	Risk Rating
Inability to appoint consultant urologists	4	3	M
Inability to appoint other key staff	4	3	M
Activity projections are not achieved	2	3	L

Inability to Appoint Consultant Urologists

There is a risk that whilst projected activity levels may be accurate, that they may not be achievable if consultant urologists cannot be appointed. This would have a major impact and is possible. However the Trust believes that if one or both posts are not filled immediately they will be filled if advertised again when further staff qualify and are able to apply.

Inability to Appoint Other Key Staff

There is also a risk that other key staff such as anaesthetic and radiology staff may not be appointed immediately. As with the urologists the Trust would advertise again until posts are filled. In the interim sessions would be provided on and in house additionality basis.

Activity Projections are Not Achieved

There is a risk that the activity projections may be too high and that they may not be achievable within the available outpatient and theatre sessions. BAUS

recommendations have been used to model the projected activity and the Trust is aware that BAUS is in the process of reviewing its standards and guidelines to reflect current clinical practice. The outcome of this review is awaited.

14) Monitoring and Post Implementation Evaluation Process – please also refer to detail contained within the Commissioner's Statement

Mrs Heather Trouton Assistant Director of Acute Services, Surgery and Elective Care will manage the implementation of this scheme. Depending on the date of approval it is anticipated that the development will be fully implemented by March 2013 (2012/13 will be the first full year for delivery of the enhanced service).

Timetable for Implementation

Task	**Timescale**
Submission of Team South Implementation Plan	23 June 10
Approval to Proceed with Implementation from HSCB	July 11
Completion of Job Plans/Descriptions for Consultant Posts	End December 11
Consultant Job Plans to Specialty Advisor	January 2012
Advertisement of Consultant Posts	End February 12
New Consultants in post	August 2012

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation of the proposal if approved. This evaluation will be undertaken by the Head of Service for ENT and Urology.

15) Other relevant information
Please note any other appendices or attachments

HSCB Costing Schedule
Appendix 1 Team South Staffing and Costs
Appendix 2 Estimated Team Costs form the 'Review of Urology Services in NI, A Modernisation & Investment Plan'

16) Signature of individuals responsible for this bid – Provider Section

Trust Authorising Officer		Date
Title		

Trust Director of Finance Signature		Date
Trust Chief Executive Signature		Date

17) Approval or rejection (Local/Regional Commissioning Use only-HSCB and PHA)

	Approved	Rejected (if yes detail reasons)	Approved in Principle (if yes detail reasons)
Yes/No			

Responsible Person

Signature Date Position

Authorising Person

Signature Date Position

Director of Finance Authorisation or delegated officer

Signature Date Position

Chief Executive Authorisation

Signature Date Position

SUMMARY OF FUNDS APPROVED – IF THIS DIFFERS FROM PREFERRED OPTION PLEASE DETAIL

TO BE UPDATED BY THE RESPONSIBLE OFFICER FOR TRAFFACS	**FYE of project (£)**	**CYE of project (£)**	**Non Recurrent (£)**
SOURCE OF FUNDS			

DRAFT

Summary Costing schedule for Investment Decision Making Templates		Ref Number	
Provider	SOUTHERN		
Hospital Site or Community development	CRAIGAVON		
Scheme Title	UROLOGY REVIEW		
Pay and Price Levels	2011/12		

Commissioner Use only
Sign and Date for TRAFFACS update

****PLEASE NOTE ATTACHED FINANCIAL COSTINGS APPENDIX 1 AND 2 PROVIDE MORE DETAILED ANALYSIS OF AMOUNTS NOTED IN COSTING SCHEDULE***

		Base Case - option 1				Option 2				Option 3				Option 4			
Pay Costs	Description	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye
BAND 1					0				0				0				0
BAND 2					0	0.00	3.43	73,433	0				0				0
BAND 3					0	0.00	3.45	81,472	0				0				0
BAND 4					0	0.00	2.10	56,644	0				0				0
BAND 5					0	0.00	6.50	216,287	0				0				0
BAND 6					0	0.00	2.36	94,056	0				0				0
BAND 7					0	0.00	1.70	81,003	0				0				0
BAND 8A					0				0				0				0
BAND 8B					0				0				0				0
BAND 8C					0				0				0				0
BAND 8D					0				0				0				0
BAND 9					0				0				0				0
Non-AFC posts please detail below					0				0				0				0
Consultant Urologist					0	0.00	2.00	282,460	0				0				0
Consultant Anaesthetist					0	0.00	1.00	125,941	0				0				0
						0.00	0.60	75,565	0								
						0.00	0.10	12,594	0								
						0.00	0.00	12,172	0								
Base Case assumed to be proposed funding of £1.233m, restated at HSCB Costing Schedule 11-12 rates (Pay)		0.00	18.04	991,538	0				0				0				0
Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)					0				0				0				0
					0				0				0				0
TOTAL PAY COSTS			18.04	991,538	0		23.24	1,111,627	0		0.00	0	0		0.00	0	0
Non-Pay Costs - please detail below																	
Base Case assumed to be proposed funding of £1.195m, uplifted by 3.18% to 11-12 rates to £1.233m . (Goods proportion only)		0.00		355,073													
Outpatient Attendances 1540 new & 334 review					0	0.00		95,574									
Day Case/23 hr stays 3146					0	0.00		314,600					0				0
FCE's -396					0	0.00		-27,720					0				0
					0								0				0
					0				0				0				0
TOTAL NON-PAY COSTS				355,073	0			382,454	0			0	0			0	0
GRAND TOTAL				1,346,611	0			1,494,081	0			0	0			0	0

Phasing/Timescale	(Can development be phased, if so provide details in this box)	(Can development be phased, if so provide details in this box)	(Can development be phased, if so provide details in this box)	(Can development be phased, if so provide details in this box)
PROGRAMME OF CARE	acute	acute		
SUB-SPECIALTY INFORMATION eg inpatients, outpatients, daycases if known	daycases	daycases		
LCG	Southern	Southern		
If more than one LCG in option above please give details				
LGD				
If more than one LGD in option above please give details				

Urology Staffing and Costs

v0.1 updated 12 Jan 2012

APPENDIX 1

Recurring	**WTE**	**Full Year Cost per SHSCT** £	**Funding per HSCB** £	***Deficit***	**Funding per HSCB restated at 11-12 rates**	***Deficit***	***Main areas of deficit***
Medical Staff							
Consultant Urologist	2.00	282,460	208,000	*-74,460*	244,530	*-37,930*	
Consultant Anaesthetist	1.00	125,941	124,800	*-1,141*	146,718	*20,777*	
Consultant Radiologist	0.60	75,565	62,400	*-13,165*	73,359	*-2,206*	
	3.60	**483,966**	**395,200**	***-88,766***	**464,607**	***-19,359***	
Specialist Nursing							
Upgrade 2 Band 5 posts to Band 6		12,172		*-12,172*		*-12,172*	
Band 5	1.00	33,275	103,605	*70,330*	119,123	*85,848*	
	1.00	**45,447**	**103,605**	***58,158***	**119,123**	***73,676***	
Theatres/Recovery Nurses							
Band 6	0.26	10,362		*-10,362*		*-10,362*	
Band 5	4.74	157,724	106,754	*-50,970*	126,778	*-30,946*	
Band 3	0.43	9,906	17,870	*7,964*	21,195	*11,289*	
Band 2	1.21	24,657		*-24,657*		*-24,657*	
	6.64	**202,649**	**124,624**	***-78,025***	**147,973**	***-54,676***	
Preassessment							
Band 6	0.13	5,181		*-5,181*		*-5,181*	
Band 5	0.26	8,652	13,833	*5,182*	13,833	*5,182*	
	0.39	**13,833**	**13,833**	***0***	**13,833**	***0***	
Outpatients							
Band 3	0.52	11,980	11,980	*0*	11,980	*0*	
	0.52	**11,980**	**11,980**	***0***	**11,980**	***0***	
Radiography							
Radiographer Band 7	1.00	47,649		*-47,649*		*-47,649*	
Radiographer Band 6	1.00	39,854		*-39,854*		*-39,854*	
Radiographer Band 5	0.50	16,638	100,782	*84,145*	119,790	*103,153*	
Radiography Helper Band 3	1.00	23,038		*-23,038*		*-23,038*	
	3.50	**127,179**	**100,782**	***-26,397***	**119,790**	***-7,389***	
Laboratory							
Consultant Pathologist	0.10	12,594		*-12,594*		*-12,594*	
BMS Cellular Pathology Band 6	0.20	7,971		*-7,971*		*-7,971*	
BMS Blood Sciences Band 6	0.77	30,688		*-30,688*		*-30,688*	
	1.07	**51,252**	**0**	***-51,252***	**0**	***-51,252***	
Pharmacy							
Clinical Pharmacist Band 7	0.70	33,354		*-33,354*		*-33,354*	
Pharmacy Technician Band 4	0.60	16,184		*-16,184*		*-16,184*	
	1.30	**49,538**	**0**	***-49,538***	**0**	***-49,538***	
CSSD							
Band 3	0.38	10,745		*-10,745*		*-10,745*	
ATO Band 2	0.76	19,024	29,770	*10,746*	29,770	*10,746*	
	1.14	**29,770**	**29,770**	***0***	**29,770**	***0***	
Admin Support							
PAS/Clinical Coding Band 4	0.50	13,487	11,632	*-1,855*	13,487	*1*	
Personal Secretary Band 4	1.00	26,973	23,265	*-3,708*	26,973	*0*	
Booking Clerk Band 3	0.62	14,284	31,438	*17,154*	36,400	*22,116*	
Health Records Band 2	0.48	9,781		*-9,781*		*-9,781*	
Radiology support Band 3	0.30	6,911	6,618	*-293*	7,602	*691*	
Theatres Band 2	0.14	2,853		*-2,853*		*-2,853*	
	3.04	**74,289**	**72,953**	***-1,336***	**84,462**	***10,173***	
Hotel Services							
Band 2	0.84	17,118		*-17,118*		*-17,118*	
Stores							
Band 3	0.20	4,608		*-4,608*		*-4,608*	
TOTAL RECURRING PAYROLL COSTS	**23.24**	**1,111,627**	**852,747**	***-258,880***	**991,538**	***-120,089***	
Goods & services							
Outpatient attendances 1540 new & 334 review		95,574	14,187	*-81,387*	15,459	*-80,115*	
Day case/23 hour stays 3146		314,600	328,230	*13,630*	339,614	*25,014*	
FCEs **-396**		-27,720		*27,720*		*27,720*	
TOTAL GOODS & SERVICES		**382,454**	**342,417**	***-40,037***	**355,073**	***-27,381***	
Inflation at c3.18%			37,836	*37,836*			
TOTALS		**1,494,081**	**1,233,000**	***-261,081***	**1,346,611**	***-147,470***	

Notes:-

1. Cons Urologist costed at 11 pa's and Cat A 1:5 to 1:8 rota (5%)
2. Cons Anaesthetist costed at 10 pa's and Cat A 1:9 rota or less (3%)
3. Cons Radiologist costed at 10 pa's and Cat A 1:9 rota or less (3%)
4. Outpatient attendances costed at marginal goods and services rate using 10-11 TFR (unit cost of £51)
5. Day Case/23 hr stays costed at marginal goods and services rate using TFR 10-11 Day Case rate (unit cost of £100)
6. FCE net off costed on same basis as Day Cases.
7. CSSD staff costed at unsocial hrs rates from HSCB 11-12 costing schedule.

Appendix 2

Estimated Team Costs for the 'Review of Urology Services in NI, A Modernisation & Investment Plan' Recommendations.

	Team South	Recosted at HSCB General Costing 11-12 rates	Whole Time Equivalent	Team North	Team East	Total	No	Unit Cost	Total
Staffing Costs									
Consultant Urologist – additional wte	2 wte			1 wte	3 wte	6	6		
Consultant	£208,000	£244,530	2.00	£104,000	£312,000	£624,000		£104,000	£624,000
Consultant	£124,800	£146,718	1.20	£62,400	£187,200	£374,400	3.6	£104,000	£374,400
Consultant Radiologist @	£62,400	£73,359	0.60	£31,200	£93,600	£187,200	1.8	£104,000	£187,200
Band 5 6 per wte Con	£100,782	£119,790	3.60	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
Nursing @ 1.8 wte per Con.	£100,782	£119,790	3.60	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
	£17,870	£21,195	0.92	£8,935	£26,805	£53,610	2.7	£19,856	£53,611
Band 7 Specialist	£103,605	£119,123	2.50	£0	£103,605	£207,210	5	£41,442	£207,210
	£5,972	£6,988	0.21	£2,986	£8,958	£17,916	0.64	£27,995	£17,917
wte per consultant urologists	£23,265	£26,973	1.00	£11,633	£34,897	£69,795	3	£23,265	£69,795
Band 3 Admin support to radiologists at 0.5 wte per	6,618	7,602	0.33	3,309	9,927	£19,854	1	£19,856	£19,856
Band 3 Admin Support to Specialist Nurses @ 0.5	£31,438	£36,400	1.58	£0	£28,129	£59,567	3	£19,856	£59,568
0.5 per unit *3	£11,632	£13,487	0.50	£23,265	£23,265	£58,162	2.5	£23,265	£58,162

	Team South	Recosted at HSCB General Costing 11-12 rates	Whole Time Equivalent	Team North	Team East	Total	No	Unit Cost	Total
Band 7 MLSO – Bio-medical					£41,442	£41,442	1	£41,442	£41,442
Sub Total	**£797,164**	**£935,955**	**18.04**	**£348,510**	**£1,172,174**	**£2,317,848**			**£2,317,853**
Support Costs									
£94,500 per	189,000	195,010		94,500	283,500	£567,000	X 6	£94,500	£567,000
Theatre les @ £50,000 per	100,000	103,180		50,000	150,000	£300,000	X 6	£50,000	£300,000
per Con.	5,000	5,159		2,500	7,500	£15,000	X 6	£2,500	£15,000
CSSD @ £32,000 per	64,000	66,035		32,000	96,000	£192,000	X 6	£32,000	£192,000
Outpatients	40,000	41,272		20,000	60,000	£120,000	X 12	£10,000	£120,000
Sub Total	**£398,000**	**£410,656**		**£199,000**	**£597,000**	**£1,194,000**			
Sub Total	**£1,195,164**	**£1,346,611**		**£547,510**	**£1,769,174**	**£3,511,848**			**£3,511,853**
2008/09					**£637,076**	**£637,076**			**-£637,076**
Less Funding allocated		**£1,233,000**							
DEFICIT		**£113,611**							
FINAL TOTAL	**£1,195,164**			**£547,510**	**£1,132,098**	**£2,874,772**			**£2,874,777**

Please note this analysis is based on the team figures included in the Review shown in Appendix 7 page 60.

3.18% inflation

*1 – this is based on the existing CNS nurse establishment and the sub specialty consultants within each of the teams. The remaining 1 CNS has been allocated to Team East for the Radical Pelvic Surgery undertaken at the Cancer Centre.

	Existing Establishment			Number of consultants with a sub-specialty interest	Additional CNS
				2	2
				2	0.5
				4	2.5

*2 – 0.5 allocated to each Team as per the Specialist Nurse
*3 – 0.5 allocated to each Trust Unit within each Team
*4 – 1 wte allocated to Belfast – for increased demand for pathology

ngements of the Board

Clinicians Name -

Consultant or Staff Grade or Clinical Nurse Specialist or GPSI or other – Please indicate

	AM – 4 Hour Session	PM – 4 Hour Session	Other
Monday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?			
Tuesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?			
Wednesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?			

Thursday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?			
Friday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?			
Saturday			
Sunday			

Mr O'Brien Job Plan

Monday AM

1st Week – 9.00 – 1.00 Banbridge outpatient clinic
2nd Week – 9.00 – 1.00 Armagh outpatient clinic
3rd & 4th week – 9.00 – 1.00 SPA

Monday PM

2.00pm-6.00pm 2 weeks Admin and 2 weeks SPA

Tuesday AM

9.00am-1.00pm – Day Surgery – CAH (2 per month)
9.00am-1.00pm – Admin (2 per month)

Tuesday PM

2.00pm – 5.00pm – Outpatients – CAH - Weekly

Wednesday AM

8.30am-9.00am – Pre-op Ward round - CAH
9.00am-1.00pm – Theatre - CAH

Wednesday PM

1.00pm – 5.00pm – theatre – CAH

Thursday AM

8.30am-9.30pm - Radiology meeting (DCC – 1hr)
9.30am-12.00pm – Grand Ward Round (DCC – 1hr and SPA 1.5hr)

Thursday PM

12.00pm-1.30pm – Departmental meeting (DCC 1.5hrs)
2.15pm,-5.00pm – Multi-disciplinary meeting (DCC 2.75hrs)

Friday AM

9.00am-12.00pm – Specialist Clinic – CAH
12.00pm-1.00pm – SPA

Friday PM

Afternoon off

Mr Akhtar – Core Sessions

Day	AM	PM
Monday	Specialist Clinic (weekly) Thorndale Unit	Outpatient clinic – CAH (weeks 1 & 3) SPA – CAH (weeks (2 & 4)
Tuesday	SPA (Week 1) Day Surgery (Weeks 2&4) – STH Day Surgery – (week 3) - CAH	Admin (week 1&3) Outpatients (weeks 2 & 4) – South Tyrone Hospital
Wednesday	Specialist Clinic (Weeks 1,2,&3) Thorndale Unit Free (Week 4)	Prostate one-stop clinic – weekly
Thursday	8.30 – 9.30 Radiology Meeting 9.30 – 12.00 Grand Ward Round 12.00 – 1.30 Departmental Meeting	MDT (Weekly)
Friday	Main Theatres – CAH (weekly)	Main Theatres – CAH (weekly)

Mr Young – Core Sessions

Day	AM	PM
Monday	Day Surgery – STH - week One SPA – week 2 Outpatients – Banbridge - week 3 Admin – week 4	Stone Treatment Clinic – CAH – (weeks, 1,2,4,5) Admin – week 3
Tuesday	Main Theatres – CAH (weekly)	Main Theatres – CAH (weekly)
Wednesday	Stone Treatment Daycases – CAH – weekly	OFF
Thursday	8.30 – 9.30 Radiology Meeting 9.30 – 12.00 Grand Ward Round 12.00 – 1.30 Departmental Meeting	MDT (Weekly)
Friday	Specialist Clinic (Day 4 & Urodynamics) Thorndale Unit	Outpatient Clinic – CAH (weekly)

Proposed Urology Job Plans - 5 Consultant Model

v0.4 Jan 12

	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
	AM	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**
MY	OPD - Banbridge 2/month 2,4 OPD CAH 1. 3, 5	Stone Treatment Clinic 2/month 1, 3, 5 Emergency Urologist 2:4	Theatre CAH 8am - 12pm 2/month 1, 3 & 5	Theatre CAH 12pm - 7pm 2/month 2 & 4	Stone Treatment DCs 2/month	Free	DSU STH 1, 3, 5	MDT	OPD CAH 2/month 1 & 3, 5	Theatre CAH 1, 3, 5 Emergency Urologist 2/month
AOB	Day Surgery Enniskillen 1/month OPD ACH 1/month	OPD Enniskillen 1/month	DSU CAH 2/month	OPD CAH weekly	Theatre CAH 8am - 12pm 2/month 1, 3 & 5	Theatre CAH 12pm - 7pm 2/month 2 & 4	DSU STH 2, 4	Emergency Urologist 4:4 weeks	OPD CAH 2, 4	
MA		OPD CAH /month 1 & 3, 5 Emergency Urologist 2:4 weeks	DSU STH 2/month	OPD STH 2/month	OPD CAH 2,4	Prostate Biopsy 2/month 1, 3, 5 Emergency Urologist 2:4 weeks		MDT	Theatre CAH weekly	Theatre CAH weekly
Cons 4	Day Surgery Enniskillen 1/month OPD CAH 1/month	OPD Enniskillen 1/month	Theatre CAH 8am - 12pm 2/month 2 & 4	Theatre CAH 12pm - 7pm 2/month 1, 3 & 5 Emergency Urologist 2:4		Prostate Biopsy 2/month Emergency Urologist 2:4 weeks	OPC CAH 1, 3, 5	MDT	DSU DHH 2/months	OPD DHH 2 & 4
Cons 5	OPD ACH 1/month week 2	Stone Treatment Clinic 2/month 2 & 4	DSU CAH 2/month	Emergency Urologist 2/month	Theatre CAH 8am - 12pm 2/month 2 & 4	Theatre CAH 12pm - 7pm 2/month 1 & 3	Stone Treatment DCs 1, 3, 5	OPD CAH weekly	Flexible Cystoscopies	Theatre CAH 2 & 4 Emergency Urologist 2/month

Printed on: 01/07/2022

CONSULTANT THREE (with Specialist interest in Oncology)

DAY	AM	PM
Monday	**(Sessions are 9am-1pm)** **DSU – Erne Hospital (week 4)** **OPD – ACH (Week 2)** **SPA – CAH (Weeks 1,3,5)**	**(Sessions are 2pm – 5pm)** **OPD – Erne Hospital (Week 4)** **Admin – CAH (1,2,3,5)**
Tuesday	**8am-12pm - Theatre – CAH (weeks 2 & 4)**	**12pm – 7pm Theatres CAH (weeks 1,3,5)** **1pm – 5pm Emergency Urologist (weeks 2 & 4)**
Wednesday	**SPA (9am-1pm) – weekly**	**2pm–5pm Prostrate Biopsy (weeks 2&4)** **1pm–5pm Emergency Urologist (weeks 1,3, &5)**
Thursday	**9am-1pm – OPD – CAH (Weeks 1,3,&5)**	**2pm – 5pm – MDT Weekly**
Friday	**9am – 1pm Theatres – DHH (week 2 & 4)** **Admin – CAH (weeks 1,3,5)**	**2pm – 5pm OPD – DHH (2 &4)**

1 PA for oncall and 1 PA for Ward Rounds

CONSULTANT 4 – WITH AN INTEREST IN ONCOLOGY

DAY	AM	PM
Monday	**9am–5pm – Admin (weekly)**	**2pm-5pm OPD CAH (weeks 1, 3 & 5)** **1pm-5pm Emergency Urologist (2 & 4)**
Tuesday	**9am–5pm – DSU – STH (weeks 2 & 4)**	**2pm–5pm – OPD – STH (weeks 2 & 4)**
Wednesday	**9am-5pm – OPD – CAH (weeks 2 & 4)** **9am-5pm – SPA – CAH (weeks 1, 3 & 5)**	**2pm-5pm - Prostate Biopsy (weeks 1,3 & 5)** **1pm-5pm – Emergency Urologist (weeks 2 & 4)**
Thursday	**9am-1pm – SPA – Weekly**	**MDT (weekly)**
Friday	**9am-1pm – Theatres – CAH**	**1:30pm-5:30pm Theatre – CAH**

1 PA for oncall and 1 PA for Ward Rounds

CONSULTANT 5 – WITH AN INTEREST IN STONES

DAY	AM	PM
Monday	**9am-1pm OPD – CAH (weeks 2 &4)** **9am-1pm SPA – CAH (weeks 1&3**	**2pm-5pm - Stone Treatment Clinic – CAH (weeks 2 & 4)** **2pm-5pm – Admin – CAH (weeks 1,3,&5)**
Tuesday	**9am-1pm DSU – CAH (weeks 1,3 & 5)** **9am-1pm Admin – CAH (weeks 2&4)**	**1pm-5pm - Emergency Urologist (weeks 1,3, &5)** **SPA – CAH (weeks 2 & 4)**
Wednesday	**8am-12pm – Theatres – CAH – weeks 2 & 4**	**12pm-7pm – Theatres – CAH – (weeks 1, 3 & 5)** **SPA – CAH weeks 2 & 4**
Thursday	**9am-1pm – Stone Treatment D/Cs (weeks 1,3, & 5)**	**2pm-5pm – OPD – CAH – weekly**
Friday		**1:30-5:30pm – Theatre – CAH (weeks 2 & 4)** **1pm-5pm –Emergency Urologist (week 1,3 &5)**

1 PA for oncall and 1 PA for Ward Rounds

Corrigan, Martina

From: Morton, Jacqueline T < [redacted]
Sent: 16 March 2010 08:53
To: Corrigan, Martina
Subject: FW: Urology Team Operational Job Plan
Attachments: urology job plans (2) 9 Mar 2010.doc

Draft FYI
Jacqueline

From: Clegg, Malcolm
Sent: 09 March 2010 16:06
To: Morton, Jacqueline T; Burns, Deborah
Cc: Chambers, Rachel
Subject: RE: Urology Team Operational Job Plan

Jacqueline,

I have 'factored in' the travel PAs based on the following;

1 journey per week to Enniskillen = 3 hours = 0.75 PA per week
1 journey per week to DHH = 80 minutes = 0.33 PA
1 journey per week to STH = 1 hour = 0.25 PA

Mr Young's SPA allocation based over 4 weeks is 1.875 PAs (6 hours per week x 5 = 30 hours) (30 hours over 4 weeks = 1.875 PAs).

As discussed earlier, morning ward round allocation might need to be amended on days when consultants travel to other sites.

If you require any thing else just let me know.

Regards

Malcolm

From: Morton, Jacqueline T
Sent: 09 March 2010 10:02
To: Burns, Deborah; Clegg, Malcolm
Cc: Chambers, Rachel
Subject: Urology Team Operational Job Plan

Debbie attached is a copy of the proposed roister for the Urology Team. I have included a summary table and notes detailing out any assumptions.

I have spoken to Malcolm and asked if he could look at a couple of queries in relation to
- Travel PA's allocated for each of the off site clinics,
- Mr Young's SPA allocation spread over 4/5 weeks.

Jacqueline

Jacqueline Morton

Head of Reform

Directorate of Performance & Reform

Southern Health & Social Care Trust

The Rowans Craigavon Area Hospital

68 Lurgan Road Portadown BT63 5QQ

Direct Dial: Personal Information redacted by USI, Personal information

Mobile: Personal information redacted by USI

Email: Personal Information redacted by USI, Personal information redacted by USI

Week One

SURGEON OF THE WEEK – MR YOUNG					
Day/Session	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
AM	Ward Round	Ward Round	Ward Round	Ward Round	Ward Round
	Day Case list	Inpatient List	Stone Treatment Centre	Outpatient Clinic	Daycase List
PM	Surgeon of The Week	Surgeon of The Week	Surgeon of The Week	Surgeon of The Week	Surgeon of The Week
	Discharge	Discharge	Discharge	Discharge	Discharge
	Administration	Administration	Administration	Administration	Administration

Direct Clinical Care	10.6
Predictable On call	0.35
Unpredictable On call	0.5
Travel	0
SpA	1.875
Total Programmed Activities	**13.33**

Table One

ENNISKILLEN – MR 0'BRIEN					
Day/Session	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
AM	Ward Round	Ward Round	Ward Round	Ward Round	Ward Round
	Administration	Day Case list	Inpatient List	Grand Ward Round SPA – X-ray SPA	SPA
PM		Outpatient Clinic	Inpatient List	Multidisciplinary Team Meeting	

Direct Clinical Care	7.1
Predictable On call	0.35
Unpredictable On call	0.5
Travel	0.75
SpA	1.5
Total Programmed Activities	**10.2**

Table Two

DAISY HILL – MR MAHMOOD AKTAR					
Day/Session	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
AM	Ward Round	Ward Round	Ward Round	Ward Round	Ward Round
			Daycase List	Grand Ward Round SPA – X-ray SPA	Inpatient List
PM	Administration	SPA	Outpatient Clinic	Multidisciplinary Team Meeting	Inpatient List

Direct Clinical Care	7.1
Predictable On call	0.35
Unpredictable On call	0.5
Travel	0.33
SpA	1.5
Total Programmed Activities	**9.78**

Table Two

SOUTH TYRONE – NEW CONSULTANT					
Day/Session	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
AM	Ward Round	Ward Round	Ward Round	Ward Round	Ward Round
	Inpatient List	Daycase List	Administration	Grand Ward Round SPA – X-ray SPA	SPA
PM	Inpatient List	Outpatient Clinic		Multidisciplinary Team Meeting	

Direct Clinical Care	7.1
Predictable On call	0.35
Unpredictable On call	0.5
Travel	0.25
SpA	1.5
Total Programmed Activities	**9.7**

Table Four

CRAIGAVON – NEW CONSULTANT					
Day/Session	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
AM	Ward Round	Ward Round	Ward Round	Ward Round	Ward Round
	Speciality Clinic	Inpatient List	Administration	Grand Ward Round SPA – X-ray SPA	Daycase List
PM		Inpatient List	SPA		Outpatient Clinic

Direct Clinical Care	7.1
Predictable On call	0.35
Unpredictable On call	0.5
Travel	0
SpA	1.5
Total Programmed Activities	**9.45**

Table Five

Notes

1. **On Call Allocation**
   - Predictable On call = 0.35 PA
   - Unpredictable On call = 0.5 PA
2. **Daily Morning Ward Round Allocation**
   - 0.6 PA per week
3. **Grand Ward Rounds**
   - 0.5 PA per week
4. **Surgeon of the week**
   - The Surgeon of the Week will provide an additional Outpatient Clinic and Daycase list to meet the weekly demand from the off site clinics that cannot be backfilled in the absence of the consultant due to annual / study leave.
   - When Mr Young is roistered to Surgeon of the Week (1/5) his Stone Clinic will be reduced to 1 only per week.
   - When Mr Young is roistered to Surgeon of The Week (1/5) his SPA programmed activity cannot be scheduled due to his clinical commitments and it is proposed that this be scheduled pro rata to his other 4 roistered weeks.
5. **Additional Roles and Responsibilities**
   - The weekly operational plans currently does not include any additional roles and responsibilities undertaken by clinicians and supported by the Trust.
6. **Stone Clinic**
   - When Mr Young is not Surgeon of the Week his weekly job plan will be adjusted to include 2 Stone Clinics.

Southern Health and Social Care Trust

Quality Care - for you, with you

Job Planning Meeting
Urology
6th March 2013
Heather's Office

Present: **Robin, Ajay, Michael, Heather Trouton, Martina Corrigan**

Ref	Issue	Discussion	Owner/Date
		Activity Based on 41 weeks	
		Clarily Clinics = 4hours 9am-1pm 1.30pm-5.30pm	Connie
		Query DHH Rooms	Robin/Connie
		Erne 10 new	
		Urodynamics x 2 + 4 day 4's	Ajay and Michael
		Look at figures – 9 in DHH – Flexis	
		Flexis to DHH - change coding of Paul Hughes to Urology	
		15 – 20 minutes (Lean Paperwork) Turnaround time	Ursula and Mary Mc Geough
		Haematuria x 2 echo in DHH	

Ref	Issue	Discussion	Owner/Date
		Emergency sessions in morning Flexible Urology assessment unit in the new unit Query virtual clinics – activity to be captured Ward Round – take out 'grand' 2 hours – Spa 2 hours – clinical activity * MOM for stones and urodynamics STC's on Thursdays Aidan protected time after MOM x 1 hour per week Nurse led – new with procedures Doctor as new = 20 minutes Urodynamics – need to sort proforma Marilyn Friday PM Room x 1 for doc * Finish @ 7pm in theatres Locum Post ??	Martina Corrigan AOB
		ASSUMPTIONS ON WHAT NEEDS TO BE INCLUDED IN CLINICS IN ORDER TO DELIVER THE AGREED ACTIVITY Stone Treatment clinics will be setup to see 6 New and 11 Review – there will be 1.5 clinics per week Outreach (SWAH/STH/DHH/BAN/ARM) will be set up to see 5 New and 7 Review - there will be 2 outreach clinics per week General at CAH will be set up to see 6 New and 8 Review which will mean PM clinic starting at 1:30pm - there will be 3 general clinic per week. Oncology will be set up to see 3 red Flag and 4 Protective Review and 4 uro-oncology review – there will be 3.75 of these per week D4 Clinics will be set up to see 4 patients (protective review) – there will be 1 of these per week Prostate D1 will be set up to see 8 red flags and 2 News and there will be 1 of these per week	

Ref	Issue	Discussion	Owner/Date
		Inpatients – it is assumed that there will be 3 on a four hour session Daycases – we have agreed 10 flexible cystoscopies on a list and 5 patients on a daycase list.	

Ref	Issue	Discussion	Owner/Date

Ref	Issue	Discussion	Owner/Date

Corrigan, Martina

From: Doherty, PaulD [Personal Information redacted by USI]
Sent: 22 August 2012 08:48
To: Corrigan, Martina
Subject: RE: Team South

Hi Martina

Sorry only getting back to you now - unfortunately it has not been possible to secure a date prior to 26th September so can I suggest we run with this and make all efforts to ensure this progresses.

If is a visit required to SWAH can you ensure that you liaise with me in relation to any visit and I will make arrangements for this to happen and walk SWAH with you along with the AD S&A.

I will respond with venue and time.

Regards

-----Original Message-----
From: Corrigan, Martina [Personal information redacted by USI]
Sent: 17 August 2012 09:38
To: Doherty, PaulD
Subject: RE: Team South

Paul

Sorry but the 29 August no longer suits Mr Young. I know you had given an alternative date of 26 September but this is quite a bit away and we were wondering if there would be anything sooner? If not I plan to on Mr Young's request to set up a meeting in the SWAH with Mr Ghareeb, General Surgeon, as Mr Young is keen to revisit our original discussions with Mr Ghareeb in preparation for November when we will have all five consultants in place and we will be expected to commence the service for the Fermanagh population.

Can you let me know if you can get a date sooner or if not we will go with the September date with the proviso that we may visit SWAH in advance of this as we are keen to see what facilities are available.

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Southern Health and Social Care Trust

Telephone: [Personal Information redacted by USI] (Direct Dial)
Mobile: [Personal Information redacted by USI]
Email: [Personal Information redacted by USI, Personal information redacted by USI]

-----Original Message-----
From: Doherty, PaulD [mailto:[Personal Information redacted by USI, Personal information redacted by USI]
Sent: 13 August 2012 09:55
To: Corrigan, Martina
Subject: RE: Team South

Sorry Martina

The meeting if confirmed will probably have to be in Omagh as we have project board in the afternoon at 2.00 pm in Causeway. Please advise?

Paul

From: Corrigan, Martina [Personal information redacted by USI
Sent: 10 August 2012 13:11
To: Doherty, PaulD
Subject: RE: Team South
Importance: High

Restricted attachments were identified and removed from this message.
These attachments will be released upon request as long as size restrictions are met and the integrity of the network is not compromised.
Please note: IT staff will not release Joke/Funny Picture or any form of chain email into the WHSCT email system.
If this is to be released please forward this email to E Personal information redacted by USI

Sent by Martina.Corrigan@Personal information redacted by USI

Attachment name image002.gif

Email Subject RE: Team South

Hi Paul

Apologies I am only responding to your email... it used to be that July and August were quiet months but not anymore!

I have spoken with Michael Young, our Clinical Lead and he would prefer if the meeting was in August so he has agreed tor 29th August commencing at 10:30am. Since the Urologists will be based in SWAH Michael is keen that the meeting will take place here in Enniskillen instead of Omagh so I would be grateful if you could organise this.

Regarding the TROC we really don't have anything written down except the pathway that I have attached which is still in draft.

You can let me know if this date and time suits

Many thanks

Martina

Martina Corrigan

Head of ENT and Urology

Southern Health and Social Care Trust

Telephone: Personal information redacted by USI

Mobile: Personal Information redacted by USI, Personal

Email: Personal Information redacted by USI

From: Doherty, PaulD [mailto Personal Information redacted by USI, Personal information redacted by USI
Sent: 20 July 2012 12:49
To: Corrigan, Martina
Subject: Team South

Hi Martina

Now that SWAH is operational I wanted to perhaps start planning the meeting we were hoping to have in June in relation to pathways and the way forward in relation to Lower Third Fermanagh and the work we need to do with consultation with GP's etc... I know we are now into Qtr performance but if we could organise another meeting.

Paul Downey is the clinical lead for Team Northwest and is available only on a Wednesday for meetings - can you check availability for the following:

29th August 2012

26th September 2012

We could meet in Omagh perhaps.

Could you also send me, confidentially, if you would any documentation you have on your Trial and Removal of Catheter service / clinic i.e. pathways & operational policy etc... I am scoping the possibility of proposing a change in our practice but is at a very early stage.

Thanks

P/aul Doherty

/Project Manager Team Northwest Urology

Ward 5 Altnagelvin

Ext Personal Information

Mobile: Personal Information redacted by USI,

Email: Personal information redacted by USI

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Southern Health & Social Care Trust IT Department [redacted]

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Corrigan, Martina

From: Dan McLaughlin - Medical Imaging [redacted]
Sent: 22 June 2010 13:58
To: Houston, Cathy
Cc: Corrigan, Martina
Subject: RE: Steering Group Meeting
Attachments: UROLOGY - WL's by Short Postcode.xls

This e-mail is covered by the disclaimer found at the end of the message.

Thanks Cathy. Really appreciate your help

Dan

Hi Martina please see attached.

In relation to the docs you sent this am I will review them and respond to you asap.

If you need any more info please get in touch.
I am still trying to get answers to your other queries

Dan

-----Original Message-----
From: Cathy Houston - Business Services
Sent: 21 June 2010 16:12
To: Dan McLaughlin - Medical Imaging
Subject: RE: Steering Group Meeting

Dan

We have looked at the Total Urology Waiting lists as at 31 May 10 by Short Postcode. I wasn't sure of all the areas that would apply to this exercise so see attached.

- Total Urology OP waiting list by Short Postcode Area
- Total IP & DC Urology waiting list (broken down by active, planned & suspended) by Short Postcode Area

If you need to know the numbers waiting greater than 9 or 13 weeks please let me know.

Regards

Cathy

-----Original Message-----
From: Dan McLaughlin - Medical Imaging
Sent: 18 June 2010 09:19
To: Cathy Houston - Business Services
Subject: FW: Steering Group Meeting

Hi Cathy please see attached.

May I ask if you could look at the info request re ins out and days for patients with Fermanagh addresses. Would you be able to pull this info together and forward to Martina please?

Thanks

Dan
-----Original Message-----
From: Corrigan, Martina [redacted]
Sent: 14 June 2010 08:02
To: McLaughlin, Dan2
Subject: Steering Group Meeting

Hi Dan,

Further to our conversation on Thursday morning and the subsequent steering group meeting, I have been asked to follow-up with a few things with you:

* We need the name and details of the GP representative from the 'southern sector' of the Western Board so that we can forward information through to them.
* We need a contact for a focus group link so that we can link in with User Groups.
* We need a definitive date for the Urologists to go to the Erne so that we can fit this into their job plans. I know that we had mentioned Tuesday's with Marie Therese when we visited the Erne and if this is the day there is no problem with that it is just that we need it confirmed as we want to ensure that it will not change.
* Finally, I need the information on waiting times for Fermanagh patients for outs/ins and days so that we can apportion the funding from the slippage.

Many thanks and happy to discuss.

Kind regards

Martina

Martina Corrigan

Head of ENT and Urology

Southern Health and Social Care Trust

Craigavon Area Hospital

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Mobile: Personal Information redacted by USI, Personal

Email: Personal Information redacted by USI, Personal information redacted by USI

Western Health and Social Care Trust

Urology

Waiting Lists by Short Postcode

As at 31 May 2010

BT Area Code	BT Area Description	OUTPATIENTS	INPATIENTS AND DAY CASES					
		Number of patients waiting	ACTIVE WL (excluding Planned)		PLANNED WL		CURRENT SUSPENSIONS (including Planned)	
			Inpatients	Day Cases	Inpatients	Day Cases	Inpatients	Day Cases
BT30	Downpatrick	-	1	-	-	-	-	-
BT45	Magherafelt	7	-	1	-	4	-	-
BT46	Maghera	2	-	-	-	-	-	1
BT51	Coleraine	3	-	1	-	2	-	-
BT47 & 48	Derry	214	50	113	-	118	-	-
BT49	Limavady	40	10	28	-	27	-	-
BT82	Strabane	32	15	31	-	32	-	-
BT81	Castlederg	11	1	10	-	8	-	1
BT78 & 79	Omagh	55	18	47	-	35	-	13
BT74 & BT92 - 94	Enniskillen	40	25	36	1	59	-	30
BT69	Aughnacloy	-	-	-	-	1	-	-
BT70	Dungannon	-	-	-	-	1	-	1
BT75	Fivemiletown	2	1	1	-	2	-	-
BT76	Clogher	-	-	-	-	1	-	-
Not recorded		3	1	4	-	1	-	1
Total Waiting		**409**	**122**	**272**	**1**	**291**	**0**	**47**

Corrigan, Martina

From: Dan McLaughlin - Medical Imaging [redacted]
Sent: 23 June 2010 11:30
To: Corrigan, Martina
Subject: RE: ****URGENT FOR RESPONSE****Team South Implementation Plan

This e-mail is covered by the disclaimer found at the end of the message.

Hi Martina thanks for these.

I don't have anything to add to them but recognise the hard work you must have put in!
Section 5. The proposed Service Model identifies a number of areas to be agreed with the western trust and I would like to be assured that the surgical team in the Erne is kept fully involved in these discussions. I appreciate the timetable is tight but am confident that the good start we have made with the process will continue and we will get the service up and running as promptly as possible

Thanks again for you hard efforts.

Regards

I have forwarded the docs to Mr Ghareeb to Mr Ghareeb to keep him in the fully informed.

Dan

-----Original Message-----
From: Corrigan, Martina [mailto:[redacted]
Sent: 21 June 2010 21:38
To: McLaughlin, Dan2
Subject: Fw: ****URGENT FOR RESPONSE****Team South Implementation Plan
Importance: High

Hi Dan

Please see attached for your comments-i need these for Wednesday lunchtime.

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Tel: [redacted]
Mob: [redacted]

----- Original Message -----
From: Corrigan, Martina
To: Young, Michael Mr; Michael Young [redacted]; [redacted] O'Brien, Aidan; Akhtar, Mehmood; Mackle, Mr E; O'Neill, Kate; McMahon, Jenny; Clarke, Paula; Carroll, Ronan; Walker, Helen
Cc: Rankin, Gillian; Trouton, Heather; Waddell, Sandra; Dignam, Paulette; McCorry, Monica; Wortley, Heather
Sent: Mon Jun 21 19:32:01 2010
Subject: ****URGENT FOR RESPONSE****Team South Implementation Plan

Dear all,

Further to our previous meetings, discussions and agreements regarding the Urology Review, please find attached a copy of the Team South Implementation Plan along with most of the appendices ((1,3 and 4 will be forwarded tomorrow). We now need to have this document with Beth Molloy by Wednesday (23rd) afternoon therefore I would be grateful if you could have any comments back to me by Wednesday lunchtime.

Many thanks for your work to date in helping to put this together.

Kind regards

Martina

Martina Corrigan

Head of ENT and Urology

Southern Health and Social Care Trust

Craigavon Area Hospital

Tel: Personal Information redacted by USI

Mobile: Personal Information redacted by USI

Email: Personal Information redacted by USI

Southern Health & Social Care Trust IT Department [redacted])

Corrigan, Martina

From: Doherty Paul D [redacted]
Sent: 13 February 2013 09:25
To: mcaleer brian [redacted]
Cc: Corrigan, Martina
Subject: OP Referral Pathway
Attachments: image001.gif; Team South referral Pathway feb 2013.xlsx

This e-mail is covered by the disclaimer found at the end of the message.

Brian

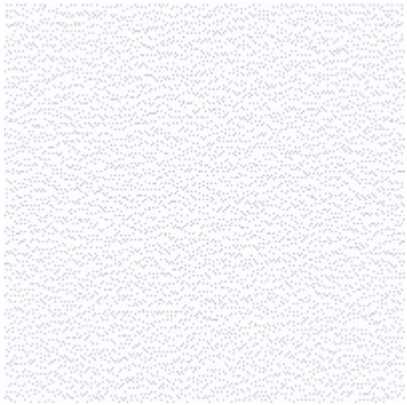
I met with Team South on Monday past and have amended the pathway as a consequence of GP concerns, please see attached which can now be disseminated to the Fermanagh GP's.

However, in your communication it is imperative if this system is to work effectively that GP's clearly indicate RED FLAGS on the referral letters and cannot assume the referrals citing FRANK HAEMATURIA is sufficient to indicate a RED FLAG. As there are different pathways to comply with the needs of Cancer Services the distinction is imperative as stated.

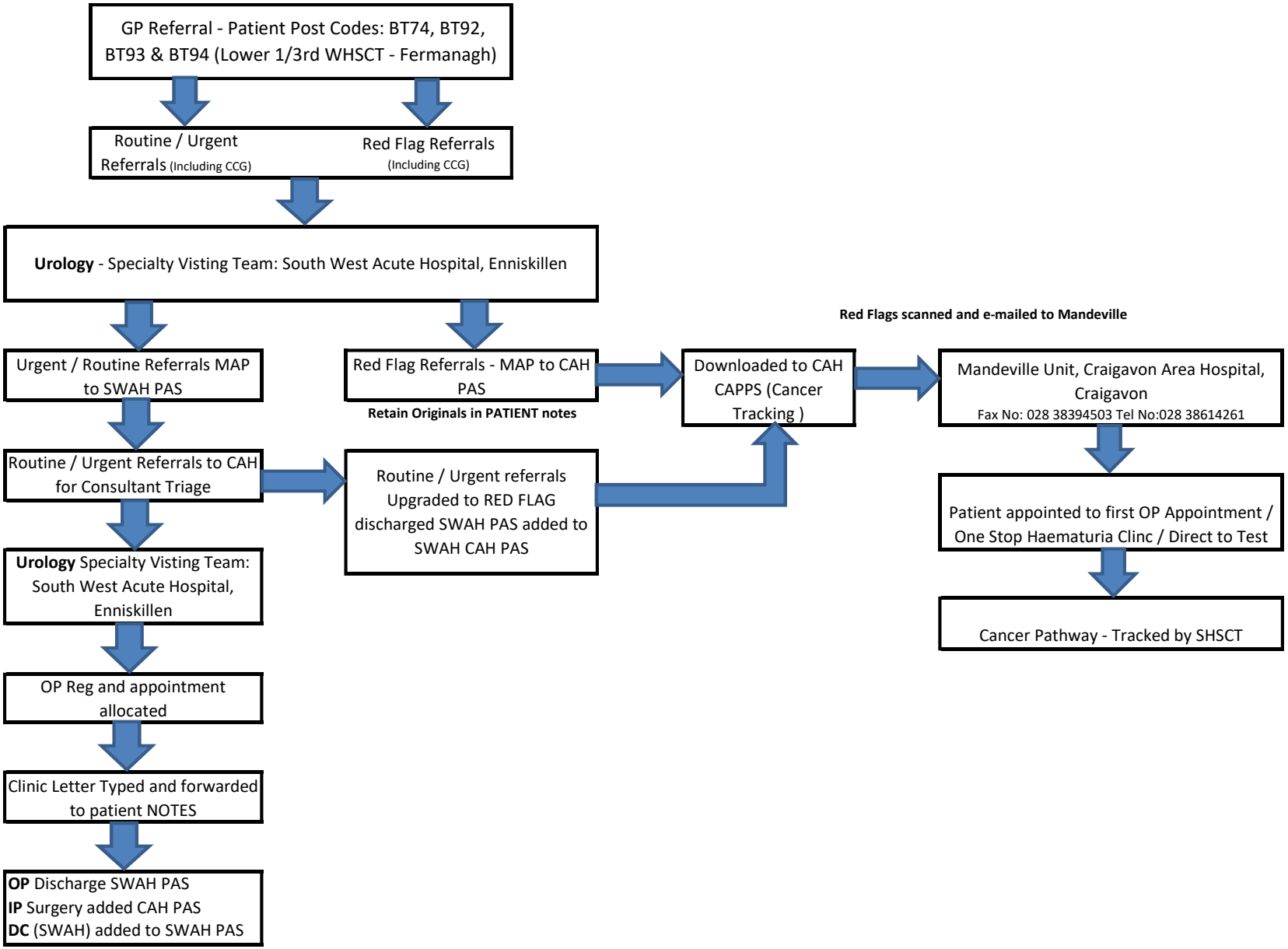
If you need to discuss further please contact me.

Thanks

Paul Doherty
Project Manager Team Northwest Urology
Ward 5 Altnagelvin
Ext [redacted]
Mobile: [redacted]
Email: [redacted]

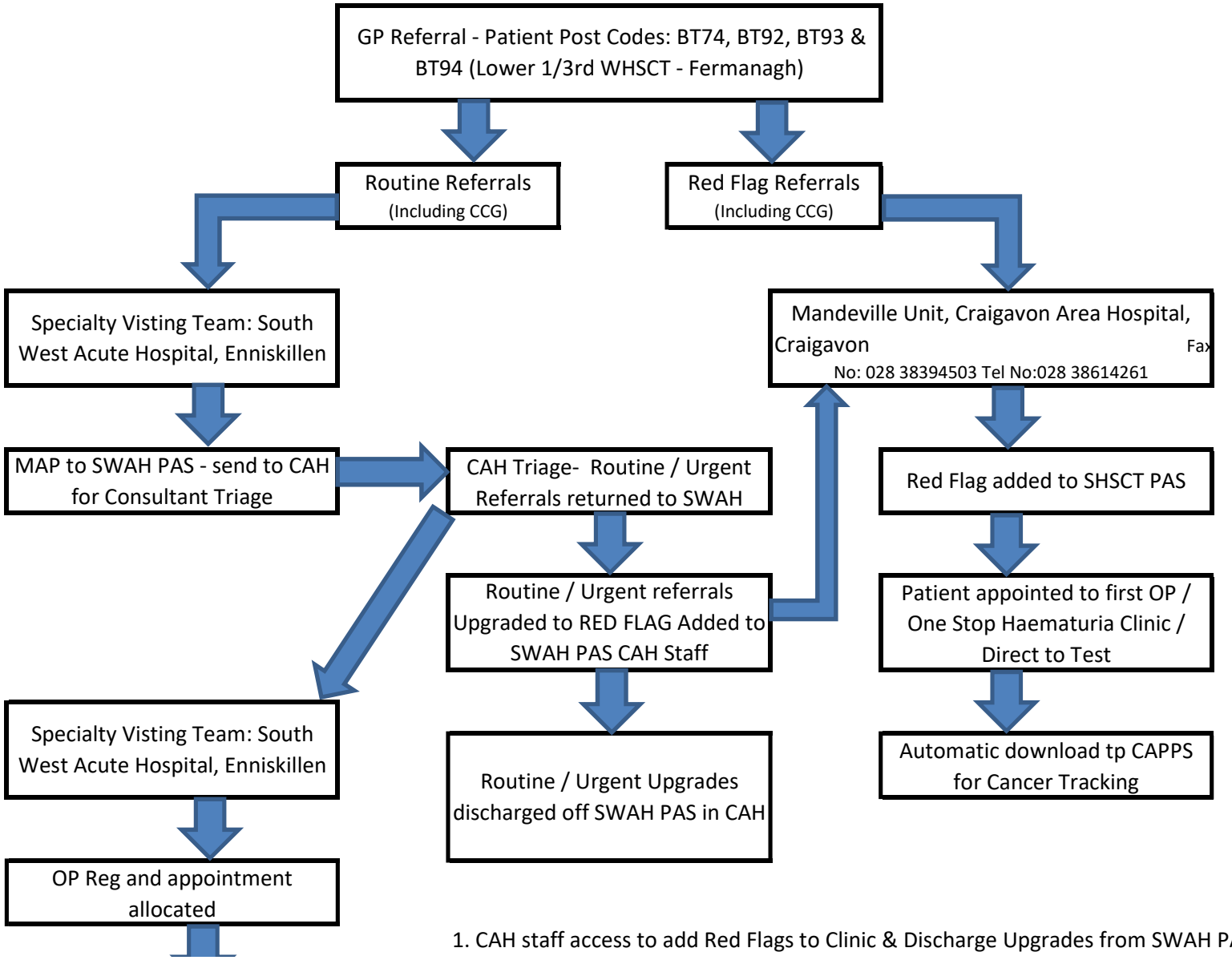


GP Referral Pathway Urology Patients (Fermanagh) Team South

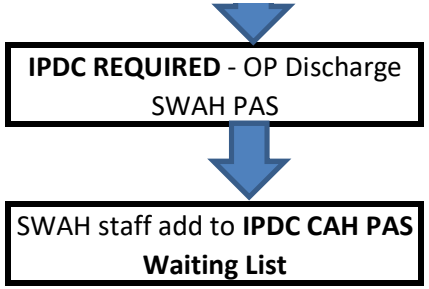


Fermanagh Patients Referral Pathway Team South February 2013

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.



1. CAH staff access to add Red Flags to Clinic & Discharge Upgrades from SWAH PAS



2. SWAH secretarry access to IPDC CAH PAS

letters to be signed?

Corrigan, Martina

From: Doherty Paul D <[redacted]>
Sent: 14 May 2013 12:10
To: Phelan Karen - Nursing Services Manager; Corrigan, Martina
Subject: RE: CCG Request for Urology

This e-mail is covered by the disclaimer found at the end of the message.

Karen

I think we should change the pathway to include CCG referrals are sent to CAH by GP's to make the process more succinct and keep, if possible, the re-direct also to forward any mis-directed by GP's

p

From: Phelan Karen - Nursing Services Manager
Sent: 14 May 2013 11:43
To: [redacted]; Doherty Paul D
Subject: RE: CCG Request for Urology

Martina & Paul,

As the new pathway states that the CCG referrals will be redirected, will I ask Emma to set up urology and do the redirect?

Or do you think we should change the pathway to include CCG urology referrals are sent to CAH by GPs?

Karen

From: Emma Bamber [redacted]
Sent: 14 May 2013 10:16
To: Phelan Karen - Nursing Services Manager
Cc: Roger McCully; Jeff Grant; Gallagher Louise - System Administrator; martina.corrigan[redacted]
Doherty Paul D
Subject: RE: CCG Request for Urology

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Hi Karen,

I have been looking at CCG in preparation for making the Urology re-direct functionality available from 1st June.

The request that I have received is for referrals sent to Western Trust South West Acute Hospital Urology to be re-directed through CCG to the relevant Southern Trust departments, but when I have checked this there is no Urology speciality currently set up at SWAH on CCG.

Kind Regards,
Emma

From: Phelan Karen - Nursing Services Manager [redacted]
Sent: 01 May 2013 13:50
To: Emma Bamber

Cc: Gallagher Louise - System Administrator; [redacted]; Doherty Paul D
Subject: RE: CCG Request for Urology

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Emma,

That's great – thank you.

Karen

From: Gallagher Louise - System Administrator
Sent: 01 May 2013 09:40
To: Phelan Karen - Nursing Services Manager
Cc: Emma Bamber; OConnor Frances - Surgical Division Secretary
Subject: FW: CCG Request for Urology

Hi Karen,

Can you confirm with Emma, the suggested implementation below.

Many Thanks

Louise Gallagher
Systems Administrator
Patient Access Projects

Tel. [redacted] Ext. [redacted]
Email. [redacted]
_____
Western Health and Social Care Trust,
Administration Building, Altnagelvin Area Hospital, Glenshane Road, Londonderry, BT47 6SB

From: Emma Bambe [redacted]
Sent: 01 May 2013 09:32
To: Gallagher Louise - System Administrator
Subject: FW: CCG Request for Urology

"This email is covered by the disclaimer found at the end of the message."

Hi Louise,

I contacted Helen Forde at SHSCT to ensure that appointments staff would be expecting to receive the re-directed Urology referrals from WHSCT. She has confirmed that this is not due to start happening until 1st June 2013 – please see below.

I'll set the re-direct up and make it active from 1st June.

Kind Regards,
Emma

From: Forde, Helen [mailto: [redacted]
Sent: 01 May 2013 09:27
To: Emma Bamber

Cc: Corrigan, Martina
Subject: RE: CCG Request for Urology

Emma – I've been speaking to Martina Corrigan who is our Head of Service for Urology and this service will be transferring to the SHSCT, but not until the 1st June 2013. So they can be re-directed but not until 1st June.

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : Personal Information redacted by USI
Mobile Personal Information redacted by USI

From: Emma Bamber [mailto: Personal Information redacted by USI
Sent: 29 April 2013 10:03
To: Forde, Helen
Subject: FW: CCG Request for Urology

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Hi Helen,

I have received a request from staff in Western Trust, please see below for info. I just want to check that this has been agreed at your side and that referrals should be re-directed to Craigavon as requested?

Kind Regards,
Emma

From: Gallagher Louise - System Administrator [mailto: Personal Information redacted by USI
Sent: 29 April 2013 08:52
To: Emma Bamber
Cc: Phelan Karen - Nursing Services Manager
Subject: RE: CCG Request for Urology

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Hi Emma,

Does the email have the information you need?
If not I've copied Karen Phelan who requested the change.

Regards

Louise Gallagher
Systems Administrator
Patient Access Projects

Tel. (Personal Information redacted by USI Ext. Personal Information redacted by USI
Email. Personal Information redacted by USI

_____

Western Health and Social Care Trust,
Administration Building, Altnagelvin Area Hospital, Glenshane Road, Londonderry, BT47 6SB

From: Phelan Karen - Nursing Services Manager

Sent: 24 April 2013 14:59
To: Gallagher Louise - System Administrator
Subject: CCG redirect

Hi Louise,

Are you still looking after CCG?

A change has happened with the urology service whereby urology referrals from Fermanagh which would be going into SWAH need to be sent onto Craigavon as the Southern Trust Urologist are now providing the service for this patient group.

I know the southern trust send all their red flags to the Mandeville unit, so I'm not sure if the urology red flags can be directed there and then the routine and urgent referrals to their central referrals office.

Can you check with the regional team (or maybe you can do it?) if this can be done, please?

Thanks,

Karen

From: Emma Bamber [mailto: Personal Information redacted by USI
Sent: 25 April 2013 09:53
To: Gallagher Louise - System Administrator
Subject: CCG Request for Urology

"This email is covered by the disclaimer found at the end of the message."

Hi Louise,

Please see request below. I can set up the re-direct, but need more info on which hospital/spec the Urology referrals from SWAH need to be re-directed to in the Southern Trust.

Kind Regards,
Emma

From: ServiceDesk@ Personal Information redacted by the USI
Sent: 24 April 2013 16:25
To: Emma Bamber
Subject: infraEnterprise Call : Irrelevant redacted by the USI : DB : Portal : Call Reminder

Email From infraEnterprise
Database Portal
Owner Bamber, Emma
Call Status In Progress
Event Call Reminder

Call No Irrelevant redacted by the USI
Customer Gallagher, Louise
Telephone Personal Information redacted by USI
Organization Western Trust
Forwarded At 24/04/2013 16:24
Priority Medium

Config Item UNKNOWN
Service GMS ICT
Type Request for Admin.
Updated By System

Description
Hi,

Please see request below as discussed.
Can referrals for Western Trust South West Acute Hospital Urology be re-directed through CCG to the relevant Southern Trust departments?

Many Thanks & Regards
Louise Gallagher

Actions & Solutions
[Call Deferred : In Progress]
[In Progress]
[Reminder Set to 24/04/2013 16:24]
have tried to call Louise to find out who/where these referrals need re-directed to. Haven't received any other info about this yet.

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Corrigan, Martina

From: Doherty Paul D [redacted]
Sent: 16 September 2013 16:02
To: Corrigan, Martina; Dougan Sorcha
Subject: Re: Monday clinics SWAH

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That's grand with me

P

----- Original Message -----
From: Corrigan, Martina [redacted]
Sent: Monday, September 16, 2013 03:56 PM
To: Dougan Sorcha; Doherty Paul D
Subject: RE: Monday clinics SWAH

Thanks Sorcha

We can confirm once we hear back from Paul

Regards

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

-----Original Message-----
From: Dougan Sorcha [mailto: [redacted]
Sent: 16 September 2013 15:53
To: Corrigan, Martina; Doherty Paul D
Subject: RE: Monday clinics SWAH

This e-mail is covered by the disclaimer found at the end of the message.

Martina

Wednesday 25th at 2.00pm suits me.

S

Sorcha Dougan
Patient Access Manager
Admin Building
Altnagelvin Hospital
Derry
BT47 6SB

Tel: [redacted] ext [redacted]

-----Original Message-----
From: Corrigan, Martina [mailto: [redacted]
Sent: 16 September 2013 15:43

To: Doherty Paul D; Dougan Sorcha
Subject: RE: Monday clinics SWAH

Dear both,

My apologies but I will no longer be able to make it on Thursday to meet as I have to meet with my consultants to finish a paper for the Board and this is the only time that they are all available to meet with me.

I can do any of the dates and times below in Altnagelvin and you can let me know if any suits and again apologies:

Tuesday 24th September AM and up to 2pm
Wednesday 25th September from 1pm onwards Tuesday 1 October AM or PM

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile:
Email: Personal Information redacted by USI

-----Original Message-----
From: Doherty Paul D [mailto: Personal Information redacted by USI
Sent: 23 August 2013 11:35
To: Dougan Sorcha
Cc: Corrigan, Martina
Subject: Re: Monday clinics SWAH

This e-mail is covered by the disclaimer found at the end of the message.

Grand

----- Original Message -----
From: Dougan Sorcha
Sent: Friday, August 23, 2013 11:04 AM
To: Corrigan, Martina Personal Information redacted by USI ; Doherty Paul D
Subject: RE: Monday clinics SWAH

I can do 19th at 2.00pm. Paul's Office?

Thanks

S

Sorcha Dougan
Patient Access Manager
Admin Building
Altnagelvin Hospital
Derry
BT47 6SB

Tel: Personal Information redacted by USI ext Personal Information

-----Original Message-----
From: Corrigan, Martina [mailto: Personal Information redacted by USI
Sent: 23 August 2013 09:51
To: Doherty Paul D; Dougan Sorcha
Subject: RE: Monday clinics SWAH

Paul,

I can do 19th PM. As I said happy to go to Altnagelvin if that suits better.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

-----Original Message-----
From: Doherty Paul D [mailto: Personal Information redacted by USI]
Sent: 23 August 2013 09:14
To: Corrigan, Martina; Dougan Sorcha
Subject: Re: Monday clinics SWAH

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How does the september 18th am, 19th pm or 20th suit to meet

P

----- Original Message -----
From: Corrigan, Martina [mailto: Personal Information redacted by USI]
Sent: Friday, August 23, 2013 08:53 AM
To: Dougan Sorcha; Doherty Paul D
Subject: RE: Monday clinics SWAH

Sorcha,

That's ok, I suppose effectively I have not been involved in the discussion either this was between Kathy and my consultant Mr O'Brien and it was only because of Kathy's email and the booking centre contacting me to find out what they had to do with the referrals that I have become involved.

Happy to meet Paul when you return from leave if you want to give me a few dates (I can come to Altnagelvin either if need be)

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

-----Original Message-----
From: Dougan Sorcha [mailto: Personal Information redacted by USI
Sent: 23 August 2013 08:48
To: Corrigan, Martina; Doherty Paul D
Subject: RE: Monday clinics SWAH

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Martina

The issue I have is that discussions are being held between other parties and as the ICATS Manager no-one has discussed anything with me.

I think it is necessary to meet.

Sorcha

Sorcha Dougan
Patient Access Manager
Admin Building
Altnagelvin Hospital
Derry
BT47 6SB

Tel: Personal Information redacted by USI ext Personal Information redacted by USI

-----Original Message-----
From: Corrigan, Martina [mailto: Personal Information redacted by USI
Sent: 23 August 2013 08:26
To: Doherty Paul D
Cc: Dougan Sorcha; Phelan Karen - Nursing Services Manager
Subject: RE: Monday clinics SWAH

Paul,

I think there has been a bit of cross-wires here.

Kathy has had a few meetings with Mr O'Brien in respect to her doing LUTs Clinics in SWAH. It was a result of these conversations that the Consultants in Craigavon have been triaging any Fermanagh patients that they deem suitable to be seen by Kathy in SWAH. All referrals in the Southern Trust go through our booking centre, who contacted me to say that they had a number of referrals that had been triaged for LUTs in SWAH and they asked me what they should do with these. I assumed that these would be dealt with by Kathy but wanted to double-check hence my email to Kathy.

On Kathy's instructions - see attached all these referrals are now being forwarded to her in SWAH for dealing with through your ICATS team.

I am happy to meet, but I would not be able to meet next week as I am covering for my AD who is on holidays and most days and evenings I am in back to back meetings.

If it is still necessary to meet let me know and we can organise a date for after your return from leave when we can discuss SBA etc.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

-----Original Message-----
From: Doherty Paul D [mailto: Personal Information redacted by USI

Sent: 22 August 2013 15:00
To: Corrigan, Martina
Cc: Dougan Sorcha; Phelan Karen - Nursing Services Manager
Subject: FW: Monday clinics SWAH

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Martina

Can we meet to discuss this as a matter of urgency to work through the finer detail.

It was agreed sometime ago that Kathy would support the patients in postcodes BT74, 92, 93 & 94 which are now under the SHSCT for their urological care however we need to work through how this can be delivered in terms of processes and particularly in the context of SBA volumes etc....

Can I suggest you, I and Sorcha, OP / ICATS Manager meet next week if possible in Omagh to discuss further - I'm go on leave on Friday until the 13thSeptember, so would be best if we sorted this sooner rather than later.

Thanks

Paul

-----Original Message-----
From: Dougan Sorcha
Sent: 22 August 2013 14:44
To: Travers Kathy
Cc: Doherty Paul D; Lock Marie - Icats
Subject: RE: Monday clinics SWAH

Kathy

Marie has passed this correspondence on to me.

I'm at a loss as to the involvement of Martina Corrigan in the ICATS Clinics in the WH&SCT as these still fall under my remit.

The booking staff in CAH do not have any involvement in the ICATS Booking of Clinics. The Trust has not agreed anything regarding all ICATS Specialities.

All referrals should be sent to Sylvia to book as is necessary as long as they don't fall under the BT Postcodes as agreed in the process which belong with CAH.

Thanks

Sorcha

Paul, I'm sending this to you as we've had discussions before. Have a missed something?

S

Sorcha Dougan
Patient Access Manager
Admin Building
Altnagelvin Hospital
Derry
BT47 6SB

Tel: Personal Information redacted by USI ext Personal Information redacted by USI

-----Original Message-----
From: Lock Marie - Icats
Sent: 15 August 2013 09:15
To: Dougan Sorcha
Subject: FW: Monday clinics SWAH

Sorcha

For your info .

Marie

-----Original Message-----
From: McSorley Sylvia
Sent: 14 August 2013 14:15
To: Lock Marie - Icats
Subject: FW: Monday clinics SWAH

Marie
For your info.
Sylvia

-----Original Message-----
From: Corrigan, Martina [mailto: Personal Information redacted by USI
Sent: 14 August 2013 14:01
To: Travers Kathy; McSorley Sylvia
Subject: RE: Monday clinics SWAH

Thanks Kathy

There are few things - firstly I haven't got agreement to run the AM clinics in SWAH just yet as there was never any funding for the nursing cover for the clinics and I am in the process of sorting this out. For now can patients still be booked to PM only.

Not sure if you have been advised that Mr O'Brien has changed his clinic dates for August and September (August is going to be next Monday 19th) and September will be on 30th as he is going to be on annual leave on 23rd.

Final point is that our booking centre have advised us that they have a number of referrals triaged to you by our consultants. Do you want me to forward these onto you and add these to your waiting list or do we send for the patients from CAH - don't want to overbook your clinics!!

You can let me know about the above and if you are alright with the new dates and what to do with the referrals - I am conscious that we really need to meet to 'thrash' out all the variables to help smooth out the processes for these clinics I had planned to come someday that the consultants are there but I've been looking in my diary and it will be October before I could meet, however, I would be happy to meet with you on any other day that maybe suited you as I think it is important to work through this. If you want to suggest some days (either first thing in the morning or later in the afternoon would be good - as I can either come from home or go home after - if this makes sense). And I will arrange to meet with you to go through these processes.

Many thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

-----Original Message-----
From: Travers Kathy [mailto: Personal Information redacted by USI
Sent: 13 August 2013 11:05
To: McSorley Sylvia

Cc: Lock Marie - Icats; Shannon Fiona; Scott Ann; Corrigan, Martina
Subject: Monday clinics SWAH

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As from beg Sept could all new referrals for Nurse clinic at SWAH be put in for the Monday clinic as the Craigavon DRs are there as well.

It will likely take a little while to build this up to a full day clinic but the plan is to have a full day clinic eventually.Maybe leave the am clinic only for Sept and I will review this. Friday clinics can continue as review appt at present but if Monday suits a patient better there is no problem coming on the Monday for review.

Sylvia leave the clinic slots as now.

Regards Kathy

Marie tried getting you on the phone but think you are on way to Sylvia at present.
Martina - for info to pass to Urologists if think need to.

Kathy Travers
Continence Nurse Specialist
Community Services Department
2 Coleshill Road
Enniskillen
BT74 7HG
Tel no: Personal Information redacted by USI

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Regional Review of Urology Services

Team South Implementation Plan

Document History	
Document Name:	Team South Implementation Plan
Status:	Draft v0.1
Version and Date:	V0.1 14 Jun 10
Origin:	Acute Planning SHSCT

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1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a Trust Grade Doctor from August 2010),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The clinical sessions which are currently being undertaken by medical and specialist nursing staff are given as Appendix 1.

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Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

ICATS	Weekly
Prostate Assessment	1.5
Prostate Biopsy	1
Prostate Histology	1
LUTS	3
Haematuria	2
Andrology	2.5
General Urology	2.5
	13.5

Main Theatres (CAH)	Weekly	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly[2]	1 monthly
Flexible Cystoscopy	1.5 weekly[3]	
Lithotripsy	1 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover
3) 2 lists/1 list on alternate weeks

Current Activity

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. The new outpatient attendances are therefore understated by approximately 240.

Table 2: 2009/10 Actual Activity for the Urology Service

		Core Activity	IHA	IS	Totals
2009/10	Cons Led New OP	610	474	0	**1084**
	ICATS/Nurse Led New OP	1233	30		**1263**
	Total New OP	1843	504	0	**2347**
	Cons Led Review OP	2391	70	0	**2461**
	ICATS/Nurse Led Rev OP	1594	0	0	**1594**
	Total Review	3985	70	0	**4055**
	Day Case	1502	3	383	**1888**
	Elective FCE	1199	29	140	**1368**
	Non Elective FCE	629	0	0	**629**

Activity by consultant for 2009/10 is provided in Table 3.

Table 3: Activity by Consultant for 2009/10

		Mr Young[2]	Mr O'Brien	Mr Akhtar[3]	All Core Activity
2009/10	New OP	242	174	193	**609**
	Review OP	964	903	327	**2194**
	Total OP	1206	1077	520	**2803**
	Day Case	696	452	354	**1502**
	Elective FCE	380	512	307	**1199**
	Non Elective FCE	233	210	186	**629**
	FCEs + DCs	**1309**	**1174**	**847**	**3330**
	Day Case Rates [1]	65%	47%	54%	56%

[1] INCLUDES flexible cystocopies (M45) and DCs/FCEs with no primary procedure recorded.
[2] Mr Young's new outpatients are understated by an estimated 240, as Stone Treatment new attendances were recorded as reviews.
[3] Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

Notes:
1) Source is Business Objects
2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)
3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).

4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.

There is a substantial backlog of patients awaiting review at consultant led clinics. The total number of patients is 4,037. The Trust's plan to deal with this backlog has been included as Appendix 2.

Pre-operative Assessment

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

Suspected Urological Cancers

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The only outstanding issue is that of oncology input to the meeting. Confirmation of when this will be available is awaited from Belfast Trust and it is expected that a date for commencement will be available in the near future.

The Southern Trust provides chemotherapy only for prostate cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers and radiotherapy for all cancers is provided by Belfast Trust. When oncology support is

available for the MDM then referral will take place during the meetings. An interim arrangement is in place with referral taking place outside the meetings.

The Trust accepts that all radical pelvic operations will be undertaken at Belfast City Hospital. The Trust asks for clarification with regard to:

- At what point in the pathway patients should be referred;
- Arrangements for review of the patients.

3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position with further detail being provided in Appendix 3.

Table 4: Regional Benchmarking

		2006/07	2007/08	2008/09	2009/10
New : Review Ratio	All Trusts	1.96	2.03	1.79	1.68
	SHSCT	**4.04**	**3.27**	**3.28**	**2.09**
Day Case Rates	All Trusts	50.1	48.5	49.8	48.5
	SHSCT	**43.8**	**45.5**	**48.8**	**40.0**
Average LOS (elective)	All Trusts	3.7	3.5	3.4	2.9
	SHSCT	**3.7**	**4.3**	**3.9**	**2.7**
Average LOS (non elective)	All Trusts	4.8	4.7	4.6	4.4
	SHSCT	**4.5**	**4.8**	**4.6**	**4.7**

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1st January – 31st December 2009. The Trust's length of spell compares very favourably with the peer group average.

Check if these were just elective procedures.

Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The Trust has compared its performance to the BADS targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete). The analysis is provided as Appendix 4. The Trust will use the BADS recommendations to determine appropriate day case rates for the new service model for urology.

4. Demand for Team South Urology Service

The Trust has utilised the methodology recommended by the Board to calculate the demand for the service. It has been assumed that the population of Fermanagh will be similar to the Southern area. As inclusion of Fermanagh will increase the population catchment area for urology by 18%, an uplift of 18% has been applied. Table 6 overleaf shows the calculation of the estimated demand for the service. It should be noted that this does not factor in any future growth in demand.

Table 6: Projected Activity for Team South

		2009/10 Actual Activity					
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**Team South Capacity Required [6]**
2009/10	Cons Led New OP	610	474	0	87	1171	1382
	ICATS/Nurse Led New OP	1233	30		100	1363	1608
	Total New OP	1843	504	0	187	2534	**2990**
	Cons Led Review OP	2391	70	0		2461	2904
	ICATS/Nurse Led Rev OP	1594	0	0		1594	1881
	Total Review	3985	70	0		4055	**4785**
	Day Case	1502	3	383	47	1935	**2283**
	Elective FCE	1199	29	140	28	1396	**1647**
	Non Elective FCE	629	0	0		629	**742**

1) Source is Business Objects
2) Activity has been counted on specialty of clinic
3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog . As shown N:R = 1:2
4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
5) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
6) 18% added for Fermanagh, based on population size relative to SHSCT population

The projected demand from Table 6 was used to calculate the numbers of session which will be required to provide the service. These are summarised in Table 7 below with the detail of the calculations provided as Appendix 5.

Table 7: Weekly Sessions for New Service Model

	Weekly Sessions
Consultant Led OPs	
General	5
Stone Treatment	1
ICATS	
Prostate Assessment	1.5
Prostate Biopsy [1]	1
Prostate Histology [2]	1
LUTS	3
Haematuria	1
Andrology/General Urology	5
Urodynamics	1.5
	14
Main Theatres	9
Day Surgery	
GA	3
Flexible Cystoscopy	3
Lithotripsy	1/2

1) Prostate Assessment and Biopsy will run side by side
2) Consultants will see their own patients, so whilst this has been noted as a single session, it is unlikely to be a single session in practice.
3) All sessions with the exception of ICATS andrology & general urology, will run over 48 weeks. ICATS andrology & general urology will run over 42 weeks.
4) Lithotripsy day case sessions have been calculated over 42 and 48 weeks. A second consultant with special interest in stone treatment will be required if sessions are to run over 48 weeks.

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The ICATS service is currently being reviewed. Some changes which will improve the service provided to patients have already been agreed by clinical staff. These include:

- The prostate pathway has been reviewed (a draft revised pathway is included in Appendix 6). Patients requiring a biopsy will be given the opportunity to have this done on the same day as their initial assessment (where this is clinically appropriate).
- Patients triaged to the haematuria service will have flexible cystoscopy carried out on the same day as their initial assessment. In the current service model these patients have to come back to the hospital to have this done in the Day Surgery Unit.
- Urodynamics will move from the inpatient ward to the Thorndale Unit and sufficient staff will be trained to avoid backlogs of patients awaiting investigation.

The Andrology and General Urology elements of the ICATS service will be reviewed over the coming months.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals. Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time. The frequency of sessions is to be agreed with the Western Trust.

Outpatient clinics will be held at Craigavon, South Tyrone, the Erne and Armagh Community Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

Consultant and Nurse led sessions will be provided over 48 weeks. The detail of job plans is to be agreed with clinical staff but they will be based around the sessions identified in the previous section. Due to available theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

Work is ongoing to develop patient flow and clinical pathways for the service. Draft pathways are included as Appendix 6. The on call urologist at Craigavon Area Hospital will be available to provide advice at any time to medical staff at the Erne or Daisy Hill Hospitals on the management or transfer of emergency cases.

6. Timetable for Implementation

Task	**Timescale**
Submission of Team South Implementation Plan	22 June 10
Approval to Proceed with Implementation from HSCB	July 10
Completion of Job Plans/Descriptions for Consultant Posts	End July 10
Completion of Job Plans/Descriptions for Specialist Nurses	End July 10
Consultant Job Plans to Specialty Advisor	End July 10
Advertisement of Consultant Posts	September 10
Advertisement of Specialist Nurse Posts	September 10
New Consultants and Specialist Nurses in post	February 11

APPENDICES

Southern Health and Social Care Trust

Regional Review of Urology Services

Team South Implementation Plan

V0.2 revised 01Nov 10

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Appendix 2 Proposal to Manage Review Backlog
Appendix 3 Benchmarking against Regional Data
Appendix 4 British Association of Day Surgery Targets
Appendix 5 Calculation of Sessions Required for Team South
Appendix 6 Patient Flow and Clinical Pathways

1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

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The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
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Andrology	2.5
General Urology/Uro Oncology	2.5
	14

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	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly[2]	1 monthly
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	SHSCT	**43.8**	**45.5**	**48.8**	**40.0**
Average LOS (elective)	All Trusts	3.7	3.5	3.4	2.9
	SHSCT	**3.7**	**4.3**	**3.9**	**2.7**
Average LOS (non elective)	All Trusts	4.8	4.7	4.6	4.4
	SHSCT	**4.5**	**4.8**	**4.6**	**4.7**

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L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The Trust has compared its performance to the BADS targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete). The analysis is provided as Appendix 4.

The Trust recognises that there is the potential to improve the performance of the urology service and will take this forward through the development of the new service model.

4. Demand for Team South Urology Service

The Trust has utilised the methodology recommended by the Board to calculate the demand for the service. It has been assumed that the population of Fermanagh will be similar to the Southern area. As inclusion of Fermanagh will increase the population catchment area for urology by 18%, an uplift of 18% has been applied. Table 6 overleaf shows the calculation of the estimated demand for the service. It should be noted that this does not factor in any future growth in demand. In addition capacity to deal with the current review backlog has not been included. It has been assumed that the Trust's proposal to manage the review backlog (Appendix 2) will be funded separately.

Table 6: Projected Activity for Team South

		2009/10 Actual Activity					
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**Team South Capacity Required [6]**
2009/10	Cons Led New OP	610	474	0	87	1171	1382
	ICATS/Nurse Led New OP	1233	30		100	1363	1608
	Total New OP	1843	504	0	187	2534	**2990**
	Cons Led Review OP	2391	70	0		2461	2904
	ICATS/Nurse Led Rev OP	1594	0	0		1594	1881
	Total Review	3985	70	0		4055	**4785**
	Day Case	1502	3	383	47	1935	**2283**
	Elective FCE	1199	29	140	28	1396	**1647**
	Non Elective FCE	629	0	0		629	**742**

1) Source is Business Objects
2) Activity has been counted on specialty of clinic
3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog . As shown N:R = 1:2
4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
5) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
6) 18% added for Fermanagh, based on population size relative to SHSCT population

The projected demand from Table 6 was used to calculate the number of sessions which will be required to provide the service. These are summarised in Table 7 below with the detail of the calculations provided as Appendix 5.

Table 7: Weekly Sessions for New Service Model

	Weekly Sessions
Consultant Led OPs	
General	5
Stone Treatment	1
ICATS	
Prostate Assessment	1.5
Prostate Biopsy [1]	1
Prostate Histology [2]	1
LUTS	3
Haematuria	1
Andrology/General Urology/Uro-oncology	5
Urodynamics	1.5
	14
Main Theatres	9
Day Surgery	
GA	3
Flexible Cystoscopy	3
Lithotripsy	2

1) Prostate Assessment and Biopsy will run side by side
2) Consultants will see their own patients, so whilst this has been noted as a single session, it is unlikely to be a single session in practice.
3) All sessions with the exception of ICATS andrology & general urology, will run over 48 weeks. ICATS andrology & general urology will run over 42 weeks.
4) Lithotripsy day case sessions have been calculated over 42 and 48 weeks. A second consultant with special interest in stone treatment will be required if sessions are to run over 48 weeks.

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The ICATS service is currently being reviewed. Some changes which will improve the service provided to patients have already been agreed by clinical staff. These include:

- The prostate pathway has been reviewed (a draft revised pathway is included in Appendix 6). Patients requiring a biopsy will be given the opportunity to have this done on the same day as their initial assessment (where this is clinically appropriate).
- Patients triaged to the haematuria service will have flexible cystoscopy carried out on the same day as their initial assessment. In the current service model these patients have to come back to the hospital to have this done in the Day Surgery Unit.
- Urodynamics will move from the inpatient ward to the Thorndale Unit and sufficient staff will be trained to avoid backlogs of patients awaiting investigation.

The Andrology and General Urology elements of the ICATS service will be reviewed over the coming months.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals. Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time. The frequency of sessions has to be agreed with the Western Trust.

There is potential to have outpatient clinics held at Craigavon, South Tyrone, Banbridge Poly Clinic, Armagh Community Hospital and Erne Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

Consultant and Nurse led sessions will be provided over 48 weeks. The detail of job plans is to be agreed with clinical staff but they will be based around the sessions identified in the previous section. Due to the availability of theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

Work is ongoing to develop patient flow and clinical pathways for the service. Draft pathways are included as Appendix 6. The on call urologist at Craigavon Area Hospital will be available to provide advice at any time to medical staff at the Erne or Daisy Hill Hospitals on the management or transfer of emergency cases.

6. Timetable for Implementation

Task	**Timescale**
Submission of Team South Implementation Plan	23 June 10
Approval to Proceed with Implementation from HSCB	July 10
Completion of Job Plans/Descriptions for Consultant Posts	End July 10
Completion of Job Plans/Descriptions for Specialist Nurses	End July 10
Consultant Job Plans to Specialty Advisor	End July 10
Advertisement of Consultant Posts	September 10
Advertisement of Specialist Nurse Posts	September 10
New Consultants and Specialist Nurses in post	February 11

APPENDICES

Southern Health and Social Care Trust

Quality Care - for you, with you

Regional Review of Urology Services

Team South Implementation Plan

V0.3 revised 05 Nov 10

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Appendices

Appendix 1 Calculation of Sessions Required for Team South

1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

The Trust submitted an Implementation Plan for Team South in June 2010 (draft v0.2). Further work was undertaken on the patient pathways and these were revised and submitted under separate cover. They have not been replicated in this document.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are currently held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes urology outpatient and day case work. It is important that capacity to deal with the demand from the Newry and Mourne area is built into the new service model as it will need to be absorbed by the Urology Consultants following Mr Brown's retirement.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2011),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The ICATS Service

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Red Flag referrals are managed within the Cancer Services Team. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics