UROLOGY SPECIALTY

UROLOGY	Total on PTL *Needing to be seen*	Capacity	Month	SWAH	CAH	Total	Comments
	87	31	July	-1	-55	-56	MA -1 AOB -14 MY -39 SWAH -1
	210	85	August	-23	-102	-125	**1 clinic in SWAH due to Bank Holiday** AOB -1 MY -55 MA -37
Total	297	116		-24	-157	-181	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS July/August 2013

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Mr O'Brien	Urology	CAH	12 (16.4.13)	3 (28.5.13)	
Mr Young		CAH	16 (16.4.13)	15 (15.5.13)	
Mr Akhtar		CAH	4 (13.6.13)	23 (24.4.13)	
Mr O'Brien		BBPC	0	0	
Mr O'Brien		ACH	0	0	
Mr Young		BBPC	0	0	
Mr Akhtar		STH	0	0	
Dr Rogers		CAH	0	N/A	N/A
GURO		CAH	103(17.4.13)	N/A	N/A
EURO		SWAH	(within GURO	4 (3.4.13)	

			figures)		

UROLOGY ICATS	Total on PTL *Needing to be seen*	Capacity	Month	ICGPUNDA	ICGPUPR2	ICSNURSA	ICSNULUP/ ICSNULUP5	Total	Comments
	106	0	July	-32			-74	-106	
	36	19	August	-14			-3	-17	**no Andrology Clinics scheduled in August**
TOTAL	142	19		-46			-77	-123	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS
July/August 2013

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Dr Rodgers/CURPR2N	Urology Icats	CAH		0	
Dr Rodgers/Uro-oncology Rev				N/A	
Nurse L Prostate				4 (4.6.13)	
Nurse L Luts				14 (11.3.13)	
Andrology				4 (16.4.13)	

ORAL SURGERY SPECIALTY – 11/7/13

ORAL SURG	Total on PTL	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	COMMENT
	128	3	JULY			-72	-53		-125	15 weeks
	128		AUGUST						128	August CAH not selected, checking clinic numbers with Miss Garrahy – 28 PTL spaces available + numbers on core clinics when made available. August DHH -14
TOTAL										

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Miss Garraghy	Oral Surgery	CAH			
Mr Ramsey-Baggs		DHH			
Mr Ramsey-Baggs	Minor ops	DHH			

ORTHODONTIC SPECIALTY 11/7/13

ORTHO-DONTICS	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	16	JULY			+16			+16	
	0	30	AUGUST			+30			+30	
Total	0	46				+46			+46	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Orthodontics	CAH			

OPTHALMOLOGY SPECIALTY

OPHTHAL	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	165	21	July	-6		-77	-51	-10	-144	3 on ptl all waiting under 18 discharge
	396	101	Aug	+12		-157	-109	-41	-295	
Total	561	122		+6		-234	-160	-51	-439	

ENT

	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
ENT	273	28	JULY	-25	0	-40	-88	-92	-245	
9WKS	968	760	AUG	-88	0	+188	-184	-124	-208	
Total	1241	760							-453	This will increase by 80 pats if we do not get a consultant for the 24/8

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS
A

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	ENT	DHH			Ok
		CAH			Ok
Personal Information redacted by the USI		CAH			Revs ok
		DHH			Revs ok
GEN ENT		CAH			

OUTSTANDING TRIAGE/NEW URGENT/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT	URGENT REVIEW					
Personal Information redacted by the USI		CAH DHH			Rev's ok					
GEN ENT		DHH								

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	ENT	CAH/STH			Revs behind
		DHH			Ok
Personal Information redacted by the USI		ACH			Ok
		CAH			Revs behind
		STH			Rev's behind
Personal Information redacted by the USI		ALL SITES			Cah rev's behind

Corrigan, Martina

From: Robinson, Katherine [redacted]
Sent: 27 March 2012 16:55
To: Adair, Loraine; Burke, Mary; Carroll, Anita; Carroll, Ronan; Clayton, Wendy; Conway, Barry; Corrigan, Martina; Devlin, Louise; Forde, Helen; Glenny, Sharon; McAreavey, Lisa; McGeough, Mary; McStay, Patricia; McVey, Anne; Murray, Eileen; Rankin, Gillian; Reid, Trudy; Richardson, Phyllis; Trouton, Heather
Subject: Demand/Capacity/Triage/Urgents
Attachments: Demand Capacity Analysis surgical division 22 Mar 2012.doc; Demand Capacity Analysis - MEDICINE 22 Mar 2012.doc; Demand Capacity Analysis - wendy - 22-03-12.doc; Demand Capacity Analysis gynae 22 Mar 2012.doc

Apologies for delay.

Please find attached information for April on demand/capacity etc for Outpatients. Feel free to raise any issues with me.

Regards

Katherine

Demand Capacity Analysis – SURGERY

Month: **Mar - Apr 2012**

Source of Information: Ref & Booking Centre, PAS & PTL

Date Prepared: **22 Mar 2012**

Prepared by: Referral & Booking Centre

O/PAEDIC	**Total on PTL** *Needing to be seen*	**Capacity**	**Month**	**Upper Limb**	**Lower Limb**	**Named**	**Total**	**Comments**
17 WEEKS	0	1	Mar	0	+1		+1	
	31	26	Apr	-23	+18		-5	
Total				-23	+19		-4	

OUTSTANDING NOT ON WAIT LIST/NEW URGENTS/URGENT REVIEWS – Mar/Apr 2012

CONSULTANT	SPECIALTY	SITE	NOT ON WAIT LIST	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Orthopaedics	CAH	**1** (earliest op reg 28/2/12)	**0**	**24** (earliest date req'd 03/2012)
			0	**0**	**12** (earliest date req'd 03/2012)
			1 (earliest op reg 19/1/12)	**0**	**2** (earliest date req'd 04/2012)
			0	**0**	**2** (earliest date req'd 04/2012)
			0	**0**	**12** (earliest date req'd 04/2012)
			5 (earliest op reg 19/12/11)	**3** (earliest op reg 05/1/12)	**20** (earliest date req'd 04/2012)
Un-named			**2** (earliest op reg 06/12/11)	**0**	**N/A**

O/PAEDIC ICATS	Total on PTL *Needing to be seen*	Capacity	Month	GPSWI	Physio	Total not incl Podiatry		Podiatry	Comments
9 WEEKS	0	14	Mar	OK	OK	OK		OK	
	126	192	Apr	OK	OK	OK		OK	
Total						OK		OK	

UROLOGY SPECIALTY

UROLOGY	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	119	36	APRIL			-83			-83	
Total	119	36				-83			-83	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Mr O'Brien	Urology	CAH	2(8wks)	1 (02.02.12)	95 (09/11)
Mr Young		CAH	2 (7 wks)	2 (15.02.12)	22 (01/12)
Mr Akhtar		CAH	1(8wks)	2 (08.02.12)	19 (11/11)
Mr O'Brien		BBPC	0	0	16 (09/11)
Mr O'Brien		ACH	0	0	2 (02/12)
Mr Young		BBPC	0	0	12 (11/11)
Mr Young		ACH	No More	0	8 (12/11)
Mr Akhtar		STH	0	0	0
Dr Rogers		CAH	0	0	N/A
GURO		CAH	11(8wks)	0	N/A

UROLOGY ICATS	Total on PTL *Needing to be seen*	Capacity	Month	ICGPUNDA	ICGPUPR2	ICSNURSA	ICSNULUP/ ICSNULUP5	Total	Comments
	31	0	MARCH				-31	-31	
	32	13	APRIL				-19	-19	
TOTAL	63	13					-50	-50	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Dr Rodgers/CURPR2N	Urology Icats	CAH	0	0	0
Dr Rodgers/Uro-oncology Rev			0	0	0
Nurse L Prostate			0	0	0
Nurse L Luts			0	0	0
Andrology			0	0	0

GENERAL SURGERY SPECIALTY

GENERAL SURGERY	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	392	305	APRIL	-2	-5	-132	+44	+27	-87	Personal Information redacted by the USI CLINICS SUSPENDED
Total	392	305	APRIL	-2-	-5	-132	+44	+27	-87	NO CAPACITY COUNTED FOR EM & no rota received for last 2 weeks in April yet

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Surgical	CAH	1(9wks)	3 (16.02.12)	19 (03/12)
			4(6wks)	0	15 (02/12)
			0	0	0
			0	1 (24.02.12)	1 (03/12)
			0	0	2 (03/12)
			1 (9wks)	1 (24.02.12)	0
			0	0	1 (01/12)
		CAH	3(6wks)	2 (15.02.12)	0
		BBPC	0	0	2 (03/12)
		STH	0	0	0
		ACH	1(3wks)	0	0
		STH		0	0

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Surgery	DHH	0	17 (31.01.12) **(Mr Brown only-no clinics all of March)**	0
			0	0	0
			0	0	11 (11/11)
			0	0	0
			0	0	0
			0	0	10 (03/12)
			0	0	0
		BBPC	0	0	0
		MHK	0	0	0
		MHK	0	0	0
		MHK	0	0	0
		BBPC	0	0	0
		MHK	0	0	0

Triage in DHH is carried out daily and all patients added to one general list

ORAL SURGERY SPECIALTY

ORAL SURG	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	6	APRIL			+4	+2		+6	·
Total	0	6	APRIL			+4	+2		+6	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Oral Surgery	CAH	0	2 (22.02.12)	0
		DHH	0	6 (02.12.11)	0
	Minor ops	DHH	0	0	5 (01/12)

ORTHODONTIC SPECIALTY

ORTHO-DONTICS	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	23	APRIL			+23			+23	
Total	0	23	APRIL			+23			+23	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Orthodontics	CAH	0	0	0

ENT

	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
ENT 9wks	0	+22	MAR	0	+2	+14	+6	0	+22	APRIL PATS B/F TO FILL MARCH SLOTS
	480	243	APRIL	-31	+17	-43	-100	-80	-237	
Total										

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	ENT	DHH	2NR ,SEC CONTACTED		OK
		CAH			OK
Personal Information redacted by the USI		CAH			OK
		DHH			OK

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

OUTSTANDING TRIAGE/NEW URGENT/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT	URGENT REVIEW
Personal Information redacted by the USI		CAH			OK
		DHH			OK
GEN ENT			6 NR GEN BEING FOLLOWED UP		

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	ENT	CAH/STH			
		DHH			OK
Personal Information redacted by the USI		ACH	10 NR BEING FOLLOWED UP		OK
		CAH	1NR , SEC CONTACTED		
		STH			
Personal Information redacted by the USI		CAH			0
		DHH/ACH/STH			NO UR ACH.STH

OPTHALMOLOGY SPECIALTY

OPHTHAL	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
26 Weeks	3	0	March	0		-2	-1	0	-3	Waiting 3 under 18 discharge outcome
	13	37	April	-1		+11	+11	+3	+24	
Total									+21	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS
March/April 2012

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
General	Opthalmology		0	11 (longest waiter 17/11/11) previous cna	n/a
Personal Information redacted by the USI		ACH	0	5 (longest waiter 22/2/12)	1 glaucoma < 4 months d/r April 12 24 glaucoma > 3 months d/r March 12 0 other
Personal Information redacted by the USI		CAH	0	1 (longest waiter 7/3/12)	0 glaucoma < 4 months d/r 44 glaucoma > 3 months d/r Feb 12 0 other
Personal Information redacted by the USI		CAH	0	1 (longest waiter 8/3/12)	0 glaucoma < 4 months d/r 109 glaucoma > 3 months d/r Dec 11 1 other earliest d/r March 12
Personal Information redacted by the USI		DHH	0	4 (longest waiter 20/2/12)	0 glaucoma < 4 months d/r 18 glaucoma > 3 months d/r Feb 12 Not all glaucoma timescales are being recorded 1 other earliest d/r Jan 12
Personal Information redacted by the USI		DHH	0	11 (longest waiter 21/2/12)	3 glaucoma < 4 months d/r April 12 20 glaucoma > 3 months d/r April 12 Not all glaucoma timescales are being recorded 3 other earliest d/r April 12
Personal Information redacted by the USI		STH	0	3 (longest waiter 24/1/12) upgraded	0 glaucoma < 4 months 0 glaucoma > 3 months d/r 2 other earliest d/r April 12

Demand Capacity Analysis - MEDICINE

Month: MARCH/APRIL

Source of Information: Ref & Booking Centre, PAS & PTL

Date Prepared: 22/3/12

Prepared by: Referral & Booking Centre

MEDICAL	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	KPC	STH	Total	Comments
	0	12	MARCH	0	0	+6	+6	0	**0**	**+12**	DPMCGMED 5NR 1NU 4R MARCH AVAIL ([redacted] Personal Information redacted by the USI)
	15	64	APRIL	0	0	+11	+35	+3	**0**	**+49**	DPMCGMED 28 REVS AVAIL APRIL ([redacted] Personal Information redacted by the USI)
Total	15	76									

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEW

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
[redacted] Personal Information redacted by the USI	Medicine	CAH	1 op reg 1/2	0	0
					0
			0	0	0
		DHH			0
			2 op reg 3rd/7th feb		0
			2 op reg8/13 feb resent	A	ALL OK

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

GASTRO SPECIALTY

GASTRO	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	2	**MAR**	0	0	0	+3	0	**+3**	8 REV SLOTS AVAIL MARCH WITH [redacted] Personal Information redacted by the USI
	33	64	**APRIL**	+5	0	+14	+19	-7	**+31**	STH GASTRO ARE NAMED TO [redacted] Personal Information redacted by the USI, THEREFORE WE NEED TO KNOW IF ANOTHER CONS IN CAH WILL SEE THESE PATIENTS, SHORTFALL BECAUSE 3 CLINIC CANC STH IN APRIL.
Total										

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEW

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI [redacted]	Gastro	DHH			0
					0
		CAH	1, op reg 20/2,phoned ltr resent	1 op reg 31/1, phoned x3, ltr resent	0
Personal Information redacted by the USI [redacted]		CAH/STH			0
					0 all rev selected

ENDOCRINE SPECIALTY

ENDO CRINE	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	0	MARCH	0	0	0	0	0	0	
	3	1	APRIL	0	0	0	-2	0	-2	REASON FOR SHORTFALL, 1ST CL IN APRIL REV'S ONLY
Total										

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEW

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Endocrine	DHH		0	REV'S ADDED LATE, ALSO DNA'S ADDED TO UR LIST

NEUROLOGY SPECIALTY

NEUROLOGY	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	4	MARCH	0	0	+1	O	+3	+4	APRIL WILL BE B/F TO FILL SLOTS
	91	38	APRIL	0	+5	-61	+3	0	-53	Personal Information redacted by the USI CLINICS ARE STILL AD HOC
Total										

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Neurology	CAH	1nr op reg 13/2 Personal Information redacted by the USI checking	1, op reg 8/2, Personal Information redacted by the USI checking	OK
		CAH			ok
		DHH	1 op reg 21/2, sec emailed	1 op reg 6/2, ltr in dhh , ref by [redacted] Personal Information redacted by the USI	ok

DIABETIC SPECIALTY

DIABETIC	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	KPC	STH	Total	Comments
	0	1	MARCH	0	0	+1	0	0	0	+1	
	14	13	APRIL	+1	0	+3	-10	+2	+3	-1	CAN WE USE KILKEEL FOR DHH NEWS
Total											

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEW

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Diabetic	CAH/BBPC			0
		ACH/STH			0
		DHH			REVS ADDED SHORT NOTICE, ALSO DNA'S ADDED

DERMATOLOGY SPECIALTY

	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
DERM 23 Weeks	0	0	March	0		0	0	0	0	
	64	136	April	-2		+76	+4	-6	+72	
Total									+72	
ACNE 19 Weeks	0	0	March			0			0	
	0	4	April			+4			+4	
Total									0	
ICATS	0	0	March			0			0	
	1	5	April			+4			+4	
Total										

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS
March/April 2012

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Dermatology	ACH	0	1 (longest waiter 21/3/12)	13 (earliest d/r April 12)
		CAH	0	0	13 (earliest d/r April 12)
		CAH	0	14 (longest waiter 15/3/12)	n/a
		CAH	0	0	0
		DHH	0	0	22 (earliest d/r March 12)
		STH	0	0	12 (earliest d/r April 12)

CARDIOLOGY SPECIALTY

CARDIOLOGY	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	5	March	0	0	+5	0	0	+5	
	47	41	April	-3	+4	+7	-16	+2	-6	9 DHH patients to see [redacted] Personal Information redacted by the only
Total									-1	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS
March/April 2012

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Cardiology	ACH	0	6 (longest waiter 29/2/12)	9 (earliest d/r April 12)
		BBH	0	0	0
		CAH	0	3 (longest waiter 27/2/12)	0
		CAH	1 (longest waiter 4 weeks)	1 (longest waiter 28/2/12)	0
		CAH	3 (longest waiter 6 weeks)	7 (longest waiter 2/3/12)	4 (earliest d/r April 12)
		CAH	0	0	0
		DHH	0	2 (longest waiter 21/3/12)	5 (earliest d/r March 12)
		DHH	0	0	0
		STH	0	0	0

RHEUMATOLOGY SPECIALTY

RHEUM 17 weeks	**Total on PTL** *Needing to be seen*	**Capacity**	**Month**	**ACH**	**BBH**	**CAH**	**DHH**	**STH**	**Total**	**Comments**
	0	4	March		+3	+1			+4	
	8	22	April		+3	+11			+14	
TOTAL									+18	
RHEUM 15 weeks										
TOTAL										

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS
March/April 2012

CONSULTANT	**SPECIALTY**	**SITE**	**TRIAGE**	**NEW URGENT (NU)**	**URGENT REVIEW (UR)**
General	Rheumatology		0	18 (longest waiter 8/3/12)	N/A
Personal Information redacted by the USI		BBPC	0	0	0
		BBPC	0	0	0
		BBPC	0	0	0
		CAH	0	0	0
		CAH	0	3 (longest waiter 14/3/12)	0
		CAH	0	0	0
		STH	0	0	0

THORACIC/RESPIRATORY SPECIALTY

Thoracic/ Respiratory	**Total on PTL** *Needing to be seen*	**Capacity**	**Month**	**ACH**	**BBH**	**CAH**	**DHH**	**STH**	**Total**	**Comments**
	0	0	March			0	0	0	0	
	79	4	April			-52	-17	-6	-75	
Total									-75	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS
March/April 2012

CONSULTANT	**SPECIALTY**	**SITE**	**TRIAGE**	**NEW URGENT (NU)**	**URGENT REVIEW (UR)**
General	Respiratory	CAH	4 (longest waiter 4 weeks)	0	n/a
Personal Information redacted by the USI	Respiratory	CAH	2 (longest waiter 5 weeks)	0	0
	Respiratory	CAH	0	0	1 (longest d/r April 12)
	Respiratory	DHH	2 (longest waiter 5 weeks)	0	11 (longest d/r April 12)

Demand Capacity Analysis

Month: March – April 2012 **Source of Information: Ref & Booking Centre, PAS & PTL**

Date Prepared: 22 March 2012 **Prepared by: Referral & Booking Centre**

BREAST	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	4	MARCH			+4			+4	
	50	8	APRIL			-42			-42	
Total	50	12				+4			-38	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Breast	CAH	0	8 (14.03.12)	1 (02/12)
	Breast	CAH	0	0	0
	Breast F/H	DHH	0	0	0
	BSUR	DHH	0	0	1 (08/11)

BREAST FAMILY HISTORY	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	3	12	APR			+9			+9	
Total	3	12				+9			+9	

Pain 9 weeks	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	0	March			0	0	0	0	
	17	17	April			+3	+2	-5	0	
Total									0	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS
March/April 2012

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Pain	CAH	1 (longest waiter 4 weeks)	0	0
	Pain	CAH	0	0	0
	Pain	CAH	0	0	3 (longest d/r Feb 12)
	Pain	DHH	0	0	1 (longest d/r April 12)
	Pain	DHH	0	0	3 (longest d/r April 12)
	Pain	STH	0	1 (longest waiter 21/3/12)	0

Haem	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	0	March				0	0	0	
	4	0	April				-4	0	-4	
Total									-4	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS
March/April 2012

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Haem	DHH	0	0	1 (longest d/r March 12)
		STH	0	0	0

Lipids	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	0	March		0	0			0	
	3	3	April		-1	+1			0	
Total									0	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS
February/March 2012

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Lipids	CAH	0	0	0

Thoracic Surgery	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	0	0	March				0		0	
	0	2	April				+2		+2	
Total									+2	

Orthoptics	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	LGH	PHC	STH	Total	Comments
	138	79	April	-10	-10	+3	-34	+12	-8	-12	-59	
Total												

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS – APRIL 2012

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Orthoptist	Orthoptics				
		ACH	0	0	12 (earliest d/r Feb 2012)
		BBH	0	0	0
		CAH	0	0	0
		DHH	0	0	0
		LGH	0	0	0
		PHC	0	0	0
		STH	0	1	0
					Figures will change once booking for April has taken place

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS – April 2012

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
VF Technician	Visual Fields	CAH	N/A	N/A	0
					**There are 55 reviews to be seen off the routine review list by April end – this will decrease once April booking has taken place*

All visual field requests are at the consultants request so are always recorded as Reviews

Demand Capacity Analysis - GYNAE

Month: **Mar - Apr 2012**

Source of Information: Ref & Booking Centre, PAS & PTL

Date Prepared: **22 Mar 2012**

Prepared by: Referral & Booking Centre

COLPOSCOPY	**Total on PTL** *Needing to be seen*	**Capacity**	**Month**	**ACH**	**BBH**	**CAH**	**DHH**	**STH**	**Total**	**Comments**
9 weeks	0	0	Mar			OK	OK		OK	
	8	18	Apr			-5	+15		+10	
Total									+10	

GYNAE SPECIALTY

GYNAE	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
9 weeks	9	34	Mar	+2	0	+17 -2 fert	+10	-2	+27 -2 fert	
	342	141	Apr	-17	+1	-70 +3 fert	-33	-85	-204 +3 fert	Includes all additionality confirmed to date (22/03/12)
Total									-177 +1 fert	Includes all additionality confirmed to date (22/03/12)
10 weeks	0	34	Mar	+3	0	+21	+10	0	+34	
	228	141	Apr	-7	+3	-25 +1 fert	-4	-55	-88 +1 fert	Includes all additionality confirmed to date (22/03/12)
Total									-54 +1 fert	Includes all additionality confirmed to date (22/03/12)

MENOPAUSE	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
9 weeks	0	2	Mar				+2		+2	
	1	3	Apr				+2		+2	
Total									+4	

URODYNAMICS SPECIALTY

URODYN	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
9 weeks	0	0	Mar				0		0	
	19	19	Apr				0		0	
Total									OK	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS – Mar/Apr 2012 (incl all NU currently on waiting lists)

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	REVIEW (R) All colp reviews are urgent
Personal Information redacted by the USI	Colp	CAH	**0**	**0**	**0**
		CAH	**0**	**0**	**0**
		CAH	**0**	**0**	**0**
		CAH	**0**	**0**	**0**
		CAH	**0**	**9** (earliest op reg 12/3/12)	**N/A**
		DHH	**1** (earliest op reg 29/2/12)	**0**	**0**
		DHH	**0**	**1** (earliest op reg 17/2/12)	**0**
Un-named		DHH	**0**	**0**	**N/A**

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Gynae	ACH	**1** (earliest op reg 27/2/12)	**3** (earliest op reg 6/3/12)	**0**
		ACH	**0**	**2** (earliest op reg 7/3/12)	**N/A**
		CAH	**0**	**0**	**1** (earliest date req'd 04/2012)
			0	**1** (earliest op reg 14/3/12)	**1** (earliest date req'd 04/2012)
			0	**0**	**0**
			1 (earliest op reg 29/2/12)	**2** (earliest op reg 07/3/12)	**7** (earliest date req'd 03/2012)
			2 (earliest op reg 10/2/12)	**0**	**0**
		CAH	**0**	**12** (earliest op reg 29/2/12)	**N/A**
		BBH	**0**	**0**	**0**
		DHH	**0**	**0**	**0**
			0	**0**	**0**
			0	**0**	**0**
			0	**0**	**0**
			0	**0**	**0**
		DHH	**4** (earliest op reg 27/2/12)	**0**	**N/A**
		MHK	**1** (earliest op reg 24/2/12)	**0**	**0**
		STH	**0**	**0**	**0**
			0	**0**	**0**
Un-named		STH	**1** (earliest op reg 22/2/12)	**9** (earliest op reg 1/3/12)	**N/A**

Corrigan, Martina

From: Leeman, Lesley [redacted]
Sent: 12 December 2011 17:23
To: Rankin, Gillian; McVeigh, Angela; Trouton, Heather; Conway, Barry; Carroll, Ronan; McVey, Anne; Hadden, Lesley-Anne; Lappin, Lynn; O'Neill, Helen; Cassells, Carol; Devlin, Louise; Corrigan, Martina; Reid, Trudy
Cc: Clarke, Paula
Subject: FW: ACTIONS/ISSUES - Operational Performance Meeting

Hi all
Quick note by way of update further to Operational Performance Meeting on Friday with Dean Sullivan, Owen Harkin, Beth Malloy, Lynn Donnelly and Jill Young. See actions/Follow-ups required.

Respiratory – Trust to liaise with HSCB(Rosa) Information to resolve issues associated with activity recorded against respiratory specialty. Trust alluded that some activity may be assigned to General Medicine which has a respiratory sub-specialty and not recorded against Respiratory – Action – Lesley Ann – can you link with Rosa to resolve this issue and agree activity data to be presented against this specialty

Ophthalmology – baseline to be amended by SLCG: Action – Lynn - can you link with Caroline/Rosa to ensure this requirement formally highlighted as early as possible to ensure amended for next meeting and correct on slides

Dermatology – baseline to be amended to reflect agreement further to SBA modelling for both New OP, review OP and daycases; Action – Lynn/Barry – can you arrange meeting with Caroline and agree position before next meeting. Barry/Hos to attend.

ENT – issue re continued underperformance. Trust needs to undertake formal analysis to qnaitfy casemix shift and agree baselines with SLCG as part of SBA modelling outputs. Action – Lynn - can you arrangement meeting with Caroline and agree position before next meeting. Heather/martina to attend. Martina – can you pull together the analysis to date of shift in casemix- examining if theatre time is constant and volumes reducing associated with larger cases and in addition if increase in OPcP is leading to shift from daycase.

Review Backlog outpatients – Trust to present formal position to HSCB/SLCG before next meeting identifying volume sof review backlog to be treated and identifying to what extend review backlogs will be cleared. Action – Lynn/Dr Rankin – clarify requirements at Tuesday am Op Performance meeting – consider quantifying backlog and volumes by length of wait as discussed; identify if additional patients require to be treated, if capacity in system to facilitate this and if additional funding required.

Orthopaedic Spend – Trust to clarify if it cannot use all the allocated funding for orthopaedic conversion work in year and advise Owen Harkin via finance lines by Tuesday – Action – Louise – can you clarify volume of conversion to be treated in year if this is less than the volumes allocated and link with Carol in finance by Tuesday

Spend General – Trust to highlight at early stage if any risk to spending allocated volumes. HSCB assumption is that spend confirmed by end of this week must be used by year end – if cannot be used Trust must seek alternative options to spend on waiting list issues – Action – Helen/Carol please note assumptions

AHP – backstops and targets by march to be confirmed in week. Discussion on need to fast track AHP recurrent solution exercise undertaken . Dean to link with Mary Emersion. Discussion on AHP specifically to be had at next meeting on 13 January 2012. Action: Angela/Francis/Paul to note re attendance at next meeting for discussion on in year and recurrent positions.

Urology – Trust to provide update on position on access times associated with urgent waits. Focus to reduce urgent waits over 13 weeks where these might exist. Action – Heather/Martina – to assess position with urgent waits.

Scopes – 'Flawless'!

Trust raised issues relating to

- Lost capacity associated with day of action
- Delay associated with oral surgery tender
- Pressure on organisation to transfer high volumes of patients to IS
- On going demand in MRI and diagnostics generally

Lesley

Lesley Leeman
Assistant Director Performance & Contracts Southern Health and Social Care Trust
Tel: Personal Information redacted by USI
Mobile: Personal Information redacted by USI

Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT62 5QQ

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 30 December 2010 12:05
To: [redacted]; [redacted]; Akhtar, Mehmood; O'Brien, Aidan; Young, Michael Mr
Cc: Dignam, Paulette; Hanvey, Leanne; McCorry, Monica; Troughton, Elizabeth
Subject: MINUTES OF MEETING RE UROLOGY 17th JUNE re review backlog
Attachments: MINUTES OF MEETING RE UROLOGY 17th JUNE re review backlog.doc

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 .

Action Plan for Patient Pathways to address Urology Review Backlog

Action/Workstream	Actions	Lead and involved individuals	To be complete by:
Patients with raised PSA could be managed by the GP with agreed Clinical Protocols	Draw up and agree clinical protocols and share with Dr Beckett	Mr Young and Mrs Corrigan	
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.	Meet with Consultants and agree patient management plans. Share with Non Consultant staff	Mr Young and Mrs Corrigan	
Agree patient pathways (a) Stable Prostate Clinics (b) Prostate Diagnostic Clinics (c) Haematuria Service (d) Andrology Service (e) Vasectomy Service (f) Urodynamics (g) Stone service (h) Female urology	(a) develop pathway for LUTs and share with Urology Team (b) develop pathways and protocols for managing these patients (c) develop pathway and protocol for managing these patients (d) develop written protocols and guidance and share with ICATS team (e) develop and agree pathway and share with urology team (f) write up pathway and share with urology team (g) develop guidance, protocols and pathways for stone service. (h) Develop and agree protocol and guidance on discharging patients back to GP	Mr Young, Mrs Corrigan and Specialist Nurses	

Prevention of growth of review backlog	Pilot pathways to be drawn up by Urology team commencing with lumps and bumps for the Prostate Assessment Clinic	Mr Akhtar, Mrs Corrigan and GPs	
Agreed pathways to be shared with GP's	It was agreed that Pathway work, including protocols for safe and appropriate discharge to GPs would commence as a priority considering the current review backlog numbers. Meetings with GPs should be arranged as soon as possible.	Mrs Trouton and Mrs Corrigan	
Continue working through backlog patient letters and taking forward the outcome from this action.	Specialist and Lead nurse to continue working with Consultants in going through patient letters and dealing with appropriately, e.g. discharge back to GP, bring for a review appointment, order more tests etc.	Mrs Corrigan and Specialist and lead nurse	
Arrange to record virtual clinics that take place in Consultants offices in order to ensure that all activity is captured	Set up virtual clinics on PAS	Mrs Corrigan and Mrs Glenny	

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 30 December 2010 10:56
To: Tedford, Shirley; O'Neill, Kate; McMahon, Jenny; [redacted]; [redacted]; Akhtar, Mehmood; O'Brien, Aidan; Young, Michael Mr
Cc: Matier, Pauline; Trouton, Heather; Dignam, Paulette; Hanvey, Leanne; McCorry, Monica; Troughton, Elizabeth
Subject: Action Plan from urology primary care meeting
Attachments: Action Plan from urology primary care meeting.doc

Importance: High

Dear all,

As discussed at our departmental meeting last week, please see attached - these were the actions drawn up from the meeting with the GP's in June regarding pathways.

thanks

Martina

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

Tel: [redacted]
Mobile: [redacted]
Email: [redacted]

Appendix 2

Proposal to Manage Urology Review Backlog

Process to manage the substantial volume of patients involved in Urology - Total = 4037 (2008 - 31 May 2010)

- Identify patients who may be at risk and require an urgent review
- Identify patients who require a consultant reassessment in an agreed timeframe
- Cleanse list – ensure that there are no duplicate open requests for same issue.

The Urology specialist nurses have agreed to coordinate the process by reviewing patient centre letters and results and collate into the following categories:-

Category 1: Urgent appointment required
Automatically arrange an urgent review appointment

Category 2: Decision required on review management
Lead nurse will meet with consultant to determine a plan for each patient, i.e. either agree review required in a specified time frame or agree an alternative plan.

Category 3: ?Discharge based on clinical results available
Lead nurse to get permission from consultant to discharge and send letter to GP +/- patient

Category 4: PAS errors/duplication
Lead nurse to get permission from consultant to discharge from PAS

Appendix 3

Regional Benchmarking

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland for:

- New to review ratios;
- Day Case rates;
- Average length of stay for elective and non elective procedures.

New : Review Ratio
1/04/06 - 28/02/10

	2006/07	2007/08	2008/09	2009/10
All Trusts	1.96	2.03	1.79	1.68

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	1.63	2.09	1.77	1.72
Northern Trust	1.97	1.67	1.31	1.75
South Eastern Trust	1.15	1.1	1.15	1.25
Southern Trust	4.04	3.27	3.28	2.09
Western Trust	2.65	2.32	2.49	1.73

Note – the review backlog will have skewed the figures for 2009/10 (perhaps for all Trusts)

Day Case Rates by Trust

April 06 - Feb 10

(Excludes Prim Op M45 and Not coded procedures) (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

		2006/07	2007/08	2008/09	2009/10
All Trusts	Day Cases	3793	3733	4255	3492
	Elective Admissions	3780	3963	4293	3710
	DCs+ElecAdm	7,573	7,696	8,548	7,202
	Daycase Rate	**50.1**	**48.5**	**49.8**	**48.5**

		2006/07	2007/08	2008/09	2009/10
Belfast Trust	Daycases	1737	1584	1896	1615
	Elective Admissions	1938	2092	2015	1873
	Total	**3,675**	**3,676**	**3,911**	**3,488**
	DC Rates	47.3	43.1	48.5	46.3
Northern Trust	Daycases	211	209	241	372
	Elective Admissions	465	430	582	448
	Total	**676**	**639**	**823**	**820**
	DC Rates	31.2	32.7	29.3	45.4
South Eastern Trust	Daycases	930	912	940	751
	Elective Admissions	257	325	369	328
	Total	**1,187**	**1,237**	**1,309**	**1,079**
	DC Rates	78.3	73.7	71.8	69.6
Southern Trust	Daycases	579	576	770	433
	Elective Admissions	742	691	807	650
	Total	**1,321**	**1,267**	**1,577**	**1,083**
	DC Rates	43.8	45.5	48.8	40.0
Western Trust	Daycases	336	452	408	321
	Elective Admissions	378	425	520	411
	Total	**714**	**877**	**928**	**732**
	DC Rates	47.1	51.5	44.0	43.9

Urology - Average LOS (Episode based)

April 06 - Feb 10

Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	3.7	3.5	3.4	2.9

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	3.9	3.5	3.5	3.3
Northern Trust	2.3	2.9	2.4	1.9
South Eastern Trust	3.8	4.0	3.4	3.2
Southern Trust	3.7	4.3	3.9	2.7
Western Trust	3.6	2.9	3.2	2.9

Non Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	4.8	4.7	4.6	4.4

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	5.5	4.9	5.4	5.0
Northern Trust	4.3	5.4	4.9	3.7
South Eastern Trust	3.9	4.4	3.5	3.8
Southern Trust	4.5	4.8	4.6	4.7
Western Trust	3.9	3.8	4.1	3.4

Appendix 4

British Association of Day Surgery (BADS)

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The tables overleaf compare the Trust's performance with the BADS targets for urology. The following notes apply:

- The first table relates to Trust activity for 2009/10. At 2nd June 2010 175 elective finished consultant episodes (FCEs) and 182 day cases were not coded;
- Elective FCEs and day cases have been included (no non elective activity);
- Only activity undertaken by the 3 consultant urologists has been included in the analysis.

British Association of Day Surgery (BADS) Basket of Procedures for Urology
2009/10 SHSCT Data

			BADS RECOMMENDATION			SHSCT PERFORMANCE		
	DESCRIPTION	OPCS Codes	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %
1	Ureteroscopic extraction of calulus of ureter	M27.1, M27.2, M27.3	50	50		0%	53%	
2	Endoscopic insertion of prosthesis into ureter	M29.2, M29.5	90	10		0%	38%	
3	Removal of prosthesis from ureter	M29.3	100			38%		
4	Endoscopic retrograde pyelography	M30.1	90	10		5%	84%	
5	Other endoscopic procedures on ureter	M27, M28, M29.1,M29.4, M29.8, M29.9	90	10		13%	46%	
6	Cystostomy and insertion of suprapubic tube into bladder	M38.2	90	10		0%	10%	
7	Endoscopic resection/ destruction of lesion of bladder	M42	20	50	30	3%	32%	23%
8	Endoscopic extraction of calculus of bladder	M44.1, M44.2	50	50		0%	10%	
9	Diagnostic endoscopic examination of bladder (inc any biopsy)	M45	90	10		87%	8%	
10	Operations to manage female incontinence	M53.3, M53.6, M53.8	80	10	10	0%	0%	100%
11	Dilation of outlet of female bladder	M58.2		90	10	100%		
12	Endoscopic incision of outlet of male bladder	M66.2	50	50		14%	71%	
13	Endoscopic examination of urethra +/- biopsy	M77		100		100%		
14	Endoscopic resection of prostate (TUR)	M65.1,M65.2, M65.3, M65.8	15	45	40	0%	0%	20%

			BADS RECOMMENDATION			SHSCT PERFORMANCE		
	DESCRIPTION	OPCS Codes	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %
15	Resection of prostate by laser	M65.4, M65.3+Y08.3, M65.3+Y08.4	90	10		0%	33%	
16	Prostate destruction by other means	M67.1,M67.2, M67.5, M67.6	90	10				
17	Operations on urethral orifice	M81	90	10		33%	50%	
18	Orchidectomy	N05, N06.1, N06.2, N06.3, N06.8, N06.9	90	10		44%	56%	
19	Excision of lesion of testis	N06.4, N07	90	10				
20	Orchidopexy - bilateral	N08	60	35	5			
21	Orchidopexy	N09	75	20	5	60%	40%	
22	Correction of hydrocoele	N11	90	10		80%	10%	
23	Excision of epididymal lesion	N15	90	10		90%	0%	
24	Operation (s) on varicocoele	N19	90	10		60%	40%	
25	Excision of lesion of penis	N27	50	50		100%		
26	Frenuloplasty of penis	N28.4	90	10		100%		
27	Operations on foreskin - circumcision, divisio of adhesions	N30	90	10		71%	14%	
28	Optical urethrotomy	M76.3	90	10		7%	56%	
29	Laparoscopic nephrectomy	M02.1,M02.5,M02.8, M02.9 (+Y75.2)	5	75	25	0%	11%	0%
30	Laparoscopic pyeloplasty	M05.1+Y75.2	10	80	10			
31	Laparoscopic radical prostatectomy	M61.1,M61.2,M61.9 (+Y75.2)		5	90		0%	0%

Appendix 5

Projected Activity & Sessions v0.1 17 June 10

Table 1 below gives the Board's calculation of the capacity gap, and using the Board's methodology, the 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) Private Patients have been excluded.
3) Activity has been counted on specialty of clinic
4) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog . As shown N:R = 1:2
5) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
6) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
7) 18% added for Fermanagh, based on population size relative to SHSCT population

Outpatients

To enable the numbers of clinic sessions to be calculated, Table 2 splits the numbers of new outpatient attendances by clinic, based on the 2009/10 attendances.

Table 2: New Outpatient Attendances

Clinic	Core	IHA [1]	Total	%	Growth [2]	SHSCT Total	Team South [3]
Prostate TRUSA (&B)	248		248	10.6%	20	268	316
LUTS	323		323	13.8%	26	349	412
Andrology/Dr Rodgers gen urology	476	30	506	21.6%	40	546	645
Haematuria	186		186	7.9%	15	201	237
Consultants clinics	374	474	848	36.1%	68	916	1080
Urodynamics (consultants)	236		236	10.1%	19	255	301
	1843	504	**2347**	100.0%	187	2534	**2990**

Stone Treatment new outpatients are being recorded as reviews and are therefore not included in the figures. This means that new outpatients at consultant clinics are under stated by approximately 240 attendances.

Sessions are based on 48 weeks unless otherwise stated.

Prostate Pathway (Revised)

1st appointment – the patient will be assessed by the specialist nurse (patient will have ultrasound, flow rate, U&E, PSA etc). A registrar needs to be available for at least part of the session eg to do DRE, take patient off warfarin etc. 5-6 patients can be seen at an assessment clinic (limited to a maximum of 6 by ultrasound). In the afternoon appropriate patients from the morning assessment would have a biopsy. 4-6 patients can be biopsied in a session (though additional biopsy probes will need to be purchased). Not all patients will need a biopsy and the session will be filled with those patients from previous weeks who did not have a biopsy on the same day as their assessment (because they needed to come off medication, wanted time to consider biopsy etc). Based on 2009/10 figures it is estimated that 69% of patients will require biopsy (218)

316 patients @ 5 per session = 63 sessions per annum (53 if 6 patients are seen) = 1.3 (or 1.1) assessment sessions per week.

218 cases for biopsy @ 5 per session = 44 sessions per annum. 1 biopsy session per week should therefore suffice (over 48 weeks).

The majority of patients with benign pathology will be given their results by telephone (Specialist Nurse time needs to be built in to job plans for this).

2nd appointment will be to discuss the test results – patients with positive pathology and those patients with benign pathology who are not suitable to receive results by telephone. It is estimated that 40% of patients who have had biopsy will have positive pathology (using 40% this would be 88 patients – have asked Brian Magee for actual figure for 2009/10). Adding on 10% for those patients with benign pathology who will need to come in for their results gives a figure of 97 patients needing a second appointment. This equates to 2 patients each week (over 48 weeks). These patients are now being seen by a registrar but the consultants want to build time into the new service model to see the patients themselves.

3rd appointment will be discussion of treatment with the estimated 88 patients per annum. Could these be dealt with promptly on a weekly basis by the surgeon of the week following the MDT? The consultants would prefer to see their own patients and feel that the appropriate model is for each to have a weekly 'Thorndale session' to do:

- 2nd and 3rd prostate appointments,
- Check urodynamic results/patients

LUTS

412 new patients. The new to review ratio is 1:0.8, therefore there will be approximately 330 reviews.

412 new patients @ 4 per session = 103 sessions

330 reviews @ 8 per session = 42 sessions

103 + 42 = 145 sessions per annum = **3 sessions per week** (over 48 weeks)

Registrar input is required.

Haematuria (Revised)

Currently ultrasound, history, bloods, urines etc done by the Specialist Nurse/Radiographer. Patients come back to DSU to have flexi carried out by a Registrar (Friday flexi sessions).

This will move to a 'one stop' service with the flexi being done on the same day in Thorndale (by a Registrar). 5 patients per session (may be a slightly longer session than normal) have been agreed.

237 new patients @ 5 per session = 48 sessions = **1 per week** (over 48 weeks)

Note – some patients will require IVP. The view of the clinical staff is that it may be rather onerous for the older patient to have this along with the other investigations done on the same day. However this will be considered further and the potential for protected slots discussed with Radiology.

Andrology/General Urology ICATS

This service will be reviewed over the next 6 months.

For planning purposes it has been agreed to use a new to review ratio of 1:1.5 with 3 new and 5 review at a clinic. It is assumed that sessions will only run over 42 weeks.

645 @ 3 news per session = 215 sessions = **5 per week** (over 42 weeks)

Consultant Clinics

Urodynamics patients are included in the consultant clinics (301 new). If these are separated out this leaves 1080 new patients at consultant clinics.

Junior doctors will not be available to support all outpatient sessions. Therefore it has been assumed that on average 1.6 doctors will attend a clinic with 10 patients each, therefore on average 16 at a clinic. Consultants believe that 5 news and 11

reviews is the appropriate number at a clinic for this staffing level. This will give a new to review ratio of 1:2.2.

1080 patients @ 5 news per clinic = 216 sessions = 4.5 per week. 5 sessions (over 48 weeks) will be built in to the service model (to allow some flexibility because of the limited junior doctor support).

Stone Treatment

240 attendances @ 6 news = 40 sessions. 1 session per week will be required.

Urodynamics (Revised Model)

Currently carried out on the ward with results reviewed by consultants. These will be moved to Thorndale/Ambulatory Care Unit to be carried out by a Specialist Nurse. Consultants wish to assess the results in their proposed Thorndale session.

301 cases at 5 per all day session = 60 all day sessions. 1.5 per week will be built in to the service model.

Time will also need to be built into the Specialist Nurses' job plans to pre assess the patients (this may not need to be face to face) as there otherwise would be a high DNA rate for this service.

Day Cases

Flexible Cystoscopy

Based on the current day case rates 2283 day cases (including flexible cystoscopies) would be undertaken.

2008/09 activity has been used to apportion flexible cystoscopies etc, as coding is incomplete for 2009/10.

1243 flexible cystoscopies were carried out as day cases (primary procedure code = M45) and this was 56% of the total daycases (2203), in 2008/09.

It has therefore been assumed that 56% of 2283 cystoscopies will be required = 1279. 237 of these will be done in Thorndale (Haematuria service), leaving1042. Numbers on lists vary between 6 -10, depending on where the list is undertaken, and whether any patients who have MRSA are included on the list. An average of 8 per list has been used for planning purposes.

1042 @ 8 per list = 131 lists = **3 flexi list per week** (over 48 weeks)

Lithotripsy

268 day cases were carried out in 2008/09. This was 12.2% of the total day cases. Assuming 12.2% of 2283 will be lithotripsy gives a requirement for 279.

279 @ 4 per session = 70 sessions. This equates to 1.5 per week if delivered over 48 weeks (will required a second consultant with SI in stone treatment) and 2 per week if delivered over 42 weeks.

Other Day Cases

The day case rate for specific procedures will be increased (assuming suitable sessions and appropriate equipment can be secured).

In 2008/09 2203 day cases and 1273 elective FCEs were carried out (3476 in total and a day case rate of 63.4%). If the British Association of Day Surgery recommended day case rates had been achieved for the basket of procedures for urology in 2008/09 then an additional 215 day cases would have been carried out increasing the total day case rate from 63.4% to 69.6%

For Team South we have projected 2283 day cases and 1647 FCEs (Day case rate of 58%). If a day case rate of 69.6% is applied to the total elective activity of 3930 then this changes the mix to 2735 day cases and 1195 elective FCEs.

Of the 2735 day cases:

- 1279 are flexible cystoscopies;
- 279 are lithotripsy
- 103 had no procedure (add 18% to account for Fermanagh region) = 121
- 279 are introduction of therapeutic substance in to bladder + 18% = 329

This leaves 727 day cases to be carried out. Some will be done in dedicated day surgery sessions and some will be more suited to main theatre via the elective admissions ward (in case an overnight stay is required). 4 patients are normally done in dedicated day surgery sessions at present but consultants feel that this could be increased to 5.

727 @ 5 per list = 146 lists = 3.1 lists (over 48 weeks). As not all cases will be done within the dedicated day case lists, 3 weekly lists will suffice.

Inpatients

1195 elective FCEs are projected. A limited number of patients may not have a procedure carried out. However some non elective cases are added to elective theatre lists. The numbers of procedures carried out on a list also varies significantly

and on occasions a single complex case can utilise a whole theatre list. For the purposes of planning, 3 cases per list has been taken as an average.

1195 @ 3 per list = 399 lists = 9 lists (over 48 weeks).

APPENDIX 6

Draft Patient Flow and Clinical Pathways

Pathways for Non-Elective Admissions to either Daisy Hill or Erne Hospitals that do not have an acute Urology Unit

Patient presents at Accident and Emergency in either Daisy Hill or Erne Hospitals

Testicular Torsion

Suspected cases of Testicular Torsion should be dealt with by the surgical team

Testicular Infection

Suspected cases of Testicular Infection should be dealt with by the surgical team at the presenting hospital

The patient should have an ultrasound carried out to exclude Testicular Tumour

Patient should then be referred to the Urological Team at Craigavon Area Hospital

Renal Colic

The patient needs to be assessed by the Surgical Team at the presenting hospital

Investigations such as non-contrast CT, IVP/Ultrasound should be undertaken to confirm diagnosis

This combined with the patient's renal function and sepsis status will govern the acuteness of the referral pathway.

Haematuria

Patients admitted with Haematuria/Clot retention that are requiring admission are to be assessed for need of catheter insertion.

Initial investigations of ultrasound and IVP should be undertaken followed by contacting the Craigavon Area Hospital for further advice on referral pathway as there may be a need for transfer or subsequent consultation

Infection – Recurrent Urinary Tract Infection/pylelonephritis

The patient needs to be assessed by the Surgical Team at the presenting hospital.

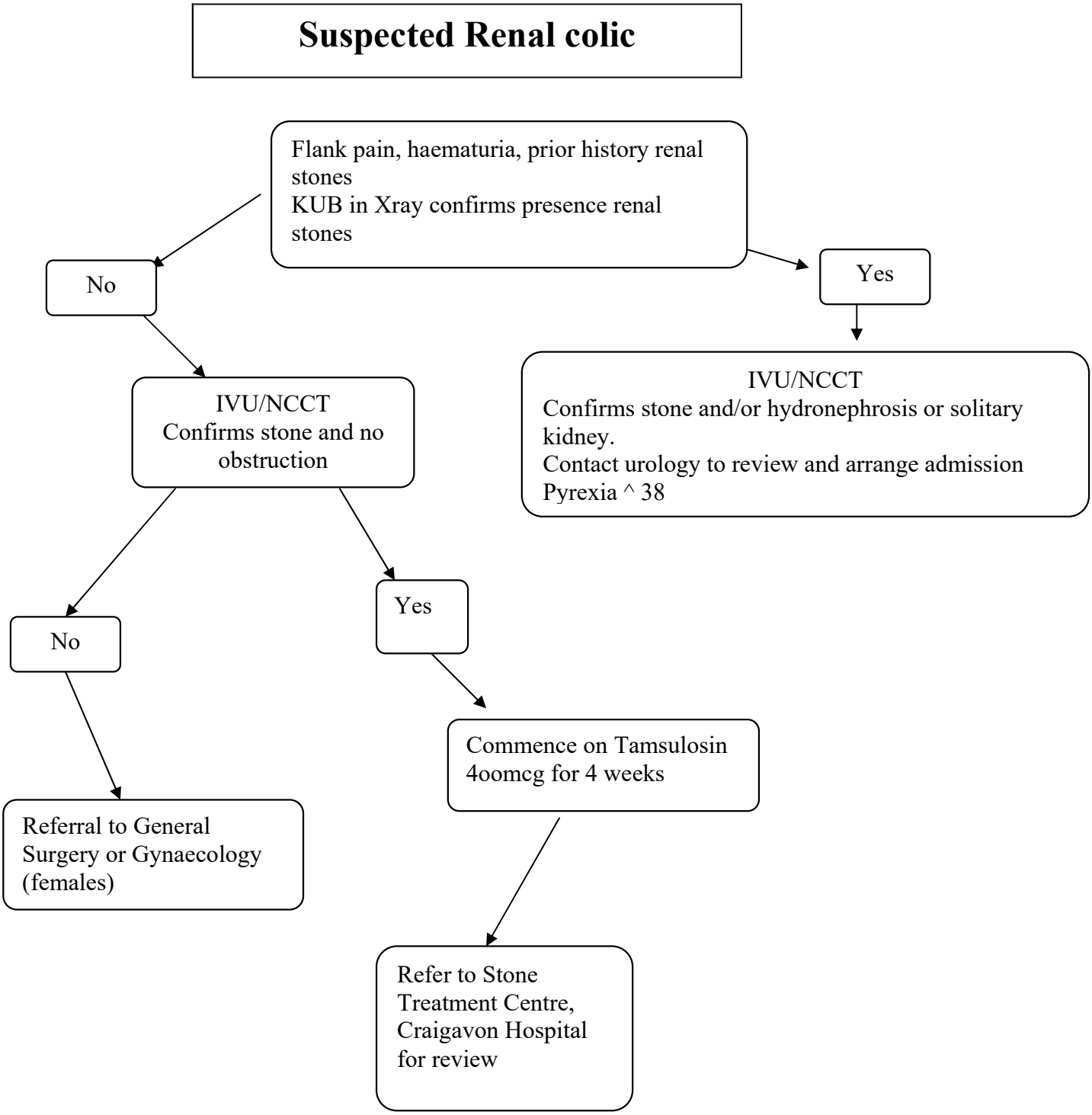
The patient will need a catheter inserted
Current guidelines and a protocol are being drawn-up for insertion of Catheter by the Urological Team at Craigavon Area Hospital and this will be available on all sites

Note: Any entity defined as a Urological Emergency can be referred/discussed with the Urological team at any time for advice/guidance on how best to manage/transfer

If advice is required on any of the above the Urology On call doctor should be contacted via Craigavon Area Hospital Switchboard

028 3833 4444

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



Making diagnosis of Urinary Retention in the A&E department

Medical assessment to include
DRE, FBP, U&E, BLOOD SUGAR, PSA

→ PSA done but not impacting on decision

↓

Administer prophylactic antibiotics (clarify)
Pass correct length urethral catheter –
Send a CSU for culture

↓

Catheterisation Successful

Catheterisation Unsuccessful

↓

Contact Urology unit
Admit

Admit to Craigavon Urology unit if

- output greater than 700mls (observe x 2 hours)
- abnormal creatinine
- unfit/elderly
- female patients
- infection suspected
- neurological deficit
- haematuria
- difficult catheterisation

Less than 400ml
Consider alternative diagnosis (UTI) or cause painful abdomen

400-700ml
Patient fit and normal creatinine
Start Alfuzosin 10mg OD

↓

Discharge Home

Refer to either Ambulatory Care Manager or Community Continence Team for follow up and or TWOC.

Ensure catheter discharge form completed and take home pack is given to patient

Recurrent Urinary Tract Infections

Step 1 – Nurse Led Service

Urine cultures- frequency to be determined by Consultant Nurse to obtain and monitor results and liaise with Consultant regarding any change to pathway including frequency of sample.

Oral antibiotic regime prescribed and altered by Consultant Urologist as per culture with input when necessary from Bacteriology

Step 2 – Intravenous Antibiotic Regime

Nurse led Service
Day case attendance

IV/SC Therapy
Co-ordinator
community

Inpatient
Culture sensitivity
Symptomatic
Venous access easily obtained

Step 3 – Intravenous Fluids and Antibiotic Regime

Nurse Led Service
Day case attendance Monday – Friday
Consultant to prescribe Intravenous Antibiotic regime as per Culture and with input when from Bacteriology

Inpatient
Symptomatic
Culture Sensitivity
Venous access compromised

Prostate Pathway

Notes

1

GP referral
Triage by Urology Consultant

Referral
Other Consultant/LUTS or Andrology Clinic

2

OP – Same day Assessment & biopsy if required
History/DRE/counselling/possible TRUS Biopsy

Appt 1

No biopsy

Discharge to GP
With appropriate instructions for future management

biopsy

Local MDT – next meeting

3

Benign pathology
Inform patient by telephone if appropriate or follow up appointment

Positive Pathology
Results clinic - Diagnosis discussed with patient

Appt 2

4

Discharge to GP
With appropriate instructions for future management

OP Waiting List
For review/repeat biopsy

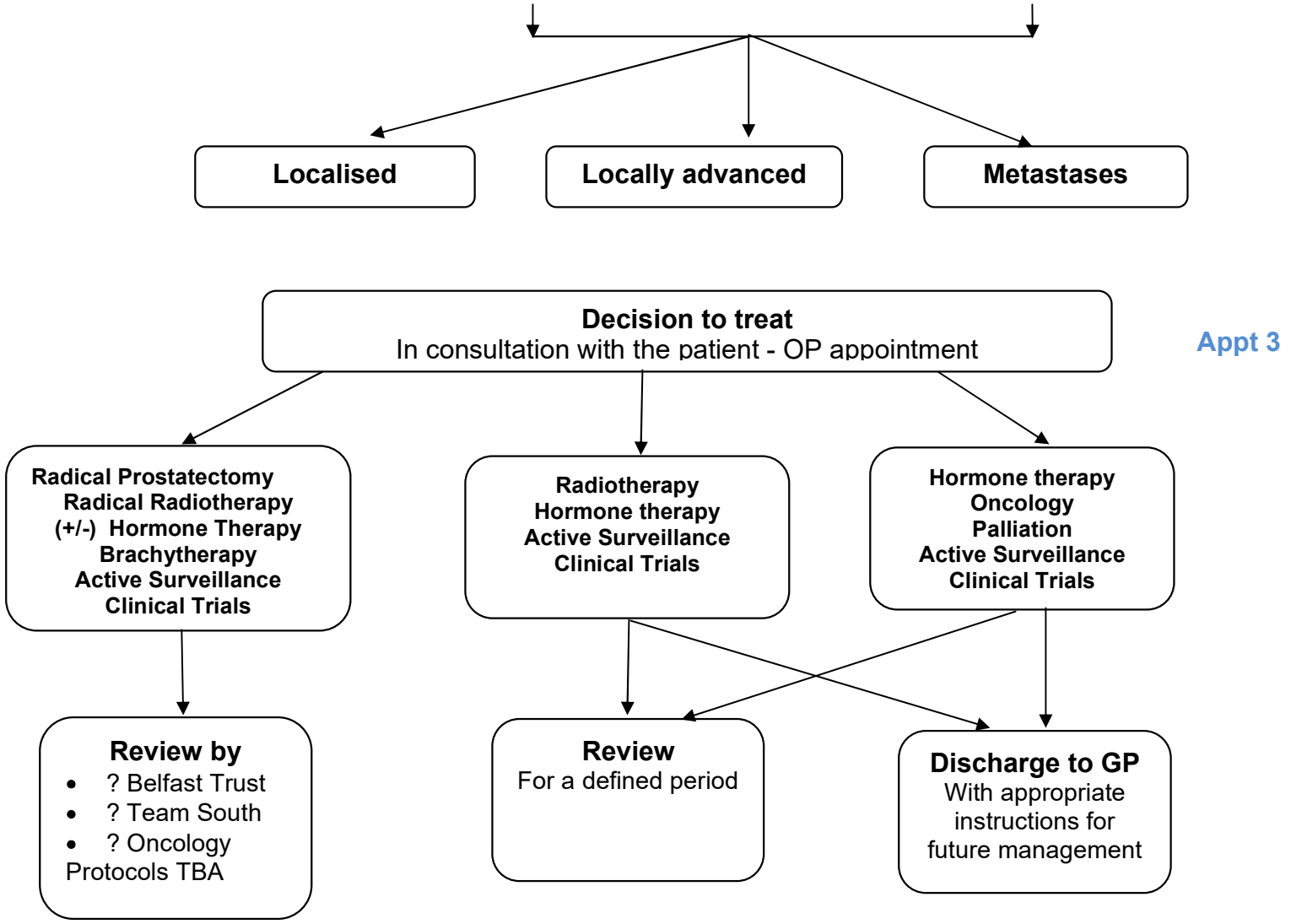
Staging
MRI/CT & Bone scan if appropriate

5

Local MDT
Present at local MDT when staging complete. If patient meets regional referral criteria discuss at specialist MDT on the same day.

Specialist MDT
Present at specialist MDT

Inter Trust Transfer by Day 28



6

Notes

1. **Referral protocol for GPs** is required. Also an information leaflet for GPs describing what will happen at the OP assessment/biopsy appointment so that they can inform and counsel the patient.
2. **First appointment** – assessment and where clinically indicated a biopsy. Results are normally back from Pathology in 5-10 days.

   Specialist Nurse should assess at this appointment if the patient is suitable to receive the results (if benign) by telephone and should discuss this with the patient.

   Scans should be booked at this point for those patients who have biopsy (to be cancelled if the biopsy is benign). **Note** another PC in Tutorial Room1 with access to NIPACS will be required to facilitate this.

   Only Dr McClure and Mr Akhtar do biopsies at present. One or both of the new consultants will also need to be trained.

   248 new patients attended TRUSA/TRUSB in 2009/10. Factoring in growth in the waiting list and also 18% of SHSCT activity for Fermanagh gives 316 patients @ 4 per session = 79 sessions = 1.7 per week. At 4 patients per clinic this will require **60 sessions** per annum.

   165 patients attended TRUSB in 2009/10 (69% of patients who were assessed). Therefore approximately 30 patients from Fermanagh will require biopsy.
3. **Benign biopsy** – will need to consider management of the outpatient waiting list for patients who need future review or repeat biopsy to ensure they do not get lost in the system.
4. **Staging** – there is a 6 week suspension between biopsy and scanning. The MRI/CT and bone scan can be done on the same day if the MRI/CT is done first. However we need to check if both scans can be booked for the same day to save 2 journeys for the patient (NIPACS issue).

   Reports need to be available within 2 – 5 days (need to be available for the next MDT).
5. **Local/Specialist MDT** – where appropriate inter Trust transfer must be made by day 28 from receipt of referral.
6. The review programme awaiting confirmation of who will review the patients managed by Belfast surgical team and also radiotherapy?

<u>Patients to be discussed at local MDT</u>

All patients with biopsies for suspected cancer (NICE)

All patients diagnosed with prostate cancer (peer review)

(From NICAN Urology Network)

Prostate cancer

Patients with locally advanced or metastatic disease, to be referred for specialist discussion if clinically appropriate. Patients over 85 do not require discussion.

Corrigan, Martina

From: Cunningham, Andrea [redacted]
Sent: 21 December 2011 13:53
To: Robinson, Katherine; Lawson, Pamela
Cc: Akhtar, Mehmood; Troughton, Elizabeth; McCann, Ciaran T; Lavery, Sean; Fletcher, Barry; Loughran, David; Corrigan, Martina; Rocks, Cathy; Thompson, FionaM
Subject: Additional Urology

Importance: High

Dear All

Mr Akhtar has kindly agreed to additional review backlog clinics on the following dates:

17/01/12 PM
31/01/12 PM

CRBLOMA
OPD, CAH (Dental Suite)
15 review patients
10 min slots
2pm-5pm

Many thanks
Andrea

Andrea Cunningham
Service Administrator SEC
SHSCT - Craigavon Area Hospital
68 Lurgan Road,
Portadown,
BT63 5QQ
Direct Line [redacted]

Corrigan, Martina

From: Young, Michael Mr [redacted]
Sent: 21 December 2010 12:58
To: Corrigan, Martina
Subject: RE: review backlog

I'm in theatre this afternoon 2618

From: Corrigan, Martina
Sent: 14 December 2010 18:12
To: Young, Michael Mr; ' [redacted]
Subject: review backlog

Hi Michael

Also meant to mention about review backlog clinics – not sure if you have identified other patients that need to be seen from the letters (Shirley has another bundle for you to look at)!

Maybe we can link up to sort out some additional review clinics for the new year???

Thanks

Martina

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

Tel: [redacted]
Mobile: [redacted]
Email: [redacted]

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 16 December 2011 17:52
To: [redacted]
Subject: Review Backlog Clinics

Eamon

What do you think? Mehmood always does 15 in a three hour clinic. KJ is triaging these patients with results etc.. before agreeing to review them but as you see Michael not in agreement. All other specialties see 15 in 3 hours for review backlog patients.

Would welcome your thoughts

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

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

From: Young, Michael
Sent: 16 December 2011 17:32
To: Corrigan, Martina; Ho, Kuo Jong
Cc: Cunningham, Andrea
Subject: RE: Urology - January Rota - KJ Ho

Still not in agreement 4 hrs is not the same as 3hrs - these pts are screened as needing a review and have not by definition been seen for a while therefore are verging on a new assessment. Not sure at all who made the decision that across the board 15 pts would be seen certainly we were not asked if this was acceptable = if 15 is to be insisted upon then clinics can only be booked for the morning session and afternoon defined as admin sessions. Could you forward the proposed January rota for Mr Ho

Ta

MY

From: Corrigan, Martina
Sent: 16 December 2011 15:48
To: Young, Michael; Ho, Kuo Jong
Cc: Cunningham, Andrea
Subject: RE: Urology - January Rota - KJ Ho

Michael,

These clinics are different from a core clinic as they are Review backlog clinics -the agreed amount at these clinics across all other specialties, e.g. gynae, general surgery, ENT etc.. is fifteen patients. Any of the review backlog clinics for Urology to date have also had 15 patients whether they have been an AM, PM or evening clinic.

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

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

From: Young, Michael
Sent: 15 December 2011 17:44
To: Corrigan, Martina; Ho, Kuo Jong
Cc: Cunningham, Andrea
Subject: RE: Urology - January Rota - KJ Ho

Not sure I agree with this you are saying a 3 hr clinic is the same as a 4hr clinic - this is not the same for the rest of us = I have done such a clinic a few Saturdays ago r/v were every 15 mins which is required for these pts and 15 took me the 4 hrs

MY

From: Corrigan, Martina
Sent: 14 December 2011 15:13
To: Ho, Kuo Jong
Cc: Cunningham, Andrea; Young, Michael
Subject: RE: Urology - January Rota - KJ Ho

KJ

I refer to the below. Just to advise that all review backlog clinics have 15 patients booked on them regardless if they are a morning or an afternoon clinic, as this is the number for this type of clinic that has been agreed by the Trust.

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

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

From: Cunningham, Andrea
Sent: 07 December 2011 11:32
To: Corrigan, Martina
Subject: FW: Urology - January Rota - KJ Ho

Hi Martina

Please advise re: email from KJ below.

Thanks
Andrea

Andrea Cunningham
Service Administrator SEC
SHSCT - Craigavon Area Hospital
68 Lurgan Road,
Portadown,
BT63 5QQ
Direct Line Personal Information redacted by USI

From: Ho, Kuo Jong
Sent: 07 December 2011 11:30
To: Cunningham, Andrea
Cc: Young, Michael
Subject: RE: Urology - January Rota - KJ Ho

Hi Andrea
Can you make sure that the pm clinics 2-5pm have 12 booked instead of 15. I understand that this is the agreed template for the urology clinics (15 for 4hr session and 12 for 3 hr session). Thanks Regards KJ

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 20 December 2010 21:42
To: Conway,Maria (OutPatient Projects)
Subject: FW: Mr O'Brien's backlog reviews

Hi Maria,

When you get time, are you able to do this as requested by Aidan?

Thanks

Martina

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

Tel: [redacted]
Mobile: [redacted]
Email: [redacted]

From: O'Neill, Kate
Sent: 17 December 2010 16:06
To: Corrigan, Martina
Cc: Hanvey, Leanne
Subject: RE: Mr O'Brien's backlog reviews

Hi Martina,
Thanks for the letters forwarded last week. Aidan will complete Banbridge 2008 as a priority. You also sent over Jan/Feb 2009 from CAH only.

Aidan wishes to proceed in the following fashion:
Jan/Feb 2009 from all three sites followed by March/April 2009 from all three sites etc etc.

Can you therefore ask for the letters for Jan/Feb from BBPC & Armagh to be sent over when available and I will let you know when we need March/April etc.

Thanks,
Kate

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 30 December 2011 16:06
To: Conway, Maria
Cc: Cunningham, Andrea
Subject: FW: OP REVIEW BACKLOG UPDATE - ELECTIVE & SURGICAL ONLY
Attachments: OP RBL TOTAL - SEC 31.12.11.xls

Hi Maria,

Just checking – did we ever get the 2009 letters from Mr Akhtar's office? If not I am happy to take a run up when I am back from leave.

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

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

From: Trouton, Heather
Sent: 30 December 2011 15:20
To: Corrigan, Martina
Subject: FW: OP REVIEW BACKLOG UPDATE - ELECTIVE & SURGICAL ONLY
Importance: High

Martina

Just in light of new developments , I see Mr Akhtar has now the most 2009 reviews still in the backlog. I know KJ is working his way through Mr Youngs

Can you p[ease advise?

heather

From: Conway, Maria
Sent: 30 December 2011 14:44
To: Connolly, Connie; Corrigan, Martina; Cunningham, Andrea; Devlin, Louise; Forde, Helen; Glenny, Sharon; Lappin, Lynn; Mackle, Eamon; mcfarland, Kelly; Nelson, Amie; Rankin, Gillian; Reid, Trudy; Robinson, Katherine; Scott, Jane M; Trouton, Heather
Subject: OP REVIEW BACKLOG UPDATE - ELECTIVE & SURGICAL ONLY
Importance: High

Please find attached updated OP Review Backlog position for Surgical & Elective Division only: month-end summary for December 2011.

Please note: Can you also check that all Consultants are accounted for, and please advise me of any changes/new Consultants/changes to OPWL codes etc. so as to ensure the accuracy of the information provided.

Please ensure that this is forwarded to all other relevant staff within your area.

Kind regards,
Maria

Maria Conway (Mrs)
Outpatient Project Manager (Acting)
Acute Services Division
Lead Nurses' Office - Surgery
Admin Floor
Craigavon Area Hospital

Tel: Personal Information redacted by USI
(Mornings only - Mon to Fri)

ISSUE	ACTIONS	WORKGROUP	TIMESCALE
EQUIPMENT Broken Equipment – letters to management over 1.5 years with virtually no response. 2 working rectoscopes by pulling all the instrumentation from two trays they could another two sets. Equipment too old, not on a service contract, pieces are vulnerable with a piece falling off intraop (Clinical incident completed – no response back) Same equipment, different suppliers STORZ and WOLF sets Can't tell the exact	Ownership of the problem Who actually owns the problem and who will take it forward? Service contract?? Guidelines on safety – does management agree with this Incident Reports – how are these brought back to the team. Does anything happen? Has there been any raised for this problem Baseline Audit required. Last one 4 – 5 years ago for urology initiative. Harvested the higher standard of equipment and investment made at that time for new equipment. Require a further audit Standardise equipment? Location of procedures – what site will procedures be carried out – what equipment needed for each site Service contracts for equipment Following eg 50 uses, should these be	Ronan Carroll Mary McGeough Martina Corrigan Mr Young Mr O'Brien Mr Akhtar Beatrice Moonan Theatre sister Sandra McLoughlin	Initial Meeting to take place by week ending 6 November. Audits etc to be completed by week ending 20 November Report back by end of end of November.

numbers of forceps for stents. Utererscopes – only have two – one is broken so only one available for procedures. Flexible uteroscope – only one 'old' scope. There should be 3-4 flexible and 4-6 rigid to meet urology service needs	serviced Decontamination of equipment and affects on equipment New technology for the future.		
WARD RECONFIGURATION	Where is the 3 month review What was to be gained from fragmenting the service between emergencies, longstay and shortstay? Would it have been better for urology to share as a specialty on one ward to bring the same number of bed reductions? Affects to patient care with patients have to move between wards so many times. Quality?? What do the urology team and nursing	Heather Trouton Martina Corrigan Noleen O'Donnell Catriona McGoldrick Nursing Staff Mr Young Mr O'Brien Mr Akhtar Sharon Glenny	3 Monthly review meeting organized for November 2009 Report of findings to Urologists by end of November

	staff see as the better “system” for caring for patients. Safety for patients Expectations on nursing staff, eg, emergency care ward and the movements of patients/patient flow. Are management aware of the concerns from clinical and nursing staff? Do they see the problem first hand? Emergency ward should be 100% emergency, not a mixture of elective and emergency. Patients could be moving 3 – 4 times during the course of their stay. Patients may only be staying on one ward for 6 hours! All wards should be equipped to deal with all types of patients, depending on where they will be staying. Was cutting beds to save money the most effective? What about clinical teams having to move around to see patients. Loss to patient care and quality of care		

	What is best for urology department? Need clear ideas and deadlines Having now sampled existing model		
Clinical Day Care Centre *IV Fluids and Antibiotics*	Business case to staff CDCC unit regularly for patients for IV fluids and antibiotics as admission avoidance to wards ??having junior anaesthetist to get peripheral venous access. Management keen for this to go ahead. Need to know which patients are suitable for this unit and how often they require treatment. Most days have access to beds and 2 side rooms. Side rooms used for intravesical chemotherapy. ??urology ambulatory day case	Shirley Tedford Martina Corrigan Sheila Mulligan In Liaison with three Urologists	Mid-December
Intravesical chemo	Janice has now moved across Cost centre required Supplies being order through 4 north	Shirley Tedford Martina Corrigan Janice	Mid- December
Trial Removal of	When in 2 south had bed capacity – now	Shirley Tedford	Mid-December

Catheter	don't Some done in the community if appropriate. Those that need brought back to CAH go to CDSW. Catheters removed, scanned, regs contacted and discharged home. Would like to move to ambulatory day area. Staff there qualified to do catheterization, bladder scans, etc. Patient who are going on end of urodynamics sessions for TRC/change of catheter could go to ambulatory area. Protocols to be written for this. Cant depend as much on community staff as have done in past. When patients attend A&E and sent out to community, this area will give a base to be referred on to.	Martina Corrigan Mairead Leonard Nicola McClenaghan In liaison with three Urologists	
Clean intermittent catheterization	There are some patients who need to come into hospital Propose that they come into ambulatory area rather than beds.	Shirley Tedford Martina Corrigan Martina (Community-based) Wendy(Community-based)	Mid-December

	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.		

SHSCT OUTPATIENT REVIEW BACKLOG - CUMULATIVE TOTAL AT 30.12.11
REVIEW APPOINTMENTS REQUIRED BY 31 DECEMBER 2011 INCLUSIVE

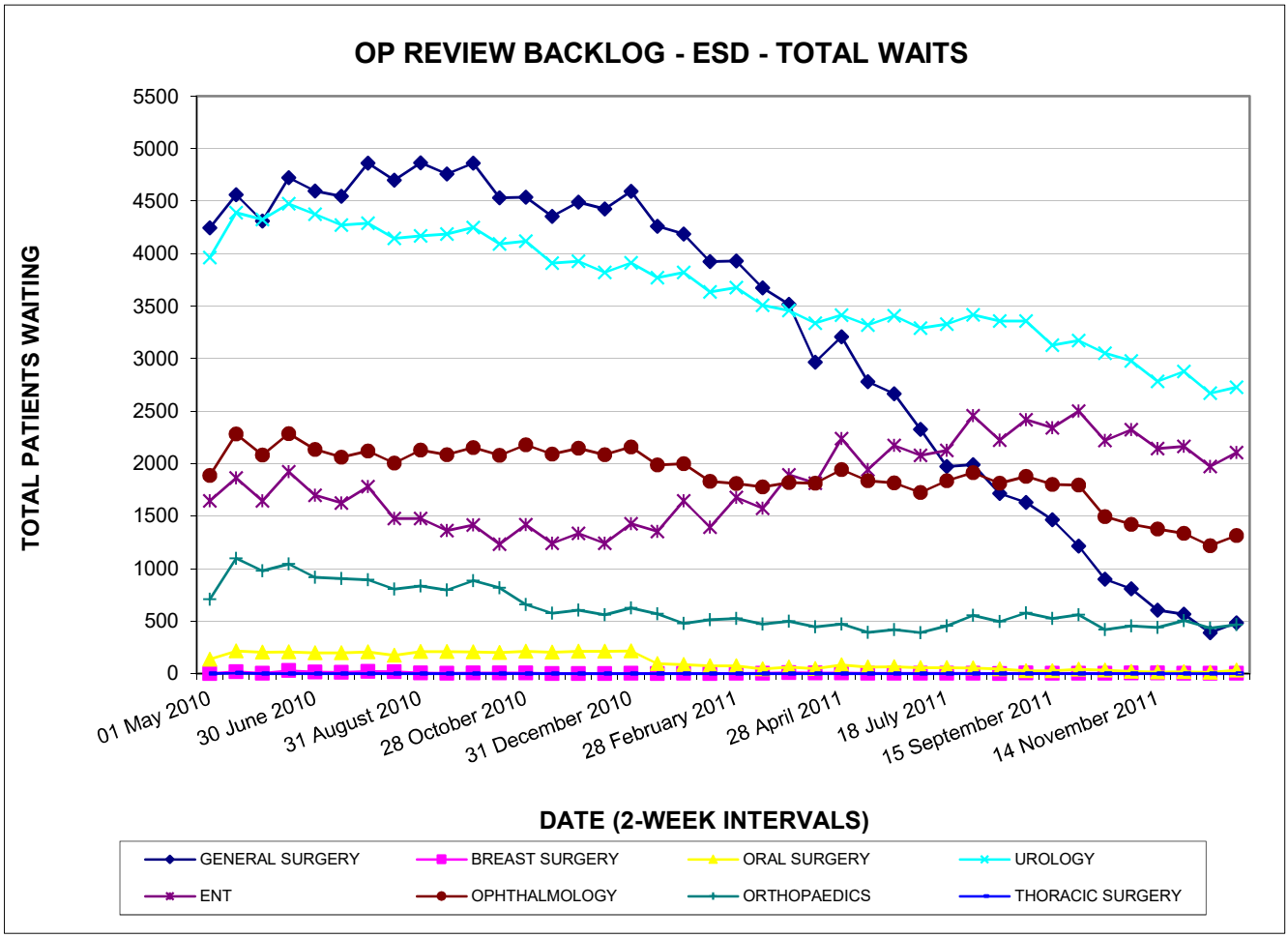
ELECTIVE & SURGICAL DIVISION ONLY

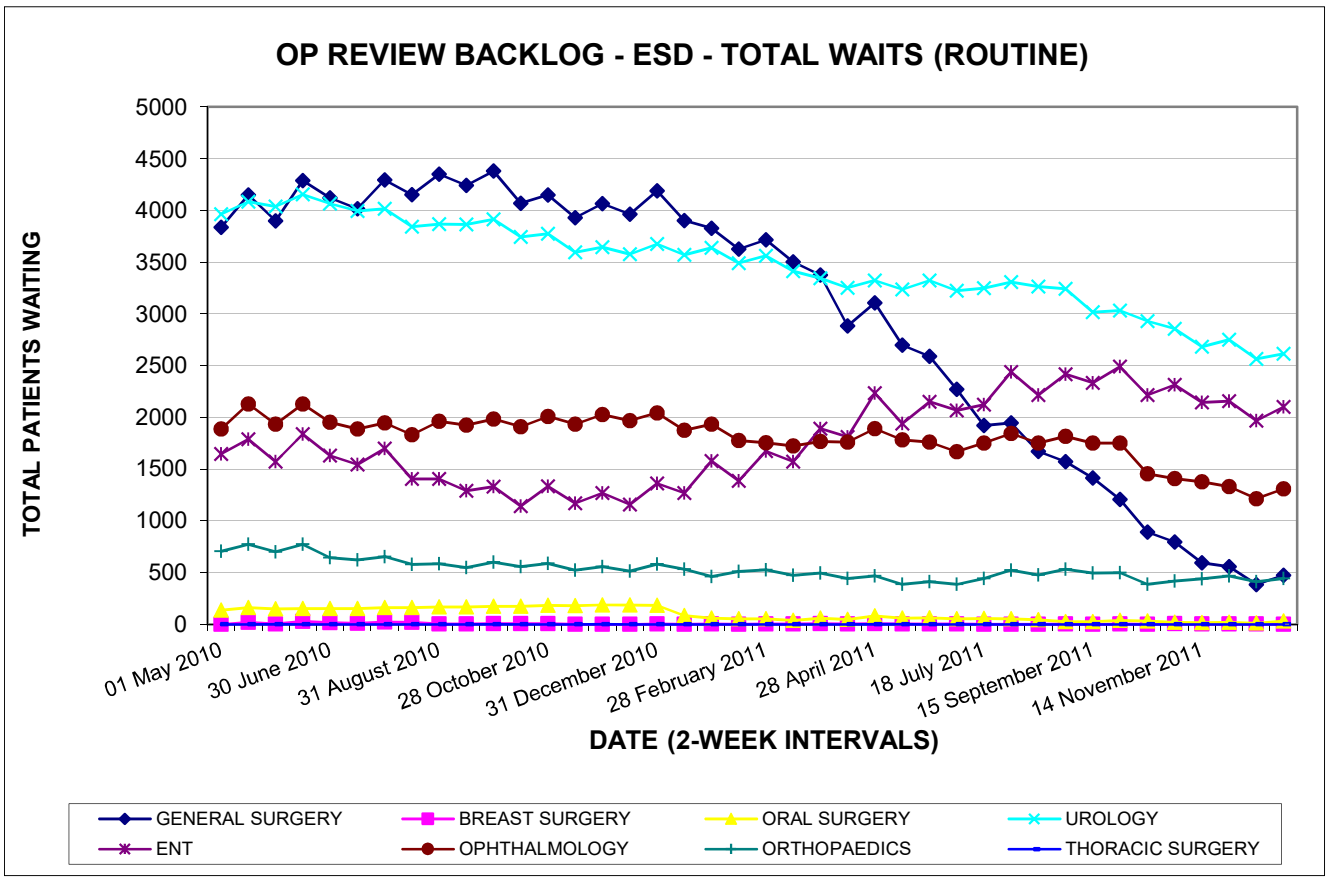
SPECIALTY DESCRIPTION	YEAR							
	2007	2008	2009	2010	2011*	OLD TOP OF LIST	URGENT REV CODES	TOTAL
GENERAL SURGERY	0	0	0	12	461	0	10	483
BREAST SURGERY	0	0	0	0	1	0	1	2
ORAL SURGERY	0	0	0	1	32	0	0	33
UROLOGY	0	1	451	621	1537	17	95	2722
ENT	0	0	0	8	2093	0	4	2105
OPHTHALMOLOGY	0	0	134	336	838	0	6	1314
ORTHOPAEDICS	0	0	0	4	438	0	24	466
THORACIC SURGERY	0	0	0	0	0	0	0	0
TOTAL	**0**	**1**	**585**	**982**	**5400**	**17**	**140**	**7125**

* 2011 total = 1 Jan 2011 to 31 DECEMBER 2011

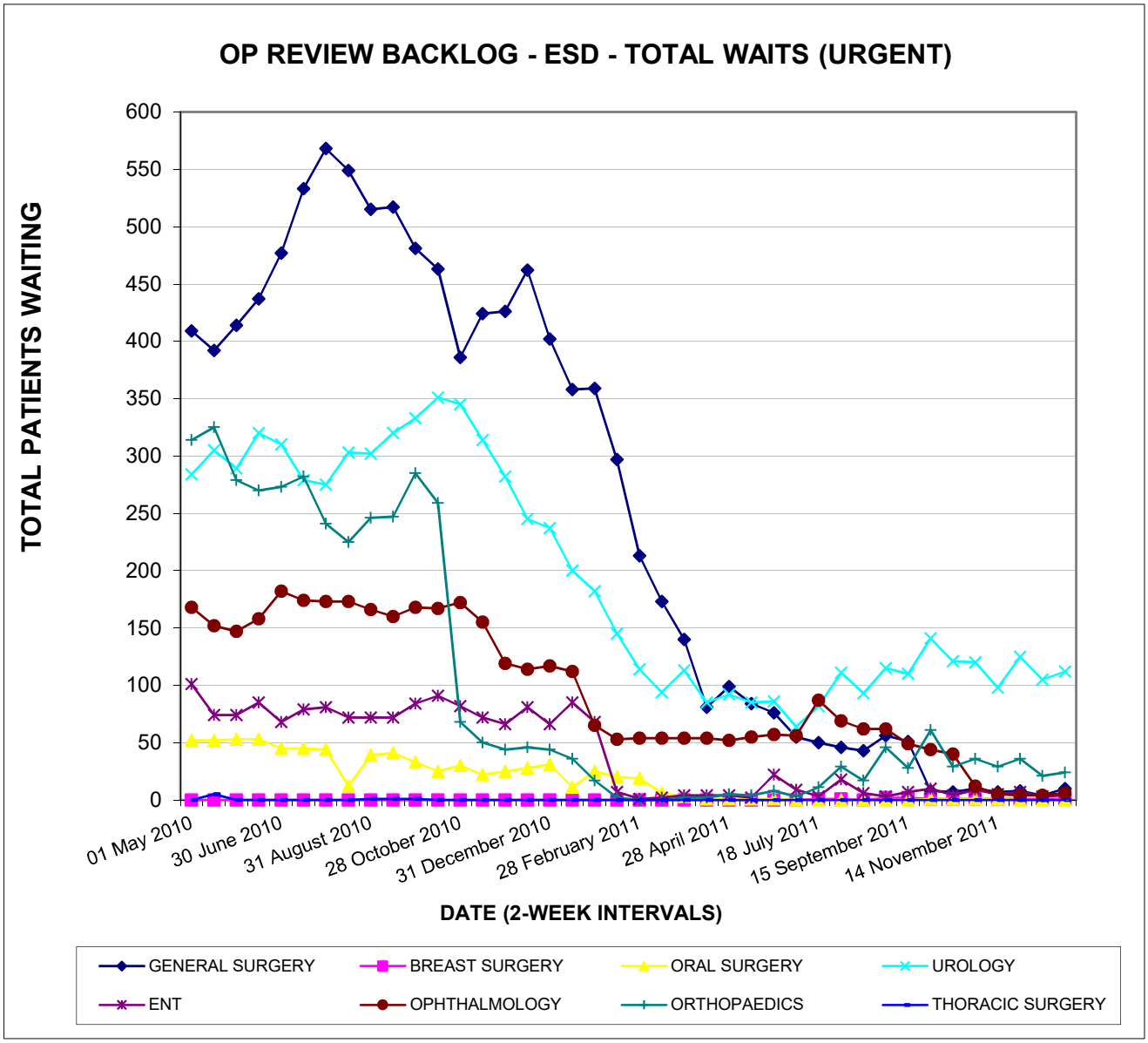
This report shows the OP review backlog for E&SD in its entirety, as well as the number of patients who are sitting at the top of the list/urgent reviews/"select next"/no "Date Reqd" reviews for each Consultant.

ELECTIVE & SURGICAL DIVISION ONLY

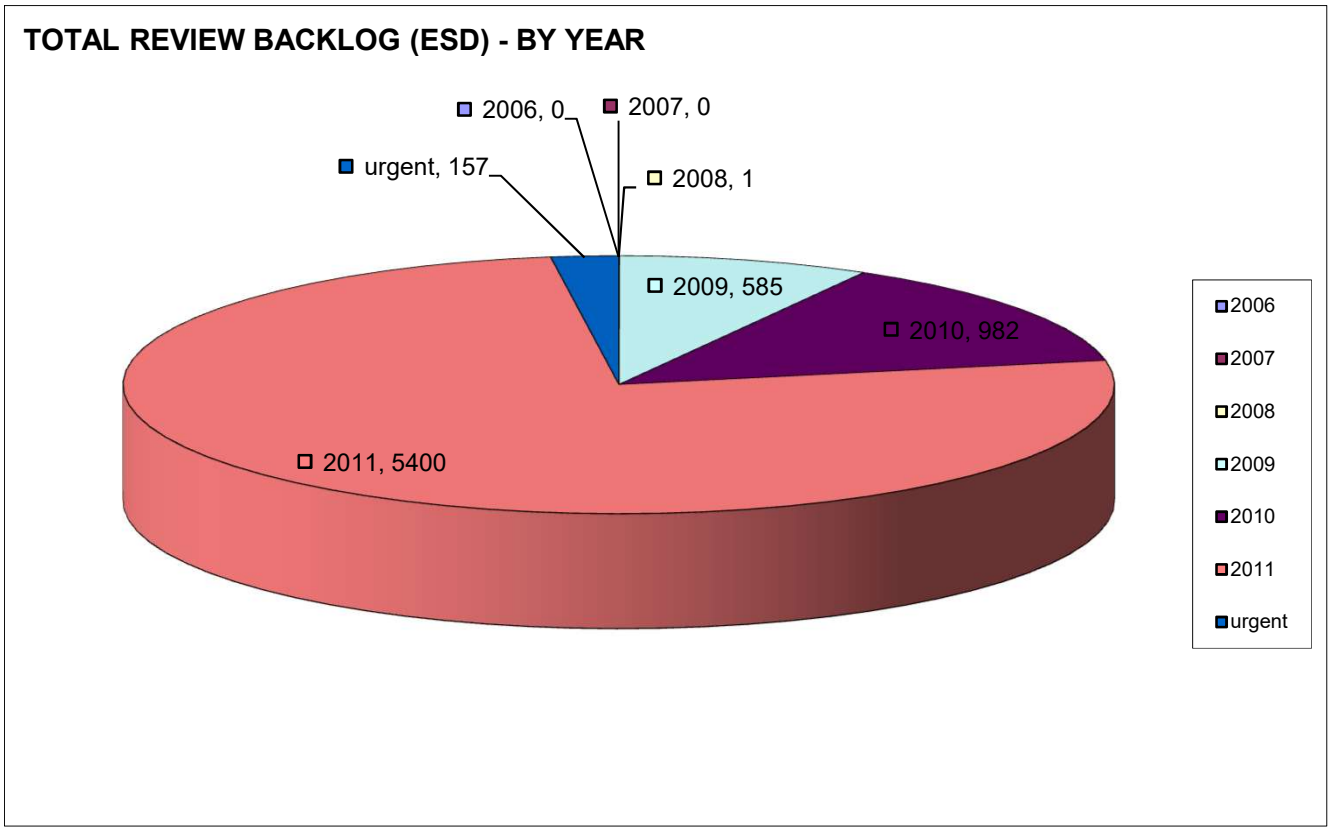


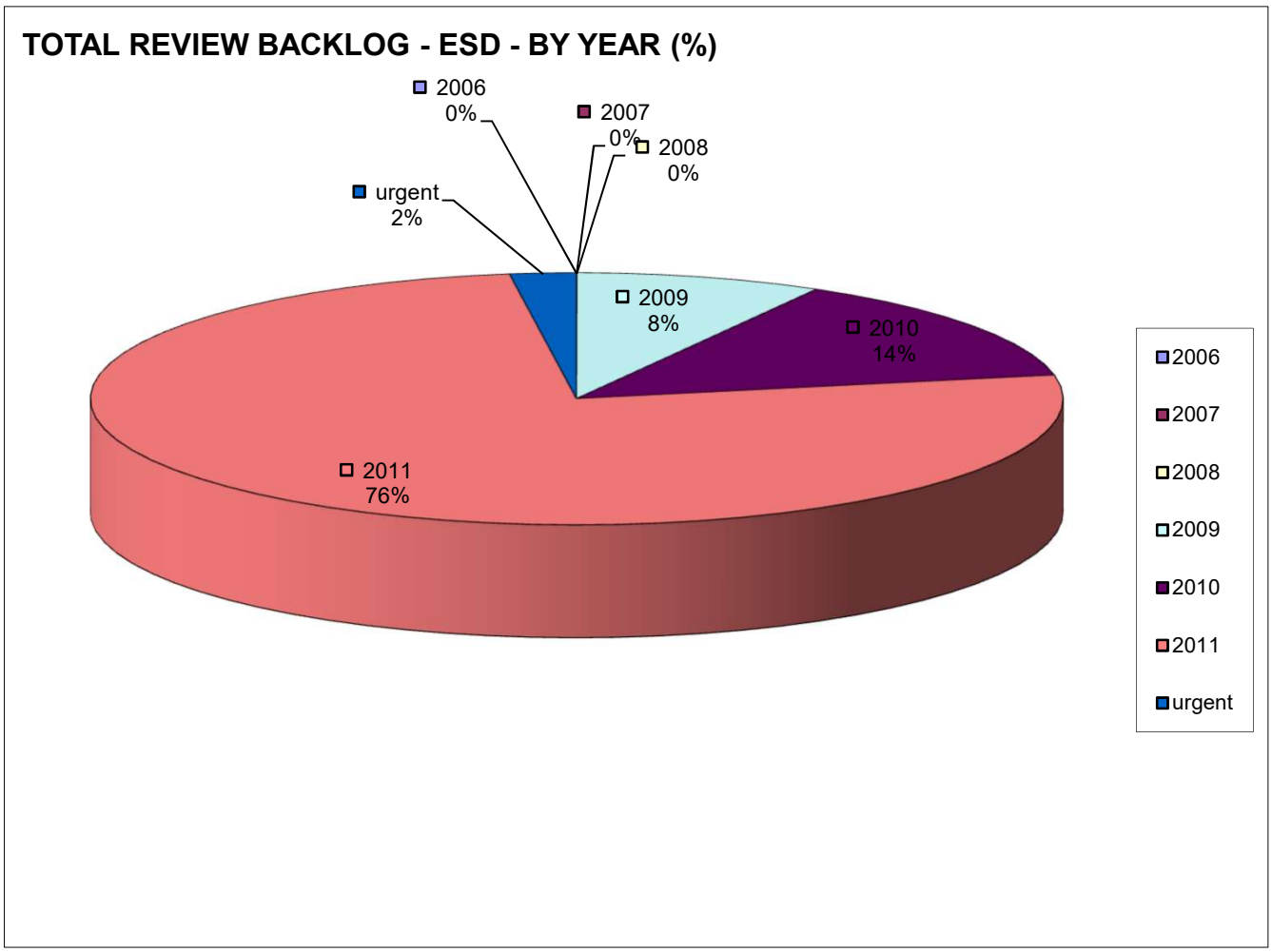


Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.


OP REVIEW BACKLOG - ESD - TOTAL WAITS (URGENT)
TOTAL PATIENTS WAITING
600
550
500
450
400
350
300
250
200
150
100
50
0
01 May 2010
30 June 2010
31 August 2010
28 October 2010
31 December 2010
28 February 2011
28 April 2011
18 July 2011
15 September 2011
14 November 2011
DATE (2-WEEK INTERVALS)
GENERAL SURGERY
BREAST SURGERY
ORAL SURGERY
UROLOGY
ENT
OPHTHALMOLOGY
ORTHOPAEDICS
THORACIC SURGERY

ELECTIVE & SURGICAL DIVISION OP BACKLOG - BREAKDOWN BY YEAR





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

SHSCT OUTPATIENT REVIEW BACKLOG - CUMULATIVE TOTAL AT 30.12.11
REVIEW APPOINTMENTS REQUIRED BY 31 DECEMBER 2011 INCLUSIVE

GENERAL SURGERY ONLY

CONSULTANT	SITE	YEAR							TOTAL
		2007	2008	2009	2010	2011*	OLD TOP OF LIST	URGENT REV CODES	
Personal Information redacted by the USI	CAH	0	0	0	0	97	0	0	97
	CAH	0	0	0	0	155	0	1	156
	CAH	0	0	0	0	11	0	1	12
	CAH	0	0	0	0	42	0	0	42
	CAH	0	0	0	12	6	0	0	18
	CAH	0	0	0	0	18	0	0	18
	CAH	0	0	0	0	74	0	0	74
	DHH	0	0	0	0	8	0	1	9
	DHH	0	0	0	0	6	0	1	7
	DHH	0	0	0	0	9	0	0	9
	DHH	0	0	0	0	0	0	0	0
	DHH	0	0	0	0	0	0	0	0
	DHH	0	0	0	0	32	0	3	35
	STH	0	0	0	0	0	0	0	0
	BBPC	0	0	0	0	0	0	0	0
	BBPC	0	0	0	0	1	0	0	1
	BBPC	0	0	0	0	2	0	2	4
	ACH	0	0	0	0	0	0	1	1
TOTAL		0	0	0	12	461	0	10	483

•includes breast patients

* 2011 total = 1 Jan 2011 to 31 DECEMBER 2011

This report shows the OP review backlog in its entirety, as well as the number of patients who are sitting at the top of the list/urgent reviews/"select next" reviews for each Consultant.

BREAST SURGERY ONLY

CONSULTANT	SITE	YEAR							TOTAL
		2007	2008	2009	2010	2011*	OLD TOP OF LIST	URGENT REV CODES	
Personal Information redacted by the USI [redacted])	DHH	0	0	0	0	1	0	1	2
TOTAL		0	0	0	0	1	0	1	2

ORAL SURGERY ONLY

CONSULTANT	SITE	YEAR							TOTAL
		2007	2008	2009	2010	2011*	OLD TOP OF LIST	URGENT REV CODES	
Personal Information redacted by the USI	CAH	0	0	0	0	0	0	0	0
	CAH	0	0	0	0	5	0	0	5
	DHH	0	0	0	1	17	0	0	18
	CAH	0	0	0	0	9	0	0	9
CAH MINOR OPS (COSMP)	CAH	0	0	0	0	0	0	0	0
DHH MINOR OPS (DPRBM)	DHH	0	0	0	0	1	0	0	1
TOTAL		0	0	0	1	32	0	0	33

has left Trust pts trfd from Personal Information

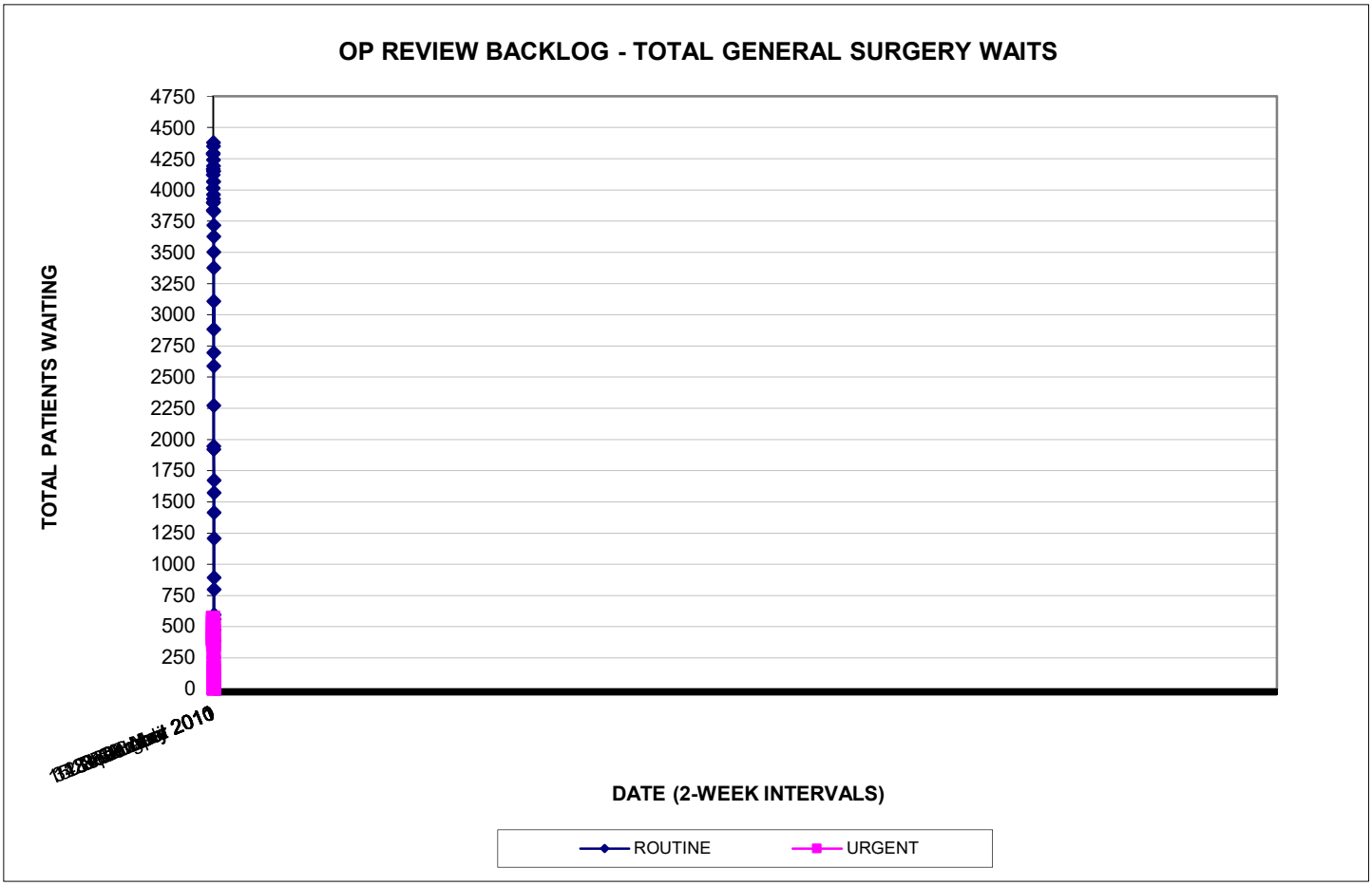
THORACIC SURGERY ONLY

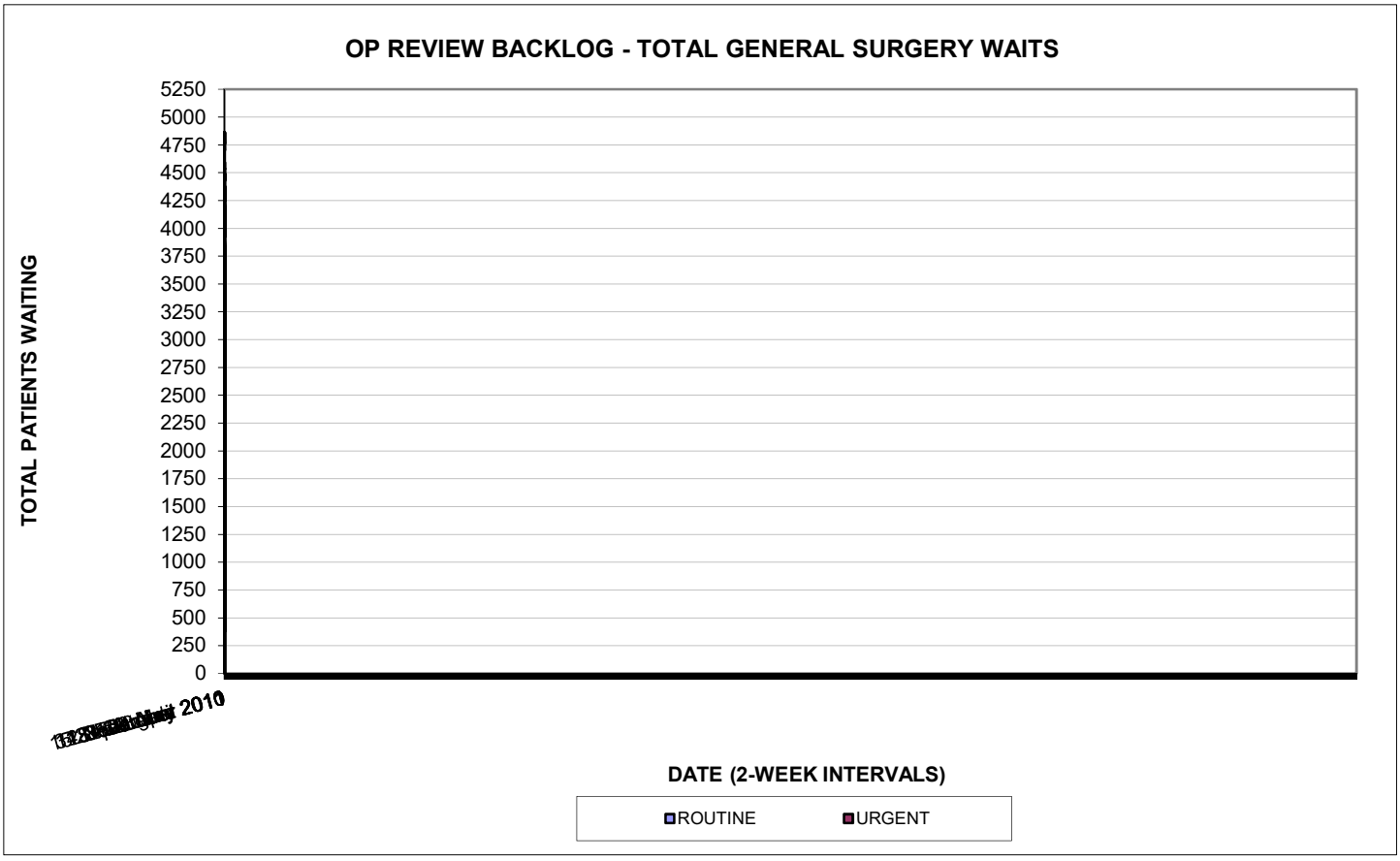
CONSULTANT	SITE	YEAR							TOTAL
		2007	2008	2009	2010*	2011*	OLD TOP OF LIST	URGENT REV CODES	
Personal Information redacted by the USI	CAH	0	0	0	0	0	0	0	0
	DHH	0	0	0	0	0	0	0	0
TOTAL		0	0	0	0	0	0	0	0

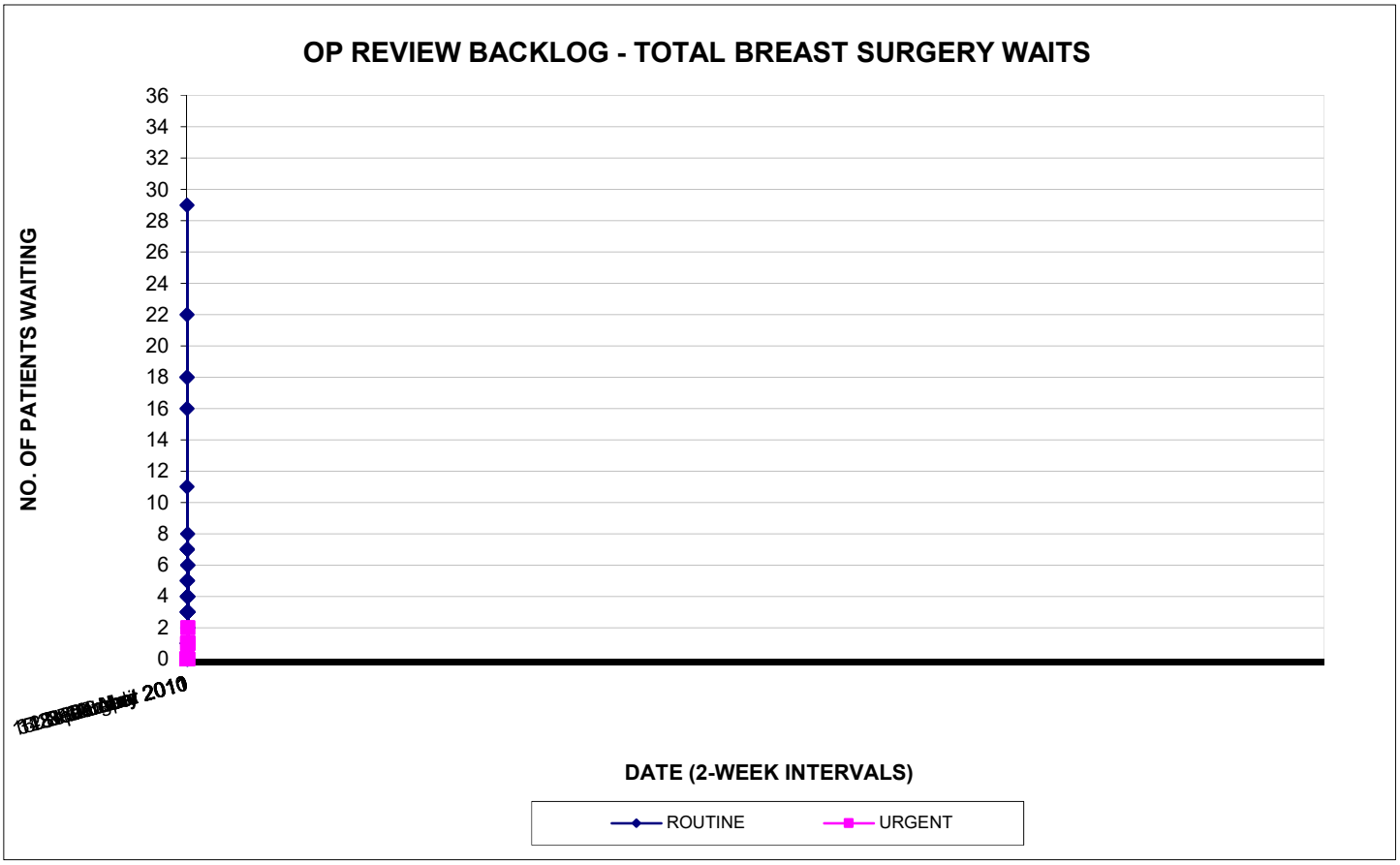
* 2011 total = 1 Jan 2011 to 31 DECEMBER 2011

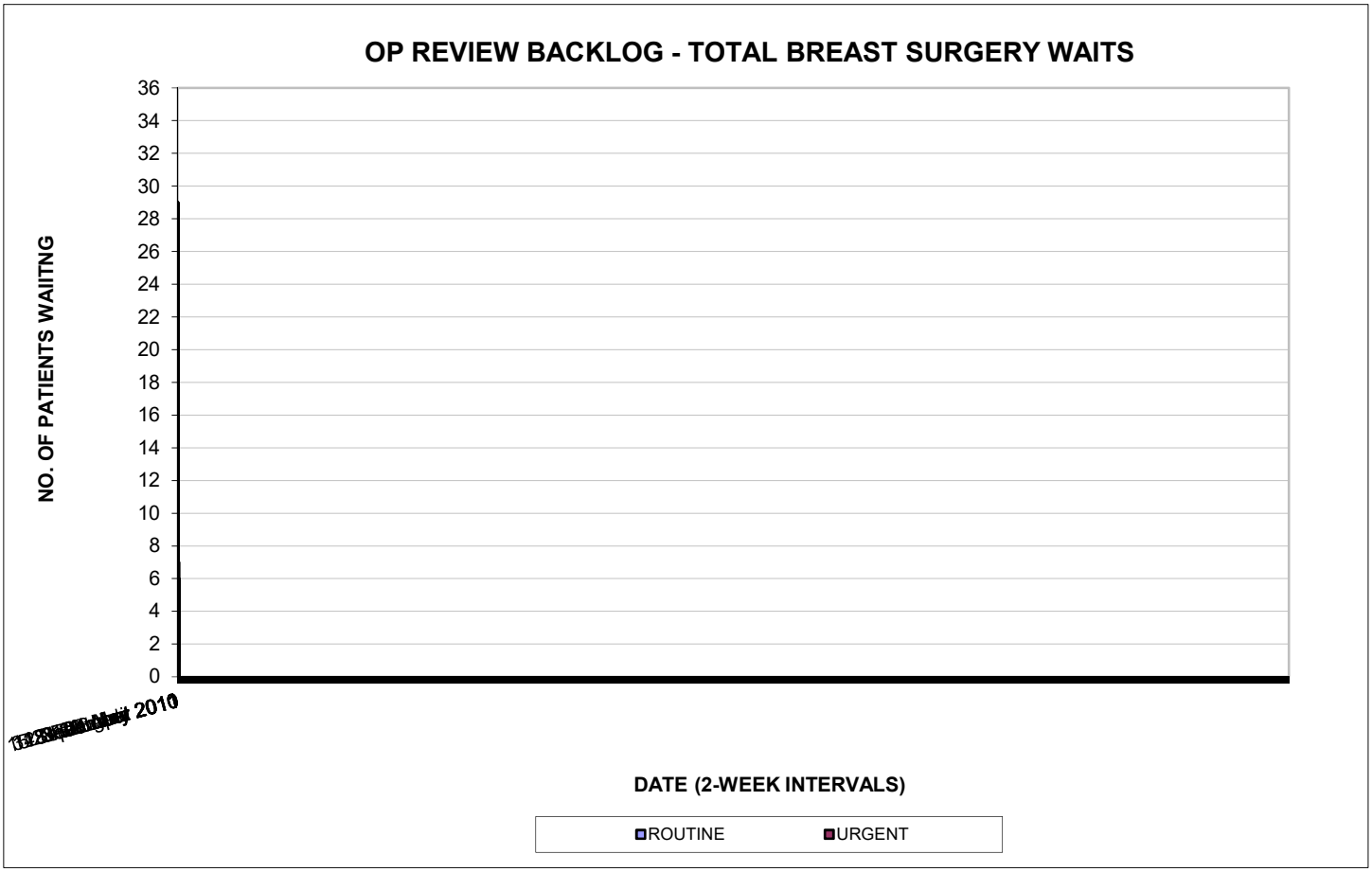
This report shows the OP review backlog in its entirety, as well as the number of patients who are sitting at the top of the list/urgent reviews/"select next" reviews for each Consultant.

KEY: Consultant has left Trust - patients transferred to another Consultant


OP REVIEW BACKLOG - TOTAL GENERAL SURGERY WAITS
TOTAL PATIENTS WAITING
4750
4500
4250
4000
3750
3500
3250
3000
2750
2500
2250
2000
1750
1500
1250
1000
750
500
250
0
2010
DATE (2-WEEK INTERVALS)
ROUTINE
URGENT


OP REVIEW BACKLOG - TOTAL GENERAL SURGERY WAITS
TOTAL PATIENTS WAITING
5250
5000
4750
4500
4250
4000
3750
3500
3250
3000
2750
2500
2250
2000
1750
1500
1250
1000
750
500
250
0
2010
DATE (2-WEEK INTERVALS)
ROUTINE
URGENT





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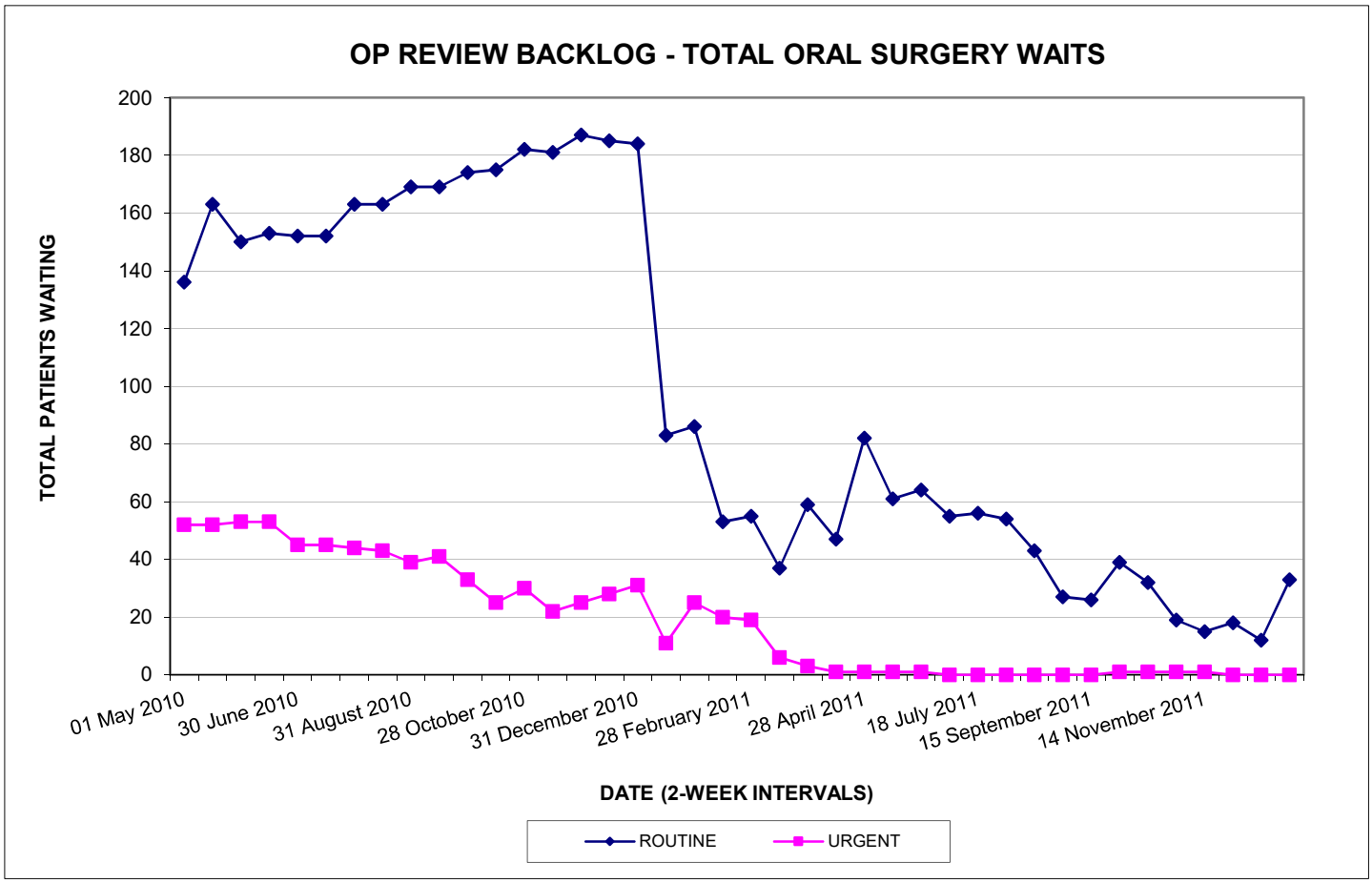
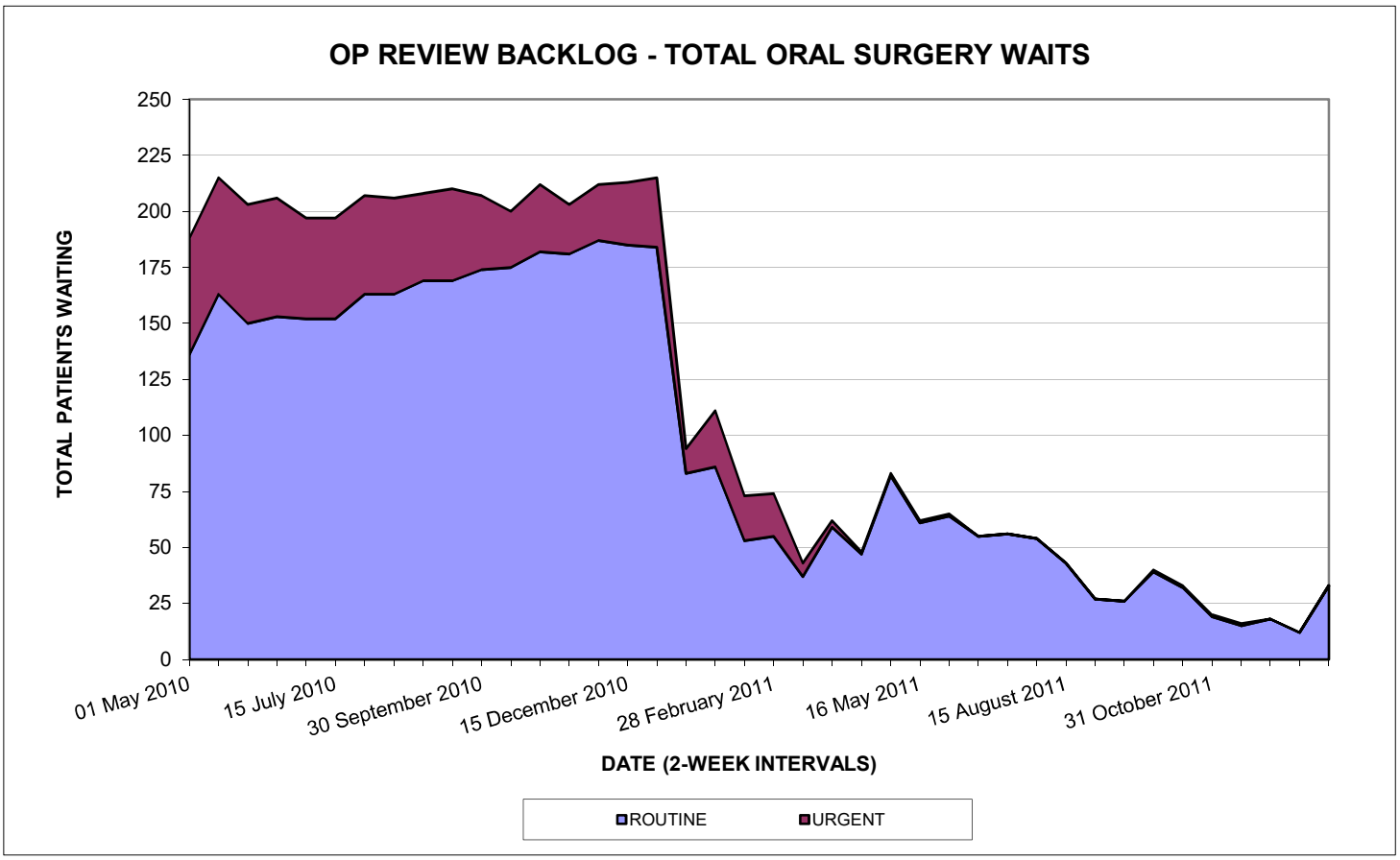

OP REVIEW BACKLOG - TOTAL ORAL SURGERY WAITS
TOTAL PATIENTS WAITING
200
180
160
140
120
100
80
60
40
20
0
01 May 2010
30 June 2010
31 August 2010
28 October 2010
31 December 2010
28 February 2011
28 April 2011
18 July 2011
15 September 2011
14 November 2011
DATE (2-WEEK INTERVALS)
ROUTINE
URGENT


OP REVIEW BACKLOG - TOTAL ORAL SURGERY WAITS
TOTAL PATIENTS WAITING
250
225
200
175
150
125
100
75
50
25
0
01 May 2010
15 July 2010
30 September 2010
15 December 2010
28 February 2011
16 May 2011
15 August 2011
31 October 2011
DATE (2-WEEK INTERVALS)
ROUTINE
URGENT

SHSCT OUTPATIENT REVIEW BACKLOG - CUMULATIVE TOTAL AT 30.12.11
REVIEW APPOINTMENTS REQUIRED BY 31 DECEMBER 2011 INCLUSIVE

UROLOGY ONLY

CONSULTANT	SITE	YEAR								
		2007	2008	2009	2010	2011*	OLD TOP OF LIST	URGENT REV CODES	TOTAL	
MR M YOUNG (CURMYR)	CAH	0	0	101	163	289	2	2	557	
MR M YOUNG (CAUM4R)	ACH	0	0	39	2	25	0	2	68	
MR A O'BRIEN (CU2R)	CAH	0	0	64	251	324	0	58	697	
DR P RODGERS (CUPR2R)	CAH	0	0	0	0	2	0	0	2	
MR M AKHTAR (CMAR)	CAH	0	0	177	30	377	0	1	585	
MR A O'BRIEN (CAU4R)	ACH	0	0	24	96	67	0	6	193	
MR A O'BRIEN (BPU4R)	BBPC	0	0	43	79	87	15	18	242	
MR M YOUNG (BURM4R)	BBPC	0	1	3	0	38	0	8	50	
MR M AKHTAR (SMAR)	STH	0	0	0	0	0	0	0	0	
DR P RODGERS (CPRURO5R) (URO-ONCOLOGY)	CAH	0	0	0	0	17	0	0	17	
MR M YOUNG - STONE TREATMENT (CMYSTCR)	CAH	0	0	3	1	311	0	0	315	new OPWL code
TOTAL		0	1	451	621	1537	17	95	2726	

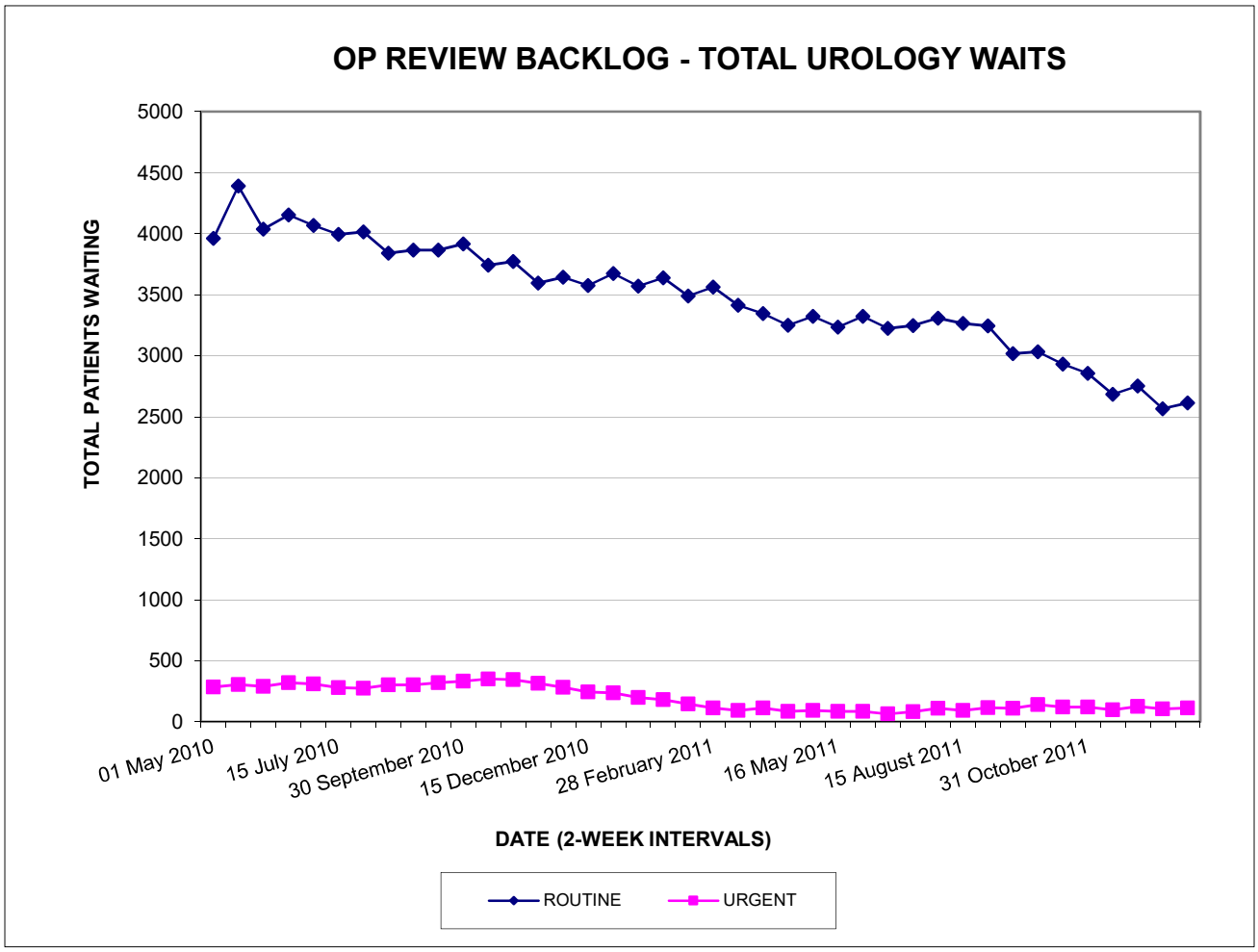
ENT ONLY

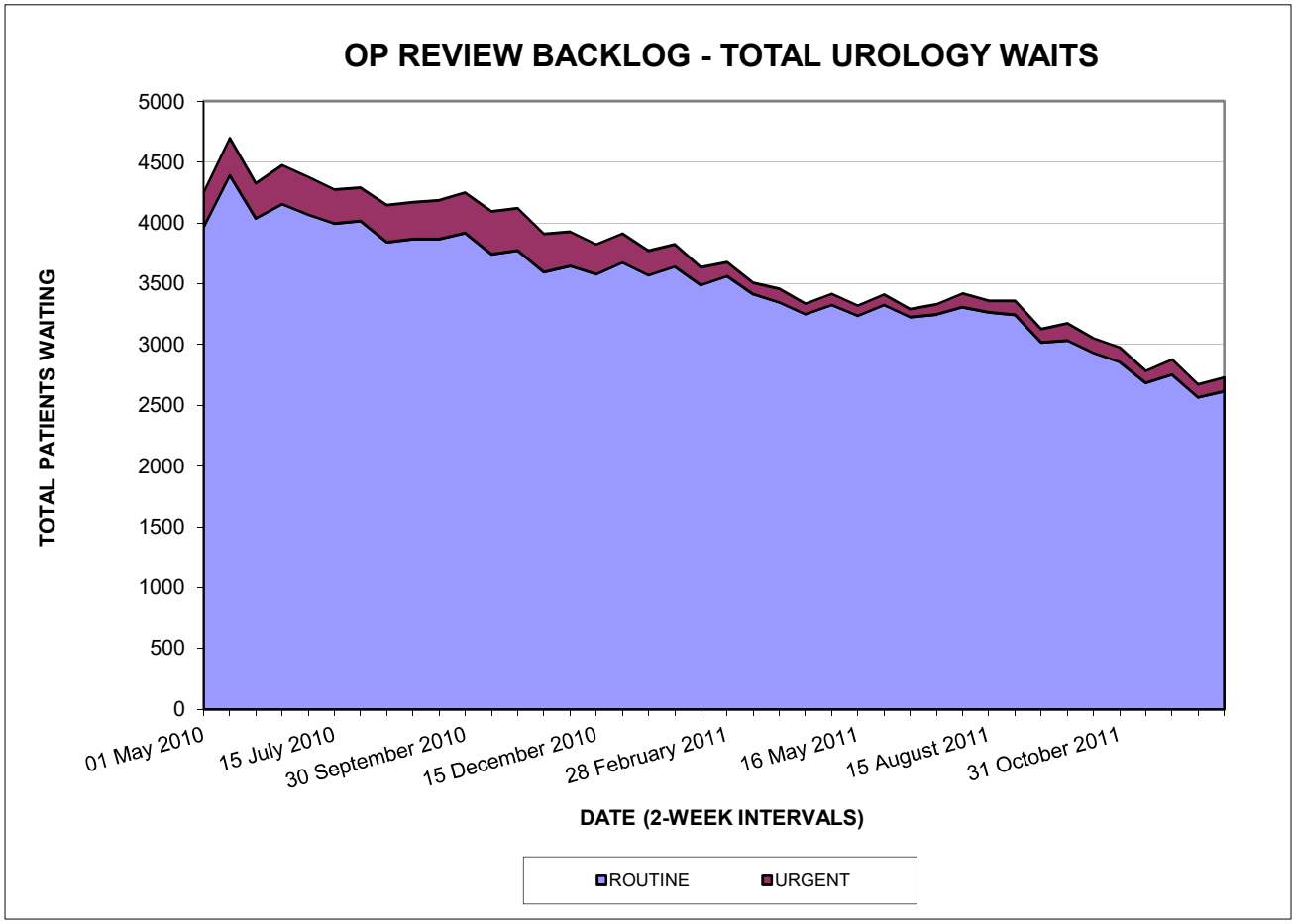
CONSULTANT	SITE	YEAR								
		2007	2008	2009	2010	2011*	OLD TOP OF LIST	URGENT REV CODES	TOTAL	
Personal Information redacted by the USI	CAH	0	0	0	3	41	0	0	44	
	CAH	0	0	0	0	105	0	0	105	
	CAH	0	0	0	0	0	0	0	0	
	CAH	0	0	0	1	320	0	2	323	
	CAH	0	0	0	0	48	0	0	48	
	CAH	0	0	0	0	318	0	0	318	
	CAH	0	0	0	0	139	0	0	139	
	CAH	0	0	0	0	118	0	0	118	
	CAH	0	0	0	0	2	0	0	2	
	DHH	0	0	0	2	140	0	0	142	
	DHH	0	0	0	1	327	0	0	328	
	DHH	0	0	0	1	85	0	0	86	
	DHH	0	0	0	0	111	0	0	111	
	DHH	0	0	0	0	3	0	0	3	
	BBPC	0	0	0	0	0	0	0	0	*DO NOT USE*
	BBPC	0	0	0	0	10	0	0	10	
	ACH	0	0	0	0	0	0	0	0	
	ACH	0	0	0	0	1	0	0	1	
	STH	0	0	0	0	307	0	1	308	
	STH	0	0	0	0	3	0	0	3	
	CAH	0	0	0	0	15	0	1	16	
TOTAL		0	0	0	8	2093	0	4	2105	

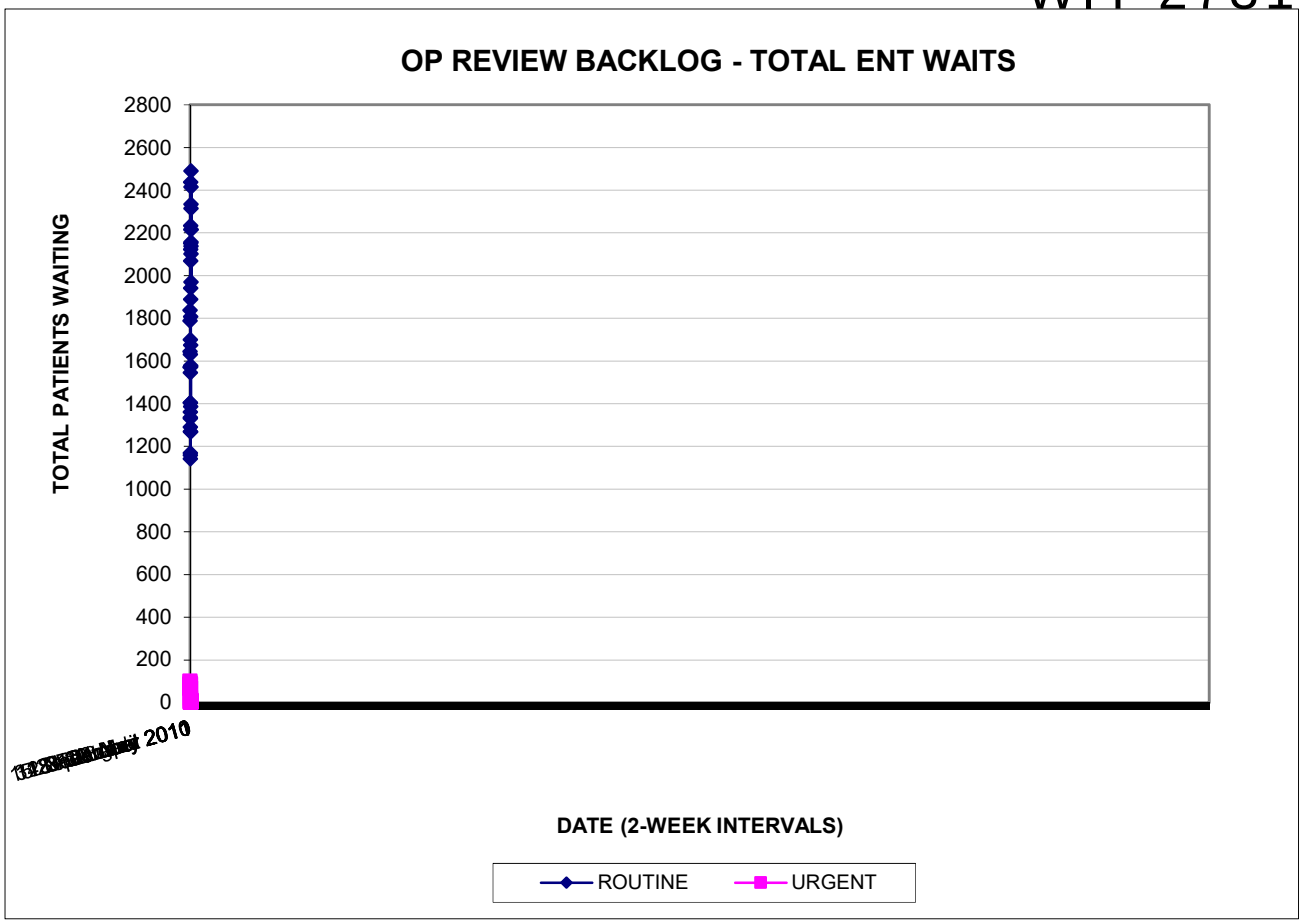
Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

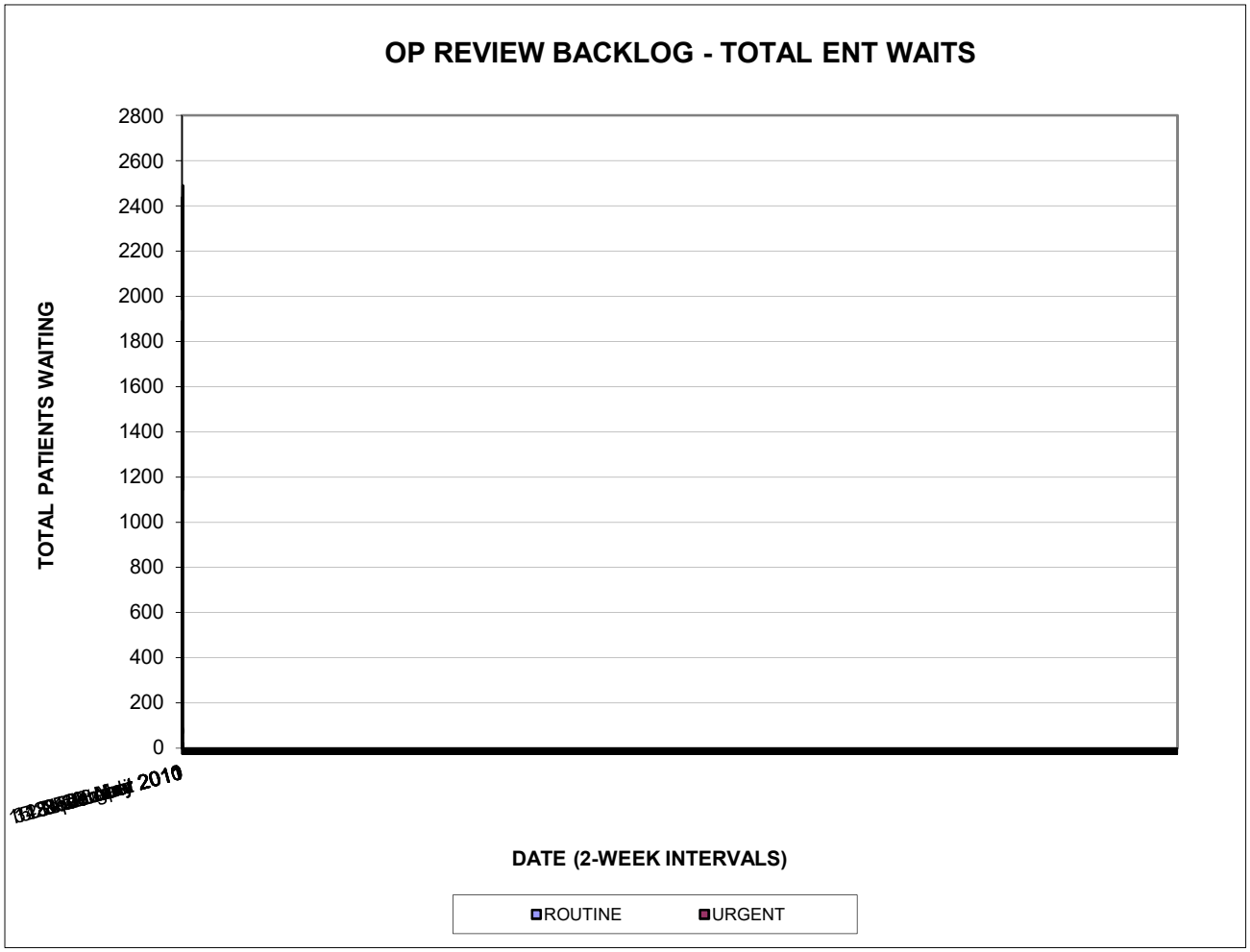
* 2011 total = 1 JANUARY 2011 to 31 DECEMBER 2011

Personal Information redacted by the USI's patients transferred to Personal Information redacted by the USI


OP REVIEW BACKLOG - TOTAL UROLOGY WAITS
TOTAL PATIENTS WAITING
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
01 May 2010
15 July 2010
30 September 2010
15 December 2010
28 February 2011
16 May 2011
15 August 2011
31 October 2011
DATE (2-WEEK INTERVALS)
ROUTINE
URGENT


OP REVIEW BACKLOG - TOTAL UROLOGY WAITS
TOTAL PATIENTS WAITING
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
01 May 2010
15 July 2010
30 September 2010
15 December 2010
28 February 2011
16 May 2011
15 August 2011
31 October 2011
DATE (2-WEEK INTERVALS)
ROUTINE
URGENT


OP REVIEW BACKLOG - TOTAL ENT WAITS
TOTAL PATIENTS WAITING
2800
2600
2400
2200
2000
1800
1600
1400
1200
1000
800
600
400
200
0
2010
DATE (2-WEEK INTERVALS)
ROUTINE
URGENT


OP REVIEW BACKLOG - TOTAL ENT WAITS
TOTAL PATIENTS WAITING
2800
2600
2400
2200
2000
1800
1600
1400
1200
1000
800
600
400
200
0
2010
DATE (2-WEEK INTERVALS)
ROUTINE
URGENT

SHSCT OUTPATIENT REVIEW BACKLOG - CUMULATIVE TOTAL AT 30.12.11
REVIEW APPOINTMENTS REQUIRED BY 31 DECEMBER 2011 INCLUSIVE

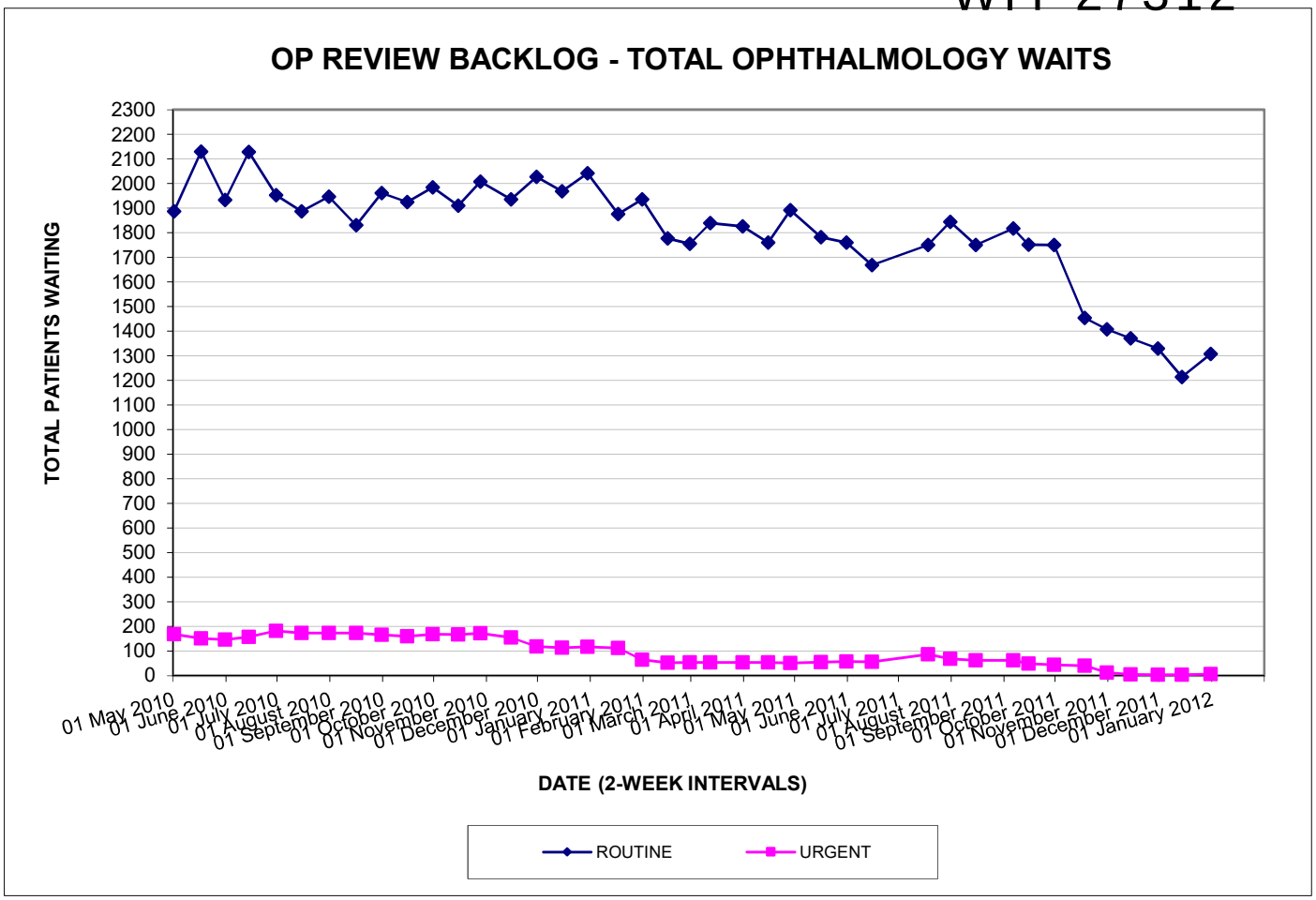
OPHTHALMOLOGY ONLY

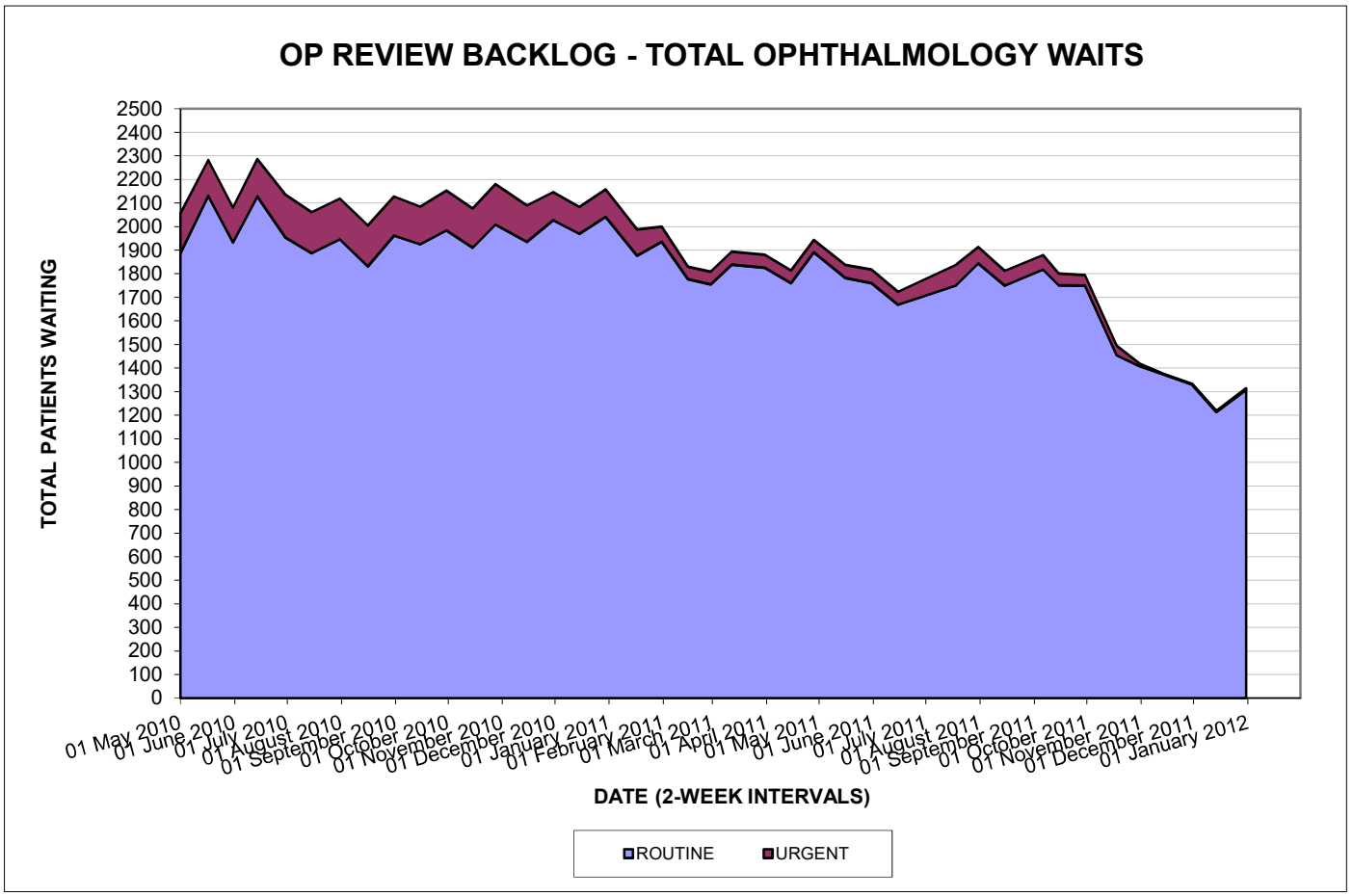
CONSULTANT	SITE	YEAR							
		2007	2008	2009	2010	2011*	OLD TOP OF LIST	URGENT REV CODES	TOTAL
Personal Information redacted by the USI	CAH	0	0	0	0	8	0	0	8
	CAH	0	0	0	92	217	0	2	311
	DHH	0	0	0	1	169	0	2	172
	DHH	0	0	3	86	189	0	1	279
	DHH	0	0	0	0	1	0	1	2
	ACH	0	0	0	0	35	0	0	35
	STH	0	0	131	157	155	0	0	443
	CAH	0	0	0	0	2	0	0	2
	CAH	0	0	0	0	33	0	0	33
	DHH	0	0	0	0	20	0	0	20
	DHH	0	0	0	0	3	0	0	3
	DHH	0	0	0	0	0	0	0	0
	ACH	0	0	0	0	1	0	0	1
	STH	0	0	0	0	5	0	0	5
TOTAL		0	0	134	336	838	0	6	1314

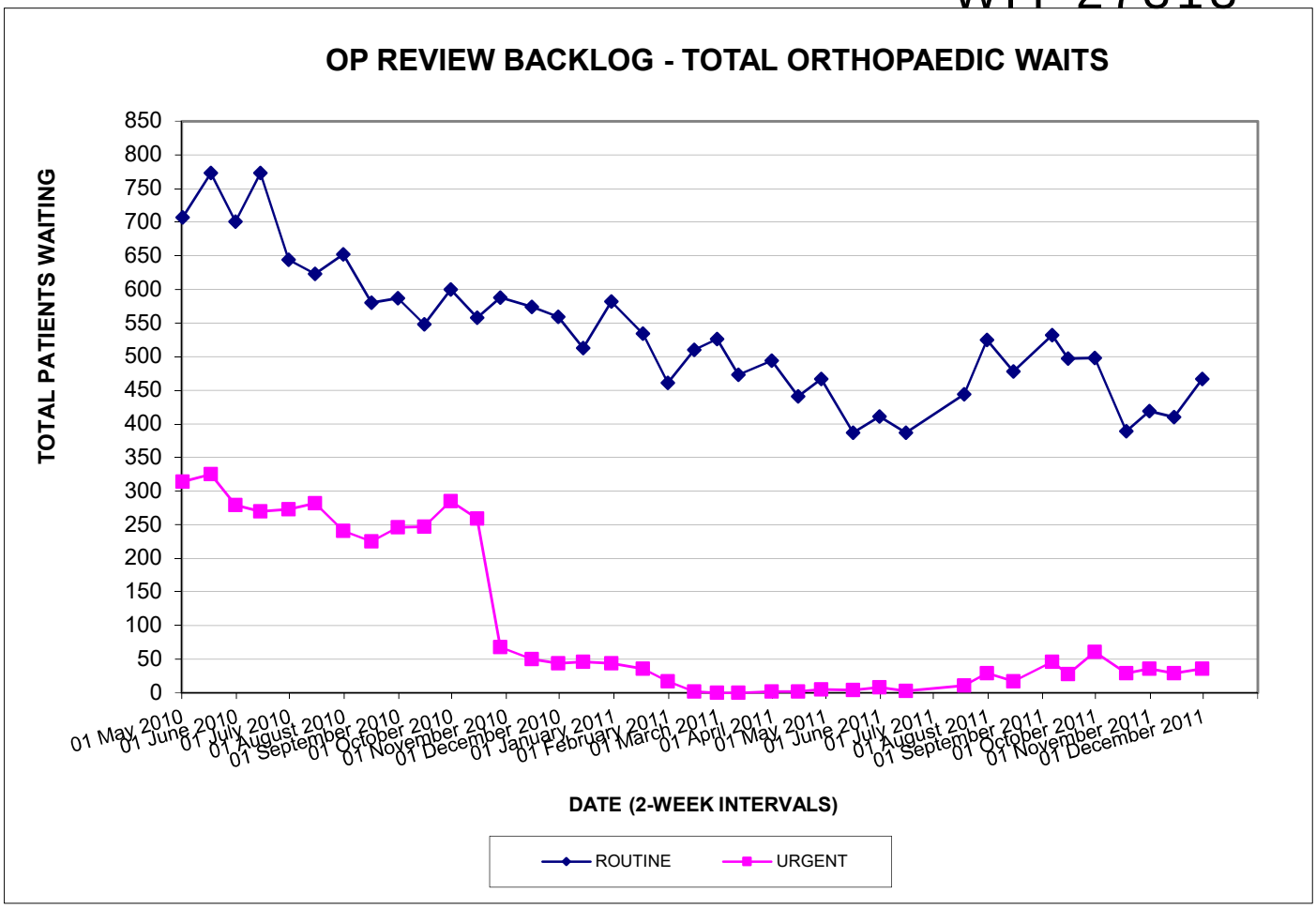
ORTHOPAEDICS ONLY

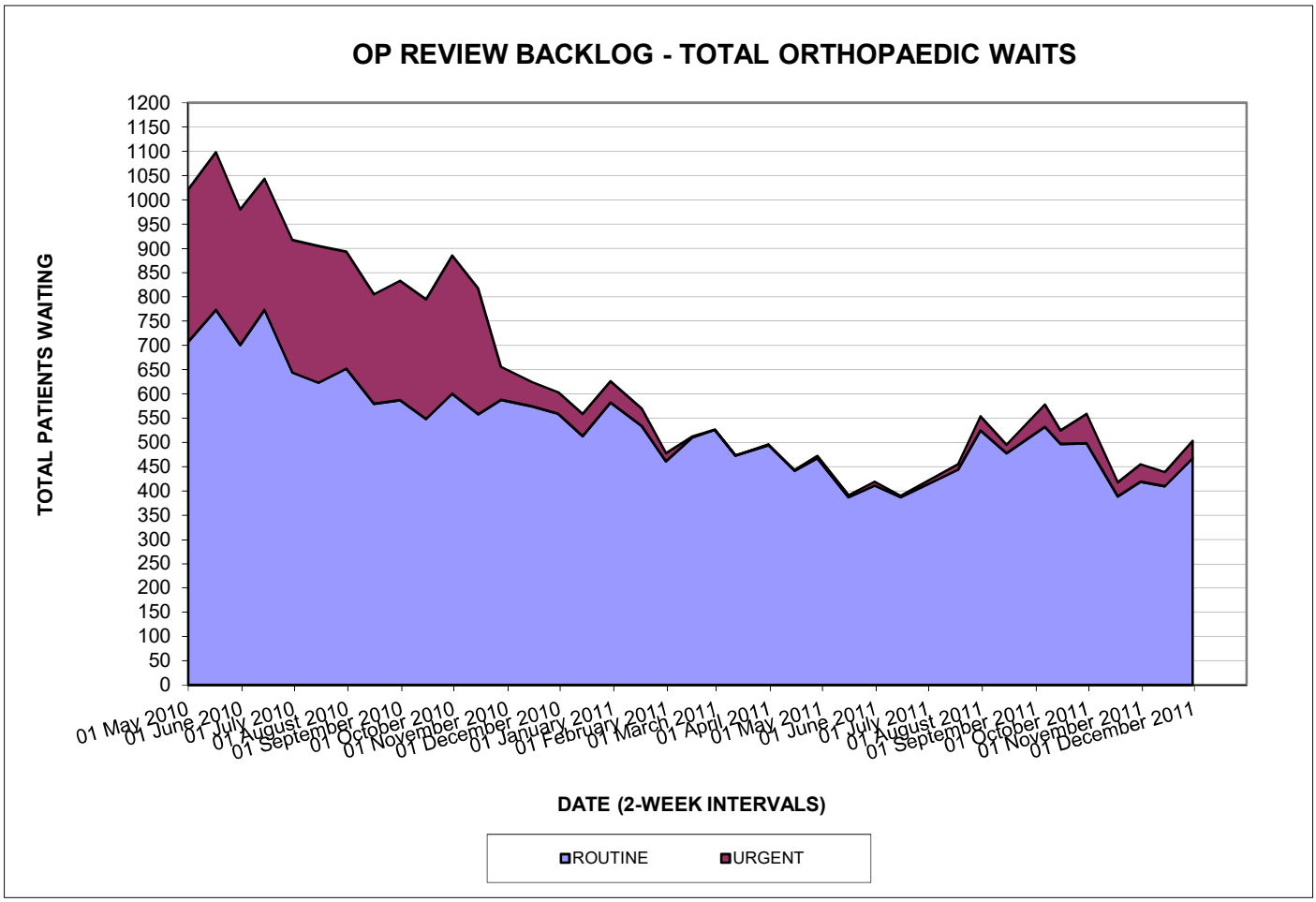
CONSULTANT	SITE	YEAR								
		2007	2008	2009	2010	2011*	OLD TOP OF LIST	URGENT REV CODES	TOTAL	
Personal Information redacted by the USI	CAH	0	0	0	1	38	0	0	39	
	CAH	0	0	0	3	189	0	15	207	
	CAH	0	0	0	0	51	0	0	51	
	CAH	0	0	0	0	41	0	4	45	
	ACH	0	0	0	0	0	0	0	0	
	CAH	0	0	0	0	66	0	5	71	
	CAH	0	0	0	0	47	0	0	47	
	CAH	0	0	0	0	6	0	0	6	
	CAH	0	0	0	0	0	0	0	0	tfrd to CBMR
	CAH	0	0	0	0	0	0	0	0	
TOTAL		0	0	0	4	438	0	24	466	

* 2011 total = 1 Jan 2011 to 31 DECEMBER 2011






OP REVIEW BACKLOG - TOTAL ORTHOPAEDIC WAITS
TOTAL PATIENTS WAITING
850
800
750
700
650
600
550
500
450
400
350
300
250
200
150
100
50
0
01 May 2010
01 June 2010
01 July 2010
01 August 2010
01 September 2010
01 October 2010
01 November 2010
01 December 2010
01 January 2011
01 February 2011
01 March 2011
01 April 2011
01 May 2011
01 June 2011
01 July 2011
01 August 2011
01 September 2011
01 October 2011
01 November 2011
01 December 2011
DATE (2-WEEK INTERVALS)
ROUTINE
URGENT


OP REVIEW BACKLOG - TOTAL ORTHOPAEDIC WAITS
TOTAL PATIENTS WAITING
1200
1150
1100
1050
1000
950
900
850
800
750
700
650
600
550
500
450
400
350
300
250
200
150
100
50
0
01 May 2010
01 June 2010
01 July 2010
01 August 2010
01 September 2010
01 October 2010
01 November 2010
01 December 2010
01 January 2011
01 February 2011
01 March 2011
01 April 2011
01 May 2011
01 June 2011
01 July 2011
01 August 2011
01 September 2011
01 October 2011
01 November 2011
01 December 2011
DATE (2-WEEK INTERVALS)
ROUTINE
URGENT

UROLOGY PERFORMANCE – 18 June 2015

New Outpatient waiting lists Total on waiting list = 1963 patients

Total Urgent = 381 with longest being 14 weeks (great improvement)

Review Backlog position as of 31 May 2015

CONSULTANT	URGENCY	OPWL CODE	TOTAL As of 30/04/15	Total as of 31 May 2015	LONGEST WAIT
MR M YOUNG	ROUTINE	BURM4R	6	6	Mar-13
MR M YOUNG	URGENT	BURM4UR	0	0	0
MR M YOUNG	ROUTINE	CURMYR	406	375	Dec-12
MR M YOUNG	URGENT	CURMYUR	57	54	Jun-14
MR M YOUNG	ROUTINE	CMYUOR	0	0	0
MR M YOUNG	ROUTINE	CMYSTCR	286	320	Feb-14
MR M YOUNG		TOTAL	755	755	Dec-12
MR A O'BRIEN	ROUTINE	CAU4R	80	77	Nov-11
MR A O'BRIEN	URGENT	CAU4UR	10	19	Jan-15
MR A O'BRIEN	ROUTINE	CU2R	448	447	Dec-11
MR A O'BRIEN	URGENT	CU2UR	105	119	Sep-14
MR A O'BRIEN	ROUTINE	CAOBUOR	273	271	Sep-13
MR O'BRIEN		TOTAL	916	933	Nov-11
MR A GLACKIN	ROUTINE	CAJGR	206	214	Apr-13
MR A GLACKIN	URGENT	CAJGUR	45	56	Feb-14
MR A GLACKIN	ROUTINE	CAJGUOR	5	14	Apr-15
MR GLACKIN		TOTAL	256	284	Apr-13
MR K SURESH	ROUTINE	CKSR	54	56	Apr-13
MR K SURESH	URGENT	CKSUR	174	180	Apr-13
MR K SURESH	ROUTINE	CKSUOR	28	38	Feb-15
MR SURESH		TOTAL	256	274	Apr-13
MR MD HAYNES	ROUTINE	CMDHR	0	2	May 15
MR MD HAYNES	URGENT	CMDHUR	0	1	May 15
MR MD HAYNES	ROUTINE	CMDHUOR	0	1	May 15
MR HAYNES		TOTAL	0	4	May 15
MR JP O'DONOGHUE	ROUTINE	CJODR	27	47	Feb-15
MR JP O'DONOGHUE	URGENT	CJODUR	3	15	Feb-15
MR O'DONOGHUE		TOTAL	30	62	Feb-15
UN-NAMED REVIEWS	ROUTINE	EUROR	42	42	Dec-13
UN-NAMED REVIEWS	URGENT	EUROUR	6	6	Feb-15
ENNISKILLEN		TOTAL	48	48	Dec-13
MR AKHTAR	ROUTINE	CMAR	125	121	Dec-12
MR AKHTAR		TOTAL	125	121	Dec-12
OVERALL TOTAL AND LONGEST WAIT			2386	2481	Nov-11

Inpatient and Daycase waiting lists

Total = 935 on waiting list = 172 with dates
249 urgent inpatients without a date longest = 91 weeks

457 Urgent - 89 booked, 368 not booked
Urgent Longest Waiter = 94 weeks (date)

Cluster of patients around 73 weeks
10 > 73 weeks

Profile of Urgent Long waiters without dates:
90+ weeks - 1 patients; no date
80-89 weeks - 4 patients; 0 with dates
70-79 weeks - 13 patients; 0 with date
60-69 weeks - 17 patients; 0 with dates
50-59 weeks - 26 patients; 3 with dates
40-49 weeks - 27 patients; 1 with date
30-39 weeks - 42 patients, 11 with dates
20-29 weeks - 44 patients, 4 with dates
10-19 weeks - 98 patients, 12 with dates
0-9 weeks - 203 patients, 60 with dates

478 Routine - 67 with dates, 411 with no dates
Longest waiter = 95 weeks (no date)

Consultant	**Total URGENT Inpts without date May Position**	**Total URGENT Inpts without date June Position**
Mr Young	56 patients 84 weeks	59 patients 88 weeks
Mr O'Brien	112 patients 81 weeks	104 patients 81 weeks
Mr Glackin	13 patients 33 weeks	19 patients 38 weeks
Mr Haynes	18 patients 52 weeks	21 patients 61 weeks
Mr Suresh	20 patients 25 weeks	19 patients 28 weeks
Mr O'Donoghue	30 patients 91 weeks	23 patients 24 weeks

Urgent daycases without a date longest = 69 weeks

Consultant	Total URGENT Daycases without date May Position	Total URGENT Daycases without date June Position
Mr Young	48 patients 69 weeks	54 patients 73 weeks
Mr O'Brien	14 patients 54 weeks	12 patients 46 weeks
Mr Glackin	11 patients 13 weeks	7 patients 14 weeks
Mr Haynes	3 patients 17 weeks	2 patients 21 weeks
Mr Suresh	23 patients 27 weeks	21 patients 19 weeks
Mr O'Donoghue	17 patients 35 weeks	16 patients 17 weeks

Review Backlog as of 31 July 2015

Review Backlog position as of 31 July 2015

CONSULTANT	URGENCY	OPWL CODE	Total as of 31 May 2015	Total as of 31 July 2015	LONGEST WAIT
MR M YOUNG	ROUTINE	BURM4R	6	8	Mar-13
MR M YOUNG	URGENT	BURM4UR	0	0	0
MR M YOUNG	ROUTINE	CURMYR	375	380	May-12
MR M YOUNG	URGENT	CURMYUR	54	45	Aug-14
MR M YOUNG	ROUTINE	CMYUOR	0	0	0
MR M YOUNG	ROUTINE	CMYSTCR	320	351	Feb-14
MR M YOUNG		TOTAL	755	784	May-12
MR A O'BRIEN	ROUTINE	CAU4R	77	74	Nov-11
MR A O'BRIEN	URGENT	CAU4UR	19	28	Jan-15
MR A O'BRIEN	ROUTINE	CU2R	447	426	Dec-11
MR A O'BRIEN	URGENT	CU2UR	119	136	Sep-14
MR A O'BRIEN	ROUTINE	CAOBUOR	271	270	Sep-13
MR O'BRIEN		TOTAL	933	934	Nov-11
MR A GLACKIN	ROUTINE	CAJGR	214	215	Apr-13
MR A GLACKIN	URGENT	CAJGUR	56	58	Feb-14
MR A GLACKIN	ROUTINE	CAJGUOR	14	5	Apr-15
MR GLACKIN		TOTAL	284	278	Apr-13
MR K SURESH	ROUTINE	CKSR	56	59	Apr-13
MR K SURESH	URGENT	CKSUR	180	181	Apr-13
MR K SURESH	ROUTINE	CKSUOR	38	0	Feb-15
MR SURESH		TOTAL	274	240	Apr-13
MR MD HAYNES	ROUTINE	CMDHR	2	15	May 15
MR MD HAYNES	URGENT	CMDHUR	1	0	May 15
MR MD HAYNES	ROUTINE	CMDHUOR	1	0	May 15
MR HAYNES		TOTAL	4	15	May 15
MR JP O'DONOGHUE	ROUTINE	CJODR	47	73	Feb-15
MR JP O'DONOGHUE	URGENT	CJODUR	15	20	Feb-15
MR O'DONOGHUE		TOTAL	62	93	Feb-15
UN-NAMED REVIEWS	ROUTINE	EUROR	42	40	Dec-13
UN-NAMED REVIEWS	URGENT	EUROUR	6	6	Feb-15
ENNISKILLEN		TOTAL	48	46	Dec-13
MR AKHTAR	ROUTINE	CMAR	121	115	Dec-12
MR AKHTAR		TOTAL	121	115	Dec-12
OVERALL TOTAL AND LONGEST WAIT			2481	2505	Nov-11

UROLOGY PERFORMANCE – 20 MAY 2015

New Outpatient waiting lists
Total on waiting list = 1842 patients
Total with a date = 70 patients

Total URGENT waiting a date is 266
(longest = 1x 45 weeks, 1 x 38 week and 1 x 34 weeks)
225 patients waiting 0-9 weeks
41 patients waiting 10-45 weeks – longest after the 34 weeks = 13 weeks

Total ROUTINE waiting a date is 1506 (longest = 50 weeks)
254 patients waiting over 40 weeks
312 patients waiting 30-39 weeks
330 patients waiting 20-29 weeks
345 patients waiting 10 – 19 weeks
265 patients waiting 0-9 weeks

Update on urology review backlog:

Data Validation (PAS) commenced December 2014 – to look for duplicate episodes etc. to ensure lists were cleansed before patient validation (letters) were sent.
There were a number of duplicates identified, as well as other PAS issues/errors such as:

- patients added to OPWL incorrectly, or to the wrong OPWL
- patients added to Consultant OPWL instead of Nurse-Led
- Date Required not changed (patient appeared to be in backlog, but should have had a future Date Required for review)
- Patients not booked from OPWL, but had been seen since their stated Date Required
- OP Discharges per Consultant letter not followed up on PAS – i.e. Episode not closed down on PAS
- Under 18 discharges – must receive confirmation from consultants first – not being processed efficiently

All PAS issues identified (mostly recurring problems) have been highlighted to Service Administrators/PAS User Group/Data Quality Team/Information Team – for action and future PAS training/refresher training

Total patients data validated – 1900 approx

Patient letter validation – commenced last week February 2015
Total 973 letters sent (to longest waiters).
260 patients were discharged (either didn't want appointment or didn't respond)
713 patients still wanted an appointment = 73%

Review Backlog position as of 30 April 2015

CONSULTANT	URGENCY	OPWL CODE	TOTAL	LONGEST WAIT
MR M YOUNG	ROUTINE	BURM4R	6	Mar-13
MR M YOUNG	URGENT	BURM4UR	0	0
MR M YOUNG	ROUTINE	CURMYR	406	Dec-12
MR M YOUNG	URGENT	CURMYUR	57	Jun-14
MR M YOUNG	ROUTINE	CMYUOR	0	0
MR M YOUNG	ROUTINE	CMYSTCR	286	Feb-14
MR M YOUNG		TOTAL	755	Dec-12
MR A O'BRIEN	ROUTINE	CAU4R	80	Nov-11
MR A O'BRIEN	URGENT	CAU4UR	10	Jan-15
MR A O'BRIEN	ROUTINE	CU2R	448	Dec-11
MR A O'BRIEN	URGENT	CU2UR	105	Sep-14
MR A O'BRIEN	ROUTINE	CAOBUOR	273	Sep-13
MR O'BRIEN		TOTAL	916	Nov-11
MR A GLACKIN	ROUTINE	CAJGR	206	Apr-13
MR A GLACKIN	URGENT	CAJGUR	45	Feb-14
MR A GLACKIN	ROUTINE	CAJGUOR	5	Apr-15
MR GLACKIN		TOTAL	256	Apr-13
MR K SURESH	ROUTINE	CKSR	54	Apr-13
MR K SURESH	URGENT	CKSUR	174	Apr-13
MR K SURESH	ROUTINE	CKSUOR	28	Feb-15
MR SURESH		TOTAL	256	Apr-13
MR MD HAYNES	ROUTINE	CMDHR	0	0
MR MD HAYNES	URGENT	CMDHUR	0	0
MR MD HAYNES	ROUTINE	CMDHUOR	0	0
MR HAYNES		TOTAL	0	0
MR JP O'DONOGHUE	ROUTINE	CJODR	27	Feb-15
MR JP O'DONOGHUE	URGENT	CJODUR	3	Feb-15
MR O'DONOGHUE		TOTAL	30	Feb-15
UN-NAMED REVIEWS	ROUTINE	EUROR	42	Dec-13
UN-NAMED REVIEWS	URGENT	EUROUR	6	Feb-15
ENNISKILLEN		TOTAL	48	Dec-13
MR AKHTAR	ROUTINE	CMAR	125	Dec-12
MR AKHTAR		TOTAL	125	Dec-12
OVERALL TOTAL AND LONGEST WAIT			2386	Nov-11

Inpatient and Daycase waiting lists

Total = 924 on waiting list = 172 with dates

249 urgent inpatients without a date longest = 91 weeks

Consultant	Total URGENT Inpts without date	Waiting time
Mr Young	56 patients	Longest = 84 weeks 38 between 14-84 weeks 19 between 0-13 weeks
Mr O'Brien	112 patients	Longest = 81 weeks 26 > 51 weeks 60 between 14-50 weeks 26 between 0-13 weeks
Mr Glackin	13 patients	Longest = 33 weeks 1 x 33 weeks 12 between 0-13 weeks
Mr Haynes	18 patients	Longest = 52 weeks 6 between 14-52 weeks 12 between 0-13 weeks
Mr Suresh	20 patients	Longest = 25 weeks 7 between 14-25 weeks 13 between 0-13 weeks
Mr O'Donoghue	30 patients	Longest 91 weeks 11 between 14-91 weeks 19 between 0-13 weeks

116 urgent daycases without a date longest = 69 weeks

Consultant	Total URGENT Inpts without date	Waiting time
Mr Young	48 patients	Longest = 69 weeks 17 between 14-69 weeks 31 between 0-13 weeks
Mr O'Brien	14 patients	Longest = 54 weeks 4 between 14-54 weeks 10 between 0-13 weeks
Mr Glackin	11 patients	Longest = 13 weeks 11 between 0-13 weeks
Mr Haynes	3 patients	Longest = 17 weeks 1 at 8 weeks 1 at 3 weeks
Mr Suresh	23 patients	Longest = 27 weeks 8 between 14-27 weeks 15 between 0-13 weeks
Mr O'Donoghue	17 patients	Longest 35 weeks 4 between 14-35 weeks 13 between 0-13 weeks

Flexible Cystoscopy

Consultant	Planned Flexis To be seen by end of June	Waiting time	On D/C list	Waiting time
Mr Young	6 patients	2 April 1 May 3 June	4 patients	7 weeks
Mr O'Brien	8 patients	1 Feb 6 May 1 June	4 patients	38 weeks
Mr Glackin	9 patients	2 May 7 June	12 patients	14 weeks
Mr Haynes	7 patients	2 May 5 June	0 patients	-
Mr Suresh	1 patient	1 April	12 patients	27 weeks
Mr O'Donoghue	0 patients	-	25 patients	25 weeks

Corrigan, Martina

From: Michael Young [redacted]
Sent: 30 December 2010 15:50
To: Tedford, Shirley; O'Neill, Kate; McMahon, Jenny; Aidan [redacted] Akhtar, Mehmood; O'Brien, Aidan; Young, Michael Mr; Corrigan, Martina
Cc: Matier, Pauline; Trouton, Heather
Subject: Re: Action Plan from urology primary care meeting
Attachments: new outpatient review system with GP.docx

Dear All
Sorry about not making it today - [redacted]

A few comments on paper.
Principle and potiential layout for working through the subject Some topics short others in detail. This is just the start others to be filled in

Do we want to do it this way or chose a different method???

MY

--- On Thu, 30/12/10, Corrigan, Martina [redacted] wrote:

From: Corrigan, Martina [redacted]
Subject: Action Plan from urology primary care meeting
To: "Tedford, Shirley" [redacted], "O'Neill, Kate" [redacted], "McMahon, Jenny" [redacted], [redacted], "Akhtar, Mehmood" [redacted], "O'Brien, Aidan" [redacted], "Young, Michael Mr" [redacted]
Cc: "Matier, Pauline" [redacted], "Trouton, Heather" [redacted], "Dignam, Paulette" [redacted] "Hanvey, Leanne" [redacted] "McCorry, Monica" [redacted], "Troughton, Elizabeth" [redacted]
Date: Thursday, 30 December, 2010, 10:56

Dear all,

As discussed at our departmental meeting last week, please see attached - these were the actions drawn up from the meeting with the GP's in June regarding pathways.

thanks

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
<http: Personal Information redacted by USI

New post-operative / post-admission Urology review follow-up Plan 2011

For discussion between Urologists CAH and General Practitioners in local region

1. Requirement and specification for follow-up of each urological procedure and condition is to be undertaken to define an enhanced streamlined service – with patient focus and clear definition of pathways.
2. This process should have the effect of trying to ensure the urology outpatient slots are being provided in the most timely fashion possible for those requiring follow-up.
3. The reduction in the numbers of *hospital* reviews will help towards meeting the DoH targets on new : review ratios .
4. The reduction in review outpatient slots should open up availability for more new patient slots.
5. The proposed reassessment of pathways needs to be agreed by both Urologists and the GP in our region.
6. It is proposed that easily attained goals should be defined initially and that this process is defined as 'work in progress'.
7. If pathways are defined for conditions, then the resultant 'new to review' balance can be regarded as a true reflection of need for the service

There are a number of topics and sub-topics to be defined and discussed. These categories could ultimately result in:

a. 'Conditions' previously offered a hospital review appointment but may not actually still require a review ***at all***

b. 'Conditions' previously offered a hospital review appointment but could now be seen by ***GP services (eg Practice or District Nurse)***

c. 'Conditions' previously offered a hospital review appointment but will now be reviewed ***by the patients General Practitioner***

d. 'Conditions' previously offered a review appointment but would be best served ***by a follow-up with the ICATS services***

e. 'Conditions' previously offered a hospital review appointment that still require a review ***by a hospital based doctor service***

Although each condition may have a general pathway there undoubtedly will be exceptions to the rule.

These exceptions should be defined at source when the review arrangements are being made

Table for urology review outcome

Topic	Current Follow-up arrangements	Proposed Follow-up	Variant	Expected R/V needs	Re-referral	comment
Inguino-scrotal						
Circumcision	Clinic / andro	None / GP	Histo. Taken / BXO - hospital	See 1\12	infection	
Frenuloplasty	Clinic / andro	None / GP	BXO	See 1\12	Further scarring	
Hydrocele	clinic	None / GP		See 1\12	recurrance	
Epididymal cyst	clinic	None / GP				
Varicocele	Clinic / andro	None / GP				
Vasectomy	clinc	GP		3\12	Positive Sem. analysis	GP to arrange Sem. analysis
Vas. Reversal	clinic	hospital		6\52		Hosp. arranged analysis
Outpatient conditions						
Suspect Ca. Prostate path.	Defined ICATS pathway	No change ICATS	Negative biopsy -D\C clinic	GP check PSA 6\12	PSA rise >20%	
Erectile Dysfunction	Defined ICATS pathway	No change - ICATS		May take a few appt	If initially successful Rx fails	?? Initiation Rx with subsequent advice to GP

Topic	Current Follow-up arrangements	Proposed Follow-up	Variant	Expected R/V needs	Re-referral	comment
Stone service						
Confirmed total extraction simple *ureteric* stone (first episode)	Hospital clinic \ stc clinic	GP / Special. Nurse clinic or virtual clinic		2\12 then D/C to GP	Continued symptoms	? STC Nurse telephone follow up
Recurrent *ureteric* stone but simple complete extraction	Hospital clinic \ stc clinic	STC / Nurse led Stone clinic		2\12 and then 1 and 2 yr. Then D/C GP	Further stone defined	
Stone removal with stent in situ	readmission	No change				Specialist Nurse coordination
Stent removal following ureteroscopy	Hospital clinic \ stc clinic	GP / Special. Nurse	Difficult ureteroscopy	2\12 as above protocol	Symptoms or recurrent stones	? initial Telephone follow-up with subsequent discharge to GP
Complex stone - Residual frag, bilateral stones, recurrent stone, metabolic issues	Hospital clinic \ stc clinic	STC		Per consultant		
ESWL post Rx	STC	STC – no change				
ESWL long term	STC	STC				Nurse / Dr clinic with D/C GP after 5-7 yrs with advise
PCNL post Rx	STC	STC				
PCNL long term	STC	STC				

Topic	Current Follow-up arrangements	Proposed Follow-up	Variant	Expected R/V needs	Re-referral	comment
Triage Letter						
Incomplete info	Appt still given	Return to GP	RED Flag			? even with red flag letter returned
Referral for advice	Appt often still given	Advice letter dictated			GP wishes appt	
Referral but added investigations advantageous	Appt given +/- investigation arranged	Advanced triage system				This may hinder timelines for outpts unless DoH accept this process and define start time as when investigation ordered. ?? back to GP to arrange via an advice letter

Southern Health and Social Care Trust

Quality Care - for you, with you

Acute Services Directorate – Adult Urology Services

Review of Adult Urology Services Implementation Project – Team South

GP Discharge Pathway Presentation 7th April 2011 at 2pm – Boardroom, Trust HQ, CAH

Present: Dr P Beckett, Mrs Heather Trouton, Mr Michael Young, Mr Aidan O'Brien, Dr Gerry Millar, Dr Mark McClure, Dr Mark McWilliams, Dr Sean Wilson, Mrs Jenny McMahon, Mrs Kate O'Neill, Mrs Alison Porter, Mrs Alexis Davidson, Mrs Pauline Matier.

Apologies: Mrs Martina Corrigan, Mr Mehmood Akhtar, Dr Gillian Rankin.

Service	Pathway	Discussion	Comments
All Services	**Referral Pathways**	Discussion took place around the need for establishing baseline referral criteria for all services. GPs agreed that this was a reasonable and acceptable proposal subject to final agreement.	
	Referral Criteria	It was agreed that the ICATS model of minimum criteria required should be used:	

		▪ U&E ▪ Blood Sugar ▪ FBP ▪ +/- Urinalysis/MSU ▪ +/- PSA – appropriate to clinical decision It was clarified that U&E request should include GPFR. It was further clarified that it should be specified that if urinalysis was normal, therefore no need for MSU. Mr Young asked if GP colleagues felt it would be appropriate to include radiological investigations such as scrotal ultrasound in referral criteria and acknowledged that whilst there were examples of when it would be appropriate as a means to appropriately signpost patients into services such as the Stone Treatment Centre and an example of when it would be inappropriate for referrals to services such as the LUTS clinic when radiological investigations would be carried out as routine. Dr Millar felt that primary care access to ultrasound was difficult with a wait of 3-4 months and wanted easier access. Mrs Davidson advised that there was a 9 week pathway for ultrasound access in the Trust and that a pilot project was under way with 5 GP practices for electronically referring. . Mr Young queried if GPs felt confident in scrotal examination. Dr Millar advised that if a scrotal lump	

		was found on examination then the referral was marked as a red flag and sent to Urology Services. Dr Williams advised that if GPs were concerned about a patient then they should contact the X-ray Department by telephone and the patient would be accommodated. Ms Porter advised that out of 510 testicular red flag referrals made last year, only 3 proved to be cancerous. Mr Young added that he was finding more red flag patients in routine referrals than there were of red flag referrals. Mrs Trouton queried the definition of red flag criteria and should pathway for referrals be staged as follows: ▪ Somewhat concerned - 9 week pathway ▪ More concerned - direct to Urology ▪ Very concerned - direct to X-ray Dr Millar advised that GPs are aware of the red flag criteria but possibly need re-educated as to it's use and that it would be helpful to have an audit of the 510 testicular red flag referrals to identify who needed re-educated. Action: Ms Porter to provide audit findings. Trust to identify urgent access telephone pathway for radiology. It was agreed that inappropriate referral letters should be returned to referrers. However it was further agreed that this should be done following the next group	

		meeting in June and that an explanation letter should be sent to GPs by the Trust once it's content has been agreed at the next meeting. Action: Trust to approve awareness letter for GPs for next meeting.	
Stone Treatment Service	**Referral Criteria**	Discussion took place re: GP access for plain renal tract x-ray to prove stone for Stone Treatment Centre referral criteria. Dr McClure advised that abdominal x-ray was not the best method of proving stone and that CTKUB was most effective. Mrs Davidson advised that the Trust did not have the capacity to provide this currently and would require another CT scanner. Dr McClure advised GP access for CTKUB was routine practice in the UK and would be money saving to the Trust as a performing a CTKUB only would negate the need for KUB/IVP/USS and was a much quicker procedure. Mrs Davidson advised that if this was the way forward then a business case would have to be developed for the three Trust sites in a bid for funding. **Action:** Trust to progress.	
Haematuria	**One Stop Clinic Referral Criteria**	Discussion took place around the proposal of a one-stop clinic. Mr O'Brien raised concerns that one-stop may be too much for patients and Mrs McMahon advised that this topic was discussed at regional meetings and agreement was reached to adjust pathway to a two day model.	

		Dr Millar advised that a one-stop clinic was reasonable and patients should be educated at to what to expect at the time of referral. Mr Young advised that investigation criteria was governed by NICAN and accepted by the Department. He further advised that +/- IVP & USS depended on clinical decision but the Trust would like IVP's done on all patients with exceptions per clinical indication and that a CT urogramme would avoid CT and IVP and generate savings. Dr Millar referred to unexplained haematuria – GPs would carry out investigations and if appropriate refer as a red flag and this should not be confused with the red flag pathway. It was agreed that the NICAN pre-referral criteria should be used but the work 'unexplained' haematuria should be underlined in the pathway document and accompanied with the word persistent'. **Action:** Mr Young to raise at regional network.	
Prostate Clinic	**One-stop Clinic**	Discussion took place in relation to referral criteria for suspected prostate cancer and GP colleagues confirmed that they were happy with NICAN guidance but queried the PSA level indicator that should trigger a referral into the service. Mrs Trouton enquired if there were trigger points for referrals. Mr O'Brien advised that there were no trigger indicators and queried if	

		patients would cope with a one-stop model as it may be too many investigations on the one day. GP colleagues confirmed that they thought a one-stop model was a good way forward and that primary care had a role to play in educating patients at the time of referral as to why they are being referred and what to expect at the clinic. It was agreed that there would be exceptions to the one-stop model for an element of patients. Dr Millar highlighted the need for a management plan for PSA results < 10 and Dr Beckett supported this and advised that GPs are very keen for this management plan and complete pathways for referrals. Mrs Trouton advised that the Trust will have draft pathways, to include the Andrology Service, for the next scheduled meeting which will include: ▪ Pre-referral ▪ Referral management ▪ Discharge ▪ Management plans Mr O'Brien supported Mrs Trouton to included Inguinal Scrotal pathways in this work. **Action:** Trust to provide pathway and management plan models for next scheduled meeting.	

Communication		Mr O'Brien enquired if other GP colleagues throughout the Trust were aware of the work currently undertaken in the Trust for Urology Services. Dr Beckett advised that GPs are aware through himself but that he would progress a formal communication strategy for the future when pathways have been agreed.	
Next Meeting		End of June 2011 – to be confirmed by P Matier.	

Pathways for Non-Elective Admissions to either Daisy Hill or Erne Hospitals that do not have an acute Urology Unit

Patient presents at Accident and Emergency in either Daisy Hill or Erne Hospitals

Testicular Torsion

Suspected cases of Testicular Torsion should be dealt with by the surgical team

Testicular Infection

Suspected cases of Testicular Infection should be dealt with by the surgical team at the presenting hospital

The patient should have an ultrasound carried out to exclude Testicular Tumour

Patient should then be referred to the Urological Team at Craigavon Area Hospital

Renal Colic

The patient needs to be assessed by the Surgical Team at the presenting hospital

Investigations such as non-contrast CT, IVP/Ultrasound should be undertaken to confirm diagnosis

This combined with the patient's renal function and sepsis status will govern the acuteness of the referral pathway.

Haematuria

Patients admitted with Haematuria/Clot retention that are requiring admission are to be assessed for need of catheter insertion.

Initial investigations of ultrasound and IVP should be undertaken followed by contacting the Craigavon Area Hospital for further advice on referral pathway as there may be a need for transfer or subsequent consultation

Infection – Recurrent Urinary Tract Infection/pylelonephritis

The patient needs to be assessed by the Surgical Team at the presenting hospital.

The patient will need a catheter inserted
Current guidelines and a protocol are being drawn-up for insertion of Catheter by the Urological Team at Craigavon Area Hospital and this will be available on all sites

Note: Any entity defined as a Urological Emergency can be referred/discussed with the Urological team at any time for advice/guidance on how best to manage/transfer

If advice is required on any of the above the Urology On call doctor should be contacted via Craigavon Area Hospital Switchboard

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

028 3833 4444

Diagnosis and Management of Urinary Retention in the Emergency Department
Daisy Hill Hospital

Medical Assessment to include

- FBP, U&E, BLOOD SUGAR, PSA
- Digital Rectal Examination
- Neurological assessment to exclude Spinal Cord Compression

Administer appropriate prophylactic antibiotic
Stat dose of Ciprofloxacin 750mgs orally
If increased morbidity (e.g. prosthetic heart valve) additional cover may be required. .
Pass appropriate urethral catheter (commonly size 14FG)
Send a CSU for culture

Catheterisation Successful
Record residual volume

Less than 300ml drained in first 30 minutes
Consider alternative diagnosis

Catheterisation Unsuccessful

Admit to Surgical ward if

- abnormal Creatinine
- female patients
- infection suspected
- haematuria
- difficult catheterisation
- social/clinical condition dictates

Patient fit for discharge and Creatinine normal
Start Alfuzosin 10mg OD

Refer to Surgical Assessment Unit 9am – 5pm
OOH Surgical team
Bleep [redacted]

Discharge Home

1. Ensure patient has been given information leaflet.
2. Give patient discharge pack containing supplies and arrange home delivery of products.
3. Forward a copy of Emergency Department patient attendance record to Surgical Assessment Unit for follow up.

Contact: - Extension 4320

VASECTOMY

Referral Received from GP to include:

- U&E
- Blood Sugar
- FBP
- +/- Urinalysis

↓

Referral Triaged and appointed to appropriate waiting list

↓

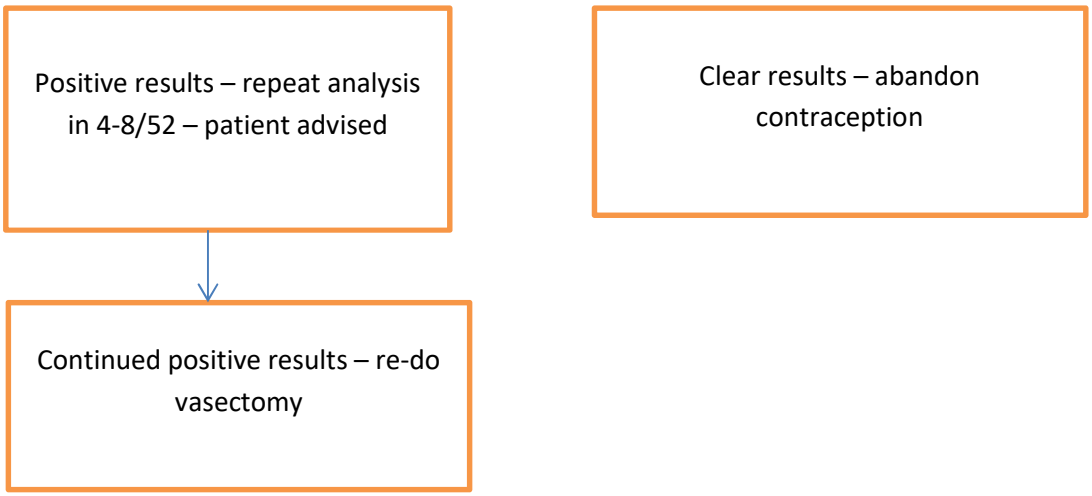
Patient attends and procedure is carried out

↓

Patient is discharged with advice to provide 2 Semen sample to labs for analysis at three months and four months with advice on contraception

↓

Written confirmation of result are forward to patient and GP by surgeon with on-going advice.


Positive results – repeat analysis in 4-8/52 – patient advised
Clear results – abandon contraception
Continued positive results – re-do vasectomy

Urology PERFORMANCE – 9 November 2018

New Outpatient waiting lists

Total on waiting list = 3436 – longest routine wait = 146 weeks

Total 699 URGENT waiting a date is (longest = 74 weeks)

Review outpatient backlog (taken from Business objects) – should have been seen by 31 December 2018

Consultant		
	total	**Longest date**
Mr Young (general)	285	July 2015
Mr Young (stones)	605	March 2015
Mr O'Brien	586	March 2015
Mr Glackin	127	February 2017
Mr Haynes	25	August 2017
Mr O'Donoghue	513	September 2015
Mr Jacob	546	May 2017
Enniskillen	273	June 2015
Total	**2960**	

Total per year

2015	**118**
2016	**218**
2017	**673**
2018	**1951**

Adult Inpatient and Daycase waiting lists – position 9 November 2018 (1755 patients)

Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Mr Young	152	216 wks	60	249 wks	128	194 wks	231	236 wks
Mr O'Brien	184	227wks	55	222 wks	31	197 wks	25	220 wks
Mr Glackin	36	95 wks	30	104 wks	47	61 wks	36	43 wks
Mr Haynes	83	163 wks	45	211 wks	37	90 wks	49	201 wks
Mr O'Donoghue	105	141 wks	31	180 wks	64	87 wks	26	188 wks
Mr Jacob	40	136 wks	21	146 wks	115	122 wks	124	152 wks
Total	**600**		**242**		**422**		**491**	

Paediatrics Inpatient and Daycase waiting lists – position 9 November 2018 (28patients)

Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Mr Young	0		0		3	10 wks	1	66 wks
Mr O'Brien	7	200 wks	3	111wks	2	42 wks	1	119 wks
Mr Glackin	0		0		0		0	
Mr Haynes	0		0		1	46 wks	1	133 wks
Mr O'Donoghue	2	80 wks	1	113 wks	1	41 wks	1	90 wks
Mr Jacob	2	55 wks	0		2	100 wks	0	
Total	**11**		**4**		**9**		**4**	

Planned patients that should have been seen

Consultant	Urgent Ins
Mr Young	54
Mr O'Brien	38
Mr Glackin	39
Mr Haynes	40
Mr O'Donoghue	23
Mr Jacob	18
Total	**212**

Urology Performance – 19 February 2019

Referrals received

2016-2017 - 5463
2017-2018 - 4594
2018-2019 – 3807 (up to end of January 2019)

Red Flag referrals (Total for one year = 3430)

62 DAY REFERRALS	Dec 17	Jan 18	Feb 18	Mar-18	April18	May 18	Jun 18	July 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Urological Cancer	118	138	161	182	157	160	183	147	193	175	197	193	180	173
31 DAY REFERRALS	Jan 18	Feb 18	Mar-18	April18	May 18	Jun 18	July 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Dec 18	Jan 19
Urological Cancer	99	86	76	64	82	77	75	101	56	104	66	57	57	73
Total	**217**	**224**	**237**	**246**	**239**	**237**	**258**	**248**	**249**	**279**	**263**	**250**	**237**	**246**

CAPACITY = 4 per consultant per clinic and if a registrar available then this increases to 6, therefore should have 6 consultants x 6 slots = 36 per week

New Outpatient waiting lists

Total on waiting list = 3687

Total URGENT waiting a date is 669 (longest = 24 weeks) (note that there are 6 others waiting longer but are in the PB cycle (1 x 147 weeks, 1 x 133 weeks, 1 x 87 weeks, 1 x 63 weeks, 1 x 58 weeks and 1 x 40 weeks)

Total ROUTINE waiting a date is 3018 (longest is waiting 161 weeks)

RED FLAGS waiting with no dates:

Referral	No waiting	Time Waiting
Urology (Prostate)	**44 patients**	**67 days**
Urology (Haematuria)	**57 patients**	**61 days**
Urology (Other)	**14 patients**	**26 days**

Dr Paul Hughes clinic in DHH has been cancelled for the first 2 weeks of March currently have 11 patients to be booked.

Review outpatient backlog (taken from Business objects) – should have been seen by 31 March 2019

Consultant		
	total	**Longest date**
Mr Young (general)	284	July 2015
Mr Young (stones)	618	March 2015
Mr O'Brien	675	March 2015
Mr Glackin	80	February 2017
Mr Haynes	59	October 2018
Mr O'Donoghue	549	September 2015
Mr Jacob	634	February 2017
Enniskillen	157	March 2016
Total	**3056**	

Total per year

2015	**77**
2016	**198**
2017	**661**
2018	**1485**
2019	**635**

Adult Inpatient and Daycase waiting lists – position 19 February 2019 (1805 patients)

Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Mr Young	161	231	66	264	114	208	208	251
Mr O'Brien	216	237	57	237	36	212	23	235
Mr Glackin	53	110	34	119	48	56	38	51
Mr Haynes	91	178	47	225	22	94	50	216
Mr O'Donoghue	119	156	34	195	88	102	26	203
Mr Jacob	37	150	18	161	102	130	117	167
Total	**677**		**256**		**410**		**462**	

Paediatrics Inpatient and Daycase waiting lists – position 19 February 2019 (27 patients)

Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Mr Young	0	0	0	0	2	4	1	81
Mr O'Brien	7	55	4	182	1	35	2	134
Mr Glackin	0	0	0	0	0	0	1	11
Mr Haynes	0	0	0	0	1	61	0	0
Mr O'Donoghue	1	9	1	128	0	0	2	105
Mr Jacob	2	70	0	0	2	115	0	0
Total	**10**		**5**		**6**		**6**	

Planned patients that should have been seen

Consultant	
Mr Young	57
Mr O'Brien	42
Mr Glackin	20
Mr Haynes	40
Mr O'Donoghue	41
Mr Jacob	23
Total	**223**

Urology PERFORMANCE – June 2022

Urology Priority 2 update as at 14/06/2022:

	16/03/2022	14/06/2022
P2A	0	1
P2B	18	21
P2C	48	49
P2D	215	208
TOTAL	**281**	**279**

The priority 2 caseload includes a mixture of proven cancers, clinically suspected cancers, and benign disease. Within the proven cancer patients a small number are undergoing multimodality treatment and have narrow treatment windows.

In order for our decision making to be objective and transparent as we assign our limited capacity to patients requiring surgery, it is agreed that we approach this activity along the following priorities, using waiting time (days on surgical waiting list) as the additional metric.

Priority A = proven cancer with short treatment window post chemotherapy / radiotherapy
Priority B = proven cancer
Priority C = suspected cancer
Priority D = benign disease

New Out Patient Waiting List (with no dates) report 1				
	16/03/2022		14/06/2022	
Urgency	**No on WL**	**Longest Wait**	**No on WL**	**Longest Wait**
Red Flags	229	19 weeks	270	2-4 weeks
Urgent	340	310 weeks	181	198 weeks
New Urgents with 352	1015	313 weeks	239	210 weeks
Routine	3632		3397	332 weeks
Total	**5216**		**4087**	

New URGENT/ROUTINE Outpatients waiting with no dates. ***As at 14/06/2022***

- Removing the patients transferred to IS the total number of New Urgents is 181.
- Due to patients, returning to trust for reasons such as not being suitable for IS or refusing IS our Trust longest waiter is **210 weeks**. If we do not count the patients, who have been offered IS but returned to trust our Longest would have been **198 weeks (Due to upgrade from Urgent).**
- The average longest waits for patients who have not be transferred to IS is 16 Weeks.
- All upgrades and new add ons will be transferred to 352 in Quarter 2

Total activity to date with 352 as at 14/06/2022

352 Activity
14.06.22

	Complete					Booked			TOTALS
	February	March	April	May	June	July	Aug	Sept	
Consultation	421	419	228	474	193	21	1	0	1757
Investigation	342	413	244	549	330	35	0	0	1913
Procedure	12	105	107	143	102	28	1	0	498
Post Op Review	0	0	11	7	11	2	0	1	32
Review	0	10	84	72	98	72	1	1	338
TOTALS	775	947	674	1245	734	158	3	2	**4538**

NOP WL breakdown as at 14/06/2022

	Urgent	Routine	Urgent	Routine
	Mar-22	Mar-22	June-22	June-22
Weeks waiting	Total with no dates	Total with no dates	Total with no dates	Total with no dates
0-10	206	176	444	146
11-20	143	149	86	93
21-30	84	99	14	102
31-40	84	116	8	99
41-50	106	125	18	94
51-60	101	123	20	135
61-70	52	70	15	112
71-80	76	80	10	86
81-90	84	66	7	78
91-100	58	66	10	69
101-110	103	123	5	69
111-120	147	136	10	86
121-130	95	168	15	122
131-140	10	155	19	141
141-150	3	164	1	178
151-160	1	134	3	122
161-170	1	131	0	135
171-180	1	161	1	130
181-190	0	164	2	124
191-200	3	134	1	152
201-210	2	99	1	113

211-220	1	98	0	101
221-230	0	100	0	86
231-240	0	108	0	90
241-250	2	109	0	91
251-260	0	119	0	91
261-270	0	116	0	94
271-280	0	97	0	104
281-290	1	89	0	90
291-300	1	69	0	88
301-310	3	100	0	69
311-320	0	0	0	68
321-332	0	0	0	39
Total	**1368**	**3644**	**690**	**3397**

Urology Referrals per year (year is April-March)

Year	**Total	Average per month
2017-2018	6208	517
2018-2019	6622	551
2019- 2020	6338	528
2020-2021	4589	382
2021-2022	5747	479
2022-2023 (to May 2022)	421	211

Review outpatient backlog update (as at for 14th June 2022)

	May 22		June 22	
	Total	**Longest Date**	**Total**	**Longest Date**
Glackin	30	Nov-20	35	Nov- 20
O' Donoghue	336	Mar-17	375	Mar- 17
Young	480	Dec-16	499	Dec- 16
Haynes	93	Feb-19	103	Feb- 19
Omer	41	Feb- 21	43	Feb- 21
Khan	34	Dec- 21	65	Dec- 21
O' Brien	159	Jul- 13	160	Jul- 13
Tyson	24	Nov-19	35	Oct- 19
Jacob	34	Jul- 17	34	Jul- 17
Total	**1231**		**1349**	

Adult Inpatient and Day case waiting lists – position as at 14/06/2022

Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Glackin	46	181	66	273	48	191	55	199
O'Donoghue	137	329	58	368	41	271	66	376
Young	162	404	74	409	132	381	174	409
Haynes	67	351	54	385	38	267	44	310
Khan	14	77	22	83	36	140	31	73
O'Brien	94	410	33	391	11	408	13	372
Tyson	31	182	21	221	13	160	21	166
Total	**405**		**328**		**319**		**404**	

Summary Adults – total = 1948 pts
Urgent Inpatients = 405 patients; longest wait 404 Weeks
Routine Inpatients = 328 patients; longest wait 409 weeks
Urgent days = 319 patients; longest wait 408 weeks
Routine days = 404 patients, longest wait 409 weeks

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
4021	12/04/2019	Provide safe, high quality care		Access Times (Outpatients) - General (not inclusive of visiting specialties)	Increase in access times associated with capacity gaps and emergent demand - Capacity gapin RF, urgent and routine.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	19/11/21 OSL update SEC, New regional guidance has been approved for Outpatient admin validation this will be for ENT, Urology and Trauma and Orthopaedics. From April 19 admin validation has been ongoing, new regional technical guidance has been approved and will commence Jan 2022 and the validation team admin support will increase, recruitment in progress.Capacity reduced due to Covid 19 social distancing guidance which is decreasing the number of booked clinics. IPC guidance is continually reviewed and updated. 160921 OSL update- Within outpatients admin validation is ongoing within the following areas: ENT, BFH and orthopaedics. OSL progressing decision with IPC if clinic sizes can be increased. 08/09/2021 - Currently only red flag and some urgent patients are being booked however demand is still greater than capacity. Redeployment of DSU and Theatre staff to ICU for surgery reduces theatre capacity on CAH, STH and DHH sites. Six urgent bookable sessions in CAH, fourteen trauma sessions and five urgent bookable sessions in DHH with cancellation of day surgery and endoscopy. 28/06/2021- OSL and HOS continue to monitor longest waiters. Currently due to social distancing reduced numbers continue and only red flag and urgent patients being booked. Agreed to contact IPC to see if we can increase numbers at clinics. Admin validation to commence. 15/02/2021New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. The trust is facing a 3rd surge at present. All outpatients cancelled again and outpatient staff redeployed. 0/10/2020 - New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present.	HIGH	DIV	

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3166	ACUTE	25/06/2012	Provide safe, high quality care	Urology Access Waiting Times	Urology access waiting times have increased significantly from 36 weeks for inpatient and daycases. First appointment ICAT patients has increased from 17 weeks.	This is currently being addressed via approval to go to Independent Sector and the appointment of new consultants.	3/3/15 - TO BE TAKEN AS PER AD CCS/ATICS 10.12.14 - Cancer targets are being met, i.e., 31 and 62 day pathway. While red flag and urgent appointment times are being met this is utilising all outpatient capacity leaving routine patients with longer waiting times. A new service model is being trialled which may improve the totality of waiting times in the long term. Inpatient/Day Case waiting times for routine patients remain challengin with the focus on treating cancer patients within the standards. 12.5.14 - with respect to the urology performance against the 62-day cancer target, there are 21 patients over 62+days of which 11 pts waiting over 85+days. With respect to haematuria 1st appointment now sitting at D16 which is an improvement on the previous positions due to a combination of drop in demand and extra capacity on a Saturday. 12.02.14 Urology waiting times are extended throughout the Province due to demand and capacity issues. The HSCB have commissioned a further Regional review of Urology Services . The SHSCT will partake in this Regional review. In the meantime, Team South will focus its resources on meeting the cancer waiting times within this specialty	MOD	03/03/2015

Corrigan, Martina

From: Trouton, Heather
Sent: 19 October 2012 08:51
To: Reid, Trudy; Corrigan, Martina; Nelson, Amie; Devlin, Louise; Irwin, Laura J
Subject: FW: OP REVIEW BACKLOG UPDATE - SURGERY & ELECTIVE CARE ONLY
Attachments: OP RBL TOTAL - SEC 12.10.12.xls

Laura Jan

Can you please arrange a meeting for 1 hour to discuss.

Heather

From: Conway, Maria
Sent: 12 October 2012 12:32
To: Reid, Trudy; Trouton, Heather
Subject: OP REVIEW BACKLOG UPDATE - SURGERY & ELECTIVE CARE ONLY

Please find attached updated OP Review Backlog position for Surgery & Elective Care only: position at 12 October 2012 (for patients who required review appointment by end September 2012).

Kind regards,
Maria

Maria Conway (Mrs)
Service Administrator
Surgery & Elective Care
Acute Services
Lead Nurses' Office - Surgery
Admin Floor
Craigavon Area Hospital

Tel: Personal Information redacted by USI
(Mornings only - Mon to Fri)

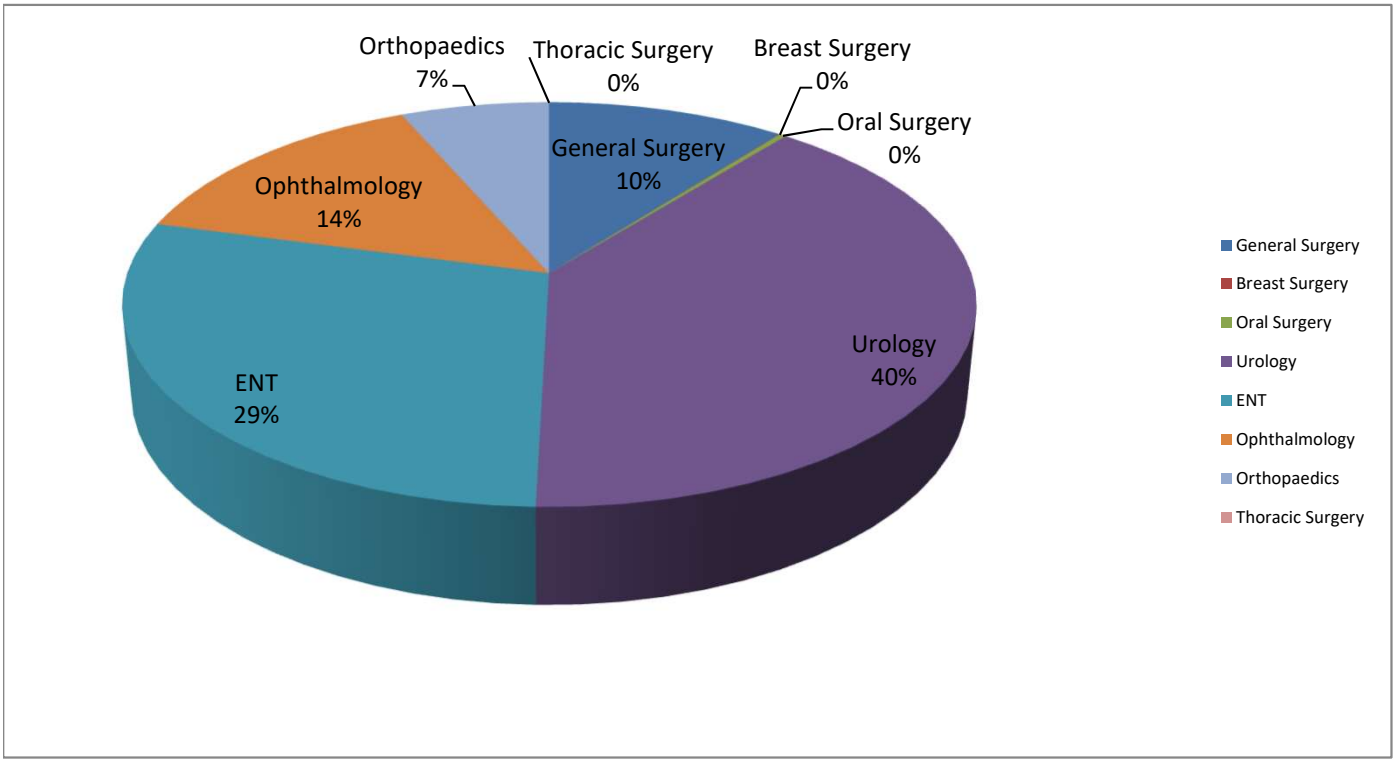
SHSCT OUTPATIENT REVIEW BACKLOG - CUMULATIVE TOTAL AT 12.10.12
REVIEW APPOINTMENTS REQUIRED BY 30 SEPTEMBER 2012 INCLUSIVE

SURGERY & ELECTIVE CARE ONLY

SPECIALTY DESCRIPTION	YEAR								
	2007	2008	2009	2010	2011	2012*	OLD TOP OF LIST	URGENT REV CODES	TOTAL
GENERAL SURGERY	0	0	0	0	0	723	0	17	740
BREAST SURGERY	0	0	0	0	1	1	0	0	2
ORAL SURGERY	0	0	0	0	1	20	0	0	21
UROLOGY	0	0	101	370	800	1385	4	132	2792
ENT	0	0	0	1	134	1880	0	11	2026
OPHTHALMOLOGY	0	0	0	39	230	736	0	3	1008
ORTHOPAEDICS	0	0	0	0	39	346	0	76	461
THORACIC SURGERY	0	0	0	0	0	0	0	0	0
TOTAL	0	0	101	410	1205	5091	4	239	7050

* 2012 total = 1 Jan 2012 to 30 SEPTEMBER 2012

SURGERY & ELECTIVE CARE - REVIEW BACKLOG - % BREAKDOWN



Corrigan, Martina

From: Trouton, Heather
Sent: 12 October 2015 11:28
To: Leeman, Lesley; Corrigan, Martina; Robinson, Katherine; Scott, Jane M
Subject: RE: Update - UROLOGY OP RBL - at 30/09/15
Attachments: image001.png; image002.jpg

Dear Jane and Katherine

Can you please see below from Lesley.

Can you please advise if we will be targeting the remainder of the 12/13 patients to ensure they will be seen and that part of the backlog cleared before Christmas?

Heather

From: Leeman, Lesley
Sent: 08 October 2015 12:44
To: Corrigan, Martina
Cc: Trouton, Heather
Subject: Update - UROLOGY OP RBL - at 30/09/15

This update from Maria is showing real progress on this review backlog for urology. Is there any chance we could offer the 194 for 12/13 appointments in the current tranche of review backlog additional before and aim to have 12/13 cleared before Christmas. Would be great to say we are now down to longest waits from 13/14 for urol
Lesley

Lesley Leeman
Assistant Director Performance Improvement Southern Health and Social Care Trust Trust Headquarters
68 Lurgan Road Portadown BT63 5QQ

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From: Conway, Maria
Sent: 08 October 2015 10:00
To: Leeman, Lesley
Cc: Turtle, Steven
Subject: RE: UROLOGY OP RBL - at 30/09/15

Hi Lesley

Update on urology OP RBL:

2011/12 – there were 7 patients remaining at 01/10/15. There is now only 1 patient remaining. This is an Under 18 patient for discharge (NFAP per Mum) – I have escalated this to Martina this morning to clear.

2012/13 – there are now 219 patients remaining.

· All 219 patients were data validated (PAS & Patient Centre). (87 of these patients also received validation letters and requested further review).

· A total of 14 patients were offered appointments, but clinic subsequently cancelled by hospital on 01/10/15. They have been re-instated on OPWL (not re-booked).

· 2 patients are currently in booking cycle for appointments in Oct/Nov.

· 8 patients were offered appointments in September – but then cancelled by patient (not re-booked yet)

· 1 patient is an Under 18 for discharge

· Total of 194 patients still awaiting an offer of appointment.

Breakdown by Consultant/OPWL code:
BURM4R (Mr Young BBPC) = 2 patients – both validated (data & patient letter); no appointment offers yet.

CAU4R (Mr O'Brien ACH) = 9 patients – all validated (data & patient letter); all offered appointments previously – however, clinic cancelled by hospital on 01/10/15 (Consultant in theatre)

CMAR (Mr Akhtar CAH) = 4 patients – all validated (data & patient letter); 2 patients in current booking cycle for Oct/Nov; 2 patients cancelled previous appts in September 2015

CU2R (Mr O'Brien CAH) = 58 patients - all validated (data & patient letter); 3 patients cancelled previous appts (September 2015); 5 patients offered appointments previously – however, clinic cancelled by hospital on 01/10/15 (Consultant in theatre); 1 x Under 18 for discharge; 49 patients still awaiting offer of appointment.

CURMYR (Mr Young CAH) = 146 patients – all data validated. 11 patients also validated by letter – no appointment offers yet. 3 patients (data & letter validated) – offered appointments in September 2015 , but cancelled by patients. The remaining 132 patients were not sent validation letters as they were due to be validated by Consultant(s) – however, this subsequently did not happen. The 132 patients have also not had any appointment offers yet.

Hoping this is helpful.

Kind regards,
Maria

From: Leeman, Lesley
Sent: 05 October 2015 11:26
To: Conway, Maria
Cc: Turtle, Steven; Larkin, Louise
Subject: RE: UROLOGY OP RBL - at 30/09/15

Thanks Maria
Keep your eye to this for me and let me know when these patients are cleared.

Would you do a wee analysis of the 12/13 cohort; volume s by speciality; numbers validated and or previously offered an appointment before the next TB meeting mid October.
Thanks
Lesley

Louise – bf 2/52

Lesley Leeman
Assistant Director Performance Improvement Southern Health and Social Care Trust Trust Headquarters
68 Lurgan Road Portadown BT63 5QQ

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From: Conway, Maria
Sent: 05 October 2015 10:46
To: Leeman, Lesley; Turtle, Steven
Subject: UROLOGY OP RBL - at 30/09/15
Importance: High

Hi Lesley & Steven

Please find attached latest Urology OP RBL update – all information taken from PAS. There are 7 patients remaining in 2011/12 – of these:
1 x Under 18 for discharge
6 patients in current PB cycle for AOB clinic (checked on PAS just now).

Kind regards,
Maria

Maria Conway (Mrs)

Performance Officer
* Performance Improvement Division
Southern Health & Social Care Trust
Room 24 (1St Floor) - The Rowans
Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ
(Direct Dial: Personal Information redacted by USI
8 E-mail: Personal Information redacted by USI
(Mornings only, Mon – Fri)

'You can follow SHSCT on Facebook and Twitter'

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 23 November 2015 15:28
To: Glackin, Anthony
Subject: FW: AOB 2011/2012 Review patients to be booked. - URGENT
Attachments: Urology NOP - Longest Waiter.eml (1.33 KB)

Good afternoon Tony

Below are the two under 18 patients that we talked about last Thursday, also attached is an email I got from Sharon earlier today regarding the same issue.

Do you think it would be ok to discharge these three back to the GP?

Thanks

Martina

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

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Trouton, Heather
Sent: 17 November 2015 15:38
To: Corrigan, Martina
Subject: FW: AOB 2011/2012 Review patients to be booked. - URGENT

Martina

Can you please get the 2 paeds taken off if appropriate?

The other 2 adults are being offered the 21st December

Heather

From: Scott, Jane M
Sent: 09 November 2015 14:02
To: Robinson, Katherine
Cc: Trouton, Heather; Glenny, Sharon
Subject: AOB 2011/2012 Review patients to be booked. - URGENT

Hi Katherine – I've detailed below 4 x patients on Mr O'Brien's waiting list with dates required 2011/2012. These patients have been escalated to our Chief Executive and need sorted as per Heather. I have detailed below PAS snapshot view of position but info is found on Non Clinical Comments. Please can you contact your relevant staff

and get these patients booked by end of this week. Please provide Heather and me with update on progress or difficulties.

CHI Number

Casenote Number

Forenames

Surname

Age

Telephone

Telephone Mobile

Telephone Work

Specialty Code

Hosp Code

Consultant Code

Waiting List Code

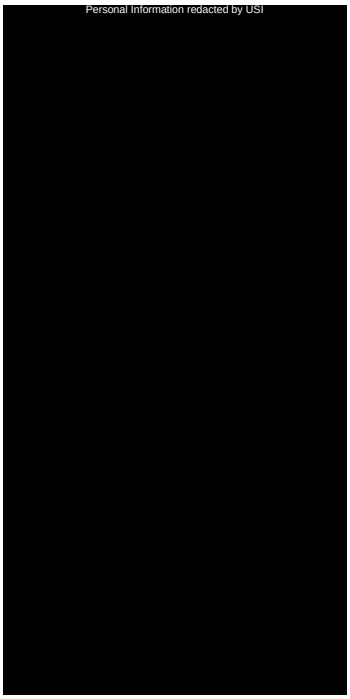
Waiting List Cancelled Code

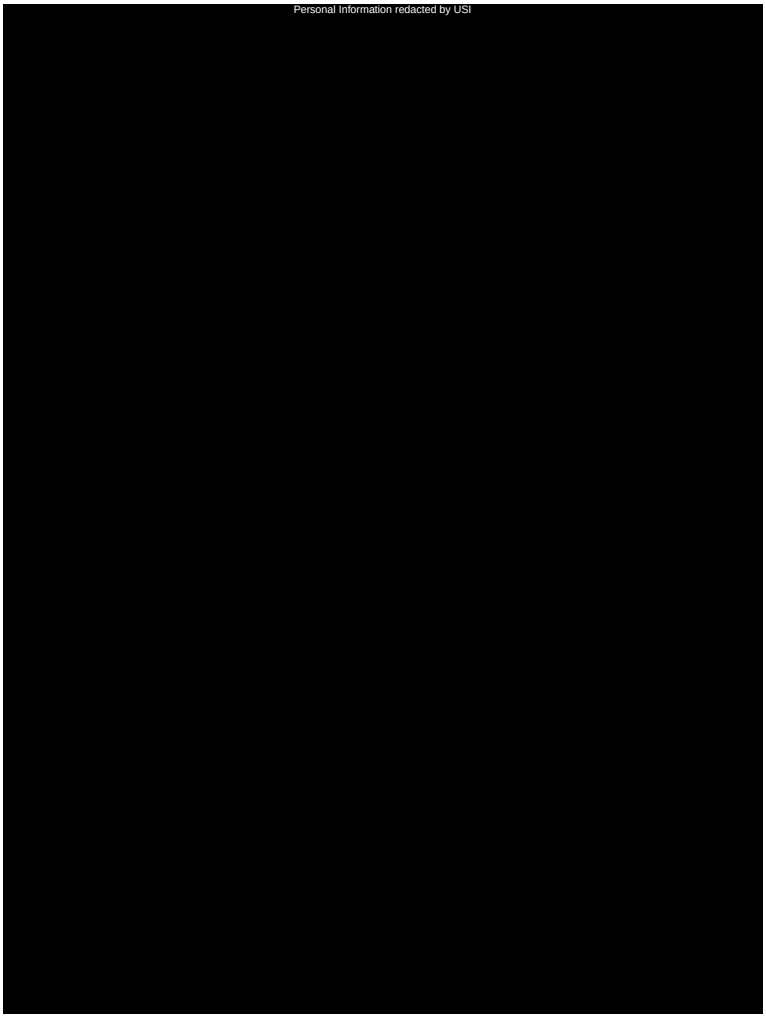
Referral Date Only

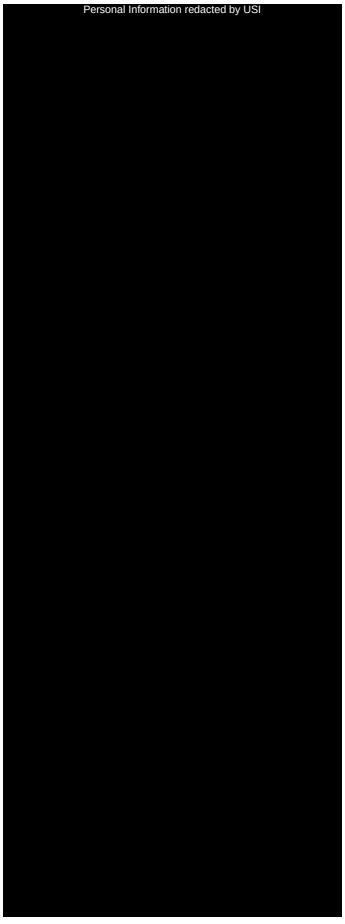
Date Required

Date on Waiting List

Non Clinical Comments







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Personal Information redacted by USI

Personal Information redacted by USI

Appointments within Episode 09/11/15 13:46 CAH

Name Personal Information redacted by USI Casenote Personal Information redacted by USI

Status Department Date Day Time Clinic Appt With Type
Site Breach By Date/Time Rev Date/Time

OP WL: CU2R Con: AOB Spec: URO Date Reqd: 06/2011 R
NFAP** Personal information redacted by USI **U18 D/C SENT TO SEC*** C15 23/09/15 13:21
AS PER CONSULTANT DVC 101214
ATT 15/03/2011 TUE 15:45 CU2 AOB R
Personal information redacted by USI : CU2R AO2 03/03/11 19:56

CHI Number

Casenote Number

Forenames

Surname

Age

Telephone

Telephone Mobile

Telephone Work

Specialty Code

Hosp Code

Consultant Code

Waiting List Code

Waiting List Cancelled Code

Referral Date Only

Date Required

Date on Waiting List

Non Clinical Comments

Total Ref

Personal Information redacted by USI

Personal Information redacted by USI

1

E p i s o d e E n q u i r y

Appointments within Episode 09/11/15 13:52 CAH

Name Personal Information redacted by USI Casenote Personal Information redacted by USI

Status Department Date Day Time Clinic Appt With Type Site Breach By Date/Time Rev Date/Time

OP WL: CU2R Con: AOB Spec: URO Date Reqd: 06/2011 R
CNA Personal information redacted by USI **SFA** FQU 21/10/15 11:51
61210-2ND NEW LTR TO AOB Personal information redacted by USI **DVC 121214**
CNC P 23/10/2015 FRI 11:30 CARUKS CARUKS R
Bk from WL : CU2R CKC 18/09/15 12:39 FQU 21/10/15 11:51

CHI Number

Casenote Number

Forenames

Surname

Age

Telephone

Telephone Mobile

Telephone Work

Specialty Code

Hosp Code

Consultant Code

Waiting List Code

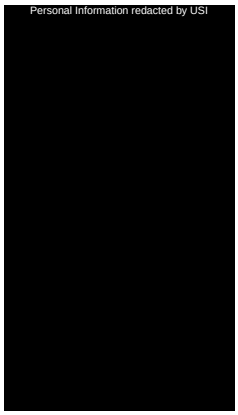
Waiting List Cancelled Code

Referral Date Only

Date Required

Date on Waiting List

Non Clinical Comments



URO

CAH

AOB

CU2R

CU2R

23/04/2012

Irrelevant redacted by the USI

17/07/2012

NRPB - UND 18YRS DISCHARGE LTR TO MR O'BRIEN 6/10/15

Appointments within Episode 09/11/15 13:55 CAH

Name Personal Information redacted by USI Casenote Personal Information redacted by USI

Status Department Date Day Time Clinic Appt With Type
Site Breach By Date/Time Rev Date/Time

OP WL: CU2R Con: AOB Spec: URO Date Reqd: 10/2012 R
NRPB - UND 18YRS DISCHARGE LTR TO MR O'BRIEN 6/10/1 B3T 06/10/15 08:41

CHI Number

Casenote Number

Forenames

Surname

Age

Telephone

Telephone Mobile

Telephone Work

Specialty Code

Hosp Code

Consultant Code

Waiting List Code

Waiting List Cancelled Code

Referral Date Only

Date Required

Date on Waiting List

Non Clinical Comments

Personal Information redacted by USI

Personal Information redacted by USI

CNA -CARUMDH-OCT 15. HAS CHEST INFECTION - SFA

E p i s o d e E n q u i r y

Appointments within Episode 09/11/15 13:58 CAH

Name Personal Information redacted by USI Casenote Personal Information redacted by USI

Status Department Date Day Time Clinic Appt With Type Site Breach By Date/Time Rev Date/Time

OP WL: SDIPN Con: DIP Spec: OPHT Date Reqd: NR
CC 10/02/2015 IOU 10/02/15 15:44
CC 10/02/2015 NEW ROUTINE PER DR MURTY
** End of List **

Many Thanks

Jane

Jane Scott
Service Administrator
Southern Trust Acute Performance
Admin Floor
CAH
T: Personal Information redacted by USI
E: Personal Information redacted by USI

Corrigan, Martina

From: Glenny, Sharon [redacted]
Sent: 23 November 2015 14:17
To: Corrigan, Martina
Subject: Urology NOP - Longest Waiter

Hi Martina

The actual longest waiter for urology NOP is sitting at 71 weeks, but is awaiting outcome from U18 discharge form from June 2015 from Mr O'Brien. This was re-sent to Mr O'Brien in September, but no response has been received to date.

Would you be able to do anything to speed this process up so action can be taken on PAS?

Thanks

Sharon

Casenote

Forenames

Surname

Age

Telephone

Telephone Work

Telephone Mobile

Spec Code

Cons Code

Priority

Referral Source

Reason for Referral

Referral Date Only

Current Date

Date Booked (Y/N)

Appt Date

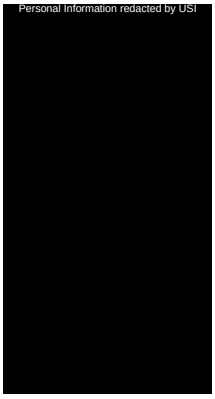
Non Clinical Comments

Clinic Identifier/Code

WL Code

WL Cnc Code

Weeks Waiting



URO

MDH

ROUTINE

GPR

ADV

15/07/2014

15/07/2014

N

UND 18YRS D/C FORM TO NOLEEN 19/6/15-resent 10/9/15

CMDHN

CMDHN

71

Mrs Sharon Glenny
Operational Support Lead
Surgery & Elective Care

Direct dial – Personal Information redacted by USI
Mobile - Personal Information redacted by USI

Corrigan, Martina

From: Darren Campbell [redacted]
Sent: 04 July 2016 11:35
To: 'Corrigan, Martina'
Cc: Trouton Heather
Subject: FW: Urology Trust Performance Actions 16/17
Attachments: Urology Trust Performance Actions 16_17.xlsx

Hi Martina,

In the last PIG we had a bit of a stocktake and talked through all the actions by HSCB / Trust colleagues and analysed where we were against when we started.

There were some definite areas of progress but also areas that we needed to progress faster.

The Trust have provided updates verbally around many of the areas on the attachment.

I have tried to summarise all of the performance actions into the above template to allow for a bit more of an at a glance action log.

Please could you complete this and get it back to me by the end of July.

I am happy to come and talk through it if that would help.

Please put as much detail as you feel would be helpful or as best describes the Southern position or constraints to completing the outcomes.

Thanks,

Darren

Urology Performance Actions

Intervention aimed	Action	Action Detail	When action will be/has been completed	Timescale for outcome of action to take affect
ALL	Deliver Core Funded Capacity	Ensure SBA performance for Urology across New OP, Review OP and IPDC is at least at funded levels		
NEW OP	In house non recurrant additionality	A plan for the additionality required to reduce backlog of new outpatients (costed with timescales if appropriate)		
REVIEW OP	Waiting List validation	past clinically indicated date. This should be a clinical and admin review. Impact from this should be captured in order to feedback		
REVIEW OP	In house non recurrant additionality	A plan for the additionality required to reduce backlog of review patients		
REVIEW OP	Plan for patients over 3 months	A combination of the above actions are likely to be required for Trusts to complete a plan for all of the patients currently waiting over 3 months. This plan should have a clear timescale against it (and costed if appropriate)		
DC	Waiting List validation	Validate all patients waiting over 52 weeks to ensure they should still be on the waiting list.		
DC	In house non recurrant additionality	A plan for the additionality required to reduce backlog of DC patients.		
DC	Other DC additionality (N code)	Plan for how many vasectomies and similar procedures can be done in the IS.		
IP	In house non recurrant additionality	A plan for the additionality required to reduce backlog of IP patients so no patient is waiting over 13 weeks		
Cancer	In house non recurrant additionality	A plan to reduce to no patients actively waiting over 62 days		

Southern Health and Social Care Trust

Performance and Reform Directorate

ACUTE DIRECTORATE - PERFORMANCE RISKS TEMPLATE
Date of Information Report: Monday 21 December 2009
Date of Escalation Report: Tuesday 22 December 2009
Time of Escalation: 10.00am

IP/DC Elective Access – December PTL		
Reported as 'Not Booked' on PAS	**Volumes**	**Update** Include in update validated position highlighting: ▪ Volumes where no capacity yet secured ▪ Volumes in IS ▪ Booking status and any operational risk (leave, sickness, etc)
Cardiology	1 IP, 1 DC	
Orthopaedics	31 IP, 3 DC	
Pain	2 DC	
Urology	62 IP, 18 DC	5 IS – 54 inpatients and 15 daycases remain on PTL and remains a high risk for this specialty
Admission Dates in Past (with no outcomes on PAS)	**Volumes**	**Update** Include in update validated position highlighting outcomes outstanding from IS and in-house outcomes
ENT (including Paed ENT)	2 IP, 1 IP (IS)	IS update needed
Gastro	3 DC	
Gen Sur	2 DC	
Gen Surgery Scopes	3 DC, 2 DC (IS)	
Oral Surgery	1 DC (IS)	
Pain Management	1 DC	
Rheumatology	19 DC	
Urology	1 DC, 8 DC (IS) 1 IP, 6 IP (IS)	IS update needed
Booked Beyond Breach (BBB) Specialty	**Volumes**	**Update** Include in update validated position identifying if Patient still BBB or resolved
Orthopaedics	Personal Information redacted by USI	
Urology	Personal Information redacted by USI	There is no capacity in-month to see these 2 patients
ENT	Personal Information redacted by USI	This patient refused Dec date and should have been reset – this has now been sorted

Outpatients – December PTL		
Reported as 'Not Booked' on PAS Specialty	**Volumes**	**Update** Include in update validated position highlighting: ▪ Volumes where no capacity yet secured ▪ Volumes in IS ▪ Partial booking cycle status and any operational risk (leave, sickness, etc)
Cardiology	15	
Colposcopy	2	
Dermatology	7	
Diabetic / Diabetology	6	
Endocrinology	2	
Gastroenterology	10	

Kelly Kingsmill, Performance and Contracts Officer, The Rowans, CAH Site, 68 Lurgan Road, Portadown, BT63 5QQ
Telephone: Personal information redacted by USI Email: Kelly.Kingsmil Personal information redacted by USI

General Medicine	39	
Gynaecology	18	
Menopause	1	
Nephrology	1	
Neurology	9	
Ophthalmology	41	
Oral Surgery	43	
Pain	4	
Rheum	2	
Thoracic Surgery	1	
Urology	22	10 patients remain on this morning's PTL with no appointment- high risk as there is no more capacity in-month.
Booked Beyond Breach (BBB)	**Volumes**	**Update** Include in update validated position identifying if Patient still BBB or resolved
Oral Surgery	[redacted]	
Dermatology	Personal Information redacted by USI	
Orthopaedics	X 34 *See OP PDF attached for casenotes, pgs 29 - 32*	

Diagnostics – December PTL			
Reported as 'Not Booked' on systems	**Specialty**	**Volumes**	**Update** Include in update validated position highlighting: ▪ Volumes where no capacity yet secured ▪ Volumes in IS ▪ Partial booking cycle status and any operational risk (leave, sickness, etc)
Ultrasound		1	
Neurophysiology		2	
Urodynamics		9	Due to annual leave and bank holidays these patients will breach month-end
Booked Beyond Breach (BBB)	**Specialty**	**Casenote**	**Update** Include in update validated position identifying if Patient still BBB or resolved
Urodynamics		Personal Information redacted by USI Personal Information redacted by USI	Due to annual leave and bank holidays these patients will breach month-end
Cardio Echo		Personal Information redacted by USI	

AHP – December PTL		
Service Area Reported as 'Not Booked' on Info Return	**Volumes**	**Update** Include in update validated position highlighting: ▪ Volumes where no capacity yet secured ▪ Partial booking cycle status ▪ Any operational risk (leave, sickness, etc)

ICATS – December PTL			
Reported as 'Not Booked' on systems	**Specialty**	**Volumes**	**Update** Include in update validated position highlighting: ▪ Volumes where no capacity yet secured ▪ Volumes in IS ▪ Partial booking cycle status and any operational risk (leave, sickness, etc)

Urology ICATS		79	62 patients remain on the PTL – high risk of breaching month-end
Booked Beyond Breach (BBB)	**Specialty**	**Casenote**	**Update** Include in update validated position identifying if Patient still BBB or resolved
Urology ICATS x 17		Personal Information redacted by USI	No capacity for these patients in-house and they will therefore breach month-end

Other Identified Risks	
Changes in total Waiting List trends (as appropriate)	**Update**
Others as Identified (Cancer Pathway, cancelled operations, DRTT, HCAI, OP Rv Backlog etc)	**Update**

General Risk noted by Director:

Information on the risks escalated above has been collated from the weekly information returns / reports. If you require any additional information or have any queries on the risks escalated please contact Kelly Kingsmill, Performance and Contracts Officer, in the first instance Personal information redacted by USI

Updates should be provided to SMT.

Exclusions:
Inpatients / Daycases:
Paed Medicine - belongs to CYPS, Grace
Paeds - belongs to CYPS, Grace
Outpatients:
Community Paeds - belongs to CYPS, Geraldine
Paeds - belongs to CYPS, Grace
Paediatric Cardiology - belongs to CYPS, Grace
Geriatric Medicine – belongs to OPPC

Year	Consultants Funded	Consultant Posts Occupied with comments
2009	3	3 Substantive posts filled (O'Brien/Young and Akhtar)
2010	5	3 Substantive posts filled (O'Brien/Young and Akhtar) Work commenced on agreeing a 5 consultant job plans along with job descriptions
2011	5	3 substantive posts filled (O'Brien/Young and Akhtar) Two new posts were advertised and from Oct 2011 Mr Ho filled one of these as an Locum Consultant
2012	5	From March 2012-August 2012 two substantive posts filled due to the resignation of Mr Akhtar. Mr Ho was a locum consultant until July 2012 From August 2012 Mr Glackin took up permanent post From September 2012 – Mr Connolly took up permanent post From November 2012 Mr Pahuja took up permanent post
2013	5	January-April 2013 – 5 substantive posts filled (O'Brien/Young/Glackin/Pahuja/Connolly) (Mr Connolly left at end of April 2013 and Mr Pahuja left October 13) May-September 2013 - Mr Jathar filled locum post December 2013 – Mr Suresh took up post to replace Mr Connolly only applicant so advertised again
2014	5	January – May 2014 - 4 substantive posts filled (O'Brien/Young/Glackin/Suresh) Interviews held in January 2014 and the Trust were successful in 'attracting' two suitable candidates and whilst only funding for 5 went at risk for the 6th consultant. Mr Haynes started in May 2014 Mr O'Donoghue started in August 2014
2015	6	6 substantive posts filled (O'Brien/Young/Glackin/Suresh/Haynes/O'Donoghue)
2016	6	6 substantive posts filled up until Mr Suresh resigned in October 2016 5 substantive posts October-December 2016 (O'Brien/Young/Glackin/Haynes/O'Donoghue)
2017	6	5 substantive posts (O'Brien/Young/Glackin/Haynes/O'Donoghue) 1 locum fill ([redacted])
		Substantive post advertised – no applicants
2018	6	5 substantive filled (O'Brien/Young/Glackin/Haynes/O'Donoghue) 1 temporary consultant (Derek Hennessey from April 2018) 1 Locum fill ([redacted])
		1 Advertised and appointed Matthew Tyson in October 2018 – couldn't take up post until out of training in February 2019.

Year	Consultants Funded	Consultant Posts Occupied with comments
2019	6	5.6 Substantive posts filled until July 2019 (O'Brien/Young/Glackin/Haynes/O'Donoghue/Tyson appointed in February 2019 and went on sabbatical in July 2019). 1 temporary consultant – D Hennessey left post in May 2019 1 Vacant post unable to recruit to and 1 locum for a few months ([redacted] – July-Sept) Note Mr Haynes works by 3 days for Southern Trust and 2 for Belfast Trust
2020	7	4.6 substantive posts up until July 2020 (O'Brien/Young/Glackin/Haynes/O'Donoghue) (Mr O'Brien retired so down to 4 substantive) 1 Locum fill for a few months ([redacted] July-Sept) 1 locum fill from October 2020 – Mr Omer who after advertisement was successful in October 2020 but requested that the Trust wait on him being added to the specialist register before taking up post – to note he never become permanent as he requested to remain as a locum due to family commitments Note M Tyson was due back from sabbatical in August 2020 but didn't come back until Jan 2022 due to travel [redacted]. 1 Locum post filled from November 2020 by Mr Khan 6th vacant substantive post was not filled.
2021	7	3.6 substantive posts 2 locums (Khan and Omer) And advertisements as listed per below
2022	7	As of 14 June there are 3.6 substantive posts and 1 locum. The Trust have advertised and have two applicants – interviews planned for end of June 2022

NO. OF TIMES ADVERTISED	DATE ADVERTISED	NORMAL ADVERTISING	APPLICATIONS RECEIVED	ENHANCED ADVERTISING
Consultant Urologist	10/01/2017		No Applicants	
Consultant Urologist	02/10/2018		Mr Matthew Tyson Started post 25/02/2019	
1	March 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	0	
2	May 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	2 (interviewed & not appointable)	
3	October 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	2 (interviewed & not appointable)	
4	February 2022	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	0	➢ BMJ website – Top Job
5	April 2022	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	Closing date: 10 May 2022 Interviews planned end of June 2022	Irish Medical Times BMJ website enhancements Top Job Premium job Promoted Job Target email to 150 registered candidates CV database search ➢ BMJ website in Australia & New Zealand

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 02 October 2014 08:41
To: Burns, Deborah
Cc: Stinson, Emma M
Subject: Urology Vision
Attachments: paper for Board re justification for 6th and 7th consultant and nursing and admin support.docx

Debbie

As discussed summary attached

Happy to discuss

Martina

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

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

Anticipated position for 31 March 2015

	Status Quo	6th consultant and nursing	7th consultant and nursing **
Outpatients without ER	42weeks	26 weeks	15 weeks
Outpatients with ER	34 weeks	15 weeks	9 weeks
Inpatients	85 weeks	70 weeks	52 weeks
Day Cases GA	85 weeks	52 weeks	36 weeks
Day Cases ESWL	40 weeks	13 weeks	13 weeks
Day Cases Flexis	66 weeks	21 weeks	9 weeks

** will depend on consultant recruitment (? Locum) and will also depend on the availability of getting the additional theatre sessions

Support Staffing (Nursing and Admin) required plus costs

Band	In Post (WTE)	Proposed (WTE)	Gap (WTE)	Approx Cost
7	1.86	3.4	1.54	74,105
5/6	2.72	4.4	1.68	56,400
2/3	0.8	3.4	2.6	61,217
5 Admin Support	0	1	1	33,570
			TOTAL	**225,292**

There are currently a number of vacancies in Support Medical Staff

GP with Specialist Interest (Full year)	-	£41,292
1 Specialty Doctor (Full year)	-	£70,800
1 Specialty Doctor (7 months)	-	£41,300
Total available	**-**	**£153,392**

Spend from these vacant posts

Internal Budget Variation for Waiting Lists = £20,568 (end of September) – none planned for this quarter
Locum Registrars for night-time/weekend rota = £29,007 (end of August) Anticipated spend on locums until end of March = £40,610

So total until 31 March 2015 = £110,753
Still in Budget = £42,639

Required spend to implement support part of the Vision (Nursing/Admin) from December – March 2015 = £68,584

So shortfall of £25,945

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 25 September 2014 08:43
To: Burns, Deborah
Cc: Stinson, Emma M
Subject: costs for Urology 'New'Model

Importance: High

Hi Debbie

As discussed yesterday below are the staff with costs needed to make the new model work:

2 x Consultants (this includes John O'Donoghue – 6th consultant) = £1,054,944 (this includes all costs associated with a consultant except for goods and services) Nursing and Admin cost = 260,023

Total cost = 1,314,967

The last IPT for consultant 5 and 6 was £148K short (the Board give nothing for Pharmacy and Labs) but included in this was two Band 7's at a cost of £96, 240 that we never appointed so I am not sure if the Board will come back to us and deduct the 2 nurses costs of the cost above?

If we get the model in with 6 consultants we will be minus 5% on New OP SBA by end of March and it will depend on the Electronic Referral where our waiting times will be but it is anticipated without the Electronic Referral being available that waiting times will be at 15 weeks and with the Electronic Referral it will be at 9weeks or below.

If you need any other information, happy to discuss

Martina

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

Telephone: [redacted]
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Year	Non Consultant Funded posts	Non Consultant Posts Occupied with comments (note this does not include Clinical Nurse Specialists)
2009	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 2 vacant Trust Staff Grade Posts
2010	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 2 vacant Trust Staff Grade Posts
2011	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 2 vacant Trust Staff Grade Posts until November 2011 then Dr Sani Aminu commenced
2012	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 1 post filled by Dr Sani Aminu (resigned July 2012) Dr Personal information redacted by USI took up locum post October 2012 Dr Maurice Fernando commenced November 2012 J Marley stopped providing clinical sessions in December 2012
2013	3	Personal information redacted by USI Dr Rogers resigned in April 2013 Dr M Fernando resigned in August 2013 3 vacant posts from August 2013 Continued to advertise through agencies and usual media forums
2014	3	1 substantive post holder (J Martin) commenced October 2014 Continued to advertise through agencies and usual media forums
2015	3	1 substantive post holder (J Martin) 2 vacancies and continued to advertise through agencies and usual media forums
2016	3	Dr Martin resigned in August 2016 L Devlin took up locum post in December 2016 3 vacancies from August 2016 and continued to advertise through agencies and usual media forums
2017	3	L McAuley took up Staff Grade post in January 2017 as full-time and in September reduced her hours to 3 days per week which is whole time equivalent of 0.60 L Devlin resigned her post in February 2017 1 vacant post and continue to advertise through agencies and usual media forums
2018	3	1 part-time staff grade in post (L McAuley) 1 vacant post filled with locum (Hasnain) Posts advertised – one successful applicant S Hasnain
2019	3	2 staff in substantive post (McAuley/Hasnain)

		Post advertised – no applicants
2020	3	2 staff in substantive post (McAuley/Hasnain) In December 2020 it was agreed by Chief Executive to go back out to advert for clinical fellows and to appoint at least 3 this was successful and three appointed with Whole Time Equivalent of 2.60
2021	3	1.63 whole time equivalent substantive post holders (McAuley and Hasnain) 2.60 whole time equivalent substantive post holders (Cull/Griffin/Asingel)
2022	3	1.63 whole time equivalent substantive post holders (McAuley and Hasnain) 2.60 whole time equivalent substantive post holders (Cull/Griffin/Asingel)

Corrigan, Martina

From: Trouton, Heather
Sent: 21 August 2013 10:20
To: Beth Malloy [redacted]
Cc: Leeman, Lesley; Burns, Deborah; Lappin, Lynn; Corrigan, Martina
Subject: Urology plan
Attachments: Urology Review Recommendations Progress August 2013.doc

Dear Beth

Following your recent conversations with Lesley re our plan to address the deficit in our Urology SBA due to numerous medical vacancies, please see the following outline of our plan for your consideration prior to our meeting on 9th September.

Please also see attached the update on the Urology Review recommendations as requested.

Current and on- going vacancies within the service causing the deficit in SBA

Staffing Gap
1 substantive consultant
3 specialty doctors
1 GP with Specialist Interest
2 Specialist nurses

Actions already taken to address the vacancies

· We have appointed a locum urologist, however his productivity would not be as you would expect from a permanent Urologist.
· We have advertised 4 times since November for the middle grade doctors with no success. We have tried every title and have gone out to Europe and beyond.
· We have scouted for a replacement GPwSI but we are reliably advised there are no further GP's with the specialist skills in Urology out there.
· We have not appointed 2 more specialist nurses as their activity to contribute to seeing patients is curtailed by the lack of medical support. While the specialist nurse can undertake certain procedures and investigations , they need to work alongside a medic for the full diagnosis. However it will be worthwhile to increase by a further band 7 specialist nurse with the proposed model. The funding for these 2 posts has been used to fund out of hours locum cover to cover the specialty doctor gaps, supplementing the funding for the specialty doctor vacancy as locum cover comes at a premium.

Overarching plan to address deficit.

· We have now successfully recruited a substantive Urologist from England who will commence in October 2013. This will however leave the remaining gap at ICATS and middle grade level with the associate gap in core outpatient and day case activity that this service and the middle grades produce.
· To address this on an interim basis , Mr Brown our General Surgeon with an interest in Urology has agreed to move sessions from General Surgery to the urology service to undertake some outpatient and day case work displaced from the GPwSI and middle grade staff in line with his experience.
· It is also planned that Mr Brown will bring with him 2 sessions of a General Surgical Associate Specialist who will further undertake an additional 2 flexible cystoscopy sessions per week as an interim, this will support core activity and facilitate better management of red flag work and improve cancer targets also.
· To further supplement core Urology activity we are re-training one of the Specialty Nurses in Urology, who has previous experience in flexible cystoscopy, to undertake planned flexible cystoscopies. Core activity lost from the

specialist nurse will be backfilled from the available nurse funding. It is anticipated that this capacity will come on stream in October and provide 4 lists per week

· Further the Trust is seeking to backfill some of the core activity displaced from the middle grade doctors. To do this Trust intends to roster current secure registrar staff into the current weekly flexible cystoscopy lists and increase this by 0.5 per week. To do this the Trust needs to secure an additional SHO to backfill and would seek funding for this. This will also release the reg to provide support to OP deficits also.

· Activity undertaken as OPwP including urodynamics and TRUS biopsies which are recorded as DC in other Trusts, will be offset against the DC core activity output as agreed by HSCB.

It is anticipated these operational plans will bring forward additional activity in Q3, which will improve the SBA underperformance to -10% by end of December.

The risks associated are as follows:-

- We can only move Mr Browns's sessions to Urology if we are able to secure a replacement general Surgeon to keep on the general Surgical activity required. We are interviewing for his replacement on 28th August with one candidate from England.
- We can only release the Registrar to fill the flexible cystoscopy sessions if we are able to recruit a SHO grade doctor.
- The specialist nurse can only perform 'planned ' and not diagnostic flexible cystoscopy so this is a constraint.

However, we are keen to really address this deficit in activity caused by lack of medical staff in this specialty so we will endeavour to bring this plan to fruition.

Happy to discuss further on 9th September.

If you require any further information in advance of the meeting please advise

Best regards
Heather

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 06 June 2014 13:33
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; Suresh, Ram; Young, Michael
Cc: Trouton, Heather; Glenny, Sharon; Burns, Deborah; Stinson, Emma M
Subject: yesterdays meeting

Importance: High

Dear all

Many thanks for your input into yesterday's meeting. This was a very worthwhile exercise and was great to be able to go back and say we have all the patients on the Cancer PTL that need a date now having got a date. So thank you.

We will continue with this scheduling next week and Aidan if you are happy maybe Sharon and I could meet with you before this, to go through and compare both of your PTL's and then once we get this sorted then we can start looking at dates for the long-waiters.

As a follow-up from today I can confirm I have emailed Ronan Carroll, Assistant Director of Anaesthetics about the issues regarding the Friday PM list, and I have asked him to look into the possibility of having Nursing Assistants working alongside you in theatres instead of juniors, and I will keep you informed on how I get on with this.

I have also emailed as previously discussed about the possibility of Mitomycin being administered in Recovery after the patient's procedure instead of on the ward which would be much better for the patient - I will again keep you appraised.

Finally I just wanted to reiterate the areas that I have been tasked with doing to assist with addressing the backlogs:

(1) Looking at the cancer targets and bringing all patients back to within the 31/62 day pathway by end of July 2014.
(2) Look at where we will be at by end of September with the long-waiting patients sitting on the PTL, the aim is that we should be in the same position as what we were at end of March which is 69 weeks, however as discussed today we will be sitting with 77 patients over this time frame, I am going to validate these patients to ensure that they are fit and if they still need their surgery etc and then we need to start giving dates to the longest waiting patients, so at least we can give Debbie and the Board and idea of where we will be at the end of September.
(3) Review backlog. The target is that by the end of September all 2011 and 2012 patients will have an outcome, i.e. discharged, telephoned, seen at a clinic or have a date to be seen. I have started on 2011 and I am going through these for 'admin' errors e.g. been seen since in urology and two or more episodes open, patient hasn't been discharged as per letter etc. I am also printing off reports (radiology etc..) on those patients who should have been reviewed with result, any patients that I have a concern with from a governance point of view I am organising an appointment and then I will get a clinical decision on the rest. Once I have this finished I will look at 2012 for Aidan and Michael's in the first instance and do the same exercise for this. Just to advise on what I have done to date I have a 10% discharge due to admin error so I do feel this has been a worthwhile exercise.
Can you please let Sharon and I know your availability for Saturday's during July/August and September to see patients. (thanks Tony we have received yours).
(4) Innovation and implementation of ideas. E.g. haematuria/prostate pathways etc…. I would be grateful for your comments on the draft proforma I passed out at the meeting yesterday so that we can implement this as soon as possible and we need to discuss soon the other areas which have been suggested:

- Nurse triage
- Nurse-led only clinics
- Streamlining haematuria (I am going to work on the scope issue with theatres)
- Streamlining prostate clinic

· Roistering to the areas that we need to concentrate on most to help meet the targets.

I am grateful for your support with this and will continue to be in touch with you over the next number of weeks.

Kind regards

Martina

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

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

Corrigan, Martina

From: [redacted] >
Sent: 09 September 2019 18:50
To: Johnston, Pamela
Cc: Murray, Helena; Corrigan, Martina; McArdle, SiobhanM
Subject: RE: Emergency Theatre Protocol CAH

Dear Pamela

I have to sadly realise that more complex issues like the management of metastatic cancer of on-resident foreign fisherman or the substandard quality of hospital accommodation or the cost and benefit value of the locum consultant are difficult tasks for a satisfactory solutions .Being a locum it is not my job to resolve multilateral problems, but I am always happy to share my views in a case if somebody is interested.

[redacted]

From: Johnston, Pamela
Sent: 06 September 2019 14:06
To: [redacted]
Cc: Murray, Helena; Corrigan, Martina; McArdle, SiobhanM
Subject: FW: Emergency Theatre Protocol CAH

Mr [redacted],

Many thanks for rebooking 2 patient's booked on emergency list yesterday, patient for circumcision and bilateral orchiectomy.

Part of my job is to oversee appropriate emergency bookings are made for emergency list.

I understand that one patient for circumcision had some urinary retention and was an impatient so that booking was appropriate

however the patient for orchiectomy was cancerous and should have needed to be booked on as red flag on an elective list in first instance.

Martina Corrigan your Head Of Service would assist you in these circumstances to help get an early slot for patient.

I appreciate you had good intentions booking this patient at end of your elective list but really there was insufficient time in session today with an overrun after 2pm and put pressure on other lists this afternoon.

I have attached copy of our protocol.

Many thanks for your support in this matter.

Regards
Pamela

[redacted]

Theatre Manager
Main Theatres
Anaesthetics, **Theatres** & Intensive Care

Southern Health & Social Care Trust
Craigavon Area Hospital

Direct Dial (028) Personal Information redacted by the USI

Corrigan, Martina

From: [redacted] >
Sent: 07 August 2019 12:18
To: Corrigan, Martina
Cc: Young, Michael; [redacted]
Subject: RE: extension of contract

Importance: High

Dear Martina
Can we meet and discuss in person as I can`t fully understand the on call week commitments and admin requirement during the clinic.

Thanks

[redacted]

From: Corrigan, Martina
Sent: 07 August 2019 11:56
To: [redacted]
Cc: Young, Michael; [redacted]
Subject: RE: extension of contract

Thanks [redacted]

Just to confirm that Mr Tyson didn't have 2 admin sessions, the second one was SPA which he used for Admin and as a locum doctor you do not get SPA.

Admin for all consultants is worked out at half an hour per clinical sessions. So as you will be doing 9 Clinical sessions this will work out at 4.5 hrs admin per week.

Just to clarify it had been agreed that Laura McAuley, Specialty Doctor would do Mr Tyson's admin until it was caught up and she has had time set aside on Monday PM to do this (I know that she has been off on 2 week's annual leave but she is back now).

Each clinical session is 4 hours with admin being done at the end of an OP clinic – New outpatient clinics have 9 patients so there will be time for admin between patients and at the end of clinic. Review outpatients clinics have patients booked for 2 hours so admin (digital dictation reviewing results etc. is done for the remainder 2 hours)
Main theatre lists have 30mins before starting theatres for post-ops and 30 mins at end for post-ops so these main theatre sessions are 4.5hrs

Proposed JP is:

Monday x 2 clinical sessions to be determined each month at scheduling
Tuesday x 2 clinical sessions to be determined each month at scheduling
Wednesday x 2 clinical sessions to be determined each month at scheduling
Thursday AM – 1 x Clinical session to be determined each month at scheduling and PM attend Cancer MDT which lasts until 3:30 and the remainder then will be for Admin (1.5hrs).
Friday AM – clinical session to be determined each month at scheduling and then as requested Friday PM will be 4-hour admin session.

Your week oncall is 2 x clinical sessions over the 7 days (09:00-17:00) and then oncall is from 17:00 until 09:00, for this you will need to detail when you are actually contacted or have to physically come in whilst during the out of hours period, this is the same for all agency consultants and this will have been discussed with your agency.

I have signed off your recent timesheets as I don't think you have been advised of the above….. but going forward I will need to sign off within the above parameters and I will need more detail of your oncall work (17:00-09:00).

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT Personal Information redacted by the (Internal)
Personal Information redacted by the USI (External)
Personal Information redacted by the USI (Mobile)

From: Personal Information redacted by the USI
Sent: 01 August 2019 10:49
To: Corrigan, Martina
Cc: Young, Michael; Loughran, Teresa; Personal Information redacted by the USI
Subject: RE: extension of contract

Thank you Martina

I came here to work full time, means 10 session per week.

The only issues are Friday afternoons enable me to catch the 6 pm flight from Belfast.
So to have admin on Friday pm will be good and I can stay longer on other day.

At this moment I am also working on Mr Tyson's admin backlogs as well.
According to Teresa Mr Tyson had 2 admin sessions per week.
I have a strong feeling that I also will need two admin sessions.
Specially because of my work stile, when I usually try to decrease follow up visits by sorting out lot of issues during my admin time.

Kindest regards

Personal Information redacted by the

From: Corrigan, Martina
Sent: 01 August 2019 10:05
To: Personal Information redacted by the USI
Subject: extension of contract

Dear Personal Information redacted by the ,

Just to advise I have given instruction to our locum team to advise your agency that we will be extending your contract until Personal information redacted by USI

I trust this will be ok for you?

I will also need confirmation from you on how many sessions you want/expect to work each week so that I can get these scheduled and booked. There will be one session a week scheduled for admin.

Kind regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT Personal Information redacted by the USI (Internal)
Personal Information redacted by the USI (External)
Personal Information redacted by the USI (Mobile)

Corrigan, Martina

From: Corrigan, Martina <[redacted]>
Sent: 21 May 2021 12:25
To: Corrigan, Martina
Subject: FW: can you have a read please if you don't mind?
Attachments: FAO Dr [redacted] Responsible Officer re [redacted]; NC Healthcare - Assessment Form.pdf

From: Corrigan, Martina [mailto:[redacted]
Sent: 24 September 2020 07:58
To: Woods, Tracey
Cc: Haynes, Mark
Subject: FW: can you have a read please if you don't mind?

Good morning Tracey

See attached from Mr Haynes regarding [redacted]

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT [redacted] (Internal)
[redacted] (External)
[redacted] (Mobile)

Corrigan, Martina

From: Parks, Zoe <[redacted]t>
Sent: 09 September 2020 10:34
To: rachael.rosso[redacted]
Cc: Haynes, Mark; McClements, Melanie; Diamond, Aisling
Subject: FAO Dr [redacted] Responsible Officer re [redacted]
Attachments: x Lettertolocumagency 8.9.2020.docx; Screening of concern - [redacted] urologist.pdf

Importance: High

Rachael,

Could you please ensure the attached correspondence is brought to the attention of Dr [redacted] Responsible Officer for [redacted] as soon as possible.

I would be grateful if you could confirm receipt.

Many thanks

[redacted]

Zoë Parks
Head of Medical HR
Southern Health & Social Care Trust
Tel: [redacted]
Mob: [redacted]
https://view.pagetiger.com/Hub/1MedicalHRHub

Southern Health and Social Care Trust

8 September 2020

FAO Personal information redacted by USI

Responsible Officer

RIG Locums Ltd

Via Rachael Rosso Personal Information redacted by the USI

Client Account Manager **NC HEALTHCARE**

01908 299457 Interchange House, Howard Way, Milton Keynes, MK16 9PY

By e-mail only

Dear Dr Personal Information redacted by USI,

RE: DR Personal Information redacted by the USI **GMC No.** Personal Information redacted by the USI

The above locum doctor was engaged with this Trust from 1 July 2020, which was intended for a longer term booking.

The Associate Medical Director, Mr M Haynes met with Personal Information redacted by USI on Wednesday 2nd September 2020 and Friday 4th September 2020 to bring concerns to his attention. Unfortunately given the nature of these concerns, a decision was taken to end our locum engagement with this doctor. I have enclosed the documented concerns

completed by the Associate Medical Director, which have been discussed with [redacted] Personal Information redacted by the USI .

As this doctor's Responsible Officer, I understand you will take forward the necessary processes and investigation for managing these concerns in the interests of protecting future patients from any risk. Can you also raise with your GMC-ELA for discussion. You can liaise with my office via my secretary (Emma.Campbell[redacted] Personal Information redacted by the USI) should you require any further information from this Trust to allow you to fulfil this role.

I would be grateful if you could acknowledge receipt of this letter

[redacted] Personal information redacted by USI

Head of Medical HR

On behalf of

Dr Maria O'Kane

Medical Director

c.c Mr M Haynes, Associate Medical Director

Melanie McClements, Acute Services Director