Ibuprofen has been proved to be of benefit in a Cochrane review, for the treatment of post-operative pain (Derry CJ, 2013). There is however clear variation in the individual patient response to NSAIDs in both therapeutics and adverse effects, and some patients seem to respond better to one drug than to others, and responses differ between patients. These differences have been attributed to variations in mechanism of action to COX enzyme inhibition different capacities for altering non-prostaglandin-mediated biologic events; and differences in pharmacodynamics, pharmacokinetics, and drug metabolism, including pharmacogenetic factors (Soloman, 2017).

The pain experienced by a patient receiving ESWL is multifactorial, but broadly speaking can be split into patient factors and lithotripter factors.

**Table 1.**

**PATHOGENESIS OF PAIN DURING ESWL**

| Patient Factors | Lithotripter Factors |
|---|---|
| Cutaneous superficial skin nociceptors* | Lithotriptor type^ |
| Visceral nociceptors such as periosteal, pleural, peritoneal* | Size and site of stone burden^ |
| Musculoskeletal pain receptors* | Location of shockwave focal stone^ |
| Pain tolerance | Size of focal zone^ |
| Pre-existing injury | Cavitation effects^ |
| | Shockwave peak pressure^ |
| * (Weber A, 1998) | Entry of shockwaves at skin^ |
| | Coupling |
| | (Basar H, 2003) |

To achieve the desired number of shockwaves delivered to a stone, at a suitable power, to generate a reasonable level of energy delivery to treat the stone requires the practitioner to limit the pain experienced by the patient.

Although many papers have been written on ESWL and pain relief, to date a consensus on what to prescribe has not been reached. The search for the ideal pain medication regime therefore continues.

A Pubmed search for the use of oral Piroxicam as pre-treatment medication for ESWL returned no studies. Search terms included 'ESWL', 'SWL', 'Extracorporeal shockwave lithotripsy' and 'Piroxicam', 9 papers were returned, 7 papers were discarded as they did not directly compare piroxicam in a trial or present study evidence for its use. The remaining 2 papers were clinical trials, a randomized placebo-controlled study and a randomised comparison trial, but neither studied the use of Piroxicam as an oral medication (Andréou A, 2006) (Aybek Z, 1998). Data is therefore required for oral Piroxicam use as a pre-medication for ESWL.

**Method,**

Data on a prospective 150 patients receiving ESWL for renal and upper ureteric stones was collected in2017. The departments guidelines for pain relief was followed, offering all patient pre-medication with paracetamol and piroxicam, with those contraindicated to piroxicam due to allergy, previous stomach ulcer, NSAID ingestion that day or personal choice only receiving Paracetamol or nothing. Oral medication was given on average 30 minutes prior to treatment by the staff nurse, in a separate room to the lithotripter and blinding radiographer who delivers the ESWL treatment.

All patients were treated by the same EDAP TMS Sonolith i-sys, which is a new generation electroconductive lithotripter. All patients were aimed to have 1000J delivered to a renal and 1400J to a ureteric calculi, with a frequency of 1.2Hz as standard. The power to the calculi was aimed at reaching 100%, requiring 3000 maximum shocks up to a one hour treatment session. Treatment can be stopped if stone successfully treated at a lower energy.

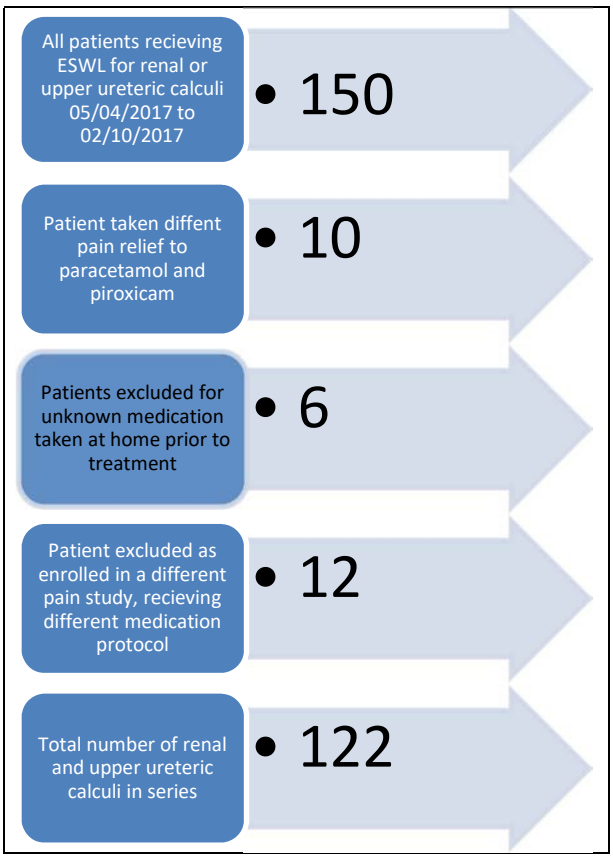



**Table 2. Patients excluded from study**

**Results,**

**Table 3. Renal and upper ureteric calculi**

| Medication | Number of Patients | Average age and (range) | Power (%) average and (range) | Energy average and (range) |
|---|---|---|---|---|
| **20mg Piroxicam and 1g Paracetamol** | 62 | 50.3 (24-80) | 59.4 (16-100) | 689.6 (55-1000) |
| **1g Paracetamol** | 56 | 54.4 (28-81) | 60.8 (12-99) | 788.8 (145-1000) |
| **No Medication** | 4 | 65.5 (60-74) | 51 (38-59) | 899.25 (713-1000) |

The statistical analysis of prioxicam and paracetamol vs paracetamol alone demonstrated no significant difference for the power or energy delivered to renal or ureteric calculi.

**Discussion**

The medication groups were well matched for age and number, 62 patients received piroxicam and paracetamol with an average age of 50.3 years and, 56 patients with an average age of 54.4 years received paracetamol only. The average power and energy was less in the joint paracetamol and piroxicam group then the paracetamol group alone. There is no significant difference between the two pain reliefs it would appear based on the treatment parameters.

There were too few patients in the no medication group to really comment, with only 4 patients, who received less power to the calculi on average then the medication groups, but received more energy due to a higher number of shockwaves.

The reason for no difference between the two medicated groups is probably due to the time of onset of the piroxicam. Although the 20mg piroxicam melt used and has a fast absorption rate (Gorham, 2013) it has a variable action of onset and take up to 2 days for a steady state with a half-life of 3 -4 hours (British Medical Association , Fourth edition, 2012). The medication may have greater benefit therefore if it was started the day before or even two days before treatment, and then possibly continued as part of the post procedure pain relief for a number of days. This however would increase cost and the complexity of prescribing the medication prior to attendance at the Stone Treatment Centre for ESWL. Further limitations of the study would include the small numbers in each group and the lack of a validated pain score. Since piroxicam activity can last up to 7-10 days a pain score once the patient had returned home may have been of benefit.

The current use of Piroxicam 20mg 30 minutes prior to ESWL should therefore be discontinued. If an NSAID is to be continued as a pre ESWL pain relief medication then an intramuscular NSIAD or Per Rectum NSAID may be of greater effect (ref). Other fast acting oral NSIAD medications would warrant further evidence for their use with ESWL, as more practical and acceptable form of medication for the patient.

# ESWL Treatment Breakthrough Medication:

Currently no breakthrough pain medication is given during ESWL treatment at Craigavon Stone Treatment Centre. Thus patient's treatments can be limited due to pain. A Prospective study was conducted looking at patient who did not receive any break though medication and the average power able to be achieved, if treatment was limited due to pain as per radiographer and a visual analogue scoring system for pain experienced during by the patient during treatment.

**Results**

A break though pain medication was sought. Since the ESWL treatments are Nurse and radiographer led, then type and route of drug is limited. IV morphine is currently not allowed to be given by a nurse, and the nurses also do not have prescribing rights.

A novel solution is therefore required, and so following consultation with A+E, Penthrox 3ml Inhaler as a

breakthrough medication is a consideration. The alternative pathway would be to include a Doctor with treatment session so IV morphine could be given as and when required, however this would increase the cost of the service and impact negatively to another aspect of the urological activity. Could the numbers requiring breakthrough pain medication be reduced further by altering or adding to the current regime, this is a further topic for research and is an ongoing topic of research in the sphere of ESWL.

In order to trial the use of Penthrox as breakthrough medication the drug had to be first approved at the drug and therapeutic committee at Craigavon Area Hospital. A review of the drug, including current use and safety was conducted, as well as the environment for its use.

**Penthrox** was given approval for use from the Craigavon Hospital Drug and Therapeutics Committee (DTC) in February 2017. An initial 50 units (Penthrox 3ml inhaler) were to be purchased by the hospital and a further 20 units were to be provided by Galan free of charge. There were all then registered to the pharmacy department and requested for use at the Stone Treatment Centre when required.

Southern Health and Social Care Trust

# New Product Application Form

This form must be completed to provide the SHSCT Drug and Therapeutics Committee (DTC) with information about the proposed product. Applications may only be made by Trust Consultants.

Requests must be sent to Dr Tracey Boyce c/o DTC Secretary, CAH Pharmacy Dept., at least **2 weeks** prior to the Drug and Therapeutics Committee meeting.

*** * Please note that incomplete forms will be returned to the consultant concerned ****

## Section 1: Background information

**Generic name of medicine**: Methoxyflurane

**Brand name/ manufacturer:** Penthrox

**Formulation**: 3ml Methoxyflurane (99.9%), liquid to be used in an inhaler

**Route of administration:** Inhaler with carbon filters for exhaled gases.

**Proposed indication:** Breakthrough pain relief for extracorpeal shockwave lithotripsy (ESWL) of renal and ureteric stones

**Dose information:** 3ml Penthrox, not to exceed 6ml on single administration, not to exceed 15ml in a week.

## Section 2: Place in treatment algorithm

**Please specify the criteria for patient selection:**

Patients have 1g Paracetamol and NSAIDS (currently oral piroxicam 20mg, may change to PR Diclofenac 75mg) 40 minutes prior to starting ESWL treatment of stone.

**If treatment limited due to pain, then breakthough pain relief to be given in the form of 3ml Penthrox as inhaler under supervision by a staff nurse**. **Only one inhaler of 3ml to be given to each patient over their treatment hour as needed, and no more than one per hour to be used in the treatment room**. Currently no breakthrough pain relief is available and so some treatments are limited or require more treatments. No breakthrough pain relief potentially increases the need for more costly treatment in main theatre, such as Flexible Ureterenoscopy, which also carries greater risk of patient complication compared with ESWL.

Penthrox **would not be given** to patients with clinically evident cardiovascular or respiratory instability, any history of anaesthetic allergy, alcohol abuse, isoniazid, phenobarbital, rifampicin, clinically significant renal impairment (e.g. CKD stage IV, V).

## Section 3: Summary of evidence on clinical effectiveness issues

**What are the principal trials supporting the indication(s) described above and the overall results regarding efficacy? Please provide copies of up to 3 (maximum) relevant references, preferably including comparative data trials.**


http://www.sciencedirect.com/science/article/pii/S027323001630126X

Derivation of an occupational exposure limit for an inhalation analgesic methoxyflurane (Penthrox®)

John Frangos, , Antti Mikkonen, Christin Down
Golder Associates, 570 – 588 Swan Street, Richmond, Victoria, 3121, Australia
Received 4 March 2016, Revised 9 May 2016, Accepted 11 May 2016, Available online 13 May 2016

Highlights
• Dose response analysis using clinical toxicity data is exemplified.
• Exposure limit for methoxyflurane of 15 ppm (8 h TWA) was derived.
• Occupational exposure estimates are well below the proposed MEL.

The peak is always less than 15 ppm in a treatment room under the following conditions:

1 vial per hour at an air change per hour (ACH) OF 1.15; and
2 vial per hour at ACH of 1.95.

Abstract
Methoxyflurane (MOF) a haloether, is an inhalation analgesic agent for emergency relief of pain by self administration in conscious patients with trauma and associated pain. It is administered under supervision of personnel trained in its use. As a consequence of supervised use, intermittent occupational exposure can occur. An occupational exposure limit has not been established for methoxyflurane. Human clinical and toxicity data have been reviewed and used to derive an occupational exposure limit (referred to as a maximum exposure level, MEL) according to modern principles. The data set for methoxyflurane is complex given its historical use as anaesthetic. Distinguishing clinical investigations of adverse health effects following high and prolonged exposure during anaesthesia to assess relatively low and intermittent exposure during occupational exposure requires an evidence based approach to the toxicity assessment and determination of a critical effect and point of departure. The principal target organs are the kidney and the central nervous system and there have been rare reports of hepatotoxicity, too. Methoxyflurane is not genotoxic based on in vitro bacterial mutation and in vivo micronucleus tests and it is not classifiable (IARC) as a carcinogenic hazard to humans. The critical effect chosen for development of a MEL is kidney toxicity. The point of departure (POD) was derived from the concentration response relationship for kidney toxicity using the benchmark dose method. A MEL of 15 ppm (expressed as an 8 h time weighted average

(TWA)) was derived. The derived MEL is at least 50 times higher than the mean observed TWA (0.23 ppm) for ambulance workers and medical staff involved in supervising use of Penthrox. In typical treatment environments (ambulances and treatment rooms) that meet ventilation requirements the derived MEL is at least 10 times higher than the modelled TWA (1.5 ppm or less) and the estimated short term peak concentrations are within the MEL. The odour threshold for MOF of 0.13–0.19 ppm indicates that the odour is detectable well below the MEL. Given the above considerations the proposed MEL is health protective.

Emergency Medicine Journal

*Emerg Med J* 2014;**31**:613-618 doi:10.1136/emermed-2013-202909

- Original article

# STOP!: a randomised, double-blind, placebo-controlled study of the efficacy and safety of methoxyflurane for the treatment of acute pain

OPEN ACCESS

Frank Coffey[1], John Wright[2], Stuart Hartshorn[3], Paul Hunt[4], Thomas Locker[5],Kazim Mirza[6], Patrick Dissmann[4]

## Abstract

**Objective** To evaluate the short-term efficacy and safety of methoxyflurane for the treatment of acute pain in patients presenting to an emergency department (ED) with minor trauma.

**Methods** STOP! was a randomised, double-blind, multicentre, placebo-controlled study conducted at six sites in the UK. A total of 300 patients, 90 of whom were adolescent patients (age 12–17 years), were randomised 150:150 to receive either methoxyflurane via a Penthrox inhaler or placebo. The primary end point of the study was the change in pain intensity as measured using the visual analogue scale (VAS) from baseline to 5, 10, 15 and 20 min after the start of study drug inhalation. Patients were supplied with one inhaler containing 3 mL methoxyflurane or 5 mL placebo after enrolment and initial assessments. Age group (adolescent/adult) and baseline VAS score were controlled for in the statistical analyses.

**Results** A total of 149 patients received methoxyflurane, and 149 patients received placebo. Demographic and baseline characteristics were comparable between the groups. Methoxyflurane reduced pain severity significantly more than placebo ($p<0.0001$) at all time points tested, with the greatest estimated treatment effect of −18.5 mm (adjusted change from baseline) seen at 15 min after the start of treatment. Methoxyflurane was well tolerated, with the majority of adverse reactions being mild, transient and in line with anticipated pharmacological action.

**Conclusion** The results of this study suggest that methoxyflurane administered via the Penthrox inhaler is an efficacious, safe, and rapidly acting analgesic.

**Trial registration number:** NCT01420159.

Anaesthesia
Journal of the Association of Anaesthetists of Great Britain and Ireland

**Self-administered methoxyflurane for procedural analgesia: experience in a tertiary Australasian centre**

1. A. L. Gaskell Research Fellow[1,*],
2. C. G. Jephcott Consultant[2],
3. J. R. Smithells Consultant[2] and
4. J. W. Sleigh Consultant, Professor[2,3]

Version of Record online: 15 FEB 2016

DOI: 10.1111/anae.13377

**Summary**

Methoxyflurane, an agent formerly used as a volatile anaesthetic but that has strong analgesic properties, will soon become available again in the UK and Europe in the form of a small hand-held inhaler. We describe our experience in the use of inhaled methoxyflurane for procedural analgesia within a large tertiary hospital. In a small pilot crossover study of patients undergoing burns-dressing procedures, self-administered methoxyflurane inhalation was preferred to ketamine-midazolam patient-controlled analgesia by five of eight patients. Patient and proceduralist outcomes and satisfaction were recorded from a subsequent case series of 173 minor surgical and radiological procedures in 123 patients performed using inhaled methoxyflurane. The procedures included change of dressing, minor debridement, colonoscopy and incision-and-drainage of abscess. There was a 97% success rate of methoxyflurane analgesia to facilitate these procedures. Limitations of methoxyflurane include maximal daily and weekly doses, and uncertainty regarding its safety in patients with pre-existing renal disease.

## Section 4: Summary of evidence on comparative efficacy

**What are the advantages of this medicine compared to other treatments? Consider medicines already recommended in the Regional Formulary or in the same therapeutic class.**

Rapid onset

Patient controlled

Compared with the opiate alternatives there would be no need for a second staff nurse present. The stone centre is run by x1 staff nurse, x1 HCA, X1 radiographer.

## Section 5: Summary of evidence on comparative safety

**What are the advantages/disadvantages of this medicine in relation to patient safety compared to other treatments?**

Self-administered by patient in the form of an inhaler

Rapid onset of analgesia (6 – 10 breaths)

Shorter recovery time then traditional opiate based medication

After 30 minutes of observation can be discharged and can safely return to highly skilled psychomotor skills tasks such as driving and daily work the same day.

Not for use in patients with clinically evident cardiovascular or respiratory instability, any history of anaesthetic allergy, alcohol abuse, isoniazid, phenobarbital, rifampicin, clinically significant renal impairment (e.g. CKD stage IV, V).

**NOTE:** The cardiovascular and respiratory caution may well be historic to its use as an anaesthetic agent as no clinically significant changes were observed for vital signs (heart rate, respiratory rate, BP or temperature).

H F Oxer, 'Effects of Penthrox® (methoxyflurane) as an analgesic on cardiovascular and respiratory functions in the pre-hospital setting, Volume 24 Number 2; April 2016, Journal of Military and Veterans' Health'.

Regarding potential occupational exposure the number of air changes per hour has been calculated by the estates department. Only one 3ml vial per patient may be used and not more than one vial per hour to be used in the treatment room. To achieve a peak of always less than 15 ppm in the treatment room then 1 vial per hour at an air change per hour of 1.15 needs to be achieved (Frangos et al, see Section 3, Summery of Evidence)

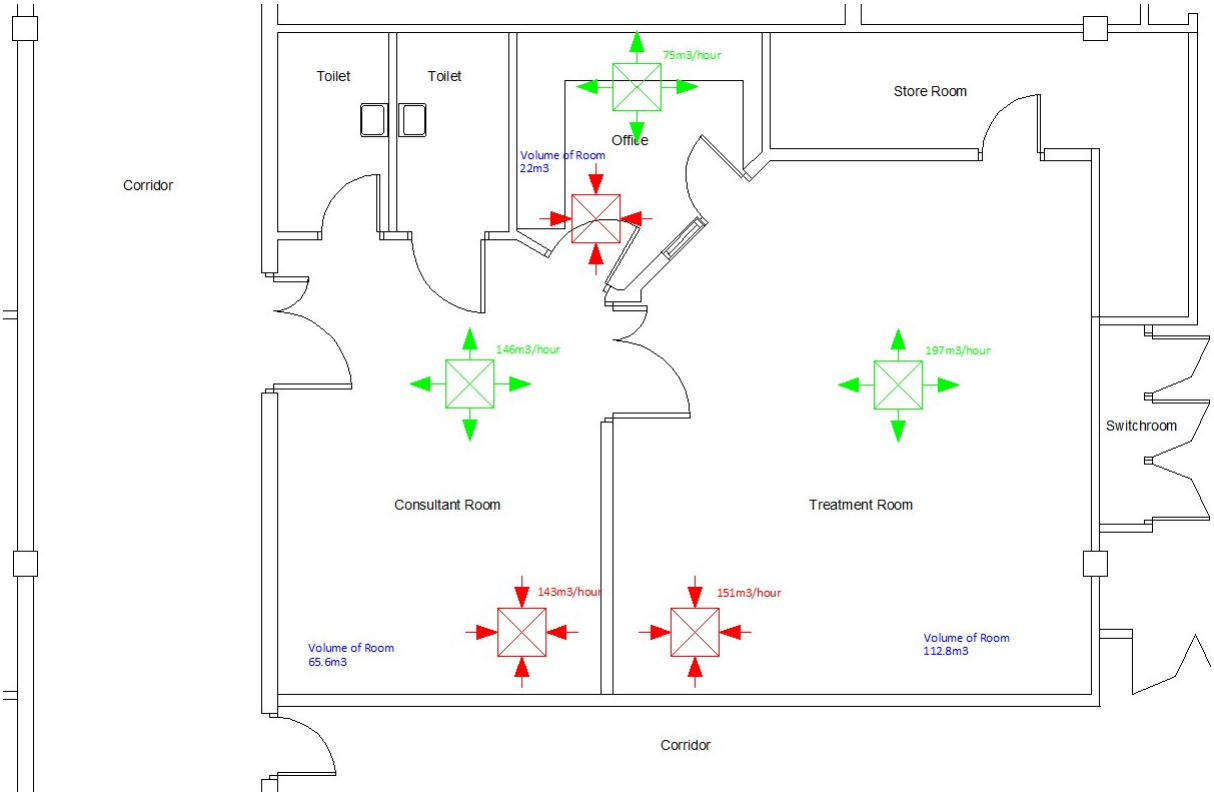
The room was tested on the 09/02/2017 by the Estates department and the treatment room meets the standard required, with an air change per hour of 1.75.

## Craigavon Area Hospital – Stone Treatment Centre Ventilation Report

Measured on 9th February 2017 by Ruairi King, Estates Department

Survey conducted to measure the number of air changes per hour within each room. This information is required to determine the use of a new inhaler type pain relief at the centre.


Stone Treatment Centre Plan showing supply and extract grilles with corresponding air flows.




$$Air\ changes/hour = \frac{Volume\ of\ air\ supplied/hour}{Volume\ of\ room}$$

Treatment room:

$$Air\ changes/hour = \frac{197}{112.8} = 1.75$$

Consultant room:

$$Air\ changes/hour = \frac{146}{65.6} = 2.23$$

Office:

$$Air\ changes/hour = \frac{75}{22} = 3.41$$

The ventilation system supplying air to the Stone Treatment Centre is not connected to the Hospitals Building Management System (BMS); therefore its status cannot be monitored by the Estates Department.

It is necessary to install airflow sensors which connect to the BMS so that the status of the ventilation system can be monitored and logged in case of faults etc.

An indicator should also be installed within the treatment centre showing the status of the system and alarm when

there is a fault or when there is no air flowing. This is needed to safeguard staff and patients when using the new inhaler type of pain relief.

## Section 6: NICE and Scottish Medicines Consortium (SMC) Adjudications

**Has NICE considered this product: Yes / No**
**If yes – what was the outcome? If No – is NICE currently considering the item?**

Nice contacted Galen in 2016 as they are considering reviewing the medication as per Dr Sarah Dolan 06/02/2017.

Penthrox was highlighted on a NIHR horizon scanning document in February 2016: http://www.hsric.nihr.ac.uk/topics/methoxyflurane-penthrox-for-emergency-relief-of-moderate-to-severe-pain/

**Has the NICE guidance been endorsed in Northern Ireland: Yes / No**

**Has SMC considered this product: Yes / No**
**If yes – what was the outcome?**
All Wales Medicines Strategy Group concluded that Penthrox was exempt from review as it is a medicinal gas: http://www.awmsg.org/docsnoindex/awmsg/June%202016.pdf

Penthrox is classed as a medicinal gas, and therefore exempt from review by SMC as per Dr Sarah Dolan from Galen 06/02/2017 – see exclusion criteria no. 7 in SMC publication: Guidance for medicines out with SMC remit.

## Section 7: Financial Information

| | No. of patients in SHSCT eligible for treatment per annum | Cost per annum (£) per patient | Total annual cost (£) |
|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **Secondary Care** | | Current ESWL capacity is 9 patients per week.<br><br>At present 9 x52 = 468 potential stone treatments per year. (not taking into account public holidays) | £17.89 + VAT | £61138 + VAT<br><br>Used as Breakthrough pain, 73% would require Penthrox, therefore 73% of 468 = 342 patients).<br>Based on ESWL questionnaire of pain during treatment 10/02/17, currently on-going. |
| **Primary Care** | | | | |
| **Cost of the therapy to be 'replaced' if applicable** | Secondary Care | **<u>Potential cost savings</u>** if further treatments of ESWL prevented by use of the pain relief, or potential failure of treatment requiring more expensive ureteroscopy or PCNL. | | |
| | Primary Care | | | |
| **TOTAL NET COST:** | | | | £8372.52 |
| **Other Cost Implications** e.g. Additional Medicine Therapy, X-rays, Lab Tests, etc. | Please state: | | | |

**If additional funding is required to purchase this product within the Trust please give details of how this will be found** (e.g. current approved business case, agreed reduction in bed-days /beds, stopping use of another product)

Increased funding is likely to be required to fund the medication, but it will have a **knock on effect to save money** from the reduction in further procedures and waiting list. The aim would also to provide emergency treatment, so reduce the cost and burden on the emergency operating theatre.

The use of Penthrox as breakthrough pain relief could increase the number of patients receiving a full treatment of ESWL and therefore reduce the need for secondary procedures such as Ureteroscopy or PCNL, both of which are more costly.

Koo and Young from Craigavon Area Hospital, published in the British Journal of Urology in November 2010 calculated the overall cost of Flexible ureteroscopy (FURS) to be £2602, compared to £426 for ESWL. If each patient had one treatment of ESWL instead of FURS, then £2176 could be saved, or to use the operating time for a different case and possibly decrease the waiting list.

**Only 2.8 patients would need to be prevented from having a further surgical procedure** (FURS) **by having successful ESWL to match the cost of 342 patients receiving Penthrox**. (Based on 342 patients x £17.89 Penthrox cost).

Many patients may have reduced number of ESWL treatments, as a greater energy can be delivered to the stone on initial treatment then the current average.

From the 4th Jan 2017 to 6th Feb 2017, 22 patients out 31patients treated by ESWL had limited treatment received, with the most common reason being pain.

## Section 8: Declaration of Interests

**SHSCT Gifts and Hospitality and Standards of Conduct Policy/ Declaration of interest (Procurement)**

The lead consultant(s) responsible for completing this application to the Drug and Therapeutics Committee are asked to declare and describe to the Chairman, any involvement that they may have with the relevant pharmaceutical company, or with the manufacturers of any comparator products.

This includes direct or indirect financial gain that they have received from the pharmaceutical company where this amounts to *greater than £500 p.a. within the last 2 years*. Such interests may be direct (e.g. lecture or consultancy fees, sponsorship for postgraduate educational activity) or indirect (egg. departmental donations, research contracts, funded staff support).

| |
|---|
| Do you have an interest in the pharmaceutical industry as described above?<br>**No** (please delete as necessary) |
| If Yes, name of Pharmaceutical Company(ies): |
| Nature of involvement or assistance: Direct and/or indirect – specify (the amount of money involved does not have to be declared): |

## Signatures **(please note all must be complete before application accepted by DTC)**

**Name of Consultant: Mr Michael Young** Date: 10/02/2017
(please print name)

**Signature of Consultant:** _____

**Associate Medical Director**

**Name:** _____ Date: 10/02/2017
(please print name)

**Signature of AMD:** _____

**Assistant Director/Director**

**Name:** _____ Date: 10/02/2017
(please print name)

**Signature of AMD:** _____

Outcome of DTC

## Craigavon Area Hospital – Stone Treatment Centre Ventilation Report

Measured on 9th February 2017 by Ruairi King, Estates Department

Survey conducted to measure the number of air changes per hour within each room. This information is required to determine the use of a new inhaler type pain relief at the centre.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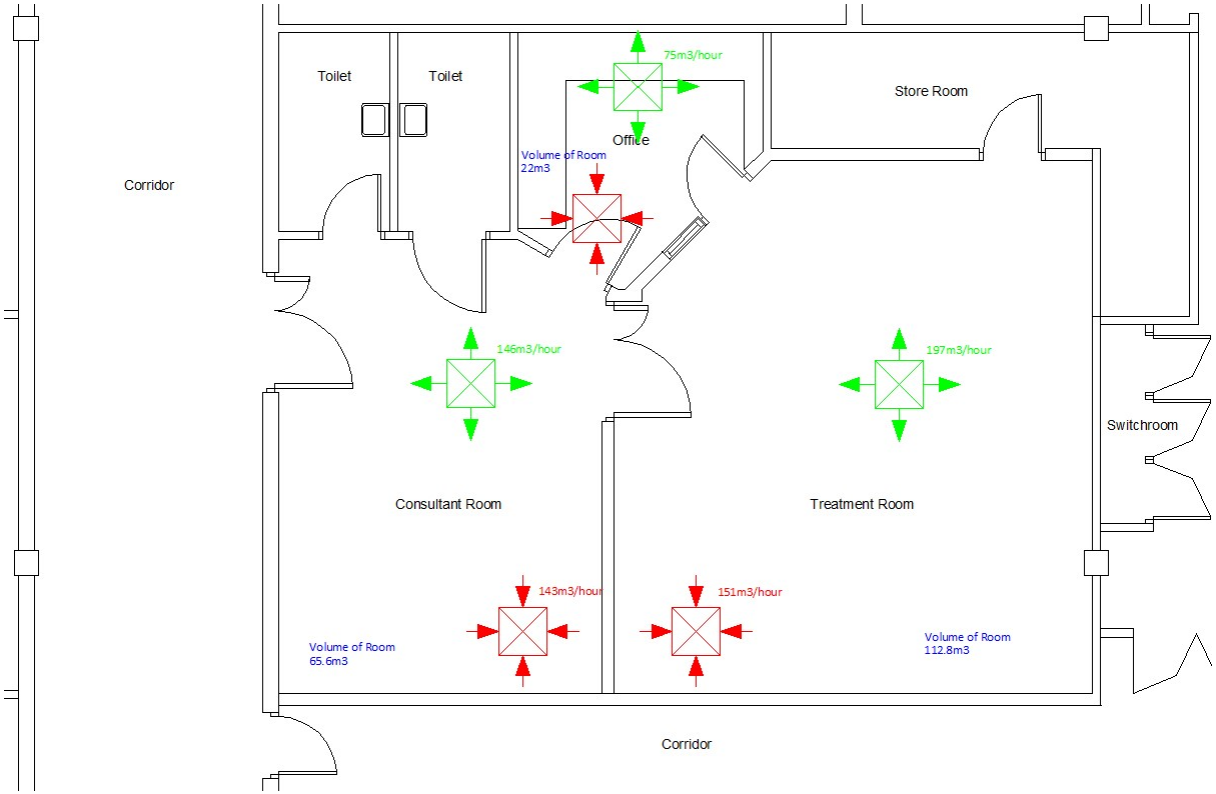


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It is necessary to install airflow sensors which connect to the BMS so that the status of the ventilation system can be monitored and logged in case of faults etc.

An indicator should also be installed within the treatment centre showing the status of the system and alarm when there is a fault or when there is no air flowing. This is needed to safeguard staff and patients when using the new inhaler type of pain relief.

The DTC required further evidence to be produced following the use of Penthrox for ESWL break through pain relief. Data was prospectively collected on the standard pre-medication given (paracetamol, piroxicam), a pain visual rating index, if breakthrough Penthrox was received, power and energy delivered to the stone and if pain limited treatment (this could be decreased power or energy delivered compared to standard expected, e.g. 1000j to renal and 1400j to ureteric stones).

Prior to use of the Penthrox the medical prescribing doctor has to check for contraindications to its use. Prior to use of Penthrox each patient is given an information sheet containing action, contraindication and side effects, as well as how to use the device. This was developed in conjunction with Galan the manufacturer. All patients were advised to attend with a chaperone. This is more from a safety standpoint that ESWL can produce small fragments and potential colic and may well be best not to drive themselves home.

To standardise the information given to the patients a standard script was developed by the nurses to explain how to use the drug. On average the script take 75 seconds to run and demonstrate how to use the Penthrox device.

Observations during Penthrox use were discussed and agreed at a Urology Stone Meeting MDM August 2017 to include continuous saturation and heart rate monitor and BP every 15 minutes.

Following ESWL treatment patients receive a minimum of 30 minute observation, including re-checking of observations prior to discharge. A Penthrox advice card is given to the patient as part of their discharge pack.

**Pain Intensity Score During ESWL Questionnaire** (To be completed by Staff Nurse following ESWL)

**Patient to give score immediately following completion of ESWL.**

**Patient Age**

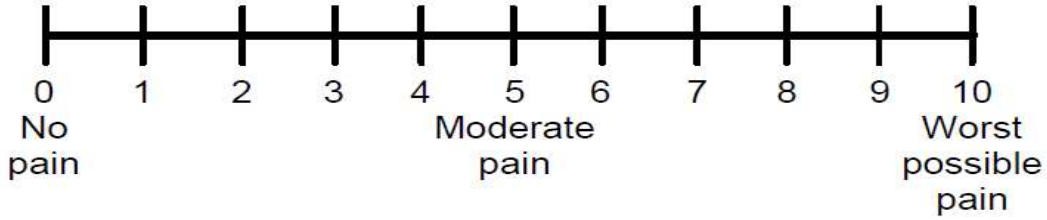
**Patient gender Male Female (circle answer)**

**Type of pain relief given,**

**Paracetamol Piroxicam Diclofenac Codeine Phosphate Penthrox (circle answer)**

1. **How would you rate your pain DURING your ESWL treatment (show to patient)**

## 0–10 Numeric Pain Rating Scale




2. **Any nausea/ sickness experienced during treatment? Yes No (circle answer)**

3. **Renal or Ureteric stone (circle answer)**

4. **Mean Power achieved …… Total energy delivered……**

5. **Did pain limit treatment Yes No (circle answer)**

**Many thanks**

## PENTHROX 3ML Inhaler Breakthrough Pain Relief

1. Patient unable to Tolerate ESWL treatment, STOP TREATMENT

2. Check no contraindications (Table 1) to Penthrox (ideally checked before ESWL started)

Table 1.

Penthrox Contraindications: (Galen Ltd )

Contraindications

- Clinically significant renal impairment , (e.g. eGFR <30, Stone Treatment Centre)
- Patients who have a history of showing signs of liver damage after previous methoxyflurane use or halogenated hydrocarbon anaesthesia
- Malignant hyperthermia: patients with known or genetically susceptible to malignant hyperthermia or a history of severe adverse reactions in either patient or relatives
- Use as an anaesthetic agent
- Hypersensitivity to PENTHROX or any fluorinated anaesthetic
- Altered level of consciousness due to any cause including head injury, drugs or alcohol
- Clinically evident cardiovascular instability
- Clinically evident respiratory depression

Galen Ltd . (n.d.). *Penthrox, Methoxyflurane*. Retrieved March 21, 2017, from Penthrox: https://www.penthrox.co.uk/hp/information/safety/contraindications/

3. If no contraindication give 3ml Penthrox inhaler as per instruction 8-10 breaths (see table 2)
4. Radiographer to resume ESWL and begin power ramping
5. Patient to self-administer further Penthrox, 2-3 breaths as required.
6. Once Penthrox treatment complete inhaler, carbon filter and drug bottle to be placed in sealed plastic bag provided and placed in clinical waste.
7. Clinical waste to be disposed of from Stone Treatment Centre every day Penthrox is in use.

**Only use with the air exchange ventilation system operating. Periodic assessment of air exchange ventilation system required by Estates Department to ensure air changes/hours of >1.15**

Nurse Administration protocol:

- Patient informed of possible Penthrox use prior to entering ESWL treatment room (patient information leaflet in pre-procedural pack and in waiting room) and demonstration given by nurse using a training pack.
- Script for explaining PENTHROX usage to patient (takes 75seconds to explain):
    - **'Hold the green inhaler in the opposite hand to the side of your treatment**
    - **Place the inhaler into your mouth and create a tight seal with your lips**
    - **Take 3 gentle breaths in AND out through the inhaler**
    - **Keep inhaler in your mouth and breath normally in AND out for 5 more loading breaths then remove it from your mouth**

- **If you experience pain during the procedure then reinsert the inhaler into your mouth and resume normal breathing in AND out through the inhaler device until you feel more comfortable.**
- **If you need a stronger dose you can place your finger over the clear plastic hole and continue your normal breathing in AND out through the inhaler.**
- **Please take your Penthrox throughout the procedure as you need it.**
- **It is normal to experience some discomfort during this procedure. It has been described as a similar sensation to being flicked with an elastic band.**
- **Do you have any questions about using the Penthrox inhaler'?**

- See Penthrox package for explanation of assembly of delivery device.
- ESWL treatment to stop if patient not tolerating treatment.
- Give the inhaler to the patient and use the directional script above to aid use.
- Radiographer should restart treatment 60seconds after first Penthrox inhalation breath.
- See flowchart for example of use.
- Encourage patient to continue using inhaler as required, including covering the dilution hole to deliver a stronger dose during treatment.
- If patient not tolerating treatment despite optimal use of inhaler then pause treatment and deliver a further five loading breaths, repeat this step to a maximum of x3 as required.
- Discontinue treatment if not tolerated/ patient requested

Patient who are unable to tolerate ESWL treatment, pause treatment, and if no contraindications use Penthrox

Initial loading with Penthrox (3 inhalation breaths and 5 loading breaths in and out of the inhaler).

Radiographer restarts ESWL treatment 60 seconds after first inhalation breath of Penthrox .

**Throughout Penthrox treatment monitor**

1. Heart Rate and Saturation using continuous monitor
2. Blood pressure every 15 minutes

Patient to continue taking normal breaths in and out through the inhaler **as required** for pain relief.

**If stronger dose required**, instruct patient to cover dilution hole whilst continuing normal breathing in and out through inhaler.

**Patient not tolerating treatment** despite optimal use of inhaler:

If after 3 cycles patient not tolerating treatment then abandon treatment.

Stop treatment and reload with 5 breaths in and out of inhaler.

Radiographer to restart ESWL 60seconds after first breath taken.

**Patient tolerating treatment**:

Continue same usage as required until treatment completed

Note: stop treatment at any point if patient requests.

**Pain Relief Future Considerations**

It is important to optimise the pain relief so ESWL treatments are not limited by this factor. Pain from ESWL is multifactorial, as seen in the section on 'Pathogenesis of pain during ESWL'. Such is the case therefore any changes which are made to the delivery of the treatment should be made in isolation and proved the change to be an improvement (e.g. change in medication only and then study, not change in medication and coupling medium).

| | Patient Factors | Nurse Factors |
|---|---|---|
| **Premedication:** | • Pain relief to act within 1 hour or 30 minutes of pre-ESWL procedure.<br>• Medication to give adequate pain relief during ESWL for a 1 hour session.<br>• Have limited side effect profile and able to be prescribed for the majority of patients who attend for ESWL | • The ideal medication should be able to administered by a single staff nurse<br>• If nurse prescribing is started then medications able to be prescribed by a nurse with prescribing rights |
| **Breakthrough Medication** | • Pain relief to act within a short time to allow ESWL treatment to resume.<br>• Medication to give adequate pain relief during ESWL for a 1 hour session.<br>• Have limited side effect profile and able to be prescribed for the majority of patients who attend for ESWL | • Can be given with only one staff nurse present<br>• Allows a discharge following procedure of 45 minutes maximum<br>• If nurse prescribing is started then medications able to be prescribed by a nurse with prescribing rights |
| **Discharge Medications** | • Provides adequate pain relief for renal colic<br>• Have limited side effect profile and able to be prescribed for the majority of patients who attend for ESWL | • Able to be dispensed the day of ESWL<br>• If nurse prescribing is started then medications able to be prescribed by a nurse with prescribing rights |

**Urology Stone MDM: Recommendations for changes in Pain Relief Medication or Delivery of ESWL**

| Medication or change in delivery of ESWL | Reason for Change | Method of action | Evidence (Such as Pubmed search or review article or guidelines) | Method to study change | Result and Outcome |
|---|---|---|---|---|---|
| Penthrox 3ml Inhalor (Methoxyflurane) | Introduced as a trail for breakthrough medication during ESWL. No breakthrough medication used prior to this. | Methoxyflurane can cause dose-related nephrotoxicity a clinical study identified that nephrotoxicity occurred at doses in excess of 2.5 MAC-hours<br>These doses were reached when methoxyflurane was used for anaesthesia.<br>As a result of this clinical study a safe upper limit for methoxyflurane exposure was determined to be 2 MAC-hours – doses below 2 MAC-hours have not been associated with nephrotoxicity.<br>Methoxyflurane administered via the PENTHROX inhaler (3 mL dose) equates to approximately 0.3 MAC-hours.[3]<br>PENTHROX was approved by the regulatory | Please refer to the Penthrox Drugs and Therapeutics Committee (DTC) submission | Keeping Paracetamol 1g oral and Piroxicam 20mg oral fast tab as premedication for ESWL. Penthrox used for breakthrough pain relief. When used as a breakthrough medication during ESWL, does it allow completion of treatment and provide adequate pain relief? | Results to be submitted to the Craigavon DTC and disseminated at the Urology Stone MDM. |

| | | | | | |
|---|---|---|---|---|---|
| | | authorities for use in the UK and Ireland in late 2015 | | | |

**Antibiotic Prophylaxis ESWL**

In keeping with European Association of Urology (EAU) Guidelines, prophylactic antibiotics are given to patients,

1. Infection stones
2. Bacteriuria (European Association of Urology , 2017)
3. Stone Treatment Centre Guidelines also includes patients who are relatively immunocompromised, such as steroids, immune modifying drugs.

- The standard at CAH STC is 500mg oral Ciprofloxacin prior to ESWL.

Recommendation for future practice would be to modify antibiotic prophylactic to urine sensitivities. This would require those patients needing antibiotic prophylaxis to have a urine culture one or two weeks prior to treatment.

A Pubmed search of 'ESWL' or Shockwave Lithotripsy' and 'Antibiotic', Prophylaxis', Urine Culture'

Returned 10 papers

Excluded was 1 case report

**e. Craigavon Area Hospital ESWL TMS i-sys Sonolith lithotripter Adult Protocol**

**(In addition to the TMS i-sys Sonolith manual, EDAP TMS 2012)**

| | |
|---|---|
| **Stone and side for treatment** | As per MDT indication, check ESWL request for stone and laterality. Recommended number of treatments and follow-up plan included |
| **Pain Relief** | As pre-prescribed by Stone MDT (nurse to check allergies prior to administration) |
| **Breakthrough pain relief** | As per pre-prescribed MDT (nurse to check allergies prior to administration)_<br>Stop ESWL to initialise break through medication and restart at last tolerated power level |
| | |
| **Imaging** | USS or Fluoroscopy or both. Regular imaging (constant if USS) to check stone position for treatment. **Stop treatment if satisfactory stone treatment achieved.** |
| **Ramping protocol** | **First 250 shocks at 25% (See 1.8.1 Power level reference chart for kV** (EDAP TMS, 2012)**)**<br>**Second 250 shocks at 50%**<br>**Third 250 shocks at 75%**<br>**Following the first 750 Shocks, aim to reach 100% power as tolerated before 1000 shocks**<br>**Average treatment power will therefore be around 80%.** |
| **Energy levels** | **Maximum 1000J to renal stone**<br>**Maximum 1400J to ureteric stone** |
| **Shockwaves** | **Maximum of 3000 shockwaves delivered per treatment session** |
| **Frequency** | **1.2Hz** |
| **Treatment session** | 1 hour |
| **Interval between treatments** | 4 weeks (EDAP TMS 2012) |
| **Discharge letter** | Radiographer to populate template and copy for ECR, Patient notes and GP. |

# Time between treatments

There is little evidence on the time between ESWL treatments; there is evidence to show that a patient can be retreated after 24 hours. A safe regime would leave the **interval between elective treatments as 4 weeks** (EDAP TMS, 2012).

**European Urology 2017 Guidelines for ESWL Treatment**

3.4.2.1.3.2 Best clinical practice

| | |
|---|---|
| Summary of evidence - Number of shock waves, energy setting and repeat treatment sessions | LE |
| Stepwise power ramping prevents renal injury. | 1b |
| Clinical experience has shown that repeat sessions are feasible (within one day for ureteral stones). | 4 |
| Optimal shock wave frequency is 1.0 to 1.5Hz. | 1a |

(European Association of Urology , 2017)

# e. REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

**To be tabled at SMT Meeting TBC**

| | |
|---|---|
| **Name of Organisation** | Southern Health & Social Care Trust |
| **Project Title** | Extra Corporeal Shockwave Lithotripsy (ESWL) & Generalised Stone Services at Southern Health & Social Care Trust Draft V.03 |
| **Total Cost** | **£TBC** |
| **Start Date** | **£TBC** |
| **Completion Date** | **Recurrent funding requested from 2018/19 onwards £TBC** |

***Complete this section if bid is for new funding***

| **BID FOR NEW FUNDING** | |
|---|---|
| **Is this bid for new funding (Y/N)** | **Yes** |
| **How much total funding required?** | **£TBC** |
| **How much funding required per year?** | **£TBC** |
| **Is this funding to be made recurrent?** | **Yes** |

***Complete this section if funding available within existing allocation***

| | |
|---|---|
| ***Funding available within existing allocation (Y/N)*** | **No** |
| **Total cost of proposal** | **N/A** |
| **Cost of proposal per year** | **N/A** |
| **Is this cost within recurrent allocation?** | **N/A** |

| ***Is this business case*** | ***Y/N*** |
|---|---|
| ***(a) Standard*** | ***Yes*** |
| ***(b) Novel*** | ***-*** |
| ***© Contentious*** | ***-*** |
| ***(d) Setting a precedent*** | ***-*** |
| ***If yes to (b) or (c) or (d) , requires Departmental & DFP approval Is Departmental / DFP approval required*** | |

**Approvals & submissions**

| | | |
|---|---|---|
| **Prepared by:** | | |
| **Name Printed** | **NICKY HAYES** | **(signed)** |
| **Grade/Title** | **Planning Officer Band 5** | |
| **Date** | **APRIL 2018** | |

| | | |
|---|---|---|
| **Approved by:** | | |
| **Name printed** | **ESTHER GISHKORI** | **(signed)** |
| **Grade /Title** | **Director of Acute Services** | |
| **Date** | **APRIL 2018** | |

| | | |
|---|---|---|
| **Approved by:** | | |
| **Name printed** | **HELEN O'NEILL** | **(signed)** |
| **Grade /Title** | **Director of Finance** | |
| **Date** | **APRIL 2018** | |

| | | |
|---|---|---|
| **Approved by:** | | |
| **Name printed** | **SHANE DEVLIN** | **(signed)** |
| **Grade /Title** | **Chief Executive** | |
| **Date** | **APRIL 2018** | |

**Complete this section if Department / DFP approval required**

| |
|---|
| **Date submitted to Department** |
| **Department/ DFP approval (y/n)** |
| **Date approved** |

**BUSINESS CASE TEMPLATE** **REVENUE FUNDING £50k - £250k**

## SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED

**Introduction**
This paper outlines a proposal associated with enhancing the Extra Corporeal Shockwave Lithotripsy & Generalised Stone Service within the Southern Health & Social Care Trust.

Associated costs of **£TBC** have been identified from **TBC** funding stream and approval is now being sought from Senior Management Team for the progression of this proposal.

The Trust's Senior Management Team confirmed at its meeting on 24 January 2018 that it was supportive of a proposal being developed.

**Background**
The Southern Health & Social Care Trust (SHSCT) was established on 1st April 2007 following the amalgamation of Craigavon Area Hospital Group, Craigavon & Banbridge Community, Newry & Mourne and Armagh & Dungannon Health and Social Services Trusts. It is one of six organisations that provide a wide range of health and social care services in Northern Ireland.

The Trust provides acute hospital and community services to council areas of Armagh, Banbridge and Craigavon; Newry, Mourne and Down; and Mid Ulster – a population of some 369,000. The acute hospital services provided by the Trust are also used by people from outside the Southern area including Fermanagh, Down and Lisburn, Antrim, Cookstown, Magherafelt and the Republic of Ireland.

The Trust's hospital network comprises two acute hospitals (Craigavon Area Hospital and Daisy Hill Hospital) with a range of local services provided at South Tyrone Hospital. The hospitals work together to co-ordinate and deliver a broad range of services to the community.

Both acute hospitals provide inpatient, out-patient and day case services across a range of specialties. These include a 24-hour Emergency Department and unscheduled medical and surgical services.

The Trust is responsible for the delivery of high quality health and social care to its resident population and employs 13,000 staff.

**Extra Corporeal Shockwave Lithotripsy (ESWL)**
This is a non-invasive procedure which is used in the treatment of kidney stones that are too large to pass through the urinary tract. The procedure is carried out by Consultant Urologists who have experience in urinary tract stone disease. In the first instance, kidney stones will be detected via the use of x-rays/scans which will determine their presence and location.

Patients within the Southern Trust area suitable for this specific treatment regime may attend on an

elective basis or in the case of patients referred for urgent admission, ESWL may be carried out during the inpatient stay. The procedure entails breaking down the stones in the kidney, bladder or ureter (tube that carries urine from the kidneys to the bladder) by sending high-frequency ultrasound shock waves directly to the stone once located with fluoroscopy (a type of x-ray) or ultrasound. The shock waves cause large stones to be broken down into smaller pieces to enable these to pass through the urinary system. Treatment sessions last for approximately an hour.

**Strategic Context**
Guidelines for the management of renal colic/renal and ureteric stones are documented in:-

- British Association of Urological Surgeons "**Standards for the Management of Acute Ureteric Colic" September 2017**
- National Institute for Health & Care Excellence guideline **"Renal & Ureteric Stones: Assessment and Management (consultation 20 January to 17 February 2017)"**

"Stone removal is recommended in the instance of persistent obstruction, failure of stone progression or increasing or unremitting colic. The choice of treatment to remove a stone depends on the size, site and shape of the stone. Options include extra corporeal shockwave lithotripsy (ESWL) ureteroscopy with laser, percutaneous nephrolithotomy or open surgery".

"Where suitable, ESWL offers a non-invasive treatment with lower complication rates and a shorter hospital stay".

In addition, the current standards associated with care for acute stone pain and use of ESWL (British Association of Urological Surgeons "***Standards for the Management of Acute Ureteric Colic" September 2017)*** states that "for symptomatic ureteric stones, primary treatment of the stone should be the goal and should be undertaken within 48 hours of the decision to intervene" – is this the text to be referred to???

**Local Context**
***"Improving Together"*** the Trust's Corporate Plan 2017/18 – 2020/21 sets out the strategic direction for the next four year period and includes challenges and opportunities to create better health outcomes for the population within the Southern area.

The Corporate Plan recognises the need for service reform as a result of the changing needs of our local population, new ways of delivering care and treatment in line with the financial and workforce resources available to us.

The key objectives which the Trust will strive to achieve are:-

- Promoting safe, high quality care
- Supporting people to live long, healthy active lives
- Improving our services
- Making the best use of our resources
- Being a great place to work, supporting developing and valuing our staff
- Working in partnership

Demographic Growth:

- The Trust has the second largest population in NI 369,000. The Trust population is projected to increase by over 20% between 2016 and 2039 (compared to the NI projected growth of 8.5%) including more significant growth in our ageing population

**Current Service Provision**
At the present time, there are a total of two Lithotripsy machines across Northern Ireland, a mobile machine sited in Belfast and a machine located within the Stone Treatment Centre (STC) at Craigavon Area Hospital.

Lithotripsy treatments are delivered to the Southern Trust's resident population in addition to patients residing outside of the Trust's catchment area (from January 2017 South Eastern Trust patients have undergone stone treatment procedures at CAH).

**Current Capacity**
The STC facilitates a total of three weekly ESWL sessions which take place on Monday, Wednesday and Friday mornings. The first treatment commences at 9.00 am with the session ending at 1.00 pm. A total of **9** patients undergo ESWL treatments every week.

Patients' referrals for stone treatment regimes are received via a number of channels including:-

1. Emergency Departments at Craigavon Area, Daisy Hill and South West Acute (Enniskillen) Hospitals
2. General Practitioners within the Southern Trust region and the South West Acute Hospital's local population
3. Wards in Craigavon Area Hospital, Daisy Hill Hospital and South West Acute Hospital
4. Consultant Urologists from Southern and South-Eastern Health & Social Care Trusts
5. Letterkenny Hospital, Republic of Ireland
6. Altnagelvin Hospital

Although emergency ESWL treatments can be made available if there is a cancellation, predominantly emergency treatments are performed on Mondays, Wednesdays and Fridays - TBC

The current staffing establishment per session consists of:-

- 0.30 wte Consultant
- 0.30 wte Radiographer
- 0.30 wte Band 5 Nurse
- 0.30 Band 3 Healthcare Assistant

**Key Issues/Assessment of Need**
The growing demands being placed upon the Trust's ESWL & Generalised Stone Service understandably proves challenging when taking into consideration the number of issues in terms of:-

**1. Demand & Capacity**
Since the introduction of the Extra Corporal Shockwave Lithotripsy (ESWL) service on 11 September 1998, there has been a steady increase in the number of patients being offered this treatment regime.

In January 2017, there were a total of 108 adult patients awaiting treatment, however by January 2018 the figure has dramatically increased to a total of 233 adult patients showing a staggering 116% rise.

This figure equates to an average of 31 patients being added to the waiting list per month.

The waiting time for treatment (as of January 2018) is presently 8 months.

**2. Emergency ESWL Provision for Upper & Distal Ureteric Stones**

In addition to the number of adult patients awaiting outpatient (elective) ESWL treatment, on average approximately 10 patients will have a ureteroscopy performed each week at Craigavon Area Hospital.

Some of these patients could be suitable to undergo "emergency ESWL" treatment, however due to the restricted use of the Lithotripser machine at the present time, this cohort of patients have to undergo their treatment within Main Theatres at Craigavon Area Hospital as there are only ESWL sessions 3 days per week.

Understandably, this practice is counter-productive as it hinders the Trust's ability to adhere with the respective guidelines associated with the assessment and treatment of ureteric stones[1] which states that "primary treatment of the stone should be the goal and should be undertaken within 48 hours of the decision to intervene" – is this the relevant text to use TBC. More non-invasive procedures and extended availability across the week would support the Trust to comply with guidelines.

**3. Service Model**

The Lithotripser machine has been in operational use since the late 1990s (circa 20 years). At that time, the working practices put in place adequately met the needs of the service. Inevitably changes in medical practice have evolved in recent years however no modifications or adaptions to the working practices within the STC have been implemented. As a consequence, it has not been possible to optimise the potential to develop the Southern Trust's ESWL & Generalised Stone Service.

Given the existing service model, provision of a service which represents value for money whilst making best use of the facilities available is not achievable. The insufficiencies are particularly prevalent within the following areas:-

- Increased number of patients being **referred** into the Service
- As the majority of patients initially opt for treatment to be given without the need for a general anaesthetic, the number of patients awaiting elective ESWL treatment inevitably causes a rise in **waiting times**
- As a consequence of current waiting lists, patients' **x-ray/scan images** become out-of-date often emanating in the loss of a treatment 'slot' as the patient cannot undergo their planned ESWL procedure if there is a possibility that their renal stones have become dislodged
- A significant amount of nursing **administration** associated with patient documentation which is undertaken on the day of treatment impinges on the allocated treatment time

**4. "Time & Motion" Study**

In an effort to address the inefficiencies with the current service model, a "Time & Motion" study was conducted in December 2017. This involved a group of multi-disciplinary staff reviewing and 'process mapping' the "Renal & Ureteric Stone" pathway in order to streamline the processes, improve treatments/safety and patient follow-up reviews.

On conclusion of the "Time & Motion" study, a number of recommendations were identified which included:-

- The need for a Stone Multi-Disciplinary Team (MDT) to be established
- With the introduction of an MDT this would facilitate:-
  - a platform for discussion of complex patients

- referrals received from Emergency Departments, Wards and GPs to be reviewed giving due consideration to each individual patient's condition
- a review of patients' imaging
- an informed decision to be made in relation to the most appropriate treatment pathway for each patient for example ESWL, Ureteroscopy etc which would be in line with guidelines (eg British Association of Urologists, NICE etc)

- New documentation to be developed such as:-
  - Ureteric & Renal Stone Referral
  - Patient Information Pack

**5. Staffing Resources**

In view of the recommendations emanating from the "Time & Motion" study, a change in practice was introduced in December 2017 which enabled a Stone Multi-Disciplinary Team to be established together with an agreed Referral Pathway to be developed.

At that time, the potential to increase capacity was identified if changes associated with the nursing administration process could be introduced.

It highlighted that if the requisite administration could be performed prior to a patient attending for their treatment, this could permit an additional patient per session to be treated (eg a total of 4 patients would undergo an ESWL procedure per session).

However, with insufficient staffing resources presently available, the delivery of an efficient and effective ESWL & Generalised Stone Service is compromised.

- **Administrative & Clerical**

With the weekly MDT meeting taking the form of a "virtual clinic" there is a significant amount of administration to be progressed in advance of the weekly meetings which encompasses:-

- ensuring all the requisite paperwork is available for the meeting (eg referral forms, prescription sheets, diagnostic results etc) which require populating during the MDT meeting when outcomes are discussed/agreed
- preparation of MDT lists
- population of worklist on NIECR for ease of access during the MDT meeting
- taking notes of the MDT meetings, completing the electronic MDT outcome form, populating patient templates with agreed outcomes from MDT in order to send to patients
- ensuring follow-up arrangements are made
- tracking follow-up arrangements/results

In addition to the duties associated with the weekly MDT meetings, there are a number of administrative tasks in respect of the elective ESWL process which are detailed below:-

- Population of appointments and preparation of lists
- Ensuring all ESWL related treatment paperwork is available (eg prescriptions, nursing checklist, post-treatment advice)
- Creating and printing of booklets and distribution of patient documentation (to negate the need for this to be undertaken on the day of treatment TBC)
- Sending for list and confirming patients' attendances
- Ordering notes for ESWL treatment day
- Arrangement/tracking of follow-up

A patient letter template was created on Patient Centre to enable Consultant Urologists' secretaries to type up the weekly patient letters. However, the increased workload is unsustainable given the

other duties assigned to Consultant secretaries. As a consequence, delays associated with the typing up of the MDT letters are regularly experienced TBC

- **Medical, Nursing & Radiology**

In view of the volume of administrative tasks associated with both the MDT meetings in conjunction with the ESWL processes, this can often result with the Specialty Doctor in Urology providing a degree of administrative support to the Stone Treatment Centre.

In terms of ESWL Sonographer training, there is a detailed protocol which must be adhered to in order for Sonographers to become competent in ESWL. This involves a period of supervised targeting and treatment of renal calculi in both adults and paediatrics which must encompass both ultrasound and fluoroscopic control. In addition, a minimum of 50 treatments must be achieved and in the event of a trainee being absent for a prolonged period of time (eg maternity leave), there may be a requirement for part of the process to be repeated. On completion of the requisite training and to allow progression, it will necessitate a Sonographer participating in ultrasound audit programmes and undertaking future training updates to ensure continuing professional development and assessment of accuracy.

***Reference 1*** *– British Association of Urological Surgeons Standards for the Management of Acute Ureteric Colic September 2017*

**SECTION 2 (a): OBJECTIVES**

| Project Objectives | Measurable Targets |
|---|---|
| 1. Improve access to ESWL Service by 31 March 2019 | • Increase access across the week<br>➢ Baseline – 3 sessions per week (as of April 2018)<br>➢ Target – 7 sessions per week |
| 2. To improve compliance with Commissioning Plan Objective 4.12<br>➢ No patient waits longer than 13 weeks for inpatient/daycase ESWL treatment by September 2019 | • Facilitation of appropriate ESWL provision which meets the demand for elective treatment:-<br>➢ Baseline – as of January 2018, a total of 148 patients are awaiting more than 13 weeks for elective ESWL treatment<br>➢ Target – minimum of 30% reduction in waiting time for routine treatment<br>** a non-recurrent exercise will be required to reduce routine waiting times in the first instance* |
| 3. Improve the efficiency of the current ESWL Service by 31 March 2019 | • Increase number of patients treated per session:-<br>➢ Baseline – a total of 3 patients per session (as of April 2018)<br>➢ Target – a total of 4 patients per session (on appointment of additional staffing resources) |

**SECTION 2 (b): CONSTRAINTS**

| Constraints | Measures to address constraints |
|---|---|
| 1. Availability to appoint additional staffing resources | The Trust will ensure that robust recruitment processes are in place, maintaining close |

| | |
|---|---|
| | links with BSO and Human Resources to ensure that any issues which may arise are promptly addressed |
| 2. Recurrent revenue funding not secured | The Trust will maintain close links with the HSCB in order to proactively seek financial support for the service |

**SECTION 3: IDENTIFY AND DESCRIBE OPTIONS**

| OPTION NO | BRIEF DESCRIPTION OF OPTION |
|---|---|
| 1 | **Do Nothing/Status Quo - continue with existing arrangements**<br>This option will entail the continuation of the existing service model of 3 ESWL sessions per week permitting a total of 9 patients to be treated.<br><br>Although this option will not meet the project objectives, it has been shortlisted as a base case comparator. |
| 2 | **Increase ESWL Sessions from 3 to 7 Sessions per week within Stone Treatment Centre at Craigavon Area Hospital**<br>This option will entail the appointment of additional staffing resources and permit the current 3 ESWL weekly sessions to be extended to 7 ESWL sessions per week.<br><br>It will accommodate a total of 4 patients per session to be treated, emanating in additional capacity to facilitate a further 19 patients per week (eg 4 patients per session x 7 sessions equates to 28 patients TBC) in comparison to the 9 patients that are presently seen each week. |
| 3 | **Provision of a Dedicated Team for Stone Treatment Centre at Craigavon Area Hospital**<br>Similar to Option 2, this option will consist of a significant number of staffing appointments being made enabling the number of weekly ESWL sessions to be extended from 3 to 7 sessions. It will permit a total of 4 patients per session to be treated, facilitating an additional 19 patients to be seen per week (eg 4 patients per session x 7 sessions equates to 28 patients TBC).<br><br>With provision of a dedicated team of multi-disciplinary staff aligned to the Stone Treatment Centre at Craigavon Area Hospital it will enable all ESWL treatments, weekly MDT meetings, the complete outpatient journey (from investigation to review) to be effectively managed.<br><br>Provision of a dedicated ESWL session for patients residing within South Eastern Trust area will also be deliverable.<br><br>Is there any additional information as to what this option will deliver that needs incorporated? |

**SECTION 4: PROJECT COSTS**

| Option | Year 1 (£'000) | Year 2 (£'000) | Year 3 (£'000) | Total (£'000) |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

**COST ASSUMPTIONS:**

**Option 2**
There will be a requirement for the following additional **posts to be appointed**
**Can you please confirm exact staffing requirements please**

- XX wte Band 5 Staff Nurse
- XX Band 3 Health Care Assistant
- XX wte Radiographer
- Xx wte Band 4 Admin & Clerical

**Option 3**
There will be a requirement for the following additional **posts to be appointed**

**Can you please confirm exact staffing requirements please**

- XX wte Band 5 Staff Nurse
- XX wte Band 3 Health Care Assistant
- XX wte Band Radiographer
- XX wte Consultant Urologist
- XX wte Registrar
- XX wte Band 4 Admin & Clerical

**Goods & Services**
- Are there any additional consumables that would be required for the no of sessions proposed TBC
- The anticipated life span of Lithotripter equipment is 10 years however it is not dependent upon the number of shocks/treatments/patients
- The current equipment has been in operational use since 1998 and is on the capital equipment list for Acute Directorate for replacement

**SECTION 5: NON-MONETARY BENEFITS**

The non-monetary benefits associated with the project are detailed below:-

| Non-Monetary Benefit | Option 1 Status Quo/Do Nothing | Option 2 Increase Sessions within the Stone | Option 3 Provision of a Dedicated Team for |
|---|---|---|---|

| | | Treatment Centre | Stone Treatment Centre |
|---|---|---|---|
| Provision of additional sessions per week | • With no improved access to the service, enhanced utilisation of Hospital facilities will be untenable | • Facilitation of an additional 4 weekly sessions will enable higher volumes of patients to undergo their treatment resulting in a total of 28 patients being seen on a weekly basis. | • Similar to Option 2, this option will facilitate a further 4 weekly sessions to take place thus enabling a higher percentage of patients to undergo treatment each week (circa 28 patients). |
| Reduced Waiting Times for Treatment | • As the number of patients being referred into the Service will continue to grow, it will result in a rise in waiting times. Therefore, patients will continue to experience lengthy waiting times for their treatment | • The patients' experience will be greatly enhanced as they will receive treatment for their conditions within an appropriate timeframe | • Similar to Option 2, the patients' experience will be significantly enhanced as the patient journey (from investigation to review) will be managed within an appropriate timeframe by a dedicated service team |
| Improved efficiency | • With the volume of administrative tasks associated with both MDT meetings and the ESWL processes, the degree of administrative support from the Specialty Doctor will still be prevalent (understandably, a situation which does not make best use of skills).<br>• With no improved service provision, the use of Main Theatres at CAH for some patients' procedures will continue. | • As administrative tasks will be progressed prior to the day of treatment, a reduction in nurse administration on the day of treatment will be deliverable. This will increase capacity for treatment of an additional patient per session (total of 4 patients as opposed to 3 patients per session).<br>• The potential loss/delay of treatment sessions will significantly reduce as x-ray scans will be up-to-date.<br>• As more non-invasive treatment will be deliverable, fewer patients will require treatment within Main Theatres | • As with Option 2, there will be a reduction of nurse administration on the day of treatment as administrative tasks will be progressed prior to the day of treatment. This will increase capacity for treatment of an additional patient per session (total of 4 patients).<br>• The potential loss/delay of treatment sessions will significantly reduce as x-ray scans will be up-to-date.<br>• This option will provide dedicated ESWL sessions for South Eastern |

| | | | |
|---|---|---|---|
| | | at CAH. Therefore, permitting patients to be managed within an appropriate environment.<br>• Delivery of a more streamlined service will be achievable. | patients<br>• With dedicated staffing within the Stone Treatment Centre this will optimise the facilities available within the Stone Treatment Centre at CAH and enhance the patient's journey. |

**SECTION 6: PROJECT RISKS & UNCERTAINITIES**

The project risks associated with this scheme are detailed in the table below:-

| | H/M/L | | | risk management/mitigation measures |
|---|---|---|---|---|
| **1.** Inability to Appoint Staff | **N/A** | **L** | **L** | **Option 1** – N/A<br>**Options 2&3** - there is the potential that no applicants may apply for the new posts, however this is deemed to be a 'low' risk.<br>• **Mitigation Measure** - the Trust will ensure that robust recruitment processes are in place and any issues raised by BSO are promptly addressed |
| **2.** Recurrent revenue funding not secured | **N/A** | **M** | **M** | **Option 1** – N/A<br>**Options 2&3** – this is a possibility that recurrent funding may not be secured and therefore this is considered a 'medium' risk<br>• **Mitigation Measure** – the Trust will maintain close links with the HSCB/continue to seek financial support from the HSCB |
| **Overall Risk (H/M/L):** | **N/A** | **L/M** | **L/M** | |

**SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION**

**Option 1 - Status Quo/Do Nothing**

- With no modifications being made to existing service model, there will be no enhanced utilisation of Hospital facilities
- The waiting times associated with ESWL treatment will continue to grow, therefore patients will continue to experience lengthy delays for treatment
- There will still be a requirement for the Specialty Doctor to provide a degree of administrative support which does not make best use of medical staffing resources
- The number of ureteroscopies will steadily increase as no additional capacity for elective ESWL treatments will be attainable
- No improvements to the efficiency of the ESWL & Generalised Stone Service within the Southern

Trust will be achievable

**Option 2 - Increase ESWL Sessions from 3 to 7 Sessions per week within Stone Treatment Centre at Craigavon Area Hospital**

- This option will enable the weekly Extra Corporeal Shockwave Lithotripsy (ESWL) sessions to be extended from 3 to 7 sessions per week
- It will provide increased capacity as a total of 4 patients per session will be treated, equating to a total of 28 patients receiving treatment per week (in comparison to 9 patients treated at the present time).
- The patient's experience will be greatly enhanced as waiting times for treatment will reduce therefore patients will receive treatment for their conditions within an appropriate timeframe
- The potential loss/delay of treatment sessions will significantly reduce as x-rays/imaging scans will be up-to-date
- As some patients may no longer require invasive treatment, fewer patients will require treatment within Main Theatres at CAH
- With more non-invasive procedures and extended availability being attainable, this will support the Trust to improve compliance with the requisite guidelines/recommendations (British Association of Urologist, National Institute for Clinical Excellence) as delivery of an enhanced ESWL Service to patients requiring treatment of renal stones will be achievable.
- An improved skill mix of staff will be attainable

**Option 3 - Provision of a Dedicated Team for Stone Treatment Centre at Craigavon Area Hospital**

- Similar to Option 2 above, this option will enable the weekly Extra Corporeal Shockwave Lithotripsy (ESWL) sessions to be extended from 3 to 7 sessions per week.
- It will provide increased capacity as a total of 4 patients per session will be treated, equating to a total of 28 patients receiving treatment per week (in comparison to 9 patients treated at the present time).
- The patient's experience will be significantly enhanced as the patient journey (from investigation to review) will be effectively managed within an appropriate timeframe
- As some patients may no longer require invasive treatment, fewer patients will require treatment within Main Theatres at CAH

- With more non-invasive procedures and extended availability being attainable, this will support the Trust to improve compliance with the requisite guidelines/recommendations (British Association of Urologist, National Institute for Clinical Excellence) as delivery of an enhanced ESWL Service to patients requiring treatment of renal stones will be achievable.
- This option will make provision for a dedicated team of staffing to be aligned to the Stone Treatment Centre at Craigavon Area Hospital which will enable all ESWL treatments, weekly MDT meetings and the complete patient journey (from investigation to review) to be efficiently and effectively managed.
- An improved skill mix of staff will be achievable.

Is there any additional information that needs to be incorporated?

**The preferred option is Option 2 – Increase ESWL Sessions from 3 to 7 Sessions per week within the Stone Treatment Centre at Craigavon Area Hospital** as this will enable a further 4 weekly sessions to be delivered giving the Trust additional capacity to treat a total of 28 patients per week. Therefore, the patient's experience will be greatly enhanced as the current waiting times for treatment will reduce.

As more non-invasive treatment regimes will be achievable this will improve the Trust's compliance with British Association of Urologists and NICE guidelines/recommendations whilst permitting patients to be managed within an appropriate environment.

Any potential loss or delay of treatment sessions due to x-rays/imaging scans being out-of-date will reduce.

With an increase in capacity, the Trust will be able to deliver a more streamlined and efficient ESWL & Generalised Stone Service to its resident population.

## SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

| AFFORDABILITY STATEMENT | Yr 0 £000's | Yr 1 £000's | Yr 2 £000's | Yr 3 £000's | Totals £000's |
|---|---|---|---|---|---|
| **Required** | | | | | |
| Capital required | | | | | |
| Revenue required | | | | | |
| **Existing budget :** | | | | | |
| Capital | | | | | |
| Revenue | | | | | |
| **Additional Allocation Required:** | | | | | |
| Capital | | | | | |
| Revenue | | | | | |

## AFFORDABILITY ASSUMPTIONS

## SECTION 9: MANAGEMENT ARRANGEMENTS

The following project management roles have been agreed:-

- Project Owner – Mrs Esther Gishkori (Director of Acute Services)
- Project Director – Mrs Heather Trouton (Interim Executive of Nursing & Allied Health Professionals (with responsibility for Cancer & Clinical Services)
- Project Manager – Mrs Martina Corrigan, Head of ENT & Urology

The project timescales associated with this proposal are detailed in the table below:-

| **Project Timescales** | |
|---|---|
| Business Case Approval | May/June 2018 |
| Submission of Business Case to HSCB | May/June 2018 |
| Confirmation of Funding | June/July 2018 |
| Recruitment Process Commenced | July/August 2018 |
| Staff in Post | October 2018 |

**SECTION 10: MONITORING AND EVALUATION**

| | |
|---|---|
| **Who will manage the implementation?** | Mrs Martina Corrigan - TBC<br>Head of Service – ENT & Urology |
| **Who will monitor and evaluate the outcomes?** | A Head of Service independent to the project - TBC |
| **What other factors will be monitored and evaluated?** | |
| **When will this take place?** | April 2019 |

**SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)**

| | **Specifiy activity, e.g. IP, DC OPN, OPR, Contacts etc** | | | | | |
|---|---|---|---|---|---|---|
| | **IP** | **DC** | **OPN** | **OPR** | | |
| **Baseline** | | | | | | |
| **Additional activity** | | | | | | |
| **New Baseline Activity** | | | | | | |

**SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION**

# HSC TRUST RESEARCH & DEVELOPMENT FUND

# APPLICATION FORM 2018 – 2019

N.B. Applications should only be submitted for research which can be completed by 31 March 2019 as funding cannot be carried forward to the next Financial Year

| | |
|---|---|
| **Name of Applicant:** | Mr Michael Young |
| **Job Title:** | Urology Consultant |
| **Work Address:** | Craigavon Stone Treatment Centre, Craigavon Hospital |
| | Tel: Mobile: Personal information redacted by USI |
| | Email: Michael.Young Personal information redacted by USI |
| **Project Title:** | Kidney and Ureteric Stones Treated With Extracorporeal Shockwave Lithotripsy Using the EDAP i-sys Sonolith Lithotripter: Successful stone clearance and complications |
| **Project Outline:** | **Context/Background – why it is important to do the research,**<br><br>Kidney Stones have afflicted the human population for thousands of years, having been identified in Egyptian mummies, and even make up part of the classical Hippocratic Oath from the 4th century BC (Tefekil A, 2013). Kidney Stones can be identified in 8% of the population (BAUS). In the United Kingdom renal colic (pain from kidney stone) is common, with 12% of men and 6% of women having at least one episode of renal colic in their lifetime, with the incidence peaking at 40-60 years of age for men and late 20's for women (Bultitude M, 2012), (NZ, 2014). The difference between male and female risk in decreasing, this is likely due to the increase in obesity and western diet in women (NICE, 2015). **The overall incidence of kidney stones is rising.** In America the 1994 incidence rate of 1 in 20 has almost doubled to 1 in 11 when compared to year 2007-2010 data (Hitt, 2012). The risk of further stones |

| | |
|---|---|
| | development is high, with 30% to 40% chance of recurring at 5 years (NICE, 2015).<br><br>The Craigavon Urological Stone Treatment Centre (CAH STC) looks after an area greater than the geographical Southern Trust boundaries, caring for a population of 420000. In addition the CAH STC receives regular referrals from the other trusts, namely the South Eastern Trust.<br><br>How the Urologist treats a kidney stone is dependent on location and size of the stone, as well as patient comorbidities. The majority of stone can be treated by Extracorporeal Shockwave Lithotripsy (ESWL), available onsite at Craigavon Area Hospital, and is the only fixed site ESWL in Northern Ireland, or in fact the North of the Ireland!<br><br>In order to fulfil the demand of ESWL stone treatments, the CAH STC must provide 1100 treatment per year. ESWL is a well-recognised treatment modality for Kidney stones, and is recommended by the European Association of Urology guidelines (C Turk 2017) and NICE (NICE 2015).<br><br>Since the invention of ESWL in 1980 we are now on the 4th Generations of Lithotripter. The Southern Trust invested around £430000 in a new EDAP TMS i-sys lithotripter to replace an older model. It has its own dedicated centre, with the treatment sessions run by a radiographer and nursing staff. The patients are awake for their treatments, with oral pain relief. ESWL has less risk of complication and is safer when compared to more invasive Urological stone procedure of Ureteroscopy and Percutaneous Nephrolithotomy.<br><br>A PubMed search using various combinations of search terms of ‘ESWL’, ‘SWL’, ‘EDAP TMS’, i-sys sonolith did not generate any clinical papers on the success outcomes of the i-sys sonolith lithotripter.<br><br>As technology progresses, evidence is required to demonstrate that the Lithotripter in use is still providing effective kidney stone clearance rates, at a low complication rate.<br><br>**Aim – broad statement about what the research will entail**<br><br>To assess the outcomes of stone clearance rates for kidney and ureteric stones using the i-sys sonolith lithotripter. To |

provide complication rates and patient satisfaction with receiving the treatment modality for their stones.

**Objectives – the actions required to meet the aim of the research**

1. **Patient demographics** (age, sex, BMI)
2. **Kidney stone factors pre-treatment** (Size, location, Hounsfield units, stone to skin distance)
3. **ESWL treatment parameters** (Ramping protocol, average power delivered, total energy delivered, type of pain relief)
4. **Patient satisfaction** with treatment, including pain score)
5. **Outcome of treatment**: (stone clearance, fragmentation, no change, other procedures needed)

**Sample/Participants – the people/data who will be the focus of the research and how you will gain access**

All patients undergoing ESWL for treatment of kidney or ureteric stones. The above data required in objectives is already recorded in the patient's clinical notes.

**Data Collection Method – Qualitative/Quantitative/Mixed Methods e.g. interviews, questionnaires, focus groups – provide some information about the proposed method(s)**

Prospective study for the outcome of ESWL using the i-sys sonolith. A data collection excel spreadsheet would be created to record the objective setting data. The data (objectives 1-4) would be best inputted at time of treatment, and outcome data (objective 5) at the Stone Multidisciplinary Meeting (MDT). The Stone MDT is the platform where patients are currently listed for ESWL and also their follow-up imaging discussed at 4-6 weeks following treatment to assess treatment success.

Objective 4, patient satisfaction would be assessed via a questionnaire, the same day of treatment completion.

**Ethical Considerations – ethical issues relating to the research e.g. Consent**

ESWL is already a recognised and recommended treatment

| | |
|---|---|
| | for kidney and ureteric stones by EAU and NICE.<br>Consideration to alternate treatment modalities or change in treatment parameters if data was to demonstrate unsatisfactory stone clearance rates or complications from the use of the i-sys sonolith lithotripter.<br><br>**Potential outputs – what will be the impact on patient care**<br><br>Provide data to support the on-going funding of the ESWL service.<br>Provide data to patients on the percentage success for stone clearance using the i-sys sonolith and complication rate. This will aid patients to make a fully informed choice on their treatment options.<br><br>Provides data to the wider clinical and scientific community on use of the i-sys sonolith lithotripter and treatment of kidney and ureteric stones.<br><br>**Data Analysis method – dependent on whether data is numerical or text based e.g. SPSS, thematic analysis**<br><br>There will be a mixed data analysis method. Stone clearance rates will be numerical, and could be statistically compared against older lithotripter data sets of clearance, as well as statistical comparison against the more invasive surgical treatment of ureteroscopy for stone clearance.<br>Patient satisfaction and complication rates can also be numerically processed, analysed and compared against similar studies for other lithotripters or surgical modalities.<br><br>**Proposed start date**<br><br>October 2018<br><br>**Proposed end date**<br><br>October 2019 (although it would be of benefit for data collection to continue for a 4 or 5 year period to potential give around 5000 treatments, and so provide robust data and one of the largest ESWL evidence bases, future funding could be discussed with the Trust)<br><br>**Specify how the time required to undertake the Study will be incorporated into your work and other personal** |

| | |
|---|---|
| | **commitments**<br><br>Study data will be collected by the proposed funding for a research radiographer or nurse, they will be aided in their write up and analysis of the data. Time to oversee and support the project will be dedicated on a weekly bases by Mr Young Urology Consultant, including time following the weekly Thursday morning MDT<br><br>**References**<br><br>BAUS. (n.d.). *Kidney Stones*. Retrieved Febuary 02, 2018, from British Association of Urology: https://www.baus.org.uk/patients/conditions/6/kidney_stones<br>Bultitude M, R. J. (2012). Management of renal colic. *BMJ*, 345.<br>C. Türk, A. N. (2017). *Urolithiasis*. Retrieved Febuary 08, 2018, from European Association of Urology Guidelines : http://uroweb.org/guideline/urolithiasis/#3<br>Hitt, E. (2012, May 24). *Incidence of Stone Disease Has Doubled Since 1994*. Retrieved November 2016, from Medscape : http://www.medscape.com/viewarticle/764518<br>NICE. (2015). *Renal or ureteric colic - acute*. Retrieved Febuary 08, 2018, from https://cks.nice.org.uk/renal-or-ureteric-colic-acute#!backgroundsub:2<br>NZ, B. (2014). Managing patients with renal colic in primary care: know when to hold them. *Best Practice Journal New Zealand*.<br>Tefekil A, C. F. (2013). The History of Urinary Stones: In Parallel with Civilization. *Scientific World Journal* . |
| **Outline how the Project relates to the Trust's Corporate Objectives:** | The project aims to deliver evidence behind the use of the i-sys sonolith lithotripter in the treatment of kidney and ureteric stones. And….<br><br>• Provides safe, high quality care<br>• Maximize independence and choice for our patients and clients<br>• Support people and communities to live healthy lives and improve their health and wellbeing<br>• Make the best use of resources<br>• Be a great place to work, with staff being actively involved in providing evidence based medicine in the form of ESWL |

| | |
|---|---|
| | • Learning opportunity for a member of staff to enhance a service, share the learning, benefit patients. |
| **Outline the potential to develop into a larger research Project:** | The data could be continued to be collected every year to provide one of the largest data sets and evidence for ESWL using the i-sys sonolith.<br><br>The data collected would aid the development of regional, national (NICE and BAUS) and international guidelines (e.g EAU) for the use of ESWL in treatment of kidney and ureteric stone using the i-sys sonolith lithotripter. |
| **Financial Support Required:** | **Please provide a full breakdown of the costs required**:<br><br>• Salary costs – The costs should support either a radiographer or nurse (band 5).<br><br>• Goods and Services costs – The cost wold be for the time of radiographer or nurse to collect the data, data analysis, presentation of data.<br><br>• Cost Centre to which any funding awarded should be credited (To be provided by your Line Manager)<br><br>• Outline how you would take forward the proposal if only a percentage of the funding requested is awarded to your application:<br><br>a) We would scale the project down if funding did not allow for complete collection and analysis of every patient.<br>b) The project is achievable with a day a week, although 2 or more days a week would produce more robust data collection, evidence and impact to any potential publication and information for patients. |
| **Line Manager Support:** | **Please provide the name and job title of your Line Manager whose agreement you have sought to submit this application:** |

| | |
|---|---|
| | **Martina Corrigan** |
| **Line Manager** | **Line Manager to provide a short statement to confirm support of this application** |
| **Line Manager's Signature and Date** | |

**Completed Forms should be returned by email to Irene Knox, Research Manager** [redacted] **no later than Friday, 13 July 2018**

## Corrigan, Martina

**From:** Corrigan, Martina <[redacted]>
**Sent:** 27 December 2017 15:37
**To:** McMahon, Jenny
**Cc:** Haynes, Mark
**Subject:** RE: Query

Yes please that would be great

Regards

Martina

---

**From:** McMahon, Jenny
**Sent:** 27 December 2017 14:48
**To:** Corrigan, Martina
**Cc:** Haynes, Mark
**Subject:** RE: Query

Hi Martina
As AOB likes to see his patients on the day, will I get him a date in Jan / Feb?
j

---

**From:** Corrigan, Martina
**Sent:** 22 December 2017 11:31
**To:** McMahon, Jenny
**Cc:** Haynes, Mark
**Subject:** FW: Query

Hi Jenny

See below……

Can you help with expediting the flexi/UDS

Thanks Mark for your advice and agree not good adding a third consultant at this stage

Regards

Martina

---

**From:** Haynes, Mark
**Sent:** 12 December 2017 06:50
**To:** Corrigan, Martina
**Subject:** RE: Query

Aidan's plan seems reasonable, only issue is his waiting list is obviously very long. (HCN is [redacted]

I could organise a flexi and clarify things which would speed things up but would add a 3rd consultant into the mix, alternatively we could ask Jenny to expedite his flexi/UDS.

What do you think?

Mark

---

**From:** Corrigan, Martina
**Sent:** 04 December 2017 10:41
**To:** Haynes, Mark
**Subject:** FW: Query

Hi Mark

Remember we talked about this? Just conscious I said I would go back to Zoe.

Regards

Martina

---

**From:** Parks, Zoe
**Sent:** 22 November 2017 11:57
**To:** Corrigan, Martina
**Subject:** RE: Query

Thanks martina – really appreciuate it

---

**From:** Corrigan, Martina
**Sent:** 22 November 2017 08:44
**To:** Parks, Zoe
**Subject:** Re: Query

Hi Zoe

Leave it with me and I will see what I can find out.

I'm in Belfast today so it will be tomorrow before I can sort.

Regards

Martina

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

Office: Personal information redacted by USI
Mobile : Personal information redacted by USI

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**From:** Parks, Zoe
**Sent:** Tuesday, 21 November 2017 18:03
**To:** Corrigan, Martina
**Subject:** Query

Martina

You know I mentioned to you today about my friend Personal information redacted by USI who had recently seen Dr Jacob and Mr OBrien. Personal information redacted by USI m) He's come away feeling a little confused about the next steps and I wondered if you would know what the plan is?

He said he saw Dr Jacob first and he had mentioned about stopping one of his medications and putting a catheter in. However when he was sitting in the waiting room, Mr O'Brien lifted his notes and called him into his room. Personal information redacted by USI said that Mr O'Brien then ripped up Dr Jacobs previousnotes in the file and told him that he wouldn't be stopping the medication and he wouldn't be getting a catheter. He left the appointment with the understanding he will need more in depth investigations to find out the cause of his pain. He said he would be contacted by letter.

Dr Jacob then contacted Personal information redacted by USI at home around 5.15 that evening to ask if she knew where Personal information redacted by was as he had lost him. He had searched everywhere but he was gone and his notes had vanished! Margaret was able to tell him that he had been called into the office by another consultant to which he said he wasn't happy about that.

He's a little anxious now as has been waiting to be seen for 1 year with Urology pains and has already lost two stone so he's now feeling worried about how long he may have to wait. He's also feeling a little uneasy as both consultants gave him conflicting views on the best way forward.

I know there is probably not a lot you can do as the consultants will be dealing with it but I just wondered if you knew if he is likely to be seen again soon? Do you think maybe Michael Young or Mark Haynes would be able to review to see if what has been arranged is the best course of action - given the conflicting views? I know the waiting lists are long but just wondered if you even had a rough estimation. Thanks Martina. Really appreciate it
Zoe

Sent from my BlackBerry 10 smartphone.

## Corrigan, Martina

**From:** Corrigan, Martina <[redacted]t>
**Sent:** 04 December 2017 10:48
**To:** Carroll, Ronan
**Subject:** FW: IPT - Final: Stent for Benign Prostatic Hyperplasia (BPH)
**Attachments:** IPT Stent for Benign Prostatic Hyperplasia (BPH)FINAL 2 11 17.docx; Costing Sheet for PBH-Fianl 02 11 17.xlsx

Ronan

Meant to ask you about this at my one to one.

This was discussed and agreed at THUGs and I was to do the business case, which is completed. How do I progress this as the Team are keen to commence using this?

Martina

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

***INTERNAL*** [redacted]
***EXTERNAL*** [redacted]
***Mobile*** [redacted]

---

**From:** Devlin, Susan
**Sent:** 06 November 2017 14:43
**To:** Corrigan, Martina
**Subject:** IPT - Final: Stent for Benign Prostatic Hyperplasia (BPH)

Hi Martina

(At last) – please find attached costed IPT proposal in respect of the Urology Stent for Benign Prostatic Hyperplasia (BPH).

I have discussed with Sandra and she doesn't feel this is an appropriate paper to submit to SMT. Sandra has suggested that you may wish to discuss with Ronan with a view to table with Esther Gishkori.

Hope you are successful with your endeavours.

Kind regards, Sue

**Please note my new extension number –** [redacted]

Susan Devlin
Senior Planner
Planning Department
Directorate of Performance and Reform
Southern Health and Social Care Trust
The Brackens, Craigavon Area Hospital
Tel No: [redacted]
Email Address: [redacted]

**Click here for Trust SharePoint site: Corporate Planning**

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**REVENUE BUSINESS CASE PROFORMA COVER**
(To be submitted with every business case)

| | |
|---|---|
| **Name of organisation** | **Southern Health and Social Care Trust** |
| **Project Title** | **Stent for Benign Prostatic Hyperplasia (BPH)** |
| **Total Cost** | **£78,000 FYE based on Single Tender quotes** |
| **Start date** | **Procurement – of Stents October/November 2017**<br>**Day case procedures commence circa January 2018** |
| **Completion date** | **Recurring** |

***Complete this section if bid is for new funding***

| **BID FOR NEW FUNDING** | |
|---|---|
| **Is this bid for new funding (Y/N)** | Y |
| **How much total funding required?** | £78,000 FYE based on Single Tender quotes |
| **How much funding required per year?** | £78,000 |
| **Is this funding to be made recurrent?** | Y |

***Complete this section if funding available within existing allocation***

| ***Funding available within existing allocation (Y/N)*** | |
|---|---|
| **Total cost of proposal** | |
| **Cost of proposal per year** | £78,000 FYE based on Single Tender quotes |
| **Is this cost within recurrent allocation?** | ***Yes*** |

| ***Is this business case*** | ***Y/N*** |
|---|---|
| ***(a) Standard*** | √ |
| ***(b) Novel*** | |
| ***© Contentious*** | |
| ***(d) Setting a precedent*** | ***N*** |
| ***If yes to (b) or (c) or (d) , requires Departmental & DFP approval Is Departmental / DFP approval required*** | |

**Approvals & submissions**

| | |
|---|---|
| **Prepared by:** | **Susan Devlin** |
| **Name Printed** | **(signed)** |
| **Grade/ Title:** | **Senior Planner** |
| **Date:** | |

| | |
|---|---|
| **Approved by:** | **Esther Gishkori** |
| **Name printed** | **(signed)** |
| **Grade / Title:** | **Director of Acute Services** |
| **Date:** | |

| | |
|---|---|
| **Approved by:** | **Ronan Carroll** |
| **Name printed** | **(signed)** |
| **Grade / Title:** | **Assistant Director, Surgery & Elective Care Division & ATICs** |
| **Date:** | |

**Complete this section if Department / DFP approval required**

| | |
|---|---|
| **Date submitted to Department:** | **N/A** |
| **Department/ DFP approval (y/n)** | |
| **Date approved** | |

## BUSINESS CASE TEMPLATE REVENUE FUNDING £50k - £250k

### SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED

**Background:**

Benign Prostatic Hyperplasia (BPH) is a common benign tumour that develops in men and is particularly bothersome in elderly patients. (The prostate is a small gland that is about the size and shape of a walnut located below the neck of the bladder – the urethra the tube that carries urine from the bladder out of the body runs through the prostate).

BPH cannot be cured therefore treatment focuses on reducing symptoms. The prevalence of lower urinary tract symptoms in the general population increases with age. The progression of BPH is observed in terms of increased prostate volume and decreased maximal urinary flow rate. In addition, disease progression increases the risk of acute urinary retention and surgery.

In Benign Prostatic Hyperplasia the prostate gland grows in size, it may compress the urethra which courses through the centre of the prostate. This can impede the flow of urine from the bladder through the urethra to the outside. It can cause urine to back up in the bladder (retention) leading to the need to urinate frequently during the day and night. Other common symptoms include a slow flow of urine, the need to urinate urgently and difficulty starting the urinary stream. More serious problems include urinary tract infections and complete blockage of the urethra, which may be a medical emergency and can lead to injury to the kidneys.

At present a transurethral resection of the prostate (TURP) is the surgical procedure offered to patients to treat problems due to an enlarged prostate. Patients with complications of BPH, such as ongoing inability to urinate, urinary tract infections, bladder stones, kidney damage, or ongoing blood in the urine, will be offered surgery. Surgery may also be a treatment option where symptoms have not been helped with other treatments.

TURP involves cutting away a section of the prostate tissue that is blocking urine flow and patients on average have a 3 day in-patient episode.

**The aim of this project is** to provide an alternative treatment option for patients presenting with Benign Prostatic Hyperplasia (BPH) which involves a less invasive procedure undertaken as a day case.

**Currently 4-6 patients** are added to the waiting list for TURP each week. It is estimated that one of these patients would be suitable for alternative treatment.

**Activity:**

**Consultant Led Attendances - Urology**

| **Out-Patients** | **2015/2016** | **2016/2017** |
|---|---|---|
| New | 3,591 | 4,389 |
| Reviews | 3,978 | 4,835 |
| **Total** | **7,569** | **9,224** |

| | **2015/16** | | | **2016/17** | | |
|---|---|---|---|---|---|---|
| | Core | IHA | Total | Core | IHA | Total |
| In-patients | 932 | 2 | **934** | 788 | 12 | **800** |
| Day cases | 3208 | 1 | **3209** | 3539 | 7 | **3546** |

**Need**:

**Advances in technology:** An alternative procedure to surgery is a Prostatic stent – this is a permanent flexible spring-like device that is placed inside of the urethra to hold it open. The device treats the symptoms of BHP by lifting or holding the enlarged prostate tissue out of the way so it no longer blocks the urethra. The devices are self-expanding and help to maintain patency of urethra. There is no cutting, heating or removal of prostate tissue unlike other procedures to treat BPH.

Minimally invasive procedures generally cause fewer complications and have a quicker recovery period than TURP. The risk of bleeding is generally higher with TURP, so it is not always the best option for certain men who take blood-thinning medications.

**Benefits** of the stent include:

- It is more suitable for men with a number of medical problems who are at high-risk of surgery
- It is a minimally invasive procedure
- The treatment is a day-case procedure
- The permanent implants are delivered through a small needle
- Patients return home typically without a catheter
- Patients have a quicker recovery period and experience a more rapid return to daily life

**National Institute for Health and Care Excellence (NICE) – Guidance:**

After careful consideration of the evidence available **The National Institute for Health and Care Excellence (NICE)** - Medical technologies guidance [MTG26] published September 2015 reported that '*The UroLift system should be considered as a beneficial* ***alternative to current surgical procedures for men aged 50***

***years and older*** *with lower urinary tract symptoms of benign prostatic hyperplasia, who have a prostate of less than 100 ml without an obstructing middle lobe.'*

Where medically appropriate Consultant Urologists at the Trust are keen to be in a position to offer this alternative treatment option to patients. It should also be noted that where patients are referred for a day procedure this negates the need for an in-patient episode which will help alleviate the bed pressures currently faced at the Trust.

**SECTION 2 (a): OBJECTIVES**

| Project Objectives | Measurable Targets |
|---|---|
| 1. To improve the treatment options for patients presenting with Benign Prostatic Hyperplasia (BPH) by December 2017 | Provision of an alternative pathway for patients with Benign Prostatic Hyperplasia.<br>Baseline: 0 |
| 2. Provision of day case surgery for appropriate patients suffering from Benign Prostatic Hyperplasia by January 2018 | Number of patients treated on a day case basis.<br>Baseline: 0 |

**SECTION 2 (b) : CONSTRAINTS**

- **Availability of recurrent funding**

**SECTION 3: IDENTIFY AND DESCRIBE OPTIONS**

| OPTION NO. | BRIEF DESCRIPTION OF OPTION |
|---|---|
| **1** | Status Quo - continue with existing arrangements. |
| **2** | Introduce day case prostatic stent insertion as an alternative treatment option for patients presenting with BPH. |
| **3** | **(if applicable)** |

## SECTION 4: PROJECT COSTS

| Option 1: Status Quo | Yr 0 17/18 £000's | Yr 1 18/19 £000's | Yr 2 19/20 £000's | Yr 3 20/21 £000's | Yr 4 21/22 £000's | Yr 5 22/23 £000's | Totals £000's |
|---|---|---|---|---|---|---|---|
| **Capital Costs** Works | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Equipment | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Design team Fees & Professional Fees | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **(a) Total Capital Cost** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Revenue Costs** | | | | | | | |
| Recurring revenue baseline | 1,603 | 1,603 | 1,603 | 1,603 | 1,603 | 1,603 | 9,618 |
| | | | | | | | |
| **(b) Total Revenue Cost** | 1,603 | 1,603 | 1,603 | 1,603 | 1,603 | 1,603 | 9,618 |
| **(c) Total Cost = (a) + (b)** | 1,603 | 1,603 | 1,603 | 1,603 | 1,603 | 1,603 | 9,618 |
| (d) Disc Factor @ 3.5%pa | 1.0000 | 0.9662 | 0.9335 | 0.9019 | 0.8714 | 0.8420 | |
| **(e) NPC = (c) x (d)** | **1,603** | **1,549** | **1,496** | **1,446** | **1,397** | **1,350** | **8,841** |

**Finance Assumptions:-**

1. Year 0 is 2017/18 Financial Year
2. Baseline costs refer to the Direct Net Urology costs from 16/17 of £1,579,148, increased by 1.5% for inflation to £1,602,835.
3. No other revenue costs or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the Net Present Cost.
5. Please note all figures above have been rounded to thousands
6. Total Net Present Cost (NPC) equates to £8,841k for this option

| Option 2:- Introduce day case prostatic stent insertion as an alternative treatment option for patients presenting with BPH | Yr 0 17/18 £000's | Yr 1 18/19 £000's | Yr 2 19/20 £000's | Yr 3 20/21 £000's | Yr 4 21/22 £000's | Yr 5 22/23 £000's | Totals £000's |
|---|---|---|---|---|---|---|---|
| **Capital Costs** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **(a) Total Capital Cost** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Revenue Costs** | | | | | | | |
| Recurring revenue baseline | 1,603 | 1,603 | 1,603 | 1,603 | 1,603 | 1,603 | 9,618 |
| Other G&S | 20 | 78 | 78 | 78 | 78 | 78 | 410 |
| **(b) Total Revenue Cost** | **1,623** | **1,681** | **1,681** | **1,681** | **1,681** | **1,681** | **10,028** |
| **(c) Total Cost = (a) + (b)** | **1,623** | **1,681** | **1,681** | **1,681** | **1,681** | **1,681** | **10,028** |
| **(d) Disc Factor @ 3.5%pa** | 1.0000 | 0.9662 | 0.9335 | 0.9019 | 0.8714 | 0.8420 | |
| **(e) NPC = (c) x (d)** | **1,623** | **1,624** | **1,569** | **1,516** | **1,465** | **1,415** | **9,212** |

**COST ASSUMPTIONS:**

**Finance Assumptions:-**

1. Year 0 is 2017/18 Financial Year.
2. Baseline costs refer to the Direct Net Urology costs from 16/17 of £1,579,148, increased by 1.5% for inflation to £1,602,835.
3. No additional Staff costs have been identified in this IPT as existing medical staff will undertake the new procedure as part of existing day-case theatre sessions.
4. The commencement date for the service is expected to be 1 January 2018.
5. To provide this service it is assumed that there will be one patient per week, each requiring four implants. The costs are provided by the only supplier (Neotract) has the lowest unit price for the stents as £375 per implant.
   The cost is calculated as one patient * 4 stents * 52 weeks @ £375 per stent = £78,000.
6. The service model assumes total recurring revenue funding from 18/19 with a 3 months effect in 17/18.
7. No other revenue or capital costs have been identified in relation to this case.
8. A discount factor @3.5% pa has been applied to calculate the Net Present Cost.
9. Please note all figures above have been rounded to thousands.
10. Total Net Present Cost (NPC) equates to £9,212k for this option.

## SECTION 5: NON-MONETARY BENEFITS

**Option 1 –** will not provide an alternative treatment option for patients presenting with BPH.

**Option 2 – will provide an alternative treatment option for patients presenting with BPH.**

**Non-Monetary Benefits** of the stent include:

- *NICE guidance (MT26)* – published in September 2015 recommends that the 'case for adoption' for specific technologies are based on the claimed advantages of introducing the specific technology compared with current management of the condition. The guidance advises that the UroLift system should be considered as an alternative to current surgical procedures for men aged 50 years and older with lower urinary tract symptoms of BPH.
- It is more suitable for men with a number of medical problems who are at high-risk of surgery
- It is a minimally invasive procedure
- The treatment is a day-case procedure
- The permanent implants are delivered through a small needle
- Patients return home typically without a catheter
- Patients have a quicker recovery period and experience a more rapid return to daily life

## SECTION 6: PROJECT RISKS & UNCERTAINITIES

- Suitability of patients to be referred for alternative day case treatment.

  This is deemed to be low risk given the current knowledge of patients presenting to Consultant Urology staff.

## SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

**Option 1 – Status Quo**

Continue with the existing arrangement and offer patients a surgical procedure to treat problems with an enlarged prostate (BPH).

Although this option does not meet the project objectives it has been taken forward as a base case comparator.

**Option 2 -** Enhance treatment options for patients presenting with BPH (purchase devices to use during minimally invasive day procedure as an alternative to surgery)

**Option 2 is the preferred option** - it will provide Consultant Urologists with the opportunity to offer men with a number of medical problems who are at high-risk of surgery an alternative treatment option to TURP. This option will accrue the benefits detailed at Section 5 above which include a less invasive procedure carried out as a day-case procedure. Patients will return home the same day, typically without the need of a catheter. Patients have a quicker recovery period and experience a more rapid return to daily life.

## SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

| AFFORDABILITY STATEMENT | Year 0 17/18 £000's | Year 1 18/19 £000's | Year 2 19/20 £000's | Year 3 20/21 £000's | Totals £000's |
|---|---|---|---|---|---|
| **Required** | | | | | |
| Capital required | 0 | 0 | 0 | 0 | 0 |
| Revenue required | 1,622 | 1,706 | 1,732 | 1,758 | 6,818 |
| **Existing budget :** | | | | | |
| Capital | 0 | 0 | 0 | 0 | 0 |
| Revenue | 1,602 | 1,627 | 1,651 | 1,676 | 6,556 |
| **Additional Allocation Required:** | | | | | |
| Capital | 0 | 0 | 0 | 0 | 0 |
| Revenue | 20 | 79 | 81 | 82 | 262 |

## AFFORDABILITY ASSUMPTIONS

**Finance Assumptions:-**

1. Year 0 is 2017/18 Financial Year
2. Baseline costs refer to the Direct Net Urology costs from 16/17 of £1,579,148, increased by 1.5% for inflation to £1,602,835.
3. No additional Staff costs have been identified in this IPT as existing medical staff will undertake the new procedure as part of existing day-case theatre sessions.
4. The commencement date for the service is expected to be 1 January 2018
5. To provide this service it is assumed that there will be one patient per week, each requiring four implants. The costs are provided by the only supplier (Neotract) has the lowest unit price for the stents as £375 per implant.

   The cost is calculated as one patient * 4 stents * 52 weeks @ £375 per stent = £78,000.
6. The service model assumes total recurring revenue funding from 18/19 with a 3 months effect in 17/18
7. No other revenue or capital costs have been identified in relation to this case
8. Revenue costs uplifted by 1.5% p.a. for inflation from 2018/19, in section 8 only.
9. Please note all figures above have been rounded to thousands

## SECTION 9: MANAGEMENT ARRANGEMENTS

It is proposed to implement the organisation and management of this scheme in accordance with the requirement of the Department of Finance and Personnel guidance relating to successful project management. The following key roles have been identified:

**Project Owner:** Mr Ronan Carroll,
Assistant Director, Surgery & Elective Care Division & ATICs

**Project Manager:** Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients

Project Timeline is as follows:

| Item | Timeline |
|---|---|
| IPT Approved by SMT | September 2017 |
| Devices procured | October / November 2017 |
| Service offered to patients deemed suitable | December 2017 |
| Introduction of new technology as a day procedure | January 2018 |

## SECTION 10: MONITORING AND EVALUATION

| | |
|---|---|
| **Who will manage the implementation?** | Martina Corrigan<br>Head of ENT, Urology, Ophthalmology & Outpatients |
| **Who will monitor and evaluate the outcomes?** | Head of Service, Surgery & Elective Care Division & ATICs (not involved in the Project) |
| **What other factors will be monitored and evaluated?** | Number of patients referred for day surgery as an alternative to a TURP procedure |
| **When will this take place?** | Following the first full year of implementation (circa January 2019) |

## SECTION 9: ACTIVITY OUTCOMES (TRUSTS ONLY)

There will be no additional activity – where clinically appropriate patients will be offered a day procedure instead of a surgical procedure.

**Specify activity, e.g. IP, DC OPN, OPR, Contacts etc.**

| | IP | DC | OPN | OPR | | |
|---|---|---|---|---|---|---|
| **Baseline** | | | | | | |
| **Additional activity** | | | | | | |
| **New Baseline Activity** | | | | | | |

## SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

**NICE – National Institute for Health and Care Excellence**
**Medical technologies guidance [MTG26] published September 2015**

Nice has developed medical technology guidance on the UroLift system.

Nice medical technologies guidance addresses specific technologies notified to NICE by companies. The 'case for adoption' recommendations are based on the claimed advantages of introducing the specific technology compared with current management of the condition.

NICE has said that the UroLift system relieves lower urinary tract symptoms while avoiding the risk to sexual function associated with surgical options. Using the system reduces the length of a person's stay in hospital. It can also be used in a day surgery unit.

The UroLift system should be considered as an alternative to current surgical procedures for men aged 50 years and older with lower urinary tract symptoms of benign prostatic hyperplasia, who have a prostate of less than 100 ml without an obstructing middle lobe.

From the 1st April 2017 NHS England and NHS Improvement have introduced a new innovation and technology tariff (ITT) with the aim of setting incentives to encourage the update and spread of innovative medical technologies that benefit patients. Prostatic Urethral Lift (PUL) system has been awarded an Innovation and Technology Tariff for 2019.

| Summary Costing schedule for Investment Decision Making Templates | Ref Number | |
|---|---|---|
| Provider | SOUTHERN | |
| Hospital Site or Community development | COMMUNITY. | |
| Scheme Title | Stent for Benign Prostatic Hyperplasia (BPH) | |
| Pay and Price Levels | 2017/18 | |

Commissioner Use only

| Sign and Date for TRAFFACS update |
|---|
| |

1,602,835

| | | Base Case - option 1 | | | | Option 2 | | | | Option 3 | | | | Option 4 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pay Costs | Description | months claimed | wte | fye | cye | months claimed | wte | fye | cye | months claimed | wte | fye | cye | months claimed | wte | fye | cye |
| | BASELINE BUDGET | | | 1,602,835 | 1,602,835 | | | 1,602,835 | 1,602,835 | | | | | | | | 0 |
| BAND 1 | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| BAND 2 | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| BAND 3 | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| BAND 4 | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| BAND 5 | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| BAND 6 | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| BAND 7 | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| BAND 8A | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| BAND 8B | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| BAND 8C | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| BAND 8D | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| BAND 9 | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| Non-AFC posts please detail below | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| | | | | | 0 | | | | 0 | | | | 0 | | | | |
| Allowances for posts noted above - please detail below | | | | | | | | | | | | | | | | | |
| | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail) | | | | | | | | | | | | | | | | | |
| | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| TOTAL PAY COSTS | | | 0.00 | 1,602,835 | 1,602,835 | | 0.00 | 1,602,835 | 1,602,835 | | 0.00 | 0 | 0 | | 0.00 | 0 | 0 |
| | | | | | | | | | 0 | | | | | | | | |
| Non-Pay Costs - please detail below | | | | | | | | | | | | | | | | | |
| | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| OTHER GOODS & SERVICES | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| 1 patient per week = 4 stents x 52 weeks x £375 - £78,000.00 | | | | | 0 | 3 | | 78,000 | 19,500 | | | | 0 | | | | 0 |
| | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| CAPITAL | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| | | | | 0 | 0 | | | 0 | 0 | | | | 0 | | | | 0 |
| | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| | | | | | 0 | | | | 0 | | | | 0 | | | | 0 |
| TOTAL NON-PAY COSTS | | | | 0 | 0 | | | 78,000 | 19,500 | | | 0 | 0 | | | 0 | 0 |
| GRAND TOTAL | | | 0.00 | 1,602,835 | 1,602,835 | | 0.00 | 1,680,835 | 1,622,335 | | | 0 | 0 | | | 0 | 0 |
| | | | | | | | | 78,000 | 19,500 | | | | | | | | |

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

## Corrigan, Martina

**From:** Corrigan, Martina [redacted]
**Sent:** 17 November 2017 08:47
**To:** Parks, Zoe
**Cc:** Haynes, Mark
**Subject:** RE: [redacted]

Hi Zoe

Mark was wondering if you could meet with him and I today to do a response back to Direct Medics and to look over the previous timesheets and current timesheets?

Mark is Urologist of the Week so he could meet you either at 12.15 or 2pm today (my office)?

Thanks

Regards

Martina

---

**From:** Parks, Zoe
**Sent:** 16 November 2017 12:54
**To:** Haynes, Mark; Corrigan, Martina
**Subject:** RE: [redacted]

We would only pay if we have told him that he needs to attend. We need to specify what the working hours are that are expected of him.

The responsibility for revalidation falls to the agency since he is a locum doctor. The difficulty is when you have locums in such long term engagements; these difficulties creep. However CPD/Revalidation is his responsibility and the agency must ensure his mandatory training and CPD requirements remain up to date.

In my view he needs to do this in his own time – making sure of course that he has enough time to do this and we wouldn't be impacting on patient safety (i.e. we are not offering him too many clinical hours on a weekly basis).

Hope this makes sense.
Zoe

---

**From:** Haynes, Mark
**Sent:** 16 November 2017 12:32
**To:** Corrigan, Martina; Parks, Zoe
**Subject:** Re: [redacted]

Who says he is required to attend audit (and be paid by us)? Maybe worth checking with Zoe if we have an obligation to pay for PSM attendance?

My understanding is that while audit and governance are part of revalidation requirements, as he is not an employee of the Trust he has to meet these himself, we have no obligation to pay him to meet these.

While the work pattern is unchanged, he has determined his own working hours and assumed this would be paid. While we may have paid the previously, the discrepancy between what was expected by us and what has been claimed has been identified and previous payment does not mean we have endorsed his claims for 20hrs+ admin.

Zoe do you have any advice?

Mark

Sent from my BlackBerry 10 smartphone.

---

**From:** Corrigan, Martina
**Sent:** Thursday, 16 November 2017 12:09
**To:** Haynes, Mark
**Subject:** FW: Personal information redacted by USI

Afternoon

Can we discuss please along with his recent timesheets which he left with me this morning.

Regards

Martina

---

**From:** Maria McCahey [redacted]
**Sent:** 16 November 2017 11:22
**To:** Corrigan, Martina
**Subject:** Personal information redacted by USI

Morning Martina

Dr Personal Information redacted by USI has asked me to clarify a few things.

1. He has asked if the department are intending to pay him for his attendance at the department audit meetings which he is required to attend? These meeting would fall outside the purposed hours

2. He also noticed on the October hours he only has 4 hours admin paid instead of the 6 agreed with him recently with yourself and Dr Haynes – please advise how the additional hours should be claimed.

3. On the 10th October he was present form 8am which I believe he discussed with yourself and DR Haynes. According to thomas it was agreed to pay him from 8.30am and not 9am – can you clarify?

4. He would like it noted from Monday 2nd October he was just back from a period of sick leave which was not covered in his absence so he had a backlog of work that he needed to catch up on.

Our understanding is that Personal information redacted by USI workload has not altered since he commenced his post and as such the hours assigned to him originally were still required to date. If indeed the work load needs to be amended this would need to be agreed with Personal information redacted by USI going forward. However he maintains that to date and particularly in reference to October his workloads and hours required were as per previous months.

Maria

**Maria McCahey**
Recruitment Consultant
**Belfast**

P: Personal Information redacted by USI | F: Personal Information redacted by USI | W: Personal Information redacted by USI | Find Our Offices

## Corrigan, Martina

**From:** Corrigan, Martina [redacted]
**Sent:** 14 November 2017 11:07
**To:** Montgomery, Ruth
**Subject:** RE: funding available for Trust Doctors

Thanks

Regards

Martina

---

**From:** Montgomery, Ruth
**Sent:** 14 November 2017 11:07
**To:** Corrigan, Martina
**Subject:** RE: funding available for Trust Doctors

Hi Martina,

I will try to get clarification on this and come back to you.

Ruth

**Ruth Montgomery**
Administrative Officer – Medical Director's Office,
Southern Health & Social Care Trust
1st Floor, Trust Headquarters, CAH


**My hours of work are - 8.30am - 3pm, Monday-Friday**

☎ Please note my new contact number – External - [redacted] / Internal ext: [redacted]

[redacted]

---

**From:** Corrigan, Martina
**Sent:** 14 November 2017 11:03
**To:** Montgomery, Ruth
**Subject:** funding available for Trust Doctors

Hi Ruth

Mr Haynes has asked me to clarify if there is funding available for Trust Grade Doctors to attend courses and if so how much?

Thanks

Martina

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

***INTERNAL:*** Personal Information redacted by USI
***EXTERNAL :*** Personal Information redacted by USI
***Mobile:*** Personal Information redacted by USI

## Corrigan, Martina

**From:** Corrigan, Martina [redacted]
**Sent:** 28 October 2017 14:48
**To:** Carroll, Ronan
**Cc:** Livingston, Laura
**Subject:** RE: Complaints Summary Spreadsheet from. 1.4.16.xls (updated 27.10.17)
**Attachments:** RE: ENQUIRY - [redacted] 14.1 KB); FW: New complaint for investigation - [redacted] /18 (86.4 KB); FW: [redacted] (370 KB); Complaints Summary Spreadsheet MC Update 28 October 2017.xls; RE: Call regarding Mr O'Brien Waiting list - possible local resolution (14.5 KB); RE: MLA enquiry: [redacted] (13.6 KB); RE: MLA enquiry - [redacted] (17.1 KB)

Ronan/Laura

My updates along with responses sent through.

I think the only one I have left is [redacted] (received this Monday - 23 October) and I need the notes to respond which Laura is getting for me.

Regards

Martina

---

**From:** Livingston, Laura
**Sent:** 27 October 2017 16:16
**To:** Corrigan, Martina; Henry, Gillian; Kelly, Brigeen; Matthews, Josephine; McGeough, Mary; Murray, Helena; Nelson, Amie; Sharpe, Dorothy; Kearney, Emmajane; McKenna, Marti
**Cc:** Carroll, Ronan; Clayton, Wendy
**Subject:** RE: Complaints Summary Spreadsheet from. 1.4.16.xls (updated 27.10.17)
**Importance:** High

Dear all

Please find attached spreadsheet.

271 total
13 unanswered of which 4 are in process and 4 not yet due

*Please note there are 5 responses overdue*

Many thanks
Laura

*Laura Livingston*

Southern Health and Social Care Trust

Personal Secretary | Mr Ronan Carroll | Assistant Director SEC & ATICs | Acute Directorate | Admin Floor | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ | [redacted]

## Corrigan, Martina

**From:** Corrigan, Martina [redacted]
**Sent:** 08 October 2017 09:25
**To:** ClientLiaison, AcutePatient; Clayton, Wendy
**Cc:** Carroll, Ronan; Livingston, Laura
**Subject:** RE: ENQUIRY - [redacted]

David

[redacted] had been seen by [redacted] on [redacted], after he had attended the Emergency Department with abdominal pain. [redacted] referred him to be seen as an outpatient by Mr O'Donoghue and he has been added to the New Outpatient Waiting list to be seen in respect of renal colic. [redacted] has now been waiting for 37 weeks and unfortunately the waiting time for New Urgent Urology appointments is at 56 weeks so it will be at least another 3 months until he will be sent an appointment. Can you assure [redacted] he is on a waiting list for outpatients and that if he feels his condition has deteriorated then he should go back to his GP.

Regards

Martina

---

**From:** ClientLiaison, AcutePatient
**Sent:** 05 October 2017 10:47
**To:** Corrigan, Martina; Clayton, Wendy
**Cc:** Carroll, Ronan; Livingston, Laura
**Subject:** ENQUIRY - [redacted]
**Importance:** High

Dear Martina, could you please look into this and provide me with a response.

Kind Regards

David Cardwell

HSC Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: [redacted] | Email: [redacted]

---

**From:** Magennis, Joscelyn
**Sent:** 04 October 2017 16:11
**To:** ClientLiaison, AcutePatient
**Subject:** Telpehone call to complaints office
**Importance:** High

[redacted]

DOB [redacted]

Personal Information redacted by USI

Due to be seen a clinic for kidney stones. Called switchboard and passed from pillar to post (1 hour 30 mins) eventually found out from Outpatients that there are no awaiting appointments to be seen. Had previously seen a surgeon who asked what he was there for? Had been originally told regarding his kidney stone that it was a 3 month waiting time for red flag and 18 month waiting time for routine. It has now been 19 months since he was told that and according to the system he has no upcoming appointment.

In the first instance Personal information redacted by USI was happy for this to be treated as an enquiry and to have someone phone him to explain to him if he has been taken of the waiting list.

Kind Regards

Joscelyn Magennis

Corporate Complaints Officer
Southern Health & Social Care Trust

Tel No: Personal Information redacted by USI

Hours of Work: Wed & Thurs 9-5 (CAH), Friday 8.15 – 1 (DHH).

## Corrigan, Martina

**From:** Corrigan, Martina [redacted]
**Sent:** 28 October 2017 12:24
**To:** Carroll, Ronan
**Cc:** Livingston, Laura
**Subject:** FW: New complaint for investigation - [redacted] [redacted]
**Attachments:** Complaint re Disabled Parking Bays and Cancellation of Outpatients appoi... (8.16 KB); FW: New complaint for investigation - [redacted] [redacted]

Ronan

This has come back to Marilyn/Josie again. Josie has responded as per attached, are you happy for this to go to complaints for inclusion in the response back (Support services have responded in respect to carparking)

Regards

Martina

---

**From:** Canning, Danielle
**Sent:** 11 October 2017 12:14
**To:** Corrigan, Martina; Carroll, Ronan
**Cc:** Livingston, Laura
**Subject:** FW: New complaint for investigation - [redacted] [redacted]

Martina/Ronan,

Further to the email below please note the response to this complaint is now overdue. We look forward to receipt for same by return.

Many thanks,
Danielle

Kind Regards,

Danielle Canning
Clinical and Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hospital
[redacted]

---

**From:** Canning, Danielle
**Sent:** 21 September 2017 12:51
**To:** Johnston, Melanie; Mulligan, Marilyn; 'Corrigan, Martina [redacted]'
**Cc:** 'Carroll, Anita [redacted]'; Carroll, Ronan
**Subject:** New complaint for investigation - [redacted] [redacted]

*Dear All*

*Please find attached a new complaint for investigation and note that you are required to provide your draft response by **3 October 2017**.*

***Please ensure that your response is accurate, answers the questions / issues raised and is worded as you wish it to appear in the final response with no abbreviations or medical jargon. Please also consider the emotional tone of the letter of complaint and ensure that your response does not contain personal disagreements or criticisms.****

**Key Considerations**

**Consider each area against the following and incorporate as appropriate into the response:**

a) **What was expected?**
b) **What was provided?**
c) **What actually happened?**
d) **Is there a difference between a) and b)? If the answer is yes, why?**
e) **What was the impact of d)?**
f) **Have you ensured staff have been spoken to & a note made of your findings?**
g) **Is an apology appropriate and who should make this?**

**Learning**

a) **What should be done to put things right?**
b) **What should be done to avoid a recurrence?**
c) **Detail the learning from the complaint.**

*Your response should be returned to* Personal Information redacted by USI *on the response template attached.*

*Finally, I attach for your attention an action plan which should be completed and returned in the event that action is required as a result this complaint. If you have any queries please do not hesitate to contact* ***Vivienne Kerr on*** Personal information redacted by USI

*I appreciate your assistance with this matter.*

Kind Regards,

Danielle Canning
Clinical and Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hospital
Personal Information redacted by USI

## Corrigan, Martina

**From:** Complaints [redacted]
**Sent:** 19 September 2017 14:02
**To:** ClientLiaison, AcutePatient
**Subject:** Complaint re Disabled Parking Bays and Cancellation of Outpatients appointment [redacted]

I received a phone call from [redacted]
She arrived at DHH she is a blue badge holder and is also wearing a splint she had an appointment for the pain clinic she was unable to walk from bottom car park.
She arrived early and couldn't get a disabled parking space, she noticed a blonde female at one of the disabled bays and asked if she was leaving she said no she was going in but the girl wasn't a blue badge holder. The girl ignored [redacted] rang through to reception to make them aware of this and Mr Heaney was going to transfer her to the correct department re this female parking in a disabled bay but she didn't get through. [redacted] then called back and asked for outpatients she got cut off twice- she was phoning to make them aware she was going to be late.
She then spoke to a groundsman and he allowed her to park in a service bay. She arrived at the clinic and there was a lady in front of her that couldn't work the check in machine. She had to wait on her using the machine. The lady in front of her didn't get checked in. [redacted] finally got checked in and she was 7 minutes late. She would have only been 3 minutes if the lady in front had been able to use the machine. She thought there should be someone available to help this lady for situations like these. This lady got taken before [redacted]. A nurse then came out to say the Dr wouldn't see her because she was late. [redacted] explained and the nurse rudely said you are late and you can get another appointment in October. [redacted] wasn't happy and asked to speak to someone in charge as she had done everything in her power to contact the department she then arrived at the dept. and due to the lady in front of her this made her even more late. The nurse then said the dr would see her. She went in to see Dr Jones and he said he couldn't give her a consultation as she was late. [redacted] explained again and he said that he knew parking was a nightmare but he had to be at another clinic. [redacted] had said she has waited for 45 minutes to an hour to be seen in that clinic before. She said her complaint isn't in relation to the Doctor she appreciates how busy he is. Her point is why couldn't she have been seen for the remainder of her time slot and her lateness was not her fault and why is nobody policing the disabled bays.

Thanks
Nicole

Nicole O'Neill
Corporate Governance Officer
Corporate Clinical & Social Care Governance Office
SHSCT Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

**PLEASE NOTE MY HOURS OF WORK ARE 9AM – 3PM MONDAY - FRIDAY**

Tel: [redacted]
Email: [redacted]

## Corrigan, Martina

**From:** Matthews, Josephine [redacted]
**Sent:** 24 October 2017 16:08
**To:** Corrigan, Martina
**Subject:** FW: New complaint for investigation - [redacted] [redacted]

**Importance:** High

Hi Martina,

See below

Mrs Matthews Lead Nurse and Sister Mulligan Outpatients Department have had an opportunity to review the complaint and discuss with nursing staff the issues raised in your letter.

- Nurse spoke rudely to Ms [redacted] and she was not seen in the remaining time of her appointment

[redacted] appointment time was for 12.05hrs unfortunately as she was not checked in the next patient (12.25hrs appointment) was automatically called.

Dr Jones was informed of Ms [redacted] attendance however he was unable to facilitate her review at the end of clinic and advised that another appointment be arranged.

The health care assistant (HCA) relayed this information to Ms [redacted] which was understandably upsetting given the difficulties she had encountered that morning and contacted a senior nurse at Ms [redacted] request.

The HCA apologies if she came across rude this was not her intention.

---

How much detail do you want to go into in this response the use of clarity I have not included but not sure if you want this covered .

regards

*Josie*

Josephine Matthews
Lead Nurse
SEC & Outpatients
Mob: [redacted]

**From:** Matthews, Josephine

---

**From:** Mulligan, Marilyn
**Sent:** Tuesday, 24 October 2017 09:15
**To:** Carroll, Ronan; Matthews, Josephine
**Subject:** RE: New complaint for investigation - [redacted] [redacted]

The Nurse was HCA [redacted] – she informed the Doctor that the patient had arrived – he refused to see her. [redacted] informed the patient that the Doctor had to leave to get to another site and did not have time to see her, as he would like to give her appropriate time and that she could re-book. The Patient became agitated and [redacted] asked S/N [redacted] to speak to her, [redacted] repeated the information above, listened while the patient continued to complain about the lack of reception staff and parking issues and apologised for this too, and offered her the complaints form.
None of the staff were rude or aggressive, the patient was very agitated as she had DNA'd her previous appointment.
Regards,
Marilyn

Marilyn Mulligan
Outpatient Manager
Daisy Hill Hospital/Banbridge polyclinic
Tel: [redacted] ext [redacted]
Work mobile [redacted]

---

**From:** Carroll, Ronan
**Sent:** 24 October 2017 08:56
**To:** Mulligan, Marilyn; Matthews, Josephine
**Subject:** FW: New complaint for investigation - [redacted]
**Importance:** High

We appear to be going around the houses with this complaint and identifying the nurse. Please can we sort it out

*Ronan Carroll*
*Assistant Director Acute Services*
*ATICs/SEC*
[redacted]

---

**From:** Murray, Helena
**Sent:** 24 October 2017 08:48
**To:** Carroll, Ronan
**Subject:** RE: New complaint for investigation - [redacted]

Marilyn Mulligan, OPD Manager, DHH, as it was one of her Nurses who covered the clinic that day.

Helena

---

**From:** Carroll, Ronan
**Sent:** 24 October 2017 08:41
**To:** Murray, Helena
**Subject:** RE: New complaint for investigation - [redacted]

So who nurse was it

*Ronan Carroll*
*Assistant Director Acute Services*
*ATICs/SEC*
[redacted]

---

**From:** Murray, Helena
**Sent:** 24 October 2017 08:24
**To:** Carroll, Ronan
**Subject:** FW: New complaint for investigation - [redacted]

FYI

**From:** McKenna, Marti
**Sent:** 24 October 2017 08:18
**To:** Corrigan, Martina
**Cc:** Mulligan, Marilyn; Murray, Helena
**Subject:** FW: New complaint for investigation - Personal Information redacted by USI Personal information redacted by USI

Martina,

Please can you answer this complaint in relation to the attitude of the nurse at OPD, Jane Mc Anerney has confirmed that this was not a pain nurse,

Kind regards,

Marti.

---

**From:** McAnerney, Briege
**Sent:** 18 October 2017 15:35
**To:** McKenna, Marti
**Cc:** Murray, Helena
**Subject:** RE: New complaint for investigation - Personal Information redacted by USI Personal information redacted by USI

Marti

I can confirm that the lady in question had an appointment at the Pain Clinic on Tuesday Personal information redacted by USI., OPD, DHH.
I was not in DHH on that day, as I was in clinic in ACH. I have spoken with Bronagh Larkin who is the Pain Clinic secretary for DHH, who tells me that this lady arrived 14 minutes late for her 15 minute appointment and this was the last appointment slot. Dr. Jones had a brief discussion with the Patient at the end of the clinic and explained the rationale of wanting to give her, her full time in a clinic appointment, she seemed to understand this and another appointment was made for her in a few weeks. She was given an appointment for Personal information redacted by USI, however cancelled this as it didn't suit. She has an appointment scheduled for Personal information redacted by USI
I can forward you a copy of Dr. Jones's clinic letter on that day of the Personal information redacted by USI if you wish?
I have spoken to Marilyn Mulligan, OPD Manager, DHH, as it was one of her Nurses who covered the clinic that day and she will forward me the name of the Nurse, I can forward this to you if you wish?

Kind regards

Briege.

---

**From:** McKenna, Marti
**Sent:** 18 October 2017 14:33
**To:** McAnerney, Briege
**Cc:** Murray, Helena
**Subject:** FW: New complaint for investigation - Personal Information redacted by USI Personal information redacted by USI

Briege,

Can you confirm if this patient attended the chronic pain clinic in DHH and if so can you please investigate the circumstances and respond to me for discussion?

Kind regards,

Marti.

---

**From:** Murray, Helena
**Sent:** 18 October 2017 14:14
**To:** McKenna, Marti
**Cc:** Canning, Danielle; Kearney, Emmajane
**Subject:** Fw: New complaint for investigation - Personal Information redacted by USI Personal information redacted by USI

Dear marti,

Complaint which we need to respond to with reference to the pain service.

Can you please Laise with pain sisters.

Regards
Helena

Sent from my BlackBerry 10 smartphone.

---

**From:** Canning, Danielle [redacted]
**Sent:** Wednesday, 18 October 2017 12:17
**To:** Murray, Helena
**Subject:** FW: New complaint for investigation - [redacted] [redacted]

Hi Helena,

Further to the emails below please see attached a new complaint for your investigation and response.

I have attached the original complaint, response template and action plan for ease of reference.

Many thanks,
Danielle

Kind Regards,

Danielle Canning
Clinical and Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hospital
[redacted]

---

**From:** Cardwell, David
**Sent:** 17 October 2017 14:19
**To:** Canning, Danielle
**Subject:** FW: New complaint for investigation - [redacted] [redacted]

Hi Danielle, can you please ask Helena Murray for a response to this complaint as per emails below.

Kind Regards

David Cardwell

HSC Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: [redacted] | Email: [redacted]

---

**From:** Matthews, Josephine
**Sent:** 16 October 2017 13:40

**To:** Cardwell, David
**Subject:** Fw: New complaint for investigation - [redacted] [redacted]

Hi David

This was the pain nurse service, no involvement with general OPD
Regards
Josie

Sent from my BlackBerry 10 smartphone.

---

**From:** Carroll, Ronan [redacted] >
**Sent:** Monday, 16 October 2017 11:42
**To:** Carroll, Anita
**Cc:** Corrigan, Martina; Matthews, Josephine
**Subject:** RE: New complaint for investigation - [redacted] [redacted]

Martina on AL this week
Josie can you pick this up please

*Ronan Carroll*
*Assistant Director Acute Services*
*ATICs/SEC*
[redacted]

---

**From:** Carroll, Anita
**Sent:** 16 October 2017 11:24
**To:** Carroll, Ronan
**Subject:** FW: New complaint for investigation - [redacted] [redacted]

Fyi A

---

**From:** Cardwell, David
**Sent:** 16 October 2017 09:42
**To:** Reid, Trudy; Carroll, Anita
**Subject:** RE: New complaint for investigation - [redacted] [redacted]

Hi, yes FSS response received. Still await Martina Corrigan's response in relation to the attitude of the nurse at OPD.

Kind Regards

David Cardwell

Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: [redacted] | Email: [redacted]

---

**From:** Reid, Trudy
**Sent:** 13 October 2017 17:15
**To:** Cardwell, David
**Subject:** FW: New complaint for investigation - [redacted] [redacted]

David please see below

Regards,

Trudy

---

**From:** Carroll, Anita
**Sent:** 10 October 2017 15:41
**To:** Reid, Trudy
**Subject:** FW: New complaint for investigation - Personal Information redacted by USI Personal information redacted by USI

This is on the o/s list but we sent on our share on 29th sept , so not sure why still o/s

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**From:** Carroll, Anita
**Sent:** 29 September 2017 14:36
**To:** Canning, Danielle
**Subject:** FW: New complaint for investigation - Personal Information redacted by USI Personal information redacted by USI

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**From:** Adams, Valerie
**Sent:** 22 September 2017 09:29
**To:** Carroll, Anita
**Cc:** Johnston, Melanie; Corley, Kate
**Subject:** FW: New complaint for investigation - Personal Information redacted by USI Personal information redacted by USI

Enclosed please find the partial response to this complaint re car parking at DHH

---

**From:** Canning, Danielle
**Sent:** 21 September 2017 12:51
**To:** Johnston, Melanie; Mulligan, Marilyn; Corrigan, Martina
**Cc:** Carroll, Anita; Carroll, Ronan
**Subject:** New complaint for investigation - Personal Information redacted by USI Personal information redacted by USI

*Dear All*

*Please find attached a new complaint for investigation and note that you are required to provide your draft response by **3 October 2017**.*

***Please ensure that your response is accurate, answers the questions / issues raised and is worded as you wish it to appear in the final response with no abbreviations or medical jargon. Please also consider the emotional tone of the letter of complaint and ensure that your response does not contain personal disagreements or criticisms.****

**Key Considerations**

**Consider each area against the following and incorporate as appropriate into the response:**

- **a) What was expected?**
- **b) What was provided?**
- **c) What actually happened?**
- **d) Is there a difference between a) and b)? If the answer is yes, why?**
- **e) What was the impact of d)?**
- **f) Have you ensured staff have been spoken to & a note made of your findings?**
- **g) Is an apology appropriate and who should make this?**

**Learning**

- **a) What should be done to put things right?**

**b) What should be done to avoid a recurrence?**
**c) Detail the learning from the complaint.**

*Your response should be returned to AcutePatient.ClientLiaison@southerntrust.hscni.net on the response template attached.*

*Finally, I attach for your attention an action plan which should be completed and returned in the event that action is required as a result this complaint. If you have any queries please do not hesitate to contact* ***Vivienne Kerr on*** Personal information redacted by USI

*I appreciate your assistance with this matter.*

Kind Regards,

Danielle Canning
Clinical and Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hospital
Personal Information redacted by USI

## Corrigan, Martina

**From:** Corrigan, Martina [redacted]
**Sent:** 28 October 2017 12:05
**To:** Carroll, Ronan
**Cc:** Livingston, Laura
**Subject:** FW: [redacted] enquiry
**Attachments:** Enquiry [redacted].docx; Final response [redacted].pdf

Ronan

I have pulled the notes for this patient and this patient was referred into General Surgery in DHH on 28 September 2016 and was upgraded to a Red Flag to the Urology Team, the word 'scab' on the GP letter has been underlined and asterisk so I can only assume this is the reason why they upgraded. Mr [redacted] would have been then contacted by Red Flag Team and advised that he had a red flag appointment and then given an appointment for [redacted], when it was deemed by the senior Registrar Mr David Curry (after consultation with Mr O'Brien), that Mr [redacted] needed a routine daycase procedure and this is documented in the notes and in the letter to GP, so I am unsure and I cannot confirm why he was ever told 4 weeks wait as none of the consultants nor the registrars tell the patients this as they all advise of the long waiting times.

I have put my suggestion below on what we should respond back to Mr [redacted] daughter for your comments/advice please.

Regards

Martina

---

**From:** Truesdale, Pamela
**Sent:** 27 September 2017 16:06
**To:** Corrigan, Martina
**Cc:** Cardwell, David; Carroll, Ronan; Livingston, Laura; Stinson, Emma M
**Subject:** [redacted] enquiry

Martina

I have received a telephone call from [redacted] today regarding our response letter to her complaint (both attached).

Mrs [redacted] was concerned at how the response was worded – 3rd paragraph states "it would appear that you were a suspected cancer originally which is why you have been told this". She feels that this is inappropriate to send to an [redacted] ear old man, and that at the initial stage the GP did not suspect cancer and the referral was routine. **We apologise if this caused your father undue distress but from the information received on the referral letter from the GP the Consultant Surgeon who triaged the letter felt that it was better to treat this as a suspected cancer until such times as it could be ruled out.**

Mrs [redacted] stated sequence of events was as follows:

28 Sept 16 – Mr [redacted] attended GP for Urology issues and referral was made. No cancer concerns.

15 June 17 – Mr [redacted] became ill, having no energy and attended GP who queried a viral infection and raised concerns of possible bowel cancer.

[redacted] Mr [redacted] attended hospital for both endoscopy and colonoscopy. Nothing sinister found.

Mrs [redacted] stated she has no concerns with the endoscopy or colonoscopy aspect of his treatment, however she wants to know why they were told initially the Urology wait would be 4 weeks. She understands that cancer patients take priority but is unhappy that her elderly father was told it was thought he had cancer, when that was not the case. **We would like to apologise that your father was told a four week wait but until cancer was ruled out we had to continue to treat and advise your father that this was the case. We are required to keep our patients informed if there is a risk that their symptoms may turn out to be cancer, but thankfully in your father's situation this was not the case, however we do understand that this upset your father but assure you that this was never our intention.**

Regards
Pamela

Pamela Truesdale
Governance Office, Acute Services
The Maples
Craigavon Area Hospital
68 Lurgan Road
Craigavon
BT63 5QQ

Tel [redacted]

**From:** Complaints
**Sent:** 19 July 2017 15:23
**To:** ClientLiaison, AcutePatient
**Subject:** Complaint Personal Information redacted by USI obo Personal Information redacted by USI

Personal Information redacted by USI
Personal Information redacted by USI

Personal Information redacted by USI
Personal Information redacted by USI
Personal Information redacted by USI
H&C Personal Information redacted by USI

Personal information redacted by USI rang in today on behalf of her father who is waiting for circumcision surgery. On 8th March Mr Personal information redacted by USI was informed by his Consultant that there was a 4 week waiting time. When he had not heard anything Personal information redacted by USI rang the booking centre to be told that her father is a routine patient and that the waiting time is at least 2 years. Personal information redacted by USI unable to go to the toilet at present and Personal information redacted by USI states that he will never be able to wait for 2 years or more.

Personal information redacted by USI would like to know where he is on the waiting list? How long will he be expected to wait? Is there any way that his surgery can be expediated?

Kind regards

Lindsey

Personal Information redacted by USI
Corporate Complaints
Personal Information redacted by USI
Personal Information redacted by USI

Southern Health and Social Care Trust

26 July 2017 **Our Ref:** Personal information redacted by USI

**Private & Confidential**

Mr Personal Information redacted by USI
Personal Information redacted by USI

Dear Mr Personal Information redacted by USI

I refer to your complaint in respect of the expected waiting time for surgery. Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them.

I am advised by the Head of Service that you were added to Mr O'Brien's waiting list on 11 October 2016 as a routine patient therefore you are currently waiting for 40 weeks.

I am sorry you were told 4 weeks initially but it would appear that you were a suspected cancer originally which is why you would have been told this. However, thankfully this was not the case and unfortunately because the Urology Services are concentrating on their cancer patients the waiting time for routine surgery is now 170 weeks and therefore that is what you will have to wait for.

If you feel your condition has changed or feel it is getting worse, we would advise you to please contact your GP who may provide updated information to the consultant who will be able to review his place on the waiting list.

I hope that you will find this response has addressed the issues that you raised.

Yours sincerely

Personal information redacted by USI

**ESTHER GISHKORI (Mrs)**
**Director of Acute Services**

for Mr Francis Rice, Chief Executive (Interim)

**Clinical and Social Care Governance Team**
**Directorate of Acute Services**
**The Maples, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ**

**Telephone:** Personal Information redacted by USI

## Corrigan, Martina

**From:** Corrigan, Martina [redacted]
**Sent:** 28 October 2017 14:18
**To:** ClientLiaison, AcutePatient
**Cc:** Carroll, Ronan; Livingston, Laura
**Subject:** RE: Call regarding Mr O'Brien Waiting list - possible local resolution

Hi David,

I can confirm that I have checked and Mr [redacted] was added to Mr O'Brien's waiting list on 10 July 2015 for a Routine Injection of Botulinum Toxin which leaves him waiting 120 weeks. Unfortunately since the Urology Team are concentrating on Cancer patients the wait for this type of procedure is now out to 178 weeks. We apologise for this long wait, I know Mr [redacted] has been advised to attend his GP and I have checked but there does not appear to be anything on the system. Perhaps if he feels his condition has worsened then he should ask his GP to send in a further referral and Mr O'Brien can see if he needs to be moved up the waiting list.

Regards

Martina

---

**From:** ClientLiaison, AcutePatient
**Sent:** 13 October 2017 15:15
**To:** Corrigan, Martina; Kelly, Brigeen; Nelson, Amie
**Cc:** Carroll, Ronan; Livingston, Laura
**Subject:** FW: Call regarding Mr O'Brien Waiting list - possible local resolution

Hi Brigeen and Amie, in Martina's absence. Could this matter be resolved locally?

Please advise.

Kind Regards

David Cardwell

Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: [redacted] | Email: [redacted]

---

**From:** Magennis, Joscelyn
**Sent:** 13 October 2017 12:11
**To:** ClientLiaison, AcutePatient
**Subject:** Call regarding Mr O'Brien Waiting list - possible local resolution

Complainant:
[redacted] (wife)

Patient: [redacted]

Personal Information redacted by USI

DOB: Personal Information redacted by USI

Personal Information redacted by USI

Consultant: Mr O'Brien

Husband awaiting prostate procedure for 2 years now. Rang secretary and was told to go to GP. GP has already attempted contact and no response. Attended Pre op a year ago and was contacted one morning asking to come in however is on warfarin so was not able to accept opportunity.

Tis lady is happy for contact to be made by telephone to get a better understanding of what is happening, where her husband is on the list, and expected timeframe for procedure.

Kind Regards

Joscelyn Magennis

Corporate Complaints Officer
Southern Health & Social Care Trust

Tel No: Personal Information redacted by USI

Hours of Work: Wed & Thurs 9-5 (CAH), Friday 8.15 – 1 (DHH).

## Corrigan, Martina

**From:** Corrigan, Martina [redacted]
**Sent:** 28 October 2017 14:28
**To:** ClientLiaison, AcutePatient
**Cc:** Carroll, Ronan; Livingston, Laura
**Subject:** RE: MLA enquiry: [redacted]

Hi David

I have checked and Mr [redacted] was added to the Ophthalmology new outpatient waiting list (upgraded from routine to Urgent by the ophthalmologist) on 29 March 2017. This means that he is waiting for 30 weeks. Unfortunately the current waiting time for and urgent ophthalmology referral is 125 weeks. And Belfast Trust who provide this service have asked that we let the MLA/Patient know that they are very sorry for the length of their waiting times and that these are longer than they would wish for but that this is because the Trust do not currently have enough capacity to see all the patients currently on their waiting list.

And to advise the patient that if they feel that their condition has changed, or they feel that it is getting worse, then please contact their GP who may provide updated information to the consultant who will be able to review their place on the waiting list.

Regards

Martina

---

**From:** ClientLiaison, AcutePatient
**Sent:** 23 October 2017 14:32
**To:** Corrigan, Martina; Murray, Helena
**Cc:** Carroll, Ronan; Livingston, Laura
**Subject:** MLA enquiry: [redacted]

Dear Martina and Helena, please see attached an MLA enquiry for your investigation and response.

I look forward to hearing from you as soon as possible.

Kind Regards

David Cardwell

Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: [redacted] | Email: [redacted]

## Corrigan, Martina

**From:** Corrigan, Martina [redacted]
**Sent:** 28 October 2017 14:37
**To:** ClientLiaison, AcutePatient
**Cc:** Carroll, Ronan; Livingston, Laura
**Subject:** RE: MLA enquiry - Mrs [redacted]

Hi David

I have checked and Mrs [redacted] was added to the Ophthalmology new outpatient waiting list as a routine patient on 6 September 2017. This means that she is waiting for 7 weeks. Unfortunately the current waiting time for a routine ophthalmology referral is 137 weeks. And Belfast Trust who provide this service have asked that we let the MLA/Patient know that they are very sorry for the length of their waiting times and that these are longer than they would wish for but that this is because the Trust do not currently have enough capacity to see all the patients currently on their waiting list.

And to advise the patient that if they feel that their condition has changed, or they feel that it is getting worse, then please contact their GP who may provide updated information to the consultant who will be able to review their place on the waiting list.

Regards

Martina

---

**From:** ClientLiaison, AcutePatient
**Sent:** 24 October 2017 17:06
**To:** Corrigan, Martina
**Cc:** Carroll, Ronan; Livingston, Laura
**Subject:** MLA enquiry - [redacted]
**Importance:** High

Dear Martina, please see below details of an MLA enquiry for your investigation and response.

I look forward to hearing from you as soon as possible.

Kind Regards

David Cardwell

Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: [redacted] | Email: [redacted]

---

**From:** Carla Lockhart
**Sent:** 23 October 2017 16:22
**To:** 'Wright, Elaine' [redacted]
**Subject:** [redacted] - Cataract Extraction

Elaine

Please pass ,my email to the appropriate department concerned:

I have been contacted by Mrs [redacted], DOB: [redacted] NHS No [redacted], in relation to the waiting list for a cataract operation. I am informed that Mrs [redacted] was referred for a consultation by her GP , however she is somewhat distraught by the lengthy waiting time for a consultation with the eye clinic, which she has been informed may be some 2-3years, as Mrs [redacted] relies heavily on driving she would at least like to know if she can continue driving and if she would be regarded as an urgent patient, as she is unsure exactly how this condition will affect her quality of life, without a consultation.

Therefore, I would be most grateful if Mrs [redacted] could have her name expedited for an initial consultation and subsequently an operation.

I thank you in anticipation of your response.

Yours Sincerely
Carla Lockhart MLA BA Hons
[redacted]

Tel: [redacted]
Mob: [redacted]

FACEBOOK: Carla Condell Lockhart or Carla Lockhart
TWITTER: @carlalockhart

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## Corrigan, Martina

**From:** Corrigan, Martina
**Sent:** 21 March 2014 17:44
**To:** McMahon, Jenny
**Subject:** RE: Staffing in Thorndale Unit

Great Jenny

Thank you

Have a good weekend

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: McMahon, Jenny
Sent: 21 March 2014 16:43
To: Corrigan, Martina
Subject: RE: Staffing in Thorndale Unit

Hi Martina
I will work on this over the weekend and get it to you next week, thanks jenny

From: Corrigan, Martina
Sent: 20 March 2014 17:36
To: ONeill, Kate; McMahon, Jenny
Cc: Sharpe, Dorothy; Henry, Gillian; Reddick, Fiona
Subject: RE: Staffing in Thorndale Unit

Hi Kate and Jenny

I refer to the email below and before I set up a meeting I would be grateful if you could please forward me the information that I had asked for, which is mostly what support is required for each of the clinics in the Thorndale (consultant, registrar, specialist e.g. haematuria, biopsy and nurse led) can you also outline what each of the support that the staff provide at these clinics. . Also if you can include if the main OPD provides support and what this is.

I need to consider this in advance of the meeting as I don't want to be spending the time going through all of this at a meeting which will be used to consider further what additional staffing we may need.

Thanks

Martina

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

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: martina.corrigan Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 13 March 2014 18:17
To: Kate.ONeil Personal Information redacted by the USI; jenny.mcmahon Personal Information redacted by the USI
Cc: dorothy.sharpe Personal Information redacted by the USI; gillian.henry Personal Information redacted by the USI; Reddick, Fiona; Glackin, Anthony (anthony.glackin Personal Information redacted by the USI; 'O'Brien, Aidan'; Suresh, Ram; 'Young, Michael'
Subject: Staffing in Thorndale Unit

Hi ladies

In order to progress our conversations earlier today. I would be grateful if you could detail for me what support is needed at each of the clinics held in TDU and what each of the support staff do, e.g. peak flow, decontamination, history taking etc…… this should include all clinics including Consultant, haematuria, uro-oncology, prostate, LUTS etc……

Once I have this information I will organise a meeting so that we can discuss the best model that we feel for taking forward what we had discussed today and have it ready for presentation to the Consultants on 17 April.

Many thanks

Martina

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

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: martina.corrigan Personal Information redacted by the USI

## Corrigan, Martina

**From:** Corrigan, Martina
**Sent:** 28 March 2014 13:02
**To:** Carroll, Ronan
**Subject:** RE: Urology BC
**Attachments:** Urology Revenue Case v1 0.pdf

**Sensitivity:** Confidential

Ronan

See attached – note this is for consultant 4 & 5 we have not agreed the final funding for the 6th consultant who is due to start on 4 August.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: martina.corrigan Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 28 March 2014 12:36
To: Corrigan, Martina
Subject: Urology BC
Importance: High
Sensitivity: Confidential

Martina
Could you send me the above pls
Ronan

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
Personal Information redacted by USI

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

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

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

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

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

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

and assessment for suspected urological cancer patients.

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

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

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

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

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

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

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

**Network Development**

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

**Activity Assumptions**

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

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

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

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

**Pathway Development**

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

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

**Performance Indicators**

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

**Objectives**

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

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

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

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

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

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

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

## PROVIDER SECTIONS

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

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

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

**Background**

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

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

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

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

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

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

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

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

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

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

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

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

| | | |
|---|---|---|
| catchment area | | |

2b) What are the Constraints of the Project?

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

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

**Current Service Model**

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

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

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

**The Urology Team**

The integrated urology team comprises:

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

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

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

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

## Current Sessions

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

**Table 1: Current Urology Sessions**

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

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

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

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

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

## Current Activity

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

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

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

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

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

## 3) Option one: Status Quo or Base Case

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

Advantages

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

Disadvantages

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

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

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

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

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

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

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

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

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

Advantages

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

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

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

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

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

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

Disadvantages

Additional recurrent revenue investment will be required.

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

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

Advantages

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

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

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

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

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

Disadvantages

Additional non recurrent revenue investment will be required.

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

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

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

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

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

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

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

PLEASE LIST & SCORE BENEFITS THEN SHOW RANK OF OPTIONS

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

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

8) Financial Quantification of chosen option

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

Please note which option is the preferred option -

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

Note: Detail to be contained in costing appendix.

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

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

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

Notes:-

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

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

**9) Value for Money**

A) Efficiency Savings (Where applicable)

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

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

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

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

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

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

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

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

10) Preferred Option (Insert option number )

*Please rank costs and benefits and summarise reasons for selection.*

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

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

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

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

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

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

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

2 additional consultants and associated support staff would be appointed;

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

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

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

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

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

SBA Activity

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

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

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

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

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

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

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

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

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

The consequence and likelihood are combined to provide a risk rating

**Risk Rating**

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

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

*Inability to Appoint Consultant Urologists*

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

*Inability to Appoint Other Key Staff*

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

*Activity Projections are Not Achieved*

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

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

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

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

**Timetable for Implementation**

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

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

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

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

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

| | | |
|---|---|---|
| Trust Authorising Officer | | Date |
| Title | | |

| | | |
|---|---|---|
| Trust Director of Finance Signature | | Date |
| Trust Chief Executive Signature | | Date |

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

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

Responsible Person

Signature Date Position

Authorising Person

Signature Date Position

Director of Finance Authorisation or delegated officer

Signature Date Position

Chief Executive Authorisation

Signature Date Position

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

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

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

| Commissioner Use only |
|---|
| Sign and Date for TRAFFACS update |
| |

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

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

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

**Urology Staffing and Costs**

**v0.1 updated 12 Jan 2012**

**APPENDIX 1**

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

Notes:-

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

**Appendix 2**

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

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

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

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

**3.18% inflation**

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

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

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

ngements of the Board

## Corrigan, Martina

**From:** Corrigan, Martina
**Sent:** 07 April 2014 11:26
**To:** Corrigan, Martina
**Subject:** Fw: Mr O'Brien triage
**Attachments:** RE: Mr O'Brien triage.eml; REFERRALS.eml

Paulette

I refer to the below. Can I ask before you sent these letters back did you discuss with Mr Young?

This change in practice was agreed at a meeting with Mrs Burns, Interim Director for Acute Services Mr O'Brien and myself. And then in follow-up conversations with Mr Young.

I am now going to have to make alternative arrangements for next week to address this outstanding triage and I will have to escalate. In future for areas that you are unclear of can you please discuss with your managers so that we can clarify before any actions are taken.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology & Outpatients
Mobile Personal Information redacted by USI

From: Coleman, Alana
Sent: Friday, April 04, 2014 02:00 PM
To: Robinson, Katherine; Corrigan, Martina; Browne, Leanne
Subject: FW: Mr O'Brien triage

Hi Katherine/Martina,

Per email below we were advised to send Mr O'Brien triage to Mr young excluding named referrals. I have sent these to Mr Young's secretary and I have just received a batch of referrals date stamped 01/04/14 and 02/04/14 not triaged (more triage was also returned yesterday un-triaged but we have sent these back to Paulette). On the pro-forma which is sent with referrals Paulette has written *Mr Young not on call – Mr O'Brien* this was also written on the returned referrals yesterday.
I have attached emails between myself and Paulette regarding the triage, can you advise if these is a change from the email below and that the referrals do actually need to go to Mr O'Brien.

Thanks
Alana

From: Browne, Leanne
Sent: 06 March 2014 19:55
To: Coleman, Alana
Subject: FW: Mr O'Brien triage

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From: Robinson, Katherine

Sent: Thursday, March 06, 2014 7:54:55 PM
To: Browne, Leanne
Subject: Fw: Mr O'Brien triage
Auto forwarded by a Rule

From: Corrigan, Martina
Sent: Thursday, March 06, 2014 06:03 PM
To: Robinson, Katherine
Cc: Carroll, Anita; Trouton, Heather; Burns, Deborah
Subject: Mr O'Brien triage

Katherine

Debbie and I met with Mr O'Brien and he has agreed that apart from his own named referrals, that on the weeks that he is oncall he will be no longer triaging general urology letters.

Mr Young has asked that during the week of Mr O'Brien's oncall, can the general urology letters that Mr O'Brien would have triaged please be left with him for triaging.

I note that the next weekday that Mr O'Brien is oncall for March is actually 31 March, so this will not happen until then.

Any issues can you please highlight to me in the first instance.

Many thanks

Martina

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

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

## Corrigan, Martina

**From:** Dignam, Paulette [redacted]s>
**Sent:** 03 April 2014 11:19
**To:** Coleman, Alana
**Subject:** RE: Mr O'Brien triage

Hi Alana

I haven't been told this and on checking with Monica this morning she has informed me Mr O'Brien is triaging himself.

Many thanks
Paulette

From: Coleman, Alana
Sent: 03 April 2014 09:29
To: Dignam, Paulette
Subject: FW: Mr O'Brien triage

Hey,

Sorry was speaking with Leanne to try and figure out what's going on, email below indicates Mr Young has agreed to triage all Mr O'Brien triage apart from his named referrals.

Thanks
Alana

From: Browne, Leanne
Sent: 06 March 2014 19:55
To: Coleman, Alana
Subject: FW: Mr O'Brien triage

---
From: Robinson, Katherine
Sent: Thursday, March 06, 2014 7:54:55 PM
To: Browne, Leanne
Subject: Fw: Mr O'Brien triage
Auto forwarded by a Rule

From: Corrigan, Martina
Sent: Thursday, March 06, 2014 06:03 PM
To: Robinson, Katherine
Cc: Carroll, Anita; Trouton, Heather; Burns, Deborah
Subject: Mr O'Brien triage

Katherine

Debbie and I met with Mr O'Brien and he has agreed that apart from his own named referrals, that on the weeks that he is oncall he will be no longer triaging general urology letters.

Mr Young has asked that during the week of Mr O'Brien's oncall, can the general urology letters that Mr O'Brien would have triaged please be left with him for triaging.

I note that the next weekday that Mr O'Brien is oncall for March is actually 31 March, so this will not happen until then.

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Many thanks

Martina

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

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

## Corrigan, Martina

**From:** Dignam, Paulette <[redacted]
**Sent:** 03 April 2014 09:24
**To:** Coleman, Alana
**Subject:** REFERRALS

Hi Alana

Have been trying to phone you back but your line is constantly engaged. Mr Young is not triaging Mr O'Brien's referrals. He did some of his backlog to help clear this a while back but Mr O'Brien is doing his own triage.

Many thanks
Paulette

## Corrigan, Martina

**From:** Corrigan, Martina
**Sent:** 14 April 2014 19:03
**To:** McMahon, Jenny
**Cc:** ONeill, Kate
**Subject:** Re: BP monitor for Thorndale unit

Hi Jenny

Happy with you ordering this.

Regards

Martina

Martina Corrigan
Head of ENT, Urology & Outpatients
Mobile [redacted]

From: McMahon, Jenny
Sent: Monday, April 14, 2014 04:07 PM
To: Corrigan, Martina
Cc: ONeill, Kate
Subject: FW: BP monitor for Thorndale unit

Hi Martina
Please see advice below – just for information to let you know I will be submitting a request for the new BP machine (the cheaper one)which will be approx 1K. Just wanted to check with you before ordering - thanks Thanks jenny

From: McCauley, Ruth
Sent: 10 April 2014 13:12
To: McMahon, Jenny
Cc: Ross, Michael
Subject: BP monitor for Thorndale unit

Hi Jenny,

As per our telephone conversation, please find below requested information on vital signs monitors.

One of your current units, (GE Dinamap Procare 300 asset 51671 serial AAW06460410SA) was reported to us on 3 April 2014, as it often displayed the error code 950. Upon investigation, it has become apparent that repair of this would require a replacement main board at a cost of Â£625. Following discussion with my manager Michael Ross, my recommendation is that it is uneconomical to repair this device; a better use of funds would be to purchase a replacement device.

A like-for-like replacement is likely to be upwards of Â£1500. While I appreciate that it is often good practice to have uniformity of equipment in a department, I feel that in this case, a more cost-effective alternative is warranted.

In our experience, the Welch Allyn monitors provide excellent value for money. There are two options which I believe would be suitable for you; the Welch Allyn Spot, and the Welch Allyn 300 series. I have attached brochures for both, and there are many of these located throughout the hospital (including in main outpatients) so you can have a look at an actual unit if you wish. You will require a unit with NIBP and Nellcor SpO2; the printer & temperature options are not required. A roll stand is Â£133. A Welch Allyn Spot is Â£750, while a 300 series is

Â£900. MDI Medical are the agents for these; the sales rep is Caroline de Lacey (07771 858834.) Upon delivery of your new unit, please submit a STEAM-05 form to us (downloadable from the Trust Intranet) so we can asset tag it and ensure it will be maintained.

As discussed, I will return the Dinamap to you in the meantime, pending delivery of the replacement. It will continue to display this error, and there is every chance that it will become more frequent. To clear the error, switch the unit off and on again.

If you have any further queries, or I can be of any further assistance, please do not hesitate to contact me.

Kind regards,

Ruth McCauley

## Corrigan, Martina

**From:** Corrigan, Martina
**Sent:** 25 March 2015 17:52
**To:** ONeill, Kate; McMahon, Jenny; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; Suresh, Ram; Young, Michael
**Cc:** Graham, Vicki; Clayton, Wendy; Glenny, Sharon
**Subject:** FW: Urology PTL's
**Attachments:** 02_-_PTL'S_CANCER_62_DAY_PATHWAY_(CAPPS)(2).xls

**Importance:** High

Hi

For action please?

Thanks

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

From: Graham, Vicki
Sent: 25 March 2015 16:11
To: Corrigan, Martina
Cc: Clayton, Wendy; Glenny, Sharon
Subject: Urology PTL's
Importance: High

Martina,

Please see Urology PTL'S. I have highlighted the ones in yellow that have something outstanding.

Regards,

Vicki

| Primary Case Note Number | Hcn | Confirmed or Suspect | Suspect Tumour Site - Description | Pathway | Current wait | 62 Day Breach (Y/N) | Date of Referral | Date First seen | Date Decision to Treat | Target date | Date treatment planned | Treatment Planned Y\N | Planned 1st treatment type | Last Diary Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 58 | N | 26/01/2015 | 12/03/2015 | | 29/03/2015 | | N | | For TRUSB - DATE TO BE ARRANGED. |
| | | Suspect | Urological Cancer | 62 | 55 | N | 29/01/2015 | 09/02/2015 | | 01/04/2015 | 01/04/2015 | Y | Surgery | Surgery scheduled on target |
| | | Suspect | Urological Cancer | 62 | 51 | N | 02/02/2015 | 11/02/2015 | | 05/04/2015 | | N | Surgery | Patient has review on 27.03.15 to schedule surgery. |
| | | Confirmed | Urological Cancer | 62 | 50 | N | 03/02/2015 | 12/02/2015 | | 06/04/2015 | | N | Watchful Waiting | 24/03/2015 Rebooked for 27.3.15 - to recommend watchful waiting. Appointment for 23.3.15 cancelled as patient needed ambulance (it was not possible to get one for that date) Marie Dabbous<br>18/03/2015 Review with Mr Haynes - 23.03.15 - to recommend watchful waiting. Vicki Graham |
| | | Suspect | Urological Cancer | 62 | 47 | N | 06/02/2015 | 03/03/2015 | | 09/04/2015 | | N | | Awaiting outcome from Clinic 05.03.15 - Mr O'Donoghue - secretary has been emailed. |
| | | Confirmed | Urological Cancer | 62 | 46 | N | 17/12/2014 | 30/12/2014 | | 10/04/2015 | | N | | For MDM on 27.03.15 with staging MRI Prostate results. |
| | | Suspect | Urological Cancer | 62 | 44 | N | 09/02/2015 | 02/03/2015 | | 12/04/2015 | 01/04/2015 | Y | Surgery | Surgery remains scheduled on target 01.04.15. |
| | | Confirmed | Urological Cancer | 62 | 42 | N | 04/12/2014 | 15/12/2014 | | 14/04/2015 | | N | | Awaiting outcome from 19.03.15 - Mr O'Donoghue - this was a clinic to decide on treatment - risk of breaching & being late ITT |
| | | Confirmed | Urological Cancer | 62 | 40 | N | 05/12/2014 | 30/12/2014 | | 16/04/2015 | | N | | For MDM on 27.03.15 with staging MRI Prostate results. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 40 | N | 13/02/2015 | 05/03/2015 | | 16/04/2015 | | N | | Date outstanding for TRUSB on sectra. |
| | | Confirmed | Urological Cancer | 62 | 40 | N | 13/02/2015 | 04/03/2015 | | 16/04/2015 | 25/03/2015 | Y | Surgery | Surgery scheduled for today, 25.05.15, on target. |
| | | Suspect | Urological Cancer | 62 | 37 | N | 16/02/2015 | 20/02/2015 | | 19/04/2015 | | N | | Await outcome from clinic on 05.03.15 - Mr O'Donoghue |
| | | Suspect | Urological Cancer | 62 | 37 | N | 16/02/2015 | 26/02/2015 | | 19/04/2015 | | N | | TRUSB appointed for 14.04.15 - Day 57 - patient at high risk of breaching. Vicki Graham<br>05/03/2015 Update from Kate - I want to discuss this patient with Karen the Reg as his PSA has fallen by half in one week without any antibiotic treatment, she may wish to repeat it in one month or given the DRE findings she may wish to go ahead with biopsy. Vicki Graham |
| | | Suspect | Urological Cancer | 62 | 35 | N | 18/02/2015 | 04/03/2015 | | 21/04/2015 | | N | | 24/03/2015 PSA to be repeated. Await clinic outcome from 4.3.15. Shauna McVeigh<br>24/03/2015 Patient attended appointment 4.3.15 await outcome. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 35 | N | 18/02/2015 | 27/02/2015 | | 21/04/2015 | | N | | O'Brien is referring him to a Urologist in Liverpool. Emailed AOB to enquire when patient is moving to Liverpool and being closed off in southern trust. Marie Dabbous<br>19/03/2015 Discussed @ Urology MDM 19.3.15. Mr O¿Brien to contact Personal information and reassure. To refer to local urologist in Liverpool for ongoing follow-up after relocation. Marie Dabbous |
| | | Suspect | Urological Cancer | 62 | 35 | N | 18/02/2015 | 09/03/2015 | | 21/04/2015 | 08/04/2015 | Y | Surgery | 18/03/2015 Surgery remains scheduled on target 08.04.15 - for MDM on 16.04.15 with results. Vicki Graham<br>13/03/2015 Pre admitted for 8.4.15 schedule for MDM with results. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 33 | N | 20/02/2015 | 03/03/2015 | | 23/04/2015 | 20/03/2015 | Y | Surgery | 18/03/2015 Surgery remains scheduled on target for 20.03.15. Vicki Graham<br>12/03/2015 Patient had been pre admitted for 20.3.15 for cystoscopy and bladder biopsy. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 33 | N | 20/02/2015 | 04/03/2015 | | 23/04/2015 | | N | | PSA is elevated - had emailed Mr Haynes results & requested management update on 18.03.15 - response awaited. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 30 | N | 23/02/2015 | 05/03/2015 | | 26/04/2015 | | N | | 23/03/2015 20.3.15 GFR 46, Hb 14.4. Urine 5.3.15 - Atypia, suspious of malignancy. Emailed secretary to request clinic outcome. Marie Dabbous<br>18/03/2015 CT U reports - No malignancy in the upper tracts identified. Clinic outcome awaited from 05.03.15 - Mr Young. Vicki Graham |
| | | Suspect | Urological Cancer | 62 | 30 | N | 23/02/2015 | 05/03/2015 | | 26/04/2015 | | N | | For MDM on 27.03.15 with bone scanning results. |
| | | Suspect | Urological Cancer | 62 | 30 | N | 23/02/2015 | 05/03/2015 | | 26/04/2015 | | N | | 24/03/2015 Await clinic outcome from 5.3.15. Emailed secretary for this. Shauna McVeigh<br>18/03/2015 Await clinic outcome from 5.3.15. Nothing on patient centre or sectra. Vicki Graham |
| | | Confirmed | Urological Cancer | 62 | 29 | N | 31/12/2014 | 07/01/2015 | | 27/04/2015 | | N | | ITT to Belfast pn Day 29. |
| | | Suspect | Urological Cancer | 62 | 29 | N | 17/02/2015 | 12/03/2015 | | 27/04/2015 | 15/04/2015 | Y | | Surgery scheduled for 15.04.15 - on target. |
| | | Suspect | Urological Cancer | 62 | 29 | N | 24/02/2015 | 11/03/2015 | | 27/04/2015 | | N | | Mr Haynes was emailed to request CTU - this is not on system. |
| | | Suspect | Urological Cancer | 62 | 29 | N | 24/02/2015 | 11/03/2015 | | 27/04/2015 | | N | | Cystoscopy & biopsy has been performed - to be discussed @ MDM on 26.03.15 with results. |
| | | Suspect | Urological Cancer | 62 | 28 | N | 25/02/2015 | 11/03/2015 | | 28/04/2015 | | N | | 23/03/2015 Await clinic outcome from 11.03.15. No request on sectra, nothing on patient centre or PAS. Shauna McVeigh<br>19/03/2015 Await clinic outcome from 11.03.15. Shauna McVeigh |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 28 | N | 25/02/2015 | 11/03/2015 | | 28/04/2015 | | N | | 23/03/2015 Await clinic outcome from 11.3.15. US urinary tract has been requested and approved as routine. Shauna McVeigh<br>19/03/2015 Await clinic outcome from 11.3.15. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 28 | N | 25/02/2015 | 10/03/2015 | | 28/04/2015 | | N | | 24/03/2015 Review appointment booked for 1.4.15. Shauna McVeigh<br>19/03/2015 Discussed @ Urology MDM 19.3.15. Personal Information s prostate biopsies have shown a Gleason 4+5=9 prostate cancer. For outpatients review with Mr Suresh to arrange CT CAP, Bone scan, commencement of hormonal manipulation and subsequent MDM discussion. Marie Dabbous |
| | | Suspect | Urological Cancer | 62 | 28 | N | 01/12/2014 | 09/12/2014 | | 28/04/2015 | | N | | 23/03/2015 Only passed fit 19.3.15. On an Urgent w/l for TURP - no date yet. Emailed RS to enquire can patient be downgraded Marie Dabbous<br>19/03/2015 On an Urgent w/l for TURP - no date yet. Emailed RS to enquire can patient be downgraded Marie Dabbous |
| | | Suspect | Urological Cancer | 62 | 27 | N | 26/02/2015 | 12/03/2015 | | 29/04/2015 | | N | | [illegible] on 27.3.15. Shauna McVeigh<br>23/03/2015 Clinic outcome from 12.3.15: On examination his abdomen was soft and non tender. He had fullness generally but no discrete mass. He did however have palpable inguinal lymph nodes. His testes were normal. Penis was normal. He had phimosis but there is no gross abnormality. On DRE I was unable to feel the whole gland but that which I did feel was benign. He underwent a flexible cystoscopy which showed a normal urethra and irregular prostatic fossa with regrowth of the prostate, a large bladder div Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 27 | N | 26/02/2015 | | | 29/04/2015 | | N | | 16/03/2015 HAEMATURIA UPGRADED REFERRAL RECEIEVED IN RED FLAG OFFICE 13.03.15- ESCALATEDCAJGTDU 25.03.15 D27 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 27 | N | 31/12/2014 | 07/01/2015 | | 29/04/2015 | | N | | [illegible] urogram but a CT with no IV contrast due to a prior reaction. No renal tract stone disease was seen. No left or right-sided renal tract dilatation. any further tests? Marie Dabbous<br>18/03/2015 CT U appointed for 20.3.15. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 27 | N | 26/02/2015 | 12/03/2015 | | 29/04/2015 | | N | | 23/03/2015 Await clinic outcome from 12.3.15. Nothing on sectra or patient centre or PAS. Shauna McVeigh<br>19/03/2015 Await clinic outcome from 12.03.15. Nothing requested on sectra. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 27 | N | 26/02/2015 | 12/03/2015 | | 29/04/2015 | | N | | 23/03/2015 Await clinic outcome from 12.3.15. Shauna McVeigh<br>06/03/2015 RB SUR 12.03.15 D14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 26 | N | 27/02/2015 | 12/03/2015 | | 30/04/2015 | | N | | 23/03/2015 Await clinic outcome from 12.3.15. Nothing on sectra or patient centre. Shauna McVeigh<br>03/03/2015 PROSTATE - ? TRUS IN CLINIC - CJODTDU 12.03.15 D13 Caroline Davies |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 26 | N | 21/02/2015 | 10/03/2015 | | 30/04/2015 | | N | | 24/03/2015 CT U remains appointed for 27.3.15. Shauna McVeigh<br>12/03/2015 CT U has been appointed for 27.3.15. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 26 | N | 27/02/2015 | 12/03/2015 | | 30/04/2015 | | N | | 23/03/2015 Await clinic outcome from 12.3.15. Emailed Eoin to get an outcome. CT 18.3.15: Progression of features of spiculated pleural thickening and bilateral pulmonary nodules. Malignancy needs to be excluded.Recommendation: Urgent respiratory opinion advised.Urgent report. Shauna McVeigh<br>03/03/2015 PROSTATE - ? TRUS IN CLINIC CJODTDU 12.03.15 D13 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 26 | N | 18/02/2015 | 19/03/2015 | | 30/04/2015 | | N | | 24/03/2015 Await clinic outcome from 19.3.15. CT U 24.2.15: No other significant abnormality identified in either the abdominal or pelvic cavity on these images with IV contrast only. Shauna McVeigh<br>04/03/2015 Paitent cancelled appointment and has been rebooked for 19.03.15. Vicki Graham |
| | | Suspect | Urological Cancer | 62 | 25 | N | 12/02/2015 | 10/03/2015 | | 01/05/2015 | | N | | 20.3.15 and requests no further appointments to be sent out. Await clinic outcome from 10.3.15. Shauna McVeigh<br>09/03/2015 Patient cancelled CT U on day of appointment & has been rebooked for 16.03.15 - adjustment added. Appointment remains booked for 10.03.15. Vicki Graham |
| | | Suspect | Urological Cancer | 62 | 24 | N | 02/02/2015 | 09/02/2015 | | 02/05/2015 | | N | | to see if he needs to proceed to prostate biopsies. Shauna McVeigh<br>09/03/2015 Email back from Jenny to say there hasnt been a decision made whether he will be for biopsy. Shauna McVeigh |
| | | Confirmed | Urological Cancer | 62 | 24 | N | 14/01/2015 | 21/01/2015 | | 02/05/2015 | | N | | when results are ready. MRI not ready for MDM 19.3.15. For MDM discussion 26.3.15. Marie Dabbous<br>10/03/2015 For MDM discussion 19.3.15 with results of MRI 14.3.15 & Bone Scan 24.2.15. Marie Dabbous |
| | | Suspect | Urological Cancer | 62 | 23 | N | 02/03/2015 | 10/03/2015 | | 03/05/2015 | | N | | 23/03/2015 Await clinic outcome from 10.03.15. CT U appointed for 24.03.15. Shauna McVeigh<br>19/03/2015 Await clinic outcome from 10.3.15. CT U has been appointed for 24.3.15. Shauna McVeigh |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 23 | N | 06/02/2015 | 19/03/2015 | | 03/05/2015 | | N | | cystoscopy its expected to be early April date to be defined. Shauna McVeigh<br>24/03/2015 Clinic outcome from 19.3.15: On examination today her abdomen was soft and tender with no obvious prolapse. Flexible cystoscopy was performed today in view of her ongoing haematuria. This revealed 2 small raised reddened areas on the posterior wall of her bladder. In view of her multiple comorbidities including rheumatoid arthritis, AF, Warfarin, heart failure, ejection fraction of 35%, pulmonary fibrosis, COPD, hypertension and diabetes she would certainly be a high anaesthetic risk. In view of Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 23 | N | 16/02/2015 | 11/03/2015 | | 03/05/2015 | | N | | 18/03/2015 Patient attended appointment 11.3.15 - await clinic outcome. Shauna McVeigh<br>06/03/2015 Appoinment rebooked for 11.3.15. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 23 | N | 02/03/2015 | 10/03/2015 | | 03/05/2015 | | N | | 19/03/2015 Await MSU results before TRUS biopsy. Shauna McVeigh<br>12/03/2015 Clinic outcome from 10.3.15: With regards to his abnormal digital rectal examination I will arrange for him to return for a red flag TRUS biopsy. Unfortunately this could not be performed today either both due to his urinary tract infection and the fact he is on Plavix. I have prescribed him a course of antibiotics and I have sent an MSSU today. He will re-attend the Thorndale Unit within 2-3 weeks for ultrasound guided biopsy of his prostate, flexible cystoscopy and post void residual. He will Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 23 | N | 02/03/2015 | 12/03/2015 | | 03/05/2015 | | N | | 23/03/2015 Await clinic outcome from 12.3.15 nothing on sectra or patient centre, and no further appointments on PAS. Shauna McVeigh<br>23/03/2015 Await clinic outcome from 12.3.15. Nothing requested on sectra. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 23 | N | 02/03/2015 | 09/03/2015 | | 03/05/2015 | | N | | 19/03/2015 PSA to be rechecked - patient has been pre assessment appointment 22.4.15. Shauna McVeigh<br>13/03/2015 Await date for TURP/TRUS is currently on WL. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 23 | N | 02/03/2015 | 18/03/2015 | | 03/05/2015 | | N | | 23/03/2015 Await clinic outcome from 18.3.15. CT U requested for 23.3.15. Shauna McVeigh<br>06/03/2015 DHH HAEMATURIA HAEMAT 18.03.15 D16 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 22 | N | 03/03/2015 | | | 04/05/2015 | | N | | 13/03/2015 cmdhtdu 250315 d22 Caroline Davies<br>11/03/2015 CT U appointed for 23.3.15. Shauna McVeigh |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 22 | N | 03/03/2015 | 10/03/2015 | | 04/05/2015 | | N | | 12/03/2015 Await PSA result in April. Shauna McVeigh<br>12/03/2015 Clinic outcome from 10.3.15: On examination today his abdomen was soft and non-tender. He did however have a tender firm enlarged prostate. I have advised him to continue with his antibiotics for a total course of 4 weeks and have advised him to have his PSA repeated at your surgery at the start of April following completion of his antibiotics. We will arrange to review him in clinic in approximately mid-April following his PSA. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 22 | N | 03/03/2015 | 19/03/2015 | | 04/05/2015 | | N | | 23/03/2015 Await clinic outcome from 19.03.15. CT U has been appointed for 26.3.15. Shauna McVeigh<br>11/03/2015 cchaem 19.03.15 d16 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 21 | N | 04/03/2015 | 18/03/2015 | | 05/05/2015 | | N | | 20/03/2015 To be added to TRUSB W/L. Emailed Thorndale to enquire if patient is remaining on RF pathway as biopsy was not taken at clinic or was it patients' choice. Marie Dabbous<br>09/03/2015 prostate - cmdhtdu 18.03.15 D14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 21 | N | 04/03/2015 | 11/03/2015 | | 05/05/2015 | | N | | 23/03/2015 Await clinic outcome from 11.3.15. Nothing has been requested on sectra and on PAS it says to review patient in 6-8 months time. Shauna McVeigh<br>19/03/2015 Await clinic outcome from 11.3.15. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 21 | N | 26/02/2015 | 19/03/2015 | | 05/05/2015 | | N | | 23/03/2015 Patient cancelled appointment for 11.3.15. Attended 19.3.15 - await outcome. US Testes has been requested and appointed for 27.3.15. Shauna McVeigh<br>19/03/2015 Await clinic outcome from 11.03.15. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 21 | N | 04/03/2015 | 11/03/2015 | | 05/05/2015 | | N | | 19/03/2015 Await clinic outcome from 11.3.15. CT U has been appointed for 24.3.15. Shauna McVeigh<br>13/03/2015 Await clinic outcome from 11.3.15. CT U has been requested but needs appointed. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 21 | N | 10/02/2015 | | | 05/05/2015 | | N | | 12.3.15 await outcome. Has been pre admitted for 16.4.15 for a flexible sigmoidoscopy. Shauna McVeigh<br>17/03/2015 Patient DNA'd US Urinary Tract. ? Any further requests - check system and if not close as this is the 3rd appointment DNA'd. Marie Dabbous |
| | | Suspect | Urological Cancer | 62 | 20 | N | 05/03/2015 | | | 06/05/2015 | | N | | 24/03/2015 Patient was a past patient of Mr O'Brien Mr Haynes' secretary emailed to advise that she had spoken with Mr O'Brien and that he is to review the patient at his clinic on the 27.03.15. Mr O'Brien is waiting on histopathology results be for determining whether patient is to continue on the Cancer Pathway. Caroline Davies<br>23/03/2015 Caroline rang to say that patients notes have been received but Mr Haynes is to look at them she has sent an email advising him that they are there. Shauna McVeigh |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 20 | N | 05/03/2015 | 19/03/2015 | | 06/05/2015 | | N | | 23/03/2015 Await clinic outcome from 19.03.15. Shauna McVeigh<br>11/03/2015 haematuria- cchaem 19.03.15 d14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 20 | N | 05/03/2015 | 19/03/2015 | | 06/05/2015 | | N | | 23/03/2015 Await clinic outcome from 19.03.15. Shauna McVeigh<br>11/03/2015 haematuria 19.03.15 d14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 20 | N | 05/03/2015 | 18/03/2015 | | 06/05/2015 | | N | | 09/03/2015 HAEMATURIA APPOINTMENT IN DHH 18.03.15 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 19 | N | 06/03/2015 | 24/03/2015 | | 07/05/2015 | | N | | 13/03/2015 prostate - late gp upgrade escalated - ckstdu 24.03.15 d18 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 19 | N | 06/03/2015 | | | 07/05/2015 | | N | | 16/03/2015 HAEMTURIA UPGRADE RECEIVED 13.03.15 CAJGTDU 25.03.15 D19 ESCALATED Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 19 | N | 06/03/2015 | 12/03/2015 | | 07/05/2015 | | N | | 23/03/2015 Await clinic outcome from 12.3.15. Nothing on sectra or PAS or patient centre. Shauna McVeigh<br>09/03/2015 PROSTATE - CJODTDU 12.03.15 D6 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 19 | N | 06/03/2015 | | | 07/05/2015 | | N | | 18/03/2015 CCHAEM 26.03.15 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 19 | N | 06/03/2015 | 11/03/2015 | | 07/05/2015 | | N | | 18/03/2015 For MDM discussion with both pathology & bone scan results. Marie Dabbous<br>12/03/2015 Prostate biopsy 11.3.15. Added for MDT discussion with pathology. Bone scan to be requested. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 19 | N | 06/03/2015 | 23/03/2015 | | 07/05/2015 | | N | | 13/03/2015 CAJGTDU 23.03.15 D17 GP UP[GRADE - PROSTATE Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 19 | N | 06/03/2015 | | | 07/05/2015 | | N | | 23/03/2015 Appointment booked for 25.3.15. Shauna McVeigh<br>16/03/2015 PROSTATE GP UPGRADE REFERRAL RECEIVED 13.03.15 CMDHTDU D19 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 19 | N | 06/03/2015 | 18/03/2015 | | 07/05/2015 | | N | | 23/03/2015 Await clinic outcome from 18.03.15. CT U has been appointed for 24.3.15. Shauna McVeigh<br>09/03/2015 HAEMATURIA APPOINTMENT IN DHH 18.03.15 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 19 | N | 06/03/2015 | 18/03/2015 | | 07/05/2015 | | N | | 23/03/2015 Await clinic outcome from 18.3.15. CT U has been appointed for 23.3.15. Shauna McVeigh<br>09/03/2015 HAEMATURIA APPOINTMENT DHH 18.03.15 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 18 | N | 02/03/2015 | 23/03/2015 | | 08/05/2015 | | N | | 11/03/2015 HAEMATURIA - CTU not performed as patient has had allergic reaction to Iv before so I have just went ahead and booked patient to CAJGTDU 23.03.15 Caroline Davies<br>10/03/2015 CT U has not been appointed. Shauna McVeigh |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 16 | N | 09/03/2015 | 19/03/2015 | | 10/05/2015 | | N | | 23/03/2015 Await clinic outcome from 19.3.15. Shauna McVeigh<br>09/03/2015 HAEMATURIA - OFFERED CCHAEM 12.03.15 D3 BUT UNABLE TO ATTEND REBOOKED FOR CCHAEM 19.03.15 D10 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 16 | N | 09/03/2015 | 16/03/2015 | | 10/05/2015 | | N | | 23/03/2015 Await clinic outcome from 16.03.15. No date for bone scan. Shauna McVeigh<br>18/03/2015 Bone Scan -await date. CT 23.3.15. On warfarin for AF. Large left pleaural effusion- getting worse. Recent proven UTIs. PSA has gone up from 14 to 17. DRE- Hard irregular prostate. Marie Dabbous |
| | | Suspect | Urological Cancer | 62 | 16 | N | 09/03/2015 | 12/03/2015 | | 10/05/2015 | | N | | 23/03/2015 Sent Leanne an email regarding this patient as no US has been requested. Shauna McVeigh<br>23/03/2015 CT U 16.3.15: Equivocal filling defect at UB anteriorly required US verification. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 16 | N | 09/03/2015 | | | 10/05/2015 | | N | | 23/03/2015 OP appointment with telescope examination of the bladder performed at the same attendance - 26.3.15 (D17). US completed on 20.3.15. Marie Dabbous<br>19/03/2015 US has been booked for 20.3.15 then outpatient appointment 26.3.15. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 16 | N | 09/03/2015 | | | 10/05/2015 | | N | | 16/03/2015 HAEMATURIA GP UPGRADE RECEIVED 13.03.15 CAJGTDU 25.03.15 D 16 ESCALATED Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 16 | N | 09/03/2015 | | | 10/05/2015 | | N | | 20/03/2015 haemat 01.04.15 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 16 | N | 09/03/2015 | 19/03/2015 | | 10/05/2015 | | N | | 23/03/2015 Await clinic outcome from 19.3.15. CT U 19.3.15: No apparent cause haematuria identified. Shauna McVeigh<br>20/03/2015 rb sur 19.03.15 d10 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 15 | N | 10/03/2015 | 24/03/2015 | | 11/05/2015 | | N | | 16/03/2015 HAEMATURIA UPGRADE CMDHTDU 25.03.15 d13 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 15 | N | 10/03/2015 | | | 11/05/2015 | | N | | 20/03/2015 25.03.15 d15 rb sur Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 15 | N | 10/03/2015 | | | 11/05/2015 | | N | | 24/03/2015 Haematuria appointment booked for 1.4.15. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 15 | N | 10/03/2015 | 19/03/2015 | | 11/05/2015 | | N | | 19/03/2015 Discussed @ Urology MDM 19.3.15. Personal information redacted by HSCB has a small renal mass on CT abdomen and Pelvis. Mr Brown to arrange a CT Renal and subsequent MDM discussion. Marie Dabbous<br>11/03/2015 RB SUR 19.03.15 D9 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 14 | N | 11/03/2015 | | | 12/05/2015 | | N | | 16/03/2015 HAEMATURIA - GP UPGRADE RECEIVED 11.03.15 CCHAEM 26.03.15 D15 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 14 | N | 11/03/2015 | | | 12/05/2015 | | N | | 16/03/2015 haematuria upgrade: cajgtdu 25.03.15 d14 Caroline Davies |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 14 | N | 11/03/2015 | 24/03/2015 | | 12/05/2015 | | N | | 13/03/2015 prostate - ckstdu 24.03.15 d13 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 14 | N | 11/03/2015 | | | 12/05/2015 | | N | | 16/03/2015 HAEMATURIA UPGRADE RECEIVED 13.03.15 CCHAEM 26.03.15 D15 - ESCALATED Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 14 | N | 11/03/2015 | | | 12/05/2015 | | N | | 16/03/2015 HAEMATURIA UPGRADE RECEIVED 13.03.15 BOOKED CMDHTDU 25.03.15 D14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 14 | N | 11/03/2015 | | | 12/05/2015 | | N | | 16/03/2015 DHH HAEMATURIA 25.03..15 D14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 14 | N | 03/02/2015 | | | 12/05/2015 | | N | | 24/03/2015 Await clinic outcome from 19.3.15. Patient has been pre admitted for 2.4.15 to DHH. CT U has been appointed for 26.3.15. Shauna McVeigh<br>13/03/2015 Patient had cancelled 11.3.15 has been rebooked for 19.3.15. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 14 | N | 27/02/2015 | | | 12/05/2015 | | N | | 11/03/2015 haematuria patient offered 19.03.15 d20 in cah but prefers to wait for date from dhhbooked for 25.03.15 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 13 | N | 12/03/2015 | 19/03/2015 | | 13/05/2015 | | N | | 23/03/2015 CTU 27.3.15 (D15) OOH 21.3.15: Cystitis. Marie Dabbous<br>13/03/2015 cmytdu 19.03.15 d 7 - haematuria Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 13 | N | 12/03/2015 | | | 13/05/2015 | | N | | 16/03/2015 CCHAEM 26.03.15 D14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 13 | N | 03/03/2015 | | | 13/05/2015 | | N | | 19/03/2015 Patient DNA appointment 12.03.15. Emailed Bronagh to advise her as patient will need one more appointment. Shauna McVeigh<br>06/03/2015 RB SUR 12.03.15 D9 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 13 | N | 12/03/2015 | | | 13/05/2015 | | N | | 20/03/2015 haemat 01.04.15 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 13 | N | 12/03/2015 | 19/03/2015 | | 13/05/2015 | | N | | 19/03/2015 Discussed at Urology MDM 19.03.15. For rediscussion at MDM when imaging has been completed. Marie Dabbous<br>13/03/2015 Patient has outpatients appointment for 19.3.15. Email for Mr Glackin to ask patient be added to MDT. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 12 | N | 13/03/2015 | | | 14/05/2015 | | N | | 18/03/2015 testicular cmdhreg 25.03.15 d 12 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 12 | N | 03/03/2015 | | | 14/05/2015 | | N | | 19/03/2015 CT U now appointed for 30.3.15. Patient was an in patient and only discharged on 16.3.15. Shauna McVeigh<br>10/03/2015 CT U has been appointed for 16.3.15. Shauna McVeigh |
| | | Suspect | Urological Cancer | 62 | 9 | N | 16/03/2015 | | | 17/05/2015 | | N | | 18/03/2015 haematuria - cajgtdu 30.03.15 d14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 9 | N | 16/03/2015 | | | 17/05/2015 | | N | | 18/03/2015 haematuria cajgtdu 30.03.15 d14 Caroline Davies |

| Personal Information redacted by USI | Personal Information redacted by USI | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Suspect | Urological Cancer | 62 | 9 | N | 09/03/2015 | | | 17/05/2015 | | N | | 11/03/2015 prostate offered d9 cmdgreg 18.02.15 didn't suit rebooked to 23.03.15 CAJGTDU d12 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 9 | N | 16/03/2015 | | | 17/05/2015 | | N | | 18/03/2015 CJODTDU 30.03.15 D14 PROSTATE Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 9 | N | 06/03/2015 | | | 17/05/2015 | | N | | 19/03/2015 Check CT U results 25.3.15. Outpatient appointment booked for 30.3.15. Shauna McVeigh<br>13/03/2015 cjodtdu - 30.03.15 D24 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 9 | N | 16/03/2015 | | | 17/05/2015 | | N | | 18/03/2015 TESTICULAR: CJODTDU 30.03.15 D 14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 9 | N | 16/03/2015 | | | 17/05/2015 | | N | | 18/03/2015 RENAL LESION: CJODTDU 30.03.15 D 14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 9 | N | 16/03/2015 | | | 17/05/2015 | | N | | 18/03/2015 haematuria cjodreg 30.03.15 d14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 9 | N | 16/03/2015 | | | 17/05/2015 | | N | | 20/03/2015 HAEMATURIA CKSTDU 31.03.15 D15 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 9 | N | 16/03/2015 | | | 17/05/2015 | | N | | 20/03/2015 HAEMATURIA - CMDHTDU 25.03.15 D9 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 9 | N | 16/03/2015 | | | 17/05/2015 | | N | | |
| | | Suspect | Urological Cancer | 62 | 9 | N | 16/03/2015 | | | 17/05/2015 | | N | | 18/03/2015 prostate cajgtdu 30.03.15 d14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 8 | N | 17/03/2015 | | | 18/05/2015 | | N | | |
| | | Suspect | Urological Cancer | 62 | 7 | N | 18/03/2015 | 24/03/2015 | | 19/05/2015 | | N | | 23/03/2015 Await clinic outcome 24.3.15. Marie Dabbous<br>20/03/2015 U/S 16.3.15. CT 19.3.15. Results emailed to AOB Marie Dabbous |
| | | Suspect | Urological Cancer | 62 | 7 | N | 18/03/2015 | | | 19/05/2015 | | N | | 19/03/2015 PROSTATE? - CKSTDU 31.03.15 D 13 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 7 | N | 18/03/2015 | | | 19/05/2015 | | N | | 19/03/2015 PROSTATE - CKSTDU D13 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 7 | N | 18/03/2015 | | | 19/05/2015 | | N | | 19/03/2015 HAEMATURIA - CAOBTDU 31.03.15 D 13 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 7 | N | 18/03/2015 | | | 19/05/2015 | | N | | 18/03/2015 HAEM: CJODTDU 26.03.15 D14 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 7 | N | 18/03/2015 | | | 19/05/2015 | | N | | 19/03/2015 haematuria - ckstdu 31.03.15 d13 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 7 | N | 18/03/2015 | | | 19/05/2015 | | N | | 20/03/2015 offered CKSTDU 31.03.15 - HAEMATURIA Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 6 | N | 19/03/2015 | | | 20/05/2015 | | N | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 6 | N | 19/03/2015 | | | 20/05/2015 | | N | | 20/03/2015 haematuria - CAJGTDU 30.03.15 D11 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 6 | N | 19/03/2015 | 24/03/2015 | | 20/05/2015 | | N | | 19/03/2015 haematuria- CKSTDU 24.03.15 D5 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 5 | N | 20/03/2015 | | | 21/05/2015 | | N | | 23/03/2015 haematuria - cmdhtdu 01.04.15 d12 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 5 | N | 12/03/2015 | | | 21/05/2015 | | N | | 16/03/2015 haematuria upgrade: cmdhtdu 25.03.15 d 13 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 5 | N | 13/03/2015 | | | 21/05/2015 | | N | | 18/03/2015 prostaste cajgtdu 30.03.15 d 17 escalated Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 5 | N | 09/03/2015 | | | 21/05/2015 | | N | | 16/03/2015 PROSTATE UPGRADE RECEIVED 13.03.15. CAJGTDU 25.03.15 D16 ESCALATED Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 5 | N | 20/03/2015 | | | 21/05/2015 | | N | | 23/03/2015 PROSTATE PATIENT - CJODTDU 26.06.15 D6 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 2 | N | 23/03/2015 | | | 24/05/2015 | | N | | 23/03/2015 Await clinic outcome: US Abdomen 20.3.15: Right kidney measures 7.9cm in bipolar diameter. There is a 5.5 x 5.5cm rounded mass of mixed echogenicity arising from the lower pole of the right kidney. Marie Dabbous<br>23/03/2015 RENAL MASS CJODTDU 26.03.15 D3 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 2 | N | 23/03/2015 | | | 24/05/2015 | | N | | |
| | | Suspect | Urological Cancer | 62 | 2 | N | 12/03/2015 | | | 24/05/2015 | | N | | 18/03/2015 cajgtdu 23.03.15 d 11 (pea sized lump in rt lobe) Caroline Davies<br>16/03/2015 AWAITING TRIAGE Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 2 | N | 23/03/2015 | | | 24/05/2015 | | N | | |
| | | Suspect | Urological Cancer | 62 | 2 | N | 23/03/2015 | | | 24/05/2015 | | N | | 23/03/2015 CAJGREG 30.03.15 PROSTATE Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 2 | N | 23/03/2015 | | | 24/05/2015 | | N | | 23/03/2015 PROSTATE - CMDHTDU 01.04.15 D9 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 2 | N | 23/03/2015 | | | 24/05/2015 | | N | | |
| | | Suspect | Urological Cancer | 62 | 2 | N | 23/03/2015 | | | 24/05/2015 | | N | | |
| | | Suspect | Urological Cancer | 62 | 1 | N | 03/03/2015 | | | 25/05/2015 | | N | | 23/03/2015 Patient cancelled 16.3.15 and rebooked for 24.3.15. Adjustment in. 1st appointment 18.3.15 - given earlier appointment. Marie Dabbous<br>06/03/2015 Cons clinic for lesion on penis - ckstdu 16.02.15 d13. Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 1 | N | 24/03/2015 | | | 25/05/2015 | | N | | |
| | | Suspect | Urological Cancer | 62 | 1 | N | 24/03/2015 | | | 25/05/2015 | | N | | |
| | | Suspect | Urological Cancer | 62 | 1 | N | 24/03/2015 | | | 25/05/2015 | | N | | |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by USI | Personal Information redacted by USI | Suspect | Urological Cancer | 62 | 1 | N | 24/03/2015 | | | 25/05/2015 | | N | | |
| | | Suspect | Urological Cancer | 62 | 1 | N | 20/03/2015 | | | 25/05/2015 | | N | | 23/03/2015 HAEMATURIA CJODTDU 02.04.15 D13 Caroline Davies |
| | | Suspect | Urological Cancer | 62 | 1 | N | 24/03/2015 | | | 25/05/2015 | | N | | |
| | | Suspect | Urological Cancer | 62 | 1 | N | 24/03/2015 | | | 25/05/2015 | | N | | |

## Corrigan, Martina

**From:** Corrigan, Martina
**Sent:** 02 June 2019 13:52
**To:** ONeill, Kate
**Subject:** AFC
**Attachments:** Changed post sign off sheet CNS.docx; Organisational Chart Urology CNS.doc; new JD for Kate and Jenny - 8A.doc; Effort Factors Kate updated.doc; original email from Kate requesting that her post be looked at.pdf

**Importance:** High
**Sensitivity:** Confidential

Good afternoon Kate

Please find attached:

1. Amended job description for your comments/agreement
2. Organisational chart
3. Effort Factors
4. Changed post sign off

Have all look at the attached and any changes amendments let me know, if none then if you are happy can you add your electronic signature to the sign-off sheet and send through to me please.

Regards

*Martina*

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

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

Southern Health and Social Care Trust

*Quality Care - for you, with you*

**APPENDIX 2**

# Confirmation of Banding – Changed post

**NAME:**

**JOB TITLE:**

**CURRENT BAND OF POST:**

This job description and associated documents (i.e. organisational chart, effort factors questionnaire etc.) is an accurate reflection of the duties undertaken and responsibilities held by the above post holder.

**SIGNATURES:**

| | |
|---|---|
| _____ | _____ |
| **Post holder** | **Date** |
| _____ | _____ |
| **Line Manager** | **Date** |
| _____ | _____ |
| **Assistant Director** | **Date** |
| _____ | _____ |
| **Assistant Director of HR** | **Date** |

Please list/note any changes to the substantive post held for the period in question (e.g. Acting up, temporary secondments etc.)

_____
_____
_____
_____
_____
_____

Where there is more than one post holder please complete the table below.

| Additional Post holder(s) | Signature |
|---|---|
| | |
| | |
| | |
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Please indicate by circling below how you would like to be notified of your outcome:

E-mail

_____

(please state your e-mail address)

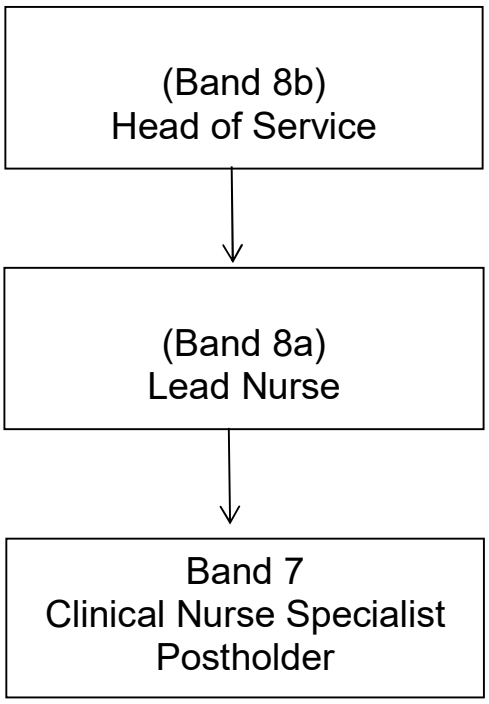
OR

Post – to your home address.

## Please return this form to:

[redacted]
Irrelevant redacted by the USI

**Current Structure**



Southern Health and Social Care Trust

# JOB DESCRIPTION

**JOB TITLE** Urology Clinical Nurse Specialist

**BAND** To be agreed

**DIRECTORATE** Acute Services

**INITIAL LOCATION** Craigavon Area Hospital

**REPORTS TO** Head of Service for Urology

**ACCOUNTABLE TO** Assistant Director Surgery Elective Care Division & ATICS

## JOB SUMMARY

The post-holder will:

Provide strategic leadership to drive forward sustained improvements in urological service provision for those with both malignant and non-malignant conditions

Deliver high quality specialist nursing care through the promotion of continuous professional development and innovative nursing practice

In conjunction with their medical and nurse colleagues the role will also involve the development of protocols for nurse led clinics and nurse management for Urological patients. The post holder will be a member of the Urology multidisciplinary team and will work closely with them to ensure that high quality patient care is maintained.

In collaboration with the Head of Service and medical colleagues the post-holder will develop, co-ordinate and deliver patient–centred urological services throughout the Southern Trust which are both cost effective and efficient

They will liaise closely with members of the multi-disciplinary team to improve channels of communication, allow maximum utilisation of resources, and promote continuity and co-ordination of the services within their sphere of responsibility

Promote reflective practice, complete personal development plans, and manage competency issues through the Trust capability procedure in order to achieve revalidation requirements.

This post will form close links with the specialist network of support coordinator's across the UK e.g. prostate UK, Macmillan, BAUN etc.

## KEY DUTIES / RESPONSIBILITIES

### Service Delivery

1. Support the Head of Service to achieve agreed Trust and regional targets for urological patients by co-ordinating the delivery of high quality clinical care in collaboration with Medical Teams and the Heads of Departments

2. Independently manage a clinical caseload in accordance with agreed levels of experience and competency

3. Provide innovative advanced nursing practice undertaking procedures including diagnostic and surveillance Flexible Cystoscopy, Prostate Biopsy and Removal of Ureteric Stent and injection of Botox into Bladder.

4. Deliver timely ongoing urological person-centred assessment and review services.

5. Identify opportunities for expanding practice, develop and sustain a team culture of continuous quality improvement, develop and lead service improvement initiatives and support the team to achieve competencies resulting in a highly skilled, flexible and motivated workforce.

6. Represent the Southern Health and Social Care Trust, in making an active contribution on local, regional and national working groups in the development of standards and guidelines.

7. Develop and implement a clinical governance framework for urological services which provides assurance to the Head Of Service that staff/team are fit for purpose, care meets standards enshrined in best practice guidelines and is responsive to learning opportunities arising from complaints, adverse incidents and feedback from service users

8. Evaluate service delivery against key performance indicators. Collect, analyse and utilise information to review performance and effectiveness, benchmarking with other similar service providers, in compliance with local data protection agreements

9. Ensure effective arrangements are in place for the identification, assessment and management of risks.

10. Ensure the processing and management of complaints, incidents and serious adverse incidents comply with the Trust policies and procedures, and are underpinned by transparency and a culture of continuous improvement.

11. Continue to improve patient experience through engagement in on-going education, research and audit of advanced nursing practice services inclusive of presentation at Patient Safety Meetings, amending service provision where indicated.

**Service Planning and Modernisation**

1. Actively lead service planning and modernisation initiatives relevant to urological services in conjunction with the Head of Service.

2. Assist the Head of Service with change management to meet the requirements of service provision and agreed strategies within the reform, modernisation and efficiency agenda for Urological Services.

3. Participate in research, evaluation of projects, quality initiatives and developments and facilitate staff undertaking research and audit projects ensuring clinical and social care governance requirements are achieved.

**Communication**

1. Develop good relationships with clinical staff so that service delivery issues can be addressed and implemented, to assist in the delivery of corporate and directorate objectives

2. Provide Reports to the Head of Service to ensure they are kept appraised of progress and priorities at all times.

3. Ensure strict confidentiality of correspondence, reports, meetings and verbal communications as appropriate.

4. Liaise with all representatives of associated agencies and organisations.

5. Maintain confidentiality of information at all times.

**Professional Leadership**

1. Act as a role model inspiring and ensuring that nurses within the Thorndale Unit think creatively, challenge current practice and implement new ways of working in a safe and measured manner

2. Contribute to a culture of continuous improvement through robust review of clinical standards, benchmarking against similar services, participating in local, regional and national audit and amending practice accordingly

3. Oversee the implementation of professional standards of practice within the urology department. Identify poor practice, support staff to meet the required standards and initiate trust procedures related to conduct and capability where improvement plans fail

4. Facilitate the Clinical Nurse Specialist team to work within and across professional and organisational boundaries maximising effective multi-disciplinary working.