6.1.4 All DNAs and CNAs must be recorded. The expectation is that this contract should operate with a maximum of 5% DNA and under 6% CNA rate. **Therefore payments for DNAs will be capped at 5% of the total volume of patients. Payments for DNAs over this volume will not be made.**

6.3 Procedure

6.3.1 The service provider should ensure that the urodynamics test is completed by a competent clinician and that the procedure is conducted in a way that ensures maximum comfort but minimum risk to the patient. All staff assisting with the procedure must be suitably qualified and experienced.

6.3.2 The Urodynamics test should have the following carried out:

Meet and Greet which will involve history taking and review of medication etc.,

1. Urine flow study (Also called - Uroflowmetry/mictiometry)
2. Post void bladder scan
3. Urinalysis – (if clear other tests can proceed)
4. Filling cystometry
5. Voiding cystometry
6. Urethral pressure profilometery (UPP) - (resting and stress profiles)

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6.3.3 The service provider must ensure robust processes and written protocols are in place for rapid transfer to Secondary Care in the event that an incident occurs

6.4 Following discharge, the Provider shall complete a formal discharge letter and provide a copy to:

- the Patient's GP
- the SHSCT Independent Sector Team
- the Consultant or Responsible Officer who treated the Patient with the Provider.

6.5.5 A copy of the discharge letter and the results from the urodynamics test must be sent to the Trust within a month of discharge. In addition the provider should provide access to a copy of the full patients' notes on request within 2 working days.

6.6 Any patient prescribing must remain consistent with the HSCB prescribing policies. All medicines administered including sedation will

be done so in accordance with all the relevant regulations and guidance.

6.7 Patients must at all times be respected and treated in a kind and considerate way by staff who should at all times demonstrate a professional and patient friendly attitude.

6.8 The Provider shall provide an on-call 24-hour liaison person to facilitate any urgent issues that arise

7.0 ADMINISTRATIVE SUPPORT

The service provider will be responsible for ensuring adequate secretarial and administrative support is in place to facilitate efficient administration of services. This includes:

- Receiving and recording referral to Provider on their systems within 3 working days and whether the patient was accepted or returned to Trust.

- Ensuring appointments are made as appropriate, with 3 weeks reasonable notice and confirmation of appointment/offer in accordance with Integrated Elective Access Policy (IEAP). Out-patient appointments must be partially booked in accordance with IEAP guidelines.

- The Trust expects that all patients are managed on waiting lists as per IEAP guidelines – by clinical urgency and chronological management.

- The Trust expects that the Provider will ensure that all patients are seen within the timeframe stipulated in order to meet maximum elective access times **in month**.

- The provider must have sufficient communication systems to deal with patient enquiries/calls and telephone numbers must be clearly communicated to patients.

- All relevant information and documentation necessary for patients appointments/surgery is available prior to attendance.

- Meeting and greeting patients on arrival for their urodynamics test.

- Maintain appropriate and accurate patient records as the record holder as per Data Protection legislation, in relation to all patient episodes/attendances e.g.
    - Nursing notes
    - Medical notes

- Theatre notes
- Patient Master Data Base (see Annex 3)
- Patient Minimum Data Set (see Annex 3)
- Outpatient with Procedure Coding (see Annex 3)
- Discharge letters

NB this is not an exhaustive list.

- Robust mechanisms are in place for the timely recording of outcomes following every patient attendance and that this is communicated back to the Trust Independent Sector Team on a regular basis in line with key performance indicators (Annex 2).

- Full compliance with the template for the Patient Master Database in terms of information requirements about patient outcomes and disposals (see Annex 3 including 3A, 3B and 3C – Information Requirements. Please note that these documents replace Schedule 2 and Appendix 1 of the contract).

- Return of Patient Master Database to Trust Independent Sector Team at least twice per week with updated outcomes – Monday and Thursday at 12 midday at a minimum. Where a Public Holiday falls on a Monday, the Trust will expect an update on the Tuesday, where the Public Holiday falls on a Thursday, the Trust will expect an update on the Friday.

- Return of the Patient Minimum Dataset (see Annex 3) to the referring Trust Clinical Coding Department within 1 week of patient discharge from Provider facility, ensuring full compliance with Trust information requirements

- Return of Out-Patient Clinical Coding Forms (see Annex 3) to the referring Trust's Independent Sector Team within 1 week of patient discharge from Provider facility, ensuring full compliance with Trust information requirements

- An Authorisation Request Form must be completed for all activity which sits outside the terms of the contract and forwarded to the Independent Sector Team within 2 working days of the decision and prior to progressing with treatments. The contract owner within SHSCT will respond to the request within 2 working days of receipt.

8.0 EQUIPMENT

8.1 The Provider will ensure that all equipment used is suitable for the provision of the required services and complies with all relevant law and Good Healthcare Practice relating to Health & Safety.

8.2 The provider shall ensure that all equipment used is regularly maintained and stored in accordance with the manufacturer's instructions.

8.3 The Provider shall ensure an audit of compliance with all appropriate standards and regulations should be carried out by a competent person external to the provider and be available for review if required.

8.4 **Cleaning Equipment -** The Provider shall ensure all equipment is cleaned as specified by and in accordance with current legislation appropriate to the Jurisdiction e.g.:

- DoH HTM 20/30 and/or HTM 20/10 and/or HTM 01/06
- The cleaning manufacturer
- The Medical Devices Agency
- COSHH requirements
- Any superseding requirements.

9.0 STAFF

9.1 The Provider shall meet the following required staffing checks

- Curriculum Vitae – When completing the Provider Submission Template (Appendix 2) the Provider is required to complete the Summary Sheet (Annex B) detailing the consultant urologist and specialist nurses (if appropriate) who the Provider proposes to engage for treatment of patients under the contract. The Trust requires copies of CVs which must include details of their experience in managing and performing urodynamic tests and subspecialist areas/sites in Schedule 1 (this should include an indication of volumes or numbers of specific procedures untaken in the last year). Following award of the contract, providers will be required to update this summary sheet with the names of any additional clinicians treating Trust patients under the contract and provide copies of CVs on an ongoing basis.

- The work that the Consultant urologists/ specialist urologist nurses are carrying out as part of the contract should reflect the conditions treated and procedures performed in their regular NHS work or public practice.

- The Service Provider shall be responsible for ensuring that the Urology Surgeons are competent, hold current professional GMC registration and licence to practice in UK or equivalent registration with IMC for Republic of Ireland Providers, and hold indemnity insurance. They should also be fully accredited by the Royal College Special Advisory Committee or equivalent.

- The Provider will comply with Royal College, General Medical Council (GMC), Nursing & Midwifery Council (NMC), Royal

College of Nursing (RCN) or equivalent bodies relevant to the jurisdiction and any other relevant professional body code of practice for clinical documentation and management of patients.

- Staff training – The provider must ensure that the mandatory, compulsory and local training of all staff groups is up to date, maintained and recorded.

- It must be highlighted if:-

    - Staff have ever been referred to the Independent Safeguarding Authority (ISA) or DHSSPS as a result of misconduct involving children and/or vulnerable adults;

    - Staff are currently the subject of a referral to, or an investigation, by a regulatory body;

    - Staff are currently the subject of police investigation or have any prosecutions pending;

    - Staff have ever been convicted, charged, prosecuted, cautioned or bound over for any offence, no matter how minor;

.

10.0 TRAVEL AND ACCOMMODATION FOR ESCORT FOR PROVIDERS OUTSIDE NORTHERN IRELAND

- All patients who travel to Independent Sector Providers outside of Northern Ireland to receive treatment as part of a waiting list initiative will be entitled to the following costs up to a maximum indicated below:

Transport for patient and 1 escort	Public transport rates
Accommodation for 1 escort	Up to £65 per night**
Subsistence for 1 escort	£20 per day

The Trust would expect that Providers will organise and pay for transport and accommodation and invoice the Trust accordingly. Where patients or relatives wish to make alternative arrangements, Providers must inform them that they will be required to complete a claim form and attach relevant receipts for submission to the Trust.

11.0 PROCEDURES AND PROTOCOLS

11.1 The Provider shall within a reasonable time after request, make available to the Trust copies of any patient guide or other written policy, procedure or protocol which the Provider implements.

The Provider shall promptly notify the Trust of any material changes to such guides, policies, procedures and protocols as have been made available to the Trust

11.2 As a minimum the Provider the provider must comply with the requirements of all existing relevant appropriate legislation, guidelines and policies relevant to their jurisdiction and in particular, but not exclusively, the following:

Trust policies:

- Protocol in relation to safeguarding and protecting the welfare of children and vulnerable adults;
- Accident and Incident reporting and review policy;
- Infection Control Policies;
- Medicines Policies;
- MRSA Policy;
- Pathology protocols including IRMER regulations;
- Health and Safety Policies;
- Complaints Policy;
- Patient Confidentiality, Data Protection Policy and Freedom of Information Act (2000).
- Recording Keeping
- Right Patient Right Blood
- VTE guidelines

Legislation

- Health and Safety Legislation
- Data Protection Act 1998
- Freedom of Information Act 2000
- Section 75 of the Northern Ireland Order 1998
- Sex Discrimination (NI) Orders 1976 and 1988,
- Fair Employment and Treatment (NI) Order 1998,
- Disability Discrimination Act 1995, Section 49A of the Disability Discrimination Order 2006
- Race Relations (NI) Order 1997
- Human Rights Act (1998)
- Article 3 of the Audit and Accountability (NI) Order 2003
- Equal Pay Act (Northern Ireland) 1970 (amended 1984)
- Employment Equality (Sexual Orientation) Regulations (Northern Ireland) 2003 and 2006
- Employment Equality (Age) Regulations NI 2006

- Fire Prevention and Precautions Legislation
- and any enactments amending, extending or replacing them

Guidelines

- Safer services report
- Guidelines for the prevention, detection and investigation of abuse of vulnerable adults
- Professional guidelines and policies
- Our duty to care
- NMC guidance on record keeping
- NMC guidance on administration of medications
- Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease (CJD) via interventional procedures- NICE Guidelines
- Guidance from the ACDP TSE Risk Management Subgroup (formerly TSE Working Group)
- Venous thromboembolism: reducing the risk: Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital -NICE Guidelines CG92

12.0 STANDARDS AND QUALITY INDICATORS

The provider will be expected to comply with the relevant quality and safety indicators.

In addition the provider will be expected to comply and provide information which will meet the baseline performance targets, Quality, Performance and productivity standards detailed in Annex 2.

13.0 GENERAL STANDARDS

In addition to the above the Service Provider will be expected to comply with the following standards and quality indicators and to present evidence that standards are being met:

- Essence of Care benchmarking
- UKCC Standards for Record Keeping (2008)
- Relevant NICE guidance
- The Health Code (2006)
- Essential steps to Safe, Clean Hospitals (2006)
- Compliance with local policies and guidelines
- Compliance with agreed local care pathways
- Compliance with confidentiality, data protection and information governance requirements

14.0 DISCRIMINATION

Neither party shall discriminate unlawfully within the meaning and scope of any Law, relating to discrimination (whether relating to race, gender, disability, religion or otherwise) in employment or performance of the Services and each Party shall take all reasonable steps to ensure observance of this by its employees, Staff and agents and (in the case of the Provider) its Sub-contractors.

15.0 COMPLAINTS AND ADVERSE INCIDENTS

15.1 The Provider shall comply with the Northern Ireland Health and Social Care Board and Trust complaints procedure(s) and Adverse Incidents and Serious Adverse Incidents (SAI) procedures including reporting to equivalent bodies relevant to the jurisdiction.

15.2 Further information on Complaints and SAI handling is contained within the Service Level Agreement.

16.0 REPORTING, ANALYSING & LEARNING FROM PATIENT SAFETY INCIDENTS

With regard to Patient Safety Incidents, the Provider will follow the procedure for the reporting and follow up of Serious Adverse Incidents April 2010 and report to equivalent bodies relevant to the jurisdiction

The provider will

- implement DHSSPS and National Patient Safety Agency (NPSA) guidance including for the avoidance of doubt, patient safety alerts and other safety solutions and products developed for the HPSS;

- have local risk management procedures in place to analyse and learn from patient safety incidents; and

- produce a Monthly monitoring report on SAI for the Commissioner as part of the monitoring arrangements in this document.

17.0 INFORMATION REQUIREMENTS

17.1 The Provider and Trust acknowledge that in order to achieve accurate activity monitoring and prompt and accurate payment, there is a need for timely regular exchange of detailed and accurate information. Accordingly the Provider shall ensure that the specified returns on patient activity and outcomes are provided to the Trust as per Annex 3 attached.

17.2 The Provider shall maintain accurate accounts and records of all payments, receipts and financial and other information relevant to the

provision of the Services (in this Section collectively referred to as "Financial Records"). This is set out in detail in Section 21 of the Contract.

18.0 PERFORMANCE INDICATORS AND MONITORING ARRANGEMENTS

18.1 The performance of the Provider will be monitored against specified Performance Indicators as outlined in Annex 3 including Annexes 3A, 3B and 3C, which replaces Schedule 2 and Appendix 1 of the contract.

18.2 The performance of the Provider will be monitored at agreed intervals. Meetings will take place between the Provider and the Trust at least quarterly and more frequently if deemed necessary by the Trust. Meetings will cover service quality, clinical and contract governance and other issues.

18.3 The Trust needs to be able to assure itself that the services it purchases for its patients are provided to the specified levels of quality and quantity as set out in the relevant contract documentation. A Contracts Compliance Reporting System to ensure concerns raised are followed up and resolved to the satisfaction of the Trust will be followed by Providers.

18.4 Each Party may, where it has a query regarding the other Party's performance under this Agreement, issue a Contract Query in writing setting out the nature of the query. Each Party is obliged to reply in writing to any Contract Query within 14 days of its issue unless otherwise agreed in writing between the Parties. The Trust, where it has reasonable evidence that the performance of the Provider fails to meet with requirements under the contract in relation to one or more of the areas set out below, may issue a written Performance Notice in respect of a Service setting out the matter or matters giving rise to such Performance Notice and containing a reminder of its implications:

- where there has been a failure to meet the Quality Standards or the Performance Indicators;
- where the Provider fails to provide the volume of activity agreed;
- where there has been a negative audit finding;
- where the percentage of Patient complaints upheld gives cause for concern;
- if there is intervention by the Independent Regulator directly affecting or, in the reasonable opinion of the Trust, likely to affect the ability of the Provider to provide any of the Services;

- where the Provider fails to reply to a Contract Query or;

- where the Provider fails to discharge any of its other obligations under this document or any other reason which may cause the Trust reasonable concern or which could bring the Provider or Trust into disrepute.

Within 7 days of its issue the Parties shall meet to discuss the subject matter of any Warning Notice and agree a plan of action to remedy the subject matter of the Performance Notice including a timetable and method for review of the planned remedial action. (See Section 34 and Schedule 7 of the Contract)

19.0 PRICES AND PAYMENT

All fees will be displayed within the Schedule 3 of the Contract.

20.0 JURISDICTION

This service specification and accompany contract shall in all respects be governed by the laws of Northern Ireland and the parties hereby agree that the courts of Northern Ireland shall have exclusive jurisdiction to hear and determine any dispute arising out of or in connection with this contract.

Schedule 1

Service Description

Providers are asked to submit their prices on the Provider Submission Template using the following structure:

No assumption should be made about access to NI HPSS Trust premises as part of the pricing submission. The costs associated with such an arrangement should be incorporated into the prices submitted.

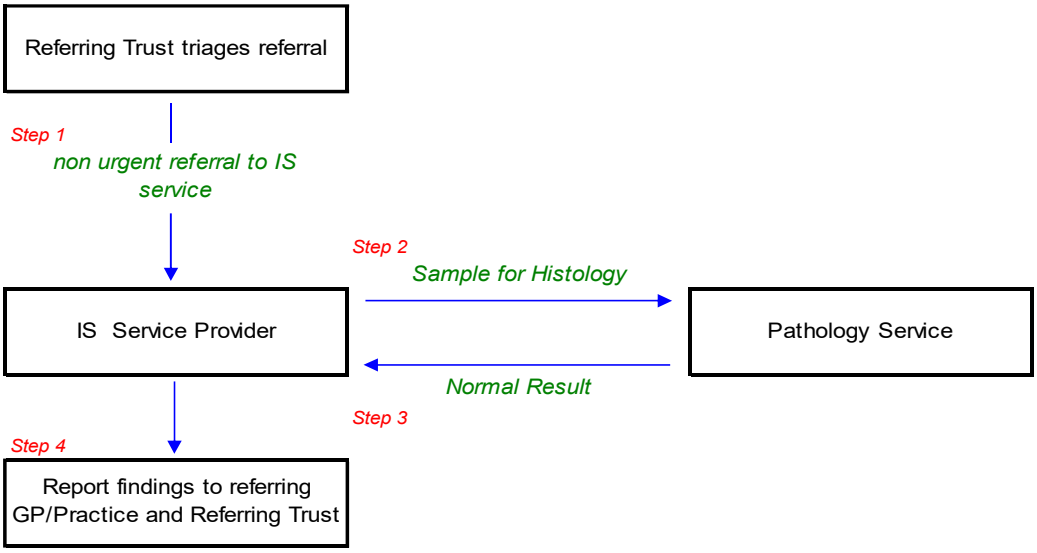
Where a provider does not have premises they will have to demonstrate that they have an access agreement commensurate with the volume of patients in any subsequent offer of contract.

Diagnostics
Providers identify the price of diagnostics including reporting consumables and laboratory tests.

Type – Urodynamics to include all of the below:	**HRG Price £**
Meet and greet to include history taking, medication etc,	
Urine flow study (Also called - Uroflowmetry/mictiometry)	
Post void bladder scan	
Urinalysis – (if clear other tests can proceed)	
Filling cystometry	
Voiding cystometry	
Urethral pressure profilometery (UPP) - (resting and stress profiles)	

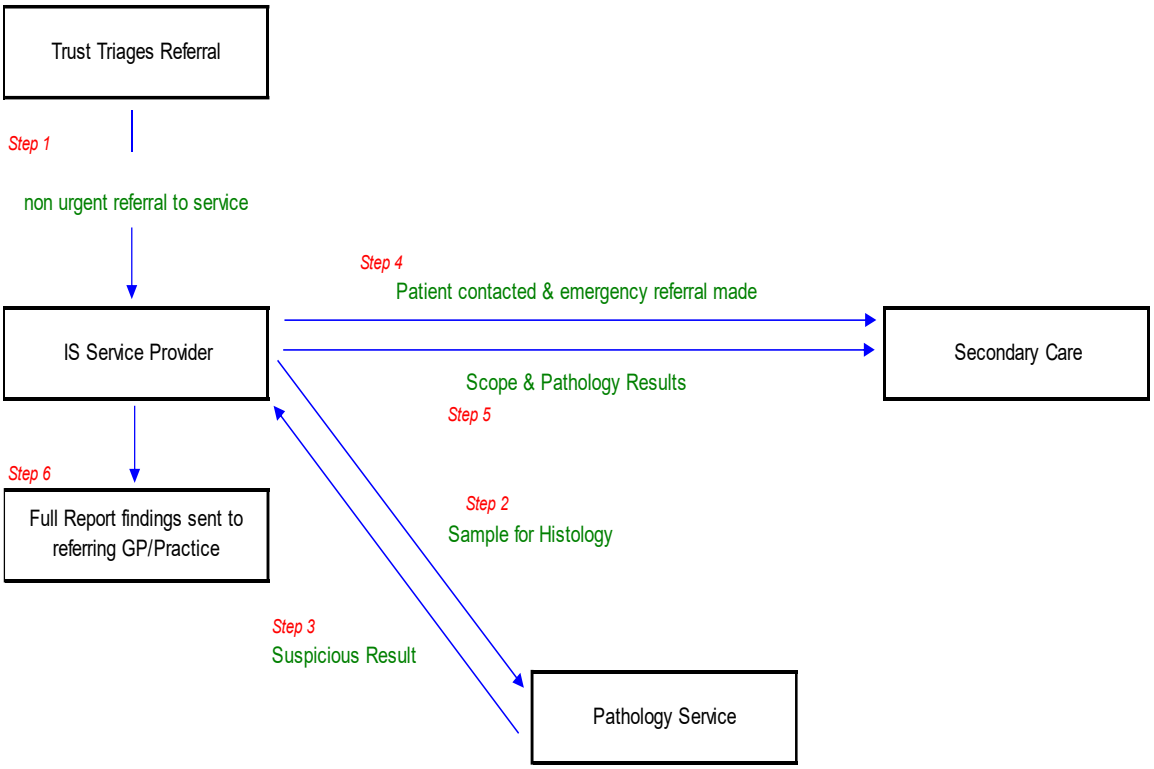
ANNEX 1A

Non- Emergency Referral by Trust and procedures suggested normal findings



ANNEX 1B

No suspicious lesion found but pathology result suggests unsuspected malignancy or other serious condition



ANNEX 2

Baseline Performance Targets, Quality, Performance and Productivity Indicators

Performance Indicator	Indicator	Threshold	Method of Measurement
Access	Patients offered appointment which is within 21 days of the referral received	98%	Provider data
	Referral to another consultant led service within 6 weeks of receipt of referral to this service	95%	Provider data
Clinical triage Guidelines (+/- 10%)	• Max 20% referred to other 2° care specialities		Provider data
	• Within 3 working days of GP referral	95%	Provider data
Activity	rate remains within a 10% range of the intervention rate parameters determined by best practice and clinical evidence. •	+/- 10%	Provider data
Referrer Communication	Outcome of patient appointments communicated to the referring clinician within 1 working day •	100%	Provider data
Pathology Reporting	• Pathology reports for patient with cancer are dispatched within one day of receipt of the pathology report	100%	Provider data
	• Pathology reports for patients without a cancer diagnosis are provided within 2 working weeks	100%	Provider data
Cancer referral	• Patients with a cancer diagnosis should be notified to the MDT	24 hours	Provider data
Educational activities	• Provider will actively engage with educational activities and interact with referrers to demonstrate improved quality of referrals and knowledge of referring	% change	Fewer patients discharged back to GP with no action taken

	clinicians.		
• **Service Quality**	% patients satisfied with the service	95%	Provider data
	• As clinical triage guidelines plus: Number and % patients returned to primary care management without face to face consultation	Benchmarked	Provider data
•	• Number and % managed by the service without onward referral	Benchmarked	Provider data
•	• Number of incidents reported	Benchmarked	Provider data
•	• 'Urgent' referral to 2° care for red flag conditions with reasons	Benchmarked	Provider data
•	• Number and % to 2° care because insufficient capacity in service	Benchmarked	Provider data
•	Number and % patients referred to secondary care and reason •	Benchmarked	Provider data
•	• Number and % complications with description of individual incidents	Benchmarked	Provider data
•	• Number and % treatment failures with description of individual incidents	Benchmarked	Provider data
•	• Number and % emergency transfers with detailed report	Benchmarked	Provider data
•	• Number and % failed day cases with description of incident	Benchmarked	Provider data
•	• % patients DNA'd	5%	Provider data
•	% patients operative procedures cancelled by the provider for - clinical reasons - Non-clinical reasons •	2%	Provider data
Activity Data and Performance Reports	To be provided to Board / Trusts monthly by the 7th working day of the following month in support of invoices	•	Provider data

The monitoring will be for the period of the contract and the provider is expected to be able to evidence compliance with each of the standards listed.

Information Requirements ANNEX 3

Please note that Annex 3 (including Annexes 3A, 3B & 3C) replaces Schedule 2 and Appendix 1 of the Contract

1 Patient Master Database
(Also referred to as the Update Spreadsheet/Report or Patient Pathway Report)

A Patient Master Database will be maintained for the contract. This database (Annex 3A) will be jointly maintained by provider and Trust staff and will be updated:

- Twice weekly – Monday and Thursday by 12 midday
- If a Public Holiday falls on a Monday, the Trust will expect this on a Tuesday
- If a Public Holiday falls on a Thursday, the Trust will expect this on a Friday.

This database will be used as the reference document to monitor all changes in patient status and both the Southern Health and Social Care Trust and the IS Provider will cooperate in maintaining it in an accurate and up to date form.

The database should be held as an Excel spreadsheet and updated and passed to the Trust as per the timescale above.

2 Performance Indicators

As part of the ongoing contract management process, providers must produce a monthly report summarising the following information:

• number of deaths
• number of serious injuries
• number of returns to theatre
• unplanned readmissions
• surgical site infections
• number of inpatient discharges per month
• number of operative procedures per month
• number of inpatient bed days per month

3 Complaints Register

A Complaints Register (Appendix 2 of the Contract) must be maintained. This register will be maintained by the IS Provider. It will be updated and passed to the HSCB and Southern Health and Social Care Trust on a weekly basis.

4 Adverse Incident Register

An Adverse Incident Register (Appendix 3 of the Contract) must be maintained. This register will be maintained by the IS Provider. It will be

updated and e-mailed to the HSCB at adverse.incidents@hscni.net and Southern Health and Social Care Trust on a weekly basis.

5 Patient Minimum Dataset

(Also referred to as the Clinical Coding Form)

Information relating to surgical procedures and treatment of outpatient with procedure must be provided to the Trust for the purposes of Clinical Coding.

For all patients undergoing surgical procedures, Providers must complete and return the Patient Minimum Dataset Form (see Annex 3B) to the Southern Trust's Clinical Coding Department within 1 week of patient discharge, ensuring full compliance with Trust information requirements

For all patients undergoing a procedures as part of the outpatient consultation or in the outpatient setting at a later point, Providers must complete and return Outpatient Clinical Coding Forms (see Annex 3C) to the referring Trust's Independent Sector Team within 1 week of patient discharge, ensuring full compliance with Trust information requirements.

This information should also be supplied as part of the patient health record which is returned to the Trust following treatment.

ANNEX 3A

Template for Patient Master Database

(Also referred to as Update Spreadsheet/Report, Patient Pathway Report)

ALL sections must be completed per specific contract requirements

Please note that Annex 3 (including Annexes 3A, 3B & 3C) replaces Schedule 2 and Appendix 1 of the Contract

		Field	Comments
PATIENT DATA			
1		Hospital Number	Should be assigned by Trust and used by both Trust and provider (but see (2) below)
2		Health & Care Number	Optional field but where entered by Trust it must be used in preference to (1) above
3		Unique Identifier for Contract Period	This should be used to identify patients being transferred for specific contract periods
4		Patient Forename	
5		Patient Surname	
6		Address 1	
7		Address 2	
8		Postcode	
9		Date of Birth	
10		Sex	
11		Phone Number	
12		Mobile Number	
13		GP Name	
14		GP Cipher Code	
15		Hospital Site	
16		Specialty	
17		Consultant	
18		Clinical information	Free field to allow any relevant clinical information to be included (e.g. history, body part)
19		Date of referral	Date of referral by GP/other
20		Referrer	
21		Date passed to Provider	Date patient data passed to Provider for action
PATIENT OFFER DATA			
22		Offer Date for First Appointment *(written communication)*	The date the provider made contact with the patient to make an offer
23		Outcome of First Offer	• No response • Patient Accepted Offer • No longer requires appointment *(date required)* • Refused offer – date and reasons to be given • Patient deceased • Other – must be specified
24		Disposal of First Offer	• Appointment made

			• Second offer made • Discharged – date and reasons • Returned to Trust – date and reasons
25		First appointment date	Actual appointment date accepted by patient
26		Offer Date for Second Appointment *(written communication)*	The date the provider made contact with the patient to make an offer
27		Outcome of second Offer	• No response • Patient Accepted Offer • No longer requires appointment • Refused offer – dates reasons to be given • Patient deceased
28		Disposal of Second Offer	• Appointment made • Discharged – date and reasons • Returned to Trust – date and reasons
29		Second appointment date	Actual appointment date accepted by patient
INVESTIGATIONS DATA			
30		Date of urodynamics investigation	
31		Outcome of urodynamics Investigation *(Attendance)*	Possible outcomes: • Attended • Cancelled by patient - date of cancellation and cancellation reason • Cancelled by Provider – date of cancellation and cancellation reasons • DNA *Where the appointment is cancelled by patient, the date the patient cancels the appointment will be the reset date for PAS*
32		Date Investigations Reviewed by Clinician	
33		Disposal of Investigation	Possible disposals: • Discharged to GP - no further intervention required • Returned to Trust - reasons to be given • DNA – Discharged • DNA – Appointment re-booked with date of appointment

ANNEX 3B

Patient Minimum Dataset
(also known as Clinical Coding Form)

Please note that Annex 3 (including Annexes 3A, 3B & 3C) replaces Schedule 2 and Appendix 1 of the Contract

ALL sections must be completed fully.

For each patient:	**For each admitted episode within spell:**
Patient ID	Consultant
HPSS number	Consultant function
Date of birth	Consultant specialty
Sex	Start date
Postcode of usual address	End date
GP	Primary diagnosis
Referrer	Secondary diagnosis
	Primary procedure
For each outpatient appointment:	Procedure (others)
	Procedure date (for each procedure)
Consultant	Site of treatment (at start of episode)
Consultant function	
Consultant specialty	**For any period of augmented care**:
Primary diagnosis	
Secondary diagnosis	Start date
Attended/did not attend	Augmented care period source
First attendance	Intensive care level days
Medical staff type	High dependency care level days
Outcome of attendance	Number of organ systems supported (IC only)
Attendance date	Augmented care planned indicator
Primary procedure	Augmented care outcome indicator
Procedure (other)	Augment care period disposal
Site of treatment	End date
	Specialty function code
For each admitted spell	Augmented care location
Start date	
Admission method	
Discharge destination	
Discharge method	
Discharge date	

<u>Please return completed forms to Clinical Coding Department, Craigavon Area Hospital, 68 Lurgan Road, Portadown.</u>

Southern Health and Social Care Trust

Quality Care - for you, with you

INVITATIONS TO PROVIDERS ON THE SELECT LIST
MINI-COMPETITIVE SIFT

Specialty:	**Urology**
Directorate Lead:	Martina Corrigan
Contact Details:	Personal Information redacted by USI
Clinical Lead:	Mr Eamon Mackle, Associate Medical Director

Summary of Requirements

As part of the on-going Northern Ireland Elective Care Reform Initiative to reduce waiting times for elective treatment the Southern Health and Social Care Trust (SHSCT) is taking action to address its waiting list in Urology where backlogs have developed.

Enclosed with this letter is a service specification for the supply of Urology services (*Appendix 1*). We are therefore contacting a number of providers from the Regional Select List for provision of Acute Services to bid for this work.

If you wish to be considered for this work please submit a proposal on the attached "Provider Submission Template" (*Appendix 2*) to the address or email given below **BY 12.00 NOON .**

The specification outlines the need for up to **987** new assessments/meet and greet and **387** Inpatient, **281** Diagnostic and **128** GA daycase operative procedures and appropriate review outpatient follow-up to be carried out for a waiting list initiative.

All Urology assessments and any resulting necessary procedures require to be completed by **30 September 2012**. Please note that more than 1 provider may be selected.

Selection and Evaluation Criterion

All applications will be considered against a range of criteria - please see 'Criteria Marking Scheme' (*Annex A*) appended for further detail:

Part 1 "Selection Criteria" Q1 – 5 will be scored Pass / Fail (Yes / No)
Provider may be asked to submit evidence of these criteria on award
Please note that if the Provider fails to pass any of the criteria in Part 1 their submission will not be considered further

Part 2 "Enhanced Quality" Q7 – 9 will be weighted scored (40%)
Please note that if the Provider fails to gain a weighted score of 30% in Part 2 their submission will not be considered further
Detail on exact requirements to meet Part 2 is outlined on the Provider Submission Template.

Part 3 "Price" Q10 will be weighted scored (60%)

Notes:

Part 2 Notes: Enhanced Quality:
Enhanced Quality criteria will be evaluated and scored. Each question will be attributed a mark as per Table A. These marks will then be converted into the percentage weighted score attributed to that question, as detailed.

Converting marks into percentage scores
The mark achieved by the Bidder (ie 0 - 5) will be divided by the total mark achievable ie 5 for that question. This will then be multiplied by the score attributed to that question and calculated to two decimal places.

Table A

Mark	Description
0	Failed to address the question / issue / specification.
1	An unacceptable response to the specification / answer / solution with serious reservations. Limited detail of the methodology to be applied only mimicking the statement of specification. High risk that the proposed approach will not be successful.
2	A response to the specification / answer / solution with reservations. Lacks convincing detail of the methodology to be applied in terms of supporting evidence / examples of experience/skills or previous application Medium risk that the proposed approach will not be successful.
3	Meets requirements. The response generally meets the requirements but lacks sufficient detail to award a higher mark.
4	Meets requirements. The response to the specification / answer / solution generally meets the Trust's requirements, but lacks sufficient detail to award a higher mark. Includes relevant supporting evidence / examples of experience / skills or previous application.
5	Excellent response that provides full detail and address all aspects of the requirements of the specification / answer / solution. Indicates an excellent response with detailed supporting evidence and no weaknesses. Response demonstrates that this Contractor will provide outstanding services if awarded.

Part 3 Notes: Price

The evaluation of price will be based on the commercial response. The total cost of the contract will be taken into consideration in award against a representative indicative casemix. Any costs not included which are thereafter sought will not be paid.

The total overall cost of the bid is then converted into a percentage – weighted score (PWS) attributed to price using the following formula below.

Formula PWS = (Lowest Overall Total Bid Cost divided by Tendered Overall Total Bid Cost) multiplied by the percentage weighting for price ie 60%.

NB. It is the responsibility of the Provider to ensure the accuracy of the figures inserted in the bid. The SHSCT is not bound to accept the lowest cost or any bid.

The Provider with the highest overall total score awarded from Part 2 and Part 3 will be awarded the contract. In instances where Providers achieve the same overall score the Provider with the highest % score in Q10 'Price' will be awarded the contract.

If this still results in a tie break, then the bidders with the highest % score in Q6 'Clinical Governance' will be considered for award of the contract.

Maximum % score achievable is 100%

Contact Information

Responses should be submitted via email or in person BY 12.00 NOON ON 2012 on the enclosed provider submission template form to:

Mrs Pamela Stewart
Performance Administrative Assistant
Directorate of Performance and Reform
Southern Health and Social Care Trust
The Rowans, Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN
BT63 5QQ

Tel: Personal Information redacted by USI
Email: Personal Information redacted by USI

It is the responsibility of the applicant to confirm that their quote has been received at the above office.

LATE SUBMISSIONS OR SUBMISSIONS NOT DEEMED COMPLIANT WITH THIS INVITATION WILL BE REJECTED.

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 01 July 2013 07:56
To: Dignam, Paulette; Corr, Sinead; Young, Michael
Cc: Forde, Helen; Robinson, Katherine; Glenny, Sharon
Subject: RE: [redacted] - CAH [redacted]

Paulette

Not sure what you need me to do about this? I would suggest that if the lady needs reviewed then should be arranged urgently? I suspect that even when the letter came back in unnamed from 3fivetwo that because it originally came from Mr Young it went back onto the Mr Young's review waiting list.

However, as it seems we are not sure where the letter went and we cannot have any further delay can this lady please be given an urgent review appointment for as soon as Mr Young comes back from Annual Leave

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

From: Dignam, Paulette
Sent: 17 June 2013 14:14
To: Corr, Sinead; Young, Michael; Corrigan, Martina
Cc: Forde, Helen; Robinson, Katherine
Subject: RE: [redacted] CAH [redacted]

Hi Martina

Can you advise on this one?

Many thanks
Paulette

From: Corr, Sinead
Sent: 17 June 2013 14:12
To: Dignam, Paulette; Young, Michael
Cc: Forde, Helen; Robinson, Katherine
Subject: RE: [redacted] CAH [redacted]

Hi Paulette

If there is a comment on PAS as per 352 it was probably one of my team put the pt on for review, you would need to speak to Martina, The providers were asked to send all letters through to the IS team to allow us to deal with any follow ups.

Thanks
Sinead

From: Dignam, Paulette
Sent: 17 June 2013 14:08
To: Corr, Sinead; Young, Michael
Cc: Forde, Helen; Robinson, Katherine
Subject: RE: Personal Information redacted by USI CAH Personal Information redacted by USI

Hi Sinead

I have highlighted your response with Mr Young. Can you advise who is best placed to investigate on this matter? Not sure if it is of help to you or not but the OREG on PAS is under Mr Young; 352 have put the lady on for review with him following her appointment last September.

Many thanks
Paulette

From: Corr, Sinead
Sent: 17 June 2013 11:50
To: Dignam, Paulette
Cc: Forde, Helen; Robinson, Katherine
Subject: FW: Personal Information redacted by USI - CAH Personal Information redacted by USI

HI Paulette

I have attached a copy of the letter from 352 that we received from them in October, as you can see there is no named consultant from CAH on the letter the 352 consultant states 'I am not entirely sure if this has been discussed further certainly the scans will need to be reviewed at an x-ray meeting or discussed with the radiologist as Personal Information redacted by USI may require further follow up ultrasound scans in 6 to 12 months' time.' I can only guess that the reason the letter did not go to Mr Young was because it was addressed to the GP and it was CC'd under a General Urologist. Normally any query pts who need to be followed up by XRAY or another speciality would be forwarded to the head of service on clarity on what the IS team is to do.

Hope this is of help

Thanks

Sinead

Hi Sinead

Mr Young has asked if you can look into this lady's case for us. She was initially referred to Mr Young by Mr Yousaf back in March 2012 but she was sent to the Independent Sector instead and seen at a 352 clinic in September 2012. Her GP has sent in a new urgent referral on 29.05.13 as this lady has had finding of a solid cyst on her kidney. The GP mentions in the referral that a copy of a letter from 352 was sent to us last September asking us to arrange for this lady to be discussed at our x-ray meeting to discuss these findings. The GP has attached a copy of the 352 letter however it would appear that this has never reached Mr Young hence this lady has not been investigated. Can you advise?

Many thanks
Paulette

From: Niki Chambers [mailto: Personal Information redacted by USI]
Sent: 12 October 2012 10:45
To: Corr, Sinead
Subject: Personal Information - CAH Personal Information redacted by USI

Dear Sinead,

Please find attached clinic letter for patient who has been discharged from the care of 3fivetwo and returned to trust care for an appointment with Urology at Craigavon Area Hospital, for possible further USS in 6-12 months.

Kind Regards,
Niki Chambers
Outcomes

3fivetwo Healthcare
21 Old Channel Road, Channel Wharf, Belfast
BT3 9DE
TEL: Personal Information redacted by USI

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 27 February 2013 16:07
To: Farrell, Roisin
Cc: Trouton, Heather
Subject: RE: Re-Opened Complaint :

Dear Roisin

This is all in connection with Mr [redacted] experience in the Independent Sector so I will have obtain responses from them before I can formally respond and will advise you of this as soon as its received.

Many thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

From: Farrell, Roisin
Sent: 27 February 2013 15:01
To: Corrigan, Martina
Cc: Reid, Trudy; Trouton, Heather
Subject: FW: Re-Opened Complaint :

Dear All
Please see below further correspondence from [redacted], can you please investigate his issues and forward me your response.
Please provide me with a response by Wednesday 13 March 2013.

I have attached a copy of his original complaint and the Trust's response.

Regards
Roisin

Roisin Farrell
Personal Secretary/
Governance Administrator
Acute Services
Office 3, Level 2, MEC
Craigavon Area Hospital
Tel: [redacted]

From: Cardwell, David
Sent: 27 February 2013 09:02

To: Farrell, Roisin
Subject: Re-Opened Complaint :

Roisin can you please send the information below to the relevant AD and HoS for re investigation.

Record as re-opened.

David.

David Cardwell
Governance Officer
Directorate of Acute Services

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

From: Vivienne Kerr [mailto: Personal Information redacted by USI]
Sent: 19 February 2013 21:41
To: Kerr, Vivienne
Subject:

Mr Personal Information redacted by USI called this afternoon (19 February 2013) to advise that he remains unhappy with the Trust response he recently received.

He feels that some queries he raised were not answered and some were answered incorrectly

Mr Personal Information redacted by USI main points are as follows;
• What is a desktop review
• Mr Personal Information redacted by USI understood that he would receive a private consultation prior to the procedure which would provide him with information of what to expect • Instead Mr Personal Information redacted by USI was brought into an area with other patients, gowned and wheeled in for his procedure with no consultation • Mr Personal Information redacted by USI felt there was a lack of privacy provided during this time • Mr Personal Information redacted by USI believes that if he had been a private patient in the same clinic, he would have been treated with much more respect and dignity • Approximately 2 months later Mr Personal Information redacted by USI received a letter informing him that as he did not attend for his procedure he was being discharged back to his GP • Mr Personal Information redacted by USI 's GP received a letter stating that as Mr Personal Information redacted by USI did not attend his review appointment he was being discharged back to his GP • Pathology results were to be forwarded to GP but never received From the conversation I had with Mr Personal Information redacted by USI these would appear to be his continued concerns.

Vivienne

Southern Health and Social Care Trust

LONE WORKING POLICY AND PROCEDURE

FEBRUARY 2010

Lone Working Policy
Policy Checklist

Name of Policy:	Lone Working Policy
Purpose of Policy:	This policy aims to ensure: • the lone worker has full knowledge of the hazards and risks to which he/she is being exposed. • the lone worker knows what to do if something goes wrong. • someone knows the whereabouts of the lone worker, what he/she is doing and when they are due back and will implement the agreed emergency response.
Directorate responsible for Policy	Directorate of Human Resources & Organisational Development
Name & Title of Author:	Janet Taylor, Head of Health & Safety Frances Hughes, SHSCT MAPA Trainer Margaret Tierney, SHSCT MAPA Trainer Eamonn Hughes, SHSCT MAPA Trainer Eamonn Connolly, Staff side (RCN)
Does this meet criteria of a Policy?	**Yes/**No/Not Applicable
Staff side consultation?	**Yes/**No/Not Applicable
Equality Screened by:	Frances Hughes, MAPA Trainer/Advisor Jane Carr, Acting Head of Health and Safety
Date Policy submitted to RM&PC:	1 March 2010
Members of RM&PC in Attendance:	
Policy Approved/Rejected/ Amended	Approved *(comments included)*
Communication Plan required?	**Yes/**no/not applicable
Training Plan required?	**Yes**/no/not applicable
Implementation Plan required?	**Yes**/no/not applicable
Any other comments:	
Date presented to SMT	
Director Responsible	Director of Human Resources & Organisational Development
SMT Approved/Rejected/Amended	
SMT Comments	
Date returned to Directorate Lead for implementation (Board Secretary)	
Date received by Office Manager (HQ) for database/intranet	
Date for further review	2 year default

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Lone Working Policy Version: 1_0 Reference number/document name:
Supersedes	Supersedes: Legacy policies for Craigavon & Banbridge, Craigavon Area Hospital, Newry & Mourne and Armagh & Dungannon Trusts. Description of Amendments(s)/Previous Policy or Version: Harmonisation of the 4 legacy Trust policies.
Originator	Name of Author: Janet Taylor Title: Head of Health & Safety
RM/Policy Committee & SMT approval	Referred for approval by: Jane Carr, Acting Head of Health & Safety Date of Referral: RM/Policy Committee Approval (Date) - SMT approval (Date) –
Circulation	Issue Date: Circulated By: Janet Taylor Issued To: As per circulation List (details below)
Review	Review Date: Responsibility of (Name): Janet Taylor Title: Head of Health & Safety

Circulation List:

This policy was circulated to the following staff and groups for consultation:
Trust Directors
Staff Side
SHSCT Security Manager
SHSCT Lone Working Sub Group
Anita Carroll – Assistant Director of Acute Services – Functional Support Services

Following SMT and Trust Board approval this Policy Document will be circulated to the following:
All Trust staff
Trust Internet site (for public release under the Freedom of Information Act 2000)
Trust Intranet site

CONTENTS

SECTION ONE

LONE WORKING

POLICY

LONE WORKING POLICY

1.0 Introduction

1.1 It is recognised that many people within the Southern Health and Social Care Trust (hereafter called the Trust) by the nature of their job can be required to work alone or can find themselves in such circumstances.

1.2 Lone working can be described as "*work that is specifically intended to be carried out by unaccompanied persons, without direct supervision or immediate access to another person for assistance*".

1.3 Lone working may expose employees/others to additional health and safety risks which do not present themselves in other circumstances. Through a process of risk assessment, significant risks will be identified and controls put in place to eliminate/reduce the risk. To achieve this, the co-operation of all involved is essential and requires all levels of management and individual staff members to work together to develop and implement local safe systems of work.

1.4 To this end, this document has been developed in support of the Trust‟s Health & Safety at Work Policy.

2.0 Rationale

This policy is underpinned by health and safety legislation and places a duty on the Trust to provide and maintain a safe working environment.

3.0 Policy Aim

This policy aims to ensure:

- The lone worker has full knowledge of the hazards and risks to which he/she is being exposed.
- The lone worker knows what to do if something goes wrong.
- Someone knows the whereabouts of the lone worker, what he/she is doing and when they are due back and will implement the agreed emergency response.

4.0 Policy Statement

The Trust is committed to ensuring, so far as is reasonably practicable, that staff who are required to work alone or unsupervised for significant periods of time are protected from risks to their health and safety.

Working alone does not contravene the law, but it can bring additional risks to a work activity. Through the process of risk assessment the Trust will identify activities that have a significant level of risk attached to them. The Trust will, so far as is reasonably practicable, employ controls to reduce the exposure to those risks or eliminate the risk all together.

5.0 Scope

This policy applies to all employees and those undertaking work on behalf of the Trust and refers to all services and activities of the Trust.

It is applicable to:

- All lone workers, as defined, whether in a clinical or non clinical environment.
- Line managers of lone workers.
- Staff who are not routinely defined as lone workers but on occasion are required to work alone as per the definition.
- Those staff who are responsible for providing information which may affect the safety of lone workers.

6.0 Responsibilities

6.1 *Trust Board*

The overall responsibility for these arrangements lies with Trust Board.

6.2 *Chief Executive*

The Trust Board"s responsibility for ensuring implementation is managed through the Chief Executive.

6.3 *Director Human Resources & Organisational Development*

The Chief Executive has appointed the Director of Human Resources & Organisational Development as the identified Lead person for Health and Safety within the Trust which includes responsibility for establishing and monitoring the implementation of the Lone Working Policy. This function will be carried out by the Head of Health & Safety.

6.4 *Directors*

The Chief Executive requires Directors to establish and monitor the implementation of these arrangements within their area of responsibility.

In collaboration with the Head of Health and Safety, Directors are required to establish local health and safety arrangements to ensure compliance.

6.5 ***Managers*** are responsible for:

- Ensuring that staff are aware of this policy and understand the methods and timing of reporting incidents.
- Ensuring risk assessments, local policies and procedures are produced and that safe systems of work are adopted including emergency response arrangements.
- Ensuring that any lone working procedures and safe systems of work implemented are subject to regular monitoring and reviewing to ensure effectiveness.
- Ensuring that staff receives appropriate information, instruction, training, supervision and equipment.

6.6 *Staff*

If staff hold a post where the nature of the job involves working alone a risk assessment must be carried out with appropriate arrangements put in place to ensure health and safety.

Staff must:

- Ensure they have all the necessary information, instruction and training to recognise the hazards and risks involved with working alone.
- Comply with policy and related procedures and co-operate with supervisors and managers on all health and safety matters.
- Take reasonable care of their own health and safety and that of others who may be affected by their acts or omissions at work.
- Advise line managers of any concerns or risks.
- Report all incidents of violence and aggression in accordance with the Trust Management of Adverse Incidents Policy.
- Attend appropriate training.
- Support colleagues who have been the victim of a violent incident or a witness to it.
- Co-operate fully in any subsequent investigation of an incident.
- Follow safe working procedures including the use of safety/ communications equipment.
- Know what to do if something goes wrong.
- Share their schedule in accordance with local arrangements.
- Report any incidents, concerns about working alone, or faulty equipment to their line manager.

7.0 Monitoring and Review

7.1 The Trust is committed to ensuring that all policies and procedures are kept under review to ensure that they remain compliant with all relevant legislation and reflect organisational development.

7.2 This document will be reviewed by the Director of Human Resources and Organisational Development within two years or earlier if required.

7.3 The Trust is committed to regular auditing of lone working arrangements and will also monitor agreed performance indicators as determined by the Trust Board and/or the Lead Director.

7.4 Additionally Trade Union Side representatives may also monitor incidents, conduct risk assessments, carry out workplace inspections, etc.

8.0 Sources of Advice and Further Information

8.1 Further advice and information regarding lone working can be obtained from the Head of Health & Safety and/or Trade Union Side representatives.

8.2 This document should be read in conjunction with related policies and procedures e.g.

- Zero Tolerance on Abuse of Staff Policy, Procedure & Management Strategies
- Management of Adverse Incidents Policy
- Health and Safety at Work Policy
- Risk Management Strategy

9.0 Equality and Human Rights Considerations

9.1 This document has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Using the Equality Commissions screening criteria, no significant equality implications have been identified. It is therefore not subject to equality impact assessment.

9.2 This document has been considered under the terms of the Human Rights Act 1998 and was deemed compatible with the European Convention Rights contained in the Act.

10.0 Alternative Formats

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audio cassette and in other languages to meet the needs of those who are not fluent in English.

11.0 Records Management

The supply of information under the Freedom of Information does not give the recipient or organisation that receives it the automatic right to re-use it in any way that would infringe copyright. This includes, for example, making multiple copies, publishing and issuing copies to the public. Permission to re-use the information must be obtained in advance from the Trust.

SECTION TWO

LONE WORKING PROCEDURE

LONE WORKING PROCEDURE

12.0 Risk Assessment and Safe Systems of Work

12.1 Where there is the potential for working alone, a risk assessment is required[2].

12.2 Risk assessments should be completed with the individuals who are involved in the task or process being assessed; they are the people who best understand the risks.

Risk Assessment includes:

STEP 1	**Identification of individual, environmental and service provision risk factors.**
STEP 2	**Development of local procedures to implement the outcome of the risk assessment.**
STEP 3	**Providing information to all staff that are affected.**
STEP 4	**Regular reviews are necessary at regular intervals and whenever there is reason to suspect they are no longer valid.**

12.3 Please refer to the Trust Risk Management Strategy for guidance on the risk assessment process.

[2] Ref: The Management of Health and Safety at Work Regulations (N.I) 1992 and amendments

13.0 STEP 1 - IDENTIFICATION OF RISK FACTORS

The **risk assessment** process should take into account the identification of hazards from; for example, means of access and/or egress, equipment, substances, environment, travel/route planning, communication, activity, individuals etc. Particular consideration should be given to: -

13.1 *Individual Risk Factors*

Patient/Client/Other Individual:

- Is the person facing high levels of stress, likely to be drunk or on drugs?
- Does the person have a history of violence?
- Does the person have a history of criminal convictions?
- Does the person suffer from a medical condition which may result in a loss of self control?

Staff:

- Are staff familiar with relevant Trust policies and local arrangements for lone workers and have they received relevant training?
- Are the staff new to the job, location or caseload?
- What is the staff medical fitness?

* Special needs or disabilities of a member of staff may have to be taken account of. This is applicable under general health & safety legislation and the Disability Discrimination Act.

Working with Groups:

- Is the history of the group/area a factor?
- Have you a planned exit route?
- Are there people attending from other services/agencies?

13.2 *Environmental Risk Factors*

- Is the remoteness or isolation of the workplace a factor?
- Are there any problems with communication?
- Is there a possibility of interference, such as violence or criminal activity from other persons?
- Is there a possibility of an animal attack?
- Position within the room?
- Are there offensive weapons present?

13.3 *Service Provision Risk Factors*

- Has the person verbally abused a healthcare worker in the past?
- Has the person threatened a healthcare worker with violence in the past?
- Has the person attacked or attempted to attack a healthcare worker in the past?
- Does the person perceive a healthcare worker/professional as a threat to his/her children, their own liberty or themselves?
- Is the work out of hours?
- Does the person have unrealistic expectations of what can be done for them?
- Does the person perceive staff as wilfully unhelpful?

14.0 STEP 2 - DEVELOPMENT OF LOCAL PROCEDURES / SAFE SYSTEMS OF WORK

From the risk assessment it should be possible to identify lone working risk areas or activities. Local procedures need to be written to ensure there is a **safe system of work** for staff working in lone worker risk areas or activities. The emphasis should be to **reduce the risk to as low as is reasonably practicable**. Suggested local procedures/safe systems of work are provided in Section 3.

15.0 STEP 3 - COMMUNICATION

The risk assessment should pay particular attention to the **process of communication**.

15.1 ***Sharing of Information between services/other agencies***

There should be communication of information about patients/clients/significant others between services/other agencies which may be providing service/treatment/care to the same individual. This should be documented. All relevant disciplines providing treatment/service/care should be informed about the risk, potential for violence and aggression, including trigger points. Managers are responsible for ensuring systems are in place to share such information and concerns.

Balancing the need to provide information on potential risks in protecting an individual's right to privacy - Legislation allows for the sharing of confidential information for the protection of health. This must be justified on a case by case basis[3].

15.2 ***Local system of communicating with each other (Buddy system)***

It is imperative that the team leader or manager establishes a local system of communicating the whereabouts of individuals and an emergency response system is agreed. All staff must be compelled to use the system once established.

When Suzy Lamplugh, the Estate Agent went missing, the biggest problem the Police had was that they had no idea of where she had gone, who she had gone to see and her colleagues had no idea about when she should have been back. **A local system of communicating with each other** will limit any such incidents for Trust staff.

Following risk assessment methods of communication will be made available, which will facilitate safe working practices, e.g. use of two-way radios, silent alarms linked to switchboard, personal safety alarms etc. Consideration should be given to mobile phone coverage and if assessed as appropriate direct telephone link to the emergency services. This procedure is not prescriptive

[3] Ref: Human Rights Act 1998, HSW Order NI 1978, The Safety & Health Practitioner, November 2002

about how each team will run a „buddy system" however, some ideas are described in Section 3.

A communication procedure must be in place in every location/team and be utilised by all staff.

16.0 STEP 4 - MONITORING & REVIEW

Managers must ensure that any lone working procedures and safe systems of work implemented are subject to regular monitoring and reviewing to ensure effectiveness. This may take the form of both informal monitoring on a day to-day basis and more formally via safety inspections.

Risk assessments must be reviewed at regular intervals and whenever there is reason to suspect they are no longer valid.

Staff are responsible for adhering to procedures and should report any incidents or concerns relating to the safety and effectiveness of the working arrangements to their line manager.

17.0 Training

It is the responsibility of the individual and the line manager to identify any training needs and to ensure that these are facilitated, for example:

- Corporate Induction
- Departmental Induction e.g. local lone working arrangements
- Management of Actual or Potential Aggression (MAPA) Training. Training will be available to all staff based upon the level of risk.
- Personal Safety
- Use of equipment e.g. mobile phone, personal alarm
- Instruction in the use of a buddy system etc.

If there are particular issues for local areas or specialist teams it is possible to arrange training to work through these concerns and devise strategies to manage them. The Health and Safety Department can be contacted for further advice.

Managers are responsible for keeping a record of staff training.

18.0 Incident Management

All incidents must be reported and investigated in accordance with the Management of Adverse Incidents Policy.

SECTION THREE

SUGGESTED LOCAL PROCEDURES / SAFE SYSTEMS OF WORK FOR LONE WORKING

19.0 BUDDY SYSTEM

- Staff member to log on for duty. (Staff may wish to use an office diary/whiteboard to record staff members logging in/out).

- Team up with a work colleague „buddy" and share details of both your work schedules for the day and your vehicle and travel details i.e. destinations and expected times of arrival/departure.

- Let your „buddy" know of **any** changes to your schedule even small changes.

- On high risk visits/tasks communicate arrival and departure to „buddy".

- Agree a schedule of regular checks on each other throughout the shift even if high risk visits/tasks are not scheduled.

- Confirm with base/"buddy" that you have returned or the visit has ended.

- Arrange for contact/emergency response if your return is overdue.

- This procedure should be followed throughout all shifts.

- Staff member to log off at end of shift.

- Communicate via mobile-phone/telephone to highlight any visit or situation causing concern.

- If no other point of contact available, especially at night, leave messages at home or where this is not possible with a designated member of staff.

- Lone workers such as catering, domestic, office staff etc may wish to inform someone they are working alone and contact them again to confirm they have finished work and left the premises.

20.0 HOME VISITS

Before Leaving Checklist

- Is the visit to the patient/client in their home necessary?
    - Can they come to you in a Trust facility?

- Will changing the time of the visit reduce risks?
    - Consider arranging visits for particular times of day such as mornings when parents are taking children to school are around and when anti-social or illegal activity should be minimal.

- Have you the knowledge that will allow you to recognise when a situation is becoming dangerous?

- Have you the communication skills to resolve the situation if safe to do so?

- Do you know when to leave and seek assistance?

- Is this to be your first visit to the patient/client?

- Have you read through their notes and records to acquaint yourself with relevant information including possible risks?

- Are you providing cover for another member of staff?
    - Brief colleagues on difficulties.
    - Is a joint visit necessary?

Useful information and checklist required by staff member prior to any visit to a patient/client's home may include:

- Name/Date of Birth.

- Address (obtain clear directions to location of residence).

- Telephone number (make sure patient/client knows you will be visiting unless there are particular reasons for an unannounced visit).

- Diagnosis.

- GP Name.

- Contact number of appropriate person if further help required e.g. Line Manager / PSNI / Colleague.

- Reason for referral.

- Is the individual known to the service or the Trust?
- Specific equipment : carry only what is necessary.
- Are there other occupants in the house or have access to it?
- Are there any perceived or previous problems e.g. patient/relative aggression/known causes of aggression?
- Should this client only be seen in Trust premises?
- Is there any indication of anti-social/ criminal activity in the area?
- Is there indication of need for staff to visit in pairs?
- Is there any indication that you should not use your own car or be easily identifiable as a health/social care worker?
- Consider the need to vary routine or routes.
- How access to the house can be obtained e.g. key to house, isolation of area.
- Aggressive /unusual pets.

It is recognised that some of the above information may not be available prior to a visit. Visits requested with little or scant information should be dealt with as a higher risk visit. **Refer to section 22.0.**

On Arrival

BE ALERT, BE AWARE, BE SAFE

- Park with care, in such a way as to ensure a quick getaway.
- Be aware of your attitude, body language.
- Keep clear of the doorway after ringing and stand sideways on so you present a narrow, non-threatening but protected stance.
- Introduce yourself and the reason for your visit.
- Always show your Trust ID card.
- Do not enter if the person you are calling to visit is not available.
- Do not enter if met with aggression at the front door or the person appears to be under the influence of alcohol or drugs.

- Only enter when you are invited and you feel safe to do so.
- Follow the occupants in when entering.
- Ask for dogs to be put in another room before you go in.
- Check how the door locks as you go in.
- Be aware of your surroundings and exits.
- Try to sit nearest the door.
- Remain aware of the behaviour of all persons in the house, watching for changes in mood, movements or expressions that may indicate a problem.
- If another person enters the room, reassess, if uncomfortable terminate the visit and leave.
- Never give your home telephone number or address.

IF AT ANY TIME YOU FEEL YOUR SAFETY IS AT RISK, OR VIOLENCE IS THREATENED LEAVE IMMEDIATELY AND SEEK HELP.[4]

On Return

If something has happened during your visit which has caused you concern or has caused you to feel threatened. Inform your line manager and discuss further action.

- Post Incident Support.
- Post Incident Analysis.

[4] Ref : Suzy Lamplugh Personal Safety at Work: Lone Working 2007/2008

21.0 STAFF WHO ARE NOT ROUTINELY DEFINED AS LONE WORKERS E.G. DOMESTIC / CATERING / OFFICE WORKER / ESTATES PERSONNEL / STAFF ON CALL ETC

If you are working alone and **feel isolated or insecure** you could:

- Inform someone that you are there and arrange for regular contact, e.g. hourly telephone checks.

- If possible lock the external doors to the building for improved security, if not possible lock corridor/kitchen/office doors (leave key on inside of lock for emergency escape in case of fire).

- If you do feel threatened or at risk from a security type incident call the Police.

22.0 HIGHER RISK VISITS/LOCATIONS

Visits assessed as higher risks should only be undertaken if considered essential. More stringent control measures need to be detailed in the local policy and procedure. It may be appropriate to call the point of contact immediately before and immediately after some visits, joint visits or an escort may be necessary, use of local taxis may require consideration etc.

Accompanied visit

- Do you have a policy on when you request other staff to assist?
- Consider if a security escort e.g. (Police) is necessary/appropriate.

NB: The Police will try to provide an escort where imminent danger is threatened, subject to resources available. Staff should bear in mind that this could exacerbate the risk given that the Police are not always welcome in certain areas.

For visits to higher risk locations (for example, areas with high-crime rates, isolated rural areas etc) an assessment of the situation and needs should be made before leaving and any additional checks that may be required should be made. If you have any doubts regarding the location:

- Double check the address, telephone number and consider ringing back to confirm the validity of the location.

- Verify information about previous treatment; ask caller to be visible at house window or door as you arrive and to leave light on/curtains drawn back at night.

23.0 SEVERE WEATHER CONDITIONS

If weather conditions are severe and roads are unsafe, do not put yourself at unnecessary risk.

Staff must communicate with their line managers and colleagues to inform them that they are going on a visit, where, how long, what route etc. If your visit is essential, make sure you are prepared for any eventuality including a means of communication.

24.0 EMERGENCIES IN PATIENTS/CLIENTS HOME

If staff identify an emergency situation in a patient/client‟s home then contact the appropriate emergency service as soon as possible, **let the experts deal with it.**

25.0 CAR SAFETY

By keeping your motor vehicle in good working order, reporting any faults and carrying out regular servicing you will limit the risk of breaking down. Simple pre driving checks will also help, such things as:

- Fuel in tank
- Extra fuel in a safety-approved can
- Oil level to correct level
- Water in radiator
- Spare tyre is inflated
- Horn & lights working
- Water in washer bottle and washers work.
- Do you know how to change a wheel, where your fuses are in the car? Do you have spare fuses?
- Do you have details of breakdown/rescue organisations?

If Your Car Breaks Down

- Turn on your hazard warning lights, (notify your „buddy"/colleague) and summon assistance as appropriate.

- Try to assess whether it is safer to stay in your car, or to get out, take account of how isolated you are and the time of day.

- If you stay inside, sit in the passenger seat to give the impression you are not alone.

- Display a "help" notice if you stay in the car.

- Keep your doors locked and the window open no more than 1.5 inches, if someone stops to offer help, ask him or her to telephone the police. Do not let people who offer to help get into your car.

- If you leave the car, lock it and note its location, if you have a personal alarm, take it and keep it in your hand. If it is dark, or will be soon, take a torch.

- If you have a warning triangle, place it in the direction of on-coming traffic, 30 metres from your car and on the same side of the road.[5]

[5] Ref : Suzy Lamplugh Personal Safety at Work: Lone Working 2007/2008

26.0 PERSONAL SAFETY IN YOUR CAR

- Make sure you carry your mobile phone with battery fully charged or coins/phone card for an emergency.
- Plan your route before setting off, when you have the choice use main roads.
- Tell someone the route you will be taking and when you expect to arrive.
- Let someone know if you change your journey plans.
- Have the directions and maps in the car so you do not have to stop to ask.
- Try to travel on main well-lit roads.
- Keep aware of the latest police recommendations regarding road rage. For example, if another driver gets annoyed with you. Do not make eye contact or make gestures.
- Do not have valuables visible in the car when driving.
- Stay in the car as much as you can. Keep the doors locked and windows closed, especially in towns where you will be stopping at junctions.
- Keep handbags, briefcases and mobile phones out of reach of open windows in case of snatch thieves.
- When you leave the car, lock personal belongings, equipment, drugs etc in the boot, not on display.
- Lock your car, even if you are only going to pay for petrol on a garage forecourt.
- When parking in daylight, consider what the area will be like in the dark.
- At night, park in a place, which is well lit, and if possible busy. Try to avoid car parks or areas where you and your vehicle are not clearly visible
- Have the keys ready before you get into the car, check the back seat.
- If you see an incident or accident, or someone tries to flag you down seek assistance, ask yourself if it is genuine and if you could really help – it might be best to phone for help or drive to the nearest Police station.
- If a car pulls up in front of you and you have to stop, keep the engine running. Stay calm and ensure all the doors and windows are locked. If the driver leaves the car to approach you, reverse as far as you can while sounding the horn and activating the hazard lights.

- If you think you are being followed, try to alert other drivers with your lights and horn. Phone or pretend to phone the Police and make an obvious note of the car registration number. Keep driving until you reach a busy area or a police/fire or ambulance station or even a garage.

- Never give lifts to strangers.[6]

27.0 PERSONAL SAFETY ON FOOT

- Avoid wearing clothing or accessories that could be used to harm you e.g. scarves, ties, heavy necklaces.

- You are more likely to escape danger wearing clothes you can move in easily and shoes that are comfortable; walking quickly is usually safer than trying to run.

- Valuables, such as wallets should be kept in an inside pocket and secured, or use a body belt or "bum bag", try to keep both hands free.

- To carry things, use a small bag slung across your body under a jacket or coat, or a shoulder bag with a short strap and secure fastenings, make sure it sits close to your body with the fastening innermost.

- Carry in your pocket coins/phone card and the telephone number to stop all your cheque cards and your keys.

- Whenever possible, avoid walking alone at night or near groups of rowdy people.

- Keep to busy, well-lit roads.

- Do not take short cuts, unless you know they are as safe as the longer route.

- Avoid poorly lit or little used underpasses, waste ground and isolated pathways especially at night.

- Carry a torch.

- Walk facing oncoming traffic.

- At night or in bad weather conditions where visibility is poor ensure you wear a high visibility jacket.

- Have a personal alarm readily at hand (available from Health & Safety).[7]

[6] Ref : Suzy Lamplugh Personal Safety at Work: Lone Working 2007/2008
[7] Ref : Suzy Lamplugh Personal Safety at Work: Lone Working 2007/2008

28.0 MANAGERS CHECKLIST

In order to manage an effective safe system of work for lone working, managers may wish to utilise one or more of the following:

- Office diary/whiteboard/clocking in-out procedures.
- Mobile phones/speed dial numbers/agreed code words with other staff members.
- Buddy lists.
- Record of staff mobile and personal numbers (with agreement).
- Record of colour/make/registration of staff cars (with agreement).
- Risk assessment and lone working standing agenda items on team meetings.

DFP GENERAL BUSINESS CASE PRO FORMA

FOR SMALL EXPENDITURES

This pro forma is designed to facilitate documentation of an expenditure appraisal for relatively small expenditures (up to a maximum of £1m) with appropriate and proportionate effort. It identifies the main elements of a business case to be covered, followed by spaces or tables for inserting the relevant information. ***The spaces and tables should be enlarged or modified as required to accommodate all the necessary information.***

Note that this is a general template covering basic requirements; it can be adapted and tailored to suit particular spending areas as desired. There are no precise rules about the length of the business case document for these relatively small expenditure decisions, but, as a broad rule of thumb, it might be anything from a few pages in the simplest cases to 20 pages or more in comparatively complex cases.

For detailed guidance on business cases and expenditure appraisal, consult the Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE) at http://www.dfpni.gov.uk/eag or seek advice from a Departmental economist.

PROJECT TITLE: CAH UROLOGY OUTPATIENTS

SPONSORING DEPARTMENT/AGENCY:

SENIOR RESPONSIBLE OFFICER: DR GILLIAN RANKIN, DIRECTOR OF ACUTE SERVICES

SIGNED: **DATE:**

APPROVING OFFICER:

SIGNED: **DATE:**

Project Team

- Dr Gillian Rankin – Director of Acute Services;
- Mrs Trudy Reid - Assistant Director (Acting) of Surgery & Elective Care;
- Mrs Martina Corrigan – Head of ENT and Urology;
- Mrs Connie Connolly – Lead Nurse for Outpatients;
- Kate O'Neill – Urology Specialist Nurse;
- Jenny McMahon – Urology Specialist Nurse;
- Mr Michael Young – Consultant Urologist;
- Mrs Claire Kelly – Head of Capital Planning;
- Mrs Pauline Grant –Planning Officer;
- Roger Sally –Teague and Sally;
- Mr Dennis Quinn – Assistant Head of Estate Development and Capital Works; and
- Mr John O'Donnell – Estates Officer.

Section 1: Project Background, Strategic Context and Need

- *Explain the background to the proposal including its relevance to NI Government or Departmental strategic aims and policy objectives.*
- *Identify the key stakeholders and explain their commitment and any outstanding issues.*
- *As specifically as possible, explain the nature of the needs or demands that are to be addressed, and detail any deficiencies in existing service provision.*
- *Include suitable quantification of needs/demands/deficiencies where possible.*

Introduction

Opened in 1972, Craigavon Area Hospital (CAH) provides a range of acute inpatient, day case, outpatient and diagnostic services as well as Intensive Care, Trauma and Orthopaedic services, consultant-led and midwife-led maternity services and an emergency service. Also provided in the hospital are a number of area-wide clinical services including neo-natal intensive care, specialist cancer services, pathology services, laboratory services and pharmacy services.

Under Developing Better Services (June 2002) CAH was designated as an acute hospital providing the full range of non-regional acute services.

Background

The Urology Nurse-Led clinics are currently held in the Thorndale building on the CAH site and the Urology Consultant-Led clinics are held in the new OPD within the Ramone building. It is proposed to merge the two functions and source accommodation that will be large enough to accommodate them at one location. The Thorndale building does not have additional space in its existing state to accommodate all the Urology services and it is deemed no longer suitable for the nature of the clinics for the following reasons:

- It does not provide good patient flows and it will not accommodate the increasing high activity that will be coming to this area;
- there are no clinical adjacencies as it is a standalone building on the CAH site;
- it has inadequate decontamination facilities;
- it has no disposal room;
- there is a lack of toilet facilities due to the nature of the clinic; and
- there is a lack of clinical space and the need for more accommodation will increase further when the 2 new Consultant Urologists take up post. The Southern Trust will soon become one of the 3 Urology Hubs of NI.

Benefits

There are a number of benefits of bringing Nurse-Led activities and Consultant-Led clinics to one location:

- The Urology Specialist Nurses will have the support of the Consultants if and when required;
- the patient flows would be greatly improved;

- increased throughput of patients and therefore this would assist with achievement of the W/L and Review appointment targets;
- the consumables for the Urology department would be all stored together which would decrease duplication/costs etc; and
- patients would be more familiar with the location/surroundings if all their clinics were in the one location.

STRATEGIC CONTEXT

Introduction

Key strategic documents relating to the improvement of accommodation at CAH Urology Department are detailed below.

SHSSB Developing Better Services – Profile of Future Services within the SHSSB, June 2002

Under "Developing Better Services" (June 2002) CAH was confirmed as one of the nine hospitals in Northern Ireland which will provide acute hospital services. Within this document it is stated "The Board is committed to ensuring that Southern Board residents have timely access to high quality hospital services and that there is the capacity to provide both the emergency and elective care that is required by our population. Any changes in services must also bring improvements to treatment and care."

DHSSPS Priorities for Action (PfA) targets for Outpatient Appointments

The following target is to be achieved in 2012-13

Outpatient performance

From April 2012 the HSCB and PHA should ensure that Trusts achieve a performance level of:

- From April 2012, at least 50% of patients wait no longer than nine weeks for their first outpatient appointment with no one waiting longer than 21 weeks, increasing to 60% by March 2013 and no one waiting longer than 18 weeks.

In order to continue to facilitate achievement of this target the Urology Department must be functioning to the best of its ability with sufficient and suitable accommodation.

Health Building Notes 12 –Outpatient Department

This Health Building Note (HBN) 12 essentially provides guidance for the planning and design of out-patient accommodation principally for use in connection with departments attached to or form part of, an acute hospital or treatment centre.

A number of design principles have been identified which help to achieve the highest standard for an out-patient department. These include:

- For patients:
  - A well-designed clinic reception;
  - Clear and simple directions and circulation routes;
  - Privacy and dignity are ensured at all times;
  - Uninterrupted consultation with the doctor;
  - Easy access to treatment facilities and WCs;

- Easy access to telephone facilities.

- For doctors:
  - Patients ready for consultation, with their case notes immediately available;
  - Accommodation that will enable consultation and examination to take place in privacy;
  - Access to diagnostic and treatment facilities;
  - Sufficient storage for equipment.
- For all staff:
  - Good visual contact with waiting patients;
  - Controlled handling of patients' records to maintain confidentiality;
  - A high-quality, safe and secure working environment.

NEED

A regional decision was recently made to provide three Urology teams to serve the population of Northern Ireland which would be known under the following headings:

Team North - Belfast area
Team West - Western Trust area plus the Altnagelvin and Coleraine population
Team South - Southern Trust area plus Fermanagh population.

The Southern Trust has a population of 358,600 and is the fastest growing population in NI over the last 10 years with projected further growth of 13.5% by 2020 compared to NI average of 6.5%. The Fermanagh population that will also be cared for by the Southern Trusts Urology department has a population of 65,000. This means that the Urology department will have a catchment population of 423,600.

The Trust has agreed the following total activity levels for the 5 Consultant model:

- **3,948 new outpatient appointments**
- **5,405 review outpatient appointments**
- **4,385 day cases/23 hour stays**
- **1,200 inpatients**

Funding for 2 additional Consultant Urologists has been approved to assist the Urology Team with the additional activity that they will be taking on from the Fermanagh area but unfortunately the current Urology accommodation within the Thorndale building and Ramone building is no longer suitable for the reasons identified above.

Approval is sought from SMT to fund this project from 2012/13 General Capital monies.

Section 2: State Objectives and Constraints

- *Explain and list the project objectives in specific measurable terms.*
- *Include quantifiable targets where possible.*
- *Identify any likely constraints to the project e.g. timing issues, legal requirements, professional standards, planning constraints and so on.*

Project Objectives	Measurable Targets
1. **To provide a clinically effective Urology Outpatient Department for the Trust's catchment area and also the Fermanagh area -** The intensity of care within the modern hospital together with the need for highly efficient patient management requires effective clinical processes and accommodation standards which support the delivery of safe care.	1.1 Staff satisfaction survey – a survey will be conducted within 6 months of completion of works to assess clinical effectiveness of the department.
2. **To ensure the provision of high quality accommodation -** The required accommodation should be provided to a high quality in terms of condition of the fabric, the internal and external environment and also to a high level of functional suitability.	2.1 Patient satisfaction survey to be conducted within 6 months of completion of works – to achieve 90% of satisfaction ratings of 'more than satisfied' with respect to the quality of the facilities.
3. **To minimise disruption and disturbance to on-going patient care activities during the construction period -** It is imperative that continuing care for patients is provided during the construction period. Some development options are likely to have a greater impact on the patient environment than others, and it is essential that this disruption to patients is minimised.	3.1 Analysis of log of incidents detailing when building work caused disruption to services.
4. **To ensure strategic fit with future developments -** Any provision of new accommodation or improvement to existing accommodation should not limit future plans to develop the Craigavon Area Hospital site.	4.1 Any provision of new accommodation or improvement to existing accommodation should not limit future plans to develop the Craigavon Area Hospital site.
Constraints	**Measures to address constraints**
1. The selected option must be accessible and affordable in terms of capital and revenue.	Ensure Project Manager is aware of any deviations in costs.
2. The preferred option must make best use of the existing estate and service infrastructure.	Ensure the Trust makes best use of the existing estate and service infrastructure

Section 3: Identify and Shortlist the Options

- *Consider alternative ways to meet the objectives e.g. variations in scale, quality, technique, location, timing etc.*
- *Start with an initial 'long list' of options and sift them to provide a shortlist. Record all the options considered and the reasons for rejecting those not shortlisted.*
- *The shortlist of options should include a baseline Status Quo or 'Do Minimum' option and a suitable number of alternative 'Do Something' options (usually at least two).*

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
1) Status Quo	S	N/A
2) Transfer all the Urology Clinics to the Ramone building	S	N/A
3) Extend the current Urology Department at Thorndale to accommodate the Consultant – led clinics.	S	N/A
4) Transfer all of the Urology Clinics to accommodation in the CAH Outpatients	S	N/A
5) New build to accommodate all of the Urology Clinics in one location	S	N/A

Section 4: Monetary Costs and Benefits of Options

1) *Appraisals should include all the costs and benefits to Northern Ireland arising from the project, not just those to a particular organisation or sector e.g. all costs and benefits to the public, private and third sectors should be included.*
2) *Costs and benefits should be valued in economic cost terms, which are generally reflected by using current market prices.*
3) *All the assets and other resources employed by each option should be costed, even if they have already been purchased. This is because they have an opportunity cost value i.e. if not used in this project they could be put to an alternative use.*
4) *Calculate the Net Present Cost (NPC) for each option:*
   - *Use the NPC spreadsheet at the NIGEAE website and append the NPC calculation for each option to the pro forma.*
   - *In the simplest cases, the table below may be used instead. Create a table for each option, adjusting the no. of columns to reflect the years of the project's life.*
5) *Treat the current financial year as Year 0.*
6) *Set out the expected capital costs and annual revenue costs for each option.*
7) *Express the figures in real terms i.e. held constant at today's prices.*
8) *The checklist of typical costs at the NIGEAE website should help identify relevant costs.*
9) *Financial savings arising from an option will be reflected in its lower costs compared to the Status Quo. Do not double count by also including them separately as benefits.*
10) *Other monetised benefits may be taken into account but are likely to be rare in small expenditure cases. Most benefits will be covered in the non-monetary Section 5 below.*
11) *For particularly uncertain cost assumptions, consider using sensitivity analysis to illustrate how NPCs and option rankings are affected by varying these assumptions.*
12) *For more in-depth guidance, see Step 5 and Step 8 of NIGEAE.*

Option 1: Status Quo	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Totals
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost	0	0	0	0	0	0	0
Revenue Costs	Nil	Nil	Nil	Nil	Nil	Nil	Nil
(b) Total Revenue Cost	Nil	Nil	Nil	Nil	Nil	Nil	Nil
(c) Total Cost = (a) + (b)	Nil	Nil	Nil	Nil	Nil	Nil	Nil
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Cost Assumptions:

We do not propose to undertake any works with this option so therefore there will be no additional capital or revenue costs incurred.

Option 2: Provide accommodation in the Ramone building for Consultant and Nurse-led clinics	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Totals
Capital Costs	£498,000	Nil	Nil	Nil	Nil	Nil	£498,000
(a) Total Capital Cost	£498,000	Nil	Nil	Nil	Nil	Nil	£498,000
Revenue Costs							
(b) Total Revenue Cost	Nil	Nil	Nil	Nil	Nil	Nil	Nil
(c) Total Cost = (a) + (b)	£498,000	Nil	Nil	Nil	Nil	Nil	£498,000
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	£498,000	Nil	Nil	Nil	Nil	Nil	£498,000

Cost Assumptions:

It is proposed to move the current Urology department from the Thorndale building to the Ramone building to be in close proximity to the Consultant- Led Clinics.

The capital costs associated with the works are £498k and will be incurred in year 0.

Option 3: Extend the current Urology department at Thorndale unit	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Totals
Capital Costs	**£550,000**	Nil	Nil	Nil	Nil	Nil	**£550,000**
(a) Total Capital Cost	**£550,000**	Nil	Nil	Nil	Nil	Nil	**£550,000**
Revenue Costs							
(b) Total Revenue Cost	Nil	Nil	Nil	Nil	Nil	Nil	Nil
(c) Total Cost = (a) + (b)	£550,000	Nil	Nil	Nil	Nil	Nil	£550,000
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	£550,000	Nil	Nil	Nil	Nil	Nil	£550,000

Cost Assumptions:

It is proposed to extend the current Urology department that is located within the Thorndale unit on the CAH site to allow it to accommodate the Consultant-Led clinics.

The capital costs associated with the works are £550k and will be incurred in year 0.

Option 4 - Relocate all Urology services to CAH Outpatients	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Totals
Capital Costs	**£498,000**	Nil	Nil	Nil	Nil	Nil	**£498,000**
(a) Total Capital Cost	**£498,000**	Nil	Nil	Nil	Nil	Nil	**£498,000**
Revenue Costs							
(b) Total Revenue Cost	Nil	Nil	Nil	Nil	Nil	Nil	Nil
(c) Total Cost = (a) + (b)	£498,000	Nil	Nil	Nil	Nil	Nil	£498,000
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	9019	.8714	8420	
(e) NPC = (c) x (d)	£498,000	Nil	Nil	Nil	Nil	Nil	£498,000

Cost Assumptions:

It is proposed to relocate the Urology Consultant clinics and the Nurse-led Clinics to CAH Outpatient department.

The capital costs associated with the works are £498,000 and will be incurred in year 0. Depreciation has been assumed to be straight line over 25 years.

Option 5: New build	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Totals
Capital Costs	**£600,000**	Nil	Nil	Nil	Nil	Nil	**£600,000**
(a) Total Capital Cost	**£600,000**	Nil	Nil	Nil	Nil	Nil	**£600,000**
Revenue Costs							
Heat, light and power for 360m^2 @ £25/m^2	Nil	£9,000	£9,000	£9,000	£9,000	£9,000	£45,000
Building maintenance for 360m^2 @ £31/m^2	Nil	£11,160	£11,160	£11,160	£11,160	£11,160	£55,800
(b) Total Revenue Cost	Nil	£20,160	£20,160	£20,160	£20,160	£20,160	£100,800
(c) Total Cost = (a) + (b)	£600,000	£20,160	£20,160	£20,160	£20,160	£20,160	£700,800
(d) Disc Factor @ 3.5%pa	1.0000	.9662	.9335	.9019	.8714	.8420	
(e) NPC = (c) x (d)	£600,000	£19,479	£18,819	£18,182	£17,567	£16,975	£691,022

Cost Assumptions:

It is proposed to provide a new building on the CAH site to accommodate all of the Urology Clinics.

The capital costs associated with the works are £600,000 and will be incurred in year 0.

Section 5: Non-Monetary Costs and Benefits

- *List and describe the relevant non-monetary costs and benefits e.g. impacts on health, education, environment, transport, equality, sustainability etc.*
- *Use a table such as the one below to show how each factor impacts on each option.*
- *Quantify the impacts if possible and highlight important differences between the options.*
- *For more detailed approaches see the NIGEAE section on multi-criteria analysis.*

Non-Monetary Factor	Impact on Option 1	Impact on Option 2	Impact on Option 3	Impact on Option 4	Impact on Option 5
1. **Clinical Effectiveness and Patient Safety** – An effective clinical service is defined as an integrated, appropriate service, flexible to changing needs, with good clinical outcomes	x	✓✓	✓✓	✓✓✓	✓✓
2. **Quality of Accommodation-** option needs to provide high quality in terms of condition of fabric and internal environment and comply with HBN 22.	x	✓✓✓	✓✓	✓✓✓	✓✓✓
3. Degree of Strategic Fit – option needs to fit in with the overall plans of the hospital and make best use of the existing resources.	x	✓✓	✓✓	✓✓✓	✓
4. **Speed of Implementation / Continuity of Service** – depends on whether the solution can be completed by end of March 2013.	✓✓✓	✓✓	✓✓	✓✓✓	✓✓

✓✓✓ = fully addresses the evaluation criteria
✓✓ = moderate score against the evaluation criteria
✓ = low score against the evaluation criteria
x = option does not meet the evaluation criteria

Section 6: Assess Risks and Uncertainties

- *Identify and describe the risks that the project may face.*
- *Explain how these compare under the various options using the table below.*
- *Identify measures to ensure that each risk is appropriately managed and mitigated.*
- *Explain any contingency allowances included for risks in the option costings.*
- *More sophisticated optimism bias adjustments should not generally be required but may be relevant in some cases e.g. ICT projects or cases with significant capital costs.*
- *For further guidance see Step 6 of NIGEAE.*

Risk Description	Likely impact of Risk H/M/L					State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	Opt 4	Opt 5	
1. Project delayed	N/A	M	H	M	H	Option 1 does not require any works completed so therefore will not impose any risks. Option 2 and 4 both scored a medium risk factor because both options require major works undertaken of which could be delayed if the correct mitigation measures are not followed. Options 3 and 5 scored a high risk as they both would require planning permissions as one is a new build and one is an extension and both could be delayed due to this reason and could also be delayed due to major works like options 2 and 4. **Option 1** N/A **Option 2, 3, 4 and 5** **Mitigation measure** • Project Management structures established. • Review of works progress against budget profile by Project Manager. • Internal reporting and escalation of issues. • Project work streams (design, construction and commissioning) managed to ensure all target dates achieved.
2. Project exceeds budgeted costs	N/A	M	H	M	H	Option 1 does not require any works completed so therefore will not impose any risks. Options 2 and 4 scored a medium risk although it involves major work it does not involve extensions or a new build.

						Option 3 and 5 both scored a high risk factor because these options require either an extension or new build undertaken of which could exceed budgeted costs if the correct mitigation measures are not followed. **Option 1** N/A **Option 2, 3, 4 and 5** **Mitigation measures** • Project Manager to sign off all deviations from budget costs. • Project Manager has overall responsibility for managing project budget.
3. Refurbished unit does not meet user expectations	**N/A**	**H**	**M**	**M**	**M**	Option 1 does not require any works completed so therefore will not impose any risks. Option 2, 3, 4 and 5 all scored a medium risk. All options require major works undertaken of which might not meet the user expectation if the correct mitigation measures are not followed. Options 3 and 5 will not offer the service the clinical adjacencies that they require. **Option 1** N/A **Option 2 and 3** **Mitigation measures** • User involvement in design to ensure that as much of the desired accommodation as possible can be provided (this may be through user feedback or focus groups).
Overall Risk (H/M/L):	**N/A**	**M**	**H/M**	**M**	**H/M**	

KEY: H = high M = medium L = low N/A = Not Applicable

Section 7: Summarise the Option Comparisons and Identify a Preferred Option

- *Summarise the main differences between the options e.g. in terms of key assumptions, NPCs, non-monetary impacts, risks and other factors.*
- *Identify which option is preferred and explain why.*

On the basis of the outcomes of the above sections **option 4** is the preferred option.

Option 1 does not propose any change/enhancement to the current Urology department and therefore would not provide any additional clinical space for the new Urology Team South that is being developed in which there will be 2 additional Consultant Urologists added to their current staffing compliment. Option 1 would not provide any additional toilets that are essential to the nature of the clinics and would not provide the required clinical adjacencies. The Consultant and Nurse-led clinics would continue to operate in separate locations.

Option 2 involves the Nurse–Led clinics moving to the Ramone OPD to be able to work alongside the Consultant–Led clinics. This option would involve decant of non-clinical activities that currently reside in the Ramone building to make room for the additional Urology Clinics required.

Option 3 involves an extension to the Thorndale Unit to accommodate the Consultant-led Clinics as well as the Nurse-led clinics. This option would provide the additional space that the department require for its expansion of services and additional toilet facilities. This option would not be feasible because it would cost approximately £550k which is over the allocated budget and another reason for discounting this option is that the Thorndale building is located too far away from the main hospital and therefore no clinical adjacencies if they were required.

Option 4 is the preferred option which would involve both the Consultant-Led and the Nurse-Led clinics to be relocated to the vacant space in the CAH Outpatients department. This option would allow the Urology department to be self-contained in the one area and provide clinical adjacencies as the department would be located within the main hospital building and other clinical services would be in close proximity if they were required.

Option 5 involves building a new Urology Department to accommodate both the Consultant-Led and the Nurse-Led clinics. This option would provide the additional space that the department require for its expansion of services and additional toilet facilities. This option would not be feasible because it would cost approximately £600k which is over the allocated budget. This option would not provide the clinical adjacencies that the service would prefer to have in the event of an emergency.

Section 8: Assess Affordability and Funding Arrangements

- *Set out the annual capital and resource Departmental Expenditure Limit (DEL) requirements for the preferred option, as per the table below.*
- *Subtract existing DEL provision from total DEL required, to get additional DEL required.*
- *Figures should allow for inflation, contingencies and (where relevant) optimism bias.*
- *Resource DEL figures should include appropriate allowance for depreciation/impairment.*
- *Identify expected sources of funding and the degree to which each funder is committed.*
- *NB DEL figures differ from cash figures e.g. their timing may differ due to distinctions between accruals and cash accounting; and cash should exclude depreciation/impairment. This pro forma only requests the DEL figures but if you also require cash figures for cash accounting purposes, then you will need to adjust the DEL figures to cash separately.*
- *Consult a finance specialist if necessary.*

	Yr 0 £000's	Yr 1 £000's	Yr 2 £000's	Yr 3 £000's	Totals £000's
Total DEL Required:					
Capital DEL	498	0	0	0	498
Resource DEL					
Allowance for depreciation/impairment (included in Resource DEL figures above)		20	20	20	60
Existing DEL Provision:					
Capital DEL					
Resource DEL					
Allowance for depreciation/impairment (included in Resource DEL figures above)					
Additional DEL Required:					
Capital DEL					
Resource DEL					
Allowance for depreciation/impairment (included in Resource DEL figures above)					

Funding Body	Sum funded & % of total	Funding secured? Yes/No	If not secured, indicate status of negotiations
SHSCT General Capital Allocation 2012/13	£498k (100%)	Yes	N/A

Section 9: Project Management

- *Explain the proposed project management structure (e.g. use of PRINCE2), key management personnel and project timetable.*
- *Where relevant, indicate the proposed approach to procurement.*
- *Consider provision for benefits management and realisation, including e.g. documentation of Benefit Profiles using the templates at the Successful Delivery NI website.*
- *Identify any significant management issues e.g. legal, contractual, accommodation, staff or TUS issues.*
- *Is any external consultancy support required? If so, it must be supported by a separate business case as per FD(DFP)04/09 and section 5 of the accompanying guidance note.*

The following Trust project management roles have been identified:

- Project Owner - Dr Gillian Rankin (Director of Acute Services)
- Project Director – Mr Alan Metcalfe (Assistant Director of Estate Services)
- Project Manager – Mr John O'Donnell (Estates Officer)

The project will be managed using PRINCE 2 Methodology.

In order to ensure the project delivers its objectives and achieves implementation within timescale and budget, progress will be monitored on a monthly basis at Project Board / Project Team meetings.

Table 1. Project Timescales	
Business Case Approval	October 2012
Tender issue	29th October 2012
Tender return	9th November 2012
Contractor appointed	19th November 2012
Commence Works	3rd December 2012
Complete Works	15th March 2013.

Table 2 - Benefits Realisation Template	
Emergency Department – Phase 3	
Benefit	**Method of Measurement**
To provide a safe, clinically effective Urology service for patients residing within the Trust's catchment area.	• Staff satisfaction surveys completed 6 months after completion of pilot.
To ensure the provision of high quality accommodation.	• Patient satisfaction surveys to be conducted within 12 months of completion of works – to achieve 90% of satisfaction ratings of 'more than satisfied' with respect to the quality of the facilities; • Staff satisfaction surveys – surveys will be conducted within 12 months of completion of works to assess clinical effectiveness of the new Urology Department.
To minimise disruption and disturbance	• Analysis of log of incidents detailing

to ongoing patient care activities during the construction period	when building work caused disruption to services.
To ensure strategic fit with future developments	• Any provision of new accommodation or improvement to existing accommodation should not limit future plans to develop the Daisy Hill Hospital site.

EQUALITY AND HUMAN RIGHTS

Section 75 of the Northern Ireland Act (1998) requires public authorities in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, martial status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

As part of ensuring compliance with the statutory duty, the SHSCT have produced an Equality Scheme demonstrating their commitment to equality of opportunity and to carrying out Equality Impact Assessments on policies which may have a differential impact on any of the categories noted above. The existence of a differential impact is determined by reference to the following four criteria:

- is there any evidence of higher or lower participation or uptake by different groups?
- is there any evidence that different groups have different needs, experiences issues and priorities in relation to the particular policy area?
- is there an opportunity to better promote equality of opportunity or better community relations by altering the policy or working with others in government or in the larger community? or
- have consultations in the past with relevant groups, organisations or individuals indicated that particular policies create problems that are specific to them?

The developments proposed within this business case have been considered in terms of their equality of opportunity implications against each of the four criteria detailed above. The proposal to relocate the Urology Department has limited scope to impact differentially on any of the nine equality groupings, as the standard of care will be improved.

The Human Rights Act 1998

Under the Human Rights Act 1998 the Trust must ensure that the way in which it carries out its functions does not breach the rights of its service users. It is felt that this proposal will not breach any of the Articles covered within the Act.

Section 10: Monitoring, and Evaluation Arrangements

- *Indicate arrangements for regular monitoring of the project's progress.*
- *State proposed evaluation arrangements e.g. when it will happen, who will do it, what factors will be evaluated?*
- *For further guidance see para 2.9.15 at Step 9 of NIGEAE.*

Monitoring of the capital investment will be undertaken under the auspices of the Project Board which includes Senior Executive Directors of the Trust. It will be conducted throughout the implementation period and at completion. It will be managed by the Project Manager and supported as necessary by the Project Team.

The key issues that will be addressed will be:

- was the project completed on time?
- was it completed at budget cost?
- what were the reasons for any delay?
- what action would management recommend to prevent future problems?

Project Evaluation

Following the implementation of the project, an assessment will be made of the effectiveness of the capital investment by carrying out a post project evaluation (PPE). The main objective of the PPE will be to assess the benefits that are being or have been derived from the project, compared with those that were envisaged.

Responsibilities

The Post Project Evaluation (PPE) will be carried out by a Head of Service independent to the project.

Timing

The PPE will be carried out 12 months after completion of the project (April 2014).

Day	Clinic code	Clinic type	Activity	Staff	Nurse total
MON AM	CUROHW	Ward histology	Results / RF's / MDM – info and support	Registrar	SPN x 2 Band 5 x 2-3
	CAJGUO	Uro-oncology clinic	Results / RF's / MDM – info and support	Mr Glackin	Band 2 x 1
	CKSUO	Uro-Oncology clinic	Results / RF's / MDM – info and support	Mr Suresh	**Can you break down duties of staff for each day and what they actually do in the clinic, need to determine what banding of staff we need to support clinics.**
	ICSNULUP If registrar available	LUTS assessment	Consult & USS / Flow rates / bladderscan	SpN x 1 & band 5 x 1 (for uro-oncology clinics and checking IVC and pre-assessment) Registrar Band 5 x 2	
	ICSNULUT	LUTS review		SpN and Band 2	
	IVC	Intravesical therapy	Consult & Flow rates / bladderscan Bladder installations	Band 5 (from ward)	
MON PM	ICSNURSH	Prostate histology	Results / MDM – info and support	Registrar / SpN	SPN x 1
	ICSNULUP	LUTS assessment	Consult & USS / Flow rates / bladderscan	Registrar / Band 5 x 2	Band 5 x 3
	CAJGTDU	OP Clinic 2nd and 4th	Consult (Flowrate/bladderscan / pre-assessment)	Mr Glackin / Band 5 x 1 Band 2 for both clinics	Band 2 x 1

	IVC	Intravesical therapy	Bladder installations	Band 5 (from ward)	
Day	**Clinic Code**	**Clinic Type**	**Activity**	**Staff**	**Nurse Total**
TUES AM	ICSNURSB	Prostate biopsy	Care pre, peri and post biopsy Decontamination	Dr McClure / Williams SpN x 1 Band 5 x 2 Band 2 x 1	SpN x 1 Band 5 x 2 Band 2 x 1
TUES PM	ICSNUHEA CU2	Haematuria clinic OP Clinic	Assess / USS / Bloods / Urines and Care pre, peri and post flexible cystoscopy Arrange / Transport of scopes Consult (flowrate/bladderscan/Pre-assessment)	Mr Suresh SpN x 1 Band 5 x 2 Band 2 x 1 Mr O'Brien Band 5 x 1	SpN x 1 Band 5 x 3 Band 2 x 1

Day	Clinic Code	Clinic Type	Activity	Staff	Nurse Total
WED AM	 CAJGPA CKSPA CKSTDU	Prostate assessment 1st and 3rd 2nd and 4th OP Clinic	 Consult / USS / Bloods / Urines and Flowrates / bladderscan Consult (flowrate / bladderscan/ Pre-assessment)	 Mr Glackin / Mr Suresh SpN x 2 Band 5 x 1 Band 2 x 1 Band 5 x 1	SpN x 2 Band 5 x 1- 2 Band 2 x 1
WED PM	 CAJGPB CKSPB ICSNULUT	Prostate biopsy 1st and 3rd 2nd and 4th Flexible cystoscopy occasionally Ad Hoc Flow clinics	 Care pre, peri and post biopsy, Decontamination Care pre, peri and post flexible cystoscopy Arrange / Transport of scopes Consult & Flow rates / bladderscan	 Mr Glackin / Mr Suresh SpN x 1 Band 5 x 2 Band 2 x 1 Staffing as above SpN x 1	SpN x 2 Band 5 x 2 Band 2 x 1

Day	Clinic Code	Clinic Type	Activity	Staff	Nurse Total
THURS AM	ICSNUHEA	Haematuria Clinic	Assess / USS / Bloods / Urines and Care pre, peri and post flexible cystoscopy Arrange / Transport of scopes Sisters meeting / Scheduling/ department meeting	Registrar / SpN x 1 Band 5 x 2 Band 2 x 1 SpN x 1	SpN x 2 Band 5 x 2 Band 2 x 1
THURS PM	Registrar clinic	Uro-oncology / LUTS RV / Andrology	Consult with flowrate / bladderscan if LUTS MDM	Registrar Band 5 x 1-2 Band 2 x 1 SpN x 1	SpN x 1 Band 5 x 1-2 Band 2 x 1

Day	Clinic Code	Clinic Type	Activity	Staff	Nurse Total
FRI AM	CMYTDU	Specialist clinic	Results / RF's / MDM – info and support	Mr Young	SpN x 2
	CAOBTDU	Specialist Clinic	Results / RF's / MDM – info and support	Mr O'Brien SpN x 1 to cover both uro-oncology clinics	Band 5 x 1 Band 2 x 1
	CURWDMY	Urodynamics	Urodynamics	Mr Young SpN x 1 Band 5 x 1 Band 2 to assist with all clinics	
FRI PM	CAOBTDU	Specialist Clinic	Results / RF's / MDM – info and support	Mr O'Brien / SpN x 1	SpN x 2
	CURWDOB	Urodynamics	Urodynamics	Mr O'Brien SpN x 1 Band 5 x 1	Band 5 x 2 Band 2 x 1
	CURMY	OP Clinic	Consult (Flowrate / bladderscan / pre-assessment)	Mr Young Band 5 x 1 Band 2 to assist with all clinics	

Specialist nurse timetable – **can you please advise what each of this support entails, e.g. supporting consultant, speaking to patients in clinics doing tests etc……

DAY	KATE	JENNY
MON AM	Uro-oncology clinic support	Review LUTS clinic
MON PM	Prostate histology clinic	Admin
TUES AM	Prostate biopsy	Off
TUES PM	Haematuria clinic	Off
WED AM	Prostate assessment	Prostate Assessment
WED PM	Prostate Biopsy	Prostate Biopsy / Ad hoc flow clinics
THURS AM	Admin / Sr's Meeting	Haematuria Clinic
THURS PM	MDM / Admin	MDM / Admin
FRI AM	Uro-oncology clinic support	Urodynamic studies
FRI PM	Admin	Urodynamic studies

Admin sessions include: **what support is required to address this and take from yourselves?**

- Day to day scheduling and functioning of clinics
- ward management duties / Education / KSF / Clinical Governance / Equipment management / Supervision
- notes dictation (From LUTS clinics and any walk in patient attendances)
- arranging prostate biopsy sessions (scheduling / patient communication and co-ordination required with radiology, pharmacy and USS personnel)
- scheduling of clinics
- arranging follow up of MDM i.e. day 3 patients and urgent cases
- We also cover all clinics during times of annual / sickness leave
- Patient/family support – includes all clinic attendances and walk ins and telephone calls
- Professional meetings – NICAN / Catheter care meetings

Corrigan, Martina

From: Carroll, Ronan
Sent: 28 January 2019 15:25
To: Corrigan, Martina; ONeill, Kate; McCourt, Leanne
Cc: Gurbanova, Esmira; Stinson, Emma M; Young, Jason; McMahon, Jenny
Subject: RE: Compliment received - Thorndale unit

VG well done

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob Personal Information redacted by USI

-----Original Message-----
From: Corrigan, Martina
Sent: 28 January 2019 13:26
To: ONeill, Kate; McCourt, Leanne
Cc: Carroll, Ronan; Gurbanova, Esmira; Stinson, Emma M; Young, Jason; McMahon, Jenny
Subject: RE: Compliment received - Thorndale unit

Dear both

Very well done, it is lovely to get some positive feedback.

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)

-----Original Message-----
From: ClientLiaison, AcutePatient
Sent: 28 January 2019 13:00
To: Corrigan, Martina
Cc: Carroll, Ronan; Gurbanova, Esmira; Stinson, Emma M
Subject: FW: Compliment received - Thorndale unit

Martina

As per email below, please see compliment received re the Thorndale Unit.

Kind regards
Pamela

Pamela Truesdale

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

Tel Personal Information redacted by USI

-----Original Message-----
From: Reddick, Fiona
Sent: 28 January 2019 12:56
To: ClientLiaison, AcutePatient
Cc: Conway, Barry
Subject: RE: Compliment received - Thorndale unit

Hi Pamela

Can you forward this to Martina Corrigan and Ronan Carroll as this is there service area

Regards

Fiona

-----Original Message-----
From: ClientLiaison, AcutePatient
Sent: 28 January 2019 12:47
To: Reddick, Fiona; ONeill, Kate; McCourt, Leanne
Cc: Conway, Barry; Witczak, Maria; Stinson, Emma M
Subject: Compliment received - Thorndale unit

Dear all

Please see compliment received below and I would be grateful if this could be shared among all relevant staff.

Please note this needs to be recorded on the new Compliments Tracker on the Intranet.

Kind regards
Pamela

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

Tel Personal Information redacted by USI

-----Original Message-----

From: User Feedback
Sent: 24 January 2019 14:46
To: ClientLiaison, AcutePatient
Subject: FW: Re Thorndale unit

Please see below for your information and appropriate action.

Kind regards

Diane

-----Original Message-----
From: Personal information redacted by USI [mailto: Personal Information redacted by USI]
Sent: 24 January 2019 14:15
To: User Feedback
Subject: Re Thorndale unit

Dear Sir or Madam
My husband Personal Information redacted by USI and I the undersigned had an appt at the above unit and may I say it was with fear and trepidation we attended. From the outset we were put at total ease. Kate O Neill the nurse specialist explained everything to us the possible outcomes and how things would progress. Personal Information redacted by had the relevant tests done on the day the following Personal information redacted by USI MRI was done and Kate called us on the Wednesday and the biopsies of the prostate were done on Thursday morning. May I on behalf of my husband compliment the service we received it was above and beyond the call of duty. Leanne Mc Court was exceptional and put Personal Information redacted by at total ease . As a retired member of the health service I was so happy to experience such a high level of care.
I sincerely hope the above mentioned staff will be complimented by management as all too often complaints are highlighted. Please keep up this excellent standard of care
Yours sincerely
Personal Information redacted by USI
Sent from my iPad

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 08 June 2016 18:03
To: Matthew Tyson [redacted]; Mukhtar, Bashir; Tyson, Matthew; Jennifer Martin; Martin, Jennifer; [redacted]
Subject: FW: TRUST EXCELLENCE AWARDS

Importance: High

Well what an afternoon!!

Not only did Thorndale win in the category - Team of the Year (Front Line) but we out of 121 nominations won the overall award……..

What can I say but really well-done and I am absolutely delighted that the whole Team have got this well-deserved recognition…….

Kind regards

Martina
PS we have also got £2000 to spend for developing our service area further) so put your thinking caps on – [redacted] ☺☺ !!!

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

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

Southern Health and Social Care Trust

Quality Care - for you, with you

Research Office

18 September 2018

Our Ref: TRF1819-03

Mr Michael Young
Urology Consultant
Craigavon Area Hospital

Dear Mr Young

HSC Trust Research Fund 2018/2019

Thank you for your application for the above Fund.

I am pleased to advise you that [redacted] has been awarded to your Study entitled "Kidney and Ureteric Stones treated with Extracorporeal shockwave Lithotripsy using EDAP i-sys Sonolith Lithotripter: Successful stone clearance and complications". I would appreciate if you could advise by return, whether or not you wish to accept the funding offered and can proceed with your Study on that basis. This funding must be spent by 31 March 2019.

All applicants who accept this funding are required to provide Finance Department and the Research Office with whichever of the following is appropriate to your Study:

- Details of all Goods and Services e-requisition numbers and dates requisitions raised;
- Scanned copies of all other receipts for associated expenditure submitted to Salaries and Wages for payment with salaries;
- Scanned copies of any extra hours Claim Forms submitted by part-time staff working specifically on this Study submitted to Salaries and Wages for payment with salaries.

Copies of the above documentation should be emailed to Sorcha O'Dowd, Finance Department [redacted] and to Irene Knox, Research Manager [redacted].

You are required to provide Irene Knox with the Protocol and associated documentation for your Study by Wednesday, 31 October 2018. Unfortunately this year there can be no concession on that date and the offer of funding will have to be withdrawn if you are unable to progress the Study. This funding must be spent by 31 March 2019.

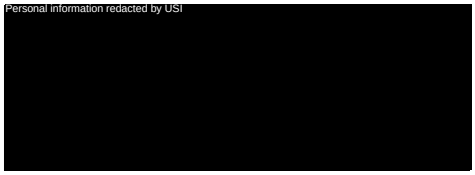
Research & Development Office Ramone Building Craigavon Area Hospital 68 Lurgan Road Portadown BT63 5QQ Tel: [redacted] Email: [redacted]

You will also be required to provide Irene Knox with an update on your Study by 30 April 2019 as a report is required by the PHA HSC Research & Development Division on the Studies awarded funding.

Please advise Irene Knox, by return, whether or not you are accepting this funding.

I wish you well with your Study which I hope will provide benefit for the Trust. Please provide this office with copies of any publications, journal articles or outcomes from the Study.

Yours sincerely



_____

Dr P Sharpe
Consultant Chemical Pathologist
Director Research & Development

Copies to:

Ms Wendy Clayton
Mr Dean Faloon, Management Accountant
Ms Sorcha O'Dowd, Management Accounts

Southern Health and Social Care Trust

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	
Contact Details:	Tel:	Mobile: [redacted]
	Email: [redacted] 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:	**<u>Context/Background – why it is important to do the research,</u>** 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). 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. 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! 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). 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. 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. 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. **Aim – broad statement about what the research will entail** 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.

Southern Health and Social Care Trust

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. 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. **Potential outputs – what will be the impact on patient care** Provide data to support the on-going funding of the ESWL service. 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. Provides data to the wider clinical and scientific community on use of the i-sys sonolith lithotripter and treatment of kidney and ureteric stones. **Data Analysis method – dependent on whether data is numerical or text based e.g. SPSS, thematic analysis** 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. Patient satisfaction and complication rates can also be numerically processed, analysed and compared against similar studies for other lithotripters or surgical modalities. **Proposed start date** October 2018 **Proposed end date** 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) **Specify how the time required to undertake the Study will be incorporated into your work and other personal commitments** 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

Southern Health and Social Care Trust

	Mr Young Urology Consultant, including time following the weekly Thursday morning MDT **References** BAUS. (n.d.). *Kidney Stones*. Retrieved Febuary 02, 2018, from British Association of Urology: https://www.baus.org.uk/patients/conditions/6/kidney_stones Bultitude M, R. J. (2012). Management of renal colic. *BMJ*, 345. C. Türk, A. N. (2017). *Urolithiasis*. Retrieved Febuary 08, 2018, from European Association of Urology Guidelines : http://uroweb.org/guideline/urolithiasis/#3 Hitt, E. (2012, May 24). *Incidence of Stone Disease Has Doubled Since 1994*. Retrieved November 2016, from Medscape : http://www.medscape.com/viewarticle/764518 NICE. (2015). *Renal or ureteric colic - acute*. Retrieved Febuary 08, 2018, from https://cks.nice.org.uk/renal-or-ureteric-colic-acute#!backgroundsub:2 NZ, B. (2014). Managing patients with renal colic in primary care: know when to hold them. *Best Practice Journal New Zealand*. 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…. • Provides safe, high quality care • Maximize independence and choice for our patients and clients • Support people and communities to live healthy lives and improve their health and wellbeing • Make the best use of resources • 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. 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:	**Option 1** • Band 4 Administrative support for 3 sessions to cover Multidisciplinary Team meeting preparation, MDT meeting and administrative letters from meeting and clinic. (2937.5 x 3 = £8812.5) • Band 5 Nurse for 3 sessions to cover MDT meeting, Nurse lead clinic and research session (3889 x 3 = £11667) • Band 6 Radiographer for 1 session to cover Data Research (£4840) **TOTAL : £25319.5** **Option 2:** • As above but Radiographer to attend MDT meeting officially (as only attends currently if there are no other commitments) plus £4840 **TOTAL: 30159.5** **Option 3**: • Option 1 plus an additional emergency treatment session. (added research potential as not currently available and is the direction unit is aiming to provide) • Cost of one session for Nurse and Radiographer (4840 + 3889 = £8729) • **TOTAL: £34048.5**

Southern Health and Social Care Trust

	• Cost Centre to which any funding awarded should be credited (To be provided by your Line Manager) C0303W Thorndale. • Three options are provided in this application and therefore contingency has been incorporated. If there would be further restriction then scaling back or elongating time for data collection would be required albeit that this would delay our plans to publish our findings in peer review surroundings.
Line Manager Support:	**Martina Corrigan (off on sick leave)** **Head of ENT Urology Ophthalmology and Outpatients** **Craigavon Area Hospital** **Wendy Clayton obo Martina Corrigan**
Line Manager	**Line Manager to provide a short statement to confirm support of this application** The Stone clinic and treatment plans were setup to be as efficient as possible due to increased referrals. We have identified this project as a way of facilitating this pathway. A presentation to SMT earlier this year was well accepted and this project would help define the future progress of the unit.
Line Manager's Signature and Date	Personal Information redacted by USI [redacted] 10/8/18

Completed Forms should be returned by email to Irene Knox, Research Manager (Personal Information redacted by USI) no later than Friday, 13 July 2018

Corrigan, Martina

From: Corrigan, Martina
Sent: 04 December 2019 14:40
To: McNaboe, Ted; O'Brien, Aidan
Subject: Job Plan

Dear both
I am conscious that we had hoped to meet this Thursday (5th) but I realise Aidan you are on annual leave.
Next Thursday 12 December is combined M&M so I have put time into our calendar for us to meet to commence discussions on your job plan after this meeting.
I hope this will suit?
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)

Corrigan, Martina

From: Corrigan, Martina
Sent: 04 December 2019 15:03
To: McNaboe, Ted; O'Brien, Aidan
Subject: RE: Job Plan

Thanks Ted

Yes I was hoping that we can meet after audit?

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)

From: McNaboe, Ted
Sent: 04 December 2019 14:51
To: Corrigan, Martina; O'Brien, Aidan
Subject: RE: Job Plan

Fine , next week ok for me .
Audit is in the morning?
Ted

-----Original Appointment-----
From: Corrigan, Martina
Sent: 04 December 2019 14:40
To: McNaboe, Ted; O'Brien, Aidan
Subject: Job Plan
When: 12 December 2019 12:00-13:00 (UTC+00:00) Dublin, Edinburgh, Lisbon, London.
Where: Ted's Office, 3 South

Dear both

I am conscious that we had hoped to meet this Thursday (5th) but I realise Aidan you are on annual leave.

Next Thursday 12 December is combined M&M so I have put time into our calendar for us to meet to commence discussions on your job plan after this meeting.

I hope this will suit?

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)

Corrigan, Martina

From: Mackle, Eamon [redacted]
Sent: 02 March 2013 17:38
To: Brown, Robin
Cc: Corrigan, Martina
Subject: Urology Job Plans

Hi Robin

Further to my email at lunchtime on Friday I met with Dr Rankin to discuss the Urology Job plans and advertising the 5th post. The situation is as I stated i.e. it is essential that the 5 job plans that are produced generate a level of activity which matches the SBA. As Kieran Donaghy stated the amount the Trust is paying for WLIs as well as activity going to the private sector is checked by the Auditors, therefore we don't have a choice but to make sure that each job plan produces an agreed level of activity. The Review of Urology Services in Northern Ireland laid down that level of activity. Other trusts work to that level therefore we have no choice but to ensure that the Southern Trust is productive. Therefore it is essential Robin when you have the job planning meetings with the urologists that this is taken into account. Kieran Donaghy suggested that HR get actively involved in job planning i.e. not just supporting but actually deciding what level of activity and type of sessions each consultant provides. I am not keen on going down this route and Dr Rankin likewise has resisted same. The quid pro quo is that if we are producing job plans we have to deliver value for money and not just what our colleagues desire.
Dr Rankin and I met with Michael and Aidan over a period of 18 months every Monday evening to regarding TYC and Urology. A lot was discussed and decided:
1. Stone Treatment clinics minimum of 6 New and 11 Review – 1.5 clinics per week 2. Outreach (SWAH/STH/DHH/BAN/ARM) minimum of 5 New and 7 Review - 2 outreach clinics per week 3. General Urology Clinics at CAH minimum of 6 New and 8 Review which means PM clinic starting at 1:30pm - 3 general clinics per week.
4. Oncology clinics minimum of 3 red Flag and 4 Protective Review and 4 uro-oncology review – total of 3.75 per week 5. D4 Clinics minimum of 4 patients (review) – 1 clinic per week 6. Prostate D1 minimum of 8 red flags and 2 News 1 clinic per week 7. Urodynamics is nurse-led and cannot be counted in Consultant activity The above activity does not include the additional activity required if a non-consultant is also at the clinic. Also note the above does NOT include the ICATS activity which is set at 1620 NEW and 1724 REVIEW and this needs to be taken into account for the support clinics and the consultants need to consider this in the future of these 'Thorndale' clinics which will be nurse and GPSWI led.
I don't know the exact amount of activity that needs to be carried out at Day Surgery lists and In-Patient lists but Martina will be able to fill you in on same.
The expected activity for Clinics and for Theatre/Endoscopy needs to be included in each job plan.
Also at the Monday meetings it was decided that the Grand Rounds are to be considered as SPA. Furthermore the 2 stone consultants are not expected to be Core Members of the MDT and thus are not expected to attend the MDTs. I know Michael has stated that Patrick Keane won't pass a job that doesn't have 2 SPAs but it has not been Trust policy nor for that matter the DHSSPS's to routinely have 2 SPAs in job plans. I am however keen not to delay the approval of the job plan by Patrick so I suggest that the 5th post is organized so that he/she teaches the third years (I think this is Tuesday morning) this equates to 0.25S PA and when you add in the monthly M&M (another 0.25) this equates to a total of 2.0 SPAs.
You will obviously have to meet with each of the Urologists to ensure that they understand what the job plan entails and what they are being asked to sign up to. I think it is essential that you lead the job planning and not Michael because as CD you better understand the demands facing the Trust and the changes that have taken place in Commissioning.
The other issue, that I mentioned in my email of 19th February, is that all this needs completed by mid-March so it is imperative that progress is made this week.
Thanks
Eamon.

Corrigan, Martina

From: Burns, Deborah [redacted]
Sent: 12 November 2013 05:56
To: Carroll, Anita; Trouton, Heather; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

Did the patient get seen? I think if we cant agree with him – John Simpson needs involved. Heather was robin addressing this with him – follow up with robin to check that happened - if it did John is next step D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Carroll, Anita
Sent: 11 November 2013 13:28
To: Trouton, Heather; Corrigan, Martina
Cc: Burns, Deborah
Subject: FW: Mr O'Brien and charts

Dear all I know we have discussed before and heather I know you met him Really don't know what we now do A

From: Forde, Helen
Sent: 11 November 2013 13:07
To: Carroll, Anita
Subject: Mr O'Brien and charts

Just to keep you in the loop as this may be going to Debbie, and I've said to Martina.

A patient was attending Dr Convery's clinic this morning but the chart was tracked to Mr O'Brien in the Thorndale Unit. When records looked for it his secretary said she thought Mr O'Brien had that chart at home and she would ask him to bring it in for the appointment at 9 am this morning. The chart didn't arrive in records and Dr Convery refused to see the patient without the chart. Pamela went to speak to Dr Convery and ask if he would see the patient as she had got as much information as she could for the appointment.

Mr O'Brien's secretary is off today so eventually Pamela got Mr O'Brien's number and phoned him to enquire about the chart. He had brought it in but had taken it over to the old Thorndale unit to have a letter typed. Pamela then went over there this morning and got the chart and then brought it round to Dr Convery, and he informed Pamela that he was going to write to Debbie about this.

Helen Forde
Head of Health Records
Admin Floor, CAH
[redacted]

Corrigan, Martina

From: Burns, Deborah [redacted]
Sent: 12 November 2013 08:40
To: Trouton, Heather; Carroll, Anita; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

SEE MY EMAIL - VIEW?

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Trouton, Heather
Sent: 12 November 2013 08:37
To: Carroll, Anita; Corrigan, Martina
Cc: Burns, Deborah
Subject: RE: Mr O'Brien and charts

Anita

I have spoken both to Mr O'Brien himself and Mr Young as clinical lead for Urology

Mr O,Brien advised that he would cease this practice.

We could ask Mr Brown to discuss with him but I don't think it would have any effect.

hetaher

From: Carroll, Anita
Sent: 11 November 2013 13:28
To: Trouton, Heather; Corrigan, Martina
Cc: Burns, Deborah
Subject: FW: Mr O'Brien and charts

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went over there this morning and got the chart and then brought it round to Dr Convery, and he informed Pamela that he was going to write to Debbie about this.

Helen Forde
Head of Health Records
Admin Floor, CAH
Personal Information redacted by USI
Personal Information redacted by USI

Corrigan, Martina

From: Carroll, Anita
Sent: 12 November 2013 11:58
To: Burns, Deborah; Trouton, Heather; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

I think to escalate to Dr Simpson might be worth a try

From: Burns, Deborah
Sent: 12 November 2013 08:40
To: Trouton, Heather; Carroll, Anita; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

SEE MY EMAIL - VIEW?

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: Trouton, Heather
Sent: 12 November 2013 08:37
To: Carroll, Anita; Corrigan, Martina
Cc: Burns, Deborah
Subject: RE: Mr O'Brien and charts

Anita

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hetaher

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Sent: 11 November 2013 13:28
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Cc: Burns, Deborah
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Sent: 11 November 2013 13:07
To: Carroll, Anita
Subject: Mr O'Brien and charts

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Helen Forde
Head of Health Records
Admin Floor, CAH
Personal Information redacted by USI

Corrigan, Martina

From: Corrigan, Martina
Sent: 01 November 2019 07:06
To: O'Brien, Aidan
Subject: RE: [redacted] Report

Aidan

Many thanks for this and for letting me know.

The extension is not a problem at all

Kind regards

Martina

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

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

From: O'Brien, Aidan
Sent: 31 October 2019 19:22
To: Corrigan, Martina
Subject: [redacted] Report

Martina,

I have not overlooked my undertaking to provide a report concerning [redacted].
I have reviewed all the documentation available to me, making notes throughout.
I just have not had the time to translate that into a fluent report.
I intend to do so over the weekend.
I will send you the report on Monday.
I would be grateful for another few days of grace,

Aidan.

Corrigan, Martina

From: Corrigan, Martina
Sent: 05 December 2019 18:23
To: McCaul, Collette
Subject: RE: [redacted] Complaint

Hi Collette

I did chase this with Mr O'Brien and he advised me a few weeks ago that he had all the information gathered and needed to write it into a report and to give him an extension on the date that I had given him.

This has now passed so I will wait to hear if you hear anything and if not I will send him a reminder as if they don't want this I will not chase.

Regards

Martina

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

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

From: McCaul, Collette
Sent: 05 December 2019 12:08
To: Corrigan, Martina
Subject: RE: [redacted] Complaint

Hi all

I have contacted this lady via email today to try and get some idea if she wishes to continue on regarding the complaint issued in 2014.
I had sent an email back in June to see where we were with this because as far as I am aware the meetings were cancelled on and off and then Mr O Brien wanted to review questions and notes do a forensic review and then for the meeting to be reorganised. This never transpired

I am currently reviewing all old charts in the office and came across this again (it went off my radar as well- as chart went to closed records). Was anything done after my email of the 07th June 2019.

Yours Sincerely

Collette McCaul

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: McCaul, Collette
Sent: 07 June 2019 15:59
To: Corrigan, Martina [redacted]
Cc: Carroll, Ronan
Subject: FW: [redacted] Complaint
Importance: High

Martina/Ronan

Following on from Davids tenure. Please I chase this up with you it was supposed to be sorted in January in respect of getting Mr Obrien to review the notes and the offer of a meeting to the family. This is still not done. Can you please help me get this moving if possible

Many thanks

Kind Regards
Collette McCaul

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown B

Corrigan, Martina

From: Corrigan, Martina
Sent: 29 September 2019 06:25
To: Haynes, Mark; Carroll, Ronan; McClements, Melanie
Subject: FW: [redacted] Complaint

Good morning

FYI

Martina

From: Corrigan, Martina
Sent: 29 September 2019 05:02
To: O'Brien, Aidan
Subject: RE: [redacted] Complaint

Thanks Aidan,

Regards

Martina

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

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

From: O'Brien, Aidan
Sent: 28 September 2019 23:18
To: Corrigan, Martina
Subject: RE: [redacted] Complaint

Martina,

I had thought that this investigation had expired!

I will address this as soon as is possible and will furnish a report during October 2019.

Aidan.

From: Corrigan, Martina
Sent: 28 September 2019 06:26
To: O'Brien, Aidan
Cc: Haynes, Mark; Carroll, Ronan; McClements, Melanie
Subject: FW: [redacted] Complaint
Importance: High

Dear Aidan

I have been asked to bring this to your attention again and to advise that if there is no response from you then I have to escalate this to the Medical Director

Regards

Martina

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

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

From: McCaul, Collette Personal Information redacted by USI
Sent: 07 June 2019 15:59
To: Corrigan, Martina
Cc: Carroll, Ronan
Subject: FW: Patient 110 Complaint
Importance: High

Martina/Ronan

Following on from Davids tenure. Please I chase this up with you it was supposed to be sorted in January in respect of getting Mr Obrien to review the notes and the offer of a meeting to the family. This is still not done. Can you please help me get this moving if possible

Many thanks

Kind Regards

Collette McCaul

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: Personal Information redacted by USI | Email: Personal Information redacted by USI

From: Cardwell, David Personal Information redacted by USI
Sent: 17 January 2019 14:17
To: Carroll, Ronan; Corrigan, Martina
Cc: Gurbanova, Esmira
Subject: Patient 110 Complaint
Importance: High

Dear Ronan and Martina, I would appreciate your assistance in moving this complaint forward.

At this time we are waiting on Mr O'Brien reviewing the notes again before we arrange the meeting with the family.

This complaint has been ongoing now for over 4 years and we need to make all necessary efforts to expedite its closure as soon as possible.

If we are unable to meet the family I believe it would be better to write to them and explain the reason why rather than keeping them lingering. If the matter progresses to the Ombudsman I can image any report produced would not make good reading.

Thanking you in anticipation of your response.

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: Personal Information redacted by USI | Email: Personal Information redacted by USI

Corrigan, Martina

From: Haynes, Mark
Sent: 08 March 2019 06:51
To: Corrigan, Martina; Carroll, Ronan; McNaboe, Ted
Subject: RE: Patient 110 RIP Complaint

Has Aidan responded to the last enquiry (from Ronan) regarding what time he needs to do this?

Mark

From: Corrigan, Martina
Sent: 07 March 2019 18:01
To: Carroll, Ronan; McNaboe, Ted; Haynes, Mark
Cc: Corrigan, Martina
Subject: RE: Patient 110 RIP Complaint

Dear Mark and Ted,

I know that we had talked about this at one of our meetings, but we really need help at resolving this complaint as it now outstanding since 2017.

Problem is that Aidan advises that we can't meet the family until he has done an in-depth timeline on the patient and then when asked says he has not the time, and we cannot move without this information.

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)

From: Carroll, Ronan Personal Information redacted by USI
Sent: 17 January 2019 14:19
To: McNaboe, Ted; Haynes, Mark
Cc: Corrigan, Martina
Subject: FW: Patient 110 Complaint
Importance: High

Ted/mark
Need a resolution to this outstanding issue
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI
Ext Personal Information

From: Cardwell, David
Sent: 17 January 2019 14:17
To: Carroll, Ronan; Corrigan, Martina
Cc: Gurbanova, Esmira
Subject: [redacted] Complaint
Importance: High

Dear Ronan and Martina, I would appreciate your assistance in moving this complaint forward.

At this time we are waiting on Mr O'Brien reviewing the notes again before we arrange the meeting with the family.

This complaint has been ongoing now for over 4 years and we need to make all necessary efforts to expedite its closure as soon as possible.

If we are unable to meet the family I believe it would be better to write to them and explain the reason why rather than keeping them lingering. If the matter progresses to the Ombudsman I can image any report produced would not make good reading.

Thanking you in anticipation of your response.

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: McAloran, Paula [redacted]
Sent: 22 September 2014 14:57
To: Corrigan, Martina
Cc: Trouton, Heather
Subject: FW: PS Enquiries for Urology outstanding including MLA and Patient & Client Council enquiries

Importance: High

Martina

Any idea when I can expect a response to the outstanding urology enquiries?

[redacted] phoned again today and tells me her symptoms have worsened and that she attended her GP last week.

Not on the list below is ; PS[redacted]/14-15 [redacted] enquiry received 16/9/14.

Regards
Paula

From: McAloran, Paula
Sent: 12 September 2014 15:21
To: Corrigan, Martina
Cc: Trouton, Heather [redacted]
Subject: PS Enquiries for Urology outstanding
Importance: High

Martina

Can you advise re the following urology enquiries;

PS[redacted]/14-15-[redacted]- Date for admission Mr O'Brien. Enquiry from Colette Hart Patient & Client Council email sent 21/8/14

PS[redacted]/14-15-[redacted]- Date for review with Mr Young- email sent 2/9/14

PS[redacted]/14-15-[redacted]- Date for admission Mr O'Brien- email sent 4/9/14. [redacted] has contacted me twice since this initial date and advises she has been suspended for planned surgical procedure until urology operation has taken place.

I appreciate your assistance in resolving these enquiries.

Paula

Paula McAloran
Patient Support Officer

Southern Health & Social Care Trust
Craigavon Area Hospital
Portadown

BT63 5QQ

Tel No: Personal Information redacted by USI (CAH Direct line)
Tel No: Personal Information redacted by USI (DHH Direct Line)

Mobile No: Personal Information redacted by USI
Email: Personal Information redacted by USI

Corrigan, Martina

From: Corrigan, Martina
Sent: 16 July 2019 14:12
To: O'Brien, Aidan
Subject: RE: New complaint for investigation [redacted] H&C: [redacted]

Aidan,

Many thanks for this, much appreciated

Regards

Martina

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

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

From: O'Brien, Aidan
Sent: 16 July 2019 14:09
To: ClientLiaison, AcutePatient
Cc: Corrigan, Martina
Subject: RE: New complaint for investigation [redacted] H&C: [redacted]

Dear Client Liaison,

I have attached a detailed report concerning [redacted] s management since 1999 to date, in addition to my comments regarding the issues raised by Mr. Mc Gimpsey in his letter of 18 May 2019.
I do hope that this report will be of assistance to Mrs. Gishkori in replying to Mr. Mc Gimpsey,

Thank you,

Aidan o'Brien.

From: ClientLiaison, AcutePatient
Sent: 23 May 2019 11:03
To: Corrigan, Martina; Reddick, Fiona; O'Brien, Aidan
Cc: Carroll, Ronan; Conway, Barry; Gurbanova, Esmira; Witczak, Maria; Stinson, Emma M
Subject: New complaint for investigation [redacted] H&C: [redacted]

Please find attached a new complaint for investigation and note that you are required to provide your draft response by 4th June 2019.

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.

I appreciate your assistance with this matter.

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 01 December 2015 23:37
To: Trouton, Heather; Corrigan, Martina
Cc: ClientLiaison, AcutePatient; Stinson, Emma M; Conlon, Noeleen
Subject: RE: Urgent FW: [redacted]

Heather and Martina,

I have arranged for [redacted] to be admitted for surgery on Wednesday 09 December 2015.
I have spoken with her husband by telephone to advise her accordingly,

Aidan.

-----Original Message-----
From: Trouton, Heather
Sent: 26 November 2015 09:50
To: Corrigan, Martina; O'Brien, Aidan
Cc: ClientLiaison, AcutePatient; Stinson, Emma M; Conlon, Noeleen
Subject: RE: Urgent FW: [redacted]

Dear all

Aidan and I spoke about this lady week before last. He advised that he would undertake her operation end Nov / early December .

Heather

-----Original Message-----
From: Corrigan, Martina
Sent: 24 November 2015 10:24
To: O'Brien, Aidan
Cc: ClientLiaison, AcutePatient; Trouton, Heather; Stinson, Emma M; Conlon, Noeleen
Subject: RE: Urgent FW: [redacted]

Dear Aidan,

I have checked on PAS this morning and note that there is no date as yet for Mrs [redacted] as per Heather's email I would be grateful if you could advise please?

Thanks

Martina

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

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

-----Original Message-----
From: Stinson, Emma M
Sent: 23 November 2015 12:36
To: Trouton, Heather; Corrigan, Martina; Nelson, Amie
Cc: ClientLiaison, AcutePatient
Subject: RE: Urgent FW: [redacted]

Hi Heather

Thanks for this. Could we check if Mr O'Brien has responded?

Many Thanks
Emma

Emma Stinson
PA to Mrs Esther Gishkori
Director of Acute Services
SHSCT, Admin Floor, Craigavon Area Hospital

Direct Line: Personal Information redacted by USI Direct Fax: Personal Information redacted by USI Personal information redacted by USI
P Please consider the environment before printing this email

Click on the link to access the Acute Services Page

-----Original Message-----
From: Trouton, Heather
Sent: 13 November 2015 16:51
To: Stinson, Emma M
Subject: RE: Urgent FW: Personal Information redacted by USI

I have spoken to Mr O'brian today. He is going to list her for surgery soon but he will provide a response to us asap

Heather

-----Original Message-----
From: Stinson, Emma M
Sent: 13 November 2015 09:53
To: Trouton, Heather
Subject: FW: Urgent FW: Personal Information redacted by USI

Heather

Did you receive a response for this query?

Many Thanks
Emma

Emma Stinson
PA to Mrs Esther Gishkori
Director of Acute Services
SHSCT, Admin Floor, Craigavon Area Hospital

Direct Line: Personal Information redacted by USI Direct Fax: Personal Information redacted by USI Personal Information redacted by USI
P Please consider the environment before printing this email

Click on the link to access the Acute Services Page

-----Original Message-----
From: Trouton, Heather
Sent: 05 November 2015 16:19
To: O'Brien, Aidan
Cc: Corrigan, Martina; Stinson, Emma M
Subject: Urgent FW: Personal Information redacted by USI

Dear Aidan

Can you please see below. I am not condoning in any way prioritising someone based on a letter to the chief executive , and you will know the patients case intimately but if the lady is having such incontinence problems and suffers from ill mental health , do you think it would be possible to consider a date for her surgery?

I would really appreciate it if you could have a look at her case and advise based on your clinical judgement.

Thanks and Best regards
Heather

-----Original Message-----
From: Stinson, Emma M
Sent: 05 November 2015 15:31
To: Trouton, Heather
Cc: ClientLiaison, AcutePatient
Subject: FW: Personal Information redacted by USI

Hi Heather

Unfortunately we have not received a response to this enquiry - would you be able to expedite please?

Many Thanks
Emma

Emma Stinson
PA to Mrs Esther Gishkori
Director of Acute Services
SHSCT, Admin Floor, Craigavon Area Hospital

Direct Line: Personal Information redacted by USI Direct Fax: Personal Information redacted by USI Personal Information redacted by USI
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-----Original Message-----
From: Corrigan, Martina
Sent: 25 October 2015 14:35
To: O'Brien, Aidan
Cc: Stinson, Emma M; Conlon, Noeleen
Subject: FW: Personal Information redacted by USI

Aidan,

Can you advise 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

-----Original Message-----

From: Stinson, Emma M
Sent: 19 October 2015 17:05
To: Corrigan, Martina
Subject: FW: Personal Information redacted by USI

Hi Martina

Could you look in to this one please - I see on PAS an urgent referral came in on Friday past (15th Oct)

Many Thanks
Emma

Emma Stinson
PA to Mrs Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

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-----Original Message-----
From: Wright, Elaine
Sent: 19 October 2015 16:43
To: Gishkori, Esther; McVeigh, Angela
Cc: Stinson, Emma M; Complaints; Taylor, Karen
Subject: Personal Information redacted by USI

Please find as below regarding Mrs Personal Information redacted by USI.

Esther - can you please provide an update on Mrs Personal Information redacted by USI position with regard to surgery.

Angela - can you please take forward to refer Mrs Personal Information redacted by USI to the Trust's continence service.

Thanks Elaine

-----Original Message-----
From: Personal information redacted by USI Personal information redacted by USI
Sent: 19 October 2015 15:37
To: Wright, Elaine
Subject: Personal Information redacted by USI

Elaine

Thank you for sorting this out for me,

On another point I spoke to Paula Clarke on Friday evening and she suggested I email you.

Back in January/February time Mairead helped me out with some issues relating to my mother, from memory Irene from David Simpsons office was involved in this too.

At that time my mum visited the ED and was seen by a Jr Dr and he examined the Mitrofanoff site on her stomach which had and continues to cause incontinence, pain and bleeding subsequently she was give a temporary bag to help with the matter.

Following that she had seen Mr O'Brien (23rd Feb 15) he then put mum on the list for surgery to try resolve the matter on a longer term basis, this was marked as urgent.

To date there has been no communication between Mr O'Brien my mum or her GP Personal information redacted by USI)

although Personal information redacted by USI has written to Mr O'Brien urging that he do the surgery.

In the meantime my mum has found that the temporary bags have been pretty much useless for a number of reasons which has left her continuously incontinent, her bed clothes are continuously being ruined and she is having to change her clothes 2 and three times in a good day.

As my mum also suffers with I'll mental health I feel that it is very important that this matter is dealt with as soon as possible to avoid further deterioration in both her physical and mental conditions.

Whilst I know that your Drs are extremely busy and under pressure I would appreciate if you could request an update in relation to this issue, I would further ask that you would look at possibly referring my mum to the appropriate people to help address the incontinence issue in the short term.

Details for patient:
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DOB: Personal Information redacted by USI

Many thanks for your help in advance and if you require any further information please let me know

Kind regards

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Tel: Personal Information redacted by USI

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 16 April 2014 22:35
To: Robinson, Katherine
Subject: Re: Missing Triage

Well now does that surprise u LOL

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

From: Robinson, Katherine
Sent: Wednesday, April 16, 2014 10:31 PM
To: Corrigan, Martina
Subject: Re: Missing Triage

Will send it to u tomorrow. Hilarious u haven't got this isn't it

From: Corrigan, Martina
Sent: Wednesday, April 16, 2014 10:14 PM
To: Robinson, Katherine
Subject: Re: Missing Triage

Will do. Can I see policy please?

Ta

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

From: Robinson, Katherine
Sent: Wednesday, April 16, 2014 10:13 PM
To: Corrigan, Martina
Subject: Re: Missing Triage

Still chase but I told her not to overly panic cause waiting time was 22 weeks

From: Corrigan, Martina
Sent: Wednesday, April 16, 2014 09:38 PM
To: Robinson, Katherine
Subject: Re: Missing Triage

Ah rite was just wondering
M

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

From: Robinson, Katherine
Sent: Wednesday, April 16, 2014 09:36 PM
To: Corrigan, Martina
Subject: Re: Missing Triage

Cause anita and heather wrote a policy and I got told off for not following procedure

From: Corrigan, Martina
Sent: Wednesday, April 16, 2014 08:32 PM
To: Robinson, Katherine
Subject: Re: Missing Triage

Just curious why is Leanne escalating to Anita?

M

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

From: Robinson, Katherine
Sent: Tuesday, April 15, 2014 04:36 PM
To: Carroll, Anita; Browne, Leanne
Cc: Rankin, Christine; Corrigan, Martina
Subject: RE: Missing Triage

Not too sure, I know Martina has been chasing but some would not matter anyway as this specialty has a waiting time of 22 weeks now. This means that we are only booking referrals with a less than date of 27/11/13 in April.

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre Ramone Building Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Carroll, Anita
Sent: 15 April 2014 16:34
To: Browne, Leanne
Cc: Rankin, Christine; Robinson, Katherine
Subject: RE: Missing Triage

Thanks Leanne
Katherine whats the issue
A

From: Browne, Leanne
Sent: 15 April 2014 16:11
To: Carroll, Anita
Cc: Rankin, Christine; Robinson, Katherine
Subject: Missing Triage

Hi Anita

Here is an updated list of Urology Missing Triage.
Emails have been sent to Consultant secretaries, Andrea Cunningham, Sharon Glenny and Martina.

Martina has given permission for the longest waiters to be booked regardless of triage, we are in the process of doing this.

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AOB

ROUTINE

17/12/2013

114

email to monica 180114

email to andrea 24.1.14

email to sharon 14/2/14

EMAIL TO MARTINA 7/3/14

EMAIL TO MARTINA & MR O'BRIEN 21.3.14 *EMAIL TO MARTINA 280314*

email to martina 7/4/14

EMAIL TO ANITA 7/4/14

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AOB

ROUTINE

19/12/2013

112

email to monica 180114

email to andrea 24.1.14

email to sharon 14/2/14

EMAIL TO MARTINA 7/3/14

EMAIL TO MARTINA & MR O'BRIEN 21.3.14*EMAIL TO SHARON 280314*

email to martina 7/4/14

EMAIL TO ANITA 7/4/14

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ROUTINE

14/01/2014

86

email to monica 3.2.14

email to andrea 14/2/14

email to sharon 27.2.14

EMAIL TO MARTINA 7/3/14

EMAIL TO MARTINA 280314

email to martina 7/4/14

EMAIL TO ANITA 7/4/14

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15/01/2014

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email to monica 3.2.14

email to andrea 14/2/14

email to sharon 27.2.14

EMAIL TO MARTINA 7/3/14

EMAIL TO MARTINA 280314

email to martina 7/4/14

EMAIL TO ANITA 7/4/14

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15/01/2014

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email to monica 3.2.14

email to andrea 14/2/14

email to sharon 27.2.14

EMAIL TO MARTINA 7/3/14

EMAIL TO MARTINA 280314

email to martina 7/4/14

EMAIL TO ANITA 7/4/14

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17/01/2014

83

email to monica 14.2.14

email to andrea 270214

email to sharon 7/3/14

EMAIL TO MARTINA 24.3.14

EMAIL TO MARTINA 280314

email to martina 7/4/14

EMAIL TO ANITA 7/4/14

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21/01/2014

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email to monica 27/2/14

email to andrea 7/3/14

EMAIL TO SHARON 24.3.14

EMAIL TO MARTINA 280314

EMAIL TO MARTINA 7/4/14

EMAIL TO ANITA 7/4/14

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23/01/2014

77

EMAIL TO MONICA 070314

email to andrea 210314

EMAIL TO SHARON 280314

EMAIL TO MARTINA 280314

EMAIL TO MARTINA 7/4/14

EMAIL TO ANITA 7/4/14

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email to monica 27/2/14

email to andrea 7/3/14

EMAIL TO SHARON 24.3.14

EMAIL TO MARTINA 280314

EMAIL TO MARTINA 7/4/14

EMAIL TO ANITA 7/4/14

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email to monica 27/2/14

email to andrea 7/3/14

EMAIL TO SHARON 24.3.14

EMAIL TO MARTINA 280314

EMAIL TO MARTINA 7/4/14

EMAIL TO ANITA 7/4/14

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ROUTINE

GPR

07/02/2014

62

EMAIL TO MONICA 070314

email to andrea 210314

EMAIL TO SHARON 280314

EMAIL TO MARTINA 7/4/14

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EMAIL TO MARTINA 7/4/14

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email to andrea 210314

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