There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes this would make sense

4.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order, taking into account planned patients expected date of admission.

4.2.4 The regional targets for a maximum inpatient and daycase waiting times are outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

4.2.5 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.

4.2.6 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
Is this relevant to elective? Consultants normally select cases based on clinical priority etc.

4.2.7 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

4.2.8 Trusts should **not** use manual administration systems to record and report patients who have been booked.

4.2.9 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

4.3 PRE-ASSESSMENT

4.3.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-assessment. This can be provided using a variety of methods including telephone, video link, postal or face to face assessment.

4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.

4.3.3 Only those patients that are deemed fit for their procedure may be offered a TCI date.

4.3.4 If a patient is assessed as being unfit for their procedure, their To Come In (TCI) date may be cancelled and decision taken as to the appropriate next action.

4.3.5 Pre-assessment services should be supported by a robust booking system.

4.4 CALCULATION OF THE WAITING TIME

4.4.1 The starting point for the waiting time of an inpatient/daycase admission is the date the appropriate clinician agrees that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is clinically and socially fit to undergo such a procedure.

4.4.2 The waiting time for each patient on the elective admission list is calculated as the time period between the original decision to admit date and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

4.5 REASONABLE OFFERS - TO COME IN (TCI) OFFERS OF TREATMENT

4.5.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner.

4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

4.5.3 A reasonable offer is defined as:

- an offer of admission, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and a choice of **two** TCI dates, and
- at least **one** of the offers must be within N. I., except for any regional specialties where there are no alternative providers within NI.

The majority of elective procedures are fixed appointments, based on when consultants are available for theatre sessions, availability of ICU capacity if required, volume of predicted in-patient beds etc. This is a complex booking process which can be difficult to adapt with partial booking.
Does there need to be a guidance for fixed elective offers?

4.5.4 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the admission was refused.

4.5.5 This does not prevent patients being offered earlier appointment dates. If the patient is offered an admission within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

4.5.6 If the patient accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional

exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

4.5.8 Providers should have robust audit procedures in place to demonstrate compliance with the above.

4.5.9 To ensure the verbal booking process is auditable, the Trust should make and cancel a TCI date using the date of the second admission date offered and refused for this transaction.

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

4.6.1 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in.

4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting lists are to be maintained in the PAS patient information system.

4.6.3 Details of patients must be entered on to the computer system (PAS) recording the date the decision was made to admit the patient or add the patient to the waiting list within **two** working days of the decision being made. Failure to do this will lead to incorrect assessment of waiting list times.

4.6.4 Where a decision to add to the waiting list depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure a decision is made in relation to the result of the investigation and the clinical patient pathway agreed.

4.7 SUSPENDED PATIENTS

4.7.1 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or personal reasons. These patients should be suspended from the active waiting list until they are ready for admission.

4.7.2 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).
- A recommended maximum period not exceeding **three** months.

4.7.3 No patient should be suspended from the waiting list without a suspension end date.

4.7.4 Suspended patients should be reviewed one month prior to the end of their suspension period and a decision taken on their admission.

4.7.5 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.

4.7.6 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.

4.7.7 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.

4.7.8 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for admission/treatment.

4.7.9 Recommended practice is that no more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

4.8 PLANNED PATIENTS

4.8.1 Planned patients are those patients who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation within specific timescales.

4.8.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

4.8.3 Trusts must have systems and processes in place to identify high risk planned patients in line with clinical guidance.

4.8.4 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.8.5 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs, with particular focus on high risk surveillance pathway patients.

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

4.9.1 Where the same clinician is performing more than one procedure at one time, the first procedure should be added to the waiting list with additional procedures noted.

4.9.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

4.9.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

4.10 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR ADMISSION

DNAs – Inpatient/Daycase

4.10.1 If a patient DNAs their inpatient or daycase admission, the following process must be followed:

4.10.1(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second date should be offered or whether the patient can be discharged.

4.10.1(b) Where the clinical decision is that a second admission should be offered, the admission date must be agreed with the patient. Trusts should put in place local agreements with clinicians regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

4.10.1(c) Patients who DNA and are not discharged but offered a second date will have their waiting time clock reset to the date of the DNA.

4.10.1(d) Where the clinical decision is that a second date should not be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

4.10.1(e) *Patients being discharged from the list should be advised to contact the Trust if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original date, a clinical decision may be made to offer a second date. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

Is there a process in place for this the same as outpatients were a letter is sent to the patient and they phone in ?

4.10.1(f) If the patient DNAs the second admission offered then the above steps should be followed.

4.10.1(g) Where a patient DNAs a fixed admission date (i.e. they have not had the opportunity to agree/ confirm the date and time of their admission), they should be offered another date.

4.10.1(h) If the patient DNAs this second fixed admission, they will be removed from the waiting list and the steps in 4.10.1(e) should be followed.

4.10.1(i) Where a patient DNAs a pre-assessment appointment they will be offered another date. If they DNA this second pre-assessment appointment, they will be removed from the waiting list and the above steps in 4.10.1(e) should be followed.

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

If a patient cancels their inpatient/ daycase admission the following process must be followed:

4.10.2(a) Patients who cancel an agreed reasonable offer will be given a second opportunity to book an admission, which should ideally be within **six weeks** of the original admission date.

4.10.2(b) If a second agreed offer of admission is cancelled, the patient will not be offered a **third** opportunity.

4.10.2(c) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second admission, the Trust may exercise discretion to offer a third admission - this should include seeking a clinical review of the patient's case where this is appropriate.

4.10.2(d) Where a decision is taken not to offer a further admission, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

4.10.2(e) Where a patient CNAs a pre-assessment appointment they should be offered another date. If they CNA this second pre-assessment appointment, the above steps should be followed, as per 4.10.1(h).

4.10.2(f) Patients who cancel their procedure (CNA) will have their waiting time clock reset to the date the Trust was informed of the cancellation.

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

4.11.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

4.11.2 The patient should be informed of the cancellation and the date of the new admission booked.

4.11.3 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

4.11.4 Where patients are cancelled on the day of an admission/operation as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.

4.11.5 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of admission a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

4.12.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trust sites or to independent sector (IS) providers.

4.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 4.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

4.13 TECHNICAL GUIDANCE

4.13.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

4.13.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- Recording inpatients who need to be added to the 28 day cardiac surgery waiting list.
- Recording paediatric congenital cardiac surgery activity.
- Centralised Funding waiting list validation.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Patients who are added to a waiting list with a planned method of admission.
- Pre-operative assessment clinics.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.
- Patients waiting for a review outpatient appointment.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

GUIDANCE FOR MANAGEMENT OF ELECTIVE ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of the elective booking processes for elective Allied Health Professionals (AHP) services, including those patients whose referral is managed virtually.

5.1.2 Allied Health Professionals work with people of all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors.

5.1.3 The administration and management of the AHP pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

5.1.4 For the purposes of this section of the protocol, the generic term ‘clinic’ will be used to reflect AHP activity undertaken in hospital, community (schools, daycare settings, leisure and community centres) or domiciliary settings (people’s own home or where they live e.g. residential or nursing homes) as AHPs provide patient care in a variety of care locations.

5.1.5 AHP services are administered on a wide range of information systems, with varying degrees of functionality able to support full IT implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

5.1.6 There will be dedicated booking offices within Trusts to receive, register and process all AHP referrals.

5.1.7 Fixed appointments should only be used in exceptional circumstances.

5.1.8 In all aspects of the AHP booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

5.2 KEY PRINCIPLES

5.2.1 All referrals, appointments and AHP waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list and allocated according to urgency of the treatment. Trusts will manage new patients in two priorities, i.e.

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

5.2.2 Patients of equal clinical priority will be selected for booking in strict chronological order.

5.2.3 Patient appointments for new and review should be **partially booked.** Where fixed appointments are being issued, Trusts should ensure that the IEAP guidance is followed in the management of patients.

5.2.4 The regional target for a maximum AHP waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

5.2.5 Maximum waiting times for urgent patients should be agreed locally with AHP professionals and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the professional and capacity issues are quickly identified and escalated.

5.2.6 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

5.2.7 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

5.2.8 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

5.2.9 Trusts should **not** use manual administration systems to record and report patients who have been booked.

5.2.10 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

5.3 NEW REFERRALS

5.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

5.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

5.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

5.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

5.3.5 Following prioritisation, referrals must be actioned on PAS or the relevant electronic patient administration system and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

5.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

5.4 CALCULATION OF THE WAITING TIME

5.4.1 The starting point for the waiting time of an AHP new referral is the date the clinician's referral or self-referral is received by the booking office or, for internal referrals, when the referral is received by the booking office/department. All referrals, including emailed and electronically delivered referrals, will have the date the referral received into the organisation recorded either by date stamp or electronically.

5.4.2 In cases where referrals bypass the booking office, (e.g. sent directly to an allied health professional), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office/department and registered at the date on the date stamp.

5.4.3 The waiting time for each patient is calculated as the time period between the receipt of the referral and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

5.4.4 The waiting time clock stops when the first definitive AHP treatment has commenced.

5.5 REASONABLE OFFERS

5.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

5.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

5.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

5.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

5.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

5.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

5.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.6 REVIEW APPOINTMENTS

5.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

5.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

5.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

5.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

5.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

5.7 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

5.7.1 DNAs – New AHP Appointments

If a patient DNAs their new appointment, the following process must be followed:

5.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(b) Under exceptional circumstances the AHP professional may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with AHP professionals, regarding those referrals or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

5.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

5.7.1(d) *Where patients are discharged from the waiting list (ref. 5.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

5.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

5.7.1(g) If the patient DNAs this second appointment the above steps should be followed.

5.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.2 DNAs – Review Appointments

If a patient DNAs their review appointment the following process must be followed:

5.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

5.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

5.7.2(c) Where the clinical decision is that a second appointment should **NOT** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they will be discharged from the waiting list. The referrer (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust.

5.7.2(e) If the patient DNAs the second appointment offered then the patient should **NOT** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they will be discharged from the waiting list.

5.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

5.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.3 **CNAs –** Patient initiated cancellations (new and review)

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

5.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

5.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

5.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring professional (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

5.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

5.7.4 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

5.8 CNAs – SERVICE INITIATED CANCELLATIONS

5.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

5.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

5.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

5.8.4 Service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.9 CLINIC OUTCOME MANAGEMENT

5.9.1 There are a number of locations within Trusts where patients present for their AHP consultation. This protocol applies to all AHP areas. It is the responsibility of the PAS/ IT system user managing the attendance to maintain data quality.

5.9.2 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

5.9.3 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.10 CLINIC TEMPLATE CHANGES

5.10.1 Clinic templates should be agreed between the relevant AHP professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

5.10.2 Templates will identify the number of slots available for new urgent and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

5.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.

5.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

5.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trusts or to independent sector (IS) providers.

5.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving AHP professional, (see also Reasonable Offers, ref. 5.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

5.12 TECHNICAL GUIDANCE

5.12.1 See also Public Health Agency; https://www.publichealth.hscni.net/publications/ahp-services-data-definitions-guidance-june-2015 re Guidance for monitoring the Ministerial AHP 13 week access target.

5.12.2 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

5.12.3 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage).
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity (June 2020).
- AHP Virtual Consultation Guidance (to be issued).

Administrative & Clerical Standard Operating Procedure

No:

TITLE	**Procedures for Referral & Booking Centre**	
S.O.P.		
Version Number	**1.0**	**Supersedes:**
Author	**Katherine Robinson, Helen Forde, Marie Loughran/Leeanne Browne**	
Page Count	**11**	
Date of implementation	**1.1.10**	
Date of Review	**1.1.12**	
Approved by	**A&C Implementation Group**	

Standard Operating Procedure (S.O.P)
Referral and Booking Centre Procedures

Introduction

This SOP outlines the procedures followed by the Referral and Booking Centre from initial receipt of referral letters to booking the appointment.

It also highlights the procedures which need to be followed should a clinic need to be cancelled or reduced.

Implementation

This procedure is already effective and in operation in the Referral and Booking Centre.

Referral Letters

There are 3 deliveries of post to the post room each day

Morning
Lunchtime
Afternoon

Post room staff open the post and sort.

Electronic Referrals

There are referrals now coming from some GP practices electronically. These are currently opened in the post room and printed. Red flag referrals are redirected to the Mandeville Unit/DHH. This project is in initial stages.

New Referrals

Date stamp the letter with the current date.

The post is then sorted out into the relevant teams and left in the appropriate trays in the RBC. Each team within the Booking Centre has responsibility for booking certain specialties.

If there are any discrepancies or queries with hospital numbers these referral letters should be placed in the registration tray in the RBC for registering on PAS. Hospital numbers should always be written in Red on the top right hand corner of the referral.

Triaged Referrals

Referrals received back following triage should be sorted into team specialties and put in appropriate trays for Add to Waiting List in RBC, **with the exception of Urology letters which are handed to directly to that team.**

ORE'ing

Priority is given to ORE'ing the referral letters – all members of the team ORE and the supervisor will monitor the flow. Referral letters should be ore'd within 24 hrs. The function set required is DWA – ORE.
You are required to ORE in site related to referral e.g, STH address has to be ORE'd in STH site. Relevant hospital number related to site is also required. All referrals are to be ORE'd to GP Specification, i.e. Urgent – GPU, priority type 2.

Creating an Episode

The function on PAS to be used when creating an episode is ORE. You will need to know which consultant code/speciality code to use – each team has a table of instructions which contains information relating to the codes and any special instructions, eg optician. You will need to check this each time you create an episode until you become familiar with the consultant's requirements.

When you have recorded the patient on PAS you then need to send the referral letters up to the consultant for triage (grading of the letter into routine / urgent).

For most specialities in Daisy Hill Hospital (DHH), South Tyrone Hospital (STH) and Armagh Community Hospital (ACH) referral letters are scanned and e-mailed to relevant secretaries for triage. In CAH referral letters are sent by post or delivered by hand.

Letters returned from Triage

When the letter is returned from the consultant they are ready to be added to the Waiting List. Each team is responsible for their own specialities. Check if:

Priority has been changed, eg from urgent to routine
The patient has been assigned to a named consultant in same speciality – previously an unnamed referral

Changes like this will mean you have to go into PAS and amend the OP REG using the function RBA which will allow you to make the amendments and also add to W/L) ensuring the correct hospital number.

To add to the Waiting List if there are no amendments to the OP REG – use the function OWL select your OP REG and then get the Waiting List code from the table of instructions and add in. Also add in additional details to the Procedure Field such as Bowels, Gastro, x-ray needed.

During this updating of PAS you must check to ensure that the date of the OP REG is the same as the date stamp on the letter and the same as the date on list on PAS.

For Dermatology ICATS and Urology ICATS the original episode needs discharged on PAS – function OD with reason code CICT.
Referral is then re-ored using relevant ICATS specification.

Selecting from Waiting List

Each month there is a “big select”. Before you do your “big select” you will need to:

- Check the front of the Select file for guidance/clinic instructions
- Check the back of the file to see what instructions are recorded on the calendar – if clinics are to be cancelled or reduced check PAS to make sure that this has been done
- Phone the consultant’s secretary to double check all holidays/reduced clinics are correct, and that there are no changes to the information
- Check that the cancelled clinic details are recorded on the cancelled clinic spreadsheet

To determine how many slots you have for NR (New Routine) patients use the function CBK and look at each individual clinic and see how many NR slots there are for the time period you are working on and this will let you know the number of patients you can send for.
The same procedure above applies for NU (New Urgent) and R (review) patients.

You’re now ready to select your patients so using SWO select the appropriate number of patients and on PAS record in the comment field:

- PB1,
- the date it was sent (todays date) and
- the code of the clinic that the patient is to be booked to, and the consultant or clinician code if appropriate eg Ortho Icats and Paeds staff grade clinics.
- the month they have to be booked into.

Patients must be selected in chronological order – your SWO screen and your PTL will guide you with this.

Only one person per speciality will work on the selection at a time to avoid duplication.

When you have completed your select you must then record the patient details etc on the SELECT SHEET You should also remove all the referral letters that you’ve selected and keep them with this list at the front of the select file.

In two weeks’ time when you’re checking to see who needs to have a PB2 sent you can use this check together with SWO to ensure that all patients have been actioned. You may also check function EPI to see if patients have responded to their PB1 letter.

When sending out the PB2 letters remember to update the comment field with your appropriate PB2 code, todays date, the clinic code/consultant code if appropriate to be booked into, and also the month the patient is to be seen in.

PB1 letter sent – if no response within 14 days from the date in the comment field the PB2 letter is sent. PB2 letter is sent – if no response within 7 days from the date in the comment field the patient is discharged and a letter sent to the patient and the GP.

Discharging a Patient

Before you can discharge a patient on PAS you must do a check on their address – phone their GP to confirm address. If this is different from what is recorded on PAS then you must get in contact with the patient to offer them an appointment – this is usually done by telephoning the patient.
If no contact can be made by telephone then the PB1 will be re-issued to the correct address.

If the address is correct then you can discharge the patient, issue a letter to the patient and to the GP, and forward the referral letter to the consultant. There are however exceptions where you need to email the secretary details of the non-responders and forward the referral letter.

Children – you cannot discharge a child (child = under 17 years and 364 days old). Fill in “Under 18’s O/P Discharge” form and forward to the consultant with the referral letter. They must inform you of the follow up action, eg discharge, send for again.

Primary Target Lists (PTL’s)

Every Monday you will get a new PTL (can be requested more frequently if required). When you get your PTL you will need to:

Look for any blanks (ie patient episodes where the W/L code is not entered)
Are there any episodes where a PB2 is now required
Are there any PB2’s that now need to be closed
Check, using CBK and SWO, if there is capacity in any of your clinics
Check, using CBK and SWO, if there is a shortfall in any of your clinics

Diary

Each team has a diary which is used as a checking mechanism. The diary is date stamped with the following headings and also includes the codes of the clinics that are held on that day:

Completed Clinic
PB1
PB2
PBG

Example

Today's date is Tuesday 19th April – the diary entry will look like this:

Completed Clinic	**26/04/11**	(this is one week in advance)
PB1	**31/05/11**	(this is 6 weeks in advance)
PB2	**05/04/11**	(this is 2 weeks previously)
PBG	**29/03/11**	(this is 3 weeks previously)

Completed Clinic

Today is the 19th April, so you want to check the clinics held on the 26th April to make sure they are all fully booked. The clinic codes are all on this page for reference.

PB1

Today you want to send out your PB1 letters for the clinics that are 6 weeks away – so you will be checking the clinics on the 31st May to check their capacity and then selecting your patients to send. The clinic codes are all on this page for reference.

PB2

Today you want to check who needs a PB2 letter sent – so you want to check the clinics that are held on a Friday that have had a PB1 sent on the 05/04/11 and that haven't responded, as they now require the PB2 letter. Use both the list at the front of the select file and also the function SWO.

PBDG

Today you want to check who has received a PB2 letter on the 29/03/11 and who have not responded – use the list at the front of the select file and also the function SWO. These patients now need discharged on PAS (except if they are a child).

Booking an appointment

When a patient phones up to make their appointment having received their letters you use function BWL.

You have to remember here:

- Breach Codes – being aware of target dates i.e. 9/17/21/26/41 weeks
- Letter codes – remember to use the relevant letter codes depending on the clinic, this gives information to patients what to expect at the clinic.
- Letter options i.e. U6/DB/VA

You may also have to use function RBA if the patient has come of an unnamed list, the consultant will have to be changed from unnamed to named. You have to ensure that when using RBA that you use the correct hospital number for the appointment.

Resetting

If a patient has an appointment for the 2nd July and phones up on the 23rd June to cancel the appointment then the date that they are reset on the PTL will be 23/6/09 – in other words PAS will always take the reset from the date the appointment was cancelled, not the date of the clinic. Their new date will be calculated to 23/6/09 by the PTL. Do not ever change the date on list for New Patients EXCEPT SFA following NRPB – no response to Partial Booking.

Cancelling a clinic

You may only cancel a clinic if you are in receipt of an e-mail containing a cancel clinic proforma from the consultant or their secretary giving the details of the clinic to be cancelled and confirming that you should now proceed and cancel same.
If the clinic is to be within 6 weeks then clearance is required from the heads of service before any action can be taken.
If the clinic is 6 weeks or beyond then clearance is not required and relevant action can be taken.

Some clinics are set up on PAS to build well into the future (on screen) while others are set up to build a few weeks into the future (not on screen).

Do a CBK, enter in clinic code and check if this date is built on PAS. At this stage make a note of the number of NU, NR, RF, REV slots on the clinic as you will need to record this information on a spreadsheet*.

<u>Built on PAS</u>

Function Set = ODM and Function = CCL (cancelled clinic)
Enter in clinic code and date of clinic to be cancelled.
If there are patients booked onto this clinic a Rebook List will be automatically produced. It is best practice to phone the patients on the Rebook List and cancel the appointment, giving them a new appointment if possible.

If you do not have capacity to rebook the patients into the correct month then this should be escalated to your supervisor/referral and booking centre manager.

- Now go to the cancelled clinic *spreadsheet and fill in the clinic details including the number of slots cancelled by category.
- Record the cancelled clinic details on the calendar at the back of the Select File.
- Record the cancelled clinic details in the diary.
- File the e-mail in the cancelled clinics team folder.

<u>Not Yet Built on PAS</u>

If the date of the clinic you have to cancel is not built on PAS then you need to:

- Record the information on the calendar at the back of the Select File
- Record the information in the diary
- File the e-mail in the cancelled clinic team folder

Reducing a Clinic

You may only reduce a clinic if you are in receipt of an e-mail containing a proforma to reduce the relevant clinic from the consultant or their secretary giving the details of the clinic to be reduced and confirming that you should now proceed and reduce same.
If the clinic is to be within 6 weeks then clearance is required from the heads of service before any action can be taken.
If the clinic is 6 weeks or beyond then clearance is not required and relevant action can be taken.

CBK – get details of the timeslots as you need to record the reduced clinic details on the cancelled clinic spreadsheet.

Some clinics are manned by one doctor while other clinics are manned by several doctors, some occur once a week, and some once a day. Therefore you need to know your clinic set up so when you get confirmation that a clinic is to be reduced you need to check:
Follow relevant instructions per consultant template.

- How many doctors are at this clinic?
- How many patients would need cancelled?
- What types of appointments should be cancelled – eg NR or Rev?

To reduce the clinic use the function TBO – this will allow you to view the clinic and see what the timeslots are and how they are set up, eg every 10 minutes, with 2 NR and 1 Rev at each timeslot.

Example of a clinic set up (using only NR and Rev as the categories)

Timeslot	NR	REV
9.00	2	1
9.10	2	1
9.20	2	1
9.30	2	1
9.40	2	1
9.50	1	1
10.00	1	1

If you were asked to reduce this clinic by 4 NR and 3 R as there will be one doctor on leave from the clinic then you need to make sure that the reductions

you make still ensure patient flow, ie you don't have all the reductions at the start of the clinic, leaving the 2 remaining doctors with no patients at 9 am. The reductions should be spread throughout the clinic. It's also important to consider the category of the patient, ie a doctor can generally see a review patient in a shorter time than a new patient.
Function set required is ODM – MS

Remember not to take away new patients from the start of an afternoon clinic to allow for ambulance patients.

- Record on PAS that the clinic is reduced to xx amount of patients, and any other instructions you have received, eg no NR patients after 10.30 am.

- Record the information in the calendar at the back of the Select File.

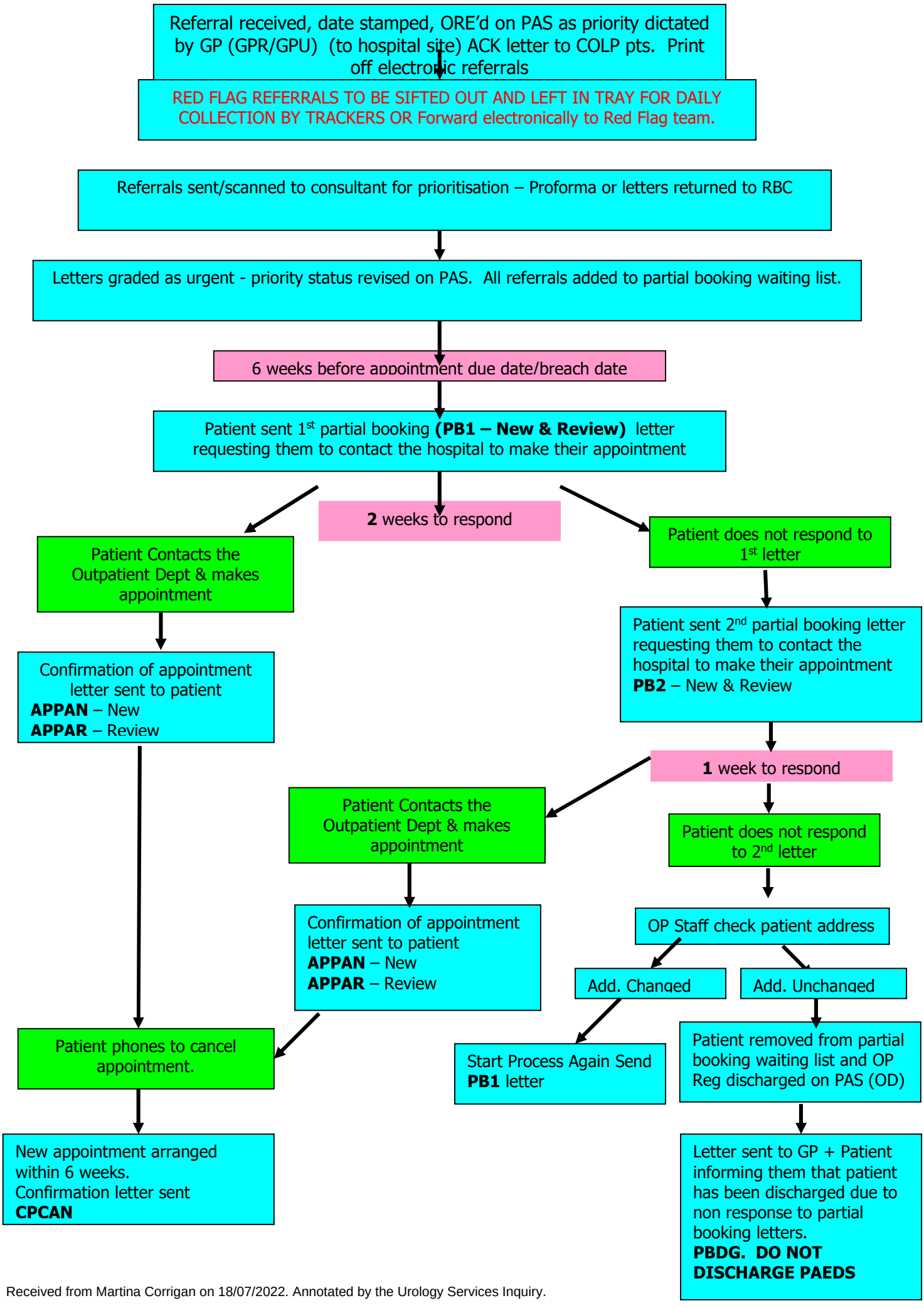
- Record the information in the diary.

- Record the information in the cancelled clinic spreadsheet.

- File the e-mail in the cancelled clinic team folder.

- Make the necessary reductions to the clinic.

PARTIAL BOOKING ROUTINE APPOINTMENTS – RBC

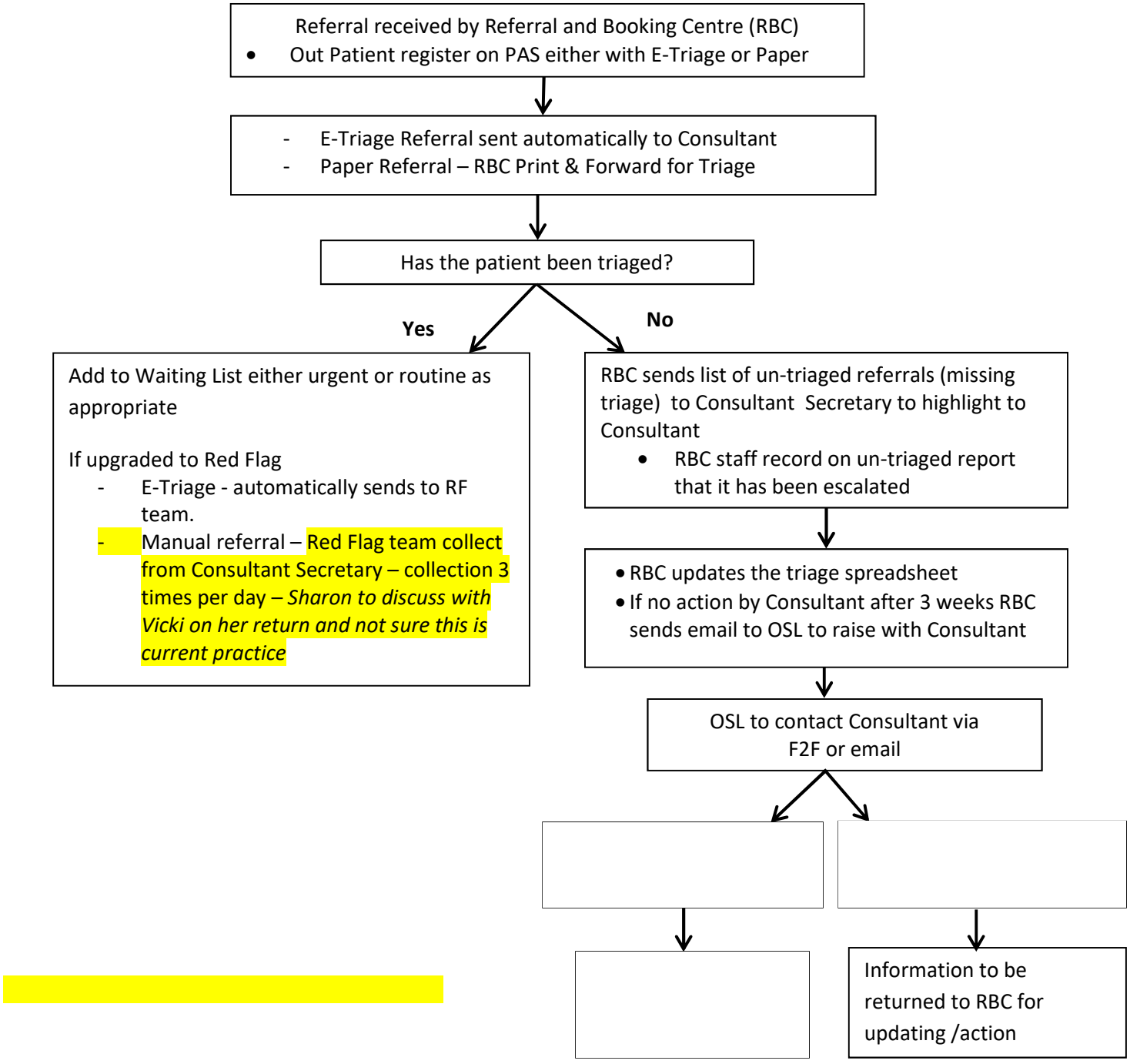


TRIAGE PROCESS

- **Red Flag referrals should be returned from Triage within 24hrs**
- **Urgent referrals should be returned from Triage within 72hrs**
- **Routine referrals should be returned from Triage within week.**

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It also serves a purpose to direct the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
- The Consultant can return referrals with advice and no outpatient attendance where appropriate.



Please Note: This process will incur a minimum of 7 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.

It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 18 January 2017 19:32
To: Reddick, Fiona
Subject: FW: [redacted]
Attachments: Timeline in preparation for screening [redacted] final.docx; Clinical Staff Inventory for [redacted].docx; copy of [redacted] Complaint.pdf

Sensitivity: Confidential

Fiona

As discussed

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

From: Connolly, Connie
Sent: 11 January 2017 14:52
To: Corrigan, Martina
Cc: Reid, Trudy; Boyce, Tracey
Subject: [redacted]
Sensitivity: Confidential

Martina- Tracey had asked me to do a timeline for the above patient in relation to a complaint.
I have attached the timeline as well as both the inventory and timeline for your reference.
I have a draft of the screening form started if needed in the future
If you have any queries, do not hesitate to contact me
I will leave both sets of notes with you. The DHH chart was with Mr Gilpin's sec, and would need re-tracked.
Kind Regards
Connie

Connie Connolly

Southern Health and Social Care Trust
PLEASE NOTE NEW PHONE EXTENTION
Acute Governance | Acute Directorate | Admin Floor | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: [redacted] | Mob: [redacted]

Personal Information redacted by the USI

05/12/16

REF: Patient 16

Personal Information redacted by the USI

H&C: Patient 16

To whom it may concern,

I am making this complaint, on behalf of my father, after much consideration and having discussed our concerns with involved personnel. It centres on the poor response to communication between the Oncology and Urology departments in Craigavon Hospital and the consequences of this which include; unnecessary suffering and denied access to a treatment option for cancer.

My father was diagnosed with bowel cancer in July 2012. He was referred to Oncology and in 2014 Chemotherapy was identified as a treatment option. Prior to the commencement of this treatment a stent was inserted into the left kidney in March 2015. We were informed at this point in time that the stent would be due for removal directly after the treatment ended as it's life span was 6 -9 months. Chemotherapy finished in November 2015 and my father was advised that arrangements would be made with Urology to have the stent removed. However, this did not happen and during follow-up reviews with the oncologists and surgical consultants the need for it to be removed was acknowledged and assurances given that letters would be written to various personnel in the Urology department. Meanwhile, for the next 6 months, my father suffered from a range of complications synonymous with a stent in place too long including; significant pain and persistent urinary tract infections. We continued to advise oncology personnel, our GP and the local Macmillian nurse of the increasing difficulties he was experiencing and again we were assured that these concerns had been passed on to Urology. In increasing desperation we began to ring Mr O'Brien's secretary in an effort to have the procedure completed.

In April 2016 during a review appointment in oncology the option of a short course of radiotherapy was raised. My father agreed to proceed with this but was made aware that first the stent would

need to be removed. In June 2016 dad received a phone call from the oncologist stating that he had viewed the latest scan results and radiotherapy was definitely a way forward. On the same day dad received a phone call from the urologist informing him of the arrangements for the removal of the stent three days later. We were bewildered about the apparent urgency, after such a long wait and wondered had something shown up on the scan. Dad attended Craigavon on the 28th June 2016 for the procedure; at this point the stent was in place for 15 months.

The procedure, which we understand generally takes about 30 minutes, took over two hours. The kidney was significant distended and the stent was encrusted and dislocated. Indeed I am aware that research suggests that the amount of stent encrustment is directly related to how long it has been in place. The aftermath was horrendous. Dad was very ill due to septicaemia and had to remain in hospital for 12 days. We were extremely upset and discussed our concerns with personnel in urology. We decided not to proceed with a formal complaint at the time, as we hoped that communication between the two departments would improve. Three weeks later there was further telephone correspondence from another oncologist advising dad that he was about to a make arrangements for him to attend the radiology department in the City Hospital to have initial measurements taken. It seems that this course of action was to be delayed for a short period, following consultation between the urologist and the oncologist, as a new stent would first have to be inserted. This happened in August 2016 and we immediately advised oncology that the stent was in place and we were on course again for radiotherapy. The next meeting with oncology was in September 2016. Dad was advised that it was deemed appropriate for a further scan to take place and he agreed to the deferral of the treatment until this was secured. It was with utter dismay at the next meeting on 1st December (13 weeks later) we learnt that this course of treatment was no longer an option as the disease had progressed. At that meeting I asked why the radiotherapy did not take place as planned in June, when the scan at that time indicated that it was feasible. I do not believe that I was given any clarification on this issue. In addition, when the oncologist was asked about the time delay between the scan and the review appointment he apologised but said it was 'out of his control'.

In summary, I believe that the delay in the removal of the original ureteral stent is undeniably linked to the removal of cancer treatment options for my father. I know that he has suffered unnecessarily as a result of the lack of response to communication from various sources to urology. Finally as a family we had the unenviable experience of dealing with a mother and father diagnosed and undergoing treatment for cancer at the same time. Ironically the experience of both parents is startlingly different. My mother suffered from mouth cancer and was under the care of the South Eastern Trust. There were a number of departments involved in her surgery and aftercare, both within the trust and outside it. The co-ordination of services was seamless and communication between departments immediate and transparent. She receives regular follow up review appointments where both oncology and her surgical consultant are present and she has access to a superb advocacy service provided by the Head and Neck nurse.

The expected outcomes of this complaint are as follows;

a) Details of all correspondence to the Urology department from all sources regarding the removal of the stent.
b) A review of protocols for communication between two departments in the same hospital. It seems incredulous, that there is a reliance on the social etiquette of writing to a colleague in the same hospital rather than emailing or using another system on the intranet.
c) Provision of a clear explanation for the delay in carrying out the procedure of removing the ureteral stent, clarification on the Urology department's policy for the time frame of insertion and removal of kidney stents, the name of the manufacture of the stent and their guidelines regarding the length of time the stent can safely remain in place.
d) Consideration of the cost to the National Health Service of dealing with the aftermath of not completing a procedure within a reasonable time frame.
e) An examination of the review arrangements for patients with cancer which is deemed to be progressive. Cancer does not wait for scans or lengthy periods between appointments!
f) A direct explanation as to why radiotherapy did not proceed as planned in June 2016.
g) Reflection on examples of good practice in other trusts.
h) Consideration given to setting up an advocacy service for patients who are undergoing treatment for cancer. Within the Southern trust this is ad hoc and seems to be left to the local Macmillan nurses, who cannot cope with the demands placed on their service.

In essence, we are a family who are dismayed and disillusioned! We are requesting answers to questions posed, seeking recognition of the unnecessary suffering endured by my father due to neglect and the subsequent lack of ability to access an appropriate cancer treatment; which may have increased his life span a little and given us more time to spend with a wonderful man!

Yours faithfully,

Southern Health and Social Care Trust

Quality Care - for you, with you

NEXT OF KIN CONSENT FORM

Full name of patient/client: Patient 16 [redacted]

Address: Personal Information redacted by the USI [redacted]

Date of birth:

Connection to person making the complaint: FATHER

I hereby authorise:

Name of person making the complaint: Patient 16's Daughter [redacted]

Address of person : (if different from above) Personal Information redacted by the USI [redacted]

to act on my behalf and to receive any and all such information as may be relevant to the complaint.

I understand that any information given is limited to that which is relevant to the investigation of the complaint and only disclosed to those people who have a need to know it in order to investigate the complaint.

Signature of next of kin: Patient 16 [redacted]

Date: 11.12.16

Clinical Staff Inventory for Patient 16		
Report Reference	Name	Grade
Dr 1	Mr Adrien Neill	Consultant Surgeon
Dr 2	Dr Robert Harte	Consultant Oncologist BCH
Dr 3	Dr B Maguire	GP
Dr 4	Mr David Gilpin	Consultant Surgeon
Dr 5	Dr Deane	GP
Dr 6	Dr Anthony McBrearty	Surgical Registrar
Dr 7	Dr Taimoor Shafiq	Surgical SHO
Dr 8	Dr Paul Hughes	
Dr 9	Mr Damien McKay	Consultant Surgeon
Dr 10	Dr Richard Parke	Consultant Oncologist BCH
Dr 11	Mr Anthony Glackin	Consultant Urologist
Dr 12	Dr Rachael Hutton	ST4 in Urology
Dr 13	Mr Aidan O'Brien	Consultant Urologist
Dr 14	Dr Aiden Cole	SpR to Dr 10
Dr 15	Mr John O'Donaghue	Consultant Urologist
Dr 16	Dr Matthew Tyson	ST6 Urology
Dr 17	Dr Richard McConville	Consultant Radiologist
Dr 18	Dr Morrison	

Southern Health and Social Care Trust
Quality Care - for you, with you

Patient 16 [redacted]

Complaint

Date/Time	Source	Time Line	Comments
2/07/12	MDM report	Sigmoid colectomy done. Confirmed Dukes C1 pT4b N1 R0 tumor with 1/14 nodes positive.	Surgical follow up by Dr 1
07/09/12	OPD letter	Patient seen by Dr 1.	Emergency Hartmanns done by Dr 4. Longstanding hx of constipation and is Personal information redacted by USI due to a fall. There has been an MDM discussion which suggests surgical follow up only, although I will query this as he has N1 disease and would be clinically able to tolerate chemotherapy
07/09/12	Letter	Letter from Dr 1 to Dr 2.	Requesting advice. This patient had been reviewed at MDM and surgical follow-up only was suggested. Wondering if adjuvant chemo would be worth while.
15/11/12	OPD letter	Letter from Dr 2 to Dr 1. Copy to Dr 3	Dr 2 contacted by patient advised he did not want to proceed with chemotherapy, which I think in his situation is understandable and perfectly reasonable. In the expectation that follow-up is maintained, and we will discuss at MDM should relapse occur.

Screening Meeting TBC

Date/Time	Source	Time Line	Comments
03/12/12	Letter	Letter from Dr 1 to Dr 5. Arranged colonoscopy, CEA done. Review again in 6/12 for repeat CEA and repeat CT of chest, abdomen and pelvis	Pt has made excellent recovery from emergency hartmanns. Has been seen by oncology and has declined chemo.
11/03/13	Colonoscopy Report	Sent from Dr 1 to Dr 5	Small polyp left colon biopsied. Normal scope remaining. Review with Dr 1 June for repeat CEA. Surveillance CT ordered.
26/04/16	Letter	Letter from Dr 1 to patient, copy to Dr 5.	CT Surveillance scan unchanged. OPD review as planned
22/07/13	Letter	Letter from Dr 6 to Dr 5	CEA checked today. On d/w Dr 1, will review in 6/12
02/12/13	Letter	Letter from Dr 7 to Dr 5.	Feeling well until 5/52 when developed crampy abdominal pain.For CEA and urgent CT. If CT normal, r/v 6/52. If not, sooner.
27/07/14	Letter	Seen by Drs 1&8.	CT NAD. Complaining of pain and gurgling at stoma. Intermittent swelling. Motions dark at times
28/07/14	NIECR		CEA 6.5 ng/ml
03/08/14	ED Flimsy	Presented with abdominal pain at stoma. Admitted to MSW	AXR faecal loading CXR no free air
20/08/14	CT Abdomen Report		Dilated small bowel proximal oedematous post-operative loop
02/09/14	Discharge letter	To Dr 5. Recurrence of bowel tumour	Resection and primary anastomosis of the small bowel-tumour recurrence. To be reviewed by Dr 9.

Date/Time	Source	Time Line	Comments
10/09/14	Letter	Letter from Dr 9 to Dr 10.	Request for review in the next 3-4 weeks. Recent admission re slow long-standing bowel obstruction secondary to a met in his pelvis. Request for adjuvant therapy.
25/09/14	NIECR		CEA 3.8 ng/ml
09/10/14	Letter	Letter from 2 to Dr 9. Copy to Dr 5	Patient 16 reviewed on 25/09/14 with his family. He has decided not to proceed with palliative chemotherapy but wished to keep an open mind about the future, Keen to be kept under close observation. As I appreciate you will be maintaining this in DHH, we will not duplicate. CEA 1.8 ng/ml
16/12/14	NIECR		CEA 9.9 ng/ml
2/03/15	NIECR		CEA 17.6 ng/ml
11/03/15	CT chest report		Irregular mass lesion in the pelvis on the left side involving the ureter causing proximal hydro-ureter and hydronephrosis. Increase in size of nodule in the posterior segment of the left upper lobe
12/03/15	Letter	Letter from Dr 9 to Dr 10. Has been referred to Dr 11 for stenting.	As discussed today and MDM, requested consideration of palliative chemo. CEA 17.6 ng/ml. He has a pelvic mass at the site of his peritoneal deposit that we operated on last year which was causing small bowel obstruction at that time He has now obstructed his left kidney.

Date/Time	Source	Time Line	Comments
12/03/15	Letter	Letter from Dr 9 to Dr 11. Red Flag referral	Patient 16 has progressive disease in his pelvis and now has a significant hydronephrosis on the left side. U&E is normal and Oncology team is keen for stenting prior to palliative chemo
12/03/15	Letter	Letter from Dr 9 to Personal information redacted	Informing Patient 16 of further disease progression and referral on to Urology.and Oncology
26/03/15	Letter	Letter from Dr 15 to Dr 5. Arrangement made for elective admission on 31 March 2015 for insertion of left ureteric stent	Seen today re further recurrence causing hydronephrosis. Imaging shows grossly hydronephrotic left side above the obstructing mass.
26/03/15	Letter	Letter from Dr 2 to Dr 9. Copy to Dr 3.	Review in CAH with daughter. Ureteric stent planned 31 March 2015. A long discussion of options and in view of time course, keen to persue chemo sooner rather than later. To review next week post-stent to finalise a plan.
31/03/15	Operation Note	Surgery done by Drs 12 and 13	Tight short urerthral stricture. Unable to advance guidewire beyond distal 1/3. Guidewire over ridged ureteroscopy. Stent inserted Admit overnight. Ocologists to contact when chemotherapy complete for stent removal/replacement.
2 April 2015	Nursing notes	Attended oncology appointment. Seen by Urology team	
2 April 2015	Discharge letter	Under the care of Dr 12. Letter to Dr 5 Copy to Mandeville Unit	Urology to be re-contacted once current chemo regime has finished for removal/change of stent to take place.
23 April 2015	OPD letter	Letter from Dr 10 to Drs 3&9.	Palliative chemo outlined and consent given. His rising CEA may be a potential indicator of disease response and we may also arrange further imaging in due course.

Date/Time	Source	Time Line	Comments
14 May 2015	NIECR		CEA 14.4ng/ml
2 June 2015	Medical admission proforma	Admitted for chemo induced nausea and vomiting.	
5 June 2015	Discharge letter	Letter to Dr 3.	Commenced on loperamide and ondansetron. For telephone assessment by oncology team 8 June 2015
11 June 2015	NIECR		CEA 7.1 ng/ml
2 July 2015	Letter	Letter from Dr 2 to Drs 3&9.	Finds combination of Ondansetron and Cyclizine works best. Agreement to try with no dose adjustments, reviewing on cycle by cycle basis. CEA 5.8ng/ml
29 July 2015			CEA 5.6ng/ml
10 August 2015	Letter	Letter from Dr 9 to Drs 2&3.	Coming to the end of chemo. Review in next 3-4 months. Then we can decide between me and oncology who will follow up longer term as I don't feel we need to replicate reviews.
28 August 2015	Letter	Letter from Dr 2 to Drs 3&9.	Long discussion with patient and regarding options noting CEA is falling suggesting chemotherapy activity. Stop Oxlaliplatin
10 September 2015	USS kidney report		Moderate hydronephrosis in the left kidney with the transverse renal pelvis. The urinary stent is visualised in the renal pelvis. The upper ureter is dilated but does not appear dilated at the level of the bladder
16 September 2015	NIECR		CEA 3.4ng/ml

Date/Time	Source	Time Line	Comments
7/10/15	NIECR		CEA 4.6ng/ml
8 October 2015	Letter	Letter from Dr 2 to Drs 3&9.	Evidence of efficacy in that CEA has fallen from 18ng/ml to 3ng/ml. Reports feeling generally anxious. Review CAH 6-8 weeks.
26 November 2015	Letter/NIECR	Letter from Dr 10 to Dr 13. Copies to Drs 3&9	Request for change of ureteric stent. Increasing left sided abdominal pain. Chemo completed. 'Would you consider this an appropriate time to change this stent?' CEA 10.0 ng/ml
30 November 2015	email	Email to Dr 13 from his secretary	'This patient is on your planned w/l for removal of left ureteric stent, ureteroscopy and ?restenting- October 2015. Personal information redacted by USI daughter was ringing this am regaurding a date for her father's surgery. She advised that her father is experiencing pain and would appreciate a date for his surgery as soon as possible
11 December 2015	Letter	Copy of letter from Dr 10 to Dr 13 in patients chart with date stamp of 11 December 2015.	No handwriting on letter.
	Letter	Copy of letter from Dr 10 to Dr 9 in chart with Dr 9's handwriting/signature.	Signature with 'file' '? Review date' Writing in red ink stating 'due for review 02/16, already on Surg OPD with tick and sort'

Date/Time	Source	Time Line	Comments
21 January 2016	Letter/NIECR	Letter from Dr 14 to Dr 3 Copy to Dr 9. Still awaiting stent change and Urology will be re-contacted regarding this. Review 2/12.	CEA up to 10ng/ml in November. Discussed the likelihood of disease progression over the next weeks. Outpatient CT arranged for DHH. I have explained that if there is only local disease progression over the months in his pelvic mass that we could consider some palliative radiotherapy to this region if he is becoming more symptomatic. CEA 11.6 ng/ml
8 February 2016	CT Report		Disease progression at thorax. Progression of left hydroureter and hydronephrosis
4 March 2016	email	Email from audiotypist to Dr 13's secretary	Patient 16 phoned re TCI date for removal of stent. c/o regular dosed of antibiotics, had chemotherapy. Patient stated urine sample needs to be sent prior to removal of stent
24 March 2016	Letter/NIECR	Letter from Dr 2 to Dr 3. Copy to Dr 9 Has had no contact from Urology and unclear whether stent is to be removed or replaced.	Having urinary symptoms, and 3 course of anti biotics since last review. CT in Feb shows progression of left hydro-ureter/hydronephrosis and development of small left upper lobe pulmonary nodule. CEA has risen. After discussion: not to proceed with further chemo but re-assess in 10/52 CEA 18.8ng/ml.
9 May 2016	Letter/NIECR	Letter from Dr 9 to Dr 3.	c/o left flank pain We are going to contact the CAH Urology Dept to see if stent can be removed/replaced. CEA is creeping up again. CEA 29.6 ng/ml Due to see Dr 2 in June. Review 4/12
9 May 2016	Letter	Letter from Dr 9 to Palliative Care Team	Please see re increasing pain

Date/Time	Source	Time Line	Comments
9 May 2916	Letter	Letter from Dr 9 to Dr 11.	Please see and review urological care. Main symptoms currently appear to be related to longstanding ureteric stent which has been in now for about 18 months. Could you perhaps review whether or not this could be removed/replaced.
10 May 2016	Email	Email to Dr 13 from his secretary	This patient was ringing to advise that he had an appointment with Dr 9 yesterday and was told that all of his current symptoms are related to his stent which should have been removed last year.
2 June 2016	Letter	Letter from Dr 14 to Dr 2. Copy to Dr 9.	Background of urosepsis. Has been on antibiotics intermittently for several months. CT in Feb showed progression of hydronephrosis. I recommend that we re-contact the Urology team for review and whenever the stent is changed and if urinary symtoms are stable, we could consider palliative IMDG. Will aim to review in 10/52 and will write a letter to Dr 11 in the meantime.
2 June 2016	Letter	Letter from Dr 14 to Dr 11.	Received in CAH 8/6/16. Please review patient in near future. Progressive left sided hydronephrosis and hydroureter. He was due possible a change of stent some time ago. We are in a position to offer further palliative chemo if urinary symptoms were stable. Handwriting on letter states: 'Known to Dr 15. Stented 3/2015.?NT required. V probable email Dr 15 to discuss mane.' Dated 22 June 2016

Date/Time	Source	Time Line	Comments
13 June 2016	CT report		Left ureteric stent seen. Gross left sided hydronephrosis and hydroureter. Nodules in right and left upper lobes. Irregular soft tissue density mass along the left pelvic wall encasing the ureter
24 June 2016	email	From Dr 13 to his secretary	'Please send letters of admission to the following patients:- Patient 16
29 June 2016	Nursing Admission Op Notes	Admitted for replacement of left ureteric stent, left ureteroscopy under Dr 13.	Procedure done by Drs 13&16. Optical urethostomy, left stent removed and laser to encrustation to distal end and left urethroscopy. Urethroscopy: reattempted passing wire Tortuous ureter. 3South please. Observe for sepsis. Nephrostomy left Thursday TWOC 3/7 30 weeks since initial request 26 November 2015
18:00 In Recovery Ward	Recovery Ward Notes	i/v paracetamol given	Temp 38.9
30 June 2016 08:30	Recovery Nursing Notes	Very distressed re surgery yesterday and further procedure. Requesting to speak to Uro team prior to procedure. Same contacted	Seen by Dr 16.
09:00	NEWS		Temp 38.1
11:20	Nursing Notes	End of list due to MRSA. Gentamycin 250 mg i/v. Feeling nauseous ++	Plan: NBM post stent, for anti biotics, IVF Temp 39.8 at 13:30
15:05 In Recovery Ward	NEWS		Temp 39.0 Pulse 126 b/p 96/50 Resps 23 SpO2 96% NEWS 7

Date/Time	Source	Time Line	Comments
30 June 2016 16:00	Nursing Notes	c/o pain	NEWS 5 Temp 38.9 b/p 77/50 Pulse 122 Blood cultures sent
17:00 X-ray	Recovery Nursing Notes/Op Notes	Left Nephrostomy insertion by Dr 17.	Nephrostomy insertion: pus++. No immediate complication. Plan: 6 hourly obs, bed rest
17:15 Recovery Ward		Returned to recovery	b/p 74/48 500 mls NaCl given stat, bed tilted Dr 16 contacted- repeat bloods Urostomy drain in situ
17:25			b/p 98/51
21:30		Seen by ICU team	For insertion of central line and norad if required. ICU Drs aware
1 July 2016 01:30		Seen by ICU team. Arterial line inserted. ? insertion of central line	
10:00		Observations stable. Left nephrostomy on free drainage- remains 'mucky' Stoma active. Seen by Dr 18- can go to the ward.	
1 July 2016 19:20 Transferred to 3S	Nursing Notes	Transferred to 3S following day 2 optical urethotomy and laser to encrusted distal end and left uretoscopy, day 1 nephrostomy insertion.	
2 July 2016 until 10 July 2016	Nursing notes		Discharged home after coursed of i/v antibiotics for uro sepsis completed. 12 inpatient days
8 July 2016	Email	From Dr 13 to his secretary	'please place Patient 16 on CURWL for nephrostogram and antegrade lt ureteric stenting. Urgency 2. Date of Entry: 10 July 2016.'

Screening Meeting TBC

Date/Time	Source	Time Line	Comments
15 July 2016	Email	From booking centre to Dr 13's secretary Copied to: Service Administrator for Urology, Urology HOS and Dr 13	'Dr 15 has triaged the attached referral (? Letter from Dr 9 to Dr 11) to see Personal information redacted urgently with no delay. I was about to select but noticed patient had been under the care of Dr 13. Can you send me some info to why they attended Dr 13, I see nothing on patient centre'
15 July 2016	Email	From Urology HOS to booking centre	'This patient was in under Dr 13's care and had his procedure done on 29 June 2016'
15 July 2016	email	Email from booking centre to Urology HOS	'I will discharge the OP REG from Dr 9.
23 July 2016	Letter	Letter from Dr 10 to Dr 3. Copies to Drs 9& 13	We discussed the possibility of palliative pelvic radiotherapy but this cannot interfere any treatment plans by Dr 13. I have spoken to Dr 13 who is in consultation with Dr 17 with regard insertion of another stent. Dr 13 suggested holding off on radiotherapy. Review September.
10 August 2016	Clinical admission and Op Notes	Admission for uteroscopy +/- stenting under Dr 13	Left ureteroscopy and ureteric stenting. The middle third of left ureter was occluded by extrinsic compression and possible infiltration by metastatic disease. Nephrostomy clamped, stent in place
10 August 2016 21:25 hrs	Email	From Dr 13 to his secretary	'Place this man on CURWL fo replacement of left ureteric stent- Feb 2017. Urgency 2. Date of entry 11 August 2016.'
12 August 2016	Clinical Notes		Seen by Dr 11, arrange as day patient to come back to exchange nephrostomy tube in 2 weeks. Dr 13 to change stents in 6/12.
22 August 2016	PAS	WLA by Dr 11 for change of nephrostomy tube	Patient 16 remains under Dr 13, but WLA done by Dr 11
1 September 2016	PAS/clinical notes	Day case to change nephrostomy	Procedure done by Dr 11

Date/Time	Source	Time Line	Comments
6 September 2016	Radiology Report	Hardcopy of radiology report in patient notes	Dr 11's handwriting 'pt of Dr 13' Dr 11's signature and 'chart please'
15 September 2016	NIECR		CEA 70ng/ml
13 October 2016	CT		Features of disease progression and development of liver metastasis. MDT advised
30 November 2016	emails	Dr 13's secretary to Dr 13.	Patient 16 was ringing this am regarding his change of left nephrostomy drain. He had it changed in September and was due to have it changed again in 12 weeks however he is not on the waiting list for this. Can you please advise. He had already rang Dr 17's secretary.'
1 December 2016 10:18	Emails	From Dr 13's secretary to Dr 13.	Patient 16 daughter was ringing to advise the the DN attending Patient 16 has said the nephrostomy tube has moved ¾ on an inch and this is why Patient 16 is in so much pain. He is currently be treated for an UTI.
23:55 hrs	email	Email from Dr 13 to his secretary. Copied to Dr 17	Dr 17 has agreed to replace Patient 16 nephrostomy drain on Tuesday 6 December 2016. I also hope to arranged for him to have his stent removed in the pm. Could you advise me who the Consultant Urologist of the week will be next Tuesday, and who the Registrar on call will on the afternoon will be. I will ask the appropriate persons to remove the stent. Please send out formal notification to Patient 16 …Lastly Patient 16 will then need to be added again on CURWL for March 2017

Date/Time	Source	Timeline	Comments
2 December 2016	Letter	Letter from Dr 2 to Dr 3. Copies to Dr 9 and Dr 13	Clearly unhappy with management with issues primarily related to urology but also a lack of liaison between Oncology and Urology has left an opportunity for pelvic radiotherapy being missed. Uro sepsis in the last week. Contacted Dr 13's secretary- arrangement made for 6 December 2016 for nephrostomy replacement and stent removal.
6 December 2016	Discharge letter	Letter from Dr 11 to Dr 3. Copy to Dr 13.	Exchange of left nephrostomy tube and removal of stent done by Dr 11. Arrangements will be made for nephrostomy tube to be changed in 3/12.
9 December 2016	Surgical Admission proforma	Admitted with bowel obstruction	
10 December 2016	CT Report		Distal small bowel obstruction, multiple hepatic metastasis
Personal information redacted by USI		Patient passed away peacefully after provision of comfort measures	

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 24 February 2017 05:50
To: Reddick, Fiona
Subject: FW: New complaint for investigation - [redacted]
Attachments: [redacted] 7118.pdf; Oncology Response [redacted]

Fiona

I need the notes to finish my response please.

Thanks

Martina

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

INTERNAL: EXT [redacted] ***if dialling from Avaya phone. If dialling from old phone please dial*** [redacted]
EXTERNAL : [redacted]
Mobile [redacted]

From: Truesdale, Pamela
Sent: 03 February 2017 13:14
To: Corrigan, Martina; Reddick, Fiona
Cc: Reid, Trudy; Kerr, Vivienne; Trouton, Heather
Subject: FW: New complaint for investigation - [redacted]

Thanks Fiona,

Martina – can I ask that this response is completed early next week? I have just issued a holding letter to [redacted] however we don't want to add to the complaint or her distress by a lengthy response time.

Many thanks for your cooperation

Pamela

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

Tel [redacted]

From: Reddick, Fiona
Sent: 01 February 2017 22:10
To: Corrigan, Martina
Cc: Carroll, Ronan; Trouton, Heather; Reid, Trudy; Kerr, Vivienne; Truesdale, Pamela
Subject: FW: New complaint for investigation - [redacted]

Martina

Please find attached response for the attached complaint from an Oncology perspective.

Can we sit down and finalise a response to this complaint together as obviously we need to be sensitive as the named patient is now deceased.

Happy to discuss further

Regards

Fiona

Fiona Reddick
Fiona Reddick
Head of Cancer Services
Southern Health and Social Care Trust
Macmillan Building
[redacted]
[redacted]

Personal Information redacted by the USI

05/12/16

REF: Patient 16

Personal Information redacted by the USI

H&C: Patient 16

To whom it may concern,

I am making this complaint, on behalf of my father, after much consideration and having discussed our concerns with involved personnel. It centres on the poor response to communication between the Oncology and Urology departments in Craigavon Hospital and the consequences of this which include; unnecessary suffering and denied access to a treatment option for cancer.

My father was diagnosed with bowel cancer in July 2012. He was referred to Oncology and in 2014 Chemotherapy was identified as a treatment option. Prior to the commencement of this treatment a stent was inserted into the left kidney in March 2015. We were informed at this point in time that the stent would be due for removal directly after the treatment ended as it's life span was 6 -9 months. Chemotherapy finished in November 2015 and my father was advised that arrangements would be made with Urology to have the stent removed. However, this did not happen and during follow-up reviews with the oncologists and surgical consultants the need for it to be removed was acknowledged and assurances given that letters would be written to various personnel in the Urology department. Meanwhile, for the next 6 months, my father suffered from a range of complications synonymous with a stent in place too long including; significant pain and persistent urinary tract infections. We continued to advise oncology personnel, our GP and the local Macmillian nurse of the increasing difficulties he was experiencing and again we were assured that these concerns had been passed on to Urology. In increasing desperation we began to ring Mr O'Brien's secretary in an effort to have the procedure completed.

In April 2016 during a review appointment in oncology the option of a short course of radiotherapy was raised. My father agreed to proceed with this but was made aware that first the stent would

need to be removed. In June 2016 dad received a phone call from the oncologist stating that he had viewed the latest scan results and radiotherapy was definitely a way forward. On the same day dad received a phone call from the urologist informing him of the arrangements for the removal of the stent three days later. We were bewildered about the apparent urgency, after such a long wait and wondered had something shown up on the scan. Dad attended Craigavon on the 28th June 2016 for the procedure; at this point the stent was in place for 15 months.

The procedure, which we understand generally takes about 30 minutes, took over two hours. The kidney was significant distended and the stent was encrusted and dislocated. Indeed I am aware that research suggests that the amount of stent encrustment is directly related to how long it has been in place. The aftermath was horrendous. Dad was very ill due to septicaemia and had to remain in hospital for 12 days. We were extremely upset and discussed our concerns with personnel in urology. We decided not to proceed with a formal complaint at the time, as we hoped that communication between the two departments would improve. Three weeks later there was further telephone correspondence from another oncologist advising dad that he was about to a make arrangements for him to attend the radiology department in the City Hospital to have initial measurements taken. It seems that this course of action was to be delayed for a short period, following consultation between the urologist and the oncologist, as a new stent would first have to be inserted. This happened in August 2016 and we immediately advised oncology that the stent was in place and we were on course again for radiotherapy. The next meeting with oncology was in September 2016. Dad was advised that it was deemed appropriate for a further scan to take place and he agreed to the deferral of the treatment until this was secured. It was with utter dismay at the next meeting on 1st December (13 weeks later) we learnt that this course of treatment was no longer an option as the disease had progressed. At that meeting I asked why the radiotherapy did not take place as planned in June, when the scan at that time indicated that it was feasible. I do not believe that I was given any clarification on this issue. In addition, when the oncologist was asked about the time delay between the scan and the review appointment he apologised but said it was 'out of his control'.

In summary, I believe that the delay in the removal of the original ureteral stent is undeniably linked to the removal of cancer treatment options for my father. I know that he has suffered unnecessarily as a result of the lack of response to communication from various sources to urology. Finally as a family we had the unenviable experience of dealing with a mother and father diagnosed and undergoing treatment for cancer at the same time. Ironically the experience of both parents is startlingly different. My mother suffered from mouth cancer and was under the care of the South Eastern Trust. There were a number of departments involved in her surgery and aftercare, both within the trust and outside it. The co-ordination of services was seamless and communication between departments immediate and transparent. She receives regular follow up review appointments where both oncology and her surgical consultant are present and she has access to a superb advocacy service provided by the Head and Neck nurse.

The expected outcomes of this complaint are as follows;

a) Details of all correspondence to the Urology department from all sources regarding the removal of the stent.
b) A review of protocols for communication between two departments in the same hospital. It seems incredulous, that there is a reliance on the social etiquette of writing to a colleague in the same hospital rather than emailing or using another system on the intranet.
c) Provision of a clear explanation for the delay in carrying out the procedure of removing the ureteral stent, clarification on the Urology department's policy for the time frame of insertion and removal of kidney stents, the name of the manufacture of the stent and their guidelines regarding the length of time the stent can safely remain in place.
d) Consideration of the cost to the National Health Service of dealing with the aftermath of not completing a procedure within a reasonable time frame.
e) An examination of the review arrangements for patients with cancer which is deemed to be progressive. Cancer does not wait for scans or lengthy periods between appointments!
f) A direct explanation as to why radiotherapy did not proceed as planned in June 2016.
g) Reflection on examples of good practice in other trusts.
h) Consideration given to setting up an advocacy service for patients who are undergoing treatment for cancer. Within the Southern trust this is ad hoc and seems to be left to the local Macmillan nurses, who cannot cope with the demands placed on their service.

In essence, we are a family who are dismayed and disillusioned! We are requesting answers to questions posed, seeking recognition of the unnecessary suffering endured by my father due to neglect and the subsequent lack of ability to access an appropriate cancer treatment; which may have increased his life span a little and given us more time to spend with a wonderful man!

Yours faithfully,

Southern Health and Social Care Trust

Quality Care - for you, with you

NEXT OF KIN CONSENT FORM

Full name of patient/client: [redacted] Patient 16

Address: [redacted] Personal Information redacted by the USI

Date of birth:

Connection to person making the complaint: FATHER

I hereby authorise:

Name of person making the complaint: [redacted] Patient 16's Daughter

Address of person : (if different from above) [redacted] Personal Information redacted by the USI

to act on my behalf and to receive any and all such information as may be relevant to the complaint.

I understand that any information given is limited to that which is relevant to the investigation of the complaint and only disclosed to those people who have a need to know it in order to investigate the complaint.

Signature of next of kin: [redacted] Patient 16

Date: 11.12.16

Draft oncology response to complaint re: Patient 16 27th January 2017

Patient 16 was first referred to our clinic in 2012, after he had undergone surgery for a pT4bN1M0 colonic adenocarcinoma. Following discussion, he opted not to proceed with chemotherapy, with concerns regarding potential urinary sepsis considered as a significant factor in the decision.

In 2014 Patient 16 was referred back after undergoing resection of recurrent intra-abdominal disease. After further discussion it was agreed that rather than proceeding with palliative chemotherapy, he would be kept under surgical review, and treatment considered in the event of progressive disease.

In 2015, a scan detected a left sided pelvic mass, causing hydronephrosis, and a new lung nodule. [redacted] Patient 16 was referred back to oncology, and it was decided to proceed with palliative Oxaliplatin Capecitabine chemotherapy. After a ureteric stent was inserted on 31/3/15, treatment began on 23/4/15. While there was an improvement in the CEA tumour marker, treatment was complicated by urinary sepsis and an episode of extravasation. It was decided to proceed with Capecitabine only for the final two cycles, and chemotherapy was completed in October 2015.

At the next scheduled review appointment in November 2015, the patient reported feeling well after completing chemotherapy, and a letter was sent to Mr O'Brien, regarding stent change. Further letters were sent to urology regarding this in January 2016, April 2016 and June 2016.

During this time, Patient 16 continued to be reviewed regularly at the oncology clinic. Options for progressive symptomatic disease were discussed at each of those appointments, which included second line palliative chemotherapy, or palliative pelvic radiotherapy. The timing and choice of modality would depend on a number of factors, including radiological and biochemical indications of progression, performance status, symptomatology, relative risk of urosepsis and patient preference.

In June 2016 the urologists admitted Patient 16 to change his ureteric stent, but despite removing the original stent, a replacement could not be inserted, and a left sided nephrostomy was created.

At his next Oncology review appointment on 22nd July 2016, therapeutic options were again discussed, with palliative pelvic radiotherapy being the preferred treatment choice, dependent on any further planned urology intervention. The following day Dr Park spoke to Mr O'Brien, who requested that radiotherapy be postponed until after a further attempt at ureteric stent insertion, which was scheduled to take place in August.

We were notified by the patient that this had taken place, and at the subsequent review appointment it was noted that the nephrostomy was still in place. A CT was requested to restage [redacted] Patient 16 disease, and unfortunately this showed progression of both pelvic and pulmonary disease, as well as new hepatic metastatic disease.

Patient 16 was appointed to the next available clinic after the scan result was received, and he attended on 1/12/16. At that appointment it was noted Patient 16 was suffering from a urinary tract infection, and had problems related to his nephrostomy. The following day Dr Harte communicated with Mr O'Brien's secretary by phone, and with Mr O'Brien by email, confirming that arrangements were in place for urology admission on 6/12/16 for nephrostomy change and stent removal.

Though a review appointment for January 2017 had been planned, notification was received on Personal information redacted by USI that Patient 16 had passed away the preceding day. He had been admitted to Daisy Hill Hospital with small bowel obstruction, where he had declined surgical intervention, and been managed conservatively.

Response to specific points raised in letter of complaint:

a) *'Details of all correspondence to the Urology department from all sources regarding the removal of the stent.'*

All letters to the urologists, a record of a phone call between Dr Park and Mr O'Brien, and copies of emails between Dr Harte and Mr O'Brien are available in the oncology chart.

b) *'A review of protocols for communication between two departments in the same hospital. It seems incredulous, that there is a reliance on the social etiquette of writing to a colleague in the same hospital rather than emailing or using another system on the intranet.'*

Though attending Craigavon for weekly clinics, as oncologists we are based in the BCH Cancer Centre, and do not have access to Southern trust intranet services. Dictated, typed, verified and recorded letters remain the preferred method of communication between disciplines, though admittedly delays can occur due to shortages of administrative staff. On occasions where was a clinical imperative for urgent communication, phone calls and emails were made from oncologists to the urology service.

c) *'Provision of a clear explanation for the delay in carrying out the procedure of removing the ureteral stent, calcification on the Urology department's policy for the time frame of insertion and removal of kidney stents, the name of the manufacture of the stent and their guidelines regarding the length of time the stent can safely remain in place.'*

This would best be answered by Urology.

d) *'Consideration of the cost to the National Health Service of dealing with the aftermath of not completing a procedure within a reasonable time frame.'*

This might possibly be best answered by a health economist.

e) *'An examination of the review arrangements for patients with cancer which is deemed to be progressive. Cancer does not wait for scans or lengthy periods between appointments!'*

From the time Patient 16 cancer was seen to be clearly progressive in March 2015 until his death in December 2016, Patient 16 attended 19 oncology clinics at the Mandeville Unit, including chemotherapy appointments. At each visit appropriate review arrangements were made, and on occasion altered on receipt of new clinical information.

f) *'A direct explanation as to why radiotherapy did not proceed as planned in June 2016.'*

The option of palliative radiotherapy to Patient 16 pelvic disease was first discussed as a potential treatment option at his appointment on 21/1/16. It was also discussed during a phone call between Dr Cole (SpR) and the patient on 24/6/16, and

subsequently at his clinic attendance on 21/7/16. While at that time it was felt appropriate to consider proceeding with a course of palliative radiotherapy, after discussion with the urologists it was agreed that this should be deferred to allow a further attempt at ureteric stent insertion.

At Patient 16 next review post stent insertion, it was decided to restage with a further CT scan, which revealed significant multisite disease progression. With this knowledge, and based on the Patient 16 clinical condition at the time, it was inappropriate to proceed with palliative radiotherapy. With the benefit of hindsight, it is clear that palliative radiotherapy would not have affected the clinical outcome, and could have been detrimental.

g) *'Reflection on examples of good practice in other trusts.'*

There are obvious limitations when comparing the experience of two different patients, with different clinical situations treated in different departments.

h) *'Consideration given to setting up an advocacy service for patients who are undergoing treatment for cancer. Within the Southern Trust this is ad hoc and seems to be left to the local MacMillan nurses, who cannot cope with the demands placed on their service.'*

This case does illustrate instances where involvement of oncological clinical nurse specialists may have had a significant benefit in terms of enhancing communication between departments and improvements in patient advocacy.

Dr Richard Park
Dr Robert Harte

Corrigan, Martina

To: Carroll, Ronan
Cc: Livingston, Laura
Subject: FW: New complaint for investigation - Patient 16
Attachments: Timeline in preparation for screening Patient 16 final.docx; Patient 16 7118.pdf; Personal Information redacted by the USI .docx

Ronan

Inserted as requested

Regards

Martina

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

Changed My Number

***INTERNAL: EX** Personal Information redacted by the USI **if dialling from Avaya phone. If dialling from old phone please dial** Personal Information redacted by the USI*
***EXTERNAL** Personal Information redacted by the USI*
***Mobile:** Personal Information redacted by the USI*

From: Carroll, Ronan
Sent: 02 April 2017 10:18
To: Corrigan, Martina
Cc: Livingston, Laura
Subject: RE: New complaint for investigation - Patient 16

Martina
Can you complete our responses in the word doc pls
Ronan

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

From: Corrigan, Martina
Sent: 02 April 2017 10:11
To: Carroll, Ronan
Cc: Livingston, Laura
Subject: FW: New complaint for investigation - Patient 16

Ronan

I have talked this through with Mark and we have went through all of the notes and in respect to the Urology part of the response (question a and b) Mark has advised that whilst there is details of dates and times of correspondence from Oncology to Urology unfortunately there is no record of this correspondence in the notes having been received

by Mr O'Brien. We have to acknowledge and apologise for this failing and we are in the process of putting a more robust system in place between Oncology and Urology. The issue here was that the Oncology department had addressed the letters direct to Mr O'Brien and that these are not on NIECR and because it was sent direct these have not been recorded on PAS. System now is that the secretary receives all correspondence and records this on PAS before giving to consultant. This has been a failing on our behalf and Mark has said we will have to apologise for this to the family.

Second point is in respect question c. The name and manufacturer of the stents that the Trust use, are Percutaneous Stents and supplied by Boston Scientific and the recommendation for the timeframe for a stent to be kept in is 6 months. However the Urology Department are experiencing significant pressures and we are not currently able to keep within these timescales, recently I have endeavoured to ensure if patients are being cancelled that we don't cancel these type of patient i.e. removal of stents. So again Mark has said that whilst we endeavour to meet the recommended timescales of 6 months for removal of stent this is not always achievable because of the current pressures experienced by the Urology Department and we apologise to the family for the delay in their late father having his stent removed and the stress and discomfort that this caused him.

Point d – Mark and I were not sure how best to respond to this?

Regards

Martina

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

Changed My Number

INTERNAL: EXT Personal Information redacted by the USI ***if dialling from Avaya phone. If dialling from old phone please dial*** Personal Information redacted by the USI
EXTERNAL : Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

From: Truesdale, Pamela
Sent: 27 February 2017 12:25
To: Carroll, Ronan; Corrigan, Martina
Cc: Reid, Trudy; Kerr, Vivienne; Trouton, Heather; Reddick, Fiona
Subject: FW: New complaint for investigation - Patient 16

Martina / Ronan

Please see emails below.

We would be grateful for your input into the complaint response as soon as possible.

Many thanks for your cooperation
Pamela

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

Tel Personal Information redacted by the USI

From: Reid, Trudy
Sent: 13 February 2017 13:59
To: Kerr, Vivienne; Corrigan, Martina; Carroll, Ronan
Cc: Reddick, Fiona; Trouton, Heather; Truesdale, Pamela
Subject: RE: New complaint for investigation - Patient 16

Vivienne Ronan may be able to give a generic answer to D)
Ronan attached is the time line Connie did to assist with deciding if this needed screened as an SAI and if not help with the complaint response

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

From: Kerr, Vivienne
Sent: 13 February 2017 13:40
To: Corrigan, Martina; Carroll, Ronan
Cc: Reddick, Fiona; Trouton, Heather; Reid, Trudy; Truesdale, Pamela
Subject: FW: New complaint for investigation - Patient 16

Martina

I have attached the response drafted so far from the information provided by Dr Harte and Dr Park. Can you please provide Urology input.

Trudy

Who can provide input regarding **question d**

Regards

Vivienne

Vivienne Kerr
Acute Governance Officer
The Maples CAH
Ext ersonal Information redacted by the USI

From: Truesdale, Pamela
Sent: 03 February 2017 13:14
To: Corrigan, Martina; Reddick, Fiona
Cc: Reid, Trudy; Kerr, Vivienne; Trouton, Heather
Subject: FW: New complaint for investigation - Patient 16

Thanks Fiona,

Martina – can I ask that this response is completed early next week? I have just issued a holding letter to Patient 16's Daughter however we don't want to add to the complaint or her distress by a lengthy response time.

Many thanks for your cooperation

Pamela

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

Tel Personal Information redacted by the USI

From: Reddick, Fiona
Sent: 01 February 2017 22:10
To: Corrigan, Martina
Cc: Carroll, Ronan; Trouton, Heather; Reid, Trudy; Kerr, Vivienne; Truesdale, Pamela
Subject: FW: New complaint for investigation - Patient 16

Martina

Please find attached response for the attached complaint from an Oncology perspective.

Can we sit down and finalise a response to this complaint together as obviously we need to be sensitive as the named patient is now deceased.

Happy to discuss further

Regards

Fiona

Fiona Reddick
Fiona Reddick
Head of Cancer Services
Southern Health and Social Care Trust
Macmillan Building
Personal Information redacted by the USI

Southern Health and Social Care Trust
Quality Care - for you, with you

Patient 16 [redacted]

Complaint

Date/Time	Source	Time Line	Comments
2/07/12	MDM report	Sigmoid colectomy done. Confirmed Dukes C1 pT4b N1 R0 tumor with 1/14 nodes positive.	Surgical follow up by Dr 1
07/09/12	OPD letter	Patient seen by Dr 1.	Emergency Hartmanns done by Dr 4. Longstanding hx of constipation and is Personal information redacted by USI due to a fall. There has been an MDM discussion which suggests surgical follow up only, although I will query this as he has N1 disease and would be clinically able to tolerate chemotherapy
07/09/12	Letter	Letter from Dr 1 to Dr 2.	Requesting advice. This patient had been reviewed at MDM and surgical follow-up only was suggested. Wondering if adjuvant chemo would be worth while.
15/11/12	OPD letter	Letter from Dr 2 to Dr 1. Copy to Dr 3	Dr 2 contacted by patient advised he did not want to proceed with chemotherapy, which I think in his situation is understandable and perfectly reasonable. In the expectation that follow-up is maintained, and we will discuss at MDM should relapse occur.

Screening Meeting TBC

Date/Time	Source	Time Line	Comments
03/12/12	Letter	Letter from Dr 1 to Dr 5. Arranged colonoscopy, CEA done. Review again in 6/12 for repeat CEA and repeat CT of chest, abdomen and pelvis	Pt has made excellent recovery from emergency hartmanns. Has been seen by oncology and has declined chemo.
11/03/13	Colonoscopy Report	Sent from Dr 1 to Dr 5	Small polyp left colon biopsied. Normal scope remaining. Review with Dr 1 June for repeat CEA. Surveillance CT ordered.
26/04/16	Letter	Letter from Dr 1 to patient, copy to Dr 5.	CT Surveillance scan unchanged. OPD review as planned
22/07/13	Letter	Letter from Dr 6 to Dr 5	CEA checked today. On d/w Dr 1, will review in 6/12
02/12/13	Letter	Letter from Dr 7 to Dr 5.	Feeling well until 5/52 when developed crampy abdominal pain.For CEA and urgent CT. If CT normal, r/v 6/52. If not, sooner.
27/07/14	Letter	Seen by Drs 1&8.	CT NAD. Complaining of pain and gurgling at stoma. Intermittent swelling. Motions dark at times
28/07/14	NIECR		CEA 6.5 ng/ml
03/08/14	ED Flimsy	Presented with abdominal pain at stoma. Admitted to MSW	AXR faecal loading CXR no free air
20/08/14	CT Abdomen Report		Dilated small bowel proximal oedematous post-operative loop
02/09/14	Discharge letter	To Dr 5. Recurrence of bowel tumour	Resection and primary anastomosis of the small bowel-tumour recurrence. To be reviewed by Dr 9.

Date/Time	Source	Time Line	Comments
10/09/14	Letter	Letter from Dr 9 to Dr 10.	Request for review in the next 3-4 weeks. Recent admission re slow long-standing bowel obstruction secondary to a met in his pelvis. Request for adjuvant therapy.
25/09/14	NIECR		CEA 3.8 ng/ml
09/10/14	Letter	Letter from 2 to Dr 9. Copy to Dr 5	Patient 16 reviewed on 25/09/14 with his family. He has decided not to proceed with palliative chemotherapy but wished to keep an open mind about the future, Keen to be kept under close observation. As I appreciate you will be maintaining this in DHH, we will not duplicate. CEA 1.8 ng/ml
16/12/14	NIECR		CEA 9.9 ng/ml
2/03/15	NIECR		CEA 17.6 ng/ml
11/03/15	CT chest report		Irregular mass lesion in the pelvis on the left side involving the ureter causing proximal hydro-ureter and hydronephrosis. Increase in size of nodule in the posterior segment of the left upper lobe
12/03/15	Letter	Letter from Dr 9 to Dr 10. Has been referred to Dr 11 for stenting.	As discussed today and MDM, requested consideration of palliative chemo. CEA 17.6 ng/ml. He has a pelvic mass at the site of his peritoneal deposit that we operated on last year which was causing small bowel obstruction at that time He has now obstructed his left kidney.

Date/Time	Source	Time Line	Comments
12/03/15	Letter	Letter from Dr 9 to Dr 11. Red Flag referral	Patient 16 has progressive disease in his pelvis and now has a significant hydronephrosis on the left side. U&E is normal and Oncology team is keen for stenting prior to palliative chemo
12/03/15	Letter	Letter from Dr 9 to Personal information redacted	Informing Patient 16 of further disease progression and referral on to Urology.and Oncology
26/03/15	Letter	Letter from Dr 15 to Dr 5. Arrangement made for elective admission on 31 March 2015 for insertion of left ureteric stent	Seen today re further recurrence causing hydronephrosis. Imaging shows grossly hydronephrotic left side above the obstructing mass.
26/03/15	Letter	Letter from Dr 2 to Dr 9. Copy to Dr 3.	Review in CAH with daughter. Ureteric stent planned 31 March 2015. A long discussion of options and in view of time course, keen to persue chemo sooner rather than later. To review next week post-stent to finalise a plan.
31/03/15	Operation Note	Surgery done by Drs 12 and 13	Tight short urerthral stricture. Unable to advance guidewire beyond distal 1/3. Guidewire over ridged ureteroscopy. Stent inserted Admit overnight. Ocologists to contact when chemotherapy complete for stent removal/replacement.
2 April 2015	Nursing notes	Attended oncology appointment. Seen by Urology team	
2 April 2015	Discharge letter	Under the care of Dr 12. Letter to Dr 5 Copy to Mandeville Unit	Urology to be re-contacted once current chemo regime has finished for removal/change of stent to take place.
23 April 2015	OPD letter	Letter from Dr 10 to Drs 3&9.	Palliative chemo outlined and consent given. His rising CEA may be a potential indicator of disease response and we may also arrange further imaging in due course.

Screening Meeting TBC

Date/Time	Source	Time Line	Comments
14 May 2015	NIECR		CEA 14.4ng/ml
2 June 2015	Medical admission proforma	Admitted for chemo induced nausea and vomiting.	
5 June 2015	Discharge letter	Letter to Dr 3.	Commenced on loperamide and ondansetron. For telephone assessment by oncology team 8 June 2015
11 June 2015	NIECR		CEA 7.1 ng/ml
2 July 2015	Letter	Letter from Dr 2 to Drs 3&9.	Finds combination of Ondansetron and Cyclizine works best. Agreement to try with no dose adjustments, reviewing on cycle by cycle basis. CEA 5.8ng/ml
29 July 2015			CEA 5.6ng/ml
10 August 2015	Letter	Letter from Dr 9 to Drs 2&3.	Coming to the end of chemo. Review in next 3-4 months. Then we can decide between me and oncology who will follow up longer term as I don't feel we need to replicate reviews.
28 August 2015	Letter	Letter from Dr 2 to Drs 3&9.	Long discussion with patient and regarding options noting CEA is falling suggesting chemotherapy activity. Stop Oxlaliplatin
10 September 2015	USS kidney report		Moderate hydronephrosis in the left kidney with the transverse renal pelvis. The urinary stent is visualised in the renal pelvis. The upper ureter is dilated but does not appear dilated at the level of the bladder
16 September 2015	NIECR		CEA 3.4ng/ml

Date/Time	Source	Time Line	Comments
7/10/15	NIECR		CEA 4.6ng/ml
8 October 2015	Letter	Letter from Dr 2 to Drs 3&9.	Evidence of efficacy in that CEA has fallen from 18ng/ml to 3ng/ml. Reports feeling generally anxious. Review CAH 6-8 weeks.
26 November 2015	Letter/NIECR	Letter from Dr 10 to Dr 13. Copies to Drs 3&9	Request for change of ureteric stent. Increasing left sided abdominal pain. Chemo completed. 'Would you consider this an appropriate time to change this stent?' CEA 10.0 ng/ml
30 November 2015	email	Email to Dr 13 from his secretary	'This patient is on your planned w/l for removal of left ureteric stent, ureteroscopy and ?restenting- October 2015. Patient 16 daughter was ringing this am regaurding a date for her father's surgery. She advised that her father is experiencing pain and would appreciate a date for his surgery as soon as possible
11 December 2015	Letter	Copy of letter from Dr 10 to Dr 13 in patients chart with date stamp of 11 December 2015.	No handwriting on letter.
	Letter	Copy of letter from Dr 10 to Dr 9 in chart with Dr 9's handwriting/signature.	Signature with 'file' '? Review date' Writing in red ink stating 'due for review 02/16, already on Surg OPD with tick and sort'

Date/Time	Source	Time Line	Comments
21 January 2016	Letter/NIECR	Letter from Dr 14 to Dr 3 Copy to Dr 9. Still awaiting stent change and Urology will be re-contacted regarding this. Review 2/12.	CEA up to 10ng/ml in November. Discussed the likelihood of disease progression over the next weeks. Outpatient CT arranged for DHH. I have explained that if there is only local disease progression over the months in his pelvic mass that we could consider some palliative radiotherapy to this region if he is becoming more symptomatic. CEA 11.6 ng/ml
8 February 2016	CT Report		Disease progression at thorax. Progression of left hydroureter and hydronephrosis
4 March 2016	email	Email from audiotypist to Dr 13's secretary	Patient 16 phoned re TCI date for removal of stent. c/o regular dosed of antibiotics, had chemotherapy. Patient stated urine sample needs to be sent prior to removal of stent
24 March 2016	Letter/NIECR	Letter from Dr 2 to Dr 3. Copy to Dr 9 Has had no contact from Urology and unclear whether stent is to be removed or replaced.	Having urinary symptoms, and 3 course of anti biotics since last review. CT in Feb shows progression of left hydro-ureter/hydronephrosis and development of small left upper lobe pulmonary nodule. CEA has risen. After discussion: not to proceed with further chemo but re-assess in 10/52 CEA 18.8ng/ml.
9 May 2016	Letter/NIECR	Letter from Dr 9 to Dr 3.	c/o left flank pain We are going to contact the CAH Urology Dept to see if stent can be removed/replaced. CEA is creeping up again. CEA 29.6 ng/ml Due to see Dr 2 in June. Review 4/12
9 May 2016	Letter	Letter from Dr 9 to Palliative Care Team	Please see re increasing pain

Date/Time	Source	Time Line	Comments
9 May 2916	Letter	Letter from Dr 9 to Dr 11.	Please see and review urological care. Main symptoms currently appear to be related to longstanding ureteric stent which has been in now for about 18 months. Could you perhaps review whether or not this could be removed/replaced.
10 May 2016	Email	Email to Dr 13 from his secretary	This patient was ringing to advise that he had an appointment with Dr 9 yesterday and was told that all of his current symptoms are related to his stent which should have been removed last year.
2 June 2016	Letter	Letter from Dr 14 to Dr 2. Copy to Dr 9.	Background of urosepsis. Has been on antibiotics intermittently for several months. CT in Feb showed progression of hydronephrosis. I recommend that we re-contact the Urology team for review and whenever the stent is changed and if urinary symtoms are stable, we could consider palliative IMDG. Will aim to review in 10/52 and will write a letter to Dr 11 in the meantime.
2 June 2016	Letter	Letter from Dr 14 to Dr 11.	Received in CAH 8/6/16. Please review patient in near future. Progressive left sided hydronephrosis and hydroureter. He was due possible a change of stent some time ago. We are in a position to offer further palliative chemo if urinary symptoms were stable. Handwriting on letter states: 'Known to Dr 15. Stented 3/2015.?NT required. V probable email Dr 15 to discuss mane.' Dated 22 June 2016

Date/Time	Source	Time Line	Comments
13 June 2016	CT report		Left ureteric stent seen. Gross left sided hydronephrosis and hydroureter. Nodules in right and left upper lobes. Irregular soft tissue density mass along the left pelvic wall encasing the ureter
24 June 2016	email	From Dr 13 to his secretary	'Please send letters of admission to the following patients:- Patient 16
29 June 2016	Nursing Admission Op Notes	Admitted for replacement of left ureteric stent, left ureteroscopy under Dr 13.	Procedure done by Drs 13&16. Optical urethostomy, left stent removed and laser to encrustation to distal end and left urethroscopy. Urethroscopy: reattempted passing wire Tortuous ureter. 3South please. Observe for sepsis. Nephrostomy left Thursday TWOC 3/7 30 weeks since initial request 26 November 2015
18:00 In Recovery Ward	Recovery Ward Notes	i/v paracetamol given	Temp 38.9
30 June 2016 08:30	Recovery Nursing Notes	Very distressed re surgery yesterday and further procedure. Requesting to speak to Uro team prior to procedure. Same contacted	Seen by Dr 16.
09:00	NEWS		Temp 38.1
11:20	Nursing Notes	End of list due to MRSA. Gentamycin 250 mg i/v. Feeling nauseous ++	Plan: NBM post stent, for anti biotics, IVF Temp 39.8 at 13:30
15:05 In Recovery Ward	NEWS		Temp 39.0 Pulse 126 b/p 96/50 Resps 23 SpO2 96% NEWS 7

Date/Time	Source	Time Line	Comments
30 June 2016 16:00	Nursing Notes	c/o pain	NEWS 5 Temp 38.9 b/p 77/50 Pulse 122 Blood cultures sent
17:00 X-ray	Recovery Nursing Notes/Op Notes	Left Nephrostomy insertion by Dr 17.	Nephrostomy insertion: pus++. No immediate complication. Plan: 6 hourly obs, bed rest
17:15 Recovery Ward		Returned to recovery	b/p 74/48 500 mls NaCl given stat, bed tilted Dr 16 contacted- repeat bloods Urostomy drain in situ
17:25			b/p 98/51
21:30		Seen by ICU team	For insertion of central line and norad if required. ICU Drs aware
1 July 2016 01:30		Seen by ICU team. Arterial line inserted. ? insertion of central line	
10:00		Observations stable. Left nephrostomy on free drainage- remains 'mucky' Stoma active. Seen by Dr 18- can go to the ward.	
1 July 2016 19:20 Transferred to 3S	Nursing Notes	Transferred to 3S following day 2 optical urethotomy and laser to encrusted distal end and left uretoscopy, day 1 nephrostomy insertion.	
2 July 2016 until 10 July 2016	Nursing notes		Discharged home after coursed of i/v antibiotics for uro sepsis completed. 12 inpatient days
8 July 2016	Email	From Dr 13 to his secretary	'please place Patient 16 on CURWL for nephrostogram and antegrade lt ureteric stenting. Urgency 2. Date of Entry: 10 July 2016.'

Date/Time	Source	Time Line	Comments
15 July 2016	Email	From booking centre to Dr 13's secretary Copied to: Service Administrator for Urology, Urology HOS and Dr 13	'Dr 15 has triaged the attached referral (? Letter from Dr 9 to Dr 11) to see Patient 16 urgently with no delay. I was about to select but noticed patient had been under the care of Dr 13. Can you send me some info to why they attended Dr 13, I see nothing on patient centre'
15 July 2016	Email	From Urology HOS to booking centre	'This patient was in under Dr 13's care and had his procedure done on 29 June 2016'
15 July 2016	email	Email from booking centre to Urology HOS	'I will discharge the OP REG from Dr 9.
23 July 2016	Letter	Letter from Dr 10 to Dr 3. Copies to Drs 9& 13	We discussed the possibility of palliative pelvic radiotherapy but this cannot interfere any treatment plans by Dr 13. I have spoken to Dr 13 who is in consultation with Dr 17 with regard insertion of another stent. Dr 13 suggested holding off on radiotherapy. Review September.
10 August 2016	Clinical admission and Op Notes	Admission for uteroscopy +/- stenting under Dr 13	Left ureteroscopy and ureteric stenting. The middle third of left ureter was occluded by extrinsic compression and possible infiltration by metastatic disease. Nephrostomy clamped, stent in place
10 August 2016 21:25 hrs	Email	From Dr 13 to his secretary	'Place this man on CURWL fo replacement of left ureteric stent- Feb 2017. Urgency 2. Date of entry 11 August 2016.'
12 August 2016	Clinical Notes		Seen by Dr 11, arrange as day patient to come back to exchange nephrostomy tube in 2 weeks. Dr 13 to change stents in 6/12.
22 August 2016	PAS	WLA by Dr 11 for change of nephrostomy tube	Patient 16 remains under Dr 13, but WLA done by Dr 11
1 September 2016	PAS/clinical notes	Day case to change nephrostomy	Procedure done by Dr 11

Date/Time	Source	Time Line	Comments
6 September 2016	Radiology Report	Hardcopy of radiology report in patient notes	Dr 11's handwriting 'pt of Dr 13' Dr 11's signature and 'chart please'
15 September 2016	NIECR		CEA 70ng/ml
13 October 2016	CT		Features of disease progression and development of liver metastasis. MDT advised
30 November 2016	emails	Dr 13's secretary to Dr 13.	Patient 16 was ringing this am regarding his change of left nephrostomy drain. He had it changed in September and was due to have it changed again in 12 weeks however he is not on the waiting list for this. Can you please advise. He had already rang Dr 17's secretary.'
1 December 2016 10:18	Emails	From Dr 13's secretary to Dr 13.	Patient 16 daughter was ringing to advise the the DN attending Patient 16 has said the nephrostomy tube has moved ¾ on an inch and this is why Patient 16 is in so much pain. He is currently be treated for an UTI.
23:55 hrs	email	Email from Dr 13 to his secretary. Copied to Dr 17	Dr 17 has agreed to replace Patient 16 nephrostomy drain on Tuesday 6 December 2016. I also hope to arranged for him to have his stent removed in the pm. Could you advise me who the Consultant Urologist of the week will be next Tuesday, and who the Registrar on call will on the afternoon will be. I will ask the appropriate persons to remove the stent. Please send out formal notification to Patient 16 …Lastly Patient 16 will then need to be added again on CURWL for March 2017

Date/Time	Source	Timeline	Comments
2 December 2016	Letter	Letter from Dr 2 to Dr 3. Copies to Dr 9 and Dr 13	Clearly unhappy with management with issues primarily related to urology but also a lack of liaison between Oncology and Urology has left an opportunity for pelvic radiotherapy being missed. Uro sepsis in the last week. Contacted Dr 13's secretary- arrangement made for 6 December 2016 for nephrostomy replacement and stent removal.
6 December 2016	Discharge letter	Letter from Dr 11 to Dr 3. Copy to Dr 13.	Exchange of left nephrostomy tube and removal of stent done by Dr 11. Arrangements will be made for nephrostomy tube to be changed in 3/12.
9 December 2016	Surgical Admission proforma	Admitted with bowel obstruction	
10 December 2016	CT Report		Distal small bowel obstruction, multiple hepatic metastasis
Personal information redacted by USI		Patient passed away peacefully after provision of comfort measures	

Personal Information redacted by the USI

05/12/16

REF: Patient 16

Personal Information redacted by the USI

H&C: Patient 16

To whom it may concern,

I am making this complaint, on behalf of my father, after much consideration and having discussed our concerns with involved personnel. It centres on the poor response to communication between the Oncology and Urology departments in Craigavon Hospital and the consequences of this which include; unnecessary suffering and denied access to a treatment option for cancer.

My father was diagnosed with bowel cancer in July 2012. He was referred to Oncology and in 2014 Chemotherapy was identified as a treatment option. Prior to the commencement of this treatment a stent was inserted into the left kidney in March 2015. We were informed at this point in time that the stent would be due for removal directly after the treatment ended as it's life span was 6 -9 months. Chemotherapy finished in November 2015 and my father was advised that arrangements would be made with Urology to have the stent removed. However, this did not happen and during follow-up reviews with the oncologists and surgical consultants the need for it to be removed was acknowledged and assurances given that letters would be written to various personnel in the Urology department. Meanwhile, for the next 6 months, my father suffered from a range of complications synonymous with a stent in place too long including; significant pain and persistent urinary tract infections. We continued to advise oncology personnel, our GP and the local Macmillian nurse of the increasing difficulties he was experiencing and again we were assured that these concerns had been passed on to Urology. In increasing desperation we began to ring Mr O'Brien's secretary in an effort to have the procedure completed.

In April 2016 during a review appointment in oncology the option of a short course of radiotherapy was raised. My father agreed to proceed with this but was made aware that first the stent would

need to be removed. In June 2016 dad received a phone call from the oncologist stating that he had viewed the latest scan results and radiotherapy was definitely a way forward. On the same day dad received a phone call from the urologist informing him of the arrangements for the removal of the stent three days later. We were bewildered about the apparent urgency, after such a long wait and wondered had something shown up on the scan. Dad attended Craigavon on the 28th June 2016 for the procedure; at this point the stent was in place for 15 months.

The procedure, which we understand generally takes about 30 minutes, took over two hours. The kidney was significant distended and the stent was encrusted and dislocated. Indeed I am aware that research suggests that the amount of stent encrustment is directly related to how long it has been in place. The aftermath was horrendous. Dad was very ill due to septicaemia and had to remain in hospital for 12 days. We were extremely upset and discussed our concerns with personnel in urology. We decided not to proceed with a formal complaint at the time, as we hoped that communication between the two departments would improve. Three weeks later there was further telephone correspondence from another oncologist advising dad that he was about to a make arrangements for him to attend the radiology department in the City Hospital to have initial measurements taken. It seems that this course of action was to be delayed for a short period, following consultation between the urologist and the oncologist, as a new stent would first have to be inserted. This happened in August 2016 and we immediately advised oncology that the stent was in place and we were on course again for radiotherapy. The next meeting with oncology was in September 2016. Dad was advised that it was deemed appropriate for a further scan to take place and he agreed to the deferral of the treatment until this was secured. It was with utter dismay at the next meeting on 1st December (13 weeks later) we learnt that this course of treatment was no longer an option as the disease had progressed. At that meeting I asked why the radiotherapy did not take place as planned in June, when the scan at that time indicated that it was feasible. I do not believe that I was given any clarification on this issue. In addition, when the oncologist was asked about the time delay between the scan and the review appointment he apologised but said it was 'out of his control'.

In summary, I believe that the delay in the removal of the original ureteral stent is undeniably linked to the removal of cancer treatment options for my father. I know that he has suffered unnecessarily as a result of the lack of response to communication from various sources to urology. Finally as a family we had the unenviable experience of dealing with a mother and father diagnosed and undergoing treatment for cancer at the same time. Ironically the experience of both parents is startlingly different. My mother suffered from mouth cancer and was under the care of the South Eastern Trust. There were a number of departments involved in her surgery and aftercare, both within the trust and outside it. The co-ordination of services was seamless and communication between departments immediate and transparent. She receives regular follow up review appointments where both oncology and her surgical consultant are present and she has access to a superb advocacy service provided by the Head and Neck nurse.

The expected outcomes of this complaint are as follows;

a) Details of all correspondence to the Urology department from all sources regarding the removal of the stent.
b) A review of protocols for communication between two departments in the same hospital. It seems incredulous, that there is a reliance on the social etiquette of writing to a colleague in the same hospital rather than emailing or using another system on the intranet.
c) Provision of a clear explanation for the delay in carrying out the procedure of removing the ureteral stent, clarification on the Urology department's policy for the time frame of insertion and removal of kidney stents, the name of the manufacture of the stent and their guidelines regarding the length of time the stent can safely remain in place.
d) Consideration of the cost to the National Health Service of dealing with the aftermath of not completing a procedure within a reasonable time frame.
e) An examination of the review arrangements for patients with cancer which is deemed to be progressive. Cancer does not wait for scans or lengthy periods between appointments!
f) A direct explanation as to why radiotherapy did not proceed as planned in June 2016.
g) Reflection on examples of good practice in other trusts.
h) Consideration given to setting up an advocacy service for patients who are undergoing treatment for cancer. Within the Southern trust this is ad hoc and seems to be left to the local Macmillan nurses, who cannot cope with the demands placed on their service.

In essence, we are a family who are dismayed and disillusioned! We are requesting answers to questions posed, seeking recognition of the unnecessary suffering endured by my father due to neglect and the subsequent lack of ability to access an appropriate cancer treatment; which may have increased his life span a little and given us more time to spend with a wonderful man!

Yours faithfully,

Southern Health and Social Care Trust

Quality Care - for you, with you

NEXT OF KIN CONSENT FORM

Full name of patient/client: Patient 16 [redacted]

Address: Personal Information redacted by the USI [redacted]

Date of birth:

Connection to person making the complaint: FATHER

I hereby authorise:

Name of person making the complaint: Patient 16's Daughter [redacted]

Address of person : (if different from above) Personal Information redacted by the USI [redacted]

to act on my behalf and to receive any and all such information as may be relevant to the complaint.

I understand that any information given is limited to that which is relevant to the investigation of the complaint and only disclosed to those people who have a need to know it in order to investigate the complaint.

Signature of next of kin: Patient 16 [redacted]

Date: 11.12.16

13 February 2017 **Our Ref:** AS312.16/17

Private & Confidential

Patient 16's Daughter
Personal Information redacted by the USI

Dear Patient 16's Daughter

I refer to your complaint in respect of the provision of treatment and care to your late father, Patient 16. Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them.

At the outset I would like to send my sympathies on the death of your father.

I am advised by the Head of Cancer and Clinical Services that your father was first referred to our clinic in 2012, after he had undergone surgery for a pT4bN1M0 colonic adenocarcinoma. Following discussion, he opted not to proceed with chemotherapy, with concerns regarding potential urinary sepsis considered as a significant factor in the decision.

In 2014 your father was referred back after undergoing resection of recurrent intra-abdominal disease. After further discussion it was agreed that rather than proceeding with palliative chemotherapy, he would be kept under surgical review and treatment considered in the event of progressive disease.

In 2015, a scan detected a left sided pelvic mass, causing hydronephrosis and a new lung nodule. Your father was referred back to oncology and it was decided to proceed with palliative Oxaliplatin Capecitabine chemotherapy. After a ureteric stent was inserted on 31 March 2015, treatment began on 23 April 2015. While there was an improvement in the CEA tumour marker, treatment was complicated by urinary sepsis and an episode of extravasation. It was decided to proceed with Capecitabine only for the final two cycles, and chemotherapy was completed in October 2015.

At the next scheduled review appointment in November 2015, your father reported feeling well after completing chemotherapy and a letter was sent to Mr O'Brien, regarding stent change. Further letters were sent to Urology regarding this in January 2016, April 2016 and June 2016.

During this time, your father continued to be reviewed regularly at the Oncology clinic. Options for progressive symptomatic disease were discussed at each of those appointments, which included second line palliative chemotherapy, or palliative pelvic radiotherapy. The timing and choice of modality would depend on a number of factors,

including radiological and biochemical indications of progression, performance status, symptomatology, relative risk of urosepsis and patient preference.

In June 2016 the Urologists admitted your father to change his ureteric stent, but despite removing the original stent, a replacement could not be inserted and a left sided nephrostomy was created.

At his next Oncology review appointment on 22nd July 2016, therapeutic options were again discussed, with palliative pelvic radiotherapy being the preferred treatment choice, dependent on any further planned urology intervention. The following day Dr Park spoke to Mr O'Brien, who requested that radiotherapy be postponed until after a further attempt at ureteric stent insertion, which was scheduled to take place in August.

We were notified by your father that this had taken place and at the subsequent review appointment it was noted that the nephrostomy was still in place. A CT was requested to restage your father's disease and unfortunately this showed progression of both pelvic and pulmonary disease, as well as new hepatic metastatic disease.

Your father was appointed to the next available clinic after the scan result was received and he attended on 1 December 2016. At that appointment it was noted he was suffering from a urinary tract infection and had problems related to his nephrostomy. The following day Dr Harte communicated with Mr O'Brien's secretary by phone and with Mr O'Brien by email, confirming that arrangements were in place for Urology admission on 6 December 2016 for nephrostomy change and stent removal.

Though a review appointment for January 2017 had been planned, notification was received on Personal information redacted by USI that your father had passed away the preceding day. He had been admitted to Daisy Hill Hospital with small bowel obstruction, where he had declined surgical intervention and been managed conservatively.

Response to specific points raised in letter of complaint:

a) *'**Details of all correspondence to the Urology department from all sources regarding the removal of the stent.'***

   All letters to the urologists, a record of a phone call between Dr Park and Mr O'Brien and copies of emails between Dr Harte and Mr O'Brien are available in the oncology chart.

b) ***'A review of protocols for communication between two departments in the same hospital. It seems incredulous, that there is a reliance on the social etiquette of writing to a colleague in the same hospital rather than emailing or using another system on the intranet.'***

   Though attending Craigavon for weekly clinics, as oncologists we are based in the BCH Cancer Centre, and do not have access to Southern trust intranet services. Dictated, typed, verified and recorded letters remain the preferred method of communication between disciplines, though admittedly delays can

occur due to shortages of administrative staff. On occasions where was a clinical imperative for urgent communication, phone calls and emails were made from oncologists to the urology service.

We have recognised that this is far from ideal and a failing of the two Trusts and as a result of your complaint we are currently working on processes to overcome these delays in that we are liaising with our information personnel for both Trusts so that all correspondence will be sent via the Northern Ireland Electronic Care Records system. We would like to apologise however that this delay had occurred for your late father because of processes and to assure you that this is being addressed.

c) ***'Provision of a clear explanation for the delay in carrying out the procedure of removing the ureteral stent, calcification on the Urology department's policy for the time frame of insertion and removal of kidney stents, the name of the manufacture of the stent and their guidelines regarding the length of time the stent can safely remain in place.'***

The name and manufacturer of the stents that the Trust use, are Percutaneous Stents and supplied by Boston Scientific and the recommendation for the timeframe for a stent to be kept in is 6 months. However the Urology Department are experiencing significant pressures and we are not currently able to keep within these timescales, recently I have endeavoured to ensure if patients are being cancelled that we don't cancel these type of patient i.e. removal of stents. So again Mark has said that whilst we endeavour to meet the recommended timescales of 6 months for removal of stent this is not always achievable because of the current pressures experienced by the Urology Department and we apologise to the family for the delay in their late father having his stent removed and the stress and discomfort that this caused him.

d) ***'Consideration of the cost to the National Health Service of dealing with the aftermath of not completing a procedure within a reasonable time frame.'***

Not sure how we respond to this.

e) ***'An examination of the review arrangements for patients with cancer which is deemed to be progressive. Cancer does not wait for scans or lengthy periods between appointments!'***

From the time [redacted] cancer was seen to be clearly progressive in March 2015 until his death in [redacted], [redacted] attended 19 oncology clinics at the Mandeville Unit, including chemotherapy appointments. At each visit appropriate review arrangements were made and on occasion altered on receipt of new clinical information.

f) 'A direct explanation as to why radiotherapy did not proceed as planned in June 2016.'

The option of palliative radiotherapy to [redacted] pelvic disease was first discussed as a potential treatment option at his appointment on 21 January 2016. It was also discussed during a phone call between Dr Cole (SpR) and [redacted] on 24 June 2016 and subsequently at his clinic attendance on 21 July 2016. While at that time it was felt appropriate to consider proceeding with a course of palliative radiotherapy, after discussion with the urologists it was agreed that this should be deferred to allow a further attempt at ureteric stent insertion.

At [redacted] next review post stent insertion, it was decided to restage with a further CT scan, which revealed significant multisite disease progression. With this knowledge and based on [redacted] clinical condition at the time, it was inappropriate to proceed with palliative radiotherapy. With the benefit of hindsight, it is clear that palliative radiotherapy would not have affected the clinical outcome and could have been detrimental.

g) 'Reflection on examples of good practice in other trusts.'

There are obvious limitations when comparing the experience of two different patients, with different clinical situations treated in different departments.

h) 'Consideration given to setting up an advocacy service for patients who are undergoing treatment for cancer. Within the Southern Trust this is ad hoc and seems to be left to the local MacMillan nurses, who cannot cope with the demands placed on their service.'

This case does illustrate instances where involvement of oncological clinical nurse specialists may have had a significant benefit in terms of enhancing communication between departments and improvements in patient advocacy.

I hope that you will find this response has addressed the issues that you raised. However, if you are unhappy with any aspect of this response you should contact a member of our Clinical & Social Care Governance Team on 028 3861 2987 or 028 3861 2030 or email: AcutePatient.ClientLiaison@southerntrust.hscni.net within 3 months of the date on this letter so that we can attempt to resolve any outstanding issues.

Should you remain dissatisfied at the end of the complaints process, you can then refer your complaint to the NI Public Services Ombudsman at the following address, “Freepost NIPSO”, Freephone: 0800 34 34 24 or email nipso@nipso.org.uk within 6 months of the completion of the Trust’s internal complaints process. Further information on the role of the NI Public Services Ombudsman can be found at www.nipso.org.uk. Please note that the Ombudsman will not normally accept your complaint until the complaints process with the Trust has been exhausted.

Yours sincerely

_____

ESTHER GISHKORI (Mrs)
Director of Acute Services

for Mr F Rice, Chief Executive (Interim)

Corrigan, Martina

From: Kingsnorth, Patricia [redacted]
Sent: 20 January 2020 14:00
To: Robinson, Katherine; Corrigan, Martina; Carroll, Ronan; Haynes, Mark
Subject: recommendations urology SAI
Attachments: recommendations Patient 16 SAI for comments.docx; Recommendations from 5 urology cases.docx

Dear all
The Patient 16 case was discussed at acute clinical governance meeting on Friday, the consensus was that the recommendations were not workable. Dr OKane wants us to be specific about why the recommendations are not workable.

This response needs to be provided to Dr OKane by the end of this week.
Please can you provide responses to each question asked?
Much appreciated
Kind regards
Patricia

Patricia Kingsnorth
Acting Clinical Governance and Social Care Coordinator
Governance Office
Ward 2 Ramone
CAH
[redacted]

TRUST

Recommendation 1

The Trust will evaluate methods of communication between clinicians; other than paper. This will be especially for 'visiting' clinical teams not based in the SHSCT and also especially when their clinic letters are not available on NIECR. Katharine is there a process or SOP which we could evaluate?

Recommendation 2

The Trust should develop written policy/guidance for clinicians and administrative staff concerning writing clinic or discharge letters, to ensure all clinical teams/clinicians, directly involved in the patient's care, are copied into the correspondence, especially if they are referred to in the letter. Katherine/ Martina is there written policy or guidance for admin staff or a process for consultants?

Recommendation 3

The Trust will develop written policy/guidance for clinicians and administrative staff on managing clinical correspondence, including email correspondence from other clinicians and healthcare staff. Katherine /Martina is there a policy or guidance or a process for managing clinical correspondence if not how easy is this to action?

This guidance will outline the systems and processes required to ensure that all clinical correspondence is actioned (receipt, acknowledged, reviewed and actioned) in an appropriate and timely manner. Martina is there an action plan consultants could follow?

An escalation process must be developed within this guidance. Martina Is there an escalation protocol ?

Monthly audit reports will be provided to Assistant Directors on compliance with this policy/guidance. Persistent failure to comply by clinical teams or individual Consultants should be incorporated into Annual Consultant Appraisal programmes. Martina/ Mark If we have a process could it be formatted in a report

Recommendation 4

The Trust will develop written policy/guidance for the tracking of clinical correspondence, to include relevant email correspondence. Katherine is there a process for tracking correspondence?

TRUST and HSCB

Recommendation 5

In the same way that the Belfast Trust Cancer service now have their Oncology letters on the NIECR, all other services, including those from other Trusts, should do the same. Katherine is there a process similar to BHSCT?

Recommendation 6

The Trust, with the HSCB, must implement a waiting list management plan to reduce Urology waiting times. This will be monitored monthly.

Mark We do currently have a waiting list but we can reduce waiting times? Does this recommendation need to be reworded.

Recommendations from 5 urology cases.

HSCB

Recommendation 1

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

Recommendation 2

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

Recommendation 3

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

HSCB, Trust and GPs

Recommendation 4

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

TRUST

Recommendation 5

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm. Katherine is this done with the CCG referral letters? If not is there some work being done to implement the recommendation?

Recommendation 6

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW. Mark / Martina can you comment ?

Recommendation 7

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner. Mark/ Martina Do we have an SOP or guidance for clinicians?

Recommendation 8

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list. is this doable?

Recommendation 9

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10. Ronan/ Mark is this workable? How could we implement this ?

Recommendation 10

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence. Is there an escalation to deal with "difficult colleagues"?

CONSULTANT 1

Recommendation 11

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner. Mark can confirm that recommendation 11 and 12 are complete

Recommendation 12

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

Corrigan, Martina

From: Kingsnorth, Patricia [redacted]
Sent: 21 January 2020 10:11
To: Corrigan, Martina
Cc: Haynes, Mark; Carroll, Ronan
Subject: RE: recommendations urology SAI

Martina
Would you have a few minutes to discuss the recommendations below please?
Many thanks
Patricia

Patricia Kingsnorth
Acting Clinical Governance and Social Care Coordinator
Governance Office
Ward 2 Ramone
CAH
[redacted]

From: Haynes, Mark
Sent: 20 January 2020 14:14
To: Kingsnorth, Patricia; Robinson, Katherine; Corrigan, Martina; Carroll, Ronan
Subject: RE: recommendations urology SAI

Responses to the specific bits with my name on…

Recommendation 3
The Trust will develop written policy/guidance for clinicians and administrative staff on managing clinical correspondence, including email correspondence from other clinicians and healthcare staff. Katherine /Martina is there a policy or guidance or a process for managing clinical correspondence if not how easy is this to action?

This guidance will outline the systems and processes required to ensure that all clinical correspondence is actioned (receipt, acknowledged, reviewed and actioned) in an appropriate and timely manner. Martina is there an action plan consultants could follow?

An escalation process must be developed within this guidance. Martina Is there an escalation protocol ?

Monthly audit reports will be provided to Assistant Directors on compliance with this policy/guidance. Persistent failure to comply by clinical teams or individual Consultants should be incorporated into Annual Consultant Appraisal programmes.
Martina/ Mark If we have a process could it be formatted in a report

In the absence of written policy / guidance and escalation protocol, I cannot comment. I would imagine that if such a policy / guidance / escalation protocol existed, the SAI team would not have commented that;
'The Review Team noted that letters to Consultants are not tracked and there is no process in place to ensure they have been reviewed and actioned by Consultants.'
And that;

'The Trust has no formal process for tracking letters or emails and ensuring they have been received, acknowledged, reviewed and actioned.'

Recommendation 6

The Trust, with the HSCB, must implement a waiting list management plan to reduce Urology waiting times. This will be monitored monthly.

Mark We do currently have a waiting list but we can reduce waiting times? Does this recommendation need to be reworded.

Has the trust engaged with HSCB specifically regarding urology waiting times?, and has a waiting list management plan, including potentially identification of IS or alternative providers, funding for provision of additional capacity to address the backlog, and workforce planning to prevent a future backlog been developed in conjunction with HSCB? If the answer is no (and I am unaware of a specific approach to the HSCB regarding this). There is currently no waiting list management plan to reduce urology waiting times that I am aware of. This is outwith the DECC work, PIG, NICAN etc.

Mark

From: Kingsnorth, Patricia
Sent: 20 January 2020 14:00
To: Robinson, Katherine; Corrigan, Martina; Carroll, Ronan; Haynes, Mark
Subject: recommendations urology SAI

Dear all
The Patient 16 case was discussed at acute clinical governance meeting on Friday, the consensus was that the recommendations were not workable. Dr OKane wants us to be specific about why the recommendations are not workable.

This response needs to be provided to Dr OKane by the end of this week.
Please can you provide responses to each question asked?
Much appreciated
Kind regards
Patricia

Patricia Kingsnorth
Acting Clinical Governance and Social Care Coordinator
Governance Office
Ward 2 Ramone
CAH
Personal Information redacted by the USI

Corrigan, Martina

From: Carroll, Ronan [redacted]
Sent: 23 December 2016 13:19
To: Corrigan, Martina; Clayton, Wendy
Subject: FW: CONFIDENTIAL - Confirmation of further oversight meeting re: Dr AOB - 10th January 1pm, Trust HQ
Attachments: Action note - 22nd December - AOB.docx

Importance: High
Sensitivity: Confidential

Sent in the strictest confidence

Martina/Wendy
So we need an AP to address the following

1- Volumes of notes tracked to AOB
2- What has been the outcome for the 318 patients
3- Determination of the volumes of pts where we have no dictation & a plan to correct same
4- Number of complaints with regard to AOB & how this compare to his peers

Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Gibson, Simon
Sent: 23 December 2016 11:27
To: Gishkori, Esther; Toal, Vivienne; Wright, Richard
Cc: Carroll, Ronan; Boyce, Tracey; Clegg, Malcolm; Stinson, Emma M; Mallagh-Cassells, Heather; White, Laura; Montgomery. Ruth
Subject: CONFIDENTIAL - Confirmation of further oversight meeting re: Dr AOB - 10th January 1pm, Trust HQ

Dear Richard, Esther and Viv

I am writing to confirm a follow-up meeting in relation to Dr A O'Brien on

Tuesday 10th January at 1pm – 2pm, Dr Wrights office, Trust HQ

I have included the action note from yesterdays meeting, detailing actions required.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted]
Mobile: [redacted]

DHH: Personal Information redacted by the USI Ext Personal Information redacted by

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 12 January 2017 20:31
To: Haynes, Mark
Subject: Re: Sept 2015 triage

Will do

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

From: Haynes, Mark
Sent: Thursday, 12 January 2017 19:45
To: Corrigan, Martina
Subject: RE: Sept 2015 triage

Finished.

33 done and sorted (just over 1 ½ hours).

1 Patient (HCN [redacted]) needs group discussion. Think is six month delay in diagnosis of cancer. Could you get notes please?

Mark

From: Haynes, Mark
Sent: 12 January 2017 18:11
To: Corrigan, Martina
Subject: Sept 2015 triage

Logging in and starting

Mark

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 20 January 2017 15:52
To: Haynes, Mark
Subject: outcomes from your triage

Hi Mark

As per your triage I have checked the following patients as requested:

1. [redacted] – [redacted] – hasn't been given an appointment – your comment was 'I would arrange XR discussion + likely discharge with no appointment – if hasn't been sent an appt let me know and I will do this'
2. [redacted] – [redacted] – not in PB or an appointment given – your comment – advice request – if not seen or sent PB I can do letter.'
3. [redacted] – [redacted] – hasn't got an appt nor is in PB – your comment – I will do a letter and arrange f/up scan (CT) and let me know
4. [redacted] – [redacted] - no appt or not in PB – I would do advise letter – let me know
5. [redacted] – [redacted] – you were going to organise a CT but he has contacted the booking centre to say condition has cleared and no further appt required
6. [redacted] – [redacted] – is partially booked for a vasectomy appt with Robin
7. [redacted] – [redacted] – your question – is he on paeds wl? Answer was referred to paeds who sent referral to surgical who then sent referral to urology
8. [redacted] – [redacted] – your question – I would respond to this with an advice letter and no appt needed. If she hasn't been offered an appt, I will do letter – answer – she had been added to wl for urodynamics and flexi and attended on 29/4/16. No outcome

Hope this makes sense

And try and have a good weekend….

Good luck on Monday and sure let me know how you get on…….

Martina

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

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

Corrigan, Martina

From: Glackin, Anthony [redacted]
Sent: 23 January 2017 10:32
To: Corrigan, Martina
Subject: Triage

Dear Martina,
I left a bundle of triage and a claim form with Amy this morning.

Kind regards

Tony

Anthony J Glackin MD FRCSI(Urol)
Consultant Urologist
SHSCT

Secretary: Elizabeth Troughton [redacted]

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 25 January 2017 10:41
To: Young, Michael
Subject: RE:

Hi Michael

Comments in red below

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

From: Young, Michael
Sent: 24 January 2017 23:35
To: Corrigan, Martina
Subject:

I put back the triage in the cabinet and took more = told Amie
Did another 50 tonight along with scheduling attempt !!! thanks any more red flags (there have been 9 upgrades so far…..)

Are you / have you gone out to replace Lisa – even if we now got cover for the days Laura not here? You have been sent two CV's from Karen for replacement
Ronan said there a meeting today with AOB as opposed to Friday yes I was contacted late on Monday evening to have update of where we were at – V short notice so started at 5am yesterday and then ended up working through until 4pm so cancelled that days leave – he was not aware of an outcome yes he had texted me for your phone number and then advised that there was no outcome – so if there is no word by Thursday am then I assume March goes ahead without inclusion. No idea as of this time today I have still not heard but I will try and suss out more and let you know
Mark says there is chaos in BT and does not trust the Board. Oh dear suspected that would happen as its PHA leading on this……
Is Assam here in March? Thought he wasn't but he had sent an email earlier in jan to say he was I copied into you and Paulette I will email and see what his dates are

[redacted]

MY

Corrigan, Martina

From: Carroll, Ronan [redacted]
Sent: 27 January 2017 15:55
To: Corrigan, Martina
Subject: RE: upgrade Red Flags

tks

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Corrigan, Martina
Sent: 27 January 2017 15:20
To: Carroll, Ronan
Subject: RE: upgrade Red Flags

I have all the bundles back and I have went through them all so just going to tally to make sure I have 783 returned. So that will be all upgrade RF which is a total of 17 patients

I will let you know the upgrade to urgent shortly.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

From: Carroll, Ronan
Sent: 27 January 2017 15:15
To: Corrigan, Martina
Subject: RE: upgrade Red Flags

How many have been triaged

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Corrigan, Martina
Sent: 27 January 2017 15:13
To: Graham, Vicki; Muldrew, Angela
Cc: Glenny, Sharon; Clayton, Wendy; Carroll, Ronan; Trouton, Heather; Reddick, Fiona
Subject: upgrade Red Flags

Hi Angela/Vicki

Please see attached a further 8 patients that have been upgraded to Red Flag.

Please book one extra on to each of the Consultant New OP Clinics next week and again if you can advise when this is sorted.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 06 February 2017 07:21
To: Graham, Vicki; Muldrew, Angela
Subject: FW: RF appointment needed

Good morning

Can you please overbook a consultant clinic for this patient please

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

From: Haynes, Mark
Sent: 06 February 2017 07:15
To: Corrigan, Martina; Browne, Leanne; rf.appointment
Subject: RF appointment needed

Morning

RE [redacted]

This man was referred with an elevated PSA on 28th July 2016 and the referral brought to my attention mid January 2017 (not triaged). His PSA has been repeated and remains elevated. Could he have a red flag appointment please (RF upgrade, met RF criteria at time of original referral).

Thanks

Mark

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 11 January 2017 08:00
To: Lawson, Pamela
Subject: missing notes for health records
Attachments: missing notes for health records.docx

Importance: High
Sensitivity: Confidential

Good morning Pamela

Can you give me a quick call on my mobile to discuss this please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

Borrower:CU2 MR AOB OBRIEN

[redacted]
Personal Information redacted by the USI

29/08/2006 14:45 UROL CL. 12/9/06
29/08/2007
29/08/2006 14:47

27/03/2012 15:12 CLINIC 03.04.12
27/03/2013
27/03/2012 15:13

30/06/2010 12:11 CLINIC 06/07/2010
30/06/2011
30/06/2010 12:15

07/04/2010 12:19 CLINIC 13/04/10
07/04/2011
07/04/2010 12:20

21/06/2012 16:11 CLINIC
21/06/2013
21/06/2012 16:13

18/01/2012 11:33 clinic 24.01.12
17/01/2013
18/01/2012 11:34

29/04/2010 16:26 CLINIC FOR 04.05.10
29/04/2011
29/04/2010 16:26

09/11/2005 13:02 UROL CL. 22/11/05
09/11/2006
09/11/2005 13:04

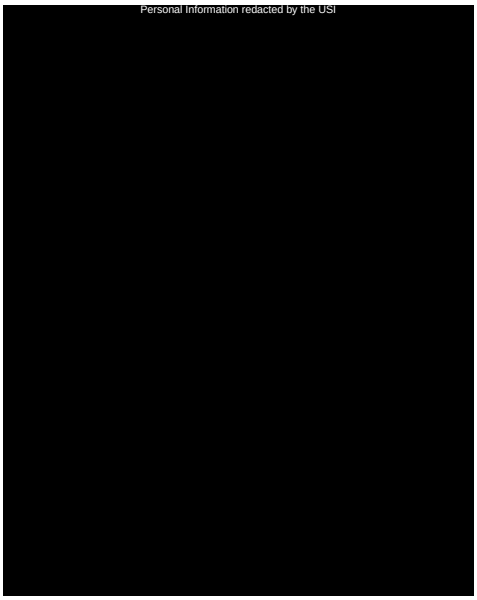
Borrower :CAOBA MR A OBRIEN, AUDIO-TYP, CAH

CN No. / Patient Name	Loc / User ID	Loan Date/Time / Exp Return Date / Trans Date/Time	Reason for Loan/ Comment
Personal Information redacted by the USI		21/08/2014 12:41 21/08/2015 21/08/2014 12:41	SARA TO TYPE STC DISCH 070 SHELF 5 IN CUPBOARD
		03/03/2014 13:41 03/03/2015 03/03/2014 13:41	

Borrower :CAOBO MR A OBRIEN, OFFICE, CAH

CN No. Loc Patient Name	Loan Date/Time Exp Return Date User ID	Reason for Loan/ Comment Trans Date/Time
[redacted]	13/06/2003 12:03	dnas
	12/06/2004	
	13/06/2003 12:09	
	03/05/2011 15:29	PIGEON HOLE 4
	02/05/2012	
	03/05/2011 15:29	
	17/07/2009 16:22	
	17/07/2010	
	17/07/2009 16:25	
	08/08/2007 11:45	
	07/08/2008	
	08/08/2007 11:46	
	16/09/2010 09:28	
	16/09/2011	
	16/09/2010 09:31	
	01/12/2016 09:29	MR O'BRIEN'S ADMIN
	01/12/2017	
	01/12/2016 09:30	
	10/04/2015 15:21	RESULT FOR MR O'BRIEN TO S
	09/04/2016	
	10/04/2015 15:22	
	11/04/2011 10:43	
	10/04/2012	BUNDLE 2
	11/04/2011 10:43	
	16/09/2010 09:27	
	16/09/2011	
	16/09/2010 09:28	
	11/04/2011 12:09	
	10/04/2012	BUNDLE 19
	11/04/2011 12:09	
	02/01/2015 14:35	FOR M+M DISCUSSION
	02/01/2016	
	02/01/2015 14:36	
	23/03/2016 16:16	ON FLOOR BEHIND DESK
	23/03/2017	
	23/03/2016 16:16	

Personal Information redacted by the USI



06/05/2016 13:22 RESULT FOR MR O'BRINE TO S
06/05/2017
06/05/2016 13:22

06/05/2016 13:19 MR O'BRINE'S ADMIN
06/05/2017
06/05/2016 13:19

11/10/2005 14:07 PT TO SEE AOB IN OFFICE
11/10/2006
11/10/2005 14:08

08/11/2016 15:50 PH 6
08/11/2017
08/11/2016 15:51

20/11/2015 12:16 AOB PP IN FILING CABINET
19/11/2016
20/11/2015 12:17

Borrower :CAOBS MR A OBRIEN, SECRETARY, CAH (total = 164)

Below are notes that have been outstanding for a while – need to check does the secretary still have these:

Personal Information redacted by the USI

18/03/2010 16:32 PERUSAL
18/03/2011
18/03/2010 16:33

07/01/2004 14:28 TYPING
06/01/2005
07/01/2004 14:28

10/10/2006 08:19 PT TO SEE AOB IN OFFICE
10/10/2007 IN PP FILING CABINET
10/10/2006 08:20

29/11/2013 16:25 BEHIND MONICA FOR TYPING
29/11/2014
29/11/2013 16:26

30/01/2013 09:20 TYPING SHELF
30/01/2014 PAGES ONLY
30/01/2013 09:21

14/09/2004 20:18 TYPING
14/09/2005
14/09/2004 20:18

13/06/2003 10:27 private patient cabinet
12/06/2004
13/06/2003 10:31

01/09/2014 14:15 TYPING
01/09/2015
01/09/2014 14:15

13/06/2003 10:17 private patient
12/06/2004
13/06/2003 10:20

05/12/2014 13:58 AWAITING RESULTS
05/12/2015
05/12/2014 13:58

Corrigan, Martina

From: Carroll, Ronan [redacted]
Sent: 24 January 2017 14:52
To: Corrigan, Martina
Subject: FW: Strictly Private & Confidential
Attachments: scan0001.pdf

FYI - update

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
[redacted]

From: Weir, Colin
Sent: 24 January 2017 10:25
To: Hynds, Siobhan; Carroll, Ronan; Khan, Ahmed
Subject: FW: Strictly Private & Confidential

Ronan

What do you want to do with this info?

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

Changed my number int [redacted] **direct** [redacted]

Secretary Jennifer [redacted]

From: Aidan O'Brien [redacted]
Sent: 24 January 2017 00:19
To: Weir, Colin
Subject: Re: Strictly Private & Confidential

Dear Colin,

I received your letter enquiring about the notes or charts of 13 patients.
I have attached all that I know, or can be ascertained, about each of them.

The first two on the list attended clinics in the 1990's.
I do not know whether I would have been the doctor who reviewed them.
Their names meant nothing to me, and of course I have not had their charts since then, if at all.

[redacted] I remember intimately.
I returned his chart to Records in September 2005 on the diagnosis of his metastatic caecal carcinoma.

The next eight I found to be remarkable! It would be interesting to find out when they were tracked to me and why?

[redacted] chart did not come to the SWAH clinic with the others on 19 September 2016, as reported.

[redacted] chart was most definitely returned to my office on Tuesday 03 January 2017,

Aidan.

-----Original Message-----
From: Weir, Colin [redacted]
To: Aidan O'Brien [redacted]
Sent: Mon, 23 Jan 2017 11:51
Subject: RE: Strictly Private & Confidential

Dear Aidan

I have been asked to send this to you in advance of tomorrow

Colin

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

Changed my number int [redacted] **direct** [redacted]

Secretary Jennifer [redacted]

From: Aidan O'Brien [redacted]
Sent: 22 January 2017 18:27
To: Weir, Colin
Cc: Hynds, Siobhan
Subject: Fwd: Strictly Private & Confidential

Dear Colin,

Thank you for your letter of 20 January 2017 and sent to me by Mrs. Hynds on your behalf.
I reply to confirm that I will be able to meet with both of you on Tuesday 24 January 2017 at 2.30 pm.
I will be accompanied by my son, [redacted].
As you clarified by telephone on Thursday 19 January 2017, I understand that the purpose of the meeting is to discuss / propose alternatives to exclusion and to be advised of progress of the investigation,

Aidan.

-----Original Message-----
From: Hynds, Siobhan [redacted]
To: aidanpobrien [redacted]
CC: Weir, Colin [redacted]
Sent: Fri, 20 Jan 2017 20:22
Subject: Strictly Private & Confidential

Dear Mr O'Brien

Mr Weir has asked me to send this letter to you on his behalf.

I would be grateful if you could confirm your attendance at the meeting with me as soon as possible.

Kind Regards,

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources Department
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ

Tel: Personal Information redacted by the USI Direct Line: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI Fax: Personal Information redacted by the USI

Click on the above image for SharePoint: Employee Engagement & Relations information

'You can follow us on Facebook and Twitter'

The Information and the Material transmitted is intended only for the person or entity to which it is addressed and may be Confidential/Privileged Information and/or copyright material.
Any review, transmission, dissemination or other use of, or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you receive this in error, please contact the sender and delete the material from any computer.
Southern Health & Social Care Trust archive all Email (sent & received) for the purpose of ensuring compliance with the Trust 'IT Security Policy', Corporate Governance and to facilitate FOI requests.
Southern Health & Social Care Trust IT Department Irrelevant redacted by the USI

Personal Information redacted by the USI Personal Information redacted by the USI

I have no recollection of this man whatsoever. According to PAS, he attended my clinic in Banbridge on 07 September 1995. He was discharged from review at the clinic that day as he was placed on the waiting list for admission. I do not have any means of determining whether I or a Registrar had the consultation with the patient. His chart would have been returned to Records following his clinic attendance in 1995. He was subsequently cancelled from or taken off the waiting list on 06 July 1998. I have not had patient's chart since, or at all, and have no knowledge of its whereabouts.

Personal Information redacted by the USI Personal Information redacted by the USI

This man would appear to have attended the Nurse Led Haematuria Clinic on 06 August 1999. He was then reviewed at and discharged from my review clinic in Craigavon Area Hospital on 09 November 1999. I have no recollection of this patient. I do not know whether the patient was reviewed by me or by another doctor. In any case, I have not had the patient's chart since then, or at all, and have no knowledge of its whereabouts.

Personal Information redacted by the USI Personal Information redacted by the USI

I recall this patient intimately Personal Information redacted by the USI Personal Information redacted by the USI He was Personal information redacted by USI At his request, I performed a radical orchiectomy for testicular tumour in 1996. I reviewed him regularly at my office in the hospital, last doing so in May 2001. He subsequently developed acute bowel obstruction due to a caecal carcinoma for which he had a right hemicolectomy in the Erne Hospital. He died of metastatic disease in Personal Information redacted by the I definitely returned his chart to Records on the diagnosis of his colonic carcinoma.

Personal Information redacted by the USI Personal Information redacted by the USI

There is no record on PAS of this person ever having been my patient, and I have no record of him having attended privately. He last attended Mr. Mulligan's clinic in February 1993.

Personal Information redacted by the USI Personal Information redacted by the USI

There is no record of this man having had any clinical episodes on PAS. He does not even have a H&C number. He has not attended me privately.

Personal Information redacted by the USI Personal Information redacted by the USI

This person has never been my patient, either NHS or privately. Her last clinical episode was in July 1988, under the care of Mr. Wallace, four years before I was appointed to Craigavon Area Hospital!

Personal Information redacted by the USI Personal Information redacted by the USI

This person was born on Personal Information redacted by the USI and discharged from hospital one week later, on Personal Information redacted by the USI. There have been no clinical episodes since then. He does not have a H&C number. He has not been my patient.

Personal Information redacted by the USI Personal Information redacted by the USI

This person has not had any clinical episodes since discharge from hospital, under the care of Mr. Mackle, in November 1992. This person has not been my patient at any time.

Personal Information redacted by the USI Personal Information redacted by the USI

There is no record on PAS of this person having had any clinical episodes. She does not have a H&C number. She has not been my patient at any time.

Personal Information redacted by the USI Personal Information redacted by the USI

This person has not been my patient at any time. I have not had his chart.

Personal Information redacted by the USI Personal Information redacted by the USI

There is no record of this patient having been my patient. She has not attended privately. I have not had her chart.

Personal Information redacted by the USI Personal Information redacted by the USI

I know this patient very well, as she is Personal Information redacted by the USI well known to all doctors. I dictated correspondence regarding Personal Information redacted by the USI in August 2016. It was typed by an audiotypist in 16 August 2016. I presume it was then returned to Records. Her chart was not available when I reviewed her at my clinic at South West Acute Hospital on 19 September 2016. I have not had her chart since August 2016.

Personal Information redacted by the USI

Personal Information redacted by the USI

I have known this patient, known as Personal Information redacted by the USI Personal information redacted by USI for many years. He attended privately on 21 November 2015. His chart was **definitely** returned to my office on Tuesday 03 January 2017. I have kept a meticulous record of all the charts of private patients that were returned. I have retained duplicate clinical records for all these private patients.

Corrigan, Martina

From: Carroll, Ronan [redacted]
Sent: 23 December 2016 10:26
To: Corrigan, Martina
Subject: FW: Backlog report - no clinic outcomes
Attachments: Backlog Report - no clinic outcomes as per 15.12.16.xlsx

Importance: High

Martina
FYI -
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Carroll, Anita
Sent: 22 December 2016 13:59
To: Carroll, Ronan
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Maybe we can get a chat about this

From: Robinson, Katherine
Sent: 20 December 2016 17:07
To: Carroll, Anita
Subject: FW: Backlog report - no clinic outcomes
Importance: High

See attached list. This is a list of clinics that Mr O,Brien has not dictated on and hence no outcome for some of these patients. There is a risk that something could be missed so I am escalating to you, although I know that a lot of the time Mr O'Brien knows himself what is to happen with patients. Unfortunately this was not highlighted on the backlog report. The secretary assumed we knew because there have always been issues with this particular consultant's admin work from our perspective.

As learning from this discovery I have asked all secretaries to provide this information on the backlog report so that we fully understand the whole picture of what is outstanding in each specialty. The secretary also advises that at present Mr O'Brien is working on some of his backlogged admin work as he is off [redacted].

Regards

K

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

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Cunningham, Andrea
Sent: 19 December 2016 13:09
To: Robinson, Katherine
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Update as discussed.

Regards
Andrea

Andrea Cunningham
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by the USI
T: Personal Information redacted by the USI

From: Elliott, Noleen
Sent: 15 December 2016 14:04
To: Cunningham, Andrea
Subject: Backlog report - no clinic outcomes

Andrea,

Please find attached list of clinics with no outcomes completed as per 15th December 2016.

Noleen

Mrs Noleen Elliott
Mr O'Brien's Secretary
Level 2
CRAIGAVON AREA HOSPITAL
Tel No: Personal Information redacted by the USI

DATE	CLINIC	CLINIC CODE
24/11/2014	SWAH	EUROAOB
22/12/2014	SWAH	EUROAOB
12/01/2015	SWAH	EUROAOB
23/02/2015	SWAH	EUROAOB
09/03/2015	SWAH	EUROAOB
13/04/2015	SWAH	EUROAOB
11/05/2015	SWAH	EUROAOB
22/06/2015	SWAH	EUROAOB
06/07/2015	SWAH	EUROAOB
28/09/2015	SWAH	EUROAOB
19/10/2015	SWAH	EUROAOB
02/11/2015	ARMAGH CLINIC	AAOBU1
06/11/2015	URODYNAMICS CLINIC	CAOBUDS
24/11/2015	NEW CLINIC	CAOBTDU
30/11/2015	SWAH	EUROAOB
04/12/2015	URODYNAMICS CLINIC	CAOBUDS
07/12/2015	ARMAGH CLINIC	AAOBU1
22/12/2015	NEW CLINIC	CAOBTDU
08/01/2016	UROONCOLOGY CLINIC	CAOBUO
11/01/2016	SWAH	EUROAOB
15/01/2016	UROONCOLOGY CLINIC	CAOBUO
08/02/2016	SWAH	EUROAOB
07/03/2016	SWAH	EUROAOB
21/03/2016	ARMAGH CLINIC	AAOBU1
01/04/2016	UROONCOLOGY CLINIC	CAOBUO
04/04/2016	REVIEW CLINIC - CAH	CAOBTDUR
08/04/2016	UROONCOLOGY CLINIC	CAOBUO
15/04/2016	UROONCOLOGY CLINIC	CAOBUO
18/04/2016	ARMAGH CLINIC	AAOBU1
19/04/2016	NEW CLINIC	CAOBTDU
22/04/2016	UROONCOLOGY CLINIC	CAOBUO
22/04/2016	URODYNAMICS CLINIC	CAOBUDS
29/04/2016	UROONCOLOGY CLINIC	CAOBUO
29/04/2016	URODYNAMICS CLINIC	CAOBUDS
03/05/2016	REVIEW CLINIC - CAH	CAOBTDUR
06/05/2016	URODYNAMICS CLINIC	CAOBUDS
23/05/2016	REVIEW CLINIC - CAH	CAOBTDUR
27/05/2016	UROONCOLOGY CLINIC	CAOBUO
27/05/2016	URODYNAMICS CLINIC	CAOBUDS
03/06/2016	URODYNAMICS CLINIC	CAOBUDS
10/06/2016	UROONCOLOGY CLINIC	CAOBUO
13/06/2016	ARMAGH CLINIC	AAOBU1
20/06/2016	SWAH	EUROAOB
04/07/2016	REVIEW CLINIC - CAH	CAOBTDUR
22/07/2016	UROONCOLOGY CLINIC	CAOBUO
26/07/2016	NEW CLINIC	CAOBTDU
09/08/2016	NEW CLINIC	CAOBTDU
12/08/2016	UROONCOLOGY CLINIC	CAOBUO
19/08/2016	UROONCOLOGY CLINIC	CAOBUO

19/08/2016	URODYNAMICS CLINIC	CAOBUDS
22/08/2016	SWAH	EUROAOB
19/09/2016	SWAH	EUROAOB
07/10/2016	URODYNAMICS CLINIC	CAOBUDS
11/10/2016	NEW CLINIC	CAOBTDU
14/10/2016	URODYNAMICS CLINIC	CABOUDS
14/10/2016	UROONCOLOGY CLINIC	CAOBUO
21/10/2016	URODYNAMICS CLINIC	CAOBUDS
28/10/2016	URODYNAMICS CLINIC	CAOBUDS
28/10/2016	UROONCOLOGY CLINIC	CAOBUO
04/11/2016	URODYNAMICS CLINIC	CAOBUDS
04/11/2016	UROONCOLOGY CLINIC	CAOBUO

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 13 January 2017 14:45
To: Young, Michael; ODonoghue, JohnP; Haynes, Mark; Glackin, Anthony
Subject: FW: Patients for review at SWAH
Attachments: Patients for Early Review at SWAH.docx

Good afternoon

For advice please and I would be happy that if needed an early appointment we can offer them appointments in CAH.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

From: Aidan O'Brien [redacted]
Sent: 10 January 2017 09:28
To: Corrigan, Martina
Subject: Patients for review at SWAH

Martina,

I had mentioned yesterday that, during the course of returning charts, I had identified six patients who required early review at SWAH.
I have attached the list.

Thank you for everything,

Aidan.

-----Original Message-----
From: Corrigan, Martina [redacted]
To: (Aidanpobrien@[redacted]
Sent: Fri, 6 Jan 2017 18:03
Subject: Outcome sheets and referral letters

Dear Aidan,

You had indicated earlier this week that you had an outcome sheet for each of the patients from the undictated clinics.

I would be grateful if you could arrange for these to be left for me so that I can organise that these outcomes are dealt with appropriately.

Also if you have any referral letters still with you could these also be returned to me please as there are a number that we do not have copies of as they didn't come through the electronic system.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

Patients for Early Review at SWAH

- Personal Information redacted by the USI Personal Information redacted by the USI

  Personal Information year old man with T2, Gleason 9, prostatic carcinoma.
  On Bicalutamide 150 mg daily.
  PSA undetectable in December 2016.

- Patient 98 Patient 98

  Personal Information year old man who had a TURP in June 2015.
  Found to have Gleason 6 carcinoma involving 3% of resected tissue.
  No features of carcinoma in residual prostatic tissue on MRI in Sept ’15.
  For active surveillance.

- Personal Information redacted by the USI Personal Information redacted by the USI

  Personal Information year old man with metastatic prostatic carcinoma diagnosed Dec ’15.
  Diagnostic PSA > 330
  On LHRH agonist.
  PSA 19 April 2016

- Patient 145 Patient 145

  Personal Information year old man with T2 prostatic carcinoma.
  On neoadjuvant Bicalutamide 150 mg.
  PSA 1.7 December 2016.
  For review prior to referral for EBRT

- Personal Information redacted by the USI Personal Information redacted by the USI

  Personal Information year old man with left renal tumour under surveillance.
  Tumour has increased in size to 4 cms in December 2016.

- Personal Information redacted by the USI Personal Information redacted by the USI

  Personal Information year old lady with a Bosniak 4 renal lesion which increased in size on CT scan in December 2016

Corrigan, Martina

From: Clayton, Wendy [redacted]
Sent: 23 December 2016 13:58
To: Department, information
Cc: Carroll, Ronan; Corrigan, Martina
Subject: AOB Turp operations in 2016
Attachments: AOB Turp operations in 2016.doc

Regards

Wendy Clayton
Operational Support Lead
ATICS/SEC
Tel: [redacted]
Mob: [redacted]

Southern Health and Social Care Trust

Information Request Form

- Please Refer to 'Information Analysis – Process for making requests (April 2010)' for guidance.
- All fields are mandatory and MUST be completed.
- Please save your completed form to your PC before emailing to the Information Department.
- If you need help when completing this form, please click on the desired field and press F1. A pop-up dialogue box will appear on screen.

Request Date: 23/12/2016

Name of Requestor:	**Job Title:**
Wendy Clayton	Operational Support Lead
Directorate:	**Division:**
Acute Services	Surgery and Elective Care
	Other (please specify):
E-mail:	**Contact Number:**
Personal Information redacted by the USI	Personal Information redacted by the USI

Background to the information requested (what is the issue in question?):

Request for number of TURP operations under Mr O'Brien in 2016

Use of Information:

☐ Freedom of Information Request	☐ Service Reform	☐ Consultant Appraisal	☐ Audit/Research
☐ Demand and Capacity Analysis	☐ New Service Development / Business Case		
☐ Performance Monitoring	☒ Other (please state)		

Request Details:

Request for number of TURP operations under Mr O'Brien in 2016
Date of admission, consultant AOB, date added to WL, adm date, discharge date

Site/Locality:	☐ SHSCT Wide									
	or Specific Site/s (please choose below)									
	☒ CAH	☐ STH	☐ LGH	☐ DHH	☐ ACH	☐ SLH	☐ LSH	☐ MUL	☐ BBH	☐ CPU	☐ MHK
	or Specific Location/s (please choose below)									
	☐ Armagh & Dungannon			☐ Craigavon & Banbridge			☐ Newry & Mourne			

Time Period (please specify):	2016 year		
Date Information is needed for:	01/01/2017		
Is this request related to any previous information provided by the Information Department?		☐ Y	☒ N
If Yes, please provide details and reference number (if known)			

Have you saved this form as a MS word document to your PC?
Then, please forward this form to: **information.department@southerntrust.hscni.net**

Corrigan, Martina

From: Clayton, Wendy [redacted]
Sent: 05 January 2017 15:53
To: Corrigan, Martina; Carroll, Ronan
Subject: TURP audit
Attachments: file.pdf; file.pdf

Ronan/Martina

I have gone through the 59 pts who had TURP under AOB in 2016. 7 pts were seen by AOB privately. I have attached PP letters.

Let me know if you need any further information.

Regards

Wendy Clayton
Operational Support Lead
ATICS/SEC
Tel: [redacted]
Mob: [redacted]

-----Original Message-----
From: wendy.clayton@[redacted]
Sent: 05 January 2017 15:50
To: Clayton, Wendy
Subject: Scan from YSoft SafeQ

Scan for the user Wendy Clayton (wendy.clayton) from the device CAH - Admin Floor - c454e

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by the USI

Tel: Personal Information redacted by the USI

17th August 2015

Personal information redacted by USI

Personal Information redacted by the USI

Dear Personal Information redacted by the

Personal Information redacted by the USI

DOB Personal Information redacted by the USI
UN

Further to my letter of 30th September 2014, I write to advise you that Personal Informatio did have ultrasound scanning of his urinary tract performed in November 2014 when he was reported to have bilateral renal cysts. His prostate gland was reported to be mildly enlarged with a volume of 40mls and bladder voiding was found to be entirely satisfactory with a residual volume of 15mls only. Even though his prostate gland was found to be mildly enlarged, it was seen to protrude into the lumen of his urinary bladder, an appearance associated with an increased probability that the prostate gland is causative of bladder outlet obstruction.

At further review in December 2014, Personal Information reported to me that he had not been taking the Nitrofurantoin for some time, and as a consequence of which he had had a coliform urinary infection earlier that month, and for which he had been prescribed Trimethoprim, though he had not begun to take it at the time of review on 13th December 2014. His lower urinary tract symptoms remained unchanged. I was pleased to find that his serum total PSA level remained normal at 1.55 ng/ml.

I advised him to take the Trimethoprim that he had been prescribed in a therapeutic dose of 200mgs twice daily for a period of one week. I then advised him to remain on Trimethoprim 200mgs daily thereafter for a period of 3 months. I advised him to remain on Finasteride as previously.

At further review on 7th March 2015, Personal Informatio reported having urgency of micturition, occasional urge incontinence, a urinary flow that was slow to finish and mild nocturia, having to rise once or twice each night to pass urine. He also reported to me that he had been having headache each day, and which he felt may be attributable to the Trimethoprim upon which he remained at that time.

Whilst there was no evidence of urinary infection on urinary culture repeated in February 2015, I was concerned to note that he had quite significant haematuria on urinary microscopy in addition to minimal pyuria. I therefore arranged for Personal Informatio to have CT urography performed on 19th March 2015 when he was reported to have a tiny right renal calculus. Apart from the additional presence of bilateral simple renal cysts as reported on ultrasound scanning, his urinary tract was otherwise normal. He was coincidentally reported to have several, small lesions of low density within his

liver, considered probably to be simple cysts. He was lastly reported to have para-oesophageal herniation of fat into his mediastinum.

In view of the possible association between Trimethoprim and headache, I advised Personal Information then to discontinue taking Trimethoprim and to resume taking Nitrofurantoin 50mgs daily indefinitely. When I spoke with him recently by telephone, I was pleased to hear him report that he remained well since with no suspicion or evidence of recurrence of infection and with urinary symptoms that had not deteriorated. In any case, I have arranged for Personal Information to attend the Day Surgical Unit at Craigavon Area Hospital on Tuesday 8th September 2015 for flexible cystoscopy in order to complete assessment of his urinary tract. I will advise you of the findings in due course.

Yours sincerely

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 17th August 2015
Date typed: 17th August 2015/LH

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by the USI Tel: Personal Information redacted by the USI

27th May 2016

Personal information redacted by USI
Personal Information redacted by the USI

Dear Personal information redacted by USI

Patient 29
Personal Information redacted by the USI
DOB Personal Information redacted by the USI
UN

My colleague, Mr O'Donoghue, wrote to you in April 2015 following this gentleman having had intramural injection of Botulinum Toxin and bladder neck incision performed in February 2015. Personal Information redacted by the came to see me as an outpatient on 30th April 2016 to report that his former, severe, lower urinary tract symptoms have remained entirely unchanged. On reviewing the urodynamic studies that Personal Information redacted by the had performed in January 2015, there was no doubt whatsoever that he had severe detrusor muscular overactivity and severe bladder outlet obstruction. In order to re-evaluate his lower urinary tract dysfunction, I have arranged for him to attend our Department on Friday 27th May 2016 for flexible cystoscopy followed by urodynamic studies. In the interim, I did feel that he may have a degree of nocturnal polyuria, for which reason I prescribed Furosemide 20mgs to be taken each morning, in the hope of promoting a diurnal diuresis and minimising his nocturnal polyuria.

As reported by Mr O'Donoghue previously, Personal Information redacted by the also reported loss of libido, erectile dysfunction and erectile deformity. I took the opportunity of checking his serum testosterone level finding it to be normal at 11.4 nmol/l. I prescribed Tadalafil 5mgs to be taken once daily whilst awaiting further assessment.

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 27th May 2016
Date typed: 27th May 2016/LH

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by the USI

Tel: Personal Information redacted by the USI

26th April 2016

Personal Information redacted by USI

Personal Information redacted by the USI

Dear Personal Information redacted by USI

Patient 115

Personal Information redacted by the USI

DOB Personal Information redacted by the USI

UN

I write to you regarding this Persona l Informati year old lady who came to see me as an outpatient on 19th March 2016 following the recent onset of visible haematuria. The only other urinary symptom which she reported was that of nocturia, having to rise once each night to pass urine. I noted that she had had a total abdominal hysterectomy and bilateral salpingo-oopherectomy performed some 30 years ago and I also noted that there was a possibility of her having had a bladder prolapse in the past.

I noted that she has had chronic renal functional impairment for some time, her mean glomerular infiltration rate being 51mls/min during 2014. However, more recently, her glomerular infiltration rate has been found to have decreased to 43mls/min. There had been no evidence of infection on urinary culture during recent months, though she was found to have significant pyuria, haematuria and bacteriuria on urinary microscopy.

In any case, I arranged for Personal Information redacted by the to have a CT urogram performed on 20th April 2016 when she was found to have an enhancing, soft tissue mass with all of the characteristic appearances of a bladder tumour, arising from the right posterolateral wall of her bladder, obstructing the right ureteric orifice, resulting in marked dilatation of her right upper urinary tract. Undoubtedly obstruction of her right upper urinary tract has contributed to the recent decline in her biochemical renal function.

Importantly, Personal Information redacted by the was also reported to have a 6mm stone in her left kidney. On reviewing the digitalised images, this opacification is indeed either a left renal stone or an area of cortical calcification, particularly as it is closely related to a focal area of cortical scarring. However, if it were a stone, and if Personal Information redacted by the did have the misfortune of having that stone migrate into her left ureter, she could suffer catastrophic, anuric renal failure.

The only other lesions or pathology noted on her recent CT scan were those of simple, bilateral renal cysts, gallstones, colonic diverticulosis and degenerative changes affecting her thoracolumbar spine.

I have advised Personal Information redacted by the of the findings of CT scanning and I have arranged for her to be admitted to our Department on Wednesday 4th May 2016 for resection of the bladder tumour and possibly right ureteric stenting. I have also arranged for her to attend for pre-operative assessment prior to her admission. You will be advised of the findings and of our plans for her further management in due course.

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 26th April 2016
Date typed: 26th April 2016/LH

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by the USI Tel: Personal Information redacted by the USI

24th March 2015

Personal Information redacted by USI
Personal Information redacted by the USI

Dear Personal Information redacted by USI

Personal Information redacted by the USI

DOB Personal Information redacted by the USI
UN

I write to you regarding this Personal Information year old gentleman who suffers from Parkinson's disease, and who has been troubled by significant, storage, urinary symptoms for some time. When I met him as an outpatient on 28th February 2015, he reported having a sensation of unsatisfactory voiding following micturition and nocturia, having to rise 2 or 3 times each night to pass urine. However, he was probably more troubled by diurnal urgency of micturition and urge incontinence in addition to the accompanying increased diurnal frequency. These symptoms persisted even though he was taking Oxybutynin 10mgs daily.

I note that he has normal biochemical renal function and I found him to have a very normal, serum total PSA level of 0.75 ng/ml. There has been no history or evidence of any urinary tract infection even though he was found to have inadequate bladder voiding when he had ultrasound scanning of his urinary tract performed in November 2014 when he was found to have a post micturitional, residual urine volume of 223mls. His prostate gland was minimally enlarged with a volume of 27mls.

It may very well be that Personal Information redacted by the has some degree of detrusor hypocontractility resulting in inadequate bladder voiding. However, even though he has a minimally enlarged prostate gland, he may in addition have a degree of bladder outlet obstruction, In order to further clarify the nature of his urinary tract dysfunction, I have arranged for him to return to our department on Friday 27th March 2015 for flexible cystoscopy and urodynamic studies. In the interim, I prescribed for him Tamsulosin, 400mcgs to be taken once daily.

Yours sincerely

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

CC *Dr Raeburn Forbes, Consultant Neurologist, CAH*

Date dictated: 24th March 2015
Date typed: 24th March 2015/LH

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by the USI

Tel: Personal Information redacted by the USI

25th August 2015

Personal information redacted by USI

SI

Dear Personal Information redacted by the USI

Personal Information redacted by the USI

DOB Personal Information redacted by the USI

UN

I write to you regarding this Personal Information year old gentleman whom you referred in June 2015 for assessment of severe lower urinary tract symptoms. When I met him as an outpatient on 15th August 2015, he reported having severe hesitancy of micturition, and a very poor urinary flow. As you indicated in your letter of referral, it can take him typically 7 or 8 minutes to pass urine. On completion of micturition, he does not have a sensation of having emptied his bladder satisfactorily. Micturition is typically followed by some degree of post micturitional incontinence. His lower urinary tract symptoms are predominantly voiding in nature. The only storage symptom was that of nocturia, having to rise once or twice each night to pass urine. His symptoms have become so severe as to be tantamount to being entirely unable to pass urine. He reported that he had derived no benefit some being prescribed Tamsulosin in April 2015, nor with the addition of Dutasteride in the form of Combodart more recently in July 2015.

On clinical examination, I found him to have normal genitalia and to have a modestly enlarged prostate gland on rectal examination. Urinary microscopy and culture were both normal. I note that his biochemical renal function has been normal and has a serum total PSA level of 1.72 ng/ml.

I have requested ultrasound scanning of his urinary tract, which hopefully will have been performed prior to his attendance on Monday 7th September 2015 for flexible cystoscopy and urodynamic studies.

Yours sincerely

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 25th August 2015
Date typed: 25th August 2015/LH

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by the USI

Tel: Personal Information redacted by the USI

30th December 2014

Personal information redacted by USI

Personal Information redacted by the USI

Personal information redacted by USI

DOB Personal Information redacted by the USI
UN

I write to you regarding this Personal Information year old gentleman who was recently referred by your colleague, Personal information redacted by USI following the acute onset of severe visible haematuria which lasted for 2 days. He had been found to have pyuria and haematuria on urinary microscopy whilst urinary culture was negative. He had been prescribed Trimethoprim, 200mgs twice daily.

When I met Personal Information redacted as an outpatient on 20th December 2014, I appreciated that he previously had had a resection of a grossly enlarged, benign prostate gland in 2007. He had remained pretty free of lower urinary tract symptoms until the recent onset of severe haematuria since when he reported having significant lower urinary tract symptoms, consisting of hesitancy of micturition, a reduced urinary flow and a sensation of unsatisfactory voiding in addition to urgency and varying degrees of nocturia. He reported that he had to rise at least once each night to pass urine, more usually 2 or 3 times, and on occasion, 4 times. He had had no recurrence of haematuria since its resolution. On clinical examination, I found him to have a very large and clinically benign prostate gland.

I was pleased to note that his biochemical renal function had been found to be normal and his serum PSA level was 6.19 ng/ml on 15th December 2014, and with a F/T PSA ratio of 26.7%.

I arranged for Personal Information redacted by to have ultrasound scanning of his urinary tract performed on 23rd December 2014. His upper urinary tracts were normal apart from the presence of 2 simple right renal cysts and a single, simple, left renal cyst. The urinary bladder appeared to be normal with no indication of any mucosal pathology. The prostate gland was found to be significantly enlarged with a volume of 79mls. Bladder voiding was satisfactory with a post micturitional, residual urine volume of 58mls. On reviewing the digitalised images, his prostate gland protrudes markedly into the lumen of his bladder.

Even though I suspected that his prostate gland would be the probable source of the haematuria, I have also requested a CT urogram which hopefully will be performed prior to his attendance at the Day Surgical Unit at Craigavon Area Hospital on Tuesday 6th January 2015 for flexible cystoscopy. In the interim, I prescribed Tamsulosin, 400mcgs to be taken once daily in addition to Trimethoprim, 200mgs, also to be taken once daily. I will advise you of the findings of CT scanning and of flexible cystoscopy in due course.

Yours sincerely

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 30th December 2014
Date typed: 30th December 2014/LH

AIDAN O'BRIEN FRCSI
Consultant Urologist

Personal Information redacted by the USI Tel: Personal Information redacted by the USI

17th August 2015

Personal Information redacted by USI
Personal Information redacted by the USI

Dear Personal Information redacted by the

Personal Information redacted by the USI
DOB Personal Information redacted by the USI
UN

Further to my letter of 30th September 2014, I write to advise you that Personal Information redacted by did have ultrasound scanning of his urinary tract performed in November 2014 when he was reported to have bilateral renal cysts. His prostate gland was reported to be mildly enlarged with a volume of 40mls and bladder voiding was found to be entirely satisfactory with a residual volume of 15mls only. Even though his prostate gland was found to be mildly enlarged, it was seen to protrude into the lumen of his urinary bladder, an appearance associated with an increased probability that the prostate gland is causative of bladder outlet obstruction.

At further review in December 2014, Personal Information redacted by reported to me that he had not been taking the Nitrofurantoin for some time, and as a consequence of which he had had a coliform urinary infection earlier that month, and for which he had been prescribed Trimethoprim, though he had not begun to take it at the time of review on 13th December 2014. His lower urinary tract symptoms remained unchanged. I was pleased to find that his serum total PSA level remained normal at 1.55 ng/ml.

I advised him to take the Trimethoprim that he had been prescribed in a therapeutic dose of 200mgs twice daily for a period of one week. I then advised him to remain on Trimethoprim 200mgs daily thereafter for a period of 3 months. I advised him to remain on Finasteride as previously.

At further review on 7th March 2015, Personal Information redacted by reported having urgency of micturition, occasional urge incontinence, a urinary flow that was slow to finish and mild nocturia, having to rise once or twice each night to pass urine. He also reported to me that he had been having headache each day, and which he felt may be attributable to the Trimethoprim upon which he remained at that time.

Whilst there was no evidence of urinary infection on urinary culture repeated in February 2015, I was concerned to note that he had quite significant haematuria on urinary microscopy in addition to minimal pyuria. I therefore arranged for Personal Informatio to have CT urography performed on 19th March 2015 when he was reported to have a tiny right renal calculus. Apart from the additional presence of bilateral simple renal cysts as reported on ultrasound scanning, his urinary tract was otherwise normal. He was coincidentally reported to have several, small lesions of low density within his

liver, considered probably to be simple cysts. He was lastly reported to have para-oesophageal herniation of fat into his mediastinum.

In view of the possible association between Trimethoprim and headache, I advised Personal Information then to discontinue taking Trimethoprim and to resume taking Nitrofurantoin 50mgs daily indefinitely. When I spoke with him recently by telephone, I was pleased to hear him report that he remained well since with no suspicion or evidence of recurrence of infection and with urinary symptoms that had not deteriorated. In any case, I have arranged for Personal Information to attend the Day Surgical Unit at Craigavon Area Hospital on Tuesday 8th September 2015 for flexible cystoscopy in order to complete assessment of his urinary tract. I will advise you of the findings in due course.

Yours sincerely

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 17th August 2015
Date typed: 17th August 2015/LH

Data source: Business Objects, Admissions and Discharge Universe, run date 04/01/17

REF 5717-1216 ELECTIVE NON-ELECTIVE FCE ACTIVITY FOR TURBT TURPT PROCEDURES (SUBMISSION)

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CONSULTANT = MR O'BRIEN - PATIENT LEVEL REPORT - ELECTIVE & NON-ELECTIVE FCE's (Finished Consultant Episodes) FOR TURBT (Transurethral Resection of Bladder) PROCEDURES
01/01/2016 - 31/12/2016

Notes:

The data is based on any patient who had a TURBT or TURPT Procedure carried out as a Primary Procedure or Secondary Procedure 'Proc Category' is based on any patient's episode coded with 'M42.1' as a Primary Procedure is grouped to TURBT; any patient's episode coded with 'M65.1 - M65.9' as a Primary Procedure is grouped to TURPT; any patient's episode coded with 'M42.1 or 'M65.1 - M65.9' as a Primary Procedure and 'M42.1' or 'M65.1 - M65.9' as a Secondary Procedure is grouped to TURPT/TURBT

OPCS codes used (provided by Clinical Coding, CAH)
M42.1 - TURBT (Transurethral Resection of Bladder)

Clinical Coding Completeness (Urology) for the time period as at run date 04/01/17 is: 78%; meaning that procedures that are uncoded will be excluded from the data

Date on Waitng List is the Original WL Date and will not take account of any clock re-sets or suspensions.
Days between Added to WL and Operation Date is calculated as: Days Between Date on Waiting List (Original Date) to Date of Operaton
Non-Elective Patients will not have a Date on Waiting List

Casenote	Health & Care Number	Hospital Description	Specialty Code (R)	Specialty Description	Start Date Only	End Date Only	Date on Waiting List	Date Operation	Days Between Added to WL and Operation Date	Proc Category	Primary Operation	Operation Description	Sec Op 1	Sec Op 2	Sec Op 3	Sec Op 4	Sec Op 5	Elective Episodes	Non-Elective FCE's
Personal Information redacted by the USI		Craigavon Area Hospital	101	UROLOGY(C)	13/04/2016	14/04/2016	~~14/06/2016~~	13/04/2016	243	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	27/07/2016	29/07/2016	~~05/07/2016~~	27/07/2016	22	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	04/05/2016	05/05/2016	~~25/04/2016~~	04/05/2016	9	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	Y14.9	Z41.3	Z94.2			1	0
		Craigavon Area Hospital	101	UROLOGY(C)	15/06/2016	16/06/2016	~~05/05/2016~~	15/06/2016	41	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	M27.5	Z94.2				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	22/12/2015	19/02/2016		13/01/2016		TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	U16.2	Y98.1	U21.2	Y98.3	Z41.1	0	1
		Craigavon Area Hospital	101	UROLOGY(C)	23/03/2016	25/03/2016	~~24/02/2016~~	23/03/2016	28	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	24/08/2016	24/08/2016	~~15/01/2016~~	24/08/2016	222	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	M27.4	Z94.3				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	24/02/2016	25/02/2016	~~10/04/2015~~	24/02/2016	320	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	24/08/2016	28/08/2016	~~04/12/2015~~	24/08/2016	264	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	18/07/2016	21/07/2016	~~24/06/2016~~	18/07/2016	24	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	16/03/2016	17/03/2016	~~03/01/2016~~	16/03/2016	68	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	M45.9					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	24/08/2016	25/08/2016	~~28/02/2016~~	24/08/2016	180	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	31/05/2016	11/06/2016	~~11/05/2016~~	31/05/2016	20	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	06/07/2016	08/07/2016	~~23/06/2016~~	06/07/2016	13	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	Y44.4					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	22/04/2016	26/04/2016	~~25/02/2016~~	22/04/2016	57	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	M70.3	Y53.2				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	04/10/2016	12/10/2016	~~12/08/2016~~	05/10/2016	54	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	U21.2	Y97.3	Y98.2	Z92.6	O16.1	1	0
		Craigavon Area Hospital	101	UROLOGY(C)	10/02/2016	13/02/2016	~~29/12/2015~~	10/02/2016	50	TURBT	M45.9	Diagnostic Endoscopic Examination Of Bladder - Unspecified	M42.1					1	0
																		16	1

7159 = 126.

Data source: Business Objects, Admissions and Discharge Universe, run date 04/01/17

REF 5717-1216 ELECTIVE NON-ELECTIVE FCE ACTIVITY FOR TURBT/TURPT PROCEDURES (SUBMISSION)

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CONSULTANT = MR O'BRIEN - PATIENT LEVEL REPORT - ELECTIVE & NON-ELECTIVE FCE's (Finished Consultant Episodes) FOR TURPT (Transurethral Resection of Prostate)/TURBT (Transurethral Resection of Bladder) PROCEDURES
01/01/2016 - 31/12/2016

Notes:

The data is based on any patient who had a TURBT or TURPT Procedure carried out as a Primary Procedure or Secondary Procedure. 'Proc Category' is based on any patient's episode coded with 'M42.1' as a Primary Procedure is grouped to TURBT; any patient's episode coded with 'M65.1 - M65.9' as a Primary Procedure is grouped to TURPT; any patient's episode coded with 'M42.1 or 'M65.1 - M65.9' as a Primary Procedure and 'M42.1' or 'M65.1 - M65.9' as a Secondary Procedure is grouped to TURPT/TURBT

OPCS codes used (provded by Clinical Coding, CAH)
M65.1 - M65.9 - TURPT (Transurethral Resection of Prostate)
M42.1 - TURBT (Transurethral Resection of Bladder)
Clinical Coding Completeness (Urology) for the time perod as at run date 04/01/17 is: 78%; meaning that procedures that are uncoded will be excluded from the data.

Date on Waiting List is the Original WL Date and will not take account of any clock re-sets or suspensions.
Days between Added to WL and Operation Date is calculated as: Days Between Date on Waiting List (Original Date) to Date of Operation
Non-Elective Patients will not have a Date on Waiting List

Casenote	Health & Care Number	Hospital Description	Specialty Code (R)	Specialty Description	Start Date Only	End Date Only	Date on Waiting List	Date Operation	Days Between Added to WL and Operation Date	Proc Categroy	Primary Operation	Operation Description	Sec Op 1	Sec Op 2	Sec Op 3	Sec Op 4	Sec Op 5	Elective Episodes	Non-Elective FCE's
Personal Information redacted by the USI		Craigavon Area Hospital	101	UROLOGY(C)	21/09/2016	23/09/2016	22/07/2016	21/09/2016	61	TURPT/TURBT	M29.2	Other Therapeutic Endoscopic Operations On Ureter - Endoscopic Insertion Of Tubal Prosthesis Into	Z94.2	M42.1	M65.1			1	0
		Craigavon Area Hospital	101	UROLOGY(C)	06/09/2016	09/09/2016	25/08/2016	07/09/2016	13	TURPT/TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder	M65.1					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	17/08/2016	21/08/2016	30/10/2015	17/08/2016	292	TURPT/TURBT	M65.1	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Using Electroto	M42.1					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	08/09/2016	14/09/2016		08/09/2016		TURPT/TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder	M65.1					0	1
																		3	1

30/12/1

1/4

Data source: Business Objects, Admissions and Discharge Universe, run date 04/01/17

REF 5717-1216 ELECTIVE NON-ELECTIVE FCE ACTIVITY FOR TURBT-TURPT PROCEDURES (DUEMISSION)

E331893

519116

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CONSULTANT = MR O'BRIEN - PATIENT LEVEL REPORT - ELECTIVE & NON-ELECTIVE FCE's (Finished Consultant Episodes) FOR TURPT (Transurethral Resection of Prostate) PROCEDURES
01/01/2016 - 31/12/2016

Notes:

The data is based on any patient who had a TURBT or TURPT Procedure carried out as a Primary Procedure or Secondary Procedure. 'Proc Category' is based on any patient's episode coded with 'M42.1' as a Primary Procedure is grouped to TURBT; any patient's episode coded with 'M65.1 - M65.9' as a Primary Procedure is grouped to TURPT; any patient's episode coded with M42.1 or 'M65.1 - M65.9' as a Primary Procedure and 'M42.1' or 'M65.1 - M65.9' as a Secondary Procedure is grouped to TURPT/TURBT

OPCS codes used (provided by Clinical Coding, CAH)
M65.1 - M65.9 - TURPT (Transurethral Resection of Prostate)

Clinical Coding Completeness (Urology) for the time period as at run date 04/01/17 is: 78%; meaning that procedures that are uncoded will be excluded from the data.

Date on Waiting List is the Original WL Date and will not take account of any clock re-sets or suspensions.
Days between Added to WL and Operation Date is calculated as: Days Between Date on Waiting List (Original Date) to Date of Operation
Non-Elective Patients will not have a Date on Waiting List

Casenote	Health & Care Number	Hospital Description	Specialty Code (R)	Specialty Description	Start Date Only	End Date Only	Date on Waiting List	Date Operation	Days Between Added to WL and Operation Date	Proc Categroy	Primary Operation	Operation Description	Sec Op 1	Sec Op 2	Sec Op 3	Sec Op 4	Sec Op 5	Elective Episodes	Non-Elective FCE's
Personal Information redacted by the USI		Craigavon Area Hospital	101	URCLOGY(C)	25/05/2016	27/05/2016	25/03/2016	25/05/2016	61	TURPT	M43.4	Endoscopic Operations To Increase Capacty Of Bladder - Endoscopic Injection Of Neurolytic Subs	X85.1	M65.3				1	0
		Craigavon Area Hospital	101	URCLOGY(C)	07/09/2016	08/09/2016	10/07/2015	07/09/2016	425	TURPT	M65.1	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Using Electrotome						1	0
		Craigavon Area Hospital	101	URCLOGY(C)	15/06/2016	19/06/2016	30/03/2015	15/06/2016	443	TURPT	M65.1	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Using Electro	N11.1	Z94.9				1	0
		Craigavon Area Hospital	101	URCLOGY(C)	29/06/2016	29/06/2016	27/05/2016	29/06/2016	33	TURPT	M65.1	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Using Electro	M79.2					1	0
		Craigavon Area Hospital	101	URCLOGY(C)	06/07/2016	08/07/2016	07/09/2015	06/07/2016	303	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	URCLOGY(C)	29/12/2015	05/01/2016	14/10/2015	30/12/2015	77	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M47.3	M47.9				1	0
		Craigavon Area Hospital	101	URCLOGY(C)	23/03/2016	27/03/2016	28/02/2016	23/03/2016	24	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	URCLOGY(C)	16/02/2016	20/02/2016		16/02/2016		TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						0	1
		Craigavon Area Hospital	101	URCLOGY(C)	27/07/2016	29/07/2016	24/06/2016	27/07/2016	33	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	URCLOGY(C)	27/07/2016	29/07/2016	29/06/2016	27/07/2016	28	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M76.4					1	0
		Craigavon Area Hospital	101	URCLOGY(C)	25/07/2016	02/08/2016	14/04/2014	27/07/2016	835	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	URCLOGY(C)	26/08/2016	28/08/2016	13/06/2016	26/08/2016	74	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	URCLOGY(C)	04/05/2016	07/05/2016	11/03/2016	04/05/2016	54	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	URCLOGY(C)	29/06/2016	03/07/2016	28/04/2015	29/06/2016	428	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M47.3	M47.9				1	0
		Craigavon Area Hospital	101	URCLOGY(C)	09/03/2016	10/03/2016	16/12/2015	09/03/2016	84	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	URCLOGY(C)	26/02/2016	28/02/2016	12/02/2016	26/02/2016	14	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	URCLOGY(C)	27/01/2016	30/01/2016	18/01/2016	27/01/2016	9	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	URCLOGY(C)	24/02/2016	26/02/2016	29/01/2016	24/02/2016	26	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	10/02/2016	25/02/2016	19/04/2016	10/02/2016	23	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	27/01/2016	29/01/2016	24/09/2014	27/01/2016	705	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	27/07/2016	29/07/2016	29/06/2016	27/07/2016	28	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M79.2					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	10/02/2016	11/02/2016	30/10/2015	10/02/2016	103	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	21/09/2016	24/09/2016	28/07/2016	21/09/2016	786	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	17/05/2016	24/05/2016	14/10/2014	17/05/2016	581	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M45.9					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	04/05/2016	08/05/2016	07/03/2016	04/05/2016	58	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	08/09/2016	30/09/2016		24/09/2016		TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M44.4	Y26.9				0	1
		Craigavon Area Hospital	101	UROLOGY(C)	22/08/2016	27/08/2016	18/11/2014	22/08/2016	643	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M45.5					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	25/08/2016	02/09/2016	07/07/2015	26/08/2016	416	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	01/06/2016	03/06/2016	15/05/2016	01/06/2016	17	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	21/09/2016	23/09/2016	29/07/2016	21/09/2016	54	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M76.4					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	16/08/2016	20/08/2016	15/07/2016	17/08/2016	37	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	21/09/2016	25/09/2016	22/07/2016	21/09/2016	61	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	24/08/2016	26/08/2016	26/06/2015	24/08/2016	422	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	09/03/2016	15/03/2016	06/02/2016	09/03/2016	33	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified	M43.4	X85.1				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	16/03/2016	18/03/2016	13/10/2015	16/03/2016	155	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	18/05/2016	21/05/2016	09/05/2016	18/05/2016	15	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	13/04/2016	19/04/2016	30/03/2016	13/04/2016	14	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	13/07/2016	15/07/2016	24/06/2016	13/07/2016	19	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	20/09/2016	23/09/2016	06/08/2015	21/09/2016	381	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	13/04/2016	18/04/2016	06/03/2015	13/04/2016	400	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	16/03/2016	20/03/2016	26/02/2016	16/03/2016	23	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
																		39	2

5 le HES

39

Produced by Directorate of Performance and Reform, Informatics Division, Information Department (Acute)

Corrigan, Martina

From: Clayton, Wendy [redacted]
Sent: 06 January 2017 10:20
To: Tallon, Denise
Cc: Carroll, Ronan; Corrigan, Martina
Subject: FW: Information Request 5717-1216 Mr O'Brien TURP Procedures
Attachments: REF 5717-1216 ELECTIVE & NON-ELECTIVE FCE ACTIVITY FOR TURBT-TURPT PROCEDURES (SUBMISSION).xlsx

Hi Denise

Thank you for the attached information which has been very helpful. We now need to look at the same information for cystoscopy pts under AOB in 2016.

Do I need to put through another information request?

Many thanks for your help.

Wendy

Wendy Clayton
Operational Support Lead
ATICS/SEC
Tel: [redacted]
Mob: [redacted]

From: Tallon, Denise
Sent: 04 January 2017 14:59
To: Clayton, Wendy
Subject: Information Request 5717-1216 Mr O'Brien TURP Procedures

Hi Wendy,

Please see attached information for Mr O'Brien – TURP Procedures for 2016 (Jan to Dec).

Any queries, please let me know.

Many thanks,
Denise

Denise Tallon
Senior Information Analyst
Acute Information Department
Glendale Building
Bannvale Site
Gilford
Co. Armagh
BT63 5JY
Tel: [redacted]

'You can follow us on Facebook and Twitter'

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Number of Elective and Non-Elective FCE's (Finished Consultant Episodes) for TURBT & TURPT Procedures - CONSULTANT = MR O'BRIEN 01/01/2016 - 31/12/2016

Notes:

The data is based on any patient who had a TURBT or TURPT Procedure carried out as a Primary Procedure or Secondary Procedure. 'Proc Category' is based on any patient's episode coded with 'M42.1' as a Primary Procedure is grouped to TURBT; any patient's episode coded with 'M65.1 - M65.9' as a Primary Procedure is grouped to TURPT; any patient's episode coded with 'M42.1 or 'M65.1 - M65.9' as a Primary Procedure and 'M42.1' or 'M65.1 - M65.9' as a Secondary Procedure is grouped to TURPT/TURBT

OPCS codes used (provided by Clinical Coding, CAH)
M42.1 - TURBT (Transurethral Resection of Bladder)
M65.1 - M65.9 - TURPT (Transurethral Resection of Prostate)

Clinical Coding Completeness (Urology) for the time period as at run date 04/01/17 is: 78%; meaning that procedures that are uncoded will be excluded from the data.

Proc Category	TURBT

Hospital Description	Specialty Code (R)	Specialty Description	Elective Episodes	Non-Elective FCE's	Total Episodes
Craigavon Area Hospital	101	UROLOGY(C)	16	1	17
	101 Total		***16***	***1***	***17***
Craigavon Area Hospital Total			**16**	**1**	**17**
Total			**16**	**1**	**17**

Proc Categroy	TURPT

Hospital Description	Specialty Code (R)	Specialty Description	Elective Episodes	Non-Elective FCE's	Total Episodes
Craigavon Area Hospital	101	UROLOGY(C)	39	2	41
	101 Total		***39***	***2***	***41***
Craigavon Area Hospital Total			**39**	**2**	**41**
Total			**39**	**2**	**41**

Proc Categroy	TURPT/TURBT

Hospital Description	Specialty Code (R)	Specialty Description	Elective Episodes	Non-Elective FCE's	Total Episodes
Craigavon Area Hospital	101	UROLOGY(C)	3	1	4
	101 Total		***3***	***1***	***4***
Craigavon Area Hospital Total			**3**	**1**	**4**
Total			**3**	**1**	**4**

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CONSULTANT = MR O'BRIEN - PATIENT LEVEL REPORT - ELECTIVE & NON-ELECTIVE FCE's (Finished Consultant Episodes) FOR TURBT (Transurethral Resection of Bladder) PROCEDURES
01/01/2016 - 31/12/2016

Notes:

The data is based on any patient who had a TURBT or TURPT Procedure carried out as a Primary Procedure or Secondary Procedure. 'Proc Category' is based on any patient's episode coded with 'M42.1' as a Primary Procedure is grouped to TURBT; any patient's episode coded with 'M65.1 - M65.9' as a Primary Procedure is grouped to TURPT; any patient's episode coded with 'M42.1 or 'M65.1 - M65.9' as a Primary Procedure and 'M42.1' or 'M65.1 - M65.9' as a Secondary Procedure is grouped to TURPT/TURBT

OPCS codes used (provided by Clinical Coding, CAH)
M42.1 - TURBT (Transurethral Resection of Bladder)

Clinical Coding Completeness (Urology) for the time period as at run date 04/01/17 is: 78%; meaning that procedures that are uncoded will be excluded from the data.

Date on Waiting List is the Original WL Date and will not take account of any clock re-sets or suspensions.
Days between Added to WL and Operation Date is calculated as: Days Between Date on Waiting List (Original Date) to Date of Operation
Non-Elective Patients will not have a Date on Waiting List

Casenote	Health & Care Number	Hospital Description	Specialty Code (R)	Specialty Description	Start Date Only	End Date Only	Date on Waiting List	Date Operation	Days Between Added to WL and Operation Date	Proc Category	Primary Operation	Operation Description	Sec Op 1	Sec Op 2	Sec Op 3	Sec Op 4	Sec Op 5	Elective Episodes	Non-Elective FCE's
Personal Information redacted by the USI		Craigavon Area Hospital	101	UROLOGY(C)	13/04/2016	14/04/2016	14/08/2015	13/04/2016	243	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	27/07/2016	29/07/2016	05/07/2016	27/07/2016	22	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	04/05/2016	05/05/2016	25/04/2016	04/05/2016	9	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	Y14.9	Z41.3	Z94.2			1	0
		Craigavon Area Hospital	101	UROLOGY(C)	15/06/2016	16/06/2016	05/05/2016	15/06/2016	41	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	M27.5	Z94.2				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	22/12/2015	19/02/2016		13/01/2016		TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	U16.2	Y98.1	U21.2	Y98.3	Z41.1	0	1
		Craigavon Area Hospital	101	UROLOGY(C)	23/03/2016	25/03/2016	24/02/2016	23/03/2016	28	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	24/08/2016	24/08/2016	15/01/2016	24/08/2016	222	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	M27.4	Z94.3				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	24/02/2016	25/02/2016	10/04/2015	24/02/2016	320	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	24/08/2016	28/08/2016	04/12/2015	24/08/2016	264	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	18/07/2016	21/07/2016	24/06/2016	18/07/2016	24	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	16/03/2016	17/03/2016	08/01/2016	16/03/2016	68	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	M45.9					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	24/08/2016	25/08/2016	26/02/2016	24/08/2016	180	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	31/05/2016	11/06/2016	11/05/2016	31/05/2016	20	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladder						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	06/07/2016	08/07/2016	23/06/2016	06/07/2016	13	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	Y44.4					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	22/04/2016	26/04/2016	25/02/2016	22/04/2016	57	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	M70.3	Y53.2				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	04/10/2016	12/10/2016	12/08/2016	05/10/2016	54	TURBT	M42.1	Endoscopic Extirpation Of Lesion Of Bladder - Endoscopic Resection Of Lesion Of Bladde	U21.2	Y97.3	Y98.2	Z92.6	O16.1	1	0
		Craigavon Area Hospital	101	UROLOGY(C)	10/02/2016	13/02/2016	22/12/2015	10/02/2016	50	TURBT	M45.9	Diagnostic Endoscopic Examination Of Bladder - Unspecified	M42.1					1	0
																		16	**1**

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CONSULTANT = MR O'BRIEN - PATIENT LEVEL REPORT - ELECTIVE & NON-ELECTIVE FCE's (Finished Consultant Episodes) FOR TURPT (Transurethral Resection of Prostate) PROCEDURES
01/01/2016 - 31/12/2016

Notes:

The data is based on any patient who had a TURBT or TURPT Procedure carried out as a Primary Procedure or Secondary Procedure. 'Proc Category' is based on any patient's episode coded with 'M42.1' as a Primary Procedure is grouped to TURBT; any patient's episode coded with 'M65.1 - M65.9' as a Primary Procedure is grouped to TURPT; any patient's episode coded with 'M42.1 or 'M65.1 - M65.9' as a Primary Procedure and 'M42.1' or 'M65.1 - M65.9' as a Secondary Procedure is grouped to TURPT/TURBT

OPCS codes used (provided by Clinical Coding, CAH)
M65.1 - M65.9 - TURPT (Transurethral Resection of Prostate)

Clinical Coding Completeness (Urology) for the time period as at run date 04/01/17 is: 78%; meaning that procedures that are uncoded will be excluded from the data.

Date on Waiting List is the Original WL Date and will not take account of any clock re-sets or suspensions.
Days between Added to WL and Operation Date is calculated as: Days Between Date on Waiting List (Original Date) to Date of Operation
Non-Elective Patients will not have a Date on Waiting List

Casenote	Health & Care Number	Hospital Description	Specialty Code (R)	Specialty Description	Start Date Only	End Date Only	Date on Waiting List	Date Operation	Days Between Added to WL and Operation Date	Proc Categroy	Primary Operation	Operation Description	Sec Op 1	Sec Op 2	Sec Op 3	Sec Op 4	Sec Op 5	Elective Episodes	Non-Elective FCE's
Personal Information redacted by the USI		Craigavon Area Hospital	101	UROLOGY(C)	25/05/2016	27/05/2016	25/03/2016	25/05/2016	61	TURPT	M43.4	Endoscopic Operations To Increase Capacity Of Bladder - Endoscopic Injection Of Neurolytic Subs	X85.1	M65.3				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	07/09/2016	08/09/2016	10/07/2015	07/09/2016	425	TURPT	M65.1	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Using Electrotome						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	15/06/2016	19/06/2016	30/03/2015	15/06/2016	443	TURPT	M65.1	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Using Electro	N11.1	Z94.9				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	29/06/2016	29/06/2016	27/05/2016	29/06/2016	33	TURPT	M65.1	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Using Electro	M79.2					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	06/07/2016	08/07/2016	07/09/2015	06/07/2016	303	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	29/12/2015	05/01/2016	14/10/2015	30/12/2015	77	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M47.3	M47.9				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	23/03/2016	27/03/2016	28/02/2016	23/03/2016	24	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	16/02/2016	20/02/2016		16/02/2016		TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						0	1
		Craigavon Area Hospital	101	UROLOGY(C)	27/07/2016	29/07/2016	24/06/2016	27/07/2016	33	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	27/07/2016	29/07/2016	29/06/2016	27/07/2016	28	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M76.4					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	25/07/2016	02/08/2016	14/04/2014	27/07/2016	835	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	26/08/2016	28/08/2016	13/06/2016	26/08/2016	74	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	04/05/2016	07/05/2016	11/03/2016	04/05/2016	54	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	29/06/2016	03/07/2016	28/04/2015	29/06/2016	428	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M47.3	M47.9				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	09/03/2016	10/03/2016	16/12/2015	09/03/2016	84	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	26/02/2016	28/02/2016	12/02/2016	26/02/2016	14	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	27/01/2016	30/01/2016	18/01/2016	27/01/2016	9	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	24/02/2016	26/02/2016	29/01/2016	24/02/2016	26	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	10/02/2016	25/02/2016	18/01/2016	10/02/2016	23	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	27/01/2016	29/01/2016	21/02/2014	27/01/2016	705	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	27/07/2016	29/07/2016	29/06/2016	27/07/2016	28	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M79.2					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	10/02/2016	11/02/2016	30/10/2015	10/02/2016	103	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	21/09/2016	24/09/2016	28/07/2014	21/09/2016	786	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	17/05/2016	24/05/2016	14/10/2014	17/05/2016	581	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M45.9					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	04/05/2016	08/05/2016	07/03/2016	04/05/2016	58	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	08/09/2016	30/09/2016		24/09/2016		TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M44.4	Y26.9				0	1
		Craigavon Area Hospital	101	UROLOGY(C)	22/08/2016	27/08/2016	18/11/2014	22/08/2016	643	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M45.5					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	25/08/2016	02/09/2016	07/07/2015	26/08/2016	416	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	01/06/2016	03/06/2016	15/05/2016	01/06/2016	17	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	21/09/2016	23/09/2016	29/07/2016	21/09/2016	54	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec	M76.4					1	0
		Craigavon Area Hospital	101	UROLOGY(C)	16/08/2016	20/08/2016	11/07/2016	17/08/2016	37	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	21/09/2016	25/09/2016	22/07/2016	21/09/2016	61	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	24/08/2016	26/08/2016	29/06/2015	24/08/2016	422	TURPT	M65.3	Endoscopic Resection Of Outlet Of Male Bladder - Endoscopic Resection Of Prostate Nec						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	09/03/2016	15/03/2016	05/02/2016	09/03/2016	33	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified	M43.4	X85.1				1	0
		Craigavon Area Hospital	101	UROLOGY(C)	16/03/2016	18/03/2016	13/10/2015	16/03/2016	155	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	18/05/2016	21/05/2016	03/05/2016	18/05/2016	15	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	13/04/2016	19/04/2016	30/03/2016	13/04/2016	14	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	13/07/2016	15/07/2016	24/06/2016	13/07/2016	19	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	20/09/2016	23/09/2016	06/09/2015	21/09/2016	381	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	13/04/2016	18/04/2016	10/03/2015	13/04/2016	400	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
		Craigavon Area Hospital	101	UROLOGY(C)	16/03/2016	20/03/2016	22/02/2016	16/03/2016	23	TURPT	M65.9	Endoscopic Resection Of Outlet Of Male Bladder - Unspecified						1	0
																		39	2