Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Sharon Glenny
Operational Support Lead (Cancer and Clinical Services)
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

26 September 2022

Dear Madam,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant

information required to provide the witness statement required now or at any stage throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and/or has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance

in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 98 of 2022]

Pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO:

Sharon Glenny
Operational Support Lead (Cancer and Clinical Services)
C/O Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 24th October 2022.**

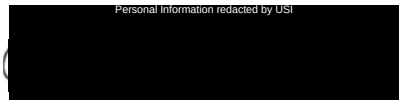
APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 17th October 2022.**

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 26th September 2022

Signed: 

Christine Smith QC
Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE
[No 98 of 2022]

SECTION 1 – GENERAL NARRATIVE

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological format.

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.

5. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

6. If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.

7. What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?

8. Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

9. Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?

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10. What performance indicators, if any, are used to measure performance for your role?

11. How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?

12. Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.

13. What systems of governance do you use in fulfilling your role?

14. Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

15. During your tenure, who did you understand was responsible for overseeing the quality of services in urology?

16. In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?

17. Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?

18. Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.

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Urology services

19. Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.

20. With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.

21. In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?

22. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?

23. Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?

24. Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:

    (i) Waiting times
    (ii) Triage/GP referral letters
    (iii) Letter and note dictation
    (iv) Patient care scheduling/Booking
    (v) Prescription of drugs

(vi) Administration of drugs
(vii) Private patient booking
(viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs
(ix) Following up on results/sign off of results
(x) Onward referral of patients for further care and treatment
(xi) Storage and management of health records
(xii) Operation of the Patient Administrative System (PAS)
(xiii) Staffing
(xiv) Clinical Nurse Specialists
(xv) Cancer Nurse Specialists
(xvi) Palliative Care Nurses
(xvii) Patient complaints/queries

Concerns

25. Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.

26. Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.

27. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.

Urology Services Inquiry

28. If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?

29. What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

30. Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?

31. Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.

32. In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?

33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?

34. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such Governance meeting minutes or notes, or in the Risk Register, whether at Departmental level or otherwise? Please provide any documents referred to.

35. What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?

Staff

36. As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?

37. In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.

Learning

38. Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.

39. Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?

40. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?

41. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

42. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

43. Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

44. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

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UROLOGY SERVICES INQUIRY

USI Ref: Notice 98 of 2022

Date of Notice: 26 September 2022

Note: An addendum amending this statement was received by the Inquiry on 12 May 2023 and it can be found at WIT-94966 to WIT-95180. Annotated by the Urology Services Inquiry.

Witness Statement of: Sharon Glenny

I, Sharon Glenny, will say as follows: -

SECTION 1 – GENERAL NARRATIVE

General

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

1.1 The SHSCT was formed in April 2007. At that time, I was working as temporary project manager for the implementation of the urology ICATS model until July 14 July 2007. My main duties and responsibilities of this post was to project manage the implementation of the Urology Integrated and Clinical Assessment & Treatment Service (ICATS) model in order to ensure the successful implementation and roll-out of the model across the Southern Trust area.

1.2 I was employed as a Band 7 Operational Support Lead (OSL) for Surgery & Elective Care (SEC) Division from 15 July 2007 to 31 March 2016. My main duties and responsibilities were the monitoring of the operational functions associated with the performance of elective care pathways, supporting the Heads of Service (HOS) and Assistant Director (AD) within SEC. I had management responsibility for all the Administrative and Clerical ('A&C') staff within the Division until a structural change in June 2013 by the then Director of Acute Services, Deborah Burns. At this time the secretaries, audio-typists and ward clerks moved to the Functional Support Services Division (FSS), but the scheduling and independent sector support teams remained within the Division.

1.4 Following a re-structuring of the Acute Services Division on 1 April 2016 by the then Director, Esther Gishkori, I had a sideways move to become OSL for Cancer and Clinical Services (CCS) and Integrated Maternity & Women's Health (IMWH) Division along with my AD at the time. Following the structural change, the number of OSL roles in the Acute Directorate reduced from four to three. My main duties and responsibilities were the monitoring of the operational functions associated with the performance of elective care pathways, supporting the Heads of Service (HOS) and Assistant Director (AD) within SEC. I had management responsibility for all the A&C staff within the CCS Division; the majority of A&C staff within IMWH Division reported through FSS Division, but there was a small number who still reported through management lines in IMWH Division

1.5 The Director of Acute Services, Melanie McClements split the CCS & IMWH Division on 1 June 2021 as it was felt the portfolio of services was too large for one Division. This become two separate divisions with Barry Conway remaining for CCS and Caroline Keown taking up post as AD for IMWH. My OSL role still covers both these separate divisions despite the recognition that these divisions have a large portfolio of services.

1.6 During my tenure as OSL for SEC (July 2007 to March 2016), there was an apparent issue with untriaged letters within urology, particularly with Mr O'Brien. As OSL for SEC, I escalated concerns from the Referral & Booking Centre (RBC), to the Head of Service (HOS), Martina Corrigan. The RBC, under the management of Katherine Robinson, had a process in place to escalate delays in triage outcome to all of the OSLs. My role as OSL in SEC was to ensure there was awareness of the concern up the managerial chain to the appropriate HOS. It was the HOS who was charged with directing steps to address these concerns. In relation to urology, it was my understanding that the HOS, Martina Corrigan, would have discussed the concerns with the clinical team and/or consultant directly, either face to face or by email, although I would not normally have been aware of the outcome of these discussions as that was not normally fed back to me. I would not have followed up on these discussions as that was outside the scope of my role as OSL.

1.7 In my current tenure of OSL for CCS & IMWH, I monitor performance against the cancer against targets which is presented at the monthly Cancer Performance Meetings to the operational HOS, ADs and OSLs who have responsibility for the delivery of cancer services across the tumour sites. These meetings are also attended by the Director of Acute Services as well as representatives from the Trust Performance Team. Unfortunately, throughout my current OSL tenure, the Trust has been unable to deliver the 31 and 62 day cancer access targets across a range of tumour sites, including urology. The monthly cancer performance meetings are used to review cancer performance across all tumour sites, including urology and a record of the internal and external risk areas recorded. Any actions agreed will be noted and this will be reviewed at the next meeting.

1.8 The CCS Division has responsibility for the co-ordination of the cancer multi-disciplinary meeting (MDT) and tracking of patients on 31 and 62 day pathways from the date of referral until first definitive treatment, using the Cancer Patient Pathway System (CaPPs). The red flag appointments team/cancer tracking team ought to escalate delays

in pathway progression to the Cancer Services Co-Ordinator/Cancer MDT Administrator who ought to escalate to the operational HOS as required. It is the operational HOS who has responsibility to take forward any corrective action required, feeding back to the Cancer Services Co-Ordinator/Cancer MDT Administrator as necessary.

1.9 The cancer tracking team report to me via the Cancer Services Co-Ordinator up until January 2022, now Cancer MDT Administrator. In my role as OSL for CCS, it has been my view that the tracking team were inadequately commissioned, in terms of the number of staff, by the Health & Social Care Board (HSCB) now Strategic Performance Planning Group (SPPG) to fully track the volume of patients on cancer pathways.

1.10 In August 2018, HSCB undertook a Regional capacity and demand analysis for cancer tracking resources, with the conclusion being that SHSCT required 8.6 whole time equivalent (wte) staff and there was a funding gap of 4.7 wte.

1.11 In January 2019 I again raised concern about the staffing situation in the cancer tracking team, noting that the average volume of patients being tracked across the tumour sites had increased from 1350 in 2015/2016 to 1766 in 2017/2018 and then 2300 in January 2019. Following this a further cancer tracker was appointed at financial risk, that this appointment has been proceeded with before funding has been secured.

1.12 I escalated further concerns on 10 & 11 February 2021 as it was noted that the average tracking volumes had further increased to 5500. I have continued to liaise with my AD, Barry Conway in relation to tracking pressures and with increases to the tracking team at financial risk, we now have a complement of 14 wte, 5.4 wte at financial risk, and are able to maintain a completed tracking standard of between 96-98% across all tumour sites.

1.13 I was a member of a Task and Finish Group in August 2021 led by Sarah Ward, Head of Clinical Assurance for Public Inquiry which was set up to implement the 11 recommendations of the Dermot Hughes report. Through my attendance at this group, I became aware of other governance issues in relation to the provision of urology services. Relevant to my role as OSL for CCS, there were a number of concerns in relation to the Urology Cancer MDT processes:

(a) Quoracy at Urology Cancer MDT Meetings;
(b) Lack of support to the Cancer MDT Meetings;
(c) Lack of audit to the Cancer MDT Meetings.

1.14 There are a large number of cancer performance reports in relation to the achievement of the Integrated Elective Access Protocol (IEAP) targets, red flag referral trends and tumour site specific information for all tumour sites. However, there were no performance reports focusing on the actual MDT performance, ie., in relation to how all tumour site MDTs are working, their effectiveness or if the systems and processes in place are robust.

1.15 The Macmillan Service Improvement Lead (Mary Haughey) has also undertaken a National Cancer Team (NCAT) MDT baseline assessment on all tumour sites during 2021, including urology, and a service improvement action plan has been developed to improve the effectiveness of MDT.

1.16 As OSL, I have been working closely with the senior management team in CCS to bring forward changes within the service set out in this plan which in my view will bring about more robust monitoring arrangements for MDT processes and improve the experience for cancer patients in the future.

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2. **Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.**

2.1 All documents referenced in this statement can be located in folder S21 98 of 2022 – Attachments**.**

3. **Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological format.**

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. **Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.**

4.1 The Southern Health & Social Care Trust (SHSCT) was formed in April 2007. Since the formation of SHSCT, my roles, duties and responsibilities have been as follows:

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Temporary Project Manager - Urology ICATS Model – Band 6

16 October 2006 to 22 July 2007

4.2 The key duties and responsibilities of this post are set out in the referenced job description and in summary these were as follows:

a) To project manage the implementation of the Urology Integrated and Clinical Assessment & Treatment Service (ICATS) model in order to ensure the successful implementation and roll-out of the model across the Southern Trust area.
b) Develop a project plan, monitor progress and compliance to the plan within the set timescales
c) Co-ordinate the commissioning and set up of accommodation and facilities to support the model
d) I reported to Lesley Leeman, Operational Performance Manager within the Acute Operations Team.

Please see:

1. 200608 Q4 JD Temporary Project Manager – Urology ICATS Model

Operational Support Lead for Surgery & Elective Care (SEC) – Band 7

15 July 2007 to 31 March 2016

4.3 SEC includes the following specialty areas - General Surgery (GSUR), Endoscopy, Breast Surgery (BSUR), Urology (URO), Ear Nose & Throat (ENT), ophthalmology (OPHTH), orthodontics, oral surgery (OSUR) and Trauma & Orthopaedics (T&O). The key duties and responsibilities of this post are set out in the referenced job description and in summary these were as follows:

a) Responsible for monitoring the day-to-day operational functions associated with performance via management of primary target lists (PTLs) and waiting list management processes.

b) Supporting the Heads of Service (HOS) and Assistant Director (AD) in the operational performance and delivery of targets within the Division

c) I had responsibility for the Administrative and Clerical (A&C) staff within the Division, who reported directly to the Service Administrators (SAs). The SAs reported directly to me.

d) There was a change to the reporting arrangements for Integrated Maternity & Women's Health (IMWH), Medicine & Unscheduled Care (MUSC) and Surgery & Elective Care (SEC) Divisions A&C staff in June 2013, when secretaries, audio-typists and ward clerks moved to the Functional Services Division, under the management structure of Anita Carroll, Assistant Director. These staff then reported to Katherine Robinson, Head of Acute Booking and Secretarial Services (secretaries and audio-typists) and Helen Forde, Head of Health Records (ward clerks).

e) During this tenure I reported to the Assistant Director (AD) of SEC, firstly Simon Gibson (July 2007 to September 2009), then Heather Trouton (October 2009 to March 2016).

Please see:

2. 200608 Q4 JD Operational Support Lead – Acute Services

Operational Support Lead for Cancer & Clinical Services (CCS) and Integrated Maternity & Women's Health (IMWH) – Band 7

1 April 2016 to present

4.4 This was a sideways move on 1st April 2016 following a structural change made by then Director of Acute Services (Esther Gishkori) when the Operational Support Leads (OSLs) moved with their existing Assistant Directors to a new Division. There was no change to the job description for this role, as all four OSLs had the same job description.

4.5 Before this change, there were four OSL posts in the Directorate:

a) Sharon Glenny – OSL for SEC
b) Wendy Clayton – OSL for CCS and Anaesthetics & Intensive Care Services Division (ATICS)
c) Lisa McAreavey – OSL for IMWH
d) Phyllis Richardson – OSL for Medicine & Unscheduled Care (MUSC)

4.6 Following the change, this reduced to three OSL posts as follows:

a) Sharon Glenny – OSL for CCS & IMWH
b) Wendy Clayton – OSL for SEC & ATICS
c) Lisa McAreavey – OSL for MUSC

4.7 This change coincided with the early retirement of Phyllis Richardson, OSL for MUSC on 31 March 2016. Phyllis's post was not replaced and the funding attached to the post was given up for savings by the Director of Acute Services (Esther Gishkori).

4.8 CCS includes a number of specialised services such as Cancer Services, Diagnostic Services including imaging, Laboratory Services and Acute Allied Health Professionals (AHP)

4.9 IMWH includes gynaecology, colposcopy, fertility, genito-urinary medicine (GUM) and urodynamics services, as well as all maternity services such as antenatal care, delivery and postnatal care

a) Responsible for monitoring the day-to-day operational functions associated with performance via management of primary target lists (PTLs) and waiting list management processes.
b) Supporting the Heads of Service (HOS) and Assistant Director (AD) in the operational performance and delivery of targets within the Division

c) I had responsibility for the A&C staff within the CCS Division, who reported directly to the SAs. The SAs reported directly to myself.

d) During this tenure I reported to the Assistant Director (AD) for CCS & IMWH, firstly Heather Trouton (April 2016 to May 2018 and then Barry Conway June 2018 to date).

Please see:

2. 200608 Q4 JD Operational Support Lead – Acute Services

5. **Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.**

5.1 The systems within Acute Services Directorate fall under four broad areas of responsibility – Performance, Governance, Human Resources and Finance and this system is followed down through the management structure from the Director of Acute Services, to Assistant Directors, Heads of Service, Operational Support Leads and Departmental Leads. I follow the same approach in the management of my team.

5.2 Some of the key thinks covered by these systems are:

1. **Performance** - Monitoring of performance against Department of Health targets (activity and waiting times) for out-patients, in-patients, day cases, cancer targets and diagnostic services and exploring opportunities for non-recurrent funding bids in order to increase capacity within the service

2. **Governance** – Review of incidents, risk registers, complaints and compliments

3. **Human Resources** – Review of staffing levels, reporting on absence levels (sickness, vacancies, maternity leaves), review of mandatory training.

4. **Finance** – Review of monthly budgets, building Investment Proposal Templates (IPTs) and business cases, monitoring Waiting List Initiative claim forms

5.3 My line management in each role can be summarised as follows:

a. Temporary Project Manager - Urology ICATS Model – Band 6

16 October 2006 to 22 July 2007

i. In this role I reported to the Operational Performance Manager, Lesley Leeman in the Acute Operations Team.

ii. I had no staff management, departmental or service responsibility for the duration of this role.

iii. implementation of the Urology ICATS model.

iv. This role was a temporary project manager post for the implementation of the ICATS model into the Urology Service.

b. Operational Support Lead for Surgery & Elective Care (SEC) – Band 7 15 July 2007 to 31 March 2016

i. In this role I reported to the Assistant Director for SEC, Simon Gibson from 15 July 2007 to 30 September 2009 and then Heather Trouton from 1 October 2009 to 31 March 2016 and provided operational support to them and also to the Heads of Service within the Division

ii. The structure at inception of the SEC Division was Noleen O'Donnell, HOS for BSUR, GSUR, ENT and URO, Roberta Wilson, HOS for T&O, Louise Devlin, HOS for Out-Patients and OPHTH. This changed over time and at the point of the structural change in April 2016, the HOS roles were Martina Corrigan, HOS for ENT, Urology, OPHTH and out-patients, Amie

Nelson, HOS for BSUR, GSUR, Endoscopy and ORTHO, Trudy Reid, HOS for T&O.

iii. As OSL in SEC, the SAs reported directly to me, the SAs had direct line management responsibility for the A&C staff within the Division. At inception of the SEC Division there was one SA post, Jane Scott. The number of SA posts grew over time, and came and went, within the Division. Unfortunately, I am unsure of exact dates when this occurred, but at the point of the A&C structural change on 1 June 2013 there were six SAs in SEC and reporting arrangements thereafter were as follows:

1. Jane Scott – remained under the SEC as an Acute Performance Service Administrator and reported to me.

2. Maria Conway – remained under the SEC structure as an Acute Performance Service Administrator and reported to me until 16 October 2013 when Maria moved to the Trust Performance Team, reporting to Lynn Lappin, Head of Performance, at the request of the Director of Acute Services at the time (Deborah Burns). The funding for this post moved with Maria to the Trust Performance Team.

3. Sinead Corr – moved to Functional Support Services and reported to Helen Forde, Head of Health Records

4. Marie Loughran – moved to Functional Support Services and reported to Katherine Robinson, Head of Acute Booking and Secretarial Services.
5. Michelle McClelland – remained in SEC structure as an Acute Performance Service Administrator until she left the Trust on 10

November 2013. Her post was not replaced as this was an unfunded position.

6. Lauri Rafferty moved to Functional Support Services and reported to Katherine Robinson, Head of Acute Booking and Secretarial Services.

5.4 The SA staffing complement has been referenced in the attached report which was prepared by Sarah Meenagh, Workforce Information Officer at 31 March 2013. At the time of the Divisional structural change in April 2016, this had returned to one SA, Jane Scott.

Please see:
3. 20130331 Q5 List of B5 A&C Staff Within SEC Division

c. Operational Support Lead for Cancer & Clinical Services (CCS) and Integrated Maternity & Women's Health (IMWH) – Band 7
1 April 2016 to present

i. In this role I reported to the Assistant Director for IMWH & CCS, Heather Trouton 1 April 2016 to 31 May 2018 and then to Barry Conway from 1 June 2018 until present.

ii. There has been two Divisional structural changes during that time, firstly when Heather Trouton was initially released to take up her role as Interim Executive Director of Nursing and Allied Health Professionals on a part-time role from 1 February 2018 to 31 May 2018 when I worked with both Heather Trouton and Barry Conway as Assistant Directors (ADs) in the Division. Secondly, there was a further structural change when the AD for IMWH and CCS role was split on 1 June 2021 as the Division was regarded as being too large by the then Director, Melanie McClements. This then

became two separate Divisions but I have continued to provide OSL support to both ADs – Barry Conway for CCS and initially Wendy Clarke as Acting AD for IMWH and subsequently Caroline Keown when she commenced the substantive post on 25 October 2021.

iii. I provide operational support to the AD and HOS within CCS Division – Barry Conway (AD), Clair Quin, HOS for Cancer Services (Interim), Denise Newell, HOS for Diagnostic Services, Geoff Kennedy, HOS for Laboratory Services and Caroline Breen, HOS for Acute Alllied Health Professional Staff (Interim)

iv. I provide operational support to the AD and HOS within IMWH Division – Caroline Keown (AD), Wendy Clarke, HOS for IMWH

v. As OSL in CCS, I have one Band 6 Cancer MDT Administrator (Angela Muldrew) and three Band 5 SAs reporting to me (Sinead Lee, Gillian Reaney, Linda McAlister). The Cancer MDT Administrator and Service Administrators have direct line management responsibility for the staff within their teams.

6. **If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.**

6.1 In both my OSL roles, I would attend the weekly Head of Service Meetings chaired by the ADs. These meetings followed 4 broad areas – performance, human resources, governance and finance - with each week rotating through a different area.

6.2 With respect to managing staff, in both my OSL posts I have had a number of SA roles reporting directly to me with a number of A&C staff reporting directly to them. I would

have provided updates to the ADs and HOS regarding A&C staffing levels, A&C service pressures and challenges, reported on absence levels whether that be vacancies, sickness, maternity leave as well as updates on mandatory training.

6.3 The AD uses the HOS meetings to update the HOS and I regarding key operational issues at the time, eg, updates from the AD Huddles and feedback from Acute Senior Management Team Meetings.

6.4 As OSL, I would have regular contact with the staff in the team, particularly the SAs who report directly to me, examples of how I carry out this role are listed below:

6.5 I hold weekly **Service Administrator Meetings** where I provide feedback to the SAs from the Head of Service Meetings, following the same topic areas of discussion from that meeting. There are no formal minutes/notes taken at these meetings.

6.6 I have regular **1:1s** with the SAs who report directly to me. These meetings are used to review any concerns, workforce issues and operational issues. There are no formal minutes/notes taken at these meetings.

6.7 Outside of the 1:1s I would have **informal daily conversations**, with the SAs as required, whether that be face to face or by telephone. The SAs are aware that they can contact me at any time if they have an issue or query that they need resolved before our next 1:1.

6.8 I operate an **open-door policy** and the SAs are aware they can call in with me should they need to for advice or discussion around a particular issue.

6.9 I would carry out yearly Knowledge and Skills Framework/Personal Development Planning (**KSF/PDP) appraisals** for those staff who report directly to me, although these have been deferred due to operational and COVID pressures.

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7. **What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?**

7.1 In both my OSL tenures, there were a number of systems in place to ensure appropriate standards were met. These are broken down in the four main areas which are as follow:

a) **Performance** - My main role was to monitor performance against the Department of Health access standards. This included Service Baseline Agreements (SBA) which is the agreed commissioned level of service by specialty area by the Trust and the Health & Social Care Board (HSCB) now known as the Strategic Performance Planning Group (SPPG), trajectories for performance and achievement against waiting times, service delivery plans, bids for additionality (non-recurrent in-year funding), review backlog performance. SBA refers to the agreed commissioned level of service between the Trust and HSCB I produced a monthly performance report which was shared with the ADs and HOS and this report would have monitored all aspects of performance. These reports would have been discussed at HOS performance meetings when we looked for trends, challenges and opportunities for improvement.

7.2 Examples of performance information in relation to SBA, trajectories and achievement against waiting times which were sent to the AD and HOS for SEC are referenced below:

4. 20131218 Q7 Email regarding performance meeting notes and update
5a. – 5c. 20131216 Q7 SEC Performance Update, Sheet 1-3
6. 20131218 Q7 Performance Notes
7. 20150914 Q7 Email regarding SEC performance update with Sept modelling
8a. – 8c. 20150914 Q7 SEC Performance Update with Sept modelling, Sheet 1-3

9. 20160104 Q7 Email regarding performance update

10a. – 10c. 20160104 Q7 SEC Performance Update, Sheet 1-3

7.3 An example of the information sent in relation to additionality (non-recurrent spend) known as In-House Additionality (IHA) and Independent Sector (IS) spend is referenced below:

11. 20131118 Q7 Email regarding September IHA and IS Spend 2022

12a. – 12f. 201309 Q7 IHA and IS Spend for SEC for the month of September 2013, Sheet 1-6

7.4 I also would have produced bespoke performance reports outside of the regular weekly departmental performance reports as required in order to drill down into specialty specific areas to better understand lengthening waiting times, referral trends and consultant activity levels. These requests were normally at the request of the HOS for Urology (Martina Corrigan during my tenure) or the AD for SEC (Simon Gibson until 30 September 2009 and then Heather Trouton until the change in Divisions in April 2016) who then would have used this data to engage with the clinical team, have an informed discussion and agree any potential course of action. Examples of these reports have been referenced in my response to Question 18 and would be representative of the reports I produced throughout my tenure as OSL for SEC.

7.5 On occasion, I would have had requests from the clinical team for information reports around performance and they would have used this information to support discussion at both local level meetings, e.g., Departmental Meetings where all members of the urology clinical team were present, as well as external meetings including meetings with representatives of the Health & Social Care Board (HSCB) to commissioning levels, workforce levels and business cases for the urology service and workforce. These requests could have been made by the consultant(s) themselves calling in with me when they were up on the floor to see the HOS (Martina Corrigan) as her office was in very close proximity

to mine, or they could have come to me via the HOS after being discussed by the consultant(s) at a Urology Departmental Meeting.

7.6 The bespoke reports, whether requested by the senior management or clinical team would all have been performance or activity related, eg, volumes of patients on waiting lists, volumes patients seen. These reports did not focus on the clinical information recorded at out-patient visits or triage outcomes. It would be difficult to extract all of the bespoke reports over my tenure as OSL for SEC as there would have been multiple requests from all specialties, including urology, but the examples below are representative of the type of performance reports I produced in relation to urology specifically. Please see:

13. 20151127 Q7 Email to TG re DHH urology Type Referrals
14. 20151125 Q7 Email to MC re Urology Urgent NOP Waits
15. 20151117 Q7 Urology Out-Patient Dashboard
16. 20151117 Q7 Urology Triaging Outcomes – Mr Haynes 15-21.10.15
17a. – 17c 20151117 Q7 Urology Out-Patient Comparison June 14 vs June 15, Sheet 1-3
18. 20151117 Q7 Email to MH re Information for Meeting with HSCB
19. 20151130 Q7 Email from MC data to be presented at meeting
20. 20151222 Q7 Email regarding urology OP and Elective activity and WL analysis
21a. – 21d. 20151210 Q7 Urology Waiting List Analysis – Planned and Elective, Sheet 1-4
22a. – 22g 20151210 Q7 Urology OP Demand vs Activity, Sheet 1-7

7.7 In relation to cancer pathway performance, I support the AD and the HOS for Cancer in the monitoring of cancer performance against the Integrated Elective Access Protocol (IEAP) standards which are set by the Department of Health and apply to all tumour sites including urology. These cancer access targets are as follows:

a) 14 day target (Breast) – 100% for the 2 week wait for first breast symptomatic appointment

b) 31 day target – 98% from date decision to treat until first definitive treatment

c) 62 day target – 95% from date of receipt of GP referral until first definitive treatment.

7.8 There is a Cancer Pathway Escalation Policy in place and the cancer trackers would track red flag referrals, including urology, from receipt of referral to first definitive treatment, escalating delays in the pathway to the Cancer Services Co-Ordinator (Vicki Graham was in post at the commencement of my tenure as OSL for CCS until 9 August 2020, followed temporarily by Sinead Lee until 25 October 2020, followed temporarily by Ciaran McCann until 31 March 2021 and currently Sinead Lee from 1 April 2021) who would onward escalate to the Operational HOS, including the HOS for urology (Martina Corrigan until October 2020 and currently Wendy Clayton). The Cancer Pathway Escalation Policy and examples of escalation are referenced below:

23. 201908 Q7 Cancer Pathway Escalation Policy
24. 20181218 Q7 Email Urology Escalation
25. 20190919 Q7 Email Urology Escalation
26. 20220126 Q7 Email Urology Escalation
27. 20220704 Q7 Email Urology Escalation

7.9 **Human Resources** – I undertook Knowledge and Skills Framework/Personal Development Planning (KSF/PDP) appraisals with my SAs, reviewing mandatory training levels. I would have dealt with disciplinary matters and grievances in line with Human Resources guidelines. I was responsible for the workforce allocations within my Divisions and specialties for the A&C staff who reported to me. This would have included bids for staffing required either for growth in service or new improvements to service. I would have given monthly updates on the staffing levels at Heads of Service meeting, discussing levels of any absence including sickness and maternity leave and the impact this could have to the service. During my tenure as OSL for SEC (July 2007 – April 2016), I had

responsibility for the A&C staff within the Division until June 2013 when line management responsibility for of some of the A&C staff within the Division moved at the request of the Director of Acute Services at the time (Deborah Burns) to the Functional Services Division structure managed by Anita Carroll, AD. This change was introduced with the aim of releasing time in the OSL role to focus more on performance. At that time the secretarial and audio-typing staff in SEC moved to Katherine Robinson, Head of Acute Booking and Secretarial Services and the ward clerk staff moved to Helen Forde, Head of Health Records. However, before this change, I would have raised any concerns in relation to workforce issues, eg, to the HOS for the specialty area (Martina Corrigan for ENT, URO, OPTH and OP, Amie Nelson for BSUR, GSUR, Endo, Trudy Reid for T&O) as well as the AD (Simon Gibson until 30 September 2009, then Heather Trouton until March 2016 when the Divisions changed). These issues would on the whole have been discussed face to face and dealt with at the time due to close proximity of my office to the HOS and AD offices on the Administration Floor and there were no notes taken of these discussions or concerns.

7.10 **Governance** – In both my OSL tenures, I would have been involved in the reviewing of clinical incidents which included investigation, completion and reviewing of datix for those incidents within my remit. Within my role I participated in the panel of Serious Adverse Incidents as required. I also contributed to the review and updating of the risk registers, in particular with reference to performance: for corporate, acute and divisional risk registers.

7.11 **Finance** – In both OSL tenures I had/have responsibility for the A&C budget within all my specialty areas. I would attend the Head of Service finance meetings and give regular updates on the budget position. I would also have met and meet with my finance manager (Dean Faloon, Orla McConville) for the division to review budget allocation.

7.12 All of the above systems were in place to ensure that I maintained appropriate standards in fulfilling my role as OSL. I would have discussed any concerns or issues in

relation to my role with my ADs in both tenures and had regular ad hoc meetings with them as required. Typically, the OSL role works very closely with AD and there is daily contact with the AD either face to face or by telephone. Any queries would have been raised during these daily conversations if required.

7.13 In both OSL tenures I also attended the weekly HOS meetings where I would have had the opportunity to raise any issues in relation to performance, eg, waiting times, activity levels, In-House Additionality (IHA) volumes or staffing related pressures for consideration of support and approval of additional resource when necessary.

7.14 As the OSL in both tenures, I attended all the weekly HOS meetings with the AD and all HOS present and would have used this as an opportunity to raise any A&C workforce, budget, or operational performance issues to them and this was also a forum for the AD and HOS to raise any issues with me. The HOS meetings followed the 4 broad areas of operational management being performance, governance, human resources and finance, with each HOS weekly meeting rotating through these areas.

8. **Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.**

8.1 Yes, all my tenures as OSL should have been subject to performance review known as KSF/PDP. My AD would have completed these reviews and I would have completed performance reviews for my Line Managers

8.2 The last KSF/PDP I had was on 25 June 2018 when I was OSL in SEC, carried out by Heather Trouton, AD at the time. However, due to operational and COVID pressures I have not had a performance review undertaken since that time, but have a date for this to be completed on 9 November 2022 with Barry Conway, AD for CCS. Please see:

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28. 20180625 Q8 Sharon Glenny PDP Review

9. **Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?**

9.1 I am aware of the SHSCT Performance and Personal Development Review Policy attached for reference:

29. 20210722 Q9 Performance and Personal Development Review Policy

9.2 Although I have not completed a formal KSF/PDP, I work towards completing all mandatory training within the required timescales.

9.3 I also work closely with the AD and all HOS on a weekly basis, particularly at the weekly HOS meeting, to identify priority areas for work and set timescales for completion of work. This workload is monitored at the weekly HOS in terms of progress and completion of timescales as part of the action update at the next meeting.

9.4 As the OSL role for all Divisions is largely focused on operational performance linked to objectives and guidelines set out in the IEAP on how targets are to be monitored, I would receive any changes to monitoring arrangements which are set by HSCB/SPPG down through the Acute Performance Team and then across to the Acute Directorate to me.

9.5 I am made aware of any updates of HR policy and relevant guidance by global circulations and/or discussion at Head of Service meetings.

10. **What performance indicators, if any, are used to measure performance for your role?**

10.1 For both of my OSL tenures there have been a number of performance indictors to measure performance within my role. While it was the Divisional responsibility to monitor performance for their specialty areas, it was the Trust's Performance Team's responsibility to monitor the Trust's performance. The main point of contact for Acute Services was and remains Lynn Lappin, Head of Performance for the Trust from 2011 (Lesley Leeman, Head of Performance 2007 – 2011).

10.2 Performance objectives for the delivery of out-patient, elective, diagnostic and cancer services are set by the Minister of Health and outlined in the Integrated Elective Access Protocol (IEAP) which was implemented in April 2008. These Department of Health targets have not changed since 2008, however, the monitoring arrangements of the targets has changed and varied over time. Initially the OSLs in the Division, in conjunction with the Trust's Acute Performance Team, monitored performance against the commissioned level of clinical activity as agreed by HSCB (now Strategic Performance Planning Group 'SPPG') against the actual out-turn of activity, known as Service Baseline Agreement (SBA). SBA was the monitoring arrangement between 2013/2014 fiscal year until March 2017 when this changed to trajectory monitoring of services. Since the covid pandemic, the Trust are now being monitored against rebuild plans.

10.3 The IEAP departmental waiting time targets are summarised below and are monitored by the Trust's Performance Team and also by the OSLs for each specialty.

a. Outpatients 9 weeks from receipt of first referral appointment;
b. Elective inpatient/day cases 13 weeks from date a patient is added to the waiting list;
c. Cancer targets:
    i. 14 days – 100% for the 2 week wait breast symptomatic outpatient appointment;
    ii. 31 days – 98% from date decision to treat to first definitive treatment;

iii. 62 days – 95% date of receipt of referral to first definitive treatment.

d. All referrals will be prioritised within a maximum of three working days of date;

e. Red flag referrals require daily triage.

f. Diagnostic 9 week wait from receipt of referral.

10.4 At the point of handing over my OSL for SEC tenure to Wendy Clayton in April 2016 the waiting times for the urology specialty in particular were:

a) 74 weeks for an out-patient appointment

b) 120 weeks for an in-patient/day case elective procedure

10.5 Martina Corrigan remained the Head of Service for Urology at that time and the AD changed from Heather Trouton to Ronan Carroll. The attached documents detail the expected year end summary position for all specialties within SEC, including urology, please note that I had started to copy Wendy Clayton and Ronan Carroll into these emails in preparation for the handover of service. Please see:

30. 20160225 Q10 Email regarding SEC SBA Year End Summary

31. 20160225 Q10 SBA Year End Summary Projections

32. 20160307 Q10 Email regarding performance update

33. 20160307 Q10 SEC Performance Update

10.6 With reference to urology, out-patient referrals to the service over a number of years have been much greater than the number that the service was commissioned to deliver, leading to a demand and capacity gap as demonstrated in the table below:

Fiscal Year	Yearly Commissioned Urology New Out-Patient Activity	Total Urology New Out-Patient Referrals Received	Gap
2016/17	5121	3588	-1533
2017/18	5965	3588	-2377
2018/19	6427	3588	-2839
2019/20	6136	3588	-2548
2020/21	4484	3588	-896
2021/22	4824	3588	-1236

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10.7 This has had an impact on the waiting times for first appointment and the number of patients waiting beyond IEAP targets. Issues around capacity challenges, including urology capacity challenges, are discussed at monthly HOS performance meetings with the AD present. Notes of the HOS meetings were taken by the Admin Support and have been submitted for evidence in the original evidence gathering exercise. These issues are also discussed at the monthly Acute SMT Performance Meeting when performance risks are presented by the Head of Performance, Lynn Lappin, to the Director of Acute Services (Joy Youart, Gillian Rankin, Deborah Burns, Esther Gishkori, Melanie McClements and now Trudy Reid).

10.8 The table below, which is populated by the Trust Performance Team, demonstrates the volumes of patients on urology waiting lists and the longest waiting patient at each year end from 2013/14 onwards. Unfortunately, the Trust Performance Team only started collecting this information, which is a point in time position on waiting lists, for the year ending 2013/14.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	@ June 2022/23
Outpatent Waiting List	1184	1782	2714	2562	2988	3754	4041	4819	4616	3982
Longest Wait	61 Weeks	46 Weeks	74 Weeks	76 Weeks	114 Weeks	167 Weeks	217 Weeks	269 Weeks	321 Weeks	334 Weeks
Inpatient Waiting List	409	413	505	623	803	899	1014	1073	1047	1014
Longest Wait	72 Weeks	96 Weeks	201 Weeks	165 Weeks	217 Weeks	269 Weeks	295 Weeks	347 Weeks	399 Weeks	412 Weeks
DayCase Waiting List	640	435	465	872	954	838	686	990	1039	1105
Longest Wait	64 Weeks	84 Weeks	116 Weeks	161 Weeks	204 Weeks	257 Weeks	309 Weeks	361 Weeks	398 Weeks	411 Weeks
Review Backlog	Not Available	Not Available	2021	1636	2234	2716	2832	2295	1368	1361
Longest Wait			Jan-13	Aug-13	Sep-14	Apr-15	Apr-15	May-15	Jul-13	Jul-13

10.9 As OSL for CCS, I would have responsibility for the monitoring of performance against the cancer access standards as set out above and providing the Operational ADs and HOS information regarding performance so that they can discuss the operational challenges with their respective clinical teams. The tables below summarise the fiscal year end position for the urology tumour site compared with the Trust overall cancer performance against the 31 and 62 day cancer performance targets during my tenure as OSL for CCS (1 April 2016 to date).

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62 Day Cancer Performance Target = 95% (Red denotes breach of target)		
Fiscal Year	Trust	Urology
2016/2017	83.93%	81.91%
2017/2018	74.29%	58.43%
2018/2019	74.33%	54.41%
2019/2020	65.92%	41.59%
2020/2021	60.75%	32.10%
2021/2022	49.75%	27.13%

31 Day Cancer Performance Target = 98% (Red denotes breach of target)		
Fiscal Year	Trust	Urology
2016/2017	99.00%	100.00%
2017/2018	97.14%	99.70%
2018/2019	99.50%	99.41%
2019/2020	98.17%	98.93%
2020/2021	92.42%	94.65%
2021/2022	85.67%	97.81%

10.10 Up until 4th January 2022, the Cancer Services Co-Ordinator was responsible for escalating all delays on the cancer pathway including first red flag appointments, delays with diagnostics, delays with first definitive treatment. When I came into post on 1st April 2016 the Cancer Services Co-Ordinator was Vicki Graham (to 9th August 2020), Sinead Lee (10th August 2020 to 25th October 2020 (temp)), Ciaran McCann (26th October 2020 to 31st March 2021 (temp)) and Sinead Lee (1st April 2021 to date). These escalations were sent to the Operational HOS who was charged with directing steps to address the concerns. However, it is recognised that at times minimal action could be taken due to ongoing capacity and demand difficulties within specific tumour sites, including urology With reference to Urology, there have been capacity and demand difficulties across the whole cancer pathway throughout my tenure as OSL for CCS, including delays with first appointment, delays with diagnostics i.e MRI, PET scan (Regional service provided in Belfast) and flexible cystoscopy, Transperineal (TP) biopsy, and delays with surgery. The actions that have been taken by HOS, including urology, around escalations of patients on cancer pathways include:

a) Increasing red flag out-patient capacity on clinic templates
b) Offering in-house additionality to increase overall out-patient capacity
c) Working with other Trusts to equalise waiting times, in particular for transperineal biopsy
d) Securing Independent Sector capacity in relation to out-patient capacity and flexible cystoscopy

10.11 Once all these options have been explored and optimised, there is usually little else the HOS is able to do to take corrective action to improve a patient's journey on the cancer pathway. All these options have already been utilised within the urology service and unfortunately there are still ongoing capacity and demand challenges.

10.12 Since 4th January 2022, there has been a change in the structure within CCS following the appointment of the Cancer MDT Administrator, Angela Muldrew. She now escalates delays with the cancer pathway outside of first appointment for all tumour sites, including urology. Sinead Lee continues to escalate delays with first appointment.

10.13 While there is a Cancer Pathway Escalation Policy in place, the Trust is currently unable to escalate fully for all tumour sites due to the large volume of patients being tracked on tumour site pathways. Unfortunately, a significant number of patients will breach the cancer target, due to specialty demand and capacity challenges. We are currently operating a modified version of escalation, with batch escalations to the Operational HOS rather than singular patient escalation. This temporary modification to the Escalation Policy has been escalated internally within the Trust to the Senior Management Team and also externally to Strategic Performance Planning Group (SPPG), formally known as Health & Social Care Board (HSCB), at the Trust Regional Cancer Performance Meetings, as referenced in the attached SPPG Action Issues Register from the meeting held on 25 May 2022. This was again raised at our most recent meeting with SPPG on 21 September 2022 (action notes from that meeting have not yet been made available to the Trust). Please see:

34. 20220525 Q10 SPPG Actions Issues Register Southern Trust Cancer Performance Meeting

10.14 Prior to COVID, we held monthly **Cancer Performance Meetings** which were attended by Operational Assistant Directors, Heads of Service and OSLs as well as the

Trust performance team, either Lynn Lappin or Lesley Leeman. The purpose of the meetings was to provide information regarding performance for each tumour site against the cancer access standards in, particular looking at areas of capacity difficulties, operational issues, trends for red flag referrals into the service and discussion around what actions, if any, the operational team could take to meet the demand. The attachments below are examples of monthly cancer performance meeting minutes and cancer performance dashboard. Please see:

35. 20180920 Cancer Performance Minutes
36. 20190321 Cancer Performance Minutes
37. 201809 Cancer Performance Dashboard
38. 201903 Cancer Performance Dashboard

10.15 During COVID, the cancer performance meeting was replaced with the **Cancer Checkpoint Meetings** which were still attended by the Operational ADS, HOS and OSLs, but were also attended by the clinical leads for each tumour site to collaboratively work together to work through the operational challenges and issues linked to the COVID pandemic. These meetings were stood down in May 2022 and the monthly Cancer Performance Meeting resumed. Please see:

39. 20210730 Q10 Cancer Checkpoint Meeting Notes
40. 20210730 Q10 Cancer Rebuild Plan Update
41. 20210730 Q10 New GP Red Flag Referrals Report
42. 20210730 Q10 New GP Red Flag Longest Waiters Report
43. 20210730 Q10 Longest Waiters by Tumour Site Report

10.16 The attachments below are documents discussed at the most recent Cancer Performance Meeting held on 15 September 2022. Please see:

44. 20220915 Q10 Cancer Performance Meeting Agenda

45. 20220915 Q10 August Cancer Performance Report

46. 20220915 Q10 Cancer Performance Meeting Action Log

11. **How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?**

11.1 As stated in questions 7 and 10, it is the OSL's responsibility to monitor performance. There are a number of systems in place to ensure these standards are being met which includes:

a) Monitoring of performance against expected levels of activity – Service and Budget Agreement (SBA) (agreed commissioned level of service by specialty area by the Trust and the Health & Social Care Board (HSCB) now known as the Strategic Performance Planning Group (SPPG), trajectories, Service Delivery Plans (SDP) which replaced SBA and rebuild plans

b) In relation to the monitoring of triage, in June 2012 I had developed an SDP monitoring report and circulated this out to the HOS for feedback. At that time the feedback from the HOS, including Martina Corrigan as HOS for urology, was that the report Katherine Robinson, Head of Acute Booking and Secretarial Services, provided gave the HOS sufficient information in relation to triage waits and urgent waits and there was no requirement on my part for any further performance reports to look at this speicifically. I have attached the email for reference as well as the SDP report. Please see:

47. 20120608 Q11 Email from MC re SDP update and KR reports

48. 20120608 Q11 SDP Update

c) Monitoring of performance against non-recurrent allocations of in-house additionality (IHA) and Independent Sector (IS) funding

d) Cancer Tracking team in place to monitor the patients along the cancer pathway, escalating any risks to achieving this target

e) Review of cancer performance dashboards at the monthly HOS meetings and Cancer performance meetings; outlining achieved 31 and 62 day targets and discussion of operational challenges

f) I also attend the monthly Acute SMT Performance and bi-monthly Regional SPPG Trust Cancer Performance Meetings where I present the monthly cancer performance in detail outlining achieved targets and risks. Lynn Lappin, Head of Performance for the Trust also attends these meetings

11.2 In addition to the performance role, as OSL I would also have budgetary responsibility for the A&C team within the Division and would discuss this at the HOS meetings, as well as meetings with my contact in Finance (Dean Faloon during my tenure with SEC and Orla McConville for my current tenure in CCS). I would also provide regular updates at the HOS meetings in relation to human resource issues, including: staff absence such as sickness absence and maternity leave; KSF/PDP compliance, and; recruitment updates.

12. **Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.**

12.1 I do not have experience of these systems being by-passed. It is recognised that the Operational role is challenging which often results in crisis management when an issue arises. This on occasions may lead to HOS being unable to respond immediately to

escalations as they are dealing with operational pressures which would have taken priority over emails, e.g., if a member of the clinical team was off sick and clinical sessions needed to be covered/re-arranged

12.2 For Urology services, the Cancer Services Co-Ordinator (Vicki Graham, then Ciaran McCann now Sinead Lee) escalated delays with red flag triage and had also been escalating delays with cancer pathways until the Cancer MDT Administrator (Angela Muldrew) came into post in January 2022 now Cancer MDT Administrator (Angela Muldrew) from January to the relevant operational HOS. It was the HOS who was charged with directing steps to address the concerns. As OSL for CCS, I would not always be copied into escalations and therefore would not always be copied into responses from HOS. However, if no corrective action was taken, the same patients would have been escalated in the next round of tracking as described above.

12.3 As outlined in question 10, we are undertaking a modified approach to the Cancer Escalation Policy currently within the Trust and it would be my understanding from the Regional Cancer Operational Meetings as well as from discussions at the SPPG Trust Cancer Performance Meeting that all other Trusts in the Region are taking a similar approach. This is due to the large number of patients on cancer pathways and the fact that the majority are unable to achieve the 62 day target currently following the impact of the COVID pandemic, increase in demand and the reduction of capacity.

13. **What systems of governance do you use in fulfilling your role?**

13.1 In both my OSL tenures, I would have had a governance supporting role to the ADs in relation to the monitoring of performance targets, identifying waiting time risks and highlighting trends and themes for shared learning.

13.2 The systems which I would have used in fulfilling this role would have included:

a. Escalation of delays in triage, including red flag triage, examples in the referenced documents below. While it was my role as OSL to escalate these concerns ensuring there was awareness of the concerns up the managerial chain, it was the HOS who was charged with directing steps to address these concerns. Please see:

49. 20131008 Q13 Email regarding outstanding triage for urology
50. 20131125 Q13 Email regarding untriaged referrals to Martina Corrigan
51. 20131126 Q13 Email regarding delays in triage needing urgent response from Mr O'Brien
52. 20131219 Q13 Email regarding untriaged referrals to Martina Corrigan
53. 20131219 Q13 List of untriaged urology patients
54. 20150914 Q13 Email to the urology consultants re urology triage
55. 20151127 Q13 Email regarding urology untriaged referral letters to Martina Corrigan
56a. – 56b. 20151127 Q13 Report of urology untriaged referral letters, Sheet 1-2

b. Escalation of patients who are delayed across the cancer pathways. While it was my role as OSL to escalate these concerns, it was the HOS for urology to action with the support of the AD as appropriate. Please see:

57. 20220909 Q13 Email regarding urology escalations

c. Updates to the risk register in relation to performance issues. Previously as OSL for SEC this would have been in relation to waiting list backlogs for out-patient, in-patient and day cases as well as planned and review backlogs. As OSL for CCS this would be in relation to the cancer access targets. In maintaining the risk registers, this would have involved the logging of new

risks, the review of existing risks and updating actions undertaken to mitigate risk.

d. Supporting the response to complaints, MLA queries and Freedom of Information (FOI) requests, in particular in relation to access times for out-patients, surgery and cancer waits

e. Supporting the review of datix/incidents and where necessary undertaking investigation. An example of a datix incident raised where I have been involved in the investigation has been referenced below:

i. Delay with typing of red flag referral from one specialty to another which resulted in a delay in first red flag appointment. Please see: *58. 20221012 Q13 Datix Incident Delay with typing RF Referral*

ii. Administrative error in the processing of a red flag referral. Please see: *59. 20220919 Q13 Datix Incident – Administrative error in processing of a red flag referral*

f. Regular updates to the AD and also updates at the HOS meetings in relation to the recruitment and retention of staff, management of sickness absence, KSF/PDP appraisal achievement, disciplinary and grievance matters. I would also have made cases to the AD regarding workforce pressures and the requirement for temporary 'at risk' posts when necessary. An "at risk post" is one where there is no identified funding stream, but deemed necessary to meet the service demands and pressures.

g. Regular meetings with the Division's finance manager (Dean Faloon for SEC tenure and Orla McConville for CCS tenure) to discuss budgetary matters. I

would also have provided updates in relation to finance matters directly to the AD and also to HOS meetings.

14. **Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.**

14.1 During my tenures the only quality improvement initiative I can recall is the Urology Pathway New Referral Process Mapping exercise which was undertaken in January 2022 and led by the QI team. Please see:

60. 20220126 Q14 Urology Pathway Process QI FINAL

14.2 More recently, I have been a member a Task and Finish Group which was established in August 2021 to implement recommendations as outlined in the Dermot Hughes report. The Terms of Reference for this group, including membership are attached for reference. Please see:

61. 20211011 Q38 TOR Trust Task and Finish Group into Urology SAI Recommendations

15. **During your tenure, who did you understand was responsible for overseeing the quality of services in urology?**

15.1 During both my OSL tenures, it is my understanding that operational responsibility for the quality of services in urology lay with the operational HOS (Martina Corrigan until October 2020 and then Wendy Clayton) and the AD (Simon Gibson July 2007 to September 2009, Heather Trouton October 2009 to March 2016 and then Ronan Carroll April 2016 to date). The clinical responsibility for urology services lies with the Clinical Lead (Michael Young throughout my tenures), Clinical Director (Robin Brown Mid 2011 to January 2014, Sam Hall January 2014 to March 2015, Colin Weir June 2016 to

December 2018, Ted McNaboe December 2018 to December 2021 – the post is currently vacant from that time) and Associate Medical Director/Divisional Medical Director (Eamon Mackle January 2008 to April 2016, Charlie McAllister April 2016 to October 2016), Mark Haynes October 2017 to January 2022 and currently Ted McNaboe from January 2022) In managing the service, it would be my understanding that the operational managers, AD and HOS, would work closely and collectively with the clinical managers, Clinical Director (CD) and Associate Medical Director (AMD) now known as Divisional Medical Director (DMD)

16. **In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?**

16.1 As outlined in my response to Question 15, the AD and HOS would work closely with the CD and AMD/DMD to oversee the clinical governance arrangements for urology. Consultants are managed through the medical structure, with the consultant team reporting through to the Medical Director via AMD/DMD.

17. **Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?**

17.1 I believe I fulfilled my OSL roles in relation to urology services, even though targets were not met and waiting times grew. There was a known capacity and demand gap, but this gap was not related to me in my role as OSL. It did have an impact on patient care in that the excess demand resulted in patients waiting longer for out-patient and in-patient/day case surgery. I would have had regular discussions with the HOS for urology (Martina Corrigan until October 2020 and then Wendy Clayton) and the AD (as OSL for SEC - Simon Gibson then Heather Trouton; as OSL for CCS Heather Trouton then Barry

Conway) regarding the performance of the urology service, it was the HOS responsibility to take any corrective action that was within their power to do.

18. **Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.**

18.1 Yes, I felt supported by staff within urology services during both my roles as OSL in SEC and CCS. I was always able to call with the Urology Head of Service, Martina Corrigan and now Wendy Clayton with any queries or concerns as well as working closely with the ADs. I feel that both SEC and CCS Divisions need to work well together, and we always have done, for the management of patients on waiting lists and on cancer pathways.

18.2 During my role as OSL for SEC I worked closely with the Urology Consultants in relation to the monitoring waiting lists and scheduling of theatre sessions. I attended meetings with Martina Corrigan and the urologists where we would have sat down and scheduled long waiting patients on a monthly basis. These meetings were at times attended by Heather Trouton, AD for the purposes of scheduling long waiting patients to elective theatre sessions. I always found the urology team worked well together and were willing to share patients across the team to ensure patients received equity of access to surgical capacity.

18.3 The referenced documents below are examples of the communication I had with the urology team in relation to the management of patients on waiting lists and scheduling to elective sessions. Please see:

62. 20131014 Q18 Email regarding urology review backlog plan
63. 20131124 Q18 Email to Martina Corrigan red flag GA cystoscopy patients
64. 20131216 Q18 Email to urology team regarding scheduling plan
65a. – 65b. 20131216 Q18 Urology 44 week PTL report, Sheet 1-2

66a. – 66b. 20131216 Q18 Urology 50 week PTL report, Sheet 1-2

67. 20131219 Q18 Email to urology team regarding planned waiting list

68. 20131219 Q18 Urology planned waiting list

69. 20131230 Q18 Email to Mr O'Brien regarding urodynamics waiting list

70. 20131230 Q18 Urodynamics 52 week PTL report

71. 20131230 Q18 Email to urology team regarding elective 50 week PTL

72. 20131230 Q18 Urology elective 50 week PTL report

73. 20131230 Q18 Email to Martina Corrigan and urology team regarding ICATS PTL

74. 20131230 Q18 Urology ICATS 22 week PTL report

75. 20150907 Q18 Email to urology team regarding elective waiting list

76. 20150907 Q18 Total urology waiting list report

77. 20160215 Q18 Email to urology team regarding waiting lists

78. 20160215 Q18 Urology planned waiting list report

79. 20160215 Q18 Total urology waiting list report

Urology services

19. **Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.**

19.1 As outlined in Questions 7, 10 and 13, my primary role and responsibility in relation to the operation and governance of urology services in both my OSL tenures was in relation to supporting the AD and HOS for the Division in the delivery of all aspects of operational performance. In particular, the monitoring of performance in relation to IEAP performance targets as well as the monitoring of SBA, trajectories, SDPs and monitoring of IHA/IS non-recurrent spend against allocation.

19.2 In relation to governance, as outlined in Q13, the main role I had in relation to urology for both tenures was the escalation of outstanding triage and escalation of patients on the 62 day pathway.

19.3 As OSL I would not have any role or responsibility in relation to the clinical aspects of urology service. However, I was aware of concerns about triage issues but these were not raised to me by the urologists or clerical staff. The Referral and Booking Centre, under the management of Katherine Robinson, Head of Acute Booking and Secretarial Services had a process in place to escalate delays in triage outcomes to the OSLs. My role as OSL in SEC was to ensure there was awareness of the concern up the managerial chain to the appropriate HOS and it was the HOS who was charged with directing steps to address these concerns. It was my understanding that the HOS (Martina Corrigan) would have discussed the concerns with the clinical team and/or consultant directly either face to face or by email, although I would not normally have been aware of the outcome of those discussions as that was not normally fed back to me. I would not have followed up on these discussions as that was outside of the scope of my role as OSL.

20. **With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.**

20.1 As OSL for SEC (April 2007 to March 2016):

a) I would have **liaised directly** with the HOS, Martina Corrigan and AD, Simon Gibson then Heather Trouton in relation to matters relating to urology. Those matters were primarily of a performance nature and would have been discussed at the following forums:

b) **HOS meetings** – these were weekly and rotated through the four areas of performance, governance, HR and finance. The agenda for those meetings would have been set by the AD who chaired the meeting and the admin support

would have taken notes from that meeting. In attendance were the AD (chair), HOS for all specialty areas, the OSL and the admin support. At times the meetings were also attended adhoc, depending on the topic of discussion, eg, representatives from the Trust Performance team.

c) I also attended the **Urology Rota Planning Meetings** which were held monthly, from memory this was the first Thursday in the month and they were chaired by the Lead Clinician (Michael Young during my tenure). These meetings were attended by the Lead Clinician, all Consultant Urologists, Registrars, HOS for urology (Martina Corrigan during my tenure), myself as OSL, the SA, and the secretarial staff. There were no formal notes taken at this meeting, however, the rota for the month ahead was agreed and issued thereafter.

20.2 As OSL for CCS (April 2016 to date):

a) I would have **liaised directly** with the HOS, Martina Corrigan until October 2020 and then Wendy Clayton and AD, Ronan Carroll in relation to matters of urology cancer performance. I also would have **direct discussions/correspondence** with the AD for CCS, Barry Conway and the HOS for Cancer, Fiona Reddick until February 2021 and since then Clair Quin in relation to urology cancer performance concerns.

b) There are **monthly cancer performance meetings** (replaced with Cancer Checkpoint during Covid) monthly where urology cancer performance is discussed along with all other tumour sites. These meetings are chaired by the AD for CCS (Barry Conway) and are attended by all Operational ADs, HOS and OSLs as well as the Trust Performance Team. The cancer dashboard is discussed in full and risks/concerns highlighted for action by the operational teams.

c) I also attend the **Acute SMT Performance Meeting** monthly which is chaired by the Director of Acute Services (Esther Gishkori, then Melanie McClements and now Trudy Reid) when the Trust's Performance Team attended and gave an overview of Acute performance which includes urology. These meetings are attended by all ADs and OSL – the HOS are not usually in attendance at these meetings unless covering for the AD.

d) There are **bi-monthly Cancer Performance Meetings with SPPG** (formerly known as HSCB). At this meeting cancer performance is reviewed for all tumour sites, including urology. These meetings are attended by SPPG representatives including the chair (Lisa McWilliams, Director of Stategic Performance) Trust Performance Team representatives (Lynn Lappin, Head of Performance and Lesley Leeman, Assistant Director Performance Improvement) Director of Acute Services (Esther Gishkori, then Melanie McClements and more recently Trudy Reid), Operational ADs, HOS and OSLs. There was a power point presentation prepared by SPPG in advance of the meeting, but no formal notes taken at the meeting.

21. **In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?**

21.1 As outlined in Q19, my role as OSL in both tenures is relevant to the operational monitoring of performance targets within urology services. My roles and responsibilities on a day-to-day basis are structured around the preparation of performance dashboards and reports, monitoring trends, highlighting risk and making bids for additional resource (non-recurrent funding) to reduce access times for patients.

21..2 As OSL, I had no role in the monitoring of untriaged referrals as the responsibility for this sat with Katherine Robinson (Head of Acute Booking and Secretarial Services)

and her team in the Referral & Booking Centre. If there were delays in triage, these were escalated to the OSL and/or HOS. My role was to ensure these escalations were brought to the appropriate operational HOS for action within the clinical team but I would not have routinely known what action was taken forward as this was not within my remit as OSL. The HOS (Martina Corrigan) would have, on occasion, verbally advised that she would be taking this forward with the clinical team or going to speak to one of the consultants directly about their outstanding triage.

21.3 Also as outlined in Q19, my role as OSL in both tenures is relevant to the governance of services within urology with respect to the supporting the update of the risk registers, supporting information gathering for responses to complaints and MLA queries as well as responding to datix/incidents relating to my areas.

21.4 My role would have no relevance to the clinical aspects of the urology service.

22. **What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?**

22.1 During my tenure as OSL in SEC, it would be my view that there was an apparent issue in relation to the triaging of referrals for urology within the recommended IEAP guideline as outlined Question 13. I regularly escalated these issues to Martina Corrigan, Head of Service for Urology, examples of which are evidenced in the response to Question 13. Following escalation, I would not have been aware of the outcome as it was not my role as OSL to action or address this escalation. It was the responsibility of the HOS (Martina Corrigan) to take forward any corrective action that was required with the clinical team. Due to the large volume of escalations and the remit within my OSL performance role for all specialties in both tenures, I followed the escalation process but did not check with the HOS to find out what action had actually been taken as that was the HOS responsibility.

22.3 During my tenure as OSL in CCS, it would be my view that there were difficulties for the urology specialty in meeting the cancer pathway targets due to the capacity and demand challenges. This was discussed at the monthly cancer performance meetings and a record of any issues and challenges recorded on the monthly cancer dashboard under the internal and external risk areas section. The urology cancer pathway in particular has experienced delays at almost every milestone in meeting the target, eg, delays with first appointment, delays with diagnostics, delays with surgery and these delays would have been noted at the cancer performance meetings. There was concern regarding the capacity and demand challenges within the urology cancer pathway and these would have been discussed at the Trust Cancer Performance Meetings with HSCB/SPPG, unfortunately there were no notes taken at these meetings. While the Trust raised concern about challenges along the urology cancer pathway, we were advised that the other Trusts were in a similar position.

22.4 I was aware from discussions at the HOS meetings during both my OSL tenures that there were consultant vacancy gaps within urology which have been ongoing for many years and so there were insufficient consultants to meet the demands of the urology service. It would be my view that this would have compounded the already challenging capacity and demand deficit with increased referrals to the service.

22.5 I would also have been aware of the capacity challenges due to the level of cancer escalations which were being sent to the Head of Service for Urology when I was copied into the email escalations. Examples of these would have been the waiting time for first red flag appointment, delay in transperineal biopsy, delay in diagnostic cystoscopy and delay in surgical treatment.

22.6 From discussion at the monthly cancer performance meetings and also at the cancer performance SPPG meetings, I was also aware that there were Regional consultant gaps in radiology and oncology specialties which resulted in inability to achieve the required quoracy attendance at Urology MDT Meetings, particularly in relation to representation

from radiology and oncology consultants. It would be my view that these gaps would have resulted in patients being deferred from MDT discussion, thereby making the MDT discussion ineffective. Examples of patients between deferred from MDT discussion are highlighted in the attached MDM Update Reports from 17 February 2022 and 16 June 2022. Please see:

80. 20220217 Q22 Update Report from Urology MDM
81. 20220616 Q22 Update Report from Urology MDM

22.7 In my role as OSL for CCS, the cancer tracking team report to me via the Cancer Services Co-Ordinator, and more recently via the Cancer MDT Administrator. It has been my view over a number of years that the cancer tracking team were inadequately staffed and inadequately funded by HSCB/SPPG to fully track the volume of patients on cancer pathways. As with all other Trusts in the Region, we currently track patients to first definitive treatment only on cancer pathways, that is, if a patient requires onward treatment and cancer support, no Trust is funded to support this level of tracking. Please see:

82. 201908 Q22 Cancer Pathway Escalation Policy Final

22.8 In August 2018, Cara Anderson, Assistant Director of Commissioning in HSCB undertook an analysis of the demand and capacity on the cancer tracker resource across all five Trusts. This analysis demonstrated that there were considerable gaps across the Region with a total of 16 whole time equivalent (wte) Band 4 cancer tracker/MDT co-ordinator gap, SHSCT had a gap of 4.7 wte. The conclusion at that time was that SHSCT required 8.6 wte to track patients on cancer pathways to first definitive treatment. This report has been attached and referenced below. Please see:

83. 201808 Q22 HSCB Cancer Tracking Resource Analysis of Capacity and Demand

22.9 In January 2019, I raised concern about the staffing situation in the cancer tracker team and the backlogs this was creating with my AD, Barry Conway. At that time the average weekly volumes of patients being actively tracked on 62 day cancer pathways had increased from 1350 in 2015/2016, 1766 in 2017/2018 to 2300 in January 2019 (pre-Covid). This was onward escalated to the Director of Acute Services (Esther Gishkori) how gave permission to go at risk for a temporary Band 4 Cancer Tracker/MDT Co-Ordinator and referenced in the attached document. Please see:

84. 20190124 Q22 Email from EG to go at risk with tracker resource

22.10 At the time of this escalation to the Director of Acute in January 2019, Barry Conway also escalated the concern with Cara Anderson, Assistant Director of Commisioning in HSCB requesting an update on the work to secure additional resources for the cancer tracker in the Trust when consideration was given to a non-recurrently allocation for the overall funding gap. This is referenced in attached document. Please see:

85. 20190805 Q22 Emails between BC and CA re cancer tracking resource

22.11 On 13 November 2019 the Trust received an allocation letter from Dr Miriam McCarthy, Director of Commissioning confirming recurrent funding for 1.0wte Band 4 cancer tracker and non-recurrent funding for 3.7wte cancer trackers for the 2019/2020 fiscal year, this letter is referenced in the attached document. Please see:

86. 20191113 Q22 Letter from HSCB Cancer Tracking Resource

22.12 I emailed my AD, Barry Conway, on 10 & 11 February 2021 to advise him regarding the increase in volume of patients on cancer pathways and to propose an increase in staffing for the tracker team. This was onward escalated to the Director of Acute Services, Melanie McClements and the Assistant Director of Performance, Lesley Leeman. At that

time, Melanie McClements gave permission to proceed with the recruitment of additional cancer trackers at risk which influencing HSCB regarding the need for investment. I contacted Helen Walker, Assistant Director for Human Resources in Acute regarding the recruitment of these posts through an Expression of Interest (EOI) process through the Acute team and this was approved. I had need to liaise with Helen Walker again on 2 June 2021 as we were losing 2 of the newly recruited cancer trackers and given the pressures, requesting support to undertake a further EOI through the Acute team. At that time it was noted that the tracking team were tracking 5500 patients on active cancer pathways, more than double pre-Covid tracking levels. All the above email discussions are referenced in the attached document. Please see:

87. 20210602 Q22 Email trail re tracking resource and approval for EOI

22.13 Further communication was received from Paul Cavanagh, Interim Director of Planning & Commissioning on 23 September 2021 recognising the increased demands on the tracking service and confirmed HSCB would be providing non-recurrent funding in 2021/2022 to close the funding gap in required staffing levels, with a view that this would then be "assumed recurrent" with effect from 2022/2023. This letter is referenced in attached document. Please see:

88. 20210923 Q22 Letter from HSCB Cancer Trackers Resource

22.14 I continued to liaise with my AD, Barry Conway, in relation to the cancer tracking resource and we submitted a request for a further 3 wte Band 4 cancer tracker/MDT co-ordintor staff through the Trust Urology Public Inquiry Team. This was discussed with Helen Walker, Assistant Director of Human Resources in Acute in terms of the recruitment of staff. This has been referenced in the attached documents. Please see:

89. 20210715 Q22 Staffing requirements to meet the request of the UPI
90. 20210820 Q22 Email from HW approving EOI for Cancer Tracker x 3

22.15 The Cancer Tracker Team has now increased from 8.6 wte to 14 wte, (5.4 wte remain funded at risk) improving the completed cancer pathway tracking to between 96-98% at all times. An analysis of funded vs unfunded posts within the Cancer Tracker Team was completed on 7 October 2021 and is attached for reference. Please see:

91. 20211007 Q22 Analysis of Cancer Tracker Staffing – Funded vs Unfunded

22.16 Although the Cancer Tracker Team continue to track considerably large volumes of patients across the cancer pathways, 5674 on the last tracking position update, the increase in staffing levels to the team has meant that the tracking for those patients has remained at an average of between 96-98% over the last number of months. The improvement in the tracking position of patients across the tumour sites has been recognised and commended at the recent SPPG Meeting on 21 September 2022. A copy of the most recent tracking position report has been attached for reference. Please see:

92. 20220907 Q22 Tracking position update report

22.17 In relation to CCS, it is my view that there has been a lack of audits undertaken to ensure the effectiveness of systems and processes within all Cancer MDTs, including urology. The lack of audit has been due to the lack of dedicated manpower and audit support within the Trust generally and also within CCS. The Trust has recently gone at financial risk and we are in the process of recruiting a Band 5 Cancer Information & Audit Officer to CCS Division who will concentrate on audit of MDT outcomes.

23. **Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?**

23.1 In relation to performance metrics, the Trust Performance Team monitor the Trust's overall performance with the team being led by the Head of Performance, Lynn Lappin.

23.2 My main role and responsibility within both OSL tenures is in relation to the monitoring of performance metrics and engaging with the HOS and ADs in delivery of performance standards within the Division.

23.3 In relation to urology performance metrics specifically, I had a pivotal role in overseeing metrics in collaboration with the HOS, Martina Corrigan and being accountable to the AD, Simon Gibson then Heather Trouton.

23.4 In both OSL roles, I would have accessed a number of monitoring reports from the Trust's SharePoint website which are developed by the Information Team, led by Lesley-Anne Reid as well as reports developed by the Performance Team, led by Lynn Lappin. I would have used these reports to develop and inform specific Divisional performance reports, including SBA monitoring reports, trajectories and service delivery plans. These reports would have been used to inform discussion at the HOS Performance meetings and Acute SMT Performance Meetings regarding capacity, demand and challenges that may arise to the HOS, ADs and Director of Acute.

23.5 These reports rely on information inputted to a number of systems used by the A&C staff within the Directorate, for example, Patient Administrative System (PAS) and the Radiology Information System (RIS). The types of information recorded on the system would include the referral and booking team for the registration of new referrals, the secretarial staff for the updating of outcomes from out-patient clinics and adding patients to waiting lists and the radiology A&C team for scheduling patients for appointments.

23.6 These reports would also have been used to develop bespoke specialty information reports with detailed analysis as requested by the HOS, AD or clinical team. Some examples of these detailed analysis are listed below. Please see:

93. 20150826 Q23 Email to Martina Corrigan re Urology NOP Analysis

94. 20150826 Q23 Urology NOP Activity Analysis Report

95. 20160212 Q23 Email to Heather Trouton re Urology Presentation

96. 201601 Q23 Urology Presentation

23.7 In relation to cancer services, the cancer tracker team would have responsibility for the input of data to the Cancer Patient Pathway System (CaPPS). This information would have been used to generate information reports from Business Objects XI (BOXI) which members of the cancer team, specifically the Cancer Services Co-Ordinator, Cancer MDT Administrator (appointed January 2022) and I as OSL for CCS would have produced for the Director, operational ADs, HOS and other OSLs in the Directorate.

23.8 In relation to how these systems would identify a concern:

a. PAS – this system can be used in the following way to help identify concerns:

i. Identification of charts which have been tracked to a particular office

b. CaPPS – this system can be used in the following way to help identify concerns:

i. The cancer tracking staff are able to add an alert/notification to a patient being tracked as a reminder to follow-up on this patient within a certain timescale which is set by the tracker which assists in the escalation process of patients to the Cancer Services Co-Ordinator

ii. The CaPPs tracking screen provides an overall summary by tumour site for those patients actively being tracked on a pathway as illustrated in the screen-shot below.

c. BOXI – this system can be used in the following way to help identify concerns:

i. Identifying referrals which have not been triaged
ii. Out-Patient and Elective Primary Target Lists (PTL) reports for all specialties, including urology
iii. Cancer Primary Target Lists (PTL) Report for all tumour sites, including urology
iv. Cancer Pathway Day 100+ Reports for all tumour sites, including urology
v. Cancer Breach Reports for all tumour sites, including urology

d. RIS – this system can be used in the following way to help identify concerns:

i. Escalation of any unexpected findings back to the referring clinician for action

24. **Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:**

(i) **Waiting times**

24.1 During my tenure as OSL for SEC, I would have supported the Operational AD and HOS in the monitoring of performance. This entailed the regular review of out-patient, elective (in-patient and day case procedures) and planned waiting lists. I produced weekly and monthly Divisional performance reports which outlined the volumes and longest waiting patient in weeks waiting for out-patient, elective (in-patient and day case) and planned procedures for all specialties in SEC, including urology, examples of these reports are referenced in my response to Questions 7, 10,

13 and 18. These would have been circulated to the Operational AD (Simon Gibson, Heather Trouton and then Barry Conway), HOS for the specialty areas (Martina Corrigan for ENT, URO, OPTH and OP, Amie Nelson for BSUR, GSUR, Endo, Trudy Reid for T&O). This information would also have been shared at various performance meetings where the Director of Acute was in attendance (firstly Joy Youart, then Deborah Burns, Gillian Rankin, Esther Gishkori, Melanie McClements and now Trudy Reid) as well as members of the Trust's Performance Team (Lesley Leeman and Lynn Lappin)

24.2 I attended regular urology rota and planning meetings on the first Thursday of each month which were attended by the HOS (Martina Corrigan during my tenure), all of the consultant team (Mr Young, Mr O'Brien, Mr Glackin, Mr O'Donoghue and Mr Haynes), the urology secretaries (Paulette Dignam, Monica McCorry, Noleen Elliott, Elizabeth Troughton, Leanne Hanvey, as well as the rotating urology senior trainee medical staff through the service as part of their training (unfortunately I cannot recall their names). The AD for SEC (Heather Trouton) attended on an adhoc basis. My role in attendance at the meeting was to inform the consultant team of the long waiting patients awaiting surgery and draw up a collective scheduling plan for those patients. I would have supplied the primary target lists (PTLs) either in advance or at the meeting. A PTL lists all the patients on a particular specialty waiting list in chronological order and in order of urgency code. Example of PTLs are referenced in my response to Question 18.

(ii) **Triage/GP referral letters**

24.3 As OSL for SEC up to 31 March 2016, there were delays in triage reports for all specialties, including urology, sent from the Referral & Booking Centre for action. I would have escalated this information to the HOS for the specialty area (see above list of HOS in response to 24(i) as evidence in my response to Question 13).

As OSL for CCS from 1 April 2016, the Cancer Services Co-Ordinator (firstly Vicki Graham, then Ciaran McCann and currently Sinead Lee) escalated untriaged red flag

referrals to the Operational HOS for action (then Martina Corrigan and now Wendy Clayton).

24.4 Ultimately, responsibility for triage rests with the clinical team, ie, the consultants. During my OSL tenure in SEC, I was not directly involved with the administrative process around the sending and returning of triage outcomes. Staff in RBC sent the referrals for triage directly to the secretarial staff who then printed off for the consultant's attention and once triaged, these were returned with the outcome to RBC. The secretarial staff provided a support mechanism for drawing the untriaged referrals to the attention of the consultant for action. Unfortunately I do not recall the secretarial staff ever raising concerns with me regarding issues around untriaged referral letters from the process described above.

24.5 However, it was apparent from the report produced by Katherine Robinson and her team in the RBC that there were delays in triage across the specialties, particularly in urology and with Mr O'Brien and I received the escalation of untriaged referral letters from the Referral & Booking Centre. My role as OSL in SEC was to ensure there was awareness of the concern up the managerial chain, ie., raised with the appropriate HOS and it was the HOS who was charged with directing steps to address these concerns. It was my understanding that the HOS (Martina Corrigan) would have discussed the concerns with the clinical team and/or consultant directly either face to face or by email, although I would not normally have been aware of the outcome of those discussions as that information was not normally fed back to me. I would not have followed up on these discussions as that was outside the scope of my role as OSL.

(iii) **Letter and note dictation**

24.6 During my tenure as OSL for SEC from 1 April 2007 to 31 March 2016, I had responsibility for the A&C staff within the Division until 31 May 2013, which included urology. Following this time, the line management responsibility of the secretarial and

audio-typing staff in SEC moved to Katherine Robinson, Head of Acute Booking and Secretarial Services Head of Admin and the ward clerk staff moved to Helen Forde, Head of Health Records. Up until that time, the urology secretaries and audio-typists would have reported directly to the SA who in turn reported to me. The SA and I would have kept the HOS informed of any backlogs with letter and note dictation and produced A&C risks matrix detailing the backlogs by secretary. This was completed for all secretaries, including urology as referenced the attached email and report.

24.7 In relation to delays with dictated triage information, I do not recall this ever being raised as an issue with me by the secretarial staff. Please see:

97. 20120618 Q24 Email re A&C SEC Backlog Risks Matrix
98. 20120618 Q24 A&C SEC Backlog Risks Matrix Report

(iv) **Patient care scheduling/Booking**

24.8 As per my response to Question 24(i), we had a urology rota and planning meeting where patients were scheduled for surgery. The secretaries were in attendance at that meeting and were then responsible for actual scheduling of the patients on PAS and adding the patients to theatre lists. Out-patient appointments were booked by the Referral & Booking Centre.

(v) **Prescription of drugs**

24.9 I have never had any responsibility or input to the prescription of drugs.

(vi) **Administration of drugs**

24.10 I have never had any responsibility or input to the administration of drugs.

(vii) **Private patient booking**

24.11 I have never had any responsibility or input to private patient booking.

(viii) **Multi-disciplinary meetings (MDMs)/Attendance at MDMs**

24.12 In my tenure as OSL for CCS, I have management responsibility for the cancer tracking team who support the MDT meetings and take note of the MDM attendance and record the outcomes. These staff report to the Cancer MDT Administrator, Angela Muldrew, who then reports to me. I was aware through the escalation of patients on cancer pathways that patients could have been deferred from discussion at Cancer MDT Meetings due to absence of a radiologist, pathologist or oncologist at the meetings. When this happened, I would have discussed this verbally with my AD (Barry Conway) who would have raised this at the relevant Departmental Meeting.

(ix) **Following up on results/sign off of results**

24.13 I have never had any responsibility or input for the following up on results/sign off of results.

(x) **Onward referral of patients for further care and treatment**

24.14 I have never had any responsibility or input for the onward referral of patients for further care and treatment.

(xi) **Storage and management of health records**

24.15 I have never had any specific responsibility for the storage and management of health records. However, up until June 2013 when the structural change occurred, the A&C staff who reported to me via the SAs would have had an input into the safe and careful storage of charts when casenote tracked to their offices and were required to have their office storage areas well labelled to assist in the easy location of charts. I am aware that charts were transported to South West Acute Hospital (SWAH) either by the Urologist or HOS (Martina Corrigan) for clinics held there, but I was not aware that there was any issue with charts not returning back to the Trust. I had no direct or indirect management of missing charts, however, I was aware from conversations in the HOS office with Martina Corrigan that there were issues with missing charts,

particularly Mr O'Brien's. The HOS, Martina Corrigan was dealing with this matter and I had no input into this.

(xii) **Operation of the Patient Administrative System (PAS)**

24.16 For both my OSL tenures, the A&C staff within my management structure, who reported to the SAs, would have inputted data on a daily basis. The SAs would have ensured that A&C staff attended PAS training as part of induction to the service and refresher training when required.

(xiii) **Staffing**

24.17 During my tenure as OSL for SEC, I would have had responsibility for the A&C staff within the Division, including the urology specialty. These staff reported directly to the SA, who reported to me.

(xiv) **Clinical Nurse Specialists**

24.18 I have never had any responsibility or input for Clinical Nurse Specialists.

(xv) **Cancer Nurse Specialists**

24.19 I have never had any responsibility or input for Cancer Nurse Specialists.

(xvi) **Palliative Care Nurses**

24.20 I have never had any responsibility or input for Palliative Care Nurses.

(xvii) **Patient complaints/queries**

24.21 I have never had any direct responsibility for patient complaints/queries, however, I did input to the data gathering and investigation to assist the HOS in response.

Urology Services Inquiry

Concerns

25. **Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.**

25.1 If I had a concern about an issue relevant to patient care and safety and governance, there are a number of ways in which I could raise this concern:

a. Discuss the concern with my line manager, Barry Conway, AD for CCS
b. Raise with the HOS for the area
c. Speak to a senior member of staff within the service on a 1:1 basis
d. Raise the issue at a team meeting
e. Put the concern in writing (email) to either my line manager or another senior staff member
f. Raise the concern anonymously through the SHSCT Your Right to Raise a Concern Policy and Procedure, as referenced in the attachment below. Please see:

99. 20180401 Q25 Your Right to Raise a Concern Policy

26. **Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.**

(i) Waiting times

26.1 The waiting times for all specialties, including urology, would have been discussed at the HOS Performance Meeting with the Operational AD (Simon Gibson then Heather Trouton) and the Operational HOS (Martina Corrigan) present. It was well known, both

internally and externally, that there are significant capacity and demand gaps within the urology service and recognised Regionally that there was significant challenges and limitations to what could be done to improve access for patients. The waiting times position for urology would also have been discussed at Acute SMT Performance Meetings and also a the HSCB/SPPG Elective Performance Meetings.

(ii) Triage/GP referral letters

26.2 As OSL for SEC up to 31 March 2016, I escalated on a number of occasions the delays with untriaged referrals. This was escalated to the HOS, Martina Corrigan, but I would not be aware of what the action and outcome was from these escalations.

26.3 In order to mitigate risk, a decision was taken by Martina Corrigan (HOS for urology) to accept the GP priority code to avoid unnecessary delays to patients receiving appointments and to permit the Referral and Booking Cycle to appoint patients to the relevant clinics

(iii) Letter and note dictation

26.4 I do not recall raising any concerns in relation to letter and note dictation and I have no recollection of any concerns being raised to me by any A&C staff within the urology specialty. In relation to delays with dictated triage information, unfortunately I do not recall this ever being raised with me as an issue by the secretarial staff during my tenure as OSL for SEC.

(iv)Patient care scheduling/Booking

26.5 As the scheduling of elective patients for urology took place in a team scheduling meeting, with all consultants taking part in the scheduling of patients and sharing of patients across consultant theatre lists for chronological management of patients in urgency order, I didn't have any concerns.

(v) Prescription of drugs

26.6 I have never had any responsibility or input to the prescription of drugs and therefore have no concerns.

(vi) Administration of drugs

26.7 I have never had any responsibility or input to the administration of drugs and therefore have no concerns.

(vii) Private patient booking

26.8 I have never had any specific responsibility or input to private patient booking and therefore have no concerns.

(viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs

26.9 In my current tenure as OSL for CCS, I have management responsibility for the cancer tracking team who support the MDT meetings and take note of the MDM attendance and record the outcomes. These staff reported to the Cancer Services Co-Ordinator (initially Vicki Graham, then Ciaran McCann and now Sinead Lee) until January 2022 when there was a change in the management structure and they now report to the Cancer MDT Administrator, Angela Muldrew. Both the Cancer Services Co-Ordinator and Cancer MDT Administrator report to me in the CCS management structure. Any concerns regarding delays with urology patients on the cancer tracking pathway are escalated to the HOS by the Cancer Services Co-Ordinator/Cancer MDT Administrator for review and action (formerly Martina Corrigan and now Wendy Clayton), It is the HOS who is charged with directing steps to address the concerns. As OSL for CCS, I would not always be copied into escalations and therefore would not always be copied into the response from HOS. However, if no corrective action was taken, the same patients would be escalated in the next round of tracking as described above.

26.10 Since becoming a member of the Task and Finish Group led by Sarah Ward, Head of Clinical Assurance for the Public Inquiry, I am now aware of quoracy issues within the Urology MDT Meeting, specifically around lack of representation of radiologists,

oncologists and pathologists at those meetings. The Urology MDT Annual Report would have demonstrated any issues or concerns in relation to this matter, however, this was in retrospect across the previous year and there was little else in the way of reports to monitor MDT performance. Unfortunately, as OSL, I do not receive a copy of the Urology MDT Annual Report.

(ix) Following up on results/sign off of results

26.11 I have never had any responsibility or input for the following up on results/sign off of results and therefore have no concerns.

(x) Onward referral of patients for further care and treatment

26.12 I have never had any responsibility or input for the onward referral of patients for further care and treatment and therefore have no concerns

(xi) Storage and management of health records

26.13 During my tenure as OSL for SEC, I would have had reason on a rare occasion to call into consultant offices in relation to the scheduling of patients from PTLs. I did observe that Mr O'Brien did appear to have a large number of patient charts in his office, although it is to be noted that large volumes of charts in some other consultant and secretarial offices were also observed. I did not raise this as an issue as it was not unique to Mr O'Brien.

(xii)Operation of the Patient Administrative System (PAS)

26.14 I do not recall raising any concerns in relation to PAS and I have no recollection of any concerns being raised to me by any A&C staff within the urology specialty in this regard.

(xiii) Staffing

26.15 During my OSL tenures, I have raised concerns regarding staffing levels with my Operational AD. These papers would have been brought to the Acute SMT Meetings and

outcome discussion fed back to me in terms of any agreement for funding for additional staffing. An example of this has been reference in my response to Question 22 regarding staffing level concerns within the Cancer Tracking Team**.**

(xiv) Clinical Nurse Specialists

26.16 I have never had any responsibility or input for Clinical Nurse Specialists and therefore have no concerns.

(xv) Cancer Nurse Specialists

26.17 I have never had any responsibility or input for Cancer Nurse Specialists and therefore have no concerns.

(xvi) Palliative Care Nurses

26.18 I have never had any responsibility or input for Palliative Care Nurses and therefore have no concerns.

(xvii) Patient complaints/queries

26.19 I have no concerns in relation to patient complaints/queries.

27. **Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.**

27.1 During my tenure as OSL for SEC (April 2007 – March 2016), I would regularly escalate untriaged referrals to the all the Operational HOS as required, including urology. I did raise concern about untriaged referrals letters to the HOS for urology (Martina Corrigan) and this is outlined in my response to Question 13 as well as examples of the types of escalation evidence in the response. A number of these escalations were

specifically in relation to untriaged referral letters with Mr O'Brien which was escalated to Martina Corrigan, HOS for urology.

28. **If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?**

28.1 The impact of untriaged referral letters would have resulted in patients waiting longer for out-patient appointments and therefore patients may have been delayed in receiving appointments and potentially onward care, particularly if the referral was categorised as red flag or urgent.

28.2 In order to mitigate risk, a decision was taken by Martina Corrigan (HOS for urology) to accept the GP priority code to avoid unnecessary delays to patients receiving appointments and to permit the Referral and Booking Cycle to appoint patients to the relevant clinics. I am unsure of the exact date the decision was made by the HOS, but I had suggested it as an option to mitigate risk on 25 November 2013 as referenced in the attached email. It would have been my view that this arrangement would have been a short-term workaround to permit the outstanding untriaged referral letters to be booked and would not have been intended to be a long-term arrangement. I am not sure when this arrangement ended but I do recall that the GP priority code was still being used when I moved tenures in April 2016 if there were delays in triage outcomes coming back to the RBC. Please see:

50. 20131125 Q13 Email regarding untriaged referrals to Martina Corrigan

29. **What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?**

29.1 The Referral and Booking Centre, under the management of Katherine Robinson, Head of Acute Booking and Secretarial Services, had a process in place to escalate delays in triage outcome to the OSLs. My role as OSL in SEC was to ensure there was awareness of the concern raised up the managerial chain with the appropriate HOS and it was the HOS who was charged with directing steps to address these concerns. It was my understanding that the HOS (Martina Corrigan) would have discussed the concerns with the clinical team and/or consultant directly either face to face or by email, although I would not normally have been aware of the outcome of those discussions as that was not normally fed back to me. I would not have followed up on these discussions as that was outside the scope of my role as OSL.

29.2 I am also aware that on at least one occasion Ms.Corrigan onward escalated these concerns to the AD (Heather Trouton) as referenced below. Please see:

49. 20131008 Q13 Email regarding outstanding triage for urology

30. **Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?**

30.1 I did consider the concern regarding untriaged referrals to be a risk to patient safety which was why I escalated it regularly to the HOS for urology, Martina Corrigan. I did not raise any datix/incidents in relation to this concern and I am not aware of any datix/incidents being raised by Martina Corrigan (HOS for Urology) or Heather Trouton (AD for SEC). The risk was mitigated by Martina Corrigan giving permission for the Referral & Booking Centre to go ahead and appoint patients as per GP referral priority. The position with untriaged referrals was continually monitored by the Referral & Booking Centre who continue to send out escalations of untriaged referrals and the triage of red flag referrals is monitored by the Cancer Services Co-Ordinator through the Cancer Pathway Escalation Policy as referenced in my response to Question 22.

Urology Services Inquiry

31. **Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.**

31.1 As OSL for SEC (April 2007 – March 2016), I would have escalated delays in triage to the Operational HOS, including urology (Martina Corrigan), as these were being raised to me by the Referral & Booking Centre. It was my role as OSL to raise concern regarding delays in triage to the HOS, but it was the HOS responsibility to take forward any action required or onward escalation. It was my understanding that the HOS (Martina Corrigan) would have discussed the concerns with the clinical team and/or consultant directly either face to face or by email, but I was not always aware of the action taken or the outcome. I had no input into the systems of oversight and monitoring that were put in place once I escalated the delays in triage concern. However, in relation to untriaged referrals, if no corrective action was taken, the same patients would have been escalated again from RBC in the process described above.

32. **In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?**

32.1 In my tenures as OSL, it is my experience that concerns that are raised by me or other staff within my team, for example, Datix following delays in 'other consultant' (OC) referrals, that the outcomes are investigated and discussed between cancer services and the relevant specialty area with an agreed outcome and action plan. An example of such a Datix is referenced in my response to Question 13.

32.3 In addition to the internal investigation, relevant datix incidents and complaints are discussed and fed back at the HOS Governance meeting. Following investigation of complaints, or a concern raised within another team which could have an impact on a system or process in my team, eg, a datix raised in the radiology department which may require a change to a system or process which impacts the A&C team.

32.4 I would update my direct reports at SA Meetings, 1:1 sessions, email communication and face to face discussions, particularly if this concern had been in relation to an A&C system or process. The SAs and I would review these together and make any necessary updates to Standard Operating Procedures (SOPs) as required and the SAs would communicate these concerns and changes with their teams.

32.5 However, if the concern raised is in relation to a staff member, the investigation and outcome are treated as confidential and would not be relayed to staff.

33. **Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?**

33.1 In both my tenures as OSL, with the exception of delays in triage concerns, I had no other concerns that governance, clinical care or issues around risk were not identified, addressed or escalated within urology.

33.2 In both my tenures as OSL, it was my view that the consultant was accountable for their triage and this should have been highlighted by them if there was a backlog. Following the escalation of untriaged referrals, it is my view that the operational managers, AD and HOS, should work closely and collectively with the clinical managers, Clinical Director (CD) and Associate Medical Director (AMD) now known as Divisional Medical Director (DMD) to bring resolution to any issues identified through the escalations.

33.3 The OSL role in any Division in Acute supports the AD and all HOS within that Division, as well as managing a large team of clerical staff, so at times I feel my role was spread thinly across the specialty areas. Therefore, once I had escalated a concern and raised it with the HOS my role in that escalation is complete, I would have moved on to

the next task at hand and would not have followed up on the response by the HOS which I considered to be the responsibility of the HOS.

34. **How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such Governance meeting minutes or notes, or in the Risk Register, whether at Departmental level or otherwise? Please provide any documents referred to.**

34.1 As outlined in my response to Question 13, concerns in relation to performance, in particular waiting list backlogs for out-patient, in-patient and day cases as well as planned and review backlogs were documented on risk registers as set out below. I would have supported the ADs and HOS in updating these risks.

34.2 Before my tenure as OSL for CCS (April 2016 to date) risks to meeting the cancer access targets had been logged as a high graded risk on the Acute Risk register from 3 September 2012 by the Head of Cancer Services at that time, Mrs Fiona Reddick. This risk related to all tumour sites, including Urology for both the 31 and 62 day target. Please see:

100. 202204 Q34 Acute Directorate Risk Register

34.3 In April 2016, the Corporate Risk Register was updated by Lynn Lappin, Head of Performance, for all areas of general performance risks for the Acute Service which would have included the urology service. These risks were in relation to out-patient and elective waiting times, out-patient reviews beyond clinically indicated timescales and failure to deliver SBA volumes. Please see:

101. 20160401 Q34 April 16 Performance Risk Register

35. **What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?**

35.1 As outlined in my response to question 12 and 13, my role as OSL is to ensure the escalations of patients with triage delays and delays along the cancer pathway take place. These are escalated by the Cancer Services Co-Ordinator (Sinead Lee) for triage and first out-patient appointment delays and the Cancer MDT Administrator (Angela Muldrew) for cancer pathway escalations to the Operational HOS. It is then the Operational HOS role to take any necessary action, as well as onward escalation as necessary. Unfortunately, the outcomes of actions taken or onward escalation are not always fed back to the Cancer Services. It would be my view that feedback on escalations to the Cancer Services would increase effectiveness in carrying out the tracking function and ensure that the updates to CaPPs are robust in terms of all the actions taken to move patients along their cancer pathway.

Staff

36. **As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?**

36.1 As outlined in my response to Question 18, I had a good working relationship with all staff in the urology team including the consultants, clinical nurse specialists, secretarial staff and the HOS, Martina Corrigan. I attended the monthly urology rota planning meeting when the whole team was present and I observed good team working and communication.

37. **In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.**

37.1 In both my OSL tenures, my experience is that medical managers and non-medical managers in urology work worked well together. As outlined above in my response to Question 36, I observed medical and non-medical managers working well together to collectively agree a monthly clinical work schedule.

Learning

38. **Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.**

38.1 I became aware of governance concerns arising out of the provision of urology services when I became a member of the Task and Finish Group led by Sarah Ward, Head of Clinical Assurance for the Public Inquiry, in August 2021 which was set up to implement the 11 recommendations of the Dermot Hughes report. The Terms of Reference for this group, including the membership are attached for reference. Please see:

61. 20211011 Q38 TOR Trust Task and Finish Group into Urology SAI Recommendations
102. 20211206 Q38 SAI Action Plan

38.2 Relevant to my role as OSL for CCS, there were a number of concerns relating to the Urology Cancer MDT processes as follows:

a) **Quoracy at Urology Cancer MDT Meetings** – A summary of attendance at Cancer MDT Meetings would be included in the MDT Annual Report, with any significant

quoracy attendance gaps being highlighted by the MDT Chair during the year and unfortunately this was the case with the Urology MDT in relation to Radiologist attendance. As the MDT Annual Report is a yearly look back at quoracy, there was no early alert to issues with MDT attendance. I do not receive the MDT Annual Reports currently and therefore was not aware of quoracy issues. The annual report is shared with all members of MDT, Associate Medical Director (Dr Shahid Tariq), Clinical Director (currently vacant, but previously David McCaul), AD (Barry Conway) and HOS for Cancer (previously Fiona Reddick, currently Clair Quin as interim).

b) **Lack of Support to the Cancer MDT Meetings** – Previously the only support to the Cancer MDT Meetings was the Cancer Tracker/MDT Co-Ordinator as commissioned by HSCB (SPPG). Recognising this, SHSCT have developed a new Cancer MDT Administrator role effective from January 2022 (Angela Muldrew), the first of its kind in Northern Ireland. This role will be reporting to me in my management structure.

c) Lack of Audit Support to the Cancer MDT Meetings – The lack of audit support has been highlighted in Cancer MDT Annual Reports, including urology. Barry Conway, AD for CCS, received approval in June 2022 to appoint a new Clinical Audit and Information Officer post which would sit within CCS and be dedicated to audits in Cancer MDTs. This post has recently been appointed at interview and the successful candidate is likely to commence in November 2022. This role will report to me in my management structure.

39. **Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?**

39.1 During my tenure as OSL for SEC (July 2007 – March 2016), there were obvious delays with the triaging of urology referrals, specifically with Mr O'Brien, as outlined in my response to Question 13. There were numerous escalations to the HOS (Martina Corrigan) regarding these concerns and I was copied into her onward escalation on at least one occasion to the AD (Heather Trouton) regarding this, referenced in my response to Question 13. Mr O'Brien undertook a form of triage which he referred to as enhanced triage which took considerably longer to complete for each patient. It is my understanding, during my tenure, there was no time allocation for this type of triage within job plans and it may well be that if this is the best form of triage for patient care that more administrative time is required to undertake triage of referral letters.

39.2 In my current tenure as OSL for CCS (April 2016 to current), I became aware of other governance issues in relation to the provision of urology services when I was a member of the Task and Finish Group as set out in my response to Question 38 in relation to urology cancer MDT Meetings.

39.3 There are a number of governance issues that in my view each consultant should be personally responsible for, specifically listing patients for discussion at Cancer MDTs, actioning the MDM outcome as agreed at the meeting and ensuring that patients are allocated a Cancer Nurse Specialist to support them in their cancer treatment and care. With respect to Mr O'Brien, this does not always appear to have happened unfortunately and there does not appear to have been an early challenge or alert about this practice.

39.4 There are a large number of cancer performance reports in relation to the achievement of the IEAP targets, red flag referral trends and tumour site specific information for all tumour sites. However, there were no performance reports focusing on the actual MDT performance in relation to how all tumour site MDTs were working, their effectiveness or if systems and processes in place were robust. The Annual MDT Report for all tumour sites was the only report where issues or concerns were

highlighted by members of the MDTs and while I was not on the circulation list for these reports, I am now aware that there were issues raised in the Urology Annual MDT Report in relation to quoracy. The Annual MDT Report takes a retrospective look at the previous year's attendance at MDT meetings and whether meetings were quorate. However, on reflection an annual report was insufficient to bring about early change to make a positive impact on the patient's journey along the cancer pathway.

39.5 The governance issues in relation to the points raised above were also identified in the Dermot Hughes report. One of the recommendations was that a Cancer MDT Administrator be appointed to provide much needed support to the MDT clinical team to oversee effectiveness of each of the MDTs, as well as ongoing assurance through audit of the systems and processes in place at the cancer MDTs for all tumour sites, including urology.

39.6 The Trust has now proceeded, at financial risk while awaiting funding from the Commissioner (HSCB/SPPG), with the appointment of a Cancer MDT Administrator (Angela Muldrew) in January 2022 which is the first of this kind of post in Northern Ireland. Given that quoracy is a key factor in the effectiveness of cancer MDTs, the Cancer MDT Administrator now runs monthly quoracy reports for all tumour sites, including urology, giving a more timely alert to issues in relation to quoracy and a better opportunity to address those issues. This report is sent to the AD for CCS (Barry Conway), Interim HOS for Cancer (Clair Quin), DMD for Cancer Services (Dr Shahid Tariq) and the CD for Cancer Services (currently vacant). It is also discussed at the monthly cancer performance meeting with the Acute Director (previously Melanie McClements, now Trudy Reid) operational ADs, operational HOSs, OSLs, and members of the Trust Performance Team present.

39.7 The Cancer MDT Administrator will also oversee audits of actions taken at MDTs, including urology MDTs, confirming that agreed actions have been completed. The Trust has also gone at financial risk to recruit a Cancer Audit and Information Officer while

awaiting funding from the Commissioner (HSCB/SPPG) and the post holder is expected to be in post by end November 2022. In the meantime, the Cancer MDT Administrator has undertaken a snap shot audit in April/May 2022 of a random sampling of patients who had been discussed at the Urology MDT in January 2022 and this has been referenced in the attachment below. Reassuringly, this audit demonstrated that all outcomes agreed were actually followed through. The audit was discussed at the Urology MDM on 12 May 2022, minutes of which are attached for reference. Please see:

103. 202205 Q39 Urology MDM Outcome Audit of January 2022

104. 20220512 Q39 Urology MDM Minutes

40. **What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?**

40.1 As OSL in CCS, there were a number of issues of concern raised through the Task & Finish Group that relate to the delivery of cancer services, in particular the Urology Cancer MDT. The Macmillan Service Improvement Lead (Mrs Mary Haughey) has also undertaken a National Cancer Team (NCAT) MDT baseline assessment on all tumour sites during 2021, including urology, and a service improvement action plan has been developed to improve the effectiveness of MDTs which has been referenced below. I have been working closely with my AD (Barry Conway), HOS for Cancer (Clair Quin) and the Macmillan Service Improvement Lead (Mary Haughey) to bring forward changes within the service, set out in the attached action plan. Please see:

105. 202206 Q40 MDT Service Improvement Action Plan

40.2 On reflection, the learning is that Mr O'Brien does not appear to have been held to account for his processes around untriaged referral letters and this practice was able to

continue as I have referenced the continuing escalations of untriaged referral letters in my response.

40.3 Also, on reflection, I believe there was insufficient audit of MDT processes, ensuring the agreed action from MDT discussion was actually undertaken. This lack of audit is not unique to SHSCT as it would be my understanding that other Trusts are in a similar position due to lack of commissioned resource.

40.4 As OSL in both tenures, I have not been involved in any of the processes looking into Mr O'Brien's practice and any investigation would be considered confidential.

41. **Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.**

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

41.1 I was aware of performance difficulties for urology services during my tenure as OSL in SEC as outlined in my response to Question 7 and Question 10. The increase in referrals to the service would have led to capacity and demand challenges against the commissioned level of service. I do feel in relation to performance that there was full engagement with myself, the clinical team, HOS (Martina Corrigan), AD (Simon Gibson then Heather Trouton) to raise these issues with HSCB (now SPPG).

41.2 In relation to the concerns around untriaged referrals, my role as OSL in SEC (July 2007 to March 2016) was to escalate to the HOS (Martina Corrigan) which I did consistently throughout my tenure. I was copied into at least one onward escalation to the AD (Heather Trouton) regarding these concerns. Given that the escalations

continued during my tenure, it would be my opinion that there was a failure to engage fully with this problem at more senior management level in addressing this issue with Mr O'Brien in particular.

41.3 As OSL in both tenures, I had minimal direct contact with Mr O'Brien with the contact that I did have primarily being in relation to the scheduling of elective patients. Any contact I had in relation to untriaged referrals would have been directly with the HOS (Martina Corrigan) whom I then understood would have taken this forward with the clinical team or consultants directly as required or discussed with the AD (Heather Trouton) as required.

41.4 Mr O'Brien never raised any concerns to me regarding untriaged referral letters, or the extent of his avoidance of triage. If he had raised such concerns, this would likely have been with the HOS (Martina Corrigan) or through the medical management lines – Clinical Lead (Mr Young), CD (Robin Brown Mid 2011 to January 2014, Sam Hall January 2014 to March 2015, Colin Weir June 2016 to December 2018, Ted McNaboe December 2018 to December 2021 – the post is currently vacant from that time) and Associate Medical Director/Divisional Medical Director (Eamon Mackle January 2008 to April 2016, Charlie McAllister April 2016 to October 2016), Mark Haynes October 2017 to January 2022 and currently Ted McNaboe from January 2022)

42. **Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?**

42.1 As OSL in both my tenures, I was following my accountable lines of management and the processes that were in place at the time. The Referral and Booking Centre,

under the management of Katherine Robinson, had a process in place to escalate delays in triage outcome to the OSLs. My role as OSL in SEC was to ensure there was awareness of the concern up the managerial chain and to the appropriate HOS It was the HOS who was charged with directing steps to address these concerns.

42.2 In my current tenure as OSL for CCS, the Cancer Services Co-Ordinator (Vicki Graham now Sinead Lee) escalated delays with red flag triage and continued escalating delays with cancer pathways until the Cancer MDT Administrator (Angela Muldrew) came into post in January 2022. Now the Cancer MDT Administrator (Angela Muldrew) from January 2022 addresses any concerns to the relevant operational HOS, including urology. As OSL for CCS, I would not always be copied into escalations and therefore would not always be copied into responses from HOS. However, if no corrective action was taken, the same patients would have been escalated in the next round of tracking as described above.

42.3 On reflection, it would appear that the escalation of these concerns has somewhat failed as it would not appear that these concerns were resolved in a timely manner as practice continued throughout my tenures. It was the responsibility of the HOS (Martina Corrigan) to escalate these concerns further if there continued to be ongoing issues in relation to triage or delays on cancer pathways. As OSL I would not have been privy to any onward escalations or discussions that took place around concerns as this was outside the scope of my role and responsibility. It would be my view that the issues in relation to urology should have been dealt with more timely to ensure triaging of referrals and timely execution of patients along their treatment of care and that the outcome of the escalations was fed back to permit appropriate updates to the CaPPS as necessary.

42.4 The scope of the OSL role in any Division within Acute is a wide one in that this is the main supporting role to the AD and all HOS within the Division, as well as A&C staff management. Within my current role of OSL to both the CCS and IMWH Divisions, I

support two ADs, Barry Conway (AD for CCS) and Caroline Keown (AD for IMWH) as well as five HOS, Clair Quin (formerly Fiona Reddick), Interim HOS for Cancer, Denise Newell, HOS for Diagnostics, Geoff Kennedy (HOS for Laboratory Services), Caroline Breen (Interim HOS for Acute Allied Health Professionals) and Wendy Clarke (HOS for IMWH). I also have a large team of A&C staff who report via the Service Administrators to me, as outlined in Question 5.

42.5 Considering the large volume of services and remit of tasks to be undertaken within my OSL role, once I escalate an issue to HOS my role in that escalation is complete, I then move on to the next operational task at hand. There is no time to look back at previous escalations to ensure action has been taken by the responsible officer, e.g. in relation to triage escalations which were the responsibility of the HOS to take forward. In order to incorporate a lookback service with regard to monitoring escalations on the part of the OSL, more resources would be required.

42.6 In relation to the investigation of Mr O'Brien's practice, as OSL I would not be aware of these details or what the issues were as this investigation would have been confidential.

43. **Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?**

43.1 In relation to the concerns being escalated around untriaged referrals, I do not feel that the governance arrangements were fit for purpose as the issue was not resolved within my tenures. As stated in my response to Question 42, my role was to escalate the concerns, however, on reflection, it would have been the expectation that the HOS (Martina Corrigan) and AD (Heather Trouton) would have taken forward any unresolved issues. I believe I was working within my accountable lines of management.

43.2 It is apparent from the issues raised through the Task and Finish Group that there was lack of audit to the Cancer MDT Meetings and in order to govern the processes, I believe there needs to be more robust auditing of clinical practice.

43.3 As an OSL we have responsibility to support all the services under the remit of the AD. In my current role, I am now split between CCS and IMWH as explained in my response to Question 5 and provide an OSL support function to both the AD for CCS (Barry Conway) and the AD for IMWH (Caroline Keown). The split in services was based on the fact that the Director of Acute (Melanie McClements) was of the view that CCS and IMWH portfolio was too large for one AD. I feel my role is spread thinly across all these services area and I am unable to dedicate the time required to each of the services to carry out the role in full, I have already raised this concern with my line manager, Barry Conway AD for CCS.

44. **If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.**

44.1 I do not wish to add anything further.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as

Urology Services Inquiry

well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: Sharon Glenny

Date: 1st November 2022

S21 98 of 2022

Witness statement of: Sharon Glenny

Table of Attachments

Attachments
1. 200608 Q4 JD Temporary Project Manager - Urology ICATS Model
2. 20070620 Q4 JD Operational Support Lead - Acute Services
3. 20130331 Q5 List of B5 AC Staff within SEC Division
4. 20131218 Q7 Email regarding performance meeting notes and update
5a. 20131216 Q7 SEC Performance Update sheet 1
5b. 20131216 Q7 SEC Performance Update sheet 2
5c. 20131216 Q7 SEC Performance Update sheet 3
6. 20131218 Q7 Performance Notes
7. 20150914 Q7 Email regarding SEC performance update with Sept modelling
8a. 20150914 Q7 SEC Performance Update with Sept modelling sheet 1
8b. 20150914 Q7 SEC Performance Update with Sept modelling sheet 2
8c. 20150914 Q7 SEC Performance Update with Sept modelling sheet 3
9. 20160104 Q7 Email regading performance update
10a. 20160104 Q7 SEC Performance Update sheet 1
10b. 20160104 Q7 SEC Performance Update sheet 2
10c. 20160104 Q7 SEC Performance Update sheet 3
11. 20131118 Q7 Email regarding September IHA and IS Spend
12a. 201309 Q7 IHA and IS Spend for SEC for the month of September 2013 sheet 1
12b. 201309 Q7 IHA and IS Spend for SEC for the month of September 2013 sheet 2
12c. 201309 Q7 IHA and IS Spend for SEC for the month of September 2013 sheet 3
12d. 201309 Q7 IHA and IS Spend for SEC for the month of September 2013 sheet 4
12e. 201309 Q7 IHA and IS Spend for SEC for the month of September 2013 sheet 5
12f. 201309 Q7 IHA and IS Spend for SEC for the month of September 2013 sheet 6
13. 20151127 Q7 Email to TG re DHH Urology Type Referrals
14. 20151125 Q7 Email to MC re Urology Urgent NOP Waits

15. 20151117 Q7 UROLOGY OUT-PATIENT DASHBOARD
16. 20151117 Q7 UROLOGY Triaging Outcomes - Mr Haynes 15-21.10.15
17a. 20151117 Q7 UROLOGY OUT-PATIENT COMPARISON - JUNE 14 VS JUNE 15 sheet 1
17b. 20151117 Q7 UROLOGY OUT-PATIENT COMPARISON - JUNE 14 VS JUNE 15 sheet 2
17c. 20151117 Q7 UROLOGY OUT-PATIENT COMPARISON - JUNE 14 VS JUNE 15 sheet 3
18. 20151117 Q7 Email to MH re Information for Meeting with HSCB
19. 20151130 Q7 Email from MC data to be presented at meeting
20. 20151222 Q7 Email regarding urology OP and Elective activity and WL analysis
21a. 20151210 Q7 Urology Waiting List Analysis - Planned and Elective sheet 1
21b. 20151210 Q7 Urology Waiting List Analysis - Planned and Elective sheet 2
21c. 20151210 Q7 Urology Waiting List Analysis - Planned and Elective sheet 3
21d. 20151210 Q7 Urology Waiting List Analysis - Planned and Elective sheet 4
22a. 20151210 Q7 Urology OP Demand vs Activity sheet 1
22b. 20151210 Q7 Urology OP Demand vs Activity sheet 2
22c. 20151210 Q7 Urology OP Demand vs Activity sheet 3
22d. 20151210 Q7 Urology OP Demand vs Activity sheet 4
22e. 20151210 Q7 Urology OP Demand vs Activity sheet 5
22f. 20151210 Q7 Urology OP Demand vs Activity sheet 6
22g. 20151210 Q7 Urology OP Demand vs Activity sheet 7
23. 201908 Q7 Cancer Pathway Escalation Policy Final
24. 20181218 Q7 Email Urology Escalation
25. 20190919 Q7 Email Urology Escalation
26. 20220126 Q7 Email Urology Escalation
27. 20220704 Q7 Email Urology Escalation
28. 20180625 Q8 Sharon Glenny PDP Review
29. 20210722 Q9 Performance and Personal Development Review Policy
30. 20160225 Q10 Email regarding SEC SBA Year End Summary
31. 20160225 Q10 SBA Year End Summary Projections
32. 20160307 Q10 Email regarding performance update
33. 20160307 Q10 SEC Performance Update

34. 22020525 Q10 SPPG Actions Issues Register Southern Trust Cancer Performance Meeting
35. 20180920 Cancer Performance Minutes
36. 20190321 Cancer Performance Minutes
37. 201809 Cancer Performance Dashboard
38. 201903 Cancer Performance Dashboard
39. 20210730 Q10 Cancer Checkpoint Meeting Notes
40. 20210730 Q10 Cancer Rebuild Plan Update
41. 20210730 Q10 New GP Red Flag Referrals Report
42. 20210730 Q10 New GP Red Flag Longest Waiters Report
43. 20210730 Q10 Longest Waiters by Tumour Site Report
44. 20220915 Q10 Cancer Performance Meeting Agenda
45. 20220915 Q10 August Cancer Performance Report
46. 20220915 Q10 Cancer Performance Meeting Action Log
47. 20120608 Q11 Email from MC re SDP update and KR reports
48. 201206008 Q11 SDP UPDATE
49. 20131008 Email regarding outstanding triage for urology
50. 20131125 Email regarding untriaged referrals to Martina Corrigan
51. 20131126 Email regarding outstanding triage needing urgent response from Mr O'Brien
52. 20131219 Email regarding untriaged referrals to Martina Corrigan
53. 20131219 List of untriaged urology patients
54. 20150914 Email to the urology consultants re urology triage
55. 20151127 Email regarding urology untriaged referral letters to Martina Corrigan
56a. 20151127 Report of urology untriaged referral letters sheet 1
56b. 20151127 Report of urology untriaged referral letters sheet 2
57. 20220909 Email regarding urology escalations
58. 20221012 Q13 Datix Incident - Delay with typing RF referral
59. 20220919 Q13 Datix Incident - Administrative error in processing of a red flag referral
60. 20220126 Q14 Urology Pathway Process Map QI FINAL
61. 20211011 Q38 TOR Trust Task and Finish Group into Urology SAI Recommendations
62. 20131014 Q18 Email regarding urology review backlog plan

63. 20131124 Q18 Email to Martina Corrigan red flag GA cystoscopy patients
64. 20131216 Q18 Email to urology team regarding January 2014 plan
65a. 20131216 Q18 Urology 44 week PTL report sheet 1
65b. 20131216 Q18 Urology 44 week PTL report sheet 2
66a. 20131216 Q18 Urology 50 week PTL report sheet 1
66b. 20131216 Q18 Urology 50 week PTL report sheet 2
67. 20131219 Q18 Email to urology team regarding planned waiting list
68. 20131219 Q18 Urology planned waiting list
69. 20131230 Q18 Email to Mr O'Brien regarding urodynamics waiting list
70. 20131230 Q18 Urodynamics 52 week PTL report
71. 20131230 Q18 Email to urology team regarding elective 50 week PTL
72. 20131230 Q18 Urology elective 50 week PTL report
73. 20131230 Q18 Email to Martina Corrigan and urology team regarding ICATS PTL
74. 20131230 Q18 Urology ICATS 22 week PTL report
75. 20150907 Q18 Email to urology team regarding elective waiting list
76. 20150907 Q18 Total urology waiting list report
77. 20160215 Q18 Email to urology team regarding waiting lists
78. 20160215 Q18 Total urology waiting list report
79. 20160215 Q18 Urology planned waiting list report
80. 20220217 Q22 Update Report from Urology MDM
81. 20220616 Q22 Update Report from Urology MDM
82. 201908 Q22 Cancer Pathway Escalation Policy Final
83. 201808 Q22 HSCB Cancer Tracking Resource Analysis of Capacity and Demand
84. 20190124 Q22 Email from EG to go at risk with tracker resource
85. 20190805 Q22 Emails between BC to CA re cancer tracking resource
86. 20191113 Q22 Letter from HSCB Cancer Tracking Resource
87. 20210602 Q22 Email trail re tracking resource and approval for EOI
88. 20210923 Q22 Letter from HSCB Cancer Trackers Resource
89. 20210715 Q22 Staffing Requirements to meet the requests of the UPI
90. 20210820 Q22 Email from HW approving EOI for Cancer Tracker x 3

91. 20211007 Q22 Analysis of Cancer Tracker Staffing - Funded vs Unfunded
92. 20220907 Q22 Tracking position update report.xlsx
93. 20150826 Q23 Email to Martina Corrigan re urology NOP analysis
94. 20150826 Q23 Urology NOP Activity Analysis Report
95. 20160212 Q23 Email to Heather Trouton re Urology Presentation
96. 201601 Q23 Urology Presentation
97. 20120618 Q24 AC SEC Backlog Risks Matrix Report
98. 20120618 Q24 Email AC SEC Backlog Risks Matrix
99. 20180401 Q25 Your Right to Raise A Concern Policy
100. 202204 Q34 Acute Directorate Risk Register
101. 20160401 Q34 April 16 Performance Risk Register
102. 20211206 Q38 SAI Action Plan
103. 202205 Q39 Urology MDM Outcome Audit of Jan 2022
104. 20220512 Q39 Urology MDM minutes
105. 202206 Q40 MDT Service Improvement Action Plan

H206/86

CRAIGAVON AREA HOSPITAL GROUP TRUST

JOB DESCRIPTION

JOB TITLE Project Manager – Urology ICATS Model
(This post will be for a period of 6 months in the first instance, however may be further extended up to 1 year)

BASED AT Craigavon Area Hospital

REPORTS TO Operational Performance Manager

RESPONSIBLE TO Interim Director of Operations

JOB PURPOSE To project manage the implementation of the Urology Integrated and Clinical Assessment & Treatment Service (ICATS) model in order to ensure the successful implementation and roll-out of the model across the Southern Board area.

KEY RESPONSIBILITIES

1. Develop a project plan for the phased roll-out of the clinical service components of the ICATs model.
2. Put systems in place to monitor progress and compliance to the project plan and timescales.
3. Manage issues of risk through out the project implementation.
4. Plan, organise and monitor project resources to ensure the effective management of project budget while delivering the agreed objectives.
5. Work with the Urology Team in the development of job descriptions and appointment of ICATs practitioners and administrative staff to the ICATs Team.
6. Identify accommodation and define capital requirements necessary in terms of minor capital works necessary to support the roll out of clinical service components.
7. Co-ordinate the commissioning and set up of accommodation and facilities necessary to support the model.
8. Agree and implement administrative systems for ICATs including an appropriate Electronic Referral Management System to support the urology model.
9. Work with the Urology Team in the development, agreement and implementation of referral guidelines and care pathways for all the clinical service components.

10. Work with the Urology Team in the development, agreement and implementation of audit and quality assurance guidelines.

11. Develop training programmes as necessary to support implementation of new practices.

12. Develop a communication and awareness strategy in respect of the ICATs urology model throughout the SHSSB.

13. Liaise with SHSSB ICATs team in developing reporting information, methodologies and structures to support monitoring and evaluation of progress.

14. Assist with minor projects associated with other ICATs models which may interface with Craigavon Area Hospital Group Trust facilities.

15. Maintain relationships with all relevant stakeholders to ensure ongoing understanding and commitment to the project.

16. Any other duties as required to support or further develop the urology ICATs model.

GENERAL REQUIREMENTS:

The post holder must:

- Carry out his/her duties with full regard to the Trust's Equal Opportunities Policy.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements and report any accidents/incidents, defects with equipment or inadequate safety arrangements to his/her manager.
- Accept legal responsibility for all records held, created or used as part of his/her duties (including manual or electronic records).
- Comply with the Trust's smoke free policy.
- Treat those whom he/she comes into contact with in the course of work, in a courteous manner.
- Accept that this job description will be subject to review in light of changing circumstances and should be regarded as providing guidance within which the individual works rather than something which is rigid and inflexible.

August 2006

CRAIGAVON AREA HOSPITAL GROUP TRUST

EMPLOYEE PROFILE

POST: ICATS Project Manager

FACTORS	ESSENTIAL	DESIRABLE
Skills / Abilities	Ability to negotiate and influence within multi-disciplinary teams Developed communication skills in order to deal effectively with sensitive and potentially contentious issues Analytical skills including the ability to think logically about processes. Well developed organisational skills with the ability to get tasks completed within tight deadlines. Ability to use IT applications to create reports and maintain project information	
Qualifications / Experience	Either have completed or be currently working towards completing a third level qualification. **OR** hold a professional qualification Have experience within the Health Service which must have exposed the postholder to: • playing a key role / managing projects within a multi-disciplinary environment within agreed timescales • playing a key role in the successful implementation of change initiatives • developing clear procedures / protocols • developing well focused training sessions / programmes for staff based on some assessment of training needs etc.	Project Management qualification
Knowledge	Knowledge of project management methodologies Knowledge of service delivery reforms within the HPSS and the ICATs model	
Other Requirements / Work related circumstances	Current driving licence and access to a car or access to a form or transport which will permit the full requirements of the post to be met. Flexible with regard to working arrangements.	

August 2006

Operational Support Lead - Acute Services (4 posts)

Southern Health and Social Care Trust

Ref: 88207120
Closing Date: 20 June 2007 12:00
Location: Craigavon Area Hospital / Daisy Hill Hospital
Contract: Permanent
Salary: Band 7 (£26,269 - £36,416)
Hours: Full-time / Job Share
Interview Dates: Expected late June / early July

Job Description:

SOUTHERN HEALTH & SOCIAL CARE TRUST

JOB DESCRIPTION

JOB TITLE: Operational Support Lead

BAND: Band 7

REPORTS TO: Assistant Director of a division within Acute Services

JOB PURPOSE: To work as a key member within a division of the Trust's Acute Services Directorate, responsible for managing the day-to-day operational functions associated with patient access and flow in line with the reform and modernisation agenda, quality of patient care and resources available.

To assist the Assistant Director within the division in the delivery of the operational functions associated with the development of a booked elective pathway and maintenance of patient access via management of the Primary Target Lists (PTL) and waiting list management processes. Where applicable, to assist the Assistant Director within the division in the delivery of the operational functions associated with the maintenance of patient access to Medicine and Unscheduled Care services in line with DHSSPS standards of care.

To assume day to day line management responsibility for the administrative and clerical staff within the division (Personal Secretaries, Audio Typists, Ward Clerks), ensuring efficient and flexible administrative support to clinical teams.

MAIN DUTIES:

OPERATIONAL MANAGEMENT – PATIENT ACCESS AND FLOW:

1. Engage with senior medical, nursing, administrative and allied health professional teams to ensure that the main focus continues to be on the management of specialty specific PTLs to meet maximum patient access targets for inpatient and daycase patients and where applicable to meet access targets for unscheduled care.

2. Work with clinical directorate teams to develop realistic capacity plans to facilitate

planning for the achievement of PTL schedules and to ensure identified capacity is fully utilised across the division. Similarly for the planning of unscheduled care capacity requirements.

3. Support and facilitate elective and non-elective clinical teams in sustaining patient flow, for example assisting in capacity assessment, job planning and service development issues particularly in relation to issues affecting capacity and service provision.

4. Assess the waiting list and unscheduled access target positions for risk, identify and communicate issues affecting access and work with clinical and functional directorate teams to ensure plans are in place to deal with bottle-necks and pressures, escalating as appropriate.
5. Support staff from all key disciplines to ensure a whole system approach to improve and sustain waiting list and unscheduled care management and the development of elective and non elective access pathways.

6. Ensure the Trust is compliant with regional access policy issues for elective and non elective patients and that all supporting processes are in place, documented and implemented.

7. Manage development projects as directed by the Assistant Director for the division to further improve patient access and operational performance across the hospital system.

8. Be the main point of contact for day-to-day operational performance issues for the division.

9. Develop excellent working relations with key stakeholders to encourage collaborative working.

10. Provide updates on performance at Trust and regional meetings as required.

INFORMATION AND ANALYSIS:

1. Work with the Trust's Information Department to co-ordinate the collection and analysis of data to facilitate the monitoring of elective and non elective access and flows across the hospital system.

2. To analyse complex performance information to identify areas for improvement and to work collaboratively to develop plans to deliver improvement.

3. To monitor ongoing projects to assess outcomes, benchmarked against expected outcomes.

GENERAL MANAGEMENT:

1. Assume day to day line management responsibility for the administrative and clerical staff within the division.

2. Participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of staff. Provide guidance on personal development requirements, advise on and initiate, where appropriate, further training.

3. Maintain good staff relationships and morale amongst staff reporting to him/her.

4. Where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.

5. Participate as required in selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

6. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

7. Promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for which he/she has responsibility.

GENERAL RESPONSIBILITIES

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come in contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's No Smoking Policy.
- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- Adhere to equal opportunities policy throughout the course of their employment.
- Ensure the ongoing confidence of the public in service provision.
- Comply with the HPSS Code of Conduct.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the postholder works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Assistant Director of the division.

Personnel Specification:

Personnel Specification

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of the Southern Health and Social Care Trust and have:

- university degree or relevant professional qualification and worked for at least 1 year in a middle management role* within an acute hospital clinical support service

OR

- have worked for at least 3 years in a middle management role* within an acute hospital clinical support service.

AND

- experience of playing a lead role / managing projects within a multi-disciplinary environment within tight timescales.
- experience of playing a lead role in the successful implementation of change initiatives.
- a proven track record of people management and organisational skills.

- a full current driving licence with access to a car or access to a form of transport to meet the mobility needs of the post.

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at nhsleadershipqualities.nhs.uk Particular attention will be given to the following:

- Self Belief
- Self Management
- Drive for results
- Leading change through people
- Effective and strategic influencing

The following additional clarification is provided:

*"middle management role" is defined as experience gained *for example* at Admin & Clerical Grade 5 and above or Nursing & Midwifery Grade F and above or equivalent. The role must have included staff management responsibility.

June 2007

Other Information:

Downloads: SHSCT rpa

Instructions: Instructions for Completing Application Form

Southern Health & Social Care Trust

List of Admin & Clerical Staff within The Acute Directorate, Surgery & Elective Division as at 31 March 2013

Prepared by/HR Contact: Sarah Meenagh, Workforce Information Officer

Prepared for: Simon Gibson, Assistant Director, Acute Services / Helen Walker, Assistant Director of HR, Acute Services

Ref: ad_2013_177_v2

Date: 2 May 2013

NOTE: Contract Type Abbreviated	
Perm	Permanent
Temp	Temporary
BB	Block Booking

Location	Cost Centre	Surname	Forename1	Grade Description	Contract Type	Job Title as per HRMS	Comments	WTE	S GLENNY - QA	COMMENTS
	CAH - AD SURG/ELECT CARE ADMIN	CONWAY	MARIA	ADMIN & CLERICAL (5)	PERM	SERVICES ADMINISTRATOR		0.8	??	DECISION TO BE MADE ON SERVICE ADMINISTRATOR SUPPORT TO DIVISION
	CAH - SCHEDULING TEAM	CORR	SINEAD DENISE	ADMIN & CLERICAL (5)	PERM	SPECIALTY SCHEDULER		1	YES	SECONDED TO IS TEAM
		MCCLELLAND	MICHELLE	ADMIN & CLERICAL (5)	PERM	SERVICES ADMINISTRATOR		1	??	DECISION TO BE MADE ON SERVICE ADMINISTRATOR SUPPORT TO DIVISION
		LOUGHRAN	MARIE	ADMIN & CLERICAL (5)	PERM	SERVICES ADMINISTRATOR		1	??	DECISION TO BE MADE ON SERVICE ADMINISTRATOR SUPPORT TO DIVISION
		SCOTT	JANE	ADMIN & CLERICAL (5)	PERM	SERVICES ADMINISTRATOR		1	??	DECISION TO BE MADE ON SERVICE ADMINISTRATOR SUPPORT TO DIVISION
		RAFFERTY	LAURI	ADMIN & CLERICAL (5)	PERM			1	??	DECISION TO BE MADE ON SERVICE ADMINISTRATOR SUPPORT TO DIVISION

This report has been compiled and is intended for use only by the official recipient.

Due to the delay in receipt of, and occasional delays in processing and verification of, some New Start, Transfer/Amendment and Termination forms, the information contained in this report may not be completely up-to-date. In order to minimise this it is essential that New Start, Amendment/Transfer and Termination forms are completed and forwarded to the relevant department in a timely manner.

For staff on pay protection, the grade and pay scale information indicates the band that the person is currently protected on, not the actual post they are working in.

If you believe the information in this report does not accurately reflect the current position, please contact the Workforce Information Department.

Please remember your responsibilities under data protection legislation, for example ensure personal information is kept secure (for example not left in view of unauthorised staff or visitors), is only used for the purpose intended, and is not shared with anyone who should not have access to it. Also, once personal information has been used for its intended purpose it should be appropriately destroyed, or kept in a secure location if it is required for future use.

Glenny, Sharon

From: Glenny, Sharon <[redacted]>
Sent: 18 December 2013 14:58
To: Reid, Trudy; Corrigan, Martina; Nelson, Amie; Trouton, Heather
Cc: Scott, Jane M; McAreavey, Lisa; Conway, Maria
Subject: PERFORMANCE MEETING TODAY
Attachments: PERFORMANCE NOTES 18.12.13.docx; SEC Performance Update for Mon 16.12.13.xlsx

Hi Ladies

Please see attached the notes and information from today's meeting – just so you have an e-copy.

Thanks

Sharon

Mrs Sharon Glenny
Operational Support Lead
Surgery & Elective Care

Direct dial – [redacted]
Mobile - [redacted]

PERFORMANCE UPDATE WEEK BEGINNING 16.12.13 - ACCESS POSITION

			2012/2013 Baseline	2013/2014	December 2013							January 2014								IHA/IS Monitoring							1/4/13 - 122.13		
Division	Specialty	Activity Type	End March Access Position	HSCB Access Standard / Backstop	Total on PTL	Booked in-month	Not booked - in PB cycle for in-month	Not booked - not in PB cycle	Booked Beyond Breach	Current Month-End Projected Access Position (Longest waiter)	Projected Volumes in Excess of HSCB Access Standard / Backstop	Comments / Risks / Actions	Total on PTL	Booked in-month	Not booked - in PB cycle for in-month	Not booked - not in PB cycle	Booked Beyond Breach	Current Month End Longest Waiter if no plan found (without a date, not in PB cycle, BBB, WLS)	Projected month end Access Position (Longest Waiter)	Projected Volumes in Excess of Access Standard / Backstop	Comments / Risks / Actions	Q1&2 Allocation	Q1&2 Actual Activity	Variance on Q1&2	Modified Q3 Allocation	Q 3 Cumulative Actual IS Activity	Q3 Cumulative Actual IHA Activity	TOTAL cumulative IHA/IS Activity	IHA/IS Variance (Remaining)	IHA/IS Variance %	Comment
SEC	Breast Surgery	IP	30-weeks	30-weeks	1	0	-	0	1	30-weeks	-	Capacity problems for December due to red flag/cancer cases and possibility that there may be no PTL patients scheduled into December escalated to HOS on 21.11.13. 27.11.13 - AN discussing with breast consultants. 1 x IP booked beyond breach 27/01/2014 - LW 27 Wks 2 x DCs not booked LW 1 x 28 wks & 1 x 24 wks	7	0	1	6	0	45-weeks	26-weeks		3xDecember patients included in January projections - ??2 patients should be recorded as planned. Also 3xbreast reductions - ??EUR approval. PEM x 2 weeks annual leave in January - 2 GSUR NOP sessions "flipped" to give theatre sessions in core. Escalated to HOS 09.12.13 and 16.12.13										
SEC		DC	30-weeks	30-weeks	2	0	-	2	0	31-weeks	-		3	0	-	3	0	28-weeks												
SEC		IP/DC	30-weeks	30-weeks	3	0	-	2	1	31-weeks	-		10	0	-	9	0	45-weeks												
SEC	Endoscopy	IP	17-weeks	11-weeks	0	0	-	0	0	13-weeks		8 x (IS) pts not booked= LW x 15 wks - Emailed Sinead. 2 x IS pts booked with past dates = LW 1x11 wks & 1x 10 wks. - Emailed Sinead. patients booked with dates in the past = LW 1x11 wks & 1x10 wks - e-mailed CDSU. 3 x (IS) patients booked beyond breach - E-mailed Sinead.	2	0	-	2	0	-	11 weeks	currently 196 patients in excess of 9 week target	January = 125 IHA/IS allocation. There are 32 ISP washthrough patients in January, leaving an allocation of 93 for IHA - approval to proceed to offer out IHA on 12.12.13 - 18 weekend sessions secured x 6 patients = 108 patients - Atts to be monitored to ensure activity does not exceed allocation	768	692, now revised to 840 per JA 19.11.13	-72	375	178	150	328	47	87%	Activity for Q3 has been calculated on specialty coding rather than clinical coding, given the delays with IS clinical coding. There are a further 17 patients to be treated in ISP to meet 11 weeks in December and 50 IHA scheduled for remainder of December, ie, a total of a further 67 patients, making projections of **20 over allocation**
SEC		DC			68	60	-	8	0				526	316	-	210	0	17-weeks (WLS)												
SEC		IP/DC			68	60	-	8	0				528	316	-	212	0	17-weeks (WLS)												
SEC		IP/DC	17 Weeks	9-weeks	75	71	0	4	0	13-weeks			524	328	-	196														
SEC	ENT	NOP	9-weeks	9-weeks	639	198	182	64	195	15 Weeks	259	**15 WEEKS OP** - 36 patients on PTL (35 booked to December; 1 pt in PBC - 13 weeks @ 16/12/13). **12 weeks OP** - 184 pts on PTL, 168 with Dec dates. 16 pts not booked, 8 patients in PBC (PB1 x 7, PB2 x 1). 3 pts not in PBC (all 11 weeks); 1 pt with IS (11 wks); U18 dsc x 4. **9 weeks OP** - total patients on PTL = 639. 393 pts booked (198 in Dec; 195 in Jan). Pts not booked = 246 (182 pts in PBC (PB1 x 181, PB2 x 1); 64 pts not in PBC which includes 16 pts not triaged, 2 pts with St Francis, 6 x U18 dsc, 40 pts not in PBC).	1628	502	231	874		18 weeks	15 Weeks	**509**	**January PTL 1628 (1620 Trust / 8 IS) at 16/12** - **Booked position includes 201 Booked December/ 301 booked January** - **874 not booked excludes 8 IS /7 DIP and 6 U18 Discharge** **9 Weeks** - 874 Not Sorted Trust (114 GPC/GPU/ 760 Other) 8 Not Sorted IS LW Trust - 1 x 12 weeks LW IS - 1 x 11 weeks **12 Weeks December** - Approx 220 patients not sorted to achieve 12 Weeks end of January (3 Voice/ 27 ACH /40 CAH / 80 DHH /41 STH / 57 Not Triage) **15 Weeks December** - **16** patients not sorted (9 not triaged/ 1 voice and 6 other NOP IHA funding for 146 Paitents - HOS securing dates and audiology support Estimated 9 Week Roll over - includes use of IHA monies	875	1054	179	438	127	127	254	184	42%	I
SEC		IP	26-weeks	13-weeks	109	40	0	51	18	17 Weeks	69	**13 Weeks December** **Day Cases** - LW Not booked 15 weeks x 1 @16/12/13 (E241470 - POA hold) LW Booked January 1 x15 weeks @16/12/13. 1 pt booked to Feb 2014 - needs date by end Jan 2014 (B/F TO 240114). 3 IS Patients LW 17 weeks x 2 (e-mail to Sinead 16/12/13) **IN Patients** - LW Not Booked 1 x 15 weeks 7 IS patients LW 3 x 16 weeks (e-mail to Sinead 16/12/13) **17 Weeks end of December** - Total pts on PTL = 0. **17 weeks PTL sorted**.	216	64		128		24 weeks	17 weeks	137	**13 Weeks December at 16/12** In Patients - 192 Trust / 24 IS 64 Booked Trust and 2 IS/ 128 Not booked Trust/ 22 IS LW Trust not booked - 1 x 20 weeks wls, 3 x 18 weeks wls, 2 x 17 weeks wls, 1 x 16 weeks ..... **Day Cases** - 182 (174 Trust / 8 IS) 47 Booked (25 Dec and 22 Jan) 135 Not Booked (127 Trust and 8 IS) LW not booked - 1 x16 weeks wls, 3 x 15 weeks, 5 x 14 weeks, 12 x13 weeks Not Booked ..... **17 Weeks end of January at 16/12** **In Patients - 66 Booked(47 Dec/19 Jan) / 73 Not booked** Not Booked - 66 Trust and 7 IS LW Trust Not booked - 1 x 20 weeks (wls), 2 x 18 (wls), 2 x 17 weeks (wls), 1 x 16 weeks, 8 x 14 weeks, 12 x 13 weeks, 13 x 12 weeks, 12 x 11 weeks, 15 x 10 weeks LW IS - 3 x 17 weeks, 1 x 15 weeks, 3 x 11 weeks **Day Cases - 34 Booked (22 Dec/11 Jan/1 Feb) / 50 Not booked** LW Not Booked - 1 x 16 weeks (wls), 2 x 15 weeks (wls), 3 x 14 weeks, 5 x 13 weeks, 14 x 12 weeks, 14 x 11 weeks, 11 x 10 weeks	170	99	-71	85	63	53	116	31	36%	HOS Decision Required : Use list on 27.12 as Core Not WLIO and advise IS only treat patients who require to be treated to meet 17 weeks access i.e. 7 patients - this will reduce variance to 2 and with some ROTT this will be sorted
SEC		DC			66	18	0	39	9	17 Weeks	48		182	47		127		20 weeks	17 weeks	133										
SEC		IP/DC			175	58	0	90	27	19-weeks	117		398	111	0	255	0	24 Weeks	17 weeks											
SEC	General Surgery Nov= <28/09/13 Dec=<29/10/13	NOP	9-weeks	9-weeks	**217**	**203**	**4**	**10**	**0**	**17 - weeks**	0	Total on PTL = 217 , 10 x pts not booked not in PB cycle - LW= 1 x 14 wks, 1 x Pt not booked (IS) @ 13 wks - E-mailed Sinead.	1039	193	97	749	0	9 weeks	9 weeks	0	January = 218 IHA/IS allocation. Activity January 2013 = 764. Projected capacity core and IHA = 982	1630	1447	183	655	133	470	603	52	8%	A volume of 250 was returned to HSCB. A request for return of 90 has been made following specialism modelling. Projected end December = 124 IS and 530 IHA - a total of 654.
SEC		IP	47-weeks	30-weeks	**8**	**1**	**0**	**0**	**0**	**30-weeks**		Total on PTL = 19 patients. 2 x patients not booked - 1x24 wks & 1 x 27 wks - All sorted No risk.	19	4	0	15	0	72 weeks (WLS)	26 weeks	0	January = 75 IHA/IS allocation. 15 patients in IS washthrough, therefore 60 allocation remaining for IHA or further direct elective transfer.	472	215	257	225	109	53	162	63	28%	Surge of IS washthrough in Q4 expected - Lynn making case for under-utilisation in Q1&2 and potentially this quarter to be used to offset Q4 bulge. Project IHA for December is 35 patients, i.e., within Q3 allocation.
SEC		DC			**38**	**16**	**0**	**2**	**0**				102	16	0	86	0	34 weeks (WLS)	26 weeks											
SEC		IP/DC			**46**	**17**	**0**	**2**	**0**				121	20	0	101	0	72 weeks (WLS)	26 weeks											
SEC	Ophthalmology	NOP	18-weeks	24-weeks	9	8	0	1	0	26-weeks		1 x patient not booked, Waiting Time at 16/12/2013 - 23 wks - Laser Clinic Cancelled 02/12/2013 - machine broke and Miss Twaij on annual leave since then and then left the Trust. Miss Patel doing a laser clinic in January	168	46	67	55	0	28 weeks (ISP)	24 weeks	0	January - 133 IHA/IS allocation. 39 on January PTL with ISP - will possibly have NOP before end December. Clarification sought from Lynn as to whether SHSCT responsible for January ISP transfer of NOP	800	767	-33	400	282	0	282	118	30%	Anticipate that the full volume of 400 will be fulfilled by end of December. Provider has been advised not to exceed this volume
SEC		NOP	18-weeks	15-weeks	444	41	0	368	35	26-weeks	403 in excess of 15 weeks																			
SEC		DC	13-weeks	13-weeks	1	1	-	0	1	16-weeks	0	1 x Patient booked beyond breach with IS. This pt cancelled appt TBA.- E-mailed Sinead	23	8	-	15	0	17 weeks (WLS ISP)	13 weeks	0	January = 58 IHA/IS. 7 patients with ISP not booked for January	491	644	153	175	105	0	105	70	40%	All washthrough activity with ISP. 28 x DIP, 32 with dates in December, 26 PTLs requiring dates in December, 32 on WL but not PTLs, a further 29 expected from future NOP as washthrough. Projections could be as much as **- 69 patients. 17.12.13 - Provider has been advised to only treat those patients to hold the 13 week target and then within the allocation.**
SEC	Orthopaedics	NOP	13-weeks	13-weeks	44	44	0	0	0	13-weeks	0	No Risk	111	70	22	19	0	17-weeks (LW)	13-weeks	0	Capacity modelling for January indicates that while sufficient capacity exists on paper, there will be a shortfall with hands requiring 2 x LW clinics or transfer of 20 patients to ISP - decision now clarified re IHA/IS on 12.12.13 - one month's allocation = 57 patients. HSCB have confirmed cover for the addtional 14 NOP in December	342	298	44	171	27	168	195	-24	-14%	JMcC 3xNOP clinics re-coded to core following last week's performance meeting. LW x 1 NOP clinic on 30.12.13. 12 x DIP with ISP which will be added to IHA/IS for last week making variance -14 patients. Decision re Miss Wilson clinic on 30.12.13 and also remaining ISP patients required. Projections if all activity continues = **-33 patients. 17.12.13 - HSCB have confirmed that they will fund the overspend on Q3 allocation.**
SEC		IP	48-weeks	30-weeks	8	5	-	3	0	51-weeks (ISP)	0	Total on PTL = 12 Patients. 8 with dates in month, 1 now WLS as needs F2F at preop first (04.01.13), 3 in ISP need date.	40	5	-	35	0	52-weeks (WLS)			Exercise on washthrough completed 12.12.13 - findings were 47 patients expected in Q3 from 12/13 washthrough funding, therefore no longer projecting activity in excess of Q3 allocation.	596	322	274	115	83	35	118	-3	-3%	December JMcC - 5 sessions remaining which will be added to IHA with a total of 16 patients. 6 x DIP with ISP which will be added to IHA/IS for last week. 7 further patients with ISP during December. If all activity continues projections = **-38 patients, however, following washthrough exercise, 47 activity is from 12/13 washthrough and needs to be removed from Q3 allocation.**
SEC		DC			4	3	-	1	4				36	8	-	28	0	35-weeks (WLS)											
SEC		IP/DC			12	8	-	4	4				76	13	0	63	0	52-weeks (WLS)											
SEC		NOP (includes ICATS)]	17-weeks	9-weeks	322	46	0	266	10	25-weeks	276	**22 week NOP - Projecting 12 breaches of 22 weeks** - priority to haematuria patients per Heather (16.12.13), requiring NOP sessions originally allocated to LUTS.						26-weeks (LUTS)	22-weeks (LUTS)		All remaining patients not booked are with ICATS - LUTS primarily										
SEC				15-weeks (Cons & ICATS)	135	48	9	78	0	25-weeks	78																				

			2012/2013 Baseline	2013/2014	December 2013							January 2014								IHA/IS Monitoring										
Division	Specialty	Activity Type	End March Access Position	HSCB Access Standard / Backstop	Total on PTL	Booked in-month	Not booked - in PB cycle for in-month	Not booked - not in PB cycle	Booked Beyond Breach	Current Month-End Projected Access Position (Longest waiter)	Projected Volumes in Excess of HSCB Access Standard / Backstop	Comments / Risks / Actions	Total on PTL	Booked in-month	Not booked - in PB cycle for in-month	Not booked - not in PB cycle	Booked Beyond Breach	Current Month End Longest Waiter if no plan found (without a date, not in PB cycle, BBB, WLS)	Projected month end Access Position (Longest Waiter)	Projected Volumes in Excess of Access Standard / Backstop	Comments / Risks / Actions	Q1&2 Allocation	Q1&2 Actual Activity	Variance on Q1&2	Modified Q3 Allocation	Q 3 Cumulative Actual IS Activity	Q3 Cumulative Actual IHA Activity	TOTAL cumulative IHA/IS Activity	IHA/IS Variance (Remaining)	IHA/IS Variance %	Comment
SEC	Urology			22-weeks (Cons & ICATS)	37	18	7	12	0		12		78	30	0	48	0														
SEC		IP		26-weeks	131	5	0	125	1	61-weeks	126	**58 week IPDC PTL** - 1x61 wk PTL pt (@ 16/12/13) cancelled by hospital - medication issue - POA. Needs December date (CAH11925) - Mr Pahuja has offered 28.12.13. 1 pt with DIP for 14/12/13. STILL PROJECTING 58 WEEKS AT END DECEMBER.																			
SEC		DC		26-weeks	90	18	0	68	4	54-weeks	72																			
SEC		IP/DC		26-weeks	221	23	-	193	5	61-weeks	198	**26 week IPDC PTL** - IPs - 131 patients on PTL - 124 pts not booked. LW @ 16/12/13 = 61 wks x 1, 56 wks x 1, 55 wks x 3, 54 wks x 6 DCs - 68 patients with no dates. LW @ 16/12/13 = 56						50-weeks	50-weeks											
SEC		IP/DC		58-weeks December	6	4	0	2	0		2																			
		IP/DC		50-weeks January									70	8	-	62	0													
	Urodynamics (Urology)	Diag	44-weeks	15-weeks	58	6	0	52	0		52		72	5	0	67	0	60-weeks	56-weeks											
SEC		Diag	44-weeks	9 - weeks	74	6	0	65	4	56-weeks	69 in excess of 9 weeks	LW not booked at 16/12/13 = 49 weeks x 1	100	5	0	95	0	60-weeks	60-weeks											

Received from SHSCT on 02/11/2022. Annotated by the Urology Services Inquiry.

PERFORMANCE UPDATE WEEK BEGINNING 16.12.13 - SBA POSITION

			2013/2014 Baseline		DECEMBER - CUMULATIVE FROM 1/4/13 - 12/12/13 - WEEK 37				End December Projections		JANUARY PROJECTIONS - WEEK 44				
Division	**Specialty**	**Activity Type**	**2013/14 SBA (ANNUM)**	**MONTHLY EXPECTED SBA**	**CUMULATIVE EXPECTED SBA**	**CUMULATIVE ACTUAL**	**Current SBA Variance**	**Current SBA Variance %**	**END DEC SBA PROJECTION - VARIANCE**	**END DEC SBA PROJECTION - VARIANCE %**	**CUMULATIVE EXPECTED SBA**	**CUMULATIVE PROJECTED SBA**	**PROJECTED SBA Variance**	**PROJECTED SBA VARIANCE %**	SBA Comments / Actions / Risks
SEC	Breast Surgery	IP	299	25	213	177	-36	-16.90%							Please refer to Breast modelling paper. 5 x lost sessions in December - 2 x SOW, 2 x Bank Holidays, 1 x Audit. Breast reconstruction paper submitted last week to HSCB. JANUARY - 4 lost sessions - 2 BMcF annual leave, 1 x PEM annual leave (NScally backfilling 13th and 20th), 1 x BMcF Audit; however, 2 x "flipped" sessions with PEM in January. 14 PEM & BMcF MT sessions x 2 patients & 2 x DPU x 4 patients = 36
SEC		DC	101	8	72	78	6	8.33%							
SEC		IP/DC	400	33	285	255	-30	-10.53%	271	-12%	338	301	-37	-11%	
SEC	Endoscopy	IP	71	6	51	141	90	176.47%							January estimated capacity - 22 sessions x 4 weeks x 6.5 patients = 624 patients (Revised to reflect Mr Hurriez leaving)
SEC		DC	8005	667	5696	5307	-389	-6.83%							
SEC		IPDC	8076	673	5747	5448	-299	-5.20%	5866	-6%	6834	6300	-534	-8%	
SEC	ENT	NOP	8473	706	6029	5960	-68.9	-1.14%	6315	-3%	7169	6955	-214	-3%	Projected End December SBA = 6315 + projected January SBA 640 = 6955
		NOP (excluding SG)	7489	624	5329	5960	631	11.85%	6315	10%	6337	6955	618	10%	
SEC		ROP	8642	720	6149	8273	2124	34.54%			7312				
SEC		IP	1238	103	881	829	-52	-5.89%			1048				excludes CAWT
SEC		DC	1290	108	918	1020	102	11.13%			1092				excludes CAWT
SEC		IPDC	2528	211	1799	1849	50	2.79%	1998	3%	2139	2163	24	1%	53 x Dec sessions x 3 patients = 159 = Total 213 55 January lists x 3 patients = 165 (74 IP and 91 DC) (End Dec Projected SBA = 1998 + projected Jan SBA 165 = 2163
SEC	General Surgery	NOP	8748	729	6225	6453	228	3.66%	147	2%	7402	7640	238	3%	January based on last year's out-turn - DHH rota not available at present
SEC		ROP	11372	948	8092	6273	-1819	-22.48%							
SEC		IP	1451	121	1032	970	-62	-6.01%							
SEC		DC	3469	289	2468	2607	139	5.63%							
SEC		IP/DC	4920	410	3500	3577	77	2.20%	-69	-2%	4163	4046	-117	-3%	330 January patients projected
SEC	Opthalmology	NOP	3719	310	2646	2457	-189	-7.14%			Miss Twaij leaving Trust in December - overperformance will continue until that time. Visiting service after that time.				Mostly visiting service. SHSCT SBA overperforming for all areas. Underperformance overall due to SEHSCT underperformance. Ms Twaij leaving Trust in December.
SEC		NOP SHSCT	731	61	520	562	42	8.08%							
SEC		ROP	7702	642	5480	5087	-393	-7.17%							
SEC		ROP SHSCT	1639	137	1166	1231	65	5.57%							
SEC		DC	991	83	705	646	-59	-8.37%							
SEC		DC SHSCT	292	24	208	278	70	33.65%							
SEC	Orthodontics	NOP	542	45	386	271	-115	-29.79%							SBA for this year has not been revised. Awaiting Regional Dentistry Review.
SEC		ROP	3932	328	2798	1963	-835	-29.84%							
SEC	Orthopaedics (excluding ICATS)	NOP	1880	157	1338	1322	-16	-1.20%	-44	-3%	1591	1572	-19	-1%	145 NOP remaining in December (after JMcC recoding) and 170 NOP anticipated in January 2014
SEC		ROP	2825	235	2010	2007	-3	-0.15%							
SEC		IP	642	54	457	450	-7	-1.53%							
SEC		DC	496	41	353	369	16	4.53%							
SEC		IP/DC	1138	95	810	819	9	1.11%	-8	-1%	963	977	14	1%	110 estimated for January as at 10.12.13.
SEC	Trauma (Fracture clinic)	NOP	3944	329	2806	3590	784	27.94%							
SEC		ROP	7656	638	5448	6377	929	17.05%							
SEC	Urology (includes	NOP	3949	329	2810	2463	-347	-12.35%		-13%	3038	2623	-415	-14%	Based on modelling of 05.11.13 and Suresh sessions
SEC		ROP	5405	450	3846	3003	-843	-21.92%							
SEC		IP	571	48	406	770	364	89.66%							
SEC		DC	4385	365	3120	1771	-1349	-43.24%							

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			2013/2014 Baseline		DECEMBER - CUMULATIVE FROM 1/4/13 - 12/12/13 - WEEK 37				End December Projections		JANUARY PROJECTIONS - WEEK 44				
Division	**Specialty**	**Activity Type**	**2013/14 SBA (ANNUM)**	**MONTHLY EXPECTED SBA**	**CUMULATIVE EXPECTED SBA**	**CUMULATIVE ACTUAL**	**Current SBA Variance**	**Current SBA Variance %**	**END DEC SBA PROJECTION - VARIANCE**	**END DEC SBA PROJECTION - VARIANCE %**	**CUMULATIVE EXPECTED SBA**	**CUMULATIVE PROJECTED SBA**	**PROJECTED SBA Variance**	**PROJECTED SBA VARIANCE %**	SBA Comments / Actions / Risks
	[redacted] ICATS)	OPwP (TRUSB & Urodynamics) - clinic attendances				370									
SEC		IP/DC	4956	413	3526	2911	-615	-17.44%	-771	-20%	4194	3310	-884	-21%	Estimate that 130 elective activity remaining in December and projecting 269 for January - see modelling

DECEMBER		
		31/12/2013
9 weeks	63	29/10/2013
12 weeks	84	08/10/2013
13 weeks	91	01/10/2013
15 weeks	105	17/09/2013
22 weeks	154	30/07/2013
24 weeks	168	16/07/2013
26 weeks	182	02/07/2013

JANUARY		
		31/01/2014
9 weeks	63	29/11/2013
12 weeks	84	08/11/2013
13 weeks	91	01/11/2013
15 weeks	105	18/10/2013
22 weeks	154	30/08/2013
24 weeks	168	16/08/2013

SEC UPDATE - 18.12.13

	DECEMBER 2013		JANUARY 2014		NOTES
	Access	**SBA**	**Access**	**SBA**	
Breast Surgery	28 weeks	-30 -10.53% Month end -12%	26 weeks	-37 -11%	5 lost lists in December. ***Amie has escalated 1 x breach for December – no capacity remaining as all December capacity now scheduled with red flag cancer cases.*** Mr Mallon x 2 weeks leave in January – GSUR clinics "swapped" with theatre sessions and N Scally backfilling Mon PM sessions to increase elective capacity Mr McFall – 3 lost sessions in January - 2 x AL, 1 x Audit DB – Amie to lay out BMcF timeline to bring to Department on Friday. Leaving date 01.04.14. EM has been in contact with Dublin re gap.
Endoscopy	11 weeks	-299 -5.20% Month End -6%	11 weeks	-534 -8%	All patients for December now have plan to meet 11 weeks. Double procedures 01.04.13 – 31.08.13 – 228 patients. January capacity has been reduced due to Mr Hurriez departure and junior doctor support at clinics. Projecting 196 in excess of 9 weeks at end of January. Additionality for January now on offer following approval on Thursday and majority secured – one month volume = 125 patients DB – need to work to 10 weeks for January access
General Surgery New OPD	9 weeks	+228 +3.24% Month End +147 +2%	9 weeks	+238 +3%	10 patients not booked for December 9 week target January PTL (excluding December) = 1039 patients – higher volume than normal, possibly due to resets from last batch of ISP transfers. January 2012 out-turn = 764 in core IHA January = 218 NOP PB cycle only just started for January – DHH rota late (issued on Monday), therefore yet to set ROTT.

SEC UPDATE - 18.12.13

					Loss of Mr Hurriez from January forward will demonstrate a reduction in capacity - ?potential to use his funding for further IHA if required. Modelling had been completed before I was aware of this on Monday * IHA/IS Q3– initial calculations on pure capacity/demand demonstrated a potential underspend of 250 NOP which was put up for savings, however, a more recent review of actual casemix once PTL closed revealed that there was a colorectal capacity problem, therefore requiring a return of 90 NOP. Lynn has requested a return of 90 NOP additionality, sessions are in place, Lynn not anticipating a problem with this. IHA/IS January – allocation of 218 confirmed on Thursday. Offers out to consultant, but poor pick up as yet. ??? need to consider ISP – to be discussed with Debbie & Lynn DB – patients to be out with ISP by cop Friday if using and dates to be allocated for patients by first week in January.
General Surgery Elective	26 weeks	+77 +2.2% Month End -69 -2%	26%	-93 -2%	6 RFA patients cancelled last week, 5 of which were December PTLs – Mr Weir had to attend theatre for emergency case. Mr Weir has agreed to re-schedule session to 31st December and ward has confirmed yesterday that they can staff the session – all 6 patients being contacted, but reasonableness of offer lost. SBA projections based on pure elective activity, however, this normally improves with endoscopy overflow into GSUR following 4 scope procedure coding. IHA/IS Q3 – all on track IHA/IS January – allocation of 75 confirmed on Friday. 17 patient on ISP waiting lists to hold 26 weeks, therefore 58 remaining for IHA. Q4 – 271 on ISP waiting lists alone for Q4 and only an anticipated allocation of 225.
Ophthalmology NOP	24 weeks	-189 -7.14%			SHSCT +42 and +8.08%. Miss Twaij now on annual leave and then leaving Trust thereafter.

SEC UPDATE - 18.12.13

					One potential breach for December – laser patient cancelled last week as machine broke on day. Miss Twaij on leave since then and no further clinics to re-schedule to – 25/26 weeks at end of December. ***Miss Patel picking up laser clinics in January **** IHA/IS Q3 – formal communication to ISP re allocation and not to exceed 400 volume. NOP outside of 24 weeks after 400 volume met to be "stacked" until January. January allocation – confirmation on Friday for allocation of 133 patients – selection completed and referrals currently being pulled by IS Team. DB – Mr Page has now formally notified of retirement. Meeting with HSCB in January to be organised.
Ophthalmology Elective	13 weeks	-59 -8.37%	13 weeks		SHSCT +70 and +33.65%. Washthrough from ISP much bigger in Q1&2 than anticipated. IHA/IS Q3 – formal communication to ISP re treatment of 13 week PTL patients only. If volume still remains then can treated further down through list, otherwise procedures are to be "stacked" until January.
Orthopaedics NOP	13 weeks	-16 -1.20% Month End -44 -3%	13 weeks	-19 -1%	All patients for 13 weeks December booked. IHA/IS Q3 – HSCB have confirmed they will cover the projected over performance on IHA/IS of 33 NOP. IHA/IS January – allocation of 57 patients – 2 additional clinics required for Miss Wilson, remaining required for Mr McConway.
Orthopaedics Elective	26 weeks	-10 -1.31%	26 weeks	-1%	8 ortho patients cancelled this week due to trauma influx – one of which December PTL ***Potentially one December breach at month end – 29 weeks**** IHA/IS – allocation of 115, with 4 remaining for December. Anticipating activity of 47 IHA/IS in December, therefore further additionality requested. Analysis of activity to date/planned for December demonstrated that there are 47 patients from 12/13 washthrough which need netted off allocation, therefore will not overperform on allocation.

SEC UPDATE - 18.12.13

					IHA/IS January – 38 patients. 10 patients with ISP, therefore 28 patients remaining for IHA (Mr McConway) DB – Non-PTL of Mr McKeown to be cancelled to replace with PTL
ENT NOP	15 weeks	-69 -1.14% without 2nd staff grade +631 +11.85%	15 weeks	-214 -3% Without 2nd staff grade +618 +10%	Problem with additionality in that audiology unable to cover the additional clinics in November and December - had late notice of this – extension in waiting time as fall out from this. Patients requiring audiology for NOP were cancelled and replaced with other patients. IHA/IS - Q1&2 overspend will not be removed from Q3 allocation, therefore projecting an underspend of 180, however, at this point unable to use the remainder of allocation – Lynn has formally informed HSCB. IHA/IS January – allocation of 146 – normally 1/3 IS and 2/3 IHA, but may need to consider increased volume for ISP given difficulty securing IHA with audiology cover – to be discussed with Lynn & Debbie. Also SJH re transfer of patients.
ENT Elective	17 weeks	+50 +2.79%	Aiming for 17 weeks	+24 +1%	IHA/IS – allocation of 85, which will be used to hold 17 weeks. 6 patients with ISP (St Francis) to hold 17 weeks in December – no dates. IS to confirm with HOS that dates have been confirmed and risk averted. - ******Breaches for December****** A further allocation of 25 was requested to reduce to 9 weeks, however, at this point we would have no theatre capacity to use this – Lynn has informed HSCB. ISP has been informed to only schedule volume of patients to hold 17 weeks PTL give close proximity to Q3 allocation at present. IHA/IS January – 28 elective – 7 with ISP, leaving 21 for IHA – 2 all day Saturdays secured, ie, 4 sessions which will account for remainder of allocation.
Urology NOP	24 weeks (LUTS)	-347 -12.35% Month End -13%	22 weeks	-415 -14%	12 LUTS patients outside of 22 weeks at end of December. AD decision to have haematuria instead of LUTS – red flag service. Therefore longest wait at end of December will be 24 weeks 78 patients in excess of 15 weeks at end of December. 48 LUTS patients for January (including 12 rollover) – Martina raising with Jenny re clinic capacity to see all patients in January.
Urology Elective	58 weeks	-615 -17.44%	50 weeks	-881 -21%	Had originally anticipated -17% by end of December, but looking more like -20%.

SEC UPDATE - 18.12.13

		Month End -771 -20%			January team scheduling this afternoon.
Urodynamics	56 weeks		56 weeks		At end of December: 69 > 9 weeks 52 > 15 weeks DB – work to 52 weeks for urodynamics.

Glenny, Sharon

From: Glenny, Sharon <[redacted]>
Sent: 15 September 2015 10:05
To: Trouton, Heather; Reid, Trudy; Corrigan, Martina; Nelson, Amie
Subject: SEC PERFORMANCE UPDATE WC 14 09 15 with SEPT modelling and IP-DC split.xlsx
Attachments: SEC PERFORMANCE UPDATE WC 14 09 15 with SEPT modelling and IP-DC split.xlsx

Importance: High

Hi Ladies

Please see attached updated performance report in advance of tomorrow's meeting with Lesley.

Happy to talk through.

Thanks

Sharon

WIT-81821

SEC PERFORMANCE REPORT
WITH SBA MODELLING, PROJECTIONS
& IP/DC SPLIT
AS AT 14.09.15

2015/2016

Speciality	Division	OP/IP/DC	15/16 SBA tbc	Apr-15: Expected SBA-April	Expected Capacity April	Capacity - ROTT 5%	Expected Activity	Actual Activity	Variance-Patients	% Variance	Projected Access	May-15: Expected SBA-May	Expected Capacity May	Capacity - ROTT 5%	Expected Activity	Actual Activity	Variance-Patients	% Variance	Projected Access
BREAST SURGERY	SEC	IP	299	25				23		0.00%	42 weeks	50				41	-9	-17.73%	35 weeks 21 > 13 weeks 5 > 26 weeks
BREAST SURGERY	SEC	DC	101	8				8		0.00%		17				13	-4	-22.77%	
BREAST SURGERY	SEC	IP/DC	400	33	32	30	30	31	-2	-7.00%		67	28	27	51	54	-13	-19.00%	
ENDOSCOPY - SYMPTOMATIC	SEC	IP	71	6		0	0	19	-6	-100.00%	34 weeks 569 > 9 weeks	12		0	0	34		0.00%	27 weeks 720 > 9 weeks
ENDOSCOPY - SYMPTOMATIC	SEC	DC	7727	644		0	0	594	-644	-100.00%		1288		0	0	1171		0.00%	
ENDOSCOPY - SYMPTOMATIC	SEC	IP/DC	7798	650	675	641	641	613	-37	-5.67%		1300	695	660	1273	1205	-95	-7.28%	
GENERAL SURGERY	SEC	OP	10384	865	845	42	803	913	48	5.51%	28 weeks (colorectal/ vascular) 415 > 15 weeks 1557 > 9 weeks	1731	870	827	1740	1658	-73	-4.20%	24 weeks (colorectal/ vascular) 1650 > 9 weeks 550 > 15 weeks
GENERAL SURGERY	SEC	IP	1529	127				131	4	2.81%	52 weeks 270 > 26 weeks	255				252	-3		58 weeks 230 > 26 weeks
GENERAL SURGERY	SEC	DC	4301	358				355	-3	-0.95%		717				645	-72		
GENERAL SURGERY	SEC	IP/DC	5830	486	470	24	447	486	0	0.03%		972	460	437	923	897	-75	-7.68%	
ENT	SEC	OP	9106	759	710	36	675	724	-35	-4.59%	28 weeks 1530 > 15 weeks 2749 > 9 weeks	1518	790	751	1425	1386	-132	-8.68%	31 weeks 3111 > 9 weeks 1880 > 15 weeks
ENT	SEC	IP	1460	122				83	-39	-31.78%	16 weeks	243				152	-91	-37.53%	18 weeks 17 > 13 weeks
ENT	SEC	DC	1390	116				171	55	47.63%		232				349	117	50.65%	
ENT	SEC	IP/DC	2850	238	234	12	222	254	17	6.95%		475	252	239	493	501	26	5.47%	
UROLOGY	SEC	OP	3949	329	330	17	314	322	-7	-2.15%	46 weeks	658	330	314	627	606	-52	-7.93%	50 weeks 1461 > 9 weeks 1142 > 15 weeks
UROLOGY - submitted SBA	SEC	OP	3591	299				322	23	7.60%		599			627	606	8	1.25%	
UROLOGY - urodynamics	SEC			0		0	0		0		39 weeks	0		0	0		0		39 weeks
UROLOGY	SEC	IP	571	48				71	23	49.21%	88 weeks 293 > 26 weeks	95				164	69	72.33%	93 weeks 323 > 26 weeks
UROLOGY	SEC	DC	4385	365				255	-110	-30.22%		731				512	-219	-29.94%	
UROLOGY	SEC	OPwP Patient activity		0				40	-70	-19.29%						84			
UROLOGY (no OPP)	SEC	IP/DC	4956	413				326	-87	-21.07%		826				676	-150	-18.16%	
UROLOGY (with OPP)	SEC	IP/DC	4956	413	380	19	361	366	-47	-11.38%		826	355	337	698	760	-66	-7.99%	
UROLOGY (with OPP) PROPOSED NEW SBA	SEC		4630	386				366	-20	-5.14%		772				760	-12	-1.51%	
ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	OP	2685	175	200	10	190	211	36	20.57%	42 weeks (upper) 703 > 15 weeks 1014 > 9 weeks	361	208	198	409	402	41	11.36%	45 weeks (upper) 770 > 13 weeks
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	IP	965	62	58			58	-4	-6.45%	66 weeks 374 > 26 weeks	127				108	-19	-14.96%	69 weeks 415 > 26 weeks
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	DC	754	49	47			47	-2	-4.08%		100				118	18	18.00%	
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	IP/DC	1719	112	111	6	105	105	-7	-6.25%		229	120	114	219	226	-3	-1.31%	
CANCELED ORTHO ELECTIVE CASES FOR TRAUM INFLUX																			
FRACTURE NOP	SEC	NOP	5866	489		0	0		-489	-100.00%		978		0	0	1230	252	25.81%	
TRAUMA Non-elective	SEC	IP/DC	1691	141		0	0		-141	-100.00%		282		0	0		-282	-100.00%	

Speciality	Division	OP/IP/DC	Jun-15: Expected SBA-June	Expected Capacity June	Capacity - ROTT 5%	Actual Activity	Variance-Patients	% Variance	Projected Access	Jul-15: Expected SBA-July	Expected Capacity July	Capacity - ROTT 5%	Expected Activity	Actual Activity	Variance-Patients	% Variance	Projected Access
BREAST SURGERY	SEC	IP	75			58	-17	-22.41%	33 weeks 5 > 26 weeks 26 > 13 weeks	100	24	23	82	77	-23	-22.74%	37 weeks 5 > 26 weeks 19 > 13 weeks
BREAST SURGERY	SEC	DC	25			31	6	22.77%		34	10	9	41	51	17	51.49%	
BREAST SURGERY	SEC	IP/DC	100	38	36	87	-13	-12.90%		133	34	32	123	128	-5	-4.00%	
ENDOSCOPY - SYMPTOMATIC	SEC	IP	18			51	33	187.32%	31 weeks 670 > 9 weeks Urgent Planned - on time Planned - 9 months backlog Urgent - 12 weeks	24	5	5	56	65	41	174.65%	99 core symptomatic sessions x 6.2 patients = 614 patients Total of 650 patients Red flag - on time Urgent - 12 weeks Urgent planned - on time Planned - 8-9 months backlog Routine - 32 weeks 900 > 9 weeks
ENDOSCOPY - SYMPTOMATIC	SEC	DC	1932			1888	-44	-2.26%		2576	646	614	2502	2396	-180	-6.98%	
ENDOSCOPY - SYMPTOMATIC	SEC	IP/DC	1950	705	670	1939	-11	-0.54%		2599	654	621	2560	2461	-138	-5.32%	
GENERAL SURGERY	SEC	OP	2596	920	874	2577	-19	-0.73%	27 weeks 1620 > 9 weeks 610 > 15 weeks	3461	600	570	3147	3135	-326	-9.43%	Per OP slot report 28 weeks 1770 > 9 weeks 940 > 15 weeks
GENERAL SURGERY	SEC	IP	382			390	8	2.03%	62 weeks 230 > 26 weeks	510	92	87	477	495	-15	-2.88%	Based on available sessions on July theatre rota 66 weeks 250 > 26 weeks
GENERAL SURGERY	SEC	DC	1075			980	-95	-8.86%		1434	238	226	1206	1292	-142	-9.88%	
GENERAL SURGERY	SEC	IP/DC	1458	490	466	1370	-88	-6.00%		1943	330	314	1684	1787	-156	-8.04%	
ENT	SEC	OP	2277	870	827	2274	-3	-0.11%	33 weeks 3095> 9 weeks 2135 > 15 weeks	3035	790	751	3025	2925	-110	-3.63%	37 weeks 3400 > 9 weeks 2380 > 15 weeks
ENT	SEC	IP	365			215	-150	-41.10%	18 weeks 15 > 13 weeks	487	58	42	257	278	-209	-42.88%	19 weeks 50 > 13 weeks
ENT	SEC	DC	348			503	156	44.75%		463	136	142	645	642	179	38.56%	
ENT	SEC	IP/DC	713	260	247	718	6	0.77%		950	194	184	902	920	-30	-3.16%	
UROLOGY	SEC	OP	987	358	260	869	-118	-11.98%	53 weeks 1480 > 9 weeks 1200 > 15 weeks	1316	190	181	1050	1054	-262	-19.93%	Based on July OP available slots per urology rota
UROLOGY - submitted SBA	SEC	OP	699			869	170	24.32%		1197			1035	1054	-143	-11.95%	
UROLOGY - urodynamics	SEC								42 weeks								
UROLOGY	SEC	IP	143	102		255	112	78.63%	97 weeks 300 > 26 weeks	190	71	67	322	324	134	70.23%	Working at 55-60% of normal activity Originally projected to be -14% at end of July due to such high levels of annual leave, however, actual activity remaining fairly high despite the leave, making July month end position much better
UROLOGY	SEC	DC	1096	294		806	-170	-15.53%		1462	167	159	965	1064	-226	-15.44%	
UROLOGY	SEC	OPwP Patient activity		32		120					28	27	147	172			
UROLOGY (no OPP)	SEC	IP/DC	1239	396		1061	-178	-14.37%		1652	238	226	1287	1388	-264	-15.98%	
UROLOGY (with OPP)	SEC	IP/DC	1239	370	352	1181	-58	-4.68%		1652	266	253	1434	1560	-92	-5.57%	
UROLOGY (with OPP) PROPOSED NEW SBA	SEC		1158			1181	24	2.03%		1543				1560	17	1.08%	
ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	OP	563	200	190	609	46	8.17%	40 weeks (upper) 810 > 13 weeks 700 > 15 weeks	765	180	171	780	808	43	5.62%	Apportioned SBA scenario 2 Capacity based on July rota
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	IP	198			184	-14	-7.07%	73 weeks 400 > 26 weeks	269	55	52	236	246	-23	-8.55%	
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	DC	155			186	31	20.00%		210	55	52	238	259	49	23.33%	
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	IP/DC	355	140	133	370	15	4.23%		481	110	105	475	505	24	4.99%	
CANCELED ORTHO ELECTIVE CASES FOR TRAUM INFLUX						38	53	14.93%						38	62	12.89%	
FRACTURE NOP	SEC	NOP	1455			2080	625	42.96%	218 on the additional "FRAC" codes	1955		0		2918	963	49.23%	345 on the additional "FRAC" codes
TRAUMA Non-elective	SEC	IP/DC	406			478	72	17.73%		564		0		648	84	14.96%	

Speciality	Division	OP/IP/DC	Aug-15: Expected SBA-Aug	Expected Capacity Aug	Capacity - ROTT 5%	Actual Activity	Variance-Patients	% Variance	Projected Access	Sep-15: Expected SBA-Sept	Expected Capacity Sept	Capacity - ROTT 5%	Expected Activity	Variance-Patients	% Variance	Projected Access
BREAST SURGERY	SEC	IP	125	18	17	95	-30	-23.75%	NO annual leave in Aug for Pete or Helen Bank holiday on 31st August Quite a few one patient only sessions in August 44 weeks at month end	150	25	24	119	-31	-20.57%	NO annual leave in Sept for Pete or Helen SL on 4th Sept only for Pete 47 weeks
BREAST SURGERY	SEC	DC	42	16	15	66	24	56.83%		51	13	12	78	28	55.15%	
BREAST SURGERY	SEC	IP/DC	167	34	32	160	-6	-3.82%		200	38	36	196	-4	-1.80%	
ENDOSCOPY - SYMPTOMATIC	SEC	IP	30	5	5	71	41	140.00%	Much Lower than average 95 sessions this month 75 core symptomatic sessions x 6.2 patients = 465 ptatients 490 actually scheduled N/E Battisti on [redacted] wef 03/08/2015 Loss of 20 sessions in-month (124 patients) If these sessions had not been lost, would have had a month end position of -4% GSUR scopes recoding jumps from an ave of 25 per month to 133 in Aug so there must be a volume of endoscopy still uncoded for August	36	8	8	79	43	121.41%	114 sessions x 6.2 patients = 707 patients 18 weeks if secure all ISP volume 39 weeks if unable to take chronologically for ISP
ENDOSCOPY - SYMPTOMATIC	SEC	DC	3220	490	466	2703	-517	-16.05%		3864	735	698	3401	-462	-11.96%	
ENDOSCOPY - SYMPTOMATIC	SEC	IP/DC	3249	495	470	2931	-318	-9.78%		3899	750	713	3644	-255	-6.55%	
GENERAL SURGERY	SEC	OP	4327	710	675	3819	-508	-11.73%	August annual leave affecting capacity Issue with junior doctor cover at clinics limiting capacity volumes per clinic 29 Weeks	5192	740	703	4522	-670	-12.90%	Issue with junior doctor cover at clinics Capacity revised to reflect lower expected volumes due to junior doctor cover Originally projected 920 for Sept 40 weeks
GENERAL SURGERY	SEC	IP	637	100	95	586	-51	-8.02%	As at 24/08/2015 Activity to Date: 230 DC and 60 IP = 290 total Scheduled: 88 DC, 21 IP = 119 total Expected August = 318 DC, 91 IP = 409 total 69 weeks I have taken an average of GSUR scopes recoding for August, as there appears to be a volume of scopes uncoded as yet which would falsely inflate GSUR figures	765	145	138	724	-41	-5.33%	September Capacity CAH M/T - 48 sessions x 2 pts = 96 CAH DSU - 10 sessions x 4 pts = 40 STH DPU - 20 sessions x 4 pts = 80 DHH Th - 59 sessions x 2.5 pts = 148 RFA - 6 sessions x 4 pts = 24 DHH MIOPS - 4 weeks x 10 pts = 40 Haem - 4 weeks x 3 pts = 12 Scopes Recoding Ave = 25 SEPT TOTAL = 465 patients 73 weeks (growth of 2.5 weeks per month)
GENERAL SURGERY	SEC	DC	1792	335	318	1597	-195	-10.89%		2151	345	328	1925	-226	-10.50%	
GENERAL SURGERY	SEC	IP/DC	2429	435	413	2183	-246	-10.13%		2915	490	466	2649	-267	-9.14%	
ENT	SEC	OP	3794	810	770	3673	-121	-3.19%	As at 24/08/2015: Attendances to date = 534 NOP Booked = 250 NOP TOTAL NOP expected = 784 NOP 38 weeks	4553	790	751	4424	-130	-2.84%	Allowance made for slight reduction in capacity - may be a little too conservative and position may be better 39 weeks (growth of 2 weeks each month) 38 weeks
ENT	SEC	IP	608	45	43	344	-264	-43.45%	Issues with junior doctors backfilling theatre sessions as per NIMDTA report which has reduced originally projected volumes for summer period and affected SBA reporting 24 weeks	730	83	79	423	-307	-42.08%	24 weeks holding position each month
ENT	SEC	DC	579	130	124	759	180	31.05%		695	171	162	921	226	32.58%	
ENT	SEC	IP/DC	1188	175	166	1086	-101	-8.53%		1425	254	241	1328	-97	-6.84%	
UROLOGY	SEC	OP	1645	250	238	1289	-356	-21.66%	High level of leave in August As at 24/08/2015 179 attendances to date 61 booked in August Total expected = 240-250 patients 66 weeks	1975	358	340	1629	-345	-17.49%	24/08/2015 - Appt slot report = 358 NOP for September 58 weeks (growth of one week approx each month)
UROLOGY - submitted SBA	SEC	OP	1496			1289	-207	-13.85%		1796			1629	-166	-9.27%	
UROLOGY - urodynamics	SEC															
UROLOGY	SEC	IP	238	78	74	392	154	64.76%	Working at 70% of normal activity when all consultants here	286	105	100	492	206	72.24%	Almost full use of theatre sessions in September - loss of just 2 sessions in month. Therefore planning assumptions based on June delivery 111 weeks (growth of 4 weeks each month)
UROLOGY	SEC	DC	1827	202	192	1293	-332	-18.18%		2193	300	285	1578	-375	-17.08%	
UROLOGY	SEC	OPwP Patient activity		30	29	202					40	38	240			
UROLOGY (no OPP)	SEC	IP/DC	2065	280	266	1685	-380	-18.40%		2478	405	385	2070	-408	-16.47%	
UROLOGY (with OPP)	SEC	IP/DC	2065	310	295	1887	-178	-8.62%		2478	445	423	2310	-168	-6.79%	
UROLOGY (with OPP) PROPOSED NEW SBA	SEC		1929			1887	-42	-2.19%		2315			2310	-5	-0.23%	
ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	OP	1000	140	133	924	-76	-7.60%	Apportioned SBA scenario 2 Capacity based on August rota 48 weeks	1235	220	209	1133	-102	-8.26%	Apportioned SBA scenario 2 Study leave x 6 consultants x 3-4 days in Sept Mr Alam and Mr Watson seeing M&G at OPD clinics only, no NOP 50 weeks (growth of 2.5 weeks per month)
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	IP	356	65	62	300	-56	-15.73%	77 weeks	443	94	89	389	-54	-12.12%	68 sessions x 2.5 patients = 170 patients 80 weeks (growth of 3 weeks per month) 480 > 26 weeks
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	DC	278	75	71	321	43	15.47%		346	76	72	393	47	13.64%	
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	IP/DC	637	140	133	621	-16	-2.51%		793	170	162	783	-11	-1.32%	
CANCELED ORTHO ELECTIVE CASES FOR TRAUM INFLUX						58	42	6.59%					58	48	5.99%	
FRACTURE NOP	SEC	NOP	2444		0	3634	1190	48.68%	451 on the additional "FRAC" codes	2933		0				
TRAUMA Non-elective	SEC	IP/DC	705		0				August not finalised as yet	846		0				

Speciality	Division	OP/IP/DC	NOTES - 14/09/2015
BREAST SURGERY	SEC	IP	**Total** BSUR waiting list = 66 patients **Urgent** = 32 patients - 13 with dates, 19 with no dates longest waiter at end Sept = 30 weeks Majority = 17 weeks or less, 3 > 17 weeks **Routine** = 34 patients - 5 with date, 29 with no dates Longest waiter at end Sept = **47 weeks (6 hr reconstruction)** **33 > 13 weeks** **19 > 26 weeks**
BREAST SURGERY	SEC	DC	
BREAST SURGERY	SEC	IP/DC	
ENDOSCOPY - SYMPTOMATIC	SEC	IP	**Total** Waiting List = 2488 patients **Urgent** = 1355 patients 511 with dates, 804 no dates Longest waiter = 31 weeks (EM IP) Cluster at 12 weeks 25 > 12 weeks 18 x SMY only to do - rolling over 3 x U/G 4 x IP **Routine** = 1133 patients 84 with dates, 1049 with no dates Longest waiter = 41 weeks 750 patients identified for potential transfer to ISP **1150 > 9 weeks by end September** **405 > 9 weeks if all ISP delivered** **Scheduling of Sessions:** April - 98 sessions, 638 patients, 6.5 per list May - 102 sessions, 639 patients, 6.3 per list June - 115 sessions, 770 patients, 6.7 per list July - 97 sessions, 596 patients, 6.14 per list Aug - 75 sessions, 490 patients, 6.5 per list
ENDOSCOPY - SYMPTOMATIC	SEC	DC	
ENDOSCOPY - SYMPTOMATIC	SEC	IP/DC	
GENERAL SURGERY	SEC	OP	**Total** NOP Waiting list = 4218 **Urgent** = 929 - 172 with dates, 757 with no dates Longest waiter = cluster at 17 weeks, few stragglers Actual longest waiter = 24 weeks 15 > 17 weeks by month end 3289 **Routine** - 151 with dates, 3138 no dates Longest Waiter = 33 weeks **NOP attendances by month** April = 913 May = 745 June = 919 July = 558 Aug = 459 to date, with 251 appts = 710 **2850 > 9 weeks** **1700 > 15 weeks**
GENERAL SURGERY	SEC	IP	**Total Elective** Waiting List = 1251 **239 Urgent** - 57 with dates, 182 with no dates Urgent Longest Waiter = cluster at 26 weeks Actual Longest Waiter - 60 weeks (EE patient) 58 weeks x 1 - EE patient 50 weeks x 1 - EE patients 44 weeks x 1 - CDW patient 16 > 26 weeks **1012 Routine** - 178 with dates, 834 with no dates Longest Waiter = 73 weeks (JYG patient) 71 weeks x 1 - vasc 70 weeks x 5 - vasc **300 > 26 weeks** **Issue with filling DHH lists and MIOPS lists in STH this month due to lack of suitable cases and patients being pre-op fit**
GENERAL SURGERY	SEC	DC	
GENERAL SURGERY	SEC	IP/DC	
ENT	SEC	OP	**Total NOP** Waiting List = 5173 261 **Urgent** - 155 with dates, 106 with no dates Urgent Longest waiter = cluster at 12 weeks 7 > 12 weeks (all in PB cycle, UGs, U18 discharge etc) Actual Urgent LW = 26 weeks 4912 **Routine** - 634 with dates, 4278 with no dates Longest waiter = 46 weeks **3300 > 9 weeks** **2800 > 15 weeks**
ENT	SEC	IP	**Issue with junior doctors not backfilling theatre sessions as per NIMDTA report** **Total** Elective WL = 517 57 **Urgent** - 49 with dates (into Sept), 8 with no dates Urgent Longest waiter = Cluster at 9 weeks 7 > 9 weeks - all have dates 460 **Routine** - 225 with dates (into Sept), 235 with no dates Longest Waiter - 24 weeks 46 **> 13 weeks**
ENT	SEC	DC	
ENT	SEC	IP/DC	
UROLOGY	SEC	OP	**Total NOP** Waiting List = 2407 patients 642 **Urgent** - 91 with dates, 551 no dates Urgent longest waiter = 47 weeks Cluster at 25 weeks 10 > 25 weeks - upgrades, U18 disc, Awaiting results before appt Actual longest waiter - 47 weeks 1825 **Routine (57 ICATS) - 39** with dates, 1726 no dates Longest Waiter - 71 weeks x 1 (awaiting result) then dropss to 57 weeks once U18 sorted **1910 > 9 weeks** **1620 > 15 weeks**
UROLOGY - submitted SBA	SEC	OP	
UROLOGY - urodynamics	SEC		
UROLOGY	SEC	IP	**Total** Elective Waiting List = 888 patients **440 Urgent** - 72 booked, 368 not booked Urgent Longest Waiter = 94 weeks (PCNL) Cluster of patients around 78 weeks 9 > 78 weeks **448 Routine** - 48 with dates, 400 with no dates Longest waiter = 111 weeks (no date) **350 > 26 weeks** **165 > 52 weeks**
UROLOGY	SEC	DC	
UROLOGY	SEC	OPwP Patient activity	
UROLOGY (no OPP)	SEC	IP/DC	
UROLOGY (with OPP)	SEC	IP/DC	
UROLOGY (with OPP) PROPOSED NEW SBA	SEC		
ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	OP	**Total** NOP waiting list = 1451 74 **urgent** - 17 with dates, 57 no dates Longest waiter = cluster at 21 weeks 6 > 21 weeks - all upgrades L/W - 33 weeks 1377 **Routine** - 76 with dates, 1301 with no dates **Longest waiter = 53 weeks** **1080 > 9 weeks** **870 > 15 weeks**
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	IP	**Total Elective Waiting List = 1277 patients** **149 Urgent - 43 booked, 106 not booked** **Urgent Longest Waiter = 39 weeks (U/G)** **Cluster at 26 weeks** **8 > 26 weeks - mostly U/Gs** **1128 Routine - 69 with dates, 1059 with no dates** **Longest waiter = 79 weeks** **445 > 26 weeks** **165 > 52 weeks**
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	DC	
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	IP/DC	
CANCELED ORTHO ELECTIVE CASES FOR TRAUM INFLUX			
FRACTURE NOP	SEC	NOP	
TRAUMA Non-elective	SEC	IP/DC	

Speciality	Division	OP/IP/DC	Oct-15: Expected SBA-Sept	Expected Capacity Oct	Capacity - ROTT 5%	Expected Activity	Variance-Patients	% Variance	Projected Access	Nov-15: Expected SBA-Sept	Expected Capacity Nov	Capacity - ROTT 5%	Expected Activity	Variance-Patients	% Variance	Projected Access	Dec-15: Expected Activity	Variance-Patients	% Variance	Projected Access
BREAST SURGERY	SEC	IP																		
BREAST SURGERY	SEC	DC																		
BREAST SURGERY	SEC	IP/DC																		
ENDOSCOPY - SYMPTOMATIC	SEC	IP																		
ENDOSCOPY - SYMPTOMATIC	SEC	DC																		
ENDOSCOPY - SYMPTOMATIC	SEC	IP/DC	4549	720	684	4328	-221	-4.86%												
GENERAL SURGERY	SEC	OP	6057	850	808	5330	-728	-12.02%		6923	920	874	6204	-719	-10.39%		7078	-711	-9.12%	
GENERAL SURGERY	SEC	IP	892	146	139	862	-29	-3.30%		1019	146	139	1001	-18	-1.78%		1124	-23	-2.01%	
GENERAL SURGERY	SEC	DC	2509	400	380	2305	-204	-8.14%		2867	477	453	2758	-109	-3.82%		3082	-144	-4.46%	
GENERAL SURGERY	SEC	IP/DC	3401	546	519	3167	-234	-6.87%		3887	623	592	3759	-128	-3.28%		4206	-167	-3.82%	
ENT	SEC	OP																		
ENT	SEC	IP																		
ENT	SEC	DC																		
ENT	SEC	IP/DC																		
UROLOGY	SEC	OP																		
UROLOGY - submitted SBA	SEC	OP																		
UROLOGY - urodynamics	SEC																			
UROLOGY	SEC	IP	333	90	86	577	244	73.30%		381	98	93	670	290	76.10%		754	326	76.05%	
UROLOGY	SEC	DC	2558	270	257	1835	-445	-17.41%		2923	250	238	2072	-535	-18.31%		2299	-650	-19.76%	
UROLOGY	SEC	OPwP Patient activity		40	38	278					40	38	316				340			
UROLOGY (no OPP)	SEC	IP/DC	2891	360	342	2412	-479	-16.58%		3304	348	331	2742	-562	-17.00%		3053	-664	-17.86%	
UROLOGY (with OPP)	SEC	IP/DC	2891	400	380	2690	-201	-6.96%		3304	388	369	3058	-246	-7.43%		3393	-324	-8.72%	
UROLOGY (with OPP) PROPOSED NEW SBA	SEC																			
ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	OP	1470	264	251	1384	-86	-5.86%		1705	264	251	1635	-70	-4.13%		1832	-108	-5.56%	
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	IP	530	90	86	475	-55	-10.42%		617	98	93	568	-49	-7.96%		644	-60	-8.54%	
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	DC	414	60	57	450	36	8.74%		482	70	67	517	35	7.20%		583	33	6.04%	
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	IP/DC	944	150	143	925	-19	-2.01%		1099	168	160	1085	-14	-1.31%		1227	-27	-2.15%	
CANCELED ORTHO ELECTIVE CASES FOR TRAUM INFLUX						58	39	4.13%					58	44	3.97%		58	31	2.48%	
FRACTURE NOP	SEC	NOP																		
TRAUMA Non-elective	SEC	IP/DC																		

SUMMARY OF SEC SEPTEMBER SBA PROJECTIONS			
	NOP	**ELECTIVE**	**NOTES**
BSUR		-4.20%	No recovery plan required
ENDO		-4.40%	No recovery plan required
GSUR	-6.48%	-10.67%	Recovery plan required
ENT	-1.93%	-4.80%	No recovery plan required
URO	-12.63%	-21.60%	Recovery plan required
ORTHO	-6.69%	-7.09%	Based on apportioned SBA submitted to HSCB 40 NOP converted to fracture clinic appointments, would leave NOP position -43 patients, -3.5% 23 Elective patients cancelled due to trauma influx, wold leave elective position -33 patients, -4.16%

		Expected SBA-April - End of October (Apportioned)	Actual Activity - end of October	Variance- Patients	% Variance	Access
UROLOGY	IP	333	623	290	87.04%	90 weeks
	DC	2558	2196	-362	-14.15%	
	IP/DC	2891	2819	-72	-2.49%	

Glenny, Sharon

From: Glenny, Sharon <[redacted]>
Sent: 05 January 2016 12:46
To: Trouton, Heather; Reid, Trudy; Nelson, Amie; Corrigan, Martina
Subject: SEC PERFORMANCE UPDATE WC 04 01 16 v2.xlsx
Attachments: SEC PERFORMANCE UPDATE WC 04 01 16 v2.xlsx

Importance: High

Hi Ladies

Please see attached performance update from this morning – orthopaedics now also projected to March 2016.

These are still high level projections made on various assumptions within specialties, but gives a picture of what we are to expect towards March 2016.

As we move on, we will be able to refine this much more.

Kind regards

Sharon

SEC PERFORMANCE REPORT - AS AT 04/01/2016

MARCH 2015 - YEAR END

Speciality	Division	OP/IP/DC	Expected SBA-April - End of March	Expected Capacity March	Capacity - ROTT 5%	Expected Activity	ACTUAL	Actual Variance-Patients	Actual % Variance	Projected Access	15/16 SBA tbc
BREAST SURGERY	SEC	IP	299			290	296	-3	-1.34%	27 weeks 1 > 26 weeks 8 > 13 weeks	299
BREAST SURGERY	SEC	DC	101			130	131	30	29.70%		101
BREAST SURGERY	**SEC**	**IP/DC**	**400**	**40**	**38**	**420**	**427**	**27**	**6.75%**		**400**
ENDOSCOPY - SYMPTOMATIC	SEC	IP	71				169	98	138.03%	33 weeks 305 > 9 weeks	71
ENDOSCOPY - SYMPTOMATIC	SEC	DC	7620				7721	101	1.33%		7727
ENDOSCOPY - SYMPTOMATIC	**SEC**	**IP/DC**	**7691**	**712**	**676**	**7794**	**7890**	**199**	**2.59%**		**7798**
GENERAL SURGERY	**SEC**	**NOP**	**9565**	**808**	**768**	**9416**	**9395**	**-170**	**-1.78%**	26 weeks 631 > 13 weeks 1405 > 9 weeks	**10384**
GENERAL SURGERY	**SEC**	**ROP**	**12424**				**7658**	**-4766**	**-38.36%**		**13475**
GENERAL SURGERY	SEC	IP	1490				1451	-39	-2.62%	50 weeks 307 > 26 weeks	1529
GENERAL SURGERY	SEC	DC	3885				3674	-211	-5.42%		4301
GENERAL SURGERY	**SEC**	**IP/DC**	**5375**	**430**	**409**	**5077**	**5125**	**-250**	**-4.64%**		**5830**
ENT	SEC	NOP	8497	243	231	8773	8923	426	5.01%	26 weeks 1604> 13 weeks 2329 > 9 weeks	9106
ENT	**SEC**	**ROP**	**8497**				**12403**	**3906**	**45.97%**		**9106**
ENT	SEC	IP	1459	87	83	1052	1033	-426	-29.20%	17 weeks 6> 13 weeks	1460
ENT	SEC	DC	1391	170	162	1835	1765	374	26.89%		1390
ENT	**SEC**	**IP/DC**	**2850**	**257**	**244**	**2868**	**2798**	**-52**	**-1.82%**		**2850**
UROLOGY	**SEC**	**NOP**	**3949**	**345**	**328**	**3454**	**3514**	**-435**	**-11.02%**	Cons - 46 weeks (SWAH) ICATS - 46 weeks 1172 > 9 weeks	**3949**
UROLOGY - submitted SBA	SEC	NOP									3591
UROLOGY	**SEC**	**ROP**	**5405**				**4787**	**-618**	**-11.43%**		**4787**
UROLOGY - urodynamics	**SEC**									44 weeks 100 > 9 weeks	

Dec-15

Speciality	Expected SBA-Dec	Expected Capacity Dec	Capacity - ROTT 5%	*Expected Activity*	Variance-Patients	% Variance	Projected Access
BREAST SURGERY IP	224	30	29	189	-36	-15.94%	15 M/T sessions x 2 patients per session = 30 patients No DSU sessions in December 1 x M/T lost to audit 2 x M/T lost to AL 1 x M/T lost to BH 2 x DSU lost to BH 1 x DSU swapped to M/T
BREAST SURGERY DC	76	4	4	111	35	46.27%	
BREAST SURGERY IP/DC	300	34	32	299	-1	-0.23%	
ENDOSCOPY - SYMPTOMATIC IP	53	9	9	121	68	126.85%	Loss with Katrina Battisti[redacted] - 21 weeks x 4 lists per week x 5 patients (backfillling 1 session per week currently) = 420 patients @ 80% for AL/SL = 336 patients Therefore, position could have been -3.11%
ENDOSCOPY - SYMPTOMATIC DC	5795	545	518	5234	-561	-9.68%	
ENDOSCOPY - SYMPTOMATIC IP/DC	5849	554	526	5355	-494	-8.44%	
GENERAL SURGERY NOP	7788	920	874	7186	-602	-7.73%	928 slots available in December per OP slot report 20/11/2015 Need to get the urgent LW bowel patients allocated, then could aim for 18 weeks max Urgent Routine = 38 weeks
GENERAL SURGERY ROP	10106						
GENERAL SURGERY IP	1147	133	126	1138	-9	-0.79%	<u>December Capacity</u> CAH MT - 45 sessions x 2 pts = 90 CAH DSU - 10 sessions x 4 pts = 40 STH DPU - 17 sessions x 4 pts = 68 DHH Th - 48 sessions x 2.5 pts = 120 DHH MIOPS - 3 weeks x 10 patients = 30 Scopes Recoding @ ave 25 per month TOTAL = 373 patients
GENERAL SURGERY DC	3226	260	247	2799	-427	-13.23%	
GENERAL SURGERY IP/DC	4373	393	373	4103	-270	-6.17%	
ENT NOP	6830	907	862	7295	465	6.81%	907 slots available in December per OP slots report 20/11/2015 (80 x at risk slots included)
ENT ROP							
ENT IP	1095	73	69	600	-495	-45.17%	<u>December Capacity</u> CAH MT - 46 sessions x 3 pts = 138 CAH DSU - 1 sessions x 4 pts = 4 STH DPU - 3 sessions x 5 pts = 15 DHH Th - 20 sessions x 4 pts = 80 TOTAL = 237 patients
ENT DC	1043	164	156	1401	358	34.37%	
ENT IP/DC	2138	237	225	2001	-136	-6.38%	
UROLOGY NOP	2962	289	275	2584	-378	-12.77%	22 CAH Cons x 9 NOP = 198 8 CAH Reg x 6 NOP = 48 2 SWAH x 4 NOP = 8 5 UDS x 3 NOP = 15 4 STC x 5 NOP = 20 TOTAL NOP available = 289
UROLOGY - submitted SBA NOP	2693			2584	-110	-4.07%	
UROLOGY ROP	3590						
UROLOGY - urodynamics							

Jan-16

Speciality	Expected SBA-Dec	Expected Capacity Jan	Capacity - ROTT 5%	*Expected Activity*	Variance-Patients	% Variance	Projected Access
BREAST SURGERY IP	249	28	27	215	-34	-13.67%	15 M/T sessions x 2 patients per session = 30 patients 1 D/C sessions x 4 patients per session = 4 patients Total of 34 patients
BREAST SURGERY DC	84	8	8	118	34	40.67%	
BREAST SURGERY IP/DC	333	36	34	334	0	0.05%	
ENDOSCOPY - SYMPTOMATIC IP	59	5	5	126	66	112.20%	95 sessions x 6.2 patients = 589 patients, less 5% DNA rate = 560 patients Loss with Katrina Battisti sickness absence - 25 weeks x 4 lists per week x 5 patients (backfillling 1 session per week currently) = 500 patients @ 80% for AL/SL = 400 patients Therefore, position could have been -2.66%
ENDOSCOPY - SYMPTOMATIC DC	6439	589	560	5794	-646	-10.03%	
ENDOSCOPY - SYMPTOMATIC IP/DC	6498	594	564	5919	-579	-8.91%	
GENERAL SURGERY NOP	8653	850	808	8036	-617	-7.13%	48 January clinics still suspended on the Slots Report 11/12/2015 - awaiting rota updates Assumptions made based on ave Sept-December FYE NOP Loss to date associated with unfilled IPT Staff Grade = 574 NOP NOP loss to date associated with lack of junior/middle grades (NIMDTA and vacancy) = 515 NOP TOTAL FYE LOSS = 1089 NOP Routine = 38 weeks
GENERAL SURGERY ROP	0						
GENERAL SURGERY IP	1274	125	109	1247	-28	-2.16%	<u>January Capacity</u> CAH MT - 45 sessions x 2 pts = 90 CAH DSU - 9 sessions x 4 pts = 36 RFA sessions - 4 sessions x 4 pts = 16 STH DPU - 18 sessions x 4 pts = 68 DHH Th - 36 sessions x 2.5 pts = 90 DHH MIOPS - 3 weeks x 10 patients = 30 Scopes recoding ave 25 per month TOTAL = 335 patients **Mr Gudyma[redacted] with effect from 06/01/2016
GENERAL SURGERY DC	3584	245	245	3044	-540	-15.07%	
GENERAL SURGERY IP/DC	4858	370	354	4291	-568	-11.68%	
ENT NOP	7588	867	824	8118	530	6.98%	867 slots available in Jnauary per OP slots report 11/12/2015 (at risk clinics not yet set up for January)
ENT ROP							
ENT IP	1217	98	93	693	-523	-43.00%	<u>January Capacity</u> CAH MT - 66 sessions x 3 pts =198 CAH DSU - 1 sessions x 4 pts = 4 STH DPU - 4 sessions x 5 pts = 20 DHH Th - 19 sessions x 4 pts = 76 TOTAL = 298 patients
ENT DC	1158	215	204	1605	447	38.57%	
ENT IP/DC	2375	313	297	2299	-77	-3.22%	
UROLOGY NOP	3291	283	269	2852	-438	-13.32%	21 CAH Cons x 9 NOP = 189 7 CAH Reg x 6 NOP = 42 1 SWAH x 4 NOP = 4 4 UDS x 3 NOP = 12 4 STC x 5 NOP = 20 Haem x 4 NOP = 16 TOTAL NOP available = 283
UROLOGY - submitted SBA NOP	2993	283	269	2852	-140	-4.68%	
UROLOGY ROP	0						
UROLOGY - urodynamics							

Speciality	NOTES - 14/12/2015
BREAST SURGERY	**Total** BSUR waiting list = 64patients **Urgent** = 25 patients - 11 with dates, 14 with no dates Longest waiter at end Dec = 41 weeks Majority = 8 weeks or less 6 > 8 weeks without dates **Routine** = 39 patients - 1 with date, 38 with no dates Longest waiter at end December = 60 weeks **25 > 26 weeks**
ENDOSCOPY - SYMPTOMATIC	**Total** Waiting List = 2132 patients **Urgent** = 1288 patients - 341 with dates, 947 no dates Longest waiter = 44 weeks, GA procedure 28 weeks x 1 - GA 27 weeks x 1 - IP prep 26 weeks x 1 - GA Top 9 longest waiters all EE patients Cluster at 14 weeks 13 > 14 weeks **Routine** = 844 patients 20 with dates, 824 with no dates Longest waiter = 52 weeks 975 **> 9 weeks by end December** Permission given for ISP to rollover refusals into October and make a reasonable offer, however, a number of patient have November dates 227 patients with ISP for treatment **<u>Scheduling of Sessions:</u>** April - 98 sessions, 638 patients, 6.5 per list May - 102 sessions, 639 patients, 6.3 per list June - 115 sessions, 770 patients, 6.7 per list July - 97 sessions, 596 patients, 6.14 per list Aug - 75 sessions, 490 patients, 6.5 per list Sept - 113 sessions, 706 patients, 6.2 per list Oct - 103 sessions, 613 patients, 6 per list Nov - 103 sessions, 650 patients, 6.3 per list
GENERAL SURGERY NOP	**Total** NOP Waiting list = 4411 **Urgent** = 868 - 168 with dates, 700 with no dates Longest waiter = cluster at 17 weeks, 9 > 17 weeks (bowel) Actual longest waiter = 27 weeks 3543 **Routine** - 341 with dates, 3102 no dates Longest Waiter = 35 weeks **<u>NOP attendances by month</u>** April = 913 May = 745 June = 919 July = 558 Aug = 695 Sept = 907 Oct = 749 **2450 > 9 weeks** **1550 > 15 weeks** **FYE NOP Loss to date associated with unfilled IPT Staff Grade = 574 NOP** **NOP loss to date associated with lack of junior/middle grades (NIMDTA and vacancy) = 515 NOP** **TOTAL FYE LOSS = 1089 NOP**
GENERAL SURGERY ROP	
GENERAL SURGERY IP / DC / IP/DC	**Total Elective** Waiting List = 1018 **223 Urgent** - 60 with dates, 163 with no dates Urgent Longest Waiter = cluster at 28 weeks Actual Longest Waiter - 73 weeks (EE patient) 10 > 28 weeks 8 x EE patients 1 x GENS 1 x HH **795 Routine** - 148 with dates, 647 with no dates Longest Waiter = 83 weeks **251 > 26 weeks** **74 > 52 weeks** **On-going issue with filling DHH lists and MIOPS lists in STH this month due to lack of suitable cases and patients being pre-op fit**
ENT NOP	**Total** NOP Waiting list = 4865 **Urgent** = 307 - 167 with dates, 140 with no dates Longest waiter = cluster at 10 weeks, 18 > 10 weeks Actual longest waiter = 23 weeks 4558 **Routine** - 703 with dates, 3855 no dates Longest Waiter = 42 weeks **<u>NOP attendances by month</u>** April = 724 May = 662 June = 888 July = 651 Aug = 748 Sept = 1052 Oct = 810 3226 **> 9 weeks** **2450 > 15 weeks**
ENT ROP	
ENT IP / DC / IP/DC	**Total** Elective WL = 528 52 **Urgent** - 41 with dates (into Jan), 11 with no dates Urgent Longest waiter = 16 weeks Cluster at 6 weeks 4 waiters > 10 weeks 476 **Routine** - 176 with dates (into Jan), 300 with no dates Longest Waiter - 30 weeks **43 > 13 weeks** **2 > 26 weeks**
UROLOGY NOP / UROLOGY - submitted SBA	**Total NOP** Waiting List = 2548 patients 724 **Urgent** - 88 with dates, 636 no dates **Urgent longest waiter = 43 weeks** Cluster at 27/28 weeks 3 > 28 weeks - upgrades, awaiting results before appt 1824 **Routine - 76** with dates, 1748 no dates **Longest Waiter - 77 weeks (U18 discharge AOB)** **Then 68 weeks** **2045 > 9 weeks** **1700 > 15 weeks** **NOP Activity** April = 322 May = 284 June = 263 July = 186 Aug = 240 Sept = 350 Oct = 330
UROLOGY ROP	
UROLOGY - urodynamics	**Total** waiting list = 162 patients **53 Urgent** - 1 with date, 52 with no dates Longest waiter = 63 weeks **109 Routine** - 16 with dates, 93 with no dates Longest waiter = 58 weeks

Feb-16

Speciality	Expected SBA - Feb	Expected Capacity Feb	Capacity - ROTT 5%	*Expected Activity*	Variance-Patients	% Variance	Projected Access
BREAST SURGERY IP	274	21	20	235	-39	-14.24%	Mr Mallon officially leaves Trust 7th February 2016, however, will be taking leave from 1st February 2016 Capacity based on theatre scheduling calendar 11 M/T sessions x 2 patients per session = 22 patients 1 D/C sessions x 4 patients per session = 4 patients Total of 26 patients
BREAST SURGERY DC	93	6	6	124	32	34.04%	
BREAST SURGERY IP/DC	367	27	26	359	-8	-2.05%	
ENDOSCOPY - SYMPTOMATIC IP	65	5	5	130	65	100.20%	Capacity based on average of last few months = 95 sessions x 6.2 patients = 589 patients, less 5% DNA rate = 560 patients Loss with Katrina Battisti[redacted] - 29 weeks x 4 lists per week x 5 patients (backfillling 1 session per week currently) = 580 patients @ 80% for AL/SL = 464 patients Therefore, position could have been -2.81%
ENDOSCOPY - SYMPTOMATIC DC	7083	589	560	6353	-730	-10.31%	
ENDOSCOPY - SYMPTOMATIC IP/DC	7148	594	564	6483	-665	-9.30%	
GENERAL SURGERY NOP	9519	840	798	8834	-685	-7.19%	February clinic reductions, suspensions still not complete - therefore assumptions based on last year's activity FYE NOP Loss to date associated with unfilled IPT Staff Grade = 574 NOP NOP loss to date associated with lack of junior/middle grades (NIMDTA and vacancy) = 515 NOP TOTAL FYE LOSS = 1089 NOP
GENERAL SURGERY ROP	12352			0			
GENERAL SURGERY IP	1402	125	109	1356	-46	-3.28%	<u>February capacity based on January</u> CAH MT - 45 sessions x 2 pts = 90 CAH DSU - 9 sessions x 4 pts = 36 RFA sessions - 4 sessions x 4 pts = 16 STH DPU - 18 sessions x 4 pts = 68 DHH Th - 36 sessions x 2.5 pts = 90 DHH MIOPS - 3 weeks x 10 patients = 30 Scopes recoding ave 25 per month TOTAL = 335 patients **Mr Gudyma[redacted] with effect from 06/01/2016
GENERAL SURGERY DC	3943	238	226	3270	-672	-17.06%	
GENERAL SURGERY IP/DC	5344	363	335	4626	-718	-13.44%	
ENT NOP	8347	769	731	8849	502	6.01%	Based on average of last 4 months capacity Loss of Mr Moran included (Feb only)- 4 clinics per week x 6 patients = 112 patients Mr Moran being replaced in March
ENT ROP	243			0			
ENT IP	1338	88	84	777	-561	-41.94%	February capacity based on last few months
ENT DC	1274	189	180	1785	510	40.06%	
ENT IP/DC	2613	277	263	2562	-51	-1.95%	
UROLOGY NOP	3620	304	289	3141	-479	-13.22%	February capacity based on average of last 3 months
UROLOGY - submitted SBA NOP	3292	304	289	3141	-151	-4.57%	
UROLOGY ROP	4388			0			
UROLOGY - urodynamics							

Mar-16

Speciality	Expected SBA - March	Expected Capacity March	Capacity - ROTT 5%	*Expected Activity*	Variance-Patients	% Variance	Projected Access
BREAST SURGERY IP	299	16	15	250	-49	-16.30%	Capacity based on 75% of February - Easter leave Loss of 12 sessions/18 patients (8 sessions per month x 2 months x 1.5 patients per session @ 80% of the time) with departure of Mr Mallon.
BREAST SURGERY DC	101	4	4	128	27	26.63%	
BREAST SURGERY IP/DC	400	20	19	378	-22	-5.46%	
ENDOSCOPY - SYMPTOMATIC IP	71	4	4	134	63	88.87%	March capacity based on January sessions @ 75% due to Easter leave = 442 patients Loss with Katrina Battisti[redacted] - 33.5 weeks x 4 lists per week x 5 patients (backfillling 1 session per week currently) = 670 patients @ 80% for AL/SL = 536 patients Therefore, position could have been -4.27%
ENDOSCOPY - SYMPTOMATIC DC	7727	465	442	6795	-932	-12.06%	
ENDOSCOPY - SYMPTOMATIC IP/DC	7798	469	446	6929	-869	-11.14%	
GENERAL SURGERY NOP	10384	645	613	9447	-937	-9.03%	Assumptions based on last year's March activity (817) @ 75% due to Easter leave = 613 FYE NOP Loss to date associated with unfilled IPT Staff Grade = 574 NOP NOP loss to date associated with lack of junior/middle grades (NIMDTA and vacancy) = 515 NOP TOTAL FYE LOSS = 1089 NOP
GENERAL SURGERY ROP	13475						
GENERAL SURGERY IP	1529	125	109	1465	-64	-4.21%	<u>January Capacity</u> CAH MT - 45 sessions x 2 pts = 90 CAH DSU - 9 sessions x 4 pts = 36 RFA sessions - 4 sessions x 4 pts = 16 STH DPU - 18 sessions x 4 pts = 68 DHH Th - 36 sessions x 2.5 pts = 90 DHH MIOPS - 3 weeks x 10 patients = 30 Scopes recoding ave 25 per month TOTAL = 335 patients **Mr Gudyma[redacted] with effect from 06/01/2016
GENERAL SURGERY DC	4301	245	245	3515	-786	-18.27%	
GENERAL SURGERY IP/DC	5830	370	354	4980	-850	-14.58%	
ENT NOP	9106	867	824	9673	566	6.22%	Need to separate out IHAR activity as this will be putting overall SBA delivery over.
ENT ROP	9106						
ENT IP	1460	66	63	840	-620	-42.48%	March capacity based on last months @ 75 due to Easter leave
ENT DC	1390	142	135	1920	530	38.09%	
ENT IP/DC	2850	208	198	2759	-91	-3.18%	
UROLOGY NOP	3949	230	219	3360	-589	-14.92%	March capacity based on last few months @75% with Easter leave
UROLOGY - submitted SBA NOP	3591	230	219	3360	-231	-6.44%	
UROLOGY ROP	4787						
UROLOGY - urodynamics							

WIT-81826

UROLOGY	SEC	IP	571	107	102	1086	1056	497	87.04%	84 weeks 272 > 26 weeks	571	428	90	86	746	318	74.22%	43 IP sessions x 3 patients = 129 7 CAH DSU x 4 patients = 28 4 CAH Flexi x 8 patients = 32 1 STH flexi x 8 patients = 8 4 Haem x 6 patients = 24 6 STC Treatments x 4 patients = 24 Chemo/TROC x 7 per week = 28 TOTAL = 273 patients + OPwP (ave 25/mont) = 298	476	86	82	828	352	73.97%	39 IP sessions x 3 patients = 117 6 CAH DSU x 4 patients = 24 7 CAH Flexi x 8 patients = 56 3 STH GA/flexi x 5 patients = 15 4 Haem x 6 patients = 24 6 STC Treatments x 4 patients = 24 Chemo/TROC x 7 per week = 28 TOTAL = 288 patients + OPwP (ave 25/mont) = 313	**Total** Elective Waiting List = 904 patients **430 Urgent** - 56 booked, 374 not booked **Urgent Longest Waiter = 97 weeks (MY)** **Next 10 longest waiters are AOB** 82 urgent patients > 52 weeks **474 Routine** - 27 with dates, 447 with no dates Longest waiter = 124 weeks (2xAOB no date) **368 > 26 weeks** **198 > 52 weeks**	523	86	82	910	386	73.76%	39 IP sessions x 3 patients = 117 6 CAH DSU x 4 patients = 24 7 CAH Flexi x 8 patients = 56 3 STH GA/flexi x 5 patients = 15 4 Haem x 6 patients = 24 6 STC Treatments x 4 patients = 24 Chemo/TROC x 7 per week = 28 TOTAL = 288 patients + OPwP (ave 25/mont) = 313	571	65	[illegible]	[illegible]	400	70.[illegible]%	39 IP sessions x 3 patients = 117 6 CAH DSU x 4 patients = 24 7 CAH Flexi x 8 patients = 56 3 STH GA/flexi x 5 patients = 15 4 Haem x 6 patients = 24 6 STC Treatments x 4 patients = 24 Chemo/TROC x 7 per week = 28 TOTAL = 288 patients + OPwP (ave 25/mont) = 313
UROLOGY	SEC	DC	4385	255	242	3087	3574	-1262	-28.78%		4385	3289	183	174	2350	-599	-18.20%		3654	227	216	2566	-725	-19.83%			4020	227	216	2782	-1216	-27.73%		4385	170	162	2943	-1031	-23.51%	
UROLOGY	SEC	OPwP Patient activity											25	24	340					25	24	364						25	24	387					25	24	411			
UROLOGY (no OPP)	**SEC**	**IP/DC**	**4956**	**362**	**344**	**4173**		**-765**	**-15.44%**		4956	3717	273	259	3096	-621	-16.69%		4130	313	297	3394	-736	-17.83%			4543	313	297	3691	-852	-18.75%		4956	235	223	3914	-1042	-21.02%	
UROLOGY (with OPP)	**SEC**	**IP/DC**	**4956**	**412**	**391**	**4880**	**4630**	**-326**	**-6.58%**		4956	3717	298	283	3436	-281	-7.55%		4130	338	321	3757	-373	-9.02%			4543	338	321	4078	-465	-10.23%		4956	260	247	4325	-631	-12.72%	
UROLOGY (with OPP) PROPOSED NEW SBA	**SEC**										4630	3473			3436	-36	-1.05%		3858			3757	-101	-2.62%			4244			4078	-166	-3.91%		4630			4325	-305	-6.58%	
ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	**SEC**	**NOP**	**1952**	**192**	**182**	**1655**	**1663**	**-289**	**-14.81%**	40 weeks (upper) 749 > 13 weeks 974 > 9 weeks	2645	1940	218	207	1788	-152	-7.86%	22 full clinics x 8 NOP = 176 patients 7 Reduced clinics x 6 NOP = 42 patients TOTAL = 218 NOP	2175	230	219	2006	-169	-7.77%	25 full clinics x 8 NOP = 200 patients 5 Reduced clinics x 6 NOP = 30 patients TOTAL = 230 NOP 9 consultants delivering 10 consultant model 1 x Reg post unfilled	**Total** NOP waiting list = 1379 **59 urgent** - 25 with dates, 34 no dates Longest waiter = cluster at 10 weeks 8 > 10 weeks - upgrades, cons specific L/W - 49 weeks **1320 Routine** - 124 with dates, 1196 with no dates **Longest waiter = 56 weeks (LW)** **1070 > 9 weeks** **810 > 15 weeks**	2410	270	257	2263	-147	-6.12%	Based on February 2016 T&O rota as at 05.01.16 30 full clinics x 8 NOP = 240 patients 5 Reduced clinics x 6 NOP = 30 patients TOTAL = 270 NOP 9 consultants delivering 10 consultant model 1 x Reg post unfilled	2645	230	219	2481	-164	-6.20%	Based on January Volumes - March small month with Easter leave, etc 9 consultants delivering 10 consultant model 1 x Reg post unfilled To bring back to -5% threshold, would require 42-45 new patients
ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	**SEC**	**ROP**	**3198**				**2879**	**-319**	**-9.97%**		3990																3658			0				3990						
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	IP	709	50	45	592	608	-101	-14.25%	62 weeks (LW) 361 > 26 weeks	965	704	80	76	645	-59	-8.44%	56 CAH sessions x 2 patients = 112 2 STH sessions x 4 patients = 8 TOTAL = 120 slight uplift for increase in small cases around Christmas period	791	77	73	718	-73	-9.26%	64 CAH sessions x 2 patients =128 2 STH sessions x 4 patients = 8 TOTAL = 136	**Total Elective Waiting List = 1370 patients** **155 Urgent - 15 booked, 140 not booked** **Urgent Longest Waiter = 38 weeks** **Cluster at 27 weeks** **3 > 27 weeks - 1 x BW (MG), 1 x SP (UG), 1 x RMcK (?WLS)** **1215 Routine - 68 with dates, 1147 with no dates** **Longest waiter = 84 weeks (LW)** **506 > 26 weeks** **90 > 52 weeks**	878	87	83	800	-78	-8.84%	74 CAH sessions x 2 patients =148 1 STH sessions x 4 patients = 8 TOTAL = 156	965	77	73	874	-91	-9.48%	Based on January Volumes - March will be small month due to Easter Leave
**ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)	SEC	DC	592	60	55	623	605	13	2.20%		754	550	50	48	572	22	4.00%		618	59	56	628	10	1.63%			686	69	66	694	8	1.11%		754	59	56	750	-4	-0.58%	
****ORTHOPAEDICS (per Sandra proposal paper and apportioned SBA based on start-dates and lead in for new consultants)**	**SEC**	**IP/DC**	**1301**	**105**	**100**	**1215**	**1213**	**-88**	**-6.76%**		1719	1254	130	124	1217	-37	-2.98%		1409	136	129	1346	-63	-4.49%			1564	156	148	1494	-70	-4.48%		1719	136	129	1623	-96	-5.57%	
CANCELED ORTHO ELECTIVE CASES FOR TRAUM INFLUX															*100*	*63*	*4.99%*					*100*	*37*	*2.61%*						100	*30*	*#DIV/0!*					*100*		*0.00%*	*On SBA when all cancelled ortho elective included back in*
FRACTURE NOP	**SEC**	**NOP**	**4810**				**6272**	**1462**	**30.40%**		5866																5377			0				5866						
TRAUMA Non-elective	**SEC**	**IP/DC**	**1455**				**1755**	**300**	**20.62%**		1691																1550			0				1691						

SUMMARY OF SEC SEPTEMBER SBA PROJECTIONS			
	NOP	**ELECTIVE**	**NOTES**
BSUR		-4.20%	No recovery plan required
ENDO		-4.40%	No recovery plan required
GSUR	-6.48%	-10.67%	Recovery plan required
ENT	-1.93%	-4.80%	No recovery plan required
URO	-12.63%	-21.60%	Recovery plan required
ORTHO	-6.69%	-7.09%	Based on apportioned SBA submitted to HSCB 40 NOP converted to fracture clinic appointments, would leave NOP position -43 patients, -3.5% 23 Elective patients cancelled due to trauma influx, wold leave elective position -33 patients, -4.16%

		Expected SBA-April - End of October (Apportioned)	Actual Activity - end of October	Variance- Patients	% Variance	Access
UROLOGY	IP	333	623	290	87.04%	90 weeks
	DC	2558	2196	-362	-14.15%	
	IP/DC	2891	2819	-72	-2.49%	

Glenny, Sharon

From: Glenny, Sharon <[redacted]>
Sent: 18 November 2013 19:43
To: Cassells, Carol; McConville, Orla
Cc: Trouton, Heather; Reid, Trudy; Corrigan, Martina; Nelson, Amie
Subject: SEPTEMBER - IHA/IS SPEND - SEC
Attachments: SEPTEMBER 2013.xls

Hi Carol/Orla

Please find attached report detailing IHA/IS spend for SEC for month of September 2013. Summary below:

SURGERY AND ELECTIVE CARE
Sep-13

In-house Additionality ECR (from costed spreadsheet) £0.00 (IN MONTH SPEND) In-house Additionality WLI (from costed spreadsheet) £125,941.00 (IN MONTH SPEND) In-house Additionality IBV (from costed spreadsheet £0.00 (IN MONTH SPEND) IS Estimated additionality (from costed spreadsheet) £543,602.00 (IN MONTH SPEND) Total £669,543.00

This is actual activity by specialty in SEC for month of SEPTEMBER 2013

Mrs Sharon Glenny
Operational Support Lead
Surgery & Elective Care

Direct dial – [redacted]
Mobile - [redacted]

SURGERY AND ELECTIVE CARE

Sep-13

In-house Additionality ECR (from costed spreadsheet)	£0.00	(IN MONTH SPEND)
In-house Additionality WLI (from costed spreadsheet)	£125,941.00	(IN MONTH SPEND)
In-house Additionality IBV (from costed spreadsheet	£0.00	(IN MONTH SPEND)
IS Estimated additionality (from costed spreadsheet)	£543,602.00	(IN MONTH SPEND)
Total	**£669,543.00**	

This is actual activity by specialty in SEC for month of SEPTEMBER 2013

SPECIALTY SUMMARY FOR THE MONTH

			Sep-13
GSUR	ECR	£	-
	WLI	£	26,088.00
	IBV	£	-
	IS	£	156,158.00
GSUR TOTAL		**£**	**182,246.00**
ENDOSCOPY	ECR	£	-
	WLI	£	49,469.00
	IBV	£	-
	IS	£	103,400.00
ENDOSCOPY TOTAL		**£**	**152,869.00**
ORAL SURGERY	ECR		£0.00
	WLI		£0.00
	IBV		£0.00
	IS		£0.00
ORAL SURGERY TOTAL			**£0.00**
ENT	ECR	£	-
	WLI	£	16,560.00
	IBV	£	-
	IS	£	13,776.00
ENT TOTAL		**£**	**30,336.00**
UROLOGY	ECR	£	-
	WLI	£	776.00
	IBV	£	-
	IS	£	-
UROLOGY TOTAL		**£**	**776.00**
T&O	ECR	£	-
	WLI	£	31,306.00
	IBV	£	-
	IS	£	184,384.00
T&O TOTAL		**£**	**215,690.00**
OPHTHALMOLOGY	ECR	£	-
	WLI	£	1,742.00
	IBV	£	-
	IS	£	79,012.00
OPHTHALMOLOGY TOTAL		**£**	**80,754.00**

SEC TOTAL **£ 662,671.00**

Excludes breast activity (C&CS)

Cost Implications of IS provision

Sep-13

Specialty	Admit Type	Average Cost[1]	Activity	Total Cost	
General Surgery	OutPatients News	£ 168.00	167	£ 28,056.00	
	OutPatients Reviews	£ 168.00	44	£ 7,392.00	
	Inpatients	£ 1,808.00	34	£ 61,472.00	
	DC Conversions	£ 1,097.00	54	£ 59,238.00	
Sub-totals				**£ 156,158.00**	
Endoscopy	Day Case	£1,100	94	**£ 103,400.00**	Costing to be confirmed
Oral Surgery	OutPatients News	£ 134.00	0	£ -	
	OutPatients Reviews	£ 134.00	0	£ -	
	DC Conversions	£ 1,445.00	0	£ -	
Sub-totals				**£ -**	
Ophthalmology	OutPatients News	£ 109.00	103	£ 11,227.00	
	OutPatients Reviews	£ 109.00	90	£ 9,810.00	
	Inpatients	£ 2,060.00		£ -	
	DC Conversions	£ 773.00	75	£ 57,975.00	
Sub-totals				**£ 79,012.00**	
Pain Management	OutPatients News	£ 200.00		£ -	
	OutPatients Reviews	£ 200.00	22	£ 4,400.00	
	Inpatients	£ 2,575.00		£ -	
	DC Conversions	£ 618.00	4	£ 2,472.00	
Sub-totals				**£ 6,872.00**	
Gynae (inc. Colp)	OutPatients News	£ 150.00		£ -	
	OutPatients Reviews	£ 150.00		£ -	
	Inpatients	£ 5,976.00	0	£ -	
	DC Conversions	£ 2,044.00	0	£ -	
Sub-totals				**£ -**	
ENT	OutPatients News	£ 168.00	81	£ 13,608.00	
	OutPatients Reviews	£ 168.00	1	£ 168.00	
	Inpatients	£ 1,808.00		£ -	
	DC Conversions	£ 1,097.00		£ -	
Sub-totals				**£ 13,776.00**	
Urology	OutPatients News	£ 168.00		£ -	
	OutPatients Reviews	£ 168.00	0	£ -	
	Inpatients	£ 1,808.00		£ -	
	Day Cases	£ 1,097.00	0	£ -	
Subtotals				**£ -**	
Rheumatology	Out-Patient Review	£ 150.00		£ -	
Subtotals				**£ -**	
Gastro	Out-Patient Review	£ 150.00		£ -	
Subtotals				**£ -**	
Ortho	Out-Patient New	£ 150.00	91	£ 13,650.00	
	Out-Patient Review	£ 150.00	93	£ 13,950.00	
	DC Conversions	£ 2,044.00	36	£ 73,584.00	Costing to be confirmed
	In-Patient Conversion	£ 3,200.00	26	£ 83,200.00	
Subtotals				**£ 184,384.00**	
MRI	1 part scan	£ 180.00	0	£ -	
Sub-totals			**0**	**£ -**	
Neurophysiology		£ 309.00		£ -	
Sub-totals				**£ -**	
Overall Estimated Cost				**£ 543,602.00**	

Notes:

Based on assumption that IHA has been exhaused activity levels noted are required using IS provision

[1] Average cost provided by Finance are only average IS specialty costs uplifted by 3% for assumed 2010-11 rates

SURGERY AND ELECTIVE CARE

SURGERY AND ELECTIVE CARE - SEPT 2013

Estimated Costs for April 2013 - March 2014

May-13

Specialty	Admit Type	Assumed no. of patients per session	OPTION 1 FULL COST: No of sessions	Average Full Cost	Activity	Total Cost	OPTION 2 CONS SURGEON or CONS ANAE ONLY: Avg Cost Cons Surgeon Only	Activity	Total Cost	OPTION 3 CONS SURGEON AND ANAE ONLY: No of sessions	Avg Cost Cons Surgeon & Anae	Activity	Total Cost	OPTION 4 CONS SURGEON AND NURSING ONLY: Avg Cost Cons Surgeon & Nursing	Activity	Total Cost	OPTION 5 NURSING ONLY: Avg Cost Nursing Only	Activity	Total Cost	OPTION 6 MARGINAL GOODS & SERVICES ONLY: No of sessions	Avg Cost Marginal G&S only	Activity	Total Cost	TOTALS: TOTAL ACTIVITY	TOTAL COST
General Surgery	Inpatients	3		£ 803.00	0	£ -	£ 372.00	0	£ -	0	£ 629.00	0	£ -	£ 554.00	0	£ -	£ 314.00	0	£ -	0	£ 54.00	0	£ -	0	£ -
	Day Cases	4		£ 258.00	0	£ -	£ 120.00	0	£ -	0	£ 202.00	0	£ -	£ 178.00	0	£ -	£ 101.00	0	£ -	0	£ 17.00	0	£ -	0	£ -
	Outpatients	14		£ 137.00	0	£ -	£ 99.00	0	£ -	0	£ -	0	£ -	£ -	0	£ -	£ 55.00	0	£ -	0	£ 9.00	0	£ -	0	£ -
Sub-Total					-	£ -		-	£ -			-	£ -		-	£ -		-	£ -			-	£ -	-	£ -
Endoscopy	Day Cases	7		£ 567.00	0	£ -	£ 263.00	0	£ -	0	£ 444.00	0	£ -	£ 391.00	0	£ -	£ 222.00	0	£ -		£ 38.00	0	£ -	0	£ -
ENT	Inpatient	2		£ 691.00	0	£ -	£ 320.00	0	£ -	0	£ 541.00	0	£ -	£ 477.00	0	£ -	£ 270.00	0	£ -	0	£ 46.00	0	£ -	0	£ -
	Outpatients	10		£ 92.00	0	£ -	£ 65.00	0	£ -	0	£ 70.00	0	£ -	£ -	0	£ -	£ 36.00	0	£ -	0	£ 9.00	0	£ -	0	£ -
Sub-Total					-	£ -		-	£ -			-	£ -		-	£ -		-	£ -			-	£ -	-	£ -
Urology	Inpatients	2		£ 837.00	0	£ -	£ 388.00	0	£ -	0	£ 655.00	0	£ -	£ 578.00	0	£ -	£ 328.00	0	£ -	0	£ 56.00	0	£ -	0	£ -
	Day Cases	4	0	£ 277.00	0	£ -	£ 128.00	0	£ -	0	£ 217.00	0	£ -	£ 191.00	0	£ -	£ 108.00	0	£ -	0	£ 18.00	0	£ -	0	£ -
	Flexi Lists	9	0	£ 208.00	0	£ -	0 £ 96.00	0	£ -	0	£ 163.00	0	£ -	£ 144.00	0	£ -	£ 81.00	0	£ -	0	£ 14.00	0	£ -	0	£ -
	Outpatients	10		£ 153.00	0	£ -	£ 110.00	0	£ -	0	£ -	0	£ -	£ -	0	£ -	£ 61.00	0	£ -	0	£ 10.00	0	£ -	0	£ -
Sub-Total					-	£ -		-	£ -			-	£ -		-	£ -		-	£ -			-	£ -	-	£ -
Trauma & Ortho	Inpatients	1		£ 1,913.00	0	£ -	£ 887.00	0	£ -	0	£ 1,497.00	0	£ -	£ 1,320.00	0	£ -	£ 749.00	0	£ -	0	£ 128.00	0	£ -	0	£ -
	Day Cases	1		£ 1,211.00	0	£ -	£ 561.00	0	£ -	0	£ 948.00	0	£ -	£ 836.00	0	£ -	£ 474.00	0	£ -	0	£ 81.00	0	£ -	0	£ -
	Outpatients	9		£ 127.00	0	£ -	£ 92.00	0	£ -	0	£ -	0	£ -	£ -	0	£ -	£ 51.00	0	£ -	0	£ 9.00	0	£ -	0	£ -
Sub-Total					-	£ -		-	£ -			-	£ -		-	£ -		-	£ -			-	£ -	-	£ -
Ophthalmology	Day Cases	4		£ 320.00	0	£ -	£ 144.00	0	£ -	0	£ 243.00	0	£ -	£ 221.00	0	£ -	£ 122.00	0	£ -	0	£ 45.00	0	£ -	0	£ -
	Outpatients	13		£ 134.00	0	£ -	£ 94.00	0	£ -	0	£ -	0	£ -	£ -	0	£ -	£ 53.00	0	£ -	0	£ 12.00	0	£ -	0	£ -
Sub-Total					-	£ -		-	£ -			-	£ -		-	£ -		-	£ -			-	£ -	-	£ -
Breast Surgery	One Stop Clinic	12		£ 151.00	0	£ -	£ 109.00	0	£ -	0	£ 115.00	0	£ -	£ -	0	£ -	£ 61.00	0	£ -	0	£ 14.00	0	£ -	0	£ -
Total Estimated Costs					-	-		-	-			-	-		-	-		-	-			-	-	-	£ -

Notes:-

1. All unit costs reflect In House Additionality cost per patient.

2. All assumed no. of patients per session has been verified.

3. All costs stated are 09-10 uplifted by 3% to reflect 10-11 pay and prices

SURGERY AND ELECTIVE CARE - SEPT 2013

Estimated Costs for April 2012 - March 2013

Sep-13			OPTION 1 FULL COST				OPTION 2 CONS SURGEON or CONS ANAE ONLY				OPTION 3 CONS SURGEON AND ANAE ONLY				OPTION 4 CONS SURGEON AND NURSING ONLY				OPTION 5 NURSING ONLY				OPTION 6 MARGINAL GOODS & SERVICES ONLY				TOTALS	
Specialty	Admit Type	Assumed no. of patients per session	No of sessions	Average Full Cost	Activity	Total Cost		Avg Cost Cons Surgeon Only	Activity	Total Cost	No of sessions	Avg Cost Cons Surgeon & Anae	Activity	Total Cost		Avg Cost Cons Surgeon & Nursing	Activity	Total Cost		Avg Cost Nursing Only	Activity	Total Cost	No of sessions	Avg Cost Marginal G&S only	Activity	Total Cost	TOTAL ACTIVITY	TOTAL COST
General Surgery	Inpatients	3	4	£ 803.00	12	£ 9,636.00	4	£ 372.00	12	£ 4,464.00	0	£ 629.00	0	£ -	0	£ 554.00	0	£ -	0	£ 314.00	0	£ -	0	£ 54.00	0	£ -	24	£ 14,100.00
	Day Cases	4		£ 258.00	0	£ -	1	£ 120.00	4	£ 480.00	0	£ 202.00	0	£ -	0	£ 178.00	0	£ -	0	£ 101.00	0	£ -	0	£ 17.00	0	£ -	4	£ 480.00
	Outpatients	14	6	£ 137.00	84	£ 11,508.00		£ 99.00	0	£ -	0	£ -	0	£ -	0	£ -	0	£ -	0	£ 55.00	0	£ -	0	£ 9.00	0	£ -	84	£ 11,508.00
Sub-Total					96	**£ 21,144.00**			16	**£ 4,944.00**			-	**£ -**			-	**£ -**			-	**£ -**			-	**£ -**	112	£ 26,088.00
Endoscopy	Day Cases	7	12	£ 567.00	84	£ 47,628.00	1	£ 263.00	7	£ 1,841.00	0	£ 444.00	0	£ -		£ 391.00	0	£ -		£ 222.00	0	£ -	0	£ 38.00	0	£ -	91	£ 49,469.00
ENT	Inpatient	2		£ 691.00	0	£ -		£ 320.00	0	£ -	0	£ 541.00	0	£ -		£ 477.00	0	£ -	0	£ 270.00	0	£ -	0	£ 46.00	0	£ -	0	£ -
	Outpatients	10	18	£ 92.00	180	£ 16,560.00	0	£ 65.00	0	£ -	0	£ 70.00	0	£ -		£ -	0	£ -	0	£ 36.00	0	£ -	0	£ 9.00	0	£ -	180	£ 16,560.00
Sub-Total					180	**£ 16,560.00**			-	**£ -**			-	**£ -**			-	**£ -**			-	**£ -**			-	**£ -**	180	£ 16,560.00
Urology	Inpatients	2		£ 837.00	0	£ -	1	£ 388.00	2	£ 776.00	0	£ 655.00	0	£ -		£ 578.00	0	£ -	0	£ 328.00	0	£ -	0	£ 56.00	0	£ -	2	£ 776.00
	Day Cases	4		£ 277.00	0	£ -	0	£ 128.00	0	£ -	0	£ 217.00	0	£ -		£ 191.00	0	£ -	0	£ 108.00	0	£ -	0	£ 18.00	0	£ -	0	£ -
	Flexi Lists	9		£ 208.00	0	£ -		£ 96.00	0	£ -	0	£ 163.00	0	£ -		£ 144.00	0	£ -	0	£ 81.00	0	£ -	0	£ 14.00	0	£ -	0	£ -
	Outpatients	10		£ 153.00	0	£ -		£ 110.00	0	£ -	0	£ -	0	£ -		£ -	0	£ -	0	£ 61.00	0	£ -	0	£ 10.00	0	£ -	0	£ -
Sub-Total					-	**£ -**			2	**£ 776.00**			-	**£ -**			-	**£ -**			-	**£ -**			-	**£ -**	2	£ 776.00
Trauma & Ortho	Inpatients	1	8	£ 1,913.00	8	£ 15,304.00		£ 887.00	0	£ -	0	£ 1,497.00	0	£ -		£ 1,320.00	0	£ -	0	£ 749.00	0	£ -	0	£ 128.00	0	£ -	8	£ 15,304.00
	Day Cases	3	0	£ 1,211.00	0	£ -		£ 561.00	0	£ -	0	£ 948.00	0	£ -		£ 836.00	0	£ -	0	£ 474.00	0	£ -	0	£ 81.00	0	£ -	0	£ -
	Outpatients	9	14	£ 127.00	126	£ 16,002.00		£ 92.00	0	£ -	0	£ -	0	£ -		£ -	0	£ -	0	£ 51.00	0	£ -	0	£ 9.00	0	£ -	126	£ 16,002.00
	ASR Clinics	9		£ 127.00	0	£ -					0																0	£ -
Sub-Total					134	**£ 31,306.00**			-	**£ -**			-	**£ -**			-	**£ -**			-	**£ -**			-	**£ -**	134	£ 31,306.00
Ophthalmology	Day Cases	4	0	£ 320.00	0	£ -	0	£ 144.00	0	£ -	0	£ 243.00	0	£ -		£ 221.00	0	£ -	0	£ 122.00	0	£ -	0	£ 45.00	0	£ -	0	£ -
	Outpatients	13	1	£ 134.00	13	£ 1,742.00		£ 94.00	0	£ -	0	£ -	0	£ -		£ -	0	£ -	0	£ 53.00	0	£ -	0	£ 12.00	0	£ -	13	£ 1,742.00
Sub-Total					13	**£ 1,742.00**			-	**£ -**			-	**£ -**			-	**£ -**			-	**£ -**			-	**£ -**	13	£ 1,742.00
Oral Surgery	Out-Patients		0	***COST TO BE CONFIRMED***			0				0				0				0				0					
	Day Case			***COST TO BE CONFIRMED***																								
Breast Surgery	One-stop clinic	12	0	£ 151.00	0	£ -	0	£ 109.00	0	£ -	0	£ 115.00	0	£ -		£ -	0	£ -	0	£ 61.00	0	£ -	0	£ 14.00	0	£ -	0	£ -
Vascular	Inpatients	2	0	£ 883.00	0	£ -	0	£ 409.00	0	£ -	0	£ 692.00	0	£ -		£ 609.00	0	£ -	0	£ 345.00	0	£ -	0	£ 59.00	0	£ -	0	£ -
Total Estimated Costs					289	39,446			18	5,720			-	-			-	-			-	-			-	-	307	£ 125,941.00

SURGERY AND ELECTIVE CARE - SEPT 2013

			OPTION 1 FULL COST				OPTION 2 PA RATE				OPTION 2 CONS SURGEON or CONS ANAE ONLY				OPTION 3 CONS SURGEON AND ANAE ONLY				OPTION 4 CONS SURGEON AND NURSING ONLY				OPTION 5 NURSING ONLY				OPTION 6 MARGINAL GOODS & SERVICES ONLY				TOTALS	
Specialty	Admit Type	Assumed no. of patients per session	No of sessions	Average Full Cost	Activity	Total Cost		Avg Cost Cons Surgeon Only	Activity	Total Cost		Avg Cost Cons Surgeon Only	Activity	Total Cost	No of sessions	Avg Cost Cons Surgeon & Anae	Activity	Total Cost		Avg Cost Cons Surgeon & Nursing	Activity	Total Cost		Avg Cost Nursing Only	Activity	Total Cost	No of sessions	Avg Cost Marginal G&S only	Activity	Total Cost		TOTAL ACTIVITY	TOTAL COST
General Surgery	Inpatients	3		£ 803.00	0	£ -			0	£ -		£372.00	0	£ -	0	£ 629.00	0	£ -		£ 554.00	0	£ -		£314.00	0	£ -	0	£ 54.00	0	£ -		0	£ -
	Day Cases	4		£ 258.00	0	£ -			0	£ -		£120.00	0	£ -	0	£ 202.00	0	£ -		£ 178.00	0	£ -		£101.00	0	£ -	0	£ 17.00	0	£ -		0	£ -
	Outpatients	14		£ 137.00	0	£ -			0	£ -		£ 99.00	0	£ -	0	£ -	0	£ -		£ -	0	£ -		£ 55.00	0	£ -	0	£ 9.00	0	£ -		0	£ -
Sub-Total					-	£ -			-	£ -			-	£ -			-	£ -			-	£ -			-	£ -			-	£ -		-	£ -
Endoscopy	Day Cases	7		£ 567.00	0	£ -			0	£ -		£263.00	0	£ -	0	£ 444.00	0	£ -		£ 391.00	0	£ -		£222.00	0	£ -	0	£ 38.00	0	£ -		0	£ -
ENT	Inpatient	2		£ 691.00	0	£ -			0	£ -		£320.00	0	£ -	0	£ 541.00	0	£ -		£ 477.00	0	£ -		£270.00	0	£ -	0	£ 46.00	0	£ -		0	£ -
	Outpatients	10		£ 92.00	0	£ -			0	£ -		£ 65.00	0	£ -	0	£ 70.00	0	£ -		£ -	0	£ -		£ 36.00	0	£ -	0	£ 9.00	0	£ -		0	£ -
Sub-Total					-	£ -			-	£ -			-	£ -			-	£ -			-	£ -			-	£ -			-	£ -		-	£ -
Urology	Inpatients	2		£ 837.00	0	£ -			0	£ -		£388.00	0	£ -	0	£ 655.00	0	£ -		£ 578.00	0	£ -		£328.00	0	£ -	0	£ 56.00	0	£ -		0	£ -
	Day Cases	4		£ 277.00	0	£ -			0	£ -		£128.00	0	£ -	0	£ 217.00	0	£ -		£ 191.00	0	£ -		£108.00	0	£ -	0	£ 18.00	0	£ -		0	£ -
	Flexi Lists	9		£ 208.00	0	£ -			0	£ -		£ 96.00	0	£ -	0	£ 163.00	0	£ -		£ 144.00	0	£ -		£ 81.00	0	£ -	0	£ 14.00	0	£ -		0	£ -
	Outpatients	10		£ 153.00	0	£ -			0	£ -		£110.00	0	£ -	0	£ -	0	£ -		£ -	0	£ -		£ 61.00	0	£ -	0	£ 10.00	0	£ -		0	£ -
Sub-Total					-	£ -			-	£ -			-	£ -			-	£ -			-	£ -			-	£ -			-	£ -		-	£ -
Trauma & Ortho	Inpatients	1		£ 1,913.00	0	£ -			0	£ -		£887.00	0	£ -	0	########	0	£ -		########	0	£ -		£749.00	0	£ -	0	£128.00	0	£ -		0	£ -
	Day Cases	1		£ 1,211.00	0	£ -			0	£ -		£561.00	0	£ -	0	£ 948.00	0	£ -		£ 836.00	0	£ -		£474.00	0	£ -	0	£ 81.00	0	£ -		0	£ -
	Outpatients	9		£ 127.00	0	£ -			0	£ -		£ 92.00	0	£ -	0	£ -	0	£ -		£ -	0	£ -		£ 51.00	0	£ -	0	£ 9.00	0	£ -		0	£ -
Sub-Total					-	£ -			-	£ -			-	£ -			-	£ -			-	£ -			-	£ -			-	£ -		-	£ -
Ophthalmology	Day Cases	4		£ 320.00	0	£ -			0	£ -		£144.00	0	£ -	0	£ 243.00	0	£ -		£ 221.00	0	£ -		£122.00	0	£ -	0	£ 45.00	0	£ -		0	£ -
	Outpatients	13		£ 134.00	0	£ -			0	£ -		£ 94.00	0	£ -	0	£ -	0	£ -		£ -	0	£ -		£ 53.00	0	£ -	0	£ 12.00	0	£ -		0	£ -
Sub-Total					-	£ -			-	£ -			-	£ -			-	£ -			-	£ -			-	£ -			-	£ -		-	£ -
Breast Surgery	One Stop Cl	12		£ 151.00	0	£ -			0	£ -		£109.00	0	£ -	0	£ 115.00	0	£ -		£ -	0	£ -		£ 61.00	0	£ -	0	£ 14.00	0	£ -		0	£ -
Vascular	Inpatients	2	0	£ 883.00	0	£ -			0	£ -		£409.00	0	£ -	0	£ 692.00	0	£ -		£ 609.00	0	£ -		£345.00	0	£ -	0	£ 59.00	0	£ -		0	£ -
Total Estimated Costs					-	-			-	-			-	£ -			-	-			-	-	-	628	-	-			-	-		-	-

Received from SHSCT on 02/11/2022. Annotated by the Urology Services Inquiry.

Glenny, Sharon

From: Glenny, Sharon <[redacted]>
Sent: 27 November 2015 15:35
To: Glackin, Anthony
Subject: RE: DHH Urology Type Referrals

No – not at all.

I'm going to check it again in a couple of weeks to ensure we are getting a true picture of the referral pattern.

Sharon

From: Glackin, Anthony
Sent: 27 November 2015 15:34
To: Glenny, Sharon
Subject: RE: DHH Urology Type Referrals

Not insignificant numbers!!

Tony

From: Glenny, Sharon
Sent: 27 November 2015 15:08
To: Corrigan, Martina
Cc: Glackin, Anthony
Subject: DHH Urology Type Referrals

Hi Martina

I have taken a look at the current out-patient waiting lists and referrals received in the last 3 weeks for Mr Brown and Paul Hughes in DHH, in particular the urology referral types. If we go much further back than 3 weeks, we will miss patients who have already been appointed/attended.

There have been a total of:

- Paul Hughes Vasectomy – 16, ie average of 5.33 per week
- Mr Brown General Urology (includes haematuria) – 36, ie average of 12 per week

On average there would appear to be 17.33 urology referrals to Mr Brown/Dr Hughes each week – this could potentially equate to a yearly demand of 901 patients.

I will take another look at this again in a few weeks to assess the referral numbers at that time and check that they are consistent with above.

Kind regards

Sharon

Mrs Sharon Glenny
Operational Support Lead
Surgery & Elective Care

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

Glenny, Sharon

From: Glenny, Sharon <[redacted]>
Sent: 25 November 2015 11:45
To: Corrigan, Martina
Cc: Glackin, Anthony
Subject: RE: Urology Urgent NOP Waits

Hi Martina/Tony

I have taken a look at the last 26 weeks for referral demand vs actual activity – see below:

	Referrals	Attendances	Variance
Red Flag	690	564	-126
Hot*		34	
Urgent	765	462	-303
Routine	1022	516	-506

**Assumption that all new Hot clinic attendances are Red Flag*

The attendances above will include all new UDS appointments – these are normally added to UDS waiting lists following new patient appointment so therefore in order to be sure we get a better feel for the actual initial appointment following referral, I have excluded the UDS appointments in next table:

	Referrals	Attendances	Variance
Red Flag	690	564	-126

Hot*		34	
Urgent	765	412	-353
Routine	1022	402	-620

**Assumption that all new Hot clinic attendances are Red Flag*

We are currently on top of the red flag demand in terms of meeting access, therefore one can only assume that some of the other appointment type slots are being used for the RF referrals, or there is downgrading at triage, or ROTT.

Effectively, as it stands, the weekly average referral demand vs actual activity is as follows:

	Average Weekly Referrals	Average Weekly Attendances	Average Weekly Variance
Red Flag	26.5	23	-3.5
Urgent	29.5	16	-13.5
Routine	39.5	15.5	-24

All "TDU" new patient clinics are set up with the following split of appointment type:

- Consultant = RFx4, NUx2, NRx3
- Registrar = RFx4, NUx1, NRx1 (split between 2 consultants, if both consultants in attendance)

Current waiting times by each category:

- Red Flag – within access time
- Urgent – 38 weeks by end November
- Routine – 71 weeks x 1 patient (AOB U18 discharge), then drops to 63 weeks

Happy to discuss further.

Sharon

From: Corrigan, Martina
Sent: 25 November 2015 09:56
To: Glenny, Sharon
Cc: Glackin, Anthony
Subject: FW: Urology Urgent NOP Waits

Hi Sharon

As discussed.

Thanks

Martina

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

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

From: Glackin, Anthony
Sent: 23 November 2015 18:21
To: Corrigan, Martina
Subject: RE: Urology Urgent NOP Waits

Dear Martina,
I had a look at my template, I presume the others are similar.
4RF, 2NU and 3 NR

Swapping 1 NR for 1 NU would allow an increase or 5 NU per week (assuming each Consultant has a new clinic each week, not taking into account leave etc and not counting the registrar clinics). This isn't really going to make much difference to 675 urgents. It would be useful to know the weekly data so that we could plan weekly activity to make some progress.

Are we weighting the clinics to heavily toward RF and NR?
It appears my CAJGREG clinic is 2RF and 1 NR, this could be changed to reflect demand.
Happy to discuss.

Tony

From: Corrigan, Martina
Sent: 23 November 2015 14:58
To: Glackin, Anthony
Subject: FW: Urology Urgent NOP Waits
Importance: High

Dear Tony,

Any thoughts on this considering our conversation last week?

Thanks

Martina

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

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

From: Glenny, Sharon
Sent: 23 November 2015 14:56
To: Corrigan, Martina
Subject: Urology Urgent NOP Waits
Importance: High

Hi Martina

I have been taking a look at the urgent waiting list volumes for urology NOP appointments and the waiting time.

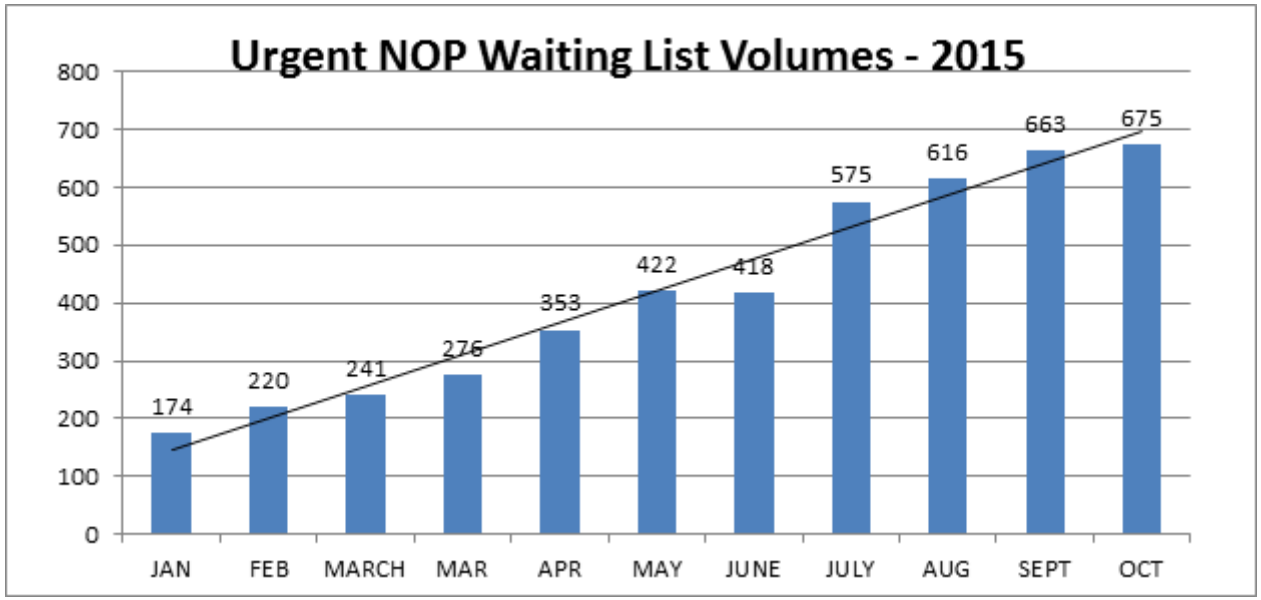
The patient volumes on the urgent waiting list have been steadily increasing month-on-month – going from 174 in January 2015 to 675 in October 2015.

The waiting time has also shown an increase from 26 weeks in January 2015 to 38 weeks by end of November. We have some erratic longest urgent waiting times during this period, with one month showing an urgent waiting time of 69 weeks (OC Referral which was backdated), 50 weeks (awaiting diagnostic tests before being seen).

Given the increasing volumes on the urgent waiting list and the creeping waiting time, is it worth reviewing the clinic templates again? Possibly consider changing NR x 1 on each clinic to NU x 1, even for a short period of time??

Happy to discuss further.

Sharon



Mrs Sharon Glenny
Operational Support Lead
Surgery & Elective Care

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

UROLOGY OUT-PATIENT WEEKLY DASHBOARD

		New Patient Referrals				New Patient Attendances											Review Attendances									New Patient Waiting List (Consultant and ICATS)							Review Waiting List (Date Required less than in month) (Consultant and ICATS)				
Date	On Call	Red Flag	Urgent	Routine	Total	Red Flag	Urgent	Routine	Hot	Virtual (Tele / Letter)	Total New Atts	New Slots Available on Rota	Unused Slots from Rota	CND Canc on Day	DNA	Total Lost Slots on the Day	DNA Rate (exc CND)	Protected Review	Review	Hot	Virtual (Tele / Letter)	ICATS Review	Total Review	CND Canc on Day	DNA	DNA Rate (exc CND)	Red Flag	Longest Waiter	Urgent	Longest Waiter	Routine	Longest Waiter	Total New Waiting List	Urgent	Longest Waiter	Routine	Longest Waiter	Total Review Waiting List
01/01/2015-07/01/2015		17	17	20	54	21	36	10		1	68			3	5		6.58%	54	61			7	122	0	4	3.17%												
08/01/2015-14/01/2015		23	35	42	100	24	40	17		0	81			1	3		3.53%	27	68			7	102	1	4	3.74%												
15/01/2015-21/01/2015		21	24	33	78	19	12	38		0	69			1	9		11.39%	43	77			5	125	1	6	4.55%	51	21 days	174	26 weeks	1587	50 weeks	1812					
22/01/2015-28/01/2015		37	31	35	103	10	12	63		0	85			2	4		4.40%	33	43			7	83	0	2	2.35%												
29/01/2015-04/02/2015	JOD	25	35	29	89	19	33	34		0	86			4	2		2.17%	40	60			0	100	1	4	3.81%												
05/02/2015-11/02/2015	MDH	30	19	66	115	27	29	46	5	0	107	100	-2	0	0	0	0.00%	35	54			6	95	2	4	3.96%	27	31 days	142	26 weeks	1547	52 weeks	1716	625	May-12	2515	Aug-11	3140
12/02/2015-18/02/2015	MY	31	19	63	113	25	36	30	1	0	92	99	4	1	3	4	3.13%	33	32			7	72	2	4	5.13%	16	30 days	220	27 weeks	1524	47 weeks	1760	685	May-12	2387	Aug-11	3072
19/02/2015-25/02/2015	AJG	23	32	55	110	21	21	43	0	0	85	95	1	2	7	9	7.45%	40	43			7	90	0	2	2.17%												
26/02/2015-04/03/2015	KS	28	38	63	129	21	14	10	0	0	48	76	23	2	6	8	10.71%	42	61			6	109	3	2	1.75%	12	40 days	241	33 weeks	1456	49 weeks	1709	733	May-12	2186	Aug-11	2919
05/03/2015-11/03/2015	MDH	30	27	46	103	44	28	23	2	0	97	108	7	2	4	6	3.88%	25	45	14		6	90	2	3	3.16%												
12/03/2015-18/03/2015	AJG	33	33	37	103	20	13	10	1	0	44	51	4	2	2	4	4.17%	12	14	6		6	38	2	1	2.44%												
19/03/2015-25/03/2015	JOD	37	25	49	111	27	27	30	0	0	84	94	3	1	6	7	6.59%	56	100	2		0	158	6	10	5.75%												
26/03/2015-01/04/2015	MY	29	22	41	92	48	17	29	2	0	96	108	8	1	5	6	4.90%	40	61	1		8	110	2	5	4.27%	22	77 days	276	28 weeks	1569	47 weeks	1867	678	May-12	2174	Aug-11	2852
02/04/2015-08/04/2015	AOB	8	17	31	56	16	7	19	0	0	42	45	2	0	1	1	2.33%	5	23	1		7	36	2	2	5.00%												
09/04/2015-15/04/2015	MDH	22	23	44	89	18	36	28	1	0	83	87	-3	3	5	8	5.49%	42	33	13		10	98	0	6	5.77%	7	49 days	199	18 weeks	1569	47 weeks	1775	702	May-12	2014	Aug-11	2716
16/04/2015-22/04/2015	KS	26	26	44	96	16	30	33	0	0	79	76	-8	0	5	5	5.95%	26	62	1		9	98	2	6	5.66%												
23/04/2015-29/04/2015	AJG	33	32	46	111	26	31	33	1	0	91	97	-1	1	7	8	7.07%	31	44	5		6	86	1	2	2.25%												
30/04/2015-06/05/2015	JOD	26	42	15	83	14	12	16	1	0	43	50	2	0	6	6	12.24%	36	52	10		5	103	0	2	1.90%												
07/05/2015-13/05/2015	MY	24	18	50	92	38	27	27	0	0	92	100	7	0	1	1	1.08%	41	49	2		7	99	2	4	3.81%	15	14 days	314	38 weeks*	1605	50 weeks	1934	820	May-12	1940	Aug-11	2760
14/05/2015-20/05/2015	AOB	15	29	41	85	22	27	25	1	0	75	82	3	1	4	5	5.00%	25	81	0		0	106	0	5	4.50%	18	14 days	353	39 weeks	1631	49 weeks	2002	697	May-12	2042	Aug-11	2739
21/05/2015-27/05/2015	MDH	35	26	35	96	14	10	10	1	0	35	41	0	5	2	7	4.76%	24	17	10		8	59	2	3	4.69%												
28/05/2015-03/06/2015	KS	29	30	55	114	25	27	33	2	0	87	76	-10	0	1	1	1.14%	37	52	1		7	97	0	0	0.00%												
04/06/2015-10/06/2015	AJG	31	36	41	108	26	19	19	1	0	65	71	1	1	5	6	7.04%	34	30	12		7	83	1	3	3.45%	8	10 days	373	49 weeks	1642	51 weeks	2023	773	May-12	1828	Aug-11	2601
11/06/2015-17/06/2015	JOD	21	45	28	94	16	11	13	1	0	41	38	-4	0	2	2	4.65%	11	4	5	4	6	30	3	2	5.71%	12	14 days	422	50 weeks	1563	51 weeks	1997	731	May-12	1807	Aug-11	2538
18/06/2015-24/06/2015	MY	25	24	46	95	29	23	20	1	1	74	79	2	1	4	5	5.06%	60	32	19	0	10	121	2	1	0.81%	26	19 days	421	44 weeks	1636	52 weeks	2083	801	Sep-13	1878	Aug-11	2679
25/06/2015-01/07/2015	AOB	29	30	53	112	17	18	15	4	0	54	53	-4	2	5	7	8.20%	37	51	6	11	9	114	0	3	2.56%												
02/07/2015-08/07/2015	KS	27	28	33	88	7	5	4	2	0	18	21	1	0	4	4	18.18%	14	24	4	0	7	49	1	0	0.00%	70	41 days	418	24 weeks	1618	54 weeks	2106	694	Sep-13	1905	Aug-11	2599
09/07/2015-15/07/2015	MDH	17	12	31	60	9	2	1	4	3	19	15	2	0	1	1	5.00%	11	2	9	0	7	29	0	0	0.00%												
16/07/2015-22/07/2015	MY/AJG	21	36	38	95	20	12	17	3	7	59			3	7	10	10.14%	32	56	12	7	7	114	2	2	1.69%												
23/07/2015-29/07/2015	JOD	34	54	30	118	17	13	15	0	0	45			0	3	3	6.25%	35	34	6	1	0	76	0	0	0.00%												
30/07/2015-05/08/2015	MY	22	33	32	87	25	16	18	0	1	60			1	1	2	1.61%	30	50	3	1	7	91	3	1	1.05%												
06/08/2015-12/08/2015	AJG	17	24	38	79	23	14	21	1	0	59			1	4	5	6.25%	4	44	5	3	6	62	0	1	1.59%												
13/08/2015-19/08/2015	MDH	24	24	59	107	23	12	28	2	2	67			2	5	7	6.76%	19	49	14	1	6	89	3	0	0.00%												
20/08/2015-26/08/2015	KS	26	33	40	99	15	16	14	0	2	47			1	3	4	5.88%	12	35	9	2	0	58	4	1	1.59%												
27/08/2015-02/09/2015	AOB	22	17	37	76	22	13	16	0	0	51			0	2	2	3.77%	22	38	1	0	6	67	0	3	4.29%	46	58 days	575	43 weeks	1782	58 weeks	2403	927	Sep-13	1935	Aug-11	2862
03/09/2015-09/09/2015	JOD	30	34	22	86	29	19	29	1	1	79			3	7	10	7.87%	35	63	7	1	7	113	4	2	1.68%												
10/09/2015-16/09/2015	MDH	25	22	48	95	17	20	22	1	14	74			0	6	6	7.50%	37	50	12	5	7	111	3	1	0.87%												
17/09/2015-23/09/2015	MY	20	27	41	88	34	22	20	6	3	85			1	4	5	4.44%	39	62	0	1	6	108	2	3	2.65%	43	21 days	616	69 weeks	1807	64 weeks	2466	813	Sep-13	1716	Aug-11	2529
24/09/2015-30/09/2015	KS	26	21	43	90	23	27	28	1	4	83			1	4	5	4.55%	40	40	0	4	7	91	1	2	2.13%												
01/10/2015-07/10/2015	AOB	30	24	29	83	28	25	22	0	1	76			1	4	5	4.94%	22	69	4	0	7	102	1	3	2.83%												
08/10/2015-14/10/2015	JOD	37	43	21	101	17	39	37	0	1	94			0	3	3	3.09%	41	108	10	3	0	162	1	1	0.61%												
15/10/2015-21/10/2015	MDH	35	25	52	112	31	30	35	0	9	105			5	5	10	4.35%	53	88	0	0	13	154	4	5	3.07%												
22/10/2015-28/10/2015	MY	30	22	53	105	20	7	11	0	5	43			2	2	4	4.26%	22	62	10	1	6	101	2	4	3.74%												
29/10/2015-04/11/2015	AJG	28	31	45	104	30	19	21	0	3	73			0	2	2	2.67%	26	32	2	3	7	70	1	1	1.39%												
05/11/2015-11/11/2015		34	35	31	100	25	16	22	2	3	68			4	0	4	0.00%	38	68	2	0	8	116	2	1	0.84%	54	14 days	663	36 weeks	1829	66 weeks	2546	787	Sep-13	1781	May-12	2568
											0												0															
		1193	1280	1831	4304	1018	923	1055	48	61	2924			61	171	232	7.93%	1282	1865	218	48	277	3584															

New patient attendances as percentage of referral demand	67.94%

Average DNA rate Red Flags = 6% (CaPPs) for first appointment

MR HAYNES - SUMMARY OF TRIAGE OUTCOME
(15/10/2015 - 21/10/2015)

Total Volume Triaged (excludes Red Flag Referrals)	**94**
Investigations Requested	**32**
Letter to patient with Treatment Plan	**31**

H&C NO	DATE OF TRIAGE	NEW OR REVIEW	INVESTIGATION REQUESTED	TYPE OF CONTACT	COMMENTS
Personal Information redacted by the USI	15/10/2015	NEW URGENT			
	15/10/2015	NEW ROUTINE	AOB CLINIC		CHILD Personal Information AOB CLINIC
	15/10/2015	WRONG REFERRAL			CONTACTED GP THIS IS THE WRONG PATIENTS REFERRAL . GP TO SEND REFERRAL TO LEANNE
	15/10/2015	NEW URGENT			
	15/10/2015	ROUTINE			
	15/10/2015	NEW ROUTINE			
	15/10/2015	WL ACTIVE ?			NO REVIEW APPT NEEDED. FORWARD LETTER TO MR O'BRIEN
	15/10/2015	HOT CLINIC			
	15/10/2015	NO APPT REQUIRED			
	15/10/2015	NO APPT REQUIRED			EXPEDITE CURMYN
	15/10/2015	URGENT			EXPEDITE TO URGENT
	15/10/2015	NEW ROUTINE	USS	LETTER	
	15/10/2015	NEW ROUTINE	USS	LETTER	
	15/10/2015	NEW ROUTINE			
	15/10/2015	NEW ROUTINE	USS	LETTER	
	15/10/2015	NEW ROUTINE			
	15/10/2015	NEW URGENT			IN 4 WEEKS
	15/10/2015				I STILL HAVE LETTER AND INVESTGATING
	15/10/2015	NEW URGENT			
	15/10/2015		CT	LETTER	
	15/10/2015	NEW URGENT	USS	LETTER	
	15/10/2015	NEW ROUTINE			
	16/10/2015	NEW URGENT			
	16/10/2015		MRI	LETTER	
	16/10/2015		GP & DISCHARGE	LETTER	
	16/10/2015	NEW URGENT			
	16/10/2015	NEW ROUTINE			
	16/10/2015	NEW ROUTINE	USS / KUB	LETTER	
	16/10/2015	NEW ROUTINE	USS	LETTER	
	16/10/2015	NEW ROUTINE	USS/KUB	LETTER	
	16/10/2015	NEW ROUTINE	USS	LETTER	
	16/10/2015	RF UPGRADE			
	16/10/2015	NEW URGENT	USS	LETTER	
	19/10/2015	RF UPGRADE			
	19/10/2015	NEW ROUTINE	USS	LETTER	
	19/10/2015	NEW URGENT	USS	LETTER	
	19/10/2015		USS	LETTER	
	19/10/2015		NONE REQUIRED	LETTER	
	19/10/2015	NEW ROUTINE	US	LETTER	
	19/10/2015	NEW ROUTINE	US	LETTER	
	19/10/2015	NEW REVIEW			REVIEW WITH KS WITHIN 1 MONTH
	19/10/2015	NEW URGENT			WITHIN 6 WEEKS
	19/10/2015	NEW URGENT			WITHIN 1 MONTH
	19/10/2015		CT + IMAGE	LETTER	
	19/10/2015	HOT CLINIC			
	19/10/2015	NEW URGENT			

Personal Information redacted by the USI

19/10/2015	REVIEW			AT STC IN 3-4 WEEKS , SENT TO CLAIRE
19/10/2015	NEW 3 WEEKS			
19/10/2015	REVIEW	MRI & US		JOD REVIEW SHE WOULD HAVE BEEN AN INPATIENT BUT NO BEDS SO WEN TO CDU.
19/10/2015	REVIEW	USS		REVIEW JOD AFTER USS
19/10/2015	NEW ROUTINE			
19/10/2015	REVIEW			MR YOUNG CLINIC WITHIN 4 MONTHS
20/10/2015	NEW ROUTINE			
20/10/2015	NEW URGENT			
20/10/2015	NEW ROUTINE			
20/10/2015	NEW ROUTINE			
20/10/2015	NEW URGENT			
20/10/2015	REVIEW		LETTER	MON 4 WEEKS
20/10/2015	NEW URGENT	USS	LETTER	
20/10/2015	NEW ROUTINE	USS	LETTER	
20/10/2015	NEW URGENT			IN 4 WEEKS
20/10/2015	NEW ROUTINE			
20/10/2015		DIRECT WL	LETTER	
20/10/2015	NEW ROUTINE			
20/10/2015	REVIEW	AFTER US	LETTER	
20/10/2015	EXPEDITE OP APPT			
20/10/2015	NEW ROUTINE	US	LETTER	
20/10/2015		FORWARD LETTER TO MR SURESH		
20/10/2015	NEW ROUTINE			
20/10/2015	NEW URGENT	US	LETTER	
20/10/2015		X-RAY MEETING	LETTER	
20/10/2015	NEW URGENT			
20/10/2015	NEW ROUTINE			
		US	LETTER	STAY ON CURRENT NEW OP WL
20/10/2015	NEW ROUTINE			
20/10/2015	NEW ROUTINE			
20/10/2015				DON'T UNDERSTAND USE OF DARO. HAS NEVER BEEN DISCHARGED. AJG PLANNED TO REVIEW IN CLINIC IN SEPT 2015 FOR HIS PROSTATE CANCER WHICH IS BEING MANAGED BY ACTIVE SURVEILANCES.
20/10/2015	RF UPGRADE	CT	LETTER	
21/10/2015	NEW ROUTINE			
21/10/2015	NEW URGENT			
21/10/2015	NEW ROUTINE			
21/10/2015	REVIEW AJGUO ASAP			
21/10/2015	NEW URGENT			
21/10/2015	NEW ROUTINE	US	LETTER	
21/10/2015	STC URGENT			
21/10/2015	NEW ROUTINE			
21/10/2015	MDT			REVIEW IN 4 WEEKS
21/10/2015	NEW URGENT			
21/10/2015				I HAVE CONTACTED DR BURKE AND AWAIT RESPONSE
21/10/2015	NEW ROUTINE	US & TREATMENT RECOMMENDATION	LETTER	LETTER
21/10/2015	REVIEW ROUTINE			MR YOUNG
21/10/2015	NEW URGENT			
21/10/2015	NEW URGENT			
21/10/2015	NEW ROUTINE			

UROLOGY RED FLAG APPOINTMENTS

June 2014 - 20 Consecutive Red Flag Patient Attendances

Hospital of Clinic Code	Casenote Number	Specialty of Clinic Description (R)	Specialty of Clinic Description	Referral Reason	Priority Type Description	Clinic Identifier/Code	Consultant of Clinic Name	Appt Type (R)	Appointment Type Description	Referral Date	Appointment Date Only	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	TOTAL DAYS TO FIRST DEFINITIVE TREATMENT	CAPPS OUTCOME
CAH	Personal Information redacted by the USI	UROLOGY	UROLOGY(C)	URC	URGENT	CKSHAEM	SURESH K MR	F	RED FLAG PATIENT	20/05/2014	03/06/2014	14	flexible cystoscopy performed at clinic - normal Requested PSA, IVU - normal Results to patient - discharged	-										**14**	No Cancer
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CKSHAEM	SURESH K MR	F	RED FLAG PATIENT	01/05/2014	03/06/2014	33	flexible cystoscopy performed at clinic - normal Requested CT urogram - normal Results to patient - discharged	-										**33**	No Cancer
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CKSHAEM	SURESH K MR	F	RED FLAG PATIENT	19/05/2014	03/06/2014	15	flexible cystoscopy performed at clinic - small urethral caruncle Requested BT urogram & U&Es - normal Results to patient - dischaged	-										**15**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CKSHAEM	SURESH K MR	F	RED FLAG PATIENT	20/05/14	03/06/2014	14	Flexible cystoscopy performed at clinic - large occlusive prostate and a 3 to 4cm papillary tumour at the site of left UO. Requested EFGR, PSA & CT urogram Added to WL for TURBT, left retrograde studies plus intravesical Mitomycin	08/08/2014	66	TURBT Histology has confirmed a superficial transitional cell carcinoma of bladder G2 pTa. For flexible cystoscopy in November 2014.								**80**	Other condition not tracked
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CKSHAEM	SURESH K MR	F	RED FLAG PATIENT	16/05/14	03/06/2014	18	Flexible cystoscopy performed at clinic - normal Small (5mm) right renal stone seen on previous CT KUB Dipstick haematuria Reassured & discharged	-										**18**	No Cancer
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CAOBTDU	O'BRIEN A MR	F	RED FLAG PATIENT	20/05/14	03/06/2014	14	No clinical documents on NIECR relating to attendance Malignant neoplasm of prostate	08/07/2014	35	Intravesical chemotherapy Attending Cancer Centre in Belfast								**49**	Recurrent cancer, not tracked
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CKSHAEM	SURESH K MR	F	RED FLAG PATIENT	20/05/14	03/06/2014	14	flexible cystoscopy performed at clinic - normal Requested IVU - normal Results to patient - discharged	-										**14**	No Cancer
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CAJGPA	GLACKIN A.J MR	F	RED FLAG PATIENT	30/05/14	04/06/2014	5	DRE the base of the prostate on the left side felt hard waitlisted for urodynamics which we will currently withhold as he needs TRUS and biopsies of the prostate for which he has been placed on the urgent waiting list	15/07/2014	41	gleason 4+3=7 prostate cancer. Requested staging with an MRI scan and isotope bone scan MRI Results - suggestive of early T3 disease but without any lymphadenopathy Keen for radical prostatectomy Isotope bone scan - normal	19/11/2014	168	Radical prostatectomy (BCH)				**214**	31-day cancer, Closed D29
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CAJGPA	GLACKIN A.J MR	F	RED FLAG PATIENT	23/05/14	04/06/2014	12	Rising PSA Ultrasound scanning of his urinary tract shows normal sized kidneys with several simple cysts Added to WL for TRUS biopsy to exclude carcinoma	02/07/2014	28	Prostate Biopsy - normal								**40**	No Cancer
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CCHAEM	CONS LED HAEMATURIA	F	RED FLAG PATIENT	08/05/14	05/06/2014	28	Attempted flexible cystoscopy - revealed a bulbar urethral stricture which would not allow the tip of the 16 French scope to advance. Procedure abandoned. Ultrasound scan of the urinary tract was essentially normal Added to WL for internal visual uretherotomy	07/10/2014	124	Optical ureteroscopy and cystoscopy								**152**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CCHAEM	CONS LED HAEMATURIA	F	RED FLAG PATIENT	30/04/14	05/06/2014	36	Flexible cystoscopy at clinic - normal lower urinary tract urothelium. Urine sample obtained for cytology & CT urogram requested - both normal											**36**	No Cancer
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CCHAEM	CONS LED HAEMATURIA	F	RED FLAG PATIENT	22/05/14	05/06/2014	14	Flexible cystoscopy at clinic - 0.5cm tuft of possible TCC was found laterally adjacent to the right ureteric opening with a few tiny sessile lesions surrounding it Requires TURBT	15/08/2014	71	TURBT - pTa G1 TCC								**85**	Other condition not tracked
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CCHAEM	CONS LED HAEMATURIA	F	RED FLAG PATIENT	14/05/14	05/06/2014	22	Persistent biochemical haematuria. Flexible cystoscopy at clinic - normal Urine cytology - normal Discharged											**22**	Not tracked, too many DNAs
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CCHAEM	CONS LED HAEMATURIA	F	RED FLAG PATIENT	09/05/14	05/06/2014	27	Visible haematuria x 1 Fluctuating PSA and PH of TURP 10 years ago Flexible cystoscopy at clinic - normal urethra to the verumontanum leading into a markedly occlusive trilobar enlargement of the prostate, middle lobe intrusive of the bladder cavity with contact bleeding seen. Bladder mucosa itself is essentially normal apart from trabeculation DRE showed a >60g but benign prostate Urine cytology - squamous epithelial cells, urothelial cells and debris. No malignant cells are seen CT urogram requested - prostatic enlargement (7.2 x 7.2 x 6.7 cm) elevating the bladder base. Both kidneys are of normal size. There are bilateral renal cysts. The largest cyst (left kidney) has a diameter of 3.4 cm. There is no evidence of a renal mass or calculi. (11/06/2014)	16/09/2014	103	Review with AOB (no letter on NIECR) On review waiting list for review Dec 2014								**130**	No Cancer
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CCHAEM	CONS LED HAEMATURIA	F	RED FLAG PATIENT	21/05/14	05/06/2014	15	Painless visible haematuria Flexible cytoscopy - normal urethra to the verumontanum leading into a minimally occlusive prostatic urethra, the rest of the lower urinary tract urothelium was essentially normal CT Urogram - no significant pathology of upper urinary tract (24/06/2014) Urine cytology - insufficient sample Discharged											**15**	No Cancer
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CMDHTDU	HAYNES M D MR	F	RED FLAG PATIENT	02/06/14	06/06/2014	4	Recent GP attendance with right sided testicular pain and palpable nodule right upper pole Perso year old) Refused examination and USS. Discharged											**4**	Not tracked, declined examination
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CAJGUO	GLACKIN A.J MR	F	RED FLAG PATIENT	14/05/14	09/06/2014	26	Carcinoma of the prostate treated with radical radiotherapy in approximately 2007 whilst living in Person . PSA 0.3ng/ml May 2014 PSA monitoring with GP November 2014 and May 2015 Review one year	06/10/2015		OPD Review PSA monitoring with GP Review one year								**26**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	EUROAOB	O'BRIEN A MR	F	RED FLAG PATIENT	01/05/14	09/06/2014	39	No letter on NIECR	19/10/2015		Attended OPD SWAH - No letter on NIECR								**39**	For MDM only
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	EUROAOB	O'BRIEN A MR	F	RED FLAG PATIENT	08/05/14	09/06/2014	32	No letter on NIECR	16/09/2014	99	Partial nephrectomy - endophytic renal cell carcinoma								**131**	31-D patient, Close D23
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	EUROAOB	O'BRIEN A MR	F	RED FLAG PATIENT	09/05/14	09/06/2014	31	No letter on NIECR	23/02/2015		Review with AOB (no letter on NIECR)								**31**	Downgraded following 1st appt

June 2014	Average Waiting Time to First Appointment (days)	21

June 2015 - 20 Consecutive Red Flag Patient Attendances

Hospital of Clinic Code	Casenote Number	Specialty of Clinic Description (R)	Specialty of Clinic Description	Referral Reason	Priority Type Description	Clinic Identifier/Code	Consultant of Clinic Name	Appt Type (R)	Appointment Type Description	Referral Date	Appointment Date Only	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome				Return Date	Waiting Time (Days)	Outcome	TOTAL DAYS TO FIRST DEFINITIVE TREATMENT	CAPPS OUTCOME
CAH	Personal Information redacted by the USI	UROLOGY	UROLOGY(C)	URC	URGENT	CAJGTDU	GLACKIN A.J MR	F	RED FLAG PATIENT	18/05/2015	01/06/2015	14	Referred with raised PSA 23. Examination normal May require prostate biopsy. To have repeat PSA - result was 7.5 Discharged back to GP for annual PSA checks											**14**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CAJGTDU	GLACKIN A.J MR	F	RED FLAG PATIENT	14/05/2015	01/06/2015	18	Biochemical haematuria P/H total colectomy for ulcerative colitis Flexible cystoscopy at clinic- normal urethra, enlarged prostate which protrudes into the bladder, bladder is grossly trabeculated DRE - not possible due to his rectal stump USS - normal sized kidneys with a small left sided simple cyst Observation rather than invasive investigations is most appropriate treatment To have PSA checked in August - fallen to 9.29. Discharged - given age, PSA monitoring not required											**18**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CAJGTDU	GLACKIN A.J MR	F	RED FLAG PATIENT	20/05/2015	01/06/2015	12	Referred with Lesion of penile prepuce Examination revealed circular lesion at approximately 12 o'clock which is about 1cm in diameter. This does not appear to have malignant features. It is not fixed to the underlying structures. Added to WL for excision of lesion	23/06/2015	22	Excision of penile lesion Histology - benign squamous keratosis								**34**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CAJGTDU	GLACKIN A.J MR	F	RED FLAG PATIENT	22/05/2015	01/06/2015	10	Referred with elevated PSA result DRE - large smooth benign feeling prostate To have repeat PSA - remained elevated, therefore to have prostate biopsy Probability of finding high risk prostate cancer is 21%	04/08/2015	64	Prostate biopsy (had CNA appointment for Bx on 21/07/2015) Gleason 3+4 adenocarcinoma of the prostate involving 4/11 cores MRI and bone scan requested - suggests bulky organ confined disease with possible abnormality in S1 Requires clarificatino with CT spect - no evidence of bony metastases	09/11/2015	97	Uro-oncology Review Following discussion at MDT - androgen deprivation with external beam radiotherapy or watchful waiting Patient given information and to contact secretary with decision				**171**	Still open currently on D65 ?close watchful wait. Patient currently suspended on pathway until patient makes contact re treatment plan
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CJODTDU	O'DONOGHUE J P MR	F	RED FLAG PATIENT	26/05/2015	01/06/2015	6	Referred with raised PSA Examination essentially normal For check PSA before decision re Prostate biopsy PSA remained raised - for prostate biopsy	20/07/2015	49	Prostate biopsy - no evidence of prostate cancer								**55**	No cancer
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CJODTDU	O'DONOGHUE J P MR	F	RED FLAG PATIENT	12/05/2015	01/06/2015	20	Person old lady with visible haematuria Flexible cystoscopy at clinic - normal Discharged											**20**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CJODTDU	O'DONOGHUE J P MR	F	RED FLAG PATIENT	22/05/2015	01/06/2015	10	Referred with swelling of right hemiscrotum x 1.5 weeks USS 27/05/2015 - diagnosis of a right testicular tumour On examination - grossly abnormal right testicle. DRE - somewhat irregular prostate but not overly suspicious. For an urgent right radical orchidectomy Tumour markers arranged	02/06/2015	1	right radical orchidectomy - diffused large B-cell lymphoma. CT chest, abdomen and pelvis organised. Referred to haematology			Appears to be having chemotherapy at Altnagelvin				**11**	Other condition not tracked

CAH	Personal Information redacted by the USI	UROLOGY	UROLOGY(C)	URC	URGENT	CJODTDU	O'DONOGHUE J P MR	F	RED FLAG PATIENT	27/05/2015	02/06/2015	6	Referred with visible haematuria History of radical prostatectomy and external beam radiotherapy 20 years earlier flexible cystoscopy at clinic, but it was impossible to insert the flexible scope past an anastomotic stenosis For cystoscopy and urethral dilatation CT urogram organised and bloods checked	10/06/2015	8	Cystoscopy and urethral dilatation very rigid stenotic proximal urethra with necrotic tissue consistent with previous radical prostatectomy and radiotherapy. He had no bladder tumours Continence Service for ISC Repeat cystoscopy in 3 months							**14**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CJODTDU	O'DONOGHUE J P MR	F	RED FLAG PATIENT	22/05/2015	02/06/2015	11	Referred with raised PSA 7.27 Family history of prostate cancer Examination normal Repeat PSA requested - result 6.15 Discharged to GP for PSA monitoring										**11**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CJODTDU	O'DONOGHUE J P MR	F	RED FLAG PATIENT	20/05/2015	02/06/2015	13	Referred with raised PSA PSA of 69.36 DRE - 50 to 60 gram malignant feeling prostate which is probably T3 at least Flow rate very poor For TRUS biopsy Bone scan, bone screen and bloods arranged	09/06/2015	7	TRUS Biopsy Adenocarcinoma of overall Gleason score of 4+5=9 in 7 of 12 cores bilaterally. The tumour occupies approximately 30% of the total tissue MDM recommended MRI and this was arranged Commended on androgren depravation therapy	03/09/2015	86	Review at OPD The bone scan showed no evidence of metastasis. His MRI showed a likely bulky bilateral prostate tumour. There was bilateral extracapsular extension and seminal vesicular infiltration, whilst there was no lymphadenopathy by size criteria there were multiple small pelvic nodes which are regarded with some suspicion. His tumour is staged as a T3b N0 M0 Already on androgen depravation therapy MDT recommended clinical oncology for radical radiotherapy and he will also be considered for the STAMPEDE trial				**106**	Closed cancer D36, commenced ADT
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CAJGTDU	GLACKIN A.J MR	F	RED FLAG PATIENT	22/05/2015	03/06/2015	12	Referred with PSA 9 & previous TURP BCH 2003 Examination - left hydrocele, small firm feeling prostate. His flow rate is reduced Added to WL for TURP +/- TURBT	12/06/2015	9	TURP + TURBT Gleason 3+4 adenocarcinoma of the prostate involving 9/12 cores representing 45% of biopsy tissue Attended clinic on 22/06/2015 for results and staging investigations arranged							**21**	Closed cancer D47, commenced Hormone therapy
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CAJGTDU	GLACKIN A.J MR	F	RED FLAG PATIENT	19/05/2015	03/06/2015	15	Perso old lady with visible haematuria Incidental finding of pancreatic mass on CT urogram 27th May 2015. Referred to gastroenterologist in SWAH for further investigation Discharged from urology					0					**15**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CAJGTDU	GLACKIN A.J MR	F	RED FLAG PATIENT	26/05/2015	03/06/2015	8	Referred with raised PSA 21 DRE normal TRUSB performed at clinic - Gleason 4+3 adenocarcinoma of the prostate involving 6/12 cores (reviewed with results 18.06.15) MRI and bone scan arranged	03/08/2015	61	Review at clinic MRI 17th July 2015 indicates organ confined prostate cancer Bone scan 22nd June 2015 indicates increase uptake in right humeral head and right ankle Options discussed - patient requested radiotherapy Referred to clinical oncology							**69**	Cancer closed on D31, hormone thearpy
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CAJGTDU	GLACKIN A.J MR	F	RED FLAG PATIENT	22/05/2015	03/06/2015	12	Referred with raised PSA - 6.5 and 8.1 Examination normal, PSA normal Continue with PSA monitoring, checked at clinic Results continue to be raised, therefore biopsy offered	04/08/2015	62	Prostate biopsy Histology - no cancer, but prostatic inflamamtion Discussed at MDT and MRI advised 09/10/15 - MRI prostate - no evidence of tumour							**74**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CMDHTDU	HAYNES M D MR	F	RED FLAG PATIENT	27/05/2015	03/06/2015	7	Referred with visible haematuria, PSA normal Examaination unremarkable Flexible cystoscopy at clinic - satisfactory Discharged					0					**7**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CMDHTDU	HAYNES M D MR	F	RED FLAG PATIENT	27/05/2015	03/06/2015	7	Referred with episode of visible haematuria Examination unremarkable DRE - benign prostate USS - normal Flexible cystoscopy at clinic - normal CT urogram requested PSA to be repeated	12/06/2015	9	CT urogram - normal Discharged							**16**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CMDHTDU	HAYNES M D MR	F	RED FLAG PATIENT	26/05/2015	03/06/2015	8	Referred with visible haematuria, long term suprapubic catheter Clinical examination unremarkable USS normal Flexiable cystoscopy normal Discharged					0					**8**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CMDHTDU	HAYNES M D MR	F	RED FLAG PATIENT	20/05/2015	03/06/2015	14	Raised PSA 17 Rectally his prostate feels malignant and consistent with a locally advanced (T3) prostate cancer On Plavix, therefore biopsy not possible at clinic Imaging arranged in first instance, then biopsy	24/06/2015	21	MRI - confirm my concerns when I examined your prostate that there is an abnormal area in your prostate and I would recommend proceeding to prostate biopsies. The scans however have not shown any signs of any problems outside of the prostate gland with the bone scan being completely normal and no enlarged lymph glands on the MRI scan Bone scan - 08/06/15	23/11/2015	152	Prostate biopsy				**187**	Other condition not tracked
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CMYTDU	YOUNG M MR	F	RED FLAG PATIENT	28/05/2015	04/06/2015	7	Referred with tight bleeding foreskin Examination unremarkable DRE normal prostate Added to WL for circumcision					0					**7**	Downgraded following 1st appt
CAH		UROLOGY	UROLOGY(C)	URC	URGENT	CMYTDU	YOUNG M MR	F	RED FLAG PATIENT	14/05/2015	04/06/2015	21	Microscopic haematuria x 2 Flexible cystoscopy - the bladder showed sacculations and trabeculations with two small red patches For repeat cystocopy end July, urine cytology by GP beforehand	26/06/2015	22	Flexible cystoscopy - called early, however, bladder clear							**43**	Downgraded following 1st appt

June 2015	**Average Waiting Time to First Appointment (Days)**	**12**

UROLOGY URGENT APPOINTMENTS

June 2014 - 10 Consectuive Urgent Patient Attendances

Hospital of Clinic Code	Casenote Number	Specialty of Clinic Description (R)	Specialty of Clinic Description	Referral Reason	Priority Type Description	Clinic Identifier/Code	Consultant of Clinic Name	Appt Type (R)	Appointment Type Description	Referral Date	Appointment Date Only	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome
CAH	Personal Information redacted by the USI	UROLOGY	UROLOGY(C)	ADV	URGENT	CKSTDU	SURESH K MR	F	URGENT NEW	03/02/2014	04/06/2014	121	Problems: Raised PSA (10.9ng/ml) Ischemic heart disease, coronary artery stenting – 2008, NSTEMI – December 2013 examination of abdomen and external genitalia were normal except for coronal hypospadias. DRE showed a large benign feeling prostate. Discharged to GP for PSA monitoring Given the cardiac condition and his poor exercise tolerance he agrees to be on watchful waiting rather than immediate prostate biopsies.													
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CKSTDU	SURESH K MR	F	URGENT NEW	07/03/2014	04/06/2014	89	Mild bilateral hydronephrosis Repeat USS of kidneys requested - mild dilatation of the left kidney (08/04/2014) Intravenous urogram requested - normal kidneys (26/08/2014) Patient discharged to GP													
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CMDHTDU	HAYNES M D MR	F	URGENT NEW	09/01/2014	06/06/2014	148	Ongoing right sided loin pain for at least a year P/H renal stone Most recent non contrast CT - fleck of renal cortical calcification in the right kidney, not a kidney stone and would not account for her symptoms IVU test arranged - normal (01/08/2015) Discharged to GP													
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CAJGTDU	GLACKIN A.J MR	F	URGENT NEW	26/02/2014	09/06/2014	103	Incidental finding of complex right renal cyst on ultrasound CT had been requested at time of triage, however, not completed before patient attended Completed on 17/07/2015 - simple cyst only. Patient discharged													
STH		UROLOGY	UROLOGY(C)	ADV	URGENT	SAJG	GLACKIN A.J MR	F	URGENT NEW	31/01/2014	10/06/2014	130	Recurrent proven e-coli urinary tract infection. Cephalexin 250mg nocte for 3 months Added to WL for urgent flexible cystoscopy	03/10/2014	115	Flexible cystoscopy - normal 6 month course prophylatic antibiotics No review											
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CMDHTDU	HAYNES M D MR	F	URGENT NEW	09/01/2014	13/06/2014	155	Previous left ureteric reimplantation Intermittent episodes of low level left sided pain and irritative urinary symptoms with no documented urinary tract infections No further investigation or treatment required at present Discharged													
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CESWL	YOUNG M MR	F	URGENT NEW	14/04/2014	16/06/2014	63	right mid ureteric stone Unsure if this was passed CT KUB organised as stone not visible on plain film CT (05/08/2015) - stone now passed Discharged													
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CESWL	YOUNG M MR	F	URGENT NEW	17/04/2014	16/06/2014	60	Had attended A&E with colic Added to WL for ESWL treatment for his left renal stones	09/10/2014	115	ESWL For review in 6 weeks	13/11/2014	35	Review at STC Stone still present For further ESWL	04/03/2015	111	ESWL For further course of treatment	26/06/2015	114	ESWL For review in 6 months	14/08/2015	49	Evident that the stone is fragmented to a degree but still present. Asymptomatic, therefore review in 4 months
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CMDHUO	HAYNES M D MR	F	URGENT NEW	13/03/2014	17/06/2014	96	Recurrent episodes of left sided loin pain Previous history of ureteric colic Non-contrast CT scan requested - CT scan has shown a number of likely stones within the left kidney (04/08/2015)	28/11/2014	164	Rigid/flexible ureteroscopy Stones cleared Discharged											
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CMDHUO	HAYNES M D MR	F	URGENT NEW	30/01/2014	17/06/2014	138	Episode left sided loin pain January 2014, now resolved USS - normal Discharged												

June 2014	Average Waiting Time to First Appointment (days)	110

June 2015 - 10 Consectuive Urgent Patient Attendances

Hospital of Clinic Code	Casenote Number	Specialty of Clinic Description (R)	Specialty of Clinic Description	Referral Reason	Priority Type Description	Clinic Identifier/Code	Consultant of Clinic Name	Appt Type (R)	Appointment Type Description	Referral Date	Appointment Date Only	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome
CAH	Personal Information redacted by the USI	UROLOGY	UROLOGY(C)	ADV	URGENT	CAJGTDU	GLACKIN A.J MR	F	URGENT NEW	22/02/2015	01/06/2015	99	Passing clots in urine February 2015 USS urinary tract and a plain film to exclude stone disease requested - normal (03/07/2015) Clinical impression - continues to have chronic prostatitis/chronic pelvic pain syndrome 6 week course of antibiotics prescribed Review in 8 weeks	26/10/2015	147	Awaiting Typing						
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CAJGTDU	GLACKIN A.J MR	F	URGENT NEW	02/03/2015	01/06/2015	91	Pelvic fracture and urethral injury aged Personal (now Personal old) Nocturnal enuresis USS at clinic - normal sized kidneys, some mild hydronephrosis of the left kidney measuring 1.3cm in AP diameter, bladder appeared thin walled and post micturition volume was only 57mls. flow rate shows a prolonged voiding pattern with a q-max of 9.8mls/sec ?Bulbourethral stricture as a consequence of his previous injury. Requested ascending and voiding urethrogram to exclude significant stricture (still awaited) Advised further trial of anti-cholinergic therapy									
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CJODTDU	O'DONOGHUE J P MR	F	URGENT NEW	13/05/2015	01/06/2015	19	Referred from DHH with right renal colic and a CT showed an 8.3mm stone at the right PUJ USS at clinic - small stone in the lower pole of the left kidney and no evidence of obstructive uropathy in either kidney Discharged to GP									
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CJODTDU	O'DONOGHUE J P MR	F	URGENT NEW	04/03/2015	01/06/2015	89	RIF and right flank pain Passing small volumes urine USS April 2015 -normal kidneys with a pre-void volume of 187ml and a residual of 17ml after voiding Examination - a little tender in the right flank and right upper quadrant Bloods taken today and USS abdomen arranged (12/10/15 - DNA x 2 USS - discharged)									
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CJODTDU	O'DONOGHUE J P MR	F	URGENT NEW	18/03/2015	01/06/2015	75	meatoplasty circumcision about 10 years ago in Belfast Used meatal dilator initially - now using catheters since and has had no difficulty inserting these Recommended Coloplast ISC Discharged									
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CJODTDU	O'DONOGHUE J P MR	F	URGENT NEW	24/09/2014	02/06/2015	251	Originally referred 24/09/2014 and directed for USS in first instance Urinary tract symptoms for some time, urgency and urge incontinence USS February 2015 showed the right kidney to measure 10.5cm and the left kidney to measure 14cm and the bladder was thick walled. The prostate measured 180cc and the post-micturition residual was 600ml Flexible cystoscopy at clinic - enlarged vascular trilobar prostate which was long. The prostate had a bull-valve appearance extending into the bladder. The bladder was sacculated and trabeculated with no obvious tumour although the mucosa was generally quite reddened DRE - very large prostate Added to WL for TURP	29/09/2015	119	TURP Review 3 months (December 2015)						
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CJODTDU	O'DONOGHUE J P MR	F	URGENT NEW	08/05/2015	02/06/2015	25	Problems with his foreskin for a few months Examination - circumferential white band in the coronal area on the foreskin side which looks very much like BXO Added to WL for circumcision									
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CKSHOT	SURESH K MR	F	URGENT NEW	11/05/2015	02/06/2015	22	Left ureteric colic 1 month ago due to a 4mm stone at the left VUJ as shown on CT KUB USS at clinic - minimal left hydronephrosis, resolved after voiding Not aware of passing stone Discharged									

CAH	Personal Information redacted by the USI	UROLOGY	UROLOGY(C)	ADV	URGENT	CAJGTDU	GLACKIN A.J MR	F	URGENT NEW	21/02/2015	03/06/2015	102	Bothersome lower urinary tract symptoms, incontinence x 1 year Previous radiotherapy for prostate cancer in 2010 Number of significant issues under investigation at present Recent ultrasound of his urinary tract which shows no evidence of hydronephrosis Flow test in clinic which showed a very poor flow Personal Information redacted by the USI old gentleman - should not be considered for surgery Discharged									
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CAJGTDU	GLACKIN A.J MR	F	URGENT NEW	18/05/2015	03/06/2015	16	Right loin pain, probable right ureteric colic A&E DHH 12/02/2015 - CT urinary tract suspicious of a tiny stone in the upper third of the right ureter Uric acid and calcium levels checked - normal Discharged									

June 2015	**Average Waiting Time to First Appointment (days)**	**79**

UROLOGY ROUTINE NEW OUT-PATIENT APPOINTMENTS

June 2014 - 10 Consectuive Routine Patient Attendances

Hospital of Clinic Code	Casenote Number	Specialty of Clinic Description (R)	Specialty of Clinic Description	Referral Reason	Priority Type Description	Clinic Identifier/Code	Consultant of Clinic Name	Appt Type (R)	Appointment Type Description	Referral Date	Appointment Date Only	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome
CAH	Personal Information redacted by the USI	UROLOGY	UROLOGY(C)	URC	URGENT	CAJGUO	GLACKIN A.J MR	F	ROUTINE NEW	10/02/2014	02/06/2014	112	Referred with visible haematuria via urethral catheter. No further haematuria at time of clinic attendance. Flexible cystoscopy 6th December 2013 normal. CTU 15th October 2013 normal. **Discharged**, if further haematuria or repeated UTIs happy to see. Advised may form stones in bladder releated to indwelling catheter	-									
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CMDHUO	HAYNES M D MR	F	ROUTINE NEW	09/01/2014	02/06/2014	144	Referred by General Surgery with right sided groin pain. CT scan no evidence of any urinary tract stones. No hernia. Clinical examination unremarkable. Unable to explain pain on clinical exmaination or CT, no evidence renal calculus disease likely musculoskeletal/ligamental in origin. Only urolgoical abnromality slightly raised PSA - **repeated at clinic 02/06/14 and write with result.**	-		Result letter 04/06/14, PSA fell into within normal limits which is reassuring. No further investigation required and discharged. PSA to be checked by GP on yearly basis and if becomes abnormal will be happy to see again.	-					
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CAJGPA	GLACKIN A.J MR	F	ROUTINE NEW	18/03/2014	04/06/2014	78	Referred with bothersome LUTS & increased PSA. USS on day of clinic, normal kidneys & prostate 115cc. Flow rate & post mict scan at clinic, reduced flow rate, post mict 38mls. DRE large benign feeling prostate. Patient to commence Combodart. **Discharge**. if symptoms not controlled on medicaiton will see again. Annual PSA with GP.	-									
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CAJGPA	GLACKIN A.J MR	F	ROUTINE NEW	20/03/2014	04/06/2014	76	Referred with PSA 4.44. Some bothersome LUTS. No haematuria. PSA February 2014 5.44 & March 4.44. Flow rate at clinic excellent. DRE prostate is small left lobe larger than right & smooth. Advised regarding fluid intake. **To have PSA rechecked September 2014 and write with result** (after using SWOP 6 risk calculator for prostate cancer)	-		Patient did not respond to 2 letters in September & October regarding PSA testing. He has been dischagred back to care of GP.						
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CAJGPA	GLACKIN A.J MR	F	ROUTINE NEW	02/04/2014	04/06/2014	63	Referred with PSA 7.63 March 2014. Bothersome LUTS primarily nocturia. Flow rate at clinic excellent. USS at clinic normal kidneys, bladder emptying satisfactory, prostate 120cc. On DRE large smooth benign feeling prostate. Explained nature of nocturia in age group, continue Tamsulosin. An option addition of medication or TURP in the future. GP to check PSA on annual basis & refer back if PSA greater than 15 ng/ml in absence of UTi. **Discharged**	-									
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CAJGPA	GLACKIN A.J MR	F	ROUTINE NEW	03/12/2013	04/06/2014	183	Referred with PSA 5.61 November 2013 & family history prostate cancer. Flow rate 12mls/sec. USS at clinic normal kidneys, prostate volume 55cc. DRE smooth prostate right lobe firm in comparison to left. **PSA checked at start of clinic and write with result.** If upward trend recommend TRUS prostate biopsy.	-		Result letter 09/06/14 - PSA fallen to 3.1 which is reassuring. GP to consider Combodart for urinary symptoms. Routine review 6 months with flow rate and bladder scan	Still on OP waiting list					
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CAJGPA	GLACKIN A.J MR	F	ROUTINE NEW	16/12/2013	04/06/2014	170	Patient referred with PSA 6.53. Suspect abnormal DRE. No haematuria/dysuria. Dipstick urinalysis unremarkable. Flow rate reduced. USS at clinic 2 normal kidneys, bladder emptying 43mls, prostate 50cc. DRE firm right lobe of prostate. Left side prostate smooth. No definite nodules. PSA checked at clinic & write with result. If higher than previous for prostate biopsy.	02/07/2014		Patient attended for prostate biopsies under local anaesthetic & antibiotic prophylaxis. Histology to be discussed at MDT & review after.	21/07/2014		Prostate biopsies shown prostate cancer gleason 3+3=6, 4 out of 12 cores, maximum tumour length 2mm. To have MRI, discuss at MDT & review	########		Patient attended for MRI result. T2 N0 disease, per MDT for active surveillance. To have PSA checked today & January 2016. Review 6 months. Seen 4th August 2015.
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CAJGPA	GLACKIN A.J MR	F	ROUTINE NEW	25/03/2014	04/06/2014	71	Referred with PSA 3.82 March 2014. Mild LUTS. No visible haematuria. No family history prostate cancer. DRE small smooth prostate. Counselled regarding risk prostate cancer using SWOP 6 calculator & based on result pt to have annual PSA monitoring. Refer back if PSA greater than 5 ng/ml in absence of UTI. **Discharged.**	-									

CAH	Personal Information redacted by the USI	UROLOGY	UROLOGY(C)	ADV	URGENT	CAJGPA	GLACKIN A.J MR	F	ROUTINE NEW	01/05/2014	04/06/2014	34	Referred with PSA 5.17 April 2014. Bothersome LUTS last year. PSA February 5.5 & rechecked April 5.17. No family history prostate cancer. DRE moderately enlarged benign feeling prostate. Lifestyle changes discussed in terms of fluid intake. Recommend Tamsulosin. PSA variables entered into SWOP 6 prsotate cancer risk calculator & based on findings counselled towards PSA monitoring rather than a biopsy. **To have PSA rechecked October 2014 and write with result**	-		Result letter 12/11/14 - PSA 5.95 result similar to prevous PSA tests. To have PSA rechecked in January 2015 & if no substantial change discharge.	-		Result letter 04/03/15 - PSA 30th January 2015 5.28, stable over period of one year, no ongoing review required. Annual PSA check in Community and if greater than 7ng/ml re-refer.			
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CAJGPB	GLACKIN A.J MR	F	ROUTINE NEW	15/04/2014	04/06/2014	50	Patient attended for TRUS biopsy of prostate under local anaesthetic & antibiotic cover. Histology at MDT & review Mr Glackin with result	16/06/2014		Seen on 16/06/14 with result of prostate biopsy which has revealed prostate cancer, gleason score 3+4=7, 4 of 12 cores positive, maximum tumour length 4.5mm, for CT pelvis & discuss at MDT. Treatment options outlined	21/07/2014		Patient attended for CT result which suggests organ confined disease. Per MDT referred to Dr Houghton for radiotherapy. Review 4 months. Seen 9th February 2015.	########		Patient seen 09/02/15 has done very well since radiotherapy. Discharge from urology & review Oncology.
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CAJGPB	GLACKIN A.J MR	F	ROUTINE NEW	21/05/2014	04/06/2014	14	Patient attended for TRUS biopsy of prostate under local anaesthetic & antibiotic cover. Histology at MDT & review Mr Glackin with result	16/06/2014		Seen on 16/06/14 with result of prostate biopsy which has revealed prostate cancer, gleason score 3+4=7, 3 of 12 cores positive, maximum tumour length 4mm, intermediate risk category. Patient advised & provided with written information and briefly outlined treatment options. MRI requested, discuss at MDT & then review Mr Glackin	16/08/2014		Seen on 16/08/14 with MRI result which suggested organ confined disease. Following MDM consider curative intent including prostatectomy, radiotherapy with hormones. Patient would like to be considered for all options, to be discussed Central MDM & review 4 months	########		Seen on 10/02/15 patient doing very well following brachytherapy treatment. Discharge from urology follow up with Oncology colleagues.
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CKSTDU	SURESH K MR	F	ROUTINE NEW	09/12/2013	04/06/2014	177	Patient referred with raised PSA 3.6. No LUTS & no history UTI. DRE small but with hard left lobe prostate. PSA rechecked 4.2 ng/ml. For TRUS prostate biopsy.	09/07/2014		TRUS prostate biopsy on 9th July 2014. Prostate measured 35cc on TRUS with anything suspicious, 12 cores taken. Discuss histology @ MDT	28/07/2014		TRUS prostate biopsy revealed gleason 3+4=7 in 3 of 12 cores, some perineural invasion, clinical stage T2. Explained to patient. For MRI, MDT discussion & review	########		Seen 16/09/14. Reassured MRI shown organ confined disease. Denies LUTS. Treatment options discussed and would like to see Surgeons & Oncologist. Discusss regional MDT & refer
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CKSTDU	SURESH K MR	F	ROUTINE NEW	10/12/2013	04/06/2014	176	Referred with chronic prostatitis. Pain in perineum & in penis on and off over last 6 years. Asymptomatic in last 6 months. No history UTI or haematuria. Abdomen, external genitalia & DRE normal. PSA 0.4. Uroflow performed normal flow. Advised try medication but patient not keen. **Reassured & discharged**	-								
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CKSTDU	SURESH K MR	F	ROUTINE NEW	06/12/2013	04/06/2014	180	Person old girl with nocturnal enuresis. Bedwetting almost every night, okay during day, no history UTI. Reassured likely to get over problem in time, advised fluid adjustment, set an alarm for 1am to go to toilet. **Reassured and discharged**	-								
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CKSTDU	SURESH K MR	F	ROUTINE NEW	12/12/2013	04/06/2014	174	Referred with nocturia, denies daytime problem, happy with urinary stream, no UTI or haematuria. On examination bladder not palpable, DRE moderately enlarged benign feeling prostate. Advised symtpoms are due to excessive intake of tea & advised fluid adjustment. PSA normal. **Reassured & discharged**	-								
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CKSTDU	SURESH K MR	F	ROUTINE NEW	12/12/2013	04/06/2014	174	Referred with cystitis & dipstick haematuria. Urine microscopy clear. Dipstick urinalysis in clinic small leukocyte & small blood. Fluid intake coffee, tea, fizzy drinks & not much water. Concerned as her mother apparently had renal cancer. Explained symptoms mainly due to inadequate water intake & to increase to 2 litres. Explained cystitis prevention measures. For USS & flexible cystoscopy & if normal discharge	24/09/2014		Patient attended for flexible cystoscopy 24/09/14. Flexible cystoscopy normal. Ultrasound scan normal. Reg advised review in 2 months. On OP waiting list November 2014						
CAH		UROLOGY	UROLOGY(C)	ADV	URGENT	CUREGY	YOUNG M MR	F	ROUTINE NEW	20/03/2014	05/06/2014	77	Referred with PSA 11.93 November 2013. No bothersome LUTS. Flow rate excellent. USS at clinic normal. Prostate volume 26cc. DRE nodule right lobe of prostate. Patient counselled re: PSA and DRE findings. After LA & administration anitbiotics prostate biopsies performed. Discuss histology at MDT and review	05/06/2014		Patient attended 05/06/14 for TRUS biopsy result. Histology shown gleason 4+3=7, 10 out of 12 cores, positive with associated perineural invasion, maximum tumour length 8mm. Discussed & explained to patient today. Per MDT an MRI of prostate as well as bone scan, discuss at MDT & then review	16/08/2014		Patient attended 16/08/14 for bone scan & MRI result. Commenced androgen deprivation therapy. Review 3 months. Once optimal PSA response repeat bone scan. Referred to Dr Houghton BCH 11/05/15			Letter to patient 6th December 2014 re: PSA result & requested a bone scan. Seen 13/04/15 repeat bone scan discussed @ MDT. For MRI & CT scapula & review

CAH	Personal Information redacted by the USI	UROLOGY	UROLOGY(C)	ADV	ROUTINE	CMDHTDU	HAYNES M D MR	F	ROUTINE NEW	02/12/2013	06/06/2014	186	Referred with haematospermia. Previously seen PSA & flexible cystoscopy normal. Occasional epsiodes of testicular pain. No UTI. Clinical examination unremarkable. Rectally small benign non tender prostate. Reassured. Advised may be due to infection/inflammation & should try course antibiotics. MRI arranged & write with result - Result letter 02/04/15 no findings of concern & discharged	-								
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CMDHTDU	HAYNES M D MR	F	ROUTINE NEW	29/11/2013	06/06/2014	189	Referred with recurrent UTIs. Breakthrough infections problematic. Residual volume scanning empties bladder to completion. Recommend USS urinary tracts & flexible cystoscopy. Suggest longterm antibiotics.	10/09/2014		Result letter 26/08/14 USS normal. Patient attended for flexible cystoscopy 10/09/14. Findings red bladder mucosa, may be reflective recurrent infections, proceed with Cystoscopy & bladder biopsies. Added to waiting list.	06/10/2014		Admitted for cystoscopy & bladder biopsies. Discuss histology MDT & review	########		Patient attended for histology results. Inflammation only. From urological perspective we have not identified any cause for her recurrent UTIs. No follow up required
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CMDHTDU	HAYNES M D MR	F	ROUTINE NEW	02/12/2013	06/06/2014	186	Referred with recurrent UTIs. No haematuria. To have USS, KUB x-ray & flexible cystoscopy. Write with USS & see at flexible cystoscopy. Continue on longterm low dose Cephalexin	04/11/2014		Result ltr 08/08/14, USS showed swelling both kidneys arranged CT. Result ltr 09/10/14 CT normal. Patient attended for flexible cystoscopy. Reassuringly normal. USS & CT scan did not reveal any underlying anatomical cause for UTIs. Remain on longterm low dose antibiotics. Discharge.						
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CMDHTDU	HAYNES M D MR	F	ROUTINE NEW	10/12/2013	06/06/2014	178	Referred with previous imaging showing multiple renal cysts. Previous history renal stones. Prevously seen in Barts. Discussed complex cysts. Review scans @ x-ray meeting. Write with blood results & decision from x-ray meeting	20/01/2015		Discussed at x-ray meeting recommedn further CT scan & enclosed kidney function blood test request form. Patient did not respond to 2 partial booking letters. Discharged						

June 2014	**Average Waiting Time to First Appointment (days)**	**128**

June 2015 - 10 Consectuive Routine Patient Attendances

Hospital of Clinic Code	Casenote Number	Specialty of Clinic Description (R)	Specialty of Clinic Description	Referral Reason	Priority Type Description	Clinic Identifier/Code	Consultant of Clinic Name	Appt Type (R)	Appointment Type Description	Referral Date	Appointment Date Only	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome	Return Date	Waiting Time (Days)	Outcome
CAH	Personal Information redacted by the USI	UROLOGY	UROLOGY(C)	ADV	ROUTINE	CAJGTDU	GLACKIN A.J MR	F	ROUTINE NEW	23/06/2014	01/06/2015	343	Patient referred with erectile dysfunction following treatment for rectal CA. Good result with Tadalafil although side effect intolerable. Patient interested in alternative. Medication changed to Sildenafil and discharged	-								
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CAJGTDU	GLACKIN A.J MR	F	ROUTINE NEW	08/07/2014	01/06/2015	328	Patient referred with discomfort from left varicocele. Intermittent discomfort, USS arranged by GP showed left varicocele & both testis normal. On examination testes normal. Reassured does not require any surgical intervention at this time. Discharged.	-								
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CJODTDU	O'DONOGHUE J P MR	F	ROUTINE NEW	28/06/2014	01/06/2015	338	Patient referred with recurrent UTIs in last year but nothing since August. CT examination no stones seen. Flexible cystoscopy at clinic normal bladder. Reassured and discharged	-								
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CJODTDU	O'DONOGHUE J P MR	F	ROUTINE NEW	30/06/2014	01/06/2015	336	Patient referred having went into urinary retention one year ago & performing ISC since. PSA 0.14. DRE 50-60g benign feeling prostate. Options outlined continue ISC or TURP, patient has opted for TURP. Patient still on waiting list	-								
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CJODTDU	O'DONOGHUE J P MR	F	ROUTINE NEW	01/07/2014	02/06/2015	336	Patient referred with perineal & testicular pain. Flow intermittent, slow and double voids. Passes urine x40 during day. He drinks up to 20 cups of tea. DRE 40-50g very tender prostate. The impression is prostatitis. Flow rate showed prolonged flow. USS showed prostate 14cc with calcification. Urine dipstick negative bar trace ntact blood. Sent bloods for PSA, CRP & U&Es. Prescribed Tamsulosin 400mcg once a day. Review 2 months for flow rate & post void residual on arrival. Date given 16/11/15, cancelled & rebooked 30/11/15									

CAH	Personal Information redacted by the USI	UROLOGY	UROLOGY(C)	ADV	ROUTINE	CAJGTDU	GLACKIN A.J MR	F	ROUTINE NEW	07/07/2014	03/06/2015	331	Patient re-referred with peristent biochemical haematuria & lower urinary tract symptoms. Asymptomatic in last 12 months. No visible haematuria. No UTI. 4 MSU samples no growth & no evidnece of red cells. No urological investigations at this time. If visible haematuria or 3 or more UTIs in 12 month period to be re-referred for CTU & flexible cystoscopy. Discharged.	-									
CAH		UROLOGY	UROLOGY(C)	ICFF	ROUTINE	CAJGTDU	GLACKIN A.J MR	F	ROUTINE NEW	18/06/2013	03/06/2015	715	Patient referred with storage LUTS for 10 years. Reports satisfactory flow, at times feels not emptying bladder. During morning marked frequency after taking diuretic. Complains of urgency & on occasions urge incontinence. No nocturia, dysuria or haemturia. On Tamsulosin since 2004. CKD stage 3. PSA 0.63 March 2014. On examination mobility limited. Obese abdomen. Large left hydrocele & normal right testis. DRE small firm prostate. Dipstick urinalysis normal. USS at clinic several renal cysts, no hydronephrosis. Residual volume 100mls. Prostate 21cc. Flow rate very good Q-max more than 12mls/sec. Patients fluid intake adequate. Advised trial Vesomni in combination with Solifenacin & Tamsulosin. Discharged see on request.	-									
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CMDHTDU	HAYNES M D MR	F	ROUTINE NEW	25/06/2014	03/06/2015	343	Patient referred with phimosis secondary to BXO. Recommended circumcision, outlined procedure & information sheet given. Added to waiting list GA daycase. No date as yet	-									
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CMDHTDU	HAYNES M D MR	F	ROUTINE NEW	25/06/2014	03/06/2015	343	Patient referred with LUTS. USS, flow rate & flexible cystoscopy performed at clinic. USS satisfactory. Flow rate reduced 13ml/sec. Prostate benign & 17cc on USS. Flexible cystoscopy revealed normal urethra & red area consistent with hunners ulcer & some adjacent papillary lesions which warrant biopsy. Added to wlist for GA cystoscopy & bladder biopsies	22/06/2015		Patient admitted on 22/06/15 for cystoscopy & bladder biopsies. Histology of biopsies will be discussed at MDT and review at clinic	08/07/2015		Patient attended clinic 08/07/15 for histology results. Histology showed inflammation only. LUTS are irritative & obstructive & in order to assess patient added to waiting list for urodynamics. Still awaiting test.			
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CMYTDU	YOUNG M MR	F	ROUTINE NEW	16/07/2014	04/06/2015	323	Patient referred with phimosis, unable to retract foreskin, added to GA daycase for circumcision. Second issue LUTS, poor flow, no emptying completely. PR examination smooth, smallish prostate. USS at clinic showed emptied bladder completely. Flow rate poor 7mls/sec. Patient might benefit from anti-cholinergic etc Contiflo 2-3 months. See at time of circumcision. On waiting list no date yet.	-									
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CMYTDU	YOUNG M MR	F	ROUTINE NEW	09/07/2014	04/06/2015	330	Patient referred with recurrent UTIs. Regarded as infrequent voider. Nocturia x2. Patient feels empties bladder fairly well which is confirmed on USS today. USS normal kidneys & no stones. Patient to be commenced on prophylactic antibiotics and advised of the importance of increased voiding. Discharged	-									
CAH		UROLOGY	UROLOGY(C)	ADV	ROUTINE	CESWL	YOUNG M MR	F	ROUTINE NEW	27/03/2015	05/06/2015	70	Patient referred with left flank pain. USS & CT has identified very small stones in left kdiney, most measuring 2mm in size, very difficult to detect on USS. Advised observational approach, episode of colic may be passage of grit. Review 6 months. Due December 2015.										

June 2015	**Average Waiting Time to First Appointment (days)**	**309**

Glenny, Sharon

From: Glenny, Sharon <[redacted]>
Sent: 17 November 2015 17:04
To: Haynes, Mark
Cc: Trouton, Heather; Corrigan, Martina
Subject: FW: Information for Meeting with HSCB
Attachments: UROLOGY OUT-PATIENT COMPARISON - JUNE 14 VS JUNE 15 (3).xlsx; UROLOGY Triaging Outcomes - Mr Haynes (15.10.15 - 21.10.15).xlsx; UROLOGY OUT-PATIENT DASHBOARD - 17.11.15.xlsx

Importance: High

Hi Everyone

Please see urology dashboard now also attached.

Kind regards

Sharon

From: Glenny, Sharon
Sent: 17 November 2015 12:06
To: Haynes, Mark
Cc: Trouton, Heather; Corrigan, Martina
Subject: Information for Meeting with HSCB
Importance: High

Hi Mark

Please see attached updated versions of requested data.

Initial analysis of referral date to new out-patient attendance has revealed the following changes pre-model and post-model change:

Referral to New OPD Appointment	June 2014 (Days)	June 2015 (Days)	Improvement (Days)	Improvement (%)
Red Flag	21	12	8	38%
Urgent	110	60	50	45%
Routine	128	309	-181	-141%

Analysis of referral triage outcomes has also demonstrated a marked shift in pre-empting diagnostics pre-visit and informing GP/patient virtually of treatment plan before first face-to-face contact:

SUMMARY OF TRIAGE OUTCOME (15/10/2015 - 21/10/2015)

Total Volume Triaged (excludes Red Flag Referrals)	**94**
Investigations Requested	**32**
Letter to patient with Treatment Plan	**31**

I am now working on the dashboard and hope to get this to you sometime this afternoon.

If you get a chance, could you call up and we can quickly chat through any other analysis you required of the data?

Thanks

Sharon

Mrs Sharon Glenny
Operational Support Lead
Surgery & Elective Care

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

Glenny, Sharon

From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 30 November 2015 12:03
To: Glenny, Sharon
Subject: FW: meeting regarding Data presentation

Hi ya

This is what we had agreed would be presented to the urology team…. I did the ins and days on Friday for the other piece of work that I was doing.

I will finish these JD and then call in…….. J

Ta ta

Martina

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

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

From: Corrigan, Martina
Sent: 23 November 2015 14:57
To: Glackin, Anthony (Personal Information redacted by the USI)
Cc: heather.trouton Personal Information redacted by the USI
Subject: meeting regarding Data presentation

Good afternoon Tony,

As agreed, please see below update on what was agreed at our meeting last Thursday 19th November.

Heather will forward an email advising the Team that at the meeting on 3 December Eamon, Heather and Amie will attend at 12:00MD to discuss Robin Brown's retirement, then when Eamon and Amie leave at 12:30, I will present the following information (which will be shared with the Team, prior to the meeting):

1. Hot Clinic Usage by Consultant
2. New OP Clinic attendances by Consultant
3. Review OP attendances and current backlog position by consultant
4. Registrar's new op clinic attendances
5. Inpatient and Daycase waiting per consultant

I think that this is all we agreed and then I was to work at the other areas of chronologically management of waiting lists. The makeup of clinics for each of the consultants, non-triaged letters etc..

I hope I have remembered everything and I am happy to work through in advance of the information being sent to the team.

Many thanks for all your help with this.

Kind regards

Martina

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

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

Glenny, Sharon

From: Glenny, Sharon <[redacted]>
Sent: 22 December 2015 15:00
To: Corrigan, Martina; Glackin, Anthony; Haynes, Mark
Subject: Urology OP and Elective activity and WL Analsysis
Attachments: UROLOGY WAITING LIST ANALYSIS - PLANNED AND ELECTIVE - WL REPORTS AS AT 10.12.15.xlsx; UROLOGY OP DEMAND VS ACTIVITY - 14 05 15 - 11 11 15 (26 WEEKS) V2.xlsx

Hi Everyone

Following on from our meeting recently, I have updated the data to reflect the changes and additions suggested.

Could you please review and let me know if we need anything more.

Sorry for the delay in sending, but has taken me a wee while to put together!

Kind regards

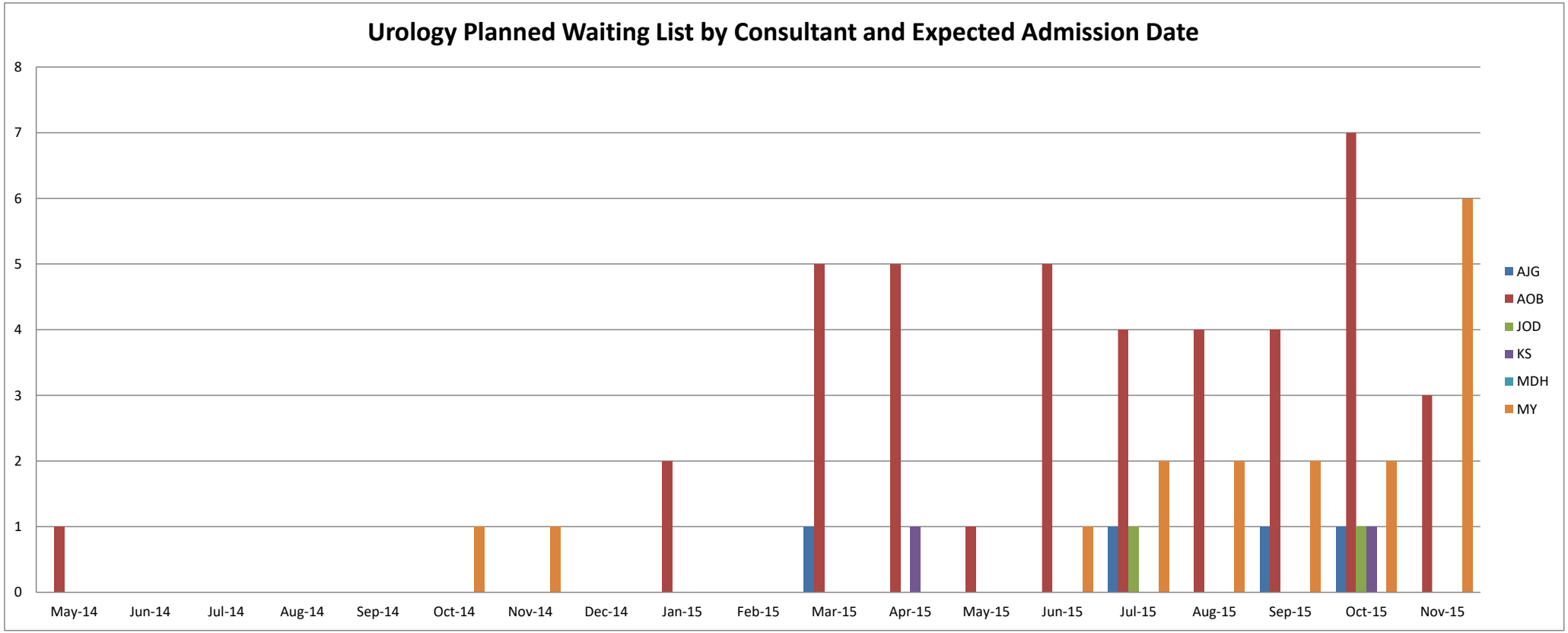
Sharon

Mrs Sharon Glenny
Operational Support Lead
Surgery & Elective Care

Direct dial – [redacted]
Mobile - [redacted]

Urology Planned Waiting List by Consultant and Expected Admission Date

Consultant Code	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	TOTAL
AJG											1				1		1	1		4
AOB	1								2		5	5	1	5	4	4	4	7	3	41
JOD															1			1		2
KS												1						1		2
MDH																				0
MY						1	1							1	2	2	2	2	6	17
TOTAL	**1**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**2**	**0**	**6**	**6**	**1**	**6**	**8**	**6**	**7**	**12**	**9**	**66**



Received from SHSCT on 02/11/2022. Annotated by the Urology Services Inquiry.

UROLOGY PLANNED WAITING LIST - EDA DECEMBER 2015 OR LESS - AS AT 09.12.15

9 Dates in past - to be updaed urgently on PAS
34 Patients with EDA August 2015 or less - no dates for procedure as yet

Hospital	H&C No.	Casenote	Title	Forename	Surname	Date of Birth	Age	Original Date	Current Date	Waiting List Code	Expected Admission Date	Date Booked	Current Suspension End Date	Consultant	Expected Method of Adm.	Urgency Code	Intended Management	Admission Reason	Remarks	Intended Primary Procedure Code	Operation Description
CAH	Personal Information redacted by the USI							20/09/2013	20/09/2013	CURWL	01/05/2014			AOB	PL	4	N	CYSTOSCOPY & INTRAMURAL BOTULINUM TOXIN (100 UNITS)	SC URODYNAMICS 200913 TCI PER AOB	M45.9	CYSTOSCOPY & INTRAMURAL BOTULTNUM TOXIN (100 UNITS) FIT (13.11.13 KK) PT ASKS IF POSSIBLE MAY 2014
CAH								02/05/2014	02/05/2014	CMY	01/10/2014			MY	PL	4	N	TURP ACTIVATE OCTOBER 14 AS ON PLAVIX UNTIL THEN	PER MR YOUNG AT CLINIC 02.05.14	M65.3	TURP ACTIVATE OCTOBER 14 AS ON PLAVIX UNTIL THEN B6QT 060814
CAH								08/05/2014	08/05/2014	CMY	01/11/2014			MY	PL	4	N	NOVEMBER 14 CYSTOSCOPY & CHANGE OF STENT	PER RAB	M45.9	NOVEMBER 14 CYSTOSCOPY & CHANGE OF STENT
CAH								17/10/2014	17/10/2014	CURWL	01/01/2015			AOB	PL	2	N	DEC 14 - INTRAMURAL INJ OF 400UNITS OF BOTULINUM TOXIN		M43.4	DEC 14 - INTRAMURAL INJ OF 400 UNITS OF BOTULINUM TOXIN HOLD(19.12.14)CD IDDM (HSQ B6QT 24/12/14)
CAH								02/12/2014	02/12/2014	CURWL	01/01/2015			AOB	PL	2	N	INTERNAL URETHROTOMY ?DILATATION (JANUARY 15)		M79.4	INTERNAL URETHROTOMY ?DILATATION (JANUARY 15)
CAH								05/12/2014	05/12/2014	CAJG	01/03/2015			AJG	PL	2	N	FLEXIBLE URETEROSCOPY MARCH 2015	PER READMISSION SJ EMAIL 08/12/14	M30.9	MARCH 15 FLEXIBLE URETEROSCOPY
CAH								02/11/2013	19/08/2015	CURWL	01/03/2015			AOB	PL	2	N	INTERNAL UETHROTOMY - MARCH 2015		M79.4	INTERNAL UREHROTOMY - MARCH 2015
CAH								03/02/2014	03/02/2014	CURWL	01/03/2015			AOB	PL	2	N	URETHROTOMY - DECEMBER 2014		M76.3	URETHROTOMY - DECEMBER 2014
CAH								20/07/2014	20/07/2014	CURWL	01/03/2015			AOB	PL	2	N	DECEMBER 14 - CHANGE OF RIGHT URETERIC STENT		M29.8	DECEMBER 14 - CHANGE OF RIGHT URETERIC STENT ON DIALISIS MON, WED, FRI AND SAT IN TCH
CAH								30/07/2014	30/07/2014	CURWL	01/03/2015			AOB	PL	2	N	JAN 2015 BLADDER IRRIGATION	PER MR OBRIEN	M47.1	JAN 2015 BLADDER IRRIGATION
CAH								29/01/2015	29/01/2015	CKSURO	01/03/2015	07/04/2015		KS	PL	2	N	MARCH 2015 LEFT URS & LASER ABLATION Personal [redacted]	PER MR SURESH	M30.9	MARCH 2015 LEFT URS & LASER ABLATION Personal [redacted] NEEDS MORE ANAESTHETIC TIME
CAH								30/01/2015	30/01/2015	CURWL	01/04/2015			AOB	PL	2	N	CYSTOSCOPY AND BLADDER NECK RESECTION - MARCH 15		M45.9	CYSTOSCOPY AND BLADDER NECK RESECTION - MARCH 15 B6QT 160315
CAH								13/02/2015	13/02/2015	CURWL	01/04/2015			AOB	PL	2	N	TURP - APRIL 15		M65.3	TURP - APRIL 15 FIT 9.3.15 KK CAH MAIN THEATRE ONLY
CAH								22/03/2014	22/03/2014	CURWL	01/04/2015			AOB	PL	2	N	INTERNAL URETHROTOMY - MARCH 2015		M79.4	INTERNAL URETHROTOMY - MARCH 2015
CAH								01/03/2014	01/03/2014	CURWL	01/04/2015			AOB	PL	2	N	REMOVAL OF STENT APRIL14		M27.5	REMOVAL OF STENT APRIL 14 rang re date 15/10/14 rang re date 27/3/15
CAH								16/01/2015	28/09/2015	CKSURO	01/04/2015			KS	PL	2	D	APRIL 2015 FLEXIBLE CYSTOSCOPY	PER JENNY DISCHARGE	M45.9	APRIL 2015 FLEXIBLE CYSTOSCOPY
CAH								10/04/2015	16/04/2015	CURWL	16/04/2015			AOB	PL	2	D	REMOVAL OF STENT		M29.3	REMOVAL OF STENT

CAH	[redacted]					04/04/2015	04/04/2015	CURWL	01/05/2015			AOB	PL	2	N	CHANGE OF SUPRAPUBIC CATHETER WITH TRACTED DILATATION MAY 15		M38.8	CHANGE OF SUPRAPUBIC CATHETER WITH TRACTED DILATATION MAY 15 MUST BE UNDER GA AS PATIENT HAS DEMENTIA
CAH						01/12/2014	01/12/2014	CURWL	01/06/2015			AOB	PL	2	N	MAY 2015 INTERNAL URETHROTOMY	SC OPD 011214 TCI MAY 2015 PER AOB	M79.4	MAY 2015 INTERNAL URETHROTOMY
CAH						16/04/2014	16/04/2014	CURWL	01/06/2015			AOB	PL	2	N	URETHRAL MEATAL DILATATION - APRIL 2015		M47.1	URETHRAL MEATAL DILATATION - APRIL 2015
CAH						27/02/2015	27/02/2015	CURWL	01/06/2015			AOB	PL	2	N	CYSTOSCOPY ?TURBT - JUNE 15		M45.8	CYSTOSCOPY ?TURBT - JUNE 15
CAH						27/02/2015	27/02/2015	CURWL	01/06/2015			AOB	PL	2	N	CYSTOSCOPY ?TURBT - JUNE 15		M45.8	CYSTOSCOPY ?TURBT - JUNE 15 COMPLETED MMC 12/5/15
CAH						15/05/2014	15/05/2014	CURWL	01/06/2015			AOB	PL	2	N	CYSTOSCOPY - JUNE 2015		M45.9	CYSTOSCOPY - JUNE 2015
CAH						28/01/2015	28/01/2015	CMY	01/06/2015			MY	PL	2	N	AIM JUNE/JULY 2015 TURP CATHETER IN SITU PLATELETCOVER	PD - PER MR YOUNG AT CLINIC 28.01.15	M65.3	AIM JUNE/JULY 2015 TURP CATHETER IN SITU B6QT 100315-TCI DB4 PER PRE-OP/ANAES TO BE INFORMED/PLATELET
CAH						03/06/2015	03/06/2015	CAJG	01/07/2015			AJG	PL	2	D	TEACHING OF CISC 4-8 WEEKS	per clinic	M38.8	TEACHING OF CISC 4-8 WEEKS AJG TO BE ON SITE
CAH						03/06/2015	03/06/2015	CURWL	01/07/2015			AOB	PL	2	N	REMOVAL OF STENT AND LEFT URETEROSCOPIC LITHOTRIPSY -JULY 15		M29.3	REMOVAL OF STENT AND LEFT URETEROSCOPIC LITHOTRIPSY - JULY 15
CAH						21/05/2015	21/05/2015	CURWL	01/07/2015			AOB	PL	2	N	CYSTOSOCPY. REMOVAL OF STENT AND LEFT URETEROSCOPY -JULY 15		M45.9	CYSTOSCOPY, REMOVAL OF STENT AND LEFT URETEROSCOPY -JULY 15
CAH						30/07/2014	30/07/2014	CURWL	01/07/2015			AOB	PL	4	N	JULY 2015 EXCHANGE URETERIC STENTS	PER MR OBRIEN	M29.8	JULY 2015 EXCHANGE URETERIC STENTS
CAH						06/02/2015	20/05/2015	CUJOD	01/07/2015			JOD	PL	2	N	JULY15CYSTOSCOPY L R'GRADE PYELOURETEROGRAM , URETERIC WASH		M45.9	JULY15 CYSTOSCOPY L R'GRADE PYELOURETEROGRAM, URETERIC WASH B6QT 280515
CAH						15/01/2015	15/01/2015	CMY	01/07/2015	29/12/2015		MY	PL	4	D	SUMMER 15 GA CONDUITOSCOPY	PD - PER MR YOUNG AT CLINIC 15.01.15	M19.8	SUMMER 15 GA CONDUITOSCOPY UPDATED 26.11.15
CAH						01/07/2015	01/07/2015	CURWL	06/07/2015	06/07/2015		AOB	PL	2	D	WEEK 6 MMC		M49.2	WEEK 6 MMC
CAH						23/06/2015	27/08/2015	CMY	28/07/2015			MY	PL	2	N	BLADDER NECK INCISION +/- IVU	PER MR YOUNG	M66.2	BLADDER NECK INCISION +/- IVU
CAH						02/08/2013	02/08/2013	CURWL	01/08/2015			AOB	PL	2	N	CYSTOSCOPY ?TURP ?INTRAMURAL INJ BOTULINUM TOXIN - AUGUST 15		M45.9	CYSTOSCOPY ?TURP ?INTRAMURAL INJ BOTULINUM TOXIN - AUGUST 15 HOLD(23.09.13) BMI36 LVAD INSITU ON WARFARIN VARIOUS MEDS
CAH						30/01/2015	30/01/2015	CURWL	01/08/2015			AOB	PL	4	N	CYSTOSCOPY ? TURBT - AUGUST 15		M45.9	CYSTOSCOPY ? TURBT - AUGUST 15
CAH						10/04/2015	10/04/2015	CURWL	01/08/2015			AOB	PL	4	N	CYSTOSCOPY ?TURBT - AUGUST 15		M45.9	CYSTOSCOPY ?TURBT - AUGUST 15
CAH						27/02/2015	27/02/2015	CMY	01/08/2015			MY	PL	2	N	AUGUST 2015 - CHANGE OF STENT WARFARIN	PER RAB	M29.8	AUGUST 2015 - CHANGE OF STENT WARFARIN
CAH						05/05/2015	30/06/2015	CMY	01/08/2015			MY	PL	2	N	JUNE 15 URETEROSCOPY & ROS	PD - PER MR YOUNG IN THEATRE 05.05.15	M30.9	JUNE 15 URETEROSCOPY DNA 30.06.15 - REBOOK AUGUST 15 PER MR YOUNG
CAH						20/08/2015	20/08/2015	CURWL	24/08/2015	24/08/2015		AOB	PL	2	D	HYACYST		M49.4	HYACYST
CAH						26/06/2015	26/06/2015	CAJG	01/09/2015	18/12/2015		AJG	PL	2	N	09/15 CYSTOSCOPY & CYSTODIATHERMY	PER RACHAEL DIS LTR	M45.8	09/15 CYSTOSCOPY & CYSTODIATHERMY
STH						23/04/2015	23/04/2015	CAJG	01/09/2015			AJG	PL	2	D	SEPT 2015 FLEXIBLE CYSTOSCOPY	PLA-PT FOR FLEXI AFTER CHEMOTHERAPY COMPLETED PER AJG	M45.9	SEPT 2015 FLEXIBLE CYSTOSCOPY NOT TO BE SENT FOR UNTIL CHEMOTHERAPY COMPLETE

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CAH	Personal Information redacted by the USI	24/08/2015	24/08/2015	CURWL	01/09/2015			AOB	PL	2	N	TURP AND BLADDER LITHOTRIPSY - SEPTEMBER 2015		M65.3	TURP AND BLADDER LITHOTRIPSY - SEPTEMBER 2015
CAH		10/07/2015	10/07/2015	CURWL	01/09/2015			AOB	PL	2	N	TURP - SEPTEMBER 2015		M65.3	TURP - SEPTEMBER 2015 (B6D 27.07.15)
CAH		06/05/2015	06/05/2015	CURWL	01/09/2015	09/12/2015		AOB	PL	4	N	INTERNAL URETHROTOMY +/- BLADDER NECK INCISION		M79.4	INTERNAL URETHROTOMY +/- BLADDER NECK INCISION (FIT 08/12/15)
CAH		17/07/2015	17/07/2015	CURWL	01/09/2015			AOB	PL	4	N	RIGHT URETEROSCOPY - SEPT 15		M30.9	RIGHT URETEROSCOPY - SEPT 15
CAH		03/08/2015	03/08/2015	CMY	01/09/2015			MY	PL	2	N	SEPTEMBER 2015 CIRCUMCISION & ENDOSCOPY	PD - PER MR YOUNG 03.08.15	N30.3	SEPTEMBER 2015 CIRCUMCISION & ENDOSCOPY
CAH		04/03/2015	04/03/2015	CMY	01/09/2015			MY	PL	2	D	SEPTEMBER 15 CHANGE OF STENT - ONCOLOGY PATIENT	PD - PER MR YOUNG 04.03.15	M29.8	SEPTEMBER 15 CHANGE OF STENT - ONCOLOGY PATIENT
CAH		26/08/2015	26/08/2015	CKSURO	02/09/2015	02/09/2015		KS	PL	2	D	HYACYST		M49.4	HYACYST
CAH		03/09/2015	03/09/2015	CURWL	07/09/2015	07/09/2015		AOB	PL	2	D	HYACYST		M49.4	HYACYST
CAH		03/09/2015	03/09/2015	CUJOD	07/09/2015	07/09/2015		JOD	PL	2	D	BCG WEEK 4		M49.4	BCG WEEK 4
CAH		01/09/2015	01/09/2015	CURWL	21/09/2015			AOB	PL	2	N	REMOVAL OF STENT AND FLEXIBLE URETEROSCOPY - SEPT 15		M29.3	REMOVAL OF STENT AND FLEXIBLE URETEROSCOPY - SEPT 15
CAH		13/04/2015	13/04/2015	CAJG	01/10/2015			AJG	PL	2	D	OCTOBER 2015 - CIRCUMCISION	PER MR GLACKIN CLINIC LETTER	N30.3	OCTOBER 2015 - CIRCUMCISION PATIENT ON TICAGRELOR UNTIL END SEPTEMBER 2015
CAH		07/11/2014	07/11/2014	CURWL	01/10/2015			AOB	PL	2	N	INTERNAL URETHROTOMY - OCT 15	PER REG CDSU	M79.4	INTERNAL URETHROTOMY - OCT 15 FIT 8.1.15
CAH		06/09/2015	06/09/2015	CURWL	01/10/2015			AOB	PL	2	N	RIGID CYSTOSCOPY +/- BIOPSY - OCTOBER 2015	PER READMISSION BOOK	M45.9	RIGID CYSTOSCOPY +/- BIOPSY - OCTOBER 2015
CAH		02/04/2015	02/04/2015	CURWL	01/10/2015			AOB	PL	2	N	REMOVAL LEFT URETERIC STENT URETEROSCOPY & ?RESTENTING-OCT15		M29.3	REMOVAL LEFT URETERIC STENT URETEROSCOPY & ?RESTENTING-OCT15 HOLD(26.03.15)CD W/C
CAH		10/10/2014	10/10/2014	CURWL	01/10/2015			AOB	PL	2	D	OCT 15 - CHECK FLEXIBLE CYSTOSCOPY		M45.8	OCT 15 - CHECK FLEXIBLE CYSTOSCOPY
CAH		24/03/2015	24/03/2015	CURWL	01/10/2015			AOB	PL	2	N	REPLACEMENT OF SUPRAPUBIC CATHETER - JUNE 15		M38.8	REPLACEMENT OF SUPRAPUBIC CATHETER - JUNE 15
CAH		17/09/2015	17/09/2015	CURWL	01/10/2015			AOB	PL	2	N	REMOVAL OF LEFT URETERIC STENT - OCTOBER 2015		M29.3	REMOVAL OF LEFT URETERIC STENT - OCTOBER 2015
CAH		23/06/2015	23/06/2015	CURWL	01/10/2015			AOB	PL	4	N	CYSTOSCOPY ?TURBT - OCT 2015		M45.9	CYSTOSCOPY ?TURBT - OCT 2015
CAH		22/10/2014	21/10/2015	CUJOD	01/10/2015			JOD	PL	4	D	OCTOBER 2015 FLEXIBLE CYSTOSCOPY		M45.9	OCTOBER 2015 FLEXIBLE CYSTOSCOPY
CAH		14/04/2015	14/04/2015	CKSURO	01/10/2015			KS	PL	2	D	OCTOBER 2015 CHANGE OF STENT	PER KS DISCHARGE	M29.8	OCTOBER 2015 CHANGE OF STENT IDDM
CAH		18/08/2015	18/08/2015	CMY	01/10/2015			MY	PL	2	N	OCTOBER 15 TURP & LITHOLAPAXY WITH STONE PUNCH	PD - PER MR YOUNG IN THEATRE 18.08.15	M65.3	OCTOBER 15 TURP & LITHOLAPAXY WITH STONE PUNCH
CAH		16/04/2015	10/11/2015	CMY	01/10/2015	18/12/2015		MY	PL	4	D	OCTOBER 2015 CHECK FLEXIBLE CYSTOSCOPY	PER JENNY AT TDU 16.04.15	M45.9	OCTOBER 2015 CHECK FLEXIBLE CYSTOSCOPY
CAH		17/06/2013	16/09/2015	CMY	01/10/2015			MY	PL	4	N	SEPTEMBER 15 NESBITT'S PROCEDURE (CHANGE TO PL PROC PR MY)	PD - PER MR YOUNG AT BBPC 17.06.13	N28.8	SEPTEMBER 15 NESBITT'S PROCEDURE - HOLS 30/09/15 X 2WKS
CAH		30/09/2015	30/09/2015	CUJOD	06/10/2015	06/10/2015		JOD	PL	2	D	WEEK 5 MMC		M49.4	WEEK 5 MMC
CAH		08/10/2015	08/10/2015	CUJOD	13/10/2015	13/10/2015		JOD	PL	2	D	WEEK 5 MMC		M49.4	WEEK 5 MMC
CAH		22/10/2015	22/10/2015	CKSURO	27/10/2015	27/10/2015		KS	PL	4	D	MMC		M49.4	MMC

CAH	Personal Information redacted by the USI	22/10/2015	11/11/2015	CMY	29/10/2015	17/12/2015		MY	PL	2	D	EXCHANGE OF NEPHROSTOMY TUBE WITH DR MCCONVILLE		M06.4	EXCHANGE OF NEPHROSTOMY TUBE WITH DR MCCONVILLE
CAH		19/05/2015	19/05/2015	CURWL	01/11/2015			AOB	PL	2	N	CHANGE OF NEPHROSTOMY - NOVEMBER 2015		M16.2	CHANGE OF NEPHROSTOMY - NOVEMBER 2015
CAH		08/09/2015	08/09/2015	CURWL	01/11/2015			AOB	PL	2	N	URETEROSCOPY - NOVEMBER 2015		M30.9	URETEROSCOPY - NOVEMBER 2015
CAH		21/02/2014	21/02/2014	CURWL	01/11/2015			AOB	PL	4	N	TURP - NOVEMBER 15		M65.3	TURP - NOVEMBER 15 POST CARDIAC CATHETERISATION
CAH		20/08/2015	20/08/2015	CUJOD	01/11/2015	29/12/2015		JOD	PL	4	N	DEC 2015 GA CYSTOSCOPY AND BLADDER BIOPSY (AFTER MMC COMPLET		M45.9	DEC 2015 GA CYSTOSCOPY AND BLADDER BIOPSY (AFTER MMC COMPLET AFTER MMC TREATMENT COMPLETED)
CAH		23/02/2015	23/10/2015	CUMDH	01/11/2015	24/12/2015		MDH	PL	4	D	08/15 CHANGE URETERIC STENT DNA 280915	PER MR HAYNES DIS LTR	M29.5	08/15 CHANGE URETERIC STENT FIT(24.09.15)CD
CAH		13/10/2015	13/10/2015	CMY	01/11/2015			MY	PL	2	D	NOVEMBER 2015 REDO LEFT FLEXIBLE URETEROSCOPY	PD - PER MR YOUNG IN THEATRE 13.10.15	M30.9	NOVEMBER 2015 REDO LEFT FLEXIBLE URETEROSCOPY
CAH		20/10/2015	20/10/2015	CMY	01/11/2015	29/12/2015		MY	PL	2	D	NOV/DEC 15 REMOVAL OF STENT & REPEAT LEFT URETEROSCOPY	PER MR YOUNG	M29.3	NOV/DEC 15 REMOVAL OF STENT & REPEAT LEFT URETEROSCOPY
CAH		20/10/2015	20/10/2015	CMY	01/11/2015			MY	PL	2	D	NOV/DEC 15 REPEAT URETEROGRAM(LEFT)	PER MR YOUNG	M30.1	NOV/DEC 15 REPEAT URETEROGRAM
CAH		19/10/2015	19/10/2015	CMY	01/11/2015	15/12/2015		MY	PL	2	N	END NOV 15 EXCHANGE OF STENT & URETEROGRAM (LEFT)	PD - PER MR YOUNG AT CLINIC 19.10.15	M29.8	END NOV 15 EXCHANGE OF STENT B6D 041215 ON CORTICOSTEROIDS
CAH		20/10/2015	20/10/2015	CMY	01/11/2015			MY	PL	2	N	NEW DATE LEFT URETEROSCOPY (NOT DONE 20.10.15)	PER MR YOUNG	M30.9	NEW DATE LEFT URETEROSCOPY (NOT DONE 20.10.15)
CAH		13/05/2014	13/05/2014	CMY	01/11/2015			MY	PL	4	D	NOVEMBER 2014 BOTOX	PD - PER MR YOUNG 12.05.14	M43.4	NOVEMBER 2014 BOTOX pt phon ? date 19.08.15
CAH		28/11/2014	04/11/2015	CMY	01/11/2015	18/12/2015		MY	PL	4	D	NOVEMBER 2015 CHECK FLEXIBLE CYSTOSCOPY	PER JENNY AT DSU 28.11.14	M45.9	NOVEMBER 2015 CHECK FLEXIBLE CYSTOSCOPY needs 2pm per tel call n/home 04.12.15 to facilitate ambo
CAH		10/02/2015	10/02/2015	CMY	01/11/2015			MY	PL	4	D	NOVEMBER 2015 CHANGE OF STENT	PD - PER MR YOUNG IN THEATRE 10.02.15	M29.8	NOVEMBER 2015 CHANGE OF STENT
CAH		05/05/2015	05/05/2015	CMY	01/11/2015			MY	PL	4	D	NOVEMBER 15 CHECK FLEXIBLE CYSTOSCOPY	PD - PER MR YOUNG IN THEATRE 05.05.15	M45.9	NOVEMBER 15 CHECK FLEXIBLE CYSTOSCOPY
CAH		08/11/2015	08/11/2015	CAJG	01/12/2015	18/12/2015		AJG	PL	2	N	URETEROSCOPY AND LASER LITHOTRIPSY	per readmission book	M30.9	DEC 2015 URETEROSCOPY AND LASER LITHOTRIPSY
CAH		12/10/2015	12/10/2015	CAJG	01/12/2015			AJG	PL	2	N	FLEXIBLE URETEROSCOPY DEC 15 LEFT SIDE	PER DISCHARGE	M30.9	DEC 15 FLEXIBLE URETEROSCOPY LEFT SIDE 6-8 WEEKS
CAH		05/06/2015	05/06/2015	CURWL	01/12/2015			AOB	PL	2	D	CHECK FLEXIBLE CYSTOSCOPY - DECEMBER 2015		M45.8	CHECK FLEXIBLE CYSTOSCOPY - DECEMBER 2015
CAH		14/10/2015	14/10/2015	CURWL	01/12/2015			AOB	PL	2	N	CIRCUMCISION - DECEMBER 2015		N30.3	CIRCUMCISION - DECEMBER 2015
CAH		17/11/2015	17/11/2015	CURWL	01/12/2015			AOB	PL	2	N	REMOVAL OF URETERIC STENTS - DECEMBER 2015		M29.3	REMOVAL OF URETERIC STENTS - DECEMBER 2015
CAH		05/06/2015	02/12/2015	CURWL	01/12/2015			AOB	PL	2	D	CHECK FLEXIBLE CYSTOSCOPY DECEMBER 2015		M45.8	CHECK FLEXIBLE CYSTOSCOPY DECEMBER 2015
CAH		03/10/2015	03/10/2015	CURWL	01/12/2015			AOB	PL	2	N	CYSTOSCOPY AND BLADDER MUCOSAL BIOPSIES/RESECTION- DEC 15		M45.9	CYSTOSOCPY & BLADDER MUSCOSAL BIOPSIES/RESECTION - DEC 15
CAH		04/12/2014	04/12/2014	CURWL	01/12/2015			AOB	PL	4	D	DECEMBER 2015 - FLEXIBLE CYSTOSCOPY		M45.9	DECEMBER 2015 - FLEXIBLE CYSTOSCOPY HOLD(16.02.15)CD

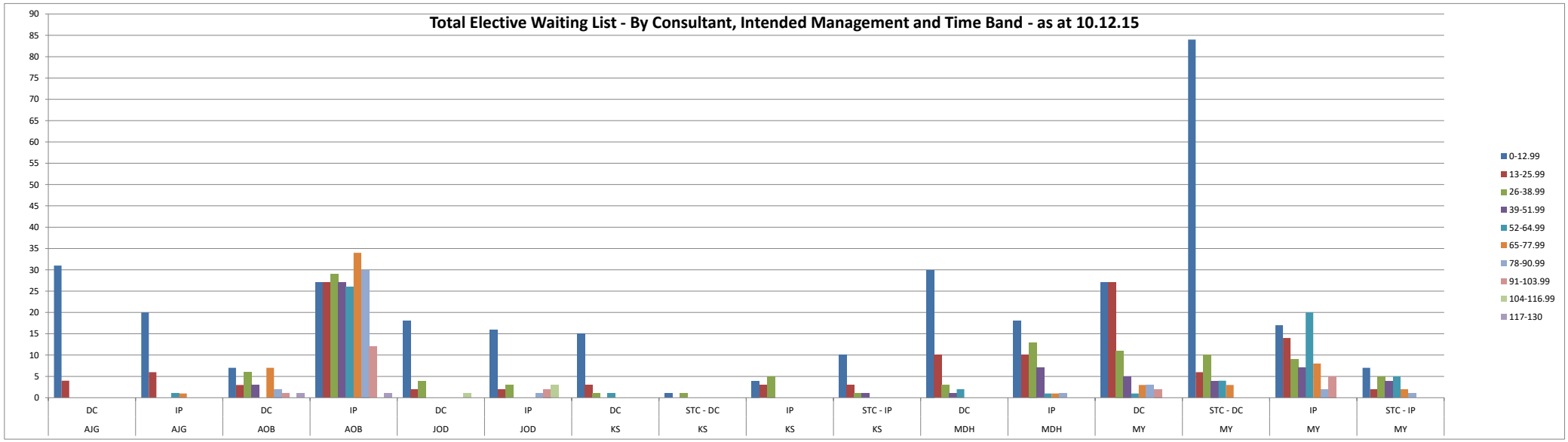
CAH	Personal Information redacted by the USI	01/06/2015	01/06/2015	CURWL	01/12/2015			AOB	PL	4	N	INTERNAL URETHROTOMY - DECEMBER 2015		M79.4	INTERNAL URETHROTOMY - DECEMBER 2015
CAH		09/06/2015	04/12/2015	CURWL	01/12/2015			AOB	PL	4	D	FLEXIBLE CYSTOSCOPY DECEMBER 2015	PER E-MAIL AOB	M45.9	FLEXIBLE CYSTOSOCPY DECEMBER 2015
CAH		28/09/2015	28/09/2015	CUJOD	01/12/2015			JOD	PL	2	D	END DEC/START JAN 16 FLEXIBLE CYSTSOCOPY		M45.9	END DEC/START JAN 16 FLEXIBLE CYSTOSCOPY
CAH		14/09/2015	14/09/2015	CUJOD	01/12/2015	29/12/2015		JOD	PL	2	N	DEC 2015 CYSTOSCOPY AND BLADDER BIOPSY	PER JOD	M45.9	DEC 2015 CYSTOSCOPY AND BLADDER BIOPSY AFTER BCG TREATMENT
CAH		17/11/2015	17/11/2015	CKSURO	01/12/2015	15/12/2015		KS	PL	2	D	DEC 2015 FLEXIBLE CYSTOSCOPY	PER KS CLINIC	M45.9	DEC 2015 FLEXIBLE CYSTOSCOPY
CAH		26/11/2015	26/11/2015	CKSURO	01/12/2015	11/12/2015		KS	PL	2	N	URETEROSCOPY, LASER ABLATION +/- STENTING	PER PAULETTE/MY ESWL LIST	M30.9	URETEROSCOPY, LASER ABLATION +/- STENTING
CAH		10/11/2015	10/11/2015	CKSURO	01/12/2015	09/12/2015		KS	PL	2	N	DEC 2015 LEFT URS & LASER ABLATION	PER MATTHEW DISCHARGE	M30.9	DEC 2015 LEFT URS & LASER ABLATION (FIT 08/12/15)
CAH		10/11/2015	10/11/2015	CKSURO	01/12/2015			KS	PL	2	N	JAN 2016 LEFT URETEROSCOPY STENT IN SITU	PER KS DISCHARGE	M30.9	JAN 2016 LEFT URETEROSCOPY STENT IN SITU
CAH		21/10/2015	21/10/2015	CKSURO	01/12/2015			KS	PL	4	N	DEC 2015 REPEAT RIGHT URS & LASER ABLATION STENT IN SITU	PER KS DISCHARGE	M30.9	DEC 2015 REPEAT RIGHT URS & LASER ABLATION STENT IN SITU
CAH		06/10/2015	06/10/2015	CKSURO	01/12/2015	22/12/2015		KS	PL	4	D	DEC 2015 FIRST CHANGE OF SPC	PER KS - DEBBIE WYLIE DOES NOT DO IN COMMUNITY	M38.8	DEC 2015 FIRST CHANGE OF SPC
CAH		27/11/2015	27/11/2015	CKSURO	01/12/2015			KS	PL	4	D	DEC 2015 FLEXI & REMOVAL OF STENT	PER KS DISCHARGE	M45.9	DEC 2015 FLEXI & REMOVAL OF STENT
CAH		20/10/2015	20/10/2015	CUMDH	01/12/2015	11/12/2015		MDH	PL	2	N	12/15 URETEROSCOPY & LASER FRAGMENTATION TO STONE	PER MR HAYNES	M30.9	12/15 URETEROSCOPY & LASER FRAGMENTATION TO STONE
CAH		13/11/2015	13/11/2015	CUMDH	01/12/2015	08/12/2015		MDH	PL	2	D	12/15 FLEXIBLE CYSTOSCOPY 3-4 WEEKS	PER JENNY	M45.9	12/15 FLEXIBLE CYSTOSCOPY 3-4 WEEKS
CAH		22/10/2015	22/10/2015	CUMDH	01/12/2015			MDH	PL	2	D	12/15 FLEXIBLE CYSTOSCOPY	PER JENNY REG	M45.9	12/15 FLEXIBLE CYSTOSCOPY
CAH		26/10/2015	26/10/2015	CUMDH	01/12/2015			MDH	PL	2	D	12/15 FLEXIBLE CYSTOSOCPY & REMOVAL OF STENT	PER MR HAYNES	M45.9	12/15 FLEXIBLE CYSTOSCOPY & REMOVAL OF STENT 6 WEEKS POST DISCHARGE
CAH		12/11/2015	12/11/2015	CUMDH	01/12/2015	11/12/2015		MDH	PL	2	D	12/15 BILATERAL URETEROSCOPY & STONE FRAGMENTATION	PER MR HAYNES	M30.9	12/15 BILATERAL URETEROSCOPY & STONE FRAGMENTATION
CAH		10/12/2014	10/12/2014	CUMDH	01/12/2015			MDH	PL	4	D	12/15 FLEXIBLE CYSTOSCOPY	PER CDSU	M45.9	12/15 FLEXBILE CYSTOSCOPY
CAH		12/10/2015	12/10/2015	CUMDH	01/12/2015	11/12/2015		MDH	PL	4	N	12/15 LEFT RETROGRADE +/- REMOVAL URETERIC STENT	PER DIS LTR	M30.1	12/15 LEFT RETROGRADE +/- REMOVAL URETERIC STENT 10 WEEKS POST DISCHARGE UPDATED 26.11.15
CAH		08/06/2015	08/06/2015	CUMDH	01/12/2015	24/12/2015		MDH	PL	4	N	12/15 CHANGE URETERIC STENT	PER MR HAYNES	M29.8	12/15 CHANGE URETERIC STENT
CAH		10/08/2015	10/08/2015	CUMDH	01/12/2015	24/12/2015		MDH	PL	4	D	12/15 CYSTOSCOPY +/- BLADDER BIOPSY	PER MR HAYNES	M45.8	12/15 CYSTOSCOPY +/- BLADDER BIOPSY AFTER MAINTENANCE DOSE MMC
CAH		08/09/2015	08/09/2015	CUMDH	01/12/2015	08/12/2015		MDH	PL	4	D	12/15 FLEXIBLE CYSTOSCOPY	PER MR HAYNES	M45.9	12/15 FLEXIBLE CYSTOSCOPY
CAH		20/07/2015	20/07/2015	CUMDH	01/12/2015			MDH	PL	4	D	12/15 FLEXIBLE CYSTOSCOPY	PER MR HAYNES	M45.9	12/15 FLEXIBLE CYSTOSCOPY END NOV/START DECEMBER MMC COMPLETE 131015
CAH		01/06/2015	01/06/2015	CUMDH	01/12/2015	08/12/2015		MDH	PL	4	D	12/15 FLEXIBLE CYSTOSCOPY	PER MR HAYNES	M45.9	12/15 FLEXIBLE CYSTOSCOPY
CAH		17/06/2015	17/06/2015	CUMDH	01/12/2015			MDH	PL	4	D	12/15 FLEXIBLE CYSTOSCOPY	PER MR HAYNES	M45.9	12/15 FLEXIBLE CYSTOSCOPY
CAH		28/09/2015	28/09/2015	CUMDH	01/12/2015	24/12/2015		MDH	PL	4	D	12/15 CHANGE URETERIC STENT	PER MR HAYNES	M29.8	12/15 CHANGE URETERIC STENT END DECEMBER/START JANUARY 2016

CAH	Personal Information redacted by the USI	02/06/2015	02/06/2015	CUMDH	01/12/2015	08/12/2015		MDH	PL	4	D	12/15 FLEXIBLE CYSTOSCOPY	PER MR HAYNES	M45.9	12/15 FLEXIBLE CYSTOSCOPY
CAH		10/12/2014	10/12/2014	CUMDH	01/12/2015			MDH	PL	4	D	12/15 FLEXIBLE URETHROSCOPY	PER CDSU	M45.9	12/15 FLEXIBLE URETHROSCOPY
CAH		31/07/2015	31/07/2015	CMY	01/12/2015	22/12/2015		MY	PL	2	N	NESBITT'S	PD - PER MR YOUNG AT CLINIC 31.07.15	N28.8	NESBITT'S (HSQ TO FRANCES 04/12/15)
CAH		10/09/2015	16/11/2015	CMY	01/12/2015	16/12/2015		MY	PL	2	D	L ESWL DECEMBER PRIVATE PATIENT	POST ESWL 100915 TCI DEC 2015 PER MR YOUNG	M14.1	L ESWL DECEMBER PRIVATE PATIENT on hols until 10.12.15
CAH		18/09/2015	18/09/2015	CMY	01/12/2015	18/12/2015		MY	PL	2	D	DECEMBER 2015 CHECK FLEXIBLE CYSTOSCOPY	PD - PER MATTHEW AT DSU 18.09.15	M45.9	DECEMBER 2015 CHECK FLEXIBLE CYSTOSCOPY
CAH		13/11/2015	13/11/2015	CMY	01/12/2015	18/12/2015		MY	PL	2	D	DECEMBER 2015 (MUST GET) CHECK FLEXIBLE CYSTOSCOPY	PD - PER MR YOUNG AT CLINIC 13.11.15	M45.9	DECEMBER 2015 (MUST GET) CHECK FLEXIBLE CYSTOSCOPY
CAH		14/10/2015	14/10/2015	CMY	01/12/2015			MY	PL	2	D	DECEMBER 2015 REPEAT URETEROSCOPY & ROS	PER MR YOUNG	M30.9	DECEMBER 2015 REPEAT URETEROSCOPY & ROS
CAH		05/10/2015	05/10/2015	CMY	01/12/2015			MY	PL	4	D	DECEMBER 2015 - CHECK FLEXIBLE CYSTOSCOPY STH PER MRY-LA	PD - PER MR YOUNG AT STH DPU 05.10.15	M45.9	DECEMBER 2015 - CHECK FLEXIBLE CYSTOSCOPY STH PER MRY-LA
CAH		19/06/2015	19/06/2015	CMY	01/12/2015	18/12/2015		MY	PL	4	D	DECEMBER 2015 CHECK FLEXIBLE CYSTOSCOPY	PER RACHAEL AT DSU 19.06.15	M45.9	DECEMBER 2015 CHECK FLEXIBLE CYSTOSCOPY
CAH		02/02/2015	03/11/2015	CMY	01/12/2015	29/12/2015		MY	PL	4	D	AIM OCT 2015 CYSTOSCOPY & VARICOCELE	PER MR YOUNG AT EXTRA CLINIC 02.02.15	M45.9	AIM OCT 2015 CYSTOSCOPY & VARICOCELE FIT 28.4.15 KK - UTA 10.11.15 (SCHOOL COMMITTMENTS) SFA
CAH		26/06/2015	26/06/2015	CMY	01/12/2015	18/12/2015		MY	PL	4	D	DECEMBER 2015 CHECK FLEXIBLE CYSTOSCOPY	PD - PER JENNY AT DSU 26.06.15	M45.9	DECEMBER 2015 CHECK FLEXIBLE CYSTOSCOPY
CAH		19/12/2014	19/12/2014	CMY	01/12/2015	18/12/2015		MY	PL	4	D	DECEMBER 2015 CHECK FLEXIBLE CYSTOSCOPY	PD - PER KAREN AT DSU 19.12.14	M45.9	DECEMBER 2015 CHECK FLEXIBLE CYSTOSCOPY
CAH		30/11/2015	30/11/2015	CKSURO	02/12/2015			KS	PL	2	N	DEC 2015 LEFT URETEROSCOPY & LASER ABLATION +/- STENTING	PER KS CLINIC	M30.9	DEC 2015 LEFT URETEROSCOPY & LASER ABLATION +/- STENTING
CAH		30/11/2015	30/11/2015	CKSURO	02/12/2015	16/12/2015		KS	PL	2	N	DEC 2015 LEFT URETEROSCOPY & LASER ABLATION	PER KS CLINIC	M30.9	DEC 2015 LEFT URETEROSCOPY & LASER ABLATION
CAH		24/09/2015	24/09/2015	CKSURO	03/12/2015	10/12/2015		KS	PL	2	N	CHANGE OF BILATERAL NEPHROSTOMY DRAINS - DECEMBER 2015		M16.2	CHANGE OF BILATERAL NEPHROSTOMY DRAINS - DECEMBER 2015
CAH		02/12/2015	02/12/2015	CUJOD	07/12/2015	07/12/2015		JOD	PL	2	D	WEEK 7 HYACYST		M49.4	WEEK 7 HYACYST
CAH		02/12/2015	02/12/2015	CUJOD	07/12/2015	07/12/2015		JOD	PL	2	D	HYACYST		M49.4	HYACYST
CAH		02/12/2015	02/12/2015	CUJOD	07/12/2015	07/12/2015		JOD	PL	2	D	WEEK 2 MMC		M49.4	WEEK 2 MMC
CAH		02/12/2015	02/12/2015	CUJOD	08/12/2015	08/12/2015		JOD	PL	2	D	WEEK 6 MMC		M49.4	WEEK 6 MMC
CAH		18/09/2015	18/09/2015	CKSURO	09/12/2015			KS	PL	4	D	DEC 2015 FLEXIBLE CYSTOSCOPY	PER BASH FLEXI LIST	M45.9	DEC 2015 FLEXIBLE CYSTOSCOPY
CAH		27/11/2015	27/11/2015	CKSURO	11/12/2015	11/12/2015		KS	PL	2	N	OCTOBER 2015 TURP CATHETER IN SITU		M65.3	OCTOBER 2015 TURP CATHETER IN SITU FIT(18.11.15)CD
CAH		02/12/2015	02/12/2015	CUJOD	14/12/2015	14/12/2015		JOD	PL	2	D	WEEK 8 HYACYST		M49.4	WEEK 8 HYACYST
CAH		02/12/2015	02/12/2015	CUJOD	14/12/2015	14/12/2015		JOD	PL	2	D	WEEK 3 MMC		M49.4	WEEK 3 MMC
CAH		04/12/2015	04/12/2015	CURGA	22/12/2015	22/12/2015		AOB	PL	2	D	FLEXIBLE CYSTOSCOPY		M45.9	FLEXIBLE CYSTOSCOPY
CAH		04/12/2015	04/12/2015	CMY	22/12/2015	22/12/2015		MY	PL	2	N	LEFT URETEROSCOPY & REMOVAL OF STENT		M30.9	LEFT URETEROSCOPY & REMOVAL OF STENT
CAH		04/12/2015	04/12/2015	CMY	30/12/2015	30/12/2015		MY	PL	2	D	LEFT ESWL STENT IN SITU		M14.1	LEFT ESWL STENT IN SITU

CAH	Personal Information redacted by the USI	25/08/2015	25/08/2015	CMY	31/12/2015			MY	PL	2	N	END DEC/BEG JAN 16 - CHANGE OF STENT	PD - PER MR YOUNG IN THEATRE 25.08.15	M29.8	END DEC/BEG JAN 16 - CHANGE OF STENT

TOTAL UROLOGY ELECTIVE WAITING LIST - EXCLUDES PATIENTS WITH DATES AND SUSPENDED PATIENTS - AS AT 10.12.15
(Potential STC patient volumes identified separately)

		WEEKS WAITING (13 WEEK BLOCKS)											
Consultant Code	Intended Management	0-12.99	13-25.99	26-38.99	39-51.99	52-64.99	65-77.99	78-90.99	91-103.99	104-116.99	117-130	TOTAL	GRAND TOTAL
AJG	DC	31	4	0	0	0	0	0	0	0	0	35	63
AJG	IP	20	6	0	0	1	1	0	0	0	0	28	
AOB	DC	7	3	6	3	0	7	2	1	0	1	30	243
AOB	IP	27	27	29	27	26	34	30	12	0	1	213	
JOD	DC	18	2	4	0	0	0	0	0	1	0	25	52
JOD	IP	16	2	3	0	0	0	1	2	3	0	27	
KS	DC	15	3	1	0	1	0	0	0	0	0	20	49
KS	*STC - DC*	*1*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*2*	
KS	IP	4	3	5	0	0	0	0	0	0	0	12	
KS	*STC - IP*	*10*	*3*	*1*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*15*	
MDH	DC	30	10	3	1	2	0	0	0	0	0	46	97
MDH	IP	18	10	13	7	1	1	1	0	0	0	51	
MY	DC	27	27	11	5	1	3	3	2	0	0	79	298
MY	*STC - DC*	*84*	*6*	*10*	*4*	*4*	*3*	*0*	*0*	*0*	*0*	*111*	
MY	IP	17	14	9	7	20	8	2	5	0	0	82	
MY	*STC - IP*	*7*	*2*	*5*	*4*	*5*	*2*	*1*	*0*	*0*	*0*	*26*	
TOTAL		332	122	101	59	61	59	40	22	4	2	802	



TOTAL UROLOGY ELECTIVE WAITING LIST - EXCLUDES PATIENTS WITH DATES AND SUSPENDED PATIENTS - AS AT 10.12.15

Indicates potential patients seen at STC

Hospital	H&C No.	Casenote	Forename	Surname	Date of Birth	Age	Original Date	Current Date	Date Booked	Current Suspension End Date	Consultant	Expected Method of Adm.	Urgency Code	Intended Management	Admission Reason	Intended Primary Procedure Code	Operation Description	Expected Ward	Remarks	Weeks waiting
	Personal Information redacted by the USI																			
CAH							23/02/2015	23/02/2015			KS	WL	2	N	FLEXIBLE URETEROSCOPY & LASER	M30.9	FLEXIBLE URETEROSCOPY & LASER HOLD(16.09.15)CD		PER KS STC CLINIC	41.35
CAH							20/05/2015	20/05/2015			KS	WL	2	N	LEFT URETEROSCOPY, LASER ABLATION & STENTING	M30.9	LEFT URETEROSCOPY, LASER ABLATION & STENTING FIT(19.08.15) BMI 35.9 ANGIOTENSION11 RECEPTOR ANTAGONISTS		PER KS CLINIC	29.05
CAH							24/07/2015	24/07/2015			KS	WL	4	N	LEFT URETEROSCOPY & LASER STONE ABLATION	M30.9	LEFT URETEROSCOPY & LASER STONE ABLATION		PER KS DISCHARGE LTR	19.77
CAH							23/08/2015	23/08/2015			KS	WL	2	N	URS & LASER +/- STENTING WHEELCHAIR/QUAD RIPLEGIA/MRSA	M30.9	URS & LASER +/- STENTING WHEELCHAIR/QUAD RIPLEGIA/MRSA ASTHMA MEDS FIT(26.11.15)CD		PER KS LETTER	15.50
CAH							08/09/2015	08/09/2015			KS	WL	2	N	RIGHT URETEROSCOPY & LASER ABLATION	M30.9	RIGHT URETEROSCOPY & LASER ABLATION NEEDS 1 WEEKS NOTICE FIT(30.10.15)CD		PER KS CLINIC	13.20
CAH							14/09/2015	14/09/2015			KS	WL	2	N	RIGHT URETEROSCOPY & LASER ABLATION +/- STENTING	M30.9	RIGHT URETEROSCOPY & LASER ABLATION +/- STENTING		PER KS STC CLINIC	12.35
CAH							05/10/2015	05/10/2015			KS	WL	2	N	LEFT URETEROSCOPY & LASER +/- RESTENTING STENT IN SITU	M30.9	LEFT URETEROSCOPY & LASER +/- RESTENTING STENT IN SITU WILLING TO TAKE CANCELLATION		PER KS STC CLINIC	9.37
CAH							05/10/2015	05/10/2015			KS	WL	2	N	LEFT URETEROSCOPY, LASER & STENTING DIABETES	M30.9	LEFT URETEROSCOPY, LASER & STENTING DIABETES		PER KS STC CLINIC	9.37
CAH							05/10/2015	05/10/2015			KS	WL	2	N	LEFT URETEROSCOPY & LASER STONE ABLATION	M30.9	LEFT URETEROSCOPY & LASER STONE ABLATION		PER KS STC CLINIC	9.37
CAH							05/10/2015	05/10/2015			KS	WL	2	N	LEFT URETEROSCOPY & LASER STONE ABLATION	M30.9	LEFT URETEROSCOPY & LASER STONE ABLATION		PER KS STC CLINIC	9.37
CAH							14/10/2015	14/10/2015			KS	WL	2	N	LEFT URS, LASER +/- STENTING EPILEPSY MRSA STRETCHER	M30.9	LEFT URS, LASER +/- STENTING EPILEPSY MRSA STRETCHER LEARNING DIFFICULTIES		PER KS CLINIC	8.06

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CAH	[redacted]						21/10/2015	21/10/2015			KS	WL	2	N	RIGHT URETEROSCOPY & LASER STONE ABLATION	M30.9	RIGHT URETEROSCOPY & LASER STONE ABLATION (B6D 30.10.15)		PER KS CLINIC	7.06
CAH							23/11/2015	23/11/2015			KS	WL	2	N	LEFT URS, LASER STONE ABLATION +/- STENTING	M30.9	LEFT URS, LASER STONE ABLATION +/- STENTING		PER KS STC	2.34
CAH							30/11/2015	30/11/2015			KS	WL	2	N	REPEAT URETEROSCOPY & LASER ABLATION +/- STENTING	M30.9	REPEAT URETEROSCOPY & LASER ABLATION +/- STENTING		PER KS CLINIC	1.34
CAH							07/12/2015	07/12/2015			KS	WL	2	N	REPEAT LEFT URS & LASER ABLATION +/- STENTING	M30.9	REPEAT LEFT URS & LASER ABLATION +/- STENTING		PER KS STC CLINIC	0.36

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Urology Attendances - 14/05/2015 - 11/11/2015 (26 weeks)
Face-to-Face, Virtual & Urodynamics

NEW PATIENT FACE-TO-FACE ATTENDANCES					
Clinic Session Type	**Red Flag**	**Urgent**	**Routine**	**Total**	**Average Weekly F/F Attendances by Clinic**
Consultant "TDU" Clinic	342	255	261	858	33
Registrar "REG" Clinic	129	95	58	282	11
Haematuria Clinic	78	1	0	79	3
Stone Treatment Clinic*	0	26	54	80	3
Consultant "HOT" Clinic	17	24	3	44	2
Uro-Oncology	0	3	0	3	0
Enniskillen	7	44	32	83	3
Armagh	0	0	0	0	0
Banbridge	0	0	0	0	0
Dungannon	0	1	0	1	0
TOTAL	**573**	**449**	**408**	**1430**	**55**

***** *Not all new patient attendances at STC are directly from referral - there are a cohort of patients referred to STC from within the urology team, but attendance at STC are recorded as new as first time seen at STC*

NEW PATIENT VIRTUAL ATTENDANCES			
Clinic Session Type	**Letter New**	**Telephone New**	**Total**
"HOT" or "TDU"	53	9	62
TOTAL	**53**	**9**	**62**

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TOTAL NEW PATIENT ATTENDANCES FOLLOWING REFERRAL						
Clinic Session Type	**Red Flag**	**Urgent**	**Routine**	**Letter New**	**Telephone New**	**Total**
Face-to-face & Virtual	**573**	**449**	**408**	**53**	**9**	**1492**

REFERRAL DEMAND VS ATTENDANCES				
Clinic Session Type	**Red Flag**	**Urgent**	**Routine**	**Total**
Referrals	690	765	1022	2477
Face-to-face & Virtual	573	449	408	1430
Variance	-117	-316	-614	-1047
Weekly Variance	**-4.5**	**-12.2**	**-23.6**	**-40.3**

URODYNAMIC ATTENDANCES				
Clinic Session Type	**Red Flag**	**Urgent**	**Routine**	**Total**
"UDS" Cinic	0	50	114	164
TOTAL	**0**	**50**	**114**	**164**

Attendances at Urodynamics following Initial Consultation (Face-to-face/Virtual)

TOTAL ATTENDANCES						
Clinic Session Type	**Red Flag**	**Urgent**	**Routine**	**Letter New**	**Telephone New**	**Total**
Face-to-face, Virtual & UDS	**573**	**499**	**522**	**53**	**9**	**1656**

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Urology Attendances - 14/05/2015 - 11/11/2015 (26 weeks)
Face-to-Face, Virtual & Urodynamics

Consultant Code	Clinic Code	New Atts	Follow up Atts	Total Atts
AJG - HOT	CAJGHOT	15	54	69
REGISTRAR	CAJGREG	48	0	48
AJG	CAJGTDU	153	19	172
AJG	CAJGTDUR	1	72	73
AJG	CAJGUDS	11	0	11
AJG	CAJGUO	0	172	172
AJG	SAJG	1	116	117
AOB	AAOBU1	0	21	21
AOB - HOT	CAOBHOT	9	28	37
REGISTRAR	CAOBREG	32	0	32
AOB	CAOBTDU	103	0	103
AOB	CAOBTDUR	0	62	62
AOB	CAOBUDS	45	0	45
AOB	CAOBUO	2	149	151
AOB	EUROAOB	30	48	78
JOD - HOT	CJODHOT	3	65	68
REGISTRAR	CJODREG	69	0	69
JOD	CJODTDU	220	14	234
JOD	CJODTDUR	0	116	116
JOD	CJODUDS	38	2	40
KS - HOT	CKSHOT	11	8	19
REGISTRAR	CKSREG	35	0	35
KS - STC	CKSSTC	13	50	63
KS	CKSTDU	139	13	152
KS	CKSTDUR	0	113	113
KS	CKSUDS	14	0	14
KS	CKSUO	1	96	97
MDH - HOT	CMDHHOT	46	70	116
REGISTRAR	CMDHREG	33	0	33
MDH	CMDHTDU	131	10	141
MDH	CMDHTDUR	3	355	358
MDH	CMDHUDS	17	0	17
MY	BURM1	0	85	85
MY - STC	CESWL	67	193	260
MY - HOT	CMYHOT	22	12	34
REGISTRAR	CMYREG	64	2	66
MY	CMYTDU	105	8	113
MY	CMYTDUR	0	184	184
MY	CMYUDS	39	1	40
MY	EUROMY	53	44	97
NURSE LED	ICSNULUT	0	163	163
RADIOLOGIST	CRADPBG	0	5	5
RADIOLOGIST	CRADPBS	0	27	27
REG HAEM	CCHAEM	79	2	81
	UROLOGY	**1652**	**2379**	**4031**

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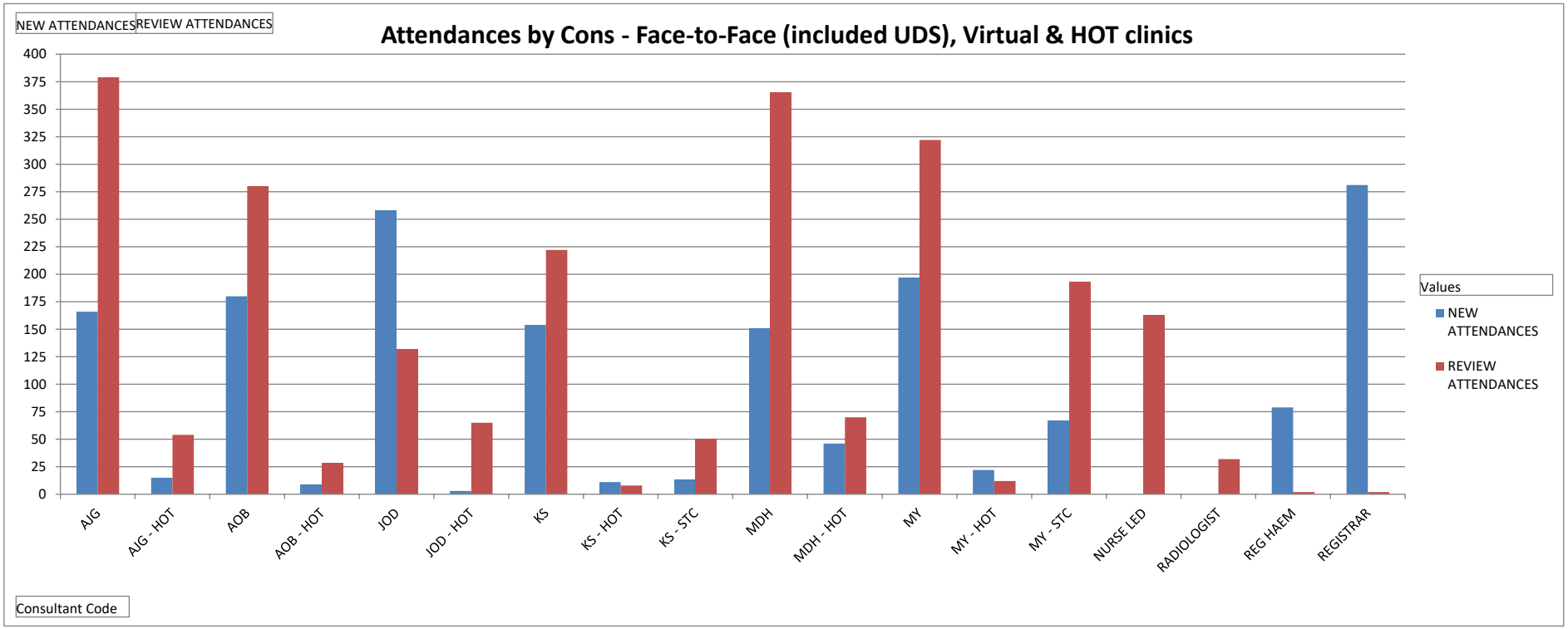
Urology Attendances - 14/05/2015 - 11/11/2015 (26 weeks)
Face-to-Face, Virtual & Urodynamics

CONSULTANT CODE	NEW ATTENDANCES	REVIEW ATTENDANCES	WEEKLY AVERAGE NEW ATTENDANCES	WEEKLY AVERAGE REVIEW ATTENDANCES	WEEKLY AVERAGE TOTAL ATTENDANCES
AJG	166	379	6.38	14.58	20.96
AJG - HOT	15	54	0.58	2.08	2.65
AOB	180	280	6.92	10.77	17.69
AOB - HOT	9	28	0.35	1.08	1.42
JOD	258	132	9.92	5.08	15.00
JOD - HOT	3	65	0.12	2.50	2.62
KS	154	222	5.92	8.54	14.46
KS - HOT	11	8	0.42	0.31	0.73
KS - STC	13	50	0.50	1.92	2.42
MDH	151	365	5.81	14.04	19.85
MDH - HOT	46	70	1.77	2.69	4.46
MY	197	322	7.58	12.38	19.96
MY - HOT	22	12	0.85	0.46	1.31
MY - STC	67	193	2.58	7.42	10.00
NURSE LED	0	163	0.00	6.27	6.27
RADIOLOGIST	0	32	0.00	1.23	1.23
REG HAEM	79	2	3.04	0.08	3.12
REGISTRAR	281	2	10.81	0.08	10.88
Grand Total	**1652**	**2379**			



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Urology Clinic Sessions - 14/05/2015 - 11/11/2015 (26 weeks)

Consultant Code	Clinic Code	New Atts	Follow up Atts	Total Atts	MAY*	JUNE	JULY	AUG	SEPT	OCT	NOV*	Actual Clinic Sessions
AOB	AAOBU1	0	21	21	0	0	0	0	1	0	1	2.0
MY	BURM1	0	85	85	1	1	1	1	0	1	0	5.0
REGISTRAR	CAJGREG	48	0	48	0.5	0.5	1.5	0	3	3	0	8.5
AJG	CAJGTDU	153	19	172	3	4	2	1	5	4	0	19.0
AJG	CAJGTDUR	1	72	73	0	0	0	1	2	2	0	5.0
AJG	CAJGUDS	11	0	11								0.0
AJG	CAJGUO	0	172	172	1	2	2	1	4	4	1	15.0
REGISTRAR	CAOBREG	32	0	32	0	0.5	0	1.5	1	2	1	6.0
AOB	CAOBTDU	103	0	103	1	1	2	2	3	3	1	13.0
AOB	CAOBTDUR	0	62	62	0	1	2	1	0	1	0	5.0
AOB	CAOBUDS	45	0	45								0.0
AOB	CAOBUO	2	149	151	3	2	4	0	5	3	1	18.0
REGISTRAR	CCHAEM	79	2	81	3	3	5	3	3	5	1	23.0
MY	CESWL	67	193	260	2	1	2	5	3	3	1	17.0
REGISTRAR	CJODREG	69	0	69	1.5	1	0	3.5	2.5	2	1.5	12.0
JOD	CJODTDU	220	14	234	3	6	2	5	5	3	3	27.0
JOD	CJODTDUR	0	116	116	1	2	1	2	3	3	2	14.0
JOD	CJODUDS	38	2	40								0.0
REGISTRAR	CKSREG	35	0	35	0	1.5	0	0	2	3	0.5	7.0
KS	CKSSTC	13	50	63	1	2	0	0	1	1	0	5.0
KS	CKSTDU	139	13	152	1	3	2	0	5	5	1	17.0
KS	CKSTDUR	0	113	113	1	3	1	0	2	1	0	8.0
KS	CKSUDS	14	0	14								0.0
KS	CKSUO	1	96	97	1	4	1	0	2	2	1	11.0
REGISTRAR	CMDHREG	33	0	33	0	1.5	0.5	1.5	0.5	1	0.5	5.5
MDH	CMDHTDU	131	10	141	1	4	2	2	2	2	2	15.0
MDH	CMDHTDUR	3	355	358	1	5	2	3	4	6	3	24.0
MDH	CMDHUDS	17	0	17								0.0
REGISTRAR	CMYREG	64	2	66	1	1	2	4	2	3	1	14.0
MY	CMYTDU	105	8	113	2	2	2	4	3	3	0	16.0
MY	CMYTDUR	0	184	184	3	2	2	4	2	2	1	16.0
MY	CMYUDS	39	1	40								0.0
RADIOLOGIST	CRADPBG	0	5	5	0	2	0	0	0	0	0	2.0
RADIOLOGIST	CRADPBS	0	27	27	0	2	0	1	2	2	1	8.0
AOB	EUROAOB	30	48	78	0	2	2	2	2	2	0	10.0
MY	EUROMY	53	44	97	0	2	2	2	2	2	2	12.0
NURSE LED	ICSNULUT	0	163	163								0.0
AJG	SAJG	1	116	117	1	1	1	0	2	2	1	8.0

Notes:

1. The currency for Registrar sessions is 0.5 when split between 2 consultants for a specific morning or afternoon, or 1 if all slots are with one particular consultant
2. Urodynamics has not been counted as separate full clinics as these sessions normally occur alongside another clinic session.

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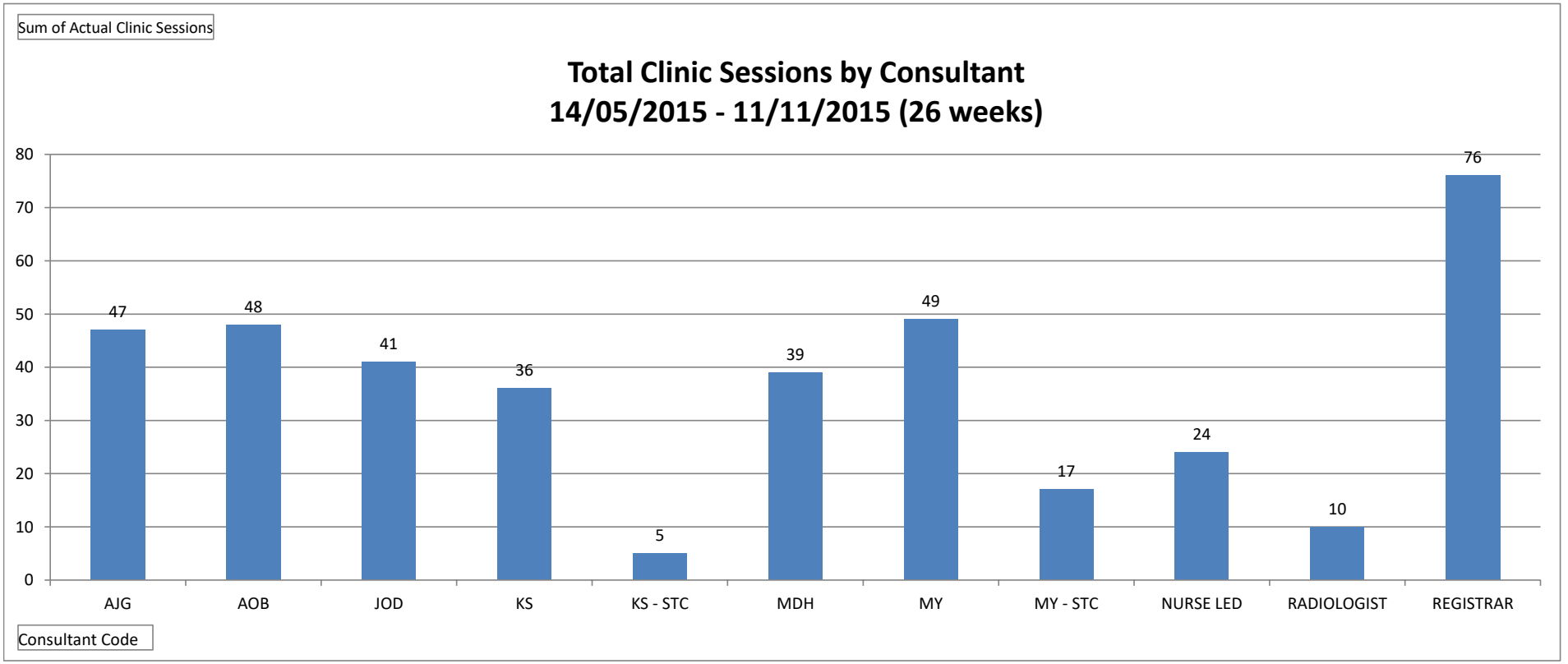
Urology Clinic Sessions - 14/05/2015 - 11/11/2015 (26 weeks)
Urodynamic Activity included in Parallel Session Volumes

Consultant Code	Clinic Code	New Atts	Follow up Atts	Total Atts	Actual Clinic Sessions
AOB	AAOBU1	0	21	21	2.0
MY	BURM1	0	85	85	5.0
REGISTRAR	CAJGREG	48	0	48	8.5
AJG	CAJGTDU*	164	19	172	19.0
AJG	CAJGTDUR	1	72	73	5.0
AJG	CAJGUO	0	172	172	15.0
REGISTRAR	CAOBREG	32	0	32	6.0
AOB	CAOBTDU	103	0	103	13.0
AOB	CAOBTDUR	0	62	62	5.0
AOB	CAOBUO*	47	149	151	18.0
REG HAEM	CCHAEM	79	2	81	23.0
MY - STC	CESWL	67	193	260	17.0
REGISTRAR	CJODREG	69	0	69	12.0
JOD	CJODTDU*	258	16	234	27.0
JOD	CJODTDUR	0	116	116	14.0
REGISTRAR	CKSREG	35	0	35	7.0
KS - STC	CKSSTC	13	50	63	5.0
KS	CKSTDU	153	13	152	17.0
KS	CKSTDUR	0	113	113	8.0
KS	CKSUO	1	96	97	11.0
REGISTRAR	CMDHREG	33	0	33	5.5
MDH	CMDHTDU	148	10	141	15.0
MDH	CMDHTDUR	3	355	358	24.0
REGISTRAR	CMYREG	64	2	66	14.0
MY	CMYTDU	105	8	113	16.0
MY	CMYTDUR	39	185	184	16.0
RADIOLOGIST	CRADPBG	0	5	5	2.0
RADIOLOGIST	CRADPBS	0	27	27	8.0
AOB	EUROAOB	30	48	78	10.0
MY	EUROMY	53	44	97	12.0
NURSE LED	ICSNULUT	0	163	163	24.0
AJG	SAJG	1	116	117	8.0
		1546	**2142**	**3521**	

*Parallel session - includes Urodynamics activity

TOTAL CLINIC SESSIONS BY CONSULTANT
14/05/2015 - 11/11/2015 (26 weeks)

CONSULTANT CODE	Sum of Actual Clinic Sessions
AJG	47
AOB	48
JOD	41
KS	36
KS - STC	5
MDH	39
MY	49
MY - STC	17
NURSE LED	24
RADIOLOGIST	10
REGISTRAR	76
Grand Total	**392**



Notes:

1. Excludes virtual and HOT clinic activity/sessions
2. Urodynamics sessions included as combined activity with parallel session

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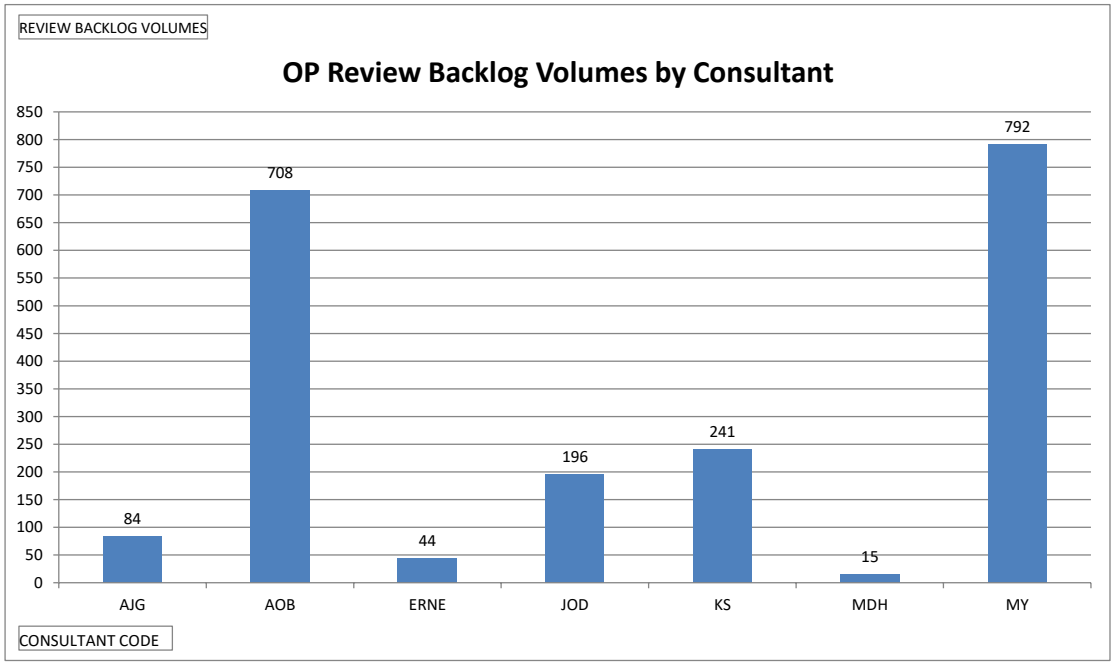
UROLOGY REVIEW OUT-PATIENT WAITING LIST - DATE REQUIRED NOVEMBER 2015 OR EARLIER (snap shot at 21/12/2015)

WAITING LIST CODE	CONSULTANT CODE	VOLUMES	LONGEST WAITER
BURM4R	MY	5	Aug-13
BURM4UR	MY	3	Aug-15
CAJGR	AJG	78	Feb-14
CAJGTR	AJG	5	Aug-15
CAOBUOR	AOB	267	Sep-13
CAU4R	AOB	43	Apr-13
CAU4UR	AOB	28	Apr-15
CJODR	JOD	154	Mar-15
CJODUR	JOD	42	Sep-15
CKSR	KS	60	May-13
CKSUOR	KS	1	Nov-15
CKSUR	KS	180	Nov-13
CMAR	AJG	1	Jan-14
CMDHR	MDH	1	Oct-15
CMDHTR	MDH	14	Mar-14
CMYSTCR	MY	393	Aug-13
CMYUOR	MY	4	Oct-15
CU2	AOB	215	Jun-11
CU2UR	AOB	155	Mar-13
CURMYR	MY	327	May-12
CURMYUR	MY	60	Jun-13
EUROR	ERNE	34	Dec-13
EUROUR	ERNE	10	Jun-15
		2080	

CONSULTANT CODE	REVIEW BACKLOG VOLUMES	LONGEST WAITER
AJG	84	Jan-14
AOB	708	Jun-11
ERNE	44	Dec-13
JOD	196	Mar-15
KS	241	May-13
MDH	15	Mar-14
MY	792	May-12
Grand Total	**2080**	



Cancer Pathway Escalation Policy

1.0 Background

This policy is to inform Cancer Tracker/ Multi-Disciplinary Team (MDT) Co-ordinators, Clinicians and Divisional Management Teams of the escalation policy for Cancer Access targets.

The current cancer access standard targets are:
14 days – 100% for the 2 week wait breast symptomatic outpatient appointment
31 days – 100% date decision to treat to first definitive treatment
62 days – 98% date of receipt of referral to first definitive treatment

The purpose of this policy to illustrate the actions that may be required at specific points along the patient's pathway. These actions will be escalated from the first trigger point. (Please see Table 1)

2.0 General Principles of Escalation

General principles of escalation are as follows:

(a) The earlier the better.
It is easier to stand people down once the problem is resolved than to catch up lost time
(b) Try everything you know to resolve the problem
(c) Recognise that you can't solve all of the problems – but by escalating it will give others a chance to help find a solution.
(d) Record on the escalation proforma the steps you have taken
(e) Take action in a timely manner
Be clear of the timescale of escalation
If a response is not received from Consultant/Clinician within outlined timescale for escalation the relevant Chair of the MDT is to be notified.

3.0 Trigger Points for Escalation

For a patient to progress along the pathway, the Cancer Trackers will start the tracking process and be responsible for escalations throughout the pathway. In order for the Trackers to track they have been given the authority to expedite referrals (either appointments/diagnostics) within their own level of responsibility. While the Red Flag Appointments Team will escalate patients outside of expected 1st appointment timescales, the tracker will track the full cancer pathway.

In the event of delays in the patient pathway, as detailed in Appendix 1, the tracker will escalate to the Cancer Services Co-ordinator (CSC) or in her absence the Operational Support lead (OSL), who will in turn advise the Head of Cancer Service. The CSC will advise the relevant Head of Service (HOS) /OSL for that specialty, of any actions required to be taken or ongoing delays.

The HOS/OSL for the specialty will escalate patients who trigger key points on the pathways to the relevant Assistant Directors and Clinical leads as required.

Table 1 - Key trigger points on the Cancer pathway for escalation if patient not booked or completed

Key Trigger	Trigger Point	Escalate To	Further Escalation Point	Also Escalate To
First appointment	By day 10	>Head of Service >OSL	By Day 21	>Assistant Director for the Specialty >Director for Acute Services
Investigations/ Diagnostics	By day 17	>Head of Service >OSL	Greater than 10 days for diagnostic investigation or reporting	>Head of Service for Radiology >Assistant Director for Cancer & Clinical Services
MDM	By day 25	>Head of Service >OSL		
ITT	By day 28	>Head of Service >OSL		
Treatment	By day 31 or 62 (relevant to pathway	>Head of Service >OSL	Breaches of 31 or 62 day pathway	>Assistant Director for the Specialty

**please note that red flag appointments will escalate 1st out-patient appointment, the tracker will be responsible for liaising with red flag team if patient is not booked or on red flag out-patient waiting list for appointment.*

3.4 Delayed Escalation Response:

If the Cancer Trackers are awaiting a response for longer than 1 week regarding a management plan for a patient on a cancer pathway, and all relevant steps have been taken as per escalation policy, the relevant Multi Disciplinary Meeting Chair will be notified to avoid any further delays for the patient and copied to HOS for the specialty.

3.5 MDT Meetings:

The tracker will raise all on going risks at the Multidisciplinary meeting which will be minuted, and communicate the outcome and any unresolved issues to the CSC. If no solution is found, the risk will be escalated through a series of senior managers (see table 2) ultimately to the Clinical Lead for Cancer, who will inform the Chief Executive in the event of failure to resolve this issue.

3.6 Deferment from MDT:

If a patient is deferred from MDT discussion, this must be escalated to the releveant specialty HOS and OSL. It is the HOS and OSL responsibility to ensure the patient is discussed the following week and this is highlighted to the Chair of the MDT.

3.7 Inter-Trust transfers:

It is recognised good practice that where a potential breach or confirmed breach requires an Inter Trust Transfer (ITT), it is the responsibility of the Southern Trust's Executive Lead for Cancer to contact the Executive Lead for Cancer in the 'referred to' Trust to discuss delayed referrals (received after 28 days) and breach situations in order to understand reasons for delay and to agree "shared breaches".

Unfortunately, as pathways for some tumour sites continue to come under increased pressure, it may not always be practical for this level of contact/discussion to take place. The Trust will continue to liaise closely with the 'referred to' Trust in these circumstances to ensure patients receive treatment and care as quickly as possible on the pathway

4.0 Escalation Chain

Table 2 – Escalation chain for trigger points throughout cancer pathway

Escalation Chain	Role Responsible for Escalating	Escalation Point	Timescale for escalation	Cumulative Timescale for escalation
1.	Red Flag Appointments Team/ Cancer Tracker/MDT Co-ordinator	Cancer Services Co-Ordinator	24 hours	24 hours
2.	Cancer Services Co-ordinator	Head of Service for the Specialty Head of Service for Cancer copied to relevant OSLs	24 hours	48 hours
3.	Head of Service for the Specialty	Assistant Director for the Specialty Assistant Director for Cancer Services *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	3 days
4.	Assistant Director for the Specialty	Chair of MDM *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	4 days
5.	Chair of MDM	Executive Lead for Cancer *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	5 days
6.	Executive Lead for Cancer	Director of Acute Services *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	6 days
7.	Director of Acute Services	Chief Executive Officer *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	7 days

Note – these timescales are the longest periods expected.

Each Cancer Tracker/MDT Co-ordinator will be aware of individual patient pathways for each tumour site and the reasonable timescales expected. A generic pathway is attached as Appendix 1, specific site pathways are are also available.

Each step of the pathway is a potential weak link in the chain; and clear observation is required at all stages to ensure:

(a) patient appointment is booked
(b) patient attends appointment
(c) the next review appointment is booked
(d) treatment is commenced

The table above illustrates the escalation chain with each level escalating as required until the delay has been addressed.

Escalation reporting and actions taken will be noted by the tracker in the diary page of the Capps system.

Table 3 – Escalation Chain Roles and Contacts

Roles	Contact Name
Cancer Tracker/ MDT Co-Ordinator	Marie Dabbous Anne Turkington Hilda Shannon Wendy Kelly Shauna McVeigh Griania White Rachel McCartney Catherine Glenny Sinead Lee Sarah Moore
Cancer Services Co-Ordinator	Vicki Graham Angela Muldrew
Heads of Service	Fiona Reddick - Cancer Services Martina Corrigan - Urology/ENT Amie Nelson - UGI / LGI / Breast Kay Carroll – Derm / Lung Wendy Clarke – Gynaecology Louise Devlin - Gastroenterology
Operational Support Lead	Sharon Glenny – IMWH & CCS Wendy Clayton – SEC Lisa McAreavey - MUSC
Assistant Director	Barry Conway – IMWH & CCS Anne McVey – MUSC Ronan Carroll – SEC
Chair of MDM	Dr McCracken – Gynae Mr Neill – LGI Mr Glackin – Urology Dr Mathers – Breast Dr Convery – Lung Dr O'Hagan – Skin Dr Boyd – Haematology Dr McCaul – Head & Neck
Executive Lead for Cancer	Dr McCaul
Director of Acute Services	Esther Gishkori
Chief Executive Officer	Shane Devlin

5.0 Pathway Breaches

Breach reports will be commenced by the Cancer Tracker/MDT Co-ordinator where patients breach the targets, i.e. 14 day for breast, 28 day for inter–trust transfers, day 31 and day 62 breaches.

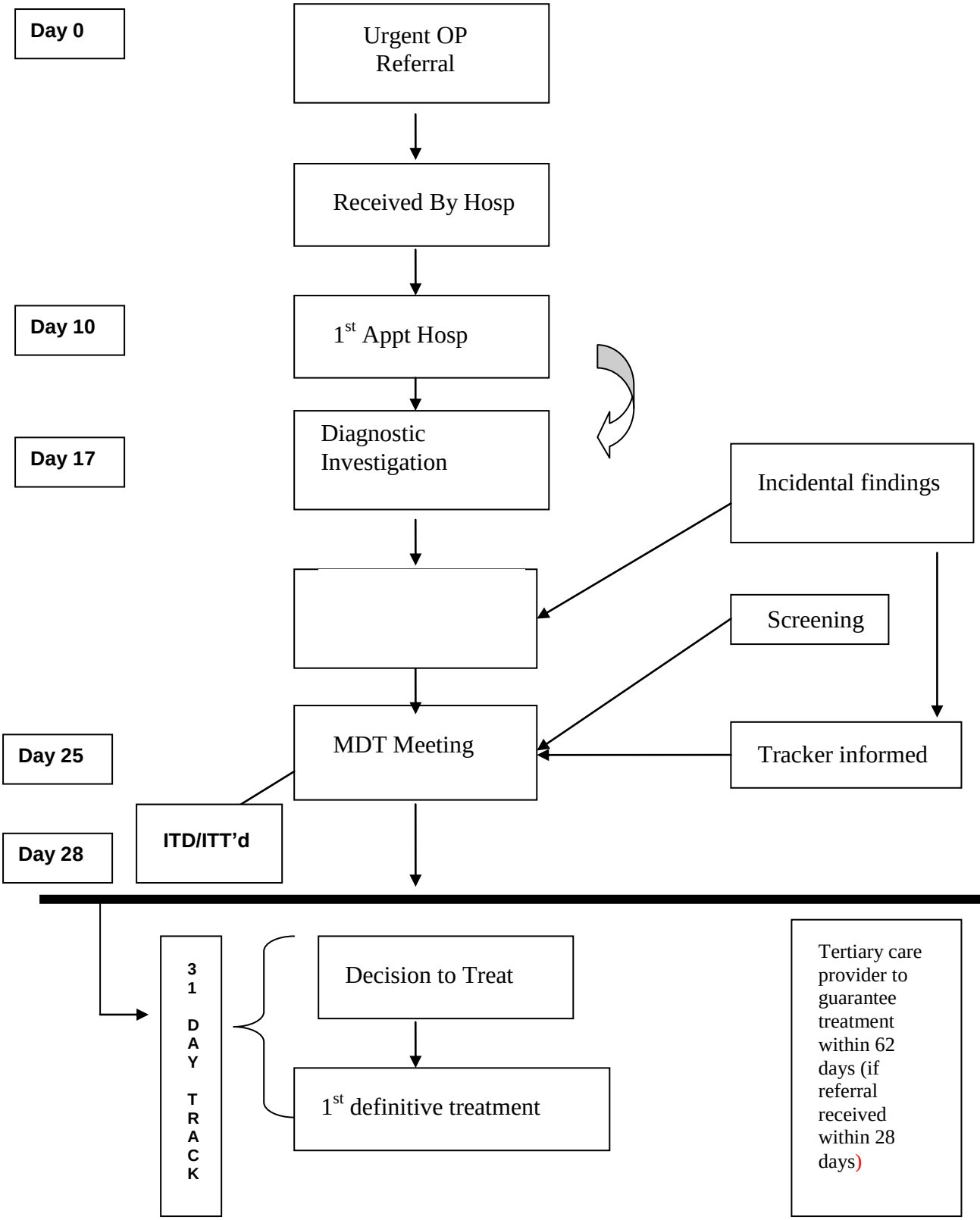
A copy of the breach report will be forwarded to the relevant Assistant Director, and the team's Clinical lead for action as appropriate.

Monthly breaches by tumour site will be discussed at the Cancer Monthly Performance Meeting and areas for improvement analysed.

This policy must be followed by all members of staff, in every event.
This policy is designed to ensure problems are resolved at the lowest level, but that an Executive Director is informed within 24 hours of any failure of the system that has not been resolved at lower organisational/divisional levels.

Appendix 1

PATIENT PATHWAY



31 day target:
Maximum 1 month wait from decision to treat to first treatment for all cancers

62 day target:
Maximum 2 month wait from an urgent GP referral to first treatment for all cancers

Glenny, Sharon

From: Glenny, Sharon <Personal Information redacted by the USI>
Sent: 18 December 2018 11:26
To: Corrigan, Martina
Cc: McVeigh, Shauna; Graham, Vicki; Reddick, Fiona
Subject: FW: Urology escalation - Personal Information redacted by the USI

Hi Martina

Please see urology escalation below – this man is at high risk of breaching, CTU has been reported as suspicious for bladder tumour.

We will keep you updated with progress.

Sharon

From: McVeigh, Shauna
Sent: 13 December 2018 13:27
To: Glenny, Sharon
Cc: Graham, Vicki
Subject: Urology escalation - Personal Information redacted by the USI

Hi,

Please see escalation of patient that is on day 28 with no 1st appointment, he has had a CTU performed on day 12. This has been reported and is suspicious for bladder tumour. He may need a date for surgery, he has been sent to DHH for an appointment. This man could be at high risk of breaching if cancer is confirmed which is likely.

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

Day	Date	Event
0	15/11/2018	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
12	27/11/2018	CTU - REQ'D
25	10/12/2018	CT(Expected on 10/12/18) at Craigavon
26	11/12/2018	e-mailed Clare McLoughlin DHH 11/12/18 to appoint
28	13/12/2018	CTU reported - Two malignant lesions in the right kidney as described. Further frond like mass in the bladder raises possibility of a third pathology,? TCC.
28	13/12/2018	Will escalate this man to OSL as he could be at risk of breaching, he may need a TURBT from CTU findings, 1st OP to be booked.

Thanks
Shauna

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator
Ext Personal Information redacted by the USI

Glenny, Sharon

From: Dignam, Paulette <Personal Information redacted by the USI>
Sent: 19 September 2019 11:06
To: Corrigan, Martina; Young, Michael
Cc: Glenny, Sharon; Reddick, Fiona; Clayton, Wendy; Conway, Barry; Carroll, Ronan; Graham, Vicki
Subject: RE: Urology escalation - Personal Information redacted by the USI

Mr Young is going to do on emergency list next Friday 27.09.19

Many thanks
Paulette

From: Corrigan, Martina
Sent: 10 September 2019 07:44
To: Young, Michael; Dignam, Paulette
Cc: Glenny, Sharon; Reddick, Fiona; Clayton, Wendy; Conway, Barry; Carroll, Ronan; Graham, Vicki
Subject: RE: Urology escalation - Personal Information redacted by the USI

Good morning

Can you please advise of planned date? And if no availability are you happy for me to share with the Team to see if anyone has anything sooner?

Regards

Martina

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

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

From: Graham, Vicki
Sent: 04 September 2019 16:25
To: Corrigan, Martina
Cc: Glenny, Sharon; Reddick, Fiona; Clayton, Wendy; Conway, Barry; Carroll, Ronan
Subject: FW: Urology escalation - Personal Information redacted by the USI
Importance: High

Hi Martina,

Please see below patient who is a confirmed cancer who is on Day 63. First appointment was on Day 57 and patient was added to Mr Young's W/L for TURBT. Any assistance securing a date for surgery would be greatly appreciated.

I will keep you updated as patient continues on RF pathway.

Regards

Vicki

From: McVeigh, Shauna
Sent: 04 September 2019 16:14
To: Graham, Vicki
Subject: Urology escalation - Personal Information redacted by the USI

Hi,

Please see escalation of patient that is a confirmed cancer and is on day 63 of her pathway, delay with 1st OP she was on seen on day 57. She has been added to Mr Young's WL for a TURBT, date to be defined, only added to WL on 29.08.19. This lady will breach her pathway.

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

Day	Date	Event
0	03/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
37	09/08/2019	FIRST RF APT-29.08.19. LETTER SENT. PT TO CONFIRM. DAY-57. ESCALATED TO ANGELA.
57	29/08/2019	First Seen at Craigavon
63	04/09/2019	Clinic outcome - I did a flexible cystoscopy today to further investigate her haematuria and this revealed small TCC around her right UO. Certainly this needs a TURBT and I?ve booked her for this accordingly as a red flag
63	04/09/2019	Will escalate this lady to OSL as she will be a breach. On MY WL for a TURBT.

Thanks
Shauna

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator
Ext Personal Information redacted by the

Glenny, Sharon

From: Muldrew, Angela <Personal Information redacted by the USI>
Sent: 26 January 2022 16:46
To: Clayton, Wendy; Carroll, Ronan; Scott, Jane M
Cc: Conway, Barry; Quin, Clair; Glenny, Sharon; McVeigh, Shauna; Glackin, Anthony; Haynes, Mark; Khan, Nasir; ODonoghue, JohnP; Omer, Shawgi; Tyson, Matthew; Young, Michael
Subject: RE: Urology escalations

Thanks Wendy

Shauna – could you put a note on CaPPS please. Thank you

Angela Muldrew
MDT Administrator & Projects Officer
Cancer Services
Tel No. Personal Information redacted by the USI

From: Clayton, Wendy <Personal Information redacted by the USI>
Sent: 26 January 2022 16:45
To: Muldrew, Angela <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>; Scott, Jane M <Personal Information redacted by the USI>
Cc: Conway, Barry <Personal Information redacted by the USI>; Quin, Clair <Personal Information redacted by the USI>; Glenny, Sharon <Personal Information redacted by the USI>; McVeigh, Shauna <Personal Information redacted by the USI>; Glackin, Anthony <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; Khan, Nasir <Personal Information redacted by the USI>; ODonoghue, JohnP <Personal Information redacted by the USI>; Omer, Shawgi <Personal Information redacted by the USI>; Tyson, Matthew <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>
Subject: RE: Urology escalations

Thanks Angela

We have 28 red flag TURBT patients and are working through them chronologically. Patients will be scheduled in due course.

Consultants are all aware of the patients requiring to be scheduled but unfortunately demand outweighs current capacity

Regards

Wendy Clayton
Acting Head of Service for ENT, Urology, Ophthalmology & Outpatients
Ext: Personal Information redacted by the
Mob: Personal Information redacted by the USI

From: Muldrew, Angela <Personal Information redacted by the USI>
Sent: 26 January 2022 16:40
To: Clayton, Wendy <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>; Scott, Jane M <Personal Information redacted by the USI>
Cc: Conway, Barry <Personal Information redacted by the USI>; Quin, Clair <Personal Information redacted by the USI>; Glenny, Sharon <Personal Information redacted by the USI>; McVeigh, Shauna <Personal Information redacted by the USI>

Subject: Urology escalations
Importance: High

Hi

Please see below patients who are awaiting TURBT or TP biopsies.

Personal Information redacted by the USI D104 Personal Information redacted by the USI CT D12, 1ST OP D31, had flex and was added to WL for RF TURBT – date for surgery awaited.

Personal Information redacted by the USI D99 Personal Information redacted by the USI 1ST OP D41, MRI D52, added to WL for TP biopsies – await date.

Personal Information redacted by the USI D105 Personal Information redacted by the USI CT D9, 1ST OP D32, added to WL for RF TURBT – await date.

Thanks

Angela Muldrew
MDT Administrator & Projects Officer
Cancer Services
Tel No. Personal Information redacted by the USI

Glenny, Sharon

From: Lee, Sinead
Sent: 07 April 2022 14:59
To: Clayton, Wendy
Cc: Glenny, Sharon; Quin, Clair
Subject: FW: UROLOGY ESCALATIONS

Good afternoon,

Please see below Urology escalations for RF patients booked to 1st RF OPD.

As you can see our waits number has decreased due to 100 x patients being sent to 352.

Best
S

From: rf.appointment <Personal Information redacted by the USI>
Sent: 07 April 2022 12:56
To: Lee, Sinead <Personal Information redacted by the USI>
Subject: UROLOGY ESCALATIONS

Hi Sinead,

Personal Information redacted by the USI	GP DAY 30
	GP DAY 28
	GP DAY 43 (OFFERED EARLIER APPT BUT DECLINED)
	GP DAY 28
	GP DAY 30
	OC DAY 27
	GP DAY 29
	GP DAY 26
	GP DAY 26
	GP DAY 24
	GP Day 26
	GP Day 26
	GP Day 26

Thank you

Ann

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

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Band 7 **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? N/A

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? Post Outlines can be accessed via Trust Intranet (KSF link) **YES** [x] **NO** [ ] **Have Post Outline levels been achieved:** **YES** [x] **NO** [ ] **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** • Played a key role in delivery of SBA performance and access targets for IMWH & CCS • Developed trajectories and plans to support under/over performance on SBA, as well as recovery of position as required • Supported AD and HOS in all aspects of performance management, out-patients, elective, OPwP, diagnostics, DRTT and cancer performance • Member of the antenatal pathway change project and led on all capacity/demand modelling, as well as clinic development and changes • Brought stability to the admin teams within IMWH & CCS, despite challenging recruitment difficulties, in order to ensure the admin teams were able to support the wider team appropriately.
Objectives for Next Year: • Continue to play key role in the delivery of performance for the Division throughout the year, escalating areas of concern and making plans to address areas of under-performance. • Maintain the stability of the admin team within the Division, improving skills of the team where possible and ensuring all staff have had KSF/PDP reviews timely • Provide expertise and knowledge and actively participate in ongoing changes and projects within the Division.	**Line Manager's Feedback on staff members performance over past year:** Personal Information redacted by USI

Reviewee Staff Name (Print) SHARON GLENNY Signature Personal Information redacted by USI Date 25/06/2018

Reviewer Manager/Supervisor (Print) HEATHER TROUTON Signature Personal Information redacted by USI Date 25/6/18

HSC Southern Health and Social Care Trust
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Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: [redacted]

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	N/A	
	Departmental Induction/Orientation	N/A	
	Fire Safety	10/05/2018	Review 10/05/2019
	Record Keeping/Data Protection/Information Governance	07/12/2015	Review 07/12/2018
	Moving and Handling	10/05/2018	Review 10/05/2021
Corporate Mandatory Training ROLE SPECIFIC	Infection Prevention Control	10/05/2018	Review 10/05/2020
	Safeguarding People, Children & Vulnerable Adults	22/03/2017	Review 22/03/2020
	Waste Management	10/05/2018	Review 09/05/2020
	Right Patient, Right Blood (Theory/Competency)	N/A	
	Control of Substances Hazardous to Health (COSHH)	10/05/2018	Review 09/05/2020
	Food Safety	N/A	
	Basic ICT	N/A	
	MAPA (level 3 or 4)	N/A	
Essential for Post	Professional Registration	N/A	
	Data Quality	12/04/16	
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)	SHSCT Display Screen Equipment Programme	10/05/2018	
	SHSCT ICT Security	10/05/2018	
	SHSCT Recruitment & Selection Refresher	10/05/2018	
	SHSCT Fraud Awareness	10/05/2018	
	SHSCT Code of Practice on Protecting the Confidentiality of Service User Information	10/05/2018	

Reviewee Staff Name (Print) SHARON GLENNY Signature [redacted] Date 25/06/2018

Reviewer Manager/Supervisor (Print) HEATHER TROUTON Signature [redacted] Date 25/6/18

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: [redacted]

Southern Health and Social Care Trust

Quality Care - for you, with you

Performance and Personal Development Review Policy Based on the Knowledge and Skills Framework (KSF)

Lead Policy Author & Job Title:	Anne Forsythe, Head of Workforce & Organisational Development
Directorate responsible for document:	HR & Organisational Development
Issue Date:	16 May 2019
Review Date:	09 October 2021
Reviewed On:	18 May 2021
Next Review Date:	17 May 2023

Working together Excellence Openness & Honesty Compassion

Policy Checklist

Policy name:	Performance and Personal Development Review Policy
Lead Policy Author & Job Title:	Anne Forsythe, Head of Workforce & Organisational Development)
Director responsible for Policy:	Vivienne Toal
Directorate responsible for Policy:	HR & Organisational Development
Equality Screened by:	Heather Clyde, Vocational Workforce and Assessment Centre
Trade Union consultation?	Yes ☒ No ☐
Policy Implementation Plan included?	Yes ☒ No ☐
Date approved by Policy Scrutiny Committee:	09 October 2018
Date approved by SMT:	N/A
Policy circulated to:	All Heads of Service/Department and Line Managers
Policy uploaded to:	Placed on Intranet and SharePoint

Version Control

Version:	Version 4.0
Supersedes:	Legacy Policies for Craigavon and Banbridge, Craigavon Area Hospital, Newry & Mourne, and Armagh & Dungannon Trusts

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
Version 1.0	Contact Details, Introduction to Policy 1:7, Appendix 2 Revalidation incorporated.	01/12/2008	Assistant Director Human Resources / ELD – Mrs Heather Ellis
Version 2.0	Contact Details, Appendix 2 Revalidation Form Removed	22/03/2016	Director Human Resources Mrs Vivienne Toal
Version 3.0	Hyperlinks added at 3.8 and 3.12 and 8.0. Differentiation between Supervision and Appraisal added at 5.1. KSF PDP Form updated (Appendix 1). Contacted details updated (Appendix 3). 9.4 change in wording due to UK leaving EU – becomes - UK General Data Protection Regulations (UK GDPR) 2018.	15/02/2021	Anne Forsythe, Head of Workforce & Organisational Development

Contents

Appendices

1.0 Introduction

1.1 The Southern Health and Social Care Trust (hereafter referred to as "the Trust") is committed to ensuring that robust corporate governance arrangements are in place in the operation of its business.

1.2 The Trust is committed to performance review and personal development and regards this as an important component of the Trust's governance process. It contributes towards organisation and service development and provides opportunities for each of member of staff to develop their potential.

1.3 The Trust will ensure that each member of staff knows what is expected of them including standards of conduct and performance required of them, this will be done through personal feedback from their line manager and set in the context of objective setting and review.

1.4 In support of this, the performance review and personal development documentation has been based on the NHS Knowledge and Skills Framework (KSF). KSF defines and describes the knowledge and skills that Health and Social Care staff need to apply in order to deliver quality services. It provides a single consistent, comprehensive and explicit framework on which to base performance review and personal development for staff. KSF is used to develop outlines for individual jobs. These outlines provide links to gateways for pay progression.

1.5 As part of this process, Continued Professional Development (CPD) will be discussed. Each individual profession will have their own requirements for this and reference should be made to these guidelines as appropriate.

1.6 The Trust is committed to supporting staff in their CPD and expects all qualified staff to undertake the necessary amount/levels of CPD as required by their profession. CPD is a personal commitment to keeping your personal professional knowledge up to date and improving your capabilities throughout your working life. It is about knowing where you are today, where you want to be in the future and making sure you have formulated a direction in association with your line manager in order to help you get there.

1.7 Also with reference to management standards Health & Social Care in Northern Ireland have adopted The Healthcare Leadership Model which has been developed by the NHS Leadership Academy. It is an evidenced based research model that reflects the values of the NHS. It comprises of nine dimensions and the model provides NHS staff with a means of analysing their leadership roles and responsibilities.

1.8 Other agreed competency frameworks may also be used for reference.

2.0 Purpose and Aims

2.1 The Southern Trust, through this policy ensures that staff have a strong and effective performance review and personal development which has a very positive effect on the individual's performance, their development and that of the organisation and can therefore contribute greatly to the improvement and development of the services the Trust provides for its patients and clients.

2.2 Recognise achievements and provide help in overcoming obstacles to successful performance.

2.3 Through this policy the Trust will ensure the roll out of performance review and personal development using the KSF Framework across the organisation.

2.4 The Trust will ensure that all staff are clear about their responsibilities for staff development.

2.5 Provide the basis for future training and workforce development strategies and plans.

2.6 Encourage the development of a flexible learning culture across the organisation.

3.0 Objectives of this Policy

3.1 The process of performance review and personal development process begins with a focus on the review of an individual's work in relation to individual service and organisational objectives. This provides an opportunity to receive feedback from the line manager on work performance, ways in which performance can be sustained or improved, and have these laid out in the form of agreed objectives.

3.2 Discussion should be honest, open and positive. An individual's strengths, successes and contribution to the service should be recognised explicitly alongside a consideration of areas in which they might need to develop or improve.

3.3 The framework provided in the documentation should be jointly considered. This should structure the discussion, enabling both parties to prepare for and contribute to the process - Appendix 1.

3.4 A set of agreed objectives will be formulated from this discussion between the member of staff and the line manager. The action points supporting these objectives should be written using the SMARTER criteria (Specific, Measurable, Achievable, Relevant, Time-bound, Evaluated and Repeated).

3.5 The individual's objectives should reflect those of the Organisation, Directorate and Team. Where improvement is not required objectives may focus upon both maintenance and innovation.

3.6 The personal development review element of performance review focuses upon reviewing an individual's skills, knowledge and experience, and how they are applied in relation to the requirements of their post using the KSF outline. Training and development needs are identified; ways in which these needs can be

addressed are discussed and set out in the form of a Personal Development Plan (PDP).

3.7 Development review is a cyclical process that comprises of four stages:-

- A joint review between the individual and their line manager (or another person acting in that capacity) of the individual's work against the demands of their post, as set out in the KSF outline for that post.

- The formulation of an agreed PDP that identifies the individual's learning and development needs and interests.

- Learning and development by the individual, supported by their manager.

- Evaluation of the learning & development that has occurred and how the individual has applied it in their work.

3.8 Outlines developed for posts within the Trust are available from the Knowledge and Skills Framework link on share-point, (click here). It is only these outlines that should be used in the performance review. These outlines will be reviewed and further developed and are therefore liable to alteration. It is the responsibility of both parties to obtain the relevant and up to date outline as part of the preparation for a performance review. However, in the event of an outline not being available the KSF team within the Vocational Workforce Assessment Centre (VWAC) should be contacted for guidance (see Appendix 2).

3.9 The performance review evaluates the individual's application of knowledge and skills in their work, using the KSF outline for the post as the basis for the discussion. Demonstrable knowledge and skills evident in a person's work will be considered in relation to all the dimensions included in the outline.

3.10 A Personal Development Plan (PDP) is formulated from this performance review. This identifies the areas an individual needs to demonstrate more fully and the help they need to develop in order to achieve the required level for their post.

3.11 The PDP will focus initially upon enabling an individual to meet the demands of their current post as described in the KSF outline. Once this has been achieved a PDP should enable an individual to maintain their knowledge and skills; developing them to meet any changing requirements, and facilitate an individual's further development within or beyond their current post, considering both individual and organisation needs and aspirations.

3.12 PDP's need to be completed annually. Line Managers should record completion of a PDP directly on HRPTS (click here for guidance). Alternatively, completed PDP's can be forwarded to the Vocational Workforce Assessment Centre to be recorded centrally. .

3.13 Managers are required to monitor that the above policy is implemented and that regular follow up is in place to ensure performance review is completed for all staff groups. The policy will be monitored Trust Wide by the Vocational Workforce Assessment Centre. KSF reports are compiled on a regular basis and forwarded to

Directors. KSF is a standing item on the agenda of Senior Management Team (SMT) meetings.

4.0 Policy Statement

The Trust has an obligation to fully implement the Agenda for Change initiative. The Trust will ensure that there are effective systems in place to support the appraisal process and include ensuring that all supervisors have the appropriate knowledge and skills to completely undertake this role.

5.0 Scope of Policy

This policy applies to all permanent staff and those on a fixed term contract and long term agency staff (6 months) other than Medical, Dental staff, and Directors for which there are separate arrangements.

5.1 It is important to differentiate between supervision and appraisal. Whilst Supervision activities should inform, and are informed by, the KSF PDR process, neither activity should be substituted for the other, as each activity has a different purpose.

6.0 Responsibilities

In the Southern Trust there are key individuals with responsibility for ensuring KSF PDR process is implemented.

6.1 Chief Executive

The Chief Executive has overall responsibility and accountability for the quality of service provision. Appraisal plays an important role in ensuring the delivery of high quality, safe and effective care.

6.2 Directors

All Directors have responsibility for ensuring that arrangements are in place to implement and ensure compliance with this policy and that resources are available to support the process including that supervisors have the appropriate skills and knowledge to undertake appraisal. Directors also have responsibility to complete KSF reviews and PDP's for all those staff they manage.

6.3 Assistant Directors

Assistant Directors have responsibility for coordinating and facilitating implementation of the KSF process. They are responsible for agreeing the models to be employed within their area of responsibility and must ensure that appropriate resources are in place to meet the requirements of this policy. They are responsible for monitoring the level and quality of activity and supporting operational and professional Heads of Services and managers in the implementation of this policy. They also have responsibility to carryout KSF reviews and PDP's for all staff they manage.