Recommendation 11
Operations should, if possible, not last longer than 60 minutes. Theatre teams **must** have an established mechanism for measuring time and procedures for alerting surgeon and anaesthetist.

4.2.5 Theatre environment

A good theatre environment in terms of team dynamics is essential for the safe performance of these surgical procedures. There must be careful monitoring of fluid balance along with the clear communication of that balance to the surgical and anaesthetic members of the team.

- Theatre staff must always be aware of the potential hazards of, and equipment used, for any surgical procedure before it is performed.
- One core member of the theatre team must be assigned to the duty of gathering together the information needed to ensure the whole theatre team are aware of the distending fluid input & output and the deficit. They will need to be proficient and practiced in this technique and must not have other duties to perform while monitoring fluid balance. It would not be expected that the surgeon should have to operate and also supervise this function at the same time. They should remain in theatre for the duration of the procedure, in the same fashion as the surgeon.
- Medical staff must always have situational knowledge of the theatre environment that they are working in and the availability (or non-availability) of any theatre equipment they consider necessary. They must be informed, in good time, of any equipment that is not working.
- Nursing staff should have a working knowledge of any equipment being used in their theatre or have the immediate presence of technical staff who do have that knowledge.

4.2.6 WHO checklist

Completion of the WHO surgical checklist with the sign in, time out and sign out must be adhered to. This will allow a surgical, anaesthetic and theatre team brief at the beginning for the whole theatre team and an opportunity to check that everything is in place to perform the biochemical and volumetric monitoring, to agree fluid absorption volume limits and should include any discussion of limiting intravenous fluids intraoperatively.

It will also ensure at the sign out that any problems e.g. over a fluid deficit, are identified early. On a regional basis, adoption of a modified WHO checklist for this kind of procedure should be investigated and piloted.

Recommendation 12
Completion of the standard WHO surgical checklist **must** be adhered to. Adoption of a modified WHO checklist for this kind of procedure should be investigated and piloted.

5.0 IMPLEMENTATION OF POLICY

This policy, after it is agreed, is to be implemented throughout NI in each of the 5 Trusts.

5.1 Resources

There will be resource implications in terms providing surgical equipment that can be used without needing glycine as an irrigant, fluid flow and pressure controllers and POCT monitoring equipment for theatres and training for staff.

6.0 MONITORING

Trust audit departments will need to monitor that the recommendations are implemented.

7.0 EVIDENCE BASE / REFERENCES

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8.0 CONSULTATION PROCESS

Consulted through the Medical Leaders Forum, DHSSPSNI, and via the Medical Directors, Directors of Nursing and Regional Urologists, Gynaecologists and Anaesthetists.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 = Suggested peri-operative theatre record form template.

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☐

SIGNATORIES

_____ **Date:** _____

Author

_____ **Date:** _____

Author

_____ **Date:** _____

Director

Insert Trust LOGO

Peri-operative fluid recording chart

Date: _____
Surgeon: _____
Anaesthetist: _____
Team Leader: _____
Circulating Nurse 1: _____
Circulating Nurse 2: _____

Addressograph Label

Fluid recorder: _____ Operation: _____

Fluid Medium: 3L 1.5% Glycine: ☐ 0.9% NaCl: ☐ Warmed: ☐

Bag Height: _____ mmHg ☐ (60 cms ≡ 50mmhg)

Preop. Serum Sodium: = _____ mmol/L Haemoglobin: _____ g/dL.

Resection: Start Time: _____:_____ Operation Finish Time: _____:_____

Irrigation fluid: Start time: _____:_____ **= 0 mins.**

Time (min)	Irrigation In	Irrigation Out	Irrigation Deficit	Running Deficit	Serum Sodium	Surg. informed	Anaes. informed	Sign
5	mls	mls	mls	mls	mmol/L			
10	mls	mls	mls	mls	mmol/L			
15	mls	mls	mls	mls	mmol/L			
20	mls	mls	mls	mls	mmol/L			
25	mls	mls	mls	mls	mmol/L			
30	mls	mls	mls	mls	mmol/L			
35	mls	mls	mls	mls	mmol/L			
40	mls	mls	mls	mls	mmol/L			
45	mls	mls	mls	mls	mmol/L			
50	mls	mls	mls	mls	mmol/L			
55	mls	mls	mls	mls	mmol/L			
60	mls	mls	mls	mls	mmol/L			
	mls	mls	mls	mls	mmol/L			
	mls	mls	mls	mls	mmol/L			

Total Fluid In =	mls	Surgeon Signature	
Total Fluid Out =	mls	Anaesthetist Signature	
Total Deficit =	mls	Nurse Signature	
		Recovery Staff Signature	

Insert Trust LOGO

Continued.

Time (mins)	Irrigation In	Irrigation Out	Deficit	Running deficit	Serum Sodium	Surg. informed	Anaes. informed	Sign
	mls	mls	mls	mls	mmol/L			
	mls	mls	mls	mls	mmol/L			
	mls	mls	mls	mls	mmol/L			
	mls	mls	mls	mls	mmol/L			
	mls	mls	mls	mls	mmol/L			
	mls	mls	mls	mls	mmol/L			
	mls	mls	mls	mls	mmol/L			
	mls	mls	mls	mls	mmol/L			
	mls	mls	mls	mls	mmol/L			

Irrigation In	Document number of mls after each fluid bag is emptied. Record amount 'in' each time use Ellick evacuator.
Irrigation Out	Record fluid in • suction canisters. • fluid in drapes. • fluid from floor suction. Record amount 'out' each time use Ellick evacuator.
Deficit	Calculate deficit or record from pump readout.
Serum Sodium	Ensure there is a Serum Sodium measurement within one bold bordered box if procedure longer than 30 mins.

Glycine		
Volume Absorbed	**Effect**	**Action**
500 mls	Limit for the Elderly : comorbidities	Continue surgery
less than 1000 mls	Well tolerated by healthy patient	Continue Surgery
greater than 1000 mls	Mild hyponatraemia	Complete surgery ASAP
1500 mls	**Severe hyponatraemia & other biochemical disturbances likely**	**Stop Surgery**
Normal Saline		
2000 mls	Limit in the healthy	Complete surgery ASAP

Public Health Agency

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Belfast
BT2 8BS

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www.publichealth.hscni.net

HSC Trust Medical Directors:-
Belfast Health and Social Care Trust
South Eastern Health and Social Care Trust
Southern Health and Social Care Trust
Northern Health and Social Care Trust
Western Health and Social Care Trust

17th September 2015

Dear Colleagues

Re: Progress on HSS(MD) 14/2015
Policy on the Surgical Management of Endoscopic Tissue Reaction

The DHSSPS wrote to your Trust (letter attached for ease of reference) requiring that :-

- The Trust should endorse the policy
- The Trust should develop action plans to implement the policy

I would ask that you provide an update on progress within your Trust by 31st October 2015.

This will facilitate progressing any issues which require input from HSCB/PHA and to enable the PHA to report to the DHSSPS by 30th November 2015.

Yours sincerely

Dr Janet Little

Assistant Director of Service Development & Screening

CC Lynn Charlton, Margaret McNally

Improving Your Health and Wellbeing

DEPARTMENTAL MEETING 22nd SEPTEMBER 2016

Chair: Mr Young

Present: Mr Glackin, Mr O'Brien, Mr Suresh, Mr O'Donoghue, Pamela Johnston, Theatre Manager & Sr. England

Apologies: Mr Haynes , Mrs Corrigan

TOPIC: SALINE RESECTION

The specifications for the saline resectoscope system were presented. Mr Young outlined the history behind the move to the saline resection, also explaining that the last year had been spent trialling the various resectoscopes. Mr Young asked the forum if they had regarded enough time had been given to each of the resectoscope providing companies so that an adequate assessment could be made for each of the scopes. The unanimous decision was that the trial period for each of the resectoscopes was adequate to make an opinion.

We all agreed that the appraisal form used was of a good standard and certainly adequate to make a surgeons' assessment of each scope. The overall assessment looked at scope quality, ease of use, product design and effectiveness of the core principal of diathermy and resection of tissue. Second component to be evaluated were costs of generators and disposables. Thirdly was the topic of CSSD and backup. Scoring was undertaken from the feedback forms with the result that the WOLF system was the poorest and was not fit for purchase. In third place was the TONTARRA system which was described as having a variable performance with regards to the resection loop activity. The STORZ and the OLYMPUS system scored virtually equally on the various points with an overall equal score. It was recorded that there was no cystoscope present on the OLYMPUS resectoscope tray for evaluation but we generally felt that this was not an issue to take into account. There was general record of a fairly good ease of use and that the vaporisation module component was good. Several negative points related to the working element of inflow/outflow not being ideal; there were some comments on excessive bubble formation on the resectoscope loop as well as some other comments relating to slow resection. Overall however this was a system that could be purchased. With regards to the STORZS system, it was felt that the cutting modality of the resectoscope loop was excellent. Overall the scope components were easily constructed and there was a generalised good ease of use. Comments with regards to consistency and haemostasis had been positive. One of the major points in its favour was that the STORZ system could be easily changed if required on an urgent basis to the use of glycine. This in the current climate of change from one system to another in association with the range of urologists within the unit was a more suitable system for the team in Craigavon Area Hospital. The STORZ system certainly was a system that could be purchased.

Purely on the ease of use principal, excluding other criteria (i.e. cost and CSSD), the option came down to either STORZ or the OLYMPUS system, the other two being excluded. Four surgeons voted for the STORZ, one electing for the OLYMPUS. Mr Haynes was not present for this vote but on subsequent conversation later in the day, Mr Young put the same question to Mr Haynes asking for his comments on ease of use and again he had no particular preference and was happy to run with the global opinion.

On reviewing the various costs, it was noted that the disposables did have a variable range. It was accepted that loop quality did vary and that loops could be purchased from different sources. We all felt that this was not a particularly focused point for making a decision (namely cost of loop).

The price of the individual resectoscope systems was recorded noting that the OLYMPUS system was significantly more expensive in totality. The OLYMPUS system would have to be purchased completely whereas the STORZ system could be involve both new scopes and modification of current sets. (The costs set out for this meeting were significantly in favour of the STORZ system but it was appreciated that if a STORZ completely new systems was to be included that this information was to be presented to the forum before a final decision was made).

A further significant contributor to decision making was the generator needed for the electrical input. Although the OLYMPUS company was going to offer a free £40,000 generator, we did record that we may need up to three generators in view of the amount of urology sessions occurring at the same time. (The forum did not know if the company would supply three free generators. They felt it unlikely but enquiries would be made). The current generator system available within the Trust is multifunctional and therefore would already suit the STORZ system more appropriately. Even with the OLYMPUS generator system, this would result in increased machinery parking within the theatre environment. Overall this was regarded as a fairly substantive pointer in favour of the STORZ system.

CONCLUSION

In concluding, the vote on several aspects namely ease of use, cost, generator type were all in favour of the STORZ system. All the urologists have backed this decision with a unanimous vote.

This decision was based on the information supplied with a final decision pending the outstanding enquiries, namely the cost of a completely new STORZ resectoscope system and the cost of the OLYMPUS cystoscope. This would give a truly like for like comparison. The additional enquiry related to the OLYMPUS generator issue.

Mr Young will add an addendum to this document when the above information becomes available before final sign off.

The paperwork with regards to this has been forwarded to the Service Administrator, Martina Corrigan and to Pamela Johnston, Theatre Manager.

M Young
22nd September 2016
Chair of Session

ADDENDUDEM to outstanding information in relation to Saline resection Systems

1/ Full cost specification for STORZ and OLYMPUS resectoscope systems (excluding generator) have now been supplied and presented by the Theatre management. This is included on the updated evaluation sheet. (see enclose document)

(*The conclusion of the forum group remains the same – namely that STORZ is less expensive*)

2/ OLYMPUS will only supply one free generator

This information is to be presented at the next Departmental meeting for ratification

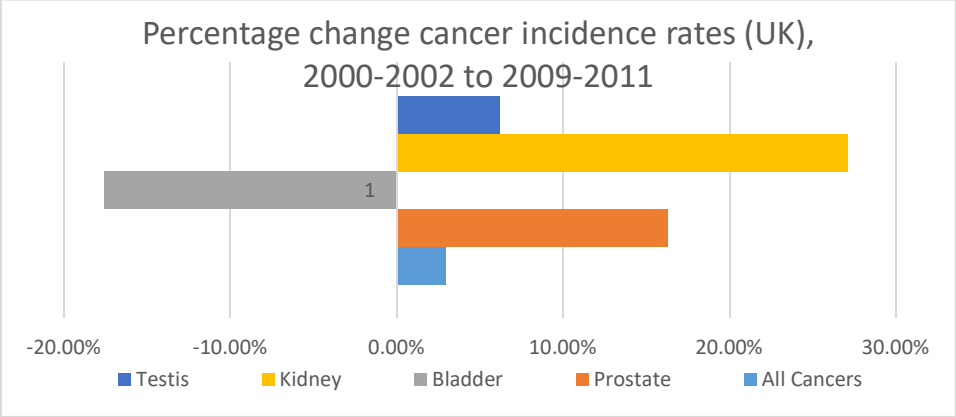
M Young

12th October 2016

Background

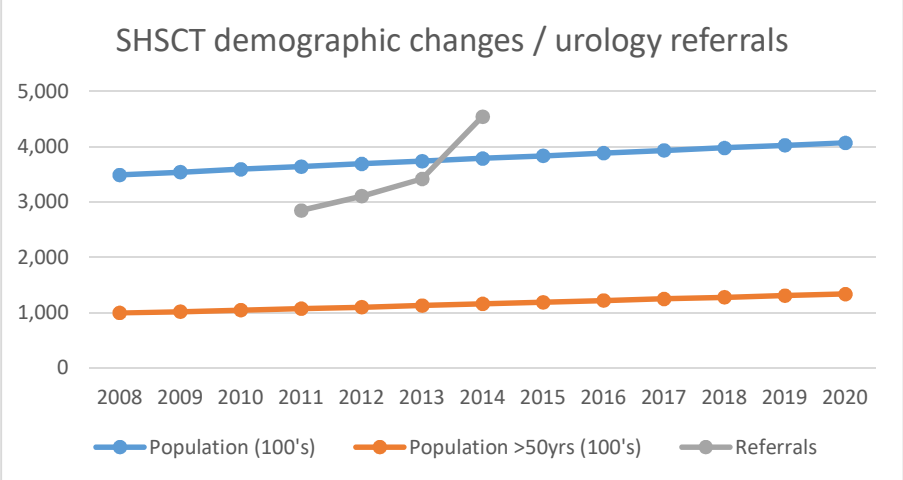
One of the biggest challenges facing the NHS is matching capacity to demand. Demand for secondary and tertiary healthcare services is rising faster than would be expected from population demographic change alone and is driven by a combination of this demographic change, increases in disease incidence, increases in available interventions, increased patient awareness and expectations and capacity constraints of primary care services.

Within urology the incidence rates of disease are rising. Published data is available regarding incidence rates of cancers. The table below shows percentage changes in incidence of the 20 most common cancer in the UK.



Corresponding figures for Northern Ireland are an increase in prostate cancer incidence of 39.9% (UK figure 16%), kidney cancer incidence of 31.4% (UK figure 27%), testes cancer incidence of 6.5% (UK figure 6.2%) and a reduction in bladder cancer incidence of 3.4% (UK figure -18%). These changes in incidence rate equate in increases in case numbers across Northern Ireland of 67.4%, 57.1%, 12.5% and 11.4% for prostate cancer, kidney cancer, bladder cancer and testes cancer respectively over the same time period. A similar pattern would be observed for benign disease but this incidence data is not as readily available as cancer incidence statistics.

Looking specifically at SHSCT, the graph below shows population demographics vs Urology outpatients referrals (nb the demographics information does not include Fermanagh which is part of the SHSCT Urology catchment). The incorporation of Fermanagh (65000 population, 17% rise in population served) into SHSCT urology catchment accounts for some of the big increase seen in 2014, prior to this year on year referral increases were at approximately 10% per year.



The result of this increasing demand for urological services in SHSCT and across the NI Healthcare system is that patients are waiting too long for their care. The SHSCT urology service received 4541 outpatient referrals between 1st July 2013 and 30th June 2014 while over the same time period 2557 of these new referrals were seen. Consultant numbers have now increased which has increased the available clinics to see new patients (to a maximum of 4100) but this does not meet demand or the expected 10% increase in demand in 2014-2015. Additionally, in order to maximise theatre utilisation above the profiled 41 weeks, SHSCT urology has cross covered theatre lists such that the profile currently being utilised runs at 47 weeks and as a result dropped some outpatient activity. This has meant that while there were 2262 available new outpatient appointments based on a 41 week profile, 1935 were actually delivered (this is based on capacity delivered for the full year and does not include sessions delivered by members of the team who started or left during this 12 month period, 622 new outpatients were seen over this period by these additional members of the team). For Inpatient / Day Case surgery an average of 140 hours of operating per month over the last twelve months has been listed for theatre within a capacity of 120 hours of operating per week. The result of this demand vs capacity mismatch is a growing waiting list across every aspect of our service, the current waiting lists are;

- New outpatients – 1586 (1250 > 9 weeks, 880 > 15 weeks)
- Follow-up outpatients – 3385 (longest waiter due OP review Feb 2011)
- Inpatient / day case surgery – 973 (115 > 52 weeks)
- Flexible cystoscopy – 185 (includes planned patients)
- Urodynamics – 117 (80 > 9weeks)

In light of this SHSCT urology has worked towards creating a vision for delivery of urological services which;

- Delivers a sustainable service.
- Is based on efficient models of care.
- Maximises available capacity.
- Maintains acceptable, equitable waiting times.
- Incorporates planning for delivery of increasing demand.
- Identifies what additional resource is required to deliver this service.
- Identifies risks which pose a threat to delivery of the vision.

Experience of previous attempts to tackle the demand vs capacity mismatch are that focus on one or two elements has resulted in short term improvement and subsequent return to the previous situation. We agreed therefore that in order to deliver this vision we would re-examine the entire urology service and redesign the entire process. For each aspect of the patient pathway we posed the question ‘what can be done differently to reduce our consultant capacity requirement?’. The output from this can be split into three aspects, demand management, capacity planning and management and service delivery which will be discussed in further detail.

1. Demand management

This is a key element in delivering a sustainable service, with the focus being an increase in primary care investigation and management prior to referral into secondary care. To assess the possible impact of managing demand a sample of routine outpatient referrals were reviewed and from these, with expectations for primary care investigation and management prior to urological referral approximately 50% of these referrals could have been avoided. The overall impact of demand management would be expected to be less than 50% as this review did not include urgent or red flag referrals, also some of these patients that did not require referral at that point will require referral after completion of additional investigation / management in primary care. A suggested reasonable expectation for demand management would be a reduction in referrals of 20%.

Existing referral systems that are utilised within NI primary care have been explored. The central vision for referrals into secondary care is to move to all referrals occurring electronically via the CCG. This Gateway provides a standardised referral form providing key demographic information and with a free text section for clinical information. From a demand management perspective, key limitations of this gateway is an absence of any mandatory, condition specific requirements for referral with the 'gateway' acting effectively as an open door; GPs can refer any patient to secondary care without any expectation placed upon them of initial management, investigation or provision of clinical information. A number of different demand management interventions have been utilised in other areas of the NHS. Many of these have been led by primary care and have resulted in an initial fall in referral numbers and this has been followed by a return to previous referral levels – referrals have been delayed rather than prevented. In order to be successful and sustained we believe demand management systems require;

- To be led by Secondary care.
- Simple safe guidance for primary care management and investigation.
- Timely primary care access to necessary investigations (eg radiology).
- Mandated clinical information at referral specific to each condition.
- Effective policing of referrals and rejection of those that do not meet mandated requirements.

The ideal demand management process would therefore consist of comprehensive guidance for primary care investigation and management of urological conditions which is readily accessible, simple to use and written by the secondary care team. The referral itself needs to include specified mandatory information, specific to the condition being referred for. The referrals need to be reviewed against the mandated requirements and returned to the referrer if they do not meet the requirements. Alongside this there is a requirement for secondary care to provide primary care access to the diagnostic investigations specified in the guidance for primary care management and investigation and a need for access for advice from secondary care without generating a secondary care referral. All of these requirements could be met by a comprehensive electronic referral process with dynamic forms which mandate provision of specific information and do not allow referral without provision of this information. Design of these forms could be such that they are simple to use (from a primary care perspective) and indeed could cover all specialities from an initial entry point (first question could be 'what speciality do you wish to refer the patient to?' which would then lead to subsequent speciality specific questions). Incorporation of secondary care guidance would enable this electronic referral process to categorise the urgency of the referral (e.g. those that meet red flag criteria would be automatically graded as red flag). Most importantly, without completion of all specified mandatory information the electronic form could automatically reject the referral. These systems are used in other areas of the NHS and to a limited extent in specific conditions within

NI (eg post menopausal bleed clinic referral). Unfortunately this ideal is a considerable distance from being available within the NI 'gateway'. Presently referral via the electronic gateway stands at 26%, dynamic protocols are not currently developed within the software (required for dynamic forms).

Having explored the existing / available referral processes available in NI it is clear that presently we cannot move immediately to the ideal mechanism of mandated electronic referral for a number of reasons. Therefore, in order to commence a mechanism of demand management the process will need to be based upon primary care guidance and education, consultant review and triage of all referrals against the agreed primary care guidance and rejection of referrals which do not meet the specified referral criteria. Over time and with training we envisage that some of this work will be performed by clinical nurse specialists. This process will use considerable consultant time and in order to maximise efficiency of consultant time we would envisage this as a 'stop gap' measure until a suitable electronic referral process is available.

2. Service delivery Model

The service delivery model was divided into elective and emergency care with a separate model of delivery for each. Across both models specific consideration is required with regards infrastructure and staffing requirements.

Elective

The Guys model of new patient outpatient service delivery model has been considered as the preferred model of initial secondary care contact for the patient. This model delivers outpatient care such that at the end of the single visit patients are either discharged back to primary care or listed for a urological intervention. The Guys model is delivered with a capacity of 18 patients seen in a session with medical staffing at 2 consultants and a trainee. In addition to the positive service aspects of this model it also had significant positive impact on training and supervision for the SPRs. It was agreed that this model should be pursued as a basic model of outpatient service delivery. The number of these sessions required will be guided by capacity requirements (see below). There needs to be agreement in planning the patient pathways on;

- Do all patients need to be seen in OP?
  Patients referred for a vasectomy can be placed directly on a waiting list rather than coming to an outpatient clinic first.
  Patients referred from the continence team can be listed directly for urodynamics.
- What will be done before the OP visit?
  Ideally all radiological investigations should be done and available at the time of the OP visit. Each referral pathway will require consideration of how appropriate investigation will be arranged.
- What will be done at the time of the OP visit?
  Ideally all investigations required to make a treatment decision will be performed at this OP visit. For each investigation have considered what will be needed to deliver this at the time of the OP visit (ie infrastructure, equipment, staff).
- Who will be followed up?
  Ideally patients will be either discharged or listed and so follow-up requirements will be minimal. Where follow-up is required does this need to be delivered by a consultant in person? Could it be delivered by a nurse in person or over the phone? Can it be delivered by letter? For example TRUS biopsy patients with cancer on biopsy need an in person follow-up with their pathology results but do patients with negative results? Published data from Guys suggests a follow-up rate of 30%.

Specific consideration of models of care and capacity planning needs to include the requirements of active surveillance TRUS biopsies of prostate (utilise radiology provision of TRUS for this group?), TCC surveillance (protocol guided, nurse delivered?), Urodynamics (direct access following continence team referral for female LUTS?) and the specific needs of the stone service which bridges acute and elective care (ESWL capacity and delivery, stent removal).

In order to deliver the demand there needs to be considerable expansion in delivery of aspects of care by non consultant staff. Staff grade post recruitment is an issue across Northern Ireland and GPwSI models have been utilised but the experience of the trust and wider NHS is that while they provide additional capacity when posts are filled, once a post is vacated they leave a gap in service delivery and recruitment to fill again is difficult. It was agreed that the delivery of care will be broadly based upon a consultant delivered service with SPR delivery (supervised) and CNS delivery of specific aspects. In order to deliver a sustainable service there is recognition that the number of

Clinical Nurse Specialists and scope of practice needs to increase above that which is currently provided. It is recognised that at inception the model will involve consultant delivery of aspects which over time, following likely recruitment and training will become CNS delivered. This training requirement will mean that at inception the capacity of the service will be reduced but this will increase as competencies are acquired. Some aspects of service will remain consultant delivered while others will be consultant led. Examples of these are below;

Consultant Delivered (provided by medical team)	Consultant Led (provided by CNS and medical staff as a team)
New OP appointments	Flexible cystoscopy
Inpatient / Daycase surgery	Urodynamics
Acute care	Intravesical treatments
	Follow-up OP appointments
	TRUS Biopsy of prostate

Specific deficiencies in the current patient pathway with regards fitness for surgery and assessment of holistic patients' needs were identified. These create specific issues in elective list planning, worsen the waiting list position with patients not fit for anaesthetic being on the waiting list and currently result in significant utilisation of consultant time. I was agreed that for elective surgery the waiting list should only include patients deemed fit for surgery. A model was agreed whereby patients listed for elective surgery will receive an initial pre-admission assessment at the time of their listing. This will include holistic needs assessment (care needs, notice requirements, transport issues, post procedure care requirements etc) in addition to an initial anaesthetic assessment. The anaesthetic assessment will identify two groups of patient, those with no major comorbidity who are fit and able to be placed directly on the waiting list, and those who require further anaesthetic assessment and will only be placed on the waiting list when deemed fit for their planned elective surgery.

There is agreement to the creation of a pooled waiting list for common urological procedures. This would bring advantages in terms of capacity planning, delivery of equitable waiting times and off site operating (see below). It was accepted that individual patients may wish to 'opt out' of this but should be made aware that this will result in longer waiting times for their procedure and that across the team capacity for delivering procedures from this list will differ.

It was acknowledged that delivery of capacity for operating theatre centred care is a major challenge. On Craigavon Area Hospital site Inpatient theatre capacity is fixed and at a premium while the location of the day surgery unit, availability of day unit recovery beds and timing of the urology allocated sessions constrains what procedures can be delivered through day case theatres. Having calculated capacity requirements for theatres we have increased the available urology theatre sessions from from 8 per week to 12 per week. This increase has been achieved with current infrastructure by extending the working day across 3 surgical specialities and anaesthetics / nursing. This increase in theatre sessions is being worked towards for implementation at the earliest opportunity. Theatre productivity will be addressed by working with theatres in order to maximise the efficiency of these sessions, specifically addressing turnaround times, start times and ensuring

that the lists finish on time by identifying issues which directly impact on these factors (eg porter availability).

There was discussion around procedures which are currently delivered as inpatient care which could be delivered as day cases. In order to increase our scope of delivery of day unit procedures there is a requirement for infrastructure work on CAH site. An alternative that is being explored is delivery of day case urological surgery off site with Daisy Hill Hospital and South West Acute Hospital being identified as potential sites. All consultants would be happy to deliver certain procedures on these sites which would offer significant advantages to the service and bring care closer to home for patients requiring suitable procedures. There are specific requirements in order to deliver off site operating which include;

- Theatre equipment.
- Theatre and ward staff training.
- Junior doctor support both in and out of hours (although intended as day case procedures, a proportion of procedures may require subsequent overnight admission).
- Provision of consultant out of hours cover.

Non-Elective

Non elective care presents specific challenges due to variation in demand and a need for prompt access. Significant numbers of referrals for outpatients originate from accident and emergency attendances. A model of non-elective care was presented and agreed which is consultant delivered. This model would entail;

- Consultant led morning ward rounds Mon-Fri.
- Hot clinic – A&E referrals plus non-elective GP referrals which don't require inpatient admission. This will entail appropriate management and investigation of these patients with some seen in an outpatient setting and others managed remotely.
- Non-elective operating (regular 1 hour morning slot on the emergency theatre list).
- GP advice and triage of referrals (demand management).
- Consultant led afternoon ward rounds Mon-Fri (of patients who had investigations to review results and make further plans).

3. Capacity management

The Demand / Capacity calculations described below include a number of assumptions and estimates. As a result of these assumptions / estimates, although we are confident in the accuracy of the data presented, the projected capacity requirements / capacity delivery and backlog reduction may upon delivery of the service be wrong (are based upon an 80% upper confidence level therefore 20% risk of true referral numbers being higher than planned for, equally a risk of numbers being lower than planned for). Staffing numbers have been considered based upon what is required to deliver the service as described but in some cases will require recruitment and training before the full capacity can be delivered.

Demand / capacity for the urology service has been calculated based upon the preceeding 12 months demand information. Projected demand for outpatients activity has been based upon an anticipated impact of demand management of a 20% reduction in referrals alongside an expected 10% annual increase in referrals. The demand projections cover a 3 year period with capacity planned at the same level for all three years (based on current demand minus 20% (demand reduction), plus 10% each year for demand increases). This will allow for some backlog reduction during years one (backlog reduction of 17% of overall capacity) and year two (backlog reduction of 8% of overall capacity) with demand matching capacity in year three. All demand projections are based upon an upper confidence level of 80% (as recommended by the NHS institute). The demand calculations are therefore;

Current demand = 80% upper confidence limit of mean demand for April 2013 – March 2014

Projected demand Year 1 = current demand – 20% (demand management impact)

Projected demand Year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

Where projected numbers of sessions are calculated, these are based on delivery over a 41 week profile. It is recognised that as the department has worked to cross cover annual leave in order to maximise inpatient theatre utilisation over the past 12 months (resulting in a 47 week profile of theatres covered) this had meant the cancellation of a number of other sessions, most of which have been outpatients activity. The net impact of this cross cover was a loss of 232 new outpatients appointment slots across the service over a 12 month period.

Regarding inpatient / daycase theatre capacity this is calculated in a similar manner however there is no element of demand management reducing required capacity (as it is anticipated that the same numbers of patients will be listed for surgery as at present). Average theatre times for procedures undertaken over the 12 month period from July 2013 – July 2014 were obtained from TMS with an addition of a turnaround time (time between anaesthetic finishing on one case to starting on the next case). These timings were then applied to all new additions to the waiting list over this period. The capacity calculations include an anticipated 10% increase in referrals each year with capacity being set at the same level for the 3 years to allow for some backlog reduction (21% of available capacity year 1, 10% of available capacity year 2). Additional backlog reduction is expected as a result of theatre productivity / efficiency work but this has not been factored into the capacity planning. Projected capacity requirements are calculated as;

Current demand = 80% upper confidence limit of mean demand for July 2013 – July 2014

Projected demand year 1 = Current demand

Projected demand year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

New Referrals

The Data for April 2013 – March 2014 as described above is below. The capacity plan is therefore set at delivering 407 new outpatients slots per month. As described in the service delivery plan the majority of these will be seen in the new patient service modelled on the Guys clinic. A proportion will be managed via the Acute clinic by the consultant of the week. We have estimated this at 5 new referrals per day (25 per week, with the acute clinic running 50 weeks of the year as the only aspect of service running 5 days a week all year round with no service on bank holidays and weekends, resulting in 1250 being managed via this service per year). The New general outpatient clinic will therefore have an annual capacity requirement of 3634 patients per year. Based upon the guys model number of 18 appointments delivered by 2 consultants plus a trainee, modelled at 41 weeks this will require 202 of these clinics to be delivered over the year, equating to 5 clinics per week. This capacity will enable reduction in the current backlog of new referrals by 1291 patients over the first 2 years of delivery of the service.

New referrals 2013 - 2014	
April	410
May	379
June	395
July	426
August	360
September	442
October	459
November	438
December	395
January	380
February	443
March	345
Total referrals	**4872**
Monthly Mean	**406**
80% CI Upper limit	**420**
Projected Monthly Demand Year 1	**336**
Projected Monthly Demand Year 2	**370**
Projected Monthly Demand Year 3	**407**
Projected Backlog reduction (over 3 year period)	**1291**

Inpatient / Daycase Theatres

Theatre time calculations have been collated from twelve months data of waiting list additions and theatre data systems information on theatre case length (time from patient entering theatre to being in recovery), unfortunately information on turnarounds (time between patient being in recovery and next patient being in theatre) was not readily available and has been estimated at 10

min. The table below shows the monthly minutes of theatre listings over a twelve month period July 2013-2014 (including the 10 min turnaround). An additional analysis of cases that could be delivered in a daycase setting has also been performed which has demonstrated that expansion in current capacity for inpatient / daycase theatres is required for inpatient theatres with adequate current capacity within daycase theatres. As discussed in the service plan, utilisation of off site theatres is being explored. Theatre capacity will therefore be planned at 2101 hours per year which profiled over a 41 week period equates to 13 theatre lists per week. As discussed previously. Work is already underway to enable delivery of this required theatre capacity in the near future. The calculations here do not include the increase in numbers of cases listed that would be expected as a result of the increase in new patient appointments delivered. It is anticipated that this increase in numbers of patients placed on the waiting list will be met to a significant degree by theatre productivity / efficiency work. We have benchmarked our required operating minutes against theatre time requirements for a large NHS Foundation trust in England which has been through a number of cycles of theatre productivity / efficiency work. If our theatre timings are brought level with these timings this will result in a further capacity of 6 hours theatre capacity per week (based upon current timings) which we anticipate will meet this demand. However it is noted that in order to get to the benchmark timings, the Benchmark trust had been through 6 year period of multiple cycles of productivity and efficiency work and therefore there is significant risk that this productivity increase does not meet the demand increase and therefore backlog reduction is reduced. Given this significant risk, backlog reduction prediction figures have not been calculated.

	Total minutes operating listed
July	8614
Aug	8845
Sept	6792
Oct	10402
Nov	7998
Dec	7245
Jan	8145
Feb	8416
Mar	7537
Apr	8741
May	8070
June	8971
Total Minutes operating listed	**99776**
Monthly Mean Operating listed	**8315**
80% confidence upper limit	**8682**
Projected Monthly Demand Year 1	**8682**
Projected Monthly Demand Year 2	**9551**
Projected Monthly Demand Year 3	**10506**

Flexible cystoscopy

As part of the 'Guys model' of new OP consultations the haematuria and diagnostic / LUTS assessment patuients will undergo their flexible cystoscopy during their Outpatient attendance. Patients undergoing TCC surveilance flexible cystoscopies and flexible cystoscopy and removal of stent will continue to need this service otside of the 'Guys model'. Between 12 – 16 patients per month undergo a planned flexible cystoscopy (TCC surveilance). We have not got patient numbers

for flexible cystoscopy and removal of stent. For planning if we assume that half of all emergency cases get a stent that requires removing (other half have stent and subsequent further procedure) and 2 elective cases per week, this will give an estimate of 16 procedures required each month. This would mean a service need of one flexible cystoscopy list per week. The elective flexible cystoscopy service is planned to be deliverred as a consultant led service delivered by clinical nurse specialist and occuring alongside elective consultant outpatient activity.

TRUS biopsy of the prostate

As with the flexible cystoscopy service most will be provided at the time of the initial consultation. Long term it is anticipated that this will be provided by clinical nurse specialists within this clinic but this will require CNS training and recruitment. Some will not be suitable for providing through this clinic (patients on anticoagulation, active surveilance as specific examples). These will be provided within the capacity currently provided by radiology consultants. It has not been possible to obtain accurate data on these numbers and the demand / capacity for this service will require close monitoring and possible adjustment during the initial months of introduction of the service.

Urodynamics

This will not be provided as part of the 'Guys model' clinic due to time and space requirements. This investigation is planned to be a consultant led, CNS delivered service with specific consultant delivered sessions for complex clinical conditions (estimated 2 CNS delivered : 1 Consultant delivered). Our initial estimate is that we will require 3 sessions per week (9 patients). However, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

ESWL

Based upon current demand 444 treatments are required per year. The year on year increase for this service is affected by both within trust referrals and referrals from other NI trusts. We have not obtained information on the last 5 years listing numbers for this tretament in order to estimate the year on year demand increases and as such have not modeled this. We treated 276 patients in the last 12 months. The service will therefore need to deliver additional treatment sessions to meet this unmet demand. Additionally there is a requiremnt for capacity to utilise this treatment modality in the acute management of ureteric colic which is currently not available. We estimate that this service will require 3/4 sessions per week to deliver the required capacity running 50 weeks per year. Again, , this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Follow-up appointments

Estimating future follow-up capacity is extremely complex and would be based upon large numbers of assumptions / estimates. FU demand for 2013-2014 was 4994 appointments, additionally there would have been further demand if we had seen the patients currently awaiting new appointments. The change in service delivery as described will reduce demand for follow-up appointments. Additionally there is a large current backlog. We anticipate patients only attending outpatients

where absolutely necessary. This will be achieved by the triage ensuring that all necessary investigations have been prerformed prior to the fist outpatients attendance. Where investigations are arranged, writing with results and if required telphone follow-up. Those patients who do need to attend for FU will be seen either by CNS or consultant. A significant proportion of this required FU will be consultant led and nurse delivered (in particular oncology FU), thus reducing the consultant time requirement to deliver the demand. We propose to provide available capacity to meet demand for the past 12 months and this capacity will be delivered in a consultant led service with approximately 50% of the capacity provided by the consultant and 50% provided by the CNS team. Ongoing capacity for follow-up will need close monitoring and adjustment once true demand within the new service is understood. A separate plan is required fro reduction of the follow-up backlog. We propose to manage this as a team working through the 3385 overdue follow-up appointments, initially by case review and discharge as appropriate and then by provision of additional capacity (outside of proposed service) which will require funding. We would be opposed to this work being outsourced to private providers as experience of this is that significant numbers are referred back for ongoing FU while our aim in reviewing this backlog is to achieve a very high discharge rate.

Staffing requirements

Staffing requirements in order to deliver the service to meet demand as illustrated have been calculated. In the Thorndale Unit (urology outpatients), in order to provide the services we will require expansion of the team of Clinic Nurse Specialists. There will need to be 4 members of this team 'on the ground' for each half day session plus support workers. In our current service significant amounts of CNS time are utilised managing the outpatients department. To free up this time we propose the creation of new outpatients administrative roles which will enable the clinical staff to spend more time delivering patient care. These staffing requiremnts are shown below, some of the gap is funded but currently unfilled;

Band	In Post (WTE)	Proposed (WTE)	Gap (WTE)
7	1.86	3.4	1.54
5/6	2.72	4.4	1.68
2/3	0.8	3.4	2.6
4 Admin Support	0	1	1
2 Admin Support	0	1	1

The CNS team is anticipated to provide opportunity for progression and development and as such we would anticipate that as the individuals acquire skills and educational requirements to deliver service at a higher band they will be afforded this opportunity in-house. Without this we would be a significant risk of providing training / development to members of staff who then leave the trust to progress their careers. Funding and subsequent appointment to these posts is essential in order to deliver the service as described.

At consultant level numbers of PA's have been calculated based upon capacity requirements as above and the following hours calculations;

Session	Consultant Hours per session (including admin time)	Weekly sessions required	Weekly Hours	Weekly PA's
Theatres (Inpatient and daycase)	5	14	70	17.5
Outpatients clinics (New, FU, Off site)	5	17.6	88	22
Urodynamics	5	1	5	1.25
ESWL	1	4	4	1
Multidisciplinary team meetings (oncology and non oncology)	5	6	30	7.5
Acute care	4.75	12.2	57.9	14.5
Unpredictable out of hours work	4	6	24	6
Supporting Professional Activities	6	7	42	10.5
Total			320.9	80.25

In order to deliver the anticipated demand the service will therefore require funding for 7 consultants (11.4 PA's) in addition to the expansion in the outpatients nursing team. Without this we will not be able to meet projected demand as consultant capacity would be reduced.

Summary

We have reviewed the Urology service wihtin SHSCT and examined every aspect from the perspective of aiming to provide a sustainable service. We believe the plan as described will enable us to provide this while maximising the efficiency of utilisation of consultant time. In order to do this there is a need for expansion of the clinical nurse specialists within the team. This expansion will require training and funding, without this the service cannot be provided in a sustainable manner. However, even with this expansion and maximisal efficiency of consultant time there is no currently sufficient consultant time available to provide capacity for projected demand. Without providing this capacity we will also not be able to deliver any backlog reduction.

Demand reduction will be a major aspect of delivery of the service. This requires support in our engagement with primary care and in the principle of secondary care defining the criteria for referral and rejection of referral which have not followed agreed primary care investigation and management guidance. The currently available mechanisms for this process will require significant consultant input. The proposed electronic mechanism for this process would be preferable and

reduce this consultant input but presently we believe this aspiration is some considerable time away.

The Vision for Urology Services in the SHSCT

Background…

- Healthcare Demand > Healthcare capacity
- Year on year demand increases
  - Demographics
  - Increasing incidence / detection of disease
  - New treatments
- CAH Urology;
  - 1586 New outpatient referrals awaiting appointments.
    - 1250 waiting > 9 weeks
    - 880 waiting > 15 weeks
  - 973 patients listed for Inpatients or daycase procedures.
    - Longest waiter 76 weeks
  - 3385 patients awaiting follow-up appointments.
  - Demand increases (new referrals) approximately 10% per year.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Background…

- 1586 New outpatient referrals awaiting appointments.
  - 1250 waiting > 9 weeks
  - 880 waiting > 15 weeks
- 973 patients listed for Inpatients or daycase procedures.
  - Longest waiter 76 weeks
- 3385 patients awaiting follow-up appointments.
- Demand increases (new referrals) approximately 10% per year.

Aim

- Sustainable service
  - Efficient models of care
  - Maximise available capacity
  - Acceptable, equitable waiting times
  - Planning for increased demand
- Identify resource required to deliver this service
- Identify risks which will threaten successful delivery

Workstreams;

- Demand Management
  - Increase urological investigation and management in primary care
  - Reduce referral to secondary care
- Service Delivery
  - Maximise efficiency of consultant input
  - Minimise requirements for multiple visits to see the consultant
- Capacity management / planning
  - Plan to deliver the required capacity
  - Pro-active capacity management

Demand Management

Demand Management;

- Key aspect in delivering a sustainable service
  - Initial Investigation / Management
  - Referral criteria
  - Passive / Mandated
- Electronic referral
  - Current electronic process designed with ease of use for the referrer as primary aim.
  - No mandated requirement for clinical information.
- Resultant consultant time required to triage referrals, with often limited clinical information.
  - Primary goal of current triage process is prioritisation.
- Predicting impact difficult
  - Small sample (48) routine referrals 50% could have had further investigations and primary care management prior to referral
  - Impact on Urgent / Red flag referrals likely to be less
- Access to advice
- GPs want diagnosis and plan and find promised but not delivered FU frustrating

Service Delivery

Elective Service

- Do all patients need to be seen in OP?
  - Vasectomy patients placed directly on waiting list.
  - Female LUTS patients (after management as per demand management) listed directly for urodynamics.
- What can be done before the OP visit?
  - Radiological and Biochemical tests done and available at the OP visit
- What can be done at the time of the OP visit?
  - Flexible cystoscopy
  - TRUS
- Operating theatre capacity
- Follow-up
  - Who?
  - How?

Pre-hospital

- Referral based upon Primary care guidance (see demand management)
- Triage
  - Specific referrals listed directly
  - Check investigations available
  - Arrange required pre hospital investigations
  - Nurse specialist input with consultant input where required

Elective Service - outpatients visit

- Based upon the Guys model
  - Single new outpatient clinic.
  - Consultant delivered service.
  - Urological diagnostics available at time of visit (flexible cystoscopy, TRUS).
  - Tried and Tested – published and recreated at other centres
- Initial pre-admission assessment
  - Current waiting lists includes patients who will ultimately be deemed unfit for surgery.
  - Identification of patients who require additional anaesthetic investigation before placing on waiting list.
  - Holistic needs assessment (avoid losing capacity).

Elective Service - Operating Theatre capacity

- Maximise Day case provision
- Theatre efficiency
  - Focus on turnaround times
- Pooled waiting list for common urological procedures (eg circumcision, TURBT)
- Off site operating
  - Daisy Hill, SWAH
  - Theatre equipment
  - Junior dr support
  - Out of Hours cover

Elective Service - Follow-up

- Minimise Follow-up appointments
  - Letters with results and plans
  - Specific primary care instructions for ongoing management and advice regarding when to refer back
  - Telephone follow-up after non-cancer elective surgery
  - Nurse led follow-up where appropriate
  - NICAN guidance

Acute Service

- Consultant of the week.
- Consultant led morning ward rounds Mon-Fri.
- Acute clinic – A&E referrals plus non-elective GP referrals which didn't require admission from previous 24 hours.
- Planned emergency theatre time.
- GP telephone advice and triage of referrals where required.
- Consultant led afternoon ward rounds Mon-Fri (of patients who had investigations to review results and make further plans).

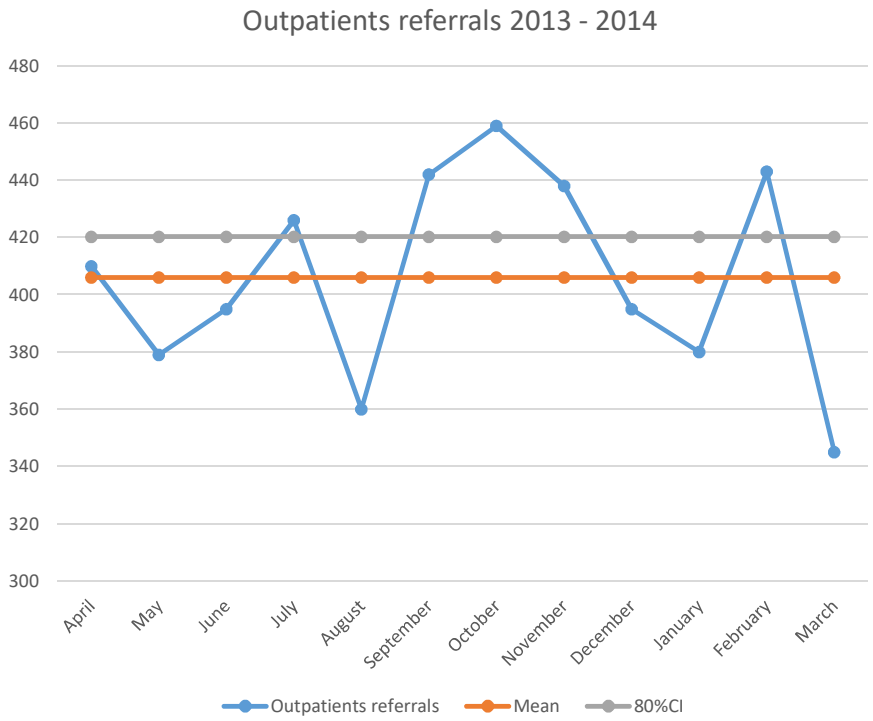
Capacity Planning

Capacity planning and Management

- Current Demand
  - Elective and Acute
  - New and Follow-up
  - Outpatients and Inpatients / day cases
- Capacity planning
  - Based upon proposed service models
  - Current demand at 80% upper confidence limit
  - 20% estimate demand reduction for new referrals
  - Annual increased demand estimated at 10%
  - Planned service capacity set at expected demand year 3 to allow backlog reduction year 1 and 2.
  - Staffing requirements to deliver required capacity

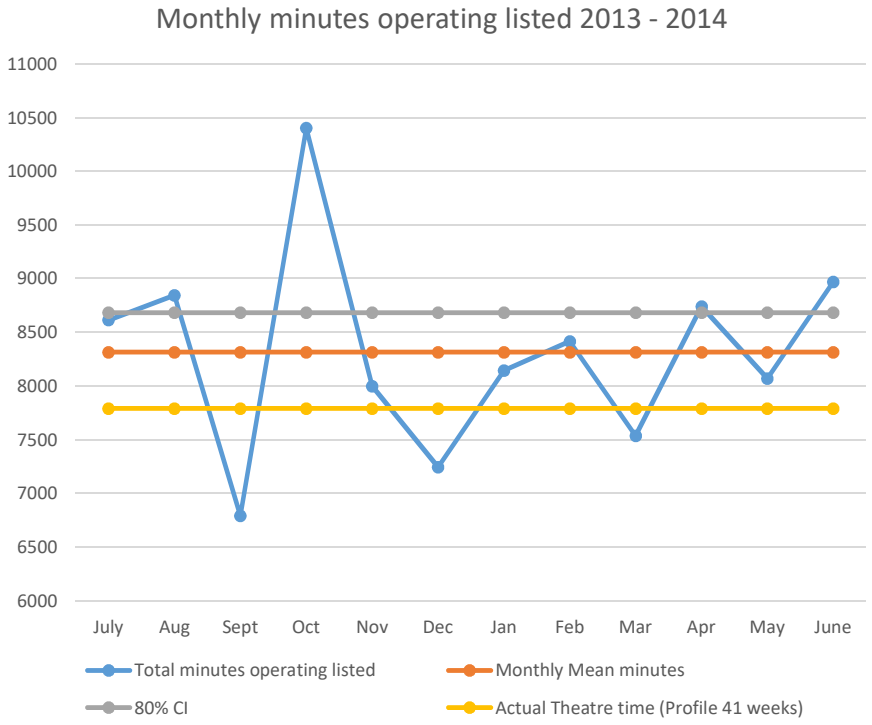
New Outpatients

- 2013-2014
  - Total 4872
  - Mean 406 per month
  - 80% confidence level 420 per month
- Capacity plan 407 referrals per month
- A proportion will be managed via the Acute clinic
  - Estimated at 5 / day, 5 days per week, 50 weeks per year (not bank holidays)
- Total 3634 new appointment capacity per year
- Modelled at 41 weeks requires 202 clinics per year (5 per week)



Operating Theatre Capacity

- Projected Capacity requirement Year 3 10506 minutes per month (2101 hours).
- Weekly list requirements profiled at 41 weeks 13 lists per week.
- Increased capacity is in inpatient theatres (12 per week required).
  - Increase in current capacity already in progress.
- This projected demand does not include demand created from the unseen referrals
  - Anticipated that efficiency measures will create capacity for this demand.
  - Benchmarking against English trust suggests this will create the equivalent of a further 4.8 hours per week operating
  - The benchmark trust has been through a number of cycles of work to reach this point and it is anticipated it will take significant time to reach this point.



Flexible cystoscopy / TRUS / Urodynamics

- Flexible cystoscopy
  - Demand estimated at 1 list per week (8 patients)
  - Outside of general new clinic this capacity will be provided in a consultant led, CNS delivered service.
- TRUS
  - Radiology consultant provided service @2 lists per month anticipated to meet demand for those patients who do not have biopsy at 1st clinic visit.
- Urodynamics
  - Weekly demand 4-6 patients per week.
  - Consultant led, CNS delivered service with specific consultant delivered sessions for complex clinical conditions (estimated 2 CNS delivered : 1 Consultant delivered).
- ESWL
  - 444 treatments per year required @ 3 per half day session (148 sessions)
  - Delivered as at present (nurse / radiographer with consultant input).
- Capacity and demand for these services will require close monitoring and adjustment over the course of the first months of delivery of the new service.

Off Site Services

- No proposed change in services currently provided off site
- Majority of new patients will be seen at CAH in general new clinic, some may be seen at off site sessions where on triage it is determined appropriate (not anticipated to require additional visit to CAH for diagnostic procedure eg TRUS / Flexible cystoscopy).
- Current profile 2.6 consultant sessions / week profiled to 41 weeks.

Follow-up Outpatients

- 3274 OP follow-up appointments last 12 months
- Number awaiting a follow-up appointment grew over the same period from 1665 to 3385
- Demand over the last 12 months was 4994.
- Added Follow-up requirements of those new referrals received but not seen (based on 30% FU rate) in the last 12 months 494.
- Total current Follow-up demand is 5488.
- Delivery planned 50:50, CNS:Consultant in consultant led service.
- Projected 7.6 sessions per week (CAH and off site clinics)

Staffing Requirements

Staffing – Nursing / Administrative

Band	In Post (WTE)	Proposed (WTE)	Gap (WTE)
7	1.86	3.4	1.54
5/6	2.72	4.4	1.68
2/3	0.8	3.4	2.6
4 Admin Support	0	1	1
2 Admin Support	0	1	1

- Some currently funded but unfilled
- Training requirements

Staffing Requirements - Medical

- Currently funded;
  - Consultants = 54.9 PA / week
  - Staff grade posts = 3 WTE (vacant, clinical fellow interviews mid Sept)
  - GPwSI = 7 PA / week
- Proposed model requirements;
  - 80.25 consultant PA's per week
  - 6 Consultants @ 13.4 PA's
  - 7 Consultants @ 11.4 PA's

Session	Consultant Hours per session (including admin time)	Weekly sessions required	Weekly Hours	Weekly PAs
Theatres (Inpatient and daycase)	5	14	70	17.5
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Unpredictable out of hours work	4	6	24	6
Supporting Professional Activities	6	7	42	10.5
Total			320.9	80.25

Work to date

- Electronic referral
  - Meetings held, Long term aspirations of the electronic referral gateway are in line with our aspirations (but long term).
  - Short / medium term will rely on education, feedback and triage.
- Primary care guidance / engagement commenced.
- Advice functionality of electronic referral gateway being turned on for Urology Southern Trust.
- Consultant of the week system starting September 2014.
- Initial trial of ‘Guys model’ to be run Sept / Oct.

The Future

- Avoid crisis management
  - Quality management
    - Waiting time indicators
    - Trigger points
- Rigid vs responsive delivery models.

- Close working between Board and CAH Urology to avoid crises.

New Referrals - Demand

- Advise functionality CCG
  - Average 13.6 per month 2016
  - Approx 2/3 advice only, 1/3 advice and OP arranged
- Triage
  - Investigation and management without hospital appointment
  - Pre hospital appointment investigation
    - Enables upgrade where clinically significant findings are identified, ensuring that 'Routine' WL is routine.
  - Direct WL
  - Review of 1 weeks non RF referrals (15-21 Oct 2015, 84 new referrals, does not include RF, additional 10 referrals received were for existing outpatients)
  - Net 20% reduction in demand
  - 37% of those on New OP WL had imaging arranged prior to their attendances.
- Suspected cancer referral guidelines
  - ?current status
- New Op Delivery, 'Snap shot' 10 consecutive patients each triage category (20 for RF)
  - 11/40 WL, 6/40 FU, 23/40 Discharged
  - 4/20 non RF referrals had Flexible cystoscopy in clinic (1/3 consultant session)
  - 5/20 RF referrals had TRUS biopsy @ New OP without the need for further attendance (1 consultant session)
  - No plan for WLI to reduce given current IP WL status.

Diagnostics

- Flexible cystoscopy
  - Nurse / Urologist delivery
  - At time of 1st OP attendance
  - WL (not planned) = 74 pts (includes patients with dates)
- TRUS
  - Nurse (to date 102 TRUS biopsies in 2016 delivered by CNS)/ Radiology / Urologist delivery.
  - At time of 1st attendance or as stand alone nurse delivered service.
  - MRI targeting (cognitive)
  - Future = investment for Fusion biopsy
- UDS
  - Nurse delivery
  - Training
  - Individuals
  - WL = 171 (178)

Review OP

- Behavioural change (wrt New referrals)
  - Most important
  - Hardest to deliver, gradual process
  - 2 consultants no backlog
  - Yet same 2 consultants deliver equal new OP consultations
- Backlog reduction
  - Validation
    - Admin
    - Clinical
  - Delivery
    - Within Job plan
    - WLIs (without rewarding bad behaviour?)
- Overdue RV numbers reducing

Day case theatre

- NCCG Drs (or lack of).
- CNS training to deliver Cystoscopy and Botox.
- Vasectomy service
  - ‘One stop’ service provided by urology.
  - Also provided by GS
  - Moving to NCCG delivered service, utilising existing GS NCCG.
- Inguino-scrotal surgery
  - Envisage expanding current utilisation of GS NCCG to deliver N code work as part of JP.
- Timing of lists, geography of DSU and available facilities as a result limit DSU procedure lists (23hr stay unit, radiology, laser etc).

IP Theatre

- Biggest Challenge
- IP theatres running from 8am-8pm
  - Utilisation challenges
    - Start time, turnaround,
- Beds, Winter pressures (in July / August)
  - Cancellations Apr-June 2016 = 38
- Future (personal view)
  - Pooled WL.
  - Central scheduling.
    - Challenge ++ (Cf England experience where this team practice is common place).
  - Infrastructure capacity increase required.

Emergencies

- Junior numbers
- Expectation / need for consultant delivery
  - No CST level juniors
  - Vacant middle grade / NCCG posts
  - Middle grade rota gaps
    - Within speciality
    - Outside speciality (eg A&E)
- Reduces elective availability

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 26 November 2015 06:42
To: Young, Michael; Corrigan, Martina
Subject: Queue jumpers

Morning Michael

I emailed you on 2nd June 2015 about the ongoing issue of patients on waiting lists not being managed chronologically and in particular private patients being brought onto NHS lists having significantly jumped the Waiting List. As I have been through our inpatients in preparation for taking over the on-call today I have once again come across examples of this behaviour continuing. Specific patient details are;

[redacted] AOB
Referred Sept 2015, Seen OP ([redacted]) Sat 10/10/15, Urodynamics @thorndale unit 6/11/15, Cystodistension 25/11/15.

[redacted] AOB
Referred 28/10/15, Seen OP ([redacted]) Sat 7/11/15, GA cystoscopy 25/11/15 (?recurrent stricture)

I have expressed my view on many occasions. This is Immoral and unacceptable. Aside from the immorality of patients who have the means to seek private consultations having their operations on the NHS list to the detriment of patients without the means, who sit on the waiting list for significant lengths of time, the behaviour is apparent to outsiders looking in. The HSC board can see it when they look at our service and any of our good work is undone by this.

Can you advise me what action has been taken since I raised this?

Mark

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 27 May 2015 20:54
To: Young, Michael; Corrigan, Martina
Subject: FW: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Attachments: UROLOGY LONGEST URGENT WAITERS WITHOUT DATE FOR SURGERY - FOR SCHEDULING - 27.05.xlsx; UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15.xls

Importance: High

Dear Michael / Martina

I feel increasing uncomfortable discussing the urgent waiting list problem while we turn a blind eye to a colleague listing patients for surgery out of date order usually having been reviewed in a Saturday non NHS clinic. On the attached total urgent waiting list there are 89 patient listed for an Urgent TURP, the majority of whom will have catheters insitu. They have been waiting up to 92 weeks.

However, on the ward this week is a man ([redacted]) who went into retention on [redacted], Failed a TROC on [redacted] He was seen in a private clinic on [redacted] and admission arranged [redacted] The immorality of this is astounding and yet this is far from an isolated event, indeed I recognise it every time I am on the wards and discussing with various members of the team it is 'accepted' as normal practice. I would not disagree with any argument that this patient got the treatment we should be able to offer to all but it is indefensible that this patient waited 5 weeks while another patient waits 92 weeks. Both with catheters insitu for retention. An argument that this man was very distressed with his catheter does not hold with me. All of our secretaries can vouch for many patients in this situation being in regular contact because of catheter related problems.

This behaviour needs to challenged a stop put to it. I am unwilling to take the long waiting urgent patients while a member of the team offers preferential NHS treatment to patients he sees privately. I would suggest that this needs challenging by a retrospective audit of waiting times / chronological listing for all of us and an honest discussion as a team, perhaps led by Debbie. The alternative is to remove waiting list management from all of us consultants and have an administrative team which manages the waiting list / pre-op / filling of waiting lists in a chronological order.

Happy to discuss and plan a strategy for taking this forward.

Mark

From: Glenny, Sharon
Sent: 27 May 2015 14:32
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Cc: Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth
Subject: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Importance: High

Hi Everyone

Following the departmental meeting last week and discussion re urgent waiting times and volumes with consultants for elective surgery – I have attached a total urgent waiting list for your review.

The table below summarises the volumes of patients by consultants – patients with dates/without dates and the longest waiter without date.

The longest waiting urgent patient without a date currently is sitting at 92 weeks, although this patient is on Mr O'Donoghue's waiting list, the patient originally was listed by Mr O'Brien.

Summary of Urgent Waits

With Dates

Without Dates

Total

Long Waiter Without Date

AJG

15

28

43

34 weeks

AOB

2

128

130

82 weeks

JOD

25

43

68

92 weeks

Originally AOB patient

KS

17

44

61

28 weeks

MDH

12

26

38

70 weeks

Originally AOB patient

MY

25

110

135

85 weeks

TOTAL

96

379

475

Martina has advised that there was agreement by consultants to work from a combined urgent waiting list to target the top longest waiters when scheduling/backfilling lists where possible – this list has also been attached and has been forwarded to the pre-op team so that they can concentrate on working these patients through the pre-op process.

These reports have been saved into the shared scheduling folder for urology.

If you need any further information, please let me know.

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

UROLOGY LONGEST WAITERS WITHOUT DATE FOR SURGERY - FOR SCHEDULING

Hosp tal	H&C No.	Casenote	Forename	Surname	Date of Birth	Age	Original Date	Current Date	Date Booked	Current Suspension End Date	Consu tant	Expected Method of Adm.	Urgency Code	Intended Management	Adm ssion Reason	Intended Primary Procedure Code	Operation Descript on	Expected Ward	Remarks	Weeks wa ting
[redacted]							23/08/2013	23/08/2013			JOD	WL	2	N	TURP DISCUSS WITH ANAETHETIST FIRST	M65.3	TURP DISCUSS WITH ANAETHETIST FIRST (FIT 10/10/13 FMCC/LN)		PER MR YOUNG AT CLINIC 23.08.13	92
							09/10/2013	09/10/2013			MY	WL	2	N	LEFT PCNL NEEDS PRE-OP NEPHROSTOMY	M09.9	LEFT PCNL NEEDS PRE-OP NEPHROSTOMY FIT 24.2.15 KK		PER RAB	85
							28/10/2013	28/10/2013			AOB	WL	2	N	CT URINARY TRACT & CYSTOSCOPY	M45.9	CT URINARY TRACT & CYSTOSCOPY		SC OPD 281013 TCI PER AOB	82
							25/11/2013	25/11/2013			AOB	WL	2	N	RIGHT URETEROGRAPHY AND PYLEPOPLASTY	M30.1	RIGHT URETEROGRAPHY AND PYLEPOPLASTY			78
							04/12/2013	04/12/2013			MY	WL	2	N	LEFT PCNL MR GLACKIN PATIENT	M09.9	LEFT PCNL MR GLACKIN PATIENT		PER EMAIL FROM GEMMA	77
							16/12/2013	16/12/2013			MY	WL	2	N	RIGHT PCNL - TCI DB4 PER PRE-OP(pre-op to be inform of date)	M09.9	RIGHT PCNL FIT (20.5.15 KK) - needs 1st & 2nd group screen on adm		PER STC CLINIC 16.12.13	75
							20/12/2013	20/12/2013			MY	WL	2	N	GA CYSTOSCOPY & CYSTOLITHOLAPAXY	M45.9	GA CYSTOSCOPY & CYSTOLITHOLAPAXY FIT(18.11.14)CD		PD - PER GEMMA AT DSU 20.12.13	75
							24/12/2013	24/12/2013			MY	WL	2	N	FLEXIBLE URETEROSCOPY - N/HOME PT	M30.9	FLEXIBLE URETEROSCOPY		PER RAB	74
							30/12/2013	30/12/2013			MY	WL	2	N	TURP-BARIATRIC EQUIP TO BE AVAIL PT 280214 & 130514 ? date	M65.3	TURP BARIATRIC EQUIPMENT TO BE AVAILABLE chang cat2 permry FIT 30/06/14 - NEW LTR 30/1/15 KEEN FOR CANCELLATION		PER FUNSHO LUTS CLINIC	73
							06/01/2014	06/01/2014			AOB	WL	2	N	LEFT URETEROGRAPHY AND URETEROSCOPY	M30.4	LEFT URETEROGRAPHY AND URETEROSCOPY (FIT/UPDATED 21/05/15) POLISH INTERPR FIT 8/1/14KK) NOT AVAIL BETWEEN 26/3 - 7/4/15			72
							15/10/2013	15/10/2013		01/06/2015	JOD	WL	2	N	TURP (on warfarin)	M65.3	TURP B6QT 070114 HOLD(06.01.14)CD BMI 39 ON CORTICOSTEROIDS			71
							14/01/2014	14/01/2014			AOB	WL	2	N	AUGMENTATION/SUBSTITUTION CYSTOPLASTY	W73.1	AUGMENTATION/SUBSTITUTION CYSTOPLASTY			71
							21/01/2014	21/01/2014			MY	WL	2	N	LEFT PCNL	M09.9	LEFT PCNL		PD - PER STC CLINIC 20.01.14	70
							22/01/2014	22/01/2014			MY	WL	2	D	VASECTOMY REVERSAL - WILLING TO COME AT SHORT NOTICE	N18.1	VASECTOMY REVERSAL - WILLING TO COME AT SHORT NOTICE		PD - PER MR YOUNG RE: LTR FROM PATIENT 22.01.14	70
							14/10/2013	14/10/2013		01/06/2015	MY	WL	2	N	RIGHT PCNL DIABETIC NIDDM	M09.9	RIGHT PCNL NIDDM broken arm 13.02.15 (needs 6/52 to heal) APRIL 15 FIT 17.2.		PER STC	70
							03/01/2014	03/01/2014		01/07/2015	MDH	WL	2	N	BILATERAL URETEROGRAPHY INTRAMURAL INJ OF 1000 UNITS	M13.4	BOTULINUM TOXIN AND POSTOPERATIVE CYSTOGRAPHY FIT (8.1.14 NEEDS OBS ON ADM)			70
							31/01/2014	31/01/2014			AOB	WL	2	N	REMOVAL URETERIC STENTS BILATERAL URETEROPYELOGRAPHY WARFARI	M27.5	REMOVAL OF URETERIC STENTS AND BILATERAL URETEROPYELOGRAPHY ON WARFARING			69
							03/02/2014	03/02/2014			AOB	WL	2	N	RIGHT URETEROGRAPHY AND URETEROSCOPY	M30.4	RIGHT URETEROGRAPHY AND URETEROSCOPY FIT(27.06.14)ACE INHIBITORS			68
							03/02/2014	03/02/2014			AOB	WL	2	N	RIGHT ORCHIDOPEXY	N08.3	RIGHT ORCHIDOPEXY			68
							11/11/2013	11/11/2013			MY	WL	2	N	LEFT PCNL - UPGRADED TO CAT 2 28.05.14 RE: LTR GP	M09.9	LEFT PCNL ASTHMA MEDS FIT(28.04.14)CD		PER MR YOUNG ERNE CLINIC 11.11.13	67
							17/02/2014	17/02/2014			AOB	WL	2	N	TURP (CATHETER)	M65.3	TURP (CATHETER)			66
							18/02/2014	18/02/2014			MY	DA	2	N	LITHOLAPAXY & PROSTATE STONE (LETTER IN B/F)	M44.1	LITHOLAPAXY & PROSTATE STONE B6QT 140414 ANTI-PSYCHOTICS		PD - PER MR YOUNG RE: REFERRAL MR BROWN DHH 17.02.14	66

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Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

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20/02/2014	20/02/2014			AOB	WL	2	N	URETEROSCOPY AND LASER	M30.4	URETEROSCOPY AND LASER			66
24/02/2014	24/02/2014			AOB	WL	2	N	RIGHT URETEROGRAPHY AND URETEROSCOPY	M30.4	RIGHT URETEROGRAPHY AND URETEROSCOPY NOT AVAILABLE 13/11/14 - 18/11/14 (ON HOLIDAY)			65
25/02/2014	25/02/2014			AOB	WL	2	N	TURP	M65.3	TURP FIT 12.5.14 KK			65
03/03/2014	03/03/2014			AOB	WL	2	N	MARSUPIALISATION OF RIGHT RENAL CYST AND	M04.1	RIGHT URETERIC REIMPLANTATION RANG 20.05.14 ? DATE FIT 3.7.14 MILD LATEX ALLERGY			64
04/03/2014	04/03/2014			AOB	WL	2	N	BILATERAL URETERIC REIMPLANTATION	Z94.1	BILATERAL URETERIC REIMPLANTATION			64
14/03/2014	14/03/2014			AOB	WL	2	N	LEFT FLEXIBLE URETEROSCOPY & URETEROGRAPHY	M30.9	LEFT FLEXIBLE URETEROSCOPY & URETEROGRAPHY B6QT 210514 RESPIRTARY ARREST		SC URODYNAMICS 140314 TCI PER ABO	63
18/03/2014	18/03/2014			AOB	WL	2	N	RESECTION OF ANTERIOR VAGINA LESION	M42.1	RESECTION OF ANTERIOR Vagina lesion (HAS YOUNG BABY) FIT 30.5.14 KK ON SSRI (NEED AS MUCH NOTICE AS POSSIBLE)			62
27/03/2014	27/03/2014			MY	WL	2	N	PCNL MR GLACKIN PATIENT	M09.9	PCNL MR GLACKIN PATIENT FIT 31.7.14 KK - PT PHON ? DATE 19&22/09/14 & 30/01/15		PD - PER STC CLINIC 27.03.14	61

UROLOGY - TOTAL WAITING LIST - AS AT 27.05.15

Summary of Urgent Waits					
	With Dates	Without Dates	Total		Long Waiter Without Date
AJG	15	28	43		34 weeks
AOB	2	128	130		82 weeks
JOD	25	43	68		92 weeks *Originally AOB patient*
KS	17	44	61		28 weeks
MDH	12	26	38		70 weeks *Originally AOB patient*
MY	25	110	135		85 weeks
TOTAL	96	379	475		

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Hosp a	H&C No	Caseno e	Forename	Surname	Da e o B r h	Age	Or g nal Da e	Curren Da e	Da e Booked	Curren Suspens on End Da e	Consu ant	Expec ed Me hod o Adm	Urgency Code	n ended Managem en	Adm ss on Reason	n ended Pr mary Procedure Code	Opera on Descr p on	Expec ed Ward	Remarks	Weeks wa ng
							11/06/2013	11/06/2013			JOD	WL	4	N	URETHROPLASTY	M73.6	URETHROPLASTY		JOINT PROCEDURE WITH Personal , SET CONSULTANT	92
							19/08/2013	19/08/2013			AOB	WL	4	D	PREPUTIOLYSIS	N32.9	PREPUTIOLYSIS TRANSFER TO AOB WL PER MR O'BRIEN FIT(04.02.15)CD/FT		PER MR YOUNG AT BB CLINIC	92
							20/08/2013	20/08/2013			AOB	WL	4	N	DIVISION OF PREPUTIAL ADHESIONS ? CIRCUMCISION	N30.2	DIVISION OF PREPUTIAL ADHESIONS ? CIRCUMCISION FIT(20.01.15)UD 21.5.15 KK			92
							24/05/2013	24/05/2013	03/06/2015		JOD	WL	2	N	TURP AND BOTULINUM TOXIN INJECTION	M65.3	TURP AND BOTULINUM TOXIN INJECTION FIT(16.10.13)CD NIDDM METFORMIN. ACE INHIBITOR.PLAVIX DISCONTINUED BY GP	1 WEST ELECTIVE ADMISSION WARD		92
							23/08/2013	23/08/2013			JOD	WL	2	N	TURP DISCUSS WITH ANAETHETIST FIRST	M65.3	TURP DISCUSS WITH ANAETHETIST FIRST (FIT 10/10/13 FMCC/LN)		PER MR YOUNG AT CLINIC 23.08.13	92
							02/08/2013	02/08/2013			AJG	WL	4	N	TURP	M65.3	TURP FIT(26.02.14)CD ON AMITRIPTYLINE			86
							09/10/2013	09/10/2013			MY	WL	2	N	LEFT PCNL NEEDS PRE-OP NEPHROSTOMY	M09.9	LEFT PCNL NEEDS PRE-OP NEPHROSTOMY FIT 24.2.15 KK		PER RAB	85
							12/08/2013	12/08/2013		01/08/2015	JOD	WL	4	N	TURP DIABETIC	M65.3	TURP DIABETIC FIT 23.1.14 IDDM/NIDDM TAB/DIET ON IRBESARTAN		PER MR YOUNG CLINIC 12.08.13	84
							02/08/2013	02/08/2013			MY	WL	4	D	GA CYSTOSCOPY & HYDROSTATIC DILATATION AS INPATIENT	M45.9	GA CYSTOSCOPY & HYDROSTATIC DILATATION AS INPATIENT (HSQ B6QT 04/12/13 LN)HOLD(29.11.13)CD		PD - PER MR YOUNG AT URODYNAMICS 02.08.13	82
							28/10/2013	28/10/2013			AOB	WL	2	N	CT URINARY TRACT & CYSTOSCOPY	M45.9	CT URINARY TRACT & CYSTOSCOPY		SC OPD 281013 TCI PER AOB	82
							25/11/2013	25/11/2013			JOD	WL	4	N	CORRECTION OF PENILE ERECTILE DEFORMITY	N28.8	CORRECTION OF PENILE ERECTILE DEFORMITY			78
							25/11/2013	25/11/2013			JOD	WL	4	N	CYSTOSCOPY ?URETHRAL DILATATION	M45.9	CYSTOSCOPY ?URETHRAL DILATATION			78
							25/11/2013	25/11/2013			AOB	WL	2	N	RIGHT URETEROGRAPHY AND PYLEPOPLASTY	M30.1	RIGHT URETEROGRAPHY AND PYLEPOPLASTY			78
							29/11/2013	29/11/2013			JOD	WL	4	N	HYDROSTATIC DILATATION BLADDER	M43.2	HYDROSTATIC DILATATION BLADDER FIT 18.5.15 KK			78
							03/12/2013	03/12/2013			JOD	WL	4	D	LEFT EPIDIDYMAL CYSTECTOMY	M34.3	LEFT EPIDIDYMAL CYSTECTOMY B6QT 260214 ON AMITRIPTYLINE/ASTHMA MEDS			77
							04/12/2013	04/12/2013			MY	WL	2	N	LEFT PCNL MR GLACKIN PATIENT	M09.9	LEFT PCNL MR GLACKIN PATIENT		PER EMAIL FROM GEMMA	77
							06/12/2013	06/12/2013			JOD	WL	4	D	GA RIGID CYSTOSCOPY, URETHRAL DILATATION +/- OPT URETHROTOMY	M45.5	GA RIGID CYSTOSCOPY, URETHRAL DILATATION +/- OPT URETHROTOMY		SC FLEXI 061213 TCI PER REG	77
							31/08/2013	31/08/2013			JOD	WL	4	D	NESBITTS PROCEDURE TRANSFER TO MR O'DONAGHUE	N28.8	NESBITTS PROCEDURE SEE IN CLINIC FIRST CORONARY STENTS NIDDM TABLET ON PRASUGREL HOLD(02.12.14)		PER MR PAHUJA	76
							13/12/2013	13/12/2013			MY	WL	4	N	BOTOX	M43.4	BOTOX FIT (5.3.14 UD 15.5.15 KK)		PD - PER MR YOUNG AT URODYNAMICS 13.12.13	76
							16/12/2013	16/12/2013			MY	WL	2	N	RIGHT PCNL - TCI DB4 PER PRE-OP(pre-op to be inform of date)	M09.9	RIGHT PCNL FIT (20.5.15 KK) - needs 1st & 2nd group screen on adm		PER STC CLINIC 16.12.13	75
							17/12/2013	17/12/2013	09/06/2015		JOD	WL	2	N	TURP	M65.3	TURP	1 WEST ELECTIVE ADMISSION WARD		75
							20/12/2013	20/12/2013			MY	WL	2	N	GA CYSTOSCOPY & CYSTOLITHOLAPAXY	M45.9	GA CYSTOSCOPY & CYSTOLITHOLAPAXY FIT(18.11.14)CD		PD - PER GEMMA AT DSU 20.12.13	75
							20/12/2013	20/12/2013			JOD	WL	4	N	BOTULINUM TOXIN ? TURP	M13.4	BOTULINUM TOXIN ? TURP			75
							24/12/2013	24/12/2013			MY	WL	2	N	FLEXIBLE URETEROSCOPY - N/HOME PT	M30.9	FLEXIBLE URETEROSCOPY		PER RAB	74
							30/12/2013	30/12/2013			MY	WL	2	N	TURP-BARIATRIC EQUIP TO BE AVAIL PT 280214 & 130514 ? date	M65.3	TURP BARIATRIC EQUIPMENT TO BE AVAILABLE chang cat2 permry FIT 30/06/14 - NEW LTR 30/1/15 KEEN FOR CANCELLATION		PER FUNSHO LUTS CLINIC	73
							03/01/2014	03/01/2014			MY	WL	4	D	CHILD CIRCUMCISION	N30.3	CHILD CIRCUMCISION fit (8.1.14 KK)		PD - PER MR YOUNG AT CLINIC 03.01.14	73
							06/01/2014	06/01/2014			AOB	WL	2	N	LEFT URETEROGRAPHY AND URETEROSCOPY	M30.4	LEFT URETEROGRAPHY AND URETEROSCOPY (FIT/UPDATED 21/05/15) POLISH INTERPR FIT 8/1/14KK) NOT AVAIL BETWEEN 26/3 - 7/4/15			72
							15/10/2013	15/10/2013		01/06/2015	JOD	WL	2	N	TURP (on warfarin)	M65.3	TURP B6QT 070114 HOLD(06.01.14)CD BMI 39 ON CORTICOSTEROIDS			71
							23/10/2013	23/10/2013			AOB	WL	4	N	RIGHT HYDROCOELECTOMY (WARFARIN PATIENT)	Z94.2	RIGHT HYDROCOELECTOMY (WARFARIN PATIENT) B6QT 060214 HOLS 16TH JULY - 30TH JULY `14			71
							14/01/2014	14/01/2014			AOB	WL	4	N	CIRCUMCISION	N30.3	CIRCUMCISION			71
							14/01/2014	14/01/2014			AOB	WL	2	N	AUGMENTATION/SUBSTITUTION CYSTOPLASTY	W73.1	AUGMENTATION/SUBSTITUTION CYSTOPLASTY			71
							02/07/2013	02/07/2013		01/07/2015	AOB	WL	4	N	TURP	M65.3	TURP ON CANDESARTAN/CHRONIC PAIN MEDS HOLD(08.10.13)CD NIDDM TABLET/ICD/PACEMAKER VARIOUS MEDS			71
							17/01/2014	17/01/2014			MY	WL	4	N	TURP INPATIENT ONLY - NOT SUITABLE DSU	M65.3	TURP (CHANGE OF PROC PER MR YOUNG AT CL 08.08.14) FIT 1.8.14 ASTHMA MEDS/CORTICOSTEROIDS		PER MR YOUNG CLINIC 17.01.14	71

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

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20/01/2014	20/01/2014			MY	WL	4	N	BOTOX AS INPATIENT - FOR I.C.	M43.4	BOTOX AS INPATIENT - FOR I.C. ON TRAMADOL (FIT 12.5.14 KK)		PD - PER MR YOUNG AT BBPC 20.01.14	70
21/01/2014	21/01/2014			MY	WL	2	N	LEFT PCNL	M09.9	LEFT PCNL		PD - PER STC CLINIC 20.01.14	70
22/01/2014	22/01/2014			MY	WL	2	D	VASECTOMY REVERSAL - WILLING TO COME AT SHORT NOTICE	N18.1	VASECTOMY REVERSAL - WILLING TO COME AT SHORT NOTICE		PD - PER MR YOUNG RE: LTR FROM PATIENT 22.01.14	70
14/10/2013	14/10/2013		01/06/2015	MY	WL	2	N	RIGHT PCNL DIABETIC NIDDM	M09.9	RIGHT PCNL NIDDM broken arm 13.02.15 (needs 6/52 to heal) APRIL 15 FIT 17.2.		PER STC	70
03/01/2014	03/01/2014		01/07/2015	MDH	WL	2	N	BILATERAL URETEROGRAPHY INTRAMURAL INJ OF 1000 UNITS	M13.4	BOTULINUM TOXIN AND POSTOPERATIVE CYSTOGRAPHY FIT (8.1.14 NEEDS OBS ON ADM)			70
28/01/2014	28/01/2014			JOD	WL	4	N	CORRECTION OF PENILE ERECTILE DEFORMITY	N28.8	CORRECTION OF PENILE ERECTILE DEFORMITY			69
17/09/2012	29/01/2014			MY	WL	4	N	TUR PROSTATE DIABETIC & WARFARIN	M65.3	TUR PROSTATE DIABETIC & WARFARIN HOLD(19.12.12)CD IDDM/ACE INHIBITORS TCI DAY BEFORE PER MY		PER MR YOUNG BURM1 17/09/12	69
31/01/2014	31/01/2014			AOB	WL	2	N	REMOVAL URETERIC STENTS BILATERAL URETEROPYELOGRAPHY WARFARI	M27.5	REMOVAL OF URETERIC STENTS AND BILATERAL URETEROPYELOGRAPHY ON WARFARING			69
18/10/2013	18/10/2013	26/06/2015		AJG	WL	4	N	INTRAMURAL INJECTION OF BOTULINUM TOXIN AND CYSTOSCOPY	M13.4	INTRAMURAL INJECTION OF BOTULINUM TOXIN AND CYSTOSCOPY B6 QUERY TRAY 05.11.13	1 WEST ELECTIVE ADMISSION WARD		68
03/02/2014	03/02/2014			AOB	WL	2	N	RIGHT URETEROGRAPHY AND URETEROSCOPY	M30.4	RIGHT URETEROGRAPHY AND URETEROSCOPY FIT(27.06.14)ACE INHIBITORS			68
03/02/2014	03/02/2014			AOB	WL	2	N	RIGHT ORCHIDOPEXY	N08.3	RIGHT ORCHIDOPEXY			68
25/11/2011	05/02/2014			MY	WL	4	D	CYSTOSCOPY & HYDROSTATIC DILATATION OF BLADDER/NEEDS INPT	M45.9	CYSTOSCOPY & HYDROSTATIC DILATATION OF BLADDER BMI FILE BMI 56.9 CITALOPRAM (FIT 19/04/12 EM)		AC/PER KJ @ BACKLOG CL 25.11.11	68
07/02/2014	07/02/2014			MY	WL	4	N	TURP	M65.3	TURP - PT PHON ? DATE 12.05.14 & 11.12.14 & 14.05.15 FIT 29.8.14 ANGIOTENSION 11 RECEPTOR ANTAONISTS		PD - PER MR YOUNG AT URODYNAMICS 07.02.14	68
07/02/2014	07/02/2014			AOB	WL	4	N	HYDROSTATIC DILATATION BLADDER	M43.2	HYDROSTATIC DILATATION BLADDER			68
11/11/2013	11/11/2013			MY	WL	2	N	LEFT PCNL - UPGRADED TO CAT 2 28.05.14 RE: LTR GP	M09.9	LEFT PCNL ASTHMA MEDS FIT(28.04.14)CD		PER MR YOUNG ERNE CLINIC 11.11.13	67
15/02/2014	15/02/2014			AOB	WL	4	N	TURP	M65.3	TURP			66
17/02/2014	17/02/2014			AOB	WL	2	N	TURP (CATHETER)	M65.3	TURP (CATHETER)			66
18/02/2014	18/02/2014			AOB	WL	4	D	LEFT HYDROCOELECTOMY	Z94.3	LEFT HYDROCOELECTOMY FIT 2.7.14 KK Not available until 18/11/14			66
18/02/2014	18/02/2014			MY	DA	2	N	LITHOLAPAXY & PROSTATE STONE (LETTER IN B/F)	M44.1	LITHOLAPAXY & PROSTATE STONE B6QT 140414 ANTI-PSYCHOTICS		PD - PER MR YOUNG RE: REFERRAL MR BROWN DHH 17.02.14	66
20/02/2014	20/02/2014			AOB	WL	2	N	URETEROSCOPY AND LASER	M30.4	URETEROSCOPY AND LASER			66
24/02/2014	24/02/2014			AOB	WL	2	N	RIGHT URETEROGRAPHY AND URETEROSCOPY	M30.4	RIGHT URETEROGRAPHY AND URETEROSCOPY NOT AVAILABLE 13/11/14 - 18/11/14 (ON HOLIDAY)			65
25/02/2014	25/02/2014			AOB	WL	2	N	TURP	M65.3	TURP FIT 12.5.14 KK			65
03/03/2014	03/03/2014			AOB	WL	4	N	CIRCUMCISION	N30.3	CIRCUMCISION NIDDM DIET (FIT 16/05/14)			64
03/03/2014	03/03/2014			AOB	WL	2	N	MARSUPIALISATION OF RIGHT RENAL CYST AND	M04.1	RIGHT URETERIC REIMPLANTATION RANG 20.05.14 ? DATE FIT 3.7.14 MILD LATEX ALLERGY			64
04/03/2014	04/03/2014			AOB	WL	4	N	TURP NOT AVAILBLE 18/5/15 - 25/5/15	M65.3	TURP NOT AVAILBLE 18/5/15 - 25/5/15 FIT(06.05.14)CD			64
04/03/2014	04/03/2014			AOB	WL	2	N	BILATERAL URETERIC REIMPLANTATION	Z94.1	BILATERAL URETERIC REIMPLANTATION			64
07/03/2014	07/03/2014			AOB	WL	4	N	CYSTOSCOPY ? TURP AND INJECTION OF BOTULINUM TOXIN	M45.9	CYSTOSCOPY ? TURP AND INJECTION OF BOTULINUM TOXIN FIT 30.5.14 KK			64
21/02/2014	21/02/2014		01/06/2015	JOD	WL	4	N	BLADDER NECK INCISION +/- TURP WARFARIN	M66.2	BLADDER NECK INCISION +/- TURP WARFARIN ON SINEMET/ON CORTICOSTEROIDS FIT(28.05.14)CD/FMCC		PD - PER MR YOUNG AT DSU 21.02.14	64
14/03/2014	14/03/2014			AOB	WL	2	N	LEFT FLEXIBLE URETEROSCOPY & URETEROGRAPHY	M30.9	LEFT FLEXIBLE URETEROSCOPY & URETEROGRAPHY B6QT 210514 RESPIRTARY ARREST		SC URODYNAMICS 140314 TCI PER ABO	63
18/03/2014	18/03/2014			AOB	WL	2	N	RESECTION OF ANTERIOR VAGINA LESION	M42.1	RESECTION OF ANTERIOR Vagina lesion (HAS YOUNG BABY) FIT 30.5.14 KK ON SSRI (NEED AS MUCH NOTICE AS POSSIBLE)			62
27/03/2014	27/03/2014			MY	WL	2	N	PCNL MR GLACKIN PATIENT	M09.9	PCNL MR GLACKIN PATIENT FIT 31.7.14 KK - PT PHON ? DATE 19&22/09/14 & 30/01/15		PD - PER STC CLINIC 27.03.14	61
27/03/2014	27/03/2014			MY	WL	2	D	LEFT URETEROSCOPY - pt phoned ?date 09.01.15	M30.9	LEFT URETEROSCOPY NA(AUG & SEPT 2014) FIT 23.7.14 KK PAIN MEDS		PD - PER STC CLINIC 27.03.14	61
31/03/2014	31/03/2014			AOB	WL	2	N	CYSTOSCOPY AND PERIPROSTATIC INJECTION	M45.9	CYSTOSCOPY AND PERIPROSTATIC INJECTION			60
01/04/2014	01/04/2014			AOB	WL	4	N	REPAIR OF RIGHT PPV	Z94.2	REPAIR OF RIGHT PPV			60
07/04/2014	07/04/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 13.8.14 KK		PER LUTS CLINIC	59
07/04/2014	07/04/2014			AOB	WL	4	N	TURP	M65.3	TURP		SC OPD 070414 TCI PER AOB	59
11/04/2014	11/04/2014			AOB	WL	2	N	CYSTOSCOPY, URETHRAL AND HYDROSTATIC DILATATION	M45.9	CYSTOSCOPY, URETHRAL AND HYDROSTATIC DILATATION FIT 17.6.14 KK		MMCC	59
11/04/2014	11/04/2014			AOB	SD	2	N	RED FLAG TURBT & URETHRAL DILATATION	M42.1	RED FLAG TURBT & URETHRAL DILATATION PLAVIX & RAMIPRIL		SC FLEXI 110414 TCI RED FLAG PER REG	59
11/04/2014	11/04/2014			AOB	WL	4	N	INTRAMURAL INJECTION OF BOTULINUM TOXIN	M13.4	INTRAMURAL INJECTION OF BOTULINUM TOXIN			59
14/04/2014	14/04/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 2.7.14 KK		SC OPD 140414 TCI PER AOB	58
14/04/2014	14/04/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 30.9.14 NA(31.08.14-05.09.14)		SC OPD 140414 TCI PER AOB	58
14/04/2014	14/04/2014			AOB	WL	4	D	RIGHT HYDROCOELECTOMY	N11.1	RIGHT HYDROCOELECTOMY FIT 16.4.14 KK NEED POLISH INTERPRER-WILL TAKE CANCELLATION		SC OPD 140414 TCI PER AOB	58
14/04/2014	14/04/2014			AOB	WL	2	N	TROC,USS & CYSTOSCOPY ?TURP	M47.3	TROC,USS & CYSTOSCOPY ?TURP		PLA PER MR O'BRIEN	58
14/04/2014	14/04/2014			AOB	WL	2	N	TURP HIGH BP NEEDS 24HR MONITORING BEFORE SURGERY	M65.3	TURP HIGH BP NEEDS 24HR MONITORING BEFORE SURGERY FIT 3.7.14 ENSURE BP HAS BEEN CHECKED BY GP BEFORE SURG		PER FUNSHO	58
18/04/2014	18/04/2014			MDH	WL	2	N	TURP	M65.3	TURP FIT 25.9.14 ON SSRI/ACE INHIBITORS/MAXITRAM		PD - PER MR YOUNG AT CLINIC 18.04.14	58

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18/04/2014	18/04/2014			MY	WL	2	N	URETHRAL DILATATION & CHOLECYSTECTOMY TAB DIABETIC	M76.4	URETHRAL DILATATION & CHOLECYSTECTOMY TAB DIABETIC BMI 51.2 ON CANDESARTAN FIT(02.04.15)CD		PD - PER MR YOUNG 18.04.14	58
24/04/2014	24/04/2014			AOB	WL	4	N	DIVISION OF ADHESION ? CIRCUMCISION	N30.3	DIVISION OF ADHESION ? CIRCUMCISION			57
25/04/2014	25/04/2014			MY	WL	2	D	EXCISION GROIN SKIN LESION CHILD	N01.2	EXCISION GROIN SKIN LESION CHILD		PD - PER MR YOUNG AT CLINIC 25.04.14	57
29/04/2014	29/04/2014			AOB	WL	2	N	TURP 85CC PROSTATE	M65.3	TURP 85CC PROSTATE FIT 12.8.14 NIDDM TABLET		PER MR SURESH HAEMATURIA CLINIC	56
29/04/2014	29/04/2014			AOB	WL	4	N	BILATERAL OCHIECTOMY	Z94.1	BILATERAL ORCHIECTOMY			56
29/04/2014	29/04/2014			AOB	WL	4	N	TURP	M65.3	TURP NIDDM DIET FIT(18.11.14)CD		MMCC	56
29/04/2014	29/04/2014			AOB	WL	4	N	RIGHT HYDROCOELECTOMY AND LEFT SCROTAL EXPLORATION	Z94.2	RIGHT HYDROCOELECTOMY AND LEFT SCROTAL EXPLORATION FIT 25.9.14 IDDM			56
30/04/2014	30/04/2014			MY	WL	4	D	PREPULOPLASTY (AVAILABLE AT SHORT NOTICE) MY TO DO	N30.1	PREPULOPLASTY (AVAILABLE AT SHORT NOTICE) MY TO DO LETTER IN B/F FIT 7.7.14 NIDDM DIET		PD - PER MR YOUNG AT HPC 30.04.14	56
30/04/2014	30/04/2014			AOB	WL	4	D	INTRAMURAL INJECTION OF BOTULINUM TOXIN	M13.4	INTRAMURAL INEJCTION OF BOTULINUM TOXIN FIT(06.05.14)CD			56
30/04/2014	30/04/2014			AOB	WL	4	N	HYDROSTATIC DILATATION BLADDER	M43.2	HYDROSTATIC DILATATION BLADDER FIT(08.05.14)CD			56
02/05/2014	02/05/2014			MY	WL	2	D	IVU	M30.1	IVU FIT 24.7.14 KK ACE INHIBITORS		PD - PER MR YOUNG AT CLINIC 02.05.14	56
02/05/2014	02/05/2014			AOB	WL	2	N	RED FLAG GA CYSTOSCOPY +/- BIOPSY +/- RESECTION	M45.9	RED FLAG GA CYSTOSCOPY +/- BIOPSY +/- RESECTION		PLA DSU 020514 WL RED FLAG PER MS HANN	56
02/05/2014	02/05/2014			AOB	WL	2	N	LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M30.9	LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY B6QT 010714, SINGLE KIDNEY		SC URODYNAMICS 020514 TCI JULY '14 PER AOB	56
06/05/2014	06/05/2014			AOB	WL	2	N	TURP	M65.3	TURP FIT 20.5.1 PER PATIENT START OF JANUARY 2015 WOULD BE IDEAL			55
09/05/2014	09/05/2014			AOB	WL	2	D	RED FLAG FLEXIBLE CYSTOSCOPY & CYSTODIATHERMY LA	M45.9	RED FLAG FLEXIBLE CYSTOSCOPY & CYSTODIATHERMY LA		PLA DSU 090514 WL RED FLAG PER FUNSO	55
09/05/2014	09/05/2014			AOB	WL	2	N	CYSTOSCOPY ? BIOPSIES AND HYDROSTATIC DILATATION	M45.9	CYSTOSCOPY ? BIOPSIES AND HYDROSTATIC DILATATION FIT 18.7.14 ACE INHIBITORS/ANTI-PSYCHOTICS			55
12/05/2014	12/05/2014	17/06/2015		KS	WL	2	N	LEFT FLEXIBLE URETEROSCOPY,LASER ABLATION+/-URET.STENTING	M30.9	LEFT FLEXIBLE URETEROSCOPY,LASER ABLATION+/-URET.STENTING		SC CESWL 120514 TCI PER KS	54
12/05/2014	12/05/2014			AOB	WL	4	N	RIGHT ORCHIOPEXY	Z94.2	RIGHT ORCHIOPEXY FIT 15.5.14 KK			54
12/05/2014	12/05/2014			AOB	WL	4	N	TURP ON HOLIDAY 15-22nd January 2015	M65.3	TURP ON HOLIDAY 15-22nd January 2015 ACE INHIBITORS/ANTI-PARKINSON DRUGS FIT(05.11.14)CD			54
14/05/2014	14/05/2014			AOB	WL	2	N	TURP	M65.3	TURP FIT 24.11. WITHHOLD UNTIL SEEN BY ANAESTHETIST (BARIATIC CL			54
15/05/2014	15/05/2014			MY	WL	2	N	LEFT FLEXIBLE URETEROSCOPY - CHANGE CAT 2 PER MRY 19.01.15	M30.9	LEFT FLEXIBLE URETEROSCOPY FIT 30.9.14 KK W/C BMI 55.6 ACE INHIBITORS SSRI TO STAY ON WARFARIN/CONS		SC CESWL 150514 TCI PER MY	54
16/05/2014	16/05/2014			MY	WL	4	D	RIGHT EPIDIDYMAL CYST EXCISION & PENILE SKIN BIOPSY	N15.3	RIGHT EPIDIDYMAL CYST EXCISION & PENILE SKIN BIOPSY FIT 1.10.14 KK - NEW LTR 04.03.15		PER MR YOUNG CLINIC	54
19/05/2014	19/05/2014	02/06/2015		MY	WL	2	D	CYSTOSCOPY, BOTOX & REPEAT BIOPSY (INPATIENT LIST PER MY)	M45.9	CYSTOSCOPY, BOTOX & REPEAT BIOPSY - NEW LTR GP 010515 DAUGHTER PHON ?DATE 15.08.14 FIT 9.3.15 VARIOUS MEDS	ELECTIVE ADMISSIONS WARD	PD - PER MR YOUNG AT BBPC 19.05.14	53
19/05/2014	19/05/2014			MY	WL	2	N	FEB 2015 INTERNAL VISUAL URETHROTOMY	M79.4	FEB 2015 INTERNAL VISUAL URETHROTOMY HOLD(09.07.14)CD (B6QT 16.07.14)		PER MR YOUNG-TCI FEB 2015 PER CARDIOLOGY DEPT	53
21/05/2014	21/05/2014			AOB	WL	4	D	GA CYSTOSCOPY (LETTER IN B/F)	M45.9	GA CYSTOSCOPY		PD - PER MR YOUNG AT HPC 21.05.14	53
27/05/2014	27/05/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT(06.08.14)			52
30/05/2014	30/05/2014			MY	WL	2	N	TURP - NEW LTR SWAH 21.07.14	M65.3	TURP change cat2 - recent sepsis per Gemma 21.07.14		PER RAB	52
30/05/2014	30/05/2014			MY	WL	4	N	TURP - wife phon?date 12.01.15	M65.3	TURP FIT 13.8.14 KK		PD - PER MR YOUNG AT URODYNAMICS 30.05.14	52
30/05/2014	30/05/2014			AOB	WL	4	N	HYDROSTATIC DILATATION OF BLADDER	M43.2	HYDROSTATIC DILATATION OF BLADDER B6QT 220914			52
31/05/2014	31/05/2014			AOB	WL	2	N	CIRCUMCISION AND FLEXIBLE CYSTOSCOPY	N30.3	CIRCUMCISION AND FLEXIBLE CYSTOSCOPY FIT 18.8.14 ANGIOTENSION 11 RECEPTOR ANTAGONISTS			51
07/04/2014	07/04/2014			MY	WL	4	N	TURP WARFARIN (AF) & TAB DIABETIC	M65.3	TURP WARFARIN (AF) & TAB DIABETIC FIT 1.8.14 KK/FMCC NEEDS TO STOP WARFARIN 5 DAYS BEFORE SURGERY/NEEDS INJECTION		PD - PER GEMMA AT HISTO CLINIC 07.04.14	51
03/06/2014	03/06/2014			MY	WL	2	D	SEPT 14 REPEAT RIGHT FLEXIBLE URETEROSCOPY +/- ROS	M30.9	SEPT 14 REPEAT RIGHT FLEXIBLE URETEROSCOPY +/- ROS		PER RAB	51
06/06/2014	06/06/2014			AOB	WL	4	N	TURP (PACEMAKER INSITU)	M65.3	TURP (PACEMAKER INSITU) FIT 8.12.14 NEEDS 7 DAYS NOTICE ON WARFARIN		SC FLEXI 060614 TCI PER REG	51
06/06/2014	06/06/2014			AOB	WL	4	N	INTRAMURAL INJECTION OF BOTULINUM TOXIN	M13.4	INTRAMURAL INJECTION OF BOTULINUM TOXIN FIT 12.6.14 KK			51
09/06/2014	09/06/2014			MDH	WL	4	N	BLADDER NECK INCISION	M66.2	BLADDER NECK INCISION ASPIRIN ALLERGY FIT 26.8.14 KK		PER MR HAYNES	50
10/06/2014	10/06/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 1.9.14 KK			50
23/10/2013	11/06/2014			MY	WL	4	D	CYSTOSCOPY & URETHRAL DILATATION (LETTER IN B/F) BMI48.5	M45.9	CYSTSOCOPY & URETHRAL DILATATION (LETTER IN B/F) BMI48.5		PD - PER MR YOUNG RE: REFERRAL MR BROWN 23.10.13	50
11/06/2014	11/06/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 30.9.14 KK			50
13/06/2014	13/06/2014			AOB	SA	2	N	RED FLAG TURP & INTRAMURAL INJECTION OF BOTULINUM TOXIN	M65.3	RED FLAG TURP & INTRAMURAL INJECTION OF BOTULINUM TOXIN FIT 27.6.14 KK ON CORTICOSTEROIDS		PER MR OBRIEN	50
13/06/2014	13/06/2014			AOB	WL	4	N	HYDROSTATIC DILATATION & INJECTION BOTULINUM TOXIN (150 UNIT	M43.2	HYDROSTATIC DILATATION & INJECTION BOTULINUM TOXIN FIT 4.11.14 H/O MRSA TO BE DONE IN MAIN THEATRE		PER MR OBRIEN	50
13/06/2014	13/06/2014			AOB	WL	2	N	CYSTOSCOPY ?TURP ?INTRAMURAL INJECTION BOTULINUM TOXIN	M45.8	CYSTOSCOPY ?TURP ?INTRAMURAL INJECTION BOTULINUM TOXIN		PER MR OBRIEN	50
16/06/2014	16/06/2014			AOB	WL	2	N	BLADDER NECK INCISION	M66.2	BLADDER NECK INCISION FIT 29.8.14 KK		PER LUTS CLINIC	49
18/06/2014	18/06/2014			AOB	WL	2	N	TURP(CATHETER INSITU)	M65.3	TURP (CATHETER IN SITU) daughter phon 29.07.14 and 25/11/14 ? date			49
18/06/2014	18/06/2014	29/05/2015		KS	WL	4	D	FLEXIBLE CYSTOSCOPY +/- URETHRAL DILATATION	M45.9	FLEXILBE CYSTOSCOPY +/- URETHRAL DILATATION	DAY SURGERY UNIT		49
20/06/2014	20/06/2014			MY	WL	2	N	AIM JUNECYSTOSCOPY & REMOVAL OF STONES AT PROSTATE +/- TURP	M45.9	AIM JUNE CYTOSCOPY & REMOVAL OF STONES AT PROSTATE +/- TURP FIT 29.10.14 KK - AIM JUNE 15		PD - PER GEMMA AT DSU 20.06.14	49

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	20/06/2014	20/06/2014			MY	WL	4	N	TURP	M65.3	TURP FIT 30.9.14 KK		PD - PER MR YOUNG AT CLINIC 20.06.14	49
	20/06/2014	20/06/2014			MY	WL	4	N	BOTOX - NOT SUITALBE FOR DSU PER ANAESTHETIST - TCI 1WEA	M43.4	BOTOX COAG ON ADMISSION FIT 23.6.14 KK - PT PHON ? DATE 23.09.14 BMI 42		PD - PER MR YOUNG AT CLINIC 20.06.14	49
	20/06/2014	20/06/2014			AOB	WL	4	N	BLADDER NECK INCISION/RESECTION	M66.2	BLADDER NECK INCISION/RESECTION FIT 25.9.14 ACE INHIBITORS		PER MR OBRIEN	49
	20/06/2014	20/06/2014			AOB	SA	2	N	RED FLAG LEFT HYDROCOELECTOMY AND LEFT TESTICULAR BIOPSY	N11.1	RED FLAG LEFT HYDROCOELECTOMY AND LEFT TESTICULAR BIOPSY ON WARFARIN FIT 22.7.14 KK BMI39.5 ON LOSARTAN			49
	27/06/2014	27/06/2014			MY	WL	2	N	TURP CATHETER IN SITU	M65.3	TURP CATHETER IN SITU (FIT 08/09/14)		PD - PER MR YOUNG AT CLINIC 27.06.14	48
	27/06/2014	27/06/2014			AOB	WL	4	N	TURP & INJECTION BOTULINUM TOXIN	M65.3	TURP & INJECTION BOTULINUM TOXIN FIT 25.9.14 KK		PER MR OBRIEN	48
	28/06/2014	28/06/2014			AOB	WL	2	N	TURP NOVEMBER 2014	M65.3	TURP NOVEMBER 2014		PER MR OBRIEN	47
	28/06/2014	28/06/2014	29/05/2015		KS	WL	4	D	FLEXIBLE CYSTOSCOPY WHEELCHAIR BOUND SPC IN SITU	M45.9	FLEXIBLE CYSTOSCOPY WHEELCHAIR BOUND SPC IN SITU REQUIRES HOISTING PER MR SURESH	DAY SURGERY UNIT		47
	30/06/2014	30/06/2014			MY	WL	2	N	LEFT PCNL	M09.9	LEFT PCNL		PD - PER STC CLINIC 30.06.14	47
	01/07/2014	01/07/2014			AOB	WL	4	D	RIGHT ORCHIDOPEXY	N09.3	RIGHT ORCHIDOPEXV FIT(07.07.14)CD		PER MR OBRIEN	47
	01/07/2014	01/07/2014			AOB	WL	4	N	RIGHT ORCHIECTOMY MUST BE MAIN THEATRE (COPD)	N13.8	RIGHT ORCHIECTOMY MUST BE MAIN THEATRE (COPD) NA 8-10 September 2014 FIT(21.01.15 ON SSRI/PERSANTIN		PER MR OBRIEN	47
	01/07/2014	01/07/2014			AOB	WL	2	N	RIGHT URETEROGRAPHY & URETEROSCOPY	M30.1	RIGHT URETEROGRAPHY & URETEROSCOPY B6QT 020914 TYPE II - TAB CONTROLLED ON HOLIDAY 12-19/4/15		PER MR OBRIEN	47
	02/07/2014	02/07/2014	29/05/2015		KS	WL	4	D	FLEXIBLE CYSTOSCOPY WILLING TO TAKE CANCELLATION	M45.9	FLEXIBLE CYSTOSCOPY WILLING TO TAKE CANCELLATION	DAY SURGERY UNIT		47
	02/07/2014	02/07/2014			MY	WL	4	N	TURP	M65.3	TURP (FIT(09.10.14)CD		PD - PER MR YOUNG RE: LTR FROM GP	47
	02/07/2014	02/07/2014			AOB	WL	4	N	RIGHT PYELOPLASTY	M10.2	RIGHT PYELOPLASTY		PER MR OBRIEN	47
	04/07/2014	04/07/2014			MY	WL	4	N	REDO TURP - PLAVIX - ON HOLS 16-30 AUG 15 (INCLUSIVE)	M65.3	REDO TURP FIT 7.10.14 NIDDM TABLET VARIOUS MEDS		PD - PER MR YOUNG AT URODYNAMICS 04.07.14	47
	04/07/2014	04/07/2014			MY	WL	2	N	BOTOX & INSERTION OF SPC (?JOD) PLAVIX (NFSN)-will tk canc	M43.4	BOTOX & INSERTION OF SPC (?JOD) (NFSN) - NEW LTR PROF MORRISON VIA PT 23.09.14 FIT(20.10.14)CD/FMCC		PD - PER MR YOUNG AT URODYNAMICS 04.07.14	47
	07/07/2014	07/07/2014			AOB	WL	4	D	DIVISION PREPUTIAL ADHESIONS	N30.2	DIVISION PREPUTIAL ADHESIONS		SC OPD 070714 TCI PER AOB	46
	07/07/2014	07/07/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 25.9.14 CHRONIC PAIN MEDS		SC OPD 070714 TCI PER AOB	46
	08/07/2014	08/07/2014			AOB	WL	2	N	TURP	M65.3	TURP FIT 23.9.14 ACE INHIBITORS (NFSN) PLAVIX (TO STOP 7DAY)		SC OPD 080714 TCI PER AOB	46
	11/07/2014	11/07/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 17.9.14 PAIN MEDS		SC URODYNAMICS 110714 TCI PER AOB	46
	11/07/2014	11/07/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 24.9.14 ACE INHIBITORS		SC URODYNAMICS 110714 TCI PER AOB	46
	16/07/2014	16/07/2014			MY	WL	4	N	TURP (LETTER IN B/F)	M65.3	TURP ACE INHIBITORS FIT(09.10.14)CD		PER MR YOUNG 11.08.14 - PT SEEN AT HPC 16.07.14	45
	17/07/2014	17/07/2014			MY	WL	2	D	LEFT FLEXIBLE URETEROSCOPY	M30.9	LEFT FLEXIBLE URETEROSCOPY		PD - PER MR YOUNG AT STC CLINIC 17.07.14	45
	18/07/2014	18/07/2014			AOB	WL	4	D	CYSTOSCOPY & HYDROSTATIC DILATATION	M45.9	CYSTOSCOPY & HYDROSTATIC DILATATION FIT 7.10.14 NA(19.10-26.10.14) ON SSRI		PD - PER MR YOUNG AT URODYNAMICS 18.07.14	45
	18/07/2014	18/07/2014			MY	WL	4	D	VASECTOMY REVERSAL & INSERTION LEFT TESTICULAR PROSTHESIS	N18.1	VASECTOMY REVERSAL & INSERTION LEFT TESTICULAR PROSTHESIS		PER MR HAYNES - AWAY AUGUST 2015	45
	18/07/2014	18/07/2014			AOB	WL	2	N	RIGHT EPIDIDYMECTOMY	N15.2	RIGHT EPIDIDYMECTOMY		PLA PER PREOPERATIVE ASSESSMENT DEPT	45
	22/07/2014	22/07/2014			AOB	WL	4	D	TUPR	M65.3	TURP		PER MR O'BRIEN DISCHARGE LETTER	44
	25/07/2014	25/07/2014			AOB	WL	4	N	HYDROSTATIC DILATATION OF BLADDER	M43.2	HYDROSTATIC DILATATION OF BLADDER		SC OPD 250714 WL TCI PER AOB	44
	28/07/2014	28/07/2014			MDH	WL	2	N	TURP	M65.3	TURP		PER MR HAYNES	43
	28/07/2014	28/07/2014			AOB	WL	2	N	REMOVAL OF STENT, RIGHT URETEROSCOPIC LASER LITHOTRIPSY	M27.1	REMOVAL OF STENT, RIGHT URETEROSCOPIC LASER LITHOTRIPSY		PER MR OBRIEN	43
	13/11/2012	12/05/2014			MDH	WL	4	D	CIRCUMCISION MR PAHUJA BMI 50 NEEDS INPATIENT	N30.3	CIRCUMCISION LOCAL ANAESTHESIA FIT(25.01.13)		PER MR PAHUJA	43
	31/07/2014	31/07/2014			AOB	WL	2	N	REMOVAL OF STENT & LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M29.3	REMOVAL OF STENT & LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY		PER MR O'BRIEN	43
	01/08/2014	01/08/2014			AOB	WL	2	N	GA CYSTOSCOPY & DIATHERMY	M45.9	GA CYSTOSCOPY & DIATHERMY		SC FLEXI 010814 TCI PER REG	43
	01/08/2014	01/08/2014			AOB	SA	2	D	GA CYSTOSCOPY & BIOPSY	M45.9	GA CYSTOSCOPY & BIOPSY ACE INHIBITORS FIT(03.04.15)CD		PER GEMMA CDSU 010814	43
	02/08/2014	02/08/2014			AOB	WL	2	N	LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M09.2	LEFT FELXIBLE URETEROSCOPIC LITHOTRIPSY			43
	03/08/2014	03/08/2014			AOB	WL	2	N	REMOVAL OF STENT AND LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M29.3	REMOVAL OF STENT AND LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY			42
	04/08/2014	04/08/2014			AOB	WL	4	N	RESECTION OF VAGINAL CYST	Y06.2	RESECTION OF VAGINAL CYST FIT 8.10.14 KK			42
	04/08/2014	04/08/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 8.10.14 ASTHMA MEDS			42
	04/08/2014	04/08/2014			AOB	WL	4	D	CORRECTION OF ERECTILE DEFORMITY	N28.8	CORRECTION OF ERECTILE DEFORMITY DIABETIC NIDDM TABLET B6QT 071014			42
	05/08/2014	05/08/2014			MY	WL	2	N	TURP WARFARIN (LETTER IN B/F)	M65.3	TURP (NFSN-WARFARIN) (FIT 05/11/14)		PER MR YOUNG RE: REFERRAL GP	42
	05/08/2014	05/08/2014			AOB	WL	2	N	LEFT NEPHROURETERECTOMY AND RIGHT URETERIC REIMPLANTATION	M20.2	LEFT NEPHROURETERECTOMY AND RIGHT URETERIC REIMPLANTATION FIT 30.9.14 ASTHMA MEDS		PLA OPD 050814 WL PER MR O'BRIEN	42
	05/08/2014	05/08/2014			AOB	WL	4	N	CYSTOSCOPY / ? URETHROTOMY	M45.9	CYSTOSCOPY / ? URETHROTOMY		PLA OPD 050814 WL PER MR O'BRIEN	42
	05/08/2014	05/08/2014			AOB	WL	4	N	RIGHT ORCHIOPEXY ? ORCHIECTOMY	N09.3	RIGHT ORCHIOPEXY ? ORCHIECTOMY FIT 7.10.14 KK		PLA OPD 050814 WL PER MR O'BRIEN	42
	05/08/2014	05/08/2014			AOB	WL	4	D	INTRAMURAL INJECTION OF 1000 UNITS OF BOTULINUM TOXIN	M13.4	INTRAMURAL INJECTION OF 1000 UNITS OF BOTULINUM TOXIN FIT 13.1.15 KK		PLA OPD 050814 WL PER MR O'BRIEN	42
	05/08/2014	05/08/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 1.12.14 KK		PLA OPD 050814 WL PER MR O'BRIEN	42
	05/08/2014	05/08/2014			AOB	WL	4	N	CIRCUMCISION	N30.3	CIRCUMCISION FIT 25.9.14 KK BMI 35 - TYPE II DIABETIC		PLA OPD 050814 WL PER MR O'BRIEN	42
	06/08/2014	06/08/2014			AOB	WL	2	N	ILEAL CONDUIT URINARY DIVERSION	M19.1	ILEAL CONDUIT URINARY DIVERSION		PER AOB EMAIL	42
	07/08/2014	07/08/2014			MY	WL	2	N	LEFT FLEXIBLE URETEROSCOPY & LASERTRIPSY	M30.9	LEFT FLEXIBLE URETEROSCOPY & LASERTRIPSY		PER STC	42
	08/08/2014	08/08/2014			MY	WL	4	N	NESBITT'S PROCEDURE	N28.8	NESBITT'S PROCEDURE		PER MR YOUNG AT CLINIC 08.08.14	42
	08/08/2014	08/08/2014			AOB	WL	2	N	BLADDER BIOPSIES & INTRAMURAL INJECTION OF BOTULINUM TOXIN	M45.1	BLADDER BIOPSIES & INTRAMURAL INJECTION OF(500U) BOTOX			42
	03/06/2014	03/06/2014			KS	WL	4	N	RIGHT FLEXIBLE URETEROSCOPY, LASER STONE ABLATION & STENTING	M30.9	RIGHT FLEXIBLE URETEROSCOPY, LASER STONE ABLATION & STENTING] fit 6.1.15 NIDDM TABLET			42
	11/08/2014	11/08/2014			MY	WL	4	D	FLEXIBLE URETEROSCOPY/LASER STONE ABLATION/URETERIC STENTING	M30.9	FLEXIBLE URETEROSCOPY/LASER STONE ABLATION/URETERIC STENTING		PER KS STC	41
	11/08/2014	11/08/2014			MY	WL	2	D	URETHRAL DILATATION +/- OPTICAL URETHROTOMY DIFFICULT	M76.4	URETHRAL DILATATION +/- OPTICAL URETHROTOMY FIT 4.11.14 IDDM		PD - PER MR YOUNG AT SWAH 11.08.14	41

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13/06/2014	13/06/2014			MDH	WL	4	N	TURP	M65.3	TURP B6QT 131114 HOLD(12.11.14)CD		PER MR HAYNES	41
12/08/2014	12/08/2014			MY	WL	2	N	IVU/URETHRAL DILATATION (LETTER IN B/F)	M30.1	IVU/URETHRAL DILATATION FIT 23.3.15 DEAF LEFT EAR ACE INHIBITORS		PD - PER MR YOUNG RE: LTR Personal	41
30/04/2014	30/04/2014		01/06/2015	AOB	WL	4	N	TURP - (SUSPEND UNTIL OCTOBER 15 PER AOB (E-MAIL)	M65.5	TURP - (SUSPEND UNTIL OCTOBER 15 PER AOB (E-MAIL) B6QT 240614 NIDDM TABLET ACE INHIBITORS/ASTHMA MEDS			41
13/08/2014	13/08/2014			AOB	WL	4	N	TURP	M65.1	TURP		per aob email	41
15/08/2014	15/08/2014			AOB	WL	2	N	CYSTOSCOPY ? URETHROTOMY & HYDROSTATIC DILATATION OF BLADDER	M45.9	CYSTOSOCPY ? URETHROTOMY & HYDROSTATIC DILATATION OF BLADDER FIT 4.11.14 NIDDM TABLET ASTHMA MEDS			41
15/08/2014	15/08/2014			AOB	WL	4	N	TURP AND BOTULINUM TOXIN	M65.3	TURP AND BOTULINUM TOXIN FIT 4.11.14 NIDDM TABLET			41
15/08/2014	15/08/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 6.1.15 ON SSRI/ASTHMA MEDS			41
20/08/2014	20/08/2014	19/06/2015		KS	WL	2	D	FLEXIBLE CYSTOSCOPY - NEEDS 2 SLOTS - NEEDS HOISTING	M45.9	FLEXIBLE CYSTOSCOPY - NEEDS 2 SLOTS - NEEDS HOISTING	DAY SURGERY UNIT		40
21/08/2014	21/08/2014			MY	WL	2	D	URETEROSCOPY - PT PHONED ? DATE 27.11.14	M30.9	URETEROSCOPY FIT 29.10.14 ACE INHIBITORS		PER STC CLINIC 21.08.14	40
26/08/2014	26/08/2014			AOB	WL	4	N	TURP	M65.3	TURP HOLS 280515-040615 - ON LOSARSTAN FIT (21.11.14)CD			39
26/08/2014	26/08/2014			AOB	WL	2	N	DIVISION OF PREPUTIAL ADHESIONS ? CIRCUMCISION	N30.2	DIVISION OF PREPUTIAL ADHESIONS ? CIRCUMCISION FIT 5.9.14 KK			39
29/08/2014	29/08/2014			AOB	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			39
29/08/2014	29/08/2014			MDH	WL	4	N	CYSTOSCOPY, RETROGRADE & URETEROSCOPY	M45.8	CYSTOSCOPY, RETROGRADE & URETEROSCOPY		PER MR HAYNES	39
29/08/2014	29/08/2014			AOB	WL	4	D	INTRAMURAL INJECTION OF 250 UNITS OF BOTULINUM TOXIN	M43.4	INTRAMURAL INJECTION OF 250 UNITS OF BOTULINUM TOXIN			39
01/09/2014	01/09/2014			AOB	WL	4	N	TURP	M65.3	TURP NIDDM TABLET8 NA(29.12.14-04.02.15) FIT(21.11.14)CD		SC OPD 010914 TCI PER AOB	38
01/09/2014	01/09/2014	29/05/2015		KS	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	PER KS LUTS CLINIC	38
06/11/2012	04/11/2013			KS	WL	4	D	CIRCUMCISION UNDER LA	N30.3	CIRCUMCISION UNDER LA		PER MR CONNOLLY	38
05/09/2014	05/09/2014	02/06/2015		MY	WL	4	D	FRENULOPLASTY POLISH INTERPRETER	N28.4	FRENULOPLASTY POLISH INTERPRETER FIT 8.9.14/UPDATED 21/05/15	DAY SURGERY UNIT	PD - PER MR YOUNG AT CLINIC 05.09.14	38
05/09/2014	05/09/2014			MY	WL	4	D	BOTOX	M43.4	BOTOX FIT(21.11.14)CD		PD - PER MR YOUNG AT URODYNAMICS 05.09.14	38
19/05/2014	19/05/2014			AOB	WL	4	D	CIRCUMCISION ECHO COMPLETED 23/4/15	N30.3	CIRCUMCISION ECHO COMPLETED 23/4/15 FIT 29.4.15 ACE INHIBITORS		PD - PER MR YOUNG AT BBPC 19.05.14	38
08/09/2014	08/09/2014			MY	WL	2	D	LEFT URETEROSCOPY, LASERTRIPSY +/- STENT NIDDM	M30.9	LEFT URETEROSCOPY, LASERTRIPSY +/- STENT NIDDM FIT 19.12.14NIDDM TAB ON SSRI/ANXIOLYTICS		PER STC CLINIC 08.09.14	37
20/08/2014	20/08/2014		01/10/2015	JOD	WL	2	N	TURP	M65.3	TURP B6QT 201114 NEEDS OK FROM MEDICS AND ASSESSED BY ANAESTHETIST FIRST JOD		PER MR O'DONOGHUE CLINIC LETTER	37
09/09/2014	09/09/2014	19/06/2015		KS	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	PER KS CLINIC	37
09/09/2014	09/09/2014			AOB	WL	2	N	ILEAL CONDUIT URINARY DIVERSION	M19.8	ILEAL CONDUIT URINARY DIVERSION FIT(30.10.14) ON SSRI/ANXIOLYTICS			37
09/09/2014	09/09/2014			AOB	WL	4	N	CYSTOSCOPY AND URETHRAL DILATATION/URETHROTOMY	M45.9	CYSTOSCOPY AND URETHRAL DILATATION/URETHROTOMY FIT 4.2.15 KK			37
10/09/2014	10/09/2014	02/06/2015		MY	WL	4	D	BOTOX (LETTER IN B/F)	M43.4	BOTOX (LETTER IN B/F) FIT 12.12.14 ASTHMA MEDS WILL TAKE LAST MIN CANCELLATION	DAY SURGERY UNIT	PD - PER MR YOUNG RE: LTR GP 04.08.14	37
11/09/2014	11/09/2014			MY	WL	2	D	LEFT RIGID URETEROSCOPY	M30.9	LEFT RIGID URETEROSCOPY		PER STC CLINIC 11.09.14	37
03/02/2014	03/02/2014		01/07/2015	AJG	WL	2	N	LEFT LAP NEPHRECTOMY (AWAIT INFO FROM NEPHROLOGY)	M02.5	LEFT LAP NEPHRECTOMY (AWAIT INFO FROM NEPHROLOGY)		PER MR GLACKIN	37
12/09/2014	12/09/2014			AOB	WL	2	N	AUGMENTATION ILEOCYSTOPLASTY	M36.8	AUGMENTATION ILEOCYSTOPLASTY			37
12/09/2014	12/09/2014			AOB	WL	2	N	GA CYSTOSCOPY AND URETHRAL STONE FRAGMENTATION	M45.9	GA CYSTOSCOPY AND URETHRAL STONE FRAGMENTATION			37
12/09/2014	12/09/2014			MY	WL	4	N	TURP PLAVIX - RES REC'D GP 27.04.15	M65.3	TURP PLAVIX ON IRBESARTAN/ELIQUIS APRIXABAN FIT(12.11.14)CD/FMCC		PD - PER MR YOUNG AT CLINIC 12.09.14	37
15/09/2014	15/09/2014			MDH	WL	4	D	EXCISION EPIDIDYMAL CYST WARFARIN & DIABETIC	N15.3	EXCISION EPIDIDYMAL CYST WARFARIN & DIABETIC		PER MR HAYNES	36
15/09/2014	15/09/2014	10/06/2015		JOD	WL	2	D	CYSTOSCOPY & CYSTODISTENTION	M45.9	CYSTOSCOPY & CYSTODISTENTION CHANGE OF URGENCY PER URODYNAMICS 09/02/15 FIT 10.3.15 KK	DAY SURGERY UNIT		36
17/09/2014	17/09/2014	19/06/2015		KS	WL	4	D	FLEXIBLE CYSTOSCOPY +/- URETHRAL DILATATION DIABETES	M45.9	FLEXIBLE CYSTOSCOPY +/- URETHRAL DILATATION DIABETES WILLING TO TAKE CANCELLATION	DAY SURGERY UNIT	PER MR SURESH	36
17/09/2014	17/09/2014	19/06/2015		KS	WL	2	D	FLEXIBLE CYSTOSCOPY URGENT	M45.9	FLEXIBLE CYSTOSCOPY URGENT	DAY SURGERY UNIT	PER MR SURESH CLINIC	36
17/09/2014	17/09/2014			MY	WL	4	D	CIRCUMCISION UNDER LA (LETTER IN B/F)	N30.3	CIRCUMCISION UNDER LA (LETTER IN B/F)		PD - PER MR YOUNG AT HPC 17.09.14	36
17/09/2014	17/09/2014			AJG	WL	4	D	NESBITT'S PROCEDURE & CIRCUMCISION CAH ONLY PER AJG	N30.3	CIRCUMCISION CAH ONLY PER AJG FIT 17.12.14 KK		PER GREEN PROFRMA	36
19/09/2014	19/09/2014			MY	WL	2	N	OPTICAL URETHROTOMY & CYSTOSCOPY +/- GLANS BIOPSY	M76.3	OPTICAL URETHROTOMY & CYSTOSCOPY +/- GLANS BIOPSY Son phoned 231014 arrange pt TCI after 10/11/14 if possible		PER KAREN AT DSU 19.09.14	36
19/09/2014	19/09/2014			MY	WL	2	N	LEFT PYELOPLASTY	M05.1	LEFT PYELOPLASTY FIT 3.12.14 KK		PD - PER MR YOUNG AT CLINIC 19.09.14	36
19/09/2014	19/09/2014			MY	WL	4	N	TURP	M65.3	TURP FIT 12.12.14 KK		PD - PER MR YOUNG AT URODYNAMICS 19.09.14	36
19/09/2014	19/09/2014			AOB	WL	2	N	INTRAMURAL INJECTION OF BOTULINUM TOXIN	M43.4	INTRAMURAL INJECTION OF BOTULINUM TOXIN			36
21/09/2014	21/09/2014			MY	WL	2	N	TURP CATHETER IN SITU	M65.3	TURP CATHETER IN SITU		PER E-DISCHARGE SUMMARY 21.09.14	35
22/09/2014	22/09/2014			MY	WL	4	N	TURP	M65.3	TURP FIT 5.12.14 NIDDM TABLET		PER LUTS CLINIC	35
23/09/2014	23/09/2014			AOB	WL	4	N	CORRECTION OF PENILE ERECTILE DEFORMITY	N28.8	CORRECTION OF PENILE ERECTILE DEFORMITY FIT 2.2.15 NA(UNTIL AFTER 1 FEB 15)			35
23/09/2014	23/09/2014			AOB	WL	2	N	LEFT URETEROSCOPIC LITHOTRIPSY	M09.2	LEFT URETEROSCOPIC LITHOTRIPSY FIT(21.11.14)CD/FMCC			35
23/09/2014	23/09/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 9.12.14 KK			35
24/09/2014	24/09/2014			MDH	WL	4	N	TURP	M65.3	TURP		PER MR HAYNES	35
26/09/2014	26/09/2014			MY	WL	4	D	GA CYSTOSCOPY & URETHRAL DILATATION	M45.9	GA CYSTOSCOPY & URETHRAL DILATATION B6QT 101214		PER KAREN AT DSU 26.09.14	35
26/09/2014	26/09/2014			MY	WL	4	D	CYSTOSCOPY & INSERTION OF URODYNAMIC CATHETERS	M45.9	CYSTOSCOPY & INSERTION OF URODYNAMIC CATHETERS FIT 3.12.14 KK		PD - PER MR YOUNG AT CLINIC 26.09.14	35

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26/09/2014	26/09/2014			MY	WL	2	N	TURP CATHETER IN SITU	M65.3	TURP CATHETER IN SITU B6D 181214		PD - PER MR YOUNG AT CLINIC 26.09.14	35
21/07/2014	21/07/2014			AJG	WL	2	N	BOTOX INJECTIONS DIABETIC INPATIENT ONLY PER PREOP	M43.4	BOTOX INJECTIONS AND CYSTOSCOPY DIABETIC INPATIENT ONLY IDDN/NIDDM TABLET ON ANXIOLYTICS MAIN THEATRES ONLY FIT		PER AJG CLINIC	34
29/09/2014	29/09/2014			MY	WL	2	N	LEFT URETEROSCOPY +/- LASERTRIPSY +/- STENT IDDM	M30.9	LEFT URETEROSCOPY +/- LASERTRIPSY +/- STENT IDDM		PER STC CLINIC 29.09.14	34
29/09/2014	29/09/2014	11/06/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	THORNDALE UNIT	FLEXIBLE CYSTOSCOPY	34
30/09/2014	30/09/2014			AOB	WL	2	N	INTRAMURAL INJECTION OF 500 UNITS OF BOTULINUM TOXIN	M43.4	INTRAMURAL INJECTION OF 500 UNITS OF BOTULINUM TOXIN			34
01/10/2014	01/10/2014			MY	WL	4	D	BLADDER STONE REMOVAL (PATIENT TO CONTACT WHEN FREE)	M39.1	BLADDER STONE REMOVAL		PER WARD DISCHARGE	34
01/10/2014	01/10/2014			MY	WL	4	D	CYSTOSCOPY - STH PER MR YOUNG	M45.9	CYSTOSCOPY - STH PER MR YOUNG		PER GREEN PROFORMA	34
02/10/2014	02/10/2014			MY	WL	2	D	LEFT URETEROSCOPY	M30.9	LEFT URETEROSCOPY		PER STC CLINIC 02.10.14	34
03/10/2014	03/10/2014			MY	WL	4	N	BLADDER NECK INCISION METHOTREXATE	M66.2	BLADDER NECK INCISION METHOTREXATE FIT 3.12.14 KK		PD - PER MR YOUNG AT URODYNAMICS 03.10.14	34
06/10/2014	06/10/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 24.12.14 KK ACE INHIBITORS			33
06/10/2014	06/10/2014			MDH	WL	4	D	CIRCUMCISION LOCAL ANAESTHETIC INPATIENT	N30.3	CIRCUMCISION LOCAL ANAESTHETIC INPATIENT		PER MR HAYNES	33
06/10/2014	06/10/2014			MY	WL	4	N	TURP	M65.3	TURP PT PHON?DATE 21.01.15-SYMPTOMS WORSE-ADVISED SEE GP		PER RACHAEL	33
07/10/2014	07/10/2014			AOB	WL	2	N	RIGHT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M09.2	RIGHT FLEXIBLE URETEROSCOPIC LITHOTRIPSY			33
07/10/2014	07/10/2014			AOB	WL	2	N	TROC, USS ?TURP	M47.3	TROC, USS ?TURP			33
08/10/2014	08/10/2014	19/06/2015		KS	WL	2	D	FLEXIBLE CYSTOSCOPY TYPE 2 DIABETES	M45.9	FLEXIBLE CYSTOSCOPY TYPE 2 DIABETES	DAY SURGERY UNIT	PER MR SURESH CLINIC	33
08/10/2014	08/10/2014			MY	WL	4	D	CYSTOSCOPY URETHRAL DILATATION HYDROSTATIC LETTER IN B/F	M45.9	CYSTOSCOPY URETHRAL DILATATION HYDROSTATIC MOTHER PHON 16.02.15 ? DATE ON OESTROGEN OCP FIT 26.2.15		PER GREEN PROFORMA	33
08/10/2014	08/10/2014			MY	WL	4	D	VASECTOMY LETTER IN B/F	N17.1	VASECTOMY FIT 9.2.15 KK		PER GREEN PROFORMA	33
09/10/2014	09/10/2014	01/06/2015		MY	WL	2	N	URETHRAL DILATATION +/- CIRCUMCISION +/- GLANS BIOPSY	M76.4	URETHRAL DILATATION +/- CIRCUMCISION +/- GLANS BIOPSY FIT 29.10.14 TRICYCLIC ANTIDEPRESSANTS	STH DAY PROCEDURE UNIT	PER KAREN AT HAEMATURIA CLINIC 09.10.14	33
13/10/2014	13/10/2014	19/06/2015		KS	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	SC CESWL 131014 URG FLEXI PER KS	32
13/10/2014	13/10/2014			MY	WL	4	D	HYDROCELE REPAIR PLAVIX CARDIAC STENTS/SLEEP APNOEA	N11.8	HYDROCELE REPAIR B6QT 090215 ON BISOPROLOL/CANDESARTAN		PLA WL PER MR YOUNG	32
14/10/2014	14/10/2014			MY	WL	4	D	EXCISION OF PENILE SKIN TAG +/- CIRCUMCISION	N27.1	EXCISION OF PENILE SKIN TAG +/- CIRCUMCISION FIT 13.2.15 KK		PER MR YOUNG RE: NEW LTR GP	32
14/10/2014	14/10/2014			AJG	WL	4	N	RIGHT FLEXIBLE URETEROSCOPY AND LASER	M30.9	RIGHT FLEXIBLE URETEROSCOPY AND LASER FIT 6.1.15 BMI 40+		PER GREEN FORM	32
14/10/2014	14/10/2014	09/06/2015		JOD	WL	2	D	FLEXIBLE CYSTOSCOPY +/- BIOPSIES	M45.9	FLEXIBLE CYSTOSCOPY +/- BIOPSIES CHECK PSA BEFORE FLEXI IF ELEVATED NEEDS BIOPSY	1 WEST ELECTIVE ADMISSION WARD	sm flexible cystoscopy	32
14/10/2014	14/10/2014	27/05/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	SM FLEXIBLE CYSTOSCOPY	32
14/10/2014	14/10/2014			AOB	WL	4	N	TURP	M65.3	TURP			32
14/10/2014	14/10/2014			AOB	WL	2	N	TROC, ULTRASOUND SCAN ?TURP (ON NO ORAL ANTICOAGULANTS)	M47.3	TROC ULTRASOUND SCAN ?TURP (ON NO ORAL ANTICOAGULANTS) FIT 15.12.14 KK TCI DAY BEFORE SURGERY FOR CLEXANE - H/O AF			32
14/10/2014	14/10/2014			AOB	WL	2	N	CIRCUMCISION	N30.3	CIRCUMCISION FIT 15.10.14 KK			32
05/09/2014	14/10/2014			AOB	WL	2	N	INTRAMURAL BOTULINUM TOXIN AND PERIPROSTATIC INJECTION	M43.4	INTRAMURAL BOTULINUM TOXIN AND PERIPROSTATIC INJECTION GIVE DATE IN 2 MONTHS TIME DUE TO TOOTH ABSCESS 14/10/14			32
15/10/2014	15/10/2014	19/06/2015		KS	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	PER KS CLINIC	32
16/10/2014	16/10/2014	27/05/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	SM FLEXIBLE CYSTOSCOPY	32
20/10/2014	20/10/2014	27/05/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	FLEXIBLE CYSTOSCOPY	31
20/10/2014	20/10/2014			AOB	WL	2	N	CYSTOSCOPY AND CYSTOGRAM	M45.9	CYSTOSCOPY AND CYSTOGRAM FIT 22.10.14 KK			31
20/10/2014	20/10/2014			MDH	WL	4	N	LEFT EPIDIDYMAL CYSTECTOMY AND FLEXIBLE CYSTOSCOPY	N15.3	LEFT EPIDIDYMAL CYSTECTOMY AND FLEXIBLE CYSTOSCOPY FIT 19.12.14 KK			31
20/10/2014	20/10/2014			AOB	WL	4	N	CIRCUMCISION (DEPENDENT UPON PUBLIC TRANSPORT)	N30.3	CIRCUMCISION (DEPENDENT UPON PUBLIC TRANSPORT) ADHD AND DEPENDENT ON PUBLIC TRANSPORT - TO HAVE SIDE ROOM			31
22/10/2014	22/10/2014	28/05/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	FLEXIBLE CYSTOSCOPY	31
22/10/2014	22/10/2014	19/06/2015		KS	WL	2	D	FLEXIBLE CYSTOSCOPY +/- URETHRAL DILATATION	M45.9	FLEXIBLE CYSTOSCOPY +/- URETHRAL DILATATION	DAY SURGERY UNIT	PER KS CLINIC	31
23/10/2014	23/10/2014	28/05/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	FLEXIBLE CYSTOSCOPY	31
23/10/2014	23/10/2014	28/05/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	FLEXIBLE CYSTOSCOPY	31
23/10/2014	23/10/2014			MY	WL	2	N	RIGHT FLEXIBLE URETEROSCOPY-CHANGE TO CAT2 PER MRY 19.01.15	M30.9	RIGHT FLEXIBLE URETEROSCOPY FIT 25.3.15 KK		SC CESWL 231014 TCI PER MY	31
24/10/2014	24/10/2014			MY	WL	2	N	ORCHIDOPEXY	N09.3	ORCHIDOPEXY FIT 29.10.14 KK		PER MY GREEN PROFORMA	31
24/10/2014	24/10/2014			MY	WL	2	N	TURP (CATHETER IN SITU)	M65.3	TURP (CATHETER IN SITU) FIT 13.1.15 NIDDM TABLET		PER MY GREEN PROFORMA	31
24/10/2014	24/10/2014			MY	WL	2	N	OPTICAL URETHROTOMY - URGENT	M76.3	OPTICAL URETHROTOMY - URGENT FIT 3.12.14 KK		PER REG CDSU DISCHARGE LETTER	31
24/10/2014	24/10/2014			MDH	WL	4	N	TURP	M65.3	TURP		PER MR HAYNES	31
26/10/2014	26/10/2014			AOB	WL	2	N	REMOVAL OF STENT AND LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M29.3	REMOVAL OF STENT AND LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY			30
26/10/2014	26/10/2014			AOB	WL	2	N	REMOVAL OF STENT AND FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M29.3	REMOVAL OF STENT AND FLEXIBLE URETEROSCOPIC LITHOTRIPSY		SC CESWL 300115 TCI APRIL 2015 PER MY	30
27/10/2014	27/10/2014	10/06/2015		JOD	WL	2	N	FLEXIBLE CYSTOSCOPY & EUA	M45.9	FLEXIBLE CYSTOSCOPY & EUA ONLY BOOK AFTER PATIENT HAS HAD MRI SCAN	1 WEST ELECTIVE ADMISSION WARD	AS PER MR YOUNG	30
27/10/2014	27/10/2014			MY	WL	2	N	FLEXIBLE URETEROSCOPY & LASERTRIPSY HUNGARIAN INTERP	M30.9	FLEXIBLE URETEROSCOPY & LASERTRIPSY HUNGARIAN INTERP FIT		PD - PER MR YOUNG AT SWAH CLINIC 27.10.14	30
27/10/2014	27/10/2014			AOB	WL	4	N	TURP	M65.3	TURP		per rachael	30
29/10/2014	29/10/2014	28/05/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	THORNDALE UNIT		30
30/10/2014	30/10/2014	11/06/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	THORNDALE UNIT		30
30/10/2014	30/10/2014	18/06/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	THORNDALE UNIT		30
30/10/2014	30/10/2014			MY	WL	4	N	LEFT FLEXIBLE URETEROSCOPIC LASERTRIPSY	M09.2	LEFT FLEXIBLE URETEROSCOPIC LASERTRIPSY PT PHON 09121480601152101158130215&260315 ?TCI WLL TAKE CNC		SC CESWL 301014 TCI PER MY	30

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30/10/2014	30/10/2014			MY	WL	4	N	RIGHT FLEXIBLE URETEROSCOPIC LASERTRIPSY	M09.2	RIGHT FLEXIBLE URETEROSCOPIC LASERTRIPSY		SC CESWL 301014 TCI PER MY	30
31/10/2014	31/10/2014			MY	WL	2	N	TURP CATHETER IN SITU	M65.3	TURP CATHETER IN SITU CERT 2 ON GREEN PROFORMA FIT 12.1.15 KK		PER GREEN PROFORMA	30
07/11/2014	07/11/2014			AOB	WL	2	N	OPTICAL URETHROTOMY	M76.3	OPTICAL URETHROTOMY FIT 8.1.15		PER REG CDSU	29
10/11/2014	10/11/2014			MY	WL	2	N	TURP PLAVIX	M65.3	TURP CAN TAKE CANCELLATION AT SHORT NOTICE FIT 9.2.15 KK		PER OUTCOME SHEET	28
10/11/2014	10/11/2014			MY	WL	4	N	TURP	M65.3	TURP FIT 9.2.15 KK ASTHMA MEDS		PER OUTCOME SHEET 101114	28
10/11/2014	10/11/2014			MY	WL	2	N	TURP WARFARIN/CATHETER IN SITU	M65.3	TURP WARFARIN/CATHETER IN SITU B6QT 260215 ON CORTICOSTEROIDS		PER OUTCOME SHEET	28
10/11/2014	10/11/2014			AOB	WL	2	N	UROSTOMY REFASHIONING OF STOMA	M19.5	UROSTOMY REFASHIONING OF STOMA		PER DISCHARGE SUMMARY	28
10/11/2014	10/11/2014			KS	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER READMISSION BOOK	28
10/11/2014	10/11/2014			MY	WL	2	D	CHANGE OF NEPHROSTOMY (XRAY TO CONTACT)	M06.4	CHANGE OF NEPHROSTOMY (XRAY TO CONTACT)		PD - PER RACHAEL AT CLINIC 10.11.14	28
10/11/2014	10/11/2014			AOB	WL	2	N	CYSTOSCOPY AND (OPEN?) SUPRAPUBIC CATHETERISATION	M45.9	CYSTOSCOPY AND (OPEN?) SUPRAPUBIC CATHETERISATION			28
10/11/2014	10/11/2014			AOB	WL	2	N	MITROFANOFF CONDUIT URINARY DIVERSION	M19.2	MITROFANOFF CONDUIT URINARY DIVERSION			28
10/11/2014	10/11/2014			MY	WL	4	N	LASERTRIPSY PROSTATIC STONES & BLADDER NECK INCISION	M67.4	LASERTRIPSY PROSTATIC STONES & BLADDER NECK INCISION FIT 27.1.15 KK		SC OPD 101114 TCI PER REG	28
11/11/2014	11/11/2014			AOB	WL	2	N	TURP	M65.3	TURP			28
11/11/2014	11/11/2014			AOB	WL	2	N	TURP (CATHETER INSITU)	M65.3	TURP (CATHETER INSITU) FIT(02.01.15)			28
11/11/2014	11/11/2014			AJG	WL	4	D	CYSTOLITHOLAPAXY	M44.1	CYSTOLITHOLAPAXY FIT(210115) ASTHMA MEDS		PER AJG GREEN FORM	28
13/11/2014	13/11/2014			MY	WL	2	N	LEFT URETEROSCOPY, RETROGRADE, +/- STONE OBLATION CYSTOSCOPY	M30.9	LEFT URETEROSCOPY, RETROGRADE, +/- STONE OBLATION CYSTOSCOPY FIT 24.4.15 KK		PER STC REV CLINIC	28
14/11/2014	14/11/2014			AOB	WL	2	N	TURP (WARFARIN AND PACEMAKER)	M65.3	TURP (WARFARIN AND PACEMAKER) ON IRBESARTAN FIT(04.02.15)CD/FMCC			28
14/11/2014	14/11/2014			MY	WL	4	N	NESBITT'S PROCEDURE	M28.8	NESBITT'S PROCEDURE		PER MR YOUNG CLINIC	28
14/11/2014	14/11/2014			MY	WL	2	N	GA CYSTOSCOPY +/- URETHRAL DILATATION +/- URETHROTOMY	M45.9	GA CYSTOSCOPY +/- URETHRAL DILATATION +/- URETHROTOMY		PER MR YOUNG CLINIC	28
14/11/2014	14/11/2014			AOB	WL	2	N	TROC,U/S AND CYSTOSCOPY ?TURP	M47.3	TROC, U/S AND CYSTOSCOPY /TURP			28
17/11/2014	17/11/2014			MY	WL	4	D	URETEROSCOPY & ABLATION	M30.9	URETEROSCOPY & ABLATION		PER STC 171114	27
17/11/2014	17/11/2014			MY	WL	4	D	URETEROSCOPY +/- STENTING & ABLATION	M30.9	URETEROSCOPY +/- STENTING & ABLATION		PER STC 171114	27
17/11/2014	17/11/2014			AOB	WL	2	N	TURP	M65.3	TURP FIT 27.1.15 KK			27
18/11/2014	18/11/2014	18/06/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	THORNDALE UNIT		27
18/11/2014	18/11/2014			AOB	WL	2	N	TROC, USS ?TURP - ECHO REQUESTED PRIOR TO SURGERY 17/12/14	M47.3	TROC, USS ?TURP NIDDM TABLET/IDDM NEEDS TO BE BROUGHT IN DAY BEFORE - INSULIN DIABETIC FIT			27
18/11/2014	18/11/2014			AOB	WL	2	N	BLADDER LITH0TRIPSY ?TURP	M09.2	BLADDER LITHOTRIPSY ?TURP FIT 3.2.15 NIDDM TABLET ON PREDNISDONE MAIN THEATRES ONLY			27
11/02/2013	19/11/2014			JOD	WL	4	N	TURP	M65.3	TURP B6 QUERY TRAY 300313 HOLD(28.03.13)CD		PER MR HENNESSEY	27
19/09/2014	19/09/2014			MDH	WL	2	N	TURP CATHETER INSITU WANTS JANUARY 2015	M65.3	TURP CATHETER INSITU WANTS JANUARY 2015		PER MR HAYNES	27
19/11/2014	19/11/2014			AJG	WL	4	N	TURP WARFARIN	M65.3	TURP WARFARIN FIT 16.1.15 ACE INHIBITORS		PER MR GLACKIN	27
19/11/2014	19/11/2014	29/05/2015		KS	WL	2	D	FLEXIBLE CYSTOSCOPY +/- URETHRAL DILATATION LATE APPT	M45.9	FLEXIBLE CYSTOSCOPY +/- URETHRAL DILATATION LATE APPT	DAY SURGERY UNIT	PER KS CLINIC	27
19/11/2014	19/11/2014			AOB	WL	2	N	GA CYSTOSCOPY & PROSTATIC MASSAGE	M45.9	GA CYSTOSCOPY & PROSTATIC MASSAGE B6QT 160115 HOLD(15.01.15)CD ACE INHIBITORS CAH MAIN THEAR		PER MR SURESH CLINIC	27
20/11/2014	20/11/2014	18/06/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	THORNDALE UNIT		27
23/11/2014	23/11/2014			MY	WL	2	D	6/52 FLEXIBLE URETEROSCOPY	M30.9	6/52 FLEXIBLE URETEROSCOPY		PER WARD DISCHARGE	26
24/11/2014	24/11/2014	24/06/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT		26
24/11/2014	24/11/2014	24/06/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT		26
24/11/2014	24/11/2014			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			26
14/10/2014	14/10/2014			KS	WL	2	N	TURP	M65.3	TURP FIT 8.12.14 KK		PER MR SURESH CLINIC	26
25/11/2014	25/11/2014			AOB	WL	2	N	LEFT RIGID AND FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M09.2	LEFT RIDID AND FLEXIBLE URETEROSCOPIC LITHOTRIPSY FIT(26.11.14)CD/KH 31/8/15-12/9/15 ON HOLIDAY			26
25/11/2014	25/11/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 26.1.15 BMI 34.7 IDDM			26
26/11/2014	26/11/2014	29/05/2015		KS	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	PER MR SURESH CLINIC	26
27/11/2014	27/11/2014	18/06/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	THORNDALE UNIT		26
27/11/2014	27/11/2014	24/06/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT		26
27/11/2014	27/11/2014	24/06/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT		26
28/11/2014	28/11/2014			MY	WL	4	N	TURP DIABETIC	M65.3	TURP DIABETIC NA(26.06-10.07.15 & 16.09-01.10.15) FIT 10.2.15 NIDDM TAB ON SSRI/ACE INHIBITORS		PER JENNY AT DSU 28.11.14	26
28/11/2014	28/11/2014			MY	WL	4	D	LEFT HYDROCELE	N11.1	LEFT HYDROCELE FIT 10.2.15 BMI 38 ON LISINOPRIL		PD - PER MR YOUNG AT CLINIC 28.11.14	26
28/11/2014	28/11/2014			MY	WL	4	N	CYSTOLITHOTRIPSY +/- TURP	M44.1	CYSTOLITHOTRIPSY +/- TURP FIT 5.2.15 KK		PER JENNY AT DSU 28.11.14	26
28/11/2014	28/11/2014	30/06/2015		MY	WL	2	N	INSERTION OF SUPRAPUBIC CATHETER	M49.8	INSERTION OF SUPRAPUBIC CATHETER B6QT 060215 W/C	1 WEST ELECTIVE ADMISSION WARD	PER MR YOUNG AT CLINIC 28.11.14	26
01/12/2014	01/12/2014			KS	WL	2	N	URETEROSCOPY, LASER STONE ABLATION +/- STENTING URGENT	M30.9	URETEROSCOPY, LASER STONE ABLATION +/- STENTING URGENT FIT 3.2.15 NIDDM TABLET ON RAMIPRIL		PER KS STC CLINIC	25
01/12/2014	01/12/2014	03/06/2015		JOD	WL	2	N	TURP (NEEDS TO STOP DABIGATRAN PRIOR TO OP)	M65.3	TURP (NEEDS TO STOP DABIGATRAN PRIOR TO OP) B6QT 200115	1 WEST ELECTIVE ADMISSION WARD		25
02/12/2014	02/12/2014			AOB	WL	2	N	TURP	M65.3	TURP B6QT 060215 ON CLOPIDOGREL			25
02/12/2014	02/12/2014			MY	WL	4	N	INSERTION OF SPC (LETTER IN B/F)	M49.8	INSERTION OF SPC (LETTER IN B/F)		PER MR YOUNG RE: RE-REFERRAL GP 01.12.14	25
04/12/2014	04/12/2014			MY	WL	4	N	RIGHT FLEXIBLE URETEROSCOPIC LASERTRIPSY	M30.9	RIGHT FLEXIBLE URETEROSCOPIC LASERTRIPSY FIT 10.2.15 ON SSRI/ANXIOLYTICS		SC CESWL 041214 TCI PER MY	25
04/12/2014	04/12/2014			MY	WL	4	N	LEFT FLEXIBLE URETEROSCOPIC LASERTRIPSY	M30.9	LEFT FLEXIBLE URETEROSCOPIC LASERTRIPSY FIT 3.2.15 KK		SC CESWL 041214 TCI PER MY	25
05/12/2014	05/12/2014			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			25
05/12/2014	05/12/2014			AOB	SA	2	N	RED FLAG CYSTODIATHERMY	M42.2	RED FLAG CYSTODIATHERMY			25
05/12/2014	05/12/2014	02/06/2015		MY	WL	2	N	TURP CATHETER IN SITU	M65.3	TURP CATHETER IN SITU B6QT 030315 ACE INHIBITORS	1 WEST ELECTIVE ADMISSION WARD	PER DISCHARGE	25

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08/12/2014	08/12/2014			KS	WL	2	N	LEFT FLEXIBLE URS & LASER STONE ABLATION WILLING CANCELLATI	M30.9	ONFT FLEXIBLE URS & LASER STONE ABLATION WILLING CANCELLATI URGENT DATE		PER KS STC CLINIC	24
08/12/2014	08/12/2014			MY	WL	4	D	CYSTOSCOPY & URETHRAL DILATATION	M45.9	CYSTOSCOPY & URETHRAL DILATATION FIT(20.02.15)CD		PD - PER MR YOUNG AT SWAH 08.12.14	24
09/12/2014	09/12/2014			KS	WL	2	N	TURP	M65.3	TURP		PER KS CLINIC	24
15/09/2014	15/09/2014	12/06/2015		KS	WL	4	N	CYSTOLITHOLAPAXY +/- TURP STENT IN SITU	M44.1	CYSTOLITHOLAPAXY +/- TURP STENT IN SITU NIDDM TABLET W/C (FIT 30/03/15)	1 WEST ELECTIVE ADMISSION WARD	PER MR SURESH CLINIC	24
10/12/2014	10/12/2014	10/06/2015		JOD	WL	2	N	TURP - CLOPIDIGREL NEEDS TO BE STOPPED	M65.3	TURP CLOPIDIGREL NEEDS TO BE STOPPED	1 WEST ELECTIVE ADMISSION WARD	AS PER CON	24
11/12/2014	11/12/2014	27/05/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	PER MR O'DONOGHUE CLINIC LETTER	24
11/12/2014	11/12/2014			KS	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER KS LETTER TO PATIENT	24
15/12/2014	15/12/2014			AOB	WL	2	N	REFASHIONING OF UROSTOMY	M19.5	REFASHIONING OF UROSTOMY FIT 3.3.15 NA(19.06-27.06.15)			23
15/12/2014	15/12/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 10.3.15 KK			23
17/12/2014	17/12/2014			AOB	WL	2	N	RIGHT RIGID AND ? FLEXIBLE URETEROSCOPY	M30.9	RIGHT RIGID AND ? FLEXIBLE URETEROSCOPY			23
19/12/2014	19/12/2014			KS	WL	2	N	REDO TURP & CIRCUMCISION	M65.3	REDO TURP & CIRCUMCISION		PER KAREN DISCHARGE	23
19/12/2014	19/12/2014			AOB	WL	2	N	MESH INCISIONAL HERNIORRHAPHY	T25.2	MESH INCISIONAL HERNIORRHAPHY FIT 19.3.15 KK			23
19/12/2014	19/12/2014			MY	WL	4	D	VASECTOMY	N17.1	VASECTOMY FIT 18.2.15 KK		PD - PER MR YOUNG AT CLINIC 19.12.14	23
22/12/2014	22/12/2014			MY	WL	4	D	LEFT URETEROSCOPY & LASERTRIPSY	M30.9	LEFT URETEROSCOPY & LASERTRIPSY		PER STC CLINIC 22.12.14	22
29/12/2014	29/12/2014	22/06/2015		MY	WL	4	D	LEFT ESWL MONDAY APPOINTMENT	M14.1	LEFT ESWL MONDAY APPOINTMENT	STONE TREATMENT CENTRE	PER STC CLINIC 29.12.14	21
29/12/2014	29/12/2014			MDH	WL	4	D	OPTICAL URETHROTOMY	M76.3	OPTICAL URETHROTOMY FIT 25.9.14 ACE INHIBITORS HERBAL MEDS STOP 2/52 B4		PER MR HAYNES	21
07/07/2014	29/12/2014	20/05/2015		MDH	WL	4	D	FLEXIBLE CYSTOSCOPY STH IF POSSIBLE	M45.9	FLEXIBLE CYSTOSCOPY NO TRANSPORT SEND MORNING APPT	DAY SURGERY UNIT	PER MR HAYNES	21
29/12/2014	29/12/2014			AOB	WL	4	N	TURP	M65.3	TURP FIT 13.1.15 KK NOT AVAILABLE FROM 4/5/15 - 18/5/15			21
29/12/2014	29/12/2014			MY	WL	4	D	BILATERAL VASECTOMY (AVAILABLE AT SHORT NOTICE)	N17.1	BILATERAL VASECTOMY (AVAILABLE AT SHORT NOTICE) FIT(09.04.15)CD		PD - PER KAREN AT DSU 29.12.14	21
30/12/2014	30/12/2014			AOB	WL	2	N	OPEN BLADDER DIVERTICULECTOMY	M35.1	OPEN BLADDER DIVERTICULECTOMY		PER DISCHARGE LETTER	21
02/01/2015	02/01/2015			KS	WL	2	D	URGENT FLEXIBLE CYSTOSCOPY	M45.9	URGENT FLEXIBLE CYSTOSCOPY		PER MR SURESH	21
02/01/2015	02/01/2015			AOB	WL	2	N	ILEAL CONDUIT URINARY DIVERSION	M19.8	ILEAL CONDUIT URINARY DIVERSION			21
24/10/2014	24/10/2014		01/07/2015	MDH	WL	2	N	BIPOLAR TURP PACEMAKER	M65.3	BIPOLAR TURP (PACEMAKER) B6QT 171114		PER MR HAYNES	21
01/10/2014	01/10/2014			JOD	WL	2	N	TURP	M65.3	TURP B6D 141114 ON RAMIPRIL/INHALERS HOLD(14.11.14)CD		PER CONSULTANT	20
05/01/2015	05/01/2015			AOB	WL	4	N	INTRAMURAL INJECTION OF 500 UNITS OF BOTULINUM TOXIN	M43.4	INTRAMURAL INJECTION OF 500 UNITS OF BOTULINUM TOXIN B6QT 030315 W/C			20
05/01/2015	05/01/2015			AOB	WL	4	N	TURP	M65.3	TURP FIT 26.3.15 KK			20
05/01/2015	05/01/2015			MDH	WL	4	N	TURP	M65.3	TURP		PER MR HAYNES	20
06/01/2015	06/01/2015			AOB	SA	2	N	RED FLAG TURBT AND TURP	M42.1	RED FLAG TURBT AND TURP		POST DISCHARGE DSU	20
06/01/2015	06/01/2015			AOB	WL	4	N	TURP - (ON WARFARIN NEEDS CLEXANE)	M65.3	TURP - (ON WARFARIN NEEDS CLEXANE) B6QT 030315 NIDDM TABLET			20
07/01/2015	07/01/2015			MY	WL	4	N	GA CYSTOSCOPY +/- URETHRAL DILATATION +/- BNI	M45.8	GA CYSTOSCOPY +/- URETHRAL DILATATION +/- BNI TYPE 2 DIABETIC & ASPIRIN 75MGS		PER KAREN	20
07/01/2015	07/01/2015			MY	WL	4	D	EXCISION OF EPIDIDYMAL CYSTS (LETTER IN B/F)-will take canc	N15.3	EXCISION OF EPIDIDYMAL CYSTS (LETTER IN B/F) n/a 02.03.15 FIT 6.3.15 KK		PD - PER MR YOUNG RE: NEW LTR GP 05.01.15	20
08/01/2015	08/01/2015			JOD	WL	2	N	NEPHROSTOMY (CHANGE)	M15.9	NEPHROSTOMY (CHANGE)		AS PER CON	20
08/01/2015	08/01/2015			MY	WL	4	D	COMPLETITION CIRCUMCISION	N30.3	COMPLETITION CIRCUMCISION FIT 26.3.15 KK (MAIN THEATRES CAH ONLY)		PER MR YOUNG AT CLINIC 08.01.15	20
09/01/2015	09/01/2015			MY	WL	2	N	RIGHT FLEXIBLE URETEROSCOPIC LASERTRIPSY	M30.9	RIGHT FLEXIBLE URETEROSCOPIC LASERTRIPSY BMI 37.5 FIT(02.04.15)CD		SC CESWL 090115 TCI PER MY	20
09/01/2015	09/01/2015			AOB	WL	2	N	TURP (CATHETER INSITU)	M65.3	TURP (CATHETER INSITU)		PER E-MAIL VIA AOB	20
11/01/2015	11/01/2015			AOB	WL	2	N	REMOVAL OF STENT AND LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M29.3	MAR 15 ROS & LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY EPILEPIC PATIENT		PER E-MAIL VIA AOB	19
12/01/2015	12/01/2015	27/05/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT		19
13/01/2015	13/01/2015			KS	WL	4	D	EXCISION OF EPIDIDYMAL CYST	N15.3	EXCISION OF EPIDIDYMAL CYST (FIT 30/03/15)		PER KS CLINIC	19
13/01/2015	13/01/2015			AOB	WL	4	N	TURP	M65.3	TURP HOLD(02.03.15)CD			19
14/01/2015	14/01/2015			MDH	WL	4	N	TURP	M65.3	TURP		PER MR HAYNES	19
15/01/2015	15/01/2015			JOD	WL	4	D	CYSTOSCOPY AND HYDRODISTENSION	M45.9	CYSTOSCOPY AND HYDRODISTENTION			19
15/01/2015	15/01/2015	27/05/2015		MY	WL	4	D	ESWL (MON OR WED AT 9AM)	M14.1	ESWL (MON OR WED AT 9AM)	STONE TREATMENT CENTRE	PER STC 15.01.15	19
16/01/2015	16/01/2015	27/05/2015		MY	WL	4	D	REPEAT LEFT ESWL	M14.1	REPEAT LEFT ESWL	STONE TREATMENT CENTRE	PER STC CLINIC 16.01.15	19
19/01/2015	19/01/2015			KS	WL	2	D	URGENT FLEXIBLE CYSTOSCOPY	M45.9	URGENT FLEXIBLE CYSTOSCOPY		PER KS STC CLINIC	18
19/01/2015	19/01/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			18
19/01/2015	19/01/2015	28/05/2015		MY	WL	4	D	RIGHT ESWL	M14.1	RIGHT ESWL	STONE TREATMENT CENTRE	PER STC CLINIC 19.01.15	18
19/01/2015	19/01/2015	28/05/2015		MY	WL	4	D	LEFT ESWL MR SURESH/AOB PT	M14.1	LEFT ESWL MR SURESH/AOB PT	STONE TREATMENT CENTRE	PER MR SURESH STC CLINIC 19.01.15	18
19/01/2015	19/01/2015			AOB	WL	4	D	INTRAMURAL INJECTION OF BOTULINUM TOXIN	M43.4	INTRAMURAL INJECTION OF BOTULINUM TOXIN			18
21/01/2015	21/01/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			18
21/01/2015	21/01/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			18
21/01/2015	21/01/2015	01/06/2015		MY	WL	2	D	MAY 2015 - GIVE DATE CYSTOSCOPY	M45.9	MAY 2015 - GIVE DATE CYSTOSCOPY FIT 27.4.15 UD 21.5.15 KK	STH DAY PROCEDURE UNIT	PD - PER MR YOUNG RE: RESULTS 21.01.15	18
21/01/2015	21/01/2015			MY	WL	2	D	LEFT FLEXIBLE URETEROSCOPY (TO HAVE ESWL 1ST)	M30.9	LEFT FLEXIBLE URETEROSCOPY (TO HAVE ESWL 1ST) FIT 29.4.15 NA(05.06-07.06.15)		PD - PER MR YOUNG RE: RESULTS 21.01.15	18
19/11/2014	19/11/2014			MDH	WL	2	D	GA CYSTOSCOPY +/- BLADDER BIOPSIES	M45.8	GA CYSTOSCOPY +/- BLADDER BIOPSIES B6QT 040215		PER MR HAYNES	18
22/01/2015	22/01/2015			AOB	WL	2	N	TROC, ULTRASOUND SCAN ?TURP	M47.3	TROC, ULTRASOUND SCAN ?TURP			18
22/01/2015	22/01/2015			AOB	WL	4	N	LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M09.2	LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY			18
22/01/2015	22/01/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			18
22/01/2015	22/01/2015			JOD	WL	4	D	VASECTOMY	N17.1	VASECTOMY			18
23/01/2015	23/01/2015			MY	WL	4	D	RIGHT HYDROCELE (LETTER IN B/F)	N11.1	RIGHT HYDROCELE (LETTER IN B/F) FIT 23.3.15 KK		PER MR YOUNG AT HPC 23.01.15	18

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26/01/2015	26/01/2015	03/06/2015		MY	WL	4	D	ESWL	M14.1	ESWL	STONE TREATMENT CENTRE	PER STC 26.01.15	17
26/01/2015	26/01/2015	03/06/2015		MY	WL	4	D	ESWL	M14.1	ESWL	STONE TREATMENT CENTRE	PER STC 26.01.15	17
26/01/2015	26/01/2015			MY	WL	4	N	TURP	M65.3	TURP FIT(13.04.15)CD		PD - PER MR YOUNG AT SWAH CLINIC 26.01.15	17
26/01/2015	26/01/2015			MY	WL	4	D	URETHROSCOPY & PREPULOPLASTY	M17.9	URETHROSCOPY & PREPULOPLASTY		PD - PER MR YOUNG AT SWAH CLINIC 26.01.15	17
26/01/2015	26/01/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			17
26/01/2015	26/01/2015			MY	WL	4	N	RIGHT FLEXIBLE URETEROSCOPY & LASERTRIPSY	M30.9	RIGHT FLEXIBLE URETEROSCOPY & LASERTRIPSY FIT(12.03.15)CD		PER KAREN RE: X-RAY CONFERENCE 26.01.15	17
27/01/2015	27/01/2015			AOB	WL	2	N	TURP	M65.3	TURP B6QT 160315			17
27/01/2015	27/01/2015			AOB	WL	4	D	FRENULOPLASTY	N28.4	FRENULOPLASTY			17
28/01/2015	28/01/2015	17/06/2015		MDH	WL	4	D	CIRCUMCISION UNDER LA	N30.3	CIRCUMCISION UNDER LA PLAVIX - PER KAREN STOP 7 DAYS BF SGY	DAY SURGERY UNIT	PER KAREN	17
28/01/2015	28/01/2015			MDH	WL	4	N	TURP CLOPIDOGREL	M65.3	TURP CLOPIDOGREL B6QT 120315 NIDDM DIET BMI 35.79		PER MR HAYNES	17
28/01/2015	28/01/2015	04/06/2015		MY	WL	4	D	RIGHT ESWL	M14.1	RIGHT ESWL	STONE TREATMENT CENTRE	PER STC 28.01.15	17
28/01/2015	28/01/2015			MY	WL	4	N	TURP	M65.3	TURP FIT 30.3.15 KK		PER MR YOUNG AT CLINIC 28.01.15	17
29/01/2015	29/01/2015			AOB	WL	2	D	EXCISION OF RIGHT EPIDIDYMAL CYST LITHUANIAN INTERPRETER	N15.3	EXCISION OF RIGHT EPIDIDYMAL CYST LITHUANIAN INTERPRETER TO HAVE USS SCROTUM FIRST FIT 4.2.15 KK		PER MR SURESH CLINIC	17
30/01/2015	30/01/2015	01/06/2015		MY	WL	4	D	RIGHT ESWL	M14.1	RIGHT ESWL	STONE TREATMENT CENTRE	PER STC CLINIC 30.01.15	17
30/01/2015	30/01/2015	12/06/2015		MY	WL	4	D	ESWL (BOTH SIDES)	M14.1	ESWL (BOTH SIDES)	STONE TREATMENT CENTRE	PER STC CLINIC 30.01.15	17
30/01/2015	30/01/2015	10/06/2015		MY	WL	4	D	LEFT ESWL - NEED WED APT	M14.1	LEFT ESWL	STONE TREATMENT CENTRE	PER STC CLINIC 30.01.15	17
30/01/2015	30/01/2015			AOB	WL	2	N	LEFT URETEROSCOPIC LITHOTRIPSY	M09.2	LEFT URETEROSCOPIC LITHOTRIPSY			17
30/01/2015	30/01/2015			MDH	WL	2	N	ILEAL CONDUIT URINARY DIVERSION	M19.1	ILEAL CONDUIT URINARY DIVERSION		PER MR HAYNES	17
30/01/2015	30/01/2015			MDH	WL	4	N	TURP	M65.3	TURP ALLERGIC TO PENICILLIN FIT 14.4.15 KK		PER MR HAYNES	17
06/11/2013	06/11/2014			MDH	WL	4	D	CYSTOSCOPY & HYDRODISTENSION OF BLADDER	M45.8	CYSTOSCOPY & HYDRODISTENSION OF BLADDER FIT (24.12.14 KK) NA W/C 13TH OCT AND 27TH OCT 2014.		PER MR PAHUJA	16
01/02/2015	01/02/2015			JOD	WL	2	N	FLEXIBLE CYSTOSCOPY AND REMOVAL OF JJ STENT 4-6 WEEKS TIME	M45.9	FLEXIBLE CYSTOSCOPY AND REMOVAL OF JJ STENT 4-6 WEEKS TIME		AS PER JOD TO BE SEEN IN 4-6 WEEKS	16
02/02/2015	02/02/2015	12/06/2015		MY	WL	4	D	ESWL PER DOWNE HOSPITAL LETTER TO STC 2/2/15	M14.1	ESWL PER DOWNE HOSPITAL LETTER TO STC 2/2/15	STONE TREATMENT CENTRE	PER DOWNE HOSPITAL LETTER SENT TO STC 2/2/15	16
02/02/2015	02/02/2015	16/06/2015		KS	WL	2	D	CIRCUMCISION UNDER LA WARFARIN	N30.3	CIRCUMCISION UNDER LA WARFARIN on holiday in month of May	DAY SURGERY UNIT	PER CLINIC OUTCOME SHEET	16
02/02/2015	02/02/2015	26/06/2015		AJG	WL	2	N	TURP +/- BOTOX	M65.1	TURP +/- BOTOX	1 WEST ELECTIVE ADMISSION WARD	PER CLINIC OUTCOME SHEET	16
02/02/2015	02/02/2015			KS	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER MR SURESH STC CLINIC	16
02/02/2015	02/02/2015	12/06/2015		MY	WL	4	D	RIGHT ESWL MR SURESH STC PATIENT LITHUANIAN INTERPRETER	M14.1	RIGHT ESWL MR SURESH STC PATIENT LITHUANIAN INTERPRETER	STONE TREATMENT CENTRE	PER MR SURESH STC CLINIC	16
02/02/2015	02/02/2015	11/06/2015		MY	WL	4	D	LEFT ESWL MR SURESH STC PATIENT POLIST INTERPRETER	M14.1	LEFT ESWL MR SURESH STC PATIENT POLISH INTERPRETER	STONE TREATMENT CENTRE	PER KS STC CLINIC	16
02/02/2015	02/02/2015			MY	WL	4	D	CYSTOSCOPY & HYDRODISTENSION	M45.9	CYSTOSCOPY & HYDRODISTENSION FIT 15.4.15 KK		PER MR YOUNG AT EXTRA CLINIC 02.02.15	16
02/02/2015	02/02/2015			MY	WL	4	D	CYSTOSCOPY & VARICOCELE	M45.9	CYSTOSCOPY & VARICOCELE FIT 28.4.15 KK		PER MR YOUNG AT EXTRA CLINIC 02.02.15	16
02/02/2015	02/02/2015			MY	WL	4	D	CYSTOSCOPY & HYDROSTATIC DILATATION	M45.9	CYSTOSCOPY & HYDROSTATIC DILATATION ON RAMIPRIL FIT(14.04.15)CD		PER MR YOUNG AT EXTRA CLINIC 02.02.15	16
03/02/2015	03/02/2015	17/06/2015		MY	WL	4	D	ESWL ASPIRIN 75MGS NEEDS WEDNESDAY APT (hols 3-22.05.15)	M14.1	ESWL ASPIRIN 75MGS NEEDS WEDNESDAY APT on hols 03/05/15 - 22/05/15	STONE TREATMENT CENTRE	PER STC 03.02.15	16
03/02/2015	03/02/2015	01/06/2015		MY	WL	4	D	ESWL	M14.1	ESWL	STONE TREATMENT CENTRE	PER STC 03.02.15	16
03/02/2015	03/02/2015			KS	WL	2	N	BNI/TURP	M66.2	BNI/TURP FIT 31.3.15 KK		PER KS UDS CLINIC	16
03/02/2015	03/02/2015			MDH	WL	2	N	TROC STAY OVERNIGHT WB 17TH FEB	M47.3	TROC STAY OVERNIGHT WB 17TH FEB		PER MR HAYNES	16
03/02/2015	03/02/2015	19/06/2015		MY	WL	4	D	ESWL LETTER POSTED TO STC	M14.1	ESWL LETTER POSTED TO STC	STONE TREATMENT CENTRE	RE: REFERRAL MR MACLEOD, ALTNAGELVIN	16
04/02/2015	04/02/2015			MDH	WL	4	D	CIRCUMCISION INPATIENT	N30.3	CIRCUMCISION INPATIENT CARDIAC & SLIGHTLY OVERWEIGHT		PER MR HAYNES	16
05/02/2015	05/02/2015	18/06/2015		MY	WL	4	D	LEFT ESWL MR HAYNES PATIENT	M14.1	LEFT ESWL MR HAYNES PATIENT	STONE TREATMENT CENTRE	PER STC 05.02.15	16
05/02/2015	05/02/2015	10/06/2015		MY	WL	4	D	ESWL (AJG PT)	M14.1	ESWL (AJG PT)	STONE TREATMENT CENTRE	PER RACHAEL	16
05/02/2015	05/02/2015	27/05/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT		16
21/10/2014	06/02/2015	10/06/2015		JOD	WL	2	N	TURP	M65.3	TURP B6QT 271114 ACE INHIBITORS	1 WEST ELECTIVE ADMISSION WARD	TURP	16
06/02/2015	06/02/2015	26/06/2015		AJG	WL	2	N	OPTICAL URETHROTOMY (ON CLOPIDOGREL) mr glackin only	M76.3	OPTICAL URETHROTOMY (ON CLOPIDOGREL) mr glackin only ACE INHIBITORS STAY ON PLAVIX PER SURGEON FIT(21.04.15)	1 WEST ELECTIVE ADMISSION WARD		16
09/02/2015	09/02/2015	15/06/2015		MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL	STONE TREATMENT CENTRE	PER STC 09.02.15	15
28/02/2014	09/02/2015			MY	WL	4	D	CYSTOSCOPY & URETHRAL DILATATION	M45.8	CYSTOSCOPY & URETHRAL DILATATION FIT (10.3.14 KK) UPDATED 20.01.15		PER MR YOUNG	15
09/02/2015	09/02/2015			KS	WL	2	D	CYSTOSCOPY, CYSTODISTENSION & BOTOX DABIGATRAN DIABETIC	M45.9	CYSTOSCOPY, CYSTODISTENSION & BOTOX DABIGATRAN DIABETIC NOT AVAIL 16TH-23RD MAY B6QT 300315		PER KS UDS CLINIC	15
09/02/2015	09/02/2015			KS	WL	2	N	TURP DIABETIC	M65.3	TURP DIABETIC		PER KAREN CLINIC	15
09/02/2015	09/02/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			15
17/09/2014	09/02/2015	10/06/2015		JOD	WL	4	D	VASECTOMY & LEFT VARICOCELE LIGATION	N17.1	VASECTOMY & LEFT VARICOCELE LIGATION	DAY SURGERY UNIT	PER CONSULTANT	15
09/02/2015	09/02/2015			AOB	WL	4	D	INTRAMURAL INJECTION OF 150 UNITS OF BOTULINUM TOXIN	M43.4	INTRAMURAL INJECTION OF 150 UNITS OF BOTULINUM TOXIN FIT 18.2.15 KK			15
09/02/2015	09/02/2015			MY	WL	4	D	VASECTOMY REVERSAL CAN COME AT SHORT NOTICE	N18.1	VASECTOMY REVERSAL CAN COME AT SHORT NOTICE FIT(02.04.15)CD		PD - PER MR YOUNG AT SWAH 09.02.15	15
09/02/2015	09/02/2015			MY	WL	4	D	ESWL	M14.1	ESWL		PD - PER MR YOUNG AT SWAH 09.02.15	15
09/02/2015	09/02/2015			AOB	WL	4	N	TURP	M65.3	TURP FIT 20.4.15 KK			15
10/02/2015	10/02/2015			KS	WL	2	D	GA CYSTOSCOPY, CYSTODISTENSION +/- BIOPSIES & DIATHERMY	M45.9	GA CYSTOSCOPY, CYSTODISTENSION +/- BIOPSIES & DIATHERMY 13-17 APRIL & 11-15 MAY 2015 HOLIDAYS FIT 20.4.15 KK		PER KS CLINIC	15

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10/02/2015	10/02/2015			AJG	WL	4	N	TURP	M65.3	TURP		PER OUTCOME SHEET	15
11/02/2015	11/02/2015			MDH	WL	4	N	BIPOLAR TURP	M65.3	BIPOLAR TURP WARFARIN		PER MR HAYNES	15
11/02/2015	11/02/2015			MY	WL	4	D	CYSTOSCOPY & URETHRAL DILATATION (LETTER IN B/F)	M45.9	CYSTOSCOPY & URETHRAL DILATATION (LETTER IN B/F) ANAESTHETIC ASSESSMENT REQUIRED PER MR YOUNG FIT 20.4.15		PD - PER MR YOUNG AT HPC 11.02.15	15
11/02/2015	11/02/2015			AJG	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		per ajg	15
12/02/2015	12/02/2015			MY	WL	2	D	OPTICAL URETHROTOMY - ON WRONG WL CHANGED TO INPT PER MRY	M76.3	OPTICAL URETHROTOMY ALLERGIC TO PENICILLIN FIT 20.4.15 NA(04.08-11.08.15)		PER RACHAEL	15
13/02/2015	13/02/2015			MDH	WL	2	N	LEFT URETEROSCOPY & LASERTRIPSY	M30.9	LEFT URETEROSCOPY & LASERTRIPSY		PER MR HAYNES	15
16/02/2015	16/02/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			14
16/02/2015	16/02/2015			AJG	WL	2	N	CYSTOLITHOPAXY	M44.1	CYSTOLITHOPAXY ON CLOPIDOGREL NEEDS CAREFUL PRE-OP		PER GREEN PROFORMA	14
16/02/2015	16/02/2015			AJG	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY AFTER MMCx6		PER OUTCOME SHEET	14
17/02/2015	17/02/2015			AOB	WL	4	N	CORRECTION OF PENILE ERECTILE DEFORMITY	N28.8	CORRECTION OF PENILE ERECTILE DEFORMITY FIT 14.4.15 PENICILLIN ALLERGY			14
17/02/2015	17/02/2015			AOB	WL	4	N	CIRCUMCISION	N30.3	CIRCUMCISION			14
17/02/2015	17/02/2015			AOB	WL	4	N	DIVISION OF PREPUTIAL ADHESIONS +/- CIRCUMCISION	N30.2	DIVISION OF PREPUTIAL ADHESIONS =/- CIRCUMCISION			14
17/02/2015	17/02/2015			AOB	WL	4	N	CIRCUMCISION	N30.3	CIRCUMCISION			14
18/02/2015	18/02/2015			JOD	WL	2	D	END JUNE/START JULY BLADDER NECK INCISION	M66.2	END JUNE/START JULY BLADDER NECK INCISION			14
18/02/2015	18/02/2015	27/05/2015		JOD	WL	2	D	URGENT FLEXIBLE CYSTOSCOPY	M45.9	URGENT FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	AS PER REFERRAL LETTER	14
19/02/2015	19/02/2015	17/06/2015		MY	WL	4	D	ESWL (JOD PT) - LETTER TO STC	M14.1	ESWL (JOD PT)	STONE TREATMENT CENTRE	PER JENNY MARTIN	14
19/02/2015	19/02/2015			MY	WL	4	D	VARICOCELE LIGATION	N19.1	VARICOCELE LIGATION FIT 20.4.15 KK		PD - PER MR YOUNG AT CLINIC 19.02.15	14
19/02/2015	19/02/2015			MY	WL	4	N	TURP	M65.3	TURP B6QT 280415 ON SSRI/APIXIBAN		PD - PER MR YOUNG AT CLINIC 19.02.15	14
19/02/2015	19/02/2015			JOD	WL	4	D	CIRCUMCISION	N30.3	CIRCUMCISION		PER JENNY MARTIN	14
19/02/2015	19/02/2015			MY	WL	4	D	CYSTOSCOPY & HYDRODISTENSION BLADDER	M43.2	CYSTOSCOPY & HYDRODISTENSION BLADDER FIT 27.4.15 KK		PER JENNY REG	14
20/02/2015	20/02/2015			MY	WL	4	D	ESWL LETTER POSTED TO STC	M14.1	ESWL LETTER POSTED TO STC N/A UNTIL AFTER 25.05.15		RE: REFERRAL MR MCKNIGHT, BANGOR HOSPITAL	14
20/02/2015	20/02/2015			MY	WL	4	N	TURP PLAVIX & ASPIRIN	M65.3	TURP FIT 30.4.15 KK		PD - PER MR YOUNG AT CLINIC 20.02.15	14
21/05/2014	20/02/2015	29/05/2015		KS	WL	4	D	FLEXIBLE CYSTOSCOPY PARKINSONS	M45.9	FLEXIBLE CYSTOSCOPY PARKINSONS	DAY SURGERY UNIT	PER MR SURESH CLINIC	14
20/02/2015	20/02/2015	10/06/2015		JOD	WL	2	D	CIRCUMCISION	N30.3	CIRCUMCISION	DAY SURGERY UNIT	PER JENNY FLEXI LIST	14
20/02/2015	20/02/2015			MY	WL	4	D	RIGHT ESWL MR O'DONOGHUE PATIENT	M14.1	PATIENT		PER JENNY FLEXI LIST	14
20/02/2015	20/02/2015			MY	WL	2	D	RIGHT URETEROSCOPY & LASERTRIPSY AOB PATIENT	M30.9	RIGHT URETEROSCOPY & LASERTRIPSY AOB PATIENT		PER MR YOUNG AT STC CLINIC 20.02.15	14
20/02/2015	20/02/2015	19/06/2015		MY	WL	4	D	2ND ESWL MR GLACKIN PATIENT	M14.1	2ND ESWL MR GLACKIN PATIENT	STONE TREATMENT CENTRE	PER MR YOUNG AT STC CLINIC 20.02.15	14
20/02/2015	20/02/2015			MY	WL	4	D	RIGHT ESWL PT PHON 25.02.15 WILL TAKE CANCELLATION	M14.1	RIGHT ESWL		PER STC CLINIC 20.02.15	14
20/02/2015	20/02/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC CLINIC 20.02.15	14
20/02/2015	20/02/2015			MY	WL	4	D	LEFT ESWL AOB PATIENT	M14.1	LEFT ESWL AOB PATIENT		PER STC CLINIC 20.02.15	14
20/02/2015	20/02/2015			MY	WL	2	D	RIGHT FLEXIBLE URETEROSCOPY	M30.9	RIGHT FLEXIBLE URETEROSCOPY		PER STC CLINIC 20.02.15	14
20/02/2015	20/02/2015	18/06/2015		MY	WL	4	D	RIGHT ESWL	M14.1	RIGHT ESWL	STONE TREATMENT CENTRE	PER STC CLINIC 20.02.15	14
20/02/2015	20/02/2015			AOB	WL	2	N	BILATERAL URETERIC REIMPLANTATION AND MITROFANOFF CONDUIT	M20.2	BILATERAL URETERIC REIMPLANTATION AND MIRTOFANOFF CONDUIT RANG REGARDING DATE 14/5/15			14
20/02/2015	20/02/2015			AOB	WL	4	D	INTRAMURAL INJECTION OF 300 UNITS BOTULINUM TOXIN	M43.4	INTRAMURAL INJECTION OF 300 UNITS BOTULINUM TOXIN B6QT 240415 BMI 35.5			14
22/01/2015	22/01/2015		01/07/2015	AJG	WL	4	D	CIRCUMCISION	N30.3	CIRCUMCISION			13
30/12/2014	30/12/2014		01/07/2015	AOB	WL	2	N	EXCISION OF LARGE EPIDIDYMAL CYST - BMI 43	N15.3	EXCISION OF LARGE EPIDIDYMAL CYST - BMI 43 HOLD(26.03.15)CD ON SSRI/ANTI-PSYCHOTICS BMI 43			13
23/02/2015	23/02/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER MR ODONOGUHE	13
23/02/2015	23/02/2015			MY	WL	2	N	LITHROTRIPSY	M14.1	LITHROTRIPSY		AS PER JOD	13
23/02/2015	23/02/2015			KS	WL	2	N	FLEXIBLE URETEROSCOPY & LASER STONE ABLATION	M30.9	FLEXIBLE URETEROSCOPY & LASER STONE ABLATION		PER KS STC CLINIC	13
23/02/2015	23/02/2015			MY	WL	4	D	LEFT ESWL MR SURESH STC PATIENT IDDM/ASPIRIN 75	M14.1	LEFT ESWL MR SURESH STC PATIENT ON HOLS JUNE 15 (19-27) - WILL TAKE CANC		PER KS STC CLINIC	13
23/02/2015	23/02/2015			MY	WL	4	D	LEFT ESWL MR SURESH STC PATIENT	M14.1	LEFT ESWL MR SURESH STC PATIENT		PER KS STC CLINIC	13
23/02/2015	23/02/2015			AOB	WL	2	D	TROC	M47.3	TROC MARCH 2015		SC WD DIS 230215 TCI 2-3/52 PER REG	13
24/02/2015	24/02/2015			AOB	WL	4	N	TURP	M65.3	TURP B6QT 280415			13
24/02/2015	24/02/2015	01/06/2015		MDH	WL	2	D	OPTICAL URETHROTOMY & CHECK CYSTOSCOPY WARFARIN	M76.4	OPTICAL URETHROTOMY & CHECK CYSTOSCOPY WARFARIN B6QT 140515	1 WEST ELECTIVE ADMISSION WARD	PER MR HAYNES	13
24/02/2015	24/02/2015			MY	WL	2	N	LEFT FLEXIBLE URETEROSCOPY	M30.9	LEFT FLEXIBLE URETEROSCOPY		PD - PER MR YOUNG IN THEATRE 24.02.15	13
24/02/2015	24/02/2015			KS	WL	4	D	CIRCUMCISION UNDER GA PATIENT ON HOLS JULY/AUG	N30.3	CIRCUMCISION UNDER GA PATIENT ON HOLS JULY/AUG		PER JENNY CLINIC	13
24/02/2015	24/02/2015			KS	WL	4	D	FRENULOPLASTY UNDER LA	N28.4	FRENULOPLASTY UNDER LA		PER KS CLINIC	13
24/02/2015	24/02/2015			AOB	WL	4	N	CIRCUMCISION	N30.3	CIRCUMCISION ON WARFARIN - NEEDS TO STOP 5 DAYS PRIOR TO PROCEDURE			13
14/03/2014	25/02/2015			MY	WL	4	D	CYSTOSCOPY & BOTOX TAB DIABETIC WISHES SUMMER 15	M45.9	CYSTOSCOPY & BOTOX TAB DIABETIC FIT(14.05.14)CD NIDDM TABLET ON AMITRYPTLINE/ACE INHBITOR		PD - PER MR YOUNG AT CLINIC 14.03.14	13
25/02/2015	25/02/2015			MY	WL	4	D	FRENULOPLASTY LETTER IN B/F	N28.4	FRENULOPLASTY LETTER IN B/F		PD - PER MR YOUNG AT HPC 25.02.15	13
25/02/2015	25/02/2015			MY	WL	4	D	CYSTOSCOPY & HYDROSTATIC DILATATION LETTER IN B/F	M45.9	CYSTOSCOPY & HYDROSTATIC DILATATION LETTER IN B/F FIT 29.4.15 KK - PT PHON ? DATE 190515 - WILL TAKE CANC		PD - PER MR YOUNG AT HPC 25.02.15	13
25/02/2015	25/02/2015	24/06/2015		JOD	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT		13
15/09/2014	25/02/2015	27/05/2015		JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	PER CONSULTANT	13
12/12/2014	26/02/2015			MDH	WL	4	D	VASECTOMY LA	N17.1	VASECTOMY LA		PER MR HAYNES	13
27/02/2015	27/02/2015			AOB	WL	2	D	HYDROSTATIC DILATATION OF BLADDER	M43.2	HYDROSTATIC DILATATION OF BLADDER FIT 7.5.15 KK			13
27/02/2015	27/02/2015			MDH	WL	2	N	LAPAROSCOPIC PYELOPLASTY BEFORE JUNE 2015	M10.2	LAPAROSCOPIC PYELOPLASTY BEFORE JUNE 2015 FIT 19.5.15 KK		PER MR HAYNES	13
27/02/2015	27/02/2015			MY	WL	2	N	TURP	M65.3	TURP B6QT 120515 ON SSRI		SC FLEXI 270215 TCI PER REG	13
02/03/2015	02/03/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC CLINIC 02.03.15	12
02/03/2015	02/03/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC 02.03.15	12
02/03/2015	02/03/2015			JOD	WL	4	D	CIRCUMCISION	N30.3	CURCUMCISION		AS PER JOD CLINIC	12

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30/01/2015	30/01/2015			KS	WL	2	N	CYSTOLITHOPAXY +/- FLEXI & LASER ABLATION HIGH RISK	M44.1	CYSTOLITHOPAXY +/- FLEXI & LASER ABLATION HIGH RISK B6QT 200315 BMI 38 ON DOSULEPIN/INHALERS CANCELLATION		PER RACHAEL DISCHARGE	12
02/03/2015	02/03/2015	01/04/2015		JOD	SA	2	N	RED FLAG CYSTOSCOPY & BLADDER BIOPSY	M45.9	RED FLAG CYSTOSCOPY & BLADDER BIOPSY FIT 11.3.15 KK	1 WEST ELECTIVE ADMISSION WARD		12
03/03/2015	03/03/2015			MDH	WL	4	D	DORSAL SLIT UNDER LA	N30.4	DORSAL SLIT UNDER LA		PER MR HAYNES	12
03/03/2015	03/03/2015	26/06/2015		AJG	WL	2	N	URGENT TURP	M65.3	URGENT TURP	1 WEST ELECTIVE ADMISSION WARD	AS PER AJG CL 3/3/15	12
04/03/2015	04/03/2015			JOD	WL	2	N	BILATERAL RETROGRADE, BILATERAL FLEXI/RIGID URETEROSCOPY	M30.1	BILATERAL RETROGRADE, BILATERAL FLEXI/RIGID URETEROSCOPY		PER JOD	12
04/03/2015	04/03/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC 04.03.15	12
04/03/2015	04/03/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC 04.03.15	12
17/11/2014	04/03/2015			MDH	WL	4	D	VASECTOMY UNDER LA	N17.1	VASECTOMY UNDER LA		PER MR HAYNES	12
05/03/2015	05/03/2015	22/06/2015		MY	WL	4	D	ESWL LETTER TO STC 10/3/15	M14.1	ESWL LETTER TO STC 10/3/15	STONE TREATMENT CENTRE		12
05/03/2015	05/03/2015			MY	WL	2	N	TURP	M65.3	TURP		PER MR YOUNG CLINIC	12
05/03/2015	05/03/2015			MY	WL	4	D	CIRCUMCISION LA	N30.3	CIRCUMCISION LA		PER JENNY MARTIN	12
05/03/2015	05/03/2015			MY	WL	4	D	CYSTOSCOPY & URETHRAL DILATATION	M45.9	CYSTOSCOPY & URETHRAL DILATATION FIT 27.4.15 KK		PD - PER MR YOUNG AT URODYNAMICS 05.03.15	12
05/03/2015	05/03/2015			JOD	WL	4	D	CIRCUMCISION	N30.3	CIRCUMCISION			12
05/03/2015	05/03/2015			MY	WL	4	N	CYSTOLITHOPAXY & TURP PLAVIX/ASPIRIN ALLERGY-TYPE II DIAB	M44.1	CYSTOLITHOPAXY & TURP PLAVIX/ASPIRIN ALLERGY-TYPE II DIAB B6QT 290415 NIDDM TABLET/ACE INHIBITORS/CORTICOSTEROIDS		SC OPD 050315 TCI PER REG	12
05/03/2015	05/03/2015			MY	WL	4	D	HYDRODISTENSION OF BLADDER STH LIST	M43.2	HYDRODISTENSION OF BLADDER		SC OPD 050315 TCI STH PER REG	12
05/03/2015	05/03/2015			MY	WL	4	D	ESWL	M14.1	ESWL		PER RED ESWL BOOK	12
05/03/2015	05/03/2015			MY	WL	4	D	REPEAT ESWL Personal information Person	M14.1	REPEAT Personal information redacted by		PER RED ESWL BOOK	12
06/03/2015	06/03/2015			AOB	SA	2	N	CYSTODIATHERMY +/-TURBT	M42.2	CYSTODIATHERMY +/-TURBT ON APIXABAN - NEEDS TO BE STOPPED PRIOR TO SURGERY			12
06/03/2015	06/03/2015			MY	WL	2	D	INSERTION OF NEPHROSTOMY TUBE	M16.2	INSERTION OF NEPHROSTOMY TUBE		PER RED ESWL BOOK	12
06/03/2015	06/03/2015			MY	WL	2	N	PCNL & INSERTION OF SPC AFTER NEPHROSTOMY	M09.9	PCNL & INSERTION OF SPC AFTER NEPHROSTOMY		PER RED ESWL BOOK	12
06/03/2015	06/03/2015			MY	WL	2	D	DYSPORT BLADDER WALL INJECTION TAB DIABETIC	M49.5	DYSPORT BLADDER WALL INJECTION		PER MR YOUNG UDS CKLINIC	12
06/03/2015	06/03/2015	02/06/2015		MY	WL	2	D	INSERTION OF JJ STENT AIM BEFORE SEPT	M29.2	INSERTION OF JJ STENT AIM BEFORE SEPT WARFARIN	1 WEST ELECTIVE ADMISSION WARD	PER MR YOUNG CLINIC	12
08/12/2014	06/03/2015			AJG	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER MR GLACKIN CLINIC LETTER	12
06/03/2015	06/03/2015			MDH	WL	2	N	LAPAROSCOPIC PARTIAL CYSTECTOMY & EXCISION ADNEXAL MASS	M34.3	LAPAROSCOPIC PARTIAL CYSTECTOMY & EXCISION ADNEXAL MASS		PER MR HAYNES	12
06/03/2015	06/03/2015			MY	WL	2	N	RIGHT FLEXIBLE URETEROSCOPY	M30.9	RIGHT FLEXIBLE URETEROSCOPY B6QT 210515		PER RED ESWL BOOK	12
06/03/2015	06/03/2015			MY	WL	4	D	RIGHT ESWL	M14.1	RIGHT ESWL		PER RED ESWL BOOK	12
06/03/2015	06/03/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER RED ESWL BOOK	12
06/03/2015	06/03/2015			MY	WL	4	D	LEFT ESWL WARFARIN NEEDS BRIDGING CLEXANE 120MG	M14.1	LEFT ESWL WARFARIN NEEDS BRIDGING CLEXANE 120MG MONDAY TREATMENT AWAY MAY/AIM EARLY JUNE		PER RED ESWL BOOK	12
07/03/2015	07/03/2015			AOB	WL	4	N	TURP AFTER CARDIOLOGY ASSESSMENT	M65.3	TURP AFTER CARDIOLOGY ASSESSMENT		PER MR OBRIEN	12
09/03/2015	09/03/2015			KS	WL	2	N	TURP DIABETIC	M65.3	TURP DIABETIC FIT 27.4.15 NIDDM DIET ACE INHIBITORS		PER JENNY CLINIC	11
09/03/2015	09/03/2015			KS	WL	4	D	FRENULOPLASTY UNDER LA	N28.4	FRENULOPLASTY UNDER LA		PER JENNY CLINIC	11
09/03/2015	09/03/2015			KS	WL	4	D	CIRCUMCISION UNDER GA WILLING TO TAKE CANCELLATION	N30.3	CIRCUMCISION UNDER GA WILLING TO TAKE CANCELLATION		PER JENNY CLINIC	11
09/03/2015	09/03/2015	08/06/2015		MY	WL	2	D	RIGHT ESWL ASPIRIN	M14.1	RIGHT ESWL ASPIRIN	STONE TREATMENT CENTRE	PER X-RAY CONF 09.03.15 (RACHAEL)	11
19/02/2015	19/02/2015		01/08/2015	JOD	WL	4	N	CIRCUMCISION & LEFT HYDROCELE REPAIR	N30.3	CIRCUMCISION & LEFT HYDROCELE REPAIR BMI 42.8		PER JENNY MARTIN	11
09/03/2015	09/03/2015	17/06/2015		MDH	WL	4	D	FLEXIBLE CYSTOSOCPY & BOTOX BLADDER AFTER TAUGHT ISC	M45.9	FLEXIBLE CYSTOSCOPY & BOTOX BLADDER AFTER TAUGHT ISC CLOPIDOGREL STOP 7 DAYS BEFORE	DAY SURGERY UNIT	PER MR HAYNES	11
13/10/2014	09/03/2015	01/06/2015		MY	WL	4	D	ESWL MR HAYNES PATIENT (NEEDS 10am APPOINTMENT)	M14.1	ESWL MR HAYNES PATIENT	STONE TREATMENT CENTRE	PER MR HAYNES	11
09/03/2015	09/03/2015			AJG	WL	2	D	BOTULINUM TOXIN	M43.4	BOTULINUM TOXIN on hol until 27/06/2015 FIT 18.5.15 NA(15.06-22.06.15) VARIOUS MEDS		PER AJG	11
10/03/2015	10/03/2015			KS	WL	2	N	GA CYSTOSCOPY & SPC INSERTION QUADRIPLEGIA WHEELCHAIR	M45.9	GA CYSTOSCOPY & SPC INSERTION QUADRIPLEGIA WHEELCHAIR B6D 290415 ON SSIR HOLD(28.04.15)CD		PER KS CLINIC	11
16/02/2015	16/02/2015		01/08/2015	JOD	WL	2	N	TURP	M65.3	TURP B6QT 020415 NIDDM DIET/TABLET			11
05/02/2015	05/02/2015		01/07/2015	JOD	WL	2	N	GA CYSTOSCOPY AND INSERTION OF R JJ STENT	M45.9	GA CYSTOSCOPY AND INSERTION OF R JJ STENT		AS PER X-RAY MEETING	11
10/03/2015	10/03/2015			AOB	WL	2	N	TURP	M65.3	TURP			11
10/03/2015	10/03/2015			AOB	WL	2	N	RIGHT RIGID ?FLEXIBLE URETEROSCOPIC LITHOTRIPSY & STENTING	M09.2	RIGHT RIGID ?FLEXIBLE URETEROSCOPIC LITHOTRIPSY & STENTING FIT 5.5.15 KK			11
11/03/2015	11/03/2015			MDH	WL	4	N	TURP	M65.3	TURP		PER MR HAYNES	11
11/03/2015	11/03/2015			AJG	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER CLINIC	11
11/03/2015	11/03/2015			AJG	WL	4	N	TURP	M65.1	TURP		PER CLINIC	11
11/03/2015	11/03/2015			AJG	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		per clinic letter	11
11/03/2015	11/03/2015			AJG	WL	2	N	TURP	M65.1	TURP		PER CLINIC	11
12/03/2015	12/03/2015			JOD	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			11
12/03/2015	12/03/2015			MDH	WL	2	N	TURP	M65.3	TURP		PER MR HAYNES	11
12/03/2015	12/03/2015			JOD	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER JOD CLINIC	11
12/03/2015	12/03/2015			JOD	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER JOD CLINIC	11
12/03/2015	12/03/2015			JOD	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER RACHAEL CLINIC	11
12/03/2015	12/03/2015	27/05/2015		MY	WL	2	D	LEFT ESWL	M14.1	LEFT ESWL JUNE 2015 TREATMENT NOT DONE 120315 DUE TO HIGH BP	STONE TREATMENT CENTRE	PER RED ESWL BOOK	11
12/03/2015	12/03/2015	28/05/2015		MY	WL	2	D	RIGHT ESWL PRIVATE PATIENT - ON CLEXANE (DVT)	M14.1	RIGHT ESWL	STONE TREATMENT CENTRE	PER RED ESWL BOOK	11
16/03/2015	16/03/2015			MY	WL	2	D	DYSPORT BLADDER WALL INJECTION	M49.4	DYSPORT BLADDER WALL INJECTION FIT 18.5.15 BMI 38.6		PER MR YOUNG CLINIC	10
16/03/2015	16/03/2015			KS	WL	2	D	GA CYSTOSCOPY +/- CYSTODISTENSION & BLADDER BIOPSIES	M45.9	GA CYSTOSCOPY +/- CYSTODISTENSION & BLADDER BIOPSIES		PER KS UDS CLINIC	10
16/03/2015	16/03/2015			AJG	WL	2	N	TURP	M65.1	TURP		PER AJG	10

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16/03/2015	16/03/2015			MY	WL	4	D	RIGHT ESWL	M14.1	RIGHT ESWL		PER RED ESWL BOOK	10
16/03/2015	16/03/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL TREATMENT NOT DONE 160315 DUE TO HIGH BP		PER RED ESWL BOOK	10
16/03/2015	16/03/2015			AOB	WL	4	D	HYDROSTATIC DILATATION OF BLADDER	M43.2	HYDROSTATIC DILATATION OF BLADDER			10
16/03/2015	16/03/2015			AOB	WL	2	N	LEFT NEPHRECTOMY (STENT INSITU)	M02.5	LEFT NEPHRECTOMY (STENT INSITU) FIT 29.4.15 KK			10
03/02/2015	03/02/2015		01/07/2015	KS	WL	2	D	INTRAVESICAL BOTOX +/- CYSTODISTENSION WARFARIN	M43.4	INTRAVESICAL BOTOX +/- CYSTODISTENSION WARFARIN WARFARIN HOLD(20.03.15)CD		PER KS CLINIC	10
18/03/2015	18/03/2015			MY	WL	4	D	VARICOCELE EMBOLISATION(XRAY TO CONTACT) - LETTER IN B/F	N19.2	VARICOCELE EMBOLISATION(XRAY TO CONTACT) - LETTER IN B/F		PER MR YOUNG AT HPC 18.03.15	10
18/03/2015	18/03/2015			AOB	WL	2	D	FLEXIBLE CYSTOSCOPY & CHANGE OF SUPRAPUBIC CATHETER(MAY 15)	M45.9	FELXIBLE CYSTOSCOPY & CHANGE OF SUPRAPUBIC CATHETER (MAY 15)			10
07/10/2014	19/03/2015	19/06/2015		KS	WL	2	N	TURP	M65.3	TURP FIT 8.12.14 KK	1 WEST ELECTIVE ADMISSION WARD	PER MR SURESH CLINIC	10
19/03/2015	19/03/2015			MY	WL	2	D	GA CYSTOSCOPY & HYDROSTATIC DILATATION	M45.9	GA CYSTOSCOPY & HYDROSTATIC DILATATION		PER MR YOUNG CLINIC	10
19/03/2015	19/03/2015	23/06/2015		AJG	WL	4	D	REMOVAL OF TESTICULAR PROSTHESIS	N10.2	REMOVAL OF TESTICULAR PROSTHESIS	STH DAY PROCEDURE UNIT	per ajg email new GP referral	10
19/03/2015	19/03/2015			MY	WL	4	D	RIGHT ESWL	M14.1	RIGHT ESWL		PER RED ESWL BOOK	10
20/03/2015	20/03/2015			MY	WL	2	N	TURP WARFARIN/CATHETER IN SITU	M65.3	TURP WARFARIN/CATHETER IN SITU FIT 18.5.15 KK ON WARFARIN		PER MR YOUNG AT CLINIC 20.03.15	10
20/03/2015	20/03/2015			JOD	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		AS PER WARD	10
20/03/2015	20/03/2015			MY	WL	2	N	RED FLAG LEFT NEPHROURETERECTOMY IDDM	M02.2	RED FLAG LEFT NEPHROURETERECTOMY IDDM		PD - PER MR YOUNG AT CLINIC 20.03.15	10
20/03/2015	20/03/2015			JOD	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		AS PER JENNY MARTIN	10
20/03/2015	20/03/2015			MDH	WL	2	N	LAPAROSCOPIC EXCISION CYST, CYSTOSCOPY & BOTOX	M10.8	LAPAROSCOPIC EXCISION CYST, CYSTOSCOPY & BOTOX FIT 12.5.15 KK BMI 42		PER MR HAYNES	10
26/07/2014	20/03/2015			MDH	WL	4	N	BLADDER NECK INCISION +/- TURP	M66.2	BLADDER NECK INCISION +/- TURP		PER MR HAYNES	10
20/03/2015	20/03/2015			MY	WL	4	N	RIGHT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M30.9	RIGHT FLEXIBLE URETEROSCOPIC LITHOTRIPSY		SC CESWL 200315 TCI PER MY	10
20/03/2015	20/03/2015			MY	WL	2	N	RIGHT FLEXIBLE URETEROSCOPIC LITHOTRIPSY-WILL TAKE CANC	M30.9	RIGHT FLEXIBLE URETEROSCOPIC LITHOTRIPSY B6QT 120515 - PT PHON ? DATE 20.05.15 WILL TAKE CANC		SC CESWL 200315 TCI PER MY	10
20/03/2015	20/03/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		SC CESWL 200315 TCI STC PER MY	10
20/03/2015	20/03/2015			MY	WL	2	N	LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M30.9	LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY		SC CESWL 200315 TCI PER MY	10
20/03/2015	20/03/2015			MY	WL	4	D	RIGHT ESWL	M14.1	RIGHT ESWL		SC CESWL 200315 TCI STC PER MY	10
21/03/2015	21/03/2015			KS	WL	2	D	FLEXIBLE CYSTOSCOPY URGENT +/- URETHRAL DILATATION	M45.9	FLEXIBLE CYSTOSCOPY URGENT +/- URETHRAL DILATATION		PER KS CLINIC	10
21/03/2015	21/03/2015			KS	WL	4	D	FLEXIBLE CYSTOSCOPY +/- URETHRAL DILATATION	M45.9	FLEXIBLE CYSTOSCOPY +/- URETHRAL DILATATION		PER KS CLINIC	10
21/03/2015	21/03/2015			KS	WL	2	D	OPTICAL URETHROTOMY	M76.3	OPTICAL URETHROTOMY HSQ WITH FIONA		PER KS CLINIC	10
21/03/2015	21/03/2015			KS	WL	2	D	GA CYSTOSCOPY +/- CYSTODISTENSION & BLADDER BIOPSIES	M45.9	GA CYSTOSCOPY +/- CYSTODISTENSION & BLADDER BIOPSIES FIT 16.4.15 KK NA(10.07-03.08.15)		PER MR SURESH CLINIC	10
21/03/2015	21/03/2015			KS	WL	2	D	GA CYSTOSCOPY+/-CYSTODISTENSION & BLADDER BIOPSIES/DIATHERMY	M45.9	GA CYSTOSCOPY+/-CYSTODISTENSION & BLADDER BIOPSIES/DIATHERMY BMI 38 HOLD(29.04.15)CD		PER KS CLINIC	10
21/03/2015	21/03/2015			AJG	WL	2	N	LEFT FLEXIBLE URETEROSCOPY	M30.9	LEFT FLEXIBLE URETEROSCOPY		PER AJG	9
21/03/2015	21/03/2015			MY	WL	2	D	SUMMER 2015 LEFT TESTICULAR PROSTHESIS PENICILLIN ALLERGY	N10.1	SUMMER 2015 LEFT TESTICULAR PROSTHESIS PENICILLIN ALLERGY		PD - PER MR YOUNG AT EXTRA CLINIC 21.03.15	9
23/03/2015	23/03/2015			AJG	SA	2	N	RF LEFT URETEROSCOPY	M30.9	RF LEFT URETEROSCOPY		PER CT UROGRAM	9
23/03/2015	23/03/2015			MY	WL	2	D	NESBIT'S PROCEDURE	N28.8	NESBIT'S PROCEDURE		SC OPD 230315 TCI PER MY	9
23/03/2015	23/03/2015			MY	WL	2	D	ESWL AFTER JUNE 2015 MR SURESH PATIENT	M14.1	ESWL AFTER JUNE 2015 MR SURESH PATIENT		PER KS STC CLINIC	9
23/03/2015	23/03/2015			KS	WL	2	N	RIGHT URETEROSCOPY, LASER STONE ABLATION & STENTING	M30.9	RIGHT URETEROSCOPY, LASER STONE ABLATION & STENTING		PER CKSSTC	9
23/03/2015	23/03/2015			MDH	WL	4	N	TURP	M65.3	TURP FIT 24.2.15 ON RAMIPRIL		PER JENNY MARTIN	9
23/03/2015	23/03/2015			MY	WL	4	D	LEFT ESWL ASPIRIN 75MG	M14.1	LEFT ESWL ASPIRIN 75MG		PER RED ESWL BOOK	9
23/03/2015	23/03/2015			AOB	WL	2	N	RECONSTRUCTION OF MITROFANOFF CONDUIT	M19.5	RECONSTRUCTION OF MITROFANOFF CONDUIT BMI 35 NA(01.07-04.07.15/17.09-20.09.15) VARIOUS MEDS B6Q			9
23/03/2015	23/03/2015			AOB	WL	2	N	REFASHIONING OF STOMA	M19.5	REFASHIONING OF STOMA NA(13.06.15-20.06.15)			9
23/03/2015	23/03/2015			AOB	WL	4	D	HYDROSTATIC DILATATION OF BLADDER	M43.2	HYDROSTATIC DILATATION OF BLADDER			9
24/03/2015	24/03/2015	23/06/2015		MDH	WL	2	D	06/15 FLEXIBLE URETHROSCOPY	M77.8	06/15 FLEXIBLE URETHROSCOPY PREVIOUS STRICTURE	THORNDALE UNIT	PER MR HAYNES	9
24/03/2015	24/03/2015			MDH	WL	4	N	TURP	M65.3	TURP 160615 - 260615 ON HOLS		PER MR HAYNES	9
24/03/2015	24/03/2015	03/06/2015		MDH	WL	4	D	CYSTOSCOPY & INTRADETRUSOR BOTOX TO BLADDER	M45.8	CYSTOSCOPY & INTRADETRUSOR BOTOX TO BLADDER	DAY SURGERY UNIT	PER MR HAYNES	9
24/03/2015	24/03/2015			AJG	WL	2	N	LEFT URETEROSCOPY +/- STENT	M30.9	LEFT URETEROSCOPY +/- STENT ALLERGIC TO IV CONTRAST		PER GREEN PROFORMA	9
02/03/2015	02/03/2015		01/07/2015	MDH	WL	4	N	TURP	M65.3	TURP B6QT 280415		PER MR HAYNES	9
24/03/2015	24/03/2015			MY	WL	4	D	ESWL	M14.1	ESWL		PER MR YOUNG RE: RESULTS 24.03.15	9
24/03/2015	24/03/2015			AOB	WL	2	N	RIGHT URETEROGRAPHY AND URETEROSCOPY	M30.1	RIGHT URETEROGRAPHY AND URETEROSCOPY			9
24/03/2015	24/03/2015			AOB	WL	4	N	TURP	M65.3	TURP			9
24/03/2015	24/03/2015			AOB	WL	4	D	BILATERAL VASECTOMY	N17.1	BILATERAL VASECTOMY (HSQ WITH FIONA)			9
25/03/2015	25/03/2015			MDH	WL	2	N	CYSTOSCOPY & MEATAL DILATATION	M45.8	CYSTOSCOPY & MEATAL DILATATION		PER MR HAYNES	9
25/03/2015	25/03/2015			KS	WL	2	D	GA CYSTOSCOPY & INTRAVESICAL BOTOX INJECTIONS	M45.9	GA CYSTOSCOPY & INTRAVESICAL BOTOX INJECTIONS		PER MR SURESH UDS CLINIC	9
25/03/2015	25/03/2015			AJG	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		per clinic outcome	9
25/03/2015	25/03/2015			AJG	WL	2	N	TURP	M65.1	TURP		PER MR GLACKIN CLINIC LETTER	9
25/03/2015	25/03/2015			AJG	WL	4	D	CYSTOSCOPY	M45.9	CYSTOSCOPY		PER CLINIC OUTCOME	9
25/03/2015	25/03/2015	03/06/2015		MDH	WL	4	D	CIRCUMCISION	N30.3	CIRCUMCISION	DAY SURGERY UNIT	PER MR HAYNES	9
25/03/2015	25/03/2015			MY	WL	4	D	RIGHT ESWL ASPIRIN 75MG	M14.1	RIGHT ESWL ASPIRIN 75MG		PER RED ESWL BOOK	9
25/03/2015	25/03/2015			MY	WL	4	D	CIRCUMCISION & VASECTOMY LETTER IN B/F	N30.3	CIRCUMCISION & VASECTOMY LETTER IN B/F PENICILLIN ALLERGY		SC PER MY @ HPC 25.03.15	9
12/03/2015	12/03/2015		01/08/2015	KS	WL	4	N	TURP ANAEMIA	M65.3	TURP ANAEMIA B6QT 010515		PER RACHAEL	9
26/03/2015	26/03/2015			JOD	WL	2	D	CYSTOSCOPY + URETHRAL DILATATION	M45.9	CYSTOSCOPY + URETHRAL DILATATION			9
26/03/2015	26/03/2015	10/06/2015		JOD	WL	2	N	CYSTODISTENSION OF BLADDER	M43.2	CYSTODISTENSION OF BLADDER	1 WEST ELECTIVE ADMISSION WARD	PER JOD	9

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26/03/2015	26/03/2015			JOD	WL	2	N	LEFT URETEROSCOPY +/- LASER	M30.9	LEFT URETEROSCOPY +/- LASER		PER JOD	9
26/03/2015	26/03/2015			MY	WL	4	D	REPEAT ESWL	M14.1	REPEAT ESWL		PER RED ESWL BOOK	9
26/03/2015	26/03/2015			MY	WL	4	D	REPEAT ESWL	M14.1	REPEAT ESWL		PER RED ESWL BOOK	9
26/03/2015	26/03/2015			MY	WL	4	D	REPEAT ESWL	M14.1	REPEAT ESWL		PER RED ESWL BOOK	9
27/03/2015	27/03/2015	17/06/2015		MDH	WL	4	D	VASECTOMY LA	N17.1	VASECTOMY LA LORRY DRIVER NEEDS 2-3 WEEKS NOTICE	DAY SURGERY UNIT	PER PT & MDH	9
27/03/2015	27/03/2015			AOB	WL	2	D	INTRAMURAL INJECTION OF 250 UNITS BOTULINUM TOXIN	M43.4	INTRAMURAL INJECTION OF 250 UNITS BOTULINUM TOXIN			9
27/03/2015	27/03/2015			AOB	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			9
27/03/2015	27/03/2015			MY	DA	2	D	GA CYSTOSCOPY - LETTER IN B/F	M45.9	GA CYSTOSCOPY - LETTER IN B/F		SC WL TCI PER MY	9
28/03/2015	28/03/2015			KS	WL	2	N	EMBOLISATION OF VARICOCELE EPILEPSY	N19.2	EMBOLISATION OF VARICOCELE EPILEPSY		PER KS CLINIC	9
28/03/2015	28/03/2015			KS	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER KS CLINIC	9
28/03/2015	28/03/2015			KS	WL	2	N	NESBITT'S PROCEDURE & CIRCUMCISION	N28.8	CIRCUMCISION		PER KS CLINIC	9
28/03/2015	28/03/2015			KS	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER KS CLINIC	9
28/03/2015	28/03/2015			KS	WL	2	D	GA CYSTOSCOPY & INTRAVESICAL BOTOX	M45.9	GA CYSTOSCOPY & INTRAVESICAL BOTOX FIT 20.4.15 KK		PER KS CLINIC	9
28/03/2015	28/03/2015			KS	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER KS CLINIC	9
28/03/2015	28/03/2015			AJG	WL	2	D	CYSTOSTAT 250 U DYSPORT	M49.4	CYSTOSTAT 250 U DYSPORT PT HAD BRADYCARDIA DURING RECENT COLONOSCOPY INVESTIGATION		PER CLINIC OUTCOME	8
28/03/2015	28/03/2015			AJG	WL	4	N	RIGHT RETROGRADE PYELOGRAM +/- URETEROSCOPY	M30.1	RIGHT RETROGRADE PYELOGRAM +/- URETEROSCOPY FIT(10.04.15)CD		PER OUTCOME SHEET	8
28/03/2015	28/03/2015		01/07/2015	KS	WL	2	N	TURP OBESITY 112KGS	M65.3	TURP OBESITY 112KGS HOLD(22.05.15)CD		PER KS CLINIC	8
30/03/2015	30/03/2015			MY	WL	2	N	LEFT RIGID DIAGNOSTIC URETEROSCOPY	M30.9	LEFT RIGID DIAGNOSTIC URETEROSCOPY NEW LTR A&E 24.04.15		PER MR YOUNG RE: RESULTS 30.03.15	8
30/03/2015	30/03/2015	29/05/2015		KS	WL	2	D	RF FLEXIBLE CYSTOSCOPY ? STRICTURE	M45.9	RF FLEXIBLE CYSTOSCOPY ? STRICTURE	DAY SURGERY UNIT	PER KS CLINIC	8
30/03/2015	30/03/2015			AOB	WL	2	N	TURP	M65.3	TURP			8
30/03/2015	30/03/2015			AOB	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			8
30/03/2015	30/03/2015	12/06/2015		AJG	WL	2	D	FLEXIBLE CYSTOSCOPY WITHIN 3/12	M45.9	FLEXIBLE CYSTOSCOPY WITHIN 3/12	DAY SURGERY UNIT	PER CLINIC	8
30/03/2015	30/03/2015			AJG	WL	2	D	CYSTOSCOPY	M45.9	CYSTOSCOPY			8
09/03/2015	30/03/2015			AOB	WL	2	D	CIRCUMCISION	N30.3	CIRCUMCISION AWAIT PROCEDURE,NEXT AVAIL W/C 200415			8
30/03/2015	30/03/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER RED ESWL BOOK	8
30/03/2015	30/03/2015			MY	WL	4	D	ESWL	M14.1	ESWL		PER RED ESWL BOOK	8
31/03/2015	31/03/2015			MDH	WL	4	N	TURP +/- TARGETTED BX	M65.3	TURP +/- TARGETTED BX EARLY AUGUST 2015 AFTER MRI		PER MR HAYNES	8
31/03/2015	31/03/2015			KS	WL	2	N	BNI/TURP	M66.2	BNI/TURP B6QT 180515 ANGIOTENSION 11 RECEPTOR ANTAGONISTS		PER KS CLINIC	8
31/03/2015	31/03/2015			MY	WL	2	N	JUNE 2015 TURP	M65.3	JUNE 2015 TURP		SC WD DIS 310315 READM 2M PER REG	8
31/03/2015	31/03/2015			KS	WL	2	N	BNI/TURP	M66.2	BNI/TURP		PER KS CLINIC	8
31/03/2015	31/03/2015			AOB	WL	4	N	TURP	M65.3	TURP			8
31/03/2015	31/03/2015			AOB	WL	2	N	TURP	M65.3	TURP			8
31/03/2015	31/03/2015			AOB	WL	4	N	TURP	M65.3	TURP			8
31/03/2015	31/03/2015			AOB	WL	2	N	URETHRAL DILATATION (ON ABATACEPT-TO BE STOPPED 2 WKS PRIOR)	M76.4	URETHRAL DILATATION (ON ABATACEPT-TO BE STOPPED 2 WKS PRIOR) MS PATIENT FIT 18.5.15 CHRONIC PAIN MEDS			8
01/04/2015	01/04/2015			AJG	WL	4	D	FLEXIBLE CYSTOSCOPY STH AJG ONLY	M45.9	FLEXIBLE CYSTOSCOPY STH AJG ONLY		per results	8
01/04/2015	01/04/2015			AOB	WL	2	N	CYSTOSCOPY AND BLADDER BIOPSIES OR TURBT	M45.9	CYSTOSCOPY AND BLADDER BIOPSIES OR TURBT			8
02/04/2015	02/04/2015	10/06/2015		JOD	WL	2	D	GA CYSTOSCOPY	M45.8	GA CYSTOSCOPY B6QT 140515 HOLD(12.05.15) ANGIOTENSION 11 RECEPTOR ANTAGON	DAY SURGERY UNIT	PER JOD	8
02/04/2015	02/04/2015			JOD	WL	4	D	LEFT TESTICULAR PROSTHESIS	N10.1	LEFT TESTICULAR PROSTHESIS		PER JOD	8
02/04/2015	02/04/2015			JOD	WL	4	D	OPTICAL URETHROTOMY & CYSTOSCOPY	M76.3	OPTICAL URETHROTOMY & CYSTOSCOPY		PER JOD	8
02/04/2015	02/04/2015			JOD	WL	2	N	LEFT FLEXIBLE URETEROSCOPY & LASER	M30.9	LEFT FLEXIBLE URETEROSCOPY & LASER FIT 15.5.15 KK ON SSRI		PER JOD	8
02/04/2015	02/04/2015			MY	WL	4	D	CIRCUMCISION, CYSTOSCOPY & HYDROSTATIC DILATATION	N30.3	CIRCUMCISION, CYSTOSCOPY & HYDROSTATIC DILATATION		PER MR YOUNG AT CLINIC 02.04.15	8
02/04/2015	02/04/2015			MDH	WL	4	D	FLEXIBLE CYSTOSCOPY & BOTOX TO BLADDER	M45.9	FLEXIBLE CYSTOSCOPY & BOTOX TO BLADDER		PER MR HAYNES	8
03/04/2015	03/04/2015			AOB	WL	4	D	CYSTOSCOPY & HYDROSTATIC	M45.9	CYSTOSCOPY & HYDROSTATIC		PER URODYNAMICS 03.04.15	8
03/04/2015	03/04/2015			MDH	WL	4	N	TURP	M65.3	TURP HEPARIN 28 DAYS BEFOREHAND SEE OPC LTR		PER MR HAYNES	8
03/04/2015	03/04/2015	17/06/2015		MDH	WL	4	D	FLEXIBLE CYSTOSCOPY & BOTOX BLADDER (LA)	M45.9	FLEXIBLE CYSTOSCOPY & BOTOX BLADDER (LA)	DAY SURGERY UNIT	PER MR HAYNES	8
03/04/2015	03/04/2015			MDH	WL	4	D	CYSTOSCOPY & CYSTODISTENSION	M43.2	CYSTOSCOPY & CYSTODISTENSION		PER MR HAYNES	8
24/11/2014	03/04/2015	10/06/2015		JOD	WL	4	D	VASECTOMY GA	N17.1	VASECTOMY GA	DAY SURGERY UNIT		8
03/04/2015	03/04/2015			MY	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER MR YOUNG AT CLINIC 03.04.15	8
03/04/2015	03/04/2015	19/06/2015		AJG	SA	2	N	TURBT RED FLAG	M42.1	TURBT RED FLAG HISTORY OF O2 THERAPY HSQ WITH FIONA	1 WEST ELECTIVE ADMISSION WARD	PER JENNY MARTIN FLEXI	8
03/04/2015	03/04/2015	26/06/2015		AJG	SA	2	N	RIGID CYSTOSCOPY & TURBT RED FLAG	M45.9	RIGID CYSTOSCOPY & TURBT RED FLAG	1 WEST ELECTIVE ADMISSION WARD	PER JENNY MARTIN FLEXI	8
03/04/2015	03/04/2015			MY	WL	2	N	BLADDER LITHOLAPAXY & RIGID CYSTOSCOPY MAY/JUNE 2015	M44.1	BLADDER LITHOLAPAXY & RIGID CYSTOSCOPY MAY/JUNE 2015		SC CESWL 030415 TCI MAY/JUNE 2015 PER MY	8
03/04/2015	03/04/2015	19/06/2015		AJG	SA	2	N	TURBT & CYSTO-DIATHERMY RED FLAG	M42.1	TURBT & CYSTO-DIATHERMY RED FLAG	1 WEST ELECTIVE ADMISSION WARD	PER JENNY MARTIN FLEXI	8
03/04/2015	03/04/2015			AOB	WL	2	N	CYSTOSCOPY, BLADDER BIOPSIES, PROSTATE BIOPSIES +/- TUR	M45.9	CYSTOSCOPY, BLADDER BIOPSIES, PROSTATE BIOPSIES +/- TUR			8
03/04/2015	03/04/2015			MY	WL	4	D	RIGHT FLEXIBLE URETEROSCOPY & LASER	M30.9	RIGHT FLEXIBLE URETEROSCOPY & LASER		PER STC CLINIC 03.04.15	8
03/04/2015	03/04/2015			MY	WL	4	D	RIGHT ESWL	M14.1	RIGHT ESWL		PER STC CLINIC 03.04.15	8
24/02/2015	24/02/2015		01/06/2015	AOB	WL	4	N	TURP	M65.3	TURP B6QT 150415 NIDDM TABLET			7
08/04/2015	08/04/2015			MDH	WL	4	N	TURP	M65.3	TURP B6D 26/5/15 WILL TAKE CANCELLATION ANGIOTENSION 11 RECEPTOR ANTAGONISTS		PER JENNY MARTIN	7
08/04/2015	08/04/2015			MDH	WL	4	D	CIRCUMCISION NEEDS 4 WEEKS NOTICE	N30.3	CIRCUMCISION TYPE 1 DIABETIC (FIT 03/04/15)		PER MR HAYNES	7
09/04/2015	09/04/2015			AOB	WL	4	N	TURP	M65.3	TURP		PER LUTS CLINIC	7
09/04/2015	09/04/2015	30/06/2015		MY	WL	2	N	AIM AUG/SEPT 15 BLADDER LITHOLAPAXY & CHANGE OF SPC	M44.1	AIM AUG/SEPT 15 BLADDER LITHOLAPAXY & CHANGE OF SPC	1 WEST ELECTIVE ADMISSION WARD	PER MR YOUNG AT CLINIC 09.04.15	7
09/04/2015	09/04/2015			MY	WL	2	N	CIRCUMCISION & BLADDER NECK INCISION +/- TURP	N30.3	CIRCUMCISION & BLADDER NECK INCISION +/- TURP		PD - PER MR YOUNG AT URODYNAMICS 09.04.15	7

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

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10/04/2015	10/04/2015			MY	WL	4	N	TURP	M65.3	TURP		PD - PER MR YOUNG AT CLINIC 10.04.15	7
06/03/2015	10/04/2015	01/06/2015		MDH	SA	2	N	RF CYSTOSCOPY +/- PROCEED, RIGHT RETROGRADE +/- URETEROSCOPY	M45.8	RF CYSTOSCOPY +/- PROCEED, RIGHT RETROGRADE +/- URETEROSCOPY B6D 120315 NIDDM TAB ACE INHIBITORS PT UNWELL SEE 1/12	1 WEST ELECTIVE ADMISSION WARD	PER MR HAYNES	7
10/04/2015	10/04/2015			MY	WL	4	D	RIGHT URETEROSCOPY & LASERTRIPSY (HOLIDAY TIMES ONLY)	M30.9	RIGHT URETEROSCOPY & LASERTRIPSY FIT 10.4.15 KK		PER STC CLINIC 10.04.15	7
10/04/2015	10/04/2015			AOB	WL	2	N	TURP AND INTRAMURAL INJECTION OF 300 UNIT OF BOTULINUM TOXIN	M65.3	TURP AND INTRAMURAL INJECTION OF 300 UNITS BOTULINUM TOXIN			7
10/04/2015	10/04/2015			AOB	SA	2	N	TURBT AND BLADDER BIOPSIES	M42.1	TURBT AND BLADDER BIOPSIES FIT 17.4.15 KK PACEMAKER			7
10/04/2015	10/04/2015			AOB	WL	2	N	GA CYSTOSCOPY +/- OPTICAL URETHROTOMY	M45.9	GA CYSTOSCOPY +/- OPTICAL URETHROTOMY			7
10/04/2015	10/04/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC CLINIC 10.04.15	7
20/03/2015	20/03/2015		01/07/2015	MDH	WL	4	D	MEATAL DILATATION DIABETIC	M81.4	MEATAL DILATATION B6D 280415 HOLD(28.04.15)CD		PER MR HAYNES	6
13/04/2015	13/04/2015			AJG	WL	4	D	REPAIR OF LEFT HYDROCELE	N11.1	REPAIR OF LEFT HYDROCELE PATIENT ON CLOPIDOGREL		PER MR GLACKIN CLINIC LETTER	6
03/02/2014	13/04/2015	19/05/2015		KS	WL	4	D	VASECTOMY REVERSAL	N18.1	VASECTOMY REVERSAL FIT 21.8.14 KK	DAY SURGERY UNIT	PER MR SURESH	6
13/04/2015	13/04/2015			AJG	WL	2	D	RIGID CYSTOSCOPY +/- RETROGRADE STUDIES	M45.9	RIGID CYSTOSCOPY +/- RETROGRADE STUDIES		PER CLINIC	6
13/04/2015	13/04/2015			AJG	WL	4	D	LEFT HYDROCELE REPAIR	N11.8	LEFT HYDROCELE REPAIR		per ajg	6
09/02/2015	13/04/2015			MDH	WL	4	D	VASECTOMY LA	N17.1	VASECTOMY LA		PER MR HAYNES	6
13/04/2015	13/04/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC 13.04.15	6
14/04/2015	14/04/2015			KS	WL	2	D	GA CYSTOSCOPY +/- CYSTODISTENSION & BLADDER BIOPSIES	M45.9	GA CYSTOSCOPY +/- CYSTODISTENSION & BLADDER BIOPSIES		PER KS CLINIC	6
14/04/2015	14/04/2015			MY	WL	2	D	JULY 2015 RIGHT FLEXIBLE URETEROSCOPY	M30.9	JULY 2015 RIGHT FLEXIBLE URETEROSCOPY		PD - PER MR YOUNG IN THEATRE 14.04.15	6
14/04/2015	14/04/2015			AOB	WL	2	N	TURP (ON WARFARIN - NEEDS CLEXANE)	M65.3	TURP (ON WARFARIN - NEEDS CLEXANE)			6
15/04/2015	15/04/2015			MDH	WL	2	N	TURP CATHETER INSITU	M65.3	TURP CATHETER INSITU		PER MR HAYNES	6
15/04/2015	15/04/2015			KS	WL	4	D	circumcision	N30.3	CIRCUMCISION FIT 5.5.15 KK		per clinic outcome	6
15/04/2015	15/04/2015			AJG	WL	2	N	TURP	M65.1	TURP		PER OUTCOME SHEET	6
15/04/2015	15/04/2015			AJG	WL	2	D	FLEXIBLE CYSTOSCOPY ONLY AFTER CHEMO WITH DR CARSER COMPLETE	M45.9	FLEXIBLE CYSTOSCOPY ONLY AFTER CHEMO WITH DR CARSER COMPLETE		PER AJG	6
16/04/2015	16/04/2015			JOD	WL	2	N	ORCHIDECTOMY	N06.3	ORCHIDECTOMY FIT 18.5.15 KK			6
16/04/2015	16/04/2015			JOD	WL	4	D	VASECTOMY	N17.1	VASECTOMY AFTER AUGUST 2015			6
16/04/2015	16/04/2015	03/06/2015		MY	WL	2	D	ESWL	M14.1	ESWL	STONE TREATMENT CENTRE	PD - PER MR YOUNG AT CLINIC 16.04.15	6
16/04/2015	16/04/2015			MY	WL	4	D	VARICOCELE EMBOLISATION WITH DR MCCONVILLE (XRAY TO CONTACT)	N19.2	VARICOCELE EMBOLISATION WITH DR MCCONVILLE (XRAY TO CONTACT)		PD - PER MR YOUNG AT CLINIC 16.04.15	6
16/04/2015	16/04/2015			JOD	WL	4	D	FRENULOPLASTY	N28.4	FRENULOPLASTY		PER CLINIC OUTCOME SHEET	6
16/04/2015	16/04/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER CLINIC OUTCOME SHEET	6
16/04/2015	16/04/2015	02/06/2015		MY	WL	2	N	RED FLAG RIGID CYSTOSCOPY & BIOPSY	M45.9	RED FLAG RIGID CYSTOSCOPY & BIOPSY	1 WEST ELECTIVE ADMISSION WARD	PD - PER JENNY AT TDU 16.04.15	6
26/11/2014	16/04/2015			MY	WL	2	D	MAY 2015 ESWL - RECENT MI - WISHES JULY 15 (AWAY 6-13/7/15)	M14.1	MAY 2015 ESWL ASPIRIN 75MGS		SC ESWL 261114 READM STC MAY 2015 PER MY	6
16/04/2015	16/04/2015	04/06/2015		MY	WL	2	D	LEFT ESWL PRIVATE PATIENT	M14.1	LEFT ESWL PRIVATE PATIENT	STONE TREATMENT CENTRE	PER STC 16.04.15	6
16/04/2015	16/04/2015			MY	WL	4	D	AFTER AUGUST 10TH 2015 BILATERAL ORCHIDOPEXY CHILD	N09.3	AFTER AUGUST 10TH 2015 BILATERAL ORCHIDOPEXY CHILD		PD - PER JENNY AT CLINIC 16.04.15	6
17/04/2015	17/04/2015			MDH	WL	2	N	LAPAROSCOPIC DEROOFING RENAL CYST	M04.1	LAPAROSCOPIC DEROOFING RENAL CYST ON METHOTREXATE		PER MR HAYNES	6
17/04/2015	17/04/2015			MDH	WL	4	N	TURP	M65.3	TURP		PER MR HAYNES & GP	6
17/04/2015	17/04/2015	27/05/2015		KS	SA	2	D	RF TURBT CARDIOLOGY ISSUES	M42.1	RF TURBT CARDIOLOGY ISSUES FIT 19.5.15 KK	1 WEST ELECTIVE ADMISSION WARD	PER FLEXI LIST	6
17/04/2015	17/04/2015			KS	WL	2	N	OPTICAL URETHROTOMY/URETHRAL DILATATION + CYSTOSCOPY	M76.3	OPTICAL URETHROTOMY/URETHRAL DILATATION + CYSTOSCOPY		PER FLEXI LIST	6
17/04/2015	17/04/2015			KS	WL	2	D	URGENT FLEXIBLE CYSTOSCOPY	M45.9	URGENT FLEXIBLE CYSTOSCOPY		PER KS TRIAGE LETTER	6
17/04/2015	17/04/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC CLINIC 17.04.15	6
17/04/2015	17/04/2015			MY	WL	4	D	RIGHT ESWL BULGARIAN INTERPRETER	M14.1	RIGHT ESWL BULGARIAN INTERPRETER		PER STC CLINIC 17.04.15	6
18/04/2015	18/04/2015	10/06/2015		MY	WL	2	D	LEFT ESWL MR SURESH PATIENT	M14.1	LEFT ESWL MR SURESH PATIENT	STONE TREATMENT CENTRE	PER KS RESULT LTR TO PATIENT	5
20/04/2015	20/04/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC 20.04.15	5
20/04/2015	20/04/2015	17/06/2015		MY	WL	2	D	ESWL STENT IN SITU (LETTER POSTED TO STC)	M14.1	ESWL STENT IN SITU (LETTER POSTED TO STC)	STONE TREATMENT CENTRE	PER MR YOUNG RE: REFERRAL MR GRAY, ULSTER HOSPITAL	5
20/04/2015	20/04/2015			AJG	WL	2	N	TURP	M65.1	TURP		PER CLINIC OUTCOME SHEET	5
20/04/2015	20/04/2015			AJG	WL	2	D	FLEXIBLE CYSTOSCOPY STH PER AJG	M45.9	FLEXIBLE CYSTOSCOPY STH PER AJG		PER CLINIC OUTCOME	5
20/04/2015	20/04/2015			AJG	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY PT AWAY JUNE 2015		PER CLINIC OUTCOME	5
20/04/2015	20/04/2015			JOD	WL	2	N	TURP	M65.3	TURP HOLD(21.05.15)CD		PER OUTCOME SHEET JOD	5
20/04/2015	20/04/2015			JOD	WL	2	D	CIRCUMCISION	N30.3	CIRCUMCISION		PER OUTCOME SHEET JOD	5
20/04/2015	20/04/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER OUTCOME SHEET JOD	5
20/04/2015	20/04/2015			MY	WL	4	N	TURP REQUIRES F2F ANAESTHETIC ASSESSMENT-BAD CHEST PLAVIX	M65.3	TURP REQUIRES F2F ANAESTHETIC ASSESSMENT-BAD CHEST PLAVIX		PD - PER MR YOUNG AT BURM1 20.04.15	5
20/04/2015	20/04/2015			MY	WL	4	D	ESWL LETTER POSTED TO STC	M14.1	ESWL LETTER POSTED TO STC		RE: REFERRAL BANGOR HOSPITAL (MR MCKNIGHT)	5
20/04/2015	20/04/2015			MY	WL	4	N	BLADDER NECK INCISION	M66.2	BLADDER NECK INCISION		PD - PER MR YOUNG AT CLINIC 20.04.15	5
21/04/2015	21/04/2015			MDH	WL	4	D	FLEXIBLE CYSTOSCOPY & BOTOX TO BLADDER	M45.9	FLEXIBLE CYSTOSCOPY & BOTOX TO BLADDER		PER MR HAYNES	5
05/01/2015	21/04/2015	27/05/2015		JOD	WL	2	N	TURP	M65.3	TURP FIT 20.4.15 KK	1 WEST ELECTIVE ADMISSION WARD		5
21/04/2015	21/04/2015			MDH	WL	4	N	TURP	M65.3	TURP Personal		PER MR HAYNES	5
21/04/2015	21/04/2015	02/06/2015		MY	WL	2	N	4-6/52 FLEXIBLE CYSTOSCOPY & REMOVAL OF BLADDER STONES	M45.9	4-6/52 FLEXIBLE CYSTOSCOPY & REMOVAL OF BLADDER STONES	1 WEST ELECTIVE ADMISSION WARD	PD - PER KAREN AT DSU 21.04.15	5
21/04/2015	21/04/2015	03/06/2015		MDH	WL	2	D	CYSTOSCOPY & URETHRAL DILATATION	M45.8	CYSTOSCOPY & URETHRAL DILATATION	DAY SURGERY UNIT	PER KAREN	5
21/04/2015	21/04/2015			MDH	WL	2	N	06/15 REVISION CIRCUMCISION/SCROTAL SKIN FLAP	N28.8	06/15 REVISION CIRCUMCISION/SCROTAL SKIN FLAP		PER MR HAYNES	5
22/04/2015	22/04/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC 22.04.15	5
22/04/2015	22/04/2015	18/06/2015		MY	WL	2	D	ESWL CBD STONE - TO BE DONE ON DAY WHEN MY PRESENT	M14.1	ESWL CBD STONE - TO BE DONE ON DAY WHEN MY PRESENT	STONE TREATMENT CENTRE	PER STC 22.04.15	5
22/04/2015	22/04/2015			MY	WL	2	D	CYSTOSCOPY & HYDROSTATIC DILATATION LETTER IN B/F	M45.9	CYSTOSCOPY & HYDROSTATIC DILATATION LETTER IN B/F		PER MR YOUNG AT HPC 22.04.15	5
22/04/2015	22/04/2015			MDH	WL	2	N	INSERTION SUPRAPUBIC CATHETER UNDER CYSTOSCOPIC GUIDANCE	M49.8	INSERTION SUPRAPUBIC CATHETER UNDER CYSTOSCOPIC GUIDANCE WHEELCHAIR, MS CANCELLATION		PER RACHAEL MDH	5
22/04/2015	22/04/2015			AJG	SA	2	D	FLEXIBLE CYSTOSCOPY - RED FLAG	M45.9	FLEXIBLE CYSTOSCOPY - RED FLAG		PER REG CLINIC LETTER	5
23/04/2015	23/04/2015			MY	WL	4	D	RIGHT ESWL MR SURESH PATIENT	M14.1	RIGHT ESWL MR SURESH PATIENT		PER STC 23.04.15	5

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23/04/2015	23/04/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC 23.04.15	5
23/04/2015	23/04/2015			MY	WL	2	D	CIRCUMCISION AUTISTIC	N30.3	CIRCUMCISION AUTISTIC FIT 7.5.15 KK		PD - PER MR YOUNG AT CLINIC 23.04.15	5
03/09/2014	23/04/2015	16/06/2015		KS	WL	4	D	VASECTOMY REVERSAL	N18.1	VASECTOMY REVERSAL FIT 4.9.14 KK	DAY SURGERY UNIT	PER CKSTDU	5
23/04/2015	23/04/2015			JOD	WL	2	D	GA CYSTOSCOPY	M45.8	GA CYSTOSCOPY		PER OUTCOME SHEET	5
23/04/2015	23/04/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER OUTCOME SHEET JOD	5
24/04/2015	24/04/2015			MY	WL	2	D	LEFT URETEROSCOPY & LASERTRIPSY	M30.9	LEFT URETEROSCOPY & LASERTRIPSY		PD - PER MR YOUNG AT CLINIC 24.04.15	5
24/04/2015	24/04/2015	30/06/2015		MY	WL	2	N	RED FLAG GA CYSTOSCOPY, BIOPSY & DIATHERMY	M45.9	RED FLAG GA CYSTOSCOPY, BIOPSY & DIATHERMY	1 WEST ELECTIVE ADMISSION WARD	PD - PER KAREN AT DSU 24.04.15	5
24/04/2015	24/04/2015	08/06/2015		MY	WL	2	D	RIGHT ESWL	M14.1	RIGHT ESWL	STONE TREATMENT CENTRE	PD - PER KAREN AT DSU 24.04.15	5
05/01/2015	24/04/2015			AOB	WL	4	D	HYDROSTATIC DILATATION OF BLADDER	M43.2	HYDROSTATIC DILATATION OF BLADDER NIDDM TABLET ACE INHIBITORS FIT(09.04.15)CD			5
27/04/2015	27/04/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC 27.04.15	4
27/04/2015	27/04/2015			MY	WL	4	D	RIGHT ESWL AOB PT - AORTIC ANEURYSM/ASPIRIN	M14.1	RIGHT ESWL AOB PT - AORTIC ANEURYSM/ASPIRIN		PER STC 27.04.15	4
27/04/2015	27/04/2015	29/05/2015		MY	WL	2	D	FLEXIBLE CYSTOSCOPY (HAEMATURIA)	M45.9	FLEXIBLE CYSTOSCOPY (HAEMATURIA)	DAY SURGERY UNIT	PD - PER MR YOUNG AT SWAH 27.04.15	4
27/04/2015	27/04/2015			JOD	WL	2	D	GA CYSTOSCOPY AND BIOPSY GLANS PENIS MRSA	M45.9	GA CYSTOSCOPY AND BIOPSY GLANS PENIS MRSA		PER JOD CLINIC 270415	4
27/04/2015	27/04/2015	01/06/2015		MY	WL	4	D	GA CYSTOSCOPY	M45.9	GA CYSTOSCOPY	STH DAY PROCEDURE UNIT	PD - PER MR YOUNG AT SWAH 27.04.15	4
30/10/2014	27/04/2015			MY	WL	2	D	ESWL UNDER GA - PAEDIATRICS LIST	M14.1	ESWL UNDER GA - PAEDIATRICS LIST		RE: EMAIL REFERRAL MR BAILIE 30.10.14	4
29/12/2014	27/04/2015			MY	WL	4	D	RIGHT ESWL - TO SEE RHEUMATOLOGY 1ST PER PATIENT	M14.1	RIGHT ESWL		PER STC CLINIC 29.12.14	4
27/04/2015	27/04/2015			MY	WL	4	D	FLEXIBLE CYSTOSCOPY & BLADDER LAVAGE STH UNDER LA	M45.9	FLEXIBLE CYSTOSCOPY & BLADDER LAVAGE		PER MR YOUNG AT SWAH 27.04.15	4
20/01/2015	27/04/2015			MY	WL	2	D	ESWL PAEDIATRIC LIST (LETTER POSTED TO STC)	M14.1	ESWL PAEDIATRIC LIST		PER MR YOUNG RE: REFERRAL MR BAILIE 20.01.15	4
10/10/2014	27/04/2015			MY	WL	2	D	FLEXIBLE CYSTOSCOPY WARFARIN	M45.9	FLEXIBLE CYSTOSCOPY		per clinic 10/10/2014	4
27/04/2015	27/04/2015	02/06/2015		JOD	SA	2	N	RED FLAG TURBT	M42.1	RED FLAG TURBT	1 WEST ELECTIVE ADMISSION WARD	PER CLINIC OUTCOME	4
27/04/2015	27/04/2015			JOD	WL	4	D	URODYNAMICS/FLEXIBLE CYSTOSCOPY (DOUBLE URODYNAMIC SLOT)	M45.9	URODYNAMICS/FLEXIBLE CYSTOSCOPY (DOUBLE URODYNAMIC SLOT)		PER CLINIC OUTCOME SHEETS	4
27/04/2015	27/04/2015			JOD	WL	2	N	REMOVAL OF URETERIC STENT	M29.8	REMOVAL OF URETERIC STENT MUST BE MAIN THEATRES		NEEDS TO BE DONE AS INPATIENT PROCEDURE PER JOD	4
27/04/2015	27/04/2015			JOD	WL	2	N	TURP	M65.1	TURP		PER CLINIC OUTCOME SHEET	4
27/04/2015	27/04/2015			AOB	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY			4
27/04/2015	27/04/2015			JOD	WL	2	D	CYSTOSCOPY & INSERTION OF URODYNAMIC CATHETERS	M45.9	CYSTOSCOPY & INSERTION OF URODYNAMIC CATHETERS		URODYNAMICS TO BE COMPLETED AFTER INSERTION OF CATHETERS	4
27/04/2015	27/04/2015	11/06/2015		JOD	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	THORNDALE UNIT		4
29/12/2014	27/04/2015			MY	WL	4	D	RIGHT ESWL PAEDIATRIC LIST	M14.1	RIGHT ESWL PAEDIATRIC LIST UTA 13.05.15 GOING TO BALMORAL SHOW - WISHES SFA		PER STC CLINIC 29.12.14	4
27/04/2015	27/04/2015	19/06/2015		AJG	WL	2	N	LEFT LAPAROSCOPIC NEPRHECTOMY (NO LATER THAN JULY 2015)	M02.5	LEFT LAPAROSCOPIC NEPRHECTOMY (JULY 2015)	1 WEST ELECTIVE ADMISSION WARD	PER AJG	4
22/12/2014	27/04/2015	08/06/2015		MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL UTA 07.05.15 HAS VISITORS COMING-UNABLE TO COPE WITH BOTH	STONE TREATMENT CENTRE	PER STC CLINIC 22.12.14	4
27/04/2015	27/04/2015			AOB	WL	4	D	LEFT EPIDIDYMAL CYSTECTOMY	N15.3	LEFT EPIDIDYMAL CYSTECTOMY FIT 30.4.15 KK			4
27/04/2015	27/04/2015			AOB	WL	2	N	TURP	M65.3	TURP			4
28/04/2015	28/04/2015			MY	WL	2	N	LEFT URETEROSCOPY STENT IN SITU	M30.9	LEFT URETEROSCOPY		PD - PER MR YOUNG IN THEATRE 28.04.15	4
28/04/2015	28/04/2015			MDH	WL	4	N	TURP ON HOLS SEPTEMBER 2015	M65.3	TURP ON HOLS SEPTEMBER 2015 LITHUANIAN INTERPRETER REQUIRED		PER MR HAYNES	4
28/04/2015	28/04/2015			MY	WL	4	D	RIGHT ESWL LTR POSTED TO STC	M14.1	RIGHT ESWL LTR POSTED TO STC		PER MR YOUNG RE: NEW LTR 28.04.15	4
28/04/2015	28/04/2015	27/05/2015		KS	SA	2	D	RF GA CYSTOSCOPY +/- TURBT	M45.9	RF GA CYSTOSCOPY +/- TURBT FIT 7.5.15 ON RAMIPRIL/CANDESARTAN	1 WEST ELECTIVE ADMISSION WARD	PER KS CLINIC	4
28/04/2015	28/04/2015	05/06/2015		KS	SA	2	D	RF GA CYSTOSCOPY, BIOPSY/TURBT +/- MMC CTU BEFORE	M45.1	RF GA CYSTOSCOPY, BIOPSY/TURBT +/- MMC CTU BEFORE B6D 290415	1 WEST ELECTIVE ADMISSION WARD	PER KS CLINIC	4
28/04/2015	28/04/2015			AOB	WL	4	N	RIGID CYSTOSCOPY AND HYDRODISTENSION	M45.9	RIGID CYSTOSCOPY AND HYDRODISTENSION			4
28/04/2015	28/04/2015			MY	WL	2	N	AUGUST 15 INSERTION OF TESTICULAR PROSTHESIS - LTR IN B/F	N10.1	AUGUST 15 INSERTION OF TESTICULAR PROSTHESIS - LTR IN B/F		PD - PER MR YOUNG AT HPC 28.04.15	4
28/04/2015	28/04/2015			AOB	WL	2	N	TURP (CATHETER INSITU)	M65.3	TURP (CATHETER INSITU) NOT AVAILABLE 30/5 - 8/6, 8/8 - 22/8. 20/9 - 30/9 PLEASE			4
29/04/2015	29/04/2015			MDH	WL	2	N	TURP CATHETER INSITU	M65.3	TURP CATHETER INSITU		PER JENNY MARTIN	4
29/04/2015	29/04/2015			MDH	WL	4	D	FRENULOPLASTY UNDER GA	N28.4	FRENULOPLASTY UNDER GA		PER MR HAYNES	4
29/04/2015	29/04/2015	17/06/2015		MDH	WL	2	D	LA CIRCUMCISION (2 SLOTS)	N30.3	LA CIRCUMCISION (2 SLOTS) NEEDS HOIST	DAY SURGERY UNIT	PER MR HAYNES	4
29/04/2015	29/04/2015			JOD	WL	2	N	TURP	M65.3	TURP		PER DISCHARGE	4
29/04/2015	29/04/2015			KS	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER KS CLINIC	4
29/04/2015	29/04/2015			KS	WL	2	D	INTRAVESICAL BOTOX INJECTIONS	M43.4	INTRAVESICAL BOTOX INJECTIONS		PER KS UDS CLINIC	4
30/04/2015	30/04/2015			AOB	WL	2	N	URODYNAMIC STUDIES AND FLEXIBLE CYSTOSCOPY	M47.4	URODYNAMIC STUDIES AND FLEXIBLE CYSTOSCOPY ON WARFARIN			4
30/04/2015	30/04/2015			MY	WL	2	N	GA CYSTOSCOPY & BOTOX (INPATIENT) - TCI DAY BEFORE	M45.9	GA CYSTOSCOPY & BOTOX (INPATIENT) - TCI DAY BEFORE pre-op to be notified of date ASAP		PER MR O'DONOGHUE AT CMYUDS 30.04.15	4
01/05/2015	01/05/2015	02/06/2015		MY	WL	2	N	TURP	M65.3	TURP FIT 6.5.15 KK	1 WEST ELECTIVE ADMISSION WARD	PD - PER MR YOUNG AT CLINIC 01.05.15	4
01/05/2015	01/05/2015			MDH	WL	4	D	INSERTION RIGHT TESTICULAR PROSTHESIS	N10.1	INSERTION RIGHT TESTICULAR PROSTHESIS END JUNE/START JULY 2015		PER MR HAYNES	4
01/05/2015	01/05/2015			AOB	WL	2	D	INTRAMURAL INJECTION OF 400 UNITS OF BOTULINUM TOXIN	M43.4	INTRAMURAL INJECTION OF 400 UNITS OF BOTULINUM TOXIN FIT 15.5.15 KK			4
01/05/2015	01/05/2015			AOB	WL	2	D	HYDROSTATIC DILATATION OF BLADDER	M43.2	HYDROSTATIC DILATATION OF BLADDER			4
01/05/2015	01/05/2015			AOB	WL	4	N	CYSTOSCOPY ?TURP	M45.9	CYSTOSCOPY ?TURP			4
01/05/2015	01/05/2015			AOB	WL	4	N	DIVISION OF ADHESIONS ?CIRCUMCISION	N30.2	DIVISION OF ADHESIONS ?CIRCUMCISION			4
11/12/2014	03/02/2015			JOD	WL	4	D	VASECTOMY	N17.1	VASECTOMY		PER MR O'DONOGHUE CLINIC LETTER	4
01/05/2015	01/05/2015			MDH	WL	4	D	CIRCUMCISION	N30.3	CIRCUMCISION		PER MR HAYNES & PT	4
01/05/2015	01/05/2015			JOD	WL	2	N	RIGHT FLEXIBLE URETERSCOPY AND REMOVAL OF STENT	M30.9	RIGTH FLEXIBLE URETEROSCOPY AND REMOVAL OF STENT LASER TO STONES		AS PER CONSULTANT	4
01/05/2015	01/05/2015			MDH	WL	4	D	FLEXIBLE CYSTOSCOPY & BOTOX TO BLADDER	M45.9	FLEXIBLE CYSTOSCOPY & BOTOX TO BLADDER		PER MR HAYNES & PT	4
01/05/2015	01/05/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PLA CESWL 010515 WL PER MR YOUNG	4
01/05/2015	01/05/2015			MY	WL	4	D	RIGHT ESWL	M14.1	RIGHT ESWL		PLA CESWL 010515 WL PER MR YOUNG	4

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

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01/05/2015	01/05/2015			MY	WL	2	D	MEATAL DILATATION (AS INPATIENT PER MR YOUNG)	M81.4	MEATAL DILATATION (AS INPATIENT PER MR YOUNG)		PD - PER MR YOUNG AT CLINIC 01.05.15	4
01/05/2015	01/05/2015			MY	WL	2	D	JUNE/JULY 15 FLEXIBLE CYSTOSCOPY & LAVAGE UNDER LA	M45.9	JUNE/JULY 15 FLEXIBLE CYSTOSCOPY & LAVAGE UNDER LA STH PR MRY		PD - PER MR YOUNG AT CLINIC 01.05.15	4
01/05/2015	01/05/2015	17/06/2015		MDH	WL	4	D	VASECTOMY LA	N17.1	VASECTOMY LA	DAY SURGERY UNIT	PER PT & MDH	4
01/05/2015	01/05/2015	29/05/2015		MY	WL	2	D	FLEXIBLE CYSTOSCOPY (TO EXCLUDE STRICTURE)	M45.9	FLEXIBLE CYSTOSCOPY (TO EXCLUDE STRICTURE)	DAY SURGERY UNIT	PD - PER MR YOUNG AT CLINIC 01.05.15	4
01/05/2015	01/05/2015			MY	WL	4	D	PREPULOPLASTY/CIRCUMCISION & CYSTOSCOPY TAB DIABETIC	N30.1	PREPULOPLASTY/CIRCUMCISION & CYSTOSCOPY TAB DIABETIC		PD - PER MR YOUNG AT CLINIC 01.05.15	4
01/05/2015	01/05/2015			MY	WL	2	D	CYSTOSCOPY & URETHRAL DILATATION	M45.9	CYSTOSCOPY & URETHRAL DILATATION		PD - PER MR YOUNG AT CLINIC 01.05.15	4
18/03/2015	01/05/2015			MDH	WL	4	D	CIRCUMCISION GA diabetic	N30.3	CIRCUMCISION GA diabetic		PER RACHAEL	4
01/05/2015	01/05/2015			AOB	SA	2	N	TURBT - AUGUST 2015	M42.1	TURBT - AUGUST 2015			4
01/05/2015	01/05/2015			AOB	WL	4	D	INTRAMURAL INJ OF 500U BOTULINUM TOXIN & URETHRAL DILATATION	M43.4	INTRAMURAL INJ OF 500U BOTULINUM TOXIN & URETHRAL DILATATION			4
01/05/2015	01/05/2015			AOB	WL	2	N	TURP	M65.3	TURP			4
03/05/2015	03/05/2015			AJG	WL	2	N	LEFT URETEROSCOPY AND LASER AND REMOVAL OF STENT	M30.9	LEFT URETEROSCOPY ADN LASER ADN REMOVAL OF STENT		PER READMISSION BOOK ?JOD	3
03/05/2015	03/05/2015	19/06/2015		MY	WL	2	D	LEFT ESWL AJG PATIENT	M14.1	LEFT ESWL AJG PATIENT	STONE TREATMENT CENTRE	PER KS LETTER FROM AJG	3
05/05/2015	05/05/2015	29/05/2015		AJG	SA	2	N	RIGHT LAPAROSCOPIC NEPHRECTOMY	M02.5	RIGHT LAPAROSCOPIC NEPHRECTOMY FIT 11.5.15 KK	1 WEST ELECTIVE ADMISSION WARD		3
05/05/2015	05/05/2015			MDH	WL	4	D	CIRCUMCISION GA	N30.3	CIRCUMCISION GA		PER MR HAYNES & PT	3
05/05/2015	05/05/2015	31/05/2015		MDH	SA	2	N	RED FLAG TURP/BN & BILATERAL STENTS (DOUBLE)	M65.3	RED FLAG TURP/BN & BILATERAL STENTS (DOUBLE) FIT(13.05.15)CD/FMCC	3 SOUTH ELECTIVE WARD	PER MR HAYNES	3
08/04/2015	05/05/2015	30/06/2015		MY	WL	2	D	URETHRAL BIOPSY (LETTER IN B/F)	M81.1	URETHRAL BIOPSY (LETTER IN B/F) CANC 19.05.15 - HAS FINAL UNI EXAMS	1 WEST ELECTIVE ADMISSION WARD	PER MR YOUNG AT HPC 08.04.15	3
05/05/2015	05/05/2015	03/06/2015		JOD	WL	2	N	2-3/52 FLEXIBLE URETEROSCOPY LASER WITH STENT REMOVAL	M30.9	2-3/52 FLEXIBLE URETEROSCOPY LASER WITH STENT REMOVAL	1 WEST ELECTIVE ADMISSION WARD	PER DISCHARGE	3
05/05/2015	05/05/2015			MDH	WL	4	D	CIRCUMCISION GA	N30.3	CIRCUMCISION GA		PER PT & MDH	3
05/05/2015	05/05/2015			MDH	WL	4	D	VASECTOMY LA	N17.1	VASECTOMY LA		PER PT & MDH	3
05/05/2015	05/05/2015			AJG	WL	2	D	FLEXIBLE CYSTOSCOPY WITHIN 6-8 WEEKS AT MOST PER AJG	M45.9	FLEXIBLE CYSTOSCOPY WITHIN 6-8 WEEKS AT MOST PER AJG		per ajg	3
05/05/2015	05/05/2015			MDH	WL	4	D	FLEXIBLE CYSTOSCOPY & BOTOX INJECTION TO BLADDER	M45.9	FLEXIBLE CYSTOSCOPY & BOTOX INJECTION TO BLADDER		PER MR HAYNES	3
05/05/2015	05/05/2015			AJG	WL	2	N	LEFT URETEROSCOPY AND LASER LITHOTRIPSY	M30.9	LEFT URETEROSCOPY AND LASER LITHOTRIPSY		PER CLINIC	3
05/05/2015	05/05/2015			MY	WL	4	D	LEFT ESWL (MDH) - LTR TO STC 08.05.15	M14.1	LEFT ESWL (MDH)		PER MR HAYNES	3
05/05/2015	05/05/2015			KS	WL	2	N	RE-DO TURP	M65.3	RE-DO TURP		PER KS CLINIC	3
05/05/2015	05/05/2015			KS	WL	4	D	CIRCUMCISION UNDER LA	N30.3	CIRCUMCISION UNDER LA		PER KS CLINIC	3
05/05/2015	05/05/2015			AOB	WL	4	D	FLEXIBLE CYSTOSCOPY AND CHANGE OF SUPRAPUBIC CATHETER	M45.9	FLEXIBLE CYSTOSCOPY AND CHANGE OF SUPRAPUBIC CATHETER			3
05/05/2015	05/05/2015			AOB	WL	4	N	TURP	M65.3	TURP			3
06/05/2015	06/05/2015	15/06/2015		MY	WL	2	D	RIGHT ESWL (LETTER POSTED TO STC)	M14.1	RIGHT ESWL (LETTER POSTED TO STC)	STONE TREATMENT CENTRE	RE: REFERRAL MR DUGGAN, DOWNE HOSPITAL	3
06/05/2015	06/05/2015	03/06/2015		MDH	WL	2	D	GA CYSTOSCOPY JUNE 2015	M45.8	GA CYSTOSCOPY JUNE 2015	DAY SURGERY UNIT	PER MR HAYNES	3
06/05/2015	06/05/2015	01/06/2015		MDH	SA	2	N	RF CYSTOSCOPY, RETROGRADE & URETEROSCOPY JUNE 2015	M45.8	RF CYSTOSCOPY, RETROGRADE & URETEROSCOPY JUNE 2015 FIT 18.5.15 NIDDM TAB	1 WEST ELECTIVE ADMISSION WARD	PER MR HAYNES	3
06/05/2015	06/05/2015			MY	WL	4	D	LEFT ESWL MR HAYNES PATIENT	M14.1	LEFT ESWL MR HAYNES PATIENT		PER STC 06.05.15	3
06/05/2015	06/05/2015			KS	WL	2	N	PCNL MR YOUNG TO ASSIST	M09.9	PCNL MR YOUNG TO ASSIST		PER KS CLINIC	3
07/05/2015	07/05/2015			AJG	WL	4	D	LEFT FLEXIBLE URETEROSCOPY AND LASER	M30.9	LEFT FLEXIBLE URETEROSCOPY AND LASER		per green proforma	3
07/05/2015	07/05/2015			AJG	WL	2	D	REMOVAL OF RETROGRADE STENT 2/52	M29.8	REMOVAL OF RETROGRADE STENT 2/52		PER REAMISSION SJ	3
07/05/2015	07/05/2015			JOD	WL	4	N	FLEXIBLE URETEROSCOPY	M30.9	FLEXIBLE URETEROSCOPY		PER DR HUTTON	3
07/05/2015	07/05/2015			JOD	WL	2	N	LEFT HYDROCELE REPAIR	N11.9	LEFT HYDROCELE REPAIR BOOK AFTER 120615		AS PER WARD	3
07/05/2015	07/05/2015			JOD	WL	2	D	CIRCUMCISION URGENT INPATIENT	N30.3	CIRCUMCISION URGENT INPATIENT		PER JOD CLINIC	3
07/05/2015	07/05/2015			JOD	SA	2	N	RF LEFT URETEROSCOPY & LEFT RETROGRADE +/- STENT & BIOPSY	M30.1	RF LEFT URETEROSCOPY & LEFT RETROGRADE +/- STENT & BIOPSY		PER OUTCOME SHEET JOD	3
07/05/2015	07/05/2015			JOD	WL	4	D	CYSTOSCOPY & URETHRAL DILATATION	M45.8	CYSTOSCOPY & URETHRAL DILATATION		PER OUTCOME SHEET JOD	3
07/05/2015	07/05/2015			JOD	WL	2	N	CIRCUMCISION & HYDROCELE REPAIR USS TESTES BEFORE	N30.3	CIRCUMCISION & HYDROCELE REPAIR USS TESTES BEFORE		PER OUTCOME SHEET JOD	3
07/05/2015	07/05/2015			JOD	WL	2	D	FLEXIBLE CYSTOSCOPY NEXT AVAIL APPT	M45.9	FLEXIBLE CYSTOSCOPY NEXT AVAIL APPT		PER CLINIC OUTCOMES	3
07/05/2015	07/05/2015			JOD	WL	2	N	TURP WARFARIN - NEEDS CLEXANE COVER ASPIRIN DIABETIC	M65.1	TURP WARFARIN - NEEDS CLEXANE COVER ASPIRIN DIABETIC		PER CLINIC OUTCOME	3
05/01/2015	07/05/2015	11/06/2015		MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL	STONE TREATMENT CENTRE	PER STC 05.01.15	3
29/12/2014	08/05/2015	11/06/2015		MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL	STONE TREATMENT CENTRE	PER STC CLINIC 29.12.14	3
09/05/2015	09/05/2015			JOD	WL	2	N	LEFT URETEROSCOPY	M30.9	LEFT URETEROSCOPY STENT IN SITU		PER DISCHARGE	3
11/05/2015	11/05/2015			MY	WL	2	N	LEFT FLEXIBLE URETEROSCOPY PLAVIX/DIET CONT DIABETIC	M30.9	LEFT FLEXIBLE URETEROSCOPY PLAVIX/DIET CONT DIABETIC		PER MR YOUNG 11.06.15	2
21/04/2015	11/05/2015	01/06/2015		MDH	SA	2	D	RED FLAG TARGETED TRUS BIOPSIES PROSTATE	M70.2	RED FLAG TARGETED TRUS BIOPSIES PROSTATE FIT 29.4.15 KK	1 WEST ELECTIVE ADMISSION WARD	PER MR HAYNES	2
08/04/2015	11/05/2015			MDH	WL	4	D	VASECTOMY LA	N17.1	VASECTOMY LA		PER MR HAYNES	2
11/05/2015	11/05/2015			MY	WL	2	D	ESWL MR SURESH STC PATIENT	M14.1	ESWL MR SURESH STC PATIENT		PER KS STC CLINIC	2
11/05/2015	11/05/2015			MY	WL	2	D	RIGHT ESWL MR SURESH STC PATIENT OBESITY 105KILOS	M14.1	RIGHT ESWL MR SURESH STC PATIENT OBESITY 105KILOS		PER KS STC CLINIC	2
11/05/2015	11/05/2015			KS	WL	4	D	FLEXIBLE CYSTOSCOPY +/- URETHRAL DILATATION	M45.9	FLEXIBLE CYSTOSCOPY +/- URETHRAL DILATATION		PER KS STC CLINIC	2
07/01/2015	11/05/2015			MY	WL	4	D	ESWL - ON HOLS 10=24 JULY 15 - WISHES 9AM APT IF POSSIBLE	M14.1	ESWL HAVING PROBS WITH POST		PER STC 07.01.15 (MR YOUNG)	2
11/05/2015	11/05/2015	12/06/2015		AJG	SA	2	D	RF FLEXIBLE CYSTOSCOPY	M45.9	RF FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT	PER CLINIC	2
11/05/2015	11/05/2015	23/06/2015		AJG	SA	2	D	RIGID CYSTOSCOPY RF	M45.9	RF RIGID CYSTOSCOPY	STH DAY PROCEDURE UNIT	PER CLINIC	2
11/05/2015	11/05/2015	02/06/2015		JOD	SA	2	N	RF CYSTOSCOPY, TURBT, LEFT URETEROSCOPY & JJ STENT	M45.8	RF CYSTOSCOPY, TURBT, LEFT URETEROSCOPY & JJ STENT FIT 20.5.15 KK	1 WEST ELECTIVE ADMISSION WARD	PER OUTCOME SHEET JOD	2
11/05/2015	11/05/2015			JOD	WL	4	N	CYSTOSCOPY & URETHRAL DILATATION	M45.8	CYSTOSCOPY & URETHRAL DILATATION		PER OUTCOME SHEET JOD	2
11/05/2015	11/05/2015			KS	WL	2	D	CIRCUMCISION	N30.3	CIRCUMCISION GA		per ajg	2
11/05/2015	11/05/2015			AOB	WL	2	N	LEFT ORCHIDOPEXY	N09.3	LEFT ORCHIDOPEXY			2
12/05/2015	12/05/2015			MY	WL	2	D	LEFT ESWL	M14.1	LEFT ESWL		PD - PER MR YOUNG RE: RESULTS 12.05.15	2
24/03/2015	12/05/2015			MY	WL	2	D	ESWL PAEDIATRIC LIST	M14.1	ESWL PAEDIATRIC LIST		PER MR YOUNG	2

Personal Information redacted by the USI															
	12/05/2015	12/05/2015			MDH	SA	2	N	RFRIGHT INGUINAL LYMPHADENECTOMY & BIL PELVIC LYMPHADENECTOM	Z61.6	RFRIGHT INGUINAL LYMPHADENECTOMY & BIL PELVIC LYMPHADENECTOM FIT 18.5.15 ON RASAGILINE		PER MR HAYNES	2
	12/05/2015	12/05/2015			KS	WL	4	N	BNI/TURP	M66.2	BNI/TURP		PER KS CLINIC	2
	12/05/2015	12/05/2015	12/06/2015		KS	SA	2	D	RF TURBT + INTRAVESICAL MMC BMI 40.7 BARIATRIC TABLE	M42.1	RF TURBT + INTRAVESICAL MMC BMI 40.7 BARIATRIC TABLE B6D 140515 HOLD(12.05.15)CD ACE INHIBITORS	1 WEST ELECTIVE ADMISSION WARD	PER KS CLINIC	2
	12/05/2015	12/05/2015			AJG	WL	4	D	DYSPORT 500 UNITS - CYSTOSCOPY	M45.9	DYSPORT 500 UNITS - CYSTOSCOPY		PER GREEN PROFORMA	2
	05/03/2015	12/05/2015			MY	WL	2	N	TURP END OF JULY/BEGINNING OF AUGUST res rec'd gp 050515	M65.3	TURP END OF JULY/BEGINNING OF AUGUST IF PSA IS HIGH BRING DATE FORWARD		PER MR YOUNG CLINIC	2
	12/05/2015	12/05/2015	27/05/2015		AOB	SA	2	N	TURBT	M42.1	TURBT FIT 20.5.15 KK (ORAL PREDNISOLONE)	1 WEST ELECTIVE ADMISSION WARD		2
	12/05/2015	12/05/2015			AOB	WL	4	N	TURP	M65.3	TURP			2
	15/01/2015	12/05/2015			JOD	WL	2	N	LEFT FLEXIBLE URETEROSCOPY AND LASER	M30.9	LEFT FLEXIBLE URETEROSCOPY AND LASER		AS PER CON	2
	13/05/2015	13/05/2015	12/06/2015		AJG	WL	2	N	TURBT	M42.1	TURBT	1 WEST ELECTIVE ADMISSION WARD	PER CLINIC	2
	13/05/2015	13/05/2015			MY	WL	4	D	CIRCUMCISION - CAN COME AT SHORT NOTICE LTR IN B/F	N30.3	CIRCUMCISION - CAN COME AT SHORT NOTICE LTR IN B/F		PD - PER MR YOUNG AT HPC 13.05.15	2
	13/05/2015	13/05/2015			MY	WL	4	D	RIGHT ESWL MR HAYNES PATIENT	M14.1	RIGHT ESWL MR HAYNES PATIENT		PER STC 13.05.15	2
	14/05/2015	14/05/2015			MY	WL	2	D	RED FLAG FLEXIBLE CYSTOSCOPY (AFTER CTU)	M45.9	RED FLAG FLEXIBLE CYSTOSCOPY (AFTER CTU)		PD - PER MR YOUNG AT CLINIC 14.05.15	2
	14/05/2015	14/05/2015	09/06/2015		JOD	SA	2	N	RED FLAG TURBT	M42.1	RED FLAG TURBT	1 WEST ELECTIVE ADMISSION WARD	PER CLINIC 140515	2
	14/05/2015	14/05/2015	24/06/2015		JOD	SA	2	D	RED FLAG FLEXIBLE CYSTOSCOPY	M45.9	RED FLAG FLEXIBLE CYSTOSCOPY QUIERY UTI GIVEN ANTIBIOTICS	DAY SURGERY UNIT	PER CLINIC 140515	2
	14/05/2015	14/05/2015			JOD	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER CLINIC 140515	2
	14/05/2015	14/05/2015	09/06/2015		JOD	SA	2	N	RED FLAG TURBT	M42.1	RED FLAG TURBT HOLD(14.05.15)CD NIDDM DIET ASTHMA MEDS B6D 26/5/15	1 WEST ELECTIVE ADMISSION WARD	PER JENNY 140515	2
	14/05/2015	14/05/2015			MY	WL	2	N	RED FLAG TURBT	M42.1	RED FLAG TURBT FIT 22.5.15 ON IRBESARTAN `		PD - PER JENNY AT CLINIC 14.05.15	2
	14/05/2015	14/05/2015	26/05/2015		AOB	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY	DAY SURGERY UNIT		2
	14/05/2015	14/05/2015			AOB	WL	2	N	TURP AND REMOVAL OF CATHETER	M65.3	TURP AND REMOVAL OF CATHETER			2
	14/05/2015	14/05/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC 14.05.15	2
	14/05/2015	14/05/2015			MY	WL	4	D	PREFERS END SUMMER/BEG SEPT 15 ESWL	M14.1	PRFERS END SUMMER/BEG SEPT 15 ESWL		PER STC 14.05.15	2
	14/05/2015	14/05/2015			MY	WL	4	N	VASECTOMY REVERSAL	N18.1	VASECTOMY REVERSAL		PD - PER MR YOUNG AT CLINIC 14.05.15	2
	15/05/2015	15/05/2015			MY	WL	4	D	ESWL LETTER POSTED TO STC	M14.1	ESWL LETTER POSTED TO STC		RE: REFERRAL MR MCKNIGHT, ULSTER HOSPITAL	2
	15/05/2015	15/05/2015			MY	WL	2	D	RIGHT ESWL LETTER POSTED TO STC	M14.1	RIGHT ESWL LETTER POSTED TO STC		RE: REFERRAL MR SCHATTKA, ALTNAGELVIN	2
	15/05/2015	15/05/2015			KS	WL	4	D	RIGHT FLEXIBLE URETEROSCOPY	M30.9	RIGHT FLEXIBLE URETEROSCOPY		PER STC CLINIC 15.05.15	2
	15/05/2015	15/05/2015			MY	WL	2	N	END JULY 15 TUR HUNNER'S ULCERS	M42.1	END JULY 15 TUR HUNNERS ULCERS		PD - PER MR YOUNG AT CLINIC 15.05.15	2
	15/05/2015	15/05/2015			MY	WL	4	D	LEFT ESWL BLOODS ON ARRIVAL	M14.1	LEFT ESWL BLOODS ON ARRIVAL		PER STC CLINIC 15.05.15	2
	15/05/2015	15/05/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC CLINIC 15.05.15	2
	15/05/2015	15/05/2015			MY	WL	4	D	RIGHT ESWL WARFARIN (TO STOP 1/52 B4-NO CLEXANE REQ'D)	M14.1	RIGHT ESWL WARFARIN (TO STOP 1/52 B4-NO CLEXANE REQ'D)		PER STC CLINIC 15.05.15	2
	15/05/2015	15/05/2015			MY	WL	4	D	RIGHT ESWL MR SURESH PT	M14.1	RIGHT ESWL MR SURESH PT		PER STC CLINIC 15.05.15	2
	15/05/2015	15/05/2015			MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL		PER STC CLINIC 15.05.15	2
	18/05/2015	18/05/2015			MY	WL	4	D	FLEXIBLE URETHRO CYSTOSCOPY	M17.9	FLEXIBLE URETHRO CYSTOSCOPY		PD - PER MR YOUNG AT CLINIC 18.05.15	1
	18/05/2015	18/05/2015			MY	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PD - PER MR YOUNG AT CLINIC 18.05.15	1
	29/10/2014	13/04/2015		01/08/2015	JOD	WL	2	D	GA CYSTOSCOPY	M45.9	GA CYSTOSCOPY FIT 19.3.15 KK			1
	18/05/2015	18/05/2015	02/06/2015		JOD	SA	2	D	RED FLAG CYSTOSCOPY AND BIOPSIES	M45.1	RED FLAG CYSTOSCOPY AND BIOPSIES LATEX ALLERGY NIDDM DIET HOLD(18.05.15)CD	1 WEST ELECTIVE ADMISSION WARD	PER JOD 180515	1
	18/05/2015	18/05/2015	12/06/2015		AJG	SA	2	N	CYSTOSCOPY +/- TURBT	M45.9	CYSTOSCOPY +/- TURBT	1 WEST ELECTIVE ADMISSION WARD	per clinic	1
	18/05/2015	18/05/2015	10/06/2015		JOD	SA	2	D	RED FLAG CYSTOSCOPY AND BLADDER BIOPSY	M45.1	RED FLAG CYSTOSCOPY AND BLADDER BIOPSY HOLD(18.05.15)CD ACE INHIBITORS	1 WEST ELECTIVE ADMISSION WARD	PER JOD 180515	1
	18/05/2015	18/05/2015	23/06/2015		AJG	WL	4	D	REVISION CIRCUMCISION	N30.3	REVISION CURCUMCISION	STH DAY PROCEDURE UNIT	PER CLINIC OUTCOME	1
	18/05/2015	18/05/2015			AJG	WL	2	N	RIGHT URETEROSCOPY +/- LASER LITHOTRIPSY	M30.9	RIGHT URETEROSCOPY +/- LASER LITHOTRIPSY NEEDS MAG 3 FIRST		PER CLINIC CAJGTDU	1
	18/05/2015	18/05/2015			AJG	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY AWAY 22 MAY-22JUNE		PER CLINIC OUTCOME	1
	18/05/2015	18/05/2015			MY	WL	4	D	ESWL MR GLACKIN PATIENT	M14.1	ESWL MR GLACKIN PATIENT		PER STC 18.05.15	1
	18/05/2015	18/05/2015	29/05/2015		AJG	SA	2	N	TURBT	M42.1	TURBT HOLD(18.05.15)CD NIDDM TAB ANGIOTENSION 11 RECEPTOR ANTAGONI	1 WEST ELECTIVE ADMISSION WARD	per clinic	1
	18/05/2015	18/05/2015	12/06/2015		AJG	SA	2	N	TURBT	M42.1	TURBT FIT 20.5.15 KK	1 WEST ELECTIVE ADMISSION WARD	PER CLINIC	1
	25/09/2014	09/03/2015		01/06/2015	MY	WL	4	D	LEFT ESWL	M14.1	LEFT ESWL PT CANC 20.01.15 (AWAY AT THAT TIME) WISHES SFA		PD - PER STC 25.09.14	1
	18/05/2015	18/05/2015	18/06/2015		JOD	WL	2	D	06/15 FLEXIBLE CYSTOSCOPY	M45.9	06/15 FLEXIBLE CYSTOSCOPY 2-3 WEEKS PER JOD 180515	THORNDALE UNIT	PER JOD 180515	1
	18/05/2015	18/05/2015			JOD	WL	2	N	INSERTION OF SUPRAPUBIC CATHETER	M49.8	INSERTION OF SUPRAPUBIC CATHETER		PER JOD 180515	1
	18/05/2015	18/05/2015			JOD	WL	4	N	TURP	M65.3	TURP		PER JOD 180515	1
	18/05/2015	18/05/2015			JOD	SA	2	N	RED FLAG BIOPSY OF RIGHT TESTICLE	N13.4	RED FLAG BIOPSY OF RIGHT TESTICLE		PER JOD 180515	1
	18/05/2015	18/05/2015			MY	WL	2	D	RIGHT ESWL POLISH INTERPRETER LEARNING DIFFICULTIES	M14.1	RIGHT ESWL POLIST INTERPRETER LEARNING DIFFICULTIES		PER KS STC CLINIC	1
	19/05/2015	19/05/2015			MY	WL	2	N	LEFT PCNL NEEDS PRE-OP NEPH TUBE	M09.9	LEFT PCNL NEEDS PRE-OP NEPH TUBE		PD - PER MR YOUNG IN THEATRE 19.05.15	1
	19/05/2015	19/05/2015	08/06/2015		MDH	SA	2	N	RED FLAG LAPAROSCOPIC LEFT NEPHRECTOMY	M02.5	RED FLAG LAPAROSCOPIC LEFT NEPHRECTOMY HOLD(19.05.15)CD DRUGS FOR OPIOID DEPENDENCE B6D 26/5/15	1 WEST ELECTIVE ADMISSION WARD	PER MR HAYNES	1
	29/12/2014	19/05/2015			MY	WL	2	D	RED FLAG URETHRAL DILATATION +/- OPTICAL URETHROTOMY & C/U	M76.4	RED FLAG URETHRAL DILATATION +/- OPTICAL URETHROTOMY & C/U FIT 30.1.15 KK		PD - PER KAREN AT CLINIC 29.12.14	1
	19/05/2015	19/05/2015			AJG	SA	2	D	FLEXIBLE CYSTOSCOPY	M45.9	RF FLEXIBLE CYSTOSCOPY		per cancer letter	1
	19/05/2015	19/05/2015	08/06/2015		MDH	WL	2	D	REVISION CIRCUMCISION	N30.3	REVISION CIRCUMCISION	1 WEST ELECTIVE ADMISSION WARD	PER MR HAYNES	1
	19/05/2015	19/05/2015	08/06/2015		MDH	SA	2	D	RED FLAG SATURATION PROSTATE BIOPSY	M70.3	RED FLAG SATURATION PROSTATE BIOPSY	1 WEST ELECTIVE ADMISSION WARD	PER MR HAYNES	1
	19/05/2015	19/05/2015			MY	WL	2	N	PAEDS RIGHT ESWL Personal - NEEDS PRE-OP ASSESSMENT	M14.1	PAEDS RIGHT ESWL Personal NEEDS PRE-OP ASSESSMENT LTR POSTED TO STC - PEG TUBE/VP SHUNT		PER MR YOUNG RE: REFERRAL MR BAILIE, RBHSC	1

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

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19/05/2015	19/05/2015			MY	WL	2	D	PAEDS LIST LEFT ESWL - LTR POSTED TO STC	M14.1	PAEDS LIST LEFT ESWL - LTR POSTED TO STC		PER MR YOUNG RE: REFERRAL MR BAILIE RBHSC	1
29/08/2014	19/05/2015			MY	WL	4	D	ESWL (LETTER WITH STC)	M14.1	ESWL (LETTER WITH STC) UTA 29.12.14 - HAS ANOTHER APT SAME DAY - WISHES SFA		RE: REFERRAL MR MORAN, LETTERKENNY 29.08.14	1
19/05/2015	19/05/2015			MDH	SA	2	N	RED FLAG TURBT	M42.1	RED FLAG TURBT TCI DAY B4 RE: ANTIBODIES & BLOOD BANK B6D 210515		PER FLEXI	1
05/05/2015	20/05/2015			MDH	WL	4	D	VASECTOMY LA	N17.1	VASECTOMY LA		PER MR HAYNES & PT	1
20/05/2015	20/05/2015			MY	WL	4	D	ESWL	M14.1	ESWL		PER STC 20.05.15	1
20/05/2015	20/05/2015			MY	WL	4	D	ESWL MR SURESH PATIENT	M14.1	ESWL MR SURESH PATIENT		PER STC 20.05.15	1
20/05/2015	20/05/2015			MDH	WL	2	D	FLEXIBLE CYSTOSCOPY JENNY TO DO AFTER CT	M45.9	FLEXIBLE CYSTOSCOPY JENNY TO DO AFTER CT JENNY TO DO PREFERS A LADY		PER MR HAYNES	1
20/05/2015	20/05/2015			AOB	WL	2	N	CYSTOSCOPY & INTRAMURAL INJECTION 1000 UNITS BOTULINUM TOXIN	M45.9	CYSTOSCOPY & INTRAMURAL INJECTION 1000 UNITS BOTULINUM TOXIN			1
15/09/2014	20/05/2015			MDH	WL	4	D	VASECTOMY LA	N17.1	VASECTOMY LA		PER MR HAYNES	1
20/05/2015	20/05/2015			MDH	WL	2	N	TURP	M65.3	TURP		PER MR HAYNES	1
20/05/2015	20/05/2015			AJG	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER CLINIC OUTCOME	1
20/05/2015	20/05/2015			KS	WL	2	N	LEFT URETEROSCOPY, LASER ABLATION & STENTING	M30.9	LEFT URETEROSCOPY, LASER ABLATION & STENTING		PER KS CLINIC	1
21/05/2015	21/05/2015			MDH	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER MR HAYNES	1
21/05/2015	21/05/2015			AOB	WL	2	N	REMOVAL OF STENT AND LEFT URETEROSCOPIC LITHOTRIPSY	M29.3	REMOVAL OF STENT AND LEFT URETEROSCOPIC LITHOTRIPSY			1
21/05/2015	21/05/2015			AOB	WL	2	D	FLEXIBLE CYSTOSCOPY AND REMOVAL OF STENT	M45.9	FLEXIBLE CYSTOSCOPY AND REMOVAL OF STENT			1
13/04/2015	21/05/2015			MY	WL	2	D	ESWL PLAVIX MR SURESH PATIENT (WISHES END AUG 15)	M14.1	ESWL PLAVIX MR SURESH PATIENT DAUGHTER PHON 21.05.15 - UTA 01.06.15 WISHES SFA		PER KS CLINIC	1
21/05/2015	21/05/2015			MDH	SA	2	N	RF CYSTOSCOPY, BLADDER BIOPSIES, BIL RETROGRADE & URS	M45.8	RF CYSTOSCOPY, BLADDER BIOPSIES, BIL RETROGRADE & URS		PER MR HAYNES	1
22/05/2015	22/05/2015			MY	WL	2	D	RIGHT ESWL LTR POSTED TO STC	M14.1	RIGHT ESWL LTR POSTED TO STC		PER MR YOUNG RE: REFERRAL MR MCKNIGHT, UIC	1
26/02/2015	22/05/2015			KS	WL	4	D	VASECTOMY UNDER LA	N17.1	VASECTOMY UNDER LA		PER KAREN	1
22/05/2015	22/05/2015			MY	WL	4	D	CYSTOSCOPY	M45.9	CYSTOSCOPY		PD - PER MR YOUNG AT CLINIC 22.05.15	1
21/10/2014	22/05/2015			JOD	WL	4	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		FLEXIBLE CYSTOSCOPY	1
19/02/2015	26/05/2015			MY	WL	4	D	ESWL (LETTER POSTED TO STC)	M14.1	ESWL (LETTER POSTED TO STC) UTA 18.06.15 ON HOLS X 10 DAYS WISHES SFA		RE: REFERRAL MR SCHATTKA, ALTNAGELVIN	0
26/05/2015	26/05/2015			MDH	WL	2	N	LAPAROSCOPIC PARTIAL NEPHRECTOMY	M02.5	LAPAROSCOPIC PARTIAL NEPHRECTOMY		PER MR HAYNES	0
26/05/2015	26/05/2015			MY	WL	2	N	JULY 2015 BLADDER NECK INCISION	M66.2	JULY 2015 BLADDER NECK INCISION		PER MR YOUNG	0
27/04/2015	26/05/2015			MY	WL	2	D	LEFT ESWL (LETTER POSTED TO STC)	M14.1	LEFT ESWL (LETTER POSTED TO STC) UTA 15.06.15 AS ONLY BACK FROM HOLS THAT DAY - WISHES SFA		RE: REFERRAL MR MACLEOD, ALTNAGELVIN	0
10/12/2014	02/03/2015		01/06/2015	MDH	WL	4	D	CIRCUMCISION UNDER LA	N30.3	CIRCUMCISION UNDER LA		PER MDH CLINIC	0
21/12/2014	31/03/2015		01/06/2015	JOD	WL	2	N	INSERTION OF CATHETER, FLEXIBLE CYSTOSCOPY & URODYNAMICS	M45.9	INSERTION OF CATHETER, FLEXIBLE CYSTOSCOPY & URODYNAMICS (POA CK ECG ON ADMISSION)			0
19/02/2015	22/05/2015		01/07/2015	JOD	WL	2	D	FLEXIBLE CYSTOSCOPY	M45.9	FLEXIBLE CYSTOSCOPY		PER MR ODONOGHUE	0

Health and Social Care Board

Directorate of Performance Management and Service Improvement

HSC Board Headquarters
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Our Ref: LMcW102

Date: 1 June 2020

Aldrina Magwood
Director of Performance and Reform
Southern HSC Trust
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Dear Aldrina

UROLOGY FUNDING

I am aware that work is ongoing to finalise the recurrent IPT for the expansion of the SHSCT Urology service.

While this work is progressing and in recognition of the current service pressures, HSCB will provide £200k non-recurrently in 2020/21 to expand this service and allow the recruitment process to start later this year. A FYE recurrent allocation will be made available next year to allow the Trust to make permanent appointments.

May I take this opportunity to thank Trust colleagues for your cooperation in taking forward this important service development. Should you require further advice, please contact David McCormick (Personal information redacted by USI Personal information redacted by USI) in the first instance or telephone

Yours Sincerely

Personal information redacted by USI

Lisa McWilliams
Acting Director of Performance Management and Service Improvement

cc David McCormick

Business Case Template	REVENUE FUNDING £250k - £1m

REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

Name of Organisation	Southern Health and Social Care Trust, Craigavon Area Hospital
HSCB Representative	David McCormick
Project Title	Expansion of Southern Trust Urology Team (7th Consultant Urologist & staff infrastructure))
Total Cost	**£869,314 FYE, £434,657 CYE (2020/21)**
Project Start Date*	01 October 2020
Completion Date	Recurrent

Project start date is the date at which the business case is approved and the project starts to incur costs. No expenditure should be committed until all approvals are in place. You should ensure that the actual start date is entered NOT the planned start date.

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	***Y***
How much total funding required?	***£869,314 FYE***
How much funding required per year?	***£869,314 FYE, £434,657 CYE (2020/21)***
Is this funding to be made recurrent?	***Y***

Complete this section if funding available within existing allocation

Funding available within existing allocation (Y/N)	***N***
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

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

Approvals & submissions

Prepared by: Susan Devlin, Planner (Band 6) and Martina Corrigan, Head of ENT, Urology, Ophthalmology and Outpatients, Craigavon Area Hospital **Name Printed (signed)** **Date**

Approved by: Melanie McClements, Interim Director of Acute Services, Southern Health and Social Care Trust **Name printed Melanie McClements (signed)** **Grade / Title: Interim Director of Acute Services** **Date** **Insert more boxes if further approvals are required by officials** **Please tick the box below to confirm that expenditure has not been committed until the necessary approvals are in place.** √ **(To be completed by the business case approver within the provider organisation).** **If expenditure has been committed before the necessary approvals are in place, please provide explanation below.**
Trust Director of Finance Signature (required) **Name printed: Helen O'Neill (signed)** **Date**
Trust Chief Executive Signature (required) **Name printed: Shane Devlin (signed)** **Date**

Complete this section if Department / DOF approval required

Date submitted to Department **Department/ DOF approval (y/n)** **Date approved**

SECTION 1(a): Commissioner Specification to include strategic context and need (to be completed by the Commissioner).

Commissioner Statement

In 2008/09 A Regional Review of (Adult) Urology Services was undertaken by a multi-disciplinary and multi-organisational Steering Group in response to service concerns regarding the ability to manage growing demand and maintain quality standards. The regional review was followed in 2013/14 by a stock-take to assess progress to date.

Over the last 10 years there have been significant changes in the way urology services are delivered, with increased focus on e-triage, enhanced roles for specialist nurses, one stop service provision and new patient pathways. This change in clinical practice, coupled with the different levels of implementation across Trusts has resulted in significant variations in waiting times across the region.

Since the completion of the stocktake, the HSCB has met with Trusts to explore how service redesign could help address the key challenges facing the service. These challenges include:

- There are regional variations in pathways for both new outpatient assessments and treatments, including cancer;
- There are regional variations in waiting times for outpatients and surgical procedures, with significant numbers of patients waiting for core urology procedures;
- There has been a significant change in referral patterns. The total number of urology referrals have increased by 7.5% since 2015, with red flag and urgent referrals increasing by 26% and 15% respectively. This has a direct impact on the cancer waiting times and those referrals classified as routine;
- A regional capacity gap across both outpatient assessments and treatments which continues to grow as demand increases;
- Across the region there are continued challenges for the recruitment and retention of clinical staff at all levels;
- There are infrastructure constraints and in particular limited access to operating theatre sessions which has resulted in excessive waiting times for routine core urology procedures;

The following IPT aims to make the urology service more sustainable by expanding the urology workforce in the Southern Trust

The Trust is asked to submit a proposal to help reduce the current waiting times for urology assessments and treatments. The proposal must demonstrate how key elements of best practice will be introduced to improve productivity.

Background and Strategic Context (Trust)

The Southern Trust was established on 1st April 2007 following the amalgamation of Craigavon Area Hospital Group, Craigavon & Banbridge Community, Newry & Mourne and Armagh & Dungannon Health and Social Services Trusts. It is one of six organisations that provide a wide range of health and social care services in Northern Ireland. The Trust is responsible for the delivery of high quality health and social care to a resident population of approximately 380,000 and employs 13,000 staff.

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

Both acute hospitals provide a range of medical, surgical and maternity specialties including emergency departments, elective/non-elective inpatient medicine and surgery,

maternity and paediatrics. Craigavon Area Hospital is the larger of the two acute hospitals hosting much of the more complex care. A range of day, outpatient and diagnostic services are offered locally at South Tyrone and Lurgan Hospitals.

The Department of Health (DOH asked the Medical Director/Director of Public Health for the Public Health Agency/Health and Social Care Board to take forward medical workforce planning for Northern Ireland for the period until 2019. The Urology Planning and Implementation Group which was led by the Health and Social Care Board (HSCB) and Public Health Authority (PHA) and included clinicians and senior managers from all Trusts with representatives from both NIMDTA and BMA. In May 2017 the HSCB/PHA issued a Urology Medical Workforce Planning Report (NI) 2017-2024. The work included:

- The identification of a set of principles and standards for urology, based on the Royal College of Surgeons and the British Association of Urological Surgeons (BAUS) standards
- A stocktake of the urology medical workforce at all grades working in hospitals in Northern Ireland
- The determination of the medical workforce required to deliver the service in line with the agreed principles and standards
- An analysis of the impacts (where possible) of modernisation work-streams and strategic service change
- Analysis of information on trainee numbers, recent trends in recruitment of trainees, attrition rates and numbers of trainees exiting per year with CCT accreditation

The subsequent Report (dated May 2017) detailed the number of additional consultants needed to meet the population needs in 2024, a total number of .13 which includes filling both the current vacant posts and the posts vacated through retirement.

The report recommended the need to fund an additional four trainees as a first phase and then to review the need for an additional two trainees once the modernisation work has been further progressed.

Whilst the current service model has urological surgical inpatient procedures delivered in only four hospitals, there are outpatient clinics and day procedures delivered in the local hospitals across NI to provide improved access for the population. The modernisation or urology services is an important element of the work of the Urology Planning and Implementation Group, including exploring the role of the Clinical Nurse Specialist. Clinical pathways for common conditions and reviews for patients with cancer are also being agreed and implemented. While these developments are expected to have an impact on the current workload of doctors, it is not yet possible to quantify the actual impacts with certainty. It will also take several years to fully implement the role of Clinical Nurse Specialists with training and mentoring requirements. If this impact is not materialised then additional trainees may be required to meet the projected population need.

There continues to be supply and demand challenges in relation to the Consultant workforce. Whilst the Trust has made progress in a number of specialties, particular challenges continue within Emergency Medicine, General Medicine, Paediatrics and Urology.

The Southern Trust continues to work to analyse and improve recruitment and advertising strategies, with the aim of reaching a wider pool of potential medical staff across the UK and further afield, with a focus on hard-to-fill posts. The Trust continues to engage with the ongoing regional International recruitment campaigns and is keen to secure the appointment of additional Consultant Urology support as subsequently detailed in this paper.

SECTION 1(b): DEMONSTRATE THE NEED FOR THE PROJECT

Current Urology Service at SHSCT

The urology service provided at Craigavon Area Hospital encompasses the entire spectrum of urological investigation and management, with the main exceptions of radical pelvic surgery, renal transplantation and associated vascular access surgery, which are provided by the Regional Transplantation Service in Belfast. Neonatal and infant urological surgery is provided by the Regional Paediatric Surgical Service in Belfast.

Craigavon Area Hospital has been designated as a Cancer Unit, with its Urological Department being designated the Urological Cancer Unit for the Area population of 425,000 (+65,000 Fermanagh) total 490,000. A wide spectrum of urological cancer management has been provided for some time. Cancer surgery includes orthotopic bladder reconstruction in the management of bladder cancer. Cancer management also includes intravesical chemotherapy for bladder cancer. Immunotherapy for renal cell carcinoma is also performed.

The Trust has a purpose built Urology outpatient facility located in the Thorndale Unit, main outpatient department at Craigavon Area Hospital. It is run by three Clinical Nurse Specialists. Outpatient services include urodynamics, ultrasound, intra-vesical therapy, prostate biopsy and flexible cystoscopy.

Outreach outpatient clinics are currently provided in Armagh, Banbridge, South Tyrone Hospital and the South West Acute Hospital in Enniskillen. Due to the recent retirement of a General Surgeon with an interest in Urology in Daisy Hill Hospital the team are currently making arrangements to move some of the urological services to Daisy Hill Hospital in order to allow the continuation of urology at Daisy Hill Hospital.

A fixed site ESWL lithotripter with full facilities for percutaneous surgery is also accommodated in Craigavon Area Hospital and the department also has a holmium laser.

Flexible cystoscopy services are undertaken by Specialist Registrars and Clinical Nurse Specialist on the Craigavon/Daisy Hill and South Tyrone sites.

The official statistics on cancers diagnosed in Northern Ireland during 1993-2017 were published on 23/3/2019. There were 9,401 patients diagnosed with cancer each year during 2013-2017 (excluding non-melanoma skin cancer, (NMSC)). Prostate cancer was one of the most common cancers diagnosed between 2013 and 2017.

The most common cancers diagnosed for this period were:

- Prostate cancer (24% of all male cancers ex NMSC), lung cancer (14%) and bowel cancer (14%) among men.
- Breast cancer (30% of all female cancers ex NMSC), lung cancer (13%) and bowel cancer (11%) among women.

Cancer risk was strongly related to age with 62% of cases occurring in people over the age of 65 years and incidence rates greatest for those aged 85-89 years. The likelihood of developing cancer by the age of 75 was 1 in 3.5 men and 1 in 3.7 for women. Over the last ten years the number of cancers (excluding NMSC) has increased by 15% from 8,269 cases in 2008 to 9,521 in 2017. These increases are largely due to our ageing population.

The table below gives the population projections for Northern Ireland and the Southern Trust area for all ages and also for the 65 and over age group. The figures demonstrate a significant projected increase with a higher increase for the Southern Trust area than Northern Ireland as a whole, in total population numbers and also in the 65 years and older population. The older population tends to be the most reliant age group on hospital care.

Northern Ireland Population Projections[1]

[1] Northern Ireland Statistics and Research Agency (NISRA) 2014 Based Population Projections, Published 2016

	2017	2020	2023	2026	2029	2032	2035	2039	% Increase 2017- 39
All Ages									
NI	1,873,502	1,903,663	1,930,407	1,954,144	1,974,120	1,990,810	2,005,005	2,021,322	**7.9%**
SHSCT	381,731	393,503	404,753	415,559	425,826	435,623	445,149	457,686	**19.9%**
Age 65 and Over									
NI	304,302	325,025	350,448	379,629	411,899	443,646	471,014	498,528	**63.8%**
SHSCT	55,427	59,798	65,003	70,998	77,832	84,632	90,973	98,104	**77.0%**

'The British Association of Urological Surgeons (BAUS) recommends a consultant workforce ratio of 1 wte per 60,000 population' which would indicate a recommended consultant workforce of 8.00 WTE for the SHSCT (including Fermanagh population)

Current Staffing Urology:

The following staff complement supports the Urology Service:

- 6.00 WTE Consultant Surgeons
- 3.00 WTE Specialist Registrars
- 0.50 WTE Specialty Doctor (currently vacant)
- 1.50 WTE Specialty Doctor

Supported by:

- 4 Nurse Practitioners - 1 funded by Macmillan for a 3 year period, (currently in year 2) to be subsequently funded by the Trust.
- An IPT was submitted to the HSCB on 21/9/19 to seek funding for a further 2 Nurse Practitioners.

The following table details the actual Urology Activity between 2017/18 compared to 2019/20:

Year	Activity Type	SBA	Activity	% Variance	Variance
2017/2018	NOP	3591	3797	+6%	+206
	IP/DC	4198	4699	+12%	+501
2018/2019	NOP	3591	3841	+7%	+250
	IP/DC	4198	4717	+12%	+519
2019/2020 (April to July)	NOP	1197	1060	-11%	-137
	IP/DC	1399	1653	+18%	+254
2019/2020 (April to September)	NOP	1796	1685	-6%	-111
	IP/DC	2099	2501	+19%	+402

The figures show an underperformance of 111 new patients, -6% in 2019/20 to date for outpatients. At the end of June a Consultant Urologist left the Trust (to go on a one year fellowship). A Locum has been covering some opd activity however priority was given to inpatient/daycase activity which had a significant impact on outpatient activity.

Changes to the NHS pension tax regime are resulting in consultants requesting reduction in their hours, considering retiring earlier than they originally planned and/or being unable to undertake any additional clinical work. This will have a significant impact on all specialties in the future including urology.

The numbers of patients waiting for a new outpatient appointment, in particular the urgent referrals are unacceptably high as shown below:

As at the **1st August 2019** there were **4107 new patients on the Urology Outpatient waiting list**.

New Outpatients:

- 859 Urgent referrals with 14 waiting over 52 weeks and the longest wait is 87 weeks
- 3,248 referrals waiting with 2,168 of these waiting over 52 weeks (the longest wait is 184 weeks)

Daycase:

- **Total patients on the waiting list 690**
- 349 Urgent cases with the longest wait 258 weeks. 90 patients waiting over 52 weeks
- 341 Routine cases with the longest wait 274 weeks. 156 patients waiting over 52 weeks

Inpatients:

- **Total on the inpatient waiting list 959**
- 675 Urgent cases with the longest wait 259 weeks. 346 patients waiting over 52 weeks
- 284 Routine cases with the longest wait 260 weeks. 212 patients waiting over 52 weeks

The backing for this service expansion is driven by the need to support the reduction in the current waiting times for urology assessments and treatments. The figures demonstrate a clear need to secure additional consultant capacity.

Key Elements of Best Practice to enhance productivity

When the Red Flag referral is received the Consultant triages this and indicates on the letter what preparations/diagnostics etc are needed for the patients visit, e.g. bloods/ Urinalysis, flexible cystoscopy, biopsy, ultrasound, CT etc. this is then processed through the Red Flag team and the patient appointed appropriately to the next available New Outpatient clinic. The wait for the appointment is within 8-14 days (as opposed to previously over 30 days).

When the patient is invited to attend the clinic they are advised that they may have to be present for a number of hours and they may require to have a number of tests carried out during their appointment.

The whole team meet before the clinic starts to discuss and make a plan for each patient. The nursing staff greet the patient and do any bloods urinalysis etc. the patient is seen for a consultation with the Consultant/Registrar who explains what other tests they may need done and the reasons why. The Nurse at this consultation accompanies the patient to have their further tests done, e.g. Flexible Cystoscopy/TRUS Biopsy/Ultrasound. Clinical Nurse Specialists (CNS) do these tests (this Trust is the only place in N. Ireland where nurses do biopsies). The Consultant/Registrar continues seeing patients but are available for the CNS if needed whilst carrying out the procedures. Once the procedure is completed the Consultant then discusses any results and the next steps (if any) with the patient. For most patients they will get an outcome from the consultation and will either be discharged, sent for further tests, e.g. MRI scan or will be added to a waiting list for surgery. All consultants keep slots free on their theatre sessions for 'red flags', patients who are seen for the majority of the time within the 62-day target. If a patient needs to come back to discuss their tests the consultant will have protected timeslots to see the patient again avoiding delay.

The Trust has been advised by the HSCB that elective baseline funding will be recurrent to appoint an additional consultant urologist and has requested submission of this IPT which sets out associated activity/implementation plan.

SECTION 2(a): OBJECTIVES

Project Objectives	Measurable Targets
1. Increase outpatient capacity for urology referrals by April 2021	**Baseline Urology OPD:** 2019/20 - SBA Baseline 3591 As at 1st August 2019 there were **4107** new patients on the waiting list. **Target:** Increase capacity by: • 299 New Outpatients • 798 Review Outpatients **Please note to achieve a reduction in waiting times a non-recurrent exercise will be required**
2. Increase daycase capacity for urology patients by April 2021	**Baseline Urology Daycase:** 2019/20 - SBA Baseline 3142 As at 1st August 2019 there were **690** patients on the waiting list **Target:** Increase capacity by: • **140 Daycases and** • **350 Flexible Cystoscopy** **Please note to achieve a reduction in waiting times a non-recurrent exercise will be required**
3. Increase inpatient capacity for urology patients by April 2021	**Baseline Urology Inpatients:** 2019/20 – SBA Baseline 1056 As at 1st August 2019 there were 959 patients on the waiting list **Target:** Increase capacity by: • **175 Elective In-patients** **Please note to achieve a reduction in waiting times a non-recurrent exercise will be required**
4. Reduce the time patients wait for their first outpatient appointment by April 2021	**Baseline:** At the 31 July 2019 there were 2179 waiting longer than 52 weeks. The longest wait was 184 weeks. **Target:** By March 2021 50% of patients should be waiting no longer than 9 weeks for an outpatient appoint and no patient waits longer than 52 weeks. The Trust cannot commit to a reduction in first outpatient appointment with this investment but will increase capacity for new outpatients and will continue to direct capacity to red flag and urgent waits in the first instance.

SECTION 2(b): CONSTRAINTS

Constraints	Measures to address constraints
1. Availability of Funding	The Health and Social Care Board has identified a conditional allocation pending submission of a robust Investment Proposal. This IPT sets out the volumes of activity to support the appointment of 1.00 WTE Consultant Urologist and staff support to expand the Urology Team at the Southern Trust.
2. Availability of trained Consultant staff and nursing support	The Trust continues to promote local and international recruitment campaigns to encourage trained nurses to apply for positions in the Trust. There may also be applicants who would be interested in relocating from the UK.

SECTION 3: IDENTIFY AND SHORTLIST OPTIONS

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
1. Status Quo - continue with existing arrangements	**S**	
3. Appoint an Additional Consultant Urologist (see below for detail)	**S**	
4. Appoint an additional 2.00 wte Consultant Urologists (see below for detail)	**S**	

Option 1 Status Quo

There would be no additional resources appointed/or additional capacity with the Status Quo.

Option 2 Appoint an additional Consultant Urologist

Option 2 involves funding a 7th Consultant Urologist. The indicative job plan and associated activity would be as follows:

Indicative job plan:

- 1 New OP clinic per week 299 pts
- 2 Review clinics OP 798 pts
- 2 In-patient lists 175 pts
- 1 x Day Case 140 pts
- 1 x Flexible Cystoscopy session 350 pts

(All of the above elective activity/elective theatre activity and opd activity is calculated x 35 weeks due to Urology Surgeon of the Week commitments).

To deliver this activity the necessary support staff and goods and services will also be required.
Additional staff resources are detailed at Appendix A

Option 3 Appoint two additional Consultant Urologists

Option 3 involves funding a 7th and 8th Consultant Urologist. The indicative job plan and associated activity would be as follows:

- 2 New OP clinic per week = 598 pts
- Review OP 1,596 pts
- 4 In-patient lists 350 pts
- 2 x Day Case 280 pts
- 2 x Flexible Cystoscopy session 700 pts

(All of the above elective activity/elective theatre activity and opd activity is calculated x 35 weeks due to Urology Surgeon of the Week commitments).

To deliver this activity the necessary support staff and goods and services will also be required.
Additional staff resources are detailed at Appendix B

SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo	Year 0 20/21 £ 000	Year 1 21/22 £ 000	Year 2 22/23 £ 000	Year 3 23/24 £ 000	Year 4 24/25 £ 000	Year 5 25/26 £ 000	Totals £ 000
Capital Costs							
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Revenue Baseline	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	11,638.8
(b) Total Revenue Cost	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**11,638.8**
(c) Total Cost = (a) + (b)	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**11,638.8**
(d) Disc Factor @ 3.5%pa	*1.0000*	*0.9662*	*0.9335*	*0.9019*	*0.8714*	*0.8420*	
(e) NPC = (c) x (d)	**1,939.8**	**1,874.2**	**1,810.8**	**1,749.5**	**1,690.3**	**1,633.3**	**10,697.9**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2020/21 Financial Year.
2. The baseline costs for this case is the 2019/20 recurring revenue budget for the HoS Urology (CA7830) in the DAS directorate of SHSCT.
3. No other revenue or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. Please note all figures above have been rounded to thousands and shown to one decimal place.
6. Total Net Present Cost (NPC) equates to £10,697.9k for this option

Option 2: Appoint an additional Consultant Urologist (7th) & support infrastructure	**Year 0 20/21 £ 000**	**Year 1 21/22 £ 000**	**Year 2 22/23 £ 000**	**Year 3 23/24 £ 000**	**Year 4 24/25 £ 000**	**Year 5 25/26 £ 000**	**Totals £ 000**
Capital Costs							
Computers	4.9	0.0	0.0	0.0	0.0	0.0	4.9
(a) Total Capital Cost	**4.9**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**4.9**
Revenue Costs							
Revenue Baseline	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	11,638.8
Payroll	344.3	688.5	688.5	688.5	688.5	688.5	3,786.8
Unsocial allowances, On-Call and excess travel	23.2	46.4	46.4	46.4	46.4	46.4	255.2
Payroll related G&S	24.8	49.5	49.5	49.5	49.5	49.5	272.3
Additional G&S Costs	42.4	84.8	84.8	84.8	84.8	84.8	466.4
(b) Total Revenue Cost	**2,374.5**	**2,809.0**	**2,809.0**	**2,809.0**	**2,809.0**	**2,809.0**	**16,419.5**
(c) Total Cost = (a) + (b)	**2,379.4**	**2,809.0**	**2,809.0**	**2,809.0**	**2,809.0**	**2,809.0**	**16,424.4**
(d) Disc Factor @ 3.5%pa	*1.0000*	*0.9662*	*0.9335*	*0.9019*	*0.8714*	*0.8420*	
(e) NPC = (c) x (d)	**2,379.4**	**2,714.1**	**2,622.2**	**2,533.4**	**2,447.8**	**2,365.2**	**15,062.1**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2020/21 Financial Year.
2. The baseline costs for this case is the 2019/20 recurring revenue budget for the HoS Urology (CA7830) in the DAS directorate of SHSCT.
3. The cost of the staff identified in Section 3 and Appendix A is calculated as per General Costing 2019.20 DRAFT 16.09.19. This includes an allowance for employee related G&S and appropriate allowances for unsocial hours payments.
4. The medical staff costs include an allowance for excess travel and an on-call provision for their rota. This also includes the cost of 11 APA's for each 1.00 WTE.
5. A provision has been made for additional G&S for the additional activity. This based on 10% of the average 2018/19 TFR cost for each procedure adjusted by 2.6% for inflation to 2019/20 Rates.
6. The G&S cost of a Flexible Cystoscopy is assumed to be the same as a day case (£122.82).
7. This work is expected to start on 01/10/2020 so a 6 month effect is included for 2020/21.
8. Office accommodation will be required for both the Consultant and Secretary on the CAH site the provision of which should be covered in the 10% G&S .
9. A computer/laptop/home access and mobile phone will be required for the Consultant Urologist and a desktop computer for the Secretary. A further laptop will be needed by the Consultant Anaesthetist. The Capital costs identified in this case is 2 * Laptops @ £1,700 plus 1 * desktop @ £1,500.
10. A discount factor @3.5% pa has been applied to calculate the NPC.
11. Please note all figures above have been rounded to thousands and shown to one decimal place.
12. Total Net Present Cost (NPC) equates to £15,062.1 for this option.

Option 3: Appoint 2.00 WTE Consultant Urologists (7th & 8th) and support infrastructure	**Year 0 20/21 £ 000**	**Year 1 21/22 £ 000**	**Year 2 22/23 £ 000**	**Year 3 23/24 £ 000**	**Year 4 24/25 £ 000**	**Year 5 25/26 £ 000**	**Totals £ 000**
Capital Costs							
Computers	8.3	0.0	0.0	0.0	0.0	0.0	8.3
(a) Total Capital Cost	**8.3**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**8.3**
Revenue Costs							
Revenue Baseline	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	11,638.8
Payroll	688.5	1,377.1	1,377.1	1,377.1	1,377.1	1,377.1	7,574.0
Unsocial allowances, On-Call and excess travel	46.4	92.9	92.9	92.9	92.9	92.9	510.9
Payroll related G&S	49.5	99.0	99.0	99.0	99.0	99.0	544.5
Additional G&S Costs	84.8	169.6	169.6	169.6	169.6	169.6	932.8
(b) Total Revenue Cost	**2,809.0**	**3,678.4**	**3,678.4**	**3,678.4**	**3,678.4**	**3,678.4**	**21,201.0**
(c) Total Cost = (a) + (b)	**2,817.3**	**3,678.4**	**3,678.4**	**3,678.4**	**3,678.4**	**3,678.4**	**21,209.3**
(d) Disc Factor @ 3.5%pa	*1.0000*	*0.9662*	*0.9335*	*0.9019*	*0.8714*	*0.8420*	
(e) NPC = (c) x (d)	**2,817.3**	**3,554.1**	**3,433.8**	**3,317.5**	**3,205.4**	**3,097.2**	**19,425.3**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2020/21 Financial Year.
2. The baseline costs for this case is the 2019/20 recurring revenue budget for the HoS Urology (CA7830) in the DAS directorate of SHSCT.
3. The cost of the staff identified in Section 3 and Appendix B is calculated as per General Costing 2019.20 DRAFT 16.09.19. This includes an allowance for employee related G&S and appropriate allowances for unsocial hours payments.
4. The medical staff costs include an allowance for excess travel and an on-call provision for their rota. This also includes the cost of 11 APA's for each 1.00 WTE.
5. A provision has been made for additional G&S for the additional activity. This based on 10% of the average 2018/19 TFR cost for each procedure adjusted by 2.6% for inflation to 2019/20 Rates.
6. The G&S cost of a Flexible Cystoscopy is assumed to be the same as a day case (£122.82).
7. This work is expected to start on 01/10/2020 so a 6 month effect is provided in 2020/21.
8. Office accommodation will be required for both the two Consultants and their Secretary on the CAH site, the provision of which should be covered in the 10% employee related G&S.
9. A computer/laptop/home access and mobile phone will be required for the two Consultant Urologists and a desktop computer for their Secretary. Further laptops will be needed by the Consultant Anaesthetist and Consultant Radiologist. The Capital costs identified in this case is 4 * Laptops @ £1,700 plus 1 * desktop @ £1,500.
10. A discount factor @3.5% pa has been applied to calculate the NPC.
11. Please note all figures above have been rounded to thousands and shown to one decimal place.
12. Total Net Present Cost (NPC) equates to £19,425.3 for this option.

SECTION 5: NON MONETARY COSTS AND BENEFITS

Impact assessment

Non-Monetary Factor	Option 1 Status Quo	Option 2 Appoint a Consultant Urologist (7th) & infrastructure	Option 3 Appoint 2.00 wte Consultant Urologists & infrastructure
1. Increase outpatient capacity	There is limited potential to increase the current outpatient activity within the existing capacity available within the Status Quo.	Option 2 will provide additional new outpatient capacity for 299 new appointments for patients who are referred to a Consultant Urologist. To deliver the activity the necessary support staff and goods & services will be required.	Compared to Option 1 and Option 2 Option 3 will provide additional new outpatient capacity of 598 appointments. This would provide a significant improvement to the current outpatient capacity for patients referred to a Consultant Urologist. To deliver the activity the necessary support staff and goods & services will be required.
2. Increase daycase capacity	There is limited potential to increase the current daycase capacity with the Status Quo.	Option 2 will provide additional capacity for 140 day cases. To deliver the activity the necessary support staff and goods & services will be required.	Compared to Option 2 this option would provide capacity for an additional 280 day cases To deliver the activity the necessary support staff and goods & services will be required.
3. Increase inpatient capacity	There is very limited potential to increase the inpatient capacity within the current service model.	Option 2 will provide additional inpatient capacity for 175 patients. To deliver the activity the necessary support staff and goods & services will be required.	Compared to Option 2 Option 3 will provide 350 additional inpatient cases. To deliver the activity the necessary support staff and goods & services will be required.
4. Compliance with Ministerial OPD waiting time target	The Ministerial target states that by March 2020 – 50% of Patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks. As at July 2019 the longest wait was 184 weeks. There would be no improvement with the status quo as the existing Consultant complement could not achieve the stated compliance target. Waiting times and numbers of patients waiting would continue to increase.	Option 2 will increase the current funded consultant urology posts from 6 to 7. This will enable the team to reduce the number of patients waiting longer than 9 weeks and 52 weeks respectively. Option 2 will improve the waiting time target compared to Option 1. This will increase capacity by 299 outpatient appointments. However to effect a decrease in waiting times from the current level a non-recurrent exercise will be required.	Compared to both Options 1 and 2, Option 3 performs better. It will increase the current Consultant Urology posts from 6 to 8. This would provide additional scope for the Trust to achieve the Ministerial OPD waiting time target. This will increase capacity by 598 outpatient appointments. However to effect a decrease in waiting times from the current level a non-recurrent exercise will be required. However to effect a decrease in waiting times from the current level a non-recurrent exercise will be required.

SECTION 6: ASSESS RISKS AND UNCERTAINTIES

Risk Description	Likely impact of Risk L/M/H			State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	
1. Reduction in current Consultant capacity (due to changes in pension tax regime)	H	H	H	Option 1, 2 and 3 all carry a high level of risk associated with the changes to pension. The changes to pension are prompting consultants and other senior medical staff to cut back on hours of work as they could obtain a significantly higher pension by cutting their hours. In relation to Northern Ireland the Permanent Secretary of Department of Health and Chief Executive of Health and Social Care for Northern Ireland are actively pursuing a way forward in respect of this issue.
2. Inability to appoint consultant/s	N/A	H	H	Option 1 involves no service change and therefore risk does not apply. This risk applies to options 2 and 3. It is deemed to be high for both options. There will be no-one completing training for the next 3 years. It may be possible that applicant/s may be interested in relocating from the UK. The Trust would however advertise for Locum staff. In the interim sessions could be considered as in-house additionality however there remains a risk with the current changes to tax regime. As noted at risk 1 above, once a doctor crosses a level of earnings the new rules come into play, this means that doctors are prompted to cut back on hours of work and it will be likely they will not wish to avail of additional working hours.
2. Inability to appoint nursing/key staff resources	N/A	H	H	Option 1 involves no service change and therefore risk does not apply. A high risk applies to options 2 and 3. There is a workforce deficit in nursing in Northern Ireland so recruiting to these posts will be a challenge. The Trust continues to progress a range of innovative approaches to recruitment including radio/ online/ social media campaigns, one-stop recruitment days, local, regional and national recruitment activities. There is also a risk with both option 2 & 3 that other key staff such as anaesthetic and radiology staff may not be appointed immediately. As with the urologist post the Trust would advertise again until posts are filled.

3. Availability of bed infrastructure	H	H	H	Due to emergency admissions the Trust continues to experience bed pressures. That said the Trust continually considers and implements new models of care/best practice and enhanced discharge planning processes with a view to alleviate bed pressures.
Overall Risk (H/M/L)	H	H	H	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 1 - Status Quo

This option will not make provision for any additional capacity within the Urology service. The waiting times for new patient referrals will continue to be a challenge for the Trust to achieve waiting time targets. The achievement of the project objectives will not be delivered.

Option 2 and Option 3 will deliver the desired benefits:

- Additional capacity will be provided for:
  - Outpatients
  - Day case patients
  - Inpatients
- Progress will be made towards compliance with the recommendations of the opd waiting time target that by March 2020 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.

Option 3 would exceed option 2 in terms of delivery of benefits. However the risk of not being able to attract two consultants, due to the limited number available across the region, is significant. In addition the annual revenue cost of option 3 at **£1,738,628** is double that of Option 2 **£869,314.** Option 3 would exceed the funding envelope identified by the HSCB and therefore has not been identified as the preferred Option on this occasion.

The preferred Option is Option 2 – Appoint an Additional 7th Consultant Urologist and associated staff support. This option will meet the project objectives, enable additional capacity for urology patient referrals to the Trust and reduce the time patients wait for an appointment to see a Consultant Urologist.

There will remain a risk associated with changes to the NHS pension tax regime which will have a significant impact on all specialities in the future including urology. The Trust will actively advertise for both a Consultant Urologist and the necessary support staff with a view to expand the Urology Service at the Southern Trust.

SECTION 8: ASSESS AFFORDABILITY AND FUNDING ARRANGEMENTS

AFFORDABILITY STATEMENT	Year 0 20/21 £ 000	Year 1 21/22 £ 000	Year 2 22/23 £ 000	Year 3 23/24 £ 000	Totals £000's
Required:					
Capital	4.9	0.0	0.0	0.0	4.9
Resource	2,375.4	2,996.3	3,194.9	3,406.7	11,973.3
Depreciation	*1.0*	*1.0*	*1.0*	*1.0*	*4.0*
Existing Budget:					
Capital	0.0	0.0	0.0	0.0	0.0
Resource	1,939.8	2,068.4	2,205.5	2,351.7	8,565.4
Depreciation	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
Additional budget Required:					
Capital	4.9	0.0	0.0	0.0	4.9
Resource	435.6	927.9	989.4	1,055.0	3,407.9
Depreciation	*1.0*	*1.0*	*1.0*	*1.0*	*4.0*

Affordability narrative

Finance Assumptions:

1. Year 0 is 2020/21 Financial Year.
2. The baseline costs for this case is the 2019/20 recurring revenue budget for the HoS Urology (CA7830) in the DAS directorate of SHSCT.
3. The cost of the staff identified in Section 3 and Appendix A is calculated as per General Costing 2019.20 DRAFT 16.09.19. This includes an allowance for employee related G&S and appropriate allowances for unsocial hours payments.
4. The medical staff costs include an allowance for excess travel and an on-call provision for their Rota. This also includes the cost of 11 APA's for each 1.00 WTE.
5. A provision has been made for additional G&S for the additional activity. This based on 10% of the average 2018/19 TFR cost for each procedure adjusted by 2.6% for inflation to 2019/20 rates.
6. No Capital costs have been identified in this case.
7. Costs have been uplifted by 6.63% for inflation from 2020/21.
8. Please note all figures above have been rounded to thousands and shown to one decimal place.

SECTION 9: PROJECT MANAGEMENT (Please see additional activity detailed at Section 11)

It is proposed to implement the organisation and management of this project in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management.

The following key roles have been identified:

- Project Owner – Mr Ronan Carroll (Assistant Director of Acute Services, Surgery & Elective Care & ATICS)
- Project Manager – Mrs Martina Corrigan, Head of ENT, Urology, Ophthalmology and Outpatients

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation.

Activity will be monitored on an ongoing basis via the Performance Management Team and submitted to the Health and Social Care Board.

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation? (please provide the name of the responsible individual where possible)	Ronan Carroll, Asst Director, Surgery and Elective Care and ATICs
Who will monitor and evaluate the outcomes? (please provide the name of the responsible individual where possible)	Acute Head of Service (independent to the project) will undertake post project evaluation
What other factors will be monitored and evaluated?	Appointment and commencement of Consultant Urologist and support staff
When will this take place? (preferably 4 to 12 months after project closure)	During the recruitment and commencement of the Consultant. A Post Project Evaluation will be undertaken 12 months after implementation.

SECTION 11: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

				Activity From (previous SBA baseline)	**Activity To (New SBA Baseline)**		**Please specify if activity relates to Investment or Productivity / Efficiency Gains**
PoC	**Service line descriptor 1**	**Service line descriptor 2**	**Currency** use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	**Full Year Effect Total**	**Current Year Effect Total**	**Full Year Effect Total**	**I - Investment** **P - Productivity**
Acute	Urology	Appointment of a 7th Consultant Urologist	New OP – 299 Review OP –798 Elective In-patients –175 Day cases –140 Flexible cystoscopy – 350	New OP – 3591 Review OP – 4489 Elective In-pts – 1056 Day cases – 3142 FCEs – 629 OP Procedures - 432	-	New OP – 3890 Review OP – 5287 Elective In-pts – 1231 Day cases – 3282 FCEs – 979	I

SECTION 11: MONITORING AND EVALUATION

Mr Ronan Carroll, Assistant Director of Acute Services, Surgery and Elective Care and ATICs will manage the implementation of this service expansion. Timescale for the implementation of the urology service expansion will primarily be dependent on the commencement date of the Consultant Urologist pursued as follows:

Task	Timescale
Approval of IPT by Trust SIC	February 2020
Approval of IPT by HSCB	March 2020
Confirmation of funding allocation	May 2020
Completion/approval of job plan to Specialty Advisor	May 2020
Advertisement of Consultant Post	July 2020
Advertisement of support staff	July 2020
New Consultant in Post	October 2020

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation of the proposal following the appointment of the new Consultant. The evaluation will be undertaken by a Head of Service independent to the Urology Team.

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

BENCHMARK

Craigavon Area Hospital has been designated as a Cancer Unit, with its Urological Department being designated the Urology Cancer Unit for the area population of 490,000 (including Fermanagh) A wide spectrum of urological cancer management has been provided for some time. Cancer surgery includes orthotropic bladder reconstruction in the management of bladder cancer. Cancer management also includes intravesical chemotherapy for bladder cancer. Immunotherapy for renal cell carcinoma is also performed.

'The British Association of Urological Surgeons (BAUS) recommends a consultant workforce ratio of 1 wte per 60,000 population' which would indicate a recommended consultant workforce for the Trust of 8.0 wte.

This IPT sets out evidence to support the need for a further Consultant Urologist in line with BAUS guidelines.

Consultant Urologist (7th) & Additonal Staffing - (Based at DHH) - APPENDIX A	
Costing Schedule provided at Appendix C	
OPTION 2	
1 New OP clinic per wk = 299 pts 2 Review OP 798 pts 2 In-patient lists 175 pts 1 x Day Case 140 pts 1 x Flexible scope session 350 pts (activity calculated x 35 weeks)	
Recurring	**WTE**
Medical Staff	
Consultant Urologist	1.00
Consultant Anaesthetist	0.62
Consultant Radiologist	0.50
Specialist Nursing	
Band 7	1.00
Pre-op Assessments	
Band 5	0.17
Band 6	0.15
Theatres Nurses	
Band 6	0.52
Band 5	1.60
Band 5 (Recovery)	0.52
Band 3 "	0.52
	3.16
Elective Admission Ward Nursing	
Band 5	1.00
Band 3	1.00
	2.00
Outpatients	
Band 5	0.40
Band 3	0.78
	1.18
Ultrasonographers Band 7	0.50
	0.50
Laboratory	
Consultant Pathologist	0.10
BMS Band 7	0.15
	0.25
Pharmacy	
Clinical Pharmacist Band 7	0.20
Pharmacy Technician Band 4	0.20
	0.40
CSSD	
ATO Band 2	0.33
	0.33
Admin Support	
PAS/Clinical Coding Band 4	0.10
Personal Secretary Band 4	0.50
Booking Clerk Band 3	0.55
Audio Typist Band 2	0.55
Health Records Band 2	0.51
	2.21
Hotel Services	
Band 2	0.30
Goods & services	
Outpatient attendances 299 new & 798 review	
Day case x 140	
Flexible scopes x 350	

Consultant Urologist (7th & 8th) & additional staff resources				APPENDIX B	
(based at DHH)					
Costing Schedule provided at Appendix C					
Option 3					
2 New OP clinic per wk = 1,596 pts Review OP 1,596 pts 4 In-patient lists 350 pts 2 x Day Case 140 pts 2 x Flexible scope session 350 pts (activity calculated x 35 weeks)					
Recurring	**WTE**				
Medical Staff					
Consultant Urologist	2.00				
Consultant Anaesthetist	1.24				
Consultant Radiologist	1.00				
Specialist Nursing					
Band 7	2.00				
Pre-op Assessments					
Band 5	0.34				
Band 6	0.30				
Theatres Nurses					
Band 6	1.04				
Band 5	3.20				
Band 5 (Recovery)	1.04				
Band 3 "	1.04				
	6.32				
Elective Admission Ward Nursing					
Band 5	2.00				
Band 3	2.00				
	4.00				
Outpatients					
Band 5	0.80				
Band 3	1.56				
	2.36				
Ultrasonographers Band 7	1.00				
	1.00				
Laboratory					
Consultant Pathologist	0.20				
BMS Band 7	0.30				
	0.50				
Pharmacy					
Clinical Pharmacist Band 7	0.40				
Pharmacy Technician Band 4	0.40				
	0.80				
CSSD					
ATO Band 2	0.66				
	0.66				
Admin Support					
PAS/Clinical Coding Band 4	0.20				
Personal Secretary Band 4	1.00				
Booking Clerk Band 3	1.10				
Audio Typist Band 2	1.10				
Health Records Band 2	1.02				
	4.42				
Hotel Services					
Band 2	0.60				
Goods & services					
Outpatient attendances 299 new & 798 review					
Day case x 140					
Flexible scopes x 350					

Appendix C

Schedule of Costs for Option 2 and 3 (page 23)

Summary Costing schedule for Investment Decision Making Templates	Ref Number
Provider	SOUTHERN
Hospital Site or Community development	CRAIGAVON
Scheme Title	Elective Care 2020/21 - Expansion of Southern Trust Urology Team -7th Consultant Urologist
Pay and Price Levels	2019/20

Commissioner Use only
Sign and Date for TRAFFACS update

		Base Case - option 1				Option 2				Option 3			
Pay Costs	Description	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye
				1,939,777	1,939,777			1,939,777	1,939,777			1,939,777	1,939,777
Specialist Nursing					0				0			0	0
Band 7	Nurse				0	6.00	1.00	50,744	25,372	6.00	2.00	101,488	50,744
Pre-op Assessments					0								
Band 5	Nurse				0	6.00	0.17	6,006	3,003	6.00	0.34	12,012	6,006
Band 6	Nurse				0	6.00	0.15	6,358	3,179	6.00	0.30	12,715	6,358
Theatre Nurses					0								
Band 5	Nurse				0	6.00	1.60	56,525	28,262	6.00	3.20	113,050	56,525
Band 6	Nurse				0	6.00	0.52	22,040	11,020	6.00	1.04	44,079	22,040
Band 5 (Recovery)	Nurse				0	6.00	0.52	18,371	9,185	6.00	1.04	36,741	18,371
Band 3	Nursing Assistant				0	6.00	0.52	12,849	6,425	6.00	1.04	25,698	12,849
Elective Admissions Ward					0								
Band 5	Nurse					6.00	1.00	35,328	17,664	6.00	2.00	70,656	35,328
Band 3	Nursing Assistant					6.00	1.00	24,710	12,355	6.00	2.00	49,420	24,710
Outpatients													
Band 5	Nurse					6.00	0.40	14,131	7,066	6.00	0.80	28,262	14,131
Band 3	Nursing Assistant					6.00	0.78	19,274	9,637	6.00	1.56	38,548	19,274
Band 7	Ultrasonographer					6.00	0.50	25,372	12,686	6.00	1.00	50,744	25,372
Laboratory													
Band 7	BMS					6.00	0.15	7,612	3,806	6.00	0.30	15,223	7,612
Pharmacy													
Band 7	Clinical Pharmacist					6.00	0.20	10,149	5,074	6.00	0.40	20,298	10,149
Band 4	Pharmacy Technician					6.00	0.20	5,786	2,893	6.00	0.40	11,572	5,786
Support Services													
Band 2	ATO - CSSD					6.00	0.33	7,465	3,732	6.00	0.66	14,930	7,465
Band 4	PAS Clinical Coding					6.00	0.10	2,893	1,447	6.00	0.20	5,786	2,893
Band 4	Personal Secretary					6.00	0.50	14,466	7,233	6.00	1.00	28,931	14,466
Band 3	Booking Clerk					6.00	0.55	13,591	6,795	6.00	1.10	27,181	13,591
Band 2	Audio Typist					6.00	0.55	12,442	6,221	6.00	1.10	24,883	12,442
Band 2	Health Records Clerk					6.00	0.51	11,537	5,768	6.00	1.02	23,073	11,537
Band 2	WBS				0	6.00	0.30	6,786	3,393	6.00	0.60	13,573	6,786
Non-AFC posts please detail below					0								
Medical	Consultant Pathologist - Cat A, No on-call, 11 APA					6.00	0.10	13,126	6,563	6.00	0.20	26,252	13,126
Medical	Consultant Urologist - Cat A on-call 1 in 7, 11 APA				0	6.00	1.00	137,885	68,943	6.00	2.00	275,770	137,885
Medical	Consultant Anaesthetist - Cat A on-call 1 in 8, 11 APA					6.00	0.62	85,489	42,744	6.00	1.24	170,977	85,489
Medical	Consultant Radiologist - Cat A on-call 1 in 16 11 APA				0	6.00	0.50	67,617	33,809	6.00	1.00	135,234	67,617
Allowances for posts noted above - please detail below					0								
Excess Travel													
Medical	£2k per 1.00 WTE					6.00		4,440	2,220	6.00		8,880	4,440
Unsocial Hours payments													
Theatre Nurses					0				0				0
Band 5	Nurse - 24 hr working - 23.09%				0	6.00		13,052	6,526	6.00		26,103	13,052
Band 6	Nurse - 24 hr working - 23.09%				0	6.00		5,089	2,544	6.00		10,178	5,089
Band 5 (Recovery)	Nurse - 24 hr working - 23.09%				0	6.00		4,242	2,121	6.00		8,484	4,242
Band 3	Nursing Assistant - 24 hr working - 28.47%				0	6.00		3,658	1,829	6.00		7,316	3,658
Ultrasonographers													
Band 7	Ultrasonographer - Weekend Working - 17.24%					6.00		4,374	2,187	6.00		8,748	4,374
Pharmacy													
Band 7	Clinical Pharmacist - Weekend Working - 17.24%					6.00		1,750	875	6.00		3,499	1,750
Band 4	Pharmacy Technician - Weekend Working - 17.24%					6.00		998	499	6.00		1,995	998
Support Services									0				0
Band 2	ATO - CSSD - Weekend Working - 21.45%					6.00		1,601	801	6.00		3,202	1,601
Band 4	PAS Clinical Coding - Weekend Working - 17.24%					6.00		499	249	6.00		998	499
Band 3	Booking Clerk - Weekend Working - 20.62%					6.00		2,802	1,401	6.00		5,605	2,802
Band 2	Health Records Clerk - Weekend Working - 21.45%					6.00		2,475	1,237	6.00		4,949	2,475
Band 2	WBS - Weekend Working - 21.45%				0	6.00		1,456	728	6.00		2,911	1,456
Salary Related G&S: /													
Band 2	Salary related G&S					6.00		2,942	1,471	6.00		5,885	2,942
Band 3	Salary related G&S					6.00		5,395	2,698	6.00		10,790	5,395
Band 4	Salary related G&S					6.00		1,762	881	6.00		3,523	1,762
Band 5	Salary related G&S					6.00		9,852	4,926	6.00		19,705	9,852
Band 6	Salary related G&S					6.00		2,134	1,067	6.00		4,268	2,134
Band 7	Salary related G&S					6.00		7,023	3,511	6.00		14,045	7,023
Medical	Consultant Pathologist					6.00		881	441	6.00		1,762	881
Medical	Consultant Urologist					6.00		9,250	4,625	6.00		18,500	9,250
Medical	Consultant Anaesthetist					6.00		5,735	2,868	6.00		11,470	5,735
Medical	Consultant Radiologist					6.00		4,537	2,269	6.00		9,074	4,537
	TOTAL PAY COSTS		**0.00**	**1,939,777**	**1,939,777**		**13.77**	**2,724,271**	**2,332,024**		**27.54**	**3,508,764**	**2,724,271**
Non-Pay Costs, Option 2 - please detail below													
Outpatient Attendences - 798 Review @ £22.46					0	6.00		17,923	8,962				
Outpatient Attendences - 299 new @ £22.46					0	6.00		6,716	3,358				0
Day Case * 140 @ £122.82						6.00		17,195	8,597				
Flexible Cystoscopy * 350 @ £122.82					0	6.00		42,987	21,494				0
									0				
Non-Pay Costs, Option 3 - please detail below													
Outpatient Attendences - 1,596 Review @ £22.46										6.00		35,846	17,923
Outpatient Attendences - 598 new @ £22.46										6.00		13,431	6,716
Day Case * 280 @ £122.82										6.00		34,390	17,195
Flexible Cystoscopy * 700 @ £122.82					0				0	6.00		85,974	42,987
					0				0				0
					0				0				0
	TOTAL NON-PAY COSTS			**0**	**0**		**13.77**	**84,820**	**42,410**		**27.54**	**169,641**	**84,820**
	GRAND TOTAL			**1,939,777**	**1,939,777**			**2,809,091**	**2,374,434**			**3,678,405**	**2,809,091**
								869,314	434,657			1,738,628	869,314

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

Clayton, Wendy

From:	Lappin, Lynn
Sent:	03 May 2022 10:42
To:	McClements, Melanie; Carroll, Ronan; Leeman, Lesley; Tally, Paula; McConville, Janet; Turbitt, Andrea; Teggart, Catherine; Cassells, Carol
Cc:	Clayton, Wendy; Martin, Linda-Jayne; Hogan, Kerri; Davis, Anita; Gervin, Kim; Burns, EmmaL; Admin Ad Performance; Wilson, Leandra; Gregory, Louise; Vennard, Paula
Subject:	FOR RESPONSE: Urology - Consultant 7 IPT and ESWL IPT
Importance:	High

Colleagues

Wendy, Linda-Jayne, myself and Mark Haynes met with SPPG (HSCB/SLCG) reps late on Wednesday afternoon (27 April 2022). This meeting had been set up, as we understood, to finalise the Urology Consultant 7 IPT.

David McCormick Chaired the meeting and advised that as Southern Trust was struggling to recruit Consultant 7 (as well as our other vacant posts) and as they had not recurrently allocated the funding for consultant 7, he would propose to divert this funding to the ESWL IPT. This would provide a fully funded Regional Stone Treatment Service, which is not reliant on the appointment of Consultants.

He further noted that if the ST was lucky enough to recruit a 7th Consultant, then the SPPG would commit to fund this post recurrently, but no additional supporting costs would be funded recurrently. These may be considered for funding non-recurrently in the first instance.

David advised that he had discussed and agreed this position with Mark Haynes prior to the meeting. When Mark joined the meeting he confirmed that he felt this to be a pragmatic approach and that it would allow the progression of the ESWL IPT.

I advised SPPG reps that we were not in a position to agree this and that we would have to take the proposal back to the Directors / SMT for approval.

Therefore, can you please confirm if you are content with the:

- ESWL IPT to be finalised and funded via the SPPG re-direction of funding from Consultant 7; and

- Appointment of Consultant 7, if and when possible, with only the commitment from the SPPG to fund the Consultant post recurrently and the support staff / infrastructure / costs to potentially only be funded yearly non-recurrently through WLI monies.

Your consideration of this is appreciated. Happy to discuss as required.

Regards.

Lynn

Lynn Lappin
Head of Performance

Making Data Count Ambassador

✉ Directorate of Performance & Reform
Southern Health & Social Care Trust
The Rowans, Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ
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Northern Ireland Department of Health Daycase Elective Care Centres

Designing future elective care operating models through the development of DECCs – Urology

July 2019

The better the question. The better the answer.
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Building a better working world

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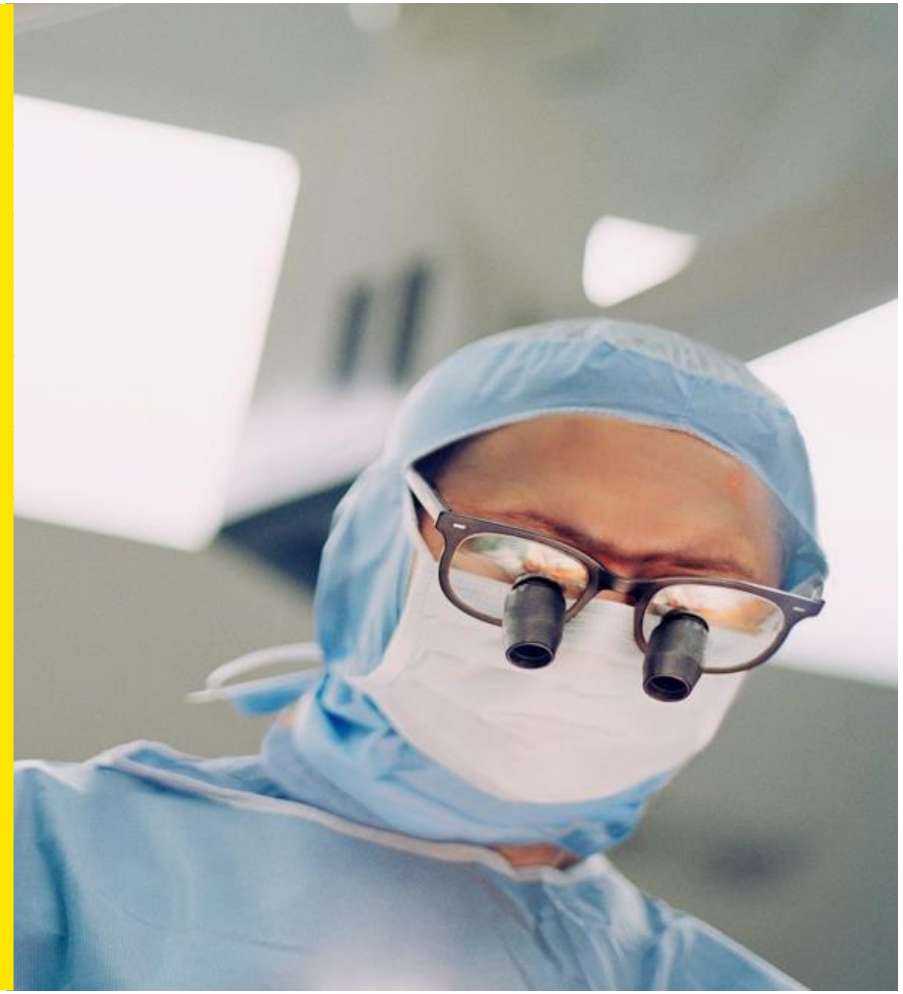


Section 1

Executive Summary

Executive Summary - Overview

Background to this report

This report builds upon, and should be considered alongside, an existing report dated 16th May 2019 and entitled '*Demand v Capacity Modelling – Initial Outputs*'. That document outlined the methodology which was used to analyse and quantify current and future demand for daycase elective procedures across 7 specialties, being; T&O, General Surgery (including Vascular Surgery), Urology, Urology, Gynaecology, Neurology, Endoscopy and Paediatrics.

The analysis which underpins this report is further detailed in the demand v capacity model, constructed in Microsoft's Power Bi platform, entitled '*NI DECC Demand v Capacity Model*'. This model has been used to facilitate meetings with the Task & Finish (T&F) Groups and, it is expected, will continue to inform scenario planning in future T&F Group meetings.

This report highlights the conclusions which have been drawn over the last 20 weeks based on the following key activities:

- Population of the model based with key data inputs including; daycase and inpatient activity, daycase and outpatient waiting lists, theatre utilisation metrics and demographic growth assumptions
- Socialising the demand v capacity model with each specialty (and wider stakeholders) to validate; input data, assumptions, forecasts and the key outputs of the analysis
- Meeting each specialty on a minimum of three occasions (one meeting with the Clinical / Service Leads, one meeting with the wider T&F Group and a final meeting with the Clinical / Service Leads to validate and finalise our analysis and conclusions drawn) to ensure that the outputs of the modelling aligns with their understanding of the operation of the services

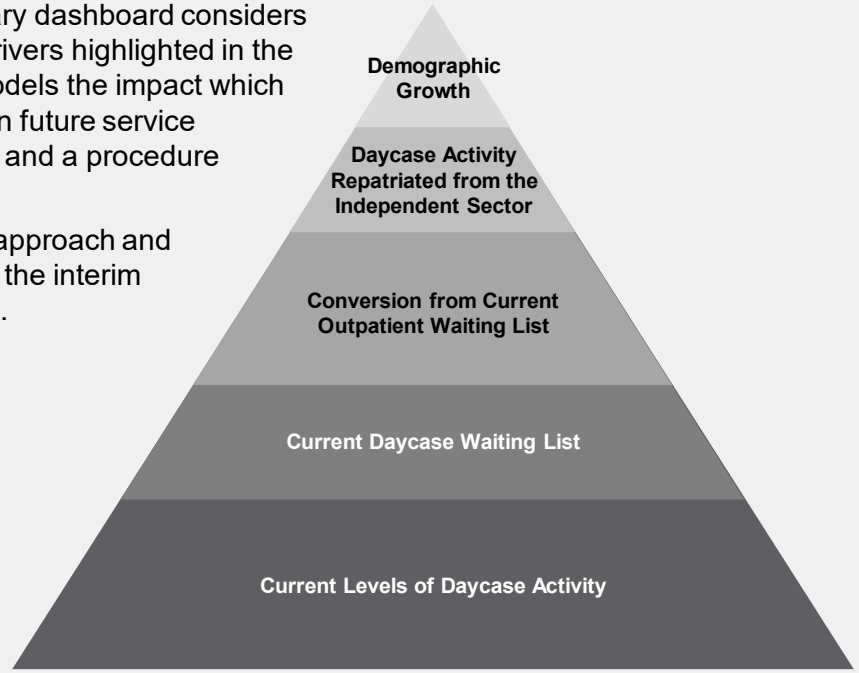
Use of the Demand v Capacity Model to support future service planning

As noted, analysis of the data which underpins the planning of future elective care delivery has been undertaken in Power BI dashboards. These agile and intuitive dashboards provide the T&F Groups with the ability to quickly and easily consider numerous scenarios, based on the selection of different baskets of procedures, and to immediately understand the impact on future capacity requirements.

It also allows the HSC, at both a specialty and a procedure level, to understand how much additional capacity would need to be created to service the future steady state and also to clear down current waiting lists over any agreed time horizon.

Within the model, a summary dashboard considers each of the 5 key activity drivers highlighted in the diagram to the right and models the impact which each is expected to have on future service demand at both a specialty and a procedure level.

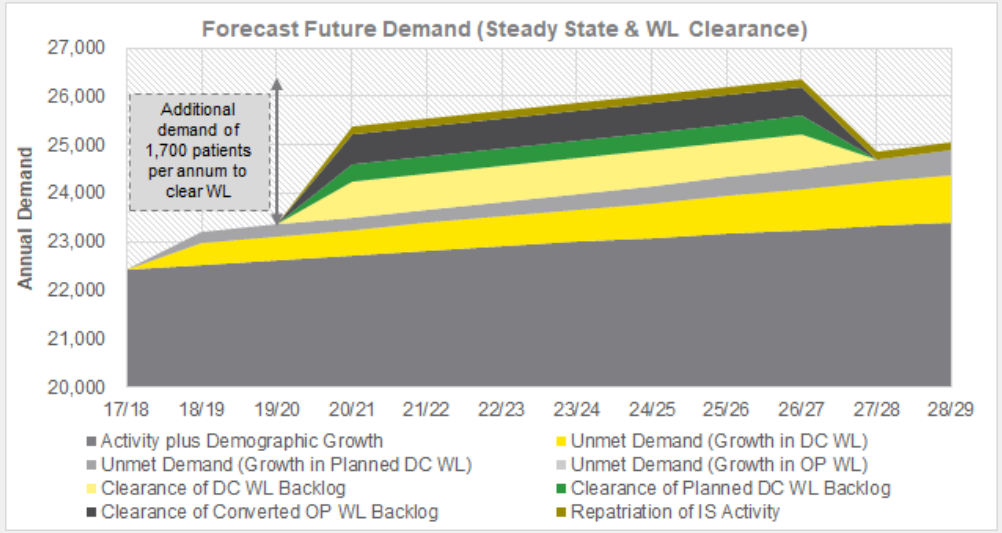
Further information on the approach and methodology is provided in the interim report dated 16th May 2019.



Executive Summary – Urology Future Operating Model

Analysis of Current & Future Steady States

Level	Modelling Outputs
Specialty	▪ Steady state demand, at a specialty level, is expected to increase by 4.5% (563 admissions) by FY28/29 ▪ The March 18 outpatient and daycase waiting list backlogs are modelled as being cleared by 2026/27 to align with the timelines of Delivering Together, creating additional annual demand of 1,700 admissions (399 lists)
Procedure	▪ 5 procedures modelled as moving to the DECCs, requiring capacity to deliver up to 1,321 lists per annum (based on maximum annual volumes of 4,070 admissions) ▪ Moving the 5 procedures from existing acute sites is expected to reduce daycase activity on those sites by 16% (3,617 admissions)



Location Analysis

Having considered the key requirements of the Urology service, the T&F Group concluded that Urology procedures could be delivered from either a standalone or a self-contained DECC with the key design principles identified as being:

Key design principles, by weighting, for Urology DECCs:	
1.	Proximity to existing services and workforce (travel time)
2.	Proximity of acute hospital in the event of patient transfer
3.	Availability of specialist equipment
4.	Availability of clinical support services - diagnostics, decontamination services etc

Workforce Implications / Opportunities

The Urology T&F Group considered a number of potential workforce implications, limitations and opportunities with the key considerations highlighted as being:

Key workforce implications:

- Shortages in workforce (i.e. nurses in theatres and acute wards) may be exacerbated by the implementation of DECCs and more attractive working conditions. This may de-stabilise the acute sector or else limit the ability to secure appropriate staff for the DECCs.
- The Urology service is moving towards an Outpatient delivery model in which low complexity procedures are delivered in the OPD – there is scope to further build on this model if suitable space is made available in the DECCs
- The roles of the specialist nurse, and how we can maximise the value delivered by this group of staff, needs to be considered in any future delivery model

Section 2

Demand v Capacity Modelling – Urology

Demand Modelling – Assumptions (Specialty Level)

Demand Modelling – Urology

As noted previously, Urology daycase elective activity has used data from the previous 3 years (FY15/16, FY16/17 and FY17/18) to understand trends in patient activity and to forecast growth in activity over a period of 20 years.

T&F Groups have been engaged to develop any assumptions, where necessary, needed to forecast future activity. Any assumptions made are detailed in the table to the right.

We note that the data relating to Urology activity is particularly challenging due to the level at which it is aggregated within the model.

Work has been done, alongside both the Urology Clinical Leads and colleagues in the HSCB , to better understand the procedures which would be most appropriate to deliver from a DECC and to identify where those procedures are aggregated within the data. A breakdown of the codes which have been modelled, and how they reconcile to the procedures identified by the Clinical Leads, are provided within Appendix.2.

Assumptions Underpinning Urology Demand Modelling:

The following assumptions underpin the demand modelling for Urology:

Assumption	Rationale & Impact on Modelling
The uncoded Outpatient Waiting List is made up of the same procedures as were delivered in FY17/18 with the volumes pro-rated in line with levels of activity	▪ The OP WL is currently uncoded, assumptions have been applied as to the daycase procedures which will convert from that WL ▪ The assumptions allow levels of demand to be projected based on conversion from OP WL to daycase activity
Specialty level conversion rates have been applied to project the number of patients who will convert from the OP WL to daycase surgery	▪ Specialty conversion rates for daycases have been provided by the HSCB based on historical understanding of conversion ▪ The conversion rate applied for Urology is: 77%
Current OP and DC waiting lists will be cleared down over a period of 9 years	▪ Clearance of the DC and OP WLs will happen by the end of 2026 to align with Delivering Together timelines
Growth in both the OP & DC waiting lists have been modelled, at a specialty level, based on average trends in the data over the past 3 years. These rates have been discussed and agreed with clinical leads as required.	▪ The growth rate applied for Urology daycase (incl. planned) is 18% ▪ The Urology daycase waiting list has grown, on average, by 18% annually over the past 3 years – this is, in effect, unmet demand. The model assumes that the WL would continue to grow at this rate if there was no change in delivery model.
ROTT rate of 10% (i.e. 10% of patients on the WL will not attend due to no longer requiring appointment) has been applied to both the OP and DC WLs prior to applying a DC conversion rate	▪ The ROTT rate applied is consistent with the approach taken by the HSCB in modelling future activity ▪ The rate has been calculated by the HSCB based on known historical trends in the activity data
Average procedure times, based on data produced by the regional TMS have been used to convert activity volumes into sessional demand	▪ Average procedure times have been applied to calculate the number of 4hr sessions required to deliver the required volume of activity
Standardised turnaround times of 15 minutes have been applied between patients for all procedures	▪ Applying a 15 minute turnaround time between procedures is consistent with the approach taken by the prototype centres / original T&F Group

Outputs of Demand Modelling (Specialty Level)

Analysis of Current & Future Demand – Specialty Level

Forecast demand has been calculated for both; the **steady state** (factoring in demographic and unmet demand which will result in the stabilisation but not reduction of overall waiting list numbers) and a **targeted reduction in waiting lists**.

Steady State

The steady state is based upon current activity levels (uplifted to reflect demographic growth based on data provided by the HSCB) plus unmet demand (i.e. average growth in the daycase, planned daycase and converted outpatient waiting lists as identified by trends in the waiting list data over the previous 3 years).
Increasing capacity to align with the steady state will stabilise waiting lists but will not reduce current waiting lists numbers.

Targeted Reduction in Waiting Lists

Based on discussions with the Urology T&F Group, it was agreed that a targeted reduction in the waiting list should be a key output of the DECCs. It was agreed that full clearance of the DC, planned DC and OP waiting lists would be targeted over a period of 7 years, to align with Delivering Together 2026.

This has been factored into the model to indicate the level of capacity which would be required, over the 7 year period, to allow the waiting list backlog to be cleared completely.

It is noted that this level of capacity would not be required, recurrently, beyond 2026 and a decision would need to reach by HSC leadership as to whether there was a willingness to commission an increase in capacity over a shorter time horizon and what options would be available to provide this supplementary capacity.

Outputs of Activity Modelling

Forecast changes in daycase activity has been modelled over a period of 20 years.

The graphic on the next page details how activity would need to increase to service both steady state demand and to clear down the waiting lists by the end of 2026 (in line with Delivering Together).

There are a number of key points which should be noted:

Points of Note – Urology Specialty Level Demand

Steady State (Baseline Scenario)	▪ Steady state activity is expected to grow significantly, driven by unmet demand identified by the growth in the daycase (18%) and planned daycase (18%) waiting lists over the past 3 years (figures are average growth over the 3 years) ▪ The model assumes that waiting lists would continue to grow at this same average rate and capacity would need to be created to allow these patients to be treated in-year rather than added to the wait lists
Targeted Reduction in Waiting Lists (Stretch Scenario)	▪ The model assumes full clearance of the March 18 daycase (5,642 waiters); planned daycase (2,839 waiters) and outpatient (6,155 waiters) waiting lists over a period of 7 years (starting in 2020) to align with Delivering Together. This will require capacity to see an additional 1,700 patients per annum to clear down those lists by FY26/27 ▪ Clearance of the waiting lists will require c.399 additional lists per year over a 7 year period (based on a specialty level average procedure time)

Outputs of Demand Modelling (Specialty Level)

Outputs of Demand Modelling at a Specialty Level

Forecast changes in daycase demand have been modelled over a period of 20 years.

The graphic to the right (which details demand growth over a 12 year time horizon) demonstrates how steady state demand is expected to increase as well as forecasting the increase in demand which would be driven by the proposed clearing down of the waiting lists (taken at March 18) over a 7 year period.

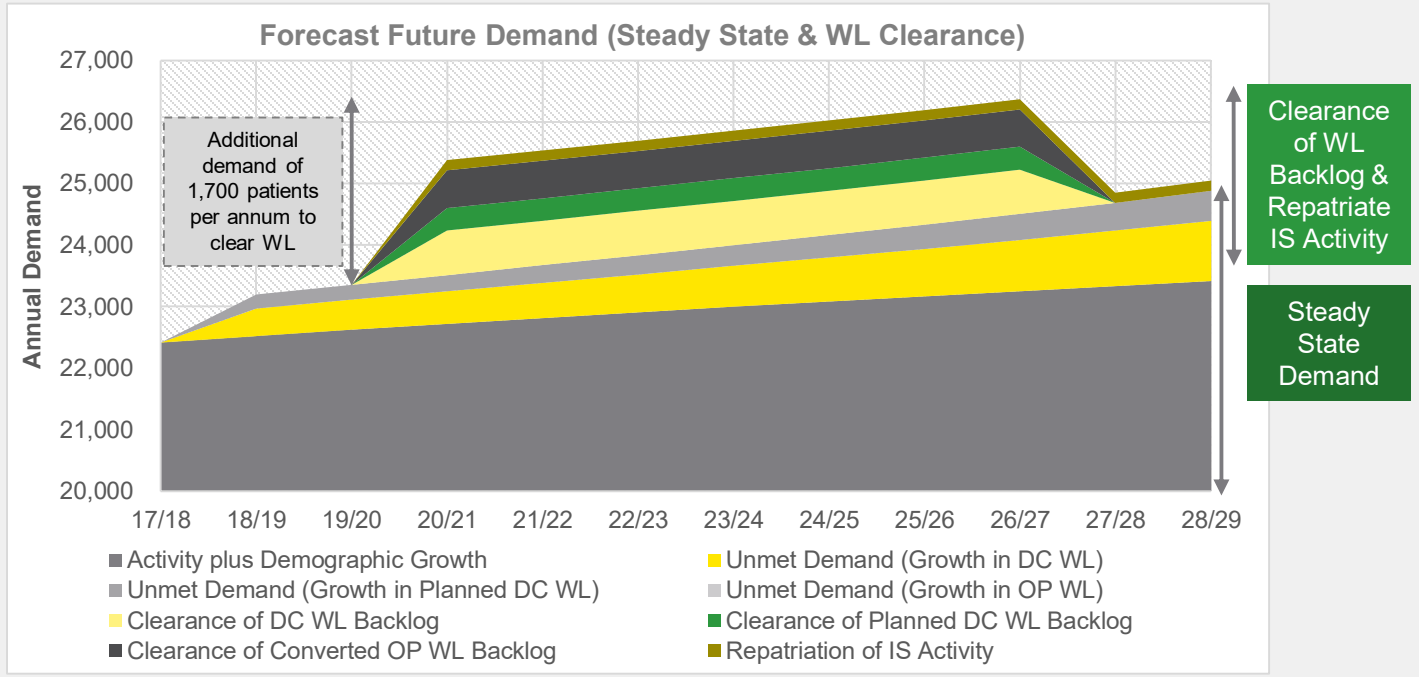
Steady State Demand

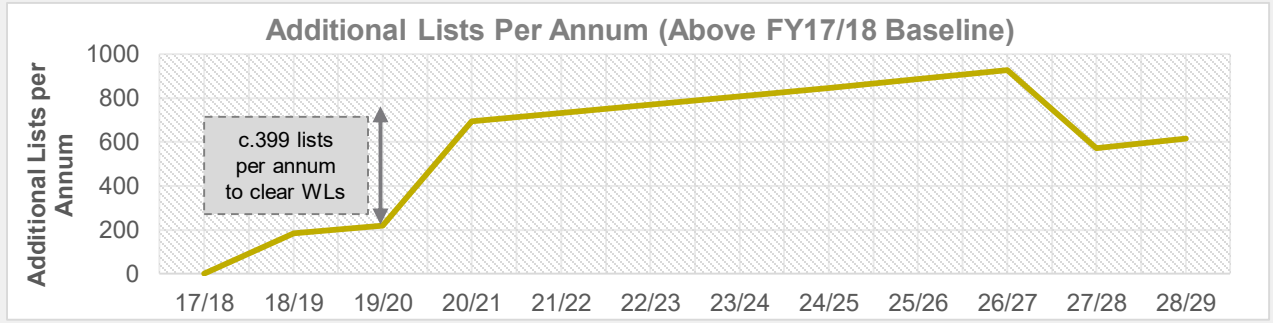
Annual steady state demand is expected to increase significantly between FY17/18 and FY28/29, driven by both demographic growth (1,001 additional admissions by FY28/29) and trends in the growth of both the daycase and planned daycase waiting lists. This unmet demand is assumed to continue to grow in line with the trends over the past 3 years.

This results in overall steady state growth of 11% (2,466 admissions per annum) over the 12 year period.

Clearance of the Waiting Lists

Complete clearance of the waiting lists (taken at March 2018) over the 7 year timeframe, based on the use of a specialty level average procedure time to convert demand into a number of lists, would require around 399 additional lists per annum (based on demand above and beyond levels of activity delivered in FY17/18) to reduce the waiting list by 1,700 waiters per annum.





Demand Modelling (Procedure Level)

Modelling the Transfer of Daycase Activity to a DECC – procedure level

Having considered the top Urology procedures delivered as a daycase, 5 were identified as being the most suitable for delivery from a DECC. The Urology T&F Group have elected to model the impact of transferring all of this activity to a number of elective care centres.

Procedure Description
TURBT
TURP / Laser Prostatectomy
Urolift
Ureteroscopies
ESWL

For each procedure, both activity which took place within a daycase setting and an inpatient setting has been modelled (although this can be altered within the model) to understand the full population of activity which could potentially be transferred to a DECC.

Note: The Paediatric activity, relating to the above procedures, has been modelled alongside the adult data (again this can be altered within the model to allow only the adult element to be considered).
Further engagement is required with the Paediatric T&F Group to understand whether the Paediatric procedures will be delivered separately or whether the Paediatric component will be delivered by the Urology surgeons alongside the adult procedures.

Outputs of Activity Modelling (Patient Level)

On the page following, current and future projected demand for the 5 chosen procedures have been modelled to understand:

- How demand for that procedures is expected to grow (both steady state demand and to reduce waiting lists)
- How much additional capacity is required to service the 'gap' between current demand and forecast future demand
- To forecast how many 4hr theatre sessions would be required annually at a DECC to service the total level of demand for that group of procedures

To provide an activity baseline the model utilises all instances of each procedure delivered across NI, whether it was carried out in a daycase or an inpatient setting over the past 3 years.

It is assumed that this cohort of procedures could and should have been delivered as a daycase and, as such, are capable of being transferred to a DECC. We note, however, that there are likely to be clinical justifications for a proportion of patients to be managed as inpatients in line with BADS best practice guidance.

Outputs of Demand Modelling (Procedure Level)

Outputs of Demand Modelling Based on the Procedures Selected as Suitable for a DECC

The graphics to the right outline the expected impact of transferring all activity relating to the 5 procedures identified by the T&F Group as being suitable for the DECC.

As noted in the specialty-level analysis above, demand has been considered from both; a steady state perspective (for Urology the forecast demand levels are impacted by both demographic growth and unmet demand) and considering the impact of reducing the waiting list for the modelled procedure (March 2018 waiting list completely cleared over a period of 7 years).

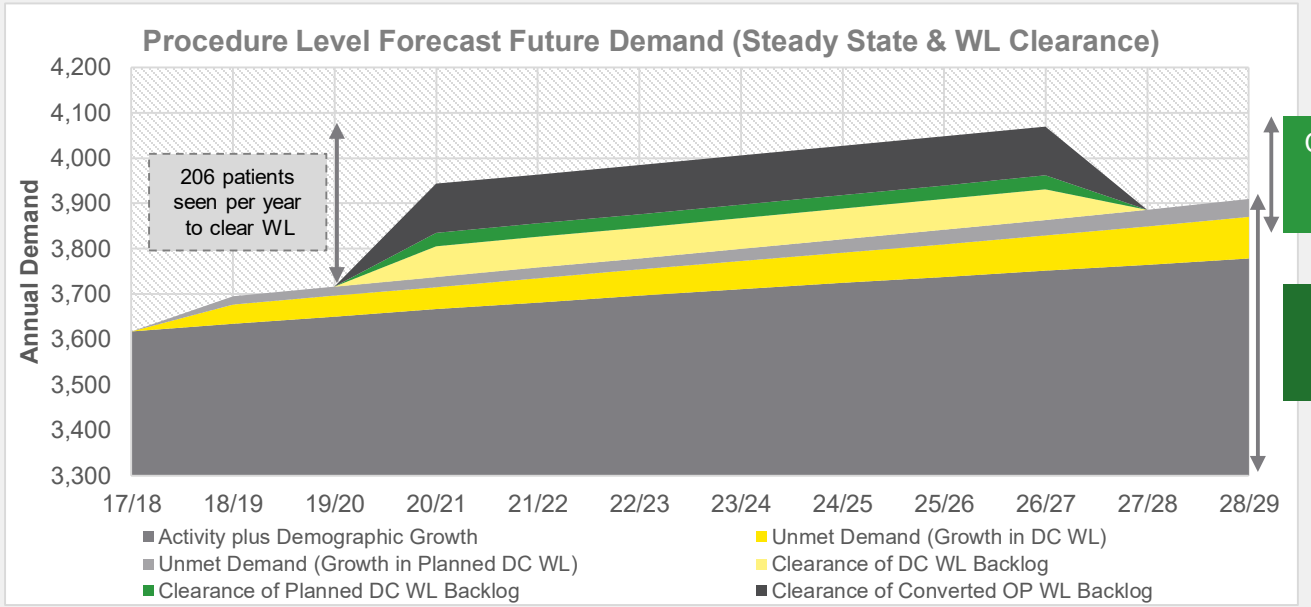
Steady State

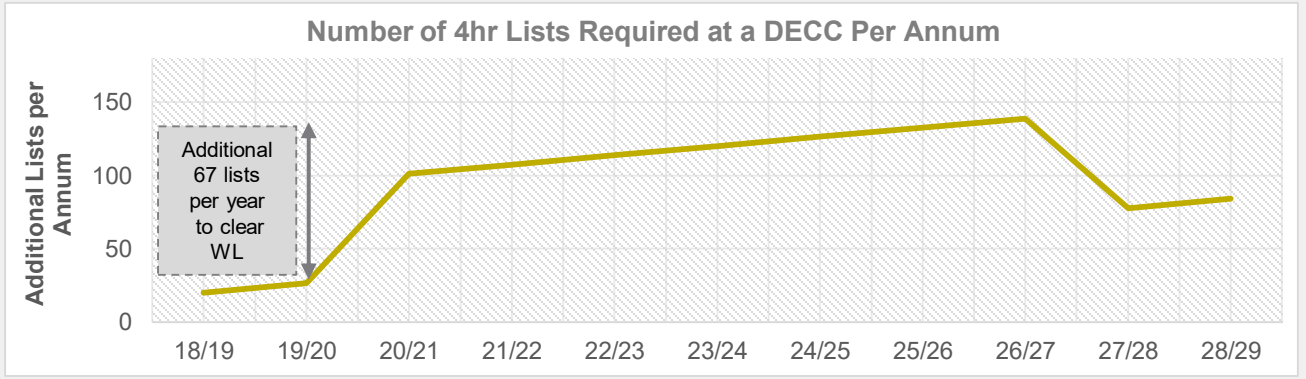
Demand for the 5 procedures are expected to grow significantly in the period FY17/18 to FY28/29, driven primarily by high levels of unmet demand. To service this level of demand, additional capacity would be required to treat an additional 292 patients per annum, requiring an additional 85 lists per year.

Waiting List Backlog Clearance

The assumed clearance of the waiting list backlog across a 7 year period drives additional demand of 206 patients per annum. Servicing this level of demand, through either a DECC or else through a BAU solution, would require capacity to be created to service an additional 67 lists per annum.

The impact of transferring all activity, relating to the 5 procedures, to a DECC and the capacity which would need to be created at any DECC location is considered on the page following.





Outputs of Demand Modelling (Procedure Level)

Outputs of Demand Modelling Based on the Procedures Selected as Suitable for a DECC

The graphic to the right details the future demand volumes for the 5 procedures highlighted as being appropriate to transfer to a DECC.

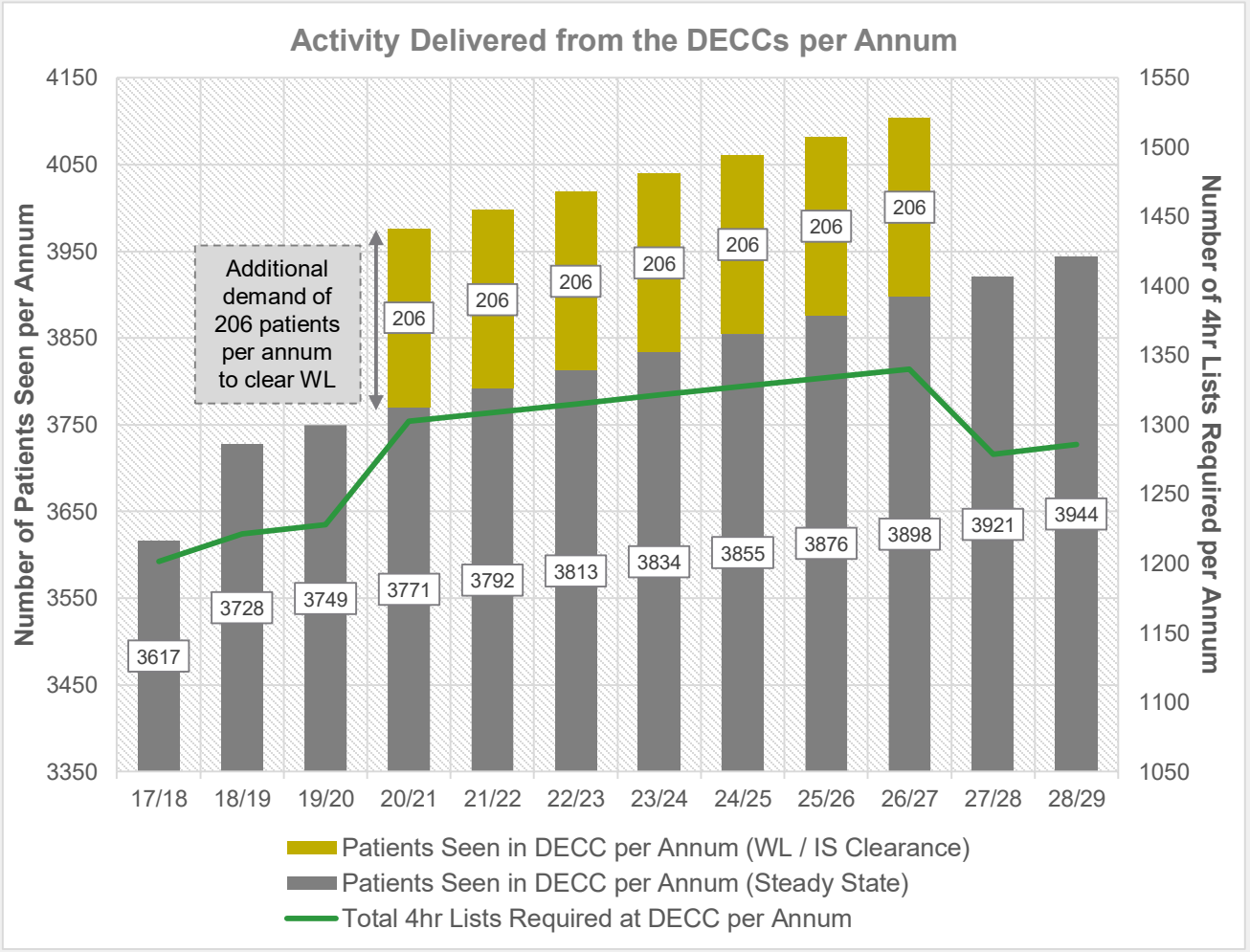
Using current average procedure times, derived from the regional Theatre Management System, and the assumption that 15 minutes of turnaround is required between cases, demand levels have been converted into a number of lists which will be required at the DECCs to service that level of demand.

The capacity required to service the various demand scenarios are as follows:

Scenario	Number of Lists Required per Annum (Capacity)
FY17/18 activity baseline	1,147 lists
FY28/29 activity levels (steady state at year 12)	1,269 lists (95 list increase on FY17/18)
FY26/27 activity levels (including clearance of WL backlog)	1,321 lists (147 list increase on FY17/18)

As noted previously the demand requirement driven by the reduction of the waiting list backlog would not be recurrent and a strategic decision would need to be reached by regulatory, commissioning and delivery functions as to both:

- Whether this is operationally and financially viable
- The resources which might be available to provide the short term levels of capacity required



Impact of Activity Transfer on Existing Acute Sites (Procedure Level)

Impact on Existing Acute Sites

The transferring of the 5 procedures (split across 9 codes within the model) identified by the T&F Group into a DECC would be expected to have the following impact on the existing acute hospitals (based on levels of activity delivered in FY17/18):

Procedure Description (Clinical Leads)	Procedure Descriptions (Aggregated Procedure per Model)	Activity Transferred to DECC
TURBT	▪ Endoscopic extirpation of lesion of bladder	934
TURP / Laser Prostatectomy	▪ Endoscopic resection of outlet of male bladder	
Urolift	▪ Endoscopic insertion of prosthesis into prostate	5
Ureteroscopies	▪ Therapeutic ureteroscopic operations on ureter ▪ Other endoscopic removal of calculus from ureter ▪ Other therapeutic endoscopic operations on ureter ▪ Diagnostic endoscopic examination of ureter	1,447
ESWL	▪ Extracorporeal fragmentation of calculus of kidney ▪ Extracorporeal fragmentation of calculus of ureter	852
Total:		**3,617**

The impact on individual sites is highlighted in the table to the right. A detailed breakdown of the procedures transferring, and the volumes which are expected to transfer from each acute site, are detailed within Appendix.2.

Current Acute Sites from which Procedures are Delivered:	Total Transfer of Activity by Site
Total Activity (based on FY17/18 activity):	**3,617**

Note: The activity data detailed in both tables includes both the adult and the paediatric activity. Further engagement with the Paediatric T&F Group will be required to ensure continued alignment in terms of future delivery models.

Analysis of Daycase v Inpatient Split & Variations in Practice

DC v IP Performance Assessed Against BADS Best Practice

The British Association of Day Surgery (BADS) published regular guidance around best practice splits of procedures carried out in both a daycase and an inpatient setting. These performance metrics are considered best practice.

Given that performance at the DECCs will be unencumbered by unscheduled activity, and their being setup to optimise patient throughput and standardisation of practice, each should be targeting best practice performance levels.

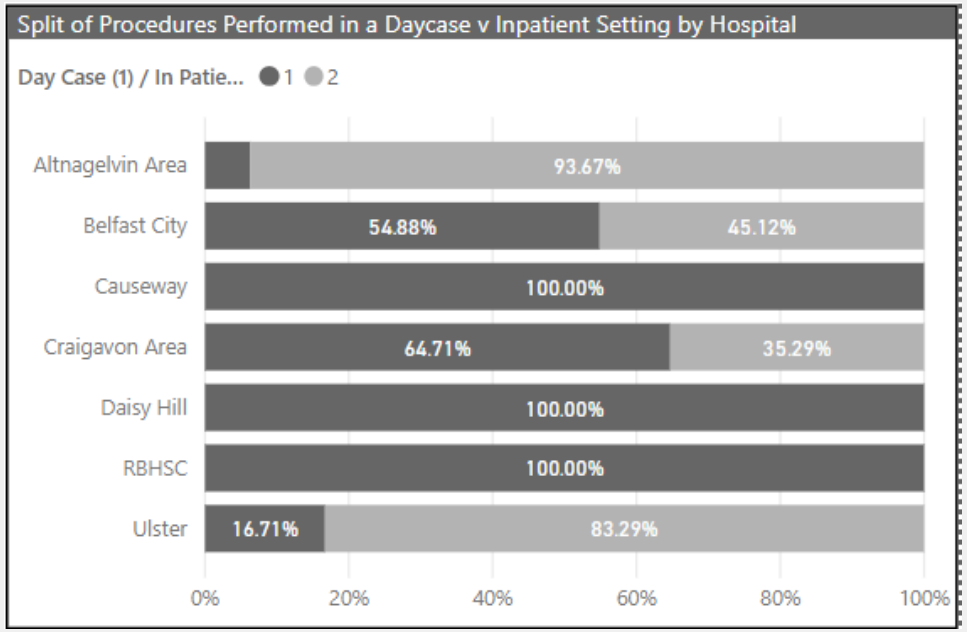
BADS best practice, in terms of the UK top quartile % of cases which should be delivered as a daycase as opposed to an inpatient, is considered in the table below alongside current performance within NI acute hospitals for each of the procedures which has been modelled as transferring to a DECC:

Procedure	BADS Best Practice	Current NI Hospital Performance
Endoscopic extirpation of lesion of bladder (TURBT) *(BADS ref: Endoscopic resection of bladder)*	**60%**	**19%**
Endoscopic resection of outlet of male bladder (TURP) *(BADS ref: Resection of prostate)*	**80%**	**8%**
Endoscopic insertion of prosthesis into prostate (Urolift)	**No data available**	**33%**
Ureteroscopies *(BADS ref: Other endoscopic procedures on ureter)*	**90%**	**66%**
Extracorporeal fragmentation of calculus of ureter / kidney (ESWL)	**No data available**	**98%**

Variations in Practice Across NI Hospitals

Key to driving efficient and effective performance within the DECCs will be development of consistent regional patient pathways and standardised practice within daycase theatres / procedure rooms.

The graphic below highlights the variations in practice, in terms of patients being treated for the procedures noted on the right of this page as either a daycase or an inpatient, across the existing acute hospitals. Whilst local variations in practice have often evolved, with extremely valid clinical justifications, agreeing a consistent approach across the DECCs (as well as any acute hospitals which continue to operate on those procedures) will ensure equality and adherence to agreed best practice across the region.



Section 3

Location Analysis

Assessing the suitability of DECC locations for Urology daycase surgery

The Urology T&F Group were asked to consider 12 potential sites in terms of their suitability to deliver Urology daycase procedures. To support this exercise, the group were provided with a number of evidence sources including; travel time analysis and details of numbers of patients referred from within 30, 60 & 90 minutes of each site.

The group were asked to consider 13 design principles and to identify those which were most important when assessing each site in terms of its suitability to deliver Urology elective daycase procedures. Each design principle was given a weighting, based upon its perceived level of importance, with 1 being 'least important' and 5 being 'most important'. The design principles which were deemed to be the most important to the Urology T&F Group were identified as being:

Key design principles for Urology DECCs:		Average Weighting
1=	Proximity to existing services and workforce (travel time)	4.5
1=	Proximity of acute hospital in the event of patient transfer	4.5
1=	Availability of specialist equipment	4.5
1=	Availability of clinical support services - diagnostics, decontamination services etc	4.5
2.	Key infrastructure considerations including both staff and patient parking	4
3.	Specialist theatre / procedure room requirements (i.e. laminar flow)	3.5
4.	Specific ICT requirements	3
5.	Facilities and access for specific patient cohorts (i.e. reduced mobility, disabled patients etc)	3
6.	Proximity of patient cohort (% of specialty referrals / population) within 30, 60 & 90min isochrones	2.5
7.	Availability of other facilities / spaces - i.e. recovery space, lecture / training / research rooms	2.5
8.	Availability of complex anaesthetic services	2.5
9.	Availability of specific child-friendly facilities	1
10.	Specific cultural considerations (i.e. prayer rooms etc)	1

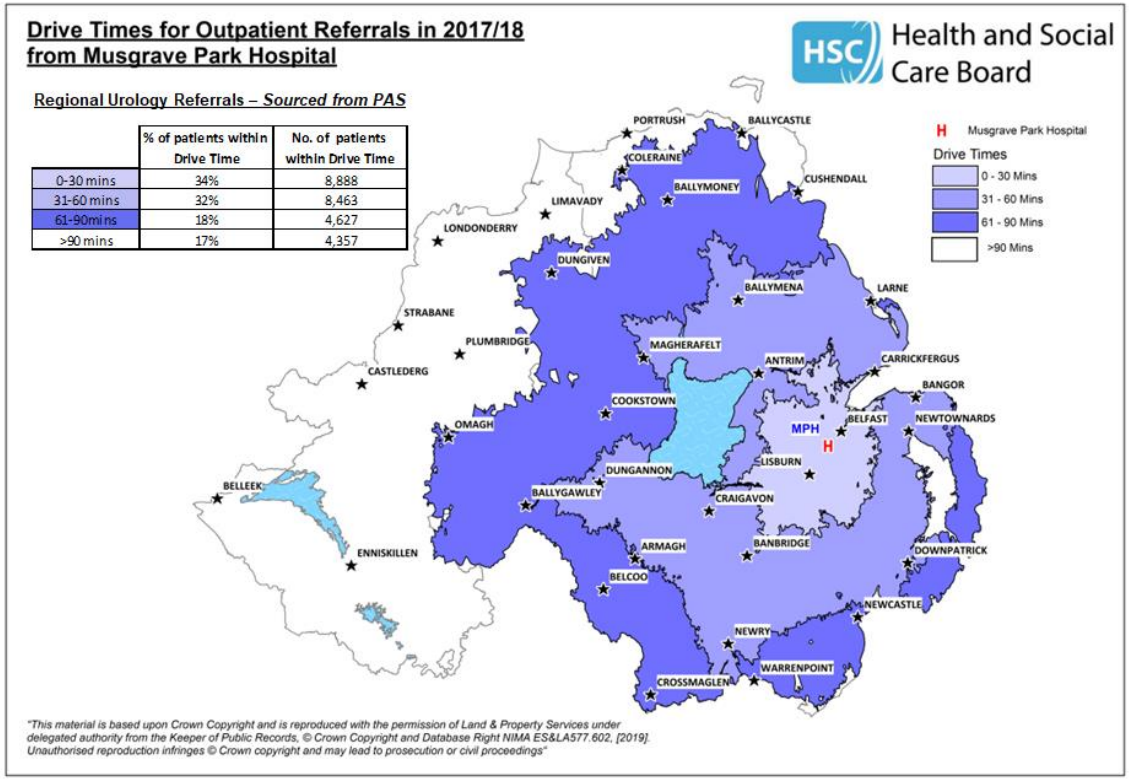
Standalone Site v Protected Site within an Acute Campus

The Urology group considered each of the 12 sites (of which 7 were standalone sites and 5 were sites within a wider acute campus – a full list is provided within Appendix.1) in terms of the service's requirements in terms of a standalone site or else a protected site within a wider campus. **The group concluded that, given the workforce requirements and procedure types, the most appropriate location would be a co-located site on a wider acute campus.**

Analysis of Sites by Travel Times & Population Proximity

To support the T&F Group in considering each site's suitability, each of the potential DECC locations has been analysed in terms of its geographic location and travel times for that specialty's patient cohort (30, 60 and 90 minute travel isochrones) based on the location from which the Urology referral was initiated.

Drive time analysis for each of the 12 sites is included within Appendix.4.
The graphic below demonstrates the output for a single hospital, Musgrave Park.



Source: *This analysis was provided by the Performance Management and Information Services Team at the HSCB.*

Travel Time Analysis (for Urology Referrals) by Potential DECC Location:

Hospital Site	% of Referrals *0-30mins*	% of Referrals *31-60mins*	% of Referrals *61-90mins*	% of Referrals *>90mins*
Daisy Hill Hospital	*6%*	*36%*	*30%*	*28%*
Musgrave Park Hospital	*34%*	*32%*	*18%*	*17%*
Mater Hospital	*39%*	*29%*	*17%*	*14%*
Ulster Hospital DSU	*21%*	*31%*	*24%*	*24%*
Craigavon Hospital DPU	*7%*	*48%*	*26%*	*20%*
Lagan Valley Hospital	*33%*	*34%*	*15%*	*18%*
Downe Hospital	*2%*	*19%*	*41%*	*38%*
Causeway Hospital	*6%*	*9%*	*42%*	*43%*
Omagh Hospital & Primary Care Complex	*1%*	*15%*	*28%*	*56%*
South Tyrone Hospital	*6%*	*26%*	*53%*	*16%*
Whiteabbey Hospital	*34%*	*27%*	*22%*	*17%*
Mid Ulster Hospital	*6%*	*39%*	*37%*	*18%*

The above analysis considers each potential site, and it's population coverage, separately. A combination of sites (which may be considered by the T&F Groups) will allow regional coverage to be increased to a level which is deemed appropriate.

Section 4

Workforce Implications

Workforce Implications of Moving to a DECC Model

The Urology T&F Group were asked to consider some of the high level workforce implications, limitations and, where possible, opportunities as a result of moving to a DECC model. The key potential considerations and opportunities are outlined in the table below:

Potential Workforce Issues / Implications / Opportunities for the Urology Service

Category	Issues / Opportunities Noted	Potential Implications / Benefits
Issue / Consideration	▪ The location of the current Consultant workforce is a key consideration – given the small workforce within Urology, having Consultants travelling long distances to deliver elective surgeries is likely to be counter-productive	▪ Travel engrains inefficiency in the surgeon's week as they spend time travelling rather than operating ▪ Having the medical workforce travelling long distances from their current acute site to deliver elective surgeries will require travel PAs and may potentially be a less efficient delivery model ▪ The medical workforce will become frustrated at spending so much time travelling rather than delivering care ▪ Full day lists would drive efficiency and maximise patient throughput
	▪ There is unlikely to be capacity within existing job plans to accommodate additional daycase sessions, so the impact on both job plans and existing acute rotas will need to be carefully considered	▪ T&F Group will need to carefully consider and model what workforce capacity exists and to engage with clinicians around potential changes in job plans ▪ A decision will need to be reached as to how to staff the DECC sessions without impact existing inpatient cover and destabilising existing rotas
	▪ Already facing shortages and difficulty recruiting / retaining substantive nursing staff – the DECCs may further exacerbate this problem	▪ Potential inability to staff DECCs which sit outside of larger population centres ▪ The opening of DECCs may be attractive to the nursing workforce leading to a further reduction in numbers of nursing staff operating in acute centres – this will destabilise the existing acute system
	▪ There should be a core team of nursing staff, including specialist nurses, who remain at each DECC at all times	▪ Nursing team will become upskilled in certain elective procedures ▪ Will create a stable nursing workforce ▪ Potential that nursing teams will become disinterested by monotony of delivering a small basket of procedures on a daily basis

Workforce Implications of Moving to a DECC Model

The Urology T&F Group were asked to consider some of the high level workforce implications, limitations and, where possible, opportunities as a result of moving to a DECC model. The key potential considerations and opportunities are outlined in the table below:

Potential Workforce Issues / Implications / Opportunities for the Urology Service

Category	Issues / Opportunities Noted	Potential Implications / Benefits
Issue / Consideration	▪ Patient selection will be paramount and should include input from the anaesthetics team	▪ The triaging and scheduling of patients will present both a great opportunity to ensure the right patient cohort attends the DECC and also a level of complexity / risk
	▪ Lists should be scheduled to ensure more complex patients are seen in the morning and less complex are seen in the afternoon	▪ Will require a cohort of procedures which allows for scheduling of patients at different times of day based on procedural complexity ▪ Will reduce the risk of more complex patients requiring admission, later in the day, to an acute centre
	▪ Other considerations around; clinical support services (i.e. equipment sterilisation, pathology, a centralised scheduling and booking service, IT support etc) all need to be subject to further consideration and planning	▪ Without efficient services wrapping around the delivery of clinical services, the DECCs will be no more effective and efficient than the existing day surgery in acute settings ▪ A centralised booking service / system would be required
Opportunity	▪ There is an opportunity to recruit and train additional specialist nurses to deliver flexible cystoscopy procedures	▪ Creates opportunities for upskilling of nursing staff ▪ Frees up Consultant time to deliver more complex procedures ▪ Reduced cost of delivery model
	▪ There is scope to better utilise either on-site lithotripters (limited capacity available at present) or the cost-effective mobile unit for ESWL	▪ Opportunity to reduce numbers of ureteroscopies and release capacity ▪ Mobile units are a cost effective solution for delivering procedures (NICE)
	▪ The DECC creates an opportunity for nursing staff career progression through taking on additional procedures, up-banding of nurses on elective care sites would be required to allow them to deliver certain procedures	▪ Creates career opportunities for nursing staff who are willing to take on additional responsibility at a DECC ▪ Up-banded positions may be extremely attractive to nursing staff working in existing acute hospitals and may lead to a reduction in nursing staff in those centres

Section 5

Key Next Steps

Key Next Steps

The T&F Group has made considerable progress, over the past few months, in developing a robust vision for the future of daycase elective care across Northern Ireland. Following on from this work, and considering the future roles of the Urology T&F Group, there are a number of activities which we consider to be key as the process moves towards detailed design and implementation. Some of these activities are considered below:

Category	Category Detail	Key Activities Identified	Indicative Timelines
Workforce	▪ Workforce has been consistently highlighted by the T&F Group as being a key rate limiting factor in acute hospitals, particularly in Urology given the small team and number of vacant roles, as well as a potential risk factor in delivering a new model for elective care ▪ The workforce implications of the DECCs, based on the proposed transfer of activity, need to be considered and modelled in detail to understand the viability of the proposals	▪ A detailed analysis of Urology workforce requirements and implications, including the impact which the opening of DECCs may have on the operational stability of existing acute hospitals, should be undertaken as soon as possible ▪ Consideration should also be given to how the staffing of DECCs aligns with wider Urology workforce considerations as outlined in the '*Urology Medical Workforce Planning Report for Northern Ireland 2017-2024*'.	Immediate
Urology Data	▪ Issues around the granularity of Urology activity data have been flagged by the T&F Group on a number of occasions, Work has been done, alongside the Clinical Leads, to reconcile the most appropriate procedures for a DECC to the aggregated data provided by the HSCB	▪ Clinical Leads to review the procedures modelled and ensure that the identified basket of procedures are the most appropriate procedures to deliver from a DECC ▪ A further piece of work, around the aggregate coding of Urology data, would support better understanding of performance data	Immediate
Key Detailed Design and Implementation Considerations	▪ Each T&F Group will need to adopt a robust project management approach, including developing a detailed implementation roadmap which outlines the key activities, timelines and individuals responsible for implementing the new delivery model	▪ Implementation of robust project management methodologies and tools to ensure successful planning and delivery ▪ Development of an implementation roadmap ▪ Putting in place a project team with the capabilities and knowledge needed to drive the detailed design and implementation phases of this programme	Immediate
Operational Governance	▪ The wider DECC Programme, as well as the individual T&F Groups, will need to consider the governance arrangements which wrap around the future delivery of elective care	▪ Design of governance arrangements around; management of referrals, regional pooling waiting of lists, patient scheduling and standardisation of care pathway	Autumn 2019

Section 6

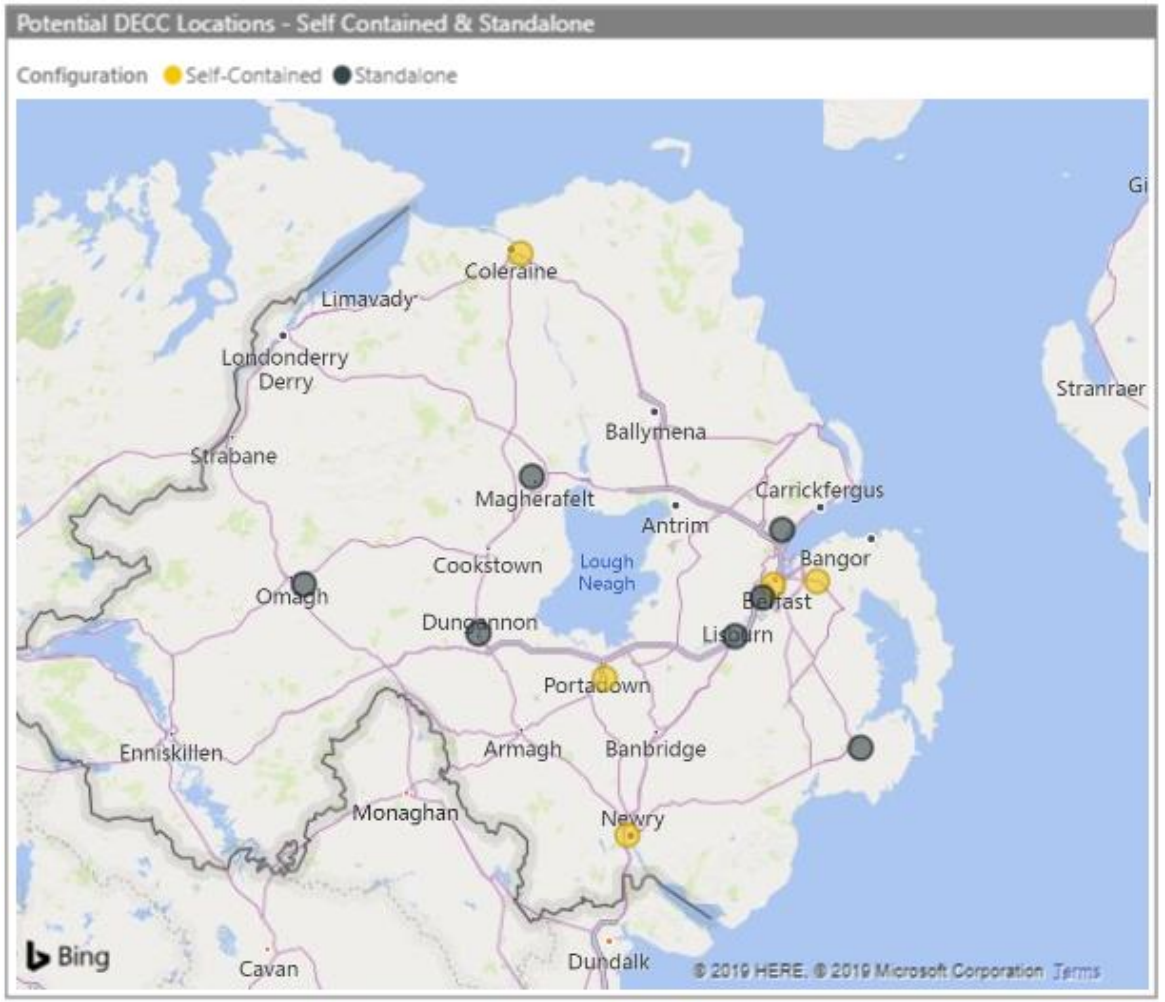
Appendices

Appendix 1
Potential DECC Locations

Potential DECC Locations

12 potential locations for Daycase Elective Care Centres (DECCs) were identified by the Programme Board, with 7 sites being standalone ambulatory centres and 5 sites being self-contained ambulatory centres on a larger acute site. The list of sites is detailed below

Category	Potential Sites for Consideration by the T&F Groups
Standalone Ambulatory Centres	▪ Downe Hospital ▪ Lagan Valley Hospital ▪ Mid-Ulster Hospital ▪ Musgrave Park Hospital ▪ Omagh Hospital and Primary Care Complex ▪ South Tyrone Hospital ▪ Whiteabbey Hospital
Self-Contained Ambulatory Centres on a Larger Acute Site	▪ Craigavon Hospital DPU ▪ Daisy Hill Hospital ▪ Ulster Hospital DSU ▪ Mater Hospital ▪ Causeway Hospital



Appendix 2
Breakdown of Urology Procedures Coded within the Model

Breakdown of Urology Procedures Coded within the Model

Granular Breakdown of the Urology Procedures Coded within the Model (Page 1 of 3)

As noted previously, there are some complexities in the coding of Urology data which are driven by cohorts of similar procedures being aggregated to a level which makes them unrecognisable to the T&F Groups and clinicians.

Following discussion with the Clinical Leads, the procedures in column 1 were identified as being the right procedures to deliver from a DECC (as they are known clinically). The HSCB then provided a breakdown of the codes against which those procedures have been recorded (column 2 - these are at a disaggregated level which is below the level used in the demand v capacity model) with further discussions then taking place with the Clinical Leads to confirm that these procedures were suitable for the DECCs.

The model has then used the aggregated procedure codes to identify the correct procedure description (column 3) which has then been modelled.

Name of Procedure (Provided by Clinical Leads)	Procedure Descriptions (disaggregated as provided by HSCB)	Procedure Description (as modelled at an aggregate level)
TURBT (Trans Urethral Removal of Bladder Tumour)	Endoscopic resection of lesion of bladder	*Endoscopic extirpation of lesion of bladder*
	Endoscopic cauterisation of lesion of bladder	
	Endoscopic destruction of lesion of bladder NEC	
	Other specified	
	Unspecified	
TURP (Trans Urethral Resection of Prostate)	Endoscopic resection of prostate using electrotome	*Endoscopic resection of outlet of male bladder*
	Endoscopic resection of prostate using punch	
	Endoscopic resection of prostate NEC	
	Endoscopic resection of prostate using laser	
	Endoscopic resection of prostate using vapotrode	
	Other specified	
Urolift	Endoscopic insertion of prosthesis to compress lobe of prostate	*Endoscopic insertion of prosthesis into prostate*
Laser Prostatectomy	Endoscopic resection of prostate using laser	*Endoscopic resection of outlet of male bladder*
ESWL (Extracorporeal Shock Wave Lithotripsy)	Extracorporeal shock wave lithotripsy of calculus of kidney	*Extracorporeal fragmentation of calculus of kidney*
	Extracorporeal shockwave lithotripsy of calculus of ureter	*Extracorporeal fragmentation of calculus of ureter*

Breakdown of Urology Procedures Coded within the Model

Granular Breakdown of the Urology Procedures Coded within the Model (Page 2 of 3)

Name of Procedure (Provided by Clinical Leads)	Procedure Descriptions (disaggregated as provided by HSCB)	Procedure Description (as modelled at an aggregate level)
Ureteroscopies	Ureteroscopic laser fragmentation of calculus of ureter	*Therapeutic ureteroscopic operations on ureter*
	Ureteroscopic fragmentation of calculus of ureter NEC	
	Ureteroscopic extraction of calculus of ureter	
	Ureteroscopic insertion of ureteric stent	
	Ureteroscopic removal of ureteric stent	
	Ureteroscopic endoluminal balloon rupture of stenosis of ureter	
	Ureteroscopic dilation of ureter	
	Other specified	
	Unspecified	
	Endoscopic laser fragmentation of calculus of ureter NEC	*Other endoscopic removal of calculus from ureter*
	Endoscopic fragmentation of calculus of ureter NEC	
	Endoscopic extraction of calculus of ureter NEC	
	Endoscopic catheter drainage of calculus of ureter	
	Endoscopic drainage of calculus of ureter by dilation of ureter	
	Other specified	*Other endoscopic removal of calculus from ureter*
	Unspecified	

Breakdown of Urology Procedures Coded within the Model

Granular Breakdown of the Urology Procedures Coded within the Model (Page 3 of 3)

Name of Procedure (Provided by Clinical Leads)	Procedure Descriptions (disaggregated as provided by HSCB)	Procedure Description (as modelled at an aggregate level)
Ureteroscopies	Endoscopic extirpation of lesion of ureter	*Other therapeutic endoscopic operations on ureter*
	Endoscopic insertion of tubal prosthesis into ureter NEC	
	Endoscopic removal of tubal prosthesis from ureter	
	Endoscopic dilation of ureter	
	Endoscopic renewal of tubal prosthesis into ureter	
	Other specified	
	Unspecified	
	Endoscopic retrograde pyelography	*Diagnostic endoscopic examination of ureter*
	Endoscopic catheterisation of ureter	
	Endoscopic ureteric urine sampling	
	Diagnostic endoscopic examination of ureter and biopsy of lesion of ureter NEC	
	Diagnostic endoscopic examination of ureter and biopsy of lesion of ureter using rigid ureteroscope	
	Other specified	
	Unspecified	

Appendix 3
Activity Transferring from Existing Acute Sites

Activity Transferring from Existing Acute Sites

Urology Procedures Proposed by Specialty

The table below details the procedures which the Urology T&F Group have agreed as being appropriate for a DECC and have been modelled in terms of moving the procedure out of the current acute sector and into a DECC. The data captures all procedures (delivered in both daycase and inpatient setting) in FY17/18:

Current Sites from which Procedures is Delivered:	Procedures Modelled Current Activity Levels (FY17/18 Admissions)									Total Transfer of Activity by Site
	Endoscopic extirpation of lesion of bladder	Endoscopic resection of outlet of male bladder	Endoscopic insertion of prosthesis into prostate	Therapeutic ureteroscopic operations on ureter	Other endoscopic removal of calculus from ureter	Other therapeutic endoscopic operations on ureter	Diagnostic endoscopic examination of ureter	Extracorporeal fragmentation of calculus of kidney	Extracorporeal fragmentation of calculus of ureter	
Altnagelvin Area	225	130	1	104	1	92	18	-	-	**571**
Ards	11	-	-	-	-	4	-	-	-	**15**
Belfast City	320	72	3	227	1	284	76	413	41	**1,437**
Causeway	10	19	1	140	-	16	12	68	20	**286**
Craigavon Area	181	100	-	83	4	153	19	305	5	**850**
Downe	3	-	-	-	-	2	-	-	-	**5**
Lagan Valley	8	-	-	-	-	3	-	-	-	**11**
Mater Infirmorum	19	-	-	-	-	-	-	-	-	**19**
South Tyrone	2	-	-	1	-	1	-	-	-	**4**
Omagh Hospital & Primary Care Complex	-	-	-	-	-	23	-	-	-	**23**
Ulster	155	58	-	120	4	49	9	-	-	**395**
Whiteabbey	-	-	-	-	-	1	-	-	-	**1**
Total Attendances (FY17/18):	**934**	**379**	**5**	**675**	**10**	**628**	**134**	**786**	**66**	**3,617**

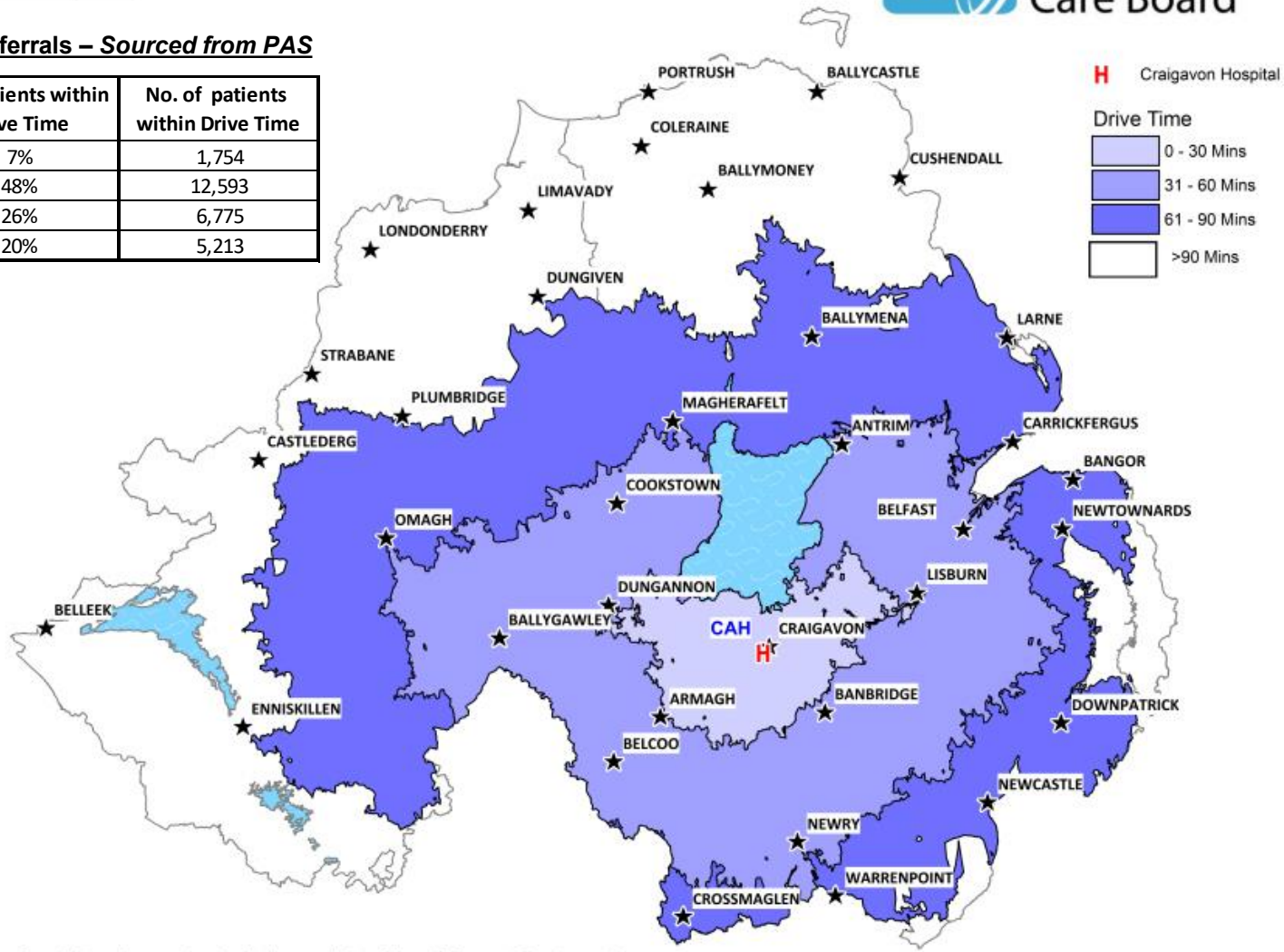
Appendix 4
Analysis of Travel Times – DECC Potential Locations

Drive Times for Outpatient Referrals in 2017/18 from Craigavon Hospital

HSC Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	7%	1,754
31-60 mins	48%	12,593
61-90mins	26%	6,775
>90 mins	20%	5,213

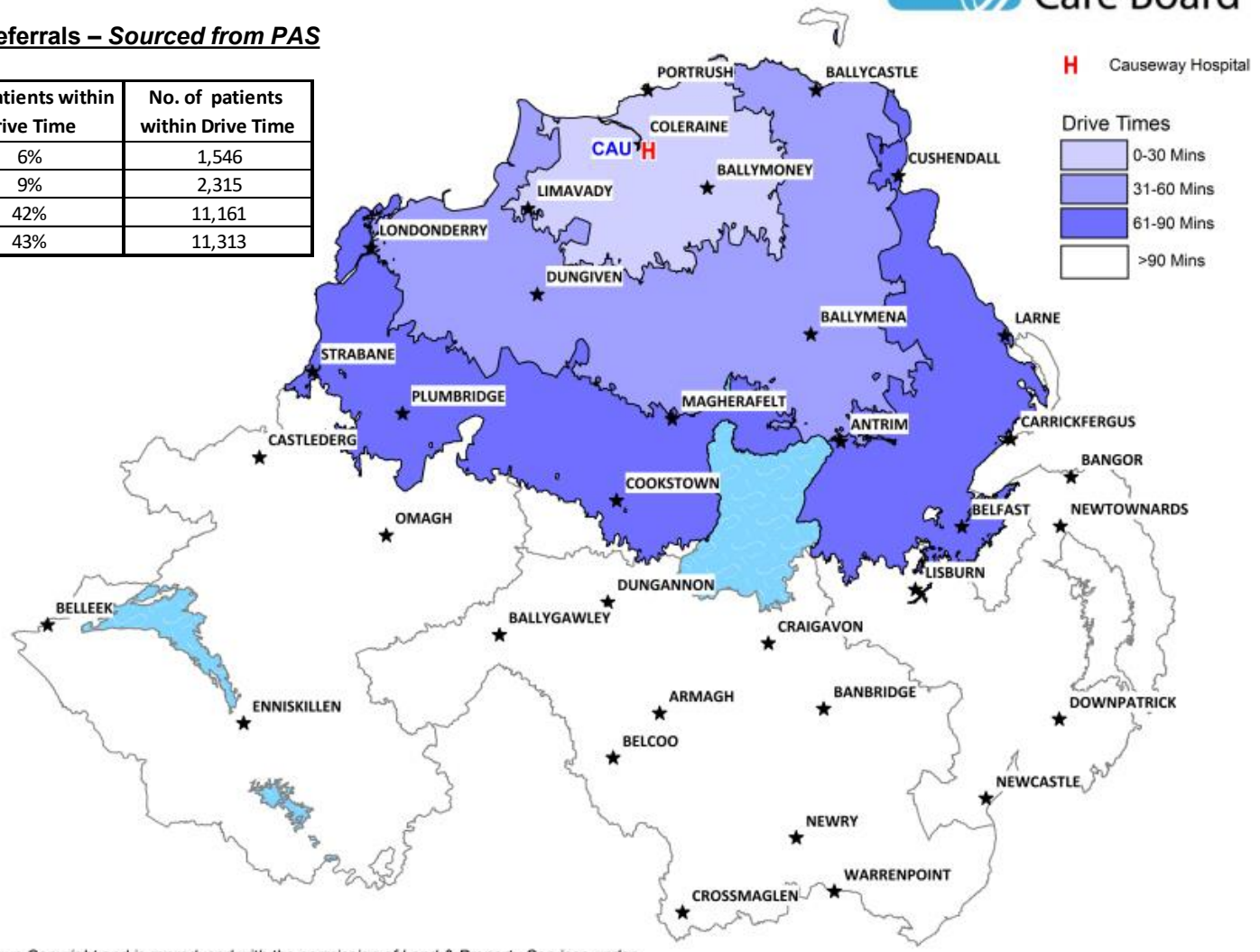


Drive Times for Outpatient Referrals in 2017/18 from Causeway Hospital

HSC Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	6%	1,546
31-60 mins	9%	2,315
61-90mins	42%	11,161
>90 mins	43%	11,313

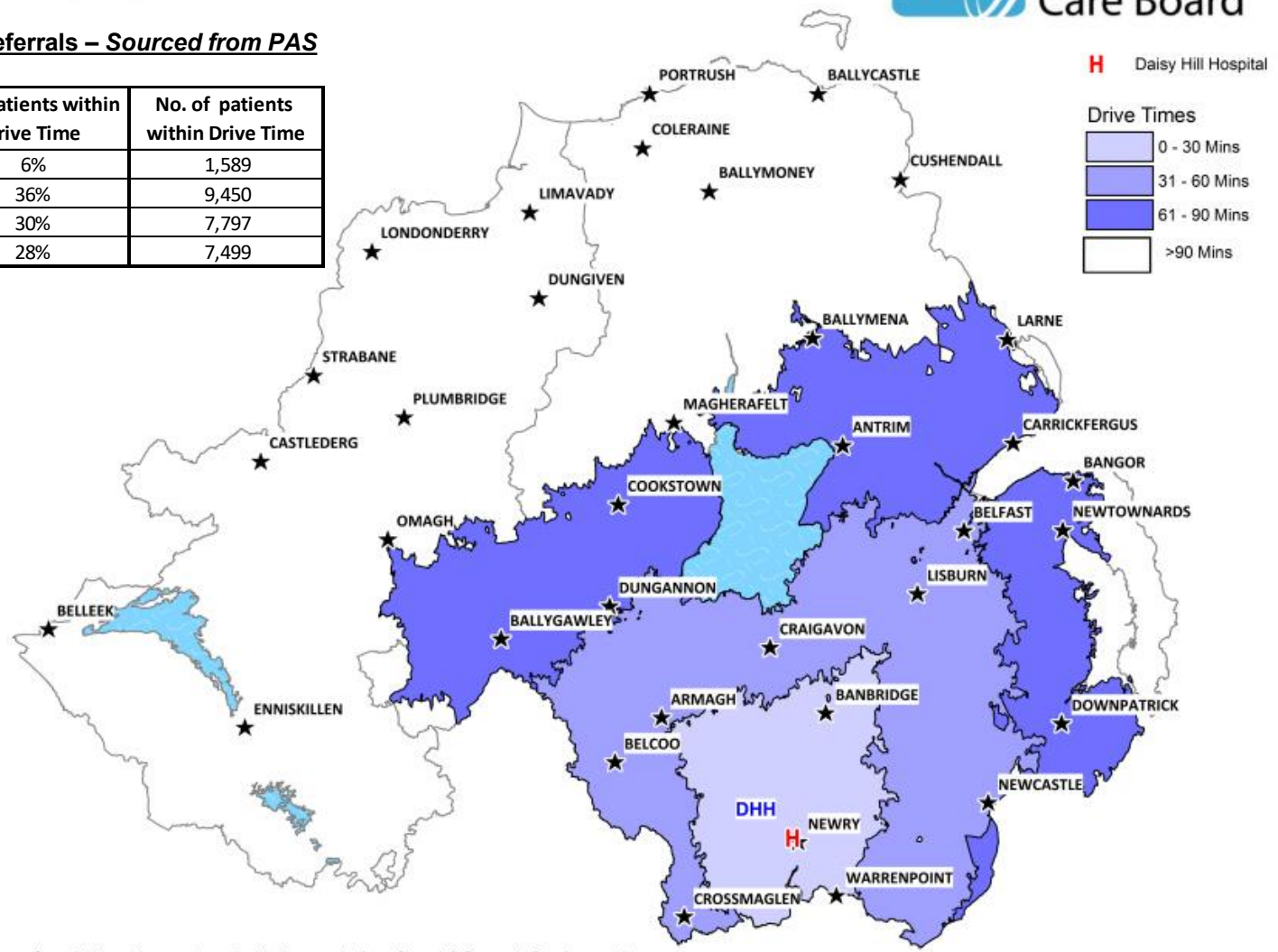


Drive Times for Outpatient Referrals in 2017/18 from Daisy Hill Hospital

Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	6%	1,589
31-60 mins	36%	9,450
61-90mins	30%	7,797
>90 mins	28%	7,499

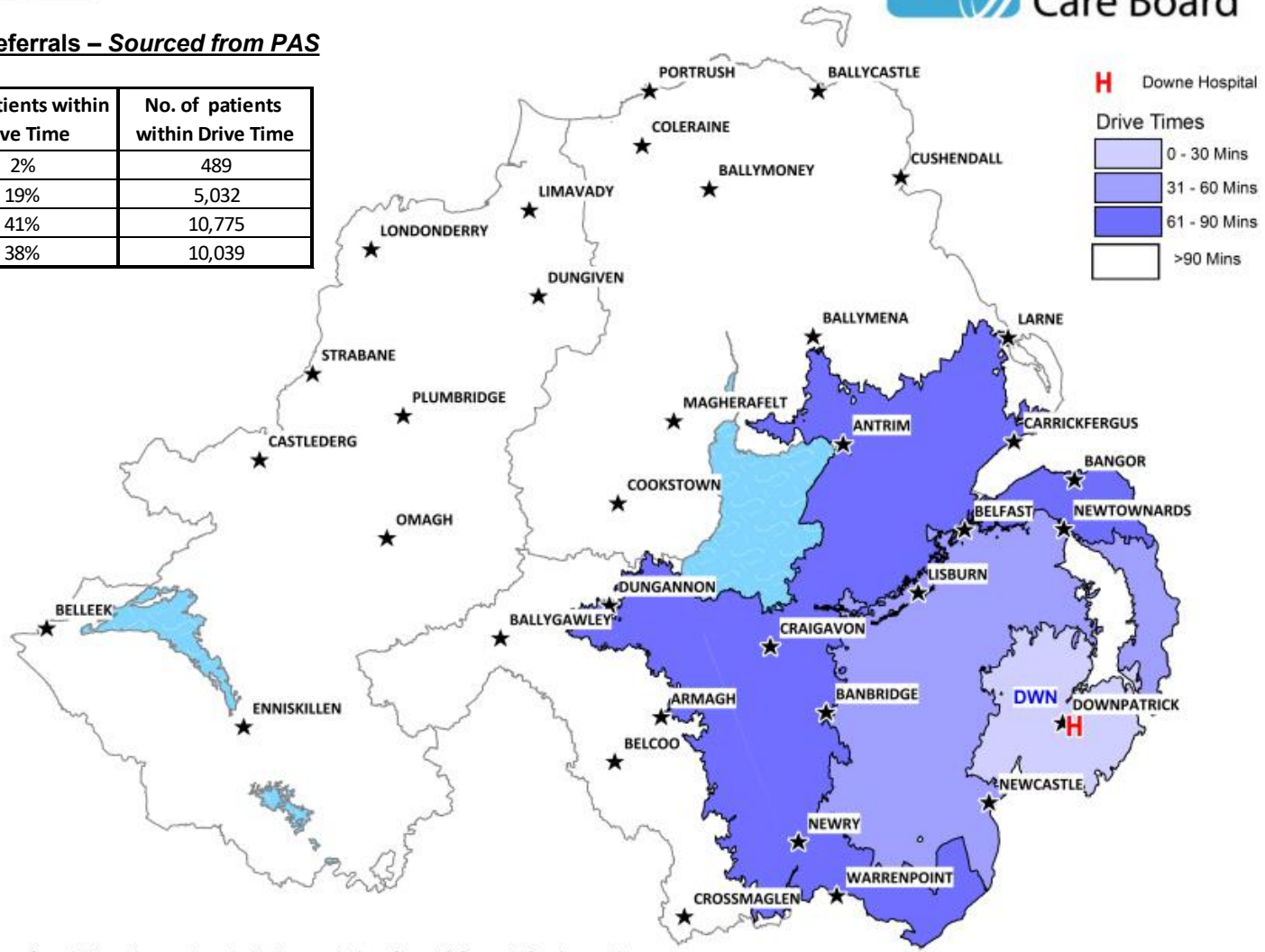


Drive Times for Outpatient Referrals in 2017/18 from Downe Hospital

Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	2%	489
31-60 mins	19%	5,032
61-90mins	41%	10,775
>90 mins	38%	10,039

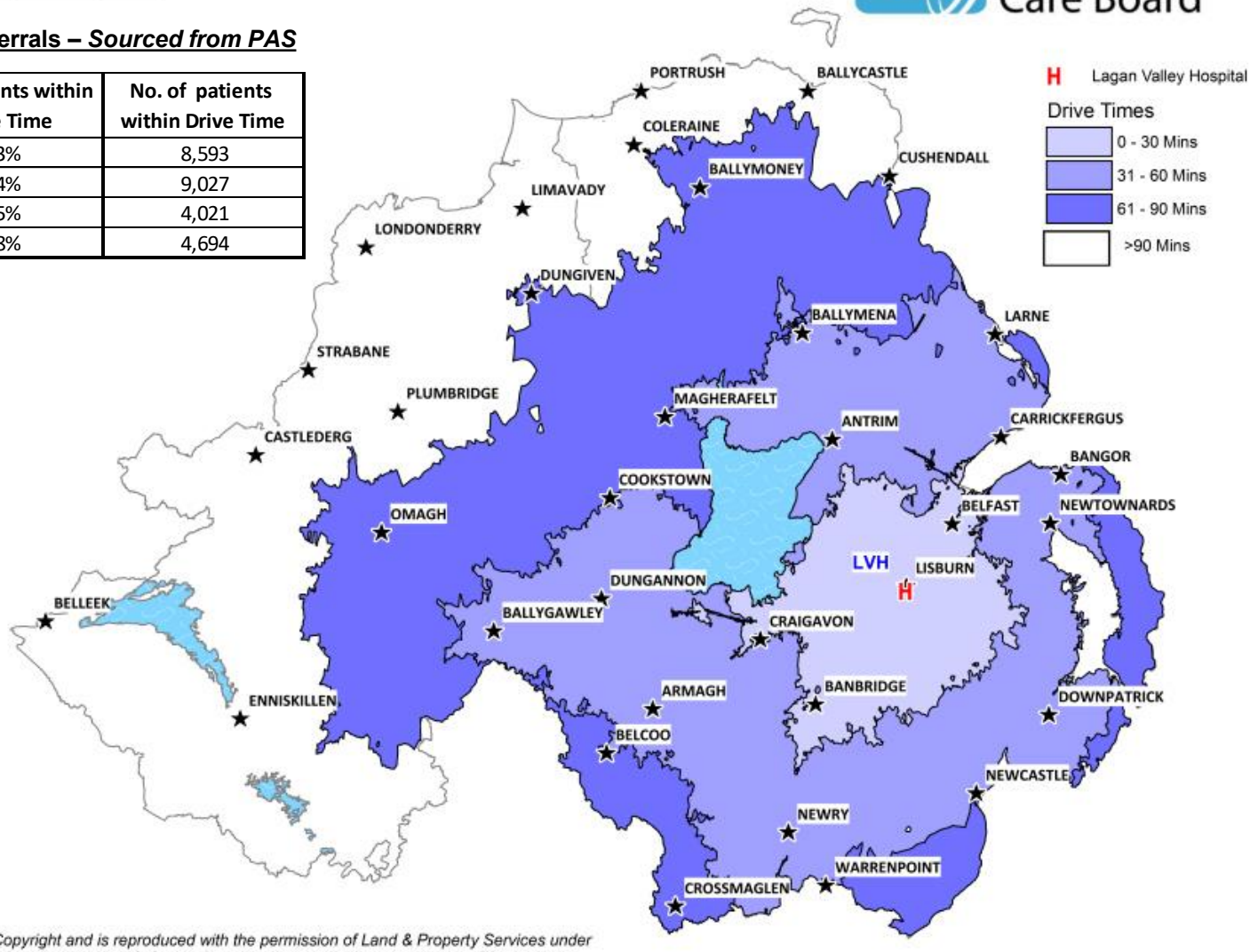


Drive Times for Outpatient Referrals in 2017/18 from Lagan Valley Hospital

Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	33%	8,593
31-60 mins	34%	9,027
61-90mins	15%	4,021
>90 mins	18%	4,694

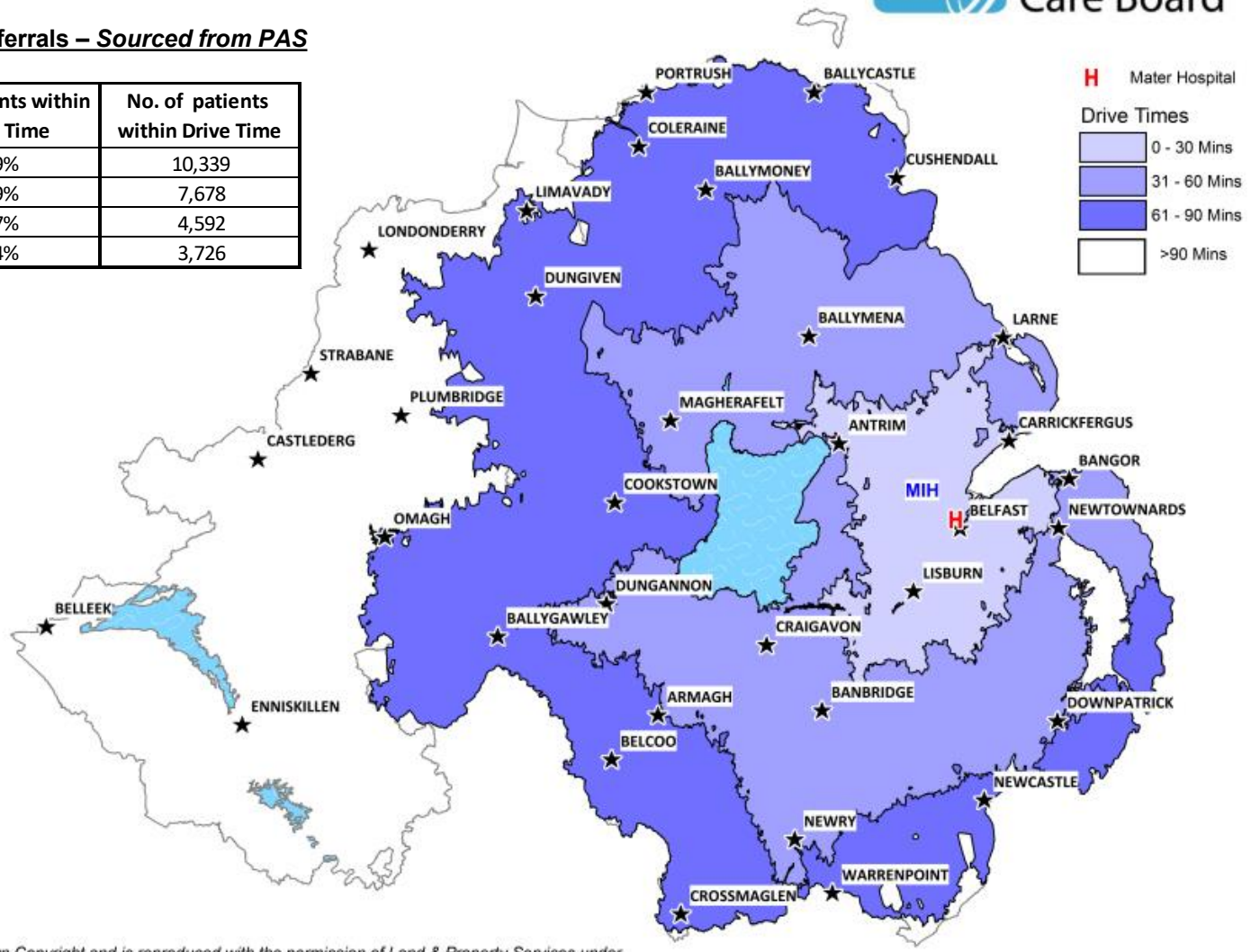


Drive Times for Outpatient Referrals in 2017/18 from Mater Hospital

HSC Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	39%	10,339
31-60 mins	29%	7,678
61-90mins	17%	4,592
>90 mins	14%	3,726

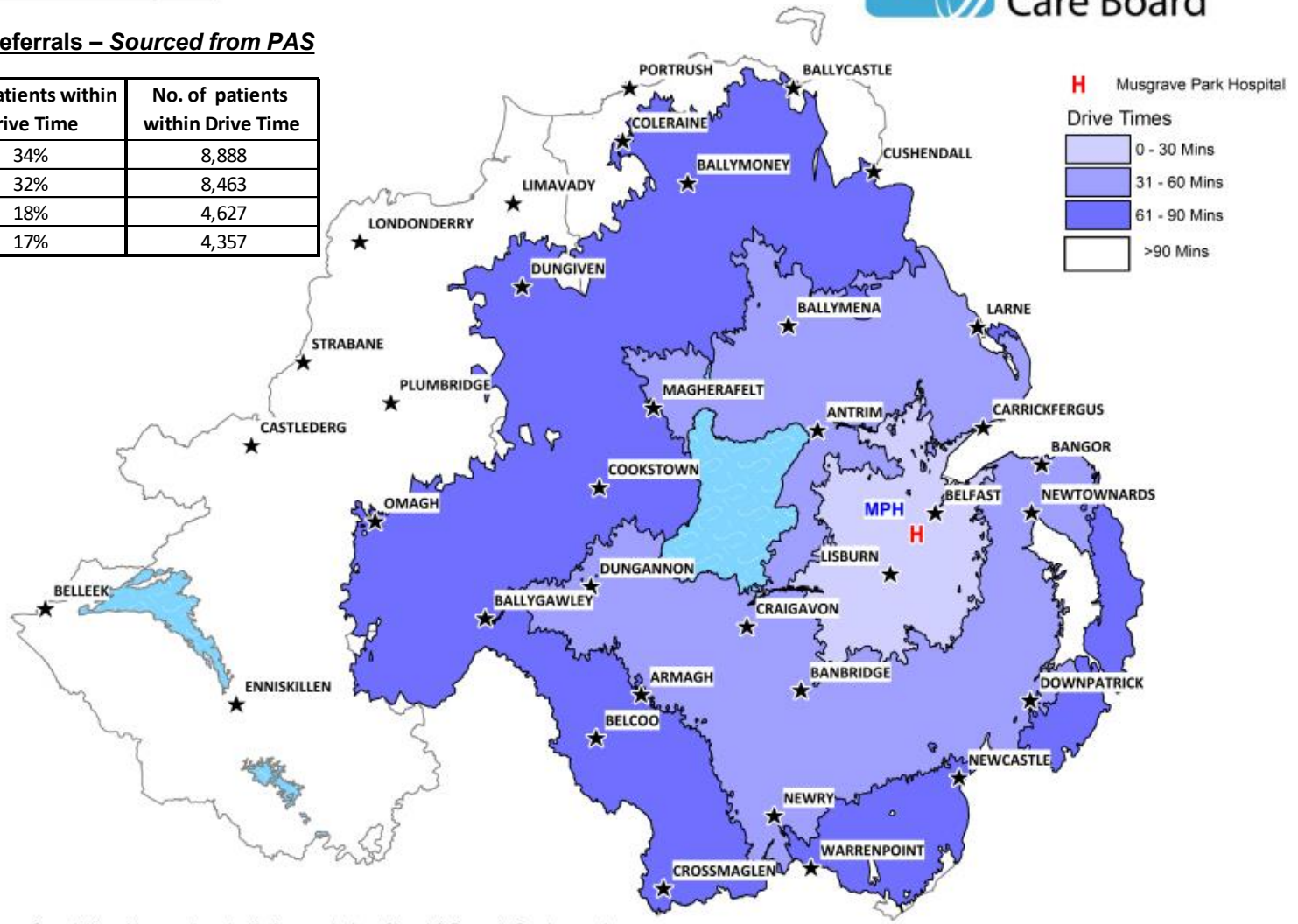


Drive Times for Outpatient Referrals in 2017/18 from Musgrave Park Hospital

Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	34%	8,888
31-60 mins	32%	8,463
61-90mins	18%	4,627
>90 mins	17%	4,357

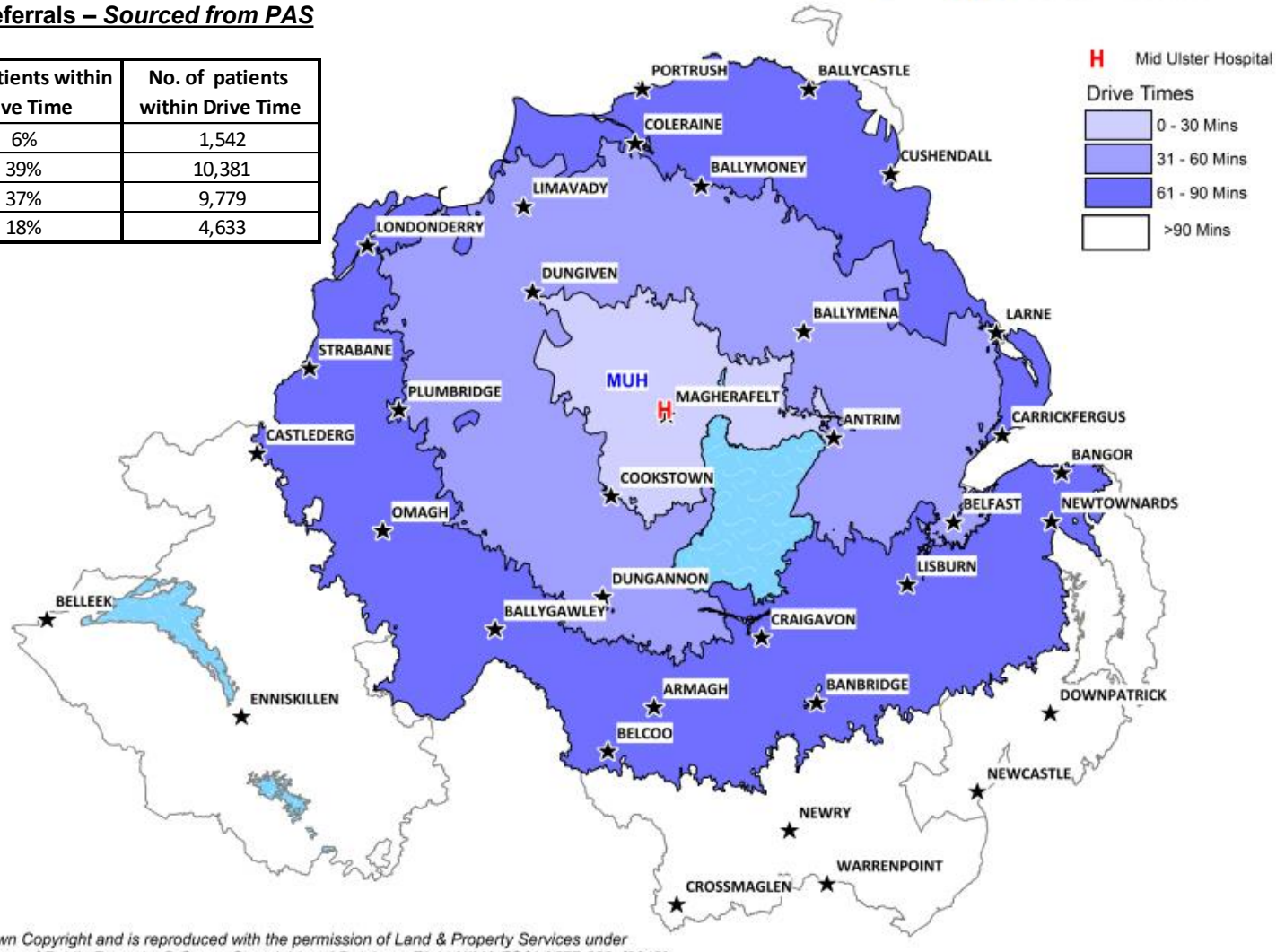


Drive Times for Outpatient Referrals in 2017/18 from Mid Ulster Hospital

HSC Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	6%	1,542
31-60 mins	39%	10,381
61-90mins	37%	9,779
>90 mins	18%	4,633

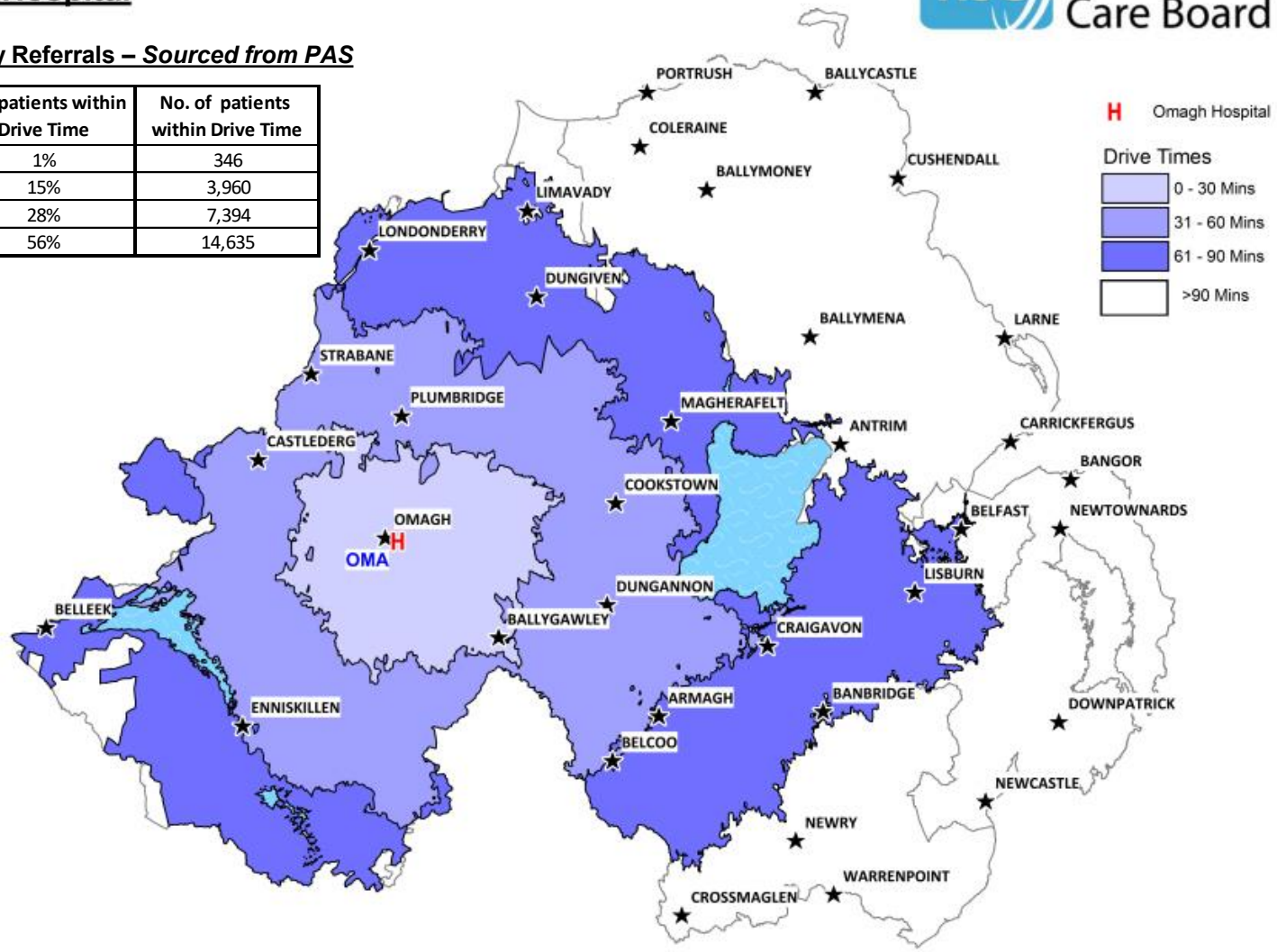


Drive Times for Outpatient Referrals in 2017/18 from Omagh Hospital

HSC Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	1%	346
31-60 mins	15%	3,960
61-90mins	28%	7,394
>90 mins	56%	14,635

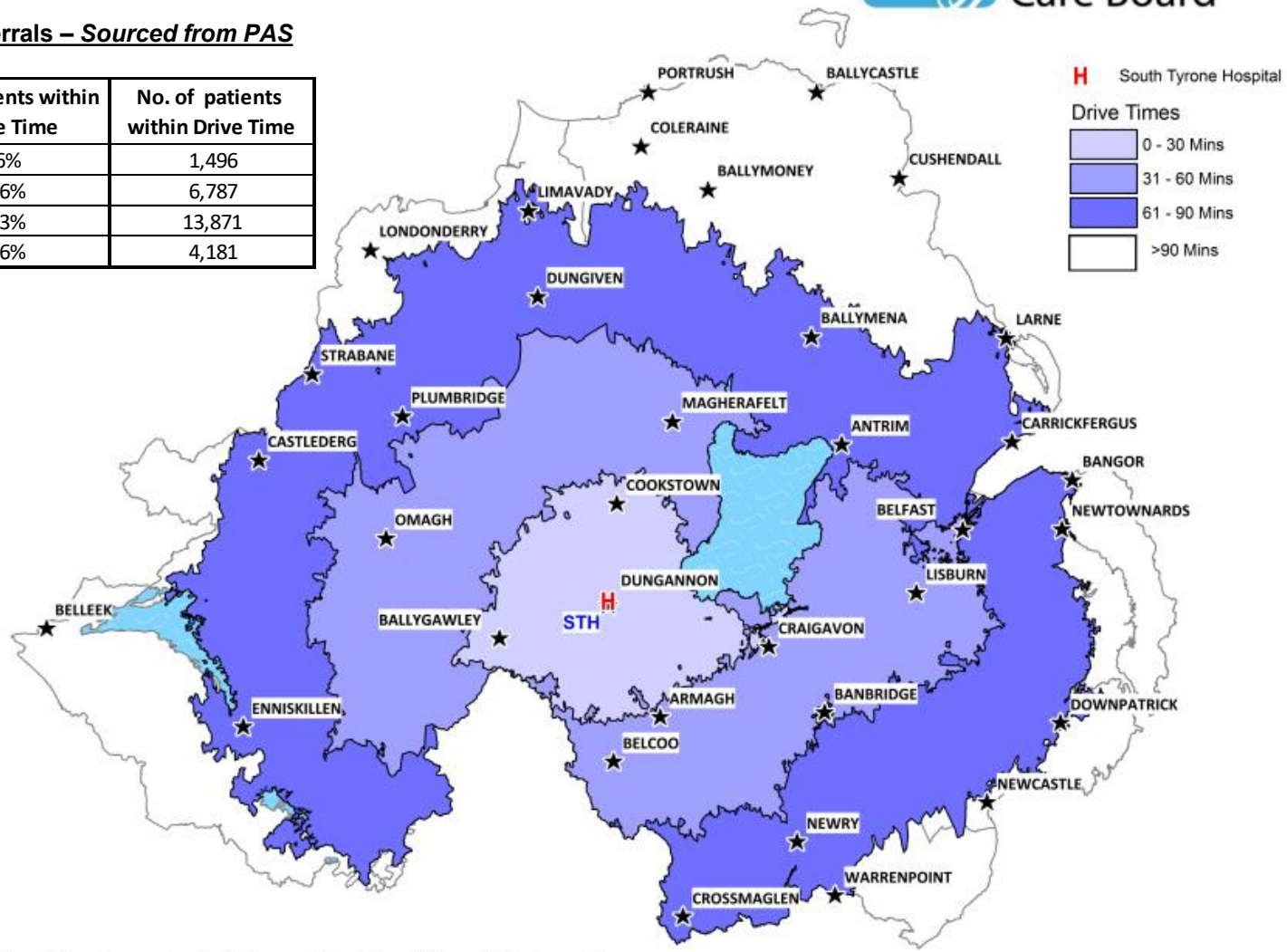


Drive Times for Outpatient Referrals in 2017/18 from South Tyrone Hospital

HSC Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	6%	1,496
31-60 mins	26%	6,787
61-90mins	53%	13,871
>90 mins	16%	4,181

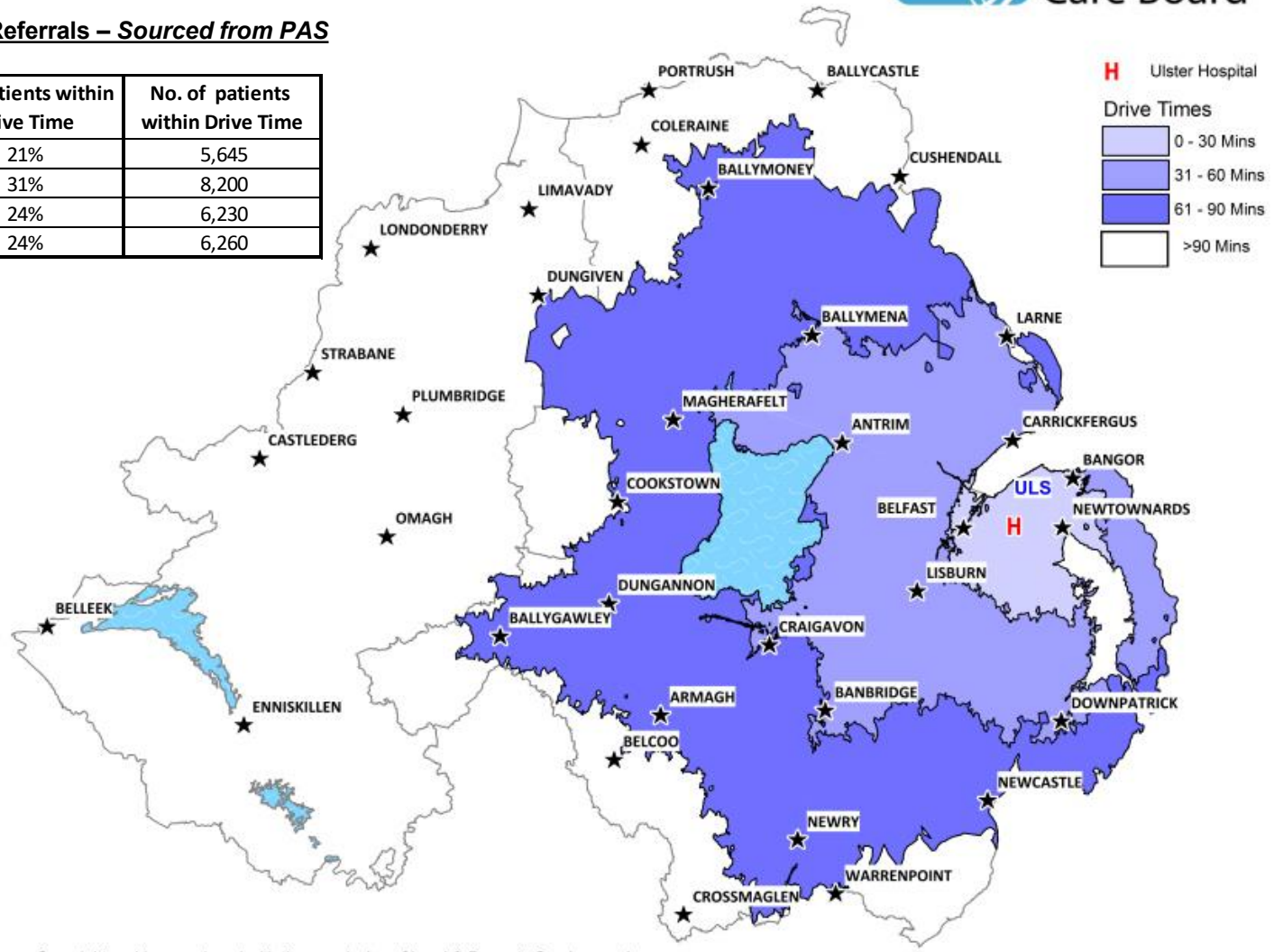


Drive Times for Outpatient Referrals in 2017/18 from Ulster Hospital

HSC Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	21%	5,645
31-60 mins	31%	8,200
61-90mins	24%	6,230
>90 mins	24%	6,260

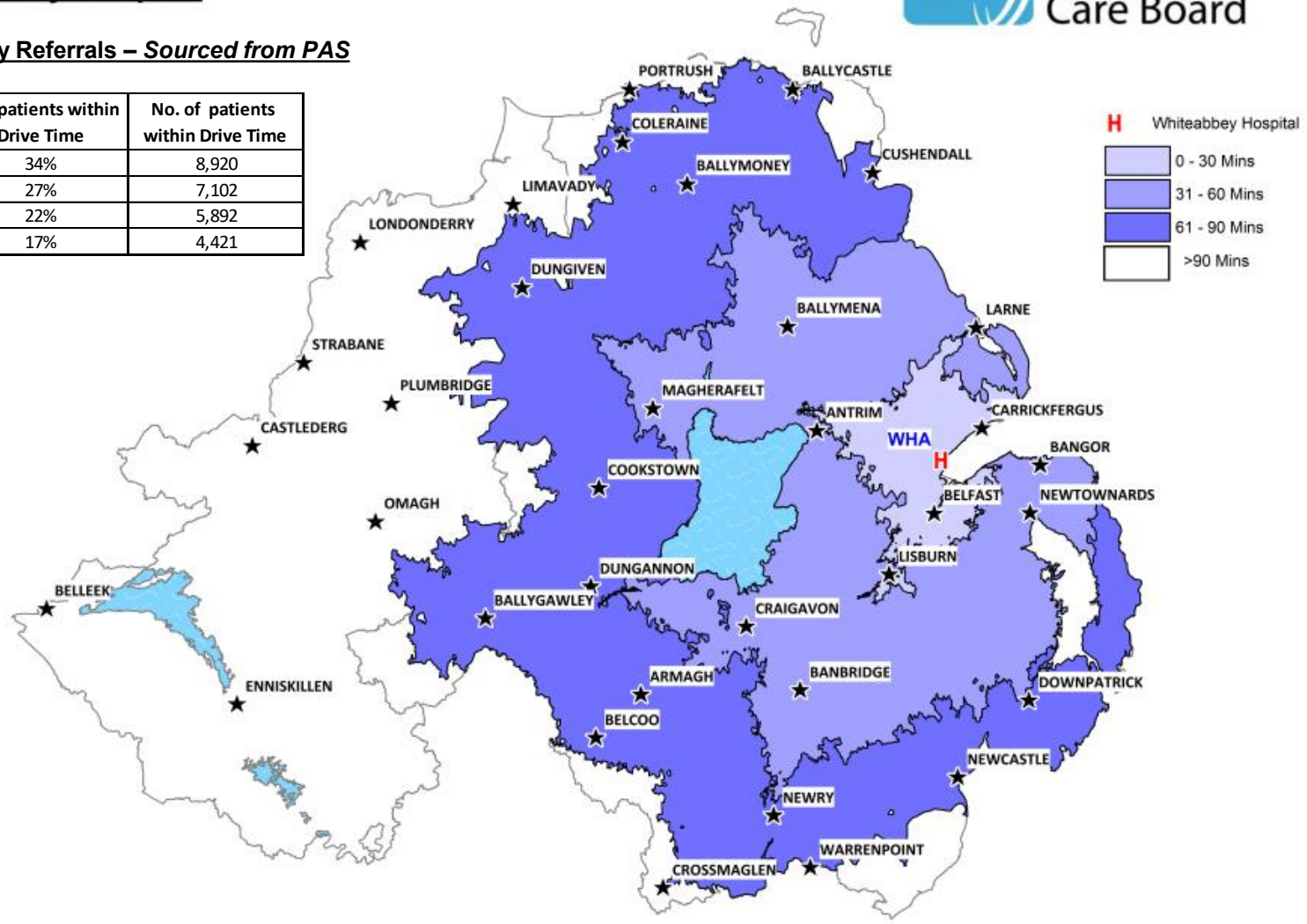


Drive Times for Outpatient Referrals in 2017/18 from Whiteabbey Hospital

HSC Health and Social Care Board

Regional Urology Referrals – *Sourced from PAS*

	% of patients within Drive Time	No. of patients within Drive Time
0-30 mins	34%	8,920
31-60 mins	27%	7,102
61-90mins	22%	5,892
>90 mins	17%	4,421



Urology Medical Workforce Planning Report

Northern Ireland 2017-2024

HSCB and PHA **March 2017**

1.Overview

The Medical Director /Director of Public Health for the Public Health Agency/Health and Social Care Board has been asked by the Department of Health (DoH) to take forward medical workforce planning for Northern Ireland for the period until 2019. This was previously under the auspices of the DoH Regional Workforce Planning Group and is currently sponsored by the Director of Workforce Policy, DoH. A Workforce Strategy for the HSC is a key element of ‘’Delivering Together’’.

Workforce plans for specialties are being developed speciality by specialty, under the direction of Dr Gillian Rankin. Urology has been identified as one of the current group of workforce plans to be developed.

The Urology Planning and Implementation Group led by the HSCB and PHA has a Workforce Subgroup which has been constituted to include clinicians and senior managers from all Trusts. This subgroup has formed the engagement group for the workforce planning process with the additions of representatives from both NIMDTA and BMA. The group is chaired by Lisa McWilliams, Assistant Director Scheduled Care, HSCB supported by senior HSCB and PHA staff who are leading on the modernisation of urology services, including the further development of Clinical Nurse Specialists. It is recognised that workforce planning is not commissioning, but rather a planning process to ensure the future workforce meets the population’s needs through investment in training, where necessary. The membership of the Workforce Subgroup is listed in Appendix A.

A review of urology workforce requirements for 2017-2024 commenced in mid -2016. This work included:

- A stocktake of the current urology medical workforce at all grades working in hospitals in NI
- The identification of a set of principles and standards for urology. These are based on the Royal College of Surgeons and the British Association of Urological Surgeons(BAUS) standards
- The determination of the medical workforce required to deliver the service in line with the agreed principles and standards
- Analysis of the impacts (where possible) of modernisation workstreams and strategic service change
- Analysis of the information from NIMDTA on trainee numbers, recent trends in recruitment of trainees, attrition rates and numbers of trainees exiting per year with CCT accreditation.

2. Summary of the Urology Workforce Review

- There are 23 permanent consultants in post with two vacancies and one locum. 26 consultant posts are recurrently funded
- The BAUS guidance for consultants is 1WTE per 60,000 population
- Projected for the population at 2024, the consultant requirement is 32.3WTE
- There are 7 predicted new CCT holders by 2022 and 5 potential retirements
- An additional 4 trainees are required and these new training posts could be accommodated as a group in addition to the existing 7 training posts
- If additional training posts are funded from August 2017, the new CCT holders could be ready for consultant posts by 2022 assuming no delay to completion of training
- A further 2 trainees may be required in 2019, after the quantification of the impacts of modernisation in urology on the workload of the consultant

3.Service context

The HSCB led the urology review and implementation of the current configuration of urology services in NI. This work was supported by Mr Mark Fordham, Urologist, representing BAUS.

Whilst the current service model has urological surgical inpatient procedures delivered in only four hospitals, there are outpatient clinics and day procedures delivered in the local hospitals across NI to provide improved access for the population.

The modernisation of urology services is an important element of the work of the Urology Planning and Implementation Group, including exploring the role of the Clinical Nurse Specialist. Clinical pathways for common conditions and reviews for patients with cancer are also being agreed and implemented.

While these developments are expected to have an impact on the current workload of doctors, it is not yet possible to quantify the actual impacts with certainty. It will also take several years to fully implement the role of Clinical Nurse Specialists with training and mentoring requirements.

4.Principles and service standards

The standard which has been identified in relation to the medical urology workforce is from the Royal College of Surgeons of England. The most recent version of this document is the 2011 report:

'Surgical Workforce 2011. A Report from the Royal College of Surgeons of England in collaboration with the surgical specialty associations' Royal College of Surgeons of England, 2011

Specialty recommendations for England, Wales and Northern Ireland:

'The British Association of Urological Surgeons (BAUS) recommends a consultant workforce ratio of 1:60,000 population.'

Other factors were considered by the workforce group as to what material impact they might have on the BAUS population standard stated above. These factors were:

- Adult N-code work (urology work previously undertaken by General Surgeons)
- Paediatric urological surgery
- BAUS guidance on outpatient clinic templates

These were discussed and it was concluded that no further adjustments to the projected workforce needed to be made to account for these factors at the present time.

5.Current medical staffing across NI

The current consultant and middle grade medical staff are set out in the tables below.

Table 1 Consultant workforce by Trust in NI as at October 2016 and from April 2017

Trust and hospital	Number of permanent consultants by headcount		Number of locum consultants by headcount		Number of vacant funded posts		Total funded posts	
	Oct 16	April 17	Oct 16	April 17	Oct 16	April 17	Oct 16	April 17
Belfast BCH	9	8	-	-	-	1	9	9
South Eastern UHD	3	4	-		1	0	4	4
Southern Craigavon	5	5	-		1	1	6	6
Western								
Altnagelvin	4	4	1	1	-		5	5
Causeway	2	2	-		-		2	2
Total	**23**	**23**	**1**	**1**	**2**	**2**	**26**	**26**

There are 24 posts filled including one post with a locum and there are 2 vacant consultant posts as at October 2016. Although there are changes to the consultants in 2 Trusts, the totals will remain unchanged at April 2017.

Table 2 Non consultant career grade (NCCG) doctors in urology in NI as at October 2016

Trust	Number of NCCG doctors	Number of vacant posts	Total number of permanently funded posts
Belfast	4 inc 2x Clinical Fellows	-	2.25
South Eastern	2*	-	2
Southern	0**	3**	3
Western	2	1 Altnagelvin	3
Total	**8**	**4**	**10**

*1 doctor currently on maternity leave and a locum covering the vacancy

**1 doctor has started in January 2017 working 0.5WTE

The table below sets out the estimated potential number of retirements in the speciality for the next 8 years. This is based on the assumptions that all surgeons over 60 years will retire, 50% of those between 55-59 years and 25% of those in the 50-54 year age band will retire.

Table 3 Consultant workforce in NI by age band as at October 2016

Trust	Number of consultants in age band 50-54 years	Number of consultants in age band 55-59 years	Number of consultants in age band >60 years	Estimated potential retirements in next 8 years
All Trusts	6	3	2	5

It is estimated that 5 urology surgeons may retire in the period of the next 8 years.

6.Trainees in urology in NI

Table 4 Trainee numbers in urology in NI from 2011 to 2016

Year of entry into specialist training	2012	2013	2014	2015	2016
Total training places	7	7	7	7	7

There are 7 training posts across all training grades at a point in time in NI. Doctors are appointed to these posts through a national selection process. If there is a vacancy in one of the training posts this post will be filled on a fixed term basis by a FTSTA or LAT appointment. There are several reasons why a training post may be vacant and these include maternity leave, going on Out of Programme training (OOPT)or Out of Programme Experience (OOPE)and rarely resignation from the training programme. The posts filled by FTSTA or LAT appointments will be used to recruit a trainee at the next selection round.

Table 5 Trainee numbers by Trust at August 2016

Training grade /Trust	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	Total
ST3						
ST4						
ST5				1	1	2
ST6						
ST7	1					1
FTSTA/LAT	1			1		2
OOP	2					2
Total	4			2	1	7

The appointment of doctors locally into two FTSTA/LAT posts rather than selection through the national scheme was due to:

- a resignation occurring just outside the annual selection process
- one trainee requiring an extended period of training in order to complete professional examinations

Table 6 Additional CCT holders by year

Year	2012	2013	2014	2015	2016
Number of new CCT holders	-	-	-	1	1

The low number of trainees achieving CCT during the years 2012-2014 was due to a combination of factors such as OOPE, OOPT, maternity leave and 1 trainee needing an extension to training to complete professional examinations.

Table 7 Predicted additional CCT holders by year

Year /grade	2016	2017	2018	2019	2020	2021	2022	2023
ST3		2*						
ST4			2					
ST5	2			2				
ST6		2			2			
ST7	1		2			2		
OOP	2**		2					
Total new CCT holders for year		1	2	2			2	
Summative total of predicted new CCT holders		1	3	5	5	5	7	

*2 ST3 posts will be appointed to commence speciality training in August 2017

** the two doctors currently on OOPE should both gain CCT in 2018

Within the current funded training programme there should be 7 doctors who gain CCT between 2017 and 2022. This assumes no attrition or delay to the achievement of CCT due to examination failure or a doctor requiring OOPT or taking OOPE.

7.Future Workforce requirements

A. Current gap in the consultant workforce to meet the BAUS standards

The BAUS standard is 1WTE for 60,000 population. The projected population for NI at 2024 is 1,939,000[1]. To meet this standard NI requires 32.32WTE at 2024.

There are currently 24 consultants in post including 1 locum consultant, while there are 26 funded consultant posts.

Therefore the WTE gap in headcount is 32.3 – 24 = 8.3WTE

B.Modernisation in urology

The impact of the modernisation workstreams on the consultant workforce is currently not quantified.

However it would be prudent to assume that there could be an impact on workload which may change the overall consultant requirement at 2024 given the gap of 7 years.

C.Requirements in consultant WTE to meet population needs including current vacant posts and retirements

Table 8 Consultant requirements taking account of projected population requirements, vacant posts and potential retirements

A Projected consultant requirements for 2024 population	B Current consultants in post	C Gap in consultant numbers	D Potential retirements	E Total additional consultants by WTE (C+D=E)
32	24	8	5	13

The total number of additional consultants needed to meet the population needs in 2024 is 13, which includes filling both the current vacant posts and the posts vacated through retirement.

[1] Northern Ireland Statistics Research Agency, Population Projections, available at http://www.nisra.gov.uk/demography/default.asp20.htm

8.Urology trainee requirements to meet projected service needs

Table 9 Additional trainee requirements to meet projected consultant WTE requirement

Projected additional consultant requirements	Current predicted new CCT holders	Gap in new CCT holders
13	7	6

This leaves a remaining balance of 6 additional consultants/trainees required to meet the population needs.

In light of the plans for modernisation within urology services, it is prudent to fund an additional four trainees as a first phase and then to review the need for an additional two trainees once the modernisation work has been further progressed. This review will take account of any material impact which the implementation of the wider role for Clinical Nurse Specialists has had on the consultant workload. If this impact is not material then an additional two trainees should be appointed to meet the projected population need.

Table 10 sets out the initial tranche of 4 trainees required prior to a further review. It is feasible to train an additional four trainees as a single group in addition to the existing trainees, and if funded these posts could be appointed to commence in August 2017 or August 2018. These doctors would potentially gain CCT in 2022 or 2023 assuming no additional period of training is required.

Table 10 Additional trainees by year to meet the projected consultant WTE requirement

Year/ Training grade	2017	2018	2019	2020	2021	2022	2023	2024
ST3	4		2*					
ST4		4		2*				
ST5			4		2*			
ST6				4		2*		
ST7					4		2*	
Total new CCT holders per year						4		2*
Total of predicted new CCT holders						4		6*

*additional 2 trainees if required after review of the impacts of modernisation on the consultant workload.

Appendix A

Membership of Workforce Subgroup

Lisa McWilliams, Assistant Director Scheduled Care, HSCB (Chair)

David McCormick, Programme Manager Scheduled Care, HSCB

Dr Catherine Coyle, Physician in Public Health Medicine, PHA

Lynne Charlton, Consultant Nurse, PHA

Hugh O'Kane, Consultant Urologist, Belfast Trust

Chris Thomas, senior manager, Belfast Trust

John McKnight, Consultant Urologist, South Eastern Trust

Maggie Parkes, senior manager, South Eastern Trust

Mark Haynes, Consultant Urologist, Southern Trust

Martina Corrigan, senior manager, Southern Trust

Alex McLeod, Consultant Urologist, Western Trust

Paul Doherty, senior manager, Western Trust

Siobhan Woolsey, Consultant Urologist, NIMDTA TPD

Anthony Dyal, urology specialty trainee, BMA representative

Gillian Rankin, medical workforce planning lead, PHA

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List of Consultants and SAS Medical Grades aligned to Urology from 1 October 2009 - 31 March 2016

Prepared by/HR Contact: Ciara Rafferty, Senior HR Data Analyst

Prepared for: Andrea McNeice and Zoe Parks, Medical HR

Ref: AD/2022/117

Date: 25 March 2022

Note: Employees with multiple posts have been highlighted in green

Staff in Post from 31 October 2009 - 30 November 2013

Note: This information was taken from staff in post reports, during the above reporting period, extracted from HRMS at time of reporting.

Surname	Forename1	Fac/Bk/Staff No	Date Commenced Post	Employment Status Description	Grade Description	Cost Centre Code	Cost Centre Description	Location of Post Description	WTE	Date Appointed to Trust	Date Left Trust	Current SHSCT Employee
O'BRIEN	AIDAN	Personal Information redacted by the USI	01/04/1993	PERMANENT	CONSULTANT (NC)	Personal Information redacted by the USI	CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	01/04/1993	17/07/2020	N
CONNOLLY	DAVID JAMES		03/09/2012	PERMANENT	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	03/09/2012	31/03/2013	N
GLACKIN	ANTHONY JUDE		01/08/2012	PERMANENT	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	01/08/2012		Y
HO	KUO JONG		01/10/2011	TEMPORARY	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	06/04/2011	01/08/2012	N
			01/10/2011	TEMPORARY	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	06/04/2011	01/08/2012	N
PAHUJA	AJAY		01/11/2012	PERMANENT	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	01/11/2012	05/01/2014	N
FERNANDO	MAURICE JAYANTH		12/11/2012	PERMANENT	SPECIALTY DOCTOR (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	12/11/2012	09/08/2013	N
AKHTAR	MEHMOOD		03/09/2007	PERMANENT	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	03/09/2007	08/04/2012	N
YOUNG	MICHAEL		01/05/1998	PERMANENT	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	14/04/1998		Y

Staff in Post from 1 December 2013 - 31 March 2016

Note: This information was taken from HRPTS, detailing all staff aligned to Urology Organisational Units during the above reporting period

Last name	First name	Pers.No.	HRMS Staff No	Org Assignment Start Date	Org Assignment End Date	Work Contract	Job Description	Organizational Unit	Cost Ctr	Cost Center	location	WTE	Date Appointed to Trust	Date Left Trust	Current SHSCT Employee
Hall	Samuel	Personal Information redacted by the USI	Personal Information redacted by the USI	01/01/2015	15/03/2016	Permanent	Consultant (NC)	Clinical Director ENT Urology T&O	Personal Information redacted by the USI	CAH E.N.T. - CAH	Craigavon Area Hosp-Main Building	1.00	01/04/1993	15/03/2016	N
				17/03/2016	31/12/2016	Temporary	Consultant (NC)	Clinical Director ENT Urology T&O		CAH E.N.T. - CAH	Craigavon Area Hosp-Main Building	0.40	17/03/2016	31/12/2016	N
O'Brien	Aidan			01/04/1993	17/07/2020	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	01/04/1993	17/07/2020	N
Haynes	Mark			12/05/2014	31/12/9999	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	12/05/2014		Y
O'Donoghue	John			04/08/2014	31/12/9999	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	04/08/2014		Y
Martin	Jennifer			20/10/2014	26/08/2016	Temporary	Specialty Doctor (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	20/10/2014	26/08/2016	N
Glackin	Anthony Jude			01/08/2012	31/12/9999	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	01/08/2012		Y
Suresh	Kothandaraman			11/12/2013	26/10/2016	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	11/12/2013	26/10/2016	N
Pahuja	Ajay			01/11/2012	05/01/2014	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	01/11/2012	05/01/2014	N
Young	Michael			14/04/1998	27/05/2022	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	14/04/1998	27/05/2022	Y

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Timeliness Issues & HRPTS Recording - In order to ensure that information is reported correctly from HRPTS, it is essential that on line processes or off line forms are actioned or forwarded for action on HRPTS as soon as possible. Delays will result in reported information not being up to date.

Data Quality - If you believe the information in this report does not accurately reflect the current position, please contact the HR Analytics & Governance Team.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

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Information Required to Support the Urology Public Enquiry

Prepared by/HR Contact: Ciara Rafferty& Roberta Parks, HR Analytics & Governance Team

Prepared for: Wendy Clayton, Head of Urology and ENT, Zoe Parks, Head of Medical Staffing, Helen Walker, AD of HR Aligned to Acute

Ref: ad_2021_435

Date: 15 October 2021

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Report 1 - List of Staff from 1 April 2016 aligned to Organisational Units under Head of Urology and ENT

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Pers.No.	Last name	First name	Org Assignment Start Date	Org Assignment End Date	On Current Staff in Post List 11 Oct 21	Work Contract	Position	Job Description	Band	Org.unit	Organizational Unit	Cost Center	Personnel Area	Date Left Trust
Personal Information redacted by the USI	Clayton	Wendy Marilyn	01/05/2021		Y	Second Internal	HOS-Urology & Ent	Admin & Clerical (8B)	8B	80035025	PCL ENT/Urology/Outpatients	PCL ENT/UROLOGY	Admin & Clerical	
	Corrigan	Martina	28/09/2009	06/06/2021		Permanent	HOS-Urology & Ent	Admin & Clerical (8B)	8B	80035025	PCL ENT/Urology/Outpatients	PCL ENT/UROLOGY	Admin & Clerical	
	Young	Michael	14/04/1998		Y	Permanent	Clinical Lead	Consultant (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	
	O'Brien	Aidan	01/04/1993	17/07/2020		Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	17/07/2020
	Glackin	Anthony Jude	01/08/2012		Y	Permanent	Consultant	Consultant (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	
	Suresh	Kothandaraman	11/12/2013	26/10/2016		Permanent	Consultant	Consultant (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	26/10/2016
	Haynes	Mark	12/05/2014		Y	Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	
	O'Donoghue	John	04/08/2014		Y	Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	
	Hutton	Rachael	05/08/2015	02/08/2016		Temporary	Locum Appointment Training	Fixed Term Spec Appointment	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	02/08/2016
	Martin	Jennifer	20/10/2014	26/08/2016		Temporary	Clinical Fellow	Specialty Doctor (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	26/08/2016
	Mukhtar	Bashir	05/08/2015	31/08/2016		Temporary	Locum Appointment Training	Fixed Term Spec Appointment	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	31/08/2016
	Tyson	Matthew	05/08/2015	02/08/2016		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	06/02/2018
	Morrow	Jessica	03/08/2016	01/08/2017		Temporary	Locum Appointment Training	Fixed Term Spec Appointment	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	31/10/2017
			02/08/2017	31/10/2017		Temporary	Locum Appointment Service	Trust Appointment For Services	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	31/10/2017
	Curry	David	03/08/2016	01/08/2017		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	01/08/2017
	McAuley	Laura	23/01/2017		Y	Permanent	Specialty Doctor	Specialty Doctor (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	
	Hennessey	Derek	02/08/2017	06/02/2018		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	06/02/2018
	Doherty	Anna	02/08/2017	06/02/2018		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	31/07/2018
			07/02/2018	31/07/2018		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	31/07/2018
	Mageean	Maire	07/02/2018	31/07/2018		Rotational	Locum Appointment Training	Fixed Term Spec Appointment	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	31/07/2018
	Hennessey	Derek	27/04/2018	31/05/2019		Temporary	Consultant	Consultant (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	31/05/2019
	Evans	Raymond	01/08/2018	06/08/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	06/08/2019
	Hiew	Kenneth	01/08/2018	06/08/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	06/08/2019
	Hasnain	Sabahat	02/01/2019		Y	Permanent	Specialty Doctor	Specialty Doctor (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	
	Tyson	Matthew	25/02/2019	16/07/2019	Y	Permanent	Consultant	Consultant (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	
			17/07/2019			Employ Break	Consultant	Consultant (NC)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	
	Elbaroni	Wesam	07/08/2019	04/08/2020		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	04/08/2020
	Sharma	Abhishek	07/08/2019	04/08/2020		Rotational	Specialty Registrar	Specialty Registrar (Str)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	04/08/2020
	Steen	Benjamin	07/08/2019	04/08/2020		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	04/08/2020
	Griffin	Fiona	04/08/2021		Y	Temporary	Clinical Fellow	Trust Appointment For Services	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	
	Cull	Susan	04/08/2021		Y	Temporary	Clinical Fellow	Trust Appointment For Services	Non AfC	80036151	CAH Urology Medical	CAH - UROLOGY	Medical & Dental	
	O'Neill	Kathleen	25/08/2021		Y	Permanent	Nurse Specialist Urology	Acute Wd Sr/CN (7)	8A	80472185	CAH - Thorndale Unit Dep Mgr	CAH THORNDALE UNIT	Nursing & Midwifery	
	McCourt	Leanne Emma	25/08/2021		Y	Permanent	Clinical Nurse Specialist - Urology	Acute Nurse (7)	7	80472185	CAH - Thorndale Unit Dep Mgr	CAH THORNDALE UNIT	Nursing & Midwifery	
	McMahon	Jennifer Eliz	01/09/2015	17/06/2019	Y	Permanent	Nurse Specialist Urology	Specialist Nurse (7)	7	80472185	CAH - Thorndale Unit Dep Mgr	CAH THORNDALE UNIT	Nursing & Midwifery	
			18/06/2019			Permanent	Nurse Specialist Urology	Specialist Nurse (7)	8A	80472185	CAH - Thorndale Unit Dep Mgr	CAH THORNDALE UNIT	Nursing & Midwifery	
	Thompson	Patricia	25/08/2021		Y	Permanent	Clinical Nurse Specialist - Urology	Specialist Nurse (7)	7	80472185	CAH - Thorndale Unit Dep Mgr	CAH THORNDALE UNIT	Nursing & Midwifery	
	Young	Jason	25/08/2021		Y	Permanent	Clinical Nurse Specialist - Urology	Specialist Nurse (7)	7	80472185	CAH - Thorndale Unit Dep Mgr	CAH THORNDALE UNIT	Nursing & Midwifery	
	Robinson	Gemma	12/03/2019	25/07/2021		Permanent	Ward Manager Support	Admin & Clerical (3)	3	80476612	Ward Support SEC	CAH 3 SOUTH SHORT STAY SURG WD	Admin & Clerical	
	Henry	Ellen	04/12/2017	28/01/2020		Permanent	Ward Manager Support	Admin & Clerical (3)	3	80476612	Ward Support SEC	CAH 3 SOUTH SHORT STAY SURG WD	Admin & Clerical	
	O'Neill	Sarah	12/10/2020		Y	Permanent	Ward Support SEC	Admin & Clerical (3)	3	80476612	Ward Support SEC	CAH 3 SOUTH SHORT STAY SURG WD	Admin & Clerical	
	Newell	Amanda	10/02/2020	11/02/2020		Block Booking	Ward Manager Support	Admin & Clerical (3)	3	80476612	Ward Support SEC	CAH 3 SOUTH SHORT STAY SURG WD	Admin & Clerical	11/02/2020
	Leonard	Una	17/08/2020		Y	Block Booking	Ward Manager Support	Admin & Clerical (3)	3	80476612	Ward Support SEC	CAH 3 SOUTH SHORT STAY SURG WD	Admin & Clerical	
	Siahaan	Maria	22/02/2021		Y	Block Booking	EPR - Ward Manager Support	Admin & Clerical (3)	3	80476612	Ward Support SEC	COVID-19	Admin & Clerical	
	Sinnerton	Jenny	03/08/2021	15/08/2021		Temporary	Ward Manager Support	Admin & Clerical (3)	3	80476612	Ward Support SEC	CAH 3 SOUTH SHORT STAY SURG WD	Admin & Clerical	15/08/2021
	Boyd	Philip	11/10/2021			Block Booking	Ward Support SEC	Admin & Clerical (3)	3	80476612	Ward Support SEC	CAH 3 SOUTH SHORT STAY SURG WD	Admin & Clerical	

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Report 2 - List of Staff from 1 April 2016 Coded to Organisational Units containing Oncology Staff

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Pers.No.	Last name	First name	Org Assignment Start Date	Org Assignment End Date	On Current Staff in Post List 11 Oct 21	Work Contract	Position	Job Description	Band	Org.unit	Organizational Unit	Cost Center	Personnel Area	Date Left Trust
Personal Information redacted by the USI	Gribben	Emma Louise	01/09/2020		Y	Permanent	Advanced Nurse Practitioner-Oncology	Specialist Nurse (8A)	8A	80036006	Oncology	C&CS ONCOLOGY	Nursing & Midwifery	
	Creaney	Laura	01/10/2015	01/01/2019		Permanent	Oncology Specialist Nurse	Acute Nurse (7)	7	80036006	Oncology	C&CS ONCOLOGY	Nursing & Midwifery	
	Porter	Adrienne	03/02/2020	07/06/2021		Permanent	Oncology Specialist Nurse	Acute Nurse (7)	7	80036006	Oncology	C&CS ONCOLOGY	Nursing & Midwifery	
	Clarke	Rose Theresa	13/04/2015		Y	Permanent	Oncology Specialist Nurse	Acute Nurse (7)	7	80036006	Oncology	C&CS ONCOLOGY	Nursing & Midwifery	
	McCourt	Leanne Emma	28/11/2016	02/04/2017		Temporary	Oncology Specialist Nurse	Acute Nurse (7)	7	80036006	Oncology	C&CS ONCOLOGY	Nursing & Midwifery	02/04/2017
	McAlary	Aine	26/03/2018	12/05/2019		Second Internal	Oncology Specialist Nurse	Acute Nurse (7)	7	80036006	Oncology	C&CS ONCOLOGY	Nursing & Midwifery	12/05/2019
	O'Connor	Claire	13/08/2018	12/05/2019		Temp Higher Bd	Oncology Specialist Nurse	Acute Nurse (7)	7	80036006	Oncology	C&CS ONCOLOGY	Nursing & Midwifery	12/05/2019
	Shannon	Nicola	15/06/2020		Y	Permanent	Oncology Specialist Nurse	Acute Nurse (7)	7	80036006	Oncology	C&CS ONCOLOGY	Nursing & Midwifery	
	Millar	Gerard Patrick	01/02/2014	01/04/2017		Permanent	Macmillan GP Facilitator	GP Sessions	Non AfC	80036035	CAH - Palliative Care	CAH PALLIATIVE CARE	Medical & Dental	01/04/2017
	Watson	Claire	01/01/2014		Y	Permanent	Speciality Doctor Oncology	Specialty Doctor (NC)	Non AfC	80036035	CAH - Palliative Care	CAH PALLIATIVE CARE	Medical & Dental	
	Anderson	Tracy Christine	01/03/2009	20/02/2019		Permanent	Consultant	Consultant (NC)	Non AfC	80036035	CAH - Palliative Care	CAH PALLIATIVE CARE	Medical & Dental	20/02/2019
	McLoughlin	Caroline	23/09/2014	30/06/2016		Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036035	CAH - Palliative Care	CAH PALLIATIVE CARE	Medical & Dental	
	Millar	Gerard	12/04/2017			Temporary	Macmillan GP Facilitator	GP Sessions	Non AfC	80036035	CAH - Palliative Care	CAH PALLIATIVE CARE	Medical & Dental	
	Cousins	Sarah	20/04/2020	31/05/2020		Temporary	Consultant	Consultant (NC)	Non AfC	80036035	CAH - Palliative Care	CAH PALLIATIVE CARE	Medical & Dental	
			01/06/2020			Permanent	Consultant	Consultant (NC)	Non AfC	80036035	CAH - Palliative Care	CAH PALLIATIVE CARE	Medical & Dental	
	Rizwan	Saira	12/10/2020	11/08/2021		Permanent	TRF-Speciality Doctor Oncology	Specialty Doctor (NC)	Non AfC	80036035	CAH - Palliative Care	CAH PALLIATIVE CARE	Medical & Dental	11/08/2021
	Treanor	Aoife	27/02/2017	21/01/2018		Temp Higher Bd	Pharmacist (7)	Pharmacist (7)	7	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	Ward	Claire Margaret	04/04/2016	27/07/2020	Y	Permanent	Lead Pharmacist Cancer Services	Pharmacist (8A)	8A	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
			28/07/2020			Permanent	Lead Oncology Pharmacist (8A)	Pharmacist (8A)	8A	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	McCarthy	Emma	18/11/2015	04/02/2018		Permanent	Pharmacist (7)	Pharmacist (7)	7	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
			05/02/2018	03/05/2018		Permanent	Pharmacist (7)	Pharmacist (7)	7	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
			04/05/2018	27/07/2020		Permanent	Haematology Pharmacist (8A)	Pharmacist (8A)	8A	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
			28/07/2020			Permanent	Lead Pharmacist Haem Cancer Ser (MOS2)	Pharmacist (8A)	8A	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	Currie	Claire	13/01/2020	06/06/2021		Permanent	Pharmacist (7)	Pharmacist (7)	7	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
			07/06/2021			Temp Higher Bd	Lead Pharmacist Haem Cancer Ser (MOS2)	Pharmacist (8A)	8A	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	Hamilton	Brian	15/06/2015	01/12/2019		Permanent	Pharmacist (7)	Pharmacist (7)	7	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	Farragher	Catherine	15/06/2015	03/05/2018		Permanent	Pharmacist (7)	Pharmacist (7)	7	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
			04/05/2018	27/07/2020		Permanent	Haematology Pharmacist (8A)	Pharmacist (8A)	8A	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
			28/07/2020			Permanent	Lead Pharmacist Haem Cancer Ser (MOS2)	Pharmacist (8A)	8A	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	Lewis	Rachel	03/12/2018	28/04/2019		Temp Higher Bd	Haematology Pharmacist (8A)	Pharmacist (8A)	7	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
			29/04/2019			Permanent	Aseptic Pharmacist (7)	Pharmacist (7)	7	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	Ferguson	Alison	12/05/2021			Permanent	Pharmacist (7)	Pharmacist (7)	7	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	McWilliams	Kim	17/12/2018	14/04/2019		Block Booking	Pharmacist (6)	Pharmacist (6)	6	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	20/09/2020
	Lavery	Mary	16/04/2019	12/01/2020		Permanent	Pharmacist (7)	Pharmacist (7)	7	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	Gervin	Joanne	24/02/2020			Permanent	Pharmacist (7)	Pharmacist (7)	7	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	Hicks	Olivia	02/12/2019			Permanent	Pharmacist (6)	Pharmacist (6)	6	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	Coulter	Pearl	01/02/2021		Y	Permanent	Lead Oncology Pharmacist (8A)	Pharmacist (8A)	8A	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	
	Lindsay	Hannah	05/10/2020	15/11/2020		Temporary	Pharmacist (7)	Pharmacist (7)	6	80473309	Chemotherapy Pharmacy Services	CAH PHARMACY - CAH	Professional & Tech.	

Report 3 - List of Staff from 1 April 2016 Coded to Organisational Units containing Radiology Staff

CONFIDENTIAL

Pers.No.	Last name	First name	Org Assignment Start Date	Org Assignment End Date	On Current Staff in Post List 11 Oct 21	Work Contract	Position	Job Description	Band	Org.unit	Organizational Unit	Cost Center	Personnel Area	Date Left Trust
Personal Information redacted by the USI	oy	Anne	01/12/2000	31/07/2016	Y	Permanent	Radiology Support Manager	Admin & Clerical (4)	4	80453361	STH - Radiology Admin	STH RADIOLOGY ADMIN	Admin & Clerical	
			01/08/2016			Permanent	Radiology Support Manager	Admin & Clerical (4)	4	80453361	STH - Radiology Admin	STH RADIOLOGY ADMIN	Admin & Clerical	
	ockhart	Michelle	01/06/2009	31/07/2016	Y	Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80453361	STH - Radiology Admin	STH RADIOLOGY ADMIN	Admin & Clerical	
			01/08/2016			Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80453361	STH - Radiology Admin	STH RADIOLOGY ADMIN	Admin & Clerical	
	Quinn	Julie	01/12/2000	31/07/2016		Permanent	Admin & Clerical (3)	Admin & Clerical (3)	3	80453361	STH - Radiology Admin	STH RADIOLOGY ADMIN	Admin & Clerical	
			01/08/2016	31/03/2017	Y	Permanent	Admin & Clerical (3)	Admin & Clerical (3)	3	80453361	STH - Radiology Admin	STH RADIOLOGY ADMIN	Admin & Clerical	
			01/04/2017	31/03/2018		WLB Term Time	Admin & Clerical (3)	Admin & Clerical (3)	3	80453361	STH - Radiology Admin	STH RADIOLOGY ADMIN	Admin & Clerical	
			01/04/2018			Permanent	Admin & Clerical (3)	Admin & Clerical (3)	3	80453361	STH - Radiology Admin	STH RADIOLOGY ADMIN	Admin & Clerical	
	McBurney	Angela	20/05/1987	31/07/2016		Permanent	Admin & Clerical (4)	Admin & Clerical (4)	4	80036065	ACH - Radiology Admin	ADT STH- RADIOLOGY	Admin & Clerical	
			01/08/2016	31/01/2021	Y	Permanent	Admin & Clerical (4)	Admin & Clerical (4)	4	80036065	ACH - Radiology Admin	ADT STH- RADIOLOGY	Admin & Clerical	
			01/02/2021			Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036065	ACH - Radiology Admin	ADT STH- RADIOLOGY	Admin & Clerical	
	McCartney	Rachel Eliz	01/05/2014	13/11/2016		Permanent	Medical Secretary (4)	Medical Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	McCorry	Andrea	01/05/2014			Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Davidson	Fiona	30/05/2016	31/03/2017		Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	31/03/2017
	indsay	Gail	01/05/2014	30/06/2019		Permanent	Medical Secretary (4)	Medical Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			01/07/2019			Permanent	TRF(PF)-Medical Secretary (4)	Medical Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Martin	Janet Linda	01/05/2014	02/09/2018		Permanent	Personal Secretary (4)	Personal Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			03/09/2018			Permanent	Personal Secretary (4)	Personal Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	McEvoy	Yvonne	09/03/2015			Permanent	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	hornbury	Rosanne	03/02/1992	31/07/2016		Permanent	Medical Secretary (4)	Medical Secretary (4)	4	80036056	Diagnostics Admin	CAH MRI ADMIN	Admin & Clerical	
			01/08/2016	31/08/2016		Permanent	Medical Secretary (4)	Medical Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			01/09/2016			Permanent	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Donnelly	Stephanie	01/04/2016	31/03/2017		WLB Term Time	Admin & Clerical (3)	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			01/04/2017	31/03/2018		WLB Term Time	Admin & Clerical (3)	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			01/04/2018			Permanent	Admin & Clerical (3)	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Chambers	Emma Sarah	06/10/2014	21/05/2021		Temporary	Clerical Officer (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	21/05/2021
	Reaney	Gillian	01/05/2014			Permanent	Administrative Co-Ordinator	Admin & Clerical (5)	5	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	lynn	Marian	01/04/2015	30/05/2018		Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	30/05/2018
	arr	Jill Alexandra	01/05/2014	01/10/2019		Permanent	Personal Secretary (4)	Personal Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	01/10/2019
	McIlkenny	Shauna	01/05/2014	22/12/2017		Permanent	Film Library Assistant	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	22/12/2017
	Hackett-Mckenna	Patricia Ann	21/05/2018	29/10/2018		Permanent	Radiology E-Roster Administrator	Admin & Clerical (5)	5	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	rwin	Laura-Jane	22/02/2018			Permanent	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	cArdle	Marian	16/04/2018	23/09/2018		Permanent	Clerical Officer (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			24/09/2018			Employ Break	Clerical Officer (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Gribben	Ruth	01/05/2014			Permanent	Medical Secretary (4)	Medical Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Murtagh	Carmel Ann	22/10/2014	18/02/2018		Job Share	Admin & Clerical (2) -JS	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	oman	Chrisy	01/04/2016	31/03/2017		Permanent	Personal Secretary (4)	Personal Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			01/04/2017	31/03/2018		WLB Term Time	Personal Secretary (4)	Personal Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			01/04/2018	01/09/2019		Permanent	Personal Secretary (4)	Personal Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	est	Pauline	01/05/2014			Permanent	Medical Secretary (4)	Medical Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	McKeown	Marie	01/09/2016	01/08/2017		Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	01/08/2017
	Gracey	Pamela Susan	01/05/2014			Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	enson	Vassey	01/05/2014	31/03/2017		Permanent	Admin & Clerical (2)	Admin & Clerical (2)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	17/05/2019
			01/04/2017	17/05/2019		Permanent	Admin & Clerical (3)	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	17/05/2019
	yan	Ciara T	01/12/2014			Permanent	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	McCann	Tracey Ann	01/05/2014	16/08/2017		Permanent	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	16/08/2017
	McConville	Lisa	01/10/2015			Permanent	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	edford	Roberta	01/05/2014	31/03/2017		Permanent	Audio Typist	Admin & Clerical (2)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			01/04/2017			Permanent	Audio Typist	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	McGlone	Brigid	01/06/2015			Job Share	Admin & Clerical (2) -JS	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Murray	Danae	09/03/2015	28/10/2016		Block Booking	Clerical Officer (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	05/07/2018
	McIlkenny	Shauna	01/10/2015			Permanent	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	lliott	Timothy	18/01/2016	28/07/2017		Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	28/07/2017
	ovtun	Viktoriya	25/01/2016	11/10/2016		Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	11/10/2016
	Wright	Amanda	12/02/2016	11/08/2016		Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	11/08/2016
	uffy	Natasha	03/10/2016	08/01/2017		Permanent	Clerical Officer With Typ/Wp	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Davidson	John	15/01/2018	04/09/2018		Permanent	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	04/09/2018
	isher	Martina	03/04/2017	03/09/2017		Permanent	Clerical Officer With Typ/Wp	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	effers	Kathryn	08/05/2017	05/10/2018		Permanent	Clerical Officer With Typ/Wp	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	05/10/2018
	Cunningham	Martin	15/05/2017	12/10/2017		Permanent	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	12/10/2017
	Murphy	Margaret	30/05/2017	28/01/2018		Permanent	Clerical Officer With Typ/Wp	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Hughes	Caroline	24/09/2017	14/10/2018		Permanent	Clerical Officer (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			15/10/2018	05/03/2020	Y	Temp Higher Bd	Clerical Officer (2)	Admin & Clerical (2)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			06/03/2020	17/11/2020		Permanent	Partial Booker	Admin & Clerical (2)	3	80453361	STH - Radiology Admin	STH RADIOLOGY ADMIN	Admin & Clerical	
			18/11/2020			Permanent	Appointments Officer (3)	Admin & Clerical (3)	3	80036056	Diagnostics Admin	STH RADIOLOGY ADMIN	Admin & Clerical	
	Millar	Lorraine	16/10/2017	14/10/2018		Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			15/10/2018	10/05/2020		Permanent	Admin & Clerical (2)	Admin & Clerical (2)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			08/07/2020	24/06/2021		Temp Higher Bd	Admin & Clerical (2)	Admin & Clerical (2)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			25/06/2021			Permanent	Appointments Officer (3)	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	McIlkenny	Catherine	16/10/2017	27/11/2017		Permanent	Clerical Officer (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Moore	Kerry	02/01/2018	20/02/2018		Permanent	Clerical Officer (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			21/02/2018	24/02/2019		Permanent	Partial Booker	Admin & Clerical (2)	2	80453361	STH - Radiology Admin	STH RADIOLOGY ADMIN	Admin & Clerical	

Pers.No.	Last name	First name	Org Assignment Start Date	Org Assignment End Date	On Current Staff in Post List 11 Oct 21	Work Contract	Position	Job Description	Band	Org.unit	Organizational Unit	Cost Center	Personnel Area	Date Left Trust
Personal Information redacted by the USI	Hutton	Lauren	30/09/2019	17/01/2021		Second Internal	Personal Secretary (4)	Personal Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			18/01/2021			Permanent	Personal Secretary (4)	Personal Secretary (4)	4	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Thomas	Moncy	04/04/2018	02/09/2018		Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			03/09/2018	20/10/2019		Permanent	Admin & Clerical (2) -JS	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			21/10/2019	05/03/2020		Temp Higher Bd	Admin & Clerical (2) -JS	Admin & Clerical (2)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			06/03/2020			Permanent	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Boyd	Emma	28/08/2018	17/11/2020		Permanent	Film Library Assistant	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			18/11/2020			Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Fenton	Carly	15/10/2018	20/10/2019		Permanent	Clerical Officer (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			21/10/2019	05/03/2020		Temp Higher Bd	Clerical Officer (2)	Admin & Clerical (2)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			06/03/2020			Permanent	Admin & Clerical (3)	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Hendron	David	14/11/2018			Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Wright	Emma	21/01/2019	18/07/2020		Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	18/07/2020
	McSorley	Carmel	19/08/2019	24/06/2021		Permanent	Clerical Officer (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
			25/06/2021			Permanent	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	McCord	Claire	16/12/2019	20/03/2020		Permanent	Clerical Officer (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	20/03/2020
	Ervine	Olive	01/06/2020			Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Glenny	Andrew	22/02/2021	03/05/2021		Block Booking	Appointments Clerk	Admin & Clerical (3)	3	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	09/07/2021
	Taylor	Janice	01/03/2021			Block Booking	Clerical Officer (2)	Admin & Clerical (2)	2	80036056	Diagnostics Admin	CAH MED RECS XRAY	Admin & Clerical	
	Fawzy	Mohamed Anwar	25/07/2015	31/10/2017		Employ Break	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	31/10/2017
	McClure	Mark Jonathan	01/09/2000	05/09/2016		Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	05/09/2016
	Milligan	Aaron Thomas	01/03/2012		Y	Permanent	Consultant	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Yarr	Julie Elaine	09/06/2008	04/06/2019	Y	Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			05/06/2019			Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Williams	Marc Edward	26/01/2009		Y	Permanent	Consultant	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Carson	Anne	22/04/1996	31/05/2019	Y	Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			01/06/2019			Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Gracey	David	01/06/2015	31/03/2018	Y	Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			01/04/2018			Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Rice	Paul Francis	02/09/2002		Y	Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Johnston	Norlinda	01/12/2009		Y	Permanent	Consultant	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Porter	Simon	04/11/2008		Y	Permanent	Consultant	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	McConville	Richard Mayne	03/11/2008		Y	Permanent	Consultant	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Smyth	Justin	03/08/2016	31/01/2017		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	31/01/2017
	James	Barry	01/09/2014	31/03/2021		Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			01/04/2021	30/09/2021	Y	WLB Term Time	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			01/10/2021			Employ Break	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	McSherry	Pauleen	05/08/2015	10/05/2020	Y	Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	14/10/2021
			11/05/2020	14/10/2021		Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	14/10/2021
	McGarry	Philip	17/08/2015		Y	Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Yousuf	Muhammad	24/08/2015	31/03/2018	Y	Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			01/04/2018			Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	McKeown	Ciara	03/02/2016	02/08/2016		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	02/08/2016
	Thompson	Robin	03/02/2016	02/08/2016		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	02/08/2016
	McGarry	Shauna	03/02/2016	01/08/2017		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	01/08/2017
	Briggs	Gavin	02/06/2016	30/06/2017		Temporary	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	30/06/2017
	Jamison	Michael	03/08/2016	24/08/2016		Temporary	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			25/08/2016	24/01/2017	Y	Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			25/01/2017	18/02/2018		Employ Break	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			19/02/2018			Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	McAnearney	Shane	03/08/2016	31/01/2017		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	31/01/2017
	Connolly	Ryan	03/08/2016	31/01/2017		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	31/01/2017
	O'Reilly	Sean	03/08/2016	31/01/2017		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	31/01/2017
	Moldovan	Anca	01/02/2017	01/08/2017		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	01/08/2017
	McReynolds	Andrew	01/02/2017	01/08/2017		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	01/08/2017
	McNabney	Charis	01/02/2017	31/07/2018		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	31/07/2018
	Khan	Sana	07/02/2017	26/02/2017	Y	Temporary	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			27/02/2017			Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Kamath	Sanjana	02/08/2017	06/02/2018		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	06/02/2018
	Toner	Stephanie	02/08/2017	06/02/2018		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	06/02/2018
	McKenna	Brendan	02/08/2017	06/02/2018		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	06/02/2018
	McArdle	Neonin	02/08/2017	04/04/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	04/04/2019
	Martin	Rachel	02/08/2017	06/02/2018		Temporary	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	06/02/2018
	McKeown	Ciara	02/10/2017	31/03/2020		Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			01/04/2020	31/03/2021	Y	WLB Term Time	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			01/04/2021			WLB Term Time	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Pyper	Michael	07/02/2018	31/07/2018		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	31/07/2018
	Hennessy	David	07/02/2018	31/07/2018		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	31/07/2018
	McLoughlin	Connor	07/02/2018	31/07/2018		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	31/07/2018
	McGarry	Shauna	07/02/2018	31/07/2018		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	31/07/2018
	O'Flaherty	Lucy	07/02/2018	31/07/2018		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	31/07/2018
	Dhillon	Ajit	01/08/2018	05/02/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	05/02/2019
	Daly	Aisling	01/08/2018	05/02/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	05/02/2019
	Magee	Claire	01/08/2018	05/02/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	05/02/2019
	Connolly	Ryan	01/08/2018	05/02/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	05/02/2019

Pers.No.	Last name	First name	Org Assignment Start Date	Org Assignment End Date	On Current Staff in Post List 11 Oct 21	Work Contract	Position	Job Description	Band	Org.unit	Organizational Unit	Cost Center	Personnel Area	Date Left Trust
Personal Information redacted by the USI	Murray	Aisling	01/08/2018	05/02/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	05/02/2019
	Martin	Rachel	10/01/2019	31/03/2020	Y	Permanent	Consultant	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			01/04/2020			Permanent	Consultant	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	O'Neill	Janice	01/02/2019	31/03/2020		Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	10/09/2021
			01/04/2020	31/03/2021		WLB Term Time	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	10/09/2021
			01/04/2021	10/09/2021		Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	10/09/2021
	aird Fraser	Patrick	06/02/2019	06/08/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	06/08/2019
	ing	Brian	06/02/2019	06/08/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	06/08/2019
	Hennessy	David	06/02/2019	06/08/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	06/08/2019
	Hassan	Mohammed	06/02/2019	06/08/2019		Rotational	Specialty Training	Specialty Registrar (Str)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	06/08/2019
	Quinn	Kathryn	10/06/2019		Y	Permanent	Clinical Radiologist - Nuclear Medicine	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	innegan	Sean	01/07/2019	28/10/2019		Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	28/10/2019
	awzy	Mohamed	01/01/2020		Y	Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	ynch	Thomas	01/01/2020		Y	Permanent	Clinical Radiologist - Nuclear Medicine	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Magee	Claire	04/05/2020		Y	Permanent	Consultant	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Connolly	Ryan	03/05/2021	06/06/2021	Y	Permanent	Consultant	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
			07/06/2021			Employ Break	Consultant	Consultant (NC)	Non AfC	80036037	CAH - Radiology	CAH RADIOLOGY - CAH	Medical & Dental	
	Conlan	Enda	02/05/2007		Y	Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036063	DHH - Radiology	DHH RADIOLOGY MEDICAL	Medical & Dental	
	hmad	Munir	11/02/2008	24/03/2017		Permanent	Consultant	Consultant (NC)	Non AfC	80036063	DHH - Radiology	DHH RADIOLOGY MEDICAL	Medical & Dental	24/03/2017
	oland	Patricia	01/05/2020	31/03/2021	Y	Bank	EPR - CT Radiographer (6) -Bank	Radiographer (6)	6	80480244	EPR - CAH Radiology Covid 1	COVID-19	Professional & Tech.	
			01/04/2021			Bank	Specialist CT Radiographer	Radiographer (6)	6	80480244	EPR - CAH Radiology Covid 1	COVID-19	Professional & Tech.	
	Henry	Charlotte	01/05/2020	30/09/2020		Temporary	EPR - Radiographer (5)	Radiographer (5)	5	80480244	EPR - CAH Radiology Covid 1	COVID-19	Professional & Tech.	31/10/2021
	cClelland	Bronagh	01/05/2020	07/08/2020		Temporary	EPR - Radiographer (5)	Radiographer (5)	5	80480244	EPR - CAH Radiology Covid 1	COVID-19	Professional & Tech.	07/08/2020
	McKerr	Niamh	01/05/2020	16/08/2020		Temporary	EPR - Radiographer (5)	Radiographer (5)	5	80480244	EPR - CAH Radiology Covid 1	COVID-19	Professional & Tech.	
	McCollum	Sharon	01/05/2020	31/03/2021	Y	Bank	EPR - Radiographer (5) -Bank	Radiographer (5)	5	80480244	EPR - CAH Radiology Covid 1	COVID-19	Professional & Tech.	
			01/04/2021			Bank	General Radiographer	Radiographer (5)	5	80480244	EPR - CAH Radiology Covid 1	COVID-19	Professional & Tech.	
	Cunningham	Heather	01/05/2020	30/11/2020		Temporary	EPR - Radiographer (5)	Radiographer (5)	5	80480244	EPR - CAH Radiology Covid 1	COVID-19	Professional & Tech.	
	Montgomery	Leah	01/05/2020	27/07/2020		Temporary	EPR - Radiographer (5)	Radiographer (5)	5	80480244	EPR - CAH Radiology Covid 1	COVID-19	Professional & Tech.	27/07/2020
	Murtagh	Cailin	07/05/2020	17/07/2020		Temporary	EPR - Radiographer (5)	Radiographer (5)	5	80480244	EPR - CAH Radiology Covid 1	COVID-19	Professional & Tech.	17/07/2020

Report 4 - List of Staff from 1 April 2016 Coded to Organisational Units containing Histopathology/Pathology Staff

CONFIDENTIAL

Pers.No.	Last name	First name	Org Assignment Start Date	Org Assignment End Date	On Current Staff in Post List 11 Oct 21	Work Contract	Position	Job Description	Band	Org.unit	Organizational Unit	Cost Center	Personnel Area	Date Left Trust
Personal Information redacted by the USI	warbrick	Christine Jane	24/10/2011	31/08/2019	Y	Permanent	Specialty Doctor	Specialty Doctor (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Permanent	Specialty Doctor	Specialty Doctor (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
	ull	Donald Richard	04/08/1999	02/01/2019		Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	02/01/2019
	almer	Jonathan	11/10/2010	31/08/2019	Y	Permanent	Specialty Doctor	Specialty Doctor (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Permanent	Specialty Doctor	Specialty Doctor (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	
	edic	Karel	01/11/2005	03/10/2018		Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	03/10/2018
	hah	Rajeev	01/02/2012	31/08/2019	Y	Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
	cClean	Gareth	26/05/2008	31/08/2019	Y	Permanent	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
	harpe	Peter Carlisle	23/12/1998	31/08/2019	Y	Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453340	CAH - Pathology - Chemical	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453340	CAH - Pathology - Chemical	CAH PATHOLOGY - CAH	Medical & Dental	
	amani	Nizamuddin	01/09/2015	13/07/2016	Y	Bank	Consultant -Bank	Consultant (NC)	Non AfC	80036036	CAH - Pathology	CAH PATHOLOGY - CAH	Medical & Dental	
			14/07/2016	31/08/2019		Bank	Consultant -Bank	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Bank	Consultant -Bank	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	
	oyd	Helen	01/03/2015	31/05/2019		Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036036	CAH - Pathology	CAH PATHOLOGY - CAH	Medical & Dental	31/05/2019
	cKillop	Derek John	01/11/2007	31/08/2019		Permanent	Clinical Scientist (8C)	Clinical Scientist (8C)	8C	80453340	CAH - Pathology - Chemical	CAH PATHOLOGY - CAH	Professional & Tech	31/10/2020
			01/09/2019	31/03/2020		Permanent	Clinical Scientist (8C)	Clinical Scientist (8C)	8C	80453340	CAH - Pathology - Chemical	CAH PATHOLOGY - CAH	Professional & Tech	31/10/2020
									8D	80453340	CAH - Pathology - Chemical	CAH PATHOLOGY - CAH		31/10/2020
			01/04/2020	31/10/2020		Permanent	Clinical Scientist (8D)	Clinical Scientist (8D)	8D	80453340	CAH - Pathology - Chemical	CAH PATHOLOGY - CAH	Professional & Tech	31/10/2020
	cGalie	Clare Emma	30/07/2009	26/08/2019	Y	Permanent	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
			27/08/2019			Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80036036	CAH - Pathology	CAH PATHOLOGY - CAH	Medical & Dental	
	rown	Martin	14/08/2014	13/07/2016		Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80036036	CAH - Pathology	CAH PATHOLOGY - CAH	Medical & Dental	24/08/2020
			14/07/2016	31/08/2019		Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	24/08/2020
			01/09/2019	24/08/2020		Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	24/08/2020
	swedi	Abdulhakim	06/05/2014	23/07/2017		Permanent	Consultant	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	23/07/2017
	athiraja	Manjula	15/12/2014	30/06/2016		Permanent	Consultant	Consultant (NC)	Non AfC	80036036	CAH - Pathology	CAH PATHOLOGY - CAH	Medical & Dental	30/06/2016
	rvine	Aaron	05/01/2015	31/08/2019	Y	Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Permanent	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
	oghlin	Caroline	12/01/2015	23/09/2016		Permanent	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	23/09/2016
	cVeigh	Gerard	09/02/2015	17/07/2016		Permanent	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	17/07/2016
	larke	Margaret	07/04/2015	31/03/2019		Temporary	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	30/09/2020
			01/04/2019	31/08/2019		Temporary	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	30/09/2020
			01/09/2019	30/09/2020		Temporary	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	30/09/2020
	organ	Eileen	25/03/2016	13/07/2016		Bank	Consultant -Bank	Consultant (NC)	Non AfC	80036036	CAH - Pathology	CAH PATHOLOGY - CAH	Medical & Dental	31/08/2016
			14/07/2016	31/08/2016		Bank	Consultant -Bank	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	31/08/2016
	cConville	Conal	16/05/2016	23/03/2017		Temporary	Consultant	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	23/03/2017
	rady	Aidan	24/04/2017	31/08/2019	Y	Permanent	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Permanent	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
	cFarland	Marie	29/08/2017	31/08/2019	Y	Permanent	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Permanent	Consultant	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
	radford	Christina	04/09/2017	26/11/2017		Temporary	Consultant	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	
			27/11/2017	31/08/2019	Y	Permanent	Consultant	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	
	edderwick	Sara	01/08/2018	31/08/2019	Y	Permanent	Consultant	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Permanent	Consultant	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	
	ull	Donald	07/01/2019	31/05/2019		Temporary	Consultant (Sessions)	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	31/05/2019
	ridgham	Mark	28/01/2019	31/05/2019		Temporary	TRF-Consultant Haematologist	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	
			01/06/2019	30/06/2019	Y	Temporary	TRF-Consultant Haematologist	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	
			01/07/2019	31/08/2019		Permanent	TRF-Consultant Haematologist	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019			Permanent	TRF-Consultant Haematologist	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	
	cKenna	Michael	01/03/2019	31/08/2019		Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019	31/03/2021	Y	Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
			01/04/2021			Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453338	CAH - Pathology - Cellular	CAH PATHOLOGY - CAH	Medical & Dental	
	uld	Victoria	20/03/2019	26/03/2019		Permanent	Physician Associate (6)	Medical Technical Officer (6)	6	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Professional & Tech	14/02/2020
			27/03/2019	31/08/2019		Permanent	Physician Associate (6)	Medical Technical Officer (6)	6	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Professional & Tech	14/02/2020
			01/09/2019	14/02/2020		Permanent	Physician Associate (6)	Medical Technical Officer (6)	6	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Professional & Tech	14/02/2020
	oyd	Helen	04/06/2019	30/06/2019		Temporary	Consultant (Sessions)	Consultant (NC)	Non AfC	80036036	CAH - Pathology	CAH PATHOLOGY - CAH	Medical & Dental	
			01/07/2019	31/08/2019	Y	Temporary	Consultant (Sessions)	Consultant (NC)	Non AfC	80036036	CAH - Pathology	CAH PATHOLOGY - CAH	Medical & Dental	
			01/09/2019	10/02/2020		Temporary	Consultant (Sessions)	Consultant (NC)	Non AfC	80036036	CAH - Pathology	CAH PATHOLOGY - CAH	Medical & Dental	
			11/02/2020			Temporary	Consultant (Sessions)	Consultant (NC)	Non AfC	80036036	CAH - Pathology	CAH PATHOLOGY - CAH	Medical & Dental	

Pers.No.	Last name	First name	Org Assignment Start Date	Org Assignment End Date	On Current Staff in Post List 11 Oct 21	Work Contract	Position	Job Description	Band	Org.unit	Organizational Unit	Cost Center	Personnel Area	Date Left Trust
Personal Information redacted by the USI	McKeating	Cara	02/09/2019		Y	Permanent	Consultant	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	
	Foy	Allister	30/09/2019		Y	Permanent	Consultant (Sessions)	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	
	Lewis	Kevin	01/10/2019	03/08/2021		Permanent	Specialty Doctor	Specialty Doctor (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	03/08/2021
	Boulos	Angel	18/11/2019	31/10/2020	Y	Permanent	Consultant	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	
			01/11/2020			Permanent	Consultant (NC)	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	
	Ali	Ismail	21/11/2019	26/10/2020		Permanent	Specialty Doctor	Specialty Doctor (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	26/10/2020
	McCauley	Christopher	24/02/2020		Y	Permanent	Consultant Haematologist	Consultant (NC)	Non AfC	80453337	CAH - Pathology - Haematology	CAH PATHOLOGY - CAH	Medical & Dental	
	Donnelly	Claire	25/01/2021		Y	Permanent	Consultant	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	
	Hamilton	Jennifer	01/04/2021		Y	Permanent	Clinical Scientist (8D)	Clinical Scientist (8D)	8D	80453340	CAH - Pathology - Chemical	CAH PATHOLOGY - CAH	Professional & Tech	
	Wu	Alan	14/06/2021			Temporary	Locum Specialty Doctor	Specialty Doctor (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	
	Johansen	Oystein	23/08/2021		Y	Temporary	Locum Consultant Microbiologist	Consultant (NC)	Non AfC	80453336	CAH - Pathology - Microbiology	CAH PATHOLOGY - CAH	Medical & Dental	
	Millar	Lisa Susan	09/02/1998		Y	Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	McCracken	Rachel	01/11/1989	09/04/2019		Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			10/04/2019	03/11/2019	Y	Temp Higher Bd	Biomedical Scientist (8A)	Biomedical Scientist (8A)	8A	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			04/11/2019			Permanent	Biomedical Scientist (8A)	Biomedical Scientist (8A)	8A	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Gadhgadhi	Emma Jean	01/11/1989		Y	Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	McPolin	Lois Faith	10/06/1991		Y	Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Megarity	Claire Teresa	08/04/2002	01/12/2019		Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	29/11/2019
	Murphy	Caroline Mary	15/04/2002	01/05/2019		Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			02/05/2019	12/05/2020	Y	Temporary	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			13/05/2020			Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Heaney	James	01/11/1987	29/03/2019		Permanent	Biomedical Scientist (8B)	Biomedical Scientist (8B)	8B	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	29/03/2019
	McAliskey	Kathleen	04/12/2006		Y	Permanent	Biomedical Science-Supp (4)	Biomedical Science-Supp (4)	4	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Calvin	Katherine	30/12/2004	17/09/2020	Y	Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			18/09/2020			Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	McCaughey	Breige	13/11/1989	31/10/2016		Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	31/10/2016
	Campbell	Catherine May	17/08/2015		Y	Permanent	Biomedical Science-Supp (3)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Clements	Lilian	01/10/1987	31/05/2021		Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	31/05/2021
	Hill	Carolanne Iris	31/03/2015	03/07/2016		Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Nelson	Shirley	01/11/1989		Y	Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Cunningham	Maria	03/07/2006	13/09/2020		Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	13/09/2020
	Armstrong	Pauline	01/10/1987		Y	Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	McCormack	Ita Mary	30/09/2002		Y	Permanent	Biomedical Science-Supp (4)	Biomedical Science-Supp (4)	4	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Quinn	Ronan	06/03/2006	31/03/2021		Permanent	Biomedical Science-Supp (4)	Biomedical Science-Supp (4)	4	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	McClelland	Kathryn	01/02/2014	06/03/2018		Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			07/03/2018	02/06/2019	Y	Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			03/06/2019	25/08/2020		Temp Higher Bd	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			26/08/2020			Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Murphy	Martin Daniel	05/01/1998		Y	Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Taylor	Christine	01/02/2014		Y	Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Blair	Elaine	01/11/1989		Y	Permanent	Biomedical Scientist (7)	Biomedical Scientist (7)	7	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Mitchell	Stephen	24/11/1993		Y	Permanent	Biomedical Science-Supp (3)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Robinson	Grace	09/06/2014	31/10/2016		Permanent	Medical Laboratory Assistant	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			01/11/2016	11/11/2019		Permanent	Biomedical Science-Supp (4)	Biomedical Science-Supp (4)	4	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	McClelland	Coilin	06/06/2016	28/07/2017		Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	5	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	28/07/2017
	McGrath	Joanne	01/04/2016	11/11/2016		Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	11/11/2016
	McMurrough	Maria	13/10/2016	13/04/2021	Y	Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	5	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			14/04/2021			Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	McElhatton	Niall	08/03/2017	04/06/2018		Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	5	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	26/01/2020
	Kirk	Ryan	24/05/2017	01/01/2018		Temporary	Biomedical Scientist (6)	Biomedical Scientist (6)	5	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	01/01/2018
	Bell	Daniel	01/06/2017	10/12/2017		Temporary	Biomedical Scientist (6)	Biomedical Scientist (6)	5	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			11/12/2017	13/04/2021	Y	Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	5	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
			14/04/2021			Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	McNiece	Michaela	04/06/2018	11/12/2019		Permanent	Biomedical Science-Supp (3)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	11/12/2019
	Brush	Gillian	20/11/2018		Y	Permanent	Biomedical Science-Supp (3)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Goan	Keva	10/02/2020	12/02/2020		Temporary	TRF-MLA Support Worker (CP)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	12/02/2020
	Byrne	Danielle	17/02/2020		Y	Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	5	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Clements	Caroline	23/03/2020	23/03/2021		Temporary	TRF-MLA Support Worker (CP)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	23/03/2021
	McCreanor	Victoria	14/09/2020	17/01/2021		Permanent	Biomedical Science-Supp (3)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Murphy	Aaron	16/11/2020		Y	Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	5	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	White	Noel	28/12/2020			Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	5	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Emerson	Hannah	15/02/2021		Y	Permanent	Biomedical Scientist (6)	Biomedical Scientist (6)	6	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Milligan	Paula	14/04/2021		Y	Permanent	Biomedical Science-Supp (3)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	

Pers.No.	Last name	First name	Org Assignment Start Date	Org Assignment End Date	On Current Staff in Post List 11 Oct 21	Work Contract	Position	Job Description	Band	Org.unit	Organizational Unit	Cost Center	Personnel Area	Date Left Trust
Personal Information redacted by the USI	Skelton	Emma	09/06/2021		Y	Permanent	TRF-MLA Support Worker (CP)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Kaminska	Daria	28/06/2021		Y	Permanent	Medical Laboratory Assistant	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	CAH HISTOPATHOLOGY - CAH	Professional & Tech	
	Flanagan	Shannen	01/04/2020	31/08/2020		Temporary	EPR - Biomedical Science-Supp (3)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	COVID-19	Professional & Tech	31/08/2020
	Dempsey	Lesley-Ann	21/04/2020	31/08/2020		Temporary	EPR - Biomedical Science-Supp (3)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	COVID-19	Professional & Tech	31/08/2020
	Quin	Adam	08/07/2021		Y	Temporary	EPR - Biomedical Science-Supp (3)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	COVID-19	Professional & Tech	
	Dempsey	Lesley-Ann	12/07/2021	26/09/2021	Y	Temporary	EPR - Biomedical Science-Supp (3)	Biomedical Science-Supp (3)	3	80036024	CAH - Cellular Pathology	COVID-19	Professional & Tech	26/09/2021

Stinson, Emma M

From: Corrigan, Martina < Personal Information redacted by the USI >
Sent: Irrelevant information redacted by the USI 07:58
To: Woods, Tracey
Cc: Haynes, Mark
Subject: FW: can you have a read please if you don't mind?
Attachments: FAO Dr F O'Kelly Responsible Officer re Dr Personal Informati (868 KB); NC Healthcare - Assessment Form.pdf

Good morning Tracey

See attached from Mr Haynes regarding Dr Perso nal

Regards

Martina

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

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

From: Haynes, Mark
Sent: Irrelevant information redacted by the USI 07:52
To: Corrigan, Martina
Subject: RE: can you have a read please if you don't mind?

Attached is the email with the letter to his RO and agency so they can be sent with the form. I have completed and added my signature.

RE time sheet he was advised at the meeting that his contract was terminated with immediate effect and therefore he should not have been doing any activity after the meeting. Approve until 12:30pm but no later. His last dictation was done at 10am (I have searched G2).

Mark

From: Corrigan, Martina
Sent: Irrelevant information redacted by the USI 07:44
To: Haynes, Mark
Subject: RE: can you have a read please if you don't mind?

Morning

Personal Information redacted by the USI

Attached is what Maria had sent to Zoe and also the timesheet for approval or not

Thanks

Martina

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

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

From: Haynes, Mark
Sent: Irrelevant information redacted by the USI 07:31
To: Corrigan, Martina
Subject: RE: can you have a read please if you don't mind?

Have largely completed (attached). Can you add in or send me the dates of employment so I can complete and then I will add my signature.

Have you got a copy of the concerns that were sent to his RO? (think Zoe sent it).

Mark

From: Corrigan, Martina
Sent: Irrelevant information redacted by the USI 18:01
To: Haynes, Mark
Subject: can you have a read please if you don't mind?

Hi Mark

Can you complete?

And what about the timesheet happy to pay him for the Friday afternoon or ask them only to pay him until 12:30 ?

I suspect he probably did go back to the office and do stuff even though you were clear he shouldn't !

Regards

Martina

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

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

From: Haugh, Karen
Sent: Irrelevant information redacted by the USI 12:12
To: Corrigan, Martina
Subject: FW: DR Persona l FEEDBACK AS DISCUSSED

Martina

This is the agency feedback form I received for Dr [redacted]

From: Rachael Rosso [mailto:[redacted]]
Sent: [redacted] 12:09
To: Haugh, Karen
Subject: FW: DR [redacted] FEEDBACK AS DISCUSSED

From: Rachael Rosso
Sent: [redacted] 11:51
To: Haugh, Karen <[redacted]>
Cc: Gavin Colquhoun <[redacted]>
Subject: DR [redacted] FEEDBACK AS DISCUSSED

Hi Karen,

Many thanks for your help with this, as discussed Dr [redacted] has been in CAH for [redacted] now covering Consultant Urology. He has asked if we can seek feedback on his performance to date from the dept please.

If they are happy with him, he is keen to extend for a further 3-4 months beyond his current end date in January ☺

Many thanks,

Rachael Rosso
Client Account Manager
[redacted] – My Direct Line During COVID-19

NC HEALTHCARE

NC Healthcare Ltd
Interchange House, Howard Way, Milton Keynes, MK16 9PY

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F: +44 (0) 1908 299 186
W: www.nc-healthcare.co.uk

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As a means of improving the service provided to our customers, we would welcome your feedback by emailing feedback@nc-healthcare.co.uk

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: Parks, Zoe < Personal Information redacted by the USI >
Sent: Irrelevant information redacted by the USI 10:34
To: rachael.rosso Personal Information redacted by the USI
Cc: Haynes, Mark; McClements, Melanie; Diamond, Aisling
Subject: FAO Dr F O'Kelly Responsible Officer re Dr Personal Informati
Attachments: x Lettertolocumagency 8.9.2020.docx; Screening of concern - Personal Information urologist.pdf

Importance: High

Rachael,

Could you please ensure the attached correspondence is brought to the attention of Dr Francis O'Kelly, Responsible Officer for Dr Personal Informati as soon as possible.

I would be grateful if you could confirm receipt.

Many thanks

Zoë Parks
Head of Medical HR
Southern Health & Social Care Trust
Tel: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI
Personal information redacted by USI

Southern Health and Social Care Trust

Irrelevant information redacted by the USI

FAO Dr Francis O'Kelly

Responsible Officer

RIG Locums Ltd

Via Rachael Rosso Personal Information redacted by the USI

Client Account Manager **NC HEALTHCARE**

Personal Information redacted by the USI Interchange House, Howard Way, Milton Keynes, MK16 9PY

By e-mail only

Dear Dr O'Kelly,

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

The above locum doctor was engaged with this Trust from Personal Information redacted by the USI, which was intended for a longer term booking.

The Associate Medical Director, Mr M Haynes met with Dr Personal Information redacted by the USI on Irrelevant information redacted by the USI Irrelevant information redacted by the USI to bring concerns to his attention. Unfortunately given the nature of these concerns, a decision was taken to end our locum engagement with this doctor. I have enclosed the documented concerns

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

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

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

Zoe Parks
Head of Medical HR
On behalf of

Dr Maria O'Kane

Medical Director

c.c Mr M Haynes, Associate Medical Director

Melanie McClements, Acute Services Director

Strictly Private and Confidential

Southern Health and Social Care Trust

Screening of Concern

Under MHPS Framework

Concerns re Locum Consultant Urologist engaged via Agency

Clinical Manager: Mr Mark Haynes
Associate Medical Director

1. INTRODUCTION

Dr [redacted] is engaged as a Locum Consultant Urologist from [redacted] via NC Healthcare Locum Agency. The contact in his agency is Rachael Rosso [redacted] His GMC Number is [redacted]. His designated Body is RIG Locums LTD and Responsible Officer is Dr Francis O'Kelly.

2. DETAILS OF THE CONCERN

Following a meeting on [redacted] the following concerns were discussed with Mr [redacted]

1) [redacted]
Attended South Tyrone Hospital for flexible cystoscopy for haematuria, having had a CTU prior to attendance. CT reported left ureteric stones and hydronephrosis. Attendance letter comments that the CT Urogram showed '…no any malignancy proven in the upper part of her urinary tract' no comment is made on the presence of ureteric stones, and she was discharged back to the care of her GP.
Your response;

- Acknowledged that the scan report must have been looked at given comment in letter.
- Initially suggested that as you had not requested the scan you should not have been expected to look at and action the result.

Concerns;

- CT report apparently not read and incorrect information and advice given to patient and GP.
- No treatment considered for ureteric stones.
- Risk that had this scan result not been checked by me ureteric stones would have gone un managed risking future renal loss.
- Initial response re responsibility of accessing results relevant to the attendance below expectation of a consultant urologist.
- Reduced confidence in the urology service provided by Southern Trust when the mistake is notified to the patients GP.

Action undertaken;

- I have contacted the patient, apologised and organised appropriate management.

Action required;

- Written reflection on case for appraisal / revalidation.

2) Personal Inform

Attended for flexible cystoscopy for investigation of haematuria. Letter states '…On the top of the bladder it is not possible to look carefully through because light source is very weak and it is not possible to see.'. No plan for FU is made.

Your response;

- Acknowledged that the letter is inadequate.
- Stated that you had read and corrected all letters, although apparent that this had not been done for this case.
- Initially suggested that appropriate outcome would be GA cystoscopy and biopsy of lesion at bladder base commented on in CT report.

Concerns;

- Attendance outcome letter demonstrating an apparent lack of consideration of further management requirements at time of procedure.
- Concern that despite your insistence that you had corrected all letters, this letter had not been amended, or a second letter containing appropriate arrangements sent, and remained as the only attendance letter visible on ECR.
- Receipt of this letter by GP will reduce confidence in patients receiving adequate care when attending the urology team.
- Your subsequent suggested plan of a GA cystoscopy to biopsy the CT finding at the base of the bladder failed to recognise that you had stated that the only area where inadequate views were obtained was the dome (top) of the bladder, and appearances of the base are therefore presumed to have been satisfactory. This would have exposed the patient to the risks of a potentially unnecessary general anaesthetic.
- Had this letter not come to my attention, a patient with haematuria who had undergone inadequate assessment would have been discharged when in a worst case scenario a bladder cancer could have been missed resulting in treatment delay.
- Both the initial outcome and subsequent plan when brought to your attention are below the standard of management expected of a consultant urologist.

Action undertaken;

- The patient has been contacted and review with me and repeat flexible cystoscopy at the time of attendance arranged.

Action required;

- Written reflection on case for appraisal / revalidation.
- Review of all consultation letters to ensure no further similar cases.

3) Personal Infor

Emergency admission with renal failure, sepsis and ureteric and bladder stone on CT. Emergency theatre, despite abnormal retrograde (hydronephrosis), presence of only one stone in the bladder (noted on CT report in addition to the ureteric stone), eGFR 36 and sepsis no stent inserted. Patient required second GA to insert a stent. Regarding bladder stone not able to use the stone punch, decided not to get the laser to treat the bladder stone and finish procedure. Initially recorded on operation note that procedure couldn't be completed because '…the staff did not find appropriate stone punch to do it.'. Amended operation note when requested by nurse in charge.

Issue; Operation note suggests that the assumption was made that because a stone was seen in the bladder the ureteric stone had passed, despite the CT findings of 2 stones and only one stone being in the bladder. Decision to abandon procedure (not treat bladder stone) despite alternative equipment being available a concern. Failure to stent a patient with hydronephrosis, sepsis and renal failure a major concern and patient subsequently required a second GA to insert a stent.

Your response;

- Did not acknowledge that surgical management was substandard.
- On questioning admitted that you do display scan images in theatre at the time of treatment, despite the ability to do this being available.
- You concluded, and in discussion continued to be of the opinion that the presence of a stone in the bladder and a retrograde ureteropyelogram not demonstrating a stone (although clearly showing hydronephrosis), meant that the 22mm upper ureteric stone had passed.
- You abandoned the cystolitholapaxy because you could not treat it with the stone punch provided and when offered alternative, appropriate equipment elected to refuse and terminate the procedure stating that ''it was already late and it would have taken time to get laser'.
- You acknowledge what you had stated in the operation note and had subsequently amended the note.
- In discussion I have concerns that you failed to recognize that CT report had shown a stone in bladder and an upper ureteric stone, and therefore in a patient with hydronephrosis, sepsis and renal failure the ureteric stone should have been assumed to be present.

Concerns;

- Abandoned procedure (to treat bladder stone)and reasoning behind this is inadequate and below expectation of a consultant urologist.
- Entry in operation note inaccurate when compared with your explanation of decision making and attempts to 'blame' other members of the team for the abandoned procedure. Only amended upon request by the nurse in charge. Behaviour not in keeping with expectation of consultant urologist and not

consistent with effective team working. No insight into this entry being inaccurate or inappropriate in our discussions.

- Failure to recognise that CT had shown 2 stones, one in the ureter and one in the bladder, and that the presence of only one stone in the bladder should have led to an assumption that the 2nd ureteric stone remained present.
- Apparent lack of recognition of the poor sensitivity of Retrograde ureteropyelogram in identification of stones.
- Failure to de-obstruct a patient with hydronephrosis despite the presence of renal failure and sepsis. This is below the standard of care expected of a consultant urologist.
- Patient required a 2nd general anaesthetic exposing the patient to addition risks.

Action undertaken;

- The patient has been appropriately managed and has appropriate ongoing follow-up planned.

Action required;

- Written reflection on case for appraisal / revalidation.

4) Personal Info

Emergency admission with renal failure and bilateral ureteric obstruction. Unilateral ureteric stent in situ. Proceeded to emergency theatre for attempt at ureteric stent which failed. Transferred to Belfast City Hospital for nephrostomy and subsequent transfer back to Southern Trust. 2nd emergency theatre attendance for TURBT which was performed. EUA (Pelvic examination) performed at end of procedure identifying pelvic mass and vesicovaginal fistula. EUA not performed at initial GA cystoscopy. My recollection is that the EUA occurred on the 2nd operation only when I entered theatre and asked if it had been done and performed it. Your recollection is that you did it without any input from me.

Your response;

- Did not acknowledge that an EUA (pelvic examination) was indicated in a patient undergoing a GA cystoscopy and attempted stent for ureteric obstruction as a standard part of the procedure.
- Stated that the difficulty with performing the cystoscopy was due to a small capacity bladder.

Concerns;

- Omission of an EUA in the initial cystoscopy falls below expectations of a consultant urologist.
- Continued inability to recognise that the bladder capacity was not limited, but that a vesicovaginal fistula resulted in the bladder not filling.
- Diagnosis may have been made earlier had an AEUA identifying the VVF and pelvic mass been performed at the first operation

Action undertaken;

- The patient has been appropriately managed and has appropriate ongoing management planned.

Action required;

- Written reflection on case for appraisal / revalidation.

5) Personal Inform

Emergency admission with sepsis and obstructed kidney, required emergency theatre for attempted ureteric stent insertion. Sent for theatre when emergency theatre available (after completion of general surgery case), patient arrived but at same time anaesthetic and nursing team called to resus and maternity to attend to 2 additional emergency situations. Patient sent back to ward. Procedure took place later that night once anaesthetic and nursing staff were available. Entry made in notes by you states '…they refused and sent the patient back to the ward.'

Your response;

- Acknowledge that your entry in the notes was made at the time.
- Stated that you put the entry in the notes to cover yourself in case the patient came to harm.
- Did not recognise or accept that your entry in the notes did not reflect the reality of the staffing difficulties faced by the team managing two life threatening emergencies in other areas in the hospital ie the staff did not 'refuse' anything.

Concerns;

- Entry in the notes was not an accurate reflection of the reasoning / decision making behind the delay in the patients emergency theatre procedure.
- Your response did not illustrate any insight into the impact of competing emergency workloads on the capacity to provide emergency treatments, in particular in the out of hours period.
- Your response did not illustrate to me any insight into what the impact of such an inaccurate entry in the notes would have on the individuals involved in the care of the patient.
- Overall concern from both the documented notes, and the discussion about your ability to effectively work as a consultant urologist within a team.

Action undertaken;

- None.

Action required;

- Written reflection on case for appraisal / revalidation.

6) Personal Inform

Patient with small renal mass on surveillance who had undergone a CT in November 2019 showing an increase in size of the renal cancer. Passed through to MDM and a letter also sent to the GP suggesting a follow-up CT in a further 12 months (22months after CT Nov 2019).

Your response;

- Acknowledge that the patient was appropriately referred to the MDM.
- Did not recognise the difficulty posed with regards the letter suggesting a follow-up CT.

Concerns;

- The letter to the GP suggesting a followup CT in 12 months, and 22 months after the CT scan is not appropriate management of an enlarging renal cancer and should not have been sent (no action should have occurred until after the MDM meeting.
- Receipt of this letter by GP will reduce confidence in patients receiving adequate care when attending the urology team.

Action undertaken;

- Patient has been discussed at MDM and appropriate follow-up and management arranged.

Action required;

- Written reflection on case for appraisal / revalidation.

3. RESPONSE TO CONCERN(S)

All the detail of the above concerns were shared with Mr Personal Information redacted by the USI He was advised that clinically the standards of care provided fell below the level required of a consultant urologist, which exposed the individual patients to unnecessary risks. As a result of these concerns The Trust would not continue with the locum employment and his contract was terminated with his agency contract with immediate effect.

4. SCOPING OF CONCERN – CONCLUSION

In line with our procedures for managing concerns involving Agency Locum doctors, we have completed our preliminary enquiries and sought the opinion of the doctor. These concerns have resulted in an early termination of a locum agency contract with immediate effect. As our concerns are with regard to clinical decision making (which is below the standard expected of a consultant urologist) the detail of our concerns must be shared with Mr Personal Information redacted by the USI Agency and Responsible Officer.

We would ask that Mr Personal Information redacted by the USI Responsible Officer **Dr F O'Kelly** to urgently consider and investigate these findings to ensure no further risk to patient safety.

NC HEALTHCARE

DOCTORS ASSESSMENT FORM

PERSONAL INFORMATION

Doctor's Name	Personal Information redacted by the USI	**Hospital**	Craigavon Area Hospital
Speciality	Urology	**Grade**	Consultant
Period of Employment	Personal Information redacted by the USI	**Unit**	Craigavon Area Hospital

The above named Doctor has recently been placed under your supervision for a locum position. As part of our follow up after care programme, we would greatly appreciate if you could provide us with a follow up assessment for the doctor's time spent at this hospital. Please could you complete and return this reference at your earliest convenience to assist this locum's ongoing development.

Please note that this information may be used as a reference for future locum placements.

Please tick the box which most reflects your view on the candidate.

CLINICAL	Excellent	Good	Average	Poor
History Taking			X	
Physical Examination			X	
Investigation and Diagnosis				X
Patient Management and Judgment				X
Clinical Skills				X

Please tick the box which most reflects your view on the candidate.

KNOWLEDGE	Excellent	Good	Average	Poor
Knowledge Basic Science			X	
Clinical Knowledge				X

Please tick the box which most reflects your view on the candidate.

ATTITUDE	Excellent	Good	Average	Poor
Reliability		X		
Leadership and Initiative				X
Administration			X	
Time Keeping		X		

Please tick the box which most reflects your view on the candidate.

RELATIONSHIPS	Excellent	Good	Average	Poor
Communication Skills			X	
Relationship with Patients			X	
Relationship with Colleagues			X	
Relationship with Other staff				X

NC Healthcare Ltd, Interchange House
Newport Pagnell, Milton Keynes, MK16 9PY
Tel: 01908 299 180 Fax: 01908 299 186

NC HEALTHCARE

Please tick the box which most reflects your view on the candidate.

PERSONAL ATTRIBUTES	Excellent	Good	Average	Poor
Appearance		X		
Professionalism and conduct			X	

[redacted]

FUTURE EMPLOYMENT

[redacted]

Would you be happy to receive this doctor again for a locum position? No

If so, do you know of any future dates, which this locum may be required? N/A

[redacted]

ADDITIONAL COMMENTS

[redacted]

Please feel free to make any additional comments, which you feel will be helpful to us i.e. training needs you have identified.

Please see enclosed details of concerns. In our experience Mr [redacted] does not meet the standards required of a Consultant Urologist.

[redacted]

SIGNATURE SECTION

We would like to thank you for talking the time to complete this assessment form. It can be returned either by mail or fax to the address or number shown below.

Please feel free to contact us should there be any other information that you would like to bring to our attention, or indeed if you wish to talk further regarding this doctor or any other service which NC Healthcare can assist you with.

Consultant Name	Mark Haynes	**Signature**	[redacted]
Grade/ Speciality	CONSULTANT UROLOGIST	**Date**	[redacted]

[redacted]

NC Healthcare Ltd, Interchange House
Newport Pagnell, Milton Keynes, MK16 9PY
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CHKS
Insight for better healthcare

Consultant Level Indicator Programme

Consultant: Mr Mark Haynes (C8244)

10100 - Urology

Southern Health and Social Care Trust

Report data period: January 2018 - December 2018

Generated 22nd February 2019

Attribution Discharge

About CHKS

CHKS is a provider of healthcare intelligence and quality improvement services. Over the last 30 years our team of NHS data experts, clinicians and quality managers have worked with more than 400 healthcare organisations around the world to improve population health.

We enable providers and commissioners to make better decisions at patient, service, organisation and population level and deliver sustainable improvements in care quality, patient outcomes and service efficiency along the entire patient pathway.

Our services include:

- Healthcare benchmarking and analytics - we identify what to improve and model the impact of change at patient, organisation and population level
- Clinical coding, data quality and costing services - we ensure data used for payment and decision making accurately reflects the care delivered
- Care quality, assurance and accreditation - we work to the latest international standards of best practice within a proven framework of continuous improvement

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1. Report Overview

This report has been produced based on information extracted from the organisation's patient administration system. The individual consultant and the data period are both detailed on the front cover of the report.

You have been assigned to a specialty based on a combination of the specialty your organisation assigned you to and the clinical information about the patients you treated. For example, you may have been assigned to trauma and orthopaedics by your organisation but based on the clinical information recorded about the patients you treated CHKS have subdivided this specialty further to hand, hip, knee, etc. The same criteria are then applied to both the local and selected peer ensuring that comparisons are as appropriate as possible.

The analysis included in this report frequently refers to consultant, local peer and selected peer which are explained below:

- Consultant - displays the consultant value, shown as an index, percentage/rate or ratio depending on each indicator's calculation. Where applicable the actual value (numerator) is shown.
- Local Peer - displays the local peer value which consists of consultant colleagues' average value within the same organisation and same specialism.
- Selected Peer - displays the external peer value which consists of a selection of consultants' average value within the same specialism but from external organisations.

The scorecard view also contains a **Peer Range** which displays a comparison with the selected peer group ONLY and is shown graphically within a RAG spectrum. The linear spectrum shows the consultants value plotted between the 10th to 90th percentile values of the selected peer. If the consultant's value is outside this range then it is displayed as a diamond.

Rating	Interpretation
	Consultant value falls within the top 75% percentile of the peer
	Consultant value falls between the 75% and 25% percentiles of the peer
	Consultant value falls within the bottom 25% percentile of the peer
	Consultant has no data
	Insufficient peer data available to make a meaningful comparison

* Data suppressed due to small number rules.

Risk adjusted indicators should be reviewed in conjunction with a range of other quality indicators and contextual information. Variation from the expected can be due to a range of issues and it is important that all are investigated and understood. These might include data quality issues and differences in service configuration. Accurate measurement of outcomes and risk also require sufficient numbers to develop robust statistical models.

Indicator definitions are either included in your report, are available locally or can be obtained by emailing info@chks.co.uk, including the name of the organisation you work for along with your GMC number and name.

Peer Sites		
Isle of Wight NHS Trust	Barts Health NHS Trust	The London North West Healthcare NHS Trust
Royal Surrey County Hospital NHS Foundation Trust	Weston Area Health NHS Trust	Yeovil District Hospital NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Southend University Hospital NHS Foundation Trust
Royal Free London NHS Foundation Trust	North Middlesex University Hospital NHS Trust	The Hillingdon Hospitals NHS Foundation Trust
Kingston Hospital NHS Foundation Trust	Taunton And Somerset NHS Foundation Trust	Dorset County Hospital NHS Foundation Trust
Walsall Healthcare NHS Trust	Wirral University Teaching Hospital NHS Foundation Trust	St Helens And Knowsley Hospitals NHS Trust
Mid Cheshire Hospitals NHS Foundation Trust	Northern Devon Healthcare NHS Trust	Bedford Hospital NHS Trust
Luton and Dunstable University Hospital NHS Foundation Trust	York Teaching Hospital NHS Foundation Trust	Harrogate And District NHS Foundation Trust
Airedale NHS Foundation Trust	The Queen Elizabeth Hospital King's Lynn NHSFT	Royal United Hospital Bath NHS Trust
Poole Hospital NHS Foundation Trust	Milton Keynes Hospital NHS Foundation Trust	Basildon And Thurrock University Hospitals NHSFT
Colchester Hospital University NHS Foundation Trust	Frimley Park Hospital NHS Foundation Trust	The Royal Bournemouth And Christchurch Hospitals NHSFT
South Tyneside NHS Foundation Trust	Royal Cornwall Hospitals NHS Trust	Aintree University Hospital NHS Foundation Trust
Barking Havering And Redbridge University Hospitals NHST	Barnsley Hospital NHS Foundation Trust	The Rotherham NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust	Peterborough And Stamford Hospitals NHS Foundation Trust	James Paget University Hospitals NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust	West Suffolk NHS Foundation Trust	Cambridge University Hospitals NHS Foundation Trust
Royal Devon And Exeter NHS Foundation Trust	University Hospital Southampton NHS Foundation Trust	Sheffield Teaching Hospitals NHS Foundation Trust
Portsmouth Hospitals NHS Trust	Royal Berkshire NHS Foundation Trust	Guy's And St Thomas' NHS Foundation Trust
Lewisham and Greenwich NHS Trust	Croydon Health Services NHS Trust	St George's Healthcare NHS Trust
South Warwickshire NHS Foundation Trust	University Hospital Of North Midlands NHS Trust	Derby Hospitals NHS Foundation Trust

Northern Lincolnshire And Goole Hospitals NHS Foundation Trust	East Cheshire NHS Trust	Countess Of Chester Hospital NHS Foundation Trust
King's College Hospital NHS Foundation Trust	Sherwood Forest Hospitals NHS Foundation Trust	Plymouth Hospitals NHS Trust
University Hospitals Coventry And Warwickshire NHS Trust	The Whittington Hospital NHS Trust	The Royal Wolverhampton Hospitals NHS Trust
City Hospitals Sunderland NHS Foundation Trust	Wye Valley NHS Trust	George Eliot Hospital NHS Trust
Norfolk And Norwich University Hospitals NHSFT	Salford Royal NHS Foundation Trust	Bolton NHS Foundation Trust
Tameside Hospital NHS Foundation Trust	Great Western Hospitals NHS Foundation Trust	Hampshire Hospitals NHS Foundation Trust
Dartford And Gravesham NHS Trust	The Dudley Group NHS Foundation Trust	North Cumbria University Hospitals NHS Trust
Kettering General Hospital NHS Foundation Trust	Northampton General Hospital NHS Trust	Salisbury NHS Foundation Trust
Doncaster And Bassetlaw Hospitals NHS Foundation Trust	Medway NHS Foundation Trust	Royal Liverpool And Broadgreen University Hospitals NHSFT
Mid Essex Hospital Services NHS Trust	Chelsea And Westminster Hospital NHS Foundation Trust	The Princess Alexandra Hospital NHS Trust
Homerton University Hospital NHS Foundation Trust	Heart Of England NHS Foundation Trust	Gateshead Health NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust	Wrightington Wigan And Leigh NHS Foundation Trust	University Hospitals Birmingham NHS Foundation Trust
University College London Hospitals NHS Foundation Trust	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Gloucestershire Hospitals NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust	Derby Hospitals NHS Foundation Trust	Oxford University Hospitals NHS Trust
Ashford And St Peter's Hospitals NHS Foundation Trust	Surrey And Sussex Healthcare NHS Trust	South Tees Hospitals NHS Foundation Trust
University Hospitals Of Morecambe Bay NHS Foundation Trust	North Bristol NHS Trust	Epsom And St Helier University Hospitals NHS Trust
East Kent Hospitals University NHS Foundation Trust	North Tees And Hartlepool NHS Foundation Trust	Southport And Ormskirk Hospital NHS Trust
Pennine Acute Hospitals NHS Trust	Hull And East Yorkshire Hospitals NHS Trust	United Lincolnshire Hospitals NHS Trust
University Hospitals Of Leicester NHS Trust	Maidstone And Tunbridge Wells NHS Trust	West Hertfordshire Hospitals NHS Trust
East And North Hertfordshire NHS Trust	Stockport NHS Foundation Trust	Worcestershire Acute Hospitals NHS Trust

Warrington And Halton Hospitals NHS Foundation Trust	Calderdale And Huddersfield NHS Foundation Trust	Nottingham University Hospitals NHS Trust
East Sussex Healthcare NHS Trust	Mid Yorkshire Hospitals NHS Trust	Brighton And Sussex University Hospitals NHS Trust
Sandwell And West Birmingham Hospitals NHS Trust	Blackpool Teaching Hospitals NHS Foundation Trust	Lancashire Teaching Hospitals NHS Foundation Trust
County Durham And Darlington NHS Foundation Trust	Buckinghamshire Healthcare NHS Trust	East Lancashire Hospitals NHS Trust
Shrewsbury And Telford Hospital NHS Trust	Imperial College Healthcare NHS Trust	Western Sussex Hospitals NHS Foundation Trust
Manchester University NHS Foundation Trust	Torbay And South Devon NHS Foundation Trust	

2. Scorecard

The scorecard below is a collection of performance and efficiency indicators at consultant level. For each indicator consultant, local peer and selected peer values are displayed along with a peer range based on a RAG spectrum. See overview for explanation of values.

Indicator	Consultant		Local	Peer	Peer Range
Average Length of Stay (FCE - zero trimmed)	1053	4.54	4.11	3.30	
Elective Average Length of Stay (FCE - zero trimmed)	351	3.28	2.96	2.41	
Non-elective Average Length of Stay (FCE - zero trimmed)	702	5.62	4.84	4.02	
Elective Average Pre-Op Length of Stay (Spell - zero trimmed)	3	0.04	0.07	0.09	
Day Case Rate	403	76.76%	82.97%	72.39%	
Day Case Overstays	27	6.28%	4.85%	8.10%	
Elective IP - procedure not carried out	1	1.61%	0.56%	0.63%	
Elective IP - procedure not carried out - patient reason	0	0%	0%	0.02%	
Elective IP - procedure not carried out - other than patient reason	1	1.61%	0.56%	0.61%	
Elective IP - no procedure	1	1.64%	0.84%	0.83%	
Mortality Rate	4	0.51%	0.24%	0.26%	
Mortality Rate - Elective	0	0%	0%	0.02%	
Mortality Rate - Non-elective	4	0.51%	0.24%	0.23%	
Readmissions within 28 days	31	4.68%	4.83%	7.45%	
Complication rate - attributed	2	0.25%	0.67%	1.41%	
Misadventure rate	1	0.13%	0.04%	0.19%	
Outpatient New to follow-up ratio	529	1 : 1.03	1 : 1.25	1 : 1.72	
Outpatient DNA Rate	41	3.78%	3.69%	6.98%	
Outpatient DNA Rate - New Attendances	27	4.98%	4.65%	6.45%	
Outpatient DNA Rate - Follow-up Attendances	14	2.58%	2.91%	7.29%	

3. Activity

The activity tables display a collection of activity based indicators split by inpatient and outpatient workload.

Admitted Workload

Indicator	Consultant		Local	Peer
Total FCEs	823	-	1110.40	453.23
% Elective FCEs	679	82.50%	81.03%	71.30%
% Elective FCEs - Inpatients	141	20.77%	16.23%	27.86%
% Elective FCEs - Day Cases	408	60.09%	75.22%	70.52%
% Regular Attenders	130	19.15%	8.74%	1.96%
% Emergency FCEs	115	13.97%	14.99%	26.66%
% Other FCEs	29	3.52%	3.98%	2.04%

Outpatient Workload

Indicator	Consultant		Local	Peer
Total Attendances (OP)	1044	-	1381.80	2757.07
Total New OP Attendances	515	-	615	1012.03
Total Follow-up OP Attendances	529	-	766.80	1743.41
Outpatient Attendances with a Procedure	48	4.60%	3.50%	38.12%
New Outpatient Attendance with a Procedure	47	9.13%	6.86%	46.34%
Follow-up Attendances with a Procedure	1	0.19%	0.81%	33.38%
New Outpatient Attendance - referred by GP	320	62.14%	61.33%	49.93%
Total DNA's	41	-	53	206.91
% of DNA's New Attendances	27	65.85%	56.60%	33.73%
% of DNA's Follow-up Attendances	14	34.15%	43.40%	66.27%

4. Risk Adjusted Indicators

This analysis displays a collection of risk adjusted indicators for the target consultant by elective and non-elective activity. The indicators compare the observed numbers in the relevant indicator to the expected number. The indices are expressed as percentages. An index of 110% suggests 10% more than expected, whilst 90% suggests 10% fewer than expected. See indicator definitions for an explanation of values for each index.

Please note that risk adjusted indicators should be reviewed in conjunction with a range of other quality indicators and contextual information. Variation from the expected can be due to a range of issues and it is important that all are investigated and understood. These might include data quality issues and differences in service configuration. Accurate measurement of outcomes and risk also require sufficient numbers to develop robust statistical models.

Indicator	Consultant		Local	Peer
Risk adjusted mortality index 2017	4	73.06	63.75	48.92
Elective	-	-	-	56.16
Non-elective	4	80.63	72.58	48.26
Risk Adjusted Length of Stay Index 2017	939	113.02	99.40	82.62
Elective	293	106.43	123.27	80.10
Non-elective	646	116.28	92.49	83.84
Risk adjusted readmissions 2017	33	74.08	80.72	108.66
Elective	18	69.37	71.31	112.20
Non-elective	15	80.66	92.45	105.57

5. Focus

Focus displays the top 10 procedures / diagnoses at consultant level split by day cases, inpatient procedures and the top 5 outpatient procedures. In medical specialties the inpatient profile will be the top diagnoses while for surgical specialities it will be procedures. The day case procedure profile includes the volume, day case rate and day case overstay rate; the inpatient profile includes the volume and average length of stay and the outpatient profile shows volume of procedures.

Please note that if your organisation or your selected peer does not clinically code, or only partially clinically code outpatient activity these values may not reflect activity. Your local clinical coding department will be able to advise you.

Day Case Top 10 Procedures by Volume

	Actual Day Cases						Day Case Overstays					
	Number			Rate			Number			Average LoS		
Procedure	Cons	Local	Peer	Cons	Local	Peer	Cons	Local	Peer	Cons	Local	Peer
M45 - Diagnostic endoscopic examination of bladder	237	285	40.61	97.93 %	97%	88.21 %	2	2	*	1	1.80	1.53
M49 - Other operations on bladder	28	139	28.88	100%	99.86 %	96.14 %	0	0	*	0	0	1.71
M29 - Other therapeutic endoscopic operations on ureter	25	15.60	7.38	89.29 %	66.10 %	67.55 %	2	3.80	*	1	3	1.93
N30 - Operations on prepuce	9	12.20	11.54	100%	92.42 %	92.03 %	0	0.40	*	0	2	1.25
M43 - Endoscopic operations to increase capacity of bladder	8	21	*	88.89 %	92.92 %	87.68 %	0	0.60	*	0	3	1.55
M27 - Therapeutic ureteroscopic operations on ureter	6	3.80	*	42.86 %	20.43 %	50.63 %	3	6.80	*	3.33	2.32	1.60
M42 - Endoscopic extirpation of lesion of bladder	5	3.40	6.45	17.86 %	12.50 %	30.39 %	3	3.20	*	2	2.06	1.65
M13 - Percutaneous puncture of kidney	4	1.40	*	80%	63.64 %	37.67 %	0	0.40	*	0	4	2.89
M16 - Other operations on kidney	3	4	*	75%	66.67 %	43.92 %	1	0.40	*	4	12	2.83
M70 - Other operations on outlet of male bladder	3	0.40	20.98	60%	66.67 %	90.93 %	2	0	*	6	0	1.38

Inpatient Top 10 Procedures by Volume

Procedure	Number			Pre-op Average LoS			IP Average LoS		
	Cons	Local	Peer	Cons	Local	Peer	Cons	Local	Peer
M42 - Endoscopic extirpation of lesion of bladder	26	27.80	15.82	0.04	0.23	-56.62	2	3.39	2.07
U21 - Diagnostic imaging procedures	18	21.40	13.90	0	-	1.94	6.89	5.72	2.51

Outpatient Top 5 Procedures by Volume

Procedure	Consultant	Local	Peer
M47 - Urethral catheterisation of bladder	43	42.20	23.48
M70 - Other operations on outlet of male bladder	5	5.80	9.08

6. Trend

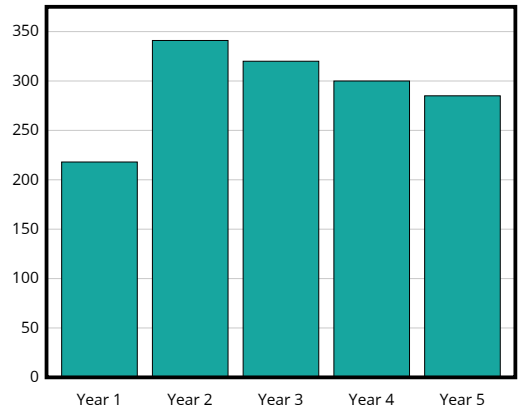
This analysis displays a collection of performance and efficiency indicators for the target consultant comparing performance year on year data for the selected time period. Up to a maximum of five years can be displayed depending on the availability of data.

Data may be missing if your organisation has not submitted historical data to CHKS or if you became a consultant at the organisation within the last five years.

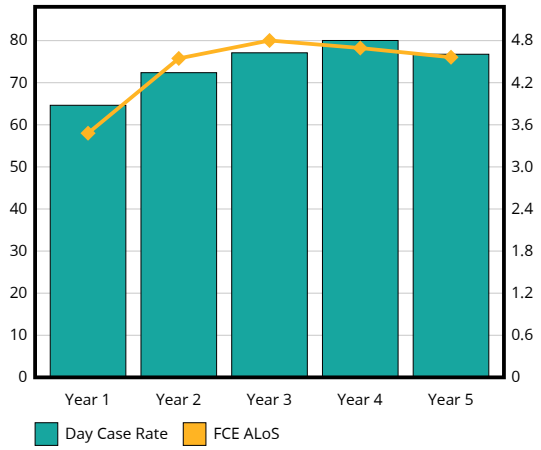
If a period of less than 12 months is selected then this is also the period that will be reported for the previous years. For example, if the selected period is January - June 2016 then the previous four years will be the January - June period in each year.

Indicator	Jan 14 - Dec 14	Jan 15 - Dec 15	Jan 16 - Dec 16	Jan 17 - Dec 17	Jan 18 - Dec 18
Total FCEs (Exclusions: Standard and Day-cases)	218	341	320	300	285
Average Length of Stay (FCE - zero trimmed)	3.46	4.52	4.78	4.67	4.54
Day Case Rate	64.64%	72.39%	77.11%	80.03%	76.76%
Mortality Rate	0%	0.33%	0.10%	0.11%	0.51%
Readmissions within 7 days	2.65%	1.80%	2.63%	2.06%	2.27%
Readmissions within 14 days	3.09%	3.86%	3.75%	2.84%	3.17%
Readmissions within 28 days	3.97%	5.66%	5.01%	4.38%	4.68%
Total New OP Attendances	376	544	629	530	515
Total Follow-up OP Attendances	447	1000	800	693	529
Outpatient DNA Rate	3.40%	3.80%	3.45%	4.60%	3.78%
Outpatient DNA Rate - Follow-up Attendances	2.61%	3.29%	2.44%	4.28%	2.58%

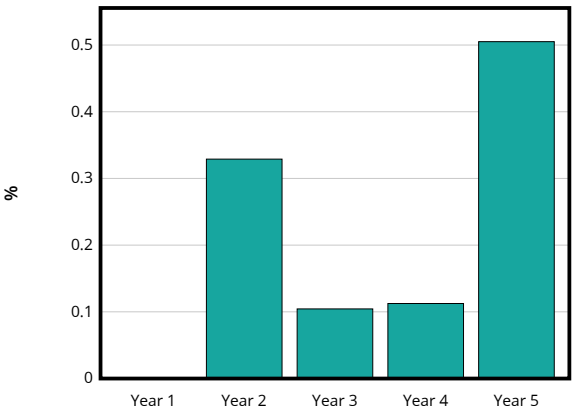
Total FCEs



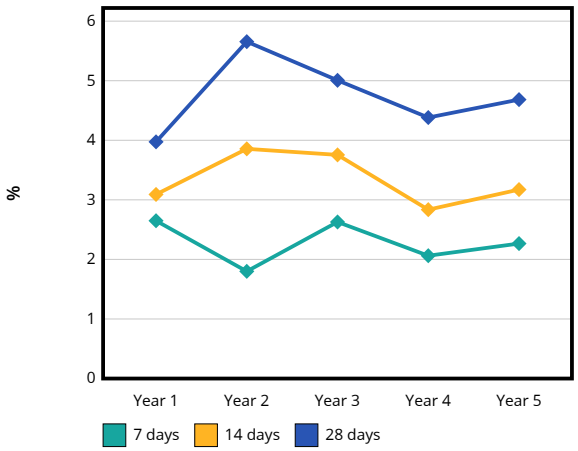
Day Case Rate & FCE ALoS



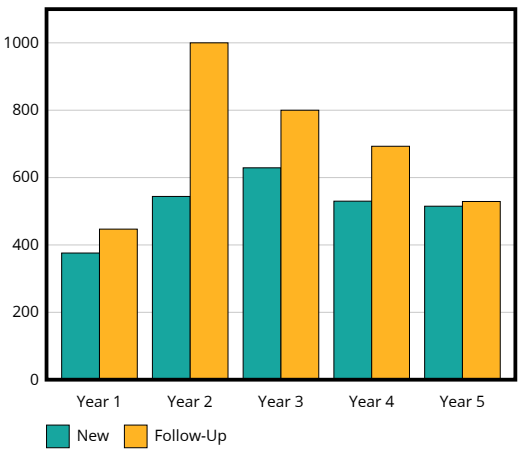
Mortality Rate



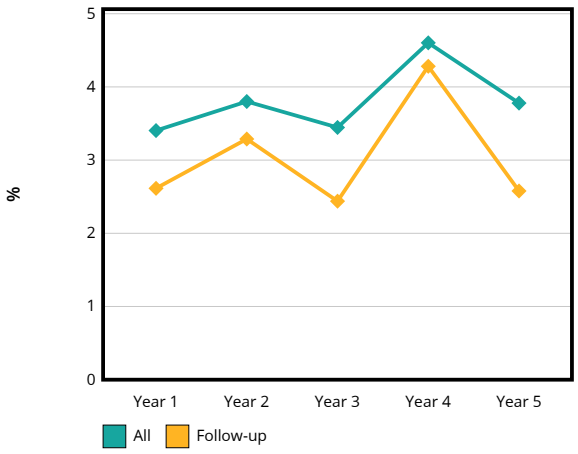
Readmission Rate



Outpatient Attendances



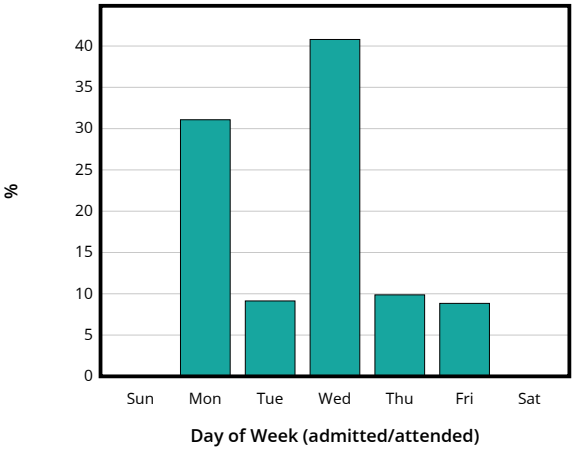
Outpatient DNA Rate



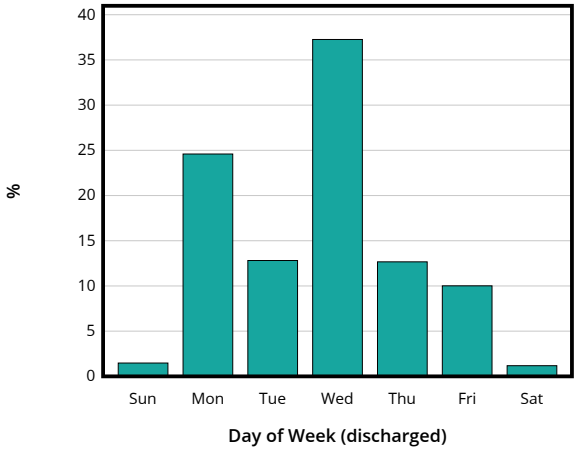
7. Schedule

This section displays the consultant profile for a selection of indicators by the day of the week of admission and discharge.

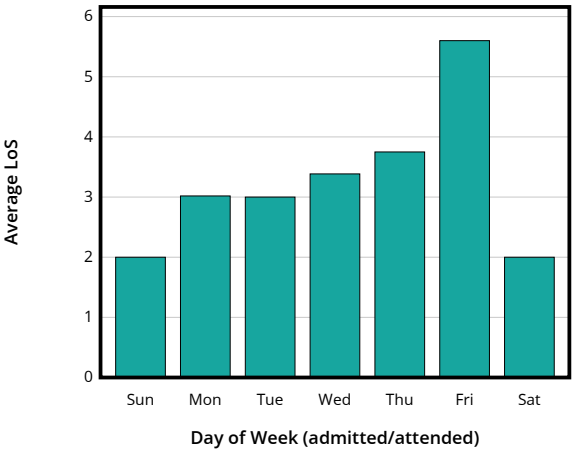
Elective Inpatient Admission Profile



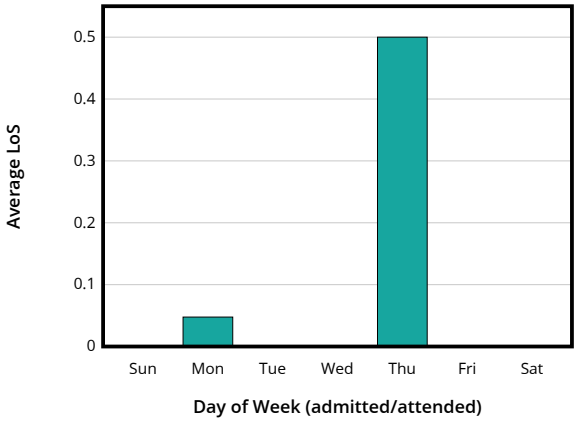
Elective Inpatient Discharge Profile



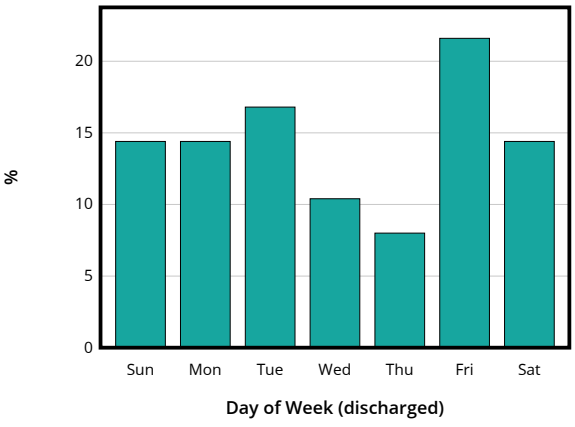
Elective Inpatient ALoS Profile



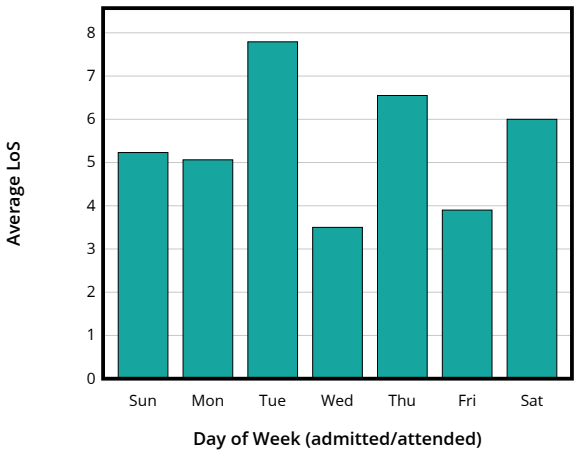
Elective Inpatient Pre-op ALoS Profile



Non-Elective Inpatient Discharge Profile



Non-Elective Inpatient ALoS Profile



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

CLIP (Consultant Led Indicator Programme) Report structured reflective template

Requirement: One annually

Name of doctor: Mark Haynes	GMC No: 4644334
Date of report: 22/02/2019	

What issues can I identify from the report?
I have ongoing significant concern regarding the validity of the data. For example the CLIP report states that I performed 14 nephrectomies in the year. The true value is in excess of 50 (I operate in BCH and CAH). As such I have concerns all other data relating to inpatients in inaccurate.
Regarding outpatient activity where the data is more likely to be robust, the CLIP report confirms my own impression that I offer a streamlined service which minimises patient visits, with a low New:Follow-up ratio.

What actions will I undertake?
Unfortunately as I do not code or collate the data there is no action I can undertake too improve the data quality.

Final outcome after discussion at appraisal:
(Complete at appraisal)

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

Medical Staff Appraisal Scheme

Southern Health and Social Care Trust –
Version 4.0 [1 July 2014]

DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Medical Staff Appraisal Scheme Version: 4.0
Supersedes	Supersedes: Medical Staff Appraisal Scheme
Originator	Name of Author: Anne Brennan Title: Senior Manager Medical Directorate
Approval	Referred for approval by: Anne Brennan Date of Referral: 7/3/14 Revalidation Group Approval (Date) 14/3/14
Circulation	Issue Date: 16/5/14 Circulated By: Medical Directorate Issued To: As per circulation List: All Medical Staff
Review	Review Date: 2 years unless legislative change necessitates earlier review Responsibility of (Name): Anne Brennan Title: Senior Manager Medical Directorate

Medical Appraisal Scheme

Southern Health and Social Care Trust

1 Introduction

This document sets out the Trust's appraisal scheme for Consultant and SAS Doctors.

The scheme will form a critical element of the Trust's corporate and clinical governance processes. It is recommended that this document is read in conjunction with these circulars and the DHSSPS document 'Guidance for Medical Appraisal'.

The Trust makes it a requirement for its entire medical staff, including locum/temporary doctors (employed for more than 6 months), to participate in this appraisal scheme. This will satisfy the requirement for medical staff to participate in an annual appraisal and present evidence of competence in the field of practice in order to retain the GMC licence to practice.

The Trust will create an 'appropriate environment' for a doctor to have a supportive and developmental annual review. It is expected that the appraisal process and completion of the attached appraisal forms, will provide doctors with the supporting documentation necessary for GMC revalidation.

This appraisal scheme will be linked closely with job planning arrangements and the appraisal meetings will provide the opportunity to draw together information and data which shape job plans.

2 Main Purpose of Appraisal

Medical Appraisal can be defined as:

A positive process of constructive dialogue, in which the doctor being appraised has a formal, structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved. It should support doctors in their aim to deliver high quality care whilst ensuring they are practicing within a safe and effective framework.

The aims and objectives of appraisal are to enable doctors and employers to:

- review regularly an individual's work and performance, utilising relevant and appropriate comparative performance data from local, regional and national sources
- optimise the use of skills and resources in seeking to achieve the delivery of service priorities

- consider the doctor's contribution to the quality and improvement of services and priorities delivered locally
- define personal and professional development needs and agree plans for these to be met
- identify the need for the working environment to be adequately resourced to enable any service objectives in the agreed job plan review to be met
- provide an opportunity for doctors to discuss and seek support for their participation in activities for the wider HSC
- contribute to the governance requirements of the organisation
- utilise the annual appraisal process and associated documentation to contribute to the requirements of revalidation.

In addition to the above aims, medical appraisal should:

- be delivered by competent, trained appraisers
- be consistently applied
- be undertaken annually
- not be a one-off event but a continual process and an integral part of a learning culture
- relate to **all areas** of a doctor's practice

3 Appraisal & Medical Revalidation

3.1 Revalidation

The General Medical Council (GMC) has implemented a system of revalidation for its registrants in December 2012. This change in medical regulation will provide an assurance to patients and the public that doctors are keeping up to date and are fit to practise. All registrants wishing to practise medicine have been issued with a licence to practise from the GMC. Renewal of this licence will be subject to the process of revalidation whereby a senior doctor in a healthcare organisation, known as a Responsible Officer, will make a recommendation to the GMC that those doctors with whom they have a prescribed relationship are practising to the standards defined by the GMC in Good Medical Practice[1].

[1] http://www.gmc-uk.org/guidance/good_medical_practice.asp

In order to make this recommendation, the Responsible Officer will review a range of information relating to individual doctors. Rather than the addition of another process that has potential to place an administrative burden on doctors, the appraisal process should be the platform for reviewing the supporting information required by the GMC for revalidation that demonstrates the doctor is practicing to the standards of *Good Medical Practice*.

All doctors will have been directly notified of their revalidation timeframe and the minimum requirements for revalidation. The Trust has adopted a two-staged approach to ensure doctors meet the GMC's revalidation requirements. An 'initial' meeting is held with each doctor approximately six weeks before their revalidation date to review their revalidation portfolio, with a further 'sign-off' meeting being held four weeks later after which time a recommendation is made to the GMC.

NB: The Trust can only revalidate those with whom it has have a direct contractual link at their actual date of Revalidation. Those who are leaving the Trust (e.g. retiring, end of temporary contract) should contact the Revalidation Support Team to obtain advice regarding alternative options for Revalidation.

4 Roles, Responsibilities and Accountabilities

4.1 Role of the Trust

- Ensure that an appraisal system is in place which covers all doctors employed by the Trust
- Ensure that the appraisal scheme meets the requirements of GMC Revalidation
- Ensure that all doctors undergo annual appraisal in line within the national framework.
- Establish workable arrangements for identifying, appointing and training appraisers.
- Ensure that appropriate mechanisms are in place to quality assure appraiser training, and to regularly review the appraisal process in the light of participant experiences and changing circumstances.
- Ensure robust processes are in place to deal with worries and complaints from individual doctors about the process or outcomes of appraisal.
- Co-ordinate the education and practice of Appraisers to ensure that objectives are focussed to meet needs of patients within Southern Trust population.
- Receive summaries of individual appraisal meetings to identify education' service needs and support required by doctors.
- Report the overall outcome of the appraisal process to the Trust Board on a yearly basis.
- Resolve concerns or disputes regarding the appraisal process.

- Lead the review and development of the Appraisal Scheme

Staff Category	Participants in Southern Trust Appraisal Scheme	Comment	Prescribed Connection to SHSCT RO
Permanent Employed Consultant Staff	Yes	Contractually obliged	Yes
Permanent Employed SAS Doctors	Yes	Contractually obliged	Yes
Locum Medical Staff [in excess of 6 months]	Yes	Contractually obliged	Yes
Doctors in Training	No	Via NIMDTA	No
Locum Medical Staff [in excess of 1 week but less than 6 months]	Yes	See Locum Medical Staff Section 5	No
GP with Special Interest/Trust Contracts	No Participate in NIMDTA GP Appraisal Scheme –	Information on SHSCT contracted work should be provided for GP Appraisal Assurance of completion of appraisal to be forwarded to Trust Medical Director	No
GP employed in Out of Hours Service	No Participate in NIMDTA GP Appraisal Scheme –	Information on SHSCT contracted work should be provided for GP Appraisal – Assurance of completion of appraisal to be forwarded to Trust Medical Director	No

4.2 Accountabilities

The Chief Executive is personally accountable to the Trust Board for overseeing the appraisal process and confirming to the Trust Board that:

- appraisals have been conducted for all medical staff;
- any issues arising out of the appraisals are being properly dealt with
- personal development plans are in place for each doctor.
- appraisers and appraisees are trained to undertake appraisal across the full range of headings within the appraisal scheme
- appointment of a Responsible Officer, normally the Medical Director to make recommendations to the General Medical Council.

The Chief Executive will operate the system through the Medical Director and Associate Medical Directors and they will be accountable for ensuring any necessary action arising from the appraisal process is undertaken

The Medical Director, on behalf of the Chief Executive, will be responsible for ensuring the integrity of the appraisal scheme and for managing potential operational difficulties so that the validity of the process is maintained.

The Medical Director will ensure the necessary links exist between the appraisal process and other Trust processes concerned with clinical governance, quality and risk management and the achievement of service priorities. In discharging this accountability, the Chief Executive and Medical Director will have confidential access to Forms 3 and 4 and personal development plans as part of the appraisal process.

Individual doctors are responsible for participating properly in the appraisal process and for undertaking any identified development.

4.3 Role of the Responsible Officer

It will not normally be the role of a Responsible officer to undertake appraisal for every doctor employed by the organisation to which they are appointed (although this may be the case where an organisation employs few doctors). Rather, the Responsible Officer must be able to demonstrate that all associated governance systems that support doctors are functioning effectively. In terms of appraisal, the Responsible Officer must ensure that the appraisal system is appropriately monitored and is of sufficient quality.

The Responsible Officer should ensure that the governance processes that support appraisal are sufficiently robust, namely:

- Accountability and oversight
- Information sharing
- Processes for escalation of concerns arising from appraisal
- Process to manage complaints in relation to the appraisal process

When the Responsible Officer is asked to make a recommendation to the GMC on revalidation, participation in, and outcomes from, appraisal will provide a key source of information upon which their recommendation will be based, alongside information obtained from clinical and social care governance systems in their organisation. Guidance on the role of the Responsible Officer has been developed and provides further information on this process. [2]

The function of appraisal, therefore, remains supportive and developmental but concurrently supports the Responsible Officer in making a recommendation to the GMC on the fitness to practice of individual doctors.

4.4 Role of the Appraisee:

[2] http://www.dhsspsni.gov.uk/index/hss/confidence_in_care.htm

- Develop an understanding of the appraisal process.
- Participate fully in appraisal
- In conjunction with Medical Management, identify an appraiser
- Make contact with appraiser to schedule appraisal meeting
- Prepare for the appraisal meeting and make the appraisal folder available to the appraiser at least 10 working days in advance of the planned appraisal meeting.
- Agree personal objectives, actions and individual development plan for the coming year.
- Identify factors that may inhibit performance.
- Prepare supporting evidence for revalidation with GMC.
- Seek to achieve defined objectives and fulfil individual learning and development plan.
- Complete form/s clearly and legibly.
- Be responsible to inform the appraiser of any performance or professional issues.
- Send the signed original of all seven forms including the Personal Development Plan [PDP] to the Medical Director's Office, Clanrye House, Daisy Hill Hospital.

4.5 Role of the Appraiser

- Undertake appropriate training in the role of an appraiser. Appraisers are required to attend an in-house Appraiser Clinic at least every 3 years.
- Undertake appraisal with a number of designated doctors – at least five but no more than eight per year.
- Prepare for appraisal and agree an agenda with the appraisee which should include an appropriate balance of personal, professional and local objectives.
- Ensure that the appraisal is conducted in line with good practice and within the national appraisal framework as defined by the DHSSPS
- Support the appraisee in considering practice over the last year.
- Agree objectives and development plan with the appraisee.
- Agree a confidential record of the appraisal meeting to be kept by appraisee and the appraiser.
- Build a positive relationship with the appraisee
- Identify any warning signs that the appraisee may be experiencing difficulties and provide further discussion with the appraisee about how this should be addressed.

- Refer to the Associate Medical Director/Medical Director if the appraiser has serious concerns about the appraisee performance or capacity to perform.

- Complete form/s clearly and legibly.

NB Where a doctor has undertakings or conditions placed on them by the GMC, the Trust's Revalidation Support Team will write to their workplace supervisor at the start of the Appraisal year in order that they can make contact with the doctor's Appraiser.

4.6 Southern Trust Medical Appraisal Structure

4.6.1 Medical Appraisal & Revalidation Group

Membership:

- Medical Director [Chair]
- Corporate Lead for Appraisal and Revalidation
- Lead Appraisers
- Associate Medical Directors
- Appraisers
- LNC Representative
- SAS Doctors LNC Representative
- Director of Human Resources and Organizational Development
- Medical Staffing Manager
- Medical Directorate Manager
- Revalidation Project Manager

4.7 Appraisal Annual Report

The Medical Director will submit an annual report on the operation of the appraisal scheme to a Public Trust Board Meeting. This information will be shared and discussed with the Trust Appraisal and Revalidation Group. The annual report will not refer, explicitly or implicitly, to any individuals who have been appraised but, rather, will highlight any Trust wide issues and action arising out of the appraisal process, for example, educational developments.

The Medical Director will formally review the appraisal process with the Chief Executive and the Director of Human Resources and Organisational Development on an annual basis.

5 Locum/Temporary Medical Staff Appraisal

Locum and temporary doctors should be actively encouraged to keep a logbook of their clinical activities, an account of their involvement in critical incidents and a record of their CPD activities.

As a general principle, locum doctors should be actively encouraged to reflect on their practice and career development and where possible locum doctors should be included in the Trust's development programmes.

5.1 Employed Less Than 6 months

An exception exit report will be completed for doctors who are employed as locum/temporary contracts [from agency] less than 6 months.

Reports of doctors contracted from locum agencies will be produced on a bi-annual basis. This will be forwarded to the relevant Associate Medical Director who will be asked to confirm that the doctors have not been involved in conduct, capability or formal serious untoward incidents/significant event investigations or are named in complaints.

Any immediate concerns should be reported on an exception basis to the relevant Associate Medical Director and Medical HR Department.

Any concerns raised through this process will be immediately reported to the relevant Associate Medical Director/Operational Director.

For Doctors employed via the Regional Medical Locums Bank, the supervising consultant sign off requires confirmation that there were no concerns about the doctor during their placement.

5.2 Employed on Initial Contracts of More Than 6 months But Less Than 1 Year

A locum/temporary doctor employed [either directly by the Trust or via agency- in either training or non-training grade posts] for periods of more than six months but less than 1 year are not included in the routine appraisal processes and may not have a prescribed connection to the Trust Responsible Officer. Click here for GMC Guidance on finding your designated body.

The Trust requires this group to undertake an 'Appraisal Induction' before the end of month 3 of their placement. The Trust Revalidation Support Team will support this process by providing relevant guidance to the doctor.

The 'Appraisal Induction' will include:

- Review of previous NHS appraisals [if available]
- Development of a Personal Development Plan
- Assessment/presentation of any complaints and incidents for the period
- Completion of Health and Probity declarations.

Any immediate concerns should be reported on an exception basis to the relevant Associate Medical Director and Medical HR Department.

5.3 Employed Via an Agency [Designated Body]

In some instances a locum doctor may be employed via an agency where the appraisal of doctors/revalidation is part of the services provided by that agency.

The doctor should confirm their arrangements at the time of appointment.

6 Appraisal for New Permanent Starts

The Trust requires details of previous appraisals from doctors previously employed in the NHS.

The Trust also requires new starts to undertake an 'Appraisal Induction' at the end of month 3 of their new appointment. The Trust Revalidation Support Team will support this process by providing relevant guidance to the doctor.

The 'Appraisal Induction' will include:

- Review of previous NHS appraisals [if available]
- Development of a Personal Development Plan
- Assessment/presentation of any complaints and incidents for the period
- Completion of Health and Probity declarations.

Irrelevant redacted by the USI

The newly employed doctor will also meet with the Trust's Medical Director / Responsible Officer once their appraisal induction is complete. This will be organised by the Trust's Revalidation Support Team.

7 GP with Special Interest/Trust Contracts Appraisal

Under the principles of whole practice appraisal General Practitioners with Special Interest or Trust contracts [e.g. GP OOH, A & E] will be expected to provide documented evidence of their special interest work for inclusion in their formal national GP appraisal.

See 'Supporting the Revalidation of General Practitioners – Guidance for GP's and their Clinical Supervisors – Irrelevant redacted by the USI.

GPs should return evidence of completion of their GP appraisal to the Medical Director on completion of the process.

8 Appraisal for Doctors in Training

All doctors in training within the Northern Ireland Deanery (NIMDTA) are required to be assessed and appraised in accordance with the principles of *Good Medical Practice*. The existing educational processes, including records of assessment, will form the basis of an appraisal portfolio for revalidation for this group of doctors.

In January 2013 the Northern Ireland Medical and Dental Training Agency [NIMDTA] requested Trusts to submit a 'Collective Exit and Exception Exit Report' for trainees allocated to the Trust in the preceding 6 months as part of revalidation process.

The Deanery have requested that the Trust provides information on any trainee who has been involved in: conduct, capability or formal serious untoward incidents/significant event investigations or are named in complaints, See 'Guideline for the Sharing of Information with NIMDTA for Trainee Irrelevant redacted by the USI

9 Whole Practice Appraisal

Revalidation will be based on all areas of a doctor's practice therefore the appraisal discussion should reflect this. Doctors are expected to bring supporting information in relation to all practice they undertake, including that in the independent sector. For further information and templates see 'Whole Practice Appraisal – Guidance for Doctors Employed in Irrelevant information redacted by the USI ***NB For those who are a joint appointee with another NHS employer, the Southern Trust will provide a Statement of No Concerns (Appendix 1).***

10 Appraisal Process

10.1 Timing

The appraisal process must be carried out annually. The Trust operates an annual appraisal cycle from January to December. With the introduction of revalidation all doctors MUST ensure that their appraisal adheres to this cycle.

Between January and March, Medical Managers and doctors should complete the process of reviewing their job plan for the appraisal year and engaging in the appraisal meeting.

10.2 Duration & Time Allocation

Good quality appraisal meetings would normally be expected to last for approximately two hours. For appraisers, it is expected that, ordinarily, four hours of SPA time will cover preparation for and the conduct of each appraisal. Appraisees will be allocated eight hours of SPA time, annually.

Arrangements should be made to ensure that the meeting is not disturbed except for extreme emergencies. Telephones and bleeps should be diverted and colleagues should be asked to provide emergency cover for the consultants' patients. Appraisers should carefully consider seating arrangements etc. to create an environment conducive to constructive dialogue.

10.3 Organisation

The appraisee is responsible for agreeing a time and venue for the appraisal that guarantees privacy and confidentiality. Where, for whatever reason, a third party is required to contribute to an appraisal (or, indeed, where a special appraiser has to be involved), this should be discussed and agreed well in advance.

10.4 Appraisal and Job Planning

In advance of the appraisal meeting each doctor should have the job plan of their appraisal year in their folder for discussion with his/her Medical Manager. Based on this, the doctor should identify those issues that he/she wishes to raise with the appraiser and prepare a workload summary to facilitate departmental planning and development. This should highlight any significant changes which might have arisen over the previous 12 months and which require discussion, which, in turn, will inform their new job plan.

10.5 What Preparation Needs to Happen Before the Appraisal Meeting?

10.5.1 Preparation by the Appraisee

Preparation is the key to a successful appraisal. Doctors must prepare using the Standardised DHSSPS Forms HSCNI Career Grade Medical Staff Appraisal Appendix 2] see Section 10 for detailed guidance on the completion of this documentation. The appraisee will be required to send documentation to the appraiser at least 10 days before the appraisal to allow for time for preparation by the appraiser.

10.5.2 Preparation by the appraiser

The role of the appraiser is to assist the appraisee in reflecting on past performance and formulating objectives to achieve future performance.

On receipt of the pre-appraisal documentation, the appraiser will contact the appraisee to agree any specific agenda items that may form the focus of the appraisal meeting. Appraisers must make themselves aware of any planned service developments and other

departmental plans so that these can inform discussions with the doctor (e.g: job plan review, training needs).

Appraisers should also be aware of:

- Any complaints pertaining to appraisee within the period [this will be provided by the MD office to both the appraiser/appraisee early in the calendar year]
- Any clinical incidents pertaining to appraisee within the period [this will be provided by the MD office to both the appraiser/appraisee early in the calendar year]

The appraisee should bring forward information on:

- Any NCAS/GMC referrals or performance concerns handled under 'Maintaining High Professional Standards'
- Any issues being handled under the Trust Disciplinary Policy

10.6 Appraisal Meeting:

The Appraisal meeting should be a two-way dialogue focussing upon joint problem solving and development.

The Agenda should consist of:

- Review of workload
- Reflection
- Identification of achievements
- Identification of challenges
- Problem solving
- Factors that have inhibited practice and development.
- Long term career plans
- Progress towards revalidation
- Training needs

10.7 Personal Development Plans

Each appraisal should identify individual needs to be addressed through a Personal Development Plan. This should include key development objectives for the following and subsequent years. These objectives may cover any aspect of the appraisal such as personal development needs, training goals, organisational issues, CME and CPD.

Information derived from Personal Development Plans (PDPs) will also provide the basis for a review with specialty teams of their working practices, resource needs and clinical governance issues.

Development needs should be prioritised on the Personal Development Plan in line with the appraisal recommendations and the needs of the Trust for safe high quality care.

Personal Development Plans will be shared with the Appraisee's Clinical Director and Associate Medical Director for the purpose of making the correct linkage between the PDP, Trusts objectives and the granting of study/professional leave. It is recommended that appraisee's refer to the GMC Guidance on CPD and Trust CPD guidance via the Southerndocs website.

11 Guidance on Completion of Appraisal Documentation Secondary Care

Appraisal documentation has been revised to reflect the GMC's *Framework for Appraisal and Revalidation*[3]. This framework is intended to encourage you to:

- Reflect on your practice and your approach to medicine
- Reflect on the supporting information you have gathered and what that information demonstrates about your practice
- Identify areas of practice where you could make improvements or undertake further development
- Demonstrate that you are up to date and fit to practise.

The GMC do not require every type of supporting information to be extensively mapped to each domain and attribute of the Framework. The revised appraisal documentation is, however, based on the four domains to provide structure to the appraisal discussion and collation of supporting information. [See Section 14]

The documentation comprises 7 Forms (refer to Appendix 2 of this document):

- **Form 1** - Background Details
- **Form 2** - Current Medical Activities
- **Form 3** - Supporting Information & Summary of Appraisal Discussion

[3] http://www.gmc-uk.org/GMP_framework_for_appraisal_and_revalidation.pdf_41326960.pdf

- **Form 4** - Personal Development Plan
- **Form 5** – Health & Probity
- **Form 6** - Sign Off
- **Form 7** – Revalidation Progress

Guidance on completion of each section is detailed below.

11.1.1 Form 1 – Background Details

The aim of this section is to provide basic background information and brief details of the appraisee's employment in the previous year. The appraisee can supplement this with any additional information they think helpful for example medical and specialist societies they belong to.

11.1.2 Form 2 – Current Medical Activities

The aim of this section is to provide the appraisee with an opportunity to describe their current posts in the HSC, other organisations or the independent healthcare sector. They should explain what their responsibilities are, where they work/practise and ensure they include all of their practice and work at all locations since their last appraisal.

The appraisal should encompass **all** areas of practice. If the appraisee undertakes any other work outside the HSC, they will need to bring supporting information to the appraisal that evidences they are up to date and fit to practice this work, as well as their work for the HSC. This may include, but is not limited to, work undertaken in the independent sector, medical work for business (e.g. insurance companies) and charities (e.g. hospices work), work undertaken as a sports doctor and work for panels, tribunals and government.

11.1.3 Form 3 – Supporting Information and Summary of Appraisal Discussion

The aim of this section is to allow the appraisee to list the supporting information they are bringing to appraisal and to document the discussion between the appraiser and appraisee that the information prompts. This discussion should include consideration of the information source and what it tells the appraiser about the appraisee's medical practice. Any actions arising from the appraisal discussion should be documented here.

Section 14 outlines suggested sources of supporting information and the appropriate Domain they may be tabled under. Due to the varied nature of medical practice, these are not prescriptive. A key component of the appraisal discussion will be consideration of the supporting information and which Domain it should be tabled under.

One type of supporting information may be applicable to one or more Domains of the GMP Framework. Reflection on supporting information may be included within a second Domain. For example, updating knowledge via CPD may lead to reflection on improving patient safety. Therefore CPD may be listed under Domain 1 (Knowledge, Skills and Performance) and reflection leading to improved safety and quality listed under Domain 2 (Safety and Quality).

Section 13 outlines the supporting information that Southern Health and Social Care Trust can provide to support appraisal. Further details on how to access this information is also available on www.southerndocs.hscni.net – Appraisal and Revalidation.

11.1.4 Form 4 – Personal Development Plan

In this section, the appraiser and appraisee should review progress against the previous years' personal development plan (PDP) and identify key development objectives for the year ahead. This will include actions identified during completion of Form 3 but may also include other development activity where this arises during the appraisal discussion. Any PDP outputs should be practical and achievable, ideally with defined outputs targeted against development needs.

The anticipated timescale within which the objectives will be met should be indicated. The appraiser should countersign the agreed PDP.

The anticipated timescale within which the objectives will be met should be indicated. In general, the same doctor who undertook the appraisal should countersign the agreed PDP.

11.1.5 Form 5 – Health and Probity

The appraisee should read the statements that apply to health and probity and sign and date them. Any supplementary proformas for health and probity should form part of the supporting documentation.

The following are examples of areas which could form part of the discussion on probity; research conduct, conflicts of interest, contacts with pharmaceutical industry, and financial probity. This list is not exhaustive.

Any health issues which may affect the appraisee's work as a doctor should be discussed during the appraisal discussion and any action arising from this noted in Form 4. Due to potential confidentiality issues, specific details of a health complaint or probity issue should not be entered directly into Appraisal Forms but recorded in the additional Forms contained in Appendix 6 of this Guidance and retained by the appraisee in their portfolio of supporting information.

11.1.6 Form 6 - Sign Off

This section requires both the appraiser and appraisee to confirm that the documentation is an accurate record of the appraisal discussion, the supporting information presented and the agreed personal development plan.

If the appraisee has been unable to provide all the required elements of supporting information, or demonstrate their practice is meeting the requirements of the *GMP Framework*, the reason/s why should be recorded in this section.

This may be due to a period of absence from employment or other mitigating circumstances. The organisation's Responsible Officer may wish to reference this information to inform the revalidation recommendation process.

This Form also includes a checklist to ensure the required sections of the appraisal documentation have been completed.

11.1.7 Form 7- Revalidation Progress

This section provides an overview of progress towards meeting revalidation requirements. It should demonstrate annual participation in appraisal and that the appraiser has evidenced they have met the GMC and employer required supporting information elements.

It is envisaged that this summary will be a valuable source of information for the Responsible Officer to reference when required to make a revalidation recommendation to the GMC.

It is the responsibility of the appraisee to send the completed Forms 1-7 to the Medical Directors Office. Receipt of forms will be acknowledged in writing.

The Southern Trust also requires appraisees to complete the following

- **Appendix 1 Education and Training Competencies for Medical Staff (Appendix 3 of this document)**

  There are several core modules of training that all doctors must undertake for their appraisal and revalidation. In addition, there are a series of optional modules that the individual doctor should agree with their Appraiser which of these necessary for them to undertake their role within the Trust.

- **Appendix 2 and 3 Evaluation Proforma – Appraisee and Appraiser Feedback Questionnaire (Appendices 4 and 5 of this document)**

The completion of these questionnaires are optional but encouraged as it may inform the organisation's quality assurance processes and highlight areas where further training may be required.

- **Appendix 4 Aide Memoire and Quality Assurance Audit Tool (Appendix 6 of this document)**

The use of this form is encouraged as an aide memoire to assist in the identification of areas of development.

- **Structured Reflective Templates**

The use of Structured Reflective templates are encouraged and where appropriate should be used to demonstrate reflection on supporting information (templates available here). These are as follows:-

- Complaints
- Declaration of Absence of Complaints
- Declaration of Absence of Significant Events/Incidents
- Significant Events/Incidents
- 360/Multisource Feedback
- Patient Feedback
- Personal Development Plan
- Appraiser Role
- Data Collection/Audit
- CLIP Report
- Case review
- Other roles

12 Minimum Requirements for Revalidation

GMC Minimum Requirements:	
The doctor must be participating in an annual appraisal process which has Good Medical Practice as its focus and which covers all of their medical practice.	The Trust appraisal Scheme is based on the principles of Good Medical Practice. The scheme and forms can be accessed at: Scheme: Medical Staff Appraisal Scheme Forms: Appraisal Forms
The doctor must have completed at least one appraisal, with Good Medical Practice as its focus, which has been signed off by the doctor and their appraiser.	You must ensure you have at minimum completed 2011 calendar year appraisal, which references the GMC supporting information requirements. The scheme and forms can be accessed at: Scheme: Medical Staff Appraisal Scheme Forms: Appraisal Forms
The doctor must have demonstrated, through appraisal, that they have collected and reflected on the following information as outlined in the GMC's guidance Supporting information for appraisal and revalidation: [see below]	Team-based information may also meet the requirements where no individualised information is available for quality improvement activities, significant events or complaints and compliments - as long as the doctor has reflected on what this information means for their individual practice.

13 Supporting Information Trust Support

Supporting Information	GMC Guidance	How the SHSCT Revalidation Support Team can help?
Continuing professional development	Evidence of continuing professional development must relate to the twelve month period prior to the appraisal that precedes any revalidation recommendation.	A summary report of your approved study leave is available from medical.revalidation@southerntrust.hscni.net In addition, guidance on CPD has been developed and is available to download. CPD Guidance A Structured Reflective template is available to assist you in demonstrating reflection/learning from your Personal Development Plan (PDP) Structured Reflective Template for PDP
Quality improvement activity	Evidence of regular participation in quality improvement activities that demonstrates the doctor reviews and evaluates the quality of their work must be considered at each appraisal. The activity should be relevant to the doctor's current scope of practice. Evidence may include: Clinical audit; review of clinical outcomes; case reviews; teaching activities; improvement projects Evaluate and reflect on results; take action; what is the outcome – improvement or maintenance of practice	Consultant Level Indicator Programme [CLIP] reports are available annually to doctors who have recorded activity on the hospital PAS system. If you have not received your CLIP Report please contact: medical.revalidation@southerntrust.hscni.net A guide for CLIP reports is available to download. CLIP Guidance For those doctors who participate in Surgical or Medical Morbidity/Mortality meetings as report of meetings attendance is available. If you have not received your CLIP Report please contact: medical.revalidation@southerntrust.hscni.net There are also Structured Reflective Templates on Data Collection and Case Review You can also request a 'Training Passport' which will summarise logged details of training you have participated in. Please contact: medical.revalidation@southerntrust.hscni.net
Significant events	Evidence of review of significant events and review of complaints and compliments must relate to the twelve month period prior to the appraisal that precedes any revalidation recommendation.	A report extracted from the Trust Datix incident management system has been forwarded to you. If you have not received please contact medical.revalidation@southerntrust.hscni.net A Structured reflective template is available to assist you in demonstrating reflection/learning from incidents. Significant event audit SEA structured reflective template
Feedback from colleagues	Evidence of feedback from colleagues must have been undertaken no earlier than five years prior to the first revalidation recommendation and be relevant to the doctor's current scope of practice. Feedback from colleagues that does not fully meet the criteria set by the GMC may also be included but must have been: Focused on the doctor, their practice and the quality of care delivered to	Colleague Feedback is available through the HSC Leadership Centre. To participate in this on-line tool please identify your appraiser and email medical.revalidation@southerntrust.hscni.net If you have already completed a non HSC Leadership Centre colleague feedback please email details to medical.revalidation@southerntrust.hscni.net so it can be assessed under the GMC criteria to ascertain acceptability for

Supporting Information	GMC Guidance	How the SHSCT Revalidation Support Team can help?
	patients Gathered in a way that promotes objectivity and maintains confidentiality	revalidation. A Structured Reflective template is available to assist you in demonstrating reflection on Colleague Feedback. Structured Reflective Template Colleague Feedback
Feedback from patients	Evidence of feedback from patients must have been undertaken no earlier than five years prior to the first revalidation recommendation and be relevant to the doctor's current scope of practice. Feedback from patients and colleagues that does not fully meet the criteria set by the GMC may also be included but must have been: Focused on the doctor, their practice and the quality of care delivered to patients Gathered in a way that promotes objectivity and maintains confidentiality	Patient Feedback is available through the HSC Leadership Centre. To participate please email medical.revalidation@southerntrust.hscni.net for a nomination form. If you have already completed patient feedback please email details to medical.revalidation@southerntrust.hscni.net so it can be assessed under the GMC criteria to ascertain acceptability for revalidation. A Structured Reflective template is available to assist you in demonstrating reflection on Patient Feedback. Structured Reflective Template Patient Feedback
Review of complaints and compliments		A report extracted from the Trust Datix complaints management system has been forwarded to you. If you have not received this report please contact medical.revalidation@southerntrust.hscni.net A Structured reflective template is available to assist you in demonstrating reflection/learning from complaints. Complaint report structured reflective template There is also a template regarding absence of complaints.
Mandatory Training		The Southern Docs website has been launched which holds all necessary information regarding mandatory training and can be accessed at www.southerndocs.hscni.net Password is 2012

14 Mapping Supporting Information to Good Medical Practice Domains

The table below provides examples of supporting information which may be appropriate to evidence each domain/attribute and is based on information cited by participants of the NI Medical Revalidation Pilot (2009).[4] **Information is required in relation to all areas of practice.**

Domain	Suggested Evidence/Supporting Information
1 - Knowledge, Skills and Performance: Attribute: 1.1 Maintain your professional performance Attribute: 1.2 Apply knowledge and experience to practice Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.	• Job plan, workload records • Evidence of how educational activity may have affected service delivery outcomes • Information about teaching and training activities. Include any information in relation to delivering workshops and lectures, mentoring activities and tutorials undertaken. • Evidence of reflective practice • Evidence of CPD and audit activity • Research activity • Relevant process and outcome data • Previous Form 4 and Personal Development Plan
2 - Safety and Quality: Attribute: 2.1 Contribute to and comply with systems to protect patients Attribute: 2.2 Respond to risks to safety Attribute: 2.3 Protect patients and colleagues from any risk posed by your health	• Evidence of any resource shortfalls which may have compromised outcomes • Up to date audit data including information on audit methodology and a record of how results of audit have resulted in changes to practice (if applicable) • Reflection on significant events/critical incidents/near misses • Records of how relevant medical guidelines have been reviewed by you and your team and how these have changed practice • Evidence of attendance at, and participation in, governance activity relevant to practice. • Evidence of risk management to include near misses and action taken to addresses/reduce risks • Evidence of registration with a GP, Statement of Health, vaccination records • Statement of satisfactory research practice • Records of training related to enhancing safety and quality of patient care • Analysis of, and reflection on, current practice

[4] http://www.dhsspsni.gov.uk/cic-revalidation-report.pdf

3 - Communication, Partnership and Teamwork Attribute: 3.1 Communicate effectively Attribute: 3.2 Work constructively with colleagues and delegate effectively Attribute: 3.3 Establish and maintain partnerships with patients	Evidence of any team development activity Description of the team you work within (medical and/or multidisciplinary) Description of all activities in which you interact with other healthcare workers e.g multidisciplinary meetings, working groups and committee work. Analysis of trainee/medical student survey (where appropriate) Patient and colleague feedback Evidence of participation in multi-professional team meetings
4 - Maintaining Trust: Attribute:4.1 Show respect for patients Attribute:4.2 Treat patients and colleagues fairly and without discrimination Attribute:4.3 Act with honesty and integrity	Statement of Probity and Health Complaints Compliments Patient and colleague feedback.

15 Allocation of an Appraiser

It is expected that a doctor will be appraised by one of the trained appraisers within their specialty/division or directorate albeit they can choose an appraiser from a different specialty.

It is recommended that you should have at least 2 appraisers within the 5 year revalidation cycle.

All new permanent appointments should have selected and contacted an appraiser from the Trust's Directory of Appraisers by Week 4 following their appointment

All temporary/locum doctors with contracts greater than six months but less than 1 year should also have selected and contacted an appraiser from the Trust's Directory of Appraisers by Week 4 following their appointment

The Medical Director will be appraised for his/her clinical work by a suitable consultant nominated by the Chief Executive (excluding any consultant appraised by the Medical Director in that year).

If a consultant is unhappy about his/her appraiser, he/she should discuss this in the first instance with their Clinical Director/ Lead Appraiser or if appropriate Associate Medical Director. If the situation cannot be resolved at this level, the Medical Director will be ultimately responsible for confirming the appraiser or nominating a suitable alternative. The decision of the Medical Director will be final.

16 Internal/External Peer Review

If during the appraisal, it becomes apparent that more detailed discussion and examination of any aspect is needed, either the appraiser or the consultant can request internal or external peer review. The Medical Director will organise this. This should normally be completed within one month and a further meeting scheduled as soon as possible thereafter (but no longer than one month) to complete the appraisal process.

In exceptional circumstances, it may be necessary to assess more specialist aspects of a consultant's clinical performance. This is best carried out by peers who are fully acquainted with the relevant areas of expertise and knowledge. Where it is apparent in advance that peer review is an essential component of appraisal, the appraiser and the consultant should plan for this into the timetable for the appraisal meeting.

As a matter of routine, the results of any other peer review or external review carried out involving the consultant or the consultant's team (e.g. by an educational body, a professional body, or similar bodies) must be considered at the next appraisal meeting. This will not prevent the Trust from following its normal processes in dealing with external reviews.

17 Serious Concerns About a Doctor's Fitness to Practise, Identified by the Appraisal Process

If an Appraiser identifies aspects of a doctor's conduct or health which may potentially be a serious cause for concern, the Appraiser will inform the doctor that the Appraiser's professional obligations require these concerns be shared with the Clinical Director/Lead Appraiser and Associate Medical Director as soon as possible and in writing within 5 days.

Such decisions will be based on the guidance in the GMC document 'Good Medical Practice'.

The responsibility for assessment and investigation lies with the Medical Director/Associate Medical Director and will be dealt with under the guidance of 'Maintaining High Professional Standards'. Appraisers may refer to Trust Guidelines on Handling Concerns about Doctors and Dentists.

The Associate Medical Director will notify the Clinical Director/Lead Appraiser when the doctor is to continue in the appraisal scheme or is to be reinstated in the appraisal process. The Clinical Director/Lead Appraiser will ensure the necessary arrangements are

made to re-register the doctor in the appraisal scheme. The doctor will be formally notified of their position and advised of the next steps by the Clinical Director/Lead Appraisal

18 The Role of the Responsible Officer in Revalidation

The Trust Responsible Officer is responsible for making recommendations to GMC on the revalidation of doctors within their designated body. The Responsible Officer will make a revalidation recommendation to GMC in one of the following categories:

- A positive recommendation that the doctor is up to date and fit to practice
- A request to defer the date of recommendation
- A notification of the doctor's non-engagement in revalidation.

The GMC will invite doctors to confirm their revalidation details [including the identity of the Responsible Officer and designated body six months before the submission date.

Four months before the submission date, the GMC will issue notice to the doctor, informing them of the date by which they expect to receive a recommendation.

Following receipt of the RO's recommendation the GMC will consider the recommendation and make a decision on the doctor's revalidation

The GMC will then notify the doctor and the RO when a decision has been made and the content of that decision.

Full details can be accessed in Appendix 7, Making Revalidation Recommendations: the GMC responsible Officer Protocol - Guide for Responsible Officers [December 2012] (click here).

19 Non Engagement in the Appraisal Process

Southern Trust Medical Staff contracts require all doctors to undergo an appraisal annually. Participation is a statutory requirement for successful revalidation and re-licencing.

Refusal by a doctor to participate in the appraisal process will be a disciplinary matter to be dealt with, where necessary, under the Trust's Disciplinary Procedures.

Failure to participate in appraisal will result in the inability of the Responsible Officer to make a recommendation to the GMC and will put a doctors licence to practice in jeopardy.

Additionally, failure or refusal to participate will debar the doctor from applying for Clinical Excellence Awards/Higher Awards/Performance Supplements Scheme until the doctor\demonstrates full participation in the appraisal process.

19.1 Non-Engagement Due to Extenuating Circumstances

On occasion a doctor may have extenuating circumstances and request postponement of their appraisal for the current year, [see Section 20 – Deferment of Appraisal]. It is the responsibility of the doctor to advise their Associate Medical Director and Medical Director of their intention to request deferment. The request form can be requested via medical.revalidation@southerntrust.hscni.net.

19.2 Non-Engagement

Either before or during the appraisal discussion the Associate Medical Director and/or Appraiser may identify that a doctor is not engaging satisfactorily in the appraisal process.

There is an expectation that the doctor will arrange and attend the Appraisal meeting without presenting any resistance, the doctor will provide a folder [at least 10 days before the planned appraisal meeting] which gives enough information to allow engagement in a meaningful appraisal discussion, and demonstrate a willingness to participate in the process recognising it as formative and developmental.

If, however, the Appraiser/Associate Medical Director finds this is not the case the Appraiser should advise the Medical Revalidation Support Team. Advice can be sought from the Corporate Lead for Revalidation or the Trust Lead Appraisers.

19.2.1 Non-engagement - Failure to Schedule an Appraisal Meeting

It is the responsibility of the Appraisee to instigate their appraisal meeting by selecting and contacting an Appraiser.

If the Appraisee has difficulty contacting an Appraiser s/he can refer that appraisal back to the Trust Revalidation Support Team [medical.revalidation@southerntrust.hscni.net] for re-scheduling.

Appraisees who fail to arrange a meeting will be referred to the Trust Medical Director for appropriate action recognising the contractual and statutory obligation to participate.

Under these circumstances a recommendation will not be made for revalidation to the GMC by the Trust Responsible Officer.

19.2.2 Non-engagement - Evidence

It is the responsibility of the doctor to provide their Appraiser with access to their appraisal folder at least 10 working days before the date of the appraisal discussion. This is to ensure the Appraiser has sufficient time to prepare for the discussion. If this access is not provided the Appraiser has a right to postpone the appraisal, which will be rescheduled at a time that will suit the Appraiser.

On gaining access to a doctor's folder the Appraiser may decide that it does not the meet the minimum standards as required by the GMC to allow a meaningful discussion to take place. In such cases the Appraiser may feel it is necessary to postpone the discussion pending receipt of adequate materials. The appraisal will be rescheduled at a time that will suit the Appraiser.

If this is the case the Appraiser will provide guidance to the doctor on what is necessary. Support and guidance is also available from the Medical Revalidation Support Team.

If, however, following facilitation from the Appraiser/Medical Revalidation Support Team, the Appraisee fails to produce evidence sufficient for discussion, despite reasonable time frames, reminders and offers of support, the matter will be referred to the Medical Director.

Under these circumstances a recommendation will not be made for revalidation to the GMC by the

19.2.3 Non-engagement Identified by the Appraiser During the Appraisal Discussion

During the appraisal the Appraiser may feel that the doctor is not participating fully in the discussion and this is preventing a meaningful appraisal from taking place or the Appraisee behaves – at any point in the process – in an aggressive or threatening manner such as the Appraiser feels unable to continue with the Appraisal meeting. The Appraiser should advise the doctor of these reservations either during or immediately after the discussion.

Guidance and support for Appraisers can be sought from the Trust Lead Appraiser/s.

If they agree that a meaningful appraisal has not taken place the appraisal will not be recorded as complete

The appraisal should be rescheduled within 3 months or before the end of the current appraisal year, whichever is the shorter period of time, on the understanding that the Trust can facilitate this appraisal at short notice. If the subsequent Appraiser decides the doctor has still not engaged in the process in a meaningful way the Medical Director will be notified.

Under these circumstances a recommendation will not be made for revalidation to the GMC by the Trust Responsible Officer.

20 Deferment of Appraisal

Southern Trust Medical Staff contracts require all doctors to undergo an appraisal annually. It is expected that this will also be a requirement for successful revalidation and re-certification.

There are however exceptional circumstances when an doctor may request that an appraisal is deferred such that no appraisal takes places during one appraisal year

Instances when doctors may request a deferment:

- breaks in practice due to sickness or maternity leave
- breaks in practice due to absence abroad or sabbaticals

Doctors who have a break from practice may find it harder to collect evidence to support their appraisal, particularly if being appraised soon after their return to clinical practice. However often an appraisal can be useful when timed to coincide with a doctor's re-induction to clinical work. Appraisers will use their discretion when guiding appraisees as to the best timing for their appraisal, and when deciding the minimum evidence acceptable for these exceptional appraisals.

As a general rule it is advised that doctors having a career breaks:

1) in excess of 6 months you should try to be appraised within 6 months of returning to work

2) less than 6 months should try to be appraised no more than 18 months after the previous appraisal and wherever possible so that an appraisal year is not missed altogether.

Each case can be dealt with on its merits and the Trust is mindful that no doctor must be disadvantaged or unfairly penalised as a result of pregnancy sickness or disability.

Doctors who think they may need to defer their appraisal should complete the deferment application form [Appendix 8] or available from medical.revalidation@southerntrust.hscni.net and submit it to the Associate Medical Director who will make a decision where necessary in consultation with the Medical Director. The decision can be appealed and appeals will be dealt with by the Medical Revalidation Support Team.

Deferment application should be submitted at the earliest possible opportunity and no later than 3 months before the doctor's appraisal date would be due. The decision to allow a deferment will depend on a number of factors:

- how many appraisals have or will have been missed in a 5 year period
- whether there is anticipated to be further breaks from practice in the near future
- if there have been problems with evidence in previous appraisals
- if the doctor is undergoing any investigation about his/her performance(this list is not exhaustive)

Informal advice on the likelihood of a deferment being agreed can be obtained from the Clinical Director/ Appraisal Lead. A formal response to the application will be either a letter advising against an appraisal or a deferment certificate.

21 Responding to Concerns and Complaints about Appraisal

21.1 Introduction

Southern Health and Social Care Trust is committed to providing its services in a professional, fair and courteous manner. The following section outlines a protocol for dealing with concerns/complains relating to the appraisal process.

The key aims of the complaints protocol are to;

- Be an open process
- Be simple to understand and use
- Allow speedy handling and resolution, keeping people informed of progress
- Address all the points at issue
- Satisfy the complaint, where ever possible
- Be fair to complainant and staff alike
- Provide information, which will help improve the appraisal process and so ensure that the problem does not arise again.

21.2 What does the protocol cover?

The protocol covers complaints about

- The standard or quality of services provided by Medical Directorate – Southern Trust
- Divergence from appraisal procedures
- The behavior of appraisers
- Any action or inaction by the Appraisal Team affecting an individual
- Administration of the scheme
- Confidentiality
- Dissatisfaction with decisions reached and or matters relating to professional or clinical judgment in individual cases

This protocol does **not** cover:

- Dissatisfaction with Southern Trust Appraisal Scheme
- Anonymous complaints

Any concerns or complaints regarding a doctor's fitness to perform should be taken forward through the Associate Medical Director & Medical Director

21.3 Duties and Accountability

This complaints protocol provides for complaints to initially be dealt with through **Local Resolution.** This is where the members of the appraisal team concerned have a direct involvement in attempting to resolve the issue at the earliest opportunity. It is essential that all appraisers are fully conversant with this protocol. Effective documentation of all concerns and complaints received will ensure the Medical Directorate, Southern Trust can consider any lessons learnt from the feedback received

21.4 Defining a Complaint

Whenever there is a specific statement on the part of the appraisee that they wish their concern to be dealt with as a complaint they will be treated as such. The Department of Health has suggested that one definition of a complaint is *"An expression of dissatisfaction that requires a response"* However it would not be appropriate to label all expressions of dissatisfaction as a complaint.

From the individual's point of view they may just want their concern documented and appropriate action taken. Clearly this means that this protocol encompasses an extremely wide definition of the term 'complaint'.

21.5 Informal Resolution of Concerns and Complaints

It is not intended that every minor concern should warrant a full-scale complaints investigation. Rather, the spirit of the protocol is that front line Appraisers are empowered to resolve minor comments and problems immediately and informally.

Appraisee should in the first instance take their concern or complaints to the appraiser who should aim to respond and resolve the issue within 2 weeks of receiving the concern or complaint (holidays not withstanding).

Where the above step has not settled the complaints, or where they feel it would inappropriate to raise the issue with the appraiser, the appraisee should be offered the opportunity to talk to the relevant Associate Medical Director who will respond within 2 weeks of receiving the concern or complaint attempting to resolve the matter informally.

In both of the above, where resolution is achieved an anonymised note should be made by the appraiser or manager of the action taken and passed to the Associate Medical Director, so the concern can be noted as having been received and settled. There is no need for the incident to be centrally logged unless the incident arose as a consequence of procedure not being followed or being inadequate or misleading.

If the complaint is still not resolved following the above steps and the individual wishes to take the matter further or the Appraiser concerned has to take action to ensure resolution of the issue a formal written submission of the complaint is to be made and forwarded as soon as possible to the Associate Medical Director.

21.6 Procedure When Responding to a Formal Written Complaint

- The Medical Director ascertains that the complaint is about the appraisal Service (if not then referral to the appropriate department)
    - If it is about the appraisal service acknowledge written complaint within 4 working days
- Medical Director coordinates fact finding about the complaint in liaison with Associate Medical Director
    - Response to complainant within 25 days by on the Medical Directors Office behalf of Associate Medical Director
- If complainant still not happy referral to Chief Executive.

In all cases:

- Lessons learnt should be logged to be reviewed as part of the appraisal QA Process
- Appraisee is informed that support is available from the Medical HR Department

21.7 Things to Cover When Responding to a Complaint

All concerns and complaints, whether oral or written should receive a positive and full response, with the aims of satisfying the individual that his/her concerns have been heeded. The written response will normally include:

- A summary of the complaint
- An explanation of the departments or teams view of events
- An apology where appropriate
- A summary of the outcome of the meeting
- Details of any changes made as a result of the complaint

- Information on what action the complainant can take if still dissatisfied

21.8 Confidentiality

Any information provided by a complainant must be treated in the strictest confidence and in accordance with the provision of the Data Protection Act 1998

21.9 Support for Complainants

Advice, support or representation is available for appraisees from the Medical HR Department

22 Confidentiality

Appraisal should be in the main a confidential process between the appraiser and the appppraisee.

A summary of the purposes for which appraisal documentation are used and who has used and who has access to them, is set out in the table below.

Task	Individuals Involved	Comments
Clinical governance	Medical Director	Has access to all appraisal forms.
Filing of completed appraisal	Administrator to check all sections complete	Held in personal secure electronic folder
Preparation for Revalidation	Medical Revalidation Support Team	Review of appraisal folder/record of appraisal to ensure it meets minimum requirement for revalidation.
Personal Development Plans	Associate Medical Directors Clinical Directors Medical Revalidation Support Team	Completed PDPs should be available to Clinical Director and Associate Medical Director to facilitate approval of study/professional leave.
Personal Development Plans	Associate Medical Directors Clinical Directors	Completed PDPs should be available to Clinical Director and Associate Medical Director to facilitate approval of study/professional leave.
Appraiser has concerns about performance and wishes to discuss this to register a “concern”	Associate Medical Director Medical Director	May include: Medical director, Associate Medical Director & Clinical Director/Lead Appraiser Medical HR Manager
Appraisee wants to make complaint about appraisal process	Medical Revalidation Support Team Medical HR Department	To follow due process
To follow through Appraisal actions.	Appraiser	Previous years Form 2 1- 7 & Personal Development Plan supplied to next years appraiser.

23 Appraiser Performance Review, Development and Support[5]

The quality and consistency of appraisal relies on the skills and the professionalism of the appraiser. The appraiser needs to understand the purpose of appraisal and revalidation and to appreciate his or her responsibilities within those structures. Whilst robust appointment processes are needed, the on-going performance review, development and support of appraisers is vital in assuring the quality of appraisal

Individual appraisers will be provided with the following support/development:

- Access to leadership and advice on all aspects of the appraisal process from the Trust Lead Appraisers and Corporate Lead for Revalidation. The Trust Medical Revalidation Team should also offer peer support and discussion of challenging appraisals.
- Structured reflective template for the appraiser should be completed once annually when they are being appraised. These will be reviewed by the Trust Lead Appraisers and will help identify development needs for appraisers.
- An annual review of development as an appraiser with the identification of a developmental needs which should be included in the Appraisers personal development plan.
- Access to training and professional development resources to continually develop appraiser skills including in-house and regional events.

For further details see 'Assuring the Quality of Medical Appraisers' click here

24 Appraisal Scheme Quality Assurance

24.1 Scheme Quality Assurance

On-going quality assurance will be maintained through the yearly undertaking of the following audits & development of associated Action Plans.

- Appraiser/Appraisee Training programmes – Audit of attendance
- Audit of all Appraisal Forms
- Audit of Appraisee Feedback and Appraiser Feedback Questionnaires
- Aide memoire and Quality Assurance Tool on individual's appraisal/revalidation folder and forms
- Appraisal participation Audit

[5] Assuring the Quality of Medical Appraisal for Revalidation

- Appraiser structured reflective template
- For the 2013 calendar year - Organisational Readiness Self-Assessment tool (ORSA)

25 Equality

The appraisal scheme and process will comply with the Trust's Equal Opportunity Policy. It has also been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Using the Equality Commission's screening criteria, no significant equality implications have been identified. Similarly, this procedure has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

This document has been produced by the Senior Manager Medical Directorate on behalf of the Appraisal & Revalidation Group.

This Scheme has been agreed with the Local Negotiating Committee and will be reviewed after one year. In the meantime, it reflects national guidance and publications as closely as possible.

26 APPENDIX 1 STATEMENT OF SATISFACTORY EMPLOYMENT

Please click here for Statement.

27 APPENDIX 2 TRUST APPRAISAL FORMS

Please click here for the Appraisal Forms

28 APPENDIX 3 EDUCATION AND TRAINING COMPETENCIES FOR MEDICAL STAFF

This form is contained within the Appraisal Forms above.

29 APPENDIX 4 APPRAISEE FEEDBACK FORM

This form is contained within the Appraisal Forms above.

30 APPENDIX 5 APPRAISER FEEDBACK FORM

This form is contained within the Appraisal Forms above.

31 APPENDIX 6 AIDE MEMOIRE AND QUALITY ASSURANCE AUDIT TOOL

This is contained within the Appraisal Forms above.

32 APPENDIX 7 MAKING REVALIDATION RECOMMENDATIONS: THE GMC RESPONSIBLE OFFICER PROTOCOL GUIDE FOR RESPONSIBLE OFFICERS [DECEMBER 2012].

Please click here for the Guide.

33 APPENDIX 8 DEFERMENT APPLICATION FORM

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

Application for deferment of appraisal

Name:	
Address	
Telephone numbers :	
Email	
GMC number	
Date of Birth	
Please indicate the dates of your last 4 appraisals: (Month and year) and names of the appraisers	
Name of appraiser Date of appraisal (M/y)	

Please indicated WHY you wish to request a deferment of your appraisal and WHEN you would next like to be appraised	
Do you anticipate having any breaks in practice in the next 2 years ?	
If you have missed any in the last 4 years please: indicate the reasons why	
Are you currently under investigation by your employer, NCAS, or GMC for any issue regarding your clinical performance ?	
Any further comments	

Please submit copies of the form4 for the last appraisals carried out

Name:
Date:
Signature:

(This form can be sent electronically or posted)

UROLOGY IMPLEMENTATION GROUP – 11 SEPT 2019

ATTENDEES: David McCormick, Karen Phelan, Andrea Turbitt, Chris Thomas, Brian McAleer, Catherine Coyle, Christine McMaster, Mark Haynes, Alex MacLeod, Martina Corrigan, Colin Mulholland, Brian Duggan, David Connelly, Sara Donaldson

Apologies Aldrina Magwood, Hugh O'kane

Issue	Action
• **1.0 DECC update –** MH gave an update on the progress in developing the new day case elective centre for urology. He indicated that the procedures were being grouped into 5 main categories: TURBT, TURP/Laser prostectomy, Urolift and Ureteroscopy. It was agreed that the clinical teams across the region should agree (for the region) what procedures should be offered in NI for bladder outflow surgery, what the indications for these will be, how this would be recorded on a minimum dataset and therefore what information is required for a patient to be listed for these procedures. Each Trust should discuss with their clinical team and share information back to the group within 4 weeks (Friday 11 October).	**Action 1.0** – Each Trust to identify the procedure and associated indications.
• **2.0 Modernisation update –** Each Trust provided an update on urology modernisation plans. It was noted that recruitment and training of specialist nurses was a particular challenge and that the variation in the Banding of these posts was adding to the problem. SET advised that they may not be able to secure the necessary theatre space to deliver the agreed day case lists and therefore may have to use the funding for specialist nurses. DMcC advised that any change of use would require a new IPT.	**Action 2.0** – SET to forward new IPT
• **3.0 RRP Surgery Update –** CH advised that the Trust aimed to undertake 40/50 cases in-house with a further 10 cases being delivered at Addenbrookes. He indicated that Addenbooks had no further capacity this year and therefore the Trust would need to use the Mater in Dublin. It was noted that the HSCB would cover the increased IS costs in 2019/20 on a non-recurrent basis.	
• **4.0 Penile Prosthesis** – CC discussed the current options paper regarding the future provision of penile cancer and penile prosthesis. It was noted that there was general consensus that the service should be centralised in the Western Trust but there was concern about the required volume of procedures to main skills. CM explained the Trust proposed developing a link with Christie Trust in Manchester and that the plan was to work as part of a wider network. He advised that approximately 24 cases would be required to make the service viable and he was confident that there was sufficient demand to maintain volumes. This work would be supported by a monthly MDT.	

Issue	Action
DMcC queried what impact this work would have on core urology. CM indicated that the penile prosthesis cases could be scheduled at times of low theatre demand and therefore there would not be a significant impact.	
It was agreed that CC would break the updated options paper to the HSCB scheduled care group with a recommendation that the service development should be supported in the Western Trust.	**Action 3.0 –** CC to submit paper to scheduled care group
It was noted that the Trust had yet to return the IPT and this would be required before funding could be released.	**Action 4.0 –** Western Trust to complete the IPT

Stinson, Emma M

From: Harrison, Eric <Personal Information redacted by the USI>
Sent: 22 October 2020 09:03
To: Elliott, Joanne; Ajay.Pahuja Personal Information redacted by the USI; 'Mark Haynes'; 'alex.macleod Personal Information redacted by the USI'; 'Connolly, David'; 'Michael Young'; anthony.glackin Personal Information redacted by the USI; JohnP.ODonoghue Personal Information redacted by the USI; filip.subin Personal Information redacted by the USI; David McCormick; 'Brian Duggan'; Catherine Coyle (Public Health Consultant); 'Chris Thomas'; 'Colin Mullholland'; 'Martina Corrigan'; michealmck Personal Information redacted by the USI; 'Ronan Caroll'; 'Sam Gray'; Stephen Boyd; Karen.Phelan Personal Information redacted by the USI; 'Sloan, Samanthaa'; 'OKane, Hugh'; Parks, Maggie (Personal Information redacted by the USI); Allam, Christine (Christine.Allam Personal Information redacted by the USI); Turbitt, Andrea; Cathy Gillan; Christine McMaster; Magwood, Aldrina; 'Robinson, David'; 'Lydia.James Personal Information redacted by the USI'; 'Katharine.Dane Personal Information redacted by the USI'; Radovana Juhazyova; 'Michael.Bradley Personal Information redacted by the USI'; 'Lisa.Boyle Personal Information redacted by the USI
Cc: 'Hogg, Rosemary'; Rachel Deyermond
Subject: Urology PIG - Actions and Date of Next Meeting
Attachments: Ureteroscopy and ESWL DECC Update 21st October 2020 FINAL.PPTX; Urology Workshop Oct 2020.pptx; decc 2final.pptx.. 20.10.pptx

All

Thank you for participating in yesterday's urology meeting. I hope you found it productive. As promised I attach the various presentations.

The date of the next meeting will be **Wednesday 9th December at 2pm** and a diary invite will follow shortly. In the meantime I have set out below the main discussion points/actions –

Stones
Potential to use up to 10 sessions per week in LVH. Brian (SET) has kindly agreed to liaise with colleagues to refine pathway (outpatients, pre-op, surgery, review etc) and to consider equipment needs (David Connolly suggested a potential loan laser). Christine Allam is happy to work with the group on the logistics of the DPC at Lagan Valley. Ultimately decisions on lists/equipment etc to be taken by the DPC Network Board.

Bladder outflow procedures

Ajay has kindly agreed to work with clinical colleagues to refine the various bladder outflow pathways (outpatients, pre-op, surgery, review etc) and to confirm the suitability of each procedure for standalone day procedure centre or 23hr centre.

TURBT
Recognised need to keep cancer pathway streamlined – concern about fragmentation if some procedures sent to DPC. Mark to keep PIG updated on the work of the cancer
Group on this pathway.

Escalation protocols and Pooled Lists

In developing pathways consideration to be given to suitability for pooled lists . Protocols required for patients with a complication during/post surgery.

Pre-op and consent

In developing pathways consideration to be given to robust pre-op and consent. The anaesthetics group have been working on these issues. [redacted] can provide advice to clinicians as they develop their pathways.

ASA

ASA3 patients who are stable, e.g. stable diabetes, stable cardiac may be suitable for the day procedure centre, especially if we are going to be doing more short acting spinal anaesthesia. They would likely require more in depth preassessment than ASA1 and 2 but that should be able to be provided. Please liaise with [redacted] and she would be happy to advise further. We will have anaesthetics represented at the next PIG meeting.

If I have missed anything, please let me know.

Kind regards

Joanne

Joanne Elliott
Department of Health
Hospital Services Reform Directorate
Annex 3 | Castle Buildings | BT4 3SQ
Tel: [redacted])
[redacted]

Ureteroscopy and ESWL DECC Update 21st October 2020

Michael Young – lead

David Connolly, Filip Subin, Brian Duggan

Ernst & Young Data (July 2019)

Procedure Description	Detailed Description	Activity Transferred to DECC
Ureteroscopies	• Therapeutic ureteroscopic operations on ureter • Other endoscopic removal of calculus from ureter • Other therapeutic endoscopic operations on ureter • Diagnostic endoscopic examination of ureter	1,447
ESWL	• Extracorporeal fragmentation of calculus of kidney • Extracorporeal fragmentation of calculus ureter	852

Ureteroscopy Activity Drill Down (HSCB)

	15/16	16/17	17/18	18/19
Elective Admissions	742	695	586	841
Elective Day Case	437	557	466	375
Non Elective Activity	329	193	192	

Ureteroscopy

- Expected demand = 1287 procedures annually
- Potential maximum capacity of 1750 procedures could be undertaken to address demand and tackle waiting list

Modelling scenarios:

Days	Weeks	Cases per day	Total Capacity
5	50	7	1750
5	48	6	1440
5	48	5	1200