Table 3 Data relating to clinical practice (therapeutic)

	Country																				
Data	A	B	DK	SF	F	D	GR	IRL	I	L	N	P	E	S	CH	NL	GB	CR	H	M	PL	CZ
Urological treatments																						
Radiotherapy	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Andrology	P	P	S	S	S	P	P	P	P	P	S	S	P	P	P	S	S	S	S	S	P	S
Male infertility	P/S	P	S	S	P/S	P	P	P	P	P	S	S	S	S	S	S	S	S	S	P	S	S
Joint clinics with gynaecologists?																						
	Yes	No	Yes	Yes	Yes	No	No	Yes	No	Yes	No	Yes	Yes	Yes	Yes	No	No	No	Yes	No	No	Yes
Assisted fertilization available?																						
	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Major cancer surgery																						
	P/S	P/S	S	P	P/S	P/S	P/S	P	P	P	S	P	P	P/S	P/S	P/S	P	S	S	P/S	P	S
%referred to specialist centre																						
	30	15	>50	50	?	25	5–10	1	?	≈1	?	10	10–20	10	10	10–20	10	50	40–60	5	10	80
Female incontinence																						
	S	P	S	P	P/S	S	P	P	P/S	P	S	P	P	S	S	P/S	P	S	P	S	S	P/S
Cooperation with gynaecologists?																						
	No	No	Yes	Yes	No	Yes	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Common?			Yes	No		No		No			No	No	No	No	No	No		No	No	No	0	No
Pelvic floor physiotherapy/stimulation																						
	S	P	A	A	P	P	A	S	P	A	A	S	S	A	S	A	A	S	NA	A	S	A
ESWL	S	S	S	P	P/S	P	S	P	P	P	S	S	S	P	P	P	S	S	P	P	S	S
PCNL	S	P	S	P	P/S	P	S	P	S	S	S	S	S	S	S	P	P	S	P	S	S	S
Laser therapy	S	P	S	P	S	P	P	P	S	NA	S	S	S	S	S	S	S	S	S	NA	S	S
Paediatric urology	P/S	P	S	A	S	P	S	S	S	P	A	S	S	S	A	S	S	S	S	S	S	S
% of major surgery performed by urologists																						
	50	>75	>75	<25	<25	<25	<25	50–75	<25	<25	<25	<25	<25	25–50	25–50	<25	<25	<25	25–50	<25	<25	25–50	50–75
Cooperation with paediatric surgeons common?																						
	No	No	No	No	Yes	No	No	No	No	No	Yes	No	No	No	No	No	Yes	Yes	Yes	Yes	No	Yes
Renal transplantation																						
	A	S	S	A	S	S	A	S	S	S	A	S	S	A	S	S	A/S	S	A	A	S	S
% totally by urologists																						
	2	0	85	10	90	40	0	100	10	50	0	40	>90	<10	20	0	20	100	0	0	7	15
Surgery																						
Vascular access	A	S	A/S	A	P/S	A	A	S	A	S	A	S	S	S	A	A	A/S	S	S	A	A	A/S
Adrenal	P	S	S	P	P/S	S	P	P	P	P	S	P	P/S	A	S	S	S	S	S	S	S	S
% by urologists	50	80	100	50	10	>1	90	80	50	90	50	25	>50	10	30	25	25	50–80	70	5	10	100

NA, not available; A, easily available; P, performed by all/most urologists; S, performed mainly by specialist urologists.

to achieving certification as a urologist, and the auditing of manpower should be an ongoing process.

The trend toward more women urologists also affects manpower and training. Job-sharing and leave for family reasons, even in this liberated age, is likely to be more commonly adopted by women. This gender issue and its impact on manpower and training demands continuous review.

A disturbing finding is the apparently persistent acceptance of the 'one-urologist' department. Such urologists are isolated both professionally and personally, but more importantly their departments cannot provide their patients with the range of expertise and continuous care that should be their right.

The standard view of a urologist is one of a surgeon specializing in genitourinary conditions. In most countries worldwide this has not changed, but over the past 20 years the advent of more endoscopic and extracorporeal therapy, and the pharmacological management of conditions formerly managed surgically, has reduced the volume of surgery, particularly open surgery, undertaken by urologists. Such developments have undoubtedly contributed to the proliferation of 'office-only' urologists. Such urologists may be particularly useful in countries with no strong GP base, but this view may be too negative. Perhaps the office-only urologists deliver a more cost-effective and patient-centred level of care, not only for the more minor urological conditions requiring only outpatient assessment and management, but also in other 'surgical' cases, by initiating appropriate investigations and management at an earlier stage before referral to a hospital-based colleague.

ANALYSIS OF UROLOGY BED REQUIREMENT

ELECTIVE

LOS < 72 hours 5 beds pre bringing in day of surgery

= 72 hours 2 beds " " "

> 72 hours 5 beds " " "

Total elective bed requirement of 12 beds

EMERGENCY

LOS < 72 hours - 3 beds

LOS = 72 hours - 1.4 beds

LOS > 72 hours - 4.3 beds

Total emergency bed requirement of 9 beds

All above pre any change of practice towards reduced length of stay , increased day case work etc.

Independent sector work to be brought back in to the Trust.

April 09 activity = 51 cases went out to the IS sector

As an approximate calculation 51 x 12 months = 612 cases to do in house on top of the calculations above.

Most of the work will be day case or short stay by the nature of work sent out.

This equates to approximately 2 more beds required but the majority of this type of work can and should be done in a day case facility so should not need to come into the Urology inpatient bed hub.

However in the first instance2 further beds can be allocated in the in day case / short stay facility.

Activity from Western Catchment Area

The information received from Catherine McNicholl shows that we may expect approximately 17% (one sixth) extra activity from this area. A proportion of this will be performed closer to the patient and not in CAH.

This activity will not be expected for at least one more year but looks like requiring 1.5 inpatient beds when it does come.

SUMMARY

It is proposed that there should be a Urology Cohort of 12 beds in Ward 4 North (One side, male and female bays). All urology long stay electives and all emergencies would flow through this area.

This would be made up of 5 beds > 72 hours LOS
9 beds for all emergencies.

It is anticipated that with gradual changes in practice with regard to reducing LOS that 12 beds would be a reasonable urology hub. There has to be consideration to the accommodation of all other speciality emergencies and this would leave 24 beds for all other emergencies.

With regard to shorter stay elective and day case work there will be 7 further beds allocated to urology work in the 3 South Unit.

This gives a total of 19 beds for use for Urology activity.

This is a reduction in total of 4 urology beds.

The reduction of beds as a percentage of all the areas is as follow:-

General Surgery has a reduction of 20% of their total bed compliment.
Urology has a reduction of 17% of their total bed compliment.
ENT has a reduction of 18% of their total bed compliment.

This shows an equal reduction across all specialities.

SS 7 UROLOGY
6 ENT
6 GEN
19

Southern Health and Social Care Trust

Acute Quality Care Project

SURGERY & ELECTIVE CARE

Paper to SMT 11th March

Draft: 7th March 2009

CONTENTS PAGE

1.0 Project Aim

The overall aim of the Acute Quality Care Project is

"To improve the quality of surgical services delivered by the SHSCT across the acute hospital system "

This will be delivered through :

- The absolute ring-fencing of surgical beds for the surgical division, to allow the modernisation of surgical practices with confidence in the ability to deliver these services
- The maximisation of the effective use of inpatient and daycase capacity across the Trust's hospital system in CAH, DHH and STH.
- The delivery of a whole systems approach for our patients, ensuring services interface effectively along the patient journey.
- The consistent management of patient flows to the acute system from primary and community care, in line with agreed protocols and multi-disciplinary care pathways

To allow this delivery, this paper focuses upon Craigavon Area Hospital and outlines 5 initial proposals:

- Absolute ring-fencing of surgical beds for the surgical division from 1st April 2009.
- An increase to 75% admission on the morning of surgery for elective procedures
- An increase of day case rates from 40% to 75%
- A decrease in average length of stay for inpatient procedures by 15%
- Creation of emergency pathways of care for a range of surgical emergency conditions

2.0 Project outcomes

The outcomes proposed in this paper are that through the delivery of the 5 proposals, the way in which the wards within the surgical division are aligned can be adjusted to ensure they best fit a modernised delivery of surgical care. Specifically, this paper proposes that through the delivery of these 5 proposals:

- The overall bed configuration within the surgical division at CAH could be reconfigured as detailed below.
- Wards are aligned to maximise efficiencies by creating wards not based on specialties but based upon the patients journey through their surgical care as detailed below

Bed configuration

Ring fencing of surgical beds

Over the last 3 months, the number of medical outliers in surgical beds has averaged between 10 - 15 per day. During this time, surgical procedures have only been cancelled due to a lack of beds on 2 separate occasions. Ring fencing beds would therefore allow between 10-15 beds to be released. The first phase of this will be an 8 bed reduction from 1st April.

Admission on the morning of surgery

Within the main surgical specialties, the admission on the morning of surgery ranges from 0% (Urology) to 30% (General Surgery) and 43% (ENT). The introduction of a comprehensive pre-operative assessment service and the completion of pre-admission assessment and documentation will allow an opportunity to admit patients on the morning of surgery. Given the volume of elective procedures, moving these specialties to 75% would release 3,000 bed days, which would allow 8 beds to be released.

Increase in day case rates

A number of meetings have been held with the various clinical teams to consider a range of procedures currently undertaken as inpatients which could convert into day case procedures. By moving to 75% as day cases for the BADS "Basket of Cases" would allow 2 beds to be released, with the potential for additional 2 beds to be released as day case levels increase for procedures outside the "Basket of Cases".

Decrease in Average Length of Stay

Between April and September 2008 in General Surgery, ENT and Urology, there were 2,231 elective admissions. Of these, 1,374 had an ALOS of 1-2 days, 316 had an ALOS of 3-4 days and 362 had an ALOS of over 5 days. It is intended as part of this project to discuss with the clinical teams how a patients journey could be optimised to allow them to reduce the ALOS by 15%. This could release between 1 and 2 beds.

Creation of emergency pathways of care

Within CAH, patients awaiting emergency endoscopy currently have their procedure undertaken on the emergency theatre list. Due to the nature of clinical need, the endoscopy patients often have to wait a number of days for this procedure to be completed. A separate emergency endoscopy list has been agreed to eliminate these delays.

This initiative is one example of how the creation of an emergency pathway of care can improve the surgical patients journey through the hospital. By implementing this and other pathways, it is estimated that between 2 and 3 beds could be released.

This paper recognises that the implementation of these proposals will take time and that the full potential of these proposals may not be realised, due to changes in case-mix and service demand. Therefore, whilst there is potential to release up to 32 beds through these 5 schemes, this paper proposes releasing 23 beds from the surgical division during the first quarter of 2009-10.

Ward configuration

Day Case Ward

This ward would operate from 7.30am to 8pm, with patients being admitted on the day and being discharged the same day.

Short stay Ward

This ward would care for patients whose surgery required an overnight stay and planned early discharge as part of their surgical journey.

Elective Inpatient Ward including a Progressive Care Unit

This ward would care for patients whose surgery required post-operative care for a period greater than defined for the short stay ward. It would include within it a Progressive Care Unit for patients who had undergone major surgery and whose post-operative care required a higher level of nursing intervention.

Emergency Ward

This ward would care for emergency surgical admissions. It would be separated into distinct areas which would care for emergency surgical admissions:

Up to 24 hours

24 to 72 hours

Over 72 hours

Trauma & Orthopaedics

These wards would retain their existing profiles.

The exact configuration of the bed volumes for each of these wards will be determined as part of the consultation process on these proposals. In addition, the critical issue of pre and post-op nursing will be addressed as part of the consultation process to ensure the current high standard of nursing is maintained.

3.0 Project process

A series of Directorate workshops were arranged within the Acute Directorate to take forward a range of projects designed to engage clinical teams in the improvement and delivery of excellent services for patients through STEEEP (Safety, timeliness, effectiveness, efficiency, equity, patient-centredness)

Workshop Date	Programme for the Workshop
15th June 08	Launch of STEEP – scoping of projects
5th Sept 08	1st Feedback from Groups.
7th Nov 08	Progress Update
16th January 09	Progress Update
3rd April 09	Final Feedback Session

The Acute Quality Care Project was launched through the STEEEP process. During this process the project has developed a picture of the most appropriate model for taking forward key workstreams, taking into account the requirements for DHSSPS standards and targets, specifically:-

- To ensure no patient waits longer than 9 weeks for an outpatient appointment, 9 weeks for a diagnostic test, and 13 weeks for inpatient or day case treatment
- To secure improvements in daycase rates for a defined range of procedures in accordance with Departmental targets for March 2010 and 2011
- To secure reductions in average length of stay for in-patient procedures in accordance with Departmental targets for March 2010 and 2011
- To ensure that 95% of patients where clinically appropriate wait no longer than 48 hours for inpatient fracture treatment
- To ensure that all urgent breast cancer referrals are seen with 14 days and 98% of urgent referral begin treatment within 62 days
- To ensure that 95% of patients attending A&E are treated and discharged or admitted within 4 hours
- To ensure that all surgical patients to have appropriate pre-operative assessment and no more than 2% of operations should be cancelled for non-clinical reasons.
- To achieve a 3% improvement in hospital productivity, from 2006-07 base year, for each year over the CSR period

4.0 Project Implementation

This stage will be focussed on the implementation of the 5 project workstreams. The monitoring and accountability arrangements will be in line with an agreed project structure with each of the workstreams required to agree key milestones to include:

- Wide engagement with staff across the Directorate including staff side representatives
- Determination of necessary revenue and capital/ infrastructure requirements and the development of relevant business cases necessary to support service change
- Agreement on operational protocols and procedures to ensure clarity around roles and responsibilities in support of the Trust's governance arrangements
- Identification of staff training and development needs and how these needs will be met
- Implementation of new/ revised job plans, job descriptions and contracts where appropriate
- Development of measures for ongoing evaluation of the objectives of each of the workstreams.

5.0 Project Structure

The project will be broken down into the 5 key workstreams, with the following core membership:

- Project Lead – Simon Gibson
- Clinical lead – Eamon Mackle
- Reform project support – Lynn Lappin
- Clinical/professional/managerial input as required.

The Workstreams will report to the Project Steering Group on the performance of the project in terms of achievement of milestones, barriers to be resolved, delivery of objectives, performance management issues, etc. A schedule of bi-weekly monitoring meetings have been agreed with the Project Director to run throughout 2009/10. The 5 surgical key workstreams are described in the following appendices.

General Surgery Workstream **Pre-operative Assessment**

Aim	Objectives	Key Milestones/ timescales:	Actions
Introduce pre-operative assessment for all elective surgical admissions. This will include a sub-group to consider pre-admission practices.	1. To ensure that from April 09 all surgical patients have an appropriate pre-operative assessment. 2. To reduce the number of cancellations on day of surgery for non-clinical reasons to not more than 2% from April 09. 3. To improve patient safety and reduce risk of infection. 4. To reduce patients pre-operative waiting time in hospital for their procedures. 5. To increase the number of patients admitted on the day of surgery **from 30% to 75%** 6. To reduce current bedday utilisation **by 8 beds**	▪ Baseline data analysis to be completed by 31st Nov 08) ▪ Sub-group to assess impact on existing pre-op admission procedures in key specialities by end of Nov 08. ▪ Engagement process with senior clinicians / key personnel (Nov 08 onward) ▪ Agree criteria for patients to be assessed by questionnaire and those to receive face to face assessment by 15th Dec 08. ▪ Confirm arrangements for medical input to pre-op by site (including cross cover from other areas) and confirm arrangements around consenting by Feb 09 and review 3 months after commencement (by 31st May 09) ▪ To maximise elective patients attending CAH and DHH to be admitted on day of surgery from 1st April 2009.	▪ Complete ▪ Complete ▪ Complete ▪ Complete

General Surgery Workstream **Day Case Surgery**

Aim	Objectives	Key Milestones/ timescales:	Action
To increase our day surgery rates for elective procedures, including: - Circumcision - Inguinal hernia repair - Excision of breast lump (sentinel node biopsy) - Anal fissure dilation or excision - Haemorrhoidectomy - Laparoscopic cholecystectomy - Varicose vein stripping / ligation	• To increase day case in these key procedures in the first instance to the 75th percentile, • To bring forward proposals for a day case ward by 1st May 09 with associated bed reconfiguration numbers	• Review baseline performance data by speciality by **End of Jan 09.** • To agree a prioritised list of procedures to be taken forward as daycases **by 1st March 09.** • Ensure pre-op assessment of all elective day surgery admissions by (link pre-op workstream) **1st April 09.** • To increase day case rate to the 75th percentile during 2009-10	

General Surgery Workstream **Average Length of Stay**

Aim	Objectives	Key Milestones/ timescales	Actions
To decrease our Average Length of Stay for an agreed list of elective inpatient procedures:	• To explore ways of reducing LOS for elective admissions • Introduction of a short stay ward • Introduction of an elective ward, including a Progressive Care unit	1. Benchmark current ALOS by speciality with best practice from other providers **by End Feb 09.** **2.** Agree with key clinicians ALOS targets **by 18th March 09** 3. Develop proposals to support performance management arrangements aimed at achieving agreed targets including identification of any support requirements i.e. training, resource requirements etc.	

General Surgery Workstream **Emergency admissions**

Aim	Objectives	Key Milestones/ timescales	Action
To eliminate unnecessary emergency admissions and streamline all emergency admissions during their acute services episode	• To reduce our monthly emergency surgical admissions by 5% • To create definite pathways of care for surgical emergency admissions : Abdominal pain Haematemisis Abscesses Endoscopys • Create an emergency admissions ward for all surgical specialties	Identify baseline data of existing services Create MDT agreed pathways of care, based on evidence based best practice	

Urology Workstream **Pre-operative Assessment**

Aim	Objectives	Key Milestones/ timescales:	Actions
Introduce pre-operative assessment for all elective urological admissions. This will include a sub-group to consider pre-admission practices.	To ensure that from April 09 all urological patients have an appropriate pre-operative assessment. To reduce the number of cancellations on day of surgery for non-clinical reasons to not more than 2% from April 09. To improve patient safety and reduce risk of infection. To reduce patients pre-operative waiting time in hospital for their procedures. To increase the number of patients admitted on the day of surgery **from 0% to 75%** To reduce current bedday utilisation **by 8 beds**	▪ Baseline data analysis to be completed by 31st Nov 08) ▪ Sub-group to assess impact on existing pre-op admission procedures in key specialities by end of Nov 08. ▪ Engagement process with senior clinicians / key personnel (Nov 08 onward) ▪ Agree criteria for patients to be assessed by questionnaire and those to receive face to face assessment by 15th Dec 08. ▪ Confirm arrangements for medical input to pre-op by site (including cross cover from other areas) and confirm arrangements around consenting by Feb 09 and review 3 months after commencement (by 31st May 09) ▪ To maximise elective patients attending CAH and DHH to be admitted on day of surgery from 1st April 2009. ▪	▪ Complete ▪ Complete ▪ Complete ▪ Complete

Urology Workstream

Day Case Surgery

Aim	Objectives	Key Milestones/ timescales:	Actions
To increase our day surgery rates for elective procedures, including: Orchidopexy, Transurethral resection of bladder tumour, Other procedures to be confirmed	• To increase day case in these key procedures in the first instance to the 75th percentile, • To bring forward proposals for a day case ward by 1st May 09 with associated bed reconfiguration numbers	• Review baseline performance data by speciality by **End of Jan 09.** • To agree a prioritised list of procedures to be taken forward as daycases **by 1st March 09.** • Ensure pre-op assessment of all elective day surgery admissions by (link pre-op workstream) **1st April 09.** • To increase day case rate to the 75th percentile by July 09	

Urology Workstream **Average Length of Stay**

Aim	Objectives	Key Milestones/ timescales	Actions
To decrease our Average Length of Stay for an agreed list of elective inpatient procedures:	• To explore ways of reducing LOS for elective admissions • Introduction of a short stay ward • Introduction of an elective ward, including a Progressive Care unit	Benchmark current ALOS by speciality with best practice from other providers **by End Feb 09.** Agree with key clinicians ALOS targets **by 18th March 09** Develop proposals to support performance management arrangements aimed at achieving agreed targets including identification of any support requirements i.e. training, resource requirements etc.	

Urology Workstream **Emergency**

Aim	Objectives	Key Milestones/ timescales	Actions
To eliminate unnecessary emergency admissions and streamline all emergency admissions during their acute services episode	• To reduce our monthly emergency surgical admissions by 5% • To create definite pathways of care for surgical emergency admissions : Urinary retention Renal colic Pylonephritis Torsion of testes • Create an emergency admissions ward for all surgical specialties	Identify baseline data of existing services Create MDT agreed pathways of care, based on evidence based best practice	

ENT Workstream **Pre-operative Assessment**

Aim	Objectives	Key Milestones/ timescales:	Actions
Introduce pre-operative assessment for all elective ENT admissions. This will include a sub-group to consider pre-admission practices.	To ensure that from April 09 all urological patients have an appropriate pre-operative assessment. To reduce the number of cancellations on day of surgery for non-clinical reasons to not more than 2% from April 09. To improve patient safety and reduce risk of infection. To reduce patients pre-operative waiting time in hospital for their procedures. To increase the number of patients admitted on the day of surgery **from 43% to 75%** To reduce current bedday utilisation **by 8 beds**	▪ Baseline data analysis to be completed by 31st Nov 08) ▪ Sub-group to assess impact on existing pre-op admission procedures in key specialities by end of Nov 08. ▪ Engagement process with senior clinicians / key personnel (Nov 08 onward) ▪ Agree criteria for patients to be assessed by questionnaire and those to receive face to face assessment by 15th Dec 08. ▪ Confirm arrangements for medical input to pre-op by site (including cross cover from other areas) and confirm arrangements around consenting by Feb 09 and review 3 months after commencement (by 31st May 09) ▪ To maximise elective patients attending CAH and DHH to be admitted on day of surgery from 1st April 2009.	▪ Complete ▪ Complete ▪ Complete ▪ Complete

ENT Workstream

Day Case Surgery

Aim	Objectives	Key Milestones/ timescales:	Actions
To increase our day surgery rates for elective procedures, including: Tonsillectomys FESS Other procedures to be confirmed	• To increase day case in these key procedures in the first instance to the 75th percentile • To bring forward proposals for a day case ward by 1st May 09 with associated bed reconfiguration numbers	• Review baseline performance data by speciality by **End of Jan 09.** • To agree a prioritised list of procedures to be taken forward as daycases **by 1st March 09.** • Ensure pre-op assessment of all elective day surgery admissions by (link pre-op workstream) **1st April 09.** • To increase day case rate to the 75th percentile by July 09 • To complete a modelling -capacity / demand to assess the impact of reduced bedday usage resulting from increase day case rates **by 1st April 2009.**	

ENT Workstream **Average Length of Stay**

Aim	Objectives	Key Milestones/ timescales	Actions
To decrease our Average Length of Stay for an agreed list of elective inpatient procedures:	To explore ways of reducing LOS for elective admissions Introduction of a short stay ward Introduction of an elective ward, including a Progressive Care unit	Benchmark current ALOS by speciality with best practice from other providers **by End Feb 09.** Agree with key clinicians ALOS targets **by 18th March 09** Develop proposals to support performance management arrangements aimed at achieving agreed targets including identification of any support requirements i.e. training, resource requirements etc.	

ENT Workstream **Emergency**

Aim	Objectives	Key Milestones/ timescales	Actions
To eliminate unnecessary emergency admissions and streamline all emergency admissions during their acute services episode	• To reduce our monthly emergency surgical admissions by 5% • To create definite pathways of care for surgical emergency admissions : Epistaxsis Quincy Epiglotitis • Create an emergency admissions ward for all surgical specialties	Identify baseline data of existing services Create MDT agreed pathways of care, based on evidence based best practice	

Trauma & Orthopaedics Workstream — Pre-operative Assessment

Aim	Objectives	Key Milestones/ timescales:	Actions
Introduce pre-operative assessment for all elective T & O admissions. This will include a sub-group to consider pre-admission practices.	To ensure that from April 09 all urological patients have an appropriate pre-operative assessment. To reduce the number of cancellations on day of surgery for non-clinical reasons to not more than 2% from April 09. To improve patient safety and reduce risk of infection. To reduce patients pre-operative waiting time in hospital for their procedures. To increase the number of patients admitted on the day of surgery **from 51% to 75%** To reduce current bedday utilisation **by 8 beds**	▪ Baseline data analysis to be completed by 31st Nov 08) ▪ Sub-group to assess impact on existing pre-op admission procedures in key specialities by end of Nov 08. ▪ Engagement process with senior clinicians / key personnel (Nov 08 onward) ▪ Agree criteria for patients to be assessed by questionnaire and those to receive face to face assessment by 15th Dec 08. ▪ Confirm arrangements for medical input to pre-op by site (including cross cover from other areas) and confirm arrangements around consenting by Feb 09 and review 3 months after commencement (by 31st May 09) ▪ To maximise elective patients attending CAH and DHH to be admitted on day of surgery from 1st April 2009.	▪ Complete ▪ Complete ▪ Complete ▪ Complete 1.

Trauma & Orthopaedics Workstream **Day Case Surgery**

Aim	Objectives	Key Milestones/ timescales:	Actions
To increase our day surgery rates for elective procedures, including: Other procedures to be confirmed	• To increase day case in these key procedures in the first instance to the 75th percentile, • To bring forward proposals for a day case ward by 1st May 09 with associated bed reconfiguration numbers	• Review baseline performance data by speciality by **End of Jan 09.** • To agree a prioritised list of procedures to be taken forward as daycases **by 1st March 09.** • Ensure pre-op assessment of all elective day surgery admissions by (link pre-op workstream) **1st April 09.** • To increase day case rate to the 75th percentile by July 09 • To complete a modelling -capacity / demand to assess the impact of reduced bedday usage resulting from increase day case rates **by 1st April 2009.**	

Trauma & Orthopaedics Workstream **Average Length of Stay**

Aim	Objectives	Key Milestones/ timescales	Action
To decrease our Average Length of Stay for an agreed list of elective inpatient procedures:	To explore ways of reducing LOS for elective admissions Introduction of a short stay ward Introduction of an elective ward, including a Progressive Care unit	Benchmark current ALOS by speciality with best practice from other providers **by End Feb 09.** Agree with key clinicians ALOS targets **by 18th March 09** Develop proposals to support performance management arrangements aimed at achieving agreed targets including identification of any support requirements i.e. training, resource requirements etc.	

Ophthalmology Workstream — Pre-operative Assessment

Aim	Objectives	Key Milestones/ timescales:	Actions
Introduce pre-operative assessment for all elective Ophthalmology admissions. This will include a sub-group to consider pre-admission practices.	To ensure that from April 09 all urological patients have an appropriate pre-operative assessment. To reduce the number of cancellations on day of surgery for non-clinical reasons to not more than 2% from April 09. To improve patient safety and reduce risk of infection. To reduce patients pre-operative waiting time in hospital for their procedures. To increase the number of patients admitted on the day of surgery **from 65% to 75%** To reduce current bedday utilisation **by 8 beds**	▪ Baseline data analysis to be completed by 31st Nov 08) ▪ Sub-group to assess impact on existing pre-op admission procedures in key specialities by end of Nov 08. ▪ Engagement process with senior clinicians / key personnel (Nov 08 onward) ▪ Agree criteria for patients to be assessed by questionnaire and those to receive face to face assessment by 15th Dec 08. ▪ Confirm arrangements for medical input to pre-op by site (including cross cover from other areas) and confirm arrangements around consenting by Feb 09 and review 3 months after commencement (by 31st May 09) ▪ To maximise elective patients attending CAH and DHH to be admitted on day of surgery from 1st April 2009. ▪	▪ Complete ▪ Complete ▪ Complete ▪ Complete

From:	Sloan, Samantha Ms
To:	Weir, Colin; McGeough, Mary; Gibson, Simon; Mackle, Eamon; Hewitt, Gareth; Lewis, Alastair; Epanomeritakis, Manos; Mackle, Eamon; McCullough, Pat; Maxwell, Sharon; "Wendy McKinney"; Hewitt, Gareth
Cc:	Sharpe, Dorothy; Hall, Sam; McNaboe, Ted; Young, Michael; O"Brien, Aidan
Subject:	RE: Endoscopy List and Ward reconfiguration
Date:	24 March 2009 17:04:09
Importance:	High

I agree entirely with both points.

Endoscopy
This has not been fully negotiated with those currently delivering the SOW service. I received a very short e mail asking if I would support or participate in this service. In prinicipal it should improve patient care if we have access to urgent endoscopy rather than patients continually being bumped on the emergency list, but when did this materialise into three fixed 3.5 hrs half day sessions? How can the committments of a consultant delivered SOW be delivered while covering this. The days of leaving a reg to do this are gone, especially as we have had three registrars unable to perform endoscopy this year alone. If these are acute bleeders needing intervention then they need appropriate staff to manage them safely.

The physicians also have not been fully involved in the practicalities of delivering this service and have their own concerns.

This appears to have been rushed in very quickly and needs to be formally staffed for it to run in conjunction with the SOW not instead off.

Ward Re-configuration

The clinical staff both medical and nursing actually delivering the service and meeting the targets have not been involved in this area. It seem a backwards step in patient care, if mixed general wards were such a good idea why did every subspeciality move to subspeciality ward care many years ago. The idea of an emergecy ward seems logical considering our workload but the changes to the other areas seem impractical. How will we run multiple ward rounds, this will potentially delay starting elective sessions in the am. The details of this have come more by chinese whispers than direct engagement, and have not involved all those affected jointly including ENT & UROLOGY they would probaly agree with the sentiments of Colin's email.

Currently medical outlyers also impact on our surgical beds can we be sure this will be resolved?

There has been no meeting that I am aware of were ENT / UROLOGY / SURGERY Consultant staff have all been in attendance and this has been discussed, we are not mutually exclusive and changes to one service will impact on the delivery of others. Perhaps this needs to be arranged so this can all be discussed inclusively.

Sam Sloan

From: Weir, Colin MR
Sent: 24 March 2009 14:25
To: McGeough, Mary; Gibson, Simon; Mackle, MR E; Hewitt, G R MR; Lewis, Alastair; Epanomeritakis, Manos Mr; Mackle, MR E; McCullough, Pat Sec. Mr Peyton & Mr Campbell); Maxwell, Sharon; Sloan, Samantha Ms; Wendy McKinney; Hewitt, G R MR
Cc: Sharpe, Dorothy
Subject: Endoscopy List and Ward reconfiguration

I think I write in agreement with some of my colleagues in saying that the endoscopy session was not to be configured as a fixed daily session. How on earth can SOW function with the juniors if we are tied up doing a morning endoscopy list? SOW work and seeing patients comes first. Unless it is reflected in job plans. I am not aware that any of us have had that negotiation. I don’t mind if ward work has finished then we can utilize the session.

I will not be doing PEG PEG replacement or Colonoscopy.

There is widespread concern regarding ward reconfiguration
This is another example of how things are not negotiated anymore. We all have concerns how this will work. When did we have a detailed discussion about it? When did we talk through the implications of it? How are we going to do a ward round when everyone including urology are in attendance? Tell me what the benefits are to quality of care and how you see this working in the real world? Maybe I have missed those discussions too and I am sorry I have.

Maybe Im out on a limb here but our team of nurses are not happy and neither am I.

Anyone else??

Colin Weir FRCS(Ed), FRCS
Consultant General and Vascular Surgeon
Craigavon Area Hospital
* Personal Information redacted by the USI
)secretary direct Personal Information redacted by the USI

Response To
Trust's Proposals for Ward Reconfiguration

Department of Urology
Craigavon Area Hospital

May 26th, 2009

The members of the Department of Urology in attendance at the meeting of the Clinical Forum of Tuesday 12 May 2009 were invited to consider the Trust's initial proposals for Ward Reconfiguration in conjunction with the discussions which took place at that meeting, with a view to returning to the next meeting of the Clinical Forum on Tuesday 26 May 2009 with their own reflections and/or proposals for the way forward.

Those members have met with others on two occasions since then. Arising from those meetings, this paper attempts to encapsulate our understanding of the challenges faced by the Trust in the future delivery of surgical services in general, in additional to the challenges faced by the Trust and our Department in implementation of the recommendations of the Regional Review of Urology Services in Northern Ireland. It seeks to articulate core values and principles which we believe should be safeguarded in meeting those challenges. It details proposals which we believe are constructive and essential if the challenges are to be met with success. Lastly, they are proposals to which all members of our Department would be wholly committed, in partnership with the Trust, in ensuring that success.

Challenge facing the Trust

It is our understanding that the Trust is presented with the need to deliver surgical services during the current financial year with a reduced budget. It is also our understanding that it is anticipated that the Trust will be required to deliver surgical services during coming years with possibly more stringent budgetary conditions.

We also understand that the Trust is required to comply with the Elective Reform Program (ERP), Developing Better Services (DBS), and the Integrated Elective Access Protocol (IEAP). We appreciate that the Trust is required to implement the measures recommended by the Scheduled Care Reform Program (SCRP), including

- Preoperative assessment, to facilitate
- Admission on day of surgery, and
- Increased day surgery rates, and
- Reduction of cancelled operations
- Maximising use and productivity of theatres

We appreciate that the Trust will be expected to benchmark their performance in these areas.

Lastly, it is our understanding that Trust management have concluded that introduction and implementation of these measures would enable the Trust to comply with HSC expectations and to remain within imposed budgetary constraints, while continuing to provide quality elective and non-elective surgical services with such capacity as to meet demand.

Regional Review of Urology Services in Northern Ireland

A regional review of Urology Services in Northern Ireland was established in September 2008 and reported in March 2009. The stated purpose was to '*develop a modern, fit for purpose in 21st century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal Colleges, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.*'

The report of the review presented a modernisation and invested plan. It presented 26 recommendations to be implemented by all Trusts and Departments of Urology in Northern Ireland. Fundamental to all is the recommendation that all Urological services in Northern Ireland should be reconfigured into a 3 Team model (known as Team North, Team East and Team South), to achieve long term stability and viability. Each Team is to have '*main, acute, elective and non-elective, inpatient unit*'.

Team South is to provide Urological services to the southern third of the current Western Trust area (County Fermanagh, population circa 61,000), in addition to all of the current population of the Southern Trust area (342,754): an increase of approx. 20%. Team South will require 5 Consultant Urologists and will have its main, acute, elective and non-elective, inpatient unit at Craigavon Area Hospital. Day surgery will be conducted at Craigavon Area, Daisy Hill, South Tyrone Hospitals. Outpatient clinics will be conducted at Craigavon Area, Daisy Hill, South Tyrone and Armagh Community Hospitals as well as Banbridge Polyclinic, as at present. In addition, it is recommended that Team South may wish to consider the provision of outreach clinics and/or day case diagnostics at the Erne Hospital, Enniskillen.

Therefore, the Review has established that its purpose requires the reconfiguration of Urological Service provision in Northern Ireland by three Teams, and that each Team requires a Urology Unit in its main, acute hospital.

Non-elective Urological Services

There are approx. 2,500 non-elective urological admissions per annum in Northern Ireland (Report 3.18). There are only two Urology Units (at Belfast City and Craigavon Area Hospitals) to which acute admissions are admitted directly or subsequently transferred, if required (Report 3.22). Team North should also have a *'main acute unit'* for non-elective admissions (Report 9.6). The Report's Recommendations 7 and 8 state that Urologists *'should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit...and for those requiring direct transfer and admission to an acute Urology Unit'*. With specific relevance to Team South, Recommendation 9 states that *'Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g., Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit, and provision of Urology advice/care by telephone, electronically or in person, also 7 days a week'*.

Therefore, the Review has emphasised the need for each Team to have a Urology Unit to which acute urological admissions can be admitted directly or transferred, and from which the care of those admitted elsewhere can be advised, monitored, supervised. Moreover, with the implementation of Development of Better Services (DBS) in future years, increasing proportions of acute urological admissions will be admitted directly to Urology Units.

Reducing Length of Stay (LOS)

The Review's recommendations 13 and 14 states that *'Trusts should implement the key elements of the elective reform program... and should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients...with a view to agreeing a target length of stay for these groups of patients'.*

In doing so, the Review acknowledged that some hospitals would expect to have longer than average LOS if they undertake more complex operations, treat patients with greater comorbidity and patients with higher levels of social deprivation (Report 5.14).

The Review also stated that ERP will require Urology Services to be creative in the development of day and short stay surgery, *'ensuring the provision of a safe model of care that provides a quality service to patients'* (Report 5.22).

Therefore, the Review requires a benchmarked reduction in Length of Stay whilst ensuring a safe, quality service to patients.

Day Surgery

The Review noted the implications of the Audit Commission recommendations for day surgical rates across a number of surgical specialties, and the more specific recommendations of the British Association of Day Surgery (BADS) for day surgical rates for 31 urological procedures (Report 5.19). Review recommendation 15 states that *'Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery... '.*

Importantly, the Review states that Trusts will need to *'consider procedures currently undertaken using theatre / day surgery facilities, and the appropriateness of transferring this work to procedure / treatment rooms, thereby freeing up valuable theatre space to accommodate increased day surgery'* (Report 5.23).

Therefore, the Review wholly requires Trusts and Urology Teams to maximise day surgery rates and to be creative in that endeavour.

Values and Principles

With all of the relentless challenges that we all have to face and for which we will be held accountable, whether collectively or individually, whether manager, doctor or nurse, we believe that it is critically important to reflect upon and to redefine our *raison d'etre.* In the context of considering ward reconfiguration, *we are a hospital.*

Several of the component activities of an integrated Urology Service detailed in the Review Report (some, such as ICATS, not referred to above) need not be conducted in a hospital at all, though for several reasons, we believe that it is preferable. However, the one component that can only be conducted in a hospital is the care of those so ill, or requiring management so significant, as to require inpatient care.

We believe that urological inpatient care can only best be provided by doctors and nurses fully trained, qualified, competent and experienced in urological inpatient care. This belief is wholly and unreservedly supported by the British Associations of Urological Surgeons and Nurses, in recent publications and communications.

Therefore, we believe that it is self-evident that the only manner in which such urological inpatient care can possibly be provided is in a distinct, dedicated, inpatient Urology Unit.

The provision of such a Urology Unit is compliant with the Recommendations of the Regional Review.

We believe that it is equally self evident that all urological inpatients should be managed in the Urology Unit, whether elective or non-elective, and irrespective of their length of stay.

We believe that elective, urological, day surgery should be provided in adequately resourced units which do not compromise the ability to maximise inpatient care.

Lastly, we assert that it is incumbent upon all to have robust evidence to support any claim that any different model proposed for urological inpatient care provides for a quality of care and clinical outcomes superior to that above.

Department of Urology Proposals

1. The Trust should firstly explore the possibility of moving all elective flexible cystoscopies out of day surgical theatres and into outpatient procedure rooms. This would be particularly worthwhile at CAH, moving flexible cystoscopies from DSU to the Thorndale Unit. This alone would free up six theatre sessions per month for elective day surgical procedures. Similar possibilities should be explored at STH and DHH.
2. The Trust should maximise the provision of adequately resourced, elective, day surgical facilities at all sites, so as to minimise the inappropriate use of inpatient beds for day surgery.
3. With concerns regarding continuity of care, we commit, where necessary, to having elective, short stay patients admitted on the day of surgery to that elective admissions ward, but only on condition that they return postoperatively to the Urology Unit.
4. All longer stay, elective admissions will be admitted to the Urology Unit, and remain there until discharge.
5. All non-elective admissions will be admitted directly to, or transferred to, the Urology Unit.
6. The Urology Unit will be singular and distinct. Any compromise of its integrity would disable implementation of the Regional Review.

Southern Health and Social Care Trust

Acting Director of Acute Services
Administration Floor
Craigavon Area Hospital

Mr Aidan O'Brien
Consultant Urological Surgeon
Southern Health & Social Care Trust
Craigavon Area Hospital

1 June 2009 **Our Ref:** JY/njh **Your Ref:**

Dear Aidan

Urology Services

Many thanks for your letter dated 29 May 2009 regarding the recent response to the consultation on the surgical reconfiguration of beds and making the time to come and see me directly on Friday.

The eight points presented in your paper on Wednesday were very helpful in reaching consensus and agreement. As requested in your letter, I am more than happy to respond to each point and outline the role of the Urology Ward Manager.

Can I at the outset, thank you and your colleagues for all the time and commitment you have personally given to move us forward to a consensus position. I very much appreciate how difficult this has been, but now feel we can all move forward with an agreed position. I will take the points in order as presented in your paper.

Point 1
Both Mairead McAlinden and myself are committed to the transfer of flexible cystoscopies and the expanded use of both the Thorndale Unit and other Trust facilities. I know already the options regarding a link corridor are being explored as a matter of priority and see no barriers presently to this occurring in the short term.

Point 2
I feel we have all been striving to achieve this point and work is currently underway with all specialties, to maximise day surgical facilities. This is now part of an action plan.

Point 3
I am delighted that there is agreement to utilise Ward 3 South for elective day surgical patients. This I believe will be further facilitated by the development of care pathways in Urology. I have asked Heather Trouton and Robin Brown to support and assist your team in developing those care pathways.

Point 4
I acknowledge the commitment to admit all patients to Ward 3 South and could I suggest that the team liaise with Connie Connolly and Heather Trouton to facilitate this.

/cont.2..

Point 5
I acknowledge there is a degree of flexibility required in utilising the elective short stay ward. I am hopeful that by developing care pathways as outlined above, this will assist in determining the best area for post-operative management.

I would like to suggest that the procedures that could utilise this facility are identified and we work through the implementation of these over the next month with the team.

Point 6
The Urology Unit will provide care for long stay and non-elective patients as appropriate, I am sure that the work to develop care pathways will assist with this. I am happy to provide support for this to be taken forward.

Point 7
I can only reiterate my thanks to the team in accepting this proposal that the Urology Unit will be located in the ward area, to which all general surgical non-elective patients will be admitted.

Point 8
I would like to outline for you the role I have discussed with Shirley Tedford. Firstly, I recognise the role she has played in co-ordinating the numerous activities in Urology, which are much wider than a Ward Manager's role. This has been a wide span of responsibility and I feel we need to recognise and give her the time to undertake the diverse role required.

With this in mind, I feel the role needs to expand to one of Nurse Clinical Lead/Co-ordinator for Urology Services. The role will encompass providing nursing leadership/co-ordination to both the Urology Unit and the patients who are being admitted to both the day case and short stay areas.

The role will also cover the services in Urodynamics and the Thorndale Unit, establishing and supporting the areas outlined alone in Point 1.

I have also discussed with Shirley the development with yourselves of care pathways with the assistance of Mr Robin Brown.

The Ward will be managed by Sheila Mulligan with nursing and clinical leadership input from Shirley.

I know they have both discussed this and are in agreement. They feel they can manage this on a day-to-day basis. I believe this will have a number of benefits to Shirley in her new role:-

- Dedicated time to develop the Urology Service without the day-to-day demands of running a 36 bedded ward ensuring clinical quality in the Urology area

- Time to develop care pathways with the clinical team

/cont..3..

Craigavon Area Hospital, 68 Lurgan Road, Portadown, County Armagh, BT63 5QQ Tel No Personal Information redacted by the USI
Fax No Personal Information redacted by the USI Email Address Personal Information redacted by the USI

- Providing clinical support to Urology nurses in both the Urology Unit, Day Case & Short Stay areas
- Development of the services that can be provided in the Thorndale Unit and Urodynamics
- Time to liaise with community colleagues in the development of protocols for aspects of care that can be delivered in a community setting.

I know when we spoke on Friday, you felt this was a role that had been suggested a while ago and you indicated your support for such a role. I really appreciate that this has been a challenging time for you and the team and I hope this letter provides the reassurance and commitment from the Senior Management Team you require.

I look forward to taking forward these developments with you and your team in a spirit of openness and partnership working.

Finally, may I thank you personally for all the time and commitment you have given to enable us to move forward on all of these points.

With best wishes.

Yours sincerely

Personal Information redacted by the USI

Mrs Joy Youart
Acting Director of Acute Services

cc Mr C Donaghy, Chief Executive
Mrs M McAlinden, Director of Performance & Reform
Mr S Gibson, Assistant Director of Acute Services (Surgery & Elective Care)
Mr E Mackle, Associate Medical Director (Surgery & Elective Care)
Mr R Brown, Clinical Director (Surgery & Elective Care – DHH Site)
Sr S Tedford, Ward 2 South (Urology)

Craigavon Area Hospital, 68 Lurgan Road, Portadown, County Armagh, BT63 5QQ Tel No Personal Information redacted by the USI
Fax No Personal Information redacted by USI Email Address Personal Information redacted by USI

3rd June 2009

Mrs Joy Youart
Acting Director of Acute Services
Craigavon Area Hospital

Dear Joy,

I write to thank you for your letter of Monday 01 June 2009. I am appreciative of the time and effort that both you and Mairead have already put into responding to our requests. I was very encouraged and reassured by the commitment of both of you to ensure that developments do actually occur, that pledges are translated into results. I have shared that encouragement and reassurance with all members of staff of our Department.

However, it is proving difficult to instill adequate confidence in all. Many of our most experienced staff are not confident of the integrity of the Urology Unit in Ward 4 North. Instilling confidence is all the more difficult by rumours that Ward 4 North will be split into male and female sides after all, and as it has been to date. Many believe that there will be little commitment to rostering urological nurses to the Urology Unit. I have been concerned, if not alarmed, to hear nurses declare such little confidence as to call into question their enthusiasm for applying for deployment to the unit.

I have tried to reassure them that it is clearly understood that the Urology Unit will be confined to a singular part of the floorplan of Ward 4 North, and that rostering will be organized to ensure that urology nurses are deployed to the Unit and that the Unit is maximally staffed by urology nurses. I believe that we all require our nursing staff to apply for their preference, with confidence that their preference will materialize, and with enthusiasm to ensure that the future configuration will work.

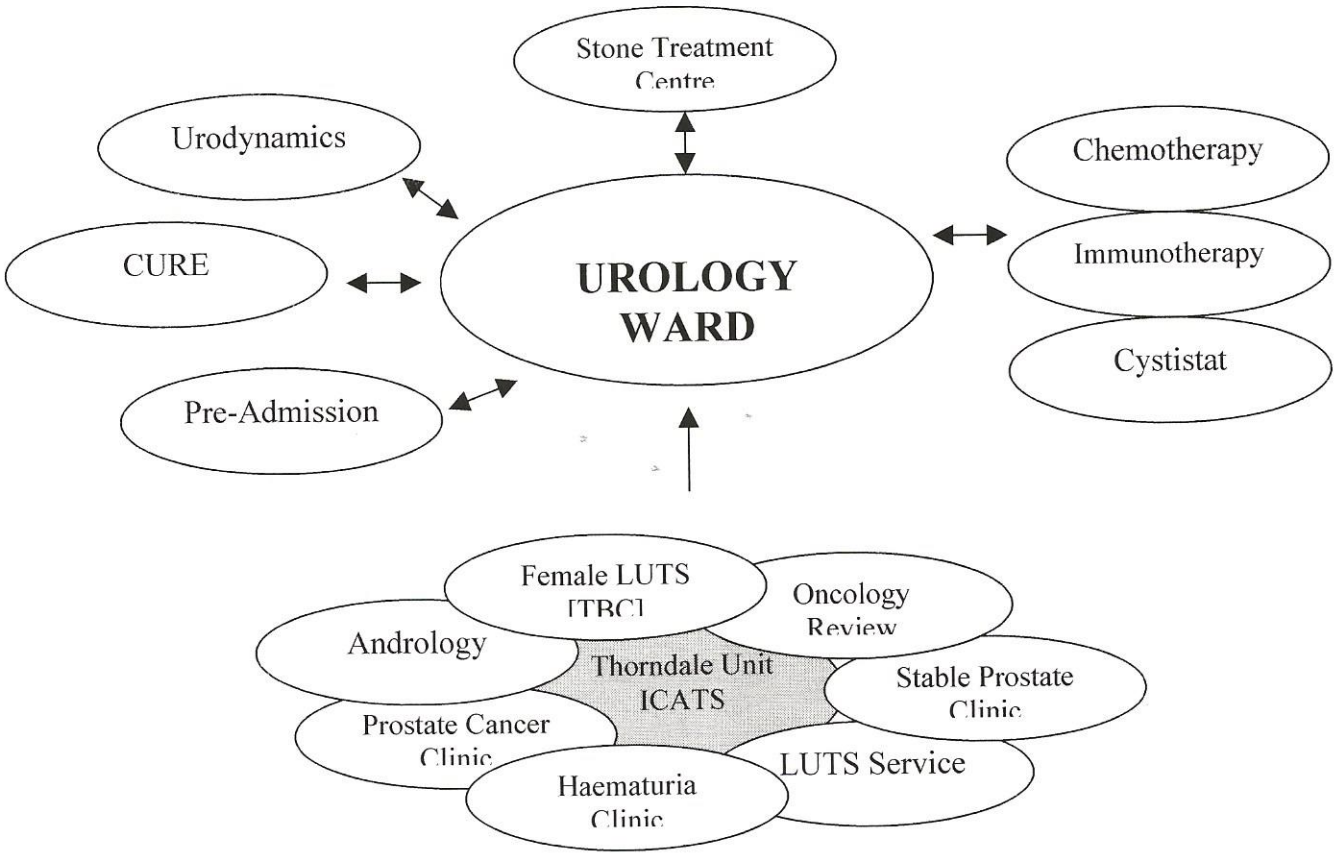
I have asked Shirley Tedford to organize a meeting of all our ward staff on Thursday 4th June at 7.30 pm, so that they can then be advised unequivocally of the integrity of the Unit. I would be grateful if you could confirm, in writing, that there is an unambiguous, unqualified commitment to have a Urology Unit as described above.

Yours sincerely

Aidan O'Brien FRCS
Consultant Urologist

Centralised Urological Services

For the past 17 years the provision and expansion of Urological services has occurred around the hub of Ward 2 South with the service currently represented as below:



Today the Urology Department comprises a series of inter-related services in the main staffed by nurses who cross boundaries between elements of the service and the main ward. It has always been the philosophy of the Department that nurses from the ward should be facilitated to develop theoretical and practical skills to offer both a general service within the ward and also to be able to work as one of a team within the different sub-speciality areas of urology. This philosophy has singularly been responsible for maintaining and enhancing three key things:

1. A progressive and reactive service capable of meeting the needs of the urological population
2. A nursing workforce of the very highest quality
3. A patient centred service

Over the past 17 years nurses within the Urology Department, in common with nursing colleagues from other sub-specialist areas within the Trust, have developed extensive expert knowledge and skills. These skills have ensured that patients experience a service that understands and anticipates their needs. In addition the existence of a stable urology focused nursing team has meant that emerging trends within urology as well as new approaches to patient care can be reacted to with

appropriate speed and understanding. These aspects of service delivery are seen as key to the modernisation agenda NHS as demonstrated in their 2005 document Action on Urology (NHS 2005, p4) when they claim that there is a "new and welcome emphasis on delivering patient focused care." The document goes on to suggest that in the near future three key drivers will also dominate the provision of urology services, namely,

- An ageing population which will generate higher demand for services
- Rising public expectations which demand higher quality care, and
- New technology which demands differently skilled workers

It is the unshakeable belief and experience of clinical staff both nursing and medical on ward 2 South that the drivers mentioned by the NHS can and will only be met from the foundation of a recognisable Urology Department based around the hub of a Urology Ward. The evolution of urology services to date has ensured a workforce that is knowledgeable and competent in the provision of urology services. The dilution of urology services throughout a multi-ward surgical model will result in the dispersal of long gained urology nursing competencies. It is our belief that this will result in a greatly decreased patient experience. In addition, we strongly believe that the dilution will expose patients to unnecessary risk with their care being provided by a workforce insufficient in knowledge, experience and competence. This point is one we cannot make strongly enough.

The Trust Delivery Plan 2009/2010 has identified some key priorities as,

- Provision of safe, high quality care
- A great place to work, valuing our people, and
- Making the best use of resources.

The current provision of services on 2 South ensures that the above priorities are realised and that this situation will be maintained. Since its inception the staff of the Urology Department has worked hard to develop a portfolio of skills, often at their own time and expense. As a result a strong team spirit has been created creating a happy and healthy workforce, something specifically mentioned as being central to the values of the Trust. Twelve years ago the Urology Department established its own charity CURE. CURE has played a vital role in providing financial support for nurses to attend training courses in urodynamic measurement, and in funding nurses to undertake diploma, degree and postgraduate study. Lastly, CURE has funded research into core aspects of urological disease.

The staff or the Urology Department has demonstrated an enthusiasm to embrace change. It should be noted that this document, with its inherent rejection of a multi-ward surgical model for patients with urological disease, is neither reactionary nor insular. We do not fear change. However, we believe that change must only occur when it can be demonstrated that the current system is suspect and not in the best interests of the patient. It is our belief that rather than diluting staff and service provision, the Department of Urology should be strengthened as it provides an excellent and expert level of care.

We are aware that there are those working within the health service that feels that there should be no specialties and that "a nurse is a nurse is a nurse". Along with many of our colleagues within the nursing and medical professions we vigorously dispute this. The NHS has held sub specialisation at the forefront of its development over the last few decades. As nurses we believe it is extremely important to maintain a cellular unit, which will deliver a high quality safe service. Any fragmentation of the urology ward and out-patient clinics delivered as extensions of this unit will be detrimental to the excellent service we currently provide. Patients, relatives, carers and other health professionals have a vital point of contact where they can receive advice and support, often preventing unnecessary admissions to a hospital already stretched in its provision of service. If the ward staff is to be dispersed throughout the hospital to whom will these people go for advice?

In the last 2-3 years the staff within the ward, especially those in the urodynamic clinic, have worked tirelessly to ensure that extra theatre sessions and patient assessments have taken place. Often these sessions were staffed by nurses working extra hours or coming in on their days off. This has resulted in us reducing our waiting lists and therefore successfully meeting government targets and provides an example of the ability and willingness of the urology staff to ensure that our service meets the needs of the population. We greatly fear that a diluted staff will make it impossible to react so positively to future service demands.

We fully understand that there is a need for the trust to save £34 million over a 3-year period and indeed we stand ready to play what part we can in assisting the Trust to meet its challenges. However, we believe that the best, indeed the only way to ensure that the Department of Urology assists the meeting of targets is to support and enhance it as a unit and not to dilute it out of existence.

The provision of urological services is a complex activity and requires a staff that is knowledgeable, integrated and competent. We believe that this is what we have developed over 17 years. Urological trends as identified by the NHS, the British Association of Urological Surgeons and the British Association of Urological Nurses clearly demonstrate the need for a workforce that is more skilled, competent and able to react to needs that because of the patient population will only increase. Out of an understanding of need and a desire to provide excellence we urge in the strongest terms a radical rethink on plans to alter the provision of urology services.

Reference:

NHS (2005) Action on Urology: The new urology workforce – overview of emerging trends London: The NHS Modernisation Agency

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LETTER TO THE EDITOR

Preliminary assessment of regular short-term intravenous fluids and antibiotic therapy in recurrent UTI

Dear Sir,

We read with interest on the article by Falagas et al., concerning antibiotic treatment in women with uncomplicated cystitis.[1] In this context, the management of recurrent urinary tract infection (rUTI) remains a therapeutic challenge. Within our department, we have identified a cohort of patients with rUTI, who have had multiple emergency admissions for severe rUTI episodes requiring intravenous fluid and antibiotic therapy. For years, these patients have been treated appropriately with multiple oral antibiotics treatment and prophylactic antibiotic courses by their GP, but with little success since their symptoms, in particular nausea and generally unwell being, have prevented compliance to oral antibiotic therapy and adequate oral rehydration. As a consequence, their condition deteriorates and inevitably leading to the need for emergency hospital admission.

Over their multiple emergency admissions, we have evolved our treatment strategy to electively administer a combination of short-term intravenous fluids and antibiotics therapy (IVT) regularly to this cohort. The duration of admission for treatment varied dependent on the patient's treatment response and usually ranges between 3 and 5 days. In this select cohort, their nausea symptoms have prevented adequate oral rehydration and hence about 1–2 L per day of intravenous fluid were administered during admission. The antibiotic choice used during IVT is dependent on the most recent MSSU culture sensitivity. When IVT is completed, further oral antibiotics are not given. The rationale for this strategy is to adequately treat any underlying UTI completely prior becoming symptomatically severe and therapeutically difficult to manage. This cohort of rUTI patient usually became symptomatic about 3 months after their emergency admission for severe UTI. The frequency and duration regime is not fixed, but rather flexibly adapted according to patient's symptoms. The intention is to gradually prolong the regularity of this regime, for example every 3 monthly, then 6 monthly and gradually yearly. The ultimate aim is help these rUTI patients achieve independence from IVT and yet maintain a reasonably good quality of life. We report our experience with regular short-term intravenous fluids and antibiotic therapy (IVT) as an adjunctive treatment.

A retrospective cohort analysis was done on 16 patients with rUTI on IVT, and was followed up for an average of 100 months. There were 11 female and 5 male patients with the mean age of 41.2 (SD $\pm$ 15.9) years. Five patients have ileal conduit/urostomy, 2 patients had long-term suprapubic catheter, 4 patients perform ISC, 1 patient has a Mitrofanoff formation and the remaining patient without significant comorbidity. In all patients, extensive and comprehensive investigations have been performed to exclude any urologically treatable conditions that predispose to rUTI. Comparative assessments included emergency admission, urinary culture, antibiotic usage, SF-36 and FACIT-TS quality of life questionnaires, between the period before and during IVT.

There were a total of 206 of IVT admission episodes contributing to a total of 934 days and a mean duration of hospital stay per admission of 4.7 days. The mean duration between each IVT admission was 2.9 months. The number of emergency admission (88 vs 16, $p = 0.001$, X_2) and outpatient clinic reviews (216 vs 5, $p = 0.001$, X_2) have decreased significantly. The IVT for elective admissions predominantly utilised Gentamicin, followed by Co-amoxiclav as shown in Table 1. Similarly in the emergency admissions, intravenous Gentamicin and Co-amoxiclav were the antibiotic of choice. In the outpatient or GP practice setting, the predominant oral antibiotics used were Trimethoprim followed by Ciproxin and Cefelexin. A total of 1050 MSSU culture and direct microscopic results were obtained. Majority of MSSU are obtained at GP setting as shown in Table 2. The most common cultured uropathogen was coliforms, followed by mixed growth, Enterococcus faecalis, Proteus and Pseudomonas. There was significantly more mixed growth culture results obtained during the IVT period comparatively (14.8% vs 4.2%). There was a decreased in ESBL cultures during IVT treatment. Otherwise, the IVT did not significantly change the proportion of the colonising uropathogen type cultured.

There was a complete response rate of 100% to the SF-36 QoL and FACIT-TS questionnaire. The overall negative impact of rUTI on the QoL confirmed the debilitating nature of the disease. There are statistically significant

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Table 1 Frequency and type of antibiotic usage.

Antibiotic therapy	IVT admission	Emergency admission	OPD & GP
Intravenous			
Gentamicin	45.5%	40.5%	–
Co-amoxiclav	36.8%	38.1%	–
Ciprofloxacin	6.4%	4.8%	–
Cefuroxime	6.4%	9.5%	–
Meropenem	2.3%	2.4%	–
Cefutaxime	1.8%	0	–
Teicoplanin	0.05%	2.4	–
Vancomycin	0.05%	0	–
Netilmicin	0	2.4%	
Oral			
Trimethoprim	–	–	43.9%
Ciprofloxacin	–	–	35.2%
Cefelexin	–	–	10.9%
Co-Amoxiclav	–	–	5.5%
Nitrofurantoin	–	–	3.3%
Ampicillin	–	–	1.1%

improvements after being on the IV regimen in six of the SF-36 domains including the physical functioning (52.3 vs 35.4, $p = 0.05$), social functioning (51.6 vs 27.3, $p = 0.01$), physical role limitation (37.5 vs 4.7, $p = 0.01$), emotional role limitation (58.3 vs 24.9, $p = 0.04$), bodily pain (53.6 vs 30.5, $p = 0.03$) and vitality (42,5 vs 21.9, $p = 0.002$). The FACIT-TS showed an overall treatment satisfaction score of 81.5% and a treatment recommendation score of 95%. There were 3 recurring themes of commentaries from patients via FACIT-TS, and they were: i) IVT is effective, more so than oral antibiotics ii) IVT has significantly improved their quality of life and reduced the rate of emergency hospital admissions iii) IVT would be much better if given in a non-hospital admission setting.

Because the major cost burden was incurred from inpatient hospital stay, one alternative solution is to develop IVT into an outpatient treatment, also known as Outpatient Parenteral Antibiotic Therapy (OPAT) or to develop a home intravenous antibiotic treatment.[2,3] OPAT and home intravenous antibiotic in various infectious conditions has been shown to be clinically efficacious and cost-effective in the United Kingdom National Health Service setting and the Australian healthcare system respectively. Administration of IVT through OPAT represents a potential economically viable option. Further, the carefully selected rUTI patients undergoing IVT are relatively well and require minimal clinical observation.

From our preliminary results, we conclude that IVT is beneficial for a carefully selected patient with rUTI and their treatment should be individually tailored. We do not claim to know the optimal duration of treatment and

Table 2 Admission and urinary culture data.

	Before IVT	During IVT	*p*-value
Mean duration of follow-up (months)	67.1	32.9	–
No. of emergency admission episodes	86	18	0.001, X_2
Mean duration of emergency episode (days)	5.6	5.8	NS
No. of OPD episodes	208	5	0.001, X_2
MSSU culture			
Not significant $<10^4$	219 (40%)	186 (37.0%)	–
No growth	73 (13.3%)	54 (10.7%)	–
Coliforms	145 (26.5%)	80 (15.9%)	–
Mixed growth	23 (4.2%)	74 (14.8%)	–
Enterococcus faecalis	40 (7.3%)	34 (6.8%)	–
Proteus	6 (1.1%)	29 (5.8%)	–
Pseudomonas	11 (2.0%)	16 (3.2%)	–
Escherichia Coli	5 (0.9%)	15 (2.9%)	–
Klebsiella	7 (1.3%)	4 (0.8%)	–
ESBL	8 (1.5%)	2 (0.4%)	–
Enterococcus faecium	2 (0.4%)	4 (0.8%)	–
Enterococci spp.	2 (0.4%)	1 (0.2%)	–
Staphalococcus aureus	2 (0.4%)	2 (0.4%)	–
Candida albicans	2 (0.4%)	0	–
MRSA	0	1 (0.2%)	–
Streptococcus Group A	2 (0.4%)	0	–
Streptococcus Group B	0	1 (0.2%)	–
MSSU origins			
Elective	–	213 (42.3%)	–
Emergency	109 (19.9%)	22 (4.4%)	–
OPD	86 (15.7%)	0	–
GP	352 (64.4%)	268 (53.3%)	–

NS – not statistically significant.

Please cite this article in press as: Koo V, et al., Preliminary assessment of regular short-term intravenous fluids and antibiotic therapy in recurrent UTI, J Infect (2011), doi:10.1016/j.jinf.2011.08.010

regularity of IVT regime, but suggest that it should be adapted to patient's condition. It is hoped that this report will serve as a pilot assessment of its efficacy and proof of concept to allow for future randomised trials.

Funding

None obtained.

Competing interest statement

None declared.

Acknowledgement

The authors would like to thank Mrs Anne Quinn from the Audit Department and Mrs. Monica McCrorry from the Department of Urology in Craigavon Area Hospital, for their assistance in the facilitation of this audit project and the preparation of medical notes.

References

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3. Chapman AL, Dixon S, Andrews D, Lillie PJ, Bazaz R, Patchett JD. Clinical efficacy and cost-effectiveness of outpatient parenteral antibiotic therapy (OPAT): a UK perspective. *J Antimicrob Chemother* 2009;**64**:1316—22.

Vincent Koo*
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Aidan O'Brien
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E-mail address: Personal Information redacted by USI

Accepted 16 August 2011

* Corresponding author. Tel.: Personal Information redacted by USI fax: +44 Personal Information redacted by USI

Please cite this article in press as: Koo V, et al., Preliminary assessment of regular short-term intravenous fluids and antibiotic therapy in recurrent UTI, J Infect (2011), doi:10.1016/j.jinf.2011.08.010

Aimee Crilly

Subject: FW: THANK YOU FROM THE CHIEF EXECUTIVE

From: CAH, Global <[redacted]>
Sent: 18 February 2011 14:16
Subject: THANK YOU FROM THE CHIEF EXECUTIVE

Dear Colleagues

I would to like express my thanks and appreciation to staff throughout Craigavon Area Hospital and the wider Trust for their patience, support and dedication during this last week when our services have been under intense scrutiny by the media.

I have worked in health and social services for nearly 30 years and I am proud to be associated with the Southern Trust and with Craigavon hospital and the people who work here. I have every confidence that we provide an excellent service to our patients and that your professionalism and integrity is appreciated and valued by the vast majority of people who use our services.

I also know how much local people appreciate and depend upon the services we provide and we value their support. During the last few days we have received many messages of support from patients, former staff and the general public.

This is undoubtedly an extremely challenging time for our service but I have every confidence in our ability and commitment to continue to provide a safe, responsive service to everyone who needs our help.

It is my privilege to be the Chief Executive of this organisation and to call Craigavon my local hospital. I am grateful for the support of my colleagues this week and I am disappointed that the coverage has not reflected the excellent work that goes on across the Trust day and daily.

Once again I would urge anyone who has serious concerns about any aspect of the care we provide to please contact myself or any member of the Senior Management Team and be assured that your concerns will be dealt with in the strictest confidence.

Thank you again for your commitment to our service.

Mairead McAlinden
Chief Executive

Aimee Crilly

Subject: FW: URGENT Triaging letters

-----Original Message-----
From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 22 February 2011 12:40
To: (Aidanpobrien Personal Information redacted by the USI <Aidanpobrien Personal Information redacted by the USI ; Personal Information redacted by the USI ; Akhtar, Mehmood <Personal Information redacted by the USI ; O'Brien, Aidan <Personal Information redacted by the USI ; Young, Michael Mr <Personal Information redacted by the USI
Cc: Glenny, Sharon <Personal Information redacted by the USI ; Dignam, Paulette <Personal Information redacted by the USI ; Hanvey, Leanne <Personal Information redacted by the USI ; McCorry, Monica <Personal Information redacted by the USI ; Troughton, Elizabeth <Personal Information redacted by the USI
Subject: URGENT Triaging letters

Dear all

I have been advised that there are 55 outstanding outpatient letters for triage that the booking centre are waiting on in order to book clinics. Can I ask that if you have any outstanding letters can you please action and return to the booking centre. I appreciate how busy you all are at the moment but I would be grateful if you could action this as soon as possible.

Many thanks

Martina

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

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

From:	Tedford, Shirley
To:	Sloan, Samantha Ms; Young, Michael Mr; O"Brien, Aidan; Corrigan, Martina
Cc:	Dignam, Paulette; McCorry, Monica
Subject:	meeting IV fluids/IV antibiotics
Date:	04 March 2011 13:37:56

Dear all,

I can understand and appreciate the commitments each of you have with clinics, theatre schedule meetings etc but can you forward some days and times which you are free to meet within the next two weeks and I will co ordinate the best suitable date and time. Does lunch time suit best or late afternoon around 4.30pm, the meeting should hopefully only last one hour, but we need to meet and discuss these patients as they are anxious re their care.

Shirley

Paulette and Monica can you please ensure the respective consultants are made aware

Shirley Tedford
ward manger
3 south
craigavon area hospital

From: Corrigan, Martina
To: McCorry, Monica; Tedford, Shirley; Sloan, Samantha Ms; Young, Michael Mr; O"Brien, Aidan; Rajendran, Rajesh
Cc: Dignam, Paulette; Mullan, Margaret (Laboratories)
Subject: RE: meeting iv fluids
Date: 08 March 2011 13:43:36

Monica,

As you know the departmental meeting suits me but I do know that Ms Sloan has an all day theatre list on a Thursday so this time would not suit her. I know it is going to be difficult to get everyone together but we do need this meeting and was wondering if an evening meeting i.e. 4:30 would suit better?

Thanks

Martina

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

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

From: McCorry, Monica
Sent: 08 March 2011 08:56
To: Corrigan, Martina; Tedford, Shirley; Sloan, Samantha Ms; Young, Michael Mr; O'Brien, Aidan; Rajendran, Rajesh
Cc: Dignam, Paulette; Mullan, Margaret (Laboratories)
Subject: RE: meeting iv fluids

Shirley

Aidan has asked that I advise you that he may not be able to attend as he may not be able to get back in time from Armagh clinic. Also will Mr Young not be doing a stone clinic? Aidan asks if the meeting might be scheduled as a departmental meeting on a Thursday at 12 noon when Mr Young and he can both definitely attend.

Thanks Monica

From: Corrigan, Martina
Sent: 07 March 2011 19:18
To: Tedford, Shirley; Sloan, Samantha Ms; Young, Michael Mr; O'Brien, Aidan; Rajendran, Rajesh
Cc: Dignam, Paulette; McCorry, Monica; Mullan, Margaret (Laboratories)
Subject: RE: meeting iv fluids

Hi Shirley,

I can make myself available

Thanks

Martina

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

Craigavon Area Hospital

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

From: Tedford, Shirley
Sent: 07 March 2011 11:10
To: Sloan, Samantha Ms; Young, Michael Mr; O'Brien, Aidan; Corrigan, Martina; Rajendran, Rajesh
Cc: Dignam, Paulette; McCorry, Monica; Mullan, Margaret (Laboratories)
Subject: meeting iv fluids

Hi all,

Can we provisionally book Monday 14th March from 1 – 2 for meeting? I will look at venue.

Paulette, Monica and Margaret can you please highlight to respective Consultants

Shirley

Shirley Tedford
ward manger
3 south
craigavon area hospital

Aimee Crilly

From: Montgomery, Angela <[redacted]>
Sent: 08 June 2011 09:55
To: Akhtar, Mehmood; O'Brien, Aidan; Young, Michael; Corrigan, Martina; Porter, Alison; O'Neill, Kate; McMahon, Jenny; Rogers, Philip; Tedford, Shirley; Brown, Robin; Graham, Vicki; Williams, Marc; McClure, Mark; McClean, Gareth; Abogunrin, Funsho; fionnuala.houghton[redacted]
Subject: Notes from Urology MDM AGM 14.04.11
Attachments: Notes Urology AGM 14.04.11.doc

Hi

Attached are notes for the Urology MDM AGM that was held on 14th April 2011. Please let me know if I have missed anyone who was at the meeting.

Thanks

Angela

Angela Montgomery
Cancer Services Co-Ordinator
Tel. No. [redacted]

Notes of Urology Team and Cancer Services meeting held
Thursday 14th April 2011

Present: Mr Akhtar (Chair), A Porter, M Corrigan, Mr O'Brien, Mr Young, K O'Neill, J McMahon, A Montgomery, Dr Rogers, S Tedford, Mr R Brown, V Graham, Dr M Williams, Dr G McClean, Dr F Aborgurnin

Apologies: Dr F Houghton, Dr M McClure

Issues	Action
1) Welcome & Apologies Mr Akhtar welcomed everyone to the Urology MDM	
2) MDT Annual Report a) Workload of MDT/cases discussed & treatment by consultant. It was agreed that the number of cases discussed should be broken down into new patient discussions and patients who are on for re-discussion. The treatments information should be able to be pulled from TMS b) Attendance at NSSG meeting. Gareth McClean and Mr Young currently nominated to go but it was agreed that Gareth and Mr Akhtar should attend. c) Team attendance. It was advised that the figures should be presented as a percentage and that Vicki, Cancer Tracker/MDT Co-ordinator should be advised of any annual leave. Discussion took place regarding extended members and the team felt that stoma nurse not applicable as the team no longer do the surgery.	Breakdown of patient cases discussed. **Action:** V Graham NICaN office to be informed **Action:** A Porter Figure to be presented as percentage **Action:** V Graham Removal of stoma care nurse from extended list. **Action:** A Porter
3) Operational Policy.	

The key areas to be listed on the above were discussed	A draft document to be formalised and circulated by August 2011 **Action:** M Akhtar, A Porter
a) Advanced Communication Training. Nominations to be forwarded to NICaN. It was agreed that Mr O'Brien would be nominated for this training and Mr Brown is currently on the waiting list.	Alison to resend Kate O'Neill and Jenny McMahon names to NICaN. **Action:** A Porter
b) Data Collection. Discussion took place regarding the cancer database, CaPPS. It was advised that all core members should have access to CaPPS.	
Mr Brown was unaware of system and asked could he have Dr Ranaghan's number to contact her regarding training.	Angela Montgomery to forward Dr Lisa Ranaghan's contact details to Mr Brown **Action:** A Montgomery
The team also asked could a training session be arranged with Dr Ranaghan for CaPPS with the possible venue being the IT training suite.	Training session to be set up **Action:** M Akhtar
Mr Akhtar advised that clinical information should be entered by clinical people and this should also be added for patients that they wish to be discussed. Mr Akhtar agreed to write out minimum data. E.g. PSA, DRE, Co-morbidities.	Mr Akhtar to write out minimum data to be entered. **Action:** Mr Akhtar
c) National & local audit It was advised that there is currently no funding or staff for audits.	
d) Audit of timeliness of notification to GP regarding new diagnosis of cancer (i.e. 48 hours). This has currently not completed and is required for all cancer services. Audit to be	**Action:** Cancer Team

designed and performed	
e) Patient & Carer Feedback & Involvement. The MDT is to appoint a patient involvement lead but Mr Akhtar advised that is currently no lead as CNS stretched but the team are working toward that.	Patient Experience Lead to be agreed **Action:** MDT
f) Patient information, Key Worker, Patient permanent record. Discussion took place regarding all these areas. Both CNS to provide information but need proper infrastructure & resource. They currently have no clinic. When all proper infrastructure in place they will have a named key worker. Currently all information is not available in all clinic areas just in Thorndale. Regarding the patient permanent record there are examples of final drafts exist within the other cancer teams and Alison agreed to circulate the drafts for team to look at.	Information leaflets to be made available in all clinic/department areas **Action:** K O'Neill, J McMahon Patient Permanent record examples to be forwarded **Action:** A Porter
g) Research The team nominated Mr O'Brien as Research & Audit Lead	
h) Pathology The pathologists should be taking part in the EQA scheme and have record of this. This is to be confirmed and evidenced by the pathology lead, Dr Gareth McClean	EQA to be confirmed **Action:** Dr McClean
i) Operational policies The team needs to have copies of all agreed NSSG policies and local policies held manually and electronically. Mr Akhtar agreed to look at this	Policies to be collated **Action:** Mr Akhtar

4) Annual Work Plan It was advised that each MDT must agree an annual work plan. Alison Porter talked through the work plan to advise what it is and what it has to contain.	Draft to be formalised and circulated for sign off **Action:** M Akhtar, A Porter
5) Cancer Pathways Discussion took place regarding the potential to reorganise the current pathway processes, no formal agreement	Pathway discussion to take place in future meetings **Action:** All
6) Cancer Target Performance A brief summary of the current performance and risk areas were discussed	Cancer Performance risks to be discussed at MDM. **Action:** V Graham Copies of cancer performance reports to be copied to Mr Akhtar **Action:** A Porter
7) A.O.B Mr Brown advised that he was not aware of the GP meeting and wished to be advised of when this meeting takes place.	Martina Corrigan to advise Pauline Matier to advise Mr Brown of dates. **Action:** Martina Corrigan/Pauline Matier

Aimee Crilly

From: Corrigan, Martina [redacted]
Sent: 27 September 2011 11:33
To: '(Aidanpobrien [redacted]; Akhtar, Mehmood; 'O'Brien, Aidan'; 'Young, Michael'
Subject: Consultant dates for Saturday theatre sessions
Attachments: Consultant dates for Saturday theatre sessions.docx

Dear all,

Please see attached.

I would be grateful if you could indicate your availability for these Saturday's from November until end of March. We have received confirmation of funding for these lists and this will include increasing the beds and staff on the ward. The funding is to bring our waiting times back down to 36 weeks (currently sitting at 62 weeks) so these lists have to be used for the long-waiting patients.

In order to plan the staffing in the ward and in theatre I would be grateful if you can indicate what you will be able to do.

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted] (Direct Dial)
Mobile [redacted]
Email: [redacted]

Date	Name of Consultant
Saturday 5 November	
Saturday 12 November	
Saturday 19 November	
Saturday 26 November	
Saturday 3 December	
Saturday 10 December	
Saturday 7 January	
Saturday 14 January	
Saturday 21 January	
Saturday 28 January	
Saturday 4 February	
Saturday 11 February	
Saturday 18 February	
Saturday 25 February	
Saturday 3 March	
Saturday 10 March	
Saturday 17 March	
Saturday 24 March	
Saturday 31 March	

From: Mackle, Eamon
To: Hall, Sam
Cc: O"Brien, Aidan; aidanpobrie[Personal information] Corrigan, Martina; Rankin, Gillian
Subject: IV Antiobiotics
Date: 30 January 2012 15:08:03

Dear Sam,

I have been advised that a patient [Personal Information redacted by the USI] may have been admitted last week to Urology by Mr O'Brien and under his instruction was given IV Antibiotics the latter necessitating a central line to be inserted.

I have checked with Dr Rajendran and he advises me that no discussion took place prior to the administration of the antibiotics.

I would be grateful if you could formally investigate this and advise me of your findings.

Many thanks

Eamon

Aimee Crilly

:

From: Farrell, Roisin
Sent: 17 November 2011 16:01
To: McAllister, Charlie; O'Brien, Aidan; Tedford, Shirley; Cunningham, Kate
Cc: Mackle, Eamon; Trouton, Heather; Reid, Trudy; Murphy, Philip; Conway, Barry; Murray, Eileen; Rankin, Gillian; Stinson, Emma M
Subject: New complaint for investigation - Personal Information redacted by the USI Personal informatio RESPONSE DUE 1.12.11

Please note response due 1 December 2011

Roisin Farrell
Governance Adminstrator
Acute Services
Office 3, Level 2, MEC
Craigavon Area Hospital
Tel: Personal Information redacted by the USI

Southern Health and Social Care Trust

MEMORANDUM

TO: Mr A O'Brien, Consultant/Urology
Dr C McAllister, Consultant Anaesthetist
Ms S Tedford, Urology Co-ordinator (Leading Care, Regional Ward Manager Project)
Sr K Cunningham, Ward Manager

cc: Mr E Mackle, Associate Medical Director
Mrs H Trouton, Assistant Director Acute Services – Surgery & Elective Care
Mrs T Reid, Head of General Surgery (inc Orthodontics)
Dr P Murphy, Associate Medical Director
Mr B Conway, Acting Assistant Director Acute Services – Medicine & Unscheduled Care
Mrs E Murray, Head of Medicine and Unscheduled Care

FROM: Governance Officer, Directorate of Acute Services

DATE: 17 November 2011

RE: **COMPLAINT –** Personal Information redacted by the USI Personal information redacted by

---

Please find attached a new complaint which has been received by the Trust. The contents of the complaint are self explanatory.

I would be grateful if you would investigate the issues pertaining to your area of responsibility and provide a report of your investigation to me by 1 December 2011. Please ensure that your response is dated, signed and includes your designation along with the name and designation of the staff involved, as these documents are discoverable under the Freedom of Information.

I also enclose a blank action and learning plan which must be used to record actions taken or required following the complaint as well as the lessons learned from same.

Both your investigation report and action plan should be returned to AcutePatient.ClientLiaison@southerntrust.hscni.net in the first instance.

If you have any queries please do not hesitate to contact me. I appreciate your assistance with this matter.

Governance Officer
Directorate of Acute Services

Clinical & Social Care Governance Team
Directorate of Acute Services
Craigavon Area Hospital, 68 Lurgan Road, Portadown, Co Armagh, BT63 5QQ

Telephone: Personal Information redacted by the USI
E-Mail: AcutePatient.ClientLiaison@southerntrust.hscni.net

Action Taken Lessons Learned Proforma

Division				**Ward/Dept/Service Area**				
Complaint Number/Name	Personal information redacted by USI ormation redacted by the USI			**Manager Responsible**				
Risk Rating – please tick	**Very Low**	☐	**Low**	☐	**Moderate**	☐	**High**	☐

Summary of Complaint
Insert Summary of Complaint Here.

Action Taken /Lessons Learned				
Area of Concern	**Desired Outcome**	**Process required to Achieve Outcome**	**Date for Completion**	**Person Responsible**
Insert Area of Concern here.			Date must be provided.	Person details must be provided.

Clinical & Social Care Governance Team
Directorate of Acute Services
Craigavon Area Hospital, 68 Lurgan Road, Portadown, Co Armagh, BT63 5QQ

Telephone: Personal Information redacted by the USI
E-Mail: AcutePatient.ClientLiaison@southerntrust.hscni.net

Does the learning that has been gained from this investigation process merit being shared with other wards/departments or service areas? (tick box)	**No** ☐	**What Wards/Departments or Service Areas have been identified.**	**Date informed and by whom**	
	Yes ☐			

Clinical & Social Care Governance Team
Directorate of Acute Services
Craigavon Area Hospital, 68 Lurgan Road, Portadown, Co Armagh, BT63 5QQ

Telephone: Personal Information redacted by the USI
E-Mail: AcutePatient.ClientLiaison@southerntrust.hscni.net

Any other Comments:

Clinical & Social Care Governance Team
Directorate of Acute Services
Craigavon Area Hospital, 68 Lurgan Road, Portadown, Co Armagh, BT63 5QQ

Telephone: Personal Information redacted by the USI
E-Mail: AcutePatient.ClientLiaison@southerntrust.hscni.net

Southern Health and Social Care Trust

Confidential
1214

FORMAL COMPLAINT RECORD FORM (internal use only)

Notes for Completion:

1. This form should be used in conjunction with the Trust's Policy and Procedure on Complaints.

2. *Please complete all sections of the form as fully as possible. It is imperative to have accurate information in order that an investigation can be carried out.*

Name and Address of Complainant

Personal Information redacted by the USI

On Behalf Of (inc address)

Personal Information redacted by the USI

Patient's Date of Birth:

Complainants Relationship to Patient:

Contact Telephone Number

Complaint Made Against Ward/Department

Summary Details of Complaint

The above lady is my mother and I am sending this e-mail on her behalf.
Please treat the content as a formal complaint, requiring a thorough investigation and detailed response.

My mother had an emergency admission to DHH ON 10/10/11 and had to be transferred to CAH. Following surgery for kidney stones and the fitting of a stent to her urethra she was in ICU from 10/10/11 to 14/10/11, She was then moved to Ward 3 South.

I was advised on the 19/10/11 that my mother was being sent back to DHH for a while before being discharged home. On the 20/10/11, I was however informed she was in fact, being discharged home later that day. Discharge was delayed until 21/10/11 as no ambulance was available to take her home. On arrival home she was generally un-well, had blood in her urine and was not eating and hardly drinking. Why was my mother sent home in this condition ?

On the 29/10/11 I had to contact the Out of Hours Service as my mother was not eating, had stopped drinking and her confusion was getting worse. The Doctor diagnosed a UTI and started her on an antibiotic. She became very un-well over the next few days and had to be admitted to Female Medical DHH, confused and dehydrated.

While in hospital I expressed concern with regard to my mothers confusion and also what appeared to be difficulty swallowing. Nursing staff said they would bring my concerns to the attention of the medical staff which they did.

I was informed that the plan was to discharge my mother on 08/11/11, however when I spoke with my mother she was very confused and informed me she did not know where she was or what was wrong with her and she said she did not feel at all well. I informed the nurse about this and she said she would ask the Doctor to re-assess my mother.

Following this I was informed that my mother had a UTI and was being started on an antibiotic and her discharge would be delayed. On the 10/11/11 my mother was seen by the SHO who is a Personal information redacted by USI believe, and he was adamant she was fit to be discharged which she was on 10/11/11.

On returning home she could not even take a sip off water without assistance, she could not swallow and she was in a very confused state.
She fell within an hour of being home as she got up to go to the toilet. My mother has not been able to stand or walk for several years and requires a hoist for all transfers.

She was very traumatised by the fall and had to be hoisted off the floor and back into bed. I checked her every hour during the night and she was sleeping, I had great difficulty getting her awake at 7.00 am, she was very drowsy. Her BS level was only 4.3 and she was seeing things in her room i.e a cat and she also told one of the carers that Personal Information redacted by {my mothers aunt} was standing in the room smiling at them.
I telephoned the GP and asked for a house call explaining how my mother was and later that morning a decision was taken to have her re-admitted to DHH.

It is my belief that the decision taken by the SHO to discharge my mother was not only inappropriate it was in fact negligent and as a direct result of this decision my mother was hurt, traumatised and is still unwell.

What I now require is a detailed explanation of the assessment carried out by the SHO prior to my mothers discharge which lead him to believe she was well enough when clearly she was not !

I also require your personal re-assurance that the next time my mother is discharged she is in fact medically fit. Please be advised that I will not tolerate my mother being subjected to any further neglect just because she is old. I am anxious to get my mother well again and have no current desire to take further action and/or involve the press with details of my mothers neglect and the medical incompetence she has been exposed to.

Yours sincerely

Personal Information redacted by the USI

Central Reporting Point Officer.....**Date** .....

Passed to for Action: .....

Aimee Crilly

From: Corrigan, Martina < Personal Information redacted by the USI
Sent: 06 February 2012 15:01
To: O'Brien, Aidan; Personal Information redacted by the USI
Cc: Scott, Jane M; ONeill, Kate
Subject: FW: Day4 outcome escalation

Importance: High

Dear Aidan,

Can you advise?

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

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

From: Montgomery, Angela
Sent: 06 February 2012 14:33
To: Corrigan, Martina
Cc: Scott, Jane M; Graham, Vicki
Subject: Day4 outcome escalation
Importance: High

HI Martina

Vicki is unable to find the below 2 patients medical notes following a day 4 appointment with Mr O'Brien and can therefore not get a clear outcome. Can you please speak to Mr O'Brien to see where these charts may be as they are still tracked to Thorndale Unit?

Personal Information redacted by the USI
Day 4 appointment 06.01.12

Personal Information redacted by the USI
Day 4 appointment 06.01.12

Thanks

Angela

Angela Montgomery
Cancer Services Co-Ordinator
Tel. No. Personal Information redacted by the USI

Aimee Crilly

From: Graham, Vicki
Sent: 08 February 2012 13:50
To: Akhtar, Mehmood; Young, Michael; O'Brien, Aidan
Subject: Urology Operation Policy Urology
Importance: High

Following last week's MDM I have enquired about the Operational Policy and at present there is no policy for Urology and that this has to be agreed by the whole team and signed off. I have attached a copy of the Colorectal Operational Policy for you to view but this has be adapted to the Urology Tumour site and perhaps Alison Porter can help you with this.

Regards

Vicki

Vicki Graham
Cancer Tracker/MDT Co-Ordinator
Urology
Direct Line Personal Information redacted by the USI
E-mail Personal Information redacted by the USI

Southern Health and Social Care Trust

DRAFT 4

Operational Policy for the Southern Health & Social Care Trust's Colorectal Cancer Service

Clinical Lead — Mr M Epanomeritakis

Trust Cancer Lead

Date Issued:

Review Date:

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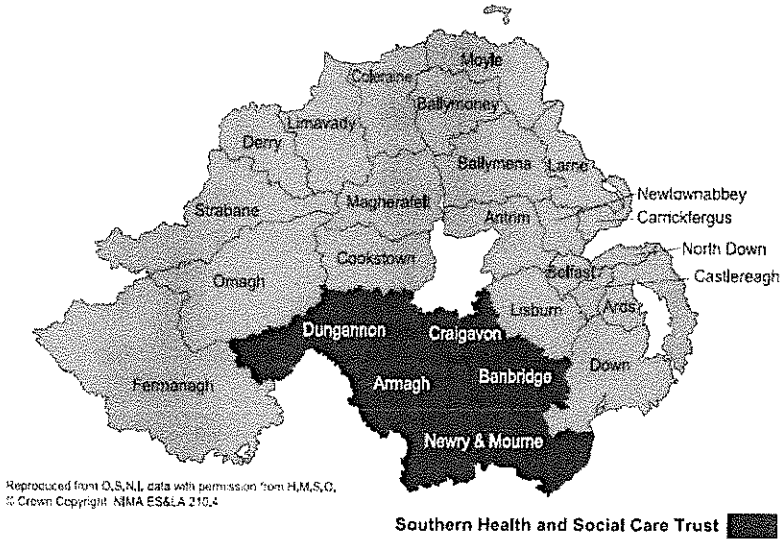
BACKGROUND

The Southern Health and Social Care Trust (SHSCT) was established on 1 April 2007, and replaced the following four Trusts:

- Armagh and Dungannon Health and Social Services Trusts
- Craigavon Area Hospital Group Trust
- Craigavon and Banbridge Community Trust
- Newry and Mourne Health and Social Services Trust

The Trust area covers a range of city, urban and rural communities.

Map of NI showing the Southern Health and Social Care Trust



The Trust provides a wide range of hospital, community and primary care services primarily to the populations of Armagh, Banbridge, Craigavon, Dungannon, Newry & Mourne. People from many other areas in Northern Ireland also use the hospital services provided by the Trust.

The new SHSCT: -

- Employs 12,000 staff
- Covers a population of 324,000
- Ethnic communities include:

- Polish 37%, Lithuanian 26%, Portuguese 23%, Russian 4%, Tatum 5%, Chinese 1%, Slovak 2%, Latvian 1%, Other 1% (based on requests for interpreter).

Acute Hospital Services

There are 664 acute inpatient hospital beds in the 2 main hospital sites:-

- Craigavon Area Hospital 452
- Daisy Hill Hospital 212

SHSCT provides all acute services including emergency care, theatres, day procedures, endoscopy, and inpatient acute care including medical, surgical, gynae, and intensive care services.
Outpatient services are provided in various sites across the Trust, which include, Craigavon, Daisy Hill, Kilkeel, Banbridge, South Tyrone and Armagh.

Following the Campbell Report (1996), Craigavon Area Hospital was designated as the Cancer Unit for the Southern area of the province in 1997. This designation led to the role out of chemotherapy, for colorectal cancers, from the central unit that had previously been based in Belfast. All patients are managed within the Network Site Specific (NSSG) guidelines for colorectal cancers. **N08 – 2D – 230- 235**

The SHSCT colorectal service supports the Southern area colorectal screening programme which commenced in December 2009. Approximately ? new colorectal cancers are diagnosed each year.

Access to SHSCT services

General referrals from GPs to the acute Trust services have been centralised to a single referral and booking centre based at the Craigavon Hospital site.
Suspected colorectal cancer referrals, referred within the Nican referral guidelines, (APP/evidence box) however continue to be referred by two 'red flag' central access referral fax machines (based in Daisy Hill Hospital and Craigavon Hospital). In order to ensure that patients are appointed and move to investigations and treatment as quickly as possible, a designated Cancer Tracking Team has been

established. This incorporates both tracking of suspect and confirmed cancers, and provides administrative support to the multi-disciplinary team meetings

The operation of the service is dependent on successful multi-disciplinary team working with the multi-disciplinary team meeting acting as the core for decision making and management of patients with the emphasises specifically on suspect and confirmed cancer.

Colorectal Referral Pathway (flowchart Appendix ?? – put in NICaN pathway)

On receipt, colorectal referrals from GPs are triaged by the Consultant Surgeons and allocated to the relevant 1st appointment e.g. outpatient clinic, straight to test, and then proceed along the timed colorectal pathway. (APP ?)

Suspect cancers must receive their first appointment within 7-14 days.

Other suspect or proven cancers which have been picked up internally within hospital systems, are directly referred to the Consultant Surgeons for presentation at the Multidisciplinary meeting (MDT).

The Southern Trust colorectal service is provided at the two main acute hospital sites (Craigavon and Daisy Hill). All patients are presented to the Southern Trust's MDT which is hosted at Craigavon with the Daisy Hill team videoconferencing in for the meetings. This includes all groups of cancers within the specialty - colonic, rectal and anal. **N08- 2D - 204**

Outpatients

Colorectal outpatient clinics are provided on the three hospital sites, Craigavon, Daisy Hill and South Tyrone. Assessment for colorectal cancer will follow the NSSG guidance.

Diagnostic Services

Ultrasound and CT imaging is available at the above three sites, with MRI being provided at Craigavon Area Hospital. PET imaging is provided as a Regional Service at the Belfast Trust. Imaging services will adhere to the NSSG guidelines.

Cellular pathology services are available at Craigavon Hospital from the initial cytology, biopsy and surgical pathology, within the NSSG guidelines. All members of the team participate in EQA. **N08 – 2D - 216**

Treatment

All treatment plans follow the Northern Ireland guidelines (APP)

- Surgical intervention is provided at Daisy Hill and Craigavon Hospitals.
- Chemotherapy is provided locally at Craigavon in the Mandeville Unit.
- Radiotherapy is provided as a Regional Service at the Belfast Trust
- Palliative and Supportive Care is provided locally by both Acute and Community Palliative Care Teams

Review and Follow-up

Review programmes are currently being discussed as part of the Nican regional group and once agreed the team will follow the agreed guidance. (APP).

As part of the patients' pathway, patients are presented at the weekly colorectal Multidisciplinary meeting. Consequently the operation of the service is dependent on successful multi-disciplinary team working with the multi-disciplinary team meeting acting as the core for decision-making and management of patients.

All cancer patients should be discussed at the MDT meeting. Effective co-ordination of MDT meetings helps to ensure that all relevant information is available and that decisions are recorded and communicated to all. It also means that waiting times are monitored and further steps in the pathway are planned and co-ordinated. The following describes the purpose and organisation of the Colorectal MDT. This will ensure the patient receives the best care, from the best person or team in the best possible place within recommended timeframes.

Purpose of the MDT

The MDT is a group of people of different health care disciplines, which meets at a given time (whether physically in one place or by videoconferencing), to discuss

given patients and who are each able to contribute to the diagnostic and treatment decisions about the patients.

The full MDT should meet annually to decide on the need for audit and to review audits performed.

N08- 2D – 207, 213

The MDT meeting occurs weekly at 1pm on Thursdays, via videoconference to ensure that both the Daisy Hill and Craigavon team members are present.

The MDT will discuss both screening and symptomatic cases which includes:

- Newly diagnosed cancer patients.
- All post-operative patients.
- All patients with recurrent disease.
- Any other complex cases needing discussion.

The MDT should also arrange to discuss their performance against cancer access targets, discussing reasons for breaches and where possible take action.

The aim of the MDT is to ensure a coordinated approach to diagnosis, treatment and care services for all patients diagnosed with Primary and Secondary colorectal Cancer.

The MDT has the combined function of diagnosis (to rapidly assess and achieve histopathological confirmation of cancer), treatment (discussing the management of all newly diagnosed cancers) and communication (with the appropriate agencies e.g. primary care teams, hospice etc). Furthermore, the MDT is committed to achieving the highest standards of care and patients outcomes by:

- Collection of high quality data
- Analysis of such data in audit cycles
- Involvement in local, national and international research studies
- Incorporation of new research and best practice into patient care
- Providing comprehensive information to patients and their relatives
- Involving patients in assessment and redesign of the services.

The clinician referring a patient to the MDT should be supported by that team in:

- Providing a rapid diagnostic and assessment service and agree treatment plans for all new cancer patients.

- Identifying and managing his/her patients with colorectal cancers (including tertiary referrals), agreeing treatment plans for current cancer patients who face new treatment options, including those patients suitable for referral for clinical trials.

- Being responsible for the provision of information, advice and support for all patients and their carers throughout the course of the illness.

- Providing treatment and follow-up for these patients and ensure that every patient with cancer receives multi-disciplinary management with appropriate oncological input. Referral processes must be confirmed within the pathway framework.

- Providing a rapid referral service for patients who require specialist management

- Collecting data for network-wide audit

- Implementing service improvement – working with the oncology, radiology and pathology departments and Lead Cancer Team to adopt modernisation to benefit the patient journey. The team should identify a service improvement lead.

- Ensuring that protocols/guidelines/standard operating procedures are developed /updated for all aspects of management /diagnosis/treatment of patients with cancer.

- Developing and agreeing an approved list of clinical trials within the colorectal network, which are supported by the nominated lead research member of the

colorectal MDT. The lead will oversee the requirement for remedial action in the event of insufficient recruitment to the local trials.
Due to the new nature of trials in N Ireland, there has not been a regional approach to trials via the NSSG, however the team has participated in a genetics study locally and is discussing the feasibility to commence a second trial.

- Participating and ensuring that the MDTs activities are audited, and the results documented and fedback to Lead Cancer Team where appropriate

- Reviewing of audit outcomes with timed action plans.

Organisation of MDT Meetings

MDT meetings must be organised in a manner that achieves efficient use of the expertise available to make the best clinical decisions in the minimum possible time.
As a result meetings must have a clear protocol for discussion that identifies; -

- Patient identity
- History
- Disease
- Treatment decision.

MDT meetings established for the purpose of clinical decision-making must be held weekly so as to ensure no delay to patient treatment exists (Thursday 1:00 PM at MEC Tutorial Room 1 (CAH) with some staff video conferencing from DHH site.

The Tracker/MDT Co-ordinator will circulate the Pre-Meeting List on the tueday before the MDT and this list can be updated till the day of the MDT.
should be given the names of every patient with a new diagnosis of colorectal cancer by Thursday 10am at the latest (only urgent cases will be excepted after the deadline). Cases to be discussed can be notified by any member of the team (e.g.

pathology, radiology, surgery, and oncology) to the MDT Tracker via telephone / email.

All cases presented are discussed with benign cases being discussed briefly to leave more time for confirmed cancers / recurrences to be be discussed.

N08- 2D – 236, 237

The MDT will work within agreed NICaN minimum data set, which has been based upon nationally agreed data sets. This will be collected electronically in the CaPPs databases.

Presentation of Patients to the MDT Meeting

All patients, where colorectal cancer is strongly suspected on clinical/diagnostic examination, are to be discussed at MDT.

All patients with a new diagnosis of cancer should be documented at the MDT at the earliest opportunity and before surgical intervention. This will have the effect of;

a) alerting all members to the existence of the case
b) facilitating Trackers in monitoring of the patient journey
c) allowing discussion of surgical options if necessary.

However discussion of cases at the MDT should <u>not</u> delay surgery if indicated.

Referral System

Primary Care Referral – Consultants may upgrade/downgrade primary care referrals in accordance with the NICaN referral guidelines. Feedback on the appropriateness and timeliness of suspected cancer referrals will be provided.

Oncology Referral – Full patient details i.e MDT report with management plan, oncology referral proforma, operation notes and diagnostic results will be forwarded to a Consultant Oncologist (or secretary) specialising in colorectal cancer within 24 hours of the MDT.

The MDT report with the management plan will also to be forwarded to the Consultant Oncologists regarding patients discussed but who are not for treatment.

Radiology Referral - any urgent radiology requests from the MDT are to be handed to the Radiology representative at the meeting, or hand delivered to the radiology partial booker. The Tracker is to ensure that the appointment is booked within the target time frame.
If radiology is requested outside of the MDT, the Consultant must discuss with Radiologist to ensure urgent priority for patient and inform the Tracker.

Palliative Care referral – Any referrals to the palliative care team can be made at MDT, or outside of the MDT meeting, however the tracker should be informed of these referrals.

Inter –Trust Referrals (ITT) – All patients who are referred to other Trusts for further investigation or treatment must be transferred by Day 28 on the 62 day pathway. For all patients on both 31 and 62 day pathways, Inter Trust transfer forms and written referrals must be sent within 48 hours of the decision to Inter Trust transfer the patient. The Consultant's secretary may forward the referral information, however it is the Tracker's responsibility to ensure that all of the required correspondence, investigations, and written referral have been sent to and received by the other Trust.

Referrals outside the MDT meeting

Where referrals are of an urgent manner and cannot be delayed until the next MDT meeting, the clinician may contact the relevant member by telephone to arrange the management. This should be communicated to the Tracker, so that this can be formally noted at the next MDT meeting.

Members of the Colorectal Multidisciplinary Team

The MDT and the MDT meeting must have a Chairperson agreed by the MDT for a 3-year term. In the absence of the Chairperson arrangements should be in place to ensure a senior individual responsible for treatment provision fulfils this role.

The MDT membership is identified on two levels: - the core and the extended members. Core members are expected to attend 66% of the MDT meetings.
The MDT membership must be representative of the complete patient pathway and include the core members, which are confirmed by the Chairperson.
The complete MDT Membership must meet at least annually to confirm policy and complete audits.

a) Core MDT Membership N08 – 2D - 201

The core membership (Appendix A) must be seen as such for both the whole MDT and for the purpose of the MDT meeting. The core membership must include: -

Chairperson - a designated member of the MDT will chair the meeting. The current designated Chair is Mr Epanomeritakis, Consultant Surgeon
It is the responsibility of the MDT Chair to ensure:

- the meeting runs to time
- each patient discussed has a clear treatment plan
- the presenting clinician is responsible for carrying out any action points (for example: contacting a patient, arranging further tests etc)
- development of the MDT and its activities

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The Chairperson's responsibilities will include the following: -

- Chairing the MDT Meeting
- Clarifying diagnosis, treatment decisions and patient consultation dates.
- Chairing an annual operational/audit meeting
- Ensuring a pathway and core policies are agreed.
- Adhering to agreed clinical management guidelines (eg. NICaN ACP, BSG).
- Ensuring a high quality integrated service, which meets local, regional and national standards.
- Participate in the regular review of the regional guidelines.
- Organise "Business Meetings" of the MDT and ensure its deliberations are recorded.
- Produce an annual workplan and report with the support of the Cancer Management Team.

- Ensure collection of appropriate cancer minimum dataset, working with the cancer management team.
- Establish an audit programme and review of outcomes.
- Ensuring governance arrangements are in place.

The Chairperson may wish to delegate some of these duties but will remain responsible for their completion.

Deputy Chairperson (In the absence of a nominated deputy arrangements should be in place to ensure that a senior clinician fulfils this role) is Dr. Hannon

Designated Surgeon/Clinician– The team should include a minimum of two designated clinicians with a special interest in colorectal cancer

Designated Specialist Nurse is Mrs. Thompson, who will provide information and support for patients and have the following responsibilities: **N08- 2D – 220, 221, 222**

- contributing to the multidisciplinary discussion and patient assessment/care planning decision of the team at their regular meetings.
- Providing expert nursing advice and support to other health professionals in the nurse's specialist area of practice.
- Involvement in clinical audit.
- Leading on patient communication issues and co-ordination of the patient pathway for patients referred to the team – acting as the keyworker or responsible for nominating the key worker for the patient's dealings with the team.
- Leading on the patient and user involvement in the service.
- Contributing to the management of the service
- Utilising research in the nurse's specialist area of practice.
- Completion of specialist study to maintain expertise

Designated Radiologist who will ensure compliance with the NSSG imaging guidelines.

Designated Histopathologist who will ensure compliance with the diagnostic and assessment within the NSSG pathology guidelines.

Designated Oncologist who will ensure compliance with the NSSG oncology management guidelines. A medical and clinical oncologist from the Cancer Centre currently support the colorectal MDT. They provide an outreach service to the Craigavon site and attend the MDT meetings. Medical oncologists have been trained to a level that they can make decisions where radiotherapy is indicated.

Palliative Care Representative – in attendance/or an agreed referral mechanism to provide ongoing support and symptom management.

Tracker/MDT Co-ordinator. The role of the Tracker/MDT Co-ordinator will be to liase with clinicians, secretaries, histopathologists and wider team to prepare for and support the weekly MDT meeting and will be responsible to:

- Take notes (as agreed with the individual clinician) on the proforma. At the end of discussion the Tracker/MDT Co-ordinator will ensure that the proforma has been signed-off as being a correct record of the meetings discussion.

- To file in the notes and give a copy to the oncology department for those patients who need to be referred to the oncologists. Either a summary sheet or the proforma will be completed by the Tracker/MDT Co-ordinator and will be posted to the referring General Practitioner within 24 hours of the MDT discussiontaking place. This will ensure timely communication with primary care. The Tracker/MDT Co-ordinator will hold a copy of the proforma and summary sheet on file.

- To record the MDT attendance for every meeting.

- To add any patient on the MDT list not discussed (notes, films or results missing, lack of time), to the following week's list.

- To prospectively track all patients with cancer or suspected cancer in achieving the regional cancer access targets

- To be responsible for ensuring all patients with cancer or suspected cancer have pre booked appointments and treatment in line with cancer access targets, and to raise delays with the MDT.

- To maintain timely and accurate data collection, within the databases.

Core members should identify their designated deputy to attend in their absence. Attendance at the core MDT meetings must be sufficient to make a clinical decision. Recognised deputies may attend instead of core members and between core members and their deputy attendance should be at least 2/3 of the number of meetings. **N08 – 2D – 208, 209**
In the absence of NICaN investigation and treatment management guidelines MDT's will operate within nationally agreed guidance frameworks.

The MDT must reach agreement on the membership whose attendance is essential to make a clinical decision.

In the absence of core members, management plans should be agreed and communicated to the absent member by the Chairperson or his nominee

Operational Policy for the Key Worker N08 – 2D - 215

For the purpose of this policy the Key Worker will be defined as the person who, with the patient's consent and agreement, takes a key role in co-ordinating the patients care and promoting continuity, ensuring the patient knows who to access for information and advice.

Main responsibilities of the Key Worker

With the agreement of the patient, the Key Worker will:
- Act as the main contact person for the patient and carer at a specific point in the pathway.

- Offer support, advice and provide information for patients and their carers, accessing services as required.
- Ensure continuity of care along the patient's pathway and that all relevant plans are communicated to all members of the MDT involved in that patient's care.
- Ensure that the patient and carer have their contact details, that these contact details are documented and available to all professionals involved in that patients care.
- Ensure that the next Key Worker has the appropriate information about the patient to fulfil the role.
- Support the patient in identifying their needs, review these as required and co-ordinate care accordingly.
- Liase and facilitate communication between the patient, carer and appropriate health professionals and vice versa.
- Assist to empower patients as appropriate.

Identification of the Key Worker

The identification of the Key Worker will be the responsibility of the designated MDT Core Nurse member.

The Key Worker can be any member of the MDT agreed with the patient and must be documented by the MDT. The name of the agreed Key Worker will be clearly documented within the patients care notes. It is important to ensure that the patient and carer understand the role of the Key Worker as early as possible in the patient's pathway of care.

It is recognised that the Key Worker, for a significant part of the pathway, will be the Specialist nurse, however it will change over time as the patient's needs change during their journey. Any changes will be negotiated with the patient and carer prior to implementation, and a clear handover provided to the next Key Worker. (APP)

b) Extended membership

Extended members have been identified, however due to limited resources, most are unable to attend the MDT, however their roles have been defined by the chairperson and are referred to as required.

These members include:
- Clinical psychologist (Mrs. Mary Daly) and counsellor (Mrs. Mavis Duggan) are available to the team, but do not attend the MDT meetings
- A Physiotherapist is available to the team
- Social work services are available at all parts of the patient pathway.

Relationship with NICaN Tumour Group (NSSG) N08 – 2D – 206, 217, 218, 219
The colorectal MDT operates as part of the wider regional colorectal group with the core members ??? represented on behalf of the Trust. Consequently the MDT

- will provide representation to all the NSSG meetings.
- will engage with the NSSG to develop and implement network-wide clinical, referral, imaging and pathology guidelines. These will include guidelines on the management of surgical emergencies, tertiary referrals, and colorectal stenting. Network Guidelines still under discussion
- agrees to collect the NSSG agreed minimum dataset
- will participate in an annual Network audit project and will present the results for discussion at one of the NSSG meetings. **N08- 2D – 238, 239**
- will engage with the NSSG to develop and agree an approved list of clinical trials. The team will provide feedback to the NSSG regarding recruitment and trial activity. **N08 – 2D – 240, 241**

Communication with the GP N08 – 2D - 214
The GP should receive written information within 48 hours following discussions with the patient regarding their diagnosis, investigation and treatment plan. This is in addition to the information that is forwarded from the MDT meetings.

Patient Information N08 – 2D – 225, 228
Members of the MDT follow guidelines issued by NICaN Patient Information Pathways. (EVIdence box) Relevant members of the MDT (usually the

Consultant) will offer the patient a permanent record of the consultation at which treatment options for their condition is discussed. see appendix This is an area under development for the service.

Written information is available for patients and is usually offered by their key worker, but can be given by any member of the MDT. Some information is available on-line on the Network website. This is an area under development within the team.

Patient Feedback N08 – 2D – 226, 227

Patient experience and quality of service are of great importance to the service; consequently feedback from service users will be obtained on a regular basis regarding their experience and also to assist in service improvement. This may be from patient surveys, focus groups, complaints and compliments or participation in the Patient and public involvement processes within the Trust and regional groups. Such feedback will be discussed in the Operational Meetings. This is an area that the team plans to formalise in the incoming months.

Audit & Service Improvement

The MDT should appoint an audit / service improvement lead who will be responsible for the co-ordination of at least one audit annually and support the service improvement within the team and service. The lead will be responsible to ensure that the team participate in the network agreed audit programme, and will present audit results to the local MDT and NSSG.

This should include the provision of education and learning for the team and wider service providers and also to support the primary care partnership.

Cancer Access Patient Pathway Database (CaPPs)

All suspect and confirmed cancer patients are recorded on a regional web based database system, CaPPs. This system has recently replaced the Cancer Registry system that has been previously been in use.

Each patient is tracked, using the CaPPs system through his or her pathway from receipt of referral to 1st definitive treatment. This tracking database leads onto tumour specific MDM modules which support the MDM meetings and once fully resourced will include the patient outcome and survival data. This is a permanent patient record of each MDM discussion. The management plan is recorded and distributed to GPs within 48 hours. Appendix ????

There is a decision support tool (business objects) module to generate reports from the Tracking module. The MDM business objects modules are under development.

General Housekeeping

Annual Leave for any member of the MDT should be provided to the MDT co-ordinator six weeks in advance of the meeting. Cover should be arranged if possible, otherwise cases to be discussed will be removed from the list and forwarded to the next appropriate meeting for discussion.

Any meetings which need to be cancelled e.g due to bank holidays, sickness, courses must be highlighted to the Tracker/MDT Co-ordinator who will ensure all members of the MDT are aware of the cancellation.

This operational policy will be reviewed on an annual basis, or more frequently if required, in response to changes in regional and national guidelines and to feedback from patients and service users. All members of the MDT are expected to adhere to the contents of the operational policy and are valued for the role that each individual plays within the wider team and service.

Job plans will be required for all core members to illustrate 50% of working week to colorectal service. Will be in evidence box

Appendix 1

GUIDELINES FOR THE INVESTIGATION AND TREATMENT OF COLORECTAL PATIENTS

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APPENDIX A **N08- 2D – 202, 208, 244**

CORE MEMBERSHIP (**core members and cover to be clarified when data re procedures is available)**

CORE MEMBERSHIP	REMIT	DESIGNATED DEPUTY
Mr Epanomeritakis	Clinical lead, MDT Chair Service Improvement and Trials Lead. Consultant surgeon (CAH)	Mr E Mackle/ Mr Hewitt
Mr Hannon	Designated Surgeon – (DHH) Deputy chair	Mr Cranley
Mr Brown	Designated Surgeon (DHH)	
Mr Blake	Designated Surgeon (DHH)	
Mr Gilpin	Designated Surgeon (DHH)	
Dr C O'Brien	Designated Physician (DHH)	
Mr Mackle	Designated Surgeon (CAH)	Mr Epanomeritakis/ Mr Hewitt
Mr Hewitt	Designated Surgeon (CAH)	
Mr B Cranley	Designated Surgeon (DHH)	Mr Blake
Dr Gibbons	Designated Physician (CAH) Endoscopy lead (gastroenterologist)	
Mrs M J Thompson	Colorectal Nurse Specialist Patient information and User lead	Ms B Trainor
Ms B Trainor	Colorectal Nurse Specialist Patient information and User lead	Mrs M J Thompson
Dr P Rice	Designated Radiologist (CAH)	
Dr J Houghton	Designated Pathologist (CAH)	
Dr R Harte	Designated Clinical Oncologist (Colonic & rectal)	Dr R Park

Dr R Park	Designated Oncologist	Dr R Harte
Ms C Nelson	Palliative Care Nurse Specialist	Palliative Care Nurse Specialist
Ms Hilda Kerr	Tracker/ MDT Co-ordinator	Ms W Kelly

EXTENDED MEMBERS N08 – 2D - 224

To be completed

Remit	**Name**	
Liver /pancreatic surgeon		
Thoracic surgeon with lung metastatic expertise		
Interventionalist radiologist		
Dietician		
Clinical geneticist/counsellor		
pyschologist		
Palliative care		
gynaecologist		
Plastic surgeon		

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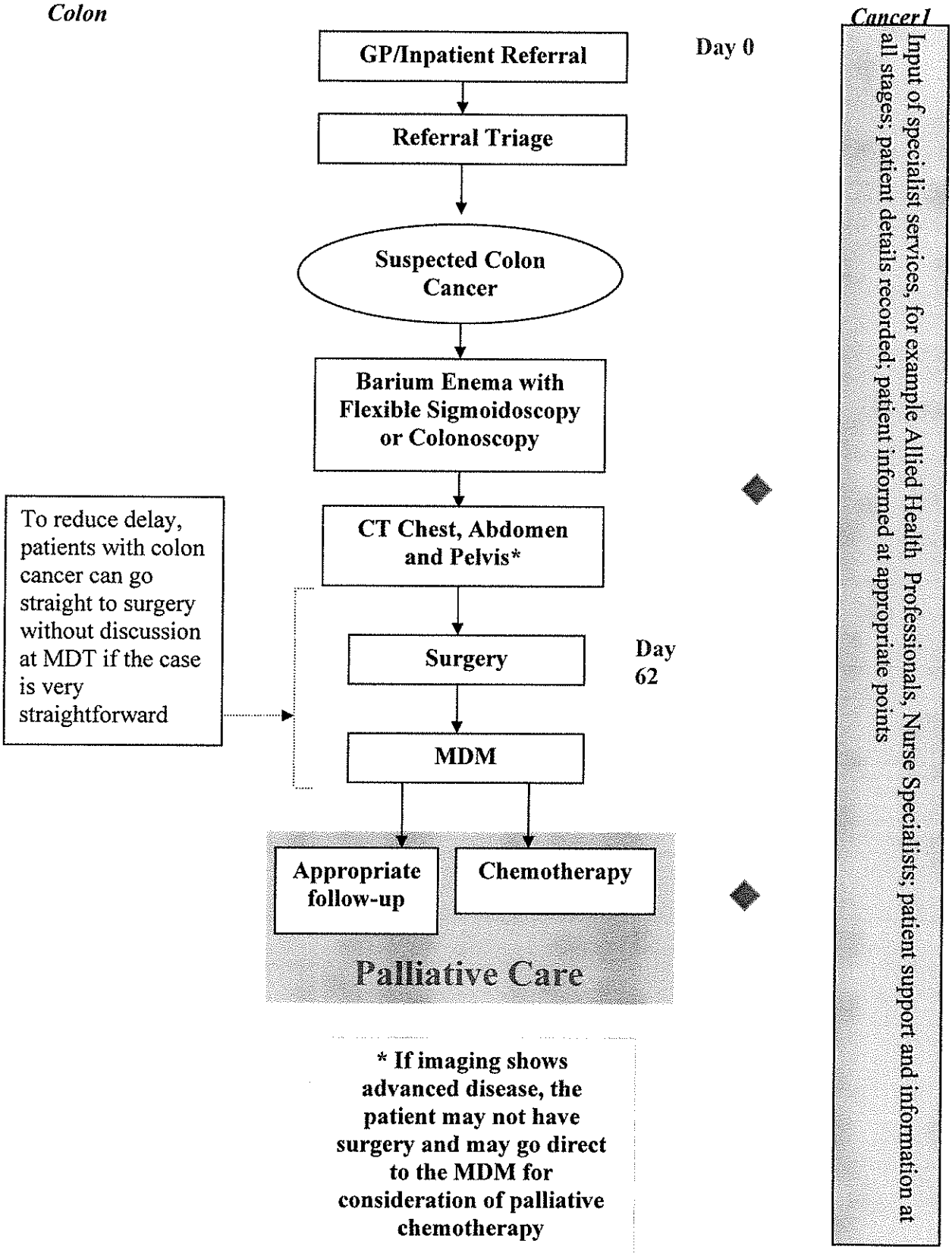
Rectal Surgeons	**Deputy cross cover is provided at CAH, with DHH patients being transferred to CAH when Mr Cranley on leave**
Mr Epanomeritakis	
Mr Mackle	
Mr Cranley	
Mr Hewitt	

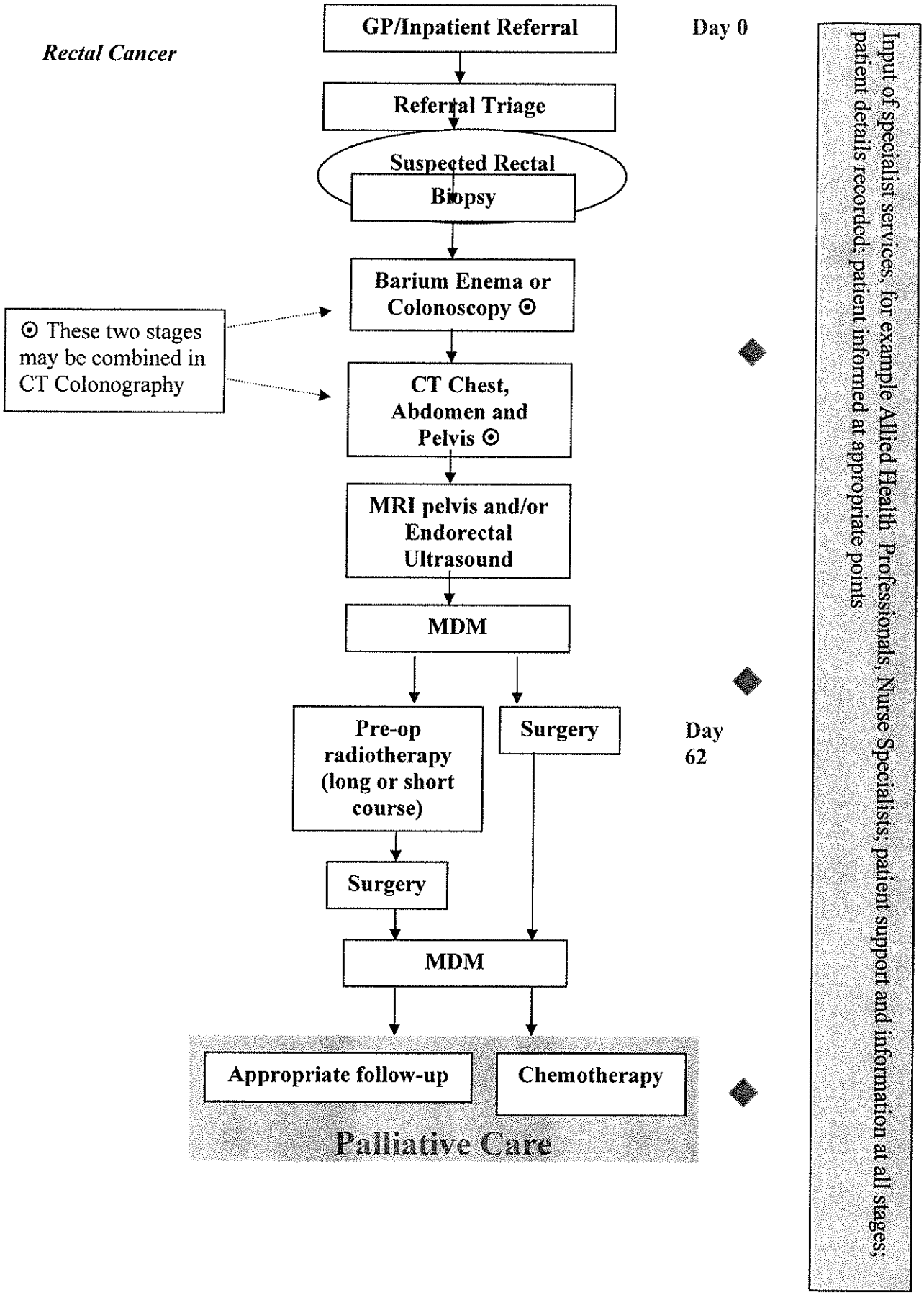
APPENDIX B

Southern Health & Social Care Colorectal Services

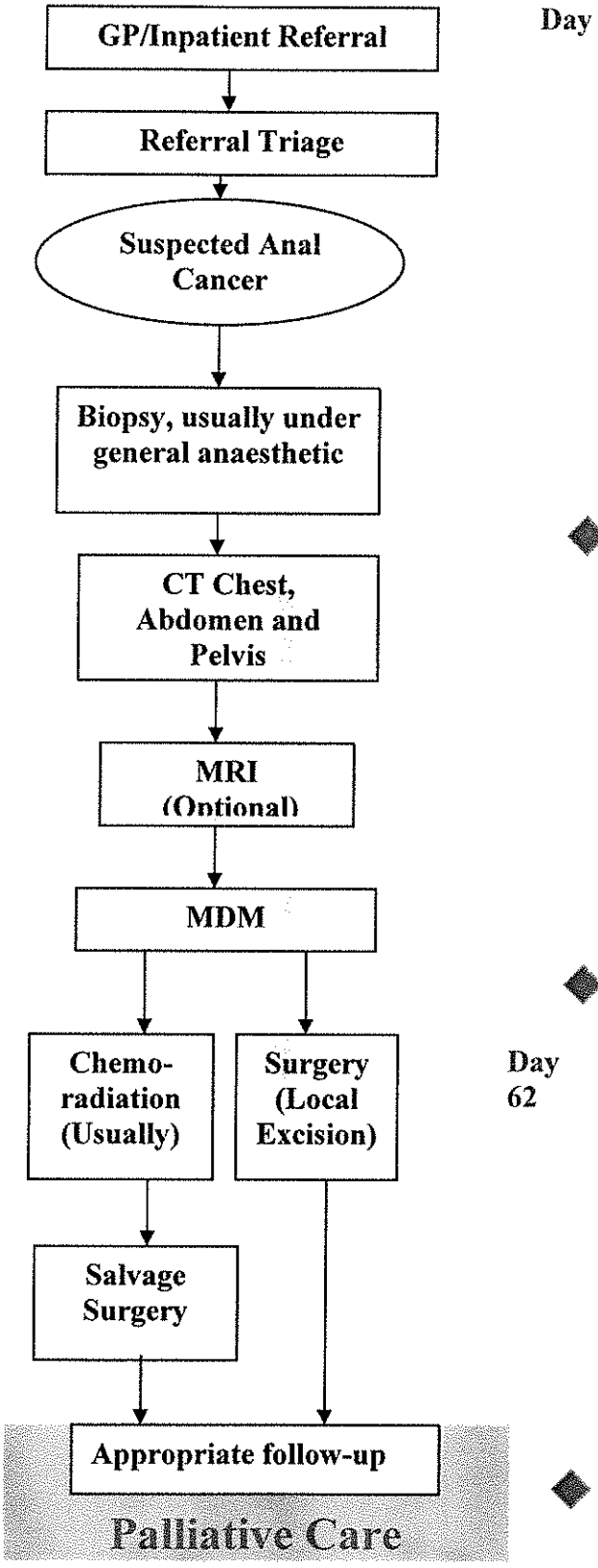
Hospital	*Outpatients*	*Endoscopy*	*Radiology*	*Surgery*
Craigavon	*x*	*x*	*x*	*x*
South Tyrone	*x*	*x*	*x*	
Daisy Hill	*x*	*x*	*x*	*x*

NICaN Colorectal Cancer Patient Pathways



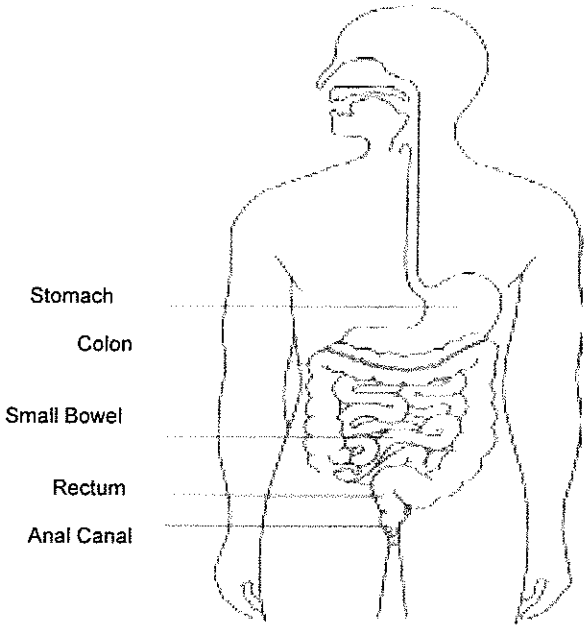


Anal Cancer



Colorectal Consultation Discussion Record

Patient Name:	Date:
Specialist Name:	



Diagnosis:	
Future Investigations:	
Proposed Treatment:	
If you or your carer have any queries or concerns about your diagnosis, treatment or condition please contact your Key Worker:	
Name of Consultant:	**Tel:**
Role:	

Specialist Signature: _____

management plan example to be inserted here N08 – 2D - 229

Key worker flow chart to be inserted here N08- 2D - 215

Aimee Crilly

From: O'Brien, Aidan <[redacted]
Sent: 09 February 2012 22:49
To: Troughton, Elizabeth
Subject: RE: 03/03/2012

Elizabeth,

I have arranged the following admissions:

[redacted] [redacted] years 3ESU
TCI Friday 02/03/12 at 2 pm for TURP on 03/03/12

[redacted] [redacted] years 3North
TCI Saturday 03/03/12 at 8 am, fasting from midnight, for bilateral orchiopexy Saturday morning
(please arrange to do first on list at 9 am)

[redacted] [redacted] years 3ESU
TCI Saturday 03/03/12 at 8 am, fasting from midnight, for TURP Saturday morning.

[redacted] [redacted] years 3ESU
TCI Saturday 03/03/12 at 8 am, fasting from midnight, for TURP Saturday morning

[redacted] [redacted] years 3ESU
TCI Saturday 03/03/12 at 8 am, fasting from midnight, for Hydrostatic Dilatation of Bladder Saturday afternoon

[redacted] [redacted] years 3ESU
TCI Saturday 03/03/12 at 10 am, fasting from 8 am, for TURP Saturday afternoon

[redacted] [redacted] years 3ESU
TCI Saturday 03/03/12 at 10 am, fasting from 8 am, for Endoscopic Bladder Lithotripsy Saturday afternoon
(please place last on operating list, due to previous MRSA).

All of above patients have agreed to their admissions Friday 02/03/12 and Saturday 03/03/12.
All you have to do is to send out letters of notification today.
Please remember to cancel preadmissions of others whom you had preadmitted but who are not on above list as they are unable to be admitted for various reasons.

Lastly, having spent considerable time arranging above admissions which are certain, I want to take this opportunity to clarify for you (and Leanne acting for KJ) is that I will not accept any other surgeons taking patients off my list weeks in advance to preadmit etc. It only places entirely unnecessary pressure on me to do things out of order. I had other plans for my time yesterday evening. So, I will select all patients of mine for surgery by Mehmood and KJ during March. I will not compromise on that, and I will do it in my own good time,

Aidan.

From: Troughton, Elizabeth
Sent: 09 February 2012 15:14
To: O'Brien, Aidan
Subject: 03/03/2012

Hello Mr O'Brien,

Please find attached list of patient planned TCI for 3rd March 2012.

Regards
Liz

Aimee Crilly

From: Farrell, Roisin <Personal Information redacted by the USI>
Sent: 29 February 2012 15:22
To: O'Brien, Aidan
Cc: McCorry, Monica; Corrigan, Martina; Trouton, Heather; Wright, Elaine; Stinson, Emma M
Subject: Trust Response - Personal Information redacted by the USI AS276.11/12
Attachments: Personal Information redacted by the USI AS276.pdf

For your information

Roisin Farrell
Governance Adminstrator
Acute Services
Office 3, Level 2, MEC
Craigavon Area Hospital
Tel: Personal Information redacted by the USI

Southern Health and Social Care Trust

25 February 2012 **Our Ref:** AS276.11/12 **Your Ref:**

Private & Confidential

Personal Information redacted by the USI

Personal Information redacted by the USI

Dear

I refer to your complaint in respect of the quality of care given and lack of communication with the family of Mr Personal Information redacted by the USI Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them.

At the outset I am delighted to learn of your positive experiences of the Haematology Department of Craigavon Area Hospital and I have taken the opportunity to share these with the staff who provided your father's care.

In relation to your complaint about the Urology Department, as part of our investigation, I have spoken directly to Mr O'Brien, Consultant Urologist who I understand has contacted your father by telephone to discuss the issues raised in your letter. Mr O'Brien has agreed with your father that at this stage, he did not need a procedure and he gave him advice on the management of his catheter. I also believe he has agreed that the next stage of treatment would be that your father would come to the Lower Urinary Tract Clinic (LUTS) in the Thorndale unit on 5 March to discuss further and agree how best to manage the catheter and to answer any other concerns with a view to decide the best way forward for your father.

I appreciate there is a recognised gap between the hospital and the community regarding catheters and the Trust is in the process of addressing this by appointing additional continence nurses in community services.

On behalf of the Trust I would like to apologise to your father for the delay in his treatment and the breakdown in communication. I do hope that by Mr O'Brien having contacted him directly and arranging a follow-up appointment that this has gone some way to addressing his concerns.

I trust that this letter addresses the issues you have raised and I wish your father well for his forthcoming consultation.

If however you remain unhappy please do not hesitate to contact a member of the Clinical and Social Care Governance Team on Personal Information redacted by the USI who will discuss the options available to you.

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

Telephone: Personal Information redacted by the USI

Yours sincerely

Personal Information redacted by the USI

DR GILLIAN RANKIN
Director of Acute Services

for Mairead McAlinden, Chief Executive

Aimee Crilly

Subject: FW: AGM Urology action plan from meeting 1st March 2012
Attachments: AGM Urology action plan from meeting 1st March 2012.docx

-----Original Message-----
From: McKnight, Lesley Jane <Personal Information redacted by the USI>
Sent: 21 March 2012 11:20
To: Akhtar, Mehmood <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>
Cc: Porter, Alison <Personal Information redacted by the USI>
Subject: AGM Urology action plan from meeting 1st March 2012

Please find attached notes and action plan following the meeting on 1st March 2012 for your approval.

I would be grateful if you would let me know any comments/amendments required if possible by the middle of next week.

Thanks

Lesley

Lesley McKnight
Clerical Support for Annie Treanor
Cancer Review and Modernisation

Notes and Actions from AGM Urology 1st March 2012

Present- G McLean, V Graham, M Akhtar, A O'Brien, K O'Neill, R Brown, H Trouton, A Porter, S Reid, A Montgomery, M McClure, M Young, R Hall, P Rodgers

Date	Item no	Issue	Action	Timeframe	Person Responsible	Date completed
01/03/12	**1 Election of chair**	Majority of core members in attendance with exception of the oncologist				
01/03/12	**2 Minutes of MDM**	M McClure does not feel we need to give a reason for absence- can record as sick/planned study leave.	All members to advise Vicki regarding leave plan			
01/03/12	**3 Oncology**	To be raised as on on-going risk area and not acceptable on as on-going basis. M Young attended regional urology meeting and raised the lack of oncologist at that meeting. Discussion took place around the proposed Acute oncologist post.				
01/03/12	**4**	Mr O'Brien- Delays in dictating letters so that Vicki can get outcomes. Mr Akhtar suggests would be better if had one clinic set up for MDT results patients, then dictated and typed immediately.				

01/03/12	5 Prostate one stop	Going well, who is going to take on this service?	KJ to fill in as an interim. P Rodgers is currently training to do this. M McClure continues Tuesdays. M Williams keen to train and would provide cover for all Tuesdays			
01/03/12	6 Haematuria clinic	Going well, regional group has commence work already	Arrange for companies to come and present systems			
01/03/12	7 NSSG Group	Attendance at the NSSG group discussed, it was agreed that the MDT chair attends	MDT chair to attend			
01/03/12	8 Advanced Comms training	Aidan and Mehmood attended	Nominated Philip, Mr Young, Kate and Michael- to be forwarded		Alison Porter	
01/03/12	9 Proctis Study	Ongoing- next chair to take PI role (Mr O'Brien to take this on as has already completed CGP training)	Mr O'Brien to be briefed on Proctis Study		R Hall	
01/03/12	10 Nomination of chair	Mr O'Brien interested, nominated by Mr Young, seconded by M McClure, appointed Mr O'Brien	To be formalized, chair from today (Vicki to arrange signature for letters)			
01/03/12	AOB	Consultants/clinicians to complete data sets for the MDT training for CaPPS	Organise a day for training (one to one timely session with Vicki)		Vicki and consultants	
01/03/12	AOB	Surgical referral information required for regional referral to be clarified	To be requested from Belfast		Alison Porter	

Aimee Crilly

Subject: FW: Image Problems - Urology Equipment

-----Original Message-----
From: Hawkins, Colin <
Sent: 28 March 2012 16:14
To: Mulholland, Pamela <
Cc: Gracey, Helen <; Young, Michael <; Wright, Helen <; Argue, Rosie <; Stothers, Wendy <; Harte, Patrick <; McCusker, Brendan <; Mullen, Adrian <; O'Brien, Aidan <
Subject: Image Problems - Urology Equipment

Hello Pamela,

I'm sure you are aware we are experiencing recurrent problems with image quality on the Storz Endoscopic systems during urology cases. I and others have found the stack system to be fully functional on several occasions when it was reported faulty.

However recently I discovered that both the light guide and rigid cystoscope from separate sets being used by the surgeon were damaged.

I and others feel it is important to check the integrity of both the light guides and rigid cystoscope before and after surgery as advised by the Storz representative Eugene.

This is a quick and simple check taking only a few seconds. It involves holding the distal end of either the light guide or rigid cystoscope up to the overhead light and checking that white light appears at the proximal end of the light connection. If an area of darkness greater than 20 percent appears at the light connection on either the cystoscope or light guide then they should be marked for repair.

I have demonstrated this to staff in Theatre 4.

This is also the first test that should be performed in response to queries over image quality on the Storz endoscopy systems.

It would be beneficial for this information to be passed on to other relevant staff.

Regards

Colin Hawkins

Critical Care Technician
Intensive Care Unit
Craigavon Area Hospital
Southern Trust
68 Lurgan Road, Portadown
Northern Ireland
BT63 5QQ

Tel:
Mo

Aimee Crilly

Subject: FW: Urology escalations- Patient 55

Importance: High

-----Original Message-----
From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 20 April 2012 11:13
To: O'Brien, Aidan <Personal Information redacted by the USI>
Cc: McCorry, Monica <Personal Information redacted by the USI>; Montgomery, Angela <Personal Information redacted by the USI>; Porter, Alison <Personal Information redacted by the USI>; Graham, Vicki <Personal Information redacted by the USI>
Subject: FW: Urology escalations- Patient 55
Importance: High

Dear Mr O'Brien,

Can we discuss some more protective slots for you on your main clinic?

Also can we get this patient seen any sooner?

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

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

From: Montgomery, Angela
Sent: 17 April 2012 11:37
To: Corrigan, Martina
Cc: Scott, Jane M; Glenny, Sharon; Clayton, Wendy; Graham, Vicki; Porter, Alison
Subject: FW: Urology escalations- Patient 55
Importance: High

Martina

Please see below patient who is having to wait 3 weeks for a day 4 appointment with Mr O'Brien. The appointment has been appointed for 04/05/12 can this please be brought forward?

Patient 55
Date of referral:05.01.12
Date of 1st OPD:11.01.12- Day 2
Date of diagnostic-25.01.12- Patient's choice- adjustment added.
Date of MDM discussions:02.02.12, 15.03.12 & 12.04.12- Day 4 is required.
Currently on day:17
Target date:01.06.12

Mr Akhtar used to be able to see these patients the Monday after MDM but following his leaving we are concerned that patients are going to be delayed can you please advise if protected slots have been set up for Mr O'Brien for these patients following MDM?

Thanks

Angela

Angela Montgomery
Cancer Services Co-Ordinator
Tel. No. Personal Information redacted by the USI

Aimee Crilly

Subject: FW: Urology Escalations

Importance: High

-----Original Message-----
From: Corrigan, Martina <[redacted]>
Sent: 24 April 2012 14:21
To: Young, Michael <[redacted]>; O'Brien, Aidan <[redacted]>;
Ho, Kuo Jong <[redacted]>
Cc: Brown, Robin <[redacted]>
Subject: FW: Urology Escalations
Importance: High

Dear all,

Please see below.

Can you advise if there is anywhere that these patients can be seen sooner?

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

From: Montgomery, Angela
Sent: 24 April 2012 10:13
To: Corrigan, Martina
Cc: McVeigh, Shauna; Graham, Vicki; Clayton, Wendy; Scott, Jane M
Subject: FW: Urology Escalations
Importance: High

Martina

Please see below. Can you please advise where we can book these patients?

Many thanks

Angela

Angela Montgomery
Cancer Services Co-Ordinator
Tel. No. [redacted]
From: McVeigh, Shauna
Sent: 24 April 2012 09:33
To: Montgomery, Angela
Subject: Urology Escalations
Importance: High

Hi Angela

I have 2 RF Urology referrals that I can't get booked. They have both been triaged for Andrology clinic or consultant clinic.

However there is no capacity.

Personal Information redacted by the USI referral date 13.4.12 target date was 23.4.12

Personal Information redacted by the USI referral date 19.4.12 target date 29.4.12

Date of next clinic for Con is 4.5.12 & 11.5.12 there is no Andrology slots all clinics are suspended. Unless the clinic code for this has changed?

Could you advise.

Thanks

Shauna

Aimee Crilly

From: Graham, Vicki [Personal Information redacted by the USI]
Sent: 08 June 2012 12:57
To: O'Brien, Aidan
Subject: FW: Urology Business Meeting- June 2012
Attachments: UROLOGY SPECIALIST MDT OPERATIONAL POLICY VERSION 1 (dmm edit).docx

Importance: High

Please see e-mail from Dr Mitchell.

Regards

Vicki

Vicki Graham
Cancer Tracker/MDT Co-Ordinator
Urology
Direct Line [Personal Information redacted by the USI]
E-mail [Personal Information redacted by the USI]

-----Original Message-----
From: Mitchell, Darren [mailto: [Personal Information redacted by the USI]
Sent: 08 June 2012 12:44
To: Williamson, Sarah; O'Kelly, Barry; Alexander, JulieA; Burgess, Elizabeth; Cantley, Hazel; Clayton, Alison; Corcoran, Bernie; Cunningham, Wendy; Eakin, Ruth; Gray, Moyra; Grey, Arthur; Hagan, Chris; Harney, Jacqui; Harvey, Barbara; Hennell, Claire; hetherington, Stacey; houghton, fionnuala; Hynds, Sharon; John McKnight; Johnston, Karen; Johnston, Margaret; Keane, Patrick; Kelly, Jenny; Lowry, Lynne; McAleese, Jonathan; McEvoy, Teresa; McLaughlin, Michelle; McPhee, Wendy; Milligan, Gail; Mills, Karen; Morgan, Sharon; Morrow, Michelle; Mort, Paula; Mr Best; Napier, Hazel; Norwood, Gillian; O'kane, Hugh; O'Malley, Sharon; ORourke, Declan; O'Sullivan, Joe; Parkinson, Melanie; Peter Ball; Rajan, Nambi; Shum, Lin; Hamilton, Stephen; Vallely, Stephen; Venney, Cara; Graham, Vicki; Walker, Jennifer; Warren, Pamela; Wilson, Brian; Wlosinski, Marie
Cc: McCann, Bronagh; McClenaghan, Karen
Subject: RE: Urology Business Meeting- June 2012

My amendments and comments enc.

DMM

From: Williamson, Sarah
Sent: 06 June 2012 17:58
To: O'Kelly, Barry; Alexander, JulieA; Burgess, Elizabeth; Cantley, Hazel; Clayton, Alison; Corcoran, Bernie; Cunningham, Wendy; Eakin, Ruth; Gray, Moyra; Grey, Arthur; Hagan, Chris; Harney, Jacqui; Harvey, Barbara; Hennell, Claire; hetherington, Stacey; houghton, fionnuala; Hynds, Sharon; John McKnight; Johnston, Karen; Johnston, Margaret; Keane, Patrick; Kelly, Jenny; Lowry, Lynne; McAleese, Jonathan; McEvoy, Teresa; McLaughlin, Michelle; McPhee, Wendy; Milligan, Gail; Mills, Karen; Mitchell, Darren; Morgan, Sharon; Morrow, Michelle; Mort, Paula; Mr Best; Napier, Hazel; Norwood, Gillian; O'kane, Hugh; O'Malley, Sharon; ORourke, Declan; O'Sullivan, Joe; Parkinson, Melanie; Peter Ball; Rajan, Nambi; Shum, Lin; Stephen Hamilton; Vallely, Stephen; Venney, Cara; Vicki Graham; Walker, Jennifer; Warren, Pamela; Wilson, Brian; Wlosinski, Marie

Cc: McCann, Bronagh; McClenaghan, Karen
Subject: RE: Urology Business Meeting- June 2012

Dear all,

See attached the final draft of the Urology operational policy for sign off at tomorrow's annual business meeting - 3pm-5pm in the Boardroom, BCH.

I would appreciate if you could bring your own copy if possible.

Kind regards,

Sarah

From: O'Kelly, Barry
Sent: 06 June 2012 17:46
To: Alexander, JulieA; Burgess, Elizabeth; Cantley, Hazel; Clayton, Alison; Corcoran, Bernie; Cunningham, Wendy; Eakin, Ruth; Gray, Moyra; Grey, Arthur; Hagan, Chris; Harney, Jacqui; Harvey, Barbara; Hennell, Claire; hetherington, Stacey; houghton, fionnuala; Hynds, Sharon; John McKnight; Johnston, Karen; Johnston, Margaret; Keane, Patrick; Kelly, Jenny; Lowry, Lynne; McAleese, Jonathan; McEvoy, Teresa; McLaughlin, Michelle; McPhee, Wendy; Milligan, Gail; Mills, Karen; Mitchell, Darren; Morgan, Sharon; Morrow, Michelle; Mort, Paula; Mr Best; Napier, Hazel; Norwood, Gillian; O'kane, Hugh; O'Malley, Sharon; ORourke, Declan; O'Sullivan, Joe; Parkinson, Melanie; Peter Ball; Rajan, Nambi; Shum, Lin; Stephen Hamilton; Vallely, Stephen; Venney, Cara; Vicki Graham; Walker, Jennifer; Warren, Pamela; Wilson, Brian; Wlosinski, Marie
Cc: Williamson, Sarah
Subject: Urology Business Meeting- June 2012

Dear All,

In advance of the business meeting tomorrow afternoon please find attached an agenda and a draft version of the Annual report for 2011/2012.

Please note that some of the data in the report is subject to change.

The operational policy to be signed off at the meeting is to follow.

Kind Regards,

Barry O'Kelly

Cancer Services

Belfast Health and Social Care Trust

Operational Policy for Belfast Trust Specialist UROLOGY Cancer MDT

MDT Operational Policy- Agreement Cover Sheet

The Belfast Trust Urology Cancer MDT is recognised as an MDT by the Northern Ireland Cancer Network (NICaN). This document outlines the Operational Policy for the MDT and the policy is reviewed on a yearly basis at an Operational Meeting.

This operational policy has been agreed by:

NAME: Professor Joe O'Sullivan
POSITION: Lead Clinician, Urology SMDT
TRUST: BHSCT
DATE AGREED:

NAME: Mr. J. McGuigan
POSITION: Trust Lead Cancer Clinician
TRUST: BHSCT
DATE AGREED:

MDT MEMBERS AGREED THIS OPERATIONAL POLICY ON

OPERATIONAL POLICY REVIEW DATE:

8. Data Collection & Audit		
APPENDIX One – Lead Clinician Job Description **APPENDIX Two** – Urology Nurse Qualifications and Working Week; Nurse Practitioner Working Week (Why?) **APPENDIX Three** – Key Worker Policy **APPENDIX Four** – MDT Outcomes Proforma **APPENDIX Five** – Permanent Record Consultation **APPENDIX Six** – Patient Information Checklist **APPENDIX Seven** – GP Letter following MDM		

2. Introduction

The Urology Specialist Multidisciplinary Team (MDT) is a multi-professional group based at Belfast City Hospital, Belfast Health and Social Care Trust which serves the City of Belfast, with a local population of 360,000 and as a Regional Cancer Treatment unit for the delivery of complex treatments such as specialist surgery and radiotherapy to Northern Ireland's population of 1,740,000. The Belfast Health and Social Care Trust serves as a cancer unit for its local population of 440,000. The Urology MDT has been recognised as a properly constituted MDM by the Northern Ireland Cancer Network.

In addition to services for the diagnostics, treatment and care of patients with urological cancer, patients can also avail of a range of supportive care services such as integrated social care.

The Urological Cancer MDT is part of the Northern Ireland Urology Cancer Network **(Measure 08-2G-103)** and holds a weekly MDT meeting in a single host hospital, Belfast City Hospital **(Measure 08-2G-204).**

Urological services within the Belfast Trust include a Multidisciplinary Team (MDT) of urological surgeons, clinical oncologists, a medical oncologist, a lead histopathologist **(Measure 08-2G-217),** radiologists, urology nurse specialists, MDT co-ordinator and an NHS employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers **(Measure 08-2G-222).** There is extensive multidisciplinary integration within the team. Nursing staff in the form of Uro Oncology Nurse Specialist and a Urology Nurse Specialist contribute to both the MDT and to service provision, and the service is well supported by other services such as clinical psychology and palliative care. A key requirement of the MDT is that each discipline can contribute independently to the decisions regarding each relevant patient.
The MDT is a local MDT for assessment, diagnosis and treatment from five Belfast Trust hospitals; the Belfast City Hospital (BCH), Mater Hospital (MH) and Royal Victoria Hospital (RVH), Ulster Hospital and Lagan Valley Hospital (South-eastern Trust) and a specialist MDT for the region of Northern Ireland.

The objectives of the Urology Multi-Disciplinary Team are:

- To ensure that designated specialists work effectively together in teams so that all new cancer patients are discussed with the MDT prior to treatment commencing.
- To ensure that care is given according to recognised guidelines (including appropriate onward referrals) with appropriate information being collected to inform clinical decision-making and to support clinical governance/audit.
- To ensure that mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.

The MDT has seen several key improvements in the last two to three years. These include:

- Introduction of the Cancer Patient Pathway System (CaPPS) for patient tracking and data collection
- Reconfiguration of Urological Cancer Services into 3 teams for Northern Ireland.
- Establishment of one stop Haematuria Clinic
- Other Successes; Teleconference Suite, new microscope, excellent recruitment to clinical trials

However, there remain large challenges ahead for the MDT in the near future. The major issues faced by the MDT are:

- Capacity at all stages of the uro-cancer pathway which mean suspect cancer patients are waiting excessive length of time for diagnosis.
- Insufficient staffing levels of Clinical Nurse Specialists to meet the needs of the services
- The absence of Nurse Specialist support on the chemo-radiotherapy part of the pathway.
- Insufficient levels of non-consultant surgical staffing to maintain patient throughput in one-stop symptomatic clinics
- Integration of day of surgery admission into patient journey

- Establishment of continuing audit programme
- Improved recruitment into clinical trials
- Poor cancer waiting times performance
- Absence of medical oncology for Testis and Renal Cancer

This document outlines the Operational Policy for the MDT, which will be reviewed on an annual basis.

3. Purpose and Goals of the MDT

The role of the MDT is to ensure that all patients with a new diagnosis of urological cancer are discussed at or by the meeting team members to agree treatment plans for new patients prior to treatment commencing.

The primary goal of the Urology MDT is to optimise survival and quality of life, providing holistic patient centred care, to explore all options of treatment available, to offer these options through clear communication and to appreciate the impact of these options on patients' lives. The IOG Urology guidelines set out the different levels of care; local care, specialist care and supra-network care they are intended to be provided by different types of MDT. One important principle underlying the NICE IOG for urological cancers is the principle of consolidation of services for relatively infrequent procedures.

There is also a requirement for the specialist team to carry out a combined total of at least 50 radical prostatectomy's and/or total cystectomies per year and an immediate requirement for surgeons performing five or less radical prostatectomy's or five or less cystectomies per year to cease the 'rule of five'. This is met by the specialist surgical team and documented in the Annual Report of the MDT.

The MDT has the following principal functions:

- **Diagnostic**
  - To rapidly assess newly diagnosed urological cancers
  - To review imaging
  - To review histopathology's for diagnosis
  - To determine further staging investigations as required
- **Treatment**
  - To discuss the management of all newly diagnosed urological cancers
- **Communication**
  - Between professional groups within the hospital
  - Between the MDT and other agencies e.g. primary care, palliative care

In addition, the MDT aims to raise standards of patient care by:

- Ensuring high quality data collection as per the NICAN agreed minimum dataset
- Analysis of data collection as part of audit cycles
- Involvement in clinical research at local, national and international level
- Integrating new research and best practice into routine clinical care

There should be an operational policy (written by the lead clinician) for the multidisciplinary team whereby it is intended that all new cancer patients will be reviewed by a multidisciplinary team for discussion of initial treatment plan **(Measure 08-2G-208)**

4. MDT Structure

a) Core membership of the MDT and Cover Arrangements

(Measure 08-2G-202,205,216,222,219)

The Urology Cancer MDT consists of the following core members:

Job Title	Name	Cover	Contact Details
Consultant Oncologist	Joe O'Sullivan (Chair)	Lin Shum (DPS/DMM)	
Consultant Oncologist	Jackie Harney	Darren Mitchell	
Consultant Oncologist	Darren Mitchell	Jacqui Harney	
Consultant Oncologist	Lin Shum	Joe O'Sullivan	
Clinical Oncologist	Jonathan McAleese,	N/A	
Clinical Oncologist	David Stewart		
Clinical Oncologist	Fionnoula Houghton	N/A	
Consultant Uro-Oncology Surgeon	Chris Hagan	Nambi Rajan	
Consultant Uro-Oncology Surgeon	John McKnight	Brian Best	
Consultant Uro-Oncology Surgeon	Nambi Rajan	Patrick Keane	
Consultant Uro-Oncology Surgeon	Brian Best	John McKnight	
Consultant Uro-Oncology Surgeons	Brian Wilson	Registrar	
Consultant Urology Radiologists	Arthur Grey	Stephen Vallely	

Consultant Urology Radiologists	Stephen Vallely	Arthur Grey	
Research Radiographer	Sharon Hynds	Stacey Hetherington	
Consultant Pathologists	Declan O'Rourke	Moyra Gray	
Consultant Pathologists	Moyra Gray	Declan O'Rourke	
Urology-Oncology CNS	Jenny Kelly	Karen Johnston	
Urology Nurse Specialist	Karen Johnston	Jenny Kelly	
Staff and Associate Specialist Grades			
Advanced Practitioner Radiographer			
Research Nurse	Barbara Harney		
MDT Co-ordinator	Colm McDonald	Stephen Donaldson	Personal Information redacted by the USI

Key Core Members:

- The designated Lead for Clinic Trials is Joe O'Sullivan
- The lead for User Issues is Jenny Kelly and Patricia Thompson who attends Patient Forums

Core members of the MDT are expected to attend at least two-thirds of the weekly MDT meetings. A record is held of attendance and this is published in the MDT Annual Report. **(Measure 08-2G-203)**

Core members should agree an individual who will cover the MDT meeting in their absence.

(Measure 08-2G-205,206)

All core consultants (surgeons, oncologists, histopathologists, radiologists) spend at least 50% or more of direct clinical care sessions on urological disorders, and this is supported by their job plans (see the evidence guide for further details). **(Measure 08-2G-202)**

The core histopathology members all participate in a Pathology EQA. **(Measure 08-2G-217)**

It is agreed that all core members with direct patient contact should attend the Advanced Communication Skills Training Course as arranged by the Northern Ireland Cancer Network. However there is currently limited access to this training within Northern Ireland due to limited capacity to provide the training and existing funding for local provision of this training has ceased. There are ongoing negotiations with education providers and local charities to explore alternatives. As an interim measure a local training package in core communication tasks such as essential communication skills, breaking bad news, patient information giving and education techniques in dealing with anger and distress has been developed and is being delivered as part of the patient experience initiatives within cancer services. **(Measure 08-2G-221)**

The following members of the MDT have participated in Advanced Communication Skills training: **(Measure 08-2G-221)**

b) Extended Members **(Measure 08-2G-222)**

In addition, the MDT has the following extended members:

Job Title	Name
Palliative care	Edna Wilson
Brachytherapy	Pat Shiels

Access to social work, chaplaincy, allied health care professionals, social care, psychological support and financial services are available on referral as are palliative care services.

c) Leadership arrangements and responsibilities

The Lead Clinician for the urology MDT is Professor. Joe O'Sullivan as agreed with the Trust Lead Cancer Clinician, Mr. J. McGuigan **(Measure 08-2G-201).**
There should be an operational policy (written by the lead clinician) for the multidisciplinary team whereby it is intended that all new cancer patients will be reviewed by a multidisciplinary team for discussion of initial treatment plan **(Measure 08-2G-208)**

Role and responsibilities of the lead clinician/ MDT Chair ***(Measure 08-2G-201),*** include the following;

- Lead Clinician for the MDT
- Provision of leadership for the MDT
- Provision of clear communication to MDT staff
- Facilitation of effective team working
- Chairing the weekly MDT meetings
- Chair regular management meetings of the MDT
- To ensure that clinical management guidelines are produced and updated regularly
- To lead on clinical governance issues
- To support and facilitate audit and research
- To actively participate in the NICaN Urology Network Group
- To ensure collection of the minimum National Dataset
- To ensure that local policies and guidelines are developed, agreed and adhered to by the MDT

A job description is attached in **Appendix One.**

d) MDT Nurse Specialist Members

There are two core nurse specialists working in the Belfast Trust; Jenny Kelly and Karen Johnston.

- Jenny Kelly, a Uro-Oncology Nurse Specialist is working in the Belfast City Hospital, specialising in testicular cancer patients

- Karen Johnston is a Urology Nurse Specialist who works 50% of her time for urology and 50% of her time for non cancer (urology conditions) in the Belfast City Hospital

All core MDT nursing members spend 100% of their work within the Urology service. See **Appendix Two. (Measure 08-2G-218)**

Additional Support;

- The Ulster Hospital also supports the Belfast Trust Urology and Oncology patients by providing a Uro-Oncology Nurse Specialist funded by Macmillan Support, Patricia Thompson.
- The Mater Hospital also supports the Belfast Trust with a Urology Nurse Specialist, Theresa McEvoy.

Responsibilities of the Core Nurse Members – Urology Nurse Specialists
These are as follows, to: **(Measure 08-2G-219)**

- Hold additional specialist knowledge and experience
- Contribute to multi-disciplinary assessment and patient care
- Act as a co-ordinator of the care pathway for patient referred to the team
- Undertake regular psychological assessment of each patient following a diagnosis of Urological Cancer in order to provide specific expert nursing care, advice, support and counselling and where necessary referral onwards fro psychological input as required
- Maintain a support network and contact point for patients/ relatives and carers from diagnosis throughout treatment and beyond except
- Act as the patient's advocate and counsel when informed discussion may lead to choices being made concerning treatment options or quality of life issues
- Act as a specialist resource for patients and the clinical team by the provision of comprehensive advice, information, education ad training both within the Belfast Trust and externally
- Lead on patient communication issues

- Participate in educational programmes for nurses and other health care disciplines as appropriate
- Participate in the provision of information to patients and their carers regarding their disease, treatment and service available at all stages of their illness/ disease process.
- Participate in service improvement and any service and practice development initiatives as appropriate initiatives.
- Engage in multiprofessional audit and research activity required to ensure good governance of the service for provided for patient with urological cancer.

NB Because of the large patient numbers and limited CNS resource the Clinical Nurse Specialists cannot act as a key worker for all patients but seek to provide as much support as possible to the patients they interact with.

Role and Responsibilities of Core Nurse Members (Measure 08-2G-218, 219,220)

The Uro-Oncology Nurse Specialist, Jenny Kelly works autonomously and in collaboration with the multidisciplinary team, demonstrating highly developed specialist knowledge and skills in formulating clinical decisions and complex management plans in the diagnosis and treatment of urological disease, and those with a family history of cancer adhering to agreed protocols.

The Nurse Specialists' duties include the following:

Clinics:-Symptomatic (One stop clinics):-

- The Belfast City Hospital's Clinical Nurse Specialist, Jenny Kelly works with other members of the Urology MDT to assess, diagnose testicular cancer patients. It is also within her duties to manage patients referred to the men's clinic.
- The Belfast City Hospital's Urology Nurse Specialist, Karen Johnston works with other members of the MDT to assess, diagnose benign and malignant disease (through LUTS assessment clinics) and manage those referred to the clinic.

Follow Up Clinics

- The CNSs work with other members of MDT to provide follow-up care for Urological Cancer patients after diagnosis, adhering to protocol carrying out physical exams, organising radiological scans (ultrasounds), social and psychological assessments and provides onwards referral to other services and agencies as appropriate.

Nurse-Led

Where appropriate the CNS may takes responsibility for the management of patients referred either by consultant or GP as follows:

- Follow up of low risk and stable Urological Cancer Patients
- Family History patients

The Urology CNSs also have more generic responsibilities consistent with the role of advanced practitioner such as participation in service improvement and any service and practice development initiatives as appropriate. Initiatives and engagement in multiprofessional audit and research activity required to ensure good governance of the service for provided for patients with urological cancer.

The Belfast City Hospital core Uro-Oncology Nurse, Jenny Kelly and the Urology Specialist Nurse Karen Johnston, have additional responsibilities which include:

- Contributing to the management of the service

The Clinical Trials nurses oversee the utilisation of research in the team's specialist area of practice and are responsible for trial recruitment with the medical team

(Measure 08-2G-219,220)

All CNSs include aspects of education and the utilisation of research and audit in addition to the clinical aspects or their role as part of their job descriptions. **(Measure 08-2B-117)**

All of the Urological Clinical Nurse Specialists are graduate level nurses with post basic qualifications in urological cancer care nursing. The qualifications of the Core Nursing Members of the MDT are included in **Appendix Three**. **(Measure 08-2G-221)**

e) **Identification of the Key Worker** **(Measure 08-2G-212)**

The role of the key worker for cancer patients is recognised and requires discussion during 12/13 to determine how this role, which is informally carried out where possible, can be carried out for a cohort of Uro-oncology patients. Additional Clinical Nurse Specialists are required to provide this service for all patients.

Role of the Key worker;

- Contribute to the MDT discussion and decisions about the patient's plan of care.
- Be present when the cancer diagnosis is discussed and at any other key points in patient's journey.
- Act as key point of contact for patients and their carers
- Work as intergal member of the MDt to ensure continutiy of care
- Co-ordination of the patient pathway across speciaities, discipline and health and social care providers.
- Undertake a holistic assessment of patient's needs at key points in the pathways and ensure onward referral to other agencies and professionals as apprpriate
- Lead on the assessment of patients information needs and provide verbal and written information with regard to their diagnosis, investigations, treatment options, information on living with cancer and guide patients with regard to locally available help and support.
- Lead in patient communication issues
- Ensure acurate documentation of key worker roles and any changes to this (Not sure about Key Worker role)

It is recognised that the Key Worker may change as the patient progresses through their treatment journey, as patient circumstances change. The responsibility for reassigning the Key Worker should be the responsibility of the Clinical nurse specialists. Such changes will be clearly agreed with the patient and the change of key worker documented in the patients notes. The patient will be furnished with the name and contact details of the new key worker. Where there is not an identified Key Worker, limited contingency arrangments are in place and point of contacts are offered to the patient and is supported by written

information. The patient is offered patient information as agreed by the patient information pathway by the generic nurses caring for them.

Belvoir Park Suite nurses, therapy radiographers and the radiotherapy nursing service seek to mitigate the absence of a Urology Oncology CNS by providing locally agreed core information and onward referral to the Macmillan Information and Support Centre on the Belfast City Hospital site.

See **Appendix Three** for the Key Worker Policy which is for discussion with the Urology CNS team and their managers and the Senior Nurse Cancer Services at present (June 2012)

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
AM	Urology CNS Karen Johnston	Urology CNS Karen Johnston	Urology Oncology CNS	Uro-Oncology CNS Jenny Kelly Results Clinics	Urology Oncology CNS Jenny Kelly Testicular Results Clinics
PM		Urology CNS Karen Johnston RRP Clinic CNS Jenny Kelly Results Clinics		Urology MDM Jenny Kelly	
		Jenny Kelly Men's Clinic			

f) Relationship with NICaN

- The MDT are key participants in the NICaN Urological Regional Group **(Measure 08-2G-230-240)**

- The MDT engage with the NICaN Urology Regional Group to develop network-wide guidelines and policies for the diagnosis, treatment and follow-up of breast cancer

- The MDT agrees to collect the NICaN agreed minimum dataset

- The MDT participates in an annual network audit projects, presenting the results for discussion at a Urological Regional Group meeting, and at MDT business meetings

- The MDT engages with the Urology Regional Group to develop and agree an approved list of clinical trials

- The MDT engages in any regional patient experience initiatives concerned with patient information and support, holistic assessment of need and patient and user involvement.

See Annual Report, NSSG Evidence Folder and Trust Evidence Folder for more information.

5. Patient Pathways

The Specialist Urology MDT adheres to the NICAN Clinical Management Guidelines which are currently in preparation and these were agreed by the Network in 2010. **(Measure 08-2G-230,231,232, 233, 234,234)**

These include:

- Diagnosis assessment imaging guidelines **(Measure 08-2G-223)**
- Diagnosis assessment pathology guidelines **(Measure 08-2G-223)**
- Guidelines for the surgical management of urological cancer
- Guidelines for adjuvant and systemic therapy in urological cancer

The Northern Ireland Urology Cancer Network agreed five cancer care pathways for patients suspected/diagnosed with urological cancer. Each pathway highlights guidelines for referral, diagnosis, treatment and follow-up procedures for each patient attending healthcare environments within the Belfast Trust.

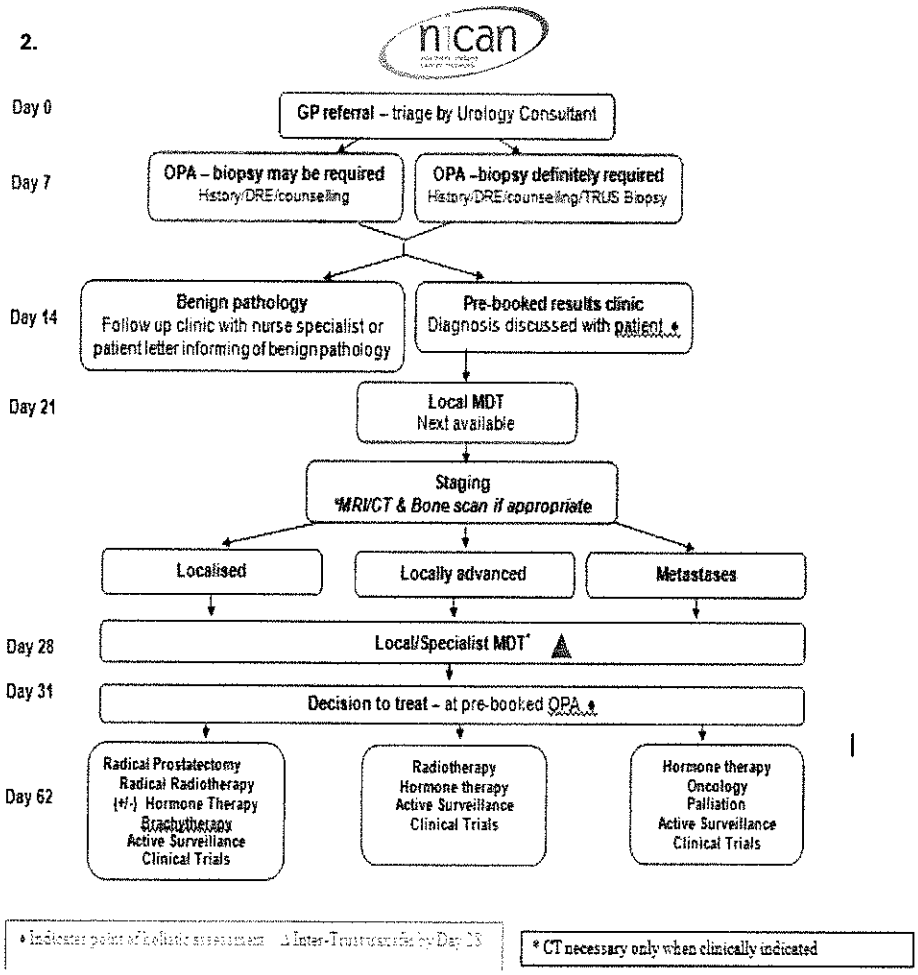
NICE guidelines for urological cancers require each network to reach a number of detailed agreements regarding patients, clinical responsibilities and referrals of patients. Such agreements have been reflected below in accordance to each respective urological cancer.

Each Urology Cancer Care Pathway (published by NICAN) has been outlined below;

1. **Prostate Pathway** – The multidisciplinary team hold regular clinics at Belfast City Hospital and Mater Hospital on the hospital outpatient department for new patients potentially having prostate cancer. Each clinic is operated by surgical core members of the MDT and is part of the work plan of the nurse specialist member of the urology MDT. A regular clinic should be indentified in GP information with a contact point for GP referrals of patients with suspected urological and specifically prostate cancer **(Measure 08-2G-226).** The lead clinician of the Specialised Urology MDT and the chair of the NSSG have agreed with the rest of the MDT a set of network wide clinical and referral guidelines for prostate cancer and for muscle invasive bladder cancer and organ confined prostate cancer **(Measure 08-2G-232 & 233).**

Prostate Pathway

2.



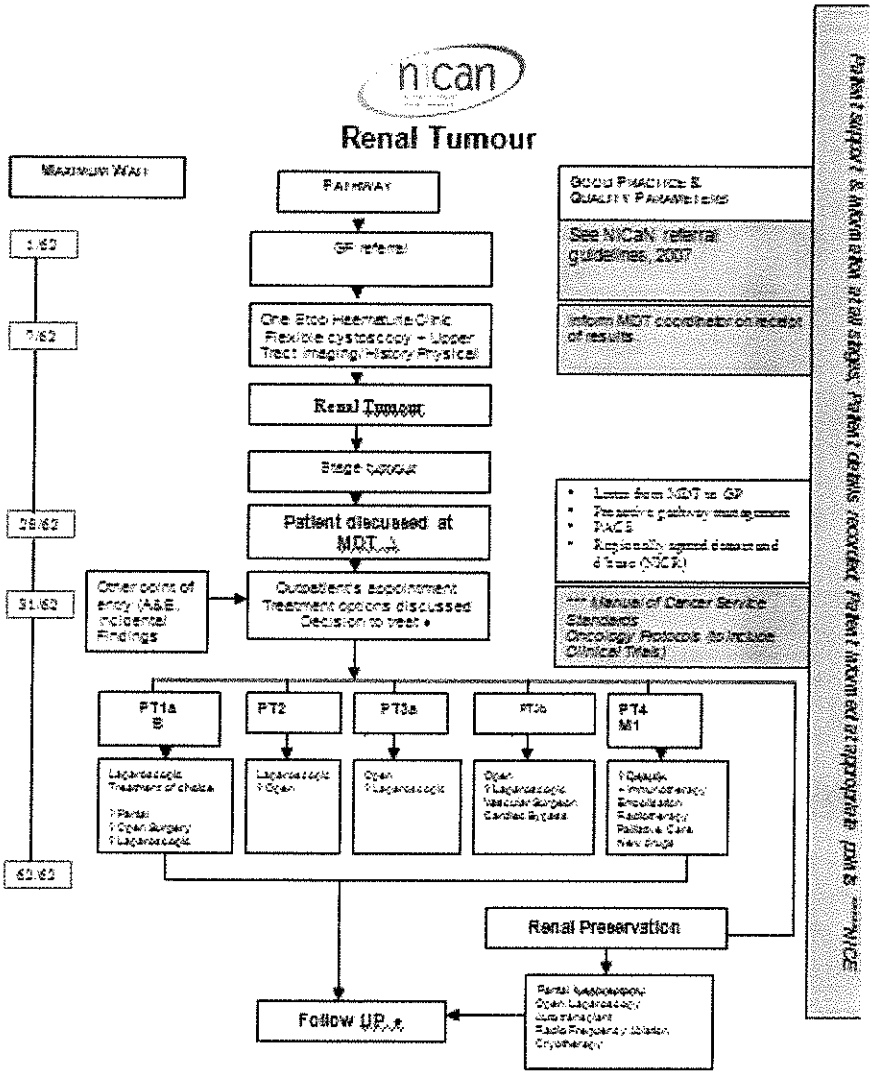
♦ Indicates point of holistic assessment Δ Inter-Trust referrals by Day 28

* CT necessary only when clinically indicated

2. Renal Tumour Pathway- Specialist care for kidney and bladder cancer should only be delivered under the care of the specialist urology team. All patients referred to the Belfast Trust with suspected or diagnosed with high risk superficial bladder cancer will be discussed by the local MDT prior to the referral. **(Measure 08-2G-209).**

As described earlier patients with renal cancer must be discussed at the Regional MDT. The MDT have also agreed that patients being referred to the Belfast Trust with suspected or diagnosed kidney cancer will be discussed in relation to patients suitability for nephron-sparing surgery prior to referral or management by the local MDT. This procedure has been set out and agreed in written policy that has been approved by the lead clinician of the MDT **(Measure 08-2G-210).** A clinical wide network and referral guidelines have been agreed for management of patients referred to the Belfast Trust with suspected kidney and bladder cancer.**(Measure 08-2G-230 &231.)**

Belfast Trust Specialist Urology Cancer MDT Operational Policy



3. **Testicular Cancer Pathway-** The Urology MDT has set up a number of written policies outlining agreed network wide clinical and referral guidelines for patients suspected or diagnosed with testicular cancer. Each policy ensures appropriate guidelines are followed in relation to diagnosis and assessment, referral for treatment from another team, MDT discussions of patients with testicular cancer, a pathway to define specialised care for the network and finally a set of guidelines for referrals to histology and radiology **(Measure 08-2G-234, 235, 236, 237 & 238).** The measures have been outlined below;

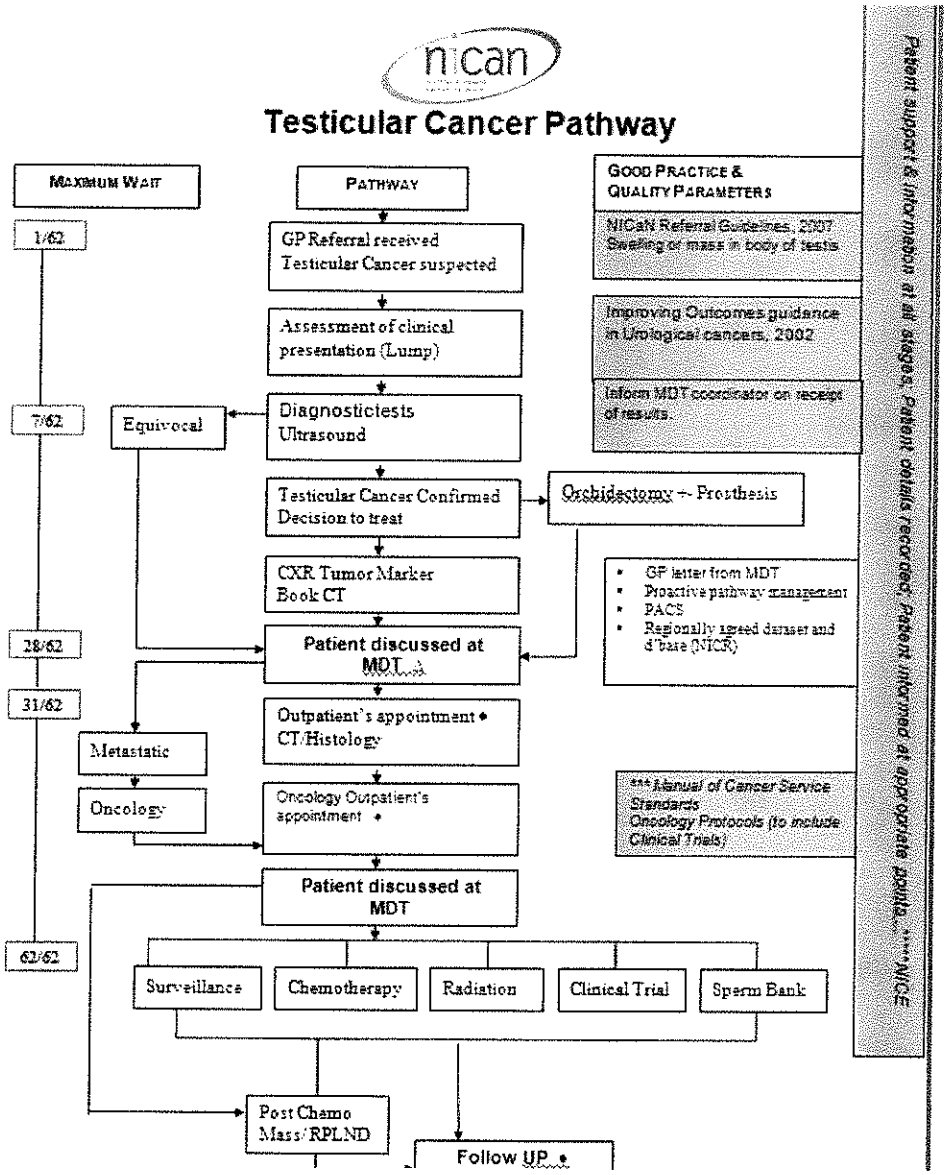
- The Urology Specialist MDT has agreed the network wide clinical and referral guidelines for testicular cancer- diagnosis and assessment as per NICAN. **(Measure 08-2G-234)**

- The Urology Specialist MDT has agreed the network wide clinical and referral guidelines to testicular cancer- referral for treatment to another team. **(Measure 08-2G-235)**

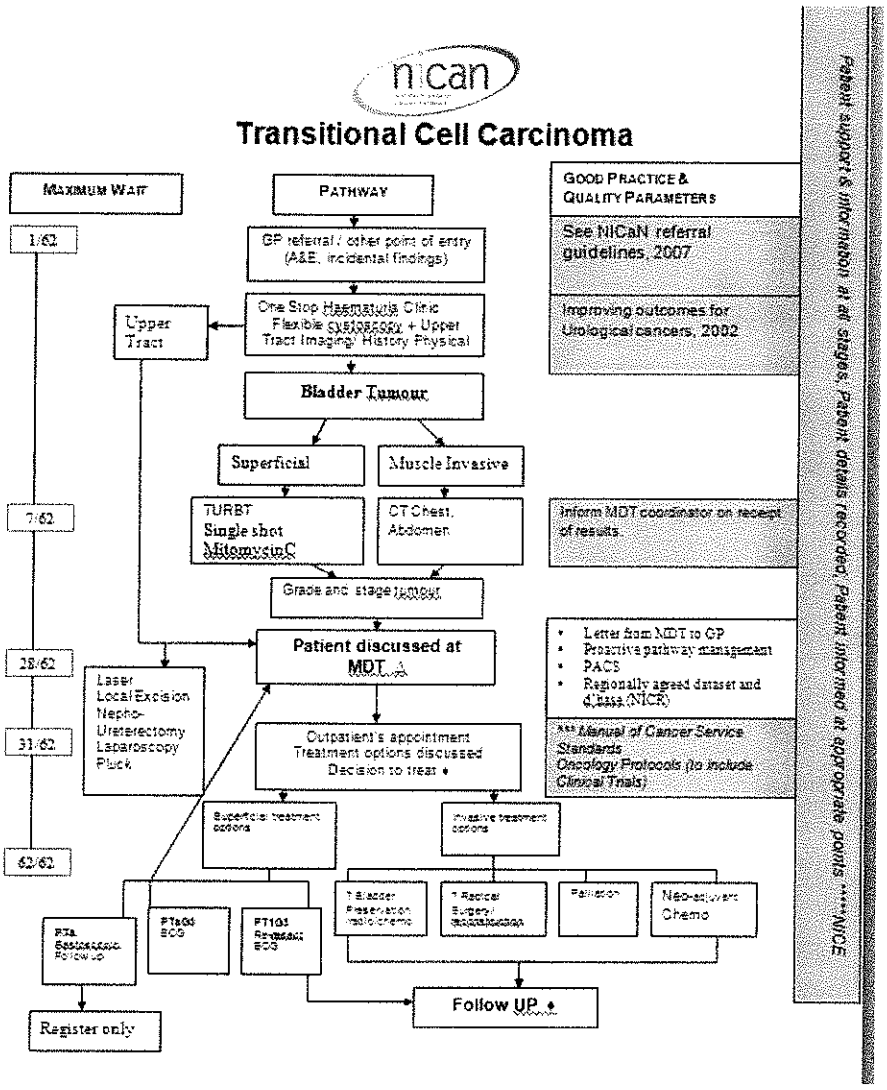
- The Urology Specialist MDT has agreed the network wide clinical and referral guidelines from testicular cancer- MDT discussion. **(Measure 08-2G-236)**

- The Urology Specialist MDT has agreed the network wide clinical and referral guidelines for testicular cancer- defining specialist care for the network. **(Measure 08-2G-237)**

See below the NICaN agreed Testicular pathway

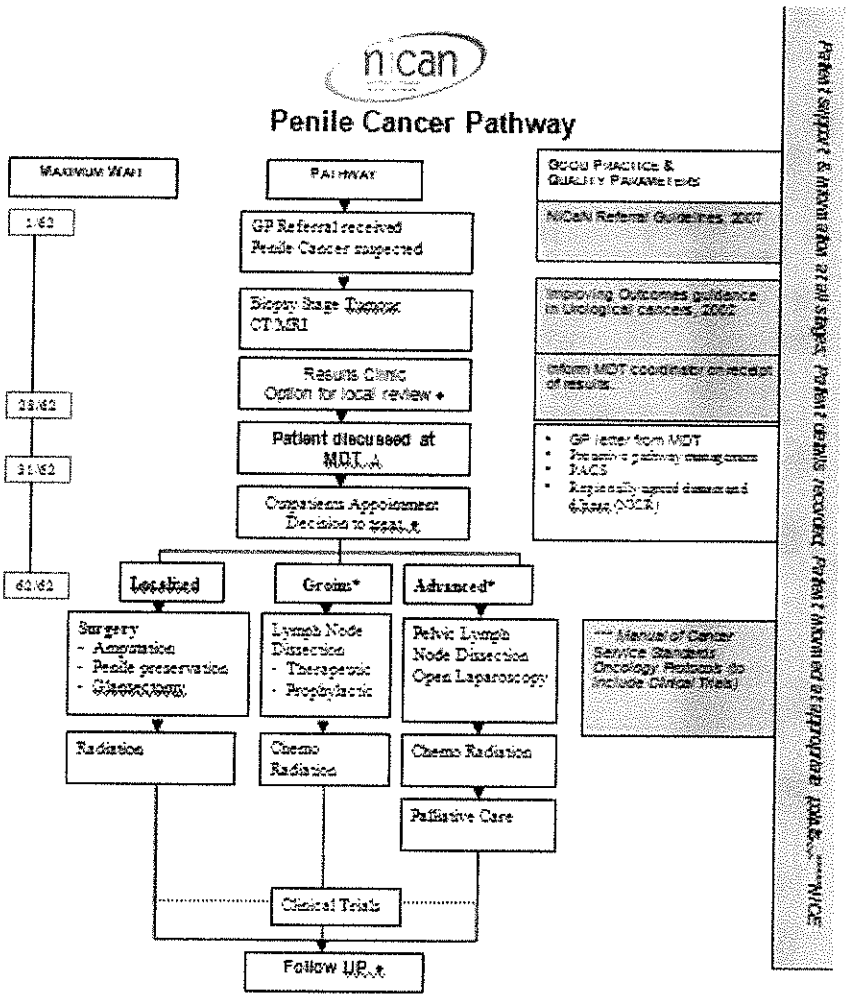


4. **Transitional Cell Carcinoma** - All patients referred to the Belfast Trust with suspected or diagnosed with high risk superficial bladder cancer will be discussed by the local MDT prior to referral and/or management. **(Measure 08-2G-209).**



5. **Haematuria Referral Guidance –** A one stop is held for new patients with haematuria. GP's have been informed of how and where to make haematuria referrals however the waiting time within Belfast for this service is currently greater than 6 weeks. **(Measure 08-2G-228).**

6. **Penile Cancer Pathway**- The lead clinician of the Urology MDT has also outlined a set of guideline policy for network wide clinical and referrals for patients suspected with or diagnosed with penile cancer. Such guidelines ensure that members of the urology MDT follow correct procedures for diagnosis, assessment, MDT discussion and appropriately define a specialist and supra-network care for the network **(Measure 08-2G-239 & 240)**



1. Referral pathway (Measure 08-2G-211)

Patients with suspected urological cancer are referred to the symptomatic urology service. All referrals are received at a central point, where they are reviewed and triaged by a Urology Consultant. This allows up-grading of non "red flag" referrals where appropriate to ensure that these patients are seen on the appropriate pathway.
Urological CNS's are present at symptomatic urological clinics where possible within current capacity.

Patients with a new diagnosis of malignancy confirmed via pathology are added to the next MDT for discussion. Patients can then be reviewed at a subsequent urology clinic to allow discussion of results and of the treatment plan, and can meet with the Urological Care Nurses if she is available. **(Measure 08-2G-216)**

The Red Flag Referral System

When a red flag referral letter is received its is date stamped in medical records. All referral letters (including GP Red Flags) are then forwarded to the consultant physicians for triage. This is to allow for appropriate referrals to be sent straight to investigation i.e. CT. This includes facilities upgrade where appropriate to red flag status of routine and urgent referrals. All red flag referrals requiring an outpatient appointment are then allocated the first red flag OPD slot.

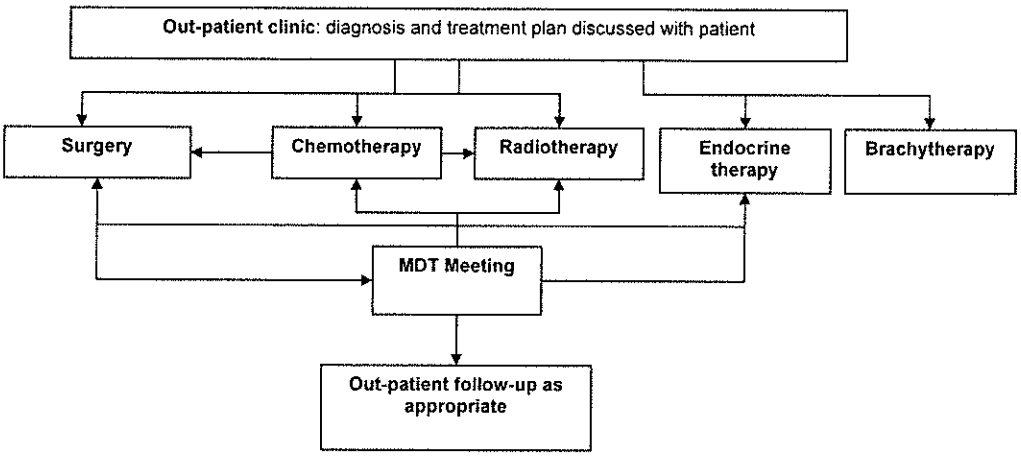
2. Diagnostic pathway (Measure 08-2G-214)

As per NICAN Urology Cancer Care Pathways shown above

3. Treatment pathway (Measure 08-2G-215, 230-240)

All treatment is undertaken by experienced staff with specific skills in the management of urology cancer. There is close collaboration between urology surgeons and medical and clinical oncologists, offering easy and rapid access to all major treatment modalities. All necessary support services are present on site in the same hospital.

A urology cancer treatment pathway for patients has been illustrated below. However this assessment and diagnostic testing will differ for each type of urological cancer.



Radiotherapy

Radiotherapy is delivered by seven Clinical Oncologists at the Northern Ireland Cancer Centre. The proximity of the City Hospital to the Northern Ireland Cancer Centre ensures timely access to this service with minimal delays and inconvenience. Radiotherapy is delivered using state of art CT planning in the radiotherapy department.

Patients are reviewed ~~daily~~ weekly by specialist therapeutic radiographers and assessed ~~weekly~~ on commencement and completion of treatment by medical staff ~~.~~(As per prostate radiotherapy protocol.) There is also specialist information and a support radiographer and pre treatment information evenings are run monthly at the Cancer Centre.

There is a urological cancer specific social work service available for patients undergoing chemo radiotherapy and patient can also benefit from an adjacent state of the art specialist oncology physiotherapy and occupational therapy service. Facilities include a fully equipped gym, activities of daily living kitchen, bedroom and bathroom and access to on site additional specialist oncology AHP support such as dietetics, speech and language therapy and podiatry services.

There is access for the patients to an onsite and award winning information and support centre which contains a Citizens Advice Bureau, information specialists, counsellors, psychology services and a range of supportive, relaxation and complimentary therapies.

Patients are also given information on other rehabilitation services and local support groups. There is a chaplaincy service and weekly services are held for patients attending for cancer treatments on the BCH site in the quiet room within the cancer centre.

Surgery

Specialist Urology Cancer surgery for Northern Ireland happens in Belfast City Hospital, where there is an increased use of the day of surgery. This includes;

- **Open prostatectomy**
- **Laparoscopic prostatectomy**
- **Renal Transplantation**

Brachytherapy

Brachytherapy is one type of radiation therapy used to treat cancer. Brachytherapy allows a physician to use a high dose of radiation to treat a smaller area and in a shorter time than is possible with external radiation treatment.

- Permanent brachytherapy, also called seed implantation, involves placing radioactive seeds or pellets (about the size of a grain of rice) in or near the tumor and leaving them there permanently. After several weeks or months, the radioactivity level of the implants eventually diminishes to zero. The inactive seeds then remain in the body, with no lasting effect on the patient.

This new service is provided in the Cancer Centre at the Belfast City Hospital.

Chemotherapy

Chemotherapy for urological cancer at the City Hospital is primarily delivered by ~~two~~ three medical oncologists and ~~two~~ four Clinical Oncologists with a specialist interest in the management of patients with urology cancer. Patients are first seen to discuss the potential

Commented [d1]: SMA, VC, AC

Commented [d2]: JOS, LS, DPS, DMM

treatment options and the benefits and risks of those treatments. They are then appointed to the Bridgewater Suite in order to receive their treatment as an outpatient. Continuity of nursing care during chemotherapy treatment is ensured via nursing staff specifically allocated to the breast cancer chemotherapy clinics. Patients are regularly reviewed by medical staff throughout the course of their chemotherapy to treat side effects of treatment and ensure patient safety.

Patients are educated in the side effects of chemotherapy and given access to 24 hour Helpline for rapid assessment and access during treatment. The first visit to Bridgewater Suite includes an invitation to see the hairdresser for fitting of wigs and other headwear.

Endocrine Hormone Therapy

Endocrine Hormone Therapy is a treatment involving the administration of hormones to treat urological cancer (in particularly prostate cancer).

4. Clinical Trials **(Measure 08-2G-245)**

The Northern Ireland Cancer Clinical Trials Centre provides the infrastructure to support clinical trials including administration staff, data managers, clinical research nurses and Radiographers. This allows the medical and clinical oncologists and the surgical team to participate in international, national and locally designed clinical trials and research. These trials are a mixture of academic and Pharma lead studies.

The MDT has a nominated lead for Clinical Trials, Professor. Joe O'Sullivan. It is the responsibility of the Chair to ensure that all patients who are appropriate for Trials are discussed and the patient is given full information. The MDT engages with the NI Clinical Trials Centre and NICAN Urology Group to develop and agree an approved list of clinical trials and state reasons why patients have not been entered. The MDT will review and discuss recruitment rates with the NICAN Urology Group and identify remedial actions as required. **(Measure 08-2G-245)**

There are currently 14 open clinical trials in urological cancer actively recruiting. A further 5 clinical trials are in the process of set-up. **(Measure 08-2G-248 & 249)**

The urology cancer team is committed to improving the recruitment to clinical trials and aims to do this through better collaboration between disciplines. This will allow earlier communication of information about clinical trials to be passed onto patients. **(Measure 08-2G-247)**

5. Supportive care and Rehabilitation services

A comprehensive range of supportive care and rehabilitation services are available for the urological cancer patients under the care of the MDT. Referral to these services can be made by any member of the team, or in some cases by the patient directly.

Lymphoedema

The Cancer Centre hosts the Trust Lymphoedema Service which is based in the Physiotherapy Department. This service accepts referrals from all sources including breast, gynaecology, urology and head & neck cancers, and palliative care. The service is based on an out-patient system however all Cancer Centre wards are covered and a limited domiciliary service is also available.

Patients attending the BHSCT for radiotherapy or chemotherapy can have lymphoedema treatment at the Belfast City Hospital site otherwise they are seen by the lymphoedema service closest to home. The Urology CNSs give advice on the management of lymphoedema and patients can be referred to the Lymphoedema Service by any member of the MDT.

Clinical Psychology Service

There is a clinical psychology service provided by the Trust for cancer patients who require psychological assessment and support. Members of the MDT can refer patients to this service.

Macmillan Support and Information Centre

The Centre has been funded greatly by the Friends of the Cancer Centre. It provides high quality information and support free of charge for people affected by cancer. They offer a wide range of services designed to support patients, carers and families.

Hairdresser/Wig fitting service

Experienced hairdressers offer confidential consultations and a wide range of wigs in different styles for patients suffering hair loss as a result of their treatment. The service is available in the support and information centre, Bridgewater Suite and inpatient wards. Patients can ring or call into the Centre to make an appointment. Patients undergoing treatment that results in hair loss will be given a referral form that provides them with one monofilament wig per six months. The Trust pays for the cost of the wig: it is therefore free of charge to the patient.

Welfare Rights Service

Citizens Advice Bureau provides financial, employment, benefits and claims advice to people who may be experiencing financial difficulties as a result of cancer. The service is available in the Centre and also inpatient wards.

Information services

The Centre Information Zone provides booklets and leaflets on all aspects of cancer, as well as information on local and regional services. The information manager will see patients and carers who wish to access the service in the support and information centre, inpatient wards and the chemotherapy suite. Patients and carers can also use the internet in the Centre to find other information.

Clinical Psychology and Counselling service

Professionally trained counsellors and clinical psychologists offer individual support for patients and family members including bereavement counselling. Referral to the clinical psychology service is by the patient's General Practitioner. Patients can also self refer to the counselling service. The service is available in the support and information centre and also inpatient wards. Support for staff is also available on a self referral basis.

Complementary Therapies

Complementary therapy promotes a sense of emotional and psychological wellbeing. Therapies on offer include aromatherapy, massage, reflexology and acupuncture.
The service is available for patients in the support and information centre and also inpatient wards. Patients can refer themselves for complementary therapy by contacting the Centre.

Ulster Cancer Foundation (UCF) Family Support Service

Commented [d3]: Now known as Cancer focus???

This regional service offers specialist support to help families cope with disruption to ordinary family life and minimise the long term impact on children's emotional well-being when a significant adult has cancer.

The service is for children/young people and their families when a significant adult has been diagnosed with cancer. The adult might be a parent, aunt, uncle, grandparent or anyone who has a central role in the child's day to day life.
This is available for individual members of the family, a parent or a child for example, or the whole family. The UCF Family Support Worker discusses individual needs with patients and arranges whatever support is best for each family.

Action Cancer

The service provides support for people with cancer in Northern Ireland. This charity provides MOT Health Checks to both males and females over the age of 16 years old. Action Cancer are now offering cancer patients, families and carers to open sessions at the Action Cancer Support and Information Group. A team of clinical staff and counsellors can provide information and advice on issues worrying cancer patient's pre and post treatment.

6. Palliative Care (Measure 08-2G-213)

The hospital specialist palliative care team are teams of hospital based doctors, nurses and pharmacists who specialise in palliative care. Referrals are made to the Hospital Specialist Palliative Care Service from any health care professional with agreement from the consultant/team primarily responsible for the patient's care. Specialist Palliative Care is

available to provide the patient/carer complex symptom control, psychological or spiritual issues, rehabilitation or end of life care management, advice and support.

A significant proportion of patients with advanced breast cancer will experience multiple and often complex physical problems requiring intervention from a wide range of disciplines across the primary, secondary and tertiary care interface.

Other Specialist Palliative Care Services available to this patient group include:

- Community Specialist Palliative Care Nurses:
- Specialist Palliative Care in an Inpatient Unit/Hospice:
- Specialist Palliative Care Day Hospice or Therapy Centre:
- Palliative Medicine Outpatient Clinic.
- Specialist Palliative Care Services/Nurses who work closely with GPs and District Nurses who will be the patient/carer key workers in the community.

6. MDT Meetings

a) The MDT meeting **(Measure 08-2B-105)**

The MDT meets weekly on a Thursday afternoon (2.15 – 4.00pm) in the Boardroom, Administration Floor on the Tower Block in the City Hospital. A list of all patients for discussion is held on the Cancer Patient Pathway System (CaPPS), and this is distributed to members prior to the meeting.

b) Criteria for Patient Discussion at MDM

The MDT will discuss: **(Measure 08-2B-109)**

- All newly diagnosed urology cancer patients prior to treatment commencing. The MDT Co-ordinator ensures that all cases are discussed by cross checking pathology, biopsy and radiology reports.
- All post-operative patients
- Any other complex cases requiring discussion at the request of the responsible clinician

All patients for discussion are added to the MDT list by 12 noon on the Tuesday prior to that meeting. Any patients added after this deadline is notified directly to the MDT co-ordinator to ensure the availability of imaging and histopathology for the meeting. Patients may be added to the meeting list by any member of the MDT, who will then be responsible for providing necessary clinical information. The only exception to this will be if the MDT co-ordinator identifies a urology cancer patient from histopathology results and is aware that this patient has not been added to the list. In these circumstances the co-ordinator may add the patient to the list and subsequently inform the responsible clinician.

The consultant radiologist is responsible for the imaging being available for review. The meeting will be chaired by one of the lead clinicians or deputies. A brief summary of each case will be presented by the consultant (or nominated deputy) responsible for that patient's care. The MDT co-ordinator will maintain a record of attendance at the meeting.

Commented [d4]: Can we acknowledge the NICE guidance to have a castrate resistant MDT as an aspiration.

c) Between the meetings

When a patient with urological cancer requires an urgent treatment decision to be made prior to MDT discussion, this requires a formal written record (usually in the form of a letter to the patient's GP) to be made of the consultation. The case should then be discussed at the next scheduled MDT. **(Measure 08-2G-213)**

In addition to its weekly clinical meetings, the MDT will meet quarterly to discuss and agree operational matters, audit data and outcomes and any relevant service improvement issues, including the results of any patient consultation exercise. Minutes are recorded and action plans generated. **(Measure 08-2G-207)**

d) Communication from the MDT **(Measure 08-2G-241)**

MDT decisions are recorded by the coordinator on CaPPS, where a record of decisions is kept. The consultant in charge of the patient's care is responsible for ensuring that the CaPPS record is correct and accurate. This system will also be used for data collection. A written record of the outcomes is available for filing in patient notes. A letter to the patient's GP is generated by the CaPPS system and is signed by the responsible clinician at the end of the meeting, ensuring prompt and accurate communication of decisions to primary care. Similarly, any onward letters of referral to Oncology or other specialities are generated at the time of the MDT.

7. Communication Policy

a) MDT Outcomes

MDT Outcome forms are generated from the CaPPs system, and data is validated by the MDT Chair as the information is entered. These are filed in patient's notes following MDM. An example can be found in **Appendix Four**. **(Measure 08-2G-223,229)**
GP Letters are generated from the MDT and mailed within 24 working hours of the meeting. **See attached Appendix Seven.**

In accordance to retrieving feedback from patients regarding treatment, services and communication between patient and consultant, the MDT aims to present and discuss the issues raised by patients at MDT meetings and learn to implement at least one change following the collation of patient feedback during the previous two years.

(Measure 08-2G-225)

b) GP Notification **(Measure 08-2G-211)**

When a patient is given a diagnosis of urological cancer, the patient's GP is informed within 48 hours of the consultation via a typed letter from the responsible consultant, with a copy filed in the patient's notes. Compliance with this measure will be the subject of audit from 2010.

c) Permanent Record of Consultation **(Measure 08-2G-204, 223)**

All patients are offered written confirmation of their diagnosis following their initial consultation (see above; document attached in Appendix Five). In addition, there is written information on both diagnosis and treatment available, and this will usually be provided by the patient's Key Worker, as well as other information as detailed below in Section d). It is recorded in the patients' notes that a permanent record of consultation has been offered.

d) Patient Information **(Measure 08-2G-223, 226)**

There is a regionally agreed patient information pathway for patients with urological cancer, which covers information and support needs all along the disease trajectory from diagnosis, through treatment and into survivorship, chronic illness or palliation has been agreed and signed off by the NICaN board. The Clinical nurse specialists were involved in the development of this and this has been accepted by the urology MDM.

The CNS's have specific responsibility for the patient experience component of the multi disciplinary team working which includes assessment of information needs, as well as that of their carers and dependants.

Patients are offered a comprehensive pack of information on diagnosis and discussion of treatment options consistent with the standards stipulated in the pathway and measure outlines in the IOG guidance; a checklist of which is found in the evidence guide. It is recorded in the patients' notes that the information pack has been offered: see the patient information checklist sticker in **Appendix Six.**

Information provided covers the diagnosis of urological cancer, information on treatments, general information on the emotional and financial impact of cancer, information about support services, information on social and spiritual support, local support groups and a leaflet containing information on the Urology Cancer MDT. Copies of these can be found in the evidence pack.

Additional information is available which patients might need depending on their individual circumstances as well as extended information for those patients who require or desire this.

Equality and Diversity Arrangements for patient information and support