In which non-HSC hospitals and clinics do you enjoy practising privileges or have admitting rights?
Please give details including:
• Number and type of cases
• Any audit or outcome data for the private practice
• Details of any adverse events, critical incidents
• Details of any investigations into the conduct of your clinical practice or working relationships with colleagues

Private Practice privileges are held at the Hillsborough Private clinic where outpatient consultations and local anaesthetic endoscopy / peno-scrotal surgery are undertaken. The majority of the endoscopy has been to date part of Contract work for the clinic on behalf of waiting list target workload for other Trusts. This has now ceased and such operations are solely on a private basis. Feedback has been given by the Clinic to the relevant Trusts. I am unaware of there being any issues. Several patient feedback questionaires have now been returned over the years with a very high satisfaction rating.

Monthly clinic and inpatient surgery is performed at the Ulster Independent Clinic. Operative work at the UIC is for endoscopic urology procedures.

I am unaware of any adverse incident on either site.

List any non-clinical work that you undertake which relates to Teaching

Partake in the Regional Urology teaching Forum for SpRs.

I am an Educational supervisor for one of our SpRs in Craigavon and am a past Urology Programme Director for Urology in Northern Ireland.
I am an undergraduate examiner, though have previously been a post graduate examiner also.

List any non-clinical work that you undertake which relates to Management

Lead Clinician for Urology in Southern Trust.

Committee member for Regional Urology Review.

Past involvement Trust Clinical Management team
SAI report committee.

List any non-clinical work that you undertake which relates to Research

- Past mentor for M.D fellowship within Trust. However there has not been a Fellow for some years now due to a change in the urology training scheme in the UK.

  Partake in Audits undertaken by our Registrars

  2018 Trust application for research project in Stone Treatment Centre - successful

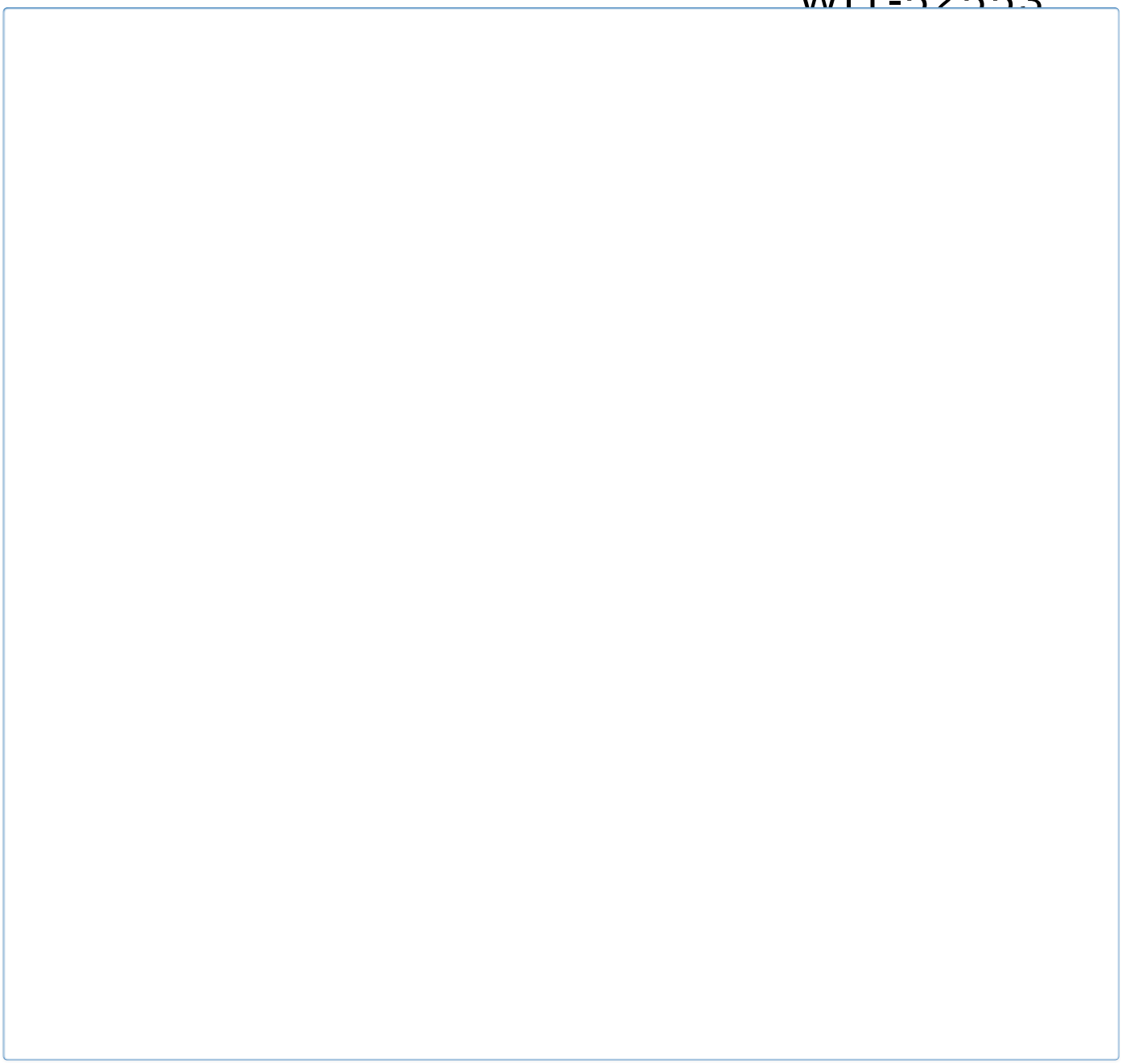
List any work you undertake for regional, national or international organisations

Member of Regional Urology review team and its sub-committees, both in 2009 and 2013.

Please list any other activity that requires you to be a registered medical practitioner

Member of the MDU

GMC registration.
Medicolegal Expert Witness – reports mainly for Trusts



Medical Education

Trainer Recognition

Are you a recognised trainer with the GMC

Yes ◉
No ○

Please list below Trainer Recognition/Discontinued Dates

Date of Recognition	Date Discontinued
22/09/2016	

Have you had an Annual Educational Review this year?

Yes ○
No ○

If Yes, please attach evidence of this year's educational review.

No File Attached

Undergraduate Medical Education

Do you have a formal role in Undergraduate Medical Education

Yes ○
No ◉

Description

Postgraduate Medical Education

Do you have a formal role in Postgraduate Medical Education

Yes ◉
No ○

Description

Urology Educational Supervisor for SpR urology trainee.

Form 3 - Supporting Information & Discussion

Document Library

Unordered Documents

Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3

Full Documents List

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
		Job Plan		✓												
1		theatre utilization	24/07/2019	✓			✓									
2		theatre team involvement	18/12/2019							✓	✓	✓		✓		
3		Complement to the whole ward	20/03/2019										✓			
4		Response tosuggestion to enhance theatre capacity for urological procedures	12/04/2018					✓								
5		urology charity fund	26/07/2018												✓	
6		Dept meeting Consultants and nursing staff	07/08/2019	✓	✓		✓				✓					
7		example of Dept Governace meeting but with reference to my audit on stent on strings service introduction	22/10/2018		✓		✓									
8		Radiation and laser protection	29/01/2018				✓	✓			✓					

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
9		committee email describing urology waiting list duration in comparison to other dept (document available)	08/06/2018				✓	✓		✓						
10		paed eswl service difficulties	03/01/2018	✓			✓						✓			
11		Ulster uro-gynae meeting	25/05/2018	✓												
12		paediatric surgeons support for CAH eswl service	08/06/2018				✓			✓						
13		Meeting with patient about toxic affects of drug and ECR recording	12/11/2018				✓	✓		✓		✓	✓			
14		STC research application to study ESWL parameters	09/07/2018	✓	✓	✓	✓			✓	✓					
15		description for stone therapy protocol for radiograghers to follow	16/02/2018		✓		✓									
16		laser protection in theatre for all staff	21/02/2018	✓			✓	✓		✓	✓					
17		study leave Trust document	20/09/2018	✓												
18		M & M 2018 repord	31/12/2018	✓			✓									
19		CLIP report	31/12/2018	✓												
20		Complaints	31/12/2018										✓			
		thank you														

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
21		cards example	11/11/2019										✓			
22		MDU consent to intimate exam CPD	03/02/2018	✓			✓									
23		ulster urogynae meeting agenda	18/05/2018	✓	✓											
24		cpd record for urogynae meeting	18/05/2018	✓												
25		World Congress Endourology meeting Paris sept 18 Whole day	21/09/2018	✓	✓											
26		world congress endourology second whole day	22/09/2018	✓	✓											
27		world congress endourology third day 1/2	23/09/2018	✓	✓											
28		ICT training in Trust	21/01/2018					✓							✓	
29		Nocturia Roadshow forum	13/03/2018	✓	✓											
30		bjui knowledge	31/12/2018	✓												
31		bjui knowledge summary 18	31/12/2018	✓												
32		job plan 2018	11/04/2018	✓												
33		Health and Probity	11/11/2019						✓						✓	
34		comments on CLIP report	11/11/2019	✓												
35		STC audit 2018	11/11/2019				✓									

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3		2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
36		SAI declaration	11/11/2019				✓									
37		Training passport	31/12/2018				✓									
38		Ulster clinic letter of good standing	03/10/2019				✓					✓				
39		MDU card	11/11/2019												✓	
40		last year PDP all areas completed	11/11/2019	✓												

Domain 1 Knowledge, Skills and Performance

Documents

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	Actions
		Job Plan		✓			
1		theatre utilization	24/07/2019	✓			
6		Dept meeting Consultants and nursing staff	07/08/2019	✓	✓		
7		example of Dept Governace meeting but with reference to my audit on stent on strings service introduction	22/10/2018		✓		
10		paed eswl service difficulties	03/01/2018	✓			
11		Ulster uro-gynae meeting	25/05/2018	✓			
14		STC research application to study ESWL parameters	09/07/2018	✓	✓	✓	
15		description for stone therapy protocol for radiograghers to follow	16/02/2018		✓		
16		laser protection in theatre for all staff	21/02/2018	✓			
17		study leave Trust document	20/09/2018	✓			
18		M & M 2018 repord	31/12/2018	✓			
19		CLIP report	31/12/2018	✓			
22		MDU consent to intimate exam CPD	03/02/2018	✓			
23		ulster urogynae meeting agenda	18/05/2018	✓	✓		
24		cpd record for urogynae meeting	18/05/2018	✓			
25		World Congress Endourology meeting Paris sept 18 Whole day	21/09/2018	✓	✓		
26		world congress endourology second whole day	22/09/2018	✓	✓		
27		world congress endourology third day 1/2	23/09/2018	✓	✓		
29		Nocturia Roadshow forum	13/03/2018	✓	✓		
30		bjui knowledge	31/12/2018	✓			

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	Actions
31		bjui knowledge summary 18	31/12/2018	✓			✎ ✖
32		job plan 2018	11/04/2018	✓			✎ ✖
34		comments on CLIP report	11/11/2019	✓			✎ ✖
40		last year PDP all areas completed	11/11/2019	✓			✎ ✖

Commentary

Appraisee Commentary

- Attendance at World Congress of Endourology = undoubtedly a good meeting for my subspecialty - particularly enjoyable and educational productive. Although an international meeting, would be beneficial to attend more regularly than Trust policy would normal allow.

- Patient and staff safety theatre laser course updated

- BJUI record of other educational activity

- Undertaking a significant research project in the Stone Treatment centre. This is multidisciplinary and patient outcome focused. This project, although funded for a year, is planned to attract subsequent funding for the following year. In addition to improved outcomes, the speed of providing the service is being addressed by the introduction of a weekly Stone meeting attended by Consultants,radiographer, stone nurse, administrative staff and a Trust Doctor with specific interest in stone work. The 'stent on string' audit is a prime example of both these principles (Pt symptoms and time lines of service provision)

- M&M within the correct attendance.

- Job plan enclosed = this will need updating soon

- CLIP report. Not so sure about the way the CLIP report is presented now. However activity general is high. The activity in the Thorndale urology unit does not recognize the number of patients attending actually having a procedure for the one stop clinic configuration. I have made a few comments in my reflection template.

- Last PDP completed

Discussion

Discussion Summary

Michael has kept up his knowledge and skills well over this year, He attended the world Endourology conference in Paris. He will upload and document his internal and external CPD points for the year and address any deficit in the next appraisal.

Core modules are up to date bar one which he will address

He has developed protocols for ESWL and audited stenting work. He has continued to develop the stone treatment service extending it to paediatric patients.

Personal performance is good within the limitations of the service. Output vs demand mismatch continues to be frustrating.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
continue to keep up high level of skill and deliver high quality service within service limits	Courses and Audits	31/12/2019	Already added to PDP
prospective project on stone treatment patient focused.	on going research project	31/12/2019	Already added to PDP

Domain 2 Safety and Quality

Documents

Order	Attd	Document Details	Applicable Date	2.1	2.2	2.3	Actions
1		theatre utilization	24/07/2019	✓			
4		Response tosuggestion to enhance theatre capacity for urological procedures	12/04/2018		✓		
6		Dept meeting Consultants and nursing staff	07/08/2019	✓			
7		example of Dept Governace meeting but with reference to my audit on stent on strings service introduction	22/10/2018	✓			
8		Radiation and laser protection committee	29/01/2018	✓	✓		
9		email describing urology waiting list duration in comparison to other dept (document available)	08/06/2018	✓	✓		
10		paed eswl service difficulties	03/01/2018	✓			
12		paediatric surgeons support for CAH eswl service	08/06/2018	✓			
13		Meeting with patient about toxic affects of drug and ECR recording	12/11/2018	✓	✓		
14		STC research application to study ESWL parameters	09/07/2018	✓			
15		description for stone therapy protocol for radiograghers to follow	16/02/2018	✓			
16		laser protection in theatre for all staff	21/02/2018	✓	✓		
18		M & M 2018 repord	31/12/2018	✓			
22		MDU consent to intimate exam CPD	03/02/2018	✓			
28		ICT training in Trust	21/01/2018		✓		
33		Health and Probity	11/11/2019			✓	
35		STC audit 2018	11/11/2019	✓			
36		Absence of SAI declaration	11/11/2019	✓			
37		Training passport	31/12/2018	✓			
38		Ulster clinic letter of good standing	03/10/2019	✓			

Commentary

Appraisee Commentary

- I would regard that our theatre utilization is actually good. We attempt to us all our sessions even adapting and changing our allocation pending on-call and other team members annual leave. I have offered suggestions on how it could be improved further. We are still short of urological theatre time and this is compromising our overall service, hence the long waiting lists.

- Paediatric ESWL service was under pressure with the move to Daisy Hill for elective surgery. It is now recognized that this service is only possible on the CAH site due to the fixed nature of the technology. Our Paediatric Belfast Surgeons are very supportive

- The STC research project is very much focused on improve quality and reflective template enclosed

- A meeting with a patient and social councel was productive in improving the Alert section of the ECR record

- absence of SAI and Training passport complete bar one or two which expire during the year.

- private practice good standing record enclosed.

Discussion

Discussion Summary

Michael has kept his safety requirements up to date for his stone work.

He has excellent attendance at patient safety meetings (88%)

His training passport has one core module outstanding which will be addressed shortly.

He has demonstrated audit activity around the work he does and plans to implement the positive findings and address any weaknesses found .

He has highlighted at a regional level the demands on the service and the difficulties experienced trying to address these issues.

He has approval for a research project into ESWL going forward which will enhance and improve the service.

He has worked well with colleagues in al aspects of service delivery to achieve safe delivery of service within the present constraints .

Any complaints have been focused around the extended waiting times for new and review consultations.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
Maintain this level of performance	Continue to focus on patient safety	31/12/2019	

Domain 3 Communication, Partnership and Teamwork

Documents

Order	Attd	Document Details	Applicable Date	3.1	3.2	3.3	Actions
2		theatre team involvement	18/12/2019	✓	✓	✓	
6		Dept meeting Consultants and nursing staff	07/08/2019		✓		
8		Radiation and laser protection committee	29/01/2018		✓		
9		email describing urology waiting list duration in comparison to other dept (document available)	08/06/2018	✓			
12		paediatric surgeons support for CAH eswl service	08/06/2018	✓			
13		Meeting with patient about toxic affects of drug and ECR recording	12/11/2018	✓		✓	
14		STC research application to study ESWL parameters	09/07/2018	✓	✓		
16		laser protection in theatre for all staff	21/02/2018	✓	✓		
38		Ulster clinic letter of good standing	03/10/2019			✓	

Commentary

Appraisee Commentary

- I am the Lead Clinician for Urology in the SHSCT. I regularly meet with the other members of the unit and am an appraiser.
- We have monthly team scheduling meeting
- I am on the Theatre Users Group as the Urology representative and Chair the meeting on occasions.
- Documents enclosed are a few examples of the variety of other teams that I liaise with during work

Discussion

Discussion Summary

Michael leads his team of 6 Consultant Urologists and communicates effectively with them through monthly meetings.

He is a team leader for the Multidisciplinary stone treatment team.

He has good standing in his private practice and there are no conflicts with his NHS

work.

Job planning is a major issue amongst Consultants due to the recent pension crisis and he has agreed to work closely with his Clinical Director to

achieve a fair and reasonable departmental plan for the future.

360 appraisal missing from folder - to add this in and update before next revalidation

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
To upload 360 appraisal and make sure it is up to date for next revalidation	review and update 360	31/12/2019	Already added to PDP

Domain 4 Maintaining Trust

Documents

Order	Attd	Document Details	Applicable Date	4.1	4.2	4.3	Actions
2		theatre team involvement	18/12/2019		✓		
3		Complement to the whole ward	20/03/2019	✓			
5		urology charity fund	26/07/2018			✓	
10		paed eswl service difficulties	03/01/2018	✓			
13		Meeting with patient about toxic affects of drug and ECR recording	12/11/2018	✓			
20		Complaints	31/12/2018	✓			
21		thank you cards example	11/11/2019	✓			
28		ICT training in Trust	21/01/2018			✓	
33		Health and Probity	11/11/2019			✓	
39		MDU card	11/11/2019			✓	

Commentary

Appraisee Commentary

- Compliments, complaints, health / probity and good standing in Private Practice are logged
- Charity Fund within Trust is logged

Discussion

Discussion Summary

Michael has clearly demonstrated that he has the trust and confidence of his team and his patients.

He has no health concerns and no probity issues.

He has addressed any complaints appropriately.

He is open and clear about his fiscal responsibilities within the department.

He will upload/ link his 360 appraisal ASAP and reference it in this section.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
Continue and maintain high standards he has achieved.	Communication and openness with colleagues and managers.	31/12/2019	

Meeting Dates

Documents

Add a Meeting Date

Dates of meetings	Brief Details	Actions
20/12/2019	final meeting	
12/12/2019	initial meeting	

Form 4 - Personal Development Plan

Form 5 - Declarations

Health Declarations

Professional Obligations

I accept the professional obligations placed on me in paragraphs 28 to 30 of Good Medical Practice (2019) and where they apply I am taking appropriate action.

Appraisee Name

Young, Michael

Declaration ☑

Date Mon Nov 11 2019

Regulatory and Voluntary Proceedings

Since my last appraisal/revalidation I have not, in the UK or outside:

• Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.

• Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

Appraisee Name

Young, Michael

Declaration ☑

Date Mon Nov 11 2019

OR If I have been subject to any of the above, I have discussed these with my appraiser.

Declaration ☐

Date

Probity Declarations

Professional Obligations

I accept the professional obligations placed upon me in paragraphs 65 to 80 of Good Medical Practice (2019).

Appraisee Name

Young, Michael

Declaration ☑

Date Mon Nov 11 2019

Convictions, findings against you and disciplinary action

Since my last appraisal/revalidation I have not, in the UK or outside:

• Been convicted of a criminal offense or have proceedings pending against me.

• Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.

• Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

Appraisee Name

Young, Michael

Declaration ☑

Date Mon Nov 11 2019

OR If I have been subject to any of the above, I have discussed these with my appraiser.

Declaration ☐

Date

Indemnity Declarations

Indemnity Declaration

I declare that I accept the professional obligations placed on me in Good Medical Practice in relation to probity, including the statutory obligation on me to ensure that I have adequate professional indemnity for all my professional roles and the professional obligation on me to manage my interests appropriately. My HSC role is covered by DOH/employer indemnity in the understanding that it is the organisation that is indemnified and not the individual. In relation to other roles that require me to hold a licence to practise I have included relevant evidence in my supporting information in accordance with GMC/Employer requirements.

For further information see Useful Links for GMC guidance.

If you feel that you are unable to make this statement for whatever reason, please explain why below.

You must ensure you are appropriately covered and include evidence in your appraisal supporting information. If this is not possible within the timeframe of your appraisal meeting your appraiser will note this as an outstanding issue with an agreed resolution date. You must therefore make arrangements for adequate cover as a matter of priority, and when it is available your appraisal can be re-opened in order to include this evidence.

You must sign off the declaration below, which is subject to any explanations noted.

Appraisee Name

Young, Michael

Declaration ☑

☑

Date Mon Nov 11 2019

Form 6 - Signoff

Mitigating Circumstances

Circumstances mitigating against achieving full requirements

Appraisee Sign Off

Appraisal Completion

I confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan.

Appraisee Name

Young, Michael

Declaration ☑

Date Thu Dec 19 2019

Appraiser Checklist

To be completed by Appraiser

When appraisee has completed the appraisal, the appraiser should check the following:

GMC Required Information

Continuing Professional Development

Yes

Quality Improvement Activity

Yes

Significant Events Review

Yes

Review of Complaints and Compliments

Yes

Feedback from Colleagues

Yes

Year Undertaken (or Planned)

2018

Feedback from Patients

Yes

Year Undertaken (or Planned)

Appraisal Checklist

Check that all sections of the documentation have been completed

Yes

Ensure previous year's Personal Development Plan has been reviewed

Yes

Appraiser Sign Off

Appraisal Completion

I confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan.

Appraiser Name

McNaboe, Edward

Declaration ☑

Date Fri Dec 20 2019

Young, Michael(2846385) - 2019 appraisal

Form 1 - Background

Personal Details

Title Mr

Forename Michael

Surname Young

Division **Specialty** **Grade**

Optional Appraisal Start/End Dates

Appraisal Start Date 01/01/2019

Appraisal End Date 31/12/2019

GMC/GDC Registered Address Personal Information redacted by the USI

Personal Information

Personal Information

Postcode Personal Information

Contact Address (If different from above)

Contact Address

Postcode

Registration Details

Primary Medical or Dental Qualification (in the UK or elsewhere)

Qualification Date 04/08/1983

GMC/GDC Registration

Registration Type Full

Registration No 2846385

Registration Date 04/08/1984

Registration Specialty Urology

Specialty (Other)

Specialist Registration/Qualification outside the UK

Specialty --Please Select--

Specialty (If Other Give Details)

Date obtained

Country obtained / Awarding Body

Please list Other Specialties or Sub-Specialties in which you are registered.

Other Specialties / Sub-Specialties

Has your registration been called into question since your last appraisal (or if this is your first appraisal, is your registration in question)?

If Yes, Please Give Details

Date of next Revalidation 08/06/2023

Employers / Posts

Please list all employers / places of work

Employer Name	Address	Main Employer
southern Health and Social Servives Board	Craigavon Area Hospital 68 Lurgan Rd Portadown	Yes

Form 2 - Current Activities

Please give a short description of your work, including the different types of activity you undertake

I am a Consultant urologist with an interest in stone management.

Work involves a general outpatient clinic at the main hospital in Craigavon, Banbridge polyclinic and at the South West Acute Hospital. In addition I have a weekly specialised stone clinic. Other specialist areas include a session of urodynamics combined with oncology assessment clinics.

I have run the Stone Treatment Centre with a team of nurses and Radiographers to provide an ESWL service three times a week, for two decades. A stone MDT has been introduced in the past few years. This is attended by myself and two other consultants, Specialty Doctor, Stone team Nurse, Radiographer and administrative secretary.

Inpatient management involves ward rounds and weekly operating sessions as well as a monthly general anaesthetic day-surgery list. A supervisory role covers flexible cystoscopy lists performed by our SpRs and Specialty Doctors.

Ad hoc additional theatre lists, clinics and urodynamic sessions have been undertaken to help meet Health Dept targets.

The New patient investigative outpatient session in a dedicated urology unit and a Surgeon of the week for on-call has been a welcome inclusion to the job plan a few years ago and has been working well.

I have a weekly Private Practice clinic held at the Hillsborough Private Clinic with a monthly theatre and clinic session at the Ulster Independent Clinic.

The lead Clinician in Urology role has continued to evolve with the changes within the Trust and the development of the service.

I am also an Educational supervisor for one of our SpR trainees in urology, having been a Urology Training Program Director in the past

List your main Sub-specialist skills and commitments / special interests

- Director of Stone Treatment Centre.
- Provide Percutaneous Nephrolithotomy renal stone surgery service.
- Urodynamic

Details of any emergency, on-call and out-of-hours responsibilities

Participate in the Craigavon hospital Consultant Urologist Rota.

This was on a 1:2 rota when first employed, changed to 1:3 in 2006, 1:4 / 1:5 in 2012 and from mid 2014 has been 1:6.

(However due to vacancies and sabbatical, on-call rota has increased again)

Emergency and On-call work involves being Urologist of the Week. A full seven day stretch for daytime activity covering the ward rounds, referrals and associated emergency theatre needs. Triaging of GP and other referral letters is incorporated in this period, with the anticipation that advanced triage investigations are arranged if

possible. Emergency cover 'after hours' is also included and for the same period of time, though a mid-week break for one night is exchanged with a colleague. This principle also applies to weekend cover.

As Lead Clinician, I am contacted out of my usual hours about a variety of issues.

Details of out-patient work if applicable

Out-patient activity is solely urological.

This generally is three clinics per week but twice a month is four / five clinics a week.

Clinic type includes one stone clinic, one to two general clinics and a specialized clinic for urodynamics and oncology patients.

The SWAH clinic is an all day general clinic and a further outreach clinic is held in Banbridge polyclinic for Review patients.

The introduced Stone Meeting is a virtual clinic and is additional to the above.

Details of any other clinical work

Urological surgery is performed for day case and inpatients.

ESWL stone therapy is provided in the Stone Treatment Centre under my stewardship.

In which non-HSC hospitals and clinics do you enjoy practising privileges or have admitting rights?
Please give details including:
• Number and type of cases
• Any audit or outcome data for the private practice
• Details of any adverse events, critical incidents
• Details of any investigations into the conduct of your clinical practice or working relationships with colleagues

Private Practice privileges are held at the Hillsborough Private Clinic where outpatient consultations and local anaesthetic endoscopy / peno-scrotal surgery are undertaken. The majority of the endoscopy has been to date part of Contract work for the clinic on behalf of waiting list target workload for other Trusts. This has now ceased and such operations are solely on a private basis. Feedback has been given by the Clinic to the relevant Trusts. I am unaware of any issues. Several patient feedback questionaires have now been returned over the years with a very high satisfaction rating.

Monthly clinic and inpatient surgery is performed at the Ulster Independent Clinic. Operative work at the UIC is for endoscopic urology procedures.
I am unaware of any adverse incident on either site.

Case type is as per NHS practice with focus on peno-scrotal conditions, stone treatment and endoscopic prostate and bladder surgery.

List any non-clinical work that you undertake which relates to Teaching

Partake in the Regional Urology Forum for SpRs.

I am an Educational and clinical supervisor for Urology SpRs in Craigavon.
I have been a past Urology Program Director for Urology in Northern Ireland.
Medical Student rotate through Urology as part of their Surgical attachment in CAH.
Although having been a post-graduate examiner before, this role has lapsed.

List any non-clinical work that you undertake which relates to Management

Lead Clinician for Urology in Southern Trust.

Committee member for Regional Urology Review.

Past involvement Trust Clinical Management team
SAI report committee.

List any non-clinical work that you undertake which relates to Research

- Past mentor for M.D fellowship within Trust. However there has not been a Fellow for some years now due to a change in the urology training scheme in the UK.

  Partake in Audits undertaken by our Registrars.

  2018 Trust application for research project in Stone Treatment Centre - This projects continues with roll over into 2020

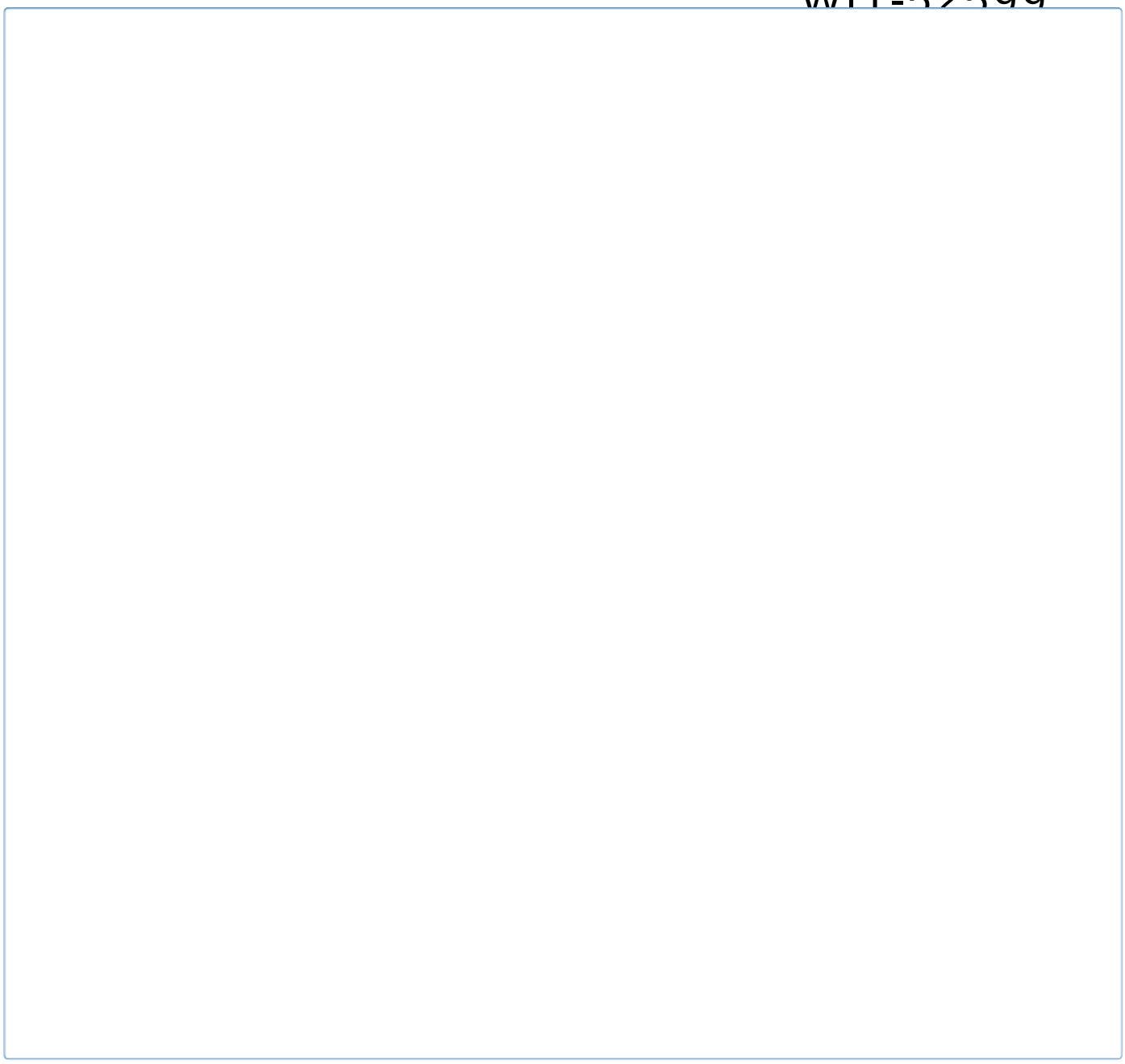
List any work you undertake for regional, national or international organisations

Member of Regional Urology review team and its sub-committees, both in 2009 and 2013.

Please list any other activity that requires you to be a registered medical practitioner

Member of the MDU

GMC registration.
Medicolegal Expert Witness – reports mainly for Trusts



Medical Education

Trainer Recognition

Are you a recognised trainer with the GMC

Yes ◉
No ○

Please list below Trainer Recognition/Discontinued Dates

Date of Recognition	Date Discontinued
22/09/2016	

Have you had an Annual Educational Review this year?

Yes ○
No ○

If Yes, please attach evidence of this year's educational review.

No File Attached

Undergraduate Medical Education

Do you have a formal role in Undergraduate Medical Education

Yes ○
No ◉

Description

Postgraduate Medical Education

Do you have a formal role in Postgraduate Medical Education

Yes ◉
No ○

Description

Urology Educational / clinical Supervisor for SpR urology trainee.

Form 3 - Supporting Information & Discussion

Document Library

Unordered Documents

Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3

Full Documents List

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
		Previous Appraisal 2018														
1		External reviewer for a submitted paper to the Ulster Medical Journal	31/12/2019		✓											
2		MDU to 2020	01/04/2020												✓	
3		Job plan 2019	11/11/2019	✓												
4		Ulster Independent Clinic Good Standing letter for 2019	31/03/2019				✓						✓			
5		BMJ hyponatraemia online course	12/02/2020	✓			✓	✓				✓				
6		Training Passport 2019	13/02/2020	✓			✓	✓						✓		
7		Mental Capacity training 4	06/12/2019	✓			✓						✓			
8		Mental Capacity Training 3a	06/12/2019	✓			✓						✓			
9		STC patient referral audit	12/11/2019		✓		✓			✓	✓	✓				
10		Fire Drill STC nov 19	12/11/2019					✓								
		Audit														

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
11		presentation to E.D – discussion outcome	30/11/2019							✓	✓					
12		Southern Trust Research Grant 2019	17/09/2019	✓		✓	✓									
13		Trilogy lithoclast probe enquiry report	12/09/2019					✓								
14		Trilogy report of incident	12/09/2019					✓								
15		Thank you email	10/09/2019								✓	✓		✓		
16		STC research Grant extension	09/09/2019		✓					✓						
17		Compliment for the Urology Unit	08/09/2019							✓	✓	✓	✓			
18		BAUS endourology meeting 2019	05/09/2019	✓	✓		✓									
19		Urology equipment issues	17/08/2019				✓	✓		✓						
20		Example of Urology M&M meeting	15/07/2019				✓				✓					
21		Review of CT KUB protocol	24/07/2019				✓				✓					
22		Stent Audit	18/07/2019		✓		✓				✓	✓	✓			
23		BAUS Annual Meeting	24/06/2019	✓	✓											
24		Example of THUGS meeting	06/06/2019		✓					✓	✓					
25		Chair of Thugs Meeting	06/06/2019							✓	✓					
26		Medical Student Feedback on urology	30/04/2019							✓	✓			✓		
		Locum urology														

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
27		hand-over issues	15/04/2019					✓			✓			✓		
28		Baus endourology meeting	06/09/2019	✓							✓					
29		letter good standing Hillsborough Private clinic	31/12/2019									✓	✓		✓	
30		CLIP report on clinical activity	08/06/2020	✓			✓									
31		Trainers contract	01/01/2019		✓					✓						
32		Learning from Stent QI audit	01/11/2019		✓		✓						✓			
33		Declaration absence of complaints	10/11/2020	✓			✓							✓		
34		Declaration absence Serious incidents	10/01/2020				✓						✓			
35		Reflection on research grant	31/12/2019		✓		✓				✓	✓		✓		
36		study leave document	31/12/2020		✓		✓									
37		M and M attendance report	31/12/2019	✓			✓					✓				
38		Educational supervisor role	31/12/2019							✓						

Domain 1 Knowledge, Skills and Performance

Documents

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	Actions
1		External reviewer for a submitted paper to the Ulster Medical Journal	31/12/2019		✓		
3		Job plan 2019	11/11/2019	✓			
5		BMJ hyponatraemia online course	12/02/2020	✓			
6		Training Passport 2019	13/02/2020	✓			
7		Mental Capacity training 4	06/12/2019	✓			
8		Mental Capacity Training 3a	06/12/2019	✓			
9		STC patient referral audit	12/11/2019		✓		
12		Southern Trust Research Grant 2019	17/09/2019	✓		✓	
16		STC research Grant extension	09/09/2019		✓		
18		BAUS endourology meeting 2019	05/09/2019	✓	✓		
22		Stent Audit	18/07/2019		✓		
23		BAUS Annual Meeting	24/06/2019	✓	✓		
24		Example of THUGS meeting	06/06/2019		✓		
28		Baus endourology meeting	06/09/2019	✓			
30		CLIP report on clinical activity	08/06/2020	✓			
31		Trainers contract	01/01/2019		✓		
32		Learning from Stent QI audit	01/11/2019		✓		
33		Declaration absence of complaints	10/11/2020	✓			
35		Reflection on research grant	31/12/2019		✓		
36		study leave document	31/12/2020		✓		
37		M and M attendance report	31/12/2019	✓			

Commentary

Appraisee Commentary

I am pleased with the research project into the further development of the STC and ESWL service - it is all very positive.

The BAUS meeting attendance was a great opportunity to met colleagues and discuss, in person, a variety of points I wished to find out how others addressed.

Content with CLIP report.

Stent audit was a productive study

Discussion

Discussion Summary

Michael has kept up to date with knowledge and skills in 2019. He attended the British Endourology Meeting in Sheffield and has always enjoyed this focused meeting.

He has provided evidence of online learning -BMJ hyponatraemia learning module.

He regularly attends internal teaching/training sessions in CAH.

His multidisciplinary ESWL project is ongoing and is part-funded by the Trust's Research Funding Programme. A paper is being prepared for the J Urological Nursing. An application to the BMJ Awards for QI projects has been submitted.

There are 5 consultants in the Department and the return of a Urology SpR from New Zealand in 2021 should allow him to reduce his workload and concentrate on setting up the Regional Day Elective Urology Centre in Lagan Valley.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
Maintain high standards in clinical care to patients	CPD, courses, conferences	31/12/2020	Already added to PDP

Domain 2 Safety and Quality

Documents

Order	Attd	Document Details	Applicable Date	2.1	2.2	2.3	Actions
4		Ulster Independent Clinic Good Standing letter for 2019	31/03/2019	✓			
5		BMJ hyponatraemia online course	12/02/2020	✓	✓		
6		Training Passport 2019	13/02/2020	✓	✓		
7		Mental Capacity training 4	06/12/2019	✓			
8		Mental Capacity Training 3a	06/12/2019	✓			
9		STC patient referral audit	12/11/2019	✓			
10		Fire Drill STC nov 19	12/11/2019		✓		
12		Southern Trust Research Grant 2019	17/09/2019	✓			
13		Trilogy lithoclast probe enquiry report	12/09/2019		✓		
14		Trilogy report of incident	12/09/2019		✓		
18		BAUS endourology meeting 2019	05/09/2019	✓			
19		Urology equipment issues	17/08/2019	✓	✓		
20		Example of Urology M&M meeting	15/07/2019	✓			
21		Review of CT KUB protocol	24/07/2019	✓			
22		Stent Audit	18/07/2019	✓			
27		Locum urology hand-over issues	15/04/2019		✓		
30		CLIP report on clinical activity	08/06/2020	✓			
32		Learning from Stent QI audit	01/11/2019	✓			
33		Declaration absence of complaints	10/11/2020	✓			
34		Declaration absence Serious incidents	10/01/2020	✓			
35		Reflection on research grant	31/12/2019	✓			
36		study leave document	31/12/2020	✓			
37		M and M attendance report	31/12/2019	✓			

Commentary

Appraisee Commentary

CLIP report as discussed in section 1

Stent audit has been a productive exercise for the department. Using more stents on strings now and shortening time of stents in situ as well as freeing up slots on the flexible cystoscopy lists for other patients.

Refinement of analgesia for ESWL a further produce excercise

Discussion

Discussion Summary

Michael has provided his CLIP report for 2019. As always, interpretation of data in CLIP reports is challenging, but allowed a discussion regarding av length of stay and other measures. One area of improvement Michael has achieved is in exceeding targets for N:R patient ratios at clinic: His was 1:5 originally and is now 1:1.

His ESWL QI project has important patient safety aspects embedded within it -they are investigating the optimal NSAID drug choice and dose to provide safe analgesia for patients receiving stone treatment and ensure that opioid analgesics are avoided.

He works well with colleagues and has addressed safety issues such as safe handover at 5.30pm when locum consultants begin a shift to provide overnight cover.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
Continue to lead the ESWL patient QI project and provide support to the Multidisciplinary team	Ongoing ESWL Project throughout 2020 and beyond	31/12/2020	Already added to PDP

Domain 3 Communication, Partnership and Teamwork

Documents

Order	Attd	Document Details	Applicable Date	3.1	3.2	3.3	Actions
5		BMJ hyponatraemia online course	12/02/2020			✓	
9		STC patient referral audit	12/11/2019	✓	✓	✓	
11		Audit presentation to E.D = discussion outcome	28/11/2019	✓	✓		
15		Thank you email	10/09/2019		✓	✓	
16		STC research Grant extension	09/09/2019	✓			
17		Compliment for the Urology Unit	08/09/2019	✓	✓	✓	
19		Urology equipment issues	17/08/2019	✓			
20		Example of Urology M&M meeting	15/07/2019		✓		
21		Review of CT KUB protocol	24/07/2019		✓		
22		Stent Audit	18/07/2019		✓	✓	
24		Example of THUGS meeting	06/06/2019	✓	✓		
25		Chair of Thugs Meeting	06/06/2019	✓	✓		
26		Medical Student Feedback on urology	30/04/2019	✓	✓		
27		Locum urology hand-over issues	15/04/2019		✓		
28		Baus endourology meeting	06/09/2019		✓		
29		letter good standing Hillsborough Private clinic	31/12/2019			✓	
31		Trainers contract	01/01/2019	✓			
35		Reflection on research grant	31/12/2019		✓	✓	
37		M and M attendance report	31/12/2019			✓	
38		Educational supervisor role	31/12/2019	✓			

Commentary

Appraisee Commentary

Continue as Lead Clinician which involves multidisciplinary meeting both within the department and with others

Discussion

Discussion Summary

Michael has been Clinical Lead for the Urology Team for many years and communicates effectively with them. He leads and supports the Stone Treatment Team.

He has letters of Good Standing from his Private Practices in UIC and HPC and there are no conflicts with his NHS Practice.

He is Chair of THUGS Meeting.

His ESWL Project involves a Urology Sp Doctor, nurse researcher, radiographer researcher, and a secretary. He oversees and encourages this group regularly.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
Continue with the current leadership roles	Ongoing evidence of roles and performance related to them in 2020 appraisal.	31/12/2020	Already added to PDP

Domain 4 Maintaining Trust

Documents

Order	Attd	Document Details	Applicable Date	4.1	4.2	4.3	Actions
2		MDU to 2020	01/04/2020			✓	
4		Ulster Independent Clinic Good Standing letter for 2019	31/03/2019	✓			
6		Training Passport 2019	13/02/2020		✓		
7		Mental Capacity training 4	06/12/2019	✓			
8		Mental Capacity Training 3a	06/12/2019	✓			
15		Thank you email	10/09/2019		✓		
17		Compliment for the Urology Unit	08/09/2019	✓			
22		Stent Audit	18/07/2019	✓			
26		Medical Student Feedback on urology	30/04/2019		✓		
27		Locum urology hand-over issues	15/04/2019		✓		
29		letter good standing Hillsborough Private clinic	31/12/2019	✓		✓	
32		Learning from Stent QI audit	01/11/2019	✓			
33		Declaration absence of complaints	10/11/2020		✓		
34		Declaration absence Serious incidents	10/01/2020	✓			
35		Reflection on research grant	31/12/2019		✓		

Commentary

Appraisee Commentary

Fulfilled most of the training passport as noting some expire during the year.

Private Practice good standing and confirming it matches my NHS activities.

Discussion

Discussion Summary

Michael has provided evidence of MDU membership and compliment letters from Urology service users. Feedback from Urology students mentioned some issues with teachers turning up at correct times for teaching session.

He has no health concerns and no probity issues.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
Continue to maintain and develop excellent working relationships with all staff members and service users	Awareness of the importance of this quality. Feedback/compliments evidence will be in 2020 appraisal	31/12/2020	Already added to PDP

Meeting Dates

Documents

Add a Meeting Date

Dates of meetings **Brief Details** **Actions**

No meeting dates saved.

Form 4 - Personal Development Plan

PDP Items from your previous appraisal are listed below.
Click Edit to Comment on progress and roll over to the new PDP if desired.

PDP Item	Development Need	Actions Agreed	Target Date	Achieved	How Achieved Details	Rolled Over
1	Review of Job plan as more endourology expected = Stone multidisciplinary meeting now up and running - not sure in job plan ? This was partial attained in terms of there being a weekly meeting but formal appreciation of this is required in the job plan		31/12/2019	Partially		Yes
2	Urology external meeting to maintain interest in endourology		31/12/2019	Yes		No
3	Complete review of job plan to acknowledge work load and field of interest		31/12/2019	Partially		Yes
4	as above	continue to keep up high level of skill and deliver high quality service within service limits	31/12/2019	Yes	Courses and Audits	No
5	positive outcomes of project actioned.	prospective project on stone treatment patient focused.	31/12/2019	Partially	on going research project	Yes
6	review of and updating of 360.	To upload 360 appraisal and make sure it is up to date for next revalidation	31/12/2019	Partially	review and update 360	Yes

Additional Previous PDP Information

Form 5 - Declarations

Health Declarations

Professional Obligations

I accept the professional obligations placed on me in paragraphs 28 to 30 of Good Medical Practice (2019) and where they apply I am taking appropriate action.

Appraisee Name

Young, Michael

Declaration ☑

Date Wed Nov 18 2020

Regulatory and Voluntary Proceedings

Since my last appraisal/revalidation I have not, in the UK or outside:
• Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
• Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

Appraisee Name

Young, Michael

Declaration ☑

Date Wed Nov 18 2020

OR If I have been subject to any of the above, I have discussed these with my appraiser.

Declaration ☐

Date

Probity Declarations

Professional Obligations

I accept the professional obligations placed upon me in paragraphs 65 to 80 of Good Medical Practice (2019).

Appraisee Name

Young, Michael

Declaration ☑

Date Wed Nov 18 2020

Convictions, findings against you and disciplinary action

Since my last appraisal/revalidation I have not, in the UK or outside:

• Been convicted of a criminal offense or have proceedings pending against me.

• Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.

• Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

Appraisee Name

Young, Michael

Declaration ☑

Date Wed Nov 18 2020

OR If I have been subject to any of the above, I have discussed these with my appraiser.

Declaration ☐

Date

Indemnity Declarations

Indemnity Declaration

I declare that I accept the professional obligations placed on me in Good Medical Practice in relation to probity, including the statutory obligation on me to ensure that I have adequate professional indemnity for all my professional roles and the professional obligation on me to manage my interests appropriately. My HSC role is covered by DOH/employer indemnity in the understanding that it is the organisation that is indemnified and not the individual. In relation to other roles that require me to hold a licence to practise I have included relevant evidence in my supporting information in accordance with GMC/Employer requirements.

For further information see Useful Links for GMC guidance.

If you feel that you are unable to make this statement for whatever reason, please explain why below.

You must ensure you are appropriately covered and include evidence in your appraisal supporting information. If this is not possible within the timeframe of your appraisal meeting your appraiser will note this as an outstanding issue with an agreed resolution date. You must therefore make arrangements for adequate cover as a matter of priority, and when it is available your appraisal can be re-opened in order to include this evidence.

You must sign off the declaration below, which is subject to any explanations noted.

Appraisee Name

Young, Michael

Declaration ☑

☑

Date Wed Nov 18 2020

Form 6 - Signoff

Mitigating Circumstances

Circumstances mitigating against achieving full requirements

Appraisee Sign Off

Appraisal Completion

I confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan.

Appraisee Name

Young, Michael

Declaration ☑

Date Thu Mar 04 2021

Appraiser Checklist

To be completed by Appraiser

When appraisee has completed the appraisal, the appraiser should check the following:

GMC Required Information

Continuing Professional Development

Yes

Quality Improvement Activity

Yes

Significant Events Review

Yes

Review of Complaints and Compliments

Yes

Feedback from Colleagues

Yes

Year Undertaken (or Planned)

2019

Feedback from Patients

Yes

Year Undertaken (or Planned)

Appraisal Checklist

Check that all sections of the documentation have been completed

Yes

Ensure previous year's Personal Development Plan has been reviewed

Yes

Appraiser Sign Off

Appraisal Completion

I confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan.

Appraiser Name

Murphy, Seamus

Declaration ☑

Date Thu Mar 04 2021

Young, Michael(2846385) - 2020 appraisal

Form 1 - Background

Personal Details

Title Mr

Forename Michael

Surname Young

Division **Specialty** **Grade**

Optional Appraisal Start/End Dates

Appraisal Start Date 01/01/2020

Appraisal End Date 31/12/2020

GMC/GDC Registered Address Personal Information redacted by the USI

Personal Information

Personal Information

Postcode Personal Information

Contact Address (If different from above)

Contact Address

Postcode

Registration Details

Primary Medical or Dental Qualification (in the UK or elsewhere)

Qualification Date 04/08/1983

GMC/GDC Registration

Registration Type Full

Registration No 2846385

Registration Date 04/08/1984

Registration Specialty Urology

Specialty (Other)

Specialist Registration/Qualification outside the UK

Specialty --Please Select--

Specialty (If Other Give Details)

Date obtained

Country obtained / Awarding Body

Please list Other Specialties or Sub-Specialties in which you are registered.

Other Specialties / Sub-Specialties

Has your registration been called into question since your last appraisal (or if this is your first appraisal, is your registration in question)?

If Yes, Please Give Details

Date of next Revalidation	08/06/2023

Employers / Posts

Please list all employers / places of work

Employer Name	Address	Main Employer
Southern Health and Social Services Board	Craigavon Area Hospital 68 Lurgan Rd Portadown	Yes

Form 2 - Current Activities

Please give a short description of your work, including the different types of activity you undertake

I am a Consultant urologist with an interest in stone management.

Work involves a general outpatient clinic at the main hospital in Craigavon as well as at Banbridge polyclinic and at the South West Acute Hospital (The SWAH clinic has now ceased). In addition I have a weekly specialised stone clinic. Other specialist areas include a session of urodynamics combined with oncology assessment clinics.

I run the Stone Treatment Centre with a team of nurses and Radiographers to provide an ESWL service three times a week. (The number of sessions have decreased from four to three sessions over the past year due to funding). A weekly stone MDT has been introduced.

Inpatient management involves ward rounds and weekly operating sessions as well as a monthly general anaesthetic day-surgery list. A supervisory role covers flexible cystoscopy lists performed by our SpRs and Specialty Doctors.

Ad hoc additional theatre lists, clinics and urodynamic sessions have been undertaken to help meet Health Dept targets.

The New patient investigative outpatient session and a Surgeon of the week for on-call has been a welcome inclusion to the job plan a few years ago and is working well.

I have a weekly Private Practice clinic held at the Hillsborough Private Clinic with a monthly theatre and clinic session at the Ulster Independent Clinic.

The lead Clinician in Urology role has continued to evolve with the changes within the Trust and the development of the service.
I am also the Educational supervisor for one of our SpR trainees in urology

List your main Sub-specialist skills and commitments / special interests

- Director of Stone Treatment Centre.
- Provide PCNL renal stone surgery service.
- Urodynamic

Details of any emergency, on-call and out-of-hours responsibilities

Participate in the Craigavon hospital Consultant Urologist Rota. This provides for after hours and weekend ward rounds and emergency theatre requirements. This was on a 1:2 rota when first employed, changed to 1:3 in 2006 and more recently to 1:4 / 1:5 in 2012 and from mid 2014 is now 1:6. (Autumn 2016 for 2 years was back to 1:5 due to a vacant post)

Details of out-patient work if applicable

Out-patient activity is solely urological. This generally is three clinics per week but twice a month is four / five clinics a week. Clinic type includes one stone clinic, one to two general clinics and a specialized clinic for urodynamics and oncology patients. The SWAH clinic is an all day general clinic and a further outreach clinic is held in Banbridge polyclinic for Review patients.

Details of any other clinical work

Urological surgery is performed on day case and inpatients.

ESWL stone therapy is provided in the Stone Treatment Centre under my stewardship.

Current Activities 2

In which non-HSC hospitals and clinics do you enjoy practising privileges or have admitting rights?
Please give details including:
• Number and type of cases
• Any audit or outcome data for the private practice
• Details of any adverse events, critical incidents
• Details of any investigations into the conduct of your clinical practice or working relationships with colleagues

Private Practice privileges are held at the Hillsborough Private clinic where outpatient consultations and local anaesthetic endoscopy / peno-scrotal surgery are undertaken. The majority of the endoscopy has been to date part of Contract work for the clinic on behalf of waiting list target workload for other Trusts. This has now ceased and such operations are solely on a private basis. Feedback has been given by the Clinic to the relevant Trusts. I am unaware of there being any issues. Several patient feedback questionaires have now been returned over the years with a very high satisfaction rating.

Monthly clinic and inpatient surgery is performed at the Ulster Independent Clinic. Operative work at the UIC is for endoscopic urology procedures.

I am unaware of any adverse incident on either site.

List any non-clinical work that you undertake which relates to Teaching

Partake in the Regional Urology teaching Forum for SpRs.

I am an Educational supervisor for one of our SpRs in Craigavon and am a past Urology Programme Director for Urology in Northern Ireland.
When asked, I am an undergraduate examiner, though have previously been a post graduate examiner also.

List any non-clinical work that you undertake which relates to Management

Lead Clinician for Urology in Southern Trust.

Committee member for Regional Urology Review.

Past involvement Trust Clinical Management team
SAI report committee.

List any non-clinical work that you undertake which relates to Research

- Past mentor for M.D fellowship within Trust. However there has not been a Fellow for some years now due to a change in the urology training scheme in the UK.

  Partake in Audits undertaken by our Registrars

  2018 Trust application for research project in Stone Treatment Centre - successful

List any work you undertake for regional, national or international organisations

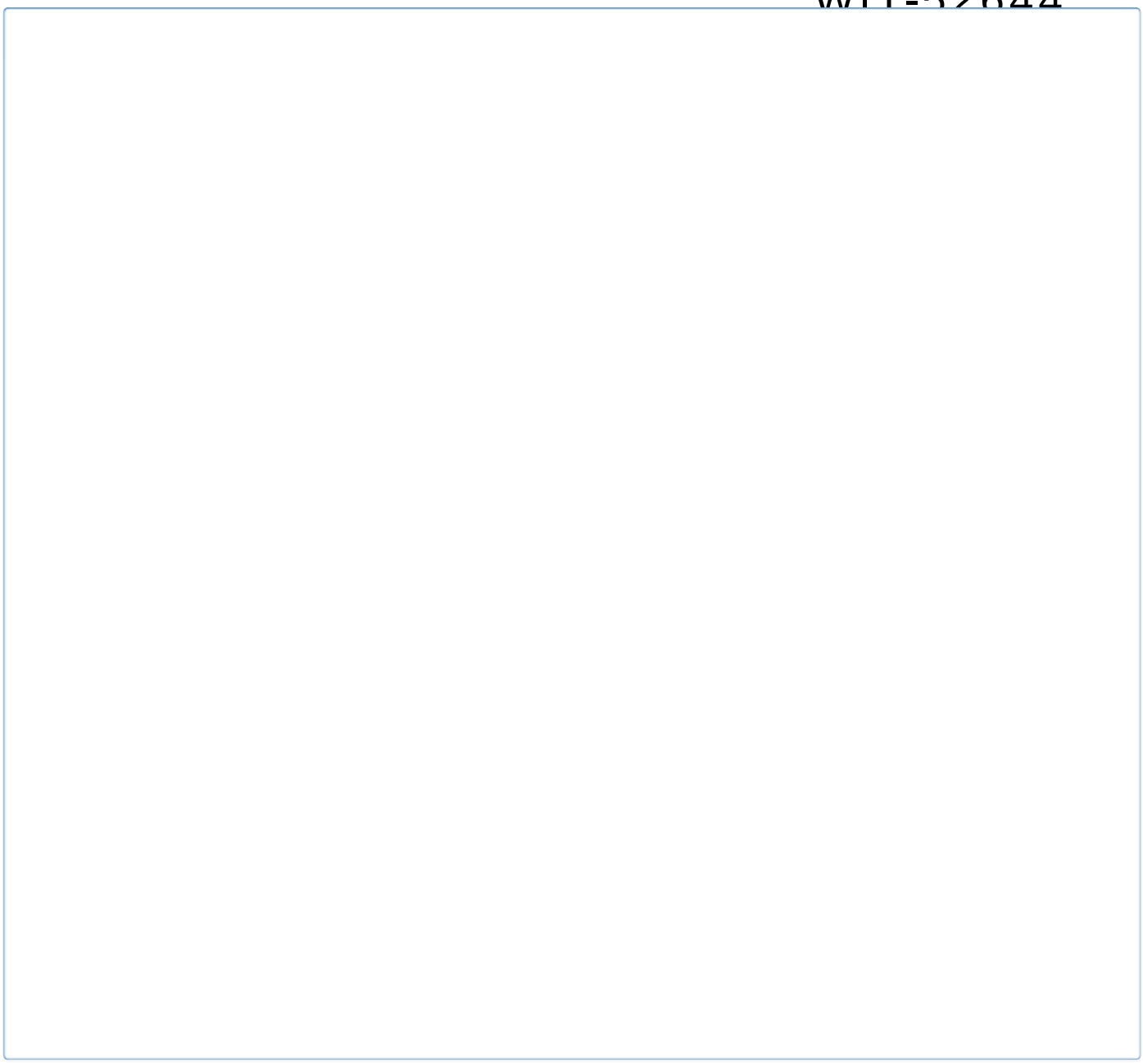
Member of Regional Urology review team and its sub-committees, both in 2009 and 2013.

Team leader of the Stone sub-committee for the proposed Day Elective Care Centres

Please list any other activity that requires you to be a registered medical practitioner

Member of the MDU

GMC registration.
Medicolegal Expert Witness – reports mainly for Trusts



Medical Education

Trainer Recognition

Are you a recognised trainer with the GMC

Yes ◉
No ○

Please list below Trainer Recognition/Discontinued Dates

Date of Recognition	Date Discontinued
22/09/2016	

Have you had an Annual Educational Review this year?

Yes ○
No ◉

If Yes, please attach evidence of this year's educational review.

No File Attached

Undergraduate Medical Education

Do you have a formal role in Undergraduate Medical Education

Yes ○
No ◉

Description

Postgraduate Medical Education

Do you have a formal role in Postgraduate Medical Education

Yes ◉
No ○

Description

Urology Educational Supervisor for SpR urology trainee.

Form 3 - Supporting Information & Discussion

Document Library

Unordered Documents

Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3

Full Documents List

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
		Previous Appraisal 2019														
		Previous Appraisal 2019														
1		Hyponariaemia BMJ training	17/03/2020	✓			✓	✓				✓				
2		Urology Cover for Covid period and Pharmacy colic pack	26/03/2020	✓	✓		✓	✓			✓					
3		SAI team member	29/09/2020		✓		✓			✓			✓			
4		Initial Draft plan Regional ESWL service	21/12/2020		✓		✓				✓					
5		Proposed Regional Day Elective Care Stone Service	23/12/2020		✓		✓				✓			✓		
6		Compliment to the Urology service	24/06/2021									✓	✓			
7		Compliment 2	18/02/2020									✓	✓			
8		Medical Student compliment	26/11/2020		✓					✓						
9		Passport updates	13/02/2020	✓					✓					✓		
10		PIG meeting for urology services	09/12/2020	✓				✓		✓	✓	✓				

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
11		Urology cover in DHH out of session time	21/10/2020					✓			✓					
12		Ethical approval re Pentrox	06/02/2020				✓	✓			✓	✓	✓		✓	
13		advice sheet of emergency colic during covid time	30/03/2020				✓					✓				
14		Fire Drill for STC	01/10/2020				✓	✓					✓			
15		Earl of Caledon letter	01/12/2020										✓		✓	
16		Mandatory Training	31/12/2020	✓			✓								✓	
17		BAUS annual Meeting CME certificate	27/11/2020	✓	✓		✓									
18		BAUS membership certification	01/01/2020	✓											✓	
19		Regional Urology Attendance	16/01/2020	✓			✓									
20		Review of Article for Ulster Medical Journal	02/03/2020		✓											
21		THUG meeting Attendance	06/02/2020								✓					
22		PIG meeting re Day surgery stone	21/10/2020				✓				✓					
23		Leads Team members in pathway services	26/03/2020				✓	✓			✓					
24		STC audit programme	04/03/2020	✓			✓				✓					
25		STC attendance	07/10/2020				✓									
26		M and M report	31/12/2020	✓			✓									
27		Study Leave	31/12/2020	✓												

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
28		Complaint section	31/12/2020													
29		Clip report	31/12/2020	✓												
30		CPD	31/12/2020	✓												
31		BAUS Membership	17/01/2021	✓								✓			✓	
32		UIC Good standing letter	06/06/2021				✓			✓					✓	
33		HPS letter of Good Standing	06/06/2021				✓					✓	✓			
34		FIT test	12/04/2020						✓				✓		✓	
35		GMC document	01/08/2020				✓								✓	
36		MDU	01/04/2020				✓								✓	
37		ICO document	01/01/2020									✓			✓	
38		Structure Reflective Template Covid times	09/08/2021		✓		✓	✓		✓	✓	✓		✓		

Domain 1 Knowledge, Skills and Performance

Documents

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	Actions
1		Hyponariaemia BMJ training	17/03/2020	✓			
2		Urology Cover for Covid period and Pharmacy colic pack	26/03/2020	✓	✓		
3		SAI team member	29/09/2020		✓		
4		Initial Draft plan Regional ESWL service	21/12/2020		✓		
5		Proposed Regional Day Elective Care Stone Service	23/12/2020		✓		
8		Medical Student compliment	26/11/2020		✓		
9		Passport updates	13/02/2020	✓			
10		PIG meeting for urology services	09/12/2020	✓			
16		Mandatory Training	31/12/2020	✓			
17		BAUS annual Meeting CME certificate	27/11/2020	✓	✓		
18		BAUS membership certification	01/01/2020	✓			
19		Regional Urology Attendance	16/01/2020	✓			
20		Review of Article for Ulster Medical Journal	02/03/2020		✓		
24		STC audit programme	04/03/2020	✓			
26		M and M report	31/12/2020	✓			
27		Study Leave	31/12/2020	✓			
29		Clip report	31/12/2020	✓			
30		CPD	31/12/2020	✓			
31		BAUS Membership	17/01/2021	✓			
38		Structure Reflective Template Covid times	09/08/2021		✓		

Commentary

Appraisee Commentary

Despite the Covid years I have managed to keep up to date.

I feel the CLIP report is reasonable.

The reflective template on COvid was a exercise to have reflected upon and actually has changed how I carry out my job

Discussion

Discussion Summary

Attended urology meetings and conference for CPD. Also supplemented by journal reviews.

Good evidence to support knowledge.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
Maintain knowledge through BAUS educational program	Recorded ZOOM meeting.	31/12/2020	

Domain 2 Safety and Quality

Documents

Order	Attd	Document Details	Applicable Date	2.1	2.2	2.3	Actions
1		Hyponariaemia BMJ training	17/03/2020	✓	✓		
2		Urology Cover for Covid period and Pharmacy colic pack	26/03/2020	✓	✓		
3		SAI team member	29/09/2020	✓			
4		Initial Draft plan Regional ESWL service	21/12/2020	✓			
5		Proposed Regional Day Elective Care Stone Service	23/12/2020	✓			
9		Passport updates	13/02/2020			✓	
10		PIG meeting for urology services	09/12/2020		✓		
11		Urology cover in DHH out of session time	21/10/2020		✓		
12		Ethical approval re Pentrox	06/02/2020	✓	✓		
13		advice sheet of emergency colic during covid time	30/03/2020	✓			
14		Fire Drill for STC	01/10/2020	✓	✓		
16		Mandatory Training	31/12/2020	✓			
17		BAUS annual Meeting CME certificate	27/11/2020	✓			
19		Regional Urology Attendance	16/01/2020	✓			
22		PIG meeting re Day surgery stone	21/10/2020	✓			
23		Leads Team members in pathway services	26/03/2020	✓	✓		
24		STC audit programme	04/03/2020	✓			
25		STC attendance	07/10/2020	✓			
26		M and M report	31/12/2020	✓			
28		Complaint section	31/12/2020	✓			
32		UIC Good standing letter	06/06/2021	✓			
33		HPS letter of Good Standing	06/06/2021	✓			
34		FIT test	12/04/2020			✓	
35		GMC document	01/08/2020	✓			
36		MDU	01/04/2020	✓			

Order	Attd	Document Details	Applicable Date	2.1	2.2	2.3	Actions

Commentary

Appraisee Commentary

The Stone service research continues

I am the lead for the regional Day surgery stone service development proposed for the Lagan Valley Hospital

Discussion

Discussion Summary

Involved in the SAI process.

Complaint received - reflected upon and discussed.

Detailed SRT reviewed and discussed r.e exceptional working circumstances during covid.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
Complete outstanding areas of training passport	On line modules	31/12/2020	

Domain 3 Communication, Partnership and Teamwork

Documents

Order	Attd	Document Details	Applicable Date	3.1	3.2	3.3	Actions
1		Hyponariaemia BMJ training	17/03/2020			✓	
2		Urology Cover for Covid period and Pharmacy colic pack	26/03/2020		✓		
3		SAI team member	29/09/2020	✓			
4		Initial Draft plan Regional ESWL service	21/12/2020		✓		
5		Proposed Regional Day Elective Care Stone Service	23/12/2020		✓		
6		Compliment to the Urology service	24/06/2021			✓	
7		Compliment 2	18/02/2020			✓	
8		Medical Student compliment	26/11/2020	✓			
10		PIG meeting for urology services	09/12/2020	✓	✓	✓	
11		Urology cover in DHH out of session time	21/10/2020		✓		
12		Ethical approval re Pentrox	06/02/2020		✓	✓	
13		advice sheet of emergency colic during covid time	30/03/2020			✓	
21		THUG meeting Attendance	06/02/2020		✓		
22		PIG meeting re Day surgery stone	21/10/2020		✓		
23		Leads Team members in pathway services	26/03/2020		✓		
24		STC audit programme	04/03/2020		✓		
28		Complaint section	31/12/2020	✓			
31		BAUS Membership	17/01/2021			✓	
32		UIC Good standing letter	06/06/2021	✓			
33		HPS letter of Good Standing	06/06/2021			✓	
37		ICO document	01/01/2020			✓	
38		Structure Reflective Template Covid times	09/08/2021	✓	✓	✓	

Commentary

Appraisee Commentary

Departmental meetings will be a great asset to restart again

Discussion

Discussion Summary

Good evidence of team working and also personal compliments. Discussed at length.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
continue with effective team building work.	re-instigated department meeting. ensure attendance. to include nursing and admin staff.	27/10/2021	

Domain 4 Maintaining Trust

Documents

Order	Attd	Document Details	Applicable Date	4.1	4.2	4.3	Actions
3		SAI team member	29/09/2020	✓			
5		Proposed Regional Day Elective Care Stone Service	23/12/2020		✓		
6		Compliment to the Urology service	24/06/2021	✓			
7		Compliment 2	18/02/2020	✓			
9		Passport updates	13/02/2020		✓		
12		Ethical approval re Pentrox	06/02/2020	✓		✓	
14		Fire Drill for STC	01/10/2020	✓			
15		Earl of Caledon letter	01/12/2020	✓		✓	
16		Mandatory Training	31/12/2020			✓	
18		BAUS membership certification	01/01/2020			✓	
28		Complaint section	31/12/2020	✓			
31		BAUS Membership	17/01/2021			✓	
32		UIC Good standing letter	06/06/2021			✓	
33		HPS letter of Good Standing	06/06/2021	✓			
34		FIT test	12/04/2020	✓		✓	
35		GMC document	01/08/2020			✓	
36		MDU	01/04/2020			✓	
37		ICO document	01/01/2020			✓	
38		Structure Reflective Template Covid times	09/08/2021		✓		

Commentary

Appraisee Commentary

Maintain the necessary educational activity and communication from all the relevant hospital worked in

Discussion

Discussion Summary

complaint reflection evidenced.

Compliments reviewed.

Good personal health.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
Maintain mental and physical health	Balanced worklife. Exercise	31/12/2020	

Meeting Dates

Documents

Add a Meeting Date

Dates of meetings **Brief Details** **Actions**

No meeting dates saved.

Form 4 - Personal Development Plan

Previous PDP

PDP Items from your previous appraisal are listed below.
Click Edit to Comment on progress and roll over to the new PDP if desired.

PDP Item	Development Need	Actions Agreed	Target Date	Achieved	How Achieved Details	Rolled Over
1	Continue developing the stone service via the Research grant provisions		31/12/2021	Partially		Yes
2	Attend external Urology meeting to maintain knowledge		31/12/2020	Yes		No
3	Educational supervisor role training updates		31/12/2021	Partially		Yes
4	Excellent working relationships	Continue to maintain and develop excellent working relationships with all staff members and service users	31/12/2020	Yes	Awareness of the importance of this quality. Feedback/compliments evidence will be in 2020 appraisal	No
5	Leadership qualities	Continue with the current leadership roles	31/12/2020	Yes	Ongoing evidence of roles and performance related to them in 2020 appraisal.	No
6	ESWL Project success	Continue to lead the ESWL patient QI project and provide support to the Multidisciplinary team	31/12/2020	Partially	Ongoing ESWL Project throughout 2020 and beyond	Yes
7	Course attendance in 2020	Maintain high standards in clinical care to patients	31/12/2020	Yes	CPD, courses, conferences	No
8	Review of Job plan as more endourology expected = Stone multidisciplinary meeting now up and running - not sure in job plan ? This was partial attained in terms of there being a weekly meeting but formal appreciation of this is required in the job plan		31/12/2019	Yes		No
9	Complete review of job plan to acknowledge work load and field of interest		31/12/2019	Yes		No

PDP Item	Development Need	Actions Agreed	Target Date	Achieved	How Achieved Details	Rolled Over
10	positive outcomes of project actioned.	prospective project on stone treatment patient focused.	31/12/2019	Yes	on going research project	No
11	review of and updating of 360.	To upload 360 appraisal and make sure it is up to date for next revalidation	31/12/2019	No	review and update 360	Yes

Additional Previous PDP Information

N/A

Form 5 - Declarations

Health Declarations

Professional Obligations

I accept the professional obligations placed on me in paragraphs 28 to 30 of Good Medical Practice (2019) and where they apply I am taking appropriate action.

Appraisee Name

Young, Michael

Declaration ☑

Date Mon Aug 09 2021

Regulatory and Voluntary Proceedings

Since my last appraisal/revalidation I have not, in the UK or outside:
• Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
• Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

Appraisee Name

Young, Michael

Declaration ☑

Date Mon Aug 09 2021

OR If I have been subject to any of the above, I have discussed these with my appraiser.

Declaration ☐

Date

Probity Declarations

Professional Obligations

I accept the professional obligations placed upon me in paragraphs 65 to 80 of Good Medical Practice (2019).

Appraisee Name

Young, Michael

Declaration ☑

Date Mon Aug 09 2021

Convictions, findings against you and disciplinary action

Since my last appraisal/revalidation I have not, in the UK or outside:

• Been convicted of a criminal offense or have proceedings pending against me.

• Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.

• Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

Appraisee Name

Young, Michael

Declaration ☑

Date Mon Aug 09 2021

OR If I have been subject to any of the above, I have discussed these with my appraiser.

Declaration ☐

Date

Indemnity Declarations

Indemnity Declaration

I declare that I accept the professional obligations placed on me in Good Medical Practice in relation to probity, including the statutory obligation on me to ensure that I have adequate professional indemnity for all my professional roles and the professional obligation on me to manage my interests appropriately. My HSC role is covered by DOH/employer indemnity in the understanding that it is the organisation that is indemnified and not the individual. In relation to other roles that require me to hold a licence to practise I have included relevant evidence in my supporting information in accordance with GMC/Employer requirements.

For further information see Useful Links for GMC guidance.

If you feel that you are unable to make this statement for whatever reason, please explain why below.

You must ensure you are appropriately covered and include evidence in your appraisal supporting information. If this is not possible within the timeframe of your appraisal meeting your appraiser will note this as an outstanding issue with an agreed resolution date. You must therefore make arrangements for adequate cover as a matter of priority, and when it is available your appraisal can be re-opened in order to include this evidence.

You must sign off the declaration below, which is subject to any explanations noted.

Appraisee Name

Young, Michael

Declaration ☑

☑

Date Mon Aug 09 2021

Form 6 - Signoff

Mitigating Circumstances

Circumstances mitigating against achieving full requirements

Appraisee Sign Off

Appraisal Completion

I confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan.

Appraisee Name

Young, Michael

Declaration ☑

Date Wed Oct 27 2021

Appraiser Checklist

To be completed by Appraiser

When appraisee has completed the appraisal, the appraiser should check the following:

GMC Required Information

Continuing Professional Development

Yes

Quality Improvement Activity

Yes

Significant Events Review

Yes

Review of Complaints and Compliments

Yes

Feedback from Colleagues

No

Year Undertaken (or Planned)

2021

Feedback from Patients

No

Year Undertaken (or Planned)

Appraisal Checklist

Check that all sections of the documentation have been completed

Yes

Ensure previous year's Personal Development Plan has been reviewed

Yes

Appraiser Sign Off

Appraisal Completion

I confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan.

Appraiser Name

Holmes, Erskine Joseph

Declaration ☑

Date Wed Oct 27 2021

FORM 4 - SUMMARY OF APPRAISAL DISCUSSION WITH AGREED ACTION AND PERSONAL DEVELOPMENT PLAN

The aim of this section is to provide an agreed summary of the appraisal discussion based on the documents listed on **Form 3** and a description of the action agreed in the course of the appraisal, including those forming the personal development plan.

This form should be completed by the appraiser and agreed by the appraisee. Under each heading the appraiser should explain which of the documents listed in **Form 3** informed this part of the discussion, the conclusion reached and say what if any action has been agreed.

SUMMARY OF APPRAISAL DISCUSSION

1. Good medical care

Commentary: Mr Young has continued registration with the general medical council and membership of the Medical Defence Union. He also is a member BAUS. He works at Craigavon Area Hospital and has admitting rights to the Ulster Independent Clinic and facilities at Hillsborough Private Clinic. He submitted a log of his work load. The figures have also been submitted to National Audit and he is satisfied with his case mix and numbers. He is currently Lead Clinician and is partaking in a review of Urological services being undertaken with the province.
Action agreed:

2. Maintaining good medical practice

Commentary: Mr Young has achieved the expected CME and CBD for both internal and external points. He has been submitting his data for national audit on laparoscopic surgery as well as PCNL. He also regularly attends the local M&M meetings.
Action agreed: It would be useful to have a summary of internal/external CME points for future appraisal folders.

3. Working relationships with colleagues

Commentary: No problems identified. Appears to be well respected and hard working member of the team indicated by increasing role in Committee work and Management work in Multi-professional and Multi-disciplinary areas with Nurse Specialist, Consultant colleagues and management/administration staff.
Action agreed:

4. Relations with patients

Commentary:
No medical legal cases pending. Has documented the three complaints against him two of which are currently closed. Has included folder of thank you letters and cards. Involved in many aspects of teaching and training.

Action agreed:

5. Teaching and training

Commentary:
Until recently was Programme Director for Urology in N Ireland. Currently he is Educational Supervisor for two trainees in Craigavon Area Hospital and has been involved in giving talks to GP's and other groups including the hospital Clinical Meeting.

Action agreed:

6. Probity

Commentary: No problems identified.
Action agreed: Discussed how to produce a probity form based on GMC Good Medical Practice.

7. Health

Commentary: No problems identified.
Action agreed: We have discussed how to complete a form based on Guidance in Good Medical Practice.

8. Any other points

Commentary: The changes to Urological Services over the past 18 months have been discussed, in particular he felt the closure of the Urology Ward had a negative impact on Urology but currently is happy with the arrangements of the ward in 3 South.
Action agreed:

PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should identify key development objectives for the year ahead, which will relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met on the template provided here.

Consultants approaching retirement age may well wish to consider their retirement intentions and actions that could be taken to retain their contribution to the HPSS.

The important areas to cover are:

- action to maintain skills and the level of service to patients
- action to develop or acquire new skills
- action to change or improve existing practice

PERSONAL DEVELOPMENT TEMPLATE

This should be used to inform discussion on development provided for on ***Form 4****. It should be updated whenever there has been a change - either when a goal is achieved or modified or where a new need is identified.*

What development needs have I?	**How will I address them?**	**Date by which I plan to achieve the development goal**	**Outcome**	**Completed**
Explain the need.	*Explain how you will take action, and what resources you will need.*	*The date agreed with your appraiser for achieving the development goal.*	*How will your practice change as a result of the development activity?*	*Agreement from your appraiser that the development need has been met.*
1. BAUS guidance would suggest all operations need to be entered into a log book.	Looking towards BAUS web site for advice regarding entering same. Also possibility of using TMS to obtain the data.	Plans to engage with same during 2011.		
2.				
3.				
4. etc				

SIGN OFF

We agree that the above is an accurate summary of the appraisal discussion and agreed action, and of the agreed personal development plan.

Appraiser: [redacted] Date: 27/10/10

GMC/GDC Number: 2646042

Appraisee: [redacted] Date: 27/10/10

Record here the names of any third parties who contributed to the appraisal and indicate the capacity in which they did so.

Southern Health and Social Care Trust
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MEDICAL APPRAISAL DOCUMENTS & CHECKLIST

PLEASE USE THESE FORMS FOR CALENDAR YEAR JANUARY TO DECEMBER 2015 ONWARDS

Remember to include:- *[Please ensure **all** boxes are checked before returning the documentation – simply click on the box to put an 'X' in it]*	✓
Your name, GMC No, and the appraisal period covered in the footer of the forms. Simply double-click on the relevant section at the bottom of the document.	☑
Evidence of Reflection on Practice and use of Structured Reflective Templates – click here	☑
Evidence of Research Activity (if applicable)	☑
Have accounted for 100% Attendance / non-Attendance at all M&M / Patient Safety / Governance or equivalent Meetings throughout the year	☑
Have reflected on a Significant Event and included implications for own practice or have used the M&M SBAR Template with appropriate detail of involvement – click here	☑
Evidence of Regular Participation in Clinical Audit	☑
Remember to send the following:- *[Please ensure **all** boxes are checked before returning the documentation – simply click on the box to put an 'X' in it]*	✓
FRONT PAGE CHECKLIST – with all boxes ticked	☐
FORM 1 – all parts completed by Appraisee	☑
FORM 2 – all parts completed by Appraisee to include whole practice i.e. Private / Medico Legal Work etc.	☑
FORM 3 – All four GMP Domains completed jointly by Appraisee and Appraiser to include list of supporting information and evidence of the discussion that took place during the appraisal meeting – click here	☑
FORM 3 – Inclusion of agreed actions against all four GMP domains – click here	☑
FORM 4 – Review of Last Year's PDP	☑
FORM 4 – PDP for the Year Ahead Developed from the Discussions Around the Four GMP Domains – click here	☑
FORM 5 – all parts completed with FIVE signatures, one for each section	☑
FORM 6 – completed, signed and dated by both Appraisee & Appraiser	☑
FORM 7 – Completed in respect of where the appraisee is in their forthcoming Revalidation Cycle i.e. Year 1, 2, 3 etc. Please ensure last section also completed in relation to whether the Revalidation Requirements have been met or when they are proposed to be met.	☑
APPENDIX 1 – all parts completed, signed and dated by Appraisee & Appraiser	☑
APPENDIX 2 – NOT REQUIRED / COMPLETE AND KEEP FOR YOUR OWN RECORDS	☐

PLEASE DO NOT SUBMIT THESE FORMS UNLESS ALL OF THE ABOVE BOXES HAVE BEEN TICKED AS THEY WILL NOT BE ACCEPTED FOR PROCESSING.

You can submit the documentation by scanning and emailing the original signed copies to:-

[redacted] Irrelevant information redacted by the USI

Or send the signed originals by internal mail to the Revalidation Support Team at the address below where they will be scanned in, saved and returned to you:- (Copies will not be accepted).

Revalidation Support Team, Medical Directorate, Clanrye House, DHH.

For further guidance and FAQ's – click here

Southern Health and Social Care Trust
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APPRAISAL DOCUMENTS

CONTENTS

FORM 1 - BACKGROUND DETAILS

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.*
- *The form includes an optional section for any additional information – click here to navigate to the relevant guidance in Appendix 4 of these forms.*

1.1	Full name	Mr Michael Robert Andrew YOUNG
1.2	GMC Registered address (contact address if different)	[redacted] Personal Information redacted by the USI
1.3	Main employer	Southern Trust Northern Ireland
1.4	Main place of work	Craigavon Area Hospital
1.5	Other employers/ places of work	Nil
1.6	Date of primary medical qualification	July 1983 MB BCh BAO
1.7	GMC registration number and type	2846385 Full
1.8	Start date of first substantive appointment in HSC as a trained doctor	August 1983 and Consultant Post May 1998
1.8	GMC Registration date and specialties	Urology 2Nd April 1998
1.9	Title of current post and date appointed	Consultant Urologist 1 st May 1998
1.10	For any specialist registration / qualification outside UK, please give date and specialty	--
1.11	Please list any other specialties or sub-specialties in which you are registered	--
1.12	Is your registration currently in question?	No
1.13	Date of last revalidation (if applicable)	June 2013
1.14	Please list all posts in which you have been employed in HSC and elsewhere	Southern Trust Health and social Care Northern Ireland

in the last five years (including any honorary and/or part-time posts)	

ANY ADDITIONAL INFORMATION

Consultant in urological surgery – general practice with specific interest in stone management.
Work involves outpatient clinics in the main hospital in Craigavon and at two outreach site, Banbridge and the new South West Acute Hospital in Enniskillen (attendance at the Armagh, previously undertaken on a monthly basis, has now been discontinued for several years). In addition, a regular specialised stone clinic is undertaken weekly. Inpatient management involves ward rounds and weekly operating sessions as well as a monthly day-surgery list. Other fixed commitments have included two specialised stone sessions (ESWL). Other areas covered include urodynamic sessions and administration. My lead Clinician role in Urology has continued to evolve with the changes within the Trust and the development of the service.
My job description generally has remained unchanged from previous appraisals though ad hoc additional theatre lists, clinics and urodynamic sessions have been undertaken to help meet targets.

Recent chances however have resulted in moving the out-reach clinics to a different time slot to accommodate the additional clinical session of urology uro-oncology MDT. This has further changed from my last appraisal. My New patient clinic now runs on a Thursday afternoon and clashes with Oncology MDT. I have been unable to attend this meeting over the past year despite attempting to gain a time slot to attend.

The External Regional Review of Urology services for Northern Ireland has resulted in several changes. Additional consultant colleagues have joined the unit and this has resulted in further stability within the unit. We work on the Consultant of the Week principle and again this has been up and running for at least three years.

The New Urology investigative Unit also has been up and running within the main hospital building.

I am a member of the following medical associations:

Fellow of the Royal College Surgeons in Ireland
British Association of Urological Surgeons
BAUS subsection of Endourology
British Medical Association

Medical Defence Union

FORM 2 - CURRENT MEDICAL ACTIVITIES

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.*
- *Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.*
- *You may wish to comment in addition on factors which affect the provision of good health care.*

Click here to navigate to the relevant guidance in Appendix 2.

2.1 Please give a short description of your work, including the different types of activity you undertake	I am a Consultant urologist with an interest in stone management. Work involves a general outpatient clinic at the main hospital in Craigavon, Banbridge outreach polyclinic and at the South West Acute Hospital. In addition I have a weekly specialised stone clinic. Other specialist areas include a session of urodynamics combined with oncology assessment clinics. I run the Stone Treatment Centre with a team of nurses and Radiographers to provide an ESWL service three times a week. (The number of sessions have decreased from four to three sessions over the past year due to funding). Inpatient management involves ward rounds and weekly operating sessions as well as a monthly general anaesthetic day-surgery list. A supervisory role covers flexible cystoscopy lists performed by our SpRs and Specialty Doctors. Ad hoc additional theatre lists, clinics and urodynamic sessions have been undertaken to help meet Health Dept targets. The recently introduced New patient investigative outpatient session and a Surgeon of the week for on-call has been a welcome inclusion to the job plan. I have a weekly Private Practice clinic held at the Hillsborough Private Clinic with a monthly theatre and clinic session at the Ulster Independent Clinic. The lead Clinician in Urology role has continued to evolve with the changes within the Trust and the development of the service. I am also the Educational supervisor for one of our SpR trainees in urology
2.2 List your main sub-specialist skills and commitments / special interests	- Director of Stone Treatment Centre. - Provide PCNL renal stone surgery service. - Laparoscopic urological procedures have now been taken over by one of my colleagues - Urodynamic

2.3 Please give details of any emergency, on-call and out of hours responsibilities	Participate in the Craigavon hospital Consultant Urologist Rota. This provides for after hours and weekend ward rounds and emergency theatre requirements. This was on a 1:2 rota when first employed, changed to 1:3 in 2006 and more recently to 1:4 / 1:5 in 2012 and from mid 2014 is now 1:6. Since late Autumn 2016 this is down to 1:5 with a locum week to cover (due to an unfilled Consultant post)
2.4 Please give details of out-patient work if applicable	Out-patient activity is solely urological. This routinely is three clinics per week but twice a month is four / five clinics a week. Clinic type includes one stone clinic, one to two general clinics and a specialized clinic for urodynamics and oncology patients. The SWAH clinic is an all day general clinic and a further outreach clinic is held in Banbridge polyclinic is for Review patients.
2.5 Details of any other clinical work	Urological surgery is performed on day case and inpatients. ESWL stone therapy is provided in the Stone Treatment Centre under my stewardship.
2.6 In which non-HSC hospitals and clinics do you enjoy practicing privileges or have admitting rights? Please give details including: ▪ Number and type of cases. ▪ Any audit or outcome data for the private practice. ▪ Details of any adverse events, critical incidents. ▪ Details of any investigations into the conduct of your clinical practice or working relationships with colleagues	Private Practice privileges are held at the Hillsborough Private clinic where outpatient consultation and local anaesthetic endoscopy is performed. The majority of the endoscopy has been part of Contract work for the clinic on behalf of waiting list target workload for other Trusts. There has been little of this over the past year or so. Feedback is given by the Clinic to the relevant Trusts. Monthly clinic and inpatient surgery is performed at the Ulster Independent Clinic. Operative work at the UIC is endoscopic based procedures in addition to day-case urology. I am unaware of any adverse incident on either site.
2.7 List any non-clinical work that you undertake which relates to teaching	Partake in the Regional Urology teaching Forum for SpRs. I am an Educational supervisor for one of our SpRs in Craigavon and am a past Urology Programme Director for Urology in Northern Ireland. I am an undergraduate examiner, though have previously been a post graduate examiner also.
2.7.1 List any non-clinical work that you undertake which relates to management	Lead Clinician for Urology in Southern Trust Committee member for Regional Urology Review Trust Clinical Management team SAI report committee.

2.7.2 List any non-clinical work that you undertake which relates to research	- Past mentor for M.D fellowship within Trust. However there has not been a Fellow for some years now due to a change in the urology training scheme in the UK. - Partake in Audits undertaken by our Registrars
2.7.3 List any work you undertake for regional, national or international organisations.	Member of Regional Urology review team and its sub-committees, both in 2009 and 2013.
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	Member of the MDU GMC registration. Medicolegal Expert Witness – reports mainly for Trusts

CURRENT JOB PLAN

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

No particular change had occurred during the initial six months but with the arrival of the sixth consultant urologist, 'blue sky' thinking and introduction of the new approach to delivering outpatients and 'surgeon of the week', has indeed altered how work is delivered. Overall however the principle of delivery and volume of work has maintained the same PA contribution. My job plan is unchanged from last year though due to commitment to my new patient clinic it has not been possible to attend Oncology MDT this past year.

ADDITIONAL INFORMATION

Please use to record issues which impact upon delivery of patient care.

The variability in the Consultant numbers with the employment of three new consultants at one interview several years ago, their arrival and subsequent departure of two, had impacted on service delivery in previous years.
For the last four years however, the unit is now much more stable with a complement of six consultants, two SpRs and a Staff Grade Fellow.

FORM 3 - SUPPORTING INFORMATION & SUMMARY OF APPRAISAL DISCUSSION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 1 - Knowledge, Skills and Performance

Attribute: 1.1 Maintain your professional performance
Attribute: 1.2 Apply knowledge and experience to practice
Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.

	List of Supporting Information	Applicable Date
1	Job Plan	
2	Clip report	
3	Reflective Template on Clip report	
4	Urology Educational Supervisor - Current and past	
5	Iscp trainers summer 2017 meeting	
6	Urology Registrar teaching programme 2017	
7	Study leave	
8	Regional urology audit	
9	Training passport	
10	Desist notice	
11	ICT Security course	
12	Radiation exposure Audit (see Domain 2)	
13	Green Light laser training	
14	BAUS endourology meeting sept 17	
15	Reflective template on BAUS Endourology meeting	
16	Previous form 4	
17	PDP Reflective template	

Discussion

We reviewed job plan. Recognition that some work as Educational supervisor is not being reflected in PA'S.
Clip report reviewed. Recognition that procedures carried out e.g. Flexible cystoscopy at outpatients are not being credited and hence not reflected in the CLIP report. This also applies to Urodynamic investigative procedures and ultrasound scans at stone clinic.
Internal and external CPD reviewed. Mr Young has made good use of his study leave and has targeted it to his sub specialty interest. An accurate tally of the hours credited should be kept however he is clearly well over the minimum recommended by the colleges.
Activity has been audited and reflections have been carried out on National Endourology updates.

Training passport reviewed. Core modules are up to date, suggestions re additional optional modules made.
Domains of Knowledge Skills and Performance have been adequately addressed in this domain.

Actions Agreed

To discuss and agree adjustments changes in Job Plan with Head of Service and AMD.
To inform and agree a process whereby an accurate record of all procedures carried out is recorded and credited.
To maintain relevance of CPD activity to area of specialist interest and to record accurately the hours completed.
To complete optional modules e.g. Hyponatraemia and NEWS/MEWS as well as keeping core modules up to date

CLICK HERE for further guidance about completing Form 3 and HERE for the Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 2 - Safety and Quality

Attribute: 2.1 Contribute to and comply with systems to protect patients
Attribute: 2.2 Respond to risks to safety
Attribute: 2.3 Protect patients and colleagues from any risk posed by your health

	List of Supporting Information	Applicable Date
1	Incident event structured reflective template	
2	M and M Attendance record (also see Regional Audit Domain 1)	
3	Reflective template on other roles - Lead clincian	
4	Suprapubic catheterization guidelines	
5	Learning / development Event Structured Reflective Template on Suprapubic catheter service teaching and education	
6	Cumulative Occupational Radiation Exposure study	
7	A series of documents re STC Meetings on new set-up and delivery of the service	
8	Stc drug regimen change safety check, email from T Boyce re: diclofenac and pentrox and its safety when driving	
9	Improvement in documentation and data collection for stc = email from the French team who supplied technology	
10	Learning / development Event Structured Reflective Template on Stone Service redesign	
11	Emails and response from Director Of Acute services in response to ward issues of excessive patient numbers on ward and A/E appearing to send patients up to ward before ward manager has accepted.	
12	Xray imaging equipment survey report - Stone Treatment Centre lithotripter	
13	Vaccination and GP registration recorded in past appraisals	
14	Absence of significant Event declaration	

Discussion

Attendance at patient safety meetings good, discussion around why regional meetings are not captured. Discussion about safety of procedures and structures in place within department to ensure patient safety. Radiation exposure study and suprapubic catheterization.
Has reflected on and applied learning from a significant event. In role as lead clinician has acted on concerns of patient safety due to severe pressures on the acute ward.
In role as lead clinician has addressed issues of safety, quality and updating of service delivery in the stone treatment centre.
No health issues of concern, No significant events in NHS or Private Practice of concern.

Actions Agreed

To look at ways regional audit attendance can be credited to overall patient safety activity.
Escalation of concerns re ward patient safety and to continue to work with HOS and Director of Acute services to try to mitigate patient risk due to these extreme pressures on the service. To continue to deliver high quality service in his area of specialist interest.
To insure own personal health is maintained.

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 3 - Communication, Partnership and Teamwork

Attribute: 3.1 Communicate effectively
Attribute: 3.2 Work constructively with colleagues and delegate effectively
Attribute: 3.3 Establish and maintain partnerships with patients

	List of Supporting Information	Applicable Date
1	Team Development = see Stone Service data in Domain 2	
2	THUGS Meeting example Chairman session	
3	Urology Departmental Meetings Autumn agenda	
4	Stone Treatment Centre MDT meeting (see Domain 2)	
5	Patient and Colleague 360 feedback (see Domain 4)	

Discussion

Recently completed Patient and colleague feedback. Reviewed and discussion about this. Excellent feedback from colleagues and patients. No negative comments in either group surveyed.
Works well with colleagues and is effective in his role in THUGS (Deputy chairman), Lead clinician and stone MDT chairman.

Actions Agreed

Keep up the high standards achieved to date.
Work constructively with colleagues to establish and stabilize the Stone treatment MDT.
Communicate concerns and find an agreed solution to the clash of times of oncology MDT and Stone treatment MDT

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 4 - Maintaining Trust

Attribute:4.1 Show respect for patients
Attribute:4.2 Treat patients and colleagues fairly and without discrimination
Attribute:4.3 Act with honesty and integrity

	List of Supporting Information	Applicable Date
1	Urology Fund Account email sent re 2017-18	
2	Reflective template on Fund and changes in donation	
3	Complaint x1	
4	Structured Reflective template response to complaint	
5	Hillsborough Private Clinic patient satisfaction survey	
6	Hillsborough Clinic - letter of good standing	
7	Ulster Independent Clinic - letter of good standing	
8	MDU most recent statement	
9	GMC letter	
10	Health and Probity forms for supporting information	
	BAUS subscription	
	Compliment	
	Patient 360 feedback	
	Colleague 360 feedback	
	Reflective template on feedback	

Discussion

Discussion around a long standing departmental complaint. Reviewed reflection on this.
Discussion about Urology fund account and how trust policy may conflict with donors wishes. Has reflected on this
No complaints from private practice and holds letters of good standing from both private clinics.
No conflict between private work and NHS work.
Patient and colleague feedback demonstrates that there is excellent respect held for him from patients and colleagues

Actions Agreed

Continue to maintain all levels of trust clearly demonstrated in his supporting information.

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

FORM 4 - PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

Review of last year's Personal Development Plan		
Development needs	**Actions agreed**	**Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?**
Urology related external meeting	BAUS endo urology meeting attended	yes
Research development plan	Planned project not undertaken due to staffing issue but another project via trust is planned now	Partially – aim to complete by next appraisal.
Outstanding known Safety issues addressed	mandatory training completed	YES

CLICK HERE for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

PERSONAL DEVELOPMENT PLAN for the year ahead		
Development needs	**Actions agreed**	**Target dates**
Urology related external meeting	To attend Endourology meeting in Oxford or Paris later this year (2018)	By 2018 appraisal
Research development plan	ESWL project	Ongoing – review progress at 2018 appraisal
Review of Job plan as more stone endourology required	Aim to expand service delivery to meet the ever increasing demand for endourology.	Review at 2018 appraisal.

CLICK HERE for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click here.

FORM 6 - SIGN OFF

Please ensure this section is fully completed, signed and dated by both Appraisee and Appraiser.

CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS	APPRAISER SIGNATURE	DATE
Full requirements achieved	Personal Information redacted by the USI	30/4/18

When you have completed the appraisal, the appraiser should check and sign the following:

GMC REQUIRED INFORMATION			PRESENT
Continuing professional development			✓
Quality improvement activity			✓
Significant events review			✓
Review of complaints and compliments			✓
Feedback from colleagues	Year undertaken OR Planned Year:	2018	
Feedback from patients (where applicable)	Year undertaken OR Planned Year:	2018	

APPRAISAL CHECKLIST	COMPLETED
Check that all sections of the documentation have been completed.	✓
Ensure the previous year's Personal Development Plan has been reviewed.	✓
Forward required Forms according to the organisation's appraisal policy.	

APPRAISAL COMPLETION

We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan:

Personal Information redacted by the USI

APPRAISEE

Signature of Appraisee: _____ Date: 30.4.18

Personal Information redacted by the USI

APPRAISER

Signature of Appraiser: _____ Date: 30-4-18

GMC Number: 03520[illegible]

CO-APPRAISER (if applicable)

Signature of Co-Appraiser: _____ Name of Co-Appraiser: N/A

GMC Number: _____ Organisation: _____

FORM 5- HEALTH AND PROBITY STATEMENTS

HEALTH DECLARATION

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

Professional Obligations
The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.

78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.

79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and wher[redacted]ing the appropriate action.

Signature: [redacted] Date: 30.4.18.

Name in Capitals: M. YOUNG

NB: Additional Health and Probity forms are on the Southern Docs website – click here

Regulatory and Voluntary Proceedings *[Please check relevant box by clicking on it and then sign below]*

☒ Since my last appraisal/revalidation **I have not,** in the UK or outside:

- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

OR

☐ If I have been subject to either of the above, I have discussed these with my appraiser.

Signature: [redacted] Date: 30.4.18

Name in Capitals: M. YOUNG

PROBITY DECLARATION

Professional obligations

I accept the professional obligations placed upon me in paragraphs 56 to 76 of *Good Medical Practice (2006).*

Signature: [redacted] Date: 30.4.18.

Name in Capitals: M-Young

Convictions, findings against you and disciplinary action *[Please check relevant box by clicking on it and then sign below]*

☒ Since my last appraisal/revalidation **I have not,** in the UK or outside:

- Been convicted of a criminal offence or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

OR

☐ If I have been subject to any of the above, I have discussed this with my appraiser.

Signature: [redacted] Date: 30.4.18

Name in Capitals: M. Young

INDEMNITY DECLARATION

I confirm that I have the relevant indemnity as per the GMC's Guidance – click here

Signature: [redacted] Date: 30.4.18

Name in Capitals: M. Young

FORM 7- REVALIDATION PROGRESS

Ensure these sections are fully completed to indicate where the appraisee is in their 5 Year Revalidation Cycle.

Year 1

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 2

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 3

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 4

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 5

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2017. has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution
None		

Signature of Appraiser: [redacted] Name of Appraiser: EJ McNabb

GMC Number: 0332617 Date: 30/4/18

Year

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Please ensure the section below is fully completed.

GMC Supporting Information Requirements	Year Completed	Reviewed by	Date
Feedback from colleagues 1 in 5 years	2018	[redacted]	30/4/18
Feedback from patients (where applicable) 1 in 5 years	2018		30/4/18
Significant Events Review	2017		30/4/18
Review of complaints and compliments	2017		30/4/18
Continuing Professional Development	2017		30/4/18
Quality Improvement Review	2017		30/4/18

Appendix 1 Education and Training Competencies Available for Medical Staff

Right Patient, Right Blood	Method	Core / Optional	Date Completed
RPRB Theory (Every 3 years)	Elearning Blood Transfusion Module Click Here	Core	1.4.16 to 1.4.19
Competency 1,2 & 4 (Every 3 Years)	Face to face – Trust Haemovigilance Staff Contact Patricia Watt on Personal Information redacted by the USI / Personal Information redacted by the USI	Core	
Desist Notice	To obtain a desist notice, click here	Core	24.10.17

Annual Updates	Method	Core / Optional	Date Completed
Fire Safety	Face to Face. Part of the Trust mandatory training day – click here for dates and program. Email Irrelevant information redacted by the USI to book a place.	Core	8.2.18
2 Yearly Updates	**Method**	**Core / Optional**	**Date Completed**
Infection Prevention and Control	SHSCT E-Learning Module Click Here	Core	11.4.16 to 11.4.18
Resuscitation	Face to Face. CAH - Helen Cullen Personal Information redacted by the USI Ext: Personal Information redacted by / Bleep: Personal Information Personal Information redacted by the USI DHH - Bernie O'Connor Personal Information redacted by the USI Ext: Personal Information / Bleep: Personal Information Personal Information redacted by the USI	Optional	
3 Yearly Updates	**Method**	**Core / Optional**	**Date Completed**
Safeguarding Children & Vulnerable Adults	Face to Face. Part of the Trust mandatory training day – click here for dates and program. Email Irrelevant information redacted by the USI to book a place.	Core	8.2.18
Information Governance/Data Protection/IT Security	SHSCT E-Learning Module Click Here	Core	18.3.16 to 18.3.19
Moving and Handling	SHSCT E-Learning Module Click Here	Core	17.3.16 to 17.3.19
Health & Safety / Control of Substances Hazardous to Health (COSHH)	SHSCT E-Learning Module Click Here	Core	17.3.16 to 17.3.19
Discovering Diversity	HSC E-Learning Module Click Here	Optional	
Recruitment & Selection	HSC E-Learning Module Click Here	Optional	12.4.16 to 12.4.19
Sickness & Absenteeism Training	Face to Face. Contact ELD on Personal Information redacted by the USI or email Irrelevant information redacted by the USI	Optional	
Hyponatraemia	BMJ E-Learning Module Click here	Optional	
Management of Actual or Potential Aggression	Face to Face. Contact ELD on Personal Information redacted by the USI or email Irrelevant information redacted by the USI	Optional	
Fraud Awareness	HSC E-Learning Module Click here	Optional	
Seeking and Obtaining Consent for Hospital Post Mortem Examination	SHSCT E-Learning Module Click here	Optional	

Once off Training	Method	Core / Optional	Date Completed
National Early Warning System	National NEWS e-learning Click here	Optional	
Obstetrics Early Warning System	Online Module Click here	Optional	
Paediatrics Early Warning System	Face to Face. Contact CAH Dr S Shah Personal Information redacted by the USI Contact DHH Dr B Aljarad Personal Information redacted by the USI	Optional	
Consent	In House E-Learning Module Click here	Optional	11.5.13
Blood Culture	In House E-Learning Module Click here	Optional	
Peripheral Line	In House E-Learning Module Click here	Optional	15.5.13
Oral Anticoagulants	MHRA Module Click here Once on the site choose the Anticoagulant Module. On completion of the module, complete the assessment and print a completion certificate. Takes 24 hours for registration.	Optional	
Naso Gastric Tube Placement	In House E-Learning module Click here	Optional	
Protocol following death of patient	In House E-Learning module Click here	Optional	
Guide to Prescribing in SHSCT	In House E-Learning module Click here	Optional	
Research and Development - Good Clinical Practice Training	Elearning Module Click here	Optional	
VTE	King's Thrombosis Centre E-learning Click here	Optional	
Safe Sedation [Module 1,2 & 3]	In House Elearning Modules Click here (Part 1) Click here (Part 2) Click here (Part 3)	Optional	
Gastrointestinal endoscopy	Face to Face Contact Dr A Murdock Personal Information redacted by the USI	Optional	
Chest Drain Insertion	Face to Face Contact Dr A Ferguson Personal Information redacted by the USI	Optional	
Blood Gas Instrument	Face to Face Contact Derek McKillop Personal Information redacted by the USI Personal Information redacted by the USI Face to face	Optional	
Appraiser Training	Face to face Dates available here	Optional	24.9.15
Appraisee Training	Face to face Dates available here	Optional	30.1.14
Insertion and Management of Indwelling Urinary Catheters	Online Module Click here	Optional	
Coroner's Investigations and Inquests Programme	Online Module Click here	Optional	
HIV Awareness Training	Face to Face Contact Lyndsey Hasson Tel: Personal Information redacted by the USI	Optional	
Patients enrolled in Clinical Trials	In House E-Learning module Click here	Optional	

Waste Management	SHSCT E-Learning Module Click Here	Optional	
Modules proposed for E-Learning	**Method**	**Core / Optional**	**Date Completed**
Better Communication/Complaint Handling	Face to face	Optional	
Incident Reporting	Face to face	Optional	
Clinical Negligence	Not currently available	Optional	

Your training record will be updated following this submission, a copy of which can be obtained from the Revalidation Support Team, [redacted]

Please note that when you complete a training module either face-to-face or via elearning, you need to email the Revalidation Support Team in order that your training passport can be updated as the Team are not automatically informed.

TRAINING DECLARATION

I understand that it is my responsibility to make the necessary arrangements to allow me to complete the Trust's Mandatory Training Core Modules and those Optional Modules as agreed between myself and my Appraiser that are necessary for me to undertake my role within the Southern Health and Social Care Trust.

APPRAISEE

Signature of Appraisee: [redacted] Name of Appraisee: M. Young

GMC Number: 2846385 Date: 30.4.18

APPRAISER

Signature of Appraiser: [redacted] Name of Appraiser: E J McMahon

GMC Number: 0332617 Date: 30/4/18

Research Project

Assessment of Kidney and ureteric stone clearance and complications treated with Extracorporeal Shockwave lithotripsy using the EDAP i-sys sonolith Lithotripter.

This project is to audit the success of the ESWL lithotripter in the Craigavon Area Hospital Stone Unit and to assess the introduction of a Stone MDT.

Recent changes have occurred to the patient management in terms of their care pathway and the mechanism of how the ESWL treatment is delivered.

We wish to review the completeness of the information surrounding the patients care pathway over a prior time period and compare it to a prospective audit.

The main course of this project is to institute a prospective complete and accurate data set of all ESWL patients, their therapy and subsequent outcomes.

Project One Effectiveness of stone clearance with the EDAP Lithotripter

The main objective is to define stone clearance, fragmentation and requirement for other procedures, having introduced the new care pathway.

Prospective data collection on the outcomes of ESWL. (Prospective study so all data entries are correctly added with prior tutorials on data entry by research radiographer). (Audit)

- Radiographer to weekly review data at the start to ensure correct data entry by all colleagues.

- Nursing input is to collect Patient factors as defined by referrals and STC MDT data.

- Outcome data by re-imaging with USS (or subsequent CT if hydronephrosis) at defined time points.

The information to be defined is based on the features noted below.

- patient demographics (age , sex, BMI, H&C, date therapy),
- nursing admission forms and the ECR / PAS – metabolic assessment
- Data from the Stone MDT,
- Stone factors (size, location, Hounsfield unit stone density, skin to stone distance)
- Side of treated stone, stent presence.
- other stone burden (treatment plans for these)
- therapy treatment form data - ESWL parameters (ramping protocol, frequency, power delivery total shockwaves deployed, method of targeting, and analgesia taken).
- stone analysis (if retrieved).
- Patient satisfaction with the therapy and pain scores during and post session.
- Haematoma rates.

- An assessment of prior investigation completeness will be undertaken. This will define type of imaging and biochemistry.
- The review will ensure the stone actually treated was that previously defined (This is in cases where the patient had multiple stones and each will be labelled).
- Predictability of number of treatments to clear, as set out in the MDT
- Timing of imaging prior to treatment and after treatment.
- Assessment of imaging modality used to follow up after treatment – (was there a need to change between modalities).
- Stone clearance rates will then be compared to other lithotripsy results.

Project Two Pain relief

- The change to ESWL outcomes having changed to pre-treatment pain relief using oral Diclofenac Potassium as per pharmacy instruction.

Proposal for comparison of Oral diclofenac potassium and paracetamol vs Per rectum diclofenac sodium and paracetamol for pre-treatment ESWL pain relief.

Validated score chart to be used

Study to be conducted by research nurse and to be put through ethics committee.

Project Three - To assess the change in care following the introduction of the Stone MDT.

This component of the study is to assess the completeness of data collected on individual patients as well as the timeliness of the patient care pathway being commenced, in comparison to a period a time before the MDT introduction.

Data sets recording patient flow in terms of timeframes will be the focus including information supplied to the patient. The dates of referral, triage date, MDTdiscussion date, investigation date and treatment dates will be assessed.

In addition to timeframes, information supplied to the MDT panel to provide the precise care pathway will be collected.

This information will be from ECR, the referral form, and xray images. The quality of information supplied prior to the MDT meeting will be assessed against the panels additional enquiry.

Retrospective and prospective timeframes will be assessed. In this way an assessment can be made on whether the weekly stone MDT decreases the demand for new OPD attendances for stone consults. A questionnaire will be defined to assess if patients find discussion on their urological stones at the weekly stone MDT and booked direct for appropriate treatment an acceptable method of care? (this is in relation to long waits for OPD, this method will decrease OPD demand, it is recognized in the GIRFT report sep 2018)

A further question to define is whether patients receive stone treatment faster having been proceeded via a Stone MDT?

Project Four - Nurse Led Stone Clinic

The wait time for clinic appointment is excessive at present.

A nurse lead clinic for a certain category of patient will be introduced. This will comprise of two clinic types.

1/ telephone interview clinic

2/ a face to face clinic with an ultrasonographer present.

Assessment of patient satisfaction with this approach and results of stone follow up will be defined, as well as the impact on reducing the wait time to be followed up.

Trust IT to be involved in data collection methodology.

M Young MD FRCS(Urol)

STC Lead

December 18

Southern Trust **Ureteric and Renal Stone Pathway**

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

Completed form send to **Booking Centre, Craigavon Hospital, BT63 5QQ**

Incomplete forms will be returned to referring Doctors

Referring Doctor and unit: _____

Date of referral**:** ___ / ___ / 20___

Patient label/ details

Patient Phone number:_____

Presenting symptoms: (circle)

Side of stone: Left Right

Side of Pain: Left Right No pain

Visible haematuria: Yes No

Past medical History: (circle)

Solitary Kidney: **Yes** **No**

Abdominal Aneurysm: **Yes** **No**

Pacemaker: **Yes** **No**

If yes, type_____

Asthma: **Yes** **No**

Cardiac Stent: **Yes** **No**

Date of stents_____

CKD Stage IV or V: **Yes** **No**

Current Gastric Ulcer: **Yes** **No**

Malignant hyperthermia: **Yes** **No**

Symptomatic heart failure: **Yes** **No**

Diabetic: **Yes** **No**

Epileptic: **Yes** **No**

Physical/ mental disability: **Yes** **No**

Other significant past medical history:

-

-

Previous stone history/management:

Imaging modality: (circle)

NCCTKUB* **USS KUB/ NC MRI**

(*CT Urinary tract) **(if <16 yo or pregnant)**

Findings:

X ray KUB done~: Yes No

Stone visible on: (circle) XRKUB USS

~(Indication: if stone not visible on CT scout film)

Anticoagulants:_____

Immunosuppressive agents:_____

ALLERGIES: (circle) **YES** **NO**

Drug:

Necessary bloods:

eGFR:_____(baseline:)_____ Creatinine:_____

Corrected Calcium:_____ Uric acid:_____

Haemoglobin:_____ Platelets:_____

White Cell Count:_____ CRP:_____

Urine dip stick:

pH:_____ Bld:_____ Leuc:_____ Nit:_____

Pregnancy test: (circle) Positive Negative

Urology only to complete- STC MDT Outcome:

ESWL Referral
Craigavon Stone Treatment Centre

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

Referral Source:

Consultant:

Date:

REFERRAL CATEGORY: *Ureteric only

Emergency* **Urgent** **Routine**

Stone for ESWL treatment:

Side: Right Left

Location:

Calyx: Upper Middle Lower

Renal: Pelvis PUJ

Ureter: Upper Lower

Size:_____ **HU:_____**

Additional stones considered suitable for ESWL:_____

Check List to be complete within 6mths of referral:

NCCTKUB: ◯

Ensure visible on USS or XRKUB: ◯

Patient able to lie flat 1hour: ◯

Bloods results within 6mths of referral:

Hb_____ **Plt_____** **U&E_____**

Medications: (inform patient to stop **ALL** herbal remedies 7days prior to ESWL)

Herbal Remedies: _____

Immunosuppressives: _____

Anticoagulants: _____

Allergies Yes No **Latex allergy** Yes No

Details:_____

Interpreter required: Yes No

Language:_____

Checklist ESWL :

Previous ESWL:	**Yes**	**No**
Stent in situ:	**Yes**	**No**
Solitary Kidney:	**Yes**	**No**
Abdominal Aneurysm:	**Yes**	**No**
Pacemaker	**Yes**	**No**

: Please check Model / ESWL compatibility before referral

General checklist Patient condition:

Diabetic (NIDDM / IDDM):	**Yes**	**No**
Epilepsy:	**Yes**	**No**
Asthma:	**Yes**	**No**
Physical / mental disability:	**Yes**	**No**

Needs:_____

Other significant past medical history:

Can patient take:

Diclofenac:	**Yes**	**No**
Codeine:	**Yes**	**No**
Paracetamol:	**Yes**	**No**
Ciprofloxacin:	**Yes**	**No**

Please inform patient that stones >5mm are offered 2 ESWL treatments with follow up scan at local hospital. Premedication will be posted to patient and needs to be signed for 2-3days prior to treatment date.

ESWL Referral
Craigavon Stone Treatment Centre

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

Name:	Date:
H&CN:	

Below for completion by STC CAH team at Stone Meeting:

Anticoagulants: _____

Bridging required: Yes (organised) No

Patient informed to stop: Yes No

Date& sign: _____

Immunosuppressives: _____

Number of ESWL to stone: 1 2 3

Treatment under: US Fluoroscopy

Next stone(s) to treat:_____

Followup imaging: XR US CT

(*Yes* √, *No* blank)	**Tx 1**	**Tx 2**	**Tx 3**	**Tx 4**
AXR req prior				
NIECR req in				
Covid swab neg				
Pre med: PCM				
Dic				
Cod				
Cipro				
Script to pharm				
Post med: PCM				
Dic				
Cod				
Patient contacted ?any issues Detail below				

Any additional information:

Ureteric and Renal Stone Pathway

Southern Trust Hospitals

HSC Southern Health and Social Care Trust

Quality Care - for you, with you

Note: **Male >50yrs, no history of renal stones, then consider AAA pathway**

History Suggestive of Renal Colic? THEN DO THE FOLLOWING

- Urine dipstick including pH
- Pregnancy test (12 to 55 years)
- Patient observations
- FBC, U&Es, CRP, Calcium and uric acid

(Same day imaging if single kidney, infection, AKI)

Not Pregnant and >18 years old

Non Contrast CT Urinary Tract

Ureteric stone or obstructing kidney stone

Is there any:
1. Infection (? SEPSIS 6)
2. Acute Kidney Injury
3. Uncontrolled pain
4. Ureteric stone >6mm
5. Diabetes
6. Immunosuppression

Yes → **Discuss with Urology**

No → **Complete Outpatient Stone Referral Form**

Non-obstructing Stone in Kidney, not ureter

Evidence of Pyelonephritis

Yes → **Consider admission if necessary (See Hospital/ NICE guidelines)**

No → **Consider alternate cause for pain**

AND

For the stone finding, complete Stone Referral Form

<18 years old

USS RENAL TRACTS

Hydronephrosis OR highly suspicious of stone, OR Urological abnormality, Discuss with Urology.

Pregnant

Discuss with Obstetrics

USS RENAL TRACTS

Discuss with Urology
Consider NC MRI Renal Tracts

Negative Imaging

Consider alternative cause of pain

(Non-visible haematuria on urine dipstick: Notify GP to re-check and refer if needed as per NICE guidance)

Pathway next due for REVIEW July 2018 Stone MDM

Nurse Led Clinic Criteria:

- Reviewed by stone meeting/ senior member of team prior to referral
- Renal stone, no ureteric component
- Appropriate for nurse led followup
- Patient risk stratified

Referrals with risk stratification (high/ low)

Letter from clinic/ stone meeting on NIECR and patient captured on Nurse led stone clinic waiting list code

Southern Health and Social Care Trust

Quality Care - for you, with you

Virtual clinic review @1yr for recurrent stone former

Virtual clinic review within 3mths for first time stone former

Patient symptoms and stone prevention and discuss thresholds for seeking advice

Ensure ca and uric acid checked and normal (if abnormal, d/w doctor)

Refer to consultant clinic at any point if nurse or patient concerns

Assessment of patient symptoms and review of stone prevention

Symptomatic of stone disease or stone growth >2mm

Discharge if:

Asymptomatic, residual burden <5mm, low risk stone former

Patient agreement and discuss thresholds for seeking advice

Virtual clinic in 2yrs with US before

No

Yes

Discharge @5yrs if:

Asymptomatic

AND

Minimal change in stone burden <2mm per stone

Patient agreement

Discuss thresholds for seeking advice

Urgent CT if none within 3mths

Refer for ESWL by completing ESWL tx form

Inform patient

Max 2 stones 6mm to 18mm in size and <1400HU

NCCTKUB within 6mths of referral

Ensure visible on USS or XRKUB

Bloods eGFR, Hb and plt checked

Patient able to lie flat 1hour

Ensure no history of aneurysm disease

No treatable stones or other concerns on imaging:

Advise patient and discuss thresholds for seeking advice

Refer to stone meeting

Stone disease or patient not suitable for ESWL

Ureteric stone

Patient complexity

L McAuley STC CAH July 2021

Southern Health and Social Care Trust

Quality Care - for you, with you

Flow Chart for referral/ patient pathway into Nurse Led Clinic

Patient identified

- From stone clinic or through stone meeting
- Patient signposted to dietary and fluid advice
- Risk stratification of patient documented (high/ low)
- Deemed suitable for Nurse led clinic follow-up

↓

Follow up as per protocol with nurse specialist

- Review of fluid and dietary advice
- Signs and symptoms review at time of appointment
- Order and review imaging as per protocol
- Bloods/ 24urine samples organised as required
- Determine ongoing management pathway as per protocol

↓ ↑ ↓

No concerns	Concerns - discuss with consultant*

*Discussion or referral back to consultant:

1. Any signs/ symptoms or results from investigations that are indicative of a change in management plan being required
2. Haematuria requiring cystoscopy
3. Any deterioration in renal function
4. At the request of the patient
5. Any question the nurse specialist is unable to answer

Created by L.McAuley Jan 2021 STC CAH urology department

Affix patient label

Name: _____

H&C: _____

D.O.B: _____

Southern Health and Social Care Trust

Quality Care - for you, with you

Renal stone Nurse Led Clinic

Consultant	Date	Risk group (low/ inter/ high)

Recent Imaging: (circle) CT / US KUB / XR	Result:

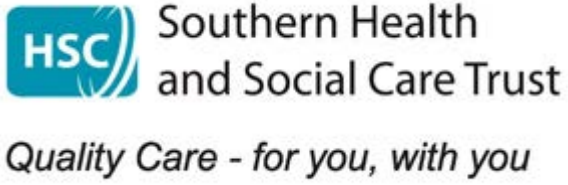
Signs & Symptoms	Y/N	Comment
Pain		
Recurrent UTIs		
Haematuria		
Other concerns		

Investigations	Date taken/ requested	Satisfactory (Y/N)	Details (if required)
FBC			
U&Es			
Ur acid			
Ca			
24hr urine			

Outcome	Details
Follow up imaging	Type of scan: CT USKUB XR (circle) Timing planned:
Nurse Led Clinic	Review: 6mths 12mths 18mths 24mths (circle)
Refer to:	Stone meeting Consultant led clinic (circle)
Discharge to GP	

CNS Name: **Sign:** **Date:**_____

Created by L.McAuley Jan 2021 STC CAH urology department



ADEPT PROJECT
Southern Trust
Stone Treatment Centre

Matthew Tyson
ST7 Urology/ADEPT Fellow

Project

1. To meet the demand for the Extra Corporal Shockwave Lithotripsy (ESWL) service for elective and emergency renal and ureteric stone treatment for the Southern Trust

2. Provide stone treatments recommended by NICE, BAUS and EAU

3. Provide patients with informed choice

To meet the demand for the Extra Corporal Shockwave Lithotripsy (ESWL) service for elective and emergency renal and ureteric stone treatment for the Southern Trust

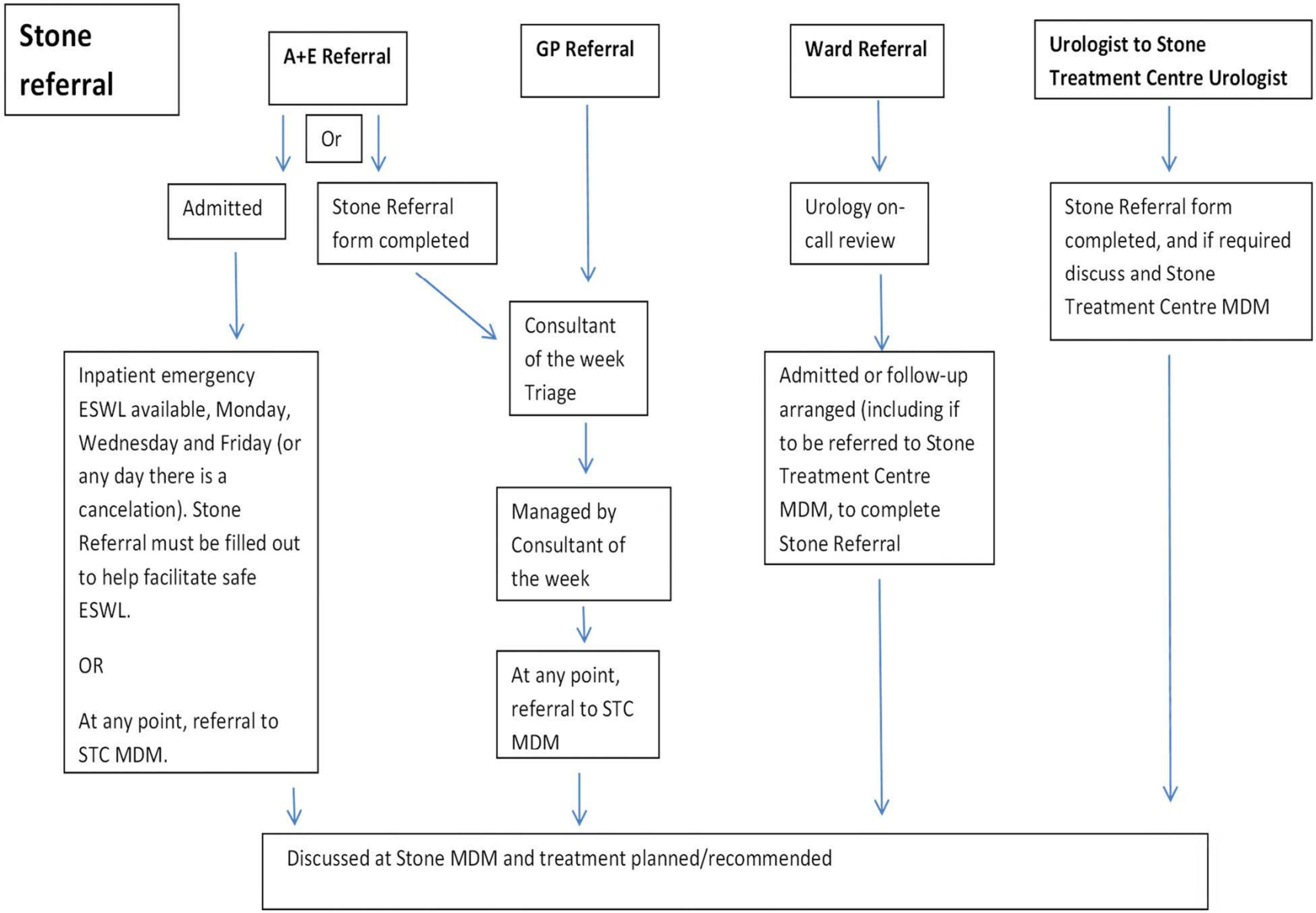
- On-site ESWL

- Southern Trust 372926
- Stone service 472000
- + Referrals from South Eastern, Northern

Aims

- Decrease waiting list times for elective ESWL treatment to 2 weeks
- To provide emergency ESWL provision for upper and distal ureteric stones
- To decrease the cost of renal and ureteric stone treatment

Stone Treatment Centre Overview



Renal and Ureteric Stone Pathway — Southern Trust

Note: **Male >50yrs, no history of renal stones, then consider AAA pathway**

History Suggestive of Renal Colic? THEN DO THE FOLLOWING

- Urine dipstick including pH
- Pregnancy test (12 to 55 years)
- Patient observations
- FBC, U&Es, CRP, Calcium and uric acid

(Same day imaging if single kidney, infection, AKI)

Not Pregnant and >18 years old

→ **Non Contrast CT Urinary Tract**

Ureteric stone or obstructing kidney stone

Is there any:

1. Infection (? SEPSIS 6)
2. Acute Kidney Injury
3. Uncontrolled pain
4. Ureteric stone >6mm
5. Diabetes
6. Immunosuppression

- **Yes** → **Discuss with Urology**
- **No** → **Complete Outpatient Stone Referral Form**

Non-obstructing Stone in Kidney, not ureter

Evidence of Pyelonephritis

- **Yes** → **Consider admission if necessary (See Hospital/ NICE guidelines)**
- **No** → **Consider alternate cause for pain**

  AND

  For the stone finding, complete Stone Referral

<18 years old

→ **USS RENAL TRACTS**

→ Hydronephrosis OR highly suspicious of stone, OR Urological abnormality, Discuss with Urology.

Pregnant

→ Discuss with Obstetrics

→ **USS RENAL TRACTS**

→ Discuss with Urology
Consider NC MRI Renal Tracts

Negative Imaging

Consider alternative cause of pain

(Non-visible haematuria on urine dipstick: Notify GP to re-check and refer if needed as per NICE guidance)

Urology Stone MDT 16/11/2017
Next due for REVIEW July 2018

Ureteric and Renal Stone Referral

Urology, Craigavon Area Hospital

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

Please refer to A+E protocol for referral guidance:

Uncompleted forms will be returned to referring Doctors

Patient identification (sticker)

Referring Doctor: _____

Referring unit: _____

Date of referral: ___ / ___ / 20___

Patient Phone number:_____

Physical or mental disability? **Yes** **No**

Presenting symptoms: (circle)

Side of stone: Left Right

Side of Pain: Left Right No pain

Visible haematuria Yes No

Acute Medication given from A+E:

Past medical History: (circle)

Solitary Kidney **yes** **no**

Abdominal Aneurysm: **yes** **no**

Pacemaker: **yes** **no**

If yes, type_____

ASTHMA: **yes** **no**

Cardiac Stent: **yes** **no**

Date of stents_____

CKD Stage IV or V: **yes** **no**

Current Gastric Ulcer **yes** **no**

Malignant hyperthermia **yes** **no**

Symptomatic heart failure **yes** **no**

Other past medical history:

-

-

Imaging modality: (circle)

NCCTKUB* **USS KUB/ NC MRI**

(*CT Urinary tract) (If <18 yrs or pregnant)

Findings:

X ray KUB done: Yes No

(Indication: if stone not visible on CT scout)

ALLERGIES: (circle) YES NO

Drug:

Anticoagulants:

Immunosuppressive agents:_____

BLOODS

Creatinine:_____ eGFR:_____

Corrected Calcium:_____ Uric acid:_____

Haemoglobin:_____ Platelets:_____

White Cell Count:_____ CRP:_____

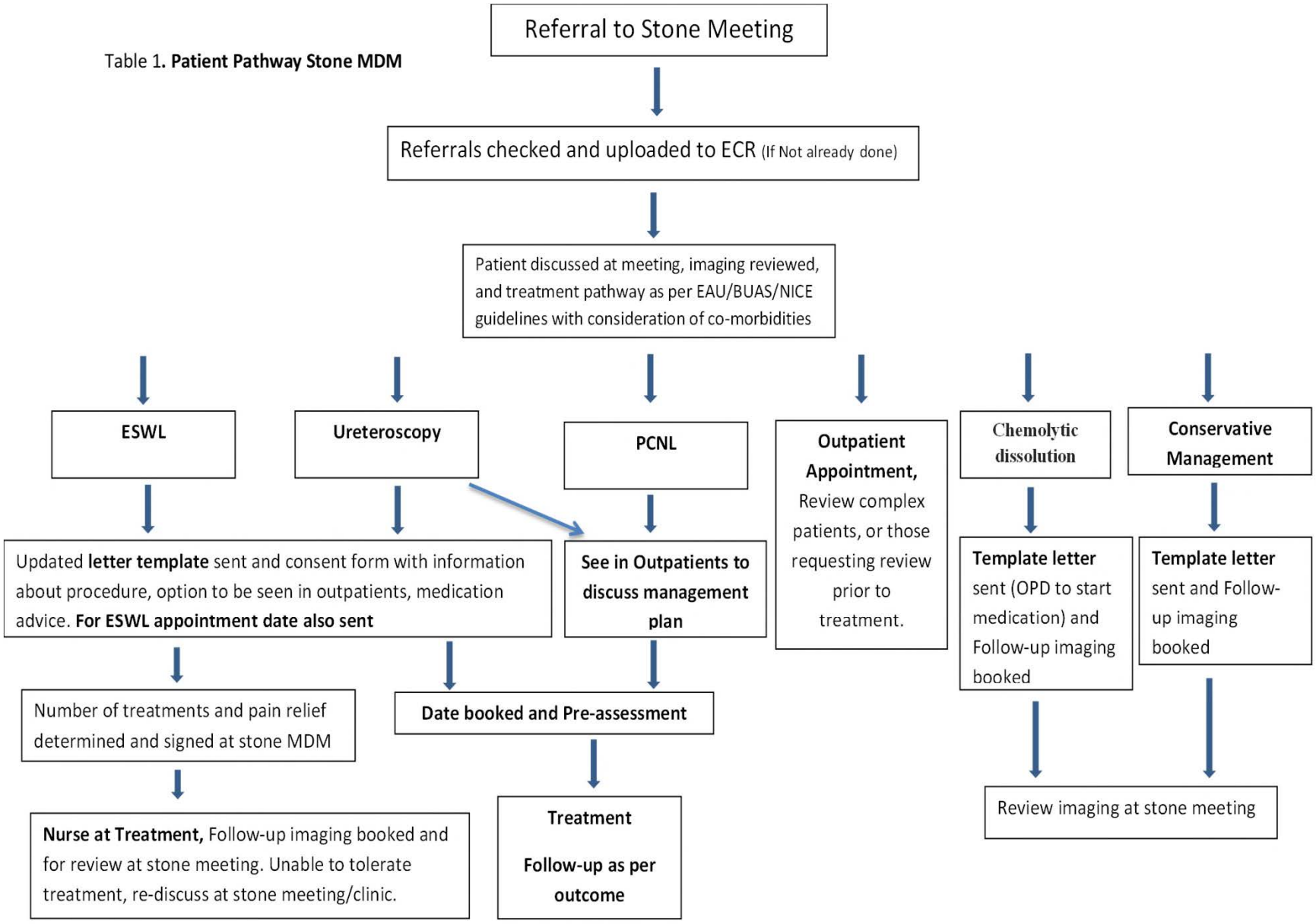
Urine dip stick:

pH:_____ Blood:_____

Leucocytes:_____ Nitrites:_____

Pregnancy test Positive Negative
(circle)

Table 1. **Patient Pathway Stone MDM**



Benefits:

1. Platform for discussion of complex patients, what is their most suitable management and by whom. The full range of therapeutic options can be discussed
2. A+E referrals can be reviewed and patients placed for appropriate treatment with only complex patients or high risk patients having outpatient's appointments. (All patients could be offered an outpatient appointment if wish to discuss their MDT outcome further, prior to any treatment).
3. Shorten delay to treatment with direct booking
4. Decrease number needing outpatient appointments
5. Patients may be happier not to see doctor in outpatients if their case has been discussed with the experience of multiple healthcare professionals then just one in clinic.
6. Education platform for staff
7. Time to disseminate any quality improvements cycles, audits or concerns and compliments.
8. Any clinical trials, allow suitable discussion and allocation
9. Potentially greater continuity of care
10. Improved and more efficient coordination of the stone service
11. Improve communication between care providers and develop clear lines of responsibility
12. Improve resource management and efficacy, such as on site lithotripter **(minimises paper work on treatment days, allowing increased capacity)**

Patient Letter and Information Pack

- The aim of the pack is to decrease the number of patients seen in clinic, yet providing the patient with reassurance they have been reviewed by the stone MDM and provided with a fully informative pack containing,

1. Letter explaining MDM OUTCOME and Imaging findings
2. Modified BAUS information leaflet and consent form (to bring on day of treatment sign last page)
3. Anticoagulation schedule for those on anticoagulants
4. Map for Blood room and Stone Treatment Centre

ESWL MDM Template Letter

Dear

Patient Details: Insert here

Your recent x-ray/scan demonstrated a kidney stone. This was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging report demonstrated: Insert here

The stone we are going to treat first is

We have organised for you, **Extra Corporeal Shockwave Lithotripsy (ESWL)** in order to treat your stone at the **Craigavon Stone Treatment Centre**

Date of ESWL is: (if no date given, then await appointment letter).

Please call **Paulette on** [redacted] or **Gemma on** [redacted] **to confirm the treatment date is suitable**

Please find enclosed with this letter:

1. *Information* on Extra Corporeal Shockwave Lithotripsy (**ESWL**)
2. ***Consent form*** - Following reading and understanding the information on ESWL provided, please sign consent form and **bring along to the day of treatment.**
3. ***Advice sheet*** for patients who take anticoagulation medication (BLOOD THINNERS), on when to stop before treatment and when to restart following treatment.
4. *Dietary advice* sheet to help decrease risk of further stones
5. *Map* of how to get to **Craigavon Stone Treatment Centre**

If you pass the stone before your ESWL treatment, please call **Paulette on** [redacted] first, otherwise call **Gemma on** [redacted], and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

On your treatment day please bring your consent form and all your medications (including over the counter medications). Report to check in desk on day of treatment (see map).

If however you would like to discuss the treatment on offer or possible alternatives then please call the number above to make an appointment.

We look forward to meeting you at Stone Treatment Centre for your treatment.

Many thanks

Mr Young FRCS(Urol)
Urology Consultant

ESWL Day of Treatment

- Radiographer and Nurse led
- Currently 3 treatment a session
- 3 sessions a week
- 9 patients a week

Day Of Treatment Improvements

Decreased Nurse administration time:

1. Patients will arrive with informed consent
2. Nursing staff will have referral information, past medical conditions, medications and allergies
3. ESWL medications pre-prescribed
4. Allows radiographer to start session on the hour
5. No prior notes review by nursing staff required

Radiographer:

1. Information on stone to be treated easily accessed on radiology request, as well as number of treatments recommended and follow-up advised (e.g. imaging modality)
2. Treatment protocol to provide enhanced treatments and safety ramping protocol

Day Of Treatment Improvements

e-Discharge

1. Radiographers trained to provide e-discharge. Provides accurate information on medications given and taken home, treatment given and follow-up plan (previously written paper discharge).
2. Safer communication, with all care givers able to access information, especially in an emergency.
3. Allows improved follow-up planning
4. Copy provided to patient for access to information on treatment and follow-up plan

Follow-up imaging

1. Nursing staff to book (to attend IRMA training and signed off by department lead)

Day Of Treatment Improvements

- Changes have been rolled out since the start of December 2017
- Will take an estimated 4 months to be fully implemented
- Once fully implemented and a period of 3 months has passed, assessment of changed to ensure they are improvements.

Waiting List

- ESWL 233 PATIENTS JAN 2018
  - 108 Patients Jan 2017
  - **116% increase in 1 year!!**

- Ureteroscopy and laser to Stone 174 (December 2017)

URS

Craigavon Urology Theatre **for elective ureteroscopy**

- As an elective day case £1608
- As an elective case with average inpatient stay £2747

Craigavon Urology Theatre for **emergency ureteroscopy**

- Long stay inpatient £2862 per patient
- Short stay inpatient £2376 per patient

ESWL

Craigavon Stone Treatment Centre for **elective ESWL**

- **£363** per **elective outpatient** patient, as of February 2017.
- **This is based on a morning session with 3 patients, giving a total session cost of £1092**
- A time and motion study conducted at the Stone Treatment Center, December 2016, noted a possible 4 patients could be treated in the same time period, thus lowering the cost further per sessions and per patient.
- **Inpatient ESWL** £627 per patient as of February 2017

Compare

One session of elective ureteroscopy with no stay is equivalent to 4.4 sessions of ESWL.

One session of emergency ureteroscopy with a short stay is equivalent to 3.9 sessions of ESWL

Costs ESWL Waiting List

With the new pathway followed:

- If 233 patients needed on average 1.5 treatments then 318 treatments needed.

- Cost of £126868

Costs ESWL Waiting List

- Currently 9 patients per week treated
- If sessions increased to 9 per week, 3x9=21patients/per week
- Therefore 16.6 weeks need to clear waiting list
- Funded for 2.5 sessions per week currently, therefore **£81675** needed to over run and clear excessive waiting list.

MDM

- If 233 patients on waiting list had been discussed at MDM, placed on a current treatment and imaging follow-up pathway then a **new and follow-up OPD might be saved**

OPD COST OF 233 PATIENTS =

- 233 X (250 (NEW) + 170 (Follow-up) = £97860

- Note: £81675, is required to potentially clear the list

Waiting List- All adult patients

- 108 Patients Jan 2017
- 233 Patients Jan 2018 (116% INCREASE)

Per month added to waiting list

- June 32 patients
- July 22 patients
- August 20 patients
- September 37 patients
- October 37 patients
- November 43 patients
- December 26 patients

Waiting time

- Currently booked patients for elective ESWL for January 2018, from patients booked May 2017.

- **8 month wait**

Projected Session (All adult patients)

- Once waiting list cleared:
- 217 Patients added June to December 2017
- Average of 31 patients per month
- Average of 8 (7.75) patients per week

ESWL session multiplier of x1.5

- Therefore 12 (11.6) patients per week
- Therefore 12/3 = 4 sessions per week

If multiplier of x2

- Therefore 16 patients per week
- Therefore 16/3 = 6 (5.3) average sessions per week (range 5 – 7 sessions per week)

South Eastern patients

- 49 patients in 7 months
- 49 X2 treatment multiplier = 98
- Therefore 14 patients per month
- Average of 3.3 patients per week
- Therefore 1 sessions per week to meet demand, with no Southern Trust emergency patients treated, with x4 patients per session

Projected week

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
am	ESWL	ESWL (South Eastern Trust)	ESWL	MDM	ESWL

Current funding for x2.5 sessions per week (7.5 patients)
Southern Trust need 5 sessions per week (3 patients per sessions)
South Eastern Trust x1 session per week (4 patients per session)
Need x6 sessions
Waiting list likely to increase when waiting list time decreases, patients may move over from URS list to ESWL. Extra sessions therefore add to account for this possibility, mindful extra session in future needed as population increases, age and obesity rises as will stone presentations.
Therefore x7 sessions needed, extra funding for x4.5 per week needed (with the South Eastern paying for x1)
(x2.5 funded at present)

Staffing

- Session needs,
  - X1 Staff nurse, Health Care Assistant, Radiographer

  - Based on 7 sessions, dedicated staff to unit,
  - Sister dedicated to Stone Treatment Centre
  - X2 Staff Nurse (flexible to work in Thorndale unit)
  - X2 Health Care Assistant (flexible to work in Thorndale unit)
  - X 1 dedicated radiographer to Stone treatment Centre

  And continued rotation of x3 radiographers as required

  Or x2 dedicated radiographers

Future

- Stone Treatment Centre
- ESWL waiting time of 2 weeks elective and daily (mon-fri) emergency ESWL available
- Dedicated nursing staff to the unit
- Nurse specialist for long term follow-up/high risk stone formers
- Dietician clinic for high risk formers and dietary modification

Future

- Sessions available for dedicated trust use other then the Southern Trust, with payment to the Southern Trust
- Cross border working
- Dedicated team to the Stone Treatment Centre, with teaching, training and research opportunities, giving a **Highly skilled and dedicated staff, providing highly effective ESWL treatment and follow-up to renal and ureteric stone patients.**

Many thanks

This is a team project,

Involving:

Mr Young and Consultant Team

Martina Corrigan, Laura McAuley, Paulette Dignam,

Hazel McBurney, Bronagh OShea, Bernadette Mohan, Wayne Heatrick

Nuala Mulholland, Mairead Leonard, Justin McCormick, Kate McCreesh, Martina O'Neil

A review of adult patients treated by ESWL with renal and ureteric stones assessing stone clearance.

Introduction

Extracorporeal shockwave lithotripsy (ESWL) is a non-invasive method of using shockwaves to treat kidney and ureteric stones to optimise passage through the urinary tract. ESWL is an outpatient day case procedure undertaken with analgesia and usually, unless a child is being treated, no general anaesthetic is used. Ureteroscopy (URS) and percutaneous nephrolithotomy are alternatives but are more invasive requiring a general anaesthetic and conducted in a theatre setting. The incidence of kidney stones is increasing, with one in eleven people (9%) likely to get stone symptoms during their lifetime. Men are more at risk than women. Kidney stones can affect any age group but the peak age for a first stone is around the age of forty-five. (The British Association of Urological Surgeons, 2022)

ESWL has been operational in our centre for approximately 20 years; we now use a fourth-generation lithotripter named the EDAP TMS i-sys Sonolith. As technology progresses, evidence is required to demonstrate that the lithotripter currently in use is still proving effective kidney stone clearance at a low complication rate. The aim of this paper is to provide a general overview of the successes and complications of stone management using the EDAP i-sys sonolith lithotripter in our centre.

Methodology

- Stones 5mm or greater were included which could be detected on ultrasound or fluoroscopy (xray).
- Patients had non contrast CT (NCCT) prior to examination to aid patient selection and ensure appropriate for ESWL.
- Stones were measured in largest axial diameter on NCCT.
- Bone windows were used to measure Hounsfield units (HU) from CT. Studies have shown that using magnified bone window settings is more accurate than using abdominal settings (Esiner, et al., 2009)
- HU was measured in three ways:
    1. Small ROI circle within the centre of the stone.
    2. The mean of 3 non overlapping consecutive areas within the stone.
    3. Freehand ROI around the borders of the stone.
- Skin to stone distance was measured by calculating the mean of three measurements from the centre of the stone to skin surface at 0 degrees, 45 degree and 90 degrees to stone on NCCT.

- Patients treated by the EDAP lithotripter and targeted using ultrasound or fluoroscopy, which ever produced optimal stone visualisation.
- Treatment was delivered by applying our departmental ramping protocol starting at 20%, increasing to 60% at 400 shocks and 80% for the following 100 shocks. After the initial 500 shocks the power is increased to 100% or as tolerated with a maximum of 3000 shocks at 100%. Frequency used was 1.2Hz which works out as 72 shockwaves per minute. Energy was reduced when patients were experiencing pain to a level they could tolerate and continue with treatment.
- Stones traditionally in our stone centre had one ESWL treatment then had ultrasound of the kidneys 6-8 weeks post treatment to reassess. This was changed in June 2019 to all patients to getting two treatments or three treatments at the discretion of the treating radiographer (depending on stone size or HU) prior to ultrasound follow up. Further treatments were then decided by the urologist at the stone meeting. Those patients who displayed no change or insignificant fragmentation of stones greater than 5mm were then given another session if felt appropriate.
- Number of ESWL treatments needed, stone clearance, complications, need for other procedures, stone fragmentation were all recorded and assessed. Factors which can affect stone clearance such as stone size, location, Skin to stone distance, stone density were also assessed.
- Treatment success was defined as complete clearance or fragments less than 5mm that no longer require ESWL. Also included in the success rate were renal calculi that had cleared from the kidney that had caused steinstrasse/obstruction and required surgery to clear as treatment had assisted the stone movement.
- Treatment failure was defined where stone remained greater than and equal to 5mm after a series of treatments. Patients who did not complete close to a full treatment due to pain intolerance were excluded from the study.

Results

The number of patients that were evaluated were 126, (30%) of which were females and 88 (70%) were males.

The total number of patients who completed treatments were 106 (84%) of which had successful treatments and 20 (16%) patients whose treatments were not successful.

106 patients out of 126 patients who completed treatment were successful with a combined number of treatments of 169. Twenty-nine (28%) of these patients were female and 77 (72%) were male.

There were twenty patients in the failed category nine of which were females (45%) and 11 were males (55%). The number of total treatments the patients had in the failed category were forty-one treatments.

There were thirty-six patients who did not have a full treatment, did not complete so were not included in the final analysis.

Number of patients awaiting further ESWL were. The Combined number of treatments of patients had that are waiting further ESWL is 32 treatments. Six patients had treatments to reduce stone burden prior to surgery with a combined total number of treatments of 14. Two patients were awaiting follow up (Covid 19 delay) had 4 treatments. 2 patients did not attend for follow up had 1 treatment. These patients were excluded from the stone clearance rate as their treatments were not complete. Table 1.

Table 1 -

	No of patients	No of treatments
Successful treatments	106	165
Failed treatments	20	41
Reduce stone burden prior to surgery	6	14
Awaiting follow up	2	4
DNA'd to follow up	2	2
Awaiting further ESWL	15	32
Total	151	258

Failed Treatments-

The failed category was split into two sections those who tolerated treatments and managed to complete treatment sessions and those who could not tolerate the treatment and were unable to finish treatment session due to pain.

There were twenty-one patients who completed treatments and noted as having failed their treatment and fourteen patients who didn't complete full treatments and consequently noted as having failed the treatment. Those who had good full treatments close to 3000 shocks were only included.

Table 2-General Overview of results

	Successful treatments	Failed treatments	Failed treatments- patients that didn't tolerate treatment
Average HU centre of stone	1052	1128	1163
Average SSD	11.7cm	9.8cm	10.7cm
Average stone size	7.8mm	10.4mm	8.6mm
Average power	58	62	34
Average energy	731	748	294
Average no of shocks	2849	3000	1467

Stone clearance rate

There were 106 patients who achieved stone clearance. Fifty two percent only required one treatment to achieve clearance, and forty percent needed two treatments. Therefore 92% of patients who achieved stone clearance are getting success with one to two treatments. The total numbers of treatments given in achieving stone clearance were 165; therefore, each patient needs approximately 1.56 treatments to treat a stone. Therefore, this justifies offering patients two treatments initially to treat a stone. Although as 52% of patients who obtained success with one treatment, and we offer two treatments to each stone are we wasting slots for second treatments? However, if we give one treatment, await imaging 6-8 weeks post treatment, review at the stone meeting to decide it needs a second treatment, the length of time between treatments increases which may make the second treatment if needed less effective.

This stone clearance rate is comparable to a study done by Al-Marhoon et al (2013), as the number of treatments needed to treat a stone was 1.3. The percentage of patients who achieved stone clearance was 77.6% (149/192). The necessity for three sessions was non-significantly affected by stone size (p=0.245). However, a higher proportion of stones sized >20 mm (18%) needed three sessions, compared with only 6% of stones sized <10mm. (Mohammed S Al-Marhoon 1, Al Balushi, Josephkunju, Venkiteswaran, & Shareef, 2013)

Table 3 – Showing stone clearance through number of treatments needed.

Achieved stone clearance through :	Number of patients	Percentage %	No of treatments
1 treatment	56	52	56
2 treatments	43	40	86
3 treatments	6	6	18
4 treatments	0	0	0
5 treatments	1	1	5
Total	106		165

Successful treatments – stone size and number of treatments needed.

Table 4- Table showing stone size and number of treatments needed.

No of treatments required	Average stone size successful treatments	Average stone size failed treatments
Treatment 1	**7.6**	**8.5**
Treatment 2	**7.6**	**10.5**

Treatment 3	**10**	**10**
Treatment 4	**9**	**0**
Treatment 5	**13**	**13**

The table shows the generally that the number of treatments needed generally increase with stone size.

Complication rate

Overall, there were sixteen complications in 283 ESWL treatments, working out as a complication rate of 5.7 %. There were twelve (4.2%) steinstrasse/ obstructions, eight of which required surgery (67%) and four of which did not require surgery (33%).

Our rate of steinstrasse/ obstruction is 4.1% and is comparable to other studies ranging from 4-7 % (Ather, Shrestha B, & Mehmood , 2009) . There was one admission immediately post treatment due to pain requiring surgery (no obstruction) – 0.3% this stone was found to be fragmented but within a diverticulum.

We had three haematomas in 284 ESWL treatments, working out as a rate of 1%. Two of which were symptomatic and one asymptomatic. Studies have reported the asymptomatic rate as being between 4-19% and symptomatic as <1%. (Dhar, Thornton, Karafa, & Streem, 2004). The asymptomatic rate, however, may be underrepresented. Follow up imaging post treatment is normally an ultrasound 6-8 weeks post treatment. Often depending on the site allocated for imaging it can often be longer giving time for resolution of haematomas. It has been reported that ultrasound can be less sensitive for detecting them. Ultrasound is sensitive for detecting free fluid but has reduced sensitivity for detecting low-grade renal parenchymal injuries like subcapsular hematomas (McGahan, Richards, Jones, & Gerscovich EO, 1999) .

Although ESWL can cause some serious complications, overall, our ESWL complication rate is quite low and comparable to other studies. When compared to the likes of PSNL and URS there are fewer overall complications (Pearle, et al., 2005).

Stone laterality

Out of the eighty-three left sided stones 64 (77%) of them were treated successfully and nineteen failed (23%)

73% (43) of the right sided stones have been treated successfully and 23% failed (16). Slightly higher success rate observed for left sided stones than right.

Stone Location –

Table 5

	Success	Failed	Total (%)
Upper pole	14	2	16 (13)
Lower pole	57	11	68 (54)
Mid pole	27	5	32(25)
upper ureter	1	0	1 (0.8)
Lower ureter	2	0	2 (1.6)
PUJ	5	2	7 (5.6)
	106	20	126

It has been reported that ESWL achieves good stone free rates for stones up to 20mm except for those at the lower pole however this is not the case here. Lower pole stones counted for 54% of the stones treated followed by 25% in the mid pole and 13% in the upper pole. Eighty eight percent of upper pole stones were treated successfully and 84% of mid and lower pole stones. Another study reported that lower pole kidneys stones have similar fragmentation and stone clearance compared with non-lower pole kidneys stone and that stone location alone should not discourage ESWL. (Torricelli, et al., 2020)

Seventy one percent of PUJ stones were treated successfully and 100 percent of ureteric stones, however they only accounted for a small sample of stones treated (2.4%). To fully assess our stone clearance rates for ureteric stones a further study with an increased sample of ureteric stones would be necessary.

Stone size and number of treatments needed.

It has been widely reported that stone free rates after ESWL are lower with increasing stone size. One study found that patients with stones greater than 20mm 66% of them had greater than two sessions compared to 11.8% in the <10mm group and 15.8% in the 11-15mm group. This confirms stone size is a significant predictor of stone fragmentation, number or treatments required and outcome of ESWL (Panchal, Krishnaswamy, Dhammdeep, & Swami, 2018). In our study we demonstrated that 91% of stones <10mm were successfully treated with one treatment compared to 9% of those sized 11mm-20mm. it is important to note that Stone size measurements done on CT have been reported to more accurate and reproducible than a plain film xray or ultrasound. There is less

magnification and less user bias. (Patel & Nakada, 2011). In our study it can be seen in table 6 that generally as the stone size increases more treatments are needed.

Table 6- Stone size and number of treatments.

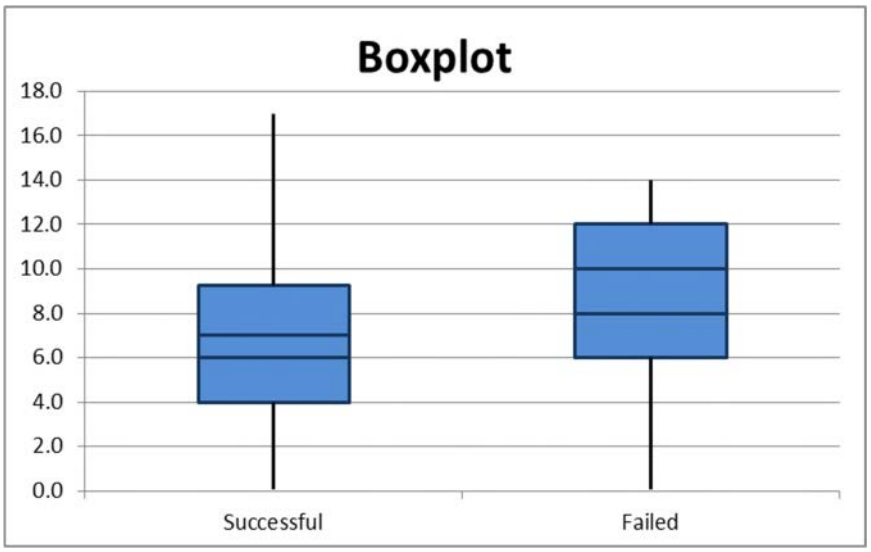
	Average stone size – successful treatments	Average stone size unsuccessful
One treatment	7.6	8.5
Two treatments	7.6	10.4
Three treatments	10.5	10
Four Treatments	9	0
Five treatments	13	14

Comparing stone size to treatment outcome.

The stone size (mm) was tested to see it was statistically significant between the sample of patients who successfully completed treatment and those who failed. More formally, we investigated if there is any statistical difference between the mean values of both samples. The stone size ranged from 5mm to 15mm.

	Successful	Failed
N	107	20
Mean	7.860	10.150
Median	7.0	10.0
StDev	2.768	2.455
SE Mean	0.268	0.549

The boxplot below and the small difference between the median and mean values illustrate the extent to which both samples are normally distributed. On this basis, we proceeded to test our hypothesis using a 2-tailed, 2 sample t-test, considering the inequality in variances and sample sizes.

In relation 

to the significance of stone size to treatment outcome, we conclude that according to our sample of patients, the mean stone size is significantly smaller in those that successfully completed treatment p=0.0007.

Skin to stone distance- (STSD)

Body mass index (BMI) is easy obtainable measure of obesity which has been found to be successful in predicting ESWL success. (Pareek, Armenakas, Panagopoulos, & Bruno, 2005). STSD Is another factor in predicting stone treatment success. Unlike BMI it takes into consideration the amount of subcutaneous and visceral fat along with the stone location and the renal parenchymal thickness. In a large retrospective review of 1282 ESWL treatments, an STSD >10 cm was associated with lower stone free rates on multivariate analysis (Patel, 2019). However, this is not the case in our centre as the mean STSD was 11.7cm in the successful category and lower at 9.8cm within the failed category. It is evident that stones with an STSD greater than 10cm can be successfully treated. This may be due to our lithotripter as it has a focal zone for treating STSD up to 17cm. This is further backed up by the experienced Scottish stone centre whose data illustrates the utility of ESWL in patients with higher SSD, achieving equivalent treatment outcomes to those with a lower STSD. (Mains, et al., 2021) The lithotripter used in their centre is the Sonolith I system which is the same as our centre. This data promotes treating patients with higher STSD more successfully, as patients with high SSTDs often have high BMIs and have other comorbidities which put them at a higher anaesthetic risk and make them less favourable for ureteroscopy.

Density of stone- Hounsfield Units (HU)

Hounsfield units have an important role to play in managing nephrolithiasis, from deciding what treatment is appropriate for a particular stone to predicting ESWL success. We wanted

to know if measuring the HU's can be predicting factor of stone treatment success. So, we applied statistical analysis to each of the different ways we measured it.

1. **Measuring the HU within the centre of the stone.**

A test to see if the Average HU of the centre of the stone is statistically significant when comparing a sample of patients who have successfully completed treatment and those who failed. Patients that failed are those who completed treatment but did not respond to the treatment.

Null hypothesis: In terms of Average HU measurements taken for the centre of the stone, there is **no statistical significance** in recordings for those who succeeded and those who failed treatment.

Alternative Hypothesis: In terms of Average HU measurements taken for the centre of the stone, the difference in recordings for those who succeeded and those who failed treatment **is statistically significant**.

Average HU Centre

t-Test: Two-Sample Assuming Unequal Variances		
	Successful	*Failed*
Mean	1053.613208	1127.95
Variance	158572.849	258124.6816
Observations	106	20
Hypothesized Mean Difference	0	
Df	24	
t Stat	-0.619425861	
P(T<=t) one-tail	0.270736064	
t Critical one-tail	1.71088208	
P(T<=t) two-tail	0.541472128	
t Critical two-tail	2.063898562	

Results:

Our P-value of 0.54 is significantly greater than our significance level of 0.05, therefore we accept the null hypothesis at the 0.05 significance level. We can conclude with a good deal of confidence therefore, based on our sample of patients, that there is no statistical significance between the average HU in the centre of the stone between those who succeeded in and those who failed treatment. It can be asserted that the average HU in the centre of the stone is not a good predictor of treatment outcome.

2. **Average HU unit using 3 measurements within a stone.**

A test to see if the Average HU of the stone using the average of 3 measurements within a stone is statistically significant when comparing a sample of patients who have successfully completed treatment and those who failed. Patients that failed are those who completed treatment but did not respond to the treatment.

Null hypothesis: In terms of the Average HU of the stone using 3 measurements, there is **no statistical significance** in recordings for those who succeeded and those who failed treatment.

Alternative Hypothesis: In terms of Average HU of the stone using 3 measurements, the difference in recordings for those who succeeded and those who failed treatment **is statistically significant**.

t-Test: Two-Sample Assuming Unequal Variances		
	Successful	*Failed*
Mean	906.7169811	934.6683333
Variance	109606.7572	141449.9264
Observations	106	20
Hypothesized Mean Difference	0	
Df	25	
t Stat	-0.310445616	
P(T<=t) one-tail	0.379397767	
t Critical one-tail	1.708140761	
P(T<=t) two-tail	0.758795535	
t Critical two-tail	2.059538553	

Results:
Our P-value of 0.75 is significantly greater than our significance level of 0.05, therefore we accept the null hypothesis at the 0.05 significance level and reject the alternate hypothesis. We can conclude with a good deal of confidence therefore, based on our sample of patients, that there is no statistical significance in the average HU of the stone using 3 measurements between those who succeeded in and those who failed treatment. It can be asserted that Average HU of the stone using 3 measurements is not a good predictor of treatment outcome.

3. **Average HU using freehand tool.**

A test to see if the Average HU of the stone using the freehand tool is statistically significant when comparing a sample of patients who have successfully completed treatment and those who failed. Patients that failed are those who completed treatment but did not respond to the treatment.

Null hypothesis: In terms of the Average HU of the stone using the freehand tool, there is **no statistical significance** in recordings for those who succeeded and those who failed treatment.

Alternative Hypothesis: In terms of Average HU of the stone using the freehand tool, the difference in recordings for those who succeeded and those who failed treatment **is statistically significant**.

t-Test: Two-Sample Assuming Unequal Variances		
	Successful	*Failed*
Mean	897.2358491	934.55
Variance	104947.4772	178407.8395
Observations	106	20
Hypothesized Mean Difference	0	
Df	23	
t Stat	-0.374823319	
P(T<=t) one-tail	0.355612928	
t Critical one-tail	1.713871528	
P(T<=t) two-tail	0.711225856	
t Critical two-tail	2.06865761	

Results:

Our P-value of 0.71 is significantly greater than our significance level of 0.05, therefore we accept the null hypothesis at the 0.05 significance level and reject the alternate hypothesis. We can conclude with a good deal of confidence therefore, based on our sample of patients, that there is no statistical significance in the average HU of the stone (using the freehand tool) between those who succeeded and those who failed treatment (i.e. there are no intrinsic differences in the Average HU of the stone using the freehand tool across the 2 samples).
We can conclude that by looking at the three different ways of measuring the HU of a stone, there is no correlation with the HU in predicting stone clearance.

It is interesting that despite the many studies suggesting that HU can accurately predict ESWL success unfortunately in our case series the HU measured by any of the methods was not significant regarding the overall ESWL success or failure. Our findings are further backed up by studies by Pareek et all 2005, Patel et al, 2009 and Mullhaupt et al, 2015 which also demonstrate the inability of HU to predict ESWL success for both ureteric and renal calculi. However, we do feel it has a role to play in deciding patient management. It is important that the right treatment for a patient is selected as failure of a stone to fragment post ESWL may require an alternative procedure increasing medical costs and unnecessary patient suffering. (El-Nahas AR, 2007). A clinical study showed that among patients treated by ESWL and had HU > 750 74% required at least 3 treatments to be stone free. HU <750 only 20% required at least 3 treatments. (Gupta NP, 2005) Our study has shown that stones

greater than 1000 HU can be treated successfully however they often need more treatments.

Table 7 **Successful treatments**

	HU<500 Group 1	**HU 500-1000 Group 2**	**>1000 Group 3**
Treatments x 1	5 (5)	19 (19)	31 (31)
Treatments x2	6 (12)	13 (26)	24 (28)
Treatments x 3	1 (3)	0 (0)	5 (15)
Treatments x 4	0 (0)	0 (0)	1 (4)
Treatments x 5	0 (0)	0 (0)	1 (5)
Total	12	32	62

NICE economic analysis reported a National Health Service reference cost of £452 for a single ESWL session vs £2172 for ureteroscopy so even if a patient needed three treatments, ESWL is still more cost effective unless additional procedures are required. (NICE, 2019)

Another non-invasive treatment option for urinary calculi is chemolysis of uric acid stones. Knowing the HU of a stone is therefore useful for predicting uric acid stones. It has been found that along with a urine PH of <5.5 and a HU of < and equal to 500 for stones > than 4mm the positive predictive values for uric acid composition is 90% (Spettel, et al., 2013) A recent study by Tsaturyan et al 2020 with suspected uric acid stones when treated by chemolysis, 61% had complete response to treatment at three months sparing most patients from interventional stone therapy avoiding potential complications, additional treatment was only required in 22% of unsuccessful chemolysis treatments. (Tsaturyan, et al., 2020)

Various studies have shown different ways to measure a stone. The ease of measuring needs to be quick and accurate. In the methods we used in this study it was found that there was no significant difference in the ways used to measure a stone. The F-(ROI) method takes into consideration the HU of the whole stone, whereas the C – (ROI) method is the HU measurement of the just the centre of the stone. The ROI – 3 method is an average of three non-overlapping areas within a stone. Stone composition can vary as

demonstrated by Zhang et al 2021, 18% of stones are made of up only one component with 67.4% consisting of two and 14.6% had three or more component (Zhang, et al., 2021) The C- (ROI) measurement our study appears to be consistently higher than the other measurements showing that stones can be more dense in the centre often with less dense outer portions, so fragmenting the outer portions can help make the dense centre stone smaller and easier to pass. Based on our sample of patients, we have found that there is no statistical significance between the methods of measuring HU and the success of ESWL for any individual patient and therefore utilised the centre technique is adequate for assessing stone density in a clinical situation.

Another interesting factor which may be useful in predicting ESWL success is the stone heterogeneity index (SHI). HU measurements are obtained by the mean value of the HU of each pixel in a particular stone determined from NCCT using PACS. SHI is the standard deviation of stone density. This is used to determine the variation within the data set. A higher standard deviation means the data is spread out of a larger range of values suggesting stone composition heterogeneity. This may explain why in our study we were able to treat stones greater than 1000 HU successfully. A study has shown that stones with A MSD of >1000 the success groups demonstrated significant SHI than in the failure groups. (Lee, et al., 2016) Therefore, a heterogeneous stone may be more fragile than a homogenous stone and may be worthwhile considering when deciding patient management. The standard deviation can be determined easily when taking HU measurements.

Conclusion

From the collected data it can be said that EDAP Sonolith lithotripter is an effective machine for treating urinary calculi. The low rate of complications demonstrate that it is also safe when used within correct parameters. An acceptable success rate has been demonstrated for renal calculi and for ureteric calculi, however the sample size on ureteric calculi was limited and a further study with an increased sample size may be of benefit in the future. Stones with a STSD distance of >10cm can be treated successfully. We have demonstrated a good success rate for lower pole stones. Stones with HU greater than 1000 can be treated successfully however they often need more treatments.

References

(2022, 03 15). Retrieved from The British Association of Urological Surgeons: www.baus.org.uk/patients/conditions/6/kidney_stones/

Ather, M. H., Shrestha B, B., & Mehmood , A. (2009). Does ureteral stenting prior to shockwave lithotripsy influence the need for intervention in steinstrasse and related complcations? *Urology international*, 222-225.

Dhar, N. B., Thornton, J., Karafa, M. T., & Streem, S. (2004). A multivariate analysis of risk factors associated with subcapsular hematoma formation following electromagnetic shock wave lithotripsy. *The Journal of Urology*, 2271-2274.

El-Nahas AR, E.-A. A. (2007). A prospective multivariate analysis of factors predicting stone disintegration by extracorporeal shock wave lithotripsy: the value of high-resolution noncontrast computed tomography. . *Eur Urol, 51*, 1688.

Esiner, B. H., Kambadakone, A., Monga, M., Anderson, J. K., Thiresin, A. A., & Lee, H. (2009). Computerized Tomography magnified bone widows are superior to standard soft tissue windows for accurate measurement of stone size: an invitro and clinical study. J Urol.2009:182:1. *Journal of Urology*, 1710-5.

Gupta NP, A. M. (2005). Role of computed tomography with no contrast medium enhancement in predicting the outcome of extracorporeal shock wave lithotripsy for urinary calculi. *BJU Int. , Jun;95(9):*, 1285-8. .

Mains, E. A., Blackmur, J. P., Abhishek , S. D., Gietzmann, , W. K., Stephenson, C., Wallace, S., . . . Cutress, M. A. (2021). Shockwave Lithotripsy Is an Efficacious Treatment Modality For Obese Patients with Upper ureteric calculi: Logistic regression and matched paor analysis from a dedicated stone centre comparing tratment outcomes by skin to stone distance. *Journal of Endourology*, 487-494.

McGahan, J. P., Richards, J. R., Jones, C. D., & Gerscovich EO, E. O. (1999). . Use of ultrasonography in the patient with acute renal trauma. *Journal of ultrasound in medicine.*, 207-213.

Mohammed S Al-Marhoon 1, A.-H. I., Al Balushi, A. S., Josephkunju, M., Venkiteswaran, K. P., & Shareef, O. (2013). Extracorporeal Shock-wave Lithotripsy Success Rate and Complications: Initial Experience at Sultan Qaboos University Hospital. *Oman Medical Journal*, 255-259.

NICE. (2019). *National institute for Health and Care and Excellence.* Retrieved April 13, 2021, from www.nice.org.uk/guidance/ng118/evidence/costing-analysis-of-surgical-treatments-pdf-6654738349

Panchal, P. G., Krishnaswamy, M., Dhammdeep, D. C., & Swami, O. (2018). Study of factors predicting clinical outcomes of extracorpeal shock wave lithtripsy in Indian patients with upper urinary tract calculi. *International Surgery Journal*, 1532-1537.

Pareek, G., Armenakas, N. A., Panagopoulos, G., & Bruno, J. J. (2005). Extracorporeal shock wave lithotripsy success based on body mass index and Hounsfield units. *Urology*, 33-36.

Patel, S. R., & Nakada, S. Y. (2011). Quantification of preoperative stone burden for ureteroscopy and shock wave lithotripsy: current state and future recommendations. *Journal of Urology*, 282-285.

Patel, T. &. (2019). Patel, Trushar & Kozakowski, Kristin & Hruby, Gregory & Gupta, Mantu. Skin to Stone Distance Is an Independent Predictor of Stone-Free Status Following Shockwave Lithotripsy23. 1383-5. 10.1089/end. *Journal of endourology / Endourological Societ*, 1383-5.

Pearle, M. S., Lingeman, J. E., Leveillee, R., Kuo, R., Preminger, G. M., Nadler, R., . . . Ogan, K. (2005). Prospective, randomised trial comparing shock wave lithotripsy and urteroscopy for lower pole caliceal calculi 1cm or less. *The Journal of Urology*, 2005-2009.

Torricelli, F., Monga, M., Yamauchi, F., Marchini, G., Danilovic, A., Vicentini, ,. F., . . . Mazzucchi, E. (2020). Renal Stone Features Are More Important Than Renal Anatomy to Predict Shock Wave Lithotripsy. *Journal of Endourogy*, 63-67.

4) 174. Lingeman, J.E., *et al.* Comparison of results and morbidity of percutaneous nephrostolithotomy and extracorporeal shock wave lithotripsy. J Urol, 1987. 138: 485. https://www.ncbi.nlm.nih.gov/pubmed/3625845

REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

To be tabled at SMT Meeting TBC

Name of Organisation	Southern Health & Social Care Trust
Project Title	Extra Corporeal Shockwave Lithotripsy (ESWL) & Generalised Stone Services at Southern Health & Social Care Trust Draft V.03
Total Cost	**£TBC**
Start Date	**£TBC**
Completion Date	**Recurrent funding requested from 2018/19 onwards £TBC**

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	**Yes**
How much total funding required?	**£TBC**
How much funding required per year?	**£TBC**
Is this funding to be made recurrent?	**Yes**

Complete this section if funding available within existing allocation

Funding available within existing allocation (Y/N)	**No**
Total cost of proposal	**N/A**
Cost of proposal per year	**N/A**
Is this cost within recurrent allocation?	**N/A**

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

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Date	**APRIL 2018**	

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Complete this section if Department / DFP approval required

Date submitted to Department
Department/ DFP approval (y/n)
Date approved

BUSINESS CASE TEMPLATE **REVENUE FUNDING £50k - £250k**

SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED

Introduction
This paper outlines a proposal associated with enhancing the Extra Corporeal Shockwave Lithotripsy & Generalised Stone Service within the Southern Health & Social Care Trust.

Associated costs of **£TBC** have been identified from **TBC** funding stream and approval is now being sought from Senior Management Team for the progression of this proposal.

The Trust's Senior Management Team confirmed at its meeting on 24 January 2018 that it was supportive of a proposal being developed.

Background
The Southern Health & Social Care Trust (SHSCT) was established on 1st April 2007 following the amalgamation of Craigavon Area Hospital Group, Craigavon & Banbridge Community, Newry & Mourne and Armagh & Dungannon Health and Social Services Trusts. It is one of six organisations that provide a wide range of health and social care services in Northern Ireland.

The Trust provides acute hospital and community services to council areas of Armagh, Banbridge and Craigavon; Newry, Mourne and Down; and Mid Ulster – a population of some 369,000. The acute hospital services provided by the Trust are also used by people from outside the Southern area including Fermanagh, Down and Lisburn, Antrim, Cookstown, Magherafelt and the Republic of Ireland.

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

Both acute hospitals provide inpatient, out-patient and day case services across a range of specialties. These include a 24-hour Emergency Department and unscheduled medical and surgical services.

The Trust is responsible for the delivery of high quality health and social care to its resident population and employs 13,000 staff.

Extra Corporeal Shockwave Lithotripsy (ESWL)
This is a non-invasive procedure which is used in the treatment of kidney stones that are too large to pass through the urinary tract. The procedure is carried out by Consultant Urologists who have experience in urinary tract stone disease. In the first instance, kidney stones will be detected via the use of x-rays/scans which will determine their presence and location.

Patients within the Southern Trust area suitable for this specific treatment regime may attend on an elective basis or in the case of patients referred for urgent admission, ESWL may be carried out during the inpatient stay. The procedure entails breaking down the stones in the kidney, bladder or ureter (tube that carries urine from the kidneys to the bladder) by sending high-frequency ultrasound shock waves directly to the stone once located with fluoroscopy (a type of x-ray) or ultrasound. The shock waves cause large stones to be broken down into smaller pieces to enable these to pass through the urinary system. Treatment sessions last for approximately an hour.

Strategic Context
Guidelines for the management of renal colic/renal and ureteric stones are documented in:-

- British Association of Urological Surgeons "**Standards for the Management of Acute Ureteric Colic" September 2017**
- National Institute for Health & Care Excellence guideline **"Renal & Ureteric Stones: Assessment and Management (consultation 20 January to 17 February 2017)"**

"Stone removal is recommended in the instance of persistent obstruction, failure of stone progression or increasing or unremitting colic. The choice of treatment to remove a stone depends on the size, site and shape of the stone. Options include extra corporeal shockwave lithotripsy (ESWL) ureteroscopy with laser, percutaneous nephrolithotomy or open surgery".

"Where suitable, ESWL offers a non-invasive treatment with lower complication rates and a shorter hospital stay".

In addition, the current standards associated with care for acute stone pain and use of ESWL (British Association of Urological Surgeons "***Standards for the Management of Acute Ureteric Colic" September 2017)*** states that "for symptomatic ureteric stones, primary treatment of the stone should be the goal and should be undertaken within 48 hours of the decision to intervene" – is this the text to be referred to??? Yes this is a good statement

Local Context
"Improving Together" the Trust's Corporate Plan 2017/18 – 2020/21 sets out the strategic direction for the next four year period and includes challenges and opportunities to create better health outcomes for the population within the Southern area.

The Corporate Plan recognises the need for service reform as a result of the changing needs of our local population, new ways of delivering care and treatment in line with the financial and workforce resources available to us.

The key objectives which the Trust will strive to achieve are:-

- Promoting safe, high quality care
- Supporting people to live long, healthy active lives
- Improving our services
- Making the best use of our resources
- Being a great place to work, supporting developing and valuing our staff
- Working in partnership

Demographic Growth:

- The Trust has the second largest population in NI 369,000. The Trust population is projected to increase by over 20% between 2016 and 2039 (compared to the NI projected growth of 8.5%) including more significant growth in our ageing population

Current Service Provision
At the present time, there are a total of two Lithotripsy machines across Northern Ireland, a mobile machine sited in Belfast and a machine located within the Stone Treatment Centre (STC) at Craigavon Area Hospital.

Lithotripsy treatments are delivered to the Southern Trust's resident population in addition to patients residing outside of the Trust's catchment area (from January 2017 South Eastern Trust patients have undergone stone treatment procedures at CAH).

Current Capacity
The STC facilitates a total of three weekly ESWL sessions which take place on Monday, Wednesday and Friday mornings. The first treatment commences at 9.00 am with the session ending at 1.00 pm. A total of **9** patients undergo ESWL treatments every week. ITS 2.25 SESSION PER WEEK MONDAY WEDNESDAY AND ONE TO TWO FRIDAY AVERAGING 7-8 pt PER

WEEK OTHER FRIDAYS IS A CLINIC

Patients' referrals for stone treatment regimes are received via a number of channels including:-

1. Emergency Departments at Craigavon Area, Daisy Hill and South West Acute (Enniskillen) Hospitals
2. General Practitioners within the Southern Trust region and the South West Acute Hospital's local population
3. Wards in Craigavon Area Hospital, Daisy Hill Hospital and South West Acute Hospital
4. Consultant Urologists from Southern and South-Eastern Health & Social Care Trusts
5. Letterkenny Hospital, Republic of Ireland
6. Altnagelvin Hospital

Although emergency ESWL treatments can be made available if there is a cancellation, ~~predominantly emergency treatments are performed on Mondays, Wednesdays and Fridays – TBC~~ THIS IS FEW AS CANCELLATIONS ARE BACK FILLED AS FREE SLOTS ARE DEFINED AS LOST OPPORTUNITY. EMERGENCY ESWL HAS NOT TILL NOW BEEN OFFERED AS THERE HAS BEEN A LACK OF CONTRACT FOR SAME. THIS WOULD HOWEVER HELP WITH THE INPATIENT ACTIVITY.

The current staffing establishment per session consists of:-

- 0.30 wte Consultant
- 0.30 wte Radiographer
- 0.30 wte Band 5 Nurse
- 0.30 Band 3 Healthcare Assistant

Key Issues/Assessment of Need

The growing demands being placed upon the Trust's ESWL & Generalised Stone Service understandably proves challenging when taking into consideration the number of issues in terms of:-

1. **Demand & Capacity**

   Since the introduction of the Extra Corporal Shockwave Lithotripsy (ESWL) service on 11 September 1998, there has been a steady increase in the number of patients being offered this treatment regime.

   In January 2017, there were a total of 108 adult patients awaiting treatment, however by January 2018 the figure has dramatically increased to a total of 233 adult patients showing a staggering 116% rise.

   This figure equates to an average of 31 patients being added to the waiting list per month.

   The waiting time for treatment (as of January 2018) is presently 8 months.

2. **Emergency ESWL Provision for Upper & Distal Ureteric Stones**

   average approximately 10 patients will have a ureteroscopy performed each week at Craigavon Area Hospital. In addition to the number of adult patients awaiting outpatient (elective) ESWL treatment, on THIS IS FINE

   Some of these patients could be suitable to undergo "emergency ESWL" treatment, however due to the restricted use of the Lithotripsy machine at the present time, this cohort of patients have to undergo their treatment within Main Theatres at Craigavon Area Hospital as there are only ESWL sessions 3 days per week. THIS IS FINE

   Understandably, this practice is counter-productive as it hinders the Trust's ability to adhere with the respective guidelines associated with the assessment and treatment of ureteric stones[1]

which states that "primary treatment of the stone should be the goal and should be undertaken within 48 hours of the decision to intervene" –THIS IS FINE is this the relevant text to use TBC. More non-invasive procedures and extended availability across the week would support the Trust to comply with guidelines. THIS IS FINE

3. **Service Model**

The Lithotripsy machine has been in operational use since the late 1990s (circa 20 years). At that time, the working practices put in place adequately met the needs of the service. Inevitably changes in medical practice have evolved in recent years however no modifications or adaptions to the working practices within the STC have been implemented. As a consequence, it has not been possible to optimise the potential to develop the Southern Trust's ESWL & Generalised Stone Service.

Given the existing service model, provision of a service which represents value for money whilst making best use of the facilities available is not achievable. The insufficiencies are particularly prevalent within the following areas:-

- Increased number of patients being **referred** into the Service
- As the majority of patients initially opt for treatment to be given without the need for a general anaesthetic, the number of patients awaiting elective ESWL treatment inevitably causes a rise in **waiting times**
- As a consequence of current waiting lists, patients' **x-ray/scan images** become out-of-date often emanating in the loss of a treatment 'slot' as the patient cannot undergo their planned ESWL procedure if there is a possibility that their renal stones have become dislodged
- A significant amount of nursing **administration** associated with patient documentation which is undertaken on the day of treatment impinges on the allocated treatment time

4. **"Time & Motion" Study**

In an effort to address the inefficiencies with the current service model, a "Time & Motion" study was conducted in December 2017. This involved a group of multi-disciplinary staff reviewing and 'process mapping' the "Renal & Ureteric Stone" pathway in order to streamline the processes, improve treatments/safety and patient follow-up reviews.

On conclusion of the "Time & Motion" study, a number of recommendations were identified which included:-

- The need for a Stone Multi-Disciplinary Team (MDT) to be established
- With the introduction of an MDT this would facilitate:-
  - a platform for discussion of complex patients
  - referrals received from Emergency Departments, Wards and GPs to be reviewed giving due consideration to each individual patient's condition
  - a review of patients' imaging
  - an informed decision to be made in relation to the most appropriate treatment pathway for each patient for example ESWL, Ureteroscopy etc which would be in line with guidelines (eg British Association of Urologists, NICE etc)
- New documentation to be developed such as:-
  - Ureteric & Renal Stone Referral
  - Patient Information Pack

5. **Staffing Resources**

In view of the recommendations emanating from the "Time & Motion" study, a change in practice was introduced in December 2017 which enabled a Stone Multi-Disciplinary Team to be established together with an agreed Referral Pathway to be developed.

At that time, the potential to increase capacity was identified if changes associated with the nursing administration process could be introduced.

It highlighted that if the requisite administration could be performed prior to a patient attending for their treatment, this could permit an additional patient per session to be treated (eg a total of 4 patients would undergo an ESWL procedure per session).

However, with insufficient staffing resources presently available, the delivery of an efficient and effective ESWL & Generalised Stone Service is compromised.

- **Administrative & Clerical**
  With the weekly MDT meeting taking the form of a "virtual clinic" there is a significant amount of administration to be progressed in advance of the weekly meetings which encompasses:-

  - ensuring all the requisite paperwork is available for the meeting (eg referral forms, prescription sheets, diagnostic results etc) which require populating during the MDT meeting when outcomes are discussed/agreed
  - preparation of MDT lists
  - population of worklist on NIECR for ease of access during the MDT meeting
  - taking notes of the MDT meetings, completing the electronic MDT outcome form, populating patient templates with agreed outcomes from MDT in order to send to patients
  - ensuring follow-up arrangements are made
  - tracking follow-up arrangements/results

  In addition to the duties associated with the weekly MDT meetings, there are a number of administrative tasks in respect of the elective ESWL process which are detailed below:-

  - Population of appointments and preparation of lists
  - Ensuring all ESWL related treatment paperwork is available (eg prescriptions, nursing checklist, post-treatment advice)
  - Creating and printing of booklets and distribution of patient documentation (to negate the need for this to be undertaken on the day of treatment TBC)
  - Sending for list and confirming patients' attendances
  - Ordering notes for ESWL treatment day
  - Arrangement/tracking of follow-up

  A patient letter template was created on Patient Centre to enable Consultant Urologists' secretaries to type up the weekly patient letters. However, the increased workload is unsustainable given the other duties assigned to Consultant secretaries. As a consequence, delays associated with the typing up of the MDT letters are regularly experienced TBC HENCE THE NEED FOR ADDITIONAL ADMISTRATIVE STAFF

- **Medical, Nursing & Radiology**
  In view of the volume of administrative tasks associated with both the MDT meetings in conjunction with the ESWL processes, this can often result with the Specialty Doctor in Urology providing a degree of administrative support to the Stone Treatment Centre.

  In terms of ESWL Sonographer training, there is a detailed protocol which must be adhered to in order for Sonographers to become competent in ESWL. This involves a period of supervised targeting and treatment of renal calculi in both adults and paediatrics which must encompass both ultrasound and fluoroscopic control. In addition, a minimum of 50 treatments must be achieved and in the event of a trainee being absent for a prolonged period of time (eg maternity leave), there may be a requirement for part of the process to be repeated. On completion of the requisite training and to allow progression, it will necessitate a Sonographer participating in ultrasound audit programmes and undertaking future training updates to ensure continuing professional development and assessment of accuracy.

Reference 1 *– British Association of Urological Surgeons Standards for the Management of Acute Ureteric Colic September 2017*

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. Improve access to ESWL Service by 31 March 2019	• Increase access across the week ➢ Baseline – 3 sessions per week (as of April 2018) ➢ Target – 7 sessions per week YES
2. To improve compliance with Commissioning Plan Objective 4.12 ➢ No patient waits longer than 13 weeks for inpatient/daycase ESWL treatment by September 2019	• Facilitation of appropriate ESWL provision which meets the demand for elective treatment:- ➢ Baseline – as of January 2018, a total of 148 patients are awaiting more than 13 weeks for elective ESWL treatment ➢ Target – minimum of 30% reduction in *reduce routine waiting times in the first instance*
3. Improve the efficiency of the current ESWL Service by 31 March 2019	• Increase number of patients treated per session:- ➢ Baseline – a total of 3 patients per session (as of April 2018) ➢ Target – a total of 4 patients per session (on appointment of additional staffing resources)

SECTION 2 (b): CONSTRAINTS

Constraints	Measures to address constraints
1. Availability to appoint additional staffing resources	The Trust will ensure that robust recruitment processes are in place, maintaining close links with BSO and Human Resources to ensure that any issues which may arise are promptly addressed
2. Recurrent revenue funding not secured	The Trust will maintain close links with the HSCB in order to proactively seek financial support for the service

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO	BRIEF DESCRIPTION OF OPTION

1	**Do Nothing/Status Quo - continue with existing arrangements** This option will entail the continuation of the existing service model of 3 ESWL sessions per week permitting a total of 9 patients to be treated. AVERAGE 7pt /week Although this option will not meet the project objectives, it has been shortlisted as a base case comparator.
2	**Increase ESWL Sessions from 3 to 7 Sessions per week within Stone Treatment Centre at Craigavon Area Hospital** This option will entail the appointment of additional staffing resources and permit the current 3 ESWL weekly sessions to be extended to 7 ESWL sessions per week. It will accommodate a total of 4 patients per session to be treated, emanating in additional capacity to facilitate a further 19 patients per week (eg 4 patients per session x 7 sessions equates to 28 patients TBC) in comparison to the 9 patients that are presently seen each week. THIS IS FINE
3	**Provision of a Dedicated Team for Stone Treatment Centre at Craigavon Area Hospital** Similar to Option 2, this option will consist of a significant number of staffing appointments being made enabling the number of weekly ESWL sessions to be extended from 3 to 7 sessions. It will permit a total of 4 patients per session to be treated, facilitating an additional 19 patients to be seen per week (eg 4 patients per session x 7 sessions equates to 28 patients TBC). With provision of a dedicated team of multi-disciplinary staff aligned to the Stone Treatment Centre at Craigavon Area Hospital it will enable all ESWL treatments, weekly MDT meetings, the complete outpatient journey (from investigation to review) to be effectively managed. Provision of a dedicated ESWL session for patients residing within South Eastern Trust area will also be deliverable. Is there any additional information as to what this option will deliver that needs incorporated? THIS IS FINE SEPARATELY AND INDIVIDUALLY FUNDED AFTER CALCULATION PER SESSION

SECTION 4: PROJECT COSTS

Option	Year 1 (£'000)	Year 2 (£'000)	Year 3 (£'000)	Total (£'000)
1				
2				
3				

COST ASSUMPTIONS:

Option 2
There will be a requirement for the following additional **posts to be appointed**
Can you please confirm exact staffing requirements please per session

- XX wte Band 5 Staff Nurse x1
- XX Band 3 Health Care Assistant X1
- XX wte Radiographer x1
- Xx wte Band 4 Admin & Clerical (NOT SURE HOW MUCH TIME PER SESSION suggest 1.5 to 2HR TO COVER ADMIN AND TELEPHONE CALLS discuss)

Option 3
There will be a requirement for the following additional **posts to be appointed**

Can you please confirm exact staffing requirements please
SAME AS PER OPTION TWO FOR TREATMENT SESSIONS

THE MDT SESSION WILL NEED ONE SESSION PER WEEK OF

- XX wte Band 5 Staff Nurse OR BAND 6 ONE SESSION
- XX wte Band 3 Health Care Assistant NOT REQUIRED
- XX wte Band Radiographer x1
- XX wte Consultant Urologist X 2
- XX wte Registrar x1
- XX wte Band 4 Admin & Clerical x1

THIS WILL COVER A VIRTUAL CLINIC AND ADMINISTRATION of the session THOUGH SECRETARY WORK WILL CONTINUE TRUST TO DEFINE QUANTUM PROBABLY A 3-4 day week DISCUSS

Goods & Services
- Are there any additional consumables that would be required for the no of sessions proposed TBC STATIONARY ETC AND NURSING ISSUES OF BED MANAGEMENT
- The anticipated life span of Lithotripter equipment is 10 years however it is not dependent upon the number of shocks/treatments/patients
- The current equipment has been in operational use since 1998 and is on the capital equipment list for Acute Directorate for replacement

SECTION 5: NON-MONETARY BENEFITS

The non-monetary benefits associated with the project are detailed below:-

Non-Monetary Benefit	Option 1 Status Quo/Do Nothing	Option 2 Increase Sessions within the Stone Treatment Centre	Option 3 Provision of a Dedicated Team for Stone Treatment Centre
Provision of additional sessions per week	• With no improved access to the service, enhanced utilisation of Hospital facilities will be untenable	• Facilitation of an additional 4 weekly sessions will enable higher volumes of patients to undergo their treatment resulting in a total of 28 patients being	• Similar to Option 2, this option will facilitate a further 4 weekly sessions to take place thus enabling a higher percentage of patients to

		seen on a weekly basis.	undergo treatment each week (circa 28 patients).
Reduced Waiting Times for Treatment	• As the number of patients being referred into the Service will continue to grow, it will result in a rise in waiting times. Therefore, patients will continue to experience lengthy waiting times for their treatment	• The patients' experience will be greatly enhanced as they will receive treatment for their conditions within an appropriate timeframe	• Similar to Option 2, the patients' experience will be significantly enhanced as the patient journey (from investigation to review) will be managed within an appropriate timeframe by a dedicated service team
Improved efficiency	• With the volume of administrative tasks associated with both MDT meetings and the ESWL processes, the degree of administrative support from the Specialty Doctor will still be prevalent (understandably, a situation which does not make best use of skills). • With no improved service provision, the use of Main Theatres at CAH for some patients' procedures will continue.	• As administrative tasks will be progressed prior to the day of treatment, a reduction in nurse administration on the day of treatment will be deliverable. This will increase capacity for treatment of an additional patient per session (total of 4 patients as opposed to 3 patients per session). • The potential loss/delay of treatment sessions will significantly reduce as x-ray scans will be up-to-date. • As more non-invasive treatment will be deliverable, fewer patients will require treatment within Main Theatres at CAH. Therefore, permitting patients to be managed within an appropriate environment. • Delivery of a more streamlined service will be achievable.	• As with Option 2, there will be a reduction of nurse administration on the day of treatment as administrative tasks will be progressed prior to the day of treatment. This will increase capacity for treatment of an additional patient per session (total of 4 patients). • The potential loss/delay of treatment sessions will significantly reduce as x-ray scans will be up-to-date. • This option will provide dedicated ESWL sessions for South Eastern patients • With dedicated staffing within the Stone Treatment Centre this will optimise the facilities available within the Stone

			Treatment Centre at CAH and enhance the patient's journey. • MDT PRINCIPLE OF PATIENT MANAGEMENT AND PROVIDE A VIRTUAL CLINIC TO IMPROVE QUANTUM < PATIENT FLOW

SECTION 6: PROJECT RISKS & UNCERTAINITIES

The project risks associated with this scheme are detailed in the table below:-

Risk Description	Likely impact of Risk H/M/L			State how the options compare and identify relevant risk management/mitigation measures
	Opt 1	Opt 2	Opt 3	
1. Inability to Appoint Staff	**N/A**	**L**	**L**	**Option 1** – N/A **Options 2&3** - there is the potential that no applicants may apply for the new posts, however this is deemed to be a 'low' risk. • **Mitigation Measure** - the Trust will ensure that robust recruitment processes are in place and any issues raised by BSO are promptly addressed
2. Recurrent revenue funding not secured	**N/A**	**M**	**M**	**Option 1** – N/A **Options 2&3** – this is a possibility that recurrent funding may not be secured and therefore this is considered a 'medium' risk • **Mitigation Measure** – the Trust will maintain close links with the HSCB/continue to seek financial support from the HSCB
Overall Risk (H/M/L):	**N/A**	**L/M**	**L/M**	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 1 - Status Quo/Do Nothing

- With no modifications being made to existing service model, there will be no enhanced utilisation of Hospital facilities
- The waiting times associated with ESWL treatment will continue to grow, therefore patients will continue to experience lengthy delays for treatment
- There will still be a requirement for the Specialty Doctor to provide a degree of administrative support which does not make best use of medical staffing resources
- The number of ureteroscopies will steadily increase as no additional capacity for elective ESWL treatments will be attainable
- No improvements to the efficiency of the ESWL & Generalised Stone Service within the Southern Trust will be achievable

Option 2 - Increase ESWL Sessions from 3 to 7 Sessions per week within Stone Treatment

Centre at Craigavon Area Hospital

- This option will enable the weekly Extra Corporeal Shockwave Lithotripsy (ESWL) sessions to be extended from 3 to 7 sessions per week
- It will provide increased capacity as a total of 4 patients per session will be treated, equating to a total of 28 patients receiving treatment per week (in comparison to 9 patients treated at the present time).
- The patient's experience will be greatly enhanced as waiting times for treatment will reduce therefore patients will receive treatment for their conditions within an appropriate timeframe
- The potential loss/delay of treatment sessions will significantly reduce as x-rays/imaging scans will be up-to-date
- As some patients may no longer require invasive treatment, fewer patients will require treatment within Main Theatres at CAH
- With more non-invasive procedures and extended availability being attainable, this will support the Trust to improve compliance with the requisite guidelines/recommendations (British Association of Urologist, National Institute for Clinical Excellence) as delivery of an enhanced ESWL Service to patients requiring treatment of renal stones will be achievable.
- An improved skill mix of staff will be attainable

Option 3 - Provision of a Dedicated Team for Stone Treatment Centre at Craigavon Area Hospital

- Similar to Option 2 above, this option will enable the weekly Extra Corporeal Shockwave Lithotripsy (ESWL) sessions to be extended from 3 to 7 sessions per week.
- It will provide increased capacity as a total of 4 patients per session will be treated, equating to a total of 28 patients receiving treatment per week (in comparison to 9 patients treated at the present time).
- The patient's experience will be significantly enhanced as the patient journey (from investigation to review) will be effectively managed within an appropriate timeframe
- As some patients may no longer require invasive treatment, fewer patients will require treatment within Main Theatres at CAH

- With more non-invasive procedures and extended availability being attainable, this will support the Trust to improve compliance with the requisite guidelines/recommendations (British Association of Urologist, National Institute for Clinical Excellence) as delivery of an enhanced ESWL Service to patients requiring treatment of renal stones will be achievable.
- This option will make provision for a dedicated team of staffing to be aligned to the Stone Treatment Centre at Craigavon Area Hospital which will enable all ESWL treatments, weekly MDT meetings and the complete patient journey (from investigation to review) to be efficiently and effectively managed.
- An improved skill mix of staff will be achievable.

Is there any additional information that needs to be incorporated? SURELY THE PRINCIPLE OF AN MDT AND VIRTUAL CLINIC INCREASES THROUGH-PUT AND REDUCES FACE TO FACE CLINIC APPOINTMENT IS GOOD THEREFORE OPTION 3 IS BEST

The preferred option is Option 2 – SHOULD THIS NOT BE OPTION 3 YES SE TRUST BUT IT'S THE MDT COMPONENT THAT WE ARE AFTER Increase ESWL Sessions from 3 to 7 Sessions per week within the Stone Treatment Centre at Craigavon Area Hospital as this will enable a further 4 weekly sessions to be delivered giving the Trust additional capacity to treat a total of 28 patients per week. Therefore, the patient's experience will be greatly enhanced as the current waiting times for treatment will reduce.

As more non-invasive treatment regimes will be achievable this will improve the Trust's compliance with British Association of Urologists and NICE guidelines/recommendations whilst permitting patients to be managed within an appropriate environment.

Any potential loss or delay of treatment sessions due to x-rays/imaging scans being out-of-date will reduce.

With an increase in capacity, the Trust will be able to deliver a more streamlined and efficient ESWL & Generalised Stone Service to its resident population.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Yr 0 £000's	Yr 1 £000's	Yr 2 £000's	Yr 3 £000's	Totals £000's
Required					
Capital required					
Revenue required					
Existing budget :					
Capital					
Revenue					
Additional Allocation Required:					
Capital					
Revenue					

AFFORDABILITY ASSUMPTIONS

SECTION 9: MANAGEMENT ARRANGEMENTS

The following project management roles have been agreed:-

- Project Owner – Mrs Esther Gishkori (Director of Acute Services)
- Project Director – Mrs Heather Trouton (Interim Executive of Nursing & Allied Health Professionals (with responsibility for Cancer & Clinical Services)
- Project Manager – Mrs Martina Corrigan, Head of ENT & Urology

The project timescales associated with this proposal are detailed in the table below:-

Project Timescales	
Business Case Approval	May/June 2018
Submission of Business Case to HSCB	May/June 2018
Confirmation of Funding	June/July 2018
Recruitment Process Commenced	July/August 2018
Staff in Post	October 2018

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation?	Mrs Martina Corrigan – TBC Head of Service – ENT & Urology
Who will monitor and evaluate the outcomes?	A Head of Service independent to the project - TBC
What other factors will be monitored and evaluated?	
When will this take place?	April 2019 SURELY BEFORE THIS

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

	Specifiy activity, e.g. IP, DC OPN, OPR, Contacts etc					
	IP	**DC**	**OPN**	**OPR**		
Baseline						
Additional activity						
New Baseline Activity						

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

Name of Organisation	Southern Health & Social Care Trust
Project Title	Development of the Northern Ireland Stone Treatment Centre for provision of ESWL for the province.
Total Cost	**£TBC**
Start Date	**£TBC**
Completion Date	**Recurrent funding requested**

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Yes
How much total funding required?	**£TBC**
How much funding required per year?	**£TBC**
Is this funding to be made recurrent?	Yes

Complete this section if funding available within existing allocation

Funding available within existing allocation (Y/N)	No
Total cost of proposal	N/A
Cost of proposal per year	N/A
Is this cost within recurrent allocation?	N/A

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

Approval & submission by Trust

This section to be completed by Trusts for all submissions

Responsible Director Signature (required for all submissions) **Name Printed MELANIE MCCLEMENTS (signed)** **Grade/Title Director of Acute Services** **Date**
Trust Director of Finance Signature (required if bid is over £100k) **Name printed CAATHERINE TEGGART (signed)** **Date**
Trust Chief Executive Signature (required if bid is over £100k) **Name printed SHANE DEVLIN (signed)** **Date**

Complete this section if Department /DOF approval required

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

BUSINESS CASE TEMPLATE REVENUE FUNDING £50k - £250k

SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED

Introduction

Craigavon Area Hospital (CAH) has the only fixed site lithotripter in Northern Ireland to provide stone treatments on a regular and predictable basis. NICE guidelines specifically focus on the delivery of ESWL as a primary method for treating suitable renal and ureteric stones. It is a recognized, cost effective method of day case treatment and has the ability to reduce the strain on elective and emergency theatre operating lists, and reduce the excessively long wait for stone treatments experienced currently by patients in Northern Ireland. From a cost analysis view point, it is a cheaper and lower risk method for treating stones than a patient requiring theatre.
Emergency ESWL - ESWL vs Main theatre: Potential saving of £874500 over 5 years -
Elective ESWL – ESWL vs Main Theatre. Potential savings of £1248 - £2235 per patient when compared to day case and inpatient Theatre Ureteroscopy. = I think a one liner on the eswl v URS cost is only needed at the introduction

GIRFT report: I think the GIRFT report may need a small introduction to expain what it is ?

'By contrast, only four providers treated more than 10% of emergency admissions with ESWL. While it is not always successful and is not appropriate for all patients and all stones, it offers the benefits that patients do not need a general anaesthetic and are usually mobile immediately after the procedure. During GIRFT visits, providers were asked why they did not provide definitive stone treatment with ureteroscopy or ESWL for more of their emergency stone patients. A range of reasons were given, from not having access to a suitable operating theatre to a lack of staff trained to use the stone laser or assist with emergency stone procedures. It was also clear that not all units offer emergency ESWL, even when a lithotripter is available in a neighbouring hospital. It should be possible to overcome all of these obstacles to effective care. **All hospitals that admit emergency urology patients should be able to provide the surgeon with facilities for ureteroscopy and laserlithotripsy for acute cases. Access to acute ESWL should be available by liaising with the urology department in the region that has a lithotripter permanently on site.'**

This paper outlines a proposal associated with enhancing the Extra Corporeal Shockwave Lithotripsy & Generalised Stone Service within the Southern Health & Social Care Trust.

Associated costs of **£TBC** have been identified from **TBC** funding stream and approval is now being sought from Senior Management Team for the progression of this proposal.

The Trust's Senior Management Team confirmed at its meeting on 24 January 2018 that it was supportive of a proposal being developed.

Extra Corporeal Shockwave Lithotripsy (ESWL)
Definitive stone treatment can be provided by ESWL. This non-invasive technology uses a machine to send highly focused pressure pulses into the body in a way that will fragment a stone and allow passage of the resultant debris. ESWL is typically provided on an outpatient basis, often over two or more treatment episodes. Suitable patients are vetted by a stone multidisciplinary team, including Consultant Urologists, and the treatment delivered by trained radiographers. In the first instance, renal tract stones will be detected via the use of CT which will determine their size, density, location and potential suitability for ESWL with ultrasound or xray confirming visibility for the treatment.

Patients within the Southern Trust area suitable for this treatment may attend on a day case elective basis or for emergency ESWL for ureteric stones if requiring inpatient admission. Treatment sessions last for approximately 40minutes.

Guidelines for the management of renal colic/renal and ureteric stones are documented in:-

- British Association of Urological Surgeons "**Standards for the Management of Acute Ureteric Colic" September 2017**
- National Institute for Health & Care Excellence guideline **"Renal & Ureteric Stones: Assessment and Management (consultation 20 January to 17 February 2017)"**

"Stone removal is recommended in the instance of persistent obstruction, failure of stone progression or increasing or unremitting colic. The choice of treatment to remove a stone depends on the size, site and shape of the stone. Options include extra corporeal shockwave lithotripsy (ESWL) ureteroscopy with laser, percutaneous nephrolithotomy or open surgery".

"Where suitable, ESWL offers a non-invasive treatment with lower complication rates and a shorter hospital stay".

In addition, the current standards associated with care for acute stone pain and use of ESWL (British Association of Urological Surgeons "***Standards for the Management of Acute Ureteric Colic" September 2017)*** states that "for symptomatic ureteric stones, primary treatment of the stone should be the goal and should be undertaken within 48 hours of the decision to intervene"

The Elective Care Framework – Restart, Recovery and Redesign (June 2021) proposes a £700m investment over five years. It sets out firm, time bound proposals for how we will systematically tackle the backlog of patients waiting longer than Ministerial standards, and how we will invest in and transform services to allow us to meet the population's demands in future. It describes the investment and reform that are both required - targeted investment to get many more people treated as quickly as possible; and reform to ensure the long-term problems of capacity and productivity are properly addressed.

Based on the success of the elective care centre prototypes in cataracts and varicose veins, and the development of the first Regional Day Procedure Unit, there is opportunities for further planning to involve other specialties and procedures to be expanded via Day Elective Care Centres.

The Southern Trust has been participating in the Urology Project Improvement Group for a number of years, alongside other Trust Urology Clinicians with a view to collectively working to develop regional pathways and service improvements to tackle the long waiting lists for urological procedures.

Current Service Provision

At the present time, there is only one fixed Lithotripsy machine in Northern Ireland, located in CAH, with a mobile unit available variably in Belfast arriving by boat from the main land provided by an external company. This expensive machine ~~lies~~ is dormant 6 sessions a week at present, due to these sessions not been funded.

The fixed Lithotripter machine at CAH provides stone treatment to the resident population of the Southern Trust and receives referrals from the SE trust.

Current Capacity

The STC facilitates a total of four weekly ESWL sessions. The first treatment commences at 9.00 am with the session ending at 1.00 pm then afternoon session 130pm – 5pm. A total of **8** patients undergo ESWL treatments every week, equating to 2 patients being seen per session.

Patients' referrals for ESWL are received via a number of channels including:-

1. Emergency Departments at Craigavon Area and Daisy Hill
2. General Practitioners within the Southern Trust region
3. Wards in Craigavon Area Hospital and Daisy Hill Hospital
4. Consultant Urologists from Southern and South-Eastern Health & Social Care Trusts
5. Altnagelvin Hospital

At present, emergency ESWL treatments can be made available adhoc if there is a cancellation but as the unit develops, we would plan to offer regular emergency slots to relieve pressure on the emergency inpatient lists.

The current staffing establishment per session consists of:- Wendy/Service Can you check?

- 0.30 wte Consultant
- 0.30 wte Radiographer
- 0.30 wte Band 5 Nurse
- 0.30 Band 3 Healthcare Assistant
- 1 PA/ week staff grade

Key Issues/Assessment of Need
The growing demands being placed upon the Trust's ESWL & Generalised Stone Service understandably proves challenging when taking into consideration the number of issues in terms of:-

1. **Demand & Capacity**
   Since the introduction of the Extra Corporal Shockwave Lithotripsy (ESWL) service on 11 September 1998, there has been a steady increase in the number of patients being offered this treatment regime.

   As at November 2021 there are 163 on the waiting list for stone treatment, 157 weeks is the longest waiter.
   - 69 urgent waits – longest wait 90 weeks
   - 94 routine waits - longest wait 157 weeks
   - On average 4 patients are added to the waiting list per week

A summary of waiting list position as per other Trusts in the region is provided below for comparison:
WHSCT – 17 urgent cases and 31 routine cases **however this may not be representative of true numbers of patients who should be offered ESWL as described by a western trust consultant:** *' Most (patients) I think would get follow up imaging primarily given lack of access to both ESWL and ureteroscopy.'*

BHSCT – 1 urgent – 23 routine

Do we emphasize or point out that other departments are current shy of logging patients for ESWL as they know it is not currently easily available

There are increasing numbers of patients being **referred** into the Service internally and externally with rising waiting times. This burden is translated into other areas like radiology waiting lists as scans need repeated prior to ESWL. Also, with delay to stone treatment there is a risk of patient morbidity and presentation as an emergency adding pressure to the emergency department and inpatient services.

what % of patients currently end up getting an emergency or planned surgical procedure due to length of wait. If service was fully maximized what expected impact would there be on theatres i.e. what capacity freed up?

2. **Emergency ESWL Provision for Upper & Distal Ureteric Stones**

In addition to the number of adult patients awaiting outpatient (elective) ESWL treatment, on average approximately 8 patients will have a Ureteroscopy performed each week at Craigavon Area Hospital.

Audit of recent admissions (Oct/Nov 21) showed that >>>>>>>>>getting numbers suitable for emergency ESWL from admissions and also how long it took for patients to get to emergency theatre
Understandably, this practice is counter-productive as it hinders the Trust's ability to adhere with the respective guidelines associated with the assessment and treatment of ureteric stones[1] which states that "primary treatment of the stone should be the goal and should be undertaken within 48 hours of the decision to intervene". More non-invasive procedures and extended availability across the week would support the Trust to comply with guidelines.

3. Service Model

The proposed regional service to meet the demand for ESWL stone treatments for the ~~Northern Irish~~ population of Northern Ireland would have the STC providing treatments 5 days a week for elective and emergency cases. Each session be would be staffed by 2 nurses and 2 radiographers with 1PA/ week for a doctor to help with documentation and preparation for the elective patients. (is one PA actually enough ?) A dedicated administrator would support the unit. The currently funded stone meeting would continue to provide multidisciplinary input to patient treatment planning and follow-up. We would expect to be able to provide 3 treatments per session totaling 30patients a week. This would cover current demand from across the province but extra lists may be needed to clear waiting list backlog. There is a dedicated stone treatment centre in CAH capable of providing such a service and with minor architectural changes and staffing increase, capacity may be further increased. In time, moving to a dedicated unit (do we really want to use the word moving) with management structure and staff developing expertise and efficiency in delivering ESWL would further improve throughput and improve the patient's experience.

Regarding the current service model, the two consecutive lithotripter machine have been in operational use since the late 1990s (circa 20 years). At that time, the working practices put in place adequately met the needs of the service. Inevitably increased demand and changes in medical practice have evolved in recent years ~~however~~ with only a few modifications or adaptions to the working practices within the STC ~~have been~~ being implemented~~. As a consequence, it has not been possible to optimise the potential to develop the Southern Trust's ESWL & Generalised Stone Service.~~

However Over the last 4 years the STC team have been actively reviewing, auditing and improving various aspects of the STC to maximize efficiency and throughput including:

- Securing funding for a dedicated STC secretary to aid with administration from the unit
- Increase of ESWL treatment frequency to 1.4Hz, maintaining treatment quality but reducing treatment time
- Organisation of pre ESWL medications being posted to the patient to reduce patient time in the unit and nursing supervision requirements
- Stone meeting setup to standardise vetting of patients, treatment plan and follow-up with multidisciplinary input. The treatment plan and self-care advice is then communicated in a timely and effective manner to the patient. The Stone meeting was short listed for the HSJ value awards in Sept 2021.

4. Resource limitations

The STC has optimized its performance within the resources available, however to further improve the efficiency and productivity of the service the following challenges remain:

- Staffing
  Currently an ESWL session has one radiographer, a nurse and a health care assistant. In order

to have the lithotripter actively treating throughout a session and reaching patients numbers of 3 per session, **2 radiographers are required and 2 nurses** to prevent lithotripter down time.

- Environment
  Particularly in the covid era, a ~~reimagining~~ reconfiguration of the STC floor plan ~~of the STC~~ would improve patient flow, reduce risk of cross infection and facilitate a recovery area to increase throughput of the unit. The preparation for this work has already been done with architects, but funding is required to action the recommended changes.

A financial analysis on the costs of current practice has been provided below:

	17/18	19/20	Difference
Craigavon Urology Theatre for elective ureteroscopy			
• As an elective day case £1,071 (based on 131 daycases)	1608	1071	-537
• As an elective case with average inpatient stay £2,495 (based on 59 elective inpatients)	2747	2495	-252
Craigavon Urology Theatre for emergency ureteroscopy			
• Long stay inpatient No long stay patients in 19/20	2862	No 19/20 costs	
• Short stay inpatient £2,706 (based on 8 non-elective short stay patients)	2376	2706	330
Craigavon Stone Treatment Centre for elective ESWL (Extra Corporal Shockwave Lithotripsy)			
• Cost per elective outpatient patient Not costed at outpatient level.	363	No 19/20 costs	
• Cost per inpatient ESWL No ESWL inpatients identified for 19/20	627	No 19/20 costs	
Cost per Daycase ESWL £451 (based on 309 daycases	0	451	

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. Improve access to ESWL Service by 31 March 2022 o Do we not require to be able to supply a slot per day to meet the GIRFT plan ?	• Increase access across the week ➢ Baseline – 4 sessions per week (as of November 2021) ➢ Target – 10 sessions per week by March 2022 • Provide emergency ESWL provision for upper and distal ureteric stones o Baseline – ad hoc provision, backfilling cancelled appointments o Target – 3 x treatment slots per week

➢ Reduction of waiting time for ESWL Treatment in CAH	• Facilitation of appropriate ESWL provision which meets the demand for elective treatment:- ➢ Baseline – 163 patients as at November 2021 ➢ Target – 2 weeks for Urgent and Routine ESWL Treatment
2. Improve the efficiency of the current ESWL Service by 31 March 2022	• Increase number of patients treated per session:- ➢ Baseline – a total of 2 patients per session (as of November 2021) ➢ Target – a total of 3 patients per session (on appointment of additional staffing resources)

SECTION 2 (b): CONSTRAINTS

Constraints	Measures to address constraints
1. Availability to appoint additional staffing resources	The Trust will ensure that robust recruitment processes are in place, maintaining close links with BSO and Human Resources to ensure that any issues which may arise are promptly addressed
2. Recurrent revenue funding not secured	The Trust will maintain close links with the HSCB in order to proactively seek financial support for the service
3. Environment development	Architectural changes to improve patient flow and throughput through the unit

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO	BRIEF DESCRIPTION OF OPTION
1	**Do Nothing/Status Quo - continue with existing arrangements** This option will entail the continuation of the existing service model of 3 ESWL sessions per week permitting a total of 9 patients to be treated. These figures need changed ? Although this option will not meet the project objectives, it has been shortlisted as a base case comparator.

2	**Increase ESWL Sessions from 4 to 10 Sessions per week within Stone Treatment Centre at Craigavon Area Hospital**
3	**Increase ESWL sessions on a phased basis by increasing from 4 to 7 sessions within Stone Treatment Centre at CAH**

SECTION 4: PROJECT COSTS

Option	Year 1 (£'000)	Year 2 (£'000)	Year 3 (£'000)	Total (£'000)
1				
2				
3				

COST ASSUMPTIONS:

Option 2

The following staffing is the requirement to provide a full 10 sessions – need to minus staffing already funded for existing sessions – Wendy can you advise or can we discuss? Also Paulette does the typing, booking and admin so ?remove some from below and add her secretarial role cost. Also how does the nurse admin session fit into below – will need increased if increased numbers

- **2 x 2.0wte Band 5 Staff Nurse**
- **1.6wte Band 3 HCA**
- **2 x 1.6wte Band 7 Radiographers** **do we have to explain the need for two at this point**
- **1.6wte Staff Grade Doctor**
- **1.6wte Band 3 Audio typist**
- **0.16wte Band 4 PAS/ Clinical Coder**
- **0.8wte Band 3 Booking Clerk**
- **0.8wte Band 2 Health Records**
- **0.48wte Band 2 Domestic**
- **1.0wte Band 6 Clinical Sister**
- **1.0wte Band 4 Administrator**

Andrea to check Pharmacy costs

NB 25 % uplift to be added to posts to cover AL, SL etc

Option 3

Please include staffing requirements to provide 7 sessions **(need to reduce the wte bits)**

- **2 x 2.0wte Band 5 Staff Nurse**
- **1.6wte Band 3 HCA**
- **2 x 1.6wte Band 7 Radiographers**
- **1.6wte Staff Grade Doctor**
- **1.6wte Band 3 Audio typist**
- **0.16wte Band 4 PAS/ Clinical Coder**
- **0.8wte Band 3 Booking Clerk**
- **0.8wte Band 2 Health Records**
- **0.48wte Band 2 Domestic**

- **1.0wte Band 6 Clinical Sister**
- **1.0wte Band 4 Administrator**

Goods & Services
List of consumables needed for increasing sessions of ESWL.

- Ultrasound gel
- Electrodes – ?As far as we are away these come with service contract. If increasing numbers will this arrangement continue ?
- Bottles of water for water in the machine. Usually changed at the service. Will service be required more often??
- Membrane for treatment head will need changed more often. This may also come with service contract. Again check if a significant issue
- Paper to print treatment plan, medication prescription and discharge plan
- Toner for laser printer.
- Paper roll.
- Wipes for cleaning down machine.
- Gloves/ aprons etc.
- Urinalysis machine and strips do we do pregnancy tests

- The anticipated life span of Lithotripter equipment is 10 years however it is not dependent upon the number of shocks/treatments/patients
- The current equipment has been in operational use since 2015 and is expected to have a lifespan of 15 years (requiring replacement in 2030). Is this correct – we did well with the first machine but will this one last that long

Support for costs attached as an appendix – Y/N (delete as appropriate)

SECTION 5: NON-MONETARY BENEFITS

The non-monetary benefits associated with the project are detailed below:-

Non-Monetary Benefit	Option 1 Status Quo/Do Nothing	Option 2 Andrea to complete	Option 3 Andrea to complete

Provision of additional sessions per week	• With no improved access to the service, enhanced utilisation of Hospital facilities will be untenable	•	•
Reduced Waiting Times for Treatment	• As the number of patients being referred into the Service will continue to grow, it will result in a rise in waiting times. Therefore, patients will continue to experience lengthy waiting times for their treatment	•	•
Improved efficiency	• With the volume of administrative tasks associated with both MDT meetings and the ESWL processes, the degree of administrative support from the Specialty Doctor will still be prevalent (understandably, a situation which does not make best use of skills). • With no improved service provision, the use of Main Theatres at CAH for some patients' procedures will continue.	•	•

SECTION 6: PROJECT RISKS & UNCERTAINITIES

The project risks associated with this scheme are detailed in the table below:-

	Likely impact of	

Risk Description	Risk H/M/L			State how the options compare and identify relevant risk management/mitigation measures
	Opt 1	Opt 2	Opt 3	
1. Inability to Appoint Staff	**N/A**	**L**	**L**	**Option 1** – N/A **Options 2&3** - there is the potential that no applicants may apply for the new posts, however this is deemed to be a 'low' risk. • **Mitigation Measure** - the Trust will ensure that robust recruitment processes are in place and any issues raised by BSO are promptly addressed
2. Recurrent revenue funding not secured	**N/A**	**M**	**M**	**Option 1** – N/A **Options 2&3** – this is a possibility that recurrent funding may not be secured and therefore this is considered a 'medium' risk • **Mitigation Measure** – the Trust will maintain close links with the HSCB/continue to seek financial support from the HSCB
Overall Risk (H/M/L):	**N/A**	**L/M**	**L/M**	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Andrea to complete once options agreed

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Yr 0 £000's	Yr 1 £000's	Yr 2 £000's	Yr 3 £000's	Totals £000's
Required					
Capital required					
Revenue required					
Existing budget :					
Capital					
Revenue					
Additional Allocation Required:					
Capital					
Revenue					

AFFORDABILITY ASSUMPTIONS

SECTION 9: MANAGEMENT ARRANGEMENTS

The following project management roles have been agreed:-

- Project Owner – Mrs Esther Gishkori (Director of Acute Services)
- Project Director – Mrs Heather Trouton (Interim Executive Director of Nursing & Allied Health Professionals and Assistant Director of Acute Services - with responsibility for Cancer & Clinical Services)
- Project Manager – Mrs Martina Corrigan, Head of ENT, Urology, Ophthalmology & Outpatients

The project timescales associated with this proposal are detailed in the table below:-

Business Case Approval	
Submission of Business Case to HSCB	
Confirmation of Funding	
Recruitment Process Commenced	
Staff in Post	

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation? (please provide the name of the responsible individual where possible)	
Who will monitor and evaluate the outcomes? (please provide the name of the responsible individual where possible)	
What other factors will be monitored and evaluated?	
When will this take place? (preferably 4 to 12 months after project closure)	

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

	Specify activity, e.g. IP, DC OPN, OPR, Contacts etc					
	IP	**DC**	**OPN**	**OPR**		
Baseline						
Additional activity						
New Baseline Activity						

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

HSJ Value awards https://valuehsj.awardsplatform.com/entry-form/entrant/start?tabSlug=ReVQXZlb

Specialist service redesign initiative: Specialist Service Redesign Initiative

Provision of specialist care in line with patient experience is driving changes in pathways, structures and the way services user interact with their treatment. Innovations and technologies as well as system led care also have an influence over the decision to update or revise a pathway, service or department.

Title:

STONES Stone meeting Timely communication Outcomes New stone referrals Evidenced based care Savings

Synopsis: Please provide a brief description of your project, service or team.

- What is it?
- Who's involved?
- Who do you serve?

A Quality Improvement Project to improve the efficiency and consistency of new stone referrals from Southern Trust Emergency Departments (EDs) to the Craigavon urology department, and to ensure timely communication of expert clinical decision making to the patient by the initiation of a Southern Trust Urology weekly Stone Meeting. There has been a core team of Stone Treatment Center staff striving to improve our service and the patient experience, collaborating with other departments including IT, Radiology, Administration and EDs to fulfil the aims and objectives. The Medical Director and executive team were kept informed and utilized as the project required.

Ambition:• Describe the context in which a redesign was necessary
• What was the ambition of the project, and what targets were set?
• How were those targets identified and what initial planning and research took place?
• What planning was put in place to work effectively with a variety of stakeholders, colleagues, partners and patients?
• What measures were put in place to ensure expectations were met?

Many patients present to emergency departments (EDs) with their first renal colic episodes. Prior to improvements, these patients were managed at the discretion of the ED doctor and a flimsy sent to the on-call urology consultant for management decision making. This led to wide variation in practice and varying degrees of compliance with best practice guidelines

(Appendix1) and therefore a redesign was necessary to ensure as a department, we deliver safe, evidenced based care to all our new stone patients. The ambition of this project was to identify key outcome measures with interventions to improve patient flow, reduce costs and facilitate a good patient experience with prompt information sharing. Current EAU, NICE and BAUS guidelines on acute stone management were consulted and, following audit of local practice and service capabilities, the following issues and therefore targets were identified:

Prior (2016) to the initiation of the stone meeting:

- Face to face stone clinic capacity 143 patients in 6months with a waiting list of 741patients as of May 2020. Costing £250 per new and £170 per review patient

TARGET: Increase capacity to discuss new/ review patients; improving patient flow, reducing clinic waiting times and saving money

- Average first urology correspondence after ED presentation on NIECR (online patient record) = 165.3 days

TARGET: Patients referred from ED to the stone meeting are contacted by the urology team within 14days of their presentation (reducing waiting times by 75%)

- Average length of time to communicating to patient a definitive plan for a ureteric stone - 177 days

TARGET: Ureteric stone patients have a definitive management plan communicated within 8weeks of referral to the stone meeting

- 56% of patients had serum calcium checked within a year of stone presentation and only 20% of patients were signposted to information regarding self-care, dietary and fluid advice for stone prevention

TARGET: 80% of referrals have serum calcium levels checked within 6months and all patients signposted to advice for future stone prevention.

TARGET: Facilitate a good patient experience by ensuring timely communication regarding their ongoing care in a way that is clear, comprehensive and accessible

It was recognized that a regular Stone Meeting would ensure consistency and timeliness of communication of recommended management plans to patients. Rota allowances for staff were secured and the meeting embedded into the unit's core clinical activity. The place and purpose of the stone meeting was communicated to relevant departments and processing pathways confirmed within administrative channels.

Outcome: • Clearly demonstrate the benefits of the redesign on patient outcomes, which could include improved patient experience, waiting time reduction, capacity increase or optimised treatment pathways.
• What additional impacts have the redesign had on staff?
• How effective was any collaboration with key colleagues, stakeholders, partners and patients?
• What was the financial impact of the redesign?
• Please provide qualitative and quantitative supporting evidence clearly referenced in the supporting information

Please see attached document of appendices for data and run charts of the following outcomes however summarized below:

Since initiation and embedding of stone meeting into routine clinical practice:

- Aim of contact within 14days (reducing waiting times by 75%) achieved; mean reduction of 91% in waiting times from ED stone presentation to first documented contact on NIECR to average 10.2days (Appendix2)

- Aim that patients will have a definitive management plan for their ureteric stone within 8weeks of presentation not achieved however there is a 79% reduction in waiting time in 2019, compared to 2017 with an average length of time being within 7.4weeks (Appendix3)

- Aim that 80% of new referrals within 6months of stone meeting discussion have had serum calcium levels checked achieved with 94% compliance achieved in phase 4 (2020) of data collection (Appendix4)

- Aim that all patients going through the stone meeting are given or signposted to information regarding self-care, dietary and fluid advice for stone prevention not achieved however 86% compliance in Phase 4, an improvement of 66% prior to the stone meeting being established (Appendix5)

Considering patient flow and value for money:

- Capacity of stone treatment center to discuss new/ review patients increased by 79% and 84% respectively due to the instigation of the Stone Meeting (Appendix6)

- Cost of Stone clinic face to face per patient: New £250 review £170 = up to £420 per patient however cost of Stone meeting discussion and correspondence per patient: £80.20

- Savings of £339.80 per patient (Appendix7)

Core staff have responded well to the integration of the stone meeting as it provides a platform for discussion, learning and team working and, as a knock-on effect, improves delivery of the ESWL service.

Collaboration has been successful with radiology engagement with the acute colic imaging pathway. Patient feedback demonstrated 97% patients happy with timeliness of stone meeting letter compared to waiting for an appointment, 90% understanding the information sent, 77% happy that their questions were answered and 68% stating a preference for stone meeting review of their case compared to attending an outpatient appointment (Appendix8). ED staff feedback confirmed increased confidence in management of acute colic and 9/12 satisfied with the referral process to the stone meeting (Appendix9).

Spread: • Outline examples where this project has embedded and spread to other departments, settings or organisations. • Alternatively, provide clear evidence the work is potentially replicable and scalable.

A Quality Improvement project write up is being completed that will be shared with stakeholders including the research grant team, medical director and executive team to demonstrate the benefits of engagement of the stone meeting and to aid further investment and planning for expanding the service. This is particularly relevant to other local health trusts as the Southern Trust considers a leading role in provision of ESWL (extracorporeal shockwave lithotripsy) to the Northern Irish patient population for which the stone meeting would be a key referral and processing point in the patient journey.

The potential spread of this project beyond our immediate locality – utilizing the Renal colic flow chart to ensure best practice at initial contact, stone meeting referral form for ongoing care and instigation of a stone meeting for triaging and communication of management plans, is already in action as we have three different ED sites utilizing the process. However successful spread to other urological centers and their EDs will require clear communication, local adaptation to their clinical environment and resources, and enlisting a creditable quality improvement colleague in a position of influence in each unit. We already receive stone referrals for ESWL with a modified stone meeting referral form from consultants out with the Southern trust, so there is already a degree of familiarity. However, contact with local teams informally to ask if sharing this project would benefit the unit is planned over the coming months. Each urology unit can then approach their own emergency departments if they feel this would benefit the teams.

Value: • Describe the impact of the redesign on staff and patient experience • Provide tangible evidence in terms of increased capacity, reduced variation and/or improved efficiencies.

By streamlining the process for referral of ED patients we have improved the efficiency of information sharing by ensuring, when appropriate, a template letter with multidisciplinary management decision outcome is sent to the patient and NIECR for access by GP and other healthcare professionals. This communication from urology to the patient and NIECR/ GP is in an average of 10.2days - a 91% reduction from the average 165.3days prior to the stone meeting. Additionally the design and use of template letters has ensured that 86% of patients were appropriately signposted regarding self care, dietary and fluid advice for stone formers compared to 20% previously. We plan to audit the impact of the template letter (Appendix12) use compared to free text letters in sparing administration time from typing.

For ureteric stones, a definitive plan for management of their ureteric stone is now communicated on average in 7.4weeks compared to 177days prior to quality improvement measures.

For ED staff, In response to 'How satisfied are you with the overall referral process for renal stone disease between the ED and the Stone meeting' none were dissatisfied, 3 were neutral, 6 were satisfied and 3 strongly satisfied as the process is efficient and consistent compared to previously.

From a patient point of view, comments received on feedback questionnaire included 'Very quick to respond post my USS - excellent service' and 'I am happy with the letter and prefer not to attend hospital during the coronavirus' with 32/33 agreed a stone meeting letter within 2 weeks of their stone presentation is preferable to waiting up to an average of 28wks for a face to face outpatients appointment, as before the stone meeting.

This all demonstrates that sharing of information through more efficient technologies, systems and processes have benefitted both patients and staff.

Involvement: • Show how patients and staff contributed towards and added value to the goals and outcomes of the redesign
• Provide clear evidence surrounding the consultative measures taken to inform, involve and enable participation in the design of the new initiatives or adaptations to existing working practices
• Show how strong partnerships and engagement were maintained with all those impacted by the redesign – including those in other organisations

To develop the ED renal colic protocol we approached our radiology department to discuss guidelines for imaging and agreed their compliance with the published protocol. Numerous

PDSA cycles were required in order to agree on the current stone meeting form (in active use since June 2017).

We had several interactions with the senior ED team; presenting at their MDMs, gaining their engagement and auditing their completion of the referral form (Appendix13). With this data we then reviewed the referral form content - amending and clarifying areas that needed further development or education. We also conducted an ED staff satisfaction questionnaire in July 2020. In total, 12 member of staff with various roles completed the questionnaire, providing a snapshot of the level of satisfaction with the process of managing and referring patients with stones, and the contribution of the flow chart and referral form from within the ED.

- 4 people (all senior staff) felt the flowchart and form were not user friendly or complete: the main issue the volume of information requested.

- Everyone polled had utilized the referral form, but many were not aware of the corresponding flowchart. This was likely due to a clerical oversite whereby the flowchart had not been printed on the reverse side of the referral form, as intended.

- In response to 'How satisfied are you with the overall referral process for renal stone disease between the ED and the Stone meeting' none were dissatisfied/ 3 neutral/ 6 satisfied and 3 strongly satisfied.

A patient satisfaction questionnaire with the Stone Meeting Letter Correspondence was performed with 100questionaires posted and 32 returned complete (1 incomplete) between May-July 2020 (see supporting documents for questionnaire and full results):

- 32/33 agreed a stone meeting letter within 2 weeks of their stone presentation is preferable to waiting up to 28wks for a face to face appointment (previous average)

- 30/32 agreed to understanding the information received from the stone meeting

- 27/32 agreed that the information given was sufficient to answer any questions they might have however, 15/32 still would have liked to speak to a healthcare professional.

- 22/32 agreed that they would prefer a stone meeting letter instead of a hospital appointment if they had the same problem again in the future

Ongoing work is happening to utilize this feedback, and acquire further feedback from these and other relevant parties, to improve our service further but demonstrate positive engagement from both staff and patients.

Stent removal service Craigavon Area Hospital

This particular service is proposed for ureteric stents that have the strings still attached and require removal within a few days of insertion.

(The service in future could expand to a more general stent removal service using a flexible cystoscopy system but is not the current proposal).

Stent on String removal Service

Provided at the Stone Treatment Centre CAH.

Times are:

Monday at 2pm for 1 patient whenever there is a Consultants stone clinic.

Wednesday at 11-30 for 2 patients whenever there is a STC MDT meeting.

Friday at 12-30 for 1 patients whenever there is a Consultants clinic or treatment session.

This will allow a patient to have a stent removed within a week of insertion and ideally within a 3-5 day period.

Booking a patient will be via an email service.

email address is: [redacted] Irrelevant information redacted by the USI

This will be on a next slot principle but plan to have completed within the week.

(The service will be reviewed at three months and if excessive referrals are being observed, then the process will be reassessed).

All the Nursing staff who work in the STC will have access to this central shared address. Since there is active in the STC each day (bar Tuesday), this will allow the administration of this service to be enacted on a daily basis. Ideally this contact should be made at the time of surgery (via email), otherwise the Ward Sister / Doctor in Charge should ensure a request has been sent prior to the patients discharge. With these arrangements it may be possible to provide a patient with their appointment before discharge. If this has not been possible then the provided information on the email will be used to contact the patient.

For those not provided an appointment before they are discharged, please inform your patient to expect a phone call to arrange this appointment and also to note that it will be from an 'unknown caller' (ie hospital phone). It is also important to inform your patient that if they have not heard from the STC staff within 48 hours of discharge, then they need to phone Consultants secretary.

Information required to make booking:

Name.

H & C, DOB , address

Phone numbers

MRSA, allergy (eg Latex) status

Contact point to notify this attendance has occurred.

If there is a patient specific factor that you regard as important for the STC staff to know about in advance, please enclose on the email as the patients chart will not be available.

If Oral antibiotic are required for removal (pre-supply to have been given on discharge).

It is assumed that subsequent follow up arrangements have been made.

M Young

STC lead

Dec.18

Southern Health and Social Care Trust

Urology Service

Benchmarking of Current Service (v0.1)

The guidance relating to the implementation plan for the urology review included a requirement to benchmark the current urology service. The following pages provide some benchmarking information.

Regional Benchmarking

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland for:

- New to review ratios;
- Day Case rates;
- Average length of stay for elective and non elective procedures.

New : Review Ratio
1/04/06 - 28/02/10

	2006/07	2007/08	2008/09	2009/10
All Trusts	1.96	2.03	1.79	1.68

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	1.63	2.09	1.77	1.72
Northern Trust	1.97	1.67	1.31	1.75
South Eastern Trust	1.15	1.1	1.15	1.25
Southern Trust	4.04	3.27	3.28	2.09
Western Trust	2.65	2.32	2.49	1.73

Note – the review backlog will have skewed the figures for 2009/10 (perhaps for all Trusts)

Note: The national new to review ratio is 1:2.1. It is accepted that there will be some variation due to case mix/complexity. The plan should explain the actions to deal with those teams who are an outlier from this level, and to achieve a performance in the upper quartile, at 1:1.5

Day Case Rates by Trust
April 06 - Feb 10
(Excludes Prim Op M45 and Not coded procedures) (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

		2006/07	2007/08	2008/09	2009/10
All Trusts	Day Cases	3793	3733	4255	3492
	Elective Admissions	3780	3963	4293	3710
	DCs+ElecAdm	7,573	7,696	8,548	7,202
	Daycase Rate	**50.1**	**48.5**	**49.8**	**48.5**

		2006/07	2007/08	2008/09	2009/10
Belfast Trust	Daycases	1737	1584	1896	1615
	Elective Admissions	1938	2092	2015	1873
	Total	**3,675**	**3,676**	**3,911**	**3,488**
	DC Rates	47.3	43.1	48.5	46.3
Northern Trust	Daycases	211	209	241	372
	Elective Admissions	465	430	582	448
	Total	**676**	**639**	**823**	**820**
	DC Rates	31.2	32.7	29.3	45.4
South Eastern Trust	Daycases	930	912	940	751
	Elective Admissions	257	325	369	328
	Total	**1,187**	**1,237**	**1,309**	**1,079**
	DC Rates	78.3	73.7	71.8	69.6
Southern Trust	Daycases	579	576	770	433
	Elective Admissions	742	691	807	650
	Total	**1,321**	**1,267**	**1,577**	**1,083**
	DC Rates	43.8	45.5	48.8	40.0
	CHKS Rates	72%	72.2%	74.3%	74.8%
Western Trust	Daycases	336	452	408	321
	Elective Admissions	378	425	520	411
	Total	**714**	**877**	**928**	**732**
	DC Rates	47.1	51.5	44.0	43.9

Urology - Average LOS (Episode based)

April 06 - Feb 10

Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	3.7	3.5	3.4	2.9

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	3.9	3.5	3.5	3.3
Northern Trust	2.3	2.9	2.4	1.9
South Eastern Trust	3.8	4.0	3.4	3.2
Southern Trust	3.7	4.3	3.9	2.7
Western Trust	3.6	2.9	3.2	2.9

Non Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	4.8	4.7	4.6	4.4

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	5.5	4.9	5.4	5.0
Northern Trust	4.3	5.4	4.9	3.7
South Eastern Trust	3.9	4.4	3.5	3.8
Southern Trust	4.5	4.8	4.6	4.7
Western Trust	3.9	3.8	4.1	3.4

Average Length of Spell

Healthcare Resource Groups (HRG) are a method of grouping inpatient and daycase episodes. Data items recorded on the Patient Administration System are used to allocate episodes to a particular HRG. The data items include:

- Primary and secondary procedures
- Primary, subsidiary and secondary diagnoses
- Age
- Sex
- Method of discharge (to indicate whether the patient was dead on discharge)
- Length of stay (duration of Finished Consultant Episode)

HRGs are used to produce casemix information which can be used for costing and comparative purposes. Chapter L relates to urinary tract and the male reproductive system.

The table below compares the Southern HSC Trust's average length of spell with the Northern Ireland peer group for the period 1st January 2009 – 31st December 2009.

Peer Group Comparison for Length of Spell
Peer Group is taken from CHKS Peer for January 2009 - December 2009

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

Note – 'Non OR' indicates a procedure which is so minor that it does not affect the resources used within the episode.

British Association of Day Surgery (BADS)

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The table overleaf compares the Trust's performance with the BADS targets for urology. The following notes apply:

- Trust activity for 2009/10 has been used (from Business Objects). At 2nd June 2010 175 elective finished consultant episodes (FCEs) and 182 day cases were not coded;
- Elective FCEs and day cases have been included (no non elective activity);
- Only activity undertaken by the 3 consultant urologists has been included in the analysis;
- The numbers of day cases and FCEs are given in the column on the right. The numbers of FCEs with a zero length of stay are also noted as these could potentially have been recorded as day cases.

British Association of Day Surgery (BADS) Basket of Procedures for Urology

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
1	Ureteroscopic extraction of calulus of ureter	M27.1, M27.2, M27.3	50	50		0%	53%		0 DCs, 41 FCEs. **8 FCEs had 0 LOS**
2	Endoscopic insertion of prosthesis into ureter	M29.2, M29.5	90	10		0%	38%		0 DCs, 8 FCEs. **1 FCE had 0 LOS**
3	Removal of prosthesis from ureter	M29.3	100			38%			6 DCs, 10 FCEs. **4 FCEs had 0 LOS**
4	Endoscopic retrograde pyelography	M30.1	90	10		5%	84%		1 DC, 18 FCEs. **10 FCEs had 0 LOS**
5	Other endoscopic procedures on ureter	M27, M28, M29.1,M29.4, M29.8, M29.9	90	10		13%	46%		11 DCs, 73 FCEs. **16 FCEs had 0 LOS**
6	Cystostomy and insertion of suprapubic tube into bladder	M38.2	90	10		0%	10%		0 DCs, 10 FCEs.
7	Endoscopic resection/ destruction of lesion of bladder	M42	20	50	30	3%	32%	23%	2 DCs, 63 FCEs. **6 FCEs had 0 LOS**
8	Endoscopic extraction of calculus of bladder	M44.1, M44.2	50	50		0%	10%		0 DCs, 10 FCEs. **1 FCE had 0 LOS**
9	Diagnostic endoscopic examination of bladder (inc any biopsy)	M45	90	10		87%	8%		775 DCs, 114 FCEs. **26 FCEs had 0 LOS**
10	Operations to manage female incontinence	M53.3, M53.6, M53.8	80	10	10	0%	0%	100%	1 FCE
11	Dilation of outlet of female bladder	M58.2		90	10	100%			1 Daycase
12	Endoscopic incision of outlet of male bladder	M66.2	50	50		14%	71%		1 DC, 6 FCEs. **1 FCE had 0 LOS**
13	Endoscopic examination of urethra +/- biopsy	M77		100		100%			6 DCs
14	Endoscopic resection of prostate (TUR)	M65.1,M65.2, M65.3, M65.8	15	45	40	0%	0%	20%	0 DCs, 111 FCEs.

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
15	Resection of prostate by laser	M65.4, M65.3+Y08.3, M65.3+Y08.4	90	10		0%	33%		3 FCEs
16	Prostate destruction by other means	M67.1,M67.2, M67.5, M67.6	90	10					None recorded
17	Operations on urethral orifice	M81	90	10		33%	50%		2 DCs, 4 FCEs. **2 FCEs had 0 LOS**
18	Orchidectomy	N05, N06.1, N06.2, N06.3, N06.8, N06.9	90	10		44%	56%		4 DCs, 5 FCEs. **2 FCEs had 0 LOS**
19	Excision of lesion of testis	N06.4, N07	90	10					None recorded
20	Orchidopexy - bilateral	N08	60	35	5				None recorded
21	Orchidopexy	N09	75	20	5	60%	40%		3 DCs, 2 FCEs. **1 FCE had 0 LOS**
22	Correction of hydrocoele	N11	90	10		80%	10%		8 DCs, 2 FCEs.
23	Excision of epididymal lesion	N15	90	10		90%	0%		9 DCs, 1 FCE.
24	Operation (s) on varicocoele	N19	90	10		60%	40%		6 DCs, 4 FCEs. **3 FCE had 0 LOS**
25	Excision of lesion of penis	N27	50	50		100%			1 DC
26	Frenuloplasty of penis	N28.4	90	10		100%			5 DCs
27	Operations on foreskin - circumcision, division of adhesions	N30	90	10		71%	14%		36 DCs, 15 FCEs. **6 FCE had 0 LOS**
28	Optical urethrotomy	M76.3	90	10		7%	56%		2 DCs, 25 FCE.

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
29	Laparoscopic nephrectomy	M02.1,M02.5, M02.8,M02.9 (+Y75.2)	5	75	25	0%	11%	0%	9 FCEs
30	Laparoscopic pyeloplasty	M05.1+Y75.2	10	80	10				None recorded
31	Laparoscopic radical prostatectomy	M61.1,M61.2, M61.9 (+Y75.2)		5	90		0%	0%	1 FCE

Southern Health and Social Care Trust

Quality Care - for you, with you

Suprapubic Catheterisation Guideline (UPDATED JULY 2017)

Title:	**Suprapubic Catheterisation Guideline**		
Ownership:	**Southern HSC Trust**	**Status:**	**Current**
Publication Date:	**July 2017**	**Next Review:**	**July 2019**
Author(s)	**Mr Michael Young - Consultant Urologist** **Miss Jessica Morrow – ST3 Urology**		
Version No. **V2**	**Evidence Base:** **NPSA Minimising the risks of Suprapubic catheterisation Circular 55/09** **BAUS Suprapubic Catheter Practice Guidelines (2010)**		

Background

The National Patient Safety Agency (NPSA) issued a Rapid Response Report in July 2009 on 'Minimising risks of suprapubic catheter insertion (Adult only)'. The agency's audit had identified two hundred and fifty nine incidents relating to suprapubic catheter insertion and management during a four year period between 2005 and 2009. Within this group there were three incidents of death and seven where there was severe harm. In this particular group, nine out of the ten cases related to bowel perforation. In this NPSA report, it references a BAUS survey of urologists (2003) reviewing the previous ten years, recording a bowel perforation rate of 0.15% and an overall death rate of 0.05%.

The subsequent document from the British Association of Urological Surgeons on Suprapubic Catheter Practice Guidelines (2010), quotes figures of 2.5% risk of bowel injury and up to 1.8% thirty day mortality, with complications being particularly prevalent amongst patients with previous lower abdominal surgery and in those with neurological disease. The headline reference papers are defined.

1.0 INTRODUCTION/PURPOSE OF GUIDELINE

1.1 This document exists as an interim guidance until the British Association of Urological Surgeons issue a formal response to NPSA, Minimising the risks of Suprapubic catheter insertion (adults only), Ref HSC (SQSD)55/09.

1.2 The purpose of this guideline is to ensure patient safety and to minimise the potential risk to patients who may require Suprapubic catheterization.

2.0 DEFINITION AND SCOPE OF GUIDELINE

2.1 The purpose of this document is to issue guidance and practical advice regarding a safe approach to suprapubic catheterisation.

2.2 It is the responsibility of relevant staff to familiarise themselves and adhere to the contents of this guideline; relevant staff include those who insert these catheters and those who are involved in the management of the catheters. Staff should ensure that difficulties with the implementation of this guideline are brought to the attention of relevant managers for appropriate action.

2.3 The NPSA key recommendations to reduce risk are recorded in Appendix 1`

3.0 COMPETENCIES OF PERSONNEL

3.1 All staff carrying out the initial insertion of a suprapubic catheter must adhere to the Southern Trust procedure for insertion of a suprapubic catheter.

3.2 Supra pubic catheterisation carries inherent risks and should only be performed by personal who are appropriately trained , competent and experienced in supra pubic catheterisation techniques or who are working under direct supervision of a person who is trained and experienced in supra pubic catheterisation.

3.3 It is the responsibility of the Clinical Director or Assistant Clinical Directors to ensure medical staff undertaking suprapubic catheter techniques within their directorate are competent and adhere to the agreed standards as outlined in NPSA, Minimising the risks of Suprapubic Catheter Insertion (adults only), Ref HSC (SQSD)55/09 . See appendix 2

3.4 All directorates must maintain a record of staff trained and deemed competent in undertaking the insertion of suprapubic catheters in adults.

3.5 It is the responsibility of all clinicians who insert suprapubic catheters to ask the questions required by the National Patient Safety Agency, see appendix 2.

3.6 Ultrasound should be used wherever possible to guide the first time insertion of the supra pubic catheter, those using the ultrasound machine must be competent in the same.

4.0 INDICATIONS FOR SUPRABUBIC CATHETERIZATION

4.1 Suprapubic catheterisation is indicated when urethral catheterisation is contraindicated or not technically possible.

4.2 Suprapubic catheterisation may be required in the acute situation where either a urethral catheter cannot be passed in a patient who has acute urinary retention or where there is urethral trauma, such as seen in fractured pelvis.

4.3 In the elective situation, the use of suprapubic catheter drainage may be used in chronic urinary retention for patients with

- neurological disease, such as multiple sclerosis or spine injury,
- intractable urinary incontinence
- post-operative, such as female stress incontinence or colorectal surgery.
- palliative care situations, where suprapubic catheterisation may simplify patient care and aid in patient comfort.

5.0 CONTRAINDICATIONS TO SUPRAPUBIC CATHETERISATION

There are a number of situations where suprapubic catheters are not appropriate option. These include:

- carcinoma of the bladder,
- anti-coagulation and anti-platelet therapy,
- abdominal wall sepsis,
- the presence of a subcutaneous vascular graph in the suprapubic region e.g. femoral crossover graft,
- prior abdominal or pelvic surgery where there is potential for bowel adhesion to the bladder or anterior abdominal wall,
- Pelvic cancer with or without pelvic radiation.
- An absolute contraindication is where the bladder cannot be easily palpated or ultrasonically localised.

6.0 PATIENT ASSESSMENT

6.1 The clinical history and examination should take into account:

- previous abdominal surgery,
- urinary history,
- evidence of neurological abnormality; such patients often have a small capacity bladder or urethral incompetence and may be at risk of developing autonomic dysreflexia. New neurological deficit should be investigated appropriately in all cases and if cauda equina syndrome is suspected an emergency MRI spine and discussion with neurosurgery is required.
- anti-coagulant history and medication.

6.2 Clinical examination must include inspection of the lower abdomen for scars with palpation and percussion to help in determining whether the bladder is sufficiently distended to allow for suprapubic catheterisation to be undertaken.

6.3 Consideration should be given to the use of antibiotic prophylaxis because this may reduce sepsis rates. It is recommended that prophylaxis is given if there is likely to be bacterial colonization of the urine, as in the patient who has recently been managed by intermittent or indwelling catheterization.

6.4 Insertion of a suprapubic catheter can be associated with haematuria or the development of a local haematoma. It is therefore recommended that consideration be given to discontinuing or modifying any anticoagulant or antiplatelet regime that the patient may be on. In an emergency situation, suprapubic catheterisation should only proceed if anticoagulation has been safely reversed.

6.5 Local anaesthetic is inappropriate for use in patients with spinal injurys at or above T6 level where autonmonic dysreflexia is more likely to occur. A general or regional anaesthetic should be used in a controlled environment where patient monitoring and specialist help is available.

6.6 Ultrasound examination of the lower abdomen, if carried out by a competent trained practitioner, will reliably determine whether the bladder is distended. Ultrasonography may also be used to determine whether there is any interposing bowel in the planned track of the catheter into the bladder. However the reliability of ultrasonography in excluding the presence of a loop of intestine in the suprapubic region has not been fully evaluated but it has been advocated by some as a method of ensuring that bowel intra-position is to be excluded from a planned tract. The BAUS guidance group have concluded that ultrasonography may be used in this way if the operator is sufficiently trained and experienced in the use of ultrasonography in this specific context. The National Patient Safety Advisory document notes that the use of ultrasound is a safer method for suprapubic catheterisation, especially in complicated patients such as those with a large body habitus, abdominal adhesions and in uncooperative patients. Training in ultrasound is essential in this situation. Ultrasound machines are located in the Emergency Department and in Theatres/ICU, however availability of these machines is at the discretion of each department and only appropriately trained individuals should use the equipment. In all other cases ultrasound guidance should be performed by a radiographer or radiologist where possible.

6.7 Informed consent must be obtained from patients, explaining the benefits along with the risks; this should include a discussion on haemorrhage, infection, pain, and injury to abdominal organs.

7.0 TECHNIQUES OF SUPRAPUBIC DRAINAGE

7.1 In the acute situation where bladder drainage is required, and either the appropriately trained personnel are not available or by physician choice as a temporising measure, may elect to perform suprapubic aspiration of the bladder using a 21 gauge needle. This is a reasonable means of temporarily relieving symptomatic urinary retention.

The needle is passed in a vertical plane, one fingers breadth above the pubic synthesis with the patient in supine position. The confirmation of a diagnosis of urinary retention may require the use of ultrasonography in cases where clinical examination is not conclusive.

7.2 Suprapubic catheter insertion can be performed under local anaesthesia if adequate and comfortable bladder distension can be achieved electively or in the emergency situation where the patient has acute urinary retention. Infiltration of local anaesthetic of the whole planned insertion tract is essential including rectus muscle and perivesically.

7.3 A general or regional anaesthetic should be used if the bladder cannot be palpated or comfortably filled with at least 300 mL of fluid, and in spinal cord injury patients with an injury level of T6 or above.

7.4 There are several techniques and commercially available kits used for suprapubic catheter insertion.

1/ The TROCAR system is widely used with direct puncture of the bladder.
2/ The modification of this technique uses the Seldinger guidewire principle.
3/ An alternative approach is to pass a urethral sound into the bladder and its tip manipulated to press on to the anterior abdominal wall allowing for a cut down onto the tip of the sound. This should only be performed by an appropriately trained urological surgeon.

The modified Seldinger technique is recommended as the safest technique. There are a number of commercial kits available. Suprapubic catheterisation kits are located in the Emergency Department, Theatres and Ward 3 South Urology.

7.5 For the safe, closed insertion technique of suprapubic insertion, it is essential that the bladder is adequately distended, typically to in excess of 300mls so that the dome of the bladder reaches a minimum of 5cm above the pubic synthesis; distension can be determined by palpation. The proposed best track site is defined by first aspirating urine (via the L.A injection needle) and/or by ultrasonographical imaging. An additional aid to catheter placement may be provided by cystoscopy. Needle and guidewire placement into the anterior wall of the bladder can be directed visually and aided by the direction of the endoscope light.

7.6 The catheter should be passed through the rectus sheath in the mid-line, no more than 2cm above the pubic synthesis or along a safe tract as defined by ultrasonographic assessment. In the difficult case of an obese patient with a roll of fat in the lower abdomen with a skin fold, it is advised that the catheter placement be passed through the skin above the skin fold but must be manipulated so that the tract punctures the rectus sheath no more than 2cm above the synthesis pubis. Alternatively, a puncture below the skin fold may be undertaken.

7.7 In patients with a readily palpable bladder and no history of lower abdominal surgery, it is considered reasonable to insert a suprapubic catheter using the closed technique providing that urine can be easily aspirated from the bladder using a needle passed along the planned catheter tract.

7.8 In patients in whom there is no history of lower abdominal surgery but where the distended bladder cannot be palpated because of obesity, it is considered that blind

insertion should not be undertaken. In this circumstance, ultrasonography may be used to identify the distended bladder or cystoscopy to ensure that an aspirating needle is entering the bladder at an appropriate point.

7.10 In patients with either a history of lower abdominal surgery or a bladder that cannot be adequately distended, the suprapubic catheter should either be inserted using an open technique or with the adjunct of imaging that can reliably exclude the presence of bowel loops on the planned catheter tract.

8.0 PROCEDURE FOR INSERTION OF A SUPRAPUBIC CATHETER

Physician's should ask themselves the questions recorded in Appendix 2 before proceeding. A management algorithm for planned Suprapubic catheter insertion is shown in Appendix 3. The Practical steps in suprapubic catheterisation are:

(1) Assess the situation
   a. Is the patient in urinary retention (History, Clinical Exam, Ultrasound scanning)
   b. Has urethral catheterisation been attempted (evaluate the experience of who has previously attempted urethral catheterisation to determine whether a further attempt should be undertaken)
   c. Does the patient have a neurological history or previous lower abdominal surgery
   d. Obtain informed consent

(2) If you are proceeding with suprapubic catheterisation then lie the patient flat and palpate the abdomen or if possible using ultrasound, scan the abdomen to assess the distended bladder.

(3) Prepare everything in advance and have an assistant. You will need;
   a. A clean procedure trolley
   b. Sterile gloves
   c. A sterile catheterisation pack including drape
   d. A suprapubic catheterisation kits which includes a sizes 12, 14 or 16F catheter.
      Commercial kits contain the following equipment;
         10ml syringe (x2)
         18G hypodermic needle (12cm long)
         Scalpel
         Dilator in peelable sheath
         Guidewire
         Long term silicone catheter (size 12 or 16F)
   e. 10mls 1% Lignocaine checked and drawn into a 10ml syringe, fitted with a 23G (Blue needle)
   f. An 18G hypodermic needle (included in commercial kit), alternatively use 18G green cannula needle with plastic sheath removed.

(4) Prepare the lower abdomen using a sterile cleansing solution and drape area.

(5) Palpate the symphysis pubis and infiltrate the skin approximately 2 fingerbreadths above in the midline with local anaesthetic (5mls 1% Lignocaine)

(6) Replace the blue needle with the 18G hydpodermic needle and gradually advance the needle into the skin at the point of previous infiltration, aiming the trajectory of the needle approximately 30 degrees towards the pelvis in the midline. Infiltrate with local anaesthetic and intermittently aspirate as you go.

(7) When you reach and enter the bladder you will be able to aspirate urine freely. If you cannot aspirate urine with the needle DO NOT PROCEED with attempted catheterisation.

(8) Unscrew the syringe from the needle, taking care to hold the needle in place within the bladder. Insert the guidewire (floppy end first) through the needle and into the bladder up to the black mark indicated on the wire.

(9) Remove the needle leaving the guidewire in place.

(10) Using the scalpel within the suprapubic kit make a 1cm incision in the skin at the needle entry point and deepen this incision until you have incised the rectus sheath (otherwise this will later present an obstacle)

(11) Insert the suprapubic trocar over the guidewire in the same direction as the needle earlier, towards the bladder. You will often find a palpable 'give' as the trocar enters the bladder and you may note urine leaking through the catheter introducing sheath.

(12) As you withdraw the trocar (leaving the sheath in place), place your finger over the end to prevent rapid emptying of the bladder and possible dislocation of the sheath.

(13) Your assistant will then pass you the (male length) catheter (Always have the catheter open and ready in advance, and water for the balloon already drawn up. Insert fully through the sheath to reach the bladder, and then inflate the balloon and unpeel the sheath from around the catheter.

(14) A suture is not required to hold the catheter in place but may be required to close the skin incision partly.

Remember to document the procedure in the patient's notes including, indication, steps taken, and problems encountered and residual urine drained from the bladder.

9.0 PATIENT OBSERVATION AND MANAGEMENT POST PROCEDURE

- Ensure appropriate referral has been made to the Urology service for appropriate follow-up to arrange the first change of catheter.

- A mucus or mucopurulent discharge around the catheter is commonly seen but should be easily managed using local hygiene measures (rather than antibiotics). The formation of a granuloma at the catheter site may be managed using a silver nitrate stick cauterisation.

1/ Haematuria after suprapubic catheter insertion is fairly common and generally self-limiting. After catheter insertion, and balloon inflation, the catheter should be pulled back against the bladder wall to provide tapenade of the suprapubic tract. Bladder washout or irrigation may be required to resolve the haematuria.

2/ Catheter wound site infection should be treated with antibiotics if there is evidence of cellulitis. Abscess formation may require aspiration or surgical drainage.

3/ Bleeding from the urethral meatus and/or failure of the catheter to drain may indicate that the catheter has passed through the bladder so that the tip is lodged in the urethra. If the catheter is not draining it should first be flushed to ensure that it is not blocked. If it still does not drain, or if there is urethral bleeding, the balloon should be deflated and the catheter withdrawn slightly and repositioned.

4/ **Vigilance in assessing and diagnosing a visceral injury** should always be considered and there should be provision of written guidance for the patient and their attendance on such signs of peritonitis.
Patients should be monitored carefully post procedure, staff should be aware of potential signs of bowel perforation including;

- Abdominal pain
- Signs of localised peritonitis
- Patient becoming systemically unwell/sepsis

If bowel injury is suspected the patient should be fasted and an urgent surgical/urology opinion should sought immediately.

9.0 REPORTING OF CLINICAL INCIDENTS / ADVERSE EVENTS / RISK ASSESSMENTS

9.1 Adverse outcomes after suprapubic catheterisation or change of suprapubic catheter must be documented on a trust incident reporting form (IR1); reporting mechanisms should review critical incidents at regular intervals.

EQUALITY STATEMENT

This guideline has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote Equality of Opportunity.

In line with the duty of equality this guideline has been screened against particular criteria and as a result no major issues requiring further impact assessment have been identified.

This guideline has also been considered and prepared with regard to the Trust's obligation under the Human Rights Act 1998. The Trust is satisfied that the guideline complies with its obligations under the Act.

If at any stage of the life of the guideline there are any issues within the guideline which are perceived by any party as conflicting with his/her rights, that party should bring these to the attention of the Director of Human Resources & Corporate Affairs or raise a complaint through the published complaints procedure.

REFERENCES

British Association of Urological Surgeons, Suprapubic Catheter Practice Guidelines, Harrison SCW et al, BJUI 2010, 107, 77 – 85.

In Rapid Response Report NPSA – 2009 – RRR 005 Minimising Risks of Suprapubic Catheter Insertion (Adults only) www.npsa.nhs.uk/patientsafety/alerts-and-directives available at http://www.nrls.npsa.nhs.uk/resourses/type/alerts/queryentryid45=61917

SIGNATORIES

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

APPENDIX 1

The NPSA Key recommendations to reduce the Risk of Harm

The NPSA suggested compliance check list for organisations include:

1. Information about the risk of this procedure should be immediately distributed to all staff who may insert or request the insertion of a suprapubic catheter as well as being involved in the management of these catheters.

2. A named lead for training be identified and training plans developed.

3. Local guidelines on policies to be developed in view of this report and the BAUS documentation.

4. Ultrasound is used where possible to visualise the bladder and guide the insertion of the catheter. There should be ultrasound machines available in the relevant areas and staff trained in their use.

5. Local incident data relating to suprapubic catheterisation should be reviewed and appropriate action taken and staff to be encouraged to report further incidents and take part in BAUS National Clinical Audit.

Appendix 2

NHS
National Patient Safety Agency
National Reporting and Learning Service

Minimising risks of suprapubic catheter insertion (adults only)

The National Patient Safety Agency (NPSA) has been notified of three incidents of death and seven causing severe harm from suprapubic catheter placement between September 2005 up to June 2009, nine of which involved bowel perforation. We know that many more incidents have not been reported, as a survey of clinicians suggested higher rates of harm. The NPSA has issued guidance for organisations to make the procedure safer, including training and access to equipment such as ultrasound. We have asked your organisation to take actions to minimise the risks associated with this procedure. As clinicians, there are six questions you can ask to keep your patients safe:

Question	Guidance
1. Does this procedure need to be done?	• Insertion of suprapubic catheter carries a risk to the patient. • Indications for the procedure are: the relief of urinary retention where urethral route is contraindicated or not technically possible. • Record in patient notes why this procedure was done and any problems.
2. Am I competent to do this?	• You should not undertake this procedure if not competent. • You need to be trained in the procedure. • You need to be familiar with local equipment and guidelines. • Senior supervision should be available, if needed.
3. Does this need to be done now?	• Emergency procedures and those performed out of hours present more risk. • Seek advice from the on-call urology team and consider other options, e.g. fine needle aspiration, as an interim measure.
4. Is it the right procedure for this patient?	Absolute contraindications: • non-palpable bladder; • non-visualisable distended bladder by ultrasound. Relative contraindications: • coagulopathy (until the abnormality is corrected); • prior abdominal or pelvic surgery (potential bowel adherence to the bladder of anterior abdominal wall. In such cases you should consider requesting a urological surgeon to perform an open cystostomy; • pelvic cancer with or without radiation (increased risk of adhesions).
5. Have I got access to an ultrasound?	Ultrasound should be used wherever possible to visualise the bladder and guide insertion of the catheter.

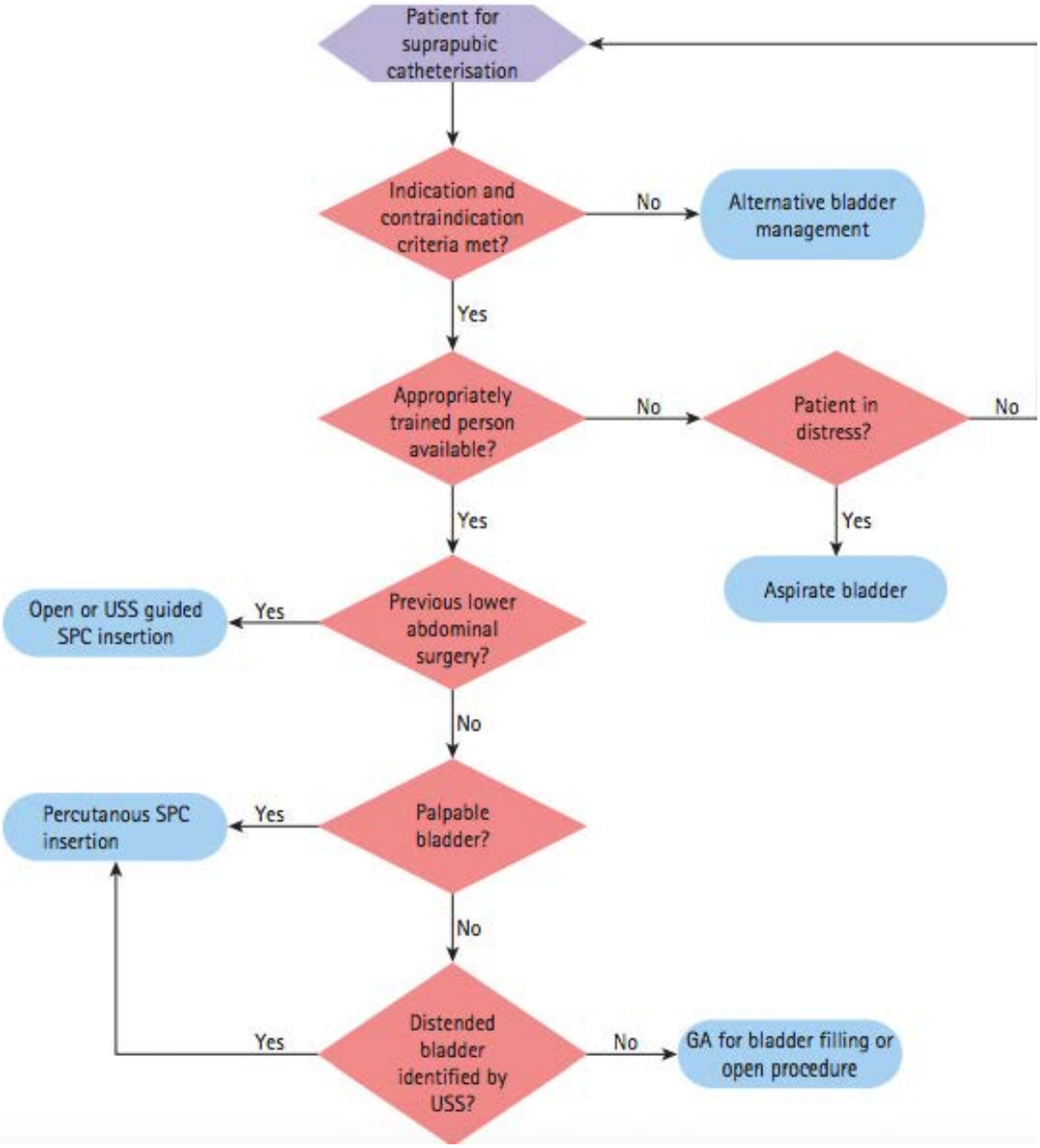
6. Do I know what to look for in the case of bowel perforation?	• Monitor patients carefully.
	• Urology team should carry out the first change of catheter.
	• Have a high index of suspicion for signs of bowel perforation including:
	  ○ patient has abdominal pain;
	  ○ patient has signs of localised peritonitis;
	  ○ patient is systemically unwell.

Appendix 3

BJUI British Association of Urological Surgeons' suprapubic catheter practice guidelines

A suggested management algorithm for a planned SPC insertion.

FIG. 1. Suprapubic catheter (SPC) insertion algorithm. GA, general anaesthesia; USS, ultrasonography.



A commentary from the Urology Unit, Craigavon Area Hospital has been requested with reference to the use of irrigating fluids for endoscopic procedures. The Consultants' in the unit have had the opportunity to discuss this as a group. The background to this request is understood to relate to the unfortunate death of a young lady from hyponatraemia and bleeding as part of a gynaecological procedure. We are not in a position to directly comment on this particular case, but will be passing general comments on certain principles.

Irrigating fluids are used in an array of urological endoscopic procedures. These procedures include cystoscopy, TUR Prostate, TUR for Bladder Tumours, Bladder Neck Incision, Rigid Ureteroscopy, Flexible Ureterorenoscopy and Percutaneous Renal Surgery. Irrigating fluid used is Glycine, normal Saline and Water. The particular choice of irrigating fluid to be used is chosen depending on the particular action to be carried out during the endoscopic procedure. Water is infrequently used but its purpose is that its properties are similar to Glycine. Its use is to flush specimen samples of prostatic chippings or bladder tumour out of the bladder at the end of a procedure. The choice between Glycine and normal Saline pertains to the technology to be used. Normal Saline is used for ureteroscopic surgery as well as percutaneous renal surgery. This is because the use of laser fragmentation of stones and ultrasound disintegration of stones is best achieved in this fluid medium as well as noting it is as isotonic and compatible with human blood. Glycine is used for resection of prostatic tissue and bladder tumours. It is used because of its compatibility with monopolar diathermy resection. Normal Saline for resection is used with a bipolar diathermy technology and would be used as part of laser prostatectomies. It is understood that Glycine is hypotonic and if absorbed can cause hyponatraemia. Glycine has been used for several decades as an irrigating fluid for resection surgery. The condition of TURP Syndrome is indeed well recognised and in urological terms has been used as opposed to the term hyponatraemia. Glycine is used worldwide and urologists, as part of their training, are trained to recognise how this comes about, its signs and symptoms and to lay out a management plan for its therapy. It is appreciated by all that technologies do move on and techniques change, but this does not necessarily negate the need for older techniques and technology to be lost.

All the urologists in Craigavon throughout their training and in consultant practice have been using Glycine for endoscopic resection. It is appreciated that a few patients have had TURP Syndrome but to our knowledge there have been no adverse long-term effects from this in any patient.

There are several key points to highlight in our practice in Craigavon. Firstly, it is recognised that this is a team approach to providing patient care. It starts with a team briefing i.e. the WHO checklist, all in the theatre environment are therefore aware the operation and the need for patient management. The commencement of resection time is noted and throughout the whole procedure it is noted that time is a significant factor.

With regards to TUR Prostates, we will generally not resect beyond the hour. The clock is watched throughout the procedure. The irrigating fluid bag is hung between 50 and 100cm above the patient's waist. The matching of the fluids running in and the fluids retrieved have in recent years not been precisely monitored but in general terms, nursing staff will monitor what is known as the in's and out's and surgeons generally ask if there is any mismatch throughout the procedure. The specific recognition of excessive bleeding and a capsular perforation is of particular importance to the operating surgeon. This bleeding risk, capsular perforation, and the increase in resection time, we all recognise as causing an increased risk of absorption. We also regard the use of the continuous irrigating scope as a major advance in TUR Prostate procedure. The use of the continuous irrigating scope has resulted in resection time being shortened and also keeps the bladder pressure constant. This we regard as decreasing the risk of absorption.

The surgical technique of bipolar TURP using Saline and monopolar TURP using Glycine is by the same surgical technique i.e. loops of prostate or bladder tumour being resected and these chips are then washed out. However the fine nuances of the procedure commented by a variety of urologists do note that the cutting mechanism is not as precise especially in the setting for bladder tumours and that the haemostasis diathermy used is not as good when using the bipolar technology in Saline. This is noted intra-operatively as well as noted in the post-operative phase and as such has led to complication of excessive bleeding. This extrapolated would theoretically increase the risk of transfusion and potential return to theatre for cautery.

We do appreciate that there could be room for improvement in intra-operative monitoring e.g. more precise real time regard for the fluid input matching output and the potential for intra-operative blood testing. There are several scientific papers dating back over the decades on these precise topics. Our understanding is that this has not been particularly productive albeit that we recognise it is a very reasonably practical monitoring modem. Our experience tells us that the 3 litre bags do not precisely contain 3 litres, inadvertent irrigate fluid spillage on the floor from inadequate capture by the drip system combined with the natural production of urine and blood loss will all lead to perspiratory in the input/output chart. Returning to the previous method of theatre staff being in charge of monitoring in real time, the bags in and volume out can be re-instigated. We are aware of new technology that does monitor the fluids in and out in real time are now available but these have not been trialled by us nor are we aware of other units using them. Intra-operative intravenous sampling to measure sodium and other electrolytes has been researched in the past and could be re-introduced and we would welcome our anaesthetic colleagues view on this.

We would like to point out that we regard TUR Prostate and bladder tumour to be a different operation to the gynaecological TCRE albeit that they are all endoscopic resection techniques. We regard the TCRE as endoscopy in a

smaller cavity where the tissue is more vascular and sinusoidal in an anatomical configuration. All these features we feel increase the risk of absorption. TUR Prostate, especially with the continuous irrigating scope is at a lower pressure. Deep resection and capsular perforation are much less of a feature in modern day TUR Prostates and diathermy technique as the procedure progresses is more often performed. In conclusion TUR Prostate and bladder tumour is one of the main core surgical techniques taught during urology training. All aspects of management are taught to a high level; this includes surgical technique and management of potential complications. The use of Glycine has been used worldwide for TUR Prostates and bladder tumours for decades. Surgical technique has been well tried and tested. We appreciate that some urologists may wish to use bipolar Saline surgical technique but this should not hinder others from using Glycine, a surgical technique they have been well used to.

Irrigating fluids used in urological procedures

Craigavon Area Hospital Urologists comments (January 2014)

A commentary from the Urology Unit, Craigavon Area Hospital has been requested with reference to the use of irrigating fluids for endoscopic procedures. The Consultants' in the unit have had the opportunity to discuss this as a group. The background to this request is understood to relate to the unfortunate death of a young lady from hyponatraemia and bleeding as part of a gynaecological procedure. We are not in a position to directly comment on this particular case, but will be passing general comments on certain principles.

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Water is infrequently used but its properties are similar to Glycine in terms of electrical impedance. It is use, in small volumes (300 mls), to flush specimen samples of prostatic chippings or bladder tumour out of the bladder at the end of a procedure.

The choice between Glycine and Normal Saline pertains to the precise technology to be used for a procedure. Normal Saline is used for ureteroscopic surgery as well as percutaneous renal surgery. This is because the use of laser fragmentation of stones and ultrasound disintegration of stones is best achieved in this fluid medium as well as noting it is as isotonic and compatible with human blood.

Glycine is used for resection of prostatic tissue and bladder tumours. It is used because of its compatibility with monopolar diathermy resection. Normal Saline for resection is used with a bipolar diathermy technology and would be used as part of laser endoscopic prostatectomies.

It is understood that Glycine is hypotonic and if absorbed can cause hyponatraemia. Glycine has been used for several decades as an irrigating fluid for resection surgery in urology. The condition of TURP Syndrome is indeed well recognised and in urological terms has been used as opposed to the term hyponatraemia. Glycine is used worldwide and urologists, as part of their training, are taught to recognise how this occurs, avoidance principles, its signs and symptoms and to lay out a management plan for its therapy.

It is appreciated by all that technologies and techniques change, but this does not necessarily negate the need for older techniques and technology to be lost.

All the urologists in Craigavon throughout their training and in consultant practice have been using Glycine for endoscopic resection. It is appreciated that a few patients have had TURP Syndrome but to our knowledge there have been no adverse long-term effects from this in any patient.

There are several key points to highlight in our practice in Craigavon. Firstly, it is recognised that there is a team approach to providing patient care. It starts with a team briefing i.e. the WHO checklist, all personel in the theatre environment are therefore aware of the operation and the need for a coordinated patient management policy. The commencement of resection time is noted and throughout the whole procedure it is appreciated that time is a significant factor. With regards to TUR Prostates, we will generally not resect beyond the hour. The 'clock is watched' throughout the procedure. The irrigating fluid bag is hung between 50 and 100cm above the patient's waist. The matching of the fluids running in and the fluids retrieved have in recent years not been precisely monitored but in general terms, nursing staff will monitor what is known as the in's and out's and surgeons generally ask if there is any mismatch throughout the procedure. The specific recognition of excessive bleeding and a capsular perforation is of particular importance to the operating surgeon. This bleeding risk, capsular perforation, and the increase in resection time, are all recognised as causing an increased risk of absorption. We also regard the use of the continuous irrigating scope as a major advance in TUR Prostate procedure. The use of the continuous irrigating scope has resulted in resection time being shortened and also keeps the bladder pressure constant. This we regard as decreasing the risk of absorption.

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Our experience tells us that the 3 litre bags do not precisely contain 3 litres, inadvertent irrigation fluid spillage on the floor from inadequate capture by the drape system combined with the natural production of urine and surgical blood loss volumes, will all lead to a discrepancy in the input/output volumes.

Re-instigating the previous regime of the theatre staff more formally being in charge of monitoring, in real time, the number of bags used and volume drained out would keep a closer 'eye on' the situation. We are aware of new technologies that monitor the fluids 'in and out', in real time, are now available but these have not been trialled by our department nor are we aware of other units using them. Intra-operative intravenous sampling to measure sodium and other electrolytes has been researched in the past and could be re-introduced and we would welcome our anaesthetic colleagues view on this.

We would like to point out that we regard TUR Prostate and bladder tumour to be a different operation to the gynaecological TCRE, albeit that they are all endoscopic resection techniques. We regard the TCRE as endoscopy in a smaller cavity where the tissue is more vascular and sinusoidal in its anatomical configuration. All these features we regard as increasing the risk of absorption. TUR Prostate, especially with the continuous irrigating scope is at a lower pressure. Deep resection and capsular perforation are much less of a feature in modern day TUR Prostates. The use of haemostatic diathermy in the procedure is more often performed. In conclusion Transurethral Resection of Prostate and bladder tumours are one of the main core surgical techniques taught during urology training. All aspects of management are taught to a high level; this includes surgical technique and management of potential complications. The use of Glycine has been used worldwide for TUR Prostates and bladder tumours for decades. Surgical technique has been well tried and tested. We appreciate that some urologists may wish to use the bipolar Saline surgical technique but this should not hinder others from using Glycine, a surgical technique they have been well used to using.

Since we first discussed this topic in our department a month ago (hence the above notation), changes have already been proactively undertaken. Fluid management is dynamically monitored with a record being written on a specifically designed fluid chart. This is formally recorded after each 3l bag of Glycine but is also inspected continuously via the suction drainage bottle. Spillage is kept to a minimum by capture in the drape system. Being conscious of the bag height being kept at less than 100cm is also at the forefront in setting up for the procedure. Surgeons are kept informed about the time as the procedure progresses rather than being told 'it's coming close to an hour'. The anaesthetic service has already introduced blood sampling before and at defined time intervals throughout the procedure (and more often if clinical thought prudent) as a mechanism of identifying the potential for this particular risk occurring. Therefore the theatre department in Craigavon Area Hospital has proactively taken measures to reduce the

risk of hyponataemia occurring in the first place and the risk of its development is continuously assessed throughout the procedure and into the recovery ward. Identification using these assessment tools will identify if there is an issue as soon as possible.

M Young on behalf of the Urologist Southern Trust 5.2.2014

11th March 2015

JULIAN JOHNSTON
CONSULTANT ANAESTHETIST
ROYAL VICTORIA HOSPITAL
FALLS ROAD
BELFAST

Dear DR JOHNSTON

I would like to take this opportunity on behalf of the Urology Unit in Craigavon Area Hospital to respond to the second draft document on irrigating fluids used in urological procedures. The Consultants in the Unit have had the opportunity to discuss this as a group. We had previously provided our response to your initial paper back in January 2014.

There are a few comments I would like to make before recording our response on the paper itself. In general terms, we thought that for such an important issue it would have been beneficial and deserving to have had the opportunity of a round the table consultation before such an advanced stage document was produced. This would have highlighted the significant difference and therefore an appreciation noted throughout the subsequent documentation that there is considerable difference between irrigation fluids used during urological and gynaecological procedures. It would also have been advantageous to have had a wider initial E-mail address list to include all Urologists so that they could have individually commented. There also appeared to be a very clear foregone conclusion from the first draft that Glycine was to be removed from use. In saying this, we as a Department have indeed found that this second draft report clarifies the situation better in terms of recommendations. I now include our comments on the paper itself.

The opening sentence suggests that Urologists are not currently fully cognisant of the risks. This is far from the reality. Urological teaching for several decades has included this topic in our syllabus. Urologists are fully aware of what is known as TUR Syndrome. Clinical practice and methods of treatment are ingrained in our teaching of this particular care pathway. We are not in a position to comment on this aspect of gynaecological teaching. We feel that this sentence requires alteration. We also feel this document requires a clearer statement defining that urology and gynaecology procedures have a different physiological response; we feel that the overall impression within the document is that they are one of the same.

As a point of information, in Section 1.2 we would record that Saline is a conductor and hence why it is used for bipolar resection.

In section 1.5 we would like to note that TUR Syndrome is only one risk. Other factors such as fluid overload and haemorrhage offer significant risks and we feel that these two factors are as important as TUR Syndrome. In general terms we agree with the statement recorded in recommendation 1.

We have several points to record in Section 2. We still don't quite understand what is meant by the meaning of curtailing the use of Glycine.

We do not have any particular comment on section 3.

For Section 4, we are indeed agreeable with the statement about increased vigilance. We are however very vigilant already as our teaching in urology has pointed this out as a significant issue. In this particular section, we would like to add further comments.

With respect to the Point 4.2.2, it is correct to state that TUR syndrome does not occur with bipolar TURP but fluid absorption and haemorrhage can still occur. Scrutiny of the meta-analysis[9] presented by the reports authors demonstrates that a single study accounted for 17 of 35 reported cases of TUR syndrome in the 22 trials. The forest plots for the other series do not show statistical significance in relation to the incidence of TUR syndrome between bipolar and monopolar surgery. Therefore, one might conclude that this single trial is a statistical outlier which has unduly influenced the outcome. A flaw of the methodology.

The third paragraph of this section overstates the efficacy of bipolar TURP versus monopolar TURP for clinical outcomes. Indeed, the meta-analysis[9] notes that "results for maximum urinary flow rate were significant at 3, 6 and 12 months (all $P < 0.001$), but no clinically significant differences were found and the meta-analysis showed evidence of heterogeneity". The same meta-analysis states "Several major methodological limitations were identified in the included trials; 22/24 trials had a short follow-up of ≤1 year, there was no evidence of a sample size calculation in 20/24 trials and the application of GRADE showed the evidence for most of the assessed outcomes to be of moderate quality, including all those in which statistical differences were found."

The assertion that bipolar techniques may reduce length of stay and have costs benefits, is not supported by high quality published evidence, rather it is an opinion given in a NICE technology appraisal

There is a focus in this document upon arterial pressures. From a urology perspective for endoscopic prostatic surgery, any such absorption of fluid occurs through open venous channels or into extravascular space. These are not arterial channels. Open veins or capsular perforation are in essence the main ways of absorbing fluid into the system. Surgeons should therefore be aware of the operative field. The principal of having the irrigating fluid at 60cm or less is in general practice what is indeed used. The introduction of continuous irrigating flow scopes has helped to keep pressure as low as

possible and operative time is kept to a minimum as we recognise that these potentially have a contributing effect.

Recommendations of 5, 6, 7 & 8 are agreeable. We would feel that the emphasis on continuous monitoring of the fluids is the ideal way to proceed. Our experience to date of the use of pumps has not been productive and in fact has had the opposite effect.

In point 9, we would like to state that the nursing staff should keep an on-going running account of fluid balances so that the Surgeon and Anaesthetist can assess the situation in advance of the agreed limits defined pre-operatively, as opposed to being told when the limit has been reached. This will allow for safer completion of the operation.

We would agree with Point 10, but the definition of the 'deficit fluid' needs clarification. Is the deficit the patient's fluid volume or the theatre irrigation fluid volume record? Ie if there is a disparity in the 'irrigation fluid volume', then if this recorded as less fluid returning in the suction bottle, does this mean it is recorded as a deficit? As such this is a gain to the patient.

In Section 11, it is a recommendation that operative time is limited to 60 minutes. We feel that this should not be a hard and fast rule. There is no evidence base for this but we do realise this is a target time. Sixty minutes is custom and practice to date yet surgical judgement needs to be exercised. We feel that the recommendation wording could be altered to accommodate this feature. We do feel that it would be a significant advantage to modify the WHO checklist to include the expected operation time and the agreed fluid limits. This would be defined pre-operatively and hence the Nurse in charge of the 'fluid system' would have a clear understanding and as such would have an early warning system to inform the Surgeon and the Anaesthetist that this limit was close to being reached rather than just informing this team when the limit had been reached (as per Point 9).

We regard this document has having significant implications for all Units who undertake such procedures, whether they perform a high or low volume in terms of numbers. This 'direction of travel' would solely be a Northern Ireland phenomenon. Experience locally would not necessarily agree with the overall safety aspect claimed as haemorrhage risk issues have been expressed. Also some have expressed concern over a potential degradation of pathological specimens. This would have staging implications for bladder tumour management.

From a urological perspective there is significant regard and experience with the use of glycine, which should not be overlooked. Although of secondary concern, there will be a considerable cost implication to Trusts and the Department of Health as changing over to the bipolar system will be an excessively expensive process. Provision will be required.

M Young
Lead Clinician
Responding for Southern Trust Urology Service.

Minutes of Urology Service Development Day

Consultants Meeting

In attendance: Mr Young,
Mr O'Brien,
Mr Haynes,
Mr Glackin,
(Mr O'Donoghue joined later).

1.1 Urologist of the week working model.

This topic was discussed extensively with each consultant able to contribute to the discussion. The consensus was that the inpatient ward round was of prime importance requiring consultant presence. The structure for referral and advice provided needs to be improved. Where possible definitive care should be delivered during the current inpatient stay.

1.2 Triage of new referrals.

The Trust needs to provide a plan detailing what exactly it expects the consultants to do in terms of triage. This must include recognition of the time constraints and time commitment required to complete triage including time spent speaking to patients, booking scans, reviewing results and mitigating risk for patients on the curent long outpatient waiting list. Consideration was given to decoupling the triage activity from that of the Urologist of the week.

1.3 Annual leave.

The team is define the number of consultants and other members of middle grade staff who can be away at any one time. Discussion of Christmas and Summer holidays should be well in advance of holiday time to permit good planning. A process for agreeing leave should be developed and adhered to.

Other business:

Mr O'Brien tabled a written document setting out his issues of concern for discussion at the meeting. Similarly Mr Young provided an email listing topics for discussion. It was suggested that those items not discussed should be given time at the weekly departmental meetings.

- First Out Patient Consultation Waiting Times
- Development of care pathways (bladder cancer, LUTS/BOO)
- Outreach clinics
- Specialty Doctor Clinics
- Consultant Job Planning

- Care of Benign Urology Patient
- Cancer MDT
- Theatre allocation and usage
- Waiting List Management
- Winter pressure planning
- Technology & Equipment

Meeting of consultants and senior nursing staff

In attendance:

Sr Caddell,
Sr McElvanna,
Sr Magill,
Sr Lockhart,
Sr Magee,
Sr O'Neill
Sr McMahon,
Sr McCourt,
Charge Nurse Young,
Mr Young,
Mr O'Brien,
Mr Haynes,
Mr Glackin,
Mr O'Donoghue

2.1 Ward issues:

1. Outlying of urology patients to facilitate medical inpatients.
2. Staff retention and vacancies.
3. Staff education program for Urology inpatient care.
4. Lack of medical support for medical inpatients on ward 3 South due to locum staff and a lack of continuity.
5. Interruptions to ward rounds.

2.2 Thorndale issues:

1. Too few cystoscopes.
2. Clinics overrunning.
3. Requests for inpatient flexible cystoscopy.
4. Introduction of endoscopy check list.
5. New patient clinic running problems due to time keeping and case mix.
6. Provision of intravesical chemotherapy service.

Sr Leanne McCourt tabled a prostate cancer option grid to be piloted within the Department.

Sr Jenny McMahon tabled the Southern Health and Social Care Trust endoscopy safety checklist.

ISSUES OF CONCERN FOR DISCUSSION
At
DEPARTMENTAL MEETING
On
24 SEPTEMBER 2018

The main issues of concern which I would wish to have discussed at the Meeting of 24 September 2018 relate to the practice of 'Urologist of the Week' (UOW), triage of referrals, the waiting times for a first outpatient consultation, the waiting times for elective admission for surgery, and the various relationships and influences between all of these.

I am honest in asserting that I have struggled to know how best to have these issues discussed, as I believe that they will be contentious, with all of us having very differing perspectives of that which is expected of us as individuals. I hope that we can express our views without confrontation and without causing offence. I hope that we can listen to each other respectfully. Above all, I do hope that we will be able to agree standards of practice to be submitted, perhaps in optional form, to senior Trust management, so that we will have a written clarification of expected practices.

UROLOGIST OF THE WEEK

From the outset in 2014, I found the discussions regarding the introduction of UOW to be frustrating and incomprehensible. I simply could not understand how it could not be a good thing to have a system where all inpatient care, whether acute or elective, would be undertaken by a consultant urologist with the assistance of junior staff (in training). I could not understand how it was considered that the Trust would not support and fund UOW without offering to undertake other duties when UOW, as it would not take all one's time to look after inpatients. At one time, it was even proposed that the UOW would be able to do an afternoon clinic! Regrettably, in my view, we did agree to include triage in the duties of UOW. In due course, I came to believe that there was a range of perspectives of the concept of UOW, from that which I expected it to be, to being 'Urologist on Call', and variations in between.

It had been my understanding that my week as UOW would begin with a Handover Ward Round at 09.00 am on a Thursday morning. The Handover would be from the consultant urologist whose week was ending, to me whose week was beginning. The Ward Round would continue until all inpatients were reviewed, their care being handed over. It would not be replaced by any other duty or practice by either consultant, with the exception of one or the other having to operate in emergency theatre. It would not be curtailed by attending departmental or other meetings, with the possible exception of the monthly scheduling meeting. The priorities of that first day would be to get to know the inpatients under my care for the next week, to meet them, to know their history, examine them, plan their further management, including definitive operative management when possible. As we all have experienced, I believe that we would also have a duty of care to those patients elsewhere, about whom advice and assessment is sought, and who may become inpatients under our care.

It had been my understanding that each of the seven days of that UOW week would be the same, including Saturdays and Sundays. It has been my experience that the most common conflict has

been when operating made it impossible to undertake ward rounds. When that has occurred on consecutive days, clinical inpatient care has been undertaken by registrars, often with different registrars on different days, with obvious risk to continuity of care. The other main concern that I have experienced when UOW has been that registrars are dealing with many calls for advice from elsewhere, without input from the UOW, resulting in the default outcome of having the patient referred to the department, to be triaged by another UOW one or two weeks later. The week would end with my handing over to the next UOW with a ward round commencing at 09.00 am the following Thursday morning, and ending when all inpatient care has been handed over.

It has been of increasing concern to me to observe an increasing divergence from the practice which I had understood UOW to require. It has increasingly become a common occurrence for no ward round to be undertaken by the UOW over a weekend, including three day, bank holiday weekends. It has been reported that one whole week went by in recent months without one ward round being conducted by the UOW. As often as not, I have begun my UOW week without handover from the previous UOW, and ended it without the next UOW being present. A recent handover took place with neither UOW being present. It had been my understanding that no activity other than emergency operating was to replace or usurp inpatient management when UOW. I did not consider that operating elsewhere, conducting Stone MDM / Clinic, urodynamic studies (I have been guilty), or getting documentation in file for (successful) appraisal, never mind triage, were to replace the primacy of inpatient management. I believe that there has been an increasing practice of 'letting them get on with it', referring to the registrars, both with inpatient management at ward level, and in some instances, operating, with I believe, suboptimal outcomes as a consequence, on occasion.

But I may have been wrong, and if the consensus is that I have been wrong, and if the Trust will underwrite that consensus, I will abide by it, even though it has been my definite experience that inpatient outcomes have been compromised, and will be again.

TRIAGE

I found it impossible to complete triage while being UOW, and I still do. Since returning to work in 2017, I spend the weekend following my UOW completing triage. In doing so, I have requested scans, initiated treatments, dictated letters to GPs, informed patients by telephone or dictated letters to them. I have done so for 45 to 66 patients referred, the equivalent of five to seven, virtual new clinics, without time allocated to doing so, never mind remuneration. Then the reports return! I find it such an anomaly that we have been allocated four hours of total administration time per week, and at least six hours of SPA time in our job plans!

I do believe that we need to consider the complexities of triage. The Red Flag referrals are relatively straight forward, though I was unable to obtain consensus regarding advanced triage of Red Flag referrals in 2015, even though they comprise a minority of the all referrals. I believe the remaining majority are the issue, particularly in the context of the waiting times for first consultation for urgent and routine referrals. If a man is referred with LUTS this month, should he wait until September 2019 before having an ultrasound scan performed, to find that he has a bladder tumour in addition to an enlarged prostate gland? Should he similarly wait until then before having a PSA, or having Tamsulosin prescribed for presumed BPH? Should these be preconditions to referral in the first instance? Should a woman referred with recurrent urinary

infection wait more than one year before she too would have an ultrasound scan performed, or have antibiotic prophylaxis prescribed? Should a man with erectile dysfunction wait even longer before he has treatment initiated? Could one with a scrotal swelling not have an ultrasound scan performed prior to referral, precluding referral in most cases?

In many instances, I find the most egregious referrals are those consequent upon consultation with our registrars. I have triaged referrals for red flag flexible cystoscopy following discharge of patients from our own department! Why was it not organised by those doing the discharging? Why does a registrar advise referral of a patient for a TROC, rather than arranging it at the time? Why does a registrar advise referral of a patient with a small stone at the lower end of the left ureter, instead of arranging the review?

I have requested several times from the Trust its stated Policy and Procedure on Triage, without acknowledgement. I can only conclude that it does not have one. I advised the Director of Acute Services in January 2017 that the issue of triage, its relation to UOW and to waiting times for first consultation, be addressed. There has been no response.

Once again, I would like us to embark upon a discussion of triage in all its complexity, and I expect that the Trust will be engaged in that process, resulting in a clear, written understanding of our obligations, so that we are not to be held liable.

WAITING TIMES FOR ELECTIVE INPATIENT SURGERY

This issue hardly needs further comment. We are all aware of the interspecialty disparity in waiting times, as of June 2018. I believe that the disparity is both scandalous and indefensible. I also believe that the lack of any substantive response from the Trust is equally so. I believe that we must collectively bring our concerns to the Trust Executive, and to the Trust Board which I understand to be unaware of the disparity, and unaware of any substantive attempt to remedy the situation.I also do believe that we should look at disparities between our own waiting lists, especially with a view to making every attempt on our part to minimise risk of serious morbidity or mortality.

In January 2015, I placed on my waiting list a pretty fit, 90 year old man for resection of his prostate gland which had regrown since it had previously been resected in 2006, and which had been the source of haematuria in 2015. He was admitted to the Cardiology Ward in August 2017 with coliform urosepsis resulting in a type II, myocardial infarct. He was readmitted again in August 2018, again with urosepsis. Since discharge, he has had visible haematuria, exacerbating a chronic anaemia. A CT Urogram has been normal. There was no evidence of urothelial pathology on flexible cystoscopy which was done during his recent inpatient stay. Yesterday, I arranged his admission on 17 October for TURP, keeping him on antibiotic prophylaxis until then.

I feel a sense of shame when dealing with such a patient. Whether it is disparity within our own specialty, or between specialties, it is unacceptable that such a man should have to wait almost four years, at risk of such morbidity, while an urgent gynaecological case would not have to wait more than three months.

Since I was appointed 26 years ago, the solution to any urological inadequacy has always been regarded as a requirement for additionality, which could either not be afforded, or there was no space for more beds, or staff could not be recruited, or whatever. I do believe that the first solution should be to cause displeasure to those specialties which do not have such a critical situation as we do have. How many gynaecological operating sessions are there per month in the Southern Trust? Why not allocate half of them to Urology?

Lastly, I often think that if I had a tumour of my left kidney, it would have to be removed within 62 days, or thereabouts. If I have a staghorn calculus in the remaining kidney, it does not receive the same clinical priority. I may just develop renal failure, requiring dialysis, a recognised complication!

SUMMARY

I hope I may be forgiven for expressing my views, frustrations and concerns, but I believe that it is time to do so. I have equally committed to listening to those of my colleagues. From doing so, I hope that we can collectively arrive at a clear understanding of our individual and collective obligations, and above all, that we have a clear, written memorandum of understanding, or agreement, or covenant, maybe even a Policy and Procedure, from the Trust of our practice obligations.

AIDAN O'BRIEN
24 SEPTEMBER 2018.

Glackin, Anthony

From: Young, Michael
Sent: 12 September 2018 12:12
To: Glackin, Anthony; Corrigan, Martina
Subject: away day thoughts

It's disappointing to think that there is a question mark about the away day.
Yes agree that a formal structure is needed.
Our last 'blue sky thinking session' was good but I'm not sure that is fully what we are after.
As previously pointed out we have had the opportunity of a weekly departmental meeting time, which this last year has been poorly attended by some and if there were so many problems then there was a great opportunity lost.
Frankly I don't see why folk could not find the time to attend. – anyway this is an opportunity to all be there and take things forward thereafter.

Tony has wished to chair and that's great.
The ward and Thorndale wish to attend as they have issues and if not for any other reason, this is why the 'day' should occur.

After the last scheduling meeting I suggested that a pre-meeting meeting on the 13th departmental slot should help define an agenda and time slot.
So here are a few thoughts of mine

Thorndale –
scope issues
clinics not so big by spreading clinics out over the week more
partial reversion to specific clinic types eg a spec Dr only clinic for luts or routine patients that they may then do as DSU surgery

Outreach clinic on specific days – take the team ie BPC and STH Dr and specialist nurse clinic in tandem like the Erne
? create more space back in the thorndale.
How about we make a decision about the Erne ourselves

Ward
Discharge comment improvement for follow up arrangements
Phone answering

Drs
Our job plans have been defined – are they actually what we want personally or for the team
I think the focus for years has been oncology so some thought on this occasion about other issues.
I personally want a change to focus more on the STC role by dropping other things
Role of the STC
This includes overall dropping of sessions either on a Monday or Friday
I'm content with the triage arrangements but others may not be

Technology and principles
Scopes
Urolift , iris stent removal - all these things help with running
Winter pressure planning – still keep our theatre session but accept less inpt work and do day surgery blitz using these session and ensure elective ward is not abused
What does the Trust expect from us for all the defined areas of practice

MY

MY AOB MDT AOB.

① UoW.

AOB. Cons. provided IP care.
Ward rounds. Operating. Answering queries providing advice
Handover between cons. Thurs 9AM.
- primacy.
Conflict between operating/ward round.
Concern re: middle grade advice.
Incomplete discharge plans.
Unsupervised registrar operating.

Written agreement of what the trust expects of us.

MY. Communication between registrar + Consultants.
Practicalities.
Availability.
Handover of elective cases. Communication with elective operater/UoW.
Ownership at time of discharge.

MDT. Consultant present on ward round
Routine weekend working not in job plan.
Direct consultant involvement in referrals from elsewhere.

Evening ward round : form / structure.
implications for FY1 work pattern.
Continuity.

AOG. Personal input. On time.
Communication with other teams.
- advice sheet documented.
Primacy of handover meeting.
Handover of elective cases.
Senior Nurse on ward round.

Consensus.

Primacy of IP ward round,
consultant present.
Structure for referral + advice.
Definitive care.

Triage.

Expectation
Use of telephone.
Advice.
Scans.
Time constraints / commitment.
Mitigation of risk.
Decouple triage from UoW.

Draft a plan for a new way of doing triage.

Annual Leave.

define number away at any time.
Timing of discussion for Christmas / Summer Holidays.
Process for agreeing leave

Waiting List Management -

5. TURBT pathway:
- dedicated lists
- 2016 : 123 TURBTs. 40 weeks x 3 cases.
- morning lists to facilitate day case surgery
- opportunity to move work out of main theatres
- shared bookable lists with proforma to identify suitable / unsuitable cases.

5&6. Bladder outlet Surgery Pathway.

AO'B.
Triage
UoW.
W/L.

List of recommendations

1. Develop a structured training curriculum for specialist urological nurses and establish accredited training departments.
2. Provide job planning for clinical nurse specialists and ensure appropriate skill mix.
3. Increase the provision of Urological Investigations Units (UIUs), providing a dedicated resource for urological outpatient care.
4. Review follow-up rates against a median of 1:2 first outpatient to follow-up.
5. Take further action to improve RTT performance for common conditions and pathways.
6. Address the potential adverse effects of existing cancer diagnostic and treatment standards.
7. Review guidance for urology cancer MDT working.
8. Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.
9. Improve the secondary care pathway for patients with urinary tract stones.
10. Provide consultant-delivered emergency urology care in every trust by reducing elective commitments for consultants on call.
11. Review workloads of on-call consultants to ensure the sustainability of on-call arrangements.
12. Ensure high-quality emergency urological care is available in all areas seven days a week by focusing available resources at weekends on a smaller number of departments, while allowing some departments to operate on a five-day basis.
13. Review the approach to providing care for patients who require urgent surgery for urinary tract trauma and related conditions.
14. Establish urology area networks (UANs), comprising several urology departments that provide comprehensive coverage of urological services, beyond existing network arrangements, to optimise quality and efficiency.
15. Reduce the numbers of complex surgical procedures that are carried out in small volume centres, using networks as they develop.
16. Align data collection efforts across urology and ensure that data collected are relevant and have a value that is in proportion to the resources needed for its collection.
17. Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and the spreading of best practice.
18. Reduce litigation costs by application of the GIRFT Programme's five-point plan.

Southern Health and Social Care Trust

Quality Care - for you, with you

SHSCT Endoscopy Safety Checklist

Time Out (To be read Aloud)	Sign Out (To be Read aloud)
Before Commencement of Procedure (with Team Leader & Endoscopist- STOP all actions)	**Before Patient leaves Procedure Room**
Team introduction carried out Yes □ Patient's identity, procedure, consent & co-morbidities confirmed with Endoscopist? Yes □ Has all equipment used on the previous patient been removed from endoscopy room? Yes □	Specimen pots and pathology forms are correctly labelled (2 Nurses read specimen labels aloud, including patient name) Yes □ N/A □
Correct endoscope and all anticipated equipment needs available? Yes □ Has the correct endoscope been tracked to the correct patient? Yes □ Oxygen, suction, monitoring equipment & drugs available and checked? Yes □ Has Essential Imaging been reviewed All IRMER requirements met Yes □ N/A □	**Nurse Verbally Confirms with Endoscopist:** Any equipment problems to be addressed? Yes □ N/A □ Any complications during the procedure Yes □ N/A □ Recovery instructions documented in Endoscopy Care Pathway Yes □ N/A □ Follow up plans recorded in Endoscopy Report Yes □ N/A □ Recommencement of medication recorded on Unisoft report Yes □ N/A □
Confirmation of patient preference for sedation Yes □ Does the patient have a known allergy? Yes □ No □ Record of Last LMP Yes □ N/A □ Other hazard? E.g. MRSA/CJD Yes □ No □ Confirm any other risks e.g. Antiplatelets □ Anticoagulants □ Recent INR □ Is Antibiotic prophylaxis required? E.g. PEG insertion Yes □ No □	Enter details or affix label here Full name: Date of birth: Hospital/H&C number:
Emergency Bleeding Trolley available & fully stocked? Yes □ No □	Procedure:
Confirm late start /reason for delay with medical staff and record on TMS? Yes □ N/A □	
SIGNATURE: NAME: DATE:	SIGNATURE: NAME: DATE:

SHSCT Endoscopy Safety Checklist (January 2017 v0.8)

U.S. English

Prostate cancer (localized, low risk): treatment options

option grid

Use this decision aid to help you and your healthcare professional talk about how best to treat your low risk, localized prostate cancer.

Frequently Asked Questions ↓	Watch and wait	Active surveillance	Low dose brachytherapy	Radiotherapy and neoadjuvant hormones	Surgery
What does this treatment involve?	Treatment will aim to control symptoms. You will get regular checks and blood tests.	You will get regular checks with blood tests and prostate biopsies. If you change your mind or if the cancer changes, you will be offered treatment aimed at cure.	Small radioactive pellets are put into your prostate under general anesthetic.	Radiation beams and hormone therapy are used together for four to eight weeks, where you visit the hospital every weekday.	The prostate gland is removed under general anesthetic. You will stay in hospital for at least one night.
How will this treatment affect long-term survival?	After around 10 years, approximately 85 in every 100 men (85%) will be alive.	After around 10 years, approximately 90 in every 100 men (90%) will be alive.	After around 10 years, approximately 90 in every 100 men (90%) will be alive.	After around 10 years, approximately 90 in every 100 men (90%) will be alive.	After around 10 years, approximately 90 in every 100 men (90%) will be alive.
Will I need additional treatment?	Perhaps. Other treatments may be needed to control your symptoms.	Perhaps. Around 30 in every 100 men (30%) will need additional treatment.	Perhaps. Some men benefit from using hormones to shrink the prostate before brachytherapy.	Yes, most patients have hormone treatment for at least three months before radiotherapy.	Perhaps. Radiotherapy might be offered to you after surgery.
What are the side effects associated with this treatment?	Does not apply	Symptoms generally occur in the first two weeks after biopsy, typically pain, and blood in sperm, urine or stools. 10 in every 100 men (10%) get a urine infection.	After the treatment, most men will pass urine frequently, and have bleeding. Some men will be unable to pass urine. After six months, around 30 in every 100 men (30%) will have problems with erections, and some men may pass urine more often than before.	After the treatment, most men will pass urine frequently, have diarrhea and tiredness. After six months or more, around 30 to 60 in every 100 men (30 to 60%) will have problems with erections. A few men will become incontinent and have bowel problems.	Most problems happen immediately after surgery. Most men will have some incontinence for the first three months. After six months or more, around 40 to 70 in every 100 men (40 to 70%) will have problems with erections. A few men will become incontinent.
How long before I return to usual daily activities?	Does not apply	2 days	2 weeks	6 weeks	12 weeks

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Thorndale. KO'Neill JMcMahon CMcCourt MYoung.

* Cystoscopes : too few
additional 4 (we have 8).
(3 out of action)
at present.

Clinics. AM overrunning

DHH: 4 haematuria pts/week. potential for expansion.
do we need to shift work around?

IP flexis. staffing/scopes.
a place to do this activity.

SHSCT Endoscopy checklist.

New patient Clinic.
feedback
timekeeping.
preview to identify casemix.

Intravesical chemo. service.
arrange admission at present.
OP with procedure (would be better).
documentation onto NIECR.

G. Magill . C McElvanna . S Lowry . S Boomi .

Ward .

Sr. Caddell. ENT / UROL / MEL . — 13 to 17.

* UROL pt. outlied to facilitate Medical.

Staff retention severe problem . 14 vacancies

Education programme cannot proceed at present.

Support from Medical Teams. Lacking.

Overrun from March 2018.

Regional Review : Urol. pt's on Urol. ward.

31 funded beds . 36 open .

Locum Staff Cons + SHO .

- lack continuity . , insufficient numbers.
- pt's seen 5 days a week.

Ward Rounds .

interruptions

several specialties . doing simultaneous rounds .

Thorndale

prostate Ca. Options Grid.
pilot.

HIGHLIGHT REPORT
DEPARTMENTAL MEETINGS
SUMMARY OF ACTIONS FOR SUMMER 2008

LINK CORRIDOR

The link corridor has been agreed to be attached to the side of the Thorndale Unit, where the small window is. The emergency exit will, therefore, open out into the link corridor. An emergency door will then be provided on the corridor. The work has been signed off on an Estates request form. The funding for the link corridor will depend on what other works are competing for the same budget.

REFURBISHMENT OF WARD 2 SOUTH (REG'S ROOM)

A meeting has been held with Estates about this. The work is on their list of works to be completed. However, the budget for the lists of work is insufficient to cover all of the projects approved. Simon is looking into this.

SPECIALIST NURSE URODYNAMICS

This post was advertised on the 26th August, internally and in the Belfast Telegraph.

STONE NURSE

After discussions about this post it was decided that the renal colic section should be taken out as this service is being provided by A&E. The postholder will, therefore, conduct one triage type clinic before the consultant sees the patient and one clinic for review patients.

CLINIC TO DETERMINE IF A STONE IS PRESENT

Letters that have been triaged as, 'query stone,' will be sent to the Stone Nurse who will then send patients for the necessary tests, to determine if a stone is present. If a stone is present the nurse will then discuss the patient with the consultant. The patient will then be booked into the Stone Treatment Clinic. If a stone is not present then the nurse will discuss this with the consultant. The outcomes for the patient without a stone will either be to be referred to the consultant outpatient clinic or to be discharged back to the G.P.

REVIEW CLINIC

This clinic remains the same as agreed in initial service design model for Urology ICATS. This may be a telephone clinic or face to face.

PATIENT APPOINTMENT LETTERS

All the necessary amendments have been made to all appointment letters sent to patients. The amended letters have been emailed to Anne Quinn in Clinical Audit, for information purposes. She will then forward them on to Conleth Grimley, for the letters to be amended on PAS. The outpatient letters can not be changed at the moment due to a review of all outpatient letters being conducted. The amended letter is with Katherine Robinson. The letters will be changed in due course. The changes to EIDO information have also been sent to Anne Quinn.

UROLOGY SERVICE ADMINISTRATOR POST

A job description at Band 5 has been compiled, for a Service Administrator for the Urology Service, including ICATS. The post is currently waiting for approval for banding and will then be sent to HR for recruitment. Sharon Glenny is taking this forward.

The next meeting will be held in Seminar Room 1 on Monday 1st September, from 10:00 to 12:00. The vision for the Urology service for the SHSCT will be discussed.

MINUTES OF UROLOGY DEPARTMENTAL MEETING
– CAH BOARDROOM 18th April 2013

In Attendance: Mr Young
Mr O'Brien
Mr Pahuja
Mr Glackin
Mr Brown
Jenny McMahon
Martina Corrigan

Minutes of this meeting records the planned reintroduction of a regular urology departmental meeting. We have decided that this should be for one hour between 12.30 and 1.30pm on Thursdays. This would match in well with the planned scheduling rota meeting which already exists. We thought the 12.30 start would be ideal as the ward round often doesn't finish till just after midday. We also decided that this would be a minuted meeting and we would discuss a topic until its completion before moving on to a new area.

The topic chosen to start these meeting was haematuria.

We defined the needs as twofold: firstly to resolve the access haematuria numbers on the books at present and secondly to address this problem in the longer term.

The agenda for this topic included current demand and how to record its volume, how patients were to be triaged to the service, making clear the entry requirements to the service, to re-evaluate what was to be included in the clinic assessment, whether the clinic design should be one, two or three stops and finally to discuss clinic locations.

Mr Brown has commented that national studies have shown that in general the referral to haematuria is one per 10,000 of the population. Therefore estimated that about 450 or so patients would be referred into our service. This would average 36 patients per month. Figures for February and March 2013 were available for our assessment. Noting that in February there were 16 referrals with an additional 4 upgrades and in March there were 41 referrals with 11 upgrades.

It was decided that the triage of letters would still continue to be consultant performed. Theoretically letters received could be as a direct referral as a Red Flag or indeed the consultant may wish to upgrade the letter to a Red Flag. A new arrangement now is that letters referred to Daisy Hill Hospital, with regards to haematuria, were to be triaged by the Craigavon team of consultants. Also the Mandeville Unit Team will now be taking over the booking of these referrals and their tracking. The allocation of patients to the Craigavon and Daisy Hill site will still continue as before and be based on the patient's address. Martina and Jenny were to liaise with the Mandeville Team about this new arrangement.

Discussion was held about the haematuria 'box' on the list of available clinics recorded on the hospital stamp. It is now recorded that a tick in the haematuria box means that all these referral letters are automatically to be regarded as a Red Flag referral (whether or not the words Red Flag or the sticker Red Flag has been attached to the letter).

We commenced discussions with regards to the care pathway. It is recorded that NICE and BAUS have nationally agreed guidelines on referral criteria for patients into this service. Discussion was held on this front as some have had reservations with regard to non-visible (microscopic) haematuria pathways. We will be commencing our next session with further discussion on this particular point but it is recorded that it is the consultants responsibility to triage referral letters to the appropriate clinic as the consultant sees fit for the patient to attend.

The next meeting will be for scheduling on Thursday, 2nd May 2013 and on the 16th May 2013 we will return to the topic of haematuria.

MINUTES UROLOGY DEPARTMENTAL MEETING

6 JUNE 2013

Attended:

M Young

A O'Brien

T Glackin

A Pahuja

Discussions:

1/ SWAH referral letters = New letters are our responsibility but there appears to be some issues over reviews of patients already in the system and under Altnagelvins wing being redirected towards our department – this was not the original agreement. Further investigation required.

2/ Mr Glackin and Mr Pahuja concerned that outpatient clinics are being overbooked despite telling booking office to keep to the official template. PM clinic is three hours and this should be 12 patients – typically 14 or 15 patients are on clinic. In the interim this should be restricted until job plans can define clinic duration more precisely. If clinics overbooked then Consultants may ask booking office to cancel patients.

3/ We do not see why the new consultants can not have their own codes for clinics and waiting lists = = to be investigated.

4/ Mr Glackin and Mr Pahuja require more flexible cystoscopy slots. Mr Glackin has one regular and Mr Pahuja may have one list per month. This is not enough. The introduction of the Wednesday pm DSU list may address this and again job planning will be required.

5/ Mr Jathar is our locum consultant. Sessions have been allocated. Mr Glackin and Mr Pahuja will supply him with flexible c/u cases (Mr O'Brien + Young will continue with existing arrangements). Mr O'Brien is to offer cases to Mr Glackin / Pahuja. Mr Young is to define general anaesthetic cases for Mr Jathar for June and July lists. A review of this will be taken in July.

MINUTES FROM UROLOGY DEPARTMENTAL GOVERNANCE MEETING

19th AUGUST 2015

In attendance: Mr O'Donoghue, Chair, Mr Young, Minutes, Mr Haynes, Mr O'Brien, Dr Martin, Mr Tyson, Mr Mukhtar, Sister O'Neill & Martina Corrigan.

Apologies: Mr Glackin, Mr Suresh (holiday leave).

1. **HAND OVER** – This is proving an on-going issue; it is still recorded that this should be in person and in writing. It is recognised that the clinical governance committee are awaiting to report on this however in the interim our Registrar's will attend the surgical hand over in the morning at 8:40am. This will be the interim measure until it is defined what exactly will be the on-going arrangement. It is also appreciated that there is a hand over in the evening.

2. **LOCUM WORK** – It's not exactly clear when Locum's are commencing their shift time. There is an appreciation that they are working in other Trusts prior to commencing work for us in the evening. A more realistic start time may be recommended. Outcome is for Martina Corrigan to audit start time.

3. Where a patient is an inpatient and a urology consult is requested we are recommending that as much as possible from a urology investigative point of view should be performed as an inpatient rather than bringing the patient back as an outpatient.

4. The daytime Registrar cover of the urology unit was discussed with regards to the change noted in July where all day cover for a full week had been instigated; Dr Martin felt that there was good continuity of care. We are currently trialling the consistency of a single Registrar covering the morning sessions from Monday to Friday for two months. In October we will again trial the all day Monday to Friday approach.

5. There has been an adoption of one bleep only for the on-call urology Registrar i.e. the bleep is handed between Registrars' as opposed to switchboard etc. having to look at a rota for each session.

6. There are on-going training issues with regards to Immax (now called - Note). The M&M form data needs to be completed by the individual consultant and then at the audit meeting this will be completed by the audit members led by the chairman.

7. The Trust audit on fifty inpatients has had a poor uptake to date. It was hoped that 'google-doc' could be used but this has not been possible due to Trust computer blocking systems. Martina Corrigan will be addressing this with the IT Department but we have suggested that if this is not immediately correctable that a paper version would be undertaken. Plan to start 01st September 2015.

8. The stent register process is on-going. Mr Haynes has liaised with BAUS central office. Update for next meeting.

9. Audits for the incoming year:

    1. Partial nephrectomy – All partial nephrectomies undertaken from 2010 onwards to be reviewed by Jenny Martin.

    2. Outcome of invasive transitional cell carcinoma from 2000 – 2010. This is a pathology based audit to identify all outcomes of such patients. Mr Mukhtar to liaise with Mr O'Brien on this topic.

    3. Audit of hand over quality – Mr Tyson.

    4. On-line catheterisation teaching questionnaire for FY1's.
    These audits are in addition to the index control audit of TURBT and TURP.

10. Dr McAllister's comment on VTE prophylaxis was noted. The outcomes for each ward are recorded. Discussion on this topic did record that for 3 South the VTE risk assessment was only at 55%. Discussion also noted that our ward was a mix of ENT and urology. This led to a discussion around whether Clexane should be given to patients where bleeding is at risk, namely haematuria, TURBT and prostate surgery. It was concluded that all patients will be given the appropriate Clexane and TED stockings unless there is a specific default from same recommended by the consultant in charge. A focus at the daily ward round on the drug kardex is to be instigated.

11. **COMPLAINTS** – There is a general trend of complaints with regards to waiting times for outpatients and inpatients. No specific complaint with learning point has been recorded.

12. **CLINIC TIMES** – It is recorded that the afternoon clinics are overrunning often finishing well after 5:00pm and sometimes at 6:30pm. The afternoon clinics start at 1:30pm. The booking times towards the end of the clinic are to be readdressed by Martina Corrigan. It is recommended that last patient appointments should be at 4:00pm; this is to be trialled, actioned by Martina Corrigan.

13. No mortalities are recorded this month.

14. **MORBIDITY** – Case of bilateral flexible ureteroscopy with resultant acute renal failure from obstruction. The case presented with bilateral diagnostic flexible ureteroscopy with passage of urine for 48 hours post-procedure which then progressed to acute onset of anuria. Renal function blood tests then defined increasing creatinine. An ultrasound scan did not show any hydronephrosis. Patient then developed pain. Nephrology input requested as unusual presentation of obstruction. Proceeded with bilateral stent insertion; this resolved the renal function.

    Outcome learning points:

    1. Treat bilateral ureteroscopy with utmost respect with insertion of ureteric catheters or stenting.

    2. A lack of hydronephrosis does not necessarily exclude obstruction – clinical judgement to take precedence.

15. **NEXT MEETING** – General hospital audit on 15th September 2015.
    (post- script = this date is same as Regional Audit in the Ulster Hospital)

UROLOGY DEPT MEETING

9/11/17

Present

MY, AOB, MC,

Discussion agenda:

IRISIS disposable cystoscope for stent removal

Disposable flex. Ureteroscopes

Urolift

Video cystoscopy

Transgender orcidodectomy

Registrar progress

Discussion

1/

ISIRIS – MY and JOD have been shown the kit by representatives and discussed use and cost.

At meeting today = kit shown to AOB and MC = Positive response to the kit and principle

We regard this as a niche area, suitable for outpatients in SWAH = clinic, STC clinic and post ESWL, A/E referral. Especially to firstly speed up patient overall treatment pathway time and secondly release slots in the DSU for other flexible cystoscope cases.

Although one monitor is supplied free of cost we felt that two monitors would suit the unit best – one for the STC and the other to be in Thorndale for wider use.

Taking this subject arena further we regard that the principle of disposable flexible cystoscopy usage could be beneficial in other areas. Ie SWAH clinic, Thorndale when not enough scopes have been cleaned for the sessions workload, ward work, A/E catheter insertion investigation.

So although assessing the ISIRIS today, this topic needs further depth in terms of all the companies producing such systems ie single use flex cystoscopes +/- biopsy and stent graspers

MY to assess other single use cystoscopes in general term

2/

Videoscope in dhh for Jenny and Jason - teaching re Botox

On capital list to purchase (still) but not top on the list presently

Discussed whether these scopes stay in DHH or move to CAH = felt best to stay in DHH meantime

3/

Transgender orchidectomy - no interest from consultants from what we can gather

JOD and MH to confirm their opinion, MY AOB AG do not have appetite for this service.

Since BCH source had written to MH on subject = MH to respond

4/

Ureteroscope and urolift topic not covered today

5/

Registrar report = we plan to have a short update on a monthly basis on Registrar progress. We all independently work with the Registrars so it was felt to be a good idea to have a collective assessment to see if there is a trend or needs in training requirements.

Next meeting relates to trans perineal Prostate biopsy.

MY

9.11.17

a/

NeoFlex – Flexible, Single Use Cystoscope™ | Neoscope
neoscope2020.com/?portfolio=flexible-cystoscope
1. Cached

?? silicon valley only

b/
CST-4000S Flexible Fiberoptic Cystoscope
Did you know that EndoSheath® Cystoscopy is a new alternative to conventional cystoscopy procedures? Stryker's CST-4000S Flexible Fiberoptic Cystoscope featuring Vision Sciences® EndoSheath technology is the only flexible fiberoptic cystoscope designed to never come in contact with the patient

c/

Isiris Scope by Coloplast - The single use stent removal
https://www.isiris-scope.com/
1. Cached
Isiris α is an innovative digital solution to the challenges associated with standard JJ stent removal; Isiris α is a **single use** flexible **cystoscope**, with an integrated ...

Urology Departmental Meetings Autumn 2017

12 noon Seminar Room 2

DATE	TOPIC
26th Oct	Scheduling for December
2nd Nov	TURP update. Stone management update
9th Nov	Devices - disposable stent removal scopes – IRIS Disposable flex. Ureteroscope Urolift Video-cystoscopes Orchidectomy transgender Registrar progress
16th Nov	Smart target transperineal prostate biopsy
23rd Nov	Stone management policy
30th Nov	January scheduling
7th Dec	Performance – Martina now using e-triage no longer have a printed CCG referral in their notes
14th Dec	Ward and Thorndale meeting
21St Dec	Feb scheduling ??

DEPARTMENTAL MEETING – 27th OCTOBER 2016

Present: Chair Mr Young
Present: Mr Glackin, Mr Haynes, Mr O'Donoghue

1. Discussion about the new replacement post and timelines were discussed. We will be asking Mrs Corrigan to enquire if the process for advertising can be speeded up and other features of the job arranged while waiting for approval from the regional speciality advisor as there appears to have been a delay.

2. To be discussed at the THUGS meeting are the points relating to the urolift, the fluid management system, disposable flexible ureteroscopy and image intensifiers for South Tyrone. We will be reporting back to the THUGS meeting on the urolift cost per case. We have confirmed that the fluid management resectoscope system to be purchased is the STORZ system. As yet to be defined is the quantum of scopes systems and the electrical generator. We are keen to include the fluid management pump and heating system as we regard this whole topic as relating to the safety issue of saline use for resection in its totality i.e. not only the resectoscopes but anything else that can improve on the safety. We needed to consider scopes mainly for Craigavon but also for South Tyrone and potentially Daisy Hill Hospital in the future. We also would regard that the Day Surgery Unit here in Craigavon should have scopes as well. We wish to trial out a disposable flexible ureterorenoscope from two companies and we would like to have the facility of the image intensifier for South Tyrone Hospital; we do appreciate that the theatre environment in South Tyrone Hospital would be compatible with radiation. On prior discussion with the theatre manager in the Day Surgery Unit it is clear that it is not suitable for image intensifier use as it isn't adequately lead lined.

3. We are aware that our green light laser is seventh on the list of seven for purchase. We are unaware of the transparency with objective criteria used by the Trust to define the order of purchasing of equipment; we will be addressing this with the Trust in further detail later. We do however feel that the green light laser would offer the facility of day use, its use in a different theatre and the ability to release beds; this is a prime example for an improvement in our waiting lists. A second purchase would relate to the video flexible cystoscopes. This is used extensively throughout other urological units; it is a very appropriate imaging system for training and on-going monitoring of our nurse practitioners. Further consideration is the MR guided biopsies system. This undoubtedly will be a necessity in the future.

4. With regards to the BT80 Cookstown patients we would wish Mrs Corrigan to speak to the Department sooner than the next PIG meeting so that the Department can lift the redirect notice on referrals from the BT80 GP's so that these patients can return to the North West Team; we understand that their waiting times are significantly better than ours.

5. We will be introducing an Andrology and peripheral nerve stimulating agenda for a future departmental meeting.

M Young
27th October 2016

DEPARTMENTAL MEETING 22nd SEPTEMBER 2016

Chair: Mr Young

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

Apologies: Mr Haynes , Mrs Corrigan

TOPIC: SALINE RESECTION

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

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

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

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

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

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

CONCLUSION

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

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

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

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

M Young
22nd September 2016
Chair of Session

ADDENDUDEM to outstanding information in relation to Saline resection Systems

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

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

2/ OLYMPUS will only supply one free generator

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

M Young

12th October 2016

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M Young

12th October 2016

Departmental Urology meeting topics Autumn 2016

Date	Topic
22 Sept	Saline Resection system
29 Sept	Monthly Scheduling for Nov
6 Oct	On –call arrangements and theatre ultilization
13 Oct	Performance (and referrals NW and resectoscope update)
20 Oct	referrals NW
27 Oct	Video scopes Thorndale / nov evening on call / referrals NW sign off Resectoscope and irrigation safety systems
3 Nov	Monthly Scheduling for Dec
10 Nov	Performance and Suresh workload
17 Nov	managing GI consequences for pelvic cancer Dr Murdock
24 Nov	Monthly Scheduling for Jan
1 Dec	Andrology services as per Dr Wright's letter
8 Dec	
15 Dec	
22 Dec	? Monthly scheduling for Feb
29 Dec	

Urology Departmental Meetings Spring 2018

12 noon Seminar Room 2

DATE	TOPIC
15th Feb	Update on instrumentation – past present future
22nd Feb	Scheduling for April
1st March	Triage
8th	Thorndale issues
15th	Performance meeting with DoH (MH and MY)
22nd	Stone Treatment Centre
29th	Scheduling for May
5th April	Ward issues
12th	Administrative issue
19th	Mitomycin and Paediatric surgery
26th	Scheduling for June

Urology Departmental Meetings Autumn 2018

12-15 Seminar Room 2

DATE	TOPIC
4 Oct	
11 Oct	Xmas cover
18 Oct	
25 Oct	
1 Nov	Dec Scheduling
8 Nov	
22 Nov	
29 Nov	
3 Dec	AWAY DAY
6 Dec	
13	

- Urologist of the Week
- Triage
- First Out Patient Consultation Waiting Times
- Development of care pathways (bladder cancer, LUTS/BOO)
- Outreach clinics
- Specialty Doctor Clinics
- Consultant Job Planning
- Annual Leave
- Care of Benign Urology Patient
- Cancer MDT
- Theatre allocation and usage
- Waiting List Management
- Winter pressure planning
- Technology & Equipment

OCT 4th

1/ Weekend ward round recognition – have to ?

unpredictable / predictable

Discussion - conclusion is for a Saturday 3 hr duration of predictable work, based on work pattern observed by all Consultants in the Unit.

This is however not an agreement for elective planned work of any kind on a Saturday morning.

2/ Sign off of job plans.

Has everyone agreed?

3/ triage

Time to perform – we are not entirely sure of the duration spent over the week. Times given were only given as a prediction but not actually timesheet assessed.

Six hours appears to be the current allocation

Assessment to be undertaken of actual time

OCT 11th

WARD CARE

Concern expressed at level of nursing care – distinct failure of orders and observations being carried out.

Stability of staff and emphasis of enacting on orders = how can this be ensured and obtained?

Consultants are expressing deep concern.

Meeting with management and senior nursing required.

Suggesting that an excess of variety of patient types is a distinct problem.

WINTER PRESSURE

What is Trust plans ?

Suggestions

– ring fence elective ward

- Day cases on T4
- Can some of our pt be sent out on WLI

Trust needs to be informed of the extent of our waiting list problem.

It is suggested that we meet with Trust Management to express concerns. A request will be made to the Chief Executive - long waiting list and winter crisis.

Recognised the Mr Haynes has raised this already and as a dept we wish to take this forward

MY to do letter on this in view of dept plans - to mitigated risk.

18th OCT

Cns pathway for turbt for the dept as a whole Mr Glackin

Should this approach be used for stented pt and catheterized pts ie give a date prior to discharged

Registrars to inform consultant of all referrals.

Communicate this cohort of patients to the Trust especially with winter crisis approaching and that this toto of patients will be addressed despite red flag or not

Paeds meeting 4th Dec who is going? John has been volunteered

Xmas

Stents and flex scope

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee

11th September 2012

Summary of Corporate Risks as at September 2012

There are 18 Corporate Risks (6 high level and 12 moderate level) as agreed by the Senior Management Team on 5th September 2012

HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since April 2012
Ongoing achievement of PfA access targets and review appointments	1	HIGH	Unchanged
Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	1	HIGH	⇧
Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living Accommodation and Residential Homes	1	HIGH	Unchanged
High Voltage capacity limit on electrical supply to Craigavon Area Hospital	1	HIGH	Unchanged
Implementation of Business Systems Transformation Programme	5	HIGH	Unchanged

MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since April 2012
Systems of assessment and assurance in relation to quality of Trust services	1	MODERATE	Unchanged
Compliance with Standards and Guidelines	1	MODERATE	Unchanged
Fire Safety	1	MODERATE	Unchanged
Asbestos – legal compliance with legislation	1	MODERATE	New risk added on 4.7.12
HCAI – risk to achievement of PfA target	1	MODERATE	Unchanged
Risk of harm to patients from water borne pathogens	1	MODERATE	New risk added on 2.5.12
Protection of Vulnerable Adults – inconsistencies in practice and Issues with interagency working	1	MODERATE	Unchanged

MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since April 2012
Implementation of new regional on-call arrangements	**1**	**MODERATE**	Unchanged
Robust Business Continuity Planning	**1**	**MODERATE**	Unchanged
Fully Embedded Appraisal system	**4**	**MODERATE**	Unchanged
Financial Balance – risk in 2012/13 that the Trust will not achieve financial balance in year and not meet requirement for £11m cash release	**5**	**MODERATE**	Unchanged
Management and monitoring of procurement and contracts	**5**	**MODERATE**	Unchanged

Issues downgraded for removal from Corporate Risk Register

Level of unallocated child care cases – will be managed as Directorate risk issue

Note – Red font indicates the changes that have been made to the Register since May 2012

Corporate Objectives

1: Provide safe, high quality care.

2: Maximise independence and choice for our patients and clients.

3: Support people and communities to live healthy lives and improve their health and wellbeing.

4: Be a great place to work, valuing our people.

5: Make the best use of resources.

6: Be a good social partner within our local communities.

Southern Health & Social Care Trust: Summary of Corporate Risks as at September 2012

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (September 2012)**	**Lead Director**	**Status**
1	Achievement of Priority for Action access targets and review appointments to secure timely assessment and treatment • A number of inpatient/day case/outpatient waiting times significantly beyond access standards (Acute and Mental Health areas) • Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust • Outpatient Reviews in a number of specialties significantly beyond clinical review timescales • Plain film X Ray reporting only maintained at current level of Ionizing Radiation Medical Exposure Regulations with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations • A number of patients waiting beyond Allied Health Professions access target	• Bi-weekly reporting to Senior Management Team • Monthly reporting to Trust Board • Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed. • Bids submitted for non-recurring funding on a quarterly basis • Performance meetings with Health and Social Care Board • Review backlog plan submitted to Health and Social Care Board • Outpatients Review backlog action plan in place and being incrementally implemented. • Bids for additional capacity submitted and secured on a specialty basis	• On-going work with Health and Social Care Board to agree capacity gaps and associated recurrent funding requirements. A number of Investment Proposal Templates (IPTs) submitted and others to be developed after notification of Commissioner intent to proceed. • Quarter 3 and Quarter 4 bids for non recurrent funding submitted to Health and Social Care Board for all specialties with gaps with requirement to maintain access at March 2012 position by March 2013. Capacity increased both in-house and in Independent Sector. • Independent Sector contracts re-let for 2012/13 include mobile MRI capacity, Ophthalmology, Oral Surgery, Orthopaedics and Urology • Business case for Team South Urology approved (July 2011) – commencement dates agreed for 3 Urologists. . • Consultant recruitment for local Ophthalmology service unsuccessful. Currently re-advertised, with interviews mid September 2012. . In discussion with Co-operation and Working Together (CAWT) and Dublin North East. Future potential for small volume of long waits to flow to Dublin North East. • In house additional capacity utilised where possible within funding allocated	Performance and Reform/ Operational Directors	HIGH

			• Risks to maintaining March 2012 access position, including agreed backstops, highlighted at fortnightly Elective Performance meetings with Health and Social Care Board. Plain Film X Ray • Independent Sector and In-house additionality utilised (but unfunded) to maintain reading of non-Ionizing Radiation Medical Exposure Regulations plain film X Rays at 28 days • Phase 1 Action Plan in progress. Phase 2 report received and Action Plan developed. Action Plan sent by Chief Executive to Chief Medical Officer and Health and Social Care Board to seek clarification on timescales and process for regional actions. Response received, but no regional action yet. Outpatient Review Backlog • Whilst significant reduction in volume of review backlog achieved initially, the number of routine waits has shown an increasing trend in 2012 as the system continues to bring in significant volumes of in-house additional new patients to meet access targets. • Of the total waits, 66% of those waiting have only been waiting from 1 April 2012. • The longest waits remain in Urology and Ophthalmology • Work continues to cleanse lists and Specialist Nurses are working with relevant consultants to screen urgent reviews and longest waiters		

			• Cutting plans formalised to monitor steady reduction of review backlog waits in association with non-recurrent funding of in-house additional capacity • Trust anticipates a rolling backlog in reviews until recurrent demand /capacity gaps have been addressed.		
2	Achievement of statutory functions/duties: Level of Older People and Primary Care Domiciliary clients Annual Reviews not completed	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process	• Domiciliary Care Reviews – exercise underway to scope the number of reviews carried out and those outstanding. 63% of all reviews completed at end of June 2012. 38% have been waiting longer than a year to have their reviews carried out • Development of an excel workbook in place for 100% of clients to provide staff with a live register of review dates for Residential and Nursing Home clients, as well as for domiciliary care reviews. • Social work capacity and demand work paper has been presented and additional capacity has been identified and recruitment is ongoing. Further capacity and demand work is being undertaken in the Memory Services. • Additional temporary social work staff remain in post to ensure the Trust reaches compliance with the expected annual review process. The outcome of the capacity and demand work will inform future staffing levels. • Permanent Placement Team in process of establishment. Operational Manager will be in place by September 2012 and service model will be developed to carry out reviews for all clients in Nursing/Residential Homes and contract reviews etc.	Older People and Primary Care	**HIGH**

3	Systems of assessment and assurance in relation to quality of Trust services	• Clinical and Social Care Governance Review completed and new structures and assurance reports being implemented • Update on implementation to Governance Committee on a quarterly basis • Governance Committee, Senior Management Team and Governance Working Body in place and operating to agreed remit • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information • Review of Specialty Mortality and Morbidity system completed. • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chief Executive • Serious Adverse Incident/Adverse Incident reporting system in place	• New Governance structures/processes embedded • Web-based incident reporting (on Datix) rolled out across the Trust • Reviewing and revising Incident Policy and Serious Adverse Incidents Management Policy • Risk Management Policy to be reviewed by October 2012 • Clinical and Quality indicator programme of work across Directorates • Executive Director of Nursing report to Trust Board in June 2012 showing performance against Nursing Quality Indicators (NFIs) • Executive Director of Nursing report on Allied Health Professions Quality Indicators to Trust Board in April 2012 • Internal Audit of complaints completed and a satisfactory level of assurance achieved • Internal Audit of incidents completed and a satisfactory level of assurance achieved • Governance Working Body in place and meeting regularly. Priority strategic areas agreed and work underway	Chief Executive	MODERATE

	Learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning	• 4 issues arising from Serious Adverse Incidents brought to Governance Working Body on 20th January 2012 and being taken forward for organisational learning. Governance Committee updated on progress in September 2012. • Presentation on National Early Warning System (NEWS) to Senior Management Team on 1st August 2012 and decision taken to progress implementation in adult in-patient settings within Acute and Older People and Primary Care. Progress report on implementation to Trust Board on 30th August 2012 • Reviewing and revising Incident Policy and Serious Adverse Incidents Management Policy		
4	Compliance with Standards and Guidelines (S&G) • Due to the volume/ complexity of new S&G being issued to the Trust by external agencies, it is a challenge for the Trust to also monitor and review the compliance status of those S&G that have already met full compliance in order to ensure that this is maintained. Since 1st January 2012, a total of 157 new standards and guidelines have been regionally endorsed from a range of different external agencies. The Trust register now indicates a total of 329 standards have been issued since 1.4. 2010.	• Establishment of six monthly performance/accountability reports for standards and guidelines. • Standard item for discussion at SMT (monthly) and Governance Committee with submission of relevant reports / assurance statements • Standard item for discussion at the Directorate Governance meetings with submission of relevant reports • For those that are „pharmacy" related a compliance report is also presented by the Trust"s Medicines Governance Pharmacist to the Operational Directors and members of the Drug and Therapeutics Committee.	• Since 19 April 2012, the Standards & Guidelines Prioritisation and Risk Review Group has met 9 times to review all of the newly regional endorsed circulars. The outcomes from the group are currently being recorded and a summary register will be made available to Directors from September 2012. • Due to financial constraints, there has not been an ability to provide approval to appoint a temporary Band 6 Senior Patient Safety Officer (initial six month secondment). The primary function of this post is to identify all standards that have been issued prior to April 2010 and determine a risk based approach for ensuring that these are effectively implemented within the organisation and that an assurance framework is in place. However, in July 2012, SMT gave approval for a	Chief Executive	**MODERATE**

	• There is often a time lag between when the external agencies require the Trust to achieve full compliance and when this is actually achieved • Standards and guidelines that have been regionally endorsed prior to January 2009 have not been reviewed / managed in line within the Trust"s new assurance processes and as a consequence the level of compliance / required action has not been identified for each. • Since 5th April 2012, the Patient Safety and Quality Service has carried a Band 5 vacancy and this has significantly impacted on service capacity. This post is currently being presented for scrutiny and following approval, will be advertised. Band 3 agency cover has been provided since 27th July 2012 to manage some of the administrative backlog.	• Database has been established and there is system of logging and monitoring standards and guidelines • SABS system in place for Safety Action Bulletins	graduate intern to be appointed to the service on a temporary 6 month basis, funded in Acute Services. The successful applicant will take up post in October 2012. • Discussions will take place in September 2012 on the feasibility of integrating the existing standards and guidelines database into the Trust"s *Datix* information system. This would facilitate more effective monitoring of the progress that is being made to ensure that standards and guidelines are implementation within the organisation. • Review of the process map to ensure effective dissemination and management of Safety Action Bulletins is on-going. Initial scoping exercise underway. Target completion date – December 2012		

5	Lack of compliance with RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living Accommodation and Residential Homes	Risk management includes • Training programme for domiciliary care staff in place – all staff have received medicines management training by November 2010 • Refresher training underway by Sept 2012 (without competency assessment - OSCE) • Trust Medicines Management policy • Medicines Management Steering Group • Review of operational procedures • Induction training for new Domiciliary Care Supervisors all of whom have now received medicines management training • SH&SCT and RQIA Incident reporting systems in place • Workshop held with Independent Sector Providers • Draft educational and competency framework rolled out to support the delivery and management of training of all Trust domiciliary care workers, day centre and social education centre staff • Risk assessment for transcribing completed • Transcribing procedure developed and implemented • Transcribing training carried out in Day Care, Supported Living and Residential Care	• Issues with achievability of compliance have been raised with the Health and Social Care Board • Risk assessment reviewed by Working Group on 23.7.2012. Outstanding actions are: - Trust Operational Procedures regarding medicines management for domiciliary care workers to be reviewed. Meeting to be held with Director of Older People and Primary Care and Director of Mental Health and Disability Services to agree which professional should/will complete assessment and detail instruction in care plan for domiciliary care workers - Implement interim guidelines for commissioners of domiciliary care services until Trust operational procedures are agreed. Guidance developed, but not yet fully implemented due to Commissioners continuing to work to local/legacy arrangements and a delay in regional workstreams in relation to the production of a pharmacy produced medication administration record. • Trust representatives on regional group. No meeting since 2011. Trust staff to contribute to Health and Social Care Board regional workstreams when they are re-established. • Transcribing competency assessments to be carried out by trained nominated staff for day care, supported living and residential care.	Older People and Primary Care/ Executive Director of Nursing	HIGH

6	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas • Fire Safety Action Plan in place (see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below)	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • £2.1m Maintaining Existing Services funding secured for 2012/13 • Craigavon Hospital Theatres1-4 in progress and to be completed by November 2012 • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k including c.£2.2m for structural works to tower block at South Tyrone Hospital • Structural engineer reports commissioned for sites at higher risk to inform action plan	Performance and Reform	HIGH
7	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place and to be monitored quarterly • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within Maintaining Existing Services • Approximately £1.2 million was invested in 2011/12 to improve fire safety by upgrading the fire alarm systems in Craigavon Area Hospital, Rathfriland and Warrenpoint Health Centres, construction of escape bed lifts in Craigavon and Lurgan Hospitals, upgrading fire hydrants at Daisy Hill and	• Additional staff have been recruited to implement highest priorities on action plan including Fire risk assessments and fire audits • Staff training on-going • New methods for delivering mandatory fire training agreed and to be implemented and tested 2012/13 • Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out • Initial Firecode funding allocation from Maintaining Existing Services for 2012/13 c. £500k to be directed to next highest priority risks and further funding continues to be sought	Performance and Reform	MODERATE

		Craigavon Hospitals and the construction of a bin store at Craigavon Area Hospital to remove fire loading from the basement			
8	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption	• Developing schemes with Northern Ireland Electricity on options for provision of increased supply capacity. • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the onsite risk. • Peak Lopping is progressing following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 12 for £2.5m spend in year.	Performance and Reform	HIGH
9	Asbestos and compliance with Control of Asbestos (N.I.) 2007 • Risk of exposure to asbestos by being unable to identify existing asbestos across all Trust property and from lack of a unified/single asbestos management plan.	• Estates Services Asbestos Management Group • Asbestos Policy in place • Revised Asbestos Management Procedures in place • Refurbishment and Demolition Surveys performed when significant work is required on any facility older than 2000 • Asbestos Registers in two legacy systems plus one on-line system	• Re-survey Armagh and Dungannon and Craigavon and Banbridge Estate and develop an integrated Trust Asbestos Management Plan for complete Trust Estate. • One year"s management inspections integrated into the Trust"s existing Asbestos Register.	Performance and Reform	**MODERATE**

10	HCAI • Risk to achievement of Priorities for Action target identified	• Dedicated isolation ward on Craigavon Area Hospital site • Comprehensive isolation policy in place and strictly adhered to • Ongoing mandatory and tailored training • Comprehensive governance structure in place, including bi-monthly Strategic Forum and fortnightly Clinical Forum • Outbreak /incident management plan in place • Independent and self-audit programme in place • Extensive action plans in place to deal with trends/prevalent HAIs • Antibiotic stewardship • Root Cause Analysis process in place	• Compliance with DHSSPS Board to Ward assurance • Further development of independent audit functions • Ongoing measurement of compliance against DHSSPS Communiqués including Independent Review of Pseudomonas • Measurement of compliance against NICE - Prevention & Control of HCAI - Quality Improvement Guide on-going. • Revision and re-launch of Trust Root Cause Analysis process for HCAI"s	Medical Director	MODERATE
11	Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas)	• Water Safety Group in place • Revised Legionella policy and procedures in place • Compliance with PHA and HEIG guidance: HSS(MD)6/12 - Water sources and potential for pseudomonas aeruginosa infection from taps and water systems • Legionella risk assessments, sampling and monitoring regime in place (as per L8, PHA & HEIG), results analysed, appropriate action taken as required • Pseudomonas sampling and monitoring regime in place in Neonatal Unit and Special Care Baby Unit; in progress in augmented care • IPC guidance on environmental cleaning developed and rolled	• Further development of formal water safety plan by September 2012 • Installing a trial system for copper sliver ionisation of Ramone Building water system • Extension of legionella testing areas • Consideration of opportunities to increase automated water temperature and flow monitoring • Review resources needed to manage water quality systems (Microbiology, IPC and Estate Services) and identify to Department of Health, Social Services and Public Safety as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines.	Director of Performance & Reform/ Medical Director	MODERATE

		out (sinks, equipment, etc.) • Infection prevention and control guidance and procedures are continuously reviewed, modified and issued to address emerging risks • Infection prevention and control audit programme and implementation of appropriate actions based on findings • On-going staff education programme highlighting risks of water borne pathogens • Design of water systems within care facility/ environment; attention is given to designing system that will reduce the likelihood of propagation of water borne pathogens			
12	Protection of Vulnerable Adults – inconsistencies in practice and issues with interagency working	• Lead Director and lead professional for Adult Safeguarding in place and Safeguarding Partnership Board/Forum/structures in place • Specialist Safeguarding Team to provide advice and support • Procedural guidance completed • Training to all managers • Report to Trust Board as part of Statutory Functions Reporting • Director of Social Work Report to Trust Board	• Development of key interfaces underway • The majority of staff across directorates now trained in the Soscare Vulnerable Adults module. A further 5 “mop up” sessions were offered over the summer months with the final session due to complete by the 12.9.12. • All Vulnerable Adults referrals now captured on Soscare with the referrals within the first 4 months of the year to be backdated on the system by 31.3.13. • Adult Safeguarding Dashboard Report became operational in July 2012. Trust wide summary report is sent to the Executive Director of SW and specific divisional/directorate reports sent to HOS and governance leads.	Children and Young People"s Services	MODERATE

			• Adult safeguarding research commenced in July 2012. On target for completion date of 31st December 2012. Learning from the research will then be disseminated throughout the Trust. • Trust Adult Safeguarding Policy to Policy and Records Committee in September 2012 for approval. • Annual Report to Trust Board on 31.5.2012 as part of Delegated Statutory Functions Report		
13	Implementation of new regional on-call arrangements. Risks in relation to disruption to services in the „out of hours" period as a result of staff withdrawing from on-call rotas from 1.10.2011 due to the reduction in on-call payments. The following services are provided by staff who will experience the biggest reductions in on-call payments: • Social Work out of hours service • Pharmacy emergency duty • Radiography out of hours service • Laboratory out of hours service	• Meetings with Directorates and Human Resources are currently ongoing to consider alternative ways of working for example, partial / full shifts, extended days, recruitment of staff to waiting lists where this is possible and appropriate in order to ensure cover can be provided during the out of hours period. • Joint Negotiating and Consultation Forum (JNCF) standing agenda item for discussion with Trade Union colleagues • Director of Social Work & Human Resources collated Out of Hours Social Work information. • Director of Social Work & Human Resources issued letter to all co-ordinators with regular update meetings with the Co-ordinators. • The Regional Out of Hours Review Group has been established of which Trust	• The Trust has been participating in the Regional group to plan for the new service model. Timelines for action are being met and the DHSSPS have agreed an extension of the current on-call rates until 30.9.12. • Regional Group has met on a number of occasions since January 2012. A regional contingency plan for a period of four months (October 2012 to January 2013) will be required until the new regional service commences on 1st February 2013. • Discussions are currently ongoing with NIPSA and the staff affected regarding the contingency arrangements • Options have been explored for shift systems in Radiography and Laboratory. A shift system will be operational in Radiography in DHH and CAH wef 1st October 2012. In relation to Laboratory, discussions are ongoing in relation to seeking agreement in relation to a shift system to be introduced once there are sufficient new staff trained, however in the interim, the oncall circular will be	Children and Young Peoples" Services/ Human Resources	**MODERATE**

		Directors are members. The Project Initiation Document (PID) has been developed and agreed by the Project Board (comprising Executive Directors of Social Work and the Director of HSCB • Collectively Trusts are seeking an extension to the implementation of the proposed new service arrangements • Social Work staff who are willing to continue on the Out of Hours rota beyond 31.03.2012 will receive current on-call payments • Out of Hours Project Team established in the Trust .	applied to this service wef 1st October 2012 • Agreement has been reached in Pharmacy in relation to the implementation of the oncall circular from October 2012. • Previous difficulties in relation to the hyperbaric chamber oncall have been worked through and arrangements are being finalised during September in relation to the implementation of the on-call circular to both nursing and technical staff.		
14	Development of robust Business Continuity Planning arrangements	• Business Continuity Plans were developed in most Directorates in preparation for pandemic in 2009. • Performance management arrangements in place between Public Health Agency/ Health and Social Care Board and Trust • Further development of plans for severe weather • Stock take undertaken • Engagement of Consultant • Business Continuity Management Policy • Progress reports provided on a monthly basis by the Business Continuity Manager to the Medical Director • Updates provided to Senior Management Team via Medical Director"s report and Governance Committee	• Temporary Business Continuity Project Manager has been working with Directors and their staff to identify key time critical services • Business Continuity Manager currently working with Directorate staff to undertake departmental level business impact analyses which will assist with the review/update of the existing suite of continuity/contingency plans for each service in line with the BS25999	Medical Director/ Operational Directors	**MODERATE**

CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
15	Fully embedded appraisal system – lack of evidence of compliance	• Succession Planning - established and on-going. Band 7 Programme „Breaking Through"being finalised • Evaluation • Governance – new arrangements in place and ongoing • Knowledge and Skills Framework (KSF) policy and monitoring system in place • Consultant appraisal policy and monitoring system in place • Mandatory Training	• Personal Development Plans received from over 44% of staff. Directorate aligned Support Staff (from HR)have been meeting with teams and demonstrating the documentation as well as encouraging team leaders to apply the policy fully in their area of responsibility and send the completed PDPs to HR for the record. • Supervision – combining staff supervision/KSF and PDP • E-learning Policy to SMT in September 2012 for approval • E-Learning packages for Moving and Handling, Safeguarding, Infection Prevention & Control, Food Safety and COSHH completed. Fire Safety and Waste Management packages almost completed • Basic ICT Skills training roll-out September-December 2012	Human Resources	**MODERATE**
CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
16	Achievement of financial balance in 2012/13 to include requirement for £11m cash release • In year • Recurring Financial impact of Transforming Your Care	• Contingency Plan for 2012/13 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board • Transforming Your Care (TYC) project leads in place in all Directorates to take forward implementation of priority	• Trust Delivery Plan, including 2012/13 financial plan, approved by Health and Social Care Board in June 2012. • Initial Draft population plan including indicative financial plans for the period to March 2015 submitted on 22nd June 2012 -	Finance and Procurement/ All	MODERATE

		projects in key workstreams. • Trust BCBV project structure supported by shared Trust/ Local Commissioning Group accountability arrangements through Southern Health Economy Population Plan (SHEPP) Programme Board.	awaiting DHSSPS /HSCB feedback.		
17	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Clarification required with respect to Centre of Procurement Excellence coverage and capacity. Issue raised with A McCormick July 2011 seeking regional way forward • Interim approach for social care procurement agreed by Senior Management Team in absence of Centre of Procurement Excellence support including awareness training for Community Contracts Team and „light touch" support/advice to ongoing procurements by Centre of Procurement Excellence • Contracts management improvement group established and key actions formed • Bimonthly reporting to SMT	• Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Interim arrangements for improved support to monitoring and workplan for review of contracts documentation agreed to improve robustness of social care contract management and monitoring • Project Team in place to undertake scoping exercise to establish central database for all Trust contracts and assess risks associated with current contract management arrangements • Initial reports providing a summary position on procurement status/risk at Directorate level to be issued by scoping team • New guidance on Single Tender Action (STA) processes issued and implemented • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited • Trust to bring forward proposals to Regional Social Care Procurement Group to address procurement deficiencies in social care	Performance and Reform/ Finance/All	MODERATE

18	Implementation of Business Systems Transformation Programme • Maintenance of existing services over the 12-18 month implementation period in light of the potential retention and morale impact on those staff to be displaced • Disruption to ongoing business resulting from the secondment of 26-30 staff to oversee the implementation • Disruption to transaction processing/quality of management information/financial forecasting and achievement of financial duties Shared Services	• The Trust has established an implementation structure • Engagement in regional process	• Human Resources strategy outlining the options for those staff potentially displaced • Secure backfill staff with the appropriate skills and experience on a timely basis • The Trust may need to reschedule corporate priorities as the workload associated with the implementation increases • Consultation on shared services completed and Ministerial decision announced • Efforts being renewed to secure suitable employment opportunities within the Trust for displaced staff and to maximize the potential for staff to stay with their current function until replacement systems are tried, tested and in place • Assurance to be sought from BSO that all functions will be maintained throughout the period of transition	Human Resources/ Finance	HIGH

Changes to Corporate Risk Register since April 2012 to date

Date	Decision taken at	Changes to Corporate Risk Register
2nd May 2012	**SMT**	Agreed to separate out risk of harm to patients from water borne pathogens from HCAI risk and include on Corporate Risk Register as moderate risk.
4th July 2012	**SMT**	Agreed addition of risk of exposure to asbestos fibres from work activities on or near asbestos containing materials within Trust facilities to Corporate Risk Register as moderate risk. Risk assessment on „Lack of compliance with RQIA recommendations in relation to the management of medicines management in domiciliary care" discussed. Risk assessment to be reviewed by Trust Medicines Management by Non Nursing Staff in the Community Steering Group on 23rd July 2012 and update to be provided to next SMT.
5th September 2012	**SMT**	Review of risks and updates received for a number of risks. Agreed removal of Corporate Risk No. 2 „**Level of unallocated child care cases'** – will be managed as Directorate risk issue. Agreed to escalate „Level of Residential Home/Nursing Home/Domiciliary Annual Reviews not completed" from moderate to high risk.

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee

10th September 2013

Reviewed by SMT on 28th August 2013

Summary of Corporate Risks as at August 2013

There are 18 Corporate Risks (8 high level and 10 moderate level) as agreed by the Senior Management Team on 28th August 2013

Note – Red font indicates the changes that have been made to the Register since June 2013

** Denotes areas highlighted for detailed review at next monthly SMT (September 2013)*

Risk No.	HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since January 2013
1.	Ongoing achievement of PfA access targets and review appointments	1	HIGH	Unchanged
2.	Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed - Care Management processes*	1	HIGH	Unchanged
5.	Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
7.	High Voltage capacity limit on electrical supply to Craigavon Hospital	1	HIGH	Unchanged
9.	High Pressure Hot Water System	1	HIGH	New risk added on 27.03.13
14	Accreditation status of Laboratory, Craigavon Area Hospital	1	HIGH	New risk added on 26.06.13
16	Financial Balance – risk in 2013/14 that the Trust will not achieve financial balance in year	5	HIGH	⇧
18.	Implementation of Business Systems Transformation Programme*	5	HIGH	Unchanged

Risk No.	MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since January 2013
3.	Systems of assessment and assurance in relation to quality of Trust services	1	MODERATE	Unchanged
4.	Compliance with Standards and Guidelines	1	MODERATE	Unchanged
6.	Fire Safety	1	MODERATE	Unchanged
8.	Asbestos – legal compliance with legislation*	1	MODERATE	Unchanged
10.	HCAI	1	MODERATE	Unchanged
11.	Risk of harm to patients from water borne pathogens	1	MODERATE	Unchanged
12.	Protection of Vulnerable Adults – inconsistencies in practice and issues with interagency working*	1	MODERATE	Unchanged

Risk No.	MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since January 2013
13	Robust Business Continuity Planning*	**1**	**MODERATE**	Unchanged
15	Fully Embedded Appraisal system	**4**	**MODERATE**	Unchanged
18	Management and monitoring of procurement and contracts	**5**	**MODERATE**	Unchanged

Corporate Objectives

1: Provide safe, high quality care.

2: Maximise independence and choice for our patients and clients.

3: Support people and communities to live healthy lives and improve their health and wellbeing.

4: Be a great place to work, valuing our people.

5: Make the best use of resources.

6: Be a good social partner within our local communities.

Southern Health & Social Care Trust: Summary of Corporate Risks as at August 2013

No	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2013)	Lead Director	Status
1	Achievement of Priority for Action access targets and review appointments to secure timely assessment and treatment • A number of inpatient/day case/outpatient waiting times beyond access standards/targets (Acute,OPPC and Mental Health areas) • Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust • Outpatient Reviews in a number of specialties significantly beyond clinical review timescales • Plain film X Ray reporting only maintained at current level of Ionizing Radiation Medical Exposure Regulations with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations	• Bi-weekly reporting to Senior Management Team • Monthly reporting to Trust Board • Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed. • Fortnightly Elective Performance meetings with Health and Social Care Board • Outpatients Review backlog action plan in place and being incrementally implemented. • Identification of capacity gaps to HSCB for non recurrent funding for additional capacity on a specialty basis	• On-going work with Health and Social Care Board to agree capacity gaps and associated recurrent funding requirements. A number of Investment Proposal Templates (IPTs) submitted and others to be developed after notification of Commissioner intent to proceed. Offers now made by Health and Social Care Board for General Surgery, Gynaecology and ENT investment. Ongoing discussion regarding level of funding proposed. • Engagement with Health and Social Care Board on Quarter 1 and Quarter 2 bids for non recurrent funding for all specialties with gaps with requirement to maintain access at March 2013 and improve in accordance with Commissioning Plan targets for 2013/14 position by September 2013. Capacity increased both in-house and in Independent Sector (IS). • Independent Sector contracts rolled over into 2013/14 for Ophthalmology, Orthopaedics, Gynaecology and new contracts being procured for Ophthalmology, Orthopaedics, General Surgery, Pain Management, Urodynamics, Mobile MRI and Mobile Catherisational Laboratory capacity • Business case for Team South Urology approved (July 2011). 3 Urologists are now in post. • Consultant recruitment for local Ophthalmology service successful with the lead post appointed. Recruitment for second Consultant	Performance and Reform/ Operational Directors	HIGH

			post not yet successful • In house additional capacity utilised where possible within funding allocated • Recovery plans developed for AHP services – awaiting Commissioner response Plain Film X Ray • Independent Sector and In-house additionality utilised (but unfunded) to maintain reading of non-Ionizing Radiation Medical Exposure Regulations plain film X Rays at 28 days • Phase 1 Action Plan in progress. Phase 2 report received and Action Plan developed. Action Plan sent by Chief Executive to Chief Medical Officer and Health and Social Care Board to seek clarification on timescales and process for regional actions. Response received and regional group now convened. • Proposal developed to extend range of x-rays read by Radiographers to be submitted to Commissioner with repeated request for recurring funding for Independent Sector additionality (see above). Current costs of £14K per month Outpatient Review Backlog • Whilst significant reduction in volume of review backlog achieved initially in the number of routine waits in Q3 and 4 of 2011/12, there has been an increasing trend in 2012/13 as the system continues to bring in significant volumes of in-house additional new patients to meet access targets.		

			• Trust anticipates a rolling backlog in reviews until recurrent demand/ capacity gaps have been addressed. • Of the total waits, 88% of those waiting have been waiting from 1 April 2012. • The largest volumes of waits are in Urology and ENT with the longest waits in Urology. • Work continues to cleanse lists and Specialist Nurses are working with relevant consultants to screen urgent reviews and longest waiters • Whilst some funding has been provided in 2012/13 to address review backlog, capacity to put in the place the additional capacity required is limited by availability in specialties that have capacity gaps and require to utilise capacity to maintain access times for new referrals also. • Health and Social Care Board has agreed funding to address review consequences of new in-house additional capacity being delivered in 2013/14.		
2	Achievement of statutory functions/duties: Care Management Processes. Risk includes: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed. • The Trust should have robust care management communication processes in place and	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Delegated Statutory Functions Report • Monthly reporting to Trust Board (from August 2013) • Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services	• Domiciliary Care Reviews – monthly reporting exercise underway to identify the number of reviews carried out and those outstanding. • Reviews completed by 31/7/2013: Domiciliary Care: 75.3% Nursing Homes – 80% Residential Homes – 84% Overall completion rate – 77% 24.7% have been waiting longer than a year to have their reviews carried out	Older People and Primary Care	**HIGH**

	an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Care Management process.		• Care Home Support Team (Permanent Placement Team) in process of establishment. This team will be established by end 2013. The service model will be developed to carry out reviews for all clients in Nursing/Residential Homes and contract reviews etc. • Adult Safeguarding Team to consider further targeted vulnerable adults training for those staff in care management and involved in annual reviews. • The review of care management processes has been completed. Draft operational guidance and recommendations from the review approved by the Senior Management Team on 26.6.2013. Implementation Plan drafted and agreed by the Senior Management Team.		

3	Systems of assessment and assurance in relation to quality of Trust services	• Clinical and Social Care Governance Review completed and new structures/processes embedded • Update on progress to Governance Committee on a quarterly basis • Governance Committee, Senior Management Team and Governance Working Body in place and operating to agreed remit • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information • Review of Specialty Mortality and Morbidity system completed. • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chief Executive • Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs) • Serious Adverse Incident/Adverse Incident reporting system in place	• Web-based incident reporting (on Datix) rolled out across the Trust • Work has commenced on review of Risk Management Policy • Clinical and Quality indicator programme of work across Directorates • Internal Audit Review of Clinical and Social Care Governance achieved satisfactory assurance. Report presented to Governance Committee - September 2013. • Review of Mortality and Morbidity process underway to be completed by December 2013, ensuring that all aspects of care considered (via nursing input) and outcomes fed into Governance systems	Chief Executive Medical Director	MODERATE

	Learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning	• 4 issues arising from Serious Adverse Incidents brought to Governance Working Body and being taken forward for organisational learning. Progress updates to Governance Committee on a rotational basis.		
4	Compliance with Standards and Guidelines (S&G) • From 1st April 2007, a total of 736 standards and guidelines have been externally endorsed to the SH&SCT by a range of external agencies and placed on the Trust register. Due to the volume/ complexity of new S&G being issued to the Trust by external agencies, it is a challenge for the Trust to monitor and review the compliance status of all of these S&G • From 1st April 2012 to 30th June 2013, a total of 279 new standards and guidelines have been	• Standards and Guidelines Risk Assessment and Prioritisation Group established in April 2011. All newly issued S&G have been reviewed and managed through the new corporate process prior to sending to the nominated Lead Director and Change Lead for action • New AMD for Standards and Guidelines (Acute Services) in post from 1 April 2013 • Establishment of six monthly performance/accountability reports for standards and guidelines. • Standard item for discussion at SMT (monthly) and Governance Committee with submission of relevant reports /	• Since 4/10/2012 a BSO graduate intern has undertaken a comprehensive look back exercise to identify all standards and guidelines that have been issued from 1/04/2007 to 31/03/2010. A total of 281 standards and guidelines have been identified and added to the Trust S&G register. The systemic review of these identified circulars is currently being finalised by the relevant Operational Directorates for prioritisation and action planning (where required) and provision of a statement of assurance to confirm that the required recommendations have been embedded within clinical practice. The outcomes from this look back exercise will be captured within the Trust S&G Accountability Report. • There is a need to establish a more effective information system for the	Chief Executive	**MODERATE**

	regionally endorsed from a range of different external agencies. There were 116 standards and guidelines received during 2011/12. This has been a 97% increase in service activity. • There is often a time lag between when the external agencies require the Trust to achieve full compliance and when this is actually achieved • From 1/9/2013, the Patient Safety and Quality Manager's post will be vacant for 1 year	assurance statements • Standard item for discussion at the Directorate Governance meetings with submission of relevant reports • For those that are 'pharmacy' related a compliance report is also presented by the Trust's Medicines Governance Pharmacist to the Operational Directors and members of the Drug and Therapeutics Committee on a quarterly basis. • Database established and system in place for logging and monitoring • SABS system in place for Safety Action Bulletins • Process map to ensure effective dissemination and management of Safety Action Bulletins	logging and project management of these standards and guidelines in order to ensure all actions are being progressed within the specified timescales by the nominated change lead. Given the volume of standards and guidelines within the system, this is now urgently required in order to effectively manage the risk and ensure that work is being progressed and monitored on an ongoing basis. • Additional Band 2 appointed for one year to support Standards & Guidelines.		
5	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • £1.99m Maintaining Existing Services funding secured for 2013/14. • Craigavon Area Hospital Main Theatres Refurbishment Project is on	Performance and Reform	HIGH

		Specific examples: • Fire Safety Action Plan in place (see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below) • High pressure hot water system (HPHW) at Craigavon Area Hospital (see below) • £2.9m secured to complete structural works to tower block at South Tyrone Hospital	programme. The 4 theatres have been completed and are in use and work has commenced on the new recovery ward. The final phase is due for completion by May 2014. • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2013/14. • Structural engineer reports commissioned for sites at higher risk to inform action plan		
6	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place and to be monitored quarterly • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within Maintaining Existing Services • Approximately £1.1 million was invested in 2012/13 to improve fire safety by upgrading the fire alarm system in Daisy Hill Hospital, fire compartmentation works throughout the Trust and installation of the bed escape lifts at Craigavon Area Hospital	• Staff training on-going • New methods for delivering mandatory fire training agreed and to be implemented and tested 2013/14 • Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out • Initial Firecode funding allocation from Maintaining Existing Services for 2013/14 c. £450k is for fire alarm systems which is to be directed to next highest priority risks and further funding continues to be sought • 2013/14 MES funding bid for bed escape lifts in Daisy Hill Hospital and new stair – funding not provided in initial allocation • Minor alterations to be carried out to escape stair in Daisy Hill Hospital to more easily accommodate ski sheet evacuations • Internal Audit undertaking audit July/August 2013	Performance and Reform	MODERATE

7	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. (our current position is this project is not sufficient to significantly impact the overall risk rating). • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the onsite risk. • Peak Lopping is installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed.	Performance and Reform	HIGH
8	Asbestos and compliance with Control of Asbestos (N.I.) 2007 • Risk of exposure to asbestos by being unable to identify existing asbestos across all Trust property and from lack of a unified/single asbestos management plan.	• Estates Services Asbestos Management Group • Asbestos Policy in place • Revised Asbestos Management Procedures in place • Refurbishment and Demolition Surveys performed when significant work is required on any facility older than 2000 • Asbestos Registers in two legacy systems plus one on-line system	• Re-survey of all applicable Trust facilities has been undertaken. • One year's management inspections integrated into the Trust's existing Asbestos Register.	Performance and Reform	**MODERATE**

9	Upgrade of High Pressure Hot water System (HPHW) at Craigavon Area Hospital required • Reliance on a single set of heating pipes for heating and hot water into all hospital areas in the main hospital block and for conditioned air for critical air handling plant into theatres etc. • Pipeline and expansion bellows beyond recommended lifespan and failure would have major impact on provision of hospital services/lead to temporary closure	• Independent expert inspection carried out at end of March 2013 • Full business case for replacement of the HPHW system/mechanical infrastructure (£8.1m) approved July 2013. • Mitigating measures (Priority Risk Mitigation and Enabling Works) have been designed to provide resilience to the system as an interim measure with the following now in place (as at 29.3.2013) - Replacement bellows ordered to facilitate urgent repairs if required - Hot air blowers on site • Emergency Plans/Business Continuity plan controls in place (see corporate risk 13)	• Service Contingency plans in place. However, due to delay in business case approval, contingency plans will be reviewed due to works programme extending into winter. Additional temporary plant will be required for CSSD plant room • Implementation of mitigating measures (Priority Risk Mitigation and Enabling Works) - Works to reconfigure the system to connect exiting steam supply to some heat exchangers and ventilation plan that will support maintenance of some hospital/theatre services - Provision of temporary Packaged/Mobile Boiler Houses to maintain acceptable but not optimum heating levels and hot water to most hospital areas	Performance and Reform	**HIGH**
10	HCAI • Risk to achievement of Priorities for Action target identified • Risk to patient safety • Financial impact of retaining Ramone Ward facility • Lack of automated HCAI surveillance system linked to Trust laboratory system	• Dedicated isolation ward on Craigavon Area Hospital site • Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored training • Manual surveillance systems in place • Comprehensive governance structure in place, including bi-monthly Strategic Forum and fortnightly Clinical Forum • Outbreak /incident management plan in place • Independent and self-audit programme in place • Extensive action plans in place	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self auditing using the RQIA Audit tools. Compliance statement completed August 2013 and action plan developed • Neonatal RQIA audit completed July 2013 • Measurement of compliance with RQIA Governance Audit Tool and presentation to HCAI Strategic Forum in May 2013 • Learning outcomes from RCAs being shared with senior and junior medical staff – May 2013. Further involvement with GPs on c.difficile cases planned. • Further development of Urinary	Medical Director	MODERATE

		to deal with trends/prevalent HAIs • Antibiotic stewardship including antibiotic ward rounds • Root Cause Analysis process in place • Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI	Catheter project to target E-coli infections. Snap shot audit undertaken. Major staff awareness audit to commence in September 2013 • Engagement with PHA and HSCB on funding streams for Ramone facility (August 2013) • Engagement with PHA on Regional Surveillance system funding and procurement to recommence in September 2013		
11	Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas)	• Water Safety Group in place • Water Safety Plan • Revised Legionella policy and procedures in place • Compliance with PHA and HEIG guidance: HSS(MD)6/12 - Water sources and potential for pseudomonas aeruginosa infection from taps and water systems • Legionella risk assessments, sampling and monitoring regime in place (as per L8, PHA & HEIG), results analysed, appropriate action taken as required • Pseudomonas sampling and monitoring regime in place in Neonatal Unit and Special Care Baby Unit; in progress in augmented care • IPC guidance on environmental cleaning developed and rolled out (sinks, equipment, etc.) • Infection prevention and control guidance and procedures are continuously reviewed, modified and issued to address	• A water dosing system for copper sliver ionisation of Ramone Building is currently under trial • Extension of legionella testing areas • Consideration of opportunities to increase automated water temperature and flow monitoring • Review of resources needed to manage water quality systems (Microbiology, IPC and Estate Services) completed and identified to Health and Social Care Board/Public Health Agency as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines (July 2013) • Independent review of water safety plans completed and draft report received – assurance and recommendations agreed at Water Safety Group (July 2013) • £450K MES funding secured for priority works identified through risk assessments	Director of Performance & Reform/ Medical Director	MODERATE

		emerging risks • Infection prevention and control audit programme and implementation of appropriate actions based on findings • On-going staff education programme highlighting risks of water borne pathogens • Design of water systems within care facility/environment; attention is given to designing system that will reduce the likelihood of propagation of water borne pathogens			
12	Protection of Vulnerable Adults – inconsistencies in practice and issues with interagency working	• Lead Director and lead professional for Adult Safeguarding in place and Safeguarding Partnership Board/Forum/structures in place • Specialist Safeguarding Team to provide advice and support • Procedural guidance completed • Training to all managers • Report to Trust Board as part of Statutory Functions Reporting • Action Plan to Governance Committee • Director of Social Work Report to Trust Board	• Corporate Mandatory Vulnerable Adults training on-going. Investigating Officer/Designated Officer training planned for September/October 2013. • Email issued to Assistant Directors on 11.7.2013 advising of updated position regarding Soscare Vulnerable Adults module. Compliance rate increased to approximately 54%. Assistant Directors requested to draw this to the attention of staff. Meeting with Community Information Department and ICT requested by Safeguarding Lead. • Protection of Vulnerable Adults Forms updated to take account of learning arising from local research paper. These were issued to all staff and to domiciliary care/residential/nursing home providers for immediate implementation. The new alert form to be issued to all community and voluntary providers. This information will form part of the roll forward letter.	Director of Children and Young People's Services/ Executive Director of Social Work	MODERATE

			• 'Sharing the Learning' conference planned for December 2013 with Margaret Flynn, author of Winterbourne View SCR report as keynote speaker. • Trust response to regional safeguarding training plan includes requirement for Joint Protocol/Achieving Best Evidence (JP/ABE) safeguarding staff to attend minimum of 2 support sessions and 2 refresher training support sessions per annum. • First phase of expression of interest process completed. 9 ASW staff taking up new role. 2nd phase underway. IPT1 proposal for 2013/14 monies approved by SMT and forwarded to HSCB.		
13	Development of robust Business Continuity Planning arrangements	• Performance management arrangements in place between Public Health Agency/ Health and Social Care Board and Trust • Further development of plans for severe weather • Engagement of Consultant • Business Continuity Management Policy • Corporate Emergency Management Plan • Trust wide Business Impact Analysis • Progress reports provided on a monthly basis by the Business Continuity Manager to the Medical Director • Updates provided to Senior Management Team via Medical Director's report and Governance Committee	• A standardised template developed to assist Heads of Service with the review and/or development of Departmental Business Continuity and Emergency Response Plans will be issued to Directors/Assistant Directors by early summer 2013. • To ensure robustness, Emergency response and Business continuity plans are best tested at the operational level (service and department) . At least 2 high level exercises will be carried out in 2013-14. This will test the overall Trust response at a high level. Arrangements will also be put in place to encourage managers to test their own individual plans annually. This will be monitored through the Medical Directors office.	Medical Director/ Operational Directors	**MODERATE**

14	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	• Action Plan in place to address non-conformances • External Quality Assurance and Internal Quality controls	• Action plan updated as progress is made. • Application for re-accreditation to be made in October 2013		**HIGH**
CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
15	Fully embedded appraisal system – lack of evidence of compliance	There are a variety of mechanisms in place to ensure appraisal takes place:- • Consultant Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF Staff Attitude Survey results provide staff view	KSF / PDPs are operational in the Trust. It is recognised that the majority of professional staff groups avail of the Supervision process, therefore the current focus is to ensure the unregulated workforce has the opportunity to have a Personal Development Review meeting with their Line Manager and develop a Personal Development Plan. Directorate aligned staff from the Vocational Workforce Assessment Centre meet with teams, managers or staff on a one to one demonstrating the documentation, giving support and encourage team leaders to complete Personal Development Plans (PDP's) with their staff. From January 2013 to May 2013, 70 KSF awareness sessions have been delivered in different locations throughout the Trust. These sessions are on-going. They have been very well attended by staff (725 in total) from various disciplines and various bands. There has been a significant increase in completed PDP forms being returned to HR. Vocational workforce Assessment Centre staff follow up staff that has have had KSF awareness training but	Director of Human Resources	**MODERATE**

			have not yet completed their PDP form and give them assistance where necessary.		
CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
16	• Achievement of financial balance in 2013/14 2013/14 to include requirement for cash release • In year • Recurring	• Contingency Plan for 2013/14 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	2013/14 Budget approved by Trust Board on 30th May 2013 A revised TDP was submitted to HSCB in July 2013 and a number of meetings have taken place with the commissioner – this work is ongoing. HSCB requested all Trusts to submit a break-even plan which would include measures that had minimal impact on services. The Trust has submitted a plan totalling £3.2m and in doing so clearly identified any service impacts to patients\clients. The Trust awaits the consideration of HSCB. Trust has put in place directorate monitoring meetings to review progress against all TYC plans both in terms of deliverability in year and recurrently. Older People and Primary Care Directorate has a continued focus on community care expenditure which includes Domiciliary Care and Care Home bed expenditure with a view to reducing current over expenditure and identifying opportunities for cash releasing. In respect of the financial pressure arising through nursing paybill, the Acute Directorate has undertaken a workforce review using 4 different tools for comparative purposes and is	Finance and Procurement/ All	**HIGH**

			currently engaged with the Public Health Agency/ Health & Social Care Board re these tools which demonstrate a usage that is compatible with the tools, but in excess of funded staffing levels		
17	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Clarification required with respect to Centre of Procurement Excellence coverage and capacity. Issue raised with A McCormick July 2011 seeking regional way forward • Interim approach for social care procurement agreed by Senior Management Team in absence of Centre of Procurement Excellence support including awareness training for Community Contracts Team and 'light touch' support/advice to ongoing procurements by Centre of Procurement Excellence • Contracts management improvement group established and key actions formed • Bimonthly reporting to SMT • Project Team established and central database for all identified local Trust contracts in place. • New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided in March 2013. • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out in November with follow up sessions delivered in January 2013	• Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing • Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Additional capacity for procurement sourced via third party provider contracted by BSO/PaLS. Further small amount of in-house capacity has been established to support low risk procurements in Estates and support key social care procurements (Domiciliary Care and Meals) under influence of CoPE • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited • Proposals brought forward by Trusts on regional basis to address procurement deficit for Estates services not agreed regionally. Regional Social Care	Performance and Reform/ Finance/All	MODERATE

			Procurement Group developing strategy for social care procurements. No agreed regional way forward for procurement capacity gaps. Issues continue to be raised with DHSSPS and Regional Procurement Board		
18	Implementation of Business Systems Transformation Programme • Maintenance of existing services over the 12-18 month implementation period in light of the potential retention and morale impact on those staff to be displaced • Disruption to ongoing business resulting from the secondment of 26-30 staff to oversee the implementation • Disruption to transaction processing/quality of management information/financial forecasting and achievement of financial duties • Maintenance of staff preparedness in light of absence of clear confirmation that system stability and functionality issues have been resolved and an achievable 're-plan' put in place	• The Trust has established an implementation structure • Engagement in regional process • Chief Executive letter to Ms Julie Thompson, on behalf of Trust Board, requesting assurance that lessons have been learned from FPL and will be applied to HRPTS	• Human Resources strategy outlining the options for those staff potentially displaced • Secure backfill staff with the appropriate skills and experience on a timely basis • The Trust may need to reschedule corporate priorities as the workload associated with the implementation increases • The Human Resources Payroll, Travel and Subsistence (HRPTS) side continues to face delays and contractual difficulties. It is expected that this side of the implementation will be delayed until September/October 2013. There will be a knock-on effect on shared service implementation.	Human Resources/ Finance	HIGH

	• Transfer to Shared Services and maintenance of service delivery		• The Trust has agreed with BSO the establishment of pathfinder with effect from 1 October 2013 within recruitment. This will mean that 14 staff will move to the employment of BSO. • The Trust is seeking update in respect of HRPTS (functionality and costs).		

Changes to Corporate Risk Register since January 2013 to date

Date	Decision taken at	Changes to Corporate Risk Register
30th January 2013	**SMT**	Agreed removal of Corporate Risk No. 13 'Implementation of new regional on-call arrangements – will be managed as Directorate risk issue. Consideration to be given to escalation of Risk No. 15 'Financial impact of Transforming Your Care' from moderate to high risk in light of unresolved gap.
27th February 2013	**SMT**	Agreed to escalate 'Financial impact of Transforming Your Care' from moderate to high risk. Although Financial Plan in place, there are a number of risks aligned to this and the Trust will also require a contingency in each of the years of the CSR period. Agreed to downgrade Risk No. 5 'Lack of compliance with RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living and Residential Homes' from high to moderate risk on the basis that the Trust has taken all possible actions within its control and is now escalating to regional level. Risk No. 9 'Asbestos and compliance with legislation' to be reviewed at end of March 2013 when surveys have been completed. Agreed additional element to 'Implementation of BSTP' Risk No. 19.
27th March 2013	**SMT**	Agreed additional risk relating to High Pressure Hot Water System at Craigavon Area Hospital
15th May 2013	**SMT**	Combine Risk No 16 'Achievement of financial balance with Risk No. 17 'Financial Impact of Transforming Your Care'
26th June 2013	**SMT**	Agreed removal of Risk No 5 'RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living Accommodation and Residential Homes' on the basis that the Trust has taken all possible actions within its control and has now escalated to regional level.

		Agreed additional risk (NO. 14) that Laboratory at Craigavon Area Hospital will not maintain its Biochemistry Accreditation status
28th August 2013	**SMT**	Review of risks and agreed no changes to status of current risks at this point in time. Discussed the risk that current levels of activity within Acute and OPPC Directorates are not funded by the Commissioner and agreed to include this under Risk No. 16 (financial risk). The following areas were highlighted for review at next SMT as regards downgrade/removal from the Corporate Risk Register:- Care Management processes Implementation of Business Systems Transformation Programme Asbestos Protection of Vulnerable Adults Business Continuity Planning

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee

9th September 2014

BRIEFING NOTE FOR GOVERNANCE COMMITTEE MEETING, 9TH SEPTEMBER 2014

There are currently **21** Corporate Risks, (13 high level 8 moderate level) as agreed by the Senior Management Team on 27th August 2014.

The Corporate Risk Register has been reviewed by the SMT on 3 occasions since the last Governance Committee meeting on 13th May 2014, most recently on 27th August 2014. Changes include:-

Review of Risk Ratings

Risk ratings have been reviewed, but have not been amended since the Corporate Risk Register was last reviewed by the Governance Committee on 13th May 2014.

Removal of Risks

Risk No. 9 - High Pressure Hot Water System, Craigavon Area Hospital

New Risks

Risk No. 6 – Medicines Management compliance
Risk No. 7 - Medical Workforce – inability to recruit/retain Consultant medical staff for specific specialties
Risk No. 8 – Long Term Placements for clients with challenging behaviour resulting in delayed discharge from hospital
(*risk assessments attached for information)*

Risks to be considered in detail at next monthly review by SMT (end September 2014)

Risk No. 19 – Implementation of Business Systems Transformation Programme (BSTP)

Summary of Corporate Risks as at August 2014

Note – Red font indicates the changes that have been made to the Register since May 2014

Risk No.	HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since April 2014
1.	Ongoing achievement of Commissioning Plan Standards/Targets	**1**	**HIGH**	Unchanged
2.	Outpatient Reviews in a number of specialties significantly beyond clinical review timescales	**1**	**HIGH**	Separated out from Risk No.1 on 30.4.14
3.	Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	**1**	**HIGH**	Unchanged
6.	Medicines Management compliance in domiciliary care	**1**	**HIGH**	New risk added on 9.7.14
7.	Inability to recruit/retain Consultant medical staff for specific specialties	**1**	**HIGH**	New risk added on 9.7.14
9.	Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	**1**	**HIGH**	Unchanged
11.	High Voltage capacity limit on electrical supply to Craigavon Hospital	**1**	**HIGH**	Unchanged
12.	Pharmacy Aseptic Suite, CAH	**1**	**HIGH**	Unchanged
15.	Accreditation status of Laboratory, Craigavon Area Hospital	**1**	**HIGH**	Unchanged
17.	Financial Balance – risk in 2014/15 that the Trust will not achieve Financial balance in year	**5**	**HIGH**	Unchanged
19.	Implementation of Business Systems Transformation Programme	**5**	**HIGH**	Unchanged

20.	GP Out of Hours Service - inability to attract adequate cover for GP shifts	1	HIGH	Unchanged
21.	Health Visiting Service – impact on families due to decreased staffing levels	1	HIGH	Unchanged

Risk No.	MODERATE RISKS		Risk Rating	Change to Status Since April 2014
4.	Achievement of statutory duties/functions: Robust Care Management processes	1	MODERATE	Unchanged
5.	Systems of assessment and assurance in relation to quality of Trust services	1	MODERATE	Unchanged
10.	Fire Safety	1	MODERATE	Unchanged
8.	Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health	1	MODERATE	New risk added on 9.7.14
13.	HCAI	1	MODERATE	Unchanged
14.	Risk of harm to patients from water borne pathogens	1	MODERATE	Unchanged

16.	Fully embedded Appraisal system	**4**	**MODERATE**	Unchanged
18.	Management and monitoring of procurement and contracts	**5**	**MODERATE**	Unchanged

Corporate Objectives

1: Provide safe, high quality care.

2: Maximise independence and choice for our patients and clients.

3: Support people and communities to live healthy lives and improve their health and wellbeing.

4: Be a great place to work, valuing our people.

5: Make the best use of resources.

6: Be a good social partner within our local communities.

Southern Health & Social Care Trust: Summary of Corporate Risks as at August 2014

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No	**Risk Area and Principal Risks**		**Action Planned/Progress update (August 2014)**		**Status**
1	Achievement of Commissioning Plan Standards and Targets and review appointments to secure timely assessment and treatment • A number of inpatient/day case/outpatient waiting times beyond access standards/targets (Acute,OPPC and Mental Health areas) • AHP services across all programmes • Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust • Plain film X Ray reporting only maintained at current level of Ionizing Radiation Medical Exposure Regulations with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations	• Bi-weekly reporting to Senior Management Team • Monthly reporting to Trust Board • Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed. • Fortnightly Elective Performance meetings with Health and Social Care Board • Identification of capacity gaps to HSCB for non recurrent funding for additional capacity on a specialty basis	• On-going work with Health and Social Care Board to agree capacity gaps and associated recurrent funding requirements. Agreement reached on Gynae; ENT General Surgery, Cardiology and Trauma and Orthopaedics with implementation progressing. Agreement remains outstanding on rheumatology and endoscopy and discussions are being undertaken between Health and Social Care Board and the Trust. • Initial Quarter 1 and 2 non-recurrent allocations provided by Health and Social Care Board to maintain end of March 2014 access positions in Quarter 1 and 2 are being regionally reviewed and subject to revision. which will not allow access position to be held. • Independent Sector contracts secured, through mini-competitive tendering process, for 2014/15 for Pain Management and General Surgery. Independent Sector capacity for Orthopaedics and Endoscopy secured through existing regional tenders. A new regional exercise has been undertaken for Orthopaedics, however, the contracts associated with this process have not yet been awarded. HSCB approved extension of Mobile MRI and Modular Cardiac Cath Lab until end of September 2014.	Performance and Reform/ Operational Directors	HIGH

			• The Trust has secured appointment of 5th permanent Consultant Urologist with additional supernumerary 6th Consultant Urologist approved by HSCB, commencing in August 2014. • SHSCT Consultant Ophthalmologist left the Trust at the end of Quarter 3 2013/2014. SHSCT and Southern Local Commissioning Group (SLCG) agreed that SHSCT service would no longer be pursued. SLCG in discussion with WHSCT to undertake 'SHSCT service' element. Visiting service continues from BHSCT with BHSCT managing transfer of patients to the Independent Sector from 1/4/2014. • The Trust continues to maximise available in-house additionally, in line with Waiting List Initiative rules, in preference to Independent Sector provision. • HSCB have confirmed that no non-recurrent resources will be provided for AHP in Quarter 1/2 until the outcome of the PHA demand / capacity exercise. Significant progress on access standards were made in Quarter 3/4 2013/2014 due to non-recurrent funding provided by HSCB. Performance against the 9-week access standard will not be held in Quarter 1/2 without additional non-recurrent resources.		

			• The Trust has been retaining a number of staff at financial risk as approved by Trust Board in April 2014. However, these staff will be released at the end of August 2014, resulting in reduced access performance. • Focus on SBA was well maintained in 2013/2014 with only a small number of specialties in Amber or Red within the HSCB RAG Status assessment. Focus remains on delivery of SBA as first priority with delivery of access standards following this. Plain Film X Ray • In 2013/2014, IS and IHA were utilised through recurrent funding from HSCB; use of Radiology MCN monies; and through a small element of non-recurrent funding. However, the level of plain film reporting was in excess of that projected through the funding so this additionality will have been unfunded. No funding has been agreed yet for 2014/2015 from HSCB for plain film reporting. This level of reporting remains within the Non-IR(MER)'d plain films. • Phase 1 Action Plan in progress. Phase 2 report received and Action Plan developed. Action Plan sent by Chief Executive to Chief Medical Officer and Health and Social Care Board to seek clarification on timescales and process for regional actions. Response received and regional group now convened.		

			• Review of Imaging Services Terms of Reference adopted by Project Board of the Review and approved by the Minister – April 2014 • Proposal submitted to SLCG for plain film reporting by Radiographers of ED films.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update (August 2014)**	**Lead Director**	**Status**
2	Outpatient Reviews in a number of specialties significantly beyond clinical review timescales (Consultant led Outpatient Clinic Review s and AHP Review/Interventions)	• Bi-weekly reporting to Senior Management Team • Monthly reporting to Trust Board • Outpatients Review backlog action plan • Review of administrative process and development of associated Standard Operating Procedure to ensure maintenance of validated 'clean' waiting list and removal of patients off the review backlog waiting list at appropriate times	Outpatient Review Backlog • Whilst significant reduction in volume of review backlog achieved initially in the number of routine waits in Q3 and 4 of 2011/12, there has been an increasing trend in 2012/13 and 2013/14 as the system continues to bring in significant volumes of in-house additional new patients to meet access targets. The Outpatient Review Backlog at 1/8/2014 has increased to a total of 24,198 (patients past their clinically indicated review). NB this excludes Mental Health) • Of the total patients on the review backlog list, only 1.5% of these date back to before 1/4/2012. The volume of patients backlogged before 1/4/14 equates to 52.5% of the total waiting list • From Q3/4 in 2013/14, the Trust has only accepted non recurrent allocations for new outpatients that include sufficient capacity for the associated review appointments to assist in not adding to the backlog		

			• Work continues to cleanse lists and Specialist Nurses are working with relevant consultants to screen urgent reviews and longest waiters • Outpatients Review backlog action plan being reviewed to reprioritise actions to be undertaken and ensure inclusion of all elements of patient care backlogged ie. Mental Health, AHPs • The Trust has submitted review backlog discussion plan to HSCB (July) and has sought regional discussion on best practice and options to address in the absence of specific funding to create additional capacity to see additional review patients. Options include renewed interface with primary care around this issue and SLCG have been asked to facilitate this approach • Review backlog discussion plan highlights emergent backlog in review/interventions in AHP services, specifically Podiatry and Speech & Language services. Options are being developed to address the governance risk created by these backlogs for discussion with commissioner.		

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
3	Achievement of statutory functions/duties: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed.	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Delegated Statutory Functions Report • Monthly reporting to Trust Board (from August 2013) • Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services and follow up of action plan	Older People and Primary Care Directorate is carrying out a Domiciliary Care review on commissioning and delivery with focus on: **1. Case note review** **–** enhancing the level of scrutiny applied to reviewing case notes, to assist practitioners in focusing on specific aspects of care during face to face reviews **2. Decision Support Tools** **–** updating and enhancing the tools available to staff for use during the assessment and review process. **3. PTLs/ Domiciliary Care Reviews** **–** introducing an enhanced level of performance management inclusive of monthly reporting in respect of the compliance with review targets in terms of both the frequency of reviews as well as the outcomes of reviews in terms of controlling overall expenditure. **4. Staff Job Planning** – to improve staff efficiency **5. Report Development** – to improve availability of reports to enhance caseload management for staff **4. Information Review** - Validation and Quality Assurance exercise of patient/client information. - **5. Trust Home Care Consultation** - Review of staff deployment and future requirements	Older People and Primary Care	**HIGH**

			6. Mixed Economy of Provision – Controlled shift of work to IS Providers. **Compliance with Review Target** 12 month annual review by 30.6.2014:- – Domiciliary Care: - 86.8% – Nursing Homes – 84.6% – Residential Homes – 85.1% Overall completion rate – 86.2% Therefore, 13.8% have been waiting longer than 12 months to have their reviews carried out. NB: Those clients whose reviews are outstanding are subject to a desktop risk assessment to ensure that the delay in having their review carried out is not detrimental to their care. **Care Home Support Team** - Commenced on 20th January 2014 with a phased approach. The service model developed will carry out reviews for all clients in Nursing/Residential Homes **Adult Safeguarding Team** - Further targeted vulnerable adults training for those staff in care management and involved in annual reviews.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
4	Achievement of statutory functions/duties: The Trust should have robust care management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Care Management process.		• A project officer has commenced the implementation of the new care management guidance & (NISAT in Physical Disability/Learning Disability Teams.) The officer reports directly to the Head of Disability Services & Assistant Director of PDIS/LDIS who are also progressing restructuring within community teams. A monthly project oversight/accountability group has been set up to monitor progress. .		**MODERATE**
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (August 2014)**	**Lead Director**	**Status**
5	Systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 4.1 Lack of compliance with Standards and Guidelines (DHSSPS/HSCB/other) 4.2 Lack of agreed indicators/measures of quality to provide assurance across all Trust services	• Standards and Guidelines report on compliance to Governance Committee and DHSSPS Accountability Review meetings • Standards and Guidelines Risk Assessment and Prioritisation Group • Clinical and Social Care Governance Review completed and new structures/processes embedded • Governance Committee, Senior Management Team and Governance Working Body in place and operating to agreed	• New I.T. system to capture Standards and Guidelines now agreed and implementation planned for September 2014 • Web-based incident reporting (on Datix) rolled out across the Trust • Review of Risk Management Strategy completed and approved by SMT on 17th April 2014 • Morbidity and Mortality Group have standardised M&M processes in the SHSCT, providing assurance that all deaths are being reviewed in the same way and to coordinate a standard approach to learning from M&M meetings which has a patient	Chief Executive Medical Director	**MODERATE**

	4.3 Effectiveness of systemic process to review all intelligence from incidents, complaints, litigation and user feedback to identify and address service safety and quality issues 4.4 Effectiveness of process for learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	remit • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information • Review of Specialty Mortality and Morbidity system completed. • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chair and Chief Executive • Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs) • Medical Director Report to Trust Board and Governance Committee includes Quality and Safety Indicators • Serious Adverse Incident/Adverse Incident reporting system in place • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy • Director, Children and Young People's Services, reports to Trust Board and Governance Committee including Roles and	safety focus. • Quality Sub Group established to develop Quality Strategy • Q2020 Strategy Regional Workstreams continue to develop regional quality indicators for reporting via Trust Quality Report		

		Responsibilities on all Looked After Children and Child Protection services • Trust Quality Report with limited range of indicators to Trust Board in January 2014 • For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning • Complaints assessed/screened for adverse incident review • Litigation process now embedded to ensure early alert to operational Directors	• 4 issues arising from Serious Adverse Incidents brought to Governance Working Body and being taken forward for organisational learning. Implementation of NEWS has now been completed across Acute, Older People and Primary Care and Mental Health and Disability Directorates. Audit in place to monitor compliance. Falls Working Group ongoing Progress on the other 2 issues remain to be reported to Governance Committee on a rotational basis. • Governance Working Body in the process of reviewing their workstreams		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
6	Lack of compliance with RQIA Standards in relation to medicines management in domiciliary care	• Trust Medicines Management policy • Review of operational procedures • Incident reporting system in place • Interim procedure on prescribing • Trust Medicines Steering Group • Trust representatives on regional group • Themed Domiciliary Care Forum (IS) focused on safe administration of medication	• Trust response letter on medicines compliance/adherence sent to Mr Joe Brogan in June 2014 • Competency based training re medicines management for domiciliary care workers completed for 939 staff. Three 'mop up' sessions scheduled for October/November 2014.	Older People and Primary Care/Mental Health and Disability	HIGH

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
7	Inability to recruit/retain Consultant medical staff for specific specialties • Consultant Medical Staff in Dermatology, Emergency Medicine, Orthodontics, T&O, Haematology and Psychiatry Old Age • SAS Medical Staff in Anaesthetics, GP Out of Hours, Urology, Dermatology, Emergency Medicine	• Recruitment campaigns • Use of Locum agencies • Risk Assessment • Detailed Action Plan is held within the HROD Directorate.	• Workforce review completed in June 2014 • Risk Assessment (as attached) highlights controls in place/action	Human Resources & Organisational Development/ Medical Director	HIGH

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
8	Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health	• Multidisciplinary Team Assessments • Monthly Delayed Discharge meeting for all Mental Health Wards including Gillis	• Continue to explore the potential for existing homes to manage cases with an individualised bespoke package • Potential to procure a specialist home for people with dementia and challenging behaviour discussed with Commissioners	Mental Health and Disability/Older People and Primary Care	**MODERATE**
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (August 2014)**	**Lead Director**	**Status**
9	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas Specific examples: • Fire Safety Action Plan in place	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • £1.99m Maintaining Existing Services funding secured for 2013/14. • Craigavon Area Hospital Main Theatres Refurbishment Project - the 4 theatres and recovery ward have been completed and are in	Performance and Reform	HIGH

		(see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below) • High pressure hot water system (HPHW) at Craigavon Area Hospital (see below) • £2.9m secured to complete structural works to tower block at South Tyrone Hospital	use. • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2013/14. • Structural repairs and replacement of external envelope to STH are progressing well. • Strategic Outline Case completed for Major Redevelopment at CAH site and Outline Business Case to be progressed.		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (August 2014)**	**Lead Director**	**Status**
10	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place and to be monitored quarterly • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within Maintaining Existing Services • Approximately £450k was invested in upgrade of fire alarm systems in 2013/14 which consisted of upgrading fire alarm systems to Hill Building, Trasna House, partial upgrade to South Tyrone Hospital and providing/upgrading fire alarm zone maps throughout the Trust	• Staff training on-going • New methods for delivering mandatory fire training agreed and to be implemented and tested 2014/15 • Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out • Firecode funding allocation from Maintaining Existing Services for 2014/15 c. £110k is for swing arm door closers in residential homes and alterations to fire alarm programme in Lurgan Hospital. • Internal Audit Report in 2013/14 – limited assurance. Priority 1 issues relate to completion of the Fire Risk Assessment Programme; attendance at training and recording of housekeeping. Action Plan in place with majority of issues to be addressed by December 2014	Performance and Reform	MODERATE

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
11	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption • Peak Lopping installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed.	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. (our current position is this project is not sufficient to significantly impact the overall risk rating). • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the onsite risk. • Contract for new Combined Heat and Power plant is due for completion mid-summer 2014 which will provide additional source of supply for the site. At this point, this risk will be re-assessed and may reduce to moderate risk.	Performance and Reform	HIGH

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
12	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified several issues: • The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). • Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding) • The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	• Increased environmental monitoring to check for failures of sterility in the unit • Expiry dates of all products prepared has been reduced to a maximum of 24 hours. • A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented • Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved • Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	• Work is nearing completion on the business case for a new build aseptic suite co-located with the Mandeville Unit. • The Capita Model for chemotherapy/cytotoxic dispensing has been applied to the current workload in the unit. This has identified a staffing deficit of 3.6wte pharmacists. A meeting to discuss staffing capacity took place on 28th April 2014 at which the HSCB requested additional information. This has now been submitted. In the interim, HSCB has funded one additional Pharmacist for 6 months – now in post. • The first replacement isolator was installed at the beginning of March 2014 and then developed various faults. These were finally rectified in July 2014 and it is now fully operational. The second isolator arrived at the end of March 2014, but could	Director of Acute Services	**HIGH**

			not be installed as the wrong ducting had been supplied despite a site visit. A new installation date is awaited – BSO PaLs are in contact with the supplier.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update (August 2014)**	**Lead Director**	**Status**
13	HCAI • Risk to achievement of Priorities for Action target identified • Risk to patient safety • Lack of automated HCAI surveillance system linked to Trust laboratory system • Lack of appropriate isolation facilities (including negative pressure facilities) within the Trust hospital network • Emerging infections (CPE & VHF)	• Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored IPC training • Manual surveillance systems in place • Comprehensive governance structure in place, including bi-monthly Strategic Forum and monthly Clinical Forum meetings • New negative pressure room opened in Medical Admissions Unit, CAH • Patient Flow Managers are prioritising single room with ensuite facilities accommodation for patients with infection/suspected infection • Daily Infection Prevention Control (IPC) HCAI report of inpatients with C.difficile and MRSA histories to bed managers and patient flow staff • Outbreak /incident management plan in place • Independent and self-audit programme in place • Extensive action plans in place for trends/prevalent HAIs • Antibiotic stewardship including antibiotic ward rounds	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self-auditing using the RQIA Audit tools. • Learning outcomes from RCAs being shared with senior and junior medical staff. Shared learning calendar for 2014 now agreed. • Engagement meeting with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases. Communication has been issued to GPs and will be supported by a Newsletter to be circulated in May 2014 • Further development of Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters. A snap shot audit undertaken at the outset of the project and has been supported via a staff awareness audit questionnaire which was completed in January 2014 in Acute/Non Acute sites across the Trust. Community staff will also receive a questionnaire to complete in the near future • Engagement with PHA on Regional Surveillance system funding and procurement to recommence	Medical Director	MODERATE

		• Establishment of antimicrobial management team to oversee antimicrobial stewardship • HCAI Root Cause Analysis process in place • Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI • Following step down of Ramone Ward (November 2013), further enhancement of Risk Management Plan • Daily meetings between IPCT/Bed Management/Senior Acute staff to discuss current IPC situation including IPC issues and bed/side room availability • Weekly meeting between Medical Director and Acute Services Senior Management/IPC nursing staff/Lead IPC Doctors to review weekly IPC activity/infection prevention and control trends • Revised and updating of Trust Outbreak Plan in line with most recent Regional Outbreak Guidance published December 2013	• IPCT continue ongoing monitoring and report against the 'time to isolation' standard of 2 hours for patients diagnosed with C.difficile infection • Director of Acute Services and ICT Clinical Lead have undertaken a series of engagements with Ward Managers to reinforce the need for effective IPC and identify any further training/support needed • Director of Performance and Reform and Medical Director have explored options on how to enhance isolation capacity through modular build and this has been included within SOC for CAH redevelopment • New weekly E-Alert issued to staff to provide a digest of current IPC threats and issues locally, nationally and internationally. E-Alert is mailed directly to Doctors, GP Out of Hours, Clinical Forum members and Operational Directors • New negative pressure room for 2 North, Craigavon Area Hospital, at planning stage. Completion targeted for early 2015 • Management Plans for emerging infections CPE and VHF in progress		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
14	Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas)	• Water Safety Group in place • Water Safety Plan • Revised Legionella policy and procedures in place • Compliance with PHA and HEIG guidance: HSS(MD)6/12 - Water sources and potential for pseudomonas aeruginosa infection from taps and water systems • Legionella risk assessments, sampling and monitoring regime in place (as per L8, PHA & HEIG), results analysed, appropriate action taken as required • Pseudomonas sampling and monitoring regime in place in Neonatal Unit and Special Care Baby Unit; in progress in augmented care • IPC guidance on environmental cleaning developed and rolled out (sinks, equipment, etc.) • Infection prevention and control guidance and procedures are continuously reviewed, modified and issued to address emerging risks • Infection prevention and control audit programme and implementation of appropriate actions based on findings • On-going staff education programme highlighting risks of water borne pathogens • Design of water systems within care facility/environment; attention is given to designing system that will reduce the likelihood of propagation of water borne pathogens	• A water dosing system for copper sliver ionisation of Ramone Building is currently under trial • Consideration of opportunities to increase automated water temperature and flow monitoring • Review of resources needed to manage water quality systems (Microbiology, IPC and Estate Services) completed and identified to Health and Social Care Board/Public Health Agency as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines (July 2013) • Independent review of water safety plans completed and draft report received – assurance and recommendations agreed at Water Safety Group (July 2013) • £200k MES General Capital funding secured for priority works identified through risk assessments • New sampling regime approved by Trust Board and new monitoring regime now in place with bi-monthly monitoring. This will continue until September 2014 at which point testing will go to quarterly (subject to satisfactory reduction in legionella positives. • Second Independent Review of Water Management arrangements to be undertaken during Autumn 2014. • New Trust wide contract for the control of water systems to be tendered by PALs (estimated start date of contract – March 2015)	Director of Performance & Reform/ Medical Director	MODERATE

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
15	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	• Action Plan in place to address non-conformances • External Quality Assurance and Internal Quality controls	• Action plan updated as progress is made. • Application for re-accreditation under the new ISO15189 standards submitted end April 2014.		**HIGH**

CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
16	Fully embedded appraisal system – lack of evidence of compliance	There are a variety of mechanisms in place to ensure appraisal takes place:- • Consultant Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings • Action Plan in place • Staff Attitude Survey results provide staff view • Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.	**Consultant Appraisal** The 2012 appraisal round is 100% complete. The 2013 appraisal round commenced in March 2014 and the current status as at 22.8.2014 is as follows:-	Director of Human Resources	**MODERATE**

Division/ Directorate	No. of Eligible Doctors	% of 2013 Appraisals Completed/ In Progress
Children & Young People's Services Directorate	46 eligible doctors	52% complete
Mental Health & Learning Disability Directorate	28 eligible doctors	21% complete
Anaesthetics, Theatre & ICU Division	24 eligible doctors	55% complete
Surgery & Elective Care	47 eligible doctors	38% complete

Cancer & Clinical Services	47 eligible doctors	51% complete
Medicine & Unscheduled Care	64 eligible doctors	34% complete
Integrated Maternity & Women's Health	27 eligible doctors	41%complete
Emergency Medicine	21 eligible doctors	38% complete
TOTAL	**304**	**42% complete**

It is anticipated that all 2013 appraisals will be completed by November 2014. In the meantime, the Medical Director and Revalidation Support Team have issued reminders to those whose appraisals are outstanding.

Knowledge and Skills Framework

KSF / Personal Development Plans (PDPs) are operational in the Trust. It is recognised that the majority of professional staff groups avail of the Supervision process, therefore the current focus is to ensure the unregulated workforce has the opportunity to have a Personal Development Review meeting with their Line Manager and develop a Personal Development Plan.

During 2013/14, 1,800 staff have attended KSF update sessions which have been delivered in different locations throughout the Trust.

June 2014 saw the re-launch of KSF and the new streamlined documentation. Roadshows took place at various locations across the Trust. Following these sessions, there has been a

			significant increase in completed PDP being returned to the HR Department. In July 2014, the returned PDPs increased to 45.7%. In order to further increase uptake levels, targeted work will be undertaken within Directorates and various methods of communication will be deployed such as desktops, e-brief, global e-mails, etc. **Staff Attitude Survey** 2012 HSC Staff Survey results for the Trust provided evidence that 60% of respondents to the survey had a Development Review/Appraisal in the last 12 months. This had increased from 48% in 2009.		

CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (August 2014)**	**Lead Director**	**Status**
17	• Achievement of financial balance in 2014/145	• Contingency Plan for 2014/15 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	The Trust has indicated that it will be unable to achieve a balance in 2014/15 and is currently working with Health and Social Care Board and Departmental colleagues to quantify what constitutes a 'doable ask' and secure solutions for any shortfall Financial Resource Budget approved by Trust Board on 29th May 2014. Further to this the Permanent Secretary issued a letter to all Trust Chief Executives on 1st August 2014 reminding Trusts of their responsibility to live within available resources and to focus more on the delivery of recurrent savings. It also reinforced the statutory duty to break-even. As a direct result, the Trust was required to submit a contingency plan to the Department by 18th August 2014. This plan was required to address the complete financial gap for 2014/15 and secure break-even in year. The Trust submitted its plan for in year contingency of £29m.	Finance and Procurement/ All	**HIGH**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
18	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Clarification required with respect to Centre of Procurement Excellence coverage and capacity. Issue raised with A McCormick July 2011 seeking regional way forward • Interim approach for social care procurement agreed by Senior Management Team in absence of Centre of Procurement Excellence support including awareness training for Community Contracts Team and 'light touch' support/advice to ongoing procurements by Centre of Procurement Excellence • Contracts management improvement group established and key actions formed • New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided in March 2013. • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out in November with follow up sessions delivered in January 2013	• Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing (Central monitoring ceased in October 2013) • Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Additional capacity for procurement sourced via third party provider contracted by BSO/PaLS. Further small amount of in-house capacity has been established to support low risk procurements in Estates • Capacity sought via IPT for social care procurement of key projects including(Domiciliary Care and Meals) under influence of CoPE Bid approved and recruitment underway. • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited • Proposals brought forward by Trusts on regional basis to address procurement deficit for Estates services not agreed regionally. Regional Social Care Procurement Group developing	Director of Performance and Reform/ Director of Finance and Procurement/ All Directors	MODERATE

			strategy for social care procurements. No agreed regional way forward for procurement capacity gaps. Issues continue to be raised with DHSSPS and Regional Procurement Board • New Structures for contract & procurement management being developed as part of Management Review • New Regional Task and Finish Group established to determine impact of new EU Directives for Social Care Procurement and provide guidance for social care. Work is ongoing on this process with input from Trust. • Measured Term Contract (MTC) in place for 2014/15 which mitigates risks to procurement for schemes <£30k • Internal Audit Report on Estates Procurement and Contract Management 2013/14 provided an unacceptable level of assurance. Improvement action plan in place and discussed at Audit Committee in June 2014. Improvement Plan in part contingent on increase in Estates team resources within current funded levels. The risks associated with not proceeding with this recruitment were noted/accepted by the Senior Management Team on 13th August 2014. Further consideration will be given to the need to escalate these risks to the Corporate Risk Register		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
19	Implementation of Business Systems Transformation Programme (BSTP) HRPTS: • Payroll & Travel Payments - potential for inaccurate and/or late payments. Negative medic publicity and impact on Trust's reputation as a good employer. • Licensing Issues - (new issue March 2014) – limited number of SAP GUI licences available across HSC. Impact on number of users within SHSCT, and risk of increased workload for HROD Directorate in relation to non-HR led training. Risk also of limited roll out of new Team Support Role (when available) and of Professional Registration Roles. • Go-live and stabilisation - resource requirements for training and support for MSS&ESS deployment • Staff Engagement - potential lack of 'buy in' from managers and staff (critical as system operates on self-service) • Staff preparedness required within	• The Trust has established an implementation structure, including a BSTP Project Board, BSTP Change Network and HRPTS Directorate LITs. • Engagement in regional process • Risks documented and shared with BSO HRPTS Central Team • Staff internally redeployed • SHSCT HRPTS E-Roster Work Group established • HRPTS ICT Lead identified and involved in project work, and participates in regional ICT work. • HRPTS Systems Team monitoring user/licensing levels and working with BSO HRTPS Central Team. • Trust Functional Specialists draw on knowledge from regional HSC colleagues, including BSO HRPTS Central Team and BSO ITS. • BSTP Change Network and HRPTS Directorate LITs • HRPTS Go-live & Stabilisation group	• Planned roll out of Manager Self Service (MSS) and Employee Self Service (ESS) for Older People and Primary Care Directorate early September 2014, and Acute Services Directorate in November 2014. Deployment plan continues to be kept under review • Payroll & Travel Department continue to experience system issues and work to resolve these to enable successful payroll closedowns. Where appropriate INFRAs are raised for the suppliers consideration.. Pension/tax code system problems experienced in April 2014 payroll (HSC wide issues). A revised/improved regional timesheet was implemented in July 2014 • Urgent review of SHSCT users and reduction in number of users/licences. BSO HRPTS Central Team is leading work on reviewing licensing options. • Awareness Sessions and MSS/ESS training continues to be provided for staff & Directorate HRPTS Local Advisors being identified • ICT infrastructure resources being progressed by BSO HRPTS Central Team. Initial focus on staff with PC access. • HRPTS System Team established with responsibility for systems management. • INFRAs for resolution by BSO ITS and/or HCL Axon continue to raised where appropriate. There	Human Resources/ Finance	HIGH

	challenging timescales for MSS/ESS roll out across the Trust • Lack of HRPTS Team Support Role and impact on service managers workloads • E-roster interfaces - non-availability of update functionality for Commcare and Allocate - 4 uploads were to be available (Master Data, Time & Enhancements, Absences etc) Only– Time & Enhancements one is available. • ICT Infrastructure – to roll out MSS/ESS • Solution functionality - full functionality of the solution is still not available - e-recruitment functionality is only like as a pilot in BSO • Reporting functionality – number of reporting concerns eg Sickness Absence reporting problems/inaccuracies • Benefits realisation - all anticipated benefits may not be achievable eg reduction in data inputting, non-availability of Team Support Role and reporting functionality). • New/ additional unforeseen work will impact benefits realisation, eg new OM work and increased		are a number of issues in relation to the HRPTS/FPL interface/mapping rules .		

	systems management work. • Data Security - risks in terms of access to staff data, at local and regional level. • Regional 'Business as Usual' Structures – not yet in place. SAP Knowledge – staff have limited knowledge and training, and risks therefore increase as supplier personnel (HCL Axon) move off the project • Unresolved HRPTS INFRAs affecting system functionality and resource implications for 'workarounds'				
	• Transfer to Shared Services and maintenance of service delivery	• Human Resources Strategy • Progress updates to Audit Committee	• Regular contract meetings continue to be held with the Trust's Head of Resourcing and the BSO Head of R&S. • The Accounts Payable function is in the process of transferring to BSO with an estimated completion date of 31st October. The date for transfer of the payroll service is now due to be January 2015. Agreement has been secured with payroll staff to continue until then but the risk of losing temporary staff as this date approaches increases, impacting the stability of the service.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
20	GP Out of Hours Service – Reduced ability to maintain adequate service provision and patient safety due to vacant GP shifts	• Recruitment process for vacant posts • Business Continuity Plan • Medical Managers with medical responsibility for the service • Call Centre Co-ordinator • Call Manager system • Late availability payment • Flexibility re shift patterns offered • Daily monitoring of rotas	• Advertisement on HSC recruit for sessional GPs has now closed with 9 applicants. 6 have been interviewed and 3 pending interviews. • Regular updates to HSCB/Integrated Care Department regarding vacant shifts. • Daily text messages and phone calls to GPs in attempts to cover shifts. • Small team of nurses in GP Out of Hours Service working extra hours, where possible to assist in covering gaps • IPT submitted to appoint 50 Nurse Triage staff. Trust proceeded at risk to commence the recruitment process. • Rolling advertisement for as and when bank Advanced Nurse Practitioner • Review of workload of clinicians ongoing by Clinical Lead • KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB • Working with Integrated Care Dept to address capacity issues and use of locum GPs. Locum agencies had been contacted and no doctors available. • Working with other OoH providers to secure additional capacity • Working ongoing with HSCB to progress Pharmacy Pilot and enable Pharmacist to undertake triage at weekends for medication related calls	Older People and Primary Care	

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2014)	Lead Director	Status
21	Health Visiting Service – Impact on children/families due to reduced ability to deliver services as a result of decreased staffing levels in the service	• Control measures in place for when staffing levels reach certain levels within teams • Direction to Team Managers and teams regarding expected service delivery during periods of extended reduced service • Team Manager access to current caseload weighting information • Utilisation of bank and additional hours of existing health visiting staff • Health Visitors from fully staffed teams providing clinic cover in depleted teams • Drop in clinics available to ensure rapid access to health visitor if parent worried or concerned about an infant / child • Rota system in place for allocation of new births and for clinic cover • Child protection cases are allocated equitably across the team • Team managers to notify Head of Service and Named Nurse for Safeguarding Children is they are unable to allocate a child protection case. • Letter has been sent to GP Practices in Lurgan / Brownlow and Armagh to keep them appraised of current situation.	• In August 2014 the Health Visiting Service is 12.46 WTE down which equates to 16% of the service. 2 Teams are in 30% step-down – Portadown and Armagh. 2 teams are in 20% step-down – Lurgan and Newry & Mourne Team 2. 7 permanent posts have been offered with staff starting in September 2014. These posts equate to 5.9 WTE. The Trust will then have no permanent vacancies. The estimated shortfall will be 7.50 WTE – 9% of the workforce (some additional Maternity leaves starting in September). Tthis shortfall is made up from long term sick leave and maternity leave. • Bank health visitors in place where available. • Ongoing monitoring of situation between Assistant Director, Head/Deputy Head of Service, Health Visitor Team Managers and Health Visitors • Regional recruitment for Health Visitor training has commenced and numbers being trained in 2014/15 will be increased subject to funding being made available from DHSSPS . In August 2014, the Trust is still awaiting confirmation of this funding . Successful candidates were advised on 7th August 2014 not to resign from their permanent posts. • Confirmation from PHA of recurrent funding to support Public Health Nursing posts. These posts to have a focused remit for	Executive Director of Nursing/ Director of Children & Young People	

			BME, homelessness, sexual health and travellers. Allocation for SH&SCT is Travellers: 1.0 WTE Band 6; BME: 0.8WTE Band 6 and 0.4 WTE Band 3		

Changes to Corporate Risk Register by SMT since April 2014 to date

Date	Decision taken at	Changes to Corporate Risk Register
30th April 2014	**SMT**	Agreed 'Outpatient Review Backlog' now of such significant risk to separate out as a high risk – to be completed by next monthly review by SMT. Further escalation to HSCB to be progressed. Agreed to merge Risk No. 5 Compliance with Standards and Guidelines with Risk No. 4 'Systems of assessment and assurance in relation to quality of Trust services'. Agreed removal of Risk No. 9 Asbestos and maintain on Estates Risk Register Escalation of Medicines Management compliance to be considered at next monthly review by SMT
28th May 2014	**SMT**	Risk No. 9 High Pressure Hot Water System, Craigavon Area Hospital now completely replaced with a new Low Temperature Hot Water System - Agreed removal from Corporate Risk Register and maintain on Estates Risk Register
9th July 2014	**SMT**	Agreed additional risks:- Risk No. 6 – Medicines Management compliance Risk No. 7 - Medical Workforce – inability to recruit/retain Consultant medical staff for specific specialties Risk No. 8 – Long Term Placements for clients with challenging behaviour resulting in delayed discharge from hospital
27th August 2014	**SMT**	Consideration given to removal of Risk No. 19 ' Implementation of BSTP' and manage at Directorate Risk Register level (HR and Finance) on the following basis:- 1. HROD Directorate will escalate as appropriate to the Corporate Risk Register any future change in the HR HRPTS risks 2. If Finance colleagues feel any payroll/travel risks need to remain on the Corporate Risk Register, or at any stage in the future need to be escalated to the Corporate Risk Register, they can progress that through Finance & Procurement Directorate risk management structures. 3. The Trust's BSTP Project Board continues to review HRPTS risks and can decide at any stage to escalate risks to SMT/Corporate Risk Register.

		4. HR HRPTS risks can move to be fully managed at HROD Directorate Risk Register and HR Departmental Risk Register levels, with payroll/travel/ finance HRPTS risks being managed via Finance Directorate and/or Departmental risk registers. Agreed to remain on Corporate Risk Register at present and review in detail at next monthly review (end September 2014).

SHSCT Risk Register

Date	Dir.	Details of Risk	Controls in Place	Risk	Action lead	Progress
CONSULTANT MEDICAL STAFF						
01/08/2014	Acute	**DERMATOLOGY** Inability to recruit to Consultant dermatology position. Recruitment has been attempted on more than 3 occasions and a global recruitment campaign attempted with no success. Also possibility of future consultant retirements within 5-10 years. Two providers advise they can provide services in is but ypou can only buy less. Cant but the complexity.. Only suitable for routine cohort of cases.	1. Consider alternative global recruitment initiatives. Have approached Australian agency 2. Approach Locum agencies to determine if they can headhunt applicants 3. Work with Royal College of Physicans via IMG Scheme to consider overseas sponsorship - at junior doctor level. 4. Consider appointment of GP's with special interest in dermatology to undertake sessions 5. Existing Consultants to be offered additional PA's above full time job plan	HIGH		
02/08/2014	Acute	**EMERGENCY MEDICINE** Inability to recruit to Consultant ED positions. There is a national shortage of Consultants in Emergency Medicine.	1. Recruitment Campaigns 2. Consideration of more cross site working 3. Locum agencies to provide cover to sustain service cover when necessary 4. Implementation of new working patterns to make junior and SAS posts more attractive.	HIGH		
03/08/2014	Acute	**ORTHODONTICS** Southern Trust only employs 1 consultant to provide the orthodontic service. Retirement may be likely within next 5-10 years. Orthodontics is on the national occupational shortage list - so successful recruitment may be a challenge. As this is a single handed specialty, if this consultant were to leave/retire; there would be a question on the future of how this service would operate in Southern Trust.	No Action at present	MEDIUM		

SHSCT Risk Register

Date	Dir.	Southern Health and Social Care Trust Details of Risk	Controls in Place	Risk	Action lead	Progress
04/08/2014	Acute	**TRAUMA & ORTHOPAEDICS** Inabiilty to recruit Consultant T&O consultants with HIP/Knee or upper limb sub specialty interest. Previous attempts at recruitment have resulted in doctors wishing to pursue only ankle surgery. Possibility that the Trust may need to offer fellowships to recently qualified surgeons to support the appropriate sub specialty training required.	1. Global recruitment Campaign 2. Initiative to support potential applicants towards fellowships for commencing in post at later date			
02/08/2014	Acute	**HAEMATOLOGY** On National Occupational Shortage Occupational List. Whilst our 3 permanent posts are currently filled - there is a Gap which is likely to require a 4th post. Retirement is also likely within next 5-10 years. Prior to most recent consultant appointment in 2014, Trust was unable to fill consultant post which resulted in expensive locum agency cover over a number of years. Risk as this service could not be bought in the IS.	1. Exploring options for regional cover as necessary	MEDIUM		
03/08/2014	Mental Health	**PSYCHIATRY - OLD AGE** On National Occupational Shortage Occupational List. Recently retired consultant - Trust has been unable to recruit replacement. Retired consultant currently working 5 PA's but attempts will have to be made at another time to recruit.	1. Retired consultant has agreed to return for period	MEDIUM		
SAS MEDICAL STAFF						
02/08/2014	Acute	**ANAESTHETICS** Inability to fill two SAS posts in Anesesthetics on DHH site with out of hours element. Existing doctors are working a high level of PA's and agency locums are used.	1. Recruitment Campaigns 2. Developing initiatives to explore SAS Fellowship development programmes. 3. Work with Royal College of Anaesthetists to consider IMG programmes	MEDIUM		

SHSCT Risk Register

Date	Dir.	Details of Risk	Controls in Place	Risk	Action lead	Progress
##########		**GP Out of Hours.** Huge challenge to cover GP Out of Hours through salaried and sessional shifts	1. Nurse Triage Recruitment 2. Review Salaried sessional commitments	HIGH		
04/08/2014	Acute	**UROLOGY** Consultant staffing has doubled in size but we only have two training positions. We have been unable to recruit to Clinical Fellow and specialty doctor positions to sustain a 1:5 middle tier rota. Whilst surgical doctors cover Uology at night, locum cover is used to cover 5-11pm which is difficult to source.	1. Recruitment Campaigns 2. Initial contact with Royal College of Surgeons regarding International Medical Graduates Scheme	MEDIUM		
05/08/2014	Acute	**DERMATOLOGY** Ongoing difficutlies to fill positions within Dermatology. Recent avdert, whilst successful was only able to appoint part time to a full time position.	1. Recruitment campaigns 2. Have attempted to recruit GP's with special interest in dermatology as an alternative which has been successful in attracting interest. 3. Working with Royal College of Physicians to identify international medical graduates interested in working in Dermatology	MEDIUM		
06/08/2014	Acute	**EMERGENCY MEDICINE** Whilst the Southern Trust has no funded vacant SAS/SPR vacancies, locum expenditure has been huge in this area due to the necessity to have middle grade cover overnight	1. Global recruitment Campaign - Clinical fellowship with Trauma initiative 2. August 2014: Pilot new 1:5 middle grade rota with cover overnight by acting up more experienced SHO's			

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

August 2015

to Governance Committee on 8th September 2015

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with DHSSPS guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to the Trust's Corporate Objectives as detailed below:-

1: Provide safe, high quality care.

2: Maximise independence and choice for our patients and clients.

3: Support people and communities to live healthy lives and improve their health and wellbeing.

4: Be a great place to work, valuing our people.

5: Make the best use of resources.

6: Be a good social partner within our local communities.

Note – Red font indicates the changes that have been made to the Register since May 2015

OVERVIEW OF CORPORATE RISK REGISTER AS AT 19th AUGUST 2015

LOW	MEDIUM	HIGH	TOTAL
0	10	15	25

New risks identified by SMT or escalated from Directorate Risk Registers	Potential new risk 'Inability to recruit into the Medical workforce leaving gaps within the current rotas within Daisy Hill Hospital'. The Trust has in place a range of measures to mitigate the risk and full risk assessment will be brought to SMT when Corporate Risk Register is next being reviewed.
Risks removed from the Register	None
Merged risks	None
Risks where overall rating has been reduced	Whilst rating has not been reduced, the focus of the risk regarding the HRPTS system (Risk No.22) is now on Payroll and Travel payments.
Risks where overall rating has been increased	None

Summary of Corporate Risks as at August 2015

Risk No.	HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since August 2014
1.	Achievement of Elective Commissioning Plan Standards and Targets	1	HIGH	Unchanged
2.	Out-Patient Reviews and Planned Treatment Backlogs	1	HIGH	Unchanged
3.	Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	1	HIGH	Unchanged
6.	Medicines Management compliance in domiciliary care	1	HIGH	Unchanged
7.	Inability to recruit/retain Consultant medical staff for specific specialties	1	HIGH	Unchanged
8.	Increasing inability to recruit registered nursing staff	1	HIGH	New risk added on 22.4.15
10.	Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
12.	High Voltage capacity limit on electrical supply to Craigavon Hospital	1	HIGH	Unchanged
13.	The lack of capacity, due to staff shortages within Estate services, to provide and maintain a safe and efficient healthcare environment.	1	HIGH	New risk added on 1st October 2014
14.	Pharmacy Aseptic Suite, CAH	1	HIGH	Unchanged

17.	Accreditation status of Laboratory, Craigavon Area Hospital	**1**	**HIGH**	Unchanged
23.	GP Out of Hours Service - inability to attract adequate cover for GP shifts	**1**	**HIGH**	Unchanged
24.	Health Visiting Service – impact on families due to decreased staffing levels	**1**	**HIGH**	Unchanged
25.	Safeguarding of Residents within HH/BC	**1**	HIGH	New risk added on 14.1.15
19.	Implementation of NMC's revised revalidation arrangements for Registered Nurses, Midwives and Specialist Community Public Health Nurses	**4**	HIGH	New risk added on 18.2.15

Risk No.	**MODERATE RISKS**		**Risk Rating**	**Change to Status Since August 2014**
4.	Achievement of statutory duties/functions: Robust Care Management processes	**1**	**MODERATE**	Unchanged
5.	Systems of assessment and assurance in relation to quality of Trust services	**1**	**MODERATE**	Unchanged
11.	Fire Safety	**1**	**MODERATE**	Unchanged

9.	Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health	**1**	**MODERATE**	Unchanged
15.	HCAI	**1**	**MODERATE**	Unchanged
16.	Risk of harm to patients from water borne pathogens	**1**	**MODERATE**	Unchanged
18.	Fully embedded Appraisal system	**4**	**MODERATE**	Unchanged
20.	Financial Balance – risk in 2015/16 that the Trust will not achieve Financial balance in year	**5**	**MODERATE**	Downgraded from high risk 19.11.14
21.	Management and monitoring of procurement and contracts	**5**	**MODERATE**	Unchanged
22.	HRPTS Payroll and Travel Payments	**5**	**MODERATE**	Separated out from BSTP risk on 15.10.14

Southern Health & Social Care Trust: Summary of Corporate Risks as at August 2015

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No	**Risk Area and Principal Risks**		**Action Planned/Progress update**		**Status**
1	**Achievement of Elective Commissioning Plan Standards and Targets** • Waiting times in excess of Commissioning Plan Standards / Targets across Out-Patients; Diagnostics (including Endoscopy); In-Patients; and Day Cases (Acute; CYPS; Mental Health; and OPPC areas) • Waiting times in excess of Commissioning Plan Standards / Targets across AHP professions • Plain film reporting only maintained at current level, which excludes films that have been categorised as IRMER'ised (Ionizing Radiation Medical Exposure Regulations) with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations	• Monthly reporting to Senior Management Team • Monthly reporting to Trust Board • Monthly exception reporting to Operational Directorate In-Year Assurance meetings • Fortnightly Operational Performance meetings within the Acute Services Directorate and the Children & Young Person's Services Directorate • Monthly Operational Performance meetings with the Mental Health & Disability Directorate • Quarterly Operational Performance meetings with the Older Persons and Primary Care Directorate • Monthly Operational AHP Performance meetings cross-directorate • Implementation plans in place for reductions in access times, where demand remains static, associated with submitted and approved IPTs • Monthly Elective and Unscheduled Performance meetings with Health and Social Care Board • Non-recurrent allocation of available funding from HSCB for elective access periodically	**Access Times** • Focus on SBA remains as first priority within Operational Directorates, where robust SBA volumes exist, into 2015/2016. Delivery of access times will follow SBA delivery on the priority list. Recurrent capacity gaps prioritised with SLCG, in line with early indication of available recurrent funding, for 2015/2016 as Symptomatic Breast Clinic and Haematology. IPT was submitted and formal allocation received for recurrent funding for symptomatic breast services (July 2015) • Non-recurrent allocation received for Diagnostics (including Endoscopy) for Quarter 1 and 2 2015/2016. Volumes allocated are insufficient to reduce access times to required 9-week wait. No allocations received for Out-Patients; In-Patients; or Day Cases. IS Providers have been given permission to undertake the treatment of the paused patients, from 2014/2015, in Quarter 1 of 2015/2016.	Performance and Reform and Operational Directors	HIGH

		• Operational plans under development to matain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times. • Operational workshop undertaken to review and implement the required processes for the monitoring; escalation; and actioning of the urgent waiting times that have been clinically agreed and communicated with the Consultants.	• SMT permission had been given, for the month of April, for additionality to be continued in previously identified risk areas. Where non-recurrent allocations have been received from HSCB the April Trust spend will be recouped from this allocation. • Key areas of risk identified within the Acute Services Directorate around . Symptomatic Breast Clinic Services, CT and Endoscopy have been partially addressed with non recurrent funding and part year effect recurrent investments. Remaining areas of risk highlighted to Health and Social Care Board formally include:- o Haematology (NOP) o Urology (OP Review Backlog) o General Surgery (OP Review Backlog) o Cardiology (OP Review Backlog) o Dermatology (OP Review Backlog) o Trauma (NOP and IP) The Trust will continue to re-direct internal resources to areas of greatest risk as funding becomes available or as operationally feasible. **Plain Film X Ray** • A non-recurrent allocation for plain film reporting has been received for Quarter 1 & 2 2015/2016. This non-recurrent funding will be utilised for the Independent Sector provision.		

			It should be noted that the IS provider is now working to full capacity with no further options for additional plain film reporting to be undertaken. • With the IS provider at full capacity and with the loss of internal additional reporting capacity the Trust is facing further pressure for plain film reporting. The CCS Division has therefore undertaken a mini-competitive tender off the Regional Eligible Providers List and anticipate ability to award a contract for additional capacity in August 2015. • An operational plan is being developed, in the first instance, to return chest x-ray plain film reporting to within the 28-day standard. • HSCB have provided recurrent funding for the implementation of plain film reporting by radiographers for ED films. HSCB have provided recurrent funding for plain film reporting of the remaining in-patient IRMER'ised patients. • A training programme is in place to increase the scope of Plain Film reporting that is carried out by Radiographers.		

			AHP Access Times No non-recurrent funding has been allocated in Quarter 1 & 2 2015/2016 as the outcome of the PHA demand and capacity exercise remains outstanding. No non-recurrent resources from HSCB were provided in 2014/2015 either. The Trust had agreed to retain a level of additionality until the end of April 2015. The Trust, in parallel with the PHA/HSCB review, is undertaking a capacity and demand exercise to calculate available capacity within the AHP professions which will inform future capacity gaps and investment priorities. This work should be completed in Q3 2015/16.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
2	**Out-Patient Review and Planned Treatment Backlogs** Out-Patient Review Waiting List Backlogs (Acute; CYPS; MHD; and OPPC Directorate) and Planned Treatment Backlogs (Acute only), are on-going with a significant volume of patients waiting past their clinically indicated review timescale (OP and AHPs)	• Monthly reporting to Senior Management Team • Monthly reporting to Trust Board • Monthly exception reporting to Operational Directorate In-Year Assurance meetings • Fortnightly Operational Performance meetings within the Acute Services Directorate and the Children & Young Person's Services Directorate	• At 1 August 2015, there were a total of 23,423 patients waiting in excess of their clinically indicated timescale for review out-patient appointment (Dr-led services only, including Visiting Specialties). 37% of these patients (8,750) are waiting in excess of 6-months past their clinically indicated timescale; 21% (4,830) are waiting between 3 – 6-months past their clinically indicated timescale; with 42% (9,839) waiting less than 3-months past their clinically indicated timescale.		

		• Monthly Operational Performance meetings with the Mental Health & Disability Directorate • Quarterly Operational Performance meetings with the Older Persons and Primary Care Directorate • Monthly Operational AHP Performance meetings cross-directorate • Short-term validation exercise undertaken in Quarter 4 2014/15 within a limited number of Acute Services Directorate specialties • Operational workshop undertaken to review the ability to identify red flag and urgent reviews on the out-patient review waiting list and the processes for monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.	The longest waiting dates back to June 2011. No non-recurrent funding has been received from HSCB in Quarter 1 and 2 2015/2016 for the out-patient review backlog. The Acute Services Directorate has identified a number of areas of clinical risk within their review backlog and these were contained within the clinical risk paper to SMT on 29 April 2015. This paper details potential contingency options for discussion and approval in order to minimise the clinical risk associated with this backlog. • As at 1 August 2015, there are a total of 1,303 patients on the planned treatment backlog. The longest waiting patient dates back to November 2013. 63% (819) of the planned treatment backlog relates to endoscopy. The non-recurrent allocation for Endoscopy in Quarter 1 & 2 will only facilitate the maintenance of planned scopes at 8-months past their clinically indicated timescale. Endoscopy, in totality, has been identified as a clinical risk within the clinical risk paper to SMT on 29 April 2015. . In line with JAG accreditation requirements the planned treatment backlog should not exceed 6-months.		

			• AHP review backlogs are not as readily quantifiable, however, manual information indicates significant review backlog volumes within Podiatry; Speech & Language Therapy; Dietetics; and Occupational Therapy. • The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
3	Achievement of statutory functions/duties: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed.	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Delegated Statutory Functions Report • Monthly reporting to Trust Board (from August 2013) • Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services and follow up of action plan	Older People and Primary Care Directorate has undertaken a Domiciliary Care review and has a process in place to implement the recommendations to achieve compliance. **Compliance with Review Target** • Overall % within 12 months for commissioned packages is 87.8% • Overall % within 12 months for Domiciliary Care packages is 83.3% • Overall % within 12 months for Nursing Home packages is 97.5% • Overall % within 12 months for Residential Home packages is 96.5% Substantial validation is ongoing with teams regarding the recording of OPPC reviews as currently two systems are being used, but this will not affect the % compliance rate.	Older People and Primary Care	**HIGH**

			Those clients whose reviews are outstanding are subject to a desktop risk assessment to ensure that the delay in having their review carried out is not detrimental to their care. **Care Home Support Team** An assurance process is embedded to ensure all residents in a Care Home with a Failure to Comply Notice in place or Vulnerable Adult investigation ongoing has an up to date review in place. 40 permanently placed clients require to be reviewed and transferred into CHST in Craigavon/Banbridge area from ICT and Memory Teams. **Adult Safeguarding Team** - Further targeted vulnerable adults training for those staff in care management and involved in annual reviews. - April 2015 Caseload Analysis being led by Social Work Governance Team, supported by Executive Director of Social Work		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
4	Achievement of statutory functions/duties: The Trust should have robust case management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Case Management process.	• New Trust Case Management Guidance	• Mental Health, Learning/Physical Disability and Older People and Primary Care training completed. • Internal Audit of Case Management being planned. • Restructuring process by Heads of Service is in progress within the Disability Division of the Mental Health & Learning Disability Directorate.	Mental Health and Disability/Older People and Primary Care	**MODERATE**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
5	Systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 1. Lack of compliance with Standards and Guidelines (DHSSPS/HSCB/other) 2 Lack of agreed indicators/measures of quality to provide assurance across some Trust services 3. Effectiveness of systemic process to review all intelligence from incidents, complaints, litigation and user feedback to identify and address service safety and quality issues 4 Effectiveness of process for learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• Standards and Guidelines report on compliance to Governance Committee and DHSSPS Accountability Review meetings • Standards and Guidelines Risk Assessment and Prioritisation Group • Web-based incident reporting (on Datix) rolled out across the Trust • Clinical and Social Care Governance Review completed and new structures/processes embedded • Governance Committee, Senior Management Team and Governance Working Body in place • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Quality Sub Group • Morbidity and Mortality Group • Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information • Review of Specialty Mortality and Morbidity system completed.	• New I.T. system to capture Standards and Guidelines has not been progressed. The Quality 2020 workstream focusing on Standards & Guidelines has proposed a regional approach to developing an IT system to the Quality 2020 Steering Group. • Q2020 Strategy Regional Workstreams continue to develop and strengthen regional quality indicators for reporting via Trust Quality Report • The Trust is presently evaluating the effectiveness of its governance arrangements - due to report by end October 2015 • The Trust has commenced the development and implementation of a Quality Framework. The role and remit of the Clinical and Social Care Governance Working Body will be reviewed within this work	Chief Executive	**MODERATE**

		• Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chair and Chief Executive • Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs) • Medical Director Report to Trust Board and Governance Committee includes Quality and Safety Indicators • Serious Adverse Incident/Adverse Incident reporting system in place • Trust Annual Quality Report • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy • Director, Children and Young People's Services, reports to Trust Board and Governance Committee including Roles and Responsibilities on all Looked After Children and Child Protection services • For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve			

		recommendations/actions and ensure shared learning • Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning • Complaints assessed/screened for adverse incident review • Litigation process now embedded to ensure early alert to operational Directors			

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
6	Lack of compliance with RQIA Standards in relation to medicines management in domiciliary care	• Trust Medicines Management policy • Review of operational procedures • Incident reporting system in place • Interim procedure on prescribing • Trust Medicines Steering Group • Trust representatives on regional group • Themed Domiciliary Care Forum (IS) focused on safe administration of medication	• Annual Competency based training re medicines management for domiciliary care workers completed for all staff. • A registered nurse has been seconded in the Newry and Mourne area for a pilot of one year since August 2014, dedicated to progressing medicines review and safer systems. A report has been shared on progress / issues to date. This pilot has now been extended to the Armagh and Dungannon areas with core teams supporting the work in Newry/Mourne areas. • As part of this, single patient medication files are being tested across providers to minimise risk of error. • Following a Regional Medication workshop held by the HSCB, a business case is being developed to secure funding to deliver an interim system which includes a specialist medicines assessment and provision of appropriate solutions for service users who are identified as potentially requiring domiciliary care support in the area of medicines management. • Interim funding is required to allow time to fully evaluate and determine the impact of the assessment process on service delivery in the redesigned Medicines Management Pathway.	Older People and Primary Care/Mental Health and Disability	HIGH

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
7	Inability to recruit/retain Consultant medical staff for specific specialties • Consultant Medical Staff in Dermatology, Emergency Medicine, Orthodontics, T&O, Haematology, Psychiatry Old Age and Radiology • SAS Medical Staff in Anaesthetics, GP Out of Hours, Urology, Dermatology, Emergency Medicine and Paediatrics	• Recruitment campaigns • Use of Locum agencies • Risk Assessment highlighting controls/action in place • Detailed Action Plan is held within the HROD Directorate.	**Dermatology:** There is a recognised UK shortage of consultant posts in Dermatology and therefore a new model to attract GPs has been introduced. From late November 2014, 4 part-time GPs have started in post so this has proved successful. Two retired consultants were engaged to undertake some WLI clinics however this arrangement ceased at the end of June 2015. An application was submitted to the Royal College of Physicians in 2014 for International Medical Graduates (IMGs) under the Medical Training Initiative (MTI) scheme, but was unsuccessful. One local doctor will reach her CCT date in July 2015, so would now be eligible to apply for a consultant post in the Trust. An IPT is currently being developed. **T&O:** Two consultants have been appointed to T&O during 2015. One commenced in post at the start of January, however the other is not able to take up post until August. In addition, 2 Temporary Specialty Doctors have also been appointed. The following posts are currently advertised (closing date 13/8/15) 1 permanent Specialty Doctor, 3 Temporary Specialty Doctors, 1 Temporary Consultant and 2 Clinical fellows. **Emergency Medicine:** A permanent Consultant commenced in Craigavon Area Hospital on 1st May 2015. Two Specialty Doctors were recently	Human Resources & Organisational Development/ Medical Director	**HIGH**

			interviewed and appointed to ED in DHH, however despite these appointments it still proves very difficult to recruit to Consultant and Specialty Doctor positions within ED The Trust has recently advertised for Consultant and Specialty Doctor posts in DHH. The adverts also featured in the ROI and stated that enhanced rates of pay and a full relocation package would be considered, however these campaigns were unsuccessful. The Trust has recently embarked on a recruitment campaign for middle grade doctors in ED with M3 Creating Connections. This company undertakes medical recruitment project work with Trusts and Health Boards on behalf of doctors.net.uk. The campaign will be live on the doctors.net.uk web site for 4 weeks. The Trust has also introduced a Clinical fellowship programme for ED. One appointment has been made – starting in August 2015. **Anaesthetics:** It is planned to develop a training programme with the aim of "growing our own" specialty doctors. A proposal has been drafted and is currently under consideration by the service. **Radiology:** There is a recognized gap in Consultant Radiologist numbers and Clinical Radiology has recently been included in the Government approved shortage occupation list. The Trust has		

			successfully appointed a number of Consultant Radiologists over the past few years; however some of these have left to take up other posts. The position remains unstable. In February 2015, the Trust successfully appointed 4 permanent Consultant Radiologists. One person has since withdrawn, however the other 3 will take up post in August 2015.		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
8	Increasing inability to recruit registered nursing staff	• Ward Sister/Charge Nurse management of available staff on a shift by shift basis • Assistant Director/Head of Service (Operational) oversight regarding availability with possible redeployment of staff to respond to prioritised need • Escalation to Operational Director as required • Open registration for Nurse Bank	• All opportunities to secure permanent staff continue to be progressed • Regular recruitment drives ongoing • Introduction of Rotational Programmes within and across Directorates. • Targeted recruitment of current nursing students for bank Band 3 roles ongoing with a view to introducing them to the Southern Trust for their Band 5 career. • Six staff have secured places on the funded Open University Pre-registration Nursing Programme commencing September 2015. A further ten staff were successful at interview. SHSCT has offered these ten deferred places for the OU PRNP commencing September 2016. • A Trust Nursing Workforce Planning Group has been established to seek to address current and future anticipated challenges regarding the demand for and supply of	**Executive Director of Nursing**	**HIGH**

			Registered Nurses across all programmes of care. • A regional Nursing Workforce Planning Group is being established at the request of the CNO and will be chaired by Mr F Rice, Executive Director of Nursing		
9	Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health	• Multidisciplinary Team Assessments • Monthly Delayed Discharge meeting for all Mental Health Wards including Gillis	• The Multidisciplinary team in Gillis now use the definition of "Multidisciplinary Fit" for discharge when deciding when a patient is fit for discharge. Patient level detailed delayed discharge information is circulated to the Multidisciplinary team in Gillis and the relevant staff in the Community Memory Teams on a monthly basis. • Continuing to explore the potential for existing homes to manage cases with an individualised bespoke package • Discussions with Commissioners have highlighted the need to enhance community services to better support individuals in their own homes or independent sector homes to manage more challenging behaviours. Currently no funding has been made available to enhance memory services or procure a specialist home for people with dementia and challenging behaviours. Consequently individuals whose discharge is delayed remain in Gillis much longer. • Discussions with regional and local Commissioners have sought to bring to the fore the current gap in	Mental Health and Disability/Older People and Primary Care	**MODERATE**

			Commissioning plans for inpatient dementia services, including multi-disciplinary input form pharmacy, social work and psychology. Some in year non recurrent allocations have helped with the overspend in bank nursing hours to meet need but will not enhance multi-disciplinary input. The absence of a commissioning strategy for inpatient dementia care is constantly raised at every available opportunity. The Trust is currently developing proposals for the future management of all dementia services into one Directorate and will continue to make the case with Commissioners for the additional resources required to meet the complex needs of the inpatient population.		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
10	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas Specific examples:	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High	Performance and Reform	HIGH

		• Fire Safety Action Plan in place (see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below) • Aging High Pressure Hot Water system (HPHW) at Craigavon Area Hospital has now been replaced with new Low Pressure Hot Water system. • £2.9m secured to complete structural works to tower block at South Tyrone Hospital • Completion of Theatre development CAH	Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2015/16. Phase 1 of Mechanical Infrastructure complete. • Strategic Outline Case submitted for major redevelopment at CAH site. Work is now being progressed on the main business case for submission in 2015/16. • New negative pressure isolation room at CAH approved for construction 2015/16. • Provision of new negative pressure isolation room at DHH awaiting decision on preferred option from Acute Services. Thereafter proposals to be incorporated in Business Case for consideration by SMT/Trust Board. • The sewage system serving the wards at CAH has reached a critical point with frequent blockages leading to bursts and subsequent contamination of patient and support areas. This presents a serious infection control risk; causes disruption to services; and has been reported in the press potentially damaging service user confidence. Whilst various efforts have been made to mitigate the risk it is clear that the system must be replaced urgently. As areas will need to be decanted during works a carefully coordinated phased programme will be implemented over the next few months.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
11	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within Maintaining Existing Services • Approximately £110k was invested for 2014/15 for swing arm door closers in residential homes; new fire alarm systems in Shanlieve, Oaklands and Burnside and alterations to fire alarm systems in Lurgan Hospital, Dromore clinic, Oakdale and South Tyrone Hospital and providing/ upgrading fire alarm zone maps throughout the Trust.	• Staff training on-going • New methods for delivering mandatory fire training agreed, implemented and tested • Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out • Firecode funding allocation from Maintaining Existing Services for 2015/16 is for £160k. Proposed works are as follows: Additional fire alarm detection for DHH Phase 2; upgrade fire alarm cause and effect for CAH; additional fire alarm panels for South Tyrone Hospital; update fire alarm system for St Luke's Hospital site; remedial works to fire compartments for Bluestone, South Tyrone Hospital and Crozier House, Elms and Appleby Day Centre. • Approximately 95% completion of baseline fire risk assessments for high risk facilities/buildings – full completion is anticipated in mid-September. Approximately 95% baseline fire risk assessment completed for all other buildings. Programme is set for review of Fire Risk Assessments. • The most recent Fire Safety Report shows 70% of staff are up to date with their Fire Safety Training • Staff can now avail of Face to Face or E-Learning in order to complete Fire Safety Training	Human Resources & Organisational Development	MODERATE

			• A rolling programme is currently in place for General Fire Safety, Ski Sheet Pad and Evacuation Chair Training • The Trust is currently in the process of tendering for the new Fire Safety Contract. This process is expected to be completed in August 2015. The new contract will be from 1st September 2015 to 31st August 2018 with the provision for 2 x 1 year extensions.		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
12	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption • Peak Lopping installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed.	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the risk. • Installation of new Combined Heat and Power plant is completed and G59 approval from NIE (to permit parallel generation) in place.	Human Resources & Organisational Development	HIGH

			Contract for operation and maintenance of plant being finalised with PALS. This will provide additional source of supply for the site. At this point, this risk will be re-assessed and may reduce to moderate risk. • CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion April 2016		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
13	The lack of capacity, due to staff shortages, to provide and maintain a safe and efficient healthcare environment. Specific risks include:- • Failure to deliver capital works programme to quality, cost and/or time • Limited ability to develop and implement processes to meet Internal Audit requirements • Limited ability to comply with procurement regulations • Failure to meet departmental requirements for PPEs, Peer Review processes etc.	• Extensive reorganisation/ restructuring of Estates Services. However, failure to fully implement restructuring through non replacement of posts removed resilience and hampered ability to effectively carry out the Estates function. • Reduction in Capital projects from c 60pa to 24pa based on priority • Heads of Service covering for vacancies within their areas • Staff redirected to higher priority areas	• Composite Estates Works Improvement Plan developed and monitored fortnightly by Assistant Director Estate Services. SMT approval given to commence recruitment of key posts (12/11/14) – recruitment of additional resource as follows:- Estate Development Team – 2 x replacement posts filled Estates Operations Team – critical Estates Officers and Directly Employed Labour being recruited. Structure discussions to be finalised to enable remaining posts (at 8a etc) to be filled; Specialist Estates Property Manager appointed Procurement team to be recruited	Human Resources & Organisational Development	**HIGH**

	• Risk to long term Estates service due to absence of resilience/succession • Limited ability to deliver effective operational service • Failure to manage property effectively				
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
14	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified several issues: • The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). • Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding)	• Increased environmental monitoring to check for failures of sterility in the unit • Expiry dates of all products prepared has been reduced to a maximum of 24 hours. • A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented • Additional activity will not be accepted by the aseptic	• The queries received in relation to the business case for a new build aseptic suite co-located with the Mandeville Unit have been addressed and the OBC was submitted to the DHSSPSNI on 1st July 2015. A letter of Commissioner Support will also be submitted once received from the HSCB. • The Capita Model for chemotherapy/cytotoxic dispensing has been applied to the current workload in the unit. This has identified a staffing deficit of 3.6wte pharmacists. Using the capacity plan as a	Director of Acute Services	**HIGH**