Signature of referring doctor (or other professional)

Date

Personal Information redacted by the USI

04 MAY 2016

For Trust use only:
HCN: Personal Information redacted by the USI
Date Sent: 04-May-2016

Referral Date: 04-May-2016
Surname: Personal Information redacted by the USI

WYNNE HILL SURGERY Personal Information redacted by the USI

Practice address

Personal Information redacted by the USI

Practice code: Personal Information redacted by the USI

Contact number(s)
Telephone: Personal Information redacted by the USI
Fax:

Practice Email:

Red Flag	TRUS
Upgrade Red Flag	Flex. C/U
Urgent	
Routine	Out Patient
Other	
Virtual	

Referral to: Craigavon Area Hospital
Specialty: UROLOGY
Urgency: **ROUTINE**
Urgency Reason: no priority reason given
Electronic Attachment Present?: No
HCP Name:
Designation:

Referral Type:

Practice Code: Personal Information redacted by the USI
Registered GP: Dr Erushani De Alwis
Registered GP Cypher: Personal Information redacted by the USI
Referring GP: Dr. Paul Conlon
Referring GP Cypher: Personal Information redacted by the

HCN Number Personal Information redacted by the USI
Title: Mr
Surname: Personal Information redacted by the USI
Forenames: Personal Information redacted by the USI
Previous Surname: -
Known as: -
DOB: Personal Information redacted by the USI
Gender: Male
Registered Contact Details: Personal Information redacted by the USI
Tel No: -
Mobile: Personal Information redacted by the USI
Patient Email: -
Preferred Contact Details if different from above:

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint
Description: lower urinary tract symptoms

Comment: Please may I have your opinion on this Personal Information year old man with lower urinary tract symptoms.

This man complains of a two year history of nocturia x 2 and daily urinary frequency. He denies any haematuria, dysuria, hesitancy or terminal dribbling.

There is a family history of bladder cancer. I understand his mother had bladder cancer in her 60's.

On examination BMI 34, BP 136/8, abdomen soft non-tender with no masses. PR reveals central skin tag and smooth prostate.

Urinalysis nad.

I referred him for an ultrasound of abdomen and urinary tract.

Please find normal report on ECR.

He has been commenced on combodart but I would appreciate your assessment.

Yours sincerely,

Dr Conlon

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Plantar fasciitis (Left)	-	22-Apr-2016	22-Apr-2016
Pre-diabetes	-	23-Apr-2015	23-Apr-2015
Hypertensive disease	-	12-Jun-2014	12-Jun-2014
Ganglion of wrist	: Laterality = Right	17-Jan-2005	17-Jan-2005
[X]Depression NOS	-	23-Dec-2004	23-Dec-2004
Fracture of ankle	: Laterality = Right	29-Nov-2004	29-Nov-2004
[X]Assault	-	13-Nov-2004	13-Nov-2004
Mitral valve prolapse	-	03-Nov-2000	03-Nov-2000
Inguinal hernia	: Laterality = Left	29-May-1997	29-May-1997
Asthma	-	20-Mar-1978	20-Mar-1978

Past procedures (High and medium priority - all)

Description	Comment	Date recorded
Barium enema normal	-	20-Jan-2010
Ultrasound scan	fatty liver	20-Jan-2010
Vasectomy NEC	-	16-Aug-2007
Appendicectomy NEC	-	08-Sep-1976

MEDICATION

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Fluoxetine Hydrochloride Capsules 20 mg	0403030E0AAAAAA	30 capsule	TAKE ONE DAILY	-	23-Apr-2015	-
Amlodipine Tablets 5 mg	-	56 tablet	TAKE ONE DAILY	-	12-Jun-2014	-
Paracetamol Tablets 500 mg	0407010H0AAAMAM	100 tablet (s)	take one or two four times/day	-	12-Mar-2010	-
Pregabalin Capsules 150 mg	-	56 capsule (s)	twice a day	-	06-Apr-2011	-
Simvastatin Tablets 40 mg	0212000Y0AAADAD	56 tablet(s)	take one at night	-	19-Jan-2012	-
Maxitram Sr M/R	-	56 capsule	take one twice	-	21-Mar-	-

capsules 200 mg	(s)	daily		2013

Recent medication (Any medication issued within last 168 days not shown above)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Amitriptyline Hydrochloride Tablets 10 mg	0403010B0AAAGAG	14 tablet	TAKE ONE NOCTE	-	18-Apr-2016	14 Days
Ibuprofen Tablets 400 mg	1001010J0AAAEAE	48 TABLET	ONE TO BE TAKEN THREE TIMES A DAY	-	18-Apr-2016	42 Days
Uniroid Hc Ointment	0107020J0BFACAE	1 x30 gram (s)	use three times/day	-	18-Apr-2016	42 Days
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	-	2 inhaler	AS DIRECTED	-	29-Feb-2016	42 Days
Paracetamol Tablets 500 mg	0407010H0AAAMAM	56 tablet	TWO TABLETS TO BE TAKEN FOUR TIMES DAILY	-	29-Feb-2016	7 Days
Dutasteride And Tamsulosin Capsules 500 micrograms 400 micrograms	-	30 capsule	TAKE ONE DAILY	-	04-Feb-2016	30 Days
Omeprazole Capsules (Gastro-Resistant) 20 mg	0103050P0AAAGAG	56 capsule	TAKE ONE DAILY	-	25-Jan-2016	42 Days
Clenil Modulite Cfc-free inhaler 100 micrograms/actuation	-	1 inhaler	AS DIRECTED	-	14-Dec-2015	42 Days
Ciprofloxacin Tablets 500 mg	0501120L0AAAFAF	14 tablet	TAKE ONE TWICE DAILY	-	09-Dec-2015	42 Days

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Ex smoker	ex-	06-Oct-2015

ALCOHOL INTAKE

Description	Comment	Date Recorded
Alcohol consumption, 0 units/week		13-Nov-2015

BMI

33.91

SOCIAL HISTORY

OTHER PATIENT DATA

Signature of referring doctor (or other professional)

Date

For Trust use only:
HCN: Personal Information redacted by the USI
Date Sent: 04-May-2016

04 MAY 2016
CAH

Referral Date: 04-May-2016
Surname: Personal Information redacted by the USI

THE HEALTH CENTRE Personal Information redacted by the USI

Practice address

Personal Information redacted by the USI

Practice code: Personal Information redacted by the USI

Contact number(s)
Telephone: Personal Information redacted by the USI
Fax:

Red Flag | TRUS
Upgrade Red Flag | Flex. C/U
Urgent | Practice Email:
Routine | Out Patient
Other
Virtual

Referral to:	Craigavon Area Hospital	**Referral Type:**	
Specialty:	UROLOGY		
Urgency:	**URGENT**		
Urgency Reason:	no priority reason given		
Electronic Attachment Present?:	No		
HCP Name:			
Designation:			

Practice Code:	Personal Information redacted by the	**Registered GP:**	Dr Slobhan Wade	**Registered GP Cypher:**	Personal Information redacted by the USI
Referring GP:	Dr Kirsty Hanna	**Referring GP Cypher:**			

HCN Number	Personal Information redacted by the USI	**Title:**	Mr
Surname:	Personal Information redacted by the USI	**Forenames:**	Personal Information redacted by the USI
Previous Surname:	-	**Known as:**	-
DOB:	Personal Information redacted by the USI	**Gender:**	Male
Registered Contact Details:	Personal Information redacted by the USI		
Tel No:	-	**Mobile:**	Personal Information redacted by the USI
Patient Email:	-		
Preferred Contact Details if different from above:			

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint

Description: haematurla

Comment: many thanks for review of this Personal y.o who has recent onset haematuria, brigh red, attended A+E, given

trimethoprim for ?UTI, culture negative, inflamm markers negative. denies any back/loin pain, no previous symptoms of same. abdo soft, non tender, renal function normal. persisting on but settling, not to same extent. still PU ok. many thanks for review/assessment ?calculi ?cause

RELEVANT PAST MEDICAL HISTORY

Past procedures (High and medium priority - all)

Description	Comment	Date recorded
Appendicectomy NEC	Laparoscopic	30-Apr-2007

MEDICATION

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 168 days not shown above)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Lansoprazole Capsules (Gastro-Resistant) 30 mg	0103050L0AAAAAA	28 CAPSULE	1 DAILY	-	29-Apr-2016	42 Days

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Current smoker		29-Apr-2016

ALCOHOL INTAKE

BMI

19

SOCIAL HISTORY

OTHER PATIENT DATA

Signature of referring doctor (or other professional)

Date

CJLD KS

SOUTHERN TRUST BOOKING CENTRE RECEIVED 04 MAY 2016 CAH

For Trust use only:

HCN: Personal Information redacted by the USI

Date Sent: 04-May-2016

Referral Date: 04-May-2016

Surname: Personal Information redacted by the USI

WYNNE HILL SURGERY Personal Information redacted by the USI

Practice address

Personal Information redacted by the USI

Practice code: Personal Information redacted by the USI

Contact number(s)

Telephone: Personal Information redacted by the USI

Fax:

Red Flag TRUS

Urgent

Routine

Practice Email:

Referral to:	Craigavon Area Hospital	**Referral Type:**	Out Patient
Specialty:	UROLOGY		Other
Urgency:	**ROUTINE**		Virtual
Urgency Reason:	no priority reason given		
Electronic Attachment Present?:	No		
HCP Name:			
Designation:			

Practice Code:	Personal Information redacted by the USI	**Registered GP:**	Dr M Stewart	**Registered GP Cypher:**	Personal Information redacted by the USI
Referring GP:	Dr Kevin Hagan	**Referring GP Cypher:**			

HCN Number	Personal Information redacted by the USI	**Title:**	Mr
Surname:	Personal Information redacted by the USI	**Forenames:**	Personal Information redacted by the USI
Previous Surname:	-	**Known as:**	-
DOB:	Personal Information redacted by the USI	**Gender:**	Male
Registered Contact Details:			
Tel No:	-	**Mobile:**	Personal Information redacted by the USI
Patient Email:	-		
Preferred Contact Details if different from above:			

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint

Description: ED and poor stream

Comment: I would be grateful if this Personal year old man could be seen in your clinic. He describes 2 x problems.

The first problem is difficulty in achieving erections over the past 6 months. He states that his morning erections are now not as strong as they used to be and he is unable to achieve a full erection before intercourse.

His second problem is poor urinary stream for approximately 10 years. He describes the stream as stop and start. He has no back pain and no weight loss.

On examination his prostate felt normal size and was smooth. Anal tone was normal. He had no spinal tenderness and his legs were neurologically intact.

He is a smoker of 20 cigarettes per day and I have told him this could be contributing to his erectile dysfunction and he is trying to stop smoking. BP is 120/80. Blood tests are unremarkable including hormone profile, PSA and HBA1c and cholesterol. He would be grateful if his symptoms could be further investigated.

Thank you.

RELEVANT PAST MEDICAL HISTORY

Past procedures (High and medium priority - all)

Description	Date recorded
Appendicectomy NEC	26-Mar-1980

MEDICATION

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 168 days not shown above)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Sildenafil Citrate Tablets 100 mg	0704050Z0AAACAC	4 tablet	AS DIRECTED	-	21-Mar-2016	78 Days
Sildenafil Citrate Tablets 50 mg	0704050Z0AAAAAA	28 tablet	AS DIRECTED	-	02-Feb-2016	42 Days
Sildenafil Citrate Tablets 100 mg	0704050Z0AAACAC	28 tablet	AS DIRECTED	-	02-Feb-2016	42 Days
Varenicline Tablets 1 mg 500 micrograms (Starter Pack)	-	25 tablet	TAKE ONE DAILY	-	01-Feb-2016	25 Days
Varenicline Tablets 1 mg	-	28 tablet	TAKE ONE DAILY	-	01-Feb-2016	28 Days
Sildenafil Citrate Tablets 50 mg	0704050Z0AAAAAA	4 tablet	AS DIRECTED	-	18-Jan-2016	42 Days

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Heavy smoker - 20-39 cigs/day		01-Feb-2016

ALCOHOL INTAKE

BMI

SOCIAL HISTORY

OTHER PATIENT DATA

Signature of referring doctor (or other professional)

Date

SOUTHERN TRUST BOOKING CENTRE
RECEIVED
04 MAY 2016
CAH

For Trust use only:
HCN: Personal Information redacted by the USI
Date Sent: 04-May-2016

Referral Date: 03-May-2016
Surname: Personal Information redacted by the USI

TYNAN SURGERY

Practice address
Personal Information redacted by the USI

Practice code: Personal Information redacted by the USI

Contact number(s)
Telephone: Personal Information redacted by the USI
Fax:

Practice Email:

Red Flag	TRUS
Upgrade Red Flag	Flex. C/U
Urgent	
Routine	Out Patient
Other	
Virtual	

Referral to: Craigavon Area Hospital
Specialty: UROLOGY
Urgency: **URGENT**
Urgency Reason: no priority reason given
Electronic Attachment Present?: No
HCP Name:
Designation:

Referral Type:

Practice Code: Personal Information redacted by the USI
Registered GP: Dr Robert M Carlile
Registered GP Cypher: Personal Information redacted by the USI
Referring GP: Dr. Sonniva McAlinden
Referring GP Cypher: Personal Information

HCN Number	Personal Information redacted by the USI	**Title:**	MR
Surname:		**Forenames:**	Personal Information redacted by the USI
Previous Surname:	-	**Known as:**	-
DOB:	Personal Information redacted by the USI	**Gender:**	Male
Registered Contact Details:			
Tel No:		**Mobile:**	-
Patient Email:			
Preferred Contact Details if different from above:			

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint
Description: Raised PSA - Urinary retention - Prostatic symtoms
Comment: Dear Team

I would be grateful if you would see Personal Information redacted by the USI who has had a four year history of LUTS. Two weeks ago he went into acute urinary retention and was seen in Craigavon where he was catheterised. Unfortunately the catheter caused quite an acute inflammation and allergic response. We have removed the catheter today on the 3rd May and are hoping for successful removal. He had of course developed a urinary tract infection in the interim. The most specific reason for referring him at this stage is because of elevated PSA which was checked in the hospital and gave a value of 24. I would be grateful if you would look at him from the point of view of intervention to prevent further episodes of acute urinary retention and to consider management of the PSA which we will of course arrange to recheck over the next few weeks.

Yours sincerely

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset	Date recorded
Duodenitis	-	-	11-Apr-2016	11-Apr-2016
Gastritis unspecified	-	-	11-Apr-2016	11-Apr-2016
Oesophagitis	-	-	11-Apr-2016	11-Apr-2016
Duodenal polyp	normal duodenal mucosa with no evidence of dysplasia.	-	20-Jan-2016	20-Jan-2016
Polyp	-	-	21-Dec-2015	21-Dec-2015
Keratosis	Lichenified Seborrhoeic Keratosis	-	24-Mar-2014	24-Mar-2014
Essential hypertension	-	First ever	15-Feb-2010	15-Feb-2010

Past procedures (High and medium priority - all)

Description	Comment	Date recorded
Diagnostic fibreoptic gastroscopy	-	11-Apr-2016
Diagnostic fibreoptic gastroscopy	-	21-Dec-2015
Bowel cancer screening programme	- result negative	30-Nov-2015
Bowel cancer screening programme	negative	24-Sep-2013
Discharged from hospital	MPH - Left C Stem total hip replacement	19-Aug-2005
Total prosthetic replacement of hip joint NOS	MPH	15-Aug-2005

MEDICATION

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Omeprazole 20mg gastro-resistant capsules	69782020	capsule	ONE DAILY	-	11-Apr-2016	-
Atorvastatin 10mg tablets	83943020	tablet	1 TABLET ONCE A DAY: ANNUAL[more]	-	09-Jan-2015	-
Alfuzosin 10mg modified-release tablets	75052020	tablet	1 TABLET DAILY	-	28-Oct-2013	-
Bendroflumethiazide 2.5mg tablets	58976020	tablet	1 IN THE MORNING	-	03-Aug-2010	-
Ibuprofen 5% gel	72459020	gram	APPLY THREE TIMES A DAY	-	27-Feb-2014	-

Recent medication (Any medication issued within last 168 days not shown above)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Clotrimazole 1% cream	61519020	gram	APPLY THREE TIMES A DAY	-	03-May-2016	-
Trimethoprim 200mg tablets	68194020	tablet	TAKE ONE TWICE A DAY	-	03-May-2016	-
Clarithromycin 500mg tablets	69353020	tablet	TAKE ONE TWICE A DAY	-	11-Apr-2016	-

Amoxicillin 500mg capsules	59330020	capsule	TWO CAPSULES TWICE A DAY	-	11-Apr-2016	-
Omeprazole 20mg gastro-resistant capsules	69782020	capsule	TAKE ONE TWICE A DAY FOR 7 WE[more]	-	11-Apr-2016	-
Omeprazole 20mg gastro-resistant capsules	69782020	capsule	ONE DAILY	-	18-Feb-2016	-
Hydrocortisone 1% / Clotrimazole 1% cream	63434020	gram	APPLY TWICE DAILY	-	18-Feb-2016	-
Omeprazole 20mg gastro-resistant capsules	69782020	capsule	ONE DAILY	-	11-Dec-2015	-
Atorvastatin 10mg tablets	83943020	tablet	1 TABLET ONCE A DAY: ANNUAL[more]	-	09-Jan-2015	-
Alfuzosin 10mg modified-release tablets	75052020	tablet	1 TABLET DAILY	-	28-Oct-2013	-

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Cigarette smoker	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 3.	11-Oct-2013

ALCOHOL INTAKE

Description	Comment	Date Recorded
Alcohol consumption	Drinking status on eventdate: Current drinker, Units of alcohol drank per week: 1. NOTES: alcohol occasionally only.	28-Oct-2013

BMI

24.8

SOCIAL HISTORY

OTHER PATIENT DATA

Signature of referring doctor (or other professional)

Date

SOUTHERN TRUST BOOKING CENTRE
RECEIVED
04 MAY 2016
CAH

For Trust use only:
HCN: Patient 93
Date Sent: 04-May-2016

Referral Date: 03-May-2016
Surname: Patient 93

MEADOWLANDS SURGERY

Practice address

Personal Information redacted by the USI

Practice code: Personal Information redacted by the USI

Contact number(s)
Telephone: Personal Information redacted by the USI
Fax:

Practice Email:

Red Flag	TRUS
Upgrade Red Flag	Flex. C/U
Urgent	Flow Rate
Routine	Ultrasound
Other	
Virtual	

Referral to: Craigavon Area Hospital
Specialty: UROLOGY
Urgency: **ROUTINE**
Urgency Reason: no priority reason given
Electronic Attachment Present?: No
HCP Name:
Designation:

Referral Type: Out Patient

Practice Code: Personal Information redacted by the USI
Registered GP: Dr Mary O'Neill
Registered GP Cypher: Personal Information redacted by the USI
Referring GP: Dr J Radcliffe
Referring GP Cypher: Personal Information

HCN Number Patient 93
Surname:
Previous Surname:
DOB:
Registered Contact Details: Personal Information redacted by the USI
Tel No:
Patient Email: -
Preferred Contact Details if different from above:

Title: MR
Forenames: Patient 93
Known as:
Gender: Male
Mobile:

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint
Description: High PSA
Comment: 10/03/2016 Dysuria pain ++ when PU
no prostatism symtoms

Good stream
no intercourse
no nocturia
PR - suspicious feeling esp left lobe seems knobbly
20/04/2016 Prostate specific antigen = 30.47 ng/mL High Original Result: "TOTAL PSA(T)" 30.47 ng/ml (0 - 6.5) Dr J Radcliffe
11/03/2016 Prostate specific antigen = 34.8 ng/mL High Original Result: "TOTAL PSA(T)" 34.80 ng/ml (0 - 6.5) Dr J Radcliffe

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset	Date recorded
Intermittent claudication	at 10 - 20 yards	-	18-Apr-2016	18-Apr-2016
Patient's condition improved	dramatic improvement in foot colour Still very sore and very cold	-	18-Apr-2016	18-Apr-2016
Dysuria	pain when PU no prostatism symtoms Good stream no intercourse no nocturia	-	10-Mar-2016	10-Mar-2016
Peripheral vascular disease NOS	[TRUNCATED]increasing severe pain right foor cramps esp at night Also claudication at only 10 yards both calves O/E Very cold right foot with early ? gangrene of 1-2 nd toes no DP pulse felt e	-	10-Mar-2016	10-Mar-2016
Insomnia NOS	advised re overuse of medication. waking 2-3 hour later and repeating dose. advised against strongly. will sit up later and take one tablety., quantitiy reduced to 28 and advised should last a month	-	04-Dec-2015	04-Dec-2015
Wrist joint pain	bilateral Probable OA in wrists - was a painter	-	06-Oct-2015	06-Oct-2015
Wrist joint pain	left wrist ganglion Quite soft but sore To me the pian is more in the wrist joint Plan - X-ray wrist joint refer for Ganglion injection / excision	-	29-Jun-2015	29-Jun-2015
Rib pain	SINCE FELL off ladder at christmas pain cannot bend over white sputum no wt loss ex smoker 7yrs O/E chest clear tender over bottom right rib at back Plan CXR and analgesics, r/v INB	-	01-May-2015	01-May-2015
Low back pain	for years - moves about Stiff and sore in AM no radiaition to legs no paraesthesia no RED flags O/E tender right L/S facetal joints To consider osteopath	-	16-Sep-2014	16-Sep-2014
Ganglion of wrist	left hyothenar eminence	-	19-Jun-2014	19-Jun-2014
Retrosternal pain	RECENTLY MAX AT NIGHT, NO RED FLAG CHECK BLOODS PPI FULL DOSE H PYLORI IF NOT SETTLING	-	30-May-2014	30-May-2014
C/O - loin pain	RIGHT, NO AB PAIN NO URINARY SYMPTOMS NO CHANGE BOWEL HABIT NEEDS BLOODS AB EXAM AND ? REFERRAL	-	30-May-2014	30-May-2014
Restless legs syndrome	-	-	26-Jun-2013	26-Jun-2013
Foot pain	esp at rest esp in bed - has to move feet to get ease no cluadication Ex heavy smoker PPulses normal PR < 2 sec	-	26-Jun-2013	26-Jun-2013
Foot pain	[TRUNCATED]Episodes of shooting pains going into toes on both feet. Feel like they are going into spasm since dec. No injury. O/E toes cool to touch but crt<2s and palpable pedal pulses. No sig hair	-	21-Mar-2013	21-Mar-2013
Cough	unwell with cough and temps, has taken to bed cover with abx and review if not settling.	-	27-Feb-2013	27-Feb-2013
Lateral epicondylitis of the elbow	[TRUNCATED]Hurt right arm 3 weeks ago when it got stuck in a railing, only sorer last week when lifting or turning arm. O/E no swelling/heat, tender on resisted extension wrist and on full grip. Adv	-	13-Feb-2013	13-Feb-2013

Chest wall pain	[TRUNCATED]right side for 3 -4 weeks Slight pain on twisting cough with white phlegm sometime green Some SOBOE esp up hills no haemoptysis no weight loss no pleuritic pain off cigs 5 years SpO2	-	15-Aug-2012	15-Aug-2012
Ganglion of wrist	bilateral - reassured	-	07-Jun-2012	07-Jun-2012
Patient's condition improved	much better - await breath test Pain settled withing 3 days of PPI - therefore either GORD / DU	-	07-Jun-2012	07-Jun-2012
Chest wall pain	[TRUNCATED]right upper chest wall pain right shoulder pain NO pain on movement Associated nausea NO V no HB no dysphagia NO weight loss BO normal not associated with exercise Some SOBOE up hills N	-	25-May-2012	25-May-2012
Toe pain	05/03/2012 Toe pain bilateral - esp bad at night Must wriggle toes O/E Good PPulses Good ROM Nails healthy IMP ? RLS Dr J Radcliffe	-	05-Mar-2012	05-Mar-2012
Chest infection NOS	-	-	06-Jan-2012	06-Jan-2012
Toe pain	[TRUNCATED]in great toes r>l over last 6 months esp at night . burning sensation and reduced feeling. p.pulses normal chronic back pain. peripheral neuropathy- check bloods try amitriptylline and re	-	25-Aug-2011	25-Aug-2011
Pruritus and related conditions	no rash Itchy all over Bloods normal Try ATARAX	-	24-May-2010	24-May-2010
Pain in joint - arthralgia	[TRUNCATED]All sore esp right hand wrist - seems to lock at times Left shoulder can lock if puts arm behind head No leg / knee pain Chronic LBP No swelling joints No paraesthesia O/E NAD FROM shou	-	23-Mar-2010	23-Mar-2010
Wrist joint pain	right side for 8/12 Can no longer throw darts! Was at A E - hairline # No Px given Is slightly tender joint line esp dorsum Good ROM	-	19-Nov-2009	19-Nov-2009
Heartburn	severe for 2 weeks Never had problems before No dysphagia No N/V No weight loss O/E NAD No masses	-	29-Apr-2009	29-Apr-2009
Sebaceous cyst - wen	Right ear - Observe	-	30-Sep-2008	30-Sep-2008
Seborrhoeic wart	Left thigh	-	30-Sep-2008	30-Sep-2008
Sciatica	Right side from hip to right calf Is very tender Right l3 - l5 facetal joints No bowel, bladder , sexual problems (On VIAGRA) Plan - See Osteopath May need Orthopedic referral	-	06-Feb-2008	06-Feb-2008
Lateral epicondylitis of the elbow	Bilateral	-	20-Nov-2007	20-Nov-2007
Adhesive capsulitis of the shoulder	Left side - severe pain for 1/12 O/E Good ROM - Abd sore at extremes Is sore to passively move shoulder Plan - Wants injeciton - Suprascap NB	-	29-Jun-2007	29-Jun-2007
Arm pain	[TRUNCATED]left arm for 4 weeks Paraesthesia into the left hand Left posterior neck pain Cant sleep with pain No response to IBUPROFEN exercises O/E mild reduced ROM left shoulder No TE Tender	-	09-Jan-2006	09-Jan-2006
Impotence	-	-	14-Feb-2005	14-Feb-2005
Cramp	in both hands Slow to release when grabs something tight No paraesthesia Sever chronic LBP O/E NAD - No swelling , triggering , dupytrens Plan - check bloods ? refer neurology ? MYOTONIC DYSTROPHY	-	31-Jan-2005	31-Jan-2005
CTS - Carpal tunnel syndrome	? left wrist - ? justifies Nerve conduction studies	-	13-May-2004	13-May-2004
Cervicalgia - pain	decreased ROM esp extension ? nerve radiation into left hand	-	13-May-	13-May-

in neck			2004	2004
Epididymal cyst	Removal	-	09-Jul-2001	09-Jul-2001
Sciatica	-	New event	26-Mar-2001	26-Mar-2001
Epididymal cyst	-	-	07-Dec-1999	07-Dec-1999
Low back pain	-	New event	05-Oct-1999	05-Oct-1999
SNORING	-	-	07-Mar-1995	07-Mar-1995
NO ALLERGIES KNOWN	Read code 2: H/O: drug allergy [14L..00].	-	19-May-1994	19-May-1994
Diet - patient initiated	Type of vegetarian diet: Vegan. NOTES: ADVICE GIVEN.	-	01-Sep-1993	01-Sep-1993
GLAUCOMA CHRONIC	[YEAR OF EVENT 1992] NOTES: BILATERAL.	Continuing	01-Jan-1992	01-Jan-1992

Past procedures (High and medium priority - all)

Description	Comment	Date recorded
Free:total prostate specific antigen ratio	--Original Result: "% F/T PSA"	20-Apr-2016
Free prostate specific antigen level	--Original Result: "FREE PSA(F)"	20-Apr-2016
Prostate specific antigen	=30.47 ng/mL. Result qualifier: High, Start of normal range: 0, End of normal range: 6.500. NOTES: Original Result: "TOTAL PSA(T)" 30.47 ng/ml (0 - 6.5).	20-Apr-2016
Medication review	Due Date: 18/04/2017, Reviewing Clinician: 2,12.	18-Apr-2016
Referral to nurse	Please check FBP Serum Iron Haemachromatosis genetic test PSA bone profile	16-Mar-2016
Transferrin saturation index	=80.20 . Result qualifier: High, End of normal range: 55.	11-Mar-2016
Serum transferrin	=2 g/L. Start of normal range: 2, End of normal range: 3.600.	11-Mar-2016
Serum iron level	=40.10 umol/L. Result qualifier: High, Start of normal range: 10, End of normal range: 30.	11-Mar-2016
Free:total prostate specific antigen ratio	--Original Result: "% F/T PSA"	11-Mar-2016
Free prostate specific antigen level	--Original Result: "FREE PSA(F)"	11-Mar-2016
Prostate specific antigen	=34.80 ng/mL. Result qualifier: High, Start of normal range: 0, End of normal range: 6.500. NOTES: Original Result: "TOTAL PSA(T)" 34.80 ng/ml (0 - 6.5).	11-Mar-2016
Blood glucose level	--	11-Mar-2016
Serum cholesterol/HDL ratio	=2.63 . End of normal range: 4.	11-Mar-2016
Serum non high density lipoprotein cholesterol level	=3.17 mmol/L. End of normal range: 7.500.	11-Mar-2016
Serum LDL cholesterol level	=2.55 mmol/L. Result qualifier: High, End of normal range: 2.	11-Mar-2016
Serum HDL cholesterol level	=1.94 mmol/L. Start of normal range: 1.	11-Mar-2016
Serum cholesterol	=5.11 mmol/L. Result qualifier: High, End of normal range: 4.	11-Mar-2016
Serum triglycerides	=1.38 mmol/L. End of normal range: 2.	11-Mar-

		2016
Corrected serum calcium level	=2.32 mmol/L. Start of normal range: 2.200, End of normal range: 2.600. NOTES: Original Result: "Corrected Calcium".	11-Mar-2016
Serum calcium	=2.34 mmol/L. Start of normal range: 2.100, End of normal range: 2.600.	11-Mar-2016
Serum inorganic phosphate	=0.70 mmol/L. Result qualifier: Low, Start of normal range: 0.800, End of normal range: 1.500.	11-Mar-2016
Serum alkaline phosphatase	=178 U/L. Result qualifier: High, Start of normal range: 30, End of normal range: 130.	11-Mar-2016
Serum albumin	=47 g/L. Start of normal range: 35, End of normal range: 50.	11-Mar-2016
Serum ferritin	=1183 ug/L. Result qualifier: High, Start of normal range: 30, End of normal range: 400.	11-Mar-2016
Serum TSH level	=1.510 mU/L. Start of normal range: 0.300, End of normal range: 4.500.	11-Mar-2016
Serum free T4 level	=16.20 pmol/L. Start of normal range: 12, End of normal range: 22.	11-Mar-2016
Serum free triiodothyronine level		11-Mar-2016
Serum C reactive protein level	=1.09 mg/L. Start of normal range: 0, End of normal range: 5.	11-Mar-2016
Serum gamma-glutamyl transferase level	=64 U/L. Result qualifier: High, Start of normal range: 8, End of normal range: 61.	11-Mar-2016
Serum alanine aminotransferase level	=28 U/L. Start of normal range: 0, End of normal range: 40.	11-Mar-2016
AST serum level	=24 U/L. Start of normal range: 0, End of normal range: 40.	11-Mar-2016
Serum alkaline phosphatase	=178 U/L. Result qualifier: High, Start of normal range: 30, End of normal range: 130.	11-Mar-2016
Serum total bilirubin level	=19.80 umol/L. End of normal range: 21.	11-Mar-2016
Serum albumin	=47 g/L. Start of normal range: 35, End of normal range: 50.	11-Mar-2016
Serum total protein	=70 g/L. Start of normal range: 60, End of normal range: 80.	11-Mar-2016
GFR calculated abbreviated MDRD	>60 mL/min. Start of normal range: 60, End of normal range: 150. NOTES: Original Result: 60 ml/min (60 - 150).	11-Mar-2016
Serum creatinine	=90 umol/L. Start of normal range: 59, End of normal range: 104.	11-Mar-2016
Serum urea level	=3.70 mmol/L. Start of normal range: 2.500, End of normal range: 7.800.	11-Mar-2016
Serum chloride	=102 mmol/L. Start of normal range: 95, End of normal range: 108.	11-Mar-2016
Serum potassium	=5.40 mmol/L. Result qualifier: High, Start of normal range: 3.500, End of normal range: 5.300.	11-Mar-2016
Serum sodium	=141 mmol/L. Start of normal range: 133, End of normal range: 146.	11-Mar-2016
Serum folate	=7.30 ug/L. Start of normal range: 4.600, End of normal range: 18.700.	11-Mar-2016
Serum vitamin B12	=1693 ng/L. Result qualifier: High, Start of normal range: 191, End of normal range: 663.	11-Mar-2016
Erythrocyte sedimentation rate	=4 mm/h. Start of normal range: 1, End of normal range: 30. NOTES: Original Result: "ESR" 4 mm/hr (1 - 30).	11-Mar-2016
Percentage basophils	=0.40 %. Start of normal range: 0, End of normal range: 2.	11-Mar-2016
Percentage eosinophils	=3.40 %. Start of normal range: 0, End of normal range: 6.	11-Mar-2016
Percentage monocytes	=21 %. Result qualifier: High, Start of normal range: 1, End of normal range: 13.	11-Mar-2016
Percentage lymphocytes	=26 %. Start of normal range: 20, End of normal range: 40.	11-Mar-2016
		11-Mar-

Percentage neutrophils	=49.20 %. Start of normal range: 45, End of normal range: 70.	2016
Total white cell count	=5.04 10*9/L. Start of normal range: 4, End of normal range: 11. NOTES: Original Result: 5.04 e9/l (4 - 11).	11-Mar-2016

Family conditions (All priorities)

Description	Extension	Date Recorded	
No FH: Hypertension	Read code of condition: Hypertensive disease [G2...00].	-	01-Sep-1993
No FH: CVA/Stroke/TIA	Read code of condition: Cerebrovascular disease [G6...00].	-	01-Sep-1993
No FH: Ischaemic heart disease	Read code of condition: Ischaemic heart disease [G3...00].	-	01-Sep-1993

MEDICATION

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Timolol 0.5% eye drops	67078020	ml	INSTILL ONE DROP TWICE DAILY [more]	-	26-Nov-2013	-
Naproxen 500mg tablets	58923020	tablet	TWICE A DAY (DISPENSE WEEKLY)	-	06-Oct-2015	-
Lansoprazole 30mg gastro-resistant capsules	75584020	capsule	1 IN THE MORNING (DISPENSE WEEKLY)	-	06-Oct-2015	-
Temazepam 20mg tablets	68343020	tablet	TAKE 1 TABLET(S) AT NIGHT (DI[more]	-	04-Dec-2015	-
Aspirin 75mg tablets	72648020	tablet	TAKE 1 TABLET(S) DAILY (WEEKL[more]	-	10-Mar-2016	-
Atorvastatin 20mg tablets	83944020	tablet	TAKE 1 TABLET(S) EARLY EVENIN[more]	-	16-Sep-2014	-

Recent medication (Any medication issued within last 168 days not shown above)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Temazepam 20mg tablets	68343020	tablet	TAKE 1 TAB NOCTE	-	18-Apr-2016	-
Atorvastatin 20mg tablets	83944020	tablet	TAKE 1 TABLET(S) EARLY EVENIN[more]	-	16-Sep-2014	-
Aspirin 75mg tablets	72648020	tablet	TAKE 1 TABLET(S) DAILY	-	10-Mar-2016	-
Temazepam 20mg tablets	68343020	tablet	TAKE 1 TABLET(S) AT NIGHT	-	04-Dec-2015	-
Paracetamol 500mg soluble tablets	65975020	tablet	1-2 FOUR TIMES A DAY WHEN REQUIRED	-	01-Mar-2016	-
Paracetamol 500mg soluble tablets	65975020	tablet	1-2 FOUR TIMES A DAY WHEN REQUIRED	-	25-Jan-2016	-
Amoxicillin 500mg capsules	59330020	capsule	TAKE 1 TABLET(S) THREE TIMES A DAY	-	31-Dec-2015	-
Temazepam 20mg tablets	68343020	tablet	TAKE 1 TABLET(S) AT NIGHT	-	04-Dec-2015	-
Naproxen 500mg tablets	58923020	tablet	TWICE A DAY	-	06-Oct-2015	-
Lansoprazole 30mg gastro-resistant capsules	75584020	capsule	1 IN THE MORNING	-	06-Oct-2015	-
Timolol 0.5% eye drops	67078020	ml	INSTILL ONE DROP TWICE DAILY	-	26-Nov-2013	-
Simvastatin 40mg tablets	72489020	tablet	TAKE 1 TABLET(S) EARLY EVENINGTIME	-	16-Sep-2014	-

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Ex smoker	Smoking status on date of event: Ex-smoker.	26-Jun-2013

ALCOHOL INTAKE

Description	Comment	Date Recorded
Alcohol consumption	Drinking status on eventdate: Current drinker, Units of alcohol drank per week: 24.	13-May-2004

BMI

28.6

SOCIAL HISTORY

OTHER PATIENT DATA

Signature of referring doctor (or other professional)

Date

Personal Information redacted by the USI

SOUTH ... BOOKING CENTRE
RECEIVED
04 MAY 2016
CAH

For Trust use only:
Personal Information redacted by the USI
Date Sent: 04-May-2016

Referral Date: 04-May-2016

Surname: Personal Information redacted by the USI

DR HUEY & PARTNERS

Practice address

Personal Information redacted by the USI

Practice code: Personal Information redacted by the USI

Contact number(s)

Telephone: Personal Information redacted by the USI

Fax:

Practice Email:

Red Flag	TRUS
Upgrade Red Flag	Flex. C/U
Urgent	Flow Rate
Routine	Ultrasound
Other	
Virtual	

Referral to: Daisy Hill Hospital

Specialty: UROLOGY

Urgency: **URGENT**

Urgency Reason: no priority reason given

Electronic Attachment Present?: No

HCP Name:

Designation:

Referral Type: Out Patient

Practice Code: Personal Information

Registered GP: Dr Brian Cupples

Registered GP Cypher: Personal Information

Referring GP: Dr Michael Huey

Referring GP Cypher: Personal Information redacted by the

HCN Number Personal Information redacted by the USI

Title: Mr

Surname: Personal Information redacted by the USI

Forenames: Personal Information redacted by the USI

Previous Surname: -

Known as: -

DOB: Personal Information redacted by the USI

Gender: Male

Registered Contact Details: Personal Information redacted by the USI

Tel No: Personal Information redacted by the USI

Mobile: -

Patient Email: -

Preferred Contact Details If different from above:

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint

Description: Personal year old man had originally attended with frank haematuria, adn been referred

Comment: US scan had been requested which shows a residual of 440ml

Prostatic size 34 ml
Most recent psa 0.36ng/ml.
u&e in February 2016 had been normal, will ask hime to have it repeated.
MAny thanks Dr M J Huey

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Epididymo-orchitis	-	16-Jun-2014	16-Jun-2014
Calcific tendinitis	-	21-Oct-2013	21-Oct-2013
Osteoarthritis	AC joint right	22-Jul-2013	22-Jul-2013
Capsulitis NOS	acute capsulitis (r) shoulder	22-Jul-2013	22-Jul-2013
Tendinitis NOS	ongoing tendonopathy (r) shoulder	22-Jul-2013	22-Jul-2013
Type 2 diabetes mellitus	TCI to discuss .	05-Jan-2012	05-Jan-2012
Diverticular disease	sigmoid diverticular disease	19-Mar-2011	19-Mar-2011
Varicocele	(L)	13-Jul-2010	13-Jul-2010
Asthma		08-Apr-2009	08-Apr-2009
Carpal tunnel syndrome	BILATERAL	10-Jul-2007	10-Jul-2007
[M]Adenomatous polyp NOS	TUBULO-VILLOUS ADENOMA	02-Apr-1997	02-Apr-1997
Diverticular disease	-	13-Mar-1996	13-Mar-1996
ME - Myalgic encephalomyelitis	-	24-Oct-1988	24-Oct-1988
Osteoarthritis NOS, of shoulder region	-	15-Apr-1984	15-Apr-1984
Osteoarthritis of cervical spine	-	13-Feb-1984	13-Feb-1984

Past procedures (High and medium priority - all)

Description	Date recorded
Nerve block NEC	01-Dec-2015
Injection given	15-Sep-2015
Diabetic retinopathy screening	26-Aug-2015
Injection of therapeutic substance into skin	02-Dec-2014
Ultrasound scan	16-Jun-2014
Injection of therapeutic substance into joint	22-Jul-2013
MRI scan abnormal	29-May-2013
Bowel cancer screening programme	16-Nov-2012
Excision of wedge of nail	26-May-2011
Plain x-ray of chest	28-May-2008
Sigmoid colectomy	11-Jan-1999
Polypectomy	05-Nov-1997
Unilateral total orchidectomy - unspecified	30-Sep-1987

MEDICATION

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Peptac Liquid (Peppermint)	9525811000001103	500 ml	10 MLS QID AS REQUIRED	-	29-Oct-2013	-
Pantoprazole Gastro-Resistant Tablets 20 mg	317322009	28 tablet	DAILY	-	15-Oct-2013	-
Atorvastatin Tablets 20 mg	320030001	28 tablet	One To Be Taken Daily	-	16-Nov-2012	-
Amlodipine Tablets 5 mg	319283006	28 tablet	One To Be Taken Daily	-	04-Apr-2012	-
Metformin Hydrochloride Tablets 500 mg	325278007	56 tablet	ONE TO BE TAKEN TWICE A DAY	-	30-Jan-2012	-
Irbesartan Tablets 300	318970006	28 tablet	ONE TO BE TAKEN	-	24-Apr-	-

mg			DAILY		2009

Recent medication (Any medication issued within last 168 days not shown above)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Eucerin Atocontrol Bath And Shower Oil	4275811000001106	400 ml	USE IN SHOWER	-	25-Apr-2016	-
Fluconazole Capsules 50 mg	324697005	7 capsule	ONE TO BE TAKEN DAILY	-	20-Apr-2016	-
Trimethoprim Tablets 200 mg	324431001	14 tablet	ONE TO BE TAKEN TWICE A DAY	-	20-Apr-2016	-
Cefalexin Capsules 500 mg	323884001	21 capsule	ONE TO BE TAKEN THREE TIMES A DAY	-	18-Apr-2016	-
Anusol Suppositories	777211000001103	12 suppository	1 TID	-	15-Apr-2016	-
Fusidic Acid M/R Eye Drops 1 %	330404003	5 gram	APPLY TWICE A DAY	-	12-Apr-2016	-
Chloramphenicol Eye Drops 0.5 %	330286001	10 ml	apply 2 hourly	-	06-Apr-2016	-
Chloramphenicol Eye Ointment 1 %	330295009	4 gram	APPLY THREE TIMES A DAY TO BOTH EYES	-	25-Mar-2016	-
Eucerin Atocontrol Bath And Shower Oil	4275811000001106	400 ml	USE IN SHOWER	-	16-Mar-2016	-
Aveeno Cream 1 %	892711000001100	300 ml	APPLY AS REQUIRED	-	16-Mar-2016	-
Hydroxyzine Hydrochloride Tablets 25 mg	321286001	28 tablet	ONE TO BE TAKEN AT NIGHT	-	16-Mar-2016	-
Cetirizine Hydrochloride Tablets 10 mg	320818006	28 tablet	ONE TO BE TAKEN DAILY	-	16-Mar-2016	-
Pregabalin Capsules 75 mg	415167006	56 capsule	ONE TO BE TAKEN TWICE A DAY	-	10-Mar-2016	-
Flexitol Heel Balm	13131311000001104	75 gram	PRN	-	09-Mar-2016	-
Salbutamol Cfc-Free Inhaler 100 micrograms/puff	320139002	1 inhaler	TWO PUFFS AS REQUIRED	-	12-Feb-2016	-
Pregabalin Capsules 75 mg	415167006	56 capsule	ONE TO BE TAKEN TWICE A DAY	-	02-Feb-2016	-
Doxycycline Hyclate Capsules 100 mg	324059006	8 capsule	BD FOR FIRST DAY THEN 1 DAILY	-	08-Jan-2016	-
Co-Phenotrope 2.5/0.025 Tablets	377216000	28 tablet	TWO TO BE TAKEN TWICE A DAY	-	04-Jan-2016	-
Maxitram Sr M/R Capsules 50 mg	14977411000001101	60 capsule	ONE OR TWO TO BE TAKEN TWICE A DAY	-	07-Dec-2015	-
Ranitidine Tablets 300 mg	317251005	30 tablet	ONE TO BE TAKEN AT NIGHT	-	07-Dec-2015	-

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Ex smoker		21-Jul-2015

ALCOHOL INTAKE

Description	Comment	Date Recorded
Alcohol consumption		23-Jul-2015
BMI		
28.7		
SOCIAL HISTORY		
OTHER PATIENT DATA		

Signature of referring doctor (or other professional)

Date

Personal Information redacted by the USI

SOUTHERN TRUST BOOKING CENTRE RECEIVED 04 MAY 2016

Referral to: Craigavon Area Hospital	Health & Care Number: Personal Information redacted by the USI
Speciality: Erectile Dysfunction Clinic	Patient Name: Personal Information redacted by the USI
Date of Referral: 29 April 2016	Address: Personal Information redacted by the USI
Urgency: Routine Referral	Date of Birth: Personal Information redacted by the USI
RED FLAG REFERRAL: ☐	Previous Surname:
Preferred Consultant:	Telephone Number: Personal Information redacted by the USI
Referring GP: Dr A Watt	
Registered GP: Dr A Watt	Hospital Number: Personal Information redacted by the USI

Reason for Referral: Erectile dysfunction

Please see this patient who complains of ED since MI in 2013. His beta blocker was changed from bisoprolol to nebivolol as this was initially queried as a factor. He was given Cialis which helped but on review of guidance in BNF in "absence of information" manufacturers advised this is contraindicated with hx of IHD. He is not on a nitrate.
I would appreciate your assessment. Many thanks.

Lifestyle (Most Recent)
Height: 1.85 m
Weight: 87.00 kg
BMI: 25.40
Blood Pressure: 100/60

Past Medical History (Priority 1's)
03/05/2013 Acute ST segment elevation myocardial infarction

Current Medication
15/02/2016 Atorvastatin 40mg tablets 1 TABLET AT NIGHT 84
15/02/2016 Perindopril erbumine 2mg tablets 1 TABLET IN THE MORNING 84
15/02/2016 Aspirin 75mg dispersible tablets 1 TABLET ONCE A DAY 84
30/03/2016 Nebivolol 2.5mg tablets ONE DAILY 84
Not Issued Calcipotriol 50micrograms/g ointment USE TWICE DAILY 360

Allergy/Intolerance Personal Information redacted by the USI

Signature of Referre **Dr A Watt** 29 April 2016

Red Flag	TRUS
Upgrade Red Flag	Flex. C/U
Urgent	Flow Rate
Routine	Ultrasou
Other	
Virtual	

[redacted]
AE Number [redacted]
Surname [redacted] Forename [redacted] Dob [redacted]
GP W MCCANDLESS
GP TEL [redacted]

[redacted]

Diagnosis
1. Renal stone
2.
3.

Investigations and Results
CT 1/7/13 – B/L stones

ED Discharge Plan
Stone clinic – return if unwell

Patient to attend GP re:

Referred to Specialty
Time

Admission Agreed By:
DTA Time

Grade of Doctor
Patient to make appt with GP

Prescription (Medicines on discharge)

Medicine	Dose	Route	Frequency	Duration	Signature	Supply required	Supply Checked by	Given by	Quantity
CODEINE	30-60mg	PO PRN	6°	3 days	Owing				
DICLOFENAC	100mg	PR	od	1 dose	Owing				

FINAL PLACEMENT

Admit to ward	GP	other hospital OPD	Sign [redacted]
CDU	ED Review	Did not wait/refuses Rx	Grade [illegible]
TNF to OH	Fracture Clinic	Died in ED	Breach Time 15:15
Home	CBYL / Psych. Assess	CTMA	Exam Finish Time 1645
OPD ✓	Physio	Absconded	Departure Time

Discharge OBS

P	BP	RESP	TEMP	SPO2	GCS	CR	BM
62	110/65	18	36.3	97.			

Transport booked — Time booked — Ref if NIAS
IV Cannula removed — Advice leaflet given — UNOCINI complete
CBYL given — GP letter given — Patient property returned

Breach Time 15:15

Time left department 1650 — Signature Nurse [redacted]

CRAIGAVON HOSPITAL EMERGENCY DEPARTMENT

Lurgan Road, Craigavon, BT6 35QQ
Tel: [redacted] Fax: [redacted]

AE Number [redacted]	HCN [redacted]	Priority Code 3	
Surname [redacted]	[redacted]	GP W MCCANDLESS [redacted]	
Forename			
Dob [redacted]	Age [redacted]		
Sex M	MS D	[redacted]	
Occ [redacted]	Tel [redacted]		
Casenote [redacted]	Mobile/Other [redacted]		

Arrival Date/Time 03/05/2016 11:15
Arrival Mode A9 Incident Type NT
Source of Referral Brought By Ambulance
Accompanied By
Patient at risk of leaving Yes/No

Prev Episodes 09 / 01
Triage Date/Time 03/05/2016 11:19
Breach Time 15:15
Nurse: KEH
KEYLEIGH HARNEY
Tetanus Status:
Booster Given Yes/No

Adult Safeguarding Concerns Yes/No
Child Protection Concerns Yes/No
Special Needs

Presenting Complaint ?RENAL COLIC
Presentation ABDOMINAL PAIN IN ADULTS
Discriminator MOD PAIN
Triage Text ?RENAL COLIC– HX OF SAME STATES IS SIMILAR PAIN MORPHINE GIVEN WITH GOOD EFFECT BY NIAS
Medication
Allergies PENICILLEN

Pulse	B/P	RR	PFR
67	133/69	20	

Visual Acuity — Right Eye — Left Eye

ECG required yes/no (< 10 minutes cardiac) — History — MRSA — CDIFF

Commenced on NEWS/CNS/PEWS ch…

Nursing Assessment
MENTAL STATE Yes No — WASH…
Alert and Orientated — Indep…
Confused — Help…
Agitated — Full A…
Aggressive — Press…
Drowsy — Com…
Trolley Sides in Situ — Pad…
MOBILITY — FEEDING…
Independent — Dietary Requirements
Walk with Help — Dentures top
Walk with Aids — bottom

Patient updated at regular intervals Yes No

On Cartstick WL for r/v in Oct '14.
WL currently running at May '13.
Expedite?

(Due r/v Oct '14)

Version – 10.9.1

HCN [redacted] Surname [redacted] Forename [redacted] Dob [redacted]
AE Number [redacted]

History and Examination

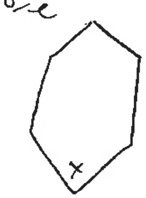
Assessment	Seen By [redacted]	Time

58 ♂
Renal stone History
Today / severe left renal flank pain
9/10 severity → relieved by morphine - now 2/10
No vomit, Recent haematuria + stone pain
Oct 2013 - Emer left 6x4mm mid calyceal stone - not destroyed
Offers
O/E

PMH
A/Th
Renal stones /
IBS

DHx
Pen allergy

Obs stable
O/E



soft
BS ✓
tender mildly

Chest
↳ B/L clear

MSU 1+ [illegible]
CRP <5
Culture sent

D/w urology
Req CT KUB

analgesia ✓
Bloods ✓
Urine ✓

CT noted ~3K stone. [illegible]

D/w [illegible] Urology Reg
Rev clinic
Accord [illegible]

"Case discussed with ED consultant" yes ☐

HCN [redacted] Surname [redacted] Forename [redacted] Dob [redacted]
AE Number [redacted]

Prescription (Medicines in Department) — Administration

Medicine	Dose	Route	Time to be given	Signature	Given by	Time
DICLOFENAC	100mg	PR	STAT	[redacted]		1140

Nursing/care delivered in ED

R 15 144 [illegible]
[illegible] 24.3
WBC 10.3
[illegible]
[illegible] 50 [illegible]
Creat 12a

Pt to d/w CT KUB of pm Urology. No need for Axn.
Pt told by Dr he can go for lunch. [illegible]

1655/ d/c home
with script
NEWS=0 [redacted]

Signatue of Nurse ____________

Admission checklist (please tick if completed)

Time Bed manager informed ____________ Ward Ready at ____________

Copy ED Flimsy	☐	MEWS/CNS	☐	IV Cannula Form	☐
Fluid Balance	☐	Relevant performa	☐	C diff completed	☐
Copy of NIAS notes stroke PTs	☐	Own Drugs	☐	Relatives aware admission	☐

Patient handover given to admitting nurse ____________ (please record their name) Time ______

Patient has previous history of C Diff	yes ☐	no ☐
Patient has vomiting and /or diarrhoea	yes ☐	no ☐
Patient had contact with anyone with vomiting and /or diarrhoea in last 5 days	yes ☐	no ☐

If yes to any of above refer to agreed guidance.

Corrigan, Martina

From: Carroll, Ronan [redacted]
Sent: 22 September 2016 15:41
To: McAllister, Charlie; Gishkori, Esther; Weir, Colin
Subject: RE: meeting re Mr O'Brien.

Importance: High

Charlie/Colin
So can I ask and offer some suggestions/solutions as to how we may monitor progress against the action listed below. The clock is ticking now toward December
Come back to me if you wish me to action anything/all

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien – At the first meeting obviously after the context of the meeting being explained the proposed plan/actions need to be shared with AOB and agreed
2. To implement a clear plan to clear triage backlog. – is this the outpatient referral letters, including RF's? How are you planning to monitor that this is cleared? I would propose with regard to the RF's that I would ask the cancer team to monitor the triage turnaround, with regard to outpatients I would ask Anita to put a process in place to monitor
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this – RBL validation – are we offering additional Pas for this to be done? If not, then something in his job plan will have to stop for this clinical validation to happen. Then when this task has been completed the remaining on the RBL can only be dealt by as your suggestion the template being adjusted, this has a lead in time of 6 weeks due to partial booking process. When this is implemented we will monitor the progress of AOBs RBL (I can have this run at anytime)
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation – I will speak to Anita to ensure AOBs secretary receives digital dictation following any consultation
5. All patient notes to be return from home without exception NA
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed absolutely
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

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

From: McAllister, Charlie
Sent: 21 September 2016 11:55
To: Gishkori, Esther; Weir, Colin; Carroll, Ronan
Subject: RE: meeting re Mr O'Brien.

Hi Colin

Thank you very much for this. Apart from the fact that you spelt my name wrong (!) this is absolutely excellent and I agree completely. It would be important to do this in a positive/constructive/supportive role and that Mr O'Brien would be aware of this. I think that this approach will give the best chance to achieve this. And for improving the current situation.

Since I can't improve on this I am forwarding in toto.

Thanks

Charlie
From: Weir, Colin
Sent: 16 September 2016 14:41
To: McAllister, Charlie
Subject: Action Plan

Charlie
These are my initial thoughts. Anything to add? Change?

Dear Dr McCallister

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

Secretary Jennifer Personal Information redacted by the USI

From: Gishkori, Esther
Sent: 15 September 2016 14:59
To: Weir, Colin; McAllister, Charlie; Carroll, Ronan
Subject: FW: meeting re Mr O'Brien.

FYI below.
……and my response will be?

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by the USI **Mobile** Personal Information redacted by the USI

[redacted]

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

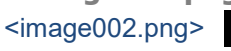
Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
Perhaps when we have seen these we could meet again to consider. regards Richard

Sent from my iPad

On 15 Sep 2016, at 14:40, Gishkori, Esther [redacted] wrote:

> Dear Richard and Vivienne,
> Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
> I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.
>
> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
> Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.
>
> I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.
>
> I appreciate you highlighting the fact that this long running issue has not yet been resolved. However, given the trust and respect that Mr O'Brien has won over the years, not to mention his life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good. This I feel would be the best outcome all round.
>
> Happy to discuss any time and I will of course brief the oversight committee of any progress we make.
>
> Many thanks
> Best
> Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust

 Office Personal Information redacted by the USI Mobile Personal Information redacted by the USI
 Personal Information redacted by the USI

Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: McAllister, Charlie [redacted]
Sent: 21 September 2016 11:55
To: Gishkori, Esther; Weir, Colin; Carroll, Ronan
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Happy to discuss any time and I will of course brief the oversight committee of any progress we make.

Many thanks
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
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Carroll, Ronan

From: Scullion, Damian [redacted]
Sent: 24 February 2017 10:55
To: Corrigan, Martina; Murray, Helena
Cc: Carroll, Ronan; Haynes, Mark
Subject: RE: Regional Urology proposal

Martina

We are stretched on Thursdays but could explore it as extra anaesthetic sessions. Mark has mentioned to me that the funding is from Belfast. Could you please clarify and I can look into anaesthetist doing them as extra sessions

Damian

From: Corrigan, Martina
Sent: 24 February 2017 08:58
To: Murray, Helena; Scullion, Damian
Cc: Carroll, Ronan; Haynes, Mark
Subject: RE: Regional Urology proposal

Thanks Helena

As discussed we can try and work around patient not staying in recovery but I was wondering about the rest as I am conscious these lists were coming up soon and Mark will need to give notice to patients. Damian same for have we any availability for anaesthetists for proposed sessions?

Regards

Martina

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

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

From: Murray, Helena
Sent: 10 February 2017 11:56
To: Corrigan, Martina; Scullion, Damian
Cc: Carroll, Ronan
Subject: RE: Regional Urology proposal

Dear Martina,

I have left this request with the sisters as I am on leave next week.

The problem lies in securing a fourth recovery nurse as currently we struggle to provide a third nurse. Also beds blocked in recovery for the remainder of the day post-surgery.

Would Saturdays be an option?

Pamela and Emmajane will be in contact next week

Regards
Helena

From: Corrigan, Martina
Sent: 09 February 2017 17:37
To: Murray, Helena; Scullion, Damian
Cc: Carroll, Ronan
Subject: Regional Urology proposal

Dear both,

Mark Haynes has been involved in Regional discussions in respect to Nephron Sparing Surgery as Belfast Trust are going to no longer able to provide this service. Part of the plan is that Mark if he can secure some additional sessions will do them here and these will be all as additional and all costs will be paid for by the Board.

For March there has been 6 suitable patients identified for here, and Mark therefore would require 3 additional theatre sessions (can do 2 cases per session).

I have had a look at the Theatre rota for March and really the only suitable 'vacant' sessions available are in Theatre 8 on Thursday mornings, i.e. 2nd March, 9th March, 16th March or 30th March.

Mark has also advised that we should plan to keep these patients in recovery overnight (again there will be funding if additional resources are required).

Ronan has asked me to email you both to advise you of this plan and to see if this will be possible to get 3 of the above sessions staffed?

Happy to discus.

Thanks

Martina

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

Carroll, Ronan

From: Scullion, Damian [redacted]
Sent: 06 September 2019 12:48
To: Carroll, Ronan
Cc: Rutherford-Jones, Neville; Clarke, Chris; Kumar, Devendra; Murray, Helena
Subject: RE: Allocation letter updated

Importance: High

Ronan

In view of 30% reduction, will not view to appoint anaesthetist as will be able to cover ophthalmology lists with current consultants.

Regards

Damian

From: Carroll, Ronan
Sent: 26 August 2019 17:10
To: Corrigan, Martina; Cassells, Carol; Murray, Helena; McClements, Melanie; Scullion, Damian; Kearney, Emmajane
Cc: McKenna, Marti
Subject: RE: Allocation letter updated
Importance: High

Great can everyone progress with appointment in accordance with our IPT submission

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

From: Corrigan, Martina
Sent: 23 August 2019 16:57
To: Carroll, Ronan; Cassells, Carol; Murray, Helena; McClements, Melanie
Cc: McKenna, Marti
Subject: FW: Allocation letter updated

Good evening,

For information , allocation letter for staffing for the STH Day Elective Centre

Regards

Martina

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

Telephone:
EXT [redacted] (Internal)
[redacted] (External)
[redacted] (Mobile)

From: Watson, Tracey [redacted]
Sent: 23 August 2019 14:51
To: Armstrong, Marian; Cathy Gillan; Chris Allam; Damien Moore; Dunwoody, Glen; Hanrahan, Mary; John McKeown; Kieran Quinn; Louise O'Dalaigh; Maggie Parks; Margaret McMullan; McKenna, Marti; Corrigan, Martina; McAteer, Patriciam; Megan West; Molloy, Monica; Pauline McGaw; Scott, Heather; sorcha dougan; Watson, Tracey
Subject: Allocation letter updated

Sorry previous email recalled a wrong attachment included.

Dear all

Please see attached allocation letter, you may have already received from your DoP.

Regards

Tracey

Tracey Watson
Project Manager Ophthalmology
RGH

[redacted]

Carroll, Ronan

From: Scullion, Damian [redacted]
Sent: 25 September 2020 11:23
To: Clarke, Chris; Rutherford-Jones, Neville; Kumar, Devendra
Cc: Carroll, Ronan
Subject: FW: Emergency General Surgery
Attachments: Emergency General Surgery.docx

Importance: High

Dear all,

Please see below and attachment from Ronan relating to the new proposed Southern Trust surgical model. This does have significant implications for ATICS moving forward and it is imperative that we are represented here. I am busy all day in orthopaedic so would appreciate if one or all of you could attend.

Please let me know and I can send nominations.

Regards

Damian

From: Carroll, Ronan
Sent: 25 September 2020 10:08
To: Weir, Colin; Gilpin, David; Nelson, Amie; Conway, Barry; Tariq, S; Wells, CharlotteAnne; Khan, Ahmed; Matthews, Josephine; Murphy, Seamus; Murphy, Philip; McVey, Anne; Burke, Mary; Hampton, Gareth; Robinson, Jeanette; Weir, Colin; Waddell, Sandra; McClements, Melanie; Kamath, Meeta; Scullion, Damian; Haynes, Mark
Cc: Livingston, Laura
Subject: FW: Emergency General Surgery
Importance: High

Morning everyone
As you are aware there will be challenges with consultant surgeon cover at DHH which requires urgent action.
I have been asked by the Interim Director of Acute Services to chair a group to develop a surgical model which will provide a safe emergency surgery service across the Trust.
I have attached a briefing paper which documents the issues which are being faced by the service.
There will be the need to engage with all stakeholders but in the first instance I want to hold an urgent internal meeting **Thursday 1st October art 11am via MySpace** to get everyone views

Could you please respond to my secretary Laura Livingstone to confirm your or your nomination attendee
No doubt I have missed someone or specialty out, if I have can you please forward onto them
Thank you.
Ronan

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

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

Future Provision of the Emergency General Surgery Service

DRAFT V0.1 22-Sep-20

1. Introduction

This paper sets out the challenges relating to the continued provision of safe and sustainable emergency surgery services on the Trust's two acute hospital sites, Craigavon Area Hospital (CAH) and Daisy Hill Hospital (DHH). Consultant cover at DHH will shortly be significantly depleted, requiring urgent action. However this situation, along with new ways of working which have had to be introduced to sustain services during the Covid-19 pandemic, also present the opportunity to develop a new service model. This paper sets out an alternative service model for consideration by the Trust's senior management team, consolidating assessment and ongoing treatment for emergency surgery patients at CAH in tandem with urgent care centres and ambulatory care centres on both sites.

2. Current Service Model

Prior to the temporary changes to emergency services introduced to manage the initial Covid-19 surge, emergency general surgery was provided at Craigavon Area and Daisy Hill Hospitals. Elective general surgery was and continues to be undertaken on both sites, albeit elective activity is currently constrained due to Covid restrictions. The current service model described below refers to the 'pre-Covid' model of care for emergency surgery.

Emergency admissions in the main are via the Emergency Departments. Separate rotas are in place in each hospital to maintain the necessary out of hours cover.

A 'surgeon of the week' (SOW) model is operated on each of the two hospital sites. A named consultant, along with a registrar and an F2/CT (foundation doctor year 2/ core trainee), is responsible for all emergency admissions for the week. The SOW team has no elective commitments and is responsible for all management of general surgery emergency cases including:

- Ward rounds
- Emergency theatre operating
- Access clinic (ambulatory patients)
- Weekly urgent bookable list

Due to the large emergency take at Craigavon Hospital a second surgeon was added to the SOW rota, working Monday to Friday between 8am and 1pm. The second surgeon is responsible for all outlying emergency surgical cases and shares in the emergency theatre/urgent bookable workload.

Funded Medical Posts

The medical staff posts shown in the table below are funded across both sites. The consultant breast surgeons have not been included in the figures as they do not participate in the general surgery rota.

Grade	
Consultants[1]	15
Specialty & Associate Specialist (SAS)	5
NIMDTA Specialty Trainee (ST)	7
NIMDTA Core Trainee (CT)	7
NIMDTA Foundation Doctor (FY1/FY2)	4 x F2, 13xF1
Trust Post filled by locums	3 x SpR, 2 x SHO[2]
Ward based SHOs[3]	2-4

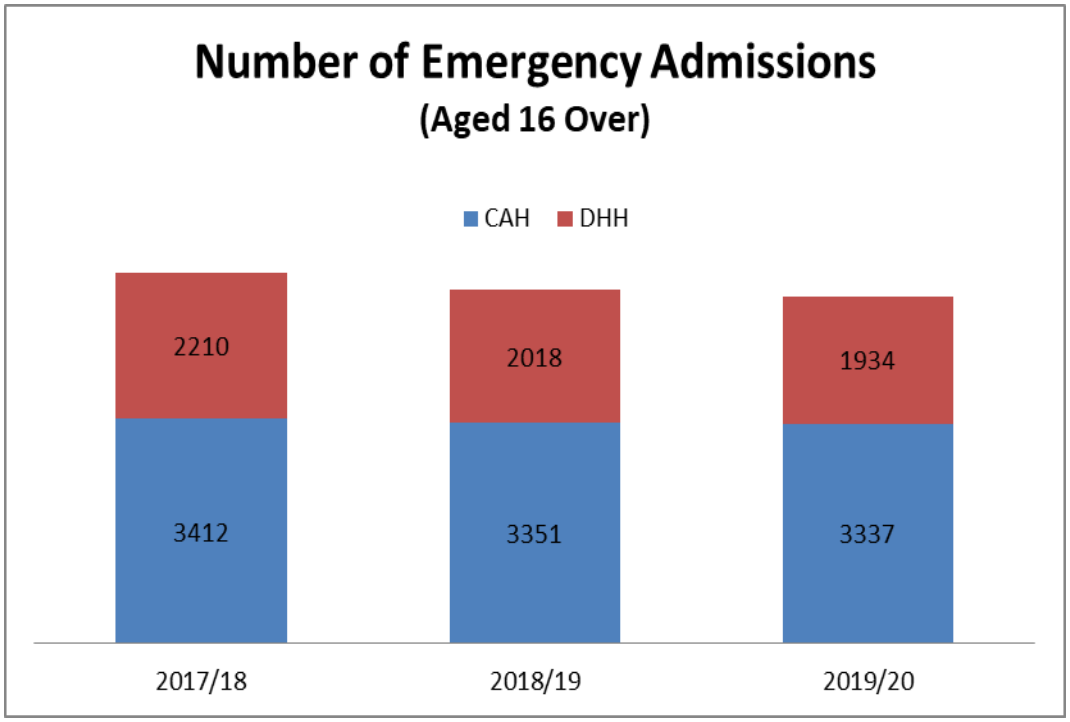
[1] 9 consultant posts are based at CAH and 6 at DHH. 1 post at DHH has been funded by the Trust at risk and is filled by a long term locum.

[2] Funded at risk by the Trust

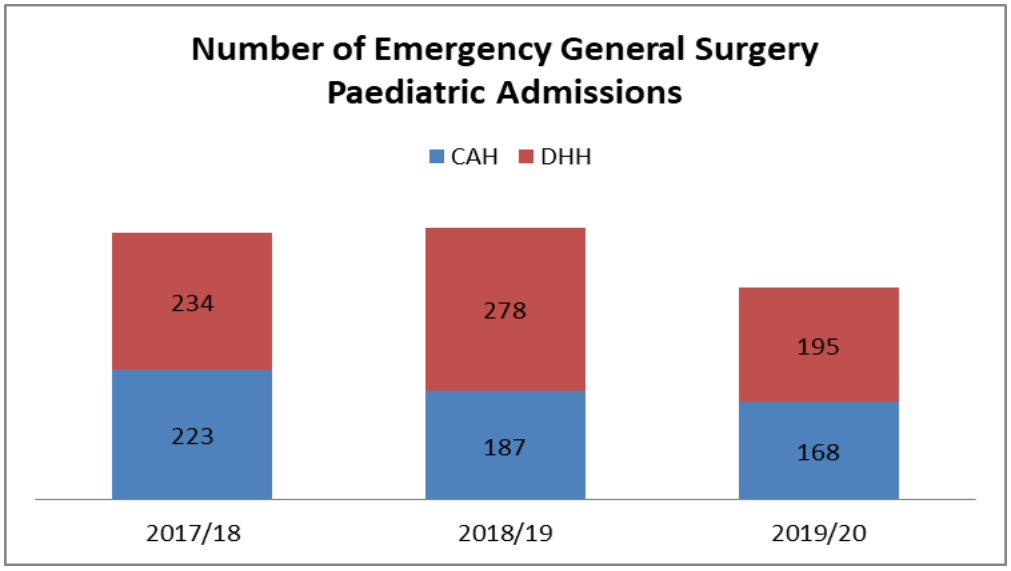
[3] Funding to be confirmed

Activity

Emergency General Surgery Admissions



- Average 5420 adult emergency surgery admissions per year across the 3 year period
- Average 9 a day to CAH and 6 a day to DHH
- We occupy 70 adult emergency beds a day



- Paediatric emergency surgery admissions average 428 per year across the 3 year period
- There is a significant reduction in 2019/20 which we believe is due to the paediatric ambulatory service
- In 2019/20 the total admissions were 363, an average of 0.6 per day at CAH and 0.5 per day at DHH.

Additional activity data are provided in Appendix 1.

3. Key Drivers

The key drivers for the need to change the way in which emergency general surgery is delivered are summarised as follows with further detail provided in the paragraphs below:

- Provision of safe, sustainable, high quality care
- Recruitment and retention of staff
- Making best use of specialist medical/professional expertise to improve outcomes for patients
- Alignment with national and regional strategic direction

Provision of Safe, Sustainable, High Quality Care

The general surgery team is committed to providing the highest standards of evidence-based care for our patients. The provision of high quality emergency general surgery services on two sites has historically been extremely challenging. Adequate consultant cover both during the day and out of hours is a prerequisite for a safe service. Maintaining consultant cover at Daisy Hill has been difficult and the situation will shortly be exacerbated as the number of consultants will be reducing from 6 to 3. On call cover for the out of hours periods will be particularly challenging. There is no potential for cover to be provided from Craigavon without diluting the cover there.

The current position with regard to general surgery consultants in post and cover for the on call rota is shown in the table below:

	In Post & Available	Participating in On Call
CAH	9	7
DHH	6	5
Trust	15	12

The following changes will adversely affect consultant cover in the near future:

- 2 consultants are moving from Daisy Hill to Craigavon for career development reasons. Both participate in the on call rota at DHH;
- 1 consultant based at CAH is going on a career break in October (to undertake his fellowship). He participates in the on call rota at CAH;
- 1 consultant based at DHH is retiring. He does not currently participate in the on call rota.

These changes will affect the numbers as follows:

	In Post & Available	Participating in On Call
CAH	10	8
DHH	3	3
Trust	13	11

This will leave 2 substantive consultants and a long term locum based at DHH and providing out of hours cover. This number is insufficient to provide a workable rota both during the in and out of hours periods. Whilst locum cover can be utilised as an interim measure, it is unsustainable particularly for the out of hours periods, and it is also extremely costly.

The changes within UK surgical training specifically subspecialty specialisation and the decline of a wider exposure to surgical specialties during specialist registrar training, means that newly appointed consultant surgeons are less experienced and less confident of their abilities in emergency general surgery than their predecessors. They are less equipped to deal with the repertoire of cases presenting to District General Hospitals. Access to adequate peer support and mentoring for newly appointed consultants is essential to ensure the provision of a safe, high quality service.

Recruitment and Retention of Medical Staff

There is a finite pool of potential applicants for surgical consultants with Trusts competing to attract candidates from the same pool. Doctors are clear about their minimum requirements from the employing Trust in terms of career development/opportunities for sub-specialisation; rotas and work-life balance; access to specialist staff and resources such as critical care, interventional radiology, theatre lists etc; peer support particularly during the early period of their consultant career; and facilities and equipment/technology. They often have a choice of posts and will consider how closely a post fulfills the criteria that are important to them. This has been demonstrated very clearly in recent recruitment drives for general surgery consultants at DHH.

There have been and remain recruitment and retention problems to DHH surgery at consultant level. Within the past 5 years 6 separate consultant interviews have taken place and 8 surgeons were offered and accepted consultant positions in DHH. Of these eight candidates:

- Two also applied for and took up positions in the Belfast area before ever starting in DHH;
- Three took up positions in DHH but subsequently applied for and accepted positions in other Trusts;

- The remaining three are in post in DHH; however, one applied for and was offered a position in CAH, and, like another DHH surgeon, is overdue for transfer to CAH.

The applicants to DHH consultant positions have also been small in number, and at the last two consultant interviews there was only one suitably qualified candidate. This is in contrast with recruitment for positions in CAH. Within the last two years there have been two consultant interview panels convened. At one, there were two jobs and three quality applicants. The unsuccessful candidate was tentatively offered a position in DHH, but declined the offer. At the second set of CAH interviews there were three jobs and five high quality applicants.

Making Best Use of Specialist Medical/Professional Expertise

Having access to a broad range of sub-specialty expertise would benefit patients and improve outcomes. Many general surgeons have specialised their practice in order to concentrate on treating conditions relating to one area or body system. While this has resulted in improved outcomes for patients requiring planned specialist intervention, it has also created difficulties in having an appropriately trained and available surgical workforce for the treatment and management of emergency general surgery patients on multiple sites. Consolidation of the available consultant expertise would enable a wider range of sub-specialty expertise to be available.

Access to the necessary resources such as emergency theatres, diagnostic investigations and critical care is essential to provide the best possible care for acutely ill patients. Again it is not always possible to provide all of these essential elements on multiple sites. Funding is not the only constraint faced by the Trust. Increasingly the availability of staff is a significant constraint. There are plans and funding to strengthen the high dependency service at DHH to meet with Intensive Care Society guidelines but it has not been possible to appoint the necessary medical staff. Level 3 critical care is only provided at CAH, limiting the surgeries that can be undertaken at DHH. Concentrating emergency surgery on a single site would provide improved access to emergency surgical sub-specialty skillsets; critical care; interventional radiology and would reduce critical transfers for the emergency patient.

Alignment with National and Regional Strategic Direction

Much of the national and regional strategy encourages Trusts to review current service models, optimise the deployment of available staff and introduce new models of care which avoid inappropriate admission and ensure patients are seen by the appropriate professional at the correct time. Nationally many Trusts have consolidated their emergency surgical surgery service on a single site with appropriate pathways.

The 2016 expert panel review of health and social care in Northern Ireland[1] highlighted that one of the major flaws of the current medical workforce mix is that

'*it is focused on filling rotas and maintaining existing services, even where there are clear signs that these are not sustainable, rather than on detailed forecasting of demography and need'*.

It recognised that it is proving extremely difficult to recruit and retain junior medical staff to deliver services where they would be unlikely to get the experience they need in terms of volumes and case mix in order to maintain their skills and develop new skills as reflected in the current, high level of vacancies in training posts. The need to invest in long term strategic change was emphasised rather than trying to maintain the 'status quo'.

'*The success of any new service model will be absolutely dependent on staff being employed and deployed in such a way that makes the best use of their skills and which allows them to continue to develop as professionals while providing the services that users and patients need'*.

The subsequent departmental strategy, *Health and Wellbeing 2026 Delivering Together*[2] presented by the then Minister of Health, endorsed the Expert Panel's recommendations. In terms of reform to community and hospital services it stated:

'*Across many different services there is very strong evidence that concentrating specialist procedures and services in a smaller number of sites produces significantly better outcomes for patients, as well as a much better and more supportive environment for staff. The role of our hospitals will therefore fundamentally change as they will focus on delivering the highest quality of specialist and acute care. However, not every service will be available in every hospital'*.

'*If we persist with our current models of care, even with the best efforts of all staff and more investment year on year, waiting lists will continue to grow, our expertise will continue to be diluted, and the best possible outcomes for patients will not be realised. This is both unsustainable and unacceptable. However, if we accept, as a whole range of reviews have, that our services are not best configured for our needs, then it follows that recruiting additional staff alone to prop up outdated service models, is not the answer. We must be able to provide safe and high quality care which keeps up with the fast pace of innovation and health and social care developments'*.

More recently the Minister's plans to support the re-build of services and transform urgent and emergency care services include ambulance only emergency departments, the creation of urgent care centres and increasing ambulatory care provision with appropriate pathways for patients who do not require admission.

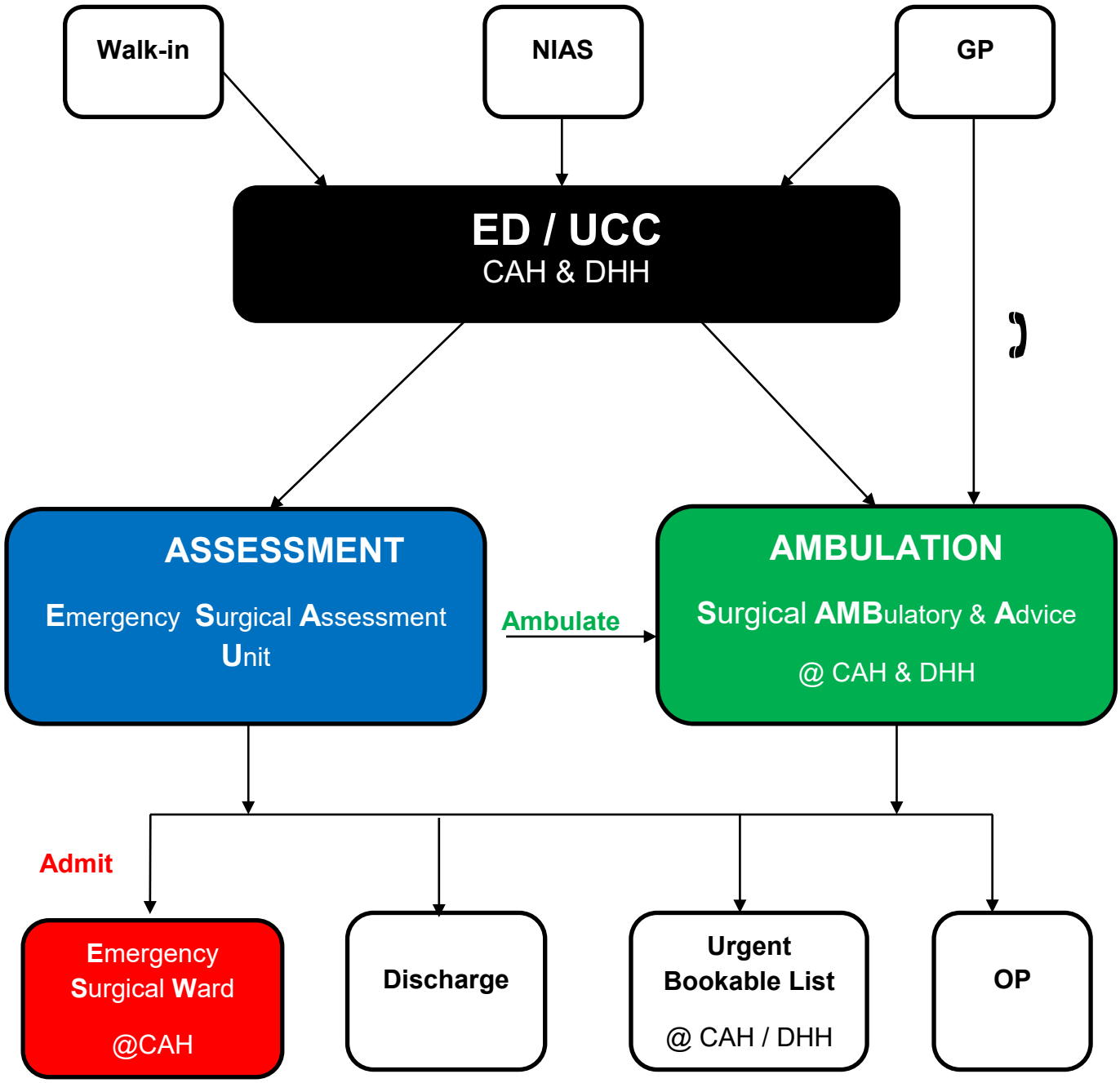
[1] SYSTEMS, NOT STRUCTURES: Expert Panel Report CHANGING HEALTH & SOCIAL CARE, Chair Professor Rafael Bengoa

[2] HEALTH AND WELLBEING 2026 DELIVERING TOGETHER, Department of Health, October 2016

4. Proposed Future Service Model

The proposed future service model involves concentrating the emergency general surgery service on the CAH site, with acute cases presenting at DHH being transferred to CAH for ongoing care. The emphasis will be on assessment, diagnosis and timely appropriate transfer to CAH. Those patients requiring admission will be admitted to CAH. There will be no emergency surgical beds at DHH. Figure 1 depicts the flow of patients.

Figure 1: Proposed Emergency General Surgical Flow



Key Features:

- All appropriate patients will be treated on an ambulatory pathway with ambulatory units established at CAH and DHH. Patients may be referred for ambulatory treatment by their GP, the emergency departments at CAH or DHH, or the urgent care centres at CAH or DHH.
- Pathways will be put in place which include pre-hospital evaluation/triage for primary care.
- Patients deemed unsuitable for ambulatory care will be assessed at CAH (emergency surgical assessment unit) and a decision made regarding their ongoing treatment:
    - Admission to the emergency surgical ward
    - Discharge to care of GP
    - Discharge with urgent bookable list date – where surgery eg cholecystectomy is required urgently but not immediately
    - Discharge with outpatient appointment
- Those patients presenting at DHH will be transferred to CAH for assessment.
- Protocols will be agreed with NIAS to ensure that those patients with symptoms requiring obvious surgical assessment are taken directly to CAH.
- Senior surgical input will be directed to reducing admissions and increasing ambulatory care. Surgical assessment and ambulatory should be consultant led. Inpatient ward rounds will also be consultant led.
- Capacity will be available at DHH for other surgical specialities to undertake elective surgery eg urology and breast as bed and theatre capacity used for emergency surgery will be released.
- The surgeon of the week model described in section 2 would continue for emergency inpatients at CAH.
- Consultant on-call cover will be in place for both CAH & DHH 24/7. At DHH this will provide cover for the general surgical elective patients, in-theatre emergencies to Obs and Gynae, advice for medical inpatients, Obs and Gynae and paediatric wards. Figures 2 and 3 demonstrate how the surgical cover for DHH will function.

  At DHH there would be middle grade cover 24/7. The middle grade cover would be provided from home at night.