**Letters waiting to be triaged from Mr O'Brien's office – 9 January 2017**

| Month of Letters | Amount | Comments |
|---|---|---|
| June 2015 | 70 | All sorted except for one, this was without letters being triaged Note 3 patients deceased before having been sent for. |
| August 2015 | 20 | The urgents in this have had appt but the routine have not had appointments yet but are due to be selected for end of January/February 2017 |
| September 2015 | 32 | |
| October 2015 | 77 | |
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| May 2016 | 111 | |
| June 2016 | 75 | |
| July 2016 | 31 | |
| August 2016 | 45 | |
| September 2016 | 70 | |
| October 2016 | 62 | |
| **Total** | **783** | |

## Carroll, Ronan

**From:** Corrigan, Martina
**Sent:** 09 May 2022 17:25
**To:** Carroll, Ronan
**Subject:** FW: CONFIDENTIAL - Confirmation of further oversight meeting re: Dr AOB - 10th January 1pm, Trust HQ
**Attachments:** outstanding notes on PAS as of 6 jan 17.docx; untriaged as of 10 january 2017.docx; RE: TURP audit (37.1 KB); Action note - 22nd December - AOB Action plan MC 10 January 2017.docx

**Sensitivity:** Confidential

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**From:** Corrigan, Martina [redacted]
**Sent:** 10 January 2017 11:51
**To:** Carroll, Ronan [redacted]
**Cc:** Boyce, Tracey [redacted]
**Subject:** RE: CONFIDENTIAL - Confirmation of further oversight meeting re: Dr AOB - 10th January 1pm, Trust HQ
**Sensitivity:** Confidential

Ronan

Attached for meeting today at 1pm.

Happy to go through any of this in advance or if there is anything during the meeting please contact me.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

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**From:** Carroll, Ronan
**Sent:** 23 December 2016 13:19
**To:** Corrigan, Martina; Clayton, Wendy
**Subject:** FW: CONFIDENTIAL - Confirmation of further oversight meeting re: Dr AOB - 10th January 1pm, Trust HQ
**Importance:** High
**Sensitivity:** Confidential

**Sent in the strictest confidence**

Martina/Wendy
So we need an AP to address the following

1- Volumes of notes tracked to AOB
2- What has been the outcome for the 318 patients
3- Determination of the volumes of pts where we have no dictation & a plan to correct same

4- Number of complaints with regard to AOB & how this compare to his peers

Ronan

*Ronan Carroll*
*Assistant Director Acute Services*
*ATICs/Surgery & Elective Care*
Personal Information redacted by the USI

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**From:** Gibson, Simon
**Sent:** 23 December 2016 11:27
**To:** Gishkori, Esther; Toal, Vivienne; Wright, Richard
**Cc:** Carroll, Ronan; Boyce, Tracey; Clegg, Malcolm; Stinson, Emma M; Mallagh-Cassells, Heather; White, Laura; Montgomery. Ruth
**Subject:** CONFIDENTIAL - Confirmation of further oversight meeting re: Dr AOB - 10th January 1pm, Trust HQ

Dear Richard, Esther and Viv

I am writing to confirm a follow-up meeting in relation to Dr A O'Brien on

**Tuesday 10th January at 1pm – 2pm, Dr Wrights office, Trust HQ**

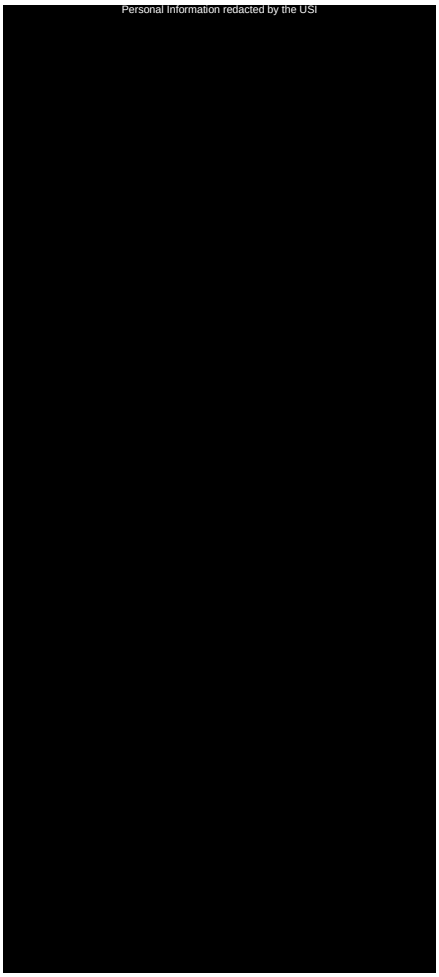
I have included the action note from yesterdays meeting, detailing actions required.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
DHH: Personal Information redacted by the USI Ext Personal Information redacted by

**Borrower:CU2 MR AOB OBRIEN**




29/08/2006 14:45 UROL CL. 12/9/06
29/08/2007
29/08/2006 14:47

27/03/2012 15:12 CLINIC 03.04.12
27/03/2013
27/03/2012 15:13

30/06/2010 12:11 CLINIC 06/07/2010
30/06/2011
30/06/2010 12:15

07/04/2010 12:19 CLINIC 13/04/10
07/04/2011
07/04/2010 12:20

21/06/2012 16:11 CLINIC
21/06/2013
21/06/2012 16:13

18/01/2012 11:33 clinic 24.01.12
17/01/2013
18/01/2012 11:34

29/04/2010 16:26 CLINIC FOR 04.05.10
29/04/2011
29/04/2010 16:26

09/11/2005 13:02 UROL CL. 22/11/05
09/11/2006
09/11/2005 13:04

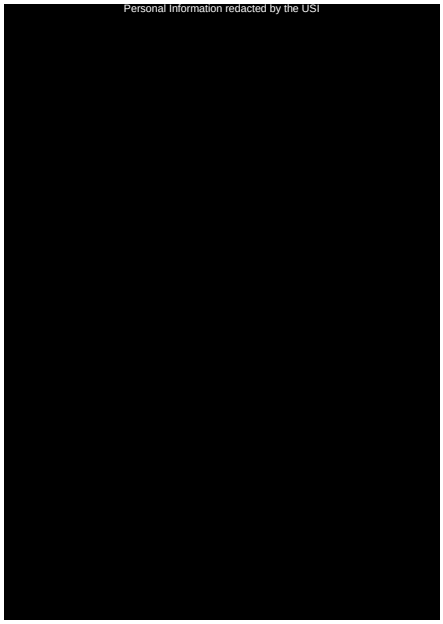
**Borrower :CAOBA MR A OBRIEN, AUDIO-TYP, CAH**

| CN No. / Patient Name | Loc / User ID | Loan Date/Time / Exp Return Date / Trans Date/Time | Reason for Loan/ Comment |
|---|---|---|---|
| Personal Information redacted by the USI | | 21/08/2014 12:41<br>21/08/2015<br>21/08/2014 12:41 | SARA TO TYPE STC DISCH 070<br>SHELF 5 IN CUPBOARD |
| | | 03/03/2014 13:41<br>03/03/2015<br>03/03/2014 13:41 | |

**Borrower :CAOBO MR A OBRIEN, OFFICE, CAH**

| CN No. Loc<br>Patient Name | Loan Date/Time<br>Exp Return Date<br>User ID | Reason for Loan/<br>Comment<br>Trans Date/Time |
|---|---|---|
| [redacted] | | 13/06/2003 12:03 dnas |
| | | 12/06/2004 |
| | | 13/06/2003 12:09 |
| | | 03/05/2011 15:29 PIGEON HOLE 4 |
| | | 02/05/2012 |
| | | 03/05/2011 15:29 |
| | | 17/07/2009 16:22 |
| | | 17/07/2010 |
| | | 17/07/2009 16:25 |
| | | 08/08/2007 11:45 |
| | | 07/08/2008 |
| | | 08/08/2007 11:46 |
| | | 16/09/2010 09:28 |
| | | 16/09/2011 |
| | | 16/09/2010 09:31 |
| | | 01/12/2016 09:29 MR O'BRIEN'S ADMIN |
| | | 01/12/2017 |
| | | 01/12/2016 09:30 |
| | | 10/04/2015 15:21 RESULT FOR MR O'BRIEN TO S |
| | | 09/04/2016 |
| | | 10/04/2015 15:22 |
| | | 11/04/2011 10:43 |
| | | 10/04/2012 BUNDLE 2 |
| | | 11/04/2011 10:43 |
| | | 16/09/2010 09:27 |
| | | 16/09/2011 |
| | | 16/09/2010 09:28 |
| | | 11/04/2011 12:09 |
| | | 10/04/2012 BUNDLE 19 |
| | | 11/04/2011 12:09 |
| | | 02/01/2015 14:35 FOR M+M DISCUSSION |
| | | 02/01/2016 |
| | | 02/01/2015 14:36 |
| | | 23/03/2016 16:16 ON FLOOR BEHIND DESK |
| | | 23/03/2017 |
| | | 23/03/2016 16:16 |

Personal Information redacted by the USI




06/05/2016 13:22 RESULT FOR MR O'BRINE TO S
06/05/2017
06/05/2016 13:22

06/05/2016 13:19 MR O'BRINE'S ADMIN
06/05/2017
06/05/2016 13:19

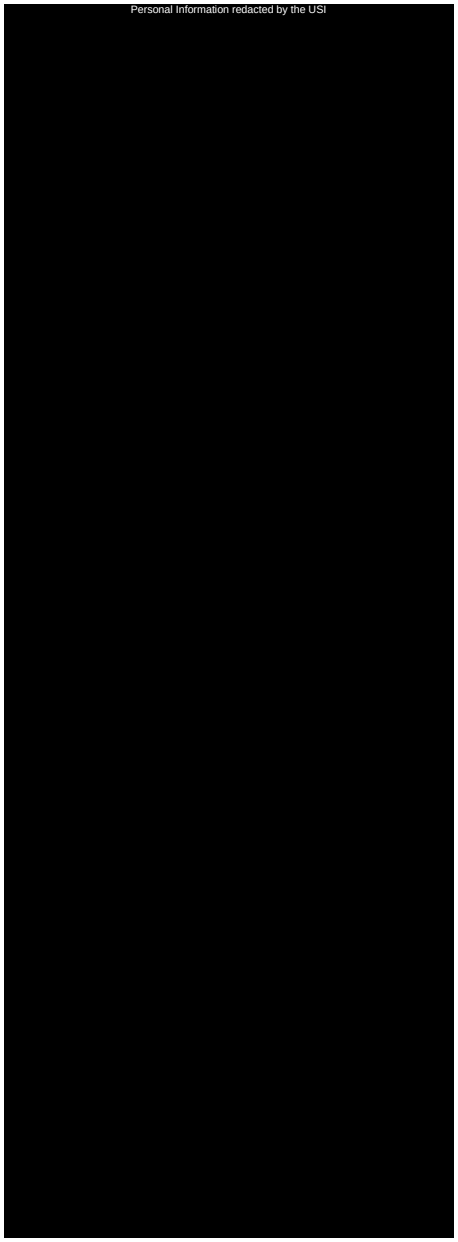
11/10/2005 14:07 PT TO SEE AOB IN OFFICE
11/10/2006
11/10/2005 14:08

08/11/2016 15:50 PH 6
08/11/2017
08/11/2016 15:51

20/11/2015 12:16 AOB PP IN FILING CABINET
19/11/2016
20/11/2015 12:17

**Borrower :CAOBS MR A OBRIEN, SECRETARY, CAH (total = 164)**

**Below are notes that have been outstanding for a while – need to check does the secretary still have these:**




18/03/2010 16:32 PERUSAL
18/03/2011
18/03/2010 16:33

07/01/2004 14:28 TYPING
06/01/2005
07/01/2004 14:28

10/10/2006 08:19 PT TO SEE AOB IN OFFICE
10/10/2007 IN PP FILING CABINET
10/10/2006 08:20

29/11/2013 16:25 BEHIND MONICA FOR TYPING
29/11/2014
29/11/2013 16:26

30/01/2013 09:20 TYPING SHELF
30/01/2014 PAGES ONLY
30/01/2013 09:21

14/09/2004 20:18 TYPING
14/09/2005
14/09/2004 20:18

13/06/2003 10:27 private patient cabinet
12/06/2004
13/06/2003 10:31

01/09/2014 14:15 TYPING
01/09/2015
01/09/2014 14:15

13/06/2003 10:17 private patient
12/06/2004
13/06/2003 10:20

05/12/2014 13:58 AWAITING RESULTS
05/12/2015
05/12/2014 13:58

**Letters waiting to be triaged from Mr O'Brien's office – 9 January 2017**

| Month of Letters | Amount | Comments |
|---|---|---|
| June 2015 | 70 | All sorted except for one, this was without letters being triaged Note 3 patients deceased before having been sent for. |
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| November 2015 | 66 | |
| February 2015 | 65 | |
| March 2016 | 59 | |
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| August 2016 | 45 | |
| September 2016 | 70 | |
| October 2016 | 62 | |
| **Total** | **783** | |

## Carroll, Ronan

**From:** Clayton, Wendy
**Sent:** 06 January 2017 10:47
**To:** Carroll, Ronan; Corrigan, Martina
**Subject:** RE: TURP audit

Ronan – this is what you need? All the below pts had a Hermitage private letter on NIECR. Doesn't mean there could be more but no private letter on NIECR

| Casenote | Health & Care Number | Hospital Description | Date on Waiting List | Date Operation | Days Between Added to WL and Operation Date | Proc Category |
|---|---|---|---|---|---|---|
| Personal Information redacted by the USI | | Craigavon Area Hospital | 07/09/2015 | 06/07/2016 | **303** | TURPT |
| | | Craigavon Area Hospital | 13/10/2015 | 16/03/2016 | **155** | TURPT |
| | | Craigavon Area Hospital | 25/04/2016 | 04/05/2016 | **9** | TURBT |
| | | Craigavon Area Hospital | 05/05/2016 | 15/06/2016 | **41** | TURBT |
| | | Craigavon Area Hospital | 30/10/2015 | 17/08/2016 | **292** | TURPT/TURBT |
| | | Craigavon Area Hospital | 18/01/2016 | 27/01/2016 | **9** | TURPT |
| | | Craigavon Area Hospital | 27/05/2016 | 29/06/2016 | **33** | TURPT |
| | | Craigavon Area Hospital | 29/06/2016 | 27/07/2016 | **28** | TURPT |

Regards

*Wendy Clayton*
*Operational Support Lead*
*ATICS/SEC*
*Tel:* Personal Information redacted by the USI
*Mob:* Personal Information redacted by the USI

-----Original Message-----
From: Carroll, Ronan
Sent: 06 January 2017 10:10
To: Clayton, Wendy; Corrigan, Martina
Subject: FW: TURP audit

Wendy
Tks can u display so that we can see the pts timeline Eg when seen, operated on - total waiting time

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

-----Original Message-----
From: Clayton, Wendy
Sent: 05 January 2017 15:53

To: Corrigan, Martina; Carroll, Ronan
Subject: TURP audit

Ronan/Martina

I have gone through the 59 pts who had TURP under AOB in 2016. 7 pts were seen by AOB privately. I have attached PP letters.

Let me know if you need any further information.

Regards

Wendy Clayton
Operational Support Lead
ATICS/SEC
Tel: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

-----Original Message-----
From: wendy.clayton Personal Information redacted by the USI
Sent: 05 January 2017 15:50
To: Clayton, Wendy
Subject: Scan from YSoft SafeQ

Scan for the user Wendy Clayton (wendy.clayton) from the device CAH - Admin Floor - c454e

**Southern Health & Social Care Trust**

**Oversight Committee**
**22nd December 2016**

**Present:**
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Ronan Carroll, on behalf of Esther Gishkori, Director of Acute Services

**In attendance:**
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager
Tracey Boyce, Director of Pharmacy, Acute Services Directorate

**Dr A O'Brien**

**Context**
On 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October.

Dr O'Brien was scheduled to return to work on 2nd January following a period of sick leave, but an ongoing SAI has identified further issues of concern.

**Issue one**
Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on sick leave.

Ronan Carroll reported to the Oversight Committee that, between July 2015 and Oct 2016, there were 318 letters not triaged, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks.

**Action**
**A written action plan to address this issue, with a clear timeline, will be submitted to the Oversight Committee on 10th January 2017**
**Lead: Ronan Carroll/Colin Weir**

**Update as of 10 January 2017**

Mr O'Brien had advised Martina Corrigan that these letters were in a filing cabinet in his office. Martina collected these on Monday 9 January and there are actually 783 letters that had never been triaged. See attached table: the longest were June 2015 and Martina has checked and these have all been dealt with apart from one who is the partial booking cycle for a Jan/Feb appointment. Therefore the longest on the untriaged waiting list has been waiting since August 2015 but these may be appointed soon due to the fact that they are nearly at the top of the waiting lists.

Plan – firstly to carry out an admin exercise with the rest of the letters and ensure that these patients have not already attended and then the remaining letters will be triaged by the four consultants who have advised that they willing to do this. After some discussion it was agreed that in keeping with their normal triage pathway that these letters will need advanced triaged which will take quite a bit of time because of the volumes. Therefore this will need to be done over and above core time and we have been asked firstly can these letters as an exceptional case be done off site (consultant home) and also as the four have already committed to additional Waiting List initiative work for next three months this will put them over their hours and also be in breach of the terms of the WLI so they would like to know how best that this will be addressed.

If there are any patients that need seen as Urgent and are waiting longer than other patients then the Consultants are willing to do additional clinics to see these patients again outside of Core time and after the above about payment has been agreed. It is very difficult for the consultants to quantify the time that it will take to do this and the volumes that may need to be seen at an additional clinic but once agreed they will via Martina keep you updated.

Also to note when Martina met with Mr O'Brien on Monday 9 January to collect the outcomes he also gave her a copy of four patient letters that were sent direct to him and have not been recorded on PAS. One was a medical inpatient discharge asking for a follow-up appointment in Urology – discharged on 10 February 2015, one was consultant referral from Dr Adams (Obs/Gynae) dated 24/03/15 and 2 were GP letters from GP's one dated 15 May 2015 and the other 19 May 2015. These will be included in Triage but I will get one of the Team to look at these urgently as they are longer than the others and they have not been recorded and if they need an appt I will get these appointed to the next available clinic

**Issue two**

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

**Action**

**Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017**

**Lead: Ronan Carroll**

**Update 10 January 2017**

Mr O' Brien returned all the notes that he had in his on Monday 2 January 2017 to his own office on 2nd floor main block CAH. These have all been casenote tracked by Martina Corrigan to her own tracking code with the comment in AMD office, Admin Floor. There were a total of 307 charts returned from his home this included 94 Southern Trust notes that Mr O'Brien had seen privately put had written his private notes in these charts. Martina then checked his office and has casenote tracked all the charts from here again to her own tracking code with comment in Mr O'Brien's office, CAH and the number on the Pigeon Hole, there were 88 notes in his office. Martina then ran another report from PAS and found that there are still 27 tracked as follows and attached to Mr O'Brien

CU2 – AOB (clinic code) = 8 dating back for quite a period of time
CAOBO – Mr O'Brien's office = 17
CAOBA – Audio Typist Mr O'Brien x 2 charts dating to 2014

Action: is to check with Health Records and Secretary that these have not been returned to them at a time and not updated on PAS – this should be completed by end of this week and Martina will advise.

**Issue three**

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

**Action**

**A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017**
**Lead: Ronan Carroll/Colin Weir**

**Update 10 January 2017**

Martina ran a report of all the undictated clinics from Business Objects and found that this related to 668 patients and dating back to November 2014. Martina spoke to Mr O'Brien and he advised her that he had an outcome on every patient from these clinics, albeit they were not dictated on nor where they all recorded on PAS. He has advised her that some of the patients have been seen again or have had their surgery since they had attended the clinic. Mr O'Brien met with Martina on Monday 9 January 2017 and hand-delivered the outcome sheets for which there are 272 handwritten outcomes for SWAH patients and 299 for other clinics, which leaves a shortfall of 97 patients.

**Plan**

1. is to check with the lists of undictated clinics and identify these 97 patients and then the consultants will do a casenote review to see if they can from these notes determine what the outcome should have been.

2. to do an admin exercise of all the outcomes and then cross reference with the clinics what is missing. This admin exercise will show what is outstanding on reviews, diagnostics and being added to waiting lists.

The consultants are willing to work with Martina outside of Core time or to displace SPA to go through patient's notes etc. The Consultants have advised that they would prefer to go with Mr O'Brien's outcome as it would be very difficult for them as they have never seen the patient to make a determination without having seen the patient but are happy if anything comes from the admin exercise to see the patients if required.

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.
**Action: Tracey Boyce**

**Consideration of the Oversight Committee**
In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.
**Action: Dr Wright/Simon Gibson**

The following was agreed:
Case Investigator – Colin Weir
Case Manager – Ahmed Khan

## Carroll, Ronan

**From:** Corrigan, Martina
**Sent:** 09 May 2022 17:13
**To:** Carroll, Ronan
**Subject:** FW: Audit of charts re AOB 13/1/17

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**From:** Corrigan, Martina [redacted]
**Sent:** 13 January 2017 16:41
**To:** Clayton, Wendy [redacted]; Carroll, Ronan [redacted]
**Subject:** RE: Audit of charts re AOB 13/1/17

Thanks Wendy

I have been working with Pamela Lawson on this and they have located 12 of these so far and they are now searching the Villas for these as I have provided her with the numbers so this will change.

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

---

**From:** Clayton, Wendy
**Sent:** 13 January 2017 16:39
**To:** Carroll, Ronan; Corrigan, Martina
**Subject:** Audit of charts re AOB 13/1/17

Ronan/Martina

I have updated the below today 13/1/17:

| Tracking code | Description | Longest date tracked to borrower | No. of charts tracked to AOB |
|---|---|---|---|
| CU2 | Mr AOB O'Brien | August 2006 | 8 |
| CAOBO | AOB office | June 2003 | 16 |
| CURWDO | AO Brien Urology cl | | 0 |
| CURWOB | AOB urology CAH | | 0 |
| EURAOB | Enniskillen AOB urology | Dec 2016 | 11 |
| **Totals** | | | **35 charts** |

Regards

*Wendy Clayton*
*Operational Support Lead*
*ATICS/SEC*
*Tel:* [redacted]
*Mob:* [redacted]

**From:** Clayton, Wendy
**Sent:** 23 December 2016 13:10
**To:** Carroll, Ronan; Corrigan, Martina
**Subject:** RE: Audit of charts re AOB

I have included longest date as requested that the chart has been tracked to the borrower:

| Tracking code | Description | Longest date tracked to borrower | No. of charts tracked to AOB |
|---|---|---|---|
| CU2 | Mr AOB O'Brien | August 2006 | 8 |
| CAOBO | AOB office | June 2003 | 210 |
| CURWDO | AO Brien Urology cl | | 0 |
| CURWOB | AOB urology CAH | | 0 |
| EURAOB | Enniskillen AOB urology | June 2014 | 147 |
| **Totals** | | | **365 charts** |

**From:** Clayton, Wendy
**Sent:** 23 December 2016 13:02
**To:** Carroll, Ronan; Corrigan, Martina
**Subject:** RE: Audit of charts re AOB

Ronan / Martina

I have ran a PAS query to see how many charts are tracked out to Mr O'Brien. I believe this will be useful for your meeting next Friday:

| Tracking code | Description | No. of charts tracked to AOB |
|---|---|---|
| CU2 | Mr AOB O'Brien | 8 |
| COABO | AOB office | 210 |
| CURWDO | AO Brien Urology cl | 0 |
| CURWOB | AOB urology CAH | 0 |
| EURAOB | Enniskillen AOB urology | 147 |
| **Totals** | | **365 charts** |

Happy to talk through.

Wendy

*Wendy Clayton*
*Operational Support Lead*
*ATICS/SEC*
*Tel:* Personal Information redacted by the USI
*Mob:* Personal Information redacted by the USI

**From:** Clayton, Wendy
**Sent:** 23 December 2016 11:59
**To:** Carroll, Ronan; Corrigan, Martina
**Subject:** Audit of charts re AOB

Ronan

I have undertaken an audit of 11 SWAH clinics

There were 183 patients attended, I did a random audit on 98 charts and 55 were tracked to AOB = 56%

Do you want me to do anymore?

Regards

*Wendy Clayton*
*Operational Support Lead*
*ATICS/SEC*
*Tel:* Personal Information redacted by the USI
*Mob:* Personal Information redacted by the USI

## Carroll, Ronan

**From:** Corrigan, Martina
**Sent:** 09 May 2022 17:14
**To:** Carroll, Ronan
**Subject:** FW: outstanding charts for Mr O'Brien
**Attachments:** updated missing notes as per 16 jan 17.docx

**From:** Corrigan, Martina [redacted]
**Sent:** 16 January 2017 16:07
**To:** Carroll, Ronan [redacted]
**Cc:** Clayton, Wendy [redacted]
**Subject:** outstanding charts for Mr O'Brien

Ronan

As discussed, Health Records have done an extensive search of the missing charts that were tracked out to Mr O'Brien.

After this search the total outstanding is 13 charts and I have attached a list of these with comments against same.

If you need any more detail please let me know

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

| Hospital Number | Date and location loaned out | Comments |
|---|---|---|
| Personal Information redacted by the USI | 2011 – Mr O'Brien's Office - CAH | No urology episodes borrowed by Mr O'Brien's secretary |
| | 2009 – Mr O'Brien's office – CAH | No urology episodes borrowed by Mr O'Brien's secretary |
| | 2009 – Mr O'Brien's office – CAH | No urology episodes borrowed by Mr O'Brien's secretary |
| | 2010 – Mr O'Brien's Office – CAH | No urology episodes borrowed by Mr O'Brien's secretary |
| | 2011 - Mr O'Brien's Office - CAH | No urology episodes borrowed by Mr O'Brien's secretary |
| | 2010 – Mr O'Brien's Office – CAH | No urology episodes borrowed by Mr O'Brien's secretary |
| | 2011 – Mr O'Brien's Office – CAH | No urology episodes borrowed by Mr O'Brien's secretary |
| | 2005 – Mr O'Brien's Office – CAH | Patient to see AOB in office |
| | 2015 – Mr O'Brien's Office - CAH | AOB PP in Filing Cabinet |
| | 2010 – Mr A O'Brien Secretary | No urology episodes borrowed by Mr O'Brien's secretary |
| | 2003 – Mr O'Brien's secretary | Private Patient Cabinet |
| | 2003 | No urology episodes borrowed by Mr O'Brien's secretary |
| | 2014 | SWAH Clinic on 9 June 2014 |

## Carroll, Ronan

**From:** Corrigan, Martina
**Sent:** 09 May 2022 17:26
**To:** Carroll, Ronan
**Subject:** FW: Action note - 22nd December - AOB Action plan MC 24 January 2017
**Attachments:** Action note - 22nd December - AOB Action plan MC 24 January 2017.docx

**From:** Corrigan, Martina [redacted]
**Sent:** 24 January 2017 10:20
**To:** Carroll, Ronan [redacted]
**Subject:** Action note - 22nd December - AOB Action plan MC 24 January 2017

Ronan

Update for today's meeting. ring me if there is anything more you require/need clarified.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

**Southern Health & Social Care Trust**

**Oversight Committee**
**22nd December 2016**

**Present:**
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Ronan Carroll, on behalf of Esther Gishkori, Director of Acute Services

**In attendance:**
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager
Tracey Boyce, Director of Pharmacy, Acute Services Directorate

**Dr A O'Brien**

**Context**
On 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October.

Dr O'Brien was scheduled to return to work on 2nd January following a period of [redacted] leave, but an ongoing SAI has identified further issues of concern.

**Issue one**
Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on sick leave.

Ronan Carroll reported to the Oversight Committee that, between July 2015 and Oct 2016, there were 318 letters not triaged, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks.

**Action**
**A written action plan to address this issue, with a clear timeline, will be submitted to the Oversight Committee on 10th January 2017**
**Lead: Ronan Carroll/Colin Weir**

**Update as of 24 January 2017**

**From 783 letters collected from Mr O'Brien's office there were 90 patients (June 2015 – 70 letters and August 2015 – 20 letters) who already had appointments. This was due to them being added to the waiting list as per the GP grading and these have been selected chronologically without being triaged by a consultant and seen at clinics. It should be noted that it has agreed by the Urology Consultants that these 90 patient's should have their outcomes followed up to ensure that there were none that had come to any harm due to delay in triage.**

**As of Friday 20 January the Consultants had returned 330 of the letters triaged – the longest dating back to September 2015. From this:**

**9 patients have been upgraded to Red Flag and all these patients have been given appointments (1 x last week and the rest this week) and we need to await the outcomes from their appointments and tests.**
**28 patients have been upgraded from Routine to Urgent – these are currently being added to clinics as per consultants as extras.**
**7 patients whilst having been seen, met the Red Flag Criteria but because they were not triaged they remained on an urgent list and have now been seen but it has been requested that all of these patients have their outcomes checked.**
**3 Patients need urgent follow-up as the letters received were in respect to outcome of results or needing a review but currently in the review back-log, these are being added as extra to clinics.**
**1 patient had urgent letter received and should have been upgraded to RF which was done 5 months later by another consultant on the receipt of a second GP referral letter. Patient then followed Red Flag pathway and has now been diagnosed as palliative. Team have discussed and this now needs to be screened for SEA/SAI.**

**The Consultants have the remainder of these letters for triage (363) and plan to have this completed by end of January 2017. But all of the patients identified above need outcomes etc followed up and this will be updated when complete.**

**Issue two**

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

**Action**

**Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017**
**Lead: Ronan Carroll**

**Update 24 January 2017**

**After thorough checking there still remains 13 sets of notes tracked to Mr O'Brien that we have not been able to locate.**

**Issue three**

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

**Action**

**A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017**

**Lead: Ronan Carroll/Colin Weir**

**Update 24 January 2017**

**Due to concentrating on the untriaged letters the Team have not had an opportunity to look at these clinics in detail. However, one of the consultants had a look at one clinic and compared against outcome sheets provided. Two of the patients had nothing written in notes but outcome advised of follow-up appointments. 4 oncology patients were overdue an oncology review appointment (being arranged now) and there were 4 patients who should have been added for diagnostic/procedures that hadn't had this actioned. As there are another 65 clinics that still need to be gone through this will take some time.**

**Another concern in respect to this which has been raised by the team was out of these undictated clinics there is no way of knowing how many patients have had tests/diagnostics requested and if these patients have had tests carried out and if the results have been seen/followed up on. This is an unknown quantity. The other consultants use the DARO (discharge awaiting results function on PAS) to keep track of their results and then get this list and chase up on outstanding ones, we have no way of tracking Mr O'Brien's as these clinics have not been dictated on and therefore we do not know what has been requested/seen/followed up on until all of these charts are gone through.**

**Private Patients**

**Update 24 January 2017**

**On request we have been provided with Mr O'Brien's admissions (electively and emergency) for 1 January 2016 until 31 December 2016. There are 853 patients on this list and due to time limitation we have not had the opportunity to go through this in any detail. However there is a concerning factor in that there are a number of patients who have been listed as being on Suspect Cancer pathway but have been waiting quite a bit of time outside of the 31 and 62 day pathway. For example, 762, 417, 329, 292, 138 days and all of these patients will need notes pulled to assess were they on the suspect cancer pathway and what their outcomes were.**

**We did do a snapshot on patients who had a TURP procedure, as there was one patient previously highlighted that they had been seen privately by Mr O'Brien and were brought in for their TURP operation quite quickly and as TURP patients are currently waiting up to 150 weeks (1050 days), we were asked to look into this. Please see table below which are patients having been identified as having seen Mr O'Brien privately. This is only a snapshot and as stated more work needs to be done on, e.g. look at these patients outcomes etc. as required.**

| Casenote | Date on Waiting List | Date Operation | Days Between Added to WL and Operation Date |
|---|---|---|---|
| Personal Information redacted by the USI | 07/09/2015 | 06/07/2016 | **303** |
| | 13/10/2015 | 16/03/2016 | **155** |
| | 25/04/2016 | 04/05/2016 | **9** |
| | 05/05/2016 | 15/06/2016 | **41** |
| | 30/10/2015 | 17/08/2016 | **292** |
| | 18/01/2016 | 27/01/2016 | **9** |
| | 27/05/2016 | 29/06/2016 | **33** |
| | 29/06/2016 | 27/07/2016 | **28** |

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.

**Action: Tracey Boyce**

**Consideration of the Oversight Committee**

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.

**Action: Dr Wright/Simon Gibson**

The following was agreed:

Case Investigator – Colin Weir

Case Manager – Ahmed Khan

## Carroll, Ronan

**From:** Corrigan, Martina
**Sent:** 09 May 2022 17:15
**To:** Carroll, Ronan
**Subject:** FW: Strictly Private & Confidential

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**From:** Corrigan, Martina [redacted]
**Sent:** 24 January 2017 14:56
**To:** Carroll, Ronan [redacted]
**Subject:** RE: Strictly Private & Confidential

Thanks for the update

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

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**From:** Carroll, Ronan
**Sent:** 24 January 2017 14:52
**To:** Corrigan, Martina
**Subject:** FW: Strictly Private & Confidential

FYI - update

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

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**From:** Weir, Colin
**Sent:** 24 January 2017 10:25
**To:** Hynds, Siobhan; Carroll, Ronan; Khan, Ahmed
**Subject:** FW: Strictly Private & Confidential

Ronan

What do you want to do with this info?

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

**Changed my number int** [redacted] **direct** [redacted]

Secretary Jennifer [redacted]

**From:** Aidan O'Brien [redacted]
**Sent:** 24 January 2017 00:19
**To:** Weir, Colin
**Subject:** Re: Strictly Private & Confidential

Dear Colin,

I received your letter enquiring about the notes or charts of 13 patients.
I have attached all that I know, or can be ascertained, about each of them.

The first two on the list attended clinics in the 1990's.
I do not know whether I would have been the doctor who reviewed them.
Their names meant nothing to me, and of course I have not had their charts since then, if at all.

[redacted] I remember intimately.
I returned his chart to Records in September 2005 on the diagnosis of his metastatic caecal carcinoma.

The next eight I found to be remarkable! It would be interesting to find out when they were tracked to me and why?

[redacted] chart did not come to the SWAH clinic with the others on 19 September 2016, as reported.

[redacted] chart was most definitely returned to my office on Tuesday 03 January 2017,

Aidan.

-----Original Message-----
From: Weir, Colin [redacted]
To: Aidan O'Brien [redacted]
Sent: Mon, 23 Jan 2017 11:51
Subject: RE: Strictly Private & Confidential

Dear Aidan

I have been asked to send this to you in advance of tomorrow

Colin

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

**Changed my number int** [redacted] **direct** [redacted]

Secretary Jennifer [redacted]

**From:** Aidan O'Brien [redacted]
**Sent:** 22 January 2017 18:27
**To:** Weir, Colin
**Cc:** Hynds, Siobhan
**Subject:** Fwd: Strictly Private & Confidential

Dear Colin,

Thank you for your letter of 20 January 2017 and sent to me by Mrs. Hynds on your behalf.
I reply to confirm that I will be able to meet with both of you on Tuesday 24 January 2017 at 2.30 pm.
I will be accompanied by my son, Michael.
As you clarified by telephone on Thursday 19 January 2017, I understand that the purpose of the meeting is to discuss / propose alternatives to exclusion and to be advised of progress of the investigation,

Aidan.

-----Original Message-----
From: Hynds, Siobhan [redacted]
To: aidanpobrien [redacted]
CC: Weir, Colin [redacted]
Sent: Fri, 20 Jan 2017 20:22
Subject: Strictly Private & Confidential

Dear Mr O'Brien

Mr Weir has asked me to send this letter to you on his behalf.

I would be grateful if you could confirm your attendance at the meeting with me as soon as possible.

Kind Regards,

Siobhan

**Mrs Siobhan Hynds**
Head of Employee Relations
Human Resources Department
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ

Tel: [redacted] Direct Line: [redacted]
Mobile: [redacted] Fax: [redacted]

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

## Carroll, Ronan

**From:** Corrigan, Martina
**Sent:** 09 May 2022 17:26
**To:** Carroll, Ronan
**Subject:** FW: Return to Work Action Plan February 2017 (2)
**Attachments:** Return to Work Action Plan February 2017 (2).docx

**From:** Corrigan, Martina [redacted]
**Sent:** 08 February 2017 15:20
**To:** Carroll, Ronan [redacted]
**Subject:** Return to Work Action Plan February 2017 (2)

Ronan

See my amendments – happy to discuss further. I am assuming that the timeliness of ward rounds etc. will be discussed as part of the review of his job plan?

Regard

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

Southern Health and Social Care Trust

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**MR A O'BRIEN, CONSULTANT UROLOGIST**
**RETURN TO WORK PLAN / MONITORING ARRANGEMENTS**

Following a decision by case conference on 26 January 2017 to lift an immediate exclusion which was in place from 30 December 2017, this action plan for Mr O'Brien's return to work will be in place pending conclusion of the formal investigation process under Maintaining High Professional Standards Framework.

The decision of the members of the case conference is for Mr O'Brien to return as a Consultant Urologist to his full job role and to include safeguards and monitoring around the 4 main issues of concerns under investigation.

Mr O'Brien's return to work is based on:

- Strict compliance with Trust procedures and policies in relation to:
    - Triaging of referrals
    - Contemporaneous note keeping
    - Storage of medical records
    - Private practice
- Agreement to read and comply with GMCs "Good Medical Practice" (April 2013)
- Agreement to an urgent job plan review
- Agreement to comply with any monitoring mechanisms put in place to assess his administrative processes

**CONCERN 1**

- That, from June 2015, 783 GP referrals had not been triaged in line with the agreed / known process for such referrals.

Mr O'Brien, when Urologist of the week (once every 6 weeks), must action and triage all referrals for which he is responsible, this will include letters received via the booking centre and any letters that have been addressed to Mr O'Brien and delivered to his office – for these letters the secretary will have to record receipt of these on PAS and then these letters must all be triaged. The oncall week commences on a Thursday AM for seven days, therefore triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends.

Red Flag referrals must be completed daily.

All referrals received by Mr O'Brien will be monitored by the Central Booking Centre in line with the above timescales. A report will be shared with the Assistant Director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets have been met.

Any deviation from compliance with the targets will be referred to the MHPS Case Manager immediately.

**CONCERN 2**

- That, 307 sets of patient notes were returned by Mr O'Brien from his home, 88 sets of notes located within Mr O'Brien's office, 13 sets of notes, tracked to Mr O'Brien, are still missing.

Mr O'Brien is not permitted to remove patient notes off Trust premises.

Notes tracked out to Mr O'Brien must be tracked out to him for the shortest period possible for the management of a patient.

Notes must not be stored in Mr O'Brien's office. (just checking on this as all other consultants do have notes in their offices?)

**CONCERN 3**

- That 668 patients have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months.

All clinics must be dictated at the end of each clinic/theatre session via digital dictation. This is already set up in the Thorndale Unit and will be installed on the computer in Mr O'Brien's office and on his Trust laptop and training is being organised for Mr O'Brien on this. This dictation must be done at the end of every clinic and a report via digital dictation will be provided on a weekly basis to the Assistant Director of Acute Services, Anaesthetics and Surgery to ensure all outcomes are dictated.

An outcome / plan / record of each clinic attendance must be recorded for each individual patient and this should include a letter for any patient that did not attend as there must be a record of this back to the GP.

**CONCERN 4**

- A review of Mr O'Brien's TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients.

Mr O'Brien must adhere to all aspects of the Trust Private Practice Policy - ' A Guide to Paying Patients' and in particular to 'Referral of Private Patients to NHS Lists i.e. *any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status: patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients;*

## Carroll, Ronan

**From:** Corrigan, Martina
**Sent:** 09 May 2022 17:21
**To:** Carroll, Ronan
**Subject:** FW: Return to Work Action Plan February 2017 (2)

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**From:** Corrigan, Martina [redacted]
**Sent:** 09 February 2017 09:02
**To:** Hynds, Siobhan [redacted]; Carroll, Ronan [redacted]
**Subject:** RE: Return to Work Action Plan February 2017 (2)

Hi Siobhan

See my comments below.

Also, few other things in my head which I am assuming will maybe discussed with Colin Weir?

Start times for Ward Rounds when he is consultant of the week – should be on the Ward by 9am.

Also the Urology Team have scheduled and signed off clinical activity until the end of March 2017 so there are no theatre sessions for him for the remainder of February and March, this will mean that when Aidan comes back it will be mainly to do clinics and perhaps some clinical validation of his Review Backlog and on his inpatient and daycase lists – which if agreed I can provide and monitor this workload as well. It's just that I don't want him coming back thinking that he is resuming his previous clinical activities because we have patients already sent for and confirmed for the theatre lists up to week of 13 March. I am assuming that this may be covered under the '*agreement to an urgent job plan review'*.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

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**From:** Hynds, Siobhan
**Sent:** 08 February 2017 22:41
**To:** Carroll, Ronan; Corrigan, Martina
**Subject:** RE: Return to Work Action Plan February 2017 (2)
**Importance:** High

Ronan / Martina

Thanks for your comments.

Just a couple of queries:

Concern 1 – no longer refers to the Elective Access Targets – do these not apply? Is there specific targets we can refer to? Because none of the consultants conform to the IEAP i.e. triage to be returned within 72 hours, the only thing to say is that it is 'good' practice and in accordance with what the rest of the Urology Team do.

Concern 2 – I'll change this to reflect notes in his office shouldn't be stored unnecessarily or for longer than is required for the care of a patient.

Concern 4- how will this be monitored? What is the process? This is very hard to monitor. The previous process has always been that Mr O'Brien picked the patients for his lists, then he ring them himself and go through all the details with them of what they were coming in for, what they to do before coming in e.g. medications etc….. (part of his problem with time management) we had no control on what he scheduled hence how the private patients were added on without our knowledge. so one of the things that can be done to prevent this is, that the secretary schedules the patients, checks the list with him and she then sends for the patients rather than him picking and ringing them himself, this will then be in keeping with the rest of the Urology Team. If there is no agreement on this then the only other way of monitoring is that once the list has been compiled I will have to go through the patients to see when they were added to the waiting list and to make sure that they haven't been seen by him privately.

Thanks

Siobhan

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**From:** Carroll, Ronan
**Sent:** 08 February 2017 15:22
**To:** Corrigan, Martina; Hynds, Siobhan
**Subject:** RE: Return to Work Action Plan February 2017 (2)
**Importance:** High

Martina tks
Siobhan please see amended AP for AOB

*Ronan Carroll*
*Assistant Director Acute Services*
*ATICs/Surgery & Elective Care*
Personal Information redacted by the USI

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**From:** Corrigan, Martina
**Sent:** 08 February 2017 15:20
**To:** Carroll, Ronan
**Subject:** Return to Work Action Plan February 2017 (2)

Ronan

See my amendments – happy to discuss further. I am assuming that the timeliness of ward rounds etc. will be discussed as part of the review of his job plan?

Regard

Martina

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

Mobile : Personal Information redacted by the USI

## Carroll, Ronan

**From:** Corrigan, Martina
**Sent:** 09 May 2022 17:21
**To:** Carroll, Ronan
**Subject:** FW: urology e-triage

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**From:** Corrigan, Martina [redacted]
**Sent:** 03 March 2017 09:36
**To:** Glackin, Anthony [redacted]; Haynes, Mark [redacted]; O'Brien, Aidan [redacted]; ODonoghue, JohnP [redacted]; Young, Michael [redacted]
**Cc:** Carroll, Ronan [redacted]; Clayton, Wendy [redacted]
**Subject:** FW: urology e-triage

Hi all

See below – all in line for going 'live' with e-triage for urology on 29 March.

Martina

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


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

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**From:** Cunningham, Kate
**Sent:** 03 March 2017 09:34
**To:** Corrigan, Martina
**Subject:** urology e-triage

Martina
All appears to be on line for rollout of urology e-triage on the 29/3. As discuss Katherine Robinson will need to attending to discuss roll out, discharge codes and other vital information required for smooth implementation. Can you ensure an invitation is sent to her. Thank you.
Kate

## Carroll, Ronan

**From:** Corrigan, Martina
**Sent:** 09 May 2022 17:24
**To:** Carroll, Ronan
**Subject:** FW: AOB

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**From:** Corrigan, Martina [redacted]
**Sent:** 13 March 2017 07:10
**To:** Carroll, Ronan [redacted]; Weir, Colin [redacted]
**Cc:** Hynds, Siobhan [redacted]
**Subject:** RE: AOB

Ronan

I have forwarded the notes of the meeting to you this morning.

Colin is working with Mr O'Brien on his JP as this hasn't been signed off as yet.

Regards

Martina

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


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***EXTERNAL :*** [redacted]
***Mobile:*** [redacted]

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**From:** Carroll, Ronan
**Sent:** 12 March 2017 20:24
**To:** Corrigan, Martina; Weir, Colin
**Cc:** Hynds, Siobhan
**Subject:** AOB
**Importance:** High

Martina
I am keen to read the note of the meeting held with AOB last week.
Can you confirm what his JP is so that the auditing processes can be commenced
Ronan

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

## Carroll, Ronan

**From:** Corrigan, Martina
**Sent:** 09 May 2022 17:24
**To:** Carroll, Ronan
**Subject:** FW: wrong notes sent through earlier - Meeting with Mr O'Brien and Mr Weir 9 March 2017V2
**Attachments:** Meeting with Mr O'Brien and Mr Weir 9 March 2017V2.docx

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**From:** Corrigan, Martina [Personal Information redacted by the USI]
**Sent:** 13 March 2017 08:12
**To:** Carroll, Ronan [Personal Information redacted by the USI]
**Subject:** wrong notes sent through earlier - Meeting with Mr O'Brien and Mr Weir 9 March 2017V2

Sorry Ronan

I had sent the wrong version through to you earlier. This is the updated one that I had amended yesterday.

Martina

Martina

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


***INTERNAL: EXT*** [Personal Information redacted by the USI] ***if dialling from Avaya phone. If dialling from old phone please dial*** [Personal Information redacted by the USI]
***EXTERNAL :*** [Personal Information redacted by the USI]
***Mobile:*** [Personal Information redacted by the USI]

# Meeting with Mr O'Brien, Mr Weir, Mrs Corrigan
# 11:30am – 9th March 2017 – AMD Office – Admin Floor

Purpose of the meeting was as a follow on from Mr O'Brien's return to work meeting that took place with Mr O'Brien and Mr Weir on Friday 24 February 2017. (Mrs Corrigan was on Annual Leave).

Following topics was discussed:

1. **Enniskillen Clinics**

   Mr O'Brien reiterated his wish to go to the clinics in South West Acute Hospital (SWAH) on a monthly basis as he felt that it wasn't fair that patients had to travel. Mr Weir advised that it wasn't that we would be stopping him from doing these clinics altogether but this was to facilitate his return to work after surgery and that we planned to reinstate them after a few months. However, Mr O'Brien advised that he was feeling much better since his surgery and that the journey would no longer be an issue for him and again this was needed to accommodate the Fermanagh patients and prevent them having to travel.

   It was agreed therefore that he could start back as soon as possible and that Mrs Corrigan would look to see when the next suitable date would be. *Follow-up note: Mrs Corrigan has checked and there are no suitable Monday's available in April:*
   *3rd – Review Clinic booked for CAH*
   *10th – Mr O'Brien is Urologist of the Week*
   *17th – Easter Monday*
   *24th – Mr Young has a clinic*
   *Mrs Corrigan has advised Mr O'Brien of this by email and that the next clinic would be held on Monday 8th May 2017.*

   Mrs Corrigan also to check is it possible to for Mr O'Brien to use his laptop in SWAH and do his digital dictation from there.
   *Follow-up note: Mr Young is going to SWAH on Monday 13th March and has agreed to trial this on his laptop and report back, if this doesn't work then Mrs Corrigan to contact IT in SWAH to see is there any way that we can link their digital dictation to our systems.*

   It was agreed that Mr O'Brien would see 16 patients (8 x AM and 8 x PM) on these clinics and that he would get one hour to dictate at the end of the clinic. Mr O'Brien agreed to this and that he would not leave SWAH until all the charts had been dictated on.

   Mr Weir asked Mr O'Brien was this fair and to which Mr O'Brien replied '*nothing about job plans was fair*'.

One point that hasn't been agreed from this meeting and needs followed up is in respect to returning the notes after the clinic – Mrs Corrigan to action.

## 2. Admin since return to work

Mrs Corrigan asked on clarification on the backlog that Mr O'Brien's secretary had reported that she was doing and Mr O'Brien advised since his return to work he had been doing any outstanding Admin/Results etc. that had not been done whilst he had been off and this included patient follow-up from his diaries. Mrs Corrigan said that there should be no information kept in diaries and that it all needed to be recorded on PAS. Mr O'Brien assured Mrs Corrigan and Mr Weir that it was all also on PAS.

*Note for clarification for MC – can I ask for these diaries to do a cross-check??*

## 3. New Outpatient Clinics

Mr O'Brien advised Mr Weir and Mrs Corrigan that he no longer felt it was fair that he would continue to see New Outpatients. Mrs Corrigan advised that this was not feasible as all Consultants needed to see New Outpatients. Mr O'Brien clarified that the reason he felt this was because he had the most patients waiting to be operated on with the longest waiting times and that it wasn't fair for him to continue to see new patients and adding to his waiting list as he couldn't deal with them.

Mrs Corrigan clarified that Mr O'Brien didn't have the most nor the longest waiting times for In and Day patients:

| | | |
|---|---|---|
| Mr Young | - | 228 patients (162 weeks) |
| Mr Suresh | - | 267 patients (93 weeks) |
| Mr O'Brien | - | 257 patients (152 weeks) |
| Mr Haynes | - | 191 patients (143 weeks) |
| Mr Glackin | - | 146 patients (62 weeks) |
| Mr O'Donoghue | - | 134 patients (101 weeks) |

Mrs Corrigan gave further detail on Mr O'Brien's total waiting with their longest waiting times:

| | |
|---|---|
| Daycases: | 37 Urgent (longest waiting 110 weeks) |
| | 25 Routine (longest waiting 137 weeks) |
| Inpatients | 124 Urgent (longest waiting 148 weeks) |
| | 71 Routine (longest waiting 152 weeks) |

Mr O'Brien advised that he didn't agree with classifications of an *Urgent* or of a daycase and that whilst these were the numbers waiting they should be classified differently.

*Follow-up note – Mrs Corrigan to work with Mr O'Brien to get these validated and classified accordingly.*

*Of note – after the meeting and as a result of outcomes from the outstanding undictated clinics that the other consultants have started to go through there will be more needing to be added to these waiting lists.*

**4. Annual Leave**

Mr O'Brien had previously requested Mrs Corrigan to provide him with how many annual leave days he had taken to date. This was emailed through to Mr O'Brien on 7th March 2017:

*Dear Aidan*

*As discussed your annual leave year commences on 1 July each year. I have recorded that up until today you have taken 18 annual leave days leaving you with 16 days to take before 30 June 2017.*

*I have also noted that you hope to take a further 4 days in April (14th, 19-21st) and I have noted this on the Annual Leave sheet.*

Mrs Corrigan asked Mr O'Brien if this was ok to which he advised he hadn't had a chance to look at this but that there was also 12 July 2016 that Mrs Corrigan hadn't added in when he came in and operated all-day on a patient of his and of note he wasn't oncall.

*Follow-up, Mrs Corrigan to clarify if this should be added in as it wasn't an oncall day-in-lieu.*

Mr O'Brien also asked for clarity on how many days he was entitled to and Mrs Corrigan advised him that he was entitled to 34 annual leave and 10 Bank Holidays. He asked for clarity if this was worked out as per his job plan which is how it is worked out in England and Mr Weir advised that for our Trust we followed a regional policy and that it was 32 days up until 7 years and then 34 days thereafter.

Mr O'Brien then advised that he was holding the last week in March for a court case (Mrs Corrigan was not aware of these dates), and that he had got word to say he was no longer needed to appear in Court but that he still wanted to take the Monday 27th and Tuesday 28th March off as Annual Leave, Mrs Corrigan advised that there was a New outpatient clinic set up for Mr O'Brien but as no patients had been booked she would cancel same and noted the annual leave dates.

## 5. Review Backlogs

Mrs Corrigan asked for clarification on the review oncology patients that Mr O'Brien had been booking to his clinics and that he kept referring to in conversations.

Mr O'Brien advised that for all of his Oncology patients he kept this information in a diary, i.e. he took a patient detail label and stuck it in the diary with notes for when they were due a review and anything that needed to be done with the patient. Mrs Corrigan and Mr Weir advised that this was causing them a lot of concern because although Mr O'Brien knew no-one else knew and if something happened to him this information would be lost. But he assured Mr Weir and Mrs Corrigan that these were on PAS.

*Again an MC note – can I ask for these diaries so I can cross-reference*

Mrs Corrigan shared Mr O'Brien's Review Urgent Outpatient backlogs:

| | |
|---|---|
| CAOBUO (oncology reviews) - | 2014 = 89 |
| | 2015 = 77 |
| | 2016 = 46 |
| | End of March 2017 =32 |
| | **Total = 244** |
| EUROU = Enniskillen Urgent | 2014 = 1 |
| | 2015 = 1 |
| | 2016 = 25 |
| | End of March 2017 = 32 |
| | **Total = 63** |

Mr O'Brien asked for clarity on how the patients were identified for the Enniskillen Urgent Review list and Mrs Corrigan advised him that if not specified then the patient if seen originally as an urgent patient then they will remain as urgent unless otherwise directed.

Mr O'Brien also advised that the patients whilst on the oncology review clinical code (CAOBUO) they were not all oncology as the list was a combination of urgent and oncology. Mrs Corrigan asked would it be possible to validate this list and separate out the oncology patients as again this is very concerning that we do not have a handle on what is Oncology and what is Urgent.

*Follow-up: Mrs Corrigan to provide patient detail on the CAOBUO review backlog and can work through getting the urgent patients moved to a different code:*

**NOTE:** after the meeting Mr O'Brien and Mrs Corrigan walked together to the Urology Departmental meeting and discussed the reviews. Mr O'Brien advised that he actually contacted a lot of patients by phone and discussed their follow-up and that there was no recognition of this. Mrs Corrigan advised

him that it was imperative that he dictated on these patients as not only was it away of capturing this activity but it was a record of the decisions that had been made on the patient because again the Trust didn't have any record of this.

## 6. MDT

Mr O'Brien raised about the Urology Oncology MDT and advised Mr Weir and Mrs Corrigan that he was no longer prepared to operate on a Wednesday until 8pm then go home and preview for the next day's MDT as he had done in the past. He advised Mr Weir and Mrs Corrigan that he hadn't quite made up his mind if he was going to continue with chairing this MDT group but if he did continue then he wouldn't be coming into work on a Thursday morning but the time would be spent previewing for the MDT. Mr O'Brien advised that he spends considerable time preparing for the meeting if he is going to Chair and that he went through all patients in great detail including all their images. He also advised that in the past he had spent considerable time after the MDT correcting the outcomes i.e. grammar etc. He advised that he prided himself on having one of the best-prepared and well-run MDT's.

Mrs Corrigan advised that as Mr Glackin was now the Lead for MDT that he should speak with him to determine his views on this.

*Follow-up note: Mrs Corrigan spoke with Mr Young who felt that it Mr O'Brien wants to continue to Chair then he should drop his theatre session once per month and give it to the Locum Consultant and this would allow him to do the preparation for the MDT.*

## 7. Investigation

Mr O'Brien raised the Investigation and the worry it was causing him. He said that he wasn't sleeping and that it was more now the mental stress that this was causing him rather than the physical. He advised that he was suffering from bad headaches and needed to go to bed early (he also advised that he was on antibiotics for a sinus infection). He told Mr Weir and Mrs Corrigan that he had a pain from his neck into his arm and that his eyesight had really deteriorated and that he needed new glasses. Mrs Corrigan asked him did he want to be referred back to Occupational Health? He replied that his wife had mentioned the same but he wasn't sure. Mr Weir discussed with him that he should attend his own GP as it sounded like he was suffering from anxiety. Mr O'Brien said he knew his GP – Dr Miller well, but of note Mr O'Brien didn't agree to go and see Dr Miller.

*Follow-up: Mrs Corrigan to check with Mr O'Brien on his health and again ask does he want to be referred to Occupational Health.*

Mr O'Brien told Mr Weir and Mrs Corrigan that whilst he had had an indication that the Investigation would be complete by mid-April he had no indication on

when he would be called for interview. He requested that when this would happen that he would have no clinical activity before or on the day of the interview. Mrs Corrigan advised that she would speak with Mrs Hynds and see if the Investigation Team had any approximate timescale for Mr O'Brien's interview and that she would ensure that his clinical activity for that day would be cancelled.

## Carroll, Ronan

**From:** Corrigan, Martina
**Sent:** 05 May 2022 12:45
**To:** Carroll, Ronan
**Subject:** FW: AOB Action plan

Note below, but I can confirm that I continued to monitor on weekly basis until I went off in June 2018 [redacted] Personal Information redacted by the USI .

Martina

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**From:** Corrigan, Martina [redacted] Personal Information redacted by the USI
**Sent:** 23 November 2018 13:22
**To:** Khan, Ahmed [redacted] Personal Information redacted by the USI
**Cc:** Hynds, Siobhan [redacted] Personal Information redacted by the USI >; Carroll, Ronan [redacted] Personal Information redacted by the USI
**Subject:** RE: AOB Action plan

Thanks and I am happy with this plan

Regards

Martina

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

***INTERNAL: EXT*** [redacted] Personal Information
***EXTERNAL :*** [redacted] Personal Information redacted by the USI
***Mobile:*** [redacted] Personal Information redacted by the USI

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**From:** Khan, Ahmed
**Sent:** 23 November 2018 13:16
**To:** Corrigan, Martina
**Cc:** Hynds, Siobhan; Carroll, Ronan
**Subject:** RE: AOB Action plan

Martina, Please note I would only need monthly reports or earlier only if any issues.

Thanks
AK

On 23 Nov 2018 13:09, "Corrigan, Martina" [redacted] Personal Information redacted by the USI wrote:
Dear all,

As requested, please see below for this week commencing 23 November 2018
(Please note that Mr O'Brien was supposed to be oncall this week but had to go off and his oncall week including the triage was covered by his colleagues)

**CONCERN 1** – There are 0 letters waiting on etriage for Mr O'Brien:

**CONCERN 2** – there are currently 27 casenotes tracked on PAS to Mr O'Brien's office.

**CONCERN 3** – Mr O'Brien has 0 clinic letters waiting on digital dictation

**CONCERN 4** – adhered to – no more of Mr O'Brien's patients that had been seen privately as an outpatient has been listed,

Should you require anything further, please do not hesitate to contact me.

Martina

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

***INTERNAL: EXT*** Personal Information redacted by the USI
***EXTERNAL :*** Personal Information redacted by the USI
***Mobile:*** Personal Information redacted by the USI

## Carroll, Ronan

**From:** Glackin, Anthony [redacted]
**Sent:** 26 August 2020 17:55
**To:** Carroll, Ronan
**Cc:** Corrigan, Martina
**Subject:** FW: Phlebotomy Pilot

Dear Ronan,
Urology has a need for
PSA testing in prostate cancer patients ( 1-4 times per year for life depending on the patients management plan, I estimate that we have up to 900 such patients across the team)
U&E tests to permit red flag CT and MRI scanning for new referrals (we receive approximately 160 referrals per week, I estimate 50 need bloods before imaging)
U&E tests for kidney cancer follow up (1-2 tests per year up to 10 years, I estimate that we have about 300 and 400 patients, largely between Mark and myself)

At present our GP colleagues have been broadly accommodating to Urology patients if we provide forms and stickers. I appreciate that the landscape has changed and they may not be willing or able to provide this in the future.

Kind regards

Tony

**From:** Medical Directors Office
**Sent:** 26 August 2020 15:59
**To:** Acheson, Janet; Adams, Dr Beverley; Aljarad, Bassam; Green, Andrea; Arava, Shiva; Armstrong, Matt; Bennett, Tim; Best, Stephen; Boggs, Edgar; Boyd, Kathryn; Bradford, Christina; Bradley, Una; Brady, Aidan; Brown, Jeffrey; Brown, Martin; Brown, Robin; Browne, Gail; Bunn, Jonathon; Bunting, Helen; Campbell, Clarke; Campbell, John; Campbell, PatriciaM; Carson, Anne; Cassidy, Lisheen; Chada, Neta; Clarke, Chris; Clarke, Rosemary; Conlan, Enda; Convery, Rory; Cosgrove, Jenny; Cotter, Paul; Coulter, Paul, G; Craig, David; Cullen, Aidan; Cunningham, Marietta; Curran, Judy; Currie, Aoife; Daly, Cathy; Damani, Nizam; DeCourcyWheeler, Richard; Donnelly, Brian; Doyle, Timothy; East, Adrian; Eedy, David J; Epanomeritakis, Manos; Ervine, Aaron; Farnan, Turlough; Fawzy, Mohamed; Flannery, Daniel; Forbes, Raeburn; Foy, Allister; Gilpin, David; Glackin, Anthony; Gormley, Damian; Gorski, Michal; Gracey, David; Graham, David; Gray, Alastair; Grier, David; Gupta, Nidhi; Hamilton, Beverley; Hampton, Gareth; Hanna, Heather; Harty, John; Haynes, Mark; Henderson, Jonathan; Hewitt, Gareth; Hillemand, Christophe; Hussain, Mumtaz; Lewis, JulieZ; McAllister, Charles; McCauley, Chris; McCormick, Eleanor; McCutcheon, Fiona; McIntyre, Gemma; McKeating, Cara; McKeown, Ciara; McKillop, Derek; McLoughlin, Laura; Millar, Sarinda; Ahmed, Gamal; Chinnadurai, Anitha; Goddard Karen; Henry, Rebecca M; Holmes, Erskine; Hughes, James; James, Barry; Jamison, Michael; John, Alexander; Johnston, Dr Linda; Jones, Michael; Kamath, Meeta; kearney, Angela; Khan, Ahmed; Khan, Sana; King, Eimear; Knox, Andrew; Korda, Marian; Kumar, Devendra; Lewis, Alastair; Leyden, Peter; Lichnovsky, Erik; Liggett, Nathaniel; Loane, Katharine; Lowry, Darrell; Mackle, Eamon; Maiden, Nicola; Martin, Laure; Mathers, Helen; Mathers, Rachel; McArdle, Gerarde; McCaffrey, Patricia; McCaul, David; McClean, Gareth; McClelland, Anthony; McConaghy, Paul; McConnell, Mae; McConville, Richard; McCormick, Tim; McCracken, Geoff; McEneaney, David; McGalie, Clare; McGarry, Paul; McGleenon, Bronagh; McGovern, Anna; McGrath, Conor; McGucken, Paul; McKay, Damian; McKee, Raymond; McKenna, Michael; McKeown, Ronan; McKinney, Karen; McKnight, Karen; McLoughlin, Caroline; McMahon, Dr; McMurray, David; McNaboe, Ted; Menown, Ian; Merjavy, Peter; Milligan, Aaron; Mills, Heather; Minay, Joanne; Mkandawire, Mercy; Mlodzianowski, Artur; Moan, Shane (Michael-John); Morgan, Neal; Morrow, Michael; Mulroe, Teresa; Murphy, Seamus; Nicholson, Gail; OHagan, Art; Morris, Osmond; Patton, David; Southwell, Chris; Yousuf, Imran
**Subject:** Phlebotomy Pilot

***Sent on behalf of Dr O'Kane.***

Dear colleague,

We are expanding the drive through phlebotomy pilot in September.

Can you identify which of your outpatient groups requires to be prioritised please so that we can ensure they are offered an appointment first.

Please pass these categories to Ronan Carroll and his team

Kind Regards

Emma Campbell
Interim PA to Dr Maria O'Kane – Medical Director's Office,
Southern Health & Social Care Trust
1st Floor, Trust Headquarters, CAH

☎ External - Personal Information redacted by the USI / Internal ext: Personal Information redacted by the USI
Personal Information redacted by the USI

HSC Southern Health and Social Care Trust

Working together Excellence Openness & Honesty Compassion

HSCB/TRUST SERVICE ISSUES AND PERFORMANCE MEETING

SOUTHERN TRUST

FRIDAY 24 JUNE 2016

11.00am – 1.00pm

Conference Room 3, 2nd Floor, HSCB, Linenhall Street

AGENDA

1. Welcome and introductions

2. Overview of 2016/17 performance meetings

3. 2016/17 CPD standards/targets – Reference Trust Board Monthly Performance Report for May (to follow)

- Elective care (Esther)

(SBA performance year end report attached – SBA improvement plans all submitted only risk is with delivery of General Surgery IP/DC which will not return to profile – work ongoing to review this position)

SBA - Any emergent issues associated with manpower will be escalated at end of quarter 1)

£700k non recurrent investment for long waits/safety issues in place and ongoing; non-recurrent also in place for Endoscsopy (Trust formally assessing max levels it can deliver and will respond formally) and diagnostics

- Unscheduled care (Esther)

4-hour/12 hour position

- Cancer services (Esther)

14 –day breast/31/62 day position

- Mental health and learning disability services (Lesley) –

Reference brief from Bryce McMurray (attached)

- HCAI (Richard)

4. Children's services

- Unallocated cases (Lesley ) _

Reference Update from Paul Morgan copy of our internal Unallocated Cases report for May 16 which goes to Trust Board. As you will see:-

5. Service delivery risks

- GP OOH (Angela) – Brief attached as per Health Committee
- Manpower (Aldrina /Richard/Angela ) brief attached as per Health Committee
- Daisy Hill – Richard (brief attached as per Health Committee)

6. Reform and modernisation

- Unscheduled Care (Aldrina)

7. AOB

Performance meeting – Agenda item 3 (mental Health)

# Performance – Mental Health & Disability – June 2016

1. 9 weeks to access Adult Mental Health Services - RED

For the past 3 years the Directorate has repeatedly referenced in the Trust TDP that achieving this target would only be possible if there was no surge in demand and/or a loss of capacity to meet demand.
During the 3rd quarter of 15/16 the service experienced a surge in demand by 20% compared to the same period in the previous year, combined with a loss of capacity through an increased number of practitioners on long-term sick leave.
The division focused on meeting all urgent referrals and in doing so this extended the waiting times for routine referrals beyond the 9 week target. There is also a direct correlation between extended waiting times and a subsequent increase in urgent referrals, as some GP's attempt to circumvent waiting times greater than 9 weeks.

The division has worked hard to address the waiting time issue by:

- Diverting agreed referrals to an independent sector provider (note contract procured and awarded to Praxis – although currently in formal performance management procedures to address underperformance)
- Additional clinics – small in number and having only a minimal impact
- Ongoing audit of DNA rates with systemic and practitioner level initiatives to reduce DNA rates and increase capacity lost.

The situation is improving although the Division recognises that the volatile relationship between demand and capacity can combine to extend the waiting times at any point during the year.

2. Psychological Therapies – 13 week Target – RED
Has improved but waiting times are likely to increase again given the number of vacant psychology posts and the difficulties associated with recruiting and retaining staff. The division will take forward plans to realign the remaining psychology staff and focus this measure on those most in need.

3. Dementia Services - RED
Current revisions to screening clinics are having a positive impact on waiting times with a projected return to the 9 week target in the next few months. Additional Psychiatrist of Age will complete a number of additional clinics commencing September which will aid the current situation.

4. Carers Assessments - AMBER
Mental Health Services secured additional funding for carers short breaks from the SLCG in 2015/16. An administrative access process was put in place which was underpinned by the submission of completed carers assessments. During 2015/16 ad additional 221 short breaks for carers were funded. Further work is required to ensure that credit for all of this additional work and performance is captured in the appropriate performance reports

5. Direct Payments - AMBER
Direct Payments in MHD has remained relatively static. Population in MHD is also relatively static.

6. Patient Discharge - Learning Disability – AMBER / Mental Health GREEN

There continues to be a consistently small number of delayed discharges from acute mental health and learning disability impatient services. While progress for individuals is made, a new population continues to emerge.

The main issue remains a constant throughout, in that there remains a dearth of appropriately supported community accommodation that can care for the complexity of need, especially in relation to behaviours that challenge services. The Directorate continues to work with the independent sector to provide for this client group, although progress can be slow. It should be noted that the Southern Trust no longer has access to long-stay hospital provision.

Agenda item 4 (childrens)

Reference Unallocated cases report attached

- We have consistently been below the regional average over the last 6 months.
- We have no unallocated child protection cases
- All child protection referrals are seen and spoken to within 24 hours (the Regionally agreed timescale)
- We have a clear pathway for referrals and allocation, that we constantly review and refine (eg applying GAIN Audit/Methodology)
- We have robust monitoring and review systems in place at Team Manager, Head of Service and AD level. Also regular scrutiny at Trust Board.
- Our longest waiting was 22 weeks for March; 25 weeks for April and under 20 weeks for May 16. Again this is favourable for the region, with the exception of WT and NT (18 & 15 weeks).

Agenda Item 5

Service pressures/issues –

## The Southern Trust's key challenges in 2016/17

1. Workforce
    a. Medical
    b. Nursing
    c. Other staff groups
2. GPOOH
3. Elective Care / Access
4. Unscheduled Care Demand

1a .Medical Workforce – Recruitment Difficulties

The Southern Trust is experiencing difficulties with service provision in a number of 'hard to fill' specialties, especially at consultant and middle grade level. Some of these specialties now appear in the Government's UK shortage occupation list.

In addition, the Northern Ireland Medical and Dental Agency (NIMDTA) have notified that there is likely to be a significant number of unfilled junior doctor posts in core medicine from August 2016. Following round 1 recruitment, there are currently two vacant posts in Craigavon and two vacant posts in Daisy Hill in core medicine.

The following specialties are currently presenting significant challenges for the Trust in terms of medical vacancies:

- Dermatology – NI has a relatively small number of Dermatology training posts and consequently this leads to a small number of trainees coming through for consultant posts.

- Consultants & Specialty Doctors in Emergency Medicine - significant difficulties recruiting to Emergency Medicine – particularly for Daisy Hill. During 2015, the Trust advertised on four occasions for Consultants and on nine occasions for SAS doctors. Three SAS doctors were appointed, however one of the doctors has since resigned and another is not able to take up post until she completes her training in August 2016. There have been a number of resignations from senior staff in Emergency Medicine since the beginning of 2016. Four consultants have resigned. This includes the Associate Medical Director, the Clinical Director and the Lead Consultant in Daisy Hill. A permanent Specialty Doctor has also resigned in Daisy Hill. More recently we have managed to successfully appoint three consultants; however two of the consultants were not willing to commit to Daisy Hill, due to the lack of SAS (middle grade) support. They have since accepted posts in CAH. The third consultant is unable to take up post until October/ November 2016.

- Consultant Radiologists – The gap in Consultant Radiologist numbers is now included in the Government's shortage occupation list. A regional recruitment initiative is currently under way to try to attract Consultant Radiologists. The Trust has actively pursued recruitment and has successfully appointed a number of Consultant Radiologists in recent years. However, some have since left to take up posts in other Trusts. The situation remains unstable, mainly because all Trusts are competing against each other for a relatively small number of eligible doctors

The Trust is currently engaged with A-Team Healthcare Recruitment Ltd in a campaign to source European Doctors for a number of hard to fill specialties including Emergency Medicine. In addition, the Trust also committed to a recruitment campaign during 2015 with medical recruitment specialists in England who undertake recruitment project work for NHS Trusts and Health Boards on behalf of Doctors.net.uk. This was unsuccessful in securing additional appointments.

1b. Nursing Workforce – Recruitment Difficulties

In line with the UK wide shortage of registered nurses there are currently approximately 98 vacant posts (*across all branches of nursing*) remaining unfilled within the Southern Trust. The area with the highest shortage is in Adult Nursing as shown below:

- 55 vacant posts in adult nursing (35 Non-acute, 13 Acute medicine, 5 surgery, 2 ATICS)
- 11 vacant posts in childrens nursing
- 31 vacant posts in Mental Health and
- 1 vacant post in Learning Disability services

In addition to permanent vacancies, the Trust has experienced significant difficulty in securing additional flexible 'temporary' staff to support period of peak pressures including additional bed capacity and cover for temporary vacancies.

The Trust welcomes the announcement of additional pre-registration places however, given the scale of vacancies across the region, this number falls well short of required numbers ,with global shortage expected to peak in 2020.

During 2016/17, the Trust will be taking forward an increase in nurse training numbers via Open University to 23. The Trust has also progressed a range of innovative approaches to recruitment including a radio/online/social media/universities advertising campaign, one- stop recruitment days, and the Trust is leading the region in local, regional and national recruitment activities and is actively involved in work to progress International nurse recruitment. Whilst, significant progress (c. 40 posts) has been made in respect of international recruitment, it is likely to be 9-11months before any additional nursing staff will be in place.

The Trust also has a problem with availability of specialist nurses eg Parkinson's, Heart Failure and Palliative care etc. There are workforce issues around lead in training time, and problems with backfill difficulties, particularly for sole postholders.

1c. Other Workforce Challenges

- Mental Health services continue to face challenges linked to the availability of trained adult mental health nurses & also qualified Clinical Psychologists. Insufficient numbers of specialist staff are being trained annually and Trusts are competing to offer posts.
- Geriatric Medicine: shortage of Consultant Geriatric Medical staff; impacting Acute Care at Home
- Domiciliary Care Service: need to recruit 120 new staff each year to replace leavers.
- Day Care (MH & LD): 25 vacancies across the Trust, recent advertisements have been unsuccessful.

2. GP Out of Hours

GPs employed in the service work during the day in local GP practices where there is already a shortage. There is no contractual obligation to work within GPOOHs. Aligned with active promotion via social media of the 'Choose Well' campaign, the Trust has in place a GPOOH Action Plan to address challenges within this service and has included for example:

- Offering GPs additional flexibility in shifts/ bases of work
- Worked with HSCB to develop a LES for GPOOH
- Implementation of a 'Home Triage' pilot
- Utilisation of Nurse Triage and Nurse Practitioners in OOH including contracting with Dalraida to triage between 6pm and 8am
- Implementing additional cover (3rd red eye shift) Dec 15- End of April during peak periods over weekends to Monday
- Use of clinical pharmacists in the OOH
- Development of additional payments scheme

The main issues contributing to the difficulties in securing medical cover include:

- Training of GPs – 100 need to be trained annually to fill the vacancies in general practice. Currently maximum of 65 completing training and high levels opting for P/T working
- Recruitment of new GPs to OOH – From Jan 16, 3 new GPs however, others reducing their shifts
- Maternity/ sick/career breaks/ resignations - Small pool of hard working GPs significant difficulty providing cover. Sick leave and 2 GPs taking career breaks impacting on 'red eye' shift

- Indemnity costs – increased costs a disincentive to work over the hours agreed with the medical defence organisations
- Take home pay - GPs claim this is reduced due to indemnity, higher superannuation and loss of tax free allowances
- Day time GP role – increasing demand for GPs in hours

Any reduction in service cover has potential to increase risk and increase numbers of people choosing to attend Emergency Departments.

3.Elective Care/ Access:

Regional estimates indicate an increase in elective referrals of 6% year on year. In the context of on-going financial constraints the Southern Trust will experience significant challenges in delivering elective access targets. Key challenges include:

- Demand exceeding commissioned
- Recurrent investment insufficient to address capacity gap
- Limited non-recurrent funding will mean there is likely to be significant additional capacity provided this year.

The Trust will continue to take the following actions to manage lists:

- Monitoring access for red flag and urgent cases and prioritising capacity to meet this demand
- Strict chronological management of routine patients
- Actively working to limit lost capacity through DNAs or cancellations on the day
- Monthly information provided to GPs on waiting time for specialties.

4. Unscheduled Care Demand

The Trust experienced an increase of over 10% in ED attendances in the 5 years prior to 2015/16. In addition, there were 6,000+ additional attendances in 15/16 from 14/15 representing an overall increase of 4%. Of these attendances, 81% were triaged as Category 1 – 3 (Immediate, very urgent or urgent).

This increased demand and overreliance on hospital services had resulted in 'winter' pressures now being experienced as sustained peak pressures throughout the year with no flexible bed capacity and / or available workforce to respond. 2016/17 Southern Trust will be increasingly challenged in respect of achieving effective patient flow. May 2016 has seen the highest ED attendances from April 2015 across Craigvon and Daisy Hill ED and South Tyrone MIU.

Key challenges include:

- The Trust has low bed flexibility/ tolerance levels and needs to ensure the level of discharges is in balance with admissions.

- Quality and Safety concerns - on- going requirement to manage governance and patient experience issues re: outliers etc
- Inability to open additional bed capacity due to manpower constraints.
- Requirement to continue to maintain contingency options to flex existing bed stock with subsequent impact on elective care /cancellations.
- Reduction in community capacity to enable effective discharge particularly in rural areas e.g. Domiciliary care and nursing home care providers and capacity for specific beds e.g. EMI.

DHH Strategic Oversight Group

Summary of Key Points (June 2016)

## Context:

A Senior Trust Oversight Group is in place to monitor USC pressures especially relating to senior medical cover in DHH ED, DHH Medicine and DHH Surgery

## Medical staffing levels:

- Operational ED medical staffing levels in CAH and DHH are well in excess of funded staff levels
- Operational ED Consultant numbers fall well short of College of Emergency Medicine guidelines
- Information in PHA Emergency Medicine workforce document shows an inequitable share of medical staffing across Trusts with Southern having the fewest

## Recruitment difficulties:

- Despite numerous trawls we struggle to secure appointments at consultant and middle grade level in ED and other specialties
- A Team project will help produce some doctors at 'SHO' level but this will not help with senior cover in any of the key specialties

## Locum expenditure:

- Due to underlying problem with staffing levels and problems with recruiting, there is an increasing reliance on locum cover at all levels
- The expenditure on ED locums has almost doubled in 2015/16 to £2.3m across CAH and DHH
- This is unsustainable

## College standards for cover during OOHs period

- Various college standards cite the need for senior cover (ST3 or above) during the out of hours period
- Trust are currently unable to meet this standard in DHH ED and only partially meet this standard in Medical and Surgery in DHH

Unscheduled Care Briefing **–** Southern Area 2015/16

Key Points:

- Demography – growth 10% higher than NI average, Growth in older people population
- Trust has optimised efficiency performance - CHKS 'top 40', triage performance, low ED conversion, lower ALOS etc.
- GPOOH – significant workforce pressures/ RQIA quality and safety
- Emergency admissions (>75 yrs) increased by 14% from 2013/14 to 2014/15 - has remained static this past year in 2015/16 – *potential impact of AC@H re: admission avoidance/ capacity c. proxy one acute ward.*
- 4 hour target: 80.1% in 2015/16. April 16 (CAH 69%, DHH 77%), May 16 (CAH 67%, DHH 75%)
- 60% of attendances triaged as Category 1-3 (immediate, very urgent or urgent)
- Increasing trend since January in ED attendances with increased peaks in consecutive days with volumes outside the normal levels for same period in previous years
- 12 hours target: 93 in 2015/16. April 16: 83 (CAH 77/DHH 5. The Daily SitRep Report indicated that the position regionally varied by site ranging from +30 - +160 during April). May16: 56 (CAH 53, DHH 3).
- May 2016 saw highest ED attendances over the past 14months (from April 2015) in all our sites: (CAH – 7305, DHH 4923, STH MIU – 2706 )
- Bed State – by HSCB/ Alamac indicated - 20 beds capacity gap. This reflects low bed flexibility/ tolerance and need to ensure level of discharges in balance with admissions. In addition, requirement to maintain quality and safety standards further impacting on need to ensure IPC, lysis and T&O c. 6 + beds.
- Quality and Safety concerns - on- going requirement to manage governance and patient experience issues re: outliers, use of inappropriate beds versus 12 hour target.
- Inability to open additional bed capacity due to manpower constraints. Trust continues to maintain contingency options to flex existing bed stock with impact on elective care – theatre/ recovery. Elective cancellations continued in April (83 cases), May (47 cases).
- Reduction in community capacity - Domiciliary care provider and Nursing home care– capacity and cost pressures in this sector. Net loss of 26 beds from 4 Seasons closure of Donaghcloney PNH, capacity for bed requirements – EMI beds
- General increase in weekly charges levied by PNH that are above the regional tariff. Requiring 3rd party arrangements

DHH

- DHH ED seeing 50,069 New/Unplanned attendances (up 10%) with 11,228 non-elective admissions (via ED and direct)
- Conversion to admission continues to be good – 18%
- DHH ED seeing increasing number of patients being referred by GPs with a letter – 5,444 (up 17%)
- DHH ED are seeing increased numbers referred by GP OOH Service – 1,229 (up 17%)
- Direct admissions to DHH have reduced significantly as activity has increased. This is due to high occupancy and means patients therefore have to attend ED
- DHH ED seeing increased numbers from SET catchment – for example numbers from Down LGD have doubled to 2,016. This can be tracked to service change in Down and Lagan valley EDs
- ROI attendances to DHH and CAH EDs are not increasing

CAH

- CAH ED seeing 81,005 new/unplanned attendances (up 4.5%) with 23,528 non-elective admissions (via ED and direct)
- Conversion to admission continues to be good – 24%
- CAH ED seeing large numbers referred by GP with letter – 11,383
- CAH ED are seeing increased numbers referred by GP OOH Service – 3,851 (up 5%)
- CAH ED seeing large number of patients brought by police / prison staff – 391 (up 50%)
- CAH ED seeing large numbers from Northern Trust – 4,638

Previous actions to address pressures / mitigate risk:

Oversight group involving PHA/HSCB/LCG agreed a range of actions to address pressures and mitigate risk as follows:

- Additional ENPs in DHH ED
- Moving towards 24*7 band 6 cover in DHH ED
- Establishment of small number of observation beds in DHH (surgery) for borderline admissions including non-specific abdominal pain
- Ongoing trawls for middle grade and consultant appointments for DHH ED
- Ongoing trawls for middle grades for DHH Medicine and DHH Surgery
- Acceptance that there would be a significant reliance on locums in the interim
- Review of further elective activity in CAH that could move to DHH
- Contingency planning in the event that cover cannot be sourced for DHH ED

Unscheduled Care Reform:

- USC Regional/ Locality structures put in place. Operational Improvement Group – Trust level specifically focused on patient flow. Key workstreams:
    - Community Pathways – GPOOH, AC@H , Rapid Assessment models and NIAS Alternative pathways
    - ED – Ambulatory services, senior decision making and flow/ communications within ED,
    - Patient Flow – ward based management of flow re: medical / MD fit, discharge planning and implementation of SAFER bundle, Daily assessment (red / green days re: patient journey), discharge to assess, ward based pharmacy.
    - Technology – maximising use of flow, IMMIX, clinical noting, Directory of Services (launch 20th June)
    - Medical Handover process
    - Bed Modelling – across acute , sub-acute, and virtual (AC@H) hospitals,
- Key analysis through locality network being undertaken to review activity over the past years – this is looking at data for acute, community and primary care. This will confirm where the pressure points are and support action planning

In summary:

Despite all efforts to date, the Trust continues to be extremely concerned with cover in DHH ED and on-going increase in USC pressures across the system.

This is further compounded by the significant increase in activity going to DHH ED.

Quality/Safety/Finance – note: 'winter' beds remain open (no funding source) as at 14th June 2016.

GP Out of Hours Summary Overview Report

## GP OOH – Contacts April 2014 – March 2016

| Ended at | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Home | 618 | 601 | 465 | 523 | 551 | 498 | 455 | 546 | 524 | 574 | 545 | 496 | **6396** |
| Base | 4195 | 4126 | 3162 | 3194 | 3041 | 2974 | 3276 | 3818 | 4005 | 3588 | 3073 | 3218 | **41670** |
| Advice | 4811 | 4536 | 4041 | 3868 | 3881 | 3280 | 3375 | 3902 | 4917 | 4521 | 4306 | 4525 | **49963** |
| **Total** | **9624** | **9263** | **7668** | **7585** | **7473** | **6752** | **7106** | **8266** | **9446** | **8683** | **7924** | **8239** | **98029** |

| Ended at | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Home | 429 | 479 | 401 | 450 | 429 | 385 | 467 | 411 | 491 | 494 | 291 | 423 | **5150** |
| Base | 3057 | 3539 | 2660 | 2838 | 2695 | 2688 | 2888 | 3122 | 3469 | 3353 | 2664 | 3292 | **36265** |
| Advice | 4421 | 4851 | 3800 | 3822 | 4082 | 3393 | 4176 | 4310 | 5170 | 5327 | 4501 | 5683 | **53536** |
| **Total** | **7907** | **8869** | **6861** | **7110** | **7206** | **6466** | **7531** | **7843** | **9130** | **9174** | **7456** | **9398** | **94951** |

## GP OOH Vacant Shift Report January – May 2016

| | Jan-16 | | Feb-16 | | Mar-16 | | Apr-16 | | May-16 | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Base** | ***Vacant Shifts*** | ***Vacant Hrs*** | ***Vacant Shifts*** | ***Vacant Hrs*** | ***Vacant Shifts*** | ***Vacant Hrs*** | ***Vacant Shifts*** | ***Vacant Hrs*** | ***Vacant Shifts*** | ***Vacant Hrs*** |
| Armagh | 34 | 144 | 57 | 245 | 24 | 102 | 22 | 92 | 20 | 87 |
| Craigavon | 48 | 247 | 74 | 374 | 63 | 329 | 35 | 184 | 28 | 145 |
| Dungannon | 57 | 307 | 85 | 424 | 55 | 302 | 23 | 118 | 38 | 197 |
| Newry | 48 | 238.5 | 57 | 292 | 39 | 197 | 35 | 187 | 35 | 181 |
| Kilkeel | 22 | 66 | 27 | 82 | 28 | 84 | 26 | 79 | 26 | 80 |
| **Total** | 209 | 1002.5 | 300 | 1417 | 209 | 1014 | 141 | 660 | 147 | 690 |
| | **Shifts** | **Hours** | **Shifts** | **Hours** | **Shifts** | **Hours** | **Shifts** | **Hours** | **Shifts** | **Hours** |
| Total Available | 645 | 3370 | 608 | 3107 | 622 | 3219 | 535 | 2824 | 561 | 2990 |
| % Vacant | 32% | 30% | 49% | 46% | 34% | 32% | 26% | 23% | 26% | 23% |
| % Filled | 68% | 70% | 51% | 54% | 66% | 68% | 74% | 77% | 74% | 77% |

## Flexible Workforce – Overtime, Bank, Agency & Locum

### Comparison of 2011/12, 2012/13, 2013/14 and 2014/15 Staff Levels (WTE), Overtime, Bank, Agency and Locum Costs and 2015/16 Costs to Date as % of YTD Total Salary Bill

| Staff Levels WTE (HRMS/HRPTS) and Costs (£) | HRMS WTE | | HRPTS WTE | | | Variance Staff WTE March 2012 and Current Month | Monthly Average Flexible Workforce Costs | | | | | | 2015/16 Costs to date as % of YTD Total Salary Bill |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline Position | | | | 2015/16 to date as at 29 February 2016 | | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2011/12 Baseline & 2015/16 YTD Variance | |
| | Mar-12 | Mar-13 | Mar-14 | Mar-15 | | | | | | | | | |
| Staff Levels WTE (HRMS/HRPTS) | 7,712.59 | 7,908.82 | 7,830.25 | 8,040.02 | 8,332.82 | 620.23 | | | | | | | |
| Overtime Cost (£) | £2,378,447 | £2,742,442 | £2,405,219 | £2,418,263 | £2,658,221 | | £198,204 | £228,537 | £200,435 | £201,522 | £241,656 | £43,453 | 0.81% |
| Bank Cost (£) | £7,988,757 | £9,427,543 | £10,316,793 | £8,880,496 | £8,524,348 | | £665,730 | £785,629 | £859,733 | £740,041 | £774,941 | £109,211 | 2.59% |
| Agency Cost (£) (including M&D Agency Costs) | £4,951,745 | £9,232,951 | £8,244,487 | £7,805,354 | £10,383,243 | | £412,645 | £769,413 | £687,041 | £650,446 | £943,931 | £531,286 | 3.16% |
| Locum Cost (£) (M&D Locum Staff employed by SHSCT) | £395,736 | £428,785 | £444,839 | £664,870 | £797,737 | | £32,978 | £35,732 | £37,070 | £55,406 | £72,522 | £39,544 | 0.24% |
| **Total Costs** | **£15,714,685** | **£21,831,721** | **£21,411,338** | **£19,768,983** | **£22,363,549** | | **£1,309,557** | **£1,819,310** | **£1,784,278** | **£1,647,415** | **£2,033,050** | **£723,493** | **6.81%** |

## SHSCT WTE Staff in Post Baseline Figures for March 2012, 2013, 2014, 2015 and 2016 Variance Information

| Personnel Area | WTE as at: | | | | | Variance Between: | | | | | | | | WTE of Personnel Area as a % of Total Staff as at March 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Mar 12 & Mar 16 | | Mar 13 & Mar 16 | | Mar 14 & Mar 16 | | Mar 15 & Mar 16 | | |
| | Mar 12 | Mar 13 | Mar 14 | Mar 15 | Mar 16 | WTE | % | WTE | % | WTE | % | WTE | % | |
| Admin & Clerical | 1,382.55 | 1,465.40 | 1,426.40 | 1,424.53 | 1,476.86 | 94.31 | 6.82% | 11.46 | 0.78% | 50.46 | 3.54% | 52.33 | 3.67% | 17.7% |
| Estates | 106.04 | 98.26 | 97.43 | 101.43 | 105.36 | -0.68 | -0.64% | 7.10 | 7.23% | 7.93 | 8.14% | 3.93 | 3.88% | 1.3% |
| Support Services | 703.82 | 671.26 | 623.10 | 595.52 | 563.06 | -140.76 | -20.00% | -108.20 | -16.12% | -60.04 | -9.64% | -32.46 | -5.45% | 6.7% |
| Nursing & Midwifery | 2,890.22 | 2,995.90 | 2,941.18 | 3,089.65 | 3,222.28 | 332.06 | 11.49% | 226.38 | 7.56% | 281.10 | 9.56% | 132.63 | 4.29% | 38.6% |
| Social Services | 1,089.24 | 1,083.93 | 1,110.42 | 1,164.58 | 1,257.23 | 167.99 | 15.42% | 173.30 | 15.99% | 146.81 | 13.22% | 92.65 | 7.96% | 15.1% |
| Professional & Technical | 1,025.77 | 1,071.67 | 1,107.10 | 1,110.23 | 1,159.31 | 133.54 | 13.02% | 87.64 | 8.18% | 52.21 | 4.72% | 49.08 | 4.42% | 13.9% |
| Medical & Dental | 514.95 | 522.40 | 524.63 | 554.09 | 561.81 | 46.86 | 9.10% | 39.41 | 7.54% | 37.18 | 7.09% | 7.72 | 1.39% | 6.7% |
| **Total:** | **7,712.59** | **7,908.82** | **7,830.25** | **8,040.02** | **8,345.91** | **633.32** | **8.21%** | **437.09** | **5.53%** | **515.66** | **6.59%** | **305.89** | **3.80%** | **100.0%** |

**Medical Workforce – Specific Detail**

- Difficulties with service provision in a number of 'hard to fill' specialties, especially at consultant and middle grade level. Some of these specialties now appear in the Government's UK shortage occupation list.
- Northern Ireland Medical and Dental Agency (NIMDTA) notification that there is likely to be a significant number of unfilled junior doctor posts in core medicine from August 2016. Following round 1 recruitment, there are currently two vacant posts in Craigavon and two vacant posts in Daisy Hill in core medicine. NIMDTA have still to undertake CT1-2 LAT interviews and complete the 'combined specialty training' option, however it is understood that numbers are small so this is unlikely to have a significant impact on vacancies.
- The following specialialites are currently presenting significant challenges for the Trust in terms of vacancies:

**Consultant Dermatologists**

- A meeting with the HSCB commissioners is being planned to review the Dermatology service
- Recognised shortage of trained Dermatology Consultants in the UK. NI has a relatively small number of Dermatology training posts and consequently this leads to a small number of trainees coming through for consultant posts. One trainee recently achieved CCT; however she has since taken up a post in the Belfast Trust.
- Dermatology trainees have not been required to rotate through SHSCT as part of their training, so local trainees are more inclined to take up posts in Belfast where they are more familiar. It has now been agreed that one registrar will rotate to Craigavon every Thursday, so this should help.
- Two retired consultants continue to undertake some waiting list initiative clinics for Dermatology. There has also been an expansion in nurse led clinics in Dermatology.
- Trust advertised for Consultant Dermatologists on 4 occasions during 2014. One person applied to the first advert. This doctor was offered the post but declined. No further adverts were raised during 2015 on the advice of management in Dermatology as there were no suitable doctors available at the time.

**Consultants & Specialty Doctors in Emergency Medicine**

- Significant difficulties recruiting to Emergency Medicine – particularly for Daisy Hill. During 2015, the Trust advertised on four occasions for Consultants and on nine occasions for SAS doctors. These posts were based in Daisy Hill or there was a requirement to rotate to Daisy Hill as part of the job plan. There were no consultants appointed. Three SAS doctors were appointed, however one of the doctors has since resigned and another is not able to take up post until she completes her training in August 2016
- Many of the above adverts were placed in the Sunday Independent and the Irish Medical Journal in the Republic of Ireland, as well as the British Medical Journal and normal recruitment channels.
- There have been a number of resignations from senior staff in Emergency Medicine since the beginning of 2016. Four consultants have resigned. This includes the Associate Medical Director, the Clinical Director and the Lead Consultant in Daisy Hill. A permanent Specialty Doctor has also resigned in Daisy Hill.
- More recently we have managed to successfully appoint three consultants; however two of the consultants were not willing to commit to Daisy Hill, due to the lack of SAS (middle grade) support. They have since accepted posts in CAH. The third consultant is unable to take up post until October/ November 2016.
- The Trust is currently engaged with A-Team Healthcare Recruitment Ltd in a campaign to source European Doctors for a number of hard to fill specialties including Emergency Medicine.

- In addition to the recruitment campaigns detailed above, the Trust also committed to a recruitment campaign during 2015 with medical recruitment specialists in England who undertake recruitment project work for NHS Trusts and Health Boards on behalf of Doctors.net.uk. This campaign included targeted listings, display banner adverts and direct emails to doctors. Over 205,000 UK GMC registered doctors were members of Doctors.net.uk at the time and the company stated there were further connections to around 100,000 doctors across Europe. Only one doctor registered interest in a post in Daisy Hill, however the doctor subsequently withdrew.

**Consultant Radiologists**

- Gap in Consultant Radiologist numbers and Clinical radiology is now included in the Government's shortage occupation list. A regional recruitment initiative is currently under way to try to attract Consultant Radiologists
- Trust has successfully appointed a number of Consultant Radiologists in recent years; however some have since left to take up posts in other Trusts – mainly for personal reasons. In Feb 2015 the Trust appointed four permanent Consultant radiologists. One candidate withdrew, however the other three took up posts in August 2015.
- Four Consultant posts have recently been advertised – Breast Imaging (2 posts), Neuroradiology and Gastroenterology/Urology. Adverts closed on 17th May 2016. There is currently only one applicant. This is for the Neuroradiology post. Interview is scheduled for 27th June 2016.
- The situation remains unstable, mainly because all Trusts are competing against each other for a relatively small number of eligible doctors
- The Associate Medical Director post in radiology is currently vacant following the passing of Dr Hall.

**Psychology**

- There are current difficulties with maintaining and recruiting psychologists. Band 7 staff leave our services to uptake posts in other trusts where they can obtain higher banding. The Trust is looking at current structures to try to redress the balance and offer more career development and opportunity.

**GP Out of Hours**

- The Trust continues to experience significant difficulties with medical cover in its GP OOHs service – regional shortage of GP's for in hours, therefore impacting on numbers willing/available to work out of hours.

**Geriatric Medicine**

- Shortage of Consultant Geriatric Medical staff – will impact on initiatives such as Acute Care at Home.

**HSCB/TRUST SERVICE ISSUES AND PERFORMANCE MEETING**
**SOUTHERN TRUST**
**WEDNESDAY 21 SEPTEMBER 2016**
**11.00am – 1.00pm**

**Conference Rooms 3 and 4, 2nd Floor, HSCB, Linenhall Street**

**AGENDA**

1. Welcome and introductions
2. Actions from last meeting (24.6.16)
3. 2016/17 CPD standards/targets
   - Elective care

***Hip fractures – 100% in August***
***noting 62% for all fractures, which is well below the regional averages; linked to demand & casemix/sub-specialism issues*
*Analysis underway of breaches to identify if specific to body parts (upper limb)*
*Trust to identify models in other Trusts*
*Future potential to operate new T&O ankle surgeon as part of network*

- Delivery of core

Do we have recovery plans /projections???
Any idea why july so poor

*Areas of underperformance, greater than 2016 in comparison to 2015, are:*

***Out-Patients:***
** Symptomatic Breast – due to medical workforce issues*
** Orthopaedics – due to Trauma and 10th Consultant in trauma facing job plan*
** Pain Management – annual leave*
** General Medicine – due to medical workforce issues – Dr Duffin on sick leave; Dr S Murphy on sabbatical from June and replacement not commenced until August*
** Endocrinology and Diabetology - ??*
** Dermatology – due to conversion of new out-patient capacity to review out-patient capacity for governance concerns*
** Thoracic Medicine – annual leave*
** Gynaecology – associated with Dr Morsy and his replacement cover*
** Urodynamics (Gynaecology) – associated with lack of demand*

***In-Patients/Day Cases:***
** Cancellations of elective activity associated with unscheduled care pressures*

| | Apr-16 | | May-16 | | Jun-16 | | Jul-16 | | Aug-16 | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | IP | DC | IP | DC | IP | DC | IP | DC | IP | DC | |
| ENT | 6 | 2 | 5 | 3 | 10 | 16 | 0 | 0 | 0 | 0 | **42** |
| Urology | 19 | 0 | 5 | 0 | 7 | 7 | 0 | 0 | 0 | 0 | **38** |
| G Surg | 0 | 1 | 6 | 2 | 28 | 15 | 0 | 0 | 0 | 0 | **52** |
| Ortho | 27 | 17 | 7 | 11 | 12 | 4 | 2 | 13 | 6 | 6 | **105** |
| Gynae | 9 | 0 | 6 | 1 | 5 | 0 | 0 | 0 | 0 | 0 | **21** |
| **Total** | **61** | **20** | **29** | **17** | **62** | **42** | **2** | **13** | **6** | **6** | **258** |

** General Surgery – change in casemix; loss of high volume low value procedures ie. Minor Ops and Robin Brown's flexible cystoscopies – new SBA proposal sent to Commissioner*
** Breast – associated with medical workforce issues*
** ENT – impact of cancellations from bed pressures*
** Gynaecology – change in casemix – new SBA proposal sent to Commissioner*

- Q1/2 Allocations (£700,000)
-

** No risk to underdelivery of £700,000*
** Any underutilisation / risk has been reallocated to other specialties to utilise*

- Diagnostics

** Neurophysiology – underperforming associated with demand*
** TTE – underperforming as SBA uplifted for investment and post only recently recruited to – also existing vacancy again only recruited to*

** CT Q1/2 OK*
** CTC awarded to 352 – date for completion extended*
** Plain Film – IS awarded and date for completion extended to mid-November*

- Endoscopy

** SBA recovery plan states will achieve -22% which equates to -1975*
** Lost 1 WTE for 2016/2017 (KB) equating to -1302*
** SBA uplifted in 2016/2017 for IPT investment – lost capacity from 1 x new Nurse Endoscopist on maternity leave*
** Endoscopy DC wait @ August 51-weeks – @ March 45-weeks*
** 1112 >9-weeks @ March – 972 >9-weeks @ August*
** 67 >26-weeks @ March – 355 >26-weeks @ August*

** Q1/2 allocations IHA overperforming – IS contract just awarded*

** Demand reviewed with HSCB on 5 August – current additionality will not return to normal*

** Would require an additional 2846 scopes along with 100% SBA and IHA/IS allocation to achieve 9-weeks routine; 6-weeks urgent; red flag 14-days; urgent planned repeat on time; routine planned repeat 6-months beyond*

** IS tested for capacity – contract awarded to one provider and available additional capacity from this provider and a second provider – could utilise subject to funding*

***AHP***
** Formal response letter submitted*
** Demography committed to gaps*
** Recruitment proceeding – anticipate posts in place February or earlier if Regional waiting lists still in place*
** Inability to clear backlog*

** SBA collectively on-track, however, Physiotherapy only profession underperforming – issues around vacancies*

- Unscheduled care

  - Resilience plan update from Trust

*(slides attached from B Conway presentation to S \McGirr)*
*Risks /Points to highlight:*
** Demand management / SLCG review and ongoing need to develop alternative pathways*
** Focus on ED paeds and older people*
** Focus on creating assessment capacity in short medium and longer term; however interim need for additional bed capacity*
** Workforce/ability to create surge capacity (medical staffing additionality essential)*
** Reduced flexible bed capacity with decant works in DHH/DHH issues*
** Ongoing community issues (stability of social care sector)*

- Cancer services

**Breast**
Heather to provide brief update on
- support from other Trusts/number of patients transferred
- Update on plan for non-urgent patients
- Number of routines and max wait time

** Routines anticipated to be waiting 37-weeks at the end of September*
** 774 over 9-weeks at the end of August with longest wait 35-weeks*

*Red flags & urgents back to 14 – 16 days currently: back to 100% October*
** Trust has secured a level of additional capacity from other Trusts to provide support to this service area during the Summer period.*
** More formal networking arrangements are required to manage this service in the medium term.*

** A scoping exercise is being undertaken with GP colleagues establish if they can provide additional capacity from GPs with Specialist Interest in the management of routine patients. Results from this exercise are awaited.*
** An Expression of Interest is being drafted to test the Independent Sector market for availability of breast assessment capacity.*

- Mental health and learning disability services

***9 weeks to access Adult Mental Health Services***

**** The number of patients waiting in excess of 9-weeks continues to demonstrate an increase. Volumes in excess of 9-weeks has increased by 241% from end of March to end of August 2016.***
**** The service have evidenced an increase in demand, 10% cumulatively, over the last 3-years. This increased demand, compounded by vacancies, is demonstrated in the growing volume of patients waiting in excess of 9-weeks.***
**** Realignment of Consultant Psychiatrists and Psychology has the potential to increase practitioner workload and reduce time available to triage***

***Actions -***
***• IS provider capacity has been increased from 60 to 100 per month for Step 2 referrals.***
***• On-going recruitment to permanent/temporary and bank for PMHC along with internal expressions of interest for additional hours.***
***• Analysis of referrals accepted to PMHC and finalisation of Urgent criteria.***
***• Development of triage and assessment centre model on-going (anticipated late 2016).***
***• Roll-out of 'Talking Therapies Hubs' to all localities, subject to receipt of additional funding (anticipated in 2017).***

** 81 patients >9-weeks @ March – 276 >9-weeks @ August*
** longest wait 32-weeks @ March (IS) – 20-weeks @ August*

*Update provided by Bryce for previous meeting.*
*For the past 3 years the Directorate has repeatedly referenced in the Trust TDP that achieving this target would only be possible if there was no surge in demand and/or a loss of capacity to meet demand.*
*During the 3rd quarter of 15/16 the service experienced a surge in demand by 20% compared to the same period in the previous year, combined with a loss of capacity through an increased number of practitioners on long-term sick leave.*
*The division focused on meeting all urgent referrals and in doing so this extended the waiting times for routine referrals beyond the 9 week target. There is also a direct correlation between extended waiting times and a subsequent increase in urgent referrals, as some GP's attempt to circumvent waiting times greater than 9 weeks.*

*The division has worked hard to address the waiting time issue by:*

- *Diverting agreed referrals to an independent sector provider (note contract procured and awarded to Praxis – although currently in formal performance management procedures to address underperformance)*

- *Additional clinics – small in number and having only a minimal impact*
- *Ongoing audit of DNA rates with systemic and practitioner level initiatives to reduce DNA rates and increase capacity lost.*

*The situation is improving although the Division recognises that the volatile relationship between demand and capacity can combine to extend the waiting times at any point during the year.*

***Psychological Therapies – 13 week Target***

*Has improved but waiting times are likely to increase again given the number of vacant psychology posts and the difficulties associated with recruiting and retaining staff. The division will take forward plans to realign the remaining psychology staff and focus this measure on those most in need.*

** 10 patients >9-weeks @ March – 83 >9-weeks @ August*
** Longest wait 21-weeks @ March – 34-weeks @ August*

4. Serious Adverse Incidents – Outstanding Review Reports

*Update for HSCB Board Directors Meeting (Margaret Marsall*

*Outstanding SAI Reports (Slide 21 of HSCB presentation)*

*Updated position for outstanding SAI Reports shows an improvement from 44 (reported in information received from HSCB) reviews to 28 outstanding as of 20th September 2016.*

*Present Position*

| | HSCB Report | New Position 21/09/16 | Acute Outstanding | CYP Outstanding | MHLD Outstanding |
|---|---|---|---|---|---|
| Level 1 | 24 | 16 | 12 | 3 | 1 |
| Level 2 | 20 | 12 | 7 | 2 | 3 |
| TOTAL | 44 | 28 | 19 | 5 | 4 |

*Please see attached updated position for SAI Reports which shows a decrease from 44 as per HSCB position at 31/7/16 to 28 as of today 20/9/16*

*Improvement Plan*

*Increased focus on strengthening our response to Adverse Incidents*

*A key element of the Trust's clinical and social care governance work programme for 2016/17 is to review how adverse incidents are managed to identify how we can further develop and strengthen a culture of safety within the Trust*

*In order to do this we need to promote and build on the fundamental purpose of patient safety investigation, which is to learn and improve. This work will provide a foundation for continuous improvement in the way we identify, investigate and learn from adverse incidents in order to minimise avoidable harm in the future.*

***Key areas of work***

- *Incident screening and apportioning of investigation resources*

- *Recommendations and Action Planning following Adverse Incident investigations*
- *Communicating Learning from Adverse Incidents*
- *Challenge and scrutiny of the Adverse Incident Process*

*The Trust are also sharing this work regionally through the Quality 2020 work streams*

***Regional Work streams***

*The Trust are also contributing to a range of regional projects to improve on our management and response to SAI's.*

- *RQIA/GAIN learning from SAI's*
- *Quality 2020 work streams – BHSCT work*
- *Regional Governance Leads Forum*

***Successful changes in approaches which will positively impact on our responsiveness and timescales for completion of reports***

- *Introduction of Child Death process*
- *Introduction of Regional MM process*
- *Falls review process*
- *Trust Training programme in place for staff – SAI investigations/incident investigations*

5. Update on TDP

*(Aldrina as per letter to DS attached)*

6. Service delivery risks (if not picked up on agenda)

- *Corporate/Cross Directorate*
  - *On-going workforce issues affecting range of services – specific any individual issues to be raised*
  - *IS regulated social care services*
    - *On-going challenges/performance management issue with IS regulated social care capacity.*
    - *Stability of sector/ability to meet unscheduled care demands*
  - *Capital Planning; thresholds /timing and impact on PALS performance*

- *Directorate specific challenges*
  - *Acute Services*
    - *Endoscopy demand; inability to reduce access times*
    - *Radiology workforce/reporting capacity; impact on reporting/scanning and impact in period of unscheduled care*
    - *Breast services; access times and current arrangements/management of risk*
  - *Older people and primary care*
    - *GP Out of Hours*

7. Reform and modernisation

*(Aldrina – update on pathway reform)*

8. AOB

# 2019/20 PERFORMANCE IMPROVEMENT TRAJECTORY

## Delivery of Core - New Outpatients

**Trust:** Southern

**PIT Lead:** Ronan Carroll, Assistant Director ATICS & SEC; Barry Conway, Assistant Director CCS & IMWH; Anne McVey, Assistant Director MUSC; Julie McConville, Assistant Director CYPS; Roisin Toner, Assistant Director OPPC

**Date Submitted (HSCB):** 14 June 2019

**Comments/escalations:** Cumulative performance for the total OP trajectory (23 specialties) demonstrates +1% (+486) above the projected levels of activity: 2 specialties (9%) are assessed as Red - **Cardiology** demonstrates -21% (-353) against the projected levels to date; **Chemical Pathology** (single-handed Consultant clinic) demonstrates underperformance of -12% (-10 patients). **1 specialty (17%) is assessed as Amber** - **Pain Management** demonstrates cumulative underperformance of -8% (-50 patients) - this has been quantified by the service and includes loss of clinics due to Consultant-on-call (on-site overnight, so OPD cancelled next day) in August & September; also more Consultant A/L taken in August and September; higher patient DNAs than anticipated. However, the trajectory shows significant improvement in Octonber, and the service advise that they envisage pulling back the trajectory before year-end.
**ACTIONS:** For those trajectories which are currently underperforming, Operational Teams have been requested to advise of the actions being taken to ensure the trajectories get back on track. **Cardiology** previously advised they had identified actions to be undertaken to improve the trajectory including - reworking specialty doctors job plans to optimise capacity at clinics, and confirmed 1 additional NOP clinic per week for Arrhythmia - effective November 2019. The Head of Service anticipates that this trajectory will be pulled back by the end of the year. **Chemical Pathology** - the service had advised that they were looking at options to increase capacity, including nurse-led clinics due to commence in January 2020. The Head of Service has also confirmed that a Specialty Doctor has been appointed to fill the gap left by the GP with Specialtist interest who left the Trust in Qtr 1 of 2019/20. the service anticipate being back on track by March 2020. **Geriatrics** - there are 4 sub-specialties, of which 3 are underperforming: *Ortho-Geriatrics* (ASD) advised that they will pull back by end of the year as 2 additional clinics have been set up for a period of 3 months initially from September. *Geriatric Medicine* (OPPC) and *Geriatric Acute* (ASD) had indicated that it is unlikely that the trajectories will recover by the end of the year - responses remain outstanding.

**Reduce the percentage of funded activity associated with elective care services that remains undelivered**

**Month: 7 (Oct. 2019)**

| Specialty | SBA | | 2018/19 outturn against SBA | | | 2019/20 Forecast Activity to be Delivered v Outturn (Actual) | | | | | | | | | | | | | Performance Against Trajectory Volume | | | | | Performance Against Agreed SBA Volume | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2018/19 | 2019/20 | Delivered 2018/19 (nn) | Variance 2018/19 (nn) | Variance 2018/19 (%) | 2019/20 SHSCT Operational Trajectory Volume | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | 2019/20 Cumulative Volume (to date) | 2019/20 Cumulative Expected Volume (to date) | Variance | % Variance | RAG status | 2019/20 Cumulative SBA (to date) | 2019/20 cumulative expected SBA | Variance | % Variance | RAG status |
| Breast Family History | 218 | 218 | 215 | -3 | -1% | 210 | 0 | 24 | 20 | 13 | 15 | 20 | 18 | 20 | 16 | 21 | 22 | 21 | | | | | | | | | | |
| **Breast Family History Actual activity** | | | | | | | **0** | **25** | **27** | **8** | **13** | **28** | **24** | | | | | | **125** | **110** | **15** | **14%** | | **125** | **127** | **-2** | **-2%** | **Y** |
| Breast Surgery | 4,205 | 4,205 | 4,035 | -170 | -4% | 3965 | 321 | 364 | 319 | 354 | 337 | 254 | 373 | 342 | 256 | 361 | 352 | 332 | | | | | | | | | | |
| **Breast Surgery actual activity** | | | | | | | **374** | **369** | **343** | **332** | **269** | **326** | **317** | | | | | | **2330** | **2322** | **8** | **0%** | | **2330** | **2453** | **-123** | **-5%** | **A** |
| Cardiology | 2,415 | 2,415 | 2,693 | 278 | 12% | 2739 | 223 | 251 | 247 | 205 | 170 | 261 | 297 | 280 | 177 | 200 | 211 | 217 | | | | | | | | | | |
| **Cardiology actual activity** | | | | | | | **179** | **231** | **212** | **120** | **110** | **214** | **235** | | | | | | **1301** | **1654** | **-353** | **-21%** | | **1301** | **1409** | **-108** | **-8%** | **A** |
| Chemical Pathology | 140 | 140 | 175 | 35 | 25% | 140 | 10 | 15 | 14 | 8 | 8 | 15 | 15 | 10 | 8 | 15 | 10 | 12 | | | | | | | | | | |
| **Chemical Pathology** | | | | | | | **8** | **12** | **13** | **4** | **9** | **15** | **14** | | | | | | **75** | **85** | **-10** | **-12%** | | **75** | **82** | **-7** | **-8%** | **A** |
| Dermatology (Cons-Led only) | 7,322 | 7,322 | 8,337 | 1,015 | 14% | 8066 | 560 | 750 | 800 | 630 | 630 | 550 | 850 | 830 | 495 | 814 | 597 | 560 | | | | | | | | | | |
| **Dermatology (Cons-Led only) actual activity** | | | | | | | **583** | **609** | **630** | **641** | **630** | **637** | **835** | | | | | | **4565** | **4770** | **-205** | **-4%** | | **4565** | **4271** | **294** | **7%** | **G** |
| Diabetology | 418 | 418 | 507 | 89 | 21% | 470 | 36 | 37 | 40 | 38 | 37 | 41 | 40 | 44 | 35 | 40 | 42 | 40 | | | | | | | | | | |
| **Diabetology actual activity** | | | | | | | **42** | **37** | **31** | **43** | **32** | **37** | **46** | | | | | | **268** | **269** | **-1** | **-0.4%** | | **268** | **244** | **24** | **10%** | **G** |
| Endocrinology | 537 | 537 | 815 | 278 | 52% | 725 | 63 | 65 | 69 | 40 | 59 | 62 | 60 | 65 | 60 | 65 | 57 | 60 | | | | | | | | | | |
| **Endocrinology** | | | | | | | **102** | **84** | **94** | **87** | **104** | **72** | **91** | | | | | | **634** | **418** | **216** | **52%** | | **634** | **313** | **321** | **102%** | **G** |
| ENT | 9,463 | 9,463 | 9,170 | -293 | -3% | 8828 | 603 | 653 | 688 | 383 | 731 | 794 | 850 | 1,021 | 733 | 816 | 806 | 750 | | | | | | | | | | |
| **ENT actual activity** | | | | | | | **774** | **710** | **821** | **633** | **685** | **843** | **776** | | | | | | **5242** | **4702** | **540** | **11%** | | **5242** | **5520** | **-278** | **-5%** | **A** |
| Gastroenterology | 2,006 | 2,006 | 2,129 | 123 | 6% | 2020 | 160 | 186 | 140 | 180 | 120 | 174 | 200 | 200 | 172 | 200 | 158 | 130 | | | | | | | | | | |
| **Gastroenterology actual activity** | | | | | | | **161** | **177** | **166** | **150** | **115** | **168** | **192** | | | | | | **1129** | **1160** | **-31** | **-3%** | | **1129** | **1170** | **-41** | **-4%** | **Y** |
| General Medicine | 487 | 487 | 326 | -161 | -33% | 216 | 17 | 17 | 16 | 15 | 20 | 20 | 18 | 19 | 17 | 18 | 19 | 20 | | | | | | | | | | |
| **General Medicine** | | | | | | | **17** | **25** | **21** | **28** | **30** | **31** | **30** | | | | | | **182** | **123** | **59** | **48%** | | **182** | **284** | **-102** | **-36%** | **R** |
| General Surgery | 9,839 | 9,839 | 7,096 | -2,743 | -28% | 7159 | 543 | 639 | 607 | 535 | 610 | 555 | 745 | 605 | 500 | 575 | 600 | 645 | | | | | | | | | | |
| **General Surgery Actual activity** | | | | | | | **589** | **643** | **507** | **435** | **349** | **732** | **912** | | | | | | **4167** | **4234** | **-67** | **-2%** | | **4167** | **5739** | **-1572** | **-27%** | **R** |
| Geriatric Medicine (combined) | 1,912 | 1,912 | 2,231 | 319 | 17% | 2190 | 166 | 200 | 188 | 170 | 162 | 193 | 218 | 181 | 142 | 217 | 172 | 181 | | | | | | | | | | |
| **Geriatric Medicine actual activity** | | | | | | | **164** | **186** | **179** | **163** | **158** | **174** | **220** | | | | | | **1244** | **1297** | **-53** | **-4%** | | **1244** | **1115** | **129** | **12%** | **G** |
| Gynae Colposcopy | 1,354 | 1,354 | 974 | -380 | -28% | 960 | 70 | 90 | 95 | 80 | 50 | 80 | 105 | 85 | 80 | 75 | 80 | 70 | | | | | | | | | | |
| **Gynae Colposcopy** | | | | | | | **98** | **67** | **88** | **84** | **54** | **93** | **96** | | | | | | **580** | **570** | **10** | **2%** | | **580** | **790** | **-210** | **-27%** | **R** |

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Gynae Fertility | 137 | 137 | 210 | 73 | 53% | 145 | 10 | 10 | 10 | 10 | 10 | 20 | 20 | 15 | 10 | 10 | 10 | 10 | | | | | | | | |
| **Gynae Fertility** | | | | | | | **19** | **14** | **13** | **10** | **13** | **12** | **9** | | | | | | **90** | **90** | **0** | **0%** | | **90** | **80** | **10** | **13%** | **G** |
| Gynae Urodynamics | 400 | 400 | 123 | -277 | -69% | 129 | 0 | 0 | 12 | 6 | 6 | 12 | 12 | 12 | 9 | 18 | 24 | 18 | | | | | | | | |
| **Gynae Urodynamics** | | | | | | | **3** | **10** | **9** | **9** | **7** | **9** | **10** | | | | | | **57** | **48** | **9** | **19%** | | **57** | **233** | **-176** | **-76%** | **R** |
| Neurology | 2,790 | 2,790 | 3,006 | 216 | 8% | 2806 | 233 | 234 | 220 | 240 | 260 | 264 | 233 | 260 | 240 | 212 | 190 | 220 | | | | | | | | |
| **Neurology Actual activity** | | | | | | | **258** | **231** | **288** | **209** | **244** | **249** | **316** | | | | | | **1795** | **1684** | **111** | **7%** | | **1795** | **1628** | **168** | **10%** | **G** |
| Obs and Gyn (Gynaecology) | 6,853 | 6,853 | 6,792 | -61 | -1% | 6445 | 517 | 517 | 650 | 470 | 530 | 601 | 570 | 640 | 470 | 570 | 420 | 490 | | | | | | | | |
| **Obs and Gyn (Gynaecology) actual activity** | | | | | | | **496** | **561** | **514** | **664** | **339** | **545** | **622** | | | | | | **3741** | **3855** | **-114** | **-3%** | | **3741** | **3998** | **-257** | **-6%** | **A** |
| Paediatrics | 2,600 | 2,600 | 2,763 | 163 | 6% | 2550 | 185 | 195 | 199 | 185 | 201 | 215 | 231 | 231 | 227 | 227 | 227 | 227 | | | | | | | | |
| **Paediatrics actual activity** | | | | | | | **219** | **226** | **232** | **155** | **223** | **287** | **274** | | | | | | **1616** | **1411** | **205** | **15%** | | **1616** | **1517** | **99** | **7%** | **G** |
| Pain Management | 1,190 | 1,190 | 1,138 | -52 | -4% | 1138 | 80 | 90 | 88 | 72 | 102 | 108 | 123 | 111 | 72 | 80 | 104 | 108 | | | | | | | | |
| **Pain Management actual activity** | | | | | | | **78** | **86** | **95** | **94** | **51** | **90** | **119** | | | | | | **613** | **663** | **-50** | **-8%** | | **613** | **694** | **-81** | **-12%** | **R** |
| Rheumatology | 1,692 | 1,692 | 1,648 | -44 | -3% | 1692 | 125 | 139 | 157 | 120 | 111 | 147 | 164 | 164 | 125 | 149 | 141 | 150 | | | | | | | | |
| **Rheumatology actual activity** | | | | | | | **127** | **133** | **151** | **130** | **126** | **139** | **154** | | | | | | **960** | **963** | **-3** | **-0.3%** | | **960** | **987** | **-27** | **-3%** | **Y** |
| Thoracic Medicine | 1,724 | 1,724 | 1,809 | 85 | 5% | 1782 | 140 | 160 | 169 | 130 | 135 | 162 | 157 | 169 | 133 | 145 | 145 | 137 | | | | | | | | |
| **Thoracic Medicine actual activity** | | | | | | | **158** | **199** | **158** | **113** | **147** | **166** | **177** | | | | | | **1118** | **1053** | **65** | **6%** | | **1118** | **1006** | **112** | **11%** | **G** |
| Trauma and Orthopaedics (Orthopaedics) | 2,872 | 2,872 | 2,598 | -274 | -10% | 2247 | 146 | 225 | 217 | 119 | 133 | 112 | 216 | 247 | 181 | 253 | 199 | 199 | | | | | | | | |
| **Trauma and Orthopaedics (Orthopaedics)actual activity** | | | | | | | **147** | **221** | **231** | **143** | **92** | **197** | **236** | | | | | | **1267** | **1168** | **99** | **8%** | | **1267** | **1675** | **-408** | **-24%** | **R** |
| Urology | 3,591 | 3,591 | 3,841 | 250 | 7% | 2866 | 292 | 361 | 364 | 202 | 251 | 157 | 289 | 260 | 157 | 239 | 147 | 147 | | | | | | | | |
| **Urology actual activity** | | | | | | | **347** | **239** | **240** | **242** | **265** | **355** | **264** | | | | | | **1952** | **1916** | **36** | **2%** | | **1952** | **2095** | **-143** | **-7%** | **A** |
| **Total** | **64,165** | **64,165** | **62,631** | **-1,534** | **-2%** | **59,488** | **4,500** | **5,222** | **5,329** | **4,205** | **4,688** | **4,817** | **5,804** | **5,811** | **4,315** | **5,320** | **4,733** | **4,744** | | | | | | | | |
| ***TOTAL ACTUAL ACTIVITY*** | | | | | | | ***4,943*** | ***5,095*** | ***5,063*** | ***4,497*** | ***4,065*** | ***5,419*** | ***5,969*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***35051*** | ***34565*** | ***486*** | ***1%*** | | ***35051*** | ***37430*** | ***-2379*** | ***-6%*** | **A** |

***Key:***

***Await response from Services RE: underperformance***

**RAG Status:**

| | |
|---|---|
| | **Operational trajectory on track or better** |
| | **Underperformance of up to 5% against operational trajectory** |
| | **Underperformance of 5% - 10% against operational trajectory** |
| | **Underperformance of 10% or more against operational trajectory/behind plan** |

**RAG status:**

| | |
|---|---|
| G | • SBA at 0% and above |
| Y | • SBA underperformance between -0.1% & -4.9% |
| A | • SBA underperformance between -5% & -9.9% |
| R | • SBA underperformance of -10% or more |

**KEY RISKS AND MITIGATIONS TO DELIVERY OF PLAN**

| Risk Description | Risk Rating | Mitigations | Risk Owner |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| | |
|---|---|
| **Trust** | **Southern** |
| **PIT Lead** | **ATICS & SEC - Ronan Carroll;<br>CCS & IMWH - Barry Conway;<br>MUSC - Anne McVey;<br>CYPS - Julie McConville<br>OPPC - Roisin Toner** |
| **Date Submitted (HSCB):** | **June 2019** |

| Outturn against SBA | | |
|---|---|---|
| 2017/18 | 2018/19 | 2019/20 (planned) |
| -10.0% | -5.2% | -8.5% |

**Comments/escalations:** Whilst cumulative performance for the total IP/DC trajectory (15 specialties) demonstrates +8% (+1129) above the projected levels of activity:
- **2 specialties (13%) are assessed as Red** - **General Medicine** demonstrates -18% (-203) against the projected levels of activity - though this should be considered along with Gastroenterology which demonstrates an over-performance of 53% associated with inpatient coding backlog. *Operational response for this underperformance remains outstanding* ; **Orthopaedics** demonstrates -11% (-124 patients) against the projected levels of activity - the service have quantified the underperformance which is primarily attributed to an increase in trauma cases being undertaken in Ortho lists during the first 7 months of 2019/20, with elective orthopaedic slots displaced during the first half of the year due to an influx of trauma cases, but more significantly in September and October when more slots were lost than predicted. April to September demonstrated 69 slots lost due to an increase in trauma cases; Consultant sick leave in May; performance impacted by more A/L being taken in August than was originally anticipated. However, 52 slots were lost in October alone - there were more trauma cases undertaken in ortho elective lists (40) than in any other month, resulting in a loss of 25 elective slots. In addition, 4 elective sessions were converted to trauma all-day sessions to meet trauma demand; 4 sessions were lost due to inability to backfill 4 middle grades; 2 Consultants were on sick leave resulting in a loss of 4 further elective sessions during October. **ACTIONS: All Operational Teams have been asked to review their assumptions where the trajectory has gone off-track. If trajectories are underperforming, the service is requested to inform the Performance Team in writing of the quantified reasons and the estimated timescales and actions to be taken to ensure that this gets back on track. Services are also to advise urgently if there is anything which was not previously considered as part of their projections which may have an impact on the ability to deliver the 2019/20 volumes - with a view to re-submission to HSCB if necessary before the window of opportunity to do this closes.**
***Early alert*** **: the Orthopaedics service advised (in November) that performance against the trajectory will be further impacted as there will be no elective activity on the CAH site in December due to the reduction in theatre nursing staff. This will result in a loss of 107 elective patients.**

**Reduce the percentage of funded activity associated with elective care services that remains undelivered**

**Month: 7 (Oct 2019)**

| Specialty | SBA Volume | | 2018/19 Outturn against SBA | | | 2019/20 Forecast Activity to be Delivered v Outturn (Actual) | | | | | | | | | | | | | Performance Against Trajectory Volume | | | | | | Performance Against Agreed SBA Volume | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2018/19 SBA | 2019/20 SBA | Delivered 2018/19 (nn) | Variance 2018/19 (nn) | Variance 2018/19 (%) | 2019/20 SHSCT Operational Trajectory Volume | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | 2019/20 Cumulative Volume (to date) | 2019/20 Cumulative Expected Volume (to date) | Variance | % Variance | RAG status | | 2019/20 Cumulative SBA (to date) | 2019/20 cumulative expected SBA | Variance | % Variance | RAG status |
| Breast Surgery | 400 | 400 | 449 | 49 | 12% | 410 | 37 | 32 | 34 | 33 | 31 | 32 | 32 | 36 | 32 | 40 | 35 | 36 | | | | | | | | | | | |
| ***Breast Surgery Actual activity*** | | | | | | | ***39*** | ***25*** | ***33*** | ***50*** | ***28*** | ***41*** | ***31*** | | | | | | ***247*** | ***231*** | ***16*** | ***7%*** | | | ***247*** | ***233*** | ***14*** | ***6%*** | G |
| Dermatology (Cons Led only) | 1,066 | 1,066 | 1,253 | 187 | 18% | 1263 | 98 | 96 | 94 | 86 | 119 | 129 | 129 | 90 | 127 | 102 | 97 | 96 | | | | | | | | | | | |
| ***Dermatology Cons-Led only actual activity*** | | | | | | | ***105*** | ***88*** | ***95*** | ***118*** | ***103*** | ***104*** | ***110*** | | | | | | ***723*** | ***751*** | ***-28*** | ***-4%*** | | | ***723*** | ***622*** | ***101*** | ***16%*** | G |
| Dermatology (Nurse Led only) | 328 | 328 | 505 | 177 | 54% | 483 | 33 | 37 | 55 | 30 | 30 | 50 | 48 | 48 | 30 | 44 | 39 | 39 | | | | | | | | | | | |
| ***Dermatology Cons-Led only actual activity*** | | | | | | | ***40*** | ***38*** | ***41*** | ***51*** | ***33*** | ***43*** | ***57*** | | | | | | ***303*** | ***283*** | ***20*** | ***7%*** | | | ***303*** | ***191*** | ***112*** | ***58%*** | G |
| ENT (Ear, Nose & Throat) | 2,850 | 2,850 | 1,990 | -860 | -30% | 1706 | 101 | 143 | 154 | 79 | 163 | 172 | 192 | 172 | 124 | 149 | 135 | 122 | | | | | | | | | | | |
| ***ENT Actual activity*** | | | | | | | ***158*** | ***177*** | ***192*** | ***131*** | ***143*** | ***188*** | ***193*** | | | | | | ***1,182*** | ***1,004*** | ***178*** | ***18%*** | | | ***1,182*** | ***1,663*** | ***-481*** | ***-29%*** | R |
| Gastroenterology (Non-Scopes) | 205 | 205 | 1,164 | 959 | 468% | 991 | 68 | 107 | 90 | 75 | 77 | 58 | 69 | 70 | 65 | 113 | 100 | 99 | | | | | | | | | | | |
| ***Gastroenterology (Non-Scopes) Actual activity*** | | | | | | | ***105*** | ***89*** | ***93*** | ***108*** | ***97*** | ***93*** | ***245*** | | | | | | ***830*** | ***544*** | ***286*** | ***53%*** | | GMED & Gastro should be considered together | ***830*** | ***120*** | ***710*** | ***594%*** | G |
| General Medicine | 1,855 | 1,855 | 1,839 | -16 | -1% | 1906 | 139 | 152 | 158 | 148 | 174 | 172 | 181 | 162 | 157 | 177 | 136 | 150 | | | | | | | | | | | |
| ***General Medicine Actual activity*** | | | | | | | ***142*** | ***134*** | ***125*** | ***132*** | ***118*** | ***126*** | ***144*** | | | | | | ***921*** | ***1,124*** | ***-203*** | ***-18%*** | | | ***921*** | ***1,082*** | ***-161*** | ***-15%*** | R |
| General Surgery | 5,830 | 5,830 | 4,127 | -1,703 | -29% | 4013 | 268 | 343 | 326 | 234 | 275 | 368 | 394 | 364 | 298 | 535 | 303 | 305 | | | | | | | | | | | |
| ***General Surgery Actual activity*** | | | | | | | ***301*** | ***334*** | ***323*** | ***296*** | ***300*** | ***367*** | ***663*** | | | | | | ***2,584*** | ***2,208*** | ***376*** | ***17%*** | | | ***2,584*** | ***3,401*** | ***-817*** | ***-24%*** | R |
| Geriatric Medicine combined | 10 | 10 | 60 | 50 | 500% | 12 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | | | | | | | | |
| ***Geriatric Medicine combined - Actual activity*** | | | | | | | ***16*** | ***8*** | ***11*** | ***5*** | ***10*** | ***6*** | ***3*** | | | | | | ***59*** | ***7*** | ***52*** | ***743%*** | | | ***59*** | ***6*** | ***53*** | ***911%*** | G |
| Obs and Gyn (Gynaecology) | 2,593 | 2,593 | 2,024 | -569 | -22% | 1842 | 150 | 155 | 155 | 155 | 155 | 155 | 155 | 155 | 150 | 150 | 150 | 157 | | | | | | | | | | | |
| ***Obs and Gyn (Gynaecology) - Actual activity*** | | | | | | | ***131*** | ***136*** | ***147*** | ***185*** | ***170*** | ***150*** | ***184*** | | | | | | ***1,103*** | ***1,080*** | ***23*** | ***2%*** | | | ***1,103*** | ***1,513*** | ***-410*** | ***-27%*** | R |
| Paediatrics | 120 | 120 | 113 | -7 | -6% | 132 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | | | | | | | | | | | |
| ***Paediatrics actual activity*** | | | | | | | ***15*** | ***18*** | ***17*** | ***17*** | ***20*** | ***25*** | ***10*** | | | | | | ***122*** | ***77*** | ***45*** | ***58%*** | | | ***122*** | ***70*** | ***52*** | ***74%*** | G |

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

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pain Management | 550 | 550 | 525 | -25 | -5% | 511 | 60 | 54 | 54 | 30 | 30 | 45 | 40 | 42 | 30 | 42 | 42 | 42 | | | | | | | | | |
| ***Pain Management actual activity*** | | | | | | | ***61*** | ***47*** | ***54*** | ***41*** | ***22*** | ***53*** | ***50*** | | | | | | ***328*** | ***313*** | ***15*** | ***5%*** | | ***328*** | ***321*** | ***7*** | ***2%*** | G |
| Rheumatology | 2,909 | 2,909 | 3,074 | 165 | 6% | 3062 | 271 | 288 | 300 | 224 | 224 | 283 | 243 | 278 | 214 | 239 | 245 | 253 | | | | | | | | | |
| ***Rheumatology actual activity*** | | | | | | | ***253*** | ***281*** | ***268*** | ***290*** | ***238*** | ***339*** | ***243*** | | | | | | ***1,912*** | ***1,833*** | ***79*** | ***4%*** | | ***1,912*** | ***1,697*** | ***215*** | ***13%*** | G |
| Thoracic Medicine | 500 | 500 | 442 | -58 | -12% | 443 | 40 | 32 | 42 | 28 | 34 | 40 | 37 | 39 | 36 | 40 | 38 | 37 | | | | | | | | | |
| ***Thoracic Medicine actual activity*** | | | | | | | ***38*** | ***47*** | ***39*** | ***43*** | ***60*** | ***51*** | ***60*** | | | | | | ***338*** | ***253*** | ***85*** | ***34%*** | | ***338*** | ***292*** | ***46*** | ***16%*** | G |
| Trauma and Orthopaedics | 1,968 | 1,968 | 1,777 | -191 | -10% | 1956 | 135 | 168 | 198 | 112 | 133 | 160 | 195 | 201 | 128 | 172 | 172 | 182 | | | | | | | | | |
| ***Trauma and Orthopaedics actual activity*** | | | | | | | ***124*** | ***154*** | ***164*** | ***132*** | ***120*** | ***144*** | ***139*** | | | | | | ***977*** | ***1,101*** | ***-124*** | ***-11%*** | | ***977*** | ***1,148*** | ***-171*** | ***-15%*** | R |
| Urology | 4,198 | 4,198 | 4,717 | 519 | 12% | 4501 | 342 | 333 | 407 | 286 | 426 | 374 | 445 | 402 | 302 | 421 | 381 | 382 | | | | | | | | | |
| ***Urology actual activity*** | | | | | | | ***421*** | ***464*** | ***373*** | ***403*** | ***406*** | ***439*** | ***416*** | | | | | | ***2,922*** | ***2,613*** | ***309*** | ***12%*** | | ***2,922*** | ***2,449*** | ***473*** | ***19%*** | G |
| **Total - trajectory volume submitted** | **25,382** | **25,382** | **24,059** | **-1,323** | **-5%** | **23,231** | **1,754** | **1,952** | **2,079** | **1,532** | **1,883** | **2,050** | **2,172** | **2,071** | **1,705** | **2,236** | **1,885** | **1,912** | | | | | | **14,551** | **14,806** | **-255** | **-2%** | |
| ***Actual activity*** | | | | | | | ***1,949*** | ***2,040*** | ***1,975*** | ***2,002*** | ***1,868*** | ***2,169*** | ***2,548*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***14,551*** | ***13,422*** | ***1,129*** | ***8%*** | | ***14,551*** | ***14,806*** | ***-255*** | ***-2%*** | y |

***Key:***

**RAG Status:**

- **Operational trajectory on track or better**
- **Underperformance of up to 5% against operational trajectory**
- **Underperformance of 5% - 10% against operational trajectory**
- **Underperformance of 10% or more against operational trajectory/behind plan**

**RAG status:**

- **G** • SBA at 0% and above
- **Y** • SBA underperformance between -0.1% & -4.9%
- **A** • SBA underperformance between -5% & -9.9%
- **R** • SBA underperformance of -10% or more

**KEY RISKS AND MITIGATIONS TO DELIVERY OF PLAN**

| Risk Description | Risk Rating | Mitigations | Risk Owner |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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PROGRAMME FOR TRAINEES
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# 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

# Change of Practice 2017

- Referral pathway agreed (Urology/Radiology/A+E)
- Urology MDT since December 2017
- Decreased Nursing paperwork
- Improved treatment safety and effectiveness
- Improved pain relief
- E-discharge
- Improved patient follow-up pathway
- Data collection to demonstrate improvement
- Audit/ research and development

# ESWL Day of Treatment

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

# 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**

# Emergency Stone Guidelines

‘For symptomatic ureteric stones, primary treatment of the stone should be the goal (LE 1b) and should be undertaken within 48h of the decision to intervene’

British Association of Urological Surgeons standards for management of acute ureteric colic
A. Tsiotras, R Daron Smith, I Pearce, K O’Flynn, O Wiseman
Journal of Clinical Urology 2018. Vol. 11 (1) 58-61

# 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 patient.**


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

# Stone Treatment Centre Improvement Project



*Quality Care - for you, with you*

## Contents

1. **Extracorporeal Shockwave Lithotripsy (ESWL)**

ESWL is a method of using shockwaves applied to the back of a patient to treat kidney stones and ureteric stones (ureter is the pipe which drains urine from the kidney to the bladder). ESWL is undertaken with pain relief and no anaesthetic is needed unless the patient is a child, and is most commonly conducted as a day case. The alternative for stone treatment is ureteroscopy and percutaneous nephrolithotomy (PCNL), both of which require general anaesthetic and are conducted in a theatre setting.

2. **Rationale**

The overall lifetime risk of renal or ureteric calculi is 10-15%, the male to female ratio is 2:1 and the peak age of presentation is 30-50 years. The recurrence rate can be high, with up to 30% of cases recurring at 10 years and 90% of cases recurring at 30 years.

The Southern Trust has an on-site lithotripter providing a maximum of 3 ESWL sessions a week, with each session treating a maximum of 3 patients, giving a total of only 9 patients per week. There is currently no capacity or model for emergency ESWL. Occasional Paediatric list in conjunction with Belfast and adult patients from the Northern and South Eastern Trusts are also accommodated. The lithotripter is therefore not used for 11 out of a possible 14 daytime clinical sessions.

The average waiting time for first elective ESWL session was 9 weeks, with the longest single wait at 55 weeks as of October 2016, but the waiting time was rapidly increasing as demand increased.

Currently all emergency stones needing treatment are operated on via the emergency list. For patients who are suitable, emergency ESWL may be a more cost effective and potentially less morbid modality for treatment. Ureteric stone patients who are admitted as an emergency have been recommended to be treated within 48 hours from the decision to treat (Wiseman, 2017).

Selected patients could be removed from overburdened inpatient elective Ureteroscopy waiting lists if ESWL capacity was increased. This could potentially provide a more cost effective modality compared to use of the operating theatre and requirement of a general anaesthetic.

**3. Project aim**

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

In order to meet the demand for ESWL the waiting list needs to be reduced and then maintained at a reasonable wait. Imaging of patient's stone must be recent to avoid re-imaging or difficulty in identifying stone location for treatment, which can only be achieved with a short wait for treatment. The desired wait time will be set following the service evaluation and visit to a 'Gold Standard' service centre.

**4. Hypothesis**

Patient numbers per session can be increased by reviewing and improving the process currently in place. Extra sessions per week can decrease the overall cost of the patients treated for renal and ureteric stones by decreasing the number treated by the more costly emergency theatre and elective theatre sessions.

**5. Objectives**

1. Review and appraise current service set-up for ESWL. Including equipment, clinical area, staff, referral, follow-up and discharge of patients. Recording of treatments and any further investigations and stone prevention.
2. Identify current funding parameters for ESWL and potential funding
3. NICE and EAU guidelines for stone treatments in relation to current practice and application to any changes
4. Obtain costs of ESWL vs Emergency ureteroscopy surgery vs Elective ureteroscopy surgery in the Southern Trust
5. Review emergency surgery conducted over 9 month period that could have received ESWL had it been available
6. Evaluate 'Gold standard service'. How do other NHS hospital work regarding onsite ESWL including follow-up and prevention. How do the top European centres implement their ESWL service.

**7. Project Scope**

The project will encompass the patient pathway of stone diagnosis to treatment and discharge for those patients suitable for ESWL in the Southern Trust. It is outside the scope of this project to provide a service for stone prevention and follow-up of recurrent or high risk stone formers. The theatre practise of alternative treatments for stones, ureteroscopy and PCNL, will not be part of the project, although recommendation for type of stone treatment patients receive will be reviewed as part of the service evaluation on how patients are selected for ESWL.

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**8. Project Sponsor**

The overarching sponsor is the Medical Director and his Executive Team. Keeping the Medical Director Richard Wright copied into important e-mails to drive the project forward is fundamental, as well as regular face to face meetings with project update presentations. The project heavily involves the Urology team especially Mr Michael Young as clinical lead and Martina Corrigan as Urology Manager and daily/weekly engagement is crucial. It is a necessity for the project sustainability and eventual outcomes to be supported that the groups of people mentioned thus far are kept regularly up to date and are in agreement with actions.

**9. Project Team**

In order to fulfil our aims for the Southern Trust the team will have a constant core team of staff who work at the Craigavon Stone Centre. Team members who are going to deliver the service are vital for inclusion, as they will drive the improvement, sustain the improvement, and hopefully continue future improvement. The team can learn together the methodology of improvement science, the need for improvement and not just change. There will be interaction required from other departments in order to fulfil the aims and objectives and the need for the team to be flexible to incorporate other personnel when required. The team in fundamental for success, especially in a National Health Service setting, where the varied skill sets and experience can be utilised, but without a team effort no project in the NHS can succeed as barriers will occur. The Medical Director and executive team will be kept informed and utilised as the project requires. In order to meet certain objectives input will be required from Estates, Trust architects, Pharmacy, IT, Radiology, Accident and Emergency and the remainder of the Urology Consultant Team.

**The Core Team**:

Mr Michael Young : Urology Clinical Lead and Project Lead

Mr Matthew Tyson: Project lead

Mr John O'Donoghue: Urology Consultant

Martina Corrigan: Manager for Urology

Saba Husnain: Staff Grade Urology Doctor

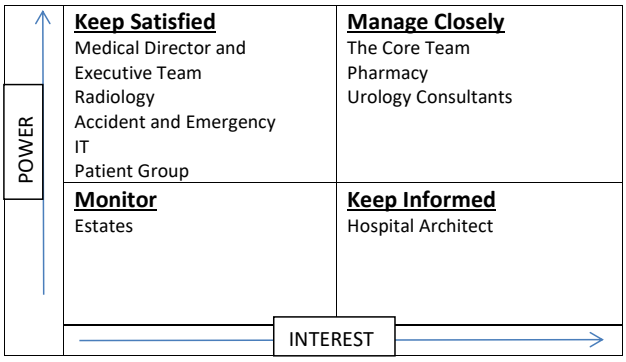
Laura McAuley: Staff Grade Urology Doctor

Paulette Dignam: Secretary and Administration

Hazel McBurney, Bronagh OShea, Bernadette Mohan, Wayne Heatrick: Radiographers

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

**Stakeholder Evaluation**



**10. Approaches and Measures (Method)**

To help plan the project improvement and due to the complexity of the task, driver diagrams were constructed. (Royal College of Physicians Ireland, 2012)

| Goal/Aim | Drivers | Project/Activity |
|---|---|---|
| To meet the demand for (ESWL) service for elective and emergency renal and ureteric stone treatment for the Southern Trust | More ESWL to reduce the demand on main theatre for Ureteroscopy and Laser to Stone | Prove ESWL treatment is more cost effective then main theatre Ureteroscopy |
| | Reduce the waiting list for ESWL by increasing activity | Time and Motion study of ESWL treatment session |
| | Increase number of patient treated per day with ESWL, allowing for emergency ESWL | Evaluation of current service |
| | Reduce the demand for outpatient appointments | Visit Scottish Lithotripter Centre a recognised high volume centre volume |
| | Staff motivation and buy in of project aim | Regular team meetings |
| | Identify method to stop patients having outpatient appointment prior to ESWL treatment, to reduce patient wait for ESWL | Patients booked directly for ESWL treatment from diagnosis of stone |

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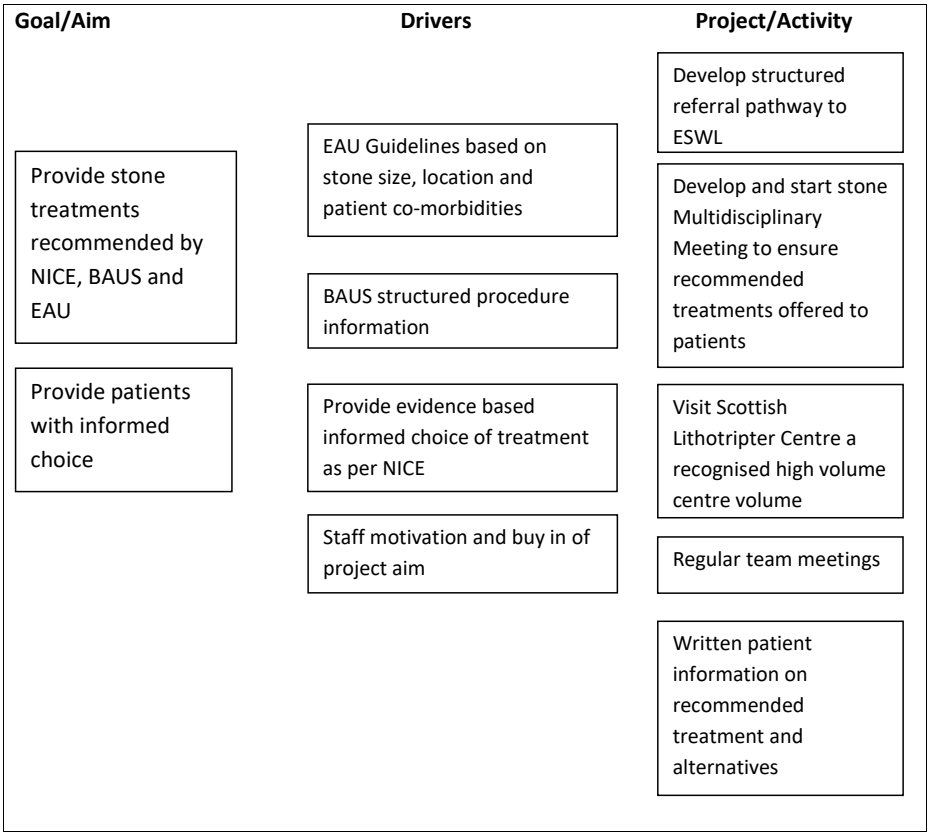



As highlighted by the driver diagram a **service evaluation** is a must and was the first step, this included the **patient pathway**, **time and motion study** of ESWL treatment session and infrastructure of the Stone Treatment Centre. This was followed by **a visit to the Scottish Lithotripter Centre** to see first-hand the processes of a high volume ESWL centre, and to determine what lessons could be relayed to the Southern Trust.

A 2 hour **Team Meeting** every Thursday morning was an opportunity for planning and review of **PDSA cycles**, keeping the team up to date, role and responsibility setting as well as motivating team members to the aim and learning.

**Patient questionnaire** following receiving ESWL treatment, as well as **patient and staff interview** of ESWL treatment sessions.

**Data Collection and Review of Patient notes** to record how many patients who received Emergency Treatment for Kidney Stones could have undergone ESWL. An analysis of the

cost implication of Emergency ESWL vs Emergency Ureteroscopy and Elective ESWL vs Elective Ureteroscopy.

**Process measures** will reflect the steps involved in the patient being identified and referred to the Stone Treatment Centre, such as the referral pathway, including the structured referral form, as well as the process and number of the patient(s) on the day of treatment.

**Structure measures** will reflect the staffing and equipment required for the Stone Multidisciplinary Meeting (MDM), and the ESWL treatment sessions.

**Outcome measures** will be assessed on proving the changes are improvements, these will be in keeping with the ethos of 'High Quality Health Care' (Southern Health and Social Care Trust). In relation to the overall aims quantitative outcomes will be measured as a reduction in the waiting times for patient to receive ESWL and the provision of Emergency ESWL. Quantitative review of Stone Meeting outcomes in relation to guidelines as per European Urology and quantitative patient questionnaire on 'informed choice on treatment of their stone'. Finally there is a chance to prove an economic benefit from the project, with quantitative outcome evidence that increasing funding of ESWL stone treatments saves money to the Trust overall. As noted by Donabedian outcome measures will be the 'ultimate validators' of the effectiveness and quality of this project (Donabedian, 2005)

**Balances** are important, so that no change or improvement has a direct or indirect negative consequence. An example for this project would be ensuring that by increasing the number of ESWL sessions that patients are successfully treated with ESWL for their stone, and only a minimal number require further treatment by Ureteroscopy in main theatre. This will be determined largely by the correct, guideline orientated selection of patients for the most recommended treatment for their stone.

**11. Data Collection (Results)**

1. **Service Evaluation**

The service evaluation looked at the patient journey from diagnosis of a ureteric or renal stone to an end point of completion of treatment of the stone. The evaluation was conducted using observation of patient pathway, interview of staff and patients and questionnaire of patients receiving ESWL treatment.

Summary of evaluation findings:

**Summary of Service Evaluation August 2016**

1. **Patients were most commonly diagnosed with kidney or ureteric stone in Accident and Emergency using NCCTKUB.**
2. **There was no Trust guideline policy on who, how or when to image when presenting with possible renal colic.**
3. **Referral of patients from Accident and Emergency was either by telephone call to registrar on-call or hand written free hand referral to consultant on call for outpatient follow-up.**
4. **Only 56% of patients had serum calcium checked (within the previous year) for referral of emergency treatment (Ureteroscopy and Laser in main theatre as emergency ESWL was not available). Serum calcium needed for potential risk of developing stones, and if raised a rare cause of morbidity and mortality (World Health Organisation , 2015). Only 37% of patients had their serum Uric acid checked, if elevated another possible cause of kidney stones.**
5. **Patients referred for outpatient review were seen in Outpatient Appointment prior to any stone treatment commencing**
6. **NO Emergency ESWL was available**
7. **The wait for ESWL was 9 weeks (and increasing)**
8. **Day of treatment for ESWL Stone Treatment Centre consisted of:**
    a. **3 patients treated per session (half day), 9 patients per week. Staff present for treatment X1 Staff Nurse, X1 Health Care Assistant, X1 Radiographer, On-call Doctor called to prescribe medications.**
    b. **Dedicated Stone Treatment Centre for ESWL, with modern Lithotripter**
    c. **Data from the staff interview indicated they were enthusiastic, dedicated, and eager to improve service, they had a good knowledge base and were eager for further learning and to share learning so far. Themed comments were 'need to reduce waiting list', 'imaging need to be up to date for day of treatment, images of stone diagnosis were often out of date due to the long wait for treatment', 'medications prescribed in advance of treatment as delays were being caused by waiting for doctor to prescribe'.**
    d. **The themed responses from the patient interviews were 'difficulty in finding the Stone Treatment Centre', 'long wait for treatment', 'nowhere to safely store personal items, no lockers', 'no dedicated changing room', they did also comment on 'excellent staff', 'kind staff', 'tea and scone post treatment' was most appreciated.**

e. The Post ESWL pain questionnaire highlighted the need to provide breakthrough pain medication for those who had pain during treatment, so effective treatments could be given. Pain medication was based on Piroxicam 20mg and Paracetamol 1g pre-treatment, with no breakthrough medication.
f. The Time and Motion study highlighted long period of time needed by nurses in the current method of working to consent and prep patient for ESWL, with some reaching 45 minutes. There was down-time of the Lithotripter whilst the nurse undertook the consent and checks. There was no dedicated room to consent patient and do pre-ESWL checks, the patient was in the same room as the patient who was being recovered from previous treatment, separated by a curtain, and thus confidentiality was an issue.
g. The discharge letter from ESWL treatment was a handwritten note, with a further formal dictated and typed letter weeks to months later.

9. Follow-up of treatment was a further outpatient appointment for patient.

2. **Visit to Scottish Stone Centre Edinburgh**

Summary of Visit to Scottish Stone Centre, Edinburgh, 14-15 November 2016

1. Patient Journey followed
   a. Structured referral to Stone Centre was viewed
   b. All referrals were reviewed and stone treatment recommended at Stone MDM. Urology Stone Consultants and Treating Radiographer were present at the meeting. Dictation was used to instruct which pre-formed letter to send to patient. Patients were booked direct to treatment as required by radiographer present.
   c. Letter for recommendation for stone treatment was sent to patient
   d. Patient arrives within a 2 week wait for ESWL treatment
2. Day of ESWL treatment
   a. Treatment staff included x2 staff nurses and x1 radiographer
   b. Medication was pre-prescribed (Diclofenac 100mg PR and Oral 1g Paracetamol)
   c. Breakthrough medication was available (IV Opiate)
   d. Discharge information was sheet given to patient
   e. Follow-up imaging was booked on completion of treatment by radiographer, to be viewed by Urology Consultant and further or alternative treatment planned as required.
3. Number of Patients treated
   a. 2 week max wait
   b. Capacity for emergency patient to be treated daily
   c. 3-4 patients were treated per session, and all sessions were filled.
   d. Centre ran 5 days a week (Monday to Friday)
4. Staff Interviews noted radiographers are dedicated to work only at the Stone

**Treatment centre and have 'developed large skill and knowledge base', 'multiple publications have evolved from the centre', feel working full time at Stone Centre 'provides a dedicated, skilled team' to providing patient treatments, the model allows for 'minimal wait from diagnosis to treatment, thus reducing the possible re-presentation to Accident and Emergency'.**

3. **Recommendations following Service Evaluation of Southern Trust Stone Treatment Centre and Visit to Scottish Stone Centre**

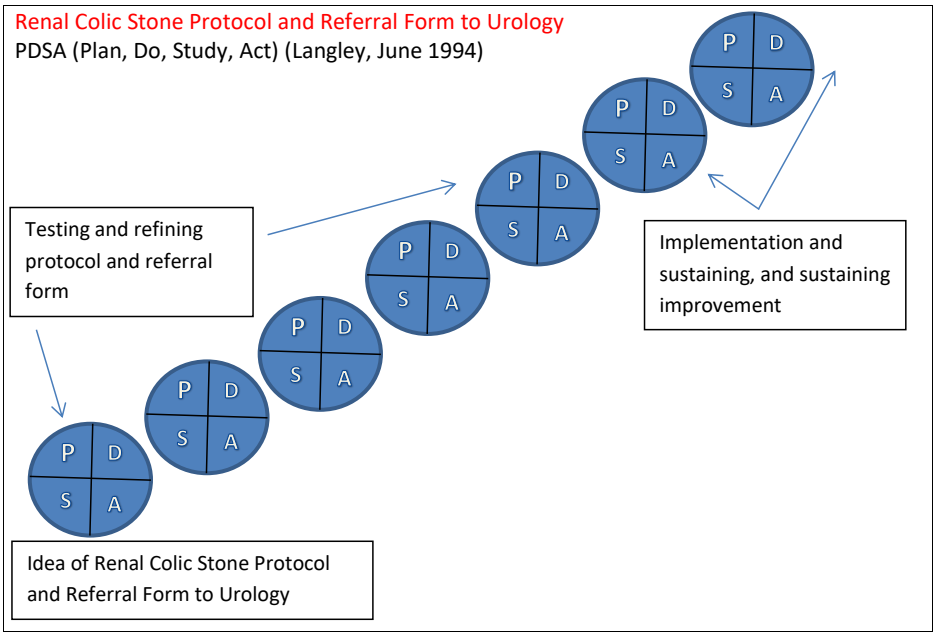
Recommendations for Craigavon Stone Treatment Centre

1. Need for Southern Trust Protocol on whom and how to image possible renal colic (Stone presentation) patients in Accident and Emergency.
2. Need for structured referral to stone treatment centre, including all information needed to recommend stone treatment at a Urology Stone MDM.
3. Need weekly Stone MDT meeting, with administrative support and dedicated meeting space with imaging available and Electronic Care Records. Pre-prescribe medication for ESWL treatment.
4. Information pack to patient on outcome of Stone MDM for recommendation of treatment of their stone, informed choice, consent form, map to ESWL Stone Treatment Centre, ability to see Doctor in Outpatient if patient doesn't want to proceed to treatment or ask further questions.
5. Decrease the wait for ESWL treatment to 2 weeks, so imaging is not out of date and prevent re-presentations to Accident and Emergency.
6. Decrease the time for Nurse to check-in patient and consent patient for ESWL treatment on day of treatment
7. Have typed discharge for patient ready upon discharge from ESWL treatment day. Have discharge uploaded on day of treatment to Electronic care records so can be viewed at any time by Doctors, especially in the event of an emergency admission to Accident and Emergency.
8. Review on pain medication given to patients at Southern Trust Stone Treatment Centre, and recommendation for breakthrough medication during ESWL treatment.
9. Have architectural drawing proposal on how to alter Stone Treatment Centre to also provide private consultation room for patients, and area to change and keep personal items secure.

4. **Renal Colic Protocol and Stone Referral Form for Southern Trust (pdsa cycles)**

The service evaluation and visit to the Scottish Stone Centre highlighted the need to provide the Southern Trust with a Renal Colic Stone Protocol to help Doctors in Accident and Emergency decide on when to image, how to image, blood tests required and how and when to refer to Urology. The referring doctor should complete a structured Stone Referral Form so all information that is a necessity is provided, so a treatment option can be recommended to a patient from Stone MDM. The Thursday Morning team meeting was utilised as a platform for ideas (plan), invited speakers from other specialities and distribution of work (do) and review (study), to eventual implementation (act).

The Renal Colic protocol and Urology Stone Referral Form needed input and agreement from Urology, Accident and Emergency and Radiology departments. Background work was required to ensure all recommendations were evidence based and fitted with current guidelines for all specialities involved (C. Türk (Chair), 2016). Numerous PDSA cycles (X7) (Langley, June 1994) were required in order to agree on the current forms which are now in active use. The current forms can be viewed in the appendix.



5. **Stone Multidisciplinary Team Meeting (MDT) benefits**

The Thursday morning team meeting evolved in to the Stone MDT.

The Stone MDT model allows a much greater through put of patients then a single doctor seeing a patient in clinic. It benefits the patient as they are discussed amongst a group of healthcare professionals, with an evidence based treatment of their stone recommended. It means the time from diagnosis to treatments is reduced. The MDT model was based on the Scottish Lithotripsy Centre model, and relies on organisation for the weekly meeting.

The weekly Thursday MDT has discussed up to 30 patients in a meeting so far. The meeting will eventually incorporate new patient referral in the first part, then review of follow-up imaging in the second part of patients who have completed their ESWL treatment to ensure their stone(s) have been successfully treated, then a template letter confirming this could be sent.

Patients have already been given their diagnosis of a stone and location when they presented, usually to Accident and Emergency. The outcome of MDT, if conservative treatment or ESWL then patient information pack can be sent so they can proceed directly to treatment or further imaging. All the information needed to make a decision on a patient in included in the Urology Stone Referral. There is always the option to see the patient in Outpatient Clinic if the option needs further discussion, such as Percutaneous Nephrolithotomy, or significant co-morbidities, although these are the minority.

**Urology Stone MDT**

**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, thus saving money.**
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).**

**Disadvantages:**

1. **Some may see discussion of straight forward cases as unnecessary, (if patients are booked direct without discussion at MDT, then data capture is required for audit purposes)**
2. **Meeting only held once a week, some patients will need treating prior and not go through MDT.**

Potential Cost Savings of Patients being booked directly to treatment for ESWL

Cost of New Outpatient Appointments = £250
Cost of Follow-up Outpatient Appointment = £170
Combined total of = £420 per patient

Number on waiting list for ESWL = 233

- Potential cost saving of £97,860 in appointments if directly booked and followed up with imaging and letter
- On average 31 new patients booked for ESWL per month (average June to December)
- The number of ESWL patients increases year on year as stones become more common due to diet factors, increases in obesity and aging population, as well as potentially global warming (stones are more common in warmer climates)
- The potential savings will therefore increase year on year by utilising the MDM model.

6. **Patient Information Pack** (see appendix)

Following an MDM discussion, the patient is placed on the correct, guideline recommend pathway for treatment of their stone. The outcome of MDM is communicated to the patient in a letter, with the majority of letter a standard template to save administrative time, see appendix. Those patients selected for ESWL treatment of their stone are also sent an information pack on the treatment.

The information pack was developed from first reviewing the Scottish Stone Centre patient information, an internet search of other centres patient information on ESWL and the British Association of Urology consent for ESWL (British Association of Urological Surgeons , 2016).

From listening to the patients we included a map, and a plan set in place to review patient's satisfaction on ease of use to arrive at their destination.

The documentation went through a number of PDSA cycles, taking around 6 months to reach agreement with the MDM Stone Treatment Group, until a version was ready for sending to patients. The next PDSA cycle will be to study the evaluations of the information from the patient group.

From the time and motion study the information pack was designed to decrease the time taken to pre-admit a patient before they commence their ESWL on the day of treatment. **This would help in time saving on day of treatment and allow an extra patient to be added to the treatment session, such as an emergency patient.**

The information pack includes: a. MDM letter outcome (template letter)

b. Information and consent on ESWL

c. Map on how to find Craigavon Stone Treatment Centre

d. Advice on discontinuation of medication pre-treatment and when to re-start

**The Next PDSA cycles**

**The patient information pack sees a number of PDSA cycles running simultaneously (Langley, June 1994).**

a. **Patient feedback questionnaire on contents on patient information pack (Study), all separate, yet linked PDSA cycles.**

b. **A repeat time and motion study to review if the patient information has decreased administration time for admission of patient prior to treatment.**

c. **Though MDM and pharmacy involvement to ensure medication advice sheet stays up to-date. Periodic review date set, and awareness of pharmacy to notify of updates.**

7. **Extracorporeal Shockwave Lithotripsy treatment session**

Recommendations were made following the service evaluation, patient and staff interviews, and patient post-treatment questionnaire

Recommendations and outcomes for Craigavon Stone Treatment Centre

1. **Decrease the time for Nurse to check-in patient and consent patient for ESWL treatment on day of treatment**
   Patient information pack and pre-prescription of pain medications. Follow-up time and motion study to be conducted.

2. Have typed discharge for patient ready upon discharge from ESWL treatment day. Have discharge uploaded on day of treatment to Electronic care records so can be viewed at any time by Doctors, especially in the event of an emergency admission to Accident and Emergency.
   Reviewing the data needed for inclusion into a discharge letter, for immediate discharge and follow-up, the letter went through a number of PDSA cycles through the stone MDM and day of treatment.
   We moved from a hand printed discharge letter to an electronic generated letter, allowing a standard letter to be generated, with all necessary information required for completion.
   The letter had to be quick (less than 5 minutes) and easy for the author to complete.
   Following meetings and successful lobbying of the Electronic Care Records team (Northern Ireland regional Electronic notes) we achieved access and upload of the discharge letter. The letter can now be uploaded to Electronic Care Records straight after its generation, and allows a printed copy to the patient.
   The patients General Practitioner (GP) had previously received a typed discharge letter some 6 weeks following the patient's treatment. The standard electronic uploaded discharge summery immediately following treatment meant the additional letter to the GP was no longer required**.** The electronic generated discharge therefore prevented any further secretarial input, and thus saving money.

3. Review on pain medication given to patients at Southern Trust Stone Treatment Centre, and recommendation for breakthrough medication during ESWL treatment.
   A literature review was conducted on the Stone Treatment Centre long standing use of Piroxicam prior to ESWL treatment. The data suggested that the NSAID diclofenac may~~be~~ provide a more successful pain relief than Piroxicam 20mg.

Prospective data on treatment parameters and pain scores were collected on the pre-ESWL medication Piroxicam and paracetamol given to patients on the day of treatment. From reviewing patients receiving 20mg Piroxicam and 1g paracetamol, compared to those who could only receive paracetamol due to Piroxicam contraindication there was no benefit of receiving the addition of Piroxicam compared to paracetamol alone.

Following the evidence collected and literature review, the pain medication was changed to pre-ESWL Diclofenac Potassium 100mg oral and paracetamol. The work included the input from the pharmacy team, who also consulted the literature and evidence available. The Stone Treatment Centre will now collect data on the pain medication change to Diclofenac Potassium 100mg oral and paracetamol, to ensure a change has been an improvement.

Patients contraindicated to NSAIDS could receive codeine phosphate or tramadol.

A breakthrough pain medication was highlighted in the review. Following investigation work, Penthrox (3mg Methoxyflurane**)** was identified as a possible solution. The medication required for breakthrough pain relief had to be administered by a staff nurse only, with no doctor present. The Scottish Stone Centre used an opiate based breakthrough medication to achieve adequate stone treatments for patients requiring additional pain relief. The Craigavon Stone Treatment centre is staffed by a radiographer, staff nurse and health care assistant, and thus not suitable for opiate administration, which requires x2 staff nurse to check the medication. Options were explored for the provision of a second staff nurse, but were restricted by cost and availability of a second staff nurse. Penthrox is a recognised pain relief and used widely in Australia, especially by Emergency Departments and Paramedics, and is safe to be administered by a single staff nurse, with very few contraindications. A medication New Product Application was successfully passed by the Hospital Drugs and Therapeutics board, which included a literature review of the current evidence (see appendix). The board required evidence of the effective use of Penthrox as a breakthrough pain relief for ESWL, for 50 patients, data collection currently ongoing.

4. Have architectural drawing proposal on how to alter Stone Treatment Centre to also provide private consultation room for patients, and area to change and keep personal items secure.
   The Stone MDM team and hospital architect reviewed the recommendation and official hospital architectural plans were drawn. We were unable to expand the floor print of the centre, but in moving several plasterboard walls, a changing room for patients and suitably sized consultation room could be constructed. This left a recovery room, which doubles as the Stone MDM room on a Thursday morning, and the treatment room for ESWL. See Appendix for the plans, which have been approved and are on the Hospital waiting list to be undertaken.

   We involved the hospital estates team to ensure the ventilation to the room was suitable. Calculations for the use of Penthrox for air changes were undertaken and

the number of air-changes was easily improved by re-calibrating the system.

**11. Leadership Approach**

The NHS Healthcare Leadership Model provided a structured road map for leadership with a view to Improvement of a service, through the nine dimensions of Leadership Behaviour (NHS, 2013). Using the model we started by Inspiring a Shared Purpose with the Stone Treatment Team on a vision of where the centre could improve for the benefit of the patient. It was also important to listen to each member of staff in helping to develop and reach their individual goals, such as the request to be involved in research and development of the centre (Research Nurse/Radiographer funding application), the aim of a radiographer to learn treatment of distal ureteric stones with ESWL (Staff sent to Edinburgh Stone Treatment Centre to observe and learn).

Data collection was important, so changes could be made following the evaluation of the information gained, and improvement could be measured in a quantitative method where possible, such as the improvement to the pain medication. It was important though to collect the data as a team and through the weekly team meeting, analyse and act through improvement science methodology, such as the numerous PDSA cycles, time and motion studies, patient questionnaires.

It was important to work collaboratively with other teams, such as Accident and Emergency and Radiology when it came to initiating the improvements to the diagnostic and referral pathway for renal and ureteric stones. The Stone Service is intrinsically connected to the wider Health Care Service and so important to build strong, workable, strategic relationships with other departments involved in the patient journey of stone diagnosis through to treatment. We took time to understand the issues affecting other departments and addressed any concerns of the new referral pathway. With the interconnectivity of the other departments involved, we had to share the vision early, and highlight the benefits this would produce for the Stone Service, for the patient and for their own departments.

It was important to keep the team united, focused and motivated on the task in hand. The weekly meeting helped bring the team together and allowed a platform for staff to air their views on aspects of the project. The provision of the meeting with tea/coffee and croissants in a room away from any active clinical duties, helped staff to openly discuss the issues in play and feel part of the team and want to contribute. Setting the right environment to succeed is fundamental for team working and achieving the aim, and there is much we can learn from how the commercial world interact and achieve the best from their staff (Deloitte, 2016).

Developing and encouraging progression of staff enabled the project to achieve the improvement aims. Developing the staff, developed the service, developed the teams skills in improvement science, giving evidence based results.

Presenting our results to the Hospital Senior Team allowed the request for further funding to develop the Stone Treatment Centre and to be on the waiting list for structural layout improvement to the Centre. By demonstrating our results on how we could decrease waiting times for stone treatments, decrease the need for outpatient appointments, cut the cost of emergency stone treatments, decrease the waiting time and cost of discharge summery from Stone Treatment Centre we hope to highlight to the Senior Team to the need and importance of the Stone Treatment Centre.

Eric Dishmans TED talk on 'health care as a team sport', a personal view through his own renal disease, and the need to be pro-active on healthcare, take the patient on the journey with you and empower them to understand and prevent their disease or disease progression (Dishman, 2014). In a stone context, treat the stone and prevent recurrence, but the patient needs to understand their stone disease. The Stone Treatment Centre improvement model will progress in the future to prevention strategies by utilising patient groups along with a Stone Treatment Centre dietician to prevent recurrence of their stone disease.

Many different staff groups were involved or impacted by the project, including Urology, Radiology, Pharmacy, Accident and Emergency, Estates, IT, Administration and Management. Leadership of the project was based on the 'Developing Collective Leadership for Health Care' Kings Fund paper (Michael West, 2014). The project needed a 'post-heroic' model of leadership, and so we undertook collaborative leadership, to create a positive environment where ownership of the implementation and success or failure of the project is a shared responsibility and mission. Using a collaborative leadership model and the inherent aims of the project a 'high concern for people and high concern for productivity', the most work with content staff was achieved (Blake R R, 1991).

The work of Parish (C, 2006) identified that a broad range of leadership styles (directive, visionary, affiliative, participative, pace-setting and coaching leadership) are demonstrated by a successful leader. The range of leadership styles still needs to be relevant to a modern Health Care Setting, with an overarching theme of collaboration…. 'Coming together is a beginning, staying together is progress and working together is success' (Ford)

**12. Outcome and improvement measures**

The improvement project is a continuum and not a single finish point. Much was achieved and improved, and the more success will follow.

| Aim | Result Outcome | Quality Improvement method and evidence | Future |
|---|---|---|---|
| 1. Emergency ESWL | Ability to provide a forth treatment on ESWL treatment session | • Time and motion study<br>• Weekly team meeting<br>• Cost analysis vs Main theatre (Potential saving of £874500 over 5 years) | • Funding application for further sessions |
| 2. Meet demand for ESWL elective sessions | Funding application with evidence submitted for extra sessions | • Cost analysis vs Main Theatre (ESWL saves potential £1248 and £2235 per patient when compared to day case and inpatient Theatre Ureteroscopy)<br>• Ability to book patient directly from Urology MDM<br>• Reducing Outpatient appointments | • Await outcome of funding<br>• Provide sessions for other trusts in Northern Ireland/ Cross boarder |
| 3. Provide stone | • Urology | • PDSA cycles | • Patient |

| | | | |
|---|---|---|---|
| treatments recommended by NICE, BAUS and EAU<br>4. Provide patient with informed choice | Stone MDM<br>• Evidence based stone pathway<br>• Patient information leaflets<br>• Chance to discuss in person | on paperwork and Stone MDM<br>• Patient interviews | questionnaire<br>• Further PDSA cycles |
| **As a result of original aims** | | | |
| a. Patient discharge summery | • Electronic and printed paper version on day of treatment | • Decreased discharge summery time from weeks to immediately following treatment<br>• Saved administration and medical cost and time | • Improvements planned to the electronic discharge sheet for 2019 |
| b. Improvement to Stone Treatment Centre Building layout | • Architectural plans and successful buildings work submission | • Time and motion study<br>• Patient interviews<br>• Staff walk around | • Await building works |
| c. Stone diagnostic and referral pathway | • Currently in use<br>• Evidence based | • Patient now having calcium and uric acid checked and point of care<br>• Appropriate information now gained for decision of treatment of stone | • Currently paper version<br>• **Should aim for electronic referral on Electronic Care Records** |
| d. Stone MDM | • Patients discussed | • Evidence based | • Needs administrative |

| | | | |
|---|---|---|---|
| | weekly via A+E referral pathway<br>• Faster decision and review of patients stone disease then waiting for outpatient appointment | treatments<br>• Staff education<br>• Patient information and education<br>• Saves on Outpatient appointments (saves £420 per patient booked for ESWL) | personal dedicated to Stone Treatment Centre |
| e. Pain medication for ESWL | • Changed to Diclofenac Potassium<br>• Trial of Penthrox breakthrough medication | • Study on Piroxicam ESWL pain medication, led to change to Diclofenac | • **Patient pain questionnaire on diclofenac and Penthrox for evidence of effectiveness of use, results awaited** |
| **f. Application for Stone Treatment Centre Research post** | • Application accepted for research funding | • Ability for collecting and analysing Stone Treatment and medications | • Await and plan for start of research project, including staff recruitment |

**13. Project sustainability**

The continuation of the project is through the collaborative team model established, and will be steered in the correct direction by Urology Clinical Lead Mr Young , Staff Grade Ms Laura McCauley and Martina Corrigan, with help from all of the Stone Treatment Team. The project is and will always be team approach.

The increasing obesity epidemic, ageing population, sedentary lifestyle and potentially global warming (increasing temperature with poor fluid intake) highlights the importance of this project, not only to meet the demand for current stone patients, but to build capacity for the future increase. It is a project therefore that cannot be ignored.

14. Bibliography

A.N.Argyropoulos, D. T. (2010). SWL is more cost-effective than ureteroscopy and Holmium:YAG laser lithotripsy for ureteric stones: A comparative analysis for a tertiary referral centre. *British Journal of Medical and Surgical Urology,*, Volume 3, Issue 2, Pages 65-71.

Better OS, A. A. (1973). Studies on renal function after relief of complete unilateral ureteral obstruction of three months' duration in man. *The American Journal of Medicine* , 234-240.

Blake R R, M. A. (1991). *LEADERSHIP DILEMMAS- GRID SOLUTIONS.* Houston : Gulf Publising .

British Association of Urological Surgeons . (2016, March). *Lithotripsy, Procedure Specific Information* . Retrieved September 10, 2017, from http://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/ESWL.pdf

C, P. (2006). Being nice is not enough for good leadership on the wards. *Nursing Standard* , 20 (41):6.

C. Türk (Chair), T. K.-c. (2016). Urolithiasis. *European Urology Guidelines* , 3.4.2.3.3.-3.4.3.3.

Campbell, D. (2015, January 19). *NHS cannot cope with ageing population, warns top doctor*. Retrieved January 06, 2017, from The Gaurdian : https://www.theguardian.com/society/2015/jan/19/nhs-we-have-not-fit-for-future-warns-top-doctor-bruce-keogh

Deloitte. (2016). *Ingedients for Success, Striking the Right Balance.* Deloitte.

Dishman, E. (2014, March 04). *Healthcare should be a team sport* . Retrieved November 01, 2016, from TED@Intel: https://www.ted.vom/talks/eric_dishman_health_care_should_be_a_team_sport/up-next#532964

Donabedian, A. (2005). Evaluating the Quality of Medical Care. *The Millbank Quarterly*, 83(4):691-729.

Fink RL, C. D. (1980). Renal impairment and its reversibility following variable periods of complete ureteric obstruction. *The Australian and New Zealand Journal of Surgery* , 77-83.

Ford, H. (n.d.).

Langley, G. N. (June 1994). *The Foundation of Improvement, Quality.*

Michael West, K. S. (2014, May 21). *Developing collective leadership for health care*. Retrieved January 6, 2016, from Kings Fund : https://www.kingsfund.org.uk/publications/developing-collective-leadership-health-care

NHS. (2013). *Healthcare Leadership Model Version 1.0.* NHS.

NICE. (2015). *Renal or ureteric colic - acute*. Retrieved Febuary 08, 2018, from https://cks.nice.org.uk/renal-or-ureteric-colic-acute#!backgroundsub:2

O'Neill, M. (2016). *Health and Wellbeing 2026: Delivering Together'* . Northern Irish Assembly.

Professor Rafael Bengoa (Chair), D. A. (2016). *Systems not structures, changing health and social care.* Northern Irish Assembly .

Royal College of Physicians Ireland. (2012, October 05). *Driver Diagrams.* Retrieved September 01, 2016, from Leadership in Quality in Healthcare : publichealth.hscni.net/sites/default/files/directorates/files/CAW%20Day%20

Southern Health and Social Care Trust. (n.d.). *Southern Health and Social Care Trust*. Retrieved January Friday, 2017, from Corporate Information : http://www.southerntrust.hscni.net/about/1594.htm

TED Talks. (n.d.). *TED Talks*. Retrieved from www.ted.com>talks

Vaughan, E. J. (1971). Mechanism of acute hemodynamic response to ureteral occlusion. *Investigative Urology*, 109-118.

World Health Organisation . (2015, October ). *Patient Advocates use past experience to change the future* . Retrieved December 03, 2016, from WHO: www.WHO.INT

**15. Appendix**

a. **Ureteric and Renal Stone Pathway (guidance and referral form)**
b. **Urology Stone Multidisciplinary Meeting**
    - **i. Patient Pathway Stone MDM**
    - **ii. Patient Information Pack**
        - **iia. Template Letters**
        - **iic. Patient Information and Consent Form**
        - **iib. Anticoagulation Pathway**
c. **ESWL Treatment Day Protocols**
d. **ESWL Medications**
e. **Craigavon Area Hospital ESWL TMS i-sys Sonolith lithotripter Adult Protocol**
f. **Business Case Proposal**
g. **Research funding proposal**

**a. Ureteric and Renal Stone Pathway**

**Including guidance for pathway and referral form**

# Ureteric and Renal Stone Pathway

Southern Trust Hospitals

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

**Completed form send to Urology Consultant on-call, 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:**

**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)**

**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:**

-

-

**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)

**Completed form send to Urology Consultant on-call, Craigavon Area Hospital**

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

**Radiology:#**

It would aid stone management if the radiologist were to record

1. Stone size
2. Stone location
3. Stone attenuation
4. Skin to stone distance
5. Hydronephrosis
6. Congenital anomalies
7. Extravasation
8. Stranding

# Based on AUA guidance http://www.auanet.org/guidelines/imaging-for-ureteral-calculous-disease accessed August 2017.

**b. Urology Stone Multidisciplinary Meeting**

**Time:** 09:00 Thursday mornings

**Location:** Stone Treatment Centre, Craigavon Area Hospital

Urology Consultants, Staff grade, STC Sister, Radiologist, Radiographer, Secretary

**Stone meeting agenda** to be produced by the Urology Staff Grade or Fellow attached to the unit. Urology referrals to be reviewed and checked for accuracy, then work list generated on ECR. Any forms missing vital information to be returned to sender unless delay may impact upon safety of a patient, in which case organise to see patient urgently.

| **Patient Details** | **Imaging modality and stone details** | **Meeting outcome** | **Specific Tasks** |
|---|---|---|---|
| Example 343234321 | NC CTKUB 01/01/17. 7MM upper ureteric stone | ESWL | Stop rivaroxaban 2 days prior |

The imaging modality and stone details can be cut and pasted into the diagnosis part of a **letter template**, pending on meeting outcome decision.

**Patient pathway** to be determined at meeting, see table 1.

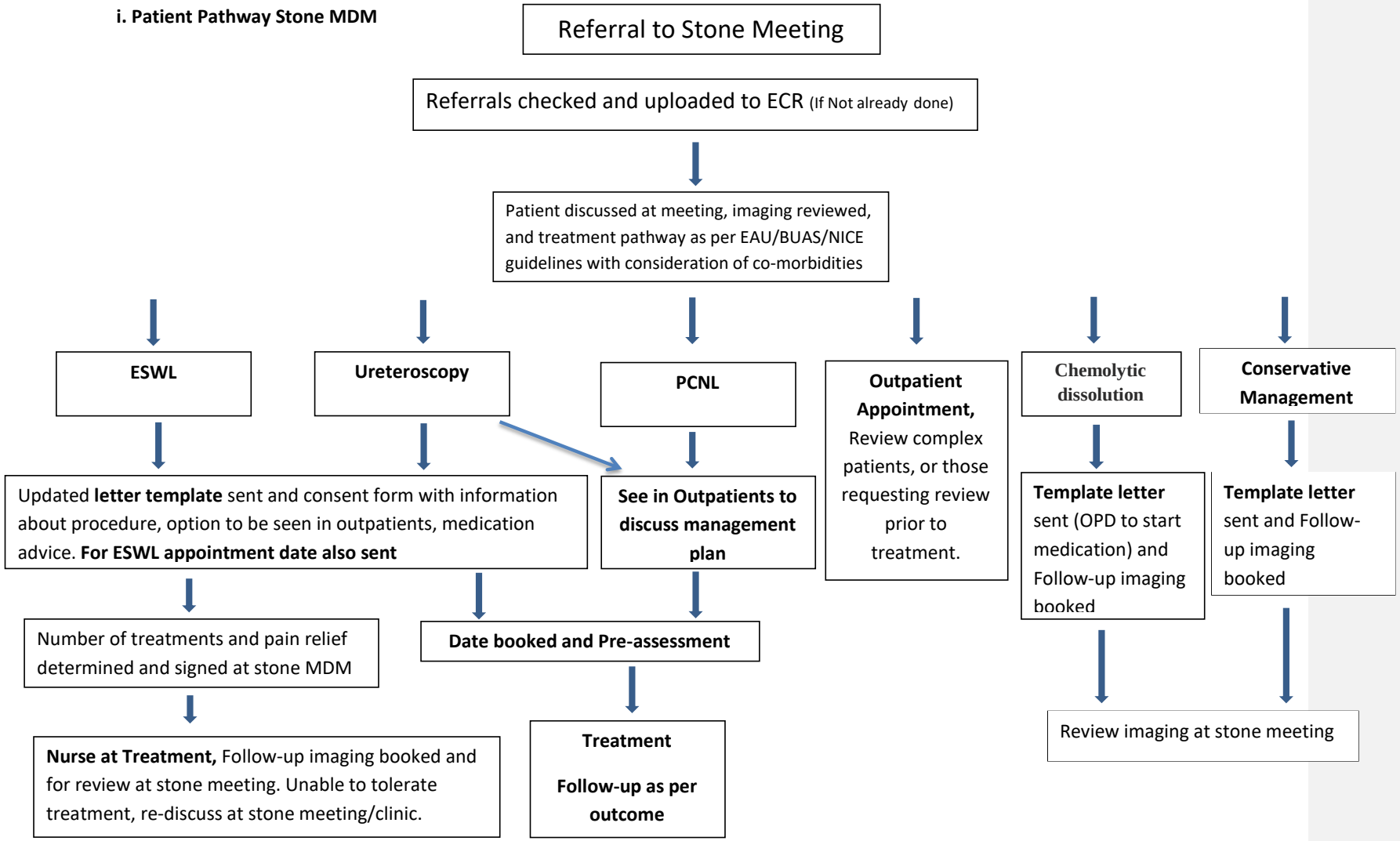
**ESWL booking** is organised at meeting. Appointment date, meeting letter (template as above), consent form, patient information, and **anticoagulation medications advice** sent out following meeting. The secretary can organise letter at time of meeting, since only the imaging modality and stone details need added to template. Alternatively the meeting outcomes can be forwarded to the secretary following meeting conclusion.

**ESWL Radiology request** completed at meeting containing: 1. Stone side and location
2. Number of ESWL sessions
3. Follow-up imaging planned

**Dictation** for complex patient may be needed and should be ready for use.

**Medications** for ESWL can be signed for each patient, Pharmacy to provide pre-printed drug cards to save time on prescribing and ensure clarity of prescription. Pre-printed outpatient script for take home medication. Allergies and contraindications are checked on referral, ECR and again on day of treatment by nursing staff prior to administration.

**i. Patient Pathway Stone MDM**



# ii. Patient Information Pack

**Patient Letter and Information Pack**

The Urology MDM allows for direct template letter to be sent to the patient, explaining they have been discussed by the multidisciplinary panel and which treatment pathway has been advised.

Patients who are not suitable for direct treatment pathway will be called to clinic to discuss management, these will include all PCNL and ureteroscopy (at present) patients and those deemed the highest risk for any treatment.

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

**Pre-assessment:** All patients listed for ureteroscopy and PCNL. ESWL patients deemed high risk on anticoagulation should undergo pre-assessment so clexane cover can be organised as per guidelines.

**Patient Hospital Contact**: The letter will contain the contact number of Stone Centre secretary, for which the patient will contact if:

1. Request OPD instead of direct to treatment
2. If date received is not suitable
3. If stone has passed (patient advised to present to GP for stone to be sent for analysis), so can be re-discussed at meeting for follow-up

**Font size**

The font size can be increased for any patient who has difficulty in reading and sent out accordingly by the secretary

**Language**

The patient information is set as English. A further copy could be provided using patient language services to translate the information before being sent. A template letter and consent form could be created for common other languages that are not English, with translator provided on day of treatment.

Dear iia. Template letter for Conservative Treatment

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

**There is a very good chance this stone will pass and not need surgery/intervention.**

We have organised repeat imaging in 6 to 8 weeks' time to check for stone passage, the x-ray department will contact you with a date. However, if you are unwell in the interim, especially with a high temperature, please attend your GP or A+E.

**Dietary Advice**

• Specific types of stone can be managed by measures aimed at the cause of your stone formation

• Generally, keeping your urine dilute & colourless reduces your risk of forming a further stone by almost one third (30 to 40%)

• In addition, a normal calcium, low-salt, low-protein dietary intake can reduce your risk of stone formation even further

If you pass the stone, please call **Paulette on** Personal Information redacted by the USI or **Gemma on** Personal Information redacted by the USI, and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

If you have any further questions please call number above.

**Your repeat imaging in 6 to 8 weeks will be discussed at the Stone Centre Meeting and we will contact you with the outcome.**

Many thanks

Mr Young FRCS(Urol)

Urology Consultant

Dear Template Letter for ESWL Stone Treatment

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** Personal Information redacted by the USI or **Gemma on** Personal Information redacted by the USI **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** Personal Information redacted by the USI first, otherwise call **Gemma on** Personal Information redacted by the USI, 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

Dear Template Letter for Ureteroscopy and Laser

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

We have recommended for you, **Ureteroscopy and laser, under general anaesthetic** in order to treat your stone.

We shall see you in our outpatient clinic to discuss your stone management further.

Enclosed with this letter:

1. Information sheet on **Ureteroscopy and laser to stone**, under general anaesthetic
2. Dietary advice sheet to help decrease risk of further stones

If you pass the stone, please call **Paulette on** Personal Information redacted by the USI or **Gemma on** Personal Information redacted by the USI, and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

We look forward to meeting you at Craigavon Area Hospital.

Many thanks

Mr Young FRCS(Urol)

Dear

# Template Letter PCNL

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

We have recommended, **Percutaneous Nephrolithotomy (PCNL), under general anaesthetic** in order to treat your stone.

We shall see you in our outpatient clinic to discuss your stone management further.

Enclosed with this letter:

1. Information sheet on **Percutaneous Nephrolithotomy (PCNL)**, under general anaesthetic
2. Dietary advice sheet to help decrease risk of further stones

If you pass the stone, please call **Paulette on** Personal Information redacted by the USI or **Gemma on** Personal Information redacted by the USI, and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

We look forward to meeting you at Craigavon Area Hospital.

Many thanks

Mr Young FRCS(Urol)

Urology Consultant

Dear

# Chemolytic Therapy

Patient Details: Insert here

Your kidney stone was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging demonstrated: Insert here

We have organised for you, **specialised dissolution therapy, this is medication to dissolve your stone.**

Enclosed in letter:

1. Information sheet on Chemolytic dissolution of kidney stones
2. Dietary advice sheet to help decrease risk of further stones

We shall see you in Stone Treatment Clinic to discuss starting the treatment medication in the near future.

When your outpatient appointment letter arrives, please phone to confirm.

If you pass the stone, please call **Paulette on** Personal Information redacted by the USI or **Gemma on** Personal Information redacted by the USI, and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

Many thanks

Mr Young FRCS(Urol)

Urology Consultant

## iib Patient information and consent form

Procedure specific information should be sent to each patient when directly booked for a procedure from Urology Stone MDM. This should provide information on the treatment selected and alternatives, as well as a clear presentation of contraindications and risks so the patient can make a balanced decision themselves if they wish to proceed or not.

Further to the procedure specific information, a consent form is attached to be signed by the patient once they understand and agree to go ahead with the treatment proposed. This consent form should be brought to the day of treatment with the patient and countersigned by the nurse.

**What if the patient doesn't wish to go ahead with the proposed treatment or wish to ask further questions?**

A telephone number for **Stone Treatment Centre** secretary is provided on the letter template from Urology Stone MDT. The patient may contact this number and arrange an outpatient appointment or phone-call appointment for further discussion as required, prior to any treatment going ahead.

**Next Page is ESWL patient information and consent form**

# Extracorporeal Shockwave Lithotripsy (ESWL)

## What does the procedure involve?

Delivering shockwaves through the skin to break kidney stones into small enough fragments to pass naturally. This involves either x-ray or ultrasound to target your stone.

## What are the alternatives to this procedure?

Telescopic surgery, keyhole, open surgery and observation to allow stones to pass on their own.

## What should I do on the day of ESWL treatment?

1. Please take all prescribed medications, except blood thinners (anticoagulants), which you should have already stopped as per anticoagulant advice sheet.
2. You can have a light meal on the morning of your treatment (or light lunch if an afternoon appointment), but you should drink only water in the two hours before the treatment.
3. **Please bring your consent form and your medications on the day of treatment.** It is helpful if you bring your own dressing gown to wear.
4. We advise you bring someone with you and not to drive yourself home following your treatment, especially if you have received any medication with a sedative effect. In the absence of a chaperone we may have to restrict your medication and treatment.
5. Please leave enough time to park at the hospital if driving; it can take up to 30 minutes to find a parking space.
6. On arrival:
   a. Book into A+E reception for your ESWL treatment (see map)
   b. (If on Warfarin proceed to blood room, see map)
   c. Proceed to Stone Treatment Centre for ESWL Treatment

## On arrival to stone treatment centre

1. Ring the bell, take a seat and the nurse will be with you shortly.
2. **Please tell your Health Care Provider before your treatment** if you have any of the following:
   A. Usually take blood thinning medication such as warfarin, aspirin, clopidogrel (Plavix®), rivaroxaban, prasugrel or dabigatran.
   B. Heart pacemaker or defibrillator
   C. Artificial joint
   D. A history of abdominal aneurysm
   E. A neurosurgical shunt
   F. Any other implanted foreign body
   G. An artificial heart valve
   H. PREGNANT
   **J. <u>Tell Your Nurse on Arrival</u> if you have <u>ANY ALLERGIES</u>**

3. You may need to pass a urine sample on arrival for analysis

4. Pain relief will be given at least 30 minutes before, and additional pain relief might be needed during the treatment

## What happens during the procedure?

You do not need an anaesthetic and you will be awake throughout the procedure. We usually only use general anaesthetic for children.

You will be asked to lie on the treatment bed and your stone will be located by Ultrasound and/or X-ray. Gel will be applied to the skin over your kidney and the treatment head, which generates the shockwaves to treat your stone, will be placed comfortably against this part of your back (as per picture).

You will have a sensation like being flicked in the back by an elastic band. You will hear a clicking noise of the machine during the treatment.

Your treatment will be monitored by a Nurse and Radiographer.

You may also feel a deeper discomfort in the kidney. If this proves too painful, we can usually give you an additional painkiller.

Your treatment will normally last up to 60 minutes, with an average total stay of 2 hours in the Stone Treatment Centre.

## Following the Procedure

Please feel free to ask how the procedure went and ask any questions.

Patients usually stay with us for up to 30 minutes, to be monitored by the nurse and light refreshments will be offered.

You will be given pain relief medication and a discharge letter from the nurse, which will include your follow-up plan.

## At Home following procedure

1. Rest for 24 hours
2. Drink 6 pints of water a day (unless told to fluid restrict by your doctor)
3. Some pain may be expected, please take your pain relief medication when needed.
4. Expect to see blood in the urine for 3 to 4 days. Restart blood thinning medication 2 days after treatment, unless heavy bleeding.
5. If any blistering or bruising appears on your treatment side, use a soothing skin cream to ease discomfort.
6. Any stone fragments passed, please collect and take to your GP for testing.

## What else should I look out for?

If you develop a fever (above 38ºC or 100.4 F), severe pain on passing urine or you cannot pass urine then attend your GP or A+E department immediately.

## Driving after ESWL

We advise not to drive for 24 hours after the procedure. It is the patient's responsibility to know when they are pain free and feel well enough to drive following ESWL treatment.

## Are there any side-effects?

Most procedures have possible side-effects. But, although the complications listed below are well recognised, most patients do not suffer any problems.

**Common (greater than1 in 10)**

- Blood in your urine for up to 72 hours after the procedure.
- Pain in your kidney as small fragments of stone pass.
- Urinary infection due to bacteria released as the stone breaks.
- Bruising or blistering of the skin.
- Need for further ESWL treatment.
- Failure to break stone(s) which may need additional or alternative treatment, especially for very hard stones.
- Recurrence of stones.

**Occasional (between 1 in 10 and 1 in 50)**

- Stone fragments may get stuck in the tube between the kidney and the bladder and require surgery to remove the fragments.

**Rare (less than 1 in 50)**

- Severe infection requiring intravenous antibiotics (less than 1%) and the need for drainage of the kidney by a small tube placed into it.
- Kidney damage (bruising) or infection needing further treatment.
- Damage to the pancreas or lungs by the shockwaves requiring further treatment.

**Information based on British Association of Urology Surgeons, Patient information, Lithotripsy for stones, Published 2016.**

**Further Information can be viewed at:**

https://www.baus.org.uk/patients/conditions/6/kidney_stones

http://patients.uroweb.org/i-am-a-urology-patient/kidney-ureteral-stones/treatment-kidney-ureteral-stones/

**Extracorporeal Shockwave Lithotripsy Consent Form**

**Patient Sticker**

**Please bring on day of ESWL**

**I have read, understood and agree to go ahead with extracorporeal lithotripsy (ESWL) treatment(s) for my renal/ureteric stone**

**……. ……. …….**

**Patient name Patient signature Date**

**…… …….. ……**

**Radiographer name Radiographer Signature Date**

**To be placed in patients notes**

**iiic Anticoagulation** (Please also refer to patient anticoagulation pathway, Stone MDM)

Patients on anticoagulation medication will be identified by the structured referral form and checked on Electronic Care Record at Stone MDT (or prior by Doctor organising the list for Stone MDM). A further check for ESWL is on treatment day by the nurse, otherwise for theatre cases by the pre-assessment team.

For ESWL, patients taking Aspirin 75mg regularly there is controversy if this should be stopped or not. The BAUS patient information leaflet would appear to lean towards stopping the medication (British Association of Urological Surgeons , 2016); the team visit to the Scottish Lithotripter Centre in October 2016 noted their current practise is to stop Aspirin 75mg, 7 days prior to ESWL. Other centres are noted to continue their patients on Aspirin 75mg, but state to stop all other NSAIDs 7 days prior (Colchester Hospital University Foundation Trust , 2016).

A PubMed Search for continued daily patient use of Aspirin 75mg and ESWL was conducted. The search terms included 'ESWL' OR 'Extracorporeal Shockwave Lithotripsy' OR Shockwave lithotripsy' and Aspirin.

A retrospective study could be undertaken in Craigavon as patients who were on 75mg Aspirin, previous to this report patients were not told to stop the medication. Has there been any clinical presentation of renal haematoma or prolonged or heavy haematuria necessitating admission. Since Urology Stone MDT August 2017 the decision was made to stop Aspirin 5 days prior ESWL (Based high bleeding procedures, Southern Trust)

Information sheet on how long before any treatment a patient should discontinue their anticoagulation medication is part of the information pack and produced as part of the Stone MDM. ESWL patients should not restart anticoagulation until 48 hours after the treatment and only when urine is no longer haematuria (European Association of Urology , 2017).

Patients who require bridging low molecular weight heparin should attend pre-assessment so this is safely facilitated for ESWL, as with main theatre procedures.

**Pharmacy and Haematology**

Before the information is to be disseminated to patients the clinical information should also be reviewed by Pharmacy and Haematology teams. When new anticoagulants are introduced to the market, a trigger should be in place to inform the stone MDM so the anticoagulation advice sheet can be updated accordingly. Alternatively this could fall as part of a periodic review of the information pack.

**List position for ESWL and Patients needing an INR**

Patients who are on Warfarin therapy will require an INR prior to treatment with ESWL. Therefore they should not be placed at the start of the morning list, this is to allow their INR blood test to be taken and processed. The haematology laboratory should therefore be contacted once the INR has been sent so to be processed promptly and reduce the chance of a patient delay in treatment whilst the result is awaited.

Blood sample for INR can be collected from the phlebotomy service located next to the Thorndale Unit. The patient could either be sent to the service direct from registering their visit to the hospital at the main reception next by A+E, with the blood form left in preparation with the phlebotomy service. Alternatively the form could be collected by the patient from the Stone Treatment Centre, but this would add on much time for the patient and potential delay in INR result and thus treatment.

## Process for Anticoagulation plan at Stone MDT

- If patient determined low risk for CVD then anticoagulation protocol followed and patient informed by letter from MDT when to discontinue their medication, given a blood form for pre-ESWL INR check and with instruction to ensure first INR check 5-7days after treatment restarted
- If patient determined high risk for CVD then consider postponing procedure or offering alternative treatment e.g. URS or observation
- If patient determined high risk for CVD but requires ESWL then green form completed at MDT and patient referred to Pre-operative assessment:
    - For bridging with low molecular weight heparin (LMWH), the Pre-Operative Assessment Nurse and Pharmacist will ensure the prescription is written and the LMWH is dispensed by the hospital pharmacy.
    - The pre-operative assessment nurse will inform the patient in writing of the dates of administration of enoxaparin and inform their GP about the pre-operative management of warfarin by sending them a copy of the green form.
    - Where possible, the patient / carer should be instructed on self-administration of LMWH by the pre-operative assessment nurse.
    - The post-op management must be documented on green form so that LMWH can be prescribed and dispensed by pre-op assessment in preparation for discharge with appointment made for INR check 5-7days post ESWL

**On day of ESWL:**

• INR should be checked to ensure it is <1.4. If INR is above this target, ESWL does not proceed and patient rescheduled

## Determination of CVD risk for patient

**Low Risk:**

- AF with no prior stroke or TIA
- VTE more than 3months ago
- 6months after MI/ PCI/ BMS/ CABG/ stroke (12months if with complications)

**High Risk:** (consider ureteroscopy/ observation/ postponing of treatment instead of ESWL)

- Mechanical heart valve
- 12 months after drug eluting stent
- Target INR >3
- AF with previous stroke or TIA
- VTE in last 3months (post pone surgery)
- Antiphospholipid syndrome
- 6weeks after MI/ PCI/ BMS/ CABG (6months if complications)
- 2weeks after stroke

(MI – myocardial infarction, PCI – percutaneous coronary intervention, BMS – bare metal stent, CABG – coronary artery bypass grafting)

***References:***


- Sharepoint: http://sharepoint/as/clinical/Anticoagulant%20Documents/Forms/AllItems.aspx
- Alsaikhan, B., & Andonian, S. (2011). Shock wave lithotripsy in patients requiring anticoagulation or antiplatelet agents. *Canadian Urological Association Journal*, *5*(1), 53–57. http://doi.org/10.5489/cuaj.09140
- https://uroweb.org/guideline/urolithiasis/#3


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

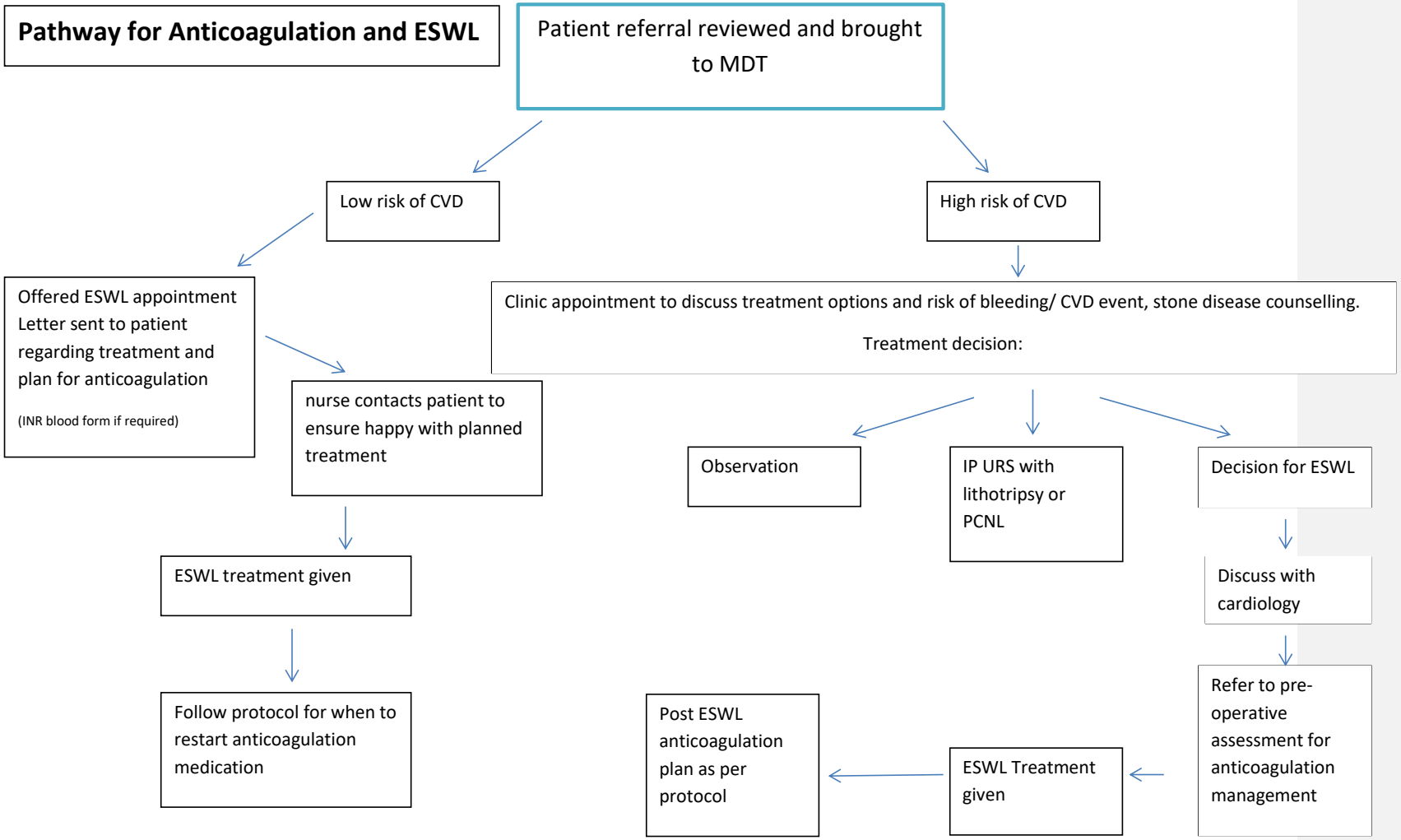
## Management of Anticoagulation in Patients for ESWL

~ CrCl ≥80 stop 48hours, CrCL 50-80 stop 72hours, CrCl 30-50 stop 96hours

| CVD risk | ASA (e.g. Aspirin) | | Thienopyridine agents (e.g. clopidogrel) | | Warfarin | | Dabigatran | | Rivaroxaban/ Apixaban/ Edoxaban | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *Pre op* | *Post op* | *Pre op* | *Post op* | *Pre op* | *Post op* | *Pre op* | *Post op* | *Pre op* | *Post op* |
| **Low Risk** | Stop 5 days | Restart 2days | Stop 5 days | Restart 2days | Stop 5 days | Restart evening (normal dose) | Stop – rv CrCl~ | Restart 2days | Stop 2days# | Restart 2 days |
| **High Risk** | Continue | Continue | Stop 5days<br>Bridge treatment dose LMWH | Restart clopidogrel 2days<br>Discontinue LMWH | Stop 5 days<br>Bridge LMWH:<br>- treatment dose (day 3 and 2 pre op)<br>- 50% of dose day 1 pre op | Restart evening<br>Prophylactic dose LMWH 48hours then resume treatment dose until INR therapeutic | Stop – rv CrCl~<br>Prophylactic dose LMWH | Restart 2days<br>Continue LMWH 2days then stop* | Stop 2 days#<br>Prophylactic dose LMWH | Restart 2days<br>Continue LMWH 2days then stop* |

*Do not give DOAC and LMWH together

# Stop 3 days if Cr Cl <30



# Patient Advice Prior to ESWL Treatment for Stones

**Plan for your anticoagulation (blood thinning) medications: Page 1 of 2**

*(Please see circled which is relevant to you)*

| | |
|---|---|
| **Warfarin** | Please stop 5 days before ESWL<br><br>Please bring the attached blood form and attend the blood (phlebotomy) room at the Thorndale Unit, Craigavon Hospital, for INR at 08:30am on the day of your treatment<br><br>Then proceed to the Stone treatment centre for result review and ESWL treatment<br><br>Please restart your normal dose of warfarin the evening of your treatment.<br>**Please ensure you have an appointment to get an INR check 5-7days after your warfarin is restarted.** |

| | |
|---|---|
| **Aspirin**<br>**Dipyridamole**<br>**Clopidogrel** | **Please stop 5 days before ESWL and restart your normal dose 2 days after your treatment** |

| | |
|---|---|
| **Rivaroxaban (Xarelto)**<br>**Apixaban (Eliquis)**<br>**Edoxaban (Lixiana)** | **Please stop 2 days/ 3days (depends on creatinine clearance) before ESWL and restart your normal dose 2 days after your treatment** |

| | |
|---|---|
| **Dabigatran (Pradaxa)** | **Please stop 2 days/ 3 days/ 4 days (depends on creatinine clearance) before ESWL and restart your normal dose 2 days after your treatment** |

| | |
|---|---|
| **Ticagrelor**<br>**Prasurgel** | **Please stop 7 days before ESWL and restart your normal dose 2 days after your treatment** |

# Patient Advice Prior to ESWL Treatment for Stones



If you have recently undergone a cardiology procedure and are on medication following this procedure, please contact **Paulette on** Personal Information redacted by the USI or **Gemma on** Personal Information redacted by the USI before you accept the appointment.

**Medications/ Supplements**

**Unless you are informed otherwise, please continue all medications that are prescribed by your doctor.**

Many herbs, vitamins and diet supplements may increase the risk bleeding during ESWL.

Certain over the counter medications may also increase your risk of bleeding.

Please stop taking all over the counter medications, vitamins, herbs and diet supplements 7 days before ESWL. You may resume taking these supplements 2 days after your treatment.

**Examples of herbal remedies to be stopped[1]:**

- Garlic[2]
- Ginseng
- St John's Wort
- Ginkgo biloba
- Danshen

**Common over the counter medication to be stopped[3]:**

- Naproxen
- Aspirin (e.g. Anadin, Anadin extra)


1. Cordier W., Steenkamp V. Herbal remedies affecting coagulation: A review. *Pharmaceutical Biology* Vol. 50 , Iss. 4,**2012**
2. Gravas S, Tzortzis V, Rountas C, Melekos MD. Extracorporeal shock-wave lithotripsy and garlic consumption: a lesson to learn. *Urol Res*. **2010** Feb;38(1):61-3. doi: 10.1007/s00240-009-0242-0. Epub 2009 Dec 15.
3. Dickman A. Choosing over-the-counter analgesics. The Pharmaceutical Journal, Vol. 281, p631 | URI: 10040592

**C. Proposed Protocols for ESWL**

**Craigavon Stone Treatment Centre**

Agreed method of working at Urology Stone MDT on

For review 3 months after start date of working at stone MDT.

1. **Staff Nurse checking in and out of Patient**
    1. Patient to Arrive 45 minutes prior to treatment and hand in patient consent and contraindications signed form (Sent by post prior to appointment)
    2. On arrival patient is asked to produce a Urine sample (and pregnancy test for child baring age 12 -55 years of age IRMA guidelines. QUOTE)
    3. In the patient consultation room, consent form checked signed. Contraindications to ESWL form checked with patient again and nurse signs check list to confirm.
    4. Medications given as per protocol (30 minutes before ESWL , ref evidence meds onset of action)
    5. Following completion of ESWL, patient to remain in waiting room, given light refreshments and observed for 30 minutes.
    6. Bloods pressure, Heart rate, respiratory rate and oxygen saturation checked prior to discharge.
    7. Radiologist books patient for either;
        1. Follow-up imaging as indicated by stone meeting or
        2. Re-book slot for ESWL and inform patient of date and time, included in discharge letter (add to hospital W/L)
    8. Upon discharge copy of discharge and medications given and explained, ESWL post procedure advice sheet given.

2. **Medication Protocols**

    1. Patient to receive medication pathway set and prescribed at Thursday morning stone meeting
    2. Nurse to check with patient allergies/ check contraindication
    3. Pathway 1,2,3,4 Nurse led, Pathway 5 Doctor led

| | Pathway 1 | Pathway 2 | Pathway 3 | Pathway 4 | Pathway 5 |
|---|---|---|---|---|---|
| 30mins prior to ESWL, oral medications | Paracetamol 1g | Paracetamol 1g, Diclofenac Potassium 50mg oral | Paracetamol 1g, Diclofenac potassium 50mg oral | Paracetamol 1g | Doctors led, meds advised |
| Breakthrough pain relief during ESWL | Not suitable | Not suitable | Penthrox 3ml inhaler | Penthrox 3ml inhaler | Penthrox or Alfentinal |

3. i. **Radiographer ESWL treatment and discharge letter**
    A. Patient consent form counter signed by radiographer
    B. Stone to be treated as per Stone meeting outcome letter or as per stone clinic outpatient letter.
    C. Stone localised using USS and/or fluoroscopy
    D. Ramping as per protocol

E. Following completion of patients dedicated treatment hour please fill **lithotripter e-discharge to state**

1. Patient full name, date of birth, address
2. Radiographer and nurse full name
3. Urologist responsible for patient
4. Blood pressure before/ during/after
5. Medication given prior, during and discharge from treatment
6. Number of shocks, energy and power
7. Stone location
8. Pain encountered during treatment
9. Fragmentation
10. **Until the software changes below have been made, please use the free text comment box to fill out <u>either</u>** a. Rebooked for second treatment to same stone
    b. Rebooked for third treatment to same stone
    c. Rebooked for fourth treatment to same stone
    d. Rebooked for treatment to concurrent stone
    e. Follow-up imaging 6weeks (option x-ray, USS, both or CTKUB)
    f. Re-discuss at MDT meeting due to treatment failure or complication
    g. Stone clinic review

**Software changes proposed;**

*i.* Hounsfield units of stone being treated
*ii.* Validated Pain score 0-10
*iii.* Treatment limited due to: drop down box
    *a)* Pain
    *b)* Nausea and vomiting
    *c)* Other patient factors
    *d)* Time constraints
*iv.* Stone to skin distance (cm)
*v.* Accurate stone size from original CT (mm)
*vi.* Number of treatments to stone
*vii.* Record of other stones present (green colour on diagram, red treated stone)
*viii.* Allergies (free text)
*ix.* Free text comments
*x.* Drop down selection of follow-up
    *a)* Rebooked for second treatment to same stone
    *b)* Rebooked for third treatment to same stone
    c) Rebooked for fourth treatment to same stone
    *d)* Rebooked for treatment to concurrent stone
    *e)* Follow-up imaging 6weeks (option x-ray, USS, both or CTKUB)
    *f)* Re-discuss at MDT meeting due to treatment failure or complication
    *g)* Stone clinic review

**<u>e-discharge is then uploaded to ECR (copy to patient/GP/patients notes)</u>**

ii. **Auxiliary Nurse during treatment**

A. Ensure patient comfort on table; supervise patients to prevent moving off the table during a treatment. Allow patient to play music they have brought in and use the earphones if patient has brought their own with them.

B. Undertake continuous observations of **heart rate** and **oxygen saturation** during Penthrox use, and ask radiologist to stop treatment and retrieve staff nurse from adjoining room if patient concerns raised, such as increased MEWS.

C. **Blood pressure** check every 15 minutes during Penthrox treatment, or more regular if required.

iii. **Staff nurse**

A. To provide Penthrox medication as breakthrough pain relief to suitable patients.

**4. When Help is needed**

1. **Treatment Query;**
   - Urgent advice needed then contact Mr Young on Mobile Personal Information redacted by the USI
   - Call Urology Registrar on call if Mr Young unavailable
   - If unable to contact then call consultant on-call via switch board (0)

2. **Unwell patient;**
   - Contact the Registrar on Call for Urology on bleep Personal Informatio or mobile through switch board. If unable to contact call the Consultant on-call.

Cardiac Arrest or Peri-arrest Dial Personal Informati and state 'cardiac arrest, stone treatment centre' Then call Urology Doctors.

## Nurse Checklist for Stone Treatment centre

**Admission**: Date: _____ **Patient Label:**

Time: _____

Signed: _____

Print Name: _____

| Prior to treatment | YES | No | Comment if required |
|---|---|---|---|
| Confirm patient details | | | |
| Confirm patient understands treatment and any questions | | | |
| Chaperone present | | | |
| Review medication list | | | |
| Allergies (incl latex) | | | |
| Medications stopped as advised | | | |
| Able to take NSAIDs | | | |
| Urinalysis (POCT urine if symptomatic of UTI, Immunosuppressed) | | | (See flow chart) |
| Pregnancy test (12 to 55 years of age) | | | |
| **Safety checklist from patient:** | | | |
| Anticoagulation stopped as per protocol | | | List medication held: |
| Artificial heart valve | | | If yes give antibiotic prophylaxis<br>Check anticoagulation protocol |
| Pacemaker or defibrillator | | | Electrophysiologist check/programme pre and post ESWL<br>**YES/NO** |
| Artificial joint or mobility concern | | | |
| Abdominal aneurysm | | | Proceed only if aneurysm discussed at MDT and ESWL recommended. **YES/NO**<br>Otherwise, cancel ESWL and discuss at Stone MDT |
| Neurosurgical Abdominal shunt | | | Cancel treatment and discuss at Stone MDT |
| Neurostimulator or other abdominal implant | | | If aware at MDT and ESWL to proceed **YES/NO**<br>Implant not to be in focal zone of treatment |
| Pregnancy test positive | | | Cancel if positive and discuss at Urology Stone MDT |
| | | | |
| **Pre ESWL Medications given and signed for** | | | |
| Counsel on use of Penthrox (if indicated) | | | |
| Consent form check – radiographer countersigned | | | |

| During treatment | YES | No | Comment if required |
|---|---|---|---|
| Penthrox used | | | |
| Comments | | | |

## Observations

**Admission**

**BP:** **Pulse:** **Sats on air**: **Temperature:**

**During Treatment**

| Time | BP | Pulse | Sats on air | Other (if required) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**After treatment and on discharge**

**BP:** **Pulse:** **Sats on air**: **Temperature:**

| After treatment | YES | No | Comment if required |
|---|---|---|---|
| Post ESWL information given | | | |
| Medications for discharge | | | |
| Chaperone | | | |
| Anticoagulation to restart | | | Restart date as per protocol/ warfarin clinic organised **YES/NO** |
| e-Discharge letter for GP and patient | | | |
| Follow up arrangements made by radiographer | | | |

**Discharge:** Date: _____

Time: _____

Signed: _____

Print Name: _____

## Management of blood pressure Prior to ESWL Treatment

Acute episodes of hypertension may arise in a variety of clinical settings due to the exacerbation of a pre-existing chronic hypertensive condition or as *de novo*. Emergency, intensive care, anaesthesia, and surgery are among the clinical settings where prompt recognition and treatment of acute hypertensive episodes (AHE) is of paramount importance. A variety of surgical and medical events may trigger intense sympathetic activity, resulting in sudden elevations in blood pressure (BP).

### Table 1

Classification of Blood Pressure for Adults Aged ≥18. **(Pre-ESWL)**

| Category | Systolic Blood Pressure | Diastolic Blood Pressure | |
|---|---|---|---|
| Normal | <120 | <80 | Proceed with ESWL. |
| Pre-hypertension | 120–139 | 80–89 | |
| Hypertension-Stage I | 140–159 | 90–99 | Proceed with treatment with ESWL. Advise patient to have BP rechecked with GP. |
| Hypertension-Stage II | ≥160 | ≥100 | Return to GP for checking and managment |
| Hypertensive Urgency | >180 | >120 | Contact oncall doctor Personal Information – to discuss with medical team. |
| Hypertensive Emergency | >180 | >120 and target organ damage | |

Adapted from Chobanian, 2003.

Tulman DB, Stawicki SPA, Papadimos TJ, Murphy CV, Bergese SD. Advances in Management of Acute Hypertension: A Concise Review. *Discovery medicine*. 2012;13(72):375-383.

**d. ESWL Medications**

**(Pain Relief and Antibiotics)**

**PATHOGENESIS OF PAIN DURING ESWL**

The pain experienced by a patient receiving ESWL is multifactorial, but broadly speaking can be split into patient factors and lithotripter factors.

| Patient Factors | Lithotripter Factors |
|---|---|
| Cutaneous superficial skin nociceptors* | Lithotriptor type^ |
| Visceral nociceptors such as periosteal, pleural, peritoneal* | Size and site of stone burden^ |
| Musculoskeletal pain receptors* | Location of shockwave focal stone^ |
| Pain tolerance | Size of focal zone^ |
| Pre-existing injury | Cavitation effects^ |
| | Shockwave peak pressure^ |
| * (Weber A, 1998) | Entry of shockwaves at skin^ |
| | Coupling |
| | (Basar H, 2003) |

To achieve the desired number of shockwaves delivered to a stone, at a suitable power, to generate a reasonable level of energy delivery to treat the stone requires the practitioner to limit the pain experienced by the patient.

Although many papers have been written on ESWL and pain relief, to date a consensus on what to prescribe has not been reached. The search for the ideal pain medication regime therefore continues.

**Pain Medication ESWL pathway Craigavon Stone Treatment Centre (still active October 2017)**

**Current Medication:**

a. Prior to treatment: **1 gram oral Paracetamol**
**20mg Piroxicam oral (FELADINE MELT)**

These are both given as long as there are no contraindications prior to procedure. Currently there is no set time prior to treatment for when given, hence a patient may take the medication and proceed straight to ESWL treatment.

b. Post Procedure : **Paracetamol 1 gram oral, QDS, 3 days**
**Diclofenac 50mg, oral, tds, PRN, 3 days**
**(Alternative to diclofenac is codeine phosphate 30-60mg, oral, QDS, PRN, 3 days)**

**Pre-medication Onset of action**

**Paracetamol:**

Paracetamol is readily absorbed from the gastrointestinal tract with peak plasma concentrations occurring about 30 minutes to 2 hours after ingestion. It is metabolised in the liver (90-95%) and excreted in the urine mainly as the glucuronide and sulphate conjugates. Less than 5% is excreted as unchanged paracetamol. The elimination half-life

varies from about 1 to 4 hours (emc+, 2016)

**Piroxicam:**

Piroxicam is a Non-steroidal Anti-inflammatory, with a half-life of 3-4 hours, and duration of action of up to 2 days, with some effect being reported up to 7-10 days (British Medical Association , Fourth edition, 2012). The Piroxicam Melt has a fast absorption and is not influenced by the fasting state (Gorham, 2013).

**The FDA gives two explicit warnings on the use of NSAIDS (Not Aspirin)** (DRUGS.COM , 2017)

## WARNING: RISK OF SERIOUS CARDIOVASCULAR AND GASTROINTESTINAL EVENTS

### Cardiovascular Thrombotic Events

- Nonsteroidal anti-inflammatory drugs (NSAIDs) cause an increased risk of serious cardiovascular thrombotic events, including myocardial infarction and stroke, which can be fatal. This risk may occur early in treatment and may increase with duration of use. *[see Warnings and Precautions (5.1)]* .
- Piroxicam Capsules USP is contraindicated in the setting of coronary artery bypass graft (CABG) surgery *[see Contraindications (4) and Warnings and Precautions (5.1)].*

### Gastrointestinal Bleeding, Ulceration, and Perforation

- NSAIDs cause an increased risk of serious gastrointestinal (GI) adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients and patients with a prior history of peptic ulcer disease and/or GI bleeding are at greater risk for serious GI events *[see Warnings and Precautions (5.2)]* .

**Pubmed Search for Piroxicam use for ESWL**

Search terms included 'ESWL', 'SWL', 'Extracorporeal shockwave lithotripsy' and 'Piroxicam'

9 papers were returned

7 papers were discarded as they did not directly compare piroxicam in a trial or present study evidence for its use.

The remaining 2 papers were clinical trials, a randomized placebo-controlled study and a randomised comparison trial.

**Andreou et al** undertook a Randomized study comparing piroxicam analgesia and tramadol analgesia during outpatient electromagnetic extracorporeal lithotripsy, 2006. They randomised 171 patients into 2 groups of 40mg IM Piroxicam and 100mg IV tramadol. The tramadol group had more side effects, but both forms of medication were deemed suitable pain relief for ESWL according to the visual pain score and researches analysis (Andréou A, 2006).

**Aybek et al** undertook a randomized, placebo-controlled study, comparing 30 patients receiving IM Piroxicam 40mg

vs 30 patients receiving IM saline as the placebo control. Medications were given as IM injection to the gluteal muscle 45 minutes before ESWL. Medication vs no medication demonstrated a significant difference on a verbal rating pain scale (Aybek Z, 1998).

The 2 papers which looked at piroxicam and ESWL did not look at the oral route and were not using the current generation or modality of shock generation used at Craigavon Area Hospital.

**Outcome:**

Data is therefore required for oral Piroxicam use as a pre-medication for ESWL. We conducted a prospective study in Craigavon, comparing 100 patients in relation to energy received to stone and premedication given.

**Comparison Study of Piroxicam and Paracetamol vs Paracetamol**

**for ESWL pain relief medication.**

**Craigavon Stone Treatment Centre**

**Aim**

Does the combination of oral Piroxicam and Paracetamol premedication for ESWL increase the power and energy delivered to renal and ureteric stones when compared to Paracetamol alone?

**Background**

The Craigavon Area Hospital Stone Treatment Centre generally follows the recommendations for ESWL based on the European Urology guidelines for Urolithiasis (European Association of Urology , 2017). It was noted the most common reason for limitation of ESWL treatment was pain experienced by the patient. The department had been traditionally using the NSAID piroxicam 20mg oral fast tab and 1 gram of oral paracetamol as pre-medication for ESWL. This had been given to the patient on average 30 minutes before their ESWL treatment.

Piroxicam is non-selective non-steroidal anti-inflammatory drug (NSAID), meaning it has action on COX-1 (Cyclo-oxygenase-1) and COX-2 enzyme inhibition. The COX-1 and COX-2 enzyme catalyzes the synthesis of cyclic endoperoxides from arachidonic acid to form prostaglandins. Prostaglandins mediate the inflammatory, fever and pain sensation (Day RO, 2013). COX-1 is distributed throughout the body, with higher concentration in kidney, stomach, endothelium and platelets. Prostaglandins produced via this pathway control renal perfusion, promote platelet aggregation and gastric protection. Whilst COX-2 is found in macropharges, leukocytes, fibroblasts and synovial cells, with the prostaglandins produced mediate inflammation, fever, and pain and inhibit platelet aggregation (Longo D, 2012).

There are several non-prostaglandin pathways NSAIDS may act upon, but further study in required to explain the mechanism of action and the importance (Soloman, 2017). The combination of paracetamol and the NSAID

Ibuprofen has been proved to be of benefit in a Cochrane review, for the treatment of post-operative pain (Derry CJ, 2013). There is however clear variation in the individual patient response to NSAIDs in both therapeutics and adverse effects, and some patients seem to respond better to one drug than to others, and responses differ between patients. These differences have been attributed to variations in mechanism of action to COX enzyme inhibition different capacities for altering non-prostaglandin-mediated biologic events; and differences in pharmacodynamics, pharmacokinetics, and drug metabolism, including pharmacogenetic factors (Soloman, 2017).

The pain experienced by a patient receiving ESWL is multifactorial, but broadly speaking can be split into patient factors and lithotripter factors.

**Table 1.**

**PATHOGENESIS OF PAIN DURING ESWL**

| Patient Factors | Lithotripter Factors |
|---|---|
| Cutaneous superficial skin nociceptors* | Lithotriptor type^ |
| Visceral nociceptors such as periosteal, pleural, peritoneal* | Size and site of stone burden^ |
| Musculoskeletal pain receptors* | Location of shockwave focal stone^ |
| Pain tolerance | Size of focal zone^ |
| Pre-existing injury | Cavitation effects^ |
| | Shockwave peak pressure^ |
| * (Weber A, 1998) | Entry of shockwaves at skin^ |
| | Coupling |
| | (Basar H, 2003) |

To achieve the desired number of shockwaves delivered to a stone, at a suitable power, to generate a reasonable level of energy delivery to treat the stone requires the practitioner to limit the pain experienced by the patient.

Although many papers have been written on ESWL and pain relief, to date a consensus on what to prescribe has not been reached. The search for the ideal pain medication regime therefore continues.

A Pubmed search for the use of oral Piroxicam as pre-treatment medication for ESWL returned no studies. Search terms included 'ESWL', 'SWL', 'Extracorporeal shockwave lithotripsy' and 'Piroxicam', 9 papers were returned, 7 papers were discarded as they did not directly compare piroxicam in a trial or present study evidence for its use. The remaining 2 papers were clinical trials, a randomized placebo-controlled study and a randomised comparison trial, but neither studied the use of Piroxicam as an oral medication (Andréou A, 2006) (Aybek Z, 1998). Data is therefore required for oral Piroxicam use as a pre-medication for ESWL.

**Method,**

Data on a prospective 150 patients receiving ESWL for renal and upper ureteric stones was collected in2017. The departments guidelines for pain relief was followed, offering all patient pre-medication with paracetamol and piroxicam, with those contraindicated to piroxicam due to allergy, previous stomach ulcer, NSAID ingestion that day or personal choice only receiving Paracetamol or nothing. Oral medication was given on average 30 minutes prior to treatment by the staff nurse, in a separate room to the lithotripter and blinding radiographer who delivers the ESWL treatment.

All patients were treated by the same EDAP TMS Sonolith i-sys, which is a new generation electroconductive lithotripter. All patients were aimed to have 1000J delivered to a renal and 1400J to a ureteric calculi, with a frequency of 1.2Hz as standard. The power to the calculi was aimed at reaching 100%, requiring 3000 maximum shocks up to a one hour treatment session. Treatment can be stopped if stone successfully treated at a lower energy.

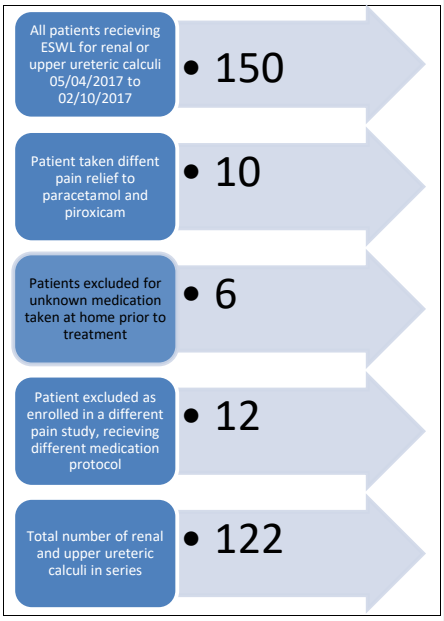



**Table 2. Patients excluded from study**

**Results,**

**Table 3. Renal and upper ureteric calculi**

| Medication | Number of Patients | Average age and (range) | Power (%) average and (range) | Energy average and (range) |
|---|---|---|---|---|
| **20mg Piroxicam and 1g Paracetamol** | 62 | 50.3 (24-80) | 59.4 (16-100) | 689.6 (55-1000) |
| **1g Paracetamol** | 56 | 54.4 (28-81) | 60.8 (12-99) | 788.8 (145-1000) |
| **No Medication** | 4 | 65.5 (60-74) | 51 (38-59) | 899.25 (713-1000) |

The statistical analysis of prioxicam and paracetamol vs paracetamol alone demonstrated no significant difference for the power or energy delivered to renal or ureteric calculi.

**Discussion**

The medication groups were well matched for age and number, 62 patients received piroxicam and paracetamol with an average age of 50.3 years and, 56 patients with an average age of 54.4 years received paracetamol only. The average power and energy was less in the joint paracetamol and piroxicam group then the paracetamol group alone. There is no significant difference between the two pain reliefs it would appear based on the treatment parameters.

There were too few patients in the no medication group to really comment, with only 4 patients, who received less power to the calculi on average then the medication groups, but received more energy due to a higher number of shockwaves.



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

The reason for no difference between the two medicated groups is probably due to the time of onset of the piroxicam. Although the 20mg piroxicam melt used and has a fast absorption rate (Gorham, 2013) it has a variable action of onset and take up to 2 days for a steady state with a half-life of 3 -4 hours (British Medical Association , Fourth edition, 2012). The medication may have greater benefit therefore if it was started the day before or even two days before treatment, and then possibly continued as part of the post procedure pain relief for a number of days. This however would increase cost and the complexity of prescribing the medication prior to attendance at the Stone Treatment Centre for ESWL. Further limitations of the study would include the small numbers in each group and the lack of a validated pain score. Since piroxicam activity can last up to 7-10 days a pain score once the patient had returned home may have been of benefit.

The current use of Piroxicam 20mg 30 minutes prior to ESWL should therefore be discontinued. If an NSAID is to be continued as a pre ESWL pain relief medication then an intramuscular NSIAD or Per Rectum NSAID may be of greater effect (ref). Other fast acting oral NSIAD medications would warrant further evidence for their use with ESWL, as more practical and acceptable form of medication for the patient.

# ESWL Treatment Breakthrough Medication:

Currently no breakthrough pain medication is given during ESWL treatment at Craigavon Stone Treatment Centre. Thus patient's treatments can be limited due to pain. A Prospective study was conducted looking at patient who did not receive any break though medication and the average power able to be achieved, if treatment was limited due to pain as per radiographer and a visual analogue scoring system for pain experienced during by the patient during treatment.

**Results**

A break though pain medication was sought. Since the ESWL treatments are Nurse and radiographer led, then type and route of drug is limited. IV morphine is currently not allowed to be given by a nurse, and the nurses also do not have prescribing rights.

A novel solution is therefore required, and so following consultation with A+E, Penthrox 3ml Inhaler as a

breakthrough medication is a consideration. The alternative pathway would be to include a Doctor with treatment session so IV morphine could be given as and when required, however this would increase the cost of the service and impact negatively to another aspect of the urological activity. Could the numbers requiring breakthrough pain medication be reduced further by altering or adding to the current regime, this is a further topic for research and is an ongoing topic of research in the sphere of ESWL.

In order to trial the use of Penthrox as breakthrough medication the drug had to be first approved at the drug and therapeutic committee at Craigavon Area Hospital. A review of the drug, including current use and safety was conducted, as well as the environment for its use.

**Penthrox** was given approval for use from the Craigavon Hospital Drug and Therapeutics Committee (DTC) in February 2017. An initial 50 units (Penthrox 3ml inhaler) were to be purchased by the hospital and a further 20 units were to be provided by Galan free of charge. There were all then registered to the pharmacy department and requested for use at the Stone Treatment Centre when required.

Southern Health and Social Care Trust

# New Product Application Form

This form must be completed to provide the SHSCT Drug and Therapeutics Committee (DTC) with information about the proposed product. Applications may only be made by Trust Consultants.
Requests must be sent to Dr Tracey Boyce c/o DTC Secretary, CAH Pharmacy Dept., at least **2 weeks** prior to the Drug and Therapeutics Committee meeting.
*** * Please note that incomplete forms will be returned to the consultant concerned ****

## Section 1: Background information

**Generic name of medicine**: Methoxyflurane

**Brand name/ manufacturer:** Penthrox

**Formulation**: 3ml Methoxyflurane (99.9%), liquid to be used in an inhaler

**Route of administration:** Inhaler with carbon filters for exhaled gases.

**Proposed indication:** Breakthrough pain relief for extracorpeal shockwave lithotripsy (ESWL) of renal and ureteric stones

**Dose information:** 3ml Penthrox, not to exceed 6ml on single administration, not to exceed 15ml in a week.

**Section 2: Place in treatment algorithm**

**Please specify the criteria for patient selection:**

Patients have 1g Paracetamol and NSAIDS (currently oral piroxicam 20mg, may change to PR Diclofenac 75mg) 40 minutes prior to starting ESWL treatment of stone.

**If treatment limited due to pain, then breakthough pain relief to be given in the form of 3ml Penthrox as inhaler under supervision by a staff nurse**. **Only one inhaler of 3ml to be given to each patient over their treatment hour as needed, and no more than one per hour to be used in the treatment room**. Currently no breakthrough pain relief is available and so some treatments are limited or require more treatments. No breakthrough pain relief potentially increases the need for more costly treatment in main theatre, such as Flexible Ureterenoscopy, which also carries greater risk of patient complication compared with ESWL.

Penthrox **would not be given** to patients with clinically evident cardiovascular or respiratory instability, any history of anaesthetic allergy, alcohol abuse, isoniazid, phenobarbital, rifampicin, clinically significant renal impairment (e.g. CKD stage IV, V).

**Section 3: Summary of evidence on clinical effectiveness issues**

**What are the principal trials supporting the indication(s) described above and the overall results regarding efficacy? Please provide copies of up to 3 (maximum) relevant references, preferably including comparative data trials.**


http://www.sciencedirect.com/science/article/pii/S027323001630126X

Derivation of an occupational exposure limit for an inhalation analgesic methoxyflurane (Penthrox®)

John Frangos, , Antti Mikkonen, Christin Down
Golder Associates, 570 – 588 Swan Street, Richmond, Victoria, 3121, Australia
Received 4 March 2016, Revised 9 May 2016, Accepted 11 May 2016, Available online 13 May 2016

Highlights
• Dose response analysis using clinical toxicity data is exemplified.
• Exposure limit for methoxyflurane of 15 ppm (8 h TWA) was derived.
• Occupational exposure estimates are well below the proposed MEL.

The peak is always less than 15 ppm in a treatment room under the following conditions:

1 vial per hour at an air change per hour (ACH) OF 1.15; and
2 vial per hour at ACH of 1.95.

Abstract
Methoxyflurane (MOF) a haloether, is an inhalation analgesic agent for emergency relief of pain by self administration in conscious patients with trauma and associated pain. It is administered under supervision of personnel trained in its use. As a consequence of supervised use, intermittent occupational exposure can occur. An occupational exposure limit has not been established for methoxyflurane. Human clinical and toxicity data have been reviewed and used to derive an occupational exposure limit (referred to as a maximum exposure level, MEL) according to modern principles. The data set for methoxyflurane is complex given its historical use as anaesthetic. Distinguishing clinical investigations of adverse health effects following high and prolonged exposure during anaesthesia to assess relatively low and intermittent exposure during occupational exposure requires an evidence based approach to the toxicity assessment and determination of a critical effect and point of departure. The principal target organs are the kidney and the central nervous system and there have been rare reports of hepatotoxicity, too. Methoxyflurane is not genotoxic based on in vitro bacterial mutation and in vivo micronucleus tests and it is not classifiable (IARC) as a carcinogenic hazard to humans. The critical effect chosen for development of a MEL is kidney toxicity. The point of departure (POD) was derived from the concentration response relationship for kidney toxicity using the benchmark dose method. A MEL of 15 ppm (expressed as an 8 h time weighted average

(TWA)) was derived. The derived MEL is at least 50 times higher than the mean observed TWA (0.23 ppm) for ambulance workers and medical staff involved in supervising use of Penthrox. In typical treatment environments (ambulances and treatment rooms) that meet ventilation requirements the derived MEL is at least 10 times higher than the modelled TWA (1.5 ppm or less) and the estimated short term peak concentrations are within the MEL. The odour threshold for MOF of 0.13–0.19 ppm indicates that the odour is detectable well below the MEL. Given the above considerations the proposed MEL is health protective.

Emergency Medicine Journal

*Emerg Med J* 2014;**31**:613-618 doi:10.1136/emermed-2013-202909

- Original article

**STOP!: a randomised, double-blind, placebo-controlled study of the efficacy and safety of methoxyflurane for the treatment of acute pain**

OPEN ACCESS

Frank Coffey[1], John Wright[2], Stuart Hartshorn[3], Paul Hunt[4], Thomas Locker[5],Kazim Mirza[6], Patrick Dissmann[4]

## Abstract

**Objective** To evaluate the short-term efficacy and safety of methoxyflurane for the treatment of acute pain in patients presenting to an emergency department (ED) with minor trauma.

**Methods** STOP! was a randomised, double-blind, multicentre, placebo-controlled study conducted at six sites in the UK. A total of 300 patients, 90 of whom were adolescent patients (age 12–17 years), were randomised 150:150 to receive either methoxyflurane via a Penthrox inhaler or placebo. The primary end point of the study was the change in pain intensity as measured using the visual analogue scale (VAS) from baseline to 5, 10, 15 and 20 min after the start of study drug inhalation. Patients were supplied with one inhaler containing 3 mL methoxyflurane or 5 mL placebo after enrolment and initial assessments. Age group (adolescent/adult) and baseline VAS score were controlled for in the statistical analyses.

**Results** A total of 149 patients received methoxyflurane, and 149 patients received placebo. Demographic and baseline characteristics were comparable between the groups. Methoxyflurane reduced pain severity significantly more than placebo ($p<0.0001$) at all time points tested, with the greatest estimated treatment effect of −18.5 mm (adjusted change from baseline) seen at 15 min after the start of treatment. Methoxyflurane was well tolerated, with the majority of adverse reactions being mild, transient and in line with anticipated pharmacological action.

**Conclusion** The results of this study suggest that methoxyflurane administered via the Penthrox inhaler is an efficacious, safe, and rapidly acting analgesic.

**Trial registration number:** NCT01420159.

Anaesthesia
Journal of the Association of Anaesthetists of Great Britain and Ireland

**Self-administered methoxyflurane for procedural analgesia: experience in a tertiary Australasian centre**

1. A. L. Gaskell Research Fellow[1,*],
2. C. G. Jephcott Consultant[2],
3. J. R. Smithells Consultant[2] and
4. J. W. Sleigh Consultant, Professor[2,3]

Version of Record online: 15 FEB 2016

DOI: 10.1111/anae.13377

**Summary**

Methoxyflurane, an agent formerly used as a volatile anaesthetic but that has strong analgesic properties, will soon become available again in the UK and Europe in the form of a small hand-held inhaler. We describe our experience in the use of inhaled methoxyflurane for procedural analgesia within a large tertiary hospital. In a small pilot crossover study of patients undergoing burns-dressing procedures, self-administered methoxyflurane inhalation was preferred to ketamine-midazolam patient-controlled analgesia by five of eight patients. Patient and proceduralist outcomes and satisfaction were recorded from a subsequent case series of 173 minor surgical and radiological procedures in 123 patients performed using inhaled methoxyflurane. The procedures included change of dressing, minor debridement, colonoscopy and incision-and-drainage of abscess. There was a 97% success rate of methoxyflurane analgesia to facilitate these procedures. Limitations of methoxyflurane include maximal daily and weekly doses, and uncertainty regarding its safety in patients with pre-existing renal disease.

**Section 4: Summary of evidence on comparative efficacy**

**What are the advantages of this medicine compared to other treatments? Consider medicines already recommended in the Regional Formulary or in the same therapeutic class.**

Rapid onset

Patient controlled

Compared with the opiate alternatives there would be no need for a second staff nurse present. The stone centre is run by x1 staff nurse, x1 HCA, X1 radiographer.

**Section 5: Summary of evidence on comparative safety**

**What are the advantages/disadvantages of this medicine in relation to patient safety compared to other treatments?**

Self-administered by patient in the form of an inhaler

Rapid onset of analgesia (6 – 10 breaths)

Shorter recovery time then traditional opiate based medication

After 30 minutes of observation can be discharged and can safely return to highly skilled psychomotor skills tasks such as driving and daily work the same day.

Not for use in patients with clinically evident cardiovascular or respiratory instability, any history of anaesthetic allergy, alcohol abuse, isoniazid, phenobarbital, rifampicin, clinically significant renal impairment (e.g. CKD stage IV, V).

**NOTE:** The cardiovascular and respiratory caution may well be historic to its use as an anaesthetic agent as no clinically significant changes were observed for vital signs (heart rate, respiratory rate, BP or temperature).

H F Oxer, 'Effects of Penthrox® (methoxyflurane) as an analgesic on cardiovascular and respiratory functions in the pre-hospital setting, Volume 24 Number 2; April 2016, Journal of Military and Veterans' Health'.

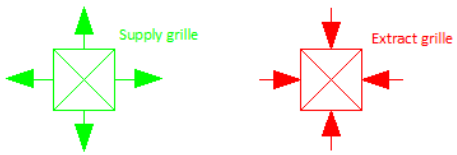
Regarding potential occupational exposure the number of air changes per hour has been calculated by the estates department. Only one 3ml vial per patient may be used and not more than one vial per hour to be used in the treatment room. To achieve a peak of always less than 15 ppm in the treatment room then 1 vial per hour at an air change per hour of 1.15 needs to be achieved (Frangos et al, see Section 3, Summery of Evidence)

The room was tested on the 09/02/2017 by the Estates department and the treatment room meets the standard required, with an air change per hour of 1.75.

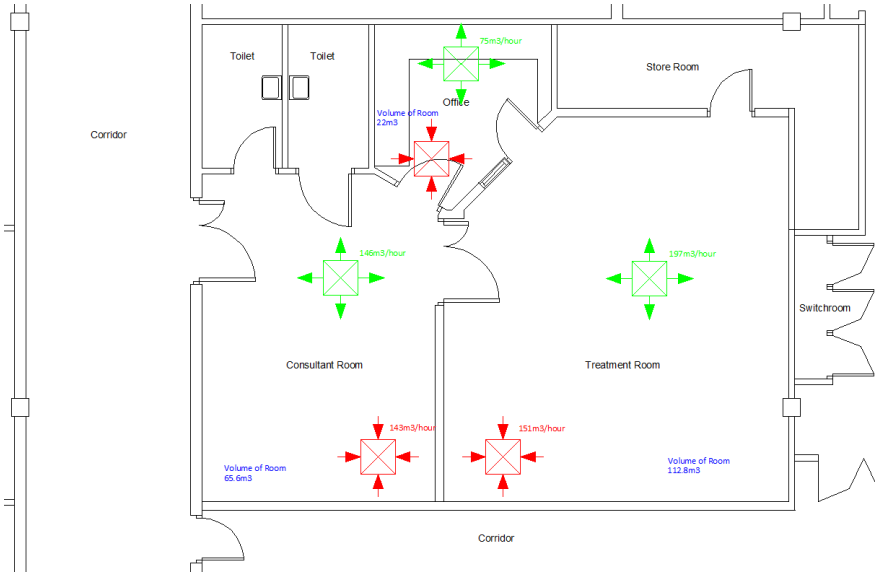
**Craigavon Area Hospital – Stone Treatment Centre Ventilation Report**

Measured on 9th February 2017 by Ruairi King, Estates Department

Survey conducted to measure the number of air changes per hour within each room. This information is required to determine the use of a new inhaler type pain relief at the centre.




Stone Treatment Centre Plan showing supply and extract grilles with corresponding air flows.




$$Air\ changes/hour = \frac{Volume\ of\ air\ supplied/hour}{Volume\ of\ room}$$

Treatment room:

$$Air\ changes/hour = \frac{197}{112.8} = 1.75$$

Consultant room:

$$Air\ changes/hour = \frac{146}{65.6} = 2.23$$

Office:

$$Air\ changes/hour = \frac{75}{22} = 3.41$$

The ventilation system supplying air to the Stone Treatment Centre is not connected to the Hospitals Building Management System (BMS); therefore its status cannot be monitored by the Estates Department.

It is necessary to install airflow sensors which connect to the BMS so that the status of the ventilation system can be monitored and logged in case of faults etc.

An indicator should also be installed within the treatment centre showing the status of the system and alarm when

there is a fault or when there is no air flowing. This is needed to safeguard staff and patients when using the new inhaler type of pain relief.

## Section 6: NICE and Scottish Medicines Consortium (SMC) Adjudications

**Has NICE considered this product: Yes / No**
**If yes – what was the outcome? If No – is NICE currently considering the item?**

Nice contacted Galen in 2016 as they are considering reviewing the medication as per Dr Sarah Dolan 06/02/2017.

Penthrox was highlighted on a NIHR horizon scanning document in February 2016: http://www.hsric.nihr.ac.uk/topics/methoxyflurane-penthrox-for-emergency-relief-of-moderate-to-severe-pain/

**Has the NICE guidance been endorsed in Northern Ireland: Yes / No**

**Has SMC considered this product: Yes / No**
**If yes – what was the outcome?**
All Wales Medicines Strategy Group concluded that Penthrox was exempt from review as it is a medicinal gas: http://www.awmsg.org/docsnoindex/awmsg/June%202016.pdf

Penthrox is classed as a medicinal gas, and therefore exempt from review by SMC as per Dr Sarah Dolan from Galen 06/02/2017 – see exclusion criteria no. 7 in SMC publication: Guidance for medicines out with SMC remit.

## Section 7: Financial Information

| | No. of patients in SHSCT eligible for treatment per annum | Cost per annum (£) per patient | Total annual cost (£) |
|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **Secondary Care** | | Current ESWL capacity is 9 patients per week.<br><br>At present 9 x52 = 468 potential stone treatments per year. (not taking into account public holidays) | £17.89 + VAT | £61138 + VAT<br><br>Used as Breakthrough pain, 73% would require Penthrox, therefore 73% of 468 = 342 patients).<br>Based on ESWL questionnaire of pain during treatment 10/02/17, currently on-going. |
| **Primary Care** | | | | |
| **Cost of the therapy to be 'replaced' if applicable** | Secondary Care | **<u>Potential cost savings</u>** if further treatments of ESWL prevented by use of the pain relief, or potential failure of treatment requiring more expensive ureteroscopy or PCNL. | | |
| | Primary Care | | | |
| **TOTAL NET COST:** | | | | £8372.52 |
| **Other Cost Implications** e.g. Additional Medicine Therapy, X-rays, Lab Tests, etc. | Please state: | | | |

**If additional funding is required to purchase this product within the Trust please give details of how this will be found** (e.g. current approved business case, agreed reduction in bed-days /beds, stopping use of another product)

Increased funding is likely to be required to fund the medication, but it will have a **knock on effect to save money** from the reduction in further procedures and waiting list. The aim would also to provide emergency treatment, so reduce the cost and burden on the emergency operating theatre.

The use of Penthrox as breakthrough pain relief could increase the number of patients receiving a full treatment of ESWL and therefore reduce the need for secondary procedures such as Ureteroscopy or PCNL, both of which are more costly.

Koo and Young from Craigavon Area Hospital, published in the British Journal of Urology in November 2010 calculated the overall cost of Flexible ureteroscopy (FURS) to be £2602, compared to £426 for ESWL. If each patient had one treatment of ESWL instead of FURS, then £2176 could be saved, or to use the operating time for a different case and possibly decrease the waiting list.

**Only 2.8 patients would need to be prevented from having a further surgical procedure** (FURS) **by having successful ESWL to match the cost of 342 patients receiving Penthrox**. (Based on 342 patients x £17.89 Penthrox cost).

Many patients may have reduced number of ESWL treatments, as a greater energy can be delivered to the stone on initial treatment then the current average.

From the 4th Jan 2017 to 6th Feb 2017, 22 patients out 31patients treated by ESWL had limited treatment received, with the most common reason being pain.

**Section 8: Declaration of Interests**

**SHSCT Gifts and Hospitality and Standards of Conduct Policy/ Declaration of interest (Procurement)**

The lead consultant(s) responsible for completing this application to the Drug and Therapeutics Committee are asked to declare and describe to the Chairman, any involvement that they may have with the relevant pharmaceutical company, or with the manufacturers of any comparator products.

This includes direct or indirect financial gain that they have received from the pharmaceutical company where this amounts to *greater than £500 p.a. within the last 2 years*. Such interests may be direct (e.g. lecture or consultancy fees, sponsorship for postgraduate educational activity) or indirect (egg. departmental donations, research contracts, funded staff support).