

Aimee Crilly

From: Corrigan, Martina <[REDACTED]>
Sent: 25 September 2019 07:41
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: Validation exercise
Attachments: RE: [REDACTED] (1.88 MB); RE: [REDACTED] (86.8 KB)

Good morning

Please see email trail below and attached emails.

Aidan had raised the issue of a patient of his who he had noticed he had been removed from the waiting list, on contacting the patient he was advised that he had received a letter asking him if he still wanted his surgery and he had said no.....

As a result of this Aidan had emailed me and Mark and you will see the email conversations below between Aidan, Mark and Wendy who had been instructed by HSCB to do this exercise.

This had been discussed originally with me as being an admin validation (i.e. determine if they are not deceased, living at the same address, check that they have not had their procedure done elsewhere etc..) however on discovering (through increased MLA and patient enquiries) that this was a letter being sent to patients to ask if they still wanted their surgery I immediately put a stop to Urology and ENT (I believe other specialties are continuing).

However as you will see from Mark and Aidan's emails there has already been fall out from this.

I have attached Wendy's email detailing the information of patients that received the letters and we have agreed that these patients would be reinstated onto the waiting lists and Mark has asked that his patients are seen at clinic as well, I will be guided by what the rest of you want to do (i.e. happier to be reinstated and contacted and/or seen again at clinic?)

Regards

Martina

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

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

From: Haynes, Mark
Sent: 24 September 2019 21:35
To: O'Brien, Aidan; Clayton, Wendy
Cc: Corrigan, Martina
Subject: RE: [REDACTED]

I think we will have to see the patients in OP but agree they should be reinstated on the WL.

I also agree, our colleagues also need to be made aware.

Not wishing to add to things... but, have any other specialities IPWL been validated in this way, and have the respective clinicians been made aware of this?

Mark

From: O'Brien, Aidan
Sent: 24 September 2019 17:11
To: Clayton, Wendy
Cc: Haynes, Mark; Corrigan, Martina
Subject: RE: [Redacted]
Personal Information redacted by the USI

Wendy,

I think that I would be happier with that.

Mark,

What do you think?

I also do think that it would be courteous if not prudent to advise Michael, Tony and John of our exchanges,

Aidan.

From: Clayton, Wendy
Sent: 24 September 2019 17:00
To: Haynes, Mark; Corrigan, Martina; O'Brien, Aidan; Hanvey, Leanne
Cc: Carroll, Ronan
Subject: RE: [Redacted]
Personal Information redacted by the USI

We can reinstate the patients back on the list with their original dates, would be easier for you all and contact the patients again to let them know.

Regards

Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC
Tel: [Redacted]
Mob: [Redacted]
Personal Information redacted by the USI

From: Haynes, Mark
Sent: 24 September 2019 16:26
To: Clayton, Wendy; Corrigan, Martina; O'Brien, Aidan; Hanvey, Leanne
Cc: Carroll, Ronan
Subject: RE: [Redacted]
Personal Information redacted by the USI

Thanks

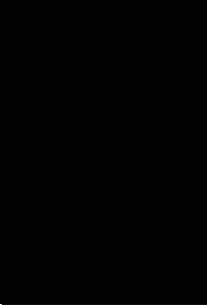
The removals from the waiting list all need to come to clinic for review.

I have looked through those from my waiting list and none of the decisions are free of clinical consequence, all carrying at minimum a risk of emergency admission, most a risk of gram negative sepsis, and in the case of one (staghorn renal stone, xanthogranulomatous pyelonephritis), the clinical consequence is a risk of life threatening sepsis / death. This was probably predictable given that these patients were on the urgent waiting list.

Mark

Leanne – the numbers for my patients are;

Personal Information redacted by the USI



From: Clayton, Wendy
Sent: 23 September 2019 15:33
To: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: Personal Information redacted by the USI

See below comment and attached list of patients. IPDC admin validation for urology has ceased, no urology routine patients have received a letter. The attached patients are all urgents

Regards

Wendy

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

From: Corrigan, Martina
Sent: 23 September 2019 14:41
To: Clayton, Wendy; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: Personal Information redacted by the USI

Thanks Wendy

Also as per Mr Haynes and Mr O'Brien's requests below can you please update?

Personal Information redacted by the USI

(Mr Haynes) – It was the admin IS/validation team that started this piece of work – urology IPDC urgents only, no routine patients. There were 48 urology patients that advised they did not want the surgery (attached). Patients details attached.

I would also be grateful if I could be furnished with a list of those patients of mine who have been so communicated with (Mr O'Brien) 2nd attachment is a list of every patient of AOB's that received an admin validation letter. There were 17 patients that belong to Mr O'Brien requested to be removed. List attached.

Regards

Martina

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

Telephone:

EXT Personal Information redacted by the USI (Internal)

Personal Information redacted by the USI (External)

Personal Information redacted by the USI (Mobile)

From: Clayton, Wendy
Sent: 23 September 2019 11:14
To: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: Personal Information redacted by the USI

Hi Martina

I confirm that the inpatient/daycase admin validation for urology has ceased, no letters or phone calls are being made to patients.

My team are working on the outpatient admin validation which includes urology. If no response from 2 x admin validation letters then they will be discharged back to the care of the GP. This is the same process for non-responders to outpatient partial booking letters. A letter will go to their GP advising same.

Regards

Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC

Tel: Personal Information redacted by the USI

Mob: Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 23 September 2019 06:40
To: Haynes, Mark; O'Brien, Aidan; Clayton, Wendy
Cc: Carroll, Ronan
Subject: RE: [Redacted]
Personal Information redacted by the USI

Good morning Aidan and Mark

I have copied Wendy into this email as she will be able to advise on your patients that were contacted and will also be able to assure that for Urology validation that this has ceased.

Wendy can you please assist?

Regards

Martina

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

Telephone:

EXT [Redacted] (Internal)
[Redacted] (External)
[Redacted] (Mobile)
Personal Information redacted by the USI

From: Haynes, Mark
Sent: 22 September 2019 21:05
To: O'Brien, Aidan; Corrigan, Martina
Subject: RE: [Redacted]
Personal Information redacted by the USI

Thanks Aidan

As I have stated before I was not aware of the process until it had started and when I became aware had requested it cease.

Where the process is administrative only (ie checking patient not deceased, and checking they haven't had it done elsewhere), then it is fine. This process went beyond that and asked if patients wanted the operation (no-one wants an operation), and then I believe offered them an opportunity of an OP review to discuss. Not only does this mean informed decisions are not possible by the patient (as no one is re-discussing the pros and cons of surgery) but is also offering something that we cannot deliver ie a timely review appointment. I believe the process also raises false hope in patients that they may get a date for their surgery in the near future.

Martina – do you know who led this work and are they able to provide the urologists with the details of all the patients who have either asked to be removed from the WL, or requested a review OPA?

Mark

From: O'Brien, Aidan
Sent: 22 September 2019 17:11
To: Corrigan, Martina
Cc: Haynes, Mark
Subject: [Redacted]
Personal Information redacted by the USI

Martina,

I write to you regarding this 69 year old, diabetic man who had a stone obstructing his upper right ureter in 2015. He was managed by ureteroscopic laser lithotripsy. He was noted to have a grossly enlarged prostate gland on endoscopic assessment. I advised him that he would be better served by having his prostate resected. He was placed on the waiting list on 08 October 2015.

On reviewing my waiting list during August, I noted that he had been removed from the waiting list in July 2019. When I contacted him by telephone, he advised that he had received a letter enquiring whether he wished to remain on the waiting list, or words to that effect. As his only symptoms was that of nocturia, he replied that he did not wish to proceed with surgery.

I requested an ultrasound scan which has since indicated that he may have recurrence of stone in his right kidney, that he has inadequate bladder voiding with a residual volume of 190 mls, and would appear to have formed a stone in his bladder.

I have again spoken to the patient by telephone, advising him of the above findings.

I have requested a CT Urinary Tract to more clarify his stone status.

He has agreed to being returned to the waiting list for admission for TURP.

I have dictated a letter to the GP requesting that he be prescribed Tamsulosin until admission for TURP, in addition to requesting optimisation of diabetic control prior to admission.

I hope that you will agree that it is appropriate that I bring such a case to your attention.

I believe that it is entirely inappropriate that non-clinical staff should correspond with patient to enquire whether they wish to remain on a waiting list, and entirely for the purpose of reducing the numbers of patients on waiting lists.

Patients have the right to decline proposed management, but should be empowered to make decisions informed by clinical advice.

I would be very reassured if this practice has been discontinued, as you had recently indicated.

I would also be grateful if I could be furnished with a list of those patients of mine who have been so communicated with.

Thank you,

Aidan.

Aimee Crilly

From: Corrigan, Martina [Personal Information redacted by the USI]
Sent: 17 December 2018 17:07
To: (Aidanpobrien@aol.com); (my [Personal Information redacted by the USI]); Glackin, Anthony; Haynes, Mark; Mark [Personal Information redacted by the USI]; Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; [Personal Information redacted by the USI] Tony Glackin [Personal Information redacted by the USI]
Cc: McCaul, Collette; Robinson, Katherine; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth
Subject: January theatres
Importance: High

Dear all

After discussion with Esther and Ronan, we have had to reduce the Urology lists for January 2019 from 11 to 10.5 lists.

Therefore the following lists are no longer available for Urology:

Thursday PM 10th January – Mr Hennessey (NOTE AM will still go ahead)

Friday PM 18th January – Mr Jacob

Thursday PM 24th January – Mr Young (NOTE AM will still go ahead)

This is outside our control as we need to give an alternative list to Gynae/ENT specialties.

Regards

Martina

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

Telephone:

[Personal Information redacted by the USI]

Aimee Crilly

From: Corrigan, Martina Personal Information redacted by USI
Sent: 11 November 2019 13:09
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael; Elbaroni, Wesam; Hasnain, Sabahat; McAuley, Laura; Sharma, AbhishekDutt; Steen, Benjamin; McCourt, Leanne; McMahon, Jenny; O'Neill, Kate
Cc: Dignam, Paulette; Elliott, Noleen; Harvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth
Subject: FW: RF 1st Appointment Longest Wait 19 08.11.19
Attachments: RF 1st Appointment Longest Wait 19.xlsx
Importance: High

Dear all

Please see attached for your information

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients

Direct line: Personal Information redacted by USI
Mobile: Personal Information redacted by USI

From: Graham, Vicki
Sent: 08 November 2019 16:16
To: Carroll, Kay; Clarke, Wendy; Clayton, Wendy; Conway, Barry; Corrigan, Martina; Devlin, Louise; Glenny, Sharon; McAreavey, Lisa; McClements, Melanie; McVey, Anne; Muldrew, Angela; Reddick, Fiona; Scott, Jane M; Dabbous, Marie; Glenny, Catherine; Shannon, Hilda; Kelly, Wendy; Lee, Sinead; McVeigh, Shauna; Moore, SarahM; Shannon, Hilda; Turkington, Ann E; White, Griania
Subject: RF 1st Appointment Longest Wait 19 08.11.19
Importance: High

Afternoon,

Please see attached spreadsheet which includes the current waiting times for RF 1ST OPD.

Regards,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT Personal Information redacted by USI

Secretary: Elizabeth Troughton

Personal Information
redacted by the USI

From: Corrigan, Martina

Sent: 01 September 2019 15:15

To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael

Subject: FW: UROLOGY TRAIGE

Good afternoon

Thoughts ??

Regards

Martina

Martina Corrigan

Head of ENT, Urology, Ophthalmology & Outpatients

Craigavon Area Hospital

Telephone:

EXT Personal Information
redacted by the USI (Internal)

Personal Information
redacted by the USI (External)

Personal Information
redacted by the USI (Mobile)

From: Robinson, Katherine

Sent: 28 August 2019 13:22

To: Corrigan, Martina

Subject: FW: UROLOGY TRAIGE

Will you let us know?

From: Coleman, Alana

Sent: 28 August 2019 12:39

To: Robinson, Katherine; Rankin, Christine

Subject: UROLOGY TRAIGE

Hi Katherine,

We have been receiving a few referrals back from grading recently where the consultants have triaged patients to be booked within 2-4 weeks etc. Example attached.

RF are booking no less than 6weeks at present.

Should these patients not wait longer than RF patients, or at least wait the same length of time?

Or should we just ask the consultants if they are willing for their clinics to be over booked to accommodate?

Thanks

Alana

Alana Coleman

Stinson, Emma M

From: Young, Michael
Sent: 16 December 2021 16:59
To: Stinson, Emma M
Subject: FW: UROLOGY TRAIGE

[more](#)

From: O'Brien, Aidan [Personal Information redacted by the USI]
Sent: 02 September 2019 14:01
To: Corrigan, Martina
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP
Subject: FW: UROLOGY TRAIGE

Martina,

I agree entirely with Tony's sentiments.

Even though one would think that I should be inured after 27 years, I find it still remarkable that administrative staff could even consider that one can add another patient or two to a clinic, without any negative consequences for those added or those already appointed, never mind the additional time required by the clinician to administer the additional attendances in their own time.

Moreover, it still remains disconcerting to gain the impression that there is a belief that only cancer, or the risk of it, poses a threat to life or its quality.

It is now exactly one year since we decided as a department to take the exceptional measure of cancelling one whole day's clinical activity to meet with senior management to discuss and address such concerns. When that day in October 2018 was cancelled, another similar day was scheduled in December 2018. That too was cancelled!

And one year later, we are left once again a proposal that additional work be dumped upon clinicians by overbooking clinics.

Aidan.

From: Glackin, Anthony
Sent: 02 September 2019 09:37
To: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: RE: UROLOGY TRAIGE

As I stated in my reply to Alana there are times when non cancer cases are clinically urgent and should be seen within the stated time frame. Based on the information provided in the referral I think I am making a reasonable clinical decision. If the trust cannot deliver this then there is an issue of demand outstripping supply. Simply relying on me or any other clinician to overbook a clinic will not solve this supply issue and I am not willing to do this work unpaid or to the detriment of my existing workload.

Regards

Tony

Anthony J Glackin MD FRCSI(Urol)
Consultant Urologist
SHSCT

Aimee Crilly

From:

Medical Directors Office

Personal Information redacted by the USI

Sent:

22 January 2020 09:36

To:

'Abdelrahman, Ammar'; 'Acheson, Janet'; 'Adams, Dr Beverley'; 'Adgey, Carolyn'; 'Adrian East'; 'ahsanalam'; 'Aljarad, Bassam'; 'Andrea Green'; 'Arava, Shiva'; 'Armstrong, Matt'; 'Bennett, Tim'; 'Best, Stephen'; 'Boggs, Edgar'; 'Boyd, Kathryn'; 'Bradford, Christina'; 'Bradley, Una'; 'Brady, Aidan'; 'Brazil, Dr R'; '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'; 'Connolly, Ivan'; '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'; 'Eedy, David J'; 'Epanomeritakis, Manos'; 'Ervine, Aaron'; 'Farnan, Turlough'; 'Flannery, Daniel'; 'Forbes, Raeburn'; 'Foy, Allister'; 'Gilpin, David'; 'Glackin, Anthony'; 'Gormley, Damian'; 'Gorski, Michal'; 'Gracey, David'; 'Graham, David'; 'Grier, David'; 'Gupta, Nidhi'; 'Hamilton, Beverley'; 'Hampton, Gareth'; 'Hanna, Heather'; 'Harty, John'; 'Haynes, Mark'; 'Henderson, Jonathan'; 'Hewitt, Gareth'; 'Hillemand, Christophe'; 'Hussain, Mumtaz'; 'Lewis, JulieZ'; 'Martin, Rachel M'; 'McCormick, Eleanor'; 'McIntyre, Gemma'; 'McKeating, Cara'; 'McKeown, Ciara'; 'McKillop, Derek'; 'McLoughlin, Laura'; 'Millar, Sarinda'; 'Mohamed, Ismail'; 'Moore, Michael'; 'Papamichail, Stylianos'; 'Perry, Michael'; 'Quinn, Kathryn'; 'Salman, Reem'; 'Sharma, Rohit'; 'Ahmed, Gamal'; 'Chinnadurai, Anitha'; 'Goddard Karen'; 'Henry Rebecca'; 'Holmes, Erskine'; 'Hughes, James'; 'Hull, Don'; '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'; 'Mackie, Eamon'; 'Maiden, Nicola'; 'Martin, Laure'; 'Masengu, Agnes'; 'Mathers, Helen'; 'Mathers, Rachel'; 'McAllister, Charlie'; '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'; 'Osmonde Morris'; 'Patton, David'; 'Southwell, Chris'; 'Yousuf, Imran'; 'Ahmed, Suliman'; 'Almousawi, Muhamad'; 'artohagan'; 'Beg, Ashfaq'; 'Bhat, Shivaram'; 'Boulos, Angel'; 'Campbell, Jamie'; 'Campbell, Patricia'; 'Campbell, Philip'; 'Eakin, Pamela'; 'Flanagan, Catherine'; 'Funston, Lesley Ann'; 'Gurunathan, Ramesh'; 'Henderson, Nicola-Ann'; 'Khwaja, Salman'; 'Magill, Paul'; 'Magowan, Lynda'; 'Mawhinney, David'; 'McConville, Barry D'; 'McFadden, Matthew'; 'McFarland, Marie'; 'McGarry, Philip'; 'McKeown, Gillian'; 'McLean, Gavin'; 'McNamara, Ryan'; 'McNicholl, Diarmuid'; 'McParland, Michael'; 'McSherry, Pauleen'; 'Murdock, Andrew'; 'Murnaghan, Mark'; 'Murphy, Philip'; 'Neill, Adrian'; 'Nelson, Elaine'; 'Niblock, Katherine'; 'Nicholl, Hilda'; 'O'Brien, Aidan'; 'O'Connor, Kieran'; 'ODonoghue, JohnP'; 'O'Neill Janice'; 'ONEILL, Judith'; 'Parks, Lorraine'; 'Patton, Sean'; 'Polley, Liam'; 'Porter, Simon'; 'Quinn, Ciara S'; 'Quinn, Phil'; 'Rafferty, Claire'; 'Rea, Margaret'; 'Reddy, Ekambar'; 'Rice, Paul'; 'Roberts, Veronica'; 'Rutherford-Jones, Neville'; 'Savage, Eimear'; 'Scullion, Damian'; 'Shah, Rajeev'; 'Shah, Shilpa'; 'Shahid, Sara'; 'Sharpe, Peter'; 'Shevlin,

To: Claire'; 'Sidhu, Harmini'; 'Sim, David'; 'Sobocinski, Dr Jacek'; 'Spedding, Ruth'; 'Stewart, Roger'; 'Subramanian, Arun'; 'Tariq, S'; 'Thompson, Richard'; 'Thompson, Sam'; 'Walker, Stephanie'; 'Watson, Bruce'; 'Weir, Colin'; 'Williams, Marc'; 'Williams, Marian'; 'Wilson, Lynn'; 'Winter, Colin'; 'Yarr, Dr Julie'; 'Yoong, Susan'; 'Young, Michael'; 'Yousaf, Muhammad'

Subject: NEDS update - NI Health service waiting times articles in Belfast Tele

Attachments: Bel Tel died on waiting list jan 19.docx; Bel Tel - waiting lists -Some will never be seen jan19.docx

Sent on behalf of Dr O’Kane

Dear All

Please find attached Articles from Belfast Telegraph regarding waiting times.

Kind regards

Lauren

Lauren Weir

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



My Hours of work are: Monday – Friday 9.00am – 5.00pm

Personal Information redacted by the USI

FYI,
The Belfast Telegraph has today published several pieces (see attached) re NI Health service waiting times.
Many Thanks
Peter Toal
Communications Manager
Southern Health and Social Care Trust

22,000 have died on health service waiting list in Northern Ireland in last five years

Almost 5,000 people died while on a health service waiting list in Northern Ireland in the last year.

The number of deaths is increasing year on year, rising by almost 50% since 2014.

In the last five years more than 22,000 died while waiting for treatment, an investigation by this newspaper found.

The timeframe includes the three-year period when Stormont was not sitting. Some people died having been on a waiting list for up to five years.

Health officials said the deaths may not be linked in any way to being on a waiting list.

Yet the extent of people passing away before undergoing treatment or operations is another shocking revelation to emerge from a health system in the midst of crisis.

The most recent official figures show a record 306,180 people were on a waiting list as of September.

Strike action by nurses and other health staff has also piled pressure on the system.

This newspaper can reveal the full impact of the spiralling waiting times for appointments and surgery in our hospitals.

Figures show:

◇ 22,001 people died while on waiting lists across the five health trust areas in the last five years.

◇ The number of deaths has risen from 3,206 in 2014 to 4,699 in 2019 - a rise of 46.5%.

◇ On average, 12 people are dying every day while on a waiting list.

◇ In one health trust the number of deaths has more than trebled since 2014.

The figures were obtained by this newspaper after Freedom of Information requests.

Each health trust provided details of how many people had been removed from their waiting lists because they had died. The figures cover inpatient and outpatient cases.

In each case, they stressed that it was not possible to determine if a patient's death was linked in any way to the reason for them being on the waiting list.

A patient may have died for another, entirely separate reason and unrelated to the waiting list they were on at the time.

However, the figures give an insight into the thousands of people dying each year while waiting for procedures.

SDLP health spokesman Mark H Durkan MLA said the figures were "shocking".

"For someone to spend their final days on a health service waiting list is unacceptable," he said.

"These people - regardless of whether their death was as a result of being left on a list or not - will have spent their last months, or as is increasingly the case, their last years in agony and pain.

"They will have died waiting for treatment for conditions and that is not acceptable."

He added: "Often people, whether it is health professionals, politicians or the media, look at waiting lists and see figures.

"Yet each of these figures is a real person, many with a family, and a story like this really brings home the human tragedy behind the health crisis."

Three health trusts provided figures by financial year, two others by calendar year, and thus the figures will not be precisely comparable.

However, the five-year totals provided by the trusts show a total of 22,001 patients on a waiting list died.

The highest number of deaths was in the Belfast Trust, Northern Ireland's biggest.

Deaths rose by 41% between 2014/15 (1,056 deaths) and 2018/19 (1,494 deaths).

In the Northern Trust, the number of waiting list deaths trebled in five years - rising from 417 in 2015 to 1,261 in 2019. In several hundred cases across the various trusts, people died after waiting on a list for more than a year. In a handful of cases they had been waiting for up to five years.

Patricia McKeown from the health workers' union Unison said: "Apart from being profoundly sad, this is utterly unacceptable.

"We saw that horrendous report before Christmas that said a patient here can expect to wait up to 100 times longer than in England - how can you justify that?

"If there has been a 40% increase in deaths in the last five years, is that caused by these unduly long waiting times?"

Ms McKeown said data should be closely examined to spot trends.

"If it can be shown that waiting lists are increasing, and there is also an increase in people dying while on them, then there is a moral imperative to act and put it right," she added.

The Department of Health said: "The Department is acutely aware of the impact of growing waiting lists on patient care and the distress they cause.

"There is a concerted effort across the HSC to ensure the most urgent patients are prioritised and staff are working tirelessly to do this.

"It is important to note that, from the figures released, it is not possible to determine if a patient's death was linked in any way to the reason for being on the waiting list or to waits for any services.

"There is ongoing analysis to further understand the impact delays are having in the care and outcomes of patients and service users. Health Minister Robin Swann has identified tackling waiting lists as a top priority for his department. This will require a combination of sustained investment and transformation of how services are delivered."

'Some will never be seen...' shock extent of waiting list crisis facing Robin Swann

The extent of the waiting list shame Robin Swann must tackle as Health Minister has been revealed.

Official statistics have exposed the deterioration of waiting times for first outpatient appointments while Northern Ireland's politicians refused to take their seats at Stormont.

They also highlight the postcode lottery of care that exists for patients, with waiting times for appointments in different trusts varying by more than a year in some cases.

Alarmingly, they have also revealed that some patients who have an urgent referral for a painful and debilitating condition can expect to wait between two and three years for their first hospital appointment.

Meanwhile, thousands of patients with routine referrals face never being seen, with one hospital doctor warning: "As it stands, there are actually people who are being referred who will simply never get an appointment.

"They will continually be bumped down the list by people being added on who need to be seen more urgently."

Figures released to the Belfast Telegraph have shown that neurology is still failing to cope with demand.

Waiting times to see a neurologist have been slowly climbing since Dr Michael Watt was suspended from working after concerns were raised about his clinical practice.

All the figures below refer to the 14-month period from September 2018 to November 2019, unless indicated otherwise.

The wait time for an urgent neurology appointment in the Belfast Trust rose from 68 weeks to 160.

Routine neurology appointments in the trust rose from 246 weeks to 264.

In the Western Trust, urgent referrals to neurology increased from 99 weeks to 247.

Meanwhile, the wait for a routine neurology appointment in the Western Trust grew from 198 to 258 weeks in the same period.

Almost all specialties saw an increase in their wait times over the period in question. Ophthalmology in the Belfast Trust saw a significant jump in waiting times, from a 28-week wait for an urgent appointment to 101 weeks.

The wait for routine appointments in the specialty rose from 173 weeks to 227.

The wait for an urgent urology appointment increased by 39% from 38 to 53 weeks.

Patients referred for a routine urology appointment in the Southern Trust faced a wait of 141 weeks in September 2018, but this had increased to 196 weeks by last November.

The trust has apologised for the waiting times and said it prioritises patients by urgency and in line with guidance.

In the South Eastern Trust, the wait time for a routine ENT appointment in September 2018 was 117 weeks, but this increased to 148-weeks by last November.

Gastroenterology saw a significant decrease in the wait time for a routine appointment, down from 208 to 149.

The wait time for a routine general surgery appointment in the Western Trust at the end of August 2018 was 195 weeks, but this climbed to 256 weeks by the end of October last year.

Routine orthopaedics appointments saw a similar decline in waiting times, from 222 weeks at the end of August 2018, to 282 weeks last October.

The Northern Trust only provided the average waiting times for November 2019, so they do not provide a true reflection of the waits being endured by patients and cannot be compared to statistics relating to September 2018.

Waiting times have played a key part in the crisis currently facing the health service.

They have spiralled out of control since the collapse of the Assembly in January 2017.

According to Department of Health figures, there were more than 306,000 people waiting for a first outpatient appointment at the end of September last year. More than 108,000 of these, or 35% of the total number waiting, had been referred more than a year before.

The number of people on the waiting list for a first outpatient appointment at the end of December 2016, just weeks before the Assembly collapsed, stood at 246,198.

Of these, 47,072 people had been waiting longer than a year, representing one fifth of the total number of patients waiting.

Mr Swann said now that the issues related to industrial action had been resolved, "my focus is on the other top priorities facing my department, which certainly includes the unacceptable level of waiting lists here".

Current Waiting List Position

The numbers of patients on Urology waiting lists who are waiting unacceptable lengths of time are detailed below: (All waiting list information below as at 30th September 23)

New Outpatients

Total number of patients waiting on a first Consultant led Outpatient appointment = 4,458 patients. The breakdown of those waiting times are;

Waiting Time	Nu of Patients	
0-9 weeks	632 patients - 14%	
9-52 weeks	1093 patients – 25%	
52 + weeks	2733 patients – 61%	Of those 2733 patients waiting 52+ weeks this breakdown is as follows Waiting up to 2 years – 538 pts Waiting up to 3 years – 484 pts Waiting up to 4 years – 579 pts Waiting up to 5 years – 591 pts Waiting 5+ years – 541 pts
Total	4458 patients	3395 patients are routine and 1063 patients are urgent.

2022/23 Draft Ministerial Waiting Time Target - By March 2023, 50% of Patients should be waiting no longer than 9 weeks for an Outpatient Appointment and no patient waits longer than 52 weeks. The SHSCT is grossly underperforming against this target.

In Patient and Day Case Waiters

The total number of inpatient and day case awaiting treatment/ admission to the consultant led service is 1341 patients.

Number of patients waiting	Waiting Time
Urology – C = 1207 patients	927 patients waiting more than 13 weeks
Urology – IS = 134 patients	36 patients waiting more than 13 weeks
Total 1341 patients	Total 963 patients waiting more than 13 weeks (72%)

2022/23 Draft Ministerial Waiting Time Target - By March 2024, 55% of patient should wait no longer than 13 weeks for inpatient / daycase treatment and no patient waits longer than 52 weeks. The SHSCT is grossly underperforming against this target.

Other factors

Formal Investigation & Exclusion

In my last appraisal for the year 2016, I included the letter of the 23 March 2016 that had been given to me by Mr. Eamon Mackle, Associate Medical Director, and accompanied by Mrs. Martina Corrigan, Head of Service for ENT and Urology, who represented Mrs. Heather Trouton, Assistant Director, detailing their concerns regarding referrals which had not been triaged, outpatient review backlog, an allegation that there had been no record of consultations in patients' notes or on Patient Centre, and my having patients' notes at home. The letter requested that I respond with a commitment and immediately plan to address the concerns. I immediately asked what I should do. I was answered with a shrug of the shoulders.

I left that brief meeting wholly despondent, knowing that I would receive no support or assistance in addressing the concerns. I still remained Lead Clinician of Urology MDT, having responsibility for endeavouring to ensure that urological cancer diagnostic and therapeutic services were delivered to patients within the required timelines. In addition, I was daily conscious of the morbidity suffered by so many patients on our waiting lists, morbidity which was often acute and life threatening, requiring acute readmission to hospital with urosepsis as a consequence of the delay in elective admission for definitive surgical management. For that reason, I used every available operating session, undertaking 22 additional operating sessions during 2016 to endeavour to mitigate the risk to patients. I similarly conducted an additional 10 oncology review clinics for similar reasons.

During all of this time, I

Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

in order to provide continued support to one of my consultant colleagues while he was urologist of the week. When he advised me that he had taken up an appointment in England, commencing in November 2016, I

Personal Information redacted by the USI

I had also received the agreement of Mrs. Corrigan, Head of Service, to use my time at home to process and have patients' charts returned from my home. I did so by contacting all patients by telephone to update their clinical status, dictating letters to GPs and to the patients themselves. In doing so, I had scheduled all inpatient and day case operating for January 2017, and had my secretary schedule review appointments for the more clinically significant patients at clinics in January and February 2017. In doing so, I had processed two thirds of all the remaining patients.

Personal Information redacted by the USI

I then received a call on 28 December 2016 to advise that the Medical Director wished to meet with me on Tuesday 03 January 2017. I advised that I would be unable to do so at the stipulated time as I would be operating. I offered to speak with him by telephone. However, I was advised that he required to meet me in person. I enquired whether he appreciated that I was still on leave. I was advised that he did. I offered to meet with

Personal Information redacted by the USI

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION:		2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE	
3. HOSPITAL / FACILITY / COMMUNITY LOCATION (where incident occurred)		4. DATE OF INCIDENT: DD / MM / YYYY	
5. DEPARTMENT / WARD / LOCATION EXACT (where incident occurred)			
6. CONTACT PERSON:		7. PROGRAMME OF CARE: (refer to Guidance Notes)	
8. DESCRIPTION OF INCIDENT:			
DOB: DD / MM / YYYY GENDER: M / F AGE: years (complete where relevant)			
9. IS THIS INCIDENT A NEVER EVENT?		If 'YES' provide further detail on which never event - refer to DoH link below https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars	
YES		NO	
DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING			
STAGE OF CARE: (refer to Guidance Notes)		DETAIL: (refer to Guidance Notes)	ADVERSE EVENT: (refer to Guidance Notes)
10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:			
11. CURRENT CONDITION OF SERVICE USER: (complete where relevant)			
12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? (please select)			YES NO N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? (please specify where relevant)			YES NO N/A
14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: (please select relevant criteria below)			
serious injury to, or the unexpected/unexplained death of:			
- a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)			
- a staff member in the course of their work			
- a member of the public whilst visiting a HSC facility.			
unexpected serious risk to a service user and/or staff member and/or member of the public			
unexpected or significant threat to provide service and/or maintain business continuity			
serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service			
serious self-harm or serious assault (including homicide and sexual assaults)			
- on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the			

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM			
incident			
suspected suicide of a service user who has a mental illness or disorder (<i>as defined within the Mental Health (NI) Order 1986</i>) and/or known to/referred to mental health and related services (<i>including CAMHS, psychiatry of old age or leaving and aftercare services</i>) and/or learning disability services, in the 12 months prior to the incident			
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner			
15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: (<i>please select</i>)			YES NO
<i>if 'YES' (full details should be submitted):</i>			
16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?		YES	DATE INFORMED: DD/MM/YY
		NO	<i>specify reason:</i>
17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? (<i>refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.</i>) <i>please specify where relevant</i>			YES NO
<i>if 'YES' (full details should be submitted including the date notified):</i>			
18. OTHER ORGANISATION/PERSONS INFORMED: (<i>please select</i>)		DATE INFORMED:	OTHERS: (<i>please specify where relevant, including date notified</i>)
DoH EARLY ALERT			
HM CORONER			
INFORMATION COMMISSIONER OFFICE (ICO)			
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)			
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)			
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)			
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)			
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)			
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)			
19. LEVEL OF REVIEW REQUIRED: (<i>please select</i>)		LEVEL 1	LEVEL 2* LEVEL 3*
* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6			
20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (<i>delete as appropriate</i>)			
Report submitted by: _____		Designation: _____	
Email: _____		Telephone: _____ Date: DD / MM / YYYY	
21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: (<i>refer to Guidance Notes</i>)			
Additional information submitted by: _____		Designation: _____	
Email: _____		Telephone: _____ Date: DD / MM / YYYY	

Completed proforma should be sent to: seriousincidents and (where relevant) seriousincidents

Personal information redacted by the USI

Personal information redacted by the USI



South Office
Tower Hill
ARMAGH
Co Armagh
BT61 9DR

Strictly Confidential

Ms D Burns
Assistant Director Clinical &
Social Care Governance
Southern Health & Social Care Trust
Old College of Nursing
Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ

Tel :

Fax :

Web Site : www.publichealth.hscni.net

Personal Information redacted by the USI

14 November 2011

Dear Ms Burns

I refer to the Trust's report on the Root Cause Analysis of this incident. The report is thorough, clearly identifying the chronology of events and making recommendations on actions to avoid recurrence. As might be expected, the report concentrates on the primary event, which occurred during the patient's operation on 15th July 2009 and the x-ray findings which might have aided detection prior to her emergency admissions in July 2010.

The patient was expected to have an outpatient review four months after her major complex cancer surgery in July 2009. It was also expected that at that review attendance the CT scan, undertaken three months post-operatively, would be available for the consultant urologist to see. This scan was done promptly in early October 2009 and the report identified an abnormality. Although not identified as a retained swab, one of the differential diagnoses was recurrence of the patient's cancer.

The RCA report identifies that, due to a backlog in outpatient reviews, in fact the patient was not seen at outpatients in the 12 months after surgery, at which stage she was admitted as an emergency. The recommendation relating to this issue was that outpatient backlog reviews should be cleared. This recommendation is reasonable, albeit not necessarily easy for the Trust to

Improving Your Health and Wellbeing

Aimee Crilly

From: Corrigan, Martina Personal Information redacted by USI
Sent: 14 December 2010 17:44
To: Personal Information redacted by the USI O'Brien, Aidan
Cc: McCorry, Monica
Subject: update on numbers of patients waiting

Dear Aidan

I had to give an update for a meeting with the Department tomorrow regarding of waiting lists. I am just sending through to each of you what your waiting times are like until end of January as these are the patients that need to be seen to help bring us in at 36 weeks by end of March 2011.

2 day patients waiting – 38.37 weeks

Personal Information redacted by USI

Inpatients – 27 patients waiting and longest patient waiting is 51.51 weeks

I am happy to discuss and agree what additional sessions that you are able to do over the next few months.

Many thanks

Martina

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

Tel: Personal Information redacted by USI

Mobile: Personal Information redacted by USI

Email: martina.corrigan@shsc.nhs.uk Personal Information redacted by USI

Angela Kerr

From: Suresh, Ram [Personal Information redacted by USI]
Sent: 22 August 2014 09:23
To: O'Brien, Aidan
Subject: [Personal Information redacted by USI]

Hi Aidan,
Good morning. Hope you are having a nice holiday. But, I could see through emails that you are working even harder during holidays!

Sorry to bother you- Re Mr [Personal Information redacted by USI] Priapism is settling, not completely though. I discussed with Martina regarding extra contractual referral for penile prosthesis. She has agreed in principle. Shall I arrange an urgent clinic appointment/ ward review for him to see you before you make the referral?

Kind regards
Ram

Aimee Crilly

From: McCorry, Monica Personal Information redacted by USI
Sent: 02 February 2011 11:54
To: Tedford, Shirley; Mulligan, Sr Judith; McElvanna, Ciara; Marsden, Jill; Montgomery, Rosemary; McDermott, Sharon; McClenaghan, Nichola; Murray, Eileen; Meredith, Lorraine; Bed Manager; Baird, Veronica; Bunting, Helen DR; Brown, Jeffrey; Cullen, David; C.S.S.D; Corrigan, Martina; Slaine, Delma; Argue, Rosie Sr; Anderson, Judith; Gray, Karyn; Jeffers, David; 3 North, Ward; O'Brien, Aidan
Subject: FW: extra list 5/2/11
Attachments: extralist050211.doc

From: McCorry, Monica
Sent: 02 February 2011 11:50
To: Tedford, Shirley; Mulligan, Sr Judith; McElvanna, Ciara; Marsden, Jill; Montgomery, Rosemary; McDermott, Sharon; McClenaghan, Nichola; Murray, Eileen; Meredith, Lorraine; Slaine, Delma; Argue, Rosie Sr; Jeffers, David; C.S.S.D; Cullen, David; Corrigan, Martina; Bed Manager; Baird, Veronica; Brown, Jeffrey; Bunting, Helen DR; Gray, Karyn; Graham, Vicki; 3 North, Ward; O'Brien, Aidan; Anderson, Judith
Subject: extra list 5/2/11

Please see attached extra list for Mr O'Brien on Sat 5/2/11

It is important to make clear that I am required to comply with Trust Policies and Procedures. Disciplinary procedures should only be used or invoked where it is considered that I am in breach of Trust policies or where my professional competence has been called into question.

The most relevant Trust Policy is entitled *Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance*, dated 23 September 2010 (hereafter referred to as the "Trust Guidelines". These guidelines were updated in October 2017. However, it is the 2010 guidelines that are relevant to the events of 2016 and the formal investigation. I will make extensive reference to the Trust Guidelines throughout this grievance. It is attached in the Schedule of Documents at Tab 4. It is this document and the processes established within it that form part of my contract of employment.

The document entitled *Maintaining High Professional Standards in Modern HPSS* issued by the English Department of Health, Social Services and Public Policy in November 2005 is **not** part of my contract. This is made clear by Clause 32 of my contract outlined above.

2.3 Events before 30th December 2016

I have provided an extensive historical context for the concerns about my administrative backlog to the Case Investigator, Dr Chada. This response is attached in the Schedule at Tab 5. I do not intend to repeat the full context in this correspondence. In summary, I have provided detail of the pressures that I was under for many years with waiting lists for both in-patient treatment and review, and how I was using available time to ease that backlog. There had been times when I fell behind in administrative work in the past and would have worked additionally to ease that backlog. **This was always known to the Trust and the Trust was always aware that the volume of work was overwhelming.** It is clear from the witness statements provided in the investigation that my administrative backlog was known to Trust managers for a very considerable period of time prior to 2016.

The problems became more acute owing to additional pressures that built up between 2012 and 2016. I was provided with 2 hours and 40 minutes of patient related, administration time per week in 2015 (Tab 6) and 2 hours per week in 2016 (Tab 7) in my job plan. I described in my response, the additional commitments required following appointment as Lead Clinician of the Southern Trust Urology Multidisciplinary Team and Chair of Urology MDM in April 2012, and as Lead Clinician of the Northern Ireland Cancer Network (NICaN) Clinical Reference Group in Urology in January 2013. These appointments were followed by a two year period of time when both the Southern Trust's and Northern Ireland's regional urological oncology services were preparing for National Peer Review in June 2015.

I was not provided with or allocated any time for any of these undertakings during the years 2012 to 2014. The most onerous and time consuming was previewing all cases to be discussed at MDM which I chaired every Thursday afternoon. This required three to four hours of work, which I typically had to undertake from 10 pm each Wednesday evening, having operated to 8 pm. To relieve the burden, I introduced a rotating chairmanship of MDM with two of my colleagues, beginning in November 2014. Thereafter, I was provided with an additional 3 hours to prepare for chairing MDM as were my two colleagues, from 2015 onwards.

However, no time was allocated in my job plan for the remaining commitments at all during the years 2012 to 2016. By the time that the Southern Trust MDT was subjected to National

19. I know Mr O'Brien finds triage arduous and he would often say he had difficulty completing triage on a timely basis. Mr O'Brien would raise issues at departmental meetings however I was unaware that the triage was not being done. I knew he didn't necessarily agree fully with all of the new introductions to the service but it was the process within the Department that we had all agreed to at prior meetings. He never said he was not going to do triage, he was very much part of the meetings when it was agreed. Mr O'Brien was very much an advocate of advanced triage and complained that others may not have done it properly. The level of triage he was aspiring to achieve was difficult to attain possibly, some may comment that he was almost trying to do it in too much detail, and as such the totality took too long.
20. My experience of Mr O'Brien is that if he was not wanting to do something he wouldn't be pushed into doing it. Mr O'Brien would be the first to politely say when he didn't agree with something. I am not aware of Mr O'Brien saying he wasn't doing triage. I knew he may have been behind with triage but not that he wasn't doing it.
21. It was only in December 2016 that I became aware of the extent to which Mr O'Brien was behind on doing triage. Again as commented upon before I appreciate that he was vocal about saying he had difficulty and didn't have enough time. I know he felt he didn't have time to do advanced triage in the way he wished. He however did not say the extent to which he was behind. I recall seeing the bundle of referrals which were not triaged in December 2016 and being particularly surprised by the volume.
22. I would have expected Mr O'Brien to have come to me and alerted me about the referrals not being triaged. I hadn't spotted that it was such an issue. I'm not in charge of his practice but I thought he would have afforded me the opportunity to speak to him. There was no reason why he couldn't approach me. I had helped him in the past. We have always had a good relationship and speak openly about a wide variety of things. We have had only 'two cross words' in the 20 years we've worked together.
23. In respect of TOR 1, I was unaware of the scale of the issue and was not told by Mr O'Brien or anyone else that triage was not being done, just that there was a delay in it being done. I was informed in late December 2016 that there was approximately 700 letters dating back to June 2015 that had not been triaged.
24. I was involved, along with my urology colleagues, in reviewing the referrals that hadn't been triaged. Of those I triaged several were upgraded to red flag. Some were clearly red-flag referrals. I am also aware my colleagues also upgraded some referrals.
25. All un-triaged referrals had the potential for patients to come to harm. During the look back exercise, I didn't see any GP coded red-flag referrals among the un-triaged referrals. i.e. it seems the red flag letters were triaged. These are printed on yellow paper to make them stand out. I'm not sure if Mr O'Brien screened the routine letters, this is not for me to comment upon. However if he had, it is unlikely he would have missed an evident red-flag referral. I am not sure if he

triaged some but ran out of time and didn't do the rest for that week. Again this is my supposition only and really not for me to officially comment upon.

26. Basic triage would not have taken any significant time, other than when there is a high volume of referrals. Advanced triage is however much more time consuming. If things are busy in the week, you do the basic triage and do the advanced version to the best of your ability in the time allocated. Its common sense in my mind and is the approach I take. In saying that the vast majority of triage I do is of the advanced version despite being busy. I suspect Mr O'Brien would not agree with the mix and match approach to basic /advanced triage so as to clear the weeks work. I have absolutely no concern about Mr O'Brien's clinical competence, in fact I and my family would go to him personally if needed. He is very capable of reading a letter and knowing what action was necessary.
27. Mr O'Brien is very fastidious about what he does, I sense he looks at the letters in detail, the minutiae is important. However the quantum in combination with the detail I think is his issue. I think it might be regarded that he does small amounts very well, whereas others can get through a larger volume.
28. All Urology Consultants, including Mr O'Brien, accept the Consultant of the Week model and what was required in the new model.
29. I am not aware of the issue regarding notes in Mr O'Brien's home. This is a Trust issue. I was unaware of charts being stored at his home. We do outreach clinics in Banbridge, Armagh, and South Tyrone. The notes are available when we go there.
30. When the new SWAH clinic started there was no transport between the two Trusts to take the charts and so files were taken to the clinic by Martina Corrigan. I bring the notes home in the back of my car and then bring them back to the Trust the next day. There is no reason to keep them longer than the time taken to do dictation of the clinic.
31. I believe Mr O'Brien works differently. I dictate at the time of the clinic, usually after each patient or at the end of the clinic. I write on the 'outcome sheet' the requirements for the patients and this is kept separate from the patient notes. I return all to my secretary the next day. The notes, dictation and outcome sheet are stored in my car / home over night before their return to the hospital the following day. There is generally a dictated letter on every encounter with a patient.
32. Mr O'Brien always requested the following Tuesday morning after the Erne clinic to be free to do his administration. (on other Tuesdays he does day surgery, but not the week of the Erne clinic). There was no indication that this was not enough time. We hold a scheduling meeting on the last Thursday of the month to define the activity for the month ahead. The schedule was sent out ahead of time to ensure everyone could plan the number of patients attending specific clinics. I run this meeting and everyone is present including the secretaries, junior medical staff and Consultants. Mr O'Brien was always very clear that he wanted to be free for admin work the day

From: [Avril Frizell](#)
To: [Donnelly, Anne](#); [Murphy, Eoin](#); [Benson, Shauna](#)
Cc: [Emmet Fox](#); [Keeva Wilson](#)
Subject: Issue for AOB regarding Patient 139
Date: 21 March 2024 16:46:56
Attachments: [emails Avril to Anne of 5.2.24 and response of Anne 13.2.24.docx](#)
[20200825 Email from M Corrigan to M O'Kane re AOB-NE contact.pdf](#)
[s-sheet - Results to Trust 20240201.xlsx](#)
[s-sheet - patient access \(1\).xlsx](#)
[20200731 - E Mr O'Brien return items to Trust \(003\).pdf](#)
[TRU 252938- TRU 252940.pdf](#)
Importance: High

"This email is covered by the disclaimer found at the end of the message."

Dear Anne

Further to our email exchange on 5 February and 13 February, I have taken further instructions on this issue from the Southern Trust, and I understand that Mr Lunny KC has raised this matter directly with Mr Wolfe KC. By way of summary, I can confirm:

1. On 18.9.23 Mr Wolfe KC raised with Donal Lunny KC an issue re Mr Glackin's involvement with Patient 139 from 2016. The issue had been raised with Mr Wolke KC by AOB's lawyers. Mr Wolfe KC cited a document at WIT-04624 when raising the issue with Mr Lunny KC. Mr Lunny KC reverted to ask what the basis was for believing Mr Glackin had any involvement as WIT-04624 did not disclose any such involvement. Mr Wolfe KC replied quoting precisely what AOB's lawyers had said in the points they wanted Mr Wolfe KC to raise with Mr Glackin:

'...It would appear that Patient 139 (WIT04624) remained on Bicalutamide 50mg daily and Tamoxifen 10 mg daily since recommended by Mr O'Brien in 2010 for organ confined, intermediate risk prostate 5 cancer with apparently good effect. The patient remained under your care after you reviewed him in 2016.

Did you find that he remained well since 2016?'

2. When Mr Lunny KC pressed the point with Mr Wolfe KC (and Mr Wolfe KC in turn pressed it with Mr Millar BL on behalf of AOB), Mr Millar BL provided 3 letters to Mr Wolfe KC. Those 3 letters can be described as follows:
 - a. They are 3 letters relating to Patient 139 from Mr Glackin to Dr Gudyma (the GP);
 - b. The first was dictated on 22.2.16. The second and third are dated 4.3.16 and 5.5.20 respectively.
3. The Trust quickly satisfied itself that none of the 3 letters was contained in any discovery provided by it or by AOB to the Inquiry.
4. The letters have since been given the Bates numbers AOB-82836, AOB-82837, and AOB-



Personal Information redacted by the USI

From: Loughran, Patrick [redacted]
Sent: 23 April 2009 08:51
To: Corrigan, Diane
Subject: RE: Contact details for Mr Fordham

Thanks Diane.

I have had another long chat with AO'B and he feels justified despite further advice which I have received from a senior microbiologist at Stoke Mandeville. I have emailed Mr Fordham to ask for advice. Paddy

-----Original Message-----

Personal Information redacted by the USI

From: Corrigan, Diane [mailto:[redacted]]
Sent: 22 April 2009 15:39
To: Loughran, Patrick
Subject: Contact details for Mr Fordham

"This e-mail is covered by the disclaimer found at the end of the message."

Paddy

Here is Mark's CV and contact details. He would have already met both Aidan and Michael as part of the urology review.

Personal Information redacted by the USI

Regards

Diane

Dr D Corrigan

Consultant in Public Health Medicine

Public Health Agency

Tower Hill

Armagh

BT61 9DR

Personal Information redacted by the USI

Tel:

Personal Information redacted by the USI

GMC No.

Personal Information redacted by the USI

"The information contained in this email and any attachments is confidential and intended solely for the attention and use of the named addressee(s). No confidentiality or privilege is waived or lost by any mistransmission. If you are not the intended recipient of this email, please inform the sender by return email and destroy all copies. Any views or opinions presented are solely those of the author and do not necessarily represent the views of HSCNI. The content of emails sent and received via the HSC network may be monitored for the purposes of ensuring compliance with HSC policies and procedures. While HSCNI takes precautions in scanning outgoing emails for computer viruses, no responsibility will be accepted by HSCNI in the event that the email is infected by a computer virus. Recipients are therefore encouraged to take their own precautions in relation to virus scanning. All emails held by HSCNI may be subject to public disclosure under the Freedom of Information Act 2000.."

This email is confidential and intended solely for the use of the individual(s) to whom it is addressed. Any views or opinions presented are solely those of the author and do not necessarily represent those of Southern Health and Social Care Trust. If you are not the intended recipient, be advised that you have received this email in error and that any use, dissemination, forwarding, printing, or copying of this email is strictly prohibited. If you have received this email in error please notify the sender.

Diane Corrigan

From: White, Laura <[REDACTED]> Personal Information redacted by the USI
Sent: 05 January 2010 14:19
To: Corrigan, Diane
Cc: Wilson, Roberta
Subject: Intravenous Fluid & Antibiotic Therapy (IVT)
Attachments: SKMBT_60002072500340.pdf

Dr Corrigan

Enclosed as per your telephone call with Dr Loughran, you are mentioned under Page 2, No 6 and Page 3, "G".

Laura

Ms Laura White

Personal Assistant to

Dr Patrick Loughran

Medical Director

Southern Health & Social Care Trust

College of Nursing

Craigavon Area Hospital

68 Lurgan Road

PORTADOWN

BT63 5QQ

Tel: [REDACTED] Personal Information redacted by the USI

Fax: [REDACTED]

E-mail: [REDACTED] Personal Information redacted by the USI

P Please consider the environment before printing this e-mail.

From: bh600

Personal Information redacted by the USI

Sent: 25 July 2002 01:35

To: White, Laura

Subject: Message from KMBT_600

This email is confidential and intended solely for the use of the individual(s) to whom it is addressed. Any views or opinions presented are solely those of the author and do not necessarily represent those of Southern Health and Social Care Trust. If you are not the intended recipient, be advised that you have received this email in error and that any use, dissemination, forwarding, printing, or copying of this email is strictly prohibited. If you have received this email in error please notify the sender.

Intravenous Fluid and Antibiotic Therapy (IVT)

This short paper sets out the involvement of the Medical Director in relation to a treatment provided in the Urology Service in SHSCT:

- (i) **Chronology**
- (ii) **Summary of Current Position**
- (iii) **Suggested Way Forward**

The following is a brief summary of the background and the involvement of the Medical Director so far:

(i) Chronology

1. March '09. These treatments for prophylaxis in patients with recurrent or the risk of recurrent urinary infection were discussed within the Trust in March following a request from 2 patients for self care in the community (via Mrs Carmel Hanna, MLA) (Appendix A).
2. March '09. There had been discussions between Mrs Joy Youart, Mrs Heather Trouton and Dr Tracey Boyce about potential new models of care for this patient cohort. It was believed that the evidence base for these treatments was weak.
3. Mrs Joy Youart invited Dr Patrick Loughran to become involved. (Appendix B).
4. March and April '09. See correspondence and phone conversations with Mr Aiden O'Brien and Mr Michael Young, (Appendix C&D). The two urologists agreed to review the individual cases within the IVT programme and to try and find alternative treatments which did not require intravenous therapy [fluids and/or antibiotics]. Each agreed to revert to Dr P Loughran in due course. There is no record of a response and Dr P Loughran set in place the arrangements for second opinions from Mr Mark Fordham and Dr J O'Driscoll.
5. 21st April '09. A meeting included Dr Loughran, Mr O'Brien, Dr Damani and Dr McAllister on 20th April '09. Dr Damani agreed to become involved in a multidisciplinary review of the patients and to provide ongoing microbiology support for the urology team as it was expected that the patient cohort would be changed from IVT to oral prophylaxis and heightened surveillance for infection. 18th May '09 Dr P Loughran to Mr Aiden O'Brien asking for review of IVT patients. (Appendix E).

6. April '09. Dr Loughran discussed with Dr D Corrigan (on behalf of the Commissioner) (Appendix F(a)) and Dr Corrigan advised that they would seek reassurance that the treatments were evidence based, mainstream and there was evidence of benefit to the patients enlisted in the programme.
7. These second opinions were sought initially by phone in April and May. (Appendix D and E (a) & (b)).
8. 1st May '09 Mr O'Brien sent Dr Loughran a draft paper which he hoped to publish with one of his registrars, looking at patient satisfaction with the IVT regime, (16 patients).
9. June '09. Dr Loughran and Mr O'Brien agreed that it would be helpful for the Trust to get a written independent assessment by Mr M. Fordham
10. 1st June '09, 24th June '09 (Appendix G, and H) Mr Young and Mr O'Brien met with Dr Loughran and agreed to review their own cases. They also asked for an "extension" of time to look at alternative arrangements. Dr Loughran agreed not to accelerate or push forward the independent review.
11. July '09 The Trust received an email reminder concerning the contact from Mrs Carmel Hanna MLA.
12. 4th August '09. Dr Loughran, Mr A O'Brien and Mr M Young agreed that each patient on IVT would be reviewed and a multidisciplinary group would agree a treatment plan for each patient, (Appendix I).
13. October '09, Dr Loughran was advised that many of the patients had been converted to other prophylactic treatments, and therefore Dr Loughran did not tighten the time scale for the independent review.
14. November '09. Dr Loughran was advised, contrary to point 12 above, that the majority of the patients remained on the IV programme and moved therefore to complete his investigations.

(ii) Summary of the Current Position

- a. The IVT is intended to avoid or postpone the recurrence of urinary infection in patients who are prone to the condition.
- b. At the initial contact with both Dr O Driscoll and Mr Fordham by phone each expressed the view that this is a difficult cohort of

patients to manage but neither had heard or read of the IVT as offered in Craigavon. Mr Fordham described his practice of oral antibiotic therapy as a prophylaxis and management mostly in primary care. Dr O Driscoll said there was no good microbiological rationale for the therapy and agreed to do a literature search and to discuss the management of such cases with colleagues.

- c. Subsequently Mr M Fordham has provided written commentary, (attached Appendix J(a) and J(b), K, L and M).
- d. Dr O'Driscoll's opinion is summarised in attached notes, (Appendix D).
- e. I have read the draft paper provided to me by Mr O'Brien and it is my view that the satisfaction reported by the patients does not amount to a scientific proof of the efficacy of the therapy. Mr O'Brien has still not provided an evidence base for the IV therapy
- f. Patients are being admitted for IV therapy and technical venous access difficulties in two patients are leading to requests for Central Venous lines to be inserted. This is an invasive procedure with potential complications, and should be reserved for absolutely essential IV access. Complications associated with CV lines can be very serious.
- g. I have discussed the above with the Commissioner and am advised informally that, on the basis of the above, the Southern Trust should organise an orderly change of clinical practice. This will include moving patients on the IVT to another treatment regime with the support of medical microbiology.

(iii) Suggested Way Forward

- 1. An orderly conversion of patients on IVT under the guidance of a multidisciplinary team [urology, nursing and microbiology].
- 2. A communication strategy to support the urology team, as the treatment is withdrawn, and replaced by hospital based outpatient treatment/ prophylaxis.
- 3. A longer term plan to base the prophylaxis in primary care, with support from the hospital based multidisciplinary team.



Northern Ireland
Assembly

Mr Michael McGimpsey MLA
Minister of Health, Social Services and Public Safety
Castle Buildings
Stormont
Belfast
BT4 3SG

Parliament Buildings
Belfast BT4 3XX

12 MAR 2009

6th March 2009

Dear Mr McGimpsey,

RE: Meeting Request for Self Care Proposal in the Community

I am writing to request a meeting with you following a discussion with two women, [Personal Information redacted by the USI] and [Personal Information redacted by the USI]. You may recall my raising the issue of self care in the community with you in relation to these women on Monday the 2nd of March in the Members Coffee Bar.

To give you some of the background medical history; [Personal Information redacted by the USI] picked up a hospital acquired coliform infection following several gynaecological surgeries, and [Personal Information redacted by the USI] too suffers from chronic and persistent coliform infections of the urinary system following a hysterectomy and oophorectomy.

Due to the severity of their conditions they are required to attend hospital every 6 to 8 weeks for a period of five days to flush out their urinary system to suppress the symptoms of urinary infection. As you can imagine the negative impact that this has on these women physically and emotionally is considerable, the effect and pressure these hospital visits has on their families is also extensive.

Ideally these women would wish to receive medical treatment in their own homes. Three proposal is supported by their Consultant Urologist, Mr. Aidan O'Brien and the Staff on Ward 2 South Urology at Craigavon Area Hospital. Undoubtedly treatment at home would improve their quality of life, lessen their exposure to other Healthcare Acquired Infection, and free up much needed acute hospital beds.

I very much hope you will facilitate a meeting to discuss the proposal of care in the community further for these women and I look forward to your response.

Yours sincerely,

[Personal Information redacted by USI]

Carmel Hanna MLA
SDLP South Belfast

SDLP South Belfast Constituency Office: 393A Lisburn Road Belfast BT9 7EW
Tel: 028 90683535 Fax: 028 90683503 e mail: carmelhannasdlp@btconnect.com


SDLP
Social Democratic and Labour Party

Appendix B

**NOTES OF MEETING
10th March, 2008**

Mr A O'Brien

Meeting with Mrs Joy Youart.

Joy believes that she has discovered a cohort where 34 patients were re-admitted to Craigavon Area Hospital for intravenous fluids and antibiotic therapy and she is not sure what the indications for this treatment are.

Joy discovered this cohort as the result of a routine patient flow exercise to find out the bed usage within different specialties.

I agreed to get further information from Dr Tracey Boyce in Pharmacy about the antibiotic usage and check with Dr Damani whether or not the Antibiotic usage fell within the Trust's guidelines.

I further agreed that I would take this information back directly to Mr O'Brien so we can determine the background to this treatment and its appropriateness or otherwise.

Notes of meeting 20-4-09
Pl, AOB, CMcA, ND
Loughran office

Three related topics were addressed

1. Compliance with Trust Antibiotic Guidance, as set out in covering letter (attached).

Mr O B said that his personal experience would support the antibiotic use as he currently followed and he was not persuaded to adopt the Trust advice.

Dr Loughran felt that the Trust had circulated the guidance for comment and was anxious that the Urology team had not joined the consultation.

The evidence base of the guidelines especially as applied to Gentamycin was debated, and all agreed should be discussed separately.

Dr McA said many clinicians were reluctant to take advice in relation to long held beliefs and habits but the adoption of guidance and then measuring outcomes was the best way forward.

It was agreed that Dr D and some or all of the urology team will meet in the immediate future to agree the Guidelines as applied to urology. Dr L asked for the final agreement to be evidence based

2. The Trust has identified a cohort of about 30 patients who are admitted as elective cases for IV antibiotics and IV fluids as a prophylaxis for recurrent UTIs. The evidence base for this was described by AOB, and he described a study of outcome which was being prepared for publication.
3. The third related issue is the letter from Mrs C Hanna MLA to Mr M McGimpsey MLA asking for the above treatment to be made available at the homes of two patients.

Dr L agreed that he would contact the Commissioner (Dr Corrigan).

Note of a phone call M Young 21 4 09 at 4pm

PL explained the 3 issues and meeting 20 th April – views as lead clinician ??

Alternative to IV therapy is to wait till patients get clinical infection - quoted a patient who does very well and family are very keen to get prophylaxis.

“low bacterial count not 10 to the power 5 as required by Dr D etc”

Expects the evidence base is not there to support the therapy but clinical experience supports use.

He expects an independ inspection will not support the therapy but then patients will be unhappy.

Notes of a phone call to Dr Jean O Driscoll Microbiologist

1145 22 4 09

PL explained the situation as per meeting on Monday

PL explained that ND believes the IV therapy is inappropriate

ND describes the existence of oral prophylaxis, and the identification and treatment of symptomatic patients using cultures.

JOD agrees – she has never heard of the IV therapy used for prophylaxis – is familiar with the oral regimen. She has recently given a lecture on urinary infections and researched prior to that lecture. She will check with some colleagues in Bristol, look again at the literature, and send me a summary email.

Notes of call aob 22 4 09

6pm

Pl explained he had contacted jod and no backing for treatment

Aob said the rx was because of the cohort morbidity 18 cases – only evidence is our draft paper he agreed to look at converting some cases to orap proh

Pl asked if he would look at all cases for alternative treatments

Aob wants an in depth look at the cohort.. not just telephone contact with specialists



Southern Health
and Social Care Trust

Medical Directorate

18 May 2009

Our Ref: PL/TC/lw

Mr Aiden O'Brien
Urology Department
CAH

Dear Aiden

I have now contacted and spoken to Mr Mark Fordham at length. I explained to him that we have patients who are being admitted for IV fluids and antibiotics. I gave him your viewpoint as best I could. He said that while he understood that you are doing your best for this group of patients, he did not know of any evidence base which would support these therapies.

We went on to a more detailed discussion about his practice and a widely accepted approach to recurrent urinary infections. He felt that once such patients had the initial standard investigations carried out, that they should be managed in primary care with no further hospital interventions. He talked about voiding techniques, advice to patients about oral hydration and the use of night time oral antibiotics. He also talked about the specifics in relation to females, and local oestrogen therapy and advising patients in relation to personal care. He also felt that if patients needed particular advice and reassurance that a once weekly MSSU provided at the hospital for 6 successive weeks would indicate that 90% of these patients did not have urinary infections and had what he described as "abacterial" cystitis.

I explained that we have a very strong antibiotic guideline in place. He supported the use of such a guideline and went on to say that he believes that such circumstances need bacteriological evidence before antibiotics should be commenced.

Summary

Over the last 6 weeks, I have spoken and written to you about a cohort of about 30 patients who are admitted for IV antibiotics and IV fluids as a prophylaxis for recurrent UTI's.

We have had a letter from a politician asking for the treatment to be provided at home. Our CX is taking this forward with Mrs C Hanna, MLA.

Cont'd.

Page 2

I have discussed the situation with a senior microbiologist from Stoke Mandeville who believes there is no evidence base to support the treatments.

In the above paragraphs I have described the reaction of a senior urological surgeon from Manchester who also believes there is no evidence to support the treatment.

Our commissioner has expressed concern and asked me to seek independent advice so that an evidence based discussion could take place around the continuation or discontinuation of such therapies.

I would now like to meet with you immediately to take this forward. In advance of the meeting perhaps you could reflect on the possibility of changing these patients to oral therapy with an MSSU taken at the hospital at a regular interval. As on previous occasions, I have copied this to Michael Young, whose opinion on the way forward might also be valuable.

Dr Patrick Loughran
Medical Director

cc Mr Michael Young, Consultant
Mr Colm Donaghy, Chief Executive

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel: Personal Information redacted by the USI

Fax: Personal Information redacted by the USI

Email: Personal Information redacted by the USI



**Southern Health
and Social Care Trust**

Medical Directorate

12 May 2009

Our Ref: PL/tc

Mr Aiden O'Brien
Urology Department
CAH

Dear Aiden

At our meeting on 21 April we discussed the cohort of patients who are elective admissions to receive IV fluids and antibiotics.

I have searched the NICE Guidelines for the current position on the prevention of recurrent UTI and have turned up clinical guidance for UTI in children – and therefore not relevant. The NICE guidance on Chronic Kidney Disease does not deal with infection.

I have contacted Dr Corrigan, on behalf of our commissioner. In the absence of NICE or other peer reviewed support for IV antibiotics and/or IV fluids, the commissioner would not support the provision of this at home. Dr Corrigan and I have therefore agreed that this Trust should immediately seek independent advice on how such patients are treated in other Trusts in N Ireland and other parts of the UK.

I have received a copy of the paper on the work you are doing in relation to this treatment. I have contacted Jean O'Driscoll who is a consultant microbiologist in the East of England who has carried out a literature search for me. This search did not show any evidence in support of intravenous fluids and IV antibiotics as a recognised prophylaxis,

I am awaiting a return call from Mr Mark Fordham who is a Consultant urologist in Manchester and who is very familiar with the NI urology service. I am hoping to ask for his independent views on the IV therapies.

Cont'd.

Appendix F_(b)

Page 2

I spoke to Mr Young on the afternoon of 21 April, as the lead clinician, to make him aware of the background to our meeting and the expectation of an Independent inspection of the IV therapy.

I will keep in touch by letter and telephone as required.

Yours sincerely

Personal Information redacted by USI
[Redacted Signature]

Dr Patrick Loughran
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: [Redacted] / Fax: [Redacted] / Email: [Redacted]
Personal Information redacted by the USI



Southern Health
and Social Care Trust

Medical Directorate

2 June 2009

Our Ref: PL/lw

Mr Aiden O'Brien
Urology Department
CAH

Dear Aiden

Thank you very much for meeting with me today. We agreed that you:

- would provide me with a complete list of the patients who are currently on the IV programme.
- will accept an independent assessment of this IV therapy.

I will arrange terms of reference with Mr Mark Fordham and speak to Jean O'Driscoll the Micro-biologist again.

I will also speak to Michael Young in due course.

Regards

Personal Information redacted by USI

Dr Patrick Loughran
Medical Director

cc Mr Michael Young, Consultant
Mr Colm Donaghy, Chief Executive

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel: Personal Information redacted by the USI

/ Fax: Personal Information redacted by the USI

/ Email: Personal Information redacted by the USI



Memorandum

Our ref:	PL/lw	Your ref:	
To:	Joy Youart, Acting Director for Acute Services		
c.c.	Mr Aiden O'Brien, Consultant, Urology Department		
From:	Dr Patrick Loughran, Medical Director		
Date:	24 th June 2009		
Subject:	Urology patients on IV Therapy		

Dear Joy

I have spoken to Mr O'Brien who has agreed to have an independent assessment on the efficacy and appropriateness of IV Therapy. Within our discussions he agreed to send me the details of this group of patients so that we could extract appropriate information from their charts. He has not replied despite telephone and written reminders.

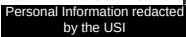
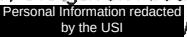
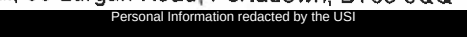
I would be grateful if you could identify a secretary or member of medical records staff who could help me. I look forward to your reply.

Regards

Personal Information redacted by USI

Dr Patrick Loughran
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel:  / Fax:  / Email: 

Meeting re Urology Clinical Practice

Date: 4th August 2009

In attendance: Dr Patrick Loughran, Medical Director
Mr Aiden O'Brien, Consultant Urologist
Mr Michael Young, Consultant Urologist

Previous positions re the treatment of the identified cohorts of patients discussed. Dr Loughran explained that the Trust had engaged two experts Mr Mark Fordham (Urologist) and Dr Jean O'Driscoll (Microbiologist) to provide an opinion on the efficacy of the present intravenous regimes. They would review the charts of a number of patients and current urology and microbiology practices.

After further explanation of each others positions the following was agreed:

1. A further meeting to take place in September
2. A meaningful active and accurate list of patient details to be provided by Friday 7th August by Mr O'Brien and Mr Young.
3. Each surgeon will personally review the current treatment regime for each patient on the list.
4. A multidisciplinary group would be convened to review the reduced list of patents and agree a treatment plan for each patient. This group would consist of microbiology and urology consultants.

c.c. Dr Nazim Damani
Mr Colm Donaghy

Update: 7th August 2009

Dr Loughran met with Dr Damani today. Dr Damani has agreed to be a member of the multidisciplinary team.

Appendix J(a)

Wilson, Roberta

From: Fordham Mark (RQ6) RLBUHT [Personal Information redacted by the USI]
Sent: 23 October 2009 11:47
To: Wilson, Roberta2
Cc: Loughran, Patrick
Subject: Mark Fordham - Royal Liverpool Hospital

Dear Roberta,

It was helpful to know about your background in rheumatology. I think you will have seen patients who can become dependant on a hospital team for their incurable but non fatal conditions.

As promised I have asked the opinion of 2 senior colleagues who are active in female, reconstructive and neuro-urology surgery.

Best wishes

Mark

My description of the cases is below with their comments.

My description of the situation:-

I have been asked to look at some cases done by another consultant working many miles from us.

He has a group of patients whose atonic bladders have been managed by a variety of surgical procedures eventually ending up with cystectomy and ileal conduit diversion.

Some of the patients have what sounds like pelvic pain syndrome too.

These patients seem to have a variety of on-going symptoms and a positive ileal conduit urine culture results in a diagnosis of UTI causing the symptoms.

The patients' management that I've been asked to comment on [by the hospital medical director] is:- admitting the patient to hospital for 5 -7 days for i.v. fluids [one litre over 24 hours] together with 5 -7 days of i.v. antibiotics, being regularly repeated on a 2 or 3 monthly basis.

This is called 'rehydration and antibiotic therapy'.

My experience of this type of patient is that they can be rather 'heart-sink' individuals who have a normal life expectancy but have recurrent and various symptoms but once you have operated on them [especially cystectomy and ileal conduit formation] they are yours for the rest of your professional life.

However, I suspect that oral antibiotics either night-time trimethoprim or rotating antibiotics, a month at a time tend to be the most usual methods of trying to manage such cases....but I will be very happy to stand corrected by you.

First colleagues reply:-

Thank you for the e-mail. I would suggest that this is an idiosyncratic way of managing patients with persistent symptoms after urinary diversion. However, there is a group of patients with conduits (who have usually been diverted for benign rather than malignant disease) who have symptoms that are difficult or impossible to manage effectively. Most urologists who deal with this patient group would agree that these individuals are a significant drain on resources as a result of repeated investigations and unplanned admissions to hospital. It often ends up with a situation where one is excluding serious, treatable complications and then providing supportive care in conjunction with the primary care team. That support can take on different forms but may include planned or unplanned admission to hospital at different times. In summary, these patients are "high-maintenance" whatever you do.

I would suggest that there is no single right way for managing these peoples' symptoms. However, I would

30/12/2009

Appendix J(b)

make the following comments:

1. If there are clear clinical reasons for suspecting infection, then there is a case for taking a catheter specimen of urine from within the ileal conduit. Bag specimens of urine are unlikely to be of any value.
2. In the absence of clinical evidence of infection, conduit samples are likely to be misleading as asymptomatic bacteruria is very likely to be present in any patient with a conduit.
3. I would be uncomfortable with the implied idea that these patients are told they have a firm diagnosis (dehydration and infection) when that may be spurious. If their symptoms are not understood, then I feel they should be told that.
4. IV rehydration for someone who is drinking normally seems to be a nonsense.
5. IV antibiotics also seem to be inappropriate if alternative, oral agents can be used in adequate doses.
6. I agree that, if infection does clearly seem to be an issue (with good clinical justification for this) then most urologists would use chronic low-dose, rotating antibiotics or a several-weeks course of oral antibiotics at full dose.
7. It sounds to me as if the clinician has used this system as a means of providing supportive care and keeping the patients "under control". I suspect that the main benefit to the patient will be psychological – being admitted to a supportive environment with support for their persistent belief that their symptoms have a physical basis – and who is to say that they might not be doing better than similar patients who do not receive this level of support? However, I would find it difficult to justify on the basis of scientific validity and standard clinical thinking.

Second colleagues reply:-

A lot depends on whether he took the bladder out. Recurrent pyocystis is a frequent long term problem especially in neuropaths if the bladder is left behind – I have rarely done a cystectomy and IC for an atonic bladder since most will tolerate ICSC pretty well. If the bladder were left behind in one of these patients recurrent pyocystis would be inevitable. Rehydration (not sure 1 litre in 24 hours really qualifies) and antibiotics would not help much – frequent bladder washouts might but usually these patients end up with a salvage "simple" cystectomy later on.

The UTIs are interesting – are these simply positive cultures from the conduit (which is usual as you know) or are they symptomatic infections? If the bladder was indeed removed then I doubt that one could attribute a chronic pelvic pain syndrome to recurrent UTI even if it were symptomatic.

Like you I would usually manage recurrent symptomatic UTI in a conduit patient with rotating low dose antibiotics.

On balance the management strategy you describe sounds to have been a little unusual

30/12/2009

Appendix K

Wilson, Roberta

From: Fordham Mark (RQ6) RLBUHT
Sent: 10 October 2009 14:52
To: Wilson, Roberta2
Subject: Mark Fordham - Royal Liverpool Hospital

Personal Information redacted by the USI

Dear Roberta,

Apologies for the delay in sending you my comments of cases 3,4,6,7 and 8.

All these patients have a diagnosis of a functionally abnormal bladder and all but one has undergone major surgery and all but one has had the bladder removed.

Two of the patients also seem to have symptoms of a pelvic pain syndrome.

These combinations add up to 'heart sink' patients where in all probability there is no 'cure' available and they become chronic hospital attenders with various and variable symptoms sometimes resulting in numerous investigations generally with little in the way of positive diagnoses. Because they have a functional problem the patients have a normal life expectancy and so will remain on the consultants books for decades.

The condition they have may be relatively uncommon [low incidence] but they live for many years and can require repeated consultations [high prevalence]. This can lead to the patients becoming hospital-dependant/institutionalised with the GP being disinclined to get involved as the case is 'complex' ie they do not know what to do.

Whether these patients have been well served by the major bladder surgery they have undergone is difficult to say as the records do not include the original letters leading up to the surgery.

The current clinical challenge is how to look after patients with ileal conduit diversions performed for functional disease and who suffer from recurrent symptoms which may or may not be related to urine infections.

Quite often a 'modus operandi' develops which 'works' for an individual patient. This allows the doctor to feel he is doing something therapeutically effective and the patient feels something is being done; although what action is taken will vary between hospitals and consultants.

To my knowledge there is no standard treatment regime for recurrent urinary infections in patient with ileal conduits, although the mainstay of management is oral antibiotic therapy. However I will ask my colleagues in BAUS who do specialise in these pathologies and see how they manage such patients and see if there is a consensus.

I'll let you know when I have heard from them

With all good wishes

Mark

Royal Liverpool Hospital
 L7 8XP

Personal Information redacted by the USI

30/12/2009

Appendix L

Key points from discussions with Dr Mark Fordham

Date 02 12 09

- 1 The management of these patients can be challenging.
- 2 They have normal life expectancy (non cancer patients)
- 3 They can become psychologically dependent on hospital services even in the absence of specific clinical needs.
- 4 Clinically diagnosed urinary tract infections are best confirmed by laboratory urine cultures but urine cultures from bowel based urine reservoirs or conduits need to be interpreted with care.
- 5 The local urology regimes for these patients do not have a scientific evidence base.
- 6 There is no need to treat patients with IV fluids who are able to drink normally.
- 7 The use of IV antibiotics should be reserved for patients with multiresistant urinary infections or severe pyelonephritis
- 8 Care can be provided with the support of primary care using various treatments relating to out patient oral antibiotic regimes.
- 9 These patients sometimes require unplanned admission when acutely unwell.

Appendix M

Wilson, Roberta

From: Wilson, Roberta
Sent: 02 December 2009 17:52
To: 'Fordham Mark (RQ6) RLBUHT'
Cc: 'Loughran, Patrick'
Subject: RE: Mark Fordham - Royal Liverpool Hospital
Attachments: Key points from discussions with Dr Mark Fordham.doc

Mark

Thank you for contacting me. Amendments as discussed. Also in a word document if formatting difficult to read.

- 1 These cohorts of patients are difficult to manage
- 2 They have normal life expectancy (non cancer patients)
- 3 They can become psychologically dependent on hospital services in the absence of clinical need for services.
- 4 Proven UTIs may be best managed with Antibiotics. Where no pure growth is identified or urine cultures are from bowel based urine reservoirs, urine sampling needs to be interpreted with care.
- 5 Their current regimes do not have a scientific evidence base.
- 6 There is no need to treat patients who are able to drink normally with IV fluids
- 7 There are other more appropriate antibiotic regimes available.
- 8 Care can be provided with the support of primary care using various other treatments relating to out patient antibiotic regimes.
- 9 They will require unplanned admissions at different times for different reasons and proven indications including acute episodes of urology care

Regards

Roberta Wilson
 Governance Lead Medical Directorate
 First floor
 Nursing Home
 Daisy Hill Hospital
 Southern Health and Social Services Trust
 Tel. DHH extn. or direct line
 Mobile no.

Personal Information redacted by the USI
 Personal Information redacted by the USI
 Personal Information redacted by the USI

24/12/2009

Diane Corrigan

From: Diane Corrigan
Sent: 19 August 2010 18:17
To: Carolyn.Harper [Personal Information redacted by the USI]; janet.little [Personal Information redacted by the USI]
Cc: libby.jones [Personal Information redacted by the USI]
Subject: Important - advice needed on issues relating to clinical practice in Urology
Attachments: NI cystectomy and ileal conduit creation stats 200506 to 200910.xls; draft SHSCT report on IVT in urology Jan 10.pdf

Dear all

I have cut and pasted in some emails below which I hope are self-explanatory. There are also some attachments. In summary, in April 2009 I was approached by Dr P Loughran, the Medical Director of SHSCT, to seek my views as a commissioner of services as to whether a particular treatment being undertaken by Urologists in CAH was appropriate. This was regular elective admission of a small cohort of patients with chronic urinary tract infections to have IV fluids and antibiotics. The patients concerned believe that this 'flushes them out' and appear to value the treatment. I thought it was biologically implausible for this form of treatment to be any more effective than oral treatment. This view concurred with opinions Dr Loughran had already garnered from clinical colleagues. Although this treatment was wasteful of resources, it did not appear at that time to pose a clinical risk to patients. I gave Dr Loughran some advice on how to deal with the issue, including a contact for an external urology opinion.

I was next involved in January 2010 when Dr Loughran approached me to say that although he had agreed with the clinicians that the treatments would be phased out this had not in fact happened. He had prepared a paper for the Trust's SMT and as it referred to me he sought my opinion on the wording of the relevant paragraph. I suggested amendments (which you will see below), but did not see a final version of the report. The report's Appendices (see PDF attachment) included comments from external urologists which concurred that the treatment was not in keeping with practice elsewhere in GB.

At a recent meeting with the Trust about the Urology Review it emerged that not only had the treatment not yet stopped, but some patients (possibly 2) were now receiving this treatment via a central line. Given the risk that having an indwelling line poses to patients I felt that I needed to take this further. I emailed Mr Eamon Mackle, Clinical Director of Surgery at the Trust (see below) who indicated that the Medical Director had now asked him to deal with the issue. On the day I spoke to him he did not appear to be aware that I had provided previous comments, hence the purpose of copying him information on the timeline and the draft report. I re-read the report and began to wonder if there was something unusual about the cohort of patients. One of the external opinions referenced the fact that several of the patients had ileal conduits. I imagined that the prevalent population of patients with ileal conduits in the CAH catchment would not have been very large. To put my mind at rest I asked for some information on the numbers of such operations done over the last 5 years in NI by consultant. This is attached above in an Excel spreadsheet. There are all sorts of caveats in interpreting this data, depending as it does on coding quality and completeness. However the raw data show that of 185 cases over the period, 170 had a diagnostic code which indicated malignancy or carcinoma in situ. Another 2 were coded as 'neoplasm uncertain'. Three were done by a single urologist in BCH for neurological disorders. Of the remaining 10 which did not have those diagnoses, six were done by a single consultant at CAH. Four had a primary diagnosis of cystitis, one had a diagnosis of faecal incontinence and one of peritonitis.

I have tried to think of possible data-related explanation for this. If there was very poor coding practice in a hospital then maybe a patient who had a longstanding ileal conduit, admitted for treatment of cystitis might, in theory at least, be coded as though they had the cystectomy and ileal conduit as elective operations each time - but if so that coding error would need to be highlighted and stopped. However if there really is an underlying issue - what is the role of the PHA in drawing this to the Trust's attention?

I have included draft wording of an email which I was considering sending to the Medical Director, Director of Acute Services and Clinical Director of Surgery at SHSCT. However I thought that before doing so I needed guidance on whether this was the correct way to deal with this issue.

I would be very grateful for your comments and advice on the following points

- (i) Do you agree that the line I had already taken on the use of regular IV fluids and antibiotics for chronic cystitis was correct?
- (ii) Do you agree that continuing this form of treatment in the light of external advice from external urologists calls for further action, especially since some of patients now appear to have had central lines inserted for the purpose?
- (iii) Do you think that the statistics on cystectomy and ileal conduit creation by one consultant at CAH are sufficiently different from the pattern of treatment in other units for me to raise this with the Trust? The numbers are small and all of the information from each Trust is subject to the quality of their coding.
- (iv) Do you think my comment in the draft email seeking assurance that, following the Urology Review, no further radical pelvic surgery should now be happening in CAH is appropriate?

Regards

Diane

COPY OF EMAIL TO CLIN DIR OF SURGERY AT SHSCT

-----Original Message-----

From: Diane Corrigan

Sent: 09 August 2010 13:12

To: 'eamon.mackle' Personal Information redacted by the USI

Subject: FW: Intravenous Fluid & Antibiotic Therapy (IVT)

Importance: High

Dear Eamon

Re our discussion at the end of the Urology meeting - I found this email and thought I should forward it to you. You may by now have had sight of the Trust's full internal file on this issue.

My timeline for events relating to this issue is:

21 April 2009 - phone discussion with Dr Loughran in which he indicated that a cohort of patients having this IV treatment had come to light when implementing the Trust's new antibiotic prescribing policy. I advised involvement of the CD and if necessary external advice from Mark Fordham. I emailed Mark's address on the 22nd April.

Paddy called me again on the 4th Jan 2010 to say that although the clinicians had agreed to change practice, it had emerged that this had not happened. He planned to prepare a paper setting out the issue for discussion (? within Trust management). He forwarded a draft to me (attached) and the email below was my response. I do not think I ever saw the final report which was for internal use in the Trust. The draft paper indicated that insertion of central lines to deliver this therapy was being considered for two patients. From your comments it sounds as though this has actually gone ahead. I am very concerned as to how this could have happened. It is a matter for the Trust to decide, but I think the latter begins to sound like an SAI.

I have re-read the Appendices to the draft report. Perhaps I am reading more into them than was meant - however am I right in thinking that almost all of these patients have had cystectomy and ileal conduits for benign disease? I would have imagined this would have been a treatment of last resort. Is there any possibility that there is a wider issue here - i.e. not just the continued use of a non evidence-based treatment for UTI, but a higher than expected use of radical surgery for the underlying pathology? As a first step maybe I can ask our information department to see whether it is possible to extract information on the number of cystectomies done in NI for benign disease over the last decade. This will depend on the coding quality - however if it shows nothing untoward in terms of numbers done at CAH then concentration on IVT would remain the most pressing issue.

This could be very difficult. I would advise a team approach within the Trust - involving the Medical Director and the Dir of Acute Services - dealing with this on your own would not be a good idea.

Please let me know if there is anything else I could do.

Diane

EXTRACT OF EMAIL TO MEDICAL DIR SECRETARY

-----Original Message-----

From: Diane Corrigan

Sent: 06 January 2010 16:13

To: 'White, Laura'; Paddy Loughran (

Personal Information redacted by the USI

Cc: Wilson, Roberta

Subject: RE: Intravenous Fluid & Antibiotic Therapy (IVT)

Thank you for letting me see this draft report. I have two comments.

Firstly, since I am now an employee of the PHA, I'm not sure it is technically correct to call me the 'commissioner' anymore - though the best alternative I can come up with is 'PHA adviser to the HSCB Southern office' which is very longwinded. With that in mind could I suggest that page 3 para g is amended to read

"I have discussed the above with Dr D Corrigan, the PHA adviser to the HSCB Southern office. On the basis of the information provided, she has advised that it would not be appropriate for SHSCT to continue to provide a treatment for which there is neither a published evidence base, nor a supporting consensus of professional opinion outwith the Trust. If SHSCT urologists feel strongly that this treatment is of value they should participate in a recognised clinical trial, with ethical committee approval. For those patients already on this treatment regimen an orderly process should be agreed and implemented to move them onto alternative treatment regimes, with the support of medical microbiology. It will be important that the reasoning behind this decision is sensitively communicated to this cohort of patients."

I also think the patient names should be removed from the Appendix (Carmel Hanna's letter) as the report may end up being copied and this could lead to a breach of patient confidentiality.

Regards

Diane

-----Original Message-----

From: White, Laura [mailto:

Personal Information redacted by the USI

Sent: 05 January 2010 14:19

To: Corrigan, Diane

Cc: Wilson, Roberta

Subject: Intravenous Fluid & Antibiotic Therapy (IVT)

Dr Corrigan

Enclosed as per your telephone call with Dr Loughran, you are mentioned under Page 2, No 6 and Page 3, "G".

Laura

Ms Laura White
Personal Assistant to
Dr Patrick Loughran
Medical Director
Southern Health & Social Care Trust

DRAFT EMAIL TO SHSCT 19 AUG 2010 VERSION

Dear

In the context of the Urology Review implementation process, which highlighted a high proportion of elective urology episodes which did not have an operative procedure, I re-read the external expert reports relating to the use of IV therapies at CAH (Appendices of the draft document I was asked to comment on last January). I picked up on a comment that many of the cases had ileal conduits. I emailed Eamon Mackle a few weeks ago to the effect that just to put my mind at rest I intended to seek NI-wide information on the numbers of cystectomies and ileal conduits carried out by Unit and consultant.

I enclose the results. These have to be interpreted with caution as they are dependent on coding quality. In addition I appreciate that the numbers are very small. It appears that cystectomy and conduit creation is done in the great majority of cases for malignant disease. However there appear to be small numbers done for other reasons. Four of the operations coded as being done by one of the CAH surgeons were for cystitis. This would appear to be unusual. Is there any possibility that this reflects incorrect coding and in fact these are multiple admissions of patients who have had the procedure in the past and who have been admitted for other reasons?

Following the Urology Review decision, as of March 2010 radical pelvic urology surgery for malignant disease should no longer be being done in SHSCT. This would include cystectomy. We have discussed the cancer cases recently at the meeting chaired by Beth Malloy from PMSI at the HSCB. The rationale for this policy decision, which is in line with IOG guidance, was to concentrate the relatively small number of such cases in the hands of a small number of surgeons who could maintain specialist skills. No reference was made in the Urology Review to radical pelvic surgery for non-malignant disease. It was perhaps assumed to be implicit that the even smaller volume of this type of work would also be centralised. I would be grateful for an assurance that the urology team is now referring on all patients being considered for radical pelvic surgery regardless of the underlying diagnosis.

Best wishes

Diane

Fiscal Year	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnosis	Diagnostic Description	Effective FCE's
FY2005/2006	Altnagelvin Hospital	Muholland C K Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C66.X	Malignant Neoplasm Of Ureter	1
	Altnagelvin Hospital	Muholland C K Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
	Altnagelvin Hospital							Total	2
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnosis	Diagnostic Description	Effective FCE's
	Belfast City Hospital	Hagan C Mr	M19.1	Urinary Diversion - Construction Of Ileal Conduit	M34.3	Total Excision Of Bladder - Cystectomy Nec	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C66.X	Malignant Neoplasm Of Ureter	1
		Keane PF Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.2	Urinary Diversion - Creation Of Urinary Diversion To Intestine Nec	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.2	Urinary Diversion - Creation Of Urinary Diversion To Intestine Nec	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
	Belfast City Hospital							Total	14
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnosis	Diagnostic Description	Effective FCE's
	Causeway Hospital	Kernohan R M Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	N30.9	Cystitis, Unspecified	1
	Causeway Hospital							Total	1
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnosis	Diagnostic Description	Effective FCE's
	Craigavon Area Hospital	O'Brien A Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	N30.2	Other Chronic Cystitis	1
		Young M Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
	Craigavon Area Hospital							Total	2
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnosis	Diagnostic Description	Effective FCE's
	Mater Hospital Has Trust	Wilson BG Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Wilson BG Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C61.X	Malignant Neoplasm Of Prostate	1
	Mater Hospital Has Trust							Total	2
FY2005/2006								Total FY2005/06	21

Fiscal Year	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnosis	Diagnostic Description	Effective FCE's
FY2006/2007	Altnagelvin Hospital	Mulholland C K Mr	M19.1	Urinary Diversion - Construction Of Ileal Conduit	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C66.X	Malignant Neoplasm Of Ureter	1
		Mulholland C K Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Mulholland C K Mr	M34.2	Total Excision Of Bladder - Cystourethrectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.2	Malignant Neoplasm Of Lateral Wall Of Bladder	1
	Altnagelvin Hospital							Total	3
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnosis	Diagnostic Description	Effective FCE's
	Belfast City Hospital	Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane FF Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane FF Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane FF Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane FF Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane FF Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane FF Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane FF Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.2	Urinary Diversion - Creation Of Urinary Diversion To Intestine Nec	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.3	Urinary Diversion - Revision Of Urinary Diversion	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C66.X	Malignant Neoplasm Of Ureter	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
	Belfast City Hospital							Total	17
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnosis	Diagnostic Description	Effective FCE's
	Craigavon Area Hospital	Batstone GRD Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Batstone GRD Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		O'Brien A Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		O'Brien A Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	N30.1	Interstitial Cystitis (Chronic)	1
		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Ileal Conduit	N30.1	Interstitial Cystitis (Chronic)	1
		Young M Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
	Craigavon Area Hospital							Total	8
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnosis	Diagnostic Description	Effective FCE's
	Mater Hospital Has Trust	Wilson BG Mr	M19.1	Urinary Diversion - Construction Of Ileal Conduit	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Wilson BG Mr	M19.1	Urinary Diversion - Construction Of Ileal Conduit	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Wilson BG Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
	Mater Hospital Has Trust							Total	3
FY2006/2007								Total FY2006/07	31

[illegible]