CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

7 March 1996

Urology Department

Ms Helen Walker
Directorate of Human Resources
Craigavon Area Hospital Group Trust

Dear Helen

You will remember my speaking with you one year ago on the subject of remuneration for work performed in excess of contractual obligations and expectations. I had been advised and requested to do so by Mr. Templeton, Chief Executive. You requested that I submit to you an outline of the reasons for and the nature of this additional work. The delay in doing so is directly related to the amount of extracontractual work performed.

The genesis of the necessity to work significantly in excess of contractual obligation lies in the fact that on my appointment as a Consultant Urologist in July 1992, I was the only Urologist providing a service for the population of 300,000 of the Southern Health and Social Services Board Area. At the time of my appointment, I was the sixth Urologist appointed to Northern Ireland, resulting in a Urologist : population ratio of 1:250,000. This is the worst Urologist : population ratio in Western Europe, where the ratio is consistently 1:50,000. There are now still only eight Urologists in Northern Ireland, an improvement in the ratio to 1:200,000, but still far short of that which has been proven for years to be necessary. The Northern Ireland ratio, which is identical to that of the Republic of Ireland, is the worst in the UK. The UK ratio is currently 1:130,000, six years after the Ministry of Health accepted the recommendations of the Collins Report that each unit of population of 250,000 - 300,000 should be serviced by a urological unit staffed by three Consultant Urologists. The Southern Health Board should have appointed three Consultant Urologists in 1992 to meet the Government's modest standards. The Southern Board Area requires six Urologists to meet international standards.

These standards are in sharp contrast to those which have pertained in the Southern Board area to date. My appointment in 1992 was the culmination of a successful struggle between Craigavon Area Hospital and the Southern Health Board. Given international standards, it is quite incredible that that struggle should have centred around the issue of whether the area required the appointment of even one Urologist. However, given that the Board would still probably balk at accepting British, never mind international, standards, then their stance was not

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68 Lurgan Road, Portadown
Craigavon, BT63 5QQ
Tel: Irrelevant Information Redacted by the USI Fax: Irrelevant Information Redacted by the USI

so surprising. The appointment of a Urologist at Craigavon was an achievement. However, even before taking up the appointment, I realised that there was a permeating belief that the appointment of one Urologist, if so difficult to achieve, must therefore have been adequate, if not more than adequate. Before taking up my post, I was so aware that I would be deluged with an amount of need that would be impossible to provide for. I vividly recall being shocked to learn prior to my arrival that General Practitioners had been written to, informing them of my appointment.

Therefore, I arrived in 1992, with an expectation that I would provide a urological service, in circumstances devoid, then and still, of any awareness of not only the global urological needs of the population but even the urgent needs of patients for a service for cancer, obstructive stone disease and acute urinary retention. There was ample evidence of this lack of awareness. the Board for its part allocated £60,000 to fund the service for the year 1992-93! The Board's 'Making Choices' policy document predicted that the urological bed requirement for the area would increase to 9 by 1997!

For the hospitals part, I was fortunate to have a bed allocation of 22. However, for the first year, I had one Junior House Officer most times and a Senior House Officer. I shared a General Surgical Registrar. I did not even have a Personal Secretary appointed. It took one year to actually justify having a Secretary appointed, for whom we still do not have full-time Audio-Typist support. One year after appointment, it was extremely difficult to gain acceptance that a single Urologist providing a service for 300,000 would require a Registrar.

It is most important to understand that all this describes only the background to and the circumstances of my work since appointment. Put must succinctly, I arrived at Craigavon to find that urology was synonymous with TURP, and even that had not always been a happy experience. I started to provide a service from scratch. More importantly, I started with Medical and Nursing Staff who were starting from scratch. During the past four years, we have established a wide range of services that are standard urological services, but which were wholly new to Junior Medical and Nursing staff. Examples of these are male catheterisation by Nurses and self catheterisation, flexible cystoscopy and videourodynamics, ureteric stenting and ureteroscopic lithotripsy, intravesical chemotherapy and systemic chemotherapy, immunotherapy and radical prostatectomy, radical cystectomy and orthotopic reconstructive surgery, urinary diversion and the management of impotence, incontinence and infertility. These services brought into our care acutely ill and seriously ill patients requiring intensive and high dependency care. It brought with it a need for high patient turnover. Perhaps most significantly, it brought with it highly dependent patients dying of urological disease.

On appointment, I found that virtually every facet of urological patient care had to be explained, discussed, taught, supervised, checked and rechecked by me. This applied to Nursing Staff, Recovery Staff, Ward Staff, Outpatients Staff and Junior Medical Staff. For the first two years, I was in effect Nurse, Junior House Officer, Senior House Officer and Registrar as well as Consultant. During this time, I committed endless hours explaining diagnoses, prognoses and management to patients and their relatives, as I was the only one able to do so. This was a seven day week occupation. With the administration entailed in coping with every increasing demand, superimposed upon this clinical commitment, I spent 70-80 hours per week at work during this time.

In particular, I would go to the hospital at 10pm on Saturday nights to work throughout the night at administration. I did so in order to spend the daytime hours at weekends with my family. In almost four years, I have had nine weeks off work : two weeks in April 1993 to move house from Dublin and three weeks to attend urological meetings abroad and to which I had been invited. In almost four years, I have had only four weeks of holiday with my family. This was not due to some form of workaholism or some kind of inefficiency. When you are the only Urologist serving 300,000 people, you cannot tell a patient who needs his/her kidney or bladder removed for cancer that the operation will be performed in a month's time when the holiday is over. It proved impossible to do so when there were several patients in the same situation. I believe that the necessity of such a commitment is reflected in there not having been a single case of litigation pursued during the past four years, though justified complaints have been received.

Even with this order of commitment, it proved just respectably possible to cope with the most urgent needs. As a consequence, those with less urgent needs awaiting treatment grew greater in number and waited ever increasingly longer. As a result, the Patient's Charter criteria were recurrently not met.

Along came waiting list initiatives. These were performed in January to March 1994 and 1995. These two waiting list initiatives earned for the Trust an additional £230,000 approx. both were executed without additional medical staff. Both periods brought me to the limits of endurance. I shall not attempt to find words to describe those periods. The facts speak for themselves.

As a single handed Consultant, I had six operating sessions, two outpatient sessions, one/two flexible cystoscopy sessions and two urodynamic sessions per weeks, before examining a patient, talking to a relative, dictating a letter or performing emergency surgery at night. Unknown to me, in February 1995, my wife kept a record of the number of hours spent at work that month. The weekly average was 89 hours. In June 95, the same average had fallen to 66 hours.

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In January of this year, I was relieved to know that the Trust would earn a further additional £90,000 with the assistance of a second Consultant, Mr. Baluch. Since Mr. Baluch's [redacted], the fixed sessional commitments have increased to twelve per week, in order to hopefully meet the Patients Charter criteria this year.

The extent of the totality of the urological service provided at Craigavon was brought home to me on reading the citation for the runner-up in the Lorex Synthelabo UK Urologist Team of the Year 1995. The three Consultant department at Morriston Hospital, Swansea, were commended for its high throughput during the year 1994-95 : 1837 inpatients, 1725 day cases and 1150 outpatients. Our corresponding figures during the same year were 1058, 560 and 2700.

In addition to all this commitment and performance, I have initiated and seen against some adversity, academic urology flourish. In our fourth year of operation, we have currently our second Research Fellow conducting doctorate research. In addition, we are developing probably the first, voice activated, clinical data base with artificial intelligent, neural networks. I have founded and seen develop Craigavon Urological Research and Education. For these activities, I seek no remuneration.

I regret the length of this letter. In it, I have sought above all to explain why such an extent of extracontractual work was a necessity. I believe the Trust, the Board and the Area have benefitted significantly. I too have gained great satisfaction at our achievements to date. These achievements have been hard earned by me, and more particularly, my family.

I feel that it would be reasonable to seek remuneration for work so significantly in excess of any contractual obligations. I sincerely believe, after much consideration, that it would be unreasonable and unfair, not to be awarded some remuneration for consistent, extracontractual work which varied from 25 to 50 additional hours per week, excluding lost holidays.

I tried every recipe of increasing efficiency during the past four years, in order to reduce the working week. Perhaps another could have done the job in less time. Perhaps another could have halved the additional commitment to 12-25 hours per week. If so, such hours would still have been a significant extracontractual commitment.

In seeking remuneration, I am mindful of the Trusts budgetary deficit, which may have been worse in the absence of my additional commitment. After much consideration therefore, I believe it would be reasonable to request that I be remunerated in the form of two additional sessions per week, retroactively from 6 July 1992, when my appointment commenced.

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Thank you for your consideration.

Yours sincerely

Personal Information redacted by USI

MR AIDAN O'BRIEN
Consultant Urologist

cc Mr J Templeton Chief Executive Craigavon Area Hospital

CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

10 July 2006

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist
Urology Department
CAH

Aidan

Dear Mr O'Brien

Further to the discussions which we have had, I now wish to confirm the Trust's intention that you will be offered 5.5PA's in recognition of additional workload over and above the 10 Programmed Activities that constitute your standard contractual duties under the New Consultant Contract. The additional PA's are reflected in the job (copy attached).

In the event of you deciding to transfer to the new contract, the requirement for you to undertake additional PA's will be reviewed annually as part of your job plan review. Termination of the contract for additional PA's is subject to a three month notice period and will have no effect on your main contract of employment. It should be noted that additional programmed activities are not subject to pay protection arrangements.

The Trust is also making you an offer of an ex gratia payment of Personal Information redacted by the USI in recognition of your extra contribution during the period 1998 until inception of the new contract.

Following discussion with your Clinical Director, your on call category has been determined as 'A' with your on call commitment being 1 in 2.

It is important to appreciate that this proposed offer is based on the understanding that the attached job plan schedule is a reflection of the time commitment given as a team member to HPSS work during 2004/05. Your acceptance will be taken as confirmation of this and also of the accuracy of the attached declaration of external duties/private practice which you have been involved in.

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
Tel: Personal Information redacted by the U
Text

Since I would like to get this matter finalised, I would be grateful if you would indicate in writing to the Office of the Medical Executive, whether you wish to progress to the next stage on the basis outlined above. In that event, I will make arrangements for Finance to finalise their calculation and for HR to prepare the necessary formal contract documentation. Your final acceptance of the contract will, of course, be subject to confirmation at that stage.

Yours sincerely

Personal Information redacted by USI

Dr I Orr
Medical Director

cc: Mrs M Richardson
Mr L Stead
Mr J W Templeton

13 July 2006.

Dr. Ian Orr,
Medical Director,
Office of the Medical Executive,
Craigavon Area Hospital Group Trust.

Dear Ian,

Re: New Consultant Contract Offer and *Ex Gratia* Payment.

Thank you for your letter of 10 July 2006. I write to confirm that I am pleased to accept the Trust's offer of 5.5 sessions of Programmed Activities, in recognition of additional workload over and above the 10 sessions that constitute my standard contractual duties under the New Consultant Contract. I also confirm my acceptance of your determination of my on-call category and commitment.

I also write to confirm my acceptance of the Trust's offer of an *ex gratia* payment of [Personal information redacted] in recognition of my extra contribution during the period from August 1998 until inception of the New Contract. Pursuant to Section 74 of the Finance Act 1988, I should be pleased if you would have confirmed that this amount shall be paid gross of all income tax, statutory or other deductions.

Lastly, I wish to avail of this opportunity to compliment you for the resolve with which you approached the above matters, and to thank you for the fair and balanced manner in which you conducted recent discussions. I do believe that the outcome is fair to both Trust and both consultant urologists. I do hope that the Trust also believes it to be so. I am pleased that these issues have been resolved to our mutual satisfaction, and that all can look forward to working together, with renewed vigour, to further develop urological services,

Yours Sincerely,

Aidan O'Brien,
Consultant Urologist.

Cc: Mr. J. Templeton, Chief Executive, CAHGT.
Mrs. M. Richardson, Director of Human Resources, CAHGT.
Mr. L. Stead, Director of Finance, CAHGT.

Dear Aidan,

Lindsay has checked the regulations and forwarded those answers

Best wishes for

Orr, I DR

From: Stead, Lindsay
Sent: 14 July 2006 10:54
To: Orr, I DR
Cc: Wortley, Heather Medical Executive
Subject: FW: Ex Gratia Payments

RW 1.8.06

Ian
this type of payment would attract NIC as well but would not be superannuable.

Lindsay
140706

From: Stead, Lindsay
Sent: 14 July 2006 09:28
To: Orr, I DR
Subject: Ex Gratia Payments

Ian

re the above, I have checked out my understanding with colleagues and I was correct that in most cases ex gratia payments should be declared as taxable income, even though in some examples the payment may be defraying expenditure incurred on the part of the individual , obviously in the case of Urology it isnt, as it's supposed to represent payment for work done and should be declared for tax, if not already taxed through the payroll system which in this case it will have been already.

I am awaiting an answer re whether it is superannuable and will pass this on once received.

L
140706

74. - (1) In section 188(4) of the Taxes Act 1988 (tax not chargeable by virtue of section 148 of that Act in respect of the first £25,000 of a payment on termination of office or employment etc.) for "£25,000" there shall be substituted "£30,000".

(2) Paragraphs 4 to 7 of Schedule 11 to that Act (relief by reduction of tax on next £50,000 of such a payment) shall cease to have effect.

(3) This section shall apply to any payment treated by section 148(4) of that Act as income received on 6th April 1988 or any later date, unless a notice is given in relation to it in accordance with paragraph 12 of that Schedule (payments in pursuance of pre-10th March 1981 obligations).

17 July 2006.

Mr. J. Templeton,
Chief Executive,
Craigavon Area Hospital Group Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear John,

I do hope that you will have received a copy of my letter of 13 July 2006, addressed to Dr. Ian Orr, Medical Director, accepting the Trust's last New Cunsultant Contractual offer, and the *ex gratia* payment in recognition of my additionally working as a Registrar up to inception of the New Contract.

Now that both issues have been satisfactorily resolved, I would like to enquire again whether it would be possible to receive an advance payment. For a number of reasons, about which I would be happy to discuss with you, it would make an enormous difference if it were possible to receive an advance payment, of even a relatively small amount, before the end of July.

I would be most grateful if you would advise me whether this is possible

Yours Sincerely,

Aidan O'Brien,
Consultant Urologist.

CRAIGAVON
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10 August 2006

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist
CAH

Dear Mr O'Brien

Transfer to Consultant Terms and Conditions of Service (Northern Ireland) 2004

Further to previous correspondence, I have pleasure in now enclosing two copies of a new Contract of Employment based on the above terms and conditions of service, effective from 1st April 2004, along with a copy of your agreed Job Plan schedule.

In addition to your full time contract, separate documentation is also enclosed to cover the Additional Programmed Activities agreed for the financial year 2004/05 and the period up to the present. As previously indicated, in signing this documentation you are confirming that the proposed offer is based on the understanding that the attached job plan schedule is a reflection of the time commitment given as a team member to HPSS work during 2004/05 and up to the present. You are also recognising that future payments for work undertaken will be in accordance with the provisions of this contract.

It is important to appreciate that in future your Job Plan will be a prospective plan which will include details of the expected number of clinics, etc to be delivered, based on a minimum of 42 working weeks per year. Future Job Plans will also incorporate the objectives agreed at your annual appraisal including agreed service objectives.

Both the main Contract of Employment and Contract for Additional Programmed Activities should be signed and returned to me by as soon as possible in order that arrangements can be made for the necessary salary adjustment to be processed.

I do recognise this has been a very slow process and I would, therefore, like to thank you for your co-operation to date.

Yours sincerely

Personal Information redacted by USI

pp

Myrtle Richardson (Mrs)
Director of Human Resources

Encs:
Letter regarding Contract for Additional Programmed Activities (2 copies – one to be returned and one for you to retain)
Job Plan
Contract of Employment (2 copies – one to be returned and one for you to retain)
Terms and Conditions of Service (Northern Ireland) 2004

Headquarters:
Craigavon Area Hospital Group HSS Tr
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Tel: Personal Information redacted by the US
Tex

AQB-00046

10 August 2006

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

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Mr A O'Brien
Consultant Urologist
CAH

Dear Mr O'Brien

Contract for Additional Programmed Activities

In accordance with Clause 7.6 of your main Contract of Employment and in recognition of additional workload, the Trust has agreed to offer and you have agreed to undertake Additional Programmed Activities over and above the ten which constitute your standard contractual duties. The Additional Programmed Activities should have been incorporated into your Job Plan schedule.

Remuneration for Additional Programmed Activities is covered by Clause 21 of your main Contract of Employment and Schedules 13 and 14 of the Consultant Terms and Conditions of Service (Northern Ireland) 2004, as amended from time to time. It should be noted that Additional Programmed Activities are not pensionable.

The contract for Additional Programmed Activities will commence on 1 April 2004 and will be reviewed as part of your annual Job Plan Review. As previously indicated in the correspondence from the Trust's Medical Director, termination of this contract for Additional Programmed Activities is subject to a three months notice period. While the next review has inevitably been delayed as a result of the time taken to resolve the existing Job Plans, this review will take place at the earliest opportunity. Additional Programmed Activities are not, of course, subject to pay protection arrangements.

Yours sincerely

pp Personal Information redacted by USI

Myrtle Richardson (Mrs)
Director of Human Resources

I, Mr A O'Brien hereby accept the offer of Additional Programmed Activities on these terms and subject to the conditions mentioned in the above letter.

Signature Personal Information redacted by USI Date: 16.08.06

Please sign and return a copy to:
Mrs Myrtle Richardson, Director of Human Resources
The Rowans, Craigavon Area Hospital.

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
Tel: Personal Information redacted by the USI
Tex

SUMMARY OF JOB PLAN

Name:	**Mr A O'Brien**
Specialty:	Urology

Contracted Programmed Activities:	**10 PA's**
Additional Programmed Activities:	**5.5**
Management Allowance (if applicable): Medical Director / Clinical Director	**N/A**
Total Programmed Activities:	**15.5**
On- Call Category:	**Category A**
On-call Frequency:	**1 in 2**

CRAIGAVON AREA HOSPITAL GROUP TRUST

Statement of Main Terms and Conditions of Employment

CONSULTANT APPOINTMENT

THE POST

1 Consultant

Your job title is Consultant Urologist

Your employing organisation is Craigavon Area Hospital Group Trust.

2 Commencement Of Employment

Your continuous employment for the purposes of this contract began on 6th July 1992.

Your continuous service for the purposes of the Employment Rights (Northern Ireland) Order 1996 began on 6th July 1992.

Schedule 1 of the Terms and Conditions of Service contains guidance on commencement of employment.

3 General Mutual Obligations

Whilst it is necessary to set out formal employment arrangements in this contract, we also recognise that you are a senior and professional employee who will usually work unsupervised and frequently have the responsibility for making important judgements and decisions. It is essential therefore that you and we work in a spirit of mutual trust and confidence. You and we agree to the following mutual obligations in order to achieve the best for patients and to ensure the efficient running of the service:

- to co-operate with each other;
- to maintain goodwill;
- to carry out our respective obligations in agreeing and operating a Job Plan;
- to carry out our respective obligations in accordance with appraisal arrangements;
- to carry out our respective obligations in devising, reviewing, revising and following the organisation's policies, objectives, rules, working practices and protocols.

THE WORK

4 Location

Your principal place of work is Craigavon Area Hospital. Other work locations including off site working may be agreed in your Job Plan where appropriate, e.g. for supporting professional activities and some direct clinical care such as audit notes. You will generally be expected to undertake your Programmed Activities at the principal place of work or other locations agreed in the Job Plan. Exceptions will include travelling between work sites and attending official meetings away from the workplace.

You may be required to work at any site within your employing organisation, including new sites.

5 Duties

5.1 Main Duties and Programmed Activities

Except in emergencies or where otherwise agreed with your manager, you are responsible for fulfilling the duties and responsibilities and undertaking the Programmed Activities set out in your Job Plan, as reviewed from time to time in line with the provisions in section 6 below.

5.2 Associated Duties

You are responsible for the associated duties set out in Schedule 2 of the Terms and Conditions of Service.

5.3 Objectives

The purpose of including agreed personal objectives in your Job Plan is to set out in clear and transparent terms what you and your clinical manager have agreed should reasonably be achieved in the year in question. These objectives are not contractually binding in themselves, but you have a duty to make all reasonable efforts to achieve them.

5.4 On-Call Duties and Emergency Responses

You may also be required to participate in an on-call rota to provide emergency cover (see section 9). When not on an on-call rota, we may in exceptional circumstances ask you to return to site for emergencies if we are able to contact you. You are not, however, required to be available for such eventualities. Where emergency recalls of this kind become frequent, we will review the need to introduce an on-call rota.

6 Job Planning

Your clinical manager has drawn up an outline job description that sets out your main duties and responsibilities, along with an initial work

Inpatient Operating 2013 - 2016

2013:	Job Plan	70 sessions
	Actual done	113
2014:	Job Plan	70 sessions
	Actual done	101.25
2015:	Job Plan	70
	Actual done	95.5
2016:	Job Plan	61
	Actual done	83.25

All of this additional operating was directed to those patients in most need.

All of this additional operating resulted in scores of patients having less poor outcomes than they would have had otherwise.

There remain 30 patients on my waiting list at risk of suffering poorer clinical outcomes as a consequence of their delayed admissions.

Elective Inpatient Operating 2013

			Sessions
Wednesday	02 January	9 am – 5pm	2.0
Wednesday	09 January	9 am – 7pm	2.5
Wednesday	16 January	9 am – 1pm	1.0
Friday	18 January	9 am – 5pm	2.0
Saturday	19 January	9 am – 5pm	2.0
Wednesday	23 January	9 am – 7pm	2.5
Wednesday	30 January	1 pm – 7pm	1.5
Wednesday	06 February	9 am – 7pm	2.5
Wednesday	13 February	9 am – 7pm	2.5
Saturday	16 February	9 am – 5pm	2.0
Wednesday	27 February	1 pm – 7pm	1.5
Wednesday	06 March	9 am – 7pm	2.5
Saturday	09 March	9 am – 5pm	2.0
Wednesday	13 March	Professional Leave: Interviews	
Wednesday	20 March	9 am – 1pm (Audit in afternoon)	1.0
Saturday	23 March	9 am – 1pm	1.0
Wednesday	27 March	9 am – 7pm	2.5
Wednesday	03 April	9 am – 7pm	2.5
Saturday	06 April	9 am – 5pm	2.0
Wednesday	10 April	9 am – 7pm	2.5
Wednesday	17 April	1 pm – 7pm	1.5
Wednesday	01 May	9 am – 7pm	2.5
Wednesday	08 May	9 am – 7pm	2.5
Saturday	11 May	9 am – 5pm	2.0
Wednesday	15 May	1 pm – 7pm	1.5
Wednesday	22 May	1 pm – 7pm	1.5
Wednesday	29 May	9 am – 7pm	2.5
Saturday	01 June	9 am – 5pm	2.0
Wednesday	05 June	1 pm – 7pm	1.5
Wednesday	12 June	9 am – 7pm	2.5
Wednesday	26 June	9 am – 7pm	2.5
Wednesday	03 July	9 am – 7pm	2.5

Wednesday	10 July	1 pm – 7pm	1.5
Wednesday	17 July	9 am – 7pm	2.5
Wednesday	24 July	9 am – 7pm	2.5
Wednesday	31 July	9 am – 7pm	2.5
Wednesday	28 August	9 am – 7pm	2.5
Wednesday	04 September	9 am – 7pm	2.5
Friday	13 September	1 pm – 5pm	1.0
Wednesday	18 September	9 am – 7pm	2.5
Wednesday	02 October	9 am – 7pm	2.5
Friday	04 October	1 pm – 5pm	1.0
Wednesday	09 October	9 am – 7pm	2.5
Wednesday	16 October	1 pm – 7pm (Audit in morning)	1.5
Wednesday	23 October	1 pm – 7pm	1.5
Wednesday	30 October	9 am – 7pm	2.5
Friday	01 November	1pm – 5pm	1.0
Saturday	02 November	9 am – 5pm	2.0
Wednesday	06 November	9 am – 7pm	2.5
Wednesday	13 November	9 am – 7pm	2.5
Friday	22 November	1 pm – 5pm	1.0
Wednesday	27 November	9 am – 7pm	2.5
Wednesday	04 December	9 am – 7pm	2.5
Saturday	07 December	9 am – 5pm	2.0
Wednesday	11 December	9 am – 7pm	2.5
Wednesday	18 December	9 am – 7pm	2.5

Total = 113 sessions

Plus 1.5 hours of perioperative patient care on each date = 82.5 hours
Total = 20.625 sessions

Plus 1 hour of administration time per session = 113 hours
Total = 28.25 sessions

Total = 161.875 sessions

Elective Inpatient Operating 2014

		Sessions
Friday 03 January	1 pm – 5 pm	1.0
Monday 06 January	1 pm – 5 pm	1.0
Wednesday 08 January	9 am – 7 pm	2.5
Wednesday 15 January	9 am – 7 pm	2.5
Wednesday 29 January	9 am – 7 pm	2.5
Saturday 01 February	9 am – 5 pm	2.0
Wednesday 05 February	9 am – 7 pm	2.5
Wednesday 12 February	9 am – 7 pm	2.5
Saturday 15 February	9 am – 5 pm	2.0
Wednesday 19 February	9 am – 1 pm (Audit in afternoon)	1.0
Wednesday 26 February	1 pm – 7 pm	1.5
Wednesday 05 March	9 am – 7 pm	2.5
Wednesday 19 March	9 am – 7 pm	2.5
Saturday 22 March	9 am – 5 pm	2.0
Wednesday 26 March	9 am – 7 pm	2.5
Wednesday 02 April	9 am – 7 pm	2.5
Wednesday 09 April	9 am – 7 pm	2.5
Saturday 12 April	9 am – 5 pm	2.0
Wednesday 16 April	9 am – 1 pm (Audit in afternoon)	1.0
Wednesday 23 April	9 am – 7 pm	2.5
Wednesday 07 May	9 am – 7 pm	2.5
Wednesday 14 May	9 am – 7 pm	2.5
Wednesday 28 May	9 am – 7 pm	2.5
Wednesday 04 June	9 am – 7 pm	2.5
Wednesday 11 June	Chairing NICaN Urology	
Wednesday 18 June	9 am – 7 pm	2.5
Wednesday 25 June	9 am – 7 pm	2.5
Tuesday 01 July	9 am – 1 pm	1.0
Wednesday 02 July	9 am – 7 pm	2.5
Wednesday 09 July	9 am – 7 pm	2.5

Wednesday 16 July	M&M / Audit in afternoon	
Wednesday 23 July	9 am – 7 pm	2.5
Wednesday 30 July	9 am – 7 pm	2.5
Wednesday 06 August	9 am – 7 pm	2.5
Wednesday 13 August	9 am – 7 pm	2.5
Wednesday 27 August	9 am – 7 pm	2.5
Wednesday 03 September	9 am – 7 pm	2.5
Wednesday 10 September	9 am – 7 pm	2.5
Wednesday 17 September	9 am – 1 pm	1.0
Wednesday 01 October	9 am – 7 pm	2.5
Wednesday 08 October	1 pm – 5 pm	1.0
Wednesday 15 October	1 pm – 8 pm	1.75
Monday 20 October	9 am – 1 pm	1.0
Wednesday 22 October	8 am – 8 pm	3.0
Wednesday 12 November	9 am – 7 pm	2.5
Wednesday 19 November	1 pm – 7 pm	1.5
Wednesday 26 November	1 pm – 7 pm	1.5
Wednesday 03 December	12 noon – 8 pm	2.0
Wednesday 17 December	12 noon – 8 pm	2.0
Wednesday 31 December	9 am – 5 pm	2.0

Total = 101.25 session

Plus 1.5 hours of perioperative care on each date = 72 hours

Total = 18 sessions

Plus 1 hour administrative time per session = 101.25 hours

Total = 25.31 sessions

Total = 144.56 sessions

Elective Inpatient Operating 2015

			Sessions
Wednesday	07 January	12 noon – 8 pm	2.0
Wednesday	14 January	12 noon – 8 pm	2.0
Wednesday	28 January	12 noon – 8 pm	2.0
Wednesday	11 February	12 noon – 8 pm	2.0
Wednesday	18 February	12 noon – 8 pm	2.0
Wednesday	25 February	12 noon – 8 pm	2.0
Wednesday	04 March	8 am – 8 pm	3.0
Wednesday	11 March	12 noon – 8 pm	2.0
Saturday	14 March	9 am – 1 pm	1.0
Wednesday	18 March	5 pm – 8 pm	0.75
Wednesday	25 March	8 am – 8 pm	3.0
Tuesday	31 March	8 am – 12 noon	1.0
Wednesday	01 April	12 noon – 8 pm	2.0
Wednesday	15 April	12 noon – 8 pm	2.0
Wednesday	29 April	12 noon – 8 pm	2.0
Wednesday	06 May	8 am – 8 pm	3.0
Friday	22 May	1.30 pm – 5.30 pm	1.0
Wednesday	27 May	9 am – 5 pm	2.0
Wednesday	03 June	9 am – 5 pm	2.0
Tuesday	09 June	12 noon – 8 pm	2.0
Wednesday	10 June	12 noon – 8 pm	2.0
Wednesday	24 June	9 am – 7 pm	2.5
Wednesday	08 July	9 am – 8 pm	2.75
Wednesday	15 July	9 am – 5 pm	2.0
Wednesday	22 July	12 noon – 8 pm	2.0
Wednesday	29 July	9 am – 7 pm	2.5
Wednesday	19 August	9 am – 1 pm	1.0
Friday	21 August	9 am – 5 pm	2.0
Wednesday	26 August	2 pm – 8 pm	1.5

Wednesday	09 September	9 am – 7 pm	2.5
Monday	14 September	9 am – 8 pm	2.75
Wednesday	16 September	12 noon – 8 pm	2.0
Wednesday	23 September	12 noon – 8 pm	2.0
Wednesday	30 September	12 noon – 8 pm	2.0
Wednesday	14 October	9 am – 7 pm	2.5
Wednesday	21 October	12 noon – 8 pm	2.0
Tuesday	27 October	8 am – 1 pm	1.25
Wednesday	28 October	12 noon – 8 pm	2.0
Wednesday	04 November	12 noon – 8 pm	2.0
Wednesday	11 November	8 am – 8 pm	3.0
Wednesday	25 November	9 am – 8 pm	2.75
Wednesday	02 December	12 noon – 8 pm	2.0
Wednesday	09 December	12 noon – 8 pm	2.0
Wednesday	16 December	12 noon – 8 pm	2.0
Wednesday	23 December	12 noon – 8 pm	2.0
Wednesday	30 December	9 am – 8 pm	2.75

Total = 94.5 sessions

Plus 1.5 hours of perioperative patient care on each date = 69 hours

Total = 17.25 sessions

Plus 1 hour of administration time per session = 94.5 hours

Total = 23.625 sessions

Total = 135.375 sessions

Elective Inpatient Operating 2016

			Sessions
Wednesday	06 January	Urologist of the Week	
Wednesday	13 January	9 am – 8 pm	2.75
Wednesday	20 January	12 noon – 8 pm	2.0
Wednesday	27 January	12 noon – 8 pm	2.0
Wednesday	03 February	12 noon – 8 pm	2.0
Wednesday	10 February	12 noon – 8 pm	2.0
Wednesday	17 February	Urologist of the Week	
Wednesday	24 February	9 am – 8 pm	2.75
Friday	26 February	1.30 am – 5.30 pm	1.0
Saturday	27 February	9 am to 1 pm	1.0
Wednesday	02 March	Professional Leave: expert witness	
Wednesday	09 March	12 noon – 8 pm	2.0
Saturday	12 March	9 am – 1 pm	1.0
Wednesday	16 March	9 am – 8 pm	2.75
Wednesday	23 March	12 noon – 8 pm	2.0
Wednesday	30 March	Urologist of the Week	
Wednesday	06 April	12 noon – 8 pm	2.0
Wednesday	13 April	9 am – 8 pm	2.75
Wednesday	20 April	Audit	
Wednesday	27 April	12 noon – 8 pm	2.0
Wednesday	04 May	12 noon – 8pm	2.0
Wednesday	11 May	Urologist of the Week	
Wednesday	18 May	12 noon – 8 pm	2.0
Wednesday	25 May	12 noon – 8 pm	2.0
Wednesday	01 June	12 noon – 8 pm	2.0
Wednesday	08 June	Urologist of the Week	
Wednesday	15 June	12 noon – 8 pm	2.0
Wednesday	22 June	Professional Leave: expert witness	
Wednesday	29 June	9 am – 8 pm	2.75

Wednesday	06 July	9 am – 8 pm	2.75
Wednesday	13 July	9 am – 8 pm	2.75
Monday	18 July	1.30 pm – 5.30 pm	1.0
Wednesday	20 July	9 am – 1 pm	1.0
Wednesday	27 July	9 am – 8 pm	2.75
Wednesday	03 August	Urologist of the Week	
Wednesday	10 August	9 am – 8 pm	2.75
Wednesday	17 August	12 noon – 8 pm	2.0
Wednesday	24 August	9 am – 8 pm	2.75
Friday	26 August	9 am – 5 pm	2.0
Saturday	27 August	9 am – 1 pm	1.0
Wednesday	31 August	9 am – 8 pm	2.75
Wednesday	07 September	12 noon – 8 pm	2.0
Wednesday	14 September	Urologist of the Week	
Wednesday	21 September	9 am – 8 pm	2.75
Wednesday	28 September	9 am – 8 pm	2.75
Wednesday	05 October	12 noon – 8 pm	2.0
Wednesday	12 October	12 noon – 8 pm	2.0
Wednesday	19 October	Audit	
Wednesday	26 October	Urologist of the Week	
Wednesday	02 November	9 am – 8 pm	2.75
Wednesday	09 November	9 am – 8 pm	2.75

Total = 83.25 sessions

Plus 1.5 hours of perioperative patient care for each date: 58.5 hours

= 14.625 sessions

Plus 1 hour of administration time per session: 83.25 hours

= 20.8125 sessions

Total =118. 6875 sessions

Number of elective inpatient sessions contracted at per Job Plan = 58

Elective Day Case Surgery 2012 – 2016

The obligation defined in my Job Plan has been to undertake two Elective Day Surgical Sessions per calendar month, with the expectation that four cases would be admitted per session.

Performance

2012:	Job Plan	42 weeks 19.38 elective day case sessions
	Actual	25 sessions
2013:	Job Plan	42 weeks 19.38 elective day case sessions
	Actual	20 sessions
2014:	(Urologist of the Week introduced in September 2014)	
	Job Plan	39.5 weeks 18.23 elective day case sessions
	Actual	23 sessions
2015:	Job Plan	35 weeks 16.15 elective day case sessions
	Actual	20 sessions
2016	(Until commencement of Sick Leave on 16 November 2016)	
	Job Plan	30.5 weeks 14.07 elective day case sessions
	Actual	17 sessions

Job Planned Sessions: 87.21 elective day case sessions
Actual Sessions: 105 sessions

Additional sessions = 17.79

Job Planned Patients: 349 patients
Actual Patients: 482 patients

Additional patients = 133

Additionality

Each additional session is 4 hours of operating:	71.16 hours
Each additional session required one hour to arrange:	17.79 hours
Each additional session preceded by 0.5 hours to consent:	08.90 hours

Total additional time allocated to elective day case operating 2012 – 16:

= 97.85 hours

Mean additional time allocated to elective day case operating per week:

= 0.52 hours

Elective Day Case Surgery 2012

Tuesday	24 January	x 5 patients
Tuesday	31 January	x 5 patients
Tuesday	14 February	x 5 patients
Tuesday	21 February	x 5 patients
Tuesday	13 March	x 5 patients
Tuesday	27 March	x 4 patients
Tuesday	03 April	x 5 patients
Tuesday	24 April	x 4 patients
Tuesday	01 May	x 4 patients
Tuesday	08 May	x 4 patients
Tuesday	29 May	x 5 patients
Tuesday	19 June	x 5 patients
Tuesday	26 June	x 5 patients
Tuesday	24 July	x 3 patients
Tuesday	07 August	x 4 patients
Tuesday	14 August	x 5 patients
Tuesday	29 August	x 3 patients
Tuesday	04 September	x 5 patients
Tuesday	11 September	x 5 patients
Tuesday	02 October	x 5 patients
Tuesday	09 October	x 5 patients
Tuesday	30 October	x 4 patients
Tuesday	06 November	x 5 patients
Tuesday	13 November	x 5 patients
Tuesday	04 December	x 5 patients

Total sessions = 25 Total patients = 115

Elective Day Case Surgery 2013

Tuesday	22 January	x 4 patients
Tuesday	05 February	x 5 patients
Tuesday	12 February	x 5 patients
Tuesday	12 March	x 5 patients
Tuesday	09 April	x 5 patients
Tuesday	16 April	x 5 patients
Tuesday	14 May	x 4 patients
Tuesday	04 June	x 5 patients
Tuesday	11 June	x 5 patients
Tuesday	02 July	x 4 patients
Tuesday	09 July	x 5 patients
Tuesday	27 August	x 5 patients
Tuesday	03 September	x 5 patients
Tuesday	10 September	x 5 patients
Tuesday	15 October	x 5 patients
Tuesday	22 October	x 5 patients
Tuesday	12 November	x 4 patients
Tuesday	26 November	x 5 patients
Tuesday	03 December	x 5 patients
Tuesday	10 December	x 5 patients

Total sessions = 20 Total patients = 96

Elective Day Case Surgery 2014

Tuesday	14 January	x 5 patients
Tuesday	28 January	x 5 patients
Tuesday	11 February	x 4 patients
Tuesday	25 February	x 3 patients
Tuesday	18 March	x 5 patients
Tuesday	25 March	x 4 patients
Tuesday	08 April	x 5 patients
Tuesday	15 April	x 5 patients
Tuesday	06 May	x 4 patients
Tuesday	27 May	x 6 patients
Tuesday	03 June	x 6 patients
Tuesday	08 July	x 5 patients
Tuesday	22 July	x 5 patients
Tuesday	29 July	x 5 patients
Tuesday	05 August	x 5 patients
Tuesday	26 August	x 5 patients
Tuesday	02 September	x 5 patients
Tuesday	16 September	x 5 patients
Tuesday	07 October	x 5 patients
Tuesday	21 October	x 5 patients
Tuesday	18 November	x 5 patients
Tuesday	16 December	x 4 patients
Tuesday	30 December	x 4 patients

Total sessions = 23 Total patients = 110

Elective Day Case Surgery 2015

Tuesday	06 January	x 4 patients
Tuesday	27 January	x 5 patients
Tuesday	10 February	x 4 patients
Tuesday	17 February	x 4 patients
Tuesday	10 March	x 4 patients
Tuesday	24 March	x 4 patients
Tuesday	28 April	x 4 patients
Tuesday	12 May	x 4 patients
Tuesday	26 May	x 4 patients
Tuesday	09 June	x 3 patients
Tuesday	23 June	x 5 patients
Tuesday	28 July	x 4 patients
Tuesday	25 August	x 4 patients
Tuesday	08 September	x 4 patients
Tuesday	22 September	x 4 patients
Tuesday	13 October	x 4 patients
Tuesday	03 November	x 5 patients
Tuesday	24 November	x 5 patients
Tuesday	08 December	x 4 patients
Tuesday	22 December	x 5 patients

Total sessions = 20 Total patients = 84 patients

Elective Day Case Surgery 2016

Tuesday	19 January	x 5 patients
Tuesday	02 February	x 4 patients
Tuesday	23 February	x 4 patients
Tuesday	15 March	x 4 patients
Tuesday	22 March	x 5 patients
Tuesday	05 April	x 5 patients
Tuesday	19 April	x 4 patients
Tuesday	03 May	x 5 patients
Tuesday	31 May	x 5 patients
Tuesday	28 June	x 5 patients
Tuesday	19 July	x 5 patients
Tuesday	26 July	x 5 patients
Tuesday	09 August	x 4 patients
Tuesday	06 September	x 4 patients
Tuesday	20 September	x 4 patients
Tuesday	11 October	x 4 patients
Tuesday	01 November	x 5 patients

Total sessions =17 sessions Total patients = 77

Lead Clinician of MDT & Chair of MDM

I was appointed Lead Clinician of Urology MDT and Chair of Urology MDM on 01 April 2012.
I held the post of Lead Clinician of Urology MDT until 31 December 2016.
I chaired every MDM from April 2012 until the introduction of a three person rotation for chairing MDM in September 2014.
The numbers of cases discussed at each MDM was limited to 40.
Chairing MDM requires the Chairperson to preview all cases for discussion.
This task was made all the more taxing due to failure of clinicians to provide clinical summaries of all cases, as is required.
Previewing each MDM required 3 to 4 hours of time depending upon the numbers discussed.
MDM was followed by proof reading outcomes prior to them being sent to GPs.

Additional Time spent previewing and proof reading MDMs chaired: (allocating a mean total of 4 hours per MDM)

2012: 31.5 weeks: MDM x 25 = 100 hours = **3.17 hours per week**

2013: 42 weeks: MDM x 44 = 176 hours = **4.19 hours per week**

2014: 39.5 weeks: MDM x 35 = 140 hours = **3.54 hours per week**

2015: 35 weeks MDM x 17 = 68 hours = **1.94 hours per week**

2016: 30.5 weeks MDM x 16 = 64 hours = **2.09 hours per week**

In addition as Lead Clinician, I brought the SHSCT Urology MDT from one which did not meet any National Cancer Plan target in 2012 to one that did not have a single case outside target timelines in 2015 when Peer Reviewed.
During the years as Lead Clinician, I established and secured agreement for all urological cancer referral and clinical management pathways.
I wrote and secured agreement for the MDT Operational Policy by having Business Meetings on alternate months.
I lead the SHSCT Urology MDT through National Peer Review in June 2015 and through the Peer Review update in September 2016.

All of these duties of Lead Clinicianship required a minimum of **1 additional hour of time allocated every week from April 2012 to September 2016.**

The mean additional time allocated to MDT and MDM from 2012 to 2016 per week = 3.9 hours.

O'Brien, Aidan

From: Haynes, Mark
Sent: 22 May 2018 13:31
To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed
Subject: Urology Waiting Lists

Importance: High

Dear Esther

I write to express serious patient safety concerns of the urology department regarding the current status of our inpatient theatre waiting lists and the significant risk that is posed to these patients.

As you are aware over the past 6 months inpatient elective activity has been downturned by 30% as part of the winter planning. This has meant that for our speciality demand has outstripped our capacity for all categories of surgery. In reality this has meant that Red Flag cases have been accommodated, with growing times from referral to treatment and increasing numbers of escalations / breaches. However, only limited numbers of clinically urgent non cancer cases have been undertaken with waiting times for these patients increasing significantly. These clinically urgent cases have also been subject to cancellation on occasion due to bed pressures. Routine surgery has effectively ceased. As you are aware there are staffing difficulties in theatres which renders it likely that there will be ongoing reduction in elective capacity. This is likely to disproportionate impact on Urology as we have, as a speciality, three 4 hour theatre sessions which take place as part of extended days and it is these sessions that will not be running.

The clinically urgent cases are at a significant risk as a result of this. Included in this group are patients with urinary stone disease and indwelling urethral catheters. The progressive waiting times for these patients are putting them at risk of serious sepsis both while waiting for surgery and at the time of their eventual surgery. In addition for the stone disease patients, their surgery can be rendered more complicated by development of further stones and / or encrustation of ureteric stents. The clinically urgent category also includes patients who are at risk of loss of kidney function as a result of their underlying urological condition (eg benign PUJ obstruction). Many of these patients are recurrently attending A&E and having unscheduled inpatient admissions with urinary sepsis while awaiting their inpatient surgery. Catheter related sepsis is a significant risk and all catheterised patients on our waiting lists are at risk of this, the recognised mortality risk for Catheter associated sepsis is 10%. Patients with stone disease and other benign urological conditions which affect upper urinary tract normal functioning are at risk of losing kidney function and consequently renal failure. The current duration of our waiting lists means significant numbers of patients are at risk of loss of renal function and consequently these patients are at a risk of requiring future renal replacement therapy. Duration of ureteric stenting in stone patients is associated with progressively increasing risk of urosepsis, and it's associated risk of death, as a post-operative complication. This risk has been quantified as 1% after 1 month, 4.9% after 2 months, 5.5% after 3 months and 9.2% after greater than 3 months. Currently our waiting lists have significant numbers of patient who have had stents in for in excess of 3 months and therefore our risk of post-operative sepsis is significant and is continuing to grow.

Tragically, a 70 year old male patient died this weekend following an elective ureteroscopy. He had a stent inserted in early March as part of his management of ureteric stones and was planned for an urgent repeat ureteroscopy. This took place 10 weeks after initial stent placement. He subsequently developed sepsis and died on ICU 2 days after the procedure. While this may have happened if his surgery took place within 1 month of insertion of the stent, and there will be other factors involved (co-morbidities etc), his risk of urosepsis was increased 5 fold by his waiting time for the procedure.

Unless immediate action is taken by the trust to improve the waiting times for urological surgery we are concerned that another potentially avoidable death may occur.

The private sector does not have a role to play in the management of this problem (previous experience) and the trust needs to therefore find a solution from within. We are aware that while our waiting times are far longer than is clinically appropriate or safe, other specialities have far shorter waiting times with waits for routine surgery being far shorter that our clinically urgent waiting times. Given the risk attached to these patients and the disproportionately short waiting times in other specialities one immediate solution is to have specialities with shorter waiting times 'give up' theatre lists to be used by the urology team until such a point as these waiting times come back to a reasonable length (less than 1 month for all clinically urgent cases).

Looking at our current waiting list there are currently approximately 550 patients in the clinically urgent category, waiting up to 208 weeks at present. In order to treat these patients we would require a minimum of 200 half day theatre lists. We would suggest the target should be 4 additional lists per week in order to treat this substantial volume of patients and this would therefore need to run for at least a year in order to bring the backlog down to an acceptable level (waiting time less than 1 month). It may require a longer period / more sessions as patients continue to be added to the waiting lists and demand outstrips our normal capacity. This requirement is on top of our full complement of weekly inpatient theatre sessions (11). With regards staffing of these lists we currently have 2 locum consultants providing sessions in the department and these individuals could be used in order to deliver the surgery or back fill other activity so the 5 permanent consultants can undertake the additional lists. In addition the department need a longer term increase in available inpatient operating in order to match demand. Clearly the above would not tackle the routine waiting list.

Once again, we would stress that without immediate action to start treating these patients there will be a further adverse patient outcome / death from sepsis which would potentially not have occurred if surgery had happened within acceptable timescale.

Ieam happy to meet to discuss timescales to implement the changes required.e

Yours Sincerely

Mark Haynes

Discussed at Urology MDM 10.03.16. Personal Information redacted by the USI 's prostate biopsies have shown no evidence of prostate cancer and his MRI is satisfactory. Mr Haynes to review in outpatients and recommend ongoing PSA monitoring.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	HAGAN C MR Personal Information redacted by the USI	None	None	None
Personal Information redacted by the USI	DOB: Personal Information redacted by the USI Age: 71	Personal Information redacted by the USI	Personal Information redacted by the USI	Target Date

Diagnosis: TCC Bladder pTa Grade 3
Staging:

MDMUpdate

CONSULTANT MR YOUNG: 71 year old man referred with history of visible haematuria and right loin pain. He has associated lower urinary tract symptoms in the form of poor flow and nocturia x 3. He has past medical history of diabetes mellitus since 1998 for which he is on Pharmacological therapy. He also has hypertension, osteoarthritis and an episode of angina in January 2006. He has been a long term chronic smoker up until three years ago. His renal function was normal on 25th September 2013. His PSA from the same date was 0.38ng/ml. Flexible cystoscopy, showed two areas of bladder growth, one on the posterior wall and the larger one occupying the anterior bladder wall. CT Urogram, 15.10.13 - Too small lesions identified in the bladder. No malignancy in the upper tracts seen. Electively admitted on 23.11.13 for TURBT. Multifocal TCC. 2 X 1cm ng plus multiple pin head TCC posterior wall. Pathology reported bladder mucosal biopsies in which there was a papillary transitional cell carcinoma of WHO Grade III. There was quite marked cauterisation artefact making interpretation difficult however unequivocal invasion into the subepithelial tissue was not identified. Discussed @ Urology MDM, 05.12.13. This gentleman has been found to have a high risk, superficial transitional cell carcinoma of his bladder on recent resection. For review by Mr Young to advise readmission in January 2014 for further resection. Electively admitted on 21.01.14 for TURBT which showed substantial recurrence despite TURBT in November. Pathology showed transitional cell carcinoma, invasive, Grade III, at least pT2. Discussed @ Urology MDM, 06.02.14. This gentleman's most recent bladder tumour resection has found muscle-invasive disease. He requires staging by way of CT Urogram, CT thorax and bone scan. To be reviewed at Histology Clinic. Attended histology clinic on 03.03.14. Staging CT Urogram, CT thorax and a bone scan were requested. CT C/A/P - 12.03.14 - Focal thickening urinary bladder wall in keeping with known TCC (muscle invasive). No metastasis seen. Bone scan - 14.03.14 - No evidence of bony metastasis. Discussed @ Urology MDM, 20.03.14. There has been no evidence of metastatic disease on recent imaging performed for staging of this gentleman's muscle invasive bladder carcinoma. For review by Mr O'Brien on 21.03.14, to discuss prospect of radical cystectomy. Patient attended for review, accompanied by his brother. His significant, comorbid status has consisted of systemic hypertension since 2005, angina in 2006, diabetes since 1998, dyslipidaemia since 2010, mild peripheral neuropathy in 2009 and upper GI symptoms of which he has remained free since H. pylori was eradicated in 2012. However, he could be considered fit for cystectomy until proven otherwise. He is not enthused by the prospect of having a urostomy, but could be persuaded. He would prefer to have orthotopic bladder replacement (there has been no suspicion of urethral pathology). A lesser preference would be chemo radiotherapy. Discussed @ Urology MDM, 27.03.14. Refer to BCH surgeons for discussion of orthotopic bladder replacement and cystectomy. MRI penis, 18.02.16 - 1.2 cm lesion within the corpus spongiosum and a possible further smaller distal lesion. No evidence of cavernosal involvement. No pelvic lymphadenopathy. The appearances are probably of T2 N0 disease. Penile biopsy, 01.03.16 - Histological examination shows fragments of papillary transitional cell carcinoma which are non-invasive (pTa) and are WHO Grade II. There is no lymphovascular invasion identified. There is no carcinoma in-situ identified. Muscularis propria is not present within this tissue.

MDMAction

Discussed at Urology MDM 10.03.16. Mr Personal Information redacted by the USI has had a previous Cystoprostatectomy for muscle invasive bladder cancer. He now has urothelial cancer on the penile urethra which is G2Ta (at least) on pathology but clinically and radiologically suspicious of invasive (T2) disease. For OP review with Mr Young to discuss Urethrectomy, arrange CT Chest abdomen and pelvis, central MDM discussion and referral.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'BRIEN A MR Personal Information redacted by the USI	None	None	None
Personal Information redacted by the USI	DOB: Personal Information redacted by the USI Age: 65	Personal Information redacted by the USI	Personal Information redacted by the USI	Target Date

Diagnosis: Prostate cancer
Staging:

MDMUpdate

CONSULTANT MR HAYNES: 65 year old with carcinoma of prostate gleason 3+3 diagnosed in 2008, 1 out of 10 cores positive. Since then he has been on Avodart and Tamsulosin for his lower urinary tract symptoms. PSA was 4.26 in March 2008, 10.47 in August 2008. Biopsies performed in July 2008, Gleason 6 in 1 core and suspicion in another. PSA 1.52 in April 2009, 1.04 in August 2010, 0.68 in May 2011 & 1.13 in June 2012. Investigations- Transrectal prostatic biopsy 10.07.12 - Histology of part 1 - part 6 shows similar features. Histology exhibits benign prostate glands within a fibromuscular stroma. There is no PIN or malignancy. Discussed @ Urology MDM 19.07.12. Whilst this man has been found to have no evidence of prostate carcinoma on this occasion he did have previously. To be reviewed by Mr O'Brien in August 2012 to be advised to continue with active surveillance consisting of PSA levels 6 monthly and for regular review. PSA increased to 3.25 in August. Advised to stop dutasteride. Repeat PSA in November 2012. Review in Thorndale December 2012. PSA levels have varied since Dutasteride was discontinued in August 2012. PSA 5.31 May 2014. Has since discontinued Tamsulosin. Tadalafil 5 mgs daily ineffective. Continues to have intermittent left flank pain. CT Abdomen and Pelvis requested. Alprostadil 10 ugs injected, with no response. Prescribed increased dose of Tadalafil 10 mgs daily. For injection of 20 ugs Alprostadil on 06 June 2014. Patient reported at review on 06 June 2014 that injection of Alprostadil 10 ugs had resulted in an modest erectile response lasting less than 1 hour. Injected and prescribed Alprostadil 20 ugs when required, in addition to Tadalafil 10 mgs daily. To continue on active surveillance. For review July 2014. Personal Information redacted by the USI has remained on active surveillance for his Gleason 6, prostate carcinoma. He is due surveillance scans and biopsies. MRI, 28.01.16 - No radiological evidence of a significant peripheral zone tumour. Small indeterminate low T2 signal lesion nodule in the left mid gland transition zone. The history of lower back pain is noted. Imaging of the lumbar spine has not been performed. It is unlikely that this patient has skeletal metastatic disease. However, if there is clinical concern, a lumbar spine MRI can be performed at your request. Transrectal prostatic biopsy, 01.03.16 - All cores show no evidence of PIN or invasive malignancy.

MDMAction

Discussed at Urology 10.03.16. Personal Information redacted by the USI's recent surveillance MRI shows no radiological progression of his prostate cancer and his surveillance biopsies show no evidence of prostate cancer on this occasion. Mr Haynes to contact Mr Personal Information redacted by the USI and recommend ongoing surveillance.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	HAYNES M D MR	None	None	None
Personal Information redacted by the USI	DOB: Personal Information redacted by the USI Age: 74	Personal Information redacted by the USI	Personal Information redacted by the USI	Target Date 14/02/2016

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR HAYNES: This 74 year old has been known to have systemic hypertension since 1980, mild mitral and tricuspid valvular regurgitation since 1996 and diabetes since 2004. She had carcinoma of her left breast diagnosed in 2011, and managed by left mastectomy, axillary lymph node clearance and radiotherapy. She had a hysterectomy and both anterior and posterior repairs performed in 2014. She was reported to have a solid lesion arising from the anterior aspect of her right kidney when she had ultrasound scanning on 10 December 2015 in the investigation of epigastric pain and nausea. On Renal CT scanning on 21 December 2015, the lesion was reported to be 2.7 cms in diameter. It was then appreciated that the lesion had been present on CT scanning in February 2012 when it measured 1.2 cms in diameter. CT scanning also reported the presence of a new nodule, 0.3 cms in diameter, in the lower lobe of the left lung. Patient remained well at review on 29 December 2015 when it was agreed to request a Renal MRI scan prior to MDM discussion of possible biopsy of the lesion. CT Chest, 21.12.15 - 1. Enhancing right renal mass, in keeping with a renal cell carcinoma. Urology referral required. 2. New tiny left lower lobe pulmonary nodule. CT follow-up in 1 year advised. MRI renal, 11.01.16 - 2.4cm enhancing right renal tumour which has increased in size from February 2012 (1.3 cm) and probably represents a small renal cell carcinoma. Discussed at Urology MDM 21.01.16. MRI scanning has indicated that the right renal lesion is probably a renal cell carcinoma. For review by Mr O'Brien to discuss partial nephrectomy. This lady was admitted on 4th March 2016 and underwent a laparoscopic partial nephrectomy. For pathology review at MDM prior to subsequent outpatient follow up with Mr Haynes Laparoscopic partial nephrectomy, 04.03.16 - await pathology.

MDMAction

Aimee Crilly

From: Haynes, Mark [redacted] Personal Information redacted by the USI
Sent: 22 May 2018 13:31
To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed
Subject: Urology Waiting Lists

Importance: High

Dear Esther

I write to express serious patient safety concerns of the urology department regarding the current status of our Inpatient theatre waiting lists and the significant risk that is posed to these patients.

As you are aware over the past 6 months inpatient elective activity has been downturned by 30% as part of the winter planning. This has meant that for our speciality demand has outstripped our capacity for all categories of surgery. In reality this has meant that Red Flag cases have been accommodated, with growing times from referral to treatment and increasing numbers of escalations / breaches. However, only limited numbers of clinically urgent non cancer cases have been undertaken with waiting times for these patients increasing significantly. These clinically urgent cases have also been subject to cancellation on occasion due to bed pressures. Routine surgery has effectively ceased. As you are aware there are staffing difficulties in theatres which renders it likely that there will be ongoing reduction in elective capacity. This is likely to disproportionate impact on Urology as we have, as a speciality, three 4 hour theatre sessions which take place as part of extended days and it is these sessions that will not be running.

The clinically urgent cases are at a significant risk as a result of this. Included in this group are patients with urinary stone disease and indwelling urethral catheters. The progressive waiting times for these patients are putting them at risk of serious sepsis both while waiting for surgery and at the time of their eventual surgery. In addition for the stone disease patients, their surgery can be rendered more complicated by development of further stones and / or encrustation of ureteric stents. The clinically urgent category also includes patients who are at risk of loss of kidney function as a result of their underlying urological condition (eg benign PUJ obstruction). Many of these patients are recurrently attending A&E and having unscheduled inpatient admissions with urinary sepsis while awaiting their inpatient surgery. Catheter related sepsis is a significant risk and all catheterised patients on our waiting lists are at risk of this, the recognised mortality risk for Catheter associated sepsis is 10%. Patients with stone disease and other benign urological conditions which affect upper urinary tract normal functioning are at risk of losing kidney function and consequently renal failure. The current duration of our waiting lists means significant numbers of patients are at risk of loss of renal function and consequently these patients are at a risk of requiring future renal replacement therapy. Duration of ureteric stenting in stone patients is associated with progressively increasing risk of urosepsis, and it's associated risk of death, as a post-operative complication. This risk has been quantified as 1% after 1 month, 4.9% after 2 months, 5.5% after 3 months and 9.2% after greater than 3 months. Currently our waiting lists have significant numbers of patient who have had stents in for in excess of 3 months and therefore our risk of post-operative sepsis is significant and is continuing to grow.

Tragically, a 70 year old male patient died this weekend following an elective ureteroscopy. He had a stent inserted in early March as part of his management of ureteric stones and was planned for an urgent repeat ureteroscopy. This took place 10 weeks after initial stent placement. He subsequently developed sepsis and died on ICU 2 days after the procedure. While this may have happened if his surgery took place within 1 month of insertion of the stent, and there will be other factors involved (co-morbidities etc), his risk of urosepsis was increased 5 fold by his waiting time for the procedure.

Unless immediate action is taken by the trust to improve the waiting times for urological surgery we are concerned that another potentially avoidable death may occur.

The private sector does not have a role to play in the management of this problem (previous experience) and the trust needs to therefore find a solution from within. We are aware that while our waiting times are far longer than is clinically appropriate or safe, other specialities have far shorter waiting times with waits for routine surgery being far shorter that our clinically urgent waiting times. Given the risk attached to these patients and the disproportionately short waiting times in other specialities one immediate solution is to have specialities with shorter waiting times 'give up' theatre lists to be used by the urology team until such a point as these waiting times come back to a reasonable length (less than 1 month for all clinically urgent cases).

Looking at our current waiting list there are currently approximately 550 patients in the clinically urgent category, waiting up to 208 weeks at present. In order to treat these patients we would require a minimum of 200 half day theatre lists. We would suggest the target should be 4 additional lists per week in order to treat this substantial volume of patients and this would therefore need to run for at least a year in order to bring the backlog down to an acceptable level (waiting time less than 1 month). It may require a longer period / more sessions as patients continue to be added to the waiting lists and demand outstrips our normal capacity. This requirement is on top of our full complement of weekly inpatient theatre sessions (11). With regards staffing of these lists we currently have 2 locum consultants providing sessions in the department and these individuals could be used in order to deliver the surgery or back fill other activity so the 5 permanent consultants can undertake the additional lists. In addition the department need a longer term increase in available inpatient operating in order to match demand. Clearly the above would not tackle the routine waiting list.

Once again, we would stress that without immediate action to start treating these patients there will be a further adverse patient outcome / death from sepsis which would potentially not have occurred if surgery had happened within acceptable timescale.

I am happy to meet to discuss timescales to implement the changes required.

Yours Sincerely

Mark Haynes

Aimee Crilly

From: Glackin, Anthony [redacted]
Personal Information redacted by USI
Sent: 11 October 2019 09:13
To: Haynes, Mark; Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; Tyson, Matthew
Cc: Carroll, Ronan; Corrigan, Martina
Subject: RE: Emergency admissions of patients on waiting lists

Mark
This is a good suggestion. It should be noted that there are some patients on our waiting lists who we are unaware of their admission to another hospital or specialty in CAH.

Tony

From: Haynes, Mark
Sent: 11 October 2019 08:24
To: Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; Glackin, Anthony; Tyson, Matthew
Cc: Carroll, Ronan; Corrigan, Martina
Subject: Emergency admissions of patients on waiting lists
Importance: High

Morning all

As we are all aware, waiting times for our patients are considerable. For some patients this results in them being admitted as emergencies, with in particular urosepsis, and these admissions would likely have been avoided if the patient had received timely elective surgery.

Amongst the key trusts targets set by the DoH is a reduction in healthcare associated gram negative bloodstream infections.

Going forwards, can we each submit an IR1 form for any patient who has waited longer than a time we consider 'reasonable' for elective treatment and is subsequently admitted as emergencies, in particular those with positive gram negative blood cultures, but including any patient whose emergency admission would have been avoided if they had received timely elective surgery? This will clearly document to the trust and HSC the patient risk and harm.

What constitutes 'reasonable' is up for debate and has to be left to each of our clinical judgement. As an initial thought I suggest;

>1 month delay for planned change of long term stent or beyond planned timescale for ureteroscopy for stone in stented patient.
>3 month wait for treatment for catheterised man awaiting TURP/incomplete bladder emptying awaiting TURP, stone disease for ureteroscopy, PCNL or nephrectomy (in non-functioning kidney), pyeloplasty.
>1 year wait for routine elective treatment

As onerous as it may be completing these forms, the documentation will heighten the recognition of our patients needs and suffering due to the lack of capacity. It will also protect us to some degree, I am aware that a speciality (not urology) in an NI trust has come in for criticism because it did not flag / document delays in cancer treatments which are felt to have resulted in patients coming to harm.

Hope this is OK with all. The IR1 form link is;

[redacted]
Irrelevant information redacted by the USI

Mark

Aimee Crilly

From: Carroll, Ronan [Personal Information redacted by USI]
Sent: 11 October 2019 10:14
To: Haynes, Mark; Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; Glackin, Anthony; Tyson, Matthew
Cc: Corrigan, Martina
Subject: RE: Emergency admissions of patients on waiting lists
Attachments: [Personal Information] final draft (4) (2).docx

Importance: High

Morning all
Mark you suggestion is in keeping with the attached SAI & the review panels recommendations
Ronan

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

From: Haynes, Mark
Sent: 11 October 2019 08:24
To: Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; Glackin, Anthony; Tyson, Matthew
Cc: Carroll, Ronan; Corrigan, Martina
Subject: Emergency admissions of patients on waiting lists
Importance: High

Mornjng all

As we are all aware, waiting times for our patients are considerable. For some patients this results in them being admitted as emergencies, with in particular urosepsis, and these admissions would likely have been avoided if the patient had received timely elective surgery.

Amongst the key trusts targets set by the DoH is a reduction in healthcare associated gram negative bloodstream infections.

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>3 month wait for treatment for catheterised man awaiting TURP/incomplete bladder emptying awaiting TURP, stone disease for ureteroscopy, PCNL or nephrectomy (in non-functioning kidney), pyeloplasty.
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Hope this is OK with all. The IR1 form link is;

Irrelevant information redacted by USI

Mark

Southern Health and Social Care Trust

APPENDIX 4
Revised November 2016 (Version 1.1)

INCIDENT REVIEW

SECTION 1

1. ORGANISATION: **SHSCT**	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: Personal Information redacted by USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	**4.** DATE OF INCIDENT/EVENT Personal Information redacted by USI
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: **NO** *Please select as appropriate*	**6.** IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF	**21 August 2018**

8. SUMMARY OF EVENT:

Personal Information redacted by USI attended Craigavon Area Hospital (CAH) Emergency Department (ED) on 4 March 2018. The impression was an infected obstructed left urinary tract. A computerized tomography scan (CT scan) of the urinary tract on 4 March 2018 reported an '*obstructing left sided ureteric renal calculus with proximal ureteric dilatation and associated moderate hydronephrosis. Imaging findings have not changed dramatically since the previous study, thus an acute on chronic deterioration is most likely*'. Personal Information went to emergency theatre for a cystoscopy and insertion of a left ureteric stent. Medical notes report Personal recovered well on the ward. Personal Information was commenced on antibiotics and was discharged home on 8 March 2018 with a plan for follow up in 6 weeks for ureteroscopy and laser (URS). Standard management of infected stones is insertion of temporary stent and treatment of sepsis infection followed by planned definitive stone fragmentation. Personal Information's planned treatment was ureteroscopy and laser fragmentation of stones.

On the 28 March 2018 Personal Information attended CAH ED and was admitted to a medical ward and was treated for acute kidney injury and a urinary tract infection. Personal Information was discharged home on 30 March 2018 with the plan for follow up with urology as previously planned.

On the 18 May 2018 Personal Information was admitted to CAH for a planned left ureteroscopy. The findings noted were an impacted stone in the proximal ureter. The stone was fragmented and 100% was removed. The stone was sent for analysis. Flexible pyeloscopy showed no stone. A 6Fr x 24cm JJ stent was inserted. The plan was for admission overnight and home tomorrow if well.

Personal Information's condition deteriorated post operatively. Personal Information and was transferred to the intensive care unit (ICU). While in ICU Personal Information required escalating inotropic support but despite aggressive intensive care management, Personal Information's condition continued to deteriorate. Following discussion with Personal Information's family a do not actively resuscitate (DNR) was put in place. Personal Information's death was confirmed on Personal Information redacted by USI

Personal Information was discussed with the Coroner and an unsigned death certificate was agreed with the cause of death recorded as:
1a. Multi-organ failure due to myocardial infarction,
b. Sepsis due to

c. left ureteroscopy for renal stone.
II. Ischaemic heart disease.

SECTION 2

9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
Mr Mark Haynes, Consultant Urologist	Mr Mark Haynes –Consultant Urologist Mrs Emma Jane Kearney – Lead Nurse Mrs Trudy Reid – Clinical Governance coordinator Mrs Carly Connolly – Clinical Governance Manager

11. SERVICE USER DETAILS:
Male DOB Personal Information redacted by USI

WHAT HAPPENED

Personal Information was a 70 year old gentleman who was brought in by ambulance to CAH ED on 4 March 2018. Personal Information presented feeling unwell with an acute all over weakness and hot and cold shivers. The clinical impression was an infected obstructed left urinary tract. A CT of urinary tract on 4 March 2018 reported '*obstructing left sided ureteric renal calculus with proximal ureteric dilatation and associated moderate hydronephrosis. Imaging findings have not changed dramatically since the previous study, thus an acute on chronic deterioration is most likely*'. Standard management of infected stones is insertion of temporary stent and treatment of sepsis infection followed by planned definitive stone fragmentation. Personal's planned treatment was ureteroscopy and laser fragmentation of stones.

Personal Information went to emergency theatre for cystoscopy and insertion of a left ureteric stent. Medical notes report urine was positive for leucocytes but no other infective source was noted and Personal recovered well on the ward. Personal was commenced on antibiotics and was discharged home on 8 March 2018 with a plan for follow up in 6 weeks for ureteroscopy and laser (URS).

On the 28 March 2018 Personal Information attended CAH ED and was admitted to a medical ward and was treated for acute kidney injury and an Escherichia coli (E. coli) urinary tract infection treated with antibiotics. Personal was discharged home on 30 March 2018 with the plan for follow up with urology as previously planned.

Personal Information had an outpatient pre-operative assessment appointment on the 07 May 2018, but was unable to attend due to inpatient status. Personal Information was subsequently sent another pre-operative assessment appointment for 22 May 2018, four days post operation procedure.

Personal Information was contacted by hospital staff on the 16 May 2018 for admission on the 18 May 2018 for ureteroscopy and laser (URS). Personal Information was admitted on 18 May 2018 to CAH for planned surgery. The preoperative assessment on the day noted Personal Information's medical history and noted that Personal Information was not "*Fit & Well*". He had a previous history of ischaemic heart disease, non-insulin dependent diabetes mellitus and hypertension. His height, weight and clinical observations were noted.

Personal Information attended theatre and intravenous Gentamicin (antibiotic) was administered prior to the procedure in theatre. The operation a left ureterorenoscopy was performed by Dr 1(Locum Urology Consultant) and Dr 3 (Urology Registrar). The operational findings noted an impacted stone in the proximal ureter. The stone fragmented and 100% was removed. The stone was sent for analysis. A flexible pyeloscopy showed no stone. A 6Fr x 24cm JJ stent was inserted. A specimen of urine was sent for microbiological testing on 18 May 2018 at 12.10 which isolated E. coli (bacteria). The results were reported the following day 19 May 2018.

Persona l Informati on

s condition deteriorated post operatively. At 13:35 his temperature was noted to be 34.8ºC and a warming blanket was applied. At 14:40 his temperature was 38ºC and he was noted to be shivering. He was reviewed by Dr 1(Locum Urology Consultant) and intravenous Tazocin was prescribed. He noted rigor post ureteroscopy and the plan was intravenous fluids and urinary catheter.

The nursing notes reflect Dr 2 (Consultant Anaesthetist) was informed and a right radial arterial line was inserted at 15:00. Intravenous paracetamol was administered at 15:00 as per Dr 4 (Consultant Anaesthetist). Intravenous fluids were erected and blood tests including a full blood picture and an ICU profile, and CRP (blood tests which can indicate if infection is present) were taken. An arterial blood gas was carried out. A 12 lead electrocardiogram (ECG) was completed at 15:30 which showed sinus tachycardia (fast heart rate). A right jugular central line was inserted at 16:30 and a Noradrenaline infusion was commenced at 16:35, the rate was subsequently increased to10ml. Blood glucose was measured as 4.0mmols at 4pm, it dropped to 3.5mmols at 16:22; Dextrose 50% 20ml was prescribed intravenously at 16:35 to manage the low blood sugars. Oxygen was administered at 5 litres per minute.

Observations were charted as:

DATE										
TIME	13:35	13:50	14:05	14:30	15:00	15:30	15:45	16:00	16:30	16:45
RESP	17	20	18	16	24	24	20	24	20	18
SPO2%	100	100	100	100	100	100	100	100	100	100
TEMP	34.8	35.3	38	37.4		38.2			39.5	39.5
BP	143/68	130/52	151/60	150/60	141/56	146/59	97/39	98/39	103/39	99/39
HR	71	83	113	130	134	134	121	125	124	115

Table 1

Blood results are as follows:

	18/8/18	18/8/18 15:00	19/8/18 02:00	19/8/18 07:00	19/8/18 15:25	19/8/18 19:00	19/8/18 21:05	20/8/18 08:00	Reference limits
CRP	29.16	14.92		66.74	76.84	93.16			
Sodium	138	144	137	138	139	136		136	133-146 mmol/L
Potassium	3.8	4.1	4.3	4.1	4.0	4.4		5.2	3.5-5.3 mmol/L
Bicarbonate	8.7	13.8	7.2	12.7	18.9	19.9		17.7	22-29 mmol/L
Urea	6.8	5.0	7.1	6.7	8.1	10.3		7.9	2.5 -7.8 mmol/L
Creatinine	187	107	213	196	215	252		178	59 104 mmol/L
Albumin	26	35	26	30	25	27		26	35-50 mmol/L
Glucose	10.5	5.9	12.9	14.0	7.0	8.5		3.6	4-6 mmol/L
Magnesium	0.88	0.42	1.55	1.13	0.93	0.96		0.09	0.7-1 mmol/L
eGFR	31	59	27	29	26	22		33	
Troponin			400	451			1571	3783	<=14 ng/L
NT-proBNP	430	9610	16672	>70000			>70000		
Amylase	65			149					28-100 U/L
Haemoglobin estimate	90	112	90	106	101	100		98	
Red blood cell count	3.19	3.81	3.01	3.59	3.42	3.38		3.34	
Platelets	173	237	191	147	108	98		61	
White cell count	27.8	2.48	40.5	48.5	53.3	55.0		61.3	

Table 2

A specimen of urine was sent for microbiological testing on 18 May 2018 at 23:00 and reported no significant growth. Blood cultures taken on the 18 May 2018 showed no growth.

Personal Information was transferred to the intensive care unit (ICU). Personal Information was intubated and ventilated and was treated with antibiotics and high dose inotropes (drugs that help maintain blood pressure), sodium bicarbonate, intravenous fluids and dialysis. He had a troponin rise between the 19 – 20 May 2018 from 400 to 3783ng/L. He proceeded to an echocardiogram which showed an ejection fraction of 15%.

Personal Information failed to improve despite maximal medical management and following discussion with Personal Information's family, the decision was made not to attempt CPR in the event of a cardiac arrest. Personal Information condition deteriorated, and on the Personal Information redacted by USI Personal Information remained seriously ill with severe sepsis and probable myocardial infarction. Personal Information died on the Personal Information redacted by USI 15:57. Personal Information was discussed with the coroner and an unsigned death certificate was agreed with the cause of death recorded as 1a. Multi-organ failure due to myocardial infarction, b. Sepsis due to C. left ureteroscopy for renal stone. II. Ischaemic heart disease.

SECTION 3 - LEARNING SUMMARY

12. WHAT HAS BEEN LEARNED:

Personal Information was discussed with the Coroner and an unsigned death certificate was agreed with the cause of death recorded as 1a. Multi-organ failure due to myocardial infarction, b. Sepsis due to C. left ureteroscopy for renal stone. II. Ischaemic heart disease.

Patient factors

Personal Information had significant comorbidities including ischaemic heart disease, non-insulin dependent diabetes mellitus and hypertension. This may have made him less able to tolerate the effects of infection. Personal Information had a recent E. coli urinary tract infection. E. coli was isolated in a sample of urine obtained on the 18 May 2018.

The general risk factors for urinary tract infections are patients of older age, immune deficiency, malnutrition, obesity, diabetes mellitus, smoking, hypoalbuminemia. The higher the American Society of Anaesthesiologists (ASA) Score (a global score that assesses the physical status of patients before surgery) the greater is the risk of infectious complications [1]. Personal Information's ASA score was 3 indicating a patient with severe systemic disease.

The European Association of Urology guidelines on urological infections suggested that bacteriuria (bacteria in the urine) is a definite risk factor in procedures entering the urinary tract and breaching the mucosa (endoscopic urological surgery), and thus it should be treated. They suggest that a urine culture must be taken prior to such interventions, and in the case of asymptomatic bacteriuria, pre-operative treatment should be given [2].

It is very important to identify and control risk factors for the development of urinary infection after endo-urological procedures, with main objective to minimise occurrence of infectious complications.

Guidelines, Policies and Procedures

September 2017 Preoperative guidelines state *"All patients who are listed for Invasive / Endoscopic procedures must have an MSU / CSU sample sent to Microbiology for O&S testing within 7 days of their admission. If their admission date is not within 7 days of pre-op then the patients must be given the sample bottle and microbiology request form and instructed to leave an MSU / CSU to their GP for testing within 7 days of their admission date".*

Personal Information was reviewed by an anaesthetist on the morning of surgery and the review team concluded that the assessment was appropriate, highlighting Personal Information's preoperative risks. The review team concluded that while it would have been advantageous to have a formal preoperative assessment prior to admission, Personal Information had no previous issues with anaesthetics and thus from an anaesthetic perspective, this assessment on the day of admission was appropriate and from an anaesthetic perspective it was reasonable to proceed with surgery.

Personal Information's comorbidities and recent urinary tract infection should have prompted the surgeon to request a preoperative assessment including microbiological testing of urine. Microbiological testing of urine was not performed prior to admission to assess if Personal Information's urinary tract infection had resolved. If a preoperative assessment had been performed and E. coli cultured from urine, the procedure would have been postponed and further treatment prescribed before the procedure would have been performed.

While [redacted] had a urine microbiology test taken on the 18 May 2018 the result was not available until the 19 May 2018. Intravenous Gentamicin (antibiotic) was administered at induction in theatre; the review team noted this was appropriate and that the E. coli later reported was sensitive to Gentamicin.

The review team acknowledge [redacted] had a pre operation assessment appointment scheduled for the 07 May 2018 and this was cancelled by [redacted] due to his inpatient status. [redacted] was offered an alternative appointment on 22 May 2018, 4 days after [redacted]'s scheduled ureteroscopy and laser surgery. It has come to the review team's attention that both pre-operative appointments were scheduled as [redacted] was on the waiting list for a general surgery procedure, added to Dr 8's waiting list on 30 January 2018. The pre-operative assessment department were not aware that [redacted] was on the waiting list for a urology procedure under the care of Dr 5 from 9 March 2018. There was no pre-op episode opened on Patient Administration System (PAS) for this waiting list episode.

The review team concluded that [redacted] should have had proactive preoperative assessment to include microbiological testing of urine.

The majority of surgical procedures are able to be managed as day cases but in a minority of cases the decision is made at the time of procedure for the patient to remain as an inpatient. In [redacted]'s case the decision would have been made at the time of surgery. It is recognised that while the majority of ureteroscopies performed to treat stones may be performed as day case procedures, many patients will need to be treated as an inpatient due to a combination of co-morbidities and procedure related factors.

The review team acknowledge [redacted]'s condition deteriorated post operatively and he required intensive care treatment. The management of sepsis is led by the critical care team as per SHSCT procedure and as [redacted]'s condition continued to deteriorate post operatively, the critical care team took over his management and care. Dr 1 (consultant urologist) noted rigor post ureteroscopy and intravenous Tazocin was prescribed, intravenous fluids were given and a catheter was inserted. [redacted]'s condition continued to further deteriorate and [redacted] was appropriately referred and reviewed by the critical care team (Dr 2 consultant anaesthetist), and transferred to the intensive care unit (ICU) for ongoing management and care by the critical care team. The review team conclude treatment and care provided in the recovery ward was appropriate and staff acknowledged [redacted]'s deteriorating symptoms and acted appropriately by contacting the critical care team (Dr 2) who then took over [redacted]'s management and care.

Waiting list, demand and capacity.

The review team noted that there are demand and capacity issues within the urology service, with 1261 patients on the inpatient and day case waiting list, and with 785 patients waiting over 52 weeks on 7 December 2018. Planned patients for change of stent are recorded in different ways and held on 6 waiting lists. [redacted] was added to the waiting list on 9 March 2018, he waited 10 weeks prior to his procedure.

The review team note that patients who undergo ureteroscopy after ureteric stent insertion have a higher risk of postoperative sepsis. Prolonged stent dwelling time can cause sepsis as an indication for stent insertion, and female gender are independent risk factors. Stent placement should be considered cautiously, and if inserted, ureteroscopy should be performed at the earliest opportunity, appropriate for an individual's circumstance, with risks of post-operative sepsis recognised to be higher where stents have been insitu for longer than 1

month[3].

Medical record and documentation.

The review team noted there was no evidence of handover from the recovery ward to ICU recorded in [redacted]s recovery ward medical documentation. Once accepted by ICU all documentation was transferred to ICCA system in recovery therefore all documentation of care continued on this system, however this should have been indicated clearly within the patient theatre/recovery care pathway record. All other medical documentation in recovery was recorded appropriately

Medical records should be factually accurate and the review team acknowledge there are several inaccurate entries made by medical staff after [redacted]'s death. The letter to [redacted]s GP was dated [redacted], the day before [redacted]s death. The performa 'checklist after the death of a patient' was also incorrectly completed recording the cause of death as Pancreatitis, Breast Cancer and Ischemic Heart Disease. [redacted]'s medical certificate of cause of death stated [redacted] was last seen alive and treated by Dr 7 on the [redacted] the day after [redacted]s death. The review team have acknowledged these errors and determine the medical staff involved in [redacted]s care will be provided with a copy of the report for reflection and learning. On behalf of the Trust the review team would like to apologise to [redacted]s wife [redacted] and extended family for the errors documented and for any distress caused.

Visiting Times

It has come to the review team's attention that [redacted]'s family have suffered further grievance due to the fact they were not allowed to see [redacted] when he was so in critically ill in ICU. [redacted]s family report they were only allowed a brief moment with [redacted] on his arrival to ICU and after that [redacted]'s wife [redacted] and daughter had another brief moment prior to intubation. [redacted]s family report they were present in the ICU waiting room throughout but were not allowed to see [redacted] until [redacted] at this stage the family feel it was too late as [redacted] was in his final hours and the family's final moments were taken away. The family have expressed they are deeply saddened by this as they were unable to be with [redacted] during his last few days of life. The family have asked that this rule should be reviewed as it was both cruel and insensitive. The review team have reflected on this and advise the Trust to review its policy and procedure on visiting times for families of ICU patients.

Communication

[redacted]'s family have underlined a number of communication issues to the review team. [redacted]s family report they had difficulty getting through to the recovery ward to get an update on [redacted]'s condition. [redacted]'s family have reported they tried to contact the ward on numerous occasions throughout the day of the 18 May 2019 but failed to get through. [redacted]'s family stressed at no time did staff try to contact them to inform them that [redacted]s condition had deteriorated post procedure and required overnight admission. The family report they finally made contact with the ward at 18:15 and were advised by the nurse to come down and a nurse would speak with them, however upon arrival the nurse refused to do so. The family requested to speak to a doctor but were told by a member of the nursing staff that it was a Friday night and they would not be able to speak to a doctor now.

The review team acknowledge communication with families post procedure is difficult due to a number of barriers. The review team determined that medical staff would have had a full theatre list booked for the day and were probably dealing with other procedures and work

pressures and therefore unable to take time out to update [redacted]s family. The review team have concluded that treatment and care within the recovery ward was appropriate but due to work pressures [redacted]'s family were not updated. The review team again have determined the report will be shared with all staff involved in [redacted]s care for reflection and learning.

13. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

Patients undergoing elective and planned procedures where the urinary tract will be entered and the mucosa breeched, including endoscopic urological surgery, must have a preoperative assessment with microbiological testing of urine within 7 days of the planned procedure and any confirmed bacteriuria treated with appropriate antibiotics prior to the planned procedure.

14. RECOMMENDATIONS (please state by whom and timescale)

Recommendation 1
This report will be presented at morbidity and mortality meetings to share learning with clinical staff.

Recommendation 2
All patients undergoing elective and planned procedures where the urinary tract will be entered and the mucosa breeched, including endoscopic urological surgery, must have a preoperative assessment with microbiological testing of urine within 7 days of the planned procedure and any confirmed bacteriuria treated with appropriate antibiotics prior to the planned procedure.

Recommendation 3
Urology waiting lists should be standardised, to include standardised description of ureteric stent change/removal procedures.

Recommendation 4
Consultant Urologists should ensure that they have a system in place which ensures that patients with ureteric stents inserted are recorded with planned removal or exchange dates in order to ensure patients do not have ureteric stents in place for longer than intended.

Recommendation 5
All patients who have ureteric stents inserted for management of urinary tract stones should have plans for definitive management within 1 month unless there are clinical indications for a longer interval to definitive treatment.

Recommendation 6
Where patients wait longer than the intended time for definitive management with a ureteric stent in situ the case should be reported on the trust DATIX system.

Recommendation 7
The Trust should review waiting times and put systems and processes in place to minimise waiting times across specialties and continue escalation to the Health and Social Care

Board as required.

References

1. Schaeffer *AJ, Schaeffer EM. Infections of the Urinary Tract. In: Wein AJ, editor. Campbell-Walsh Urology. 10th ed. Vol. 8. St. Louis, Mo: WB Saunders; 2012. pp. 258–326.*
2. Guidelines on Urological Infections. European Association of Urology 2014.
3. *BJU International 2017 Ureteric stent dwelling time: a risk factor for post-ureteroscopy sepsis. Nevo A1, 2, Mano R1,2, Baniel J1,2, Lifshitz DA1,2. BJU Int. 2017 Jul; 120(1):117-122.*

15. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

16. FURTHER REVIEW REQUIRED? YES / NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

17. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	**18.** PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY

19. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

20. TERMS OF REFERENCE *(If known or submit asap)*:

SECTION 5

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

21. NAME:	**22.** DATE APPROVED:

23. DESIGANTION:

SECTION 6

24. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		HSCB Ref Number:	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓)				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

	a) Draft review report has been shared and further engagement planned to share final report	
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))

Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*

1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**				**NO**			
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**				**NO**			
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

O'Brien, Aidan

From: Haynes, Mark
Sent: 08 June 2018 13:28
To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Reid, Trudy; Stinson, Emma M; Devlin, Shane
Subject: RE: Urology Waiting Lists

Dear Esther

Following on from below, a meeting took place. However, that meeting was to resolve the issues of the impact of the loss of extended day operating on the urology team such that the impact of this was spread across the surgical teams. The meeting did not result in Urology having its full number of weekly theatres (11 with backfill), nor was it intended to address any increase in urology operating to address the waiting list backlog.

In preparation for the meeting, waiting time information across different specialities were collated as below (as at 25/5/18);

Specialty	Urgent Inpatients	Weeks Waiting	Routine Inpatients	Weeks waiting	Urgent Daycases	Weeks waiting	Routine Daycases	Weeks waitin
Urology	596	208	237	225	378	173	541	212
ENT	29	1x38 19	142	64	64	23	923	80
General Surgery	113	147	75	139	437	131	901	121
Breast	16	1 x 41 27	15	82	10	1 x 19 4	9	38
Orthopaedics	200	1 x 160 85	1155	171	130	1 x 101 80	805	128
Gynae	28	11	168	50	26	1 x 26 6	106	44

As such, consideration needs to be given as to how the clinical risk associated with such significant waiting time disparities across specialities should be managed. As highlighted in my previous e-mail, amongst the urology cases are patients where there is well documented increased risk associated with longer waiting times. Unfortunately given the current constraints of available theatre time and inpatient beds along with nursing staffing pressures, [illegible] solution that doesn't impact on the waiting times of patients from other specialities. However, I do not believe we can justify accepting the current situation.

Could we look to meet at some point next week to discuss this, perhaps we could use our 1:1 meeting next Tuesday with Ronan, Martina and Barry joining us?

From a urology team perspective, I think it would also be helpful to meet the full consultant team. We are all available on Thursday 14th June at 12:30 and would be happy to meet then if that suits?

Thanks

Mark

MR O'BRIEN: I would ideally like to. I think what you should do --

COLIN WEIR: The process will be that you will have to agree it.

MR O'BRIEN: Of course. I should have said to you, did I say it in the email, you remember when previously I think when I was trying to reduce the number of new clinics I would do and so forth, you were saying you would need to consult with your colleagues and so forth. I have done all of that.

COLIN WEIR: That's fine.

MR O'BRIEN: They would not only be entirely in agreement but we could very well see a movement to join me.

COLIN WEIR: Okay.

MR O'BRIEN: I think it is a pretty overworked speciality.

COLIN WEIR: Yeah, yeah

MR O'BRIEN: And the other big issue that needs to have a response from the trust, which is appalling at present, is having 597 patients awaiting urgent in-patient admission.

COLIN WEIR: Yes.

MR O'BRIEN: With A waiting time of 210 weeks and gynaecology have 28 patients waiting 11 weeks.

COLIN WEIR: All right.

MR O'BRIEN: How does have an organisation stand over that?

COLIN WEIR: Well, (inaudible).

MR O'BRIEN: Thank you for accommodating me.

COLIN WEIR: No problem.

Personal Information redacted by the USI

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

Personal Information redacted by the USI

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

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Thank you,

Aidan.

Aimee Crilly

From: O'Brien, Aidan [redacted]
Sent: 23 September 2019 00:03
To: Haynes, Mark
Subject: RE: [redacted] CAHE [redacted]

Mark,

I agree entirely with you and am grateful for your support,

Aidan.

From: Haynes, Mark
Sent: 22 September 2019 21:05
To: O'Brien, Aidan; Corrigan, Martina
Subject: RE: [redacted] CAHE [redacted]

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] CAHE [redacted]

Martina,

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Thank you,

Aidan.

Aimee Crilly

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

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:
[redacted] nal)
External)
Mobile)

From: Haynes, Mark
Sent: 22 September 2019 21:05
To: O'Brien, Aidan; Corrigan, Martina
Subject: RE: [redacted] CAHE [redacted]

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: Personal Information redacted by the USI CAHE Personal Information redacted by the USI

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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.

From: Clayton, Wendy [redacted]
Sent: 23 September 2019 11:14
To: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted] CAHE [redacted]

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 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 their GP advising same.

Regards

Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC
Tel [redacted]
Mo

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

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

Telephone:

Personal Information redacted by USI
rnal)
External)
Mobile)

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

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Cc: Haynes, Mark
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Thank you,

Aidan.

Aimee Crilly

From: Corrigan, Martina [redacted]
Sent: 23 September 2019 14:41
To: Clayton, Wendy; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted] CAHE [redacted]

Thanks Wendy

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

[redacted] *(Mr Haynes)*

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)

Regards

Martina

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

Telephone:
[redacted] rnal)
(External)
(Mobile)

From: Clayton, Wendy
Sent: 23 September 2019 11:14
To: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted] CAHE [redacted]

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 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 their GP advising same.

Regards

Wendy

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

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

Good morning Aidan and Mark

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Martina

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

Telephone:
Personal Information redacted by USI rnal)
External)
Mobile)

From: Haynes, Mark
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Subject: RE: Personal Information redacted by the USI CAHE Personal Information redacted by the USI

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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

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Sent: 22 September 2019 17:11
To: Corrigan, Martina
Cc: Haynes, Mark
Subject: Personal Information redacted by the USI CAHE Personal Information redacted by the USI

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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.

Personal Information redacted by the USI

From: Clayton, Wendy Personal Information redacted by USI
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 CAHE Personal Information redacted by the USI
Attachments: Book1.xlsx; Book1.xlsx

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 USI
Mo

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 CAHE Personal Information redacted by the USI

Thanks Wendy

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

(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:
Personal Information redacted by USI rnal)
(External)
(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 CAHE 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 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 their GP advising same.

Regards

Wendy

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

From: Corrigan, Martina
Sent: 23 September 2019 06:40
To: Haynes, Mark; O'Brien, Aidan; Clayton, Wendy
Cc: Carroll, Ronan
Subject: RE: Personal Information redacted by the USI CAHE 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:
Personal Information redacted by USI ernal)
(External)
(Mobile)

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

Year Month	Trust PAS box	* Trust Reassigned	Specialty Description (R)
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
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2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
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2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
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2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
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2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY
2019/05	Southern Health and Social Care Trust	Southern Health and Social Care Trust	UROLOGY

Intended Management Description (R)	Hospital Name	Urgency Code Description	Casenote	Original Date
Day Case	SOUTH TYRONE HOSPITAL	URGENT	Personal Information redacted by USI	24/01/2018
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		13/04/2018
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		20/04/2018
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		09/03/2016
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		03/02/2017
Day Case	CRAIGAVON AREA HOSPITAL	URGENT		04/05/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		14/08/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		16/08/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		28/12/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		02/01/2018
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		05/09/2014
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		25/08/2015
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		08/10/2015
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		27/11/2015
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		21/12/2015
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		11/01/2016
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		17/02/2016
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		04/07/2016
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		03/08/2016
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		12/08/2016
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		30/05/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		21/07/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		03/10/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		02/01/2018
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		20/02/2018
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		06/03/2018
Day Case	CRAIGAVON AREA HOSPITAL	URGENT		05/03/2018
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		22/11/2016
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		15/08/2016
Day Case	CRAIGAVON AREA HOSPITAL	URGENT		04/04/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		10/05/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		11/09/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		05/03/2018
Day Case	CRAIGAVON AREA HOSPITAL	URGENT		22/05/2018
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		20/03/2015
Day Case	CRAIGAVON AREA HOSPITAL	URGENT		03/04/2015
Day Case	CRAIGAVON AREA HOSPITAL	URGENT		10/04/2015
Day Case	CRAIGAVON AREA HOSPITAL	URGENT		24/04/2015
Day Case	CRAIGAVON AREA HOSPITAL	URGENT		17/08/2015
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		19/10/2015

			Personal Information redacted by USI	
Day Case	CRAIGAVON AREA HOSPITAL	URGENT	[redacted]	03/02/2016
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		30/06/2016
Day Case	CRAIGAVON AREA HOSPITAL	URGENT		03/10/2016
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		18/11/2016
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		13/02/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		29/06/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		20/10/2017
Normal Inpatient	CRAIGAVON AREA HOSPITAL	URGENT		21/12/2017

Current Date	Waiting more than 52 weeks	Consultant Name		* Prim OP Type	Total Days Waiting
24/01/2018	1	Glackin A.J Mr		Other	492
13/04/2018	1	Glackin A.J Mr		Other	413
20/04/2018	1	Glackin A.J Mr		Other	406
09/03/2016	1	Haynes M D Mr		Other	1178
03/02/2017	1	Haynes M D Mr		Other	847
04/05/2017	1	Haynes M D Mr		Other	757
14/08/2017	1	Haynes M D Mr		Other	655
16/08/2017	1	Haynes M D Mr		Other	653
28/12/2017	1	Haynes M D Mr		Other	519
02/01/2018	1	Haynes M D Mr		Other	514
14/10/2014	1	O'Brien A Mr		Other	1690
25/08/2015	1	O'Brien A Mr		Other	1375
08/10/2015	1	O'Brien A Mr		Other	1331
27/11/2015	1	O'Brien A Mr		Other	1281
21/12/2015	1	O'Brien A Mr		Other	1257
11/01/2016	1	O'Brien A Mr		Other	1236
17/02/2016	1	O'Brien A Mr		Other	1199
04/07/2016	1	O'Brien A Mr		Other	1061
03/08/2016	1	O'Brien A Mr		Other	1031
12/08/2016	1	O'Brien A Mr		Other	1022
30/05/2017	1	O'Brien A Mr		Other	731
21/07/2017	1	O'Brien A Mr		Other	679
03/10/2017	1	O'Brien A Mr		Other	605
02/01/2018	1	O'Brien A Mr		Other	514
20/02/2018	1	O'Brien A Mr		Other	465
06/03/2018	1	O'Brien A Mr		Other	451
20/03/2018	1	O'Brien A Mr		Other	437
22/11/2016	1	O'Donoghue J P Mr		Other	920
15/08/2016	1	O'Donoghue J P Mr		Other	900
04/04/2017	1	O'Donoghue J P Mr		Other	787
10/05/2017	1	O'Donoghue J P Mr		Other	751
11/09/2017	1	O'Donoghue J P Mr		Other	627
05/03/2018	1	O'Donoghue J P Mr		Other	452
22/05/2018	1	O'Donoghue J P Mr		Other	374
20/03/2015	1	Young M Mr		Other	1533
03/04/2015	1	Young M Mr		Other	1519
10/04/2015	1	Young M Mr		Other	1512
24/04/2015	1	Young M Mr		Other	1498
17/08/2015	1	Young M Mr		Other	1383
19/10/2015	1	Young M Mr		Other	1320

03/02/2016	1	Young M Mr		Other	1213
30/06/2016	1	Young M Mr		Other	1065
03/10/2016	1	Young M Mr		Other	970
18/11/2016	1	Young M Mr		Other	924
13/02/2017	1	Young M Mr		Other	837
29/06/2017	1	Young M Mr		Other	701
20/10/2017	1	Young M Mr		Other	588
21/12/2017	1	Young M Mr		Other	526

Timebands	TRUST RESPONSE - has record been reviewed	1st letter sent	DATE TO RESOND TO 2ND Letter
12- 18 months	CFNR		
12- 18 months	CFNR	25/07/2019	
12- 18 months	CFTP	25/07/2019	
36-42 months	CFNR	23/07/2019	
24-30 months	CFNR	23/07/2019	
24-30 months	CFNR		
18 - 24 months	CFNR	25/07/2019	
18 - 24 months	CFNR	25/07/2019	
12- 18 months	cfnr	25/07/2019	
12- 18 months	CFTE	25/07/2019	
54-60 month	CFNR		
42-48 months	CFNR	23/07/2019	
42-48 months	CFNR		
36-42 months	CFNR		
36-42 months	CFNR	23/07/2019	
36-42 months	CFTE		
36-42 months	CFNR		
30-36 months	CFNR		
30-36 months	CFNR	23/07/2019	
30-36 months	CFNR		
18 - 24 months	CFNR		
18 - 24 months	CFNR	25/07/2019	
18 - 24 months	CFNR	25/07/2019	
12- 18 months	CFNR	25/07/2019	
12- 18 months	CFNR	25/07/2019	
12- 18 months	CFNR	25/07/2019	
12- 18 months	CFNR	25/07/2019	
30-36 months	CFTE	23/07/2019	
24-30 months	CFTE	23/07/2019	
24-30 months	CFNR		
24-30 months	CFTP		
18 - 24 months	cfnr	25/07/2019	
12- 18 months	CFTE	25/07/2019	
12- 18 months	CFTE	25/07/2019	
48-54 months	CFTE		
48-54 months	CFTE	23/07/2019	
48-54 months	CFTE	23/07/2019	
48-54 months	CFNR		
42-48 months	CFNR	23/07/2019	
42-48 months	CFNR	23/07/2019	

36-42 months	CFTE	23/07/2019	
30-36 months	CFNR	23/07/2019	
30-36 months	CFNR	23/07/2019	
30-36 months	CFNR	23/07/2019	
24-30 months	CFNR	23/07/2019	
18 - 24 months	CFNR		
18 - 24 months	CFNR	25/07/2019	
12- 18 months	cfnr	25/07/2019	

Comments
DONE PRIVATLEY ALREADY REMOVED
DOES NOT WANT TO WAIT ANY LONGER
I FEELING VERY GOOD
REMOVE AS PER CONS - ALREADY REMOVED
BEING SEEN BY MR HAYNES - HE DONE PROCEDURE IN 2018
I am ok at the moment with taking my medication. If it stays like this im happy enough.
NOT ANY WORSE THAN IT WAS 10 YEARS AGO
NLR
I HAVE BEEN REFERRED TO ALTNAGELVIN HOSPITAL ON 10/08/19 FOR SURGERY.
BY LETTER- 25.7.19
I HAVE HAD NO PROBLEMS FOR THE LAST 18 MONTHS, NO PAIN OR DISCOMFORT, SHOULD I GET PROBLEMS I WILL INFORM MY DOCTOR.

I HAD SURGERY LAST JULY NEED APPOINTMENT TO SEE MR YOUNG JUST TO SEE IF EVERYTHING IS OK
NLR
PT SAYS WAS DONE
I PASSED THE STONE 3 WEEKS AFTER I WAS SEEN

Year Month	Trust PAS box	* Trust Reassigned	Specialty Description (R)	Intended Management Description (R)	Hospital Name	Urgency Code Description	Casenote
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	Personal Information redacted by USI [redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Day Case	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Day Case	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Day Case	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Day Case	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]

							Personal Information redacted by USI
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Day Case	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Day Case	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Day Case	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Day Case	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVOI	URGENT	

Personal Information redacted by USI

2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Day Case	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Day Case	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Day Case	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]
2019/05	Southern He	Southern He	UROLOGY	Normal Inpa	CRAIGAVO	URGENT	[redacted]

Original Date	Current Date	Waiting more than 52 weeks	Consultant Name	Date Booked	* Prim OP Type	Total Days Waiting
05/09/2014	14/10/2014	1	O'Brien A Mr		Other	1690
25/08/2015	25/08/2015	1	O'Brien A Mr		Other	1375
08/10/2015	08/10/2015	1	O'Brien A Mr		Other	1331
27/11/2015	27/11/2015	1	O'Brien A Mr		Other	1281
21/12/2015	21/12/2015	1	O'Brien A Mr		Other	1257
11/01/2016	11/01/2016	1	O'Brien A Mr		Other	1236
17/02/2016	17/02/2016	1	O'Brien A Mr		Other	1199
04/07/2016	04/07/2016	1	O'Brien A Mr		Other	1061
03/08/2016	03/08/2016	1	O'Brien A Mr		Other	1031
12/08/2016	12/08/2016	1	O'Brien A Mr		Other	1022
30/05/2017	30/05/2017	1	O'Brien A Mr		Other	731
21/07/2017	21/07/2017	1	O'Brien A Mr		Other	679
03/10/2017	03/10/2017	1	O'Brien A Mr		Other	605
02/01/2018	02/01/2018	1	O'Brien A Mr		Other	514
20/02/2018	20/02/2018	1	O'Brien A Mr		Other	465
06/03/2018	06/03/2018	1	O'Brien A Mr		Other	451
05/03/2018	20/03/2018	1	O'Brien A Mr		Other	437
13/08/2014	13/08/2014	1	O'Brien A Mr		Other	1752
04/08/2014	04/08/2014	1	O'Brien A Mr		Other	1747
01/09/2014	01/09/2014	1	O'Brien A Mr		Other	1733
12/09/2014	12/09/2014	1	O'Brien A Mr		Other	1722
23/09/2014	23/09/2014	1	O'Brien A Mr		Other	1711
30/12/2014	30/12/2014	1	O'Brien A Mr		Other	1613
22/01/2015	22/01/2015	1	O'Brien A Mr		Other	1590
30/01/2015	30/01/2015	1	O'Brien A Mr		Other	1582
03/03/2015	03/03/2015	1	O'Brien A Mr		Other	1550
31/03/2015	31/03/2015	1	O'Brien A Mr		Other	1522
31/03/2015	31/03/2015	1	O'Brien A Mr		Other	1522
14/04/2015	14/04/2015	1	O'Brien A Mr		Other	1508
27/04/2015	27/04/2015	1	O'Brien A Mr		Other	1495
01/05/2015	01/05/2015	1	O'Brien A Mr		Other	1491
23/06/2015	23/06/2015	1	O'Brien A Mr		Other	1438
31/07/2015	31/07/2015	1	O'Brien A Mr		Other	1400
24/08/2015	24/08/2015	1	O'Brien A Mr		Other	1376
04/09/2015	04/09/2015	1	O'Brien A Mr		Other	1365
21/09/2015	21/09/2015	1	O'Brien A Mr		Other	1348
19/10/2015	19/10/2015	1	O'Brien A Mr		Other	1320
30/12/2015	30/12/2015	1	O'Brien A Mr		Other	1248
04/01/2016	04/01/2016	1	O'Brien A Mr		Other	1243
08/01/2016	08/01/2016	1	O'Brien A Mr		Other	1239
11/01/2016	11/01/2016	1	O'Brien A Mr		Other	1236
19/01/2016	19/01/2016	1	O'Brien A Mr		Other	1228
29/12/2015	29/12/2015	1	O'Brien A Mr		Other	1189

22/03/2016	22/03/2016	1	O'Brien A Mr	Other	1165
03/05/2016	03/05/2016	1	O'Brien A Mr	Other	1123
23/05/2016	23/05/2016	1	O'Brien A Mr	Other	1103
24/05/2016	24/05/2016	1	O'Brien A Mr	Other	1102
26/07/2016	26/07/2016	1	O'Brien A Mr	Other	1039
03/08/2016	03/08/2016	1	O'Brien A Mr	Other	1031
04/08/2016	04/08/2016	1	O'Brien A Mr	Other	1030
20/08/2016	20/08/2016	1	O'Brien A Mr	Other	1014
23/08/2016	23/08/2016	1	O'Brien A Mr	Other	1011
30/09/2016	30/09/2016	1	O'Brien A Mr	Other	973
28/10/2016	28/10/2016	1	O'Brien A Mr	Other	945
30/04/2017	30/04/2017	1	O'Brien A Mr	Other	761
16/05/2017	16/05/2017	1	O'Brien A Mr	Other	745
17/07/2017	17/07/2017	1	O'Brien A Mr	Other	683
18/07/2017	18/07/2017	1	O'Brien A Mr	Other	682
18/07/2017	18/07/2017	1	O'Brien A Mr	Other	682
29/08/2017	29/08/2017	1	O'Brien A Mr	Other	640
06/10/2017	06/10/2017	1	O'Brien A Mr	Other	602
23/10/2017	23/10/2017	1	O'Brien A Mr	Other	585
21/11/2017	21/11/2017	1	O'Brien A Mr	Other	556
21/11/2017	21/11/2017	1	O'Brien A Mr	Other	556
24/11/2017	24/11/2017	1	O'Brien A Mr	Other	553
20/12/2017	20/12/2017	1	O'Brien A Mr	Other	527
02/01/2018	02/01/2018	1	O'Brien A Mr	Other	514
08/01/2018	08/01/2018	1	O'Brien A Mr	Other	508
16/01/2018	16/01/2018	1	O'Brien A Mr	Other	500
19/01/2018	19/01/2018	1	O'Brien A Mr	Other	497
02/02/2018	02/02/2018	1	O'Brien A Mr	Other	483
05/02/2018	05/02/2018	1	O'Brien A Mr	Other	480
07/02/2018	07/02/2018	1	O'Brien A Mr	Other	478
12/02/2018	12/02/2018	1	O'Brien A Mr	Other	473
06/03/2018	06/03/2018	1	O'Brien A Mr	Other	451
09/03/2018	09/03/2018	1	O'Brien A Mr	Other	448
27/03/2018	27/03/2018	1	O'Brien A Mr	Other	430
30/03/2018	30/03/2018	1	O'Brien A Mr	Other	427
06/04/2018	06/04/2018	1	O'Brien A Mr	Other	420
03/05/2018	03/05/2018	1	O'Brien A Mr	Other	393
17/05/2018	17/05/2018	1	O'Brien A Mr	Other	379
18/05/2018	18/05/2018	1	O'Brien A Mr	Other	378
18/05/2018	18/05/2018	1	O'Brien A Mr	Other	378
25/05/2018	25/05/2018	1	O'Brien A Mr	Other	371

29/05/2018	29/05/2018	1	O'Brien A Mr	Other	367
12/01/2015	12/01/2015	1	O'Brien A Mr	Other	1600
13/01/2015	13/01/2015	1	O'Brien A Mr	Other	1599
29/01/2015	29/01/2015	4	O'Brien A Mr	Other	E
30/12/2014	30/12/2014	1	O'Brien A Mr	Other	1524
11/05/2015	11/05/2015	1	O'Brien A Mr 12/06/2019	Other	1481
27/07/2015	27/07/2015	1	O'Brien A Mr	Other	1404
17/08/2015	17/08/2015	1	O'Brien A Mr	Other	1383
24/08/2015	24/08/2015	1	O'Brien A Mr	Other	1376
04/09/2015	04/09/2015	1	O'Brien A Mr	Other	1365
04/09/2015	04/09/2015	1	O'Brien A Mr	Other	1365
19/11/2015	19/11/2015	1	O'Brien A Mr	Other	1289
23/11/2015	23/11/2015	1	O'Brien A Mr	Other	1285
24/11/2015	24/11/2015	1	O'Brien A Mr	Other	1284
02/02/2016	02/02/2016	1	O'Brien A Mr	Other	1214
07/03/2016	07/03/2016	1	O'Brien A Mr	Other	1180
08/03/2016	08/03/2016	1	O'Brien A Mr	Other	1179
22/03/2016	22/03/2016	1	O'Brien A Mr	Other	1165
15/04/2016	15/04/2016	1	O'Brien A Mr	Other	1141
08/08/2016	08/08/2016	1	O'Brien A Mr	Other	1026
24/09/2016	24/09/2016	1	O'Brien A Mr	Other	979
15/12/2016	15/12/2016	1	O'Brien A Mr	Other	897
06/01/2017	06/01/2017	1	O'Brien A Mr	Other	875
13/03/2017	13/03/2017	1	O'Brien A Mr	Other	809
03/04/2017	03/04/2017	1	O'Brien A Mr	Other	788
25/04/2017	25/04/2017	1	O'Brien A Mr	Other	766
30/05/2017	30/05/2017	1	O'Brien A Mr	Other	731
05/06/2017	05/06/2017	1	O'Brien A Mr	Other	725
06/07/2017	06/07/2017	1	O'Brien A Mr	Other	694
25/08/2017	25/08/2017	1	O'Brien A Mr	Other	644
26/09/2017	26/09/2017	1	O'Brien A Mr	Other	612
01/09/2016	05/10/2017	1	O'Brien A Mr	Other	603
17/10/2017	17/10/2017	1	O'Brien A Mr	Other	591
08/01/2018	08/01/2018	1	O'Brien A Mr	Other	508
09/01/2018	09/01/2018	1	O'Brien A Mr	Other	507
09/02/2018	09/02/2018	1	O'Brien A Mr	Other	476
15/03/2018	15/03/2018	1	O'Brien A Mr	Other	442
09/04/2018	09/04/2018	1	O'Brien A Mr	Other	417
21/05/2018	21/05/2018	1	O'Brien A Mr	Other	375

Timebands	TRUST RESPONSE - has record been reviewed	1st letter sent
54-60 month	CFNR	
42-48 months	CFNR	23/07/2019
42-48 months	CFNR	
36-42 months	CFNR	
36-42 months	CFNR	23/07/2019
36-42 months	CFTE	
36-42 months	CFNR	
30-36 months	CFNR	
30-36 months	CFNR	23/07/2019
30-36 months	CFNR	
18 - 24 months	CFNR	
18 - 24 months	CFNR	25/07/2019
18 - 24 months	CFNR	25/07/2019
12- 18 months	CFNR	25/07/2019
12- 18 months	CFNR	25/07/2019
12- 18 months	CFNR	25/07/2019
12- 18 months	CFNR	25/07/2019
54-60 month		
54-60 month		
54-60 month		23/07/2019
54-60 month		
54-60 month		
48-54 months		23/07/2019
48-54 months		
48-54 months		
48-54 months		
48-54 months		
48-54 months		
48-54 months		
48-54 months		
48-54 months		23/07/2019
42-48 months		
42-48 months		23/07/2019
42-48 months		
42-48 months		23/07/2019
42-48 months		
42-48 months		23/07/2019
36-42 months		
36-42 months		25/07/2019
36-42 months		
36-42 months		
36-42 months		
36-42 months		

36-42 months		23/07/2019
36-42 months		
36-42 months		23/07/2019
36-42 months		
30-36 months		23/07/2019
30-36 months		
30-36 months		23/07/2019
30-36 months		23/07/2019
30-36 months		23/07/2019
30-36 months		
30-36 months		
24-30 months		
24-30 months		24/07/2019
18 - 24 months		
18 - 24 months		
18 - 24 months		25/07/2019
18 - 24 months		25/07/2019
18 - 24 months		25/07/2019
18 - 24 months		25/07/2019
18 - 24 months		25/07/2019
18 - 24 months		25/07/2019
18 - 24 months		25/07/2019
12- 18 months		25/07/2019
12- 18 months		25/07/2019
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12- 18 months		25/07/2019
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12- 18 months		25/07/2019
12- 18 months		25/07/2019
12- 18 months		25/07/2019
12- 18 months		

12- 18 months		25/07/2019
48-54 months		23/07/2019
48-54 months		
48-54 months		
48-54 months		23/07/2019
48-54 months		
42-48 months		
42-48 months		23/07/2019
42-48 months		23/07/2019
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42-48 months		23/07/2019
42-48 months		23/07/2019
42-48 months		23/07/2019
42-48 months		
36-42 months		23/07/2019
36-42 months		
36-42 months		23/07/2019
36-42 months		
36-42 months		23/07/2019
30-36 months		23/07/2019
30-36 months		
24-30 months		
24-30 months		23/07/2019
24-30 months		23/07/2019
24-30 months		23/07/2019
24-30 months		
18 - 24 months		24/07/2019
18 - 24 months		
18 - 24 months		24/07/2019
18 - 24 months		25/07/2019
18 - 24 months		
18 - 24 months		25/07/2019
18 - 24 months		25/07/2019
12- 18 months		25/07/2019
12- 18 months		25/07/2019
12- 18 months		25/07/2019
12- 18 months		25/07/2019
12- 18 months		25/07/2019
12- 18 months		

Comments
REMOVE AS PER CONS - ALREADY REMOVED
I PASSED 2 STONES BACK IN FEB THIS YEAR.
BEING SEEN BY MR HAYNES - HE DONE PROCEDURE IN 2018
I am ok at the moment with taking my medication. If it stays like this im happy enough.
NOT ANY WORSE THAN IT WAS 10 YEARS AGO
NLR
still required
still required
still required
still required
DISAPPOINTED HE IS WAITING 4 YRS
still required
PT TREATED AS EMERGENCY - WL ALREADY CLOSED
Has an OPD apt for 22/07/19
STILL REQUIRED
STILL REQUIRED
STILL REQUIRED
STILL REQUIRED
STILL REQUIRED
HAVING A REVIEW BEFORE SURGEY
STILL REQUIRED
I WOULD LIKE TO GET ANOTHER ULTRA SOUND AS IT HAS BEEN A LONG TIME NOW, THANK YOU.
STILL REQUIRED
CURRENT INPATIENT STH
STILL REQUIRED
STILL REQUIRED
STILL REQUIRED

STILL REQUIRED
STILL REQUIRED
Mr O'Brien had contacted patient already to say they will be called July/August
I would like it to take place as soon as possible as my condition has got a lot worse.
STILL REQUIRED
STILL REQUIRED
STLL REQUIRED
STILL REQUIRED
STILL REQUIRED - pt is going to put in a complaint
WANTS ASAP. WILL TAKE A CANCELLATION
I have now been on the urology for just over two years. See chronological summary below: 01/06/17 - reffered by my gp to urology. 30/06/17 - CT urogram done at CAH. 06/10/17 - cystoscopy successfully completed following three cancellation due to urine infections. 17/11/17 - irregular heart beat detected pre-op clinic.
HAD PRE OP IN 2016- 3 YRS AGO !!!
NEEDS TRANSPORT- ADDED TO PAS
I STILL WANT TO HAVE SURGERY BECAUSE SOMETIMES I FEEL SICK IN MY OPERATION.
I HOPE TO GET A DATE ASAP
WANT THIS ASAP, STILL HAVE TO TAKE TABLETS
DESPERATELY NEED THIS DONE. WAS TOLD MAY OR JUNE 2018
HAS M.S, HAS PROBLEMS WITH BLADDER & BOWELS, HAS BEEN TAKEN OFF TECFAERA(sic) 240MG
I STILL NEED THE OPERATION MY CONDITION IS GETTING WORSE AS TIME GOES ON.
still required

Have wheelchair under repair, have to wait for a new one
pt wants to see Mr O'Brien in OPD CLINIC - Disgusted hes been waiting 4 years and no one has contacted him or been foloowed up with any scans
PROCEDURE COMPLETE 18/07/19
PROCEDURE COMPLETED
PT WOULD LIKE TO BE REVIEWED IN CLINIC TO SEE IF SURGERY STILL REQUIRED
NOT SURE IF STILL REQUIRED, GOING TO ASK SECRETARY
DECEASED
STILL REGUIRED IF NECESSARY
date for 22/08/19
YES, I STILL WANTS TO HAVE SURGERY
Pt unsure if surgery is still required - would like seen again in OPD to discuss
WOULD I HAVE TO WEAR A CATHETER(SHORT TIME OR LONG TIME)?
Pt unsure if surgery is still required - would like seen again in OPD to discuss
DECEASED
Preadmitted for17/07/19
PREADMITTED 18/07/19
PROCEDURE COMPLETED 08/07/19
PROCEDURE COMPLETED 15/07/19
Personal Information redacted by USI IS AT BLUESTONE CAH
CURRENTLY UNDER MEDICAL INVESTIGATIONS
PROCEDURE DONE 08/07/19
procedure completed 14/07/19

Aimee Crilly

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

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 CAHE Personal Information redacted by the USI

Thanks Wendy

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

[redacted] *(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:
Personal Information redacted by USI rnal)
(External)
(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 CAHE 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.

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Regards

Wendy

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

From: Corrigan, Martina
Sent: 23 September 2019 06:40
To: Haynes, Mark; O'Brien, Aidan; Clayton, Wendy
Cc: Carroll, Ronan
Subject: RE: Personal Information redacted by the USI CAHE 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:
Personal Information redacted by USI rnal)
(External)
(Mobile)

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

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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: Personal Information redacted by the USI CAHE 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.
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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.

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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: Haynes, Mark [redacted]
Sent: 24 September 2019 16:29
To: Clayton, Wendy; Corrigan, Martina; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted] CAHE [redacted]

With regards the outpatient validation, what communication / agreements have been made with my primary care AMD colleagues (to whom the patients are being discharged back to) regarding the process and similarly with the clinical teams whose patients are being contacted?

Mark

From: Clayton, Wendy
Sent: 23 September 2019 11:14
To: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted] CAHE [redacted]

Hi Martina

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Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC
Tel: [redacted]
Mo

From: Corrigan, Martina
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To: Haynes, Mark; O'Brien, Aidan; Clayton, Wendy
Cc: Carroll, Ronan
Subject: RE: [redacted] CAHE [redacted]

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Craigavon Area Hospital

Telephone:
Personal Information redacted by USI rnal)
(External)
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Subject: RE: Personal Information redacted by the USI CAHE Personal Information redacted by the USI

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Thank you,

Aidan.

Aimee Crilly

From: O'Brien, Aidan [redacted]
Sent: 24 September 2019 16:37
To: Haynes, Mark
Subject: RE: [redacted]

Mark,

I have experienced all of this many times before during these past 27 years.
The bizarre aspect of outpatient revalidation is that a letter is sent twice to the patient.
If a response is not received, a letter is then sent only to the GP advising that their patient has been discharged back to their care.
Now I know this to be a fact that the GP is of the belief that their patient has been discharged with their consent, while the patient may be oblivious to that being so!
You couldn't write the script!

Aidan

From: Haynes, Mark
Sent: 24 September 2019 16:29
To: Clayton, Wendy; Corrigan, Martina; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted]

With regards the outpatient validation, what communication / agreements have been made with my primary care AMD colleagues (to whom the patients are being discharged back to) regarding the process and similarly with the clinical teams whose patients are being contacted?

Mark

From: Clayton, Wendy
Sent: 23 September 2019 11:14
To: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted]

Hi Martina

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Regards

Wendy

Aimee Crilly

From: O'Brien, Aidan [redacted]
Sent: 24 September 2019 17:22
To: Clayton, Wendy
Cc: Devlin, Louise; Haynes, Mark; Corrigan, Martina
Subject: RE: [redacted] CAHE [redacted]

Wendy,

I do appreciate you providing this information.
In essence, the most important word in these documents is the discharge criterion of the procedure / review / appointment not being 'required'.
The examples provided prove again, as proven before, that the patient does not know whether the procedure / review / appointment is advisable or 'required'.
Administratively driven validation exercises are unsafe.
I note that the documents do include a provision for review of the process in September 2019.
I believe that it would be prudent to advise David Mc Cormack of our concerns.
Lastly, not all of the exercise is unsafe or inappropriate.
If the patient is deceased, has changed address, has had the said procedure performed elsewhere etc, such information would be worth pursuing.
I just think that the criterion '....is not required' should be excluded,

Enough said!

Aidan.

From: Clayton, Wendy
Sent: 24 September 2019 16:57
To: Haynes, Mark; Corrigan, Martina; O'Brien, Aidan
Cc: Carroll, Ronan; Devlin, Louise
Subject: RE: [redacted] CAHE [redacted]

Please see original communication from the Board to the AD's and HOS on the 16 July. I am unsure if there was communication with the primary care AMD.

We are concentrating on OPD admin validation and have nearly completed sending letters to all urgent and routine patients who are waiting over 52 weeks. If they decide they do not want their appointment then a letter is sent to their GP to advise same.

I will discuss your concerns with Louise who is the Trust led and the link with HSCB.

Regards

Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC
Tel: [redacted]
Mob: [redacted]

From: Haynes, Mark
Sent: 24 September 2019 16:29
To: Clayton, Wendy; Corrigan, Martina; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: Personal Information redacted by the USI CAHE Personal Information redacted by the USI

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ATI CS/SEC
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From: Corrigan, Martina
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Craigavon Area Hospital

Telephone:
EXT Personal Information redacted by USI (Internal)
Personal Information redacted by USI (External)
Personal Information redacted by USI (Mobile)

From: Haynes, Mark
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To: Corrigan, Martina
Cc: Haynes, Mark
Subject: Personal Information redacted by the USI CAHE Personal Information redacted by the USI

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Aidan.

Personal Information redacted by the USI

From: Haynes, Mark Personal Information redacted by USI
Sent: 24 September 2019 20:44
To: O'Brien, Aidan
Subject: RE: Personal Information redacted by the USI CAHE Personal Information redacted by the USI

In 2 weeks time I am in a quarterly liaison meeting between primary care and the trust. I can guarantee that at that meeting I will have major concerns raised to me and demands to know why I organised this – with the medical director looking to me to provide the answers. Pisses me off, but at least on this occasion I know beforehand (I didn't at the last one where a different speciality 'validation exercise' was raised).

Mark

From: O'Brien, Aidan
Sent: 24 September 2019 16:37
To: Haynes, Mark
Subject: RE: Personal Information redacted by the USI CAHE Personal Information redacted by the USI

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Cc: Carroll, Ronan
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Wendy

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

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Craigavon Area Hospital

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Personal Information redacted by USI (External)
(Mobile)

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

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Subject: [redacted] Personal Information redacted by USI

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Thank you,

Aidan.

Aimee Crilly

From: Haynes, Mark [redacted]
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]

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 an 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]

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: Personal Information redacted by USI
Mob: Personal Information redacted by 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: Personal Information redacted by 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 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 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 USI
Mob: Personal Information redacted by 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 USI

Thanks Wendy

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

(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

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To: Corrigan, Martina
Cc: Haynes, Mark
Subject: [redacted] Personal Information redacted by 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 <[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: 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 an 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: 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: Personal Information redacted by the USI
Mob: 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: 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?

[redacted] *(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)
(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 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 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: 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 Personal Information (Internal)
Personal Information redacted by the USI (External)
(Mobile)

From: Haynes, Mark
Sent: 22 September 2019 21:05
To: O'Brien, Aidan; Corrigan, Martina
Subject: RE: 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: 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.
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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.

Southern Health and Social Care Trust

Cancer Performance Dashboard Report December 2017

CANCER PERFORMANCE SUMMARY REPORT – December 2017

Inter-Trust Transfer Breaches – 62 Day

	Dec -16	Jan -17	Feb -17	Mar -17	Apr -17	May 17	Jun -17	July -17	Aug -17	Sep -17	Oct -17	Nov -17	Dec -17	Total
Urology	2	2	1	4	1	4	6	5	4	6	2	1	1	**39**

Internal Breaches – 62 Day

	Dec -16	Jan -17	Feb -17	Mar-17	Apr-17	May-17	Jun-17	July-17	Aug -17	Sept 17	Oct -17	Nov -17	Dec- 17	Total
Urology	3	3	4	4	2	9	7	6	4	5	7	5	6	**65**

Day 31 Breaches

	Dec-16	Jan -17	Feb -17	Mar-17	Apr-17	May-17	Jun-17	July -17	Aug -17	Sept-17	Oct-17	Nov -17	Dec -17	Total
Urology	0	0	0	0	0	2	0	0	0	0	1	0	0	**3**

Summary of Breach Reports – Dec 2017

Modality	Internal/External	Reason
Urology	Internal (DM)	• Treatment completed on D68 - Anti-cancer drug/Chemotherapy. **Delays in Pathway - 19 day delay for 1st OPD, 16 day delay for MRI, 12 day delay for TRUSB, 9 day delay for MDM, 12 day delay for Consultant review, 12 day delay for treatment.** Pathway - US D0, 1st OPD D19, MRI D35, TRUSB D47, MDM D56, Consultant Review D68, Treatment D68.
Urology	Internal (BO)	• **Treatment completed on D81 - Active Monitoring. Delays in Pathway - 27 day delay for 1st OPD, 14 day delay for MRI, 8 day delay for MRI to be reported on, 20 day delay for Consultant review.** Pathway - 1st OPD D27, MRI D41, TRUSB D53, MDM D61, Consultant review D81, Treatment D81.
Urology	Internal (COM)	• **Treatment completed on D74 - Anti-cancer drug/Chemotherapy. Delays in Pathway - 24 day delay for 1st OPD, 16 day delay for MRI, 8 day delay for MRI to be reported on, 14 day delay for TRUSB.** Pathway - 1st OPD D24, MRI D40, Consultant review D58, TRUSB D62, MDM D68, Consultant review D73, Treatment D74
Urology	Internal (BD)	• **Treatment completed Day 111 - Active Monitoring. Reason for delay - 1st OPD D34, 25 day delay for TRUSB & then 36 day delay for review with Consultant.** Pathway - 1st OPD D34, MRI D40, TRUSB D65, and pathology reported D74, MDM D75, review Day 111 - Active Monitoring.

		delay for TRUSB, 21 day wait for review with Consultant, followed by 14 day wait for review to commence hormones. Pathway - 1st OPD D29, MRI D39, TRUSB D56, path reported Day 59, MDM D65, review Day 86, Bone scan Day 101, MDM D108, review Day 121
Urology	Internal (HQ)	• **Treatment completed - D73 - Hormones. Reason for delay - 1st OPD D22, 11 day wait for MRI to be reported and 6 day wait for review with Consultant.** Pathway - 1st OPD D22, MRI D27, MRI reported D38, TRUSB D58, path reported Day 65, MDM D67, review Day 73.
URO	External (JM)	• **Treatment completed on D173 - Brachytherapy. ITT on D63. Delays in Pathway - 21 day delay for 1st OPD, 14 day delay on MDM as pathology not available, 11 day delay for Consultant review, 31 day delay from ITT to Consultant appointment due to availability, 71 day delay for Brachytherapy due to patient medication and availability.** Pathway - 1st OPD D21, MRI D28, Consultant review D37, TRUSB D37, MDM DS1, Consultant review D62, ITT D63, Oncology appointment D100, Oncology review D101, Cardiology appointment D101, Treatment D173.

Risk Areas for February/March 2018

Internal

- Late updating of routine/urgent outpatient referrals within 48 hours
- Capacity for 1st RF appointment for Urology,
- Reporting of diagnostics (CT 's & MRI scanning)
- Urology Pathway
- Radiology/Pathology cover @ MDM's due to annual leave and a deputy not being able to attend. The cases are still being listed for discussion with reports. Cases only being deferred and escalated if they are unable to be discussed.
- Urology – TURBT's from 01.01.18 are to be treated as a diagnostic procedure and not first definitive treatment. This will have an impact on 62D performance. There has been no regional agreement regarding this – to be discussed at Cancer Operational Meeting on 31.01.18.

External

- Brachytherapy
- Robotic Prostatectomy

REFERRAL – SUSPECT CANCER Nov 2016 – Dec 2017

62 DAY REFERRALS	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov-17	Dec-17
Testicular Cancer	6	6	12	7	3	6	5	8	8	6	6	2	9	**10**
Urological Cancer	185	149	194	142	129	143	138	147	119	132	138	161	163	**145**

31 DAY REFERRALS	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr-17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17
Testicular Cancer	0	0	0	0	2	0	0	1	0	0	0	0	3	**0**
Urological Cancer	65	52	76	87	81	66	73	75	73	70	58	73	77	**73**

Red Flag Outpatient DNA

	Oct- 17			Nov- 17			Dec- 17		
Speciality	Attendances	DNA& CND	Oct 17 %DNA/ CND	Attendances	DNA& CND	Nov 17 %DNA/ CND	Attendances	DNA& CND	Dec 17 %DNA/ CND
Urology	176	6	3%	188	7	4%	114	9	6%

62 Day Confirmed Cancers

Tumour Site	Nov-16	Dec-16	Jan - 17	Feb - 17	Mar-17	Apr-17	May-17	Jun -17	July -17	Aug -17	Sept 17	Oct 17	Nov 17	Dec 17	Total
Testicular	0	3	3	3	0	0	0	3	0	0	0	1	1	0	**14**
Urology	9	10	14	14	8	10	14	14	11	6	18	7	9	11	**155**

31 Day Confirmed Cancers

Tumour Site	Nov-16	Dec-16	Jan -17	Feb -17	Mar-17	Apr-17	May-17	Jun-17	July -17	Aug -17	Sep -17	Oct -17	Nov-17	Dec 17	Total
Urology	23	9	22	14	14	8	16	16	17	18	17	16	15	7	**212**

62D % cancer conversion Oct 17 – Dec 17

Tumour Site	No. of referrals	No. of confirmed cancers	% conversion
Testicular	21	2	10%
Urology	469	27	6%

62D % cancer conversion July – Sept 17

Tumour Site	No. of referrals	No. of confirmed cancers	% conversion
Testicular	20	0	0%
Urology	389	35	9%

62D % cancer conversion April – June 17

Tumour Site	No. of referrals	No. of confirmed cancers	%conversion
Testicular	19	3	16%
Urology	428	38	9%

62D % cancer conversion July – September 16

Tumour Site	No. of referrals	No. of confirmed cancers	%conversion
Testicular	16	1	6%
Urology	403	39	10%

Southern Health and Social Care Trust

Cancer Performance Dashboard Report December 2017

CANCER PERFORMANCE SUMMARY REPORT – December 2017

	% Breast 2WW	% 31D Performance	% 62D Performance
October 17	21.7%	97%	69%
November 17	21.6%	96%	75.3%
December 17		97%	74.5%

Inter-Trust Transfer Breaches – 62 Day

	Dec -16	Jan -17	Feb -17	Mar -17	Apr -17	May 17	Jun -17	July -17	Aug -17	Sep -17	Oct -17	Nov -17	Dec -17	**Total**
Breast	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Colorectal	0	2	0	0	1	0	1	2	1	0	1	1	1	**10**
Head & Neck	0	0	1	0	0	0	0	0	0	0	0	0	0	**1**
Haematology	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Gynae	0	0	1	0	0	2	0	1	2	0	0	1	0	**7**
Lung	2	2	3	2	1	1	3	2	2	2	2	2	0	**24**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Skin	0	0	0	0	1	0	1	0	0	1	1	0	1	**5**
UGI	1	0	2	5	2	2	1	0	1	3	2	1	0	**20**
Urology	2	2	1	4	1	4	6	5	4	6	2	1	1	**39**
Oral Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total	5	6	8	11	6	9	12	10	10	12	8	7	3	**107**

Internal Breaches – 62 Day

	Dec -16	Jan -17	Feb -17	Mar-17	Apr-17	May-17	Jun-17	July-17	Aug -17	Sept 17	Oct -17	Nov -17	Dec- 17	**Total**
Breast	0	0	0	0	0	0	2	3	1	0	5	6	4	**21**
Colorectal	0	0	0	1	1	1	1	1	2	2	1	3	1	**14**
ENT	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Gynae	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Haem	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Lung	0	0	1	0	0	1	1	2	0	1	0	0	0	**6**
Skin	0	0	0	0	0	0	0	0	0	0	1	0	0	**1**
UGI	0	0	1	0	2	0	1	2	0	0	0	1	0	**7**
Urology	3	3	4	4	2	9	7	6	4	5	7	5	6	**65**
Total	3	3	6	5	5	11	12	14	7	9	14	15	11	**115**

Day 31 Breaches

	Dec-16	Jan -17	Feb -17	Mar-17	Apr-17	May-17	Jun-17	July -17	Aug -17	Sept-17	Oct-17	Nov -17	Dec -17	**Total**
Breast	0	1	1	0	0	0	1	0	0	0	3	2	2	**10**
Colorectal	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**
ENT	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Gynae	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Lung	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Skin	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**
UGI	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Urology	0	0	0	0	0	2	0	0	0	0	1	0	0	**3**
Total	1	1	1	0	0	2	1	2	0	0	4	2	2	**16**

Modality	Internal/External	Reason
Urology	Internal (DM)	• **Treatment completed on D68 - Anti-cancer drug/Chemotherapy. Delays in Pathway - 19 day delay for 1st OPD, 16 day delay for MRI, 12 day delay for TRUSB, 9 day delay for MDM, 12 day delay for Consultant review, 12 day delay for treatment.** Pathway - US D0, 1st OPD D19, MRI D35, TRUSB D47, MDM D56, Consultant Review D68, Treatment D68.
Lower GI	Internal (DL)	• **Treatment completed on D98 - Surgery. Delays in Pathway - 22 day delay for 1st OPD, 9 day delay for OGD, 27 day delay for CTC, 16 day delay for Colonoscopy, 19 day delay for CT (although CT never requested from MDM on 26/10/17), 12 day delay for treatment.** Pathway - 1st OPD D22, OGD D31, CTC D49, MDM D58, Colonoscopy D74, MD D79, Consultant review D86, Treatment D98, MDM D107.
Breast	Internal (LMH)	• **Treatment completed on D72 - Surgery. Delays in Pathway - 31 day delay for 1st OPD.** Pathway - 1st OPD D31, USS BX D31, Mammogram D31, MDM D36, Consultant review D37, MDM D39, and Treatment D72.
Urology	Internal (BO)	• **Treatment completed on D81 - Active Monitoring. Delays in Pathway - 27 day delay for 1st OPD, 14 day delay for MRI, 8 day delay for MRI to be reported on, 20 day delay for Consultant review.** Pathway - 1st OPD D27, MRI D41, TRUSB D53, MDM D61, Consultant review D81, Treatment D81.
Breast	Internal (IC)	• **Treatment completed on D86 - Surgery. Delays in Pathway - 31 day delay for 1st OPD, 17 day delay for MRI, 8 day delay for MDM as MRI not reported, 19 day delay for Treatment**. Pathway - 1st OPD D31, USS BX D31, Mammogram D31, MDM D36, Consultant review D37, MRI D48, MDM D52 deferred, USS BX D60, Mammogram D60, MDM D60, MDM D67, Treatment D86
Breast	Internal (CR)	• **Treatment completed on D78 - Surgery. Delays in Pathway - 38 day delay for 1st OPD, 13 day delay for MRI, MDM deferred for 1 week D56, and 12 day delay for treatment.** Pathway - 1st OPD D38, USS BX D38, MDM D43, CT D48, MRI D51, MDM D56 deferred, Bone scan D58, MDM D64, FNA D64, MDM D66, Treatment D78.
Breast	Internal (LMT)	• **Treatment completed on D76 - Anti-cancer Drug/Chemotherapy. Delays in Pathway - 36 day delay for 1st OPD, 19 day delay for MRI, 14 Day delay for treatment.** Pathway - 1st OPD D36, Mammogram D36, USS BX D36, MDM D41, MDM D48, ITT D49, MRI D60 Oncology appointment D61, MDM D62, DTT D69, Treatment D76.
Urology	Internal (COM)	• **Treatment completed on D74 - Anti-cancer drug/Chemotherapy. Delays in Pathway - 24 day delay for 1st OPD, 16 day delay for MRI, 8 day delay for MRI to be reported on, 14 day delay for TRUSB**. Pathway - 1st OPD D24, MRI D40, Consultant review D58, TRUSB D62, MDM D68, Consultant review D73, Treatment D74

Urology	Internal (BD)	• **Treatment completed Day 111 - Active Monitoring. Reason for delay - 1st OPD D34, 25 day delay for TRUSB & then 36 day delay for review with Consultant**. Pathway - 1st OPD D34, MRI D40, TRUSB D65, and pathology reported D74, MDM D75, review Day 111 - Active Monitoring**.**
Urology	Internal (CMcC)	• **Treatment completed Day 121 - Hormone Therapy. Reason for delay - 1st OPD D29, 17 day delay for TRUSB, 21 day wait for review with Consultant, followed by 14 day wait for review to commence hormones.** Pathway - 1st OPD D29, MRI D39, TRUSB D56, path reported Day 59, MDM D65, review Day 86, Bone scan Day 101, MDM D108, review Day 121
Urology	Internal (HQ)	• **Treatment completed - D73 - Hormones. Reason for delay - 1st OPD D22, 11 day wait for MRI to be reported and 6 day wait for review with Consultant.** Pathway - 1st OPD D22, MRI D27, MRI reported D38, TRUSB D58, path reported Day 65, MDM D67, review Day 73.
LGI	External (GH)	• **Treatment completed on D90 - Chemoradiotherapy. ITT on D49. Delays in Pathway - 18 day delay for 1st OPD, 13 day delay for Colonoscopy, 10 day delay for MRI, 11 day delay for CT, 18 day delay for Oncology appointment as 1st OPD was cancelled, and 23 day delay for Treatment as patient had to attend BWS for chemo assessment.** Pathway - 1st OPD D18, Colonoscopy D31, MRI D41, CT D42, MDM D42, ITT D49, PET D60, MDM D63, Oncology appointment D67, Treatment D90.
URO	External (JM)	• **Treatment completed on D173 - Brachytherapy. ITT on D63. Delays in Pathway - 21 day delay for 1st OPD, 14 day delay on MDM as pathology not available, 11 day delay for Consultant review, 31 day delay from ITT to Consultant appointment due to availability, 71 day delay for Brachytherapy due to patient medication and availability.** Pathway - 1st OPD D21, MRI D28, Consultant review D37, TRUSB D37, MDM D51, Consultant review D62, ITT D63, Oncology appointment D100, Oncology review D101, Cardiology appointment D101, Treatment D173.
Skin	External (POH)	• **Treatment completed on D85 - Surgery. ITT on D31. Delays in Pathway - 12 day delay for Consultant review, 34 day delay for Plastics 1st OPD, 20 day delay for Treatment.** Pathway - 1st OPD D8, Shave Biopsy D8, MDM D16, and Consultant review D28, ITT D31, Plastics appointment D65, Treatment D85**.**

Breast Surgeons have agreed to come down from SET to help reduce current waiting times. Ms Mathers is due to return to SHSCT in February 2018.

Internal

- Breast screening and assessment, routine symptomatic breast service
- Breast deferrals at MDM due to a change in Radiologist's schedule so MRI's are unable to be viewed prior to MDM, so most will be waiting 7-9 days before being discussed at MDM with staging results.
- Late updating of routine/urgent outpatient referrals within 48 hours
- Outpatient Hysteroscopies – Then having to proceed to inpatient Hysteroscopy – lengthening pathway
- Capacity for 1st RF appointment for Urology, Lung, General Surgery & Ultrasound Guided Biopsy procedures
- Barium Swallow/Meal
- Reporting of diagnostics (CT 's & MRI scanning)
- Capacity issues with CT Colonography's – There has been a request for 4 additional slots per weeks.
- Urology Pathway
- Radiology/Pathology cover @ MDM's due to annual leave and a deputy not being able to attend. The cases are still being listed for discussion with reports. Cases only being deferred and escalated if they are unable to be discussed.
- Urology – TURBT's from 01.01.18 are to be treated as a diagnostic procedure and not first definitive treatment. This will have an impact on 62D performance. There has been no regional agreement regarding this – to be discussed at Cancer Operational Meeting on 31.01.18.
- Oncology cover – Lung & GU patients – New Locum working in Trust so this service will continue to be provided locally.

External

- Lung and Upper GI patients are at risk due to PET capacity – PET waiting times is around 3 weeks.
- Brachytherapy
- Plastics – Current waiting time is around 3-4 weeks.
- Thoracic Surgery
- Robotic Prostatectomy

REFERRAL – SUSPECT CANCER Nov 2016 – Dec 2017

62 DAY REFERRALS

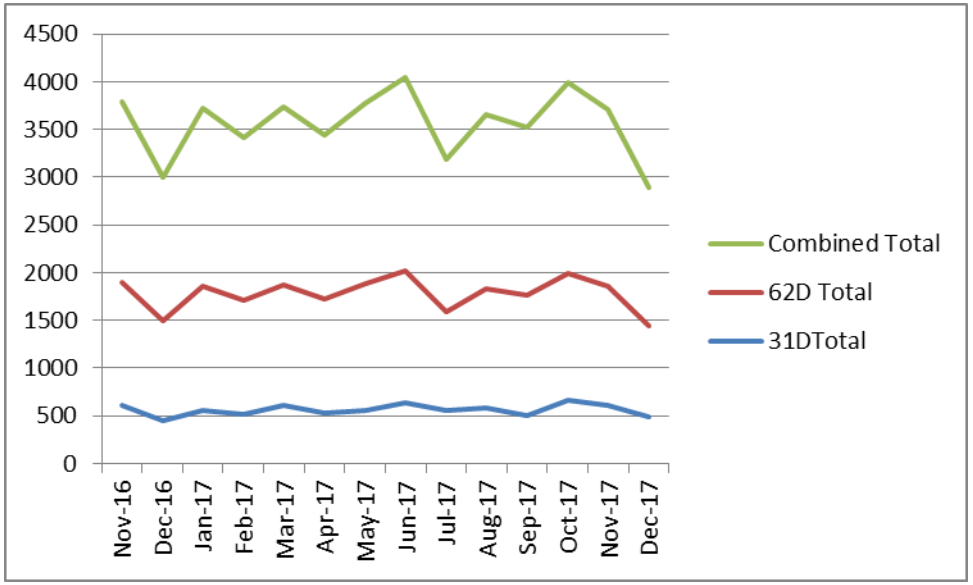
62 DAY REFERRALS	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov-17	Dec-17
Acute Leukaemia	0	0	0	0	0	0	0	1	0	0	2	0	0	**0**
Brain/Central Tumour	4	0	0	5	13	10	13	17	8	11	14	5	6	**5**
Breast Cancer	236	205	252	227	223	215	260	250	213	219	234	289	235	**168**
Children's Cancer	0	1	0	0	0	0	1	0	0	2	0	0	0	**0**
Gynae Cancers	115	112	127	127	118	100	140	110	89	123	120	125	113	**101**
Haematological Cancers	19	12	17	14	22	17	18	13	13	14	12	17	18	**9**
Head/Neck Cancer	90	72	94	84	98	99	116	115	99	101	120	83	78	**58**
Lower Gastrointestinal Cancer	262	200	236	217	229	215	238	268	218	250	219	240	231	**184**
Lung Cancer	50	40	52	47	52	54	56	57	41	25	21	31	24	**22**
Other Suspected Cancer	29	3	16	7	28	14	17	14	18	23	24	19	23	**13**
Sarcomas	0	0	0	3	1	0	0	0	0	1	0	2	3	**0**
Skin Cancers	151	128	165	162	178	180	209	220	205	195	199	178	170	**122**
Testicular Cancer	6	6	12	7	3	6	5	8	8	6	6	2	9	**10**
Upper Gastrointestinal Cancer	133	120	144	141	160	143	124	169	9	142	152	174	163	**118**
Urological Cancer	185	149	194	142	129	143	138	147	119	132	138	161	163	**145**
62D Total	1280	1048	1309	1183	1254	1196	1335	1389	1040	1244	1261	1326	1236	**955**

31 DAY REFERRALS

31 DAY REFERRALS	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr-17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17
Acute Leukaemia	7	2	0	2	6	10	6	5	11	7	17	3	6	**0**
Brain/Central Tumour	19	4	10	7	17	17	16	16	10	22	13	14	6	**10**
Breast Cancer	54	36	43	51	46	58	37	65	53	60	52	69	64	**39**
Children's Cancer	2	4	1	6	2	0	0	0	0	0	0	0	0	**0**
Gynae Cancers	40	35	46	31	50	36	44	41	37	44	41	65	57	**50**
Haematological Cancers	35	38	33	19	29	32	31	26	34	26	18	29	23	**35**
Head/Neck Cancer	21	16	26	26	47	20	32	39	26	31	22	29	36	**26**
Lower Gastrointestinal Cancer	114	96	101	101	127	68	106	135	92	103	86	113	98	**81**
Lung Cancer	83	67	66	51	56	68	65	72	60	71	62	82	61	**39**
Other Suspected Cancer	5	3	2	3	5	1	5	3	4	4	4	5	4	**6**
Sarcomas	2	0	0	0	0	1	0	2	4	3	7	1	1	**2**
Skin Cancers	68	29	62	54	50	49	47	66	69	60	42	82	78	**63**
Testicular Cancer	0	0	0	0	2	0	0	1	0	0	0	0	3	**0**
Upper Gastrointestinal Cancer	98	68	88	84	99	102	94	87	79	86	81	94	103	**92**
Urological Cancer	65	52	76	87	81	66	73	75	73	70	58	73	77	**73**
31DTotal	613	450	554	522	617	528	556	633	552	587	503	681	617	**493**

	Nov 16	Dec 16	Jan 17	Feb17	Mar 17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17
31DTotal	613	450	554	522	617	528	556	633	552	587	503	670	617	**493**
62D Total	1280	1048	1309	1183	1254	1196	1335	1389	1040	1244	1261	1326	1236	**955**
Combined Total	1893	1498	1863	1705	1871	1724	1891	2022	1592	1831	1764	1996	1853	**1448**

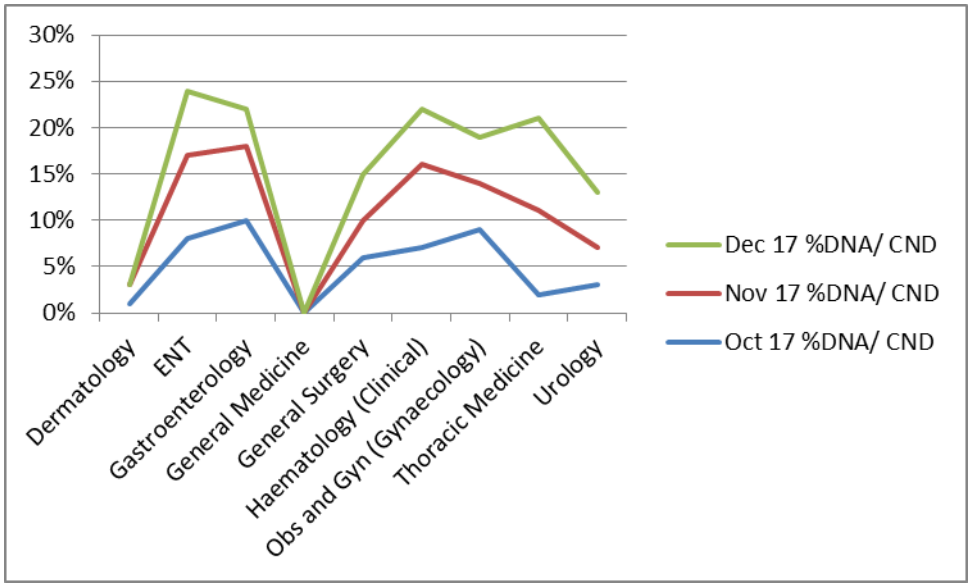
Nov 16 – Dec 17 Suspect Cancer Referrals



Red Flag Outpatient DNA

	Oct- 17			Nov- 17			Dec- 17		
Speciality	Attendances	DNA& CND	Oct 17 %DNA/ CND	Attendances	DNA& CND	Nov 17 %DNA/ CND	Attendances	DNA& CND	Dec 17 %DNA/ CND
Dermatology	140	1	1%	132	2	2%	58	0	0%
ENT	90	8	8%	85	8	9%	77	6	7%
Gastroenterology	67	7	10%	38	6	8%	53	2	4%
General Medicine	0	0	0%	0	0	0%	0	0	0%
General Surgery	570	38	6%	468	21	4%	462	24	5%
Haematology (Clinical)	13	1	7%	21	2	9%	16	1	6%
Obs and Gyn (Gynaecology)	125	12	9%	120	6	5%	91	5	5%
Thoracic Medicine	42	1	2%	44	4	9%	28	3	10%
Urology	176	6	3%	188	7	4%	114	9	6%
	1223	74	6%	1096	56	5%	899	50	6%

Red Flag Outpatient DNA



Confirmed Cancers

62 Day Confirmed Cancers

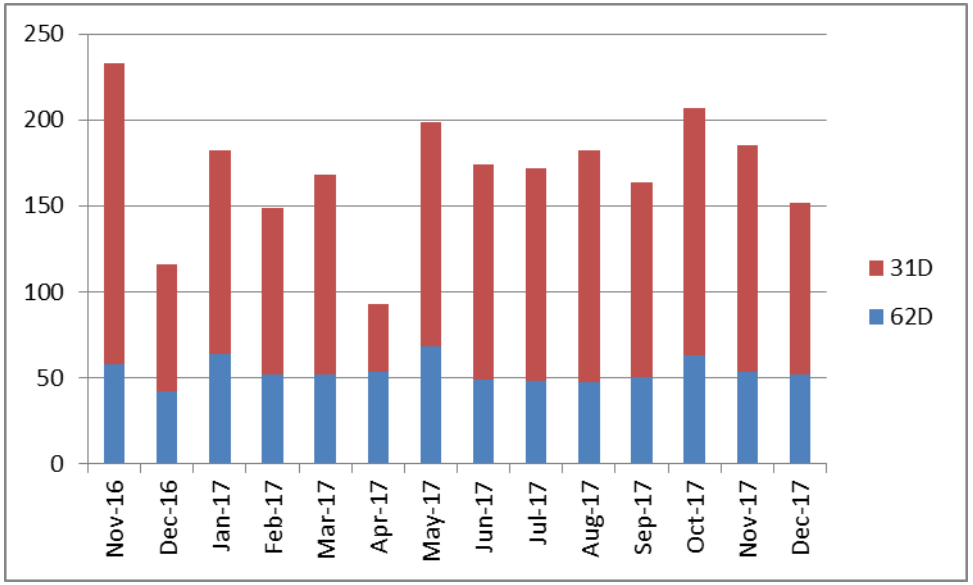
Tumour Site	Nov-16	Dec-16	Jan - 17	Feb - 17	Mar-17	Apr-17	May-17	Jun -17	July -17	Aug -17	Sept 17	Oct 17	Nov 17	Dec 17	Total
Acute Leukaemia	0	0	0	0	0	0	0	0	0	0	2	0	0	0	**2**
Brain	3	0	0	0	0	0	2	0	0	0	0	0	0	0	**5**
Breast	9	3	3	2	4	5	4	1	5	6	4	3	5	5	**59**
Children's	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Gynae	1	3	6	2	6	4	8	6	8	3	6	5	5	7	**70**
Haem	3	1	4	1	1	3	1	0	1	2	1	2	2	2	**24**
Head & Neck	6	3	5	1	8	3	7	3	5	6	1	7	4	5	**64**
LGI	3	2	3	2	5	5	4	6	1	4	2	3	2	0	**42**
Lung	8	5	6	6	10	4	8	6	5	3	5	8	5	1	**80**
Other	1	0	0	0	0	1	0	0	0	2	0	0	0	0	**4**
Sarcomas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Skin	10	5	9	11	5	13	13	5	4	5	5	22	15	16	**138**
Testicular	0	3	3	3	0	0	0	3	0	0	0	1	1	0	**14**
UGI	5	6	11	10	5	5	7	5	8	10	6	5	5	5	**93**
Urology	9	10	14	14	8	10	14	14	11	6	18	7	9	11	**155**
62D Total	58	42	64	52	52	53	68	49	48	47	50	63	53	52	**751**
%62D confirmed	25%	36%	35%	35%	33%	57%	34%	28%	28%	25%	30%	30%	29%	34%	

31 Day Confirmed Cancers

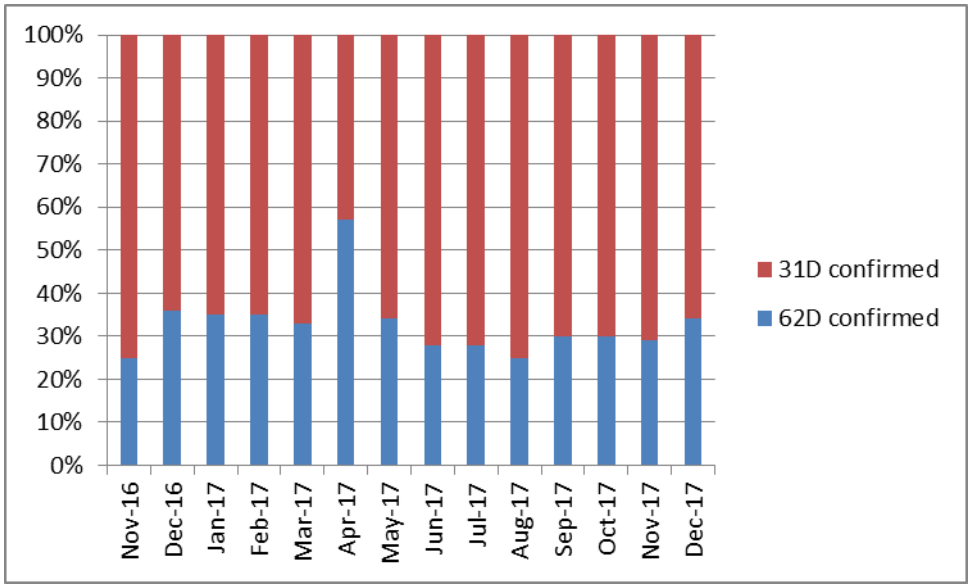
Tumour Site	Nov-16	Dec-16	Jan -17	Feb -17	Mar-17	Apr-17	May-17	Jun-17	July -17	Aug -17	Sep -17	Oct -17	Nov-17	Dec 17	Total
Acute Leukaemia	4	0	0	0	2	0	2	0	5	2	13	5	0	0	**33**
Brain	11	0	0	1	9	0	6	5	0	3	2	2	3	0	**42**
Breast	19	2	3	6	10	0	12	11	9	20	13	11	7	6	**129**
Children's	0	0	0	2	1	6	0	0	0	0	0	0	0	0	**9**
Gynae	14	7	12	2	11	3	5	11	11	3	6	13	19	6	**123**
Haem	26	29	24	13	16	6	26	19	17	19	10	19	15	21	**260**
Head & Neck	3	1	0	4	2	3	10	10	4	4	1	4	7	2	**55**
LGI	8	2	8	6	7	5	11	11	10	8	5	5	7	4	**97**
Lung	27	9	17	15	11	3	11	17	16	32	14	28	20	8	**228**
Other	0	0	0	0	13	0	0	0	0	0	0	0	0	0	**13**
Sarcomas	2	0	0	0	0	0	0	0	0	0	0	1	0	0	**3**
Skin	19	9	22	16	13	2	16	15	21	18	19	31	27	32	**260**
UGI	19	6	10	18	7	4	16	10	14	8	14	9	12	14	**161**
Urology	23	9	22	14	14	8	16	16	17	18	17	16	15	7	**212**
31D Total	175	74	118	97	116	40	131	125	124	135	114	144	132	100	**1625**
%31D confirmed	75%	64%	65%	65%	67%	43%	66%	72%	72%	75%	70%	70%	71%	66%	

Tumour Site	Nov-16	Dec-16	Jan - 17	Feb - 17	Mar-17	Apr -17	May -17	Jun -17	July -17	Aug -17	Sep -17	Oct -17	Nov-17	Dec-17	Total
62D Total	58	42	64	52	52	53	68	49	48	47	50	63	53	52	**751**
31D Total	175	74	118	97	116	40	131	125	124	135	114	144	132	100	**1625**
TOTAL 31D +62D	233	116	182	149	168	93	199	174	172	182	164	207	185	152	**2376**

Number of confirmed cancers Nov 16 – Dec 17



% of Confirmed cancers split between 31/62 Days
Nov 16 – Dec 17



62D % cancer conversion Oct 17 – Dec 17

Tumour Site	No. of referrals	No. of confirmed cancers	% conversion
Acute Leukaemia	0	0	0%
Brain	16	0	0%
Breast	692	13	2%
Children's Cancer	0	0	0%
Gynae	339	17	5%
Haem	44	6	2%
Head & Neck	219	16	7%
LGI	655	5	1%
Lung	77	14	18%
Other	55	0	0%
Sarcoma	5	0	0%
Skin	470	53	11%
Testicular	21	2	10%
UGI	455	15	3%
Urology	469	27	6%

62D % cancer conversion July – Sept 17

Tumour Site	No. of referrals	No. of confirmed cancers	% conversion
Acute Leukaemia	2	2	100%
Brain	33	0	0%
Breast	666	15	2%
Children's Cancer	2	0	0%
Gynae	332	17	5%
Haem	39	4	10%
Head & Neck	320	12	3%
LGI	687	7	1%
Lung	87	13	15%
Other	65	2	3%
Sarcoma	1	0	0%
Skin	599	14	2%
Testicular	20	0	0%
UGI	303	24	8%
Urology	389	35	9%

62D % cancer conversion April – June 17

Tumour Site	No. of referrals	No. of confirmed cancers	%conversion
Acute Leukaemia	1	0	0%
Brain	40	2	5%
Breast	725	10	1.4%
Children's Cancer	1	0	0%
Gynae	350	18	5%
Haem	48	4	8%
Head & Neck	330	13	4%
LGI	721	15	2%
Lung	167	18	11%
Other	45	1	2%
Sarcoma	0	0	0%
Skin	609	31	5%
Testicular	19	3	16%
UGI	436	17	4%
Urology	428	38	9%

62D % cancer conversion July – September 16

Tumour Site	No. of referrals	No. of confirmed cancers	%conversion
Acute Leukaemia	4	0	0%
Brain	25	0	0%
Breast	714	29	4%
Children's Cancer	2	0	0%
Gynae	338	9	3%
Haem	47	3	6%
Head & Neck	297	15	5%
LGI	660	7	1%
Lung	123	16	13%
Other	51	1	2%
Sarcoma	4	0	0%
Skin	547	24	4%
Testicular	16	1	6%
UGI	390	16	4%
Urology	403	39	10%

MDT UROLOGY CANCER MEETING
THURSDAY 08 February 2018
VENUE: TUTORIAL ROOM 1, MEC

PRESENT
Mr Glackin (Chair), Mr O'Brien, Mr Jacob, Dr McClean, Dr Williams, Dr Stewart, Stephanie Reid, Kate O'Neill & Shauna McVeigh.

MINUTES

1. **APOLOGIES**
   Mr Haynes, Mr O'Donoghue.

2. **MINUTES OF LAST MEETING**
   E-mailed to the Urology MDM circulation list on 02 February 2018.

3. **PRESENTATION OF CASES**
   Meeting started @ 2:10pm meeting finished @ 4:.35
   42 cases were listed to be discussed.
   Belfast City linked in.

4. **A.O.B**
   N/A

5. **DATE OF TIME OF NEXT MEETING**
   The next meeting is to take place at 2.15 pm on **Thursday 15 February 2018,** Tutorial Room 1, MEC, CAH, Ennis Room, Belfast & DHH.

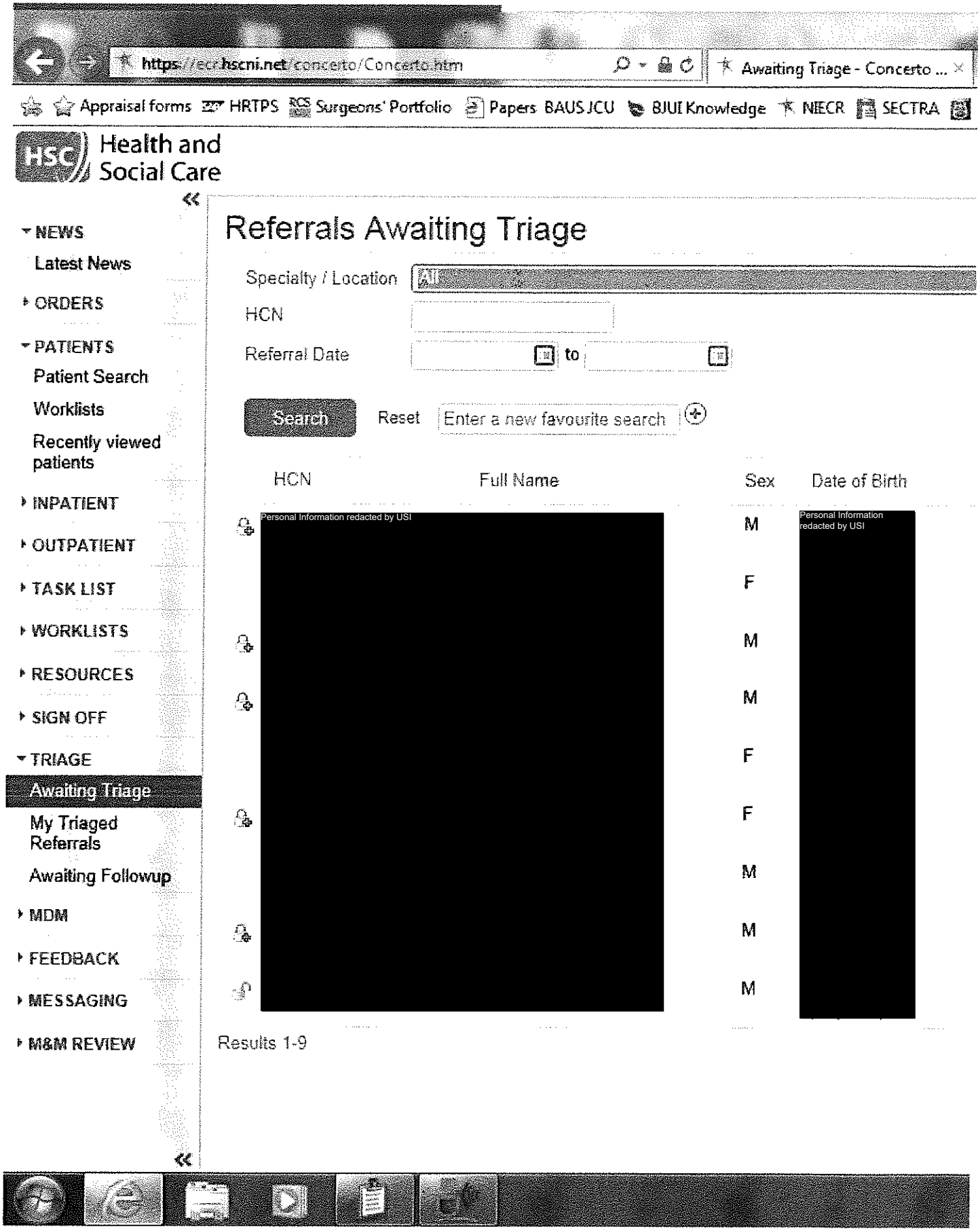
Personal Information redacted by the USI

From: Haynes, Mark Personal Information redacted by USI
Sent: 09 February 2018 17:31
To: O'Brien, Aidan; Young, Michael; Glackin, Anthony; Jacob, Thomas
Subject: e-triage

Evening Aidan / Michael / Tony / Thomas

Please see below screen shot. There are referrals on e-triage that have been assigned to each of you (a couple from me today, some from back to January).

Mark



Personal Information redacted by the USI

From: Elliott, Noleen Personal Information redacted by USI
Sent: 13 February 2018 09:27
To: O'Brien, Aidan
Cc: Doherty, Anna
Subject: FW: Personal Information redacted by USI

Aidan,

Please see e-mail from Anna below. This patient is on your waiting list for TURP since 13/9/16.

Noleen

From: Doherty, Anna
Sent: 12 February 2018 12:13
To: Elliott, Noleen
Subject: Personal Information redacted by USI

Hi Noleen,

This man has come to clinic. He tells me he is on Mr O'Brien's waiting list for TURP. He was pre-assessed in October 2016 but nil since then. Just wondering if he is still on the books? His symptoms are getting quite bad.

Thanks!
Anna

Personal Information redacted by the USI

From: Corrigan, Martina Personal Information redacted by USI
Sent: 13 February 2018 11:03
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael; ONeill, Kate; McMahon, Jenny
Cc: Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth
Subject: FW: Urology escalation - Personal Information redacted by USI
Importance: High

Dear all

Can anyone help with an earlier date please?

Thanks

Martina

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

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

From: Graham, Vicki
Sent: 13 February 2018 10:03
To: Corrigan, Martina
Cc: Glenny, Sharon; McVeigh, Shauna
Subject: FW: Urology escalation - Personal Information redacted by USI
Importance: High

Hi Martina,

Please see below patient who is currently on Day 19 – patient has been triaged to go straight to RF Flexi and Circumcision. Patient has been scheduled for this procedure for 20.03.18 which will be Day 53. Any help securing a sooner date would be very much appreciated as patient is at risk of breaching if a bladder tumour is identified at flexi.

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Red Flag Appointment Office
Tel. No. Personal Information redacted by USI

Internal Ext: Personal Information redacted by the USI *(Note: if dialling from the old system please dial* Personal Information redacted by the USI *in front of the extension)*

From: McVeigh, Shauna
Sent: 13 February 2018 09:30
To: Glenny, Sharon
Cc: Graham, Vicki
Subject: Urology escalation - Personal Information redacted by USI

Hi,

Please see escalation of patient who is on day 19 of his pathway, is not being seen at OP is proceeding straight to RF flexible cystoscopy and circumcision. He is on Mr Young's WL for this and I had emailed secretary for a date for this and have been advised that he is to be preadmitted for 20.03.18 which would be day 53. I have emailed to ask for something sooner, and response is awaited.

Personal Information redacted by USI

Day	Date	Event
5	30/01/2018	Patients referral triaged for investigation as - change to RF circumcision and flex cysto for haem - still do under dsu and local anaesthetic - needs to come off warfarin. I have emailed Mr Young to see if patient requires investigation only or an additional rf appt.
10	04/02/2018	Patient on RF WL for procedure - date to be defined on MY WL.
15	09/02/2018	Not for RF appointment as patient on for RF circumcision.
15	09/02/2018	Have emailed Paulette to ask when this patient can be seen for his RF Flex and circumcision - he is to proceed straight with investigations.
19	13/02/2018	Paulette advised - I have come across this chap in a message; apparently he?s now to come to a GADAY list. The next one here in CAH is one Laura is doing for MY on 20.03.18 and I can add in there.
19	13/02/2018	Patient is to be preadmitted for 20.03.18 - patient would need procedure sooner if possible will ask Paulette is this the soonest ad escalate this patient to OSL. D53 when procedure would be performed.

Thanks

Shauna

Personal Information redacted by the USI

From: Corrigan, Martina Personal Information redacted by USI
Sent: 13 February 2018 11:59
To: O'Brien, Aidan
Subject: Red Flag Triage during Week of 18 January - 24 January

Dear Aidan,

To follow-up on our conversation last Thursday (8 February) regarding timely triage of the red flags during your last oncall week. We have agreed during our discussion that this was a particularly busy week and you advised that you were unable to get to these during the agreed timeframe.

We also discussed that you hadn't escalated that you were finding it difficult to do the red flag triage on a daily basis, nor had you sought help in getting these completed. We have agreed that should this happen again that you will escalate to me and I will arrange for some of the rest of the Team to do these as they are willing to help anytime.

Regards

Martina

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

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Personal Information redacted by the USI

From: Corrigan, Martina Personal Information redacted by USI
Sent: 13 February 2018 12:02
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: Departmental Meetings

Importance: High

Dear all,

I know we have already talked about getting these weekly meetings up and running again.

Can we aim to have these starting again from 1 March 2018 from 12:30-1:30, Seminar Room 2, MEC?

Items that need to be discussed for the future agendas:

1. Triage (as per Aidan's request) (1 March 2018)
2. Performance (waiting times/lists etc)
3. Stone Treatment Centre (With Laura etc in attendance)
4. Thorndale (with Thorndale staff in attendance)
5. Ward issues (with Sisters in attendance)
6. Backlogs in discharges/admin
7. Mitomycin
8. Paediatric urology in DHH – equipment and rota

There are also times when I am being asked to arrange meetings with you to discuss various issues, e.g. procedural SBA and I would like to use this time for these meetings as it means no clinical activity is cancelled.

Hope that this is ok with everyone.....

Kind regards

Martina

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

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Mobile: Personal Information redacted by USI

Personal Information redacted by the USI

From: Young, Michael Personal Information redacted by USI
Sent: 13 February 2018 14:46
To: Corrigan, Martina; O'Brien, Aidan; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; McMahon, Jenny; ONeill, Kate; Caddell, Caroline
Subject: Urology Departmental Meetings Spring 2018
Attachments: Urology Departmental Meetings Spring 2018.docx

Dear All
Please see enclosed dept meeting schedule for this Spring session

Introducing Ward and Thorndale dates – these are open sessions for the staff to discuss issues or to put forward suggestions
Plan for these on a rolling basis every few months

MY

Urology Departmental Meetings Spring 2018

12 noon Seminar Room 2

DATE	TOPIC
15th Feb	Update on instrumentation – past present future
22nd Feb	Scheduling for April
1st March	Triage
8th	Thorndale issues
15th	Performance
22nd	Stone Treatment Centre
29th	Scheduling for May
5th April	Ward issues
12th	Administrative issue
19th	Mitomycin and Paediatric surgery
26th	Scheduling for June

Personal Information redacted by the USI

From: Corrigan, Martina Personal Information redacted by USI
Sent: 13 February 2018 15:08
To: Doherty, Anna; Hasnain, Sabahat; McAuley, Laura; Mageean, Marie; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: FW: Cancer Performance Meeting - Thursday 15th February 2018
Attachments: CANCER PERFORMANCE JANUARY 2018.doc

Importance: High

Dear all

For your information

Regards

Martina

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

INTERNAL: Personal Information redacted by USI
EXTERNAL : Personal Information redacted by USI
Mobile: Personal Information redacted by USI

From: Graham, Vicki
Sent: 12 February 2018 15:46
To: Carroll, Kay; Carroll, Ronan; Clayton, Wendy; Conway, Barry; Corr, Sinead; Corrigan, Martina; Devlin, Louise; Glenny, Sharon; Kavanagh, Catriona; Kelly, Brigeen; Kennedy, Geoff; Lappin, Lynn; Leeman, Lesley; McAreavey, Lisa; McGoldrick, Kathleen; McStay, Patricia; McVey, Anne; Reddick, Fiona; Robinson, Jeanette; Trouton, Heather
Subject: Cancer Performance Meeting - Thursday 15th February 2018 ** CANCELLED**
Importance: High

Afternoon,

Please see attached Dashboard and breach reports for January 2018. I have also attached minutes from last month's meeting, please let me know if you would like anything changed. Due to a large number of apologies the meeting has been **cancelled** for Thursday 15th February, but happy to meet with individual teams if you would like to discuss anything that is included in dashboard.

Regards,

Vicki Graham
Cancer Services Co-ordinator
Red Flag Appointment Office
Tel. No. Personal Information redacted by USI

Southern Health and Social Care Trust

Cancer Performance Dashboard Report January 2018

CANCER PERFORMANCE SUMMARY REPORT – December 2017

	% Breast 2WW	% 31D Performance	% 62D Performance
November 17	21.6%	96%	75.3%
December 17	67.2%	97%	74.5%
January 18	98%	87%	67%

Inter-Trust Transfer Breaches – 62 Day

	Jan -17	Feb -17	Mar -17	Apr -17	May 17	Jun -17	July -17	Aug -17	Sep -17	Oct -17	Nov -17	Dec -17	Jan -18	Total
Breast	0	0	0	0	0	0	0	0	0	0	1	0	0	**1**
Colorectal	2	0	0	1	0	1	2	1	0	1	1	1	1	**11**
Head & Neck	0	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Haematology	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Gynae	0	1	0	0	2	0	1	2	0	0	1	0	2	**9**
Lung	2	3	2	1	1	3	2	2	2	2	2	0	1	**23**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Skin	0	0	0	1	0	1	0	0	1	1	0	1	0	**5**
UGI	0	2	5	2	2	1	0	1	3	2	1	0	2	**21**
Urology	2	1	4	1	4	6	5	4	6	2	1	1	4	**41**
Oral Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total	6	8	11	6	9	12	10	10	12	8	7	3	10	**112**

Internal Breaches – 62 Day

	Jan -17	Feb -17	Mar-17	Apr-17	May-17	Jun-17	July-17	Aug -17	Sept 17	Oct -17	Nov -17	Dec- 17	Jan - 18	Total
Breast	0	0	0	0	0	2	3	1	0	5	6	4	8	**29**
Colorectal	0	0	1	1	1	1	1	2	2	1	3	1	0	**14**
ENT	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Gynae	0	0	0	0	0	0	0	0	1	0	0	0	0	**1**
Haem	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Lung	0	1	0	0	1	1	2	0	1	0	0	0	0	**6**
Skin	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**
UGI	0	1	0	2	0	1	2	0	0	0	1	0	0	**7**
Urology	3	4	4	2	9	7	6	4	5	7	5	6	2	**64**
Total	3	6	5	5	11	12	14	7	9	14	15	11	10	**122**

Day 31 Breaches

	Jan -17	Feb -17	Mar-17	Apr-17	May-17	Jun-17	July -17	Aug -17	Sept-17	Oct-17	Nov -17	Dec -17	Jan -18	Total
Breast	1	1	0	0	0	1	0	0	0	3	2	2	14	**24**
Colorectal	0	0	0	0	0	0	0	0	0	0	0	0	1	**1**
ENT	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Gynae	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Lung	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Skin	0	0	0	0	0	0	1	0	0	0	0	0	0	**1**
UGI	0	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Urology	0	0	0	0	2	0	0	0	0	1	0	0	0	**3**
Total	1	1	0	0	2	1	2	0	0	4	2	2	15	**30**

AOB-80494

Modality	Internal/External	Reason
Breast	Internal (Personal Informati	• Treatment completed on Day 82 - Surgery (57 Day wait from DTT) **Reason for delay - Surgery was scheduled on target but was cancelled x 2 - 1st time list was overbooked, then cancelled due to ED pressures.** Pathway - 1st OPD D15, path reported D18, MDM D23, DTT D25, surgery performed on Day 82
Breast	Internal (Person al	• Treatment completed Day 81 - Surgery (54 Days from DTT) **Reason for delay - 54 Day wait from DTT to surgery.** Pathway - 1st OPD D6, MDM D8, MDM D13, MRI D22, MDM D27, DTT - D27, Surgery Day 81.
Breast	Internal (Personal Informatio n	• Treatment completed Day 88- Surgery. **Reason for delay - 1st OPD D33 & 45 day wait for surgery to be performed.** Pathway - 1st OPD D33, MDM D41, DTT D43, MDM D43, Surgery Day 88.
Breast	Internal (Personal Informati	• Treatment completed Day 77- Surgery. **Reason for delay - 1st OPD D30 & then 42 day wait for surgery.** Pathway - 1st OPD D30, path reported D34, MDM D35, DTT D35, surgery D77.
Breast	Internal 31D (Personal Informatio n redacted	• Treatment completed Day 62 - Surgery (31D Breach) - **Reason for delay - 49 day wait for surgery due to no sooner capacity.** Pathway - 1st OPD D11, DTT D13, MDM D13, Surgery D62.
Breast	Internal 31D (Perso nal Inform	• Treatment completed Day 51 – Surgery (31D Breach) **Reason for delay - surgery could not be scheduled within target due to reduced capacity.**
Breast	Internal 31D (Perso nal Inform ation	• Treatment completed Day 47 - Surgery - **Reason for delay - surgery could not be scheduled within target due to reduced capacity.**
Breast	Internal 31D (Personal Informati	• Treatment completed Day 53 - Surgery (31D). **Reason for delay - surgery could not be scheduled within target due to reduced capacity.**
Breast	Internal 31D (Personal Information redacted by the	• Closed on D94 - Treatment complete - Surgery. **Reason for delay - 1st OPD D31, complex case in that HER 2 was awaited, then required Bone scan & CT before proceeding to Surgery - delay with surgery due to capacity issues.** Pathway - 1st OPD 31, MDM D33, MDM D37, Bone Scan D45, CT D60 - Surgery D94.
Breast	Internal 31D (Person al	• Treatment completed Day 83 - Surgery - **Reason for delay - No capacity to perform surgery within target - 64 day wait.** Pathway - 1st OPD D10, MDM D19, DTT D19, Surgery D83.

		within target (51D Wait). Pathway - 1st OPD D14, USS Guided Core BX D17, MDM D[illegible], D28 - Surgery D79.
Breast	Internal 31D [redacted]	• Treatment completed Day 78- Surgery. Reason for delay - no capacity for surgery to be performed on target & patient required x 2 MRI's due to high risk of tissuing. Pathway - 1st OPD D29, MDM D36, DTT D37, MRI D40, MDM D52 - repeat MRI, MRI D54, Surgery D78.
Breast	Internal 31D [redacted]	• Treatment completed Day 37 - Surgery. Reason for delay - surgery could not be scheduled within target due to no capacity.
Breast	Internal 31D [redacted]	• Treatment completed Day 58 - Surgery. Reason for delay - Surgery could not be scheduled within target due to no capacity.
LGI	Internal 31D [redacted]	• Surgery completed Day 43 (31D Breach) Reason for delay - surgery would have been performed on target but due to ED pressures surgery was cancelled and was unable to be scheduled on target.
Urology	Internal [redacted]	• Treatment completed Day 76 - Hormones - Reason for delay - 26 day wait for TRUSB. Pathway - 1st OPD D13, MRI D26, MRI reported D34, TRUSB D63, MDM D72, review D76.
Urology	Internal [redacted]	• Treatment completed Day 100 - Hormones. Reason for delay - 18 day wait for MRI scan, 30 day wait for TRUSB, 9 day wait for MDM, 11 day wait for review with Consultant. Pathway - 1st OPD D16, CT D18, MRI D41, TRUSB D71, MDM D80, review D95, DTT D91, hormones commenced Day 100.
Gynae	External [redacted]	• ITT Day 28 - Treatment Completed - Day 63 - Radiotherapy. Reason for delay - Radiotherapy could not be scheduled within target, following staging. Pathway - 1st OPD D3, Vulval biopsy Day 20, path reported Day 23, MDM D28, ITD D28, ITT D28.
UGI	External [redacted]	• ITT Day 58 - Treatment completed Day 86 - Chemotherapy. Reason for delay - Complex pathway - OGD, CT, staging laparoscopy and multiple discussions at local and regional MDM. Pathway - 1st OPD D11, OGD D22, path D24, ITD D30, CT D31, staging Lap D38, Regional OGD D46.
UGI	External [redacted]	• ITT - Day 49 - Treatment completed Day 77- Chemotherapy. Reason for delay - complex pathway requiring OGD, CT, PET, USS Guided BX & several OG MDM discussions. Pathway - Straight to scope D9 (OGD), path reported Day 16, CT D20, Regional OG MDM D23, PET D24, MDM D30, USS Guided BX D37, path reported Day 41, Regional OG MDM D44.
Urology	External [redacted]	• ITT - Day 75. Treatment completed on D90 - Hormone Therapy. Delays in Pathway - 12 day delay for MRI, 12 day delay for Bone scan, 28 day delay for TRUSB, 14 day delay for Bone scan. Pathway - 1st OPD, MRI D24, Bone Scan D24, TRUSB D40, MDM D48, Consultant

		Oncology appointment D90, Treatment D90.
Urology	External [Personal Information redacted by the]	• **ITT Day 100 - Treatment completed Day 155 - Active Monitoring. Reason for delay - 1st OPD D28, 26 Day wait on TRUSB being performed, 5 day wait for review with Consultant.** Pathway - 1st OPD D28, MRI D37, MRI reported D44, MDM D49, TRUSB D75, MDM D84, review D89, MDM D100.
Urology	External [Personal Information redacted by the]	• **ITT D71 - Treatment completed Day 100 - Hormone therapy. Reason for delay - 1st OPD D20, 17 Day wait for approval of MRI scan, 16 day wait for TRUSB to be arranged following MRI.** Pathway - 1st OPD D20, MRI D37, TRUSB D53, path reported D62, MDM D63, Regional MDM D70
Urology	External [Personal Informati on]	• **ITT Day 86 - Treatment completed Day 176 - Radiotherapy. Delays in pathway - 1st OPD D32, 18 day delay with MRI being reported, 6 day wait on review with Consultant following MDM.** Pathway - 1st OPD D32, MRI D45, MRI reported D68, TRUSB D70, path reported D71, MDM D79, review with Consultant D85.
Lung	External [Person al Informa]	• **ITT Day 62 - Treatment completed Day 103 - Active monitoring. Reason for delay - Complex case, requiring multiple diagnostic investigations & MDM discussions - 1st OPD D24 & 19 day wait for PET Scan.** Pathway - 1st OPD D24, PET D44, MDM D44, EUS D53, path reported D55, biopsy D58, MDM D60
LGI	External [Personal Informatio n]	• **ITT Day 61- Treatment completed Day 88 - Radiotherapy. Reason for delay - 1st OPD D26, deferral from MDM as per Mr Hewitt (loss of 7 days), and the lost days over the Christmas period.** Pathway - 1st OPD D26, colonoscopy D31, MRI D36, CT D40, pathology reported D48, MDM 49.
Gynae	External [Person al Informa]	• **ITT Day 47 - Treatment completed Day 75 - Surgery. Reason for delay - 1st OPD D18 & 16 Day wait for CT scan.** Pathway - 1st OPD D18, endometrial biopsy D18, path reported D24, MDM D25, MRI D41, CT D42, MDM D46, ITD D46.

Risk Areas for March/April 2018

Internal

- Breast screening and assessment, routine symptomatic breast service
- Breast deferrals at MDM due to a change in Radiologist's schedule so MRI's are unable to be viewed prior to MDM, so most will be waiting 7-9 days before being discussed at MDM with staging results.
- Late updating of routine/urgent outpatient referrals within 48 hours
- Outpatient Hysteroscopies – Then having to proceed to inpatient Hysteroscopy – lengthening pathway
- Capacity for 1st RF appointment for Urology, Lung, General Surgery & Ultrasound Guided Biopsy procedures
- Barium Swallow/Meal
- Reporting of diagnostics (CT 's & MRI scanning)
- Capacity issues with CT Colonography's – There has been a request for 4 additional slots per weeks.
- Urology Pathway
- Radiology/Pathology cover @ MDM's due to annual leave and a deputy not being able to attend. The cases are still being listed for discussion with reports. Cases only being deferred and escalated if they are unable to be discussed.
- Urology – TURBT's from 01.01.18 are to be treated as a diagnostic procedure and not first definitive treatment for muscle invasive bladder cancers.
- Oncology Cover – Regional agreement awaited – to be signed off at CRG. There currently is a locum Oncologist on-board and this service will continue to be provided locally.

External

- Lung and Upper GI patients are at risk due to PET capacity – PET waiting times is around 3 weeks.
- Brachytherapy
- Plastics
- Thoracic Surgery
- Robotic Prostatectomy

REFERRAL – SUSPECT CANCER Dec 2016 – Jan 2018

62 DAY REFERRALS

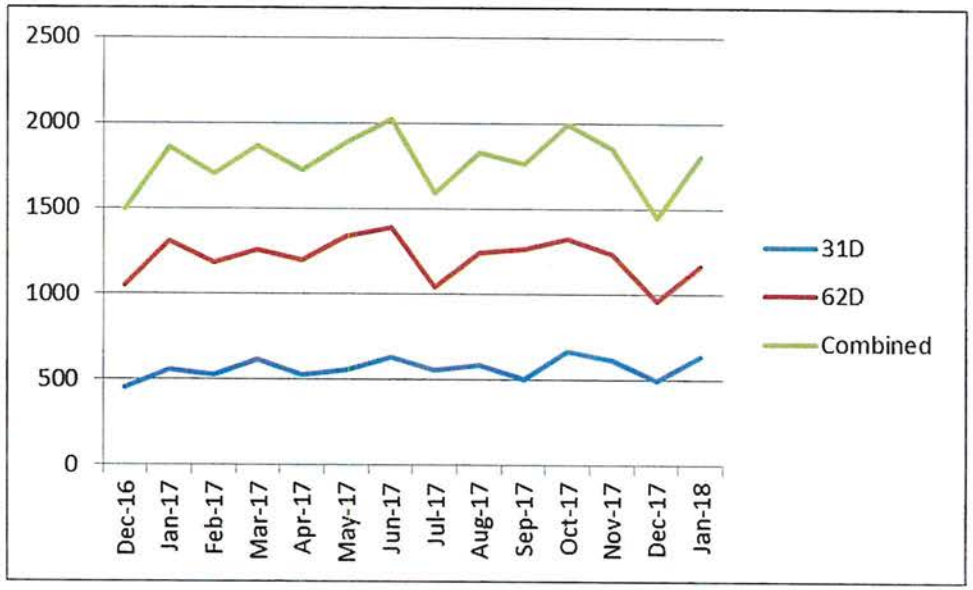
62 DAY REFERRALS	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov-17	Dec-17	Jan-18
Acute Leukaemia	0	0	0	0	0	0	1	0	0	2	0	0	0	3
Brain/Central Tumour	0	0	5	13	10	13	17	8	11	14	5	6	5	11
Breast Cancer	205	252	227	223	215	260	250	213	219	234	289	235	168	233
Children's Cancer	1	0	0	0	0	1	0	0	2	0	0	0	0	0
Gynae Cancers	112	127	127	118	100	140	110	89	123	120	125	113	101	118
Haematological Cancers	12	17	14	22	17	18	13	13	14	12	17	18	9	17
Head/Neck Cancer	72	94	84	98	99	116	115	99	101	120	83	78	58	94
Lower Gastrointestinal Cancer	200	236	217	229	215	238	268	218	250	219	240	231	184	209
Lung Cancer	40	52	47	52	54	56	57	41	25	21	31	24	22	39
Other Suspected Cancer	3	16	7	28	14	17	14	18	23	24	19	23	13	17
Sarcomas	0	0	3	1	0	0	0	0	1	0	2	3	0	1
Skin Cancers	128	165	162	178	180	209	220	205	195	199	178	170	122	134
Testicular Cancer	6	12	7	3	6	5	8	8	6	6	2	9	10	9
Upper Gastrointestinal Cancer	120	144	141	160	143	124	169	9	142	152	174	163	118	146
Urological Cancer	149	194	142	129	143	138	147	119	132	138	161	163	145	135
62D Total	1048	1309	1183	1254	1196	1335	1389	1040	1244	1261	1326	1236	955	1166

31 DAY REFERRALS

31 DAY REFERRALS	Dec 16	Jan 17	Feb 17	Mar 17	Apr-17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18
Acute Leukaemia	2	0	2	6	10	6	5	11	7	17	3	6	0	6
Brain/Central Tumour	4	10	7	17	17	16	16	10	22	13	14	6	10	16
Breast Cancer	36	43	51	46	58	37	65	53	60	52	69	64	39	70
Children's Cancer	4	1	6	2	0	0	0	0	0	0	0	0	0	0
Gynae Cancers	35	46	31	50	36	44	41	37	44	41	65	57	50	52
Haematological Cancers	38	33	19	29	32	31	26	34	26	18	29	23	35	40
Head/Neck Cancer	16	26	26	47	20	32	39	26	31	22	29	36	26	23
Lower Gastrointestinal Cancer	96	101	101	127	68	106	135	92	103	86	113	98	81	106
Lung Cancer	67	66	51	56	68	65	72	60	71	62	82	61	39	64
Other Suspected Cancer	3	2	3	5	1	5	3	4	4	4	5	4	6	0
Sarcomas	0	0	0	0	1	0	2	4	3	7	1	1	2	0
Skin Cancers	29	62	54	50	49	47	66	69	60	42	82	78	63	70
Testicular Cancer	0	0	0	2	0	0	1	0	0	0	0	3	0	0
Upper Gastrointestinal Cancer	68	88	84	99	102	94	87	79	86	81	94	103	92	99
Urological Cancer	52	76	87	81	66	73	75	73	70	58	73	77	73	92
31DTotal	450	554	522	617	528	556	633	552	587	503	681	617	493	640

	Dec 16	Jan 17	Feb 17	Mar17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18
31DTotal	450	554	522	617	528	556	633	552	587	503	670	617	493	640
62D Total	1048	1309	1183	1254	1196	1335	1389	1040	1244	1261	1326	1236	955	1166
Combined Total	1498	1863	1705	1871	1724	1891	2022	1592	1831	1764	1996	1853	1448	1806

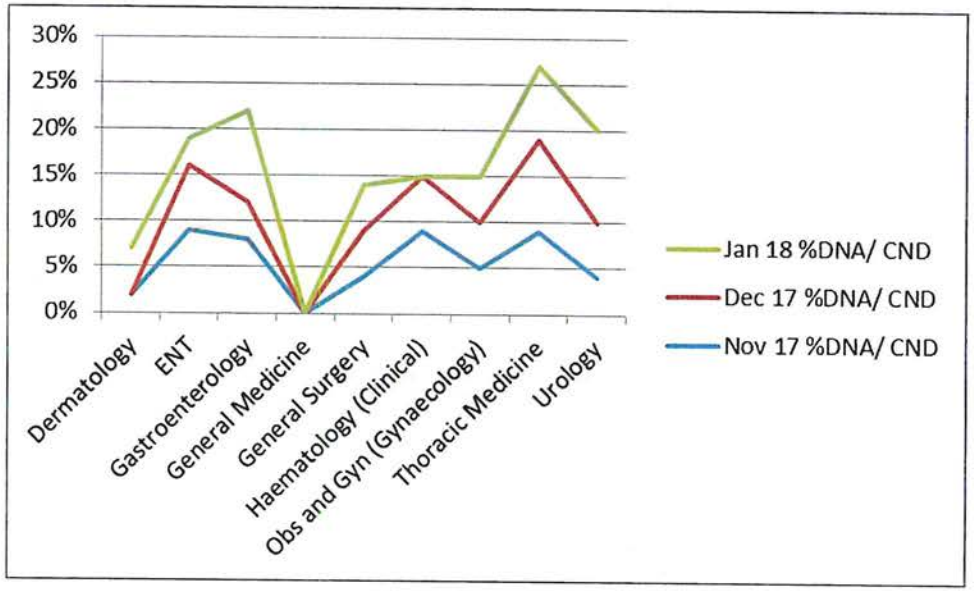
Dec 16 – Jan 18 Suspect Cancer Referrals



Red Flag Outpatient DNA

	Nov- 17			Dec - 17			Jan - 18		
Speciality	Attendances	DNA& CND	Nov 17 %DNA/ CND	Attendances	DNA& CND	Dec 17 %DNA/ CND	Attendances	DNA& CND	Jan 18 %DNA/ CND
Dermatology	132	2	2%	58	0	0%	108	6	5%
ENT	85	8	9%	77	6	7%	100	3	3%
Gastroenterology	38	6	8%	53	2	4%	65	7	10%
General Medicine	0	0	0%	0	0	0%	0	0	0%
General Surgery	468	21	4%	462	24	5%	528	25	5%
Haematology (Clinical)	21	2	9%	16	1	6%	13	0	0%
Obs and Gyn (Gynaecology)	120	6	5%	91	5	5%	132	7	5%
Thoracic Medicine	44	4	9%	28	3	10%	37	3	8%
Urology	188	7	4%	114	9	6%	159	17	10%
	1096	56	5%	899	50	6%	1142	68	6%

Red Flag Outpatient DNA



62 Day Confirmed Cancers

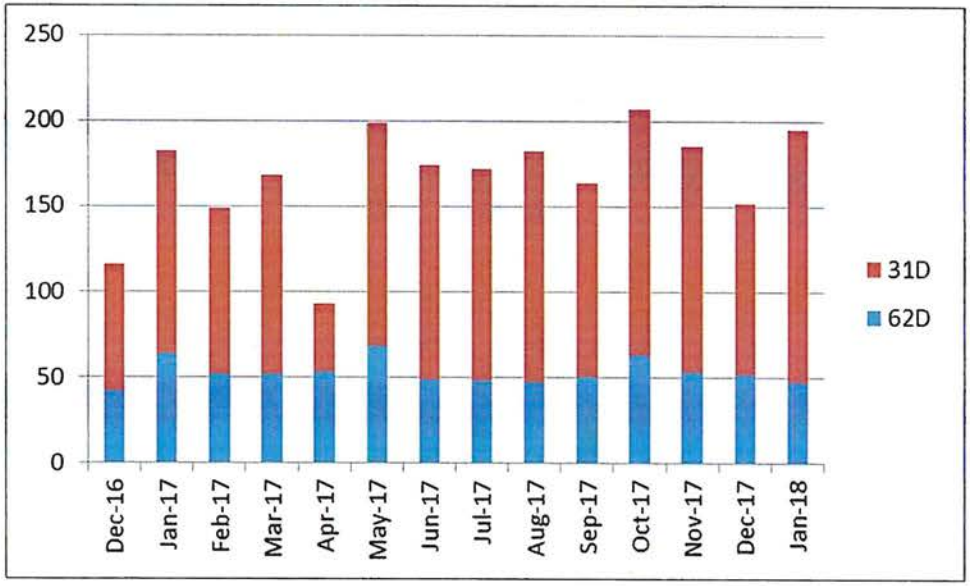
Tumour Site	Dec-16	Jan - 17	Feb - 17	Mar-17	Apr-17	May-17	Jun -17	July -17	Aug -17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Total
Acute Leukaemia	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2
Brain	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
Breast	3	3	2	4	5	4	1	5	6	4	3	5	5	7	57
Children's	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Gynae	3	6	2	6	4	8	6	8	3	6	5	5	7	5	74
Haem	1	4	1	1	3	1	0	1	2	1	2	2	2	1	22
Head & Neck	3	5	1	8	3	7	3	5	6	1	7	4	5	2	60
LGI	2	3	2	5	5	4	6	1	4	2	3	2	0	3	42
Lung	5	6	6	10	4	8	6	5	3	5	8	5	1	4	76
Other	0	0	0	0	1	0	0	0	2	0	0	0	0	0	3
Sarcomas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Skin	5	9	11	5	13	13	5	4	5	5	22	15	16	7	135
Testicular	3	3	3	0	0	0	3	0	0	0	1	1	0	0	14
UGI	6	11	10	5	5	7	5	8	10	6	5	5	5	1	89
Urology	10	14	14	8	10	14	14	11	6	18	7	9	11	17	163
62D Total	42	64	52	52	53	68	49	48	47	50	63	53	52	47	740
%62D confirmed	36%	35%	35%	33%	57%	34%	28%	28%	25%	30%	30%	29%	34%	24%	

31 Day Confirmed Cancers

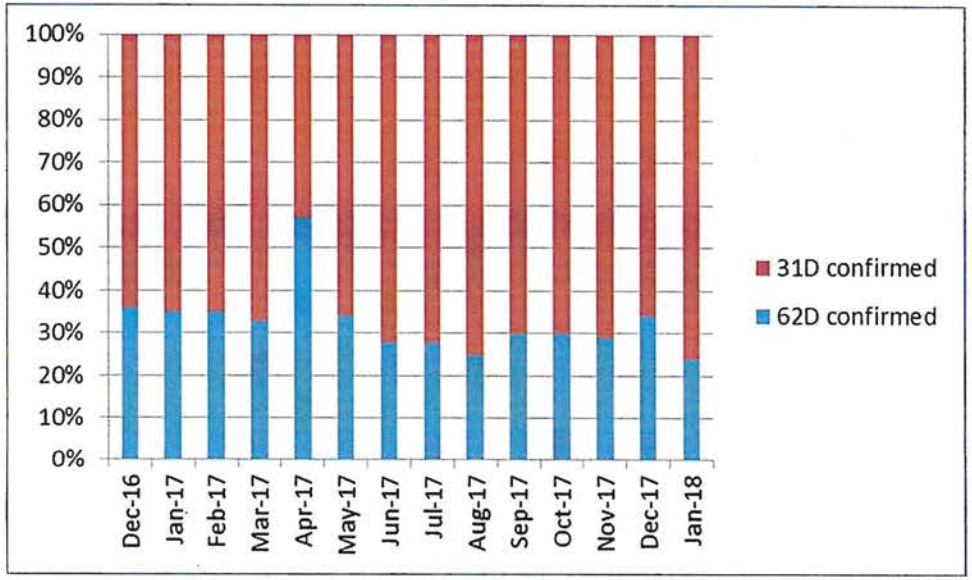
Tumour Site	Dec-16	Jan -17	Feb -17	Mar-17	Apr-17	May-17	Jun-17	July -17	Aug -17	Sep -17	Oct -17	Nov-17	Dec 17	Jan 18	Total
Acute Leukaemia	0	0	0	2	0	2	0	5	2	13	5	0	0	2	**31**
Brain	0	0	1	9	0	6	5	0	3	2	2	3	0	2	**33**
Breast	2	3	6	10	0	12	11	9	20	13	11	7	6	14	**124**
Children's	0	0	2	1	6	0	0	0	0	0	0	0	0	0	**9**
Gynae	7	12	2	11	3	5	11	11	3	6	13	19	6	14	**123**
Haem	29	24	13	16	6	26	19	17	19	10	19	15	21	25	**259**
Head & Neck	1	0	4	2	3	10	10	4	4	1	4	7	2	3	**55**
LGI	2	8	6	7	5	11	11	10	8	5	5	7	4	7	**96**
Lung	9	17	15	11	3	11	17	16	32	14	28	20	8	12	**213**
Other	0	0	0	13	0	0	0	0	0	0	0	0	0	0	**13**
Sarcomas	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Skin	9	22	16	13	2	16	15	21	18	19	31	27	32	27	**268**
UGI	6	10	18	7	4	16	10	14	8	14	9	12	14	17	**159**
Urology	9	22	14	14	8	16	16	17	18	17	16	15	7	25	**214**
31D Total	74	118	97	116	40	131	125	124	135	114	144	132	100	148	**1598**
%31D confirmed	64%	65%	65%	67%	43%	66%	72%	72%	75%	70%	70%	71%	66%	76%	

Tumour Site	Dec-16	Jan - 17	Feb - 17	Mar-17	Apr -17	May -17	Jun -17	July -17	Aug -17	Sep -17	Oct -17	Nov-17	Dec-17	Jan-18	Total
62D Total	42	64	52	52	53	68	49	48	47	50	63	53	52	47	**740**
31D Total	74	118	97	116	40	131	125	124	135	114	144	132	100	148	**1598**
TOTAL 31D +62D	116	182	149	168	93	199	174	172	182	164	207	185	152	195	**2338**

Number of confirmed cancers Dec 16 – Jan 18



% of Confirmed cancers split between 31/62 Days
Dec 16 – Jan 18



62D % cancer conversion Oct 17 – Dec 17

Tumour Site	No. of referrals	No. of confirmed cancers	% conversion
Acute Leukaemia	0	0	0%
Brain	16	0	0%
Breast	692	13	2%
Children's Cancer	0	0	0%
Gynae	339	17	5%
Haem	44	6	2%
Head & Neck	219	16	7%
LGI	655	5	1%
Lung	77	14	18%
Other	55	0	0%
Sarcoma	5	0	0%
Skin	470	53	11%
Testicular	21	2	10%
UGI	455	15	3%
Urology	469	27	6%

62D % cancer conversion July – Sept 17

Tumour Site	No. of referrals	No. of confirmed cancers	% conversion
Acute Leukaemia	2	2	100%
Brain	33	0	0%
Breast	666	15	2%
Children's Cancer	2	0	0%
Gynae	332	17	5%
Haem	39	4	10%
Head & Neck	320	12	3%
LGI	687	7	1%
Lung	87	13	15%
Other	65	2	3%
Sarcoma	1	0	0%
Skin	599	14	2%
Testicular	20	0	0%
UGI	303	24	8%
Urology	389	35	9%

62D % cancer conversion April – June 17

Tumour Site	No. of referrals	No. of confirmed cancers	%conversion
Acute Leukaemia	1	0	0%
Brain	40	2	5%
Breast	725	10	1.4%
Children's Cancer	1	0	0%
Gynae	350	18	5%
Haem	48	4	8%
Head & Neck	330	13	4%
LGI	721	15	2%
Lung	167	18	11%
Other	45	1	2%
Sarcoma	0	0	0%
Skin	609	31	5%
Testicular	19	3	16%
UGI	436	17	4%
Urology	428	38	9%

62D % cancer conversion July – September 16

Tumour Site	No. of referrals	No. of confirmed cancers	%conversion
Acute Leukaemia	4	0	0%
Brain	25	0	0%
Breast	714	29	4%
Children's Cancer	2	0	0%
Gynae	338	9	3%
Haem	47	3	6%
Head & Neck	297	15	5%
LGI	660	7	1%
Lung	123	16	13%
Other	51	1	2%
Sarcoma	4	0	0%
Skin	547	24	4%
Testicular	16	1	6%
UGI	390	16	4%
Urology	403	39	10%