

With thanks

Gillian

Dr Gillian Rankin

Interim Director of Acute Services

Emma Stinson

PA to Dr Gillian Rankin, Interim Director of Acute Services

Admin Floor

Craigavon Area Hospital

Tel:

Personal Information redacted by the USI

Fax:

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Southern Health & Social Care Trust IT Department

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Diane Corrigan

Personal Information redacted by the USI

From: Armstrong, Brian <[redacted]>
Sent: 21 September 2010 18:05
To: Rankin, Gillian
Cc: Corrigan, Diane; Hall, Stephen; Beth Malloy; Welsh, Jennifer; Donnelly, Patricia; Hagan, Chris; McCann, Bronagh; McClenaghan, Karen; Seamus.McGoran <[redacted]>; Williamson, Sarah; McNicholl, Catherine; Thompson, Jennifer
Subject: Radical Pelvic Surgery Patients

Dear Gillian,

Further to the recent request from the SHSCT to BHSCT re the treatment of 5 radical pelvic surgery patients, I would like to confirm the BHSCT have managed to identify capacity to treat these patients in October. The Belfast Trust (as part of Team East) is working with PMSID to implement the recommendations within the Regional Review, however these have not been funded recurrently to date. Therefore, in this instance, given the significant impact this displaced activity will have on the service in Belfast in October, I would request the SHSCT could work with us to identify the equivalent capacity within their Trust to treat the displaced BHSCT demand. This is equivalent to 5 inpatient lists.

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Kind regards

Brian

Co-Director

Acute Services

Mobile

Personal Information redacted by the USI

This message contains information from Belfast Health And Social Care Trust which may be privileged and confidential.

Diane Corrigan

From: Diane Corrigan
Sent: 21 September 2010 21:13
To: 'Lyn.Donnelly' [Personal Information redacted by the USI]; 'caroline.cullen' [Personal Information redacted by the USI]
Subject: Re: BCH response to request to accept Radical Pelvic Surgery Patients

As of last Fri there were two cases - don't know where another 3 came from since then.
 I think they would be suggesting that since each takes a full theatre list 10 to 15 patients will be 'swopped out'.
 The reasoning behind my suggestion that non SLCG pts should be moved instead of 'our' residents on the BCH list, is because being moved is upsetting for any patient. Why should our residents be discommoded when it is not due to any failing on behalf of the south LCG in commissioning terms. If North LCG haven't paid for their patients to be treated in BCH then they can explain to them why they have to be moved. Either way we lose as no more SLCG patients treated in the process - albeit an improvement in quality for those needing care in the regional centre.

Diane

----- Original Message -----
From: Donnelly, Lyn <[Personal Information redacted by the USI]>
To: Corrigan, Diane <[Personal Information redacted by the USI]>; Donnelly, Lyn <[Personal Information redacted by the USI]>; Cullen, Caroline
Sent: Tue Sep 21 20:40:58 2010
Subject: RE: BCH response to request to accept Radical Pelvic Surgery Patients

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Diane

Thanks for this -

Caroline - can we ensure that when we are agreeing the BHSCT contract for this year that these 5 patients are within our current contract volumes and not additional.

Lyn

Mrs Lyn Donnelly
 Commissioning Lead Southern Area
 HSCB
 Tower Hill
 Armagh
 BT61 9DR
 Tel: [Personal Information redacted by the USI]
 Fax: [Personal Information redacted by the USI]
 Email: [Personal Information redacted by the USI]
 Website: www.hscboard.hscni.net

----- Original Message -----
From: Corrigan, Diane [mailto:[Personal Information redacted by the USI]]
Sent: 21 September 2010 19:44
To: Donnelly, Lyn; Cullen, Caroline

Subject: Fw: BCH response to request to accept Radical Pelvic Surgery Patients

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Interference is my middle name... For info.

Diane

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

From: Diane Corrigan

To: 'brian.armstrong' <brian.armstrong>;

'gillian.rankin' <gillian.rankin>;

Cc: 'stephen.hall' <stephen.hall>; 'beth.Malloy' <beth.Malloy>;

'jennifer.welsh' <jennifer.welsh>;

'patricia.donnelly' <patricia.donnelly>;

'chris.hagan' <chris.hagan>; 'bronagh.mccann' <bronagh.mccann>;

'karen.mcclenaghan' <karen.mcclenaghan>;

'Seamus.McGoran' <Seamus.McGoran>;

'sarah.williamson' <sarah.williamson>;

'Catherine.McNicholl' <Catherine.McNicholl>;

'Jennifer.thompson' <jennifer.thompson>;

Sent: Tue Sep 21 19:43:03 2010

Subject: Re: Radical Pelvic Surgery Patients

Brian

Thank you very much for accommodating these patients. I am sure the HSCB colleagues in the Armagh office will be prepared to discuss contract issues with you. However last time I checked the BHSCT performance against SBA volumes for the south LCG seemed to be substantially below contract. In contrast it is way over for patients from the north LCG, so from your point of view the work may be exceeding your capacity - but that is not the fault of too little income from the southern office.

I think some further discussion is needed on which patients should be transferred out. Possibly north LCG residents living close to the catchment boundary with CAH?

Regards

Diane

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

From: Armstrong, Brian <>

To: Rankin, Gillian <>

Cc: Corrigan, Diane <>; Hall, Stephen <>; Beth

Malloy <>; Welsh, Jennifer <>; Donnelly, Patricia

<>; Hagan, Chris <>; McCann, Bronagh

<>; McClenaghan, Karen <>;

Seamus.McGoran <>; Williamson, Sarah

<>; McNicholl, Catherine <>;

Thompson, Jennifer <>

Sent: Tue Sep 21 18:05:11 2010

Subject: Radical Pelvic Surgery Patients

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Kind regards

Brian

Co-Director

Acute Services

Mobile

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[REDACTED]

Diane Corrigan

From: Diane Corrigan
Sent: 22 September 2010 09:59
To: Donnelly, Lyn; Cullen, Caroline
Subject: FW: Radical Pelvic Surgery Patients

fyi

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

From: Diane Corrigan

Sent: 22 September 2010 09:57

To: Hagan, Chris; Armstrong, Brian; Gillian Rankin

Personal Information redacted by the USI

Cc: stephen.hall

Personal Information redacted by the USI

beth.Malloy

Personal Information redacted by the USI

Welsh, Jennifer; Donnelly, Patricia; McCann,

Bronagh; McClenaghan, Karen; Seamus McGoran

Personal Information redacted by the USI

Williamson, Sarah; McNicholl, Catherine;

Thompson, Jennifer; Keane, Patrick; Rajan, Nambi

Subject: RE: Radical Pelvic Surgery Patients

Dear Chris

I think you may have misunderstood the point I was trying to make. I acknowledge absolutely the stresses your service is under and appreciate your frustration that investment has not happened more quickly. I also appreciate that accepting these patients was difficult for BHSC.

What many people are not aware of is that before the Boards were stood down and the LCGs created, a major financial exercise was done to ensure that, for all the major specialities, the income to Trusts from each LCG should reflect their SBA volume. In the case of the legacy SHSSB, when that was done additional money was put into the BHSC contract to reflect that rebalancing. That is how we have arrived at the contract volumes we have today.

The population of the south LCG has over decades had less money spent on it per head than other parts of NI (all health and social services, not urology alone). Although efforts had been made in recent years to address this inequity by way of a shift in capitation funding, that was suspended this year given the dire financial circumstances of government. That leaves the populations of the East and North with far more money being spent on them than those in the South.

I accept absolutely that by agreeing to treat these patients from the south LCG other patients will need to be displaced. That is in the best interests of complex cancer cases and was the model accepted in the urology review (albeit that is not yet implemented). However other patients referred to BCH from this area may already have chosen not to be treated at CAH for personal or clinical reasons. Patients from the part of the north LCG closest to Belfast are more likely to have been referred to BHSC because that is the closest location for urology services. It is going to disrupt patients to be moved in this way whatever way it is done. On balance I felt that it would be fairer to move patients who (at this point) have not been funded to have their care in BHSC, rather than those whose local commissioner has paid for their care in advance. Either way the south LCG gets no more of its residents treated in total but the south LCG patients already on BHSC waiting lists would not be discommoded. My aim was to think about equity and fairness on behalf of the populations we serve.

Once the urology review has been fully implemented and each team has been funded to meet the needs of its natural catchment these issues will hopefully disappear.

Regards

Diane

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

From: Hagan, Chris [mailto:Personal Information redacted by the USI]
 Sent: 22 September 2010 09:13
 To: Corrigan, Diane; Armstrong, Brian; gillian.rankin [Personal Information redacted by the USI]
 Cc: stephen.hall [Personal Information redacted by the USI]; beth.Malloy [Personal Information redacted by the USI]; Welsh, Jennifer; Donnelly, Patricia; McCann, Bronagh; McClenaghan, Karen; Seamus.McGoran [Personal Information redacted by the USI]; Williamson, Sarah; McNicholl, Catherine; Thompson, Jennifer; Keane, Patrick; Rajan, Nambi
 Subject: RE: Radical Pelvic Surgery Patients

Diane it's somewhat depressing to read your reply particularly with your comments about work exceeding capacity and that it is not the fault of the south LCG.

Belfast Trust urology has a finite theatre capacity and for years has performed over SBA. We make no distinction as to where these patients come from; indeed we provide an acute urology service for the vast majority of NI. When it was raised through the NI review of urology that a postcode "firewall" be created to protect teams from excess numbers of referrals from outwith catchment areas, this was rejected.

We have accommodated onto theatre lists in BCH these complex pelvic cancer cases that should be done here to meet IOG guidance. This was done at very short notice with little or no warning and in a very unusual fashion. These patients should have been referred some time ago via the appropriate MDT and it would have been much easier to accommodate them.

The point remains though that despite the NI review of urology being signed off some time ago, and that from March 2010 all pelvic cancers should have been done in BCH, we still have not seen any monies realised by PMSID / DoH to fund this. It is also an inescapable reality that to accommodate these patients on finite lists other patients have been displaced. These displaced patients also deserve treatment in a timely fashion and we should pull together to try and achieve this by using all available resources.

Chris

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From: Corrigan, Diane [mailto:Personal Information redacted by the USI]
 Sent: 21 September 2010 19:43
 To: Armstrong, Brian; gillian.rankin [Personal Information redacted by the USI]
 Cc: stephen.hall [Personal Information redacted by the USI]; beth.Malloy [Personal Information redacted by the USI]; Welsh, Jennifer; Donnelly, Patricia; Hagan, Chris; McCann, Bronagh; McClenaghan, Karen; Seamus.McGoran [Personal Information redacted by the USI]; Williamson, Sarah; McNicholl, Catherine; Thompson, Jennifer
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Brian

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Regards

Diane

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 To: Rankin, Gillian <[redacted]>
 Cc: Corrigan, Diane <[redacted]>; Hall, Stephen <[redacted]>; Beth Malloy <[redacted]>; Welsh, Jennifer <[redacted]>; Donnelly, Patricia <[redacted]>; Hagan, Chris <[redacted]>; McCann, Bronagh <[redacted]>; McClenaghan, Karen <[redacted]>; Seamus.McGoran <[redacted]>; Seamus.McGoran <[redacted]>; Williamson, Sarah <[redacted]>; McNicholl, Catherine <[redacted]>; Thompson, Jennifer <[redacted]>
 Sent: Tue Sep 21 18:05:11 2010
 Subject: Radical Pelvic Surgery Patients

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Acute Services

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Diane Corrigan

From: Diane Corrigan
Sent: 22 September 2010 11:54
To: beth.Malloy [Personal Information redacted by the USI]
Subject: FW: Radical Pelvic Surgery Patients

Beth
 Sorry - I didn't mean to stir up such a storm. I will resist the temptation to respond to any more emails. It would be interesting if GPs in NI were to be given the commissioning role they are about to have in GB. If he thought SBAs with 4 or more recently 5 areas were outrageous....watch that space!

Diane

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

From: Keane, Patrick [mailto:[Personal Information redacted by the USI]]
Sent: 22 September 2010 11:39
To: Corrigan, Diane; Hagan, Chris; Armstrong, Brian; gillian.rankin [Personal Information redacted by the USI]
Cc: stephen.hall [Personal Information redacted by the USI]; beth.Malloy [Personal Information redacted by the USI]; Welsh, Jennifer; Donnelly, Patricia; McCann, Bronagh; McClenaghan, Karen; Seamus.McGoran [Personal Information redacted by the USI]; Williamson, Sarah; McNicholl, Catherine; Thompson, Jennifer; Rajan, Nambi
Subject: RE: Radical Pelvic Surgery Patients

Dear All,

Why do we have an SBA with the Southern area? There are 3 urologists to cover the population who don't have to do radical pelvic surgery plus Robin Brown?

Is the historical contract bound to general surgery as the Northern Board contract was?

I have always failed to see the sense in this bizarre accounting.

BCH has 6 urologists who deal with Belfast the southern part of the Northern Board and a large SBA from the southern Board. i.e. 6 urologists cover a population of 8-900k 1:150000 even if you include the Mater its 7 and the ration changes little. Meanwhile 3 cover a population of 250k in the Northern 1:80 and 3.5 cover the Southern board 1:<100000. This is a huge discrepancy and in my opinion the disadvantage is to our local population regardless of nominal capitation spend.

Meanwhile 1300 patients at BCH require treatment as the funding is stalled. Its an absolute mess!!!!

The monies from the review should be released today patients are being severely disadvantaged by this farce.

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

From: Corrigan, Diane [mailto:[Personal Information redacted by the USI]]
Sent: 22 September 2010 10:05
To: Hagan, Chris; Armstrong, Brian; gillian.rankin [Personal Information redacted by the USI]
Cc: stephen.hall [Personal Information redacted by the USI]; beth.Malloy [Personal Information redacted by the USI]; Welsh, Jennifer; Donnelly, Patricia; McCann, Bronagh; McClenaghan, Karen; Seamus.McGoran [Personal Information redacted by the USI]; Williamson, Sarah; McNicholl, Catherine; Thompson, Jennifer; Keane, Patrick; Rajan, Nambi
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 To: Rankin, Gillian <Personal Information redacted by the USI>
 Cc: Corrigan, Diane <Personal Information redacted by the USI>; Hall, Stephen <Personal Information redacted by the USI>; Beth Malloy <Personal Information redacted by the USI>; Welsh, Jennifer <Personal Information redacted by the USI>; Donnelly, Patricia <Personal Information redacted by the USI>; Hagan, Chris <Personal Information redacted by the USI>; McCann, Bronagh <Personal Information redacted by the USI>; McClenaghan, Karen <Personal Information redacted by the USI>; Seamus.McGoran@Personal Information redacted by the USI; Williamson, Sarah <Personal Information redacted by the USI>; McNicholl, Catherine <Personal Information redacted by the USI>; Thompson, Jennifer <Personal Information redacted by the USI>
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Co-Director

Acute Services

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Diane Corrigan

From: Rankin, Gillian <[REDACTED]>
Sent: 23 September 2010 11:13
To: Corrigan, Diane
Subject: RE: Radical Pelvic Surgery Patients

Personal Information redacted by the USI

Dear Diane,

I would welcome your guidance on next steps here, but wanted to let some of the heat come out of the system before I formally respond.

All the patients are now transferred, have been phoned by us and have an appointment in Belfast on Monday.

I presume that there is no option but to accept some patients in the reverse direction although we have some clinical resistance to this. If we do, I have discussed with Michael Young and agreed that it would be preferable to receive some new referrals rather than people already seen and booked for a planned procedure.

If you agree with this approach I would welcome guidance on what would be an appropriate number of referrals to equate to the 5 patients/inpatient lists as I have no objective information on conversion rates etc. I agree the best solution is for people with post codes close to our Lisburn boundary to transfer.

I look forward to your response,

Many thanks,

Gillian

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

From: Corrigan, Diane [mailto:[REDACTED]]
Sent: 22 September 2010 10:05
To: Hagan, Chris; Armstrong, Brian; Rankin, Gillian
Cc: Hall, S DR; beth.Malloy [REDACTED]; Welsh, Jennifer; Donnelly, Patricia; McCann, Bronagh; McClenaghan, Karen; Seamus.McGoran [REDACTED]; Williamson, Sarah; McNicholl, Catherine; Thompson, Jennifer; Keane, Patrick; Rajan, Nambi
Subject: RE: Radical Pelvic Surgery Patients

Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

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Dear Chris

I think you may have misunderstood the point I was trying to make. I acknowledge absolutely the stresses your service is under and appreciate your frustration that investment has not happened more quickly. I also appreciate that accepting these patients was difficult for BHSCT.

What many people are not aware of is that before the Boards were stood down and the LCGs created, a major financial exercise was done to ensure that, for all the major specialities, the income to Trusts from each LCG should reflect their SBA volume. In the case of the legacy SHSSB, when that was done additional money was put into the BHSCT contract to

reflect that rebalancing. That is how we have arrived at the contract volumes we have today.

The population of the south LCG has over decades had less money spent on it per head than other parts of NI (all health and social services, not urology alone). Although efforts had been made in recent years to address this inequity by way of a shift in capitation funding, that was suspended this year given the dire financial circumstances of government. That leaves the populations of the East and North with far more money being spent on them than those in the South.

I accept absolutely that by agreeing to treat these patients from the south LCG other patients will need to be displaced. That is in the best interests of complex cancer cases and was the model accepted in the urology review (albeit that is not yet implemented). However other patients referred to BCH from this area may already have chosen not to be treated at CAH for personal or clinical reasons. Patients from the part of the north LCG closest to Belfast are more likely to have been referred to BHSCT because that is the closest location for urology services. It is going to disrupt patients to be moved in this way whatever way it is done. On balance I felt that it would be fairer to move patients who (at this point) have not been funded to have their care in BHSCT, rather than those whose local commissioner has paid for their care in advance. Either way the south LCG gets no more of its residents treated in total but the south LCG patients already on BHSCT waiting lists would not be discommoded. My aim was to think about equity and fairness on behalf of the populations we serve.

Once the urology review has been fully implemented and each team has been funded to meet the needs of its natural catchment these issues will hopefully disappear.

Regards

Diane

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

From: Hagan, Chris [mailto: Personal Information redacted by the USI]

Sent: 22 September 2010 09:13

To: Corrigan, Diane; Armstrong, Brian;

gillian.rankin Personal Information redacted by the USI

Cc: stephen.hall Personal Information redacted by the USI

beth.Malloy Personal Information redacted by the USI

Welsh,

Jennifer; Donnelly, Patricia; McCann, Bronagh; McClenaghan, Karen;

Seamus.McGoran Personal Information redacted by the USI Williamson, Sarah; McNicholl,

Catherine; Thompson, Jennifer; Keane, Patrick; Rajan, Nambi

Subject: RE: Radical Pelvic Surgery Patients

Diane it's somewhat depressing to read your reply particularly with your comments about work exceeding capacity and that it is not the fault of the south LCG.

Belfast Trust urology has a finite theatre capacity and for years has performed over SBA. We make no distinction as to where these patients come from; indeed we provide an acute urology service for the vast majority of NI. When it was raised through the NI review of urology that

a postcode "firewall" be created to protect teams from excess numbers of referrals from outwith catchment areas, this was rejected.

We have accommodated onto theatre lists in BCH these complex pelvic cancer cases that should be done here to meet IOG guidance. This was done at very short notice with little or no warning and in a very unusual fashion. These patients should have been referred some time ago via the appropriate MDT and it would have been much easier to accommodate them.

The point remains though that despite the NI review of urology being signed off some time ago, and that from March 2010 all pelvic cancers should have been done in BCH, we still have not seen any monies realised by PMSID / DoH to fund this. It is also an inescapable reality that to accommodate these patients on finite lists other patients have been displaced. These displaced patients also deserve treatment in a timely fashion and we should pull together to try and achieve this by using all available resources.

Chris

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

From: Corrigan, Diane [mailto:Personal Information redacted by the USI]
 Sent: 21 September 2010 19:43
 To: Armstrong, Brian; gillian.rankin@Personal Information redacted by the USI
 Cc: stephen.hall@Personal Information redacted by the USI; beth.Malloy@Personal Information redacted by the USI; Welsh, Jennifer; Donnelly, Patricia; Hagan, Chris; McCann, Bronagh; McClenaghan, Karen; Seamus.McGoran@Personal Information redacted by the USI; Williamson, Sarah; McNicholl, Catherine; Thompson, Jennifer
 Subject: Re: Radical Pelvic Surgery Patients

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Brian

Thank you very much for accommodating these patients. I am sure the HSCB colleagues in the Armagh office will be prepared to discuss contract issues with you. However last time I checked the BHSCCT performance against SBA volumes for the south LCG seemed to be substantially below contract. In contrast it is way over for patients from the north LCG, so from your point of view the work may be exceeding your capacity - but that is not the fault of too little income from the southern office.

I think some further discussion is needed on which patients should be transferred out. Possibly north LCG residents living close to the catchment boundary with CAH?

Regards
 Diane

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

From: Armstrong, Brian <[redacted]>
 To: Rankin, Gillian <[redacted]>
 Cc: Corrigan, Diane <[redacted]>; Hall, Stephen
 <[redacted]>; Beth Malloy
 <[redacted]>; Welsh, Jennifer
 <[redacted]>; Donnelly, Patricia
 <[redacted]>; Hagan, Chris
 <[redacted]>; McCann, Bronagh
 <[redacted]>; McClenaghan, Karen
 <[redacted]>;
 Seamus.McGoran <[redacted]>;
 Williamson, Sarah <[redacted]>; McNicholl,
 Catherine <[redacted]>; Thompson,
 Jennifer <[redacted]>
 Sent: Tue Sep 21 18:05:11 2010
 Subject: Radical Pelvic Surgery Patients

Dear Gillian,

Further to the recent request from the SHSCT to BHSCT re the treatment of 5 radical pelvic surgery patients, I would like to confirm the BHSCT have managed to identify capacity to treat these patients in October. The Belfast Trust (as part of Team East) is working with PMSID to implement the recommendations within the Regional Review, however these have not been funded recurrently to date. Therefore, in this instance, given the significant impact this displaced activity will have on the service in Belfast in October, I would request the SHSCT could work with us to identify the equivalent capacity within their Trust to treat the displaced BHSCT demand. This is equivalent to 5 inpatient lists.

It would be helpful going forward if the SHSCT patients are taken via the Regional MDM route. I understand there have been delays in realising this due to lack of Oncology support. However, as an interim measure it would be useful if a surgeon could telelink into the MDM to handover the cases. Regardless of what interim arrangements are put in place however, in the short term it is imperative that appropriate referrals are sent to the specialist surgical team in BHSCT in a timely fashion to ensure appropriate management of these patients.

Kind regards

Brian

Co-Director

Acute Services

Mobile

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by the USI

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Diane Corrigan

From: Diane Corrigan
Sent: 29 September 2010 13:09
To: 'beth.Malloy' Personal Information redacted by the USI
Subject: Re: Urology Review Implementation Plans

Beth
No this move of patients has never been done before.

Has Gillian Rankin spoken to you about whether they can be allowed to take new outpt referrals (from the long end of the BHSCT list) as opposed to taking patients already on the inpt waiting list at BHSCT? If the former, then we have to devise some formula predicting the no of new outpts who will generate the requisite amount of inpatient operating time.

In the longer term, are we suggesting trying to switch current referral patterns from say Moira/Crumlin towards CAH? Allowing pts to continue to flow into the 'wrong' queue and then trying to extract them will always be cumbersome. The alternative is to try to size each team to match its natural catchment?

Diane

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

Personal Information redacted by the USI
From: Beth Malloy <Personal Information redacted by the USI>
To: Corrigan, Diane <Personal Information redacted by the USI>
Sent: Wed Sep 29 12:48:00 2010
Subject: RE: Urology Review Implementation Plans

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

Diane

Yes 12.00pm will be fine - shall we meet at LHS - will sort out a venue

We had agreed the transfer of cases from Belfast to Southern Trust - have you done this before as part of regional issues previously or should it be done as per a waiting list initiative and patient taken from the waiting list and offered an appointment at ST?

Regards

Beth

Mrs Beth Malloy

Assistant Director Scheduled Services

Performance Management and Service Improvement Directorate Health and Social Care Board

Personal Information redacted by the USI

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

From: Corrigan, Diane
Sent: 29 September 2010 12:47
To: Beth Malloy
Subject: Re: Urology Review Implementation Plans

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

Beth

Yes I am planning on coming (though slightly apprehensive - I hear the social medical network is being told I am 'taking away work' from CAH. Combined with the views I stirred up from BCH staff I think I will be the default hate figure of the event!).

Just checking - it is now in linenhall st rather than Templeton House?

I could get away from Armagh around 11am so a pre-meeting sometime after 12 would be OK with me if that suits.
Diane

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

From: Beth Malloy <[redacted] Personal Information redacted by the USI >
To: David McCormick <[redacted] Personal Information redacted by the USI >; Corrigan, Diane <[redacted] Personal Information redacted by the USI >
Sent: Wed Sep 29 11:58:00 2010
Subject: FW: Urology Review Implementation Plans

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

For info - see below

Diane - apologies for not getting back to you yesterday - was not out of meetings until after 6pm Are you coming to the meeting on Friday? Are you able to attend for a pre meeting on Friday am?

Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate Health and Social Care Board

[redacted] Personal Information redacted by the USI

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

From: Hughes, Dermot2 [mailto:[redacted] Personal Information redacted by the USI]
Sent: 29 September 2010 10:08
To: Beth Malloy
Cc: Bridget Tourish
Subject: RE: Urology Review Implementation Plans

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Dear Beth

There currently are leads in Pathology for urology in each trust and they attend Urology meetings and work well together.

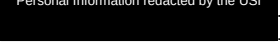
- Pathology lead for each team is a basic Peer Review standard for all MDTs
- Review of urology cases currently happens for each individual trust (or should do for governance reasons). Has been standard practice in WT for at least years

- Working as a regional team would prevent endless triple review of cases in Team East for anything discussed at regional meeting. Probably a more cost effective way of working and will ensure same quality across NI
- Not sure about pathology network as there seems to be little progress> I would emphasise the 3 team structure agreed by Urology review and ensure it's needs are met.
- Turnaround times should be agreed by pathologists and then sent to implementation board for agreement or otherwise. I feel it is important that ownership resides with those delivering service. I would suggest we seek standards from networks in UK and benchmark. Will include Bridget in this email.
- Urology pathology supported service prior to Urology review and resource was previously available to some extent. WT had 1PA for pathologist to prepare attend meetings and perform urology related cancer audit. Feel pathology some group meetings could be covered as part of this. We cannot be responsible for trust's refusal to appropriately fund basic service in past.

Regards

Dermot

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

From: Beth Malloy [mailto:
Sent: 29 September 2010 09:36
To: Hughes, Dermot2
Cc: David McCormick; Corrigan, Diane
Subject: RE: Urology Review Implementation Plans

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Dermot

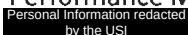
Thanks you very much for these suggested KPI for pathology.

I have added some questions/comments below re each

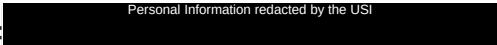
Thanks

Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate Health and Social Care Board


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

From: Hughes, Dermot2 [mailto:
Sent: 31 August 2010 09:36
To: Beth Malloy
Cc: David McCormick
Subject: RE: Urology Review Implementation Plans

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

Dear Beth

I would suggest the pathology outcomes to be

- Designated urology pathology lead at each local team - will this require additional resources - the review only includes pathology for team East?
- All cases reviewed prior to MDT by lead uro-pathologist (double reading) will this require additional resources - the review only includes pathology for team East?
- Formation of urology pathology network by 1 uro-pathologist from team North, 1 from team south and 2 from team east - How does this fit in with the pathology network?
- Agreed regional reporting, agreed regional turnaround times and agreed regional pathology audit - what standards and times?
- Regular urology pathology QA meetings to review complex cases, QA service and provide post graduate training - will this require additional resources - the review only includes pathology for team East?

Regards

Dermot

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

From: Beth Malloy [mailto:Personal Information redacted by the USI]
Sent: 30 August 2010 22:48
To: Hughes, Dermot2; Stephen.Hall Personal Information redacted by the USI
Cc: David McCormick
Subject: Fw: Urology Review Implementation Plans

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

Dear Stephen and Dermot

Please find attached recent information sent regarding the development of the plans for the implementation of urology.

Please could/would you suggest any key outcome indicators you would suggest for Pathology or Radiology associated with urology.

Please could you send to David McCormick by Friday 17 September.

Please do not hesitate to contact if you need clarification.

Kind Regards

Beth

Sent by Blackberry
Beth Malloy

Performance Management and Service Improvement Directorate Health and Social Care Board

Personal Information redacted
by the USI

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

From: Beth Malloy

To: Hillick, GeraldineA2 <[redacted]>; Seamus.McGoran setrust; Rankin, Gillian
<[redacted]>; Donnelly, Patricia <[redacted]>; Jackson,

Valerie <[redacted]>

Cc: David McCormick; Sullivan, Dean; Michael Bloomfield; Corrigan, Diane; Armstrong, Brian

<[redacted]>; 'McCann, Bronagh' <[redacted]>;

'Catherine McNicholl' <[redacted]>;

'Groogan, Sara2' <[redacted]>; 'Clarke, Paula' <[redacted]>;

'Sloan, Martin' <[redacted]>; 'John Simpson' <[redacted]>

<[redacted]>; 'margaret.ohagan' <[redacted]>

<[redacted]>; 'Waddell, Sandra' <[redacted]>;

'Keane, Patrick' <[redacted]>

Sent: Fri Aug 27 20:59:57 2010

Subject: Urology Review Implementation Plans

Dear Colleagues

As you will be aware from the Urology Review Project Board Meeting on the 1 July 2010 the plans did not contain sufficient evidence to show the expected outcomes for patients from the additional investment. There was limited evidence of the exploration of changes to working practices to deliver these levels of activity. It was accepted by members that the planned activity associated with the appointment of the additional Consultants had been estimated using the existing practices with limited quantified evidence of reform or modernisation of working practices.

As outlined in Hugh Mullen's letter dated the 27 April 2010 (Appendix 3), the Board provided initial assumptions for the activity expected from each team, as shown in the Urology Review. These figures are based on the recommendations and assumptions within the Review, which were sourced from the British Association of Urological Surgeons. These have been used as the basis to develop the workload model for each team. I have attached a summary of these assumption based on the planned individual work for one Consultant. It is appreciated that this will be challenging and will require considerable changes to current working practices, therefore the team should outline the expected timescales to achieve these expected levels of activity. As agreed at the Project Implementation Board Meeting, the revised implementation plans should be submitted to the Board by the end of October 2010.

I appreciate that these levels of planned activity also generate a number of questions that each of the teams should consider and will require further discussion at the next Project Implementation Board Meeting.

QUESTIONS

1. The Board is committed to the introduction of One Stop Clinics - do you think these should be measured in a different way and how best can these be measured?
2. Clinical Nurse Specialists are working under a Consultant how best should this be acknowledged or counted?
3. Is Urology disadvantaged by the BADS definition of urology day surgery (day anaesthesia) and would this be resolved by recording 23 hours stay separately. How could this be resolved?

4. How do you consider that 'coding' for IP/DC (procedure coding) and OP, has affected the Boards analysis?

I am aware that BAUS Council are considering shortly 'Planning Urology Services for the Future' and we will need to consider how the development of One Stop Clinics/Poly Clinics are taken into account as we move forward to implement the £3.5m investment and the Urology Review Recommendations.

At the next Project Implementation Board Meeting to be held on Friday 1 October, each of the teams has agreed to present the details of the patient pathways. This will focus on the four following areas:

- * Non Elective
 - * Renal Colic/Acute kidney obstruction
 - * Recurrent UTIs
- * Elective
 - * Lower Urinary Tract infection (Male)
 - * Raised PSA

This is intended this will facilitate discussion and agreement across the teams, in relation to the standardised pathway and management for patients with these conditions.

The Board has agreed with the Department that it is not necessary to complete a Green Book Standard Business Case and the Board Business Case Template will be sufficient. I will arrange for these to be sent to you.

As you will be aware the Board has previously made it clear to all Trusts that from March 2010, all radical pelvic surgery should only be undertaken on the Belfast City Hospital site. All Trusts should ensure that prior to the establishment of the new teams there are appropriate processes in place for the timely referral of these patients to the Belfast City Hospital.

As per the Project Implementation Board, it was agreed that teams would submit their suggested Key Performance and Patient Outcome Measures to the Board. Please ensure these are submitted to Personal Information redacted by the USI by Friday 17 September 2010.

Please will you arrange to circulate to your clinical teams?

Regards

Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate Health and Social Care Board Templeton House
411 Hollywood Road
Belfast
BT4 2LP
Northern Ireland

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by the USI
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Diane Corrigan

From: Louise McMahon <[REDACTED]>
Sent: 30 November 2010 22:58
To: Corrigan, Diane
Subject: RE: Today's discussion re benign surgery

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

O.K. It would also be useful to discuss - at your convenience - my mobile no. Is

Louise.

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

From: Corrigan, Diane
Sent: 30 November 2010 22:19
To: Louise McMahon
Subject: Today's discussion re benign surgery

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

Louise

Apologies if I was very twitchy on this issue at the meeting. Some months ago I sought some information on the numbers of such cases done by consultant in NI. This appeared to show that one Trust (largely because of one consultant) seemed to be undertaking a high number of cases given its catchment population. I had developed a concern that this might be the case following identification of an unusual non-surgical treatment regime being used within the same Trust for urinary tract infections.

I asked the Trust to investigate the issue, if necessary with external expert advice. Gillian Rankin and the Medical Director are taking this forward.
 Carolyn and Dean were aware of the issue.

In the meantime I was content that, as a result of letters written by both Beth and I some months ago, no further surgeries of this type could take place until the Trust concludes its investigation.

I was very concerned therefore that today's discussion could have changed our position and left the decision open to consultant discretion - when all those thinking it would be madness to do small numbers were not from the Trust which generated the concern.

I hope this makes sense and explains what may have seemed like a prickly response! I would be happy to fill you in sometime if you would like more detail.

Best wishes

Diane

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Diane Corrigan

From: Diane Corrigan
Sent: 02 December 2010 17:15
To: louise.mcmahon Personal Information redacted by the USI
Subject: FW: Confidential: Concern re Urology at CAH
Attachments: urologyletterploughran1sept2010.doc; NI cystectomy and/or creation of an ileal conduit as a primary procedure 200506 to 200910.xls

Louise

This is the background to the debate on radical pelvic surgery which arose again on Tuesday. Gillian Rankin and the Medical Director are taking this forward internally, ensuring that an appropriate process is followed to address the issues raised. It may be that the outcome of the investigation reveals that the clinical decision-making was within accepted clinical practice. If it does not, then it would become an SAI. Either way the precautionary principle seemed to dictate that no further benign cases would be operated on pending this process coming to a conclusion.

Subsequently, the issue was raised by SHSCT as a general query at the Urology Review Group. I believe that clinicians outside SHSCT may not be aware of the internal review being undertaken at CAH, hence the significance of the query may have escaped them. Even so, no clinicians working outside CAH were supportive of this surgery being done other than in a specialist centre.

If you have any questions please let me know.

Best wishes

Diane

From: Diane Corrigan
Sent: 03 September 2010 12:25
To: 'Donnelly, Lyn'
Subject: Confidential: Concern re Urology at CAH

Lyn

I thought that I should make you aware of a concern I have about urology at CAH. I enclose a letter sent to the Trust this week which is hopefully self-explanatory. I have been told that the morning before the letter arrived Dr Loughran, Dr Rankin and Mr Mackle had met to discuss the same issues. They have directed the consultants concerned to attend a meeting with them next Monday evening.

Senior colleagues in the PHA are aware of what I have done. I will keep you updated on developments.

Diane

Dr D Corrigan BA MPH FFPH
 Consultant in Public Health Medicine
 Public Health Agency
 Tower Hill

Armagh

BT61 9DR

Personal Information redacted by the USI

Personal Information redacted by the USI

GMC no. 2758116

Diane Corrigan

From: Diane Corrigan
Sent: 07 December 2010 12:33
To: Donnelly, Lyn
Subject: FW: SBA capacity - Urology

Importance: High

Fyi only

From: Beth Malloy [mailto: [Personal Information redacted by the USI]]
Sent: 07 December 2010 12:30
To: 'patricia.kilpatrick' [Personal Information redacted by the USI]
Cc: Louise McMahon; Corrigan, Diane
Subject: SBA capacity - Urology
Importance: High

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

Pat

I would appreciate some clarification re the SBA assumptions work, and I understand with the snow you are not likely to come over this week.

As you appreciate I am trying to continue to implement the Urology Review (with the caveat that the SBA capacity process may show areas of improvement) – one of the key issues the Board has tackled re the Urology Review is the transfer of the complex pelvic surgery to Belfast as an priority issue to ensure clinical/patient outcomes (this is for 3 of the 12 Consultants in Belfast – Team East which the Review explains).

Please can you confirm how the SBA capacity work will take into account this issue of Sub-Specialty work and that these complex patients will take longer in both outpatients and in surgery time? As recently as last Tuesday at the Urology Review Project Implementation Board some of the Consultants outside Belfast are still wishing to complete this complex surgery and we need to make sure that we consistently give the message this work is to be transferred into Belfast

Regards

Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate
Health and Social Care Board
Templeton House
411 Hollywood Road
Belfast
BT4 2LP
Northern Ireland

Mobile [Personal Information redacted by the USI]

Landline

Personal Information redacted by the
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Diane Corrigan

From: Diane Corrigan
Sent: 21 December 2010 09:38
To: Beth Malloy
Subject: RE: Urology

The number of patients who should come to complex cystectomy surgery is tiny. The MDT meetings should therefore be very short. However as a means of exercising control over what has been up to now single practitioner judgement this is important. What I hope I have misinterpreted is the intention to discuss all patients who have had urodynamic studies. This includes lots of patients with incontinence 99.99% of whom would never have cystectomy. I will gently query with Patrick.

Diane

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

From: Beth Malloy [mailto:]

Personal Information redacted by the USI

Sent: 21 December 2010 09:23

To: Corrigan, Diane

Subject: FW: Urology

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

Diane

A Regional MDT etc- This seems very complicated process for this group of patients - do you know what number of patients this will include - I assume if it is an uncommon procedure the numbers are small?

Regards

Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate Health and Social Care Board

Personal Information redacted
by the USI

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

From: Keane, Patrick [mailto:]

Personal Information redacted by the USI

Sent: 21 December 2010 08:49

To: Beth Malloy

Subject:

Dear Beth,

Further to our last meeting of the implementation group is the reply of all the urologists to the issue of.

This subject was not addressed at any stage by the review and relates to commissioning of services in services in individual hospitals. Benign cystectomy may form a part of the treatment of patients undergoing urinary diversion for a wide spectrum of urological conditions. It is an uncommon procedure but there is no guidance from IOG as to how this service should be delivered. There is widespread concern that erosion of the teams outside team east ability to provide these services would be very detrimental to Northern Ireland urology.

Benign cystectomy forms part of what is best described as functional surgery of the urinary tract. Functional surgery is widely diverse and needs to be provided in each urological unit.

We have had a meeting of the vast majority of urologists and all have been kept informed by email of the discussion.

We have reached consensus on how to proceed and I believe the system proposed below represents an elegant solution to the problem.

- * There should be a designated Lead Consultant for Functional Urology in each Team.
- *
- * The Lead Consultant should be responsible for the quality assurance and audit of diagnostic services in Functional Urology.
- *
- * All patients who have undergone urodynamic studies could / should be presented and discussed at a local MDT for Functional Urology.
- *
- * A Regional MDT structure should be established, with a Regional Chair.
- *
- * The Regional MDT should include Lead Consultants and Lead Urodynamicists.
- *
- * All patients considered for any non-endoscopic, surgical management should be presented and discussed at Regional MDM (which could take place once monthly).
- *
- * Such surgical management to be provided only with agreement at Regional MDM.
- *
- * Agreed surgical management to be provided by designated surgeons in appropriate location with agreement of referring clinician.
- *
- * The designated surgeons are Mr. Duggan and / supported by Ms. Woolsey at BCH, and Mr. O'Brien and / supported by Mr. Young at CAH (and designated surgeons in team North)
- *
- * Neuropathic reconstruction will be centred in team east.

This system should provide clinicians with the clinical backup they require and provide quality assurance for the HSC for the treatment of some of our most challenging patients.

There are a few technical details to sort out before finalising this response and a further meeting will be held in early January at which stage I will send you a formal reply. I assume they would be no issues from the Trusts in setting up an MDT structures such as proposed or more importantly PMSID would support this proposal to the Trusts.

The purpose of this letter is to allow you to consider the proposals and I would be grateful if you could indicate your general reaction to the proposals before 6/1/2011.

Happy Christmas

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Diane Corrigan

From: Diane Corrigan
Sent: 21 December 2010 10:46
To: Beth Malloy
Subject: FW: Urology

Beth

I'm a bit confused by his final comment - don't know if he means I intervened in an omnipotent way in an overbearing way or fortuitous - but hey ho.... but largely reassured by this - minimal resource requirement but a significant shift in clinical engagement and safer for patients who will have the collective wisdom of a group of consultants and not just one.

Watch this space.
Diane

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

From: Keane, Patrick [mailto:Personal Information redacted by the USI]
Sent: 21 December 2010 10:30
To: Corrigan, Diane
Subject: RE: Urology

Happy xmas

I will clarify this point in detail in January. The email is the preliminary view of the urologists of NI.

My understanding is that each team will have an interested surgeon/(s) but that patients being considered for major reconstructions would be discussed once per month at a regional MDT. This should be 1 hour every 4 weeks i.e 0.075 pa. The volume of this work should be very small.

This should obviate the need for 'benign cystectomy' as one assumes the MDT would rule it out as only 1 person is doing it.

The general feeling amongst the urologists outside Belfast is that they need to retain the skill base to do ileal conduits and augmentation provided the cases has been fully discussed. The proposed model of surgeons with an interest in this large group of patients should improve the standard of care. My understanding is that there is to be a review of incontinence services in NI and this structure for surgical services may be put in place anyway.

Their concern is that if this surgery goes to Belfast then we can have the lot i.e. huge numbers of patients which would swamp Belfast.

This is probably the best way forward and interestingly has engaged some wayward sheep in the process!!!!!! Your own intervention in this matter could be considered 'Divine'.

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

From: Corrigan, Diane [mailto:Personal Information redacted by the USI]
Sent: 21 December 2010 09:45
To: Keane, Patrick
Subject: FW: Urology

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

Dear Patrick

Beth forwarded your email to me. I detect between the lines some significant diplomatic skills at work!

Can I clarify bullet point 3 - are you suggesting that all patients who ever have urodynamic studies should be discussed at an MDT, or only those in whom surgery is being considered by their consultant? Even if it is the latter subgroup, does that include patients being considered for more common surgical procedures than cystectomy? If so, that would have wide implications for gynae colleagues as well as Trust management and commissioners.

Maybe I have misunderstood?

Best wishes

Diane

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

From: Keane, Patrick [mailto:]

Personal Information redacted by the USI

Sent: 21 December 2010 08:49

To: Beth Malloy

Subject:

Dear Beth,

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* The designated surgeons are Mr. Duggan and / supported by Ms. Woolsey at BCH, and Mr. O'Brien and / supported by Mr. Young at CAH (and designated surgeons in team North)

*

* Neuropathic reconstruction will be centred in team east.

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Diane Corrigan

From: Diane Corrigan
Sent: 29 March 2011 17:25
To: Lyn Donnelly
Subject: FW: UROLOGY
Attachments: 20110311_Ltr_dcorrigan_urology_PLABlw_.doc

Lyn
For the file
Diane

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

Personal Information redacted by the USI

From: White, Laura [mailto:
Sent: 11 March 2011 13:04
To: Corrigan, Diane
Cc: Rankin, Gillian; Mackle, Eamon; Brennan, Anne
Subject: UROLOGY

Dear Dr Corrigan

Please find attached letter from Dr Loughran in relation to the above.

Laura

Ms Laura White

Personal Assistant to

Dr Patrick Loughran

Medical Director

Southern Health & Social Care Trust

FIRBANK HOUSE

Craigavon Area Hospital

68 Lurgan Road

PORTADOWN

BT63 5QQ

Tel:
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Southern Health
and Social Care Trust

Medical Directorate

Dr D Corrigan
Consultant in Public Health Medicine
Public Health Agency
Southern Office
Towerhill
Armagh

Dear Dr Corrigan

The following is an updated position of the Trust's investigation and resolution of clinical matters within our urology services, about which we have spoken and corresponded. I refer to your letter of 01st September 2010.

IV fluid and anti-biotic patient group

All of these patients have been formally reviewed and the clinical management of each member of the cohort taken forward within a multi-disciplinary team chaired by the Clinical Director of Surgery [nursing, urological surgery and microbiology]. Patients are reviewed if symptomatic, and then managed on an agreed clinical pathway, which is initiated by a specialist nurse. Admission to the ward is possible but only if outpatient or day case management fails – usually in cases of severe sepsis. Antibiotic use is determined by surgeon and microbiologist in agreement and in line with the Trust's guidelines. The two patients with central venous access have had the venous cannulae removed last autumn.

There are no patients therefore remaining in the old group which was treated with episodic IV fluids and antibiotics.

Review of cystectomies.

The Trust has already confirmed that all urology patients with the potential for radical resection of the bladder for malignant disease are referred to the Belfast Trust for definitive treatment and follow up.

Also since last September 2010 all patients with benign disease and potential for cystectomy are referred to the Belfast Trust. The Southern Trust, therefore does not do any cystectomies, and this has been the position since last September 2010.

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

Tel: [redacted]
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/ Fax: [redacted]
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/ Email: [redacted]

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