RESPONSE TO REPORT OF FORMAL INVESTIGATION

I am writing this report in response to the report of formal investigation from Dr Neta Chada. My response is structured in parallel to the Dr Chada's report. In responding to the report, I have considered to set the reasons for the investigation in an historical context. Thereafter, I have commented upon the investigative process and the report itself. Lastly, I respond directly to the five terms of reference.

Historical Context

Igraduated in Medicine from the Queen's University of Belfast in 1978. After basic, postgraduatea surgical training in Northern Ireland, including a year as Demonstrator in Anatomy, and duringa which time I had spent some time in every surgical specialty, except for Urology, I applied for aa post as a Registrar in Urology at Belfast City Hospital in 1984. During my tenure in that post froma August 1984, I became increasingly impressed with Urology as a surgical specialty for a number ofa reasons: the greater ability to apply objective diagnostic tools to assessment of urinary tracta pathology, such as renography and urodynamic studies; the rapidly increasing role of endoscopica and minimally invasive surgery, and most importantly at that time, the varied spectrum ofa malignancies of the urinary tract. I became increasingly interested in new diagnostic tools in thea assessment of bladder carcinoma, such as nuclear image analysis and DNA flow cytometry.a

As DNA flow cytometry was unavailable in Northern Ireland at that time, I applied for and was appointed to the post of Registrar in Urology at St. James' Hospital, Dublin in July 1985, followed by a Research Fellowship at the Meath Hospital, Dublin, in 1986. I was appointed a Senior Registrar in 1988, and completed Higher Surgical Training in Urology on 30 June 1991. During that training, I was particularly aware that it pertained exclusively to adult Urology. As a consequence, I applied for and was appointed Senior Registrar in Paediatric Urology at the Royal Hospital for Sick Children in Bristol, taking up that post on 01 September 1991.

In May 1991, I received a phone call from Mr. Ivan Stirling, (now retired) Consultant Vascular Surgeon at Craigavon Area Hospital, to advise that Mr. W. Graham, Consultant Surgeon at Craigavon Area Hospital, was due to retire on 30 June 1991. He was a general surgeon who had developed an interest in urological surgery. Mr. Stirling advised me that there had been some discussion among colleagues as to whether he should be replaced by a general surgeon or by a urologist, and sought my view. I immediately advised that he should be replaced by a general surgeon and by a urologist. Some days later, I was invited to meet with him, his consultant colleagues and with the Chief Executive, Mr. John Templeton, over lunch. It was during that meeting that they appreciated that I had a two month hiatus prior to taking up the post in Bristol. I was asked whether I would spend some time during that two month period as a Locum Consultant at Craigavon Area Hospital, as Mr. Graham had 77 patients on his waiting list for elective admission for prostatic resection (TURP). After a one week break, I came to Craigavon Area Hospital, performing 77 TURPs, and a left ureteric reimplantation for ureteric stenosis, in seven weeks.

On Wednesday 28 August 1991, I was invited once again to meet with the Chief Executive and the remaining three Consultant General Surgeons, Mr. John O'Neill, Mr. Osmond Mulligan and Mr.

Ivan Stirling. I was earnestly requested to remain as a Locum Consultant Urologist with the intent that I would be appointed to a substantive post when approval was granted. However, as I passionately believed in the importance of a period of training in Paediatric Urological Training, I declined. However, the Chief Executive then advised me that obtaining approval would require a long battle, and which he was not prepared to embark upon, without my promise to apply for the post, if successful. I pledged to apply for the post, without fully understanding how it could possibly require such a battle to gain approval.

The only specialist urological service in Northern Ireland at that time was provided by the Department of Urology at Belfast City Hospital, led by five consultant urologists. I did anticipate that there would be strong resistance from that Department to the appointment of a Consultant Urological Surgeon, and indeed there was. I did not anticipate at all that the greater battle would be with the Director of Public Health at the South Health and Social Services Board, and who did not believe that there would be enough work for one consultant, and at a time when Northern Ireland had the least adequate urological services in the 34 EBU countries and in the 42 OECD countries!

In any case, the struggle was successful, the battle was won. I was appointed by competitive interview on 11 June 1992, and took up post 26 years ago, on Monday 06 July 1992. Mr. Graham had indeed been replaced by a urologist and by a general surgeon, Mr. Eamon Mackle, who had taken up post earlier in 1992.

On taking up post, I was provided with four inpatient beds in Ward 2 South, one inpatient operating session per week, one outpatient clinic per week, and the assistance of half a Registrar, Mr. Shamim Khan, who was then embarking upon the third year of a four year work visa in the UK. It was only after some time that I came to appreciate the reason for struggle to gain approval for the appointment in the first place, followed by such minimal provision of capacity on appointment. It was because in the minds of the majority of clinicians and managers, 'Urology' was spelt 'TURP'. However, during that first year, I had introduced ureteroscopic lithotripsy to Northern Ireland, performed the first and only radical prostatectomies in Northern Ireland, and on 15 December 1992, performed the first radical cystectomy and orthotopic bladder replacement in Ireland, and one of the first to be performed on a female in the UK. By 31 March 1993, the end of that first financial year, over 850 referrals had been received.

The first four years were most difficult, until the appointment of a second consultant urologist in 1996. During that four year period, I provided a continuous, 24/7, emergency urological service, except for one week when colleagues at Belfast City Hospital agreed to provide emergency cover while I attended the Annual Meeting of the American Urological Association. I did take off either two or three separate weeks from elective work each year, made possible by the continued assistance of Mr. Shamim Khan, who ensured that elective work continued, while I provided a continuous emergency service. I had also succeeded on obtaining Home Office approval for Mr. Shamim Khan to remain in the UK for one further year, from August 1994 until July 1995, as our Department's first Clinical Research Fellow.

That appointment was a necessity at that time as it had otherwise become impossible for a single consultant urologist to provide an adequate service to meet the increasing urological needs of the population of the then Southern Health and Social Services Board. By then I had secured four

inpatient operating sessions per week, and occupied 20 to 30 inpatient beds in Ward 2 South. We had begun to have outreach clinics in Armagh and Banbridge. We had urodynamic and flexible cystoscopy sessions, while still providing a continuous emergency service. It was also only made possible by the founding of CURE (Craigavon Urological Research and Education) by Mrs. Roberta Brownlee and myself in 1994. That enabled CURE to fund all of the costs of research while the Trust agreed to provide the salary of the Fellow as he provided clinical sessions in addition to undertaking research. Mr. Khan's research enabled him to be appointed a Senior Registrar in Dublin in 1995. He was appointed a Consultant Urological Surgeon at Guy's Hospital, London, in July 1999, was awarded an OBE in 2007, and was appointed Professor of Urology at King's College School of Medicine in 2017. Mrs. Brownlee progressed on several fronts, not least becoming Chair of the Southern Health and Social Care Trust Board in March 2011.

During subsequent years and much hard work, including numerous collections, charity lunches and Gala Dinners with guest speakers, including Lord Eames, Lord Trimble and Sir Kenneth Bloomfield, CURE had raised approximately £250,000, used to fund research by some five trainees, leading to their higher degrees. Our Ward Manager, Mrs. Eileen O'Hagan, since deceased, was a founding member of the British Association of Urological Nursing (BAUN). CURE still jointly sponsors with BAUN its annual keynote lecture given by an eminent international speaker, the Eileen O'Hagan Memorial Lecture. Through its collaboration with the Faculty of Health Sciences of the University of Ulster, CURE promoted the joint appointment of Mr. Jerome Marley as Lecturer Practitioner in Urological Nursing in 1998. Since then, through on site and distance learning, numerous urological nurses from around the world have been able to study academically accredited, urological nursing modules as part of their primary and higher nursing degrees. Mr. Marley was a founding member of the European Association of Urological Nurses in Brussels in 2000. In 2006, we launched the International Journal of Urological Nursing, with Mr. Jerome Marley as its first Editor in Chief. The Journal is the official organ of all national associations of urological nursing throughout the world, apart from the Society of Urological Nurses of America, which has its own Journal. I have to confess that it has been one of my proudest days was when I presented to Mr. John Templeton the first edition of the Journal on his last day as Chief Executive of Craigavon Area Hospital Group Trust.

The second Consultant Urologist, Mr. Wahid Baluch regrettably left his post at Craigavon Area Hospital in 1998, but was replaced by the appointment of Mr. Michael Young, who took up post in May 1998. By then, I had secured the approval of the Trust, with the support of the Southern Health and Social Services Board, for the establishment of first (and still only) on site, extracorporeal shock wave lithotripter (ESWL). During 1997, I had visited a number of leading on site ESWL centres in Belgium and Germany, and concluded that we should have the multipurpose Dornier Lithotripter in a setting adjacent to theatres, with anaesthetic facilities if required, but one also amenable to ambulatory access. With some resistance from other interests, I secured the current location of the Stone Treatment Centre which had been vacated by CSSD. On his appointment, I charged Mr. Young with the task of designing its interior. On his appointment, I had my first holiday with my family, outside of Northern Ireland, Personal Information redacted by the USI, since appointment in 1992.

The Urological Department at Craigavon Area Hospital had been remarkably successful in its first decade, and was widely recognised throughout Northern Ireland for being so. However, that success was achieved at the cost of much personal sacrifice for me and for my family, and also particularly for Mrs. Eileen O'Hagan, our Ward Manager, and whose death Personal Information redacted by the USI

in 2001 was, in hindsight, perhaps a harbinger of more difficult times to come. It is often said that everyone can be done without. I would add that not everyone can be done without as well. There is no doubt that the success of our Department led to some envious resentment, the Chief Executive having received complaints and delegations alleging favouritism. I believe that charge led to a long delay in further, desperately needed development of the service. It was after a commissioned, external review of urological services by Professor Sam Mc Clinton of Aberdeen that the Trust could be impressed of the dire need for further, urgent development.
Mr. Mehmood Akhtar was appointed to a third Consultant Urologist post in July 2007, facilitating the introduction of laparoscopic renal surgery. However, in 2008, we were devastated to be advised that we had lost our single inpatient department in Ward 2 South, our patients being dispersed throughout three general surgical wards. Even though our inpatients were later concentrated in one ward, Ward 3 South, it remains my contention that inpatient care has never been of the high standard it had been previously. Then, in September 2010, radical pelvic surgery for bladder and prostatic carcinoma was centralised to Belfast City Hospital. I was strongly opposed to this centralisation, in the belief that patients would suffer and die as a consequence. I submitted a written proposal that radical prostatectomy continue to be performed in both Derry and Belfast, while radical cystectomy would continue to be performed in Craigavon and Belfast. Of course, the proposal was dismissed. Meanwhile, I believe that two patients died of bladder cancer due to their not having radical cystectomies performed when they could have been, and radical prostatectomies have not been performed at all anywhere in Northern Ireland for several years. Moreover, the loss of radical pelvic surgery at Craigavon Area Hospital contributed to the departure of Mr. Akhtar in April 2012.

Mr. Akhtar had established and chaired a weekly Urology MDM in April 2010. On his departure two years later, I was appointed Lead Clinician of the Southern Trust Urology Multidisciplinary Team and Chair of the Urology MDM, in April 2012. Concurrently, my colleague, Mr. Michael Young, and I became increasingly concerned by ever increasingly long, waiting lists for elective admission for surgery, with the consequential risks of death and morbidity for those patients. We therefore embarked upon extended operating days, Mr. Young operating until 7 pm each Tuesday and my operating until 8 pm each Wednesday. After arriving home at 9 pm, and having the meal of the day, I would then typically spend three to four hours previewing the 30 to 50 cases to be discussed at MDM which I chaired the following day, finishing at 02.00 to 03.00 am. After each MDM, all clinical summaries were corrected and amended if required, and all outcomes were reviewed and signed off, with Mrs. Vicky Graham, Cancer Tracker and Coordinator, finishing by 7 pm each Thursday evening. So doing enabled formatted letters to be generated from CaPPS and sent by post to each patient's GP each Friday morning. No time was allocated in job planning for extended operating sessions, or for the previewing or reviewing patients discussed at MDM which I chaired each week.

In late 2012, I was requested by consultant colleagues and by the secretariat of NICaN to consider taking on the role of Lead Clinician of NICaN's Clinical Reference Group in Urology. I agreed to do so, if no one else offered to do so. Regrettably, no one did do so. I was appointed to that post in January 2013. Being Lead Clinician of the Southern Trust's Urology MDT and Chair of its MDM in addition to being Lead Clinician of the Regional Clinical Reference Group was a heavy burden and consumed much time and energy, particularly during the two years leading up to National Peer Review of Urological Cancer Services, both by the Southern Trust and Regionally, in June 2015. I wrote the required Operational Policy for the Southern Trust's Urology MDT, holding monthly

meetings with multidisciplinary colleagues to discuss and seek consensus for its many parts. I commissioned ongoing audits of histopathological diagnosis of prostatic carcinoma. I addressed deficiencies in input by radiology and oncology, which compromised MDM quoracy, and which still does. More successfully, I received a weekly update of those patients who were at risk of breaching cancer target timelines, undertaking to review and/or operate on these patients myself, with the result that not one patient had breached a target timeline during the previous six months by the time the Southern Trust was peer reviewed in June 2015.
It is worthy of note that there were some failures in preparedness for Peer Review. Firstly, I had sought the agreement of my consultant colleagues to advanced triage of red flag referrals to facilitate and expedite their assessment, diagnosis and management with the required timelines. It was not possible to obtain that agreement as my colleagues asserted that there was not enough time, while being urologist of the week, to do so. Similarly, they declined to provide to the Cancer Tracker a clinical summary of each patient to be discussed as is required, insisting instead that they would ask the Tracker to list patients for discussion at MDM, providing a copy of a letter dictated to a GP or other referrer, the Tracker having to compose a clinical summary for CaPPS, and which is contrary to the regulations. Once again, they declined to do so because of time constraints. Lastly, I failed to obtain the agreement of my colleagues to compile a management plan for each patient, a copy to be given to each patient and a copy to be included in the chart. This too has been a requirement of the National Cancer Plan. I do have to agree that this requirement was, and remains, entirely unrealistic, as there was simply not enough time to do so, and certainly not enough time when my colleagues had already asserted that there was not enough time to undertake advanced triage or to provide clinical summaries.

Concurrently, I was responsible for ensuring that Northern Ireland's Regional Uroiogical Cancer Services were prepared for National Peer Review by June 2015. This proved to be a significantly more complex process than preparing the Southern Trust for review. This entailed not only the Operational Policy for Regional MDM, it involved the composition of Clinical Management Guidelines for all aspects of referral pathways, investigations, diagnoses, management and review for all of the urological cancers. It entailed compliance with NICE and EAU Guidelines. It particularly included the identification of aspects of the patient pathways that could not be compliant with NICE or EAU Guidelines, either throughout Northern Ireland as a whole, or in areas within Northern Ireland. It included the commissioning of Operational Policies from Urological Surgeons, Clinical and Medical Oncologists, Pathologists, Radiologists, Clinical Nurse Specialists, Palliative Care Specialists and Nurse Practitioners. I believe that my work over a period of two years led to a successful Peer Review of Northern Ireland's Urological Cancer Services. During that time, I was also requested to join the National Peer Review Panel, being a member of the panel which reviewed the North West Urology MDT in June 2015.

Having completed the three year tenure as Lead Clinician of NICaN's Clinical Reference Group for Urology, I stepped down from that post in January 2016. I remained as Lead Clinician of the Southern Trust's Urology MDT until 31 December 2016, having completed National Peer Review updates in September 2015 and again in September 2016. With some substantial success, I addressed the chronic lack of input by Clinical Oncology to our MDM, and with much less success, the chronic inadequacy of radiological input to MDM, even though I met with the Medical Director for the first time in April 2016 to discuss the concerns of the MDT regarding this particular issue. Both these issues continue to pose an existential threat to the continuation of a Southern Trust Urology MDM.

The burden of the roles of Lead Clinician of the Southern Trust's Urology MDT, Chair of the Southern Trust's Urology MDM, Lead Clinician and Chair of NICaN's Clinical Reference Group in Urology from 2012 to 2016, and preparing both the Southern Trust and the Region for National Peer Review in June 2015 was considerable, particularly in terms of the time and energy required, both of which were additional to continuation of the usual and preceding, clinical commitments.

Since the departure of Mr. Akhtar in April 2012, the compliment of Consultant Urologists at Craigavon Area Hospital had increased to six. However, the operating capacity allocated to the Urological Service had not been correspondingly increased. Irrespective of the number of consultant urologists, and irrespective of operating capacity, the number of referrals continued to increase annually. One obvious consequence was that increased numbers of urologists were unable to provide operative management to increased numbers of patients referred, resulting in increasing numbers of patients waiting for ever longer periods of time for admission for surgery. The cohort of patients who suffered most severely were those acutely admitted in the first place. As there was no consultant staff available to operate on these patients when required, and no theatre capacity to facilitate their surgery, these patients were attended to after elective surgery had terminated, and by staff who had already completed an elective day, and in a manner which only temporised the acute condition, those patients then being discharged to a waiting list for readmission for definitive surgery, and at risk of acute readmission due to acute morbidity as a consequence.

After a long gestation period, the 'Urologist of the Week' was introduced in 2014. I have no doubt in asserting that the reason for the delayed introduction was the belief on the part of one or two of my colleagues that the Trust would not agree to funding its introduction as there would not be enough work to sustain it, and the reason for that belief was the failure to appreciate the distinction between 'Urologist of the Week' and 'Urologist on Call'. The latter would just have required the Consultant Urologist to be available when required and called upon by a Registrar. As a consequence, it was even proposed that we would have time to conduct an afternoon clinic each day when Urologist of the Week. It was as a consequence that it was agreed that we would be able to conduct triage when Urologist of the Week.

Even though I too agreed with the conduct of triage while being Urologist of the Week, I soon came to realise that there simply was not enough time to do so effectively and optimally whilst also delivering optimal, definitive and timely management to those patients who had been acutely admitted. I could not do so in addition to spending three to five hours conducting inpatient ward rounds with the registrar, assessing patients in the Emergency Department, advising regarding the management of acutely admitted patients elsewhere in Craigavon Area Hospital, Daisy Hill and South West Acute Hospitals, in addition to performing zero to six operations each day. It has been my belief and understanding that the primary purpose of Urologist of the Week is to optimally care for those patients acutely admitted to the above three hospitals due to urological pathology. To do this, the Urologist of the Week is required to undertake the duties described above and these are time consuming and it is therefore not possible to accommodate triage in addition to those duties without compromising the standard of care provided as Urologist of the Week, or compromising the standard of triage, or both.

In order for my colleagues to accommodate triage, it has been necessary for them to reduce the work done as Urologist of the week. For example, some do not come in to the hospital at all over the weekend. Some colleagues may not conduct a ward round during a particular day or days, letting the Registrar "get on with it." It has also recently been reported to me and other colleagues that one consultant did not do one ward round during an entire week on call. I have also observed some colleagues undertaking triage whilst the registrar "got on with it" in theatre. It has been the case that patients did not have their definitive operative management following their acute admissions, being discharged by the Urologist of the Week, only to be readmitted at a later date, suffering complication as a consequence. In outlining the above examples, it is not my intention to be critical of my colleagues but rather I am setting these out to explain that the demands of triage and the demands of the Urologist of the Week are not compatible and it has been my experience that having triage included in the workload of Urologist of the Week has compromised patient management and was therefore unsafe.

It is stated in the investigation report that I had argued for advanced triage to be employed as the method of triage by the department. It is important to point out that the reason why I believe this to be necessary is because the waiting times for first appointment for routine and urgent referrals are so lengthy that to allow that time to elapse without having directed some further investigations can lead to a compromised outcome. An example best illustrates the issue. Personal is a 63 year old man who was routinely referred in December 2017 with symptoms indicative of bladder outlet obstruction. He did not have any Red Flag symptoms such as haematuria. He had normal renal function and a normal serum PSA level. Urinary microscopy and culture were both normal. I triaged that referral and concluded that it should remain categorised as Routine. However, in addition, I wrote to the patient to advise that I would request an ultrasound scan of his urinary tract. I also wrote to the GP requesting that he prescribe Tamsulosin for the patient. When ultrasound scanning was performed at Daisy Hill Hospital in January 2018, it did indeed confirm that the patient had an enlarged prostate gland probably causative of of bladder outlet obstruction. However, it also indicated that he probably had a bladder tumour. That impression was then further assessed and confirmed by flexible cystoscopy. The patient has since had multifocal, high grade, transitional cell carcinoma with carcinoma in situ resected. He is currently undergoing intravesical BCG therapy.

If I had not taken the time to request ultrasound scanning, writing to the GP and the patient in the process, and acting upon the report, this man may not have received an appointment until 2019. I have absolutely no doubt that only one of my colleagues may have requested a scan. The probability would have been that he would have still been awaiting a routine appointment. However, it probably would have taken me a minimum of 15 minutes to review his details on NIECR, request the scan and write to both GP and patient. We currently receive approximately 160 referrals per week. Even if triage time per patient were a mean of half the time spent on the referral of Personal, that represents 20 hours of work while Urologist of the Week. Yet, to date, there has been no predictable sessional PA time allocated to triage in any of our Job Plans. Moreover, in my comments relating to the SAI report concerning Patient 10, in January 2017, I requested the Trust to address the issue of triage, determining who, when and in what manner it should be done. To date, there has been no response.

The year of 2016 proved to be difficult for several reasons. I had become increasing concerned by the morbidity, and risk of mortality, suffered by patients awaiting admission for surgery. I had

shared my concerns with colleagues and with the Head of Service on many occasions, at Departmental meetings during that year, as I had done during many years previously. I was so often advised that the waiting lists were a Trust issue, if only! It had been my experience that the Trust was either unaware of the waiting lists or times, and of the disparity between specialties, or were aware, but it was not an issue. For several years, I had not taken any leave for any reason on an operating day, or on any day when operating sessions were made available to me, when my colleagues did take leave. I continued with this practice during 2016 in an endeavour to mitigate so far as was possible the risk of harm to patients. I did so even though I was suffering increasingly from Personal Information redacted by the USI. In addition, I had undertaken to defer Personal Information for as long as possible to enable me to provide backup support to Mr. Suresh, for whom we had been requested to provide such support when he was Urologist of the Week, and which some of my colleagues had declined to do. It was when Mr. Suresh confirmed to me that he was returning to a Consultant post in England in October 2016 that I decided that I should Personal Information redacted by the USI [redacted]

The Investigation

I received a telephone call from the Medical Director's office, also on Wednesday 28 December 2016, to advise that the Medical Director wished to meet with me the following Tuesday, 03 January 2017 at 11.00 am. I advised that I would be unable to do so as I had a Day Surgical operating list that morning. However, I advised that I was happy to speak with him by telephone before then. I then was advised that the Medical Director was of the view that he required to meet with me in person, and offered to do so on Friday 30 December 2018. I enquired whether he was aware that I was on sick leave. I was advised that he did. I telephoned later to request an agenda, which was provided by email. Otherwise, I would have attended, unaccompanied, recovering from Personal Information redacted by the USI, while on sick leave.

The meeting was both shocking and devastating for both me and for my wife who accompanied me. It initiated the worst month in my life with serious consequences for my health. It initiated a period of trauma which still persists. Inter alia, I was advised of my immediate exclusion in accordance with the Southern Trust Guidelines for handling Concerns about Doctors and Dentists' Performance (September 2010) and Maintaining High Professional Standards in the Modern HPSS (November 2005). The exclusion was subsequently confirmed by the Medical Director in writing on 06 January 2017, when it was also confirmed that Dr. Khan had been appointed Case Manager, and Mr. Weir had been appointed Case Investigator. I was not advised of the appointment of a non - Executive member.

Cognisant of the stipulation in the Southern Trust Guidelines that the Investigation had to be completed within four weeks of the date of exclusion, and not having received any communication from the Case Investigator, I contacted Mr. Weir by telephone on 16 January 2017, when he advised me that he was equally cognisant of the significance of the four week period, but was alarmed to be advised by him that a meeting had been scheduled for him to meet with the HR Representative, appointed to assist him in the Investigation, on Thursday 26 January 2017, the

Personal Information redacted by the USI

20 December 2008

Ms. Catherine Mc Nicholl
Service Delivery Unit
Personal Information redacted by the USI

Dear Catherine,

I have reflected at length upon the direction of the Regional Review of Urological Services since attending the meeting at the Park Avenue Hotel on the 9th October 2008. I appreciated the opportunity afforded to me to share some of my concerns with you and with Mark Fordham when we last met at the same venue on 4th December 2008. I confess that it had been some years since I had once scanned 'Improving Outcomes in Urological Cancers'. I have since digested it twice. I have also had an opportunity to read and discuss the 'Models for Future Delivery' document. After all of that, I still do have genuine and grave concerns regarding the future of urological services, particularly those outside of Belfast.

In your introductory remarks on 9th October 2008, you expressed the view and desire that the Review was not about the past, or even about the present, but about the future. Whilst I understand the conceptual rationale, I believe that there is every probability that the mistakes of the past may be repeated, if not reviewed. More importantly, without a complete appreciation of the precarious journey from past to present, and the tenuous nature of the present, its simplistic replacement by the future carries with it risk of profoundly negative consequences. I am entirely honest in stating that I have not heard from anyone involved in the review to date, any sense of appreciation of how difficult it has been to achieve the present status, and how negatively the Review may impact upon it.

In 1990, there still remained a single, specialist urological department in Northern Ireland, at Belfast City Hospital, with five consultant urologists. Like many other singular specialist departments located in Belfast, it called itself the Regional Urology Service. Behind that title worked a mindset, which I often heard expressed, that they were singular out of necessity because of their specialist nature, and more significantly, that their specialist nature could only be optimally preserved if they remained singular. Moreover, that mindset completely superceded, for decades, any other considerations regarding need, demand or capacity throughout Northern Ireland. The claim to have, or the perception of the presence of, a 'first class' or 'world class' singular, specialist department, and worthy of the Regional title, blinded all to any inadequacy anywhere.

On 30 June 1991, Mr. Graham, a consultant general surgeon at Craigavon Area Hospital, and who had developed an interest in urology, retired. He did so leaving a waiting list which included 77 patients requiring TURP. On 30 June 1991, I completed higher professional training in Dublin. Surgeons at Craigavon Area Hospital learned that I had a 2 month hiatus before taking up a fellowship in paediatric urology in Bristol. I was asked if I would come to Craigavon to do some of those on the waiting list. I did all 77 in July and August 1991. By then, it was apparent to the Chief Executive and to all surgeons that there was undoubtedly a need to appoint a urologist. I was advised by them that this would entail a long and difficult battle, and I was asked to promise that I would apply if they won that battle. I was entirely unable to understand then, or since, how there could possibly be such a battle.

The battle lasted nine months, and it was very difficult. The late Mr. J. Kennedy, then senior Consultant Urologist, wrote that it was impossible to appoint a urologist at Craigavon Area Hospital as he or she would 'need special equipment'. The Board's Director of Public Health was most concerned that there would be adequate need or demand for one urologist, from a resident population of 290,000. Relentless pressure was placed upon the Board that the only safe and effective way of providing urological services at Craigavon Area Hospital was by a consultant jointly appointed by Craigavon Area and Belfast City Hospitals. However, in April 1992, the Chief Executive and surgeons at Craigavon Area Hospital gained the Board's agreement to appoint a urologist independently.

Meanwhile, I had fallen in love with paediatric urology and with Bristol, and the West Country. I had by then been offered a further year in Great Ormond Street, with the prospect of returning to Bristol as a consultant paediatric urologist. Everyone in Bristol thought that I was mad to decline that offer to return to a place in Northern Ireland, of which they had never heard. I was concerned about taking my family to Northern Ireland at that time. Even though I was born in Lurgan Hospital, the decision to honour my commitment to apply caused me great concern. I must be honest in confessing that the dominant reason I did, was to return home. I took up the post in July 1992.

This was the first appointment of a consultant urologist or urological surgeon in Northern Ireland outside of Belfast. I find it impossible to completely understand the origins or justifications of such forceful opposition to development in the face of such overwhelming need. The consultant : population ratio for Northern Ireland then was 1:260,000. If Northern Ireland was then a sovereign state, it would have had the worst or least adequate urological services in the EU or OECD countries.

I tried to tempt Colin Mulholland to come to Craigavon in 1993 as a second consultant urologist, but he preferred Altnagelvin Area Hospital, and precisely for the same reason that I had returned to Craigavon. He was returning home. All the better as there were now two fledgling departments outside of Belfast.

We appointed Mr. Wahid Baluch in 1996. Trained in Dublin and delighted to be appointed a consultant, Craigavon (in rural Northern Ireland) did not meet his aspirations. He left in 1998 for Personal Information redacted by the USI We offered his post to Mr. Michael Young in 1998. He did not accept until he was interviewed four days later for a consultant post in Belfast City Hospital, a post he expected to be offered and which he intended

to accept. The post at Belfast City Hospital was offered to Mr. Thomas Lynch instead, enabling Mr. Young to accept our offer. In 2004, we offered a third consultant post to Mr. Tariq Sami, who ultimately preferred to remain in his post at [redacted] Hospital, rather than return to Craigavon. Mr. Richard Batstone withdrew in 2007 because he and his family felt isolated in rural, mid Ulster. Mr. Akhtar was appointed to that third post at Craigavon in 2007. [redacted] It has taken 15 years for us to increase our consultant complement to three, for a resident population now approx. 320,000, and there is no guarantee that the third will remain. This has been our experience in the Southern Area. With respect, it is not an experience of anyone in SDU, or elsewhere in the Department, or NICE, or even in our own Southern Board. It has been my experience, of 16 years duration, and Mr. Young's during these last 10 years, and the greatest burden is the daily struggle to compensate for the inadequacy.

Similarly, Mr. G. Lennon was appointed a consultant at Altnagelvin Area Hospital in 1997. He left three years later for the richer pastures of [redacted] Mr. Schattka was appointed in his place, and remains in post.

Mr. Robert Kernohan, Consultant Urologist at Belfast City Hospital, developed a presence in Coleraine during the nineties. He transferred to Coleraine full time, when the new Causeway Hospital opened, including a substantial investment in urological services. Mr. Paul Downey was appointed to a second consultant post in Coleraine. Mr. Downey left a consultant post in endo-urology, at the University Hospital of South Manchester, as his wife severely wanted to return home to Northern Ireland. Mr. Kapasi was appointed to a third consultant post in Coleraine earlier this year, and concurrent with the resignation of Mr. Kernohan. His resignation is the loss of one of the most talented, skilful, urological surgeons in Northern Ireland, and that loss is suffered by rural Northern Ireland in particular. I believe that there should be no doubt in anyone's mind that his resignation is the first negative consequence of the changes which have already taken place, and those considered to be imminent.

I would never have imagined in 1991 or 1992 that it would be such a painful, frustrating, disappointing and disillusioning experience to see urological services throughout Northern Ireland reach adequacy, at least for the demand, if not the need. In 1996, BAUS recommended a consultant : population ratio of 1:80,000. This was accepted by the Department of Health at Westminster, in 1997, as the standard to be aimed for in England and Wales. I participated in a Review in Northern Ireland in 1998, and chaired by Dr. Hall, then Principal Medical Officer. Due to Northern Ireland having a younger age profile than England and Wales, the Department insisted that it would aim instead for a ratio of 1:100,000, and to have reached that standard by 2008! It would appear from 'Models of Future Delivery' that the BAUS recommendation of 1996 may now be considered an appropriate hallmark of consultant numbers in Northern Ireland, as a whole. Meanwhile, in 1999, the Urological Manpower Committee of the European Board of Urology reported that the mean ratio in the 33 member, associated and affiliated countries was 1:54,000. That calculation excluded all office urologists. That ratio has since fallen to 1:45,000 by 2005.

I really do regret this long narrative, but do believe it essential to ensure that you have a certain and complete grasp of the status quo, particularly that outside of Belfast. For me, the huge elephant in the room has always been service inadequacy, in recent times referred to as 'capacity issues'. When a region is served by a singular specialist department, service inadequacy in a sense does not exist, as it is invisible, as the specialists do not work in the locations where it is visible. And so for years, it is entirely possible to have a 'first class' but grossly inadequate service. This centralising force can be powerful and influential, tempting but deceptive. The alternative attempt to proceed towards adequate capacity by establishing specialist services in locations where none have previously existed, and enhancing those which do exist, may be resisted and frustrated by several 'interests', from general surgeons with an interest in urology, to Medical Directors and Chief Executives, to Trust Boards and Health Boards, to the Department of Health, and with urologists with their own vested interests scattered along the way. It would appear that the pursuit of quality and that of quantity are perceived to be in endless conflict. The first casualty of limited resources has always been quantity, and those who have made those 'difficult decisions' to sacrifice quantity always assuaged by the reassurances given that they have ensured that the limited services provided are 'first class', 'world class', 'gold standard'.

However, the need for the long narrative has little to do with the conflicting demands of quality and quantity, of which you are entirely au fait. I believe that it is vitally important that you fully appreciate that the dominant factor in the development of specialist services outside of Belfast, ab initio to date, has been the existence of a few trainees preferring to be appointed to consultant posts outside of Belfast. I did not apply for a post at Craigavon Area Hospital in 1992 because it was advertised. In fact, the post would never have materialised without my commitment to apply. Similarly, the post at Altnagelvin Area Hospital was advertised in the rare belief that a highly desirable appointee actually wanted to be appointed there, and to stay there. Indeed, when Mr. Kernohan began services in Coleraine, there was not even a post to go to. The development of services in all three locations has been chiefly frustrated by the preference of the overwhelming majority of potential applicants to be appointed to posts in Belfast or other cities in UK and Ireland.

It had been intended that centralisation of complexity would have been facilitated by the introduction of a two-tier training, producing consultant urologists after three years of training, and consultant urological surgeons after six years. Thankfully, in my view, it took only a short time for those committed to this concept, to realise and acknowledge that the concept was flawed. Now, we have reverted to a five year training programme, and with the option of applying for one additional year in a fellowship. Future training will be substantially similar to that of previous years, and possibly structurally better. I would expect that the overwhelming majority of competitive, ambitious, future trainees will complete fellowships, either in UK or elsewhere. I believe that urological departments in hospitals in rural Northern Ireland will face the same difficulties in recruitment and retention of consultants in future years as in past years. If those departments are to become deskilled, I fear that those difficulties will become impossibilities.

I have been advised that the number of trainees in UK is expected to significantly exceed the number of available posts for some years to come, and thus reassured that the prospect of unemployment on completion of training should ensure that all posts will be filled. If so, I fear once again that Colchester will come before Craigavon. I believe that there is a significant risk that the future status of urological service provision outside of Belfast will be so relegated.

It is for all of these reasons that I believe that the Regional Review of Urological Services should not arrive at any conclusions that put at risk the gains which have taken so long to achieve.

It may come as a surprise to read that I found much in 'Improving Outcomes in Urological Cancers' of merit. However, I do have grave concerns regarding the weakness of the evidence, particularly that upon which empirical recommendations are made regarding institutionalised work load. I am profoundly concerned that the authors saw fit to do so, even though they had reported that 'little direct research has been carried out on the organisation and delivery of services...Research designs which might be regarded as of relatively poor quality for evaluating a clinical intervention, may therefore be the most reliable available for assessing the organisational issues'. I would strongly recommend that you read 'Volume-outcome relationship in surgical urology: myth or reality?' by Erik K. Mayer et al., in the British Journal of Medical and Surgical Urology, Volume 1, Issue 2, September 2008. The authors report that the 'methodological quality of volume-outcome research does not appear to have vastly improved...with the implication that, at best, existing study design is only modest. This potentially limits the transferability of existing studies' reported correlations to clinical practice, and also raises the question whether much of the volume-outcome relationship will be voided by more methodologically robust research'. In particular, there are strong justifications for dissociating volume-outcome relationships pertaining to individual surgeons from the volume-outcome relationships pertaining to the institutions in which they work. In fact, more recent awareness of the multitude of factors contributing to institutional outcomes would question the legitimacy of that association in the first instance. Yet, the chief recommendation pertaining to complex pelvic surgery relates to the institution rather than the surgeon! I believe that the selective referral hypothesis is the determinant of individual volumes and outcomes in Northern Ireland, and should remain so.

Similarly, and with particular relevance to Northern Ireland, I do not believe that there is robust evidence to combine radical prostatectomy with radical cystectomy in institutionalised complex pelvic surgery. Apart from the fact that they both involve viscera in the anatomical pelvis, and that radical cystectomy includes removal of the prostate when performed in the male, they have little else in common. They are performed for radically different pathologies, with different urgencies, in very different patient cohorts (for whom geographical access have relatively different import), with entirely different complication and adverse risks, and requiring entirely different surgical experience and expertise. Cystectomy performed for bladder cancer may not always necessitate being radical, may be sexuality-preserving, and followed by orthotopic bladder replacement or by continent diversion. I do therefore find it somewhat alarming and deeply worrying that urological cancer service provision in Northern Ireland would be compelled to be compliant with Guidelines which give precedence to institutional volumes of two different operations for different

pathologies in different patient cohorts, without any justifying evidence, while relegating the experience (volume) of individual surgeons to a secondary status of transitional import, and their expertise to that of hypothetical aspiration. As there is no statutory or similarly binding obligation to be compliant, I would indeed agree that one should be pragmatic and sensible in the application of the Guidelines.

For all of these reasons, I would ask that the following recommendations be considered:

That any surgeon performing radical prostatectomies should perform a minimum of 10 per year

That any surgeon performing cystectomies for bladder cancer (usually radical) should perform a minimum of 10 per year

That radical prostatectomies be performed only at Altnagelvin Area and Belfast City Hospitals.

That radical cystectomies be performed only at Belfast City and Craigavon Area Hospitals.

I believe that the above configuration would largely preserve the current skill status at Altnagelvin Area and Craigavon Area Hospitals, without compromising the future enhancement of Belfast City Hospital. I do also believe that it would enhance the rationale for the Three Team Model of Regional Service Delivery.

Whilst I believe that the Three Team Model will probably become the preferred model, it does remain my view that urological need at Antrim Area Hospital will not be adequately met by providing outreach services of an outpatient, diagnostic and day surgery nature alone. If a presence is to be provided 7 days per week, the only point of so additionally doing is to be able to provide emergency and urgent care. Such will inevitably require inpatient surgery. It is my view that such surgery should be provided at Antrim Area Hospital, and that it would not be appropriate to have to transfer such patients to Belfast City Hospital. Therefore, it is my view that two or three consultants should be appointed to Antrim Area Hospital, irrespective of the Model option chosen. If part of Team East, those appointments may be of greater immediate priority than the next two appointments at Belfast City Hospital.

While all of the contents, views and recommendations contained in this letter are mine and mine alone, I can advise you that I have discussed my views with my two colleagues at Craigavon Area Hospital, and that they are supportive of my recommendations. In seeking your consideration of them, I do earnestly believe that these recommendations, and any others, should be submitted to another meeting of all consultant urologists early in the New Year. I therefore formally request that the above recommendations be so,

Yours most sincerely,

Aidan O'Brien,
Consultant Urological Surgeon.

100.7126264.1

Regional Review of Urology Services

Team South Implementation Plan

Document History	
Document Name:	Team South Implementation Plan
Status:	Draft v0.1
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Origin:	Acute Planning SHSCT

Contents

Tables

Appendices

1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a Trust Grade Doctor from August 2010),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The clinical sessions which are currently being undertaken by medical and specialist nursing staff are given as Appendix 1.

The ICATS Service

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

ICATS	Weekly
Prostate Assessment	1.5
Prostate Biopsy	1
Prostate Histology	1
LUTS	3
Haematuria	2
Andrology	2.5
General Urology	2.5
	13.5

Main Theatres (CAH)	Weekly	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly[2]	1 monthly
Flexible Cystoscopy	1.5 weekly[3]	
Lithotripsy	1 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover
3) 2 lists/1 list on alternate weeks

Current Activity

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. The new outpatient attendances are therefore understated by approximately 240.

Table 2: 2009/10 Actual Activity for the Urology Service

		Core Activity	IHA	IS	Totals
2009/10	Cons Led New OP	610	474	0	**1084**
	ICATS/Nurse Led New OP	1233	30		**1263**
	Total New OP	1843	504	0	**2347**
	Cons Led Review OP	2391	70	0	**2461**
	ICATS/Nurse Led Rev OP	1594	0	0	**1594**
	Total Review	3985	70	0	**4055**
	Day Case	1502	3	383	**1888**
	Elective FCE	1199	29	140	**1368**
	Non Elective FCE	629	0	0	**629**

Activity by consultant for 2009/10 is provided in Table 3.

Table 3: Activity by Consultant for 2009/10

		Mr Young[2]	Mr O'Brien	Mr Akhtar[3]	All Core Activity
2009/10	New OP	242	174	193	**609**
	Review OP	964	903	327	**2194**
	Total OP	1206	1077	520	**2803**
	Day Case	696	452	354	**1502**
	Elective FCE	380	512	307	**1199**
	Non Elective FCE	233	210	186	**629**
	FCEs + DCs	**1309**	**1174**	**847**	**3330**
	Day Case Rates [1]	65%	47%	54%	56%

[1] INCLUDES flexible cystocopies (M45) and DCs/FCEs with no primary procedure recorded.
[2] Mr Young's new outpatients are understated by an estimated 240, as Stone Treatment new attendances were recorded as reviews.
[3] Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

Notes:
1) Source is Business Objects
2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)
3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).

4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.

There is a substantial backlog of patients awaiting review at consultant led clinics. The total number of patients is 4,037. The Trust's plan to deal with this backlog has been included as Appendix 2.

Pre-operative Assessment

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

Suspected Urological Cancers

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The only outstanding issue is that of oncology input to the meeting. Confirmation of when this will be available is awaited from Belfast Trust and it is expected that a date for commencement will be available in the near future.

The Southern Trust provides chemotherapy only for prostate cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers and radiotherapy for all cancers is provided by Belfast Trust. When oncology support is

available for the MDM then referral will take place during the meetings. An interim arrangement is in place with referral taking place outside the meetings.

The Trust accepts that all radical pelvic operations will be undertaken at Belfast City Hospital. The Trust asks for clarification with regard to:

- At what point in the pathway patients should be referred;
- Arrangements for review of the patients.

3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position with further detail being provided in Appendix 3.

Table 4: Regional Benchmarking

		2006/07	2007/08	2008/09	2009/10
New : Review Ratio	All Trusts	1.96	2.03	1.79	1.68
	SHSCT	**4.04**	**3.27**	**3.28**	**2.09**
Day Case Rates	All Trusts	50.1	48.5	49.8	48.5
	SHSCT	**43.8**	**45.5**	**48.8**	**40.0**
Average LOS (elective)	All Trusts	3.7	3.5	3.4	2.9
	SHSCT	**3.7**	**4.3**	**3.9**	**2.7**
Average LOS (non elective)	All Trusts	4.8	4.7	4.6	4.4
	SHSCT	**4.5**	**4.8**	**4.6**	**4.7**

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1st January – 31st December 2009. The Trust's length of spell compares very favourably with the peer group average.

Check if these were just elective procedures.

Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The Trust has compared its performance to the BADS targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete). The analysis is provided as Appendix 4. The Trust will use the BADS recommendations to determine appropriate day case rates for the new service model for urology.

4. Demand for Team South Urology Service

The Trust has utilised the methodology recommended by the Board to calculate the demand for the service. It has been assumed that the population of Fermanagh will be similar to the Southern area. As inclusion of Fermanagh will increase the population catchment area for urology by 18%, an uplift of 18% has been applied. Table 6 overleaf shows the calculation of the estimated demand for the service. It should be noted that this does not factor in any future growth in demand.

Table 6: Projected Activity for Team South

		2009/10 Actual Activity					
		Core Activity	IHA	IS	Growth in WL	SHSCT Activity to be Provided	Team South Capacity Required [6]
2009/10	Cons Led New OP	610	474	0	87	1171	1382
	ICATS/Nurse Led New OP	1233	30		100	1363	1608
	Total New OP	1843	504	0	187	2534	**2990**
	Cons Led Review OP	2391	70	0		2461	2904
	ICATS/Nurse Led Rev OP	1594	0	0		1594	1881
	Total Review	3985	70	0		4055	**4785**
	Day Case	1502	3	383	47	1935	**2283**
	Elective FCE	1199	29	140	28	1396	**1647**
	Non Elective FCE	629	0	0		629	**742**

1) Source is Business Objects
2) Activity has been counted on specialty of clinic
3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog . As shown N:R = 1:2
4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
5) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
6) 18% added for Fermanagh, based on population size relative to SHSCT population

The projected demand from Table 6 was used to calculate the numbers of session which will be required to provide the service. These are summarised in Table 7 below with the detail of the calculations provided as Appendix 5.

Table 7: Weekly Sessions for New Service Model

	Weekly Sessions
Consultant Led OPs	
General	5
Stone Treatment	1
ICATS	
Prostate Assessment	1.5
Prostate Biopsy [1]	1
Prostate Histology [2]	1
LUTS	3
Haematuria	1
Andrology/General Urology	5
Urodynamics	1.5
	14
Main Theatres	9
Day Surgery	
GA	3
Flexible Cystoscopy	3
Lithotripsy	1/2

1) Prostate Assessment and Biopsy will run side by side
2) Consultants will see their own patients, so whilst this has been noted as a single session, it is unlikely to be a single session in practice.
3) All sessions with the exception of ICATS andrology & general urology, will run over 48 weeks. ICATS andrology & general urology will run over 42 weeks.
4) Lithotripsy day case sessions have been calculated over 42 and 48 weeks. A second consultant with special interest in stone treatment will be required if sessions are to run over 48 weeks.

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The ICATS service is currently being reviewed. Some changes which will improve the service provided to patients have already been agreed by clinical staff. These include:

- The prostate pathway has been reviewed (a draft revised pathway is included in Appendix 6). Patients requiring a biopsy will be given the opportunity to have this done on the same day as their initial assessment (where this is clinically appropriate).
- Patients triaged to the haematuria service will have flexible cystoscopy carried out on the same day as their initial assessment. In the current service model these patients have to come back to the hospital to have this done in the Day Surgery Unit.
- Urodynamics will move from the inpatient ward to the Thorndale Unit and sufficient staff will be trained to avoid backlogs of patients awaiting investigation.

The Andrology and General Urology elements of the ICATS service will be reviewed over the coming months.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals. Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time. The frequency of sessions is to be agreed with the Western Trust.

Outpatient clinics will be held at Craigavon, South Tyrone, the Erne and Armagh Community Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

Consultant and Nurse led sessions will be provided over 48 weeks. The detail of job plans is to be agreed with clinical staff but they will be based around the sessions identified in the previous section. Due to available theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

Work is ongoing to develop patient flow and clinical pathways for the service. Draft pathways are included as Appendix 6. The on call urologist at Craigavon Area Hospital will be available to provide advice at any time to medical staff at the Erne or Daisy Hill Hospitals on the management or transfer of emergency cases.

6. Timetable for Implementation

Task	Timescale
Submission of Team South Implementation Plan	22 June 10
Approval to Proceed with Implementation from HSCB	July 10
Completion of Job Plans/Descriptions for Consultant Posts	End July 10
Completion of Job Plans/Descriptions for Specialist Nurses	End July 10
Consultant Job Plans to Specialty Advisor	End July 10
Advertisement of Consultant Posts	September 10
Advertisement of Specialist Nurse Posts	September 10
New Consultants and Specialist Nurses in post	February 11

APPENDICES

Proposal to Manage Urology Review Backlog

Process to manage the substantial volume of patients involved in Urology - Total = 4037 (2008- 31 May 2010)

- Identify patients who may be at risk and require an urgent review
- Identify patients who require a consultant reassessment in an agreed timeframe
- Cleanse list – ensure that there are no duplicate open requests for same issue.

The Specialty Nurses have agreed to coordinate the process by reviewing patient centre letters and results and collate into the following categories:-

Category 1: Urgent appointment required
Automatically arrange an urgent review appointment

Category 2: Decision required on review management
Lead nurse will meet with consultant to determine a plan for each patient, i.e. either agree review required in a specified time frame or agree an alternative plan.

Category 3: ?Discharge based on clinical results available
Lead nurse to get permission from consultant to discharge and send letter to GP and patient

Category 4: PAS errors/duplication
Lead nurse to get permission from consultant to discharge from PAS

To date there has been a reduction in the waiting list by 6%.

ICATS: Haematuria pathway – MALE & FEMALE

Referral from GP/ other hospital dept/other urology service

Triaged to ICATS haematuria service by consultant & appointment managed by ICATS secretary with priority given to red flag referrals

Appointment arranged at haematuria assessment clinic ICSNUHEA 4 patients – currently Wed am

Assessment at clinic includes USS urinary tracts, urinalysis, MSSU, direct microscopy & cytology, bloods i.e. U&E,COAG, FBP, Glucose+/- PSA after counselling & clinical observations. History taking (inclusive of clinical history & medications, symptoms, gynaecological history, risk factors i.e. smoking or occupational factors.

Appointment details given for flexible cystoscopy (2 weeks later)

Flexible cystoscopy & physical examination

All results collated and discussed with patient & GP informed of outcome

Outcomes: *no review option at this service*

- Diagnostics: e.g. IVP
- Direct treatment on inpatient/daycase list e.g. GA biopsy / TURBT
- Return to primary care with advice
- Hospital OPD / Other ICATS service as appropriate i.e. LUTS, Andrology

Additional information

- Refer to NICAN haematuria pathway
- Aim to provide this assessment at one stop visit
- Haematuria service also provided at DHH – initial appointment at flexible cystoscopy with diagnostics to follow ?? direct booking at DHH

ICATS: LUTS pathway – MALE ONLY

Referral from GP/ other hospital dept/other urology service

Triaged to ICATS LUTS service by consultant & appointment managed by central booking (in line with PTL targets)

Appointment arranged at either new male LUTS clinic – ICSNULUP Mon pm 4 patients / ICSNULU5 Fri am 4 patients

Assessment at clinic includes USS urinary tracts, Urine flow study & urinalysis, IPSS & history taking (inclusive of clinical history & medications, urinary symptoms & sexual function history, bloods i.e. U&E, Glucose +/- PSA after counselling & MSSU).

Results (where possible at same visit) & information to patient & GP

Outcomes: *aim a maximum of 2 reviews before discharge from ICATS*

- Diagnostics: e.g. flexible cystoscopy, Urodynamic studies
- Direct treatment on inpatient/daycase list e.g. Prostate biopsy, TURP
- Return to primary care with advice
- Hospital OPD / Other ICATS service as appropriate i.e. Andrology
- Review at LUTS clinic – see above

Additional information

- LUTS review clinic ICSNULUT – Mon am 8 patients
- BPH / chronic urinary retention are examples of conditions routinely assessed & where possible managed via this clinic

ICATS: Prostate diagnostic pathway - MALE

Referral from GP/ other hospital dept/other urology service

Triaged to ICATS Prostate Diagnostic service by consultant & appointment managed by central booking (in line with PTL targets) & red flag referrals appointed by cancer services

Appointment arranged at either new prostate assessment clinic – ICSNURSA Mon am 4 patients / alternate Thursday am 4 patients

Assessment at clinic includes USS urinary tracts, Urine flow study & urinalysis, IPSS & history taking (inclusive of clinical history & medications, urinary symptoms & sexual function history, bloods i.e. U&E, Glucose & MSSU, PSA & DRE).

Results (where possible at same visit) & information to patient & GP

Outcomes: *no review option at this service*

- Diagnostics: e.g. CT / Bonescan / MRI
- Direct treatment on inpatient/daycase list e.g. prostate biopsy
- Return to primary care with advice / PSA monitoring
- Hospital OPD / Other ICATS service as appropriate i.e. LUTS, Andrology

Additional information

- Refer to NICAN prostate pathway
- Red flag patients currently scheduled into Thursday clinic and any free space on Monday clinic

Suspected Renal colic

Flank pain, haematuria, prior history renal stones
KUB in Xray confirms presence renal stones

No

Yes

IVU/NCCT
Confirms stone and no obstruction

IVU/NCCT
Confirms stone and/or hydronephrosis or solitary kidney.
Contact urology to review and arrange admission
Pyrexia ^ 38

No

Yes

Referral to General Surgery or Gynaecology (Females)

Commence on Tamsulosin 4oomcg for 4 weeks

Refer to Stone Treatment Centre, Craigavon Hospital for review

Recurrent Urinary Tract Infections

Step 1 – Nurse Led Service

- Urine cultures- frequency to be determined by Consultant Nurse to obtain and monitor results and liaise with Consultant regarding any change to pathway including frequency of sample.
- Oral antibiotic regime prescribed and altered by Consultant Urologist as per culture with input when necessary from Bacteriology

Step 2 – Intravenous Antibiotic Regime

- Nurse led Service
  Day case attendance
- IV/SC Therapy
  Co-ordinator
  community
- Inpatient
  Culture sensitivity
  Symptomatic
  Venous access easily obtained

Step 3 – Intravenous Fluids and Antibiotic Regime

- Nurse Led Service
  Day case attendance Monday – Friday
  Consultant to prescribe Intravenous Antibiotic regime as per Culture and with input when from Bacteriology
- Inpatient
  Symptomatic
  Culture Sensitivity
  Venous access compromised

Making diagnosis of Urinary Retention in the A&E department

Medical assessment to include
DRE, FBP, U&E, BLOOD SUGAR, PSA

→ PSA done but not impacting on decision

↓

Administer prophylactic antibiotics (clarify)
Pass correct length urethral catheter –
Send a CSU for culture

→ Catheterisation Unsuccessful

↓

Contact Urology unit
Admit

Catheterisation Successful

→ **Admit to Craigavon Urology unit if**

- output greater than 700mls (observe x 2 hours)
- abnormal creatinine
- unfit/elderly
- female patients
- infection suspected
- neurological deficit
- haematuria
- difficult catheterisation

→ **Less than 400ml**
Consider alternative diagnosis (UTI) or cause painful abdomen

→ **400-700ml**
Patient fit and normal creatinine
Start Alfuzosin 10mg OD

↓

Discharge Home

Refer to either Ambulatory Care Manager or Community Continence Team for follow up and or TWOC.

Ensure catheter discharge form completed and take home pack is given to patient

Pathways for Non-Elective Admissions to either Daisy Hill or Erne Hospitals that do not have an acute Urology Unit

Patient presents at Accident and Emergency in either Daisy Hill or Erne Hospitals

Testicular Torsion

Suspected cases of Testicular Torsion should be dealt with by the surgical team

Testicular Infection

Suspected cases of Testicular Infection should be dealt with by the surgical team at the presenting hospital

The patient should have an ultrasound carried out to exclude Testicular Tumour

Patient should then be referred to the Urological Team at Craigavon Area Hospital

Renal Colic

The patient needs to be assessed by the Surgical Team at the presenting hospital

Investigations such as non-contrast CT, IVP/Ultrasound should be undertaken to confirm diagnosis

This combined with the patient's renal function and sepsis status will govern the acuteness of the referral pathway.

Haematuria

Patients admitted with Haematuria/Clot retention that are requiring admission are to be assessed for need of catheter insertion.

Initial investigations of ultrasound and IVP should be undertaken followed by contacting the Craigavon Area Hospital for further advice on referral pathway as there may be a need for transfer or subsequent consultation

Infection – Recurrent Urinary Tract Infection/pylelonephritis

The patient needs to be assessed by the Surgical Team at the presenting hospital.

The patient will need a catheter inserted
Current guidelines and a protocol are being drawn-up for insertion of Catheter by the Urological Team at Craigavon Area Hospital and this will be available on all sites

Note: Any entity defined as a Urological Emergency can be referred/discussed with the Urological team at any time for advice/guidance on how best to manage/transfer

If advice is required on any of the above the Urology On call doctor should be contacted via Craigavon Area Hospital Switchboard

Personal Information redacted by the USI

Making diagnosis of Urinary Retention in the A&E department

Medical assessment to include
DRE, FBP, U&E, BLOOD SUGAR, PSA

→ PSA done but not impacting on decision

↓

Administer prophylactic antibiotics (clarify)
Pass correct length urethral catheter –
Send a CSU for culture

→ Catheterisation Unsuccessful

↓ Contact Urology unit
Admit

Catheterisation Successful

→ **Admit to Craigavon Urology unit if**

- output greater than 700mls (observe x 2 hours)
- abnormal creatinine
- unfit/elderly
- female patients
- infection suspected
- neurological deficit
- haematuria
- difficult catheterisation

→ **Less than 400ml**
Consider alternative diagnosis (UTI) or cause painful abdomen

→ **400-700ml**
Patient fit and normal creatinine
Start Alfuzosin 10mg OD

↓

Discharge Home

Refer to either Ambulatory Care Manager or Community Continence Team for follow up and or TWOC.

Ensure catheter discharge form completed and take home pack is given to patient

Urology Review

Projected Activity & Sessions v0.1 17 June 10

Table 1 below gives the Board's calculation of the capacity gap, and using the Board's methodology, the projected activity for 'Team South'.

		2009/10 Actual Activity							
		Core Activity	IHA	IS	Growth in WL	SHSCT Activity to be Provided	SBA	SHSCT Capacity Gap	Team South Capacity Required [6]
2009/10	Cons Led New OP	610	474	0	87	1171	1014	157	1382
	ICATS/Nurse Led New OP	1233	30		100	1363	990	373	1608
	Total New OP	1843	504	0	187	2534	2004	530	**2990**
	Cons Led Review OP	2391	70	0		2461	3290	-829	2904
	ICATS/Nurse Led Rev OP	1594	0	0		1594	990	604	1881
	Total Review	3985	70	0		4055	4280	-225	**4785**
	Day Case	1502	3	383	47	1935	1239	696	**2283**
	Elective FCE	1199	29	140	28	1396	780	616	**1647**
	Non Elective FCE	629	0	0		629	816	-187	**742**

1) Source is Business Objects
2) Activity has been counted on specialty of clinic
3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog (4037 in June 2010). As shown N:R = 1:2
4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
5) 18% added for Fermanagh, based on population size relative to SHSCT population
6) SBA for ICATS is 1980 (no split between new and reviews so have just divided equally)

Outpatients

To enable the numbers of clinic sessions to be calculated, Table 2 splits the numbers of new outpatient attendances by clinic, based on the 2009/10 attendances.

Table 2: New Outpatient Attendances

Clinic	Core	IHA	Total	%	Growth	SHSCT Total	Team South
Prostate TRUSA (&B)	248		248	10.6%	20	268	316
LUTS	323		323	13.8%	26	349	412
Andrology/Dr Rodgers gen urology	476	30	506	21.6%	40	546	645
Haematuria	186		186	7.9%	15	201	237
Consultants clinics	374	474	848	36.1%	68	916	1080
Urodynamics (consultants)	236		236	10.1%	19	255	301
	1843	504	**2347**	100.0%	187	2534	**2990**

Stone Treatment new outpatients are being recorded as reviews and are therefore not included in the figures. This means that new outpatients at consultant clinics are under stated.

Appendix 5

Sessions are based on 48 weeks unless otherwise stated.

Prostate Pathway (Revised)

1st appointment – the patient will be assessed by the specialist nurse (patient will have ultrasound, flow rate, U&E, PSA etc). A registrar needs to be available for at least part of the session eg to do digital rectal examination (DRE), take patient off warfarin etc. 5-6 patients can be seen at an assessment clinic (limited to a maximum of 6 by ultrasound). In the afternoon appropriate patients from the morning assessment would have a biopsy. 4-6 patients can be biopsied in a session (though additional biopsy probes will need to be purchased). Not all patients will need a biopsy and the session will be filled with those patients from previous weeks who did not have a biopsy on the same day as their assessment (because they needed to come off medication, wanted time to consider biopsy etc). Based on 2009/10 figures it is estimated that 69% of patients will require biopsy (218)

316 patients @ 5 per session = 63 sessions per annum (53 if 6 patients are seen) = 1.3 (or 1.1) assessment sessions per week.

218 cases for biopsy @ 5 per session = 44 sessions per annum. 1 biopsy session per week should therefore suffice (over 48 weeks).

The majority of patients with benign pathology will be given their results by telephone (Specialist Nurse time needs to be built in to job plans for this).

2nd appointment will be to discuss the test results – patients with positive pathology and those patients with benign pathology who are not suitable to receive results by telephone. It is estimated that 40% of patients who have had biopsy will have positive pathology (using 40% this would be 88 patients – have asked Brian Magee for actual figure for 2009/10). Adding on 10% for those patients with benign pathology who will need to come in for their results gives a figure of 97 patients needing a second appointment. This equates to 2 patients each week (over 52 weeks). These patients are now being seen by a registrar but the consultants want to build time into the new service model to see the patients themselves.

3rd appointment will be discussion of treatment with the estimated 88 patients per annum. Could these be dealt with promptly on a weekly basis by the surgeon of the week following the MDT? The consultants would prefer to see their own patients and feel that the appropriate model is for each to have a weekly 'Thorndale session' to do:

- 2nd and 3rd prostate appointments,
- Check urodynamic results/patients

LUTS

412 new patients. The new to review ratio is 1:0.8, therefore there will be approximately 330 reviews.

412 new patients @ 4 per session = 103 sessions

330 reviews @ 8 per session = 42 sessions

103 + 42 = 145 sessions per annum = **3 sessions per week** (over 48 weeks)

Registrar input is required.

Haematuria (Revised)

Currently ultrasound, history, bloods, urines etc done by the Specialist Nurse/Radiographer. Patients come back to DSU to have flexi carried out by a Registrar (Friday flexi sessions).

This will move to a 'one stop' service with the flexi being done on the same day in Thorndale (by a Registrar). 5 patients per session (may be a slightly longer session than normal) have been agreed.

237 new patients @ 5 per session = 48 sessions = **1 per week** (over 48 weeks)

Note – some patients will require IVP. The view of the clinical staff is that it may be rather onerous for the older patient to have this along with the other investigations done on the same day. However this will be considered further and the potential for protected slots discussed with Radiology.

Andrology/General Urology ICATS

This service will be reviewed over the next 6 months.

For planning purposes it has been agreed to use a new to review ratio of 1:1.5 with 3 new and 5 review at a clinic. It is assumed that sessions will only run over 42 weeks.

645 @ 3 news per session = 215 sessions = **5 per week** (over 42 weeks)

Consultant Clinics

Urodynamics patients are included in the consultant clinics (301 new). If these are separated out this leaves 1080 new patients at consultant clinics.

Junior doctors will not be available to support all outpatient sessions. Therefore it has been assumed that on average 1.6 doctors will attend a clinic with 10 patients each, therefore on average 16 at a clinic. Consultants believe that 5 news and 11

reviews is the appropriate number at a clinic for this staffing level. This will give a new to review ratio of 1:2.2.

1080 patients @ 5 news per clinic = 216 sessions = 4.5 per week. 5 sessions (over 48 weeks) will be built in to the service model (to allow some flexibility because of the limited junior doctor support).

Stone treatment is not included as they have been recorded as reviews – need to get an estimate of numbers of news.

Urodynamics (Revised Model)

Currently carried out on the ward with results reviewed by consultants. These will be moved to Thorndale/Ambulatory Care Unit to be carried out by a Specialist Nurse. Consultants wish to assess the results in their proposed Thorndale session.

301 cases at 5 per all day session = 60 all day sessions. 1.5 per week will be built in to the service model.

Time will also need to be built into the Specialist Nurses' job plans to pre assess the patients (this may not need to be face to face) as there otherwise would be a high DNA rate for this service.

Day Cases

Flexible Cystoscopy

Based on the current day case rates 2283 day cases (including flexible cystoscopies) would be undertaken.

2008/09 activity has been used to apportion flexible cystoscopies etc, as coding is incomplete for 2009/10.

1243 flexible cystoscopies were carried out as day cases (primary procedure code = M45) and this was 56% of the total daycases (2203), in 2008/09.

It has therefore been assumed that 56% of 2283 cystoscopies will be required = 1279. 237 of these will be done in Thorndale (Haematuria service), leaving1042. Numbers on lists vary between 6 -10, depending on where the list is undertaken, and whether any patients who have MRSA are included on the list. An average of 8 per list has been used for planning purposes.

1042 @ 8 per list = 131 lists = **3 flexi list per week** (over 48 weeks)

Lithotripsy

268 day cases were carried out in 2008/09. This was 12.2% of the total day cases. Assuming 12.2% of 2283 will be lithotripsy gives a requirement for 279.

279 @ 4 per session = 70 sessions. This equates to 1.5 per week if delivered over 48 weeks (will require a second consultant with Specialist Interest in stone treatment) and 2 per week if delivered over 42 weeks.

Other Day Cases

The day case rate for specific procedures will be increased (assuming suitable sessions and appropriate equipment can be secured).

In 2008/09 2203 day cases and 1273 elective FCEs were carried out (3476 in total and a day case rate of 63.4%). If the British Association of Day Surgery recommended day case rates had been achieved for the basket of procedures for urology in 2008/09 then an additional 215 day cases would have been carried out increasing the total day case rate from 63.4% to 69.6%

For Team South we have projected 2283 day cases and 1647 FCEs (Day case rate of 58%). If a day case rate of 69.6% is applied to the total elective activity of 3930 then this changes the mix to 2735 day cases and 1195 elective FCEs.

Of the 2735 day cases:

- 1279 are flexible cystoscopies;
- 279 are lithotripsy
- 103 had no procedure (add 18% to account for Fermanagh region) = 121
- 279 are introduction of therapeutic substance in to bladder + 18% = 329

This leaves 727 day cases to be carried out. Some will be done in dedicated day surgery sessions and some will be more suited to main theatre via the elective admissions ward (in case an overnight stay is required). 4 patients are normally done in dedicated day surgery sessions at present but consultants feel that this could be increased to 5.

727 @ 5 per list = 146 lists = 3.1 lists (over 48 weeks). As not all cases will be done within the dedicated day case lists, 3 weekly lists will suffice.

Inpatients

1195 elective FCEs are projected. A limited number of patients may not have a procedure carried out. However some non elective cases are added to elective theatre lists. The numbers of procedures carried out on a list also varies significantly

and on occasions a single complex case can utilise a whole theatre list. For the purposes of planning, 3 cases per list has been taken as an average.

1195 @ 3 per list = 399 lists = 9 lists (over 48 weeks).

From: Aidan O'Brien [redacted]
To: Siobhan.Hynds [redacted]
Subject: Formal Investigation
Date: Mon, 31 Jul 2017 10:06

Siobhan,

In preparation for the interview on 03 August 2017, I would be grateful if you would provide me with the following:

- A copy of the minutes of the meeting in December 2016 of the Oversight Groupe
- A copy of correspondence and / or communication with NCAS in December 2016e
- An amended copy of the Note of the Meeting of 30 December 2016 (previously requested)
- An amended copy of the Note of the Meeting on 24 January 2017 (previously requested)e
- A copy of the Trust's Policy and Procedure regarding Triage (previously requested)e
- A list of the Witnesses and their statementse

Thank you,

Aidan O'Brien

From: Aidan O'Brien [redacted]
To: Siobhan.Hynds [redacted]
Subject: Re: FORMAL INVESTIGATION
Date: Mon, 31 Jul 2017 13:16

Siobhan

In addition to my earlier request, could you please add the details of the 9 Private Patients included in the investigation and the name or names of those who identified them.

Aidan O'Brien.

[redacted]

Dr Ahmed Khan
Case Manger

From: O'Brien, Aidan
Sent: 21 October 2018 16:16
To: Khan, Ahmed
Cc: Toal, Vivienne; Wilkinson, John
Subject: RE: Information Request

Dear Dr. Khan,

I am disappointed to have not yet received the information that I have previously requested.

I also write to advise you that I have since had the opportunity of discussing my concerns with Dr. Lynn of Practitioner Performance Advice (formerly NCAS).
I have been further concerned to be advised by her that there had been an earlier consultation with and communication from NCAS in September 2016, and about which I had not been advised.

Therefore, in addition to the information previously requested, I now request copies of all communications with and correspondence from NCAS pertaining to me during 2016.

As previously, if you are unable or unprepared to do so in a timely manner, I would be grateful if you would advise of the reason(s), and similarly advise me from whom the information may be obtained,

Aidan O'Brien

From: Khan, Ahmed
Sent: 03 October 2018 10:36
To: O'Brien, Aidan
Cc: Hynds, Siobhan
Subject: RE: Investigation

Dear Mr O'Brien, thank you. I have requested some information & will be in touch soon.

Regards,
Ahmed

Dr Ahmed Khan
Case Manger- MHPS

From: O'Brien, Aidan
Sent: 01 October 2018 22:27
To: Khan, Ahmed
Subject: Investigation

Dear Dr. Khan,

Further to our meeting today, and specifically with regard to information previously requested, I write to clarify that I wrote to Dr. Wright on 14 February 2017, detailing a number of errors and omissions in the Note of the Meeting of 30 December 2016, requesting that amendments be made. On 01 March 2017, I received from Siobhan Hynds an acknowledgement of receipt of my letter to Dr. Wright. She advised that she would arrange for an amended Note to be sent to me, taking into consideration my suggested amendments. No amended Note was sent to me. On 19 April 2017, I sent an email to Siobhan Hynds, advising that I still awaited an amended Note. I did not receive any response, reply or amended Note. A further request was submitted on 31 July 2017. Again, I did not receive a response or an amended Note. An amended Note was included in the Investigator's report.

On 28 March 2017, I submitted to Siobhan Hynds a list of amendments to be made to the Note of the Meeting with her and with Mr. Weir, and which took place on 24 January 2017. I requested that she return a copy of the amended Note. I received no reply or response. On 31 July 2017, I again requested an amended Note of the Meeting, without response. The original Note of the Meeting was included in the Investigator's report, without amendments having been made.

On 31 July 2017, I submitted to Siobhan Hynds, by email, a request for a copy of the minutes of the meeting of the Oversight Group and which took place in December 2016. I have still not been provided with a copy of the minutes.

On 31 July 2017, I submitted to Siobhan Hynds, by email, a request for a copy of a record of communication and correspondence with NCAS in December 2016. I have still not been provided with a copy.

On 31 July 2017, I also requested a copy of the Southern Trust's Policy & Procedure on Triage, and which I had previously requested. I still have not been provided with a copy.

On 10 June 2018, I again sent an email to Siobhan Hynds requesting responses to the requests made previously, as detailed above. As before, I still await the information.

Therefore, I would be grateful, even at this late juncture, if you would have the requested information sent to me, and specifically, lest there be any doubt:

- A copy of the Record of Communication and / or Correspondence with NCAS in December 2016, and subsequently.
- A copy of the Minutes or Note of the Meeting of the Oversight Group in December 2016
- A copy of Southern Trust's Policy & Procedure for Triage

Most importantly, if you are unable or unprepared to provide me with these requested documents, or have them provided to me, in a timely manner, I would be grateful if you would advise me of the reasons why, and of whom I may request the information,

Aidan.

Lastly, I request that you acknowledge receipt of this email, and confirm that the sought documentation will be provided within the time periods stated above, and further and in the alternative (if they cannot be provided) full and precise reasons why this is the case.

Yours Sincerely,

Aidan O'Brien.

From: Khan, Ahmed
Sent: 23 October 2018 16:57
To: O'Brien, Aidan
Cc: Wilkinson, John; Hynds, Siobhan
Subject: RE: Information Request

Dear Mr O'Brien,

Further to your request, please find comments from Ms Siobhan Hynds below and attached documents as requested. I have also attached copy of September 2016 NCAS correspondence.

- In respect of the note of the meeting on 30 December 2016. This meeting was attended by Mr O'Brien, his wife, Dr Richard Wright and Lynne Hainey, HR Manager. The information I have from that early stage of the process outlines that a note of the meeting was produced and sent to Mr O'Brien at the time. Mr O'Brien wrote to Dr Wright outlining some factual errors with the note of the meeting from his perspective. These comments were considered and Dr Wright responded to Mr O'Brien with an amended note of the meeting. In correspondence to Mr O'Brien, Dr Wright outlined that he was content to amend some aspects of the note, others he felt were reflective of the meeting. As the note of the meeting remained under question by Mr O'Brien, as part of the Case Investigators report to you as the Case Manager, the note of the meeting from Dr Wright was appended to the report along with Mr O'Brien's comments to ensure both positions were known. Both documents are contained within the appendices of the Investigation Report. It has been previously clarified with Mr O'Brien, that the note of this meeting would not be further amended. Mr O'Brien's request for information was discussed with him and dealt with at the meeting of 3 August 2018. Mr O'Brien has been provided with all of the documents referred to above.

- In respect of the note of the meeting on 24 January 2017 – as per above, Colin Weir (then Case Investigator) was satisfied with the content of the note as an accurate reflection of the meeting with Mr O'Brien on 24 January. Mr O'Brien submitted his comments on the note. Both have been appended to the final investigation report to ensure both positions could be considered. Mr O'Brien has been provided with these documents.

- Copy of the minutes of the meeting of the Oversight Group December 2016 attached.

- Copy correspondence with NCAS in September & December 2016 attached.

- Copy of the Integrated Elective Access Protocol attached. It has been previously clarified with Mr O'Brien that this is the document referred to at the outset of the investigation. It has previously been clarified with Mr O'Brien that there is no separate Southern Trust Policy or Procedure on Triage.

Aidan, I take this opportunity to ask if you are adherent to agreed MHPS action plan (attached)?

Regards,
Ahmed

INFORMATION REQUEST 1

- In respect of the contention that Dr. Wright responded to me with an amended Note of the Meeting of 30 December 2016, I require strict proof of the following:

  a) The identity of the person or persons who amended the Note
  b) The date or dates on which the Note was amended
  c) The identity of the person or persons who approved the amendments
  d) The date or dates on which the amendments were approved
  e) The date on which the amended Note was sent to me
  f) The method by which it was sent
  g) The identity of the person who sent it
  h) A copy of the dated, amended Note, and all attached correspondence and documentation referring to it, or associate with it.

See attached e-mail from Ms L Hainey.

- In respect of the contention that '*in correspondence to Mr.O'Brien, Dr.Wright outlined that he was content to amend some aspects of the Note, others he felt were reflective of the meeting,* and as I have yet to receive such correspondence, I require strict proof of the following:

  a) The date of the correspondence referred to
  b) The method by which it was sent
  c) The identity of the person who sent it
  d) A copy of the correspondence referred to
  e) Details of the aspects of the Note that Dr. Wright was content to amend
  f) Details of the aspects of the Note that Dr. Wright felt were reflective of the meeting
  g) The identities of all other persons to whom the correspondence was sent, if any

See attached e-mail from Ms Lynne Hainey.
See attached letter from Dr Wright.

- In respect of the contention that '*As the note of the meeting remained under question by Mr. O'Brien',* and as I did not receive an amended Note to hold in question, I require strict proof of:

    a) The method or mechanism by which Ms. Hynds believed or knew that an amended Note, not received by me, remained in question by me
    b) Any communication from me advising or informing Ms. Hynds, or others, that an amended Note remained in question by me

- An amended Note of the Meeting of 30 December 2016 was included in the copy of the Investigator's Report provided to me in June 2018. A copy of my proposed amendments of 14 February 2017 was not included in the copy of the Investigator's Report provided to me in June 2018. In respect of Ms. Hynds' contention that '*Both documents are contained within the appendices of the Investigator's Report',* I require strict proof that a copy of my proposed amendments are contained within the appendices of the Report provided to me.

- In respect of the assertion that *'It has previously been clarified with Mr.O'Brien, that the note of this meeting would not be further amended',* and as I never had or received any such clarification, I require strict proof of full and precise particulars of any and all occasions on which it was previously clarified or clarified that the Note would not be further amended, including:

    a) The date or dates when such clarifications were made
    b) The identity of the person or persons who made such clarifications
    c) The method or medium by which such clarifications were made
    d) Copies of all such clarification, documentation, minutes, notes or records of same

- In respect of the assertion that '*Mr. O'Brien's request for information was discussed with him and dealt with at the meeting of 3 August 2018',* and as I did not attend a meeting in relation to the Investigation on 3 August 2018, I require strict proof of

a) The location of the meeting
b) The time and duration of the meeting
c) The identity of the persons who attended the meeting
d) The identity of the person or persons who allegedly discussed with me on 3 August 2018 the request for information
e) The detailed and precise meaning of the request for information having been *'dealt with'* on 3 August 2018
f) Copies of all minutes, notes, records, documentation and any additional materials relating to the asserted meeting of 3 August 2018

- In respect of the Ms. Hynds' assertion that *'Colin Weir (then Case Investigator) was satisfied with the content of the note as an accurate reflection of the meeting with Mr. O'Brien on 24 January',* I assert that this has been the first time that I have been advised that Mr. Weir was satisfied that the content of the Note was an accurate reflection of the meeting, even though I had requested an amended Note on 28 March 2017 and again on 31 July 2017, without reply or response, and even though I had been assured by her that there would be no problem in providing me with an amended Note.

- In respect to the Note of the Meeting of 24 January 2017, I assert that the Note is not an accurate reflection of the meeting, and that a Note, amended to include my comments, would have rendered it a more accurate reflection of the Meeting. I therefore require strict proof of:

a) The date when my proposed amendments were submitted to Mr. Weir for his consideration
b) Any and all record, notes and documentation relating his dissatisfaction with each and all of my proposed amendments

- In respect of the statement '*Copy of the Integrated Elective Access Protocol attached. It has been previously clarified with Mr. O'Brien that this is the document referred to at the outset of the investigation. It has previously been clarified with Mr. O'Brien that there is no separate Southern Trust Policy or Procedure on Triage',* it has been the case that I have been provided with a copy of the Integrated Elective Access Protocol when I have requested on a

number of occasions a copy of the Southern Trust Policy and Procedure on Triage. I have been familiar with the Protocol prior to the initiation of the Investigation. However, it has been alleged in writing that I have not been compliant with the Southern Trust Policy and Procedure on Triage, and which I am now informed does not exist. I therefore require strict proof of full particulars of:

a) The date on which my employer had previously clarified to me that the Southern Trust Policy and Procedure on Triage did not exist
b) The identity of the person or persons who had previously clarified with me that the Southern Trust Policy and Procedure on Triage was non-existent.
c) The manner, method or medium through which my employer had previously clarified with me that there was no Southern Trust Policy and Procedure on Triage.

Information in respect of rest of above, will be provided by Friday 11th January 2018.

11 January 2019

INFORMATION REQUEST 1

Point 1 and 2

Responded - 21 December 2018

Point 3

Email from A O'Brien to S Hynds 31 July 2018 and discussion at meeting on 3 August 2017.

Point 4

On review, copy of Mr O'Brien amendments not included in the investigators report.

Point 5

Refer to letter from Dr R Wright of 13 March 2017

Point 6

Reference should refer to 3 August 2017 not 2018.

Point 7

Noted.

Point 8

a.e No date documented.e
b.e No record or note on file.e

Point 9

Clarified verbally at 6 November 2017 meeting.by Siobhan Hynds.

INFORMATION REQUEST 2

- e Points 1, 2 and 3e

Responded to on 21 December 2018

- e Point 4e

No further relevant correspondence identified.

- e Point 5e

Responded to on 21 December 2018

- Point 6

Mr Carroll is continuing to source the information requested. Part of this is not available.

- Point 7

Attached

- Point 8

Attached

DRAFT

Minutes of Morbidity & Mortality Surgical, Anaesthetic, Radiology and A&E on 17th July at 1.30pm in Lecture Theatre, MEC

Attendance

General Surgery		**Anaesthetics**	
Dr F Abogunrin	Research Registrar	Dr R Barclay	ST2
Mr M Akhtar	Consultant Surgeon	Dr J Brown	Consultant Anaesthetist
Mr E Epanomeritakis	Consultant Surgeon	Dr H Bunting	Consultant Anaesthetist
Dr D McKay	ST3	Dr C Clarke	Consultant Anaesthetist
Mr A O'Brien	Consultant Surgeon	Dr B Donnelly	Consultant Anaesthetist
Dr A Shahabuddin	ST	Dr R McKee	Consultant Anaesthetist
Ms S Sloan	Consultant Surgeon	Dr M J Morrow	Consultant Anaesthetist
Mr M Young	Consultant Surgeon	Dr I A Orr	Consultant Anaesthetist
		Dr N Rutherfoord-Jones	Consultant Anaesthetist
Radiology		Dr D Scullion	Consultant Anaesthetist
Dr S Hall	Consultant Radiologist		
Dr M J McClure	Consultant Radiologist	**Emergency Medicine**	
Dr S Porter	Consultant Radiologist	Mr S O'Reilly	Consultant in Emergency Medicine
Dr P Rice	Consultant Radiologist		
Trauma & Orthopaedics			
Mr A Kirk	ST4		
Mr B Mockford	Conslt Orthopaedic Surgeon	Dr D Spence	ST1-3

Daisy Hill Hospital			
Mr G Blake	Consultant Surgeon	Dr B Swanton	Consultant Anaesthetist
Mr R Hannon	Consultant Surgeon	Dr J Wright	Consultant Anaesthetist

Effectiveness & Evaluation			
Mrs A Quinn	E & E Manager	Mrs G Watson	Senior Facilitator

Apologies			
Mr G Hewitt	Consultant Surgeon	Mr C Weir	Consultant Surgeon
Dr G MacAuley	ST3	Mr M Yousaf	Consultant Surgeon
Mr R McKeown	Consultant Orthopaedic Surgeon		

	Lessons / educational points from the previous meeting
	Issues pertaining to non-medical staff
1	**Updates**
(i)	**Pancreatitis:** **Case 1: cause of death: pancreatitis** within 24 hrs; MEWS and handover; feedback following

	review of case in conjunction with Mr O'Reilly. **Defer to next month.** **Case 2: Pt with pancreatitis (? Adm to ICU) – Mr Lewis to review** Mr Lewis has reviewed this case – no issues. Remove from updates.
(ii) Med Case Ref Personal Information redacted by the **(Mar 09)**	**Correspondence with Medical M&M:** **Issues raised:** • **Lack of communication of junior surgical staff to more senior staff** • **F2s giving opinions which the physicians feel are completely inappropriate** • **Lack of continuity with the weekly system** Mr Lewis has drafted a response and circulated this for feedback from his surgical colleagues. The response will be forwarded to Dr McConnell next week.
(iii)	**MEWS training and re-audit** Dr Loughran had responded to Ms Sloan to say that a lot of training has already been done to prepare the SHSCT for the implementation of a modified MEWS scoring system and that this is continuing with a number of opportunities for both medical and nursing staff. He went on to say that it is important that training for MEWS and the use of SBAR is incorporated into all Junior Medical Doctors' induction and becomes an ongoing agenda item for the multidisciplinary M&M meetings within the Trust. **Regional Audit on unplanned admissions to ICU (Physiological Early Warning Scoring System {PEWSS})**: report awaited from South Eastern Trust who were the co-ordinators for this work. **SHSCT Re-audit on MEWS** Preliminary results of the S&EC component of this audit were positive; findings will be validated with Catriona McGoldrick, who will then distribute these within the division.
(iv)	**Feedback from Neurosurgery** ***(case ref:*** Personal Informatio n redacted ***Mar 09; window for neurosurgical intervention was missed.) Ms Sloan*** Still awaiting reply from Neurosurgery. Defer to next meeting.
(v)	**Patient transferred from UHD to ICU (septic colon)** ***(case ref:*** Personal Informatio n ***Apr 09)*** – Dr Clarke Defer to next month.
(vi)	**Audit Projects planned / underway:** • Audit on patients admitted with melaena: awaiting analysis from medical students • Facilitation from Colorectal MDT regarding peer review processes: Mr Cranley has written to Dr Convery and Mr Carroll highlighting concerns regarding the lack of resources to facilitate this process • Indications for out of hours OGD in DHH: Mr Campbell / Dr McConville. This is to be presented in DHH within the next 2 weeks and will be carried forward for presentation at M&M in CAH It was agreed that there is a need to address the issue of presenting audits in M&M with the new intake in August. Mr Lewis advised his term of office as Chair of M&M is now complete and he will be taking on the role of NCEPOD Reporter and Audit Co-ordinator. A vote of thanks was recorded for Mr Lewis' work as Chair. **Audit projects – completed** **HaN evaluation :** Results have been presented to the HaN group. **NCEPOD Organisational questionnaire: Parenteral Nutrition** : this has been completed by

	Dr Clarke and returned to NCEPOD.
(vii)	**Awaiting Coroner's report / feedback from PM** • Pt with end stage hepatic failure – awaiting aetiology of cirrhosis from PM *(case ref:* Personal Information *Jan 09) – Mr Lewis* This patient had end stage liver disease with a viral component. Non conclusive report. Remove from updates. • Acute abdomen, multiple bony mets, unknown primary (Persona l Informati June 09) – *Mr Lewis* Family were unhappy with the sudden demise of this patient. Was there a PM done – no. • Pt with liver failure *(case ref:* Personal Informati on *Dec 08)* – awaiting Coroner's report (slides have gone to Leeds) – *Mr Hewitt* - Still awaiting feedback – defer to next meeting.
(viii)	**Update on admission / transfer of fracture patients, DHH (Mr Bunn and DHH teams)** Referred to management and can therefore be removed from the M&M updates.
2	**Mortality with discussion**
Personal Informatio	Fell x2 from standing height, C_2H_5OH on board. Resus – GCS 3/15, hypothermic, pupils fixed and dilated. CT – large right subdural with midline shift. No other injuries. Films to RVH – no Sx indicated. T/F ICU – ? organ retrieval. **Discussion** Patient had been taken home after the fall. When they became unrousable at home they were brought into hospital. A junior doctor in DHH had contacted a junior doctor in NSU, Belfast and was asked to send scans. Because of the low coma scale and late presentation patient transfer was declined. It was felt that with a patient of this age with a treatable condition, they should have been given the benefit of the doubt. Ms Sloan commented that she is now getting a 'letter of consultation' in cases which have been discussed with Neurosurgery in Belfast. Organ retrieval was not carried out in this case. The question was asked, should the patient have been tubed and sent on to Belfast – the patient remains the responsibility of the admitting hospital until they are accepted into a regional centre. **Action:** • **Daisy Hill team to contact Neurosurgery and ask what level of consultation went on in this case. Patient case notes to be retrieved for further discussion and presentation at the next meeting.**
Personal Information redacted by	Collapse alcohol 200+ CT Bilateral Subdural. T/F RVH following day - craniotomy. Transferred back to CAH 11 days after craniotomy. Accepted for Musgrave awaiting t/f. Poor nutrition – oral supplements, pulled up NG discussions with family re peg, developed aspiration pneumonia / cardiac failure – treated with antibiotics / diuretics, peripheral nutrition commenced DNR placed when severely unwell but recovered and removed. Sudden deterioation - further aspiration / pulmonary oedema, DNR after discussion with family; failed to respond to medical therapy and died. Discussed with Coroner – Proforma. **Discussion** There was no PM carried out. There had been a 24hr delay in getting craniotomy done. Currently awaiting feedback from RVH with regard to this. **Action** Ms Sloan to feedback at next meeting.
Personal Information	Admitted - # NOF requiring hemiarthroplasty. PMHx COPD (ASA IV). Theatre. Died two days after admission. **Discussion** This patient was very sick in Theatre and had arrested twice in Recovery. No PM was done.

	There is a high mortality rate with these patients – 30-40% within 1 year of surgery and approx 10% within 30 days.
Personal Information redacted by the USI	Referred with haematuria. Admitted from clinic in view of very significant lower urinary tract symptoms, haematuria and renal failure; creatinine 200. Bilateral hydronephrosis on ultrasound. Cystoscopy and TUR bladder tumour. No improvement in U&E. Bilateral nephrostomies – creatinine improved. Histology confirmed T1 GIII but probably understaged as CT suggested invasion; bone scan clear. DMSA: left 70% right 30%. Echo confirmed ejection fraction 60%. CPX machine broken. Anaesthetist willing to offer cystectomy. Consultant wished oncology review. Oncology review consult. Planned for high dose radiotherapy. 3 months after oncology consult – complaining of swelling of arm. Commenced on Steroids by Oncology. Admission followsing month for conversion of nephrostomies to antegrade stents – elective. Haemoglobin 8. transfused three units. CT scan intrahepatic duct dilatation. CBD 10mm. No lymphadenopathy abdomen or chest. 3 weeks later, drowsiness, nausea, vomiting. CT brain no secondaries. Normal OGD. NG tube required, aspiration pneumonia diagnosed. Respiratory rate 22. Chest x-ray patchy consolidation Po2 7.8. Antibiotic therapy. DNR. Continued deterioration. Died. Aspiration pneumonia. Gastro paresis II. T2 TCC ureteric obstruction. **Discussion** Radiotherapy is not as good as surgery in these cases and surgery would normally be offered, however this patient was elderly and deteriorating. Intra hepatic duct dilatation seen on CT – something was 'going on' - ?microscopic spread.
Personal Information redacted by	Diabetic. Smoked 80 cigarettes a day. Referred DHH with bladder mass and hydronephrosis. October 2007 – large bladder tumour resected; pT2 GIII i.e. invasive disease. CT scan small volume nodes peri aortic region 7.5mm. Chest clear. Bone scan clear. December 2007 – cystoprostatectomy ileal conduit. Confirmed pathology pT2 TCC but with extensive lymphovascular invasion, prostate clear. Referred to Oncology for consideration of chemotherapy. Planned review 2 months. Seen oncology 09/01/08 (no correspondence received). Next seen by Nephrology June 2008 with decreased renal function, no signs of obstruction. Review July 2008. Records delay in review appointment. Notes the recent fall and query fractured pelvis. X-rays indicated pathological fracture. Oncology due to give radiotherapy soon. Admitted from clinic for evaluation. Creatinine noted at 274. Oncology review notes patient is not a candidate for chemotherapy in view of GFR of 17mls/sec. Oncology advised against further investigation or staging pain control. Readmitted Sept 2008. Nausea, back pain and creatinine 1600. Discussion with patient. He felt he was at the end of the road, wished no intervention. Died. **Discussion regarding review patients ensued following presentation of the last 2 patients.** Main issue from Urology perspective is that the Clinicians' recommended timescale for patients' review at OPD are not being adhered to. It was commented current waiting time for review within Urology is 18 months. There are targets for new patients to be seen in OPD therefore reviews are suffering a backlog because there is no corresponding target for them. It was felt that there is a hierarchy of reviews – those patients needing review with investigations take priority. Orthopaedics have similar experience with review patients and commented that they do not see new patients until reviews are done and up to date. It was suggested that new patients should be cancelled if reviews are backlogged. Delayed OP review is included on the Directorate Risk Register. **Action:** • **Mr Young to report delay in OPD reviews as a clinical incident** • **Mr Lewis to communicate concerns to the Medical Director and Joy Youart**
Personal Information redacted by	June 2007 – haematuria assessment. Flexible endoscopy bladder mass planned for TURBT August. Eventual admission early November 2007. Endoscopy/TURBT. Pathology T2 GIII i.e.

	invasive bladder tumour. Bone scan clear; creatinine 230. CT scan planned – delayed until end November 2007. Psycho-geriatrician consult – past history depression 18 years. Conclusion: mental stability adjustment reaction. CT scan December – hospital cancelled. (Appointment January 2008 DNA'd – GP contacted, encouraged to attend). April 2008 – CT scan DNA'd. April 2008. GP referral May 2008 notes difficulty in getting patient to attend. July 2008 – failed to attend. Another appointment July 2008 – Hospital cancelled. GP had been contacted again on Emergency admission 07/08. Haemoglobin 6.8. Possible haematemesis but continued haematuria. Bone scan now very positive. Palliative Care Team involved. DNR. Died. Death Certificate: Metastatic Transitional Cell Carcinoma bladder. **Comment** Patient DNAd ++++
Personal Information	PMHx- COPD, Alcoholic liver disease. A&E resus with haematemesis - hypotensive, tachycardic. Hb 14,Urea 22, Creat 222, pH 7.19. Theatre for OGD. Gross ulceration / ?ischaemia of oesophagus, multiple gastric and duodenal ulcers, no active bleeding. Cardiorespiratory arrest post procedure, CPR, regained output but persistently hypotensive. D/W family- not for further active resuscitation. RIP that evening, coroner advised of case. **Discussion** On scoping, the gullet had a very unusual appearance. Based on the patient's history, the Coroner advised that PM was unnecessary although the Consultant would have liked a PM done for definitive cause of death. The family were not keen, however, for a hospital PM.
3	**Morbidity**
Personal Information	Referred by GP with haematuria and malignant cells on urine cytology; lifelong non-smoker. General health good, increased cholesterol, past history resurfacing left hip, medication Simvastatin. General anaesthetic cystoscopy /TURBT. ASA grade II. Smooth induction, towards end of TURBT (bladder noted not to be over distended). Developed heart rate of twenty five per minute leading to no output and CPR for three minutes. Atropine and adrenaline given. ICU admission. No ST elevation. Day one - echocardiogram; right heart function normal, hypokinetic left side posterior wall, ejection fraction 35%. Sinus bradycardia. Aspirin and Clexane 60mgs given. Day six – haematuria and spasm; haemoglobin 7. Three unit transfusion organised but thirty five minutes into transfusion rigors; blood returned to lab. Day seven – coronary angiogram normal. Blood bank report transfusion reaction usually after second unit, therefore unlikely cause of rigor. Consultant Cardiologist report hypokinesia probably related to CPR. Cardiology - no significant arrhythmia and no further problem. ECG shows no channelopathy. Clinical diagnosis of profound vaso vagal relating to surgical procedure, extubation or drug therapy. **Discussion** Vaso vagal happened before the patient was extubated, no electrical issue, arteries were fine. It was commented that transfusion reaction usually occurs after the 2nd unit. It was asked whether treatment of sinus bradycardia intraop should be more aggressive – it is becoming more frequent. In this case there was no cerebral impairment. Patient had broken ribs and was otherwise fine.
Personal Information redacted by	Mx & ANC, obese pt. Day three – cellulitis, C/O. Antibiotics. Progressed – pus via drain, Returned to theatre, wound washed out & closed. Ongoing sepsis, Wound opened 48hrs later at ward level. Vac dressing applied, discharged for OPD management; removed day 10 after application, wound granulating well.
Personal Information redacted by	Sigmoid Colectomy 22/04/09 – Crohn's stricture mid sigmoid colon. Handsewn anastomosis. D6 post op – pyrexic, abdo pain, raised inflammatory markers. CT – free intra- abdominal air + fluid. One week later – laparotomy + Hartmann's for anastomotic leak. Transferred to CAH ICU post op. Discharged home from CAH.

4	**Inevitable deaths**
Personal Information	Massive GI Haemorrhage, Alcohol History – Antibodies on crossmatch. OGD – Bleeding From Duodenal area / ulcer – injected. Rebleed – laparotomy – unsewn, ongoing bleeding / coagulopathy . Duodenum laid open and packed, T/F to ICU. Transfused , coagulopathy attempted to be reversed but poor result. Ongoing ooze from nasogastric tube etc **Discussion** Duodenal area was left open and packed. Patient got Novoseven x2. Patient had an abnormal blood group. It was asked if this had been 'got to' any earlier would it have made any difference to the outcome? – no.
Personal Information redacted by	3 day h/o coffee-ground vomit (warf). Admitted with distended abdo, LIF tenderness. eCXR = air under L hemi diaphragm. Lac 9, INR 4.5, CRP 200, Urea 16, Creat 158 HB 16. Theatre, persistent hypotension. Died. Barium enema = apple core tumour distal sigmoid colon. **Comment** The operation did not go ahead. Patient was due to be seen and had perforated week before.
Personal Information redacted	Admitted following fall – pathological # prox femur requiring IM nail. PMHx – Mastectomy 07 but widespread mets, on home O_2. Palliative care team. Died two days after admission. **Comment** This patient was not fit for surgery.
Personal Information redacted by	Admitted with 3 day hx abdo pain and nausea. Discharged from A+E. NIDDM,MI,AF,COPD, AAA (4.5cm) Pale, clammy, tachycardic, abdo soft tender RIF. WBC 17.9/CRP 308. CT – air in mesenteric vessels and liver. Sm bowel dilatation. Open and close laparotomy (large and small bowel). Died that day. Coroner informed of case (I) Mesenteric ischaemia. **Comment** It was commented that patient had their first MI at age 35. They had an aneurysm which was not operated on. Was the patient very thin – no.
Personal Information redacted by	12 hours of painful haematuria. No anticoagulants. COPD, massive PE – 2005, required CPR. Day 2 – Syncope and hypoxia. ABG – pH normal, hypoxic. Cardiac arrest – PEA. Died ? PE. **Comment** Patient did not have a PM. Most likely diagnosis was PE.
Personal Information	DOA – Collapse, palpable AAA presumed rupture. Severe dementia, Nursing Home – fully dependent. Not suitable for intervention. Died same day.
Personal Information	No PM. Inoperable breast cancer, severe dementia. Admitted abdominal pain, raised inflammatory markers & lactate. LIF mass. Treated with antibiotics, not surgical candidate. COD – Intra-abdominal sepsis
Personal Information	Coffee ground vomit, bruising. Admitted with 4 quadrant tenderness, absent BS. Pernicious anaemia, Hb 8, platelets 19, WCC & CRP normal, lactate 2. CT = ascites, fluid filled dilated SB. Died ?ischaemic small bowel.
Personal Information redacted by	Admitted following fall - # R NOF – required DHS. PMHx – Angina, Type II DM, chronic renal failure. 2 days after admission - SOB and chest pain – MI – transferred to CCU, developed LVF. Failure to improve and developed ARF. Not fit for surgery. Poor response to inotropes and diuretics. Died.

DRAFT

Personal Information redacted by	Admitted after fall - # R NOF. PMHx – COPD – on home Oxygen, very limited exercise tolerance. On admission developed acute on chronic resp failure with acidosis. Transferred to Resp ward for NIPPV. Not fit for surgery. DNAR. Died.
Personal Informatio n redacted	Admitted with left #NOF. Lived alone, found by carers. Hx of NIDDM, arthritis, HTN, confusion. On admission hypoxic and signs of UTI. CXR – nil acute. Treated with Abx and d-dimer perfomed – 3642 (no other cause for hypoxia found). Therapeutic clexane. CTPA – no PE, small effusions. Day 2 hypotensive, hypothermic. Inflammatory markers elevated. CXR - ? New infective changes. D/W family – NFR. Died day 2. Coroner informed. (I) bronchopneumonia.
Personal Informatio	Admitted with melaena. Past medical history: R hemi, L lateral hepatectomy, further mets and porta adenopathy. Admission 1 month earlier – obstructive jaundice. Likely malignant compression at confluence – stent to L CHD. Consider for PTC. Still deeply jaundiced. OGD – bleeding ulcer in D1 – adrenaline. Very weak and responsive to painful stimuli. D/W family – no aggressive management. Died day 6. Metastatic adenocarcinoma of colon.
Personal Information redacted	Epigastric pain and vomiting. Unwitnessed haematemesis. PMHx – OPD anaemic / wt loss, refused all investigations. Abdo – distended, reducible LIH. Hb 9.0, AXR – SBO. Despite NG tube likely aspiration. Hypoxic, tachyopnoeic. D/W family – keep comfortable. Coroner informed. Cause of death: (I) SBO
Personal Informati on	Nursing home resident. PR bleeding, hypotension. Hx severe AS, MI, AF, dementia. Hb 8.3 – resus with crystalloid and PRC. Day 3 – no further bleed, ↑ WBC/CRP. Creps in chest, seen by Cons Physician – HA pneumonia. Abx but worsening sepsis. COD pathway. Died day 6
Personal Information redacted by	PMHx – resection transverse colon tumour, partial gastrectomy, end colostomy and mucous fistula (Duke's B - from pathology analysis). Admitted - 1/52 h/o vomiting, abdo pain, decreased stoma output. AXR / CT- Small bowel obstruction. Hypoxic, CXR – bibasal consolidation, raised inflammatory markers. c/o IV a/bs for aspiration pneumonia. Condition deteriorated. D/w family, DNAR. RIP Day 3. Cause of death- (I) aspiration pneumonia -metastatic colonic carcinoma.
Personal Informatio n redacted	Full care, poor mobility, schizophrenia, recurrent DVT, left hemicolectomy 6 years ago. Abdo pain and vomiting. Soft abdomen, small bowel loops on AXR Laparotomy – closed loop obstruction through band adhesion. Bowel resection. Post-op chest sepsis and pleural effusion. Progressive deterioration with maximal therapy. Died day 17 on COD pathway.
5	**HCAI cases**
Personal Information **CDIFF**	C. Difficile. Root cause analysis. Learning points. **The only issue in this case was inappropriate sampling.**
	Two other HCAI cases, within DHH, will be presented at next month's meeting.
6	**Any other business**
(i)	**Revised root cause analysis process** A feedback form is to be completed by the Heads of Service after the RCA has been done. Areas of non-compliance only will be sent to Anne Quinn, for monitoring trends. It is intended the feedback form will assist in the monitoring of issues at ward, division and directorate level and provide a mechanism to escalate these issues, as appropriate, via Head of Service or other clinical representative. As requested by Directors, RCAs outstanding more than five working days will be highlighted to the Heads of Service, Strategic and Clinical Fora via the Effectiveness and Evaluation Unit.

(ii)	**Antibiotic guidelines** It was reported that a number of patients in urology had developed infection, which it was felt was related to the antibiotic guidelines. It was pointed out that Dr Damani had circulated the draft antibiotic guidelines by email for feedback. It was commented clinicians can digress from the antibiotic guidelines provided a clear, written record is made in the patient notes regarding the reason for doing so. **Action** • **It was agreed the consultant should liaise with Dr Damani** • **The cases should be presented as morbidity at the next M&M**
7	**Date of next meeting:** Tuesday 18th August at 9.00am Lecture Theatre, MEC

Personal Information redacted by the USI

From: Murphy, Jane S Personal Information redacted by the USI
Sent: 16 October 2009 13:09
To: 'Youart, Joy'
Cc: Young, Michael; O'Brien, Aidan; Akhtar, Mehmood; Mackle, Eamon; Tally, Paula; Burrell, Debbie; Clarke, Paula; Corrigan, Martina; Trouton, Heather
Subject: 5 Consultant Model

Joy,

As you are aware over the last few months Performance and Reform have been working with Urology them looking at demand and capacity data to established the requirements with regard to Out patients, In Patients and Day Case sessions to met the complete activity demand for the Urology Service in the Southern Trust.

This demand is inclusive of the projected demand expected from the West when the Southern Trust becomes one of the designated Regional Urology centres.

The sessions required will be improved by a 5 consultant team model and will utilise all sites within the Southern Trust.

The Performance & Reform Team have thought data analysis concluded that the following sessions would be required to meet demand for Urology services:
4 Outpatients session per week
9 Inpatients sessions per week
4 Day case sessions per week

After considerable discussions it is felt by the Urology Consultants that this would not be workable due to lack of junior medical staff in the team and that the following sessional activity would be required:
6-7 Outpatient sessions per week
9 Inpatient sessions per week
5 day case sessions per week

However if there were more junior medical staff available to assist with clinics then it may be acceptable that 4 Outpatient clinics per week may suffice likewise if middle grade staff were available to assist with flexible cystoscopies then 4 Consultant Led Day case sessions may suffice. Agreement was reached with regard to 9 Inpatient sessions.

Throughout our discussions the Consultant relationship with the Urology ICATS Service was raised on numerous occasions. Although this is a separately commissioned service and the demand and capacity analysis detailed earlier was based solely on the Consultant Led Urology Service. It is widely felt by the Consultant body that the 2 services are inextricably linked.

Indeed it is felt that to separate the 2 services would result in a loss of proficiency and effectiveness within Urology as a whole.

It was therefore suggested by Performance & Reform that within a 5 Consultant Model that each consultant could base himself in the Thorndale Unit for a administration session where they would be available for consultation should the Nurse Led Service require Consultant advice, direction or support.

Much work by Paula Tally, Mr Young, Mr O'Brien, Mr Aktar and Mr Mackle has gone into the development of an effective service model over the last number of weeks. We would appreciate your views on the conclusion details and your input into resolving some of the outstanding issues so that we can move ahead with the necessary Business Case required to secure the funding necessary to provide a 5 Consultant Urology service in the Southern Trust.

Thank you

Regards
Jane on behalf Heather Trouton, Acting Assistant Director Acute Services, Surgery & Elective Care

Jane Murphy
Admin Support for
Assistant Directors - Acute Services
Southern Trust and Social Care Trust
Tel: Personal Information redacted by the USI
Fax
EMail: Personal Information redacted by the USI

Craigavon Urological Research and Education

(A company limited by guarantee)

Annual report for the year ended 30 April 2010

Craigavon Urological Research and Education

(A company limited by guarantee)

Reference and administrative details

Charity registration number XR1 3643

Company registration number NI 32294

Directors/Trustees

Mr A O'Brien
Dr M Murphy Resigned 22 April 2010
Mrs R Brownlee
Mr M Young
Ms V Clarke Resigned 22 April 2010

Company secretary

Mrs R Brownlee Resigned 22 April 2010
Mrs S Tedford Appointed 22 April 2010

Registered office and principal office

Sister Shirley Telford
C/o CURE – 2 South - Urology Dept
Craigavon Area Hospital
Craigavon
BT63 5QQ

Bankers

Personal Information redacted by USI

Solicitors

Personal Information redacted by USI

Craigavon Urological Research and Education

(A company limited by guarantee)

Directors' report for the year ended 30 April 2010

The directors, who are also the trustees, submit their annual report and the financial statements for the year ended 30 April 2010. The directors have adopted the provisions of the Companies Act 2006 and the Statement of Recommended Practice (SORP) "Accounting and Reporting by Charities" issued in March 2005 in preparing the annual report and financial statements of the company.

Reference and administrative details

Details of this information are included in page 1.

Structure, Governance and Management

The charity is a company limited by guarantee and does not have a share capital. It is governed by a Memorandum and Articles of Association and the liability of each member is limited to an amount not exceeding £1.

The directors are elected to serve until the next annual general meeting, when one third of the directors who are subject to retirement by rotation will retire. If the vacancy is not filled, the retiring director shall, if willing to act, be deemed to have been reappointed unless at the meeting it is resolved not to fill the vacancy. New directors may be appointed if recommended by directors or proposed by a member qualifying to vote at the annual general meeting.

Risk

The directors have examined the business and operational risks faced by the organisation and confirm that systems to mitigate significant risks are in place

Objectives and activities

The charity's objects as defined in the Memorandum and Articles of Association are:-

- To conduct and commission research into Urological disorders and the effective treatment of persons suffering from Urological disorders and to disseminate the useful results of such research;
- To raise public awareness and understanding of Urological disorders and their treatment; and
- To promote training in the treatment of Urological disorders.

In line with previous years, 2010 continued to offer considerable challenge to the provision of urological services in Craigavon however greater stability was evident albeit against a worsening economic climate, something that contributed to make educational efforts difficult this year. As indicated last year CURE has begun the process of internal and external consultation on how best to meet its aims and objectives, particularly with regards to research activity.

Achievements and performance

CURE continues to support the running of the peer reviewed journal, the International Journal of Urological Nursing [IJUN], published by Wiley-Blackwell Publishing and The British Association of Urological Nurses [BAUN]. Consistent with our founding aims, the charity continues to spend funds to sponsor education and training courses for urological medical and nursing staff. A number of nurses have again benefited from CURE sponsorship to undertake undergraduate and postgraduate education in urology. CURE continues to promote the attendance of Urology Department nurses at major urology conferences, in particular the European Association of Urology Conference. This year CURE funded a total of 3 nurses and 1 doctor to attend this European meeting. However, due to travel chaos caused by the Icelandic ash cloud their flights were cancelled on the morning of travel and so attendance could not occur. CURE also funded a urologist-in-training to attend the annual meeting of the America Urological Association. Lastly, the charity sponsored another urologist-in-training to attend a training course in Paris, France to learn updated techniques in laparoscopic surgery. In the same vein, CURE purchased a laparoscopic surgery training hardware package to support the safe training of urologists in this area of surgery.

CURE again organised a free-to-delegates research conference this year as we had committed to doing last year. However, due to the current economic climate all study leave for nursing staff has been radically revised and as such this conference was reluctantly cancelled for this year despite venue, speakers and programme being finalised.

Directors' report for the year ended 30 April 2010 (continued)

Achievements and performance continued

CURE sponsored an MSc Nursing Research project this year and results are currently being published within the nursing literature. In addition the CURE Committee met with a Professor of Nursing to examine ways in which the charity could further contribute to the nursing agenda within urology. Some concrete proposals are being investigated and will hopefully form part of the work for the year ahead. The Committee has also considered establishing an educational website and has consulted on how this is best achieved. A formal presentation to the committee will be undertaken to assist decision making on this project.

Plans for future periods

This year has been challenging for the provision of urological services in Craigavon and required that we consider very carefully where its place was to be found in the new arrangements. These challenges stem from two central issues; clinical reorganisation of services with associated personnel redeployment and changes made to the structure of education for Urologists in Training. The Department of Urology at Craigavon Area Hospital (CURE's base) has been fragmented in a reorganisation of service delivery. Some nursing personnel previously working within the unit have been redeployed and new staff require a substantial period of time to 'bed in' before they would be in a position to profit from formal courses in urological care. So whilst CURE continues to support those nurses who have embarked upon 3rd level education programmes new staff were only ready for such programmes in September 2010 and shall be support by CURE. Regarding the training programme for Urologists in Training, there is no longer an explicit requirement for junior urologists to complete a mandatory research programme. Historically CURE has always been an enthusiastic supporter of such research and remains very keen to support medical research. However, this past year, due to the decreased need for aspiring Urologists to complete a research project there have not been any projects undertaken requiring CURE support. The CURE Committee has discussed this issue with a view to establishing a Northern Ireland / UK wide research scholarship to reinvigorate this vital area of activity. We have also discussed the creation of a CURE Website to publicise details of such research support as well as to provide public information on urological care concerns.

The CURE Committee undertook an exercise to examine its role and value to re-orientate itself with regard to future activities. The difficulties faced within urology in the past year have resulted in a new and determined effort to be even more active in the promotion of urology education within the wider local health community. This has resulted in a commitment to considerable increase in expenditure and activity next year via a number of identified projects as mentioned above.

Financial review

The net outgoing resources for the year amounted to Irrelevant information redacted by the USI (2009: net outgoing resources Irrelevant information redacted by the USI. The charity continues to retain an appropriate financial cushion to meet unexpected needs and to support new and innovative research and educational activities. Despite our financial outgoings this year CURE has continued to receive modest income from patients and well wishers. However, whilst respecting the need for financial prudence and to maintain an appropriate cushion, the charity is determined that its reserves will continue to be used generously to support the original aims and objectives.

Reserves policy

The charity has reserves of Irrelevant information redacted by the USI The directors consider the ideal level of reserves to be Irrelevant information redacted by the USI CURE has no desire to maintain a large financial reserve, however it is considered prudent by the Board that a sufficient reserve remains in order that CURE can respond to unexpected requests for financial assistance from sources that are commensurate with the aims of the charity. This policy is reviewed annually by the directors.

Statement of directors' responsibilities

The directors are responsible for preparing the Annual Report and the financial statements in accordance with applicable law and regulations.

Company law requires the directors to prepare financial statements for each financial year. Under that law the directors have elected to prepare the financial statements in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards and applicable law). Under company law the directors must not approve the financial

Craigavon Urological Research and Education

(A company limited by guarantee)

Directors' report for the year ended 30 April 2010 (continued)

Statement of directors' responsibilities (continued)

statements unless they are satisfied that they give a true and fair view of the state of affairs of the company and of the profit or loss of the company for that period. In preparing these financial statements on the going concern basis unless it is inappropriate to presume that the company will continue in business.

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the company will continue in business.

The directors are responsible for keeping adequate accounting records that are sufficient to show and explain the company's transactions and disclose with reasonable accuracy at any time the financial position of the company and enable them to ensure that the financial statements comply with the Companies Act 2006. They are also responsible for safeguarding the assets of the company and hence for taking reasonable steps for the prevention of fraud and other irregularities.

Small companies' exemption

The above report has been prepared in accordance with the special provisions relating to small companies within part 15 of the Companies Act 2006.

By order of the board

Mrs S Tedford
Company secretary
Date: 27 January 2011

Craigavon Urological Research and Education

(A company limited by guarantee)

Statement of Financial Activities (including income and expenditure account) for the year ended 30 April 2010

		2010	2009
		£	£
Incoming resources/income			
Incoming resources from generated funds			
Voluntary income	2	[redacted]	
Investment income - bank interest			
Total incoming resources			
Resources expended/expenditure			
Charitable activities			
Courses and expenses			
Research funding			
Governance Costs			
Total resources expended			
Net movement in funds/Net income			
Total funds brought forward			
Total funds carried forward			

Irrelevant information redacted by the USI

All amounts above relate to continuing unrestricted operations of the charity.

The company has no recognised gains and losses other than those included in the results above, and therefore no separate statement of total recognised gains and losses has been presented.

There is no material difference between the net movement in funds in the year stated above, and their historical cost equivalents.

Craigavon Urological Research and Education

(A company limited by guarantee)

Balance Sheet as at 30 April 2010

	Notes	2010 £	2009 £
Current Assets			
Debtors	4	[redacted]	
Cash at bank and in hand			
Total Current Assets			
Liabilities			
Creditors: Amounts falling due within one year	5		
Net Current Assets			
Funds			
Unrestricted funds	6		
Total funds			

Irrelevant information redacted by the USI

For the year ending 30 April 2010 the company was entitled to exemption under Article 257A of the Companies (Northern Ireland) Order 1986. No members have required the company to obtain an audit of its accounts for the year in question in accordance with Article 257B(2).

The directors acknowledge their responsibilities for complying with the requirements of the Companies Act 2006 with respect to accounting records and the preparation of accounts.

These accounts have been prepared in accordance with the provisions applicable to companies subject to the small companies' regime.

The financial statements on pages 4 to 7 were approved by the board on 27 January 2011 and were signed on its behalf by:

Mr M Young
Director

Craigavon Urological Research and Education

(A company limited by guarantee)

Notes to the financial statements for the year ended 30 April 2010

1 Accounting policies

These financial statements have been prepared on the going concern basis under the historical cost convention and in accordance with the Companies Act 2006, the Statement of Recommended Practice (SORP) "Accounting and Reporting by Charities" published in March 2005 and applicable accounting standards. The principal accounting policies are set out below.

The company has availed itself of and adapted the Companies Act 2006 format to reflect the special nature of the Charity's activities.

Cash flow statement

The company is exempt from the requirement to publish a cash flow statement under FRS 1.

Incoming resources

Voluntary income

Voluntary income is received by way of grants donations and gifts and is included in full in the Statement of Financial Activities when the charity is legally entitled to income and the amount can be quantified with reasonable accuracy.

Investment income

Investment income relates to bank interest receivable and is included in the Statement of Financial Activities on an accruals basis.

Resources expended

Charitable activities

Charitable activities comprises those costs incurred by the charity in the delivery of its activities and services for its beneficiaries. It includes costs which can be allocated directly to such activities and those costs of an indirect nature to support them.

Fund accounting - Unrestricted funds

Unrestricted funds are available for use at the discretion of the trustees in furtherance of the general objectives of the charitable company which have not been designated for other purposes.

2 Incoming resources

	2010	2009
	£	£
Voluntary income	Irrelevant information redacted by the USI	
Donations		

3 Employee information

The company has no employees other than the directors (2009: nil). The directors received no emoluments or reimbursements of expenditure during the year (2009: nil).

No indemnity insurance was taken out on behalf of directors (2009: nil).

Craigavon Urological Research and Education

(A company limited by guarantee)

Notes to the financial statements for the year ended 30 April 2010

4 Debtors

	2010	2009
	£	£
Prepayments and accrued income	[redacted]	

Irrelevant information redacted by the USI

5 Creditors: Amounts falling due within one year

Creditors	[redacted]

6 Unrestricted funds

	£
At 1 May 2009	[redacted]
Net incoming resources	
At 30 April 2010	

Irrelevant information redacted by the USI

7 Taxation

The charity is a registered charity, and as such is entitled to certain tax exemptions on income and profits from investments, and surpluses on any trading activities carried out in furtherance of the charity's primary objectives, if these profits and surpluses are applied solely for charitable purposes.

The charity is not registered for VAT and accordingly, all expenditure is recorded inclusive of any VAT incurred.

8 Liability of members

Craigavon Urological Research and Education is a company limited by guarantee and does not have share capital. The liability of each member is limited to an amount not exceeding £1.

9 Ultimate controlling party

There is no ultimate controlling party.

Department of Urology
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

18 January 2010

Dr. Gillian Rankin
Interim Director of Acute Services
Southern Health and Social Care Trust
Craigavon Area Hospital
Craigavon
BT63 5QQ

Dear Dr. Rankin,

It was with shock and disbelief that we learned from you on Monday 11 January 2010 that the Trust had appointed a Locum Consultant Urologist, without any consultation with us and without our participation in due process of appointment. It remains for us incredible and untenable the excuse that one of us could not be contacted when the appointment was apparently made, during the third week of December 2009. In addition, we can only conclude that the failure to inform us until Monday 11 January 2010, was with intent, rather than oversight.

Previous appointments of Locum Consultant Urologists have always been conducted in consultation with, and with the active participation of, us in the due process of the construction of job descriptions, advertising, short listing and interviewing. This involvement has proven to be an indispensable component in the time – honoured method of ensuring that any appointee is qualified and adequately experienced for the post, with the ultimate objective of ensuring, so far as is possible, patient safety. In our collective experience and awareness, the manner in which the Trust has made this appointment is unprecedented.

Our concerns regarding the manner of appointment have been completed on review of the appointee's curriculum vitae. It would appear to us that the appointee did not have urological training in specialist urological departments, or in a specialist urological training programme. Since 1998, he has been employed as a Locum or Temporary Consultant General Surgeon in various locations in Ireland. Therefore, it would appear that the appointee is neither trained or qualified to be a Urologist, as a consequence of which he has not been employed as one.

As urologists, we too find ourselves unable to support the Trust's appointment, and incapable of advising the Trust on his deployment.

During the past year, and despite our expressed concerns, the Trust proceeded with its ward reconfiguration, resulting in compromised inpatient care and safety as feared, in addition to significantly diminishing the specialist status of our department. Compliance with the loss of radical pelvic surgery as proposed by the Regional Review of Adult Urological Services similarly has the potential to compromise patient care and safety, and will certainly diminish the status of our department further. The capacity to provide enhanced urological services in the future is entirely dependent upon the ability to recruit and retain specialist staff, and that is entirely dependent upon the attractiveness of the department's current status at any point in time. We would earnestly request that the management of the Trust seriously reflect upon its actions and proposals before any prospect of a future has been completely eliminated. If it is the case that only a General Surgeon can be appointed, we fear that we may have already arrived at that point,

Yours Sincerely,

Mr. Mehmood Akhtar.

Mr. Michael Young.

Mr. Aidan O'Brien.

Cc: Dr. Patrick Loughran, Medical Director, SHSCT.

Regional Review of Urology Services

Team South Implementation Plan

Document History	
Document Name:	Team South Implementation Plan
Status:	Draft v0.1
Version and Date:	V0.1 14 Jun 10
Origin:	Acute Planning SHSCT

Contents

Tables

Appendices

1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a Trust Grade Doctor from August 2010),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The clinical sessions which are currently being undertaken by medical and specialist nursing staff are given as Appendix 1.

The ICATS Service

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

ICATS	Weekly
Prostate Assessment	1.5
Prostate Biopsy	1
Prostate Histology	1
LUTS	3
Haematuria	2
Andrology	2.5
General Urology	2.5
	13.5

Main Theatres (CAH)	Weekly	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly[2]	1 monthly
Flexible Cystoscopy	1.5 weekly[3]	
Lithotripsy	1 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover
3) 2 lists/1 list on alternate weeks

Current Activity

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. The new outpatient attendances are therefore understated by approximately 240.

Table 2: 2009/10 Actual Activity for the Urology Service

		Core Activity	IHA	IS	Totals
2009/10	Cons Led New OP	610	474	0	**1084**
	ICATS/Nurse Led New OP	1233	30		**1263**
	Total New OP	1843	504	0	**2347**
	Cons Led Review OP	2391	70	0	**2461**
	ICATS/Nurse Led Rev OP	1594	0	0	**1594**
	Total Review	3985	70	0	**4055**
	Day Case	1502	3	383	**1888**
	Elective FCE	1199	29	140	**1368**
	Non Elective FCE	629	0	0	**629**

Activity by consultant for 2009/10 is provided in Table 3.

Table 3: Activity by Consultant for 2009/10

		Mr Young[2]	Mr O'Brien	Mr Akhtar[3]	All Core Activity
2009/10	New OP	242	174	193	**609**
	Review OP	964	903	327	**2194**
	Total OP	1206	1077	520	**2803**
	Day Case	696	452	354	**1502**
	Elective FCE	380	512	307	**1199**
	Non Elective FCE	233	210	186	**629**
	FCEs + DCs	**1309**	**1174**	**847**	**3330**
	Day Case Rates [1]	65%	47%	54%	56%

[1] INCLUDES flexible cystocopies (M45) and DCs/FCEs with no primary procedure recorded.
[2] Mr Young's new outpatients are understated by an estimated 240, as Stone Treatment new attendances were recorded as reviews.
[3] Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

Notes:
1) Source is Business Objects
2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)
3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).

4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.

There is a substantial backlog of patients awaiting review at consultant led clinics. The total number of patients is 4,037. The Trust's plan to deal with this backlog has been included as Appendix 2.

Pre-operative Assessment

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

Suspected Urological Cancers

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The only outstanding issue is that of oncology input to the meeting. Confirmation of when this will be available is awaited from Belfast Trust and it is expected that a date for commencement will be available in the near future.

The Southern Trust provides chemotherapy only for prostate cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers and radiotherapy for all cancers is provided by Belfast Trust. When oncology support is

available for the MDM then referral will take place during the meetings. An interim arrangement is in place with referral taking place outside the meetings.

The Trust accepts that all radical pelvic operations will be undertaken at Belfast City Hospital. The Trust asks for clarification with regard to:

- At what point in the pathway patients should be referred;
- Arrangements for review of the patients.

3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position with further detail being provided in Appendix 3.

Table 4: Regional Benchmarking

		2006/07	2007/08	2008/09	2009/10
New : Review Ratio	All Trusts	1.96	2.03	1.79	1.68
	SHSCT	**4.04**	**3.27**	**3.28**	**2.09**
Day Case Rates	All Trusts	50.1	48.5	49.8	48.5
	SHSCT	**43.8**	**45.5**	**48.8**	**40.0**
Average LOS (elective)	All Trusts	3.7	3.5	3.4	2.9
	SHSCT	**3.7**	**4.3**	**3.9**	**2.7**
Average LOS (non elective)	All Trusts	4.8	4.7	4.6	4.4
	SHSCT	**4.5**	**4.8**	**4.6**	**4.7**

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1st January – 31st December 2009. The Trust's length of spell compares very favourably with the peer group average.

Check if these were just elective procedures.

Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)

HRG V4.2	Spells	Subject LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The Trust has compared its performance to the BADS targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete). The analysis is provided as Appendix 4. The Trust will use the BADS recommendations to determine appropriate day case rates for the new service model for urology.

4. Demand for Team South Urology Service

The Trust has utilised the methodology recommended by the Board to calculate the demand for the service. It has been assumed that the population of Fermanagh will be similar to the Southern area. As inclusion of Fermanagh will increase the population catchment area for urology by 18%, an uplift of 18% has been applied. Table 6 overleaf shows the calculation of the estimated demand for the service. It should be noted that this does not factor in any future growth in demand.

Table 6: Projected Activity for Team South

		2009/10 Actual Activity					
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**Team South Capacity Required [6]**
2009/10	Cons Led New OP	610	474	0	87	1171	1382
	ICATS/Nurse Led New OP	1233	30		100	1363	1608
	Total New OP	1843	504	0	187	2534	**2990**
	Cons Led Review OP	2391	70	0		2461	2904
	ICATS/Nurse Led Rev OP	1594	0	0		1594	1881
	Total Review	3985	70	0		4055	**4785**
	Day Case	1502	3	383	47	1935	**2283**
	Elective FCE	1199	29	140	28	1396	**1647**
	Non Elective FCE	629	0	0		629	**742**

1) Source is Business Objects
2) Activity has been counted on specialty of clinic
3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog . As shown N:R = 1:2
4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
5) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
6) 18% added for Fermanagh, based on population size relative to SHSCT population

The projected demand from Table 6 was used to calculate the numbers of session which will be required to provide the service. These are summarised in Table 7 below with the detail of the calculations provided as Appendix 5.

Table 7: Weekly Sessions for New Service Model

	Weekly Sessions
Consultant Led OPs	
General	5
Stone Treatment	1
ICATS	
Prostate Assessment	1.5
Prostate Biopsy [1]	1
Prostate Histology [2]	1
LUTS	3
Haematuria	1
Andrology/General Urology	5
Urodynamics	1.5
	14
Main Theatres	9
Day Surgery	
GA	3
Flexible Cystoscopy	3
Lithotripsy	1/2

1) Prostate Assessment and Biopsy will run side by side
2) Consultants will see their own patients, so whilst this has been noted as a single session, it is unlikely to be a single session in practice.
3) All sessions with the exception of ICATS andrology & general urology, will run over 48 weeks. ICATS andrology & general urology will run over 42 weeks.
4) Lithotripsy day case sessions have been calculated over 42 and 48 weeks. A second consultant with special interest in stone treatment will be required if sessions are to run over 48 weeks.

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The ICATS service is currently being reviewed. Some changes which will improve the service provided to patients have already been agreed by clinical staff. These include:

- The prostate pathway has been reviewed (a draft revised pathway is included in Appendix 6). Patients requiring a biopsy will be given the opportunity to have this done on the same day as their initial assessment (where this is clinically appropriate).
- Patients triaged to the haematuria service will have flexible cystoscopy carried out on the same day as their initial assessment. In the current service model these patients have to come back to the hospital to have this done in the Day Surgery Unit.
- Urodynamics will move from the inpatient ward to the Thorndale Unit and sufficient staff will be trained to avoid backlogs of patients awaiting investigation.

The Andrology and General Urology elements of the ICATS service will be reviewed over the coming months.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals. Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time. The frequency of sessions is to be agreed with the Western Trust.

Outpatient clinics will be held at Craigavon, South Tyrone, the Erne and Armagh Community Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

Consultant and Nurse led sessions will be provided over 48 weeks. The detail of job plans is to be agreed with clinical staff but they will be based around the sessions identified in the previous section. Due to available theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

Work is ongoing to develop patient flow and clinical pathways for the service. Draft pathways are included as Appendix 6. The on call urologist at Craigavon Area Hospital will be available to provide advice at any time to medical staff at the Erne or Daisy Hill Hospitals on the management or transfer of emergency cases.

6. Timetable for Implementation

Task	Timescale
Submission of Team South Implementation Plan	22 June 10
Approval to Proceed with Implementation from HSCB	July 10
Completion of Job Plans/Descriptions for Consultant Posts	End July 10
Completion of Job Plans/Descriptions for Specialist Nurses	End July 10
Consultant Job Plans to Specialty Advisor	End July 10
Advertisement of Consultant Posts	September 10
Advertisement of Specialist Nurse Posts	September 10
New Consultants and Specialist Nurses in post	February 11

APPENDICES

Proposal to Manage Urology Review Backlog

Process to manage the substantial volume of patients involved in Urology - Total = 4037 (2008- 31 May 2010)

- Identify patients who may be at risk and require an urgent review
- Identify patients who require a consultant reassessment in an agreed timeframe
- Cleanse list – ensure that there are no duplicate open requests for same issue.

The Specialty Nurses have agreed to coordinate the process by reviewing patient centre letters and results and collate into the following categories:-

Category 1: Urgent appointment required
Automatically arrange an urgent review appointment

Category 2: Decision required on review management
Lead nurse will meet with consultant to determine a plan for each patient, i.e. either agree review required in a specified time frame or agree an alternative plan.

Category 3: ?Discharge based on clinical results available
Lead nurse to get permission from consultant to discharge and send letter to GP and patient

Category 4: PAS errors/duplication
Lead nurse to get permission from consultant to discharge from PAS

To date there has been a reduction in the waiting list by 6%.

ICATS: Haematuria pathway – MALE & FEMALE

Referral from GP/ other hospital dept/other urology service

Triaged to ICATS haematuria service by consultant & appointment managed by ICATS secretary with priority given to red flag referrals

Appointment arranged at haematuria assessment clinic ICSNUHEA 4 patients – currently Wed am

Assessment at clinic includes USS urinary tracts, urinalysis, MSSU, direct microscopy & cytology, bloods i.e. U&E,COAG, FBP, Glucose+/- PSA after counselling & clinical observations. History taking (inclusive of clinical history & medications, symptoms, gynaecological history, risk factors i.e. smoking or occupational factors.

Appointment details given for flexible cystoscopy (2 weeks later)

Flexible cystoscopy & physical examination

All results collated and discussed with patient & GP informed of outcome

Outcomes: *no review option at this service*

- Diagnostics: e.g. IVP
- Direct treatment on inpatient/daycase list e.g. GA biopsy / TURBT
- Return to primary care with advice
- Hospital OPD / Other ICATS service as appropriate i.e. LUTS, Andrology

Additional information

- Refer to NICAN haematuria pathway
- Aim to provide this assessment at one stop visit
- Haematuria service also provided at DHH – initial appointment at flexible cystoscopy with diagnostics to follow ?? direct booking at DHH

ICATS: LUTS pathway – MALE ONLY

Referral from GP/ other hospital dept/other urology service

Triaged to ICATS LUTS service by consultant & appointment managed by central booking (in line with PTL targets)

Appointment arranged at either new male LUTS clinic – ICSNULUP Mon pm 4 patients / ICSNULU5 Fri am 4 patients

Assessment at clinic includes USS urinary tracts, Urine flow study & urinalysis, IPSS & history taking (inclusive of clinical history & medications, urinary symptoms & sexual function history, bloods i.e. U&E, Glucose +/- PSA after counselling & MSSU).

Results (where possible at same visit) & information to patient & GP

Outcomes: *aim a maximum of 2 reviews before discharge from ICATS*

- Diagnostics: e.g. flexible cystoscopy, Urodynamic studies
- Direct treatment on inpatient/daycase list e.g. Prostate biopsy, TURP
- Return to primary care with advice
- Hospital OPD / Other ICATS service as appropriate i.e. Andrology
- Review at LUTS clinic – see above

Additional information

- LUTS review clinic ICSNULUT – Mon am 8 patients
- BPH / chronic urinary retention are examples of conditions routinely assessed & where possible managed via this clinic

ICATS: Prostate diagnostic pathway - MALE

Referral from GP/ other hospital dept/other urology service

Triaged to ICATS Prostate Diagnostic service by consultant & appointment managed by central booking (in line with PTL targets) & red flag referrals appointed by cancer services

Appointment arranged at either new prostate assessment clinic – ICSNURSA Mon am 4 patients / alternate Thursday am 4 patients

Assessment at clinic includes USS urinary tracts, Urine flow study & urinalysis, IPSS & history taking (inclusive of clinical history & medications, urinary symptoms & sexual function history, bloods i.e. U&E, Glucose & MSSU, PSA & DRE).

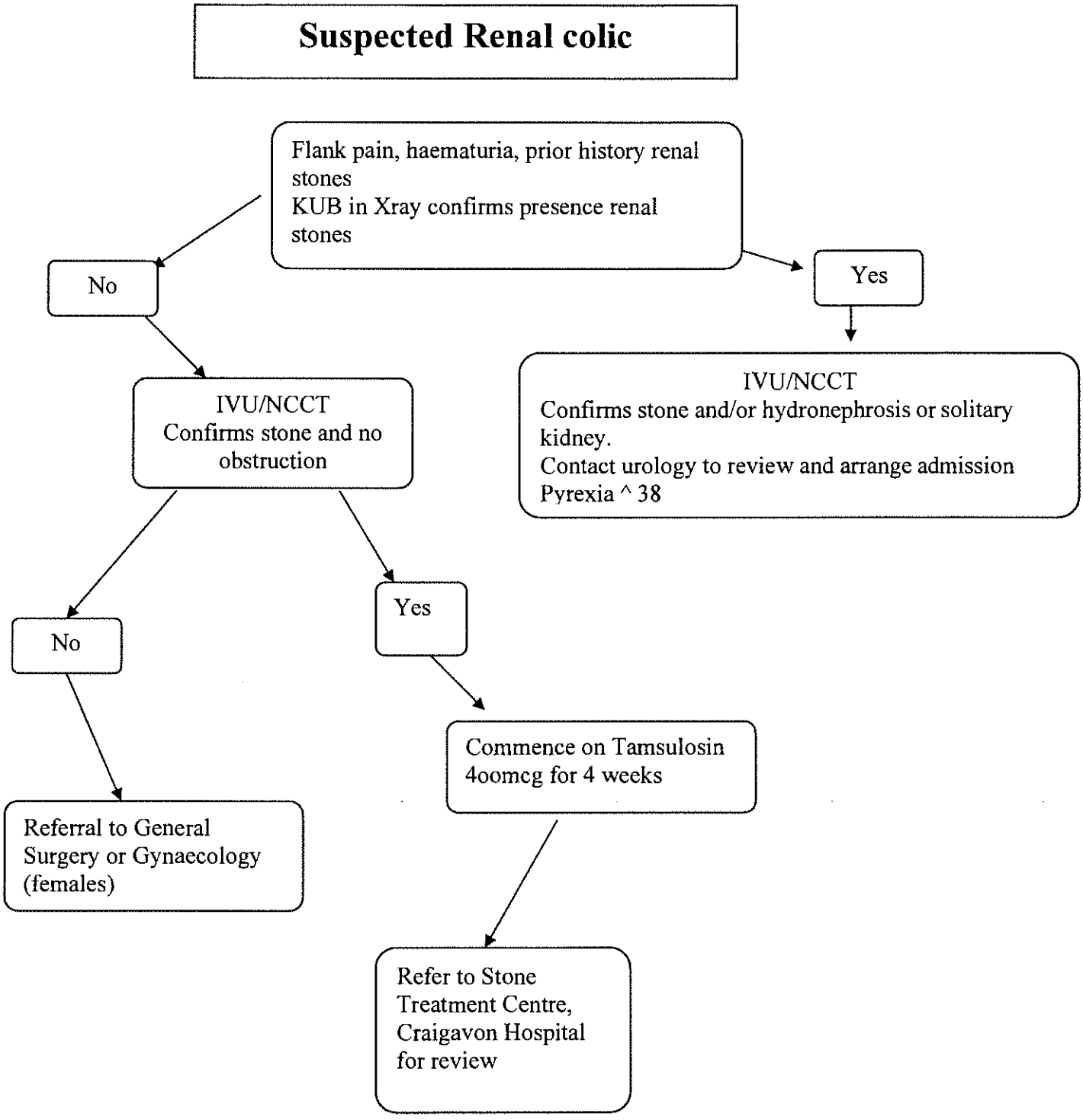
Results (where possible at same visit) & information to patient & GP

Outcomes: *no review option at this service*

- Diagnostics: e.g. CT / Bonescan / MRI
- Direct treatment on inpatient/daycase list e.g. prostate biopsy
- Return to primary care with advice / PSA monitoring
- Hospital OPD / Other ICATS service as appropriate i.e. LUTS, Andrology

Additional information

- Refer to NICAN prostate pathway
- Red flag patients currently scheduled into Thursday clinic and any free space on Monday clinic



Recurrent Urinary Tract Infections

Step 1 – Nurse Led Service

- Urine cultures- frequency to be determined by Consultant Nurse to obtain and monitor results and liaise with Consultant regarding any change to pathway including frequency of sample.
- Oral antibiotic regime prescribed and altered by Consultant Urologist as per culture with input when necessary from Bacteriology

Step 2 – Intravenous Antibiotic Regime

- Nurse led Service
  Day case attendance
- IV/SC Therapy
  Co-ordinator
  community
- Inpatient
  Culture sensitivity
  Symptomatic
  Venous access easily obtained

Step 3 – Intravenous Fluids and Antibiotic Regime

- Nurse Led Service
  Day case attendance Monday – Friday
  Consultant to prescribe Intravenous Antibiotic regime as per Culture and with input when from Bacteriology
- Inpatient
  Symptomatic
  Culture Sensitivity
  Venous access compromised

Making diagnosis of Urinary Retention in the A&E department

Medical assessment to include
DRE, FBP, U&E, BLOOD SUGAR, PSA

→ PSA done but not impacting on decision

↓

Administer prophylactic antibiotics
(clarify)
Pass correct length urethral catheter –
Send a CSU for culture

↓

Catheterisation Successful

Catheterisation Unsuccessful

↓

Contact Urology unit
Admit

Admit to Craigavon Urology unit if

- output greater than 700mls (observe x 2 hours)
- abnormal creatinine
- unfit/elderly
- female patients
- infection suspected
- neurological deficit
- haematuria
- difficult catheterisation

Less than 400ml
Consider alternative diagnosis (UTI) or cause painful abdomen

400-700ml
Patient fit and normal creatinine
Start Alfuzosin 10mg OD

↓

Discharge Home

Refer to Urology Ambulatory Care Centre for TROC and Ultrasound and further evaluation for follow up

An onward referral to Community Continence team if required
Ensure catheter discharge form completed and take home pack is given to patient

Pathways for Non-Elective Admissions to either Daisy Hill or Erne Hospitals that do not have an acute Urology Unit

Patient presents at Accident and Emergency in either Daisy Hill or Erne Hospitals

Testicular Torsion

Suspected cases of Testicular Torsion should be dealt with by the surgical team

Testicular Infection

Suspected cases of Testicular Infection should be dealt with by the surgical team at the presenting hospital

The patient should have an ultrasound carried out to exclude Testicular Tumour

Patient should then be referred to the Urological Team at Craigavon Area Hospital

Renal Colic

The patient needs to be assessed by the Surgical Team at the presenting hospital

Investigations such as non-contrast CT, IVP/Ultrasound should be undertaken to confirm diagnosis

This combined with the patient's renal function and sepsis status will govern the acuteness of the referral pathway.

Haematuria

Patients admitted with Haematuria/Clot retention that are requiring admission are to be assessed for need of catheter insertion.

Initial investigations of ultrasound and IVP should be undertaken followed by contacting the Craigavon Area Hospital for further advice on referral pathway as there may be a need for transfer or subsequent consultation

Infection – Recurrent Urinary Tract Infection/pyelonephritis

The patient needs to be assessed by the Surgical Team at the presenting hospital.

Catheter Insertion
Current guidelines and a protocol are being drawn-up for insertion of Catheter by the Urological Team at Craigavon Area Hospital and this will be available on all sites

Note: Any entity defined as a Urological Emergency can be referred/discussed with the Urological team at any time for advice/guidance on how best to manage/transfer

If advice is required on any of the above the Urology On call doctor should be contacted via Craigavon Area Hospital Switchboard

Personal Information redacted by the USI

Appendix 5

Urology Review

Projected Activity & Sessions v0.1 17 June 10

Table 1 below gives the Board's calculation of the capacity gap, and using the Board's methodology, the projected activity for 'Team South'.

		2009/10 Actual Activity							
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**SBA**	**SHSCT Capacity Gap**	**Team South Capacity Required [6]**
2009/10	Cons Led New OP	610	474	0	87	1171	1014	157	1382
	ICATS/Nurse Led New OP	1233	30		100	1363	990	373	1608
	Total New OP	1843	504	0	187	2534	2004	530	**2990**
	Cons Led Review OP	2391	70	0		2461	3290	-829	2904
	ICATS/Nurse Led Rev OP	1594	0	0		1594	990	604	1881
	Total Review	3985	70	0		4055	4280	-225	**4785**
	Day Case	1502	3	383	47	1935	1239	696	**2283**
	Elective FCE	1199	29	140	28	1396	780	616	**1647**
	Non Elective FCE	629	0	0		629	816	-187	**742**

1) Source is Business Objects
2) Activity has been counted on specialty of clinic
3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog (4037 in June 2010). As shown N:R = 1:2
4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
5) 18% added for Fermanagh, based on population size relative to SHSCT population
6) SBA for ICATS is 1980 (no split between new and reviews so have just divided equally)

Appendix 5

Outpatients

To enable the numbers of clinic sessions to be calculated, Table 2 splits the numbers of new outpatient attendances by clinic, based on the 2009/10 attendances.

Table 2: New Outpatient Attendances

Clinic	Core	IHA	Total	%	Growth	SHSCT Total	Team South
Prostate TRUSA (&B)	248		248	10.6%	20	268	316
LUTS	323		323	13.8%	26	349	412
Andrology/Dr Rodgers gen urology	476	30	506	21.6%	40	546	645
Haematuria	186		186	7.9%	15	201	237
Consultants clinics	374	474	848	36.1%	68	916	1080
Urodynamics (consultants)	236		236	10.1%	19	255	301
	1843	504	**2347**	100.0%	187	2534	**2990**

Stone Treatment new outpatients are being recorded as reviews and are therefore not included in the figures. This means that new outpatients at consultant clinics are under stated.

Appendix 5

Sessions are based on 48 weeks unless otherwise stated.

Prostate Pathway (Revised)

1st appointment – the patient will be assessed by the specialist nurse (patient will have ultrasound, flow rate, U&E, PSA etc). A registrar needs to be available for at least part of the session eg to do digital rectal examination (DRE), take patient off warfarin etc. 5-6 patients can be seen at an assessment clinic (limited to a maximum of 6 by ultrasound). In the afternoon appropriate patients from the morning assessment would have a biopsy. 4-6 patients can be biopsied in a session (though additional biopsy probes will need to be purchased). Not all patients will need a biopsy and the session will be filled with those patients from previous weeks who did not have a biopsy on the same day as their assessment (because they needed to come off medication, wanted time to consider biopsy etc). Based on 2009/10 figures it is estimated that 69% of patients will require biopsy (218)

316 patients @ 5 per session = 63 sessions per annum (53 if 6 patients are seen) = 1.3 (or 1.1) assessment sessions per week.

218 cases for biopsy @ 5 per session = 44 sessions per annum. 1 biopsy session per week should therefore suffice (over 48 weeks).

The majority of patients with benign pathology will be given their results by telephone (Specialist Nurse time needs to be built in to job plans for this).

2nd appointment will be to discuss the test results – patients with positive pathology and those patients with benign pathology who are not suitable to receive results by telephone. It is estimated that 40% of patients who have had biopsy will have positive pathology (using 40% this would be 88 patients – have asked Brian Magee for actual figure for 2009/10). Adding on 10% for those patients with benign pathology who will need to come in for their results gives a figure of 97 patients needing a second appointment. This equates to 2 patients each week (over 52 weeks). These patients are now being seen by a registrar but the consultants want to build time into the new service model to see the patients themselves.

3rd appointment will be discussion of treatment with the estimated 88 patients per annum. Could these be dealt with promptly on a weekly basis by the surgeon of the week following the MDT? The consultants would prefer to see their own patients and feel that the appropriate model is for each to have a weekly 'Thorndale session' to do:

- 2nd and 3rd prostate appointments,
- Check urodynamic results/patients

Appendix 5

LUTS

412 new patients. The new to review ratio is 1:0.8, therefore there will be approximately 330 reviews.

412 new patients @ 4 per session = 103 sessions

330 reviews @ 8 per session = 42 sessions

103 + 42 = 145 sessions per annum = **3 sessions per week** (over 48 weeks)

Registrar input is required.

Haematuria (Revised)

Currently ultrasound, history, bloods, urines etc done by the Specialist Nurse/Radiographer. Patients come back to DSU to have flexi carried out by a Registrar (Friday flexi sessions).

This will move to a 'one stop' service with the flexi being done on the same day in Thorndale (by a Registrar). 5 patients per session (may be a slightly longer session than normal) have been agreed.

237 new patients @ 5 per session = 48 sessions = **1 per week** (over 48 weeks)

Note – some patients will require IVP. The view of the clinical staff is that it may be rather onerous for the older patient to have this along with the other investigations done on the same day. However this will be considered further and the potential for protected slots discussed with Radiology.

Andrology/General Urology ICATS

This service will be reviewed over the next 6 months.

For planning purposes it has been agreed to use a new to review ratio of 1:1.5 with 3 new and 5 review at a clinic. It is assumed that sessions will only run over 42 weeks.

645 @ 3 news per session = 215 sessions = **5 per week** (over 42 weeks)

Consultant Clinics

Urodynamics patients are included in the consultant clinics (301 new). If these are separated out this leaves 1080 new patients at consultant clinics.

Junior doctors will not be available to support all outpatient sessions. Therefore it has been assumed that on average 1.6 doctors will attend a clinic with 10 patients each, therefore on average 16 at a clinic. Consultants believe that 5 news and 11

reviews is the appropriate number at a clinic for this staffing level. This will give a new to review ratio of 1:2.2.

1080 patients @ 5 news per clinic = 216 sessions = 4.5 per week. 5 sessions (over 48 weeks) will be built in to the service model (to allow some flexibility because of the limited junior doctor support).

Stone treatment is not included as they have been recorded as reviews – need to get an estimate of numbers of news.

Urodynamics (Revised Model)

Currently carried out on the ward with results reviewed by consultants. These will be moved to Thorndale/Ambulatory Care Unit to be carried out by a Specialist Nurse. Consultants wish to assess the results in their proposed Thorndale session.

301 cases at 5 per all day session = 60 all day sessions. 1.5 per week will be built in to the service model.

Time will also need to be built into the Specialist Nurses' job plans to pre assess the patients (this may not need to be face to face) as there otherwise would be a high DNA rate for this service.

Day Cases

Flexible Cystoscopy

Based on the current day case rates 2283 day cases (including flexible cystoscopies) would be undertaken.

2008/09 activity has been used to apportion flexible cystoscopies etc, as coding is incomplete for 2009/10.

1243 flexible cystoscopies were carried out as day cases (primary procedure code = M45) and this was 56% of the total daycases (2203), in 2008/09.

It has therefore been assumed that 56% of 2283 cystoscopies will be required = 1279. 237 of these will be done in Thorndale (Haematuria service), leaving1042. Numbers on lists vary between 6 -10, depending on where the list is undertaken, and whether any patients who have MRSA are included on the list. An average of 8 per list has been used for planning purposes.

1042 @ 8 per list = 131 lists = **3 flexi list per week** (over 48 weeks)

Lithotripsy

268 day cases were carried out in 2008/09. This was 12.2% of the total day cases. Assuming 12.2% of 2283 will be lithotripsy gives a requirement for 279.

279 @ 4 per session = 70 sessions. This equates to 1.5 per week if delivered over 48 weeks (will require a second consultant with Specialist Interest in stone treatment) and 2 per week if delivered over 42 weeks.

Other Day Cases

The day case rate for specific procedures will be increased (assuming suitable sessions and appropriate equipment can be secured).

In 2008/09 2203 day cases and 1273 elective FCEs were carried out (3476 in total and a day case rate of 63.4%). If the British Association of Day Surgery recommended day case rates had been achieved for the basket of procedures for urology in 2008/09 then an additional 215 day cases would have been carried out increasing the total day case rate from 63.4% to 69.6%

For Team South we have projected 2283 day cases and 1647 FCEs (Day case rate of 58%). If a day case rate of 69.6% is applied to the total elective activity of 3930 then this changes the mix to 2735 day cases and 1195 elective FCEs.

Of the 2735 day cases:

- 1279 are flexible cystoscopies;
- 279 are lithotripsy
- 103 had no procedure (add 18% to account for Fermanagh region) = 121
- 279 are introduction of therapeutic substance in to bladder + 18% = 329

This leaves 727 day cases to be carried out. Some will be done in dedicated day surgery sessions and some will be more suited to main theatre via the elective admissions ward (in case an overnight stay is required). 4 patients are normally done in dedicated day surgery sessions at present but consultants feel that this could be increased to 5.

727 @ 5 per list = 146 lists = 3.1 lists (over 48 weeks). As not all cases will be done within the dedicated day case lists, 3 weekly lists will suffice.

Inpatients

1195 elective FCEs are projected. A limited number of patients may not have a procedure carried out. However some non elective cases are added to elective theatre lists. The numbers of procedures carried out on a list also varies significantly

and on occasions a single complex case can utilise a whole theatre list. For the purposes of planning, 3 cases per list has been taken as an average.

1195 @ 3 per list = 399 lists = 9 lists (over 48 weeks).

Aimee Crilly

From: Rankin, Gillian [redacted] Personal Information redacted by USI
Sent: 19 July 2011 11:43
To: Young, Michael; O'Brien, Aidan; Akhtar, Mehmood; Mackle, Eamon; Trouton, Heather; Corrigan, Martina
Cc: Dignam, Paulette; Troughton, Elizabeth; McCorry, Monica
Subject: Urology development

Dear all,

The Trust has received approval to proceed with the development of the urology service in line with the regional review and the activity levels agreed as our last proposal.
The detail of what additionally will be delivered in year will need to be confirmed with HSCB.

This is good news and after much hard work, discussion and agreement it is good to get to this stage.
However we still have much to do to implement the full service.

In relation to recruitment of new urologists we need firstly to finalise the current 3 person job plan which Eamon has discussed as this is required as a first step.
We then need to finalise the job plans for the new consultants which mean a further review and identifying speciality interest for each consultant in the team. Once job plans are agreed we are then able to seek speciality advisor approval which is required prior to advertising the posts. Obviously the sooner we can get these steps completed the sooner we get to recruitment and I hope that we can get agreement on these issues in the next few weeks and prior to the end of the summer.

Heather will be chairing the group to agree the other areas for recruitment such as anaesthetist, radiology, spec nurses etc as they will be needed to fulfil the workload; and also the continuing work on the service models which we have in process.

Thank you for your continued efforts to take this forward,

Gillian

Aimee Crilly

From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 20 July 2011 08:31
To: Aidan O'Brien's email address; Michael Young's email address; Akhtar, Mehmood; O'Brien, Aidan; Young, Michael
Cc: Dignam, Paulette; Hanvey, Leanne; McCorry, Monica; Troughton, Elizabeth
Subject: OP RBL TOTAL - SEC 18 7 11 (3).xls
Attachments: OP RBL TOTAL - SEC 18 7 11 (3).xls

Dear all,

Please see attached for your information and action.

I have been advised that there is some more funding for additional review backlog clinics and I would be grateful if you could let me know if you have any availability to do additional clinics from now until end of September.

Mr O'Brien/Mr Akhtar, your patients from 2008 have already been offered appointments and have advised that they could not attend, they should be offered another appointment in September and should come off the 2008 list (the reason they were kept on and not reset was to ensure that they didn't get mixed up in the 2011 backlog).

I am happy to discuss.

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

SHSCT OUTPATIENT REVIEW BACKLOG - CUMULATIVE TOTAL AT 18.7.11
REVIEW APPOINTMENTS REQUIRED BY 30 JUNE 2011 INCLUSIVE

ELECTIVE & SURGICAL DIVISION ONLY

SPECIALTY DESCRIPTION	YEAR							
	2007	2008	2009	2010	2011*	URGENT/ TOP OF LIST	URGENT REV CODES	TOTAL
GENERAL SURGERY	0	0	85	760	1077	41	9	**1972**
BREAST SURGERY	0	0	0	0	2	0	1	**3**
ORAL SURGERY	0	0	0	1	55	0	0	**56**
UROLOGY	0	135	1049	1270	793	29	53	**3329**
ENT	0	0	1	141	1981	0	3	**2126**
OPHTHALMOLOGY	0	31	271	661	787	34	53	**1837**
ORTHOPAEDICS	0	0	0	95	349	0	11	**455**
THORACIC SURGERY	0	0	0	0	0	0	0	**0**
TOTAL	**0**	**166**	**1406**	**2928**	**5044**	104	130	**9778**

* 2011 total = 1 Jan 2011 to 30 JUNE 2011

This report shows the OP review backlog for E&SD in its entirety, as well as the number of patients who are sitting at the top of the list/urgent reviews/"select next"/no "Date Reqd" reviews for each Consultant.

Nadeina Willis-McCooke

From:
Sent:
To:
Subject:

-----Original Message-----
From: [Aidan O'Brien's email address]
To: Martina.Corrigan[Personal Information]
Sent: Wed, 7 Mar 2012 23:29
Subject: Re: Copy of PTL REPORTS AS AT 05032012 AOB.xls

Hello Martina,

Another late night call!

Firstly, due to a cancellation this Saturday, I have been able to have [Personal Information redacted by the USI] admitted then.
Secondly, by my reckoning, I now have 19 patients on the PTL list awaiting dates. I would hope to be able to give dates to the majority of these cases. Bearing in mind that other patients are phoning every day requesting admission, I would hope to be able to offer admission dates to 15 of these patients by 31 March. So, with inherent minor variability on that figure, you may assure the department that every effort will be made to offer dates to almost all of these patients. I am sorry that I cannot be more precise at this time.

With regard to the numbers of patients on urgent waiting list for long periods, I believe that there is a rational explanation. The only category available for all patients who are not routine is 'urgent'. This is entirely due to the fact that there are only 2 categories of clinical priority available. When there were 4, we had available a much wider and more appropriate, 4 lane carriageway, along which to streamline patients. I believe that it was unwise to have dispensed with that years ago. I voiced that opinion at the time, but found myself in the wilderness, as usual! However, the department should be reassured that those urgent patients waiting a long time are so because patients much more urgent have since been attended to, but still have a greater clinical priority than those labelled as routine. Mind you, it would help greatly if one recurrently did not have to consume operating time to the routine and in chronological order, at the whim of the same department,

Aidan.

-----Original Message-----
From: Corrigan, Martina [Personal Information redacted by the USI]
To: [Aidan O'Brien's email address]
Sent: Wed, 7 Mar 2012 15:32
Subject: RE: Copy of PTL REPORTS AS AT 05032012 AOB.xls

Dear Aidan,

Many thanks for your response. [Personal Information redacted by the USI]

[Personal Information redacted by the USI]

Many thanks for your response back I do appreciate your sentiments about

chronological order and I can get this highlighted to the Board. As long as I can tell them what the situation will be at the end of March as I have been saying that it will be 40 weeks so I do need to let them know this Friday if it will be longer and they want to know by how many patients we are not going to meet the 36 week target so thank you for the information below it is very helpful. The only other thing that the Board have picked up on is the number of urgents that are on the long-waiters PTL I note you have categorised 11 as urgent on the list I sent through yesterday and they have highlighted that we should not have urgent patients waiting this long.

Many thanks again

Martina

Martina Corrigan

Head of ENT and Urology

Craigavon Area Hospital

Tel: Personal Information redacted by the USI (Direct Dial)

Mobile: Personal Information redacted by the USI

Email: Personal Information redacted by the USI

Personal Information redacted by the USI

From: Aidan O'Brien's email address
Sent: 07 March 2012 00:13
To: Corrigan, Martina
Subject: Re: Copy of PTL REPORTS AS AT 05032012 AOB.xls

Martina,

Personal Information redacted by the USI

With regard to PTLs, I do hope that it is appreciated how difficult and inappropriate it is to allocate all of one's inpatient operating capacity on the sole grounds of chronology, and irrespective of clinical priorities. For example, today I arranged to have admitted next week two patients awaiting admission since December for resection of bladder tumours.

With regard to some patients on the list:

* Personal Information redacted by the USI This lady will be admitted on Saturday 31 March. Earlier dates did not suit. She has agreed to be admitted that day. She just has not been preadmitted yet.
* Personal Information redacted by the USI This man is working Personal Information redacted by the USI at present, and will not be available for admission until May 2012
* Personal Information redacted by the USI For admission Wednesday 14 March
* Personal Information redacted by the USI For admission Tuesday 13 March
* Personal Information redacted by the USI For admission Wednesday 21 March
* Personal Information redacted by the USI Tuesday 27 March

I will try to arrange as many other PTL admissions as is possible and will let you know as soon as is possible,

Aidan.

-----Original Message-----
From: Corrigan, Martina Personal Information redacted by the USI
To: O'Brien, Aidan Personal Information redacted by the USI
Aidan O'Brien's email address
CC: McCorry, Monica Personal Information redacted by the USI
Sent: Tue, 6 Mar 2012 17:04
Subject: Copy of PTL REPORTS AS AT 05032012 AOB.xls

Hi Aidan,

Please see attached PTL of patients that need to be seen before end of March. Can you please advise how many of these that can be fitted in as I have to give an update to the Board on Friday.

I note that there are 26 patients left on the INPT PTL. I have advised the Board that we most likely will breach inpatients by 40 weeks MAXIMUM as I have assured the Board that we have been booking in chronological order.

There is 1 D/C also on this:

Personal Information redacted by the USI

We need dates for all of the above as well as we cannot breach 36 weeks for daycases.

The Board meeting is this Friday so I would be grateful if you could come back to me by Thursday at the latest.

Many thanks and I am happy to discuss this with you.

Kind regards

Martina

Martina Corrigan

Head of ENT and Urology

Craigavon Area Hospital

Tel: Personal Information redacted by the USI (Direct Dial)

Mobile: Personal Information redacted by the USI

Email: Personal Information redacted by the USI

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

Aimee Crilly

From: Fernando, Hirron [redacted]
Sent: 05 October 2012 12:42
To: Young, Michael
Cc: O'Brien, Aidan; Corrigan, Martina
Subject: RE: SPECIALITY DOCTOR IN UROLOGY

Dear Mr Young

I am writing to you following recent interview for the above post. Thank you for offering this post to me but after careful consideration I have made decision not to proceed with the job offer for the following reason

1) The job description for the above post says 10 PA , which I was in the impression half of the activity involve theatre sessions; as many speciality doctor urology does have a significant theatre time.
2) This job is merely providing service to the trust but I have nothing to gain from this job ,I mean from theatre experience point of view. I am simply facilitating two SPR'S to attend theater
3) Wage for this job unfortunately doesn't meet my personal expectations. Therefore I have decided not to proceed with the job.I am happy to provide as a locum basis if any help 3 days a week as a agency locum and two on calls a week and one weekend.If this is any help.I am sorry for the inconvenience this may have cause

Best Regards

Hirron

Aimee Crilly

From: Corrigan, Martina <[redacted]>
Sent: 20 May 2013 07:33
To: McMahon, Jenny; ONeill, Kate; [redacted]; AJay Pahuja [redacted] Glackin, Anthony; Young, Michael; O'Brien, Aidan; Tony Glackin [redacted]
Cc: Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; McCorry, Monica; Troughton, Elizabeth
Subject: **URGENT INFORMATION** Saturday operating Lists

Importance: High

Dear all,

You may be aware that I had been using the funding from the vacant consultant's post to fund the additional lists during April and May. Since we have now employed a locum from today, there is currently no more funding for these additional lists. I have put in a bid for more funding but for now please do not send for any patients for Saturday's 8th, 15th, 22nd and 29th June. It is ok to go ahead with 1 June list and with the additional clinics that I have agreed for June, however I cannot agree to any more additionality for June.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

Angela Kerr

From: Mark Haynes <[redacted]>
Sent: 18 July 2014 07:57
To: Corrigan, Martina
Cc: [redacted]; Glackin, Anthony; Haynes, Mark; 'Mark'; Young, Michael; O'Brien, Aidan; [redacted] 'Ram Suresh'; Suresh, Ram; 'Tony Glackin'
Subject: Meeting Notes
Attachments: Urology Vision Meetings 10th July and 17th July.docx

Morning Martina

As per yesterdays meeting attached is the summary I had written of the discussions from last weeks meeting and I have added in points from yesterday.

I may have missed aspects off and so please feel free to amend as necessary.

Are we meeting next Thursday? If so can I suggest we use next week to try and define the capacity requirements for the service?

Mark

Urology Vision Meeting 1 10/07/14

Case for Change

There is agreement amongst the team and broader recognition within the NI healthcare service (primary care, Board) that the principle challenge facing SHSCT Urology is that patients are simply waiting too long for their care. Review of the current status of the SHSCT Urology service shows that we receive an average of 416 new outpatient referrals per month while we are only currently delivering 366 new OP appointments per month (and this includes any additional OP activity performed outside of job plans). For inpatient / day case surgery we list approximately 160 hours of operating per month while our capacity to deliver is 140 hours per month. The Demand vs capacity mismatch is therefore 50 new referrals per month and 20 hours operating. This does not account for follow-up outpatient reviews or the ESWL, flexible cystoscopy or urodynamics waiting lists. The current total backlog (numbers of patients without dates) stands at;

- 1390 New outpatients without appointments (1250 waiting > 9 weeks, 880 waiting > 15 weeks).
- 802 patients listed for IP or Day case procedures (Flexi, Urodynamics and ESWL excluded).
- 3600 FU appointments pending.

In addition to the current situation NI data demonstrates a year on year increase in urological workload of 10%. It may also be the case that the current status of waiting times may be having a restrictive effect on this expansion and with reduced waiting times the expansion requirements may be greater (MDH aware that similar figures for the South Yorkshire area were 17% year on year increase in workload).
We have been tasked by the board to come up with a vision for the SHSCT urology service that;

- Delivers a sustainable service.
- Is based on efficient models of care.
- Maximises available capacity.
- Maintains acceptable, equitable waiting times.
- Incoorporates planning for delivery of increasing demand.
- Identifies what additional resource is required to deliver this service.
- Identifies risks which pose a threat to delivery of the vision.

Principles

Experience of previous attempts to tackle the demand vs capacity mismatch are that focus on one or two elements has resulted in short term improvement and subsequent return to the previous situation. In examining the other urology services in NI attempts to tackle the same issue it is clear from discussion with the board that The Ulster is felt to have managed this better than other services. It was agreed that the reason behind this is that they started with no urology service and designed the patient pathways and service processes from scratch. We agreed that the board want us to look to re-examine the entire urology service and redesign but that the board expects us to fail to deliver its requests and anticipates us to return with one or two ideas that ultimately fail to deliver real change. We accepted that service modernisation can only be achieved by redesigning the entire process and not by tinkering at the edges with this in mind the basic principles that will underpin the vision are;

- Starting point is a blank sheet.

- Start broad before focussing on individual aspects.
- Efficiency of consultant input in delivery of care essential.
- Nothing is off limits.
- Can't and won't, nor historical experience are not sufficient in dismissing ideas.

Patient pathway

The broad patient pathway was illustrated and consists of;

- GP / A&E / other speciality consultation
- Referral to urology
- New OP visit
- Diagnostic tests
- Treatment
- Follow-up
- Discharge

It was agreed that for each aspect of the patient pathway we pose the question 'what can be done differently to reduce our consultant capacity requirement?'

Broadly it was agreed that in service planning there are three key aspects;

1. **Demand management**

   This is a key element in delivering a sustainable service. 48 routine outpatients referrals had been reviewed and from this it was suggested that with reasonable criteria for urological referral approximately 50% of these referrals could have been avoided. The overall impact of demand management will be less that 50% as this review did not include urgent or red flag referrals, also some of these patients that did not require referral at that point will require referral after completion of additional care (eg review of urinary symptoms after trial of alpha blockade). A suggested reasonable expectation for demand management would be a reduction in referrals of 20%. There was also discussion of whether we should offer all services given the current capacity constraints (eg vasectomy reversal) an it was agreed that the vision will include optional aspects of non-delivery of specific services for consideration by the board.

   Existing referral systems that are utilised within primary care were outlined and it was agreed that electronic referral proformas offer the opportunity to mandate specific aspects of care prior to referral and present a means of removing consultants from triaging every referral letter. It was agreed that this system should be pursued as the cornerstone of demand management. Alongside the electronic referral there is a requirement for GP guidelines that are readily accessible and easy to follow to enable and empower primary care in management of urological conditions. Specifically for both male and female LUTS a process whereby all patients with these conditions are assessed by the continence team as a first line for a range of initial assessment (eg Residual volume, U&E, F:V chart) and treatments (eg lifestyle advice, PFE, alpha blockade, anticholinergics) and subsequent review of treatment response with onward referral to the urology service coming from the continence team (akin to similar models for some orthopaedic conditions eg back pain) was discussed and agreed. There was further discussion regarding referrals from other hospital specialities and agreement that the same referral mechanisms should apply. Workstreams in demand management are;

   - Electronic referral.
   - Referral criteria, information requirements, pre hospital investigations.

- Radiology engagement and agreement regarding GP access and appropriate radiological investigation prior to urology review.
- Primary care guidelines for management.
- Continence team engagement and model of service.

2. **Service delivery Model**

The service delivery model was divided into elective and emergency care with a separate model of delivery for each. Across both models specific consideration is required with regards infrastructure and staffing requirements.

Elective

The Guys model of new patient outpatient service delivery model was presented and discussed. This model delivers outpatient care such that at the end of the single visit patients are either discharged back to primary care or listed for a urological intervention. The Guys model is delivered with a capacity of 18 patients seen in a session with medical staffing at 2 consultants and a trainee. It was agreed that in addition to the positive service aspects of this model it also had significant positive impact on training and supervision for the SPRs. It was agreed that this model should be pursued as a basic model of outpatient service delivery. The number of these sessions required will be guided by capacity requirements (see below). There needs to be agreement in planning the patient pathways on;

- Do all patients need to be seen in OP?
  Can some conditions which fulfil strict criteria at referral from primary care be listed directly upon receipt of the referral (LA vasectomy was cited as an example)?
- What will be done before the OP visit?
  There was agreement that ideally all radiological investigations should be done and available at the time of the OP visit. Each referral pathway will require consideration of how appropriate investigation will be arranged.
- What will be done at the time of the OP visit?
  Ideally all investigations required to make a treatment decision will be performed at this OP visit. For each investigation we need to examine what will be needed to deliver this at the time of the OP visit (ie infrastructure, equipment, staff).
- Who will be followed up?
  Ideally patients will be either discharged or listed and so follow-up requirements will be minimal. Where follow-up is required does this need to be delivered by a consultant in person? Could it be delivered by a nurse in person or over the phone? Can it be delivered by letter? For example TRUS biopsy patients with cancer on biopsy need an in person follow-up with their pathology results but do patients with negative results?

Specific consideration of models of care and capacity planning needs to include the requirements of active surveillance TRUS biopsies of prostate (utilise radiology provision of TRUS for this group?), TCC surveillance (protocol guided, nurse delivered?), Urodynamics (direct access following continence team referral for female LUTS?) and the specific needs of the stone service which bridges acute and elective care (ESWL capacity and delivery, stent removal).

Staffing models for the service were discussed. Staff grade post recruitment is an issue across Northern Ireland and GPwSI models have been utilised but the experience of the trust and wider NHS is that while they provide additional capacity when posts are filled, once a post is vacated they leave a gap in service delivery and recruitment to fill again is difficult. It was agreed that the delivery of care will be broadly based upon a consultant delivered service with SPR delivery

(supervised) and CNS delivery of specific aspects. It is recognised that at inception the model will involve consultant delivery of some aspects which over time, following likely recruitment and training will become CNS delivered.

Specific deficiencies in the current patient pathway with regards fitness for surgery and assessment of holistic patients' needs were identified. These create specific issues in elective list planning, worsen the waiting list position with patients not fit for anaesthetic being on the waiting list and currently result in significant utilisation of consultant time. I was agreed that for elective surgery the waiting list should only include patients deemed fit for surgery. A model was agreed whereby patients listed for elective surgery will receive an initial pre-admission assessment at the time of their listing. This will include holistic needs assessment (care needs, notice requirements, transport issues, post procedure care requirements etc) in addition to an initial anaesthetic assessment. The anaesthetic assessment will identify two groups of patient, those with no major comorbidity who are fit and able to be placed directly on the waiting list, and those who require further anaesthetic assessment and will only be placed on the waiting list when deemed fit for their planned elective surgery.

It was acknowledged that delivery of capacity for operating theatre centred care is a major challenge. On Craigavon Area Hospital site inpatient theatre capacity is fixed and at a premium while the location of the day surgery unit, availability of day unit recovery beds and timing of the urology allocated sessions constrains what procedures can be delivered through day case theatres. When theatre 6 is completed there will be an increase in urology inpatient theatre sessions such that the available theatre time will be 4 all day lists with two being extended days plus a half-day session on Friday afternoon. There was agreement that we work with theatres in order to maximise the efficiency of these sessions, specifically addressing turnaround times, start times and ensuring that the lists finish on time by identifying issues which directly impact on these factors (eg porter availability). There was discussion around procedures which are currently delivered as inpatient care which could be delivered as day cases (eg small TURBT), and around procedures currently delivered as general / regional anaesthetic procedures which could be delivered as local anaesthetic procedures (eg Vasectomy, cystoscopy and Botox). There was agreement to the creation of a pooled waiting list for common urological procedures. This would bring advantages in terms of capacity planning, delivery of equitable waiting times and off site operating (see below). It was accepted that individual patients may wish to 'opt out' of this but should be made aware that this will result in longer waiting times for their procedure and that across the team capacity for delivering procedures from this list will differ.

Recognising the constraints of theatre space there was discussion around off-site operating as theatre capacity exists on both Daisy Hill and the South West Acute Hospital (SWAH) sites. There was agreement that all consultants would be happy to deliver certain procedures on these sites which would offer significant advantages to the service and bring care closer to home for patients requiring suitable procedures. There are specific requirements in order to deliver off site operating which include;

- Theatre equipment.
- Theatre and ward staff training.
- Junior doctor support both in and out of hours.
- Provision of consultant out of hours cover (discussion was held regarding overnight stays for consultant after operating in SWAH with OP activity the following day).

Non-Elective

Non elective care presents specific challenges due to variation in demand and a need for prompt access. Significant numbers of referrals for outpatients originate from accident and emergency attendances. A model of non-elective care was presented and agreed which is consultant delivered. This model would entail;

- Consultant of the week.
- Consultant led morning ward rounds Mon-Fri.
- Hot clinic – A&E referrals plus non-elective GP referrals which didn't require admission from previous 24 hours.
- GP telephone advice and triage of referrals where required.
- Consultant led afternoon ward rounds Mon-Fri (of patients who had investigations to review results and make further plans).

This model of care will require specific additional support with creation of a urology coordinator administrative post which will be responsible for coordinating the booking of patients into the hot clinic service, taking GP details to enable the consultant to return calls and reducing the current administrative burden of the outpatients nursing staff. There is also a need for non-elective theatres. This has been previously raised and the slot from 09:30-11:00 on the emergency list identified as a potential urology emergency slot (similar to the Gynaecology slot from 08:00-09:30). This will be required in order to enable delivery of non-elective surgery and the hot clinic.

Workstreams in the service delivery model are;

- Trialling of the elective clinic to assess infrastructure needs, staffing needs and timings.
- Liaison with pre-operative assessment team regarding the proposed urology delivered initial pre-admission assessment.
- Commencement of consultant of the week system from September including the planned hot clinic, consultant ward rounds and referral triage.
- Creation and commencement of the hot clinic.
- Creation of the urology coordinator post.
- Progression of the emergency theatres urology slot.

3. Capacity management

Two aspects of capacity management need to be considered;

New service capacity

In defining the capacity requirements for the new service we need to consider the current demands, the impact of any demand management and future demand increases. Given established data that suggests an increase in demand of 10% per year it was agreed that this is a reasonable demand increase each year to factor in to capacity planning. As detailed earlier a 20% reduction in demand was considered as a reasonable assumption of impact of demand management. Factoring these two aspects it was agreed that the service capacity should be set at current demand as this will enable backlog reduction for the first two years and steady state delivery in year three. The initial expectation would be that after year three capacity will need to increase year on year to meet demand but this would be further guided by demand data / capacity management over the first two years of the service. In defining the capacity requirements we will identify the impact of the in-built backlog reduction on current new outpatient and theatre waiting lists and identify what excess backlog reduction is required to eliminate the backlogs by

the end of year two. Addressing the follow-up backlog will be more complex. The new models of care will deliver FU in different ways to those currently on follow-up review lists and the vision will include a specific model for eliminating this backlog over a six month period. Once the capacity requirement of the service is defined we need to define the consultant time requirements to deliver this service including necessary administrative time and then this needs to be translated into job planning in order to define the consultant staffing requirements to deliver the service.

Capacity management and service planning
To ensure ongoing capacity management the following information will be provided on an on-going basis and we can agree the frequency of this information:

Outpatient service planning;

- Outpatient referrals received from GP, A&E, other Consultants (?Monthly).
- Red flag referrals for Haematuria, Prostate and others (?Weekly).
- Total number of patients waiting to be seen both within and over their target (?weekly) – this will then dictate the capacity for the next month – although as we should be working six-weeks in advance we need to gauge the timing of when this information is produced.
- Total number of outpatients seen per clinic (?monthly).
- Total number of DNA's (monthly).
- Total number of patients on Review Backlog (?monthly).

Elective inpatient and daycase service planning;

- Conversions from OP clinics (?weekly).
- Conversions from 'hot' clinics (?weekly).
- Total number of patients waiting to be seen both within and over their target (?weekly).
- Lists of suitable patients for DHH and SWAH.
- Standardisation of waiting list procedures to allow theatre time estimation.

Workstreams in capacity management and service planning are;

- Capacity requirements of new service.
- Staffing requirements of new service.
- Operational model of capacity management and service planning.

Timescale
The presentation to the board is scheduled for Monday the 1st September. The chief executive wants the vision presented to her 2 weeks before this (W/C 18th August) and wants a written update on progress in two weeks (W/C 4th August). Clearly all detail will not be finalised at the time of presentation to the board but there will be an expectation of progress in key areas and a proposed timeframe for implementation of the complete vision. With this in mind I suggest that our next steps are;

- Define capacity requirements
- Define staffing requirements
- Initiate non-elective week (consultant of the week, hot clinics etc from September)
- Action plan for addressing/considering each aspect of the model
- Plan for weekly meetings from now until end of August in preparation of the meeting with Dean on 1 September 2014.

Angela Kerr

From: Haynes, Mark [Personal Information redacted by the USI]
Sent: 27 June 2014 07:47
To: [Aidan O'Brien's email address]; [Michael Young's email address]; Glackin, Anthony; Haynes, Mark; Mark [Mark Haynes's email address]; Young, Michael; O'Brien, Aidan; Ram Suresh ([Ram Suresh's email address]); Suresh, Ram; Tony Glackin ([Anthony Glackin's email address])
Cc: Corrigan, Martina
Subject: FU from meeting with Dean Sullivan

Morning all

Below are some thoughts I have had since the meeting with Dean Sullivan...

From the meeting last Thursday evening it is clear that Dean wants a 'vision' from us for a sustainable secondary care urology service. The plan he wants is to include within a degree of future planning (making reasonable assumptions for increases in demand) and also some contingency planning for medical staff sickness. He was also clear that this vision for presentation mid August (did you all spot the moving time scale that went from early September, to End of August, to Mid August in his final statement?) was expected to be a vision with reasonable plans but did not expect all aspects to be ready for immediate implementation. He did expect a degree of risk analysis with respect to how implementing the vision may meet obstacles such that he can look to provide support / mitigate these risks.
The concept of a sustainable service is wide and relates to all aspects of our service. In defining the capacity we need to deliver we need to know what our demand is across the board – ie how many referrals we get into the service, how many patients subsequently require procedures and what OP follow-up requirements we have. Martina has already started looking at this and has already looked at the new referrals into the service. The approximate numbers for this are; Red Flag referrals – 900 GP referrals – 4000 Referrals from other consultants (includes A&E) – 1000 This means that to provide a sustainable service to new referrals we need to provide 4900 new patient slots per year - 98 slots per week for 50 weeks (ten bank holidays per year = 2 weeks). Our current new patient slot provision is 45.75 per week (366 provided in the last 8 weeks). This means that over the course of a year we can expect our waiting list for new patients to grow by approximately 2000!
It is clear that we cannot work to meet demand as it is at present without huge capacity expansion. From the meeting it was clear that Dean wants this shortfall to be met largely by demand management. In England a variety of models of demand management have been used (referral caps, procedures of limited benefit lists, Primary care referral management services). My experience of these is that they have all had initial short term effects but this short term referral reduction has been matched by a later referral increase (referral caps result in limited referrals at the end of the financial year and surges in referrals at the start of the year, disagreement between primary and secondary care on procedures of limited benefit and differences in application across neighbouring primary care trusts, primary care referral management services managed by primary care with no specific speciality input meaning no primary care management advise given). The key difference here is Dean has come to secondary care with the request and this I believe presents an opportunity for a workable model of demand management.
Below are some initial thoughts from me regarding demand and capacity management and what is needed ASAP in order to deliver an adequate vision for Dean in mid-August. Can I suggest we start to consider these aspects and any other aspects that I have missed with a view to meeting to discuss and finalise as an initial blueprint on Thurs 10th July.

Demand Management
The panacea for us would be a service where 100% of new patient referrals result in a urological procedure – either diagnostic (flexible cystoscopy, TRUS) or treatment (Theatre, ESWL). The challenge is how can we move towards this. It is a fact that any form of demand management we institute will have an impact on primary care workloads and expectations. While we should be aware of this the clear message from Dean was that we should design our secondary care services around what we should be doing and highlight the impacts and risks to him for him to work with primary care where obstacles exist. Below are a list of referral types and some of my initial thoughts regarding demand management in each of these areas. I believe we need to urgently consider each of these areas (and any I haven't thought of) as demand management has to form a major aspect of our 'vision'. For each area we will need to produce a standard information sheet for GPs advising regarding all aspect of the expected primary care management. Once agreed we will need to write these but these will not need to be finalised for the meeting with Dean.
Male LUTS; What tests would it be reasonable to demand of a GP? - PSA? DRE? Post-void residual? U&E?
What should the GP do if above tests are abnormal? – this may link into other referral pathways.

What treatments should have been tried prior to us seeing the patient? – Lifestyle advice? Alpha blocker / 5-alpha reductase inhibitor? Anticholinergic?

What should the trigger for secondary care referral be? – Failure to respond to maximal medical therapy and desire for surgical treatment? Post-void residual >500ml?

Female LUTS; What tests would it be reasonable to demand of a GP? - Post-void residual? U&E?

What should the GP do if above tests are abnormal?

What treatments should have been tried prior to us seeing the patient? – Lifestyle advice? PFE? Anticholiniergics?

What should the trigger for secondary care referral be? – Failure to respond to maximal medical therapy and desire for surgical treatment? Post-void residual >500ml?

UTIs; What tests would it be reasonable to demand of a GP? – Urinalysis / MSU? Post-void residual? U&E? USS renal tract?

What should the GP do if above tests are abnormal?

What treatments should have been tried prior to us seeing the patient? – Lifestyle advice? Anticholiniergics? LTLD Abx? TOP Oestrogens?

What should the trigger for secondary care referral be? – Does everyone need a flexible cystoscopy? I suspect not so which patient groups do?

Loin Pains; What tests would it be reasonable to demand of a GP? – Urinalysis / MSU? Post-void residual? U&E? USS renal tract? NCCT ?

What should the GP do if above tests are abnormal? – Only refer those with abnormality on scan?

What treatments should have been tried prior to us seeing the patient?

What should the trigger for secondary care referral be? – Only those with stones or renal abnormality on USS?

Peno-scrotal; What tests would it be reasonable to demand of a GP? – USS of testicular swellings (except where red flag referral?)?

What should the GP do if above tests are abnormal? Solid testicular mass to red flag pathway

What treatments should have been tried prior to us seeing the patient? – Lifestyle advice? Steroid creams for phimosis (I've never done this but some people do)?

What should the trigger for secondary care referral be? – Only patients wishing to consider surgical treatments / maldescent?

ED; What tests would it be reasonable to demand of a GP? – testosterone / FSH / LH / Prolactin? What should the GP do if above tests are abnormal? – refer to endocrinology?

What treatments should have been tried prior to us seeing the patient? – PDE5 inhibitors? Vacuum device? Muse / intracavernosal injections?

What should the trigger for secondary care referral be? – Only those wanting Surgical prosthesis? Do we even offer this service?

Fertility; What tests would it be reasonable to demand of a GP?

What should the GP do if above tests are abnormal?

What treatments should have been tried prior to us seeing the patient?

What should the trigger for secondary care referral be? – Patients wishing vasectomy? Do we offer Vas reversals?

Red Flags; Standard referral criteria, tick box form, ideally electronic which prompts for all info required from GP – needs to specify the critical aspects eg raised PSA >20 direct, <20 repeat 1 month later and referral if remains elevated, Haematuria as per BAUS Guidance (2 from 3 for non-visible haematuria after exclusion of transient causes etc), must have had U&E within last 3 months etc.

Other speciality referrals

The same criteria for referral to our service should apply to our secondary care colleagues as is applied to A&E, eg loin pain needs USS or CT and referral if abnormal. This does not necessarily need to be done by A&E but can be referred back to the GP by A&E. Clearly red flag findings should be referred to us along the same pathways as from GPs with the same expectations and as such should be referred through the same process.

Referral Processes

With robust referral criteria the opportunity exists for standardised electronic referral which prompts GPs for the expected pre referral management and also will result in standardised pathways on receipt removing the necessity for consultant triage of all letters. I believe this should be included in our vision and we should be seeking IT support for this ASAP. There would likely be an 'others group' for patients who do not fit into the standardised symptom groups but would need a free text referral and would need consultant triage.

Capacity Management

When planning our vision I believe we should set our capacity at 120% of our current capacity requirement. This will build in a degree of backlog reduction over the first 2 years (assuming a continuation of the current 10% year on year demand increases) and reach stable delivery in year 3. Beyond that there would need to be further capacity increase to account for ongoing demand increases but this could be modelled based on years on and two. In order to assess capacity I am happy to look at a sample of current referrals in order to estimate the potential impact of demand management on our outpatient capacity need. We also need to define our inpatient capacity requirements (how many

patients, and for what procedures do we currently list per year). I understand that Martina is already looking to obtain this information.
In delivering our service and with a view to maintaining a sustainable service, it is my view that we cannot continue to deliver in the model we currently have and we must move towards practices where we aim to provide a single visit service with the outcomes from the visit being either listing for procedure or discharge (with primary care management plan and re-referral criteria). If we are all in agreement with this idea (akin to the Guys / Tim O'Brian service) we need to consider what impact a one stop OP service for all patients will have on clinic capacity (ie will this reduce our requirement for DCU Flexible cystoscopies). How this new model can be delivered in the other units also needs to be considered – do we see all new referrals here and only do FUs in other units?

What do you all think?

I am happy to work with Martina on the aspects I have identified regarding demand and capacity management / planning.
If you are in agreement with the principle of providing guidance for referral for GPs this guidance will need writing and we should all take on some aspects each to create a first draft for consideration by each of us.
Someone will also need to explore the potential of a standardised electronic referral form. Any volunteers?

Mark

Angela Kerr

From: O'Brien, Aidan [Personal Information redacted by the USI]
Sent: 18 July 2014 15:25
To: Mark Haynes; Corrigan, Martina
Cc: [Aidan O'Brien's email address]; [Michael Young's email address]; Glackin, Anthony; Haynes, Mark; Young, Michael; [John P O'Donoghue's email address]; 'Ram Suresh'; Suresh, Ram; 'Tony Glackin'
Subject: RE: Meeting Notes

Dear Mark et al,

Firstly, I feel hugely indebted to you for the amount of work that you have put into the Vision to date.
In fact, on reading your notes, I believe that we should aim to be able to submit a draft document to Debbie, then to Mairead with the approval of Debbie, and eventually to Dean, prior to meeting with him on 01 September 2014.
I am always sceptical of the clichéd request for 'something on an A4 page'.
I believe that we should aim to submit a document in advance of the meeting...we can of course have an executive summary...it can be presented by powerpoint or flipchart, and may indeed include a flowchart of the global pathway as proposed by Michael.
If it were agreed to do so, we should omit our speculations as to what Dean may be expecting of us to 'propose and fail'.
I also think that we should omit reference to our speculative ideas, from a distance, as to how other services, such as at the Ulster, have 'succeeded'.
The reasons for the configuration and demand/capacity balances of any service can be so complex to render a simplistic analysis wrong.
One of my favourite quotations of Mencken: 'for every human problem, there is a solution, which is simple, straight-forward and wrong'.

For this reason, I do wonder whether it has been agreed that the principal challenge facing SHSCT Urology is that patients are waiting too long for their care.
Is this not a symptom or consequence of its causes, which could include a disparity between demand and capacity, as well as inefficiencies in the use of capacity?

Some other thoughts:

- I am somewhat uncomfortable with our suggesting to the Commissioner any item or aspect of service which should not be available on the NHS. I think that could be the thin edge of a wedge, the slippery slope. What next? Are there tragic circumstances in which vasectomy reversal would be considered so reasonable to offer, but which would be unaffordable to a couple to have done privately? Peyronie's? Lesser incontinence? I believe we should stay clear of any such suggestions, as they are arbitrary, etc.
- I am cautious with regard to the establishment of a practice of having all male and female LUTS referred to a community continence team. I believe that so doing will result in the establishment of another layer of practice which could prove to be huge, expensive, bureaucratic and effectively a barrier to effective care, in addition to inherent risk of delay. In proposing a Vision, I believe that we should try to avoid giving birth to more complexities. My listening to the experiences of patients suffering back pain and who have been processed in this manner, has not always been impressive.
- This matter also impinges upon one old chestnut! I would much prefer that all patients with LUTS have an ultrasound scan of their entire urinary tract, including measurement of prostatic volume in the male, and residual urine volumes in male and female, performed, than have a F/V chart, Flow Rate and PVR. As I have experienced in countless cases, you could end up having your prostate biopsied before it is realised that the prostatic volume was 150 mls. As at MDM one week ago, a patient proceeded to staging MRI for it to be appreciated that he had a huge prostate, no ultrasound scan having been done, biopsies having been done which would not have been done if it had been appreciated that his prostate gland was so large, and which now needs to be resected.
- Whilst I would not mind if I were never to do another vasectomy, is it necessary to refer specifically to LA vasectomy rather than 'vasectomy' which I believe can be directly listed on a waiting list, perhaps specifying whether the patient preference is for LA or GA, and preadmission assessment arranged if the latter.
- I don't recall agreeing to pooled lists. I would however agree to the establishment of a pooled list for any procedure, following the express agreement of the patient to be listed on it (informed consent).

Anyhow, great work!

Aidan

From: Mark Haynes [Mark Haynes's email address]
Sent: 18 July 2014 07:57
To: Corrigan, Martina
Cc: [Aidan O'Brien's email address]; [Michael Young's email address] Glackin, Anthony; Haynes, Mark; 'Mark'; Young, Michael; O'Brien, Aidan; [John P O'Donoghue's email address] 'Ram Suresh'; Suresh, Ram; 'Tony Glackin'
Subject: Meeting Notes

Morning Martina

As per yesterdays meeting attached is the summary I had written of the discussions from last weeks meeting and I have added in points from yesterday.

I may have missed aspects off and so please feel free to amend as necessary.

Are we meeting next Thursday? If so can I suggest we use next week to try and define the capacity requirements for the service?

Mark

DR WRIGHT: So that will be team. There will also be a non-executive director of the Trust (inaudible) to oversee the process. That would be someone that you could go to if you felt in any way the process was not being run properly or you were unfairly treated. That person has not yet been -- usually the chair will nominate someone and we'll let you know who that is. (inaudible) involved in process and (inaudible) ensure there has been, you know, (inaudible).

Now during the process, Aidan, I am not sure what your plans were for coming back to work. (inaudible) but I am not sure.

MR O'BRIEN: I had planned to come back to work next Tuesday, though, frankly, I don't know whether I am fit to come back next Tuesday.

DR WRIGHT: I think that's fair.

MR O'BRIEN: Because even though I have done the operation thousands of times, it is the first time I have been the victim. Personal Information redacted by the USI [redacted]

DR WRIGHT: I am sure there is. (Inaudible).

MR O'BRIEN: I don't know what is your view about that because the—…….I mean, some of the context of this though is the enormous pressure to operate. The complaints and the enquiries that I deal with every day are, ~~when~~'When am I having my operation done?~~-~~' People's clinical outcomes are being compromised all of the time, day in day out, because of not only the lack of capacity as a whole but, in addition, the inequity within departments.

For example, in performance data -- I think it's ironic that it's called performance data because it is not the performance, it is not what you do, it is what has to be done. In October, I had 288 people on my waiting list for in-patient admission and one of my colleagues has 29. And I have implored that that situation would be addressed. What was driving ~~me~~my back was, you know, the demands for operating. In fact when I went off I circulated a list of the ten most urgent people to be done and the two who are waiting the shortest period of time have been done by one colleague and none of the rest.

I—…… just to give you, Richard, a context. It is very, very important to appreciate, you know, the totality of the work that we do. I have said when we had a

meeting to deal with triage, I triaged the red flag referrals, that you don't have the time to triage. This thing of triaging non-red flag referrals it is a historical hangover from a time when we as a department, and particularly if I may, in the view of Michael Young, there wasn't enough to do when you are call so we need to have something to fill in the time in order to justify the new system. And if you are a person who tries to operate on the acute admissions as they come in -- like the last week I was on call I did 21 additional operations that week, whereas others, and particularly the person who recently left you know, and I always followed him on the week on call and then this past year more --

MRS O'BRIEN: You supervised him.

MR O'BRIEN: -- I have been supervising him and backing him up. As Martina Corrigan used to say, now you are starting your week on call after having the other week in call.

DR WRIGHT: Yes.

MR O'BRIEN: And then you picked up, you know, everything that had been up long-fingered and deferred, and when you are operating and you have already worked 12, you don't have the time to sit down and triage.

DR WRIGHT: One of the things that I said in this, in my experience (inaudible) whilst sometimes (inaudible) criticisms of individuals, there is almost inevitably a detailed look back at the Trust systems. (Inaudible) and they are often a contributor, so I don't doubt that that will be an issue that will be looked at.

MRS O'BRIEN: I would back up this. Aidan is now going into his 25th year as a consultant here. I can say with hand on my heart he has worked between 70 and 90 hours a week in those 25 years and that's Saturdays, Sundays, everything.

DR WRIGHT: I understand.

MRS O'BRIEN: I mean, he goes in here at 8.30 in the morning. He comes home about 8.30 at night. He has something to eat and he -will go.. and he'll be doing work again, preparing operating lists, ringing patients. Because his waiting list is so long, if he is picking patients from his ~~longest~~long list waiting list, and ~~there~~they are three years on a wait listing, their circumstances have changed so much. So he takes the time. He rings the patient, he checks all their biochemistry.

MR O'BRIEN: It takes me session and then I have been doing extended operating ~~days~~lists. I know there's a context (inaudible) but I just actually—….. I have done 19 additional theatre sessions in the ten months of this year, my being off the last six weeks, 15 extra oncology clinics, 14 extra urodynamic sessions and all under pressure to do so and expectation to do so.

———And you wrote to us all about the highly recompensed consultant in the earlier part of

SIOBHAN HYNDS: What has been the time line, what has been the significance of that.

COLIN WEIR: Has this been raised as an issue before.

MICHAELR O'BRIEN: Yes. You're aware that there was a letter of 23 March. You will be aware of that.

SIOBHAN HYNDS: Yes.

MICHAEL O'BRIEN: Which is (inaudible)basically registers the fact there are some issues that need to be dealt, an administrative back log, and no follow-up, no suggestion we should have a meeting. You are aware of the time constraints that your employees are under regarding the workload that they have and there is no follow-up to that (inaudible).

MR O'BRIEN: It didn't constitute an informal process at all, Colin.

COLIN WEIR: The letter from?

MR O'BRIEN: There was a letter given to me by --

COLIN WEIR: By Heather and Eamon?

MR O'BRIEN: No, Eamon and Martina. Martina was standing in for Heather.

COLIN WEIR: right.

MR O'BRIEN: Heather couldn't attend that day and --

COLIN WEIR: Did Eamon ever speak to you in person about it?

MR O'BRIEN: Like, since or at that time?

COLIN WEIR: At any stage in the (inaudible).

MR O'BRIEN: I was called to the meeting that day from -- I don't know where I was, on a ward or whatever. I think it was — it might have been a Thursday. I have not checked the day of the week. I went up to the AMD AMD office I think it was. And Eamon just said to me, you know, thanks for coming. We have number of concerns about your practice. He mentioned the first three of them and he couldn't remember the fourth one. So he opened the envelope to remind himself of the fourth one, and said, you know, I thought that it would be better to give you the letter rather than sending it to you. So I scanned down the headlines of it. And I said, you know, like what am I supposed to do? Where do we go from here? And I remember the response, Colin.

COLIN WEIR: Nothing. Oh, that was it?

MR O'BRIEN: And Martina said to me I hope you don't mind my being here but Heather wasn't able to be here today. And I left despondent because, you know, the letter wasn't telling me anything new.

COLIN WEIR: Okay.

MR O'BRIEN: The letter was just telling me that others shared my concerns. And the biggest concern that I had then and had for years and had since then was the big elephant in the

room, which is not on any of these things, and that is the sheer numbers of patients awaiting admission and readmission for procedures and operations and suffering poor clinical outcomes as a consequence.

SIOBHAN HYNDS: Can I ask who you were raising that with at a point?

MR O'BRIEN: At a point.

SIOBHAN HYNDS: No, I mean at the various points, who was it you were raising that with?

MR O'BRIEN: I have raised that with everybody that I can think of over 20 years. This is -- I have raised this with -- the titles have changed it's that long. Clinical directors, Ivan Sterling, Liam ~~McCathy,~~ McCaughey, John Templeton, Michael Young. And they, sort of, cliched response that you these is, these are Trust issues. Except for the fact, regrettably, the Trust doesn't make them an issue. It is -- I mean, I do have already prepared, I have gone through all of my operating over recent years, and in fact whilst I would like to have the opportunity at a subsequent time when meeting both to share these with you, but like, for example, in 2013, as far as the job plan would go I would have been expected to do 84 sessions. I did 113 elective sessions that year.

COLIN WEIR: Is that operating?

MR O'BRIEN: Operating. I would have been expected to do 79 sessions in 2014 as the urologist of the week was introduced that year and I did 101. 2015, 707 ~~7~~ sessions according to my job plan. I actually did 95.5 four hour sessions. You multiply that by four for every hour. In 2016, up until I left, I would have been pro rata expected to do 61 sessions. I did 83.25.

And in the doing of that and the organisation of that -- that's just operating. I mean, I am not talking about other activities as well, like extra clinics and so forth, I have been directing in a sense in a lonely manner without any response to raising the concerns with regard to the inequity involved in such lists.

Like in October of last year when performance data were published, which is a contradiction in itself because they didn't publish performance data they published the things that still needed to be performed you know, and when I had 233 I think patients on my in-patient waiting list at that time one of my colleagues had 29. Can you get that addressed? No.

And just to -- I'll do this all in detail in due course, but I do think actually two things about it. One is, when have you been raising it and talking about it and worrying about it and trying to get a response for 20-odd years, you know, you stop talking about it. And lastly, do you know, I was -- I must say after these 25 years I was so disappointed. On 7 November I sent Martina and my colleagues a list of ten patients whom I really wanted

to have done next and come the end of December there weren't even addressed. I was coming back [redacted] too early. Why? Because of the need to address this.

SIOBHAN HYNDS: I am trying to get that down. You sent Martina a list of a patients that you wanted seen next. Was that what you were --

MR O'BRIEN: I sent it to my colleagues and I copied it to Martina.

COLIN WEIR: To operate (inaudible)?

MR O'BRIEN: Yes.

COLIN WEIR: Yes, okay.

SIOBHAN HYNDS: You are saying by the end of December (inaudible).

MR O'BRIEN: But I'll do all of that in due course.

MICHAEL O'BRIEN: Two were seen to. Isn't that right?

MR O'BRIEN: I think two were seen. I have not checked up. I don't know whether they have yet been operated on.

COLIN WEIR: So, Aidan, issues over these 20 years are just that: the workload and the capacity to do the workload. Is that what you -- the gist of it?

MR O'BRIEN: Colin, if I were to put my case in one sentence, if I had not been overworked, if I hadn't agreed to be overworked, I wouldn't be in this position today and others are not in this position today.

COLIN WEIR: Because they manage --

MR O'BRIEN: Because they didn't overwork.

COLIN WEIR: -- control --

MR O'BRIEN: No, they wouldn't.

COLIN WEIR: Okay.

MR O'BRIEN: I can expand on that in due course but we'll not do that today.

COLIN WEIR: Okay. Because I have said to you all the way through this, my role is to be scrupulously fair. I need to hear --

MR O'BRIEN: You will hear --

COLIN WEIR: I need to hear --

MR O'BRIEN: -- but I want to do it --

COLIN WEIR: -- everything.

MR O'BRIEN: -- fully and properly in due course and today is not day as you said.

COLIN WEIR: Just to get the general tenor of what you are saying about workload and you tried to engage with the Trust's management over an extended period of time to help manage that in some way.

MR O'BRIEN: Yes.

COLIN WEIR: But the work has just kept coming.

MR O'BRIEN: And a failure of management to deal with it.

COLIN WEIR: To deal with it. Right. Okay.

MICHAEL~~R~~ O'BRIEN: (Inaudible) when he's asked in March 2016 to deal with also a review back log and you do extra sessions, you do review back logs and you're doing extra sessions to undertake operating, and you're getting (inaudible) an administrative back log and what that would take to resolve. If you're doing more sessions, more operating, you're increasing the amount of administration you have to do and you're eliminating the time in the job plan -- any time that you are meant to do it.

I think there will be a time (inaudible) response to be put into all of this. I understand you're at an early stage of your investigation (inaudible) terms of reference really. But what I really find very strange for somebody who has looked at investigations in employment matters for a long time, is this escalation from the letter of March without any follow-up, without any warning, (inaudible) for example, a very simple thing. And I do not -- I don't really understand why it is the case that there hasn't been an attempt to take a collaborative approach to this one person's --

COLIN WEIR: You've got -- I think you've got to park that. I am not here -- I was asked to do something. I was asked by the medical director would I be an investigator to this and I said no, I am not doing it. He said, well, I can tell you to do it. I said okay but I know Aidan. I have known Aidan for years and so there is an issue there. So it can only be done if it is done as a scrupulously fair process and that Aidan is completely happy for me to do it. And that was the only basis on which, you know, I will engage with this.

So I'm not taking sides on this. I'm doing it as any fair-minded individual would do it. So there may be things in the process between 23 March and 30 December, I am not representing those decisions or being in any way made accountable for those decisions. We've got to just -- that might be a different strand or part of --

MR O'BRIEN: (Inaudible) to resolve (inaudible).

COLIN WEIR: Exactly. I know you may be raising it --

MICHAEL O'BRIEN: I'm not raising it as a criticism of you personally.

COLIN WEIR: No, no.

MICHAEL O'BRIEN: I'm suggesting this. It is the incongruity of that. I'm raising it because it appears to me that the Trust would still have the opportunity to reconsider that approach.

COLIN WEIR: There will be an opportunity to (inaudible).

SIOBHAN HYNDS: (Inaudible) an assurance we will be looking at that.

DR KHAN: On top of the clinical director -- or the clinical director is also the investigator.

SIOBHAN HYNDS: is also involved as case investigator ~~(Inaudible).~~

DR KHAN: So Colin as a clinical director but also the case investigator. So from my point of view I would like assurance from these people that there is a balance going on. There going forward. So these arrangements as you have raised and the other arrangements and job planning and some concerns, and if there is something not going right, what is -- whose responsibility is, so I have asked that question as well. Roles and responsibilities. Because I am sitting here and don't want to be involved in these things. My role as a case manage~~rment~~ is once the investigation is completed, formal or informal, comes to me, that I need to make a judgment on the basis of the investigations. I have no role to investigate and I would like to keep myself out of that.

MICHAEL O'BRIEN: I guess I am just asking to help us understand how we can make sure that there will be no suggestion of in any way interfering with the investigation itself. And when you have an investigation that is going expansively into administrative practice it can touch on any patients that you have in your care. How do you ensure that you're not in any way (inaudible) but that's tricky I think.

DR KHAN: It is quite tricky but also quite complex as well because there is a large number of patients involved in that and there are going to be. So we need to have a system that these patients (inaudible).

SIOBHAN HYNDS: Again, Colin Weir, I think is key to this. He is the investigator and he's clinical director. He is best to guide on this and we can certainly get him to do that for you.

DR KHAN: Yes.

MICHAEL O'BRIEN: Okay.

MR O'BRIEN: That is a concern. It is also a concern of mine from the point of view of the patients because there is another reality here and that is that, you know, if I -- if I am not -- if I am quarantined from a whole load of patients and as a consequence they are not going to be reviewed by anybody else, because there's a limited capacity, you know, they're suffering. Like, as I was saying, I had certainly booked up until the first three monthly clinics of 2017 in South West Acute hospital. To my knowledge only two of those patients have been reviewed and there's a lot of people needing to be reviewed. I mean, I think a lot of these 668 patients with no outcomes formally dictated would have been cancer review patients that I would have done updates on Caps, which my colleagues ~~s~~ didn't do, instead of dictating letters, but these people all need to be reviewed. My concern on the one hand is, yeah, I don't want to be accused of anything more. And I have

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another concern that's for the patients themselves.

DR KHAN: Yes. And that's something for the Trust to address. Patients are obviously -- yes, they are your patients but the Trust has to address the other part of your concern that these patients need to be seen. And how they are going to be seen that's -- I think just for the sake simplicity if you leave that for the Trust to decide how they are going to be seen and who they are going to see or how they are going to be reviewed. At this point in time --

MR O'BRIEN: Once they have identified who they are.

DR KHAN: Yes.

MR O'BRIEN: Meanwhile I don't know who they are and I don't know who are the patients that are not those patients. It's impossible.

DR KHAN: Yes, but I am sure they are doing it.

MICHAEL O'BRIEN: If you, for example, have outcomes that weren't formally dictated (inaudible) patient, what happens to the patient? Is there supposed to be a catch up there? Are you supposed to go back and do that now?

MR O'BRIEN: No, you see, these 668 patients that they were referring to they will all have had outcomes done. Outcome forms done. They didn't have a letter dictated. They had an updated done on Caps if they were cancer patients because I did updates on them until April of this last year when I got disillusioned seeing other people not -- never doing it and not doing clinical ~~summarise~~. summaries.

DR KHAN: So from April last year you haven't done the outcome and you haven't done the dictations?

MR O'BRIEN: No, no. The outcomes have all been done.

DR KHAN: Dictations.

MR O'BRIEN: I haven't uploaded updates. Caps is the cancer archival patient pathway system or something. Cancer patient, yes, something like that. And so that's where you --

DR KHAN: Update that.

MR O'BRIEN: You know, those MDM outcome things that you'll see in the front of charts and so forth and they go out in letter format. So I would have done those as updates so that the next time a person is discussed there is a complete linear history throughout. I would have done the outcomes. So the outcomes would have -- so review and whatever for MDM discussion and then that person. So I would have done a report in the third person, you know, patient was feeling well. PSA has gone up or whatever. And then it would have discussed at MDM and then that reportage of that episode would have gone out in letter form.

DR KHAN: Yes.

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MICHAEL O'BRIEN: Okay. Well it is just I suppose -- (Inaudible).

MR O'BRIEN: But you see the Trust are under the impression that, I think, there must be no outcomes formally dictated on these people and therefore there's no outcomes if you know what I mean.

DR KHAN: That is useful information which can be fed into the investigation. That it's not really that there was no dictation but you did part of that. You did outcome forms and you do that.

MR O'BRIEN: That's another part of the drip feed putting my case. I find that a concern in this whole process. I have to confess it's been such a stressful time and I've been quantifying of all of the additionality since 2012 and I haven't completed it yet. But I just do not know when is the best time to be doing this, because, as you have just said right now, it's very useful to know that because it can -- and when is it useful to know what? Do you know how much more I have to tell you.

DR KHAN: Yes. (Inaudible).

MR O'BRIEN: I'll just give you a snippet. I quantified all of my additional elective in-patient operating. Right. My additional. Over what I was job planned or expected to do. from 2012 through to the end of 2016. And that has required 3.78 additional hours per week.

DR KHAN: Nearly a PA.

MR O'BRIEN: A PA. Probably my administration time. And that's only one activity. I can tell you MDM and what I was previewing, four hours. Another one. Gone. Non-existent in the scam job plan. But I can tell you something, if I hadn't done any of that we wouldn't be sitting having this meeting with me and I feel very angry when it comes to that.

DR KHAN: Yes.

MR O'BRIEN: And for a Trust that has been completely derelict in its obligations to patients by sorting out those disparities. Either they don't know or they just -- this is a Trust that is dysfunctional in a vertical sense. You are talking about escalating up. I have escalated up before and I can tell you horror stories.

DR KHAN: Okay.

MR O'BRIEN: I mean, I remember once sitting with John Templeton many years ago and all of a sudden I realised he was doing you, know, nodding his head. I realised I'd been there before and nothing happens. And then you stop escalating. Because you have done it before.

DR KHAN: So (inaudible).

MICHAEL O'BRIEN: (Inaudible) Do you have any idea of when you're going to have a meeting with job plan you think in the week or so after?

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Additional Work Time 2012 to 2016

This folder includes calculations of additional time required to undertake additional elective inpatient operating and elective day case surgery, additional clinics at all locations and all types, and to undertake the duties of Lead clinician of MDT, Chair of MDM, Lead Clinician of and Chair of NICaN Urology.

The calculations are minima required. In truth, they were much greater.

They take no account of public holidays and other reasons when such work could not be undertaken. Equally well, they take no account of the sacrifice of annual leave to have them undertaken

But most importantly, they do not include time to listen to and talk to ill patients and their relatives, taking phone calls of concern of the same nature, addressing issues raised by email each day, etc.

And then, in addition to all of that, to time long since consumed by additionality,

Aidan O'Brien

03 August 2017.

Lead Clinician and Chair of NICaN Urology 2013 to 2015

I was appointed Lead Clinician and Chair of the Northern Ireland Cancer Network's Specialty Reference Group in Urology.

This is the Group appointed by the Health & Social Care Board to advise the Board regarding all matters relating to Urological Cancer in Northern Ireland, to ensure that it is compliant with NICE Guidelines, National Cancer Plan criteria and with EAU Guidelines, so far as is possible, and to advise the Board of the reasons for lack of compliance, such as inadequate human resource, equipment, infrastructure.

During the period 2013 to 2015, I proposed the referral, clinical management and review pathways for all stages and treatment modalities of prostate cancer, securing the agreement of urologists, radiologists, pathologists, oncologists and clinical nurse specialists. The same was achieved for all other urological cancers. This enabled the compilation of the Clinical Management Guidelines for all urological cancers for Northern Ireland, a necessity for Peer Review of all MDTs in Northern Ireland in June 2015.

I trained and became a Peer Reviewer, being a member of the Peer Review Panel for Urology MDT North West in June 2015.

To achieve all of this over a three year period, I convened and chaired NICaN meetings on alternate months (excepting the summer months), holding preparatory meetings with the administrative secretariat in intervening months.

This required four hours for each of 10 months per year.

Mean time allocated to NICaN per week during 2012 to 2015: 1 hour.

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.

Additional Time Allocated to All Clinics 2012 to 2016

Total
Additional Time allocated to all clinics from 2012 to 2016

= 501.71 hours

Mean Additional Time allocated to all clinics from 2012 to 2016 per week:

= 2.65 hours

NB: It is important to note that these calculations are underestimates as no account has been made for public holidays and other occasions when it was not possible to hold clinics.

ISSUES OF CONCERN FOR DISCUSSION
At
DEPARTMENTAL MEETING
On
24 SEPTEMBER 2018

The main issues of concern which I would wish to have discussed at the Meeting of 24 September 2018 relate to the practice of 'Urologist of the Week' (UOW), triage of referrals, the waiting times for a first outpatient consultation, the waiting times for elective admission for surgery, and the various relationships and influences between all of these.

I am honest in asserting that I have struggled to know how best to have these issues discussed, as I believe that they will be contentious, with all of us having very differing perspectives of that which is expected of us as individuals. I hope that we can express our views without confrontation and without causing offence. I hope that we can listen to each other respectfully. Above all, I do hope that we will be able to agree standards of practice to be submitted, perhaps in optional form, to senior Trust management, so that we will have a written clarification of expected practices.

UROLOGIST OF THE WEEK

From the outset in 2014, I found the discussions regarding the introduction of UOW to be frustrating and incomprehensible. I simply could not understand how it could not be a good thing to have a system where all inpatient care, whether acute or elective, would be undertaken by a consultant urologist with the assistance of junior staff (in training). I could not understand how it was considered that the Trust would not support and fund UOW without offering to undertake other duties when UOW, as it would not take all one's time to look after inpatients. At one time, it was even proposed that the UOW would be able to do an afternoon clinic! Regrettably, in my view, we did agree to include triage in the duties of UOW. In due course, I came to believe that there was a range of perspectives of the concept of UOW, from that which I expected it to be, to being 'Urologist on Call', and variations in between.

It had been my understanding that my week as UOW would begin with a Handover Ward Round at 09.00 am on a Thursday morning. The Handover would be from the consultant urologist whose week was ending, to me whose week was beginning. The Ward Round would continue until all inpatients were reviewed, their care being handed over. It would not be replaced by any other duty or practice by either consultant, with the exception of one or the other having to operate in emergency theatre. It would not be curtailed by attending departmental or other meetings, with the possible exception of the monthly scheduling meeting. The priorities of that first day would be to get to know the inpatients under my care for the next week, to meet them, to know their history, examine them, plan their further management, including definitive operative management when possible. As we all have experienced, I believe that we would also have a duty of care to those patients elsewhere, about whom advice and assessment is sought, and who may become inpatients under our care.

It had been my understanding that each of the seven days of that UOW week would be the same, including Saturdays and Sundays. It has been my experience that the most common conflict has

been when operating made it impossible to undertake ward rounds. When that has occurred on consecutive days, clinical inpatient care has been undertaken by registrars, often with different registrars on different days, with obvious risk to continuity of care. The other main concern that I have experienced when UOW has been that registrars are dealing with many calls for advice from elsewhere, without input from the UOW, resulting in the default outcome of having the patient referred to the department, to be triaged by another UOW one or two weeks later. The week would end with my handing over to the next UOW with a ward round commencing at 09.00 am the following Thursday morning, and ending when all inpatient care has been handed over.

It has been of increasing concern to me to observe an increasing divergence from the practice which I had understood UOW to require. It has increasingly become a common occurrence for no ward round to be undertaken by the UOW over a weekend, including three day, bank holiday weekends. It has been reported that one whole week went by in recent months without one ward round being conducted by the UOW. As often as not, I have begun my UOW week without handover from the previous UOW, and ended it without the next UOW being present. A recent handover took place with neither UOW being present. It had been my understanding that no activity other than emergency operating was to replace or usurp inpatient management when UOW. I did not consider that operating elsewhere, conducting Stone MDM / Clinic, urodynamic studies (I have been guilty), or getting documentation in file for (successful) appraisal, never mind triage, were to replace the primacy of inpatient management. I believe that there has been an increasing practice of 'letting them get on with it', referring to the registrars, both with inpatient management at ward level, and in some instances, operating, with I believe, suboptimal outcomes as a consequence, on occasion.

But I may have been wrong, and if the consensus is that I have been wrong, and if the Trust will underwrite that consensus, I will abide by it, even though it has been my definite experience that inpatient outcomes have been compromised, and will be again.

TRIAGE

I found it impossible to complete triage while being UOW, and I still do. Since returning to work in 2017, I spend the weekend following my UOW completing triage. In doing so, I have requested scans, initiated treatments, dictated letters to GPs, informed patients by telephone or dictated letters to them. I have done so for 45 to 66 patients referred, the equivalent of five to seven, virtual new clinics, without time allocated to doing so, never mind remuneration. Then the reports return! I find it such an anomaly that we have been allocated four hours of total administration time per week, and at least six hours of SPA time in our job plans!

I do believe that we need to consider the complexities of triage. The Red Flag referrals are relatively straight forward, though I was unable to obtain consensus regarding advanced triage of Red Flag referrals in 2015, even though they comprise a minority of the all referrals. I believe the remaining majority are the issue, particularly in the context of the waiting times for first consultation for urgent and routine referrals. If a man is referred with LUTS this month, should he wait until September 2019 before having an ultrasound scan performed, to find that he has a bladder tumour in addition to an enlarged prostate gland? Should he similarly wait until then before having a PSA, or having Tamsulosin prescribed for presumed BPH? Should these be preconditions to referral in the first instance? Should a woman referred with recurrent urinary

infection wait more than one year before she too would have an ultrasound scan performed, or have antibiotic prophylaxis prescribed? Should a man with erectile dysfunction wait even longer before he has treatment initiated? Could one with a scrotal swelling not have an ultrasound scan performed prior to referral, precluding referral in most cases?

In many instances, I find the most egregious referrals are those consequent upon consultation with our registrars. I have triaged referrals for red flag flexible cystoscopy following discharge of patients from our own department! Why was it not organised by those doing the discharging? Why does a registrar advise referral of a patient for a TROC, rather than arranging it at the time? Why does a registrar advise referral of a patient with a small stone at the lower end of the left ureter, instead of arranging the review?

I have requested several times from the Trust its stated Policy and Procedure on Triage, without acknowledgement. I can only conclude that it does not have one. I advised the Director of Acute Services in January 2017 that the issue of triage, its relation to UOW and to waiting times for first consultation, be addressed. There has been no response.

Once again, I would like us to embark upon a discussion of triage in all its complexity, and I expect that the Trust will be engaged in that process, resulting in a clear, written understanding of our obligations, so that we are not to be held liable.

WAITING TIMES FOR ELECTIVE INPATIENT SURGERY

This issue hardly needs further comment. We are all aware of the interspecialty disparity in waiting times, as of June 2018. I believe that the disparity is both scandalous and indefensible. I also believe that the lack of any substantive response from the Trust is equally so. I believe that we must collectively bring our concerns to the Trust Executive, and to the Trust Board which I understand to be unaware of the disparity, and unaware of any substantive attempt to remedy the situation.I also do believe that we should look at disparities between our own waiting lists, especially with a view to making every attempt on our part to minimise risk of serious morbidity or mortality.

In January 2015, I placed on my waiting list a pretty fit, 90 year old man for resection of his prostate gland which had regrown since it had previously been resected in 2006, and which had been the source of haematuria in 2015. He was admitted to the Cardiology Ward in August 2017 with coliform urosepsis resulting in a type II, myocardial infarct. He was readmitted again in August 2018, again with urosepsis. Since discharge, he has had visible haematuria, exacerbating a chronic anaemia. A CT Urogram has been normal. There was no evidence of urothelial pathology on flexible cystoscopy which was done during his recent inpatient stay. Yesterday, I arranged his admission on 17 October for TURP, keeping him on antibiotic prophylaxis until then.

I feel a sense of shame when dealing with such a patient. Whether it is disparity within our own specialty, or between specialties, it is unacceptable that such a man should have to wait almost four years, at risk of such morbidity, while an urgent gynaecological case would not have to wait more than three months.

Since I was appointed 26 years ago, the solution to any urological inadequacy has always been regarded as a requirement for additionality, which could either not be afforded, or there was no space for more beds, or staff could not be recruited, or whatever. I do believe that the first solution should be to cause displeasure to those specialties which do not have such a critical situation as we do have. How many gynaecological operating sessions are there per month in the Southern Trust? Why not allocate half of them to Urology?

Lastly, I often think that if I had a tumour of my left kidney, it would have to be removed within 62 days, or thereabouts. If I have a staghorn calculus in the remaining kidney, it does not receive the same clinical priority. I may just develop renal failure, requiring dialysis, a recognised complication!

SUMMARY

I hope I may be forgiven for expressing my views, frustrations and concerns, but I believe that it is time to do so. I have equally committed to listening to those of my colleagues. From doing so, I hope that we can collectively arrive at a clear understanding of our individual and collective obligations, and above all, that we have a clear, written memorandum of understanding, or agreement, or covenant, maybe even a Policy and Procedure, from the Trust of our practice obligations.

AIDAN O'BRIEN
24 SEPTEMBER 2018.

Personal Information redacted by the USI

From:
Sent:
To: **Subject:**

-----Original Message-----
From: Corrigan, Martina Personal Information redacted by the USI
To: Aidan O'Brien's email address >; Michael Young's email address >;
Glackin, Anthony Anthony Glackin's email address Haynes, Mark Personal Information redacted by the USI
Mark Haynes's email address Young, Michael
Personal Information redacted by the USI O'Brien, Aidan Personal Information redacted by the USI ODonoghue, JohnP
Personal Information redacted by the USI ; John P O'Donoghue's email address Tony Glackin
Anthony Glackin's email address
Sent: Fri, 30 Nov 2018 14:49
Subject: Monday 3 December

Dear all,

Apologies as I had meant to send this email earlier.

It has been agreed that the away day on Monday is cancelled but that the consultants and I would get together at 10am for a couple of hours to discuss some of the issues that had been raised on 24th September.

I have reinstated the PM activity.

Regards

Martina

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

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

Southern Health and Social Care Trust

Quality Care - for you, with you

17th August 2020

Ref: MOK/ec

Via email [redacted]

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street,
Manchester

Dear Mr Brammall,

RE: GENERAL MEDICAL COUNCIL - MR AIDAN O'BRIEN GMC NO. 1394911

Further to your email dated 30th July 2020 requesting further information regarding concerns raised in relation to Mr Aidan O'Brien, Consultant Urologist employed by the Southern Health and Social Care Trust, please see below itemised responses and where required, attached items.

A copy of Mr O'Brien's job plan	Copies of the last two electronic job plans that are held in our job planning system for Mr O'Brien are attached in Appendix 1. Please note that they were not signed off by Mr O'Brien. These were previously sent to the GMC in response to this communication by Zoe Parks on 30th July 2020.
Any update that you may have about contacting the RCS for advice on the parameters of a possible lookback / patient recall exercise and information that	The Trust has hosted a discussion with the Royal College Surgeons Invited Review Service on the 28th July 2020 which explored the options for and extent of any potential lookback should this be required. A follow up call was conducted on 4th August with the

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Tel: [redacted] Email: [redacted]

may have arisen out of any review	Royal College of Surgeons Head of Invited Review manager where potential scale and scope of a lookback was discussed. The Trust will be discussing the potential for progressing with any lookback with the Department of Health over the next week.
An update about the new MHPS investigation that was being considered due to the additional concerns about Mr O'Brien that arose recently	The Trust has commenced preliminary enquiries in respect of the additional concerns which have now arisen under the MHPS Framework. Mr O'Brien's former clinical manager Mr Haynes, as Associate Medical Director, is the clinical manager co-ordinating preliminary enquiries under para 15 of Section I of MHPS. Mr O'Brien has been notified of this and a request has been made for his input to the preliminary enquiries process. A formal investigation has not been commenced at this point. Mr O'Brien is seeking advices in respect of his engagement in the MHPS preliminary enquires process and the Trust awaits his decision in this regard, via his solicitor.
Any updates concerning the SAI reviews for the following patients identified in the information originally sent to the GMC (if SAIs have been completed, please could you provide copies of these?): • Patient 14 Personal Information redacted by the USI • Patient 11 Personal Information redacted by the USI • Patient 13 Personal Information redacted by the USI • Patient 12 Personal Information redacted by the USI	The Serious Adverse Incident Reviews for the listed patients have been completed. Copies of the review which was provided in a consolidated single report can be found attached in Appendix 2.

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Any updates concerning the SAI reviews for service user A and service user B as identified in the new concerns that were recently sent to the GMC	Both Service User A and B have been screened and meets the requirement for a Serious Adverse Incident review and are being progressed as per regional and Trust processes. Since our last update a third case, Service User C has also been identified as meeting the requirement for a Serious Adverse Incident review.
Any data that you may hold for comparison purposes regarding the triage process and Mr O'Brien's peers (for example, any audit data / data gathered in relation to other urology consultants) in relation to patients who may have been mis-triaged	The Trust does not have formal data on the triage comparison between Mr O'Brien and his peers. All incidents have been identified by exception; no other triaging related incidents have been identified with any other Urology Consultant.
The outcome (or a copy of) the independent review into the administrative procedures that is due to be concluded by September 2020 (when this becomes available)	The review of administrative procedures is underway and will be shared following completion in September 2020 at which point a copy will be shared with the GMC.
Any guidance or protocols that were put in place for the urology department in terms of triaging incoming referrals using the three tier system and how this was shared with the urology consultants including Mr O'Brien	The Trust do not use the three tier system for triaging but follow the Northern Ireland Cancer Network (NICaN) referral guidance, which is based on NICE guidelines. Appendix 3 show the prostate and bladder guidance for triage (which is usually updated every year) and which is shared and used by all urology consultants in Northern Ireland.

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The relevant medical records for service user A and service user B as identified in the more recent concerns.	Copies of Service Users A and B redacted notes are attached as Appendix 4.
The relevant medical records for the following patients as identified in the concerns originally sent to the GMC. • Patient 10 Personal Information redacted by the USI • Patient 14 Personal Information redacted by the USI • Patient 11 Personal Information redacted by the USI • Patient 13 Personal Information redacted by the USI • Patient 12 Personal Information redacted by the USI	Copies of the patient will not be available until 24th August 2020 and will be forwarded following this.
Please could you provide details of the circumstances of the cancellation of the meeting in September 2018 and the lack of senior management availability in December 2018 including details of any plans that were put in place for Mr O'Brien / other consultants to raise their concerns to senior management	The meeting that was scheduled to take place between Urology Consultants and management in September 2018 was cancelled following the unexpected sickness absence of the Head of Service for Surgery. The Consultant body agreed that in the absence of the head of service the meeting should not progress. The meeting scheduled for December 2018 did not progress as 3 of the 6 Consultant Urology staff were unable to attend.

I trust this provides the necessary detail required. Should you have any queries, please do not hesitate to contact me.

Yours sincerely

Personal Information redacted by the USI

Dr Maria O'Kane
Medical Director

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

3 December 2018

FILE REFERENCE: 20

AIDAN O'BRIEN
(MANAGEMENT MEETING)
TONY GLACKIN
MICHAEL YOUNG
MARK HAYNES
JOHN O'DONOGHUE
MARTINA CORRIGAN

Audio Transcription Prepared by:

Personal Information redacted by the USI

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MR O'BRIEN: Good morning.
MR GLACKIN: Good morning. ~~(Pause)~~
MR YOUNG: (Inaudible)
MR GLACKIN: You also have to provide … there's a huge amount of documentation to be put through the procedure route ….
MR YOUNG: (Inaudible)
MR GLACKIN: (Inaudible)
MR YOUNG: Would you rather the Parker Knoll, Mr O'Brien?
MR O'BRIEN: I think so.
MR YOUNG: Is Mark coming?
MR GLACKIN: I looked at the rota….
MR O'BRIEN: This is his usual seat …
MR GLACKIN: …. What the story was, and if you are already a UK consultant, it's very straight forward, but if you were starting from scratch coming in from a non-EU country. They charge a huge fee for that assessment.
MR YOUNG: Do they? Very good. Anyway …. (inaudible) …. I am just trying to have a look at the rota there….
MR O'BRIEN: Michael, I am summoned to the same court case.
MR YOUNG: Oh, sugar.
MR O'BRIEN: It's for the five days for the two of us. It's not for three days.
MR YOUNG: (Inaudible). You have been actually? When did you hear that?
MR O'BRIEN: I got an e-mail on Friday. Well, it was sent on Friday and I got it yesterday.
MR YOUNG: What date is that?
MR O'BRIEN: Monday 21 January.
MR YOUNG: It's that week there then.
MR O'BRIEN: The same case.
MR YOUNG: (Inaudible).
MR O'BRIEN: Apparently I must have missed out on it because it was --
MR YOUNG: It was (inaudible).
MR O'BRIEN: It was forwarded from June of last year.
MR YOUNG: Yes, I just kept on forgetting about it.
MR O'BRIEN: I must have. I've forgotten all of the issues.
MARTINA CORRIGAN: Hi.

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MR O'BRIEN: Good morning.

~~MALE SPEAKER 1:~~ MICHAEL YOUNG:: I put on the wee stove in the corner.

MARTINA CORRIGAN: (Inaudible) it's colder than in here.

MR YOUNG: Is there a plug over and you get the -- is Mark coming, yes?

MARTINA CORRIGAN : Yes, he is. He's in the office. So, He will go to the office.

MR YOUNG: (Inaudible)…… Have you not got it yet?

~~MALE SPEAKER 2:~~ MR O'DONOGHUE: (Inaudible).

MR GLACKN: Is it that week …?

MR YOUNG: Now, just before we kick off.

MR O'BRIEN: Which week is that? Where's that block?

MR YOUNG: This is January 19. That one there.

MR O'BRIEN: I would say that we ~~were~~ would just --

MR YOUNG: You see the nature of it, Aidan, is that it might run. This is our ~~(inaudible).~~

Personal Information redacted by the USI . You probably remember.

MR GLACKIN : Is he still a patient here?

MR YOUNG: Yes.

MR O'DONOGHUE: Who's he under?

~~MALE SPEAKER 1: (Inaudible)~~

MR YOUNG: I took his bladder out.

MR O'BRIEN: What I do know from previous experience is that the court will exercise a degree of flexibility as to --

MALE SPEAKER 1: (Inaudible).

MR O'BRIEN: Yes, when they would accommodate you. And in that regard I have stipulated previously, for example if I were to take that week, that the most precious day on it is Wednesday and that I would be available on any day other than the Wednesday for example. You could do like…..

MR YOUNG: Yes, but the only thing is --

MR O'BRIEN: It' on your on-call week.

MR YOUNG: Well, it's not -- it's on my on-call week. But it is nice to be there to hear what other people have been saying because if you're the one that's being pointed at, fingers pointed at you, you want to know (inaudible).

MR GLACKIN: Do you want to…. ~~(**Inaudible**).~~

~~MALE SPEAKER 1~~: MR YOUNG: (**Inaudible**).

MR O'BRIEN: It's what?

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MR YOUNG: We've been dragged in because ~~there were three of them~~ we treated him and so ~~(inaudible)~~ Personal Information redacted by the USI passed comment about something as usual ~~That's unusual~~.

MR O'BRIEN: ~~What do you (inaudible)~~ What did he pass comment about?

MR O'BRIEN: I did read it a long time ago.

MR GLACKIN: Personal Information redacted by the USI tends to be ….

MR YOUNG: : He's asking why we didn't do ~~a IO~~ an ileal conduit as to opposed to doing a ~~(inaudible)~~ cystectomy … why I did a cystectomy?

MR O'DONOGHUE: He's quite (inaudible)

MR O'BRIEN: Yes, yes. That's the whole issue. He is now really looking it reconstructed. ~~at reconstructive. Is~~ Isn't that right?

MR YOUNG: Yeah.

MR GLACKIN: He wants a ~~(inaudible)~~ neo- bladder created.

MR O'BRIEN: Well, the accusation is that we didn't need, which is true to a degree.

MR YOUNG: He was certainly not a candidate for doing ~~(inaudible)~~ a Mitrofannoff or --

MR O'BRIEN: At that time.

MR YOUNG: He was psychiatric.

MR O'BRIEN: And didn't I -- I did a report to that effect.

MR YOUNG: Yeah. It's funny they will do an ~~IO~~ ileal conduit. But back in 2000 if you had ~~(inaudible)~~ interstitial cystitis you took ~~a (inaudible)~~ the bladder out. Anyway. That's beyond now but it may (inaudible).

Now, the other thing is we will interviewing on Wednesday for a job which will probably start in …..February?

MARTINA CORRIGAN: Yes.

MR YOUNG: And I told Personal Information redacted by USI that we are advertising and interviewing and so he has already been thinking about moving on and he may go to Personal Information redacted by USI.

MARTINA CORRIGAN: (Inaudible).

MR YOUNG : But interestingly they may wish him to -- there will be one further ….(inaudible)…. Go on through.

MR O'BRIEN: Into the desk.

MR YOUNG: Go on into the desk. There will be another seat in there.

MR HAYNES: I was going to put the kettle on.

MR YOUNG : You can do that as well. They may actually want him to start in January.

MARTINA CORRIGAN:: Who?

MR YOUNG: Personal Information redacted by the .

MARTINA CORRIGAN : Oh …. Right… so

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MR YOUNG: ~~May do. so~~ So, expect a phone call from the guys in [redacted]

MARTINA CORRIGAN: Okay.

MR YOUNG : As a reference.

MR GLACKIN: ~~(Inaudible)~~ Are there not retired people that … ~~(inaudible).~~

MR O'BRIEN: Well, [redacted] has retired and…..

MR YOUNG: I haven't got a clue who (inaudible).

MR O'BRIEN: And [redacted] has retired and it's [redacted] .

MR YOUNG: [redacted] . ~~(Inaudible)~~

MR YOUNG: That's right, yes. And there's a guy called -- is it [redacted] .

MR O'BRIEN: Sure [redacted] … he was here.

MR YOUNG: Yes, years ago. So he was there but apparently he has gone back to [redacted] .

MR O'BRIEN: [redacted] has?

MR YOUNG : Yeah. That's who this post is about. Is there not another seat?

MR HAYNES: This is all right. It's fine. (Inaudible), Michael, this will do.

MR O'BRIEN: I took your seat.

MR YOUNG : So ~~he got here first. So I was (inaudible).~~

MR HAYNES: He got here first. So (inaudible)

MR YOUNG: (Inaudible)

MR O'BRIEN: I didn't realise it ~~was lined~~ reclined.

MR YOUNG: It should come out.

MR O'BRIEN: Okay.

MARTINA CORRIGAN: (Inaudible).

MR YOUNG: I did encourage him to try to stay until February since we had scheduled.

MR HAYNES : [redacted]

MR YOUNG : No, [redacted] Anyway, that's just that bit.

MR O'BRIEN: And who's coming instead.

MR YOUNG : We'll be interviewing.

MR O'BRIEN: Mmm?

MR YOUNG: We will be interviewing.

MR O'BRIEN: I see.

MARTINA CORRIGAN : And then (inaudible).

MR O'DONOGHUE: (Inaudible).

MR YOUNG: (Inaudible).

MR O'BRIEN: Who has applied?

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MRYOUNG: Personal Information.

MR O'BRIEN: But he's not taking up the job, is he?

MR YOUNG: Well, he has to be interviewed first.

MR O'BRIEN: Yes, but ...

MR HAYNES: If he is successful, he will work (inaudible). I've encouraged him to have already opened the conversation of wishing to defer his start date.

MR YOUNG : He may wish to come and work. He wants to take a year out to go to get a fellowship but that starts in July.

MR O'BRIEN: I see.

MR YOUNG: But I got the impression that he wanted to work as we had a conversation (inaudible).

MR HAYNES: I said you need to start that conversation now because it is very difficult to start work, be allocated to your own waiting list and then disappear for a year. So you need to have a very clear view. If you are starting work, if you're just doing nothing but waiting list work and not creating any new workload or stay as a registrar until July.

MR YOUNG: Yes.

MR O'BRIEN: Has he organised the fellowship?

MR YOUNG: Yes.

MARTINA CORRIGAN: Yes, Personal Information redacted by USI.

MR HAYNES: Or the employer could say no.

MARTINA CORRIGAN : Just on that, what about Personal Information redacted by because Personal Information redacted by 's in, Ronan did mention, (inaudible) because we were interrupted. But Personal Information redacted by is in as extra and ~~(inaudible)~~ at the moment I'm paying him two ~~(inaudible)~~ staff grade monies. So I can continue to pay that. But if we have appointed Personal Information and Personal Information redacted comes back, I don't have.

MR YOUNG: Did you hear of any other interview? ~~(inaudible)~~. Sorry, we'll get to your meeting now.

MARTINA CORRIGAN: I suppose it is all connected…

~~MALE SPEAKER 1:~~ MR YOUNG: Is Personal Information redacted by going to apply for the locum job in the City?

~~MALE SPEAKER 2:~~ MR HAYNES: He has applied.

~~MALE SPEAKER 1:~~ MR YOUNG: (Inaudible).

~~MALE SPEAKER 2:~~ MR HAYNES: I don't know when interviews are. And there's -- Personal Information tells me there's a job in Personal Information as well.

~~MALE SPEAKER 1:~~ MR YOUNG: That's the one that's he wanting. That's his one that…

~~MALE SPEAKER 3:~~ MR O'DONOGHUE: But he said the closing date closed three months

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ago and he hasn't heard anything else, so they are taking a while to sort it out so he's frustrated about that.

MR O'BRIEN: Is that a new job or is it a replacement job?

~~MALE SPEAKER 3:~~ MR O'DONOGHUE: It's in the Personal Informatio, so I don't know whether it's -- I don't know whether it is new role.

~~MALE SPEAKER 1:~~ MR YOUNG: They were making it an up job I think.

~~MALE SPEAKER 3:~~ MR O'DONOGHUE: I'm not too sure.

MR O'BRIEN: Personal Information redacted by USI is the same vintage as I am. In fact, he's older than me.

~~MALE SPEAKER 2:~~ MR O'DONOGHUE: He's the Personal Information Hospital.

MR O'BRIEN: He's the Personal Information Hospital.

MR YOUNG: ~~MALE SPEAKER 1~~ (Inaudible).

MR O'DONOAGHUE: Personal Information redacted by USI is in the Personal Information redacted by …

MR O'BRIEN: ~~Well,~~ Personal Information redacted by USI wouldn't be necessarily retirement age.

~~MALE SPEAKER 2:~~ MR YOUNG: (inaudible).

~~MALE SPEAKER 1:~~ MR HAYNES: (Inaudible) ~~And driving to Belfast on the hard shoulder.~~

MR O'BRIEN: So Personal Information redacted by has applied for a locum post in Belfast but didn't apply --

~~MALE SPEAKER 4:~~ MR HAYNES: Didn't apply here.

~~MALE SPEAKER 3:~~ MR O'DONOGHUE:: He actually -- Personal Information redacted by did say to me he might have overplayed his and because I said why didn't you apply here? And he said I might have overplayed my hand. So I think he might have regretted this.

~~MALE SPEAKER 2:~~ MR HAYNES: Not just that. I applied for a job, a locum job in Belfast, including the on-call, and been less than forthcoming in wanting to be part of our on-call rota.

~~MALE SPEAKER 2:~~ MR O'DONOGHUE: I think he felt he had made a mistake he didn't apply for here.

~~MALE SPEAKER 1:~~ MR YOUNG: Well, he said that before and he didn't want to take a job and to walk away from it at the end of the day. Anyway. Right.

As far as this here is concerned, January rota, I tried to encourage Personal Information to stay for the month since we've already scheduled.

~~MALE SPEAKER 2:~~ MR HAYNES: What was his perspective?

~~MALE SPEAKER 1:~~ MR YOUNG: He just wants continued employment basically, so he's happy enough to stay until the February date. He's okay on that.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: So Personal Information is staying until the February -- or, sorry, end of January.

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~~MALE SPEAKER 1:~~ MR YOUNG: (Inaudible).

~~MALE SPEAKER 2:~~ MR GLACKIN: (Inaudible) Personal Information (inaudible).

~~MALE SPEAKER 1:~~ MR YOUNG: (Inaudible) the locum agency might push him into it.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: He'll probably get more money down south and I think at the end of the day that's what's driving it.

~~MALE SPEAKER 1:~~ MR YOUNG: Is our terms and conditions such that they are employed on a month to month basis and that if you've committed to a month you are committed to it?

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Not on an agency. It's week.

~~MALE SPEAKER 2:~~ MR HAYNES: Agency is one week notice.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Yeah, one week notice because he's paid weekly.

MR YOUNG: ~~MALE SPEAKER 1: (Inaudible).~~ That's the way it works. So he could say he wanted to go in the middle of the January.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Yes.

~~MALE SPEAKER 2:~~ MR HAYNES: He could say he wants to go next week.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Yes.

~~MALE SPEAKER 1:~~ MR YOUNG: Okay.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: If that happens we're just going to have to --

~~MALE SPEAKER 1:~~ MR YOUNG: We'll just have to reschedule. I don't know if you were in but Aidan demand and I have to go to this court case that (~~inaudible~~) week there. So that's really what I am really trying to have get at.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGNA: Okay.

~~MALE SPEAKER 1:~~ MR YOUNG: Then I would move him into doing the locum during the day and then I would just do my usual stuff at night.

~~MALE SPEAKER 3:~~ MR O'DONOGHUE: What happened to all his patients? Were they (inaudible). He probably has quite a lot of patients.

~~MALE SPEAKER 2:~~ MR HAYNES: That's why we've always said we've only got six waiting lists because we've only six posts.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Yes. There is seven consultants I suppose. If Personal Information is successful (inaudible) he will become (inaudible).

~~MALE SPEAKER 3:~~ MR O'DONOGHUE: If Personal Information (inaudible).

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~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: If Personal Information (inaudible) doesn't (inaudible).

~~MALE SPEAKER 2:~~ MR GLACKIN: He could act up, couldn't he?

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Pardon? He can, yes.

~~MALE SPEAKER 2:~~ MR HAYNES: He could act up as a registrar or we can say yes, you start but (inaudible). To just do a three-month period and then be disappearing without any clarity as to what is happening, you really wouldn't want him taking on a new case load in that period of time. There's enough of a back log on Personal Information 's work load to actually work through some back log.

~~MALE SPEAKER 1:~~ MR YOUNG:: Even just doing that (inaudible) that makes a great sense (inaudible). Is it six months grace?

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Six months. Yes, six months.

~~MALE SPEAKER 1:~~ MR YOUNG:: There is six months grace when acting up.

~~MALE SPEAKER 3:~~ MR GLACKIN: You should know all this now.

~~MALE SPEAKER 5:~~ MR YOUNG: I would love to know all this.

~~MALE SPEAKER 3:~~ MR HAYNES: I am certain that between Personal Information 's waiting list and your own waiting list there would be stone work to keep Personal Information busy during that three months.

MR O'BRIEN: Three years.

~~MALE SPEAKER 1:~~ MR YOUNG: (inaudible). Right. Let's move on to our meeting.

MR O'BRIEN: Just before you do, a little… I think an email. Was that a mistake or I just want --

~~MALE SPEAKER 1:~~ MR YOUNG: I wrote it down as I've sent an e-mail to Leanne Brown in order to put so Personal Informati, and then in brackets whoever's work he is doing of course. For instance you know here Personal Informati is doing my clinic. And in December I had Personal Informati doing all of yours. But has Personal Informati got a list? Is he accredited to that, so its accredited to -- and is it always Mr O'Donoghue, or (inaudible) will that always be cases assigned of mine? Am I being accredited for Personal Informati doing my --

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Yes. Yes. Although, no, no, the TMS (inaudible).

~~MALE SPEAKER 2:~~ MR HAYNES: (Inaudible) Personal Information redacted by USI but the patients are selected from your waiting list.

~~MALE SPEAKER 1:~~ MR YOUNG: Alright … Okay.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: TMS is Personal Informati because it has to be.

MR O'BRIEN: Can we just take this one step further back because this is a thing that I looked at the patients that had already been allocated to that and you see when you triage

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anything, it doesn't have to be what category it is, and you designate it to a ~~new clinic~~ New Clinic and typically then it will be AOB but it doesn't --

~~MALE SPEAKER 1:~~ MR YOUNG: I think just because -- I wondered that as well. I see a lot of your patients that you triage. So it's not --

MR O'BRIEN: I wondered but in relation to the cancer performance figures because when you ~~looked~~ look through -- one of the problems about that cancer performance we can't identify the patients. They're just given initials so it's meaningless exercise because you can't look back and see the breach report.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: (inaudible).

MR O'BRIEN: So but I was wondering, like I had triaged a number -- four of them but actually Mark, for example, had triaged a patient but he's appointed. The most important thing was you have done it as Personal Informati OD.

~~MALE SPEAKER 1:~~ MR YOUNG: Yes, yes.

MR O'BRIEN: I had it on my diary that it was Personal Informati OB. I am also going to do on 18 December a cancer review clinic, which would be my last until the New Year ~~new year,~~ and I was really depending on it. So I just didn't want to have somebody appointing ODs for Personal Informati to do.

~~MALE SPEAKER 1:~~ MR YOUNG: And OB.

MR O'BRIEN: And OBs and me coming along and doing a cancer review clinic and then it all being unmanageable on the 18th.

~~MALE SPEAKER 1:~~ MR YOUNG: I am taking it after we do the schedule and save it that that is the final version. So I have it as OD.

MR O'BRIEN: But OBs have certainly been appointed to a ~~new clinic~~ New Clinic … I believe… Five out of nine so far.

~~MALE SPEAKER 1:~~ MR YOUNG: OB.

MR O'BRIEN: And I am doing this here.

~~MALE SPEAKER 1:~~ MR YOUNG: Okay…. Well

~~MALE SPEAKER 3:~~ MR HAYNES: On the ~~new clinic~~ New Clinic, it's a pooled waiting list, so just take from the end.

~~MALE SPEAKER 1:~~ MR YOUNG: It is a pooled waiting list so there shouldn't be…

~~MALE SPEAKER 3:~~ MR HAYNES: They shouldn't (inaudible).

~~MALE SPEAKER 1:~~ MR YOUNG: (Inaudible). Nine of yours and nine of Personal Informati's.

~~MALE SPEAKER 3:~~ MR HAYNES: If Personal Informati is doing a clinic and it's got you in the bracket next to it you're continuing their follow-up, their follow-up in (inaudible).

MR O'BRIEN: That's all that matters.

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~~MALE SPEAKER 3:~~ MR HAYNES: (Inaudible) your care. That's all that matters. Not who's (inaudible).

MR O'BRIEN: That's not a concern at all. I am just concerned that there's another --

~~MALE SPEAKER 1:~~ MR YOUNG: There's going to be nine of yours and nine of [redacted]'s (inaudible).

MR O'BRIEN: ~~(Inaudible)~~ and there's nine of [redacted]'s and it's unmanageable.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Which is actually what happened last Tuesday or Wednesday (inaudible) six patients or (inaudible).

~~MALE SPEAKER 1:~~ MR YOUNG: Can you check? Which day are you talking?

MR O'BRIEN: Tuesday 18 December.

~~MALE SPEAKER 1:~~ MR YOUNG: I have sent it on. I've already written to --

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Tuesday 18 December (inaudible).

MR O'BRIEN: And is Leanne Brown, I thought she had gone.

~~MISS BENSON:~~ MARTINA CORRIGAN: No. In the morning she's in ante-natal and then in the afternoon she comes back in to do the urology… So…

~~MALE SPEAKER 1:~~ MR YOUNG: Okay.

MR O'BRIEN: Because she's the --

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: I'll check.

MR O'BRIEN: A great link person.

~~MALE SPEAKER 1:~~ MR YOUNG: (Inaudible).

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: I know but I'll double check because what happened last week, Jason contacted me to say that and whoever, I can't remember whose clinic it was, but I said cancel it and we'll try and … inaudible). I suppose the other thing is with regards to ….. inaudible)…. We'll move on to that there is Mark had a conversation with (inaudible) with regard to the scopes and I am going to have to cut back on the haematuria.

~~MALE SPEAKER 2:~~ MR HAYNES: ~~(Inaudible) this~~ This came from the girls down in Thorndale. ~~(inaudible) standards.~~ The scope situation is completely unmanageable and unchanged. I know on Friday they were essentially down to one cabinet in the washroom period. And for anything that was needed in out-patients ~~or in~~ or in main theatres, they are typically getting ~~(inaudible)~~ between four or -- well, between either four or five scopes for any session. As we all know, when we're in emergency theatre it's actually the emergency theatre team that take the call to go and put the scopes through. So there's no -- not even that capacity to get the number of scopes.

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~~MALE SPEAKER 1:~~ MR YOUNG: Is the cabinet -- can the cabinet store (inaudible)

~~MALE SPEAKER 3:~~ MR HAYNES: No, cabinets are not open. That's gone defunct.

~~MALE SPEAKER 1: That's gone defunct.~~

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Yes.

~~MALE SPEAKER 1:~~ MR YOUNG: Why? ~~(inaudible).~~

~~MALE SPEAKER 3:~~ MR HAYNES: We have nothing. We've got to stop bringing three haematurias to one, three to another, three to another, when we're never going to have the scopes to manage them. And given that two months ago I raised -- I had that meeting with the Director of Performance~~director of performance~~, who was acting on behalf of the Chief Executive ~~chief executive~~ and fuck all has happened, we just -- to me we just have to say one haematuria to each session, so one for each consultant, and one's the registrar, because that is all we can cope with in the session.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: So instead of three and --

~~MALE SPEAKER 3:~~ MR HAYNES: Instead of three, three and three --

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: It's one, one and --

~~MALE SPEAKER 3:~~ MR HAYNES: It's one, one and one. So you get that maximum. If we know that whenever (inaudible)…

~~MALE SPEAKER 1:~~ MR YOUNG: (Inaudible) ….push down. ~~that out.~~

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Yes.

~~MALE SPEAKER 2:~~ MR HAYNES: It's the only thing that triggers change.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Yes, and because of that, because Mark come to see this morning and we went round to Ronan, so Ronan sent ~~a~~ an email to the Chief Executive ~~chief executive~~ to say that our cancer targets are going to increase from 46 days to goodness knows what because of the result of not having scopes and, like, I've asked for a scope. This is the third year in a row.

~~MALE SPEAKER 1:~~ MR YOUNG: So it's a matter of not having enough scopes as opposed to being able to clean them and store them.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Well, there is issues with the cleaning as well.

~~MALE SPEAKER 2:~~ MR HAYNES: There are issues with the cleaning but there are not enough scopes.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: There's not enough scopes. It would help if we had another six more scopes in the system as well but there is an issue with cleaning because apparently the cabinets are producing oil or something like that.

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MALE SPEAKER 2: MR HAYNES: If you are able to start the list with ten scopes then you can deliver. If you can start -- only start the list with four or five scopes then you can't turn them round.

MALE SPEAKER 1: MR YOUNG: And why is the cabinet round there not suitable? It's been down for a while. Is there a sterility problem with (inaudible)?

FEMALE SPEAKER 1: MARTINA CORRIGAN: Er, yeah.

MALE SPEAKER 1: MR YOUNG: No, but the actual storage cabinet. If you had enough (inaudible) scopes cystoscopies, could they not be stored there?

MALE SPEAKER 3: MR HAYNES: There's an ongoing cycle of issues with sterility.

FEMALE SPEAKER 1: MARTINA CORRIGAN: Yes.

THE PROSECUTION: MR O'DONOGHUE: Does that cabinet not move or is it --

FEMALE SPEAKER 1: MARTINA CORRIGAN: It is, yeah.

MALE SPEAKER 1: MR YOUNG: That's the point.

MALE SPEAKER 2: MR GLACKIN: What are we doing in Daisy Hill?

MALE SPEAKER 3: MR HAYNES: In terms of?

MALE SPEAKER 2: MR GLACKIN: Haematuria. In January.

MALE SPEAKER 3: MR HAYNES: They've got their scopes but we can't use them because we need a member of staff. They use a shared… (inaudible).

FEMALE SPEAKER 1: MARTINA CORRIGAN: But what you're saying… (inaudible).

MALE SPEAKER 2: MR GLACKIN: I am asking what activity are you actually getting from them? doing (inaudible?.

MALE SPEAKER 3: MR HAYNES: That one session each week.

FEMALE SPEAKER 1: MARTINA CORRIGAN: Yeah, (inaudible).

MALE SPEAKER 2: MR GLACKIN: How many patients go to that session? (inaudible).

FEMALE SPEAKER 1: MARTINA CORRIGAN: Between three…

MALE SPEAKER 3: MR HAYNES: Up to about six. I think it only starts at 11.

MALE SPEAKER 4: MR GLACKIN:: Is there capacity for us to get another session in Daisy Hill because the equipment is there? Is that not feasible?

FEMALE SPEAKER 1: MARTINA CORRIGAN: Yes. I'll have a look at it. Who would do it? Paul?

MALE SPEAKER 4: MR GLACKIN: I don't mind going and doing my clinic at Daisy Hill if it means that I do a (inaudible) new patient clinic there instead of doing it here (inaudible) and we can do an appropriate number of haematurias.

MALE SPEAKER 2: MR HAYNES: You'd have no ultrasound.

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MALE SPEAKER 4: MR GLACKIN: I don't ultrasound as the biggest … (Inaudible)… as many will have had CT before they are ever touched.

MALE SPEAKER 2: Mr HAYNES: (Inaudible).

MALE SPEAKER 4: MR GLACKIN:Brand … (Inaudible) new clinic.

MALE SPEAKER 1: MR YOUNG: I must say it is pretty atrocious that we don't have (inaudible) have to come.

MALE SPEAKER 4: MR HAYNES: And this is.

MALE SPEAKER 1: MR YOUNG: We agree with what you're saying, Tony, but we are going to dig ourselves into a hole (inaudible).

MALE SPEAKER 2: MR HAYNES: We've raised the issue. We just have to say we can't do it.

FEMALE SPEAKER 1: MARTINA CORRIGAN: It is bit like TURPs TROPs, whenever we threatened --

MALE SPEAKER 4: MR HAYNES: I do agree, Tony, that we should be delivering some activity in Daisy Hill and I would share your happiness to do it.

FEMALE SPEAKER 1: MARTINA CORRIGAN: Which I think is part of this conversation here as well.

MALE SPEAKER 4: MR HAYNES: But I can tell you what the issue is, that they won't have the endoscopy room.

MALE SPEAKER 4: MR GLACKIN: Can you put it forward that there is a willingness, from me anyway, to try and do that, whether or not that is going to be feasible.

MALE SPEAKER 2: MR HAYNES: I've used for asked for clinical to do a Daisy Hill clinic the whole year and there is none.

MALE SPEAKER 1: MR YOUNG: Could I ask, where does Paul Hughes do the vasectomies?

MALE SPEAKER 3: MR HAYNES: In a theatre.

MALE SPEAKER 1: MR YOUNG: In a theatre. Right. Now I think the vasectomy service is going to go out to the GPs and actually I know in Belfast this is happening.

MALE SPEAKER 2: MR HAYNES: That's been happening for 12 months and Paul's still got as long a waiting list as wherever.

MALE SPEAKER 1: MR YOUNG: But the idea is that GPs the GP service will … (inaudible)…. It's very close.

MALE SPEAKER 4: MR GLACKIN:It's very close. I can tell you that Deirdre (inaudible) was at a federation last week. She was sitting down next to Edward Sharkey, who is one of the people … (inaudible). And what they need is actually -- the limiting fact for the

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GPS is a suitable premises.

~~MALE SPEAKER 3:~~ MR HAYNES: That is what I was going to come to and so what is holding up them up is they have come to the Trust to ask for premises to do it.

~~MALE SPEAKER 4:~~ MR GLACKIN: So they are ready to go. They've just --

~~MALE SPEAKER 1:~~ MR O'DONOGHUE: ~~(inaudible) where~~ Where have they got their training?

~~MALE SPEAKER 2:~~ MR GLACKIN: I ~~man~~ don't know who's trained them.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: There are actually doing them in Belfast.

~~MALE SPEAKER 3:~~ MR HAYNES: One of the great ironies might be that we find that Paul might loss his list as GPs come in and do it in same place.

~~MALE SPEAKER 1:~~ MR YOUNG: That's something that we have resist ~~them~~ that because I had heard that he is worried about if he is stops doing that what's he going to do but there's a great opportunity if he stops doing that then there's --

MR O'BRIEN: I thought GPs were so overwhelmed with work how are they getting on with vasectomies? ~~vase set applies.~~

~~MALE SPEAKER 2:~~ MR GLACKIN: Many of them don't want to be GPs anymore ~~and,~~ Aidan, they are looking for something else to be doing, ~~inaudible).~~ That's essentially what (inaudible)

~~T~~

~~HE PROSECUTION:~~ MR HAYNES: Paul has already been over and done the Botox course in order to deliver more endoscopic urology as local … (inaudible).

~~MALE SPEAKER 4:~~ MR GLACKIN: It's apt that we are now looking for work to be done there by him because it fits with some of our …. (inaudible)…. Service development

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: Yes, that's what he's saying.

~~MALE SPEAKER 4: Service development.~~

~~MALE SPEAKER 1:~~ MR YOUNG: So I think …..(inaudible)….. ~~for~~ before that theatre is now shifted sideways is that we can use the opportunity of getting him in and doing his vasectomies and --

~~MALE SPEAKER 4:~~ MR GLACKIN: And doing Botoxes or something.

~~MALE SPEAKER 1:~~ MR YOUNG: And doing -- using that session for it.

~~MALE SPEAKER 2:~~ MR O'DONOGHUE: Is he part of our team or is he …. (inaudible)

~~MALE SPEAKER 3:~~ MR HAYNES: Associate specialist in General Surgery. ~~(inaudible).~~

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: No, it's General surgery and he's named for the rota in general surgery but he has an interest in urology.

MR O'BRIEN: But as blue sky thinking, along the lines that Tony is talking about I must say

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as the number of referrals relentlessly increase I do think actually should we not be thinking about how we could have a ~~new clinic~~ New Clinic at South Tyrone. I often look at -- I'm reading a referral and it is an [redacted], or whatever, and I am thinking of Tony doing a clinic and I know how the structure has been, that we have the ~~new clinic~~ New Clinic here, particularly when red flags and cancers and timelines are very much an integral part of that structure, but is there any reason why the New Clinic -- we can't have a New Clinic set up in south Tyrone, we couldn't have a New Clinic set up in Daisy Hill, and, so long as it pertains, because effectively what I run is I run a New Clinic ~~new clinic~~ set up by ordering the CTUs and so forth in Enniskillen, and I am sure you do likewise, would that not ease ~~easy~~ the load make it more logistically feasible and maybe even more efficiently in many ways.

~~MALE SPEAKER 2:~~ MR HAYNES: ~~Problem (inaudible)~~ The problem is no outpatient space. Both. So Daisy Hill,. No out ~~and out~~ patient space and South ~~south~~ Tyrone, ~~and out patient~~ no outpatient space.

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: The only thing about South Tyrone now --

~~MALE SPEAKER 3:~~ MR HAYNES: The only think we've always had an advantage is that the Thorndale Unit ~~(inaudible)~~ is ours. So we have been able to flex up and down within our own space.

MR O'BRIEN: Yes. And I do know when I was lead and when I was preparing for and when -- in fact on the day that we were peer reviewed, it seemed to be an issue that was stood upon by the peer review panel that, you know, we did not see new patients, new cancer patients, at outlying clinics. In fact I do and have done since because I just do, particularly Fermanagh. In fact that's the only --

~~MALE SPEAKER 1:~~ MR YOUNG: That's because we have facility there.

MR O'BRIEN: Mmm?

~~MALE SPEAKER 1:~~ MR YOUNG:: That's because we have facility there. Martina, what were you going to tell us there?

~~FEMALE SPEAKER 1:~~ MARTINA CORRIGAN: No ~~south~~ South Tyrone…. (inaudible)… I have to go and speak to staff, but it looks like we are going to be losing ~~(inaudible)~~ eyes out of it …

(Ms Corrigan, Head of Service, left the meeting.)

(**Audio ends**)

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From:
Sent:
To:

-----Original Message-----
From: Corrigan, Martina [redacted]
To: [redacted]; Glackin, Anthony [redacted]; Haynes, Mark [redacted] Young, Michael [redacted]; O'Brien, Aidan [redacted]; ODonoghue, JohnP [redacted]; Tony Glackin [redacted]
Sent: Mon, 12 Nov 2018 12:52
Subject: UROLOGY lists from December

Dear all,

I am hoping to discuss this in more detail on Thursday but I have to in principle let Theatres know what is happening as they need this for the off-duty

You may be aware that Urology will be getting their 11 inpatient operating lists reinstated from 3 December 2018.

The way that this will work is as follows:

All day Monday
All day Tuesday
All day Wednesday
All day Thursday
All day Friday plus 1,3 and 4th week PM list and 2nd Friday AM list

I am aware that there is no list normally on Thursday but we have to use this all-day and we cannot give up any lists, we have to remember that we have Derek in as an extra consultant so we need to ensure that he and Thomas uses the lists when one of you are doing UOW etc...

Can I suggest the following:

All day Monday – Mark (apart from when he is UOW and then Derek to do)
All day Tuesday – alternating between Michael and John
All day Wednesday – alternating between Aidan and John
All day Thursday – this will be either Michael/John/ Aidan or Thomas (before I went off on leave I know that Derek could not work Thursday so I am assuming that this is still the case?)
All day Friday – Tony and 1,3 and 4th week PM list and 2nd Friday AM list – Thomas

So in doing this I have had a look at December scheduling and therefore would suggest as follows:

Week one – 3rd December
Monday – Derek AM and PM (Mark is UOW)
Tuesday – Michael AM and PM
Wednesday – Aidan AM and PM
Thursday – John AM and PM
Friday – Derek AM and PM (Tony study leave) and Thomas PM

Week two – 10 December
Monday – Mark AM and PM
Tuesday – John AM and PM
Wednesday – Derek AM and PM (Aidan on AL)
Thursday – Michael AM and PM

Friday – Tony AM and PM and Thomas AM

Week three – 17th December
Monday – Mark AM and PM
Tuesday – Michael PM (audit in AM)
Wednesday – Aidan AM and PM
Thursday – John AM and PM
Friday – Derek AM and PM (Tony UOW) and Thomas PM

Week four – 24 December
Monday – Mr Young PM (Mark AL)
Tuesday – Christmas Day
Wednesday – Boxing Day
Thursday – Thomas AM and PM
Friday – Tony AM and PM and Thomas PM

Week five – 31 December
Monday – Mark AM and PM

Can you have a look at this please and let me know thoughts and comments for tomorrow at the latest and if I don't hear from you I will be assuming that this is ok and therefore I will be letting theatres know.

Thanks

Martina

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

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

From:
Sent:
To:

-----Original Message-----
From: O'Brien, Aidan [Aidan O'Brien's email address]
To: Corrigan, Martina [Martina Corrigan's email address]; [Aidan O'Brien's email address]; [Michael Young's email address]; Glackin, Anthony [Anthony Glackin's email address]; Haynes, Mark [Mark Haynes's email address]>; Young, Michael [Michael Young's email address]>; ODonoghue, JohnP [John P O'Donoghue's email address]>; Tony Glackin [Anthony Glackin's email address]
Sent: Mon, 12 Nov 2018 21:29
Subject: RE: UROLOGY lists from December

Martina et al,

I welcome the belated acknowledgement that the allocation of theatre sessions to our specialty has been disproportionately inadequate.
I hope that this reversal of fortunes may also be an indication of an acceptance of the suffering and risk of mortality endured by hundreds of our patients awaiting admission for surgery.
I wish to take this opportunity to acknowledge Mark's contribution to this recent increased allocation of theatre sessions.

I only have two caveats:

- It has always been my view, and it remains so, that the only cohort of patients at proportionately greater risk than those awaiting admission, is that group of patients who have been admitted, whether acutely or electively, and who remain as inpatients. Therefore, it is my view that the handover, consultant led, ward round on Thursday mornings should not be sacrificed or compromised by the availability of a theatre session on Thursday mornings.
- I would also be concerned that the utilisation of the available theatre session on Thursday afternoons will erode attendance at MDM. However, if I had to make the choice, I would prefer to have even one more patient have his or her surgery than having an extra consultant attend MDM, so long as there will be two consultants attending MDM to ensure its quoracy.

Aidan.

From: Corrigan, Martina
Sent: 12 November 2018 12:52
To: [Aidan O'Brien's email address]); [Michael Young's email address]; Glackin, Anthony; Haynes, Mark; Mark [Mark Haynes's email address]; Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; [John P O'Donoghue's email address]; Tony Glackin [Anthony Glackin's email address]
Subject: UROLOGY lists from December

Dear all,

I am hoping to discuss this in more detail on Thursday but I have to in principle let Theatres know what is happening as they need this for the off-duty

You may be aware that Urology will be getting their 11 inpatient operating lists reinstated from 3 December 2018.

The way that this will work is as follows:

All day Monday

Angela Kerr

From:
Sent:
To:

-----Original Message-----
From: Corrigan, Martina [Personal Information redacted by the USI]
To: [Aidan O'Brien's email address] [Michael Young's email address] Glackin, Anthony [Anthony Glackin's email address]; Haynes, Mark [Mark Haynes's email address] Young, Michael [Michael Young's email address] O'Brien, Aidan [Aidan O'Brien's email address] ODonoghue, JohnP [John P O'Donoghue's email address]; Tony Glackin [Anthony Glackin's email address] >
CC: McCaul, Collette < [Personal Information redacted by the USI] >; Robinson, Katherine < [Personal Information redacted by the USI] Dignam, Paulette < [Personal Information redacted by the USI] Elliott, Noleen < [Personal Information redacted by the USI] >; Hanvey, Leanne < [Personal Information redacted by the USI] >; Loughran, Teresa < [Personal Information redacted by the USI] >; Robinson, NicolaJ < [Personal Information redacted by the USI] >; Troughton, Elizabeth < [Personal Information redacted by the USI] >
Sent: Mon, 17 Dec 2018 17:06
Subject: January theatres

Dear all

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

Therefore the following lists are no longer available for Urology:

Thursday PM 10th January – Mr Hennessey (NOTE AM will still go ahead)
Friday PM 18th January – Mr Jacob
Thursday PM 24th January – Mr Young (NOTE AM will still go ahead)

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

Regards

Martina

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

Telephone: [Personal Information redacted by the USI]

Angela Kerr

From: Corrigan, Martina [redacted]
Sent: 22 January 2019 11:00
To: Hasnain, Sabahat; Evans, Mark; Hiew, Kenneth; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael; McCourt, Leanne; McMahon, Jenny; ONeill, Kate; Young, Jason
Subject: FW: RF 1st Appointment Longest Wait.xlsx
Attachments: RF 1st Appointment Longest Wait.xlsx

Importance: High

Good morning

FYI

Regards

Martina

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

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

From: Graham, Vicki
Sent: 21 January 2019 11:44
To: Nelson, Amie; Carroll, Kay; Clarke, Wendy; Clayton, Wendy; Conway, Barry; Corrigan, Martina; Devlin, Louise; Glenny, Sharon; McAreavey, Lisa; McVey, Anne; Reddick, Fiona; Scott, Jane M
Cc: Carroll, Ronan
Subject: RF 1st Appointment Longest Wait.xlsx
Importance: High

Morning,

Please see attached updated waiting times for RF 1st OPD's.

Regards,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT [redacted]

RF Longest Wait

	21/01/2019	28/01/2019
Breast	11	
Gynae	5	
E-Gynae	6	
ENT	10	
Surgical (GPC)	11	
Surgical (OC)	10	
E-Gastro	10	
Gastro	7	
Urology (Prostate)	**67**	
Urology (Haematuria)	**60**	
Urology (Other)	31	
Lung	10	
Skin	6	
Oral Surgery	20	

From: Elliott, Noleen [redacted]
Sent: 12 May 2016 14:42
To: O'Brien, Aidan
Subject: FW: Scheduling

Importance: High

Aidan,

Please see e-mail below from Angela Cunningham to secretaries for your information. This is yet another task that management are expecting secretaries to do. I do not think it is the responsibility of the secretary to ensure patients are operated on in chronological order rather than on clinical need.

Regards.

Noleen

From: Cunningham, Andrea
Sent: 12 May 2016 13:00
To: MAXWELL, Sharon; Hare, Nicola; Richardson, Shirley; McStay, Sarah; Magee, Lisa; Heslip, Jennifer; OHagan, SineadM; Sullivan, Claire; OReilly, Janice; Renney, Cathy; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Troughton, Elizabeth; Robinson, NicolaJ; Loughran, Teresa; Cowan, Anne; Hall, Pamela; Wortley, Heather; Mulholland, Angela; Cooke, Elaine; Burke, Catherine
Cc: Coleman, Orlagh
Subject: Scheduling
Importance: High

Dear All,

All secretaries/schedulers should be using the PTL reports populated in the shared folder to add comments e.g. long waiters to provide updates of what is happening with the patient and an explanation of why they have not been seen so far.

Any discussion, offers or other detail should be updated in the shared folder to evidence chronological and appropriate management of patients/waiting lists. **This is not routinely happening despite specific instructions to do so back in November 15.**

It is essential that all staff action at least on a monthly basis waiting list reports (including planned) and suspension reports.

It is good practice to run your own WL report and put 'All' for diagnostic groups so that you are not missing anyone. Suspension reports should be run monthly as well and all patients should come out of suspension on the 1st of the month. Patients should not be suspended for longer than 3 months in total. Dates in the past should be updated on a regular basis.

Any queries please let me know.

Regards

Andrea

Andrea Cunningham
Service Administrator
Ground Floor
Ramone Building
CAH

E: [redacted]
T: [redacted]

Personal Information redacted by the USI

Response of Department of Urology
To
Trust's Proposals for Ward Reconfiguration

The members of the Department of Urology in attendance at the meeting of the Clinical Forum of Tuesday 12 May 2009 were invited to consider the Trust's initial proposals for Ward Reconfiguration in conjunction with the discussions which took place at that meeting, with a view to returning to the next meeting of the Clinical Forum on Tuesday 26 May 2009 with their own reflections and/or proposals for the way forward.

Those members have met with others on two occasions since then. Arising from those meetings, this paper attempts to encapsulate our understanding of the challenges faced by the Trust in the future delivery of surgical services in general, in addition to the challenges faced by the Trust and our Department in implementation of the recommendations of the Regional Review of Urology Services in Northern Ireland. It seeks to articulate core values and principles which we believe should be safeguarded in meeting those challenges. It details proposals which we believe are constructive and essential if the challenges are to be met with success. Lastly, they are proposals to which all members of our Department would be wholly committed, in partnership with the Trust, in ensuring that success.

Challenge facing the Trust

It is our understanding that the Trust is presented with the need to deliver surgical services during the current financial year with a reduced budget. It is also our understanding that it is anticipated that the Trust will be required to deliver surgical services during coming years with possibly more stringent budgetary conditions.

We also understand that the Trust is required to comply with the Elective Reform Program (ERP), Developing Better Services (DBS), and the Integrated Elective Access Protocol (IEAP). We appreciate that the Trust is required to implement the measures recommended by the Scheduled Care Reform Program (SCRP), including

- Preoperative assessment, to facilitate
- Admission on day of surgery, and
- Increased day surgery rates, and
- Reduction of cancelled operations
- Maximising use and productivity of theatres

We appreciate that the Trust will be expected to benchmark their performance in these areas.

Lastly, it is our understanding that Trust management have concluded that introduction and implementation of these measures would enable the Trust to comply with HSC expectations and to remain within imposed budgetary constraints, while

continuing to provide quality elective and non-elective surgical services with such capacity as to meet demand.

Regional Review of Urology Services in Northern Ireland

A regional review of Urology Services in Northern Ireland was established in September 2008 and reported in March 2009. The stated purpose was to '*develop a modern, fit for purpose in 21st century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal Colleges, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.*'

The report of the review presented a modernisation and invested plan. It presented 26 recommendations to be implemented by all Trusts and Departments of Urology in Northern Ireland. Fundamental to all is the recommendation that all Urological services in Northern Ireland should be reconfigured into a 3 Team model (known as Team North, Team East and Team South), to achieve long term stability and viability. Each Team is to have '*main, acute, elective and non-elective, inpatient unit*'.

Team South is to provide Urological services to the southern third of the current Western Trust area (County Fermanagh, population circa 61,000), in addition to all of the current population of the Southern Trust area (342,754): an increase of approx. 20%. Team South will require 5 Consultant Urologists and will have its main, acute, elective and non-elective, inpatient unit at Craigavon Area Hospital. Day surgery will be conducted at Craigavon Area, Daisy Hill, South Tyrone Hospitals. Outpatient clinics will be conducted at Craigavon Area, Daisy Hill, South Tyrone and Armagh Community Hospitals as well as Banbridge Polyclinic, as at present. In addition, it is recommended that Team South may wish to consider the provision of outreach clinics and/or day case diagnostics at the Erne Hospital, Enniskillen.

Therefore, the Review has established that its purpose requires the reconfiguration of Urological Service provision in Northern Ireland by three Teams, and that each Team requires a Urology Unit in its main, acute hospital.

Non-elective Urological Services

There are approx. 2,500 non-elective urological admissions per annum in Northern Ireland (Report 3.18). There are only two Urology Units (at Belfast City and Craigavon Area Hospitals) to which acute admissions are admitted directly or subsequently transferred, if required (Report 3.22). Team North should also have a *'main acute unit'* for non-elective admissions (Report 9.6). The Report's Recommendations 7 and 8 state that Urologists *'should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit...and for those requiring direct transfer and admission to an acute Urology Unit'*. With specific relevance to Team South, Recommendation 9 states that *'Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under*

General Surgery in hospitals without Urology Units (e.g., Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit, and provision of Urology advice/care by telephone, electronically or in person, also 7 days a week'.

Therefore, the Review has emphasised the need for each Team to have a Urology Unit to which acute urological admissions can be admitted directly or transferred, and from which the care of those admitted elsewhere can be advised, monitored, supervised. Moreover, with the implementation of Development of Better Services (DBS) in future years, increasing proportions of acute urological admissions will be admitted directly to Urology Units.

Reducing Length of Stay (LOS)

The Review's recommendations 13 and 14 states that *'Trusts should implement the key elements of the elective reform program...and should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients...with a view to agreeing a target length of stay for these groups of patients'.*

In doing so, the Review acknowledged that some hospitals would expect to have longer than average LOS if they undertake more complex operations, treat patients with greater comorbidity and patients with higher levels of social deprivation (Report 5.14).

The Review also stated that ERP will require Urology Services to be creative in the development of day and short stay surgery, *'ensuring the provision of a safe model of care that provides a quality service to patients'* (Report 5.22).

Therefore, the Review requires a benchmarked reduction in Length of Stay whilst ensuring a safe, quality service to patients.

Day Surgery

The Review noted the implications of the Audit Commission recommendations for day surgical rates across a number of surgical specialties, and the more specific recommendations of the British Association of Day Surgery (BADS) for day surgical rates for 31 urological procedures (Report 5.19). Review recommendation 15 states that *'Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery... '.*

Importantly, the Review states that Trusts will need to *'consider procedures currently undertaken using theatre / day surgery facilities, and the appropriateness of transferring this work to procedure / treatment rooms, thereby freeing up valuable theatre space to accommodate increased day surgery'* (Report 5.23).

Therefore, the Review wholly requires Trusts and Urology Teams to maximise day surgery rates and to be creative in that endeavour.

Values and Principles

With all of the relentless challenges that we all have to face and for which we will be held accountable, whether collectively or individually, whether manager, doctor or nurse, we believe that it is critically important to reflect upon and to redefine our *raison d'etre.* In the context of considering ward reconfiguration, *we are a hospital.*

Several of the component activities of an integrated Urology Service detailed in the Review Report (some, such as ICATS, not referred to above) need not be conducted in a hospital at all, though for several reasons, we believe that it is preferable. However, the one component that can only be conducted in a hospital is the care of those so ill, or requiring management so significant, as to require inpatient care.

We believe that urological inpatient care can only best be provided by doctors and nurses fully trained, qualified, competent and experienced in urological inpatient care. This belief is wholly and unreservedly supported by the British Associations of Urological Surgeons and Nurses, in recent publications and communications.

Therefore, we believe that it is self-evident that the only manner in which such urological inpatient care can possibly be provided is in a distinct, dedicated, inpatient Urology Unit.

The provision of such a Urology Unit is compliant with the Recommendations of the Regional Review.

We believe that it is equally self evident that all urological inpatients should be managed in the Urology Unit, whether elective or non-elective, and irrespective of their length of stay.

We believe that elective, urological, day surgery should be provided in adequately resourced units which do not compromise the ability to maximise inpatient care.

Lastly, we assert that it is incumbent upon all to have robust evidence to support any claim that any different model proposed for urological inpatient care provides for a quality of care and clinical outcomes superior to that above.

Proposals

1. The Trust should firstly explore the possibility of moving all elective flexible cystoscopies out of day surgical theatres and into outpatient procedure rooms. This would be particularly worthwhile at CAH, moving flexible cystoscopies from DSU to the Thorndale Unit. This alone would free up six theatre sessions per month for elective day surgical procedures. Similar possibilities should be explored at STH and DHH.
2. The Trust should maximise the provision of adequately resourced, elective, day surgical facilities at all sites, so as to minimise the inappropriate use of inpatient beds for day surgery.
3. With reservations, we commit to trying the elective admissions ward for elective day cases who cannot be accommodated elsewhere. They will be admitted to that ward, and will return to it following surgery, and be discharged from there.
4. With greater concerns regarding continuity of care, we commit to having elective, short stay patients admitted on the day of surgery to that elective admissions ward, but only on condition that they return postoperatively to the Urology Unit.
5. All longer stay, elective admissions will be admitted to the Urology Unit, and remain there until discharge.
6. All non-elective admissions will be admitted directly to, or transferred to, the Urology Unit.
7. The Urology Unit will be singular and distinct. Any compromise of its integrity would disable implementation of the Regional Review.