Assistant Director of Acute Services
Functional Support Services
5 Hospital Road
Newry
Co. Down
BT35 8DR

Tel: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI

From: Dougan, David
Sent: 26 June 2013 17:32
To: Laverty, Peter
Cc: Carroll, Anita; Forde, Helen; Robinson, Katherine; Cassells, Carol
Subject: RE: Acute Directorate Admin Staff / AFC Band Uplifts

Hi Peter,

Some work is probably needed here and I am trying to understand how we take it forward.

We had identified two particular areas as problem areas:
· The Band 5's were not fully funded, can we identify if any of the Band 5 in our list have came out of AFC with an uplift from Grade 4?
· Also there seemed to be a view that the Grade 3 Medical Secretaries have come out as Band 4 could we get a list of them as well.

Would you be able to take this forward with the AFC team in the first instance?

Regards
David

From: Laverty, Peter
Sent: 26 June 2013 15:41
To: Carroll, Anita; Forde, Helen; Robinson, Katherine
Cc: Dougan, David
Subject: Acute Directorate Admin Staff / AFC Band Uplifts

Dear all,

I have had a conversation with the AFC Team and they have confirmed with me that when staff have received an uplift in Banding under AFC this information may not have been sent to the Financial Management Team.

David - this may explain why some of the discrepancies in Banding/funding allocations in some of the Cost Centres.

More than happy to discuss should any further information be needed

Regards,

Peter

Peter Laverty
HR Officer
Case Management/Pay & Employment Services Employee Engagement & Relations Section Human Resources Department The Hill Building Loughgall Road ARMAGH
BT61 7NQ

Telephone No: Personal Information redacted by the USI

From: Carroll, Anita
Sent: 22 December 2016 13:59
To: Carroll, Ronan <[redacted]>
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Maybe we can get a chat about this

From: Robinson, Katherine
Sent: 20 December 2016 17:07
To: Carroll, Anita
Subject: FW: Backlog report - no clinic outcomes
Importance: High

See attached list. This is a list of clinics that Mr O,Brien has not dictated on and hence no outcome for some of these patients. There is a risk that something could be missed so I am escalating to you, although I know that a lot of the time Mr O'Brien knows himself what is to happen with patients. Unfortunately this was not highlighted on the backlog report. The secretary assumed we knew because there have always been issues with this particular consultant's admin work from our perspective.

As learning from this discovery I have asked all secretaries to provide this information on the backlog report so that we fully understand the whole picture of what is outstanding in each specialty. The secretary also advises that at present Mr O'Brien is working on some of his backlogged admin work as he is off sick recovering.

Regards

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Cunningham, Andrea
Sent: 19 December 2016 13:09
To: Robinson, Katherine
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Update as discussed.

Regards

Andrea

Andrea Cunningham
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by the USI
T: Personal Information redacted by the USI

From: Elliott, Noleen
Sent: 15 December 2016 14:04
To: Cunningham, Andrea
Subject: Backlog report - no clinic outcomes

Andrea,

Please find attached list of clinics with no outcomes completed as per 15th December 2016.

Noleen

Mrs Noleen Elliott
Mr O'Brien's Secretary
Level 2
CRAIGAVON AREA HOSPITAL
Tel No: Personal Information redacted by the USI

DATE	CLINIC	CLINIC CODE
24/11/2014	SWAH	EUROAOB
22/12/2014	SWAH	EUROAOB
12/01/2015	SWAH	EUROAOB
23/02/2015	SWAH	EUROAOB
09/03/2015	SWAH	EUROAOB
13/04/2015	SWAH	EUROAOB
11/05/2015	SWAH	EUROAOB
22/06/2015	SWAH	EUROAOB
06/07/2015	SWAH	EUROAOB
28/09/2015	SWAH	EUROAOB
19/10/2015	SWAH	EUROAOB
02/11/2015	ARMAGH CLINIC	AAOBU1
06/11/2015	URODYNAMICS CLINIC	CAOBUDS
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01/04/2016	UROONCOLOGY CLINIC	CAOBUO
04/04/2016	REVIEW CLINIC - CAH	CAOBTDUR
08/04/2016	UROONCOLOGY CLINIC	CAOBUO
15/04/2016	UROONCOLOGY CLINIC	CAOBUO
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From: Carroll, Anita <[redacted]>
Sent: 05 January 2017 16:01
To: Robinson, Katherine <[redacted]>
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Katherine could you run a clinic attendance report starting with oldest that we could use to send to mr o brien to write on outcomes
A

From: Robinson, Katherine
Sent: 20 December 2016 17:07
To: Carroll, Anita
Subject: FW: Backlog report - no clinic outcomes
Importance: High

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Regards

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Cunningham, Andrea
Sent: 19 December 2016 13:09
To: Robinson, Katherine
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Update as discussed.

Regards
Andrea

Andrea Cunningham
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by the USI
T: Personal Information redacted by the USI

From: Elliott, Noleen
Sent: 15 December 2016 14:04
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Noleen

Mrs Noleen Elliott
Mr O'Brien's Secretary
Level 2
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04/11/2016	UROONCOLOGY CLINIC	CAOBUO

From: Carroll, Anita <[redacted]>
Sent: 12 November 2018 12:35
To: Robinson, Katherine <[redacted]>
Subject: RE: Urology KSFs

Thanks K

From: Robinson, Katherine
Sent: 08 November 2018 15:27
To: Carroll, Anita; Corrigan, Martina; Carroll, Anita
Subject: FW: Urology KSFs
Importance: High

Keeping you all in the loop re this specialty. Am trying to secure funding re WLI route, but if anyone has any suggestions let me know. I suspect Mr Obrien's activity at triage needs recorded as virtual.

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: McCaul, Collette
Sent: 07 November 2018 17:00
To: Robinson, Katherine
Subject: Urology KSFs
Importance: High

Katherine

As you are aware I carried out Urology KSFs for Urology over the last couple of days.

A few concerning things have come to light. The majority of the secretaries are feeling extremely under pressure with the work load currently. Although this is not reflected when we look at the backlogs(mainly because they are staying over to get stay up to date). This has only come to light whilst doing these KSFs and has never been mentioned before nor have I been contacted regarding any issues and I been up on a regular basis to both offices. May I add that I have had some very upset, emotional and just deflated staff at the moment as they feel they have no back up (not management wise but just support

wise admin wise). We have one audiotypist in post with them and one who was seconded to a Band 4 who was never replaced as there was no one on the waiting list for audio typist and this went out 3 times with no one to fill post coming forward.

1. Mr Youngs secretary Paulette has said the Stone MDT and stone treatment work has had an extreme impact on her work day and this is not reflected in activity –ie. Stone outcomes MDT meetings, the typing up of the MDT etc. This is extra work on top of her normal working week which has severely impacted her core work.

2. The e-triage work for Aidan Obrien and Mr Young also as when they are doing their week of e-triage a letter is being dictated on every single patient with an investigation /test/ or information to the patient to let them know what is happening. So not only has this to be recorded on e-triage it also now has attached letter needing typed (nearly like virtual clinic).

Collette McCaul
Acting Service Administrator (SEC)
Ground Floor
Ramone Building
CAH
Ext Personal Information

Kate - Key Priorities 2017/18

Service	SMART Objective	Responsibility	Completion Date	Progress Update
Domestic Services	Review staff working patterns across the Trust.	Kate and Locality Managers	Ongoing	Staff working patterns have been reviewed in community facilities in N/M and A/D. A wider piece of work is required to ensure that starting times and finishing times are appropriate for all sites, and a Lean Project is planned.
Domestic Services	Implement new version of the C4C audit monitoring tool.	Kate and Locality Managers	Ongoing	The new software is still in development stage and a trial in the SE Trust has not been successfully completed. The current version of C4C continues to be used within the SHSCT.
Domestic / Catering / Portering	Complete recruitment exercise to regularise Agency staff.	Kate and Locality Managers	Ongoing	Discussions have been ongoing with Finance which has led to a limited number of posts being released. To date DHH Domestics, C/B Support Services, Lurgan Domestics and Dungannon Domestics have undertaken recruitment exercises. CAH Portering Recruitment Days are 28 February and 1 March. 40 posts have been advertised for CAH Domestics, and this has closed but Recruitment Days to be agreed. CAH Catering, DHH Catering and Portering and the remainder of the CAH Domestic posts will be recruited when released by Finance.
Domestic / Catering / Portering	All staff are up-to-date with their Corporate Mandatory training.	Kate and Locality Managers	Ongoing	The December figures are being compared to previous figures to identify areas for improvement.
Domestic / Catering / Portering	Increase awareness of Major Incident Plans with Managers and Staff.	Kate	Complete	Major Incident Files are now available for all staff in all areas. Awareness has been raised through Support Services Managers Meetings.
Catering Services	Implement the recommendations from the Internal Audit Finance Report.	Kate and Locality Managers	Ongoing	See Audit Report Action Plans
Catering Services	Complete the implementation of Saffron Catering Information System.	Kate and Locality Managers	Ongoing	See Saffron Action Plans
Catering Services	Implement the new Minimum Nutritional Standards for Catering in Health and Social Care.	Kate and Locality Managers	Ongoing	A working group has been established to take this forward and Support Services is represented on this group. Audits of compliance against the Standards have commenced.
Portering / Security	Continue to monitor the performance of the postal contract.	Kate and Locality Managers	Complete Dec 2017	The postal contract with Whistl was terminated and a new contract with Postal Sort commenced on 6/12/2017. The new contract was successfully implemented with minimum disruption to the service.

Helen - Key Priorities 2017/18

Service	SMART Objective	Responsibility	Completion Date	Progress Update
Head of Health Records	Review ED Admin Rota	H Forde N Terris and ED Working Group	Apr-18	Analysis of peaks and troughs in patient activity to be carried out - graphs prepared. Workshop with staff and union representation to be arranged in Sept 17 to look at rota in terms of needs of the service. ED workshop held Jan 18 and agreement on the process and membership of the group agreed with HR and Unions
Head of Health Records	Moving of ED typing to new clinic templates	H Forde N Terris	Apr-18	changes in eEMS - project deferred, but looking at changing process and not typing clincs.
Head of Health Records	Continue with destruction of records in OASIS	H Forde K Watters P Lawson	ongoing	Ongoing
Head of Health Records	Pilot scanning of MIU documentation onto eEMS	H Forde BSO Konica Minolta	Need installation of new MFDs	MFDs now updated to allow scanning of A4 and A3 documents and tested on 23/1/18 and scanned documents (training system) went through to the patient record. BSO have some work to do before we can progress into testing in live.
Head of Health Records	Look at Electronic tracking of charts and cost efficiencies	Helen		9/8/17 met with Catherine Weaver to discuss. SET implementing system and visit in November to be arranged so we can see the system in operation. CW to get initial basic costs of implementation. RVH have implemented system mid Jan 18 and will host a visit in a month when issues are resolved. Feedback is that the system is working well.
Head of Health Records	Carry out TNA on the IT skills of staff and identify how to upskill staff	Helen and Managers		TNA completed. Need now to look at the forms and develop a training programme to upskill staff.
Head of Health Records	Develop a Manager's induction	Helen and Managers		Being piloted with Nicola Terris (Jan 18)
Head of Health Records	Run a Supervisors Development Programme	Helen and Managers		Commenced in Jan 18 - will run to May 18.
Head of Health Records	Increase electronic methods of working for admin staff in ED and on the wards	Helen and Managers		
Head of Health Records	Work with BSO to develop barcoded labels to include HCN on eEMS	Helen and BSO		Implemented in CAH on 31/1/18. To be implemented in DHH in Feb 18.
Head of Health Records	work with BSO to see if voice recognition works with eEMS	Helen and BSO		Visit to be arranged with Edith Doyle and members from BSO

Katherine - Key Priorities 2018/19

Service	SMART Objective	Responsibility	Completion Date	Progress Update
Admin & RBC	Review and update Major Incident Plan and Actions for RBC staff	K Robinson	ongoing	role of RBC not entirely clear, need Trust position on this
Admin & RBC	Activity Analysis for all secretarial areas with a view to providing more equitable support to Clinicians	K Robinson Service Administrators	ongoing	always changing due to increase/decrease in services, consultants being placed on different sites etc, sec support on another site
Admin & RBC	Ongoing work with developing admin processes and crib sheets	K Robinson Service Administrators	ongoing	well under way, this year to concentrate on all the investigative areas; cardiac investigations, respiratory investigations etc
Admin & RBC	KSF - continue this for all staff	K Robinson Service Administrators	ongoing	very difficult given time constraints
Admin & RBC	Participate in Regional CCG group	K Robinson		ongoing
Admin & RBC	Review Staff Induction and general training	Katherine & SA	ongoing	Well underway, continually being updated and added to.
Admin & RBC	Data Quality issues to be addressed	Katherine & SA	ongoing	Ongoing meetings and dialogue with Data Quality team to get this sorted.
Admin & RBC	Working on recording virtual activity for most specialties	Katherine, Conor M and Lesley Ann	ongoing	Lots of recording issues surrounding this, big piece of work.
Admin & RBC	E' Triage	Katherine & Christine	ongoing	Started, Gynae, Urol, Paeds complete, next specialty General Surgery, then Cardiology
Admin & RBC	Establish Check lists for SA to ensure patients are not being missed and are being actioned appropriately	Katherine & SA	ongoing	well underway, checks for DARO, checking patients have been added to waiting lists. Proper spot checks of offices.
Admin & RBC	IMWH - go through all the processes for this area, assist new manager etc, with a training programme	Katherine	Dec-18	
Admin & RBC	Roll out of new policy of DNA/IEAP	Katherine & Anita	Jun-18	awaiting final version from Aldrina
Admin & RBC	Work on budget amalgamating some cost centres	Katherine	Apr-18	Meeting with Alan Mahon
Admin & RBC	Risk Assessments for all areas (Health & Safety)	Katherine & SA		was completed but with some changes to offices, needs revisited.

Helen & Katherine - Key Priorities 2017/18

Service	SMART Objective	Responsibility	Completion Date	Progress Update

Joint Admin	Assist with the implementation of the Electronic Document Transfer Project	K Robinson H Forde	as per Project group	Alerts currently being managed. Letter templates confirmed Awareness given to admin staff Awareness sessions to be set up Project cancelled per Siobhan Hanna
Joint Admin	Process map ED, virtual ward, AMU with Helen's team to sort recording issues and paperwork	Katherine & Helen		
Joint Admin	Develop an Admin Recruitment model			April 18 - waiting for the outcome of the Ward Clerk review
Joint Admin	Work with OSLs in developing a Major Incident flow of information model			Two meetings held on 7/9/17 and 25/10/17. Worked through the Information Flow. Queries identified with the model and these have been sent to Teresa Cunningham to address. No further progress can take place until the queries are answered. 12/3/18 sent a reminder to Teresa re outstanding queries. Also informed Teresa that this is outside of the Health Records and ED role so Helen would no longer be part of the group working on this.

Sandra - Key Priorities 2017/18

Service	SMART Objective	Responsibility	Completion Date	Progress Update
Decontamination Services	Carry out a complete review of the ISO quality management system in the SSDs to maintain accreditation of the management system.	S McLoughlin	Mar-18	On going but needs to be completed by June 2018
Decontamination Services	Carry out annual customer survey and analyse the results.	S McLoughlin / M Harbinson	Mar-18	still to be completed
Decontamination Services	Seek assurance from HoS that daily checks are being completed on bedpan washer disinfectors throughout the Trust.	S McLoughlin	Jan-18	Approx 50% have given assurance. A reminder e-mail has been sent.
Decontamination Services	Participate in the short life working group set up by DHSSPSNI to review the decontamination of specialist probes	S McLoughlin	on going	Fe 18 - trophon system commisioning reports have been forwarded to AE(DA) for auditing. Once approved the trophon systems will be put into use.
Decontamination Services	Represent Trust on regional CAG for decontamination chemicals	S McLoughlin	Dec-17	completed. Framework in place from 1-12-17

Laundry Services	Carry out a satisfaction survey with users in the Southern Trust and Belfast Trust and analyse the results.	G White	Mar-18	completed
Laundry Services	Participate in the re-tender for laundry chemicals as part of a regional contract to include the trial of products. Extend the current STA for another 6 months or until a new supplier is appointed.	G White	Dec-17	completed
Laundry Services	Complete business case for replacement equipment	S McLoughlin / G White	Sep-17	Aug 16 - Business case presented to SMT who requested another option to be costed. To be presented again to SMT Feb 18.
CAH Switchboard	Roll out computerised system to manage the rotas within Switchboard	S McLoughlin / C Campbell	Jun-17	completed
CAH Switchboard	In conjunction with Estates roll out the iMessage computerised call management system.	S McLoughlin / C Campbell	Mar-18	iMessage rolled out Nov 17. Still liaising with Estates to use iMessage for emergency planning - dependent on the Estates installation of new phone system and IT replacing mobile phones.

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

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: AD of Functional Support Services **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? __N/A____

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** ☑ **NO** ☐ **Have Post Outline levels been achieved:** **YES** ☐ **NO** ☐ **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** I feel I work to my brief + cover all of my responsibilities. **Line Manager's Feedback on staff members performance over past year:** Anita delivers highest standards across all of FSS. Her annual report was highly commended @ Trust Board due to the breadth & depth of work covered. She is self-managing & drives innovation whilst acknowledging the staff support she has

Objectives for Next Year:

1. Ensure ongoing robust food hygiene arrangements and monitoring of same throughout all production kitchens
2. Rollout use of Saffron (Catering system) in main production kitchens
3. Work in conjunction dietitians on the nutritional strategy in the workplace to make changes in the Dining rooms and coffee bars to provide healthier options
4. Ensure and oversee arrangements to maintain high standards of Environmental Cleanliness throughout the Trust
5. Roll out use of Micad Cleanliness monitoring system to all hospitals.
6. Maintain BS EN ISO 13487 2016 accreditation in CSSD and BS EN ISO 9001 2015in Laundry.
7. Maintain all 4 controls assurance standards (Food Hygiene, Decontamination, Security and Environmental Cleanliness). Decontamination now part of medical device control assurance standards.
8. Maintain sound financial management arrangements in FSS Division.
9. Project Management of the Acute Return to Balance project.
10. Represent SHSCT on Regional task and finish group for IEAP
11. Roll out scanning of documentation to EEMS

Reviewee Staff Name (Print) _Anita Carroll Personal Information redacted by USI Signature Personal Information redacted by USI Date 2/9/19

Reviewer Manager/Supervisor (Print) Personal Information redacted by USI Signature Personal Information redacted by USI Date 2/9/19

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

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: [redacted]

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	n/a	
	Departmental Induction/Orientation	n/a	
	Fire Safety	13/03/2019	
	Information Governance Awareness	29/11/2017	
	Equality & Human Rights	14/12/2017	
	Moving and Handling	04/12/2017	
	Infection Prevention Control	30/07/2019	
	Equality, Good Relations and Human Rights – Making A Difference	14/12/2017	
Corporate Mandatory Training ROLE SPECIFIC	Safeguarding People, Children & Vulnerable Adults	01/08/2017	
	Waste Management	n/a	
	Right Patient, Right Blood (Theory/Competency)	n/a	
	Control of Substances Hazardous to Health (COSHH)	n/a	
	Food Safety	n/a	
	Basic ICT	n/a	
	MAPA (level 3 or 4)	n/a	
	Professional Registration	n/a	
Essential for Post			
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) _Anita Carroll_ [redacted] Signature [redacted] Date 2/9/19.

Reviewer Manager/Supervisor (Print) _[redacted] Signature [redacted] Date 2/9/19

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL TO: -
[redacted]

Friday 14th December 2018

Noleen asked to see me in her office. I called up around 2pm. Noleen was visibly upset and she then explained that she cannot cope and is feeling very "harassed" by all the questions asked by myself on a Friday regarding Aidan O Briens backlogs etc. This is information that I have been asked to gather regarding Mr Obrien and I then explained to Noleen I was under instruction from my management to obtain this information , that I was unsure as why and that it was a sensitive matter was all I was aware of . I explained as she was our direct link for this information as his secretary we were obtaining what we could from her. Noleen said she found it all very overwhelming and again used the phrase harassed.

She was crying throughout and just said that not once in the 2 years since all this started has anyone ever asked her how it has affected her. She said she felt "she could not do this anymore" and might need to go off.

I then tried to comfort her and tried to reassure her that I knew very little on the matter but that I was not directly doing this to involve or affect her. She went on to say that she no longer wanted to be involved and if management want the information that they should come and get it themselves that "sitting in their ivory tower and getting us (ie myself and her) to do their dirty work".

She said she had a loyalty to Mr O'Brien as her consultant and it felt that we were trying to get her to "shop" him. She didn't want any part of it and that again management should come and get the information themselves. She also had said Mr Obrien was in his office that I could go over and ask him myself. I explained that is not what I was here to do.

Noleen then handed me a leaflet about inclusion and had highlighted the C area saying we should be clear on why we are doing something (management) but that she felt we were not being clear with our intentions of why this information is needed. I again reiterated that I knew nothing regarding what was going on or why this information was needed and explained if I knew any information I would have made clear the reasons for gaining this information and that I was following out my duty of being asked to carry this task out.

She then went on to show me the working well together policy with a paragraph highlighted about making work harmonious for the staff but felt this was doing exactly the opposite and again said it felt that all the questions was questioning her fitness for her post. I said I would duly note and take this to my manager Katherine Robinson.

Noleen brought up in this as well about an email I had sent regarding AADs and I had put the title in capitals. She said this felt I was directly shouting at her to get something done but I had told her and apologised she felt this way that that was not my intention that it was just a clerical typo and I was probably doing AADs at speed and never took off CAPS lock. I said my intention was never to

maker her feel that way. She accepted my apology and then had asked why she was sent this and I explained the AAD report is a report we run every month to make sure all outcomes are done and this particular patient flagged but it was no more than a paper exercise. Again I reiterated this was not a direct thing I had asked her to do to single out her that all depts and all secretaries who had patients on that report would have got an email by me.

I then had asked Noleen did she feel she needed me to refer her to occupational health or to CBD or any service her that may help regarding her feelings about all of this and she declined. I told her if she felt she needed some time to let me know and if she was feeling overwhelmed or anything like that in future to please pick up the phone or let me know.

She said she would think about it over the weekend and let me know on Monday (17th December). I again told her my door was always open and that she could come to me at any time.

Collette McCaul

Acting service Administrator

Noelene Elliott 18/12/18

Had to go to Noelene's office to chase up on follow up of some patients that I had received queries on.

- Noelene advised that AOB had confided in her.

- I reassured her we were not harassing her but needed to get evidence from her re follow up of patients etc. All part of whatever was going on. Advised that I was being asked for the information and I had to do my job.

- She said AOB is putting up a 'big fight'

- And that actually as part of the investigation the Trust had caused harm to patients by sending charts back to file without dictation (Martina and cancelling clinics, these patients were only being seen now. He was told to cancel clinics to get some admin work done.

- Advised that she was doing on average 50 triage letters per week and in fact AOB was more thorough that any other consultant.

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 03 March 2017 20:45
To: Trouton, Heather <Personal Information redacted by the USI>
Subject: Fw: admin pressures

Really appreciate this heather

Sent from my BlackBerry 10 smartphone.

From: McAlinden, Matthew <Personal Information redacted by the USI>
Sent: Friday, 3 March 2017 16:22
To: Robinson, Katherine; Forde, Helen
Cc: Carroll, Anita; Glenny, Sharon; Magee, Brian; McIlroy, Cathie; McStay, Patricia; Reddick, Fiona; Robinson, Jeanette
Subject: FW: admin pressures

Dear Katherine and Helen,

In regards to below email from Anita, Heather would like to invite you to have a monthly slot in our Heads of Service meetings to discuss all issues pertaining to Admin/Health Records.

This slot will be the first Tuesday of every month from 9.30am to 10.00am.

This will begin Tuesday 7th March.

Many Thanks,

Matthew McAlinden

HSC Southern Health and Social Care Trust

Personal Secretary to Mrs Heather Trouton | Assistant Director of Integrated Maternity & Women's Health and Cancer & Clinical Services Division | Acute Directorate | Admin Floor | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ | Tel: Personal Information redacted by the USI

From: Carroll, Anita
Sent: 02 March 2017 15:51
To: McVey, Anne; Trouton, Heather; Carroll, Ronan
Cc: Forde, Helen; Robinson, Katherine
Subject: FW: admin pressures

Dear AD colleagues

I need to make you aware of tensions within Admin and Clerical areas over a range of issues for eg

- Staff under pressure due to short notice cancellations and additionality, inpatients being cancelled as late as 4pm day before theatre booking.
- Staff under pressure due to plans never being put in place when a consultant leaves/retires/sick leave or returns from maternity leave.
- Staff from the RBC feel they are constantly chasing HOS on answers to emails and can experience long delays .
- Errors by directorates in rotas , clinic code changes results in added pressure
- Admin managers not kept up to date with changes in procedures on wards/directorates which impact on secs. Most recent example is a trial of 2 Surgeons of the week and the impact of this
  - patients are admitted under one consultant, seen by another, tests requested by another, discharged by original admitting consultant. Impact is that the chart goes to the discharging consultant who never actually saw the patient, the result of the test will go back to the consultant who requested it, follow up is needed by consultant the patient was seen by but this is not the consultant who is on PAS. All very confusing.

While I appreciate that service divisions are busy I am faced with staff going to TU colleagues regarding issues . I need you to remind HOS that A and C colleagues need to be kept in the loop and communicated with. Some of these bullet points will not relate to all your teams however there are clear messages, and I know in the past I had asked for inclusion of Service admin staff at specialty meeting if even only for 10 mins so that they can be kept up to date but this has never really embedded.
Katherine is the manager of the services administrators and line management responsibility for secretaries and RBC and I think it would be good to involve her in communications to ensure we get messages down to admin staff , likewise Helen has responsibility for ED, ward clerks and health records and needs to be kept in the loop.

Happy to discuss
Anita

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 16 August 2017 12:07
To: Hynds, Siobhan <Personal Information redacted by the USI>
Subject: FW: Witness Statement - Mrs A Carroll 190517
Importance: High

Small changes

From: Hynds, Siobhan
Sent: 15 August 2017 23:20
To: Carroll, Anita
Cc: Chada, Neta
Subject: Witness Statement - Mrs A Carroll 190517
Importance: High

Hi Anita

Good to hear you are back. Hope you are well!

Please see attached statement from our meeting on 19 May. I would be grateful if you could review and sign and return a copy to me if you are happy with the content.

If you wish to make any changes please highlighted them on the attached document and return for consideration.

Many thanks

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: Personal Information redacted by the USI Mobile: Personal Information redacted by the USI Fax: Personal Information redacted by the USI

Click on the above image for SharePoint: Employee Engagement & Relations information

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Witness Statement

NAME OF WITNESS	**Mrs Anita Carroll**
OCCUPATION	Assistant Director, Functional Support Services
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Friday 19 May 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations
NOTES	The terms of reference were shared prior to the date of statement.

1. My name is Anita Carroll. I am employed by the Southern Health and Social Care Trust as Assistant Director of Functional Support Services. I have held this position from 2007. Within this role I have responsibility for the Referral and Booking Centre.

2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and / or clinical practice of Mr Aidan O'Brien, Consultant Urologist being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.

3. I agreed to answer questions specifically related to the terms of reference previously shared with me.

4. I explained that I became aware of problems with Mr O'Brien's triage in February 2014. I was in attendance at a meeting with Debbie Burns when a triage process was shared and implemented. I understood this was because of problems with triaged letters. I have attached the triage process to my statement for information.

5. The Acute Directorate at that time had in place acute performance meetings which I sometimes attended but ~~and~~ some of my heads of sevice Katherine Robinson and Helen forde attended ~~of the staff from the booking centre attended. Katherine Robinson who is the manager of the booking centre would have attended~~. General issues about triage were discussed and it was felt it was a good opportunity to document a flowchart.

6. I am aware that on a regular basis~~and off~~ Leanne Brown who is~~was~~ the Supervisor in the RBC and who had responsibility for urology would have raised issues regarding triage within her area which is urology . The issues related specifically to Mr O'Brien. These issues were flagged with the Director, the Assistant Director for surgery and the Head of Service for urology.

7. A triage report went out every Friday and there were regular delay issues ~~problems~~ with Mr O'Brien's triage.

~~8.~~ Around December 2015 I sent an e-mail to my Assistant Director colleagues advising that there were delays ~~problems~~. I did not specifically name any Consultant but I highlighted that the triage was not being done in line with the IEAP guidance. I sent this to Heather Trouton, Barry Conway Ronan carroll anne mcvey and Simon Gibson. The purpose of my e-mail was to agree a process whereby if triage was not done and returned the patient would be categorised as per the GP referral. This was agreed at that time. ~~Whilst I was pinpointing the problem at urology, my sense from members of my team was that the problems were specifically with Mr O'Brien's triage.~~

8.

9. The default process commenced around December 2015. In earlier 2015 referrals were waiting but staff in the booking centre were probably already adding patients to the lists as per the GP category on the referral. In general there wouldn't have been many referrals downgraded or upgraded. The Referral and Booking Centre get around 180,000 referrals every year.

10. Other than there were delays with triage I don't know anything about patient care delay or harm.

11. I know the IEAP was meant to be regional guidance which recommends 72 hours for triage. There would have been delays outside of this across specialities but in the main it was generally done within a week which I feel is reasonable. Some of the other specialties may not have had the same level of referrals as urology.

12. In terms of notes, within PAS and case note tracking, charts are generally tracked out to an address which on the system may just have been 'Aidan O'Brien'. There would be no way of knowing that notes are not in the office or in the secretary's office. The only time an issue regarding charts might be escalated to me is if a chart is to be pulled for a clinic and it can't be found. Generally staff would check with the secretary for the chart if it can't be found. I am aware the secretary may have said Mr O'Brien had that set of notes at home and he would bring them in. There was no specific issue being flagged to me on a regular basis about charts.

13. A few times Mr O'Brien's name would have come up and so I suggested we put a Datix in to alert that a chart was not available for a clinic. I was advised to refer such issues to the Head of Service. Debbie Burns told my head of health records helen forde ~~me~~ not to put Datix's in the system for charts. Helen shared this information with me and I accept that maybe this wasn't the right mechanism for flagging the issue.

14. Now there is a lot of information in NIECR and so the chart is not as important as it previously would have been.

15. In December 2016, I was sent an email by KCatherine Robinson to say she had become aware of undictated clinics and patient outcomes not being completed. I am not aware if this led to delays in treatment.

16. I am not aware of any issues relating to Mr O'Brien's private patients.

17. I didn't attend many of the acute performance meetings issues so I wouldn't necessarily have been aware about issues of concern. Katherine Robinson would have attended these meetings and so would have been more aware of the issues.

This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.

This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.

SIGNATURE	
DATE	

From: Carroll, Anita [redacted]
Sent: 22 October 2018 16:15
To: Hynds, Siobhan [redacted]
Subject: FW: Urology Triage & Escalation

FYI

From: Robinson, Katherine
Sent: 19 October 2018 15:37
To: Carroll, Anita; Clayton, Wendy
Subject: FW: Urology Triage & Escalation

SEE below. We will look at dictation etc when Collette returns on Monday. However given the amount of charts in AOB office there would seem to be some charts that need action. I believe Martina was watching this previously so am not sure what is happening in her absence

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Rankin, Christine
Sent: 19 October 2018 15:23
To: Robinson, Katherine
Cc: Browne, Leanne
Subject: Urology Triage & Escalation

Katherine

Looking at this week's report there has been a vast improvement in Urology triage.

Anything more than 5 weeks from date of referral tends to be OC referrals which may not have arrived with us yet (typing backlog), attendances not done, RF DNAs or GP letters passed to named Consultant awaiting further advice.

All of the above will be chased with copy letters (if available) printed and passed for triage. RF if not reappointed will be escalated to RF team.

No one Consultant appears to be standing out however there are a total of 3 referrals which have been chased a number of times and escalated to OSL twice (Sinead 30/07/17 & Jane 10/09/18) as per our new process which is still in its infancy and will most likely need tweaked as weeks go by.
2 of these are registered to Mr O'Donoghue and 1 to Mr O'Brien see below:

Hosp	CHI Number	Casenote	Forenames	Surname	Spec Code	Cons Code	Priority	Referral Source	Referral Date Only	Days From Ref Date	Follow up Comment 1	Follow up Comment 2	CR 1st Escalation	CR 2nd Escalation
CAH	Personal Information	Personal Information	Personal Information redacted by the USI	Personal Information	URO	JOD	ROUTINE	OC	24/04/2018	177	LB EMAILED NR 310718	email to NR 13.09.18	Sinead 30/07/18	Jane 10/09/18
CAH	Personal Information redacted by USI				URO	EURO	ROUTINE	OTH	23/05/2018	148	ORED as EURO-thought was on NIECR for traige-printed for TDU 100718	email to PD 11.07.18	Sinead 30/07/18	Jane 10/09/18
CAH	Personal Information	Personal Information	Personal Information	Personal Information	URO	JOD	ROUTINE	OC	29/05/2018	142	,EMAILED TO NR 200618	EMAIL TO NR 14/9/18	Sinead 30/07/18	Jane 10/09/18

C

Christine Rankin
ACTING BOOKING MANAGER
SOUTHERN TRUST BOOKING CENTRE
Southern Health & Social Care Trust
Ramone Building
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Changed My Number

t: Personal Information redacted by USI

EXT Personal Information redacted by the USI *if dialling from Avaya phone.*
If dialling from old phone please dial Personal Information redacted by the USI

e: christine.rankin Personal Information redacted by USI

From: Robinson, Katherine <[redacted]>
Sent: 23 October 2018 17:20
To: Carroll, Anita <[redacted]>
Subject: FW: AOB notes and dictation

The loop

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Clayton, Wendy
Sent: 23 October 2018 17:19
To: Gibson, Simon; Carroll, Ronan; Khan, Ahmed; Toal, Vivienne
Cc: Robinson, Katherine; Weir, Colin
Subject: FW: AOB notes and dictation

The backlog report is generated monthly. For October 18, the report was completed 3rd Oct. At this time there were 91 outpatient letters to be dictated. The oldest of the 91 extended back to June 18. We asked Katherine to update the report as of yesterday and it was down to 16 clinical notes, oldest now 28/9/18. Therefore, from the 3/10/18 to the 23/10/18 Mr O'Brien has gone from 91 to 16 outpatients letters to be dictated.

The numbers in the report are derived from a manual count i.e the secretary feeds the information to the Service Administrator who populates the table.

We will complete actions on a weekly basis as requested:

- Outstanding dictation
- Number of charts in AOB office

Regards

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
SEC
Ext: [redacted]
External number: [redacted]
Mob: [redacted]

EXT [redacted] if dialling from Avaya phone.

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External No. Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 23 October 2018 16:54
To: Robinson, Katherine; Clayton, Wendy
Subject: FW: AOB notes and dictation

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Information redacted by

From: Hynds, Siobhan
Sent: 23 October 2018 16:40
To: Gibson, Simon; Carroll, Ronan; Khan, Ahmed; Toal, Vivienne
Subject: RE: AOB notes and dictation

Ronan

Could I get a look at the actual report from the digital dictation system? We need to be clear about if and when there may have been backlogs and when these may have been cleared i.e. need to see the date of the clinical contact, the date of the dictation and the timescales in between those 2 events.

Thanks

Siobhan

From: Gibson, Simon
Sent: 23 October 2018 15:53
To: Carroll, Ronan; Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne
Subject: RE: AOB notes and dictation

Dear Ronan

Are the figures of 91 and 16 both definitely accurate?

If so, this means that Aidan dictated 75 letters in one day. Can that be validated?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust

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Personal Information redacted by the USI (DHH)

From: Carroll, Ronan
Sent: 23 October 2018 15:05
To: Gibson, Simon; Khan, Ahmed; Hynds, Siobhan; Kerr, Vivienne
Subject: RE: AOB notes and dictation

Can only speculate

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Information redacted by

From: Gibson, Simon
Sent: 23 October 2018 15:04
To: Carroll, Ronan; Khan, Ahmed; Hynds, Siobhan; Kerr, Vivienne
Subject: RE: AOB notes and dictation

Dear Ronan

Thanks for this – how has the number gone from 91 to 16 so quickly?

Kind regards

Simon

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

From: Carroll, Ronan
Sent: 23 October 2018 15:02
To: Khan, Ahmed; Hynds, Siobhan; Gibson, Simon; Kerr, Vivienne
Subject: FW: AOB notes and dictation
Importance: High

Please see updated position – apologies for the delay

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Information redacted by

From: Clayton, Wendy
Sent: 23 October 2018 13:43
To: McCaul, Collette; Robinson, Katherine

Cc: Carroll, Ronan
Subject: RE: AOB notes and dictation

Ronan

Summary:

Outpatient charts waiting dictation = 16 (Oldest 28/9/18)

Notes in office = 54

- Deceased charts
- Telephone reviews
- Awaiting dictation
- Secretary queries
- Awaiting results (DARO)

Regards

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
SEC
Ext: Personal Information
External number: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

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External No. Personal Information redacted by the USI

From: McCaul, Collette
Sent: 23 October 2018 13:41
To: Clayton, Wendy; Robinson, Katherine
Cc: Carroll, Ronan
Subject: RE: AOB notes and dictation

Wendy the column highlighted clinic awaiting typing in that actual column it says awaiting dictation and there are 16 charts awaited

Collette

From: Clayton, Wendy
Sent: 23 October 2018 13:14
To: Robinson, Katherine; McCaul, Collette
Cc: Carroll, Ronan
Subject: AOB notes and dictation

Thanks for the table left on my desk. Collette – I tried to phone you

Need to clarify **number of clinics notes waiting dictation**? You have discharges awaiting dictation but not OPD

Notes:
There are 54 notes in the office. Made up of:

- Deceased charts
- Telephone reviews
- Awaiting dictation
- Secretary queries
- Awaiting results (DARO)

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
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From: Robinson, Katherine <Personal Information redacted by the USI>
Sent: 23 October 2018 16:34
To: McCaul, Collette <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>; Clayton, Wendy <Personal Information redacted by the USI>
Cc: Carroll, Anita <Personal Information redacted by the USI>
Subject: RE: AOB notes and dictation

Plus remember there are the 16 opd charts that need dictated and the 17 discharges which are to be dictated = 33. Also note this is from information available to us.

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: McCaul, Collette
Sent: 23 October 2018 16:29
To: Robinson, Katherine
Subject: RE: AOB notes and dictation

The 91 was from the start of the month of October clinics have been dictated and typed up to this which is not uncommon as we are now 3 weeks into the month so things get caught up relatively quickly. This is correct

Collette

From: Robinson, Katherine
Sent: 23 October 2018 16:19
To: McCaul, Collette
Subject: FW: AOB notes and dictation
Importance: High

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 23 October 2018 16:09
To: Robinson, Katherine; Clayton, Wendy
Subject: FW: AOB notes and dictation
Importance: High

Please see below. If I finish in SMT soon can we chat this through

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Information redacted by

From: Khan, Ahmed
Sent: 23 October 2018 16:08
To: Carroll, Ronan
Cc: Gishkori, Esther; Gibson, Simon; Hynds, Siobhan; Toal, Vivienne
Subject: RE: AOB notes and dictation

Ronan, The action plan must be closely monitored with weekly report collected as per AP. Can you also clarify that yesterday, 22/10/18 there were 91 outstanding dictations and today only 16 (Oldest 28/9/18)?

Thanks,
Ahmed

From: Gibson, Simon
Sent: 23 October 2018 15:57
To: Carroll, Ronan; Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne
Cc: Gishkori, Esther
Subject: RE: AOB notes and dictation

Dear Ahmed

I assume that would be a question for you as Case Manager (or the Oversight Committee)?

Kind regards

Simon

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

From: Carroll, Ronan
Sent: 23 October 2018 15:34
To: Gibson, Simon; Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne
Cc: Gishkori, Esther
Subject: RE: AOB notes and dictation
Importance: High

Re the outcome of today's meeting can I ask are we to continue monitoring AOB against the 4 elements of the AP?
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Information redacted by

From: Carroll, Ronan
Sent: 23 October 2018 15:05
To: Gibson, Simon; Khan, Ahmed; Hynds, Siobhan; Kerr, Vivienne
Subject: RE: AOB notes and dictation

Yes

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Information redacted by

From: Gibson, Simon
Sent: 23 October 2018 15:05
To: Carroll, Ronan; Khan, Ahmed; Hynds, Siobhan; Kerr, Vivienne
Subject: RE: AOB notes and dictation

P.S - Maybe should have gone to Viv Toal?

Kind regards

Simon

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

From: Carroll, Ronan
Sent: 23 October 2018 15:02
To: Khan, Ahmed; Hynds, Siobhan; Gibson, Simon; Kerr, Vivienne
Subject: FW: AOB notes and dictation
Importance: High

Please see updated position – apologies for the delay

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Information redacted by

From: Clayton, Wendy
Sent: 23 October 2018 13:43
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Cc: Carroll, Ronan
Subject: RE: AOB notes and dictation

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Regards

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
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To: Robinson, Katherine; McCaul, Collette
Cc: Carroll, Ronan
Subject: AOB notes and dictation

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- Awaiting results (DARO)

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
SEC
Ext: Personal Information
External number: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

EXT Personal Information redacted by the USI *if dialling from Avaya phone.*
If dialling from old phone please dial Personal Information redacted by the USI

External No. Personal Information redacted by the USI

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 28 June 2019 15:47
To: Gormley, Damian <Personal Information redacted by the USI>
Subject: FW: Admin Issues

Damian
Sorry for torturing you, but looking some advice. see draft e mail below, I would like to share this with consultants ,as there is some confusion regarding lines of responsibility and thought this might be good to send out to all .welcome your thoughts , thanks Anita

I would be grateful if you could help with the following administrative processes. These processes are already in place but just not always followed and if they were adhered to they would help admin and clerical staff greatly and minimise risk of delays to patients. Also, I think there may be confusion at times over our structure and whose responsibility it is regarding administrative staff.

I am the Assistant Director with responsibility for Health Records, ED, ward clerks, secretaries, audio typists, booking centre and miscellaneous other admin staff. Helen Forde and Katherine Robinson are the Heads of Service for Admin in these areas and any issues regarding processes, recording issues etc should be brought to their attention. They and the Service Administrators will then work alongside the HOS for the Divisions to resolve.

- Highlight RF, Cancer and high risk patients as appropriate on G2
- Junior doctors should select the appropriate supervisor (Consultant of clinic) on G2 for their clinic dictation
- Clinic outcome forms should be used to ensure no unnecessary delays in the patient pathway, oc referrals, adding patients to waiting lists etc.
- If a patient needs reviewed within a specific timescale this needs highlighted by using the comment – Must be seen (MBS 3 months) or Urgent 3 months to ensure the patient is added to the urgent review waiting lists etc.
- Proformas should be put in an envelope along with the clinic not inside the patients chart – if the chart is taken away or delay in typing the patient wont be added to the waiting list until the clinic is typed.
- E Discharges – junior doctors often advise on these that patients will be 'reviewed in due course'. This is ambiguous, a timeframe should be

specified because clerical staff can't guess this and the ward clerk/secretary do not have time to chase medics.
– if a patient has to be referred on to another specialty/hospital full details of the consultant, the specialty and the hospital site must be recorded on the discharge letter.
– if a discharge letter is changed the ward clerk must be informed – eg it may be changed to record that a review appointment is required, but if the ward clerk hasn't been told that changes have been made they will not know to make the follow up appointment.

- Results and x-rays on the ward must be signed – if they are not signed they must remain on the ward until such time as they are signed – this is leading to boxes of results being held at ward level.
- Results in paper form should be viewed/actioned and not held back until a chart is available or previous clinic letter is typed. You can action the results and advise for urgent typing straight away.
- When completing the ED flimsy you must ensure that the time of discharge, the diagnosis, if any x-ray was performed and any follow up is clearly recorded on the back of the ED flimsy – failure to record this means that the patient may be lost to follow up and there are delays in the patient going through the system as the admin staff have to look for the doctor to find out the necessary information.

Regards

Anita

RECORDS - combined figures for all sites

Month	Charts Filed	SARS	M/LEGAL	AUDIT	DISPOSED	ISSUE DESK OUTSIDE 5 WORKING DAYS	% Availability of charts for clinics
Apr-19	52223	20	28	4	0	0	99.92%
May-19	43403	29	44	12	0	0	99.93%
Jun-19	42178	16	45	88	0	0	99.64%
Jul-19	49364	18	80	46	0	0	99.50%
Aug-19	43657	21	105	17	0	0	99.91%
Sep-19	40672	38	90	0	0	0	99.54%
Oct-19	50078	30	106	238	0	0	99.70%
Nov-19	45077	23	101	6	0	0	99.70%
Dec-19	39661	9	59	11	0	0	99.69%
Jan-20	45912	16	103	189	0	0	99.85%
Feb-20	39079	34	121	210	0	0	COVID
Mar-20	37227	21	111	0	0	0	COVID

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 10 September 2020 23:03
To: McClements, Melanie <Personal Information redacted by the USI>
Cc: Carroll, Ronan <Personal Information redacted by the USI>; Corrigan, Martina <Personal Information redacted by the USI>
Subject: FW: Helpline documentation
Importance: High

Melanie

I spoke to John Mitchell and he can get 2 numbers he will advise me asap .

I think we need to have this line manned with good people so I think for at least week 1. Helen and Katherine , they have excellent experience and skills and are highly confidential , this will test out how it will work .

They both can work from Katherine's office and , we had a chat today to start on documentation and we can keep tight to this , see our first thoughts there are some blanks .
Ronan when we fill in spread sheet on a 2 times per day basis can we pass to Martina ? for follow up ?
Maybe we suggest the help line to be 10 to 4 daily to give us a chance to get paperwork tidied each day .
Happy to discuss
A

From: Forde, Helen
Sent: 10 September 2020 17:15
To: Carroll, Anita; Robinson, Katherine
Subject: Helpline documentation

There's a starter

So fill in the proforma with the patient on the phone
Transfer details to the spreadsheet to have as an index of the calls received
Send copy of the proforma and spreadsheet to ??? at regular intervals (to be confirmed)

Head of service to inform Helpline desk of outcome of call so it can be recorded on the spreadsheet re Complete, Pending etc

Helen Forde
Head of Health Records
Admin Floor, CAH

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

Urology Lookback Patient Proforma

Date	Time	Ref Number
PATIENT'S First Name	**PATIENT'S** Surname	
DOB	Address	
PATIENT'S Contact Number	HCN	
RELATIVE'S Contact Number (if applicable)		
Query relating to : ☐ Inpatient ☐ Outpatient ☐ WL Query		
Details		
Outcome		

Script for Lookback Exercise – Urology – Sept 2020

Urology Helpline

Helpline Telephone Number: xxxxxxxxxxxxxxx

Welcome to the Urology helpline .

To help us deal with your query can I take some details.

First of all are you phoning for yourself or another member of your family?

Does your ? know that you are contacting us?

I will take your details and they will be passed on to xxxxxx who will contact you xxxxxxxxxxx in relation to your query.

Could I have your / the patient's :

Name

DOB

Address

What is your concern?

Urology Helpline Database - September 2020

Number	Patient First Name	Patient Surname	Name of person if not patient & relationship	DOB	Contact No Patient or Relative?	HCN	Inpt	Outpt	Concern if necessary see sep she	W/Time Query

Outcome

From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 30 October 2020 08:24
To: Forde, Helen <Personal Information redacted by the USI>; Robinson, Katherine <Personal Information redacted by the USI>
Cc: Carroll, Ronan <Personal Information redacted by the USI>; Carroll, Anita <Personal Information redacted by the USI>; McClements, Melanie <Personal Information redacted by the USI>
Subject: Information line spreadsheet up until thursday 30 October 2020

Good morning

Updated information line spreadsheet.

Update summary below:
Monday – 35 calls and 2 patients in the Review Backlog being seen by P Keane
Tuesday – 53 calls and none are part of the enquiry
Wednesday – 31 calls and 1 pt on Bicalutamide and had been identified by Mark and will get an appointment for the clinic next week and 1 pt getting advice from clinical team as if they should be included
Thursday – 15 calls and none are part of the enquiry

So total calls = 134 with 3 definite in review and 1 clinical query as to whether they need to be included or not

Martina

Urology Helpline Database - October 2020

Numbe	Patient First Name	Patient Surname	DOB	Contact Number	HCN	Concern	part of review	outcome
Monday 26 October 2020								
Personal Information redacted by USI						Saw MY privately wants to know was this the consultant mentioned and would his treatment be impacted	no	CONTACTED
						Are they impacted by enquiry	on review backlog not part of review	CONTACTED
Patient 125						Diagnosis of prostate cancer - concerned he is impacted. Aware AOB has retired.	is under review of oncologists and will be followed up in Independent Sector and will get an appointment soon	MC - contacted and advised that he will be follow-up in Hillsborough happy with AOB care
Personal Information redacted by USI						Are we confident that if there is anyone impacted that the person will be contacted - father had bladder cancer - 2 - 3 doctors involved in care.	no Patient of Mr Haynes	CONTACTED
						Is his mum impacted by this review - nephrostomy tubes	NO patient of MY	CONTACTED
						Are they impacted by enquiry	No - JOD	CONTACTED
						Are they impacted by enquiry	No - JOD	CONTACTED
						Are they impacted by enquiry	No - JOD	CONTACTED
						Has had MRI but hasn't had an appointment to discuss this and if any impact	had MRI on 12 October and will be followed up within the next number of weeks.	MC contacted daugher has requested that patient receives his appointment by letter
						Are they impacted by enquiry	No- case reviewed by Mr Haynes Patient written to on 2 October	CONTACTED
						Are they impacted by enquiry	No has been discharged back to GP May 2018	CONTACTED

[redacted]						Are they impacted by enquiry	No had procedure in June 2020 and has been added to urodynamics WL which due to covid is currently not happening	CONTACTED
[redacted]						Are they impacted by enquiry	No - JOD patient	CONTACTED
						Are they impacted by enquiry	No - AJG patient	CONTACTED
						Are they impacted by enquiry	No - MY patient	contacted
						Are they impacted by enquiry	No - MYT patient	CONTACTED
						Are they impacted by enquiry	No - being FU oncology	CONTACTED
						Are they impacted by enquiry	No - AJG patient	CONTACTED
						Are they impacted by enquiry	No - RBL patient	CONTACTED
						Had op on 2/12/19 and in pain	No - MY patient	Contacted
						Are they impacted by enquiry	No - JOD pt	CONTACTED
						Waiting on x-ray - had no contact	No AJG patient	CONTACTED
						Are they impacted by enquiry	No - MY patient	CONTACTED
						Are they impacted by enquiry	NO - on routine wL	CONTACTED
						Are they impacted by enquiry	No but on review BL	CONTACTED
						Are they impacted by enquiry	no - JOD patient	CONTACTED
						Are they impacted by enquiry	no - JOD patient	CONTACTED
						Has complaint in about AOB	No - GP last written to Feb 2020 on urgent WL for TURP - not aware of complaint but may be do with his waiting time	WANTS CONTACTED BY URO TEAM
						Are they impacted by enquiry	No - JOD	CONTACTED
						Will the details of the con be made available like with Dr Watt	No - never been a urology patient	Due to Litigation need MC to contact
						Waiting 7 years for surgery - has had pre op but nothing else. GP says they need to start again	No - is on WL for procedure	CONTACTED
						March 2018 got phone call from dr who said to go on Oxybutuin and take it until he was seen by doctor but has never been seen by doctor	No - on NOP list	CONTACTED
						Recall patient - got phone call from Hillsborough and want more details	yes	Contacted by MC
						Are they impacted by enquiry	no - MDH patient	CONTACTED
						Are they impacted by enquiry	no - AJG patient	CONTACTED
						Are they impacted by enquiry	no - MDH patient	CONTACTED

Personal Information redacted by USI

Tuesday 27 October 2020

36	[redacted]	Are they impacted by enquiry	No - discharged to continence team	CONTACTED
37		AOB patient no right since op in Spring 2020	No - SOM patient	CONTACTED
38		Are they impacted by enquiry	No JOD patient	MESSAGING SERVICE NO MESSAGE LEFT
39		Are they impacted by enquiry	No MDH patient	CONTACTED
40		Are they impacted by enquiry	NO-RBL	CONTACTED
41		Are they impacted by enquiry	No -MDH/MY patient	CONTACTED
42		Are they impacted by enquiry	No -FU DH/TF	CONTACTED
43		Are they impacted by enquiry	N0 - discharged	CONTACTED
44		Are they impacted by enquiry	NO- AJG patient	CONTACTED
45		Are they impacted by enquiry	no - MY patient	CONTACTED
46		Are they impacted by enquiry	No - not under urology (Gynae Pt)	CONTACTED
47		Are they impacted by enquiry	no - MDH patient	MESSAGING SERVICE NO MESSAGE LEFT
48		Are they impacted by enquiry	No - FU with oncology	CONTACTED
49		Are they impacted by enquiry	No - MY patient	CONTACTED
50		Are they impacted by enquiry	No - AJG patient	CONTACTED
51		Are they impacted by enquiry	No - RBL	CONTACTED
52		Are they impacted by enquiry	No - JOD pt	CONTACTED
53		Are they impacted by enquiry	No - nurse FU	CONTACTED
54		Are they impacted by enquiry	No - discharged to GP by MDH	CONTACTED
55		Are they impacted by enquiry	No- JOD pt	**Why contacted by Hillsborough?** Had been part of review BL from AOB being reviewed now by JOD so I have asked to be removed from IS list so patient doesn't need to attend IS
56		Are they impacted by enquiry	no - MY pt	CONTACTED
57		Are they impacted by enquiry	No- MDH/MY pt	CONTACTED
58		Are they impacted by enquiry	No MY/AJG pt	CONTACTED
59		Are they impacted by enquiry	Patient for Review will be seen in Hillsborough	MC
60		Are they impacted by enquiry	No - RBL	CONTACTED
61		Are they impacted by enquiry	No - JOD pt	MESSAGING SERVICE NO MESSAGE LEFT

62	[redacted]	Are they impacted by enquiry	No - AJG patient	CONTACTED
63		Are they impacted by enquiry	no - FU Stone clinic	CONTACTED
64		Are they impacted by enquiry	No - WL for procedure	CONTACTED
65		Are they impacted by enquiry	No - WL for procedure	CONTACTED
66		Are they impacted by enquiry	No - discharged	CONTACTED
67		Are they impacted by enquiry	No - MY patient	CONTACTED
68		Are they impacted by enquiry	No - NOP Sept 20	CONTACTED
69		Are they impacted by enquiry	no - referred & FU with Belfast	CONTACTED
70		Are they impacted by enquiry	No - MY pt	CONTACTED
71		AOB surgery 6 years ago	No - MDH pt	CONTACTED
72		Are they impacted by enquiry	No - TAF FU	CONTACTED
73		FATHER RIP 25/1/20	No - JOD pt	CONTACTED
74		Are they impacted by enquiry	No - under gynae BCH	CONTACTED
75		Are they impacted by enquiry	No - MYT pt	CONTACTED
76		Pt RIP 1/11/19	No - MDH pt	CONTACTED
77		Lots of UTIs	No - AJG patient	CONTACTED
78		Are they impacted by enquiry	No - discharged (MYT)	CONTACTED
79		Are they impacted by enquiry	No - JOD pt	CONTACTED
80		Are they impacted by enquiry	No - discharged	CONTACTED
81		Are they impacted by enquiry	No - FU TAF	CONTACTED
82		Are they impacted by enquiry	No - RBL	CONTACTED
83		Are they impacted by enquiry	no - MY pt	CONTACTED
84		Are they impacted by enquiry	No - AJG patient	CONTACTED
85		Are they impacted by enquiry	No - JOD pt	CONTACTED
86		Are they impacted by enquiry	no - MDH patient	CONTACTED
87		Are they impacted by enquiry	No - discharged (2017)	CONTACTED
88		Are they impacted by enquiry	No - On WL for procedure	CONTACTED
Wednesday 28 October 2020				
8	[redacted]	Are they impacted by enquiry	No - on RBL	CONTACTED
9		Are they impacted by enquiry	No - New referral May 2020	CONTACTED
9		Rang yesterday for appt in Hillsborough wants to know why he got this appointment - does this mean he is impacted by the review	No as Hillsborough is dealing with patients who should have had a review (pt in RBL) but is being followed up by Belfast	CONTACTED

92	Pt RIP Personal Information - daughter wants to know if he is part of the review	No - was AJG pt	EMAILED
93	Are they impacted by enquiry	No- has been FU	NR THURSDAY
94	Are they impacted by enquiry	No - MY pt	CONTACTED
95	Rang yesterday for appt in Hillsborough wants to know why he got this appointment - does this mean he is impacted by the review	need clinical advice and I have emailed AJG	MC
96	Had surgery and it has not been successful. Seen privately first.	No- was part of RBL but has had a Virtual appt in July 2020	CONTACTED
97	Are they impacted by enquiry x-ray kidney - Friday	No - MYT pt, being fu by SMDT	CONTACTED
98	Are they impacted by enquiry	No AJG patient	CONTACTED
99	Are they impacted by enquiry	No - discharged to GP by LMcA	CONTACTED
100	Had concerns at the time about daddy's treatment. Seen by AOB and O'Donaghue. Also saw AOB privately and felt daddy was forgot about. Are they impacted by enquiry	No - JOD patient	CONTACTED
101	Are they impacted by enquiry	No - discharged to GP by MDH	CONTACTED
102	Rang yesterday and thought someone was to get back to them today. Advised it could be a few days.	DUPLICATE No - SOM patient	CONTACTED
103	Are they impacted by enquiry	No - was being reviewed and noww discharged to WT	CONTACTED
104	Are they impacted by enquiry. Saw Mr Glackin Jan 2020	no - AJG patient	CONTACTED
105	Are they impacted by enquiry	no- ajg/jod pt	CONTACTED
106	Are they impacted by enquiry	No AJG pt - discharged	CONTACTED
107	Had surgery April 2019. Are they impacted by enquiry	NO - AJG pt	CONTACTED
108		no- discharged from uro in 1997	CONTACTED
109		No - never been under Urology	MESSAGING SERVICE NO MESSAGE LEFT
110	Personal Information redacted by the USI very unwell	No - MY patient Will be reviewed by MY in Nov	CONTACTED
111		no but will be getting an appt for hillsborough (see script)	NR THURSDAY

112	[redacted]					No - on NOP for MY as routine	CONTACTED
113						No - AJG pt	CONTACTED
114					kidney cancer	No - MDH pt	CONTACTED
115						Yes - bicalutamide	mc
116						No - MDH pt	CONTACTED
117						No - MYT pt	CONTACTED
118					had received call few days ago said rpt would be in press about uro. Was being contacted as urology SAI in 2017. Knew a lot about SAI	previous SAI - referred to PK for advice	MC - For logging that she has contacted the information line as she has already been spoken to earlier in the week
119					Mum in law RIP on [redacted] wants to know if she is affected by this.	No- MYT and MDH pt	CONTACTED
Thursday 29 October 2020							
120	[redacted]	[redacted]	[redacted]	[redacted]	Are they impacted with enquiry	No - JOD pt	
121	[redacted]	[redacted]	[redacted]	[redacted]	Are they impacted with enquiry	No - RJB (2014)	
122	[redacted]	[redacted]	[redacted]	[redacted]	on WL for surgery	No - on urgent RBL	
123	[redacted]	[redacted]	[redacted]	[redacted]	Are they impacted with enquiry	No - AJG pt	
124	[redacted]	[redacted]	[redacted]	[redacted]	Are they impacted with enquiry	No - AJG pt	
125	[redacted]	[redacted]	[redacted]	[redacted]	Had procedure 2012 - has had issues since	No - MA pt (2012)	
126	[redacted]	[redacted]	[redacted]	[redacted]	Are they impacted with enquiry	No - AJG pt	
127	[redacted]	[redacted]	[redacted]	[redacted]	Are they impacted with enquiry	No - on urgent RBL	
128	[redacted]	[redacted]	[redacted]	[redacted]		No - MY patient	
129	[redacted]	[redacted]	[redacted]	[redacted]	Are they impacted with enquiry	No - on RBL	
130	[redacted]	[redacted]	[redacted]	[redacted]	Concerns about AOB - straightforward op but nearly died after with sepsis	No - was in Procedure backlog and is now being seen by MY	
131	[redacted]	[redacted]	[redacted]	[redacted]	Are they impacted with enquiry	No - has not been under urology	
132	[redacted]	[redacted]	[redacted]	[redacted]	Are they impacted with enquiry	No - TAJ pt (2017)	
133	[redacted]	[redacted]	[redacted]	[redacted]	Got a call for Hillsborough - are they part of the enquiry	No - Hillsborough are seeing Mr O'Brien's patients that are overdue a review	
134	[redacted]	[redacted]	[redacted]	[redacted]	Are they impacted with enquiry	also on Wednesday's calls no - as being FU	
Friday 30 October 2020							

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 26 October 2020 08:42
To: Robinson, Katherine <Personal Information redacted by the USI>
Cc: Forde, Helen <Personal Information redacted by the USI>
Subject: FW: AOB statement 251020202

Just fyi

Action Katherine following our conversation to just share this content with NE nothing more do not confirm name

Speak to other urology sec s and advise them re info line if they get any calls

Katherine to speak to all other surgical sec to advise if by chance they get a call e gent then to reassure patient not ent , etc

October 25, 2020

Statement to Irish News

The Southern Health and Social Care Trust can confirm that clinical concerns in relation to the work of a consultant urologist, who no longer works in the health service, are currently being reviewed.

At this stage, a small number of patients have been contacted so that their care can be reviewed.

The Department of Health is being kept updated on the progress of the review and the potential impact on patients.

If anyone is concerned and would like information please phone us on 0800 4148520

ENDS

Southern Health and Social Care Trust

POLICY FOR THE SAFEGUARDING, MOVEMENT & TRANSPORTATION OF PATIENT/CLIENT/STAFF/TRUST RECORDS, FILES AND OTHER MEDIA BETWEEN FACILITIES

Lead Policy Author & Job Title:	Catherine Weaver – Head of Information Governance
Directorate responsible for document:	**Performance & Reform**
Issue Date:	TBC
Review Date:	**March 2023**

Policy Checklist

Policy name:	Policy for the safeguarding, movement and transportation of Patient/Client/Staff/Trust Records, Files and other media between facilities.
Lead Policy Author & Job Title:	Catherine Weaver – Head of Information Governance
Director responsible for Policy:	Aldrina Magwood
Directorate responsible for Policy:	**Performance & Reform**
Equality Screened by:	Claire Graham
Trade Union consultation?	Yes ☒No ☐
Policy Implementation Plan included?	Yes ☐ No ☒
Date approved by Policy Scrutiny Committee:	TBC
Date approved by SMT:	TBC
Policy circulated to:	Directors and Information Governance Committee
Policy uploaded to:	Sharepoint

Version Control

Version:	Version 2.4
Supersedes:	Version 2.3

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
V2.4	Amendments to include updated Good Management, Good Records (GMGR) 2021	02032021	Catherine Weaver

POLICY FOR THE SAFEGUARDING, MOVEMENT & TRANSPORTATION OF PATIENT/CLIENT/STAFF/TRUST RECORDS, FILES AND OTHER MEDIA BETWEEN FACILITIES

1.0 INTRODUCTION

1.1 The aim of this policy is to ensure that staff safeguard all confidential information while travelling from one facility/location to another during the course of their working day.

1.2 This may include confidential information contained within work diaries, notebooks, case papers, patient/client notes, Trust documents, 'lap top' computers etc.

1.3 This may also include from time to time the necessity to store confidential information overnight in staff members own home.

1.4 All Trust staff are bound by a common law duty of confidentiality. (See 9.0)

1.5 It is the responsibility of all staff to familiarise themselves and to implement practice of the contents of this policy.

2.0 GUIDING PRINCIPLE

2.1 The DHPSS Code of Practice on Protecting the Confidentiality of Service User Information (January 2012) states that "staff working within health and social services have an ethical and legal obligation to protect the information entrusted to them by users of the services."

2.2 Staff must notify their line managers immediately on suspicion of loss of any confidential information.

2.3 Line Managers must inform/notify Information Governance Team of any loss and contact Catherine Weaver, Head of Information Governance, Ferndale, Bannvale Site Gilford. [redacted] Tel: [redacted].

2.4 Managers must ensure staff, are aware that disciplinary action may be taken when it is evident that a breach in confidentiality has occurred as a result of a member of staff's neglect in ensuring the safeguarding of confidential information.

3.0 TRACKING / TRACING RECORDS

3.1 Managers must ensure that effective systems are in place for tracking the location of files/records/documentation containing confidential information. The system in place by managers/service leads should be

appropriate to the type of confidential information concerned (e.g. a card index system may be appropriate to a small department, tracking sheet for outpatient type clinics while large scale libraries may benefit from a computerised tracking system – e.g. PAS/Clinical Manager. Detailed guidance on tracking/tracing systems should be documented in departmental procedures relating to records management/ transportation and should take into account relevant professional standards where such exist. The following points should be incorporated into Departmental guidelines:

- A clear record of the files which have been removed from the designated storage area, date removed, by whom and reason should be maintained;
- Files should be logged out to the borrower, who will be responsible for them whilst out of their designated storage;
- The tracking/tracing system should be updated by the borrower if the files are passed on, prior to being returned to the storage area;
- The minimum number of files required for the purpose should be removed;
- Should staff need to store records/information in their own home they need to ensure that they are stored in a safe place and cannot be accessed by unauthorised people;
- A system for following up outstanding returns should be implemented;
- Responsibility for ensuring the availability of the files should be assigned to one individual/supervisor within the Department.

4.0 MOVEMENT OUTSIDE THE WORK BASE

4.1 Movement of patient/client/staff records off-site may be required for a variety of reasons, e.g.

- To facilitate care or treatment at a different Trust facility;
- To facilitate care or treatment at a different facility outside of the Trust;
- To facilitate patient/service user access;
- Recruitment, selection and other H.R. functions;
- For domiciliary visits;
- To meet legal or statutory requirements;
- Delivery of drugs/specimens;
- Disciplinary Investigations;
- For home working
  (In some circumstances, records may be stored at the patient's home e.g. maternity notes, domiciliary care records and NISAT assessments etc. Confidentiality of the records stored in the client's home is the responsibility of the client/family members and they should be informed of their responsibility in this matter by the professional involved).

5.0 SAFEGUARDING OF PATIENT/CLIENT/STAFF RECORDS TRANSPORTED BETWEEN FACILITIES/LOCATIONS

5.1 It is recommended that employees should avoid taking confidential information outside the work base wherever possible. However, it is accepted that there are certain circumstances where this will be necessary or unavoidable**. Departmental procedures should detail the level of authorization required for the removal of files from Trust premises** or from one Trust premise to another.

5.2 Records should be transported in sealed boxes or sealed pouches when being transported between Trust sites and locations within the Southern Trust area.

5.3 All records should be prepared and tracked from the current location to the new location on PAS, Clinical manager or manual tracking system (or other relevant administration system) to ensure traceability at all times.

5.4 Transport boxes are used by health records departments. Each box is security sealed using the tamper evident seals by health records staff and collected from the health records department on a daily basis by Trust transport staff.

5.5 Charts must be securely transferred by SHSCT transport vans or on occasion, staff personal cars. Charts should never be left in a vehicle on view to the public and must be stored in the locked boot when being transported.

5.6 Transport boxes used for health records are delivered to the health records department at each site, emptied in health records department and charts left for delivery onto final internal destination by portering staff.

5.7 If it appears that security seals have been tampered with, this should be reported to your Line Manager immediately and must be reported as per Adverse Incident reporting procedure. If a loss of data occurs, this must also be reported immediately to Catherine Weaver, Head of Information Governance, Ferndale, Bannvale Site, Gilford [Personal Information redacted by the USI] Tel: [Personal Information redacted by the USI].

5.8 Records should be returned to their original hospital site as soon as possible after use.

6.0 TRANSPORTATION OF ORIGINAL PATIENT/CLIENT/STAFF RECORDS WITHIN TRUST FACILITIES / AROUND HOSPITAL SITES

6.1 TRANSPORTATION OF RECORDS FOR CLINICS

6.1.1 All records should be tracked from the current location to the new location on PAS/other administration system or manual tracking as necessary to ensure traceability at all times.

6.1.2 Records are to be transported using the appropriate trolleys to and from wards, clinics and departments. If taking records in your car these should be stored in the locked boot of the car and never left unattended in the vehicle.

6.1.3 Smaller quantities of records not requiring a trolley should be sealed within an envelope, marked private and confidential and clearly marked with the recipient's name and the destination address.

6.1.4 Records being transported from clinical areas to medical staff/secretarial offices must at all times be covered appropriately ensuring patients' personal details are concealed.

6.1.5 Trolleys containing casenotes or any other patient information should never be left unattended.

6.1.6 Staff preparing records for transport must ensure:

- Bundles of records are no larger than 8 inches.
  The records are well secured to ensure that they cannot fall out of the bundle and patient details cannot be viewed.
- The records are clearly labelled indicating the recipient and the delivery destination.
- The records are appropriately tracked out and returned when no longer required.

6.1.7 If a patient is being transferred to theatres or another ward an appropriate member of staff should accompany the patient and will be responsible for the transfer of the patient's record.

6.1.8 Records are not to be given to patients or their relatives to take to another department. If it is absolutely necessary, the record must be placed in a sealed envelope which is fully addressed.

6.2 TRANSPORTATION OF COPY RECORDS BETWEEN DEPARTMENTS FOR PROCESSING EXTERNAL REQUESTS e.g. SUBJECT ACCESS REQUESTS

In order to facilitate the processing of requests for records received from patients / clients / external agencies, some transfer of **copy** records is necessary between Departments. Copies of records should be sealed within an envelope, marked confidential and clearly marked with the recipient name and destination address.

7.0 TRANSPORTATION OF ORIGINAL RECORDS OUTSIDE OF THE SOUTHERN TRUST

7.1 This policy advises that original health records are **not** sent outside the Trust except in strictly defined circumstances. The exceptional circumstances include case notes accompanying patients who are transferred to another hospital out of hours or records requested by the Court. Staff must follow CREST guidelines. (See 9.0)

7.2 Where original or copy case notes are sent via external mail, high grade envelopes or tamper proof envelopes must be used to provide adequate protection for the contents, and they must be sent via special delivery or registered mail with sender details on the postage franking if not already included.

7.3 In exceptional circumstances where original records are required for court, a copy of the records must be made and the Staff Member must ensure that the original records have been returned. Staff Member must record details of person requesting records so that they can be contacted to ensure return.

7.4 If health records held in electronic format are being sent by post, then the data must be password protected and password sent separately following Trust procedure. (e.g. sending data such as a diagnostic tests or images etc. on a CD via special delivery or courier).

7.5 If a Courier service is being used, then it is essential to confirm that the Courier service has tracking systems in place, including recorded delivery and traceability of packages.

In these circumstances and for other personal information sent by external mail the addressing must be accurate, and the senders name and address must be given on the reverse of the envelope.

8.0 TRANSPORT AND STORAGE FOR DOMICILIARY VISITS

- Client records are to be transported in a secure transport briefcase/bag.
- During transport client records are to be kept in the boot of the car and out of sight in a briefcase or a secure transport bag.
- Professional to decide with Line Manager on individual case whether it is best to bring only records pertaining to the client into their home and other client records to be kept in a secure transport briefcase/bag in the boot of car.
- Records should be returned to base when visit is complete as soon as possible.
- Staff should not leave portable computers, medical notes or mobile data devices (e.g. Dictaphones, PDAs, digital cameras) that are used to store patient records/patient identifiable information in unattended cars or in easily accessible areas. Staff should store all files and portable equipment under lock and key, when not actually being used.
- Staff should not normally take health/client records home and where this cannot be avoided, procedures should be place to safeguard that information effectively. If records are being held by staff member's home overnight then they must be kept in a secure place. The responsibility for the records is held by the staff member.

9.0 RELATED POLICIES/MANUALS INCLUDE:

1. Code of Practice on Protecting the Confidentiality of Service User Information. Privacy Advisory Committee (NI) (January 2012) http://www.dhsspsni.gov.uk/confidentiality-consultation-cop.pdf

2. Records Management Policy, Southern Health & Social Care Trust (March 2021).

3. Records Management Procedures, Southern Health & Social Care Trust (January 2015).

4. Records Retention and Disposal Schedule, DHSSPSNI January 2021. gmgr-disposal-schedule.pdf (health-ni.gov.uk)

5. Data Protection Requests Flowchart (GDPR) Southern Health & Social CareTrust (May2018). GDPR SAR Flowchart

6. Protocol for the Inter Hospital Transfer of Patients and Their Records.

Clinical Resource Efficiency Support Team (CREST) (August 2006) ISBN: 1-903982-23-5

7. Guidance for Social Work and clinical staff responses to: Subject Access Requests, PSNI Form 81 Requests & Litigation Cases
Subject Access Guidance

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
3402	25/04/2013		Trustwide	Tracking of chart	If a chart is incorrectly tracked it will lead to a delay in the retrieval of the chart, or that the chart may not be found. Time is wasted in looking for the chart.	PAS tracking module is in place for tracking charts from one location to another. SOP in place for tracking. Issue of charts not being tracked has been raised at AD level, and also with Heads of Service, OSL's, and Service Administrators.		MOD	HOS	18/12/2013
3396	25/04/2013		Trustwide	Chart Not Available	If a chart is not available for a clinic or ward admission vital medical information will not be available.	Charts are tracked on PAS. Numerical system is used. Patient information is available on Patient Centre, PAS, Labs, NIPACS, Filemaker. Missing charts are recorded on a database, and alert cards are put into the filing bay, and investigation takes place when the chart turns up to see where it had been. Tracking issues have been raised at AD level, OSL and Service Administrators.		LOW	TEAM	18/12/2013

-----Original Message-----
From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 21 December 2015 12:01
To: Trouton, Heather <Personal Information redacted by the USI>; Conway, Barry <Personal Information redacted by the USI>; Gibson, Simon <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>; McVey, Anne <Personal Information redacted by the USI>
Cc: Robinson, Katherine <Personal Information redacted by the USI>; Lappin, Aideen <Personal Information redacted by the USI>; Walker, Helen <Personal Information redacted by the USI>
Subject: FW: Admin Issues - FAO Nursing & Medical Staff

Dear all see below from Katherine and her team a list of things that would assist admin staff and add clarity in the patient pathway Can you discuss the same in your teams with HOS and amds and let me know the outcomes Maybe we can discuss at teamtalk in the new year A

From: Robinson, Katherine
Sent: 18 December 2015 12:31
To: Carroll, Anita
Subject: Admin Issues - FAO Nursing & Medical Staff

I would be grateful if you would bring the following to the attention of the AMD's, AD's and HOS etc. These processes are all in place but just not always followed and if they were adhered to they would help admin and clerical staff greatly and minimise risk of delays to patients.

· Highlight RF, Cancer and high risk patients as appropriate on G2
· Junior doctors should select the appropriate Supervisor (Consultant of clinic) on G2 for their clinic dictation
· Clinic outcome forms should be used to ensure no unnecessary delays in the patient pathway, oc referrals, adding patients to waiting list etc.
· If a patient needs reviewed within a specific timescale this needs highlighted by using the comment Must Be Seen(MBS 3 mths) or Urgent 3 mths to ensure the patient is added to the urgent review waiting list etc.
· Proformas should be put in an envelope along with the clinic not inside the patient chart – if the chart is taken away or a delay in typing the patient won't be added to the waiting list until the clinic is typed.
· E Discharges –junior doctors often advise on these that patients will be 'reviewed in due course'. This is ambiguous, a timeframe should be specified because clerical staff can't guess this and the ward clerk/secretary does not have time to chase the medics.

Many thanks

K
Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre Ramone Building Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 02 March 2017 15:51
To: McVey, Anne <Personal Information redacted by the USI>; Trouton, Heather <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>
Cc: Forde, Helen <Personal Information redacted by the USI>; Robinson, Katherine <Personal Information redacted by the USI>
Subject: FW: admin pressures

Dear AD colleagues

I need to make you aware of tensions within Admin and Clerical areas over a range of issues for eg

- Staff under pressure due to short notice cancellations and additionality, inpatients being cancelled as late as 4pm day before theatre booking.
- Staff under pressure due to plans never being put in place when a consultant leaves/retires/sick leave or returns from maternity leave.
- Staff from the RBC feel they are constantly chasing HOS on answers to emails and can experience long delays .
- Errors by directorates in rotas , clinic code changes results in added pressure
- Admin managers not kept up to date with changes in procedures on wards/directorates which impact on secs. Most recent example is a trial of 2 Surgeons of the week and the impact of this
  - patients are admitted under one consultant, seen by another, tests requested by another, discharged by original admitting consultant. Impact is that the chart goes to the discharging consultant who never actually saw the patient, the result of the test will go back to the consultant who requested it, follow up is needed by consultant the patient was seen by but this is not the consultant who is on PAS. All very confusing.

While I appreciate that service divisions are busy I am faced with staff going to TU colleagues regarding issues . I need you to remind HOS that A and C colleagues need to be kept in the loop and communicated with. Some of these bullet points will not relate to all your teams however there are clear messages, and I know in the past I had asked for inclusion of Service admin staff at specialty meeting if even only for 10

mins so that they can be kept up to date but this has never really embedded.
Katherine is the manager of the services administrators and line management responsibility for secretaries and RBC and I think it would be good to involve her in communications to ensure we get messages down to admin staff , likewise Helen has responsibility for ED, ward clerks and health records and needs to be kept in the loop.

Happy to discuss
Anita

From: Robinson, Katherine <[redacted]>
Sent: 20 June 2017 11:03
To: Haynes, Mark <[redacted]>; Evans, Marie <[redacted]>; Corrigan, Martina <[redacted]>
Cc: Carroll, Anita <[redacted]>; Cunningham, Andrea <[redacted]>; Cunningham, Lucia <[redacted]>
Subject: RE: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Mark

Thank you for your email. The first point does relate to clinic letters and not clinics, we will correct this.

You are correct in that the data collected last year was not accurate and this came to light in Dec 16 when a secretary advised that there were clinics not dictated on. This secretary was advised of the importance of highlighting this issue on the backlog report. Furthermore, I held a meeting with all secretaries and this was reiterated to everyone. The secretaries collect the data and it is our only way of knowing what is outstanding and what needs escalated further. Everyone is now fully aware of the need for this information and for it to be accurate.

I plan to do a walk about in the summer months of offices checking on data received to ensure everyone is completing honestly and accurately.

We will continue to strive to improve the risks associated with admin work not being completed or actioned correctly, any further thoughts, ideas are very welcome.

Regards

Katherine

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Haynes, Mark
Sent: 17 June 2017 07:05
To: Evans, Marie; Corrigan, Martina; Robinson, Katherine
Subject: RE: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Morning Marie / Martina / Katherine

Thanks for continuing to send this round, it is useful to have a clear picture of the pressures on our admin and clerical team. One minor point relates to the clinics to be dictated / clinics to be typed columns – I assume these should read clinic letters to be dictate / clinic letters to be typed?

However, I am concerned regarding the robustness of this data, particularly in relation to 'results to be dictated'.

Could you advise me of the process whereby this data is collected? From recent experiences I would suggest that the data presented in this column is inaccurate. My concern relates to how this information would be used in the event of a significant issue arising due to a delayed / not acted on result – corporately are we kidding ourselves that all results are acted on / dictated on in a timely manner? That is the conclusion you could draw from the information, particularly in relation to some consultants. If a backlog were identified after an issue were to arise, are the staff who collect the data (I presume our secretaries) liable to be found culpable for not highlighting the backlog through this process? One could argue that the information presented whereby some consultants seem to barely ever have any results to dictate is not untrue – not all of us dictate letters on results! An illustration of the inaccuracy of the data may be seen in last years data in relation to number of clinics to be dictated, which has been proven to be inaccurate.

As stated, I think collection of this information is important and I would like it to continue to be circulated to us but would like to ensure that the data collected is robust. I am happy to be involved in any discussion required.

Thanks

Mark

From: Evans, Marie
Sent: 30 May 2017 11:20
To: Young, Michael; O'Brien, Aidan; Jacob, Thomas; Haynes, Mark; Glackin, Anthony; ODonoghue, JohnP
Cc: Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Robinson, Katherine
Subject: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Dear all

Please find attached the backlog reports for May 17.

Any queries let me know.

Kind Regards
Marie

Marie Evans
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by the USI
T: Personal Information redacted by the USI

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 31 July 2019 15:13
To: Murphy, Philip <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; Scullion, Damian <Personal Information redacted by the USI>; Tariq, S <Personal Information redacted by the USI>; Hogan, Martina <Personal Information redacted by the USI>
Cc: OKane, Maria <Personal Information redacted by the USI>; McClements, Melanie <Personal Information redacted by the USI>; Forde, Helen <Personal Information redacted by the USI>; Robinson, Katherine <Personal Information redacted by the USI>; Lappin, Aideen <Personal Information redacted by the USI>
Subject: FW: Admin Issues

Dear all

I would be grateful if you could help with the following administrative processes which also impact on patient safety. These processes are already in place but are not always followed and unfortunately when these processes are not adhered to there is a significant risk of delay and ultimately harm to patients. If they were adhered to they would also improve efficiency amongst admin and clerical staff and reduce risk to patients .

Also, I think there may be confusion at times over the admin structure and who has responsibility for administrative staff. I am the Assistant Director with responsibility for Health Records, ED, Ward Clerks, Secretaries, Audio typists, Booking Centre and miscellaneous other admin staff. Helen Forde and Katherine Robinson are the Heads of Service for Admin in these areas and any issues regarding processes, recording issues etc should be brought to their attention. They and the Service Administrators will then work alongside the HOS for the Divisions to resolve.

Main Issues

<u>Outpatients</u>

- Can I ask that all medical staff are reminded to highlight RF, Cancer and high risk patients as appropriate on G2. This will ensure the clerical and admin staff can prioritise these communications.

- Junior doctors should select the appropriate supervisor (Consultant of clinic) on G2 for their clinic dictation. Unfortunately, frequently this is not done and therefore dictation will not appear on the appropriate worklists for clerical staff. In some circumstances they may not be visible to the appropriate staff at all.

- Clinic outcome forms should be used to avoid unnecessary delays in the patient pathway, oc referrals, adding patients to waiting lists etc. The clinic outcome form records the outcome for each patient after their outpatient consultation, e.g. review in 6/52, review in 3/12, add to WL, Discharge

etc. This is a vital communication tool for admin staff as they use the clinic outcome sheet to action any follow up immediately instead of waiting to listen to dictation, and so avoid delays in getting patients added to the WL/referred on to another consultant etc.

- If a patient needs reviewed within a specific timescale this needs highlighted by using the comment – Must be seen (MBS 3 months) or Urgent 3 months to ensure the patient is added to the urgent review waiting lists etc. When the booking centre are selecting patients for review at the outpatient clinics they select from the MBS and Urgent WLs first, and so ensure that these patients are seen within the required timeframe.

- Waiting list Proformas should be put in an separate envelope and placed on top of the charts after the clinic. When the secretary receives the envelope she will add the patients to the waiting list immediately. If the proformas is placed inside the patients chart this will cause a delay in adding the patient to the waiting list as they will not be dealt with until the clinic is typed.

Inpatients

E Discharges –

- The information recorded on the e-discharge letter is often unclear, eg 'review in due course', or refer to Dr Smyth. This is ambiguous– if a patient has to be reviewed then a timeframe must be stated.

- If a patient has to be referred on to another consultant/specialty/hospital full details of the consultant, the specialty and the hospital site must be recorded on the discharge letter.

- If a discharge letter is changed the ward clerk must be informed – eg it may be changed to record that a review appointment is required, but if the ward clerk hasn't been told that changes have been made they will not know to make the follow up appointment.

- Delay in completing a discharge letter or not completing one at all which could lead to a patient's review/referral not being made.

- Doctors not authorising the discharge letter when they have finished it – this means the ward clerk cannot print the letter and therefore complete the follow up action and file the letter in the chart.

Misfiling

- Misfiling – some medical and nursing staff gather up patient documentation and put it all into one chart – this may contain more than one person's information. If that patient is then transferred to another ward without the ward clerk having had a change to check the loose filing the chart will contain incorrect information.

- Following an SAI where the Coroner was scathing about a missing Kardex the ward clerks have commenced a new process whereby when they are filing up

the patient information at discharge they record any missing information. This has highlighted a problem with the Kardex. From 26/6/19 to date five Kardexs have been missing – the ward clerk searches for these but it does highlight a problem with this particular piece of documentation.

Results

- Results and X-rays on the ward must be signed – if they are not they must remain on the ward until such time as they are signed – this is leading to boxes of results being held at ward level. This has been highlighted by the Medical Director.

- Results in paper form should be viewed/actioned and not held back until a chart is available or previous clinic letter is typed. You can action the results and advise for urgent typing straight away.

I hope this is helpful

Regards
Anita

Mrs Anita Carroll
Assistant Director of Acute Services -
Functional Support Services
Daisy Hill Hospital
5 Hospital Road
Newry
Co. Down
BT35 8DR

Tel: Personal Information redacted by the USI

Changed My Number

Please consider the environment before printing this email

From: Wallace, Stephen <[redacted]>
Sent: 01 April 2022 14:57
To: Carroll, Anita <[redacted]>
Cc: OKane, Maria <[redacted]>
Subject: Memo - Administrative Processes

Anita – some comments on the memo text as shared with Maria – can you review the comments changes

Thanks
Stephen

Southern Health and Social Care Trust

Medical Directorate

Memorandum

To:	All Medical Staff
c.c.	Anita Carroll, AD Functional and Support Services; Katherine Robinson, Booking Centre Manager
From:	Maria O'Kane, Medical Director
Date:	1st April 2022
Subject:	~~Administrative Processesc~~

Commented [WS1]: Acute Services Administrative Processes

For all Medical Staff working within Acute Services

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Dear Colleagues,

I would be grateful if you could assist with the following administrative processes, which also impact on patient safety. These administrative processes are already in place but are not always followed which unfortunately can lead to a significant risk of delay and ultimately harm to patients. If the administrative processes are adhered to can also improve efficiency amongst administration and clerical staff and reduce risk to our patients.

Commented [WS2]: Within Acute Services? Are these seperaet to CYP etc

Management of Administrative Staff

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For purposes of ~~role~~ clarity ~~and~~ management responsibility regarding administrative staff the following applies. Anita Carroll is the Assistant Director with responsibility for Health Records, ED, Ward Clerks, Secretaries, Audio typists, Booking Centre and miscellaneous other administrative staff within Acute Services. Helen Forde , Head of Health Records and Katherine Robinson, Booking Centre Manager are the Heads of Service for Administration in these areas and any issues regarding processes, recording issues ~~etc~~ should be brought to their attention. They and the relevant Service Administrators will then work alongside the Head of Service for the Divisions to resolve identified issues. ~~-~~

Commented [WS3]: Is this ED records?

Commented [WS4]: Can you remind me who took over from Helen

~~**Main Issues**~~

Outpatients

- Can I ask that all medical staff are reminded to highlight Red Flag, Cancer and high risk patients as appropriate on G2. This will ensure the clerical and ~~admin~~administration staff can prioritise these communications.

- Junior doctors should select the appropriate supervisor (Consultant of clinic) on G2 for their clinic dictation. Unfortunately, frequently this is not ~~done~~ completed and therefore dictation will not appear on the appropriate worklists for clerical staff. In some circumstances they may not be visible to the appropriate staff at all.

- Clinic outcome forms should be used to avoid unnecessary delays in the patient pathway, oc referrals, adding patients to waiting lists etc. The clinic outcome form records the outcome for each patient after their outpatient consultation, e.g. review in 6/52, review in 3/12, add to WL, Discharge etc. This is a vital communication tool for administration staff as they use the clinic outcome sheet to action any follow up immediately instead of waiting to listen to dictation, and so avoid delays in getting patients added to the Waiting list~~L~~/referred on to another consultant etc.

- If a patient needs reviewed within a specific timescale this needs highlighted by using the comment – *Must be seen (MBS 3 months)* or *Urgent 3 months* to ensure the patient is added to the urgent review waiting lists ~~etc~~. When the booking centre are selecting patients for review at the outpatient clinics they select from the MBS and Urgent ~~WLs~~ Waiting Lists first, and so ensure that these patients are seen within the required timeframe.

Commented [WS5]: what is this abbreviation

- Waiting list Proformas should be placed in an separate envelope and placed on top of the charts after each ~~the~~ clinic. When the secretary receives the envelope they will add the patients to the waiting list immediately. If the proforma is placed inside the patients chart this will cause a delay in adding the patient to the waiting list as they will not be dealt with until the clinic is typed.

Inpatients

E Discharges

- The information recorded on the e-discharge letter is often unclear, eg *'review in due course'*, or *'refer to Dr Smyth'*~~.~~ This is ambiguous– if a patient has to be reviewed then a timeframe must be stated.

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- If a patient has to be referred on to another consultant/specialty/hospital full details of the consultant, the specialty and the hospital site must be recorded on the discharge letter.

- If a discharge letter is changed the ward clerk must be informed – eg it may be changed to record that a review appointment is required, but if the ward clerk hasn't been told that changes have been made they will not know to make the follow up appointment.

- Delay in completing a discharge letter or not completing a discharge letter~~one~~ at all ~~which~~ could lead to a ~~-~~patient's review/referral not being made.

- Doctors not authorising the discharge letter when they have finished it – this means the ward clerk cannot print the letter and therefore complete the follow up action and file the letter in the chart.

Misfiling

- Misfiling – some medical and nursing staff collect patient documentation and place this into a single chart – this may contain more than one person's information. If that patient is then transferred to another ward without the ward clerk having had a change to check the loose filing the chart will contain incorrect information.

- Following an SAI where the Coroner was ~~scathing~~ critical regarding~~about~~ a missing Kardex ~~the~~ ward clerks have commenced a new process whereby when they are filing up the patient information at discharge they record any missing information. This has highlighted a problem with the Kardex. From 26/6/19 to date five Kardexs have been missing – the ward clerk searches for these but it does highlight a problem with this particular piece of documentation.

Commented [WS6]: is this still the case

Results

- Results and X-rays on the ward must be signed – if they are not they must remain on the ward until such time as they are signed – this is leading to boxes of results being held at ward level. ~~This has been highlighted by the Medical Director.~~

- Results in paper form should be viewed/actioned and not held back until a chart is available or previous clinic letter is typed. You can action the results and advise for urgent typing straight away.

If you have any questions regarding these issues please contact Anita Carroll, Assistant Director Functional and Support Services. It is important that we all adhere to established administration processes to ensure that our patients remain safe, effective and efficient for the patients we serve.

Yours sincerely

Personal Information redacted by USI

DR MARIA O'KANE
MEDICAL DIRECTOR

From: Carroll, Anita <[redacted]>
Sent: 07 February 2019 15:32
To: Haynes, Mark <[redacted]>
Subject: FW: Patients awaiting results

Mark

Thank you for supporting this , and reinforcing the governance issue.
A

From: Robinson, Katherine
Sent: 07 February 2019 14:48
To: Carroll, Anita
Subject: FW: Patients awaiting results

Realised I should have copied you into this.

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Robinson, Katherine
Sent: 07 February 2019 10:00
To: Haynes, Mark; O'Brien, Aidan; McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; 'derek.hennessey[redacted] Corrigan, Martina
Subject: RE: Patients awaiting results

Folks

Can I just back this up by saying that Dr Rankin introduced this process trust wide many years ago due as a result of safety issues with patients. It actually increases secretarial work load due to extra checks but this is in the best interest of patients. I am aware Mr O'Brien that your secretary in particular does not use DARO in all cases and will put patients directly on the review waiting list as per your instruction. I have expressed my concern with her not implementing the DARO process fully.

Collette McCaul is the Line Manager to Urology, ENT, Opthalmology and Oral Surgery, it is her responsibility to follow directives and remind staff of processes that are in place. Collette was merely doing her job.

Regards

Katherine

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by USI
e: Personal Information redacted by USI

From: Haynes, Mark
Sent: 07 February 2019 06:24
To: O'Brien, Aidan; McCaul, Collette; Robinson, Katherine
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; 'derek.hennessey Personal Information redacted by the USI'; Corrigan, Martina
Subject: RE: Patients awaiting results

Morning

The process below is not a urology process but a trust wide process. It is intended, in light of the reality that patients in many specialities do not get a review OP at the time intended (and can in many cases take place years after the intent), to ensure that scans are reviewed and in particular unanticipated findings actioned. Without this process there is a risk that patients may await review without a result being looked at. There have been cases (not urology) of patients imaging not being actioned and resultant delay in management of significant pathologies. As stated this is a trust wide governance process that is intended to ensure there are no unactioned significant findings. There is no risk in the process described.

If the patient described has their scan in May, the report will be available to you and can be signed off and the patient planned for review in June, there is no delay to the patients care. The DARO list is reviewed regularly by the secretarial team and would pick up if the scan has been done but you hadn't received the report, if the scan hasn't been done etc.

It may be ideal that such a patient described would be placed on both the DARO list and a review OP WL but PAS does not allow for this.

I have no issue (as a clinician or as AMD) with the process described as it does not risk a patient not being seen and acts as a safety net for their test results being seen.

Mark

From: O'Brien, Aidan
Sent: 06 February 2019 23:33
To: McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; 'derek.hennessey Personal Information redacted by the USI'; Corrigan, Martina
Subject: FW: Patients awaiting results
Importance: High

Dear Ms. McCaul,

I have been greatly concerned, indeed alarmed, to have learned of this directive which has been shared with me, out of similar concern.

The purpose of, the reason for, the decision to review a patient is indeed to review the patient.
The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.
The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.
One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.
One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?
Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed.
I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

Perhaps, one example will suffice.
The last patient on whom I operated today is a [redacted] old lady who has been known for some years to have partial duplication of both upper urinary tracts.
She has significantly reduced function provided by her left kidney.
She also has left ureteric reflux.
However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.
She has been suffering from intermittent right loin and flank pain, as well as left flank pain when she has a urinary infection.
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She is scheduled for discharge tomorrow.
I planned to have a CT scan repeated in May and to review her in June.
The purpose of reviewing her is to determine whether her surgical intervention has relieved her of her pain, reduced the incidence of infection, and as a consequence, reduced the frequency and severity of her left flank pain.
Review of the CT images at the time of the patient's review will inform her review.
It will evidently not replace it.

Lastly, I find it remarkable that your process be clarified with secretarial staff without consultation with or agreement with consultants who, by definition, should be consulted!

I would request that you consider withdrawing your directive as it has profound implications for the management of patients, and certainly until it has been discussed with clinicians.
I would also be grateful if you would advise by earliest return who authorised this process,

Aidan O'Brien.

From: Elliott, Noleen
Sent: 01 February 2019 13:17
To: O'Brien, Aidan
Subject: FW: Patients awaiting results
Importance: High

From: McCaul, Collette
Sent: 30 January 2019 12:33
To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, NicolaJ; Troughton, Elizabeth
Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

Hi all

I just need to clarify this process.

If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result not put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward

Collette McCaul
Acting Service Administrator (SEC) and EDT Project Officer
Ground Floor
Ramone Building
CAH
Ext Personal Information redacted by USI

From: Carroll, Anita <[redacted]>
Sent: 11 February 2019 17:11
To: Gishkori, Esther <[redacted]>; Carroll, Ronan <[redacted]>
Subject: FW: DARO issue

Keeping you in the loop

From: Robinson, Katherine
Sent: 11 February 2019 16:55
To: Carroll, Anita
Cc: OKane, Maria; McCaul, Collette
Subject: DARO issue

Anita

Just to keep you in the loop, Dr Maria O'Kane emailed Collette McCaul asking her to phone her this afternoon re the email regarding secs and DARO. Remember Mr O'Brien had an issue with the instruction to secs.

Dr O'Kane has asked us to quality assure 1 weeks' worth of discharges in Medicine to see in particular what is actually written on the discharge summary and what we do then at our end.

We aim to do this within the next couple of weeks but as you know we are doing large pieces of validation at the minute so lots of competing priorities.

We will keep you posted.

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Robinson, Katherine <Personal Information redacted by the USI>
Sent: 07 February 2019 14:48
To: Carroll, Anita <Personal Information redacted by the USI>
Subject: FW: Patients awaiting results

Realised I should have copied you into this.

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Robinson, Katherine
Sent: 07 February 2019 10:00
To: Haynes, Mark; O'Brien, Aidan; McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; 'derek.hennessey Personal Information redacted by the USI'; Corrigan, Martina
Subject: RE: Patients awaiting results

Folks

Can I just back this up by saying that Dr Rankin introduced this process trust wide many years ago due as a result of safety issues with patients. It actually increases secretarial work load due to extra checks but this is in the best interest of patients. I am aware Mr O'Brien that your secretary in particular does not use DARO in all cases and will put patients directly on the review waiting list as per your instruction. I have expressed my concern with her not implementing the DARO process fully.

Collette McCaul is the Line Manager to Urology, ENT, Opthalmology and Oral Surgery, it is her responsibility to follow directives and remind staff of processes that are in place. Collette was merely doing her job.

Regards

Katherine

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Haynes, Mark
Sent: 07 February 2019 06:24
To: O'Brien, Aidan; McCaul, Collette; Robinson, Katherine
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; 'derek.hennessey Personal Information redacted by the USI '; Corrigan, Martina
Subject: RE: Patients awaiting results

Morning

The process below is not a urology process but a trust wide process. It is intended, in light of the reality that patients in many specialities do not get a review OP at the time intended (and can in many cases take place years after the intent), to ensure that scans are reviewed and in particular unanticipated findings actioned. Without this process there is a risk that patients may await review without a result being looked at. There have been cases (not urology) of patients imaging not being actioned and resultant delay in management of significant pathologies. As stated this is a trust wide governance process that is intended to ensure there are no unactioned significant findings. There is no risk in the process described.

If the patient described has their scan in May, the report will be available to you and can be signed off and the patient planned for review in June, there is no delay to the patients care. The DARO list is reviewed regularly by the secretarial team and would pick up if the scan has been done but you hadn't received the report, if the scan hasn't been done etc.

It may be ideal that such a patient described would be placed on both the DARO list and a review OP WL but PAS does not allow for this.

I have no issue (as a clinician or as AMD) with the process described as it does not risk a patient not being seen and acts as a safety net for their test results being seen.

Mark

From: O'Brien, Aidan
Sent: 06 February 2019 23:33
To: McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; 'derek.hennessey Personal Information redacted by the USI ; Corrigan, Martina
Subject: FW: Patients awaiting results
Importance: High

Dear Ms. McCaul,

I have been greatly concerned, indeed alarmed, to have learned of this directive which has been shared with me, out of similar concern.

The purpose of, the reason for, the decision to review a patient is indeed to review the patient. The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.

The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.
One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.
One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?
Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed.
I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

Perhaps, one example will suffice.
The last patient on whom I operated today is a Personal Information redacted by the old lady who has been known for some years to have partial duplication of both upper urinary tracts.
She has significantly reduced function provided by her left kidney.
She also has left ureteric reflux.
However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.
She has been suffering from intermittent right loin and flank pain, as well as left flank pain when she has a urinary infection.
Today, I have managed to virtually completely clear stone from the diverticulum after the second session of laser infundibulotomy and lithotripsy.
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Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

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If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result not put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

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Can we make sure we are all following this process going forward

Collette McCaul
Acting Service Administrator (SEC) and EDT Project Officer
Ground Floor
Ramone Building
CAH
Ext Personal Information

From: Poland, Orla <Personal Information redacted by the USI>
Sent: 10 June 2022 13:15
To: Carroll, Anita <Personal Information redacted by the USI>
Subject: FW: REPORT_11_-_ACTIVE_WAITS_WITH_SUSPECT_CANCER_METHOD_OF_ADMISSION.xlsx

Example of suspect cancer patients who have not been coded with one of the new priority 2A-D Codes

From: Poland, Orla
Sent: 30 May 2022 14:50
To: Brannigan, Joanne <Personal Information redacted by the USI>; Burke, Catherine <Personal Information redacted by the USI>; Carleton, Joy <Personal Information redacted by the USI>; Carville, Gail <Personal Information redacted by the USI>; Daly, Laura <Personal Information redacted by the USI>; Dignam, Paulette <Personal Information redacted by the USI>; Doran, Moya <Personal Information redacted by the USI>; Elliott, Hazel <Personal Information redacted by the USI>; Elliott, Noleen <Personal Information redacted by the USI>; Hall, Pamela <Personal Information redacted by the USI>; Hanvey, Leanne <Personal Information redacted by the USI>; Harbinson, Laura <Personal Information redacted by the USI>; Henry, Ellen <Personal Information redacted by the USI>; Hopps, Caroline <Personal Information redacted by the USI>; Lennon, Pauline <Personal Information redacted by the USI>; Loughran, Teresa <Personal Information redacted by the USI>; Magee, Lisa <Personal Information redacted by the USI>; MASSEY, JOANNE <Personal Information redacted by the USI>; Maxwell, Sharon <Personal Information redacted by the USI>; McCann, Nicola G <Personal Information redacted by the USI>; McConville, Carrie <Personal Information redacted by the USI>; McGuigan, Paula <Personal Information redacted by the USI>; Mollon, Alix <Personal Information redacted by the USI>; Nugent, Carol <Personal Information redacted by the USI>; OHagan, SineadM <Personal Information redacted by the USI>; Park, Janice M <Personal Information redacted by the USI>; Renney, Cathy <Personal Information redacted by the USI>; Richardson, Shirley <Personal Information redacted by the USI>; Robinson, NicolaJ <Personal Information redacted by the USI>; Sullivan, Claire <Personal Information redacted by the USI>; Tierna <Personal Information redacted by the USI>; Troughton, Elizabeth <Personal Information redacted by the USI>; Wortley, Heather <Personal Information redacted by the USI>
Cc: Cunningham, Lucia <Personal Information redacted by the USI>; Rafferty, Lauri <Personal Information redacted by the USI>; McAlinden, AnneMarie <Personal Information redacted by the USI>
Subject: REPORT_11_-_ACTIVE_WAITS_WITH_SUSPECT_CANCER_METHOD_OF_ADMISSION.xlsx

HI All,

Please see attached report showing patients added to a WL with a suspect cancer code but a 2A-D priority level was not selected. Can you please validate the list and remember to add this code at the time of putting on system as it affects the figures reported to the monthly regional meeting.

Lucia/Anne-Marie/Laurie I have filtered for my area but if you want check as there were some for your areas also on the attached

Kind Regards

Orla Poland
Service Administrator SEC
Second Floor | Tower Block | Craigavon Area Hospital | 68 Lurgan Road | Craigavon | BT63 5QQ |
T: External Personal Information redacted by the USI Internal Personal Information Mob: Personal Information redacted by the USI | E: Personal Information redacted by the USI

Specialty Description (R)	Specialty Description	Consultant Name	HCN	Casenote	Current Date	Date Booked	Expected Method of Adm.	Urgency Code Description	Intended Primary Procedure Code	Admission Reason	Expected Ward	Total Days Waiting	Weeks waiting	Total Waiting
GENERAL SURGERY	GENERAL SURGERY(C)	Mcelvanna K Mr	Personal Information redacted by the USI		21/10/2020		SA	URGENT OTHER	Y75.2	LAPAROSCOPIC SIGMOID COLECTOMY		586	83.63	1
GENERAL SURGERY	GENERAL SURGERY(C)	Hewitt G.R. Mr			04/03/2021		SA	URGENT OTHER	H44.4	ANAL PAIN RF DC		452	64.48	1
GENERAL SURGERY	GENERAL SURGERY(C)	Epanomeritakis E Mr			27/06/2021		SA	URGENT OTHER	H02.9	R.F LAPAROSCOPIC APPENDICECTOMY +/- CECECTOMY		337	48.08	1
GENERAL SURGERY	GENERAL SURGERY(C)	Epanomeritakis E Mr			04/10/2021		SA	URGENT OTHER	H41.2	R.F TRANSANAL RESECTION / TAMIS PROCEDURE		238	33.94	1
GENERAL SURGERY	GENERAL SURGERY(C)	Epanomeritakis E Mr			08/12/2021		SA	URGENT OTHER	H07.9	RED FLAG RT HEMICOLECTOMY+ILEOCAECAL RESECTION EE LIST		173	24.60	1
GENERAL SURGERY	GENERAL SURGERY(C)	Yousaf M Mr			26/01/2022		SA	URGENT OTHER	G45.9	BCS OGD, BIOPSIES AND COLONOSCOPY		124	17.64	1
GENERAL SURGERY	GENERAL SURGERY(C)	Mark D A Mr			09/02/2022		SA	URGENT OTHER	T87.7	GROIN LYMPH NODE BIOPSY GA ARABIC INTERPRETER		110	15.66	1
GENERAL SURGERY	GENERAL SURGERY(C)	Epanomeritakis E Mr			07/03/2022		SD	URGENT OTHER	G45.9	RED FLAG OGD EE LIST ONLY PER EMAIL 070422		84	11.92	1
GENERAL SURGERY	GENERAL SURGERY(C)	Neill A K Mr			26/04/2022		SC	URGENT OTHER	H01.2	APPENDICECTOMY		34	4.79	1
GENERAL SURGERY	GENERAL SURGERY(C)	Neill A K Mr			09/05/2022	31/05/2022	SC	URGENT OTHER	T30.9	LAPAROTOMY & EXCISION OF LESION	1 WEST ADMISSIONS WARD	21	2.95	1
GENERAL SURGERY	GENERAL SURGERY(C)	Mackle E Mr			20/05/2022		SC	URGENT OTHER	H25.9	FLEXIBLE SIGMOIDOSCOPY		10	1.34	1
GENERAL SURGERY	GENERAL SURGERY(C)	Epanomeritakis E Mr			26/05/2022	16/06/2022	SA	URGENT OTHER	H07.9	CAECAL TUMOUR RF INPATIENT EE LIST 16.6.22	1 WEST ADMISSIONS WARD	4	0.57	1
GENERAL SURGERY	GENERAL SURGERY(C)	Mcelvanna K Mr			30/05/2022	01/06/2022	SA	URGENT OTHER	X55.9	EUS IN RADIOLOGY	1 WEST ADMISSIONS WARD	0	0.00	1
UROLOGY	UROLOGY(C)	Omer S Dr			30/03/2021		SA	URGENT OTHER	M45.9	RF FLEXI HEMIPLEGIC STRETCHER TRANSFER		426	60.79	1
UROLOGY	UROLOGY(C)	Khan N Mr			18/05/2022		SA	URGENT OTHER	M42.1	RF TURBT & BIOPSY		12	1.64	1
ENT	EAR NOSE AND THROAT(C)	Gurunathan R Mr			15/11/2021	13/06/2022	SA	URGENT OTHER	E34.9	MLS & BX & LASER RESECTION P2D CAH ONLY	1 WEST ADMISSIONS WARD	196	27.93	1
ENT	EAR NOSE AND THROAT(C)	Korda M Mr			23/05/2022		SA	URGENT OTHER	B08.4	LEFT THYROID LOBECTOMY		7	0.93	1
GENERAL SURGERY	GENERAL SURGERY(C)	Mark D A Mr			29/03/2022		SD	URGENT OTHER	H22.9	POOR BOWEL PREP 2ND ATTEMPT COLON WITH DIFF BOWEL PREP		62	8.79	1
GENERAL SURGERY	MINOR OPS. - GEN SURGERY (C)	Minor Ops. - Gen Surgery			08/03/2022		SD	ROUTINE	S06.9	LUMP LEFT POSTERIOLATERAL THORACIC REGION		83	11.79	1
GENERAL SURGERY	MINOR OPS. - GEN SURGERY (C)	Minor Ops. - Gen Surgery			08/03/2022		SD	ROUTINE	S06.9	SEBACEOUS CYST MIDLINE SUPRASTERNAL NOTCH		83	11.79	1
GENERAL SURGERY	MINOR OPS. - GEN SURGERY (C)	Minor Ops. - Gen Surgery			30/03/2022		SD	ROUTINE	S06.9	SEBACEOUS CYST BACK		61	8.65	1
UROLOGY	UROLOGY(C)	Khan N Mr			09/05/2022	10/06/2022	SA	URGENT OTHER	M45.9	RF CYSTOSCOPY +/- BIOPSY/RESECTION - TURBT	DHH ELECTIVE ADMISSIONS WARD	21	2.94	1
GENERAL SURGERY	GENERAL SURGERY(C)	General Surgeon A			15/09/2020		SA	URGENT OTHER	S06.9	RED FLAG EXCISION OF SKIN LESION		622	88.79	1
GENERAL SURGERY	GENERAL SURGERY(C)	General Surgeon A			14/06/2021		SA	ROUTINE	S06.9	EXCISION SEBACEOUS CYST LEFT AREOLA AND RIGHT BREAST		350	49.90	1

Received from Anita Carroll on 26/06/2022. Annotated by the Urology Services Inquiry.

From: Poland, Orla <[redacted]>
Sent: 10 June 2022 13:13
To: Carroll, Anita <[redacted]>
Subject: FW: 15_-_NEW_OP_REFERRALS__-_REFERRAL_SOURCE_PTN_(PRIVATE_TO_NHS).xlsx

Example of Private to NHS Report

From: Poland, Orla
Sent: 04 April 2022 10:58
To: Robinson, Katherine <[redacted]>
Subject: 15_-_NEW_OP_REFERRALS__-_REFERRAL_SOURCE_PTN_(PRIVATE_TO_NHS).xlsx

PTN Report all ok for my areas for March 2022

Referral Fiscal Year	Hospital Name	Speciality Description (R)	Specialty Description	Consultant Name	Casenote	HCN	Referral Date Only	Referrals	Referral Source Description	
					Personal Information redacted by the USI					
FY2021/2022	CRAIGAVON AREA HOSPITAL	ENT	EAR NOSE AND THROAT(C)	GURUNATHAN R MR			17/03/2022	1	PRIVATE TO NHS (N)	DARO FOR MRI SCAN
FY2021/2022	CRAIGAVON AREA HOSPITAL	ENT	EAR NOSE AND THROAT(C)	MCNABOE E.J. MR						DARO FOR CT
FY2021/2022	CRAIGAVON AREA HOSPITAL	ENT	EAR NOSE AND THROAT(C)	REDDY CEE MR			07/03/2022	1	PRIVATE TO NHS (N)	DARO FOR AUDIOLOGY
FY2021/2022	CRAIGAVON AREA HOSPITAL	ENT	EAR NOSE AND THROAT(C)	REDDY CEE MR						DARO FOR MRI SCAN
FY2021/2022	CRAIGAVON AREA HOSPITAL	GENERAL SURGERY	GENERAL SURGERY(C)	MCELVANNA K MR			01/03/2022	1	PRIVATE TO NHS (N)	ADDED TO IPWL - URGENT 2C
FY2021/2022	CRAIGAVON AREA HOSPITAL	GENERAL SURGERY	GENERAL SURGERY(C)	MCELVANNA K MR						ADDED TO IPWL
FY2021/2022	CRAIGAVON AREA HOSPITAL	GENERAL SURGERY	GENERAL SURGERY(C)	MCELVANNA K MR			14/03/2022	1	PRIVATE TO NHS (N)	ADDED TO IPWL
FY2021/2022	CRAIGAVON AREA HOSPITAL	TRAUMA AND ORTHOPAEDICS	FRACTURE(C)	DOYLE T D MR						ADDED TO OPWL - ROUTINE
FY2021/2022	CRAIGAVON AREA HOSPITAL	TRAUMA AND ORTHOPAEDICS	ORTHOPAEDICS(C)	MCLEAN G MR			10/03/2022	1	PRIVATE TO NHS (N)	ADDED TO NU WL
FY2021/2022	CRAIGAVON AREA HOSPITAL	UROLOGY	NURSE LED UROLOGY(N)	NURSE LED UROLOGY						ADDED TO NURSE LED ROUTINE WL
								18		

Received from Anita Carroll on 26/06/2022. Annotated by the Urology Services Inquiry.

From: Robinson, Katherine
Sent: 19 October 2018 15:37
To: Carroll, Anita; Clayton, Wendy
Subject: FW: Urology Triage & Escalation

SEE below. We will look at dictation etc when Collette returns on Monday. However given the amount of charts in AOB office there would seem to be some charts that need action. I believe Martina was watching this previously so am not sure what is happening in her absence

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Rankin, Christine
Sent: 19 October 2018 15:23
To: Robinson, Katherine
Cc: Browne, Leanne
Subject: Urology Triage & Escalation

Katherine

Looking at this week's report there has been a vast improvement in Urology triage.

Anything more than 5 weeks from date of referral tends to be OC referrals which may not have arrived with us yet (typing backlog), attendances not done, RF DNAs or GP letters passed to named Consultant awaiting further advice.

All of the above will be chased with copy letters (if available) printed and passed for triage. RF if not reappointed will be escalated to RF team.

No one Consultant appears to be standing out however there are a total of 3 referrals which have been chased a number of times and escalated to OSL

twice (Sinead 30/07/17 & Jane 10/09/18) as per our new process which is still in its infancy and will most likely need tweaked as weeks go by.
2 of these are registered to Mr O'Donoghue and 1 to Mr O'Brien see below:

Hosp	CHI Number	Casenote	Forenames	Surname	Spec Code	Cons Code	Priority	Referral Source	Referral Date Only	Days From Ref Date	Follow up Comment 1	Follow up Comment 2	CR 1st Escalation	CR 2nd Escalation
CAH	Personal Information redacted by the USI				URO	JOD	ROUTINE	OC	24/04/2018	177	LB EMAILED NR 310718	email to NR 13.09.18	Sinead 30/07/18	Jane 10/09/18
CAH					URO	EURO	ROUTINE	OTH	23/05/2018	148	ORED as EURO- thought was on NIECR for traige- printed for TDU 100718	email to PD 11.07.18	Sinead 30/07/18	Jane 10/09/18
CAH					URO	JOD	ROUTINE	OC	29/05/2018	142	,EMAILED TO NR 200618	EMAIL TO NR 14/9/18	Sinead 30/07/18	Jane 10/09/18

C

Christine Rankin
ACTING BOOKING MANAGER
SOUTHERN TRUST BOOKING CENTRE
Southern Health & Social Care Trust
Ramone Building
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

t: Personal Information redacted by the USI

EXT Personal Information redacted by the USI if dialling from Avaya phone.
If dialling from old phone please dial Personal Information redacted by the USI

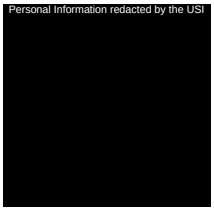
e: Personal Information redacted by the USI

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 10 March 2021 17:29
To: Corrigan, Martina <Personal Information redacted by the USI>
Cc: Robinson, Katherine <Personal Information redacted by the USI>
Subject: RE: Missing notes

M Do you recall we had raised with you the fact that charts were in his office when kath and I met Noeleen , but we can look at these and if possible get them back to records

From: Corrigan, Martina
Sent: 05 March 2021 18:38
To: Carroll, Anita
Subject: FW: Missing notes

Also as a matter of curiosity I checked PAS and there are five of these notes still tracked to his office:



What should we do about these do you think?

Would welcome your advice please.

Thanks

Martina

From: Corrigan, Martina
Sent: 05 March 2021 18:25
To: Carroll, Anita
Subject: Missing notes

Hi Anita

At one of our urology oversight meetings we had talked about notes that had gone missing for AOB away back in 2016/17 (I have attached as a reminder of the investigation at the time).

I have been asked to check with you is this a regular occurrence where a set of notes may never ever be found despite lots of searches (outside of AOB)? And if never found is there a procedure followed?

Thanks

Regards

Martina

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

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

Southern Health and Social Care Trust

Quality Care - for you, with you

Standard Operating Procedure	
Title	Missing charts
Author	Andrea Cunningham & Pamela Lawson
Date	27/11/19
Review	27/11/21
Scope of the Procedure	All staff handling patient charts

A missing chart is defined as a chart that cannot be found or its' location is unknown (even if the chart has been tracked)

1. Staff member is to look for the chart extensively and document all areas covered on the Unavailable/Missing charts database (green page). Check tracking code, all pigeon holes in office/area, audio typists, consultant's office, check previous locations from PAS etc)

2. Staff member is then to approach the supervisors for assistance. Supervisors may suggest other areas/sites to be searched. Staff member is to search the suggested areas and add to database.

3. The supervisor/manager will then take the decision whether or not to issue pages and labels.

Pages and labels must be made up as follows.

- New Cases – Referral letter (if not e-traiged), 2 CA2s/continuation sheets, first one stamped, dated and labelled plus one set of barcode labels. Completed cover sheet (green) to be placed at the front of the pages and labels, all to be stapled together and placed in a polypocket.
- Review cases – 2 CA2s/continuation sheets, first one stamped, dated and labelled. Any relevant information from patient centre eg previous clinic letters, discharge letters printed and one set of barcode labels. Completed cover sheet (green) to be placed at the front of the pages and labels, all to be stapled together and placed in a polypocket.

4. Staff member will enter details of the missing chart on to the database (green page) documenting chart number, name, last tracking location and details of all the areas checked and by whom.

5. Staff member will make up an “Alert Tracer Card” to include patient name, unit number and areas searched. This will be filed on the shelf where the chart is supposed to be filed.

6. In the event of the original chart being filed the filer must bring the “Alert Tracer Card” plus the chart (tracking appropriately) to the supervisors who will investigate where the chart has been.

7. This database will be kept under review and charts searched for periodically until found.

From: McEvoy, Joanne <Personal Information redacted by the USI>
Sent: 09 March 2021 10:15
To: Carroll, Anita <Personal Information redacted by the USI>
Subject: RE: Missing notes

Anita

Attached is the SOP for missing charts. Doesn't mention what happens if a chart is never found.

I will find out how frequently this happens. And anything we have around the charts named below.

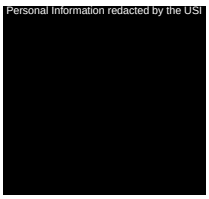
Joanne

From: Carroll, Anita
Sent: 09 March 2021 09:54
To: McEvoy, Joanne
Cc: Lappin, Aideen
Subject: FW: Missing notes

And this

From: Corrigan, Martina
Sent: 05 March 2021 18:38
To: Carroll, Anita
Subject: FW: Missing notes

Also as a matter of curiosity I checked PAS and there are five of these notes still tracked to his office:



What should we do about these do you think?

Would welcome your advice please.

Thanks

Martina

From: Corrigan, Martina
Sent: 05 March 2021 18:25
To: Carroll, Anita
Subject: Missing notes

Hi Anita

At one of our urology oversight meetings we had talked about notes that had gone missing for AOB away back in 2016/17 (I have attached as a reminder of the investigation at the time).

I have been asked to check with you is this a regular occurrence where a set of notes may never ever be found despite lots of searches (outside of AOB)? And if never found is there a procedure followed?

Thanks

Regards

Martina

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

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

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 09 March 2021 09:53
To: McEvoy, Joanne <Personal Information redacted by the USI>
Cc: Lappin, Aideen <Personal Information redacted by the USI>
Subject: FW: Missing notes

Can we chat re this

From: Corrigan, Martina
Sent: 05 March 2021 18:25
To: Carroll, Anita
Subject: Missing notes

Hi Anita

At one of our urology oversight meetings we had talked about notes that had gone missing for AOB away back in 2016/17 (I have attached as a reminder of the investigation at the time).

I have been asked to check with you is this a regular occurrence where a set of notes may never ever be found despite lots of searches (outside of AOB)? And if never found is there a procedure followed?

Thanks

Regards

Martina

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

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

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

I have no recollection of this man whatsoever. According to PAS, he attended my clinic in Banbridge on 07 September 1995. He was discharged from review at the clinic that day as he was placed on the waiting list for admission. I do not have any means of determining whether I or a Registrar had the consultation with the patient. His chart would have been returned to Records following his clinic attendance in 1995. He was subsequently cancelled from or taken off the waiting list on 06 July 1998. I have not had patient's chart since, or at all, and have no knowledge of its whereabouts.

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

This man would appear to have attended the Nurse Led Haematuria Clinic on 06 August 1999. He was then reviewed at and discharged from my review clinic in Craigavon Area Hospital on 09 November 1999. I have no recollection of this patient. I do not know whether the patient was reviewed by me or by another doctor. In any case, I have not had the patient's chart since then, or at all, and have no knowledge of its whereabouts.

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

I recall this patient intimately as he was Personal Information redacted by the USI Personal Information redacted by the USI He later became Personal Information redacted by the USI He was Personal Information redacted by the USI At his request, I performed a radical orchiectomy for testicular tumour in 1996. I reviewed him regularly at my office in the hospital, last doing so in May 2001. He subsequently developed acute bowel obstruction due to a caecal carcinoma for which he had a right hemicolectomy in the Erne Hospital. He died of metastatic disease in Personal Information redacted by the I definitely returned his chart to Records on the diagnosis of his colonic carcinoma.

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

There is no record on PAS of this person ever having been my patient, and I have no record of him having attended privately. He last attended Mr. Mulligan's clinic in February 1993.

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

There is no record of this man having had any clinical episodes on PAS. He does not even have a H&C number. He has not attended me privately.

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

This person has never been my patient, either NHS or privately. Her last clinical episode was in July 1988, under the care of Mr. Wallace, four years before I was appointed to Craigavon Area Hospital!

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

This person was born on Personal Information redacted by the USI and discharged from hospital one week later, on Personal Information redacted by the USI. There have been no clinical episodes since then. He does not have a H&C number. He has not been my patient.

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

This person has not had any clinical episodes since discharge from hospital, under the care of Mr. Mackle, in November 1992. This person has not been my patient at any time.

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

There is no record on PAS of this person having had any clinical episodes. She does not have a H&C number. She has not been my patient at any time.

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

This person has not been my patient at any time. I have not had his chart.

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

There is no record of this patient having been my patient. She has not attended privately. I have not had her chart.

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

I know this patient very well, as she is Personal Information redacted by the USI of the Personal Information redacted by the USI well known to all doctors. I dictated correspondence regarding Personal Information redacted by the USI in August 2016. It was typed by an audiotypist in 16 August 2016. I presume it was then returned to Records. Her chart was not available when I reviewed her at my clinic at South West Acute Hospital on 19 September 2016. I have not had her chart since August 2016.

Personal Information redacted by the USI

Personal Information redacted by the USI

I have known this patient, known as Personal Information redacted by the USI personally for many years. He attended privately on 21 November 2015. His chart was **definitely** returned to my office on Tuesday 03 January 2017. I have kept a meticulous record of all the charts of private patients that were returned. I have retained duplicate clinical records for all these private patients.

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 18 March 2021 13:24
To: Corrigan, Martina <Personal Information redacted by the USI>
Cc: McEvoy, Joanne <Personal Information redacted by the USI>
Subject: FW: Missing Notes
Importance: High

Martina see detail below happy to discuss as needed
A

From: Lawson, Pamela
Sent: 18 March 2021 13:03
To: Carroll, Anita; McEvoy, Joanne
Subject: FW: Missing Notes
Importance: High

Please see updated list below

Pamela

Patient	Chart Number and Details on Tracking / PAS	Checked in Old Office?
Personal Information redacted by the USI	Personal Information redacted by the USI – tracked by Monica 08/08/2007 • There are no episodes on PAS , and this chart has only ever been tracked to Monica • Pamela has queried if this was perhaps a private chart that Monica made up and she may have tracked it when she shouldn't have • Pamela can't find chart mentioned anywhere	
Personal Information redacted by the USI	Personal Information redacted by the USI – tracked by Monica 11/04/2011 • There are episodes on PAS but - no urology episodes on PAS • Chart tracked to bundle 2 by Monica • There is an old chart in storage – Personal Information redacted by the USI • Pamela has suggested that Monica could have tracked the wrong number	
Personal Information redacted by the USI	Personal Information redacted by the USI – tracked by Monica 16/09/10 • Infant • No urology episodes on PAS • Chart tracking only Monica	

	• Old neo-natal chart in storage Personal Information redacted by the USI • Pamela has suggested this could have been a mis- track by Monica	
Personal Information redacted by the USI	Personal Information redacted by the USI – tracked by Monica 11/04/2011 • No urology episodes on PAS • chart tracked to bundle 19 by Monica • old chart in storage – APE 22	
Personal Information redacted by the	Personal Information redacted by the USI – tracked by Monica 11/10/2005 • Chart tracked to office by Leanne Hanvey – AOB to see patient in office • Only ever tracked by Leanne. • There is an old chart in storage Personal Information redacted by the USI	
Personal Information redacted by the USI	Personal Information redacted by the USI Tracked by Monica on 13/06/2003 which was initial tracking day Old chart in storage – Personal Information redacted by the USI	
Personal Information redacted by the USI	Personal Information redacted by the USI Chart in health records	
Personal Information redacted by the USI	Personal Information redacted by the USI Chart in health records	
Personal Information redacted by the USI	Personal Information redacted by the USI Chart in health records	
Personal Information redacted by the USI	Personal Information redacted by the USI Tracked by BBPC staff to Monica on 18/03/2010 for perusal – first tracking No urology episodes on PAS	
Personal Information redacted by the USI	Personal Information redacted by the USI Chart in health records	
Personal Information redacted by the USI	Personal Information redacted by the USI Chart in health records	

Personal Information redacted by the USI	Personal Information redacted by the USI Chart in Oasis	

Head of Health Records & Admin Services
Functional Support Services | Acute Directorate
Admin Floor | Craigavon Hospital
Personal Information redacted by the USI / Ext: Personal Information

Noelene Elliott 1/9/20

Spoke to Noelene following a complaint from Jeanette Collins whereby NE had been very unhelpful and when a call was put through to her she said “why are you sending your rubbish through to us”?

I advised that really this was not nice and really Jeanette was trying to help a patient out. I advised her she also had set the phone down on Orla Poland recently and that this was not on. Noelene said that was because one minute she was to work with Reem Salman the next the job was given to someone else. I explained the reasoning behind the decision and the reason it was reversed was because Mr O’Brien was going to be replaced and we didn’t know that at the time plus Noelene had expressedly said she would prefer to stay in Urology. Noelene said she was stressed over the AOB investigation/SAI.

2/9/20

On reflection I rang Noelene to see how she was because our conversation did not end well the previous day and that she said she was stressed about the investigation. I advised it was nothing to do with her but as long as she was doing what she was supposed to be doing she was ok. She said AOB had asked her to change some things and she did. I advised she should not have done this and she had to do the right thing and also that she should be taking her instructions from her line management team. She said it was difficult because she worked so closely with AOB. I said I appreciate that but she still should have advised her line manager and she had to the right thing or we could not protect her. I reminded her that I had also told her this before.

I advised now that AOB had left the Trust that she needed to do the right thing at all times no matter what her relationship with the consultant was.

From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 03 September 2020 16:58
To: Carroll, Anita <Personal Information redacted by the USI>; Robinson, Katherine <Personal Information redacted by the USI>
Subject: RE: areas to raise with Noleen

Thanks Anita

Regards

Martina

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

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

From: Carroll, Anita
Sent: 03 September 2020 16:06
To: Corrigan, Martina; Robinson, Katherine
Subject: RE: areas to raise with Noleen

Martina we met Noeleen and Katherine will update
A

From: Corrigan, Martina
Sent: 03 September 2020 13:17
To: Carroll, Anita; Robinson, Katherine
Subject: FW: areas to raise with Noleen

Dear both,

See below, sorry for delay as I had sent to Mark but he hasn't had a chance to look at this, so don't want to delay any longer

As discussed earlier the purpose of the meeting is to try and understand the processes that existed between Mr O'Brien and Noleen.
(as agreed this will come from the view of knowing that she was loyal to him and that she had a good working relationship but now we want to make sure that she is kept right and that there is nothing outstanding that may come back on her now that he has retired)

- What were the communication methods for escalating any issues (GP's patients, other enquiries from labs/theatres/radiology/MDM etc)

- We are aware that Mr O'Brien didn't use DARO so how did NE and AOB ensure that no patients 'slipped' through the net in that they were aware as to which patients were waiting their investigation and which results had been returned or not returned?
- Letters from outside the Trust (e.g. oncology, other Trusts etc.) how were they brought to AOB's attention and did Noleen have a mechanism to ensure that they were actioned?
- We all know that AOB had a delay in dictation had NE any processes which she was able to chase on what was outstanding?

Regards

Martina

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

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

From: Robinson, Katherine <[redacted]>
Sent: 04 September 2020 13:27
To: Carroll, Anita <[redacted]>; Corrigan, Martina <[redacted]>
Subject: Notes of Meeting with NElliott updated

These are the notes from meeting yesterday with Noelene Elliott. She has made a couple of minor changes.

K

Notes of Meeting with N.Elliott, Anita Carroll & Katherine Robinson via desktop

3/9/20

Anita introduced herself and explained that KR had raised the issue of Noelene's stress with her. Anita advised that these concerns had led her to ask to meet to discuss. Anita asked her how long she had worked for AOB and NE advised 5 years, Anita recognised that the relationship between consultant and secretary but said they needed to discuss admin arrangements and get a clear position on paperwork / admin functions and how things worked in particular as to get a feel for what was stressing Noelene and also the fact that she had advised KR the previous day that AOB had asked her to change some things When asked about this at this meeting, she denied that she changed things but advised she didn't use all admin processes in particular the DARO function.

- **DARO-** Noelene advised that AOB hated using this function so Noelene had only approx. 50 on her Daro list because she only used it when Regs sent patients for results. For AOB's pts she used the outpatient waiting list as per AOB. This method was felt by them to be their safety net. EG
  CT scan requested, 6 mths, this was put on the review w/l to be seen within 7 mths time.

- **Results** – on receipt of paper form of results, these would be passed to AOB and the chart would be tracked to CAOBS – Result for AOB to see (*Awaiting results)*. This was proof that AOB had been passed the actual result. These charts remained in the sec office until a result was returned to Noelene for further action. Routine results never made their way back to Noelene, only urgent ones. Periodically Noelene went through the charts in the Awaiting results section of her office to chase up anything outstanding. It was explained to Noelene that this was not foolproof and this is why DARO was introduced some years ago.

- **Outstanding paperwork for AOB –** Mr Fell was working his way through things and Noelene was using the function DARO per admin policy.

- **Backlog Reports – delays in dictation etc,** Noelene advised that AOB didn't get to tidy everything up due to the way he retired. She advised that there were approx. 100 charts in the Awaiting Results section of her office that need checked. Martina to be informed.

- **Oncology Letters from Belfast –** These letters were passed to AOB and because now they are on NIECR they were not always (never were) passed back to Noelene.

Following discussion Noeleen did advise that she was unhappy with how changes were communicated with her recently (following AOB retirement) she said she was asked to work for Ms Salaman in Breast surgery and then this offer was withdrawn , Anita and Katherine agreed the communication had been poor and then discussed the current role in urology, Noeleen expressed that she would prefer to work in another specialty as

she feels at present she is being ignored by Urology Consultants. It is now arranged that Noelene will leave Urology and go and work with the Breast team as a secretary. Noelene is happy with this new arrangement.

From: Carroll, Anita <[redacted]>
Sent: 10 September 2020 13:42
To: McClements, Melanie <[redacted]>
Cc: Carroll, Ronan <[redacted]>
Subject: FW: Notes of Meeting with NElliott updated

fyi

From: Robinson, Katherine
Sent: 04 September 2020 13:27
To: Carroll, Anita; Corrigan, Martina
Subject: Notes of Meeting with NElliott updated

These are the notes from meeting yesterday with Noelene Elliott. She has made a couple of minor changes.

K

Notes of Meeting with N.Elliott, Anita Carroll & Katherine Robinson via desktop

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- **DARO-** Noelene advised that AOB hated using this function so Noelene had only approx. 50 on her Daro list because she only used it when Regs sent patients for results. For AOB's pts she used the outpatient waiting list as per AOB. This method was felt by them to be their safety net. EG

  CT scan requested, 6 mths, this was put on the review w/l to be seen within 7 mths time.

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- **Backlog Reports – delays in dictation etc,** Noelene advised that AOB didn't get to tidy everything up due to the way he retired. She advised that there were approx. 100 charts in the Awaiting Results section of her office that need checked. Martina to be informed.

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she feels at present she is being ignored by Urology Consultants. It is now arranged that Noelene will leave Urology and go and work with the Breast team as a secretary. Noelene is happy with this new arrangement.

From: Corrigan, Martina <[redacted]>
Sent: 25 October 2020 14:25
To: Robinson, Katherine <[redacted]>
Cc: Carroll, Anita <[redacted]>
Subject: RE: NE

Katherine

I had spoken with Mr Omer on Friday and he has been doing this exercise and will be continuing to do this admin

Regards

Martina

From: Robinson, Katherine
Sent: 21 October 2020 15:52
To: Corrigan, Martina
Cc: Carroll, Anita
Subject: RE: NE

Anita

The secretary Carrie and Orla Poland have gone through charts in NE office and is leaving queries with Mr Omer. I think its necessary to perhaps advise Mr Omer to make sure he does do this exercise. The office is now well sorted and lots of charts have gone back to filing, no obvious need for them to be there.

K

From: Corrigan, Martina
Sent: 12 October 2020 10:54
To: Robinson, Katherine
Cc: Carroll, Anita
Subject: RE: NE

Mr Fel has left (4 September)and I am not sure if Mr Omer his replacement is working through these at the moment?

Regards

Martina

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

Telephone:
EXT [redacted] (Internal)
[redacted] (External)

Personal Information redacted by the USI (Mobile)

From: Robinson, Katherine
Sent: 12 October 2020 10:14
To: Corrigan, Martina
Cc: Carroll, Anita
Subject: RE: NE

So the charts that are there currently is Mr Fell not working through these?

From: Corrigan, Martina
Sent: 12 October 2020 10:11
To: Robinson, Katherine
Cc: Carroll, Anita
Subject: RE: NE

Katherine

The reason we had said that she was not to look at or do anything with the charts in Mr O'Brien's office was that there was a concern raised that Noleen was liaising with Mr O'Brien regarding what was in his office and this couldn't continue to happen. As he has now retired totally this is no longer a problem. The conversation that Noleen had with Melanie was along the same lines as yourselves in that she was concerned that the charts were sitting and no-one was looking at these, when Melanie asked her what they were concerning she did say mostly awaiting results.

Therefore as with all other secretaries we would expect that they are being highlighted to their consultants and in this case anything of concern needs to be raised and then we will bring this to one of the team which is why we need Noleen to be doing a plan on what needs to be looked at (this is because Noleen and Mr O'Brien didn't use DARO).

Regards

Martina

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

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

From: Robinson, Katherine
Sent: 12 October 2020 10:03
To: Corrigan, Martina
Cc: Carroll, Anita
Subject: RE: NE

Martina

We can get this sorted but remember you advised me to ask Noelene not to touch any charts in Mr O'Brien's office and to not go into his office. Noelene did not raise a concern re charts as such, she

mentioned that there were some things outstanding and that Mr Fel was working his way through them. I have no idea what Melanie's discussion with Noelene entailed etc. If these are charts for other reasons and no action is being taken, I don't understand why as I understood you were looking into these as part of some look back exercise, no?

By all means however, we will look into these now as a matter of urgency if this is now required.

K

From: Corrigan, Martina
Sent: 12 October 2020 08:04
To: Robinson, Katherine
Subject: NE

Good morning Katherine

At the meeting with Anita, yourself and Noleen Elliott and subsequent meeting that Noleen had with Melanie, Noleen had raised concern over charts in her office and in Mr O'Brien's office (which are now in my office). Melanie has asked that as Noleen knows why these notes have been casenote tracked to her and Mr O'Brien and what her concerns are in respect to these that she is asked to go through these and make a plan and identify what is required from these. Melanie has also asked that someone sit with her whilst she is doing this so that we can ascertain what are the concerns that she has.

Can you advise when this piece of work will be completed and also let me know where the charts in my office need to be sent to.

Regards

Martina

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

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

From: Robinson, Katherine <[redacted]>
Sent: 06 November 2020 15:13
To: Carroll, Anita <[redacted]>; Corrigan, Martina <[redacted]>
Subject: Oncology letters - AOB

Following meeting this am, I spoke to NE:

When oncology letters were received into our Trust from April 2017 NE kept a log book of what letters she passed to AOB. I put this process in place at that time as a result of a datix. She did not log anything on PAS, ie add pats to a waiting list without AOB instructions. This would be correct as it was not her decision, only a consultant can decide this.

K

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 20 July 2021 11:48
To: Stinson, Emma M <Personal Information redacted by the USI>
Cc: Carroll, Ronan <Personal Information redacted by the USI>; Boyce, Tracey <Personal Information redacted by the USI>
Subject: FW: *For Action* AOB Internal Audit Report

Emma

Some comments below for Jennifer please.

Thanks
Anita

Page 4 – Change of Status Process
We now have codes PHS & PTN, 1 for Inpatients and 1 for Outpatients, may need reflected in report.

Page 12 – Recommendation 1.7
As above but we now have the report set up in Business Objects and I have shared with Private Patient Officer to cross check. Also all secretaries reminded of codes and when to use.

Page 18 – Recommendation 2.2
I think this will be Speciality Specific, this sits with Operational ADs and to advise AD FSS, I should not be responsible for this as this is service led.

Page 22- 3.2 Responsible manager
The report advised above can be run via Business objects by Pre Op team – Ronan would need to advise the Team.

Page 22 – Bullet point 3
Discharge awaiting results outcome – DARO is used only for patients awaiting results and is reflected in monthly Service Administrators reports.

From: Stinson, Emma M
Sent: 14 July 2021 14:57
To: Carroll, Anita; Boyce, Tracey; Carroll, Ronan
Subject: *For Action* AOB Internal Audit Report

Dear all

Please see attached for your information and action as per your areas of responsibility.

Ronan – as mentioned in recommendations 3.1 and 3.2 could you update the 2019/20 Management of Pre-Op Assessments Audit Report please?

Let me know if you need the password.

Many thanks
Emma

Emma Stinson

PA to Mrs Melanie McClements, Director of Acute Services
SHSCT, Admin Floor, Craigavon Area Hospital

Direct Line: Personal Information redacted by the USI

Personal Information redacted by the USI

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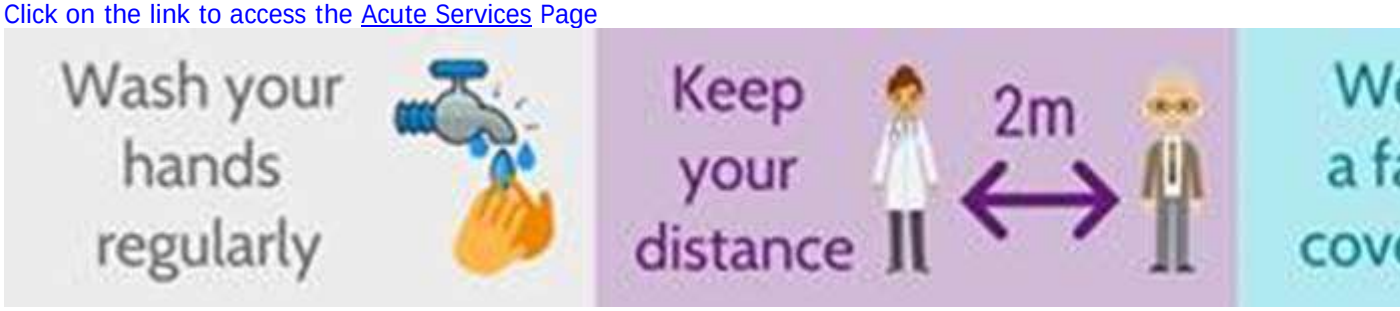
Click on the link to access the Acute Services Page



From: Jennifer McCaw [mailto: Personal Information redacted by the USI]
Sent: 13 July 2021 16:17
To: Trouton, Heather; McClements, Melanie; OKane, Maria; Wallace, Stephen; Corrigan, Martina
Subject: AOB

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

Dear All
Thank you for taking the time to meet today I have updated the report and included responsible officers and implementation dates. I have asked Alison Rutherford for a timescale in relation to the final recommendation.
I would be grateful if you could review the updated report and confirm if you are content for the final report to be issued.
Kind Regards
Jenny
Password as usual

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Southern Health & Social Care Trust

Review of Mr A's Compliance with Relevant Authorities/Guidance in terms of his Private Work 2020/21

nqa ISO 9001 Registered Quality Management

Contents

Acknowledgement

Internal Audit wishes to thank management and staff at the Southern Health and Social Care Trust for their assistance and co-operation during the course of the assignment.

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Distribution List

Shane Devlin	Chief Executive
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Introduction

In November 2020, at the request of the Urology Assurance Group, the SHSCT Chief Executive requested a review of Mr A's patients transferring into SHSCT as HSC patients. In addition, the review will consider any Trust involvement with the Craigavon Urological Research & Education organisation.

Terms of Reference

The audit focused primarily on Mr A's change of status private patient's work during the period 1 January 2019 to 30 June 2020 in order to:

1. Establish the extent of SHSCT awareness of Mr A's private work, through the job plan process and their private patient identification and management processes.
2. Establish the extent to which Mr A's private work interacted with HSC services and facilities.
3. To identify all of Mr A's patients that changed status (private/NHS) and check that there is evidence that relevant guidance/authorities have been adhered to. This will include providing assurance that:
    - The appropriate Change of Status paperwork has been completed and authorised and that this is supported by an assessment, by the consultant, of the patient's clinical priority for treatment as a Health Service patient.
    - For all private work identified above, the patient joined the HSC waiting list at the same point as if their consultation had taken place as an NHS patient.
    - The Consultant fulfilled all obligations with regard to recording and identifying private activity.
    - Where private work was conducted on HSC premises, ensure the patient has been invoiced for relevant costs.

Internal Audit also considered whether the Trust has any involvement with CURE - Craigavon Urological Research & Education, to understand if there was a flow of money into the Trust and to check, as much as is possible from review of Trust records and engagement with Trust staff, whether any Directors/staff benefited from the operation of the company.

Limitation of Scope: Internal Audit would caution that the analysis conducted is largely based on the data provided by the Trust. Internal Audit did not walk through each individual patient's journey on their patient file and therefore the analysis may not be fully complete.

Internal Audit has identified issues with Mr A's compliance with relevant guidance around private practice. Significant issues with the timing, completion and approval of change of status paperwork were identified when patients transferred from private to NHS care. Occasions were also found when patients that had been seen privately, were treated more quickly that than the Trust standard waiting times.

Significant issues were also found around the Trust's management and monitoring of compliance with private patient guidance in particular the change of status process and their ability to monitor that patients transferring from private to NHS care, are treated in an equitable manner. The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue.

In total in the review period, 5 of Mr A's private patients were identified as having been treated at the Trust without/prior to receipt of a change of status form. A further 8 patients were potentially private when they were seen in the Trust (excluding those cases that the Trust believe are poor administration rather than private work). 5 patients switched status more than once (from NHS-private-NHS). 6 change of status patients were seen ahead of Trust waiting times. A further 2 patients were added to PAS retrospectively effectively being placed on the waiting list ahead of where they should have been placed.

In addition to private practice issues, there are also patient safety matters identified in the report primarily around performance of Pre Operative Assessments.

The findings of the review are summarised as:

Trust Processes and Awareness of Mr A's Private Work

Trust Knowledge of Mr A's Private Work

1. The Trust were aware that Mr A holds a private outpatient clinic at his home. It is unclear what happened these private outpatients if they required diagnostics and/or inpatient/daycase procedures. The Trust does not appear to have explored or challenged the potential interaction with the Trust in the scenario where private outpatients may require diagnostics/procedures etc. There is learning for the Trust in this matter in terms of considering circumstances when a Consultant conducts private outpatients work only.

Job Planning & Payment

2. In line with job planning guidance and Consultant terms and conditions, a job plan review should take place annually. The most recent job plan available for Mr A is an unsigned job plan, dated 1 April 2018.
3. There is a query over the accuracy of APA payments to Mr A. As per HRPTS during the period January 2014 to July 2020, Mr A was paid for 2 Additional PAs. This does not agree to the various unsigned job plans available which show a range of APAs (from 1.275 to 2.5) for this period.

The Trust's Change of Status Process

4. The Trust's Change of Status form for when a private patient transfers to NHS treatment, has limited monitoring or control value. The Change of Status activity is not effectively approved by the Medical Director or reviewed by the Trust Clinical/Directorate Management. The Change of Status form itself and the Change of Status process require strengthening.
5. The Trust is not compliant with the regional guidance issued in 2018 which requires all Change of Status patients to be identified with a 'PTN' code on PAS.
6. The Trust does not have a process in place to ensure all change of status patients have been identified for monitoring purposes and to ensure that the process for changing status is effectively controlled and documented, as an assurance that the delivery of service is equitable.

Identification of Private Work

7. Laboratories, Radiology and Pharmacy are reliant on Consultants highlighting any private activity. There is a risk therefore that private activity in these departments may not be identified.
8. There is insufficient control over prescriptions pads to prevent the use of Trust prescription pads for private work.

Mr A's Change of Status Patient Activity

Approved Effective Change of Status Date

9. Contrary to Trust written procedure, the date the patient is added to PAS as an NHS patient is the effective date as per the Change of Status form, not the date the Change of Status form was approved by Medical Director.

Change of Status Patients who had Diagnostic (Radiology) Tests

10. In 10 out of the 21 Change of Status cases during the period from January 2019 to June 2020, the patient was referred for 1 or more imaging tests. In 3 of these 10 cases, the patient had the imaging tests in the Trust prior to changing status to NHS ie whilst still private patients. A further 5 out of the 10 patients had diagnostic requests made on the same date as the effective change of status date and the same date the patient was last seen privately. Given that these 5 Change of Status forms are unlikely to have been submitted and approved by the Medical Director on the same day as the patients' private appointments, these patients should potentially have been treated by the Trust as private patients.
11. 3 (including 1 of the 3 patients found to be private) out of the 10 patients were seen sooner than the Trust waiting time for the diagnostic/imaging test.

Patients who changed Status and had Inpatient/Daycase Procedure

12. Out of the 13 Change of Status cases transferred into the NHS for an inpatient/day procedure, 5 had their procedure during the review period (ie up to June 2020). The Trust Consultant Urologist assisting Internal Audit in this review considered that 2 of the 5 patients were not seen in line with the Trust waiting list time. These cases were not Urgent/red flag procedures (as categorised on PAS) and were seen significantly sooner than other patients on the waiting lists.

Retrospective Entry to PAS

13. Two change of status forms had been added retrospectively to PAS. Most significantly, one of these patients was added to the waiting list from September 2018 but this was not actually added to PAS in May 2020. At December 2020 this Change of Status had not been approved by Medical Director.

Protected Reviews

14. The Trust does not monitor the use of protected review appointments and there is a risk that private patients or Change of Status patients could potentially be seen quicker in a protected review appointment slot.
15. Internal Audit identified 1 case where a routine outpatient was seen in a protected review slot, 15 days after being added to the waiting list and therefore seen ahead of NHS patients with the same clinical priority.

Multiple Switches in Status

16. Contrary to guidance, in 5 of the 21 cases where a change of status form had been completed, the patient moved between NHS to Private to NHS for the same referral.

Analysis of Mr A Activity Data

Pre-Operative Assessments (POAs)

17. In 86 (25%) of the 351 procedures conducted by Mr A during the period January 2019 to June 2020 which required a Pre-Operative Assessment, a POA was not completed.
18. Upon further analysis, 1 of these 86 cases related to a private patient who was subsequently treated in the NHS. No Change of Status form had been completed.
19. 95% of the POAs completed on Mr A patients during the review period were completed less than 3 weeks before admission for surgery. The Trust requires POAs to be competed at least 3 weeks before (and up to 13 weeks before) admission for surgery,
20. The lack of POA or the short time scales between the completion of a POA and the date of admission for surgery is a potential indicator that a patient may have been seen privately and then had their procedure in the NHS.

Elective Surgery With No Outpatient Appointment

21. Out of a sample of records where a patient had surgery but there was no evidence on PAS of an outpatient appointment, we found:
    - 1 patient changed from NHS to private and back to NHS status in one day, with no Change of Status forms. This is a blatant breach of proper process and is an example whereby a significant advantage has been gained in terms of speed of treatment, by paying privately for an outpatient appointment. In the absence of an approved Change of Status form, this is arguably a private patient having a procedure using trust facilities and staffing.
    - In 2 cases, there was no outcome letter completed for the procedure potentially indicating that the patient may have transferred back to the private sector for review. *It should be noted that the Trust believe that these are poor administration issues rather than private patients.*

Elective Surgery with an Outpatient Appointment

22. Out of a sample of 29 patients who had an elective procedure and an outpatient appointment in the period under review, 4 occasions were found where the patient may potentially have been a private patient. In one case the patient was a retired Consultant and in another case the patient was a close relative of a GP. *It should be noted that the Trust believe that one of these cases associated with non completion of an outcome letter is poor administration rather than a private patient.*

Other Observations

23. Other issues have been noted by Internal Audit around the audit trail when ordering scans on NIPACS (Sectra); changes being made to the referral date on PAS (which should not be changed); registrations for episodes of care on PAS that remain open rather than being closed; and use and monitoring of electronic sign off on NIECR.

Extent of Trust Involvement with CURE

24. CURE - Craigavon Urological Research & Education – is an independent entity, separate from the Trust. Whilst a number of Trust staff sit on the CURE Committee, these roles are independent from their role in the Trust. From discussion with Trust Management and Trust staff involved with CURE, there is no indication of any flow of money into the Trust or Trust involvement in fund raising in recent years. Internal Audit understands from the Committee members that Trust staff may apply to CURE for funding and if granted, a cheque will be written from CURE to the applicant. Trust procedures do not provide guidance in respect of staff involvement in independent organisations with a potentially perceived affiliation to the Trust by their nature.
    Internal Audit did not have access to CURE financial records as part of this review and therefore do not have visibility over any payments made by CURE to Trust staff.

Detailed Findings Of The Review

1. TRUST'S AWARENESS OF MR A'S PRIVATE WORK AND MANAGEMENT OF COMPLIANCE WITH PRIVATE PATIENT GUIDANCE

1.1 Job Plan Document

The Consultant Job Planning - Standards of Best Practice (November 2003) and Consultant Terms and Conditions of Service (Northern Ireland) 2004 states that a job plan review should take place annually. A similar requirement is contained in the Medical and Dental terms and conditions 2008.

Internal Audit requested a copy of Mr A's job plan for the period 1 January 2019 to 30 June 2020. In line with the annual job plan review schedule, there should be 2 job plans to cover this period. There is no signed off job plan held by the Trust for the period 1 April 2011 to 30 June 2020. The most recent job plan available for Mr A is an unsigned job plan, dated 1 April 2018 and there is no end date recorded. This document is not signed by Mr A or his Clinical Director.

The most recent job planning meeting appears to have been held in November 2018. Regular, annual job plan meetings have not been held.

1.2 Trust Knowledge of Mr A's Private Practice

"A Code Of Conduct For Private Practice - Recommended Standards Of Practice For HPSS Consultants (An Agreement between the BMA(NI) Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland) (November 2003)" requires that Consultants declare any private practice and as part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work.

Trust procedures "Trust Guidance on Paying/Private Patients – 2018 states:
In section 2.2 "Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser"
In Section 5.1 "While Medical Consultant staff have the right to undertake Private Practice within the Terms and Conditions of the Consultant Contract (2004) as agreed within their annual job plan review, it is the responsibility of Consultants, prior to the provision of any diagnostic tests or treatment to:

- *ensure that their private patients are identified and notified to the Paying Patients Officer.*
- *ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.*
- *ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, hospital charges.*
- *Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.*

Although there is no private work identified in Mr A's most recent job plan, the Trust were aware that Mr A conducted private work outside the Trust:

- Mr A submitted a Trust "Declaration of Private Practice" in February 2018. In this declaration form, Mr A advised that he did not complete private practice within the Trust, however he did

treat private patients outside of the Trust. The declaration form is not sufficiently clear to clarify the type of private practice undertaken (ie outpatient/daycases/inpatients). On the Declaration Mr A did not confirm that he had read and understood the Trusts Guidance on Paying/Private patients. He did declare that he understood that any private patient work whether undertaken inside or outside of the Trust must be included in his job plan. *The Trust Declaration of Private Practice process should be conducted every year. A declaration therefore should have been made by Mr A in 2019 however this was not submitted to the Trust and the annual declaration process was not conducted in 2020 due to COVID-19.*

- The most recent appraisal completed for Mr A was in 2018. Internal Audit do not require access to this appraisal document, however the Trust have confirmed that Mr A declared that he conducted a private outpatient clinic at his home.

In the event that a private outpatient seen at Mr A's home clinic required diagnostics including blood tests or a daycase/inpatient procedure, it is unclear how this private activity was administered and whether or not such work entered the Trust either as private or NHS work. This issue is considered further in sections 2 and 3 of this report.

The Trust does not appear to have explored or challenged the potential interaction with the Trust in the scenario where private outpatients may require diagnostics/procedures etc. There is learning for the Trust in this matter in terms of considering circumstances when a Consultant conducts private outpatient work only.

1.3 Reconciliation of Job Plan to Payroll

Internal Audit reviewed HRPTS to ascertain what Mr A was paid. From 1 January 2014 to 17 July 2020 payment details were as follows:-

- 10 PAs – (full time contract – *agrees to most recent job plan*)
- 2 Additional PAs (APAs)
- 5% Category A on call from 12/05/2014 to 17/07/2020 *(agrees to operational rota)*
- Step 2 clinical excellence award *(awarded for the remainder of consultants career by the Trust's Local Clinical Excellence Award Committee in April 2009, with effective date from April 2008.)*

There is a query over the accuracy of APA payments to Mr A. As per HRPTS during the period January 2014 to July 2020, Mr A was paid for 2 Additional PAs (additional to full time PAs). This does not agree to the various unsigned job plans available for this period which record a range of APAs (2.5, 1.275 and 1.733) throughout this period.

1.4 Change of Status Process

The "Management of Private Practice in Health Service Hospitals in Northern Ireland: A Handbook – November 2007" requires that patients changing status from Private to NHS must have a Change of Status form completed by the consultant. The form must also detail the clinical priority for treatment as a health service patient. The Trust should be able to clearly identify these patients for monitoring purposes. It is important that the process of changing patient status is effectively controlled and documented as an assurance that the delivery of service is equitable.

The Trust Guidance on Paying/Private Patients procedures require Consultants to complete a Change of Status form when a private patient transfers to NHS treatment. However, effectively this form has limited monitoring or control value because:

1. The form is signed by the Consultant and stamped as approved by the Medical Directors office. It is not possible to establish who applied this stamp or the date it was applied. The change of status forms are filed in the cash offices at Craigavon Area Hospital/Daisy Hill Hospital and no

action or reporting takes place within the Trust. The Change of Status activity is not effectively approved by the Medical Director or reviewed by the Trust Clinical/Directorate Management.

2. The form contains no detail of the reason for the change of status.
3. The date the patient changes status to NHS is recorded on PAS as the effective date as per the Change of Status form, not the date the Change of Status form was approved by the Medical Director. This appears contrary to Trust Guidance on Paying/Private Patients procedures which state *"It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."* The Change of Status form is confusing this matter, by including an effective date of change of status rather than, an approved date. The form does not clearly state that the approval date will be the date of transfer to NHS from private status.
4. There are no dates applied to the change of status form by either the Paying Patient Officer on receipt of the form or by the Medical Director's Office on approval of the form. Therefore Internal Audit were unable to establish whether the Change of Status forms were approved prior to the patient receiving an appointment/treatment, potentially impacting on income that may have been due to the Trust.

Prior to 11 September 2018 when the regional PAS Technical Guidance approved a code (PTN) to identify private patients transferring to NHS status, the Patient Administration System (PAS) did not require a change of status to be recorded on the system. The change of status may have been entered in a free text field which is not a mandatory field. The Southern HSC Trust has not yet implemented the regional code 'PTN' for patients transferring from private practice to NHS. A PAS report cannot therefore be run showing all change of status patients.

The Trust does not have a process in place to ensure all change of status patients have been identified for monitoring purposes and to ensure that the process for changing status is effectively controlled and documented, as an assurance that the delivery of service is equitable.

1.5 Private Patient Identification Processes

In line with the "Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007)" Consultants have a contractual obligation to cooperate in recording all private outpatient and day patient attendances, treatments and procedures. The patient's records and referral forms etc should always be suitably marked. Records kept in departments away from the main outpatient area (e.g. x-ray, pathology and physiotherapy) should identify private patients.

Internal Audit met with senior staff in Laboratories, Radiology and Pharmacy to discuss the processes in these departments for the identification and management of private patients. All three departments are reliant on Consultants highlighting any private activity. There is a risk therefore that private activity in these departments may not be identified.

Pharmacy:

When a consultant prescribes medication to a private/NHS patient at an outpatient clinic, there are 2 different prescription pads used:-

- Prescription which can be written and given to the patient to take to the hospital pharmacy for dispensing. These are numbered but there is no control over the issue of the prescription pads. These are in quadruplicate – White copy –to GP, yellow copy to Pharmacy, Blue copy community nursing and pink copy patient notes.
- Prescription letter which the patient must take to their GP and the GP writes a prescription for dispensing at the community pharmacist.

There are inadequate controls surrounding the issue and use of prescription pads. Pads are held in consulting rooms and may be used by multiple consultants who apply their own name labels to the scripts.

If a patient takes the script to the Trust pharmacy for dispensing, the pharmacy have no mechanism to identify whether the patient is private or has come from a NHS outpatient appointment. Similar to the rest of private practice, the Trust are reliant on the Consultant declaring activity as private and in this case, writing the prescription advising that the patient is private so that pharmacy can ensure that the cost of the medications are invoiced.

Internal Audit discussed 6 sampled cases with Pharmacy to identify if any of these patients had received medication while still private patients. No issues were identified.

Laboratory Services:

The Head of Laboratory Services advised that within the Trust they are reliant on the Consultant/doctor who completes the laboratory request ticking a box to identify a private patient. There is no other mechanism to identify private patients.

Laboratory results are put on NIECR and there is nothing to identify private tests unless the consultant has declared this on the lab request.

Diagnostic Services:

The Head of Acute Information in conjunction with the NIPACS Manager confirmed referrals received for scans etc are all completed on the same referral form and there is no mechanism to identify private or change of status patients on the system. Consultants order scans etc directly themselves on the NIPACS (Sectra) system.

As per Section 2 of this report, radiology activity was identified that should potentially have been declared and treated as private.

Recommendations Specific to Review of Mr A's Practice:

Recommendation 1.1	The Trust should review Mr As job plan and actual APAs worked in order to ascertain if overpayments have occurred, and seek recompense if required.
Management Action	ACEPTED
Responsible Manager	Medical Director and Director of Acute Services
Implementation Date	October 2021

General Recommendations Regarding Trust Process:

Internal Audit completed an audit in 2019/20 (finalised in October 2020 following delay in obtaining Management Response to the report due to COVID-19) and provided limited assurance in relation to Management of Private Medical Practice (including patient change of status processes). A number of the recommendations included in the 2019/20 report have been restated throughout this report.

Recommendation 1.2	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report and as per the 'Code of Conduct for Private Practice - recommended standards of practice for HPSS consultants (November 2003)', the Trust must ensure that: • All consultants have an annual job planning review. • All consultants completing private practice declare any private practice and as part of the annual job planning process, consultants should

	disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of HPSS work and out of hours cover. • As part of the job planning process, the Trust should consider total working hours across HSC and private practice. Job plans should be signed and dated by the consultant and their Clinical Director.
Management Action	**ACCEPTED**
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	Februaury 2022

Recommendation 1.3	The Trust should strengthen their management arrangements in scenarios where a Consultant declares that they conduct private outpatient work only, specifically where the work is carried out outside the NHS including premises not regulated by RQIA. The following specific measures are suggested: • Assurances should be sought as to how associated diagnostics/subsequent required treatment are managed. • Medical Director approval should be introduced in the event that Consultants conduct outpatient work privately. • Trust monitoring processes should be alert to ensuring Change of Status patients are placed on the waiting list based on clinical priority. • The Trust "Declaration of Private Practice" form should be amended to clearly identify the type of private practice undertaken (ie outpatient/daycases/inpatients). Trust management should review these declaration as and triangulate the information with appraisals and job plans.
Management Action	ACCEPTED
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	February 2022

Recommendation 1.4	The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue. The Trust should review and strengthen management of private patient procedures. As part of this process the new procedures should be shared with all relevant trust staff and roles and responsibilities should be reiterated where required. Specifically consulants must be reminded of their responsibility to ensure that all private work and change of status patients are declared. Consideration should be given as to how Radiology, Laboratories and Pharmacy can strengthen their processes, scrutiny and challenge of service requests that could potentially originate from the private sector.

Management Action	ACCEPTED
Responsible Manager	Assistant Director Systems Assurance,
Implementation Date	February 2022

Recommendation 1.5	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, Consultants should be instructed to complete the required declaration in relation to Private practice for the current year.
Management Action	**ACCEPTED**
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	October 2021

Recommendation 1.6	The Change of Status process should be strengthened. Specifically: • The Change of Status form currently in use within the Trust for patients transferring from Private Practice to NHS must be reviewed and updated to include all relevant information including clear documentation of the reason for change. The effective date of change of status should be amended to the approved date for change of status and it should be clear on the form that the effective date of change will be the date that the form is approved by the agreed appropriate senior clinical and operational leads. The agreed appropriate senior clinical and operational leads should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the by the agreed appropriate senior clinical and operational leads. *Previously reported in 2019/20* • The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form, namely until the form is approved, the patient will remain private and may be liable for charges. *Previously reported in 2019/20*
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Recommendation 1.7	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, the Trust should develop a process to monitor change of status patients and to ensure that the process for changing status is effectively controlled and documented as an assurance that the delivery of service is equitable.

	The Trust should implement the regional PAS code for patients transferring from private to NHS and develop a mandatory requirement to indicate changes of status on PAS. A printout from PAS should then be regularly reviewed and reconciled to Change of Status forms received.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance, Assistant Director Functional Support Services
Implementation Date	February 2022

Recommendation 1.8	The Trust should increase controls over prescription pads held in consulting rooms. These should be maintained as controlled stationery.
Management Action	**ACCEPTED**
Responsible Manager	Director of Pharmacy
Implementation Date	February 2022

2 REVIEW OF MR A's COMPLIANCE WITH RELEVANT PRIVATE PRACTICE GUIDANCE/AUTHORITIES – CHANGE OF STATUS PATIENTS

2.1 Change of Status Activity During the Period January 2019 to June 2020

The "Management of Private Practice in Health Service Hospitals in Northern Ireland: A Handbook – November 2007" requires that patients changing status from Private to NHS must have a Change of Status form completed by the consultant. The form must also detail the clinical priority for treatment as a health service patient. The Trust should be able to clearly identify these patients for monitoring purposes. It is important that the process of changing patient status is effectively controlled and documented as an assurance that the delivery of service is equitable.
The Trust's procedures and Change of Status form states "It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."

Internal Audit requested all of Mr A's patient Change of Status forms for the period January 2019 to June 2020, from the cash office at Daisy Hill Hospital. Internal Audit were provided with the database which recorded 21 Change of Status Patients.

Internal Audit requested and reviewed the 21 Change of Status forms completed by Mr A from January 2019 to June 2020 and noted the following issues:

- 16 Change of Status forms had the Medical Director stamp on them as evidence of approval but it is not possible to establish who applied this stamp or the date it was applied.
- 4 Change of Status forms were still with the Medical Director at the 7 December 2020 awaiting approval. The dates that these patients transferred to NHS as per the change of status forms ranged from 2 - 14 months earlier than December 2020. Internal Audit were unable to establish when the forms were received in the Medical Directors Office.
- 1 Change of status form had been physically signed by the Medical Director, approximately 10 weeks after the effective Change of Status date.

2.2 Management of Patients Transferring from Private to NHS, Joining the HSC waiting list

Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) states:
"A change of status from private to Health Service must be accompanied by an assessment, by the appropriate consultant, of the patient's clinical priority for treatment as a Health Service patient. It is important that any private patient who wishes to become a Health Service patient should gain no advantage over other Health Service patients by so doing."
"No patient should proceed –except in emergencies – to an investigation or treatment in a Health Service hospital until some mechanism has been applied which makes their status clear. Whichever system is introduced it must be capable of identifying the patient's status at every stage."

Internal Audit reviewed PAS data (provided by the Trust) for the 21 patients who changed status from private practice to NHS during the audit period January 2019 to June 2020. 13 of the 21 Change of Status forms related to day case or inpatient referrals and the remaining 8 forms were for outpatient appointments.

A range of issues were found in respect of Mr A's practice and administration of these 21 Change of Status cases (as outline below). However the issues also demonstrate the inadequacies in Trust monitoring processes around Change of Status patients and the limited control in the current process. The following issues were identified on review of the Change of Status forms:

Approved Effective Change of Status Date

The date the patient is added to PAS as an NHS patient is the effective date as per the Change of Status form, not the date the Change of Status form was approved by Medical Director. *This is contrary to Trust's procedures and Change of Status form which state "It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."*

On all 21 Change of Status forms, the effective date of transfer to NHS was the same as the date the patient was last seen privately.

Change of Status Patients who had Diagnostic (Radiology) Tests

In 10 of the 21 change of status cases, the patient had been referred for a diagnostic test (radiology) in the period 1 January 2019 to 30 June 2020:

- In 3 of the 10 cases, the diagnostic work was performed prior to the date of change of status. This diagnostic work was performed at a time when there was no referral on PAS for the patient ie whilst they were still a private patient.
  - One patient had a change of status date of 31/08/2019 – this patient had 2 imaging tests requested and performed in June 2019 whilst still private.
  - One patient had a Change of Status date of 09/11/2019 - this patient had 3 imaging tests requested and performed in June 2019 whilst still private.
  - One patient had a change of status date 09/11/2019 and had 1 imaging test requested in June 2019 with the test performed in July 2019 whilst still private.
- 5 of the 10 diagnostic tests were requested on the same date as the effective change of status date and the same date the patient was last seen privately (according to the Change of Status Form). Given that these Change of Status forms are unlikely to have been submitted and approved by the Medical Director on the same day as the patients' private appointments, these patients should potentially have been treated by the Trust as private patients.
- 2 of the 10 Change of Status patients had an exam/diagnostic test requested after the effective date on the Change of Status form (1 was 3 weeks, 1 was 4 months). However given the weaknesses in the Change of Status process, it is unclear if this NHS test was performed after the change of status was approved.

3 (including 1 of the 3 patients found to be private) out of the 10 patients were seen sooner than the Trust waiting time for the diagnostic/imaging test:-

- 1 of the 3 patients identified as private (above) was seen within 6 weeks against a waiting list of 21-32 weeks (at least 15 weeks earlier than Trust waiting time). This patient was seen in South Tyrone Hospital.
- For 1 patient the Trust waiting time for the imaging was 16-20 weeks and the patient had their imaging test within 5 weeks of request (at least 11 weeks earlier than Trust waiting time).
- For 1 patient the Trust waiting time was 5-10 weeks and the patient had their imaging test within 3 weeks of request (at least 2 weeks earlier than Trust waiting time).

Patients who changed Status and had Inpatient/Daycase Procedure

Out of the 13 Change of Status cases transferred into the NHS for an inpatient/day procedure, 5 had subsequently had their procedure. The other 8 patients, whilst added to waiting list, had not had their procedure as at June 2020.

Internal Audit in conjunction with Senior Trust staff reviewed the patient journeys of the 5 cases who have had their inpatient/daycase procedures. All 5 cases were classed as URGENT on PAS per the report received by Internal Audit.

As part of this audit review, a Trust Urology Consultant considered the waiting times for treatment in the context of the clinical priority and Trust standard waiting times. The Consultant advised that:

- 3 cases were in line with Patient Target List (PTL) waiting times/ for the procedure for the relevant clinical priority.
- 2 of the 5 patients were not seen in line with the Trust waiting list time. The Trust Consultant Urologist assisting Internal Audit in this review considered that these cases were not Urgent/red flag procedures and were seen significantly sooner than other patients on the waiting lists:
  - Patient 1 - the time between being added to waiting list and the procedure taking place was 23 days (approx. 3 weeks). The PTL waiting times for the same procedure for Mr A patients at this time were between 15 weeks and 217 weeks so we can conclude this Change of Status patient was seen much quicker than other patients waiting on the same procedure.
  - Patient 2 - the time between being added to the waiting list and the procedure taking place was 12 days. The Consultant Urologist advised that given the symptoms, this patient was seen much quicker than other patients requiring the same procedure at that time.

Retrospective Entry to PAS
Through review of change of status patients on PAS, it was noted that two change of status forms had been added retrospectively to PAS:

- One patient was added to the waiting list from 09/09/2018 but this was not actually added to PAS until 12/05/2020. At December 2020 this Change of Status had not been approved by Medical Director.
- One patient had a Change of Status on 11/10/2019 however the patient was not added to PAS by the consultant secretary until 01/02/2020, 4 months after the Change of Status.

See section 6 for related registration issue.

2.3 Protected Reviews

Internal Audit understand from the Trust that most Consultants retain a number of protected review appointments at each of their outpatient clinics. These slots should be for patients that the Consultant needs to see urgently (for example cancer patients) however there is no documented Trust procedure around the use of protected review clinic slots. The Trust does not monitor the use of protected review appointments and there is a risk that private patients or Change of Status patients could potentially be seen quicker in a protected review appointment slot.

Internal Audit were advised that the central booking team at the Trust are responsible for booking new and review outpatient appointments. However Mr A's secretary was responsible for booking Mr A's Protected Review appointments.

Internal Audit have not specifically tested Protected Review bookings however we identified 1 case where a routine outpatient was seen in a protected review slot, 15 days after being added to the waiting list. Internal Audit queried this case with the Trust and the Consultant Urologist agreed that the protected review appointment had not been used for the correct purpose and therefore the patient would have been seen ahead of NHS patients with the same clinical priority.

2.4 Capturing and Invoicing of Private work Conducted on HSC Premises

In line with the "Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007)" Consultants have a contractual obligation to cooperate in recording all private outpatient and day patient attendances, treatments and procedures. The patient's records and referral forms etc should always be suitably marked. Records kept in departments away from the main outpatient area (e.g. x-ray, pathology and physiotherapy) should identify private patients.

As per Trust procedures no private activity was declared to the Cash Office in Daisy Hill Hospital during the audit period by Mr A and no invoices have been raised for private treatment – both indicating that Mr A did not perform private work on HSC premises.

However, as outlined above, upon review of the 21 Change of Status Forms, Internal Audit noted cases whereby Mr A's Private Patients had received treatment in the NHS while still being a private patient.

Furthermore as described below, there are examples of patients seemingly switching several times between private and NHS and potentially receiving private treatment on the NHS, without declaration or charging. As per the *NHS A Code of Conduct for Private practice and* The Trust Change of Status Form – *"Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private practice"*

In 5 of the 21 cases where a change of status form had been completed, the patient moved between NHS to Private to NHS for the same referral.

- In one case the patient had been under the care of another urology consultant within the Trust around the time of seeing Mr A privately.
- In one case from the review of PAS it was determined that the patient has seen a number of urology consultants and had been NHS and moved to Private and then subsequently transferred back to NHS.
- One patient had been seeing another Urology Consultant in 2018 and was called for a follow up outpatient appointment in July 2018 but didn't attend. It would appear that this patient then attended Mr A privately who completed a Change of Status form with an effective date of 17/08/2019.
- One patient had been under the care of the Trust at 31/01/2019 and was due for review at the end of 2019. This appointment was delayed and it would appear that this patient then attended Mr A privately who completed a Change of Status form with an effective date of 15/02/2020 and added the patient to the waiting list.
- One patient who had been added to the Elective waiting list for a procedure on 09/11/2019 (effective date of Change of Status) but had a consultation with Mr A in early March 2020 which is not on PAS. This patient would have had a procedure done in late March 2020 except for COVID-19 resulting in all elective procedures being cancelled from approximately w/c 16 March 2020.

Recommendations Specific to Review of Mr A's Practice:

Recommendation 2.1	The Trust should consider charging for the identified private activity. Internal Audit appreciate that this needs to be considered, and may not be feasible, in the wider context of a patient recall.
Management Action	**ACCEPTED** This has been considerd by the Trust and it was felt it would not be appropriate to charge these patients.
Responsible Manager	Medical Director
Implementation Date	July 2021

General Recommendations Regarding Trust Process:

Recommendation 2.2	The Trust should develop a written procedure around the use of protected review clinic appointments. The Trust should also introduce monitoring of compliance with the procedure.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Functional Support Services and Operational ADs
Implementation Date	February 2022

Recommendation 2.3	Trust Guidance and Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) should be re-issued and sign-off by doctors engaging in private practice. Where concerns are raised about a consultants' compliance, the Department of Health's framework *Maintaining High Professional Standards in the Modern HPSS should be followed*.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Also see recommendations in section 1

3 REVIEW OF MR A's COMPLIANCE WITH RELEVANT PRIVATE PRACTICE GUIDANCE/AUTHORITIES – DATA ANALYSIS

Internal Audit completed data analysis using information provided by the Trusts Acute Informatics department. Internal Audit were provided with the following reports from PAS, TMS, Pre Operative Assessment Unit:

- Patient Level List of Elective Inpatient Admissions, Daycases and Regular Attenders for Mr A Date of Admission only between 01/01/2019 and 30/06/2020 from PAS
- Patient Level List of Outpatient Attendances (Including Outpatient Urodynamic Attendances) for Mr A Appointment Date only between 01/01/2017 and 30/06/2020 from PAS
- Patient Level List of Outpatient Urodynamic Attendances for Mr A Appointment Date Only between 01/01/2019 and 30/06/2020 from PAS
- Patient Level List of Imaging Exams Performed which were Requested by Referring Clinician Mr A Exams Performed between 01/01/2019 and 30/06/2020 from NIPACS
- Patient Level Report of Theatre Cases Carried out by Mr A – By hospital, theatre and operation date based on operation date between 01/01/2019 and 30/06/2020 from TMS.
- Pre-operative Assessment Database for Urology with the Trust Identifying Mr A's patient's for pre-op assessments performed between 01/01/2019 and 30/06/2020

3.1 Pre-Operative Assessments

All elective patients who require a General Anaesthetic whilst undergoing a procedure are required to have a Pre-Operative Assessment (POAs) to assess their fitness for surgery. The Trust deem the optimum time to complete a patients' POAs is between 13 weeks and approximately 3 weeks ahead of planned admission date for surgery. Consequently to ensure this happens in a timely manner and no patients scheduled for theatre are overlooked, it is essential that all elective theatre lists are prepared and notified to the POA team 6 weeks in advance of the theatre date.

Theatre rotas are compiled by the Head of Service for Theatres, detailing which surgeons have access to the theatres at each session. When Consultants become aware of the theatre rota they then select the patients for each list, any who require pre op should be sent to the pre op assessment unit. Mr A selected his own patients and arranged his own theatre lists. It is understood that Mr A would have provided his secretary with a list of patients to be booked into his theatre lists and she would have completed an "Arrange Admission List".

Completion of POA

According to Trust PAS report provided, during the period January 2019 to June 2020, there were a total of 1,096 elective procedures performed on 576 of Mr A's patients. In consultation with the Head of Urology and Pre-operative Assessment Manager, Internal Audit analysed a PAS report of all elective procedures performed on Mr A's patients during January 2019 to June 2020. With the Trust's expert input, we were able to eliminate procedures where a pre op assessment was not required from our analysis. These cases related to procedures done under a local anaesthetic; or where the patient had previous surgery and the previous POA was still valid.

For 351 of the 1,096 procedures performed by Mr A, a POA was required. In 86 (25%) of these 351 cases, a POA was not completed. Internal Audit reviewed these 86 cases with the Pre-Operative Assessment Manager and found:

- In 24 procedures, the patient was assessed upon admission rather than having a scheduled POA ahead of time. An appropriate POA in line with Trust requirements was not therefore conducted.
- 62 procedures required a POA for the procedure but this was not completed. In 2 of these procedures, the patient did not attend/complete their POA but a POA had been requested in both cases. Both patients underwent surgery nonetheless.

Lack of POA as Potential Indicator that Patient was Seen Privately and then Treated in NHS

Internal Audit reviewed these 86 cases further from information on PAS and NIECR to establish if there was any information that pointed to these 86 cases being private patients. This work identified:

- In 49 procedures, the patient had an appropriate footprint on PAS.
- For the remaining 37 procedures, the patient had either no outpatient appointment (according to the PAS data provided by the Trust) or there was a short timeframe between being seen at an outpatient appointment and the date of surgery. Internal Audit selected a sample of 23 of these procedures for further analysis on PAS and NIECR in conjunction with the Head of Urology. In 22 of the 23 procedures whilst a pre-op assessment was required, the patient was not deemed to be private as they had come in initially through ED and been given date for surgery on discharge, another Speciality or another Consultant was involved in their care. 1 of the 23 procedures related to a private patient who was subsequently treated in the NHS. No Change of Status form had been completed.

Timeliness of POA

As outlined above, the optimum time for a patients' POAs to take place is between 13 weeks and approximately 3 weeks ahead of planned admission date for surgery. In effect, PoAs are valid for a period of 13 weeks pre-admission for surgery.

On review of 265 procedures where a POA was undertaken for Mr A's patients, Internal Audit noted:-

- There were only 8 procedures (3%) where the POA was conducted within the timescale required by the Trust, in advance of surgery.
- 252 procedures (95%) were added to the POA list less than 21 days before their admission:
  - 105 procedures (40%) were added to POA list 5 days or less before admission
  - 131 procedures (49%) were added to POA list 10 days before admission
  - 16 procedures (6%) were added to POA list between 11 and 20 days before admission
- In 5 (2%) cases, there was insufficient information to confirm the timeliness of the POA.

3.2 Elective Surgery With No Outpatient Appointment

From the PAS data received from the Trust Acute Information Department, Internal Audit joined elective surgery data in the period 01/01/2019 to 30/06/2020 to outpatient appointments in the period 01/01/2017 to 30/06/2020. The purpose of this analysis was to establish patients who had surgery but did not have an outpatient appointment potentially indicating that they may have been seen privately for an outpatient appointment by Mr A prior to surgery.

Note: We considered outpatient information for a longer period than the audit period to factor in the waiting list times.

We found that there is no record of a Trust outpatient appointment (either pre or post surgery) for 220 patients who had at least one elective procedure (total 284 procedures) between 1 January 2019 and 30 June 2020.

Where a patient had surgery and no outpatient appointment, the patient could potentially have been a private patient as the normal patient route for elective surgery is to be seen at an outpatient appointment and then if required, listed for elective surgery.

Internal Audit reviewed the 284 procedures where there was no recorded Trust outpatient appointment on PAS. With the expert input of Head of Service for Urology, 138 records were excluded from further analysis because the nature of the procedure did not involve the need for an outpatient appointment (for example stent replacement/removal); or the waiting time for the procedure appeared in line with Trust waiting list; or the patient (5 cases) was declared as a Change of Status patient.

Out of the remaining 146 records, Internal Audit selected a sample of 54 records (relating to 50 patients) which the Head of Service for Urology then reviewed on PAS and NIECR, particularly considering whether referrals had been received for these cases and where patients had been seen in relatively short-timeframe that there were valid clinical reasons for this. Internal Audit then walked through 21 of these 50 patients with the Head of Urology to validate the data. This work identified:

- 1 patient who was initially referred by a GP in January 2018 but was then discharged from this referral on PAS in July 2019 to attend Mr A privately. This patient was added to Mr A's Day Surgery waiting list from the same date in July 2019 as an Urgent case. This was done retrospectively on PAS on 20 August 2019, approximately a week before the patient had their Pre-Op Assessment in late August 2019. The patient had their procedure in early September at CAH Day Surgery Unit, 2 weeks after being entered onto the waiting list on PAS (albeit the entry was made retrospectively to an earlier time in July). The Trust has advised that the normal waiting time for this procedure is 91 weeks.
  In effect, this patient changed from NHS to private and back to NHS in one day, with no Change of Status forms. This is a blatant breach of proper process and is an example whereby a significant advantage has been gained in terms of speed of treatment, by paying privately for an outpatient appointment.
  In the absence of an approved Change of Status form, this is arguably a private patient having a procedure using trust facilities and staffing.
- In 2 cases, there was no outcome letter completed for the procedure potentially indicating that the patient may have transferred back to the private sector for review. It should be noted that the Trust believe that these are poor administration issues rather than private patients.

3.3 Elective Surgery with an Outpatient Appointment

There were 812 records (356 patients) out of the 1,096 (576 patients) that had elective procedures who also had an outpatient appointment in the period under review.

From review of a sample of 29 of these patients, Internal Audit noted 4 occasions where the patient may have potentially been a private patient:

- 1 patient (a retired consultant) who had been seen privately by Mr A in 2017 was then seen in 2020 in the Trust as an NHS patient. A change of status form had not been completed.
- 1 patient was under the care of another urology consultant on PAS but the patient was seen by Mr A. There was no rationale as to why Mr A became involved in the patient's care.
- 1 patient was seen within 2 days of a red flag referral. Internal Audit observed that as per a letter on NIECR, this patient was a close relative of a GP.
- In 1 case, there was no outcome letter completed following the procedure, which potentially could be an indicator that the patient may have been reviewed privately following the procedure. It should be noted that the Trust believe that these are poor administration issues rather than private patients.

3.4 Other Observations

During the course of the audit, Internal Audit identified a number of other issues:

- There were 371 radiology diagnostic tests requested by Mr A from Urology Outpatients in the period 1 January 2019 to 30 June 2020 where the patient had no outpatient/surgical procedure, as per the PAS reports provided by the Trust. Upon further investigation and sample checking by Internal Audit in conjunction with the Head of Service for Urology, Head of Diagnostics and a Urology Consultant, it was identified that these cases were not all Mr A patients. When a junior doctors signs in with their own log-in into NIPACS (Sectra), their request will default to the last Consultant they ordered a scan on behalf of. The junior doctor should amend this to the name of the consultant they are actually making the request on behalf of, however Internal Audit was advised that this is not routine practice. Therefore scan requests are being attributed to

consultants when the patient wasn't actually under their care. If a consultant makes the request themselves, this is not an issue as system maps directly to them it doesn't default to the last user. This means the audit trail on the system in terms of the requesting Consultant is incorrect in some cases and could mean that the test results go to the wrong Consultant, potentially creating a patient safety issue.

- The referral date on PAS, which is the date the referral of the patient is received by the hospital and will be the date the patient enters any relevant waiting lists, should not be changed however the date can be changed on the system. Internal Audit noted instances where the date had been changed, affecting the patient's position on the waiting lists. In the context of this audit, Internal Audit observed referral dates being changed to later dates rather than earlier dates.
- When a patient is entered onto PAS, a registration will be opened for the episode of care, this registration should be closed when a patient is discharged with their treatment complete. Open registrations on PAS should be reviewed on an ongoing basis. Instances were observed where the patient had been discharged but the registration had not been closed.
- Up to 2020 there was no mechanism for electronic signoff on NIECR. From 2020 this became available and is reportedly monitored however it is not routinely used across the Trust. Internal Audit queried how the Trust ensures that consultants are getting their own patient results – and where advised that there is a monthly check completed of all patients who are recorded as "DISCHARGE AWAITING RESULT" by Consultant secretaries. Internal Audit were advised that this is not conducted routinely. Internal Audit were advised that there 1,000 records on NIECR not signed off by Mr A.

General Recommendations Regarding Trust Process:

Recommendation 3.1	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned admission date for surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including Urology.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director of ATICS
Implementation Date	September 2021

Recommendation 3.2	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director of ATICS, Assistant Director Functional Support Services
Implementation Date	September 2021

Recommendation 3.3	The Trust should liaise with BSO in order to resolve this referring Consultant recording error in the NIPACS system.
Management Action	**ACCEPTED**

Responsible Manager	Director Performance & Reform
Implementation Date	February 2022

Recommendation 3.4	The processes for registration should be reviewed and training given to all appropriate staff on the correct use of PAS, including consultant secretaries.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Recommendation 3.5	The processes surrounding electronic and manual sign off and review of the "DISCHARGE AWAITING RESULT" should be strengthened and monitored.
Management Action	**ACCEPTED**
Responsible Manager	Assistant Medical Director Clinical Directors and Assistant Operational Directors
Implementation Date	February 2022

See also recommendation 1.4

4 INTERACTION OF MR A's PRIVATE WORK WITH HSC SERVICES AND FACILITIES

A Code Of Conduct For Private Practice - Recommended Standards Of Practice For HPSS Consultants (November 2003) states that HSC facilities, staff and services may only be used for private practice with the prior agreement of the HSC employer.

Internal Audit were advised by the Trust that Mr A's private practice did not interact with HSC services and facilities. However as per the findings in this report, there are a number of issues and exceptions that would indicate a degree of interaction – particularly for services that could not be performed or delivered from Mr A's home practice.

The queries around the timing of changes of status outlined in this report, mean there is a risk that Trust staff have been involved in the administration or treatment of patients that should have been categorised as private.

General Recommendations Regarding Trust Process:

See recommendations in section 1-3

5 CRAIGAVON UROLOGICAL RESEARCH EDUCATION (CURE)

In line with the Terms of reference of this review, Internal Audit also considered whether the Trust has any involvement with CURE - Craigavon Urological Research & Education, to understand if there was a flow of money into the Trust and to check, as much as is possible from review of Trust records and engagement with Trust staff, whether any Directors/staff benefited from the operation of the company.

According to the Companies House website/Articles of Association, a previous Trust Chairperson and Mr A set up CURE in 1996 as a 'Charitable Company Limited by Guarantee and not having Share Capital'.

The objectives of CURE are:

- To advance education for the public benefit in Urological disorders.
- Conducting and commissioning research into Urological disorders and the effective treatment of persons suffering from Urological disorders and to disseminate the useful results of such research.
- Raising public awareness and understanding of Urological disorders and their treatment and promoting training in the treatment of Urological disorders.

The CURE committee is currently made up of Mr A and three other people - 2 of whom are current Trust employees (1 Consultant Urologist and 1 Specialist Nurse in Health Promotion). The CURE committee secretary is a previous Trust employee.

Whilst these Trust staff are members of the CURE Committee, Internal Audit were advised by Senior Trust staff that their role should be separate and independent from their roles in the Trust. Internal Audit met with the two Trust staff who are currently on the Committee of CURE who both confirmed that their role within CURE is entirely independent of their job with the Trust. The Trust advised of some historical Trust involvement with CURE (pre-creation of SHSCT) including preparation of CURE accounts. Internal Audit also note that the registered office of CURE (until July 2012) was on the Craigavon Area Hospital site.

From discussion with Trust Management and Trust staff involved with CURE, there is no indication of any flow of money into the Trust or Trust involvement in fund raising in recent years.

Internal Audit understands from the Committee members that Trust staff may apply to CURE for funding. A written request is completed and will be reviewed/approved by the CURE committee. If approval is granted by the Committee, the staff member will pay for the course and on submission of relevant paperwork invoices, a cheque from the CURE bank account is made payable to the applicant.

It should be noted that Internal Audit did not have access to CURE financial records as part of this review and therefore do not have visibility over payments made by CURE to Trust staff.

Trust procedures do not provide guidance in respect of staff involvement in independent organisations with a potentially perceived affiliation to the Trust by their nature.

General Recommendations Regarding Trust Process:

Recommendation 5.1	The Trust should review the appropriateness of Trust staff being office bearer/cheque signatories in Charities where due to the close associations, the reputation of the Trust may be impacted by the actions of these charities. Trust procedures should be developed for this area and the potential for such charities to be seen in effect as an unofficial Charitable Fund at ward level, should be

	considered.
Management Action	ACCEPTED
Responsible Manager	Director of Finance
Implementation Date	October 2021

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in in fulfilling their responsibilities.

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From: McClements, Melanie <[redacted]>
Sent: 10 September 2020 23:29
To: Carroll, Anita <[redacted]>; Carroll, Ronan <[redacted]>
Cc: Corrigan, Martina <[redacted]>
Subject: RE: administratrion of urology referrals review

Yes it is a prospective review of the admin systems/processes, martina guiding the scope of it

From: Carroll, Anita
Sent: 10 September 2020 16:17
To: Carroll, Ronan; McClements, Melanie
Subject: FW: administratrion of urology referrals review

Is this linked with aob ?? why did she send this
This is a worry

From: Robinson, Katherine
Sent: 10 September 2020 16:14
To: Carroll, Anita
Subject: FW: administratrion of urology referrals review

????

From: McCullagh, Rose
Sent: 10 September 2020 16:09
To: Robinson, Katherine; Rankin, Christine
Cc: Donnelly, Mary
Subject: administratrion of urology referrals review

Hello Katherine and Christine,
Mary and I are AMD Primary care and have been tasked with the reciew of admin or urology referrals.
In order to understand better the working of the booking centre and the operations within regarding the referrals , paper referrals ,
what you consider could/ should be altered to improve this for all and more,
Could we arrange a time on Wednesday or Thursday next week .
Thursday 9 am would be good if it suits .

Thanks
Rose

Many Thanks ,

Rose
Rose McCullagh FRCGP
AMD Primary Care
Tel [redacted]
Days of Availability : All day Thursday 8am - 6 pm ,
by arrangement Friday afternoon 2pm - 6 pm

From: Forde, Helen <Personal Information redacted by the USI>
Sent: 30 September 2020 15:24
To: Carroll, Anita <Personal Information redacted by the USI>
Subject: FW: confidential Adminstrative review

You weren't copied in to the email so forwarding it on to you.

Helen Forde
Head of Health Records
Admin Floor, CAH

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

From: McClements, Melanie
Sent: 30 September 2020 14:30
To: Forde, Helen
Subject: confidential Adminstrative review

As discussed Helen for your thoughts in this confidential loop.
Anita I will spek to you confidentially re this, m

From: Corrigan, Martina
Sent: 29 September 2020 08:33
To: Carroll, Ronan; Gormley, Damian; Haynes, Mark; Hynds, Siobhan; McClements, Melanie; OKane, Maria; Toal, Vivienne; Wallace, Stephen
Subject: Adminstrative review

Dear all

Can we discuss please (document 2 is what Mary sent me and I for ease I have attached what the TOR were) as conscious this needs to be complete and sent to RCS by tomorrow

Regards

Martina

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

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

From: Donnelly, Mary
Sent: 21 September 2020 12:39
To: Corrigan, Martina

Cc: 'rose mccullagh'
Subject: FW: Document2

Hi Martina
Just to let you know Rose is going to complete this as I have taken on some additional duties with Bannview practice.
If you have any comments would you mind emailing them to Rose at her gmail account as above as she is on leave this week.
Many thanks again
Mary

Findings

1. **The administration processes regarding the receipt of and triage of patients referred to the urology service from all sources**

Current process – *Referrals to Southern Trust Urology come from a number of different sources within Primary and Secondary Care and also include referrals from the private sector. Referrals are made mainly via CCG (Clinical Communications Gateway) from Primary care (although not exclusively) and in paper format from other sources.*

All referrals are triaged by the Consultant of the week, for the CCG referrals this involves working through a digital list and paper referrals are viewed physically by the Consultant after they have been scanned and dated.

Recommendation –*We recommend moving to an amalgamated electronic list which would incorporate all CCG referrals and also all paper referrals, this list would be locked at an agreed time each week to ensure no patient could be added after the list had been triaged. This process would provide an additional layer of assurance regarding the avoidance of referrals becoming mislead and also to ensure chronicity of referrals in terms of triage was adhered to.*

2. **The effectiveness of monitoring of the administration processes including how and where this is information is reviewed**

Current process- *The monitoring of this service is carried out by the Administration team with cross cover arrangements in place*. There is also a level of oversight by the booking centre.

Recommendation-*We recommend that this process in terms of the administration team and booking centre is formalised and an effective Standard Operating Procedure is put in place with regular review*.

3. **The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes**

Current process – *The role of the Consultant of the week and the checking mechanism by the member of the administration team are clear.*

Recommendation – *Again we recommend an effective SOP for the administration processes but also feel that increased communication between clinical teams regarding roles may be helpful and may prevent*

the need to escalate difficulties. In particular the role of locum Consultants should be clearly defined with appropriate safety-netting in place.

4. **The effectiveness of the triggers and escalation processes regarding non-compliance with administration processes**

Current Process – *The administration checking process allows non-compliance to be detected and remedied.*

Recommendation – *Formalisation of the current escalation processes involving the administration team is likely to be beneficial and as already described open communication between clinical teams where difficulties arise may result in the need for less escalation.*

5. **To identify any potential gaps in the system where processes can be strengthened**

Current Process- *The dual system of digital referrals and paper referrals may present issues with dealing with referrals in an appropriate chronological manner.*

Recommendation – *In conclusion the amalgamation of both paper and digital referrals into a single list which can be easily checked is likely to be beneficial.*

Formalised Standard Operating procedures for all processes with adequate safety netting and increased open communication between clinical teams and locum Consultants is likely to see benefits

Purpose

The purpose of the review, is to review the Trust urology administrative processes for management of patients referred to the service.

Objectives

The review will consider the present Trust urology administrative processes regarding referrals to the service and recommendations for the future, rather than past and pre-existing processes. The review in particular will consider the following:

- The administration processes regarding the receipt of and triage of patients referred to the urology service from all sources
- The effectiveness of monitoring of the administration processes including how and where this is information is reviewed
- The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes
- The effectiveness of the triggers and escalation processes regarding non-compliance with administration processes
- To identify any potential gaps in the system where processes can be strengthened

Outputs

The Reviewer should provide a report which seeks to address the issues listed above. The report should provide recommendations on improvements to Trust urology administrative processes. Any recommendations should be evidence-based and proportionate, with consideration given to their implementation.

Scope

The review should consider current Trust urology administrative processes for the management of referrals to the service. This is a forward-looking review and, as such, will not consider past decisions.

Timing

The report, including any recommendations of the review, must be submitted to the Trust Acute Director by end September 2020.

Governance and Methodology

The Reviewer will be accountable to, the Trust Acute Director for delivery of the review. Details of the governance which achieves this accountability and the methodology for the review - including evidence gathering, consultation with operational and clinical staff - will be agreed between the Reviewer and the Trust Acute Director by 5th August 2020.

From: Corrigan, Martina <[redacted]>
Sent: 09 November 2020 16:55
To: Carroll, Anita <[redacted]>; Robinson, Katherine <[redacted]>
Subject: Admin Process V2 - 6 Nov 2020

Updated from our conversations on Friday

Let me know if there are any amendments please

Thanks

Martina

Admin Review Processes

Issue Identified	Description of issue	Gaps that led to the problems	Policies or processes in Place	Ongoing Risks/flaws
1. Triage	**783 letters not triaged**. GP referrals were sent to Consultants in paper form and were added to the PAS system as per the clinical priority that the GP had put on their referral letter. Because of the longer waiting times for a first appointment if the consultant didn't triage then this may have disadvantaged a patient who should have been upgraded	This gap only applied to Routine and Urgent letters as referrals sent in by GP's as a Red Flag went a different route, Previously a business objects report had been ran regularly and this picked up that a patient had not been added to an outpatient waiting list and was escalated to OSL/HOS/AD for addressing. A decision was made in April 2014 by the Director of Acute services that all patients would be added to the OP waiting list by the clinical priority that the GP deemed on their letter. This meant that all patients were added to a waiting list but also meant that any patients who should have been triaged and upgraded may not necessarily been done if the consultant didn't look at the letters. Copies of all letters were kept by the booking centre so if a consultant didn't return the letter and the patient was due an appointment the letter was still	The introduction of ETriage has increased the visibility and the implementation of robust escalation protocols throughout the management structure to include clinical management teams. Patients are not added to waiting list until they have been triaged by the consultant. The recent roll out (October 2020) of the new escalation process as per March 2019  flow chart triage escalation.docx	Consultant to Consultant referrals including outside Trust cannot be added to the ETriage (this is being addressed and should be available in January 2021) so this is currently a risk that the secretary and the consultant do not action this. There are a few specialties that still do not triage using ETriage and this is being addressed. For Consultant to Consultant referrals all Consultants need to be reminded that when using Digital dictation they need to highlight that a letter is Red Flag or urgent so that secretary will give priority to typing these letters Reminder to secretaries

		available for the clinic. The Booking Centre also added a comment MTNL (Missing Triage, No letter) so as to highlight the issue that the letter had never come back.		to that they need to escalate any issues, in relation to concerns they may have of 'paper' letters waiting on triage.
2. Undictated Clinics	There were **668 patients** who had not had a letter dictated for them after an outpatient clinic and had no follow-up outcomes recorded on PAS. This meant that patients had not had their episode updated on PAS i.e. discharged/added to a waiting list for another appointment, procedure etc…	The attendances at the clinic were recorded on the PAS system which didn't highlight that there was a problem of no dictation. The dictation was done on a handheld dictaphone and the tape was given to secretary so there was no way of knowing if the clinic and all patients had been dictated on and outcomes actioned. This consultant did do a clinic outcome sheet but didn't always return them to secretary.	Consultants should be reminded that it is their responsibility to ensure that an outcome sheet is completed and returned with the charts at the end of every clinics to the secretary. Consultants to be reminded that they must dictate a letter for every patient at the end of the clinic even for those patients that do not attend	Whilst G2 can tell what has been dictated and how many letters need to be typed there is no way of knowing if this relates to 5 letters on one patient and none on three others. No electronic method of monitoring this
3. Hospital Notes	**307 Hospital notes** were returned from Consultants home these notes were tracked out on PAS as being either in the Consultants or his secretary's office	Only alert to this problem had been that when a chart couldn't be found and the consultant was contacted direct he was able to make the chart available. Whilst this was a recognised and known problem for this particular	None currently available	There is no system which highlights that a chart is not where it is tracked out to. If a report is run as to how many charts are in each of the consultant's

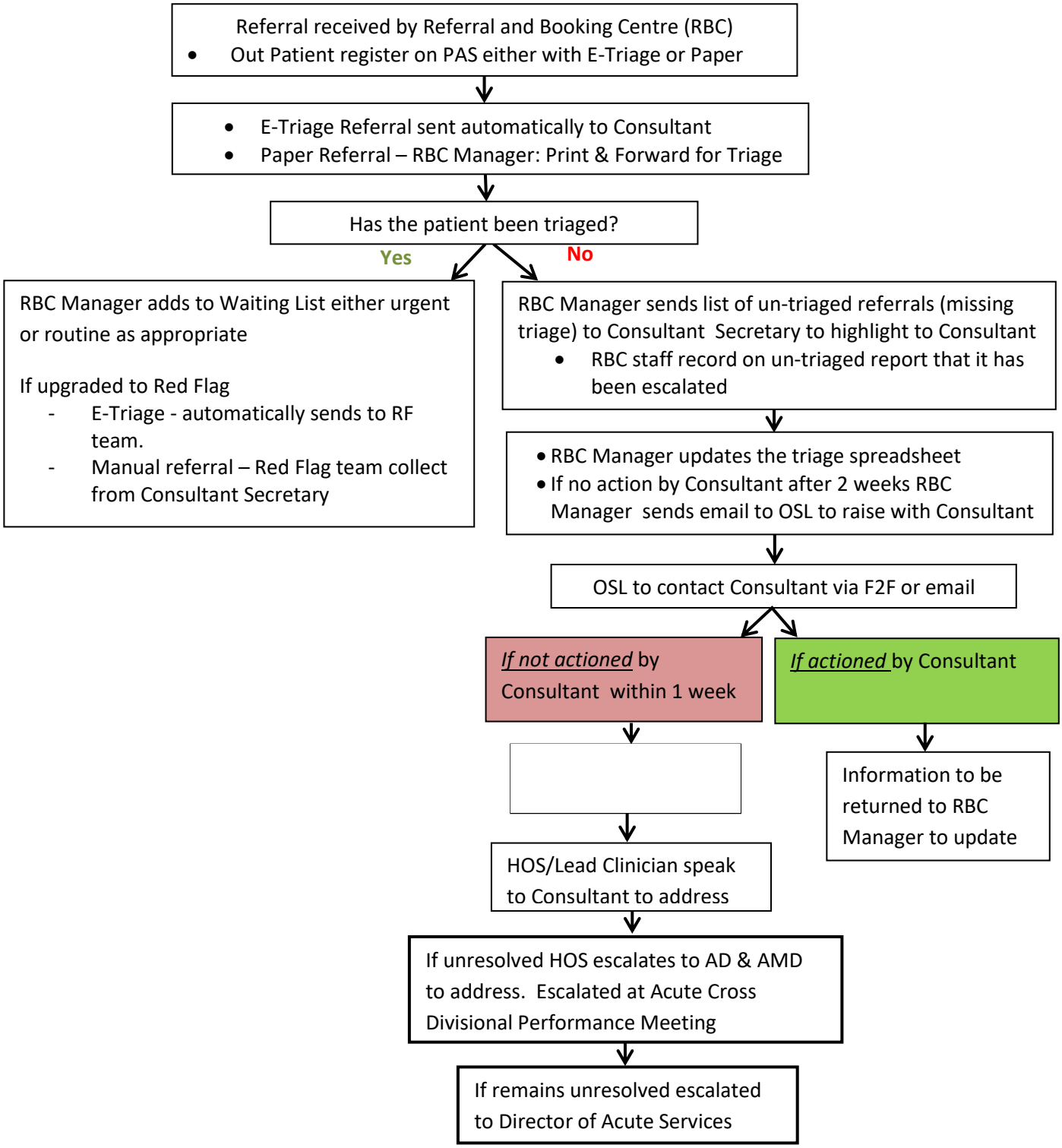
		consultant the volumes were never known until all the charts had been returned. Charts are transferred in boxes between Southern Trust sites by Trust transport. However, this was not applicable for South West Acute Hospital, as the notes had to be transported between Southern Trust and SWAH via Trust members private vehicles		offices this is still difficult to manage as what constitutes 'too many' charts in an office, e.g. if chart is waiting on results there may be multiple charts, or if the consultant has been the consultant on call and it's been a busy week then there will be quite of number of charts waiting on discharge and follow-up actions
4. Private Patients	**13 Patients** that had been seen privately had been operated on ahead of NHS patients that had required the same operation, thereby disadvantaging patients who were waiting longer. It should be noted that these private patients had their procedure done on the NHS	The consultant scheduled his own patients by contacting them direct and then gave the patient details to secretary for adding to theatre lists for TMS and sending out a confirmation letter. The secretary didn't highlight the patients that had no previous episode but created a new episode	Private Patient Policy for transferring patients that have been initially seen privately onto the NHS and ensuring that they are not advantaged over someone who hadn't paid	The secretary needs to go on what the consultant advises them, e.g. where the patient should be placed on the list and what the patient's clinical priority is.

TRIAGE PROCESS

- **Red Flag referrals should be returned from Triage within 24hrs**
- **Urgent referrals should be returned from Triage within 72hrs**
- **Routine referrals should be returned from Triage within week.**

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It directs the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
- The Consultant can return referrals with advice and no outpatient attendance where appropriate.



Please Note: This process will incur a minimum of 7 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.

It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above

From: Carroll, Anita
Sent: 19 October 2020 16:07
To: McClements, Melanie [redacted]
Subject: FW: UROLOGY

Melanie can you substitute with this version sorry for messing that up
From: Carroll, Anita
Sent: 09 October 2020 16:16
To: McClements, Melanie [redacted]
Cc: Forde, Helen; Robinson, Katherine
Subject: UROLOGY

Melanie ,

following on from our conversation I have included a few things for consideration

1. Admin review doc : looked at what Rose/ Mary produced and added some context and redid the recommendations :if you are content myself and Katherine can chat through with Rose/ Mary

2 .Re your concerns with regards to charts and volumes of charts I can advise : All patient charts must be tracked on PAS using a tracking code which gives information on the current location of the chart. Every time a chart moves location the tracking code must be updated. Not only does this help in the relocation of the chart but it also serves as a governance tool to show who has access to the chart and when.

PAS provides the facility to run a report giving the number of charts tracked to a specific code, and the patient details. These reports are not run routinely but can be run as and when requested, eg in a ward move to ensure all charts are accounted for. Health records staff retrieve charts from the various offices and are aware of where there are large volumes of charts and would bring this to their Line Managers attention if there was an issue, eg large volumes of charts not normally in the office, or so many charts that finding a chart was difficult.

The volume of charts held in an office are indicative of the working practices for that consultant/specialty and not that there is a problem with the working practices – eg number of tests performed, audits being carried out, or if due to the nature of the patient's treatment there are regular enquiries re the treatment/drug regime it is easier to have the chart readily available. If a chart cannot be found the Health Records staff carry out a thorough search of all areas that the chart has been tracked to. If the chart is not found it is added to a Missing List and kept under review. A Datix is not usually completed for a missing chart as it is usually that someone has taken the chart to another location without tracking it appropriately.

3.with regards to your concern that there maybe other issues , we had a chat with martina and she agreed to send some details to Katherine so that Katherine would check pas logs etc to assure that the issue lay firmly with the consultant

As you know we haven't been heavily involved but I attach a work flow that would be useful as an overview of triage and appropriate escalation that acute services needs to adopt and implement

Finally if all worked as it should the admin process for the patient journey attached would be followed and maybe martina can highlight with the look back exercise what elements of this process went wrong and from that we could develop recommendations to provide assurances in future .

Many thanks
Anita

Mrs Anita Carroll
Assistant Director of Acute Services -
Functional Support Services
Daisy Hill Hospital
5 Hospital Road
Newry
Co. Down
BT35 8DR
Tel: Tel: Personal Information redacted by the USI or mob Personal Information redacted by the USI

Please consider the environment before printing this email

Many thanks
Anita

Mrs Anita Carroll
Assistant Director of Acute Services -
Functional Support Services
Daisy Hill Hospital
5 Hospital Road
Newry
Co. Down
BT35 8DR
Tel: Tel: Personal Information redacted by the USI or mob Personal Information redacted by the USI

Please consider the environment before printing this email

Admin Process for Patient Journey

Referral & OPD

- Pt attends GP/A/E etc with a medical issue.
- Referral sent to RBC, registered on PAS
- Referral sent for triage
- Following triage, pt added to opd waiting list or straight to an inpt waiting list
- Pt selected for OPD apt in chronological order. Partially booking process adhered to.
- Medical Records pull charts for forthcoming clinics.
- PT attends, attendance recorded, charts forwarded to sec.
- Clinician dictates a letter re each pts attendance.
- Sec or A/T types letter to advise GP of action plan or discharge. Outcome of clinic visit is recorded ie review, add to inpt waiting list, order more tests etc.
- Sec or A/T does the PAS work from info on the letter ie add pt to review waiting list etc

Patient is to come for a Procedure

- Pt is to come for an operation, pt selected per chronological management
- Scheduler or Sec schedules pt, slot booked and confirmed.
- Sec or scheduler preadmits pt on PAS for operation.
- TMS Completed
- Medical Records pull chart for admission

Admission & Discharge

- Pt arrives at hospital and goes to Elective Admission ward or other venue stipulated on their letter.
- Pt is admitted on PAS by ward clerk.
- Pt operated on, chart goes from Theatres with operation notes to ward.
- Pt goes to ward for some recovery, e discharge is completed by Junior doc , lots of clinicians prefer a typed discharge letter

Discharge letter & Follow up

- If there is to be a typed discharge letter then the consultant dictates a letter. At this stage the chart should be with the secretary. If the chart is removed while awaiting dictation, Medical Records leave info of what the chart was removed for etc and for the chart to be returned to the secs office.

- Sec types discharge letter and adds any follow up needed to PAS, any results pending she puts into DARO on PAS etc.

From: Robinson, Katherine <[redacted]>
Sent: 10 November 2020 14:40
To: Carroll, Anita <[redacted]>
Subject: Admin Process V3- 10 Nov 2020

Agree with all your changes, just changed a couple of wee things.

Admin Review Processes

Issue Identified	Description of issue	Gaps that led to the problems	Policies or processes in Place	Ongoing Risks/flaws
1. **Triage**	**783 letters not triaged**. Maybe add date eg 2015 ? GP referrals were sent to Consultants in paper form and were added to the PAS system as per the clinical priority that the GP had put on their referral letter. Because of the longer waiting times for a first appointment if the consultant didn't triage then this may have disadvantaged a patient who should have been upgraded	This gap only applied to Routine and Urgent letters as referrals sent in by GP's as a Red Flag went a different route, Previously a business objects report had been ran regularly and this picked up that a patient had not been added to an outpatient waiting list and was escalated to OSL/HOS/AD for addressing. A decision was made in April 2014 by the Director of Acute services that where there was a significant delay in triage then referrals ~~all patients~~ would be added to the OP waiting list by the clinical priority that the GP deemed on their letter. This meant that all patients were added to a waiting list but also meant that any patients who should have been triaged and upgraded may not necessarily have been done if the consultant didn't triage ~~look at~~ the letters. Copies of all letters were kept by the booking centre so if a consultant didn't return the letter	The introduction of ETriage has increased the visibility of the triage process and the implementation ~~?? are we doing this as much as required~~ of robust escalation protocols throughout the management structure to include clinical management teams. Patients are not added to waiting list until they have been triaged by the consultant. The recent roll out (October 2020) of the new escalation process as per March 2019	Consultant to Consultant referrals including outside Trust cannot be added to the ETriage (this is being addressed and should be available in January 2021) so this is currently a risk if the secretary and the consultant do not action this. There are a few specialties that still do not triage using ETriage and this is being addressed. Attach o/s list ? For Consultant to Consultant referrals all Consultants need to be reminded that when using Digital dictation they need to highlight that a letter is Red Flag or urgent so that secretary will give priority to typing these letters

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		and the patient was due an appointment the letter was still available for the clinic. The Booking Centre also added a comment MTNL on PAS (Missing Triage, No letter) so as to highlight the issue that the letter had never come back. This was visible to osl / hos /ad via the PTL	 flow chart triage escalation.docx	Reminder to secretaries to that they need to escalate any issues, in relation to concerns they may have of 'paper' letters waiting on triage.
2. **Undictated Clinics**	Again add when ?There were **668 patients** who had not had a letter dictated for them after an outpatient clinic and had no follow-up outcomes recorded on PAS. This meant that patients had not had their episode updated on PAS i.e. discharged/added to a waiting list for another appointment, procedure etc…	The attendances at the clinic were recorded on the PAS system which didn't highlight that there was a problem of no dictation. The dictation was done on a handheld dictaphone and the tape was given to secretary so there was no way of knowing if the clinic and all patients had been dictated on and outcomes actioned. This consultant did do a clinic outcome sheet but didn't always return them to secretary.	Consultants should be reminded that it is their responsibility to ensure that an outcome sheet is completed and returned with the charts at the end of every clinic to the secretary. Consultants to be reminded that they must dictate a letter for every patient at the end of the clinic even for those patients that do not attend	Whilst G2 can tell what has been dictated and how many letters need to be typed there is no way of knowing if this relates to 5 letters on one patient and none on three others. No electronic method of monitoring this
3. **Hospital Notes**	**Again add when 307 Hospital notes** were returned from Consultants home these notes were	Only alert to this problem had been that when a chart couldn't be found and the consultant was contacted direct he was able to	None currently available	There is no system which highlights that a chart is not where it is tracked out to.

	tracked out on PAS as being either in the Consultants or his secretary's office	make the chart available. Whilst this was a recognised and known problem for this particular consultant the volumes were never known until all the charts had been returned. Charts are transferred in boxes between Southern Trust sites by Trust transport. However, this was not applicable for South West Acute Hospital, as the notes had to be transported between Southern Trust and SWAH via Trust members private vehicles		If a report is run as to how many charts are in each of the consultant's offices this is still difficult to manage as what constitutes 'too many' charts in an office, e.g. if chart is waiting on results there may be multiple charts, or if the consultant has been the consultant on call and it's been a busy week then there will be quite of number of charts waiting on discharge and follow-up actions However we will start to run a report by tracking code to identify volume of charts to consultants / secretaries and this will be sharef with hos/ ad to review in terms of specialty comparisons and to address any non standard working practices
4. Private Patients	**13 Patients** that had been seen privately had been operated on ahead of NHS patients that had required the	The consultant scheduled his own patients by contacting them direct and then gave the patient details to secretary for adding to	Private Patient Policy for transferring patients that have been	The secretary needs to go on what the consultant advises them, e.g. where the patient should be

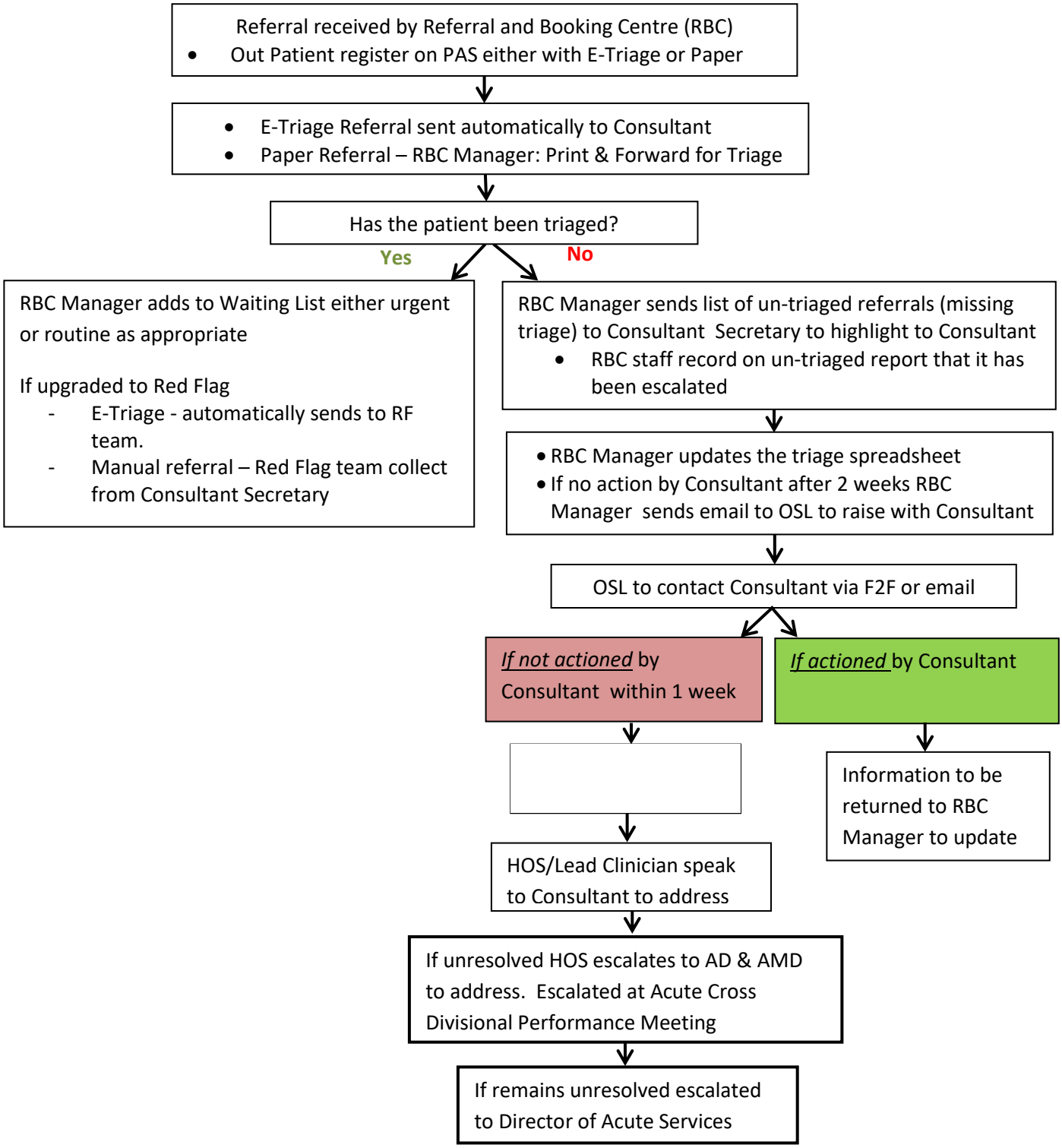
	same operation, thereby disadvantaging patients who were waiting longer. It should be noted that these private patients had their procedure done on the NHS	theatre lists for TMS and sending out a confirmation letter. The secretary didn't highlight the patients that had no previous episode but created a new episode	initially seen privately onto the NHS and ensuring that they are not advantaged over someone who hadn't paid	placed on the list and what the patient's clinical priority is.

TRIAGE PROCESS

- **Red Flag referrals should be returned from Triage within 24hrs**
- **Urgent referrals should be returned from Triage within 72hrs**
- **Routine referrals should be returned from Triage within week.**

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It directs the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
- The Consultant can return referrals with advice and no outpatient attendance where appropriate.



Please Note: This process will incur a minimum of 7 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.

It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above

From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 18 December 2020 09:47
To: Robinson, Katherine <Personal Information redacted by the USI>
Subject: FW: review of admin processes paper

For a chat later

From: Denise Lynd [mailto:Personal Information redacted by the USI]
Sent: 17 December 2020 22:31
To: Carroll, Anita; Corrigan, Martina
Cc: denise.lynd Personal Information redacted by the USI
Subject: review of admin processes paper

Ladies

Please see attached

I'm afraid I made a good few changes to this and have highlighted a few things for further clarification

I will be in work on Monday if either of you are free to have a chat over the phone after lunchtime

Denise

Sent from Mail for Windows 10

Admin Review Processes

Issue Identified	Description of issue	Gaps that led to the problems	Policies or processes in Place	Ongoing Risks/flaws	Action required	Owner/Action/Date for Completion
1. Triage	Pre e-Triage, GP referrals to Consultants were in paper form and added to PAS as per the GP's indication of clinical priority. Due to longer waiting times for a first appointment if the consultant didn't triage then this may have disadvantaged a patient who should have been upgraded.	This issue only applied to Routine and Urgent GP referrals, Red Flag referrals were managed using a different process i.e., may need to elaborate on this? Previously a business objects report was run on a regular basis to identify patients with open registrations who had neither an appointment nor were on a waiting list. These were escalated to Operational Services Lead, Head of Service and Assistant Director for checking and follow up action. In April 2014 the Director of Acute services decided that where there was a significant delay in triage, referrals would be added to the OP waiting list by the clinical priority that	The introduction of e-Triage on 27/3/17 has increased the visibility of the triage process and the implementation of robust escalation protocols throughout the management structure to include clinical management teams. Patients were no longer added to a waiting list until they had been triaged. The roll out in October 20 of the new escalation process as per March 19 and this is based on the current IEAP guidance. This is a bit confusing?? Does it mean that the	1.1 Consultant-to-Consultant referrals (including outside Trust) are not currently managed through e-Triage so there is still a risk that these could be delayed if the Consultant and their Secretary do not follow the current SOP ADD Copy of SOP 1.2 There are a few specialties that still do not triage using e-Triage and this is being addressed. 1.3 For Consultant-to- Consultant referrals, Consultants are reminded that when using Digital dictation they need to highlight that a letter is Red Flag or urgent so that secretary will give priority to typing these referral letters. Reminder to secretaries that they	1.1 Consultant to Consultant referrals to be added to e-Triage 1.2. Remaining specialties to be added to e-Triage i.e., provide details of Specialties 1.3. Standing agenda item on Service Departmental meetings and included as part of Junior Doctor changeover Induction. 1.4 Standing agenda item on regular team meetings with Service	1.1 K Cunningham, Transformational Lead in liaison with BSO to set up system to support Consultant-to-Consultant e-referrals **January 2021** 1.2 K Cunningham, Transformational Lead to work with Service Leads for specialties that need to commence e-Triage **May 2021** 1.3 Heads of Services at their specialty and patient safety meetings **Ongoing** 1.4 Service Administrators at their team meetings **Ongoing**

Issue Identified						
		the GP indicated on the referral letter. This ensured that all patients were a least added to a waiting even if the Consultant hadn't triaged the referral so avoiding referrals being 'lost'. Copies of all referral letters were kept by the booking centre so if a Consultant didn't return the letter and the patient was due an appointment the letter was still available for the clinic. The Booking Centre also added a comment MTNL on PTL (Missing Triage, no letter) so as to highlight the issue that the letter had never been triaged by a consultant.	escalation process was 1st updated in Oct 20?  flow chart triage escalation.docx	need to send any paper referrals to RBC escalate any issues, in relation to concerns that they may have of 'paper' letters waiting on triage. Patients are no longer added to a waiting list until they have been triaged by the consultant.	Administrators and Secretaries. The PTL Report is monitored regularly (? Monthly??) by the Operational Support Leads in conjunction with the RBC Manager and reviewed with Heads of Services and their Administrative teams (sample attached)  01M OPEN OP REG 301120.xlsx	

Issue Identified	Description of issue	Gaps that led to the problems	Policies or processes in Place	Ongoing Risks/flaws	Action required	Owner/Action/Date for Completion
2. Undictated Clinics	Some patients did not have a letter dictated for them after an outpatient clinic and therefore had no follow-up outcomes recorded on PAS. All patients should have an outcome following a Consultation i.e. Discharged, review appointment (booked if less than 6 weeks) or added to a review waiting list or added to an inpatient/daycase waiting list.	Attendances after the clinic were recorded on the PAS system which did not highlight that there was a problem of no dictation. Pre-digital dictation, dictation was done on a handheld Dictaphone and the tape was given to the secretary so there was no way of knowing if the clinic and all patients had been dictated on and outcomes actioned. Some consultants did do a clinic outcome sheet but this wasn't always return by them to the secretary.  Clinic Outcome Sheet nov 20.docx . Digital dictation enables the monitoring of dictated letters.	Consultants should be reminded that it is their responsibility to ensure that an outcome sheet is completed and returned with the charts at the end of every clinic to the secretary. Whilst there is no policy this is perceived as best practice. Consultants to be reminded that they must dictate a letter for every patient at the end of the clinic even for those patients that do not attend Backlog reports are completed monthly by secs which highlight issues in relation to clinical admin.	Whilst G2 can tell what has been dictated and how many letters need to be typed there is no way of knowing if this relates to 5 letters on one patient and none on three others. The Trust has been working on the G2 PAS interface. This major piece of work required integration with the help of BSO. It is now in 'live' mode and is being piloted by one consultant with positive feedback. This will provide the Trust with more assurance around the dictation of outpatient clinics	2.1 Work will continue to develop this system and then this will be rolled out to all clinical teams 2.2 Completion of clinic outcome sheets and the importance both of dictating on all patients and ensuring that important letters are highlighted is a standing agenda item on Service Departmental meetings and needs to be included as part of Junior Doctor Changeover Inductions 2.3 Update typing SOP to highlight that when a letter is not dictated for a patient that the sec raises with the consultant and line manager in the first instance. Secretaries to stipulate on their backlog reports if they know of any undictated clinics/letters	2.1 IT Team with BSO and the clinical Teams **June 2021** 2.2 Heads of Services at their specialty and patient safety meetings and this needs noted in the minutes **Ongoing** 2.3 ?? Who ?? Update Typing SOP and circulate to all Secretarial Support By ??

3. Hospital Notes	Problem with missing patient notes which on investigation were found in a Consultants home. These notes were 'tracked' on PAS as being either in the Consultants or his secretary's office.	The only alert to this problem arose when a chart could not be found and when the consultant was contacted he was able to make the chart available. Whilst this is a rare occurrence, there is no way of knowing the charts held this way as they were not tracked on PAS.	Current tracking systems and?? Booking Manual Systems Missing charts are investigated completed for any not found.	There is currently no system which identifies that a chart is not where it is tracked to other than manual searches.	3.1 Any missing notes need to have an IR1 raised, to highlight the problem. These should be reported to the respective areas. 3.2 All staff managing patient notes should be reminded of the need for accuracy on PAS when tracking notes and patient records should be returned to file as soon as possible. 3.3 Business Case for an electronic tracking system using barcode technology (as used in other Trusts in NI) to be considered for funding until the NI Electronic Patient Record replaces paper records under the Encompass Project.	3.1 Health Records to be advised that if there is missing patient notes to raise a IR1 **Ongoing** 3.2 Medical Director and Acute Director to advise all clinical teams and admin support that all patient records need to be 'tracked' accurately using either PAS or local systems and that records should be returned to the Health Records Library as soon as is reasonable. **January 2021** 3.2 Service Administrators to do spot-checks of offices and highlight any issues of charts being stored beyond a reasonable time period. **Ongoing** 3.3 AD Functional Support to submit a Business Case for an electronic tracking system for patient records. **April 2021**

Issue Identified	Description of issue	Gaps that led to the problems	Policies or processes in Place	Ongoing Risks/flaws	Action required	Owner/Action/Date for Completion
4. Private Patients	It has been highlighted that some patients that had been seen privately had been operated on ahead of NHS patients who had required the same operation, thereby disadvantaging patients who were waiting longer. It should be noted that these private patients had their procedure done on the NHS.	The consultant scheduled his own patients by contacting them direct and then gave the patient details to secretary for adding to theatre lists for TMS and sending out a confirmation letter. The secretary didn't highlight the patients that had no previous episode but created a new episode.	Private Patient Policy for transferring patients that have been initially seen privately onto the NHS and ensuring that they are not advantaged over someone who hadn't paid	The secretary relies on what the consultant advises them, e.g., where the patient should be placed on the list and what the patient's clinical priority is.	Revise the policy for Paying Patients in the Trust and share with all clinical Teams Guide-to-Paying-Patients-Southern-Trust- Data Quality Release notice for recording of private patient activity on PAS to be shared amongst clinical teams 0023-18 PAS OP REFERRRAL PRIVATE	Deputy Medical Director and AD for Medical Directorate to revise the Guide to Paying Patients in Southern Trust and ensure that it is shared with all clinical Teams **April 2021** AD Functional Services To re issue the Data Quality Release notice for the recording of private patient activity on PAS with all teams. **November 2020 - complete**

TRIAGE PROCESS

- **Red Flag referrals should be returned from Triage within 24hrs**
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- **Routine referrals should be returned from Triage within week.**

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It directs the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
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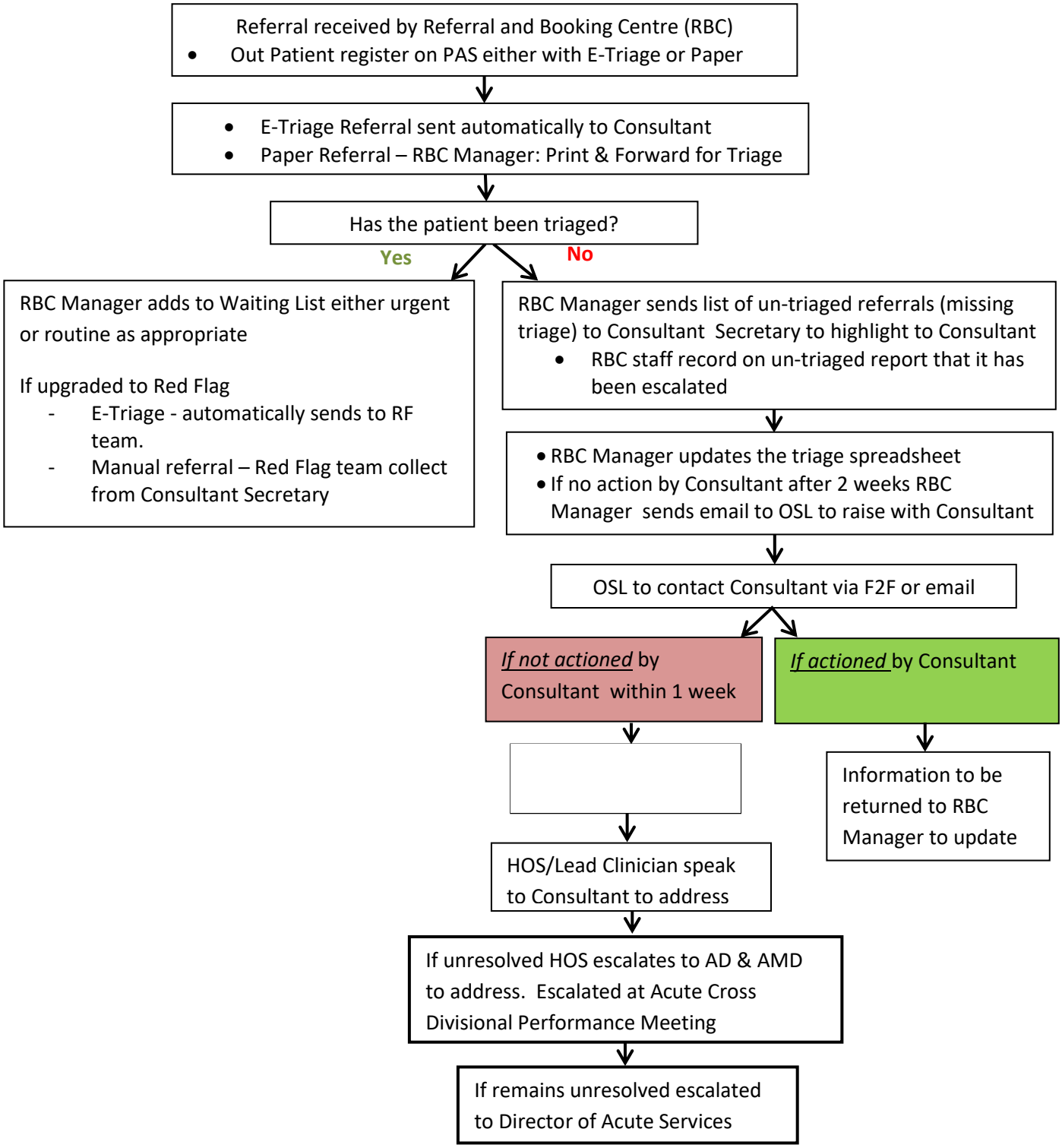

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It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above

CLINIC – OUTCOME FORM

CLINIC:_____ **DATE:**_____

NAME	PATIENT SEEN BY:	ACTION *Please Tick*				COMMENTS
		Review with Results	Review Later	Add to W/L	Discharge	

Southern Health and Social Care Trust

Quality Care - for you, with you

A GUIDE TO PAYING PATIENTS

V.2 [11th February 2016]

DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Guide to Paying Patients Version: 2
Supersedes	Supersedes: Guidelines for Management of Private Patients
Originator	Name of Author: Anne Brennan Title: Senior Manager Medical Directorate
Approval	Referred for approval by: Anne Brennan Date of Referral: 27th March 2014 to: • Trust Senior Management Team • Trust LNC
Circulation	Issue Date: 16th October 2014 Circulated By: Medical Directorate Issued To: As per circulation List: All Medical Staff
Review	Review Date: February 2017 Responsibility of (Name): Norma Thompson Title: Senior Manager Medical Directorate

CONTENTS

1. INTRODUCTION

1.1 The Trust came into existence on 1 April 2007 and is responsible for providing acute care across three sites namely:-

- Craigavon Area Hospital, Portadown
- Daisy Hill Hospital, Newry
- South Tyrone Hospital, Dungannon

1.2 The Trust welcomes additional income that can be generated from the following sources:-

- Private Patients
- Fee Paying Services
- Overseas Visitors

1.3 All income generated from these sources is deemed to make a valued contribution to the running costs of the Trust and will be reinvested to improve our facilities to benefit NHS and private patients alike.

1.4 All policies and procedures in relation to these areas will be carried out in accordance with Trust guidelines.

1.5 For further information please do not hesitate to contact the Paying Patient Office. [email: paying.patients@southerntrust.hscni.net or http://www.southerndocs.hscni.net/paying-patients/

2. OBJECTIVES

2.1 The purpose of this guideline is to:

- Standardise the manner in which all paying patient practice is conducted in the organisation.
- Raise awareness of the duties and responsibilities within the health service of medical staff engaging in private practice and fee paying services within the Trust.
- Raise awareness of the duties and responsibilities of all Trust staff, clinical and non-clinical in relation to the treatment of paying patients and fee paying services within the Trust.
- Ensure fairness to both NHS patients and fee paying patients at all times.
- Clarify for relevant staff the arrangements pertaining to paying patients and to give guidance relating to
  - record keeping
  - charging

- procedures and
- responsibilities for paying patient attendances, admissions and fee paying services.

- Clarify charging arrangements when consultants undertake fee paying services within the Trust.

3. CATEGORIES OF WORK COVERED BY THIS GUIDE

3.1 Fee Paying Services

3.1.1 Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

3.2 Private Professional Services *(also referred to as 'private practice')*

3.2.1 The diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions.

3.2.2 Work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

3.3 Overseas Visitors

3.3.1 The National Health Service provides healthcare free of charge to people who are a permanent resident in the UK/NI. A person does not become an ordinarily resident simply by having British Nationality; holding a British Passport; being registered with a GP, or having an NHS number. People who do not permanently live in NI/UK are not automatically entitled to use the NHS free of charge.

3.3.2 **RESIDENCY** is therefore the main qualifying criterion.

4. POLICY STATEMENT

4.1 Medical consultant staff have the right to undertake Private Practice and Fee paying services within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review and with the approval of the Medical Director.

4.2 This Trust provides the same care to all patients, regardless of whether the cost of their treatment is paid for by HSC Organisations, Private Medical Insurance companies or by the patient.

4.3 Private Practice and Fee Paying services at the Trust will be carried out in accordance with:

- The Code of Conduct for private practice, the recommended standard of practice for NHS consultants as agreed between the BMA and the DHSSPS (Appendix 2).
- Schedule 9 of the Terms and Conditions of the Consultant contract which sets out the provisions governing the relationship between HPSS work and private practice (Appendix 8).
- The receipt of additional fees for Fee Paying services as defined in Schedule 10 of the Terms and Conditions of the Consultant Contract (Appendix 1).
- The principles set out in Schedule 11 of the above contract (Appendix 5).

4.4 All patients treated within the Trust, whether private or NHS should, where possible:

- be allocated a unique hospital identifier
- be recorded on the Patient Administration System and
- have a Southern Health & Social Care Trust chart.

4.5 The Trust shall determine the prices to be charged in respect of all income to which it is entitled as a result of private practice or other fee paying services which take place within the Trust.

5. CONSULTANT MEDICAL STAFF RESPONSIBILITIES

5.1 Private Practice

5.1.1 While Medical consultant staff have the right to undertake Private Practice within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review, it is the responsibility of consultants, prior to the provision of any diagnostic tests or treatment to:

- ensure that their private patients (whether In, Day or Out) are identified and notified to the Paying Patients Officer.

- ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.
- ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, Pathologist, hospital charges. Leaflets can be obtained from the Paying Patients Officer or the Paying Patients section of Southern Docs website – click here.
- obtain prior to admission and at each outpatient attendance a signed, witnessed Undertaking to Pay form (Appendix 3) which must then be sent to the Paying Patient Officer for the relevant hospital at least three weeks before the admission date. This document must contain details of all diagnostic tests and treatments prescribed.
- Establish the method of payment at the consultation stage and obtain details of insured patients' private medical insurance policy information. The Trust requires this information to be forwarded to the Paying Patient Officer **prior to admission** so that patients' entitlement to insurance cover can be established. This should be recorded on the Undertaking to Pay form [Appendix 3].
- Ensure that all patients, where appropriate, are referred by the appropriate channels, i.e. GP/other consultant.
- Ensure that private patient services that involve the use of NHS staff or facilities are not undertaken except in emergencies, unless an undertaking to pay for treatment has been obtained from (or on behalf of) the patient, in accordance with the Trust's procedures.
- Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.

5.2 Fee Paying Services - *see Appendix 1 for examples*

5.2.1 The Consultant job plan review will cover the provision of fee paying services within the Trust. Consultants are required to declare their intention to undertake Fee Paying Services work by forwarding the Paying Patient Declaration form to the Medical Director's office.

5.2.2 A price list for fee paying services is available from the Paying Patients Office or the Paying Patients section of Southern Docs website – click here. It is the responsibility of the Consultant to ensure that the Trust is reimbursed for all costs incurred while facilitating fee paying services work undertaken. These costs could include:

- use of Trust accommodation;
- tests or other diagnostic procedures performed;
- radiological scans.

5.2.3 Consultants who engage in fee paying activities within the Trust are required to remit to the Trust on a quarterly basis the income due.

1.2.4 Consultants should retain details of all patients seen for medical legal purposes. These should be submitted by the consultant on a quarterly basis along with the corresponding payment. See Section 11 for further details.

5.3 Additional Programmed Activities

5.3.1 Consultants should agree to accept an extra paid programmed activity in the Trust, if offered, before doing private work. The following points should be borne in mind:

- If Consultants are already working 11 Programmed Activities (PAs) (or equivalent) there is no requirement to undertake any more work.
- A Consultant could decline an offer of an extra PA and still work privately, but with risk to their pay progression for the year in question.
- Any additional PAs offered must be offered equitably between all Consultants in that specialty; if a colleague takes up those sessions there would be no detriment to pay progression for the other Consultants.

5.3.2 Consultant Medical Staff are governed by The Code of Conduct for Private Practice 2003 (at Appendix 2).

6. RESTRICTIONS ON PRIVATE PRACTICE FOR CONSULTANT MEDICAL STAFF

6.1 New Consultants

6.1.1 Newly appointed consultants (including those who have held consultant posts elsewhere in the NHS, or equivalent posts outside the NHS) may not undertake private practice within the Trust or use the Trusts facilities or equipment for private work, until the arrangements for this have been agreed in writing with the Trust Medical Director. A job plan must also have been agreed. An application to undertake private practice should be made in writing to the Medical Director through completion of the Paying Patient Declaration. New consultants permitted to undertake private work must make themselves known to the Paying Patients Officer.

6.2 Locum Consultants

6.2.1 Locum consultants may not engage in Private Practice within the first three months of appointment and then not until the detailed Job Plan has been agreed with the relevant Clinical Manager and approval has been granted by the Medical Director. This is subject to the agreement of the patient/insurer.

6.3 Non Consultant Grade Medical Staff

6.3.1 Non-consultant medical staff practitioners such as Associate Specialists may undertake Category 2 or private outpatient work, with the approval of the

Medical Director following confirmation that the practitioner undertakes such work outside his/her programmed activities as per their agreed job plan.

6.3.2 Other than in the circumstances described above, staff are required to assist the consultant to whom they are responsible with the treatment of their private patients in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of the hospital treatment including that of all associated staff.

7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

7.1 Treatment Episode

7.1.1 A patient who sees a consultant privately shall continue to have private status throughout the entire treatment episode.

7.2 Single Status

7.2.1 An outpatient cannot be both a Private and an NHS patient for the treatment of the one condition during a single visit to an NHS hospital.

7.3 Outpatient Transfer

7.3.1 However a private outpatient at an NHS hospital is legally entitled to change his/her status for any a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking he/she has made to pay charges.

7.4 Waiting List

7.4.1 A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient.

7.5 Inpatient Transfer

7.5.1 A private inpatient has a similar legal entitlement to change his/her status. This entitlement can only be exercised when a significant and unforeseen change in circumstances arises e.g. when they enter hospital for a minor operation and they are found to be suffering from a different more serious complaint. He/she remains liable to charges for the period during which he/she was a private patient.

7.6 During Procedure

7.6.1 A patient may request a change of status during a procedure where there has been an unpredictable or unforeseen complexity to the procedure. This can be tested by the range of consent required for the procedure.

7.7 Clinical Priority

7.7.1 A change of status from Private to NHS must be accompanied by an assessment of the patient's clinical priority for treatment as an NHS patient.

7.8 Change of Status Form

7.8.1 Where a change of status is required a 'Change of Status' Form (Appendix 4) must be completed and sent to the Paying Patients Officer. This includes the reason for the change of status which will be subject to audit and must be signed by both the consultant and Paying Patients Officer. The Paying Patients Officer will ensure that the Medical Director approves the 'Change of Status' request.

7.8.2 It is important to note that until the Change of Status form has been approved by the Medical Director the patient's status will remain private and they may well be liable for charges.

8. TRUST STAFF RESPONSIBILITIES RELATING TO PRIVATE PATIENTS AND FEE PAYING SERVICES

8.1 A private patient is one who formally undertakes to pay charges for healthcare services regardless of whether they self-pay or are covered by insurance and all private patients must sign a form to that effect (Undertaking to Pay form at Appendix 3) prior to the provision of any diagnostic tests or treatments. Trust staff are required to have an awareness of this obligation.

8.2 The charge which private patients pay to the Trust covers the total cost of the hospital treatment excluding consultant fees. Trust staff are required to perform their duties in relation to all patients to the same standard. No payment should be made to or accepted by any non-consultant member of Trust staff for carrying out normal duties in relation to any patients of the Trust.

9. OPERATIONAL ARRANGEMENTS

9.1 Each hospital within the Trust has a named officer [Paying Patients Officer] who should be notified in advance of all private patient admissions and day cases. The Paying Patient Officer is responsible for ensuring that the Trust recovers all income due to the Trust arising from the treatment of private patients.

9.2 The Paying Patients Officer, having received the signed and witnessed Undertaking to Pay **Form at least three weeks** before the planned procedure will identify the costs associated with the private patient stay, will confirm entitlement to insurance cover where relevant and will raise invoices on a timely basis. [See Flow Chart 1]

9.3 The Medical Director will advise the Paying Patients Officer when a consultant has been granted approval to undertaken private practice. The Paying Patients Officer will advise the consultant of the procedures involved in undertaking private practice in the Trust.

9.4 Clinical governance is defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

9.5 This framework applies to all patients seen within this Trust. It is therefore a fundamental requirement of Clinical Governance that all patients treated within the Trust must be examined or treated in an appropriate clinical setting.

9.6 Any fee or emolument etc. which may be received by an employee in the course of his or her clinical duties shall, unless the Trust otherwise directs, be surrendered to the Trust. For further information please see Southern Trust Gifts and Hospitality Standards of Conduct policy.

9.7 Record Keeping Systems and Private Patients

9.7.1 All patients regardless of their status should, where possible, be recorded on Hospital Systems and their status classified appropriately. These systems include for example:

- Patient Administration System (PAS)
- Northern Ireland Maternity System (NIMATS)
- Laboratory System
- Radiology System(e.g. Sectra, PACS, NIRADS, RIS etc)

9.8 Health Records of Private Patients

9.8.1 All hospital health records shall remain the property of the Trust and should only be taken outside the Trust to assist treatment elsewhere:

- when this is essential for the safe treatment of the patient
- when an electronic record of the destination of the notes is made using the case note tracking system
- when arrangements can be guaranteed that such notes will be kept securely
- provided that nothing is removed from the notes

9.8.2 Consultants who may have access to notes for private treatment of patients must agree to return the notes without delay. Either originals or copies of the patient's private notes should be held with their NHS notes. Patients' notes should not be removed from Trust premises. Requests for notes for medico-legal purposes should be requested by plaintiff's solicitor through the normal channels.

9.8.3 Since the Trust does not have a right of access to patient notes held in non NHS facilities, when patients are seen privately outside the Trust their first appointment within the Trust, unless with the same consultant, will be treated as a 'new appointment' rather than a 'review appointment'.

9.8.4 In the event of a 'Serious Adverse Incident' or legal proceedings the Trust may require access to private patient medical records which should be held in accordance with GMC Good Record Keeping Guidance.

9.9 Booking Arrangements for Admissions and Appointments

9.9.1 A record of attendance should be maintained, where possible, for all patients seen in the Trust. All private in, day and out patients should as far as possible be pre-booked on to the hospital information systems. Directorates are responsible for ensuring that all relevant information is captured and 'booking in' procedures are followed. Each department should ensure that all such patients are recorded on PAS etc. within an agreed timescale which should not extend beyond month end.

9.10 Walk Ins

9.10.1 A private patient who appears at a clinic and has no record on PAS should be treated for record keeping purposes in exactly the same manner as an NHS patient (walk in) i.e. relevant details should be taken, registry contacted for a number and processed in the usual fashion. A record should be kept of this patient and the Paying Patient Officer informed.

9.11 Radiology

9.11.1 All patients seen in Radiology should be given a Southern Health and Social Care hospital number.

9.12 Private Patient Records

9.12.1 All records associated with the treatment of private patients should be maintained in the same way as for NHS patients. This includes all files, charts, and correspondence with General Practitioners.

9.12.2 Accurate record keeping assists in the collection of income from paying patients.

9.12.3 It should be noted that

- any work associated with private patients who are not treated within this Trust or consultants private diary work and correspondence associated with patients seen elsewhere should not be carried out within staff time which is paid for by the Trust.

9.13 Tests Investigations or Prescriptions for Private Patients

9.13.1 The consultant must ensure that the requests for all laboratory work, ie. radiology, prescriptions, dietetics, physiotherapy etc. are clearly marked as Private.

9.13.2 Consultants should not arrange services, tests investigations or prescriptions until the person has signed an Undertaking to Pay form which will cover the episode of care [Appendix 3]. This must be submitted three weeks before any planned procedure.

9.14 Medical Reports

9.14.1 In certain circumstances Insurance Companies will request a medical report from the consultant. It is the consultant's responsibility to ensure that this report is completed in the timeframe required by the insurance company otherwise the Trust's invoice may remain unpaid in whole or in part until the report has been received and assessed.

10. FINANCIAL ARRANGEMENTS - PRIVATE PATIENTS

10.1 Charges to Patients

10.1.1 Where patients, who are private to a consultant, are admitted to the hospital, or are seen as outpatients, charges for investigations/diagnostics will be levied by the hospital. A full list of charges is available from the Paying Patient Office on request. Patients should be provided with an estimate of the total fee that they will incur **before** the start of their treatment.

10.1.2 Prices are reviewed regularly to ensure that all costs are covered. A calendar of pricing updates will be agreed.

10.2 Charges for Use of Trust Facilities for Outpatients

10.2.1 It is the responsibility of the Doctor to recover the cost from the patient and reimburse the Trust, on a quarterly basis, for any outpatients which have been seen in Trust facilities. [See Flow Chart 2]

10.2.2 A per patient cost for the use of Trust facilities for outpatients is available. This will be reviewed annually.

10.2.3 It is responsibility of the doctor to maintain accurate records of outpatient attendances. It is an audit requirement that the Trust verifies that all income associated with use of Trust facilities for outpatients has been identified and collected. Accordingly, Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees as outlined above.

10.2.4 A Undertaking to Pay form will only be required if investigations/diagnostics are required.

10.3 Basis of Pricing

10.3.1 Charges are based on an accommodation charge, cost of procedure, including any prosthesis, and on a cost per item basis for all diagnostic tests and treatments e.g. physiotherapy, laboratory and radiology tests, ECGs etc. They do not include consultants' professional fees. Some package prices may be agreed.

10.4 Uninsured Patients – Payment Upfront

10.4.1 Full payment prior to admission is required from uninsured patients. Consultants should advise patients that this is the case. The patient should be advised to contact the Paying Patients Officer regarding estimated cost of treatment. [See Flow Chart 4]

10.5 Insured Patients

10.5.1 The Undertaking to Pay Form also requires details of the patient's insurance policy. The Paying Patients Officer will raise invoices direct to the insurance company where relevant, in accordance with the agreements with individual insurance companies.

10.5.2 Consultants, as the first port of contact and the person in control of the treatment provided, should advise the patient to obtain their insurance company's permission for the specified treatment to take place within the specified timescale. [See Flow Chart 4]

10.6 Billing and Payment

10.6.1 The Paying Patients Officer co-ordinates the collation of financial information relating to patients' treatment, ensures that uninsured patients pay deposits and that invoices are raised accordingly. The financial accounts department will ensure all invoices raised are paid and will advise the Private Patient Officer in the event of a bad debt.

10.7 Audit

10.7.1 The Trust's financial accounts are subject to annual audit and an annual report is issued to the Trust Board, which highlights any area of weakness in control. Adherence to the Paying Patient Policy will form part of the Trust's Audit Plan. Consultants are reminded that they are responsible for the identification and recording of paying patient information. Failure to follow the procedures will result in investigation by Audit and if necessary, disciplinary action under Trust and General Medical Council regulations.

11. FINANCIAL ARRANGEMENTS FOR FEE PAYING SERVICES

11.1 Consultants may see patients privately or for fee paying services within the Trust only with the explicit agreement of the Medical Director, in accordance with their Job Plan. Management will decide to what extent, if any, Trust facilities, staff and equipment may be used for private patient or fee paying services and will ensure that any such services do not interfere with the organisation's obligations to NHS patients. This applies whether private services are undertaken in the consultant's own time, in annual or unpaid leave. [See Flow Chart 3]

11.2 In line with the Code of Conduct standards, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients.

11.3 Fee Paying Services Policy (Category 2)

11.3.1 Fee Paying Services (Category 2) work is distinct from private practice, however it is still non NHS work as outlined in the 'Terms and Conditions for Hospital Medical and Dental Staff'. Refer to schedules 10 and 11 (Appendices 1 & 5 respectively) for further details.

11.3.2 There are a number of occasions when a Category 2 report will be requested, and they will usually be commissioned by, employers, courts, solicitors, Department of Work and Pensions etc. the report may include radiological opinion, blood tests or other diagnostic procedures

11.3.3 It is the responsibility of the Doctor to ensure that the Trust is reimbursed for all costs incurred in undertaking Category 2 work, this not only includes the use of the room but also the cost of any tests undertaken.

11.3.4 In order to comply with the Trusts financial governance controls it is essential that all Fee Paying services are identified and the costs recovered. It is not the responsibility of the Trust to invoice third parties for Category 2 work.

11.3.5 It is the responsibility of the Doctor to recover the cost from the third party and reimburse the Trust, on a quarterly basis, for any Category 2 services they have undertaken, including the cost of any treatments/tests provided.

11.3.6 The Category 2 (room only) charge per session will be reviewed annually.

11.3.7 A per patient rate may be available subject to agreement with the Paying Patient Manager

11.3.8 It is responsibility of the doctor to maintain accurate records of Category 2 attendances. It is an audit requirement that the Trust verifies that all income associated with Category 2 has been identified and collected.

11.3.9 Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees of Category 2 work as outlined above and should be submitted no later than ten days after the quarter end.

11.3.10 In order to comply with Data Protection requirements, Doctors must therefore inform their Category 2 clients that this information is required by the Trust and obtain their consent. Consultants should make a note of this consent.

11.3.11 Compliance to this policy will be monitored by the Paying Patient Manager and the Medical Director's Office.

11.3.12 The Consultant is responsible to HM Revenue and Customs to declare for tax purposes all Category 2 income earned. The Trust has no obligation in this respect.

11.3.13 Any Category 2 work undertaken for consultants by medical secretaries must be completed outside of their normal NHS hours. Consultants should be aware of their duty to inform their secretaries that receipt of such income is subject to taxation and must be declared to HM Revenue and Customs. It is recommended that Consultants keep accurate records of income and payment.

12. RENUNCIATION OF PRIVATE FEES

12.1 In some departments, consultants may choose to forego their private fees for private practice or for fee paying services in favour of a Charitable Fund managed by the Trust that could be drawn upon at a later stage for, by way of example, Continuous Professional Development / Study Leave.

12.2 For income tax purposes all income earned must be treated as taxable earnings. The only way in which this income can be treated as non taxable earnings of the consultant concerned is if the consultant signs a 'Voluntary Advance Renunciation of Earnings form' (Appendix 7) and declares that the earnings from a particular activity will belong to a named charitable fund and that the earnings will not be received by the consultant. In addition a consultant should never accept a cheque made out to him or her personally. To do so attracts taxation on that income and it cannot be subsequently renounced. Therefore all such income renounced in advance should be paid directly into the relevant fund. Income can only be renounced if it has not been paid to the individual and a Register of these will be maintained by the Charitable Funds Officer.

12.3 The Trust will be required to demonstrate that income renounced in favour of a Charitable Fund is not retained for the use of the individual who renounces it. Thus, in the event of any such consultant subsequently drawing on that fund, any such expenditure approval must be countersigned by another signatory on the fund.

13. OVERSEAS VISITORS - NON UK PATIENTS

(Republic of Ireland, EEA, Foreign Nationals)

PLEASE NOTE THIS IS ONLY A BRIEF GUIDE FOR FURTHER INFORMATION PLEASE CONTACT THE PAYING PATIENT OFFICE

13.1 The NHS provides healthcare free of charge to people who are 'ordinarily resident' in the UK. People who do not permanently live in the UK lawfully are not automatically entitled to use the NHS free of charge.

13.2 **RESIDENCY** is the therefore the main qualifying criterion, applicable regardless of nationality, being registered with a GP or having been issued a HC/NHS number, or whether the person holds a British Passport, or lived and paid taxes or national insurance contributions in the UK in the past.

13.3 Any patient attending the Trust who cannot establish that they are an ordinary resident and have lawfully lived in the UK permanently for the last 12 months preceding treatment are not entitled to free non ED hospital treatment whether they are registered with a GP or not. A GP referral letter cannot be accepted solely as proof of a patient's permanent residency and therefore entitlement to treatment.

13.4 For all new patients attending the Trust, residency must be established. All patients will be asked to complete a declaration to confirm residency, (regardless of race/ethnic origin). If not the Trust could be accused of discrimination.

13.5 Where there is an element of doubt as to whether the patient is an 'ordinary resident' eg no GP/ H&C number or non UK contact details, the Paying Patients Officer must be alerted immediately.

13.6 Emergency Department

13.6.1 Treatment given in an Emergency Department, Walk in Clinic or Minor Inuries Unit is free of charge if it is deemed to be immediate and necessary.

13.6.2 The Trust should always provide immediate and necessary treatment whether or not the patient has been informed of or agreed to pay charges .There is no exemption from charges for 'emergency' treatment other than that given in the accident and emergency department. Once an overseas patient is transferred out of Emergency Department their treatment becomes chargeable.

13.6.3 All patients admitted from Emergency Department must be asked to complete declaration of residency status.

13.6.4 This question is essential in trying to establish whether the patient is an overseas patient or not and hence liable to pay for any subsequent care provided.

13.6.5 If the patient is not an ordinary resident or there is an element of doubt eg no GP/ no H&C Number, the patient should be referred to Paying Patients Office to determine their eligibility.

13.6.6 If the person has indicated that they are a visitor to Northern Ireland, the overseas address must be entered as the permanent address on the correct Patient Administrative System and the Paying Patients Office should be notified immediately.

13.7 Outpatient Appointments

13.7.1 In all cases where the patient has not lived in Northern Ireland for 12 months or relevant patient data is missing such as H&C number, GP Details etc the patient must be referred to the Paying Patients Office to establish the patient's entitlement to free NHS treatment. This must be established before an appointment is given.

13.8 Review Appointments

13.8.1 Where possible follow up treatment should be carried out at the patient's local hospital, however if they are reviewed at the Trust they must be informed that they will be liable for charges.

13.8.2 If a consultant considers it appropriate to review a patient then they must sign a statement to this effect waiving the charges that would have been due to the Trust.

13.9 Elective Admission

13.9.1 A patient should not be placed onto a waiting list until their entitlement to free NHS Treatment has been established. Where the Patient is chargeable, the Trust should not initiate a treatment process until a deposit equivalent to the estimated full cost of treatment has been obtained.

13.10 Referral from other NHS Trusts

13.10.1 When a Consultant accepts a referral from another Trust the patients' status should, where possible, be established prior to admission. However, absence of this information should not delay urgent treatment.

13.10.2 The Trust will operate a policy of 'Stabilise and Transfer'.

14. AMENITY BED PATIENTS

14.1 Within the Trust's Maternity Service, a number of beds are assigned Amenity Beds. It is permissible for NHS patients who require surgical delivery and an overnight stay to pay for any bed assigned as an Amenity Bed. This payment has no effect on the NHS status of the patient. All patients identified as amenity will be recorded on PAS as APG and an Undertaking to Pay for an Amenity Bed form (Appendix 6) should be completed ideally before obtaining the amenity facilities.

15. GLOSSARY

Undertaking to Pay Form

Private Patients may fund their treatment, or they may have private medical insurance. In all cases Private Patients must sign an 'Undertaking to Pay' form (Appendix 3). This is a legally binding document which, when signed prior to treatment, confirms the patient as personally liable for costs incurred while at hospital and confirms the Patient's Private status. ALL private patients, whether insured or not are obliged to complete and sign an 'Undertaking to Pay' form, prior to commencement of treatment. Consultants therefore, as the first point of contact should ensure that the Paying Patients Officer is advised to ensure completion of the 'Undertaking to Pay' form.

Fee Paying Services
Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

Private Professional Services *(Also referred to as 'private practice')*

- the diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions (Appendix 1).

- work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

Non UK patients
A person who does not meet the 'ordinarily resident' test.

Job Plan
A work programme which shows the time and place of the consultant's weekly fixed commitments.

16. APPENDIX 1: SPECIFIC EXAMPLES OF FEE PAYING SERVICES - SCHEDULE 10

1. Fee Paying Services are services that are not part of Contractual or Consequential Services and not reasonably incidental to them. Fee Paying Services include:

   a. work on a person referred by a Medical Adviser of the Department of Social Development, or by an Adjudicating Medical Authority or a Medical Appeal Tribunal, in connection with any benefits administered by an Agency of the Department of Social Development;

   b. work for the Criminal Injuries Compensation Board, when a special examination is required or an appreciable amount of work is involved in making extracts from case notes;

   c. work required by a patient or interested third party to serve the interests of the person, his or her employer or other third party, in such nonclinical contexts as insurance, pension arrangements, foreign travel, emigration, or sport and recreation. (This includes the issue of certificates confirming that inoculations necessary for foreign travel have been carried out, but excludes the inoculations themselves. It also excludes examinations in respect of the diagnosis and treatment of injuries or accidents);

   d. work required for life insurance purposes;

   e. work on prospective emigrants including X-ray examinations and blood tests;

   f. work on persons in connection with legal actions other than reports which are incidental to the consultant's Contractual and Consequential Duties, or where the consultant is giving evidence on the consultant's own behalf or on the employing organisation's behalf in connection with a case in which the consultant is professionally concerned;

   g. work for coroners, as well as attendance at coroners' courts as medical witnesses;

   h. work requested by the courts on the medical condition of an offender or defendant and attendance at court hearings as medical witnesses, otherwise than in the circumstances referred to above;

   i. work on a person referred by a medical examiner of HM Armed Forces Recruiting Organisation;

   j. work in connection with the routine screening of workers to protect them or the public from specific health risks, whether such screening is a statutory obligation laid on the employing organisation by specific regulation or a voluntary undertaking by the employing organisation in pursuance of its general liability to protect the health of its workforce;

   k. occupational health services provided under contract to other HPSS, independent or public sector employers;

   l. work on a person referred by a medical referee appointed under the Workmen's Compensation (Supplementation) Act (Northern Ireland) 1966; work on prospective students of universities or other institutions of further education, provided that they are not covered by Contractual and Consequential Services. Such examinations may include chest radiographs;

m. Appropriate examinations and recommendations under Parts II and IV of the Mental Health (Northern Ireland) Order 1986 and fees payable to medical members of Mental Health Review Tribunals;

n. services performed by members of hospital medical staffs for government departments as members of medical boards;

o. work undertaken on behalf of the Employment Medical Advisory Service in connection with research/survey work, i.e. the medical examination of employees intended primarily to increase the understanding of the cause, other than to protect the health of people immediately at risk (except where such work falls within Contractual and Consequential Services);

p. completion of Form B (Certificate of Medical Attendant) and Form C (Confirmatory Medical Certificate) of the cremation certificates;

q. examinations and reports including visits to prison required by the Prison Service which do not fall within the consultant's Contractual and Consequential Services and which are not covered by separate contractual arrangements with the Prison Service;

r. examination of blind or partially-sighted persons for the completion of form A655, except where the information is required for social security purposes, or by an Agency of the Department of Social Development, or the Employment Service, or the patient's employer, unless a special examination is required, or the information is not readily available from knowledge of the case, or an appreciable amount of work is required to extract medically correct information from case notes;

s. work as a medical referee (or deputy) to a cremation authority and signing confirmatory cremation certificates;

t. medical examination in relation to staff health schemes of local authorities and fire and police authorities;

u. delivering lectures;

v. medical advice in a specialised field of communicable disease control;

w. attendance as a witness in court;

x. medical examinations and reports for commercial purposes, e.g. certificates of hygiene on goods to be exported or reports for insurance companies;

y. advice to organisations on matters on which the consultant is acknowledged to be an expert.

17. APPENDIX 2 - A CODE OF CONDUCT FOR PRIVATE PRACTICE

November 2003

Recommended Standards of Practice for NHS Consultants

An agreement between the BMA's Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland.

A CODE OF CONDUCT FOR PRIVATE PRACTICE: RECOMMENDED STANDARDS FOR NHS CONSULTANTS, 2003

Contents

Part I: Introduction

Scope of Code

1.1 This document sets out recommended standards of best practice for NHS consultants in England about their conduct in relation to private practice . The standards are designed to apply equally to honorary contract holders in respect of their work for the NHS. The Code covers all private work, whether undertaken in non-NHS or NHS facilities.

1.2 Adherence to the standards in the Code will form part of the eligibility criteria for clinical excellence awards.

1.3 This Code should be used at the annual job plan review as the basis for reviewing the relationship between NHS duties and any private practice.

Key Principles

1.4 The Code is based on the following key principles:

- NHS consultants and NHS employing organisations should work on a partnership basis to prevent any conflict of interest between private practice and NHS work. It is also important that NHS consultants and NHS organisations minimise the risk of any perceived conflicts of interest; although no consultant should suffer any penalty (under the code) simply
- because of a perception;
- The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services;
- With the exception of the need to provide emergency care, agreed NHS commitments should take precedence over private work; and
- NHS facilities, staff and services may only be used for private practice with the prior agreement of the NHS employer.

Part II: Standards of Best Practice

Disclosure of Information about Private Practice

1.2 Consultants should declare any private practice, which may give rise to any actual or perceived conflict of interest, or which is otherwise relevant to the practitioner's proper performance of his/her contractual duties. As part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work and out of hours cover.

2.2 Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser.

Scheduling of Work and On-Call Duties

2.3 In circumstances where there is or could be a conflict of interest, programmed NHS commitments should take precedence over private work. Consultants should ensure that, except in emergencies, private commitments do not conflict with NHS activities included in their NHS job plan.

2.4 Consultants should ensure in particular that:

- private commitments, including on-call duties, are not scheduled during times at which they are scheduled to be working for the NHS (subject to paragraph 2.8 below);
- there are clear arrangements to prevent any significant risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late or to be cancelled;

- private commitments are rearranged where there is regular disruption of this kind to NHS work; and private commitments do not prevent them from being able to attend a NHS emergency while they are on call for the NHS, including any emergency cover that they agree to provide for NHS colleagues. In particular, private commitments that prevent an immediate response should not be undertaken at these times.

2.5 Effective job planning should minimise the potential for conflicts of interests between different commitments. Regular private commitments should be noted in a consultant's job plan, to ensure that planning is as effective as possible.

2.6 There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments.

2.7 Where there is a proposed change to the scheduling of NHS work, the employer should allow a reasonable period for consultants to rearrange any private sessions, taking into account any binding commitments entered into (e.g. leases).

Provision of Private Services alongside NHS Duties

2.8 In some circumstances NHS employers may at their discretion allow some private practice to be undertaken alongside a consultant's scheduled NHS duties, provided that they are satisfied that there will be no disruption to NHS services. In these circumstances, the consultants should ensure that any private services are provided with the explicit knowledge and agreement of the employer and that there is no detriment to the quality or timeliness of services for NHS patients.

Information for NHS Patients about Private Treatment

2.9 In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf.

2.10 Where a NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, consultants should ensure that any information provided by them, is accurate and up-to-date and conforms with any local guidelines.

2.11 Except where immediate care is justified on clinical grounds, consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

Referral of Private Patients to NHS Lists

2.12 Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.

2.13 Where a patient wishes to change from private to NHS status, consultants should help ensure that the following principles apply:

- a patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation;
- any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient;
- any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status;
- patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients; and
- should a patient be admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.

Promoting Improved Patient Access to NHS Care and Increasing NHS Capacity

2.14 Subject to clinical considerations, consultants should be expected to contribute as fully as possible to maintaining a high quality service to patients, including reducing waiting times and improving access and choice for NHS patients. This should include co-operating to make sure that patients are given the opportunity to be treated by other NHS colleagues or by other providers where this will maintain or improve their quality of care, such as by reducing their waiting time.

2.15 Consultants should make all reasonable efforts to support initiatives to increase NHS capacity, including appointment of additional medical staff.

Part III – Managing Private Patients in NHS Facilities

3.1 Consultants may only see patients privately within NHS facilities with the explicit agreement of the responsible NHS organisation. It is for NHS organisations to decide to what extent, if any, their facilities, staff and equipment may be used for private patient services and to ensure that any such services do not interfere with the organisation's obligations to NHS patients.

3.2 Consultants who practise privately within NHS facilities must comply with the responsible NHS organisation's policies and procedures for private practice. The NHS organisation should consult with all consultants or their representatives, when adopting or reviewing such policies.

Use of NHS Facilities

3.3 NHS consultants may not use NHS facilities for the provision of private services without the agreement of their NHS employer. This applies whether private services are carried out in their own time, in annual or unpaid leave, or – subject to the criteria in paragraph 2.8 - alongside NHS duties.

3.4 Where the employer has agreed that a consultant may use NHS facilities for the provision of private services:

- the employer will determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable;

- any charge will be collected by the employer, either from the patient or a relevant third party; and

- a charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used.

3.5 Except in emergencies, consultants should not initiate private patient services that involve the use of NHS staff or facilities unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient, in accordance with the NHS body's procedures.

3.6 In line with the standards in Part II, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients. Only in unforeseen and clinically justified circumstances should an NHS patient's treatment be cancelled as a consequence of, or to enable, the treatment of a private patient.

Use of NHS Staff

3.7 NHS consultants may not use NHS staff for the provision of private services without the agreement of their NHS employer.

3.8 The consultant responsible for admitting a private patient to NHS facilities must ensure, in accordance with local procedures, that the responsible manager and any other staff assisting in providing services are aware of the patient's private status.

18. APPENDIX 3 - PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

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

PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

Private Patient: Yes ☐ No ☐ **Non-Ordinarily Resident in UK:** Yes ☐ No ☐

Name of Patient:			
Address:			
Postcode:	Telephone No:		
Date of Birth:			
H&C Number:			
Name of Insurer:		**Self Funding**	☐
Insurer Policy No:			

I have been seeing this person as a private patient. They are to be admitted / referred to Hospital on _____ as an _____

Inpatient Referral	☐	**Obstetrics** ☐ Estimated Duration of Stay	**Medical** ☐ Estimated Duration of Stay	**Surgical** ☐ Estimated Duration of Stay	**T & O** ☐ Estimated Duration of Stay
Day Case Referral	☐				
Diagnostics (Inpatient or Outpatient)	☐	**Laboratory** ☐ [please detail]	**Radiology** [pleas ☐ detail]	**Other** [e.g. ☐ Pharmacy]	

Undertaking to Pay Confirmation To be completed by Consultant			
I have advised the patient named above of the estimated hospital charges and of my fees			
Signed Consultant		**Date**	
Undertaking to Pay To be completed by the person who will pay the account			
I understand and agreed to pay Southern Health and Social Care Trust all charges[1] associated with this episode of care[2] .Where the Consultant may deem further procedures/investigations necessary which will incur additional charges, I understand that this may result in a different cost from that quoted to me and I undertake to pay the full costs incurred.			
Signed Patient		**Date**	

RETURN TO PAYING PATIENTS OFFICE CRAIGAVON AREA HOSPIAL/DAISY HILL HOSPITAL [email: Personal Information redacted by the USI]

[1] A list of Tariffs is available from the Private Patients office

[2] Episode of Care – The total treatment of either an inpatient or day case patient from diagnosis through to discharge

Southern Health and Social Care Trust - A Guide to Paying Patients

19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

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

APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
H&C Number:	
Name of Consultant	
Date of Last Private Consultation	

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

		Clinical Priority
Inpatient Referral	☐	
Outpatient Referral	☐	
Day Case Referral	☐	

Signed Consultant	
Effective Date	

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

PLEASE FORWARD TO PAYING PATIENTS OFFICE [Personal Information redacted by the USI **]**

20. APPENDIX 5 PRINCIPLES GOVERNING RECEIPT OF ADDITIONAL FEES – SCHEDULE 11

Principles Governing Receipt of Additional Fees - Schedule 11

1. In the case of the following services, the consultant will not be paid an additional fee, or - if paid a fee - the consultant must remit the fee to the employing organisation:

- any work in relation to the consultant's Contractual and Consequential Services;
- duties which are included in the consultant's Job Plan, including any additional Programmed Activities which have been agreed with the employing organisation;
- fee paying work for other organisations carried out during the consultant's Programmed Activities, unless the work involves minimal disruption and the employing organisation agrees that the work can be done in HPSS time without the employer collecting the fee;
- domiciliary consultations carried out during the consultant's Programmed Activities;
- lectures and teaching delivered during the course of the consultant's clinical duties;
- delivering lectures and teaching that are not part of the consultant's clinical duties, but are undertaken during the consultant's Programmed Activities.
- Consultants may wish to take annual leave [having given the required 6 week notice period] to undertake fee paying work [e.g. court attendance] in this instance the consultant would not be required to remit fees to the Trust.

This list is not exhaustive and as a general principle, work undertaken during Programmed Activities will not attract additional fees.

2. Services for which the consultant can retain any fee that is paid:

- Fee Paying Services carried out in the consultant's own time, or during annual or unpaid leave;
- Fee Paying Services carried out during the consultant's Programmed Activities that involve minimal disruption to HPSS work and which the employing organisation agrees can be done in HPSS time without the employer collecting the fee;
- Domiciliary consultations undertaken in the consultant's own time, though it is expected that such consultations will normally be scheduled as part of Programmed Activities1;
- Private Professional Services undertaken in the employing organisation's facilities and with the employing organisation's agreement during the consultant's own time or during annual or unpaid leave;
- Private Professional Services undertaken in other facilities during the consultant's own time, or during annual or unpaid leave;
- Lectures and teaching that are not part of the consultant's clinical duties and are undertaken in the consultant's own time or during annual or unpaid leave;

- Preparation of lectures or teaching undertaken during the consultant's own time irrespective of when the lecture or teaching is delivered.

This list is not exhaustive but as a general principle the consultant is entitled to the fees for work done in his or her own time, or during annual or unpaid leave.

And only for a visit to the patient's home at the request of a general practitioner and normally in his or her company to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital.

21. APPENDIX 6 - UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

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

UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
Hospital Number:	

Site: Craigavon ☐ Daisy Hill ☐

I was allocated an amenity bed on (date): _____ **(time)**

Ward: _____ **Consultant:** _____

I undertake to pay the Southern Health Social Care Trust £39 per night for an amenity bed, which has been provided for me at my request.

Number of days Amenity Bed required: _____

I understand that if I am required to stay in hospital more days than anticipated, the midwifery staff will ask me if I wish to continue and pay for the amenity bed, or if I wish to be transferred to the open ward.

Patient's Signature: _____ **Date:** _____

Midwife's Signature: _____ **Date:** _____

To be completed by WARD CLERK OR MIDWIFE when patient is being transferred /discharged from an amenity bed.

Date transferred / discharged from amenity bed _____

Signed by midwife / ward clerk when transferred / discharged _____

22. APPENDIX 7 – AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

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

AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

I *(name)* _____

Request that any monies due to me from patients in relation to fees from
(description of activity)

_____

_____

_____

_____

_____

_____

_____

Shall be transferred to *(Charity title and reference)* _____

For its sole use in the advancement of its aims in accordance with the Trust Deed until directed otherwise by me in writing.

This request is to take effect from (date*):* _____

Signed, sealed and delivered by: _____
(Full name in BLOCK CAPITALS)

Date: _____

In the presence of: _____

Date: _____

Address:: _____

_____

_____

_____ **Postcode:** _____

_____

23. APPENDIX 8 - PROVISIONS GOVERNING THE RELATIONSHIP BETWEEN HPSS WORK AND PRIVATE PRACTICE - SCHEDULE 9

1. This Schedule should be read in conjunction with the 'Code of Conduct for Private Practice', which sets out standards of best practice governing the relationship between HPSS work and private practice.

2. The consultant is responsible for ensuring that their provision of Private Professional Services for other organisations does not:

   - result in detriment to HPSS patients;
   - diminish the public resources that are available for the HPSS.

Disclosure of information about Private Commitments

3. The consultant will inform his or her clinical manager of any regular commitments in respect of Private Professional Services or Fee Paying Services. This information will include the planned location, timing and broad type of work involved.

4. The consultant will disclose this information at least annually as part of the Job Plan Review. The consultant will provide information in advance about any significant changes to this information.

Scheduling of Work and Job Planning

5. Where a conflict of interest arises or is liable to arise, HPSS commitments must take precedence over private work. Subject to paragraphs 10 and 11below, the consultant is responsible for ensuring that private commitments do not conflict with Programmed Activities.

6. Regular private commitments must be noted in the Job Plan.

7. Circumstances may also arise in which a consultant needs to provide emergency treatment for private patients during time when he or she is scheduled to be undertaking Programmed Activities. The consultant will make alternative arrangements to provide cover if emergency work of this kind regularly impacts on the delivery of Programmed Activities.

8. The consultant should ensure that there are arrangements in place, such that there can be no significant risk of private commitments disrupting HPSS commitments, e.g. by causing HPSS activities to begin late or to be cancelled. In particular where a consultant is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of Programmed Activities for such emergency work to be carried out.

9. Where the employing authority has proposed a change to the scheduling of a consultant's HPSS work, it will allow the consultant a reasonable period in line with Schedule 6, paragraph 2 to rearrange any private commitments. The employing organisation will take into account any binding commitments that the consultant may have entered into (e.g. leases). Should a consultant wish to reschedule private commitments to a time that would conflict with Programmed Activities, he or she should raise the matter with the clinical manager at the earliest opportunity.

Scheduling Private Commitments Whilst On-Call

10. The consultant will comply with the provisions in Schedule 8, paragraph 5 of these Terms and Conditions. In addition, where a consultant is asked to provide emergency cover for a colleague at short notice and the consultant has previously arranged private commitments at the same time, the consultant should only agree to provide such emergency cover if those private commitments would not prevent him Or her returning to the relevant HPSS site at short notice to attend an emergency. If the consultant is unable to provide cover at short notice it will be the employing organisation's responsibility to make alternative arrangements and the consultant will suffer no detriment in terms of pay progression as a result.

Use of HPSS Facilities and Staff

11. Where a consultant wishes to provide Private Professional Services at an HPSS facility he or she must obtain the employing organisation's prior agreement, before using either HPSS facilities or staff.

12. The employing organisation has discretion to allow the use of its facilities and will make it clear which facilities a consultant is permitted to use for private purposes and to what extent.

13. Should a consultant, with the employing organisation's permission, undertake Private Professional Services in any of the employing organisation's facilities, the consultant should observe the relevant provisions in the 'Code of Conduct for Private Practice'.

14. Where a patient pays privately for a procedure that takes place in the employing organisation's facilities, such procedures should occur only where the patient has given a signed undertaking to pay any charges (or an undertaking has been given on the patient's behalf) in accordance with the employing organisation's procedures.

15. Private patients should normally be seen separately from scheduled HPSS patients. Only in unforeseen and clinically justified circumstances should a consultant cancel or delay an HPSS patient's treatment to make way for his or her private patient.

16. Where the employing organisation agrees that HPSS staff may assist a consultant in providing Private Professional Services, or provide private services on the consultant's behalf, it is the consultant's responsibility to ensure that these staff are aware that the patient has private status.

17. The consultant has an obligation to ensure, in accordance with the employing organisation's procedures, that any patient whom the consultant admits to the employing organisation's facilities is identified as private and that the responsible manager is aware of that patient's status.

18. The consultant will comply with the employing organisation's policies and procedures for private practice

Patient Enquiries about Private Treatment

19. Where, in the course of his or her duties, a consultant is approached by a patient and asked about the provision of Private Professional Services, the consultant may provide only such standard advice as has been agreed between the employing organisation and appropriate local consultant representatives for such circumstances.

20. The consultant will not during the course of his or her Programmed Activities make arrangements to provide Private Professional Services, nor ask any other member of staff to make such arrangements on his or her behalf, unless the patient is to be treated as a private patient of the employing organisation.

21. In the course of his/her Programmed Activities, a consultant should not initiate discussions about providing Private Professional Services for HPSS patients, nor should the consultant ask other staff to initiate such discussions on his or her behalf.

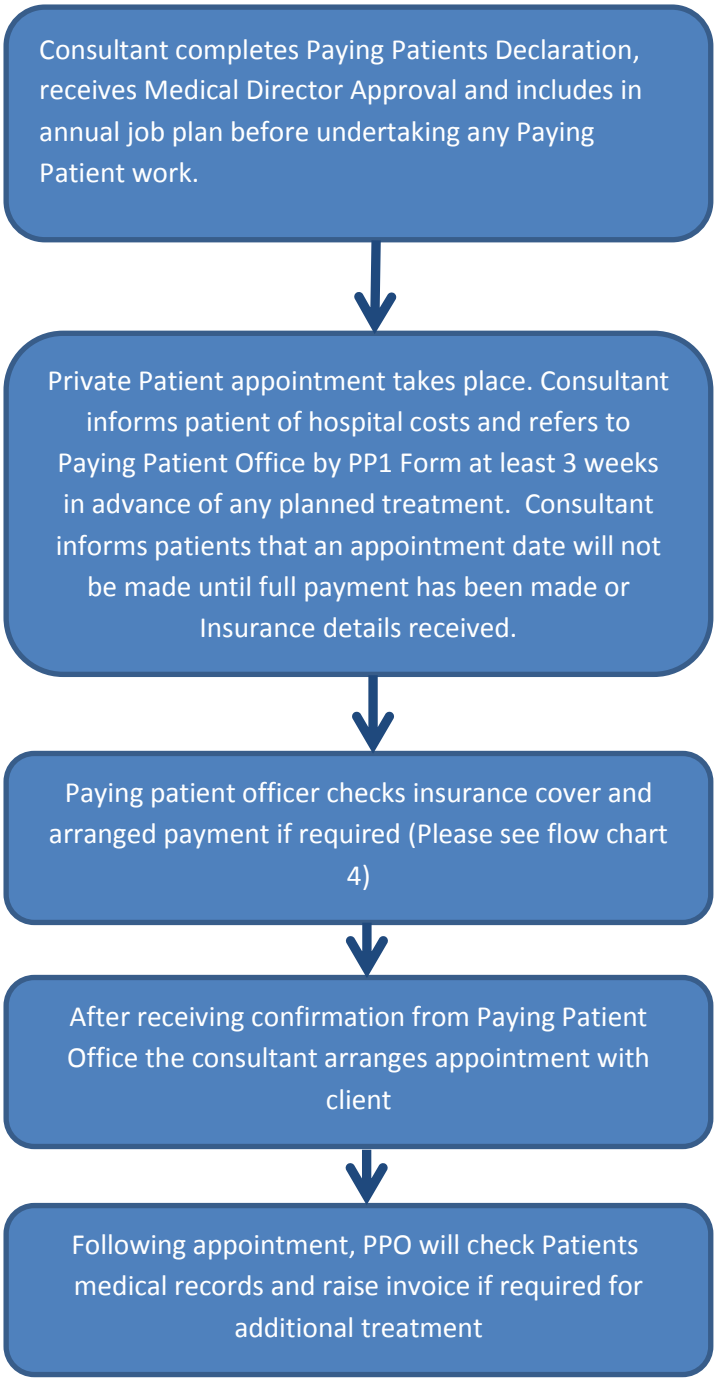
22. Where an HPSS patient seeks information about the availability of, or waiting times for, HPSS services and/or Private Professional Services, the consultant is responsible for ensuring that any information he or she provides, or arranges for other staff to provide on his or her behalf, is accurate and up-to-date.

Promoting Improved Patient Access to HPSS Care

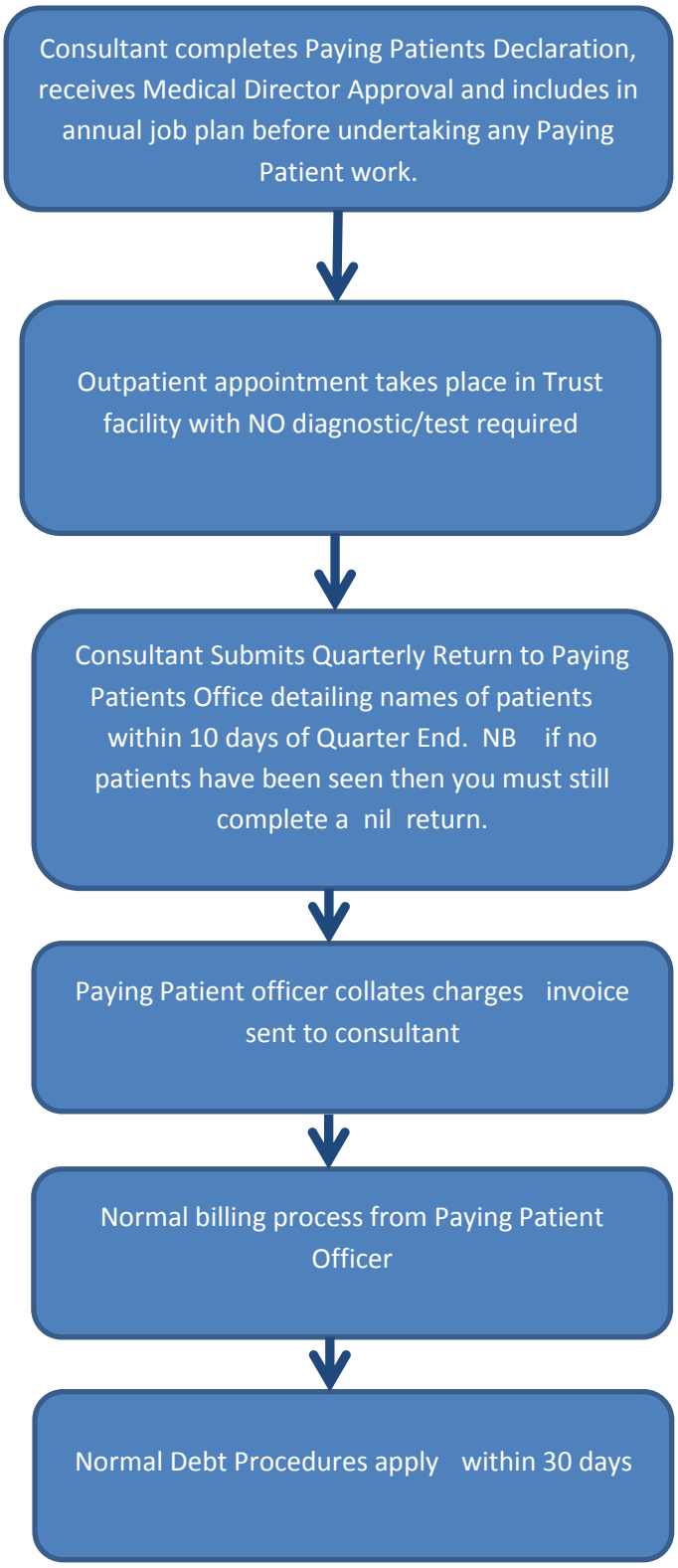
23. Subject to clinical considerations, the consultant is expected to contribute as fully as possible to reducing waiting times and improving access and choice for HPSS patients. This should include ensuring that, as far as is practicable, patients are given the opportunity to be treated by other HPSS colleagues or by other providers where this will reduce their waiting time and facilitate the transfer of such patients.

24. The consultant will make all reasonable efforts to support initiatives to increase HPSS capacity, including appointment of additional medical staff and changes to ways of working.

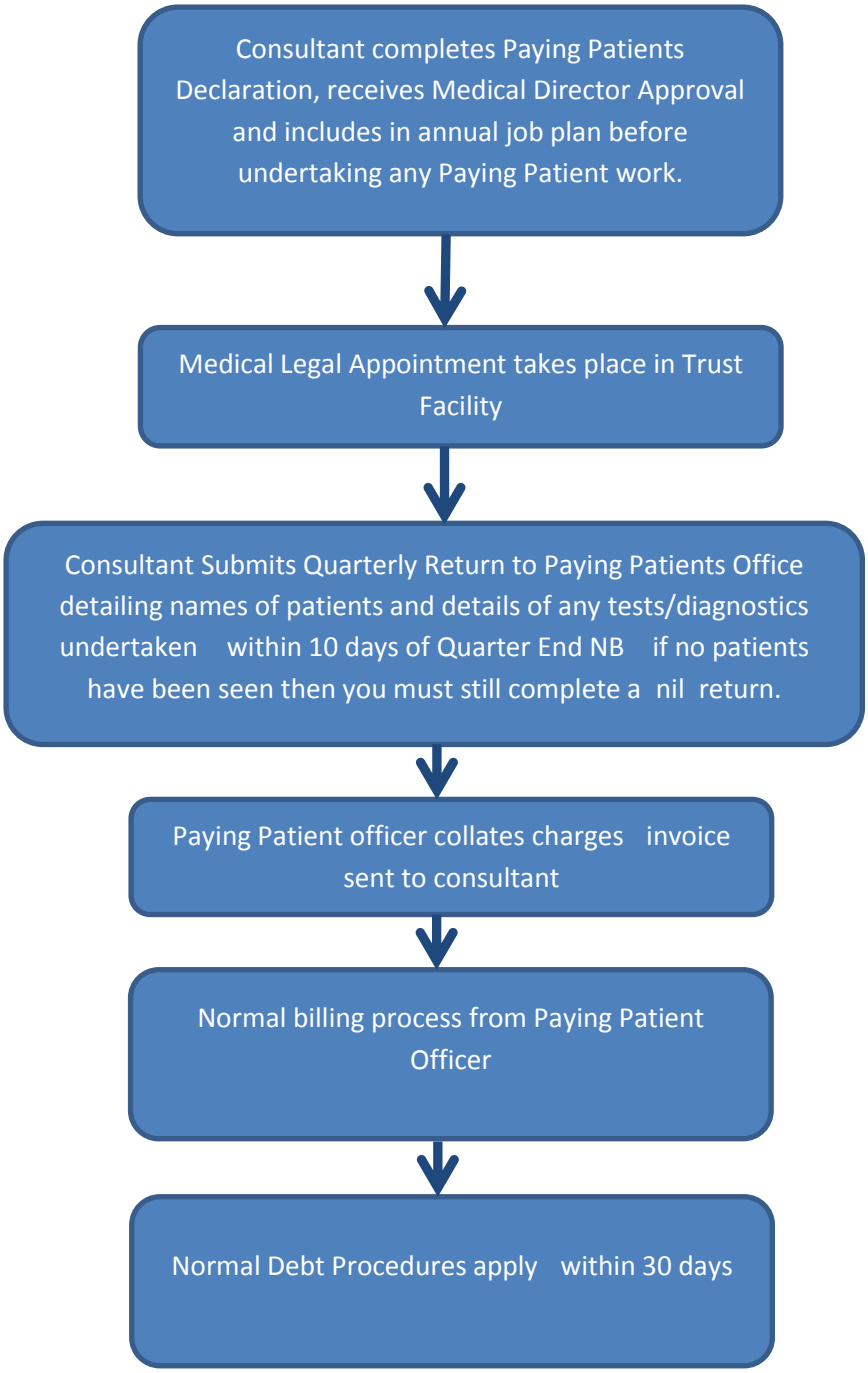
24. FLOW CHART 1 - PAYING PATIENTS [Inpatients]



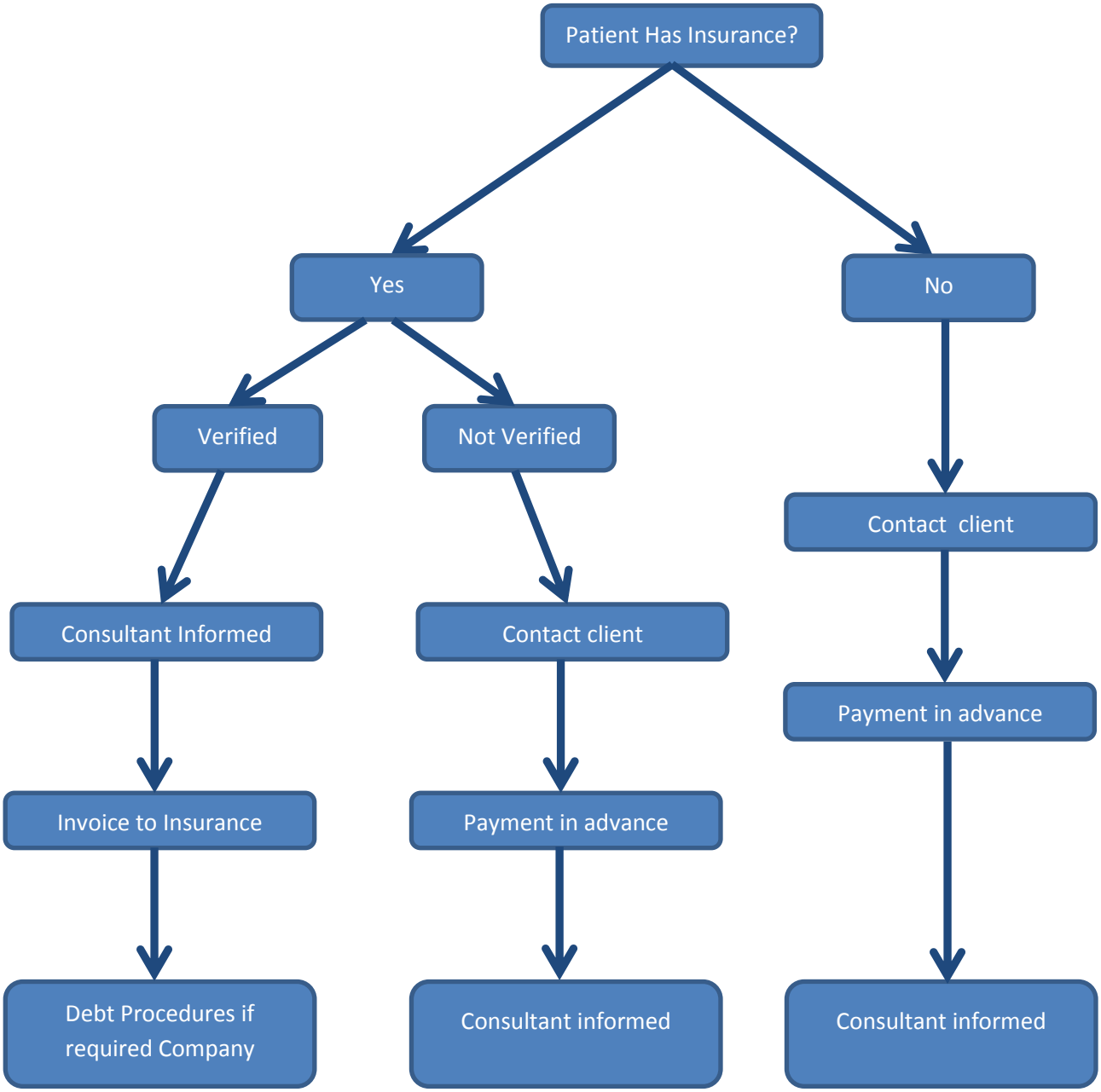
25. FLOW CHART 2 - PAYING PATIENTS [Outpatients]



26. FLOW CHART 3 - PAYING PATIENTS [Fee Paying Services]



27. FLOW CHART 4 – PATIENT INSURANCE



Health and Social Care Board

0023/18

Query Request Form

Requires Immediate Response: Yes

Reason for Immediate Response: Required as an action following Internal Audit review of management of private patients

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☐	**Data Definition**	X	**Recording Issue**
X	**Technical Guidance**	☐	**Other**

Name: Personal Information redacted by USI

Date: 8th August 2018

Organisation: BHSCT

Contact Number: Personal Information redacted by the USI

Subject Heading: PAS OP Referral Source Code – Private to NHS

a) Issue: ***Please provide as much detail as possible in order for the query to be considered and resolved as quickly as possible. This query form will be published on SharePoint when resolved.***

Belfast Trust requests a Referral Source Code on PAS for outpatients who change status from Private to NHS. Currently there is no guidance for identifying such patients.

Patient who attends Trust as a private patient has category recorded as PPG. When treatment completed OP registration should be closed with Discharge Reason – Treatment Completed, however if during their treatment the patient decides to change status to NHS the OP registration should be closed with Discharge Reason – Transfer to NHS and a new OP registration opened:
PAS with referral source PTN (Private to NHS) (suggested code), mapped to Internal Value (2) and CMDS Value (11) on Referral Source Masterfile and category as NHS.

This will ensure that the original category of PPG is not overwritten to NHS and the information recorded as per the Draft Technical Guidance on Private and Overseas Patients is not lost.

Belfast Trust request that the above is adopted as regional PAS Technical Guidance.

b) Response:

When a patient transfers from Private to NHS during their treatment period the OP registration should be closed using:

Discharge Reason code: TNHS – Transfer from Private to NHS

A new OP registration should be opened using:

Referral Source code: PTN – Private to NHS

Approved by: Acute Hospital Information Group

Date: 11/09/2018 **Response Published:** Yes / ~~No~~

Email: Personal Information redacted by the USI
HSC Data Standards Helpdesk: Personal Information redacted by the USI

These forms are available on the Information Standards & Data Quality SharePoint Site at *http://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Helpdesk.aspx*

SOUTHERN HEALTH & SOCIAL CARE TRUST

PATIENTS WHO HAVE AN OPEN OUTPATIENT REFERRAL REGISTRATION ON PAS AND THE PATIENT IS NOT ON AN OUTPATIENT WAITING LIST AND THEIR LAST OUTPATIENT APPOINTMENT IS MORE THAN 6 MONTHS AS AT RUN DATE 30/11/2020

Notes:
Discipline Mapping based on Specialty Suffix e.g. If Specialty Description matches (C) then Discipline Mapping = Consultant-Led; If Specialty Description matches (M) then Discipline Mapping = Midwifery-Led etc.
Data is based on patients where 'Date of Discharge" is not recorded and the patient is not on an Outpatient Waiting List.

SUMMARY BY LAST APPOINTMENT YEAR AND DISCIPLINE MAPPING

	Discipline Mapping								
Appointment Year	**Allied Health Professional**	**Consultant-Led**	**ICATS-Led**	**Midwifery-Led**	**Multi-Disciplinary Team**	**Nurse-Led**	**Technician-Led**	**Pharmacy-Led**	**Grand Total**
2012		137	31			14			182
2013		35	197			24			256
2014		31	435			38			504
2015	1	66	501			267			835
2016		99	500			609			1208
2017		97	226			422			745
2018	10	152	335			1147	38	2	1684
2019	267	795	494	87	1	2766	71	34	4515
2020	302	692	251	365	4	1771	19	19	3423
Grand Total	**580**	**2104**	**2970**	**452**	**5**	**7058**	**128**	**55**	**13352**

SUMMARY BY REASON FOR REFERRAL AND DISCIPLINE MAPPING

Last Appointment Date Year (Multiple Items)

	Discipline Mapping								
Reason for Referral	**Allied Health Professional**	**Consultant-Led**	**ICATS-Led**	**Midwifery-Led**	**Multi-Disciplinary Team**	**Nurse-Led**	**Technician-Led**	**Pharmacy-Led**	**Grand Total**
Non-Suspect Cancer	580	2104	2970	452	5	7058	128	55	13352
Grand Total	**580**	**2104**	**2970**	**452**	**5**	**7058**	**128**	**55**	**13352**

SUMMARY BY PRIORITY TYPE AND DISCIPLINE MAPPING

Last Appointment Date Year (Multiple Items)

	Discipline Mapping								
Priority Type	**Allied Health Professional**	**Consultant-Led**	**ICATS-Led**	**Midwifery-Led**	**Multi-Disciplinary Team**	**Nurse-Led**	**Technician-Led**	**Pharmacy-Led**	**Grand Total**
ROUTINE	574	1834	2720	448	5	6798	127	54	12560
URGENT	6	270	250	4		248	1	1	780
(blank)						12			12
Grand Total	**580**	**2104**	**2970**	**452**	**5**	**7058**	**128**	**55**	**13352**

REASON FOR REFERRAL - SUSPECT CANCER

Count of Casenote	Column Labels
Row Labels	Grand Total
Grand Total	

SUMMARY BY YEAR AND CONSULTANT

Last Appointment Date Year	(All)

Consultant Name	Specialty Description
A PHYSIOTHERPIST	PHYSIOTHERAPY FOR FRACTURE (A)
A SLEEP SERVICE EXPERT	SLEEP SERVICE(T)
ABDELRAHIM Z DR	PAEDIATRICS - COMMUNITY(C)
ACHESON J R DR	OBSTETRICS ANTE-NATAL (C)
ADAMS B DR	OBSTETRICS ANTE-NATAL (C) OBSTETRICS POST-NATAL (C)
AKHTAR M MR	UROLOGY(C)
ALJARAD B DR	PAEDIATRIC ALLERGY(C) PAEDIATRIC ASTHMA(C) PAEDIATRIC(C)
ANAESTHETICS	ANAESTHETICS(C)
BILY M DR	HAEMATOLOGY(C)
BOGGS E DR	OBSTETRICS ANTE-NATAL (C)
BOYD H.K. DR	ANTI-COAGULANT VIR (C) ANTI-COAGULANT(C) HAEMATOLOGY(C)
BRADFORD C DR	HAEMATOLOGY(C)
BRADLEY U DR	ENDOCRINOLOGY(C)
BROWN R.J. MR	GENERAL SURGERY(C)
BUNN J MR	FRACTURE(C) ORTHOPAEDICS(C)
CASSIDY D DR	PAEDIATRIC(C)
CHINNADURAI A DR	OBSTETRICS ANTE-NATAL (C)
COMMUNITY PAEDIATRIC CON A	PAEDIATRICS - COMMUNITY(C)
CONNOLLY D MR	UROLOGY(C)
CRAIG D DR	GERIATRIC MEDICINE(C)
CURRIE A DR	OBSTETRICS ANTE-NATAL (C)
DE COURCY-WHEELER R. MR	GYNAECOLOGY(C) OBSTETRICS ANTE-NATAL (C)
DEVLIN B DR	PAEDIATRICS - COMMUNITY(C)
DIETETICS ANTE-NATAL	DIETETICS ANTE-NATAL (A)
DOOLEY A DR	PAEDIATRICS - COMMUNITY(C)
DOYLE T D MR	FRACTURE(C)
DUFFIN D. DR	CARDIOLOGY MEDICINE(C)
EEDY D.J. DR	DERMATOLOGY(C)
EL FAKI S DR	GERIATRIC MEDICINE(C)
EPANOMERITAKIS E MR	GENERAL SURGERY(C)
FARNAN T MR	EAR NOSE AND THROAT(C)
FENTON A DR	ONCOLOGY(C)
FLANAGAN C DR	PAEDIATRIC(C) PAED CHILD DEVELOPMENT (C)
FLANNERY D J DR	CARDIOLOGY MEDICINE(C)
GASKIN P G DR	GYNAECOLOGY(C)
GENERAL ANAESTHETIST A	ANAESTHETIC PREOP ASS(WLIO)(C) ANAESTHETIC PREOP ASS. (C)
GENERAL COLORECTAL CONS A	COLORECTAL(C)
GENERAL DERMATOLOGIST A	DERMATOLOGY(C)
GENERAL ENDOCRONOLOGIST A	ENDOCRINOLOGY(C)
GENERAL ENT CONSULTANT A	

GENERAL ENT CONSULTANT A	EAR NOSE AND THROAT(C)
GENERAL FRACTURE CONS. A	FRACTURE(C)
GENERAL GYNAECOLOGIST A	GYNAECOLOGY(C)
GENERAL HAEMATOLOGIST A	HAEMATOLOGY(C)
GENERAL ORTHOPAEDIC CONS A	ORTHOPAEDICS(C)
GENERAL PAEDIATRICIAN A	PAEDIATRIC ALLERGY(C) PAEDIATRIC(C)
GENERAL RHEUMATOLOGIST A	RHEUMATOLOGY(C)
GENERAL SURGEON A	GENERAL SURGERY(C)
GENERAL UROLOGIST A	UROLOGY(C)
GIBBONS M J DR	GENERAL MEDICINE(C)
GORMLEY D DR	GERIATRIC ASSESSMENT(C)
GRAHAM D DR	PAEDIATRIC(C) PAED CHILD DEVELOPMENT (C)
GRIER D DR	PAEDIATRIC(C) PAEDIATRICS - COMMUNITY(C)
HAMILTON B A DR	GERIATRIC ASSESSMENT(C)
HANNON R MR	GENERAL SURGERY(C)
HARTY J DR	NEPHROLOGY(C)
HEASLEY R.N. MR	FERTILITY (GYNAE)(C)
HENDERSON J DR	PAEDIATRIC ALLERGY(C) PAEDIATRIC ASTHMA(C) PAEDIATRIC(C)
HENDERSON N A DR	OBSTETRICS ANTE-NATAL (C)
HEWITT G.R. MR	GENERAL SURGERY(C)
HOGAN M DR	PAEDIATRIC(C) SPECIAL CARE BABIES(C)
HUGHES J.I. DR	PAEDIATRIC(C) PAEDIATRICS - COMMUNITY(C)
HULL D.R. DR	HAEMATOLOGY(C)
ICATS TEAM	CARDIOLOGY (ICATS) DERMATOLOGY (ICATS) EAR NOSE AND THROAT (ICATS) ORTHOPAEDICS (ICATS)
JATHAR H L MR	UROLOGY(C)
JONES A.M. DR	GERIATRIC ACUTE(C)
KAMATH M DR	OBSTETRICS ANTE-NATAL (C) OBSTETRICS POST-NATAL (C)
KHAN A.F DR	PAEDIATRIC(C)
KNOX A E DR	OBSTETRICS ANTE-NATAL (C)
KORDA M MR	EAR NOSE AND THROAT(C)
LEE R.J. DR	RHEUMATOLOGY(C)
LEWIS J DR	PAEDIATRIC(C)
LIGGETT N.W. DR	GENERAL MEDICINE(C) RHEUMATOLOGY(C)
LOANE K.H DR	OBSTETRICS ANTE-NATAL (C) OBSTETRICS POST-NATAL (C)
MACKLE E MR	GENERAL SURGERY(C)
MAGILL P MR	FRACTURE(C)
MCBREEN G DR	PAEDIATRICS - COMMUNITY(C)
MCCAFFREY P M DR	GERIATRIC ASSESSMENT(C) GERIATRIC MEDICINE(C) GERIATRIC AMBULATORY (C)
MCCLELLAND A DR	CARDIOLOGY MEDICINE(C)
MCCONVILLE C DR	HAEMATOLOGY(C)
MCCORMICK M DR	GER ASSESSMENT/REHAB(C)

MCCORMICK M DR	GERIATRIC ACUTE(C)
MCCORMICK T DR	
	FERTILITY (GYNAE)(C) OBSTETRICS ANTE-NATAL (C)
MCCRACKEN G DR	
	GYNAECOLOGY(C) OBSTETRICS ANTE-NATAL (C)
MCENEANEY D.J. DR	
	CARDIOLOGY MEDICINE(C)
MCGLEENON B DR	
	GER ASSESSMENT/REHAB(C)
MCGRATH C DR	
	DERMATOLOGY(C)
MCGUCKEN P W DR	
	GERIATRIC ASSESSMENT(C)
MCKEOWN G DR	
	GYNAECOLOGY(C) OBSTETRICS ANTE-NATAL (C)
MCKEOWN R MR	
	FRACTURE(C) ORTHOPAEDICS(C)
MCKEVENEY P DR	
	NEPHROLOGY(C)
MCKINNEY K.A. DR	
	CERVICAL CYTOLOGY(C) OBSTETRICS ANTE-NATAL (C)
MCLEAN G MR	
	FRACTURE(C)
MCMURRAY D MR	
	FRACTURE(C)
MCNABOE E.J. MR	
	EAR NOSE AND THROAT(C)
MENOWN I B A DR	
	CARDIOLOGY MEDICINE(C)
MIDWIFE	
	MIDWIFERY ANTE-NATAL (M) MIDWIFERY LED CARE (M) MIDWIFERY POST-NATAL (M) MIDWIFERY SCAN/BLOOD RESULT(M) MIDWIFERY ANTE-NATAL EDUC (M)
MILLAR S L DR	
	NEWBORN BABY(C) PAEDIATRIC(C)
MOAN S DR	
	THORACIC MEDICINE(C)
MOCKFORD B MR	
	ORTHOPAEDICS(C)
MORGAN N DR	
	NEPHROLOGY(C)
MULROE T DR	
	NEWBORN BABY(C) PAEDIATRIC(C)
MURDOCK AM DR	
	GASTRO-ENTEROLOGY(C)
MURNAGHAN M MR	
	FRACTURE(C) ORTHOPAEDICS(C)
MURPHY P DR	
	GASTRO-ENTEROLOGY(C) GENERAL MEDICINE(C)
NELSON E DR	
	GERIATRIC MEDICINE(C)
NIBLOCK K R DR	
	GYNAECOLOGY(C) OBSTETRICS ANTE-NATAL (C)
NICHOLSON G DR	
	GERIATRIC MEDICINE(C)
NURSE LED ACUTE DIABETIC	
	NURSE LED ACUTE DIABETIC (N)
NURSE LED CANCER HNA	
	NURSE LED BREAST CANCER (N)
NURSE LED CLINIC	
	NLED PAED RESP AND ALLERGY (N) NURSE LED BREAST CARE(N) NURSE LED CARDIOLOGY(N) NURSE LED CRYOTHERAPY(N) NURSE LED DERMATOLOGY (N) NURSE LED DIABETIC BLOODS (N) NURSE LED ENDOSCOPIST(N) NURSE LED GYNAECOLOGY(N) NURSE LED HAEMATOLOGY(N) NURSE LED PAEDIATRICS (N) NURSE LED RESPIRATORY(N)
NURSE LED CLINICS	
	NURSE LED DIABETIC BLOODS (N)
NURSE LED CLINICS - DHH	
	NLED PAED RESP AND ALLERGY (N) NURSE LED FIELDS CLINIC(N) NURSE LED HAEMATOLOGY(N) NURSE LED PREADMISSION(N) NURSE LED RESPIRATORY(N)
NURSE LED DERMATOLOGY	
	NURSE LED DERMATOLOGY (N)
NURSE LED FERTILITY	
	NURSE LED FERTILITY (GYNAE)(N)
NURSE LED GYNAECOLOGY	

NURSE LED GYNAECOLOGY	NURSE LED GYNAECOLOGY(N)
NURSE LED NEPHROLOGY	NURSE LED NEPHROLOGY (N)
NURSE LED PRE-PREG DIAB	NURSE LED PRE-PREG DIABETIC(N)
O'BRIEN A MR	UROLOGY(C)
OCONNOR K DR	ANAESTHETICS(C)
O'HAGAN AH DR	DERMATOLOGY(C)
O'HARE M.F. MR	CERVICAL CYTOLOGY(C)
O'NEILL E DR	LEARNING DISABILITY(C)
OPTOMETRIST A	AHP OPTOMETRY CLINIC(A)
ORTHOTIST A	ORTHOTIC (T)
PATTON S MR	FRACTURE(C) ORTHOPAEDICS(C)
PERROTT S DR	PAEDIATRIC(C)
POLLEY L DR	THORACIC MEDICINE(C)
PRE-ASSESSMENT CLINICS	NURSE LED ENDOSCOPIST(N) NURSE LED PREASSES (N)
PSYCHIATRIC MEMORY TEAM	PSYCHIATRIC MEMORY TEAM (MDT)
QUINN P DR	PAEDIATRIC(C) SPECIAL CARE BABIES(C)
REA M DR	ANAESTHETICS(C)
ROBERTS M DR	GERIATRIC MEDICINE(C)
ROBERTS V MISS	FRACTURE(C)
SHAH S.R DR	PAEDIATRIC(C) PAEDIATRIC VIR (C)
SHAHID S DR	OBSTETRICS ANTE-NATAL (C)
SHARMA R DR	OBSTETRICS ANTE-NATAL (C)
SIDHU H K DR	GYNAECOLOGY(C)
SIM D MR	OBSTETRICS ANTE-NATAL (C) OBSTETRICS POST-NATAL (C)
SMEW M DR	GER ASSESSMENT/REHAB(C)
SMITH M.B.H DR	PAEDIATRIC(C)
SURGICAL ASSESSMENT UNIT	GENERAL SURGERY(C)
WATSON B MR	FRACTURE(C)
WEIR C.D. MR	GENERAL SURGERY(C)
WILLIAMS M DR	PAEDIATRIC(C) PAED CHILD DEVELOPMENT (C)
WILSON L MISS	FRACTURE(C)
YOUNG M MR	UROLOGY(C)
YOUSAF M MR	GENERAL SURGERY(C)
(blank)	(blank)
PHARMACY LED ANTI-COAG	PHARMACY LED ANTI-COAG(PH)
NURSE LED PAEDIATRIC	NURSE LED PAED ALLERGY (N) NURSE LED PAED RESPIRATORY (N)
ADESINA A DR	NEPHROLOGY(C)
FUNSTON L A DR	PAEDIATRIC(C)
HUMPHREYS K MRS	PAEDIATRIC DENTISTRY(C)
FOY A DR	HAEMATOLOGY(C)
MASENGU A DR	NEPHROLOGY(C)
BANNAGA A DR	HAEMATOLOGY(C)
HEDDERWICK S DR	INFECTIOUS DISEASES (C)
BRIDGHAM M DR	HAEMATOLOGY(C)
SANGAY R MR	OBSTETRICS ANTE-NATAL (C)

EVANS R DR	
	ONCOLOGY(C)
E REF RHEUMATOLOGY	
	RHEUMATOLOGY(C)
VASI V DR	
	PAEDIATRIC ALLERGY(C) PAEDIATRIC ASTHMA(C) PAEDIATRIC(C)
A PAEDIATRICIAN (E)	
	PAEDIATRIC ALLERGY(C) PAEDIATRIC(C)
KEENAN D DR	
	NEPHROLOGY(C)
SLOAN G DR	
	GER ASSESSMENT/REHAB(C)
MCCAULEY C DR	
	HAEMATOLOGY(C)
THOMPSON S DR	
	PAEDIATRIC(C)
KUMAR A DR	
	GERIATRIC ASSESSMENT(C) GERIATRIC MEDICINE(C)
COVID-19 SCREENING	
	COVID-19 SCREENING (N)
Grand Total	

TOTAL BY SPECIALITY

Last Appointment Date Year	(All)

Row Labels	Count of Casenote
AHP OPTOMETRY CLINIC(A)	3
ANAESTHETIC PREOP ASS(WLIO)(C)	12
ANAESTHETIC PREOP ASS. (C)	30
ANAESTHETICS(C)	140
ANTI-COAGULANT VIR (C)	9
ANTI-COAGULANT(C)	133
CARDIOLOGY (ICATS)	6
CARDIOLOGY MEDICINE(C)	26
CERVICAL CYTOLOGY(C)	3
COLORECTAL(C)	1
DERMATOLOGY (ICATS)	6
DERMATOLOGY(C)	23
DIETETICS ANTE-NATAL (A)	10
EAR NOSE AND THROAT (ICATS)	20
EAR NOSE AND THROAT(C)	10
ENDOCRINOLOGY(C)	4
FERTILITY (GYNAE)(C)	152
FRACTURE(C)	154
GASTRO-ENTEROLOGY(C)	3
GENERAL MEDICINE(C)	7
GENERAL SURGERY(C)	60
GER ASSESSMENT/REHAB(C)	7
GERIATRIC ACUTE(C)	2
GERIATRIC ASSESSMENT(C)	82
GERIATRIC MEDICINE(C)	64
GYNAECOLOGY(C)	16
HAEMATOLOGY(C)	60
LEARNING DISABILITY(C)	2
MIDWIFERY ANTE-NATAL (M)	186
MIDWIFERY LED CARE (M)	23
MIDWIFERY POST-NATAL (M)	200
MIDWIFERY SCAN/BLOOD RESULT(M)	32
NEPHROLOGY(C)	38
NEWBORN BABY(C)	2
NLED PAED RESP AND ALLERGY (N)	8
NURSE LED ACUTE DIABETIC (N)	25
NURSE LED BREAST CARE(N)	975
NURSE LED CARDIOLOGY(N)	1
NURSE LED CRYOTHERAPY(N)	1
NURSE LED DERMATOLOGY (N)	33
NURSE LED DIABETIC BLOODS (N)	841
NURSE LED ENDOSCOPIST(N)	139
NURSE LED FERTILITY (GYNAE)(N)	147
NURSE LED FIELDS CLINIC(N)	2
NURSE LED GYNAECOLOGY(N)	5
NURSE LED HAEMATOLOGY(N)	100
NURSE LED NEPHROLOGY (N)	406
NURSE LED PAED ALLERGY (N)	23
NURSE LED PAEDIATRICS (N)	5
NURSE LED PREADMISSION(N)	16
NURSE LED PREASSES (N)	4196
NURSE LED PRE-PREG DIABETIC(N)	3
NURSE LED RESPIRATORY(N)	88
OBSTETRICS ANTE-NATAL (C)	492
OBSTETRICS POST-NATAL (C)	30
ONCOLOGY(C)	8
ORTHOPAEDICS (ICATS)	2938
ORTHOPAEDICS(C)	6
ORTHOTIC (T)	127
PAEDIATRIC ALLERGY(C)	28
PAEDIATRIC ASTHMA(C)	8
PAEDIATRIC(C)	252
PAEDIATRICS - COMMUNITY(C)	43
PHARMACY LED ANTI-COAG(PH)	55
PHYSIOTHERAPY FOR FRACTURE (A)	567
PSYCHIATRIC MEMORY TEAM (MDT)	5

RHEUMATOLOGY(C)	95
SLEEP SERVICE(T)	1
SPECIAL CARE BABIES(C)	19
THORACIC MEDICINE(C)	3
UROLOGY(C)	25
(blank)	
NURSE LED PAED RESPIRATORY (N)	22
MIDWIFERY ANTE-NATAL EDUC (M)	11
PAEDIATRIC DENTISTRY(C)	2
INFECTIOUS DISEASES (C)	18
PAED CHILD DEVELOPMENT (C)	32
GERIATRIC AMBULATORY (C)	2
NURSE LED BREAST CANCER (N)	2
PAEDIATRIC VIR (C)	1
COVID-19 SCREENING (N)	20
Grand Total	**13352**

HCN	Casenote	Hospital Name	Consultant Code	Consultant Name	Specialty Code	Specialty Description	Discipline Mapping	Priority Type Description	Referral Source (R)	Referral Source Description (R)	Referral Source	Referral Source Description	Referral Date Only	Referral Reason	Referral Reason Suspect Cancer / Non Suspect	Referral Reason Description	Last Appointment Date	Last Appointment Date Year	Days Between Last App &	Count on Total Referrals
Personal Information redacted by the USI		CRAIGAVON AREA H	MY	YOUNG M MR	URO	UROLOGY(C)	Consultant-Led	URGENT	2	Consultant Initiated	WD	WARD REFERRAL (I	23/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/11/2012	2012	2940	1
		CRAIGAVON AREA H	EM	MACKLE E MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	URGENT	2	Consultant Initiated	CON	CONSULTANT (R)	31/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	26/11/2012	2012	2926	1
		CRAIGAVON AREA H	GDERM	GENERAL DERMAT(	DERM	DERMATOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFER	15/07/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	26/11/2012	2012	2926	1
		DAISY HILL HOSPIT/	DUFFIN	DUFFIN D. DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	28/05/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	26/11/2012	2012	2926	1
		CRAIGAVON AREA H	EM	MACKLE E MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	25/07/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	26/11/2012	2012	2926	1
		CRAIGAVON AREA H	EM	MACKLE E MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	URGENT	5	Other	OC	OTHER CONSULTAN	05/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	26/11/2012	2012	2926	1
		ARMAGH COMMUNI	AOB	O'BRIEN A MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (I	27/06/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	26/11/2012	2012	2926	1
		DAISY HILL HOSPIT/	GENT	GENERAL ENT CON	ENT	EAR NOSE AND THROAT(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	07/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	26/11/2012	2012	2926	1
		DAISY HILL HOSPIT/	EJM	MCNABOE E.J. MR	ENT	EAR NOSE AND THROAT(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	14/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	26/11/2012	2012	2926	1
		CRAIGAVON AREA H	NURSE	NURSE LED CLINIC!	NURD	NURSE LED DIABETIC BLOODS (N)	Nurse-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	26/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	26/11/2012	2012	2926	1
		CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	URGENT	5	Other	OC	OTHER CONSULTAN	15/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	13/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		DAISY HILL HOSPIT/	PG	GASKIN P G DR	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	16/06/2000	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		CRAIGAVON AREA H	BMO	MOCKFORD B MR	ORTH	ORTHOPAEDICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (I	25/07/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		CRAIGAVON AREA H	GRH	HEWITT G.R. MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	URGENT	5	Other	OC	OTHER CONSULTAN	03/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		SOUTH TYRONE HO	GGYN	GENERAL GYNAEC(	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	26/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		CRAIGAVON AREA H	GDERM	GENERAL DERMAT(	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	01/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	17/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	13/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFER	24/01/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		CRAIGAVON AREA H	GGYN	GENERAL GYNAEC(	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	20/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		CRAIGAVON AREA H	ICATS	ICATS TEAM	IDER	DERMATOLOGY (ICATS)	ICATS-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	06/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		CRAIGAVON AREA H	ICATS	ICATS TEAM	IDER	DERMATOLOGY (ICATS)	ICATS-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	22/06/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/11/2012	2012	2925	1
		BANBRIDGE HOSPI	AMK	MURDOCK AM DR	GTR	GASTRO-ENTEROLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	31/01/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/11/2012	2012	2924	1
		DAISY HILL HOSPIT/	RA	SURGICAL ASSESSI	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	5	Other	AE	EMERGENCY DEPAI	23/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/11/2012	2012	2924	1
		DAISY HILL HOSPIT/	EJM	MCNABOE E.J. MR	ENT	EAR NOSE AND THROAT(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	15/09/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/11/2012	2012	2924	1
		CRAIGAVON AREA H	MMU	MURNAGHAN M MR	ORTH	ORTHOPAEDICS(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	15/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/11/2012	2012	2924	1
		DAISY HILL HOSPIT/	DJE	EEDY D.J. DR	DERM	DERMATOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	26/03/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/11/2012	2012	2924	1
		CRAIGAVON AREA H	IBM	MENOWN I B A DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	14/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/11/2012	2012	2924	1
		BANBRIDGE HOSPI	AMK	MURDOCK AM DR	GTR	GASTRO-ENTEROLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	12/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/11/2012	2012	2924	1
		DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	11/04/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/11/2012	2012	2924	1
		CRAIGAVON AREA H	CN9964	NURSE LED CLINIC	NURR	NURSE LED RESPIRATORY(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (I	27/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/11/2012	2012	2924	1
		CRAIGAVON AREA H	CDW	WEIR C.D. MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (I	03/04/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	29/11/2012	2012	2923	1
		DAISY HILL HOSPIT/	MFOH	O'HARE M.F. MR	CYTO	CERVICAL CYTOLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	20/11/2009	PRO	Non-Suspect Cancer	SPECIFIC PROCEDURE	29/11/2012	2012	2923	1
		DAISY HILL HOSPIT/	RA	SURGICAL ASSESSI	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	5	Other	AE	EMERGENCY DEPAI	28/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	29/11/2012	2012	2923	1
		CRAIGAVON AREA H	MJG	GIBBONS M J DR	GMED	GENERAL MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	04/01/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	29/11/2012	2012	2923	1
		SOUTH TYRONE HO	AHOH	O'HAGAN AH DR	DERM	DERMATOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	10/01/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	29/11/2012	2012	2923	1
		SOUTH TYRONE HO	AHOH	O'HAGAN AH DR	DERM	DERMATOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFER	20/10/2010	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	29/11/2012	2012	2923	1
		CRAIGAVON AREA H	MJG	GIBBONS M J DR	GMED	GENERAL MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	30/01/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	29/11/2012	2012	2923	1
		CRAIGAVON AREA H	ICATS	ICATS TEAM	ICAR	CARDIOLOGY (ICATS)	ICATS-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	23/08/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/11/2012	2012	2923	1
		DAISY HILL HOSPIT/	DHNURS	NURSE LED CLINIC!	FOV	NURSE LED FIELDS CLINIC(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	25/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	29/11/2012	2012	2923	1
		CRAIGAVON AREA H	HKS	SIDHU H K DR	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	21/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	30/11/2012	2012	2922	1
		DAISY HILL HOSPIT/	RDCW	DE COURCY-WHEE	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	01/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	30/11/2012	2012	2922	1
		CRAIGAVON AREA H	GMCC	MCCRACKEN G DR	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	15/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	01/12/2012	2012	2921	1
		DAISY HILL HOSPIT/	EJM	MCNABOE E.J. MR	ENT	EAR NOSE AND THROAT(C)	Consultant-Led	URGENT	5	Other	AE	EMERGENCY DEPAI	27/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	03/12/2012	2012	2919	1
		CRAIGAVON AREA H	AOB	O'BRIEN A MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	09/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	03/12/2012	2012	2919	1
		CRAIGAVON AREA H	JB	BUNN J MR	ORTH	ORTHOPAEDICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (I	07/10/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	03/12/2012	2012	2919	1

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	BANBRIDGE HOSPIT	RJL	LEE R.J. DR	RHEU	RHEUMATOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFER	06/02/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	03/12/2012	2012	2919	1
	SOUTH TYRONE HO	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	26/09/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/12/2012	2012	2919	1
	SOUTH TYRONE HO	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	18/09/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/12/2012	2012	2919	1
	SOUTH TYRONE HO	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	18/09/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/12/2012	2012	2919	1
	DAISY HILL HOSPIT	RJB	BROWN R.J. MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	05/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	CRAIGAVON AREA H	AHOH	O'HAGAN AH DR	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	04/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFER	18/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	27/09/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	URGENT	5	Other	OA	OTHER CONS-ADVI	15/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	LURGAN HOSPITAL	DAG	GORMLEY D DR	GASS	GERIATRIC ASSESSMENT(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (	27/02/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	CRAIGAVON AREA H	AHOH	O'HAGAN AH DR	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	21/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	CRAIGAVON AREA H	GDERM	GENERAL DERMAT(	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	16/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	CRAIGAVON AREA H	GGYN	GENERAL GYNAEC(	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	10/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	CRAIGAVON AREA H	GURO	GENERAL UROLOGI	URO	UROLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	04/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	CRAIGAVON AREA H	AOB	O'BRIEN A MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	26/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	SOUTH TYRONE HO	S9964	NURSE LED CLINIC	NURD	NURSE LED DIABETIC BLOODS (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	13/09/2010	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	SOUTH TYRONE HO	S9964	NURSE LED CLINIC	NURD	NURSE LED DIABETIC BLOODS (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	09/02/2010	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/12/2012	2012	2918	1
	DAISY HILL HOSPIT	RJB	BROWN R.J. MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (	19/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	05/12/2012	2012	2917	1
	CRAIGAVON AREA H	GORTH	GENERAL ORTHOPA	ORTH	ORTHOPAEDICS(C)	Consultant-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	05/12/2012	2012	2917	1
	CRAIGAVON AREA H	IBM	MENOWN I B A DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	10/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	05/12/2012	2012	2917	1
	CRAIGAVON AREA H	GMCC	MCCRACKEN G DR	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	29/06/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	05/12/2012	2012	2917	1
	CRAIGAVON AREA H	IBM	MENOWN I B A DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	06/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	05/12/2012	2012	2917	1
	CRAIGAVON AREA H	EE	EPANOMERITAKIS E	GSUR	GENERAL SURGERY(C)	Consultant-Led	URGENT	2	Consultant Initiated	CON	CONSULTANT (R)	24/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	05/12/2012	2012	2917	1
	SOUTH TYRONE HO	GGYN	GENERAL GYNAEC(	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	10/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	05/12/2012	2012	2917	1
	DAISY HILL HOSPIT	RA	SURGICAL ASSESSI	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	04/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	05/12/2012	2012	2917	1
	CRAIGAVON AREA H	GDERM	GENERAL DERMAT(	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	15/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	06/12/2012	2012	2916	1
	CRAIGAVON AREA H	RMCK	MCKEOWN R MR	ORTH	ORTHOPAEDICS(C)	Consultant-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/06/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	06/12/2012	2012	2916	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	ICAR	CARDIOLOGY (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	18/10/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/12/2012	2012	2916	1
	SOUTH TYRONE HO	S9964	NURSE LED CLINIC	NURD	NURSE LED DIABETIC BLOODS (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	31/01/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	06/12/2012	2012	2916	1
	DAISY HILL HOSPIT	DHNURS	NURSE LED CLINIC	FOV	NURSE LED FIELDS CLINIC(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	09/11/2005	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	06/12/2012	2012	2916	1
	CRAIGAVON AREA H	MKO	KORDA M MR	ENT	EAR NOSE AND THROAT(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	07/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	07/12/2012	2012	2915	1
	CRAIGAVON AREA H	GDERM	GENERAL DERMAT(	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	03/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	07/12/2012	2012	2915	1
	DAISY HILL HOSPIT	DJE	EEDY D.J. DR	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	03/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	07/12/2012	2012	2915	1
	CRAIGAVON AREA H	HKS	SIDHU H K DR	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	10/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	07/12/2012	2012	2915	1
	CRAIGAVON AREA H	MYO	YOUSAF M MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	04/02/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	07/12/2012	2012	2915	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IDER	DERMATOLOGY (ICATS)	ICATS-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	24/07/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	07/12/2012	2012	2915	1
	CRAIGAVON AREA H	C9964	NURSE LED CLINIC	NURF	NURSE LED DERMATOLOGY (N)	Nurse-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	13/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	07/12/2012	2012	2915	1
	DAISY HILL HOSPIT	GEPPC	GENERAL GYNAEC(	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	07/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	08/12/2012	2012	2914	1
	CRAIGAVON AREA H	MYO	YOUSAF M MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	06/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	09/12/2012	2012	2913	1
	BANBRIDGE HOSPIT	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	02/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1
	CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	21/06/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1
	CRAIGAVON AREA H	GCOLO	GENERAL COLORE(	COLO	COLORECTAL(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	15/11/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1
	CRAIGAVON AREA H	GDERM	GENERAL DERMAT(	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	17/10/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1
	CRAIGAVON AREA H	IBM	MENOWN I B A DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	20/07/2010	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1
	BANBRIDGE HOSPIT	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	02/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1
	CRAIGAVON AREA H	GDERM	GENERAL DERMAT(	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	31/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1
	CRAIGAVON AREA H	GENS	GENERAL SURGEOI	GSUR	GENERAL SURGERY(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	22/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1
	CRAIGAVON AREA H	EM	MACKLE E MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (	17/05/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1

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	CRAIGAVON AREA H	GENS	GENERAL SURGEOI	GSUR	GENERAL SURGERY(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFER	25/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1
	CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	01/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1
	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IDER	DERMATOLOGY (ICATS)	ICATS-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	29/06/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/12/2012	2012	2912	1
	CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	20/06/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/12/2012	2012	2911	1
	BANBRIDGE HOSPIT	GRHEU	GENERAL RHEUMA	RHEU	RHEUMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	31/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/12/2012	2012	2911	1
	CRAIGAVON AREA H	MA	AKHTAR M MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	08/09/2009	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/12/2012	2012	2911	1
	SOUTH TYRONE HO	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	01/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/12/2012	2012	2911	1
	CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	12/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/12/2012	2012	2911	1
	DAISY HILL HOSPIT/	RJB	BROWN R.J. MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	13/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/12/2012	2012	2911	1
	SOUTH TYRONE HO	AHOH	O'HAGAN AH DR	DERM	DERMATOLOGY(C)	Consultant-Led	URGENT	5	Other	OC	OTHER CONSULTAN	17/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/12/2012	2012	2911	1
	CRAIGAVON AREA H	GRH	HEWITT G.R. MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	15/05/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/12/2012	2012	2911	1
	DAISY HILL HOSPIT/	RJB	BROWN R.J. MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	21/11/2007	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/12/2012	2012	2911	1
	CRAIGAVON AREA H	SP	PATTON S MR	ORTH	ORTHOPAEDICS(C)	Consultant-Led	ROUTINE	5	Other	ICT	REFERRED BY ICAT	22/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/12/2012	2012	2911	1
	CRAIGAVON AREA H	EE	EPANOMERITAKIS E	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	03/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/12/2012	2012	2911	1
	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	19/06/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/12/2012	2012	2911	1
	DAISY HILL HOSPIT/	RJB	BROWN R.J. MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	05/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/12/2012	2012	2910	1
	SOUTH TYRONE HO	GMK	MCKEOWN G DR	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	30/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/12/2012	2012	2910	1
	DAISY HILL HOSPIT/	RA	SURGICAL ASSESSI	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	5	Other	AE	EMERGENCY DEPA	08/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/12/2012	2012	2910	1
	DAISY HILL HOSPIT/	DJE	EEDY D.J. DR	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	25/05/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/12/2012	2012	2910	1
	DAISY HILL HOSPIT/	RJB	BROWN R.J. MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	24/09/2008	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/12/2012	2012	2910	1
	CRAIGAVON AREA H	MY	YOUNG M MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	22/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/12/2012	2012	2910	1
	CRAIGAVON AREA H	IBM	MENOWN I B A DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	22/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/12/2012	2012	2910	1
	SOUTH TYRONE HO	GMK	MCKEOWN G DR	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	5	Other	SEL	SELF REFERRAL (N	12/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/12/2012	2012	2910	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	ICAR	CARDIOLOGY (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	08/11/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/12/2012	2012	2910	1
	CRAIGAVON AREA H	CN9964	NURSE LED CLINIC	NURR	NURSE LED RESPIRATORY(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	23/06/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/12/2012	2012	2910	1
	DAISY HILL HOSPIT/	RA	SURGICAL ASSESSI	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	12/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	13/12/2012	2012	2909	1
	DAISY HILL HOSPIT/	KAM	MCKINNEY K.A. DR	CYTO	CERVICAL CYTOLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	01/08/2011	PRO	Non-Suspect Cancer	SPECIFIC PROCEDURE	13/12/2012	2012	2909	1
	CRAIGAVON AREA H	GDERM	GENERAL DERMATO	DERM	DERMATOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFER	02/07/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	13/12/2012	2012	2909	1
	CRAIGAVON AREA H	DJM	MCENEANEY D.J. DI	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	30/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	13/12/2012	2012	2909	1
	CRAIGAVON AREA H	CDW	WEIR C.D. MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	29/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	13/12/2012	2012	2909	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	ICAR	CARDIOLOGY (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	09/11/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/12/2012	2012	2909	1
	SOUTH TYRONE HO	S9964	NURSE LED CLINIC	NURD	NURSE LED DIABETIC BLOODS (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	03/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	13/12/2012	2012	2909	1
	CRAIGAVON AREA H	AMJ	JONES A.M. DR	GERA	GERIATRIC ACUTE(C)	Consultant-Led	ROUTINE	5	Other	AE	EMERGENCY DEPA	02/12/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	14/12/2012	2012	2908	1
	CRAIGAVON AREA H	AOB	O'BRIEN A MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (	13/11/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	14/12/2012	2012	2908	1
	DAISY HILL HOSPIT/	RA	SURGICAL ASSESSI	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	13/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	14/12/2012	2012	2908	1
	DAISY HILL HOSPIT/	GENT	GENERAL ENT CON	ENT	EAR NOSE AND THROAT(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	22/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	15/12/2012	2012	2907	1
	DAISY HILL HOSPIT/	RA	SURGICAL ASSESSI	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	30/08/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	17/12/2012	2012	2905	1
	CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	02/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	17/12/2012	2012	2905	1
	DAISY HILL HOSPIT/	RA	SURGICAL ASSESSI	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	5	Other	AE	EMERGENCY DEPA	15/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	17/12/2012	2012	2905	1
	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	06/10/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/12/2012	2012	2905	1
	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	13/09/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/12/2012	2012	2905	1
	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	30/07/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	17/12/2012	2012	2905	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	04/02/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/12/2012	2012	2905	1
	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	11/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	17/12/2012	2012	2905	1
	CRAIGAVON AREA H	LPY	POLLEY L DR	TMED	THORACIC MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	13/04/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	18/12/2012	2012	2904	1
	CRAIGAVON AREA H	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	29/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	18/12/2012	2012	2904	1
	CRAIGAVON AREA H	PM	MURPHY P DR	GMED	GENERAL MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	03/07/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	18/12/2012	2012	2904	1
	DAISY HILL HOSPIT/	DJE	EEDY D.J. DR	DERM	DERMATOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFER	24/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	19/12/2012	2012	2903	1

Personal Information redacted by the USI

[redacted]	DAISY HILL HOSPIT/	DJE	EEDY D.J. DR	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFEF	13/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	19/12/2012	2012	2903	1
[redacted]	DAISY HILL HOSPIT/	DJE	EEDY D.J. DR	DERM	DERMATOLOGY(C)	Consultant-Led	URGENT	5	Other	OC	OTHER CONSULTAN	06/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	19/12/2012	2012	2903	1
[redacted]	DAISY HILL HOSPIT/	EJM	MCNABOE E.J. MR	ENT	EAR NOSE AND THROAT(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFEF	16/12/2010	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	19/12/2012	2012	2903	1
[redacted]	CRAIGAVON AREA H	C9964	NURSE LED CLINIC	NURF	NURSE LED DERMATOLOGY (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	17/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	19/12/2012	2012	2903	1
[redacted]	CRAIGAVON AREA H	GENT	GENERAL ENT CON	ENT	EAR NOSE AND THROAT(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	13/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	20/12/2012	2012	2902	1
[redacted]	SOUTH TYRONE HO	PM	MURPHY P DR	GMED	GENERAL MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFEF	08/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	20/12/2012	2012	2902	1
[redacted]	DAISY HILL HOSPIT/	RH	HANNON R MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFEF	23/04/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	20/12/2012	2012	2902	1
[redacted]	CRAIGAVON AREA H	MJG	GIBBONS M J DR	GMED	GENERAL MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFEF	19/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	20/12/2012	2012	2902	1
[redacted]	CRAIGAVON AREA H	CDW	WEIR C.D. MR	GSUR	GENERAL SURGERY(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	14/08/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	20/12/2012	2012	2902	1
[redacted]	CRAIGAVON AREA H	AOB	O'BRIEN A MR	URO	UROLOGY(C)	Consultant-Led	URGENT	2	Consultant Initiated	WD	WARD REFERRAL (I	26/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	20/12/2012	2012	2902	1
[redacted]	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	29/05/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2012	2012	2902	1
[redacted]	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	16/05/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2012	2012	2902	1
[redacted]	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	20/04/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2012	2012	2902	1
[redacted]	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	30/03/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2012	2012	2902	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	18/10/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2012	2012	2902	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	14/11/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2012	2012	2902	1
[redacted]	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	26/03/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2012	2012	2902	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	20/10/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2012	2012	2902	1
[redacted]	DAISY HILL HOSPIT/	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	29/05/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2012	2012	2902	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IENT	EAR NOSE AND THROAT (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	29/11/2011	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2012	2012	2902	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	ICAR	CARDIOLOGY (ICATS)	ICATS-Led	ROUTINE	5	Other	CIC	CONSULTANT TO IC	20/11/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2012	2012	2902	1
[redacted]	CRAIGAVON AREA H	C9964	NURSE LED CLINIC	NURF	NURSE LED DERMATOLOGY (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	26/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	20/12/2012	2012	2902	1
[redacted]	CRAIGAVON AREA H	EJM	MCNABOE E.J. MR	ENT	EAR NOSE AND THROAT(C)	Consultant-Led	URGENT	2	Consultant Initiated	CON	CONSULTANT (R)	21/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	21/12/2012	2012	2901	1
[redacted]	DAISY HILL HOSPIT/	GEPPC	GENERAL GYNAEC(	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFEF	17/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	21/12/2012	2012	2901	1
[redacted]	DAISY HILL HOSPIT/	GEPPC	GENERAL GYNAEC(	GYNA	GYNAECOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFEF	17/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/12/2012	2012	2900	1
[redacted]	CRAIGAVON AREA H	DJE	EEDY D.J. DR	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFEF	11/07/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/12/2012	2012	2895	1
[redacted]	SOUTH TYRONE HO	PM	MURPHY P DR	GTR	GASTRO-ENTEROLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	14/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/12/2012	2012	2895	1
[redacted]	DAISY HILL HOSPIT/	KAM	MCKINNEY K.A. DR	CYTO	CERVICAL CYTOLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	07/11/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	27/12/2012	2012	2895	1
[redacted]	CRAIGAVON AREA H	MMCC	MCCORMICK M DR	GERA	GERIATRIC ACUTE(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	10/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/12/2012	2012	2894	1
[redacted]	CRAIGAVON AREA H	MMCC	MCCORMICK M DR	GEAR	GER ASSESSMENT/REHAB(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (I	16/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/12/2012	2012	2894	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IDER	DERMATOLOGY (ICATS)	ICATS-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFEF	18/09/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/12/2012	2012	2894	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IDER	DERMATOLOGY (ICATS)	ICATS-Led	URGENT	2	Consultant Initiated	WD	WARD REFERRAL (I	28/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/12/2012	2012	2894	1
[redacted]	SOUTH TYRONE HO	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	URGENT	5	Other	OC	OTHER CONSULTAN	11/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	31/12/2012	2012	2891	1
[redacted]	DAISY HILL HOSPIT/	RA	SURGICAL ASSESSI	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	5	Other	AE	EMERGENCY DEPAI	26/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	31/12/2012	2012	2891	1
[redacted]	CRAIGAVON AREA H	AHOH	O'HAGAN AH DR	DERM	DERMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	27/07/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	31/12/2012	2012	2891	1
[redacted]	DAISY HILL HOSPIT/	RA	SURGICAL ASSESSI	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (I	18/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	31/12/2012	2012	2891	1
[redacted]	SOUTH TYRONE HO	DJF	FLANNERY D J DR	CMED	CARDIOLOGY MEDICINE(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFEF	07/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	31/12/2012	2012	2891	1
[redacted]	CRAIGAVON AREA H	C9964	NURSE LED CLINIC	NURA	NURSE LED CRYOTHERAPY(N)	Nurse-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFEF	10/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	31/12/2012	2012	2891	1
[redacted]	CRAIGAVON AREA H	NURSE	NURSE LED CLINICS	NURD	NURSE LED DIABETIC BLOODS (N)	Nurse-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	31/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	31/12/2012	2012	2891	1
[redacted]	CRAIGAVON AREA H	CN9964	NURSE LED CLINIC	NEND	NURSE LED ENDOSCOPIST(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	20/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/01/2013	2013	2880	1
[redacted]	CRAIGAVON AREA H	CN9964	NURSE LED CLINIC	NEND	NURSE LED ENDOSCOPIST(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	20/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/01/2013	2013	2880	1
[redacted]	CRAIGAVON AREA H	CN9964	NURSE LED CLINIC	NEND	NURSE LED ENDOSCOPIST(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	20/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/01/2013	2013	2880	1
[redacted]	CRAIGAVON AREA H	CN9964	NURSE LED CLINIC	NEND	NURSE LED ENDOSCOPIST(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	20/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/01/2013	2013	2880	1
[redacted]	CRAIGAVON AREA H	CN9964	NURSE LED CLINIC	NEND	NURSE LED ENDOSCOPIST(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	20/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	18/01/2013	2013	2873	1
[redacted]	CRAIGAVON AREA H	CN9964	NURSE LED CLINIC	NEND	NURSE LED ENDOSCOPIST(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	20/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	18/01/2013	2013	2873	1
[redacted]	CRAIGAVON AREA H	CN9964	NURSE LED CLINIC	NEND	NURSE LED ENDOSCOPIST(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	20/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	18/01/2013	2013	2873	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/01/2013	2013	2867	1
[redacted]	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	11/01/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	25/01/2013	2013	2866	1

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[redacted]	CRAIGAVON AREA H	AOB	O'BRIEN A MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	30/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	05/02/2013	2013	2855	1
[redacted]	ARMAGH COMMUNI	GRHEU	GENERAL RHEUMAT	RHEU	RHEUMATOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	24/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	07/02/2013	2013	2853	1
[redacted]	CRAIGAVON AREA H	AOB	O'BRIEN A MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	14/03/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/02/2013	2013	2848	1
[redacted]	CRAIGAVON AREA H	AOB	O'BRIEN A MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	06/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/02/2013	2013	2848	1
[redacted]	DAISY HILL HOSPITA	DHNURS	NURSE LED CLINICS	PRE	NURSE LED PREADMISSION(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	18/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/02/2013	2013	2838	1
[redacted]	DAISY HILL HOSPITA	DHNURS	NURSE LED CLINICS	PRE	NURSE LED PREADMISSION(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	18/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/02/2013	2013	2838	1
[redacted]	DAISY HILL HOSPITA	DHNURS	NURSE LED CLINICS	PRE	NURSE LED PREADMISSION(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	18/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/02/2013	2013	2838	1
[redacted]	DAISY HILL HOSPITA	DHNURS	NURSE LED CLINICS	PRE	NURSE LED PREADMISSION(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	18/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/02/2013	2013	2838	1
[redacted]	DAISY HILL HOSPITA	DHNURS	NURSE LED CLINICS	PRE	NURSE LED PREADMISSION(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	18/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/02/2013	2013	2838	1
[redacted]	DAISY HILL HOSPITA	DHNURS	NURSE LED CLINICS	PRE	NURSE LED PREADMISSION(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	18/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/02/2013	2013	2838	1
[redacted]	DAISY HILL HOSPITA	DHNURS	NURSE LED CLINICS	PRE	NURSE LED PREADMISSION(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	15/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/02/2013	2013	2838	1
[redacted]	DAISY HILL HOSPITA	DHNURS	NURSE LED CLINICS	PRE	NURSE LED PREADMISSION(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	15/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/02/2013	2013	2838	1
[redacted]	DAISY HILL HOSPITA	DHNURS	NURSE LED CLINICS	PRE	NURSE LED PREADMISSION(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CNL	CONS TO NURSE LE	18/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	01/03/2013	2013	2831	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/03/2013	2013	2828	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/03/2013	2013	2828	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/01/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	06/03/2013	2013	2826	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/03/2013	2013	2825	1
[redacted]	CRAIGAVON AREA H	HKB	BOYD H.K. DR	HAEM	HAEMATOLOGY(C)	Consultant-Led	URGENT	5	Other	OC	OTHER CONSULTAN	15/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/03/2013	2013	2821	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/03/2013	2013	2819	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	14/03/2013	2013	2818	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	14/03/2013	2013	2818	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/03/2013	2013	2811	1
[redacted]	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	01/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/03/2013	2013	2810	1
[redacted]	CRAIGAVON AREA H	UB	BRADLEY U DR	ENDY	ENDOCRINOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	14/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/03/2013	2013	2810	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/03/2013	2013	2810	1
[redacted]	CRAIGAVON AREA H	DCY	CONNOLLY D MR	URO	UROLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFER	12/03/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	25/03/2013	2013	2807	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	22/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/03/2013	2013	2807	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/03/2013	2013	2803	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/03/2013	2013	2803	1
[redacted]	DAISY HILL HOSPITA	DRH	HULL D.R. DR	HAEM	HAEMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GP	GENERAL PRACTITI	17/12/2002	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	08/04/2013	2013	2793	1
[redacted]	CRAIGAVON AREA H	AOB	O'BRIEN A MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	11/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	09/04/2013	2013	2792	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/04/2013	2013	2790	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/04/2013	2013	2785	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/04/2013	2013	2782	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/04/2013	2013	2779	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/04/2013	2013	2779	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/04/2013	2013	2778	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	25/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/04/2013	2013	2778	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/04/2013	2013	2777	1
[redacted]	LURGAN HOSPITAL	DAG	GORMLEY D DR	GASS	GERIATRIC ASSESSMENT(C)	Consultant-Led	ROUTINE	5	Other	OTH	OTHER REFERRAL (	12/04/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	30/04/2013	2013	2771	1
[redacted]	CRAIGAVON AREA H	AOB	O'BRIEN A MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (I	24/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	30/04/2013	2013	2771	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/05/2013	2013	2770	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/05/2013	2013	2770	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/05/2013	2013	2770	1
[redacted]	BANBRIDGE HOSPIT	GRHEU	GENERAL RHEUMAT	RHEU	RHEUMATOLOGY(C)	Consultant-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	28/12/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	02/05/2013	2013	2769	1
[redacted]	CRAIGAVON AREA H	GENS	GENERAL SURGEON	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	26/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	02/05/2013	2013	2769	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/05/2013	2013	2764	1
[redacted]	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	25/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/05/2013	2013	2764	1

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	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/05/2013	2013	2763	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/05/2013	2013	2755	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/05/2013	2013	2751	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/05/2013	2013	2749	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/05/2013	2013	2743	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	25/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/05/2013	2013	2741	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/06/2013	2013	2737	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/06/2013	2013	2736	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/06/2013	2013	2735	1
	BANBRIDGE HOSPIT	NWL	LIGGETT N.W. DR	RHEU	RHEUMATOLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	14/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	06/06/2013	2013	2734	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/06/2013	2013	2730	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/06/2013	2013	2730	1
	URGAN HOSPITAL	DAG	GORMLEY D DR	GASS	GERIATRIC ASSESSMENT(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	21/11/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	18/06/2013	2013	2722	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/06/2013	2013	2722	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/06/2013	2013	2722	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/06/2013	2013	2721	1
	CRAIGAVON AREA H	DRH	HULL D.R. DR	HAEM	HAEMATOLOGY(C)	Consultant-Led	URGENT	5	Other	OC	OTHER CONSULTAN	17/01/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	20/06/2013	2013	2720	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/06/2013	2013	2720	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/06/2013	2013	2720	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/06/2013	2013	2720	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/06/2013	2013	2719	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/06/2013	2013	2713	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ICT	REFERRED BY ICAT	23/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/06/2013	2013	2712	1
	CRAIGAVON AREA H	HLJ	JATHAR H L MR	URO	UROLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	18/04/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	01/07/2013	2013	2709	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/07/2013	2013	2705	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/07/2013	2013	2701	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/07/2013	2013	2701	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/07/2013	2013	2700	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/07/2013	2013	2700	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/07/2013	2013	2699	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/07/2013	2013	2699	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/07/2013	2013	2695	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/07/2013	2013	2694	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/07/2013	2013	2692	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	02/07/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	23/07/2013	2013	2687	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/07/2013	2013	2686	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/07/2013	2013	2685	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/07/2013	2013	2685	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/07/2013	2013	2684	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/07/2013	2013	2684	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/07/2013	2013	2681	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	25/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/07/2013	2013	2680	1
	CRAIGAVON AREA H	GRHEU	GENERAL RHEUMA	RHEU	RHEUMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	01/03/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	31/07/2013	2013	2679	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	02/08/2013	2013	2677	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/08/2013	2013	2674	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/08/2013	2013	2673	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/08/2013	2013	2673	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/08/2013	2013	2673	1

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	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/08/2013	2013	2666	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/08/2013	2013	2666	1
	LURGAN HOSPITAL	PMMCC	MCCAFFREY P M DI	GASS	GERIATRIC ASSESSMENT(C)	Consultant-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	21/06/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	14/08/2013	2013	2665	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/08/2013	2013	2664	1
	LURGAN HOSPITAL	DAG	GORMLEY D DR	GASS	GERIATRIC ASSESSMENT(C)	Consultant-Led	ROUTINE	5	Other	OTH	OTHER REFERRAL (	05/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	20/08/2013	2013	2659	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/08/2013	2013	2659	1
	CRAIGAVON AREA H	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	08/08/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	21/08/2013	2013	2658	1
	ARMAGH COMMUNI	GRHEU	GENERAL RHEUMA	RHEU	RHEUMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	23/01/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/08/2013	2013	2651	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/08/2013	2013	2651	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/09/2013	2013	2645	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/09/2013	2013	2644	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/09/2013	2013	2643	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/09/2013	2013	2643	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/09/2013	2013	2642	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/09/2013	2013	2642	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/09/2013	2013	2642	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/09/2013	2013	2638	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/09/2013	2013	2635	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/09/2013	2013	2635	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ICT	REFERRED BY ICAT	26/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/09/2013	2013	2632	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/09/2013	2013	2631	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/09/2013	2013	2631	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/09/2013	2013	2630	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/09/2013	2013	2630	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/09/2013	2013	2630	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/09/2013	2013	2628	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/09/2013	2013	2628	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/09/2013	2013	2628	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/09/2013	2013	2628	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	11/09/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	24/09/2013	2013	2624	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	11/09/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	24/09/2013	2013	2624	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/09/2013	2013	2624	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/09/2013	2013	2624	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/09/2013	2013	2622	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/09/2013	2013	2622	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/09/2013	2013	2620	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/09/2013	2013	2620	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/09/2013	2013	2618	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/10/2013	2013	2617	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/10/2013	2013	2617	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/10/2013	2013	2614	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/10/2013	2013	2614	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/10/2013	2013	2611	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/10/2013	2013	2611	1
	BANBRIDGE HOSPI	NWL	LIGGETT N.W. DR	GMED	GENERAL MEDICINE(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	13/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	08/10/2013	2013	2610	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/10/2013	2013	2610	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	22/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/10/2013	2013	2609	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	01/10/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/10/2013	2013	2607	1

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[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/10/2013	2013	2607	1
[redacted]	DAISY HILL HOSPIT	C9964	NURSE LED CLINIC	NPRA	NLED PAED RESP AND ALLERGY (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	11/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/10/2013	2013	2607	1
[redacted]	DAISY HILL HOSPIT	C9964	NURSE LED CLINIC	NPRA	NLED PAED RESP AND ALLERGY (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	11/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/10/2013	2013	2607	1
[redacted]	DAISY HILL HOSPIT	C9964	NURSE LED CLINIC	NPRA	NLED PAED RESP AND ALLERGY (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	11/02/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/10/2013	2013	2607	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/10/2013	2013	2603	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/10/2013	2013	2603	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/10/2013	2013	2603	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/10/2013	2013	2602	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/10/2013	2013	2602	1
[redacted]	DAISY HILL HOSPIT	DHNURS	NURSE LED CLINIC	PRE	NURSE LED PREADMISSION(N)	Nurse-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	23/07/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	16/10/2013	2013	2602	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/10/2013	2013	2601	1
[redacted]	CRAIGAVON AREA	C9964	NURSE LED CLINIC	NURR	NURSE LED RESPIRATORY(N)	Nurse-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	17/09/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	17/10/2013	2013	2601	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/10/2013	2013	2600	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/10/2013	2013	2600	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/10/2013	2013	2600	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/10/2013	2013	2596	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/10/2013	2013	2596	1
[redacted]	CRAIGAVON AREA	HKB	BOYD H.K. DR	HAEM	HAEMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFE	30/07/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/10/2013	2013	2590	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/10/2013	2013	2589	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/10/2013	2013	2589	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/10/2013	2013	2588	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/10/2013	2013	2588	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/10/2013	2013	2588	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	31/10/2013	2013	2587	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	31/10/2013	2013	2587	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/11/2013	2013	2586	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/11/2013	2013	2582	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/11/2013	2013	2582	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/11/2013	2013	2580	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/11/2013	2013	2579	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	25/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/11/2013	2013	2576	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/11/2013	2013	2575	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/11/2013	2013	2575	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/11/2013	2013	2575	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	14/11/2013	2013	2573	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	14/11/2013	2013	2573	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/11/2013	2013	2572	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/11/2013	2013	2569	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/11/2013	2013	2569	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/11/2013	2013	2568	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/11/2013	2013	2568	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/11/2013	2013	2568	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/11/2013	2013	2567	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/11/2013	2013	2567	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/11/2013	2013	2567	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/11/2013	2013	2566	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/11/2013	2013	2566	1
[redacted]	CRAIGAVON AREA	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/11/2013	2013	2565	1

Personal Information redacted by the USI																			
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/11/2013	2013	2565	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/11/2013	2013	2562	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT I	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	12/11/2013	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	25/11/2013	2013	2562	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/11/2013	2013	2561	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/11/2013	2013	2561	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/11/2013	2013	2561	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/11/2013	2013	2560	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/11/2013	2013	2560	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/11/2013	2013	2560	1
	BANBRIDGE HOSPIT	GRHEU	GENERAL RHEUMA	RHEU	RHEUMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	01/08/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/11/2013	2013	2559	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	IDG	ICATS DIAG(ICATS (	31/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/11/2013	2013	2559	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/11/2013	2013	2559	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/11/2013	2013	2559	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	25/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/11/2013	2013	2558	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/11/2013	2013	2558	1
	CRAIGAVON AREA H	CN9964	NURSE LED CLINIC	NUBC	NURSE LED BREAST CARE(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	18/11/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	29/11/2013	2013	2558	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/11/2013	2013	2557	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	02/12/2013	2013	2555	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/12/2013	2013	2554	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/12/2013	2013	2554	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/12/2013	2013	2554	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/12/2013	2013	2554	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/12/2013	2013	2554	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/12/2013	2013	2554	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/12/2013	2013	2553	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/12/2013	2013	2551	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	17/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/12/2013	2013	2551	1
	CRAIGAVON AREA H	GENS	GENERAL SURGEOI	GSUR	GENERAL SURGERY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	23/10/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	09/12/2013	2013	2548	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/12/2013	2013	2548	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/12/2013	2013	2548	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/12/2013	2013	2548	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	31/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/12/2013	2013	2548	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/12/2013	2013	2546	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/12/2013	2013	2546	1
	CRAIGAVON AREA H	NWL	LIGGETT N.W. DR	RHEU	RHEUMATOLOGY(C)	Consultant-Led	URGENT	5	Other	OC	OTHER CONSULTAN	05/11/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/12/2013	2013	2545	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/12/2013	2013	2545	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/12/2013	2013	2545	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/12/2013	2013	2544	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/12/2013	2013	2544	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/12/2013	2013	2544	1
	CRAIGAVON AREA H	GRHEU	GENERAL RHEUMA	RHEU	RHEUMATOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFER	11/10/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	16/12/2013	2013	2541	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/12/2013	2013	2540	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/12/2013	2013	2540	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/12/2013	2013	2539	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/12/2013	2013	2539	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/12/2013	2013	2538	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/12/2013	2013	2538	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/12/2013	2013	2538	1

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	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/12/2013	2013	2537	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/12/2013	2013	2534	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	17/12/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	24/12/2013	2013	2533	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	17/12/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	24/12/2013	2013	2533	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/12/2013	2013	2533	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/12/2013	2013	2527	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	31/12/2013	2013	2526	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/01/2014	2014	2523	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/01/2014	2014	2523	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/01/2014	2014	2523	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/01/2014	2014	2520	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/01/2014	2014	2520	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/01/2014	2014	2519	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/01/2014	2014	2519	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/01/2014	2014	2519	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/01/2014	2014	2519	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/01/2014	2014	2518	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/01/2014	2014	2518	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/01/2014	2014	2518	1
	CRAIGAVON AREA H	HKB	BOYD H.K. DR	HAEM	HAEMATOLOGY(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	13/01/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	13/01/2014	2014	2513	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	31/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/01/2014	2014	2513	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	14/01/2014	2014	2512	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	14/01/2014	2014	2512	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	14/01/2014	2014	2512	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/01/2014	2014	2511	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/01/2014	2014	2511	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/01/2014	2014	2511	1
	DAISY HILL HOSPIT/	DHNURS	NURSE LED CLINIC!	PRE	NURSE LED PREADMISSION(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (I	16/12/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	15/01/2014	2014	2511	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/01/2014	2014	2510	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/01/2014	2014	2510	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/01/2014	2014	2510	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/01/2014	2014	2510	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/01/2014	2014	2508	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/01/2014	2014	2506	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/01/2014	2014	2506	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/01/2014	2014	2505	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/01/2014	2014	2504	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/01/2014	2014	2504	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/01/2014	2014	2504	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/03/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/01/2014	2014	2503	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/01/2014	2014	2503	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/01/2014	2014	2502	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ICT	REFERRED BY ICAT	22/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/01/2014	2014	2501	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/01/2014	2014	2499	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/01/2014	2014	2499	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT /	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	09/01/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	27/01/2014	2014	2499	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/01/2014	2014	2498	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/01/2014	2014	2497	1

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	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/01/2014	2014	2497	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/01/2014	2014	2496	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/01/2014	2014	2496	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/01/2014	2014	2496	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/01/2014	2014	2496	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	31/01/2014	2014	2495	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	31/01/2014	2014	2495	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	31/01/2014	2014	2495	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	31/01/2014	2014	2495	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	31/01/2014	2014	2495	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/02/2014	2014	2494	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/02/2014	2014	2492	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	22/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/02/2014	2014	2492	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	25/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/02/2014	2014	2491	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/02/2014	2014	2491	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/02/2014	2014	2491	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/02/2014	2014	2490	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	31/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/02/2014	2014	2490	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	25/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/02/2014	2014	2489	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/02/2014	2014	2489	1
	LURGAN HOSPITAL	PMMCC	MCCAFFREY P M DI	GERM	GERIATRIC MEDICINE(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	06/02/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	07/02/2014	2014	2488	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/02/2014	2014	2488	1
	CRAIGAVON AREA H	GRHEU	GENERAL RHEUMA	RHEU	RHEUMATOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPU	GP URGENT REFER	18/12/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	10/02/2014	2014	2485	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/02/2014	2014	2485	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/02/2014	2014	2485	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/02/2014	2014	2485	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	22/01/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	10/02/2014	2014	2485	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	27/01/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	10/02/2014	2014	2485	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	04/02/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	10/02/2014	2014	2485	1
	BANBRIDGE HOSPIT	GRHEU	GENERAL RHEUMA	RHEU	RHEUMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	10/12/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/02/2014	2014	2484	1
	CRAIGAVON AREA H	AOB	O'BRIEN A MR	URO	UROLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPC	GP SUSPECT CANC	28/03/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/02/2014	2014	2484	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/02/2014	2014	2484	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/02/2014	2014	2484	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/02/2014	2014	2484	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/02/2014	2014	2484	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/02/2014	2014	2483	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/02/2014	2014	2483	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/02/2014	2014	2483	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/02/2014	2014	2483	1
	BANBRIDGE HOSPIT	GRHEU	GENERAL RHEUMA	RHEU	RHEUMATOLOGY(C)	Consultant-Led	URGENT	3	GP Written Request	GPR	GP ROUTINE REFER	03/12/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	13/02/2014	2014	2482	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	14/02/2014	2014	2481	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	14/02/2014	2014	2481	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/02/2014	2014	2478	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/02/2014	2014	2477	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/02/2014	2014	2477	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/02/2014	2014	2477	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/02/2014	2014	2477	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/02/2014	2014	2476	1

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	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/02/2014	2014	2476	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/02/2014	2014	2475	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/02/2014	2014	2474	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/02/2014	2014	2471	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/02/2014	2014	2471	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	19/02/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	25/02/2014	2014	2470	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/02/2014	2014	2469	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/02/2014	2014	2469	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/02/2014	2014	2469	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/02/2014	2014	2469	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/02/2014	2014	2468	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/02/2014	2014	2468	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/02/2014	2014	2468	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/02/2014	2014	2468	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/02/2014	2014	2468	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/02/2014	2014	2467	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/02/2014	2014	2467	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/02/2014	2014	2467	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/02/2014	2014	2467	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/03/2014	2014	2464	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/03/2014	2014	2464	1
	MULLINURE	PWM	MCGUCKEN P W DR	GASS	GERIATRIC ASSESSMENT(C)	Consultant-Led	ROUTINE	5	Other	OTH	OTHER REFERRAL	26/11/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	04/03/2014	2014	2463	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	22/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/03/2014	2014	2463	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/03/2014	2014	2463	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/03/2014	2014	2463	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/03/2014	2014	2462	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/03/2014	2014	2461	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/03/2014	2014	2461	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/03/2014	2014	2461	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/03/2014	2014	2461	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/03/2014	2014	2460	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/03/2014	2014	2460	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/03/2014	2014	2457	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/03/2014	2014	2457	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/03/2014	2014	2457	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/03/2014	2014	2457	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/03/2014	2014	2455	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/03/2014	2014	2455	1
	LURGAN HOSPITAL	PMMCC	MCCAFFREY P M DI	GASS	GERIATRIC ASSESSMENT(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	06/12/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	13/03/2014	2014	2454	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	14/03/2014	2014	2453	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	07/03/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	18/03/2014	2014	2449	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/03/2014	2014	2448	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/03/2014	2014	2448	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/03/2014	2014	2447	1
	CRAIGAVON AREA H	NWL	LIGGETT N.W. DR	RHEU	RHEUMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPU	GP URGENT REFER	03/04/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	21/03/2014	2014	2446	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/03/2014	2014	2446	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/03/2014	2014	2446	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/03/2014	2014	2445	1

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	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/03/2014	2014	2443	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	13/03/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	25/03/2014	2014	2442	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/03/2014	2014	2442	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/03/2014	2014	2442	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/03/2014	2014	2439	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/03/2014	2014	2439	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/03/2014	2014	2439	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/03/2014	2014	2439	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/03/2014	2014	2439	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	25/03/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	31/03/2014	2014	2436	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/04/2014	2014	2435	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/04/2014	2014	2435	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/04/2014	2014	2429	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	27/03/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	07/04/2014	2014	2429	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/04/2014	2014	2428	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	31/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/04/2014	2014	2428	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/04/2014	2014	2427	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/04/2014	2014	2427	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/04/2014	2014	2425	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	02/04/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	14/04/2014	2014	2422	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/04/2014	2014	2421	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	25/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/04/2014	2014	2421	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/04/2014	2014	2421	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/04/2014	2014	2421	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/04/2014	2014	2419	1
	CRAIGAVON AREA H	GRHEU	GENERAL RHEUMA	RHEU	RHEUMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	19/12/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	18/04/2014	2014	2418	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/04/2014	2014	2418	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/04/2014	2014	2413	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/04/2014	2014	2413	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	08/04/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	23/04/2014	2014	2413	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/04/2014	2014	2408	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/04/2014	2014	2407	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/04/2014	2014	2407	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/04/2014	2014	2407	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/04/2014	2014	2407	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/04/2014	2014	2406	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/04/2014	2014	2406	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/04/2014	2014	2406	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	24/04/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	30/04/2014	2014	2406	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/05/2014	2014	2405	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	02/05/2014	2014	2404	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/05/2014	2014	2400	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/05/2014	2014	2400	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/05/2014	2014	2398	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/05/2014	2014	2398	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/05/2014	2014	2394	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	06/05/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	13/05/2014	2014	2393	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/05/2014	2014	2393	1

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	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/05/2014	2014	2393	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	14/05/2014	2014	2392	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/05/2014	2014	2391	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/05/2014	2014	2391	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/05/2014	2014	2390	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/05/2014	2014	2387	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	15/04/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	19/05/2014	2014	2387	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/05/2014	2014	2386	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/05/2014	2014	2386	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	25/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/05/2014	2014	2386	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/05/2014	2014	2385	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/05/2014	2014	2385	1
	LURGAN HOSPITAL	PMMCC	MCCAFFREY P M DI	GASS	GERIATRIC ASSESSMENT(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (	04/03/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/05/2014	2014	2384	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/05/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/05/2014	2014	2384	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/05/2014	2014	2379	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	21/05/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	27/05/2014	2014	2379	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/05/2014	2014	2378	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/05/2014	2014	2378	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/05/2014	2014	2377	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/05/2014	2014	2377	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/05/2014	2014	2376	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	22/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	02/06/2014	2014	2373	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/06/2014	2014	2372	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/06/2014	2014	2372	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/06/2014	2014	2372	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/06/2014	2014	2371	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/06/2014	2014	2370	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/06/2014	2014	2364	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/06/2014	2014	2364	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	07/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/06/2014	2014	2364	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	22/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/06/2014	2014	2364	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/06/2014	2014	2364	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/09/2012	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/06/2014	2014	2364	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/06/2014	2014	2364	1
	SOUTH TYRONE HO	S9964	NURSE LED CLINIC	NURR	NURSE LED RESPIRATORY(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	NLC	NURSE LED CLINIC	02/11/2007	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	12/06/2014	2014	2363	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/06/2014	2014	2362	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/06/2014	2014	2359	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	11/06/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	16/06/2014	2014	2359	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/06/2014	2014	2358	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/06/2014	2014	2358	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/06/2014	2014	2357	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/06/2014	2014	2357	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/06/2014	2014	2357	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/06/2014	2014	2357	1
	CRAIGAVON AREA H	PWM	MCGUCKEN P W DR	GASS	GERIATRIC ASSESSMENT(C)	Consultant-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	19/03/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	20/06/2014	2014	2355	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/06/2014	2014	2355	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/06/2014	2014	2355	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/06/2014	2014	2355	1

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	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	17/06/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	23/06/2014	2014	2352	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/01/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/06/2014	2014	2351	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/06/2014	2014	2351	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/06/2014	2014	2350	1
	CRAIGAVON AREA H	GRHEU	GENERAL RHEUMA	RHEU	RHEUMATOLOGY(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	01/10/2012	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	26/06/2014	2014	2349	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/06/2014	2014	2349	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/06/2014	2014	2349	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	02/07/2014	2014	2343	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	03/06/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	07/07/2014	2014	2338	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/07/2014	2014	2337	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/07/2014	2014	2337	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ICT	REFERRED BY ICAT	25/04/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/07/2014	2014	2337	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	31/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/07/2014	2014	2336	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/07/2014	2014	2336	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/07/2014	2014	2335	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	18/06/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	11/07/2014	2014	2334	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/07/2014	2014	2334	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	26/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/07/2014	2014	2330	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/07/2014	2014	2330	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	22/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/07/2014	2014	2329	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/07/2014	2014	2328	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/07/2014	2014	2328	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/07/2014	2014	2328	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/07/2014	2014	2328	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/07/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/07/2014	2014	2327	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/07/2014	2014	2327	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/07/2014	2014	2324	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/07/2014	2014	2324	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/07/2014	2014	2323	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/07/2014	2014	2323	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/07/2014	2014	2322	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/07/2014	2014	2322	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/07/2014	2014	2322	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/07/2014	2014	2322	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/07/2014	2014	2322	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/07/2014	2014	2322	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/07/2014	2014	2321	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/07/2014	2014	2321	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	17/07/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	25/07/2014	2014	2320	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/07/2014	2014	2320	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/02/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/07/2014	2014	2320	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/07/2014	2014	2320	1
	CRAIGAVON AREA H	C9964	NURSE LED CLINIC	NURR	NURSE LED RESPIRATORY(N)	Nurse-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	18/03/2011	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/07/2014	2014	2317	1
	SOUTH TYRONE HO	PREAS	PRE-ASSESSMENT	NPOA	NURSE LED PREASSES (N)	Nurse-Led	ROUTINE	2	Consultant Initiated	BCS	BOWEL CANCER SC	24/07/2014	PREA	Non-Suspect Cancer	PRE-OP ASSESSMENT	28/07/2014	2014	2317	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/07/2014	2014	2316	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	09/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/07/2014	2014	2316	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	31/07/2014	2014	2314	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	31/07/2014	2014	2314	1

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	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/08/2014	2014	2313	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/08/2014	2014	2313	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/08/2014	2014	2313	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	18/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/08/2014	2014	2313	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	02/08/2014	2014	2312	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/08/2014	2014	2310	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	03/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/08/2014	2014	2310	1
	LURGAN HOSPITAL	DAG	GORMLEY D DR	GASS	GERIATRIC ASSESSMENT(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (I	23/12/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	05/08/2014	2014	2309	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/08/2014	2014	2309	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/07/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	05/08/2014	2014	2309	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	06/08/2014	2014	2308	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/09/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/08/2014	2014	2307	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/11/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	07/08/2014	2014	2307	1
	CRAIGAVON AREA H	CN9964	NURSE LED CLINIC	NURR	NURSE LED RESPIRATORY(N)	Nurse-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	01/08/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	07/08/2014	2014	2307	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/08/2014	2014	2306	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/08/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/08/2014	2014	2306	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	22/07/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	08/08/2014	2014	2306	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/10/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/08/2014	2014	2303	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/08/2014	2014	2302	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/08/2014	2014	2302	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	13/08/2014	2014	2301	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/08/2014	2014	2299	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/08/2014	2014	2299	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/08/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/08/2014	2014	2299	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/07/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/08/2014	2014	2296	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/08/2014	2014	2296	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/08/2014	2014	2295	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	21/07/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/08/2014	2014	2295	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	07/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/08/2014	2014	2294	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	11/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/08/2014	2014	2294	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/08/2014	2014	2294	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/08/2014	2014	2294	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/08/2014	2014	2294	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/08/2014	2014	2294	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/08/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	20/08/2014	2014	2294	1
	BANBRIDGE HOSPIT	NWL	LIGGETT N.W. DR	RHEU	RHEUMATOLOGY(C)	Consultant-Led	ROUTINE	5	Other	OC	OTHER CONSULTAN	18/11/2013	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	21/08/2014	2014	2293	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	21/08/2014	2014	2293	1
	SOUTH TYRONE HO	HKB	BOYD H.K. DR	ACOA	ANTI-COAGULANT(C)	Consultant-Led	ROUTINE	5	Other	SEL	SELF REFERRAL (N	09/05/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	22/08/2014	2014	2292	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/08/2014	2014	2292	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/08/2014	2014	2292	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	26/08/2014	2014	2288	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	30/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/08/2014	2014	2287	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	25/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	27/08/2014	2014	2287	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/08/2014	2014	2286	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	28/08/2014	2014	2286	1
	SOUTH TYRONE HO	S9964	NURSE LED CLINIC	NURR	NURSE LED RESPIRATORY(N)	Nurse-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	06/08/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	28/08/2014	2014	2286	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/07/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	01/09/2014	2014	2282	1
	CRAIGAVON AREA H	HKB	BOYD H.K. DR	ACOA	ANTI-COAGULANT(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	WD	WARD REFERRAL (I	12/08/1991	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	02/09/2014	2014	2281	1

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	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	02/09/2014	2014	2281	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	02/09/2014	2014	2281	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/04/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/09/2014	2014	2280	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/09/2014	2014	2280	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	24/01/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/09/2014	2014	2280	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	29/08/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	03/09/2014	2014	2280	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/09/2014	2014	2279	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/08/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	04/09/2014	2014	2279	1
	CRAIGAVON AREA H	ANAES	ANAESTHETICS	ANAE	ANAESTHETICS(C)	Consultant-Led	ROUTINE	2	Consultant Initiated	CON	CONSULTANT (R)	16/07/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	09/09/2014	2014	2274	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/09/2014	2014	2274	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/07/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	09/09/2014	2014	2274	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/09/2014	2014	2273	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/09/2014	2014	2273	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	06/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	10/09/2014	2014	2273	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	11/09/2014	2014	2272	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/09/2014	2014	2271	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/09/2014	2014	2271	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	05/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	12/09/2014	2014	2271	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	20/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	15/09/2014	2014	2268	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/09/2014	2014	2267	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	14/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/09/2014	2014	2267	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/09/2014	2014	2267	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	16/07/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/09/2014	2014	2267	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	16/09/2014	2014	2267	1
	MULLINURE	PWM	MCGUCKEN P W DR	GASS	GERIATRIC ASSESSMENT(C)	Consultant-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	23/07/2014	ADV	Non-Suspect Cancer	ADVICE AND CONSULTATION	17/09/2014	2014	2266	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	08/09/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/09/2014	2014	2266	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	3	GP Written Request	GPR	GP ROUTINE REFER	08/08/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/09/2014	2014	2266	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/09/2014	2014	2266	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	19/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	17/09/2014	2014	2266	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/09/2014	2014	2265	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	28/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/09/2014	2014	2265	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	15/09/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	18/09/2014	2014	2265	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	20/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	19/09/2014	2014	2264	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	12/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/09/2014	2014	2261	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	02/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	22/09/2014	2014	2261	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	04/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/09/2014	2014	2260	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	01/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/09/2014	2014	2260	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	10/02/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	23/09/2014	2014	2260	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/09/2014	2014	2259	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/09/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/09/2014	2014	2259	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	23/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/09/2014	2014	2259	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	13/03/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	24/09/2014	2014	2259	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/09/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/09/2014	2014	2258	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/05/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	25/09/2014	2014	2258	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/12/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	29/09/2014	2014	2254	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/07/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/09/2014	2014	2253	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	27/06/2014	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/09/2014	2014	2253	1
	CRAIGAVON AREA H	ICATS	ICATS TEAM	IORT	ORTHOPAEDICS (ICATS)	ICATS-Led	ROUTINE	5	Other	ITR	ICATS TRIAGE (N)	17/06/2013	ICFF	Non-Suspect Cancer	ICATS TIER 2 F2F ASSESSMENT	30/09/2014	2014	2253	1