INTRODUCTION

The number of consultant urologists in the United Kingdom has increased by 40% in the past 5 years. This has resulted in the formation of many new departments of Urology. The government has recently announced a significant increase in health service funding so it seems probable that this expansion of urological services will continue, but is likely to be delivered with specific targets. This document has been produced by the Council of the British Association of Urological Surgeons to assist Health Authorities, Trust Chief Executives, Clinical Directors and Consultant Urologists to plan Urological Services for their community.

Clinical Governance is the framework through which the NHS is accountable for continuously improving the quality of the service and safeguarding high standards of care (1). The object of these guidelines is to create the environment in which excellence in care will flourish, and ensure that patients have rapid access to a safe, high quality service by fully trained specialists.

The guidelines suggest the appropriate workload activity for a Consultant Urologist and by implication the caseload for a Urological Unit. The Council of the British Association of Urological Surgeons firmly believes that long waiting times are part of the quality agenda and must be tackled. In order to achieve this objective there must be sufficient consultant urologists with access to adequate numbers of beds and operating sessions and supported by appropriate numbers of properly trained nurses and theatre staff.

In recent years much more emphasis has been placed on:

Clinical Effectiveness & Audit,

Clinical Governance,

Professional Development and Training (Including assembly of CPD portfolio and appraisal in protected time)

Service Targets (Waiting lists and Waiting times)

Training of young surgeons

These tasks make heavy demands on consultant time and cannot be accomplished unless adequate time is formally set aside in the work programme.

Urological activity may be considered under three specific headings:

- **The Consultant Programme**
- **Provision of Outpatient Services**
- **In-patient activity**

It is important to understand that the operative workload should relate to the Outpatient throughput, so that a balance can be achieved and long waiting times for inpatient or day case treatment avoided. It is doubtful whether urologists should see outpatients whom they are unable to treat within a reasonable time scale. Trusts and Health Authorities have often overlooked this issue when discussing manpower planning.

THE CONSULTANT PROGRAMME

The specific guidelines for a Consultant job plan based on a commitment of ten notional half days (three and a half-hour sessions) have been agreed by the Royal College of Surgeons and adopted by the Association of Surgeons of Great Britain and Ireland. These guidelines have been used by regional advisors and regional speciality advisors to assess new Consultant contracts. The traditional Consultant contract has 6+1 (special interest) fixed sessions with three flexible sessions.

BAUS Council believes that a **5+1 fixed session contract** with four flexible sessions is a more appropriate scheme for the future, thus formally allocating a further session to take into account all the tasks listed under Postgraduate Education, especially if the consultant has obligations to train a Specialist Registrar.

Recommended Job Plan:

(Fixed sessions in **bold type**)

Operating Theatre		**3 NHD**
Outpatient Clinics		**2 NHD**
Special interest		**1 NHD**
Ward round + On Call		1 NHD
Postgraduate Education		1 NHD
To include:	Audit, Teaching	
	Pathology & X-Ray meetings	
	Clinical Governance	
	Quality assurance	
	Mortality and morbidity meetings	
Flexible commitment		2 NHD
On call 1:5		

- *Special interest sessions may be used to provide additional operating, specific Outpatient clinics, Urodynamics, Lithotripsy or to supervise the research activities of the department.*
- *Involvement in Clinical Management, Audit and Clinical Governance will occupy significant clinical time and provision must be made for these activities within the job plan.*
- *Flexible sessions cover duties, which may be performed at different times, over different weeks and even sometimes outside standard working hours. These will include clinical administration, travel, interdepartmental referral and continuing clinical responsibility. They will also include time spent after operating sessions and clinics "tidying the desk", talking to patient's relatives, visiting patients on the ward prior to operation, reviewing patient notes, results and ensuring that these are made known to patients and to the relevant medical practitioners.*

On Call

The on call commitment included in the job plan has traditionally been linked to the size of the department (e.g. a two man department on 1:2), whereas BAUS Council considers that a 1:5 rota is more appropriate and this is already established practice in larger departments and for current trainees. Where it is not possible to arrange a 1:5 rota, a sessional allowance **must** be allocated appropriately in the job plan (ref 2). Consultants in smaller units have a particularly onerous on-call commitment with the need to cover colleagues on leave and unfilled vacancies often with limited and inexperienced junior staff. The scenario of a consultant continuously on-call for 2 - 3 weeks at a time, in addition to fulfilling a standard job plan, is to be deplored. It is crucial that the on-call component of their job plan is fully recognised.

The following sessional allowances are recommended for consultants who are supported by a urology SpR or senior SHO:

1:5	1 NHD
1:4	2 NHDs
1:3	2.5 NHDs
1:2	3 NHDs

For those consultants on call 1:3 or more with a Pre-registration house officer, junior SHO or with intermediate cover provided from another specialty, the emergency workload is more demanding , and BAUS Council recommends in this situation:

1:3	3 NHDs
1:2	4 NHDs

Study leave

Patients have a right to expect high standards of care. "Life long learning" is essential if these high standards are to be maintained over 25-30 years of consultant practice. The Trust annual appraisal should include a plan for CPD and at least two weeks per annum should be allocated for external CME (Training courses, national and international meetings, visiting other centres etc.).

In practice the 52 week year is reduced to 42 weeks or less by:

6 weeks annual leave
1 week bank holidays
2 weeks study leave (CME/CPD)
1 week Xmas & New Year

PROVISION OF OUTPATIENT SERVICES

There is general agreement that overloading the outpatient clinic leads to dissatisfaction both for the patient, due to inadequate consultation time, and for medical staff because of the lack of time to provide a safe quality service. Poor communication due to lack of time is a common cause for complaint.

Analysis of the consultation process can be illustrated as follows and these items must be taken into consideration when calculating clinic time allocations:

1. Read referral Letter
2. Evaluate notes, X-rays and any associated material
3. Introduce patient (and relatives)
4. Adequate time for consultation and examination
5. Arrange further investigations
6. Obtain informed consent for future management
7. Write clear notes on history and examination
8. Dictate letter
9. Additional time for completion of waiting list card, discussion with trainee and completion of audit / research proforma.

Review of referral letters enables the consultant to arrange appropriate investigations prior to the clinic appointment with the aim of ensuring a smooth and effective outpatient 'one stop' consultation, and to allocate a longer consultation time for patients with complex urological problems.

The Royal College of Surgeons recommendation is that a surgeon should see 7 new patients and 7 follow up patients per clinic to allow sufficient time for proper assessment, counselling and to keep up to charter standards (ref 3). An indicative time of 20 minutes for a new patient consultation and 10 minutes for follow up is accepted practice in General Surgery. Although no formal assessment has been made in Urology, BAUS Council believes that these times are required to properly diagnose, investigate, counsel, and treat the patient. BAUS Council therefore recommends that a normal clinic should not exceed the equivalent of 7 new and 7 old patients. Depending on case complexity, these figures can be adjusted locally, and the ratio between old and new patients varied up to a **maximum** of 20 patients / urologist per clinic.

It is usual to have the assistance of a trainee in the major clinics but the contribution they make to the workload will depend on their seniority and experience. However the presence of an experienced SpR or Staff Grade does allow cover during vacation and study leave.

For example;

1 Consultant	14 - 20 patients
1 Consultant +1 year 3 SpR Ass Specialist or Staff Grade	20 - 30 patients
1 Consultant + SHO or year 1 SpR	25 patients

In this example the figures are based on a third year SpR. A first year SpR or SHO will require intensive surveillance and consequently fewer patients can be seen in the clinic.

Based on a 42 week working year, it therefore follows that a consultant working alone should see approximately 1176 outpatients with a maximum of 1680 patients. If the consultant has the support of an experienced SpR or staff grade this workload might be increased to 2520 patients.

Consultants with a major subspecialty interest, e.g. oncology, will see significantly fewer patients due to case complexity and the need to allocate more time to each patient. Teaching, particularly undergraduates and house officers, will also reduce the number of cases per clinic.

Because of the pressure to reduce outpatient waiting time Urologists have pioneered ways to streamline service delivery e.g.:

- *Single visit haematuria clinics*
- *Prostate Assessment Clinics*
- *Andrology Clinics*
- *Nurse led follow up clinics.*

Nurse led clinics, which still need to be supervised by the consultant who is responsible for the care of the patient, result in an altered case mix in the consultant outpatient clinics, which become much more demanding due to residual case complexity.

IN-PATIENT ACTIVITY

The average Consultant Urological Surgeon, and his team, should be performing between 1000 and 1,250 inpatient and day case FCEs per annum. The exact number will depend on sub-specialty interest, case mix, the number of operating sessions in the job plan and whether the urologist has an obligation to train a specialist registrar. For example, sub-specialists in Oncology, who perform lengthy complex procedures, would be expected to have fewer FCEs than their generalist counterparts.

The time required to perform a procedure varies significantly between surgeons. The allocated times for each case should be increased by 30% to 50% if the procedure is to be performed by a trainee under supervision or the Consultant has a teaching commitment on the list in question.

Day case activity varies considerably around the UK and is dependent upon the facilities available. The average DGH urologist with appropriate facilities should achieve a day case target of at least 60% of total FCEs.

Higher Surgical Training

As the number of consultant urologists has increased there has also been an expansion of the number of trainees and training units. It seems likely that this expansion will continue. The Calman training programme has significantly reduced the length of training, thus trainees start their urological training with much less experience than their previous Senior Registrar counterparts. Because the training has to be concentrated into a much shorter time period a greater percentage of the operating time available has to be devoted to direct supervision of the trainee. The Joint Committee for Higher Surgical Training no longer permits trainees to have independent or twinned operating lists, except in the case of final year SpRs who are gaining independent operating experience under supervision. This means that the overall number of operations per session is reduced, particularly if the SpR is in the early stages of training.

Academic training and regular trainee appraisal also has to be fitted into the timetable. Most of these activities are additional to the normal consultant working practice and should be taken into account when trying to define "workload". These factors influence hospital activity and reduce the time available for service provision by Consultants.

MANPOWER REQUIREMENTS

The present ratio of consultant urologists to population in the United Kingdom is: 1:119,000. We have fewer urologists than any of our European partners with the exception of the Irish Republic (ref 4):

Greece	1:15,150
Austria	1:20,160
Spain	1:21,505
Germany	1:24,550
Sweden	1:29,330
Italy	1:30,500
Belgium	1:33,330
Denmark	1:46,720
France	1:60,000
Netherlands	1:62,000
Norway	1:67,140
UK	1:119,000
Eire	1:184,000

It is therefore hardly surprising that demand for urological services exceeds supply with unacceptable waiting times for outpatient consultations and inpatient treatment.

The impact of the proposed cancer wait times illustrates the challenge ahead of us. At the moment the waiting time for 90% of urgent Urological cancer referrals to receive first definitive treatment in England is longer than for all other common malignancies. (ref 5)

We currently have 504 consultants, and 119 non-consultant career grades. To get through the total amount of urological work generated each year in the UK of approximately 1.2 million FCEs we will require 1000 urologists, 1:60,000 of the population. Non-consultant career grades make a significant contribution to the workload but the aim should be to provide a consultant led service. It therefore seems sensible to aim for at least 750 consultant urologists in the UK (1 consultant per 80,000 population) with the majority of them working in groups large enough to offer a sub specialty expertise and to be able to arrange a satisfactory on-call rota.

A reasonable timetable is proposed: 1:100,000 by 2003
1:80,000 by 2007

CONCLUSIONS

The object of these guidelines is to create the environment in which excellence in care will flourish, and ensure that patients have rapid access to a safe, high quality service by fully trained specialists. In order to achieve this objective there must be sufficient consultant urologists with access to an adequate number of beds and operating sessions and be supported by appropriate numbers of properly trained nurses and theatre staff.

It is therefore recommended that Trusts and Health Authorities should plan urological services on the basis of one consultant per 80,000 population. It is recognised that this cannot be achieved until enough urologists have been trained, however the timetable for implementation should be:

1:100,000 by 2003
1:80,000 by 2007

Until that time it is proposed that for each Urologist (based on 1:100,000 population) the following maximum activity levels are recommended, based on a 42 working week year, to provide a safe service within the remit of clinical governance:

Outpatients:

Consultant alone	14 - 20 per clinic
Consultant & SpR, Associate Specialist or Staff Grade	20 - 30 per clinic
Consultant & BST or First Year SpR	25 per clinic

In-patients: 1000 - 1250 FCEs with at least a 60% Day Case activity level.

The Consultant Job Plan should contain 5+1 fixed sessions, (3 lists, 2 clinics and 1 special interest) with 2 recognised sessions for PGE, teaching, audit, governance including On Call and ward rounds etc. and 2 flexible sessions. A Consultant should be On Call no more than 1:5 with additional sessions allocated for more frequent on call and 2 weeks recognised study leave for external CME.

References:

1 "A First Class Service - Quality in the New NHS", NHS Publication p32 June 1998
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4 European Board of Urology; Manpower Committee 1999
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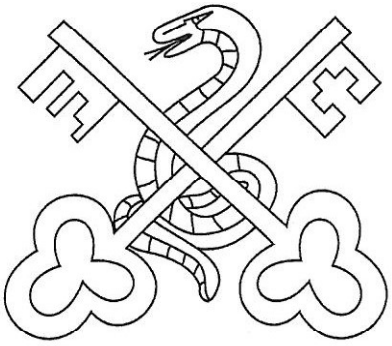

THE BRITISH ASSOCIATION
OF UROLOGICAL SURGEONS

The Provision of Urological Services in the UK

Produced by the Council of
the British Association of Urological Surgeons
February 2002

Introduction

This document has been produced by the Council of the British Association of Urological Surgeons to assist Health Authorities, Trust Chief Executives, Clinical Directors and Consultant Urologists in planning Urological Services for their community. The information contained within this document complements advice contained in 'A Quality Urological Service for Patients in the New Millennium' (1), which set down guidelines on workload, manpower and standards of care. The conclusions reached in this document apply to the whole of the United Kingdom including Scotland, Wales and Northern Ireland.

It is eight years since the first edition of this document was published. Since 1993 there have been many changes in the structure of the NHS and in the training of Urological surgeons. Some of these developments were foreseen in the 1993 report; other changes were not anticipated. This new document takes account of the changes that have occurred, and also attempts to anticipate future developments in service delivery and training.

The object of these guidelines is to create the environment in which excellence in care will flourish, and ensure that patients have rapid access to a safe, high quality service by fully trained specialists. In order to achieve this objective there must be sufficient consultant urologists with access to an adequate numbers of beds and operating sessions, supported by appropriate numbers of properly trained nurses and theatre staff.

The NHS plan clearly intends that patients should be seen and treated promptly. It has an emphasis on fairness, equity of access, and high quality. It also highlights the potential for the use of staff other than consultants for the delivery of healthcare. This includes the use of nurses and other health-care professionals and an emphasis on team working.

Many factors impact on Urologists and Urological Departments and thus influence the direction of change and the planning of Urological Services. We have tried to identify and evaluate significant drivers of change, and in so doing we have considered a number of different models of service provision.

Team Working

Every Department of Urology should be organised so as to take account of the recommendations contained in the document 'Team Working in Surgical Practice' (4). In particular, newly appointed consultants should be appointed to work within a clearly specified team with more experienced consultants, who can act as mentors to provide support and advice.

The Multidisciplinary Team

A modern Urological team requires the support of consultant staff from several other disciplines. The requirements for multidisciplinary team working, not only in the delivery of cancer services but also in endourology and female urology, mean that these consultants in other specialities must have a declared subspecialty interest and devote a significant number of their fixed sessions to Urology. For a population of 500,000 the minimum number of whole time equivalent consultants recommended is:

2-3	Radiologists
2	Clinical (Radiation) Oncologists
1	Medical Oncologist
1	Palliative Care Specialist
2	Histopathologists

Because of the knowledge base and special skills required, the need for specialisation in these supporting services is essential.

Nurses

Recent years have seen the introduction of Specialist Urological Nurses or Urological Nurse Practitioners in clinical urology. The role has developed and expanded in such a way that these nurses are now essential to the running of any major Urological unit.

These Nurse Practitioners may be ward based, working as a team with House Officers and Registrars to provide the inpatient care and Pre-Admission Clinics.

They may also contribute to a range of outpatient services, either nurse led or nurse supported:

- Single visit haematuria clinics
- Prostate Assessment Clinics
- Andrology / Erectile Dysfunction Clinics.
- Continence Clinics
- Flexible Cystoscopy (5)

Urological Community Nurses have also developed a parallel role, taking many procedures into the patients' homes thus freeing up valuable clinic and day-case space:

- Intravesical chemotherapy
- Urethral and Suprapubic catheter change
- Domiciliary pre-admission assessment.

A whole time Oncology Nurse Specialist, trained in Urology, is an essential member of the Cancer MDT.

Nurse specialists play an important role in effective communication and co-ordination between the Urological clinical team, patients, relatives, other hospital departments and General Practitioners. They must have secretarial support and access to a computer for data collection and management.

Continence Services

Close links should be established between the Urology Department and the local Continence Service. The Department of Health Document 'Good Practice in Continence Services' (6) sets out a framework for the organisation of a nurse led service which should provide a seamless and comprehensive service for patients in secondary and primary care.

Trainees & Training

The duties of a consultant urologist include the training of junior medical staff at every level. The are special requirements for a department which undertakes higher surgical training of Specialist Registrars and these are set out in Appendix 1

Resources:

Beds

The number of inpatient beds required at the Hub will depend on the population to be served and the nature and degree of sub-specialisation within the Urological Team, which will determine the case mix. It will also depend on the adequacy and extent of the day case and short stay facilities provided. The minimum required would be 8 inpatient beds (with guaranteed access) per 100,000 population. In addition there should be some short stay or overnight beds, which can close at weekends.

It is essential that these beds are located in a clearly defined location (The Urology Ward or Department) appropriately equipped and staffed by nurses who can develop and practice the special skills required to care for Urological patients.

It is desirable that inpatient services for colo-rectal surgery, gynaecology, peripheral vascular surgery and renal medicine are located on the same site. This facilitates cross specialty collaboration in complex major surgery.

There must be guaranteed access to intensive care and high dependency beds on site.

Imaging

The Hub site must provide rapid access to good quality modern methods of imaging including:

- Spiral CT
- MRI
- Ultrasound (Abdominal and Transrectal)
- Nuclear Imaging
- Vascular Imaging
- Video-urodynamic screening
- Operating theatre based Image Intensifier Screening

The Spoke sites will require the ability to perform at least:

- Routine X-rays
- Intravenous Urography
- Ultrasound (Abdominal and Transrectal)

The value of good specialised ultrasound and radiological services cannot be overemphasised.

Day & Ambulatory Care

Day case activity varies considerably around the UK and is dependent upon the facilities available. At least 65% of urological procedures can and should be undertaken as either an outpatient or a day case. Adequate modern facilities are essential. Properly trained staff should work to agreed protocols for the appropriate selection of patients for procedures carried out under general or regional anaesthesia.

Outpatients

The traditional outpatient department should be replaced by a Diagnostic Unit, which may be shared with other surgical specialties. Where possible the facilities for the following services should be provided in one geographical location within the hub site:

Consultation
Flexible cystoscopy (including stent removal)
Abdominal Ultrasound
Transrectal Ultrasound
Catheter Change (Urethral & Suprapubic).
Single Stop Haematuria clinics.
Prostate Assessment
Prostate cancer diagnostic & follow up clinics
Urodynamics
Lithotripsy (Fixed or Mobile)
Nurse Counselling
Stoma Care
Admission office

The range of services at the spoke sites will be less comprehensive.

The objective should be to provide a seamless, single visit, diagnostic service to the patient thus eradicating unnecessary visits to the hospital and minimising the delay between referral, diagnosis and treatment. A single geographical site for all outpatient and day case events makes the best use of manpower and skills. It also encourages multi-skilling of Nurse Practitioners.

Equipment

Urologists, more than any other group of surgeons, rely on high quality, state of the art, endoscopic and imaging equipment in order to deliver the highest standards of care. It is beyond the scope of this document to list all the individual items of equipment required in a modern urological department. The items required will to some extent depend on the subspecialty services provided by the department, but every urological department must have a full range of rigid and flexible endoscopic equipment. Lightweight camera systems must be available for all endoscopic work and triple chip cameras for laparoscopic procedures. All equipment must be properly maintained and regularly replaced on a rolling programme. Patient and urologist will be subjected to unnecessary risk if the quality or quantity of equipment is inadequate.

All modern endoscopic equipment can be sterilised by autoclaving. This is now the method of choice as chemical sterilisation and pasteurisation are no longer acceptable. All departments must have a sufficient number of endoscopes to permit sterilisation in a CSSD and timely return to theatre to support operating lists.

Operating Theatres

Endoscopic surgery is highly specialised and the equipment is expensive and fragile. For this reason urological operating theatres must be staffed by individuals who have the special skills, training, and experience in the use and maintenance of urological equipment.

All inpatient surgery should be undertaken at the centre (Hub site). There should be 24-hour access to a fully staffed emergency operating theatre in accordance with the recommendations of the National Confidential Enquiry into Peri-Operative Death (NCEPOD).

Administration

Modern surgical practice requires high standards of communication between the Urologist, other health care professionals and above all patients and their relatives. The demands of Clinical Governance, staff and trainee appraisal, data collection, surgical audit and the need to demonstrate clinical effectiveness in national league tables increase daily.

The consultant urologist therefore requires high standards of administrative support and information technology:

- A personal office
- A personal PC
- A personal assistant / secretary
- Good IT support with specialty specific software for data collection and analysis
- Access to E Mail & Internet
- Trained staff to collect and enter data.
- Administrative support for MDT meetings
- A seminar room equipped with audio-visual and X-ray viewing for MDT, teaching and audit meetings

Conclusion

Service Provision is intimately related to and dependent on the staffing levels and patterns of work within each department. This document should therefore be read in conjunction with our previous complementary publication, 'A Quality Urological Service for Patients in the New Millennium; Guidelines on workload, manpower and standards of care' (1).

References

1. A Quality Urological Service for Patients in the New Millennium; Guidelines on workload, manpower and standards of care. British Association of Urological Surgeons (October 2000).

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3. Good Surgical Practice. Royal College of Surgeons of England (November 2000)

4. Team Working in Surgical Practice. Senate paper 7. The Senate of Surgery of Great Britain & Ireland (May 2000).

5. Nurse Cystoscopy. Report of a working party of the British Association of Urological Surgeons (2000).

6. Good Practice in Continence Services. NHS Executive (April 2000)

Appendix 1

Higher Surgical Training in Urology

Trainees entering Urological training programmes do so with less experience than before. With the reduction in junior doctors' hours and consequent reduced exposure to patients, concerns have been expressed about the experience gained by trainees when they take up their first consultant post. To respond to this, urology is moving from time sensitive training to a system based on regular appraisal and assessment of competence and it is expected that most newly appointed consultants would undergo a period of mentorship.

Trainees gain experience in core urology in the first 3-4 years and take the FRCS Urol. after four years of training. Since single training posts cannot offer a complete training, rotation between posts in other urological departments is arranged by the Programme Director. During years 5 & 6 trainees need exposure in one or two areas in greater depth, allowing them to deliver more complex urological care in areas of andrology, endourology, stones, female urology, neuro-urology, oncology, paediatric, reconstruction and renal transplantation. Transfer between training schemes may be necessary for this more advanced training.

The SAC in Urology regularly inspects training posts. The trainee's time table usually involves three sessions in theatre and two sessions in outpatients to include haematuria clinics, urodynamics, transrectal ultrasound scanning etc., one session for administration, x-ray meetings, pathology meetings, a session for personal research and a session for the formal regional teaching programme. The programme for this is structured to cover the whole curriculum over a period of 2-3 years.

The unit should have a dedicated ward and it is unlikely that a satisfactory training unit would function with less than 12 beds at a minimum with additional day stay bed facilities. Trainees need dedicated office space and 24 hour access to computer databases and core urology texts and journals. They should be exposed to emergency urology, but should not be expected to cover two inpatient urological sites when on-call. Trainers need to provide good supervision with time available in both theatre and outpatients for training. They should see their trainees at regular monthly intervals for appraisal, to make necessary changes in their programme according to their training requirements.

Working Party Members

Mr F James Bramble - Chairman
Professor David Neal
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Urology Service

Benchmarking of Current Service (v0.1)

The guidance relating to the implementation plan for the urology review included a requirement to benchmark the current urology service. The following pages provide some benchmarking information.

Regional Benchmarking

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland for:

- New to review ratios;
- Day Case rates;
- Average length of stay for elective and non elective procedures.

New : Review Ratio
1/04/06 - 28/02/10

	2006/07	2007/08	2008/09	2009/10
All Trusts	1.96	2.03	1.79	1.68

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	1.63	2.09	1.77	1.72
Northern Trust	1.97	1.67	1.31	1.75
South Eastern Trust	1.15	1.1	1.15	1.25
Southern Trust	4.04	3.27	3.28	2.09
Western Trust	2.65	2.32	2.49	1.73

Note – the review backlog will have skewed the figures for 2009/10 (perhaps for all Trusts)

Note: The national new to review ratio is 1:2.1. It is accepted that there will be some variation due to case mix/complexity. The plan should explain the actions to deal with those teams who are an outlier from this level, and to achieve a performance in the upper quartile, at 1:1.5

Day Case Rates by Trust
April 06 - Feb 10
(Excludes Prim Op M45 and Not coded procedures) (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

		2006/07	2007/08	2008/09	2009/10
All Trusts	Day Cases	3793	3733	4255	3492
	Elective Admissions	3780	3963	4293	3710
	DCs+ElecAdm	7,573	7,696	8,548	7,202
	Daycase Rate	**50.1**	**48.5**	**49.8**	**48.5**

		2006/07	2007/08	2008/09	2009/10
Belfast Trust	Daycases	1737	1584	1896	1615
	Elective Admissions	1938	2092	2015	1873
	Total	**3,675**	**3,676**	**3,911**	**3,488**
	DC Rates	47.3	43.1	48.5	46.3
Northern Trust	Daycases	211	209	241	372
	Elective Admissions	465	430	582	448
	Total	**676**	**639**	**823**	**820**
	DC Rates	31.2	32.7	29.3	45.4
South Eastern Trust	Daycases	930	912	940	751
	Elective Admissions	257	325	369	328
	Total	**1,187**	**1,237**	**1,309**	**1,079**
	DC Rates	78.3	73.7	71.8	69.6
Southern Trust	Daycases	579	576	770	433
	Elective Admissions	742	691	807	650
	Total	**1,321**	**1,267**	**1,577**	**1,083**
	DC Rates	43.8	45.5	48.8	40.0
	CHKS Rates	72%	72.2%	74.3%	74.8%
Western Trust	Daycases	336	452	408	321
	Elective Admissions	378	425	520	411
	Total	**714**	**877**	**928**	**732**
	DC Rates	47.1	51.5	44.0	43.9

Urology - Average LOS (Episode based)

April 06 - Feb 10

Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	3.7	3.5	3.4	2.9

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	3.9	3.5	3.5	3.3
Northern Trust	2.3	2.9	2.4	1.9
South Eastern Trust	3.8	4.0	3.4	3.2
Southern Trust	3.7	4.3	3.9	2.7
Western Trust	3.6	2.9	3.2	2.9

Non Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	4.8	4.7	4.6	4.4

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	5.5	4.9	5.4	5.0
Northern Trust	4.3	5.4	4.9	3.7
South Eastern Trust	3.9	4.4	3.5	3.8
Southern Trust	4.5	4.8	4.6	4.7
Western Trust	3.9	3.8	4.1	3.4

Average Length of Spell

Healthcare Resource Groups (HRG) are a method of grouping inpatient and daycase episodes. Data items recorded on the Patient Administration System are used to allocate episodes to a particular HRG. The data items include:

- Primary and secondary procedures
- Primary, subsidiary and secondary diagnoses
- Age
- Sex
- Method of discharge (to indicate whether the patient was dead on discharge)
- Length of stay (duration of Finished Consultant Episode)

HRGs are used to produce casemix information which can be used for costing and comparative purposes. Chapter L relates to urinary tract and the male reproductive system.

The table below compares the Southern HSC Trust's average length of spell with the Northern Ireland peer group for the period 1st January 2009 – 31st December 2009.

Peer Group Comparison for Length of Spell
Peer Group is taken from CHKS Peer for January 2009 - December 2009

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

Note – 'Non OR' indicates a procedure which is so minor that it does not affect the resources used within the episode.

British Association of Day Surgery (BADS)

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The table overleaf compares the Trust's performance with the BADS targets for urology. The following notes apply:

- Trust activity for 2009/10 has been used (from Business Objects). At 2nd June 2010 175 elective finished consultant episodes (FCEs) and 182 day cases were not coded;
- Elective FCEs and day cases have been included (no non elective activity);
- Only activity undertaken by the 3 consultant urologists has been included in the analysis;
- The numbers of day cases and FCEs are given in the column on the right. The numbers of FCEs with a zero length of stay are also noted as these could potentially have been recorded as day cases.

British Association of Day Surgery (BADS) Basket of Procedures for Urology

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
1	Ureteroscopic extraction of calulus of ureter	M27.1, M27.2, M27.3	50	50		0%	53%		0 DCs, 41 FCEs. **8 FCEs had 0 LOS**
2	Endoscopic insertion of prosthesis into ureter	M29.2, M29.5	90	10		0%	38%		0 DCs, 8 FCEs. **1 FCE had 0 LOS**
3	Removal of prosthesis from ureter	M29.3	100			38%			6 DCs, 10 FCEs. **4 FCEs had 0 LOS**
4	Endoscopic retrograde pyelography	M30.1	90	10		5%	84%		1 DC, 18 FCEs. **10 FCEs had 0 LOS**
5	Other endoscopic procedures on ureter	M27, M28, M29.1,M29.4, M29.8, M29.9	90	10		13%	46%		11 DCs, 73 FCEs. **16 FCEs had 0 LOS**
6	Cystostomy and insertion of suprapubic tube into bladder	M38.2	90	10		0%	10%		0 DCs, 10 FCEs.
7	Endoscopic resection/ destruction of lesion of bladder	M42	20	50	30	3%	32%	23%	2 DCs, 63 FCEs. **6 FCEs had 0 LOS**
8	Endoscopic extraction of calculus of bladder	M44.1, M44.2	50	50		0%	10%		0 DCs, 10 FCEs. **1 FCE had 0 LOS**
9	Diagnostic endoscopic examination of bladder (inc any biopsy)	M45	90	10		87%	8%		775 DCs, 114 FCEs. **26 FCEs had 0 LOS**
10	Operations to manage female incontinence	M53.3, M53.6, M53.8	80	10	10	0%	0%	100%	1 FCE
11	Dilation of outlet of female bladder	M58.2		90	10	100%			1 Daycase
12	Endoscopic incision of outlet of male bladder	M66.2	50	50		14%	71%		1 DC, 6 FCEs. **1 FCE had 0 LOS**
13	Endoscopic examination of urethra +/- biopsy	M77		100		100%			6 DCs
14	Endoscopic resection of prostate (TUR)	M65.1,M65.2, M65.3, M65.8	15	45	40	0%	0%	20%	0 DCs, 111 FCEs.

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
15	Resection of prostate by laser	M65.4, M65.3+Y08.3, M65.3+Y08.4	90	10		0%	33%		3 FCEs
16	Prostate destruction by other means	M67.1,M67.2, M67.5, M67.6	90	10					None recorded
17	Operations on urethral orifice	M81	90	10		33%	50%		2 DCs, 4 FCEs. **2 FCEs had 0 LOS**
18	Orchidectomy	N05, N06.1, N06.2, N06.3, N06.8, N06.9	90	10		44%	56%		4 DCs, 5 FCEs. **2 FCEs had 0 LOS**
19	Excision of lesion of testis	N06.4, N07	90	10					None recorded
20	Orchidopexy - bilateral	N08	60	35	5				None recorded
21	Orchidopexy	N09	75	20	5	60%	40%		3 DCs, 2 FCEs. **1 FCE had 0 LOS**
22	Correction of hydrocoele	N11	90	10		80%	10%		8 DCs, 2 FCEs.
23	Excision of epididymal lesion	N15	90	10		90%	0%		9 DCs, 1 FCE.
24	Operation (s) on varicocoele	N19	90	10		60%	40%		6 DCs, 4 FCEs. **3 FCE had 0 LOS**
25	Excision of lesion of penis	N27	50	50		100%			1 DC
26	Frenuloplasty of penis	N28.4	90	10		100%			5 DCs
27	Operations on foreskin - circumcision, division of adhesions	N30	90	10		71%	14%		36 DCs, 15 FCEs. **6 FCE had 0 LOS**
28	Optical urethrotomy	M76.3	90	10		7%	56%		2 DCs, 25 FCE.

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
29	Laparoscopic nephrectomy	M02.1,M02.5, M02.8,M02.9 (+Y75.2)	5	75	25	0%	11%	0%	9 FCEs
30	Laparoscopic pyeloplasty	M05.1+Y75.2	10	80	10				None recorded
31	Laparoscopic radical prostatectomy	M61.1,M61.2, M61.9 (+Y75.2)		5	90		0%	0%	1 FCE

Corrigan, Martina

From: Personal Information redacted by USI

Sent: 26 May 2009 04:52

To: Personal Information redacted by USI; Young, Michael; Personal Information redacted by USI; Personal Information redacted by USI; Personal Information redacted by USI

Subject: Response of Department of Urology

Attachments: Response of Department of Urology.doc

<META HTTP-EQUIV="Content-Type" CONTENT="text/html; charset=iso-8859-1"> Dear all,

 I have attached my response. I do hope that you approve of it. See you at noon

 Aidan
 <hr style="margin-top:10px"/>Click here to get the very best of AOL, including news, sport, gossip, lifestyles updates and email.

Response of Department of Urology
To
Trust's Proposals for Ward Reconfiguration

The members of the Department of Urology in attendance at the meeting of the Clinical Forum of Tuesday 12 May 2009 were invited to consider the Trust's initial proposals for Ward Reconfiguration in conjunction with the discussions which took place at that meeting, with a view to returning to the next meeting of the Clinical Forum on Tuesday 26 May 2009 with their own reflections and/or proposals for the way forward.

Those members have met with others on two occasions since then. Arising from those meetings, this paper attempts to encapsulate our understanding of the challenges faced by the Trust in the future delivery of surgical services in general, in additional to the challenges faced by the Trust and our Department in implementation of the recommendations of the Regional Review of Urology Services in Northern Ireland. It seeks to articulate core values and principles which we believe should be safeguarded in meeting those challenges. It details proposals which we believe are constructive and essential if the challenges are to be met with success. Lastly, they are proposals to which all members of our Department would be wholly committed, in partnership with the Trust, in ensuring that success.

Challenge facing the Trust

It is our understanding that the Trust is presented with the need to deliver surgical services during the current financial year with a reduced budget. It is also our understanding that it is anticipated that the Trust will be required to deliver surgical services during coming years with possibly more stringent budgetary conditions.

We also understand that the Trust is required to comply with the Elective Reform Program (ERP), Developing Better Services (DBS), and the Integrated Elective Access Protocol (IEAP). We appreciate that the Trust is required to implement the measures recommended by the Scheduled Care Reform Program (SCRP), including

- Preoperative assessment, to facilitate
- Admission on day of surgery, and
- Increased day surgery rates, and
- Reduction of cancelled operations
- Maximising use and productivity of theatres

We appreciate that the Trust will be expected to benchmark their performance in these areas.

Lastly, it is our understanding that Trust management have concluded that introduction and implementation of these measures would enable the Trust to comply with HSC expectations and to remain within imposed budgetary constraints, while

continuing to provide quality elective and non-elective surgical services with such capacity as to meet demand.

Regional Review of Urology Services in Northern Ireland

A regional review of Urology Services in Northern Ireland was established in September 2008 and reported in March 2009. The stated purpose was to '*develop a modern, fit for purpose in 21st century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal Colleges, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'*

The report of the review presented a modernisation and invested plan. It presented 26 recommendations to be implemented by all Trusts and Departments of Urology in Northern Ireland. Fundamental to all is the recommendation that all Urological services in Northern Ireland should be reconfigured into a 3 Team model (known as Team North, Team East and Team South), to achieve long term stability and viability. Each Team is to have '*main, acute, elective and non-elective, inpatient unit'*.

Team South is to provide Urological services to the southern third of the current Western Trust area (County Fermanagh, population circa 61,000), in addition to all of the current population of the Southern Trust area (342,754): an increase of approx. 20%. Team South will require 5 Consultant Urologists and will have its main, acute, elective and non-elective, inpatient unit at Craigavon Area Hospital. Day surgery will be conducted at Craigavon Area, Daisy Hill, South Tyrone Hospitals. Outpatient clinics will be conducted at Craigavon Area, Daisy Hill, South Tyrone and Armagh Community Hospitals as well as Banbridge Polyclinic, as at present. In addition, it is recommended that Team South may wish to consider the provision of outreach clinics and/or day case diagnostics at the Erne Hospital, Enniskillen.

Therefore, the Review has established that its purpose requires the reconfiguration of Urological Service provision in Northern Ireland by three Teams, and that each Team requires a Urology Unit in its main, acute hospital.

Non-elective Urological Services

There are approx. 2,500 non-elective urological admissions per annum in Northern Ireland (Report 3.18). There are only two Urology Units (at Belfast City and Craigavon Area Hospitals) to which acute admissions are admitted directly or subsequently transferred, if required (Report 3.22). Team North should also have a *'main acute unit'* for non-elective admissions (Report 9.6). The Report's Recommendations 7 and 8 state that Urologists *'should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit…and for those requiring direct transfer and admission to an acute Urology Unit'*. With specific relevance to Team South, Recommendation 9 states that *'Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under*

General Surgery in hospitals without Urology Units (e.g., Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit, and provision of Urology advice/care by telephone, electronically or in person, also 7 days a week'.

Therefore, the Review has emphasised the need for each Team to have a Urology Unit to which acute urological admissions can be admitted directly or transferred, and from which the care of those admitted elsewhere can be advised, monitored, supervised. Moreover, with the implementation of Development of Better Services (DBS) in future years, increasing proportions of acute urological admissions will be admitted directly to Urology Units.

Reducing Length of Stay (LOS)

The Review's recommendations 13 and 14 states that *'Trusts should implement the key elements of the elective reform program… and should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients…with a view to agreeing a target length of stay for these groups of patients'.*

In doing so, the Review acknowledged that some hospitals would expect to have longer than average LOS if they undertake more complex operations, treat patients with greater comorbidity and patients with higher levels of social deprivation (Report 5.14).

The Review also stated that ERP will require Urology Services to be creative in the development of day an short stay surgery, *'ensuring the provision of a safe model of care that provides a quality service to patients'* (Report 5.22).

Therefore, the Review requires a benchmarked reduction in Length of Stay whilst ensuring a safe, quality service to patients.

Day Surgery

The Review noted the implications of the Audit Commission recommendations for day surgical rates across a number of surgical specialties, and the more specific recommendations of the British Association of Day Surgery (BADS) for day surgical rates for 31 urological procedures (Report 5.19). Review recommendation 15 states that *'Trusts will be required to include in their implementation plans, an action plan for increasing th percentage of elective operations undertaken as day surgery…'.*

Importantly, the Review states that Trusts will need to *'consider procedures currently undertaken using theatre / day surgery facilities, and the appropriateness of transferring this work to procedure / treatment rooms, thereby freeing up valuable theatre space to accommodate increased day surgery'* (Report 5.23).

Therefore, the Review wholly requires Trusts and Urology Teams to maximise day surgery rates and to be creative in that endeavour.

Values and Principles

With all of the relentless challenges that we all have to face and for which we will be held accountable, whether collectively or individually, whether manager, doctor or nurse, we believe that it is critically important to reflect upon and to redefine our *raison d'etre.* In the context of considering ward reconfiguration, *we are a hospital.*

Several of the component activities of an integrated Urology Service detailed in the Review Report (some, such as ICATS, not referred to above) need not be conducted in a hospital at all, though for several reasons, we believe that it is preferable. However, the one component that can only be conducted in a hospital is the care of those so ill, or requiring management so significant, as to require inpatient care.

We believe that urological inpatient care can only best be provided by doctors and nurses fully trained, qualified, competent and experienced in urological inpatient care. This belief is wholly and unreservedly supported by the British Associations of Urological Surgeons and Nurses, in recent publications and communications.

Therefore, we believe that it is self-evident that the only manner in which such urological inpatient care can possibly be provided is in a distinct, dedicated, inpatient Urology Unit.

The provision of such a Urology Unit is compliant with the Recommendations of the Regional Review.

We believe that it is equally self evident that all urological inpatients should be managed in the Urology Unit, whether elective or non-elective, and irrespective of their length of stay.

We believe that elective, urological, day surgery should be provided in adequately resourced units which do not compromise the ability to maximise inpatient care.

Lastly, we assert that it is incumbent upon all to have robust evidence to support any claim that any different model proposed for urological inpatient care provides for a quality of care and clinical outcomes superior to that above.

Proposals

1. The Trust should firstly explore the possibility of moving all elective flexible cystoscopies out of day surgical theatres and into outpatient procedure rooms. This would be particularly worthwhile at CAH, moving flexible cystoscopies from DSU to the Thorndale Unit. This alone would free up six theatre sessions per month for elective day surgical procedures. Similar possibilities should be explored at STH and DHH.
2. The Trust should maximise the provision of adequately resourced, elective, day surgical facilities at all sites, so as to minimise the inappropriate use of inpatient beds for day surgery.
3. With reservations, we commit to trying the elective admissions ward for elective day cases who cannot be accommodated elsewhere. They will be admitted to that ward, and will return to it following surgery, and be discharged from there.
4. With greater concerns regarding continuity of care, we commit to having elective, short stay patients admitted on the day of surgery to that elective admissions ward, but only on condition that they return postoperatively to the Urology Unit.
5. All longer stay, elective admissions will be admitted to the Urology Unit, and remain there until discharge.
6. All non-elective admissions will be admitted directly to, or transferred to, the Urology Unit.
7. The Urology Unit will be singular and distinct. Any compromise of its integrity would disable implementation of the Regional Review.

Corrigan, Martina

From: Nelson, Amie
Sent: 11 March 2014 09:29
To: Corrigan, Martina
Subject: Integrated Elective Access Protocol Revised 30apr08 (2)
Attachments: Integrated Elective Access Protocol Revised 30apr08 (2).doc

Here you go!

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

INTEGRATED ELECTIVE ACCESS PROTOCOL
30th April 2008

DOCUMENT CONTROL INTEGRATED ELECTIVE ACCESS PROTOCOL			
Authors	Michelle Irvine – Programme Director, Elective Workstream Maria Wright – Associate Director, Outpatients Rosemary Hulatt – Associate Director, Diagnostics		
Issue Date **1st Draft**	Wednesday 20th February 2008		
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Issue Date	Friday 9th May 2008		
Screened By	Service Delivery Unit, DHSSPSNI		
Approved By		**Signature**	
Distribution	Trust Chief Executives; Directors of Planning and Performance; Directors of Acute Care; DHSSPS		
Review Date	April 2009		

CONTENTS

ABBREVIATIONS

AHP	Allied Health Professional
BCC	Booking and Contact Centre (ICATS)
CNA	Could Not Attend (Admission or Appointment)
DHSSPSNI	Department of Health, Social Services and Public Safety
DNA	Did Not Attend (Admission or Appointment)
DTLs	Diagnostic Targeting Lists
ERMS	Electronic Referrals Management System
GP	General Practitioner
HIC	High Impact Changes
HROs	Hospital Registration Offices
ICATS	Integrated Clinical Assessment and Treatment Services
ICU	Intensive Care Unit
LOS	Length of Stay
PAS	Patient Administration System
PTLs	Primary Targeting Lists
SDU	Service Delivery Unit
TCI	To Come In (date for patients)

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.

1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' polices and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.1.5 This protocol will be available to all staff via Trusts' Intranet.

1.1.6 The DHSSPSNI has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.1.7 There is an imperative to identify capacity constraints that could threaten the delivery of these key access targets and speed up the planning and delivery of extra capacity, where it is needed, to address these constraints. The health community will need to develop a co-ordinated approach to capacity planning taking into account local capacity on a cross Trust basis and independent sector capacity on an on-going partnership basis.

1.1.8 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.1.9 The intention is that this protocol will be further developed to consider all aspects of access to a range of quality healthcare at a date and time of the patients' choice.

1.1.10 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.1.11 Delivery of this protocol will require a step change in the way Trusts function. Trusts will need to transform themselves and this can only be achieved through a change in the way its staff approach their work on a day-to-day basis. Through this protocol, Trusts will aspire to work with patients and staff to raise expectations basing them not on where we are but on where we need to be.

1.1.12 For the purposes of this protocol, the term inpatient refers to inpatient and day case elective treatment. The term 'PAS' refers to all patient

administration systems, whether in a hospital or community setting, or an electronic or manual system.

1.1.13 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on PAS and the waiting times for treatment. All staff involved in the implementation of this protocol, clinical and clerical, will undertake initial training and regular annual updating. Trusts will provide appropriate information to staff so they can make informed decisions when implementing and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2 UNDERPINNING PRINCIPLES

1.2.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by specialty / procedure / service.

1.2.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.2.3 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient - they are fit, ready, and able to come in.

1.2.4 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures, not the norm. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving day case surgery to outpatient care, and outpatient care to primary care or alternative clinical models where appropriate.

1.2.5 Change No 1 within the publication "10 High Impact Changes for Service Improvement and Delivery"[1] focuses on day surgery and the document provides Trusts with tools and resources to help implement this high impact change.

1.2.6 Trusts will introduce booking systems aimed at making hospital appointments more convenient for patients. Booking systems are chronologically based and will move Trusts onto a system of management and monitoring that is chronologically as opposed to statistically based.

1.2.7 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority with immediate effect. The intention is to provide patients with certainty and choice enabling them to access services that are sensitive to their needs.

1.2.8 This will require changes in working practices. It will also require technological change to information systems to enable provision of quality information to support the booking process.

1.2.9 There is a need to balance the flow of patients from primary care through outpatients and on to booking schedules should they need elective admission. It follows that the level of activity in the Service and Budget Agreements and the level of provision of outpatient and inpatient capacity must be linked. If one changes, all should change.

1.2.10 This "bottom up" approach is based on the belief that services need to be built on firm clinical foundations. Trusts need a clinical vision built up specialty by specialty and department by department through debate and agreement between clinicians across the health community as to the best way to meet patient needs locally.

1.2.11 It is essential that patients who are considered vulnerable for whatever reason have their needs identified at the point of referral.

[1] "10 High Impact Changes for Service Improvement and Delivery" – September 2004, NHS Modernisation Agency, www.modern.nhs.uk/highimpactchanges

1.2.12 All relevant information must be recorded to ensure that when selecting a vulnerable patient for admission, their needs are identified early and appropriate arrangements made. This information should be recorded in detail in the episodic comment field of PAS relating to the listing. The patient master index comment field should not be used due to confidentiality issues.

1.2.13 Communication with this patient group will recognise their needs and, where appropriate, involve other agencies.

1.2.14 An operational process should be developed by Trusts to ensure that children and vulnerable adults who DNA or CNA their outpatient appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.2.15 In implementing this protocol the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.3 OWNERSHIP

1.3.1 Ownership is key to delivering quality of care. Trusts must ensure that all staff are conversant with the Departmental targets and standards and are comfortable with the local health communities' approach to their delivery.

1.3.2 These targets and standards must be seen to be core to the delivery of all aspects of care provision by all levels of staff within the Trust.

1.3.3 This is a major change agenda requiring significant commitment and investment at corporate and individual level. An Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.

1.3.4 Trusts must be committed to training and developing staff and providing the supporting systems to ensure that together we can bring about the improvement in patient care.

1.4 REGIONAL TARGETS

1.4.1 The targets in respect of elective treatments are:

- A maximum waiting time of 13 weeks for inpatient and daycase admissions by March 2009
- A maximum waiting time of 9 weeks for a 1st outpatient appointment by March 2009
- A maximum waiting time of 9 weeks for a diagnostic test by March 2009
- A maximum waiting time of 13 weeks from referral to treatment by an Allied Health Professional (AHP) by March 2009
- By March 2009, sustain the target where 98% of patients diagnosed with cancer should begin treatment within a maximum of 31 days of the diagnosis
- By March 2009, 95% of patients with suspected cancer who have been referred urgently should begin their first definitive treatment within a maximum of 62 days

1.5 DELIVERY OF TARGETS

1.5.1 The waiting time targets are based on the “worst case” i.e. they reflect the minimum standards with which every Trust must comply.

1.5.2 The expectation is that these targets are factored into plans at Trust Board, divisional, specialty and departmental levels as part of the normal business

and strategic planning processes. Divisional, specialty and departmental managers will be expected to have produced implementation plans setting out the key steps they need to take to ensure the delivery of the Trust and Departmental protocol objectives within the area(s) of their responsibility. Trusts will manage implementation through a regular review of "local" divisional, specialty and departmental plans for the implementation of waiting and booking targets.

1.5.3 It is expected that Trusts will develop robust information systems to support the delivery of these targets. Daily management information should be available at both managerial and operational level so that staff responsible for selecting patients are working from up to date and accurate information. Future developments should also look towards a clinic management system which will highlight the inefficiencies within the outpatient setting.

1.6 CAPACITY

1.6.1 It is important for Trusts to understand their baseline capacity, the make-up of the current cohort of patients waiting and the likely changes in demand that will impact on their ability to treat patients and meet the Departmental Targets.

1.6.2 To manage at specialty and departmental level it is anticipated that managers will have, as a minimum, an overview of their core capacity including:

- Number of clinic and theatre sessions
- Session length
- Average procedure / slot time
- Average length of stay

1.6.3 It is expected that similar information will be available at consultant level. For inpatients this is at procedure level, and for outpatients and diagnostics at service level.

1.6.4 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).

1.6.5 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and LOS targets and agreeing plans to deliver them. In addition, systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.

1.6.6 Theatre sessions should be seen as corporate resources and used flexibly to ensure the delivery of waiting list and waiting time targets across consultants within the same specialty and specialties within the same Trust. This ties in with the Real Capacity Paper which also requires commissioners to demonstrate that they have used capacity flexibly across Trusts. The expectation is that divisions and/ or specialties will be able to demonstrate that they have optimised the use of existing capacity to maximise the treatment of patients within existing resources.

1.6.7 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.

1.6.8 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners. The Real Capacity Planning exercise will support this process locally.

1.6.9 Divisions/specialties will monitor referrals and additions to lists in terms of their impact on clinic, theatre time, bed requirements and other key resources e.g. ICU facilities, to ensure a balance of patients in the system and a balance between patients and resources.

1.6.10 When the balance in the system is disturbed to the extent that capacity is a constraint, divisional/specialty managers will be expected to produce plans

to expedite solutions and agree these through the accountability review process.

1.6.11 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

1.6.12 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

1.6.13 In summary, the intention is to link capacity to the Service and Budget Agreement i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively. The existing arrangements whereby patients are added to waiting lists irrespective of whether Trusts have the capacity to treat them must change.

1.7 BOOKING PRINCIPLES

1.7.1 These booking principles have been developed to support all areas across the elective pathway where appointment systems are used.

1.7.2 Offering the patient choice of date and time is essential in agreeing and booking appointments with patients. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them. This takes away the uncertainty of not knowing how long the wait will be as patients are advised of their expected wait. Advanced booking in this way also gives patients notice of the date so that they can make any necessary arrangements, such as child care or work arrangements.

1.7.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.7.4 Booking development work within Trusts should be consistent with regional and local targets, which provide a framework for progress towards ensuring successful and consistent booking processes across the health community in Northern Ireland.

1.7.5 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff of the day to day requirements and escalation route, for example: management of patients who cancel / DNA their appointment, process for re-booking patients, and monitoring of clinical leave and absence.

1.7.6 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.7.7 The definition of a booked appointment is:

a) The patient is given the choice of when to attend.
b) The patient is advised of the total waiting time during the consultation between themselves and the healthcare provider / practitioner or in correspondence from them.
c) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment
d) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within 2 weeks if cancer is suspected.
e) The patient may choose to agree a date outside the range of dates offered or defer their decision until later

1.7.8 Booking Process

1.7.9 There are 3 main patient appointment types to be booked. Booking systems for these appointments should be designed around an agreed patient pathway and accepted clinical practice. They are:

a) New Urgent patients (including suspected cancer)
b) New Routine patients
c) Review patients

1.7.10 Clinic templates should be constructed to ensure that sufficient capacity is carved out to meet the local and maximum waiting time guarantees for new patients, and the clinical requirements of follow-up patients.

1.7.11 Principles for booking Cancer Pathway patients

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral
b) Dedicated registration functions for red flag and suspected cancer referrals should be in place within centralised HROs
c) Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients
d) Patients will be contacted by telephone twice (morning and afternoon)
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of 3 days of receipt of referral
f) Systems should be established to ensure the Patient Tracker / MDT Co-ordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient

1.7.12 Principles for booking Urgent Pathway patients

a) Local agreements should be in place with consultants to determine the timeframe within which urgent patients should be booked, and made explicit to booking teams

b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation
c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency
d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.7.13 Principles for booking Routine Pathway patients

a) Patients should be booked to ensure appointment within the maximum waiting time guarantees for routine appointments
b) Referrals will be received, registered within one working day at HRO's and forwarded to consultants for prioritisation
c) Patients will receive an acknowledgement from the Trust indicating their expected length of wait and information on the booking process they will follow
d) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified
e) Patients should be selected for booking in chronological order from the PTL
f) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment

1.7.14 Principles for Booking Review Patients

a) Patients who need to be reviewed within 6 weeks will agree their appointment before they leave the clinic

b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list
c) Patients will be added to the review waiting list with an indicative date of treatment and selected for booking according to this date
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment

1.7.15 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey. Examples of this include:

a) midwives contacting patients directly by telephone to arrange their appointment
b) clinical genetics services where family appointments are required
c) mental health or vulnerable children's services where patients may need additional reminders or more than one professional contacted if patients fail to make an appointment.

SECTION 2

GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

2.1 INTRODUCTION

2.1.1 The administration and management of ICATS referrals and ICATS requests for diagnostics must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.2 ICATS services are managed in accordance with the Data Definitions and Guidance Document for Monitoring of ICATS Services Sept 2007 **(Appendix 1).**

2.1.3 The level of functionality available on the Electronic Referral Management System to support the administration of patients in an ICATS setting is developmental. Achievement of the standards outlined will be where functionality permits.

2.1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto ERMS according to the date received by the Trust.

2.1.5 All new patients should be able to book their appointment in line with the guidance outlined in Booking Principles Section 1.7 The expectation is that follow up patients should also be offered an opportunity to choose the date and time of their appointment.

2.2 KEY PRINCIPLES

2.2.1 Where ICATS is in place for a specialty, all referrals should be registered and scanned onto Electronic Referral Management System (ERMS) within 24 hours of receipt.

2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed

rules, within three working days of receipt in any Hospital Registration Office (HRO). Triage rotas must take multi-site working into account. A designated officer in ICATS should oversee the triage arrangements.

2.2.3 The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).

2.2.4 ICATS clinical staff will be aware of all exclusions that prevent patients from being assessed or treated within the ICATS setting.

2.2.5 Patients of equal clinical priority will be selected for booking in chronological order in order to meet the maximum waiting time guarantee for patients and local access standards.

2.2.6 All patients deemed appropriate will be offered an ICATS appointment within six weeks from the triage date.

2.2.7 Data collection should be accurate, timely, complete and subject to regular audit and validation.

2.2.8 Staff should be supported by appropriate training programmes.

2.3 CALCULATION OF THE WAITING TIME

2.3.1 The waiting time clock for ICATS starts after the triage decision has been taken that an appointment in ICATS clinic is the appropriate next step.

2.3.2 The ICATS clock stops when the patient attends for first appointment or when the patient has been discharged from ICATS.

2.3.3 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the

verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

2.3.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

2.3.4 No patient should have his or her appointment cancelled. If the ICATS service cancels a patient's appointment, the patient's waiting time clock will not be reset and the patient should be offered another appointment, ideally at the time of the cancellation, and which is within six weeks of the original appointment date.

2.4 NEW REFERRALS

2.4.1 All ICATS referrals will be registered and scanned onto ERMS within 24 hours of receipt. All referrals forwarded for ICATS triage must be triaged or assessed to make a clear decision on the next step of a referral within three working days of the referral being logged by the HRO onto ERMS.

2.4.2 Within five working days of the referral being recorded onto ERMS, the GP and patient must be issued with written confirmation of the next stage of the patient's treatment.

2.4.3 Where there is insufficient information for the professional to make a decision, they have the option to either return the referral to the referrer requesting the necessary information or contact the referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the referrer requesting the necessary information and a new referral may be initiated.

2.4.4 Those patients identified for outpatients and diagnostic services following triage will be managed in line with the relevant sections of this IEAP.

Flowcharts illustrating the Triage Outcomes Process can be found in **Appendix 2.**

2.5 BOOKING

2.5.1 All patients requiring an appointment in an ICATS will have the opportunity to agree the date and time of their appointment, in line with the booking principles outlined in Section 1.7.

2.5.2 If a patient requests an appointment beyond the six week ICATS standard the patient will be discharged and told to revisit their GP when they are ready to be seen at the ICATS clinic. This will ensure that all patients waiting for an ICATS appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate recalculation of the patient's waiting time and to facilitate booking the patient into the date they requested.

2.5.3 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

2.6 REASONABLE OFFERS

2.6.1 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the second appointment date declined.

2.6.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

2.6.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date the service was notified of the cancellation, as the patient has entered into an agreement with the Trust.

2.6.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

2.7 MANAGEMENT OF PATIENTS WHO CANCELLED OR DID NOT ATTEND (DNA) THEIR APPOINTMENT

2.7.1 If a patient DNAs their first ICATS appointment the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

2.7.2 If a patient cancels their outpatient appointment the following process must be implemented:

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

2.7.3 If a patient has been referred back to their referring clinician and the referrer still wishes a patient to be seen in ICATS, a new referral is required.

2.7.4 The Implementation Procedure for the Management of Patients who DNA or Cancel can be found in **Appendix 4.**

2.8 MAXIMUM WAITING TIME GUARANTEE

2.8.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen. This will ensure that all patients waiting for an appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

2.9.1 It is essential that leave/absence of ICATS practitioners is organised in line with Trusts' notification of leave protocol. It is also necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.

2.9.2 The protocol should require a minimum of six weeks' notification of intended leave. A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

2.10 CLINIC OUTCOME MANAGEMENT

2.10.1 There are a number of locations within Trusts where patients present for their ICATS consultation. This protocol applies to all ICATS locations. It is the responsibility of the ERMS user managing the attendance to maintain data quality.

2.10.2 Changes in the patient's details must be updated on ERMS and the medical records on the date of clinic.

2.10.3 When the assessment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on ERMS.

2.11 REVIEW APPOINTMENTS

2.11.1 All review appointments must be made within the time frame specified by the ICATS practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the ICATS practitioner.

2.11.2 As previously stated, the Booking Centres will be responsible for partially booking all new appointments. Booking Centres will also book review appointments that are required to be more than 6 weeks in the future. ICATS administration staff will make bookings directly with the patient at the clinic for any further appointments needing to occur within 6 weeks.

2.12 TEMPLATE CHANGES

2.12.1 Templates should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

2.12.2 Templates will identify the number of slots available for new and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated to each appointment slot.

2.12.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.

2.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for management of Clinic Template Changes can be found in **Appendix 5.**

2.13 VALIDATION

2.13.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.

2.13.2 The data validation process will apply to both new and follow up appointments. The Implementation Procedure for data validation can be found in **Appendix 6.**

SECTION 3

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

3.1 INTRODUCTION

3.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of outpatient services.

3.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

3.1.3 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto the Electronic Referrals Management System (ERMS) and PAS.

3.1.4 There will be dedicated booking functions within Trusts and all new and review outpatients should have the opportunity to book their appointment. The booking process for non-routine groups of outpatients or those with additional service needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.2 CALCULATION OF THE WAITING TIME

3.2.1 The starting point for the waiting time of an outpatient new referral is the date the clinician's referral letter is received by Trusts. All referral letters, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received into the organisation.

3.2.2 In cases where referrals bypass the dedicated HRO's, (e.g. sent directly to a consultant), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the HRO and registered at the date on the date stamp.

3.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who

refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

3.2.3 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

3.3 KEY PRINCIPLES

3.3.1 Referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference. As a minimum, all un-named referrals should be pooled.

3.3.2 All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine. Templates should be constructed to ensure enough capacity is available to treat each stream within agreed maximum waiting time guarantees. The Implementation Procedure for Template Redesign can be found in **Appendix 7.**

3.3.3 The regional target for a maximum OP waiting time is outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

3.3.4 Maximum waiting times for urgent patients should be agreed locally with clinicians, and made explicit to staff booking these patients to ensure that they are appointed within the clinical timeframe indicated by the consultant and capacity issues quickly identified and escalated.

3.3.5 Patients of equal clinical priority will be selected for booking in strict chronological order. Trusts must ensure that Department waiting and booking targets and standards are met.

3.3.6 Data collection should be accurate, timely, complete and subject to regular audit and validation.

3.3.7 Trusts should provide training programmes for staff which include all aspects of this IEAP and its Implementation Procedures. It is expected that training will be cascaded at and by each clinical, managerial or administrative tier within Trusts, providing the opportunity where required, for staff to work through operational scenarios.

3.3.8 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

3.4 NEW REFERRALS

3.4.1 All outpatient referrals sent to Trusts will be received at the dedicated HRO's and registered within one working day of receipt. GP priority status must be recorded at registration.

3.4.2 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and which are not returned can be identified.

3.4.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

3.4.5 All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records

manager or departmental manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.

3.4.7 Inappropriate and inadequate referrals should be returned to the referral source. A minimum referral criteria dataset has been agreed and is outlined in **Appendix 8**

3.4.8 An Effective Use of Resources Policy is in place for some services and Trusts should ensure that this is adhered to. The policy is included for reference in **Appendix 9.**

3.5 URGENT AND ROUTINE APPOINTMENTS

3.5.1 All consultant led outpatient appointments where the patient attends the Trust should be booked. The key requirements are that the patient is directly involved in negotiating the appointment date and time, and that no appointment is made more than six weeks into the future.

3.5.2 All routine patients must be booked within the maximum waiting time guarantee. Urgent patients must be booked within the maximum wait agreed locally with clinicians, from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

3.5.3 Acknowledgment letters will be sent to routine patients within five days of receipt of the referral. The estimated length of wait, along with information on

how the patient will be booked, should be included on the acknowledgement letter.

3.5.4 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients refusing short notice appointments (i.e. less than three weeks' notice) will not have their waiting time reset, in line with guidance on reasonable offers.

3.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

3.6 BOOKING

3.6.1 All new and review consultant led outpatient clinics should be able to book their appointment. This will entail patients having an opportunity to contact the hospital and agree a convenient date and time for their appointment. The use of the Patient Choice field on PAS is mandatory. The only fields that should be used are 'Y' to indicate that the appointment has been booked or 'N' to indicate that an appointment has not been booked. No other available field should be used as compliance with booking requirements will be monitored via the use of the Patient Choice field. For non-ISOFT and manual administration systems, Trusts should ensure that they are able to record and report patients who have been booked.

3.7 REASONABLE OFFERS

3.7.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.7.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

3.7.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.

3.7.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

3.8 MANAGEMENT OF PATIENTS WHO CANCELLED (CNA) OR DID NOT ATTEND (DNA) THEIR APPOINTMENT

3.8.1 If a patient DNAs their outpatient appointment, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

3.8.2 There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to partial booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

3.8.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

3.8.4 If a patient cancels their outpatient appointment the following process must be implemented:

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

3.8.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

3.8.6 The Implementation Procedure on DNAs and Cancellations can be found in **Appendix 4.**

3.9 MAXIMUM WAITING TIME GUARANTEE

3.9.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen in the Outpatient Clinic. This will ensure that all patients waiting for an outpatient appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

3.10 COMPLIANCE WITH LEAVE PROTOCOL

3.10.1 Capacity lost due to cancelled or reduced clinics at short notice has negative consequences for patients and on the Trust's ability to successfully

implement booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

3.10.2 It is essential that planned medical and other clinical leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments. There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

3.10.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies.

3.10.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit. The Implementation Procedure for Compliance with Leave Protocol can be found in **Appendix 10.**

3.11 CLINIC OUTCOME MANAGEMENT

3.11.1 There are a number of locations within Trusts where patients present for their outpatient consultation. This protocol applies to all outpatient areas. It is the responsibility of the PAS user managing the attendance to maintain data quality.

3.11.2 All patients will have their attendance registered on PAS upon arrival in the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS and the medical records.

3.11.3 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

3.11.4 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic. The implementation procedure for the Management of Clinic Outcomes can be found in **Appendix 11.**

3.12 REVIEW APPOINTMENTS

3.12.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative month of treatment and take the necessary action to ensure capacity is available for this cohort.

3.12.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the department and PAS updated. Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the indicative appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

3.13 CLINIC TEMPLATE CHANGES

3.13.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement and ensure that there is sufficient capacity allocated to enable each appointment type to be booked in line with clinical requirements and maximum waiting time guarantees for patients.

3.13.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

3.13.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.

3.13.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for the management of Clinic Template Changes can be found in **Appendix 5.**

3.14 VALIDATION

3.14.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times. The Implementation Guidance for Data Validation can be found in **Appendix 6.**

3.14.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

3.14.3 For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their appointment.

3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

3.15.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

3.15.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Outpatient Transfers can be found in **Appendix 15a.**

SECTION 4

PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

4.1 INTRODUCTION

4.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of diagnostic waiting lists. Where possible, the principles of good practice outlined in the Outpatient and Elective Admissions Section of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

4.1.2 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.

4.1.3 There will be a centralised registration process within Trusts to receive, register and process all diagnostic referrals. It is expected that this will be in a single location, where possible.

4.1.4 The Trust should work towards introducing choice of the date and time of tests to all patients. The Booking Principles outlined in Section 1 of this document should be considered in the development of this strategy.

4.2 CALCULATION OF THE WAITING TIME

4.2.1 The starting point for the waiting time of a request for a diagnostic test is the date the clinician's request is received into the department, in line with the guidance on Completing Diagnostic Waiting Times Collection (Definitions Document), September 2007. This can be found in **Appendix 14.** All referral letters and requests, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received.

4.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the service was informed of the cancellation.

4.2.3 Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.2.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

4.3 KEY PRINCIPLES

4.3.1 Trusts must have in place arrangements for pooling all referrals unless there is specific clinical information which determines that the patient should be seen by a particular consultant with sub-specialty interest.

4.3.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list, and patients managed in 2 streams, i.e. urgent and routine. Session or clinic templates should be constructed to ensure enough capacity is available to treat each stream within the maximum waiting time guarantees outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

4.3.3 Data collection should be accurate, timely, complete and subject to regular audit and validation.

4.3.4 Staff should be supported by appropriate training programmes.

4.3.5 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there may be services which require alternative processes.

4.4 NEW DIAGNOSTIC REQUESTS

4.4.1 All diagnostic requests sent to Trusts will be received at a single location within the specialty Department. Trusts should explore the setting of one centralised diagnostic registration centre.

4.4.2 All requests will be registered on PAS / relevant IT system within one working day of receipt. Only authorised staff will have the ability to add, change or remove information in the outpatient module of PAS or other diagnostic system.

4.4.3 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system and that letters sent for prioritisation and not returned can be identified. Trusts should consider the introduction of clinical tracking systems similar to that used in patient chart tracking.

4.4.4 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for requests to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

4.4.5 All requests will be prioritised and returned to the central registration point within 3 working days. It will be the responsibility of the health records manager or departmental manager to monitor this performance indicator. Monitoring on a consultant level will take place by consultant on a monthly basis. Following prioritisation, requests must be actioned on PAS / IT system and appropriate correspondence issued to patients within 1 working day.

4.4.6 Where clinics take place, or requests can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby the GP's priority is accepted in order to proceed with booking urgent patients.

4.4.7 Inappropriate and inadequate requests should be returned to the referral source. Minimum referral criteria is being developed to ensure the referral process is robust.

4.5 URGENT AND ROUTINE APPOINTMENTS

4.5.1 All requests must be booked within the maximum waiting time guarantee. The key requirement is that the patient is directly involved in negotiating the date and time of the appointment and that no appointment is made more than six weeks in advance.

4.5.2 Urgent requests must be booked within locally agreed maximum waits from the date of receipt. It is recognised that there will be exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

4.5.3 All routine patients must be booked within the maximum waiting time guarantee. Acknowledgement letters will be issued to routine patients within 5 working days of receipt of request. The estimated wait, along with information on how the patients will be booked should be included on the acknowledgement letter.

4.5.4 A minimum of three weeks notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients who refuse short notice appointments (i.e. less than three weeks notice) will not have their waiting time reset in line with guidance on reasonable offers.

4.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

4.6 CHRONOLOGICAL MANAGEMENT

4.6.1 Patients of equal clinical priority will be selected for appointment in chronological order and Trusts must ensure that regional standards and targets in relation to waiting times and booking requirements are met. The process of selecting patients for diagnostic investigations is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources.

4.6.2 It is expected that Trusts will use two prioritisation categories; urgent and routine.

4.7 BOOKING METHODS

4.7.1 Booking will enable patients to have an opportunity to contact the service and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

4.8 REASONABLE OFFERS

4.8.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

4.8.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.

4.8.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

4.9 PATIENT CANCELLATIONS (CNAS) AND DID NOT ATTENDS (DNAS)

4.9.1 If a patient DNAs their diagnostic test, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

4.9.2 There may be instances for follow-up patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

4.9.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

4.9.4 If a patient cancels their appointment, the following process must be implemented.

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

4.9.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

4.10 TRANSFERS BETWEEN HOSPITALS

4.10.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals. Transfers should not be a feature of an effective scheduled system.

4.10.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly.

4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

4.11.1 One of the major issues regarding the operation of healthcare services is the capacity lost due to cancelled or reduced clinics at short notice. This has negative consequences for patients and on the ability to successfully implement booking requirements. Clinic or session cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

4.11.2 It is therefore essential that leave/absence is organised in line with the Trust's Human Resources leave protocol. It is necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of diagnostic sessions and the work associated with the rebooking of appointments. Where cancelling and rebooking is unavoidable the procedures used must be equitable and comply with clinical governance principles.

4.11.3 The local absence/leave protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed policies.

4.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

4.12 SESSION OUTCOME MANAGEMENT

4.12.1 There are a number of locations within Trusts where patients present for their diagnostic tests. This protocol applies to all diagnostic services. It is the responsibility of the PAS / relevant system user administrating the clinic to maintain data quality.

4.12.2 All patients will have their attendance registered on PAS / IT system upon arrival at the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS / IT system and the medical record.

4.12.3 Changes in the patient's details must be updated on PAS / IT system and the medical record on the date of clinic.

4.12.4 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

4.13.1 DIAGNOSTIC TEST OUTCOME

4.13.1 The outcome of the diagnostic test must be available to the referrer without undue delay. A standard for the reporting turnaround time of tests will be introduced during 2008 and Trusts will be expected to monitor and report compliance to the standard.

4.14 FOLLOW UP APPOINTMENTS

4.14.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

4.14.2 Where follow up appointments are not booked, patients who require a review within six weeks will negotiate the date and time of this appointment before leaving the department and PAS / IT system updated. Patients requiring an appointment outside six weeks will have their appointment managed through a 'hold and treat' system. They will be managed on a review waiting list, with an indicative date of treatment and sent a letter confirming their appointment date six weeks in advance.

4.15 TEMPLATE CHANGES

4.15.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

4.15.2 Templates will identify the number of slots available for new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

4.15.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for session template changes.

4.15.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

4.16 VALIDATION

4.16.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times.

4.16.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

4.16.3 For patients in specialties which still issue fixed appointments, they will be contacted to establish whether they require their appointment.

4.16.4 Until follow-up and planned appointments are booked, the validation process will apply to follow up appointments.

4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

4.17.1 Trusts should ensure that the relevant standards in the Elective Admissions section of this document are adhered to.

4.18 PLANNED PATIENTS

4.18.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.

4.18.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

4.18.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.19 HOSPITAL INITIATED CANCELLATIONS

4.19.1 No patent should have his or her admission cancelled. If Trusts cancel a patient's admission, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity, which should must be within the maximum waiting time guarantee.

4.19.2 Trusts should aim to have processes in place to have the new proposed admission date arranged before that patient is informed of the cancellation.

4.19.3 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

4.19.4 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

4.19.5 Where patients are cancelled on the day of a test as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.

4.19.6 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of hospital initiated reasons, i.e. equipment failure, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

4.20.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.

4.20.2 Where different clinicians are working together will perform more than one test at one time the patient should be added to the waiting list of the clinician for the priority test with additional clinicians noted, subject to local protocols.

4.20.3 Where a patient requires more than one test carried out on separate occasions by different (or the same) clinician, the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

4.20.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

SECTION 5

GUIDANCE FOR MANAGEMENT OF ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 Allied Health Professionals work with all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors. This guidance provides an administrative framework to support the management of patients waiting for AHP services.

5.1.2 Although it is written primarily for services provided in Trusts, it is recognised that there are a number of AHPs who provide services for children with physical and learning disabilities within special schools and with special educational needs within mainstream schools. Operational practices in these settings should be in line with the principles of the IEAP and provide consistency and equity for patients. Trusts should collaborate with colleagues within the Department of Education and the relevant schools to harmonise practices and ensure that children are able to access services equitably and within the maximum waiting time guarantees. A robust monitoring process will be required.

5.1.3 For the purposes of this section of the protocol, the generic term ‘clinic’ will be used to reflect AHP activity undertaken in hospital, community or domiciliary settings as it is recognised that AHPs provide patient care in a variety of care locations.

5.2 KEY PRINCIPLES

5.2.1 Trusts should ensure that there is a systematic approach to modernising AHP services which will help to improve access to services and quality of care for patients. This section should be read within the overall context of both the IEAP and the specific section governing the management of hospital outpatient services.

5.2.2 When looking at the experience of the patient it is important to consider the whole of their journey, with both the care and administrative pathways designed to support the patient's needs at each stage. The wait to receive outpatient therapy is likely to be one of many they experience in different parts of the system. It is the responsibility of all those involved to ensure that the patient wastes as little time as possible waiting and is seen by the right person as quickly as possible.

5.2.3 Booking will enable patients to have an opportunity to contact the hospital and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

5.3 CALCULATION OF THE WAITING TIME

5.3.1 The waiting time clock for an AHP referral commences on the date the referral letter is received by the AHP service within the Trust. All referral letters, including faxed, emailed and electronically received referrals, will be date stamped on the date received.

5.3.2 The waiting time clock stops when the first definitive AHP treatment has commenced or when a decision is made that treatment is not required. Further information on definitions and sample patient pathways is contained in the Data Definitions and Guidance Document for AHP Waiting Times and can be found in **Appendix 12.**

5.3.3 As booking systems are introduced, patients should be made a reasonable offer, where clinically possible. Patients who refuse a reasonable offer of treatment, or fail to attend an AHP appointment, will have their waiting time clock re-set to the date the service was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs).

5.4 NEW REFERRALS

5.4.1 All AHP referrals will be registered on the relevant information system within 1 working day of receipt.

5.4.2 Trusts should work towards a system whereby all AHP referrals sent to the Trust are received at a dedicated registration function (s). Trusts should ensure that adequate systems are in place to deal with multiple referrals for the same patient regarding the same condition from a number of sources.

5.4.3 All referrals must be triaged or assessed to make a clear decision on the next step of a referral and clinical urgency (urgent or routine) clearly identified and recorded. All referrals will be prioritised and returned to the registration point with 3 working days.

5.4.4 Trusts must ensure that protocols are in place to prevent unnecessary delay from date stamping / logging of referrals to forwarding to the AHP department responsible for referral triage and/or initiation of treatment. It will be the responsibility of the relevant manager to monitor this performance indicator.

5.4.5 A robust system should be in place to ensure that cover is provided for referrals to be read and prioritised during practitioners' absence. A designated officer should oversee this and a protocol will be required for each service.

5.4.6 Where referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with AHPs whereby the referrer's prioritisation is accepted in order to proceed with booking patients.

5.4.7 Following prioritisation, referrals must be updated on the relevant information system and appropriate correspondence issued to patients within 1 working day. Where there is insufficient information for the AHP to make a decision, they should contact the originating referrer in the first instance to access the

necessary information. If this cannot be gained, the referral should be returned to the referral source.

5.4.8 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and letters which are not returned can be identified.

5.4.9 If at the referral stage the patient / client is identified as being clinically or socially unfit to receive the necessary service the referral should not be accepted (not added to a waiting list) and returned to the originating referrer with a request that they re-refer the patient / client when they are clinically or socially fit to be treated.

5.5 URGENT AND ROUTINE APPOINTMENTS

5.5.1 All routine patients should be appointed within the maximum waiting time guarantee. Urgent patients must be booked within locally agreed maximum waits from the date of receipt. Local booking process should be based upon the principles outlined in Section 1.7.

5.5.2 For routine waiting list patients, an acknowledgement letter will be sent to patients within 5 working days of receipt of the referral, which should provide information to patients on their anticipated length of wait and details of the booking process.

5.5.3 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered an earlier appointment. Patients refusing short notice appointments (i.e. less than three weeks notice) will not have their waiting time clock reset, in line with guidance on reasonable offers.

5.5.4 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

5.6 CHRONOLOGICAL MANAGEMENT

5.6.1 Patients, within each clinical priority category, should be selected for booking in chronological order, i.e. based on the date the referral was received. Trusts should ensure that local administrative systems have the capability and functionality to effectively operate a referral management and booking system that is chronologically based.

5.7 CAPACITY PLANNING AND ESCALATION

5.7.1 It is important for AHP services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

5.7.2 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

5.8 REASONABLE OFFERS

5.8.1 As booking systems are introduced, patients should be offered reasonable notice, where clinically possible. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure a verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

5.8.3 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of cancellation as the patient has entered into an agreement with the Trust.

5.8.3 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

5.9 AHP SERVICE INITIATED CANCELLATIONS

5.9.1 No patent should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable appointment date, ideally at the time of cancellation, and no more than 6 weeks in advance. The Trust must ensure that the new appointment date is within the maximum waiting time guarantee.

5.9.2 The patient should be informed of the reason for the cancellation and the date of the new appointment. This should include an explanation and an apology on behalf of the Trust.

5.9.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

5.9.4 AHP service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of AHP service initiated reasons, i.e. equipment failure, staff sickness, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.10 MAXIMUM WAITING TIME GUARANTEE

5.10.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their referrer when they are ready to be seen. This will ensure that all patients waiting for an AHP appointment / treatment are fit and ready to be seen.

5.10.2 There will undoubtedly be occasions and instances where local discretion is required and sensitivity should be applied when short periods of time are involved; for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

5.11 COMPLIANCE WITH LEAVE PROTOCOL

5.11.1 Capacity lost due to cancelled or reduced clinics or visits at short notice has negative consequences for patients and on the Trust's ability to successfully implement robust booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

5.11.2 It is therefore essential that AHP practitioners and other clinical planned leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of AHP clinics and the work associated with rebooking patient appointments. There should be clear practitioner agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient and comply with clinical governance principles.

5.11.3 The protocol should require a minimum of six weeks' notification of planned leave, in line with locally agreed HR policies.

5.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

5.12 CLINIC OUTCOME MANAGEMENT

5.12.1 All patients will have their attendance recorded or registered on the relevant information system upon arrival for their appointment. The patient must verify their demographic details on every visit. The verified information must be cross-checked on information system and the patient records. Any changes must be recorded and updated in the patient record on the date of the clinic.

5.12.2 When the assessment/treatment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.13 REVIEW APPOINTMENTS

5.13.1 All review appointments must be made within the time frame specified by the practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the practitioner. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the practitioner.

5.13.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the service and PAS / information system updated. Patients requiring an appointment outside six weeks should be managed on a review waiting list, with the indicative date recorded when appointment is required and booked in line with the booking principles outlined.

5.13.3 If domiciliary review appointment is required within 6 weeks, the appointment date should be agreed with the patient and confirmed in writing by the booking office. Where a domiciliary review appointment is required outside 6 weeks, the patient should be managed on a review waiting list, within the indicative date recorded, and booking in line with the booking principles outlined.

5.14 CLINIC TEMPLATE MANAGEMENT

5.14.1 Clinic templates should be agreed between the practitioner and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

5.14.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

5.14.3 All requests for template and temporary clinic rule changes will only be accepted in writing to the relevant service manager. A minimum of six weeks notice will be provided for clinic template changes.

5.14.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.15 ROBUSTNESS OF DATA / VALIDATION

5.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure Primary Targeting Lists are accurate and robust at all times.

5.15.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

5.15.3 For patients in AHP services that are not yet booked, they will be contacted to establish whether they will still require their appointment.

SECTION 6 PROTOCOL GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

6.1 INTRODUCTION

6.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of elective waiting lists.

6.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

6.2 COMPUTER SYSTEMS

6.2.1 To ensure consistency and the standardisation of reporting with Commissioners and the Department, all waiting lists are to be maintained in the PAS system.

6.2.2 Details of patients must be entered on to the computer system within two working days of the decision to admit being made. Failure to do this will lead to incorrect assessment of waiting list size when the daily / weekly downloads are taken.

6.2.3 As a minimum 3 digit OPCS codes should be included when adding a patient to a waiting list. Trusts should work towards expanding this to 4 digit codes.

6.3 CALCULATION OF THE WAITING TIME

6.3.1 The starting point for the waiting time of an inpatient is the date the consultant agrees with the patient that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is medically fit to undergo such a procedure.

6.3.2 The waiting time for each inpatient on the elective admission list is calculated as the time period between the original decision to admit date and the date

at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

6.3.3 Patients who refuse a reasonable offer of treatment, or fail to attend an offer of admission, will have their waiting time reset to the date the hospital was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs). Any periods of suspension are subtracted from the patients overall waiting time.

6.4 STRUCTURE OF WAITING LISTS

6.4.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided into a limited number of smaller lists, differentiating between active waiting lists, planned lists and suspended patients.

6.4.2 Priorities must be identified for each patient on the active waiting list, allocated according to urgency of the treatment. The current priorities are urgent and routine.

6.5 INPATIENT AND DAY CASE ACTIVE WAITING LISTS

6.5.1 Inpatient care should be the exception in the majority of elective procedures. Trusts should move away from initially asking “is this patient suitable for day case treatment?” towards a default position where they ask “what is the justification for admitting this patient?” The Trust’s systems, processes and physical space should be redesigned and organized on this basis.

6.5.2 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in.

6.5.3 All decisions to admit will be recorded on PAS within two working days of the decision to admit being taken.

6.5.4 Robust booking and scheduling systems will be developed to support patients having a say in the date and time of their admission. Further guidance will be provided on this.

6.5.5 Where a decision to admit depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure the result of the investigation is timely and in accordance with the clinical urgency required to admit the patient.

6.5.6 The statements above apply to all decisions to admit, irrespective of the decision route, i.e. direct access patients or decisions to directly list patients without outpatient consultation.

6.6 COMPLIANCE WITH TRUST HR LEAVE PROTOCOL

6.6.1 Trusts should have in place a robust protocol for the notification and management of medical and clinical leave and other absence. This protocol should include a proforma for completion by or on behalf of the consultant with a clear process for notifying the theatre scheduler of leave / absence.

6.6.2 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed consultant's contracts.

6.6.3 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

6.7 TO COME IN (TCI) OFFERS OF TREATMENT

6.7.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner and confirmed in writing.

6.7.2 Patients should be made reasonable offers to come in on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

6.7.3 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of admission, irrespective of provider, that gives the patient a minimum of three weeks' notice and two TCI dates. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the refused admission.

6.7.4 If the patient is offered an admission within a shorter notice period and it is refused, the waiting time cannot be recalculated.

6.7.5 If the patient however accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of that admission as the patient has entered into an agreement with the Trust.

6.7.6 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

6.8 SUSPENDED PATIENTS

6.8.1 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for social or

medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc).

- A maximum period not exceeding 3 months.

6.8.2 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or social reasons. These patients should be suspended from the active waiting list until they are ready for admission. All patients who require a period of suspension will have a personal treatment plan agreed by the consultant with relevant healthcare professionals. One month prior to the end of the suspension period, these plans should be reviewed and actions taken to review patients where required.

6.8.3 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.

6.8.4 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.

6.8.5 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.

6.8.6 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for surgery.

6.8.7 No patient should be suspended from the waiting list without a review date. All review dates must be 1st of the month to allow sufficient time for the patient to be treated in-month to avoid breaching waiting times targets.

6.8.8 No more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

6.8.9 Trusts should ensure that due regard is given to the guidance on reasonableness in their management of suspended patients.

6.9 PLANNED PATIENTS

6.9.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria (e.g. check cystoscopy).

6.9.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

6.9.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

6.9.4 Ideally, children should be kept under outpatient review and only listed when they reach an age when they are ready for surgery. However, where a child has been added to a list with explicit clinical instructions that they cannot have surgery until they reach the optimum age, this patient can be classed as planned. The Implementation Procedure for Planned Patients can be found in **Appendix 13.**

6.10 CANCELLATIONS AND DNA'S

6.10.1 Patient Initiated Cancellations

Patients who cancel a reasonable offer will be given a second opportunity to book an admission, which should be within six weeks of the original admission date. If a second admission offer is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

6.10.2 Patients who DNA

If a patient DNAs their first admission date, the following process must be implemented:

- Where a patient has had an opportunity to agree the date and time of their admission, they will not normally be offered a second admission date.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second admission. The second admission date must be agreed with the patient.

6.10.3 In a period of transition where fixed TCIs are still being issued, patients should have two opportunities to attend.

6.10.4 Following discharge patients will be added to the waiting list at the written request of the referring GP and within a four week period from date of discharge. Patients should be added to the waiting list at the date of the written request is received.

6.10.5 It is acknowledged that there may be exceptional circumstances for those patients identified as being ‘at risk’ (children, vulnerable adults).

6.10.6 No patient should have his or her operation cancelled prior to admission. If Trusts cancel a patient’s admission/operation in advance of the anticipated TCI date, the waiting time clock (based on the original date to admit) will not be reset and the patient will be offered an alternative reasonable guaranteed future date within a maximum of 28 days.

6.10.7 Trusts should aim to have processes in place to have the new proposed admission date arranged before the patient is informed of the cancellation.

6.10.8 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

6.10.9 Trusts will make best efforts to ensure that a patient's operation is not cancelled a second time for non clinical reasons.

6.10.10 Where patients are cancelled on the day of surgery as a result of not being fit for surgery / high anaesthetic risk, they will be suspended, pending a clinical review of their condition either by the consultant in outpatients or by their GP. The patient should be fully informed of this process.

6.10.11 Hospital-initiated cancellations will be recorded and reported to the relevant department on a monthly basis.

6.11 PERSONAL TREATMENT PLAN

6.11.1 A personal treatment plan must be put in place when a confirmed TCI date has been cancelled by the hospital, a patient has been suspended or is simply a potential breach. The plan should:

- Be agreed with the patient
- Be recorded in the patient's notes
- Be monitored by the appropriate person responsible for ensuring that the treatment plan is delivered.

6.11.2 The listing clinician will be responsible for implementing the personal treatment plan.

6.12 CHRONOLOGICAL MANAGEMENT

6.12.1 The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources of theatre time and staffed beds.

6.12.2 The Booking Principles outlined in Section 1.7 should underpin the development of booking systems to ensure a system of management and monitoring that is chronologically as opposed to statistically based.

6.12.3 It is expected that Trusts will work towards reducing the number of prioritisation categories to urgent and routine.

6.13 PRE-OPERATIVE ASSESSMENT

6.13.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-operative assessment. This can be provided using a variety of methods including telephone, postal or face to face assessment. Please refer to the Design and Deliver Guide 2007 for further reference.

6.13.2 Pre operative assessment will include an anaesthetic assessment. It will be the responsibility of the pre-operative assessment team, in accordance with protocols developed by surgeons and anaesthetists, to authorise fitness for surgery.

6.13.3 If a patient is unfit for their operation, their date will be cancelled and decision taken as to the appropriate next action.

6.13.4 Only those patients that are deemed fit for surgery may be offered a firm TCI date.

6.13.5 Pre-operative services should be supported by a robust booking system.

6.14 PATIENTS WHO DNA THEIR PRE OPERATIVE ASSESSMENT

6.14.1 Please refer to the guidance outlined in the Outpatient section.

6.15 VALIDATION OF WAITING LISTS

6.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis, and ideally on a weekly basis as waiting times reduce. This is essential to ensure the efficiency of the elective pathway at all times.

6.15.2 As booking processes are implemented and waiting times reduce, there will no longer be the need to validate patients by letter. For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their admission.

6.15.3 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

6.16 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

6.16.1 Where the same clinician is performing more than one procedure at one time, the first procedure should be added to the waiting list with additional procedures noted.

6.16.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

6.16.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

6.17 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

6.17.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

6.17.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Inpatient Transfers can be found in **Appendix 15b.**

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 18 October 2012 11:25
To: Lappin, Lynn; Reid, Trudy
Cc: Leeman, Lesley; Trouton, Heather
Subject: cutting plans for Urology
Attachments: Copy of 20120524_AcuteServicesPTL_CuttingPlan_urology_outs October 2012.xlsx; Copy of 20120524_AcuteServicesPTL_CuttingPlan_urology_INs October 2012.xlsx; Copy of 20120524_AcuteServicesPTL_CuttingPlan_urology_days October 2012.xlsx; Copy of 20120524_AcuteServicesPTL_CuttingPlan_urology_flexisOctober 2012.xlsx

Dear all

Attached my cutting plans for Urology.

Outpatients

As with ENT the outpatients is an estimate on last year's referrals in. We are taking on Fermanagh Population on 1 January so don't know the impact on this as yet, however I will be able to put some additionality if required into the system to meet this demand as the three new consultants are all willing at the moment to do additional sessions. So no risk with Consultant outpatients.

ICATS

As the ICATS activity is included in the consultant activity we continue to put additionality into the system to do these clinics and again as the new consultants are willing to do additionality we have only a minimal risk of not meeting 9 weeks in March for both ICATS and Consultant.

Inpatients

I have taken what is currently on the PTL and added in red flag estimates and urgency estimates and I have worked out where I will be at end of March for 21 weeks. With every all-day Saturday I think we will be ok for 21 weeks.

GA Daycases

I've used the same formula for GA daycases and again I hope that this will be ok to meet the 21 weeks

Flexis

Because we sent a lot out the IS this has brought our waiting times down for Flexis to 9 weeks. I have taken what is on the PTL, added on red flags, urgents and planned and I think we will remain at 9 weeks for end of March.

Again I hope the above and the attached are ok and if you require anything further, please give me a call on the mobile.

Thanks

Martina

GA Daycases

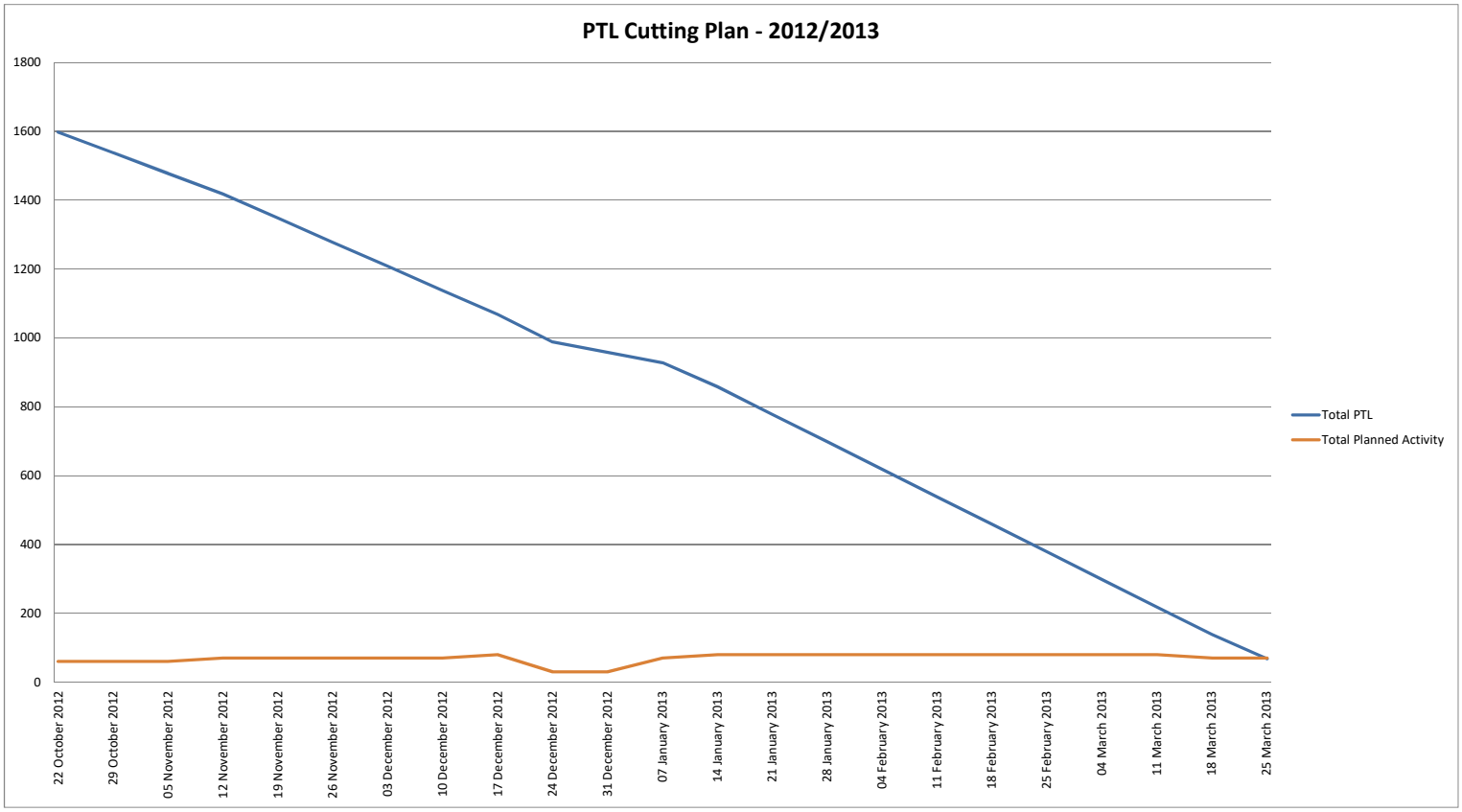
Southern Health and Social Care Trust

Quality Care - for you, with you

ACUTE SERVICES DIRECTORATE - PTL CUTTING PLAN 2012/2013

Specialty: Urology **Access Target: outpatients - 9 weeks**

HoS: Martina Corrigan



Week Commencing	Total PTL	Planned Core Activity	Planned Core Activity (Cummulative)	Planned IHA Activity	Planned IS Activity	Total Planned Activity	Comments / Management Actions
22 October 2012	1598	60		0		**60**	
29 October 2012	1538	60		0		**60**	
05 November 2012	1478	60		0		**60**	
12 November 2012	1418	60		10		**70**	
19 November 2012	1348	60		10		**70**	
26 November 2012	1278	60		10		**70**	
03 December 2012	1208	60		10		**70**	
10 December 2012	1138	60		10		**70**	
17 December 2012	1068	60		20		**80**	
24 December 2012	988	30		0		**30**	reduced because of New Year
31 December 2012	958	30		0		**30**	reduced because of Christmas
07 January 2013	928	60		10		**70**	
14 January 2013	858	60		20		**80**	
21 January 2013	778	60		20		**80**	
28 January 2013	698	60		20		**80**	
04 February 2013	618	60		20		**80**	
11 February 2013	538	60		20		**80**	
18 February 2013	458	60		20		**80**	
25 February 2013	378	60		20		**80**	
04 March 2013	298	60		20		**80**	
11 March 2013	218	60		20		**80**	
18 March 2013	138	50		20		**70**	reduced because of Bank holiday
25 March 2013	68	60		10		**70**	
	-2		**1310**	**290**	**0**		

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

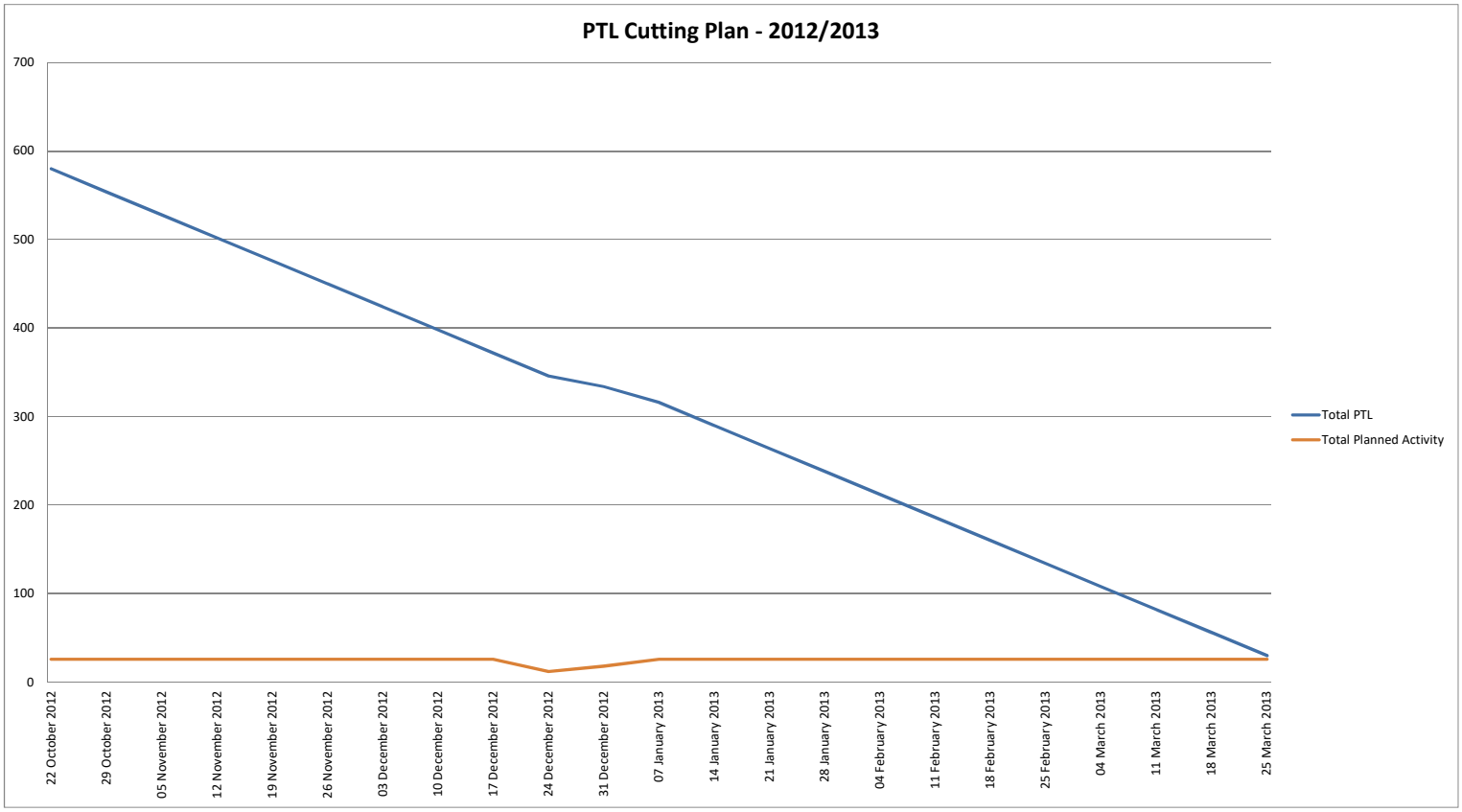
Southern Health and Social Care Trust

Quality Care - for you, with you

ACUTE SERVICES DIRECTORATE - PTL CUTTING PLAN 2012/2013

Specialty: Urology **Access Target: outpatients - 9 weeks**

HoS: Martina Corrigan



Week Commencing	Total PTL	Planned Core Activity	Planned Core Activity (Cummulative)	Planned IHA Activity	Planned IS Activity	Total Planned Activity	Comments / Management Actions
22 October 2012	580	20		6		**26**	
29 October 2012	554	20		6		**26**	
05 November 2012	528	20		6		**26**	
12 November 2012	502	20		6		**26**	
19 November 2012	476	20		6		**26**	
26 November 2012	450	20		6		**26**	
03 December 2012	424	20		6		**26**	
10 December 2012	398	20		6		**26**	
17 December 2012	372	20		6		**26**	
24 December 2012	346	6		6		**12**	reduced because of New Year
31 December 2012	334	12		6		**18**	reduced because of Christmas
07 January 2013	316	20		6		**26**	
14 January 2013	290	20		6		**26**	
21 January 2013	264	20		6		**26**	
28 January 2013	238	20		6		**26**	
04 February 2013	212	20		6		**26**	
11 February 2013	186	20		6		**26**	
18 February 2013	160	20		6		**26**	
25 February 2013	134	20		6		**26**	
04 March 2013	108	20		6		**26**	
11 March 2013	82	20		6		**26**	
18 March 2013	56	20		6		**26**	
25 March 2013	30	20		6		**26**	
	4		**438**	**138**	**0**		

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

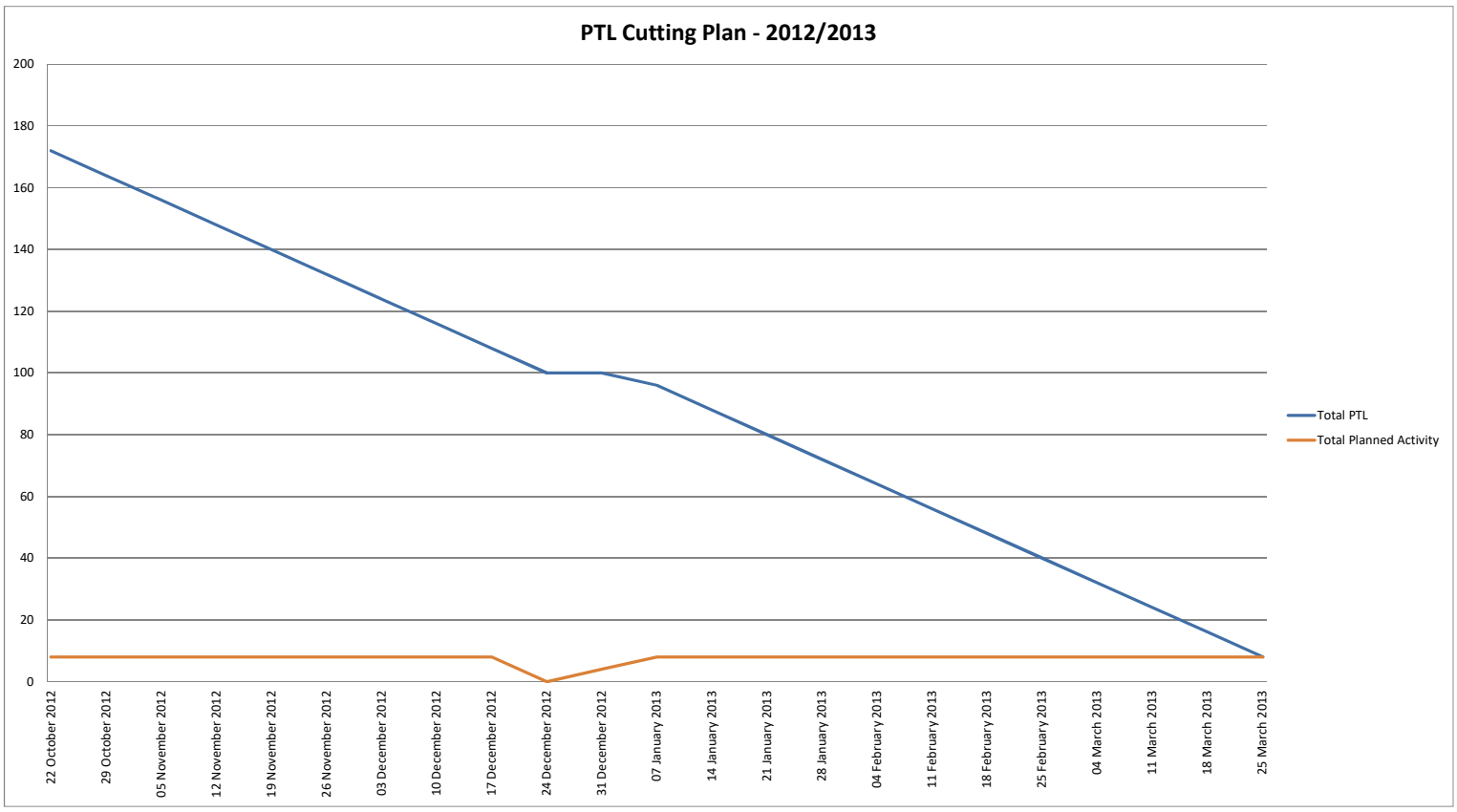
Southern Health and Social Care Trust

Quality Care - for you, with you

ACUTE SERVICES DIRECTORATE - PTL CUTTING PLAN 2012/2013

Specialty: Urology **Access Target: outpatients - 9 weeks**

HoS: Martina Corrigan



Week Commencing	Total PTL	Planned Core Activity	Planned Core Activity (Cummulative)	Planned IHA Activity	Planned IS Activity	Total Planned Activity	Comments / Management Actions
22 October 2012	172	8		0		**8**	
29 October 2012	164	8		0		**8**	
05 November 2012	156	8		0		**8**	
12 November 2012	148	8		0		**8**	
19 November 2012	140	8		0		**8**	
26 November 2012	132	8		0		**8**	
03 December 2012	124	8		0		**8**	
10 December 2012	116	8		0		**8**	
17 December 2012	108	8		0		**8**	
24 December 2012	100	0		0		**0**	reduced because of New Year
31 December 2012	100	4		0		**4**	reduced because of Christmas
07 January 2013	96	8		0		**8**	
14 January 2013	88	8		0		**8**	
21 January 2013	80	8		0		**8**	
28 January 2013	72	8		0		**8**	
04 February 2013	64	8		0		**8**	
11 February 2013	56	8		0		**8**	
18 February 2013	48	8		0		**8**	
25 February 2013	40	8		0		**8**	
04 March 2013	32	8		0		**8**	
11 March 2013	24	8		0		**8**	
18 March 2013	16	8		0		**8**	
25 March 2013	8	8		0		**8**	
	0		**172**	**0**	**0**		

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

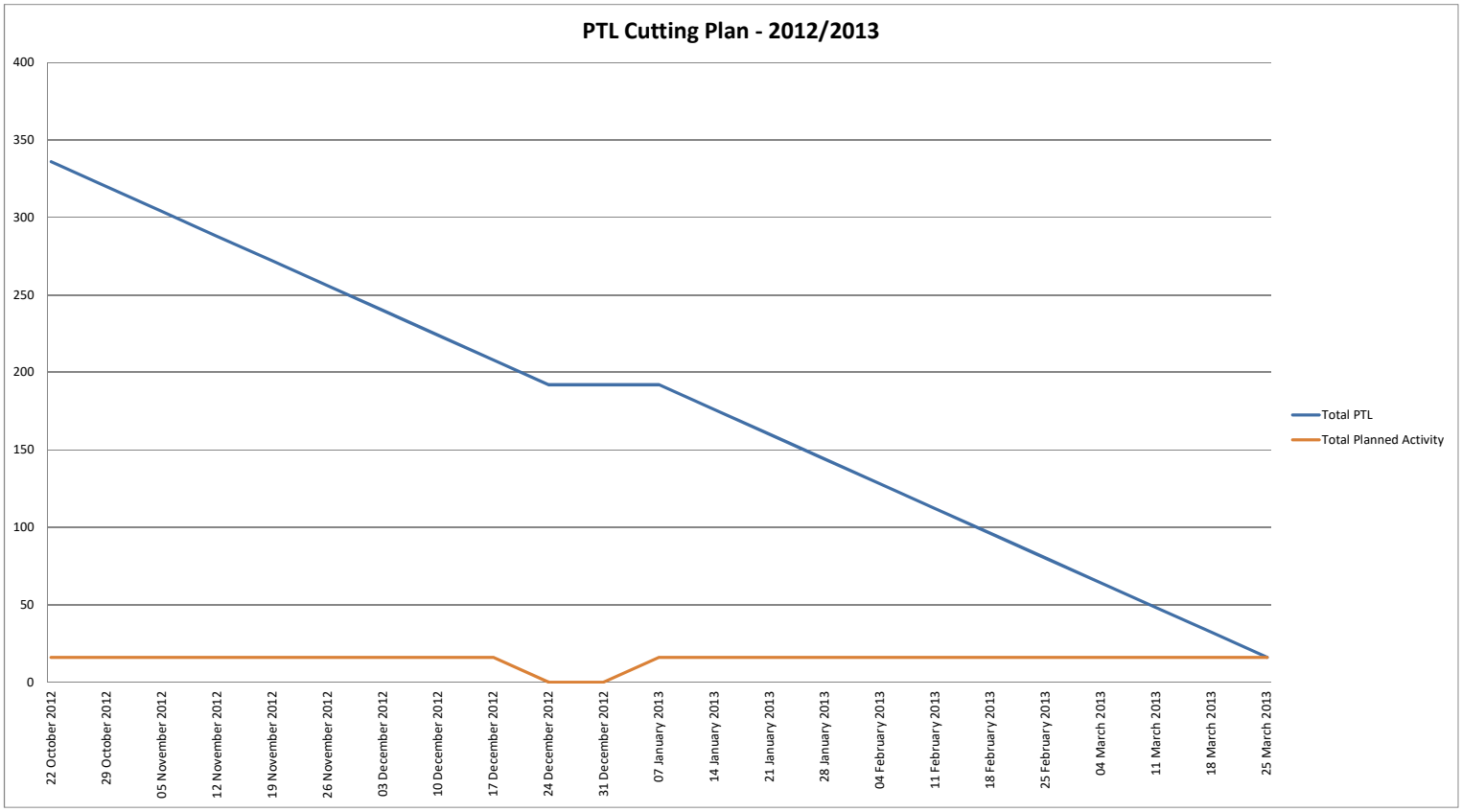
Southern Health and Social Care Trust

Quality Care - for you, with you

ACUTE SERVICES DIRECTORATE - PTL CUTTING PLAN 2012/2013

Specialty: Urology **Access Target: flexis- 9 weeks**

HoS: Martina Corrigan



Week Commencing	Total PTL	Planned Core Activity	Planned Core Activity (Cummulative)	Planned IHA Activity	Planned IS Activity	Total Planned Activity	Comments / Management Actions
22 October 2012	336	16		0		**16**	
29 October 2012	320	16		0		**16**	
05 November 2012	304	16		0		**16**	
12 November 2012	288	16		0		**16**	
19 November 2012	272	16		0		**16**	
26 November 2012	256	16		0		**16**	
03 December 2012	240	16		0		**16**	
10 December 2012	224	16		0		**16**	
17 December 2012	208	16		0		**16**	
24 December 2012	192	0		0		**0**	reduced because of New Year
31 December 2012	192	0		0		**0**	reduced because of Christmas
07 January 2013	192	16		0		**16**	
14 January 2013	176	16		0		**16**	
21 January 2013	160	16		0		**16**	
28 January 2013	144	16		0		**16**	
04 February 2013	128	16		0		**16**	
11 February 2013	112	16		0		**16**	
18 February 2013	96	16		0		**16**	
25 February 2013	80	16		0		**16**	
04 March 2013	64	16		0		**16**	
11 March 2013	48	16		0		**16**	
18 March 2013	32	16		0		**16**	
25 March 2013	16	16		0		**16**	
	0		**336**	**0**	**0**		

Corrigan, Martina

From: Irwin, Laura J [redacted]
Sent: 16 October 2012 15:48
To: Nelson, Amie; Corrigan, Martina; Devlin, Louise; Connolly, Connie; Henry, Gillian; Sharpe, Dorothy
Subject: FW: *for info* 20121010_PerformanceUpdate_Report_SMT_Final_LLappin.xlsx
Attachments: 20121010_PerformanceUpdate_Report_SMT_Final_LLappin.xlsx

Dear all,

For info.

Regards
Laura Jane obo Trudy

Laura-Jane Irwin
Personal Secretary To|Mrs Heather Trouton| Assistant Director of Surgery & Elective Care|Transforming Your Care|& Mrs Trudy Reid| Acting Assistant Director of Surgery & Elective Care|Operational| Acute Services | Admin Floor|Craigavon Area Hospital | Contact Number [redacted] | Fax Number [redacted]

From: Stinson, Emma M
Sent: 11 October 2012 16:24
To: McVey, Anne; Burke, Mary; Carroll, Ronan; Reid, Trudy
Cc: Ward, LauraAnne; Conlon, Noeleen; Graham, Michelle; Lappin, Aideen; Irwin, Laura J
Subject: *for info* 20121010_PerformanceUpdate_Report_SMT_Final_LLappin.xlsx

Dear all

Please find attached report submitted to SMT yesterday.

Thanks

Emma

Emma Stinson
PA to Dr Gillian Rankin
Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Tel: [redacted]
Fax: [redacted]

Email: [redacted]
P Please consider the environment before printing this email

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

Performance Update: SMT Report
SMT - 10 October 2012

Target Area	Target and Performance Update for August PTL / position at 28/9/12 (unless specified otherwise)	Longest Waiter (in-month) per PTL Report **	CP	IOP	Indicator		Trend
Acute Mental Health (Consultant-Led)	*From April 2012, no patient waits longer than 9 weeks to access adult mental health services:* 1 patient waiting 13-weeks - date in the past; 3 patients waiting 9 - 13-weeks - 2 dates in the past and 1 date in October.	13-weeks	*		🟡	A	⇔
Acute Paediatrics	*From April 2012, at least 50% of patients wait no longer than nine weeks for their first outpatient appointment with no one waiting longer than 21 weeks, increasing to 60% by March 2013 and no one waiting longer than 18 weeks:* Longest waiter booked - 10-weeks; not booked 9-weeks.	10-weeks	*		🟢	G	↑
AHPs	*From April 2012, no patient waits longer than 9 weeks from referral to commencement of AHP treatment:* 422 patients waiting in excess of 9-weeks. Dietetics - 7 patients waiting >9-weeks. Longest waiter 13-weeks for paediatrics and 9-weeks for adults; OT Paediatrics - 12 patients waiting >9-weeks. Longest waiter 13-weeks; OT OPPC - 83 patients waiting >9-weeks. Longest waiter 26-weeks; OT Learning Disability - 2 patients waiting >9-weeks. Longest waiter 10-weeks; OT Phys Dis - 44 patients waiting >9-weeks. Longest waiter 30-weeks; Orthoptics - 2 patients waiting >9-weeks. Longest waiter 10-weeks; Physio Adults - 105 patients waiting >9-weeks. Longest waiter 10-weeks; Physio Paediatrics - 11 patients >9-weeks. Longest waiter 10-weeks; Podiatry - 51 patients waiting >9-weeks. Longest waiter 9-weeks; SLT Adults - 11 patients waiting >9-weeks. Longest waiter 15-weeks; SLT Children - 6 patients waiting >9-weeks. Longest waiter 9-weeks.	30-weeks (Phys Dis OT)	*		🔴	R	↓

Target Area	Target and Performance Update for August PTL / position at 28/9/12 (unless specified otherwise)	Longest Waiter (in-month) per PTL Report **	CP	IOP	Indicator		Trend
	Action - Whilst a final position on the recurrent capacity gaps has not yet been achieved HSCB have given the Trust approval to move forward with IHA to maintain access standards. **Action - All Heads of Service to validate longest waiters in excess of 9-weeks and develop recovery plan to return to 9-weeks, where required.**						
Autism	*Not separately specified in the Commissioning Plan; Indicator of Performance or TDP (previous 13-week standard to be maintained):* 0 patients waiting more than 13 weeks. Holding 13 week standard to end September.	-			●	G	⇔
CAMHS	*From April 2012, no patient waits longer than 9-weeks to access child and adolescent services:* Holding 9-week standard.	-	*		●	G	⇔
Cancelled Operations	*Less than 2% of operations should be cancelled for non-clinical reasons:* **No update available yet** @ 31 August 2012 - 1.5% same as position at 31 July 2012	-		*	●	G	⇔
Community Mental Health (PMHC)	*From April 2012, no patient waits longer than 9 weeks to access adult mental health services:* Patients waiting in excess of 9-weeks - 286 (279 PMHC - Longest Waiter 18.5-weeks and 7 Addictions). **Action: IPT recruitment being progressed. A recovery plan is required to include the impact of recruitment within a realistic timescale along with the any other interim opportunities to increase capacity. Work ongoing with Performance Team to seek additional capacity through the utilisation of the Independent Sector.**	PMHC 18.5-weeks	*		●	R	⇔
Community Paediatrics	*From April 2012, at least 50% of patients wait no longer than nine weeks for their first outpatient appointment with no one waiting longer than 21 weeks, increasing to 60% by March 2013 and no one waiting longer than 18 weeks:* Holding 9-week standard.	9-weeks	*		●	G	⇔

Target Area	Target and Performance Update for August PTL / position at 28/9/12 (unless specified otherwise)	Longest Waiter (in-month) per PTL Report **	CP	IOP	Indicator		Trend
Delayed Discharges	*From April 2012, ensure 90% of complex discharges from an acute hospital take place within 48 hours; all non-complex discharges from an acute hospital take place within 6 hours; and no discharge from an acute hospital takes more than 7 days:* Weekly position @ 5 October 2012 Complex - 93.33% (1 patient out of 15 breached 48 hour target) Non-Complex - 95.21% 7-Day Backstop - 100% Coding Status - SHSCT 84.58%; CAH 86.53%; DHH 80.26% - slight fall in performance compared to 21 September 2012 which was SHSCT 87.41% CAH 89.41% DHH 82.23% **Action: Performance to be monitored weekly to ascertain if improvement is sustained.** **Action: Divisions to concentrate on individual wards where performance has shown a decrease, considering linkage to uncoded position.** **Action: Directorate to review issues contributing to poor coding levels of discharge status.**	-	*		🟡	A	↔
Diagnostics - Imaging	*From April 2012, no patient waits longer than nine weeks for a diagnostic test:* Total of 5814 patients for 9-week October PTL - 74% booked; 26% not booked	-	*		🟢	G	↑
Diagnostics - Non-Imaging	*From April 2012, no patient waits longer than nine weeks for a diagnostic test:* @ 5 October 2012 - 1123 patients for 9-week October PTL - 65% booked and 35% not booked: 183 cardiac investigations not booked - non-recurrent bid submitted to HSCB to return to 9-weeks; 188 urodynamics - position slowly improving as Specialty continue to explore internal options; 5 audiology not booked; 2 neurophysiology not booked; 15 sleep studies not booked. **Action: Validation and recovery plan required for cardiac investigations to return to 9 weeks.** **Action: Plan required to address urodynamic waits.** **Action: Heads of Service to validate longest waiters.**	-	*		🔴	R	↔

Target Area	Target and Performance Update for August PTL / position at 28/9/12 (unless specified otherwise)	Longest Waiter (in-month) per PTL Report **	CP	IOP	Indicator		Trend
DRTT - 14-Day Routine	*From April 2012, 75% of all routine tests are reported on within 14-days:* **Update not yet available** @ 31 August 2012 Imaging - 93% compared to 93.2% at 31 July 2012	-		*	●	G	↓
DRTT - 28 Day Routine	*From April 2012, all routine tests are reported on within 28-days:* **Update not yet available** @ 31 August 2012 Imaging - 100% compared to 100% as at 31 July 2012	-		*	●	A	⇔
DRTT - Urgents	*From April 2012, all urgent diagnostic tests are reported on within 2 days of the test being undertaken:* **Update not yet available** @ 31 August 2012 Imaging - 90.2% compared to 90.4% at 31 July 2012 Non-Imaging - 88% compared to 79.3% at 31 July 2012 Negative impact of Annual Leave noted. Performance against Urgent DRTT standard continues to be a focus at the Trust's 1:1 Performance Meeting with HSCB. **Action - Whilst performance has increased within the non-imaging urgent DRTT a plan is required, with particular focus on cardiac investigations, to increase performance against the standard.**	-	*		●	A	↑

Target Area	Target and Performance Update for August PTL / position at 28/9/12 (unless specified otherwise)	Longest Waiter (in-month) per PTL Report **	CP	IOP	Indicator		Trend
Emergency Department	*From April 2012, 95% of patients attending ED should be treated and discharged home, or admitted, within 4 hours of their arrival in the department; and no patient should wait longer than 12 hours.* @ week ending 5 October 2012 SHSCT - 88.1% - slight increase in performance compared to week ending 28 September 2012 which achieved 87% CAH - 81.5% - slight increase in performance compared to week ending 28 September 2012 which achieved 79.4% DHH - 90.8% - slight decrease in performance from week ending 28 September 2012 which achieved 92.1% 12-hours - 0 Actions ongoing to review ED plan to maintain improved performance.	-	*		●	A	↑
Fractures	*From April 2012, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures:* @ week ending 5 October 2012 48 hours - 71.4% (2 out of 7 patients breached the 48-hour standard) (**Regional update not yet available -** Cumulative performance to date 88%, compared to a regional average of 87%) 7-Day Backstop - 87.5% (1 out of 8 patients breached the 7-day backstop) Performance against Fracture standard continues to be a focus at the Trust's 1:1 Performance Meeting with HSCB. **Action - The Trust has been asked to take forward IPT development for an additional 2 Consultants, to assist with the elective capacity gap. A resultant outcome from this will be increased trauma list availability which should assist the service in the achievement of the 48-hour standard.** **Action - Breach reports to be collectively reviewed to establish reasons for occurence and consider opportunities for avoidance.**	-	*		●	A	↓

Target Area	Target and Performance Update for August PTL / position at 28/9/12 (unless specified otherwise)	Longest Waiter (in-month) per PTL Report **	CP	IOP	Indicator		Trend
HCAI	*By March 2013 secure a reduction of 29% in MRSA and C Difficile infections compared to 2011/2012:* @ 1 October 2012 MRSA - 1 (April 0; May 0; June 0; July 0; August 1; September 0; October 0) C Difficile - 19 (April 2; May 6; June 1; July 6; August 3; September 1; October 0) MSSA - 18 (April 7; May 2; June 2; July 3: August 2; September 2; October 0) The Trust's C Diff level is currently at 86% of the total yearly target.	-	*		1 2	G R	⇔ ⇔
ICATS	370 patients waiting in excess of 9-weeks, booked and not booked - reduction in number of patients waiting in excess of 9 weeks (476 on previous report). **Update not yet available** Orthopaedics - holding 9 weeks at end September. Cardiology - 2 patients waiting >9-weeks. Longest waiter 27-weeks not booked. ENT - 94 patients waiting >9-weeks. Longest waiter 35-weeks booked beyond breach and 26-weeks not booked - were aiming to achieve 14 weeks by end September; Urology - 61 patients waiting >9-weeks. Longest waiter 29-weeks no date. BBB 16 weeks - were aiming to achieve 14 weeks by end September; Dermatology - (19-week backstop) 213 patients waiting >9-weeks - 4 of those patients are waiting > 19-weeks - all booked in Sept. Longest waiter 25-weeks booked - no risk identified to achievement of 19-weeks; **Action - Heads of Service to validate long waits and dates in the past.**	34-weeks ENT				A	↑

Target Area	Target and Performance Update for August PTL / position at 28/9/12 (unless specified otherwise)	Longest Waiter (in-month) per PTL Report **	CP	IOP	Indicator		Trend
In-Patients and Day Cases - Acute	*From April 2012, at least 50%, of inpatients and daycases are treated within 13 weeks with no one waiting longer than 36 weeks, increasing to 60% by March 2013, and no patient waiting longer than 30 weeks for treatment:* 4341 patients waiting in excess of 13-weeks, booked and not booked - 1625 for 13-week access target specialties and 2716 for agreed backstop specialties. Longest Waiter - Urology 72-weeks not booked and 71-weeks booked; Orthopaedics 54-weeks not booked and 62-weeks booked; Cardiology 51-weeks not booked and 56-weeks booked; General Surgery 46-weeks not booked and 51-weeks booked date in the past; Ophthalmology (IS) 42-weeks not booked (dependent on IS provider) and 34-week booked date in the past; Rheumatology 33 weeks not booked and 36-weeks booked; ENT 20-weeks not booked and 32-weeks booked date in the past; Gynaecology 26-weeks not booked and 28-weeks booked; Oral Surgery 28-weeks not booked and 29-weeks booked beyond breach; Scopes 19-weeks not booked and 24-weeks booked date in the past; **Action - Heads of Service to validate longest waiters and dates in the past that are in excess of estimated access position.** **Action - Heads of Service to develop recovery plans to return to required 'steady state' access times/backstops.** **Action - Performance Team have quantified volumes required to achieve further cut for specialties, outside of 13-weeks, to return to maximum waiting time of 30-weeks as per Commissioning Plan standards. HSCB have been notified of these volumes. Heads of Service to develop specialty plans to profile ability to reduce access times through in-house additionality and identify any potential additional IS requirements.**	72-weeks (Urology)	*		●	A	↓

Target Area	Target and Performance Update for August PTL / position at 28/9/12 (unless specified otherwise)	Longest Waiter (in-month) per PTL Report **	CP	IOP	Indicator		Trend
Learning Disability	Not separately specified in the Commissioning Plan; Indicator of Performance or TDP: (previous 9 week standard to be maintained) 5 patients with dates in the past. **Head of Service to validate and action as appropriate.**	9-weeks			●	G	↔
Memory Service	*From April 2012, no patient waits longer than 9 weeks to access adult mental health services:* 201 patients waiting in excess of 9-weeks. Longest waiter 48.5-weeks. Total volume of patients in excess of 9-weeks and longest waiter has increased. **Action - Additional temporary staffing to be recruited to assist in the recovery of this area. Detailed recovery plans required to profile, with the additional staffing, when the access time will return to 9-weeks.**	48.5-weeks	*		●	R	↓
Out-Patient Review Backlog	As at 30 September 2012 the Trust has a total of 12,734 patients whose out-patient review appointment has gone past their clinically indicated date (please note this excludes Mental Health). Breakdown per Directorate as follows: * Acute Services Directorate - 12,201 * Children and Young Person's Services Directorate - 525 * Older Persons and Primary Care - 8 Breakdown per Financial Year (of indicated review appointment) as follows: * 2008/2009 - 7 * 2009/2010 - 191 * 2010/2011 - 553 * 2011/2012 - 2,357 * 2012/2013 - 9,093 **Action - Heads of Service to validate longest waiting patients, with particular attention to those waiting from 2008/2009.**	-			●	R	↓

Target Area	Target and Performance Update for August PTL / position at 28/9/12 (unless specified otherwise)	Longest Waiter (in-month) per PTL Report **	CP	IOP	Indicator		Trend
Out-Patients - Acute	*From April 2012, at least 50% of patients wait no longer than nine weeks for their first outpatient appointment with no one waiting longer than 21 weeks, increasing to 60% by March 2013 and no one waiting longer than 18 weeks:* 7371 patients waiting in excess of 9-weeks, booked and not booked - 3115 for 9-week access target specialties and 4391 for agreed backstop specialties. Longest Waiter - Oral Surgery 38-weeks not booked; Ophthalmology 42-weeks booked; Orthopaedics 35-weeks booked dates in the past (dependent on IS); ENT 19-weeks not booked and 17-weeks booked; Urology 23-weeks not booked and 28-weeks booked (dependent on IS provider); Haematology 10-weeks booked; Anaesthetics 24-weeks not booked; Rheumatology 17-weeks not booked and 20-weeks booked dates in the past; Cardiology 10-weeks not booked and 54-weeks booked; Gynaecology 11-weeks not booked and 11-weeks booked; General Surgery 71-weeks not booked and 13-weeks booked; Endocrinology - 9-weeks not booked and 17-weeks booked; General Medicine - 8-weeks not booked and 14-weeks booked. **Action - Heads of Service to validate longest waiters, dates in the past and booked beyond breach that are in excess of estimated access positions.** **Action - Heads of Service to develop recovery plans to return to required 'steady state' access times/backstops.** **Action - Performance Team have quantified volumes required to achieve further cut for specialties, outside of 9-weeks, to return to maximum waiting time of 18-weeks as per Commissioning Plan standards. HSCB have been notified of these volumes. Heads of Service to develop specialty plans to profile ability to reduce access times through in-house additionality and identify any potential additional IS requirements.**	71-weeks (General Surgery)	*		●	R	↑

Target Area	Target and Performance Update for August PTL / position at 28/9/12 (unless specified otherwise)	Longest Waiter (in-month) per PTL Report **	CP	IOP	Indicator		Trend
Paediatric Cardiology	*From April 2012, at least 50% of patients wait no longer than nine weeks for their first outpatient appointment with no one waiting longer than 21 weeks, increasing to 60% by March 2013 and no one waiting longer than 18 weeks:* Longest waiter 9.5 weeks booked and 9.5 weeks not booked.	9.5-weeks	*		●	G	↑
Plain Film X-Ray Reporting	*All plain films, that require to be reported by a Consultant Radiologist, will be undertaken within a rolling 28-days:* Division aiming to maintain 15-day reporting turnaround for required plain film reporting. 0 films waiting in excess of 15-days - 93 films are waiting in the 8-14 days category.				●	G	↑
Planned Patients	**Update not yet available** As at 1 October 2012 the Trust has a total of 426 patients whose planned admission has gone past their clinically indicated date. Breakdown per Financial Year (of indicated planned admission) as follows: * 2011/2012 - 22 * 2012/2013 - 404 **Action: Heads of Service to validate position, especially in relation to patients waiting from 2011/2012, to ensure all patients have had an offer of treatment in keeping with the indicative review period for call back screening.**				●	A	↓
Psychological Therapies	From April 2012, no patient waits longer than 13 weeks for psychological therapies (any age): 166 patients waiting in excess of 13-weeks - 147 Adult Health (Adult Psychology and Pain) and 19 Adult Mental Health. Longest Waiter - 43-weeks. The total number of patients in excess of 13-weeks and the longest waiter have increased. **Action: IPT recruitment being progressed. A recovery plan is required to include the impact of recruitment within a realistic timescale along with the any other interim opportunities to increase capacity.**	43-weeks	*		●	R	↓

Target Area	Target and Performance Update for August PTL / position at 28/9/12 (unless specified otherwise)	Longest Waiter (in-month) per PTL Report **	CP	IOP	Indicator		Trend
Unallocated Child Care	*From February 2012 the Trust monitors unallocated child care cases greater than 20 days:* **Update not yet available** @ 31 August 2012 - 12 cases in comparison to 5 @ 31 July 2012.	-			🟡	A	↓

Note:

** Longest waiters to be validated by Heads of Service

Key:

R 🔴	**Standard / target not achieved**
A 🟡	**Standard / target partially achieved / limited progress towards achievement of target**
G 🟢	**Standard / target achieved**

CP - Commissioning Plan
IOP - Indicator of Performance

Trend:

↑ improvement in performance

↓ fall in performance

⇔ performance static

Source - Inpatients Waiting Monthly Universe, Business Objects

SOUTHERN HEALTH AND SOCIAL CARE TRUST

on PAS after Month End WL Position Date

Patient Level List - Inpatients and Daycases Waiting More than 13 Weeks on Month End Waiting List Extract

Month End Waiting List Position Date	30/09/2009
Acute Information Team Report Run Date	01/10/2009

Notes

Please Select Validated Outcome from the Drop-Down list in Column B - 'Trust Validated Outcome'

When Selecting the Reason 'No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date', please ensure that the Validated Outcome has been Recorded on PAS with an Activity Date (i.e. Admission Date / Attendance Date / Clock-Reset Date / Waiting List Cancellation / Discharge Date) prior to the 1st day of the new month following the above WL Position Date. Otherwise, this will statistically continue to look like a Breach on PAS as at the Month End Position Date listed above.

If you wish to record any additional information in relation to the Validated Outcome listed in the Column 'Trust Validated Outcome', please enter this in Column C for information purposes.

Trust Validated Outcome	Additional Information on Validated Outcome	Hospital	Casenote	Specialty	Consultant	Admission Reason	Intended Pri	Intended Mg	Urgency Co	Current Dat	Date Booke	WL Effectiv	Operation Description	Waiting mor	Total Days
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH	[redacted]	URO	Young M Mr	ONISLT R URETEROSCOPIC LASERTRIPSY(DIVERTICULAR STONE)BFC	M30.9	N	ROUTINE	11/05/2009	27/09/2009	30/09/2009	R URETEROSCOPIC LAS	1	142
Confirmed Month End Breacher		CAH		URO	Young M Mr	INPATIENT CYSTOSCOPY (SUITABLE FOR TRANSFER TO IS)	M45.9	N	ROUTINE	22/06/2009		30/09/2009	INPATIENT CYSTOSCOP	1	100
Confirmed Month End Breacher		CAH		URO	Young M Mr	GA CYSTOSCOPY & INSERTION OF SPC POA HOLD - TCI DB4	M45.9	N	ROUTINE	17/06/2009		30/09/2009	GA CYSTOSCOPY & INS	1	105
Confirmed Month End Breacher		CAH		URO	Young M Mr	ONISTL TURP BFC	M65.3	N	ROUTINE	30/06/2009	25/10/2009	30/09/2009	TURP POA HOLD FOR F	1	92
Confirmed Month End Breacher		CAH		URO	Young M Mr	TURP - INSULIN DEP DIABETIC POA HOLD	M65.3	N	ROUTINE	18/06/2009		30/09/2009	TURP - INSULIN DEP DIA	1	104
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	OPTICAL URETHROTOMY - POA HOLD F2F 29/09	M76.3	N	URGENT	05/06/2009	02/10/2009	30/09/2009	OPTICAL URETHROTOM	1	117
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	CYSTOSCOPY AND TURBT - POA HOLD 29/09	M45.9	N	URGENT	10/06/2009	30/10/2009	30/09/2009	CYSTOSCOPY AND TUR	1	112
Confirmed Month End Breacher		CAH		URO	Young M Mr	PER PATIENT MUST BE CAH PER IP DR JEFF BROWN	M65.3	N	ROUTINE	03/06/2009		30/09/2009	TURP - LET IN BF - POA	1	119
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Young M Mr	ONISTL URETEROSCOPY & LASERTRIPSY BFC POA FIT	M30.9	N	ROUTINE	22/06/2009	27/09/2009	30/09/2009	URETEROSCOPY & LASE	1	100
Confirmed Month End Breacher		CAH		URO	Young M Mr	FLEXIBLE CYSTOSCOPY (ONLY WANTS CAH)	M45.9	D	ROUTINE	19/06/2009	30/10/2009	30/09/2009	FLEXIBLE CYSTOSCOPY	1	103
Confirmed Month End Breacher		CAH		URO	Young M Mr	LEFT FLEXIBLE URETEROSCOPIC LASERTRIPSY - ASPIRIN POA FIT	M30.9	N	ROUTINE	15/06/2009		30/09/2009	LEFT FLEXIBLE URETER	1	107
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	EXPLORATION LEFT SCROTUM-INSULIN DEPENDENT DIABETIC-POA FIT	N03.4	N	ROUTINE	16/06/2009	02/10/2009	30/09/2009	EXPLORATION LEFT SCI	1	106
Confirmed Month End Breacher		CAH		URO	Young M Mr	BOTOX POA FIT	M43.4	N	URGENT	26/06/2009		30/09/2009	BOTOX	1	96
Confirmed Month End Breacher		CAH		URO	Young M Mr	LFT FLEX URETEROSCOPY-PT WHEELCHAIR(CVA)POAFIT LONG ST WARF	M30.9	N	ROUTINE	30/03/2009	05/10/2009	30/09/2009	LEFT FLEXIBLE URETER	1	184
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	RIGHT URETEROSCOPY - INPT GA Q POSTED	M30.9	N	ROUTINE	16/06/2009	02/10/2009	30/09/2009	RIGHT URETEROSCOPY	1	106
Confirmed Month End Breacher		CAH		URO	Young M Mr	JUNE 2009-IVU-48HR-POA FIT- (NOT SUITABLE FOR IS - PER MY)	M76.3	N	ROUTINE	26/03/2009	13/10/2009	30/09/2009	JUNE 2009 - IVU	1	188
Confirmed Month End Breacher		CAH		URO	Young M Mr	SEEPROCEDBELOW-PT ONLY WANTS CAH ASPERGP14/05/09 LONGSTPOAFI	M45.9	N	URGENT	14/05/2009		30/09/2009	GA CYSTSOCOPY +/- BL	1	139
Confirmed Month End Breacher		CAH		URO	Young M Mr	TURPDONOTTRANSFERONPLAVIX-WAITINGDECISIONMCNEOWN LONGSTAY-QP	M65.3	N	ROUTINE	17/12/2008		30/09/2009	TURP Q/POSTED	1	129
Confirmed Month End Breacher		CAH		URO	Young M Mr	FLEXIBLE CYSTOSCOPY (PT HAD STROKE - NEEDS CAH)	M45.9	D	URGENT	19/06/2009		30/09/2009	FLEXIBLE CYSTOSCOPY	1	103
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	POST VOID RESIDUAL MEASUREMENTS +/- CISC - POA FIT		N	ROUTINE	02/06/2009	03/10/2009	30/09/2009		1	120
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	TURP - POA HOLD F2F 29/9	M65.3	N	URGENT	27/06/2009		30/09/2009	TURP	1	95
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	LEFT EPIDIDYMECTOMY&FLEX CYSTOSCOPY-POA FIT (ONLY WANTS CAH)	M45.9	D	URGENT	02/06/2009	06/10/2009	30/09/2009		1	93
Confirmed Month End Breacher		CAH		URO	Young M Mr	R URETEROSCOPY & LASERTRIPSY -UNFIT FOR TRANSFER/POAHOLD	M30.9	N	ROUTINE	03/06/2009	11/10/2009	30/09/2009	R URETEROSCOPY & LA	1	119
Confirmed Month End Breacher		CAH		URO	Young M Mr	REPAIR OF INCISIONAL HERNIA - POA FIT	T25.9	D	ROUTINE	12/06/2009		30/09/2009	REPAIR OF INCISIONAL	1	110
Confirmed Month End Breacher		CAH		URO	Young M Mr	LEFT FLEXIBLE URETEROSCOPY - POA HOLD F2F 29/09	M30.9	N	ROUTINE	03/06/2009		30/09/2009	LEFT FLEXIBLE URETER	1	119
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Young M Mr	ONISTL SEE BELOW BFC	M45.9	N	URGENT	13/02/2009	26/09/2009	30/09/2009	GA CYSTOSCOPY & URE	1	112
Confirmed Month End Breacher		CAH		URO	Young M Mr	ONISTL TURP BFC	M65.3	N	ROUTINE	11/06/2009	21/10/2009	30/09/2009	TURP POA HOLD FOR F	1	111
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	optical urethrotomy&cystolithopaxy(DO NOT TRANSFER)-POA HOLD		N	URGENT	02/06/2009	02/10/2009	30/09/2009	history of hepatitis C and H	1	120
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	GA CYSTOSCOPY - POA FIT	M45.9	N	ROUTINE	16/06/2009		30/09/2009	GA CYSTOSCOPY	1	106
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Akhtar M Mr	ONISTL OPTICAL URETHROTOMY&URETHRAL DILATATION BFC-Q/POSTED	M76.3	N	URGENT	15/06/2009	27/09/2009	30/09/2009	OPTICAL URETHROTOM	1	107
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Young M Mr	ESWL UNDER ULTRASOUND - MON APPT	M14.1	D	ROUTINE	08/06/2009	21/09/2009	30/09/2009	ESWL UNDER ULTRASO	1	114
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	RIGHT LAPAROSCOPIC NEPHRO-URETERECTOMY POA FIT	M02.2	N	URGENT	08/06/2009	09/10/2009	30/09/2009	RIGHT LAPAROSCOPIC	1	114
Confirmed Month End Breacher		CAH		URO	Young M Mr	L URETEROSCOPIC FLEX LASERTRIPSY-ASPIRIN-DIABETIC POA FIT	M30.9	N	ROUTINE	15/06/2009		30/09/2009	LEFT URETEROSCOPIC	1	107
Confirmed Month End Breacher		CAH		URO	Young M Mr	RIGHT EPIDIDYMAL CYST EXCISION & CYSTOSCOPY (await mri 1st)	N15.3	D	ROUTINE	29/05/2009		30/09/2009	RIGHT EPIDIDYMAL CYS	1	124
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	cystoscopy ?TURBT - POA HOLD		N	URGENT	30/06/2009		30/09/2009	cystoscopy ? TURBT PAT	1	92
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	TUR PREVIOUS RESECTION SCAR Q POSTED POA HOLD	M42.1	N	URGENT	22/06/2009	05/10/2009	30/09/2009	TUR PREVIOUS RESECT	1	100
Confirmed Month End Breacher		CAH		URO	Young M Mr	AUGUST 2009 - TROC (REF. FROM MANOS) Q POSTED	M47.3	D	ROUTINE	16/06/2009	23/10/2009	30/09/2009	AUGUST 2009 - TROC (R	1	106
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Akhtar M Mr	ONISTL CYSTOSCOPY&INSERTION JJSTENT RIGHT URETEROSCOPY BFC	M45.9	N	URGENT	17/05/2009	26/09/2009	30/09/2009	CYSTOSCOPY & INSERT	1	136
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Young M Mr	ONISTL CYSTOS,RETROGRADE STUDY URETER+/-RIDIG URETERSCOPYBFC	M45.9	N	URGENT	26/06/2009	27/09/2009	30/09/2009	CYSTOSCOPY, RETROG	1	96
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	orchidopexy +/- orchidectomy right testis POA FIT	N09.3	N	ROUTINE	23/06/2009		30/09/2009	orchidopexy +/- orchidecto	1	99
Confirmed Month End Breacher		CAH		URO	Young M Mr	FLEXIBLE CYSTOSCOPY - LET IN BF POA FIT - WARFARIN	M45.9	N	URGENT	17/06/2009	16/10/2009	30/09/2009	FLEXIBLE CYSTOSCOPY	1	105
Confirmed Month End Breacher		CAH		URO	Young M Mr	INSERTION OF SPC (ALEX SAW PT A&E 15.06.09)	M49.8	N	ROUTINE	17/06/2009		30/09/2009	INSERTION OF SPC	1	105
Confirmed Month End Breacher		CAH		URO	Young M Mr	TURBT - POA HOLD	M42.1	N	URGENT	26/06/2009	12/10/2009	30/09/2009	TURBT POA HOLD - ECG	1	96
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	REVISION OF NEO-MEATUS - POA FIT		N	ROUTINE	07/05/2009	02/10/2009	30/09/2009	REVISION OF NEO-MEA	1	146
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Akhtar M Mr	ONISTL NESBITTS PROCEDURE BFC	N28.8	N	ROUTINE	27/06/2009	27/09/2009	30/09/2009	NESBITTS PROCEDURE	1	95
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Akhtar M Mr	ONISTL CYSTO & URETHRAL DILATATION BFC	M45.9	N	ROUTINE	24/06/2009	27/09/2009	30/09/2009	CYSTO & URETHRAL DIL	1	98
Confirmed Month End Breacher		CAH		URO	Young M Mr	FLEXIBLE CYSTOSCOPY (ONLY WANTS CAH)	M45.9	D	URGENT	19/06/2009		30/09/2009	FLEXIBLE CYSTOSCOPY	1	103
Confirmed Month End Breacher		CAH		URO	Young M Mr	CYSTOLITHOLAPAXY LONG STAY - Q/POSTED	M44.1	N	ROUTINE	20/03/2009		30/09/2009	CYSTOLITHOLAPAXY	1	134
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	CYSTOSCOPY AND OPTICAL URETHROTOMY - Q/POSTED	M45.9	N	ROUTINE	10/06/2009	30/10/2009	30/09/2009	CYSTOSCOPY AND OPT	1	112
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	HYDROCOELE (autism) POA FIT		N	URGENT	30/06/2009		30/09/2009		1	92
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	TURP - POA FIT	M65.1	N	ROUTINE	09/06/2009	23/10/2009	30/09/2009	TURP POA FIT	1	113
Confirmed Month End Breacher		STH		URO	Akhtar M Mr	FLEXIBLE CYSTOSCOPY - POA (ONLY WANTS CAH)	M45.9	D	ROUTINE	24/06/2009	28/10/2009	30/09/2009	flexible cystoscopy	1	98
Confirmed Month End Breacher		STH		URO	Akhtar M Mr	FLEXIBLE CYSTOSCOPY (NEEDS CAH-LATEX ALLERGY & EPI PEN)	M45.9	D	ROUTINE	07/06/2009	28/10/2009	30/09/2009	flexible cystoscopy	1	115

Produced by Performance and Reform Directorate, Informatics Division, Information Team (Acute)

Source - Inpatients Waiting Monthly Universe, Business Objects

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Patient Level List - Outpatients (Consultant-Led) Waiting More than 9 Weeks on CH3 Outpatients Month End Waiting List Extract

Month End Waiting List Position Date 30/09/2009
Acute Information Team Report Run Date 05/10/2009 Build Date 03/10/09

Notes

Please Select Validated Outcome from the Drop-Down list in Column B - 'Trust Validated Outcome'

When Selecting the Reason 'No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date', please ensure that the Validated Outcome has been Recorded on PAS with an Activity Date (i.e. Admission Date / Attendance Date / Clock-Reset Date / Waiting List Cancellation / Discharge Date) prior to the 1st day of the new month following the above WL Position Date. Otherwise, this will statistically continue to look like a Breach on PAS as at the Month End Position Date listed above.

If you wish to record any additional information in relation to the Validated Outcome listed in the Column 'Trust Validated Outcome', please enter this in Column C for information purposes.

Trust Validated Outcome	Additional Information on Validated Outcome	Hospital Name	Main Special	Casenote	Consultant C	Current Date	Appointmen	Clinic Identifi	Attendance (	Non Clinical (	Waiting List (	Waiting List (	Total
		ARMAGH COMMUNITY HOSPITAL	Gastroenterc	Personal Information redacted by USI	MJG	09/07/2009	24/09/2009	CPTLOGPM		Personal Information redacted by the USI			1
		ARMAGH COMMUNITY HOSPITAL	Gastroenterc		MJG	16/07/2009	24/09/2009	CPTLOGPM					1
		ARMAGH COMMUNITY HOSPITAL	Gastroenterc		MJG	23/07/2009	30/09/2009	CPTLOGPM					1
		ARMAGH COMMUNITY HOSPITAL	Gastroenterc		MJG	23/07/2009	24/09/2009	CPTLOGPM					1
		ARMAGH COMMUNITY HOSPITAL	Obs and Gyn		RNH	23/07/2009	30/09/2009	I352GYN					1
		ARMAGH COMMUNITY HOSPITAL	Obs and Gyn		RNH	10/07/2009	30/09/2009	I352GYN					1
		ARMAGH COMMUNITY HOSPITAL	Obs and Gyn		RNH	01/07/2009	30/09/2009	I352GYN					1
		ARMAGH COMMUNITY HOSPITAL	Obs and Gyn		RNH	08/07/2009	30/09/2009	I352GYN					1
		ARMAGH COMMUNITY HOSPITAL	Ophthalmolc		AK	07/07/2009	30/09/2009	IALLOPH					1
		ARMAGH COMMUNITY HOSPITAL	Ophthalmolc		AK	23/07/2009	30/09/2009	IALLOPH					1
		ARMAGH COMMUNITY HOSPITAL	Ophthalmolc		AK	20/07/2009	30/09/2009	IALLOPH					1
		ARMAGH COMMUNITY HOSPITAL	Ophthalmolc		AK	24/07/2009	29/09/2009	IALLOPH					1
		ARMAGH COMMUNITY HOSPITAL	Ophthalmolc		AK	07/07/2009	30/09/2009	IALLOPH					1
		ARMAGH COMMUNITY HOSPITAL	Ophthalmolc		AK	20/07/2009	30/09/2009	IALLOPH					1
		ARMAGH COMMUNITY HOSPITAL	Ophthalmolc		AK	30/06/2009		IALLOP	C				1
		ARMAGH COMMUNITY HOSPITAL	Ophthalmolc		AK	28/07/2009	30/09/2009	IALLOPH					1
		ARMAGH COMMUNITY HOSPITAL	Ophthalmolc		RMB	30/06/2009	26/10/2009	CEY1B					1
		CRAIGAVON AREA HOSPITAL	Cardiology		IBM	27/07/2009	30/09/2009	CPTLOIBM					1
		CRAIGAVON AREA HOSPITAL	Cardiology		IBM	22/07/2009	30/09/2009	CPTLOIBM					1
		CRAIGAVON AREA HOSPITAL	Cardiology		IBM	24/07/2009	30/09/2009	CRACP					1
		CRAIGAVON AREA HOSPITAL	Cardiology		IBM	22/07/2009	30/09/2009	CPTLOIBM					1
		CRAIGAVON AREA HOSPITAL	Cardiology		IBM	27/07/2009	30/09/2009	CPTLOIBM					1
		CRAIGAVON AREA HOSPITAL	Cardiology		IBM	05/06/2009							2
		CRAIGAVON AREA HOSPITAL	Cardiology		IBM	24/06/2009							1
		CRAIGAVON AREA HOSPITAL	Cardiology		IBM	22/07/2009	30/09/2009	CPTLOIBM					1
		CRAIGAVON AREA HOSPITAL	Cardiology		IBM	02/07/2009	30/09/2009	CRACP					1
		CRAIGAVON AREA HOSPITAL	Cardiology		IBM	27/07/2009	30/09/2009	CPTLOIBM					1
		CRAIGAVON AREA HOSPITAL	Cardiology		IBM	27/07/2009	30/09/2009	CPTLOIBM					1
		CRAIGAVON AREA HOSPITAL	General Med		MJG	22/07/2009	28/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	10/07/2009	28/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	08/07/2009	24/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		MJG	09/07/2009	22/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		MJG	21/07/2009	22/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	28/07/2009	30/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	24/07/2009	22/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		MJG	20/07/2009	22/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	23/07/2009	24/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	27/07/2009	28/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		MJG	09/07/2009	30/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	17/07/2009	28/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	23/07/2009	30/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	21/07/2009	30/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		MJG	24/07/2009	30/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	24/07/2009	22/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		MEM	16/06/2009							1
		CRAIGAVON AREA HOSPITAL	General Med		MJG	20/07/2009	22/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		MJG	21/07/2009	22/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	09/07/2009	24/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	23/07/2009	28/09/2009	CPTLOGPM					1

Produced by Performance and Reform Directorate, Informatics Division, Information Team (Acute)

Source - Inpatients Waiting Monthly Universe, Business Objects

Trust Validated Outcome	Additional Information on Validated Outcome	Hospital Name	Main Special	Casenote	Consultant C	Current Date	Appointmen	Clinic Identifi	Attendance (	Non Clinical (	Waiting List (	Waiting List (	Total
		CRAIGAVON AREA HOSPITAL	General Med	Personal Information redacted by USI	CGMEN	27/07/2009	28/09/2009	CPTLOGPM		Personal Information redacted by the USI			1
		CRAIGAVON AREA HOSPITAL	General Med		MJG	24/07/2009	22/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		MJG	09/07/2009	30/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	08/07/2009	24/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		MJG	09/07/2009	24/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	General Med		CGMEN	27/07/2009	28/09/2009	CPTLOGPM					1
		CRAIGAVON AREA HOSPITAL	Geriatric Me		BMG	03/07/2009	05/08/2009	CSYE1					1
		CRAIGAVON AREA HOSPITAL	Haematology		HKB	28/07/2009		CA2B	D				1
		CRAIGAVON AREA HOSPITAL	Haematology		HKB	14/07/2009		CA2B	H				1
		CRAIGAVON AREA HOSPITAL	Obs and Gyn		GGYN	30/06/2009	30/09/2009	I352GYN					1
		CRAIGAVON AREA HOSPITAL	Ophthalmolc		GEYE	17/07/2009	29/09/2009	IALLOPH					1
		CRAIGAVON AREA HOSPITAL	Ophthalmolc		GEYE	03/07/2009	29/09/2009	IALLOPH					1
		CRAIGAVON AREA HOSPITAL	Ophthalmolc		GEYE	21/07/2009	30/09/2009	IALLOPH					1
		CRAIGAVON AREA HOSPITAL	Ophthalmolc		GEYE	09/07/2009	29/09/2009	IALLOPH					1
		CRAIGAVON AREA HOSPITAL	Ophthalmolc		GEYE	21/07/2009	30/09/2009	IALLOPH					1
		CRAIGAVON AREA HOSPITAL	Ophthalmolc		GEYE	28/07/2009	30/09/2009	IALLOPH					1
		CRAIGAVON AREA HOSPITAL	Ophthalmolc		GEYE	28/07/2009	29/09/2009	IALLOPH					1
		CRAIGAVON AREA HOSPITAL	Ophthalmolc		GEYE	15/07/2009	30/09/2009	IALLOPH					1
		CRAIGAVON AREA HOSPITAL	Ophthalmolc		GEYE	17/07/2009	30/09/2009	IALLOPH					1
		CRAIGAVON AREA HOSPITAL	Ophthalmolc		GEYE	23/07/2009	30/09/2009	IALLOPH					1
		CRAIGAVON AREA HOSPITAL	Ophthalmolc		GEYE	03/07/2009	29/09/2009	IALLOPH					1
		CRAIGAVON AREA HOSPITAL	Oral Surgery		MIP	16/07/2009	28/09/2009	I352ORA					1
		CRAIGAVON AREA HOSPITAL	Oral Surgery		MIP	09/07/2009	28/09/2009	I352ORA					1
		CRAIGAVON AREA HOSPITAL	Oral Surgery		MIP	10/07/2009	14/09/2009	I352ORA					1
		CRAIGAVON AREA HOSPITAL	Oral Surgery		MIP	06/07/2009	14/09/2009	I352ORA					1
		CRAIGAVON AREA HOSPITAL	Oral Surgery		MIP	03/07/2009	28/09/2009	I352ORA					1
		CRAIGAVON AREA HOSPITAL	Oral Surgery		MIP	27/07/2009	14/09/2009	I352ORA					1
		CRAIGAVON AREA HOSPITAL	Oral Surgery		MIP	14/07/2009	28/09/2009	I352ORA					1
		CRAIGAVON AREA HOSPITAL	Oral Surgery		MIP	07/07/2009	30/09/2009	I352ORA					1
		CRAIGAVON AREA HOSPITAL	Oral Surgery		MIP	01/07/2009	28/09/2009	I352ORA					1
		CRAIGAVON AREA HOSPITAL	Oral Surgery		MIP	14/07/2009	14/09/2009	I352ORA					1
		CRAIGAVON AREA HOSPITAL	Pain Manage		PMC	16/07/2009	30/09/2009	I352PAI					1
		CRAIGAVON AREA HOSPITAL	Pain Manage		PMC	27/07/2009	30/09/2009	I352PAI					1
		CRAIGAVON AREA HOSPITAL	Thoracic Me		GTMED	10/07/2009	06/09/2009	CPTLOAJ					1
		CRAIGAVON AREA HOSPITAL	Trauma and		KHA	16/07/2009							1
		DAISY HILL HOSPITAL	Cardiology		DUFFIN	23/07/2009	13/08/2009	DHH CPA					1
		DAISY HILL HOSPITAL	Cardiology		DUFFIN	27/07/2009	13/08/2009	DHH CPA					1
		DAISY HILL HOSPITAL	Cardiology		DUFFIN	28/07/2009	13/08/2009	DHH CPA					1
		DAISY HILL HOSPITAL	Cardiology		DUFFIN	10/07/2009	12/08/2009	DHH CPA					1
		DAISY HILL HOSPITAL	Cardiology		DUFFIN	08/07/2009	12/08/2009	DHH CPA					1
		DAISY HILL HOSPITAL	Cardiology		DUFFIN	08/07/2009	12/08/2009	DHH CPA					1
		DAISY HILL HOSPITAL	ENT		EJM	13/03/2008							1
		DAISY HILL HOSPITAL	ENT		EJM	28/07/2009	29/09/2009	I352ENT					1
		DAISY HILL HOSPITAL	General Med		DUFFIN	06/07/2009		DHH HF	D				1
		DAISY HILL HOSPITAL	General Med		SMY	02/06/2009							1
		DAISY HILL HOSPITAL	General Med		COB	24/06/2009	30/09/2009	CPTLOGPM					1
		DAISY HILL HOSPITAL	General Med		SMY	28/05/2009							1
		DAISY HILL HOSPITAL	General Med		DUFFIN	09/07/2009		DHH HF	H				1
		DAISY HILL HOSPITAL	General Surg		MIOPS	27/07/2009	09/10/2009	DHH RA					1
		DAISY HILL HOSPITAL	Neurology		JOC	29/06/2009	30/09/2009	JOC NEUR					1
		DAISY HILL HOSPITAL	Neurology		JOC	28/07/2009	30/09/2009	DPTLOJOC					1
		DAISY HILL HOSPITAL	Neurology		JOC	23/07/2009	30/09/2009	DPTLOJOC					1
		DAISY HILL HOSPITAL	Neurology		JOC	14/07/2009	30/09/2009	DPTLOJOC					1
		DAISY HILL HOSPITAL	Neurology		JOC	23/07/2009	30/09/2009	DPTLOJOC					1
		DAISY HILL HOSPITAL	Neurology		JOC	08/07/2009	30/09/2009	JOC NEUR					1
		DAISY HILL HOSPITAL	Neurology		JOC	23/07/2009	30/09/2009	DPTLOJOC					1
		DAISY HILL HOSPITAL	Neurology		JOC	08/07/2009	30/09/2009	JOC NEUR					1
		DAISY HILL HOSPITAL	Neurology		JOC	23/07/2009	30/09/2009	DPTLOJOC					1
		DAISY HILL HOSPITAL	Neurology		JOC	27/07/2009	30/09/2009	JOC NEUR					1
		DAISY HILL HOSPITAL	Neurology		JOC	10/07/2009	30/09/2009	DPTLOJOC					1
		DAISY HILL HOSPITAL	Obs and Gyn		DAS	20/07/2009	30/09/2009	I352GYN					1
		DAISY HILL HOSPITAL	Obs and Gyn		DAS	17/07/2009	30/09/2009	I352GYN					1
		DAISY HILL HOSPITAL	Obs and Gyn		MFOH	24/07/2009	30/09/2009	I352GYN					1

Produced by Performance and Reform Directorate, Informatics Division, Information Team (Acute)

Source - Inpatients Waiting Monthly Universe, Business Objects

Trust Validated Outcome	Additional Information on Validated Outcome	Hospital Name	Main Special	Casenote	Consultant C	Current Date	Appointmen	Clinic Identifi	Attendance (	Non Clinical (	Waiting List (	Waiting List (	Total
		DAISY HILL HOSPITAL	Obs and Gyn	Personal Information redacted by the USI	RDCW	28/07/2009	30/09/2009	I352GYN		Personal Information redacted by the USI			1
		DAISY HILL HOSPITAL	Obs and Gyn		KAM	07/07/2009	30/09/2009	I352GYN					1
		DAISY HILL HOSPITAL	Obs and Gyn		DAS	17/07/2009	30/09/2009	I352GYN					1
		DAISY HILL HOSPITAL	Obs and Gyn		RDCW	21/07/2009	30/09/2009	I352GYN					1
		DAISY HILL HOSPITAL	Obs and Gyn		MFOH	22/07/2009	30/09/2009	I352GYN					1
		DAISY HILL HOSPITAL	Ophthalmolc		MCI	02/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	14/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	21/07/2009	30/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	23/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		MCI	02/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	20/07/2009	30/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	21/07/2009	30/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	22/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		MCI	01/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	09/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	23/07/2009	30/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	08/07/2009	30/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	09/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	22/07/2009							1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	23/07/2009	30/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	09/07/2009	30/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		MCI	22/07/2009	30/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		MCI	03/07/2009	30/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	09/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	24/07/2009	30/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	20/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	22/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	22/07/2009	30/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	06/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	09/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	14/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Ophthalmolc		ABP	17/07/2009	29/09/2009	IALLOPH					1
		DAISY HILL HOSPITAL	Oral Surgery		PRB	24/07/2009	28/09/2009	I352ORA					1
		DAISY HILL HOSPITAL	Oral Surgery		PRB	22/07/2009	28/09/2009	I352ORA					1
		DAISY HILL HOSPITAL	Paediatrics		JIH	29/06/2009							1
		DAISY HILL HOSPITAL	Paediatrics		JIH	28/04/2009							1
		DAISY HILL HOSPITAL	Paediatrics		JIH	24/06/2009							1
		DAISY HILL HOSPITAL	Paediatrics		JIH	18/06/2009							1
		DAISY HILL HOSPITAL	Paediatrics		JIH	12/06/2009							1
		DAISY HILL HOSPITAL	Paediatrics		JIH	19/05/2009							1
		DAISY HILL HOSPITAL	Paediatrics		JIH	21/07/2009							1
		DAISY HILL HOSPITAL	Paediatrics		JIH	29/05/2009							1
		DAISY HILL HOSPITAL	Paediatrics		JIH	28/07/2009							1
		DAISY HILL HOSPITAL	Paediatrics		JIH	17/06/2009							1
		KILKEEL PRIMARY CARE CENTRE	Endocrinolog		MMA	02/07/2009							1
		SOUTH TYRONE HOSPITAL	Dermatology		GDERM	06/11/2008							1
		SOUTH TYRONE HOSPITAL	General Med		PM	28/07/2009	28/09/2009	CPTLOGPM					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		GEYE	16/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		GEYE	28/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		AK	30/06/2009		SAK2	H				1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		AK	03/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		GEYE	20/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		GEYE	28/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		AK	03/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		GEYE	06/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		GEYE	22/07/2009	29/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		AK	06/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		AK	30/06/2009		SAK2	H				1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		AK	03/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		GEYE	03/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		GEYE	16/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		GEYE	03/07/2009	30/09/2009	IALLOPH					1
		SOUTH TYRONE HOSPITAL	Ophthalmolc		GEYE	08/07/2009	30/09/2009	IALLOPH					1

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Source - Inpatients Waiting Monthly Universe, Business Objects

Trust Validated Outcome	Additional Information on Validated Outcome	Hospital Name	Main Special	Casenote	Consultant C	Current Date	Appointmen	Clinic Identifi	Attendance (	Non Clinical (	Waiting List (	Waiting List (	Total
		SOUTH TYRONE HOSPITAL	Ophthalmolc	[redacted]	GEYE	28/07/2009	30/09/2009	IALLOPH		[redacted]			1
			Count All:	176									

Produced by Performance and Reform Directorate, Informatics Division, Information Team (Acute)

Corrigan, Martina

From: Leeman, Lesley [redacted]
Sent: 24 May 2013 17:16
To: Trouton, Heather; Conway, Barry; McVey, Anne; Carroll, Ronan; Carroll, Anita; Corrigan, Martina; Reid, Trudy; Nelson, Amie; Glenny, Sharon; Burke, Mary; Carroll, Kay; Murray, Eileen; Richardson, Phyllis; McStay, Patricia; McAreavey, Lisa; Reddick, Fiona; Robinson, Jeanette; Clayton, Wendy; Forde, Helen; Robinson, Katherine
Cc: Burns, Deborah; Lappin, Lynn
Subject: **UPDATE FROM ELECTIVE PERF MEETING** Agenda for Tuesday Discussions
Attachments: 20130521_SBA Recovery PlanSHSCT_Final.docx; 20130523_SBA20132014 _ProposedVolumes_V0_1_LLappin.docx; 20130517 _UnconfirmedVolumeSplit_SBA_V0_1_LLappin.xlsx; OP Backlog Review DNA Action Plan May 2013.doc; 20130503_2013-14_April13 _SBAFortnightlyUpdateReport_Final_JA.XLSX

Importance: High

Please see below key messages and actions from this mornings Elective performance Meeting for further discussion on Tuesday

SBA
SBA recovery plans accepted in the main – thanks to all who provided input (Final copy attached for information) Action – All must be implemented in full and delivered – please ensure systems in place to monitor any variation from the plan prospectively if possible and identify remedial actions Action – MUSC to confirm how WHSCT cath lab sessions are being recorded ie. Core SBA or IHA?

SBA to be reviewed for all other areas not identified in initial recovery plans and any risk escalated to HSCB Action – all to review SBA where SBA is underperforming by -5% or more and confirm no risk to full delivery of SBA by September (see attached latest SBA report)

Urology – separate meeting to be arranged David McCormick, Caroline Cullen, Martina Corrigan, Sharon Glenny, Lynn Lappin and Lesley to review urology SBA and IP/DC split and practical capacity; Heather , will copy you in should you wish to attend this.

SBA Uplift - 2% productivity/outturn – Trust has formally responded to HSCb citing a number of areas that it cannot accept 2%/OT increase on SBA on (See attached). All other areas outside this will hve the 2%/OT productivity applied. Therefore the template provided by Lynn further to the volumes quoted in Dean Sullivan letter of 17 April will apply and all monitoring will be against these new volumes(see attached for reference)

Performance
End of April Position
Action – Colposcopy showing 8 patients in excess of 9-weeks at the end of April – no breaches had been reported in-house – HSCB to forward casenote numbers to the Trust for validation Action – Imaging showing 30 patients in excess of 9-weeks at the end of April – no breaches had been reported in-house – HSCB to forward casenote numbers to the Trust for validation

May performance not acceptable across the Trust. June must see improved position in terms of numbers over backstop/targets and longest waits Action - No BBB of any IP/DC or OP without agreement (process for same to be discussed on Tuesday) Action – Individual Patient Treatment plans required for those areas over 30 week and 18 week backstop (general surgery, orthopaedics, urology, cardiology) and (dermatology, rheumatology and ophthalmology)

IS Tenders – Gynae to be dispatched this w/c 28 MAY; General Surgery/orthopaedics/Pain to be scored & awardED by close of play Wednesday 29th by Cotnract Owners. IS team to prepare for dispatch of referrals

Chronological management key focus. Reasons include selection of IS patients for transfer out of order and late submission of IHA clinics leading to patients booked out of order. Plus WL suspensions and fit/not fit status on waiting lists Action – All IHA clinics to be with Katherine Robinson by close of play Tuesday to avoid BBB in July – which is not acceptable Action –Review of all WL suspensions required (no use of WLS for more than a cumulative period of 3 month unless exceptional circumstances which are practical and in patients benefit) Action – Review of POA arrangements and waiting list add arrangements

Review Backlog
HSCB willing to fund RVBL. Formal permission should be available next week. Clear plan required to demonstrate upstream actions and any additionality that requires to be done . Commissioner to also review actions to address review backlog Action – review of RVBL good practice template/actions on Tuesday 28 May & establishment of new targets Action – All to review new:review ratios against planning assumptions Action – identification of any additional RVBL activity that can be undertaken beyond that currently identify and submitted last week

Recurrent Investment
Scopes – Paper required asap with proposals for nurse endoscopy Gynae & ENT – Trust has formally requested review of the 70% payment rate via finance lines; in respect of volumes ENT agreed and Gynae pending agreement but looking positive (acceptance of lower IP/DC SBA level) General Surgery – Position of non-agreement. Now escalated to HSCB formally Cardiology & T&O – IPT s required asap

Cancer Performance
Whilst 62 day performance improved; 85 + days performance not acceptable.
Action – update on 85 day tacking for June required with escalation to Board of any risk (Meeting to discuss urology performance t b agreed)

Agenda for Tuesday
Review Backlog Plan
Update Theatre Cancellations/POA actions further to discussion previously Process for BBB/POA Immediate performance actions

Lesley

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Southern Health and Social Care Trust

Quality Care - for you, with you

SBA Recovery Plan – SHSCT

Background

Further to significant underperformance against the core SBA, the Trust has been asked by HSCB to bring forward a plan to identify the following for identified specialties

- If it is able to deliver core SBA in full by June 2013 (apportioned level)
- If it is able to deliver core SBA by June, the plan must detail arrangements for the pull back of the current underperformance and plans to hold the position in Quarter 2

If the specialty is unable to deliver the core SBA by June, this will be escalated to the CX via Director of Acute Service. However the plan must detail arrangements for the delivery and pull back of the underperformance by September.

Areas identified at the Elective Performance Meeting on 10th May requiring a plan included:

Specialty	Outpatients	IPDC
Breast Surgery		✓
Cardiology	✓	✓
Dermatology	✓	
ENT	✓	
General Medicine	✓	
Geriatric Medicine	✓	
Obs & Gynae		✓
Ophthalmology		✓
Rheumatology	✓	✓
Urology	✓	✓

For the purposes of this plan it has been assumed that the recent proposals for uplift in SBA to 2% or outturn have been applied. These are attached in appendix i

Speciality Proposals

Breast Surgery IP/DC – Will not achieve SBA in June; will pull back Q2

- Current SBA= 400 (33 per month, 11.4 per elective working week)
- Current underperformance = -10 at 26 April (HSCB report)
- Reason for underperformance =
    - 1 out of 3 Consultant Surgeon absent (MOD service) due back 23 June 13
    - combination of routine lost capacity for existing 2 surgeons due to clash of bank holidays on surgical operating days, audit and surgeon of the week commitments
    - only 2/3 lists undertaken in April
- Recovery Plan: - In May and June 2 remaining surgeons will hold the core activity by undertaking IHA sessions in absence of colleague to avoid any worsening of position however will be unable to pull back from the -10 position until the full complement of staff available in Q2.

Trust has identified changing casemix which is impacting on ability to delivery core SBA volumes. Demand for primary reconstruction (which is a longer procedure) is increasing, rather than the traditional route of no reconstruction or reconstruction after surgery. In 12/13 there were approximately 12 of these procedures undertaken and the full year SBA was -73 IP/DC (-19%)

Trust raised this issue with commissioner previously and is preparing short paper to seek view on way forward.

Cardiology – Will achieve SBA in June

- Current SBA (including ICATs) = 2220 pa (185 per month, 43 per week) extrapolates to 555 end of June
- Current underperformance at 6 May = 214 patients seen equating to +59 at end of May
- Reason for underperformance = Consultant Cardiologist Vacancy
- Number of slots lost per week = 7 new and 7 review , equates to 70 + 70 until of June
    - (thur)Arrhythmia Clinic – 3 new patient per week, 1 review
    - (Mon)Cardiology Clinic – 4 new patients per week, 6 reviews
- Plan to recover core lost new session – 9 IHA OP sessions provided by consultant colleague.
- Plan to recover core lost review sessions - 6 IHA Op sessions provided by consultant colleagues (Based on 12 per clinic) Plan required to pull back review SBA (
- Funding from vacancy for IHA sessions

Currently working to replace consultant, as interim plan seek to secure Locum

Rheumatolgy – Will achieve SBA in June

OP & Daycase

- Current OP SBA = 1300 pa (116 per month, 27 per week) extrapolates to 135 end of June
- Current underperformance at 6 May = 94 patients seen = -41
- Current SBA Dc = 2680 (223 per month; 52 per week) extrapolates to 553 end of June
- Current underperformance at 26 April (HSC) - 57
- Reason for underperformance = Consultant Rheumatology Career Break (0.5 wte), Locum resigned on 3 April; offered 2 more locums rheumatology only post– refused due to 0.5 wte nature.
- Number of slots lost per week = 9, equates to 93 until end of June;
    - (Tue)rheumatology Clinic – 3 new patient per week; 7 review
    - (Wed)rheumatology Clinic – 3 new patients per week; 7 reviews
    - (Thur) rheumatology – 3 New patients per week; 7 reviews
    - (Wed) rheumatology Dc session – 7 per week
- Plan to recover –
    - locum to commence on 20 May and work 1 wte rheumatology for 6 week until the end of june to pull back 6 weeks of no cover for the 0.5 wte rheumatology post.
    - From 1 June onward locum to work rheum/med split job plan which will sustain SBA
- Will achieve SBA in June assuming locum in place
- Funding for locum available from con vacancy monies

Dermatology – will not achieve SBA in June; No active plan to pull back until Locum appointed

- Current SBA (including ICATs) = 8830 pa (736 per month, 170 per week) extrapolates to 849 end of June
- Current underperformance at 6 May = 652 patients seen equating to -197 at end of May
- Reason for underperformance =
    - 1 wte specialty doctor maternity leave commenced 15 ;
    - + 0.3 wte vacancy specialty doctor 30 June affecting Q2
    - + 0.73 wte specialty doctor planned absence due to sickness end May
- Number of slots lost per week = (Kay to check with Jeannette)
    - (Wed)Dr O'hagan Clinic all day– 4 new & 8 review
    - (Tues)Dr O'hagan am – 4 new and 3 review
    - (Tues pm) Dr O'Hagan – 6 new
- Plan to recover core lost session: TBC Locum specialty Doctor – 3RD trawl – not yet secured
- Trust has no funding to transfer patients to IS therefore must continue to pursue locum option, now seeking consultant locum
- No funding available for this locum

ENT – Will achieve SBA in June

Current underperformance is due to the loss of 32 clinics in Quarter 1 due to Bank Holidays and Audit there was also a lot of Annual Leave in April which led to a number of clinics being cancelled. Plan is that Juniors are attending clinics with Consultants during May and June which will increase the clinics and pull this back.

SBA will not be achieved in May but will be achieved by end of June.

General Medicine/Gastro – Will achieve New OP SBA in June; Will pull back Review Op SBA in Q2

- Current SBA=
- Current underperformance AT 26 April (HSCB report) -76
- Reason for underperformance = Consultant Physician sick leave(due back 3 June 13)
- Number of slots lost
- 2 Op clinics per week (4 new and 8 review x 8 weeks) = 64 NOP + 128 ROP
- Recovery Plan
  - Consultant returning in June and will undertake addition OP clinics in core capacity instead of scope lists as part of rehab. Therefore 6 additional OP clinics focused on new patients which will pull back NOP underperformance.
  - Review OP underperformance will not be pulled back until Q2
  - 6 core Scope lists displaced will be undertaken by Dr King on IHA
  - No funding in place to pay for sessions

Gynaecology IP.DC – Will not achieve SBA in June: Formulate plan to pull back in Q2

- Current SBA= 2510 PA (lower SBA) = 1122 In patients and 1388 Day Cases (209 Per month , 48 per week) extrapolates to 624 to end of June 13
- Current underperformance at 12 May = - 47 patients which equates to - 100 by end of June
- Reason for underperformance
  - 1.0 WTE Consultant Gynaecologist/Obstetrician on maternity leave since April 2013
  - Locum appointed but cannot start until 1st August 13
- Recovery Plan
- **Short Term Plan**- Appointment of Temporary Locum for month of June and July to provide backfill core theatre sessions
  - 5 Main Theatres = 5 x 2.5 = 12.5 patients
  - 2 Day Case Session = 6 x 2 = 12 patients
  - Total 24.5 Patients
  - SBA Shortfall at end of June with locum activity = 100 minus 25 patients = - 75
  - Estimated shortfall on SBA at end of July with anticipated locum activity = - 65
  - No funding in place for Locum
- **Long Term Plan -** Replacement locum consultant expected to start 1st August and to seek agreement with Consultant Team to utilise locum replacement to pull back elective SBA

- Unlikely to pull SBA by at the end of September.
- No funding in place for locum

For period August to October to also seek additional In House Activity and code to Core to pull SBA back in line - subject to funding being made available.

Ophthalmology Day Cases (Visiting Service) – will not achieve DC SBA in June – will utilise sessions to same value in agreement with BHSCT

- Current SBA= 1270 pa (106 per month, 24.5 per week) extrapolates to 318 by end of June)
- Current underperformance as at 16 May = 90 patients seen equating to -195 by end of June, ie, potential underperformance of 123 patients
- Reason for underperformance = Due to out-patient conversion there is not enough demand for day cases to fill capacity in this visiting service, therefore the Trust has engaged with the Service Provider to ascertain how this wish this capacity to be utilised. The Trust has suggested either
    - transfer of long day case waits from BHSCT to SHSCT to assist with access time targets ,or
    - swing of the daycase sessions into OP session to clear review backlogs which would include high risk glaucoma patients.
- The Belfast Trust has indicated that their preferred option may be review backlog although this is not as yet confirmed. If the Belfast Trust chose to use this capacity for review backlog, the equivalent SBA will have to be transferred to this equivalent volume.
- Recovery Plan = dependent on Belfast Trust response

Urology -

OP; Will not achieve OP SBA in June: will achieve in Q2.

IP: Will achieved IP SBA in June

DC; Will not achieve IP/DC SBA in June – recovery plan in development

Out-Patients

- Current SBA= 4028 new patients pa (336 per month, 77.5 per week) extrapolates to 1008 by end of June
- Current underperformance as at 16 May = 316 patients seen equating to 685 at end of June, ie, underperformance of 323 patients
- Reason for underperformance =
    - GPwSI on long-term sick leave
    - One consultant left at end of March, Locum not available until 20 May, hence a number of clinics not covered during April.
- Recovery Plan
    - Locum consultant commencing Monday 20.05.13 = flexible job plan focused on elective for first 2 weeks. (7 clinics x 10 news x 2 weeks = 140 new patients then moving to 4 clinics x 5 news x 4 weeks = 80 new patients)

- Locum specialty doctor in lieu of GPcSI - Dr [redacted] = 3 clinics x 5 news x 6 weeks = 90 new patients
  Total of 310 new patients
  Remaining 6 shortfall to be smoothed out from 1st July with locum consultant
- Funding in place for consultant locum from vacancy and for GPwSI due to long term nature of sickness

Elective IP/DC

- Original SBA= 5585 per b case (including non-elective) = (465.5 per month, 107.5 per week)

  Non-elec: 629 (52 per mth) – April = 60 (+8)

  Elective IP: 571 (48 per mth) @ 2% increase – 582 (49 per month)– April = 95 (+46)

  DC 4385 – 4385 (366 per mth) @ 2 % increase 4473 (373 per mth)– April = 124 (-249)

  Total elective SBA set at 88% daycase rate

  CHKS peer daycase rate – 75.2%, SHSCT daycase rate 64% for 12/13

  SHSCT operational Daycase rate April 57%

- Current underperformance relates all to daycases only
- Reason for underperformance =
  - One consultant vacancy
  - High DC rate (88% of elective patients) making SBA difficult to achieve. System not designed to deliver DC volumes at this level which is significantly above peer and Trust performance
  - IP currently over performing; and still significant increase in over 30 week waits from 0 to 77 in April (associated with significant increase in red flags and urgents, higher than typical level of patients coming out of suspension and more routine lost capacity in this month – untypical month)
  - Analysis of demand for non routine capacity shows 14 redflag/urgent daycases per week and 16.3 red flags/urgent IP per week; this equates to 60 DC and 71 IP red flag/urgents per typical month – this exceeds the IP total capacity
  - DC underperforming – need to realign SBA volumes and work to increase daycase capacity in the system

- Recovery Plan for daycase
  - Long-term – develop nurse cystoscopist role to increase daycase capacity (Skill-up existing member of staff with view to bringing on mid-year – backfill this person internally)
  - Re-align daycase rate to reflect peer performance and develop recovery plan to increase daycase capacity

- Replace consultant vacancy with locum due to start May
- Trust is currently not in position to identify when DC SBA can be achieved but proposed works with HSCB/SLCG to review existing capacity in this regard and come to interim arrangement

Geriatric SBA – SBA will achieve

On review of the underperformance note it appears that all the activity for this specialty has not been counted against the agreed SBA

Trust estimated the SBA is on track and presents no risk. Trust has engaged with HSCB Information team to resolve technical issue

SERVICE AND BUDGET AGREEMENT VOLUMES (AS PER DEAN SULLIVAN'S LETTER OF 17 APRIL 2013
(TRUST POSITION TO BE CONFIRMED)

Specialty	New OP	IP/DC
Breast Surgery including Symptomatic Breast Clinic and Breast Family History	3472	400
Cardiology including ICATS	2220	950
Dermatology including ICATS	8830	1200
Endocrinology	580	0
ENT including ICATS	8614	2528
General Medicine including Gastroenterology	2976	2060
General Surgery	8748	4920
Geriatric Medicine including Aucte and Non-Acute	1912	0
GP Non-Maternity (Community Dentistry)	0	1746
Neurology including Virtual	2790	390
Gynaecology	5298	2768
Colposcopy	1570	0
Fertility	250	0
Urodynamics (Gynaecology)	400	0
Ophthalmology includes Visiting Service and Trust Service	3720	1270
Paediatric Cardiology	174	0
Paediatrics	2600	120
Pain Management	1190	550
Rheumatology	1390	2680
Thoracic Medicine	1724	500
Thoracic Surgery	56	0
Orthopaedics including ICATS	6500	1138
Urology including ICATS	4028	5056
Chemical Pathology	140	0
Clinical Oncology	550	200
Haematology including Anti-Coagulant	720	1150
Nephrology	160	104
Palliative Medicine	116	0

Note:
1. New Out-Patient Volumes only listed

2. Review Out-Patient Volumes ? Will be based on N:R ratio planning assumptions and will require to be confirmed once Trust position is confirmed

3. In-Patient/Day Case volumes in total - IP/DC split will require to be confirmed once Trust position is confirmed

4. Cardiology DC is incorrect as it is based on a mix of patients and procedures and will required to be confirmed once Trust position is confirmed

5. Endoscopy to be confirmed by Rosemary Hulatt

6. Imaging 2% uplift versus outturn to be confirmed

2013/2014 SBA BASELINE PROPOSALS – AREAS REQUIRING RESOLUTION

Specialty	Activity Type	HSCB Proposal	SHSCT Proposal
Fertility	NOP	250 based on projected outturn	137 based on actual outturn (reviewed following data close-down of 3/5/13)
Dermatology	IP/DC	1200 based on projected outturn	1092 based on actual outturn (reviewed following data close-down of 3/5/13)
General Surgery	NOP	8748 based on 2% productivity	7504 based on IPT proposal
Urology	NOP	4028 based on 2% productivity	3949 based on 5-consultant model which is not fully embedded
Urology	IP/DC	5056 based on 2% productivity	4956 based on 5-consultant model which is not fully embedded
Gynaecology	IP/DC	2728 based on based on 2% productivity	2510 based on IPT proposal

Areas to Note:

- Palliative Medicine – NOP – HSCB proposal of 116 based on 2% productivity – the Trust will accept this volume, however, would ask HSCB for a degree of tolerance on SBA performance as this service is patient driven and therefore, the Trust cannot control the demand for the clinics.
- GP Non-Maternity (Community Dentistry) DC and Orthodontics – HSCB proposal based on 2% productivity – the Trust will accept the proposed volumes until the outcome of the Regional Dental Review, which the Trust would presume will establish new SBA baselines.

Visiting Services:

- The Trust notes the following SBA associated with Visiting Services:

    - Oral Surgery (SEHSCT)
    - Ophthalmology (BHSCT)
    - Clinical Oncology (BHSCT)
    - Paediatric Cardiology (BHSCT)

    The Trust has forwarded HSCB proposed volumes to the respective Trusts.

SERVICE AND BUDGET AGREEMENT VOLUMES (AS PER DEAN SULLIVAN'S LETTER OF 17 APRIL 2013 (TRUST POSITION TO BE CONFIRMED)

**** TRUST ANALYSIS OF SPECIALTY SPLIT AND IP / DC SPLIT ****

Specialty	New OP	Review OP	IP	DC
Anti-Coagulant	322	6246	0	0
Breast Family History	241	769	0	0
Breast Surgery	0	0	298	101
Cardiology Consultant-Led	1800	2045	30	920
Cardiology ICATS	420	0	0	0
Chemical Pathology	140	263	0	0
Clinical Oncology	550	4729	0	200
Colposcopy	1570	769	0	0
Dermatology Consultant-Led	6687	8676	137	1063
Dermatology ICATS	2143	0	0	0
Endocrinology	580	3911	0	0
ENT Consultant-Led	6466	6339	1237	1291
ENT Dr ICATS	1004	984	0	0
ENT Nurse ICATS	1144	1870	0	0
Fertility	250	2068	0	0
Gastroenterology	1179	4130	47	935
General Medicine	1797	3545	87	991
General Surgery	8748	11149	1506	3414
Geriatric Acute	667	4.7	9	0
Geriatric Assessment	465	1089	0	0
Geriatric Medicine	736	1145	0	0
GP Non-Maternity (Community Dentistry)	0	0	0	1746
Gynaecology	5298	5194	1237	1491
Haematology	398	4164	0	1150
Nephrology	160	1364	0	104
Neurology F2F	1666	3270	0	390
Neurology Virtual	1124	443	0	0
Ophthalmology Trust Service	784	1692	0	292
Ophthalmology Visiting Service	2936	5945	0	686
Orthopaedic Geriatrics	44	60	0	0
Orthopaedics Consultant-Led	1469	2770	642	496
Orthopaedics ICATS	5031	3768	0	0
Paediatric Cardiology	174	147	0	0
Paediatrics	2600	7715	0	120
Pain Management	1190	754	0	550
Palliative Medicine	116	321	0	0
Rheumatology	1390	3449	0	2680
Symptomatic Breast	3231	1728	0	0
Thoracic Medicine	1724	3546	0	500
Thoracic Surgery	56	186	0	0
Urodynamics (Gynaecology)	400	0	0	0
Urology including ICATS	4028	4747	1224	3832

Note:

1. New Out-Patient Specialty split - based on Performance analysis
2. Review Out-Patient Volumes - not yet confirmed with HSCB but early indication that they will remain the same as
3. In-Patient/Day Case split - based on Performance analysis
4. Cardiology DC is incorrect as it is based on a mix of patients and procedures and will required to be confirmed once
5. Endoscopy to be confirmed by Rosemary Hulatt
6. Imaging volumes to be confirmed by HSCB
7. AHP volumes to be confirmed by HSCB

Action	Update May 13
a) Corporate Actions:-	
Implement review partial booking. This will be introduced on a specialty by specialty basis with protocols for discharge of patients being agreed with each Clinical Director.	Trust has in place review partial booking system Action – Review protocols for discharge in place, and identify any further requirements Meeting 28 May 2013
Set internal Trust review backlog targets and monitor these through monthly meetings of the OP Review backlog & DNA Group chaired by the Co-Director.	Internal targets in place and monthly reporting in place (see attached) Action – Review targets established in 2012/13 at Meeting 2013 and agree any new targets RVBL and DNA KPIs reviewed alternate week at Acute Elective performance meeting – chaired by Director of Acute Services
Target longest waiting patients in each specialty and either validate or appoint the patient.	Validation processes undertaken in 2011/12. Action – Review longest waits and agree Further validation work required at specialty level - Meeting on 28th May
Remind all appointments staff regarding the DNA protocol regarding review outpatients	Action - Review of DNA protocol and establish if any revision/clarification required Meeting 28 may
Ensure that all clinics are fully booked. Monitor this using the Clinic Slots report which shows clinics with unused slots.	Action – Need to agree process and roles for this Meeting 28 May
Produce a monthly suite of reports to allow service managers to monitor their review backlog and identify why backlogs are increasing e.g. clinics where more patients are added to hold and treat lists than taken off each month.	RVBL reports in place monthly Action – consider need for waiting list additions report – v - monthly capacity Meeting 28 May
Implement a phone appointment reminder system to reduce the DNA rate at clinics and	In place with 60% coverage

Action	Update May 13
release review outpatient capacity.	Action – consider efforts to increase contact numbers and % coverage Meeting 28 May
Meet with Clinical Directors and senior managers from specialties with high OP review backlogs and DNA rates, to develop and monitor specific action plans. Produce information packs for each meeting with consultant level information e.g. new to review ratios, DNA rates.	Action – area areas of focus and develop specific plans Meeting 28 May
Send consultant level review backlog reports monthly to individual consultants in all specialties. Include month on month data to show progress.	Consultant level information on RVBL available and copied to HoS Action – consider approach to dissemination of this information to clinicians; circulation – v – Divisional meetings Meeting 28 May
Produce good practice guidelines for consultants e.g. case review with junior medical staff, consultant seeing patient every 3rd visit, management of patients who defer/are abroad, time for clinic wrap up	Some good practice guidance in place Action – consider coverage and further work required at specialty level Meeting 28 May
Issue reminder to consultants re the Trust DNA/CNA protocol for review patients	Post review of protocol
Guidelines for bringing patients for review to be included in induction for all medical staff	Consider post establishment of good practice guidance
Monitoring of new to review and discharge rates as part of the medical appraisal process to be discussed with AMDs.	Information available on new to review rates Actions – review with Medical Directors office for inclusion in revalidation/appraisal process
All consultants to manage their review patients on hold and treat lists. Review partial booking cannot be implemented without this.	In place
Where agreed by consultants, specialist/lead nurses to validate review backlogs and appoint or discharge patients as per agreed protocols e.g. where normal results back.	To be considered in context of agreed validation processes above

Action	Update May 13
Consultants to validate backlogs and either:- • Discharge patient back to the care of their GP or • Indicate whether urgent or routine review required	To be considered in context of agreed validation processes above
Specialties to investigate alternate methods of managing review patients e.g. through collaboration with GPs, nurse led and telephone reviews.	Range of management techniques in place for review including nurse led, virtual clinic activity Action - Consider applications at specialty level Meeting 28 May

Additional considerations by commissioner:

- No Follow-up: Assumed norm to become 'no follow up unless there is a specific reason', i.e. clinical need or patient-led request.
- Streamlining Pathways: streamline the patient's journey to create a 'one-stop' approach where all relevant tests are planned, scheduled and booked to occur in one visit. This requires the visit process to be carefully co-ordinated to ensure access to relevant tests occurs in sequence and results are available within a timescale that allows health professionals to make the appropriate clinical decisions.

  For example: J Epidemiol Community Health 1999;53:118–124 - Planned outpatient appointments after uncomplicated surgery seem to be neither necessary nor cost effective. A policy of “no planned follow up” results in no increase in primary care costs, and savings in hospital and patient costs.
- The National Patient Access Team (NPAT) report, Variations in NHS Outpatient Performance recommended that ‘every Trust that is responsible for outpatients should identify an executive director with specific responsibility for outpatient improvement.
- Allocate quotas for services in line with the commissioned new to follow up rate.
- Maximise use of telephone reviews. Approximately 7400 telephone reviews take place out of a total of 430,000.
- Undertake regular waiting list validation which is established good practice in managing the waiting list;

- Consideration has been given to the role of GPwSIs and/or in community services;

- While developing review guidelines for medical staff, Trusts should also considering introducing a process whereby follow-up decisions are discussed with trainees as part of clinical supervision;

- Consider the development of condition management protocols for the management of common long-term conditions eg diabetes, pain management;

- Only rebook review DNAs after notes/letters have been reviewed. A conversation with the referrer may be needed and feedback to say no further appointment will be made is essential.

ELECTIVE IN-PATIENT SERVICE BUDGET AGREEMENT

Activity Period: 01/04/13 - 02/05/13 **Month No:** 1.25

Specialty:	Expected SBA	Actual SBA Activity (Cumulative)	Variance Against Expected SBA	% Variance Against Expected SBA
General Surgery	157	130	-27	-17.13%
Breast Surgery	30	16	-14	-47.40%
Urology	58	81	23	39.54%
Trauma	0	5	5	#DIV/0!
Orthopaedics	66	65	-1	-0.95%
ENT	126	98	-28	-22.44%
General Medicine	9	19	10	104.94%
Gastro-enterology	8	0	-8	-100.00%
Haematology	10	5	-5	-51.02%
Cardiology	3	10	7	231.03%
Dermatology	14	4	-10	-71.97%
Thoracic Medicine	1	2	1	113.33%
Nephrology	3	14	11	307.27%
Rheumatology	1	0	-1	-100.00%
Paediatric Medicine	4	21	17	492.94%
Geriatric Medicine	1	1	0	6.67%
Gynaecology	129	87	-42	-32.48%
Oncology	1	2	1	174.29%
Endoscopy	7	10	3	35.21%
Total	**629**	**570**	**-59**	**-9.36%**

Notes:

1. SBA for Elective In-Patients is monitored on Admissions not FCEs.
2. Endoscopy activity is based on the activity against the General Surgery; General Medicine and Gastro-enterology Scope Sub-Specialties only and is not based on the clinically coded activity data.

Corrigan, Martina

From: Leeman, Lesley [redacted]
Sent: 09 September 2013 17:15
To: Burns, Deborah
Cc: Trouton, Heather; Lappin, Lynn; Corrigan, Martina; Waddell, Sandra
Subject: Notes from Urology meeting 09 Sept 13

Debbie
See brief note further to urology meeting this morning for further consideration this week re approach/next steps

09 September 2013
Meeting David McCormick, Beth Malloy, Martina Corrigan, S Waddell

Background & Update
Heather provided update on staffing issue further to email of 21 August Locum leaving September and gap until new consultant starts in December 13 Not fruitful in attracting middle grade doctors, range of reasons (training programme, lack of AS grades); cant put specialist nurses in place due to lack of medical cover Buying in locum to cover middle grade doctors - 3 nights and 5 weekends out 6, bank holidays Robin Brown will not be coming to CAH due to inability to attract a locum in short term - short term plan only, Paul Hughes will however take on additional PA, Nurses training on cystoscopy, cant attract SHO

Access and SBA
Martina provided an overview on what can be done within core and that Trust will work to pull back to -14% by December with current plan Modelled to -14% by December for IP/DC Trust seeing increase in confirmed cancer in SHSCT only in urology; BM identified across the board red flags increasing, not aware of increase in confirmed cancers.
Need to balance cancer and longest waits.

Options discussed
· Can nurses undertake more flexible cytoscopy - guidance indicates planned work only so whilst current proposals useful additional capacity may be unable to be utilised
· Can additional consultant be secured based on funding from 3specialty doctors/GPS SI - DMcC ? - Trust considered this during recent recruitment however SBA would not be fulfilled with consultant post
· Can Trust buy additional PA from con - using funding (for additional flex lists) - impact ? SBA - Action - Trust to discuss and model out impact on SBA and access times
· Can primary care options to be developed to manage/assist - ? Stop/govern PSA screening - Action - C Cullen to discuss with SLCG
· Can Trust secure additional Registrars - NIMDTA trying to take reg away and replace with SHO- Trust has fought this in year. Gap in NIMDTA thinking and surface needs
· Can Trust secure additional SHO - Struggling to fill core needs
· Can CAWT assist - no single handed in Sligo, seeking our support

Longer term
Can Trust Develop diagnostic post (office based urologist) with support package (Nurses) - longer term (?18 months)

Next Steps
Thoughts -
· What are longest waits- HSCB advised will be measured by this - If can't get to 26 weeks by December, ? offer volume SBA back - then can discuss regionally about how we manage gap

· DMcC Option - go down to 4 consultant and hand back funding/SBA and underperform to a lesser extent (let another unit expand) - keep West activity and drop East activity - have appointed 5 so this will not work however ?? could consider offering up volume of SBA against middle grade doctors and funding for same
· Action - ? SBA for specialty doctor and funding we can 'offer back' (netting off night rota) or buy externally - can we buy diagnostics in IS or via other NHS team (?SET) and bring back in house post diagnostics for tx
· Seek to develop shared care - Would we consider PCNL as longer term initiative in whsct - IF SO ? Local solution - suggest to commissioner wish to consider this in WHSCT (shared arrangement with Causeway)

Timescale
Need to confirm plan and way forward for Friday perf meeting - 27 September, 2 weeks time- option generation short term and longer term plan

Plan may need to say Middle tier - we can get it/recruit it/its not in system - HSCB - advise please on medical manpower issues

Original email/plan sent to Beth in advance of meeting - Below

Subject

Urology plan

From

Trouton, Heather

To

Beth Malloy (Personal Information redacted by USI)

Cc

Leeman, Lesley; Burns, Deborah; Lappin, Lynn; Corrigan, Martina

Sent

21 August 2013 10:20

Attachments

<<Urology Review Recommendations Progress August 2013.doc>>

Dear Beth

Following your recent conversations with Lesley re our plan to address the deficit in our Urology SBA due to numerous medical vacancies, please see the following outline of our plan for your consideration prior to our meeting on 9th September.

Please also see attached the update on the Urology Review recommendations as requested.

Current and on- going vacancies within the service causing the deficit in SBA

Staffing Gap
1 substantive consultant

3 specialty doctors
1 GP with Specialist Interest
2 Specialist nurses

Actions already taken to address the vacancies

· We have appointed a locum urologist, however his productivity would not be as you would expect from a permanent Urologist.
· We have advertised 4 times since November for the middle grade doctors with no success. We have tried every title and have gone out to Europe and beyond.
· We have scouted for a replacement GPwSI but we are reliably advised there are no further GP's with the specialist skills in Urology out there.
· We have not appointed 2 more specialist nurses as their activity to contribute to seeing patients is curtailed by the lack of medical support. While the specialist nurse can undertake certain procedures and investigations , they need to work alongside a medic for the full diagnosis. However it will be worthwhile to increase by a further band 7 specialist nurse with the proposed model. The funding for these 2 posts has been used to fund out of hours locum cover to cover the specialty doctor gaps, supplementing the funding for the specialty doctor vacancy as locum cover comes at a premium.

Overarching plan to address deficit.

· We have now successfully recruited a substantive Urologist from England who will commence in October 2013. This will however leave the remaining gap at ICATS and middle grade level with the associate gap in core outpatient and day case activity that this service and the middle grades produce.
· To address this on an interim basis , Mr Brown our General Surgeon with an interest in Urology has agreed to move sessions from General Surgery to the urology service to undertake some outpatient and day case work displaced from the GPwSI and middle grade staff in line with his experience.
· It is also planned that Mr Brown will bring with him 2 sessions of a General Surgical Associate Specialist who will further undertake an additional 2 flexible cystoscopy sessions per week as an interim, this will support core activity and facilitate better management of red flag work and improve cancer targets also.
· To further supplement core Urology activity we are re-training one of the Specialty Nurses in Urology, who has previous experience in flexible cystoscopy, to undertake planned flexible cystoscopies. Core activity lost from the specialist nurse will be backfilled from the available nurse funding. It is anticipated that this capacity will come on stream in October and provide 4 lists per week
· Further the Trust is seeking to backfill some of the core activity displaced from the middle grade doctors. To do this Trust intends to roster current secure registrar staff into the current weekly flexible cystoscopy lists and increase this by 0.5 per week. To do this the Trust needs to secure an additional SHO to backfill and would seek funding for this. This will also release the reg to provide support to OP deficits also.
· Activity undertaken as OPwP including urodynamics and TRUS biopsies which are recorded as DC in other Trusts, will be offset against the DC core activity output as agreed by HSCB.

It is anticipated these operational plans will bring forward additional activity in Q3, which will improve the SBA underperformance to -10% by end of December.

The risks associated are as follows:-

· We can only move Mr Browns's sessions to Urology if we are able to secure a replacement general Surgeon to keep on the general Surgical activity required. We are interviewing for his replacement on 28th August with one candidate from England.
· We can only release the Registrar to fill the flexible cystoscopy sessions if we are able to recruit a SHO grade doctor.
· The specialist nurse can only perform 'planned ' and not diagnostic flexible cystoscopy so this is a constraint.

However, we are keen to really address this deficit in activity caused by lack of medical staff in this specialty so we will endeavour to bring this plan to fruition.

Happy to discuss further on 9th September.

If you require any further information in advance of the meeting please advise

Best regards
Heather

Lesley Leeman
Assistant Director – Performance /Improvement Southern Health & Social Care Trust Trust Headquarters
68 Lurgan Road Portadown BT63 5QQ

Tel: Office Personal Information redacted by USI
Tel: BB Personal Information redacted by USI

Corrigan, Martina

From: Trouton, Heather [redacted]
Sent: 20 March 2013 18:04
To: Nelson, Amie; Corrigan, Martina; Reid, Trudy
Cc: Rankin, Gillian; Burke, Mary
Subject: FW: ELECTIVE PERFORMANCE MEETINGS - w/c 25 March 2013

Dear All

Can you please see below

I know things are so fluid but can you please advise if there are any new unresolvable risks to performance for end March.

Amie I know new risk around scopes but I know you and Mary will sort.

Heather

From: Rankin, Gillian
Sent: 20 March 2013 16:39
To: McVey, Anne; Conway, Barry; Trouton, Heather; Carroll, Ronan
Cc: Burns, Deborah
Subject: FW: ELECTIVE PERFORMANCE MEETINGS - w/c 25 March 2013

Dear all,

Please see the performance meeting next week has been cancelled.
Please alert me by return whether there are any new performance risks which we face prior to year end which we were not aware of previously.
These also need to be made known at Trust Board next week verbally, Many thanks, Gillian

From: Jill Young [mailto[redacted]]
Sent: 20 March 2013 11:20
To: Clarke, Paula; Coulter, Roisin; 'Groogan Sara'; 'Sloan, Martin'; 'Devlin, Shane'
Cc: Dean Sullivan; Michael Bloomfield; Owen Harkin; David McCormick; Cathy Gillan; Iain Deboys; Alan Marsden; Paula Tweedie; Paul Turley; Michael Taylor; Roger Kennedy; Caroline Cullen; Paul Cavanagh; Brian McAleer (HSCB); Rankin, Gillian; Leeman, Lesley; Seamus.McGoran setrust; 'Allam, Christine'; Hillick, GeraldineA2; 'OHagan, Margaret'; 'Thompson, Jennifer'; Beth Minnis; Karen McKay; helen.moore[redacted] Paula Treanor (PMSID); Sarah Louise Dornan; Melissa Patterson; 'McCune, Joyce'; Stephen McDowell (PMSID); colm.mclarnon[redacted] 'paula.mcsparron[redacted] 'donna.allen@[redacted] Jeff Featherstone; 'norah.mulligan[redacted] marion.moffett@[redacted]
Subject: ELECTIVE PERFORMANCE MEETINGS - w/c 25 March 2013

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

All

Please note that the elective care performance meetings scheduled for week commencing 25 March will not take place.

As previously advised, it is the Board's expectation that Trusts will continue to take all possible steps to achieve the best possible end of March position and deliver previously agreed core and additional activity volumes. Where there is likelihood of any material change to the year-end position from that most recently reported can you please let Michael and I know immediately.

I would be grateful if you could please advise appropriate Trust colleagues.

Many thanks.

Jill
Performance Management and Service Improvement Directorate Health and Social Care Board
Tel: Personal Information redacted by USI, Personal Information redacted by USI

Corrigan, Martina

From: Lappin, Lynn [redacted]
Sent: 08 May 2013 18:03
To: Corrigan, Martina; Leeman, Lesley
Cc: Trouton, Heather; Burns, Deborah
Subject: Re: update on performance for Friday's meeting

Martina

Thanks for this.

For the IP/DC that are breaching 28 weeks could you please advise how many of these are in excess of 30 weeks?

Thanks.

Lynn
Lynn Lappin
Head of Reform
Mobile: [redacted]

Sent via Blackberry

From: Corrigan, Martina
To: Leeman, Lesley
Cc: Trouton, Heather; Lappin, Lynn; Burns, Deborah
Sent: Wed May 08 17:41:11 2013
Subject: update on performance for Friday's meeting

Lesley,

Please see below for an update for your meeting with the Board for my two specialties:

POSITION AT END OF APRIL 2013

UROLOGY

Outpatients – Consultant-led – breached 9 weeks by 18 patients and waiting time was 11 weeks this was due to Bank Holiday and consultant annual leave during April.
Outpatients – ICATS – breached 9 weeks x 93 patients and the longest wait was 15 weeks this was due to ongoing sick leave of GPWSI and Bank Holidays and nursing annual leave during April.

Plan – we are interviewing on 16 May 2 specialty doctors (one funded from BLG and the other would be funded from GPWSI) although neither doctor can start until August we hope to start pulling back these breaches and waiting times and start to meet SBA but not until quarter 2.

Inpatients – 59 inpatients breached the 28 week backstop longest wait came out of suspension 85 weeks (PCNL) then next wait is 43 weeks.
Daycase patients – 29 patients breached the 28 week backstop – longest wait came out of suspension is 56 weeks then next wait is 32 weeks

Urodynamics – 139 patients waiting over 9 weeks – longest = 55 weeks (plan is to go to IS if the Board fund this). I have met with team and I now am in a position to complete the specification and forward to Judith next week although I wont be able to give indicative volumes until this has been confirmed by the Board.

Update on recruitment: Locum will be commencing on 20 May for 3 months the permanent urologist post will be advertised next week. I will be using the locum to ensure that we meet the Core SBA in all areas.

SBA - Urology
Outpatients was short 95 patients but this was mostly in relation to the ICATS clinics – and I am working with the Consultants on pulling this back in May and June – particularly using the locum.

Inpatient SBA was less 23 patients this is due to the Saturday's being coded as WLI and I have asked for this to be changed to Core which equates to 24 patients so we will have met our SBA for inpatients

Daycase SBA we are less 130 and I will need to look at this as the overall SBA seems very high (it works out at 75 patients per week and I will come back to you tomorrow),

In-house additionality we have none for this specialty as there is no recognised GAP.

ENT

Outpatients – Consultant-led – we breached by 119 patients and the waiting time is 12 weeks – this was due to 2 Bank Holidays and Consultant Annual Leave.
Outpatients – ICATS – met 9 weeks
Inpatients – 96 inpatients breached 13 weeks (longest was 24 weeks waiting) – this is due to bank holidays, annual leave and bed pressures at the beginning of April and the unwillingness to do additionality in April Daycase patients – 28 Day breached 13 weeks (longest was 16 weeks) this is due to bank holidays, annual leave and bed pressures at the beginning of April and the unwillingness to do additionality in April

SBA - ENT

Outpatients we were minus 136 – this was due to losing 13 clinics x 7 new patients for Bank Holidays = 91 plus 6 clinics x 7 new patients due to annual leave. We will not pull this back fully in May due to losing another 12 clinics x 7 new patients = 84 patients but we will pull this back by end of June as I have worked with consultants on bringing this back in by putting an extra registrar at some clinics during May and June to see additional patients.

Inpatients – we are minus 28 patients and this is due to bank holidays, annual leave and casemix on lists. Plan is to bring this back in May using registrars backfilling some lists and more patients can be added to these lists.

Daycases – we are minus 11 patients again due to the bank holidays, annual leave – this will be pulled back in May.

In-House Additionality

I have been working from original submission of 550 outpatients to be seen in-house by end of June and although there was no clinics in April (consultant choice) I have arranged clinics to meet this number. However as per our conversation yesterday when Lynn sent through the information for in-house additionality I note that this figure had changed to 875 and I am not sure where this figure has come from as in all our previous submissions it was as I said 550? Yesterday was the first time I had saw this figure and had not planned for this and I now have a copy of the letter and the correspondence that you gave me from Dean. At the most I will be able to get another 2 x 80 patients Saturday's and this will mean that we I will not be able to fit in 155 patients of this additionality.

Inpatient/Daycase additionality again due to annual leave and the bank holidays and consultant choice we only did 10 additional patients in April, but I have additionality planned for May and June which will see the rest of these volumes so no risk with this.

Happy to discuss any of this

Kind regards

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

Corrigan, Martina

From: Giambonini, Glenda [redacted]
Sent: 20 June 2014 13:50
To: Robinson, Katherine; Glenny, Sharon; Clayton, Wendy; McVeigh, Angela; Trouton, Heather; Corrigan, Martina; Nelson, Amie; Toner, Roisin; McNally, ClaireA; Edgar, Olive; Forde, Helen; Adair, Loraine; Conway, Barry; Burke, Mary; Murray, Eileen; Lappin, Lynn; Richardson, Phyllis; Anderson, Judith; Thompson, Martina; Devlin, Louise; Thompson, Bruce; Conway, Maria
Subject: FOR INFORMATION: AVAILABILITY OF SHAREPOINT REPORTS - ICATS PTL'S
Attachments: image001.png

Please click on the link below for an updated version of this week's ICATS PTL Reports:

Click Here For Reports

A useful facility within these reports is that you can double click on a cell and patient level data including casenote number, current date etc will be displayed on another worksheet.

If you have any queries, please do not hesitate to contact us.

Regards

Acute Information Team
Performance and Reform Directorate
Informatics Division – Information Department Glendale Building, Bannvale Site
10 Moyallen Road
GILFORD
Co.Armagh
BT63 5JX

Click on the icon below for SharePoint: Information Management Site

Corrigan, Martina

From: McAlinden, Edele [redacted]
Sent: 07 March 2014 12:59
To: Carroll, Anita; Carroll, Ronan; McVey, Anne; 'ADAIR, Loraine'; McGeough, Mary; Forde, Helen; McStay, Patricia; Glenny, Sharon; Richardson, Phyllis; Stinson, Emma M; Boyce, Tracey; Jackson, Valerie; Clayton, Wendy; McAreavey, Lisa; Burns, Deborah; Trouton, Heather; Corrigan, Martina; Reid, Trudy; Brashaw, Isla; Devlin, Louise; 'Ross, Anne'; Hughes, Daniel; Robinson, Katherine; Burke, Mary; McCready, Elsie; 'Ross, Anne'; Murray, Eileen; Lappin, Lynn; Scott, Jane M; Nelson, Amie; Anderson, Judith; OHagan, Ann; Carroll, Kay
Subject: FOR INFORMATION: AVAILABILITY OF SHAREPOINT REPORTS - OUTPATIENT PTL'S
Attachments: image003.png

Please click on the link below for an updated version of this week's Outpatient PTL Reports:

Click Here for Updated Reports

A useful facility within these reports is that you can double click on a cell and patient level data including casenote number, current date etc will be displayed on another worksheet.

If you have any queries, please do not hesitate to contact us.

Regards

Acute Information Team
Directorate of Performance and Reform
Informatics Division – Information Department Glendale Building, Bannvale Site
10 Moyallen Road
GILFORD
Co.Armagh
BT63 5JX

Click on the icon below for SharePoint: Information Management Site

Corrigan, Martina

From: McAlinden, Edele [redacted]
Sent: 07 March 2014 12:51
To: Carroll, Ronan; Devlin, Louise; Glenny, Sharon; Clayton, Wendy; Richardson, Phyllis; Conway, Barry; McAreavey, Lisa; Trouton, Heather; Reid, Trudy; Corrigan, Martina; 'ADAIR, Loraine'; McGeough, Mary; Stinson, Emma M; Burke, Mary; Oliver, Michelle; Maguire, Geraldine; 'Ross, Anne'; Hughes, Daniel; Murray, Eileen; Robinson, Katherine; Lappin, Lynn; Scott, Jane M; Nelson, Amie; Anderson, Judith; Carroll, Kay; Burns, Deborah
Subject: FOR INFORMATION: AVAILABILITY OF SHAREPOINT REPORTS - INPATIENT AND DAYCASE PTL'S
Attachments: image003.jpg

Please click on the link below for an updated version of this week's Inpatient and Daycase PTL Reports:

Click Here for Updated Reports

A useful facility within these reports is that you can double click on a cell and patient level data including casenote number, current date etc will be displayed on another worksheet.

If you have any queries, please do not hesitate to contact us.

Regards

Information Team (Acute)
Glendale Building, Bannvale Site
10 Moyallen Road
GILFORD
Co.Armagh
BT63 5JY

Click here for the Sharepoint Site - Information Management

Corrigan, Martina

From: Macmillan, Julie [redacted]
Sent: 06 March 2014 11:26
To: Leeman, Lesley; Carroll, Ronan; Burns, Deborah; Devlin, Louise; Glenny, Sharon; Clayton, Wendy; Richardson, Phyllis; Conway, Barry; McAreavey, Lisa; Trouton, Heather; Reid, Trudy; Corrigan, Martina; McGeough, Mary; Stinson, Emma M; Burke, Mary; Murray, Eileen; McStay, Patricia; Anderson, Judith; Lappin, Lynn; Nelson, Amie; Carroll, Kay; McVey, Anne; Scott, Jane M
Subject: FOR INFORMATION: AVAILABILITY OF SHAREPOINT REPORTS - ACTUAL IP AND DAYCASE WAITING LISTS
Attachments: image001.jpg

Dear all

Please click on the link below for an updated version of this month's reports on Actual Waits – Inpatients and Daycases.

Click Here for Updated Reports

If you have any queries in relation to this report, please do not hesitate to contact the Acute Information Team.

Kind regards

Acute Information Team
Directorate of Performance and Reform
Informatics Division – Information Department Glendale Building, Bannvale Site
10 Moyallen Road
Gilford
BT63 5JX

Click on the icon below for SharePoint: Information Management

Corrigan, Martina

From: Macmillan, Julie [redacted]
Sent: 03 March 2014 13:45
To: 'Carroll, Ronan'; 'McVey, Anne'; 'Glenny, Sharon'; 'Clayton, Wendy'; 'Richardson, Phyllis'; 'Tate, Ann'; 'McAreavey, Lisa'; 'Trouton, Heather'; 'Corrigan, Martina'; 'ADAIR, Loraine'; 'Donnelly, Anne'; 'Burke, Mary'; 'Murray, Eileen [redacted]'; 'Robinson, Katherine'; 'Lappin, Lynn'; 'McStay, Patricia [redacted]'; 'Anderson, Judith'; Lilburn, Diane; Cunningham, Lucia; Lockhart, Gail; 'McEneaney, David'; Vennard, Ruth; 'Reid, Trudy [redacted]'; 'Burns, Deborah'
Subject: FOR INFORMATION: AVAILABILITY OF SHAREPOINT REPORTS - DIAGNOSTIC PHYSIOLOGICAL MEASUREMENT PTL
Attachments: image001.jpg

Please click on the link below for an updated version of this week's Diagnostic Physiological Measurement PTL Report.

Please click here for reports

If you have any queries, please do not hesitate to contact us.

Regards

Information Department (Acute)
Informatics Division
Performance and Reform Directorate
Glendale Building, Bannvale Site
10 Moyallen Road, Gilford, Co.Armagh, BT63 5JX

Click here for the Sharepoint Site - Information Management

Corrigan, Martina

From: Glenny, Sharon [redacted]
Sent: 07 April 2014 10:28
To: Lappin, Lynn; Clayton, Wendy; McAreavey, Lisa; Richardson, Phyllis
Cc: Reid, Trudy; Corrigan, Martina; Nelson, Amie; Trouton, Heather
Subject: RE: FOR RESPONSE BY 7/4/14: MONTH END IP/DC WL POSITION REPORTS AS AT 31/03/14
Attachments: SEC IP DC 13+ WK BREACHERS (INC 9+ WEEK SCOPES) SENT PERF TEAM 01-04-14 - UPDATED SG 07.04.14.xlsx; image001.jpg

Hi Lynn

Please see update for SEC specialties.

Kind regards

Sharon

From: Lappin, Lynn
Sent: 02 April 2014 14:31
To: Clayton, Wendy; Glenny, Sharon; McAreavey, Lisa; Richardson, Phyllis
Subject: FOR RESPONSE BY 7/4/14: MONTH END IP/DC WL POSITION REPORTS AS AT 31/03/14
Importance: High

Dear all

Please find attached the IP/DC End of Year Validation Report which requires to be submitted to HSCB.

Please note that each patient requires to have a response against it – using the drop down options in the far right column.

The options are as follows:

- Patient treated by 31st March
- Patient cancelled and date reset
- Patient cancelled and removed from WL
- Patient breached 13 weeks but within maximum backstop (13-week specialties only)
- Patient breached 13 weeks but achieved backstop target
- Patient breached maximum backstop

As a first step I would suggest that you concentrate on those patients that are showing in excess of your expected positions and confirm if these are correct or not. Then as a second step I would select the appropriate drop down for the remaining patients ie.

Can I please ask that this be returned to me by close of play on Tuesday, 8 April 2014.

Please do not hesitate to contact me if you have any queries in respect of this.

Regards.

Lynn

Lynn Lappin
Head of Performance

Directorate of Performance & Reform
Southern Health & Social Care Trust
The Rowans, Craigavon Area Hospital
68 Lurgan Road, PORTADOWN
BT63 5QQ

Direct Dial: Personal Information redacted by USI
Blackberry: Personal Information redacted by USI
E-mail: Personal Information redacted by USI

Sharepoint Link:

Specialty Description (R)	Specialty Description	Intended Primary Proced	SCOPES PROCEDURES	Intended Prim. Proc. Desc.	Hospital Name	Casenote	Intended Management Description (R)	Specialty Description	Consultant Name	Original Date	Current Date	Currently Suspended (Y/N)	Current Suspension End Date	Date Booked	Total Waiting	Total Days Waiting	Weeks Waiting	Actual Waiting List 13 WK+	Waiting more than 13 weeks	Waiting more than 18 weeks	Waiting more than 26 weeks	Trust Response - Please pick from the drop down list	
GENERAL SURGERY	GENERAL SURGERY(C	T20.2		PRIMARY R	CRAIGAVC	Personal Information redacted by USI	Day Case	GENERAL SURG	Lewis A Mr	05/11/2013	05/11/2013	N			1	92	13	1	1			Patient breached 13 Weeks but achieved backstop target	
UROLOGY	UROLOGY(C)	M76.3		THERAPEU	CRAIGAVC		Day Case	UROLOGY(C)	Pahuja A Mr	06/11/2013	28/12/2013	N			1	93	13	1	1			Patient breached 13 Weeks but achieved backstop target	
ENT	EAR NOSE AND THROA	D15.1		DRAINAGE	CRAIGAVC		Day Case	EAR NOSE AND	Hall S.J. Mr.	27/12/2013	27/12/2013	N			1	94	13	1	1			Patient breached 13 Weeks but within maximum backstop (13 week specialties only)	
ENT	EAR NOSE AND THROA	F34.4		EXCISION C	CRAIGAVC		Normal Inpatient	EAR NOSE AND	Mcnaboe E.J. Mr	27/12/2013	27/12/2013	N		03/04/2014	1	94	13	1	1			Patient breached 13 Weeks but within maximum backstop (13 week specialties only)	
GENERAL SURGERY	GENERAL SURGERY (IS	L87.4		OTHER OP	CRAIGAVC		Day Case	GENERAL SURG	Independent Con	27/12/2013	27/12/2013	N			1	94	13	1	1			Patient breached 13 Weeks but achieved backstop target	
GENERAL SURGERY	GENERAL SURGERY (IS	L87.9		OTHER OP	CRAIGAVC		Day Case	GENERAL SURG	Independent Con	27/12/2013	27/12/2013	N			1	94	13	1	1			Patient breached 13 Weeks but achieved backstop target	
GENERAL SURGERY	GENERAL SURGERY (IS	L87.9		OTHER OP	CRAIGAVC		Day Case	GENERAL SURG	Independent Con	27/12/2013	27/12/2013	N			1	94	13	1	1			Patient breached 13 Weeks but achieved backstop target	
GENERAL SURGERY	GENERAL SURGERY (IS	L88.2		TRANSLUM	CRAIGAVC		Day Case	GENERAL SURG	Independent Con	27/12/2013	27/12/2013	N			1	94	13	1	1			Patient breached 13 Weeks but achieved backstop target	
GENERAL SURGERY	MINOR OPS. - GEN SUR	S06.9		OTHER EX	DAISY HILL		Day Case	MINOR OPS. - GE	Minor Ops. - Gen	27/12/2013	27/12/2013	N			1	94	13	1	1			Patient breached 13 Weeks but achieved backstop target	
ORAL SURGERY	ORAL SURGERY(C)	F09.4		SURGICAL	CRAIGAVC		Day Case	ORAL SURGERY	Garrahy A Miss

GENERAL SURGERY	GENERAL SURGERY(C	A65.1		RELEASE C	CRAIGAVC	Personal Information redacted by USI	Day Case	GENERAL SURG	Lewis A Mr	17/12/2013	17/12/2013	N			1	104	15	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	H44.4		MANIPULA	SOUTH TY		Day Case	GENERAL SURG	Eganomeritakis E	17/12/2013	17/12/2013	N			1	104	15	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	L85.1		LIGATION C	CRAIGAVC		Day Case	GENERAL SURG	Weir C.D. Mr	17/12/2013	17/12/2013	N			1	104	15	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	L85.1		LIGATION C	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	17/12/2013	17/12/2013	N			1	104	15	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	L88.2		TRANSLUM	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	17/12/2013	17/12/2013	N			1	104	15	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	N17.1		EXCISION C	DAISY HILL		Day Case	GENERAL SURG	Hughes P Dr	17/12/2013	17/12/2013	N			1	104	15	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	N17.1		EXCISION C	DAISY HILL		Day Case	GENERAL SURG	Hughes P Dr	17/12/2013	17/12/2013	N	11/04/2014		1	104	15	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	N17.1		EXCISION C	DAISY HILL		Day Case	GENERAL SURG	Hughes P Dr	17/12/2013	17/12/2013	N

ENT	EAR NOSE AND THROA	F34.4			EXCISION (C	CRAIGAVC	[redacted]	Day Case	EAR NOSE AND	Leyden P J Mr	11/12/2013	11/12/2013	N		11/04/2014	1	110	16	1	1		Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
GENERAL SURGERY	GENERAL SURGERY(C	J18.9			EXCISION (C	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	11/12/2013	11/12/2013	N			1	110	16	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	S06.5			OTHER EXC	SOUTH TY		Day Case	GENERAL SURG	A General Surgeo	11/12/2013	11/12/2013	N			1	110	16	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	S06.8			OTHER EXC	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	11/12/2013	11/12/2013	N			1	110	16	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	S68.8			EXCISION (C	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	11/12/2013	11/12/2013	N			1	110	16	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	T20.9			PRIMARY R

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ENT	EAR NOSE AND THROA	D12.2			OTHER OP	CRAIGAVC		Normal Inpatient	EAR NOSE AND	Mcnaboe E.J. Mr	04/12/2013	04/12/2013	N			1	117	17	1	1			Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
ENT	EAR NOSE AND THROA	D14.2			REPAIR OF	CRAIGAVC		Normal Inpatient	EAR NOSE AND	Reddy CEE Mr	04/12/2013	04/12/2013	N	01/04/2014		1	117	17	1	1			Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
ENT	EAR NOSE AND THROA	E03.6			OPERATIO	DAISY HIL		Day Case	EAR NOSE AND	Mcnaboe E.J. Mr	04/12/2013	04/12/2013	N	30/04/2014		1	117	17	1	1			Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
GENERAL SURGERY	GENERAL SURGERY(C)	H44.4			MANIPULA	SOUTH TY		Day Case	GENERAL SURG	Epanomeritakis E	03/10/2013	04/12/2013	N			1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS(C)	W37.3			TOTAL PR	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	04/12/2013	04/12/2013	N	04/04/2014		1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS(C)	W37.3			TOTAL PR	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	04/12/2013	04/12/2013	N	28/05/2014		1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS(C)	W37.9			TOTAL PR	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Mcmurray D Mr	04/12/2013	04/12/2013	N			1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS(C)	W87.9	Arthroscopy		DIAGNOST	CRAIGAVC		Day Case	ORTHOPAEDICS	Murnaghan M Mr	04/12/2013	04/12/2013	N			1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS(C)	W90.3			PUNCTURE	CRAIGAVC		Day Case	ORTHOPAEDICS	Murnaghan M Mr	04/12/2013	04/12/2013	N	22/05/2014		1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS (IS)	A65.1			RELEASE C	CRAIGAVC		Day Case	ORTHOPAEDICS	Independent Con	04/12/2013	04/12/2013	N			1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS (IS)	A65.1			RELEASE C	CRAIGAVC		Day Case	ORTHOPAEDICS	Independent Con	04/12/2013	04/12/2013	N			1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS (IS)	T59.1			EXCISION C	CRAIGAVC		Day Case	ORTHOPAEDICS	Independent Con	04/12/2013	04/12/2013	N			1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS (IS)	T72.3			OTHER OP	CRAIGAVC		Day Case	ORTHOPAEDICS	Independent Con	04/12/2013	04/12/2013	N			1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS (IS)	W42.4			OTHER TO	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Independent Con	16/01/2013	04/12/2013	N			1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M09.9			THERAPEU	CRAIGAVC		Normal Inpatient	UROLOGY(C)	Young M Mr	04/12/2013	04/12/2013	N			1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N15.2			OPERATIO	CRAIGAVC		Day Case	UROLOGY(C)	Young M Mr	04/12/2013	04/12/2013	N			1	117	17	1	1			Patient breached 13 Weeks but achieved backstop target
ENT	EAR NOSE AND THROA	E03.6			OPERATIO	CRAIGAVC		Day Case	EAR NOSE AND	Mcnaboe E.J. Mr	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
ENT	EAR NOSE AND THROA	F34.4			EXCISION C	CRAIGAVC		Normal Inpatient	EAR NOSE AND	Hall S.J. Mr.	03/12/2013	03/12/2013	N	02/04/2014		1	118	17	1	1			Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
ENT	EAR NOSE AND THROA	F34.4			EXCISION C	CRAIGAVC		Normal Inpatient	EAR NOSE AND	Hall S.J. Mr.	03/12/2013	03/12/2013	N	02/04/2014		1	118	17	1	1			Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
ENT	EAR NOSE AND THROA	F34.8			EXCISION C	CRAIGAVC		Normal Inpatient	EAR NOSE AND	Hall S.J. Mr.	03/12/2013	03/12/2013	N	25/04/2014		1	118	17	1	1			Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
ENT	EAR NOSE & THROAT (T	F34.4			EXCISION C	CRAIGAVC		Day Case	EAR NOSE & THI	Mcnaboe E.J. Mr	03/12/2013	03/12/2013	N	04/04/2014		1	118	17	1	1			Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
GENERAL SURGERY	GENERAL SURGERY(C)	A65.1			RELEASE C	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.3			EXCISION C	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8			EXCISION C	CRAIGAVC		Normal Inpatient	GENERAL SURG	Yousaf M Mr	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8			EXCISION C	CRAIGAVC		Day Case	GENERAL SURG	Yousaf M Mr	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8			EXCISION C	CRAIGAVC		Normal Inpatient	GENERAL SURG	Yousaf M Mr	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	N17.1			EXCISION C	DAISY HILL		Day Case	GENERAL SURG	Hughes P Dr	03/12/2013	03/12/2013	N	04/04/2014		1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	N17.1			EXCISION C	DAISY HILL		Day Case	GENERAL SURG	Hughes P Dr	03/12/2013	03/12/2013	N	04/04/2014		1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	N17.1			EXCISION C	DAISY HILL		Day Case	GENERAL SURG	Hughes P Dr	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	N17.1			EXCISION C	SOUTH TY		Day Case	GENERAL SURG	Lewis A Mr	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9			OTHER EX	SOUTH TY		Day Case	GENERAL SURG	A General Surge	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S64.1			EXTIRPATI	SOUTH TY		Day Case	GENERAL SURG	A General Surge	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T27.9			REPAIR OF	CRAIGAVC		Normal Inpatient	GENERAL SURG	Yousaf M Mr.	03/12/2013	03/12/2013	N	14/04/2014		1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	Y20.4			BIOPSY OF	SOUTH TY		Day Case	GENERAL SURG	A General Surge	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	Y20.4			BIOPSY OF	SOUTH TY		Day Case	GENERAL SURG	A General Surge	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS(C)	A65.1			RELEASE C	CRAIGAVC		Day Case	ORTHOPAEDICS	Mcconway J Mr	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS(C)	W28.3			OTHER INT	CRAIGAVC		Day Case	ORTHOPAEDICS	Mcconway J Mr	03/12/2013	03/12/2013	N			1	118	17	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOR	ORTHOPAEDICS(C)	W37.1			TOTAL PR	CRAIGAVC		Normal Inpatient

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UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	27/11/2013	27/11/2013	N			1	124	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N17.1		EXCISION	DAISY HILL	[redacted]		Day Case	UROLOGY(C)	Brown R.J. Mr.	27/11/2013	27/11/2013	N			1	124	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N17.1		EXCISION	DAISY HILL	[redacted]		Day Case	UROLOGY(C)	Brown R.J. Mr.	27/11/2013	27/11/2013	N			1	124	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N17.1		EXCISION	DAISY HILL	[redacted]		Day Case	UROLOGY(C)	Brown R.J. Mr.	27/11/2013	27/11/2013	N			1	124	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N17.1		EXCISION	DAISY HILL	[redacted]		Day Case	UROLOGY(C)	Brown R.J. Mr.	27/11/2013	27/11/2013	N			1	124	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N17.1		EXCISION	DAISY HILL	[redacted]		Day Case	UROLOGY(C)	Brown R.J. Mr.	27/11/2013	27/11/2013	N			1	124	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N17.1		EXCISION	DAISY HILL	[redacted]		Day Case	UROLOGY(C)	Brown R.J. Mr.	27/11/2013	27/11/2013	N			1	124	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N17.1		EXCISION	DAISY HILL	[redacted]		Day Case	UROLOGY(C)	Brown R.J. Mr.	27/11/2013	27/11/2013	N			1	124	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N17.1		EXCISION	DAISY HILL	[redacted]		Day Case	UROLOGY(C)	Brown R.J. Mr.	27/11/2013	27/11/2013	N			1	124	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	H44.4		MANIPULAT	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Hewitt G.R. Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.1		EXCISION	CRAIGAV	[redacted]		Normal Inpatient	GENERAL SURG	Hewitt G.R. Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.1		INJECTION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	27/06/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	N30.3		OPERATIO	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	20/06/2013	26/11/2013	N		26/04/2014	1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	26/11/2013	26/11/2013	N		02/04/2014	1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surge	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surge	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surge	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surge	26/11/2013	26/11/2013	N		07/04/2014	1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surge	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.8		PRIMARY R	CRAIGAV	[redacted]		Normal Inpatient	GENERAL SURG	Epanomeritakis E	05/06/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T59.1		EXCISION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L86.2		INJECTION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	26/11/2013	26/11/2013	N		09/04/2014	1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
ORAL SURGERY	ORAL SURGERY(C)	F09.4		SURGICAL	DAISY HILL	[redacted]		Day Case	ORAL SURGERY	Ramsay-Baggs P	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W37.9		TOTAL PRO	CRAIGAV	[redacted]		Normal Inpatient	ORTHOPAEDICS	Patton S Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M30.4	Ureteroscopy	DIAGNOST	CRAIGAV	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAV	[redacted]		Normal Inpatient	UROLOGY(C)	Glackin A.J Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOP	CRAIGAV	[redacted]		Normal Inpatient	UROLOGY(C)	Pahuja A Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N15.3		OPERATIO	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Glackin A.J Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N17.1		EXCISION	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N27.1		EXTIRPATI	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Glackin A.J Mr	26/11/2013	26/11/2013	N			1	125	18	1	1			Patient breached 13 Weeks but achieved backstop target
ENT	EAR NOSE AND THROA	E03.6		OPERATIO	CRAIGAV	[redacted]		Day Case	EAR NOSE AND	Korda M Mr	25/11/2013	25/11/2013	N			1	126	18	1	1			Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
GENERAL SURGERY	GENERAL SURGERY(C)	A65.1		RELEASE	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	13/06/2013	25/11/2013	N			1	126	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	H44.4		MANIPULAT	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Epanomeritakis E	25/11/2013	25/11/2013	N			1	126	18	1	1			Patient breached 13 Weeks but achieved backstop target
ORAL SURGERY	ORAL SURGERY(C)	F17.5		OPERATIO	DAISY HILL	[redacted]		Day Case	ORAL SURGERY	Ramsay-Baggs P	25/11/2013	25/11/2013	N			1	126	18	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	T52.1		EXCISION	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	20/11/2012	30/09/2013	N			1	126	18	1	1			Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W40.1		TOTAL PRO	CRAIGAV	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	23/09/2013	23/09/2013	N			1	126	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Glackin A.J Mr	25/11/2013	25/11/2013	N			1	126	18	1	1			Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N30.3		OPERATIO	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	25/11/2013	25/11/2013	N			1	126	18	1	1			Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	A65.1		RELEASE	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Independent Con	24/11/2013	24/11/2013	N			1	127	18	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N28.4		PLASTIC O	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	23/11/2013	23/11/2013	N			1	128	18	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	H44.4		MANIPULAT	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Epanomeritakis E	02/10/2013	22/11/2013	N			1	129	18	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	L85.9		LIGATION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Independent Con	22/11/2013	22/11/2013	N			1	129	18	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	L86.2		INJECTION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Independent Con	22/11/2013	22/11/2013	N			1	129	18	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	S06.9		OTHER EX	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Independent Con	22/11/2013	22/11/2013	N			1	129	18	1	1	1		Patient breached 13 Weeks but achieved backstop target
ORAL SURGERY	ORAL SURGERY(C)	F09.4		SURGICAL	CRAIGAV	[redacted]		Day Case	ORAL SURGERY	Garrahy A Miss	22/11/2013	22/11/2013	N		04/04/2014	1	129	18	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M29.3		OTHER THI	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Young M Mr	22/11/2013	22/11/2013	N		29/04/2014	1	129	18	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Young M Mr	22/11/2013	22/11/2013	N			1	129	18	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	11/07/2013	22/11/2013	N			1	129	18	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N30.1		OPERATIO	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Young M Mr	22/11/2013	22/11/2013	N			1	129	18	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	A65.1		RELEASE	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	D02.1		EXTIRPATI	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Hewitt G.R. Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L85.1		LIGATION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.2		INJECTION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L87.4		OTHER OP	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L87.4		OTHER OP	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.3		TRANSLUM	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.5		OTHER EX	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N		01/04/2014	1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.5		OTHER EX	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Mallon P Mr	23/09/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T24.9		PRIMARY R	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	L84.1		COMBINED	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Independent Con	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L88.2		TRANSLUM	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	21/11/2013	21/11/2013	N		04/04/2014	1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	A65.1		RELEASE	SOUTH TY	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	21/11/2013	21/11/2013	N		18/04/2014	1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	T79.1		REPAIR OF	CRAIGAV	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mckeown R Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W88.9	Arthroscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Mckeown R Mr	21/11/2013	21/11/2013	N		07/04/2014	1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Young M Mr	21/11/2013	21/11/2013	N			1	130	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION	DAISY HILL	[redacted]		Normal Inpatient	GENERAL SURG	Brown R.J. Mr.	20/11/2013	20/11/2013	N		08/04/2014	1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.1		INJECTION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	14/05/2013	20/11/2013	N			1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.1		INJECTION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	20/11/2013	20/11/2013	N			1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L87.4		OTHER OP	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	13/11/2013	20/11/2013	N			1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.5		OTHER EX	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surge	26/06/2013	20/11/2013	N			1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surge	20/11/2013	20/11/2013	N		07/04/2014	1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T25.2		PRIMARY R	DAISY HILL	[redacted]		Normal Inpatient	GENERAL SURG	Gudyma J Mr	20/11/2013	20/11/2013	N		10/04/2014	1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W57.0		EXCISION F	CRAIGAV	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mckeown R Mr	01/08/2013	20/11/2013	N			1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	20/11/2013	20/11/2013	N			1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	20/11/2013	20/11/2013	N			1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N30.3		OPERATIO	CRAIGAV	[redacted]		Normal Inpatient	UROLOGY(C)	Pahuja A Mr	20/11/2013	20/11/2013	N			1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N30.4		OPERATIO	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Young M Mr	20/11/2013	20/11/2013	N			1	131	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
ENT	EAR NOSE AND THROA	D14.4		REPAIR OF	CRAIGAV	[redacted]		Normal Inpatient	EAR NOSE AND	Mcnaboe E.J. Mr	19/11/2013	19/11/2013	N		03/04/2014	1	132	19	1	1	1		Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
ENT	ENT CAWT (C)	F34.8		EXCISION	CRAIGAV	[redacted]		Day Case	ENT CAWT (C)	Korda M Mr	19/11/2013	19/11/2013	N		04/04/2014	1	132	19	1	1	1		Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
GENERAL SURGERY	GENERAL SURGERY(C)	L87.4		OTHER OP	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	19/11/2013	19/11/2013	N			1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.8		OTHER EX	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	19/11/2013	19/11/2013	N			1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T24.9		PRIMARY R	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	19/11/2013	19/11/2013	N		14/04/2014	1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T25.9		PRIMARY R	DAISY HILL	[redacted]		Normal Inpatient	GENERAL SURG	Hurreiz H Mr	10/10/2013	19/11/2013	N			1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L88.2		TRANSLUM	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	19/11/2013	19/11/2013	N		04/04/2014	1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L88.3		TRANSLUM	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	19/11/2013	19/11/2013	N		08/04/2014	1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W37.1		TOTAL PRO	CRAIGAV	[redacted]		Normal Inpatient	ORTHOPAEDICS	Patton S Mr	19/11/2013	19/11/2013	N			1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W74.2		OTHER RE	CRAIGAV	[redacted]		Normal Inpatient	ORTHOPAEDICS	Patton S Mr	19/11/2013	19/11/2013	N			1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	19/11/2013	19/11/2013	N			1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	19/11/2013	19/11/2013	N			1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	19/11/2013	19/11/2013	N			1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W90.3		PUNCTURE	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	19/11/2013	19/11/2013	N			1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M49.8		OTHER OP	CRAIGAV	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	19/11/2013	19/11/2013	N			1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N30.3		OPERATIO	CRAIGAV	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	19/11/2013	19/11/2013	N			1	132	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
ENT	EAR NOSE AND THROA	B08.4		EXCISION	CRAIGAV	[redacted]		Normal Inpatient	EAR NOSE AND	Mcnaboe E.J. Mr	18/11/2013	18/11/2013	N			1	133	19	1	1	1		Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
ENT	EAR NOSE AND THROA	B14.4		EXCISION	CRAIGAV	[redacted]		Normal Inpatient	EAR NOSE AND	Korda M Mr	18/11/2013	18/11/2013	N			1	133	19	1	1	1		Patient breached 13 Weeks but within maximum backstop (13 week specialties only)
GENERAL SURGERY	GENERAL SURGERY(C)	H48.2		EXCISION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Mackle E Mr	18/11/2013	18/11/2013	N			1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.1		EXCISION	CRAIGAV	[redacted]		Normal Inpatient	GENERAL SURG	Hewitt G.R. Mr	11/06/2013	18/11/2013	N			1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.8		OTHER EX	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Mallon P Mr	18/11/2013	18/11/2013	N			1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	X55.9		OTHER OP	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Independent Con	18/11/2013	18/11/2013	N			1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	A65.1		RELEASE	SOUTH TY	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	18/11/2013	18/11/2013	N		18/04/2014	1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	T52.1		EXCISION	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	18/11/2013	18/11/2013	N			1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W62.1		OTHER PR	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	18/11/2013	18/11/2013	N			1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W74.2		OTHER RE	CRAIGAV	[redacted]		Normal Inpatient	ORTHOPAEDICS	Bunn J Mr	04/02/2013	18/11/2013	N		29/04/2014	1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W90.1		PUNCTURE	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Bunn J Mr	18/11/2013	18/11/2013	N		29/04/2014	1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS (WLIO	W84.8		THERAPEU	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Mcconway J Mr	12/03/2013	18/11/2013	N		17/04/2014	1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Young M Mr	18/11/2013	18/11/2013	N		20/12/2013	1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	20/04/2013	18/11/2013	N			1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	DAISY HILL	[redacted]		Day Case	UROLOGY(C)	Brown R.J. Mr.	04/09/2013	04/09/2013	N		03/04/2014	1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOP	CRAIGAV	[redacted]		Normal Inpatient	UROLOGY(C)	Pahuja A Mr	18/11/2013	18/11/2013	N			1	133	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	A65.1		RELEASE	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	16/11/2013	16/11/2013	N			1	135	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION	CRAIGAV	[redacted]		Normal Inpatient	GENERAL SURG	Yousaf M Mr	16/11/2013	16/11/2013	N			1	135	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	N30.3		OPERATIO	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	16/11/2013	16/11/2013	N			1	135	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T24.9		PRIMARY R	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	16/11/2013	16/11/2013	N			1	135	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	T79.1		REPAIR OF	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Mcconway J Mr	16/08/2013	16/08/2013	N			1	135	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	BREAST SURGERY(C)	B27.6		TOTAL EXC	CRAIGAV	[redacted]		Normal Inpatient	BREAST SURGE	Mallon P Mr	15/11/2013	15/11/2013	N			1	136	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	A73.5		OTHER OP	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Epanomeritakis E	15/11/2013	15/11/2013	N			1	136	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L85.1		LIGATION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	04/06/2013	15/11/2013	N			1	136	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	N30.3		OPERATIO	DAISY HILL	[redacted]		Day Case	GENERAL SURG	Brown R.J. Mr.	15/11/2013	15/11/2013	N			1	136	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	15/11/2013	15/11/2013	N			1	136	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	T79.1		REPAIR OF	CRAIGAV	[redacted]		Day Case	ORTHOPAEDICS	Mcconway J Mr	15/11/2013	15/11/2013	N			1	136	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W37.1		TOTAL PRO	CRAIGAV	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	15/11/2013	15/11/2013	N			1	136	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Young M Mr	15/11/2013	15/11/2013	N		18/04/2014	1	136	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAV	[redacted]		Day Case	UROLOGY(C)	Young M Mr	15/11/2013	15/11/2013	N			1	136	19	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Hewitt G.R. Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.3		TRANSLUM	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.3		TRANSLUM	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S64.1		EXTIRPATI	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surge	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	CRAIGAV	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target

GENERAL SURGERY	GENERAL SURGERY (IS	S06.8		OTHER EXI	CRAIGAVC	Personal Information redacted by USI	Day Case	GENERAL SURG	Independent Con	20/09/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	T27.9		REPAIR OF	CRAIGAVC		Normal Inpatient	GENERAL SURG	Independent Con	15/08/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	A65.1		RELEASE C	SOUTH TY		Day Case	ORTHOPAEDICS	Wilson L Miss	14/11/2013	14/11/2013	N		11/04/2014	1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	A65.1		RELEASE C	SOUTH TY		Day Case	ORTHOPAEDICS	Wilson L Miss	20/06/2013	14/11/2013	N		11/04/2014	1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	A67.8		RELEASE C	CRAIGAVC		Day Case	ORTHOPAEDICS	Wilson L Miss	14/11/2013	14/11/2013	N		01/04/2014	1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	T52.1		EXCISION C	CRAIGAVC		Day Case	ORTHOPAEDICS	Wilson L Miss	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	T79.1		REPAIR OF	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Mckeown R Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	T79.1		REPAIR OF	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Mckeown R Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	T96.2		OTHER OPI	SOUTH TY		Day Case	ORTHOPAEDICS	Wilson L Miss	18/07/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W16.4		OTHER DIV	CRAIGAVC		Day Case	ORTHOPAEDICS	Wilson L Miss	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W45.1		OTHER TO	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Mckeown R Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W62.1		OTHER PR	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Wilson L Miss	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W77.1		STABILISIN	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Mckeown R Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W88.9	Arthroscopy	DIAGNOST	CRAIGAVC		Day Case	ORTHOPAEDICS	Wilson L Miss	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC		Day Case	UROLOGY(C)	Young M Mr	14/11/2013	14/11/2013	N			1	137	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION C	DAISY HILL		Normal Inpatient	GENERAL SURG	Hurreiz H Mr	13/11/2013	13/11/2013	N			1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L85.9		LIGATION C	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	13/11/2013	13/11/2013	N			1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.2		INJECTION	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	13/11/2013	13/11/2013	N			1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.2		INJECTION	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	13/11/2013	13/11/2013	N			1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	SOUTH TY		Day Case	GENERAL SURG	Lewis A Mr	13/11/2013	13/11/2013	N			1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S68.2		EXCISION C	SOUTH TY		Day Case	GENERAL SURG	A General Surge	13/11/2013	13/11/2013	N			1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	DAISY HILL		Normal Inpatient	GENERAL SURG	Gudyma J Mr	13/11/2013	13/11/2013	N		17/04/2014	1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	T79.1		REPAIR OF	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Mckeown R Mr	13/11/2013	13/11/2013	N			1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	T79.1		REPAIR OF	CRAIGAVC		Day Case	ORTHOPAEDICS	Mcconway J Mr	13/11/2013	13/11/2013	N			1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W28.3		OTHER INT	CRAIGAVC		Day Case	ORTHOPAEDICS	Bunn J Mr	13/11/2013	13/11/2013	N		29/04/2014	1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W37.1		TOTAL PRO	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	13/11/2013	13/11/2013	N		22/05/2014	1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W37.1		TOTAL PRO	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	13/11/2013	13/11/2013	N		15/05/2014	1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W37.1		TOTAL PRO	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	13/11/2013	13/11/2013	N		22/05/2014	1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W37.1		TOTAL PRO	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	13/11/2013	13/11/2013	N			1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W37.1		TOTAL PRO	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	13/11/2013	13/11/2013	N		21/05/2014	1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W37.9		TOTAL PRO	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Mcmurray D Mr	13/11/2013	13/11/2013	N			1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W40.1		TOTAL PRO	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	13/11/2013	13/11/2013	N		22/05/2014	1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC		Day Case	UROLOGY(C)	Young M Mr	13/11/2013	13/11/2013	N			1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC		Normal Inpatient	UROLOGY(C)	Glackin A J Mr	13/11/2013	13/11/2013	N		28/04/2014	1	138	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	A65.1		RELEASE C	SOUTH TY		Day Case	GENERAL SURG	Lewis A Mr	12/11/2013	12/11/2013	N		01/04/2014	1	139	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	A65.1		RELEASE C	SOUTH TY		Day Case	GENERAL SURG	Lewis A Mr	12/11/2013	12/11/2013	N		28/04/2014	1	139	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	A73.5		OTHER OPI	SOUTH TY		Day Case	GENERAL SURG	Weir C.D. Mr	23/05/2013	12/11/2013	N			1	139	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION C	CRAIGAVC		Day Case	GENERAL SURG	Weir C.D. Mr	12/11/2013	12/11/2013	N			1	139	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION C	CRAIGAVC		Day Case	GENERAL SURG	Weir C.D. Mr	12/11/2013	12/11/2013	N			1	139	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L85.1		LIGATION C	SOUTH TY		Day Case	GENERAL SURG	Lewis A Mr	12/11/2013	12/11/2013	N			1	139	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.2		INJECTION	SOUTH TY		Day Case	GENERAL SURG	Lewis A Mr	12/11/2013	12/11/2013	N			1	139	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L87.4		OTHER OPI	CRAIGAVC		Day Case	GENERAL SURG	Weir C.D. Mr	14/02/2013	12/11/2013	N			1	139	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	12/11/2013	12/11/2013	N			1	139	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.3		TRANSLUM	CRAIGAVC		Day Case	GENERAL SURG	Weir C.D. Mr	12/11/2013	12/11/2013	N			1	139	20	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	N17.1		EXCISION C	DAISY HILL		Day Case	GENERAL SURG	Brown R.J. Mr.

UROLOGY	UROLOGY(C)	N17.1			EXCISION (	CRAIGAVC	[redacted]	Day Case	UROLOGY(C)	Pahuja A Mr	06/11/2013	06/11/2013	N			1	145	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	A65.1			RELEASE C	CRAIGAVC		Day Case	GENERAL SURG	A General Surge	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	A65.1			RELEASE C	SOUTH TY		Day Case	GENERAL SURG	A General Surge	05/11/2013	05/11/2013	N		07/04/2014	1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	J18.8			EXCISION (	CRAIGAVC		Day Case	GENERAL SURG	Weir C.D. Mr	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	L85.1			LIGATION C	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	L86.2			INJECTION	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	S06.5			OTHER EX	SOUTH TY		Day Case	GENERAL SURG	A General Surge	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	S06.5			OTHER EX	SOUTH TY		Day Case	GENERAL SURG	Lewis A Mr	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	S06.9			OTHER EX	SOUTH TY		Day Case	GENERAL SURG	A General Surge	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	S06.9			OTHER EX	SOUTH TY		Day Case	GENERAL SURG	A General Surge	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	T20.2			PRIMARY R	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	T24.9			PRIMARY R	CRAIGAVC		Day Case	GENERAL SURG	Lewis A Mr	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	T59.1			EXCISION (	SOUTH TY		Day Case	GENERAL SURG	A General Surge	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	T79.1			REPAIR OF	CRAIGAVC		Day Case	ORTHOPAEDICS	Mcconway J Mr	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W37.1			TOTAL PR	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W37.1			TOTAL PR	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W74.2			OTHER RE	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Patton S Mr	05/11/2013	05/11/2013	N			1	146	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C	A65.1			RELEASE C	SOUTH TY		Day Case	GENERAL SURG	Lewis A Mr	07/05/2013	17/10/2013	N			1	147	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
ORAL SURGERY	ORAL SURGERY(C)	F09.1			SURGICAL	DAISY HILL		Day Case	ORAL SURGERY	Ramsay-Baggs F	04/11/2013	04/11/2013	N			1	147	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W16.4			OTHER DIV	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	04/11/2013	04/11/2013	N			1	147	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W37.1			TOTAL PR	CRAIGAVC		Normal Inpatient	ORTHOPAEDICS	Bunn J Mr	04/11/2013	04/11/2013	N		13/05/2014	1	147	21	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W84.8			THERAPEU	CRAIGAVC		Day Case	ORTHOPAEDICS	Mcconway J Mr	04/11/2013	04/11/2013	N	

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TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W40.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Patton S Mr	22/10/2013	22/10/2013	N			1	160	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	22/10/2013	22/10/2013	N			1	160	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	22/10/2013	22/10/2013	N			1	160	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M14.1		EXTRACOR	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	22/10/2013	22/10/2013	N			1	160	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M43.2		ENDOSCOP	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	22/10/2013	22/10/2013	N			1	160	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.5		OTHER EXC	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surgeo	21/10/2013	21/10/2013	N		01/04/2014	1	161	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EXC	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	A General Surgeo	21/10/2013	21/10/2013	N		02/04/2014	1	161	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	CRAIGAVO	[redacted]		Normal Inpatient	GENERAL SURG	Epanomeritakis E	21/10/2013	21/10/2013	N		17/04/2014	1	161	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Mallon P Mr	21/10/2013	21/10/2013	N			1	161	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Mallon P Mr	21/10/2013	21/10/2013	N		08/04/2014	1	161	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W28.3		OTHER INT	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	21/10/2013	21/10/2013	N		13/05/2014	1	161	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W74.2		OTHER REC	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Bunn J Mr	21/10/2013	21/10/2013	N		01/04/2014	1	161	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS (WLIO	W28.1		OTHER INT	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	21/10/2013	21/10/2013	N		18/04/2014	1	161	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Suresh K Mr	21/10/2013	21/10/2013	N		08/04/2014	1	161	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.5	Cystoscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	21/10/2013	21/10/2013	N			1	161	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N06.5		OTHER EXC	CRAIGAVO	[redacted]		Day Case	UROLOGY(C)	Glackin A.J Mr	21/10/2013	21/10/2013	N			1	161	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	03/09/2013	03/09/2013	N		23/04/2014	1	163	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W62.1		OTHER PRI	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	17/01/2013	04/09/2013	N			1	163	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N15.8		OPERATIO	CRAIGAVO	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	19/10/2013	19/10/2013	N		01/04/2014	1	163	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N32.8		OTHER OP	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Pahuja A Mr	19/10/2013	19/10/2013	N			1	163	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M13.4		PERCUTAN	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	18/10/2013	18/10/2013	N			1	164	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	18/10/2013	18/10/2013	N			1	164	23	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	A65.1		RELEASE C	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Hewitt G.R. Mr	17/10/2013	17/10/2013	N		01/04/2014	1	165	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	A65.1		RELEASE C	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surgeo	17/10/2013	17/10/2013	N		14/04/2014	1	165	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.2		INJECTION	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	17/10/2013	17/10/2013	N		09/04/2014	1	165	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	12/02/2013	30/08/2013	N		19/04/2014	1	165	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T30.9		OPENING C	CRAIGAVO	[redacted]		Normal Inpatient	GENERAL SURG	Hewitt G.R. Mr	17/10/2013	17/10/2013	N			1	165	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L86.2		INJECTION	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	17/10/2013	17/10/2013	N		02/04/2014	1	165	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	17/10/2013	17/10/2013	N		15/04/2014	1	165	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	M76.4		THERAPEU	DAISY HILL	[redacted]		Day Case	GENERAL SURG	Brown R.J. Mr.	16/10/2013	16/10/2013	N		28/04/2014	1	166	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	L85.1		LIGATION C	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Independent Con	16/10/2013	16/10/2013	N		21/04/2014	1	166	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS (IS)	W90.3		PUNCTURE	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Independent Con	05/06/2013	16/10/2013	N		14/04/2014	1	166	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M30.1	Ureteroscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	16/10/2013	16/10/2013	N			1	166	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Day Case	UROLOGY(C)	Young M Mr	16/10/2013	16/10/2013	N			1	166	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOSTI	DAISY HILL	[redacted]		Day Case	UROLOGY(C)	Brown R.J. Mr.	09/09/2013	16/10/2013	N			1	166	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION C	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	16/04/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L85.1		LIGATION C	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	15/10/2013	15/10/2013	N		10/04/2014	1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L85.1		LIGATION C	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L85.1		LIGATION C	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	15/10/2013	15/10/2013	N		25/04/2014	1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.2		INJECTION	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L87.4		OTHER OP	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	15/10/2013	15/10/2013	N		10/04/2014	1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EXC	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surgeo	15/10/2013	15/10/2013	N		07/04/2014	1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T27.9		REPAIR OF	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	15/10/2013	15/10/2013	N		08/04/2014	1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	J18.8		EXCISION C	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Independent Con	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	J18.8		EXCISION C	CRAIGAVO	[redacted]		Normal Inpatient	GENERAL SURG	Independent Con	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	L87.3		OTHER OP	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Independent Con	15/10/2013	15/10/2013	N		07/04/2014	1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	T24.2		PRIMARY R	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Independent Con	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L86.2		INJECTION	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	15/10/2013	15/10/2013	N		09/04/2014	1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	15/10/2013	15/10/2013	N		04/04/2014	1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	T96.2		OTHER OP	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W28.3		OTHER INT	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W58.1		OTHER REC	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Patton S Mr	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	15/10/2013	15/10/2013	N		30/04/2014	1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOP	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOP	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOP	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	15/10/2013	15/10/2013	N			1	167	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L85.1		LIGATION C	DAISY HILL	[redacted]		Normal Inpatient	GENERAL SURG	Hurreiz H Mr	14/10/2013	14/10/2013	N			1	168	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W19.9		PRIMARY C	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Wilson L Miss	14/10/2013	14/10/2013	N			1	168	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS (IS)	W84.8		THERAPEU	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Independent Con	14/10/2013	14/10/2013	N		23/04/2014	1	168	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M09.9		THERAPEU	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	14/10/2013	14/10/2013	N			1	168	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M09.9		THERAPEU	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	14/10/2013	14/10/2013	N			1	168	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M09.9		THERAPEU	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	14/10/2013	14/10/2013	N			1	168	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Day Case	UROLOGY(C)	Young M Mr	14/10/2013	14/10/2013	N			1	168	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M49.8		OTHER OP	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	14/10/2013	14/10/2013	N			1	168	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	H59.9		EXCISION C	CRAIGAVO	[redacted]		Normal Inpatient	GENERAL SURG	Epanomeritakis E	12/10/2013	12/10/2013	N		05/04/2014	1	170	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	N30.3		OPERATIO	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	12/10/2013	12/10/2013	N		08/04/2014	1	170	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOP	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Suresh K Mr	12/10/2013	12/10/2013	N			1	170	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EXC	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Hurreiz H Mr	05/09/2013	11/10/2013	N		16/04/2014	1	171	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	CRAIGAVO	[redacted]		Normal Inpatient	GENERAL SURG	Yousaf M Mr	11/10/2013	11/10/2013	N		07/04/2014	1	171	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	11/10/2013	11/10/2013	N		29/04/2014	1	171	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	A65.1		RELEASE C	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Murnaghan M Mr	11/10/2013	11/10/2013	N		15/05/2014	1	171	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M29.8		OTHER THI	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	11/10/2013	11/10/2013	N			1	171	24	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	10/10/2013	10/10/2013	N			1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	10/10/2013	10/10/2013	N		14/04/2014	1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	10/10/2013	10/10/2013	N		14/04/2014	1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T24.9		PRIMARY R	CRAIGAVO	[redacted]		Normal Inpatient	GENERAL SURG	Yousaf M Mr	10/10/2013	10/10/2013	N		17/04/2014	1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	L85.9		LIGATION C	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Independent Con	10/10/2013	10/10/2013	N			1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	L85.9		LIGATION C	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Independent Con	10/10/2013	10/10/2013	N		27/04/2014	1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	N17.1		EXCISION C	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Independent Con	10/10/2013	10/10/2013	N		02/04/2014	1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	T20.2		PRIMARY R	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Independent Con	10/10/2013	10/10/2013	N		02/04/2014	1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	T20.8		PRIMARY R	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Independent Con	10/10/2013	10/10/2013	N			1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	T24.2		PRIMARY R	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Independent Con	10/10/2013	10/10/2013	N			1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	10/10/2013	10/10/2013	N		04/04/2014	1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W06.8		TOTAL EXC	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Wilson L Miss	10/10/2013	10/10/2013	N		06/05/2014	1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W06.8		TOTAL EXC	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Wilson L Miss	10/10/2013	10/10/2013	N			1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W19.9		PRIMARY C	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Wilson L Miss	10/10/2013	10/10/2013	N		13/05/2014	1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W55.1		PROSTHET	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	10/10/2013	10/10/2013	N		29/04/2014	1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M05.1		OPEN REPA	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	10/10/2013	10/10/2013	N			1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	10/10/2013	10/10/2013	N			1	172	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	09/10/2013	09/10/2013	N		28/04/2014	1	173	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W37.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	09/10/2013	09/10/2013	N		14/05/2014	1	173	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W40.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcmurray D Mr	09/10/2013	09/10/2013	N		24/04/2014	1	173	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W40.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcmurray D Mr	10/09/2013	10/09/2013	N		25/04/2014	1	173	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W40.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcmurray D Mr	09/10/2013	09/10/2013	N			1	173	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W40.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	09/10/2013	09/10/2013	N		10/04/2014	1	173	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS (WLIO	W40.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	09/10/2013	09/10/2013	N		17/04/2014	1	173	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M09.9		THERAPEU	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	09/10/2013	09/10/2013	N			1	173	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.8	Cystoscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	09/10/2013	09/10/2013	N			1	173	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	A65.1		RELEASE C	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	08/10/2013	08/10/2013	N		10/04/2014	1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.2		INJECTION	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	08/10/2013	08/10/2013	N		09/04/2014	1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	08/10/2013	08/10/2013	N		28/04/2014	1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	08/10/2013	08/10/2013	N		28/04/2014	1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L86.2		INJECTION	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	08/10/2013	08/10/2013	N		09/04/2014	1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W37.9		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Patton S Mr	08/10/2013	08/10/2013	N			1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W40.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Patton S Mr	08/10/2013	08/10/2013	N		02/04/2014	1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W40.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Patton S Mr	08/10/2013	08/10/2013	N			1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W40.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Patton S Mr	08/10/2013	08/10/2013	N			1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W42.4		OTHER TOT	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Patton S Mr	08/10/2013	08/10/2013	N			1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W45.3		OTHER TOT	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mckeown R Mr	22/11/2012	08/10/2013	N		06/04/2014	1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	08/10/2013	08/10/2013	N		09/04/2014	1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS (IS)	W42.1		OTHER TOT	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Independent Con	15/01/2013	08/10/2013	N		09/04/2014	1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS (WLIO	W40.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	08/10/2013	08/10/2013	N		16/04/2014	1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS (WLIO	W78.8		RELEASE C	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	08/10/2013	08/10/2013	N		23/04/2014	1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Day Case	UROLOGY(C)	Young M Mr	08/10/2013	08/10/2013	N			1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOP	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Pahuja A Mr	08/10/2013	08/10/2013	N			1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N30.2		OPERATIO	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	08/10/2013	08/10/2013	N			1	174	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EXC	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Mallon P Mr	07/10/2013	07/10/2013	N		16/04/2014	1	175	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EXC	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surgeo	07/10/2013	07/10/2013	N		28/04/2014	1	175	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S68.2		EXCISION C	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Mallon P Mr	07/10/2013	07/10/2013	N			1	175	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W19.9		PRIMARY C	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Wilson L Miss	07/10/2013	07/10/2013	N			1	175	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS(C)	W28.3		OTHER INT	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	07/10/2013	07/10/2013	N		29/04/2014	1	175	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS (WLIO	W37.1		TOTAL PRO	CRAIGAVO	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	07/10/2013	07/10/2013	N		16/04/2014	1	175	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	07/10/2013	07/10/2013	N			1	175	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOP	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Pahuja A Mr	07/10/2013	07/10/2013	N			1	175	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N08.2		BILATERAL	CRAIGAVO	[redacted]		Day Case	UROLOGY(C)	O'Brien A Mr	07/10/2013	07/10/2013	N			1	175	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.2		INJECTION	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	05/10/2013	05/10/2013	N		09/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L87.3		OTHER OP	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	05/10/2013	05/10/2013	N			1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L87.4		OTHER OP	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	05/10/2013	05/10/2013	N		14/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	05/10/2013	05/10/2013	N		14/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (IS	H44.4		MANIPULAT	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Independent Con	22/07/2013	22/07/2013	N		02/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L86.2		INJECTION	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	05/10/2013	05/10/2013	N		02/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L86.2		INJECTION	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	05/10/2013	05/10/2013	N		08/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	05/10/2013	05/10/2013	N		08/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	05/10/2013	05/10/2013	N		08/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	05/10/2013	05/10/2013	N		08/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	05/10/2013	05/10/2013	N		15/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L88.2		TRANSLUM	CRAIGAVO	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	05/10/2013	05/10/2013	N		08/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOP	ORTHOPAEDICS (IS)	T52.1		EXCISION C	CRAIGAVO	[redacted]		Day Case	ORTHOPAEDICS	Independent Con	05/10/2013	05/10/2013	N		16/04/2014	1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M79.4		OTHER OP	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	05/10/2013	05/10/2013	N			1	177	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.8		OTHER EXC	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surgeo	04/10/2013	04/10/2013	N		01/04/2014	1	178	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOSTI	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	04/10/2013	04/10/2013	N			1	178	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M42.1		ENDOSCOP	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	04/10/2013	04/10/2013	N			1	178	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M44.1		OTHER THI	CRAIGAVO	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	04/10/2013	04/10/2013	N			1	178	25	1	1	1		Patient breached 13 Weeks but achieved backstop target

						Personal Information redacted by USI																	
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	04/10/2013	04/10/2013	N			1	178	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M76.4		THERAPEU	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	04/10/2013	04/10/2013	N			1	178	25	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	H44.4		MANIPULAT	CRAIGAVC	[redacted]		Normal Inpatient	GENERAL SURG	Epanomeritakis E	03/10/2013	03/10/2013	N		03/04/2014	1	179	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX(	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surge(	03/10/2013	03/10/2013	N		03/04/2014	1	179	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	CRAIGAVC	[redacted]		Normal Inpatient	GENERAL SURG	Yousaf M Mr	03/10/2013	03/10/2013	N		28/04/2014	1	179	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T20.9		PRIMARY R	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	03/10/2013	03/10/2013	N		29/04/2014	1	179	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	T96.2		OTHER OPI	CRAIGAVC	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	11/04/2013	03/10/2013	N		08/04/2014	1	179	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS (IS)	W62.1		OTHER PRI	CRAIGAVC	[redacted]		Day Case	ORTHOPAEDICS	Independent Con	03/10/2013	03/10/2013	N		11/04/2014	1	179	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS (IS)	W90.3		PUNCTURE	CRAIGAVC	[redacted]		Day Case	ORTHOPAEDICS	Independent Con	03/10/2013	03/10/2013	N		10/04/2014	1	179	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	A65.1		RELEASE C	CRAIGAVC	[redacted]		Day Case	GENERAL SURG	Hurreiz H Mr	24/07/2013	02/10/2013	N		02/04/2014	1	180	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	G75.3		ATTENTION	CRAIGAVC	[redacted]		Normal Inpatient	GENERAL SURG	Epanomeritakis E	02/10/2013	02/10/2013	N		05/04/2014	1	180	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W37.9		TOTAL PRC	CRAIGAVC	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcmurray D Mr	02/10/2013	02/10/2013	N		25/04/2014	1	180	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W37.9		TOTAL PRC	CRAIGAVC	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcmurray D Mr	02/10/2013	02/10/2013	N			1	180	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W40.1		TOTAL PRC	CRAIGAVC	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcmurray D Mr	02/10/2013	02/10/2013	N			1	180	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W40.1		TOTAL PRC	CRAIGAVC	[redacted]		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	02/10/2013	02/10/2013	N			1	180	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.8	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Pahuja A Mr	26/06/2013	02/10/2013	N			1	180	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	H59.9		EXCISION (	SOUTH TY	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	27/02/2013	19/07/2013	N		29/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	J18.8		EXCISION (	CRAIGAVC	[redacted]		Normal Inpatient	GENERAL SURG	Epanomeritakis E	08/05/2013	08/05/2013	N		03/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L85.1		LIGATION (	CRAIGAVC	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	01/10/2013	01/10/2013	N		23/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L86.2		INJECTION	CRAIGAVC	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	01/10/2013	01/10/2013	N		15/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVC	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	01/10/2013	01/10/2013	N		15/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVC	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	01/10/2013	01/10/2013	N		11/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVC	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	01/10/2013	01/10/2013	N		01/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	L88.2		TRANSLUM	CRAIGAVC	[redacted]		Day Case	GENERAL SURG	Lewis A Mr	01/10/2013	01/10/2013	N		11/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX(	CRAIGAVC	[redacted]		Day Case	GENERAL SURG	Epanomeritakis E	01/10/2013	01/10/2013	N		05/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	S06.9		OTHER EX(	CRAIGAVC	[redacted]		Day Case	GENERAL SURG	Yousaf M Mr	18/01/2013	07/08/2013	N		08/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	T01.3		PARTIAL E)	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surge(	01/10/2013	01/10/2013	N		03/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	X38.2		SUBCUTAN	SOUTH TY	[redacted]		Day Case	GENERAL SURG	A General Surge(	01/10/2013	01/10/2013	N		01/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY (W	L86.2		INJECTION	CRAIGAVC	[redacted]		Day Case	GENERAL SURG	Weir C.D. Mr	01/10/2013	01/10/2013	N		15/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W40.1		TOTAL PRC	CRAIGAVC	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcmurray D Mr	12/12/2012	01/10/2013	N			1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W77.2		STABILISIN	CRAIGAVC	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	16/10/2012	01/10/2013	N		08/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W87.9	Arthroscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	ORTHOPAEDICS	Patton S Mr	01/10/2013	01/10/2013	N		09/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS (WLIO	W37.9		TOTAL PRC	CRAIGAVC	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	30/01/2013	30/01/2013	N		23/04/2014	1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M43.4		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	01/10/2013	01/10/2013	N			1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N28.8		PLASTIC OI	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	01/10/2013	01/10/2013	N			1	181	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
GENERAL SURGERY	GENERAL SURGERY(C)	H44.4		MANIPULAT	DAISY HILI	[redacted]		Day Case	GENERAL SURG	Neill A K Mr	26/11/2012	26/11/2012	N			1	182	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W45.9		OTHER TO'	CRAIGAVC	[redacted]		Normal Inpatient	ORTHOPAEDICS	Murnaghan M Mr	21/08/2013	21/08/2013	N		15/05/2014	1	182	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS(C)	W62.1		OTHER PRI	CRAIGAVC	[redacted]		Day Case	ORTHOPAEDICS	Wilson L Miss	30/09/2013	30/09/2013	N			1	182	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS (IS)	W57.2		EXCISION F	CRAIGAVC	[redacted]		Day Case	ORTHOPAEDICS	Independent Con	03/02/2013	03/08/2013	N		23/04/2014	1	182	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
TRAUMA AND ORTHOI	ORTHOPAEDICS (WLIO	W40.1		TOTAL PRC	CRAIGAVC	[redacted]		Normal Inpatient	ORTHOPAEDICS	Mcconway J Mr	30/09/2013	30/09/2013	N		14/04/2014	1	182	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	30/09/2013	30/09/2013	N			1	182	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	30/09/2013	30/09/2013	N			1	182	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	30/09/2013	30/09/2013	N			1	182	26	1	1	1		Patient breached 13 Weeks but achieved backstop target
UROLOGY	UROLOGY(C)	N30.3		OPERATIOI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	27/09/2013	27/09/2013	N			1	185	26	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Suresh K Mr	25/09/2013	25/09/2013	N		04/04/2014	1	187	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	25/09/2013	25/09/2013	N			1	187	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	25/09/2013	25/09/2013	N			1	187	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	25/09/2013	25/09/2013	N			1	187	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N30.3		OPERATIOI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	25/09/2013	25/09/2013	N			1	187	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	24/09/2013	24/09/2013	N			1	188	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	23/09/2013	23/09/2013	N			1	189	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	23/09/2013	23/09/2013	N			1	189	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	23/09/2013	23/09/2013	N			1	189	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	20/09/2013	20/09/2013	N			1	192	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	20/09/2013	20/09/2013	N			1	192	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	20/09/2013	20/09/2013	N			1	192	27	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M79.4		OTHER OPI	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	19/09/2013	19/09/2013	N			1	193	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M09.9		THERAPEU	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Pahuja A Mr	18/09/2013	18/09/2013	N			1	194	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	18/09/2013	18/09/2013	N			1	194	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Suresh K Mr	18/09/2013	18/09/2013	N		07/04/2014	1	194	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	17/09/2013	17/09/2013	N			1	195	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	17/09/2013	17/09/2013	N			1	195	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M79.4		OTHER OPI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	17/09/2013	17/09/2013	N			1	195	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M05.3		OPEN REP/	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Glackin A.J Mr	16/09/2013	16/09/2013	N			1	196	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Suresh K Mr	16/09/2013	16/09/2013	N			1	196	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	16/09/2013	16/09/2013	N			1	196	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M81.4		OPERATIOI	SOUTH TY	[redacted]		Day Case	UROLOGY(C)	Glackin A.J Mr	16/09/2013	16/09/2013	N			1	196	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	15/09/2013	15/09/2013	N			1	197	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M76.4		THERAPEU	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Glackin A.J Mr	13/09/2013	13/09/2013	N			1	199	28	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	11/09/2013	11/09/2013	N			1	201	29	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	09/09/2013	09/09/2013	N			1	203	29	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	09/09/2013	09/09/2013	N			1	203	29	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N30.3		OPERATIOI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	09/09/2013	09/09/2013	N			1	203	29	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N30.3		OPERATIOI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	07/09/2013	07/09/2013	N		01/04/2014	1	205	29	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M13.4		PERCUTAN	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	06/09/2013	06/09/2013	N			1	206	29	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	06/09/2013	06/09/2013	N			1	206	29	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	06/09/2013	06/09/2013	N			1	206	29	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	04/09/2013	04/09/2013	N			1	208	30	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M43.2		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	03/09/2013	03/09/2013	N			1	209	30	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	02/09/2013	02/09/2013	N			1	210	30	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	02/09/2013	02/09/2013	N			1	210	30	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	02/09/2013	02/09/2013	N			1	210	30	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N15.3		OPERATIOI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Glackin A.J Mr	02/09/2013	02/09/2013	N			1	210	30	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N28.8		PLASTIC OI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	31/08/2013	31/08/2013	N			1	212	30	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M13.1		PERCUTAN	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	14/08/2013	30/08/2013	N			1	213	30	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	30/08/2013	30/08/2013	N			1	213	30	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M76.4		THERAPEU	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	30/08/2013	30/08/2013	N			1	213	30	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N17.1		EXCISION (	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	30/08/2013	30/08/2013	N			1	213	30	1	1	1	1	Patient breached maximum Backstop
ORAL SURGERY	ORAL SURGERY(C)	F09.3		SURGICAL	DAISY HILI	[redacted]		Day Case	ORAL SURGERY	Ramsay-Baggs F	29/08/2013	29/08/2013	N		03/04/2014	1	214	31	1	1	1	1	Patient breached maximum Backstop
ORAL SURGERY	ORAL SURGERY(C)	F38.9		EXTIRPATI(	DAISY HILI	[redacted]		Day Case	ORAL SURGERY	Ramsay-Baggs F	29/08/2013	29/08/2013	N		03/04/2014	1	214	31	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	28/08/2013	28/08/2013	N			1	215	31	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M09.9		THERAPEU	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Pahuja A Mr	27/08/2013	27/08/2013	N			1	216	31	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.8	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	14/03/2013	14/03/2013	N			1	216	31	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	02/10/2012	27/08/2013	N			1	216	31	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N17.1		EXCISION (	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	27/08/2013	27/08/2013	N			1	216	31	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M13.4		PERCUTAN	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	23/08/2013	23/08/2013	N			1	220	31	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	23/08/2013	23/08/2013	N			1	220	31	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	23/08/2013	23/08/2013	N			1	220	31	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N18.1		REPAIR OF	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Pahuja A Mr	23/08/2013	23/08/2013	N			1	220	31	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N30.3		OPERATIOI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	21/08/2013	21/08/2013	N			1	222	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M43.2		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	20/08/2013	20/08/2013	N			1	223	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	20/08/2013	20/08/2013	N			1	223	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	20/08/2013	20/08/2013	N			1	223	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	20/08/2013	20/08/2013	N			1	223	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M47.3		URETHRAL	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	20/08/2013	20/08/2013	N			1	223	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N30.2		OPERATIOI	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	20/08/2013	20/08/2013	N			1	223	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M02.5		TOTAL EXC	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	19/08/2013	19/08/2013	N			1	224	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M09.9		THERAPEU	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	19/08/2013	19/08/2013	N			1	224	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	19/08/2013	19/08/2013	N			1	224	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	19/08/2013	19/08/2013	N			1	224	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	19/08/2013	19/08/2013	N			1	224	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	19/08/2013	19/08/2013	N			1	224	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N28.8		PLASTIC OI	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	19/08/2013	19/08/2013	N			1	224	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N32.9		OTHER OPI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	19/08/2013	19/08/2013	N			1	224	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.8	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	16/08/2013	16/08/2013	N			1	227	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	16/08/2013	16/08/2013	N			1	227	32	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N11.1		OPERATIOI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	14/08/2013	14/08/2013	N			1	229	33	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	12/08/2013	12/08/2013	N			1	231	33	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	12/08/2013	12/08/2013	N			1	231	33	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M27.1		THERAPEU	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	09/08/2013	09/08/2013	N			1	234	33	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	09/08/2013	09/08/2013	N			1	234	33	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N30.3		OPERATIOI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	09/08/2013	09/08/2013	N			1	234	33	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Suresh K Mr	06/08/2013	06/08/2013	N			1	237	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M02.5		TOTAL EXC	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	05/08/2013	05/08/2013	N			1	238	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M09.9		THERAPEU	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	05/08/2013	05/08/2013	N			1	238	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M14.1		EXTRACOR	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	05/08/2013	05/08/2013	N			1	238	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	05/08/2013	05/08/2013	N			1	238	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	05/08/2013	05/08/2013	N			1	238	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M49.8		OTHER OPI	SOUTH TY	[redacted]		Day Case	UROLOGY(C)	Glackin A.J Mr	05/08/2013	05/08/2013	N			1	238	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N30.3		OPERATIOI	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Pahuja A Mr	13/11/2012	05/08/2013	N			1	238	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M43.4		ENDOSCOF	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	02/08/2013	02/08/2013	N			1	241	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	02/08/2013	02/08/2013	N			1	241	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	02/08/2013	02/08/2013	N			1	241	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N15.3		OPERATIOI	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	02/08/2013	02/08/2013	N			1	241	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	Y38.8		INJECTION	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	02/08/2013	02/08/2013	N			1	241	34	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	01/08/2013	01/08/2013	N			1	242	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	03/09/2012	15/04/2013	N			1	242	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M79.4		OTHER OPI	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	01/08/2013	01/08/2013	N			1	242	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Suresh K Mr	31/07/2013	31/07/2013	N		05/04/2014	1	243	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M14.1		EXTRACOR	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	30/07/2013	30/07/2013	N			1	244	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	Young M Mr	29/07/2013	29/07/2013	N			1	245	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M49.8		OTHER OPI	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	29/07/2013	29/07/2013	N			1	245	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M29.3		OTHER THI	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	Young M Mr	26/07/2013	26/07/2013	N			1	248	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M34.3		TOTAL EXC	CRAIGAVC	[redacted]		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	26/07/2013	26/07/2013	N			1	248	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	[redacted]		Day Case	UROLOGY(C)	O'Brien A Mr	26/07/2013	26/07/2013	N			1	248	35	1	1	1	1	Patient breached maximum Backstop

UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC	Personal Information redacted by USI	Day Case	UROLOGY(C)	Young M Mr	26/07/2013	26/07/2013	N			1	248	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC		Normal Inpatient	UROLOGY(C)	Young M Mr	26/07/2013	26/07/2013	N			1	248	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	26/07/2013	26/07/2013	N			1	248	35	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC		Day Case	UROLOGY(C)	Young M Mr	25/07/2013	25/07/2013	N			1	249	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M30.9	Ureteroscopy	DIAGNOST	CRAIGAVC		Day Case	UROLOGY(C)	Young M Mr	25/07/2013	25/07/2013	N			1	249	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M49.8		OTHER OP	CRAIGAVC		Normal Inpatient	UROLOGY(C)	Young M Mr	21/05/2012	25/07/2013	N			1	249	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N17.1		EXCISION C	CRAIGAVC		Day Case	UROLOGY(C)	Suresh K Mr	25/07/2013	25/07/2013	N			1	249	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M29.3		OTHER TH	CRAIGAVC		Day Case	UROLOGY(C)	Young M Mr	24/07/2013	24/07/2013	N			1	250	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC		Day Case	UROLOGY(C)	Suresh K Mr	24/07/2013	24/07/2013	N			1	250	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N17.1		EXCISION C	CRAIGAVC		Day Case	UROLOGY(C)	Pahuja A Mr	24/07/2013	24/07/2013	N			1	250	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	23/07/2013	23/07/2013	N			1	251	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N09.3		OTHER PL	CRAIGAVC		Day Case	UROLOGY(C)	Glacklin A J Mr	23/07/2013	23/07/2013	N			1	251	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	N09.3		OTHER PL	CRAIGAVC		Day Case	UROLOGY(C)	O'Brien A Mr	23/07/2013	23/07/2013	N			1	251	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOF	CRAIGAVC		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	22/07/2013	22/07/2013	N			1	252	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M43.2		ENDOSCOF	CRAIGAVC		Normal Inpatient	UROLOGY(C)	O'Brien A Mr	20/07/2013	20/07/2013	N			1	254	36	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST

UROLOGY	UROLOGY(C)	M47.4		URETHRAL	CRAIGAVC	Personal Information redacted by USI		Day Case	UROLOGY(C)	Young M Mr	06/04/2012	18/09/2012	N			1	440	63	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M45.9	Cystoscopy	DIAGNOST	CRAIGAVC			Day Case	UROLOGY(C)	Young M Mr	09/01/2013	09/01/2013	N			1	446	64	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M79.4		OTHER OPI	CRAIGAVC			Day Case	UROLOGY(C)	Young M Mr	12/10/2012	12/10/2012	N			1	450	64	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M02.5		TOTAL EXC	CRAIGAVC			Normal Inpatient	UROLOGY(C)	Young M Mr	04/01/2013	04/01/2013	N			1	451	64	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M19.1		URINARY D	CRAIGAVC			Normal Inpatient	UROLOGY(C)	O'Brien A Mr	11/12/2012	11/12/2012	N			1	475	68	1	1	1	1	Patient breached maximum Backstop
UROLOGY	UROLOGY(C)	M65.3		ENDOSCOI	CRAIGAVC			Normal Inpatient	UROLOGY(C)	Young M Mr	27/09/2012	27/09/2012	N			1	481	69	1	1	1	1	Patient breached maximum Backstop

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

Source - Inpatients Waiting Monthly Universe, Business Objects

SOUTHERN HEALTH AND SOCIAL CARE TRUST

on PAS after Month End WL Position Date

Patient Level List - Inpatients and Daycases Waiting More than 13 Weeks on Month End Waiting List Extract

Month End Waiting List Position Date	30/09/2009
Acute Information Team Report Run Date	01/10/2009

Notes

Please Select Validated Outcome from the Drop-Down list in Column B - 'Trust Validated Outcome'

When Selecting the Reason 'No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date', please ensure that the Validated Outcome has been Recorded on PAS with an Activity Date (i.e. Admission Date / Attendance Date / Clock-Reset Date / Waiting List Cancellation / Discharge Date) prior to the 1st day of the new month following the above WL Position Date. Otherwise, this will statistically continue to look like a Breach on PAS as at the Month End Position Date listed above.

If you wish to record any additional information in relation to the Validated Outcome listed in the Column 'Trust Validated Outcome', please enter this in Column C for information purposes.

Trust Validated Outcome	Additional Information on Validated Outcome	Hospital	Casenote	Specialty	Consultant	Admission Reason	Intended Pri	Intended Mg	Urgency Co	Current Dat	Date Booke	WL Effectiv	Operation Description	Waiting mor	Total Days
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH	Personal Information redacted by USI	URO	Young M Mr	ONISLT R URETEROSCOPIC LASERTRIPSY(DIVERTICULAR STONE)BFC	M30.9	N	ROUTINE	11/05/2009	27/09/2009	30/09/2009	R URETEROSCOPIC LAS	1	142
Confirmed Month End Breacher		CAH		URO	Young M Mr	INPATIENT CYSTOSCOPY (SUITABLE FOR TRANSFER TO IS)	M45.9	N	ROUTINE	22/06/2009		30/09/2009	INPATIENT CYSTOSCOP	1	100
Confirmed Month End Breacher		CAH		URO	Young M Mr	GA CYSTOSCOPY & INSERTION OF SPC POA HOLD - TCI DB4	M45.9	N	ROUTINE	17/06/2009		30/09/2009	GA CYSTOSCOPY & INS	1	105
Confirmed Month End Breacher		CAH		URO	Young M Mr	ONISTL TURP BFC	M65.3	N	ROUTINE	30/06/2009	25/10/2009	30/09/2009	TURP POA HOLD FOR F	1	92
Confirmed Month End Breacher		CAH		URO	Young M Mr	TURP - INSULIN DEP DIABETIC POA HOLD	M65.3	N	ROUTINE	18/06/2009		30/09/2009	TURP - INSULIN DEP DIA	1	104
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	OPTICAL URETHROTOMY - POA HOLD F2F 29/09	M76.3	N	URGENT	05/06/2009	02/10/2009	30/09/2009	OPTICAL URETHROTOM	1	117
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	CYSTOSCOPY AND TURBT - POA HOLD 29/09	M45.9	N	URGENT	10/06/2009	30/10/2009	30/09/2009	CYSTOSCOPY AND TUR	1	112
Confirmed Month End Breacher		CAH		URO	Young M Mr	PER PATIENT MUST BE CAH PER IP DR JEFF BROWN	M65.3	N	ROUTINE	03/06/2009		30/09/2009	TURP - LET IN BF - POA	1	119
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Young M Mr	ONISTL URETEROSCOPY & LASERTRIPSY BFC POA FIT	M30.9	N	ROUTINE	22/06/2009	27/09/2009	30/09/2009	URETEROSCOPY & LASE	1	100
Confirmed Month End Breacher		CAH		URO	Young M Mr	FLEXIBLE CYSTOSCOPY (ONLY WANTS CAH)	M45.9	D	ROUTINE	19/06/2009	30/10/2009	30/09/2009	FLEXIBLE CYSTOSCOPY	1	103
Confirmed Month End Breacher		CAH		URO	Young M Mr	LEFT FLEXIBLE URETEROSCOPIC LASERTRIPSY - ASPIRIN POA FIT	M30.9	N	ROUTINE	15/06/2009		30/09/2009	LEFT FLEXIBLE URETER	1	107
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	EXPLORATION LEFT SCROTUM-INSULIN DEPENDENT DIABETIC-POA FIT	N03.4	N	ROUTINE	16/06/2009	02/10/2009	30/09/2009	EXPLORATION LEFT SCI	1	106
Confirmed Month End Breacher		CAH		URO	Young M Mr	BOTOX POA FIT	M43.4	N	URGENT	26/06/2009		30/09/2009	BOTOX	1	96
Confirmed Month End Breacher		CAH		URO	Young M Mr	LFT FLEX URETEROSCOPY-PT WHEELCHAIR(CVA)POAFIT LONG ST WARF	M30.9	N	ROUTINE	30/03/2009	05/10/2009	30/09/2009	LEFT FLEXIBLE URETER	1	184
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	RIGHT URETEROSCOPY - INPT GA Q POSTED	M30.9	N	ROUTINE	16/06/2009	02/10/2009	30/09/2009	RIGHT URETEROSCOPY	1	106
Confirmed Month End Breacher		CAH		URO	Young M Mr	JUNE 2009-IVU-48HR-POA FIT- (NOT SUITABLE FOR IS - PER MY)	M76.3	N	ROUTINE	26/03/2009	13/10/2009	30/09/2009	JUNE 2009 - IVU	1	188
Confirmed Month End Breacher		CAH		URO	Young M Mr	SEEPROCEDBELOW-PT ONLY WANTS CAH ASPERGP14/05/09 LONGSTPOAFI	M45.9	N	URGENT	14/05/2009		30/09/2009	GA CYSTSOCOPY +/- BL	1	139
Confirmed Month End Breacher		CAH		URO	Young M Mr	TURPDONOTTRANSFERONPLAVIX-WAITINGDECISIONMCNEOWN LONGSTAY-QP	M65.3	N	ROUTINE	17/12/2008		30/09/2009	TURP Q/POSTED	1	129
Confirmed Month End Breacher		CAH		URO	Young M Mr	FLEXIBLE CYSTOSCOPY (PT HAD STROKE - NEEDS CAH)	M45.9	D	URGENT	19/06/2009		30/09/2009	FLEXIBLE CYSTOSCOPY	1	103
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	POST VOID RESIDUAL MEASUREMENTS +/- CISC - POA FIT		N	ROUTINE	02/06/2009	03/10/2009	30/09/2009		1	120
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	TURP - POA HOLD F2F 29/9	M65.3	N	URGENT	27/06/2009		30/09/2009	TURP	1	95
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	LEFT EPIDIDYMECTOMY&FLEX CYSTOSCOPY-POA FIT (ONLY WANTS CAH)	M45.9	D	URGENT	02/06/2009	06/10/2009	30/09/2009		1	93
Confirmed Month End Breacher		CAH		URO	Young M Mr	R URETEROSCOPY & LASERTRIPSY -UNFIT FOR TRANSFER/POAHOLD	M30.9	N	ROUTINE	03/06/2009	11/10/2009	30/09/2009	R URETEROSCOPY & LA	1	119
Confirmed Month End Breacher		CAH		URO	Young M Mr	REPAIR OF INCISIONAL HERNIA - POA FIT	T25.9	D	ROUTINE	12/06/2009		30/09/2009	REPAIR OF INCISIONAL	1	110
Confirmed Month End Breacher		CAH		URO	Young M Mr	LEFT FLEXIBLE URETEROSCOPY - POA HOLD F2F 29/09	M30.9	N	ROUTINE	03/06/2009		30/09/2009	LEFT FLEXIBLE URETER	1	119
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Young M Mr	ONISTL SEE BELOW BFC	M45.9	N	URGENT	13/02/2009	26/09/2009	30/09/2009	GA CYSTOSCOPY & URE	1	112
Confirmed Month End Breacher		CAH		URO	Young M Mr	ONISTL TURP BFC	M65.3	N	ROUTINE	11/06/2009	21/10/2009	30/09/2009	TURP POA HOLD FOR F	1	111
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	optical urethrotomy&cystolithopaxy(DO NOT TRANSFER)-POA HOLD		N	URGENT	02/06/2009	02/10/2009	30/09/2009	history of hepatitis C and H	1	120
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	GA CYSTOSCOPY - POA FIT	M45.9	N	ROUTINE	16/06/2009		30/09/2009	GA CYSTOSCOPY	1	106
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Akhtar M Mr	ONISTL OPTICAL URETHROTOMY&URETHRAL DILATATION BFC-Q/POSTED	M76.3	N	URGENT	15/06/2009	27/09/2009	30/09/2009	OPTICAL URETHROTOM	1	107
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Young M Mr	ESWL UNDER ULTRASOUND - MON APPT	M14.1	D	ROUTINE	08/06/2009	21/09/2009	30/09/2009	ESWL UNDER ULTRASO	1	114
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	RIGHT LAPAROSCOPIC NEPHRO-URETERECTOMY POA FIT	M02.2	N	URGENT	08/06/2009	09/10/2009	30/09/2009	RIGHT LAPAROSCOPIC I	1	114
Confirmed Month End Breacher		CAH		URO	Young M Mr	L URETEROSCOPIC FLEX LASERTRIPSY-ASPIRIN-DIABETIC POA FIT	M30.9	N	ROUTINE	15/06/2009		30/09/2009	LEFT URETEROSCOPIC	1	107
Confirmed Month End Breacher		CAH		URO	Young M Mr	RIGHT EPIDIDYMAL CYST EXCISION & CYSTOSCOPY (await mri 1st)	N15.3	D	ROUTINE	29/05/2009		30/09/2009	RIGHT EPIDIDYMAL CYS	1	124
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	cystoscopy ?TURBT - POA HOLD		N	URGENT	30/06/2009		30/09/2009	cystoscopy ? TURBT PAT	1	92
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	TUR PREVIOUS RESECTION SCAR Q POSTED POA HOLD	M42.1	N	URGENT	22/06/2009	05/10/2009	30/09/2009	TUR PREVIOUS RESECT	1	100
Confirmed Month End Breacher		CAH		URO	Young M Mr	AUGUST 2009 - TROC (REF. FROM MANOS) Q POSTED	M47.3	D	ROUTINE	16/06/2009	23/10/2009	30/09/2009	AUGUST 2009 - TROC (R	1	106
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Akhtar M Mr	ONISTL CYSTOSCOPY&INSERTION JJSTENT RIGHT URETEROSCOPY BFC	M45.9	N	URGENT	17/05/2009	26/09/2009	30/09/2009	CYSTOSCOPY & INSERT	1	136
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Young M Mr	ONISTL CYSTOS,RETROGRADE STUDY URETER+/-RIDIG URETERSCOPYBFC	M45.9	N	URGENT	26/06/2009	27/09/2009	30/09/2009	CYSTOSCOPY, RETROG	1	96
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	orchidopexy +/- orchidectomy right testis POA FIT	N09.3	N	ROUTINE	23/06/2009		30/09/2009	orchidopexy +/- orchidecto	1	99
Confirmed Month End Breacher		CAH		URO	Young M Mr	FLEXIBLE CYSTOSCOPY - LET IN BF POA FIT - WARFARIN	M45.9	N	URGENT	17/06/2009	16/10/2009	30/09/2009	FLEXIBLE CYSTOSCOPY	1	105
Confirmed Month End Breacher		CAH		URO	Young M Mr	INSERTION OF SPC (ALEX SAW PT A&E 15.06.09)	M49.8	N	ROUTINE	17/06/2009		30/09/2009	INSERTION OF SPC	1	105
Confirmed Month End Breacher		CAH		URO	Young M Mr	TURBT - POA HOLD	M42.1	N	URGENT	26/06/2009	12/10/2009	30/09/2009	TURBT POA HOLD - ECG	1	96
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	REVISION OF NEO-MEATUS - POA FIT		N	ROUTINE	07/05/2009	02/10/2009	30/09/2009	REVISION OF NEO-MEA	1	146
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Akhtar M Mr	ONISTL NESBITTS PROCEDURE BFC	N28.8	N	ROUTINE	27/06/2009	27/09/2009	30/09/2009	NESBITTS PROCEDURE	1	95
No Breach Risk - Outcome Recorded on PAS after Month End WL Position Date		CAH		URO	Akhtar M Mr	ONISTL CYSTO & URETHRAL DILATATION BFC	M45.9	N	ROUTINE	24/06/2009	27/09/2009	30/09/2009	CYSTO & URETHRAL DIL	1	98
Confirmed Month End Breacher		CAH		URO	Young M Mr	FLEXIBLE CYSTOSCOPY (ONLY WANTS CAH)	M45.9	D	URGENT	19/06/2009		30/09/2009	FLEXIBLE CYSTOSCOPY	1	103
Confirmed Month End Breacher		CAH		URO	Young M Mr	CYSTOLITHOLAPAXY LONG STAY - Q/POSTED	M44.1	N	ROUTINE	20/03/2009		30/09/2009	CYSTOLITHOLAPAXY	1	134
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	CYSTOSCOPY AND OPTICAL URETHROTOMY - Q/POSTED	M45.9	N	ROUTINE	10/06/2009	30/10/2009	30/09/2009	CYSTOSCOPY AND OPT	1	112
Confirmed Month End Breacher		CAH		URO	O'Brien A Mr	HYDROCOELE (autism) POA FIT		N	URGENT	30/06/2009		30/09/2009		1	92
Confirmed Month End Breacher		CAH		URO	Akhtar M Mr	TURP - POA FIT	M65.1	N	ROUTINE	09/06/2009	23/10/2009	30/09/2009	TURP POA FIT	1	113
Confirmed Month End Breacher		STH		URO	Akhtar M Mr	FLEXIBLE CYSTOSCOPY - POA (ONLY WANTS CAH)	M45.9	D	ROUTINE	24/06/2009	28/10/2009	30/09/2009	flexible cystoscopy	1	98
Confirmed Month End Breacher		STH		URO	Akhtar M Mr	FLEXIBLE CYSTOSCOPY (NEEDS CAH-LATEX ALLERGY & EPI PEN)	M45.9	D	ROUTINE	07/06/2009	28/10/2009	30/09/2009	flexible cystoscopy	1	115

Produced by Performance and Reform Directorate, Informatics Division, Information Team (Acute)

Corrigan, Martina

From: Robinson, Katherine [redacted]
Sent: 19 July 2013 16:09
To: Burke, Mary; Burns, Deborah; Carroll, Anita; Carroll, Kay; Carroll, Ronan; Clayton, Wendy; Conway, Barry; Corrigan, Martina; Devlin, Louise; Forde, Helen; Glenny, Sharon; McAreavey, Lisa; McGeough, Mary; McIlroy, Cathie; McStay, Patricia; McVey, Anne; Murray, Eileen; Nelson, Amie; Reid, Trudy; Richardson, Phyllis; Trouton, Heather
Subject: Demand/Capacity for Access Target
Attachments: Demand Capacity Analysis - MEDICINE 18th July 2013.doc; Demand Capacity Analysis - wendy - 18 7 13.doc; Demand Capacity Analysis gynae 18 7 13.doc; Demand Capacity Analysis surgical division 18th July 2013.doc

Please find attached most recent position. I have not gone through these in massive detail so feel free to query any of these with the OSL's who are also working on the position. Hope this helps.

K

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

t: [redacted]
e: [redacted]

Demand Capacity Analysis - MEDICINE

Month: July/August 13 **Source of Information: Ref & Booking Centre, PAS & PTL**

Date Prepared 18th July 2013 **Prepared by: Referral & Booking Centre**

MEDICAL	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	KPC	STH	Total	Comments
	10	12	JULY	0	0	-8	+12	0	**0**		Mostly Endo pts are in this backlog in CAH.
	72	45	AUGUST	0	0	-26	-1	0	**0**		
Total											

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEW

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Medicine	CAH			0
					0
					0
		DHH			0
		DHH	Clinic code changing, figures may change, await grading, card/med		

GASTRO	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	16	7	**July**	-3		-8	-1	+3	**-9**	
	156	64	**August**	-15		-50	-29	+2	**-92**	
Total	172	71							**-101**	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEW

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Gastro	DHH			Rev's behind
					0
		CAH			0
		CAH/STH			Revs behind
					0 all rev selected

ENDOCRINE SPECIALTY

ENDO CRINE	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	KKPC	Total	Comments
	13	0	JULY	0	0	0	-13	0	0	-13	Cl's in July reduced to rev's only
	28	15	AUGUST	0	0	0	-13	0	0	-13	1cl Aug reduced to rev and I cl
											Cancelled.
Total										-26	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEW

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Endocrine	DHH		0	Revs behind

NEUROLOGY SPECIALTY

NEUROLOGY	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	4	18	JULY	0	0	+14	0	0	+14	
	192	41	AUG	0	0	-151	0	0	-151	
Total	196	59							-137	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Neurology	CAH			ok
		CAH			ok
		DHH			ok

DIABETIC SPECIALTY

DIABETIC	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	KPC	STH	Total	Comments
	2	2	JULY	0	0	+1	-1	0	0	-1	
	31	28	AUG	0	+2	-6	0	+1	0	-3	
											=
Total											

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEW

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Diabetic	CAH/BBPC			0
		ACH/STH			0
		DHH			Rev's behind

DERMATOLOGY SPECIALTY

	Total on PTL *Needing to be seen*	**Capacity**	**Month**	**ACH**	**BBH**	**CAH**	**DHH**	**STH**	**Total**	**Comments**
DERM	285	31	July	-6		-81	-99	-68	-254	
	429	180	Aug	-41		-55	-103	-50	-249	This includes 30 additional capacity
Total	714	211		-47		-136	-202	-118	-503	
ACNE	0	2	July	+2		0			+2	
	1	42	Aug	+29		+12			+41	
Total	1	44		+31		+12			+43	
ICATS	0	0	July			0	0		0	
	17	36	Aug			+17	+2		+19	
Total	17	36				+17	+2		+19	

CARDIOLOGY SPECIALTY

CARDIOLOGY	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	114	77	July	-11	0	-28	+3	-1	-37	This includes 50 additional capacity
	287	329	Aug	-23	+7	+44	+18	-4	+42	This includes 160 additional capacity
Total	401	406		-34	+7	+16	+21	-5	+5	August patients were incorrectly selected for July
ARRYTHMIA Personal Information redacted by the USI	1	0	July			-1			-1	Waiting outcome on 1 arrythmia patient from Derry –This comment is old query same patient?
	0	0	Aug			0			0	
Total	1	0				-1			-1	
DRONEDARONE Personal Information redacted by the USI	0	2	July			+2			+2	
	0	10	Aug			+10			+10	
Total	0	10				+12			+12	
RAPID CHEST Personal Information redacted by the USI	6	43	July			+37			+37	Work in progress
	44	105	Aug			+61			+61	
Total	50	148				+98			+98	

RHEUMATOLOGY SPECIALTY

RHEUM	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	124	52	July		-33	-39			-72	Personal Information redacted by the USI numbers slightly changed while doing figures
	130	81	Aug	-7	-19	-15		-8	-49	Numbers changed slightly While doing figures
TOTAL	254	133		-7	-52	-54		-8	-121	

THORACIC/RESPIRATORY SPECIALTY

Thoracic/ Respiratory	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	94	10	July			-46	-17	-21	-84	
	116	56	Aug			-54	+1	-7	-60	
Total	210	66				-100	-16	-28	-144	

Demand Capacity Analysis

Month: July/August 2013 **Source of Information: Ref & Booking Centre, PAS & PTL**

Date Prepared: 18th July 13 **Prepared by: Referral & Booking Centre**

Pain 9 weeks	**Total on PTL** *Needing to be seen*	**Capacity**	**Month**	**ACH**	**BBH**	**CAH**	**DHH**	**STH**	**Total**	**Comments**
	42	1	July	-2		-34	-1	-4	-41	
	150	37	Aug	+8		-84	-12	-25	-113	
Total	192	38		+6		-118	-13	-29	-154	

Haem	**Total on PTL** *Needing to be seen*	**Capacity**	**Month**	**ACH**	**BBH**	**CAH**	**DHH**	**STH**	**Total**	**Comments**
	3	0	July				-3	0	-3	
	8	4	Aug				0	+4	-4	
Total	11	4					-3	+4	-7	

Lipids	**Total on PTL** *Needing to be seen*	**Capacity**	**Month**	**ACH**	**BBH**	**CAH**	**DHH**	**STH**	**Total**	**Comments**
	0	0	July		0	0			0	
	1	7	Aug		+7	-1			+6	
Total	1	7			+7	-1			+6	

Thoracic Surgery	**Total on PTL** *Needing to be seen*	**Capacity**	**Month**	**ACH**	**BBH**	**CAH**	**DHH**	**STH**	**Total**	**Comments**
	0	2	July				+2		+2	
	0	1	Aug				+1		+1	
Total	0	3					+3		+3	

BREAST	**Total on PTL** *Needing to be seen*	**Capacity**	**Month**	**ACH**	**BBH**	**CAH**	**DHH**	**STH**	**Total**	**Comments**
	5	17	JULY			+12			+12	
	115	53	AUGUST			-62			-62	
TOTAL	120	70				-50			-50	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	**SPECIALTY**	**SITE**	**TRIAGE**	**NEW URGENT (NU)**	**URGENT REVIEW (UR)**
Personal Information redacted by the USI	Breast	CAH			
	Breast	CAH			
	Breast	CAH			
	Breast F/H	DHH			
	BSUR	DHH			

BREAST FAMILY HISTORY	**Total on PTL** *Needing to be seen*	**Capacity**	**Month**	**ACH**	**BBH**	**CAH**	**DHH**	**STH**	**Total**	**Comments**
	1	5	July			+4	ok		+4	
	26	35	August			+9	ok		+9	
TOTAL	27	40				+13	ok		+13	

Orthoptics	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	LGH	PHC	STH	Total	Comments
	0	0	July	OK	OK	OK	OK	Ok	OK	Ok	OK	
	109	112	August	+8	-6	+8	+38	-9	-34	-2	+3	
Total	109	112		+8	-6	+8	+38	-9	-34	-2	+3	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS – July 2013

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Orthoptist	Orthoptics				
		ACH	0	1 (2/7/13)	
		BBH	0	2 (11/6/13)	
		CAH	0	0	
		DHH	0	0	
		LGH	0	2 (24/6/13)	
		PHC	0	2 (1/7/13)	
		STH	0	0	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS – July/August 2013

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
VF Technician	Visual Fields	CAH	N/A	N/A	ok

All visual field requests are at the consultants request so are always recorded as Reviews

Month: **JULY/AUGUST** **Source of Information: Ref & Booking Centre, PAS & PTL**

COLPOSCOPY	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
9 weeks	0	24	July			+13	+11		+24	
	40	76	August			+20	+16		+36	
Total	40	100				33	27		60	

GYNAE SPECIALTY

GYNAE	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
9 weeks	152	28	July	-16	-4	-44 -6 fert	-42	-12	-124	Figures take into account pts booked in August when PTL was running at 10wks
	554	220	August	-44	-9	-150 -2 fert	-45	-84	-332 -2 fert	
Total	706	248		-60	-13	-202	-87	-96	-458	

MENOPAUSE	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
9 weeks	0	0	July				OK		OK	
	1	5	August				+4		+4	
Total	1	5					+4		+4	

URODYNAMICS SPECIALTY

URODYN	**Total on PTL** *Needing to be seen*	**Capacity**	**Month**	**ACH**	**BBH**	**CAH**	**DHH**	**STH**	**Total**	**Comments**
9 weeks	5	4	July				-1		-1	
	39	18	August				-21		-21	
Total										Tuesday clinic book 3 Friday clinic book 4

Demand Capacity Analysis – SURGERY

Month: **July - Aug 2013**

Source of Information: Ref & Booking Centre, PAS & PTL

Date Prepared: **18 July 2013**

Prepared by: Referral & Booking Centre

O/PAEDIC	Total on PTL Needing to be seen	Capacity	Month	Upper Limb	Lower Limb	Named	Comments
13 WEEKS	112	5	July	-52	+1	Personal Information redacted by the USI	Includes 2 July patients already booked to August.
	95	70	Aug	-30	+46		
Total				-82	+47		

O/PAEDIC ICATS	Total on PTL *Needing to be seen*	Capacity	Month	GPSWI	Physio	Total not incl Podiatry		Podiatry	Comments
9 WEEKS	433	2	July	-51	-270	-321 (Includes 31 July patients already booked to August.)		-110	
	546	191	Aug	-9	-254	-263		-92	
Total						-584		-202	

GENERAL SURGERY	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
Colorectal	11 419 2 26	38 228 11 22	JULY AUGUST AUGUST JULY AUGUST	+1 OK	+3 +7	+12 -187 +9 -4	+11 212	OK -11	+27 -191 +9 -4	Not Selected JULY AUG Personal Information redacted by the USI 0 9 0 2 0 1 0 9 0 2 0 0 0 10 6 11 0 1 0 3 gent 0 37 0 2 0 43 0 5 e 0 60 0 16 0 25 0 1 0 0 0 0 0 0 Colorectal 0 25 July DHH – Personal Information redacted by the has 3 patients to be seen – now sorted August DHH rotas not available as yet – 212 on PTL.

										CAH Surgical – reduced to Cons only as junior Doctors rota not available – changeover beg August.
TOTAL										
Total										

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Surgical	CAH			
		CAH			
		BBPC			
		STH			
		ACH			
		STH			

Mr McKay					

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Personal Information redacted by the USI	Surgery	DHH			
		MHK			
		BBH			
		BBPC			
		MHK			
		MHK			
		MHK			
		BBPC			
		MHK			

Triage in DHH is carried out daily and all patients added to one general list