Clayton, Wendy

To: Carroll, Ronan
Cc: Conway, Barry; Quin, Clair; Haughey, Mary
Subject: FW: RE Audit of CNS involvement in results clinics
Attachments: Urology Cancers Sept & Oct 2022.xlsx

Please see outcome of CNS Keyworker audit for Sept and Oct 22 as requested

Regards

Wendy Clayton
Interim Head of Service for ENT, Urology, Outpatients & Ophthamology
Landline: Personal Information redacted by USI
Mob: Personal Information redacted by USI

From: ONeill, Kate Personal Information redacted by USI
Sent: 24 November 2022 11:50
To: Clayton, Wendy Personal Information redacted by USI; McKay, Paula Personal Information redacted by USI
Cc: Thompson, PatriciaA Personal Information redacted by USI McCourt, Leanne Personal Information redacted by USI; Crothers, Clare Personal Information redacted by USI
Subject: RE Audit of CNS involvement in results clinics

Morning Wendy/Paula,

Please find attached audit outcomes as requested.

There are some facts worth noting:

- Out of 69 patients 53 were seen by the CNS (or on a few occasions where that was not possible they were contacted via telephone within a day or two, thanks Leanne)
- 4 patients were being managed by other providers (Altnagelvin or 352)
- 3 had no pathology as yet

2024 when further details of the Inquiry timetable will be uploaded on Urology Services Inquiry Website.

5.0 Reflections on Public Inquiry Proceedings

Veryan Richards shared with the meeting her notes and reflections the detailed of which referred as Appendix B on this minutes.

NB: Comments in blue types are Veryan's views on what she considered the Trust Leadership should be demonstrating and will be addressing.

6.0 Individual Sub Groups proposals for next steps

Data Analytics

The Data and Intelligence Group has met on a number of occasions to develop the key strands of a future Data and Intelligence Strategy for the Trust. The Group explained that their approach was rooted in themes that emerged from the clinical issues that were being identified in the Urology Review. The meeting was also advised that the themes emerging from the wider analysis of the External Reference Group had also been considered in the approach taken; in particular, they need for a strong, respectful and collaborative organisational culture. The final recommendations in the paper shared at today's meeting were reflect all these considerations and the wider landscape of Healthcare, and including some projected future needs of the Trust and the Public it serves.

Analytics Sub Group recommendations

We recommend that the Trust commissions a formal strategic plan for data and intelligence that should include consideration of the following five key areas

1. Supporting continuous improvement in clinical and care processes.
2. Create a warning system to identify emerging Clinical Care or Clinical Governance concerns.
3. Empower patients through information sharing to support better self-care
4. Deploy 'machine learning technologies' to support business and clinical activity
5. Create formal collaborations with strategic partners from other sectors, critically Academia

Analytic Sub Group conclusions

There is never an ideal time to embark on a new data and intelligence strategy. Nevertheless, the lessons emerging from the ongoing Public Inquiry and need to develop a culture built on team working, leadership and governance all require intelligence insight and knowledge to inform action and importantly to evaluate progress. As the saying goes, 'In God We trust, all others bring data'. Furthermore, the world is at a crossroads in the current information age and organisations that do not plan now may be limiting their influence over the future. The Sub Groups

believes these are compelling reasons for the Trust to develop a new Data and Intelligence Strategy.

The five key ambitions outlined above represent specific themes that have emerged in various discussions. They are not intended to be an instruction or requirement for the Trust. The Sub Groups commands them as key strands of a new strategy. They should prompt discussion in the wider consultations required for strategic planning and it is expected by the Sub Group that they may be supplemented, or replaced, by alternative or additional ambitions or objectives.

Finally, consideration should be given to the integration of the recommendations from this Group with those from other Sub Groups and their work streams of the wider External Reference Group.

Governance and Accountability

Robbie Pearson advised the meeting of a number of key points pertaining to Governance and Accountability that his believe it would be beneficial for the Trust to consider:

- 'Triangulation of systems' to facilitate the analysis of data and perhaps a call for greater use of 'soft intelligence'
- An integration of learning systems to be put in place going forward. In particular, the Trust should consider adopting 'A Framework for Measuring and Monitoring Safety' this Robbie explained was an approach which was

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COMMITTEE	**SHSCT Morbidity & Mortality Strategic Oversight Group** **Terms of Reference**
CONSTITUTION	The Medical Director hereby resolves to establish a sub-group to the Trust's Senior Management Team, to be known as the Mortality & Morbidity (M&M) Strategic Oversight Group.
PURPOSE	The purpose of the M&M Strategic Oversight Group is to: • Provide high level oversight and assurance that effective systems and processes are in place for review of mortality and morbidity. • Ensure the capturing, sharing and implementation of learning and good practice arising from M&M meetings • Consider mortality reports i.e. SHMI / RAM I to identify early alerts or areas where more detailed review is required.
MEMBERSHIP	**Chair:** • Medical Director • Executive Director of Nursing / AHP (Co-Chair) **Membership:** • Non-Executive Director • Associate Medical Directors x 2 • Assistant Directors, Operational Directorates x 2 • Clinical Directors x 2 • M&M Chairs x 2 • Assistant Director, Medical Director's team • Assistant Director, Clinical & Social Care Governance • Assistant Director, Nursing Governance • Assistant Director, AHP Governance • Head of Performance • Head of Information and Data Quality • SAS Lead • Chief Registrar / Trainee doctor representative • ADEPT Fellow, (as applicable) • Head of Midwifery / Lead Midwife • Clinical and Social Care Governance Co-Ordinator, MHLD • Senior M&M Facilitator • Head of Patient Safety Data & Improvement • CYP Medical Representative • Social Services Representative Members should aim to attend all meetings. Should a member be unavailable to attend, they may nominate a deputy to attend in their place subject to the agreement of the Chair. **In attendance:** Any officer of the Trust or of an external agency such as the HSCB or PHA may, where appropriate, be invited to attend. **Member appointments:** The membership of the M&M Strategic Oversight Group shall be determined by the Medical Director, taking into account the skills and expertise necessary to deliver the Group's remit.
DUTIES	The **main responsibilities** of the group are to: • Provide assurance to Trust Board that all hospital deaths are proactively

December 2023

Directorate	Ward / Facility / Team	Date of walk	Time	SMT rep(s)	Service lead and contact number	Feedback received
ACS	Urgent care centre CAH	4th December	9.30-11	Dr Austin Trudy Reid	Karen Walker Interim Head of urgent care services Personal Information redacted by USI	

November 2023

Directorate	Ward / Facility / Team	Date of walk	Time	SMT rep(s)	Service lead and contact number	Feedback received
CYPS	Child Development Centre and Lurgan Children's Centre	7th Nov	2pm	Jan McGall Dr Austin	Fionnuala McKerr, Operational Lead Personal Information redacted by USI	✓
NMAHP FSS	School Nursing team Chesnutt building – Lurgan Hospital	13th Nov	2.30-4.30pm	Heather Trouton Geraldine Donaghy	Margaret Bunting Personal Information redacted by USI	✓
MHD	Integrated Liaison service CAH Admin Floor	16th Nov	10-11.30	~~Brian Beattie & Pauline Leeson~~ Colm McCafferty	Richard Gardner, Integrated Liaison Co-ordinator Ext **Mobile –** Personal Information redacted by USI	✓
CYPS	Oakland's short breaks unit- Armagh	20th November	9-11am	Trudy Reid Hilary McCartan	Lucia McKee, Unit Manager Personal Information redacted by USI Paula Feathers	
ACS	DHH Physiotherapy Department	22nd November	10 am – 12 noon	Cathrine Reid and John Wilkinson	Roisin Lynch Physiotherapy Clinical Lead Personal Information redacted by USI Joanne	Cancelled-reschedule to 2024

NM AHP Functional support services	Laundry services at CAH	5th October	11-12.30	Colm McCafferty Vivienne Toal	Gerard White [redacted]	X
ACS	Community equipment store- Manor Drive Lurgan	5th Oct	11-12.30	Brian Beattie Martin McDonald	Robert Black CES Manager [redacted]	X
SCS	CAH Labs	6th October	11.30-12.30	Catherine Teggart Dr Austin	Head of Laboratory Services Geoff Kennedy CAH 028 [redacted]	Cancelled – reschedule for 2024
ACS	Clover Physiotherapy Department,- St Luke's	16th Oct	9.30-11	Eileen Mullan Trudy Reid	Cathy McKeown, Head of Physiotherapy [redacted] Michelle McGeown, Lead Physiotherapist [redacted]	X
SCS	Bernish house outpatients & ENT	27th	2pm	Brian Beattie Elaine Wilson	Wendy Clayton [redacted] Josie Matthews – Marilyn Lead nurse / ward manager [redacted]	**Cancelled due to staff sickness. Needs rescheduled for 2024**

Introduction

Director visits replaced Leadership Walks in 2021. These are an informal method for Directors (Non-Executive, Executive and Operational) to meet with front line staff from across the organisation. They allow teams to share the work they do, the achievements and challenges. This provides an opportunity for all Directors to understand the organisation more and get a sense of the culture and dynamics within.

In relation to Non-Executive Director visits, a report is completed within 14 days of each visit and shared with the Chair. Issues identified (if any) are escalated to the Chief Executive and relevant Director. The relevant Director addresses any issues raised. Assurance is then provided back to the Chair by either explaining the issue or assurance that remedial action has been taken to address concerns. This process also enables Board members to offer appreciation and encouragement where performance is excellent.

In relation to Executive and Operational Directors, they have been undertaking structured visits following a detailed 15 step process. Details of these visits will be provided in the next report to Governance Committee.

Reports on visits completed by Non Executive Directors are held in the Chair's office and summary information is provided to the Governance Committee on a six-monthly basis (see Table 1).

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DIRECTOR VISITS

Summary Report for Period
1st January 2023 – 31st March 2023

Period January 2023 – March 2023

Table 1 provides a summary of the visits undertaken by Non Executive Directors during the period January 2023 – March 2023. During this period a total of 9 visits were undertaken.

Date	Name	Visit to
February 2023	Mr Martin McDonald, Non Executive Director	Crozier House, Banbridge
	Mrs Pauline Leeson, Non Executive Director	Trust Home Care Team, Banbridge
	Mrs Pauline Leeson, Non Executive Director	Occupational Health Department, St. Luke's Hospital site
	Ms Eileen Mullan, Chair	Referral and Booking Centre, Magowan Buildings, Portadown*
March 2023	Ms Geraldine Donaghy, Non Executive Director	Finance Department, Daisy Hill Hospital
	Mrs Hilary McCartan, Non Executive Director	Mental Health Department, Daisy Hill Hospital
	Mr Martin McDonald, Non Executive Director	Planning Department, The Brackens, Craigavon Area Hospital
	Ms Eileen Mullan, Chair	Woodlawn House, Dungannon*
	Ms Eileen Mullan, Chair	Mental Health Support and Recovery Team, South Tyrone Hospital*

*No Key Issues

Appendix 1

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Director Visit

Trust location	Crozier House Banbridge
Date	6 February 2023 2pm
Staff member leading	Tierna Armstrong, Head of Service
Non-Executive/Director	Martin McDonald

Areas for escalation to CEO and Accountable Director

A significant percentage of dementia/ memory loss patients and others with complex needs dispersed across the home.

Home has two Band 5 and one further vacancy. Shift pattern usually has one band 5 starting pm and sleeping overnight. It has been difficult to avoid loss of sleep for Band 5 and alternative shift patterns under consideration.

Challenges:

1. BSO recruitment processes have been very slow - 4 months from start to end of process. Also a difficult referencing system used by BSO makes it difficult to keep track of individual applicants and posts. The HOS appears to have to spend too much of their time on this. Perhaps there is a need to consider an admin resource officer to expedite manage the process.

2. The complexity of care needs amongst a changing resident population is a risk requiring careful assessment and management. Dementia patients are probably better located in one defined area and prior to Covid this was being considered. Estates Department did look at this. Now that things are settling perhaps this could be looked at again. Estates Assistant Director had been involved and was suggesting better signage and navigation.

3. Trust Board and management focus has of necessity seen such residential units as a means to improve discharge (ie empty beds) and not necessarily looked at the residents and their needs. We need to spend some time readjusting our focus and send a clear message to HOS/AD's and Home Managers that our focus is upon ensuring psychological safety for staff and ensuring their well- being is protected. The social services side of our business might perhaps

Southern Health and Social Care Trust

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CORPORATE RISK REGISTER

September 2022

Southern Health and Social Care Trust

COVER SHEET

Meeting and Date of meeting	Trust Board 25th January 2024		
Title of paper	Trust Risk Appetite Statement		
Accountable Director	Name	Dr Stephen Austin	
	Position	Medical Director	
Report Author	Name	Stephen Wallace	
	Email	Personal Information redacted by USI	
This paper sits within the Trust Board role of:		Accountability	
This paper is presented for:		Assurance	

Links to Trust Corporate Objectives	☒	Promoting Safe, High Quality Care
	☒	Supporting people to live long, healthy active lives
	☒	Improving our services
	☒	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

The report author will complete this report cover sheet fully. The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the report. The expectation is that the Accountable Director has read and agreed the content (cover sheet and report).

Its purpose is to provide the Trust Board/Committee with a clear summary of the report/paper being presented, how it impacts on the people we serve and the key matters for attention and the ask of the Trust Board/Committee

1. Detailed summary of paper contents:
As part of the improving risk management maturity of the Trust, which will include a revised Board Assurance Framework, Corporate Risk Register and Risk Management Strategy the Trust is required to have a risk appetite statement. This is requirement as part of the Annual Governance Statement and is an expectation of external auditors when reviewing the risk management and corporate governance of the Trust. This paper sets out the Trust's risk appetite detailing the amount and type of risk that the organisation is prepared to pursue, retain or take in pursuit of its strategic objectives. It represents risk optimisation - a balance between the potential benefits of innovation and the threats that change inevitably brings.

2. Areas of improvement/achievement:
Not applicable

3. Areas of concern/risk/challenge:
Not applicable

4. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.	
Corporate Risk Register	Trust Risk Appetite position will be used to inform the Corporate Risk Register entries risk ratings
Board Assurance Framework	Updates to Trust Board, Audit and Risk and SLT as required
Equality and Human Rights	No applicable

Southern Health and Social Care Trust

Risk Appetite Statement

12th October 2023

Background

1. As part of the improving risk management maturity of the Trust, which will include a revised Board Assurance Framework, Corporate Risk Register and Risk Management Strategy, the Trust is required to have a Risk Appetite statement. This is requirement as part of the Annual Governance Statement and is an expectation of external auditors when reviewing the risk management and corporate governance of the Trust.

2. The Risk Appetite is the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives. It represents risk optimisation - a balance between the potential benefits of innovation and the threats that change inevitably brings.

3. This should not be confused with Risk Tolerance, which reflects the boundaries within which the executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the board's strategy and Risk Appetite. It is the level of the current (residual) risk within which the board expects sub-committees to operate and management to manage and escalate.

4. Put simply, Risk Appetite is how much risk you want, Risk Tolerance is how much risk you can live with. The Board should therefore not see each level of Risk Appetite as being better or worse than any other.

5. Key to this will be boards taking responsibility for identifying their Risk Appetite and Risk Tolerance for each strategic objective and agreeing what is sufficient in terms of controls and the assurances that the controls are operating effectively. The greater the Risk Appetite, the more controls should be put in place by management to avoid or mitigate the risk.

Risk Appetite

6. The Risk Appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's Risk Appetite should address several dimensions:
   - The nature of the risks to be assumed;
   - The amount of risk to be taken on;
   - The desired balance of risk versus reward;

Summary & Purpose

The Purpose of the Medical and Dental Oversight Group is to support the Responsible Officer / Medical Director in the discharge of statutory responsibilities by ensuring there is;

- a process for review of all cases where a practitioners practice, conduct, health gives cause for concern,
- regular review of all cases where a practitioner is subject to procedures under Maintaining High Professional Standards in a Modern HPSS (MHPS),
- regular review of all cases where a practitioner is subject to Fitness to Practice procedure (or restriction to practice or similar sanction) of the GMC, GDC or any national professional regulatory body of another sovereign state,
- no undue delays in addressing practitioner performance issues.
- Adequate support, guidance for clinical managers and individual practitioners
- Consistency in approach and decision making where appropriate across the organisation

MEMBERSHIP

The members of the Medical and Dental Oversight Group will comprise:

- Responsible Officer / Medical Director (Chair)
- Senior Manager MD Office
- Director of HR / Deputy Director of HR
- Head of Medical HR

During their relevant timeslot:

- Divisional Medical Director from the Service
- Director of Service or a nominated deputy.

The Oversight Panel may request additional members (including a legal representative) to provide expertise in particular areas. In the event of a member being unable to attend meetings an alternative representative should be arranged to attend on his/her behalf.

If the practitioner is a doctor in training then the Director of Medical Education and/or a representative of NIMDTA shall attend.

Terms of Reference

Divisional Medical Directors will discuss at a monthly oversight meeting all medical and dental practitioners employed within their Directorate, or engaged via Agency for whom concerns have been raised. This applies to any medical or dental practitioner registered with the GMC and/or GDC who is currently employed, engaged or was

IMPROVEMENTS TO DATE - REPORTING
Enhanced quarterly reporting to Governance Committee
Introduction of a standalone Service User Feedback Report to Governance Committee
Weekly reporting / escalation of issues to SLT
Quarterly Reporting to Safety & Quality Steering Group
Quarterly Reporting to Standards, Compliance and Regulation Steering Group
Introduction of Patient Safety Data & Improvement Team (M&M) Report to Safety & Quality Steering Group
Extended scope of Weekly Governance meeting agenda
Reporting of outstanding Enquiry responses at Weekly Governance meeting
IMPROVEMENTS TO DATE – INCIDENT MANAGEMENT
Development of Datix system for recording, monitoring and reporting of SAI Recommendations
Monthly updates requested on progression of SAIs from Operational Directorate Governance teams, with maintenance of central database
Escalation of SAI progression to AD CSCG as required
Escalation of Overdue SAIs to SLT
IMPROVEMENTS TO DATE – DATIX INCIDENT MANAGEMENT SYSTEM
Datix Upgrade
Development of Datix System for recording, monitoring and reporting of RQIA recommendations
IMPROVEMENTS TO DATE – SERVICE USER FEEDBACK
Quarterly meetings with NIPSO and PCC to assist with progression, oversight and assurance
IMPROVEMENTS TO DATE – LIAISON SERVICE
Extended scope of Liaison Service to support the Urology Lookback Review and Cervical Cytology Review
Extended scope of Liaison Service to support Complex Complaints

IMPROVEMENTS UNDERWAY – SERVICE USER FEEDBACK
Development of Service User Feedback Awareness training package – Corporate Mandatory Training for all staff across the organisation, aiming to go live by 1st April 2024
Service User Feedback Pilot in relation to early resolution – to commence April 2024
Implementation of a procedure for the management of Independent Clinical Record Review of Complaint. Information on how complaints relating to professional members of staff are managed across the Trust along with the opinions, thoughts and views on the process of an Independent Review have been obtained. Staffing resources within the Corporate Service User Feedback team has prevented progression of this work. It is planned this will be revisited in April 2024
IMPROVEMENTS UNDERWAY – PATIENT SAFETY DATA & IMPROVEMENT
SHSCT Safety Framework – Drafted and presented to SLT on 20.02.24
IMPROVEMENTS STILL TO BE ACHIEVED – INCIDENT MANAGEMENT
Increased use of 'Hot Debrief' for Level 1 SAI reviews across the Trust to ensure Learning is rapidly identified and shared
Audit evidence provided to support SAI recommendations which have been fully implemented
SAI Theming
Audit compliance with Corporate SAI Policy and Procedure
Inclusion of SAI recommendations in the triangulation of Governance activity information
Development of a Professional Governance Information System (PGIS) to further improve oversight and assurance of governance activity in relation to staff
IMPROVEMENTS STILL TO BE ACHIEVED – DATIX INCIDENT MANAGEMENT SYSTEM
Focus on Unapproved Datix incidents and reporting of these in the Weekly Governance Meeting, Governance Committee and at Governance Coordinators meeting
Development of Datix Training package for reviewers
Development of Datix Workshops for staff to access to learn or refresh on Datix functionality

Development of Risk Register module on Datix
Explore the interfaces between Datix and Northern Ireland Digital Identity Service (NIDIS) and Encompass
Development of standardised datasets for reporting of Complaints from Datix
IMPROVEMENTS STILL TO BE ACHIEVED – SERVICE USER FEEDBACK
Implementation of NIPSO Model Complaints Handling Procedure
Development and implementation of Complaints Reviewer training package
Develop a pathway for Liaison Service involvement in Complaints
IMPROVEMENTS STILL TO BE ACHIEVED – LIAISON SERVICE
Development of Liaison Service to support staff impacted by SAIs and Complex Complaints, either directly, as a manager or member of the review team
IMPROVEMENTS STILL TO BE ACHIEVED – RISK & LEARNING
Provide support to operational directorates to ensure that each directorate level risk register is dynamically populated and consistent with corporate requirements
Support the implementation of the Datix system upgrade and adaptation of modules regarding the management of risk
Coordinate the Trustwide Risk and Clinical Governance Training programmes for all relevant staff including developing a training matrix for Clinical and Social Care Governance activities
Support the creation and provision of an education and learning programme which integrates learning between SAI's/M&M/Litigation/Datix Trust-wide
IMPROVEMENTS STILL TO BE ACHIEVED – PATIENT SAFETY DATA & IMPROVEMENT
Further develop the support to Patient Safety meetings to maximise feedback and learning

Urology – Number Consultant Led Outpatients Waiting on First Appointment – 1st Jan 2024

Total Waiting = 3857 , waiting over 52 wks + = 2321 Longest Waiter= 414 weeks

Priority Type Description	(All)
Red Flag Referral Following Triage	(All)

Specialty Description (R)	Specialty Description	0-9Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 41Wks	41+ to 52Wks	52+Wks	TOTAL
UROLOGY	UROLOGY(C)	497	158	149	84	157	148	112	81	150	2321	3857
UROLOGY Total		**497**	**158**	**149**	**84**	**157**	**148**	**112**	**81**	**150**	**2321**	**3857**
TOTAL		**497**	**158**	**149**	**84**	**157**	**148**	**112**	**81**	**150**	**2321**	**3857**

Total Urgent Waiting = 874 , waiting over 52 wks +
= 25 Longest Waiter= 335 weeks

Priority Type Description	URGENT
Red Flag Referral Following Triage	(All)

Specialty Description (R)	Specialty Description	0-9Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 41Wks	41+ to 52Wks	52+Wks	TOTAL
UROLOGY	UROLOGY(C)	357	101	95	46	83	83	59	15	10	25	874
UROLOGY Total		**357**	**101**	**95**	**46**	**83**	**83**	**59**	**15**	**10**	**25**	**874**
TOTAL		**357**	**101**	**95**	**46**	**83**	**83**	**59**	**15**	**10**	**25**	**874**

Total Routine Waiting = 2983 , waiting over 52 +wks = 2296
Longest Waiter= 414 weeks

Priority Type Description	ROUTINE
Red Flag Referral Following Triage	(All)

Specialty Description (R)	Specialty Description	0-9Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 41Wks	41+ to 52Wks	52+Wks	TOTAL
UROLOGY	UROLOGY(C)	140	57	54	38	74	65	53	66	140	2296	2983
UROLOGY Total		**140**	**57**	**54**	**38**	**74**	**65**	**53**	**66**	**140**	**2296**	**2983**
TOTAL		**140**	**57**	**54**	**38**	**74**	**65**	**53**	**66**	**140**	**2296**	**2983**

Source: Sharepoint

Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

Review Outpatient Backlog update – 01/01/2024

	January 23		October 23		January 24	
	Total	Longest Date	Total	Longest Date	Total	Longest Date
Glackin	79	Feb 21	84	July 21	81	Sept 21
O' Donoghue	460	Mar 17	540	April 17	470	Jan 19
Young	535	Dec 16	226	March 18	214	Mar 18
Haynes	139	Feb 19	81	Oct 17	61	June 20
Omer	34	May 19	21	May 21	3	May 21
Khan	145	Dec21	51	April 22	42	April 22
O' Brien	115	May 17	8	April 18	1	Oct 23
Tyson	72	Nov 19	20	March 22	31	March 22
LMCA	0	-	2	Oct 23	6	Oct 23
Total	1579		1042		909	

Source: Sharepoint

Southern Health and Social Care Trust

Southern HSC Trust
Getting it Right First Time
Urology

Southern Trust Recommendations
Action plan updated 6th March 2024

RAG rating	No. of actions
	7 (39%)
	9 (50%)
Both regional	2 (11%)

Outpatients and diagnostics					
RECOMMENDATION 6					
There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.					
	Responsible Director	**Action(s) Required to Deliver Recommendation(s)**	**Timescale**	**Status RAG**	**Evidence of Completion**
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	Cathrine Reid / Barry Conway / Lynn Lappin / Mark Haynes/ Wendy Clayton	Suspected Prostate cancer pathway is currently being reviewed regionally as part of NICAN and also being considered along with the Regional Diagnostic Centre (RDC) project There is a meeting arranged Wed 10 Jan 24 between Cancer, Radiology and Urology team to discuss and consider a Prostate RDC pathway Commissioning assistance will be required to achieve this recommendation However, Southern trust would welcome discussion regarding haematuria and whether imaging prior to flex cyst is more efficient from a provision perspective than imaging at the time of attendance	Est. Dec 2024		