Sharon Gallagher
Deputy Secretary
Strategic Planning and Performance Group (SPPG).
Department of Health
Castle Buildings
Stormont
Belfast
BT4 3SQ

14 July 2022

Dear Madam

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring Witness Statement & the production of documents

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry is investigating the matters set out in its Terms of Reference. A key part of that process is gathering all of the relevant documentation from relevant departments, organisations and individuals.

In keeping with the approach we are taking with other departments, organisations and individuals, the Inquiry is now issuing a Statutory Notice (known as a 'Section 21 Notice') pursuant to its powers to compel the production of relevant documentation.

This Notice is issued to you as Deputy Secretary of SPPG. It relates to documents within the custody or control of the SPPG. The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

/ SPPG taken any steps with a view to preventing the recurrence of such issues?

50. Does the HSCB / SPPG consider that it did anything wrong or could have done anything differently which could have prevented or mitigated the governance failings of the Trust?

51. From the HSCB / SPPG's perspective, what lessons have been learned from the issues of concern which have emerged from urology services within the Trust? Has this learning informed or resulted in new practices or processes for the HSCB / SPPG? Whether your answer is yes or no, please explain.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 17 of 2023

Date of Notice: 5th July 2023

Witness Statement of: Paul Cavanagh, Director of Hospital Care, Strategic Planning and Performance Group, Department of Health

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I, Paul Cavanagh, will say as follows:

Introduction

1. I make the following statement for the purpose of the Urology Services Inquiry (USI) (hereafter referred to as "the Inquiry").

2. The statement is made on behalf of the Strategic Planning and Performance Group (SPPG) in response to a request for evidence by the Inquiry Panel. This is my first statement to the Inquiry. SPPG previously provided a statement signed by Sharon Gallagher, Deputy Secretary, Department of Health who is the SPPG lead officer. She provided the statement [redacted]. However, I had the opportunity to review a draft in advance of it being submitted on 25 October 2022.

3. My statement below begins with a summary of my personal qualifications and career history, including the roles and responsibilities that I have held during my time of employment at the Health and Social Care Board (HSCB) and subsequently within SPPG. To provide background and context for the specific questions asked of me, I

Urology Services Inquiry

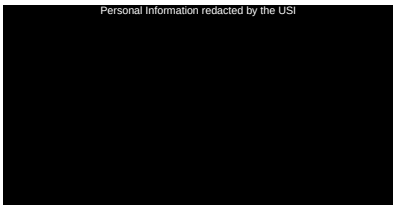
Section 11 – Conclusion

468. In this statement I have provided as much information as I can to assist the Inquiry. I have provided background information and I have sought to answer, as best I can, the questions asked in the Section 21 Notice. If any further queries arise from what I have said, I will seek to assist the Inquiry with these.

Section 12 – Declaration of Truth

469. The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed:



Date: 3rd November 2023

Lessons learned

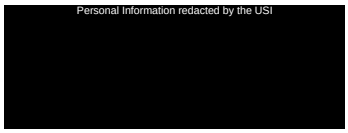
365. The Inquiry has asked, in Paragraph 51 of the Notice, what lessons HSCB/SPPG has learned from the issues of concern which have emerged from urology services within the Trust.

366. Whilst there are processes and mechanisms in place to identify safety and quality concerns and apply the learning, the robust application of these and the ability to triangulate multiple sources of information is an area that requires further attention at system level.

I, SHARON GALLAGHER, will say as follows: -

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: 

Date: 17 October 2022

Section 3 – Policies and Procedures: Monitoring the Quality and Safety of Care through the HSCB Commissioning and Performance Management functions.

87. Article 34 of the Health and Personal Social Services (NI) Order 2003, referred to earlier at paragraphs 31 to 33, places a responsibility on both the Trust and the HSCB to have in place arrangements for monitoring and improving the quality of health and social care which it provides to individuals and the environment in which it provides them.

88. I have extracted the HSCB commissioning and performance management processes from the 2011 Framework Document which were used to ensure quality and safety in secondary care services below:

At section 4 it states:

"4.13 The HSCB and PHA must maintain appropriate monitoring arrangements in respect of provider performance in relation to agreed objectives, targets, quality and contract volumes.

4.14 The HSCB incorporating its LCGs must have appropriate monitoring arrangements to confirm that commissioned services are delivered, to benchmark comparative performance, and to ensure that quality outcomes, including positive user experience, are delivered."

At section 6, it states:

"Safety and Quality Dimension

6.13 The HSCB, working with the PHA on (i) to (viii) and (xii) below, is responsible for monitoring and reporting to the Department on:

i. Compliance with Priorities for Action safety and quality requirements at least quarterly e.g. quality improvement plans;

ii. Implementation of the RQIA and other independent safety and quality review recommendations in accordance with agreed plans;

		making or intending to make a complaint relating to health and social care; • To promote the provision of advice and information to the public about the design, commissioning and delivery of health and social care services; and • To undertake research and conduct investigations into the best methods and practices for consulting the public about, and involving them in, matters relating to health and social care; and provide advice regarding those methods and practices.	
	RQIA	The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.	As regulator RQIA monitor and inspect Trust services on an ongoing basis
	Royal College of Surgeons	The Royal College of Surgeons (RCS) is an independent professional body and registered charity that promotes and advances standards of surgical care for patients	The RCS have been engaged to support the Trust by conducting an Invited Review regarding Urology Services
	Chief Nursing Officer	The Chief Nursing Officer (CNO) is the senior professional Nurse responsible for Nursing and Midwifery	The Trust Executive Director of Nursing, Midwifery and AHPs liaises with the CNO regularly and the CNO will write formally to myself regarding any Departmental Directions that require Chief Executive input.
	General Medical Council	The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK	GMC has ongoing interactions with the Trust regarding medical professional governance issues

Q63	**What has been your experience of the efficacy or otherwise of the bodies set out at (i) – (x) above in assisting or promoting service provision, good governance, clinical care**
Response	My answer to question to 63 should be read in line with my answer to question 60 where I address the relevant role of each of the bodies. My views of the efficacy of the bodies are as follows:

Health & Social Care Board;	The commissioning process (as discussed in my answers to questions 36-41), through the HSCB, has struggled to deliver high quality services. This was recognised in 2017 by the then Minister for Health, Simon Hamilton, when he announced that the HSCB should be closed. Since then, in my opinion, the HSCB has struggled to retain

NICaN Board

Mossley Mill, Newtownabbey

9:30a.m – 12.30pm, Monday 26th February 2018

Attendees	Apologies
Eatock, Dr Martin	Anderson, Cara
Gavin, Dr Anna	McKay, Geraldine
Gishkori, Esther	Stewart, Dr David
Gribben, Loretta	
Johnston, Jackie	
Leonard, Caroline	
Magee, Joe	
McAleese, Dr Jonathan	
McCarthy, Dr Miriam	
McCaughey, Hugh	
McGoran, Seamus	
Mitchell, Dr Mike	
Monteverde, Heather	
O'Brien, Clodagh	
O'Hagan, Margaret	
Scullin, Dr Paula	
Reilly, Dr Michael	

Guests in attendance:

Dr Anne-Marie McClean, Adept Clinical Fellow

Dr Damien Bennett, ST5 Speciality Registrar, Public Health Agency

- encourage innovation in how services are provided;
- provide clinical advice and leadership to support decision making and strategic planning.

118. NICaN, which has been coordinated by HSCB, played an important role in supporting HSCB in enacting its duty of quality in respect of cancer-related services, including urology. Although NICaN cannot compel the use of the guidelines or protocols developed, it acts as a regional CRG to gain consensus on quality and safe clinical approaches, as well as treatment pathways based on evidence. It was confirmed at the NICAN Board meeting in February 2018 that it is the responsibility of individual Trusts, all of which are members of the Urology CRG, to adopt these guidelines and protocols, (**PC Appendix 16 – NICAN Board Minutes February 2018**).

Complaints

119. The HSC complaints procedures and standards are set out in two documents:

- Complaints in HSC Standards and Guidance 2009 (**SG Statement – Appendix 199 – SPPG – D – 0001 File 1 HSC Complaints Guidance 2009 - WIT to 72419 to WIT 72518**) and;
- HSC Complaints Procedure (updated 2019), (**PC Appendix 17 – HSCB Complaints Procedure 2019 – April 2019**).

120. In accordance with the HSC Complaints Procedure, (**PC Appendix 17 – HSCB Complaints Procedure - April 2019**), the HSCB formulated its own policy on the management of complaints. Attached is the most recent version of the HSCB Complaints Policy, (**PC Appendix 18 – HSCB Complaints Policy amended 2020**).

121. As well as dealing with complaints against HSCB, the Board also analysed complaints made about Trusts with a view to sharing on a regional level any learning from that analysis.

122. The HSCB was required to monitor how it and its commissioned services, including those provided by Trusts, dealt with complaints. This included monitoring complaints

processes, outcomes and service improvements. The Standards for Complaints Handling provided a level against which HSC service performance can be measured (Annex 1 Page 54 of (**SG Appendix 199 – SPPG – D – 0001 File 1 HSC Complaints Guidance 2009 - WIT 72419 to WIT 72518**) refers).

123. The HSCB would review to identify any trends of concern or clusters of complaints. However, the information the HSCB received from Trusts was anonymised (both the complainants and the practitioners). Therefore, if complaints kept arising in respect of the same practitioner, unless this detail was specified by the Trust in the body of its report, the HSCB would not be directly alerted to this. The HSCB's role was to identify trends in the more general sense. When identified, any resulting learning was shared on a regional basis.

124. In order to provide effective oversight of safety and quality processes, including complaints, the HSCB created joint working/decision making groups.

125. A Regional Complaints Group was established in 2009 and chaired by the then Director of Social Care. Membership of this group also included HSCB Directors, HSCB complaints staff, PHA staff, and the Patient and Client Council (PCC). The Regional Complaints Group reviewed monitoring reports, prepared by HSCB complaints staff, of complaints received from the respective HSC Trusts.

126. Following the establishment of the Quality Safety and Experience Group (QSE) in 2013/14 (as further described below), the Regional Complaints Group became the Regional Complaints Sub-Group (RCSG) of the QSE. A copy of the terms of reference for the QSE group is attached as an appendix (**PC Appendix 19 – Final Terms of Reference QSE Sept 2015**).

127. The RCSG reviewed complaints information received from Trusts and any complaints received by the PHA. To inform the RCSG, specific categories of complaint would be sent to designated professionals in the HSCB and PHA for review/consideration and determine if any further action was required.

128. From 2020, the RCSG was jointly co-chaired by the HSCB Complaints and Litigation Manager and the PHA Nurse Consultant for Patient Safety/ Quality and Experience.

SG Appendix 284- SG Appendix 286 SPPG-D-0085 –SPPG-D-0087 (WIT 73197 to WIT 73242)	Action logs of the RCSG at which there was discussion regarding Urology services complaints
SG Appendix 287 (WIT 73243 to WIT 73244) and SG Appendix 290 SPPG -D-0088 & 89 (WIT 73280 to WIT 73282)	Lookback review from the HSCB review of urology services and email trail regarding complaints
SG Appendix 291 SPPG-D-0090 (WIT 73283 to WIT 73295)	Information relating to a complaint concerning Urology Services which appeared in the quarterly SMT monitoring report
SG Appendix 292 to SG Appendix 296 (WIT 73296 to WIT 73311)	Emails between HSCB and SHSCT regarding the above complaint following receipt of the Trust monitoring report, through to request for further information from the HSCB/PHA professional adviser and closure

137. The HSCB did receive anonymised complaints concerning the urology service in Southern Trust as part of the monitoring process (**SG Appendix 205 to SG Appendix 286 SPPG-D-0006 to SPPG-D-0087 - WIT 72560 to WIT 73242**). No trends of concern or clusters of complaint were identified within those complaints.

138. As part of the review of urology services, a lookback of complaints was undertaken by a nursing professional for the period 2014/15 (as distinct from the more recent lookback exercise). The 2014/15 lookback involved a review of urology complaints regionally

from all Trusts. This information has been provided at (**SG Appendix 287 - SPPG-D-0088 SHSCT April 2015 - March 2016 Urology Complaints - WIT 73243 to WIT 73244**). No concerns, patterns or clusters of complaints were identified from the information reviewed by the nursing professional.

Serious Adverse Incidents (SAIs) including interface incidents

139. An adverse incident is described as "*any event or circumstances that could have, or did lead to harm, loss or damage to people, property, environment or reputation*" arising during the course of the business of an HSC. Trusts are responsible for reporting, management of and learning from AIs within their own organisation. Each Trust holds its own Adverse Incident Policy to be used in conjunction with the Regional Procedure for the Reporting and Follow Up of Serious Adverse Incidents (2016) (**SG Appendix 301 - SPPG – C- 00410 File 410 HSCB Procedure for the Reporting and Follow up of SAIs November 2016 - WIT 73380 to WIT 73487**). Section 4.2 of the procedure sets out the criteria to be applied to determine whether an AI constitutes a SAI, which was then reported by the Trust to the HSCB.

140. SAI reviews should be conducted at a level appropriate to the incident under review. Reporting Organisations may use a Regional Risk Matrix to determine the level of 'seriousness' and subsequently the level of review to be undertaken (HSC Regional Risk Matrix – refer Appendix 16) (**SG Appendix 301 - SPPG – C- 00410 File 410 HSCB Procedure for the Reporting and Follow up of SAIs November 2016 - WIT 73380 to WIT-73487**). There are three levels of SAI reviews: *Level* 1 reviews required a Significant Event Audit (SEA) which could be undertaken for less complex SAI reviews; Level 2 and Level 3 continued to be reviewed using Root Cause Analysis (RCA) methodology. Each level is summarised below:

a) **Level 1 Reviews.** A Level 1 review requires a Significant Event Audit (SEA) to be undertaken and submitted to the HSCB within 8 weeks of the SAI being notified. Most SAI notifications will enter the review process at this level and a SEA will immediately be undertaken to:

- assess what has happened;

Section 4 – Concerns Prior to 31 July 2020

Background

227. The questions at paragraphs 12 to 15 of the schedule to the section 21 Notice ask about the extent of the HSCB's knowledge of specific events and circumstances. Before responding to each of these questions directly, the paragraphs below provide background information on the HSCB's knowledge of concerns and actions more generally in respect of urology services, both regionally and in the Southern Trust, prior to the 31st July 2020.

228. By way of brief introduction, there was a review of urology services in 2009, a further stocktake in 2014 following up on that review, and then the HSCB asked each Trust to submit to it an Improvement Plan in order to establish a robust system of providing quality urology services. A new Urology Planning and Implementation Group (PIG) was established. Therefore, there were considerable efforts to improve urology services generally, including in the Southern Trust. The steps taken are set out in chronological order in the subsections below.

229. After those steps are set out, my statement then summarises the three SAIs the HSCB was notified of by the Southern Trust concerning their urology services in the period from March 2016 to September 2017.

Review of Urology Services 2009 and Urology Stocktake 2014

230. A regional review of Adult Urology Services was undertaken by the DHSSPS Service Delivery Unit during September 2008 to March 2009. This review was in response to concerns regarding the ability to manage growing demand; meet cancer and elective waiting times; maintain quality standards; and provide quality elective and emergency services. The review made 26 recommendations covering a range of issues including patient pathways, centralisation of radical pelvic surgery, workforce, and the development of a 3-team model. The review did not look at individual consultant performance. It analysed data for each Trust and each site.

231. In December 2013, the HSCB Director of Commissioning requested a regional stocktake of adult urology services in Northern Ireland to assess what progress had been made in the 5 years since the review. The stocktake was undertaken in February 2014 and examined individual Trust performance. A copy of the Terms of Reference for the stock-take exercise is attached as an appendix, (**PC Appendix 39 – Terms of Reference for Urology Review Stocktake 2014**) The narrative report on the urology review stocktake, (appended at **PC Appendix 40 – Report on the Urology Review Stocktake 2014**), which included suggestions for continuing to improve urology services, was shared with Trust Directors and HSCB ADs of Commissioning in May 2014.

232. Following the stocktake, the Director of Commissioning wrote formally to all HSC Trusts in July 2014 asking the Trusts to bring forward proposals for the establishment and maintenance of a robust sustainable model for urology provision through the submission of an improvement plan. The letter issued to the Southern Trust is appended at **SG Appendix 317 - SPPG-A-00027 Letter to Debbie Burns regarding Urology Modernisation - WIT 73765 to WIT 73766**).

233. The Southern Trust submitted a Urology improvement plan to the HSCB in September 2014 (**PC Appendix 41 – 20140901 – SPPG – B – 00132 File 1 UrologyVisionBoardPaper1Sep14(V2)**) was subsequently given approval to begin implementation of the model, which started in December 2014.

234. The HSCB agreed that the implementation of the improvement plan by the Trust would take precedent for a period over delivery of agreed activity required within the SBA as noted in correspondence from Mairead McAlinden, Chief Executive Southern Trust, to Valerie Watts, Chief Executive HSCB, on 19 December 2014 (**PC Appendix 42 – 20141219 – SPPG – B – 00131 File 1 CExSHSCTLett19Dec14ToHSCBCEx-UnderdeliveryCoreVols**).

urology was also completed in 2017 and is appended at **SG Appendix 324 - SPPG-A-00044 Draft Urology Workforce Review - WIT 73783 to WIT 73792.**

2015 NICaN Peer Review

240. As outlined in section 3, NICaN was responsible for commissioning review exercises by NCPR from NHS England. One such review was carried out in 2015. The team was made up of visiting reviewers, cross Trust clinical reviewers and lay reviewers (i.e. patients with lived experience). As part of this Peer Review, the Southern Trust local Urology MDT and the regional Specialist Urology Cancer MDT (located in the Belfast Trust) were separately reviewed in June 2015. A document which sets out the National Peer Review Programme measures for Urology Cancer is attached, (**PC Appendix 43 - Peer Review - Resources Measures Urology_Jan2014**).

241. In keeping with standard practice, after the Peer Review visit the quality surveillance team from NHS England wrote directly to the Trust Chief Executive to outline immediate risks and any serious concerns raised at the visit. The HSCB and NICaN would typically have been copied into such correspondence, although my team has searched for this and is unable to locate it. The Trust was then given one month to respond to the NHS England quality surveillance team with their action plan. If the quality surveillance team was content with the plan there was no further communication and it was assumed that the Trust would take forward actions as outlined. If the quality surveillance team had queries with the quality of the plan submitted, they would request clarification.

242. Trusts received their own outcome report and Trusts were each required to develop a local action plan. Where issues raised related to concerns prevailing at a regional level, the HSCB Urology PIG would take this forward.

2015 Southern Trust Local MDT Peer Review

243. While I have been unable to locate a copy of the relevant outcome letter, the key themes arising across cancer services in the Southern Trust were summarised in the overview of the findings from the 2015 National Peer Review of Cancer Services in Northern Ireland (which is appended at **PC Appendix 44 – Northern Ireland Cancer Network Report 2015**). The issues raised were as follows:

- Procedures being undertaken outside specialist centre or by consultants who are not members of or attend the appropriate MDT;
- Absence or inadequate Clinical Nurse Specialist (CNS) provision;
- Delays in seeing routine referrals;
- Shortage of consultants in the specialty or over reliance on locum consultants;
- Absence of core membership of, or lack of attendance at, MDT leading to a significantly low percentage of MDT meetings being quorate; and
- Lack of specialist radiologist or histopathologist input to the service or MDT.

244. In accordance with the agreed process, the Trust would take forward the local issues. The regional issues relating to Urology were taken forward via the Urology PIG and HSCB commissioning and are set out in paragraphs 252 to 256 in this section.

245. The Trust subsequently submitted to the NHS England quality surveillance team a Peer Review Self-Assessment of Urology MDT in 2016, which was signed by the MDT Urology Lead, Mr Aidan O'Brien, and the Trust's Chief Executive on 28th September 2016. This is attached at (**PC Appendix 45 – Self Assessment Report - SHSCT Urology Local MDT_Sep16**). This assessment stated that there were no immediate risks or serious concerns; and it identified the following three 'concerns':

- Availability of the clinical oncologist and radiologist at all of the MDT meetings;
- Highest percentage increase in red flag referrals across the region;
- Operating theatre capacity and operator time.

SELF ASSESSMENT REPORT

(MULTI-DISCIPLINARY TEAM)

Network	NICaN
Organisation	Southern
Team	Craigavon Area Hospital Urology Local MDT Measures (N14-2G-1) - 2016
Date of Validated Self Assessment	30th September 2016
MDT Lead Clinician	Mr Aidan O'Brien
Compliance	
UROLOGY LOCAL MDT MEASURES	**Self Assessment** 55.0% (11/20)
Key Themes	
Structure and function of the service	

Southern Health and Social Care Trust has provided a Urology service for patients living in the Southern area of Northern Ireland since 1992. At that time, there was one Consultant Urologist appointed. A second consultant urologist was appointed by Craigavon Area Hospital Group Trust in 1996. Since then, the service has increased incrementally in size and capacity, with a sixth consultant urologist appointed in 2014. Particular features of the service have been the provision of Extracorporeal Shock Wave Lithotripsy at the Stone Treatment Centre at Craigavon Area Hospital since 1998, and the provision of all outpatient services at a dedicated unit, the Thorndale Unit, since 2007. This unit moved to a new location within the hospital in 2013, with increased capacity, to enable all outpatient consultations to be conducted there, in addition to ultrasound scanning, prostatic biopsies, flexible cystoscopy, urodynamic studies and intravesical chemotherapy. The Unit is staffed by Clinical Nurse Specialists, Staff Nurses and Health Care workers, in addition to visiting Radiographers and Radiologists.
A review of urological service provision in Northern Ireland was conducted in 2008/09, resulting in a reconfiguration of responsibilities for services to be provided to changed geographical areas and by three separate teams of urologists. Team South, based at Southern Health and Social Care Trust (SHSCT), took on responsibility for the provision of services to the population of County Fermanagh, with effect from 1st January 2013. County Fermanagh has a population of 61,175. More recently, SHSCT has agreed to provide urological services to the population of and surrounding Cookstown, County Tyrone, bringing the entire catchment population to 427,000.
Since their commencement in 1992, urological services have been based in the Department of Urology at Craigavon Area Hospital. When the future configuration of all cancer services was advised in the Campbell Report of 1996, Craigavon Area Hospital was designated a Cancer

Concerns

Immediate Risks Identified?

Not Identified

Immediate Risks

Immediate Risks Resolved?

Not Applicable

Immediate Risks Resolution

Serious Concerns Identified?

Not Identified

Serious Concerns

Serious Concerns Resolved?

Not Applicable

Serious Concerns Resolution

Concerns

Availability of the clinical oncologist and radiologist at all of the MDT meetings

Highest percentage increase in red flag referrals across the region

Operating theatre capacity and operator time

General Comments

The Urology MDT is a well structured and attended MDT which is fully constituted with core and extended members. Whilst the attendance by urologists and pathologists, palliative care and clinical nurse specialists has been very good, that of radiologists and by clinical oncologists has been unsatisfactory. The MDT has made every attempt to have this issue addressed and resolved.

This has been a difficult and challenging year for the team due to the competing pressures of achieving targets with increasing referrals.
A work programme has been developed which outlines the work for the incoming year, however this is viewed positively as it includes many aspects to improve the quality of the service provided to our patients.

Summary of validation process

A working group was established to examine documentation. The group consisted of Urology Clinical Lead, Clinical Nurse Specialist, Urology Head of Service, Head of Cancer Services & Service Improvement Lead. At regular intervals the documentation was circulated to MDT members for review and comments. Feedback was received and documents were adjusted accordingly. The Self-assessment was carried out by the Clinical Lead for Colorectal MDT, the Colorectal Nurse Specialist, the Head of Service and a Lay reviewer. The Lay Reviewer also reviewed the patient information evidence folder.

Organisational Statement

I, Aidan O'Brien *(Lead Clinician)* on behalf of Southern agree this is an honest and accurate assessment of the Urology Local MDT Measures.

Agreed by Francis Rice *(Chief Executive)* on 28th Sep 2016.

weeks for urology treatment, which was the accepted longest "backstop" target agreed with the HSCB where services had an accepted challenge in meeting demand. 114 people waited longer than 17 weeks.

53. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, or any previous or subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants and staff in the SHSCT? If yes, how and by whom was this done? If not, why not?

52.1 It is my understanding that the *'Integrated Elective Access Protocol'* published by DOH in April 2008 remained extant for the whole period I worked at the Trust from March 2008. As Director of Performance and Reform (acting from September 2009, substantive March 2011 to March 2015), my performance team was in a support role to the operational Directorates who were responsible for ensuring the requirements of the Protocol were being applied. I had no responsibility for outpatient booking and referrals as this function had transferred out of the portfolio of the Director of Performance and Reform before I took up post in September 2009. I did not personally disseminate the IEAP, having only joined the Trust in March 2008 as an Assistant Director of Performance Improvement. I had a brief discussion with Mrs Lesley Leeman, who was my Head of Performance in 2008, to remind me about the IEAP processes at that time and how this was disseminated, and she confirmed that training had been led by the Operational Service Managers within Acute Services and this had primarily targeted admin and booking staff. Specific information regarding dissemination to urology consultants and to wider staff across the Trust might be best sought from the Director of Acute Services in 2008 (Mrs Joy Youart) and the Director of Performance and Reform at that time (Mrs Mairead McAlinden).

52.2 I have been reminded by reference to documents provided to me by the Trust Public Inquiry Team that, in January 2015 when I was Director of Performance and Reform, the HSCB had completed a short pathway review to "*assess the systems and processes currently in place for the booking of outpatient services regionally to ensure they support the consistent application of the Integrated Elective Access Protocol*

(IEAP)." The performance against chronological management at speciality level within each Trust was analysed and those specialties with a higher percentage of routine new outpatients being seen out of chronological order were selected for review. In addition, specialties where there was a particular concern regarding patients currently waiting over 9 weeks were also selected for review. Five specialties were identified for review across the region including urology. The report from this audit was sent to Mrs Aldrina Magwood as Acting Director of Performance and Reform in June 2015/16 by Mr Michael Bloomfield, HSCB Director of Performance and Corporate Services (*relevant document can be located at S21 No 11 of 2022 Attachments, 82.* MB334 - ltr to Aldrina Magwood re Review of OP booking processes).

52.3 With respect to training and understanding of staff, section 6 of the report states that "*Staff are aware of the IEAP and were able to show examples of local policies and procedures to follow. There is an ongoing process for refresher training on IEAP, which will include specific training for all relevant staff on correct recording of clinical priority type*." This provides some evidence that dissemination was achieved, particularly for booking staff, noting that one of the report recommendations was that "*All booking staff should receive refresher training on the IEAP standards on a regular basis."* Further information on this review is provided in my response to question 53.

54. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of that protocol or any previous or subsequent protocol? What action, if any, was taken (and by whom) if time limits were not met?

53.1 The urology service was the same as any other clinical service and was expected to operate under the IEAP. Responsibility for management, oversight and governance of urology was as set out in my response to questions 7 and 8 above. The Director of Acute Services and her service operational team were responsible for managing, overseeing, and governing the urology service to comply with extant

standards and guidelines which would have included the IEAP and the access targets stated at section 4.0 of the Protocol (*relevant document can be located at, Relevant to Acute/ Document Number 6/ 20080430 No.6 Integrated Elective Access Protocol)* and the prevailing commissioning plan access targets in each year. Detail of how the IEAP was specifically delivered within urology services might be more completely answered by the Head of Service for urology services Mrs Martina Corrigan and Mrs Katherine Robinson (Head of the Booking Centre).

53.2 I recall that compliance with time limits for urology services against the Protocol was monitored through performance reporting within an overall performance management framework (*relevant document can be located at S21 No 11 of 2022 Attachments, 83.* Performance Framework Version2 PROGRESS REPORT JUN09). As advised in my response to question 51, performance on the access targets was reported at every public board meeting and compliance with elective access targets was also the subject of regular performance meetings with HSCB and DHSSPS as performance across all Trusts was reported regionally in their Board meetings. I recall that compliance with the IEAP was an ongoing issue for assurance from operational Directors into Performance Reporting that I became responsible for as Director in September 2009. An example of this can be referenced in the Monthly Performance Report for October 2015 presented to public Board on 26/11/15 *(relevant document can be located at S21 No 11 of 2022 Attachments, 46. 20151126 Performance Report a).* The covering template to the report summarises SMT discussion and challenge and specifically refers to assurance being sought on adherence to the IEAP, strict chronological management and DNA/CNA practices as well as to assurance sought on ongoing validation of waiting lists by service leads.

53.3 In 2015/16, during my tenure as interim Chief Executive, the pathway review completed by HSCB and referenced in paragraph 52.2 assessed the systems and processes in place for the booking of outpatients in urology services against the Integrated Elective Access Protocol (IEAP) with a specific focus on performance against chronological management. Key findings from that report were as follows:

a. Regarding Triage times, it was reported that, "*For the majority of urology*

referrals, daily triage is now achieved, but there is a long-standing issue with turnaround time from one consultant and referrals not returned from triage continues to be a key issue for booking staff."

b. Regarding clinic templates it was reported generally that clinic templates "*are carved out to new urgent, new routine and review slots in line with best practice*." For Urology specifically it was reported that "*since December 14, all clinic slots are designated red flags. Unallocated slots are notified to the Referral and Booking Centre who book with patients from the PTL, selecting urgent patients first, and then proceeding to routines. Urgent patients are mostly being booked within 4-6 weeks, but the waiting time for new routine patients is currently at 40 weeks.*

c. With respect to chronological management, it was reported that, "*in some specialties, e.g. urology and ophthalmology, the Referral and Booking Centre will be contacted by referrers with information about a change in clinical priority and a second referral usually sent in. Staff will administer this on the system, retaining the patient's original date but amending the clinical priority and appointment type. This can mean that sometimes urgent patients will appear to have waited longer than routines."*

d. Regarding booking processes, it was reported that, *"The process for booking new routine and review patients is in line with regional guidance. In the new urology model, all patients are now telephone booked."*

53.4 The relevant recommendations from this process and noted in 1 and 2 below:

Prioritisation of referrals: **Daily Triage for Red Flags** **Within 3 working days for other referrals**	1. Where the 3-day turnaround standard is not being met, a process should be agreed with clinicians whereby the referrers' priority is accepted and the booking staff proceed to book urgent appointments. 2. The areas outlined with particular challenges with late triage / missing referrals should be escalated as a matter of urgency. 3. A process should be put in place to ensure that all staff who book or make changes to appointments make the correct amendment to clinical priority type.	By the end of September 2015

53.5 I have some recollection of being generally aware of the issues raised in this report regarding daily triage and that the reference to turnaround time for one consultant referred to Mr O'Brien, as well as a general awareness of the recommendation that I believe was made by HSCB to five Trusts in the region, to agree a process for using the referral priority grading for a patient where the 3-day turnaround standard was not being met. I have not seen, nor do I recall, any escalation of the issues in this report formally into SMT, Board or to me as interim Chief Executive and expect I was aware as the review commenced when I was Director of Performance and Reform, and through informal discussions/one to one meetings with the extant Acting Director of Acute Services, Debbie Burns and Acting Director of Performance and Reform, Aldrina Magwood. As interim Chief Executive, I would reasonably have expected that follow up on the recommendations was the responsibility of these two Directors and the incoming Director of Acute Services, Mrs Esther Gishkori from August 2015, working together. I refer to this matter again in my response to questions 96 and 97.

53.6 If IEAP time limits were not being met there were a range of actions taken. These actions were the responsibility of the urology operational service team and information on this could be sought form Mrs Martina Corrigan, Head of Urology Services. With respect to improving performance against the access targets, actions were reported at a corporate level in the Monthly Trust Performance Reports. This usually included actions to improve performance within existing capacity as well as actions to identify gaps between the capacity of the team to deliver and the demand for assessment and treatment, and secure support from commissioners to invest to close those gaps. Examples of both types of actions, that I have seen reference to in the documents provided to me by the Trust Public Inquiry Team, include moving procedures normally undertaken as an in-patient admission to a day case admission (as proposed for the TURP procedure in the April 2010 baseline assessment against Regional Review of Adult Urology Services update (item 11 in the paper included in papers in 50.1b above). Addressing the lack of capacity for urology services regionally and locally to achieve elective standards was part of the Regional Review. As at June 2010, the Performance Report to the Board (ST 256/10) (*relevant document can be located at S21 No 11 of 2022 Attachments,* Trust Board 2007 - 2022 including packs

directors, of which there was three because I believe it covered geriatric medicine, which was a different directorate, Paediatrics and Acute. So I wouldn't have expected that document to be any surprise. As I said, it had been circulating before it was formally issued. 10:37
I would have asked the usual question if there is any concerns around anything within the recommendations in terms of deliverability, to have been alerted to that so that I could at least have a follow-up conversation with Michael. I don't recall at any stage there being 10:38
any particular issue coming up. I did try to find through evidence if there has been any formal responses to me on that but I don't recall there being so.

I know certainly the way that would have worked back in 10:38
the day when Directors of Planning met every month, and Michael would have joined our meetings, so we would have had a follow-up discussion. My impression of that was that a patient review was done across the piece.
I didn't feel that the Southern Trust was sitting in 10:38
any more challenging position than any others in terms of implementing and adhering and complying with the IEAP than anybody else at that point in time.

109 Q. Perhaps if I suggest to you that they were in a slightly different position because they had a very, 10:38
very focussed and specific spotlight on an issue that was causing lack of triage and referrals?

A. Mm hmm.

110 Q. Do you know where the HSBC got that information from

that informed their report? Where did they find out this bit about "a longstanding issue with turnaround time from one consultant and referrals not returned from triage continues to be a key issue for booking staff"? 10:39

A. I think that would have been from Maria, who would have done the report. And I'm assuming, and even having heard and read Katherine Robinson's evidence here to the Panel, I don't think the team would have been holding back with an honest issue if they had a challenge. They would have been reporting that. 10:39

111 Q. So you think Maria Wright from the HSCB went out and spoke to members of staff and took evidence effectively?

A. I think that was part of the review. She was working in amongst the team. That would have been my understanding of how it was conducted. 10:39

112 Q. In your role as Director of Performance, and given the very significant impact triage has for targets and turnaround, what did you do when you saw that specifically to assure yourself of any concerns around patient safety or risk? 10:39

A. I suppose the assurance that would have been received then, and throughout I have to say, was - right, wrong or otherwise - that there was a workaround in terms of what was being managed within the service to work in the way with Mr. O'Brien to adhere, to sort of chase up, if you will, to follow up another systems. That said, I didn't understand the detail of it. I did hear 10:40

particular concern around a particular clinician, I would have expected that to have come up again, as evidenced, for example, in Dr. Rankin's letter, of a request for some support or whatever to go in and do something if there was a view that there would be something that could change that.

123 Q. You have mentioned that you were surprised that the HSCB, in their own report, their own review, mentioned one consultant?

A. Yes. 10:45

124 Q. You have said that it wasn't just Mr. O'Brien. Do you think that that was an unfair representation in that report?

A. I do in the sense of I think -- like I said - I mean, again I have to go back, it's some years - but I do recall that it uncovered quite a lot of issues we had in paediatrics, for example, and attention going into the work with the Director of Children's Services at that time to sort of address some of the challenges there. So, those to me were the bigger system issues that needed addressed. 10:45

Naming one individual. I mean, it's like anything from an information perspective. If you say one individual, you know, it is clearly naming an individual. For a report that was to do a review of an entire system, I thought it was unusual. It's an unusual comment. 10:45

125 Q. But it does give a timeframe for the knowledge for HSCB of this issue?

258. The external reviewer recommended a further self-assessment in 2018. However, the NCPR system was then stood down and replaced by quality surveillance programme, which changed the self-assessment and external validation process. As such, the self-assessment and external validation process did not take place thereafter in NI. NI did not have the required data stipulated by NHS England to participate in the external validation process.

Peer Review of Proposed Programme of Visits 2018 - 2020

259. Following the change to the Peer Review arrangements mentioned above, a discussion was held by the NICAN Board in February 2018, (**PC Appendix 16 – NICAN Board Minutes February 2018**) about which organisation was responsible for acting on peer review findings. There was clarification that Trusts remained responsible for developing action plans to address serious concerns or immediate risks identified during a Peer Review.

260. In contrast, the HSCB was to address any regional issues identified within the peer review process.

Southern Trust's Urology Service SAIs (2016 & 2017)

261. In 2016 and 2017, there were 3 SAIs relating to urology services in Southern Trust. Each is considered in turn below.

1) SAI – RCA Personal Information redacted by USI

262. All correspondence relating to SAI Personal Information redacted by USI together with a position report from the DATIX risk management database have already been shared with the Inquiry team through Sharon Gallagher's statement (**SG Appendix 331 to SG Appendix 555 SPPG-C-00159 - SPPG-C-00383 WIT 73818 to WIT 74647**) and (**SG Appendix 620-694 SPPG-C-00001 to SPPG-C-00075 WIT 74913 to WIT 75480**).

263. The HSCB was notified about the SAI *via* the SAI mailbox on 22nd March 2016. The notification explained that the incident had occurred in January 2016, meaning there were 10 weeks from the date the incident before it was reported to HSCB. The HSCB was not informed of the date the Trust formally discovered an incident occurred. As per

the SAI procedure outlined in Section 3 of this statement, Trusts are required to inform the HSCB within 72 hours of the incident being discovered.

264. Upon receipt of the Terms of Reference for the level 2 review on 5 April 2016, the DRO encouraged the Trust to consider "*adding someone from outside the Trust to the team membership"*. (**SG Appendix 632 - SPPG-C-00013 - Email from DRO with query re Team Membership - WIT 74936 to WIT 74937**). Following discussion between the DRO and Trust Governance Lead, as would be the practice, it was agreed the membership would remain unchanged, though expert opinion would be requested during the course of the review, if required.

265. The Final RCA Report for SAI [redacted] was due to be submitted to HSCB within 12 weeks from notification of the SAI, by 14th June 2016. The report was not received until 16th March 2017, i.e. 39 weeks after the agreed date of receipt.

266. Correspondence was issued from the Chief Executive of the HSCB to Trust Chief Executives on all overdue reports across the region on a quarterly basis. Letters highlighting concerns regarding all reports overdue from the Southern Trust were sent from Valerie Watts, Chief Executive of HSCB, to Francis Rice, Interim Chief Executive of Southern Trust, in August 2016 and January 2017. (**SG Appendix 304 to SG Appendix 307 - SPPG – C – 00461 – SPPG – C – 00464 WIT 73614 to WIT 73619**)

267. Following consideration of the RCA Report by the Acute SAI Professional Group on 6th June 2017, the following queries were sent by the DRO to the Trust. It responded on 15th September 2017. The queries and the Trust's responses are set out in the table below.

Table 6 - SAI – RCA [redacted] Queries & Trust response

Query from DRO	Trust Response
Request further clarification on who ordered the CT scan, Ultrasound and MRI and why the results were not	The CT MRI and US were ordered by or on behalf of an individual Consultant General Surgeon. A further CT was ordered by a

serious incidents

From: serious incidents
Sent: 21 September 2017 17:10
To: 'Corporate.Governance'
Subject: Trust Ref: SHSCT SAI [redacted] HSCB Ref: [redacted]
Attachments: SAI Notification Form. [redacted] pdf

Importance: High

Lindsey,

Please see below DRO queries, in relation to the above SAI. The DRO requests an **urgent response**:

1. What action has been taken to prevent further referrals slipping through processes like this?
2. Has the Trust assured itself that there are no other urology referrals have slipped through?
3. Have they considered if this is likely to be a problem in other specialities?

Also, the DRO wishes to draw the Trust's attention to the attached SAI (HSCB Ref: [redacted] and check if the cases in SAI below were found following a review prompted by this SAI as the case is not on the list of new ones?

Many Thanks
Roísín
Roisin Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [redacted]
T: [redacted]

From: Corporate.Governance [mailto: [redacted]
Sent: 21 September 2017 12:49
To: serious incidents
Subject: ENCRYPTION: SAI NOTIFICATION [redacted]

Please find attached SAI Notification ID [redacted]

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site

serious incidents

From: Corporate.Governance <Personal Information redacted by the USI>
Sent: 29 September 2017 10:40
To: serious incidents
Subject: FW: Trust Ref: SHSCT SAI Personal Information HSCB Ref: Personal Information

Categories: Work in progress

Response to DRO queries:

1. What action has been taken to prevent further referrals slipping through processes like this?
    a. *Electronic referral process is being piloted which make triage more accessible and timely. It allows easy identification of referrals that have not been triaged & reporting of same*
2. Has the Trust assured itself that there are no other urology referrals have slipped through?
    a. *There has been a look back exercise within urology to identify any other referrals which were not triaged, this review is complete.*
3. Have they considered if this is likely to be a problem in other specialities?
    a. *If Consultants fail to comply with the IEAP process and there are delays in triaging this is escalated to the HoS & AD for action*

SAI Personal Information was identified from review of a complaint sent by his family.

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ
Telephone Personal Information redacted by the USI
Ext Personal Information redacted by the USI

From: serious incidents [mailto:Personal Information redacted by the USI]
Sent: 21 September 2017 17:10
To: Corporate.Governance
Subject: Trust Ref: SHSCT SAI Personal Information HSCB Ref: Personal Information redacted by USI
Importance: High

Section 5 – Overview of period 31 July 2020 to 30 October 2020

309. Paragraph 16 of the schedule to the section 21 Notice asks :

"When and in what circumstances did you first become aware of the contents of an Early Alert Communication from the Trust to the Department on 31 July 2020?"

310. I first became aware on 21st August 2020. This is explained below.

From the Early Alert to 1st meeting of UAG

311. On 21st August 2020 I received an email from Jackie Johnston, Deputy Secretary in the Department, about an Early Alert (EA 181190) received from Southern Trust regarding urology services. The email was also directed to Olive McLeod, Chief Executive of PHA. Jackie Johnston attached the Early Alert form from Dr Maria O'Kane, Medical Director, Southern Trust, which outlined the Trust's concerns about delays in treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. It also said that a "*lookback*" exercise had been conducted of the Consultant's work for a 17-month period (January 2019 to May 2020) to ascertain if there were wider service impacts. The Early Alert Form noted the initial actions the Trust had taken (**SG Appendix 761 - SPPG-B-00172 Email trail between Hugo Van Woerden and Paul Cavanagh to discuss lookback review – WIT 75705 to WIT 75711**).

312. The Department's Early Alert system is designed to ensure that the Department and the Minister receive prompt and timely details of events (including potential SAIs) which may require urgent attention or possible action by the Department. The Early Alert notification sent by the Trust on 31st July 2020 provided necessary details to alert the Department and explained the Trust's efforts to ascertain the extent of concerns regarding the practice of the Consultant in question.

313. The Departmental Early Alert circular issued on 27th February 2019 requires organisations to notify the Department of any event meeting the Early Alert criteria within 48 hours and the notification proforma must be completed and forwarded to both Department and HSCB within 24 hours after notification. The Trust did not meet this requirement.

314. The Early Alert explained that the Trust had become aware of the potential concerns on 7th June 2020 and had undertaken a lookback exercise bounded to a 17-month period (1st January 2020 to 31st May 2020). The lookback identified concerns with patient care and two potential SAIs. The Trust also referred to steps it had taken to raise concerns about the Consultant's practice and initiate a Review of Service.

315. The HSCB was not notified of the issue prior to receiving the Early Alert. The Trust could have raised the issue with the HSCB earlier through established channels given that there would be an impact on service delivery due to any lookback activities.

316. It is important to emphasise the actions which followed took place in the context of ongoing work to manage the HSC's pandemic response, most notably planning for the second and more challenging wave of infection anticipated in late Autumn 2020. Work had largely moved online with colleagues and I linking remotely through video conferencing facilities. Moreover, work-life balance had become problematic for senior managers and clinicians across the entire sector, all of whom, myself included, were working long hours, including at weekends, without prospect of any break in sight.

317. Jackie Johnston's (DoH) email to me and Olive McLeod (PHA) said the Department would look to the HSCB and PHA to provide advice on the need for a recall/lookback of identified patients and oversee the governance and process of any recall/lookback if required (**PC Appendix 53 - FW HPRM MM01212020 -CONFIDENTIAL EARLY ALERT – Urology**).

318. Paragraph 17 of the schedule to the section 21 Notice asks:

> *"Outline all steps taken by yourself and the HSCB upon receipt of the information contained within the Early Alert Communication from the Trust to the Department on 31 July 2020. Specifically, outline the following:*
>
> *I. The immediate action (naming each actor) taken by the HSCB on receipt of the information contained within the Early Alert Communication;*
>
> *II. The individuals within the HSCB to whom the contents of the Early Alert Communication was shared;*

Aimee Crilly

From: O'Brien, Aidan [redacted]
Sent: 22 September 2019 17:11
To: Corrigan, Martina
Cc: Haynes, Mark
Subject: [redacted] CAHE [redacted]

Martina,

I write to you regarding this [redacted], diabetic man who had a stone obstructing his upper right ureter in 2015.
He was managed by ureteroscopic laser lithotripsy.
He was noted to have a grossly enlarged prostate gland on endoscopic assessment.
I advised him that he would be better served by having his prostate resected.
He was placed on the waiting list on 08 October 2015.

On reviewing my waiting list during August, I noted that he had been removed from the waiting list in July 2019.
When I contacted him by telephone, he advised that he had received a letter enquiring whether he wished to remain on the waiting list, or words to that effect.
As his only symptoms was that of nocturia, he replied that he did not wish to proceed with surgery.

I requested an ultrasound scan which has since indicated that he may have recurrence of stone in his right kidney, that he has inadequate bladder voiding with a residual volume of 190 mls, and would appear to have formed a stone in his bladder.
I have again spoken to the patient by telephone, advising him of the above findings.
I have requested a CT Urinary Tract to more clarify his stone status.
He has agreed to being returned to the waiting list for admission for TURP.
I have dictated a letter to the GP requesting that he be prescribed Tamsulosin until admission for TURP, in addition to requesting optimisation of diabetic control prior to admission.

I hope that you will agree that it is appropriate that I bring such a case to your attention.
I believe that it is entirely inappropriate that non-clinical staff should correspond with patient to enquire whether they wish to remain on a waiting list, and entirely for the purpose of reducing the numbers of patients on waiting lists.
Patients have the right to decline proposed management, but should be empowered to make decisions informed by clinical advice.

I would be very reassured if this practice has been discontinued, as you had recently indicated.
I would also be grateful if I could be furnished with a list of those patients of mine who have been so communicated with.

Thank you,

Aidan.

Aimee Crilly

From: Haynes, Mark [redacted]
Sent: 22 September 2019 21:05
To: O'Brien, Aidan; Corrigan, Martina
Subject: [redacted] CAHE [redacted]

Thanks Aidan

As I have stated before I was not aware of the process until it had started and when I became aware had requested it cease.

Where the process is administrative only (ie checking patient not deceased, and checking they haven't had it done elsewhere), then it is fine. This process went beyond that and asked if patients wanted the operation (no-one wants an operation), and then I believe offered them an opportunity of an OP review to discuss. Not only does this mean informed decisions are not possible by the patient (as no one is re-discussing the pros and cons of surgery) but is also offering something that we cannot deliver ie a timely review appointment. I believe the process also raises false hope in patients that they may get a date for their surgery in the near future.

Martina – do you know who led this work and are they able to provide the urologists with the details of all the patients who have either asked to be removed from the WL, or requested a review OPA?

Mark

From: O'Brien, Aidan
Sent: 22 September 2019 17:11
To: Corrigan, Martina
Cc: Haynes, Mark
Subject: [redacted] CAHE [redacted]

Martina,

I write to you regarding this [redacted], diabetic man who had a stone obstructing his upper right ureter in 2015.
He was managed by ureteroscopic laser lithotripsy.
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