Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 15 of 2022

Date of Notice: 28th April 2022

Addendum Witness Statement of: Anita Carroll

I, Anita Carroll, will say as follows:-

I wish to make the following amendments and additions to my existing response, dated 24th June 2022, to Section 21 Notice number 15 of 2022.

1. At paragraph 8.9 (WIT-21273-21274), I have stated '*He PTL is still available but with the introduction of eTriage (2016, 2017 in urology), the triage status is visible to each clinician/HOS on the system*.' This should state '***The*** *PTL is still available but with the introduction of eTriage (2016, 2017 in urology), the triage status is visible to each clinician/HOS on the system*.'

2. At paragraph 24.7 (WIT- 21301), I have stated '*On 20th December 2016, Katherine Robinson HOS RBC emailed me to advise that Mr Noleen Elliott (Mr O'Brien's Secretary) emailed her SA, Andrea Cunningham, to advise regarding a list of clinics that Mr O'Brien had not dictated*.' This should state '*On 20th December 2016, Katherine Robinson HOS RBC emailed me to advise that* ***Mrs*** *Noleen Elliott (Mr O'Brien's Secretary) emailed her SA, Andrea Cunningham, to advise regarding a list of clinics that Mr O'Brien had not dictated.'*

3. At paragraph 36.8 (WIT-21315), I have stated '*When the announcement was made, I was asked by the Melanie McClements DAS to speak to Noleen Elliott, Mr O'Brien's Secretary and the other Urology Secretaries to advise them that the announcement was being made and to ensure if patients rang the secretary they would be directed to the helpline*.' This should state '*When the announcement was made, I was asked by* ~~***the***~~ ***the*** *Melanie McClements DAS to speak to Noleen Elliott, Mr O'Brien's Secretary and the*

other Urology Secretaries to advise them that the announcement was being made and to ensure if patients rang the secretary they would be directed to the helpline.'

4. At paragraph 41.3 (WIT- 21320), I have stated '*Case note tracking is a function / embedded in PAS for recoding the last known location of a chart*.' This should state '*Case note tracking is a function / embedded in PAS for **recording** the last known location of a chart.*'

5. I would like to remove the phrase '*HOS Urology'* from the last line at paragraphs 47.2 (WIT-21328), 50.2 (WIT-21337) and 54.5 (WIT-21342).

6. At paragraph 6.1 (WIT-21252), I want to add 'Since September 2022, I report to Heather Trouton as Executive Director of Nursing.

7. At paragraph 6.2 (WIT-21253), I have stated *'I was appointed as Acting Director of Acute Services from 26th July 2018 to 29th September 2018 and I reported for this period to the Chief Executive, Shane Devlin*.' I wish to add to the end of paragraph 6.2 'Following *Esther Gishkori's (Director of Acute Services) return* Personal Information redacted by the USI *, I had prepared a handover document (please see 1. 20180924 AC Handover to Acute Director EG on return* Personal Information redacted by the USI *). I talked Esther Gishkori through the details and then gave her a copy of the document. If Esther Gishkori needed clarity, I was either available in person or by phone to discuss further and Esther Gishkori's Personal Assistant could have provided any necessary files or correspondence. Further, when I was covering for Esther Gishkori, Director of Acute Services, when she was* Personal Information redacted by the Personal Information redacted by *I sent an email to Shane Devlin, Chief Executive on 21 August 2018 regarding the Urology Waiting List issues raised via email by Mr Mark Haynes (TRU-259145) with me (please see 4. FW Urology Waiting Lists).*'

8. My MHPS statement (TRU-259115-259117) contains a number of errors which I would like to address. The reason for these errors is that I received the MHPS request late in the afternoon on Monday 15th May 2017 and I was trying to get cleared up as I was Personal Information redacted by the USI. I was under pressure to get things cleared up at work before Personal Information redacted by the USI and I was anxious about Personal Information redacted by the USI. I accept the following inaccuracies in my MHPS statement:

a. Paragraph 4 - I explained I became aware of problems with Mr O'Brien's triage in February 2014 but that should have read November 2013.

b. Paragraph 9 - The default process start date I said December 2015 but that should have read April 2014.

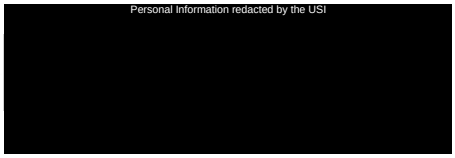
c. Paragraph 12 –I advised there were no specific issue being flagged to me on a regular basis about charts, but I should have said there were issues being flagged to me about Mr O'Brien having charts at home.

9. I recall circa 2014 or early January 2015 having a conversation with Siobhan Hanna, Assistant Director of Informatics regarding charts issues with Mr O'Brien but I do not recall the content of this conversation.

10. At paragraph 40.3 (WIT-21318-21319), I have referenced the Trust policy on the safeguarding movement of charts. I would also like to attach the Standard Operating Procedure (SOP) for the Safeguarding and Transportation Policy (*please see 2. Requests by Staff - Removal of Health Records from Trust Premises*). The new SOP was issued via global email to all staff on 30 March 2023 and on 3 April 2023 I sent the new SOP to Directors and asked for them to highlight this with their teams (*please see 3. FW New SOP for Requests to Remove Acute Patient Chart from Trust Premises*).

Statement of Truth

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

Signed: 

Date: 7 June 2023

Anita Carroll Addendum Statement

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Handover for Director

Planning

1. Paper gone to SMT to open Winter Ward 3N – approved.

2. Cath Lab paper gone to Alana Laverty, HSCB. For a further 6 months. Now approved.

3. Emergency Ambulatory Unit CAH – Revenue funding received of £248k Year 1 and £496k Year 2.

   - Capital has been allocated £1m
   - Additional Capital needed for equipment
   - Restarted project and formalised structure
   - Initially to concentrate on Respiratory 3 clinics per week – 2 at CAH 1 at DHH
   - All staff affected by the move have been communicated with already.

4. Pathfinder – Outpatients to move to Nurses Home in November.
   HDU – agreement was reached in June re service noted for HDU – Discussions ongoing to ensure adequate cover for HDU between Intensivists and Anaesthetists
   DAU – Specialty Dr post due to close end of August.

5. CT Scanners – issues CAH and DHH

Workforce

6. Forensic work ongoing to establish normative nurse staffing levels against what is in place at each shift by ward to gather evidence regarding actual staffing position and identify gaps. (Linked to Winter Ward)

7. Job Description developed for a Rota Co-ordinator, EOI now sent out to assist HOS (Brigeen & Louise in particular), i.e. give them more capacity as they are spending a lot of time on rotas and this is not appropriate for Band 8B.

8. Upcoming Consultant Interview Panels:

24th September	Consultant Radiologist	Anita Attending
1st October	Consultant Physician	Anita Attending
4th October	CD IMWH	
29th October	Cellular Pathologist	
29th October	Orthodontist	
1st November	Nephrologist	
8th November	Urologist	

Unscheduled

9. EOI has gone into the system for a post to manage Winter Wards and pressures (Post 8A) to report to AD MUSC, detailed work undertaken by ADs to agree.

10. Hospital Hub/Control room ongoing work and QI project around outcomes from investment. EOIs have been sent out for Band 3 – got 5.8wte. Business case agreed by SMT for funding for Clinical Co-ordinator on back of Junior Doctor gaps – 3wte. Going to communicate this out via workshop on 19th September morning.

11. Escalation plan – we are using the "HEWS" proforma on a daily basis and reinstated the Sitrep to establish when we are "Code Black". Finalised version of escalation plan sent to other Operational Directors

12. Update after Paula Bennett visit.

Service

13. A series of meetings between Paediatric Consultants and Surgeons re prescribing fluids progress made to date.

14. Meeting with Orthopods re Spinal Fractures pathway to be developed

15. Update on Whistle Blowing – Dr S Murphy – Developed Action Plan

16. Elective Care Centre – Ophthalmology

Performance

17. Issue raised by Mr Haynes re urology query on the back of contact via Personal Informati [redacted] (patient). Meeting to be arranged by Ronan.

18. Backlogs – Mr D McKay

19. Bowel Prep Issue – Prescribing issue

Governance

20. Update re Cawdery Case

21. Upcoming Coroners Inquests – Trudy to provide an update to EG

22. Maternal Death – Out of Hospital arrest – Reported Early Alert

Other

23. Finance Position - Update

24. SMT minutes collated for your update. All papers are available for Esther to peruse.

25. 1:1 meetings held with all AMDs and ADs – Full file in office

Southern Health and Social Care Trust

Quality Care - for you, with you

Standard Operating Procedure	
Title	Requests by Staff to Remove Health Records from Trust Premises
Author	Joanne McEvoy (Head of Health Records and Admin),Anita Carroll AD
Date	20/03/23
Review	20/03/24
Scope of the Procedure	Clinical Staff, Secretaries, Assistant Directors in MUSC and Surgery and Elective Care, Health Records Managers and HOS

1.0 Background

This SOP supports the Policy for the Safeguarding Movement and Transport of Records and in particular, the removal of Acute Health Records by clinical staff from a Trust Premises.

Taking charts off Trust premises is only appropriate by exception and charts should be returned within **three days.**

Removal of charts off Trust premises must be authorized. The request to take charts off Trust premises must be made to the Health Records Managers by emailing the address [redacted] and copied to the relevant Assistant Director for your Specialty. The email should

Personal Information redacted by the USI

1. Outline the reason for taking charts off Trust Premises
2. List the H&C numbers and patient names for the charts to be removed
3. Detail the date(s) of removal of the chart(s) from Trust premises and expected return date.

Charts should only be removed after receipt of an approval email should the records be removed from Trust premises. The relevant Medical Secretary/ or admin support should update the casenote tracking system appropriately (as per guidance below).

Health Records Managers will check if charts have been returned within 3 days. If charts have not been returned this will be escalated to the Assistant Director for the service, and to the Assistant Director FSS. The Head of Health Records will provide an update on this activity and any escalations that have been required to the Information Governance Committee.

Any charts removed from Trust premises must be secured and not left unsecured or unattended at any time. It will be the responsibility of the practitioner to ensure that this is done. Any breach of security of the chart must be reported via IR-1 and to the Trust's data protection officer (who will consider if ICO referral is required).

2.0 Roles and Responsibilities

Consultant / clinical staff

Email your request outlining the justification to Personal Information redacted by the USI

- Include the H&C numbers, patient names, and date(s) of removal and return for charts which are being requested to be removes from Trust premises.
- Copy the email to your Assistant Director.

- Await email of approval before removing the charts
- Forward email to your secretary/ admin support so that they can update the tracking system

Assistant Director

- If deemed an appropriate request, return an email of approval.
- Ensure to “reply to all” so that secretary and Health Records Managers are included in the communication.

Secretary

- Upon email from Clinical staff that chart is being removed it must be tracked appropriately to CCOFF populating the name of the staff member in the comment field

Health Records Managers

- Run a report on a weekly basis to check for overdue charts borrowed under CCOFF
- If charts are not returned within 3 days, escalate to Head of Health Records Service.

Head of Health Records

Head of Service to escalate to the Assistant Director for the service, and to the Assistant Director FSS.

- Report to the Information Governance Committee on the activity under this casenote tracking code and any escalations that have been required.

If removal of records is absolutely necessary it is important that the following points are adhered to;

- A tracking system must be used
- Only the minimum amount of charts should be removed.
- No information should be separated from the chart
- Records should not be carried loosely, instead transport in a secure bag (tamperproof bag with return address should be used if possible)
- Records must never be left in public view in your vehicle
- Records should be kept in the locked boot of your vehicle during transport
- Records should not be left in your vehicle overnight
- If records are not able to be returned to Trust premises at the end of the clinical session, you should ensure, if you bring these records with you overnight, that the records are stored securely (at your home) and are protected from unauthorised access by any person (eg family members ,etc).The records should then be returned to Trust Premises as soon as possible after this.

From: Carroll, Anita
Sent: 03 April 2023 09:44
To: Reid, Cathrine; Reid, Trudy; Austin, Stephen; Beattie, Brian; McCafferty, Colm
Cc: Keown, Caroline B; Lappin, Lynn; Burke, Mary; Conway, Barry; Wamsley, Chris; McEvoy, Joanne; Trouton, Heather
Subject: FW: New SOP for Requests to Remove Acute Patient Chart from Trust Premises

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Dear All

I realise this went out as global message to staff last week but can I bring your attention to new SOP Requests by Clinicians to Remove Acute Charts from Trust Premises which provides arrangements for clinicians requests to take charts off Trust premises.

I would be grateful if you could highlight this with your teams.

Thank you

From: Global circular <Personal Information redacted by the USI>
Sent: 30 March 2023 19:05
To: SHSCT_DL_Global_Circular <Personal Information redacted by the USI>
Subject: New SOP for Requests to Remove Acute Patient Chart from Trust Premises

Dear Colleagues

To support the Policy on Safeguarding the Movement and Transport of Records, a new Standard Operating Procedure has been developed - Requests by Clinicians to Remove Acute Charts from Trust Premises
This new SOP describes the process to be followed in the exceptional circumstance of removal of Acute Health Records from Trust premises.

It will provides better governance around the approval and notification of intent to remove records, location tracking, a mechanism for monitoring return of records and escalation of non-compliance.

There are roles and responsibilities outlined within the guidance, and this procedure will take effect from 1st April 2023.

For any queries relating to this new process please contact the Head of Health Records, Joanne McEvoy.

From: Adams, Valerie
Sent: 05 June 2023 15:02
To: Adams, Valerie
Subject: FW: Urology Waiting Lists

From: Carroll, Anita [redacted]
Sent: 21 August 2018
To: Devlin, Shane [redacted]
Subject: FW: Urolo

Shane

Mark met me today to discuss the information below .
I know this feeds into the endoscopy information that has gone to ahmed to respond to Dr mckay but thought maybe we need to discuss this also
Sorry to trouble
Anita

From: Haynes, Mark
Sent: 15 August 2018 08:09
To: Carroll, Anita
Cc: Carroll, Ronan
Subject: FW: Urology Waiting Lists

Morning Anita

We didn't get to discuss this yesterday – there are too many 'challenges' in SEC!

Below is an email chain sent back in May / June. The shortest summary is that the current state of the urology waiting lists presents a very real risk of preventable mortality to our patients.

Added to this it is clear from current waiting lists (below) across acute services that some services are better provisioned than others. Despite the state of our waiting lists, as we have no extended days running we are continuing to operate with a minimum of 1 theatre list per week less than we are supposed to have.

Urology is the worst but the same applies to other specialities in SEC (ie the endoscopy planned waiting list), albeit with different risks.

In acute services and across the trust, a decision is needed between;

1) Accept that a further death will occur and that patients for routine elective gynaecological surgery will continue to be treated with wait times of a quarter of the wait for a clinically urgent urological procedure. The disparity between mens and womens healthcare provision in the trust being a disgrace – if a man requires a urological procedure to treat incontinence he will wait more than 4 years. A women gets her treatment within a year (that is after waiting to be seen in OP clinic and there are further longer waits for urology OP appointments which again are considerably longer than our gynaecological colleagues). It would be interesting to know how many O&G consultant and Breast consultants are employed in the trust compared to urology (accepting that a significant amount of urological workload is also female!).

2) Redistribute access to inpatient theatres for a period of time to enable an equalisation of waiting times across specialities.

3) Gain access to an additional fully staffed theatre and corresponding bed space for use by urology and those other specialities with considerable waits to bring waiting times down to acceptable levels (drop in 'chip van' theatre with staff).

Please note, we cannot move this work to alternative trust sites as it is inpatient work and we have no inpatient team outside of CAH (indeed the consultants are regularly acting down as SPR due to a lack of junior staff) and we do not have theatre kit / lasers etc on any site other than CAH.

I have spent the last two evenings in operating on emergencies long into the night. As a result there are a further 3 patients (5 hours of operating) requiring 'planned urgent' repeat ureteroscopies which should be performed within 4 weeks as evidence shows that the risk of sepsis if done in this timescale is 1%, after 4 weeks the risk goes up to 4.5%, after 12 week >9%. I am currently booking patients at >6 months after their emergency procedure. My situation is mirrored across the urology team, some waits are longer.

In addition to this group we have over 300 men awaiting a TURP. The expectation is that this is for benign disease. However, it is recognised that approximately 10% with befound to have an unexpected cancer on their TURP pathology. Most of these will be incidental low risk cancers that are of no consequence. However around 5-10% of the cancers identified will be significant disease which requires treating. I have a patient who was on my urgent waiting list (currently running at well over 2 years) who paid to have his procedure privately in dublin after waiting 15 months. His subsequent pathology showed a high grade prostate cancer and staging has shown metastatic disease. He is now on palliative treatment. Had we

been able to offer him surgery in a reasonable time frame for a clinically urgent procedure (<3months), it is likely that his disease would have been treatable with curative intent. Of the 300+ on the waiting list there are likely to be between 3 and 6 further patients in the same situation.

Action is required for these patients. Perhaps we could meet again to talk through the available options?

Mark

From: Haynes, Mark
Sent: 08 June 2018 13:28
To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Reid, Trudy; Stinson, Emma M; Devlin, Shane
Subject: RE: Urology Waiting Lists

Dear Esther

Following on from below, a meeting took place. However, that meeting was to resolve the issues of the impact of the loss of extended day operating on the urology team such that the impact of this was spread across the surgical teams. The meeting did not result in Urology having its full number of weekly theatres (11 with backfill), nor was it intended to address any increase in urology operating to address the waiting list backlog.

In preparation for the meeting, waiting time information across different specialities were collated as below (as at 25/5/18);

Specialty	Urgent Inpatients	Weeks Waiting	Routine Inpatients	Weeks waiting	Urgent Daycases	Weeks waiting	Routine Daycases	Weeks waiting	Total on waiting list
Urology	596	208	237	225	378	173	541	212	1752 patients
ENT	29	1x38 19	142	64	64	23	923	80	1158 patients
General Surgery	113	147	75	139	437	131	901	121	1526 patients
Breast	16	1 x 41 27	15	82	10	1 x 19 4	9	38	50 patients
Orthopaedics	200	1 x 160 85	1155	171	130	1 x 101 80	805	128	2290 patients
Gynae	28	11	168	50	26	1 x 26 6	106	44	328 patients

As such, consideration needs to be given as to how the clinical risk associated with such significant waiting time disparities across specialities should be managed. As highlighted in my previous e-mail, amongst the urology cases are patients where there is well documented increased risk associated with longer waiting times. Unfortunately given the current constraints of available theatre time and inpatient beds along with nursing staffing pressures, I cannot see a solution that doesn't impact on the waiting times of patients from other specialities. However, I do not believe we can justify accepting the current situation.

Could we look to meet at some point next week to discuss this, perhaps we could use our 1:1 meeting next Tuesday with Ronan, Martina and Barry joining us?

From a urology team perspective, I think it would also be helpful to meet the full consultant team. We are all available on Thursday 14th June at 12:30 and would be happy to meet then if that suits?

Thanks

Mark

From: Gishkori, Esther
Sent: 22 May 2018 18:05
To: Haynes, Mark
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Reid, Trudy; Stinson, Emma M
Subject: RE: Urology Waiting Lists

Dear Mark,
Thank you for sharing this.
Prima Fascia, it looks like the death of this gentleman could have been avoided.
Ronan,
For this reason, please begin the SAI process in the first instance. Once screened, we can grade appropriately.

Also though, Mark reports here that the longer urology patients have to wait, the higher the incidence of an adverse incidence occurring.
I know that regionally urology is an issue but during our conversation with Mark today, he told us we had the longest waiters. I need to understand fully why this is but also if we have it within our gift to improve the situation within the Trust without making any other service unsafe or unstable.
I would also be grateful if you would, in the first instance, set up a meeting with Mark, you, me, Martina and Barry so that initial steps to reduce this waiting list can be discussed and actioned.
Shane,
For your information only at this point. I will keep you informed as we go but am happy to discuss at any point.
Dr Khan,
You are welcome to join us any time although the first few steps in this are probably operational. I will of course copy you into all correspondence.

Many thanks
Best,
Esther.

From: Haynes, Mark
Sent: 22 May 2018 13:31
To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed
Subject: Urology Waiting Lists
Importance: High

Dear Esther

I write to express serious patient safety concerns of the urology department regarding the current status of our Inpatient theatre waiting lists and the significant risk that is posed to these patients.

As you are aware over the past 6 months inpatient elective activity has been downturned by 30% as part of the winter planning. This has meant that for our speciality demand has outstripped our capacity for all categories of surgery. In reality this has meant that Red Flag cases have been accommodated, with growing times from referral to treatment and increasing numbers of escalations / breaches. However, only limited numbers of clinically urgent non cancer cases have been undertaken with waiting times for these patients increasing significantly. These clinically urgent cases have also been subject to cancellation on occasion due to bed pressures. Routine surgery has effectively ceased. As you are aware there are staffing difficulties in theatres which renders it likely that there will be ongoing reduction in elective capacity. This is likely to disproportionate impact on Urology as we have, as a speciality, three 4 hour theatre sessions which take place as part of extended days and it is these sessions that will not be running.

The clinically urgent cases are at a significant risk as a result of this. Included in this group are patients with urinary stone disease and indwelling urethral catheters. The progressive waiting times for these patients are putting them at risk of serious sepsis both while waiting for surgery and at the time of their eventual surgery. In addition for the stone disease patients, their surgery can be rendered more complicated by development of further stones and / or encrustation of ureteric stents. The clinically urgent category also includes patients who are at risk of loss of kidney function as a result of their underlying urological condition (eg benign PUJ obstruction). Many of these patients are recurrently attending A&E and having unscheduled inpatient admissions with urinary sepsis while awaiting their inpatient surgery. Catheter related sepsis is a significant risk and all catheterised patients on our waiting lists are at risk of this, the recognised mortality risk for Catheter associated sepsis is 10%. Patients with stone disease and other benign urological conditions which affect upper urinary tract normal functioning are at risk of losing kidney function and consequently renal failure. The current duration of our waiting lists means significant numbers of patients are at risk of loss of renal function and consequently these patients are at a risk of requiring future renal replacement therapy. Duration of ureteric stenting in stone patients is associated with progressively increasing risk of urosepsis, and it's associated risk of death, as a post-operative complication. This risk has been quantified as 1% after 1 month, 4.9% after 2 months, 5.5% after 3 months and 9.2% after greater than 3 months. Currently our waiting lists have significant numbers of patient who have had stents in for in excess of 3 months and therefore our risk of post-operative sepsis is significant and is continuing to grow.

Tragically, a Personal Information redacted by the USI patient died this weekend following an elective ureteroscopy. He had a stent inserted in early March as part of his management of ureteric stones and was planned for an urgent repeat ureteroscopy. This took place 10 weeks after initial stent placement. He subsequently developed sepsis and died on ICU 2 days after the procedure. While this may have happened if his surgery took place within 1 month of insertion of the stent, and there will be other factors involved (co-morbidities etc), his risk of urosepsis was increased 5 fold by his waiting time for the procedure.

Unless immediate action is taken by the trust to improve the waiting times for urological surgery we are concerned that another potentially avoidable death may occur.

The private sector does not have a role to play in the management of this problem (previous experience) and the trust needs to therefore find a solution from within. We are aware that while our waiting times are far longer than is clinically appropriate or safe, other specialities have far shorter waiting times with waits for routine surgery being far shorter that our clinically urgent waiting times. Given the risk attached to these patients and the disproportionately short waiting times in other specialities one immediate solution is to have specialities with shorter waiting times 'give up' theatre lists to be used by the urology team until such a point as these waiting times come back to a reasonable length (less than 1 month for all clinically urgent cases).

Looking at our current waiting list there are currently approximately 550 patients in the clinically urgent category, waiting up to 208 weeks at present. In order to treat these patients we would require a minimum of 200 half day theatre lists. We would suggest the target should be 4

additional lists per week in order to treat this substantial volume of patients and this would therefore need to run for at least a year in order to bring the backlog down to an acceptable level (waiting time less than 1 month). It may require a longer period / more sessions as patients continue to be added to the waiting lists and demand outstrips our normal capacity. This requirement is on top of our full complement of weekly inpatient theatre sessions (11). With regards staffing of these lists we currently have 2 locum consultants providing sessions in the department and these individuals could be used in order to deliver the surgery or back fill other activity so the 5 permanent consultants can undertake the additional lists. In addition the department need a longer term increase in available inpatient operating in order to match demand. Clearly the above would not tackle the routine waiting list.

Once again, we would stress that without immediate action to start treating these patients there will be a further adverse patient outcome / death from sepsis which would potentially not have occurred if surgery had happened within acceptable timescale.

I am happy to meet to discuss timescales to implement the changes required.

Yours Sincerely

Mark Haynes