An Own Initiative Investigation issued under s23 of the Public Services Ombudsman (Wales) Act 2019 against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202002273

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Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019 ("the Act").

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted.

Summary

During another investigation into concerns raised by Mr Y, the Ombudsman received evidence from the Health Board which indicated that, at the time Mr Y was placed on the urgent list for prostate cancer treatment in August 2019, there were a total of 16 other patients with the same urgent clinical priority awaiting the same procedure (prostatectomy - surgery to remove the prostate). As I had reasonable suspicion there were other possible incidents of service failure and maladministration in relation to the other patients on the waiting list, I commenced an investigation using my own initiative power of investigation to consider whether the Health Board exceeded the Referral to Treatment Time ("RTT" – the waiting time management rules) target for cancer waiting times for treatment of prostate cancer in respect of the 16 patients who were awaiting prostatectomies.

My investigation found that, in August 2019, the Welsh policy position in accordance with Welsh Government guidance was that, only patients treated in Wales were reported against the Welsh cancer waiting time targets. The Health Board therefore only produced "breach reports" and undertook harm reviews for the patients it treated. This did not apply to patients referred by the Health Board for treatment in England. Of the 16 patients on the waiting list in August 2019, 8 were referred to England for treatment. If they had been treated in Wales, the breaches of the target timescales would have been reported for all 8 patients because the amount of time they waited for treatment exceeded the 62 and 31-day target for cancer RTT (the target times relate to whether a patient had been designated as urgent suspected cancer or non-urgent suspected cancer). Four of the patients on the waiting list who were treated by the Health Board had exceeded the cancer waiting time target and these breaches of the target timescales were reported and harm reviews were completed.

While the Welsh policy position at the time meant there was no requirement to produce breach reports to the Welsh Government or to carry out harm reviews for Health Board patients treated in England, the geographical location of treatment should not have left these 8 patients in the position where they were denied the harm review process because

they were treated outside Wales. Regardless of the Welsh policy position at the time, the Health Board was obliged to undertake appropriate monitoring of the care and treatment of its patients under its commissioning and contracting arrangements. It should also have considered the impact of the delay in treatment. These failures amounted to maladministration.

The new Single Cancer Pathway ("SCP") which has replaced all previous cancer targets, has addressed the anomaly of the previous approach and all patients now referred from secondary care for treatment outside Wales for their cancer treatment must be included in cancer waiting times monitoring arrangements and all patients not treated within the target should have an internal breach report completed. However, to remedy the injustice to the 8 patients, in line with my approach to remedy, I recommended that the Health Board should return these patients to the position they would have been in had they been treated in Wales and carry out a harm review for each patient. I also recommended that the Health Board reviewed its harm review process to ensure it was in line with the requirements of the SCP.

I have reported on the Health Board's urology service several times and I am concerned that issues relating to capacity and succession planning within the urology department seems to be longstanding. I therefore recommended that the Health Board refers the report to its Board to consider capacity and succession planning for the urology department. The Health Board accepted my recommendations.

My jurisdiction

1. Under Section 4 of the Public Services Ombudsman (Wales) Act 2019 ("the Act"), I may carry out an investigation using my own initiative power of investigation. I am required, under section 5 of the Act, to publish criteria for own initiative investigations. The criteria allow me, where I have already commenced an investigation, to embark on an own initiative investigation into matters that have a "substantial connection" with the matter already being investigated. I can therefore begin an extended investigation using my own initiative power. Such investigation may be carried out where a complaint about 1 element of a service and / or 1 service provider is closely linked to another possible incidence of service failure.

The background

2. In December **2019** I received a complaint from an individual ("Mr Y") about the prostate cancer care and treatment he received from Betsi Cadwaladr University Health Board ("the Health Board"). Mr Y was concerned that the Health Board failed to meet the guidelines for cancer diagnosis which led to him seeking private treatment due to concerns about the impact of the wait for treatment. I commenced an investigation into Mr Y's complaint in January **2020**.[1] The investigation considered the following:

- "that the Health Board exceeded the referral-to-treatment target for cancer waiting times for treatment of prostate cancer. Mr Y was concerned that following a biopsy which confirmed this diagnosis, there was a delay in providing him with an appointment for treatment. As Mr Y was concerned about the impact of the delay, he sought private treatment".

3. During the course of the investigation into Mr Y's concerns, I received evidence from the Health Board which indicated that, at the time Mr Y was placed on the urgent list for cancer treatment in August 2019, there were a total of 16 other patients with the same urgent clinical priority awaiting the same procedure (prostatectomy - surgery to remove the prostate).

[1] Case reference: 201905373

4. As I had a reasonable suspicion that there were other possible incidents of service failure and maladministration in relation to the other patients on the waiting list, I commenced an investigation on my own initiative on 22 September 2020. The investigation considered whether the Health Board exceeded the Referral to Treatment target ("RTT") for cancer waiting times (this sets out the waiting time management rules, including cancer waiting time targets) for treatment of prostate cancer in respect of the other 16 patients with urgent clinical priority awaiting prostatectomies in August 2019. I was satisfied that the own initiative criteria had been met as there was a "substantial connection" with Mr Y's investigation, namely, a possible incidence of service failure linked to the Health Board's urology service in terms of RTT breaches in relation to provision of urology cancer care. I was concerned that there was a possibility that these 16 patients may have waited beyond the 62-day wait for treatment with potential consequences for their prognosis / treatment. Additionally, previous investigations by my office also highlighted concerns about the Health Board's prostate cancer care management.

5. On 3 December 2020 I published a public interest report against the Health Board in relation to the investigation of Mr Y's complaint.[2] The Health Board had breached the RTT in Mr Y's case; it acknowledged that it had done so and apologised for this. Based on the evidence, I found that Mr Y would not realistically have received his treatment until at least 168 days after receipt of the urgent suspected cancer ("USC") referral. [3] The Health Board would therefore, at a minimum, have missed the 62-day target by 106 days. Given that advice from my professional adviser, indicated that early radical treatment was essential in high-risk disease (and Mr Y was deemed high-risk), the wait for treatment was unacceptable and a service failure. As Mr Y had opted to receive private treatment, the actual impact of the delay was mitigated in Mr Y's case and the delay was not as significant as it would have been, had he waited for treatment by the Health Board. However, when Mr Y sought private treatment, he was concerned that the cancer would spread if he waited for NHS treatment. The delay caused Mr Y distress and anxiety, and the decision to seek private treatment, rather than wait for the Health Board to

[2] https://www.ombudsman.wales/wp-content/uploads/2020/12/CASE_201905373_231.pdf
[3] USC referral – a referral where a suspicion of cancer is stated by the GP and confirmed by the specialist.

provide treatment, did not lessen the impact of the Health Board's service failure on him at a very worrying time. I found that Mr Y suffered an injustice as a consequence.

Relevant guidance

My guidance

6. The "Principles of Remedy" outlines my approach to remedying injustice. My aim is to secure suitable and proportionate remedies. I am satisfied that these principles are relevant to my investigations using my own initiative power. A key driver in my approach to remedy is to return a complainant, and where appropriate, others who have suffered injustice and been treated unfairly, to the position they would have been in or, if not possible, to take remedial action. I advocate that people should be treated consistently.

7. The "Principles of Good Administration and Good Records Management" elaborates on the above points, and relevant to this investigation is the principle of acting fairly and proportionately. In seeking to achieve this, public service providers should ensure that people are treated fairly and consistently so that those in similar circumstances are dealt with in a similar way. Additionally, public service providers should seek to address the unfairness if applying the law, regulations or procedures strictly would lead to an unfair result for an individual.

Welsh Government and Health Board guidance

8. The Welsh Government's "Rules for Managing Referral to Treatment Waiting Times" ("the RTT Rules"), which was in place at the time of the events under investigation, set out the waiting time management rules, including cancer waiting time targets. The guiding principles included the values that, "all patients should wait the shortest possible time for treatment"

and that “RTT targets are maximum acceptable waits and urgent patients should be treated as their clinical need dictates”. In relation to cancer target times, there were 2 targets – the 62 day and 31-day targets:

- Newly diagnosed cancer patients that have been referred as USC, and confirmed as urgent by the specialist, to start definitive treatment within 62 days from receipt of referral at the Local Health Board (“LHB”).

- Newly diagnosed cancer patients not included as USC referrals (“NUSC” – non urgent suspected cancer)[4] to start definitive treatment within 31 days of a decision to treat.[5]

In relation to accountability for monitoring, performance and reporting of the RTT target, the RTT Rules stated:

- “When a referral is made to an English provider, the LHB commissioning the pathway is accountable for monitoring of that patient’s pathway. LHBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately”.

- “Where NHS activity is commissioned from an English provider, the accountability for performance against the targets lies with the LHB commissioning the activity”.

- “When a referral is made to an English provider, that provider is responsible for reporting performance against the target. LHBs must ensure that requirements for reporting are contractually included in commissioning agreements”.

- “The LHB with clinical responsibility for the patient…is responsible for reporting performance against the open pathway waiting time target”.

[4] Any patient diagnosed as having cancer who was not referred by their GP as a USC or upgraded by the specialist on analysis of the GP referral.
[5] Decision to treat - the date upon which the decision to treat was confirmed between a designated member of the multi-disciplinary team and the patient.

9. Cancer specific additional guidance to support revised RTT Guidance (issued April 2017) – the guidance provided by the Health Board and which it said it followed at the time of the events being investigated - repeated the 62 and 31-day targets.

10. Welsh Health Circular (2019) 028 ("the WHC") The Consolidated Rules for Managing Cancer Waiting Times (September 2019) was circulated to the Chief Executives of all Welsh health boards in September 2019; this was noted as the final version of the updated rules for managing cancer waiting times ("CWT") which would replace all previous guidance with effect from 1 December 2019. The document provided guidelines relating to the management of CWT and the reporting of performance against the cancer targets.

11. The guiding principles stated that the guidance, "is to ensure that the patients' wait for suspected cancer diagnosis and treatment are measured and reported in a consistent and fair manner. The guiding principles of CWT clearly reflect the prudent health principles. Patients should be managed with the aim of starting treatment at the earliest clinically appropriate time rather than against any performance measures".

12. The WHC, when published, indicated in relation to Welsh patients treated in England that:

- "At a later date, our intention is to report on Welsh patients treated in England. At present (August 2019) this is not possible. Discussions are taking place with NHS Digital to explore how this might be achieved. Until a solution is agreed, patients treated in England will be treated in line with the English cancer standards".

- "When a referral is made to an English NHS provider, the English NHS provider is accountable for the monitoring of that patient's pathway. English NHS providers must ensure that communication protocols are utilised so that appropriate information is shared, and CWTs are measured accurately. The Welsh targets need to be communicated as part of any contracts with other NHS providers (England and Wales). It is the responsibility of the commissioning Welsh health board to ensure they have processes in place to monitor and performance

manage their contracts for cancer provision, ensuring targets are met. It is our intention to capture patients treated in England on the SCP,[6] however systems and process do not allow this at present. Discussions are underway with NHS Digital and this guidance will be updated when the systems to allow this are in place".

- "Where NHS activity is commissioned from an English provider, the accountability for manging the patient wait lies with the health board commissioning the activity. The commissioning health board will need to ensure data is shared with the reporting health board, if different, as the reporting of the patients' pathway remains with the health board who received the original patient referral".

13. In terms of reporting, the WHC stated that:

- "All patients who are not treated within the NUSC and USC targets should have a breach report completed detailing their pathway journey and outlining the lessons learnt and remedial actions taken within the health board".

14. The 'Consolidated Guidelines for Managing Patients on the Suspected Cancer Pathway' (December 2020, Version 2.0) ("the Guidelines for SCP") provides guidelines relating to the management of patients on a suspected cancer pathway and the reporting of performance against the cancer target. The updated guidance introduces new rules around the management of patients on a suspected cancer pathway and includes the reporting of patients treated outside of NHS Wales when referred from secondary care in NHS Wales. In terms of CWT targets, a new single cancer pathway replaces the previous 2 standards - the USC and the NUSC. In relation to patients treated outside Wales, it states:

- "Those patients who are referred from NHS Wales secondary care to have their further investigation, and/or first definitive treatment undertaken outside of NHS Wales must be included in cancer waiting times reporting but those referred directly from primary care will not".

[6] Single Suspected Cancer Pathway – measures CWTs from the point of suspicion of cancer until start of first definitive treatment for all newly diagnosed patients.

- "When a referral is made to an English NHS provider, the English NHS provider is accountable for the monitoring of that patient's pathway. English NHS providers must ensure that communication protocols are utilised so that appropriate information is shared, and CWTs are measured accurately. The Welsh targets need to be communicated as part of any contracts with other NHS providers. It is the responsibility of the commissioning Welsh health board to ensure they have processes in place to monitor and performance manage their contracts for cancer provision, ensuring targets are met. All patients referred for treatment outside NHS Wales from secondary care will be included in CWT reporting".

- "Where NHS activity is commissioned from outside NHS Wales, the accountability for managing the patient's wait lies with the health board commissioning the activity. The commissioning health board will need to ensure data is shared with the reporting health board, if different, as the reporting of the patient's pathway remains with the health board who received the original patient referral".

15. In relation to patients not treated within target, it states:

- "All patients who are not treated within the target should have an internal breach report completed detailing their pathway journey and outlining the lessons learnt and remedial actions taken within the health board. All patients who have waited too long from POS[7] for their treatment and are suspected of coming to harm should have a clinical review undertaken and submitted to Welsh Government".

16. The Health Board's "Cancer 104 Day Harm Review Group" Terms of Reference (April 2020 – "the Harm Review Group") aim to review the care of cancer patients with a waiting time of over 104 days to identify any avoidable clinical and non-clinical factors. The Harm Review Group will consider whether harm has been caused by the wait, and the process will be used for patients presenting to and treated by the Health Board. If a

[7] Point of suspicion – the waiting time for patients on the suspected cancer pathway starts at the point which cancer is suspected (i.e. the point of suspicion).

patient's pathway starts and remains outside of the Health Board, the Health Board's commissioning team "will request harm reviews be completed by treating organisations".

The Health Board's evidence

17. I obtained comments and copies of relevant documents from the Health Board. In summary, the Health Board confirmed:

- That it was working to the Welsh Government Policy in terms of the 62/31-day cancer target times.

- In line with Welsh Government policy at the time of the events under investigation, only patients treated in Wales were reported against Welsh cancer waiting time targets which is why breach reports and harm reviews were only completed for patients treated by the Health Board. The Welsh Government changed this position with effect from January 2021 to include patients treated in England. This was following requests to include reporting of these patients treated in England from the Health Board and others (the Health Board referred to the relevant sections in the WHC and the Guidelines for SCP outlining these guideline changes – see paragraphs 10 - 15).

- Of the 17 patients (including Mr Y), there were 2 NUSC breaches reported, harm reviews were completed for both patients and no harm was identified; 2 USC breaches were reported, harm reviews were completed for both patients and no harm was identified; 8 patients were treated in England (a mixture of USC/NUSC patients); 2 NUSC where there were no breaches; 2 USC patients where there were no breaches and 1 patient who was not reportable against the Welsh cancer waiting times target.

- That harm reviews are completed for all cancer patients treated by the Health Board over day 104 on their cancer pathway (see paragraph 16) and that this was not mandated by Welsh Government in 2019 but completed by the Health Board as good practice.

- It would only complete harm reviews for patients treated by the Health Board. It will review this decision in line with the Guidelines for SCP and when it reviews the harm review process at the next harm review panel.

- The 4 harm reviews completed identified action points for learning including placing prostatectomy capacity on the Health Board risk register (added 24 July 2018 - current risk is scored as high) and to review how patients are counselled over treatment options for prostate cancer (an agreement was made to develop a protocol at the urology clinical advisory group in October 2020).

- A risk register entry (updated on 16 September 2020) identified risk relating to urology surgical capacity impacting on the ability to deliver RTT targets for urology. To address this risk, the Health Board identified the need to move forward with service remodelling and that there were short term contracts in place with 2 English Trusts to support with the delivery of prostate surgery and other urological cancers.

- It wrote to the Welsh Government Health and Social Services Group in September 2020 in response to the WHC, and amongst other things, noted that there was no mention in the document of reporting waiting times for patients treated in England. It said that it did not, at that time, report waits for those patients which it said "appears to be an anomaly".

- It had contracts with 2 English Hospital Trusts ("the First Trust" and the "Second Trust" respectively): with the exception of the contract with the Second Trust for 2018/2019, they were unsigned. The contracts were implied by performance given the contracts were issued to both providers. The contracts' operational standards in terms of cancer waiting times indicated that any breach of the 62-day USC wait target would lead to formal escalation of performance reporting to the Health Board; a breach of the 31-day target NUSC resulted in a financial penalty.

- The arrangement for the First Trust to treat prostatectomy patients is an ongoing historical one. A contract with another English Hospital Trust ("the Third Trust") started in February 2020 for prostatectomies.

- It holds regular weekly access meetings to discuss the performance of English providers in relation to RTT Rules.

18. A urology service update report in September 2020 identified recruitment and contractual capacity concerns.

Welsh Government comments

19. I obtained comments from the Welsh Government relating to cancer treatment time targets. In summary:

- It clarified that, since the introduction of RTT Rules, Welsh policy has been to report on the performance of Welsh health boards as providers only; it does not formally report, or performance manage their commissioning arrangements.

- It said there was a very clear expectation that the Health Board through its own commissioning policy ensures that patients are treated in a timely manner in line with Welsh standards; the performance with English providers is discussed at the regular quality and delivery meetings between each health board and the Welsh Government and any issues or concerns are raised in that forum. Health boards report to their board on the effectiveness of their commissioning strategies and performance of Welsh patients treated in England.

- It would expect, as a minimum, that the Health Board had a policy regarding delayed treatment with their providers to mirror Welsh standards that included formal reviews, breach reports, harm reviews and serious incidents on all patients who breach cancer waiting times.

- From January 2021 all patients will be managed on the new single cancer pathway and the other cancer pathways will no longer be managed and reported on. In introducing the pathway, it has decided

that all patients referred from secondary care for treatment outside Wales for their cancer treatment must be included in cancer waiting times.

- Guidelines (i.e. before the single cancer pathway) required all health boards to produce a breach report for any patient who did not start treatment within 62 or 31 days, depending on the pathway they were on, but it did not appear that breach reports were always used in a systemic manner to drive improvements and highlight service issues. It is currently reviewing whether health boards need to formally submit breach reports to the Welsh Government in future, but its expectation is clear that these need to continue within each health board and be used for service improvement and peer review.

- In response to the Health Board stating that only patients treated in Wales are reported against Welsh cancer waiting times targets, which is why breach reports and harm reviews have only been completed for patients treated by the Health Board (which it said was in line with Welsh Government policy), it said that it expected this to be embedded in health boards' commissioning contracts and that the health boards would have requested this from their English providers who currently operate a harm review process.

Analysis and conclusions

20. I commenced this investigation on my own initiative to consider whether the Health Board had exceeded the RTT target for cancer waiting times for treatment of prostate cancer in respect of 16 patients who, in August 2019, were awaiting prostatectomies. The Health Board told me during my investigation into Mr Y's complaint that all 16 patients had an urgent clinical priority. My own initiative power allowed me, in this case, to extend my investigation of Mr Y's complaint to consider whether there were systemic issues within the Health Board's urology service in terms of delivery of prostate cancer treatment (particularly prostatectomies) within Welsh cancer targets.

21. In August 2019 only patients treated in Wales were reported against Welsh cancer waiting time targets, the Health Board only produced breach reports and harm reviews for patients treated by the Health Board; this did not apply to patients referred by it for treatment in England. My guidance is clear, good administration requires that public service providers need to ensure that people are treated fairly and consistently so that those in similar circumstances are dealt with in a similar way.

22. Of the 16 patients, 8 were referred to England for treatment. If these 8 patients had been treated in Wales, all 8 would have been reported because they breached the 62 and 31-day target for RTT. Additionally, each of these 8 patients would have received a harm review to determine if the breach in waiting time had any clinical impact on their treatment or prognosis; harm reviews were completed for the 4 patients who were treated by the Health Board who breached the RTT target.

23. Whilst I accept that the Welsh policy position at the time meant there was no requirement to produce breach reports to the Welsh Government or to carry out harm reviews for Health Board patients being treated in England, in terms of fairness and consistency of patient treatment, the geographical location of treatment should not have left these 8 patients in the position where they were denied the harm review process because they were treated outside Wales. Regardless of the Welsh policy position at the time, the Health Board was obliged to undertake appropriate monitoring of the care and treatment of its patients under its commissioning and contracting arrangements. It should also have considered the impact of the delay in treatment. These failures amounted to maladministration which caused injustice to those 8 patients who were treated differently to the patients who were treated by the Health Board. My guidance is clear that if applying procedures strictly would lead to an unfair result for an individual, then a public service provider should seek to address this unfairness.

24. The rules in place in August 2019 stipulated that when a referral was made to an English provider, the Health Board commissioning the pathway was accountable for monitoring the patient's pathway and that accountability for performance against the targets lay with the commissioning Health Board. The Health Board had responsibility for

monitoring compliance of its commissioning arrangements and the contracts I have seen indicated that the Health Board had escalation processes in place for breaches of the 62 and 31-day target. The information I received confirms general high-level oversight of commissioned services was undertaken, with concerns being expressed about the need for extra provision of urology services. However, I have seen no evidence that the Health Board proactively monitored these contracts specifically in line with its contractual operational standards or had regard to the impact of delayed services on the individual patients.

25. The Guidelines for SCP has now addressed the inconsistency of the previous approach; all patients referred from secondary care for treatment outside Wales for their cancer treatment must be included in cancer waiting times (with the exception of those referred directly from primary care) and all patients not treated within the target should have an internal breach report completed, including identifying any lessons learnt and remedial action to be taken. In addition, all patients who have waited too long from POS for their treatment and are suspected of coming to harm, should have a clinical review. Whilst I welcome this change which now addresses the anomaly of the previous approach, the inequity of not carrying out harm reviews for the patients treated in England meant there was a loss of opportunity to ensure harm to individuals did not go unremedied, for potential learning and for improvement. Harm reviews provide health boards with the opportunity to identify service issues and to contribute towards service delivery improvements. In line with my approach to remedy, the Health Board should return these patients to the position they would have been had they been treated in Wales in terms of carrying out a harm review.

26. I have reported on the Health Board's urology services several times, and I am concerned that, even in September 2020, it identified recruitment and contractual capacity concerns. This is not a new issue. Healthcare Inspectorate Wales ("HIW") carried out a Urological Cancer Peer Review of the Health Board in February 2014. Whilst good practice was identified, several serious concerns were highlighted, including:

- A lack of clinically or management led consensus for the delivery model of urological cancer services in North Wales.

- The Multi-Disciplinary Teams ("MDT") stated that patients had been lost or delayed to follow-up and have deteriorated while waiting for their appointment.

- A lack of succession planning for the service "compounded by the lack of strategic direction from management on the delivery of urological services for the population of [the Health Board]".

- The Peer Review team were very concerned that they had not been reassured that high quality and safe urological cancer services would be provided in the future.

- Outpatient and Inpatient capacity.

- Lack of key worker support in general across the Health Board.

27. Additionally, the HIW report stated that "All MDTs stated that it is common practice for patients, who are due to breach, to be invited to have their surgery in centres in England, however the Health Board has had difficulty in finding nearby centres with the capacity to undertake this work. The Review team were informed that this practice was not clearly communicated to medical and specialist nursing staff and has led to some anxiety and confusion". This is concerning, and whilst I am unable to reach a finding that the 8 patients treated in England were referred outside the Health Board in order to avoid breaching the cancer waiting times target, the fact it was recognised that this was its approach in 2014, does raise the question whether this was still happening 5 years later.

28. I am also concerned that capacity issues continue to be a problem and the impact of this on patient care. I am currently investigating another complaint against the Health Board's Urology service. The fact that locum consultants were engaged to support the only 2 employed consultants at that time appears to have led to inconsistent follow up of patients. I will be reporting on this case separately, but it appears that capacity and succession planning for the Urology department is still an issue.

Recommendations

29. I **recommend** that the Health Board, within **3 months** of the date of this report:

a) Carries out harm reviews for the 8 patients treated in England. If the reviews identify that harm was caused, the Health Board should write to the patient explaining this and consider the individual cases under the Putting Things Right Process.

b) Asks the Harm Review Group to review the Guidelines for SCP and review the harm review process to ensure that the terms of reference are updated and in line with the requirements of the Guidelines for SCP.

c) Refers the report to the Board to consider capacity and succession planning in the urology department.

30. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Nick Bennett 26 August 2021
Ombwdsmon/Ombudsman

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