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PUBLIC SERVICES OMBUDSMAN FOR WALES

# The investigation of a complaint against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202102604

| Contents | Page |
|---|---|

## Introduction

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

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. The report therefore refers to the complainant as Mr A.

## Summary

Mr A complained about his care and management following his referral to an NHS Hospital Trust in England ("the Trust") which was commissioned by Betsi Cadwaladr University Health Board ("the Health Board") to provide care/treatment. (The Health Board having commissioned the care from the Trust, remained responsible for the monitoring and oversight of the care which the Trust provided). Mr A complained that a Consultant Neurologist ("the First Neurologist") based at the Trust failed to diagnose his multiple sclerosis ("MS" - a condition which affects the brain and the spinal cord) between 18 May 2018 and 19 September 2019. Mr A also said that the Health Board should have explored a local referral option before sending him to the Trust. Finally, Mr A complained that the complaint responses received from both the Trust and the Health Board were not robust and were inaccurate.

The Ombudsman found that the investigation into and the time taken to diagnose Mr A's condition fell below the appropriate standard of care. The investigations following the first consultation were inadequate, despite the First Neurologist noting that Mr A's presentation in May 2018 was strongly indicative of underlying physical disease. Mr A had clear and ongoing physical signs which strongly suggested a neurological disorder from the first time he was seen in May 2018. The First Neurologist did not question or seek an explanation of Mr A's ongoing abnormal physical symptoms but attributed them firstly to an unrelated back problem and later to a psychiatric or psychological disorder. The First Neurologist also failed to discuss, recognise, and later review the significance of the ongoing abnormal physical signs that Mr A demonstrated on examination.

The Ombudsman was satisfied that an earlier diagnosis would not have materially altered the outcome of Mr A's disease, but she was concerned the delay in diagnosis and the attribution of his symptoms to psychological or psychiatric factors caused Mr A unnecessary anxiety and uncertainty. This was a significant injustice to him and therefore this aspect of Mr A's complaint was upheld.

The Ombudsman was satisfied with the Health Board's explanation that although there are clinics available locally, the waiting list for a clinic appointment is often longer than at the Trust which is why patients are often referred to the Trust. This aspect of Mr A's complaint was not upheld.

In relation to complaint handling the Ombudsman was troubled that the Trust, on behalf of the Health Board, did not identify the failings in care provided to Mr A by the First Neurologist when considering Mr A's complaint. The Health Board also failed to seek an independent clinical opinion to address Mr A's concerns. The Ombudsman was concerned that the Health Board, both at a commissioning level and in its own right, had failed to ensure that the Trust fully acknowledged and recognised the extent of failings evident in this case together with the impact on Mr A. The Ombudsman concluded that the lack of an open and timely response to Mr A's complaint was not only maladministration but further added to the injustice caused to Mr A. It also meant that an important part of the Health Board's monitoring role, which requires it to have rigorous oversight and scrutiny of the commissioned body, was lost. Inevitably, this would have added to the stress and anxiety Mr A experienced, and this aspect of his complaint was upheld.

Mr A was awarded PIP (a benefit to help with extra living costs for people with a long-term health condition) following his diagnosis. The Ombudsman concluded, on balance, that he would have been awarded this had his condition been diagnosed earlier. She therefore calculated the payment Mr A would have received, together with interest at the rate of a County Court Judgment (8%)

The Ombudsman **recommend** that within **1 month** from the date of the this report the Health Board should:

a) provide an apology to Mr A for the failings identified in this report which extended to poor complaint handling

b) in recognition of the financial loss caused to Mr A as a result of the failings pay him the sum of £4,835.38

c) in recognition of the distress and inconvenience caused to Mr A as a result of the delayed diagnosis and having to pursue the matter rigorously himself, at a time when he was unwell, make a payment to him of £1,500

d) in recognition of the distress and inconvenience caused by the failures in complaint handling, make a payment to Mr A of £500

e) write to the Trust as part of its commissioning arrangements, to bring to its attention the concerns highlighted by the Adviser about the need to monitor the First Neurologist's working practices, including reminding him of the need to adhere to the General Medical Council Guidelines as part of his professional obligations

f) as part of its commissioning arrangements, ask the Trust to ensure that its Neurological Team discuss this case at an appropriate forum as part of reflective and wider learning

g) review its response to this complaint to establish what lessons can be learnt, particularly in relation to when it would be appropriate to seek independent clinical advice on a complaint, as set out in the PTR guidance

h) share this report with the Chair of the Health Board and its Patient Safety and Clinical Governance Group.

## The Complaint

1. Mr A complained about his care and management following his referral to an NHS Trust in England ("the Trust") which was commissioned by Betsi Cadwaladr University Health Board ("the Health Board") to provide care/treatment. Mr A's concerns related to the following:

a) that a Consultant Neurologist ("the First Neurologist") based at the Trust failed to diagnose his multiple sclerosis ("MS" - a condition which affects the brain and the spinal cord) between 18 May **2018** and 19 September **2019**

b) that the Health Board should have explored a local referral option before sending him to the Trust

c) that the complaint responses received from both the Trust and the Health Board were not robust and were inaccurate.

## Investigation

2. My investigator obtained comments and copies of relevant documents from the Health Board and the Trust and considered those in conjunction with the evidence provided by Mr A. Clinical advice was obtained from Dr R A Grunewald, a Consultant Neurologist ("the Adviser"). The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. It is my role to determine whether the standard of care was appropriate by referring to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. The Health Board has commissioning arrangements in place with the Trust. As a Welsh patient receiving treatment commissioned by a Health Board in Wales, the treatment falls within my jurisdiction as set out by schedule 3 of the Public Services Ombudsman (Wales) Act 2019.

4. Mr A, the Trust and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

## Relevant legislation, regulation and guidance

5. The General Medical Council's ("GMC") Good Medical Practice guideline 2013 ("the GMC Guidance") states that a doctor must "Listen to patients, take account of their views, and respond honestly to their questions".

6. The Welsh Health Specialised Services Committee ("WHSSC") holds the contract with the Trust, which covers all of the services provided by the Trust to patients in North Wales. There is a single contract in place through WHSCC which covers both the specialist services commissioned by WHSSC and the non-specialist services commissioned by the Health Board, which includes medical neurology services. As the funding body, WHSSC also holds the Service Level Agreement ("SLA") on behalf of the Health Board for the commissioning of neurology services from the Trust. WHSSC and the Health Board collaborate on the running of the contract. The Health Board has day-to-day management responsibility with the Trust which sets the practical operational arrangements for the monitoring of the quality of the commissioned services provided and the handling of complaints (see paragraphs 29-31).

7. The SLA sets out that all concerns will be managed in line with the Welsh Government's National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations") and accompanying Putting Things Right guidance ("the PTR Guidance").

8. The Regulations set out specific actions that health bodies should complete when considering complaints, together with timescales for completion. Public bodies are expected to have regard to any guidance, and in the event that it is not followed, document the rationale for not doing so.

9. Section 10 of the PTR Guidance sets out Cross Border Arrangements for considering redress - in general, it states that concerns about care and treatment provided on behalf of the NHS in Wales by organisations outside Wales should be dealt with in accordance with the relevant concerns procedure which applies to that organisation.

10. The PTR Guidance says that there may be occasions when it is necessary to secure an independent opinion on a matter relating to a concern, with a view to resolving it. This may include, for example, obtaining a second opinion to aid a patient's understanding of the care they have received.

11. My predecessor issued guidance "Principles of Good Administration and Good Records Management" (2016 - an updated version was issued in 2022) ("the Guidance") to which bodies within my jurisdiction are also expected to have regard, in order to deliver good administration and customer service. The Guidance sets out the good administration principles that public sector providers are expected to adopt when it comes to service delivery and dealing with service users. These principles include, for example, the need to be open and accountable.

12. My predecessor issued a thematic report "Ending Groundhog Day - Lessons from Poor Complaint Handling 2017". Which was focussed on driving improvement in public services using learning derived from complaints.

13. The Social Security Regulations 2013 (Statutory Instrument 377) set out the main rules for Personal Independence Payments ("PIP"). PIP is a non-means-tested benefit to help with extra living costs for people with a long-term physical or mental health condition or disability, and/or difficulty doing certain everyday tasks or getting around because of their condition. PIP is paid every 4 weeks. PIP has 2 parts: a daily living component and a mobility component. A person might be able to claim one or both components. Each component can be paid at either:

- Standard rate – where the person's ability to carry out daily living/mobility activities is limited by their physical or mental condition.

- Enhanced rate – where the person's ability to carry out daily living/mobility activities is severely limited by their physical or mental condition.

## The background events

14. Mr A was referred by his GP to the Neurology services at Ysbyty Gwynedd on 12 February 2018 and was seen by the First Neurologist at the Trust on 19 May. The First Neurologist's clinic letter noted that Mr A had a 2-year history of erectile dysfunction followed by urinary hesitancy and urgency. More recently, he had experienced mobility problems, felt tired and had jerks and spasms in his left leg. An examination carried out by the First Neurologist revealed unsteadiness, positive Romberg's sign (a tendency to fall when standing with eyes closed), brisk deep tendon reflexes (during a reflex test, a doctor tests deep tendon reflexes with a reflex hammer to measure response - quicker responses may lead to a diagnosis of brisk reflexes) and extensor plantars (reflex characterised by upward movement of the great toe and an outward movement of the rest of the toes, when the sole of the foot is stroked). It was noted that Mr A also had pain in his left leg. The First Neurologist arranged for Mr A to undergo a magnetic resonance imaging scan (("MRI") a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body) of his thoracolumbar spine (parts of the spine supporting the chest and lower back and the nerves supplying these areas).

15. At the First Neurologist's follow-up outpatient clinic on 20 July, he advised Mr A that the MRI scan showed a left-sided disc bulge (protrusion) touching the left spinal (S1) nerve root and that he would be referring Mr A to a neurosurgeon.

16. On 23 July Mr A's GP wrote to the First Neurologist highlighting that Mr A was extremely concerned because he felt the MRI scan only explained the sciatica in his left leg, which had occurred in the period between his initial consultation and the MRI scan, and not his other symptoms. The GP noted that Mr A had been referred to a neurosurgeon and that Mr A had said that the First Neurologist had discharged him from his care. The GP said

that Mr A was worried about his ongoing presenting problems (see paragraph 14) and wondered whether he needed a brain scan which the First Neurologist had said he would arrange if there was nothing abnormal on the MRI scan. The GP requested the First Neurologist review Mr A's case record and answer his concerns.

17. On 25 July Mr A emailed the First Neurologist asking that the original plan of him having a brain scan be carried out. A few days later Mr A sent a further email to the First Neurologist repeating his request for a brain scan and noting that his symptoms were those of somebody with MS, including muscle spasms, balance issues, bladder and bowel issues, fatigue, and walking difficulties.

18. On 1 August the First Neurologist wrote to Mr A's GP advising that he had arranged an MRI head scan which he said appeared normal. He noted that he had made a referral to the Neurosurgeons for an opinion.

19. On 6 August Mr A sent a further email to the First Neurologist asking how he might obtain a second opinion.

20. On 21 September Mr A was reviewed at the Trust's spinal physiotherapy clinic by an extended scope practitioner (a specialist physiotherapist) who wrote to the First Neurologist noting Mr A's complaints of poor balance, lack of co-ordination, and inability to run. Following this, the First Neurologist again reviewed Mr A on 7 January **2019**. During this consultation the First Neurologist noted that Mr A had "severe anxiety and depression" as well as symptoms suggestive of restless legs or periodic movements of sleep. He reassured Mr A that he did not have a neurological illness, and that his symptoms were psychological or psychiatric in nature. The First Neurologist asked the GP to make an urgent referral to a general psychiatrist.

21. On 4 February Mr A wrote to the First Neurologist setting out his ongoing debilitating condition and noting that the 3 MRI scans in 2018 had not revealed any evidence of degenerative neurological conditions, which could be causing his symptoms. He urged the First Neurologist and his

team to re-read the scans and re-examine him or refer him to another NHS Hospital to look more deeply into the possible physical root causes of his symptoms. In his email Mr A said:

> "Whilst the ongoing nature of my symptoms has understandably affected my outlook, and I very much do want to have the psychological evaluation, I want to state that I am of sound mind, and I am certain that the cause of this constellation of very persistent symptoms is physical, and not psychological. It has been eight months since I first was seen at the [name of hospital], and whilst I am happy to have the psych evaluation done, I don't want this to end without the exploration of possible physical root causes".

22. Following an exchange of correspondence between the First Neurologist and Mr A's GP, Mr A was referred by his GP to another Consultant Neurologist ("the Second Neurologist") at the Trust, who saw him on 19 September. Mr A was diagnosed with MS on 14 November, 16 months after his initial referral.

23. On 3 April **2020** Mr A complained to the Trust about what he said was the First Neurologist's dismissive approach to his symptoms and his failure to undertake the necessary tests to rule out MS. Mr A said that had he been diagnosed sooner he could have been receiving the appropriate treatment. The Trust provided a response on 14 May, which concluded that the care and treatment provided to Mr A had been appropriate and acceptable given the timeliness of investigations carried out, the referrals made, and the plan for further review and investigations before Mr A sought a second opinion. Mr A remained unhappy with the response. His complaint was then considered by the Health Board and Mr A received a response on 28 May **2021**.

24. The Health Board, following a review of the investigation into Mr A's care provided by the Trust, said that its Clinical Director was assured that the investigation by the Trust had been conducted fully. The Health Board said that it did not employ its own neurologists who would be able to comment on the investigation from a neurological perspective. The

Health Board said that both the neurologists involved in Mr A's care provide services for its patients and were unable to investigate the case from an independent perspective, as Mr A had requested.

## Mr A's evidence

25. Mr A said that he was not satisfied with the responses from the Trust or the Health Board as both failed to acknowledge that the First Neurologist did anything wrong. Mr A said the response from the Trust stated that when he saw the First Neurologist in January 2019 there was "no evidence" to suggest that he had MS. Mr A said that the First Neurologist stopped investigating before he could rule out MS and therefore his diagnosis was completely missed.

26. Mr A said that the Trust and the Health Board's responses stated that he "sought a second opinion" from the Second Neurologist; Mr A said that this was an inaccurate representation of how things happened (see paragraph 22).

27. Mr A said that once he asked for a different doctor, he was able to see the Second Neurologist locally. He questioned why he was not referred to the Second Neurologist in the first place. He added that this would have saved him much time, distress, and the expense of travelling back and forth to England for appointments.

28. Mr A said that he had lost a whole year of his life waiting for the diagnosis and it had been extremely distressing to be told that there was nothing wrong when he could see from his own experience that there was clearly something seriously wrong. Mr A said that this delay meant he was unable to seek further help both in managing his MS and obtaining financial help. Mr A said that he lost out on claiming the PIP (standard rate for daily living and mobility) which he had been receiving since his diagnosis.

## The Health Board's evidence

29. The Health Board noted that to enable WHSSC to have oversight of the contract, the Trust is required to share all contract monitoring information with WHSSC. The Health Board set out the day-to-day processes that it has

in place with the Trust for monitoring the quality of the commissioned neurology services provided by the Trust. This includes quarterly SLA meetings with representatives from WHSCC, the Health Board and the Trust. The Health Board noted that these were supplemented with regular SLA meetings between itself and the Trust with the focus being on operational matters/issues relating to service delivery and patient experience.

30. The Health Board said that the Trust deals with all patient complaints relating to the commissioned neurology services. It said that such complaints are recorded and investigated in line with the Trust's Complaints Policy and Procedure.

31. The Health Board said any complaints that the Trust's Patient Experience Team are concerned about are escalated to its Chief Nurse and brought to the Health Board's attention. The Health Board said that as per the contract, the Trust would go through its own claims and legal process. Its processes around safety and quality are overseen by the NHS England Improvement Team.

32. The Health Board said that its referrals are triaged by the Trust, and patients are offered an appointment at the most appropriate clinic following this clinical triage. Although there are clinics available locally, the waiting list is often longer than those for a clinic at the Trust. Therefore, patients are often offered appointments at the Trust as they are available sooner than those locally.

33. The Trust provided nothing further in its response to that which it had provided to Mr A.

## Professional Advice

34. The Adviser said that the First Neurologist's initial examination documented Mr A's unsteadiness, brisk reflexes and extensor plantar responses. He said that these were "hard" neurological signs - i.e., those which are strongly indicative of underlying physical disease. These signs were not explained by the nerve root compression noted on the MRI scan of Mr A's thoracic lumbar spine, and an alternative explanation should have

been sought. Given the presence of these neurological signs, most consultant neurologists would have ordered an MRI of the whole neuraxis (head and the total spine) at the initial consultation. The Adviser said that limiting neuroimaging to the thoracic and lumbar spine is considered poor practice. He added that whilst an MRI of Mr A's head was later undertaken and reported as normal, there was no evidence that Mr A was then appropriately re-examined by the First Neurologist to confirm or refute the presence of the hard neurological signs.

35. The Adviser concluded that the First Neurologist's management of Mr A was sub-optimal at the first consultation, that inadequate neuroimaging was initially requested, that no explanation for Mr A's abnormal physical examination was found, and that attribution of his symptoms to a psychiatric or psychological disorder was "inappropriate and rash".

36. The Adviser commented that whilst there are no relevant local or regional guidelines covering this presentation, nevertheless he was of the view that the First Neurologist appeared not to have met the requirements of the GMC Guidance to provide a good standard of practice, to assess Mr A's condition adequately and take into account his history, views and values, and where necessary examine him. He said that this implied that the First Neurologist's working practices should be scrutinised closely.

37. The Adviser noted that Mr A's presentation of demyelinating disease (when the protective coating that surround parts of the brain and the spinal cord, is damaged) was unusual and appeared to be consistent with a diagnosis of primary progressive MS. The Adviser said that unfortunately, as there is not yet any treatment for MS which has been shown to change the prognosis of the disorder, it was unlikely that more prompt diagnosis would have materially altered the outcome of Mr A's disease. He added, however, that the delayed diagnosis and attribution of his symptoms to psychological or psychiatric factors did cause Mr A unnecessary anxiety and uncertainty.

38. The Adviser said that there were inconsistencies between the Trust's response to Mr A's complaint and the entries in the clinical records. The Adviser commented that the Trust's complaint response suggested that the First Neurologist intended to undertake further investigations "if a patient

was to progressively present with more neurological signs" but did not get the opportunity so to do. However, the Adviser said that the clinical documentation implied instead that the First Neurologist recommended a second opinion at another health care setting in February 2019, despite Mr A writing to him pointing out his symptoms were worsening and despite the presence of physical signs on examination. The Adviser said that this was inaccurate and unreasonable.

39. The Adviser said that the Trust's response also stated that "When [the Second Neurologist"] saw Mr A, he had further abnormal neurological signs on examination. Hence after the initial scan, he undertook a lumbar puncture to look for evidence of the very rare form of MS that is not associated with scan abnormalities". The Adviser said that the clinical documentation indicated that abnormal physical signs were already present when the First Neurologist examined by Mr A in May 2018. The suggestion that further investigations were undertaken because Mr A's clinical examination had changed was therefore not reasonable.

40. In conclusion, the Adviser said that Mr A experienced delayed diagnosis of his demyelinating disease. Whilst the Adviser was of the opinion that this did not cause an adverse clinical outcome, it did result in a great deal of anxiety, frustration and uncertainty. The delayed diagnosis was partly attributable to failures on the part of the First Neurologist in investigation, interpretation and re-examination of Mr A.

## Analysis and conclusions

41. I have been assisted by the advice and explanations of the Adviser, which I accept in full. The conclusions reached, however, are my own. I will address each of Mr A's concerns in turn.

### That there was a failure to diagnose Mr A's MS between May 2018 and September 2019

42. My investigation has concluded that the investigations into, and the time taken to diagnose, Mr A's condition during this period fell below the appropriate standard of care. As the Adviser has highlighted, the investigations following the first consultation were inadequate, despite the

First Neurologist noting that Mr A's presentation in May 2018 was strongly indicative of underlying physical disease. I accept that Mr A's MS presented in an unusual way, in that there were no obvious indications on the scans carried out, as there usually would be for a patient with MS. It was not until a lumbar puncture was arranged by the Second Neurologist that a definitive diagnosis was made. However, as the Adviser has explained, Mr A had clear and ongoing physical signs which strongly suggested a neurological disorder from the first time he was seen in May 2018. It is concerning that the First Neurologist did not question or seek an explanation of Mr A's ongoing abnormal physical symptoms but attributed them firstly to an unrelated back problem and later to a psychiatric or psychological disorder instead. This was also despite Mr A contacting the First Neurologist on a number of occasions to set out the ongoing physical symptoms he was experiencing and the impact they were having on him.

43. For these reasons, I am concerned that the First Neurologist failed to provide an appropriate standard of care to Mr A, as required by the GMC Guidance. As set out above, he failed to discuss, recognise, and later review the significance of the ongoing abnormal physical signs demonstrated on examination and which Mr A was continuing to report.

44. Whilst I am satisfied that an earlier diagnosis would not have materially altered the outcome of Mr A's disease, I consider the delay in diagnosis and attribution of his symptoms to psychological or psychiatric factors caused Mr A unnecessary anxiety and uncertainty. Moreover, Mr A lost out financially as a result. I note that Mr A is now in receipt of PIP on account of his disability, (see paragraph 48). This was a significant injustice to him. I have therefore **upheld** this aspect of Mr A's complaint.

**The Health Board should have explored a local referral**

45. In relation to Mr A's concerns that the Health Board should have explored the option of a local referral before sending him to the Trust, I am satisfied with the Health Board's explanation (see paragraph 32) for this and that had he been seen locally, it might have delayed his initial consultation. I have therefore not upheld this aspect of Mr A's complaint.

**The handling of Mr A's complaint**

46. I am troubled that the Trust, on behalf of the Health Board, did not identify the failings in care provided to Mr A by the First Neurologist when considering his complaint. It is also disappointing that the actual clinical events were not always recounted as accurately in the Trust's complaint response as they should have been, based on the evidence. Further, the Health Board's investigation of Mr A's complaint appears only to have rubber stamped the investigation carried out by the Trust, despite the PTR Guidance providing a mechanism for seeking an independent clinical opinion to address Mr A's concerns. Had the Health Board properly considered the complaint response it should have identified the clear inaccuracies in the Trust's response as identified by my Adviser.

47. The Health Board, both at a commissioning level and in its own right, has failed to ensure that the Trust fully acknowledged and recognised the extent of failings evident in this case and the impact on Mr A. The lack of an open and timely response to Mr A's complaint was not only maladministration but further added to the injustice caused to Mr A. In this instance the Health Board not engaging with the PTR process or obtaining an independent clinical opinion on the complaint meant that an important part of its monitoring role, which requires it to have rigorous oversight and scrutiny of the commissioned body, was lost. As a result, there was a missed opportunity to properly learn lessons, and equally important, to put things right quickly and effectively, which is not in keeping with my office's guidance or the lessons from my predecessor's thematic report on complaints handling. This will inevitably have added to the further stress and anxiety Mr A was experiencing. I have therefore upheld this aspect of Mr A's complaint.

48. In considering the financial redress in this case, my initial starting point has been to put Mr A back in the position he would have been in, had he been diagnosed following his initial consultation with the First Neurologist on 19 May 2018. In doing so, I have taken into account the fact that Mr A's condition was not dissimilar during this period to what it was when he was awarded PIP, and on balance therefore, I consider it is more likely than not that he would have been awarded this earlier, had he been diagnosed sooner. In calculating the retrospective redress, I am of the view that it is

reasonable to assume that it would have taken 2 months to reach a diagnosis. I am also mindful that Mr A should not be disadvantaged by the delay, and therefore, I have applied the interest rate which the County Court awards on its judgements of 8%. Therefore, the PIP payment to which Mr A would have been entitled would have been £4,477.20 (made up of £319.80 per month at the rate applicable in 2018) (made up of both daily living allowance and mobility at the standard rate) for 14 months plus interest of £358.18, which makes a total figure of £4,835.38. I am also mindful that the mental anguish the uncertainty caused to Mr A about his physical symptoms, and having to fight to get a diagnosis, has caused him significant distress. I have therefore arrived at a distress figure of £1,500 to reflect the additional impact this has had on him.

## Recommendations

49. I **recommend** that within **1 month** of the date of the final version of this report the Health Board should:

a) provide an apology to Mr A for the failings identified in this report which extended to poor complaint handling

b) in recognition of the financial loss caused to Mr A as a result of the failings pay him the sum of £4,835.38

c) in recognition of the distress and inconvenience caused to Mr A as a result of the delayed diagnosis and having to pursue the matter rigorously himself to get a diagnosis, at a time when he was unwell, make a payment to him of £1,500

d) in recognition of the distress and inconvenience caused by the failures in complaint handling, make a payment to Mr A of £500

e) write to the Trust as part of its commissioning arrangements, to bring to its attention the concerns highlighted by the Adviser about the need to monitor the First Neurologist's working practices, including reminding him of the need to adhere to the GMC Guidelines as part of his professional obligations

f) as part of its commissioning arrangements, ask the Trust to ensure that its Neurological Team discusses this case at an appropriate forum as part of reflective and wider learning

g) review its response to this complaint to establish what lessons can be learnt, particularly in relation to when it would be appropriate to seek independent clinical advice on a complaint, as set out in the PTR guidance

h) share this report with the Chair of the Health Board and its Patient Safety and Clinical Governance Group.

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

**Michelle Morris** 21 September 2022
Ombwdsmon Gwasanaethau Cyhoeddus/Public Services Ombudsman

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