

The investigation of a complaint by
Mr D against
Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201503554

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Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

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 D.

Summary

Mr D complained about the care and treatment he received from Betsi Cadwaladr University Health Board following his referral to its Urology Service. Mr D, who was subsequently diagnosed with an aggressive form of prostate cancer, complained that there were excessive delays in:

- Conducting diagnostic investigations
- Scheduling appropriate surgery following his diagnosis
- Arranging post-surgical radiotherapy.

Mr D also complained about numerous communication failings and about the Health Board's handling of his complaints about these matters.

The Ombudsman did not find that Mr D's post-operative radiotherapy was delayed but did find that there were excessive delays in conducting diagnostic investigations and in the scheduling Mr D's surgery. The Ombudsman also upheld Mr D's complaint about communication failings and the Health Board's handling of his complaint.

The Ombudsman recommended that:

- a) The Health Board provides Mr D with a fulsome written apology.
- b) The Health Board, in recognition of these failings and of the distress caused to Mr D, makes a payment to him of £3,500.
- c) The Health Board urgently reviews its capacity to provide or to commission template biopsies within 31 days of referral.
- d) The Health Board provides the Ombudsman with an account of how decisions taken at cancer care MDTs are coordinated and disseminated.

- e) The Health Board shares this report with the Concerns Team and draws to their attention the complaint handling failings identified.
- f) The Health Board undertakes a detailed review of its Urology Service's compliance with the Welsh Government's Referral Guidelines for Suspected Cancer. This review should refer to:
 - Action taken in response to the increasing demand for radiotherapy.
 - Action taken to reduce the backlog of Urology follow-up waiting lists.
 - Action taken to increase administrative support for Consultant Urologists.
 - Whether referrals from the pan-North Wales MDT to Merseyside has improved patient pathways in the treatment of urological cancer.

The Health Board agreed to implement these recommendations.

The complaint

1. Mr D complained about the care and treatment he received from Betsi Cadwaladr University Health Board following his referral to its Urology Service with a raised prostate-specific antigen¹ (PSA) and symptoms of urinary dysfunction. Mr D, who was subsequently diagnosed with an aggressive form of prostate cancer, complained that there were excessive delays in:

- Conducting diagnostic investigations
- Scheduling appropriate surgery following his diagnosis
- Arranging post-surgical radiotherapy.

2. Mr D also complained about numerous communication failings and about the Health Board's handling of his complaints about these matters.

Investigation

3. I obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mr D. Clinical advice was obtained from Mr John Hetherington, a Consultant Urologist with many years experience of conducting prostate cancer surgery. I refer to him throughout as "the Adviser". Whilst I have not exhaustively recorded in this report every detail of the information that the investigation considered, I am satisfied that nothing of significance has been overlooked.

Relevant legislation and guidelines

4. In 2013-14, The Welsh Government's Referral Guidelines for Suspected Cancer stated that:

- Patients suspected of having cancer and urgently referred by their GP, should wait no more than 62 days for their treatment to commence.

¹ PSA is a protein made only by the prostate gland and its raised level in the blood can indicate the presence of cancer (among other things). Broadly, for men aged 50-69, the PSA level is considered raised if it is 3ng/ml or higher. Mr D (who was then 63) had a PSA level of 10.6

- Patients who have been newly diagnosed as having cancer, not through a GP referral, should start their treatment within 31 days of a decision to treat.

The Guidelines also stated that:

“The Welsh Government’s aim is to ensure that all those patients with suspected cancer undertake diagnostic tests as quickly as possible to minimise any anxiety that they may be feeling”.

5. Regulations governing how NHS bodies in Wales should deal with complaints are set out in guidance entitled: ‘Putting Things Right’: the ‘NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 (“the PTR Regulations”).
6. The PTR Regulations stipulate that final responses to complaints (where qualifying liability² is denied) should be issued within 30 working days of receiving the complaint. If this is not possible, the complainant must be informed of the reason for delay. The response must then be sent as soon as possible and within six months of the date the complaint was received. If, in very exceptional circumstances, the response cannot be issued within six months, then the complainant must be informed of the reason for delay and given an expected date for response.

The background events

7. On 15 October 2013, Mr D was referred by his GP to a Consultant Urologist (“the First Consultant”) at Ysbyty Glan Clwyd (YGC) following a blood test that revealed an elevated PSA. Mr D’s GP completed an Urgent Suspected Cancer referral form which also recorded that Mr D had presented with LUTS³ and a hardening of the prostate gland.

² A legal term in which an individual or body is shown to be legally responsible for unfairly causing someone else to suffer loss or harm. In PTR this amounts to a necessary condition for awarding financial redress.

³ LUTS: Lower Urinary Tract Symptoms—problems with urination not caused by urinary tract infection

8. The First Consultant arranged for Mr D to undergo a TRUS biopsy⁴ on 29 October which failed to identify any sign of cancer. The First Consultant discussed this result with Mr D on 22 November and recorded that he would arrange a three-month follow-up appointment.

9. In February 2014, Mr D decided to contact the First Consultant as he had not received a follow-up appointment as promised. After numerous failed attempts to speak with the First Consultant's secretary, Mr D eventually obtained an appointment for 17 March through the intervention of the Urology Manager. At this appointment, the First Consultant recorded that Mr D's PSA level had risen to 13.3 and that he continued to experience LUTS. The First Consultant proposed that Mr D undergo a more thorough template biopsy⁵ at Wrexham Maelor Hospital (WMH), and, to this end, undertook to refer Mr D to a Second Consultant Urologist ("the Second Consultant") based at WMH. On 27 March, Mr D contacted the First Consultant seeking an update on the progress of the referral to WMH but was told that the referral had not yet been sent. At Mr D's request, the referral was faxed to WMH that day.

10. Mr D was seen by the Second Consultant at WMH on 7 April but was told that there was a long waiting list for template biopsies and that it was likely he would have to wait several months. Mr D's template biopsy was eventually carried out on 3 June and he was subsequently seen by the Second Consultant on 16 June, to discuss the results. At that appointment, Mr D was told that the biopsy had revealed the presence of an extremely aggressive form of prostate cancer.

11. The Second Consultant advised Mr D that his case would be discussed at an MDT⁶ meeting the following day and that arrangements would be made for him to undergo a bone scan and an MRI Scan⁷ (as a prelude to possible

⁴ TRUS: A trans-rectal ultrasound guided biopsy (where samples of prostate tissue are taken via a rectal probe guided by an ultrasound image).

⁵ A template or targeted biopsy is performed under local or general anaesthetic. The doctor puts a template with holes approximately 5 mm apart over the area of skin behind the testicles (the perineum). Under transrectal ultrasound guidance the doctor then puts a biopsy needle in through the different holes in the template and samples different areas of the prostate. Between 30 to 50 samples may be taken.

⁶ MDT: Multi-disciplinary-team. Health care workers and social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for complex medical conditions.

⁷ Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body

surgery). Mr D's bone scan was carried out on 20 June and his MRI scan on 15 July. The results of the scans were discussed at an MDT meeting held at WMH on 22 July and at a further (North Wales) MDT held at YGC on 30 July.

12. It was decided on 30 July that Mr D's condition warranted a Radical Prostatectomy operation (an operation to remove the whole prostate gland) and that the operation would be performed laparoscopically (i.e. as keyhole surgery). A referral was therefore made to a third Consultant Urologist ("the Third Consultant") based at YGC. Mr D met with the Third Consultant on 6 August but was informed that his operation could not be performed laparoscopically due to the fact that, in 2009, he had undergone bowel surgery. The operation would therefore have to be done as an open procedure. The Third Consultant informed Mr D that, whilst he tended to specialise in laparoscopic surgery, he would discuss Mr D's case with a fourth Consultant Urologist ("the Fourth Consultant") based at Ysbyty Gwynedd (YG) before making a final decision. Mr D was asked to return the following week to learn the outcome of this discussion.

13. Mr D met with the Third Consultant on 13 August and was advised that, to expedite his surgery, he had been placed on both the Third and the Fourth Consultants' operation waiting lists. The following day, Mr D received a telephone call to inform him that the Third Consultant would perform the operation on 16 September and that Mr D should attend YGC for a pre-operative assessment on 2 September. However, on 22 August Mr D received a letter stating that the proposed pre-operative assessment had been cancelled. The following day, Mr D received another letter stating that there had been a change of plan to the effect that the Fourth, rather than the Third, Consultant would now be performing the operation. However, this would no longer take place on 16 September as the Fourth Consultant would be on annual leave between 8 and 29 September.

14. Mr D was subsequently seen by the Fourth Consultant on 3 September and underwent a pre-operative assessment on 10 September. Mr D was admitted to YG on 12 October and underwent his Radical Prostatectomy operation on 13 October. Following a successful operation and period of recovery, a referral for post-operative radiotherapy was made on 20 October. Mr D said he wondered if radiotherapy would have been necessary if his surgery had not been delayed. Mr D's radiotherapy began on 12 February **2015** and was completed on 11 March.

15. Since his surgery, Mr D has experienced intermittent symptoms of LUTS and was diagnosed with proctitis⁸ in early 2016. Mr D wondered whether his condition of proctitis was linked to the protracted stress that he suffered as a result of the delays in his treatment.

Mr D's exchange of correspondence with the Health Board

16. On 8 April 2014, Mr D formally complained to the Health Board. In his letter, Mr D expressed his distress and anxiety at having to wait several months for a biopsy and commented that "I would have thought that, when cancer is a possibility, speed would be of the essence, but evidently, not so in my case". The Health Board acknowledged Mr D's letter on 11 April and issued an update letter on 12 May, apologising for the delay in providing a response.

17. Mr D had not received a response by 26 August, and so wrote to the Health Board again. Mr D (who, by then, had received his diagnosis) set out a chronology of events surrounding the various referrals to different consultants, the confusion regarding the type of surgical procedure he would undergo and the cancellations and re-scheduling of appointments. Mr D also referred to appointments cancelled in error⁹ and to the difficulty of contacting any of the consultants via their secretaries. Mr D concluded his letter as follows: "Please help me as I am very worried, I feel I have been greatly let down by the Health Board. Could I not be referred elsewhere for the procedure to be undertaken quicker?"

18. On 3 September, Mr D's Assembly Member (AM) wrote a further letter to the Health Board's Chief Executive (CEO) on Mr D's behalf. The AM asked that Mr D's situation be given the "utmost priority" and requested that an earlier date for his surgery be identified. The AM also reminded the CEO that Mr D had yet to receive a formal response to either of his letters of complaint.

⁸ Proctitis is an inflammation of the lining of the rectum.

⁹ Mr D received three letters from the First Consultant's secretary on the same day (28 July 2014) stating, respectively, that an appointment had been cancelled, then reinstated, then cancelled again. On enquiring further Mr D was told that all three letters were sent in error

19. The CEO replied to the AM on 18 September. He began by offering an apology for the length of time that Mr D had been waiting for his surgery and confirmed that a provisional date had now been set for 13 October. The CEO also undertook to contact the Concerns Team with regard to Mr D's outstanding complaint response.

20. Mr D received the Health Board's formal letter of response to his complaint on 22 October. The Executive Director of Nursing ("the Director"), on behalf of the CEO, apologised for the delays in both the provision of the template biopsy and in the scheduling of Mr D's surgery. The Director commented that "this is not the level of service we would wish for our patients". With regard to the delay in the scheduling of the template biopsy, the Director explained that, until recently, template biopsies were not undertaken at WMH and patients requiring them were sent to a hospital in Manchester. However, it was no longer able to accommodate such referrals "due to capacity issues". The Health Board therefore made arrangements to hire the necessary equipment and associated laboratory support.

21. Finally, the Director confirmed the Health Board's view that, despite the "considerable distress" caused by the delays Mr D had experienced (and despite conceding that that the level of care fell below the expected standard) this did not amount to a breach in the Health Board's duty of care.

22. On 27 November, Mr D's AM responded to the Director's letter on Mr D's behalf. The AM began by observing that, following a decision taken on 20 October that Mr D required post-operative radiotherapy, he had yet to receive any notification of when this treatment would begin. The AM then outlined a series of further issues raised by Mr D that he felt had not been adequately addressed in the Director's letter. These included:

- The First Consultant failing to refer Mr D to WMH for the template biopsy on 17 March and only doing so on 27 March as a result of Mr D's intervention
- Clarification of what the Director meant when she observed that Mr D's care had "fallen below the expected standard".

23. The Health Board's Director of Corporate Services ("the Second Director") replied, on behalf of the CEO, on 14 May **2015**. The Second Director began by noting that Mr D had, by then, completed his course of radiotherapy between 12 February and 11 March. The Second Director attributed the delay in Mr D commencing this treatment to "increasing demand" and to the fact that "more cancers are now eligible for treatment with radio and chemotherapy". The Second Director also explained that the Health Board had formed a new MDT, with clinicians from a hospital in Merseyside and this has "significantly improved how we treat patients suffering from a urological cancer".

24. The Second Director responded to Mr D's additional points as follows:

- The failure to promptly refer Mr D to WMH for his template biopsy was caused by the fact that the First Consultant's secretary would have "...prioritised administrative work for the specific cancer-related clinics first (before general clinics)". In any event, the First Consultant should not have informed Mr D that the referral would be completed immediately
- The Second Director conceded that an "acceptable standard of care" was not met because Mr D had not undergone his surgery within 31 days from his diagnosis; it was also conceded that Mr D did not receive his radiotherapy "in a timely manner" from the date of his post-operative referral.

The Health Board's response to the Ombudsman

25. The Health Board's response to my investigation included the following comments:

- With regard to the initial failure of the First Consultant to provide Mr D with a three-month follow up appointment as promised, the Health Board stated that Mr D was on a follow-up waiting list but "there is a known capacity issue with urology follow-up clinics...[however] there have been several initiatives in recent times to try and reduce this backlog".

- With regard to Mr D's unsuccessful attempts to contact the First Consultant's secretary on numerous dates in January, February and April 2014, the Health Board commented that there was a high level of sickness in the urology secretarial team in January 2014 and this may have impacted on Mr D's ability to contact the First Consultant's secretary. The Health Board added that the secretary's office is inundated with telephone queries but that, recently, additional administrative and secretarial support has been enlisted.
- With regard to the delay in Mr D receiving his template biopsy, the Health Board had taken steps (since Mr D's complaint) to obtain charitable funding to purchase the necessary equipment. The funding had been obtained but the equipment was "awaited". The Health Board did not comment on whether, in the interim, it considered commissioning a template biopsy from an alternative hospital or clinic.
- With regard to the six week gap between the biopsy and Mr D's MRI scan, the Health Board stated that this was appropriate as the scan should not be conducted less than six weeks from the date of a template biopsy.
- With regard to the subsequent gap between the MDT discussion on 30 July and Mr D's surgery on 13 October, the Health Board stated that Mr D was, shortly after the MDT discussion, referred to the Third and Fourth Consultants who placed him on their respective waiting lists. Mr D was operated on by the Fourth Consultant at the first available opportunity.
- With regard to the excessive delay in the Health Board providing a formal response to Mr D's complaint letters of 8 April and 26 August 2014, this was due to "a decision [that] was made not to complete and send out the Health Board's response letter until such time that arrangements had been put in place for him to undergo his surgery at YG".

Professional advice

26. The Adviser began by considering the overall timeframe from Mr D's diagnosis to surgery. The Adviser noted that the prostate biopsies were performed on 3 June 2014 and reported on 9 June and considered that it was reasonable that the results were discussed with Mr D on 16 June. The Adviser acknowledged that Mr D's tumour had to be staged¹⁰ with a bone scan and an MRI scan and that the Health Board was correct in saying that it is advisable to perform the MRI scan six weeks after the biopsy. However, given that the MRI scan was performed on 15 July, it would have been reasonable to have expected Mr D's surgery to have been carried out by the middle of August "at the latest". The Adviser considered that there was an excessive delay in moving Mr D on from his biopsy to his eventual surgery. Mr D was diagnosed with prostate cancer at the beginning of June and should have been on an urgent 31 day cancer pathway.

27. With regard to the specific explanations that the Health Board provided to Mr D for the delay between referral and treatment, the Adviser considered them to be unacceptable. He added that the Health Board not only failed to acknowledge this, but also failed to recognise that there were unnecessary delays at every step of Mr D's pathway.

28. The Adviser then considered the delay surrounding Mr D's template biopsy. He noted that Mr D's PSA had risen since the previous biopsy in 2013 but, despite this, Mr D did not receive his template biopsy until 11 weeks after referral. The Adviser considered this delay to be unacceptable. Mr D's referral should have been clearly identified as a case of suspected cancer and, accordingly, he should have been placed on the cancer pathway with a target date for a biopsy within 31 days. The Adviser added that all requests for template biopsies will be for similar reasons to those that applied to Mr D and so there was no reason whatsoever why Mr D was given a lower priority.

29. The Adviser then considered the timeframe in which Mr D was offered radiotherapy following his surgery. The Adviser stated that post-operative analysis of the excised prostate specimen suggests that Mr D's radiotherapy would have been necessary even if his diagnosis and

¹⁰The process of identifying the stage of development of a tumour

surgery had not been delayed. The Adviser explained that Mr D was referred for radiotherapy because post-operative examination of the excised prostate showed that the tumour had spread through the capsule of the prostate and therefore “there was a high probability that some residual tumour cells might remain in the prostate bed”. The histology report from the prostate specimen would have been available before the end of October so there appears to have been a three month wait, until 12 February 2015 for radiotherapy. Given that the idea of the radiotherapy is to treat the disease that is left behind after the prostatectomy, this wait was unacceptable. The Adviser stated that Mr D should not have waited longer than 31 days for his radiotherapy in accordance with Welsh Government guidelines.

30. The Adviser considered Mr D’s overall care plan was reasonable in that his case was discussed at both local and regional MDT meetings and the referrals between the consultant urological surgeons were acceptable. However, the Adviser went on to say that “...what was not acceptable were the delays between every event”.

31. With regard to recommendations about future clinical management of patients such as Mr D, the Adviser stated that:

- The provision for template prostate biopsies needs addressing with some urgency. The Health Board must decide whether to provide a service which can perform biopsies within two weeks of referral for every patient or secure external provision.
- The MDT meetings on 22 and 30 July 2014 did not appear to have been overseen by a Clinical Coordinator (usually a Nurse Practitioner) who (normally) takes responsibility for actioning urgent and appropriate referrals as soon as a decision has been made in the MDT meeting. It appears that there was a two week delay in the Fourth Consultant being sent documentation from the MDT meeting held on 30 July and a further one week delay before the Third Consultant wrote a standard referral letter to the Fourth Consultant suggesting he perform an open prostatectomy.

- The whole patient pathway needs coordinating from the MDT meeting. If the Health Board is offering a radical prostatectomy service then there should be a sufficient number of urological surgeons employed in order to keep the waiting times down and to avoid patients waiting while one surgeon is on holiday. The waiting lists should be shared to offer all patients an equal waiting time.

32. The Adviser stated that Mr D's post-operative symptom of intermittent LUTS is not uncommon after a radical prostatectomy and is not necessarily linked to delays in Mr D's care and treatment. He added that Mr D's post-operative development of proctitis is almost certainly a side effect of the radiotherapy that he underwent and is not stress-related.

33. The Adviser concluded as follows: "I am concerned that there was generally no apparent urgency in treating Mr D's aggressive prostate cancer when, from early June, he should have been on the urgent cancer pathway. I am critical of all the consultants involved in Mr D's care...no one is seen to show any sense of urgency in treating this aggressive cancer".

Additional comments from the Health Board

34. On seeing a draft of this report, the Health Board provided new evidence that, following his referral for radiotherapy, Mr D had elected to participate in a clinical trial that combined hormone therapy with radiotherapy. The Health Board explained that the clinical trial entailed Mr D's radiotherapy being deferred while he received hormone therapy between 11 December 2014 and 12 February 2015. The Health Board provided evidence that Mr D agreed to this treatment plan and that, as such, he received his radiotherapy as it was scheduled under the terms of the RADICALS¹¹ clinical trial.

35. The Health Board also commented that, despite the long waiting list for template biopsies in 2014, Mr D's biopsy was carried out within two months of seeing the Second Consultant.

¹¹ The RADICALS (Radiotherapy and Androgen Deprivation In Combination After Local Surgery) clinical trial is a randomised control trial in men who have suffered cancer of the prostate and who have had a radical prostatectomy. It essentially seeks to determine the most effective combination of radiotherapy and hormone therapy.

36. The Health Board commented that the technique of template biopsy is under review by the All Wales Urology Planned Care Board.¹²

37. The Health Board stated that the Second and Fourth Consultants did appreciate the urgency of Mr D's situation. The Second Consultant updated Mr D on test results via email and the Fourth Consultant scheduled Mr D's surgery at the first available opportunity.

Additional comments from Mr D

38. On seeing a draft of this report, Mr D stated that the decision to conduct open surgery (rather than laparoscopic surgery) was conveyed to him by a Cancer Services Nurse following the MDT meeting on 22 July 2014. Mr D therefore questioned the Health Board's suggestion that this decision was made by the Third Consultant on 6 August 2014. Mr D contended that the ensuing delay in the Third Consultant referring him to the Fourth Consultant (on the grounds that only the Fourth Consultant could undertake an open procedure) was therefore avoidable.

39. Mr D questioned how the Director could concede that the level of care fell below the expected standard, but deny that this amounted to a breach in the Health Board's duty of care.

40. Mr D acknowledged that he did elect to participate in the RADICALS clinical trial.

Additional comments from the Adviser

41. Further to the Health Board's additional comments, I returned to the Adviser who said that, in view of Mr D's participation in the RADICALS clinical trial, his radiotherapy was not delayed. Mr D was selected to receive hormone therapy prior to the start of the radiotherapy and so his post-operative treatment began in December 2014. This timescale was reasonable and was agreed by Mr D. The Adviser considered Mr D to be an appropriate participant in the trial.

¹² The All Wales Urology Planned Care Board is part of the Welsh Government's Planned Care Programme which has been set up to support health boards to improve patient experience by sharing good practice and creating sustainable pathways of care. Urology is one four clinically led specialty boards set up to identify variation across services

42. With regard to the Health Board's comments about template biopsies being under review by the All Wales Urology Planned Care Board, the Adviser stated that, whilst many centres are beginning to use MRI scans to improve the diagnostic accuracy of transrectal prostate biopsies, if the Health Board continues to offer template biopsies "they should have the resources to perform the biopsies on an urgent basis".

Analysis and conclusions

43. In reaching my conclusions I have been assisted by the advice and explanations of the Adviser, which I accept in full. The investigation has considered four complaint elements and I will address each of them in turn:

Excessive delays in conducting diagnostic investigations

44. I concur with the Adviser's view that it was unacceptable that Mr D should have had to wait 11 weeks to undergo his template biopsy. Whilst I note the Health Board's comment that the biopsy was performed within two months of Mr D seeing the Second Consultant, there was, nevertheless, a ten day delay in the First Consultant making the referral (which might have been longer were it not for Mr D's intervention) and a further week before he was seen by the Second Consultant. The signs and symptoms that Mr D exhibited, which included a rising PSA, LUTS and the palpable hardening of the prostate on examination, were, taken together, strong clinical grounds for suspecting prostate cancer and clearly should have placed Mr D on an urgent, 31 day cancer pathway.

45. In addition, I note that in its account of the delay in the provision of the template biopsy, the Health Board appears not to have given any consideration to commissioning the biopsy from another Health Board or clinic or to how the referral to treatment targets embodied in the Welsh Government's Referral Guidelines for Suspected Cancer were to be met. The Health Board did not appear to have considered that diagnostic tests should be conducted as quickly as possible to minimise the anxiety of patients.

46. I consider that these failings amounted to a significant injustice to Mr D. Consequently, I **uphold** this complaint.

Excessive delay in scheduling appropriate surgery following diagnosis

47. I concur with the Adviser's view that Mr D should have been on an urgent 31 day cancer pathway, and, given that he underwent his MRI scan on 15 July 2014, his surgery should have been carried out by the middle of August at the latest. I also share the Adviser's view that there was a disturbing lack of urgency in the manner in which referrals between consultants across the Health Board's various hospital sites were conducted. This appears to have been compounded by the way in which decisions made at MDT meetings did not appear to have been overseen by a Clinical Co-ordinator.

48. There appears to have been a systemic failure to recognise and respond to the fact that Mr D was suffering with an aggressive, potentially life-threatening form of prostate cancer that required urgent and radical treatment. As a patient on an urgent 31 day cancer treatment pathway, it was entirely unacceptable that Mr D should have had to wait a total of 132 days to receive his first definitive treatment. Moreover, I have seen nothing in the Health Board's response to my investigation that could justify such a disquieting failure. I therefore **uphold** this complaint.

Excessive delay in arranging post-surgical radiotherapy

49. In view of the fact that Mr D elected to take part in the RADICALS clinical trial, I do not consider that his post-operative radiotherapy was delayed. Whilst it is disappointing that the Health Board did not inform me of Mr D's participation in the clinical trial before receiving a copy of the draft report, I accept that Mr D was selected to receive hormone therapy prior to the start of the radiotherapy and that his post-operative treatment therefore began in December 2014. I consider that this timescale was reasonable and was agreed in advance by Mr D. For this reason, I **do not uphold** this complaint.

Communication failings and poor complaint handling

50. Having carefully considered Mr D's account of the communication and complaint handling failings that he experienced, alongside the Health Board's responses to them, I have concluded that:

- The failure to provide Mr D with a three month follow-up appointment was compounded by the unavailability of the First Consultant.

- It was unacceptable that Mr D's referral for a template biopsy had not been sent some ten days after the decision to make the referral had been made (which represents a third of the 31 day urgent cancer referral pathway). This failing was compounded by the fact that the referral may have been overlooked for a considerably longer period were it not for Mr D's intervention.
- The errors in arranging and notifying Mr D of appointments were not acceptable.
- It was not acceptable (and contrary to the provisions of PTR Regulations) that the Health Board decided not to issue any responses to Mr D's formal letters of complaint until he had completed his treatment. Mr D complained on 8 April (and 26 August) and received a response on 22 October; his AM's letter of 27 November 2014 did not receive a response until 14 May 2015. Between these dates, Mr D and his AM made numerous attempts by email and telephone to elicit a response, but were at no time informed that the Health Board was awaiting the completion of Mr D's treatment before addressing his complaint.

51. In conclusion, I consider that these communication and complaint handling failures would have significantly intensified the level of distress and anxiety that Mr D would have been experiencing as a result of the alarming nature of the diagnosis he had received. Moreover, these failings would have undermined Mr D's confidence in the competence of Health Board personnel at a time when such confidence was absolutely crucial. As such, I consider these failings represent a significant injustice to Mr D and I therefore **uphold** this complaint.

Recommendations

52. I **recommend** that, within one month of the final report being issued:

- a) The Health Board provides a fulsome written apology to Mr D which recognises the serious nature of the clinical, communication and complaint-handling failings identified in this report.

- b) The Health Board, in recognition of these failings and of the distress and injustice that they caused Mr D at a time of acute anxiety about his condition, makes a payment to Mr D of £3,500.
- c) The Health Board provides me with an update on its capacity to provide or to commission template biopsies within 31 days of referral (insofar as it continues to offer template biopsies while awaiting the outcome of the All Wales Urology Planned Care Board's consideration of this matter). This update should include details of ongoing or planned measures that will enable the Health Board to achieve this service standard.
- d) The Health Board provides the Ombudsman with an account of how decisions taken at cancer care MDTs are coordinated and disseminated. This should include details of who takes responsibility for actioning urgent and appropriate referrals, together with details of how referrals across the Health Board's various hospital sites are expedited.
- e) The Health Board shares this report with the Concerns Team and draws to their attention the complaint handling failings identified.

I further **recommend** that within three months of the final report being issued:

- f) The Health Board undertakes a detailed review of its Urology Service's compliance with the Welsh Government's Referral Guidelines for Suspected Cancer. This review should report on the performance of the Urology Service in this respect from March 2015 (when Mr D's treatment was completed) to the present and include reference to:
 - Action taken in response to the increasing demand for radiotherapy.
 - Action taken to reduce the backlog of Urology follow-up waiting lists.
 - Action taken to increase administrative support for Consultant Urologists.

- Whether referrals from the pan-North Wales MDT to Merseyside has improved patient pathways in the treatment of urological cancer.

53. I am pleased to note that in commenting on the draft of this report **Betsi Cadwaladr University Health Board** has agreed to implement these recommendations.

A handwritten signature in black ink, appearing to read 'Nick Bennett'.

Nick Bennett
Ombudsman

26 October 2016

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