SPSO decision report

Case: **201705291, Grampian NHS Board**
Sector: health
Subject: admission / discharge / transfer procedures
Decision: upheld, recommendations

Summary

Mr C complained about delays in the care and treatment he received for his eye at Dr Gray's Hospital and Aberdeen Royal Infirmary (ARI). Mr C had developed diabetic retinopathy (a complication of diabetes, caused by high blood sugar levels damaging the back of the eye, which can cause blindness if left undiagnosed and untreated). He also complained about the impact the delays had on his sight, which he said left him almost blind, and about the delay in his treatment following routine diabetic screening by the board at a local health centre.

We took independent advice from a senior consultant ophthalmologist (a specialist in the branch of medicine concerned with the study and treatment of disorders and diseases of the eye). We found that there were delays in Mr C being seen following his initial appointment at Dr Gray's Hospital and following his original laser treatment at the hospital. It appeared that due to a failure in the booking system, the board failed to arrange a follow-up appointment for Mr C at ARI after his original laser treatment. The board accepted and apologised for this failing, and indicated that remedial action has been taken. However, we considered that further action should be taken by the board in this area and we addressed this in our recommendations. We upheld this part of Mr C's complaint.

In relation to the follow-up appointment's, we found that the delay contributed to him developing more severe diabetic retinopathy and the subsequent need for surgery. Although the surgery was successful, the poor clarity of vision that finally occurred was possibly not related to the delay and may have been due to other elements of diabetic retinopathy.

We also found that there was a long delay of over three months from Mr C's diabetic screening at the health centre to his laser treatment at ARI. This was outwith the timescales recommended and we considered that Mr C should have been seen within a shorter timescale. We noted it was difficult to determine whether the deterioration in Mr C's sight occurred as a consequence of the previous problems with diabetic retinopathy or whether this was a secondary event. We upheld this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the delays in his treatment following his initial appointment at Dr Gray's Hospital and following his diabetic screening at the health centre. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/leaflets-and-guidance" www.spso.org.uk/leaflets-and-guidance .

What we said should change to put things right in future:

- The board should have a follow-up system that ensures patients are seen within an appropriate time frame; and appropriately followed up across different sites. The system put in place should also take into account relevant standards/guidelines.