# SPSO decision report

**Case:** **201806165, Lothian NHS Board - Acute Division**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Decision:** upheld, recommendations


## Summary

Mrs C complained on behalf of her late husband (Mr A) that the Royal Infirmary of Edinburgh Hospital failed to call Mr A to a follow-up review appointment with the cardiology department.


Mr A had been diagnosed with heart disease. He attended an out-patient appointment and saw a consultant cardiologist. During that appointment, it was agreed that Mr A should be reviewed two years from then. Some years later, Mr A collapsed. An ambulance took Mr A to hospital, but he died on arrival. On becoming aware that Mr A had not attended his follow-up appointment with cardiology, Mrs C wrote to the board to ask why he had not been called back to the follow-up appointment as agreed. The board said that Mr A had been asked to make a follow-up appointment but nothing was noted in the system, and they were unable to explain this conclusively. Mrs C complained about the board's failure to call Mr A in for his review appointment. She said that the appointment system seemed flawed and there needed to be a backup system in place so no one else missed an important appointment.

We found that at the time when Mr A was advised to make a review appointment, all patients were advised during their consultation if and when a follow-up appointment was required. The patient would be asked to book an appointment accordingly at the reception desk. Once the appointment was booked, a letter was sent out confirming the date and time of the appointment. No further letters or reminders were sent. It was the patient's responsibility to remember to attend the appointment.

The board told us that having reflected on Mr A's case, they acknowledged that there were failings in the appointment process. They told us that going forward, when staff typed the clinic outcome letter, they would now check that any requested follow-up appointments had been made. If an appointment had not been made, staff would contact the out-patient department requesting that the appointment be made and confirmation sent to the patient.

We took independent advice from a consultant cardiologist. We found that the appointment process described by the board was not common practice and it was susceptible to problems. We found that the boards process placed undue responsibility on the patient.

We considered that the appointment process was open to weaknesses and because of that, the board had been unable to say whether Mr C's review appointment was in fact scheduled. We noted that the most common appointment process would be for each patient to be given a routing card at the end of their consultation which they would return to the clinic reception desk; this would be a record of the discussion held with the patient and the next steps agreed. Even though the board's proposed change would be an improvement to the current process, it did not go far enough as it relied only on verbal communication between clinical staff, the patient and staff at the reception desk. Therefore, we upheld Mrs C's complaint.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to arrange an appropriate review appointment for Mr A. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- The board should reflect on these findings, particularly the view of the adviser and the feedback provided by Mrs C, and consider what further improvements can be made to the appointment process.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.