Ombudsman Ombwdsmon

PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint by Ms A against Betsi Cadwaladr University Health Board

A report by the Public Services Ombudsman for Wales
Case: 201301339

Contents

Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 ("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. The report therefore refers to the complainant as Ms A.

Summary

Ms A complained that Betsi Cadwaladr University Health Board ("the Health Board") delayed two of her appointments, at its Glaucoma[1] Review Clinic ("the Clinic"), unreasonably. She said that she needed emergency treatment as a result. She contended that she sustained significant vision loss in her right eye and experienced "considerable distress" because of these appointment delays. She indicated that she was dissatisfied with the Health Board's response to her complaint because it took too long to provide it and asserted that her sight was "unaffected" by these appointment delays.

The Acting Ombudsman upheld Ms A's complaint. She considered that the Health Board delayed Ms A's Clinic appointments unreasonably and failed to manage her glaucoma-related risks appropriately. She was also of the view that it took too long to respond to Ms A's complaint and failed to update her and manage the issue of possible qualifying liability appropriately. She recommended that the Health Board should:

(a) **Apology** – Write to Ms A to apologise for the failings identified.

(b) **Qualifying liability** – Write to Ms A to explain how it determined that there was no qualifying liability in her case.

(c) **Review** – Review its ophthalmology services with reference to her investigation report and a pre-existing "Situation Background Assessment Recommendation" ("SBAR") report.

(d) **SBAR report** – Prepare another SBAR report following this review.

She also considered it appropriate to recommend financial redress for Ms A. However, she did not do so because Ms A did not want such redress.

The Health Board agreed to comply with the recommendations made.

[1] Glaucoma is a disease which damages the optic nerve and causes vision loss.

The complaint

Outpatient care

1. Ms A complained that Betsi Cadwaladr University Health Board ("the Health Board") delayed two of her appointments, at its Glaucoma[2] Review Clinic ("the Clinic"), unreasonably. She said that she required emergency treatment as a result. She contended that she sustained significant vision loss in her right eye and experienced "considerable distress" because of these appointment delays.

Complaint handling

2. Ms A indicated that she was dissatisfied with the Health Board's response to her complaint because it took too long to provide it and asserted that her sight was "unaffected" by these appointment delays.

Investigation

3. My Investigator obtained the Health Board's comments on Ms A's complaint, Ms A's medical records for the relevant period and other information from the Health Board. She also obtained advice from one of my Professional Advisers ("my Adviser"). My Adviser, Mr Wojciech Karwatowski, is an experienced Consultant Ophthalmologist. I considered the records and other material supplied in conjunction with the documents that Ms A provided in support of her complaint. I gave Ms A and the Health Board the opportunity to see and comment on a draft version of this report before issuing it in its final form.

4. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

[2] Glaucoma is a disease which damages the optic nerve and causes vision loss.

Relevant legislation

5. Specific regulations[3] ("the Regulations") govern how Health Boards handle complaints. Regulation 24 requires them to "take all reasonable steps" to send a response to a complainant within 30 working days of receiving his/her complaint. It also stipulates that, if they are unable to do this, they "must" notify the complainant and explain why. Regulation 26 places a duty on them to consider redress if they determine that "a qualifying liability exists or may exist". Qualifying liability is deemed to exist when a duty of care breach has caused the patient concerned harm. Regulation 26 requires them to prepare an interim report, which explains the availability of free legal advice and the procedure for determining whether any qualifying liability exists. It notes that they should send such reports to the complainants concerned. The rationale for their final qualifying liability decisions is required by regulation 31.

Background

Outpatient care

6. Ms A has bilateral glaucoma. On **5 July 2011** the Health Board completed a visual field[4] test. It recorded that the mean defect[5] ("the MD") for Ms A's right eye was -5.76.

7. The Health Board performed a combined phacoemulsification[6] and viscocanalostomy[7] operation, on Ms A's left eye, on 8 August. Ms A attended the Clinic on 14 December. The Health Board noted that she had inflammation in her right eye, which was suggestive of Fuch's heterocyclitis ("FHC").[8]

[3] The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
[4] The term visual field refers to how much an individual can see whilst looking straight ahead. An individual's visual field includes both his/her central and peripheral vision.
[5] The MD is the total amount of visual field loss detected. The greater the minus figure the greater the visual field defect.
[6] Phacoemulsification is a type of cataract surgery. It involves removing the cataract and replacing the affected lens with an artificial one.
[7] A viscocanalostomy is a surgical procedure used to lower eye pressure. It involves the removal of a piece of the eye's tough outer wall to leave a thin membrane which allows the clear fluid within the eye to drain away.
[8] FHC is an inflammatory eye condition.

8. On **21 February 2012** the Health Board performed the same operation on Ms A's right eye. Ms A attended the Clinic on 30 March. The Health Board recorded that her eye pressure, in both eyes, was 14mmHg.[9] It noted that the visual acuity[10] score, for her right eye ("her right visual acuity score"), with glasses correction, was 0.02 [6/6].[11] It advised her that she would be seen again, at the Clinic, in three months, that is on or around 30 June.

9. On 4 May the First Community Optician recorded that Ms A's right visual acuity score, with glasses correction, was 6/5.

10. The Consultant Ophthalmic Surgeon ("the Consultant Surgeon") and some of her colleagues wrote a "Situation Background Assessment Recommendation" ("SBAR") report[12] ("the SBAR report"), about ophthalmology services, for the Health Board, on 11 July. They noted that around 10,000 ophthalmic outpatients were "overdue their review date by more than 25% of the clinically determined safe interval for their follow-up appointment" across the Health Board. They said that this figure had been rising steadily for over twelve months. They indicated that the Health Board's booking processes, which prioritised new patients over those requiring review, had contributed to this problem. They reported that there had been "numerous critical incident reports relating to avoidable patient harm resulting from delayed review appointments". They noted that they were very concerned about patient safety. They recommended that patients

[9] The eye requires a certain amount of pressure to keep its shape. The flow of fluid within the eye maintains this pressure. An increase in resistance to the outflow of this fluid, through the internal drain of the eye, causes eye pressure to rise. Eye pressure is measured in millimetres of mercury (mmHg). Normal eye pressure ranges from 12-22 mmHg. High eye pressure can cause glaucoma.
[10] The term visual acuity refers to the sharpness of an individual's central vision, that is the vision used to see detail.
[11] The visual acuity scores available for Ms A are recorded in two different forms, namely the LogMAR and the Snellen. The scores for both forms are achieved by using visual acuity testing charts, which consist of letters. However, these charts and the scoring methods used are fundamentally different. LogMar scores are represented as a decimal. Each letter is assigned a score of 0.02; this score is awarded when a letter is read incorrectly. Lower scores therefore correspond with better vision. A LogMAR score of "0" indicates no visual acuity loss. Snellen scores are represented as a fraction. The first figure refers to an individual's distance from the chart, in metres, as s/he reads it. The second figure refers to the number of rows that s/he can read on the chart. These rows have a numerical value. Letter rows, as distinct from individual letters, are scored. The row value decreases in accordance with a reduction in letter size. Larger second numbers therefore correspond with worse vision. A score of 6/6 means that an individual can, from six metres away, read that row of the chart which has a numerical value of 6. A Snellen score of 6/6 indicates normal visual acuity. I will provide the Snellen equivalent of the LogMAR scores recorded in square brackets for ease of reference. My Adviser has calculated the Snellen equivalents supplied.
[12] SBAR Ophthalmic Review Appointment Backlog 11/07/2012 – Consultant Surgeon et al.

who might "suffer irreversible harm from delayed appointments", like those with progressive glaucoma, should, irrespective of their new or review status, take clinical priority. They identified these patients as Category 1 patients.

11. On 16 July Ms A wrote to the Consultant Surgeon. She expressed concern because she had not received another Clinic appointment.

12. The Consultant Surgeon saw Ms A on 10 August. She recorded that her right eye pressure was 20mmHg and that her right visual acuity score, with glasses correction, was 0.04 [6/6-1].[13] She advised Ms A that she would be seen again, at the Clinic, in three months, that is on or around 10 November. She indicated that if Ms A's right eye pressure had not fallen below 16mmHg, at that time, she would consider alternative treatment.

13. On 17 December Ms A wrote to the Consultant Surgeon again. She expressed concern because she had not received another Clinic appointment.

14. Ms A was seen, at the Clinic, on **9 January 2013**. The Health Board recorded that her right eye pressure was 50-52mmHg. She received urgent medical intervention as a result. The Health Board noted that her right visual acuity score, with glasses correction, was 0.28 [6/11.4] and that her right eye's MD was -20.02. It recorded, on 11 January, that her right eye pressure was 36mmHg and that her right visual acuity score, without glasses correction, was 0.24 [6/10.4]. On 25 January it noted that her right visual acuity score, with glasses correction, and her right eye pressure were 0.12 [6/7.8] and 20mmHg respectively.

15. The Second Community Optician recorded, on 11 February, that Ms A's right visual acuity score, with glasses correction, was 6/9-1. On 15 February, 3 April, 15 May and 26 June the Health Board noted that Ms A's right visual acuity score, without glasses correction, was 0.14 [6/8.28], 0.22 [6/9.9], 0.18 [6/9] and 0.20 [6/9.6] respectively. It recorded that her right eye pressure on these dates was 21mmHg, 20mmHg, 22mmHg and 26/28mmHg respectively. It noted that her right eye's MD, on 15 February, was -17.84.

[13] This Snellen score indicates that Ms A could read part of the chart's sixth row. Partial row readings can also be expressed as a decimal.

Complaint handling

16. On **15 January 2013** Ms A wrote to the Administration Manager ("the Manager"). She complained about her delayed Clinic appointments. The Manager received Ms A's letter on 16 January. Ms A wrote to the Manager again on 27 February. She indicated that she had not acknowledged or responded to her letter of 15 January. The Manager referred Ms A's letter of complaint to the Health Board's Concerns Team on 1 March. The Concerns Team acknowledged Ms A's complaint on 8 March.

17. Ms A wrote to the Concerns Team on 24 April. She indicated that it had not contacted her since 8 March. On 13 May she wrote to the Concerns Team again. She noted that she had not received a response to her letter of 24 April. On 15 May the Concerns Team wrote to Ms A and advised her that the Health Board's investigation of her complaint was ongoing. It indicated that its response to her complaint had been delayed because it was "still waiting for further comments" from the relevant Clinical Programme Group. The Chief Executive wrote to Ms A, in response to her complaint, on 17 May. Her letter appears to have been sent to Ms A on 21 May.[14]

Ms A's evidence

Outpatient care

18. Ms A said that she had thought that her vision loss would be permanent. She also indicated that she had been concerned, between 9 and 11 January, that she would lose her driving licence and encounter "all the difficulties attending the partially sighted and blind". She told me that she had "regained a substantial degree" of her lost vision. However, she said that she does not believe that she has regained the level of vision that she had, in her right eye, prior to the occurrence of these appointment delays. She provided the results of the visual acuity tests completed by the Community Opticians, on 4 May 2012 and 11 February 2013, as "independent evidence" of her vision loss.

[14] Ms A has provided a copy of an envelope, with an address window, which was franked by the Health Board. The postal date given on this envelope is 21 May 2013.

The Health Board's evidence

Outpatient care

19. The Chief Executive, in her letter of 17 May, said that the Health Board had investigated Ms A's concerns "under" the Regulations. She acknowledged that her Clinic appointments, for June and November 2012, had been delayed by six and eight weeks respectively. She apologised for these delays. She said that the Health Board, having investigated Ms A's concerns, was "satisfied" that there was "no qualifying liability" and that financial redress should not be offered to her. She accepted that Ms A's care fell below "a reasonable standard" but contended that "harm was not caused" and that her sight had been "unaffected by the delay". She reported that an "increasing number of patients" were experiencing delays in receiving appointments because the Health Board was receiving more referrals for patients with suspected glaucoma and age-related macular degeneration[15] due to guidance recently issued by the National Institute for Health and Care Excellence ("NICE"). She indicated that staff members had been working to address the delay in Clinic appointments.

20. During this investigation, the Health Board indicated that it had complied with the recommendation made by the SBAR report's authors by only booking appointments for Category 1 patients. It said that this had increased capacity for review patients. It indicated that the waiting list for review appointments had decreased, because of this and the provision of additional clinics, from 591 on 25 November 2012 to 143 on 28 March 2013. However, it also reported that it had begun to book appointments for other patients, who did not fall into Category 1, recently. It acknowledged that the number of patients waiting for a review appointment had increased to 445 on 8 July 2013 as a result. It did not specify the category status of these patients.

21. It acknowledged that there had been ongoing capacity issues. It reported that there was "planning to create extra capacity" which would "include training and up skilling professionals to carry out extra glaucoma

[15] Age-related macular degeneration is an eye condition that affects a small area of the retina, known as the macula. It causes central vision problems and can sometimes lead to rapid vision loss.

clinics". It said that it planned to open an extra clinic "on the Colwyn Bay site" and indicated that, if additional staffing were approved, it could accommodate "an extra 30 patients per week".

22. It stated, when responding to a draft version of this report, that it could not say how many Category 1 patients were currently waiting for review ophthalmology appointments. It explained that this was because of a variation in "compliance" with clinical classification and prioritisation recording. It indicated that it was addressing this issue.

Complaint handling

23. The Chief Executive, in her letter of 17 May, apologised for the delayed nature of her response. The Health Board did not comment on its handling of Ms A's complaint during this investigation.

Professional advice

Outpatient care

24. My Adviser noted that Ms A's right eye pressure increased significantly between 10 August 2012 and 9 January 2013. He said that it is "impossible to say at which point", during this period, this increase occurred. He also observed that it is not possible to determine the rate at which this pressure rose. He confirmed that there is evidence, which demonstrates that Ms A's vision, in her right eye, has deteriorated since 10 August 2012. He noted that her right visual acuity was recorded as being between 6/6 and 6/5, on three separate occasions (30 March, 4 May and 10 August), between 30 March and 10 August 2012. He observed that, after 10 August, her right visual acuity was "poorer at around 6/9 and sometimes a little less" when measured by both the Health Board and the Second Community Optician. He considered that this change was "significant".

25. He explained that visual field tests are used to monitor glaucoma because it primarily damages this visual area. He said that Ms A's visual field test results show that "a significant deterioration", in her right visual field, occurred between 5 July 2011 and 9 January 2013. He observed that it is

not possible to say when this deterioration occurred. He noted that the test completed on 15 February 2013 "confirmed the significant deterioration" in Ms A's right visual field.

26. He said that it "is reasonable to conclude" that Ms A's "right visual field has deteriorated due to glaucoma". He also said that "it is probable" that her right visual acuity "has deteriorated due to glaucoma in the absence of any other evidence to the contrary in the clinical notes that might suggest a different cause for this". He did not consider that the delay associated with Ms A's first Clinic appointment, that is the one that was scheduled to take place on or around 30 June, contributed to this deterioration or her need for emergency treatment on 9 January. He indicated that he had reached this view because her right eye pressure was satisfactory on 10 August and no change in her treatment was required at that time.

27. He considered that the delay associated with Ms A's second Clinic appointment, that is the one that was scheduled to take place on or around 10 November, "could have delayed" the diagnosis and treatment of her right eye pressure rise "and thus contributed to the deterioration in [her] vision". However, he also pointed out that her right eye pressure might have been normal at the time of her scheduled second Clinic appointment, that is on or around 10 November, and that any damage might have occurred after that. He indicated that he could not say, with any certainty, that the Health Board's failure to see Ms A, at the Clinic, during November, was responsible for the vision loss in her right eye. However, he said that this is "a significant possibility". He also pointed out that frequent appointments increase the chance of detecting any eye pressure rise earlier or at a lower level, thereby "diminishing" the risk of "glaucomatous damage". He said that the deterioration in Ms A's vision is "unlikely to improve with time or further treatment" if it is due to glaucoma.

28. He noted that the relevant clinical guideline[16] ("the Guideline") suggests that a patient in Ms A's position on 10 August, when her eye pressure was not at the target level specified by the Consultant Surgeon but there was no evidence of her glaucoma worsening, should have been reviewed in one to four months. He noted that this was the Consultant Surgeon's plan. He also observed that there was a possibility that the glaucoma in Ms A's right eye

[16] Glaucoma: Diagnosis and management of chronic open angle glaucoma and ocular hypertension NICE clinical guideline 85 – National Institute for Health and Care Excellence (April 2009).

had an inflammatory component, that is FHC. He said that FHC could make glaucoma "more aggressive" and pressure control "erratic". He noted that the relevant quality standard[17] emphasises the need for timely follow-up appointments. He reported that it also suggests "a tolerance of 15%", for follow-up appointment delays, as an appropriate standard. He indicated that, in terms of Ms A's second Clinic appointment, the Health Board exceeded her review interval by 66%.

29. He noted that it is clear that the Health Board was made aware of "the clinical consensus" concerning the delays for follow-up appointments in July 2012. He observed that the Health Board has provided evidence, which indicates that it is attempting to address these delays. However, he concluded, based on the evidence provided by the Health Board, that its efforts to do this have only been "partially successful".

30. He confirmed that the Health Board's management of Ms A's Clinic appointments on 10 August 2012 and 9 January 2013 was clinically acceptable.

Complaint handling

31. My Adviser said that the Chief Executive's response to Ms A's complaint "does not appear to reflect any of the relevant clinical issues or [the] risks" associated with her Clinic appointment delays.

Analysis and conclusions

32. I have taken account of the advice provided by my Adviser when analysing Ms A's complaint and reaching my conclusions.

Outpatient care

33. I consider that the Health Board delayed Ms A's Clinic appointments unreasonably, albeit unintentionally. I am also concerned that Ms A would have experienced further delay if she had not contacted the Consultant Surgeon about these appointments. I am also satisfied, given the visual field and acuity test results available, that Ms A sustained significant vision loss, in

[17] Glaucoma quality standard Quality statement 8: Service capacity – National Institute for Health and Care Excellence (March 2011).

her right eye, after 10 August 2012. I understand that Ms A's vision improved following the Health Board's intervention during January 2013. However, her right visual acuity scores on 4 May 2012 and 11 February 2013, which were, with glasses correction, 6/5 and 6/9-1 respectively, indicate that she has not regained the level of vision that she had, in her right eye, prior to these appointment delays. It also seems likely, given the clinical evidence currently available, that glaucoma has caused this deterioration. I understand that, if this is the case, the vision in Ms A's right eye is unlikely to recover further.

34. I am not persuaded, in light of the clinical findings made on 10 August 2012, that the delay associated with this Clinic appointment contributed to Ms A's vision loss. Nor can I determine, given my inability to identify the point at which Ms A's right eye pressure began to rise, that the delayed nature of her second Clinic appointment did so. However, it seems to me that it could have done so. I also consider that the length of the delay, given the Consultant Surgeon's apparent concern about Ms A's right eye pressure, at her previous Clinic appointment, and the possibility of FHC, increased the likelihood of this.

35. The SBAR report exacerbates my concern about Ms A's appointment delays because it indicates that systemic failings have adversely affected the Health Board's ophthalmology services for a significant period. I recognise that the Consultant Surgeon and others have, to their credit, tried to address these failings by preparing the SBAR report. I also understand that the Health Board complied with their recommendation. However, I am not convinced, given Ms A's experience and the renewed rise in the number of patients waiting for review appointments, that the Health Board has resolved these failings. I also note, with alarm, that their persistence could result in patients suffering irreversible harm.

36. I **uphold** the outpatient care component of Ms A's complaint because I consider that the Health Board delayed her Clinic appointments unreasonably and failed to manage her glaucoma-related risks appropriately.

Complaint handling

37. The Health Board did not comply with the Regulations when responding to Ms A's complaint. It took at least 84 working days, that is between 16 January and 17 May 2013, to send its response to her. It should have made every effort to do this within 30 working days of receiving her complaint, that is by 27 February. The delay associated with the provision of the Health Board's response is, given its content, unacceptable. Nor did the Health Board explain this delay, to Ms A, until 15 May. I also note that it only appears to have done this in response to her letters of 24 April and 13 May. The explanation offered, given that the Chief Executive apparently wrote the Health Board's response to Ms A's complaint, within two days of the Concerns Team providing it, is unconvincing. I am also very concerned, given the nature of this response and Ms A's demonstrable vision loss, that the Health Board did not consider the issue of qualifying liability thoroughly. I also note that it did not send Ms A an interim report, about this issue, as required.

38. I **uphold** the complaint handling part of Ms A's complaint because I consider that the Health Board took too long to respond to her complaint and failed to update her and manage the issue of possible qualifying liability appropriately.

Recommendations

39. I considered it appropriate to recommend financial redress because of the failings identified. I therefore recommended, in a draft version of this report, that the Health Board should pay Ms A a nominal sum of £750 to reflect the fact that its failure to give her timely Clinic appointments could possibly have contributed to her vision loss and caused her unnecessary distress. I also recommended that it should pay her an additional £250 because the time and trouble involved in her pursuing her complaint exceeded the norm due to its failings. However, Ms A, when responding to a draft version of this report, indicated that she appreciated these financial redress recommendations but said that she did "not wish to receive any money in compensation". She also noted that she wanted the Health Board "to direct its corporate mind and funds to the best possible patient care". I remain of the view that financial redress would be appropriate. However, I have decided, in recognition of Ms A's comments, to remove my original financial redress recommendations.

40. I recommend that the Health Board should:

(a) **Apology** – Write to Ms A to apologise for the failings identified in this report.

(b) **Qualifying liability** – Write to Ms A to explain how it determined that there was no qualifying liability in her case.

(c) **Review** – Review its ophthalmology services with reference to this report and the SBAR report completed on 11 July 2012. The SBAR report's authors should be involved in this review.

(d) **SBAR report** – Prepare another SBAR report following its review of its ophthalmology services. It should specify, within this report, the measures that it will take to ensure, as far as is possible, that its ophthalmology patients do not suffer irreversible harm because of appointment delays.

41. I am pleased to note that the Health Board, when commenting on a draft version of this report, has agreed to implement these recommendations.

Prof Margaret Griffiths 17 June 2014
Acting Ombudsman

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