SPSO decision report

Case: **202207990, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the ophthalmology treatment (the branch of medicine that deals with the anatomy, physiology and diseases of the eye) that they were provided by the board. They were referred by a consultant (Doctor 1) for a second opinion from a corneal specialist. C complained that they should have been seen by a consultant (Doctor 2) but were instead treated by a junior doctor (Doctor 3). Additionally, C complained about the treatment provided by Doctor 3 and the decision to discharge them from the ophthalmology service.

We took independent advice from a consultant in ophthalmology. We found that it was clear that Doctor 1 intended a specialist to examine C and that this did not happen. Although it may have been reasonable for C to have been seen by a junior doctor in clinic, there should have been clinical oversight by Doctor 2, with direct input to C's management plan. We found that it would have been good practice for the outcome of the consultation to be reported back to Doctor 1, copying the letter to the GP and C. Instead, the outcome was only reported to C's GP. We upheld this complaint. We also found that Doctor 3 should have tested C's eye pressure before prescribing fluorometholone (a mild steroid). We upheld this aspect of C's complaint. Finally, we also found it was unreasonable for the board to discharge C from their ophthalmology service, when Doctor 1 had agreed to follow-up in one year. We upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings our investigation has identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- When apologising to C, the board should address their treatment plan and communications in relation to their discharge.
- The board should offer C a further consultation with Doctor 1, given they had agreed to a follow-up consultation with C.

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

- Clinical staff ensure that they write back to the referring clinician, copying to the GP and patient.
- Eye pressure is tested, in accordance with good clinical practice, prior to FML being prescribed.
- Where a tertiary consultant to consultant referral is made, the consultant should be aware that the case is there for their specialist opinion and provide some direct input to their management plan.
- Where referrals are made for a second opinion, the patient is discharged back to the referring clinician.

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.