Provision of timely follow-up ophthalmology care
16HDC01912, 20 June 2018

District health board ~ Ophthalmology service ~ Keratoconus ~ Follow-up ~ Right 4(1)

A girl was referred to the DHB's ophthalmology service to assess an unexplained reduction in visual acuity of both eyes. At her first specialist appointment (FSA) she was diagnosed with possible early Frust form keratoconus (progressive thinning of the cornea). The girl was scheduled for a follow-up appointment in a year, however this did not occur. A year after the appointment was to have occurred the DHB sent two letters to the girl to arrange an appointment, but these were not received.

The DHB told HDC the delay in providing the 12-month follow up appointment was caused by the huge demand for the cornea service, and the limited anterior segment and contact lens service at the DHB.

At the time, the ophthalmology service used an electronic follow-up reporting system to capture overdue appointments. There were so many overdue follow-up appointments that all had the same clinical priority, it became extremely difficult to manage. There was no specific clinical acuity tool used at the time to assist prioritisation.

A year after the cancelled follow-up appointment, a letter was sent to the family outlining that an appointment had been made to see the ophthalmology team. This letter was not received. Another letter to the family was sent outlining that the appointment had been missed, and that the specialist had reviewed the notes and wanted them to make another appointment. The letter stated that if the DHB had not heard anything within 14 days, the girl's care could be discharged back to the family doctor. The family did not receive this letter, and the girl was discharged from the ophthalmology service.

Another referral was sent to the DHB. The DHB issued a letter to the girl's parents indicating that an appointment with the ophthalmology service had been made.

Two years and nine months after her FSA, the girl attended the ophthalmology clinic with her grandmother. The girl was diagnosed with bilateral keratoconus. Her right eye was very severe and was beyond crosslinking treatment.

Findings

It was held that the DHB failed to arrange a timely follow-up appointment in line with appropriate clinical timeframes and did not have an adequate prioritisation system for overdue follow-up specialist appointments. There were missed opportunities to identify and remedy the ongoing delay in the girl being seen for specialist follow-up. The DHB did not take sufficient account of potential clinical risks associated with heavy demand and a lack of capacity at the ophthalmology service, and did not take sufficient or adequate action to rectify the situation despite awareness of the issue. The DHB did not provide services with reasonable care and skill and, accordingly, breached Right 4(1).

The DHB was referred to the Director of Proceedings. The Director of Proceedings filed proceedings by consent against the DHB in the Human Rights Review Tribunal. The Tribunal issued a declaration that CMDHB breached Right 4(1) of the Code by failing to provide services with reasonable care and skill.

Recommendations
It was recommended that the DHB provide HDC with:

a) An independent evaluation of the systems in place to identify and prioritise overdue ophthalmology appointments.
b) An update on progress of the work done alongside the Ministry to track and monitor progress toward zero ophthalmology patients waiting beyond clinically appropriate time frames.
c) A report on the investigation into the iPM system shortcomings identified by this matter.

It was recommended that the DHB also provide a detailed update report on the steps taken that relate to the expert advisor's recommendations, those arising out of its own reviews, and its work alongside the Ministry of Health.

The DHB provided a formal written apology.