Patient Story

Author: Director of Safety and Risk Sponsor: Medical Director **Trust Board paper D**

Executive Summary

Context

1. Following the AQuA Trust Board session on the 1st and 2nd March 2016, it was agreed that the Director of Safety and Risk would bring patient stories quarterly to the Board which detailed a safety incident with the purpose of really hearing and understanding the human story behind it.

2. Today's video tells Christine's story. In September 2009, Christine underwent surgery under local anaesthetic to remove a basal cell carcinoma (BCC) in her nose. She subsequently developed a rare but recognised complication for which she needed to undergo an additional three surgical procedures.

Questions

1. Is the Trust seeking to hear the human stories behind incidents and complaints?
2. Is the Trust learning when things go wrong?
3. Have sufficient actions been identified and implemented since this patient safety incident?

Conclusion

1. The full impact of a safety incident on the patient is sometimes little understood by an organisation. This video, and the story behind it, seek to expose the patient's experience, anxieties and concerns as she underwent the process of corrective surgery and pursued a complaint and claim against the Trust.

Input Sought

Trust Board members are invited to watch this patient story video and discuss the issues raised. The Board is also asked to note the learning and actions detailed in the paper.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Not applicable
Integrated care in partnership with others	Yes
Enhanced delivery in research, innovation & ed'	Not applicable
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Yes
Financially sustainable NHS organisation	Yes
Enabled by excellent IM&T	Not applicable

2. This matter relates to the following governance initiatives:

Organisational Risk Register	No
Board Assurance Framework	Yes

3. Related Patient and Public Involvement actions taken, or to be taken: [Insert here]

4. Results of any Equality Impact Assessment, relating to this matter: [Insert here]

5. Scheduled date for the next paper on this topic: Quarterly

6. Executive Summaries should not exceed 1 page. My paper does comply

7. Papers should not exceed 7 pages. My paper does comply

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

REPORT BY: **DIRECTOR OF SAFETY AND RISK**

DATE: **1ST DECEMBER 2016**

SUBJECT: **PATIENT STORY**

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1. INTRODUCTION

1.1 Following the AQuA Trust Board session on the 1st and 2nd March 2016, it was agreed that the Director of Safety and Risk would bring patient stories quarterly to the Board which detailed a safety incident with the purpose of really hearing and understanding the human story behind it.

2. CHRISTINE'S STORY

2.1 Today's video tells Christine's story. In September 2009, Christine underwent surgery under local anaesthetic to remove a basal cell carcinoma (BCC) in her nose. She subsequently developed a rare but recognised complication for which she needed to undergo an additional three surgical procedures.

2.2 Christine tells of the impact that this incident has had on her life. She also describes how she was treated during her care and her reflections on this since it occurred.

2.3 Her dissatisfaction in her care led Christine to write a letter of complaint to the Trust. The handling of her complaint is also described in the video. Finally Christine pursued a claim against the Trust which was settled in 2013.

2.4 The principal issue is that no detailed information was given to Christine before she was prepared for the operation. Christine was already on the operating table when she was told that a wide area of tissue would have to be removed from her nose and that skin from her cheek may need to be stretched, or alternatively the procedure could be carried out using cartilage from her ear, but this would mean stopping the procedure and making a new appointment for surgery. Christine says she agreed to proceed despite some concerns because she was worried about wasting the clinicians' time.

2.5 Christine sent a letter of complaint to the Trust in May 2010 which was responded to on 14th May. The response accepted some failings in care and included various apologies from the Consultant Dermatologist, the nursing staff and the surgeon. A meeting was subsequently held in July 2010 with Christine and her husband. A review of the complaint handling reveals that the incident was fully investigated and that staff did engage with Christine and attempt to address some of her concerns. However the video describes that some of the apologies made were qualified and that the complaint process was not successful in addressing all of her concerns.

3. LEARNING AND ACTION POINTS

3.1 This patient story is rich in learning points, many of which have been addressed. Following this incident and complaint, the Trust has provided feedback to the nursing team who were asked to reflect on the incident and consider how they might be perceived by patients. In addition, workloads were reallocated to try and ensure that in such cases, the operative consultation is with a surgeon rather than a dermatologist so that patients can be informed in advance about what surgery might be required. A new patient information leaflet has been

produced and patients have subsequently been given the opportunity to request an additional appointment if they require further information or time to consider treatment options.

3.2 Since this incident the Trust has reviewed and strengthened the consent process to ensure that patients are provided with sufficient information on which to make informed decisions. The treatment options, risks of the procedure, alternatives and risks of no treatment are now better described and documented.

3.3 The statutory Duty of Candour regulation was introduced in 2014 and this requires Trusts to provide a full and frank apology to patients when things go wrong and to follow this up with a letter. The Trust is meeting the Duty of Candour Regulations.

3.4 Complaint handling has been centralised since this complaint was received with much more focus now on resolving patients' concerns and supporting them through the process. A project collaborating with colleagues from Leicester University has reviewed the 'quality of apology' provided in complaints letters. The evaluation of this is now informing better complaint responses, and as a consequence, a reduction in reopened complaints.

3.5 The relatively new NatSSIPs and LocSSIPs processes have been rolled out throughout the Trust which ensure that surgical and interventional procedures are properly implemented and governed.

3.6 Staff attitude, team dynamics and a 'patient first' approach have all been reviewed and considered in the relevant clinical area since this incident and complaint.

3.7 This video was filmed and produced by the NHS Litigation Authority with the purpose of learning and sharing patient stories relating to incidents, complaints and claims.

4. RECOMMENDATIONS

4.1 Trust Board members are invited to watch this patient story video and discuss the issues raised. The Board is also asked to note the learning and actions detailed in the paper.

Moira Durbridge,
Director of Safety and Risk
November 2016