Patient Story

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

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 Mrs. Ruth Astle is attending Trust Board herself to present her story. In April 2014 Ruth underwent a chest x-ray as an investigation during her admission to CDU at GH. Ruth was discharged from CDU by the cardiology team, with no reference made to the completion or findings of the chest x-ray report. The findings were not acted upon or followed up. Ruth presented to her GP in March 2016, two years later, and following chest x-ray and CT scan that showed a progression of a cancerous mass that had previously not been acted upon. Ruth was subsequently diagnosed with lung cancer.

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. The patient story behind it, seeks to expose the patient's experience, anxieties and concerns as she underwent the process of being told she had lung cancer had been missed earlier and her subsequent care and treatment.

Input Sought

Trust Board members are invited to listen to this patient story 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: **2nd MARCH 2017**

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. RUTH'S STORY

2.1 Today Mrs. Ruth Astle is attending Trust Board herself to present her story. In April 2014 Ruth underwent a chest x-ray as an investigation during her admission to CDU at GH. Ruth was discharged from CDU by the cardiology team, with no reference made to the completion or findings of the chest x-ray report. The findings were not acted upon or followed up on. Ruth presented to her GP in March 2016, two years later, and following a chest x-ray and CT scan the results showed a progression of a cancerous mass that had previously not been acted upon. Ruth was subsequently diagnosed with lung cancer.

2.2 Ruth will tell of the impact that this incident has had on her life. She will also describe how she was and is being treated during her care and her reflections on this since it occurred.

2.3 This incident was investigated as a Serious Incident within UHL, with Moira Durbridge, Director of Safety and Risk as the Chair for this investigation.

2.4 The principal issue was the failure to acknowledge and act upon the chest x-ray report. Root causes for this incident were identified as;

- Failure to review all requested investigations prior to discharge due to diagnosis bias and normalising reporting delays;
- Inconsistent approach to chest x-ray coding, referral and report sharing;
- Lack of a robust electronic system to flag abnormal results and identify when results have not been acknowledged.

2.5 The investigation acknowledged that alternative treatment options could have been identified if Mrs. Astle's lung cancer was diagnosed after her 2014 admission. It cannot be certain that this treatment would have been curative; however an earlier diagnosis could have provided alternative options and psychological support to Mrs. Astle, which sadly was delayed.

3. LEARNING AND ACTION POINTS

3.1 This patient story and incident investigation are rich in learning points, many of which have been addressed. Following this incident, the CMG revised the on call Consultant rota and changed the allocation system with the reviewing team also being the named team / Consultant to ensure follow up of results.

3.2 Since this incident, the Trust has implemented the EMRAD system which has the functionality of flagging abnormal results. This function however is not yet live.

3.3 The Respiratory Service has reviewed their local results management processes in line with the revised UHL policy.

3.4 The management of test results remains a key safety improvement priority to reduce harm and has been included in the proposed safety plan in the Quality Commitment for 2017/18.

4. RECOMMENDATIONS

4.1 Trust Board members are invited to listen to this patient story 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
March 2017