NHS
Maidstone and Tunbridge Wells
NHS Trust

NHS
West Kent
Clinical Commissioning Group

APPENDIX – SUPPORTING PATIENT STORIES

NOTE THESE ARE NOT BASED ON REAL PATIENTS BUT ARE ILLUSTRATIVE

How will this be different for patients? (1/2)

Mary, requiring elective excision of rectal cancer

Maidstone and Tunbridge Wells NHS Trust

NHS West Kent Clinical Commissioning Group

Before surgical reconfiguration,

Mary is a **78 year old woman** who has been **waiting for an operation** 'an anterior resection' for her rectal cancer. The **surgeon at Maidstone removes the diseased area of bowel laparoscopically and forms a temporary stoma** to protect the join in the bowel. The **surgery and recovery went well** and Mary is **discharged on the 5th post-operative day.**

At home Mary becomes **unwell and is re-admitted** to Tunbridge Wells Hospital where she is found to be in **renal failure due to de-hydration**. The **surgical team (not her original surgeon who is never made aware of her re-admission**) ask the physicians to look after her.

They correct her electrolytes and discharge her. After a few days Mary becomes **dehydrated again and is re-admitted again and again discharged** following fluid treatment. She becomes dehydrated for a third time. Fortunately, on this occasion the **surgeon who performed Mary's cancer surgery is on call at Tunbridge Wells**. The surgeon finds that Mary has been admitted and visits her on the ward. Immediately, the **surgeon diagnoses a 'high output stoma'** which requires careful management. By now Mary's renal function is very poor and she requires a **prolonged period of fluid therapy for her to be fit enough to safely undergo corrective surgery**.

The surgeon arranges for Mary to be **transferred back to Maidstone hospital for the stoma to be closed the following week**. Mary makes a good recovery and is discharged home to complete her recovery.

DISADVANTAGES OF CURRENT MODEL

- **Limited access to sub specialist opinion**
- **Unnecessary transfers across site from TWH to Maidstone**
- **Multiple admissions and discharges**
- **Multiple handovers, poor continuity of care**

How will this be different for patients? (2/2)

Mary, requiring elective excision of rectal cancer

NHS Maidstone and Tunbridge Wells NHS Trust

NHS West Kent Clinical Commissioning Group

After surgical reconfiguration

Mary is a **78 year old woman on the waiting list for and anterior resection for cancer**. The **surgeon at Maidstone removes the diseased area of bowel laparoscopically and forms a temporary stoma** to protect the join in the bowel. The **surgery and recovery went well** and Mary is **discharged on the 5th post-operative day**.

At home Mary becomes **unwell and is re-admitted to Tunbridge Wells Hospital where she is found to be in renal failure** due to de-hydration.

She is **referred back to the surgeon who performed Mary's cancer surgery**. They **instantly they diagnose a high output stoma and manage this in conjunction with the stoma nurses** using medication and diet to reduce the output.

Despite maximal intervention, the stoma output continues to be high and the **consultant arranges for the stoma to be closed later that week on his elective list** at Tunbridge Wells Hospital. Mary makes **a good recovery and is discharged home** to complete her recovery.

ADVANTAGES OF PROPOSED MODEL

- **Continuity of care under specialist**
- **Specialist opinion allows for rapid formulation of appropriate multi disciplinary care plan**
- **Good multidisciplinary working**
- **Due to effective treatment with diet and medication although surgery is required it is not delayed due to the patients physical state**

How will this be different for patients? (1/2)

Maud presenting with acute cholecystitis

NHS Maidstone and Tunbridge Wells NHS Trust

NHS West Kent Clinical Commissioning Group

Before surgical reconfiguration,

Maud is a 59 year old woman who develops sudden pain in her upper abdomen. She is admitted to Tunbridge Wells Hospital one Saturday and is **diagnosed with gallstones leading to acute cholecystitis**. She is **treated with antibiotics and intravenous fluids**. She appears to be **making good progress and on Monday is handed over to the care of the "red" acute team**. The consultant covering this team is on annual leave and the patients are covered by a locum middle grade doctor. **Maud becomes increasingly unwell over the next few days, the middle grade arranges a scan which confirms an empyema** (a collection of pus trapped in the gallbladder). They **ask for advice from the on call surgeon who is a colorectal specialist.**

The **specialist advises asking the radiologists to place a drain, which successfully relieves the abscess**. Maud **recovers slowly and is discharged after 7 days** in hospital with the drain in situ.

She is **referred to an upper gastrointestinal surgeon who is able to see her in clinic 8 weeks later**. Maud has been in **pain from the drain all of this time**. The surgeon removes the drain and arranges for her to be put on the waiting list for elective cholecystectomy.

Whilst waiting for this procedure Maud is **readmitted as an emergency with further pain and fever which responds to antibiotics** this time but **necessitates a further 5 day hospital stay.**

She eventually **undergoes her operation 4 months after presentation**. This is successful and she makes a good recovery.

DISADVANTAGES OF CURRENT MODEL

- **Lack of specialist upper GI input into the cases from an early stage**
- **Delay in definitive treatment (discharged home with drain in situ) with a painful and prolonged wait for treatment**
- **Lack of options for definitive surgical treatment in a timely manner**

How will this be different for patients? (2/2)

Maud presenting with acute cholecystitis

NHS Maidstone and Tunbridge Wells NHS Trust

NHS West Kent Clinical Commissioning Group

After surgical reconfiguration

Maud is a **59 year old woman who develops sudden pain in her upper abdomen**. She is **admitted to Tunbridge Wells Hospital one Saturday and is diagnosed with gallstones leading to acute cholecystitis**. She is **treated with antibiotics and intravenous fluids**. She appears to be making good progress and on Monday is **handed over to the upper gastrointestinal team who have an emergency gallbladder operating list that day**.

Unfortunately, the list that day is already full but Maud is **placed on the "hot gallbladder" list for the following day**.

She undergoes an **"emergency" cholecystectomy performed by a senior trainee under the supervision of an experienced consultant**. The operations is a success and she is **discharged home the following day making a full recovery.**

ADVANTAGES OF PROPOSED MODEL

- **Care handed over straight to specialist upper GI team**
- **Availability of hot gallbladder lists provides immediate opportunity for definitive surgical treatment**
- **Rapid care and pain experienced by the patient is kept to a minimum**

How will this be different for patients? (1/2)

James presenting at Maidstone with Ulcerative Colitis

NHS Maidstone and Tunbridge Wells NHS Trust

Before surgical reconfiguration, without a Digestive Diseases Unit

James is a **48 year old man, with ulcerative colitis**, who has been under the long term care of a consultant gastroenterologists based at Maidstone Hospital. They have established a very good relationship over the years. He experiences a **flair up of his colitis and presents to the gastroenterology clinic.** James is **admitted to Maidstone hospital** and treatment with intravenous steroids and infliximab is started. On this occasion, James **does not respond well to the treatment** and becomes increasingly weak with his bowels opening up to 12 times a day and his albumin levels falling.

There are significant **delays in the gastroenterology team being able to obtain senior colorectal surgical opinion**. James is finally **seen on a Friday by a consultant colorectal surgeon, 10 days after his admission,** and needs to be **transferred to Tunbridge Wells Hospital for emergency surgery.**

On arrival at Tunbridge Wells Hospital the **surgical team on call, who are not colorectal specialists,** feel that James should wait for the colorectal team who will be taking over on Monday. However, on Sunday James becomes increasingly unwell with severe abdominal pain. He undergoes an **emergency laparotomy and colectomy.**

After surgery, James requires intensive care. Initially, he makes a good recovery and is returned to the ward. On the 5th post-operative day however, he **develops a wound infection requiring the wound to be opened**. He has a **large wound from the emergency surgery** and requires extensive wound management, intravenous antibiotics and the placement of a VAC dressing. He is eventually **discharged with the VAC in place which remains for a further 3 weeks**. **Throughout the admission at Tunbridge Wells he has not seen the gastroenterologist he knows or the surgical consultant who operated on him** on Sunday.

DISADVANTAGES OF CURRENT MODEL

- **Delay in referral from gastroenterologists to surgical team**
- **Extended stay in hospital waiting for plan**
- **Gaps in specialist cover**
- **The requirement for an emergency transfer from Maidstone to TWH**
- **Emergency operation required when condition worsens**
- **Unplanned surgery delays recovery**
- **Multiple handovers, poor continuity of care**

How will this be different for patients? (2/2)

James presenting at Maidstone with Ulcerative Colitis

NHS
Maidstone and Tunbridge Wells
NHS Trust

After surgical reconfiguration with a Digestive Diseases Unit

James is a **48 year old man, with ulcerative colitis**, who has been under the long term care of one of the consultant gastroenterologists based at Maidstone Hospital. They have established a very good relationship over the years. He experiences a **flair up of his colitis and presents to the gastroenterology clinic** and is **admitted to the digestive diseases unit at Tunbridge Wells Hospital.**

He remains under the care of the gastroenterologist that he knows , who commences treatment with intravenous steroids and infliximab. After 72 hours it is clear that James is **not responding as well as would be hoped**. The **gastroenterologist promptly involves one of the colorectal specialist consultant surgeons who visits James with the gastroenterologist**. They decide to closely watch and wait for another few days to see if things improve. They both keep him under close observation but by the 7th day of his admission it is **decided to perform surgery**. The consultant **surgeon re-arranges a case from his elective operating list** and is able to promptly perform an **"urgent" laparoscopic colectomy**.

James is returned to ITU. Initially, he makes a good recovery and is returned to the ward. **On the 5th post-operative day he develops a wound infection**. As the **operation was laparoscopic the wound is small** and management is relatively simple. James is able to go **home with antibiotics the following day**.

Throughout his admission the gastroenterologist and surgical consultant that James knows have been involved in his care every day.

ADVANTAGES OF DIGESTIVE DISEASES UNIT

- **Continuity of care under specialist**
- **Prompt care plan**
- **Good multidisciplinary specialist cover**
- **Urgent but planned elective operation pathway available to manage urgent conditions**
- **Laparoscopic planned surgery enhances recovery**
- **Reduced stay in hospital**