NHS

Edenbridge

Latest news on plans for a health and wellbeing centre

EDENBRIDGE MEMORIAL HEALTH CENTRE
CLINICAL OPERATING MODEL

21 September 2023

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Introduction

The vision for the exciting new Edenbridge Memorial Health Centre is an integrated care model delivered by Kent Community Health NHS Foundation Trust and Edenbridge Medical Practice bringing health, GP and community services together to support the local community. The clinical operational model was developed with local people and staff, and focusses on the needs of the local population, with the ambition to create a health and wellbeing hub for people to receive care and advice, close to home.

When the new Edenbridge Memorial Health Centre opens it will offer a range of services incorporating general practice alongside a wellbeing day centre, proactive frailty unit, same-day urgent care services and a range of outpatient clinics. This is the start of a new journey for healthcare in Edenbridge and we will continue to develop services as needs change.

Population Profile

- 13,138 local population
- One GP surgery with 95% of the local population registered there
- Average age = 42.5 years-old with male life expectancy of 81.8 years-old and female life expectancy of 85.4 years-old
- 36% of people have one or more long-term health conditions – main conditions being hypertension, depression, diabetes and asthma
- More than 120 babies born each year to Edenbridge families and 3,000 children and young people live in Edenbridge
- A growing older population, most people in Edenbridge are aged between 55 and 64
- There are areas of Edenbridge which are deprived and this has been taken into consideration when developing the provision

Target groups

For families, there will be services to support your children from birth to adulthood

Services are expanding to provide for children's needs which would reduce travelling for Edenbridge residents who use existing services elsewhere. Maternity services are already provided and will be complemented with ante-natal new-birth clinics provided by our Health Visiting Service.

For older people,

We will support you to stay independent and well at home, the town has a population that is getting older with a high percentage of people between 55 and 64-years-old. We know as people age they can become frail and need extra support.

The development of a community hub links key services together to provide a proactive frailty model that optimises the ability to work closely with GPs, with on-site assessments as part of a joined-up community response linking in with rapid response, complex care and community nursing teams, including home with support. Services will work collaboratively, using the benefits of having a wellbeing day centre and health and wellbeing team, working together to wrap care, support and education around people and their families and carers to keep people well for longer. The potential for falls prevention clinics at the wellbeing day centre will provide extra support, enabling people to safely remain in their own homes, recognising this is also an indicator for future needs. Wound care clinics will be delivered to provide a more comprehensive service that improves wound healing and support for non-housebound people, which is currently provided by the GPs, community nursing and minor injury teams.

For people who need support and connection to their community,

the hub will support more than just physical wellbeing. The wellbeing day centre, which provides support and signposting to people with frailty and dementia and respite for their carers, will expand to six days-a-week. As it develops, the centre will offer social prescribing to help tackle loneliness, depression and anxiety. Collaborative working with Sevenoaks Borough Council, will lead to the development of a more integrated offer for housing, wellbeing and local voluntary providers. Our intention is, when not being used for clinics, the space will be available for community groups to meet where there is a health benefit to be gained. This wider wellbeing approach will be led by a social value coordinator, who will work with local groups to provide more health and wellbeing offers, building on and working with the existing Eden Centre facilities.

OPERATIONAL OVERSIGHT

Service Provision

Many existing services provided at the Edenbridge Memorial Hospital and the GP practice are transferring with some expanding and others being new. The clinical model in summary will provide:

- Full primary care service
- Transfer of existing outpatient clinics: Dermatology, ear, nose and throat (ENT), Midwifery pre-natal support, Orthopaedics, Parkinson's, Psychiatry, Heart failure, Podiatry, Physiotherapy
- Phlebotomy
- Wellbeing day centre with extended opening times
- Catering facility to serve the wellbeing day centre and people using our services.
- Change of minor injury provision to same day urgent care offer linked in with primary care surgery provision
- Proactive frailty model (Ambulatory care) providing support for people who have fallen, continence and comprehensive geriatric assessments to develop plans of care as part of our community response including rapid response, complex care and community nursing
- Frequent service user service to support people's complex health and wider need, reducing the reliance on emergency care
- Expansion of outpatients to include Children's therapies, community paediatrician and new birth clinics that are currently provided elsewhere and require Edenbridge residents to travel
- New clinics including ultrasound
- Wound care provision with the vision to become a centre of excellence for all wound types supporting non-house bound population
- Social value provision allowing local community groups to use space where it supports a person's health and wellbeing
- Voluntary drivers service under contract

What will be provided in the new health centre	Existing	Expanding	New
A new, purpose-built health centre, providing general practice services and:			
• Dermatology	✓		
• Ear, nose and throat	✓		
• Midwifery – pre-natal clinics	✓		
• Minor injuries service, Monday to Friday	✓		
• Orthopaedics	✓		
• Parkinson's assessments and reviews	✓		
• Rheumatology	✓		
• Psychiatry	✓		
Community services for children and families, including:			
• Children's therapies – such as speech and language and physiotherapy		✓	
• Community paediatrics – support for children with ADHD, autism, cerebral palsy and muscular dystrophy		✓	
• Looked after children's services	✓		
• School health – a counselling support group for young people	✓		
Community services for adults, including:			
• Community neuro rehabilitation – support for people after suffering a stroke or traumatic brain injury, multiple sclerosis (MS), Parkinson's or motor neurone disease		✓	
• Community nursing	✓		
• Community rehabilitation – supporting people to stay independent	✓		
• Continence service		✓	
• Dementia day centre		✓	
• Dietetics			✓
• Falls prevention service			✓
• Frailty – a rapid assessment and care planning service for vulnerable, older people			✓
• Heart failure clinic	✓		
• Learning disabilities – preventative health checks, counselling, education and family support services			✓
• Phlebotomy – blood testing	✓		
• Podiatry	✓		
• Physiotherapy	✓		
• Wound care clinics			✓
• Ultrasound			✓
Additional services that may be available at the health and wellbeing centre:			
• Bookable space to be used by the public and community groups			✓
• Kitchen facility for hot food and drinks			✓
• Children's assessments – such as newborn checks			✓
• Health and wellbeing support, including health checks and other One You services			✓
• Free car parking			✓

Key roles

Site manager

The site manager will have overall responsibility for site management including compliance with standard statutory healthcare requirements e.g. health and safety, infection control and estates management. They will provide operational management and clinical supervision for all KCHFT staff and work collaboratively with the GP practice. A key impact is the collaborative work across providers and pathways to embed new ways of working, and deliver seamless, high quality patient care. They will be a role model to staff in developing a 'one team' approach to integrated services.

Darzi Fellow

The Darzi Fellow will support the ongoing journey of development during the first year of operation. They will be focused on improving patient care and transforming community services to meet the future needs of our changing population. The purpose of this post is to provide an objective review of new and innovative ambulatory pathways of care in Edenbridge, working with the GPs and community teams and in partnership with local people. This post will support embedding the new clinical model, while identifying learning that can be applied across all our services to improve the patient experience. This post will be in place for 12 months, commencing September 2023.

Social Value coordinator

The aim of this post is to optimise the local community response and infrastructure to support the health and wellbeing of local people. The coordinator will reach out to work with community groups, developing support networks and linking in with health and wellbeing provision, including NHS health checks and other One You services.

Administration/Business management

The administration team are fundamental to the efficient and effective working of all services and will be pivotal in developing the one team approach. Whilst existing administrators will focus on their primary role and be managed by separate organisations we are aiming to develop a spirit of collaboration and peer support. In support of the aspiration, the GP business manager will have operational oversight of the reception and core shared administration upstairs space. They will work closely with the site manager.

Meet and Greet

Administration staff will be part of a rota to provide a meet and greet service for users of the health centre to make people are signposted to the right person and zone. They will be instrumental in flow management and act as a point of contact for patients and visitors entering the site. They will have a range of key tasks that may include:

- Greet and welcome patients and visitors
- Ensuring infection prevention and control guidance is being followed, such as using hand gel or face masks
- Providing clear and accurate directional information and escorting if necessary
- Supporting people to register their attendance
- Distributing patient leaflets
- Ensure public facing signage and communication in regards waiting times is updated
- Working with the site team to promote positive patient experience.

Edenbridge Voluntary Transport Service support

Significant feedback has been received on the transport challenges in the area, both from the residents and staff. We are working in collaboration with the Edenbridge Voluntary Transport Service to contract with them on providing a bespoke transport service. We are actively working with the service on a recruitment campaign so they can provide support to people who have difficulty finding transport to Doctors' Surgery or clinic appointments. They are a registered charity independent of the NHS relying on donations from passengers and others to keep our service running. We are aiming to develop the transport offer in preparation for the new centre's opening.

CLINICAL MODEL

The clinical model has been designed building on six key components being:

Frailty and Proactive Care Including West Kent Enhanced with Support

The British Geriatrics Society defines frailty as “a long-term condition in which multiple body systems gradually lose their in-built reserves, resulting in an increased risk of unpredictable deterioration from minor events. The consequences of escalating frailty are adverse outcomes such as disability and its consequences, frequent hospital admissions and increasing demand for long-term social care support.”

The innovative approach for Edenbridge is to bring a range of services together to offer a frailty and proactive care model that builds and expands existing provision to a more comprehensive and cohesive model to ensure early intervention and reduce hospital admissions.

Clinical offer	**Frailty and proactive care**
Model description	
The Edenbridge Frailty and Proactive Care model will provide an integrated service to the local community, delivering the best possible treatment and outcome following holistic clinical assessment, diagnosis and treatment. It will deliver a trusted shared working environment across the system to ensure there is efficiency regarding right person and right place, and a reduction in duplication based on trusted decision making. The purpose of the service is to keep people living with frailty well and living at home. The aim is to provide the right care, at the time when it is needed. An ambition is to recognise people who may be becoming frailer, help them to manage this as far as possible and help those people and their families/carers to plan for the future. The Frailty service, utilising the resources and dedicated clinical space within the health centre, would be operational across all 7 days of the week, providing planning and advanced care planning to support people when their needs change or when a crisis occurs, and enabling early supported discharge from acute and community hospitals. The service will provide treatment at: • Patients home linking with complex care and West Kent Urgent Care Home Treatment Service. These teams can provide hospital-level care in people’s homes when in line with a person’s goals and when the risks & benefits of hospital admission have been explored for them personally. • Clinic/frailty hub for proactive assessment and advance care planning • Clinic/frailty hub as part of crisis support including diagnostics, assessment and treatment planning (this may be completed at home by the Complex Care Nurse or West Kent Urgent Care Home Treatment Service if required to avoid an admission) • Wellbeing day centre short term intervention for on-going assessment, monitoring, education and treatment. This includes social interaction, exercise, therapy, nutrition, social care review and support	

The service will work in collaboration with the Wellbeing Day Centre; with support from community multidisciplinary teams (including Complex Care, Home Treatment, Rapid Response and Rehabilitation services); and work closely with GPs Primary Care, Integrated Community Teams, and Social Services. The development of the model would provide increased resources to build resilience into established services and to enable flexibility and responsiveness.

There has been a significant increase in services that can provide treatment at home, including virtual wards however there are challenges in matching clinical services with practical care. This home with support component will increase care at home, integrating it with existing services is to provide at least the equivalent mitigation of inpatient beds; reducing the days our patients spend away from home and releasing resources to deliver more proactive care in our community.

The new service will give the ability to provide personal care for admission avoidance and to support increased supported discharges at home being aligned to patient led, therapy supported enablement. The home treatment service capacity will provide personal care/ enablement services that will enable patients to avoid admission to a hospital and stay at home without increasing demands on domiciliary care.

The Proactive Frailty Unit within the Health Centre will provide:

Rapid and proactive assessment:

- Clinical, nursing and therapy assessment (including a Comprehensive Geriatric Assessment)
- Simple diagnostics (point of care testing such as bloods and ECGs)
- Multidisciplinary plan of care

Home with Support:

- Workforce enabling personal care/enablement at home
- Enablement and therapy support
- Early Supported Discharge

Immediate intervention:

- Wellbeing Day Centre support with signposting, education, carers assessments and crisis avoidance
- Clinical intervention delivered through the unit in conjunction with Community services
- Therapy rehabilitation delivered within the Wellbeing Day Centre including equipment assessment and provision
- Technology support (e.g. Virtual Ward)

The service will support older people who are frail, after a fall or if they have continence issues to support better diagnosis and management. Specific deliverables would be provision of:

- Proactive assessment including advanced care planning
- Continence service
- Falls prevention service
- Frailty – a rapid assessment and care planning service for vulnerable, older people
- Care at home preventing hospital admission

Criteria

KCHFT definition of frailty is: A person with multiple, complex needs, at risk of developing adverse outcomes such as dramatic changes in their physical and mental well-being, after even an apparently minor event which may compromise their health. The majority of people living with frailty will be over 70

The GP register will be used to identify individuals to support advanced care planning allowing for a more comprehensive and planned response should the persons needs change and risk compromising their health.

Services will work to establish an agreed definition of housebound care and therefore eligible cohort

4 points of entry into the service being from Home Treatment service, Proactive case finding from primary care or other source, frequent service user and those identified as frail discussed at fortnightly MDT in place with local primary care.

Outcomes

The model will deliver improved patient outcomes and experience, a reduction in emergency hospital attendance, admission and length of stay. Fewer patients are admitted where there is an alternative management option which reduces the overall numbers of patients requiring a hospital bed.

Expected Measurables:

- Number of people safely managed at home who would normally need hospital admission
- Number and impact of advanced care plans
- Clinical outcomes and patient stories
- Patient experience
- The correct level of staff attending patients to ensure hub model is working for patient/clinician/family

<table>
<tr><td colspan="5">Collaborative working will create an environment of trusted decision making to reduce duplication (e.g. multiple triage processes) and improve efficiency to achieve:
Shared competencies
Shared governance
Shared responsibility
Shared working
Robust MDT meetings
Shared learning of supporting services e.g. SeCAMB, MTW, KMPT, Social Care</td></tr>
<tr><td>Operating Hours</td><td>7 days per week
08:00 – 18:00 hours</td><td></td><td>Staffing</td><td>Embedded as an addition to existing teams:

Complex care nurse
ACP in Home Treatment service
HCA home with support
Healthcare coordinator/planner
Therapist practitioner
Therapist (MDT/Rapids)
Admin support
Darzi Fellow</td></tr>
</table>

Health and Wellbeing Services

Clinical offer	Health and Wellbeing Services
Model description	
Providing a one stop shop wrap around team who will support people, patients, carers who have social, health or wellbeing needs with the aim of enabling them to achieve/address what's important to them. This will be part of the one you service and utilise the one you branding. One You advisors work with people for up to one year to support you to make meaningful changes to your lifestyle, including: • Eating healthily and losing weight • Getting more exercise • Drinking less alcohol • Having a better mental wellbeing • Falls prevention education/classes. The provision will link with existing community groups and activities including those delivered at the Eden Centre to optimise a range of options for a person to support their health and wellbeing. The wellbeing service will support other healthcare teams in adopting Making Every Contact Count (MECC) approach to behaviour change that enables the opportunistic delivery of consistent and concise healthy lifestyle information to support people in making positive changes to their physical and mental health and wellbeing. The focus for a MECC brief intervention might be on individuals losing weight, quitting smoking, reducing alcohol intake, or helping to reduce social isolation. MECC includes short signposting conversations to help people to access more active interventions such as stop smoking services. The one team approach at Edenbridge is aimed at reducing referrals and more into helping the person access all services that are right for them, this includes areas such as the wellbeing day centre, introduction to groups run in the Eden centre, assessment by appropriate health clinician including GP and frequent service user lead. Interventions are normally for a maximum of 12 weeks support involving 1:1 and group work via telephone, face to face or via zoom/teams	
Criteria	
Those who want a boost to their motivation or kick-start to some lifestyle changes or help to regain independence, manage everyday situations and boost their wellbeing if living with a long-term condition.	

Weight loss programme: 30-40 BMI, BAME patients 27.5-40 BMI

The support is open to anyone over 18 years old and can self-refer or be connected to the support via GP or other healthcare professional

Exclusion criteria – Outside of the BMI above:

- Clients with a BMI 40+ require one of the above conditions (attached above) required to go to Tier 3 services.
- Clients with a BMI of 50+ would require Tier 3 services no matter how many conditions they have.
- Individuals from Minority Ethnic Communities would require these criteria to begin at earlier BMI's (2.5 lower)

Signposted on or work with GP:

- Pregnancy/still Breast-feeding 6 months following birth – refer to Midwife pathway.
- Previous Gastric Surgery – refer to clinical team support post-surgery
- Eating Disorders – should go to the Kent and Medway eating disorder service.
- Type 1 Diabetics – Discuss with GP
- Unexplained Weight Loss – 5% in the last 6 months – discuss with GP

Expected that a one you adviser will be onsite Monday to Friday.

Outcomes

Key metrics may include

- Reduction in weight and BMI
- Improved physical fitness and activity levels
- Improved mental health
- Patient experience
- Number of fall prevention interventions/classes provided

A range of tools and self-assessment are available to people on the One You app.

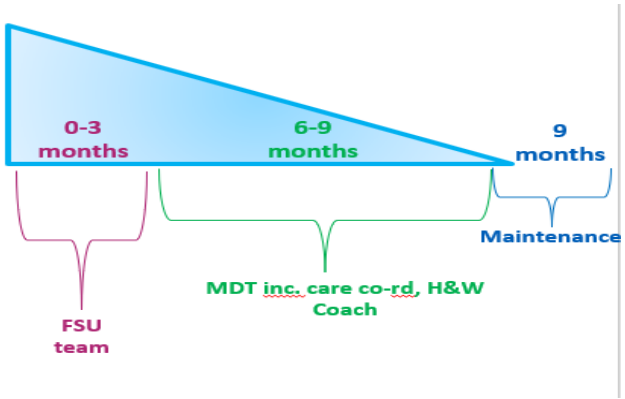
Operating Hours	Monday to Friday 09:00 – 17:00 Occasional weekends Groups and activities may run outside these hours		**Staffing**	Admin support: Behaviour change Health lifestyle advisor Social value coordinator

Frequent Service User

Clinical offer	Frequent service user
Model description	

A Service to help people who have been contacting their GP surgery or visiting A&E more frequently over the past few months. The services can help identify concerns and aims to find solutions to help people to stay well and become less reliant on urgent care services.

The service takes a MDT approach in the locality to include resources and support from care co-Ordinator, health and wellbeing lifestyle coach and social prescriber.



A Step up and then down model is used taking on average 0-9 months to get a person to 'maintenance' stage. Initially intense support usually 1:1 for approximately 0-3 months then gradually working to 'maintenance' status. 1:1 activity normally undertaken in the home or agreed suitable place e.g. café, wellbeing day centre or other location – not the centre itself necessarily. The approach to step-down includes group sessions held within the wellbeing day centre and/or Eden centre. There will be close relationship with the wellbeing service and behavioural change champion to support a person help to regain independence, manage everyday situations and boost their wellbeing

A range of elements are provided such as:

- being at the end of the phone if a person needs to talk
- guiding people through housing problems linking with local counsel and support functions held at the Eden centre
- linking people to support groups, other people or services, for example a local support or health group
- introducing people to an activity or group they may like to join with close links to the wellbeing service

- giving advice on health or social worries and talking through ways to solve problems
- understanding letters, for example benefits letters
- attending health appointments and work meetings with the person
- talking to their family, GP and other healthcare professionals to provide education and coping strategies

Criteria

People who have been contacting their GP surgery or visiting A&E more frequently over the past few months.

Service focus is for the top 5 % of people identified by GP practice who would benefit from FSU 'intervention'

All people able to self-refer back into the service, therefore never discharged as classed as 'maintenance' status.

Exclusion criteria – End of life and Dementia

Outcomes

Client reported documentation to assess improvement:

- GAD7
- EQ5D
- Loneliness questionnaire
- Numbers of people supported
- Reduction in GP consultations with clients

			Staffing	Frequent service user: Non-clinical, life experience, right attitude and approach to working with complex people, solution focussed. Would take approximately 3 months to 'train' someone by working with/shadowing existing team. Supervision and support/line management provided by existing frequent user central team.

Outpatients

Clinical offer	Outpatients
Model description	
Outpatients has a range of existing clinics provided by KCHFT services, MTW and Sussex Dermatology. Nursing support is provided on rotation between Sevenoaks and Edenbridge.Clinical supervision and leadership will be provided by clinical lead who will have oversight of all clinics, building relationships and optimising the benefits of having services provided at Edenbridge to improve patient access and urgent / MDT advice and support. Clinics scheduled over a 5-week period with further capacity to grow. Planned activity is dependent on each clinic and the agreed schedule based on demand. Clinic preparation of patient notes, ensuring results are available, equipment etc will be managed by the administration team. We are working with acute providers as it is hoped that additional clinics will be able to be provided to meet local needs such as diabetes clinics that work collaboratively with the wellbeing service, frailty team and GP to optimise outcomes and support for people to management their long-term condition.	
Outcomes	
Development of further outpatient clinics would enable improved access for the local population. Vision to create a gold standard for the local population to management of long-term conditions such as diabetes including all annual diabetes checks undertaken in one day in the same location to maximise efficiency of clinicians and making appointments easier for patients and reduces the amount of appointments required. This could include Eye check, Diabetic foot clinic, Diabetic specialist nurse, Education programmes/assessments Individual service measure impact and clinical outcomes Patient satisfaction Reduced travel Range of long-term needs meet	

Wellbeing Day Centre

Clinical offer	Wellbeing day centre
Model description	
Providing a one stop shop wrap around team who will support people, patients, carers who have social, health or wellbeing needs with the aim of enabling them to achieve/address what's important to them. The centre will provide a broad range of holistic services to support the health and wellbeing of people in the local community especially those with dementia or who are frail. The model of care will support people of all ages to live well with their health conditions, focussing upon health and social care interventions to promote and enable prevention, self-management, and health optimisation. This will be achieved by a focus on social interaction and activity with comprehensive basic health assessment to support management of long-term conditions or specialist advice. Wellbeing advice will support frailty or those with a diagnosis of dementia, to promote optimisation and reduce deconditioning. This includes signposting and advice for patients and families, and social interaction including activities and seated exercises. The day centre provides care for people with dementia offering clinical assessment, interaction and activities. The centre will expand to six operational days including Saturday. Whilst the focus will be to support people with dementia it would also be used for: • Frailty short term intervention for on-going assessment, monitoring, education and treatment • Wellbeing and lifestyle sessions including groups and educational sessions including frequent service user • Support with signposting, education, carers assessments and crisis avoidance • Therapy rehabilitation including equipment assessment and provision The centre over time will expand the provision to include more clinical services such as therapy, dietetics and podiatry for those visiting the centre. The room when opened will provide 81m^2 of functional space for groups and training. Clinics will provide for up to 10-12 people at any time reducing to 6-8 people on days that support people more complex dementia needs. 2 sessions per day being am: 09:30 – 2:00 including lunch for all those attending, pm: 14:30 – 17:00. 2 morning sessions will be ringfenced to facilitate rapid access for people requiring timely assessment or support.	

Indicative Wellebing day centre weekly schedule								
		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Am	09:30- 14:00	Dementia/Frailty	Advanced Dementia	Dementia/Frailty	Dementia/Frailty	Condition specific	Wellbeing	
	Attendees	12	8	12	12	12	6	
	Staffing level	4	5	4	4	4	2	
PM	14:30 - 17:00	Wellbeing/health checks	Frailty	Education session	Wellbeing/health checks	Condition specific		
	Attendees	10	8	10	10	10		
	Staffing level	4	5	4	4	4		

The sessions will be run by an assistant practitioner and health activities lead who are dedicated staffing for the day centre. They will be supported by healthcare assistants, volunteers and a therapist. Clinical oversight and supervision will be provided by the site clinical lead who will flex resources across outpatients and the Day centre based on needs at the time ensure clinical outcomes and safety of the clients.

All sessions will be provided with regular refreshments from the kitchen.

Activities will vary each day and may include:

- Arts and crafts based
- Quiz and board games
- Exercise including chair bound exercises
- Music and signing
- Staff lead education sessions
- Pet therapy (one per week)
- Use of the Memorial garden subject to assessment of need and risk with appropriate levels of supervision at all times

People will be monitored with monthly/weekly checks of BP, MUST, health lifestyle questionnaire and have a care plan that support treatment plan and anticipated outcomes

Changes in a person functionality will be highlighted to relevant healthcare professional / GP for advice and updating of treatment plan including any additional interventions or review such as the frailty team.

Therapy and other specialist intervention will be provided by existing services who will in-reach to the day centre to provide support with specific therapy resource from the rapid response team. People regularly attending the wound or other clinics may be allocated to the day centre to help reduce social isolation and support on-going treatment on the same day.

Volunteers including support from local schools will be used to support activities and provide the benefits that an all age community support can offer. The social value coordinator will explore links with the Edenbridge U3A.

Transport where needed will ideally be provided by the Edenbridge Voluntary Transport Services with the ambition that a regular voluntary supports the same person on a regular basis thereby allowing consistency of support and the benefits that they will be able to identify changes in a person's condition outside of the day centre e.g. mobility, ability to cope at home. Transport will be book and planned in advanced supported by a dedicated administrator who will support liaison with the drivers.

To support health needs including mobility and continence issues the staff ratio has been increased with the following staff ratio in place:

- Non-complex days: maximum 12 people : 4 staff
- Complex days: maximum 8 people : 5 staff
- In addition, support is available from the floating HCA within outpatients, the therapist for part of the day and the clinical lead

The therapy room will be used for 1:1 session, assessment, treatment where required and a quiet space.

Criteria

People who are or require support to manage their needs:

- Pre-frail
- Living well with dementia/frailty
- Dementia
- General health and wellbeing support
- Long term health conditions/needs
- Family respite
- Frequent service users
- Health education groups
- Social isolation

Connecting and allocating space at the wellbeing centre will be a collaborative approach with the services based at Edenbridge Memorial health centre to reduce delays in accessing the support e.g. frailty team will directly allocate a person to attend to support the management of their crisis.

Attendance will be a mixed model with some static and some rotational for an initial period of up to 4 months followed by review sessions and periodically check for deterioration and support requirements

<table>
<tr><td colspan="5">Outcomes</td></tr>
<tr><td colspan="5">

Monitoring and supporting nutrition and hydration needs for vulnerable clients
Monitoring health condition and identify signs of change
Wellbeing advice to support frailty or those with a diagnosis of dementia, to promote optimisation and reduce deconditioning
Care and treatment plan to identify outcomes that are what the person wants to achieve
Achievement of health outcomes and care plan
Therapy assessments
Podiatry assessments and interventions
flu jabs, vision and hearing supporting GP access

</td></tr>
<tr><td>Operating Hours</td><td>The centre will operate Monday to Friday
09:30 – 17:00 with staff on site from 09:00 – 17:30
Saturday sessions will be 09:00 – 12:30</td><td></td><td>Staffing</td><td>Health activities:
Assistant practitioner
HCA
Therapist
Clinical lead/supervision
Voluntary Transport admin support:
Darzi Fellow</td></tr>
</table>

Wound Care Centre

Clinical offer	Wound care centre
Model description	
The Wound Centre is a nurse led unit comprising of registered and unregistered nurses whose role will be to undertake key wound management interventions and identify required outcomes for individual patients in order to promote and drive a high-quality outcomes and healing. Robust and standardised care pathways and treatment plans will be used to facilitate complex wound healing that are flexible to ensure any care is tailored to individual patient requirements leading to improved patient outcomes and satisfaction. Regular review of assessment, clinical intervention and healing rates to ensure treatment plans are affective. Patients will be given an appointment time/date and patient transport provided if required via telephone at time of triage. Domiciliary visits will be arranged if appropriate and this allocated to the correct Health Care professional within the community nursing team. Patients with complex wounds will remain on the pathway indefinitely providing healing is maintained and patients are compliant in support of treatment regime. New patients will be assessed over the first 2 week appointments and then allocated to a monthly clinic with an expected discharge date of 6-7 months. MDT review for those patients whose wounds are not healing for longer term management and control/stabilise or referral for further surgical or vascular advice. All patients accessing care in the wound centre will be provided with relevant wound care information to support self-management between visits and following discharge from the centre e.g. skin care; leg ulcer care/after care. The Wound Centre will have a minimum of 1 member of staff on each day covering two clinic chairs for patients that are booked in. This will be a registered practitioner and nurse associate. Additional support can be provided by the HCA supporting same day urgent care if required. Where no clinic is operational the staff will support ambulatory care provision including catheter care, IV provision and PICC line management either in clinic or domiciliary supporting the district nurse team Appointments for non-complex wounds will be 15-minute slots and complex wounds, lower limb assessments will be up to 1 hour. Each clinic session will include 30 minutes for clinical handover. Clinics will be booked 6 weeks in advance. ½ day per week will be allocated to assessment, care / treatment plan and triage.	

The centre has direct access to tissue viability specialists one day a week who will support complex wound management and provide clinical oversight and supervision for staff. In addition, the Tissue Viability specialists will be available for clinical advice and use MS teams to support remote assessment.

The wound centre will work alongside other services seeking share care and supervision:

- podiatry service for lower limb and foot care management
- vascular for complex vascular and reduced mobility management plan
- Lymphoedema for joint assessment for wraps and hosiery

Documentation on complex wounds will be completed on wound matrix system and non-complex sing session dressings on EMIS or same day urgent care system. A range of clinical assessment tools will be used in line with the Trust wound centre management standard operating protocol. This includes doppler purpose T, SSKIN, MUST and observations covering TPR, BP, O2 saturation, infection makers

A base stock of first choice dressings will be available in the wound centre via a ONPOS delivery system to support a change in clinical presentation requiring a different dressing regime. Clinical stores will be also obtained via NHS Supplies. The wound dressing formulary will be used for all wound types.

Staff will need to be Non-medical prescribers or have access to prescribers from the urgent care team to cover antibiotics for infected wounds, steroid creams and hosiery.

The Wound Centre will facilitate support of competencies within community nursing team and GP practice nurses.

Criteria

Wounds for all age above 1 year, both acute and chronic being:

- Follow-up dressing following acute trauma, cut initially assessed by the same day urgent care team
- Post-surgical wounds
- Non-healing, hard to heal wounds
- Varicose Eczema (undiagnosed)
- Complex wounds including complex non-healing post-surgical wounds
- VAC, SKIN grafts. Lymphoedema with wounds, vascular involvement
- Doppler assessments to support diagnosis and on-going management

All house bound patients 18 years and above, that require assistance to leave their home either by family support, Voluntary Transport or Hospital Transport will be triaged for acceptance into the Wound Centre

Exclusion Criteria:

- Patients with new traumatic wounds not assessed or treated by same day urgent care or A&E.
- Acute burns that will be managed by the same day urgent care team or referred to specialist centre

Outcomes

When out coming appointments the Healthcare Professional will allocate activities to evidence procedures carried out within appointment and impact.

1. Promoting Self care
2. Dietary Advice
3. Education/Training
4. Wound healing rates (assessed within wound matrix)
5. Infection marker – point of care testing
6. Patient satisfaction
7. Extend frequency of dressings – weekly opposed to daily
8. Reduce costs associated with dressings, clinical time and improved healing rate
9. Right dressing provided in right timeframe
10. Regular reviews
11. Supportive student environment for wound management, holistic assessment building competency and confidence
12. Adherence to wound dressing formulary

Operating Hours	3 - 4 days per week including Saturdays based on demand 08:30 – 16:30 with last appointment at 16:00		**Staffing**	Nurse Nurse Associate TVN supervision Darzi Fellow Competency Level 4 in all aspects of Wound Care and have completed the University of Kent Advanced Wound Management Module or equivalent academic course

GP services

Clinical offer	GP Services
Model description	
The new GP surgery will continue to offer face-to-face, phone and video appointments for patients, giving the patient the choice of how they want to access their doctor. The practice will have sufficient capacity with 11 consultation rooms, 2 nurse consultation rooms and a treatment room. On-line e-consult consultation service Range of services via the Patient Access GP services on-line for repeat prescriptions, view medical record, change your address, send secure message to the GP practice, view results The team of practice nurses offer appointments for: • Chronic disease clinics • Well person screening • Child immunisation • Adult immunisation • Antenatal care • Cervical cytology and well woman • Clinics for diabetes, asthma, COPD, coronary heart disease and epilepsy • Hypertension • Phlebotomy The following services are provided by the doctors: • GP consultation and treatment • LD checks • ARRS roles eg clinical pharmacist, nurse practitioner, GP assistant, FCP, physician associate, pharmacy technician • Minor surgery • Care home reviews • Child health surveillance • Family planning – This is run by family planning association trained nurses with the doctors and covers all aspects of family planning including caps and coils. • Health promotion	

<table>
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Telephone and electronic consultations: Calls taken in before 12noon will usually be answered by 4pm; after 12 noon they may not be answered until the following day.
Home visits: Patients should come to the surgery if possible. If people are housebound or very ill and unable to get to the surgery they can telephone the surgery between 8.30am and 10.30am. A doctor or nurse may telephone initially. Children can be brought to the surgery in a car if they are feverish. If the child has a possible infectious disease, the receptionist will arrange for them to be seated separately.
Repeat prescriptions

</td></tr>
<tr><td colspan="5">Criteria</td></tr>
<tr><td colspan="5">Primary care GP services open to registered patients</td></tr>
<tr><td colspan="5">Outcomes</td></tr>
<tr><td colspan="5">Clinical management of health and wellbeing needs</td></tr>
<tr><td>Operating Hours</td><td>Monday to Friday
08:00 – 18:00

Enhanced Access for out of hours GP appointments available on Tuesday and Thursday evenings and a Wednesday morning. Out of hour Nurses appointments on Tuesday and Wednesday morning and Thursday evenings</td><td></td><td>Staffing</td><td>GP x 12
Practice Nurse x 2
Advanced Nurse Practitioners x 2
Health care assistants x 2
Practice Manager x 1
Administration, finance and reception
Darzi Fellow</td></tr>
</table>

SERVICES:

Reception and Office:

Clinical offer	Reception and office
Model description	
Reception staff are responsible for supporting booking and check in for all EMHC services. The reception will be staffed by joint personnel from both GP and KCHFT to provide reception support for all areas of the building. IT and booking systems will at present remain separate with staff having access to both systems. Shared working protocols and operational agreements are to be developed as the site becomes operational and clinic practices are established. The administration team are fundamental to the efficient and effective working of all services and will be fundamental in developing the one team approach. Whilst existing administrators will focus on their primary role and be managed by separate organisations we are aiming to develop a spirit of collaboration and peer support. In support of the aspiration, the GP business manager will have operational oversight of the reception and core shared administration upstairs space. They will work closely with the site manager. **Meet and Greet** Administration staff will be part of a rota to provide a meet and greet service for users of the health centre to ensure people are signposted to the right person and zone within the health care. They will be instrumental in flow management and act as a point of contact for patients and visitors entering the site. They will have a range of key tasks that may include: • Greet and welcome patients and visitors and identify destination • Ensuring IPC guidance if in place for public is being followed such as using hand gel • Providing clear and accurate directional information and escorting if necessary • Supporting people to register attendance • Distributing patient leaflets • Ensure public facing signage and communication in regards waiting times is updated Patient communication system and directional signposting will be developed with appropriate IT solution to allow the smooth operation of the site.	

Voluntary drivers service

Clinical offer	Voluntary Drivers Service
Service lad	Manager of service, Jo Brown

Model description

Working in collaboration with the NHS the Edenbridge Voluntary Transport Service will be looking to support people who have difficulty finding transport to Doctors' Surgery or clinic appointments. They are a registered charity independent of the NHS relying on donations from passengers and others to keep our service running. However, the NHS will be contracting the service to support the wellbeing centre, wound centre and proactive frailty service to support people's regular attendance at these services and who live within a 10-mile range of the health centre. The NHS will provide administration support to aid the planning and booking of planned appointments for specific people who would normally rely on other NHS transport services. The Edenbridge Voluntary Transport Service will have an office within the health centre.

Criteria

Patients attending wellbeing day centre, wound centre or clinic who have difficulty finding transport or unable to make their own way to the Edenbridge memorial health Centre
Live within a 10-mile radius of the health centre
Transport and agreed and booked by KCHFT will be funded by KCHFT, other trips would be part of the charity service where they rely on donations from passengers and others to keep our service running

Outcomes

Improved patient attendance and access
Consistency in provider building a trusted relationship with the day centre user

Operating Hours			**Staffing**	Voluntary drivers Administration support