Update on Edenbridge Memorial Health Centre – one year on

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Introduction

This paper updates on the service delivery and benefits of Edenbridge Memorial Health Centre during the first year of operation. It follows the report to Health Oversight Scrutiny Committee (HSOC) in October 2023, prior to the centre opening.

The new Edenbridge Memorial Health Centre is an integrated care model delivered by Kent Community Health NHS Foundation Trust and Edenbridge Medical Practice that has brought health, GP and community services together to support the local community. The clinical operational model was developed with local people and staff. It is focussed 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.

The Edenbridge Memorial Health Centre offers a range of services, including general practice alongside a wellbeing day centre, proactive frailty unit (ageing well clinic), MIU and a range of outpatient clinics. This remains early days in our journey for healthcare in Edenbridge, which will continue to develop as the needs change.

The centre supports around 4,500 people per month, seeing more than 54,000 people each year.

Clinical development

Our aspiration was to support people to stay independent and well at home. The town has an ageing population 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.

Ageing well clinics

Following a pilot led by our Darzi Fellow, an ageing well clinic is now providing a proactive approach to frailty, where a number of services are working together to give patients the best experience. These include: specialist or complex care nurses, therapy, including physiotherapy, and health and social care coordinators. This allows the person to be seen by all clinicians on the same day. It brings a new

approach to patient assessment, where it captures ‘what matters to you’, in a way that does not separate wellbeing from medical need and reflects the person’s own priorities for staying well. The ageing well clinic has now seen 28 people, all with positive feedback such as:

- “*I found coming to the clinic really beneficial and the actions prompted by it from my GP, who are now doing ongoing investigations.”*
- *“A calm environment. I didn’t feel rushed and sometimes when I see my GP I feel rushed. Nothing was too trivial. I was given advice on things I would not have considered before attending the Ageing Well Clinic.”*
- *“Both ladies were wonderful. I was made to feel very comfortable. We feel very lucky to have this.”*
- *“I have told all of my friends about how wonderful the Ageing Clinic is and how lovely everyone was.”*

Early outcomes for those who have gone through the clinic indicate an overall improvement in quality of life, with capability for earlier identification of deterioration and timely support. This innovative approach has generated a number of benefits, shown in the table, below:

Understanding and support
• Better understanding of "what matters to you"; staff and patients.
• Identification of staff development and support needs.
Network and service integration
• Creation of a cohesive locality-wide frailty network.
• Mapping of existing frailty services to inform further integration and service design.
• Relationships forged with primary care network (PCN) and INT Frailty Pilot, fostering positive relationships for closer working and improved integration of PCN wellbeing offers.
Pilot and clinic development
• Development and evaluation of the Ageing Well Clinic, a multi-disciplinary frailty assessment pilot, including operational resources and shared electronic templates. This has now been implemented as business as usual
• Integration of the One You Lifestyle Service into the Ageing Well Clinic • Establishing relationships with Alzheimer’s and Dementia Support Service for future collaboration.
Role creation
• Pilot has informed the creation of a new Social Value Coordinator role.

Through this collaborative working, an average of four hours’ clinician time per patient has been released through delivering holistic frailty assessments, resulting in an estimated cost saving of £109 per patient. The time released has been re-invested in additional clinical provision. Additionally, patients receive their assessments 43 days sooner on average.

Importantly, the clinic's patient centred approach creates a welcoming environment that prioritises fostering trust-based relationships between staff and patients and patient-identified meaningful measures. The Ageing Well clinic also provides an ideal setting for training and supervision.

Wound Centre

The Wound Centre provides a more comprehensive service to improve wound healing and support for non-housebound people, which is currently provided by the GPs, community nursing and minor injury teams. The clinic is overseen by specialist tissue viability nurse (TVN) to support treatment of more complex wounds.

The centre is a nurse-led unit. Nurses undertakes key wound management interventions and identify required outcomes for individual patients to promote and drive high-quality outcomes and healing. Care pathways and treatment plans are 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.

People will attend for up to six weeks and tare then transferred back to the GP practice with their ongoing plans and an ability for the GP to seek expert advice and support as needed. Clinics run on Tuesdays and Fridays, with a plan to increase with demand.

Wellbeing Centre

To support people who need connection to their community, we have developed the wellbeing day centre. The centre has expanded and is now seeing 38 clients each week over the four days. It is open Monday to Thursday, 10am to 2:30, except on Tuesday where the centre finishes at 2pm.

As demand and the reputation for this centre increases, we will be extending to five days. Within the Wellbeing Centre we are monitoring client's mental health as well as their physical wellbeing, staff are able to complete internal referrals to our other services as well as their GPs and signpost them to where to get support that we might be unable to provide. The ambition is to support the clients being independent in their own setting. Referrals for the Wellbeing Centre come from community rehab teams for home assessments and equipment, GPs for further assessments for weight loss, speech and language therapy, blood pressure issues and wounds and people's own recommendation as they can self-refer.

Additional dietician support is now available to the Wellbeing Centre to support nutrition advice and assessment for people attending the centre. Referrals are made via the GP with education given to people from the staff while waiting for the appointments to come through for those that attend the Wellbeing centre.

We continue to work with Sevenoaks Borough Council through funding of their One You service. The One You service, in addition to linking with the primary care network resource, supports people to live well. The offer is flexed based on needs and continues to change as the needs/demands of the population change. Part of the service has been to provide health checks for patients who are now able to walk-in and be assessed on the same day.

Care support is available through a number of areas and is part of the social value development led by the social value coordinator. Within the Wellbeing Centre, on-going support and education is being provided to users and their carers. We are also looking at other ways to be support carers and hope to have some education sessions or drop in room on certain days to be able to support local people with a number of issues that might arise.

There were initial concerns about the location and size of the wellbeing centre, but it is working well. Users like to see the outside; the memorial garden is used well and the traffic continues to flow.

When the centre is not open, the space is used by the GPs and community teams to provide training and meeting space, that was not previously available.

Ultrasound clinic

We are pleased that we have been able to establish an ultrasound clinic, run by Surgimed healthcare initially two days per week with the space allocated to expand up to five days per week, as demand grows. The provider has been working closely with the GPs to ensure easy and timely access for local residents. The feedback received so far has been very positive from patients as Edenbridge patients are currently waiting less than a week for an appointment at the practice.

ENT Clinic

There is monthly ENT outpatient's clinic running and also the availability of getting hearing aid batteries from KCHFT reception.

Community services and clinics

Existing community clinics continue to be delivered such as podiatry and a Parkinson nurse-led service. They have collectively seen more than 500 patients, providing nearly 1,000 appointments

KCHFT Clinic	Patients	Contacts
Cardiac Nursing	26	55
Continence	7	7
Complex Care Nursing	76	144
Podiatry	208	446
Orthopaedics	240	287
TOTAL	**557**	**939**

Other outpatient clinics provided by Maidstone and Tunbridge Wells NHS Trust (MTW) and Sussex Dermatology transferred to the new centre. These clinics are increasing as the need of the services grow. For instance, we have 13 more dermatology clinics running each month and have capacity to increase these more if needed.

The West Kent Frailty service runs seven days a 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 support older people who are frail to support better diagnosis and management, we are working with Sevenoaks primary care network to identify patients at risk of frailty and proactively supporting the population to age well.

Specific deliverables include:

- rapid and proactive assessment, including advanced care planning
- Continence service
- falls prevention service in development
- frailty – a rapid assessment and care planning service for vulnerable, older people
- care at home preventing hospital admission.

The Frequent Service user continues to help people who have been contacting their GP surgery or visiting A&E more frequently. The services aim to find solutions to help people to stay well and become less reliant on urgent care services. We are achieving good outcomes, with some clients referred onto the Wellbeing Centre for support. The service provides intensive support usually 1:1 for approximately up to three months. One-to-one support is offered at home or in an agreed suitable place e.g. café, wellbeing centre or other location.

Dementia support

We continue to provide a day for more advanced Dementia day care but are also able to support dementia clients on other days in the Wellbeing centre.

GP and minor injury service

GPs are pleased with the new health centre, which now allows the practice to offer more services, including group work. With a new GP on board, more than 85 per cent of appointments are now face-to-face.

The GPs have also developed a range of online services. The streamlined Accurx appointment system means patients no longer need to call to book an appointment, reducing phone wait times and freeing up GP time to see more patients.

Additionally, the GPs have been running Covid and flu vaccine clinics on weekends for eligible patients.

The MIU service is run by the GP practice, five days per week, seeing around 250 each month. Between 15 – 20 come from outside the local area.

One team approach to support the community and ongoing co-design

There is ongoing work across providers to deliver a one team approach.

The site manager is responsible for the building, while our receptionist supports and direct clients to services. We are recruiting a volunteer 'meet and great 'role to support GPs with the online service and checking in-desk.

Our social prescriber works with community groups, developing support networks and linking local people with health and wellbeing services, including NHS health checks and One You services.

Feedback has been extremely beneficial to develop services and we used the early engagement to help shape how the centre operates. The table below highlights some key areas and points the public raised during the initial build and what we have done since.

Theme	Feedback	What we are doing in response
Travel and transport	Travel and transport were a key theme in the feedback we heard. There were several solutions suggested to overcome travel and transport challenges: • Voluntary transport • Bus stop outside the centre.	We are actively working with the charity 'Edenbridge Voluntary Transport Service' on a recruitment campaign, including support to gain DBS checks to enable the new drivers to be able to start, so they can provide support to people who have difficulty finding transport to Doctors' Surgery or clinic appointments. It is a registered charity independent of the NHS relying on donations from passengers and others to keep our service running. The two bus stops were repositioned being closer to the entrance on Four Elms Road. A new uncontrolled pedestrian road crossing with associated dropped kerbs, tactile paving was installed. New lighting in Four Elms Road to improve lighting at entrance into the centre has been installed with works

		completed in time for this winter. In addition, improved lighting at the entrance of the building. The centre provides 100 car parking spaces. The car park remains under continuing monitoring and currently there have not been any issues of patients not being able to park when needing to attend for an appointment.
Access	Signs and information in the building need to be accessible for people with sight loss and literacy problems.	Edenbridge Memorial Health Centre is fully compliant with the Equality Act 2010. There is an induction loop for people with hearing impairments and all clinic rooms are on the ground floor with level access throughout the building. The signage has been reviewed and improved to enable patients to use the centre, we have easy to read signs and they include accessible elements and are dementia friendly. The site is wheelchair-friendly with wide, open corridors to make navigation easier.
	Some people are concerned about future housing development and the impact of a larger population might have on services and this will need to be taken into consideration.	The centre has room to expand and capacity to increase service provision, including opening hours. Future needs will be evaluated as any new development is designed. There are ongoing plans to build new houses nearby but as they are developed we will continue to see how they affect the needs of the services that are required at the time and what changes need to be made.

Future plans

During the past year, the clinical model has been successfully implemented, with further developments planned to support the Edenbridge Community as service needs evolve.

We aim to provide additional clinics, such as diabetes clinics, which will collaborate with the wellbeing service, frailty team, and GPs to optimise outcomes and support long-term condition management. A potential falls prevention clinic at the wellbeing day centre will offer extra support, helping people safely remain in their homes.

We plan to extend the wellbeing centre's opening hours and days as demand increases.

We are also exploring ways to support carers, including education sessions or drop-in rooms on certain days to assist local people with various issues.