

Edenbridge Minor Injuries Unit

1. Definition of a Minor Injury Unit

There is no one definition of a Minor Injuries Unit. The Health Care Commission, working with Price Waterhouse Coopers, undertook reviews of all A&E units during 2004/5. These were mandatory audits carried out in acute trusts and PCTs that delivered significant levels of A&E services. This included nurse led Minor Injury units and walk in centres. They defined them as type 1, 2 and 3. Types 1 are those units with access to a full range of specialist departments, such as eye departments and children's A&E departments. Type 2 included Gravesham Community Hospital as it treats 20,000 patients a year whilst type 3 included those minor injuries units departments where the level of attendances were more than 10,000 patients per year. Whilst Gravesham and Sevenoaks MIUs were included in these audits the Edenbridge Minor Injuries Unit was excluded by the auditors as its attendances were deemed too low. Therefore, in this context, it can be argued that Edenbridge MIU was not regarded as an MIU.

The PCT has also assessed the access criteria and key characteristics of both minor injuries units and walk in centres across England. The following seem to be common features in all minor injury units and are also reflected in a Kings Fund Document on Walk in Centres.¹

- *Initial Point of Contact.* Patients attend with new unforeseen health problems to the unit as the first point of contact. They are not referred to the unit by another service;
- *Immediate Access.* Patients require neither appointment nor referral;
- *No or limited follow-up care.* Treatment or advice is given for the presenting problem. If further care is needed patients are advised and redirected to attend the appropriate services;
- *No substitution of care.* Minor Injuries Units are not substitutes for care that is provided elsewhere.

2. Observations

It appears that the Edenbridge Minor Injuries Unit is working outside these criteria as patients are often referred to the unit, there are high levels of follow up care given and a primary care treatment/redressing service makes up a significant part of its activity. In all these aspects it is an outlier when compared to the other units. Therefore it is the PCT's view that this service is not serving its primary function of a MIU and should be renamed as a treatment/redressing service. This is not changing the service that it provides, but giving it a name that more accurately describes the service offered. Legal advice was taken prior to this action being instigated.

¹ Mountford L, Rosen R (2001) 'NHS Walk-in Centres in London An initial assessment', Kings Fund

3. Activity Levels

To provide care safely, health care professionals need to treat a critical mass of patients to be able maintain their skills. This argument would apply even in a health system with unlimited resources. The strategic review looked at the statistics for average attendances at a range of MIUs and took note of the Healthcare Commission report previously mentioned. On the basis of this and the professional judgement of the members of the management team responsible for clinical governance an MIU would need to see a minimum of 20-30 appropriate patients per day to be clinically viable. Edenbridge falls far short of these levels.

On average Edenbridge MIU sees between 9 – 11 patients a day. It has recently increased up to 14 patients a day but often a service under scrutiny will gain a temporary increase in activity. Up to 50% of these are for redressings that could be undertaken in a clinic or GP practice environment. These also do not require to be undertaken by an Emergency Nurse Practitioner. A local GP practice also sends patients to the unit for ECGs whereas it is more usual (and we would argue better for the patient) for these to be undertaken at the practice.

There has been concern that the opening hours limit the number of patients attending the unit. Modelling the peak activity times against the other three units the PCT manages (Sevenoaks, Gravesend and the Urgent Care Centre at Darent Valley Hospital) it is clear that mornings (9 – 12) and early evenings (4 – 7) are the busiest times. However looking at the data opening the unit for longer hours would only mean an increase of 3 – 5 patients a day and would require a disproportionate increase in staffing costs. Also as up to 50% of attendees at Edenbridge MIU are for redressings, only 1 to 3 of these patients would be true MIU attendees.

It has been suggested to the review team that the Minor Injuries Unit should provide leg ulcer care on behalf of a local practice. However, it is not normal practice for a minor injuries unit to provide this service and is outside the key characteristics of an MIU as described above. Redressings and leg ulcer care also do not require an emergency nurse practitioner. The Minor Injuries Unit would not be functioning appropriately.

Another issue that has been raised is that the unit is not effectively advertised and so unknown by the local population. This is incorrect. The unit is advertised on websites, in directories, and in neighbouring cottage hospitals. Also we had 140 people attending a stakeholder workshop in April who were all aware of the unit. The unit has come under scrutiny in 2002 and 2004 and on these occasions up to 4,000 people have expressed their views on the unit. Therefore it is well known locally.

Concerns had been expressed that the threat to the MIU was as a result of financial considerations. While it is the PCT's duty to ensure that it obtains value for money, as we have shown the reason for these recommendations are clinically based.

COMMUNITY HOSPITAL MIU ATTENDANCES

COMMUNITY HOSPITALS	ATTEND per DAY	ATTEND per MONTH	ATTEND per YEAR
Cromer Hospital	25	173	>9,000
Weymouth Hospital	43	1,333	16,000
St Albans Hospital	27	834	10,000
Orsett Hospital (Thurrock)	36	1108	13,300
North Cambridgeshire Hospital	33	1000	12,000
Royal Victoria Infirmary Newcastle	19	583	7,000
Trafford Hospital	27	808	9,700
Uckfield Hospital	33	1000	12,000
Crowborough Hospital	11	333	4,000
Chippenham Hospital	79	2416	29,000
Withernsea Hospital	16	475	5,700
Southmead Hospital (Bristol)	55	1666	20,000
Stratford (Warwicks) Hospital	23	691	8,300
Mendip Hospitals	26	800	9,600
Panteg Hospital (Gwent)	27	833	10,000
St Mary's Hospital (Portsmouth) [includes Walk-in Centre)	137	4166	50,000
Grinden Lane Primary Care Centre (Sunderland)	55	1666	20,000
Average (minus highest and lowest)	35	1026	12773

Figures assume opening 365 days per year.

This page is intentionally left blank

West Kent Community Hospital Review

Conclusions & Recommendations

1. Introduction

This document brings to the PCT Board the recommendations of the review team looking into the future of our Community Hospitals.

The purpose of this report is to provide a summary for the PCT Board concerning:

- The outcome of the review of the Community Hospitals;
- To outline the strategic review document;
- The key recommendations of the review;
- To seek approval of the recommendations of the review.

The review has taken a long time to complete and it is recognized that this has been an unsettling period for stakeholders – particularly for staff who have been concerned about their futures. The executive management team is grateful for the contributions made by stakeholders and appreciative of the patience shown. There are some significant findings arising which would probably not have come to light without such a comprehensive exercise.

If the recommendations are supported, public consultation will be needed regarding:

- the closure of the Minor Injuries Unit at Edenbridge and District Memorial Hospital
- The reprovision of the Livingstone Hospital.

2. Summary of Key Proposals

- There is a significant degree of variation in practice throughout the 6 community hospitals. By adopting best practice consistently in all of them, particularly with a focus on active rehabilitation, we expect to make major improvements to the quality of care provided while at the same time improving efficiency and cost effectiveness.
- Based on an exercise to model the need for community hospital beds, the current open bed base would be sufficient were all community hospitals currently operating in the optimum way. However, since they are not, it will be necessary to reopen 18 beds in the short term to meet demand.
- As services evolve over the next 3-5 years, it will be necessary to reopen all the existing closed beds. While these will not all be required in the short term, we propose to open them in advance of need just as soon as the revised models of service are put in place and staff recruited.
- Not surprisingly, there is strong and widespread support within the area for our community hospitals. This is shared by our executive team as we see community hospitals as being a key component of our strategy to provide more care for people more locally.
- There is a need for all the hospitals in the south of the area to remain in place and continue to provide the majority of services as at present, though many of these services will need to be modernized. We plan to make a number of investments in these to augment service.

- The fabric of the Livingstone Hospital in Dartford no longer meets modern requirements. A cost benefit analysis of refurbishment, reprovion or rebuilding will need to be done. The working assumption, subject to the cost benefit analysis and a full business case, is that reprovion may be the most likely option. However, the model of care provided at the Livingstone is excellent despite the challenging physical environment and will be retained in whatever the physical manifestation of the successor building.
- The MIU at Edenbridge Hospital is not clinically viable and should be closed.

3. Background & Context

The former PCTs in South West Kent and Maidstone Weald commissioned a review of their community hospitals in August 2006. The scope of the review originally focused on the four community hospitals in the south of the PCT area. However the formation of West Kent PCT on 1st October 2006 resulted in 2 more community hospitals being part of the PCT and so the scope was expanded. Originally, the review had an emphasis on the financial aspects of the community hospitals. However the brief was made more extensive and comprehensive to ensure that it was patient focused, considered quality, efficiency, effectiveness and sustainability of the services. These areas were placed at the heart of the review.

Most of the PCT's community hospitals pre-date the NHS and were established and/or have benefited from local benefactors. One was built with local donations as a war memorial. The PCT recognizes that its community hospitals have a civic importance for communities and that there is a strong sense of local ownership. However, the current locations reflect history rather than an overall plan. To some extent the services currently provided in community hospitals also reflect history as much as strategic planning.

4. Principles

The following principles set the context for the review:

- West Kent PCT has a challenging financial position. The community hospital review is set within this context. Affordability and sustainability are key to the future of the community hospitals.
- However it was equally important to ensure that the following were also core to the review:
 - Safety & Governance
 - Quality
 - Efficiency
 - Quality of environment
 - Equity

Considerations of privacy and dignity, infection prevention and control were intrinsic to the Safety & Governance and Quality of environment.

5. Findings

5.1 Patients in community hospitals need high quality care that gets them well as quickly as possible to enable them to return home and to families. There are real

dangers for patients remaining in hospital beds for longer than necessary. There are unnecessary variations in the average length of stay in the community hospitals. There is also potential to improve the efficiency in the use of community hospital beds by improving the average stay to 18 days. This requires an active rehabilitation focus which will be necessary if the PCT is to deliver the service modernisation required by our aspiration for many more people to be cared for in local settings. The current range varies from 26 to 18 days once long stay patients, such as continuing care patients, are excluded. Therefore the community hospitals need to improve efficiency and the throughput of patients to allow an increase in capacity. The PCT has a range of adult community health services that can provide care in the patient's home to allow this to happen. The PCT is also about to commence a review of adult community health services to ensure that it is well placed to support the improvement in the average length of stay in the community hospitals.

Not all of the hospitals were able to demonstrate that they have written and agreed admission and referral criteria, operational policies and a modern set of service standards. It is essential that each hospital has these written and agreed as well as a service level agreement against which they are performance managed.

Further work can also be undertaken to use the day centres more effectively and efficiently. This would mean that some patients could be offered day care to provide for their health needs rather than being admitted to a community hospital bed. This is particularly the case for those who need rehabilitative care.

5.2 The PCT needs to ensure that all the community hospitals implement the best practices as advised by the Department of Health and the Chief Nursing Officer of England. These include The Essence of Care and the Chief Nursing Officer's 10 Key Roles for Nurses and 10 Key Roles for Allied Health Professionals. 'The Essence of Care' has been designed to support the measures to improve quality set out in 'A First Class Service' and is an important part of implementing clinical governance at a local level. The benchmarking process outlined in 'The Essence of Care' helps practitioners to take a structured approach to sharing and comparing practice, and enables them to identify best practice and to develop action plans to remedy poor practice. The 10 key roles empower nurses and allied health professionals to undertake a wider range of clinical tasks including the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe drugs. At present the implementation of both of these has not been systematic or even (in the case of the Essence of Care) implemented at all in some of the community hospitals. Implementation of these would help to ensure that the effectiveness and efficiency of the services is consistent across the PCT area. They would also be used as the tools that would ensure that the National Service Frameworks for Older People and Long Term Conditions are consistently implemented and evidenced in all the community hospitals. This would include the following:

- Performance data on activity, length of stay, skill mix levels, costs and standards of care;
- An agreed number of clinical and documentation audits;
- The clinical audits focussed upon evidence based care;
- A programme for the Essence of Care will be implemented and monitored;

- Yearly benchmarking exercises.

Each hospital should have its own governance framework based on the models that have already been put in place within the PCT. Each hospital should have its own governance group with terms of reference that covers:

- Patient care issues such as complaints, falls, infections;
- Essence of Care and other benchmarks
- Sharing lessons learnt from incidents elsewhere in the PCT;
- Checking that clinical supervision is in place and is being effective;
- Organization and delivery of care is evidenced based.

5.3 The 6 community hospitals have 177 beds of which 115 are currently open. The modelling has shown that if we were more efficient we currently have the correct number of beds open for the current and future population growth. Our future plans for services closer to local communities will allow for the prospect of the PCT making greater use of community hospital beds and facilities – providing the care is up to date, the standards are high and the costs are economic. Whilst we still have work to do to agree the balance between inpatient beds and other services it is clear that we need to provide these beds more efficiently. The modelling we have done is based on improving our average length of stay to 18 days. The current range varies from 26 to 18 days once long stay patients, such as continuing care patients, are excluded. Whilst the current model of care is not as efficient as it could be, it is clear that there is enthusiasm, vision, expertise and commitment by the staff in the care and expertise that they provide.

5.4 The PCT needs to make its services affordable and it appears that there are variations in the costs of running the community hospitals. This seems mainly to be a variation in skill mix with some hospitals having a high level of registered nurses and a low level of band 2 and 3 nurses i.e. support staff or “health care/rehabilitation assistants”. There are also apparent differences in the cost of hotel services and in particularly catering costs. It is planned that further work will be undertaken once the Head of Facilities management is in post to understand this across the three current providers within the PCT area.

5.5 Edenbridge Minor Injuries Unit

5.5.1 Definition

There is no one definition of a Minor Injuries Unit. The Health Care Commission, working with Price Waterhouse Coopers, undertook reviews of all A&E units during 2004/5. These were mandatory audits carried out in acute trusts and PCTs that delivered significant levels of A&E services. This included nurse led Minor Injury units and walk in centres. They defined them as type 1, 2 and 3. Types 1 are those units with access to a full range of specialist departments, such as eye departments and children’s A&E departments. Type 2 included Gravesham Community Hospital as it treats 20,000 patients a year whilst type 3 included those minor injuries units departments where the level of attendances were more than 10,000 patients per year. Therefore, whilst Gravesham and Sevenoaks MIUs were included in these audits the Edenbridge Minor Injuries Unit was excluded by the auditors as its attendances were deemed too low.

During this process the PCT has assessed the access criteria and key characteristics of both minor injuries units and walk in centres across England. The following seem to be common features in all minor injury units and are also reflected in a Kings Fund Document on Walk in Centres.²

- *Initial Point of Contact.* Patients attend with new unforeseen health problems to the unit as the first point of contact. They are not referred to the unit by another service;
- *Immediate Access.* Patients require neither appointment nor referral;
- *No or limited follow-up care.* Treatment or advice is given for the presenting problem. If further care is needed patients are advised and redirected to attend the appropriate services;
- *No substitution of care.* Minor Injuries Units are not substitutes for care that is provided elsewhere.

5.5.2 Observations

It appears that the Edenbridge Minor Injuries Unit is working outside these criteria as patients are often referred to the unit, there are high levels of follow up care given and a primary care treatment/redressing service makes up a significant part of its activity. In all these aspects it is an outlier when compared to the other units. Therefore it is the PCT's view that this service is not serving its primary function of a MIU and should be renamed as a treatment/redressing service.

5.5.3 Activity Levels

To provide care safely, health care professionals need to treat a critical mass of patients to be able maintain their skills. This argument would apply even in a health system with unlimited resources.

The strategic review looked at the statistics for average attendances at a range of MIUs and took note of the Healthcare Commission report previously mentioned. On the basis of this and the professional judgement of the members of the management team responsible for clinical governance an MIU would need to see a minimum of 20-30 appropriate patients per day to be clinically viable. Edenbridge falls far short of these levels.

On average Edenbridge MIU sees between 9 - 11 patients a day. It has recently increased up to 14 patients a day but often a service under scrutiny will gain a temporary increase in activity. Up to 50% of these are for redressings that could be undertaken in a clinic or GP practice environment. These also do not require to be undertaken by an Emergency Nurse Practitioner. A local GP practice also sends patients to the unit for ECGs whereas it is possible that these could be undertaken at the practice.

There has been concern that the opening hours limit the number of patients attending the unit. Modelling the peak activity times against the other three

² Mountford L, Rosen R (2001) 'NHS Walk-in Centres in London An initial assessment', Kings Fund

units the PCT manages (Sevenoaks, Gravesend and the Urgent Care Centre at Darent Valley Hospital) it is clear that mornings (9 – 12) and early evenings (4 – 7) are the busiest times. However looking at the data opening the unit for longer hours would only mean an increase of 3 – 5 patients a day and would require a disproportionate increase in staffing costs.

It has been suggested to the review team that the Minor Injuries Unit should provide leg ulcer care on behalf of a local practice. However, it is not normal practice for a minor injuries unit to provide this service and is outside the key characteristics of an MIU as described above. Redressings and leg ulcer care also do not require an emergency nurse practitioner. The Minor Injuries Unit would not be functioning appropriately.

Concerns had been expressed that the threat to the MIU was as a result of financial considerations. While it is the PCT's duty to ensure that it obtains value for money, as we have shown the reason for these recommendations are clinically based. The Edenbridge service is not expensive to run and its unit costs are within the expected range.

5.6 There is an opportunity to provide a new service at Tonbridge Cottage Hospital for renal dialysis patients. This arises from the desire of Guys & St Thomas's NHS Trust to relocate from the Pembury site. Work has been ongoing to confirm the viability of this proposal, which also envisages an increase in provision from 14 to 20 units.

5.7 Edenbridge Hospital: The current x-ray facility is close to the end of its useful life and is in serious need of upgrading if the facility is to meet the challenge of expansion envisaged in this paper.

5.8 Livingstone Hospital: The service model in place at the hospital is modern and up-to-date and has been commended by the NHS National Director for Older People.

The main estates problems are concentrated at the Livingstone Hospital where inpatient facilities are based in the original hospital building. Although it is notionally a 38 bedded inpatient unit on the ground floor layout restricts the practical use to 30 beds and has done for some time. The inpatient unit was extended in 2002 but still provides cramped working and unacceptable patient care conditions. The beds are too close together and breach infection control guidelines. At present this risk is minimised by not using all the beds but even this measure is inadequate.

5.9 The NHS run day centres should be remodelled so that they maximise their potential. Any patient not requiring clinical care should be discharged. The current provision is focussed on social activities rather than healthcare.

5.10 Quality of the Environment

Despite the age of 5 of the 6 community hospitals, the problems associated with the current buildings are perhaps not as significant as may be expected. The overall backlog maintenance figure of £500k is relatively low. The bed pan

washers in all of the community hospitals need to be replaced immediately. This is an urgent infection prevention and control measure.

Sevenoaks Hospital: The biggest cost will be the refurbishment of the kitchen at Sevenoaks. It is recommended that a decision as to whether to refurbish this or not will depend on the outcome of the review of the hotel services. A capital bid will be developed for 2007 to further develop and improve the infra structure of Sevenoaks Hospital.

6. Detailed Recommendations

6.1 The PCT should implement modern service models, appropriate to individual need across all sites.

6.2 All sites should develop a range of operational, clinical, professional and managerial policies consistent with national and local best practice.

6.3 Current beds should be reopened in a phased manner once new service models are in place and recruitment is completed. There are other dependent factors, for example, if we are successful in a capital bid for Sevenoaks Hospital we will need to keep some or all of the ward space available for decanting.

6.4 The PCT should aim to open the all the beds at Edenbridge and Hawkhurst Hospitals within three to six months. Seven beds at Sevenoaks will also be opened within the same timescale. The timetable for the remaining beds at Sevenoaks will be subject to the outcome of the capital bid (see below) as if that is successful it will be used as decanting space and in any event are not currently essential.

6.5 Further work should be undertaken within the next twelve weeks with Guys and St Thomas's NHS Trust on the development of the potential renal dialysis unit at Tonbridge Cottage Hospital. The trust is looking to relocate the unit currently at Pembury and increase the dialysis units from 14 to 20 for the local population.

6.6 A capital bid should be made in 2007 for Sevenoaks Hospital. The bid should aim for improvements in:

- outpatients
- ward areas
- rehabilitation facilities
- MIU

6.7 Edenbridge MIU:

- The MIU service should be renamed as a treatment clinic with immediate effect for safety reasons
- The PCT should consult on the closure of the treatment service, currently the MIU
- The PCT should provide a redressing clinic for 1 to 2 days a week for existing patients until such time as current patients are discharged when it should cease
- That new redressing patients are redirected to other services

6.8 Edenbridge X-Ray

A capital bid should be made to replace and upgrade the current x-ray facility.

6.9 Livingstone Hospital

Although the hospital has a successful model of care in place the building no longer meets modern requirements. A cost benefit analysis of refurbishment, reprovision or rebuilding should be commissioned.

The working assumption, subject to the cost benefit analysis and a full business case is that reprovision may be the most likely option with a dedicated 'Livingstone Unit' run and managed by PCT staff on the Darent Valley or Gravesham Hospital sites.

6.10 The PCT should work with local voluntary groups to reprovide current day centre activity.

6.11 The PCT should do further work to assess the value for money of the hotel services. The PCT has three providers and a significant variance in the costs of the service.

6.12 There is a mixed model of medical cover across the hospitals and the PCT should work with GPs and practice based commissioners on this service.