	Business Case	Project Stage **Define**

Project Name	Rosewell House	**Date**	16.08.21
Author	Sarah Gibbon	**Version**	FINAL (10)

Contents

1. Summary of Project

Rosewell House has been a major part of the 'Frailty Pathway' programme, which sought to deliver a redesigned frailty pathway, including the realignment of resources and staff to support cross system flow, in order to prevent acute admissions to hospital from our communities in line with Operation Home First and optimise flow out following acute in-patient interventions.

The original intention had been to operate Rosewell House fully as a Care-Inspectorate registered facility to deliver a whole-system resource for rehabilitation and 'Frailty Pathway' beds (step-up, step-down, delirium/dementia and end of life care).

After a period of closure in late 2020 due to Covid19 outbreaks, Rosewell House opened with interim registration arrangements in January 2021.

- **Rehabilitation beds:** 20 beds, known collectively as the rehabilitation beds, (18 rehabilitation, 1 place of safety and 1 permanent resident) to continue to be registered with the care inspectorate, under Aberdeen City Council, who contract Bon Accord Care for the service
- **Frailty Pathway beds:** The remaining 40 beds, known as Frailty Pathway beds, having their scrutiny and assurance from HIS. The primary need for the interim arrangements had been due to restrictions to accessing the beds at Rosewell House impacting on whole-system flow from ARI.

On 27 April 2021, the Integration Joint Board (IJB) approved an extension to the interim registration arrangements and instructed officers to undertake an options appraisal to determine the best option for registering the service in the longer term. This paper presents the results of this options appraisal.

It is important to note that the options presented here look at different options for delivering the same integrated, intermediate care facility, examining how the different registration options could impact on the service that ACHSCP are able to deliver. The principles underpinning the service model is consistent between the options. This is especially important given the finding during research for the engagement that patients rarely differentiate between the 'NHS' and 'social care' –

in fact nearly two-thirds (63%) of respondents believed that the NHS provides social care services for older people[1].

2. Business Need & Background

National Context

The landscape in which Rosewell House operates is changing rapidly and the time is right to look at reconfiguring the service it provides to meet the needs of the population. Our population is ageing, and it is estimated that by 2036, one in four people will be over 65.[2]

As outlined in ACHSCP's Acute Care at Home evaluation:
"Scotland's demographic climate is changing, with predictions the population of 65-74 years will increase by 17%, and over 75 years by 79% in the next 25 years. As a result, services are becoming increasingly challenged, with unscheduled acute hospital admissions rising primarily from those over 65 years. Furthermore, over 75 years olds make up the majority of delayed discharges from hospital (69%). Inefficiencies are predominantly due to a lack of resources available in the community which are able to provide escalated levels of care in situations of temporary decline or ill health" (Karacaoglu & Leask, 2019).

In essence, our population will become older, frailer and with more complex comorbidities. Older people living in residential settings such as care homes also have increasingly complex health and care needs[3]. This means that our traditional view of 'healthcare' in 'hospital' and 'social care' at home, will not be fit for purpose in the future, and the boundaries will need to become less distinct to ensure person-centred care. In order to prevent unnecessary admissions into acute hospital b, support early discharges, and help as many people return to their homes as possible, we need to strengthen our community-based services and provide the opportunity for preventative, step-up care.

The narrative around step-up, preventative care is reflected in the recent national view of adult social care, which contrasts the old thinking of social care only being available in a crisis, with the new thinking that is needed – focusing on care being preventative and anticipatory. We could view Rosewell House as a spring-board to helping individuals recover to be more able to live in their own homes – regardless of whether it is step-up or step-down care that has been provided.

[1] https://www2.deloitte.com/content/dam/Deloitte/uk/Documents/public-sector/deloitte-uk-the-state-of-the-state-report-2017.pdf

[2] https://www.gov.scot/publications/independent-review-adult-social-care-scotland/documents/

[3] https://www.kingsfund.org.uk/sites/default/files/2017-11/Enhanced_health_care_homes_Kings_Fund_December_2017.pdf

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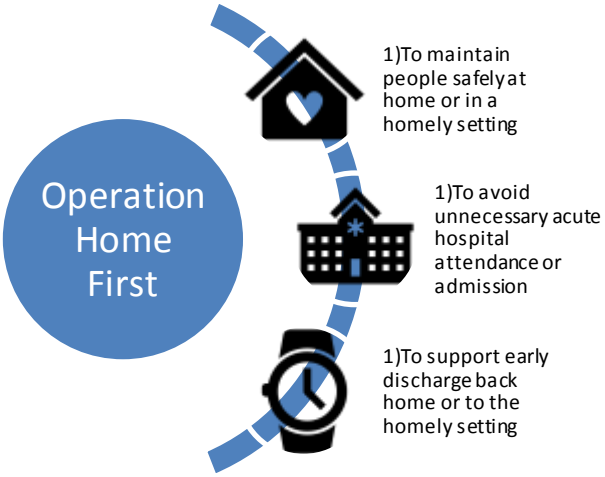
Local Context

In response to the national context, and learning from the Covid19 pandemic, 'Operation Home First'[4] is NHSG's system-wide commitment is to reforming our service delivery in line with the following key principles:



The service at Rosewell House has been redesigned in line with several workstreams which have changed the landscape in which it operates:

- The development of a frailty pathway – access to rapid assessment and intervention for people presenting with decompensated frailty syndrome.
- The development of a stepped care approach – community capacity to provide hospital at home, enhanced support and keeping connected at home.
- The implementation of the newly commissioned care at home contract – an outcomes focussed, locality based contract, with providers commissioned to meet the needs of the local population.
- The alignment of ACHSCP teams within localities, with a focus on delivering unscheduled care in a planned way.
- The recommissioning of planned residential respite – an alternative provision to the previous provision within Rosewell.

[4] https://www.nhsgrampian.org/news/2020/july/operation-home-1st/

Demand Analysis

Admissions

- **Frailty Beds:** Since opening the initial beds on 18 January 2021, Rosewell House has had 343 admissions to the Frailty Pathway beds

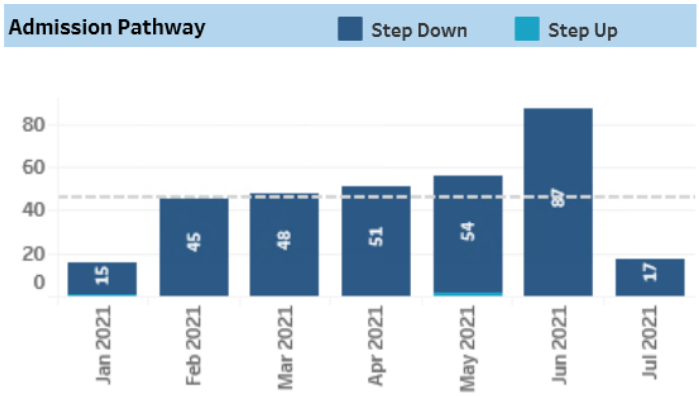


Figure 1 Admissions for NHS registered Frailty Pathway Beds

- **Care Inspectorate Registered rehabilitation beds:** Over a similar time-frame, the 18 Care Inspectorate registered beds available for rehabilitation have received a total of 99 admissions.

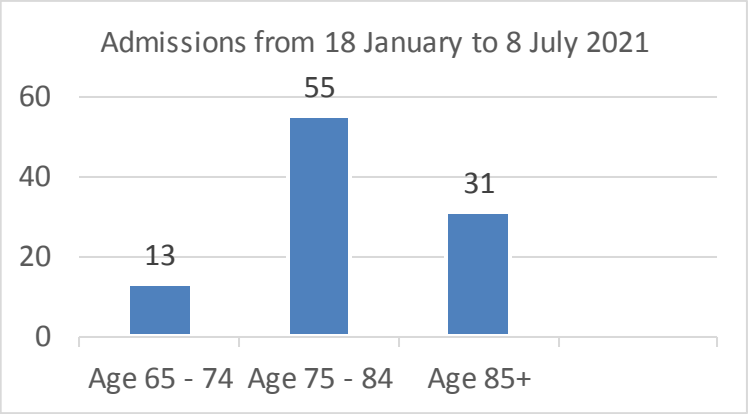


Figure 2 Admission for Care Inspectorate registered rehabilitation beds

- The majority of admissions into the Frailty Pathway beds have been step-down admissions (98.3%) from Ward 102 (71.3%). "Other ARI Ward" largely refers to boarded patients[5] from Ward 102, though the Older Person's Liaison Team (OPAL) can also refer in. The BAC beds have had 2 step-up admissions during the same time period.

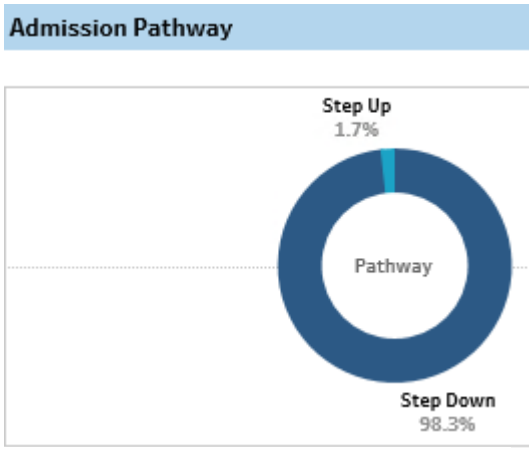


Figure 3 Step Up / Step Down admissions for HIS registered Frailty Pathway Beds

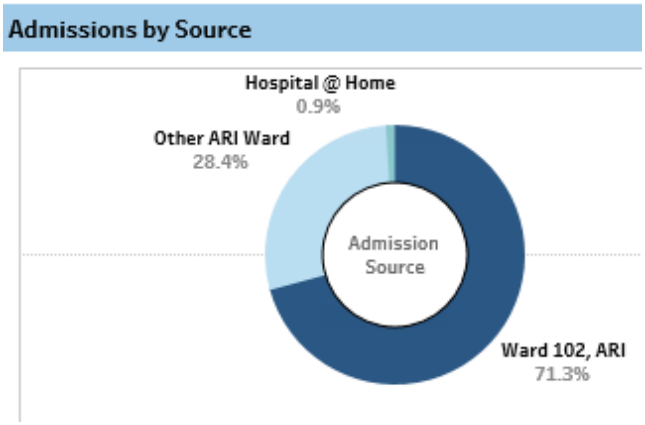


Figure 4 Admissions to HIS Registered Frailty Pathway Beds by source

Length of Stay

Overall, the length of stay in the rehabilitation beds is longer than in the Frailty pathway beds, which have a faster turnaround. The 40 Frailty Pathway beds have an average length of stay of 16 days. The 18 Care Inspectorate registered rehabilitation beds available for rehabilitation have an average length of stay of 24 days.

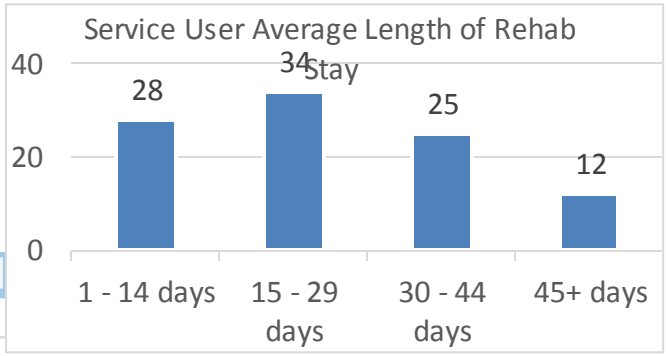


Figure 5 Length of Stay Care Inspectorate Registered Rehab beds

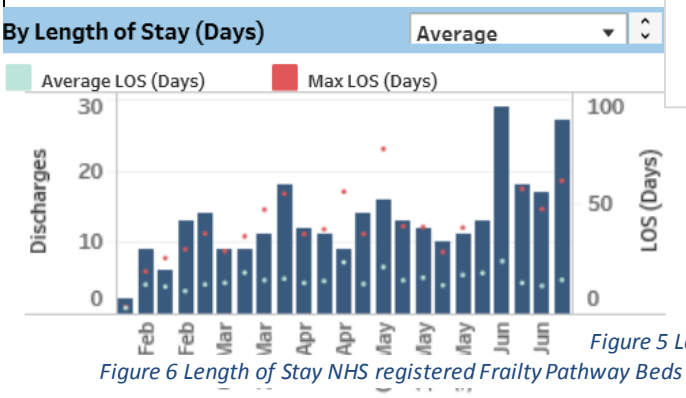
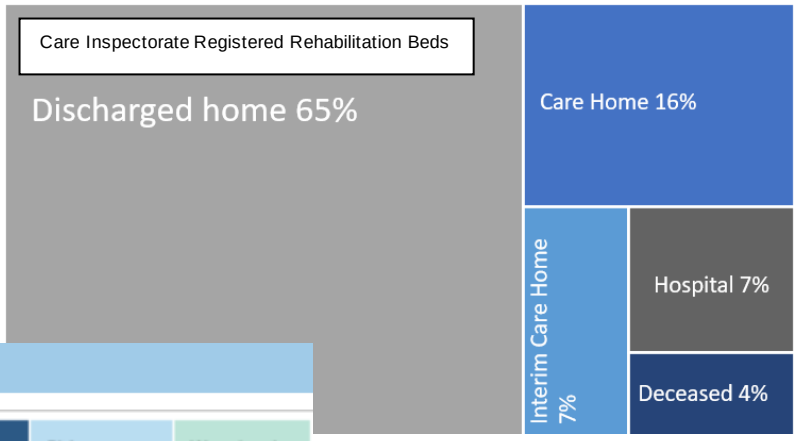


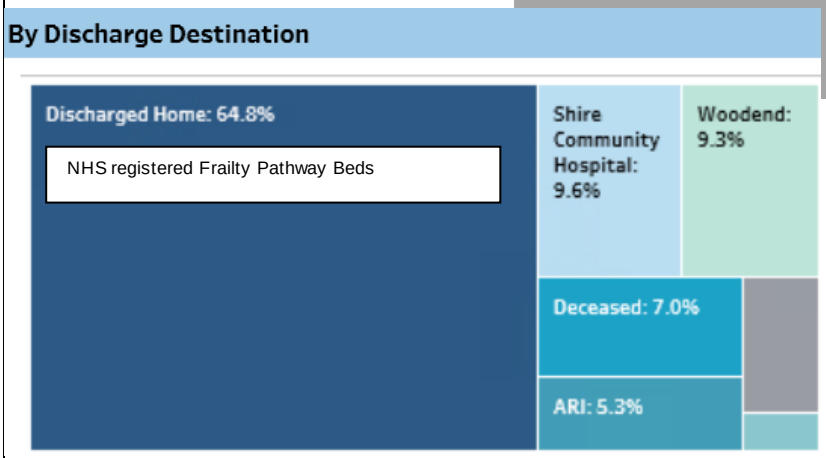
Figure 6 Length of Stay NHS registered Frailty Pathway Beds

[5] A 'boarded patient' is generally defined as a boarded patient is a patient that is moved out-with a specialty (such as geriatrics) to enable that specialty to admit demand. This could include patients ready for discharge and awaiting arrangements or patients who need to remain in the acute setting but who are deemed can be safely managed in another clinical area. The specialty that is requesting that a patient is boarded retains senior medical responsibility and host ward undertakes junior medical workload for patient.

Discharge Destination

- The majority of people are discharged home following their stay at Rosewell House (for both the rehabilitation (are Inspectorate) and frailty pathway (NHS) beds,

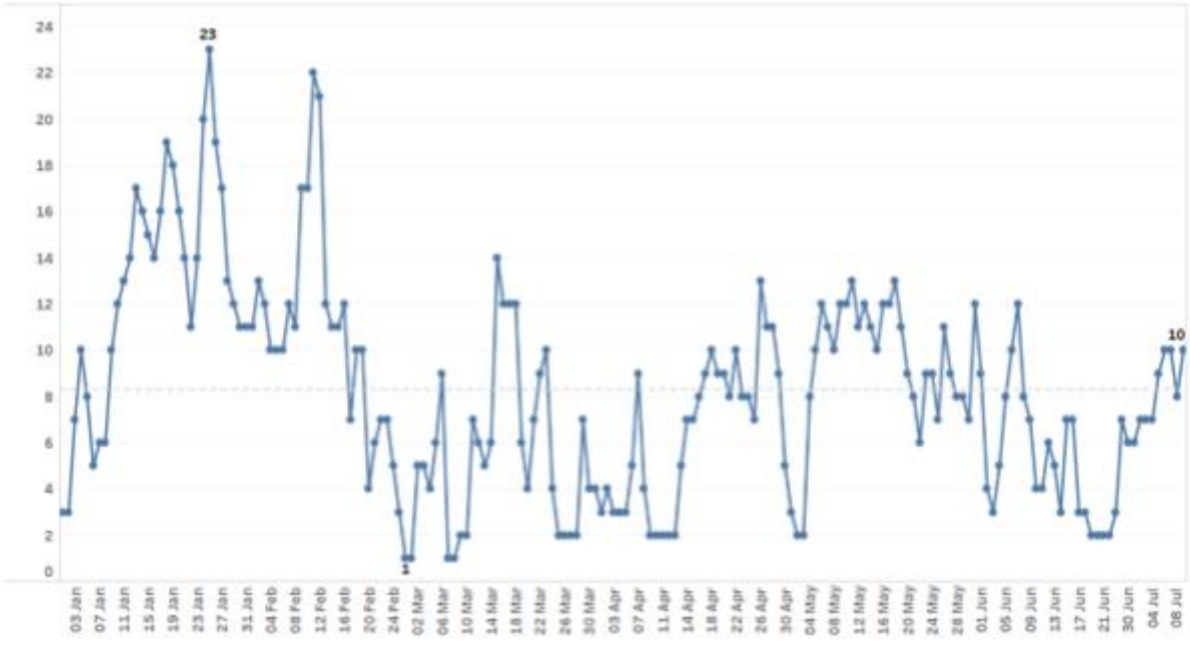




indicating that this is functioning well as an intermediate facility – bridging the gap in care before a patient can be discharged safely home.

Ward 102 (Step-Down)

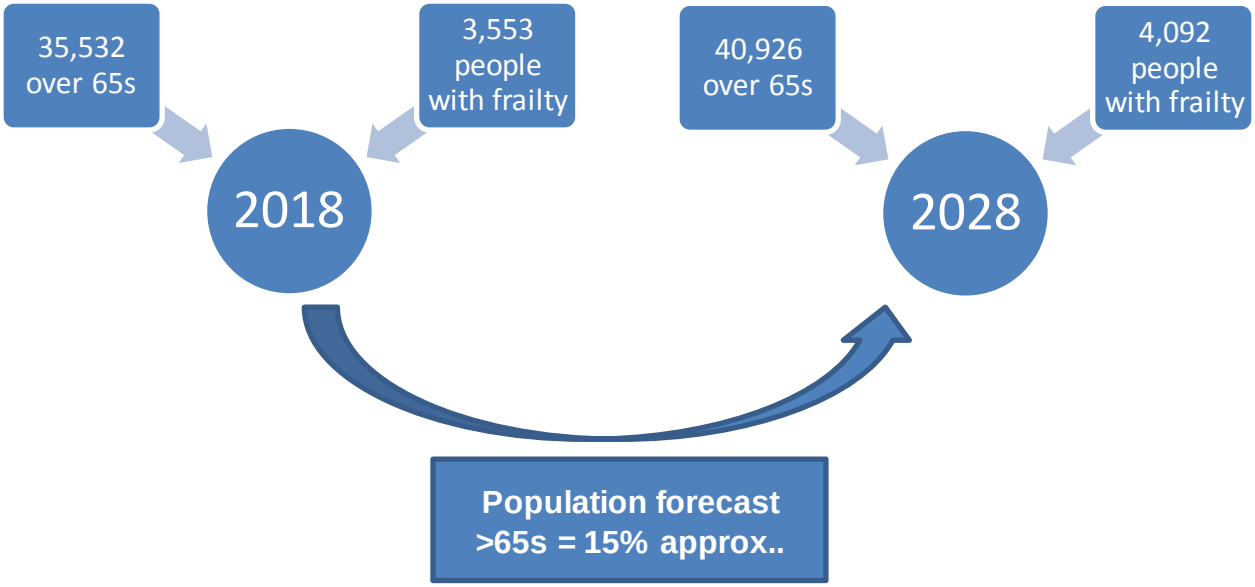
Over the same time period, Ward 102 has experienced an average of 8 daily boarders.



Demand Forecast

Forecasting demand is a difficult and approximate effort, however there are 2 broad assumptions we can make whilst attempting to understand our future demand.

1. **Demand will increase:** with a greater proportion of our population being over 65, there will be a larger number of patients for the Frailty Pathway.



In 2018, there were 35,532 residents in Aberdeen who were over the age of 65. Research indicates that around 10% of people aged over 65 years old also experience frailty[6]. This would result in approximately 3,553 people in Aberdeen living with frailty.

The projected population change by age group for Aberdeen predicts that from 2018-2028 the population of 65-74 year olds will increase by 14.4% and the population of those 75 and over will increase by 16.1%[7].

This means that 40,926 residents in Aberdeen will be over 65 (an increase of 5,394), and that there could be approximately 4,092 people in Aberdeen living with Frailty (an increase of 539)

2. **Complexity will increase:** Not all people with frailty will be cared for at Rosewell House, in line with our overall principles of Home First. As our population increases, and the Frailty Pathways works to embed change in community-based care provision (such as Hospital @ Home and our community teams and services), more people will be able to be cared for at home. This will mean that there will be an increase in the complexity and acuity of the patients that will need step-up care to prevent an acute hospital admission, or step-down

[6] https://www.bgs.org.uk/resources/introduction-to-frailty
[7] http://128.1.223.40/accopendata/People/Demography

care at Rosewell House as part of their treatment and rehabilitation needs before being able to go back home.

3. **Demand for Intermediate Care will increase:** The Social Care Institute for Excellence highlights that investment in intermediate care is not keeping pace with rising need. Quoting the National Audit of Intermediate care, they emphasise that capacity has remained static and is half of what is required. Additionally, "*Reablement capacity is actually falling, despite increasing evidence of its effectiveness*"[8]

3. Vision & Values

ACHSCP are very aware that prolonged hospital stays are not good for a person's wellbeing[9], especially in respect of their mobility and independence, with potential risks such as functional decline due to immobility and acquiring infections, rising with increasing length of stay. This in turn leads to increasing demands on care at home services.

"Research has shown that during hospitalisation, between 30% and 55% of older patients show a decline in the ability to perform routine activities such as bathing, getting dressed and toileting, and up to 65% of hospitalised older adults experience a decline in ambulatory function. These changes can lead to a loss of independence and the need for residential care. Deconditioning syndrome is also associated with a variety of physiological effects including pneumonia, skin breakdown leading to pressure ulcers, constipation, incontinence, depression and an increased risk of falls."[10]

We aim to reduce these risks by working to:

- **Reduce avoidable admissions** to an acute setting: provision of step-up care in Rosewell House with a preventative approach to reduce escalation of a person's needs. This helps an individual access support early to prevent reaching acute-levels of need.

- **Reduce avoidable admissions to a care home**: the recovery time promoting reablement, with access to treatment and rehabilitation as required, in Rosewell House will avoid unnecessary admission to care homes as we have seen that too many older people are discharged directly from hospital to a care home when they are low in confidence and ability following an acute illness. There is a movement towards community-based models which seek to reduce use of institutional/residential care: a step-up and step-down model at Rosewell House will reduce the number of people admitted to care homes as it will allow time for treatment, rehabilitation and reablement post-acute-illness, or preventative rehabilitation, to allow people to stay in their own homes longer.

[8] https://www.scie.org.uk/prevention/independence/intermediate-care/highlights
[9] https://www.hi-netgrampian.org/wp-content/uploads/2019/08/Acute-Care-at-Home-Evaluation-Final-Report.pdf
[10] https://www.bgs.org.uk/policy-and-media/%E2%80%98sit-up-get-dressed-and-keep-moving%E2%80%99

- **Reduce length of stay in an acute setting** where admission is absolutely necessary, maximising recovery and enabling the opportunity to recover at home or within a community setting.

1.1. Vision:

The partnership's vision as outlined in its Strategic Plan is:

"We are a caring partnership, working in and with our communities, to enable people to achieve fulfilling, healthier lives".

The provision of an enabling intermediate care resource is a significant element in the reshaping of our health and care services for older people and those with long term conditions, providing a "bridge" between being cared for at home, and being cared for within an acute setting. Within Rosewell House, professionals will work together better across the traditional boundaries of health & social care support to provide a holistic service.

The reshaping of the service at Rosewell House will increase whole system capacity and help us deliver better outcomes for those individuals who need the care and support that is provided.

1.2. Values:

Our value base which should be evident in all our activities and working practices is: Caring, Person-led, Enabling and our Aims can be captured in five key words: Prevention, Resilience, Personalisation, Connections and Communities.

Previous work by the Scottish Government's Joint Improvement Team (JIT, which is now disbanded) identified aspects of an effective intermediate care system, which will be integral values of the service model at Rosewell House. These included: a focus on prevention, rehabilitation, reablement and recovery; accessibility; holistic assessment; coordination; and being managed for improvement.[11]

4. Development To Date

Following the IJB decision 27 April 2021, a small, focused working group was formed to develop the options appraisal, reporting to the weekly Rosewell Project Board. Attendance included:

[11] https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/countries-and-regions/scotland/2017/september/the-landscape-for-bed-based-intermediate-care-in-scotland.pdf?la=en

- Rosewell House management
- BAC Senior Management representation
- Social Work representation
- Nursing representation
- AHP representation
- Geriatrician representation
- Project support & evaluation representation.

Rosewell Options Appraisal

Aside from the membership outlined above, other services, including pharmacy and primary care have been engaged during the process of developing the options appraisal, as noted in table 22.

Through a series of workshops, the group:

- Reviewed the **overarching principles** underpinning new model for Rosewell House;
- Reviewed the **definition of intermediate care**;
- Reviewed the **objectives** for Rosewell House which were developed into evaluation criteria;
- Reviewed what **data** we will need to support the development of the service and the options appraisal;
- Reviewed the options, their **advantages and disadvantages** and considered what additional data might be needed to support these assumptions;
- Began our **health inequalities impact assessment** journey, considered how these might impact the options, and planned for completed the HIIA for the completed options appraisal.

The options appraisal process itself involved:

1. Individual evaluation of the appropriate weighting for each objective.
2. Collective agreement of the appropriate weighting for each objective.
3. Individual evaluation of the scoring of each option against each objective.
4. Collective agreement of the score for each option against each objective, reviewing the averages and spread of the individual evaluations.

Evaluation & Engagement

The completed evaluation of the interim arrangements was referred to throughout development and in particular in developing the engagement for this options appraisal. ACHSCP's Development Officer for Service User and Carer Involvement was onsite at Rosewell House and had conversations with services users. With the support of the Discharge Co-Ordinators, conversations were had with family members and carers to understand what was important about the experience.

An online survey, accessible via. QR code, was displayed on poster at Rosewell, though this had limited engagement. A thorough summary of engagement activities, findings and how these have been applied can be found in the engagement checklist in the appendices.

Research & Analysis

Through the work on the Frailty Pathway programme, the options appraisal was able to draw on a comprehensive tableau data-dashboard for Rosewell House and linking to Hospital at Home and Ward 102. Literature was also reviewed to take learning from other national consultations / initiatives and is summarised in the appendices.

5. Objectives

The following objectives were identified and agreed by the development group, following a review of previous papers including the draft documents for a Rosewell House registration.

Following agreement, they were developed further into the objectives for the options appraisal. Each individual on the development group was asked to weight the objectives individually using a Microsoft Form. The group then reviewed the outputs of this survey as a collective and agreed the weighting together.

Person-Centred

- **The service-model is person-centred and enabling:**
  - 1: To provide high-quality, compassionate, person-led care, support and treatment that meets each individual's health, wellbeing and social needs and desired outcomes as best as possible, focusing on a pro-active enablement approach to service delivery
  - 2: Experience of a stay at Rosewell to be as positive and compassionate as possible, ensuring expressed choices in respect of their clothes, personal needs, routines and activities is respected and facilitated as far as is reasonably practicable.

Connecting

- **The service model is situated in the centre of the Frailty Pathway and has excellent lines of communication with stakeholders:**
  - 3: To promote and facilitate working in a whole-system approach across the broader Frailty Pathway
  - 4: To liaise and communicate effectively with an individual's carers and other family members as appropriate

Effective

- **To use pathways as appropriate to ensure that the individual is best placed considering their needs, health and wellbeing:**
  - 5: Provides sufficient capacity to promote step-up care and avoid unnecessary admissions to acute hospitals.
  - 6: Aims to provide sufficient capacity to ensure step-down care from Ward 102 in a timely manner, reducing length of stay in and the number boarders within the wider acute setting.
  - 7:Ensures access to the capacity where possible i.e. in event of Covid19 surge

Flexible

- **The service model is responsive and adaptable given known and unknown circumstances:**
  - 8: The service model is able adapt to cope with different levels of demand i.e. during winter pressures
  - 9: The service model is able to adapt to cope with different type of demand i.e. increases in acuity

Empowering

- **The service model is empowering and enabling to staff that work there:**
  - 10: Provide clear lines of accountability and professional management
  - 11: Enables staff to make best use of their skills and personal development, regardless of professional background
  - 12: Enables a "one-team" ethos and reduces barriers to working as an integrated team

6. Options Appraisal

6.1 Option 1 – Do Nothing / Do Minimum

Description	Rosewell House returns to its original status at the end of 16-weeks and the previously scoped, agreed by the IJB model is not progressed.
Expected Costs	Costs of the previous model were met by Bon Accord Care via Service Level Agreement from ACHSCP / ACC.
Risks Specific to this Option	The most significant risk to this option is that Rosewell House, and the intended direction of travel as an integrated, intermediate care facility, underpins the functioning of the revised Frailty Pathway. Returning Rosewell House back to its prior function does not fulfil the ambition of working in a system-wide way to deliver improved outcomes for the population. Additionally, the capacity would be at risk if admissions were paused for up to 14 days due to a positive case[12].

Advantages & Disadvantages

	Advantages	Disadvantages
Patients		Increased risk of delays or boarding for Frailty Pathway patients. Increased risk of not being able to access the Frailty Pathway services. Increase risk of deterioration in hospital. Increased change of preventable admission to care home. Potential delay in receiving medication that might be required for acute treatment (e.g. injectable antibiotics)
Staff	Removes joint-staffing model	Reverses previous direction of travel which may be unsettling for staff who have worked within the interim arrangements for a period of time.
Service Model		Not an integrated model. No capacity for step-down or Frailty patients and additional capacity would need to be found within ARI as an acute setting. Not aligned with strategic direction, either locally or nationally. More fragmented model.

[12] https://publichealthscotland.scot/media/8220/2021-06-24-covid-19-information-and-guidance-for-care-homes-v22.pdf

			No stock medication or oxygen could be held on the premises as all medication would need to be individually prescribed for each resident.
	System		Not a whole-system solution.
	Resource	No additional resource required.	
Other Points	Any other relevant information: This option has been included as the status quo primarily to have a baseline option in which comparisons can be made, however it is highly unlikely that this option would be recommended due to its lack of strategic alignment and reversal of previous agreements by the IJB in relation to the wider Frailty Pathway.		

6.2 Option 2 – Maintain Interim Arrangements	
Description	Rosewell House continues to operate as it is currently, with a split of intermediate Frailty Pathway beds (scrutiny & assurance from HIS) and Care Inspectorate registered rehabilitation beds to deliver the integrated model. This is currently configured as: • Rehabilitation beds (20) – 18 rehabilitation beds, 1 place of safety, 1 permanent resident • Frailty Pathway beds (40) – step-up / step-down intermediate care There would be the possibility for reviewing the proportion of beds allocated to either bed-type, as well as the potential for flexible approach to allocation over year / in line with demand.
Expected Costs	Staffing costs as previously agreed for interim arrangements of £2,215,000 (from within Frailty redesign resource)

Advantages & Disadvantages

	Advantages	Disadvantages
Patients	There is a reduced risk of boarding/delays for Frailty Pathway patients compared with option 1 due to increase in available Frailty Pathway beds, resulting in less deterioration in a hospital/acute setting.	Patients have to isolate on admission to Care Inspectorate beds, either from ARI or from the Frailty Pathway beds. Engagement with patients/families found that this is a negative experience for patients and is sometimes unexpected and distressing.
		A person's experience of care can be different depending on which 'side' they are in, for example there are different visiting protocols; access to facilities ; isolation etc.
Staff	Minimal disruption to staff who are beginning to become familiar with the current arrangements.	Separate facilities prevent fully integrated working; this applies visiting staff too and can cause confusion
		Co-horted staffing will limit how well staff can work in an integrated model.
		Limitations to BAC staff within Frailty Pathway beds which may result in staff becoming deskilled in areas such as medication management.
		Potential for confusing lines of accountability / management as different 'sides' of the building are accountable to different organisations / policies. This includes two different routes of supplying medication, which could lead to confusion for staff and be time consuming to manage.

	Service Model	Involves minimal changes to existing arrangements	Works to multiple standards i.e. care home standards and hospital standards within the same building which causes inconsistencies and confusion within the model. Different medication management processes for NHS beds and for Care Inspectorate beds, therefore lack of consistency for staff across the whole unit.
		Provides some benefits of both the Care Inspectorate / HIS scrutiny model. If beds fall under HIS for scrutiny/assurance, this means that a formal' discharge letter to registered GP practice, reducing the risk of errors relating to changes to medication whilst patient resident at Rosewell	Does not provide fully benefits of either, and the additional confusion it provides to the overall building may not justify the benefits
	System	There is evidence that the current model has reduced pressure for step-down from ARI.	Only able to evidence reduced pressure for step-down, not step up
	Resource		Staffing general assistants to required level not possible within current budget & would require a review
Risks Specific to this Option	• **Patient wellbeing:** There is a risk to patient wellbeing if needing to isolate to move between HIS assured and Care-Inspectorate registered beds, or between ARI and Care Inspectorate registered beds. • **System flow:** There is a risk to system flow if 20 Care Inspectorate registered rehabilitation beds are closed due to a positive Covid19 case being identified. This is not the case in an HIS setting. • **Step-up capacity:** There is a risk that the current arrangements do not allow sufficient step-up capacity to be developed. • **Integration:** There is a risk that the current arrangements prevent working in an integrated way across the whole building.		

Other Points	This is the current situation at Rosewell House and has been set up in this way since January 2021.

6.3 Option 3 – Care Inspectorate: Assurance and Scrutiny for all 60 beds is provided via a Care Inspectorate Registration	
Description	Rosewell House operates fully as a Care Inspectorate registered facility, with Aberdeen City Council as the registered manager, to deliver the integrated model working in partnership with BAC (as previously agreed by IJB 02 October 2021 in report HSCP.20.052)
Expected Costs	
Advantages & Disadvantages	

	Advantages	Disadvantages
Patients	Reduced risk of boarding/delays compared with option 1. Consistent patient experience across the whole building.	Patients may experience a longer stay in an acute setting due to limitations to model for Rosewell House, limiting the patient acuity can be safely looked after i.e. cannot provide oxygen or intravenous medications. This may result in further deconditioning.
	Pre-Covid19, a Care Inspectorate registration would have allowed for the provision of a more homely setting i.e. soft furnishing.	In line with current Covid19 restrictions, *all* patients would need to isolate on arrival at Rosewell House.
	Consistent patient experience across the whole building.	
Staff	BAC staff may have opportunities to be up-skilled and may find this model more motivating/satisfying	Potentially de-skilling for nursing staff, as the Care Inspectorate model would necessitate a reduction in patient acuity that could be cared for at Rosewell House.
	Opportunity for BAC to broaden its employment of roles such as AHPs	Currently, there are more rigid staff co-horting requirements from Care Inspectorate registered facilities than in NHS

			facilities, which adds barriers to integrated staff working together.
	Service Model		Demand forecasting (outlined above) demonstrates that the complexity and acuity of patients is expected to increase in future years, and a Care Inspectorate model would be less able to deliver this type of care and adapt to the needs of the population.
			Limitations to the medical/pharmacy model • No stock medication could be held (all medication would have to be individually prescribed for each patient / resident). • No oxygen (unless prescribed for an individual) could be held on site. • Potential delay in receiving medication that might be required for acute treatment (e.g. injectable antibiotics). • No 'formal' discharge letter to registered GP practice. Risk of errors relating to changes to medication whilst patient resident at Rosewell.
			Reduced access the liaison psychiatry service. The Liaison Psychiatry team will be unable to support with any complex advanced Dementia or cognitive impairment issues as they only support NHS in-patient facilities. This would be detrimental to patient care.
			Outdated legislation and a very cautious approach to innovation may reduce opportunities for an innovative, intermediate model. Attempts to achieve an appropriate registration in late 2020 were difficult.

	System		Increases risk to system-wide Frailty Pathway flow with the possibility of loss of 60 bed capacity in case of positive covid19 case, resulting in closure to admissions, preventing discharges and stopping visiting. For example, between October 2020 and January 2021, Rosewell House was closed to admission for a total of 107 days due to Covid19 outbreaks, a total of 6,420 bed days[13].
	Resource		Nursing staffing would not be used to the best of their skills looking after a lower acuity of patients in line with Care Inspectorate requirements.
Risks Specific to this Option	• **Approval:** There is a significant risk that discussions with the Care Inspectorate would not progress sufficiently, or at sufficient pace, to allow the implementation of the model under a Care Inspectorate registration. • **Capacity and System Flow:** There is a significant risk to system flow if 60 Care Inspectorate registered rehabilitation beds are closed due to a positive Covid19 case being identified. • **Recruitment & Retention:** There is a risk that NHSG employed staff would not find a Care Inspectorate model an attractive place to work and therefore this may impact on recruitment and retention. • **Patient Wellbeing:** There is a risk to patient wellbeing if required to have a longer stay in an acute setting due to the lower capacity threshold for Rosewell House.		
Other Points	Any other relevant information.		

[13] **TURAS Daily Safety Huddle Tool**

	Additional Pharmacy Resource: • Depending on the how medications are managed, there would be a requirement for some additional primary care pharmacy team support. The pharmacy team at Garthdee Medical Practice would not have the capacity to subsume this into their role (& it would be inequitable for them to have to do so, as patients could be registered at any medical practice in the City). • Further scoping of demand / workload would be required if this was the option chosen. Likely to require at least 0.5WTE Band 5 technician plus 0.5WTE Band 7 Pharmacist.

6.4 Option 4 – Health Improvement Scotland: Assurance & Scrutiny for all 60 beds is provided by HIS

Description	Rosewell House operates fully with scrutiny/assurance for all beds provided by HIS to deliver the integrated model in partnership with Bon Accord Care.		
Expected Costs			
Advantages & Disadvantages		Advantages	Disadvantages
	Patients	Beds under HIS can accept a higher level of acuity for both step-down and step-up care. This means that it is less likely that a patient will deteriorate in terms of their functional independence during a hospital stay as they can be discharged to a more homely setting earlier. It also increases the range of patients who can be admitted on a step-up basis.	Less homely environment than a care-inspectorate registered facility (pre-ovid19) due to requirements around infection prevention and control.
		No requirement for isolation period on transfer from ARI / Ward 102, which results in less negative impacts on patients due to isolation/loneliness.	

	Consistent patient experience across the whole building therefore patient expectations are more likely to be met.		
	Reduced risk of boarding/delays compared with all other options, therefore patients are		
	Removes requirement to be 'transferred' Frailty Pathway to Rehabilitation beds and removes need for further isolation.		
Staff	Medication management procedures allow NHS nurses to work at higher skill level	Limitations to BAC staff within HIS Frailty Pathway beds which may result in staff becoming deskilled in areas such as medication management.	
	Less rigid requirements for staff co-horting than in a care inspectorate registered facility.		
Service Model	Fewer limitations to model for Rosewell House which would have a positive impact on people using the service – for example, being able to step-down patients with higher acuity into a more community focused setting, reducing the time needed in a hospital setting and providing an earlier op	Could become a medically-focused admissions model i.e. where a medic could overrule a decision based on the admissions criteria. Risk that the step-up capacity is not developed.	
	Improved access to community teams such as the liaison psychiatry service to support patient well-being.		

		Better model for innovation if HIS provides assurance/scrutiny due to the constraints around registration with the Care Inspectorate.	
		Greater flexibility in adapting the levels and types of care delivered in line with HIS assurance/scrutiny than in a Care Inspectorate model which will better help meet future demand.	
		Benefits to the medication and pharmacy elements of the model including: • Ability to hold stock medicines (including Oxygen) on site for patients in Frailty Pathway beds will allow a fast response to requirement for new or additional medicines for acute treatment • Consistency of medicines processes across the whole facility and across the whole week including weekend and out of hours • Formal hospital discharge (IDL) would be sent to registered GP practice to allow medicines reconciliation (reducing the potential for medication errors)	
	System	Reduces risk of closure and bed loss due to Covid19 positive cases , therefore reducing the risk of boarders / patients not being able to access the service.	
	Resource		

Risks Specific to this Option	• **Recruitment & Retention:** There is a risk that BAC employed staff would not find working under HIS assurance an attractive place to work and therefore this may impact on recruitment and retention. • **'Takeover':** There is a risk that this is perceived as an 'NHS takeover', particularly as there may be a perception that the NHS is 'in charge' at Rosewell House currently. • **Step-down focus:** There is a risk that focus remains on flow out of the hospital, rather than step-up care preventing flow in.
Other Points	Any other relevant information.

Weighting of the Objectives

The above objectives were weighted as follows: (1 = not important, 2 = moderately important, 3 = very important)

Objective 1 person-centred care	3	**Objective 7** access to capacity:	3
Objective 2 positive experience, personal choice	3	**Objective 8** adapts to level of demand:	3
Objective 3 whole system across frailty pathway	3	**Objective 9** adapts to type of demand:	2
Objective 4 effective communication	3	**Objective 10** clear lines of accountability:	3
Objective 5 promote step-up care	3	**Objective 11** enables staff:	3
Objective 6 provides step-down care	2	**Objective 12** enables one-team working	3

The objectives were then scored as follows: Fully Delivers = 3 Mostly Delivers = 2 Delivers to a Limited Extent = 1 Does not Deliver = 0
The table overleaf provides the weighted scores for each option against each objective (i.e. score x weight)

6.5 Scoring of Options Against Objectives

Objectives	Options Scoring Against Objectives				
	1	2	3	4	Summary of Narrative
Objective 1 person-centred care	0	0	3	3	• Interim arrangements do not allow seamless service for patients • This is particularly if transferring between rehabilitation and Frailty pathway beds
Objective 2 positive experience, personal choice	3	3	6	6	• Facilities are kept entirely separately in the interim arrangements • Resulting in increased periods of self-isolation if transferring between services • This is both from ARI and from beds within Rosewell
Objective 3 whole system across frailty pathway	0	3	3	6	• Rosewell House is a central element of the redesigned Frailty Pathway • Options 1 & 2 are not a whole system approach • Option 4 provides most opportunity in relation to changing patient demand • Option 4 provides the most flexibility to deliver care
Objective 4 effective communication	6	3	6	6	• Options 1, 2 & 3 simplify communication as single assurance provider/regulator
Objective 5 promote step-up care	0	3	3	6	• Options 1, 2 & 3 have limitations in the type of care that can be delivered
Objective 6 provides step-down care	0	2	2	4	• Acuity levels for step-down care could not be cared for under Care Inspectorate • i.e. where provision of oxygen is required
Objective 7 access to capacity	0	3	0	6	• A CI registered facility is not accessible in case of Covid19 cases • This has previously closed Rosewell, most recently on 21st June
Objective 8 adapts to level of demand	0	3	3	6	• CI registered beds would be at risk of closure to admissions • If HIS provide assurance, the facility will be more easily able to change service provision in line with demand
Objective 9 adapts to type of demand	0	2	2	4	• If assurance was provided by HIS, the facility can adapt to level of care more easily and care for a higher acuity of patients care for a higher acuity of patients • This provides greater scope for the type of intermediate care that can be provided
Objective 10 clear lines of accountability	6	3	6	6	• Interim arrangements have separate process and accountabilities in different parts of the building which can cause confusion • Options 1, 2 & 3 would have a single scrutiny body for the whole facility

Objective 11 enables staff	3	3	3	6	• Different impacts on different staffing groups for different options • Option 3 restricts NHSG nurses from working at top of skills set • Option 4 removes some medication management responsibility from BAC HCSWs • Option 4 allows development of all staff groups for new skills which would be less accessible in other models such as phlebotomy and increased MDT working
Objective 12 enables one-team working	0	3	3	3	• The interim arrangement creates separate teams within Rosewell House • Care Inspectorate policy has stricter rules on staff co-horting
Total	**18**	**31**	**40**	**62**	
Ranking	**4**	**3**	**2**	**1**	

Scores given above are weighted using the weights of the objectives. See appendix X for breakdown.

In summary, the preferred option is for the assurance and scrutiny of the integrated model at Rosewell House to be provided by Health Improvement Scotland.

Option	**Score**	**Rank**
4 – Assurance & Scrutiny provided by HIS	62	1
3 – Care Inspectorate Registration	40	2
2 – Keep Interim Arrangements	31	3
1 – Do Nothing	18	4

6.6 Recommendation

Based on the options appraisal above, it is recommended that option 4, providing assurance and scrutiny via HIS, is implemented following the end of the interim period in October. Option 4 has the ability to provide the most needed types of care within the Frailty Pathway, is most likely to be able to adapt to future demand and is most likely to guarantee access to this capacity.

7.1. Scope

The project will ensure the delivery of an integrated, intermediate care facility for the people of Aberdeen as a part of the Frailty Pathway. The project will work to gain the appropriate registration, embed the changes and develop the step-up provision to transition the project to 'business as usual'

7.2. Out of Scope

8. Benefits

8.1. Service User/ Citizen / Unpaid Carer Benefits

Benefit	Measures	Source	Baseline	Expected Date	Measure Frequency
Reduced admissions to hospital, prevention and early intervention	Proportion of step-up admissions	Frailty Pathway Dashboard (Rosewell)	2-3%	March 2022	Available daily, weekly, monthly
Reduced hospital length of stay, early discharge home	Proportion of step-down admissions	Frailty Pathway Dashboard (Rosewell)	97-98%	March 2022	Available daily, weekly, monthly
Reduction in admissions to care home, increased independence, reduced	Number of discharges to home	Frailty Pathway Dashboard (Rosewell)	65%	March 2022	Available daily, weekly, monthly

need for care packages					
Less time in an acute / intermediate setting reducing risk of becoming dependent during stay	Length of Stay	Frailty Pathway Dashboard (Rosewell)	16 days (HIS) 24 days (CI)	March 2022	Available daily, weekly, monthly
Increased patient satisfaction	Patient satisfaction	Discharge 'Making Every Opportunity Count' conversations	Qualitative	March 2022	Ad-hoc

8.2. Staff Benefits

Benefit	Measures	Source	Baseline	Expected Date	Measure Frequency
Increased staff satisfaction	Vacancy factor Sickness absence iMatter survey	NHS / BAC	NA	March 2022	Weekly / Monthly
Skill sharing	Qualitative	Management	NA	March 2022	Ad-hoc

8.3. System Benefits

Benefit	Measures	Source	Baseline	Expected Date	Measure Frequency
Increased access to capacity at Rosewell House	Reductions in bed-days lost at Rosewell House	Frailty Pathway Dashboard / Surge & Flow dashboard	107 days	March 2022	Monthly
Increased access to the right care, at	Reduction in over 65s	Unscheduled Care dashboard	226.5 per 1,000 12 month trend		Monthly trend

the right time, in the right place	emergency admissions				
	Reduction in Emergency department / AMIA attendance from care homes	Unscheduled Care dashboard	3 per day	March 2022	Monthly
	Reduction in W102 Boarders	Unscheduled Care dashboard	Average 8	March 2022	Available daily, weekly, monthly

9. Costs

The integrated, intermediate care facility at Rosewell House will not incur any additional costs but is a redesign of existing resource:

	£	**Notes**
NHSG Staffing Model	£2,215,000.00	*Frailty pathway redesign budget*
BAC Staffing Model	£2,878,800.00	*BAC budget*
Rent	£375,000.00	*Transfer to ACHSCP*
Premises Cost	£129,500.00	*Transfer to ACHSCP*
Total	**£5,598,300.00**	

10. Procurement Approach

The current BAC contract will need reviewed considering the recommendations of this report. A variation will need to be put in place to reflect the changes in service delivery, removing reference to respite and the number of rehabilitation beds, and instead focusing on the services to be delivered to take account of non-residential services being offered at Rosewell House by Bon Accord Care.

The current arrangements in place with regard to the interim position would need to be terminated and new contracts put in place or varied as required. NHS Grampian would thereafter take occupation of Rosewell House and a support service would be delivered by Bon Accord Care in respect of those 60 beds. Those support services being delivered by Bon Accord Care would require a contract for services with ACC as commissioning body. NHSG, BAC and ACC will need to put in place a contractual arrangement for the delivery and operation of the integrated service.

11. State Aid Implications

This project will not have any state aid implications.

12. Equalities Impact Assessment

A health inequalities impact assessment has been completed and can be found in the appendices.

	13. Key Risks	
	Description	**Mitigation**
Operational Risk	There is a risk that focus remains on flow out of the hospital, rather than step-up care preventing flow in. There is a risk that the proportion of step-up care does not increase and allow prevention of avoidable acute bed base admissions.	Test of Change with Hospital @ Home triaging all calls to 102 and redirecting care which may enable some step up capacity. Dedicated communications plan with community services such as GP practices. Community focused leadership and proposed ANP / AHP led model for the rehabilitation beds
Reputational Risk	There is a risk that this is perceived as an 'NHS takeover', particularly as there may be a perception that the NHS is 'in charge' at Rosewell House currently.	The options appraisal and registration **does not** fundamentally change the vision of the model which ACHSCP/BAC are trying to deliver. The model is for an integrated, intermediate care facility. HIS is noted as the lead for intermediate care facilities so could be considered appropriate[14].
	There is a risk of a negative impact on the local residents due to ongoing issues relating to staff parking / resident access to driveways.	Promote green travel with staff where possible; promote parking sensitively to local residents needs explore installing bike lockers; explore 'park & ride' between Summerfield House / Woodend and Rosewell; explore possibility of creating additional on-site parking

[14] https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/countries-and-regions/scotland/2017/september/the-landscape-for-bed-based-intermediate-care-in-scotland.pdf?la=en
https://ihub.scot/improvement-programmes/living-well-in-communities/our-programmes/

Workforce Risk	There is a risk of deskilling BAC staff if medication administration needs to be delivered by registered nurses. There is a risk that BAC employed staff would not find working under HIS assurance an attractive place to work and therefore this may impact on recruitment and retention.	Whilst this is a risk, ACHSCP will actively progress discussions to seek to clarify or adapt current policies to allow BAC Support Workers to continue to keep this in their role remits. Additionally, there is scope for further upskilling staff, with additional clinical skills such as phlebotomy and increased exposure to the multi-disciplinary team. A skills audit planned for post-organisational change process. Involve consultation with staff to identify what skills they might like to develop. Ensure that this is reflected in development plan.
	There is a risk that the two staff groups do not integrate and work well together.	Regular meetings with staff to resolve any concerns. Ongoing organisational development provided.
	There is a risk that recruitment is not able to fully staff the intended model.	Ongoing, recurring recruitment, monitoring skill-mix and adapting workforce as required.
Governance Risks	There is a risk that the option is not approved by all relevant parties (ACHSCP, NHSG, BAC & ACC)	Co-development of options appraisal Workshops with IJB and BAC board members

14. Time

14.1. Time Constraints & Aspirations

October 2021 – End of interim arrangements

14.2. Key Milestones

A full implementation plan has been developed and oversight of its delivery will be provided by the Rosewell House project board.

Description	Target Date
IJB Board	August 2021
BAC Board	September 2021
Develop and implement action plan to promote proportion of step-up care	September 201
Notification / Application to HIS	September 2021

Notification to Care Inspectorate	September 2021
Amendments to BAC SLA / creation of additional arrangements	September 2021
Cease license to occupy / develop lease for NHSG	October 2021
Interim Arrangements end	October 2021
Amendments to medical cover SLA	March 2022
IJB update report & interim evaluation	Summer 2022
Full evaluation and review of arrangements	March 2023

15. Governance

The Rosewell House Clinical & Professional Oversight Group will continue to meet. A whole-facility report will be completed and reported to both BAC and ACHSCP clinical & care governance meetings. Further details around governance are given below.

Role	Name
Project Sponsor	Fiona Mitchelhill, Lead Nurse, ACHSCP Pamela McKenzie, BAC MD
Project Manager	Sarah Gibbon, Programme Manager, ACHSCP
Other Project Roles	Julie Warrender, Transitional Lead (Rosewell), ACHSCP Nicola Dinnie / Alison Wills, Operations Directors, BAC Zoe Pirie, Home Manager (Rosewell), BAC

16. Resources

Task	Responsible Service/Team	Start Date	End Date
Project Support	Sarah Gibbon, Programme Manager, ACHSCP	TBC	TBC
Health Improvement Scotland	Fiona Mitchelhill, Lead Nurse, ACHSCP	Sept 21	Sept 21
Care Inspectorate	BAC Managing Director	Sept 21	Sept 21
Lease	Stephen Booth, Chief Officer (Corporate Landlord) ACC Gerry Donald, Head of Properties and Assets, NHSG	Oct 21	Oct 21
BAC SLA	Anne McKenzie, Lead Commissioner	TBC	TBC
Medical Cover SLA	Emma King, Lead for Primary Care (GMS)	Jan 22	Mar 22

17. Stakeholders

- **IJB Members**: reports, briefings, 1-1s
- **BAC Board Members**: reports, briefings, 1-1s
- **NHSG Leadership Team:** flash reports
- **BAC Leadership Team:** flash reports
- **ACHSCP Leadership Team:** flash reports
- **ACC Elected Members:** briefings
- **NHSG Staff:** briefings, drop-ins, 1-1s, meetings, OD sessions
- **Rosewell House Staff:** briefings, drop-ins, 1-1s, meetings, OD sessions; Rosewell newsletters
- **Wider Frailty Pathway colleagues: Frailty** Pathway newsletter
- **Patients:** face-to-face, phone calls, discharge conversations
- **Families & Carers:** discharge co-ordinators; surveys; face-face, phone calls
- **Staff Partnership Involvement:** project groups, meetings, 1-1s, briefings

18. Assumptions

- Demand modelling is sufficiently accurate in the prediction of an increase in both numbers of people with frailty and the complexity of their care.
- The integrated, intermediate care facility will continue to be delivered as a shared staffing model in collaboration between BAC, ACHSCP, ACC and NHSG.
- BAC staff will have opportunities for personal development for enhanced skills in line with those that NHSG staff will have access to.
- Proposals are agreed by all parties involved including BAC, ACHSCP, ACC and NHSG.

19. Dependencies

- Agreement of recommended option by all partners involved in model delivery.
- Agreement for lease from ACC.
- Agreement to registration from HIS.

20. Constraints

End of the interim arrangements in October 2021.

21. ICT Hardware, Software or Network infrastructure

Description of change to Hardware, Software or Network Infrastructure	Approval Required?	Date Approval Received
NA – in place	NA	NA

22. Support Services Consulted

Service	Name	Sections Checked / Contributed	Their Comments	Date
Rosewell Project Board	Rosewell Project Board Attendees	Entire document		06.07.21
IJB Statutory Consultees	Derek Jamieson (Committee Clerk)	All		July / August
BAC Board	BAC Board	Seminar		18.08.21
BAC	Alison Wills (Operations Director)	All	Part of development group	Ongoing
	Nicola Dinnie (Operations Director)		Part of development group	Ongoing
	Zoe Pirie (Home Manager)	All	Part of development group	Ongoing
	Gail Woodcock (Interim MD)	All		06.07.21
	Pamela MacKenzie	All		02.08.21
Nursing	Fiona Mitchelhill (Lead Nurse) Julie Warrender (Transitional Lead)	All	Part of development group	Ongoing
AHPs	Lynn Morrison (Allied Health Professions Lead) Catriona Cameron (Physiotherapy Lead) Beth Thomson (Occupational Therapy Lead)	All	Part of development group	Ongoing
Social Work	Claire Wilson (Lead Social Work) Barbara Dunbar (Acting Service Manager)	All	Part of development group	Ongoing
Geriatricians	Sarah Alder (Consultant Geriatrician)	All	Part of development group	Ongoing
Pharmacy	Kim Cruttenden	All	Detail on the implications of each	22.07.21

	(Pharmacy Lead) (Alison Davies (Lead Pharmacist) Liz Robertson (Lead Pharmacist)		option on the medical /pharmacy model	
Frailty Pathway	Jason Nicol (Lead Specialist Older Adults and Rehabilitation Services)	All		Ongoing
Finance	Scott Thomson (Management Accountant)	Finance & Costings		
Commissioning	Catherine King (Category Manager – Residential Services/Support Services) Neil Stephenson (Strategic Procurement Manager (Social Care)		Advice regarding the current contract	Late July / Early August
Legal	Jess Anderson Suzanne Douglas		Directions, scheme of delegation Representing ACC's interests regarding contracts/delegations	Several meetings during late July
ACC Property	Stephen Booth		Discussions on license to occupy	04.08.21
NHSG Property	Gerry Donald		NHSG LTO /lease requirements	02.08.21
Information Governance	Alan Bell Roohi Bains	NA – input	DPIA / IS / access to records	05.08.21

23. Document Revision History			
Version	**Reason**	**By**	**Date**
V1	Initial Draft	Sarah Gibbon	08.07.21
V2	Draft for IJB Consultation	Sarah Gibbon	20.07.21
V3	Committee Clerks comment's included	Sarah Gibbon	22.07.21
V4	IJB Legal's comments included	Sarah Gibbon	22.07.21

V5	Additional information from pharmacy consultation added; additional information on additional workforce added	Sarah Gibbon	26.07.21
V6	**IJB Pre-Agenda Draft:** Outputs of delivery model workshop added;	Sarah Gibbon	30.07.21
V7	**Post IJB Agenda:**	Sarah Gibbon	03.08.21
V8	Updates following EPB meeting	Sarah Gibbon	05.08.21
V9	**IJB – 2nd Formal Consultation**	Sarah Gibbon	16.08.21
V10	**Final Draft – IJB**	Sarah Gibbon	18.08.21

1. Rosewell House – Overview

Delivery Model

Rosewell will provide appropriate care, treatment and rehabilitation to Aberdeen-based older people aged 65 + who meet the stepped-care admissions criteria although younger adults whose health and wellbeing is such that they meet the criteria will also be considered for admission.

Registration

The options appraisal undertaken to determine the most appropriate registration for Rosewell House evaluated the options and determined that HIS providing the assurance and scrutiny would be the best registration to take forward the proposed service model.

Admissions

Admissions for intermediate care will be on a short-term basis with criteria-led planning for discharge commencing at the point of admission so that the individual can achieve the goals required to safely return them to a homely setting.

Our admissions and discharge to assess criteria are set out in Rosewell's Admission and Discharge procedure. Final determination of which individuals will be admitted to Rosewell will be undertaken by the multi-disciplinary team with a criteria-led admissions process supporting decision making.

Types of Care

Step-up Care

Step-up care is an alternative support for someone who is unable to safely remain in their own home. Step up to Rosewell will provide care at the point of crisis and emergencies to avoid unnecessary acute hospital admission. Examples of this may include:

Mr Smith lives with a long-term neurological condition called Parkinsons disease. He is having a tough time as their condition has deteriorated. He is admitted to Rosewell on a step-up basis and provided with treatment, rehabilitation and enablement to prevent further deterioration and admission to an acute hospital.

Mrs Fraser is usually manages fairly well at home, but is suffering from a urinary tract infection, which is giving her a little delirium and is increasing her risk of a fall in her home. She is admitted to Rosewell on a step-up basis, provided with short-term treatment to bring things under control and to prevent further injury /potential admission

Mx MacKay has been being looked after by the Hospital @ Home teams. Whilst they are not acutely ill enough to to be admitted to hospital, the Hospital @ Home team is concerned about their safety overnight. They are admitted to Rosewell on a step-up basis.

Step up will not include people who are awaiting admission to long term care, people who are awaiting rehousing where their current house is deemed to be unsuitable or people who are awaiting aids and adaptations where their current accommodation is unsuitable.

Step-down care

Mr Johnson has been receiving care in Ward 102 at ARI. He has had a comprehensive geriatric assessment and is stepped-down to Rosewell once stable for continuing care and rehabilitation.

Mrs Gilchrist was admitted to Ward 102 as an emergency admission at 3am overnight. She is not acutely unwell, and after assessment, is able to be stepped-down to Rosewell for continuing care before returning home.

Mx Stephen is recovering from a pelvic fracture and requires some rehabilitation that cannot be provided in their home. They are stepped down to Rosewell House to received the rehabilitation until they are enabled to be discharged home.

Step-Down care is for those who require ongoing care, treatment and rehabilitation after having been in Ward 102 (the Acute Frailty Unit) at ARI or Woodend Hospital.

Care plans will be in place for each resident irrespective of the pathway by which they were admitted to Rosewell and their expected length-of-stay. An identified staff member will be the keyworker with responsibility for ensuring that the care file reflects the assessed needs and expressed choices of the individual. It is expected that residents and their carers will be offered reasonably practicable opportunities to contribute to the development of their own care file.

<u>Residents' Profile</u>

Rosewell is a 60-bedded unit split into six units that will function as a 'whole-system' resource whose broad configuration will be as follows:

Rehabilitation	Resident	Place of Safety	Frailty Pathway Beds Step up, step down including delirium and place of safety
18 beds	1 bed	1 bed	40 beds
Individual resident goal setting to lead care Will need (daily) medical input. Need for 2 to mobilise Falls/Upper limb fractures who cannot cope at home Optimising independence after acute episodes : Neuro/ Medical/ Other	Long-stay	Resource to be utilised by SW where individuals require to be placed due to harm/risk of harm	24-hour medical cover & Advanced practitioner Oxygen monitoring & titration IV therapies; Fluids or antibiotics Pneumonia – swallow concern (therapeutic assessment & intervention) Intensity of intervention greater than 4 x daily H@H visits MH / Psychiatric liaison support Specialist wound care where appropriate

Rosewell Bed Configuration

The First floor will be mostly for acutely unwell individuals who will either have been 'stepped-up' from the community or 'stepped-down' from the Acute Frailty Unit. These individuals will require 24-hour medical and nursing input with multiple interventions per day and will have therapy input. The ground floor will be utilised for rehabilitation however one bed will be set aside for 'place of safety' purposes and there is also currently one permanent resident. Utilisation of beds within these broad categories will be flexible dependent on individual need.

Medications & Pharmacy Arrangements

Stock medicines for Rosewell House will be supplied by Aberdeen Royal Infirmary and held on-site. Medication for patients' discharge would be supplied from the ARI dispensary.

Initially, the medical cover for the 20 rehabilitation beds will continue to be provided by Garthdee Medical Group until the end of their current SLA in March 2022 when the medical cover will be reconsidered.

It is the long-term ambition that the 20 rehabilitation beds will be an advanced-nurse practitioner or allied health professional led unit, where patients are enabled to manage their own medications. In line with community pharmacy guidelines, this could be with staff acting in a 'prompting' or 'assisting' manner, rather than in an 'administering' manner. This will require further work, including collaboration with pharmacy colleagues.

Staffing and Workforce

Management Structure

Given that this is a new integrated model of service deliver, careful consideration has been given to its operational management, professional governance and wider accountabilities to Aberdeen City Council & NHS Grampian.

The scrutiny and assurance for Quality of Care of services in Rosewell House will be provided by HIS. This means that NHS Grampian will be accountable for the delivery of care and support provided at Rosewell House. However, the responsibility for the operation of the service however will be delegated under the Integration Scheme to the HSCP's Integration Joint Board (IJB). The HSCP's Chief Officer is accountable to the IJB and the Chief Executive of NHS Grampian and Chief Executive of Aberdeen City Council for the operational delivery and performance of the delegated functions.

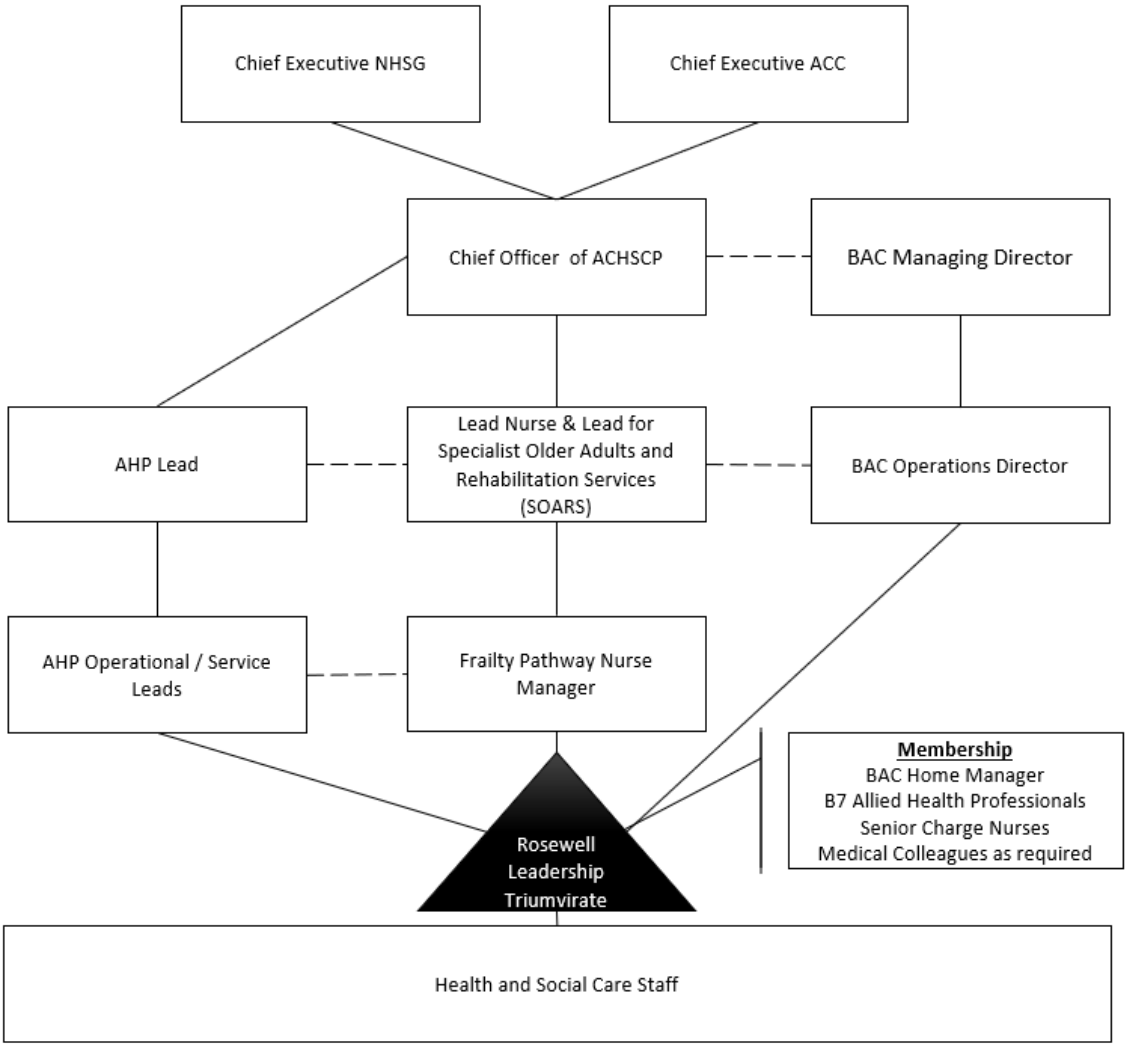


Figure 7 Rosewell House Management & Governance Structure

The Rosewell House ACHSCP/NHSG manager of the integrated service will have responsibility for the strategic and operational delivery of care at Rosewell House and as such will ensure that safe, effective, person-led care and support will be delivered in line with the national Health and Social Care Standards and all other regulatory and professional standards, policies and procedures. The Lead Nurse for the HSCP will provide professional leadership and supervision to the Rosewell House ACHSCP/NHSG manager of the integrated service. The Lead for Social Work and the BAC Operations Director will also provide appropriate management and professional oversight to ensure the safe, effective delivery of care and support.

The Rosewell House ACHSCP/NHSG manager of the integrated service will also have a responsibility for liaising with appropriate colleagues from across Aberdeen City Council, the HSCP, NHS Grampian, and Bon Accord Care to ensure that the care delivered meets the expectations of all stakeholders including of course the individual, their carer and other family members as appropriate.

Operational Management

The operational day to day management will ensure ongoing high-quality care is delivered and will provide the necessary management and direction to all staff within the integrated service.

A key working relationship within the structure is the HSCP/NHS Manager and the 'Leadership Triumvirate' as outlined above. The HCSP/NHS manager will work closely together with the triumvirate onsite within Rosewell House to manage the teams collaboratively.

Any concerns not resolved between the managers will be escalated to the relevant HSCP/NHS or Bon Accord Care Manager.

The HSCP/NHS Manager will be directly supported by a Senior Charge Nurse and the Bon Accord Care Manager supported by Assistant Managers, working together to meet the needs of the service. If at any point further intervention and or support is required at a higher level, this will be taken forward by the Rosewell House ACHSCP/NHSG manager of the integrated service and the most appropriate route.

Staff Governance

The management and staffing structure for the new integrated service reflects our desire to have a high-functioning multi-disciplinary workforce capable of meeting the needs of all residents irrespective of their health and wellbeing and the pathway by which they came to be cared for in Rosewell. Allowing for the different professional roles that will be evident in the newly configured service and the accompanying professional governance obligations and employer attachments, a 'one team' ethos that is mindful of the underpinning multi-agency partnership (ACHSCP/BAC/NHSG/ACC) will be promoted by the service management team at all times.

Staff contracts of employment will be with their respective employer: Aberdeen City Council, NHS Grampian or Bon Accord Care as appropriate. Individual staff conduct, performance and development will be in line with the appropriate policies and procedures of these organisations.

Areas in which a joint-policy may be desirable include:

- Moving & handling
- Leave & absences
- Recruitment
- Uniform policy

These will be explored, in collaboration with staff, over the initial months of implementation of the model.

The Rosewell House ACHSCP/NHSG manager of the integrated service has responsibility for the safe, effective delivery of care and appropriate regulatory compliance and has the authority to direct all staff members in pursuit of these goals, irrespective of who their employer is.

Staff registered with a regulatory body are personally accountable for their professional conduct, in accordance with the requirements of these bodies and will be governed through their employer's management/professional structures. Should there be a concern about the conduct or performance of any staff member then Rosewell House ACHSCP/NHSG manager of the integrated service will discuss this with the relevant senior manager from ACC, NHSG/HSCP or BAC as soon as possible

and support that senior manager with whatever actions the appropriate HR procedures require to be undertaken.

Staffing Structure

ACHSCP and BAC will work together to collaboratively design the workforce model required for the longer-term model.

There will be different staffing requirements required between the Frailty Pathway and rehabilitation beds due to the differing levels of acuity of the patients. The patients on the ground floor should be medically stable and requiring rehabilitation therefore there should be a predominant therapy-based requirement. The first floor will require more nurse staffing due to the nature of the acute episode the patient has had, which requires further medical and nursing intervention.

This will involve the following roles:

Management & Team Leaders:

- Senior Charge Nurses
- BAC Home Manager
- BAC Assistant Managers
- BAC Senior Supervisors

NHS Grampian roles:

- Registered nurses
- Health care support workers
- Housekeepers
- Receptionists
- Allied Health Professionals

BAC roles:

- Support workers
- General assistants
- Occupational therapists
- Administrators
- Admission & discharge co-ordinator

Staff Induction & Development

Organisational Development

Organisational Development will hold weekly sessions with staff in Rosewell House to ensure the staff have the necessary support throughout the changes that are happening. These sessions will focus on helping promote team building, communication and embedding new ways of working.

These will be supported by various methods including writing a purpose statement and setting team objectives.

Workshops will be held for staff, to promote team building but will also look at ensuring staff have role clarity, improving communication between the Rosewell House team and other stakeholders in the frailty pathway and starting to build the culture of Rosewell House as an integrated, intermediate care facility.

Staff experience will be measured to address any areas that could be improved upon and to identify areas that are working well.

New Staff Induction

Every new staff member at Rosewell will undertake an appropriate employer-specific induction in line with its stated corporate objectives and also a Rosewell-specific induction that reflects the operational activities of the service and what the staff member needs to be aware of to deliver safe, effective, good quality care and support to the residents. It is the responsibility of both the staff member and the Rosewell House ACHSCP/NHSG manager of the integrated service to ensure that this induction is completed; a record will be maintained by the Rosewell House ACHSCP/NHSG manager of the integrated service showing that every colleague who has worked at Rosewell, irrespective of their job function has undertaken this service induction.

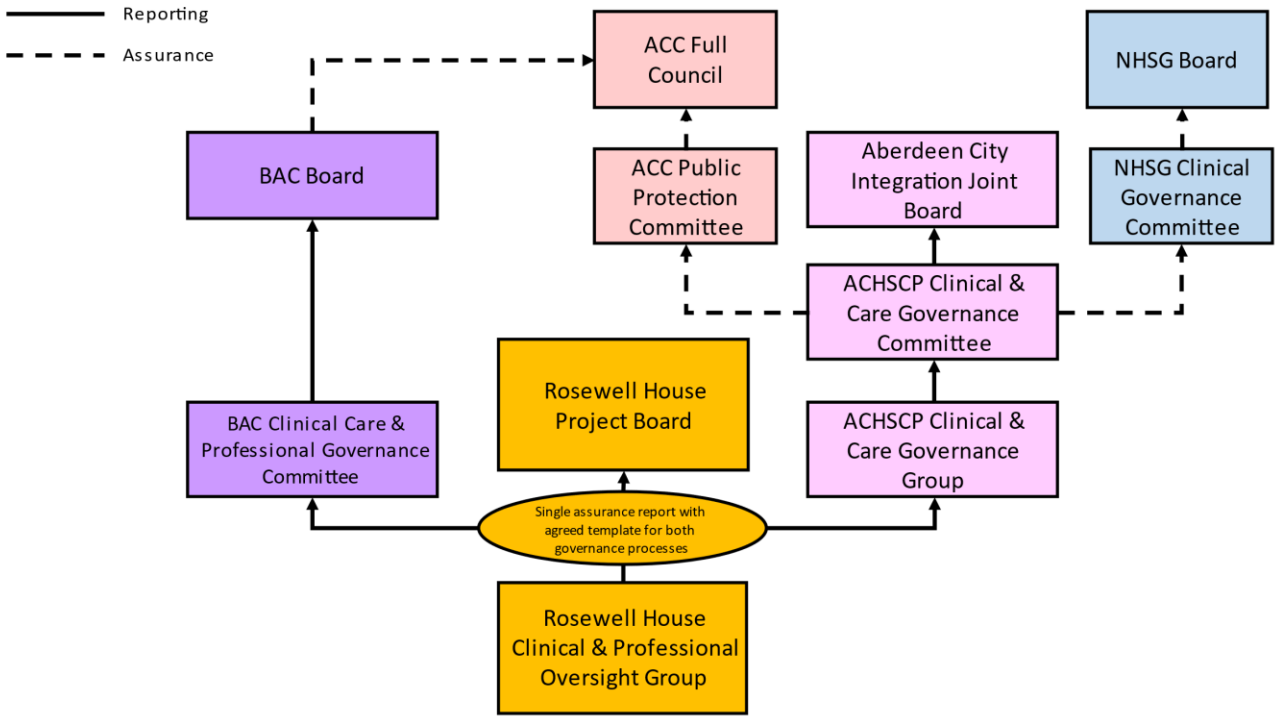
Clinical Governance & Accountability

This service will fit in to the partnership's existing health and social care governance and assurance framework. The Aberdeen City Integration Joint Board (IJB) has a responsibility for planning the delivery of appropriately delegated health and social care services from NHS Grampian and Aberdeen City Council, allocating funds appropriately, and monitoring the practice and performance of these delegated services. To support its scrutiny and oversight role, the IJB has established a Board Assurance and Escalation Framework which sets out the governance structure, systems and performance and outcome indicators through which the IJB receives assurance. It also describes the process for the escalation of concerns or risks which could threaten delivery of the IJB's priorities, including risks to the quality and safety of services.

Staff members will be accountable to their own governing bodies.

A cross-system 'Clinical & Professional Oversight Group' has been established at Rosewell House and meets fortnightly to discuss clinical & care governance issues which are of relevance to all organisations on a building-wide basis. This will continue in the new registration arrangements.

Additional joint-governance and oversight will be provided by the existing fortnightly Rosewell House project board, attended by senior leadership representatives from BAC and ACHSCP, as well as operational management (BAC & ACHSCP) from Rosewell House. The project board will be accountable for the implementation plan for the recommended option as well as providing scrutiny of the Roswell House Clinical & Professional Oversight Group.



A single template will be developed for reporting from this group through both BAC's and ACHSCP's clinical and care governance reporting routes, along with any standard reporting for the service (i.e. Rosewell will be reported through the nursing services highlight report).

For ACHSCP, reporting will be via the Clinical & Care Governance Group, to the Clinical & Care Governance Committee, to the IJB (as required, and operating within the IJB's risk management framework). For Bon Accord Care, reporting will be via their 'Clinical Care & Professional Governance Committee'.

The Rosewell House ACHSCP/NHSG manager of the integrated service will work within this governance framework and ensure that the operation of the service meets all professional and regulatory obligations and in doing so, provide the IJB and its statutory partners with the assurance they require that Rosewell is providing safe, effective and high-quality care and support to its residents at all times.

Policies and Procedures

Rosewell House has a comprehensive portfolio of policies and procedures that govern all aspects of its delivery of care and support, including:

- Medication Management
- Admissions
- Criteria-led Discharge
- HR Policies
- Recruitment
- Infection Control

- Rota Planning

Given its multi-agency workforce there are also relevant policies and procedures from Aberdeen City Council, NHS Grampian and Bon Accord Care for the Rosewell House ACHSCP/NHSG manager of the integrated service to be mindful of also.

It is not expected that the professional discharge of any worker's responsibilities should bring them into conflict with the stated expectations and requirements of any individual policy or procedure however it is accepted that there may be, depending on circumstances, discussions that require the input of professional leads, unions and partnership colleagues. The Rosewell House ACHSCP/NHSG manager of the integrated service will have the responsibility for agreeing what steps are necessary to clarify, revise or update Rosewell policies and procedures.

Evaluation of the Service

The Rosewell House ACHSCP/NHSG manager of the integrated service and the HSCP's Chief Officer and Senior Leadership Team are committed to ensuring that the delivery of care and support meets the highest standards at all times and that individual outcomes and experiences are positive. We recognise the importance of ensuring that the service is able to demonstrate that we are meeting the Health and Social Care Standards and using this framework to drive improvement and promote innovation in how people are cared for and supported.

Formal Evaluation

A formal evaluation of the service, supported by the ACHSCP's Lead for Research and Evaluation will be essential. It is intended that the results of this evaluation will be available in Spring 2023.

Self-Evaluation

We recognise that Self-evaluation is central to continuous improvement. It enables our care home to reflect on what we are doing so they can get to know what they do well and identify what they need to do better. Self-evaluation is based on three questions.

1. How are we doing? – Do we understand how good our service is and the impact it has on the lives of people experiencing it?
2. How do we know that? – Do we have evidence to show how good we are? Staff can look at performance measures, outcomes and processes but we should also speak to the people experiencing our service, and their families to get their views.
3. What do we plan to do next? – What is our improvement plan? What are our improvement priorities? What changes do you plan to test out?

We will then use a model for improvement to ensure that the changes we make will actually lead to the improvements we intended. Tests of change will be created following feedback from the residents, representatives of residents, home Manager, care home staff, stakeholders both internal and external and once we are getting consistent and positive results, we will set a date for implementing them. We will ensure all staff know about the changes, and when, how and where they will happen. We will involve staff throughout the process. We will update written guidance and policies to include any new ways of working.

Feedback will be obtained in various ways. This will include direct participation, being part of a reference group, questionnaires, feedback from care reviews, comments and suggestions boxes, resident and representatives' meetings, staff meetings. Where a representative requires additional support to be able to participate this will be supported by the necessary means such as talking mats, pictorial support.

We recognise that because we are developing an innovative, integrated intermediate resource that there will be much focus and scrutiny on the operation of the service and the outcomes it is delivering for the individuals who use this service and the wider frailty pathway. We are confident that we will be able to demonstrate how multi-agency, multi-disciplinary knowledge, skills and expertise can be harnessed in the best interests of the residents.