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ROSEWELL HOUSE - EVALUATION

JANUARY 2022 – JULY 2022

Rosewell Evaluation

This paper provides an interim evaluation of Rosewell House, to review the implementation of the service to date and identify improvement areas to target for the next year. This marks a halfway milestone of the 2-year life of the project, as approved by the Integration Joint Board & Bon Accord Care Board in August 2021. A full evaluation will also be required in Summer 2023, to inform a recommendation to both Boards in Winter 2023.

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1. Executive Summary

Background

Rosewell House is a 60-bedded integrated, intermediate care facility where Bon Accord Care and Aberdeen City Health & Social Care Partnership are delivering person-centred care and therapy, with a reablement and rehabilitation focus. The Integration Joint Board and Bon Accord Care Board approved a transition of the whole facility to Healthcare Improvement Scotland in August 2020, implemented in January 2021. This report provides an evaluation of the service to drive continuous improvement.

Methods

- Quantitative data review including TRAK Care and Datix.
- Multi-model qualitative methods of 1-1s, focus groups and surveys.
- Thematic analysis applied; responses coded then grouped into themes.

Themes and Recommendations

Vision	1. renewed, comprehensive communications and engagement plan 2. consider renaming the service
Patients	3. promote activities co-ordinator across whole facility 4. review the escalation pathways
Staffing	5. review of the workforce model from an integrated perspective. 6. review of the medical rotas to increase consistency 7. empower all staff to communicate with families about care 8. implement and embed Criteria-led Discharge Planning
Service Model	9. continue to develop the step-up pathway 10. consistently apply criteria-based admissions to step-down beds 11. align processes in Frailty and Rehab beds where possible 12. undertake test of change with H@H support for rehab beds
Environment	13. explore opportunities for improved staff amenities 14. review the responsibilities matrix
Logistics	15. explore portable x-ray machine for diagnostics support 16. promote Rosewell as 'in-patient' for access to diagnostics 17. further develop test of change with support from NERVs for logistics 18. priority protocol for portering services where supporting discharge 19. new transport solution to be developed
IT & Systems	20. review alarm systems with current contractor/new contract 21. prioritised implementation of electronic patient record 22. IT and systems access audit for BAC staff

2. Background

Rosewell House is a 60-bedded integrated, intermediate care facility where Bon Accord Care (BAC) and Aberdeen City Health & Social Care Partnership (ACHSCP) are delivering person-centred care and therapy, with a reablement and rehabilitation focus. Care and therapy can be provided as a step-up from the community as an alternative to hospital admission or as a step-down from Aberdeen Royal Infirmary to help recovery. The main admission routes for Rosewell House are from the Frailty pathway (40 beds) or from the Rehabilitation pathway (20 beds).

This evaluation has been produced given the following agreements from the IJB and BAC boards, when approval to transition all 60 beds within Rosewell House under the scrutiny of Healthcare Improvement Scotland (HIS):

- a) To instruct the Chief Officer ACHSCP / BAC Managing Director to bring a report to the March 2022 IJB meeting which outlines the progress against developing the step-up elements of care at Rosewell House; (*deferred to August meeting*) and
- b) To instruct the Chief Officer ACHSCP / BAC Managing Director, to bring a joint evaluation report to the IJB / BAC board in summer 2022, summarising ongoing progress delivering the intended outcomes and actions for continuous improvement.

The original objectives for the service are as follows:

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

3. Research Questions

The overall research question for this evaluation is:

Is Rosewell House attaining its goals and objectives?

To understand this, we are going to explore three separate elements (described below) in more detail:

How is Rosewell House performing against the outcomes in the business case?

What's working well?

What could be improved?

Research Question	Description of Question	Data Collection Approach	Capacity Required
How is Rosewell House performing against the outcomes in the business case?	The original business case submitted to the IJB, and BAC Boards had high-level performance indicators to demonstrate the anticipated benefits for patients, staff, and the system	Quantitative data - Tableau / Health Intelligence analysis	½ day data analyst 22.08.2022
What's working well?	This research question will focus on identifying the areas in which Rosewell House is performing well, from the perspectives of all stakeholders for Rosewell House.	Semi-structured interview Focus group Survey	1 hour per attendee 1-2 hours per focus group
What could be improved?	This research question will focus on identifying the areas in which Rosewell House is not performing well, from the perspectives of all stakeholders for Rosewell House.	Semi-structured interview Focus group Survey	1 hour per attendee 1-2 hours per focus group

4. Methodology

A mixed method, multi-modal approach was applied to generate an understanding of the above research questions, to ensure that appropriate context is provided when attempting to understand the *why* behind the data.

The following stakeholders were consulted in the development of the approach for the evaluation: Rosewell House Transitional Lead; BAC Integrated Care Lead; Lead Nurse; Organisational Development facilitator; Senior Project Manager for Data and Evaluation; Evaluation Lead (stakeholders as consultants); Public Health Researchers; Rosewell House Project Board.

Further details on all methods outlined below, including the number of participants, can be found in appendix 1.

4.1. Pre-Existing Work

A previous evaluation identified the development of the step-up model as a priority. As a result, an extensive programme of engagement was undertaken to develop an action plan – this evaluation will draw on the learnings from this engagement, as well as the outputs of a cross-system workshop on the wider Frailty Pathway which took place on the 11th of May 2022.

4.2. Data Collection

4.2.1. Interviews & Focus Groups

The qualitative data informing this evaluation was gathered through a series of interviews and focus groups, using a purposeful sampling approach to allow a 'systems perspective' to be generated through the findings. These took a semi-structured format, with guided yet open questions to allow participants to talk freely about their perspective and opinions, with prompts to help facilitate the discussion. For the 1-1 interviews, these were captured on a standard recording template. To increase the likelihood of truthful opinions being captured, sessions were anonymous not recorded, however detailed notes were taken during the discussions and sense-checked with participants to ensure the data captured were reflective of their thoughts and experiences. Fieldnotes taken during discussions were subsequently coded and organised into themes and sub-themes to provide a systematic presentation of the data.

4.2.2. Patient Survey

A patient survey was run from the 19th of July to the 2nd of August and consisted of several both qualitative and quantitative questions, focusing on what they valued about the support provided; the communication; involvement in care planning and how the service could be improved. The survey was distributed in hard copy at Rosewell House, as well as via posters displaying a QR code and a social media campaign. Given the recommendation of the previous evaluation, families and carers were the primary targets for the survey, however a small sample size was returned (n=12). A summary of the patient survey and approach can be found at appendix 2.

4.2.3. Review of Other Qualitative Data Sources

A review of available qualitative data (complaints; compliments, letters; and Care Opinion stories) was also completed to identify themes within these sources.

4.2.4. Quantitative Data

Source of existing quantitative data were also reviewed. Rosewell House has a performance dashboard established on Tableau which provides easily accessible data relating to the service, including admission sources, length of stay, and discharge destinations. Additional data was gathered with support from the Health Intelligence team, utilising sources such as Trak and Datix.

A key activity was to review the original data that was included in the benefits section of the original business case, to provide a comparison. The Frailty Pathway dashboard on Tableau was also reviewed. A review of available data relating to incidents and feedback on the NHS Feedback system Datix also took place.

5. How is Rosewell performing against the outcomes in the business case?

This section looks at quantitative data to provide contextual information, which will be further explored in the qualitative discussions later in this paper.

Service User / Citizen / Unpaid Carer Benefits

The following indicators were included in the original business case, aiming to demonstrate the benefits for the people we look after in Rosewell and their families/friends. 100% of the patients admitted to Rosewell have been over 65 (61% are over 85). This reflects the prevalence of Frailty within the community. Further data is provided in table 1 below.

Staff Benefits

Along with many services across Grampian, Rosewell House is experiencing staffing pressures, which is similar across the health board, and these issues are explored further in the paper. Due to the timing of this evaluation, over the summer holiday period and currently high Covid19 levels, these figures and impacts will be higher than at other times of the year.

Table 1 Rosewell House Staffing Statistics

	Bon Accord Care	NHS Grampian Nursing and HCSW
Vacancy Factor	6% July 2022	22% July 2022
Absence Factor	17% May, 15% June, 30% July <i>(Annual leave + sickness)</i>	29% May, 27% June, 18% July <i>(annual leave + sickness)</i>

Understanding the current Covid19 situation is important context when considering the staffing information above, and the staffing challenges described in detail further in this paper. The initial data was gathered in early 2021, when Covid19 positivity rates were estimated to be much less than when the comparison data was gathered for the same period in 2022. This means that the current data will be more impacted by the associated staff absences across the system – whilst Covid19 restrictions are lifted for the public, Rosewell staff are still testing twice per week, and if positive must be off for 6-10 days depending on attaining a negative result. This also impacts the wider system, impacting on flow through Rosewell from both directions.

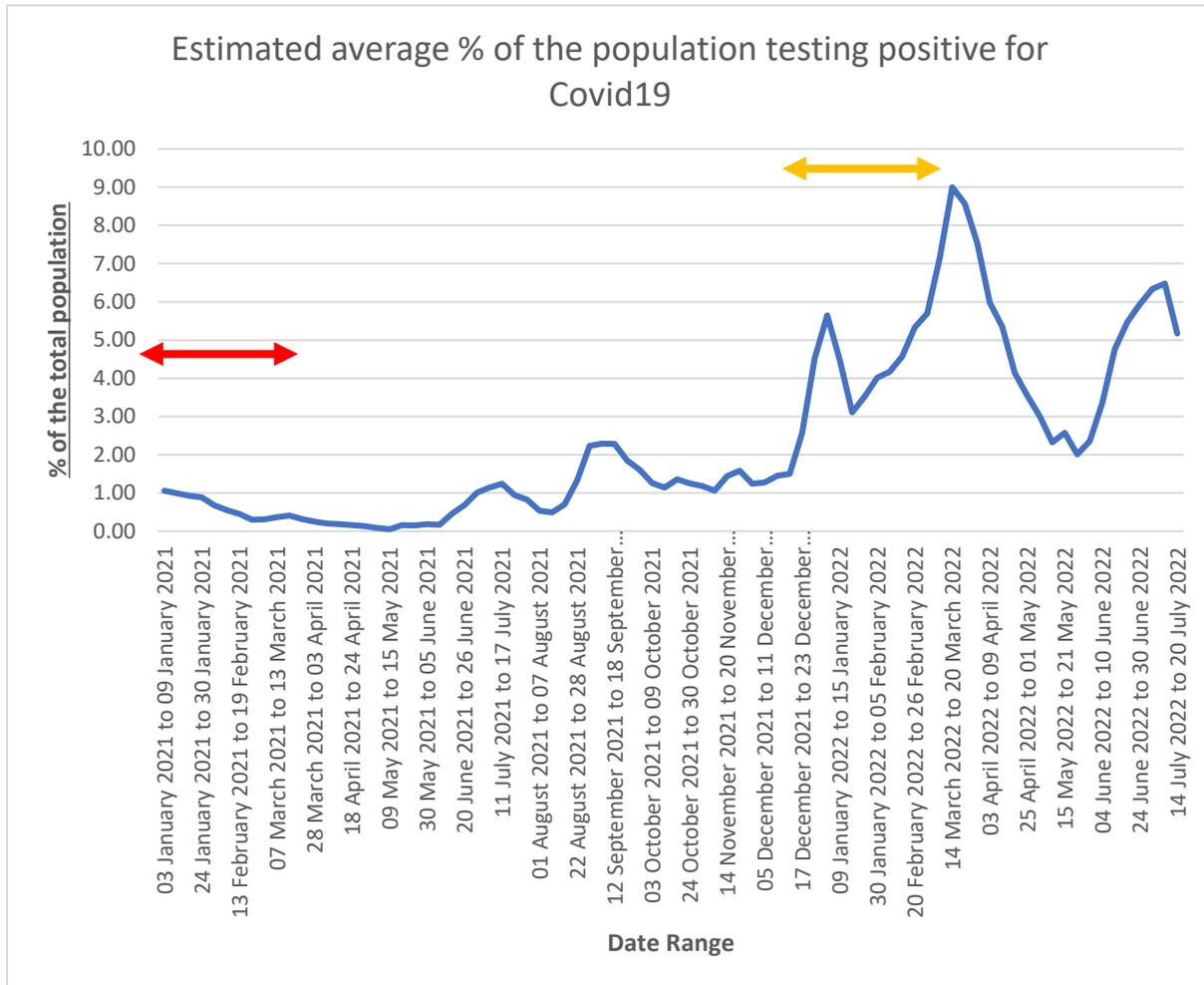


Figure 1 Covid19 Estimate Positivity Rates¹

 Baseline data
 Comparison data

System Benefits

The original business case identified several potential benefits for the wider system, as outlined in table 2 below. Many of the benefits assumed successful increase of the step-up care provision within Rosewell House. Additionally, it is difficult to directly attribute causality for any improvement/decline in these figures to Rosewell House as they are influenced by several factors. However, they do demonstrate an important benefit for the system: Rosewell House has not needed to be closed in its entirety since transitioning to HIS, ensuring access to the critical capacity for step-down admissions.

Table 3 describes the potential loss of bed-days, which were avoided by transitioning the entire facility to Healthcare Improvement Scotland. This resulted in an 80% reduction in

1

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveys/pilot/29july2022>

possible bed days experienced if guidance for care homes had remained the same – however guidance for care homes is more in line with the guidance for hospital settings now compared to winter 20/21, and where possible closures are limited to a unit.

Table 2 System Benefits from Original Business Case

Benefit	Measure	Baseline	Current	Difference	Notes
Increased access to capacity at Rosewell House	Days whole facility closed	107	0	Decreased	Transitioning to a HIS-model has enabled Rosewell House to continue to accept admissions during incidents of Covid19+ patients
	Number of potential “bed days lost” avoided by avoiding total closure	3,630	870	Decreased	
Increased access to the right care, at the right time, in the right place	Reduction in over 65s emergency admission	226.5 per 1,000 12-month trend	208.8 per 1,000 12-month trend	Decreased	
	Reduction in ED/AMIA attendances from care home	3 per day	Not available	NA	Revisions to the unscheduled care dashboard meant these figures were unavailable
	Reduction in W102 Boarders	Average daily boarders = 8	Average daily boarders = 14	Increased	W102 borders are influenced by a range of factors beyond Rosewell

Table 3 Detailed Rosewell Bed Closure Statistics

	Start Date	End Date	Days Closed	Bed Days' Lost
Fern	07/01/2022	09/02/2022	33	330
Poppy	06/02/2022	16/02/2022	10	100
	05/07/2022	15/07/2022	10	100
Daffodil	04/02/2022	14/02/2022	10	100
	21/03/2022	02/04/2022	12	120
Bluebell	21/03/2022	02/04/2022	12	120
			87	870

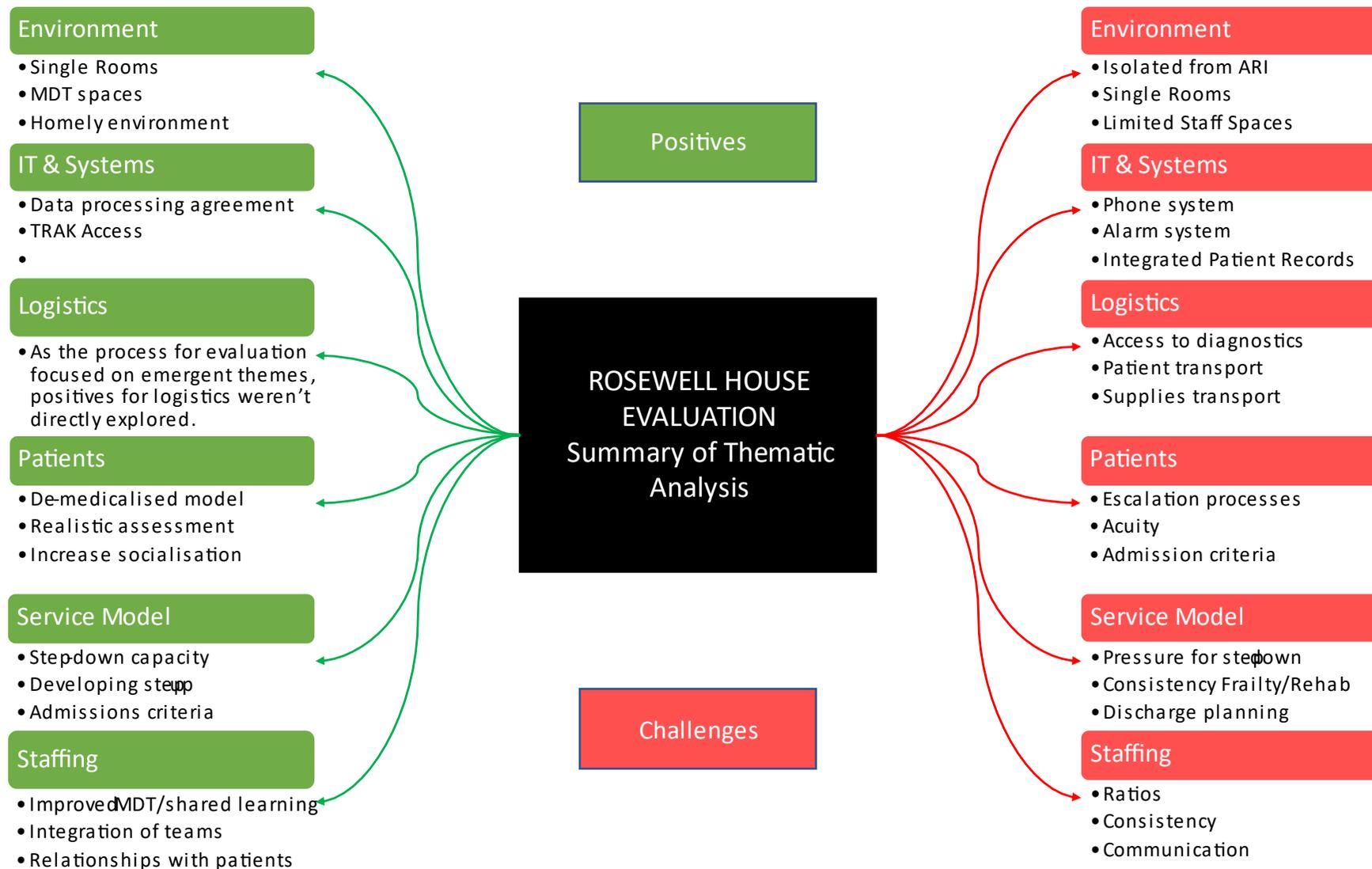
If RW as a whole had closed over same period 4500
Potential bed-loss days avoided by HIS model **3630**

Table 4 Rosewell House - Patient Benefit Measures

Benefit	Measure	Care Type	18-01-21 to 01-03-21	18-01-22 to 01-03-22	Difference	Notes
Reduced admissions to hospital, prevention, and early intervention	Proportion Step-Up Care	Frailty	1%	3%	Increased	Explored further later in the paper (6.4) There has been a slight improvement in the proportion of admissions, and there is an action plan to increase this further.
		Rehab	NA ²	20%		
Reduce hospital length of stay, support early discharge home	Number of admissions	Frailty	86	70	Decreased	Admissions to Rosewell for continuing care reduces the overall time spent in an acute setting.
		Rehab	NA [1]	24		
	Step-Down Care	Frailty	99%	97%	Decreased	Explored further later in the paper (6.4) There has been a slight improvement in the proportion of admissions. There is an action plan to increase this
		Rehab	NA	80%		
Reduction in admissions to care home, increased independence, reduced need for care package	Proportion of discharges to home	Frailty	65%	60%	Decreased	There has been a slight decrease in the proportion of discharges to home. This may be related to the increased pressures across the system and reduced availability of care home / care at home support.
		Rehab				
Less time in an acute / intermediate setting, reducing risk of becoming dependent during stay	Average length of stay	Frailty	12.4 days	19.81 days	Increased	The data from 2021 is slightly skewed as the timeframe was only 3 months since transitioning to HIS. There is a long-stay patient in the rehab beds which impacts these figures.
		Rehab	NA	24.43 days		
	Maximum length of stay	Frailty	36 days	107 days	Increased	As a further comparison, the average length of stay for Ward 16 / 17 in 2018 was 33, and for Ward 17 in 2019 was 48, though it is important to note these compare a different service model.
		Rehab	NA	75 days		
Increased patient satisfaction	Qualitative	This indicator was explored via a patient survey and collation of existing feedback methods.				

² Please note that as the baseline measures were taken before the rehabilitation beds transitioned to HIS (and therefore data was recorded on TRAK), there is no available comparison data for these measures.

6. What's working well, and what could be improved?



The following section, exploring the key themes uncovered during the evaluation engagement, will draw on all qualitative research methods to provide a singular, holistic view.

6.1. Vision

The vision for Rosewell House is innovative and both the staff working within Rosewell, and the teams that surround Rosewell, need to reframe how they interact with the service compared to other ‘traditional’ services to ensure it is successful.

6.1.1. Positive

There was a lot of positivity amongst staff members (across all roles and employing organisations) for the model and the opportunities that it offers, and there was an increased ownership of this model by the staff members at Rosewell House, compared with the early stages of implementation. Colleagues are excited by the prospect of the model, describing it as a *“good philosophy”*, the *“right thing to do”* and *“so different from what went before”*. However, it was recognised that it is an early stage of the journey and that *“we are just a little bit away”*

Leadership has been challenging with a high turnover of senior charge nurses in a short period of time. The leadership around the vision has strengthened over the past months, with increased visibility from senior leaders in ACHSCP and BAC and is expected to increase further with the appointment of a Bon Accord Care Lead for Intermediate Care and an NHS Service Manager for Rosewell House.

6.1.2. Challenges

Many participants commented that it there remains a lack of understanding of the service, *“who we are and what we can do”*, both from ARI and primary/community care. There is a feeling that other services are not clear on what Rosewell House can offer and that *“not many people realise that it is different from a care home”*. This was reinforced in in the patient evaluation, where respondents sometimes referred to Rosewell House as a nursing home or care home. Additionally, there is a need to embed the vision of Rosewell as a single, 60-bedded unit moving from the view of two units of *“20 beds and 40 beds”* (explored further in section 6.4)

6.1.3. Opportunities and Future Recommendations

- a. *Communication & Engagement*: Rosewell House should create and deliver a renewed, comprehensive communications and engagement plan to promote the service across the wider system. This could include hosting open days at Rosewell House and inviting acute and primary care colleagues to visit the service.

- b. *Rebranding*: Rosewell House may wish to consider renaming the service to mark a transition away from the care-home model to the intermediate care facility – to show “a clear change in the direction of the place”.

6.2. Patient Experience

There are many positive aspects to the patients’ experience at Rosewell House, and points relating to the environment are explored later in the report.

6.2.1. Positive

De-Medicalised Model

One of the main perceived benefits of Rosewell House is that it is de-medicalised, taking patients out of a hospital setting once they’re not acutely unwell. This supports the individual, reducing the risk of deteriorating independence and functionality whilst in hospital.

Realistic Assessment

Staff, particularly AHPs, felt that Rosewell House provides a more realistic, homely environment to assess a patient, recognising that previously “*the clinical environment is constraining*”. Rosewell House was felt to offer much more scope for the multi-disciplinary team (MDT) to understand a patient’s capabilities and challenges before returning home, by “*having the ability to adapt [the environment] to replace a person’s life*”. This, coupled with an increased focus on enablement approach, is felt to result in improved patient outcomes and a reduced need for support.

Social

Colleagues commented that Rosewell House provides more activities for patients, particularly with the access to the activities co-ordinator in the rehabilitation beds. The increased access to shared spaces provides more opportunities to socialise with other patients, for example to share meals, and the open visiting is a benefit for families.

6.2.2. Challenges

Patient Acuity

There were comments made that Rosewell House cannot provide for patients with high levels of medical acuity, resulting in escalation back to ARI (see below). For example, Rosewell House does not provide piped oxygen therapy, and the inability to accommodate patients on high oxygen requirements or provide better monitoring can mean that if

individuals escalate and require oxygen, they cannot stay in Rosewell, disrupting flow. This also would provide a poor patient experience, if their care needs are not being met, resulting in an additional move within the pathway.

Escalation

Whilst staff feel supported with the acuity of patients and are “*comfortable knowing that [they] can escalate to ARI if required*”, there can be delays in escalating patients to ARI. It was felt that there is a lack of a clear pathway for escalation back to ARI, with difficulty making suitable arrangements with the Emergency Department if required. Colleagues described how this can be particularly difficult in the rehabilitation beds, which are not covered by the medical staff, as they must call through to the GP Out of Hours service (GMEDs). This can be further exacerbated by transport issues (explored in section 6.6.2 below).

Patient’s journey through the pathway

Some staff highlighted that Rosewell House creates an additional stage in a patient’s journey, which can be unsettling particularly when patients’ may also be experiencing delirium and confusion. The focus group highlighted that patients can be moved multiple times before being transferred to Rosewell House and are sometimes transferred 24 hours or less before discharge.

6.2.3. Opportunities and Future Recommendations

- a) *Activities Co-Ordinator*: To maximise the benefits from increasing social opportunities, all staff should be encouraged to approach the Activities Co-Ordinator for support within their wings. Rosewell House leadership should ensure that all staff are aware that the remit of the activities co-ordinator includes the whole facility.
- b) *Escalation*: Review the escalation pathways to avoid the rehabilitation beds requiring to call GMED Out of Hours to escalate to ARI. This may be mitigated by existing plans to utilise Hospital @ Home to provide enhanced medical cover for the rehabilitation beds (see below)

6.3. Staffing

6.3.1. Positive

Multi-Disciplinary Teams

Many team members spoke highly of the good multi-disciplinary approach within Rosewell House, with comments arising frequently around the quality of the MDT. People described how “*having a diverse team under one roof, including care, means that you’re seeing...the person from lots of different angles [with] enriched information and much more*”

personalised. Additionally, it was described how all the different disciplines have come together to work collaboratively to “*share the patient journey from referral to discharge*”. It is felt that the MDT based at Rosewell makes access to the services provided by Allied Health Professionals easier than in ARI and that communication between members of the MDT is strong within Rosewell. Nursing colleagues commented that the level of support from the AHPs is excellent.

Creating Integrated Teams

Recognising the speed with which teams were brought together during the early stages of the projects, many colleagues were positive about how the teams came together. Having the split between Healthcare Improvement Scotland and Care Inspectorate registrations made integration difficult initially “*the processes that were in place were initially for the 4 wings, and there was a difficult time downstairs with a Covid19 outbreak – this didn’t help how the teams integrated together as the first thing we did was divide into the two units*”.

However, since the transition in January this year, it was felt that day-to-day the teams work well together, and colleagues enjoy how the two organisations have come together to problem solve and “*formulate a plan together*”. Developing shared spaces, such as the MDT spaces and shared office space for leaders, has helped to reinforce the relationships.

There is recognition that the integration of the teams still growing and developing. There is an opportunity for further work to ensuring that everyone within Rosewell really understands the different roles and responsibilities of the teams, and how the team interplays with the system. Opportunities to design a more integrated team structure was identified during the evaluation, for example with the administrative and domestics services.

Shared Learning

Shared learning was a common theme throughout the engagement and was identified as a key benefit of Rosewell House. This was multifaceted as respondents commented on the shared learning between BAC and NHSG staff members, as well as between members of the MDT, and across the Frailty Pathway, including a deeper understanding of the community teams and care management: “*there is shared learning, shared experience and this is beneficial for the staff not just in Rosewell, but in the wider health and social care system*”.

Colleagues spoke of the benefits of being able to have conversations about patients in different ways, drawing on the perspectives of the different disciplines – “*This is what I see as one of the main benefits, to learn from other services, professionals, from BAC*”. BAC have benefited from being up skilled in clinical care and NHSG have benefited from BAC’s expertise in enablement.

Bon Accord Care staff described how initially aspects of their roles were removed during the transition, but how this turned around when all beds were brought under HIS: “*basically once the final two [wings] changed, this change – we can do medications, can do observations, can do blood glucose monitoring – [we] have gained skills*”.

There was a desire to ensure that all staff members are trained equally and to the same standard across the range of activities which Rosewell House delivered – to truly integrate the training for health care support workers / support workers and to ensure that processes/procedures are understood commonly across colleagues whether employed by BAC or NHSG. Staff in the focus groups also highlighted the possibility of job-role sharing or shadowing to increase flow by improving the knowledge and relationships between 102 and Rosewell.

Leadership

Over the course of the year to date, and learning from the experience, the leadership structure at Rosewell House has been revised. The previous iteration saw a ‘triumvirate’ of Band 7 leadership within Rosewell House (AHP, nurse, BAC), reporting through their professional lines. It was recognised that to have the strength of leadership displayed during the transitional period and to drive the service forward to continually improve, that a permanent NHS Service Manager role was required, to work in close partnership with the BAC Intermediate Care Lead, as well as the AHP, Nursing and Medical leadership within the unit. This role has been successfully appointed to and the new candidate will join Rosewell House shortly. This is a promising development for the leadership of Rosewell House and will help to work through embedding the vision and the recommendations from this report.

Relationships with Patients

Patients at Rosewell House, and their families/friends/carers are incredibly positive about the staff at Rosewell House, commonly praising their friendliness, compassion, and motivated care. Rosewell House frequently received thank you letters, cards and collections which express the gratitude towards staff members, whilst recognising the pressures that they work under. This was recognised explicitly in 100% of survey responses where additional comments were provided:

- *“The manner in which they dealt with the patient. There were friendly and it felt like they care”*
- *“Very patient and considerate of patient needs”*
- *“She was never left alone when the family couldn’t be there, and they were so supportive of all the family. They made a terrible time bearable and treated my mum with respect at all times, I can’t praise the carers enough for all that they did”*

To Sunflower Staff

Can't thank you enough for
taking care of dad's

...very, very much!

welfare during his last days.

Nothing was too much
trouble and you were all
so caring.

We will never forget your
address.

Rotate

Dear Rosewell House

I would like to say a very big 'THANK YOU' to all your staff for looking after my Mum [redacted] the Thistle and Bluebell Sections.

During her time with you rehabilitating after a hip injury the care and attention she received from everybody was outstanding; nursing, physiotherapy, occupational, stewarding and serving staff should all be individually thanked and praised for their professionalism and patience.

At the moment Mum is at an Aberdeen Care Home and this is where she will be living meantime. She misses Rosewell and the happy staff who helped her with everything, and thanks to your help and understanding was able to be discharged and almost walking again.

I would be very grateful if you would please let all staff aware of this letter both in Thistle and Bluebell Sections as a letter can be 'just filed' without being viewed.

6.3.2. Challenges

Staffing Ratios

From feedback during the evaluation, it was apparent that Rosewell House was facing reduced staffing, particularly for nursing, occupational therapy, senior service supervisors and healthcare support workers. At the time of writing this evaluation, the NHS nursing staffing at Rosewell House had 7.8 wte vacancies, mainly nursing and healthcare support worker vacancies (21%). The BAC OT service has been unable to recruit occupational therapists to the rehabilitation unit, so NHS Grampian have been providing supplementary staffing.

This is not unusual to the system now, where a combination of increased Covid19 cases and the summer holiday season has created staffing shortages across the system. Again, at the time of writing this evaluation, there was an 18% absence rate for Rosewell nursing staff (sickness + annual leave) which adds additional pressure with the current vacancy factor.

Whilst not a problem for Rosewell alone, it was felt that with the separated wings, private rooms, and isolation from the wider ARI campus, that the impacts of staffing shortages are more intense for Rosewell House:

"Staffing is tight across a lot of disciplines; when someone doesn't turn up it really has an impact as running with the minimum amounts. Thinks that the staffing pressures are the same as elsewhere, but causes more stress when it happens, due to isolated nature of Rosewell"

This was reflected in the patient evaluation, where respondents often spoke highly of the staff's care and commitment yet found that communication was difficult.

- *“Very difficult to find nurses or GP – moved the patient to another floor and family not advised”*
- *“During the first 7 weeks of the stay there was little communication from the medical staff even when asked to see someone”*

Several respondents explicitly commented that improvements in the staffing ratios were required and gave examples of when patient care had been impacted, for example by taking too long to respond to patient requests or help delays with help for toileting.

Current recruitment efforts will reduce the vacancy factor to 2% by October, which will greatly improve the staffing ratios.

Consistency of Staffing - Agency

Given the current level of vacancy and absence, there are high levels of agency use in Rosewell House currently, both for registered nurses and for BAC support workers. Combined, this creates challenges, particularly around ensuring routines and processes are followed, and increases the workload for substantive members of staff. This impacts flow, continuity of care and the experience of substantive staff who can find it stressful supporting unfamiliar staff in addition to their usual workload. Some staff commented that certain staff groups are moved to cover absences more often, whilst others have a *“designated area to work”*.

The impact of agency staff affects the patient/family/carer experience, as it highlighted by several respondents, one of whom described *“when we do approach [a staff member] to ask for an update they do not seem aware of the current situation – they are just at Rosewell for a day”*

Consistency of Staffing - Medical Staffing

Some colleagues commented that there can be *“inconsistent medical cover, especially senior wise”*. It was felt that this could be due to the way the rota is currently designed which does not contribute towards consistency and results in many different medical colleagues who work within Rosewell for a shorter period, and the implications when consultants are on call in the Acute Frailty Unit (Ward 102). Positively though, for the junior doctors’ training and development, it was felt that they had *“autonomy and independence between consultant-led days”*.

Communication

In the patient/family/carer evaluation, whilst being incredibly praising of the attitude and care from staff at Rosewell House, there was a strong theme of people being dissatisfied with the level of communication they received, with an average rating of 3.10 out of 5:

- *“Difficult to find nurses or doctor. Moved the patient to another floor and family was not advised”*
- *“When we do approach a nurse or doctor for a specific update, they do not seem aware of the current situation, they are just at Rosewell for the day”*

- *“During the first 7 weeks of the stay there was little communication from the medical staff even when asked to see someone”*

Communication was also raised by staff members highlighting that they’re *“still not getting in the information that’s important”* and can have *“difficulties knowing who to escalate to”*.

6.3.3. Opportunities and Future Recommendations

Rosewell House is continually recruiting, and it is anticipated that the registered nursing vacancies will be filled by mid-October, drawing on both international recruitment and New Graduate Nurses.

- Workforce model:* Review of the workforce model within Rosewell House from an integrated, whole-facility perspective to reduce duplication between NHSG and BAC teams, for example within the administrative and domestic services. Working within the existing resource envelope, this could allow for funds from both BAC and ACHSCP to be re-invested in different ways at Rosewell House. This could include, for example, additional care management support, additional discharge co-ordinator support, or additional domestic support to facilitate quick turnover of beds, which were identified as opportunities during the evaluation.
- Medical rotas:* Consideration should be given to the existing medical rotas to explore whether a reduced number of clinician (headcount) could deliver the same number of clinical hours. This may increase the consistency of medical staffing for Rosewell House. A review of on-call arrangements should also take place.
- Family communication:* Both NHSG and BAC staff should be empowered to communicate with families /carers of patients without having to defer to a registered nurse or a medic. This may improve the flow of information and increase families’ participation in care planning.
- Criteria-led Discharge Planning:* Consistent leadership should be identified to reinvigorate efforts to implement criteria-led discharge planning by the multi-disciplinary team, which will reduce demand on the consultant geriatrician team and facilitate timely discharges.

6.4. Service Model

6.4.1. Positive

Step Down

Rosewell House has provided a much-needed resource for the step-down model of care over continued periods of pressures within the wider system.

Previously, under the guidance for care homes as directed by the Health Protection Team, Rosewell House was closed to admissions in its entirety for 107 days, an effective loss of 6,420 bed days. Under the new model, where wings can be closed due to Covid19 outbreaks rather than the whole facility, individual wings were closed for a total of 87 days to date in 2022, resulting in a loss of 870 bed days. However, it should be noted that the guidance for care homes has evolved and a reduction in the bed days lost would have been possible without transitioning to HIS, though it would have likely been fewer.

Admissions Criteria

The admissions criteria have been continually monitored and reviewed for effectiveness since the transition to HIS. Staff focus groups indicated that they felt the admissions process was working well. Although there are no specific criteria for the intermediate care beds, there does have to be a discussion with the Geriatricians prior to admission as there is requirements for a Comprehensive Geriatric Assessment prior to admission. Most of the work has been in relation to the rehabilitation beds to ensure our processes for admission are seamless and offers a timely response to the referring area. Pathways have also been developed to allow for step up from the community and ensuring we have a seamless process for timely response and admission.

Developing the Step-Up Model

Sustained pressured for the step-down model, particularly over Winter 21/22 and Summer 22 have delayed focus on developing the step-up pathway, however recently with dedicated project management support, work is underway to promote this care.

One of the key components of Rosewell House as an intermediate care facility is to provide “step-up” care where patients are temporarily moved from their homely settings to intermediate care to address possible deterioration early. For both rehab and frailty beds, those patients are typically medically stable, therefore not requiring to be treated in an acute setting. This in turn leads to the provision of better and more autonomous care experiences to the community and avoids a potentially unnecessary hospital admission.

While “step-up” has been a fundamental part of the intermediate care concept at Rosewell House, admissions since the launch of the facility in early 2021 have been primarily “step-down” (97.8% of admissions between August 2021 and January 2022). The graph below shows the split between step-up and step-down care, as well as the source of admissions (being exclusively Hospital@Home for the observed period).

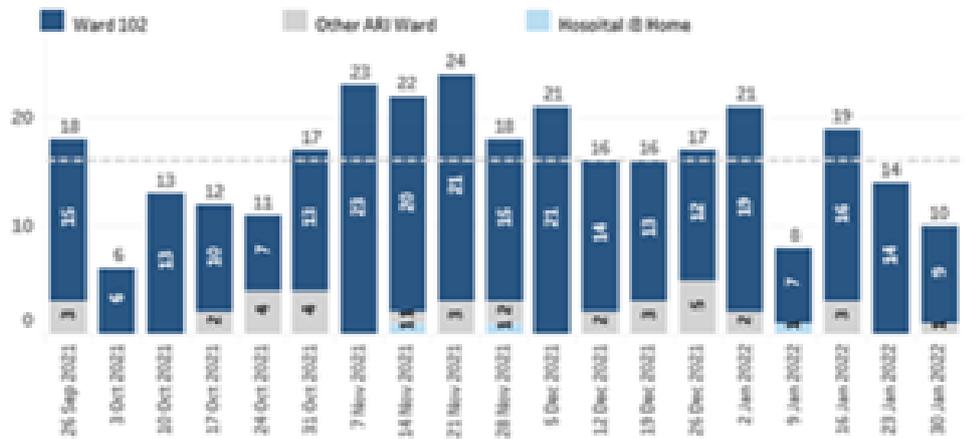
With the decrease in pandemic-related pressures, it was decided it was the appropriate time to review the existing provisions with a view to increase the provision of step-up care.

The desired end-result is a system that 1) ensures an adequate split between step-up and step-down care, and 2) is adequately used by referrers 3) has adaptive capacity to respond adequately to system

Admission Pathway



Admissions by Source





pressures. An initial survey was issued to key staff in April 2022 to map challenges and opportunities around step-up care at Rosewell, the results of which are mapped out below.



The survey highlighted a wide array of challenges. It was agreed to focus on 1) reviewing admission criteria and pathways for both rehab and frailty 2) develop new pathways 3) communicate any changes through easily accessible communication products

Progress to date

Rehab beds

- 1) Admission criteria and pathways for step-up into rehab have been reviewed and updated incl. ensuring that any patients referred are medically stable.
- 2) A leaflet with flowchart designed to mobilise more referrals – final comments and currently being incorporated and the leaflet will be disseminated in late August
- 3) 1 bed will be ringfenced for step-up rehab care once long-term resident is relocated

→ Outlook: Progress on the above is dependent on the long-term resident being relocated to allow for ringfencing. This has been escalated and timescales are predicted to become clearer in due course.

Frailty beds

- 1) Agreement was reached that step-up referrals to frailty beds will require a Comprehensive Geriatric Assessment (CGA).
- 2) Admission and referral criteria are currently being reviewed.
- 3) Therefore, previously considered pathways (e.g., direct admission from GP) were discarded, and emphasis on strengthening the admission pathway via Hospital @ Home (who provide CGAs) and exploring an ED/AMIA pathway (pre-admission triage).
- 4) An ED/AMIA triage test-of-change was undertaken for a week in early July. During that week, 3 patients were stepped-up to Rosewell House rather than being admitted to Ward 102. This initial test of change was successful, and it is envisaged to repeat this test-of-change before rolling out, depending on competing demands and change processes.
- 5) Some preliminary explorations around how to flexibly ringfence step-up beds, e.g., ringfencing beds for step-up until 1PM, if not used, made available for step-down.

→ Outlook: The project delivery group meets bi-weekly to drive and monitor progress. Timelines regarding a follow-on test-of-change (ED/AMIA triage) are expected to be confirmed soon and enhancing the H@H pathway will be explored over the coming weeks.

6.4.2. Challenges

Step Down

Given the increased pressure that the entire system is facing, there has been pressure on Rosewell House to be flexible in broadening the admission criteria for the step-down model to enable flow throughout the wider system. This has sometimes resulted in delays within Rosewell House, reducing the number of beds available, whilst also creating tension

between trying to support others in the system whilst developing the step-up pathway. Some colleagues reported that the pressure to discharge people quickly can be demotivating, stating that the *“pressure doesn’t make it any easier to do – and doesn’t acknowledge that you’re already doing all you can”*.

The medical staff also reporting difficulties in communication between 102 and Rosewell, sometimes resulting in poorer handovers – which was felt to be similar as with the step-down wards in ARI, however the isolated nature of Rosewell House removes the ability to physically go to the ward.

Medical staff from 102 also reported how it is more difficult to identify patients suitable for Rosewell House: *“we have to now select people as appropriate for Rosewell – whereas previously the step-down wards would just be for all people – this adds time and complexity, and we sometimes get this wrong”*

Consistency across Frailty / Rehabilitation Beds

A critical success factor for the vision at Rosewell House is to ensure that the separate care pathways (Frailty and Rehabilitation) still allow the building to function as an integrated whole. Examples given through the evaluation include:

- Patient escalation to ARI has different processes between rehab (GMED) and frailty beds (consultant).
- Support from psychiatry differs, with support for the frailty beds coming from the liaison psychiatry service, and for rehab from the community psychiatry teams.
- Medical model including processes for pharmacy and discharge letters (see below for further details)

Medical Cover in the Rehabilitation Beds

There remains inconsistency in processes between the Frailty beds and the Rehabilitation beds. This is largely due to the medical cover model: whilst the Frailty beds are covered by the geriatrician team, the rehabilitation beds are covered by a service level agreement with Garthdee Medical Practice and a supporting Advanced Nurse Practitioner (ANP). The ANP allows the medical model to function well when they are available, however during periods of leave or re-deployment this can result in delays to patient care and an increased demand on the GP Practice. To mitigate this short term, the service has put in place an arrangement with the Northeast Rider Volunteers (NERVs) to support the transport of prescriptions (which must be original copies) between Rosewell and the practice. Longer term, the service is exploring support from Hospital at Home to allow for a more consistent cover from an advanced practitioner.

Discharge Planning

Rosewell House has been experiencing difficulties in delays, like the rest of the system given the current high pressures facing the care home and care at home sectors. An example given during the evaluation was on that day there were a total of *“19 delays awaiting care*

or care at home, and 9 patients waiting for a Shire bed – almost half the building”. Some voiced the opinion that the increased pressure to accept step-down admissions can contribute to delays and poor flow in Rosewell by “accepting patients that are not the ideal patient type for Rosewell... and if that person sticks and hasn’t moved... slows the stream of rehab beds in the city”.

There can be delays in discharge planning due to delays in medication coming from the pharmacy at ARI, as deliveries are only undertaken twice a day.

Some colleagues voiced the opinion that there are currently sometimes delays in discharges as there is a reliance on medical staff (often consultants) to approve the discharges. Whilst the vision is for an MDT-led discharge team, it was felt many staff members will not do this without the consultant taking responsibility. Empowering the multi-disciplinary team to support discharge planning with criteria-led discharges will reduce these delays and allow for more effective planning of the discharges. There has been ongoing effort to implement criteria-led discharges though this has lacked the leadership

6.4.3. Opportunities and Future Recommendations

- a) *Step-Up*: Progression with the step-up action plan should be prioritised and endorsed by leadership, linking clearly with colleagues in Ward 102 during their on-going test of change. Dedicated communication and engagement with wide primary and community care colleagues should be undertaken to ensure a clear understanding of the patient cohort suitable for step-up and the benefits it can bring.
- b) *Step-down*: Ensure that criteria-based admissions policies are applied to admission decisions where possible, and empower staff to make these decisions, recognising the pressure faced by the system
- c) *Frailty / Rehab*: review the processes within the Frailty/Rehab to identify areas where these differ and where appropriate, continue to develop plans to streamline these.
- d) *Medical Cover*: Implement a test of change with Hospital @ Home providing cover for the rehabilitation beds, as outlined above, for an extended period.
- e) *Criteria-led Discharge Planning*: Like the previous recommendation in section 6.3. Consistent leadership should be identified to reinvigorate efforts to implement criteria-led discharge planning by the multi-disciplinary team, which will reduce demand on the consultant geriatrician team and facilitate timely discharges.

6.5. Environment

6.5.1. Positive

There was a strong theme of the positivity of the environment for the patients, with respondents often citing the following benefits:

- A more relaxed, sociable environment which is easy to replicate a routine which is more like at home.
- Increased privacy for patients and for conversations with families.
- Greater access to outdoors with the gardens, which allows for increased socialising.
- Modern environment with improved access to modern, equipped facilities for rehabilitation.
- Shared dining spaces for patients to share meals.

The interim evaluation recommended that the internal configuration of Roswell was reviewed to address challenges, which resulted in some changes such as implementing some lounges into MDT spaces, a new break room and reviewing the storage arrangements, including clearing out unnecessary equipment. Staff focus groups also identified the additional of the bike shed at Rosewell as a “*great bonus*” and liked the availability of showers in the changing rooms.

6.5.2. Challenges

Single Rooms

Whilst the single rooms provide the benefits outlined above, staff also feel that they can sometimes cause difficulties when it comes to monitoring patients within the wings, as it is hard to observe fall risks patients or those with higher monitoring requirements.

Staff Spaces

Whilst improvements have been made, the staff spaces within Rosewell House are still felt to be limited (for example office space for visiting staff members) and there are no on-site or easily accessible local amenities (such as a café). There has been a reduction in the lounges available to patients as some lounges have been converted into MDT spaces, however this has been welcomed by staff. Colleagues also reported that storage space remains limited within Rosewell House – though the staff focus groups queried whether limitations of storage is due to existing storage space being poorly utilised.

Separated Buildings

However, the isolated nature of Rosewell House also causes some challenges as Rosewell House is detached from the rest of the centralised services at Aberdeen Royal infirmary. This causes challenges relating to the transfer of patients, access to diagnostics and provision of supplies (such as pharmacy supplies). It was also felt to reduce access for the

geriatrician team to services such as a quick specialist opinion. This also increases the pressure of staffing shortages, as described above, as it is felt there is not the informal support available as readily as in other parts of ARI.

Parking

Despite efforts to improve the parking at Rosewell House, parking was still felt to be a pressure for both resident and visiting staff.

Responsibilities

During the initial phases of the project, a responsibility matrix was drawn up which outlines the responsibilities of Aberdeen City Council, ACHSCP, Bon Accord Care and NHS Grampian in delivering the integrated model. However, it has become apparent during the operationalisation of the model that there remain some areas which lack clarity, for example the maintenance of beds removal and replacement of large pieces of equipment such as washing machines and baths.

6.5.3. Opportunities and Future Recommendations

- a) *Staff amenities*: Explore options, such as endowments or the wellbeing fund, to provide improved staff amenities within Rosewell House, such as healthy vending machines or a visiting cafe service.
- b) *Review Responsibilities Matrix*: The responsibility matrix should be reviewed with senior managers and financial representative to ensure that the learning of the 1st year of implementation is incorporated into a revised document, with clear lines of escalation should there be future unclarity or disagreement.

6.6. Logistics

6.6.1. Challenges

Access to diagnostics

As Rosewell House is off the main Foresterhill Campus, there is a need to transfer patients from Rosewell back to ARI for diagnostics such as scans or x-rays. This can be time-consuming, but also requires a member of staff to accompany the patient for their investigation. Additionally, these requests can be treated as an outpatient appointment, resulting in long waits, particularly for the 20 rehabilitation beds as the request is often coming from a GP. Combined, this can result in a delay to investigation, which impacts on patient care.

Patient Transport

Patient transport was highlighted by many as a key pressure within Rosewell House, again exacerbated by its location away from the Foresterhill site, with impacts felt especially keenly at the weekend. The staff focus groups also highlighted difficulty in sourcing transport after 3pm for outpatient appointments. The current arrangements, with dedicated travel provided by ABC, have been reduced from two vehicles to one which will put further pressure on transport – both to a patient’s discharge destination, and between Rosewell and ARI. It was felt in the staff focus groups that the patient transport services ideally need to be 24 hours.

Supplies Transport

Colleagues described difficulties with getting supplies, such as medication from the ARI pharmacy, in a timely manner, which can cause delays. At times, it is felt that the portering service does not prioritise medications for Rosewell, given its isolated nature – for other wards in ARI, a staff member could pop down to the central pharmacy, however this is not as feasible for Rosewell. This can result in delays to discharge which has an impact on the wider system.

The challenge with logistics has a knock-on effect on timely discharge: *“if we decide someone is a discharge at 9am in the morning, it can take almost 48 hours to get drugs and transport organised”*. This was also echoed in the staff focus groups, where staff felt the discharge process can be delayed due to transport / pharmacy / discharge letters.

N.B. As the process for evaluation focused on emergent themes, positives specifically associated with logistics weren’t directly explored.

6.6.2. Opportunities and Future Recommendations

- a) *Access to diagnostics:* Rosewell House should work with colleagues within ARI to raise awareness of the ‘in-patient’ status of Rosewell House patients to expedite timely access to diagnostics.
- b) *Access to diagnostics:* Whilst there is limited opportunity for in-house diagnostics at Rosewell House, a portable x-ray machine would reduce the proportion of patients who would require transfer to ARI. This should be explored.
- c) *Logistics:* Rosewell House has begun a test of change with the Northeast Volunteer riders to support the transport of prescriptions between Rosewell, ARI, and the supporting GP Practice. Learning from this should be expanded and applied to other areas where NERVs could support the logistics between Rosewell House, ARI, and the supporting GP Practice.

- d) *Portering*: Rosewell House should work with colleagues within ARI to allow Rosewell to be prioritised for portering services, particularly when this may help facilitate a timely discharge.
- e) *Patient Transport*: Rosewell House will require a new solution to patient transport to compensate for the removal of one of the ABC transport vehicles.

6.7. IT & Systems

6.7.1. Positive

The interim evaluation highlighted that there was a barrier to systems as BAC staff could not access Trak Care for service user notes. Rosewell House has successfully completed the appropriate Data Protection Impact Assessments and associated Data Processing Agreements to allow Bon Accord Care employed colleagues access to TRAK Care. Whilst this took some time to embed and learn, this is a big achievement in working in an integrated way. An audit of IT access and future requirements would be beneficial at this stage to identify any further systems that it would be beneficial for BAC staff to have access to.

6.7.2. Challenges

Phones

Medical staff reported that the phone system is not currently adequate for the needs of Rosewell. It was felt there are too few phones, and signal can be an issue. This results in delays when colleagues are trying to get hold of the doctors within the building, particularly when compounded with the alarm system issues (below). A 'bleep system' would be preferable

Alarm Systems

Many staff reported that the alarm system is poorly designed, resulting in patients often incorrectly pressing the 'emergency' button on their handset, rather than the 'call' button. This results in very frequent emergency calls, which must be responded to. This causes stress for the members of the team responding, as they must treat every alarm as if it is an emergency. This was also highlighted in the patient/family/friend service, with one respondent highlighting: "*responding to the buzzers – if the patient requires the bathroom, they need prompt assistance*"

Integrated Patient Records

Aberdeen Royal Infirmary is currently transitioning to an Electronic Patient Record (EPR), which Rosewell has not been prioritised for. This means that parts of the Frailty Pathway are on the EPR but when patients transfer to Rosewell, records need to revert to paper. This does not facilitate continuity, smooth patient transition and common goal setting.

6.7.3. Opportunities and Future Recommendations

- a) *Alarm systems:* BAC to work with the current contractor deliver improvements to the alarm systems to allow clearer distinction between the call or emergency buttons, or by considering a new contract
- b) *Patient records:* NHSG to liaise with colleagues directing the electronic patient record to allow Rosewell House to be prioritised for transfer due to the unique nature of the facility and the increased impact, as outlined above.
- c) *IT & Systems:* With support from E-Health and Information Governance, undertake an audit of the IT systems and structure in place to identify any further access requirements to facilitate BAC in their roles to ensure as supportive as possible.

7. Conclusions

Rosewell House has come a long way since the initial review in 2021. We are beginning to see the benefits of the new model, but there is still some way to go towards fully achieving the vision for the integrated, intermediate care facility. The recommendations contained within this report should be reviewed by the Rosewell House Project Board, and an action plan developed, for joint ownership by the BAC Intermediate Care Lead and NHSG Service Manager, to continue to build on the progress to date. These should be prioritised in agreement with the operational teams and the project board.

Developing as an intermediate facility: As outlined in the report so far, there is great opportunity surrounding the vision for Rosewell House. With the leadership arrangements finalised, and the initial changes beginning to embed, the project team should focus on developing the elements of a successful intermediate care facility for the next year. The Social Care Institute for Excellent highlight the key elements of an effective system, which have been used by the project management team to date to develop plans for Rosewell House. A revised implementation plan should be developed, incorporating both the recommendations contained throughout this report, as well as actions to further develop each of these elements.

Key elements of an effective system³:

- A single point of access for all types of local intermediate care services, including a referral process that is widely understood across the whole system and a single assessment process.
- Shared access to health and social care records – ideally single patient record.

³ <https://www.scie.org.uk/prevention/independence/intermediate-care/highlights>

- A single management structure for the service as a whole and individual elements within it.
- An agreed multidisciplinary team composition in which staff can work flexibly across services and undertake transdisciplinary roles.
- Joint training and induction programme for health and social care staff.
- Weekly multidisciplinary team meetings attended by health and social care staff.
- A mental health specialist included in the establishment of the service.
- A joint or integrated commissioning function for the service in which health and social care resources are aligned, if not pooled.
- A single performance management framework.

8. Acknowledgements

Sincere thanks are given to all staff, service users, families and friends who participated in this evaluation. Special thanks are given to the team based at Rosewell House, without who's hard work, dedication, and passion for caring for their patients, it could not have come this far.

Thank you to a host of colleagues for their time, input, and advice throughout the process including Sophie Beier, Fiona Nairn, Calum Leask, Jacqueline Bell, Fiona Murray, Michelle Grant, and Alex Bertram.

Appendix 1 – Engagement Summary

Session Type	#	Participants	Completed When	Led By	Business Case Objectives
Semi-Structured Interviews	8	NHS Lead Nurse; BAC Managing Director; RW Transitional Lead; Integrated Care Lead; Senior Charge Nurse; BAC Assistant Manager; Senior AHP; Frailty Nurse Manager; Lead AHP; Lead OT; Lead SOARS		Programme Manager	1-12
Focus Group (Geriatricians) ⁴	1	Consultant Geriatrician Team	02.08.2022	Programme Manager	1-12
Focus Group (Rosewell Staff) 1	5	4 NHS Nurses 1 NHS HCSW	19.07.2022	Organisational Development	1-12
Focus Group (Rosewell Staff) 2	24	AHP/GA/Cook/BAC/NHS/Reception	10.08.2022	Organisational Development	1-12
Survey (Rosewell Staff)	TBC	For those unable to attend the in-person sessions.			
Focus Group (Frailty Pathway Huddle)	5		25.07.2022	Programme Manager	1-12
Patient Survey	12	Patients; Families; Carers; Other	19.07.22 02.08.22	P. Manager SPM Evaluation	1-12
Survey (Geriatricians)	3	Geriatrician Consultants	22.07.2022 02.08.2022	Programme Manager	1-12
Survey (Junior Doctors)	3	Junior Doctors	26.07.2022 02.08.2022	Programme Manager	1-12
Review of Feedback	NA	Patients; Families; Carers; Other	NA	Programme Manager	1-12

⁴ Attendance at Geriatrician's existing meeting 02.08.2022 and supported by a survey for those who were unable to attend.

Appendix 2 – Patient Survey Summary

Promotion – Digital

A social media campaign, targeting families and carers, took place for 13 days from Wednesday 20th of July to Tuesday 2nd of August. There was a total of 10 posts across Twitter and Facebook over the period, with 36 reshares by other users and organisations (18 Facebook and 18 Twitter). The total reach of the posts with 9,100 people (5,500 Facebook and 3,600 twitter).

Promotion – Physical

Posters were also displayed in Rosewell House, alongside paper copies and QR Code Posters to link to the survey online. Staff, particularly the receptionist, encouraged the completion of the surveys by those visiting.

Recommendation - Despite this, the return rate was low (n=12). To have a more substantial sample size for future evaluation, Rosewell House should embed the evaluation process throughout the year.

1. Who is completing this questionnaire?

[More Details](#)

 Insights

	Patient	0
	Friend / Family Member / Infor...	11
	Staff Member	1



2. How did you/the patient come to Rosewell House?

[More Details](#)

	Admitted from home	1
	Admitted from a hospital (i.e. A...	11



3. Do you feel that your / the patient's needs were fully met during their stay?

[More Details](#)

 Insights

	Yes	5
	No	1
	Partially	6



4. Please add any further comments: N = 6

Positive Themes

*Happy as can be with the service
All so kind and caring and Mum received excellent care
Well fed*

Negative Themes

*Staff extremely busy
Not cared for mentally
I feel my family member didn't get the care
I would have liked
Help with toileting
Items out of reach*

5. What did you / they value most about the support at Rosewell House? N = 79

Positive Themes

*Friendliness
Patience
Attention to detail
Consideration to needs
Never left alone
Caring motivated staff
Round the clock care
Help with all personal needs
Safe environment*

Negative Themes

6. How would you rate the communication from staff throughout the stay at Rosewell House?

[More Details](#)

 Insights

12
Responses



3.25 Average Rating

7. Please add any comments on communication N = 8

Positive Themes

Everyone is friendly
We were updated about everything
Staff updates on family members progress

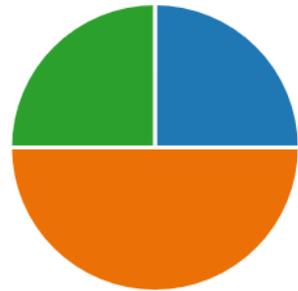
Negative Themes

Difficult to find staff
Staff not consistent
Chase up
Communication not great with nurses/care team

8. Were you involved in care planning as much as you would like to be?

[More Details](#)

● Yes	3
● No	6
● Not applicable	3



9. Please add any further comments: N = 7

Positive Themes

Someone there at all times
As comfortable as possible

Negative Themes

Not involved/aware of care plan
No planning for getting home
Anytime I called, any time of day, I never got to speak to anyone

10. How do you think the service could be improved? N = 8

Positive Themes

No improvement, first class service

Negative Themes

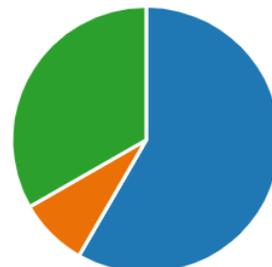
Communication with family members
System for entry after 5pm
Weekly update

11. For those who find themselves in a similar situation, would you recommend this service?

[More Details](#)

[Insights](#)

● Yes	7
● No	1
● Unsure	4



Appendix 3 – Summary Improvement Plan

The following action plan has been developed by the Rosewell House team in response to the recommendations of this survey. Much work was already underway and is highlighted below. This improvement plan will be owned by the NHSG Rosewell House Service Manager and the BAC Integrated Care Lead, who have presented this to the Rosewell House Clinical and Professional Oversight Group (Local Assurance Meeting). I will

Recommendation	Action	Expected Completion Date
VISION		
Renewed, comprehensive communications and engagement plan	Work with staff to understand what this looks like from their perspective. Have tried several ways to communicate – email and newsletters. Agreement to develop action plan with focus on external stakeholders (primary and acute care). First step will be to meet with Rosewell staff to generate ideas.	31 st August 2022 (initial meeting)
Consider renaming the service	In the process of creating Rosewell leaflets to better inform the public of the changes within Rosewell. Review and decide whether this requires further rebranding or if renaming is the preferred route, to be agreed by Rosewell House Project Board if required.	30 September 2022
PATIENTS		
Promote activities co-ordinator across whole facility	Is starting to involve patients across the whole building in activities and producing an activities timetable, which will be shared with all teams within Rosewell House. Will require ongoing work and support.	30 August 2022.
Review Escalation Pathways	Meet with all disciplines staff to understand what needs to happen. Initial scoping meeting to take place by 31 August 2022. Further actions TBD	31 August 2022
STAFFING		
Review of the workforce model from an integrated perspective	Have completed workload tools for the whole building so in process of reviewing to understand what is required and level of acuity. This will be subject to ongoing review.	30 September 2022
Review of the medical rotas to increase consistency	New medical clinical lead in post who is in the process of reviewing this.	31 August 2022

Recommendation	Action	Expected Completion Date
Empower all staff to communicate with families about care	Work with Health Care Support workers to allow them to build confidence to speak to families about the care of their relative and involve the family in the care provision. Support from Senior and Staff Nurses to do this. Seek organisational development support as appropriate.	30 September 2022
Implement and embed Criteria-led Discharge Planning	Senior Staff Nurse leading on this work with the Therapists. Meetings and discussions began w/c 15 th August	Complete roll out across building 31 October 2022
SERVICE MODEL		
Continue to develop the step-up pathway	This work is ongoing and supported by a dedicated step-up project group, and project management support. Pathway flow chart developed and ready to be shared with primary care colleagues. Work in progress to ensure we have capacity to enable step up. Linking with Redesign of Urgent Care pathways programme to identify further opportunities.	Improvement in step up data by 30 September 2022
Consistently apply criteria-based admissions to step-down bed	Pathways are developed but often due to surge pressures this can deviate from the norm to create acute capacity. Improvement in step up availability may help with this.	30 September 2022.
Align processes in Frailty and Rehab beds where possible	Have met with Acute colleagues to inform of changes within Rosewell to ensure all aware rehab and frailty are same building and require same processes. Still meet with other specialist services.	31 August 2022
Undertake test of change with H@H support for rehab beds.	This has been successfully completed. Ongoing work to understand how we can make this a sustainable change going forward.	30 September 2022.
ENVIRONMENT		
Explore opportunities for improved staff amenities	Have discussed the option of a vending machine with NHSG Head of Catering, currently this is out to tender and will be in touch when completed. Looked at option of a small Aroma but not enough footfall to make it viable.	30 September 2022
Review the responsibilities matrix	Arrange meeting with finance team from both ACHSCP and BAC to discuss and clarify grey areas.	30 September 2022
LOGISTICS		
Explore portable x-ray machine for diagnostics support	Discuss options with Radiology team	30 September 2022
Promote Rosewell as 'in-patient' for access to diagnostics	Have met with Radiology management team and GP and robust process in place.	Completed.

Recommendation	Action	Expected Completion Date
Further develop test of change with support from NERVs for logistics	Working with Pharmacy and Information Governance to look at how we make this viable. SBAR being developed.	31 August for completion and escalation of SBAR.
Priority protocol for portering services where supporting discharge	Discuss with Portering Manager but staff availability often a barrier.	31 August 2022
New transport solution to be developed	Identify ways to progress (i.e. business case) and link with wider NHS Grampian Transport Programme Board. Paper to Rosewell House Project Board with proposed solutions.	31 October 2022
IT & SYSTEMS		
Review alarm systems with current contractor/new contract	Current buzzer system will remain in place, but some adaptations and other buzzer accessories have been ordered to improve use.	31 October 2022
Prioritised implementation of electronic patient record	Confirmation this week that this will commence September 2022	30 September 2022
IT and systems access audit for BAC staff	Received further mobile equipment to enable better access for staff. Audit to ensure all staff have appropriate access and know how to use it.	31 August 2022.