Rosewell House

Evaluation Report

July 2023

Executive Summary

Background

Rosewell House is a 60-bedded integrated, intermediate care facility where Bon Accord Care and Aberdeen City Health & Social Care Partnership aspire to deliver person-centred care and therapy, with a reablement and rehabilitation focus. The main admission routes for Rosewell House are from the Frailty pathway (40 beds) or from the Rehabilitation pathway (20 beds). This evaluation is designed to inform the future direction ahead of the expiration of the existing arrangements in October 2023. It aimed to explore four evaluation questions:

Evaluation Question 1) - What have we learned from previous evaluations of this model?

Existing data exploring the perspective of individuals in receipt of care at Rosewell were reviewed. From here, the decision was taken to collect further data from this cohort through surveys. The majority of individuals who contributed to this evaluation (N=47, either service users or their unpaid carers) cite high satisfaction with the care and support they receive, in addition to feeling the facility would be appropriate for others in similar circumstances. Their feedback suggests that, from their perspective, the service could be even better through greater integrated collaboration with support from other services, ranging from increasing the quantity of physiotherapy and mental wellbeing support, to social activities.

Data were reviewed from previous evaluations from a staff perspective and was deemed to have a sufficient sample size for the purpose of this review. The data collected from a staff perspective (N=88) suggests general agreement in the philosophy of the service, and optimism about the benefits that could be achieved through having integrated teams. The areas for improvement identified were consistent across data collection periods, including the need for further work on enhancing the 'Team Rosewell' culture; ongoing challenges with staffing (that are not unique to this facility); and further communication with broader colleagues.

Evaluation Question 2) - How has the implementation of the model changed since 2022?

The implementation plan was reviewed following completion of the previous evaluation to understand the progress that has been made against the outstanding actions. Several actions are either competed or in progress across each of the themes, such as: vision (for example, development of a high level communication plan); patients (establishing escalation pathways, for example rehab escalation to Hospital @ Home); staffing (for example, pilot project being undertaken to instigate an initial multi-disciplinary team meeting with families within 48 hours of admission); service model (for example, accepting admissions direct from Acute Medical Initial Assessment / Emergency Department); environment (for example, installing a vending machine within the Rosewell staff room); logistics (for example, delivering in-house training for staff to undertake portering activities) and IT / Systems (for example, prioritised implementation of the electronic patient record).

Evaluation Question 3) - How is the service performing against the original business case?

Data were reviewed across a variety of metrics from the original business case across regular time periods. Rosewell has been effective at supporting the Grampian health and social care system, particularly Aberdeen Royal Infirmary (through providing a high proportion of step-down care for patients) and Aberdeenshire Health & Social Care Partnership (through providing a proportion of beds for this area to use whilst their associated infrastructure continues to develop). This was achieved during a highly pressurised period of implementation, through factors including the redesign of the

frailty pathway, coupled with increased demand for health and care services as an ongoing consequence of the COVID pandemic.

Rosewell has faced challenges in realising one of the key components of intermediate care in operating as a community-facing, predominantly step-up / high turnover facility. Whilst this can largely be explained by prioritising providing support to hospital-based services to improve flow during the COVID pandemic, the step-up pathway will require continued and deliberate action (and associated governance), otherwise there is a high risk that the current proportion of step-up / step-down care becomes 'business as usual'.

As Rosewell House is a central component of the frailty pathway and social care pathway, its performance against traditional metrics cannot be judged in isolation. For example, Rosewell may experience delays discharging individuals into the community for a variety of reasons, consequently inhibiting their ability to accept further admissions. Such external factors emphasise the complex environment in which this model has been implemented and reiterates the value of planning and designing pathways of care from a systems perspective. Different lengths of stay would be anticipated for admissions to both frailty beds and rehabilitation beds given the cohort of these individuals are different, with differing reasons for admission.

Evaluation Question 4) - Should the service continue moving forward?

Taking this information together, it is recommended that the current arrangements at Rosewell House are extended. Given the findings from this evaluation, the following actions are also recommended to support the next iteration of its development:

- Conduct a separate evaluation with a focus on the rehabilitation beds exclusively

- Update the existing action plan with revised timescales and in response to the data presented within this report

- Calculate the demand for step-up provision and subsequently, the appropriate staffing cohort to deliver against that demand

- Consider what processes can be implemented to support more regular feedback from both service user and staff perspectives as the service model further develops

Background

In August 2021, Aberdeen City's Integration Joint Board agreed that all beds at Rosewell House would be the responsibility of NHS Grampian, with Healthcare Improvement Scotland (HIS) functioning as regulator, for a period of two years until 23 October 2023. Rosewell House is a 60-bedded integrated, intermediate care facility where Bon Accord Care and Aberdeen City Health & Social Care Partnership aspire to deliver person-centred care and therapy, with a reablement and rehabilitation focus. The main admission routes for Rosewell House are from the Frailty pathway (40 beds) or from the Rehabilitation pathway (20 beds).

Care in Rosewell House is provided to aid recovery as a 'step-down' service following hospital discharge from Aberdeen Royal Infirmary. Through partnership working the aim was to also develop a new 'step-up' pathway into the rehabilitation pathway. It was anticipated that this would be led by the Rosewell therapy teams and Bon Accord Care's Reablement Facilitators (RFs) to promote a shift in the balance to step-up care; help to avoid unnecessary hospital admissions, to provide the right care, at the right time, in the right place.

Original objectives of the service are shown below:

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

Multi-disciplinary services are co-located across the facility and include Medical; Nursing; Occupational Therapy, Physiotherapy; Service Supervisors; Health and Social Care support workers (BAC & NHS); general assistants and administrative staff. Staff continue to work together to explore new ways of working both within Rosewell House and when connecting with wider services in the Health and Social Care system. The team have been working together to realise the integrated care vision and develop their integrated-team model in Rosewell, with each organisation building on strengths and learning from each other's experience.

This evaluation is designed to inform the future direction ahead of the expiration of these arrangements. It is the third standalone evaluation that has been conducted on the service; the first, published in March 2021, explored the first two months of the interim service model; with a further evaluation being published in August 2022 that examined the interluding period.

Methods

This evaluation was centred around four key questions. A high level overview of this is visible in the table below:

Evaluation Question	Approach
1)What have we learned from previous evaluations of this model?	Review of 2021 and 2022 evaluations
2)How has the implementation of the model changed since 2022?	Review of implementation plan derived from 2022 evaluation
3)How is the service performing against the original business case?	Comparison of metrics derived from original business case over time
4)Should the service continue moving forward?	Synthesis of Q1-3

An Evaluation Working Group was established that generated this set of questions, through reviewing the work that had been undertaken to date, and agreeing what questions still required answering. The group was comprised of a Programme Manager (who conducted the first evaluation of the model); a Deputy Chief Nurse; a Service Manager and an Integrated Care Lead. This approach was sense-checked and agreed by two external groups of stakeholders independently, the first being the Rosewell Assurance Board, and the second being the Senior Responsible Officer for the Frailty Pathway. Progression of the evaluation was reported into the Rosewell Assurance Board on a monthly basis.

Results

Evaluation Question Number One

What have we learned from previous evaluations of this model?

Reviewing the previous evaluations of this model was considered to be an important first step. This would allow for an understanding about what is already known on the topic and as such, what information does not require collection again. This ensures that limited resources can be used most effectively by targeting them towards only collecting further data when it is necessary, and where outstanding questions remain regarding the potential benefits of elements of the service.

The below tables summarise what information has already been generated on the model previously, with a subsequent appraisal about what can be concluded from this evidence. It covers the perspectives of individuals who receive the services and staff perspectives; with resourcing considerations being reviewed as part of Evaluation Question 3 looking at the performance of the model against the benefits identified within the original business case.

Patient / Service User Perspective

Evaluation Report	Number of individuals engaging	Stakeholder group	Data collection approach	Summary of findings
2021 Evaluation	N=3	Patients / service users	Case Studies x 3	Case 1 -Rated stay as very good (+) -Felt all care needs were met (+) -Described staff as friendly and attentive (+) -Felt further conversations about support required to return to home would have been helpful (-) Case 2 -Rated stay as very good (+) -Felt all care needs were met (+) -Couldn't think of anything to improve stay (+) -Described staff as 'brilliant' (+) -Unaware of anticipated LOS (-) Case 3 -Rated stay in Rosewell as very good (+) -Reported staff as friendly and nice (+) -Would have welcomed additional pain medication (-)
2022 Evaluation	N=12	Friends / family members of patients / service users	Survey x 1 (Additional data supplemented by Complaints/compliments/letters/care opinion stories)	-91.7% of respondents felt patients needs were either partially or fully met (+) -58.3% of respondents would recommend the service to others (+) -50% of respondents wished to be more involved in their care planning (-) -Average rating of staff communication of 3.25/5

Synthesis of findings	N=15	Patients / service users Friends / family of patients / service users	Case Studies x 3 Survey x 1	-Strong agreement that care needs are met (+) -Further communication and input into care and support needs would be welcomed (-)

Appraisal of findings – There is some evidence to suggest that patients / service users are satisfied with the care and support they receive. However, potential improvements in communication and involvement in care and support was highlighted, and the sample size of feedback was relatively small. As such, it was agreed by the Evaluation Working Group that resources would be prioritised to collecting additional patient / service user fe edback. See the 'Further patient / service user feedback' section.

Staff perspective

Evaluation Report	**Number of individuals engaging**	**Staff cohorts**	**Data collection approach**	**Summary of findings**
2021 Evaluation	N=29	Frontline staff (both BAC and NHSG) Support staff (from ACHSCP)	Individual interviews x7 Focus groups x5	Frontline Staff -Optimism about multi-disciplinary working (+) -Preferable working environment than hospital (+) -Need to further establish 'Team Rosewell' culture (-) -Staffing challenges and long patient stays (-) -Infrastructure challenges including IT systems and storage (-) -Revision of admission criteria felt as necessary (-) Support Staff -Optimism about holistic approach towards care delivery (+) -More 'homely' setting compared to hospital (+) -Reducing pressure on secondary care (+) -Differing cultures between employers (-) -Perceived same cohort as hospital patients (-) -Challenges with space and car parking (-) -Need for more effective communication (-)

2022 Evaluation	N=59	Rosewell Staff Geriatricians Frailty Pathway Huddle Attendees Junior Doctors	Individual interviews x8 Focus groups x4 Surveys x2	-Increased ownership and correct philosophy (+) -Lack of understanding about function of Rosewell (-) -Unclear escalation pathway back to hospital (-) -More appropriate assessment setting (+) -Development of integrated teams (+) -Positive feedback received from patients (+) -High staffing vacancies (-) -Further comms wanted (-) -Reducing demand on secondary care (+) -Limited development of step-up model (-) -Transport challenges (patients and supplies) (-) *NB: Secondary analysis, therefore did not allow for disaggregation of findings*
Synthesis of findings	N=88	System-wide cohort including: Staff delivering care in Rosewell Staff referring into Rosewell Staff responsible with developing the model and related services	Individual interviews x15 Focus groups x9 Surveys x2	-Reducing demand on secondary care (+) -Staffing challenges (-) -Further communication required (-) -Optimism about philosophy and integrated approach (+) -More appropriate setting for patients / service users (+) -Further pathway improvements necessary, including step-up provision and length of stay (-)

Appraisal: The key themes derived from both evaluations are consistent whilst being conducted independently. This suggests the presence of data saturation, meaning that the feedback provided around potential benefits and drawbacks to how the service functions has been exhausted. This is reinforced by a large, cross-system sample size. The implementation plan being examined as part of Question 2 is a cumulation of these key themes and it is for this reason that existing data collected from staffing is deemed sufficient for this work, rather than conducting further primary data collection with staff groups on this topic.

Further patient / service user feedback

Data were collected from a further 32 patients / service users in June 2023 to supplement the existing data that already existed. This took the form of individual surveys that were based upon the 2022 surveys, allowing for the data to be aggregated more easily. The information provided below describes these aggregated responses from both the 2022 and 2023 data collection periods.

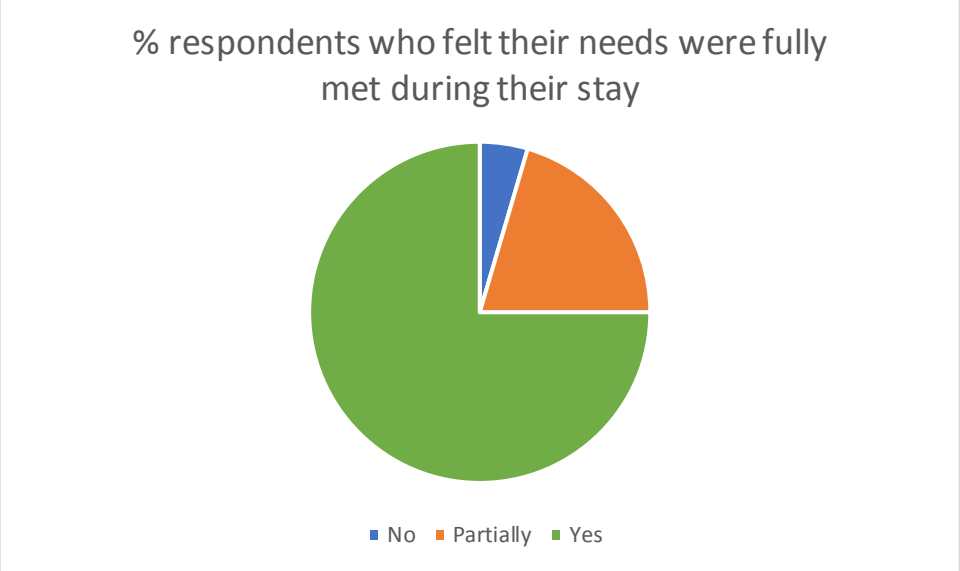
Responses were collected for 44 service users (32 from service users directly; 11 from family members / friends of service users; and one from a member of staff on behalf of a service user. Of responders, 35 reported to be admitted from hospital, with nine being admitted from home. The mean rating of communication with staff throughout their stay in Rosewell House was 4/5.

The table below shows responses to the question: *"were you involved in care planning as much as you would like to be?"* Responses indicate a large improvement in the number of individuals who agreed with this question when comparing the 2023 data collection to the 2022 data collection.

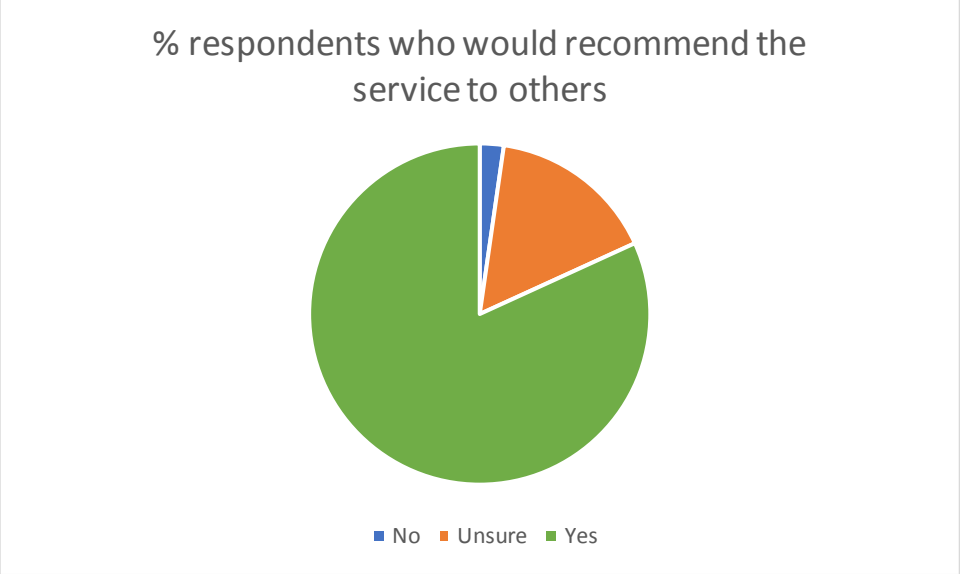
Responses to the question: *"were you involved in care planning as much as you would like to be?"*

Possible Responses	2022 findings (%)	2023 findings (%)
Yes	25	62.5
no	50	18.75
Not applicable	25	18.75

The graph below visually illustrates the percentage of respondents who felt their needs were fully met during their stay. The percentage of responses for each option were 75% (for 'Yes'); 20% (for 'Partially') and 5% (for 'No').



The graph below visually illustrates the percentage of respondents who would recommend the service to others. The percentage of responses for each option were 82% (for 'Yes'); 16% (for 'Unsure') and 2% (for 'No').



When individuals were asked about what aspects of care they valued the most, the key themes are visible and described below:

Themes of elements respondents most valued
Company
Food
Staff
Support

Company – respondents identified the enjoyment of being in an environment whereby they could spend time with other people; ***Food*** – was described as excellent; ***Staff*** – were highlighted to be approachable, pleasant and kept individuals informed about what was happening; and ***Support*** – the quality of care, regular check-ins, feeling safe and being allowed to do things with the help and support or staff.

When asked about how the service could be improved, the key themes that emerged are visible and described below:

Themes of elements requiring improvement from respondents' perspectives
Discussions about care
Mental wellbeing
No improvements identified
Physiotherapy
Social activities

Discussions about care – it was felt updates on this could be provided more frequently, both to service users and their families; ***Mental wellbeing*** – some individuals felt that further support was required to address other challenges they were facing, for example anxieties; ***No improvements identified*** – was the most common response, with individuals feeling they were getting all the support they required; ***Physiotherapy*** – more frequent input would improve the mobility of individuals; and ***Social activities*** – providing greater opportunities for individuals to spend time with others.

In summary, we have learned that the data collected from a staff perspective suggests general agreement in the philosophy of the service, and optimism about the benefits that could be achieved through having integrated teams. The areas for improvement identified were consistent across data collection periods, including the need for further work on enhancing the 'Team Rosewell' culture; ongoing challenges with staffing (that are not unique to this facility); and further communication with broader colleagues. From either service users or their unpaid carers perspective, they cite high satisfaction with the care and support they receive, in addition to feeling the facility would be appropriate for others in similar circumstances. Their feedback suggests that, from their perspective, the service could be even better through greater exposure to other services, ranging from increasing the quantity of physiotherapy and mental wellbeing support, to social activities.

Bon Accord Care

Aberdeen City Health & Social Care Partnership
A caring partnership

Evaluation Question Number Two

How has the implementation of the model changed since 2022?

A comprehensive implementation plan was developed following the exhaustive staff feedback from both previous evaluations conducted on Rosewell, that aimed to address the key themes that required addressing. The below table articulates the progress that has been made against these actions during the intervening period.

Recommendation *(identified in July 2022)*	**Action** *(identified in July 2022)*	**Expected Completion Date** *(identified in July 2022)*	**RAG Status as of April 2023**	**Comments** (if required)
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.	31st August 2022 (initial meeting)		A comprehensive, high level communication plan has been developed. Simplified version also being compiled for clarity on what this means day-today across teams. New contact meeting with family within 48 hours of admission to Rosewell also now implemented. Established staff distribution lists to ensure consistent dissemination of information / updates / changes. Senior management team meetings also in place. Onward discussion around RW bulletin / newsletter.
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		Rosewell leaflet completed. No decision taken currently to rename the service.
PATIENTS				

ABERDEEN CITY COUNCIL

NHS Grampian

Recommendation *(identified in July 2022)*	Action *(identified in July 2022)*	Expected Completion Date *(identified in July 2022)*	RAG Status as of April 2023	Comments (if required)
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.		Bon Accord Care recruiting 1 FTE, start date awaiting. NHS are proceeding to interview for a part time post to allow for 7-day cover.
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		Some escalation pathways in place (eg. Rehab escalation to H@H ANP, clinical escalations for rehab beds). Table top and review around escalations being planned.
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		Bon Accord Care currently doing work on this and workload tools will be an ongoing review process.
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		Meeting held with the clinical lead to discuss how best to do this. Continues to be reviewed alongside rotas.
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		Pilot project being undertaken to instigate initial MDT meeting with families within 48 hours of admission.
Implement and embed Criteria-led Discharge Planning	Senior Staff Nurse leading on this work with the Therapists. Meetings and discussions began w/c 15th August	Complete roll out across building 31 October 2022		One of service managers priority areas for full embedding. Schedule of huddle attendance being compiled to push this out and ensure full multi-disciplinary teams understanding and use.

Recommendation *(identified in July 2022)*	**Action** *(identified in July 2022)*	**Expected Completion Date** *(identified in July 2022)*	**RAG Status as of April 2023**	**Comments** (if required)
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 flowchart 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		Step up pathways completed and shared. Capacity remains a challenge but currently managing the step up demand. Admissions direct from Acute Medical Initial Assessment / Emergency Department ongoing, which can support as an alternative to 102.
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		No knowledge of ongoing concerns around this.
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.		Options appraisal developed for ACHSCP Senior Leadership Team to develop medium to longer term plan to provide cover for these beds.
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.	30 September 2022		Vending machine now in situ in Rosewell staff room

Recommendation *(identified in July 2022)*	Action *(identified in July 2022)*	Expected Completion Date *(identified in July 2022)*	RAG Status as of April 2023	Comments (if required)
	Looked at option of a small Aroma but not enough footfall to make it viable.			
Review the responsibilities matrix	Arrange meeting with finance team from both ACHSCP and BAC to discuss and clarify grey areas.	30 September 2022		Meeting took place to discuss this but further action necessary
LOGISTICS				
Explore portable x-ray machine for diagnostics support	Discuss options with Radiology team	30 September 2022		Not perceived as viable after review, with other processes in place instead.
Promote Rosewell as 'in-patient' for access to diagnostics	Have met with Radiology management team and GP and robust process in place.	Completed.		
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.		SBAR completed and shared, with wider Partnership work ongoing around this.
Priority protocol for portering services where supporting discharge	Discuss with Portering Manager but staff availability often a barrier.	31 August 2022		Wasn't viable to do this after review, so instead, staff were trained in house to undertake this instead of portering, for example waste disposal.
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		Yellow lines to reduce obstruction + bike sheds implemented.
IT & SYSTEMS				
Review alarm systems with current contractor/new contract	Current buzzer system will remain in place, but some adaptions and other buzzer accessories have been ordered to improve use.	31 October 2022		Buzzer panel for rehab beds remains in corridor rather than within each wing. Integrated Care Lead currently progressing

Recommendation *(identified in July 2022)*	Action *(identified in July 2022)*	Expected Completion Date *(identified in July 2022)*	RAG Status as of April 2023	Comments (if required)
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.		Still have some issues with staff passwords for accessing EPR but in hand.

Bon Accord Care

Aberdeen City Health & Social Care Partnership
A caring partnership

Evaluation Question Three

How is the service performing against the original business case?

The below tables outline the benefits and measures described within the original business case for Rosewell. As these data are derived from a variety of sources, it is not always possible to display these all over the same date ranges. References are provided to describe how particular measures were calculated.

Benefit	Measure	Care Type	18-01-21 to 01-03-21	18-01-22 to 01-03-22	18-01-23 to 01-03-23
Reduced admissions to hospital, prevention, and early intervention	Proportion Step-Up Care[1]	Frailty	1%	2%	2.0%
		Rehab	Not available	14%	9.5%
Reduce hospital length of stay, support early discharge home	Number of admissions[2]	Frailty	86	62	50
		Rehab	Not available	21	21
	Step-Down Care[3]	Frailty	99%	98%	98.0%
		Rehab	Not available	86%	90.5%
Reduction in admissions to care home, increased independence, reduced need for care package	Proportion of discharges to home[4]	Frailty	65%	60%	75%
		Rehab			
Less time in an acute / intermediate setting, reducing risk of becoming dependent during stay	Average length of stay[5]	Frailty	12.4 days	18.16 days	30.1 days
		Rehab	Not available	20.26 days	40.3 days
	Maximum length of stay[6]	Frailty	36 days	73 days	171 days
		Rehab	Not available	59 days	121 days

[1] **Step-up identified by is first ward = true (not transferred from another ward)** Using Ward Changes - Distinct count but split by Frailty/Rehab. Transfers within Frailty or Rehab not counted however transfers from Frailty to Rehab and vice versa are counted

[2] Using Ward Changes - Distinct count but split by Frailty/Rehab. Transfers within Frailty or Rehab not counted however transfers from Frailty to Rehab and vice versa are counted

[3] **Step-up identified by is first ward = false (transferred from another ward)** Using Ward Changes - Distinct count but split by Frailty/Rehab. Transfers within Frailty or Rehab not counted however transfers

[4] From frailty dashboard using selected date range

[5] Using ward changes - ward end dates used so will include those moved between wards. LOS stay calculated on ward by ward basis.

[6] Using ward changes - ward end dates used so will include those moved between wards. LOS stay calculated on ward by ward basis.

ABERDEEN CITY COUNCIL

NHS Grampian

NB: Large maximum length of stays in 2023 data were individuals awaiting Guardianship, which restricts interim moves.

Benefit	Measure	Baseline	2022 Report	Current
Increased access to the right care, at the right time, in the right place	Reduction in over 65s emergency admission[7]	211.5	219.9	228.8
	Reduction in ED/AMIA attendances from care home[8]	3 per day	Not available	Not available
	Reduction in W102 Boarders	Average daily boarders = 8	Average daily boarders = 14	Average daily boarders = 14[9]

The data above show variability in levels of improvement throughout the implementation of these arrangements. The percentage of step-up care has increased, as has the proportion of individuals being discharged home. Other measures, such as large increases in maximum length of stay, can be explained by individuals awaiting Guardianship, thus restricting interim moves. However, many of the measures described within the original business care are complex. This means that they are influenced and impacted upon by a variety of factors, many of which are external to and outwith the control of those who have developed and implemented the service at Rosewell. Such factors are important to highlight so as to provide appropriate context when interpreting the findings described within.

The first of which is understanding the pressure the Grampian health and care system was facing at the time of implementing this model. Grampian uses the G-OPES metric to provide an indicative sense of the pressure the system faces on any given day. This can range from a Level 1 (whereby acute and community health care systems are able to maintain flow and meet demand) up to Level 4 (significant pressure on system in meeting demand, high risk of clinical care and safety to be compromised.

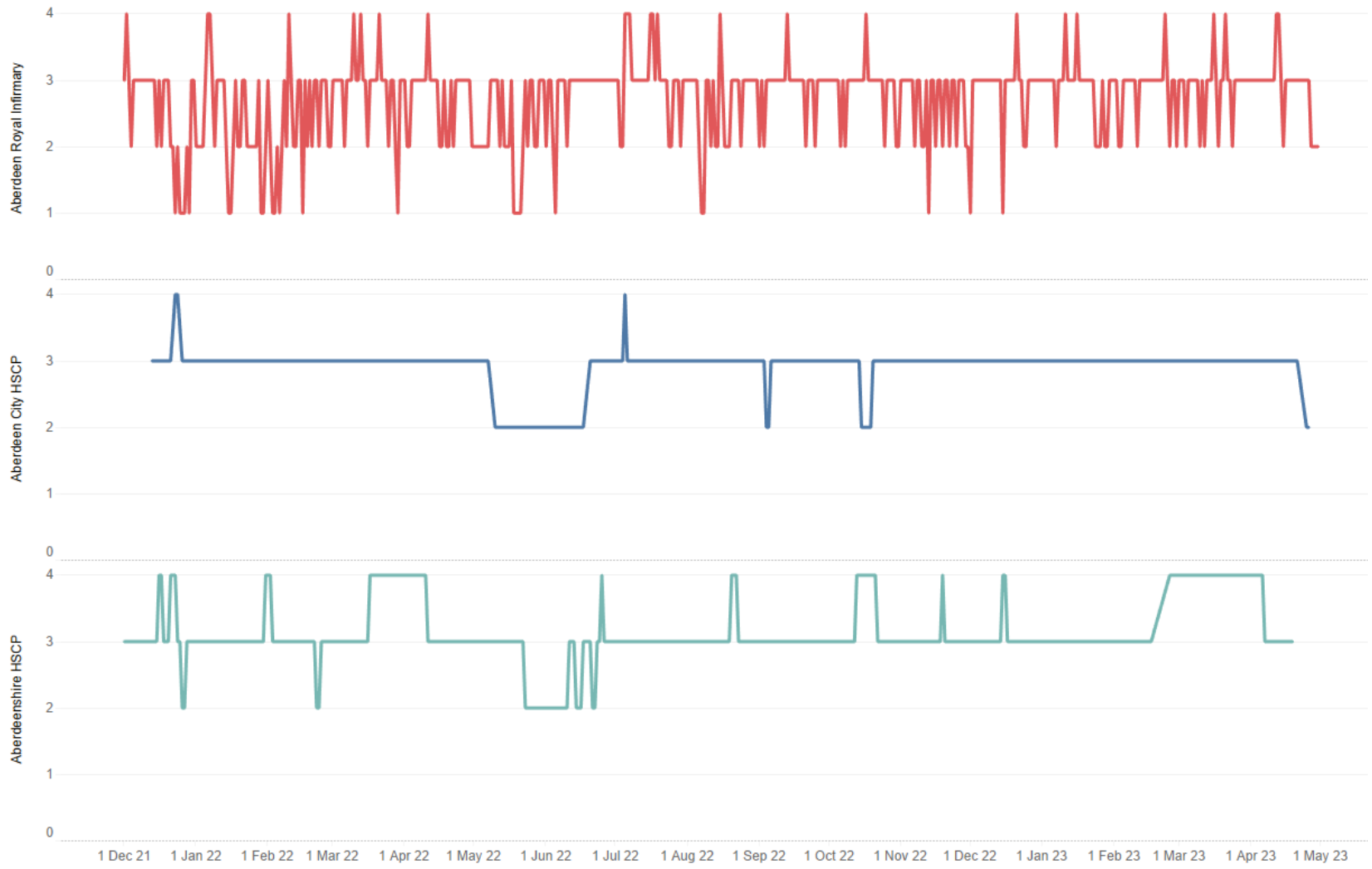
[7] Data provided as 12 month rolling trend (per 1,000) for Aberdeen City only as of Dec 2020, Dec 2021 and Dec 2022 respectively
[8] This dashboard was retired / no longer updated as of October 2021, therefore no additional data available
[9] Date range June 2022- March 2023

The below visual shows the G-OPES metrics of Aberdeen Royal Infirmary (the main referrer into Rosewell House); and the Health and Social Care Partnerships of Aberdeen City and Aberdeenshire. The visual shows that all areas have regularly been reporting a Level 3 for some two years (Level 3 is described as the system experiencing major pressures through service flow; staffing issues; with urgent actions required to reduce this). This is a direct consequence of, amongst other challenges, the COVID pandemic.

Bon Accord Care

Aberdeen City Health & Social Care Partnership
A caring partnership

G-OPES Metric History



ABERDEEN CITY COUNCIL

NHS Grampian

Further data are presented below that provide additional context. Firstly, during implementation, the decision was taken to allow Aberdeenshire residents to be referred into Rosewell as an alternative to hospital whilst localised elements of their frailty pathway were being developed. This allows for more equitable use of resources at a regional level at the expense of greater improvements at a HSCP level. Furthermore, data are provided regarding delayed discharges out of Rosewell and the associated number of bed days lost as a result. This further emphasis that the ability of Rosewell House to both receive admissions and discharge individuals can be influenced by a broad range of factors.

LOS Breakdown by HSCP (HSCP determined from patient postcode)							
		18-01-22 to 01-03-22			18-01-23 to 01-03-23		
		Aberdeen City	Aberdeenshire	Other	Aberdeen City	Aberdeenshire	Other
Number of Discharges	Frailty	40	21	--	45	7	Data excluded as numbers <5
	Rehab	16	--	--	22	0	
Average length of stay	Frailty	19.43	15.74	--	24.3	60.6	
	Rehab	20.26	--	--	38.9	--	
Maximum length of stay	Frailty	72.88	52.29	--	71.8	171	
	Rehab	59.21	--	--	120.9	--	

NB: HSCP determined from patient postcode

Rosewell House Delayed Discharges and Monthly Bed Days (Standard and Complex Delays, All Delay Reasons)				
	2022 (Jan-May)		2023 (Jan-May)	
	Aberdeen City	Aberdeenshire	Aberdeen City	Aberdeenshire
Delay Episodes	30	17	28	7
Total Monthly Bed Days	310	214	241	139

NB: Standard and complex delays, all delay reasons

Evaluation Question Four

Should the service continue moving forward?

From a patient / service user perspective, the majority of individuals who contributed to this evaluation cite high satisfaction with the care and support they receive, in addition to feeling the facility would be appropriate for others in similar circumstances. Their feedback suggests that the service could be further enhanced through greater integrated collaboration with support from other services, ranging from increasing the quantity of physiotherapy and mental wellbeing support, to social activities. However, when sense-checked with health professionals, it was recognised that in some instances it is not always necessary to do so.

From a staff perspective, the data collected suggests general agreement in the philosophy of the service, and optimism about the benefits that could be achieved through having integrated teams. The areas for improvement identified appear to be exhaustive, including the need for further work on enhancing the 'Team Rosewell' culture; ongoing challenges with staffing and further communication with broader colleagues.

From a resourcing perspective, Rosewell has been effective at supporting the Grampian health and care system, particularly Aberdeen Royal Infirmary (through providing a step-down pathway for patients) and Aberdeenshire Health & Social Care Partnership (through providing a proportion of beds for this area to use whilst their associated infrastructure was developed). This was achieved during a highly pressurised period of implementation, through factors including the redesign of the frailty pathway, coupled with increased demand for health and care services as an ongoing consequence of the COVID pandemic.

Taking this information together, it is recommended that the existing arrangements at Rosewell House are extended. Positive progress appears to have been made in several areas and there is a clear plan about how further improvements can be made. There are particular elements that would require specific attention moving forward however, such as the step-up pathway. Rosewell has faced challenges in realising one of the key components of intermediate care in operating as a community-facing, predominantly step-up / high turnover facility. Whilst this can largely be explained by prioritising providing support to hospital-based services to improve flow during the COVID pandemic, the step-up pathway will require continued and deliberate action (and associated governance), otherwise there is a high risk that the current proportion of step-up / step-down care becomes 'business as usual'. It is recommended that understanding what the step-up demand could look like would be helpful for future service planning, including the best staffing mix to address that. Further ongoing challenges, such as staffing issues, are complex and not unique to this service, and likely form part of a regional-type approach to sufficiently address them.

At present the way in which the beds in Rosewell are split means that the staffing and model of care is different between the 40 frailty beds and the 20 rehabilitation beds. There is currently a service review ongoing about the future model of care and purpose of these 20 beds currently used for rehabilitation. Historically these beds were looked after by an independent General Practice who withdrew their service in May 2023 and has been replaced by medical support from Hospital and Home clinicians whilst patients are registered at a different Practice. When looking at this Evaluation report it is important to understand that the model of medical support to these beds has changed recently and whilst its evaluation has not been included in this report, this would be important to investigate further moving forward.

There are some limitations that should be acknowledged. First, the largest proportion of data collected from a service user / patient perspective was whilst these individuals were in receipt of care, meaning they may have felt obliged to provide more positive feedback than otherwise. This was mitigated by having no identifiable information when the data was collected and having individuals who do not provide care in the facility administering the survey. Anecdotal feedback from service users / patients suggests they could provide more honest feedback in this instance. Second, given the complex system in which Rosewell operates, further data were provided to try and illustrate this context. However, this means there are likely other measurable metrics that could have informed this evaluation that have not been described within. This was mitigated by the evaluation questions and approaches used to answer those questions, being developed in Partnership by different stakeholders to try and use only the most relevant metrics so this report did not become unwieldly. Further, additional data collection was not conducted with staff. This was because a large volume of staff feedback has been collected over the two previous evaluations and given the themes between them remain consistent, it is argued this is exhaustive and the implementation plan that has been developed is being delivered on an ongoing basis to address these themes. However, given further staff turnover and new developments in how staff groups work together, there may be value in including broader staff views as the model progresses. Considering what processes could be implemented to collate this feedback from both staff and service user groups to inform service planning on a more agile basis would also be advantageous.

Acknowledgements

Acknowledgements have been redacted from this version of the evaluation report as it will be visible within the public domain.