Aberdeenshire
Health & Social Care
Partnership

**REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD,
6 DECEMBER 2023**

# ROSEWELL HOUSE – ABERDEENSHIRE USE OF BEDS IN THIS FACILITY

## 1 Recommendation

**It is recommended that the Integration Joint Board (IJB):**

**1.1 Cease commissioning of beds in Rosewell House that was commenced during the COVID 19 Pandemic as a result of work around the frailty pathway at that time**

## 2 Direction

2.1 This report requires a direction to be issued to NHS Grampian and the details of this direction are contained in Appendix 1.

## 3 Risk

3.1 Risk 1589 Risk of failure to deliver standards of care expected by the people of Aberdeenshire by reviewing and developing our frailty pathway in Aberdeenshire.

## 4 Background

### Changes to the Frailty pathway

4.1 During the COVID 19 pandemic there was a decision made in NHS Grampian to review the frailty pathway. This work was progressed by an NHS Grampian Group and saw the previous frailty pathway and resources being redesigned and aligned. Prior to this work, the acute beds supporting frailty in Aberdeen Royal Infirmary (ARI) were located in three ward areas. This redesign saw a reduction to a 25 bedded unit in ward 102, in ARI.

4.2 The intension for Aberdeenshire was that an element of the associated funding would be made available to develop a Hospital at Home service to support the population of Aberdeenshire patients as part of the frailty pathway. The funding made available was £1.6m.

4.3 The original intention was to develop three Hospital at Home teams for Aberdeenshire, based on a similar model that operates in Aberdeen City. The Aberdeen City model of Hospital at Home involves clinical cover from Geriatricians. The first area to test this was agreed as central Aberdeenshire.

4.4 It became apparent that establishing a Hospital at Home service in Aberdeenshire was challenging both in relation to recruitment of the

multidisciplinary team but primarily because success of this model for the frailty pathway patients in Aberdeenshire required securing eight sessions of Geriatrician cover. The recruitment of Geriatricians in Grampian has and continues to be challenging and the last set of interviews only saw the ability of the Geriatrician team to fill gaps in the resources required to deliver a service in the acute unit, ward 102 in ARI.

4.5 Aberdeenshire Health and Social Care Partnership recognised during the pandemic that it was taking time to deliver a Hospital at Home model and so agreement was reached that Aberdeenshire patients would be able to be admitted into Rosewell House in ARI for 9 months in 2021/22 financial year. Subsequently when Hospital at Home continued not to be able to be viably established Aberdeenshire HSCP was charged for the continued use of ten beds at Rosewell House in Aberdeen. The budget for 10 beds in Rosewell House for 2022/23 was £553k, however the charge received was £726k. The charge received for the first 4 months of 2023/24 year have been £266k, which then would give us an estimate cost of £800k full year costs.

4.6 In emerging from the pandemic, planning work recommenced on Hospital at Home. This identified that the proposed model to deliver this activity, based on duplicating the service in Aberdeen City, was not possible.

4.7 In October of 2022, the development of the Central Hospital at Home was paused for a variety of reasons:

- Unable to gain Geriatrician time to support the team
- Recruitment to other team members due to the above gap
- The team recruited had been small (2.5 whole time equivalents and of these, one individual indicated that they were to retire)
- The team remaining could be used to support core services in the partnership over the busy winter period to come.

4.8 As a result of the challenges above it was concluded that an approach would need to be taken to Hospital at Home in Aberdeenshire which enabled a service to be developed which supported our rural geography and existing resources including our model of Virtual Community Wards and our Community Hospitals.

4.9 Work commenced looking at future modelling around the enhancement of core services in order to be able to deliver more acute services at home for patients. Key to this is understanding our data, how our residents are supported currently and what resource and expertise is required to support more acute care at home.

4.10 A first step to understanding and developing our Aberdeenshire model of frailty care was the appointment of a frailty clinical lead post. To do this a GP with Specialist Interest role job description was developed and we have recently recruited to this post with the new post holder commencing on 27 November 2023. This post is temporary for 12 months to bring expertise and capacity to review our frailty care and work alongside clinical teams in the partnership.

**Funding associated with the Rosewell House Beds**

4.11 The Integration Joint Board will be aware of the decision to bring Aberdeenshire out of hours nursing service in house. This change took place in September 2023. The commissioned service was not sustainable. In order to provide a sustainable service delivering reliable essential nursing care out of hours additional funding was required. The only non-recurrently allocated resource was the funding set aside to deliver a Hospital at Home service. In 2023/24 the part year additional cost for the out of hours community nursing service was found non recurrently however in 2024/25 a recurrent funding source will be required.

4.12 In order to release the funding required, notice now needs to be given that Aberdeenshire Health and Social Care Partnership will no longer commission the ten beds at Rosewell House.

**Opportunity to enhance our Virtual Community Wards**

4.13 Aberdeenshire Health and Social Care Partnership has offered a unique Virtual Community Ward service since March 2016. The model offers local health and social care teams communicating and working closely together to identify vulnerable people earlier to ensure crises and acute interventions are prevented where possible. This model is a key component of our frailty service with predominant focus being on older people (70+). National comparison data demonstrates that we admit less individuals to acute hospital care and a key element of this is our Virtual Community Ward service.

4.14 In reflecting on how to develop a model of Hospital at Home in Aberdeenshire, we are keen to optimise and build on our Virtual Community Ward, moving it to a 24/7 model.

4.15 In response to an invitation from Scottish Government to introduce Hospital at Home capacity in time for winter 2023/24, Aberdeenshire Health and Social Care Partnership has bid successfully for funding to test this enhancement to our Virtual Community Wards in central Aberdeenshire. In addition, our data tells us that a key gap in care which results in admissions is a lack of responsive care at home resource. Consequently we have bid to enhance our ARCH (in house rapid response care at home) resources across Aberdeenshire to support all our Virtual Community Wards.

4.16 The above bid has been made on the understanding that the funding will be made recurrent however funding will only be drawn down from Scottish Government once staffing is in place.

## 5 Summary

5.1 Aberdeenshire Health and Social Care Partnership has been using ten beds at Rosewell House in Aberdeen City for frailty care. This is at an estimated cost for 2023/24 of £800k which was funding identified to support individuals in their own homes.

5.2 An element of this funding has been committed recurrently for out of hours nursing services.

5.3 Aberdeenshire Health and Social Care Partnership has reviewed its approach to Hospital at Home and is now looking to develop a model which builds on our Virtual Community Wards and infrastructure of Community Hospitals across Aberdeenshire.

5.4 A frailty clinical lead post has been appointed who will review our data and services with a view to enhancing our frailty pathways/ways of working.

5.5 Aberdeenshire Health and Social Care Partnership's use of the beds at Rosewell House should have been for a limited period of time and then an exit out of these should have happened some time ago. Giving notice to exit out of these beds ties in with work to enhance our Virtual Community Wards and the review to be undertaken by our clinical lead for frailty.

5.6 The Integration Joint Board is requested to agree to give notice to exit the use of the Rosewell House beds.

5.7 The Chief Officer, along with the Chief Finance Officer and the Legal Monitoring Officers within Business Services of the Council have been consulted in the preparation of this report and their comments have been incorporated within the report.

## 6 Equalities, Staffing and Financial Implications

6.1 An Integrated Impact Assessment (IIA) has been carried out as part of the development of the proposals set out above and the screening stage identified that a full IIA was required. The full IIA report is included as Appendix 2 and details all identified impacts and associated mitigations.

6.2 Positive and negative impacts were identified in relation to the following assessment areas:

1. Equalities and Fairer Scotland Duty
2. Health Inequalities
3. Climate Change and Sustainability

6.3 The report acknowledges that although there is a risk for some people being negatively impacted, this will be mitigated through person centred discharge planning and the enhancement of community-based services, providing support to an increased number of people in their own home or locality.

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Date 9.11.2023

## List of Appendices:

**Appendix 1 - Direction**
**Appendix 2 - Integrated Impact Assessment**