APPENDIX 2

Aberdeenshire Council

Integrated Impact Assessment

Rosewell House - Aberdeenshire use of beds in this facility

Assessment ID	IIA-001704
Lead Author	Kim Anderson
Additional Authors	Lynne Gravener, Denni Kerr, Catriona Cameron
Service Reviewers	Angela Macleod
Subject Matter Experts	Susan Forbes, Claudia Cowie, Kakuen Mo, Caroline Hastings, Annette Johnston
Approved By	Pamela Milliken
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1. Overview

This document has been generated from information entered into the Integrated Impact Assessment system.

During the Covid-19 pandemic a review of Grampians frailty pathway commenced which saw acute frailty beds in Aberdeen Royal Infirmary reduce and the introduction of ten beds, commissioned by Aberdeenshire HSCP, within Rosewell House in Aberdeen City, which can be used for step down care at an estimated cost of £800,000 per annum.
A Hospital at Home model was developed and trailed in Central Aberdeenshire but experienced significant challenges and was therefore paused in October 2022.
Work commenced looking at future modelling and if the funding currently allocated to the commissioned beds within Rosewell House could be used to support the enhancement our existing services such as our Virtual Community Wards.

This Integrated Impact Assessment will consider the potential impacts on any groups with protected characteristics associated with the de-commissioning of beds within Rosewell House.

During screening 3 of 10 questions indicated that detailed assessments were required, the screening questions and their answers are listed in the next section. This led to 3 out of 5 detailed impact assessments being completed. The assessments required are:

- Equalities and Fairer Scotland Duty
- Health Inequalities
- Sustainability and Climate Change

In total there are 6 positive impacts as part of this activity. There are 6 negative impacts, all impacts have been mitigated.

A detailed action plan with 1 points has been provided.

This assessment has been approved by pamela.milliken@aberdeenshire.gov.uk.

The remainder of this document sets out the details of all completed impact assessments.

2. Screening

Could your activity / proposal / policy cause an impact in one (or more) of the identified town centres?	No
Would this activity / proposal / policy have consequences for the health and wellbeing of the population in the affected communities?	Yes
Does the activity / proposal / policy have the potential to affect greenhouse gas emissions (CO2e) in the Council or community and / or the procurement, use or disposal of physical resources?	Yes
Does the activity / proposal / policy have the potential to affect the resilience to extreme weather events and/or a changing climate of Aberdeenshire Council or community?	No
Does the activity / proposal / policy have the potential to affect the environment, wildlife or biodiversity?	No
Does the activity / proposal / policy have an impact on people and / or groups with protected characteristics?	Yes
Is this activity / proposal / policy of strategic importance for the council?	No
Does this activity / proposal / policy impact on inequality of outcome?	No
Does this activity / proposal / policy have an impact on children / young people's rights?	No
Does this activity / proposal / policy have an impact on children / young people's wellbeing?	No

3. Impact Assessments

Children's Rights and Wellbeing	Not Required
Climate Change and Sustainability	Only Some Negative Impacts Can Be Mitigated
Equalities and Fairer Scotland Duty	Only Some Negative Impacts Can Be Mitigated
Health Inequalities	Only Some Negative Impacts Can Be Mitigated
Town Centre's First	Not Required

4. Equalities and Fairer Scotland Duty Impact Assessment

4.1. Protected Groups

Indicator	Positive	Neutral	Negative	Unknown
Age (Younger)		Yes		
Age (Older)	Yes		Yes	
Disability	Yes		Yes	
Race		Yes		
Religion or Belief		Yes		
Sex		Yes		
Pregnancy and Maternity		Yes		
Sexual Orientation		Yes		
Gender Reassignment		Yes		
Marriage or Civil Partnership		Yes		

4.2. Socio-economic Groups

Indicator	Positive	Neutral	Negative	Unknown
Low income	Yes		Yes	
Low wealth	Yes		Yes	
Material deprivation		Yes		
Area deprivation		Yes		
Socioeconomic background		Yes		

4.3. Positive Impacts

Impact Area	Impact

Impact Area	Impact
Age (Older)	The de-commissioning of beds at Rosewell House will allow for funding to be re-directed to support and enhance existing key services, positively impacting older people's health and wellbeing. The monies will be used to support the newly established Out of Hours Nursing Service in additional to supporting the potential enhancement of our Virtual Community Wards to offer a 24 hour service. Both of these services are key components within our frailty pathway, working collaboratively with other initiatives such as rehabilitation and enablement services, to minimise hospital admissions and support the residents of Aberdeenshire. By enhancing existing services in the community people are enabled to remain in their own home and this could assist to reduce pressure on beds and achieve better outcomes for individuals. Patients being discharged from Aberdeen Royal Infirmary will be discharged to a setting closer to their own home, enabling visitors and family members to provide support more easily and visit more often. Many of whom may be elderly and find travelling long distances challenging as they may be reliant on public transport or family. This approach supports a place based, person centred model of care, meaning people will receive support in their own community from local services, ensuring continuity of care.

Impact Area	Impact
Disability	The de-commissioning of beds at Rosewell House will allow for funding to be re-directed to support and enhance existing key services, positively impacting older people's health and wellbeing. The monies will be used to support the newly established Out of Hours Nursing Service in additional to supporting the potential enhancement of our Virtual Community Wards to offer a 24 hour service. Both of these services are key components within our frailty pathway, working collaboratively with other initiatives such as rehabilitation and enablement services, to minimise hospital admissions and support the residents of Aberdeenshire. By enhancing existing services in the community people are enabled to remain in their own home and this could assist to reduce pressure on beds and achieve better outcomes for individuals. Patients being discharged from Aberdeen Royal Infirmary will be discharged to a setting closer to their own home, enabling visitors and family members to provide support more easily and visit more often. Many of whom may be elderly and find travelling long distances challenging as they may be reliant on public transport or family. This approach supports a place based, person centred model of care, meaning people will receive support in their own community from local services, ensuring continuity of care.
Low income	Visitors may find it easier and more cost effective to visit patients who are discharged to a setting within their own locality.
Low wealth	Visitors may find it easier and more cost effective to visit patients who are discharged to a setting within their own locality.

4.4. Negative Impacts and Mitigations

Impact Area	Details and Mitigation

Impact Area	Details and Mitigation
Age (Older)	People may be negatively impacted if our community hospital's and /or community services do not have the capacity to provide support or are unable to meet the needs of the patient. This may result longer stay time in Aberdeen Royal Infirmary and for some patients may result in them being transferred to a community hospital setting out with their local area. This may mean that visitors are required to travel greater distances. Can be mitigated: Yes Mitigation: Person centred discharge planning will take place and people will be discharged to a setting as close to their own home as possible. Therapy staff are part of the Discharge Hub team, supporting an MDT approach to discharge, linking into community based services such as rehabilitation and enablement and ARCH. Work is ongoing around the enhancement of our Virtual Community Wards, which will seek increase the number of people being supported in their own home who have increased acuity and care needs due to illness. Timescale: Ongoing
Disability	People may be negatively impacted if our community hospital's and /or community services do not have the capacity to provide support or are unable to meet the needs of the patient. This may result longer stay time in Aberdeen Royal Infirmary and for some patients may result in them being transferred to a community hospital setting out with their local area. This may mean that visitors are required to travel greater distances. Can be mitigated: Yes Mitigation: Person centred discharge planning will take place and people will be discharged to a setting as close to their own home as possible. Therapy staff are part of the Discharge Hub team, supporting an MDT approach to discharge, linking into community based services such as rehabilitation and enablement and ARCH. Work is ongoing around the enhancement of our Virtual Community Wards, which will seek increase the number of people being supported in their own home who have increased acuity and care needs due to illness. Timescale: Ongoing

Impact Area	Details and Mitigation
Low income	The impact on people with low income is currently unknown however the report acknowledges that some visitors may find it difficult to travel and visit patients who are not discharged to a setting within their own locality due to increased travel costs and the availability of public transport. Can be mitigated: Yes Mitigation: Person centred discharge planning will take place and people will be discharged to a setting as close to their own home as possible. Timescale: Ongoing
Low wealth	The impact on people with low wealth is currently unknown however the report acknowledges that some visitors may find it difficult to travel and visit patients who are not discharged to a setting within their own locality due to increased travel costs the availability of public transport.. Can be mitigated: Yes Mitigation: Person centred discharge planning will take place and people will be discharged to a setting as close to their own home as possible. Timescale: Ongoing

4.5. Evidence

Type	Source	It says?	It Means?
Other Evidence	Healthcare Improvement Scotland: Guiding Principles for Service Development	This document highlights and brings together the published evidence on the effectiveness of caring for people in their local community. It is recognised that older people with frailty are at particular risk of being affected by institutionalisation and delirium and many experience a reduction in their functional ability between admission to hospital discharge.	This guide supports a person centred, place based approach and is intended to assist in local planning for services supporting older people.

Type	Source	It says?	It Means?
Other Evidence	National Institute for Health and Care Research	This report, published in 2021, describes how caring for vulnerable, elderly people at home can help to improve patient outcomes. A team of researchers engaged over 1000 older participants in their research from across the UK, over a 3 year period. The study found that slightly less patients were likely to be in long term residential care and were less likely to develop acute delirium. The study also reported higher levels of satisfaction when receiving care in their own home.	The report indicates that the participants who took part in the research were supportive of care being provided in their own home and that this would help to relieve pressure on hospital beds.

Type	Source	It says?	It Means?
Other Evidence	Joining the dots: A blueprint for preventing and managing frailty in older people	The British Geriatrics Society launched Joining the dots: A blueprint for preventing and managing frailty in older people in March 2023. The document is intended to support commissioners in the design and delivery of health and social care services for older people. The blueprint outlines seven system touchpoints and outcomes including:- "Integrated urgent community response, reablement, rehabilitation and intermediate care" and "Frailty-attuned acute hospital care". The top two priorities of older people living with moderate or severe frailty are:- 1) Staying in my own home 2) Staying independent For many older people with complex care needs, secondary care may be a requirement, however, systems need to work with local communities and partner organisations, creating inclusive communities that support older people to live well at home for longer.	The blueprint advises that all localities should offer high quality MDT urgent community response care that optimises recovery through rehabilitation and enablement. Often older people admitted to hospital could return home the same day if they were assessed and diagnosed swiftly if pathways were attuned to the needs of older people with frailty.

4.6. Overall Outcome

Only Some Negative Impacts Can Be Mitigated.

Mitigations have been added to all identified negative impacts in this section of the assessment demonstrating how negative impacts will be reduced as far as possible.

The de-commissioning of the beds at Rosewell House should positively impact the vast majority of patients and visitors.
Patients will benefit from continuity care in their local community and improved access to own local support network.
Visitors will be able to visit and provide support more easily, reducing their travel costs and time and lessening the distance they are required to travel, which will in turn positively impact on the environmental.

Work is ongoing in relation to the development of our frailty pathways in Aberdeenshire and the

enhancement of existing services. Additional Integrated Impact Assessments will be completed to explore any potential negative and positive impacts and mitigations as required as part of this work.

5. Health Inequalities Impact Assessment

5.1. Health Behaviours

Indicator	Positive	Neutral	Negative	Unknown
Healthy eating		Yes		
Exercise and physical activity		Yes		
Substance use – tobacco		Yes		
Substance use – alcohol		Yes		
Substance use – drugs		Yes		
Mental health	Yes		Yes	

5.2. Positive Impacts

Impact Area	Impact
Mental health	Patients mental health is likely to be positively impacted for those receiving support within their own home or as close to their own home as possible, improving their access to important support networks, reducing loneliness and isolation.

5.3. Negative Impacts and Mitigations

Impact Area	Details and Mitigation
Mental health	It must be acknowledged that patients mental health may be negatively impacted for those who have to remain in ARI for a longer period or if transferred to a setting further away from their local area which could make it more difficult for visitors to offer support, potentially causing an increase in loneliness and isolation. Can be mitigated: Yes Mitigation: Person centred discharge planning will take place and people will be discharged to a setting as close to their own home as possible. Therapy staff are part of the Discharge Hub team, supporting an MDT approach to discharge, linking into community based services such as rehabilitation and enablement and ARCH. Work is ongoing around the enhancement of our Virtual Community Wards, which will seek increase the number of people being supported in their own home who have increased acuity and care needs due to illness. Timescale: Ongoing

5.4. Evidence

Type	Source	It says?	It Means?
External Consultation	How has Covid-19 impacted on care and support at home in Scotland?	In 2020 the Health and Sport Committee at the Scottish Parliament carried out an online survey to gather views from people to try and understand the impact of the pandemic had on those receiving care at home services in the community. One of the key messages documented within the report is the importance of continuity of care and access to local care. Maintaining a routine was important to participants and many respondents indicated that they had increased feelings of loneliness and social isolation without access to local supports and services.	The report states that continuity of care was an important factor to respondents. By providing support to people within their local community it is likely that people will experience improved continuity of care and access to support from family and friends, helping to reduce the risk of isolation and loneliness.

5.5. Overall Outcome

Only Some Negative Impacts Can Be Mitigated.

Mitigations have been added to all identified negative impacts in this section of the assessment demonstrating how negative impacts will be reduced as far as possible.

The de-commissioning of the beds at Rosewell House should positively impact the vast majority of patients and visitors.

Patients will benefit from continuity care in their local community and improved access to own local support network.
Visitors will be able to visit and provide support more easily, reducing their travel costs and time and lessening the distance they are required to travel, which will in turn positively impact on the environmental.

Work is ongoing in relation to the development of our frailty pathways in Aberdeenshire and the enhancement of existing services. Additional Integrated Impact Assessments will be completed to explore any potential negative and positive impacts and mitigations as required as part of this work.

6. Sustainability and Climate Change Impact Assessment

6.1. Emissions and Resources

Indicator	Positive	Neutral	Negative	Unknown
Consumption of energy	Yes		Yes	
Energy efficiency		Yes		
Energy source		Yes		
Low carbon transition		Yes		
Consumption of physical resources		Yes		
Waste and circularity		Yes		
Circular economy transition		Yes		
Economic and social transition		Yes		

6.2. Biodiversity and Resilience

Indicator	Positive	Neutral	Negative	Unknown
Quality of environment		Yes		
Quantity of environment		Yes		
Wildlife and biodiversity		Yes		
Infrastructure resilience		Yes		
Council resilience		Yes		
Community resilience		Yes		
Adaptation		Yes		

6.3. Positive Impacts

Impact Area	Impact

Impact Area	Impact
Consumption of energy	The full impact regarding the consumption of energy is unknown however, it is likely that discharging patients to a setting closer to their own home is likely to reduce travel emissions in two ways:- 1. A reduction in the miles and patient journeys being travelled - patients currently discharged to a commissioned bed at Rosewell House are firstly transported to Rosewell House and have a further onward journey to another setting or their own home. The distance between Aberdeen Royal Infirmary and Rosewell House is 1.3 miles and therefore a 2.6 mile journey if the patient is being supported by hospital transport staff. 2. Patients being discharged to a setting closer to their own locality will mean that visitors are likely to have less distance to travel to visit or offer support. This will impact visitors travelling from the North of Aberdeenshire the most. Due to the rural nature of Aberdeenshire's geography the furthest community hospital setting from Aberdeen Royal Infirmary is Chalmers Community Hospital in Banff which is 45.7 miles from ARI.

6.4. Negative Impacts and Mitigations

Impact Area	Details and Mitigation
Consumption of energy	It is acknowledged that some visitors may have further to travel if a patient is discharged out with their locality. Can be mitigated: Yes Mitigation: Person centred discharge planning will take place and people will be discharged to a setting as close to their own home as possible. Therapy staff are part of the Discharge Hub team, supporting an MDT approach to discharge, linking into community based services such as rehabilitation and enablement and ARCH. Work is ongoing around the enhancement of our Virtual Community Wards, which will seek increase the number of people being supported in their own home who have increased acuity and care needs due to illness. Timescale: Ongoing

6.5. Evidence

Type	Source	It says?	It Means?

Type	Source	It says?	It Means?
Internal Data	Internal mileage calculations	Due to Aberdeenshire's rurality many of our communities are located a significant distance from Aberdeen. Some of our communities are situated over 40 miles away and are as follows:- Aberdeen - Portsoy = 49.7 miles Aberdeen - Banff = 45.7 miles Aberdeen - Fraserburgh = 41.7 miles The average distance between Aberdeen Royal Infirmary and our community hospital settings is approximately 31 miles one way.	Through discharge planning and the enhancement of the virtual community ward's patients would be closer to their own home or transferred to a community hospital closer to their own locality which would significantly reduce the distance some visitors are required to travel.

6.6. Overall Outcome

Only Some Negative Impacts Can Be Mitigated.

Mitigations have been added to all identified negative impacts in this section of the assessment demonstrating how negative impacts will be reduced as far as possible.

The de-commissioning of the beds at Rosewell House should positively impact the vast majority of patients and visitors.
Patients will benefit from continuity care in their local community and improved access to own local support network.
Visitors will be able to visit and provide support more easily, reducing their travel costs and time and lessening the distance they are required to travel, which will in turn positively impact on the environmental.

Work is ongoing in relation to the development of our frailty pathways in Aberdeenshire and the enhancement of existing services. Additional Integrated Impact Assessments will be completed to explore any potential negative and positive impacts and mitigations as required as part of this work.

7. Action Plan

Planned Action	Details	
Work commenced looking at our current Frailty Pathway and future modelling around the enhancement of core services to deliver more acute care for patients at home. A clinical lead has been recruited into post for a period of 12 months to work alongside our clinical teams in developing our model of frailty care. A key focus will be to develop and enhance existing services such as Virtual Community Wards. Virtual Community Wards have been operating in Aberdeenshire since 2016 and is a fundamental component of our frailty service.	**Lead Officer**	Catriona Cameron
	Repeating Activity	No
	Planned Start	Monday November 27, 2023
	Planned Finish	Sunday November 24, 2024
	Expected Outcome	The further development and enhancement of our Frailty Pathway in Aberdeenshire, with the potential to offer a 24 hour Virtual Community Ward Service, providing support to people with increased acuity in their own home.
	Resource Implications	Yet to be agreed.