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| February 2021 |
|  NHS SWL CCG Evaluation of the eRedBag  *eRedBag Logic Model* |

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| Context and rationaleWhen frail, vulnerable care home residents attend ED or have an unplanned hospital admission, they may be: too ill to describe their condition; unable to share their story in a reliable way; unable to advocate for themselves due to communication and/or cognitive impairments. If hospital staff or ambulance staff lack knowledge about the patient, this may affect treatment and length of stay. When the resident returns to the care home, staff there may receive little or no communication about changes in management and medication required. The initial Red Bag pathway, launched in 2015, was a physical red bag designed to be sent to and from hospital with the care home resident when attending ED or having an unplanned hospital admission. The bag contained physical documentation about the resident as well as important personal possessions. The Red Bag improved information transfer and communication between hospitals and care homes when residents were transferred to hospital for urgent or emergency care and returned to their care home. However, the use of paper entailed risks of documents going missing, hospital staff not knowing about the Red Bag and so missing it, out of date documents accidentally being used, and hospital staff being unable to read handwriting.  | A digital version of the Red Bag, the eRedBag Pathway, was launched in 2019. The Sutton Demonstrator project was intended to test whether digitalising documents would reduce the risks associated with paper documents and improve communication between hospitals and care homes. The project showed that two care homes could electronically send the Red Bag documentation directly to the local hospital where it was uploaded to the Electronic Patient Record (EPR). The Social Care Digital Pathfinders programme, funded by NHS Digital, has provided funding to test whether the eRedBag Pathway can be scaled up, covering more care homes, new social care software providers and be accessed by more hospitals. The current implementation phase is focused on digital integration, specifically increasing the number of care homes in Sutton and Southern Merton passing the DSPT at ‘Standards Met’ and using the eRedBag, as well as creating a National eRedBag Standard and ‘how to’ guides for implementers. eRedBag information can now be uploaded onto the local shared care records (Connecting your Care) for access by all acute trusts and general practices in SWL and other organisations providing direct care. A link via the National Record Locator also allows ambulance staff to access the information. To complete the pathway, discharge summary documents can be emailed directly to care homes via a shared mailbox. |
| Objectives *Overarching aim: Improve experience and outcomes for care home residents when they require urgent or emergency care by facilitating digital sharing of key information via the eRedBag.* * Work with Professional Records Standards Body to publish a standard set of data that is transferred with care home residents when they go to hospital for urgent or emergency care
* Support care homes and hospital staff to implement and use the pathway effectively
* Develop technical solutions and standards to transfer data from care homes to the NHS
* Support care homes to achieve Standards Met on the Data Security and Protection Toolkit
* Expand model to include new social care software providers and be accessed by more hospitals, covering more care homes and residents
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| Inputs* *Funding*: £313,110 from NHS Digital’s Social Care Pathfinder Programme
* *Project management and support*: including a Programme Manager, Project Manager, Project Implementation Support and Project Support Officer from London Borough of Sutton and South West London Health and Care Partnership (STP)
* *Technical support and development*: technical leadership from Care Software Providers Association (CASPA) set up by Person Centred Software, technical support from hospital staff and NHS Digital on provision of data from care homes to hospitals
* *HSCN connection* (secure network and connection to NHS Digital in care homes): direct payment from CASPA to HSCN providers
* *Clinical leadership*: from the Head of Nursing at Epsom and St Helier University Hospitals NHS Trust, and London Ambulance Service
* *Care home engagement*: from care home managers and staff
* *Information Governance advice*: support from the IG Lead at North East London CSU
* *Communications support*: including communications staff from various organisations, such as South West London Health and Care Partnership (STP), SL HIN, NHS London
* *Service user support*: in Steering Group and engagement events by Healthwatch for Sutton and Merton
 | Activities*Development of the current pathway and support for eRedBag users* * Development of an eRedBag professional standard
* Creation of ‘How to’ guides for eRedBag users including health and social care commissioners, care software providers, care home staff and owners (including large providers and head offices), acute staff, ambulance staff, community staff and care home residents’ carers/family members
* Development of materials to support evaluation of eRedBag in a locality
* Delivery of workshops, focus groups, interviews, webinars and online surveys with users of the eRedBag, including clinicians, therapists, ambulance users, family members, and management and clinical staff at acute trusts to develop ways to improve the eRedBag
* Engagement with residents and family members/carers about how the eRedBag pathway works.

*Creation of technical solutions** Development of a technical solution ready for national rollout through:
	+ Connection to Health Information Exchange
	+ Direct connection to more local hospitals (from care homes)
	+ Continued work on connecting End of Life Care plans and eRedBag with the National Record Locator and Connecting your Care to enable the eRedBag to be accessed by ambulance crews, acute and community staff
	+ Set-up and use of NHSmail for patient discharge back to care home
* Development of a technical standard for care software providers to connect uniformly with the NHS
* Liaison between software providers and hospital technical staff to build joint understanding of issues and solutions

*Stakeholder engagement** Development of relationships with new care homes and large group providers
	+ To support care homes to achieve Standards Met in the Data Security and Protection Toolkit
	+ To gather service user views from hospitals
	+ To connect with technical teams at hospitals, Person Centred Software, Cerner, SWL Hospital Trusts, and other Local Health and Care Record exemplar sites
* Ensuring inter-operational relationships between health and social care are retained
* Keeping stakeholders up to date with developments by email, one-to-one meetings, and steering groups
* National collaboration through engagement with other Pathfinders

*Project management and governance, administration** Establishment of steering group (with representatives from large group providers and SWL Digital Team) and Standards Development Working Group
* Oversight of communications, engagement approach and strategy, business contingency and mitigation strategies
* Development of plans for monitoring, evaluation and benefits realisation.
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| Outputs*National** A National eRedBag Professional Standard
* A national mobilisation pack of ‘How to Guides’
* A technical solution ready for national rollout to 70,000 care home beds
* A technical standard for care software providers to connect uniformly with the NHS (50 care software providers reached within health and care sector, covering 90% of care software providers (over 2,000 care homes, about 15% of all care homes))
* Interactions with other Pathfinders

*Local** Interactions with users of the eRedBag to develop their understanding of the pathway and gather feedback on improvements to the eRedBag
* New relationships with new care homes, large group providers, hospital technical teams, software providers, SWL Hospital Trusts etc.
* Informed, up to date stakeholders
* Steering Group and Standards Development Working Group meetings
* Monitoring, evaluation and benefits realisation plans.
 | Outcomes*For care homes and hospitals** Increased take up of the DSPT
* More digitally mature care homes that can connect digitally with the NHS
* More digitally mature care homes offer improved care to residents (through better tracking of care and data-recording)
* Improved digital systems provide an opportunity for more effective infection control
* eRedBag in use by care homes in SW London:
	+ 60% beds from Sutton and southern Merton (approx. 730 beds) who use St Helier hospital over a 12-month period send residents to hospital with an eRedBag
	+ 20% beds from the rest of SWL (approx. 1,130 beds) over a 12-month period send residents to hospital with an eRedBag.
* Time saved on filling in forms and making telephone calls for care home staff and hospital staff
* Improved communication across organisations resulting in reliable, up-to-date, consistent quality information about patients/residents
* Reduced risk of data breaches

*For patients / care home residents** Fewer ambulance conveyances
* Fewer ED attendances
* Fewer hospital admissions (NELs)
* Reduced length of stay
* Reduced readmissions (NEL)
* More efficient assessments at ED attendances and on admission
* Reduced need to repeat unnecessary tests
* Needs met in a timely way
* Improved end of life care through advanced care plans and DNAR availability
* Reassurance for residents’ family/carers
 | Impacts[Against national Pathfinders logic model]* Better sharing of information across the health and social care system
* Increased prevention of escalating health and social care needs
* Improved patient experience, quality of care and safeguarding (and experience of family/carers)
* More time available by hospital staff to spend on patients with greater need due to fewer ambulance conveyances, ED attendances, NEL admissions, readmissions and shorter LOS.
* Improved job satisfaction for care home and hospital staff
* Savings of £5.7m over life cycle of programme (ROI of 5.9)
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| Assumptions and drivers of change |
| *Strategy** The NHS Long Term Plan contains a commitment to roll out the Enhanced Health in Care Homes Framework by 2024. One element of the EHCH Framework is secure sharing of information between care homes and NHS staff via access to NHSmail and other digital communication.
* Funding from NHS Digital when five key milestones are met
* Information failures cause poorer quality care, delay care and discharges, and an uncoordinated journey between health and social care
* There are common technologies and processes that can be used across the health and social care sectors
* The Covid-19 pandemic has increased the importance of electronic data-sharing due to the risk of transmitting infection via physical documents
* CQC values effective monitoring of care home residents and effective communication e.g. sharing advanced care plans across services
 | *Delivery** There is sufficient interest in and capacity to engage in the programme from care home and hospital staff for the full project timeframe
* Residential and nursing home staff have sufficient digital skills
* It is possible to schedule enough time with care homes for DSPT support
* Both digitally mature and immature care homes are able to implement the eRedBag pathway
* Care software providers are able to reach the correct IG level in a timely way
* There is continued support and involvement from Steering Group members and partners
* Coronavirus does not unduly impede different aspects of the project
 | *Benefits** Use of the eRedBag results in higher quality care and patient experience
* The amount of funding is sufficient to make a difference to intended outcomes/impacts
* Programme timescales are sufficient to realise outcomes and impacts
* Without the eRedBag, care homes may not have achieved the benefits brought by the eRedBag at all or to the same scale or as quickly
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