Evaluation of the 'Red Bag' Hospital Transfer Pathway in South London

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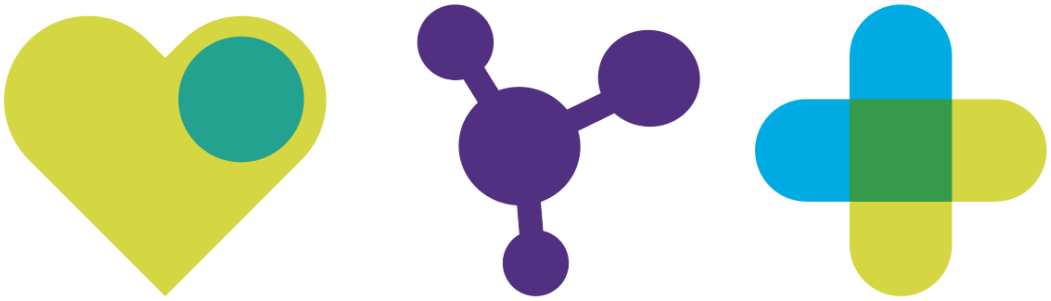
Contents

About

The 'Red Bag' Hospital Transfer Pathway, originally developed in Sutton in 2015, aims to improve communication between care home, ambulance and hospital staff - to improve the quality of care for care home residents conveyed to hospital in an emergency.

This evaluation by the Health Innovation Network is to understand the impact and stakeholder experiences of implementing the Hospital Transfer Pathway within three south London boroughs: Lambeth, Kingston and Richmond.



Acknowledgements

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NHS Kingston Clinical Commissioning Group

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Your Healthcare Kingston

Hounslow and Richmond NHS Community Trust

London Ambulance Service NHS Trust

Healthwatch Lambeth

Kingston Hospital NHS Foundation Trust

Guy's and St Thomas' NHS Foundation Trust

Kings College Hospital NHS Foundation Trust

Executive Summary

The "Red Bag" Hospital Transfer Pathway has now been implemented across South London. This evaluation explores the impact and stakeholder experiences of implementing the pathway within three south London boroughs.

Overview

The 'Red Bag' Hospital Transfer Pathway was developed by Sutton Homes of Care Vanguard in 2015 and has been cited as an example of good practice to support health care systems by NHS England[1] and aligns with NICE Guidance (NG27) on Transitions of Care[2]. It has now been implemented in older adult care homes, London Ambulance Service (LAS) and hospitals throughout south London.

The Health Innovation Network aimed to understand stakeholder experiences and the impact of implementing the "Red Bag" Hospital Transfer Pathway within Lambeth, Kingston and Richmond. The evaluation was undertaken during January and October 2018 using a mixed methods approach, involving care home managers, hospital clinicians, London Ambulance Service (LAS) paramedics, community service providers, commissioners and managers from clinical commissioning groups (CCG) and local authorities.

Findings

Out of 90 survey responses from care home, LAS and hospital staff, over two-thirds of respondents believed that the Hospital Transfer Pathway had improved communication between partners across the care pathway. Nearly all care home managers stated they were using the red bag and associated documentation all or some of the time and two-thirds of care home managers reported that residents returned from hospital with their documentation and belongings in the red bag. Over half of care home managers reported the pathway had improved the transfer process for residents.

However, hospital staff, paramedics and care home managers also highlighted challenges with the pathway. Standardised red bad documentation was sometimes missing or incomplete when residents were transferred to hospital, or lacked discharge information when residents were discharged back to the care home. There were particular difficulties in locating and retrieving bags that had become lost at hospital. In addition, both care homes and hospitals faced challenges with successfully promoting the pathway in the face of high turnover of staff and during the busy winter period.

In Kingston and Richmond there was a reduction in the average length of stay of 5.2 and 0.3 days respectively for every residential and nursing care home emergency admission in the six-month period following implementation compared to the same six-month period in the previous year. In Lambeth (for nursing homes only) there was a 1.7-day increase. However,

[1] NHS England Quick Guide: Hospital Transfer Pathway (Red Bag), 2018, NHS England and NHS Improvement
[2] NICE Guidance (NG 27) Transition between inpatient hospital settings and community or care home settings for adults with social care needs, NICE, 2015

due to the wide range of factors influencing length of stay in acute settings, it is not possible to determine the role played by the "Red Bag" Hospital Transfer Pathway in the changes observed here.

Conclusions

The evaluation showed there was real enthusiasm and passion for the aims of the "Red Bag" Hospital Transfer Pathway from care home, ambulance and hospital staff. People involved in the Hospital Transfer Pathway believe it provides a valuable opportunity to improve the care of residents. When professionals across the system (i.e. care homes, LAS and NHS acute trusts) used the pathway well, respondents believed that communication had improved and the transition of care into and out of hospital was smoother, which was perceived to lead to improved quality of care. However, the evaluation also found that elements of the pathway have not been fully embedded within all individual professional practice and care settings. When the pathway was not adhered to – either in the care home or hospital setting – this caused practical difficulties and could result in despondency and frustration amongst professionals. This needs to be resolved to optimise the pathway and fully realise the benefits.

Introduction

Policy context

The NHS England Enhanced Health in Care Homes (EHCH) Framework[3], published in September 2016, sets out a clear vision for working in care homes as part of a partnership approach between primary care, secondary care and community services. Key principles from the Framework are that a successful model for enhanced health should be co-produced, person centred and focused on quality. As one of six EHCH Vanguard sites, Sutton Homes of Care developed the Hospital Transfer Pathway (also called the Red Bag Pathway), which was designed to ensure that residents living in Sutton care homes receive safe, coordinated and efficient care should they need to go into hospital in an emergency. This pathway has now been promoted nationally via NHS England's publication of a Quick Guide for the Red Bag[4] in 2018.

The pathway additionally meets NICE guidance (NG27) on Transition of care between hospital and care home settings[5].

The Hospital Transfer "Red Bag" Pathway

The Hospital Transfer Pathway (often called the Red Bag Pathway) aims to ensure[6]:

- Every care home resident has a red bag containing their personal information documents, medications, belongings, and clothes for travelling
- Every professional the resident has contact with on their journey to hospital knows key personal information (e.g. health and social care needs) and the reasons for them going into hospital
- A care home manager (or nominated deputy) is available to support the resident during their hospital admission, visits within 48-72 hours of admission, and is involved in the resident's care during the admission
- Every resident (or resident's lasting power of attorney, where appropriate) consents to their personal information being shared with the care home, the hospital and the ambulance service
- Hospital and ambulance service staff communicate all relevant information about the resident with each other and with the care home

The Hospital Transfer Pathway is designed to support care homes, the ambulance service and the local hospital to ensure a safe transfer between care home settings and inpatient hospital settings for frail, older adults, many of whom have dementia. The greatest impact of the Hospital Transfer Pathway has been on the improved quality of care provided to care home residents.

[3] https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf
[4] NHS England Quick Guide: Hospital Transfer Pathway (Red Bag), 2018, NHS England and NHS Improvement
[5] NICE Guidance (NG 27) Transition between inpatient hospital settings and community or care home settings for adults with social care needs, NICE, 2015
[6] Evaluation of Sutton Homes of Care Vanguard

Spread of Hospital Transfer Pathway in south London

As an innovative example of a pathway redesign to improve the quality of care for care home residents, the Health Innovation Network (HIN)[7] has worked with the other eleven boroughs across south London to spread the Hospital Transfer Pathway that was developed by Sutton Homes of Care Vanguard.

The Hospital Transfer Pathway is a whole systems approach and success has been dependent on working collaboratively with all partners involved in the admission/discharge process of a care home resident across the pathway. Between November 2016 and late 2018 the Health Innovation Network supported the eleven other clinical commissioning groups (CCGs) and local authorities in south London to implement the Hospital Transfer Pathway by working with care homes, CCGs, community services, local authorities and hospital staff.

As part of the implementation process all local areas collectively agreed the core documentation that was to be included with the Hospital Transfer Pathway. Table 1 provides an overview of the core documentation and its function. In addition to core documentation, care homes are encouraged to include any urgent and advanced care plans (e.g. Do Not Attempt Resuscitation forms) and highlight if a resident has a Coordinate My Care record.

Table 1 Core documentation used within the Hospital Transfer Pathway

Documentation	Intended use	Completed by / when	Used by
Older Persons Assessment Form / Health Care Record Summary (OPAF)	To record baseline information about a resident's health condition	Care home, on admission and updated following care plan review or hospital stay	Ambulance crews and hospital staff
CARES (Concern, Action, Response, Shared Information) Escalation Record	To record the concerns and actions of care home staff when residents need emergency care	Care home, at the time of the emergency	Ambulance crews and hospital staff
Checklist	To record all items within the red bag	Care home, Ambulance and Hospital staff when receiving the red bag	Care home, ambulance and hospital staff
Medication Administration Record (MAR) Sheet / Updated MAR Sheet	To record medication	Care home staff / hospital staff if medication changed	Care home, ambulance and hospital staff
This is Me, or equivalent	To record personal preferences for residents with dementia	Care home staff	Care home and hospital staff
Nurse Transfer Letter	To record nursing information and care needs on discharge	Hospital staff on discharge	Care Homes, community services
Discharge Summary	To inform GP of chief complaint, diagnostic findings and any recommendations	Hospital staff on discharge	Care homes, GP, community services

[7] The Health Innovation Network is the Academic Health Science Network (AHSN) for south London

Evaluation of Hospital Transfer Pathway in south London

The Health Innovation Network has undertaken this evaluation to understand the impact and stakeholder experiences of implementing the Hospital Transfer Pathway within three south London boroughs: Lambeth, Kingston and Richmond.

Evaluation Approach

Overall design

The evaluation used a mixed methods case study approach comprising surveys, quantitative data (i.e. length of stay), and qualitative data (i.e. interviews and mini-focus group with staff from care homes, London Ambulance Service (LAS), and hospital staff.

Evaluation questions

The evaluation aimed to understand:

- Is the Hospital Transfer Pathway being used?
- Is the Hospital Transfer Pathway being used as intended?
- Has the Hospital Transfer Pathway improved care?
- Has length of stay reduced?

The evaluation framework is outlined in the appendices (Table 3).

Locations for evaluation

Three case study locations were selected for the evaluation: Lambeth, Kingston and Richmond. These were selected because they had implemented the Hospital Transfer Pathway more than 6 months prior to the evaluation, which was considered sufficient time post-implementation to explore experiences and potential impacts of the new pathway. In addition, residents from care homes in these areas were likely to go to a limited number of hospitals (i.e. Kingston, Guy's and St Thomas', West Middlesex and Kings College hospitals), which made the scale of the evaluation more feasible.

Data collection and analysis

The evaluation used a range of data collection methods:

- Online surveys with care home managers, LAS paramedics, and hospital staff
- Interviews with a range of stakeholders involved in all parts of the pathway
- Mini focus groups with care home managers
- Hospital length of stay (LOS) for residents admitted for emergency care

Surveys

Care home staff - A survey was sent to all care home managers (n=55) in Richmond (n=18), Kingston (n=24) and Lambeth (n=13) between January and June 2018. There was a 58% response rate (i.e. 32 responses out of 55).

Hospital staff – During March to June 2018 a survey was cascaded to staff via a named Hospital Transfer Pathway clinical lead at Kingston, Guy's and St Thomas', West Middlesex and Kings College Hospital. There was a total of 33 responses.

London Ambulance Service (LAS) paramedics – During May 2018 a survey was sent to LAS leads for the Hospital Transfer Pathway across south London and cascaded to LAS paramedics via an internal newsletter. A total of 27 responses were received (N.B. not all responses were from paramedics in south London).

Interviews

A series of one-to-one in-depth interviews took place during September and October 2018 with stakeholders involved in and/or leading the implementation and subsequent delivery

of the Hospital Transfer Pathway locally. Interviewees were selected to obtain a range of perspectives from across the different parts of the Hospital Transfer Pathway and localities. A discussion guide was used in the interviews (see Appendix).

A total of 11 interviews were undertaken:

- 1 Local authority commissioner
- 1 CCG commissioner
- 1 Joint commissioner for CCG and Local Authority
- 2 Paramedics
- 1 Discharge coordinator
- 2 Hospital consultants
- 2 Community Healthcare Team Leaders, incl 1 Advanced Nurse Practitioner
- 1 Frailty nurse, secondary care

Focus Group

A mini focus group of care home managers was undertaken in September 2018 with three care home managers from Kingston and Lambeth. A discussion guide was used to facilitate the discussion (see Appendix). The ambition had been to recruit more care home managers to the focus group (six were invited); however, many care home managers were unable to attend due to limited time availability.

Resident perspective

The evaluation aimed to obtain the perspectives of care home residents about the Hospital Transfer Pathway. However, there were challenges in identifying care home residents who had been admitted via the Hospital Transfer Pathway who were able to participate in an interview. Healthwatch Lambeth interviewed two care home residents to gain this perspective between July and September 201. Feedback from these interviews is included.

Length of Stay

Length of stay (LOS) was calculated based on an emergency admission for an older adult (>75 years old) from one of the care home postcodes. This calculation may include some admissions for older adults who share a postcode with a care home; therefore, this is a pragmatic measure.

Data analysis

All data analysis was undertaken by the Health Innovation Network:

- *Qualitative data* – all interviews and the focus group were recorded, transcribed verbatim and analysed using thematic analysis.

- *Surveys* – all surveys were analysed using descriptive statistics. Survey response rates and the detailed analysis of each survey question are provided in the appendices.

- *Length of stay* – aggregate non-identifiable patient data for hospital LOS were provided by each CCG and analysed.

Findings

Structure of the findings

The findings are structured to follow the resident's journey:

- Preparing the red bag for transfer from care homes
- Conveying the hospital from London Ambulance Service
- Using the red bag in hospital settings
- Discharging the resident back to their care home

In addition, the overall impact of the pathway (e.g. on length of stay) and lessons from implementing the pathway will be explored. All data sources (i.e. surveys, qualitative data, and length of stay) are integrated together under each section of the findings.

Preparing the red bag for transfer from care homes

Care home managers reported that in the majority of cases the red bag was used as intended. 24 out of 31 managers (77%) stated that the red bag and associated documentation are prepared by care home staff when residents are conveyed to hospital in an emergency transfer of residents. However, care home manager acknowledged that in some cases they were unable to prepare all documentation. For example, when emergencies occur at night care home managers reported that reduced staffing levels made it more challenging to complete all documentation correctly:

> *"It makes a big difference (if the emergency is at night) as we have less staff on and the administrative staff are not there. They do manage but certain things are not available, it's the manpower. I think other care homes reduce much more at night time."* Care Home Manager, Lambeth

In addition, in cases when new residents had recently been admitted to the home some care homes were not able to prepare the baseline documentation quickly enough if the resident was conveyed to hospital in an emergency within 24-48 hours. One care home manager highlighted that when new resident admissions took place, staff were under time pressure to complete the baseline Older Persons Assessment Form (OPAF) in case the resident needed urgent care the same night or next day. Therefore, newly admitted residents may not have the red bag paperwork completed if they were conveyed to A&E in the first 48 hours:

> *"Well, you to have everything all ready. If it wasn't because of the red bag you would take your time. But come the new admission that's the first thing you do because you never know, if in the first 24 hours if they will be admitted, so it's a pressure doing all the documentation and getting the paperwork ready."* Care Home Manager, Kingston

A care home manager also described that when paramedics arrived very quickly and a resident needed to be conveyed urgently due to clinical deterioration there was often not enough time to complete all the documentation:

> *"But when it comes to do the forms at that minute it's really like under pressure because you have to do it and if they're querying TIA [a mini stroke] the paramedics won't take it [the red bag paperwork] – so when they go in a blue light – in an emergency they just get them out, they won't wait and there is not sufficient time to do the paperwork."* Care Home Manager, Kingston

Care home managers noted that paramedics' awareness of the Hospital Transfer Pathway had increased following its initial implementation and LAS crews now ask for the red bag when attending a resident – the majority of care home managers (23 out of 27) stated that paramedics were aware of the red bag all or some of the time. Whereas, 17 out of 27 (63%) of paramedics reported that they were given a red bag all or most of the time when attending a call to a care home and a third stated that core documentation was missing. However, the majority of paramedics reported that the Hospital Transfer pathway allowed patients to carry their belongings safely (85%) and made the handover process smoother (74%) and more structured (74%). The paramedic survey findings need to be interpreted cautiously due to the relatively small response rate.

Using the red bag in the hospital settings

While this evaluation received 32 survey responses from hospital clinicians and staff on the use and perceptions about the Hospital Transfer Pathway, only 16 out of 32 respondents reported that they had seen enough patients with a red bag to give an informed opinion on the pathway. However, those staff who had seen patients with a red bag in hospital perceived that it had improved communication and supported decision-making. One interviewee working for a community provider expressed how positively the pathway was working in hospital settings, at least in some departments:

> *"In A&E they [clinicians] are saying how useful it is to have all the medical history there at hand and knowing about the patient is a definite step forward Impact in A&E and AMU is where the impact is more noticeable but, in other wards/palliative care, it is not really fully impacting positively." Team Leader /* Advanced Nurse Practitioner, Community Provider

However, some hospital staff highlighted several instances where red bag documentation was missing or incomplete for care home residents – this may point to the issues associated with completing documentation in a timely way that was raised by care home managers (above).

Care home managers and hospital clinicians acknowledged that red bags get lost in hospital and that there is difficulty in finding and returning them. Care homes found that wards would not know where the bag was, or if the bag had been lost in A&E. This was particularly a problem if a resident died in hospital. Even where local Hospital Transfer Pathways had protocols for lost bags they did not seem to be working effectively:

> *"When a bag is not returned, trying to track it down is a nightmare and you are moved all around the hospital. No-one will take responsibility to find out what has happened to it.* Care Home Manager, Richmond

The relatively large number of hospital respondents reporting they had not seen enough red bags to comment raises questions about the level of awareness and/or integration of the pathway into locally practice and processes. This suggests that during residents' journey within the hospital:

- The red bag may become lost or removed (e.g. to a bedside locker or stored away from the bedside for safety).
- Core documentation is not being used and is possibly being removed from the red bag (e.g. into medical records), or simply misplaced.

Concerns about the relatively low awareness and a failure to use the red bag by hospital staff was shared by care home managers, commissioners and Local Authority staff. Care

home managers reported that they were still being called by clinicians for information they knew was included in the red bag. Concern about hospital staff not using the red bag and core documentation properly, or not following the patient through within the hospital (i.e. from A&E to the ward and between wards) was expressed by two participants who were responsible for implementing the pathway:

> *"I don't think it's working well from a hospital perspective because they could be making far better use of the information … when it goes into A&E it's not being used by the people that are meeting them or the therapists … when they get to the wards, the therapists that go around don't bother to look in the bags because it's in the cupboards." Commissioning Officer,* Local authority representative

> *"The only problem is, it [red bag / paperwork] never made it past A&E for admissions so, I think the value of it being on the wards and then the ward providing information back to the care home was lost really in translation"* Joint Commissioning Officer, CCG / Local Authority representative

At the same time, hospital clinicians when interviewed, did express the belief that the red bag performed a useful function in alerting staff to the fact that the patient was from a care home, as expressed by this respondent:

> *"The bags are there and they do a useful thing because they highlight the person is from a care home and that's important in itself in a patient setting because we know that if we identify those patient as being at risk of more adverse events that should help with their care." Frailty Nurse, Hospital*

The red bag was not always following the patient from A&E onto the wards, or between wards.

A number of challenges to embedding the Hospital Transfer Pathway within hospital settings were identified:

- The low volume of care home residents being admitted to hospital, compared with other patients
- The high turnover of hospital staff
- The phased implementation of the pathway across local areas meant there was not a consistent, common approach for all care home residents (from different areas)

> *"We have a huge number of staff with a massive turnover and … a lot of priorities…so the amount of headspace that people can give to new initiatives tends to be fairly small"* Frailty Nurse, Hospital

> *I think that the problem [is] the lack of number of patients coming in [with a red bag]. You find people haven't had the density of cases … to become usual practice".* Consultant Geriatrician, Hospital

> *"I used to shout, "Oh they're from a care home, have they got a red bag?", and then we'd get 'Oh no, they're from [area], they won't have one"* Frailty Nurse, Hospital

Resident back to the care home

Two-thirds of care home managers reported that the red bag and personal belongings were returned with the resident. However, a smaller number (42%) stated that the correct discharge information was being provided with the red bag at the time of discharge. In the focus group, care home managers perceived that the pathway had not improved the discharge process and this was particularly disappointing in light of the work they had put in to prepare the red bag and associated documentation:

> *"The only thing for us is, when they are discharged, there is no discharge letter, no documentation, the form from the hospital is always empty, no one has filled it in. The challenge is the same but nothing has changed."* Care Home Manager, Lambeth

> *"The ward is not planning the discharge with the care home in time. It is still the old practice where they are like right, the patient is ready to go so let's call the care home… the most challenging has been the discharge pathway."* Transformation Lead, Community Services Provider

13 out of 31 care homes managers said that residents were being discharged back home in their own clothes; however, it is not clear if this is an improvement. One said:

> *"They come back in hospital gowns still, rather than their own clothes. Patients aren't getting changed into their own clothes, they come back in hospital gowns. We have so many could sell them!"* Care Home Manager, Kingston

Two-thirds of managers said the red bag was returning with the resident, however a smaller number said the correct discharge information was being provided.

Overall impact of the Hospital Transfer Pathway

Staff perception on impact

A widely reported positive impact of the pathway has been the improvement in communication between care home, LAS and hospital staff. Two-thirds of hospital staff and 60% of care home staff believed communication had improved between each other. Similarly, 71% of care home managers and 74% of paramedics reported improvements in communicating with each other.

> *"We still get phone calls from the hospital, but it's happening less now with the red bag. It's an excellent system – it tells the hospital we have a system and they know we're sending paperwork in. I've never had a problem"* Care Home Manager, Richmond

However, with only a fifth to a third of care home managers reporting core documentation being returned in the red bag with residents, care home managers highlighted that there was scope for further improvement.

There were mixed opinions amongst care home managers about the perceived overall impact of the pathway for residents and care home staff. In Lambeth there was a clear

perception that the pathway had delivered positive impacts for residents and staff (Figure 1). However, in Kingston and Richmond over half of managers responded that the pathway had made no difference to residents, and over half responded that the pathway had either made no difference to care home staff or had a negative impact on care home staff in terms of workload. These results need to be interpreted in light of the relatively small sample size.

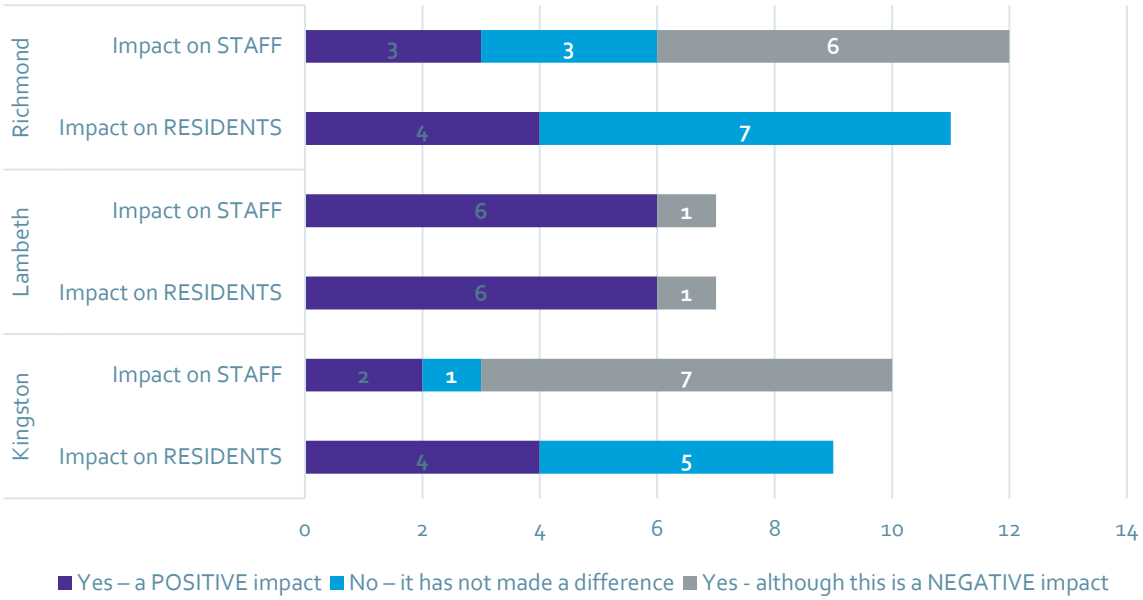


Figure 1 Care Home Managers: Impact of the red bag on residents and staff (n=31)

Nearly two-thirds (62%) of paramedics considered the pathway had a positive impact on the handover process, compared to just over a quarter (27%) who stated that it had made no difference.

The majority of hospital clinicians who had seen patients with a red bag and the documentation agreed that the pathway had made clinical decision making easier and supported improved decision making (figure 2). However, the sample size is small and half of clinicians stated they had not seen enough patients with a red bag to provide an answer.

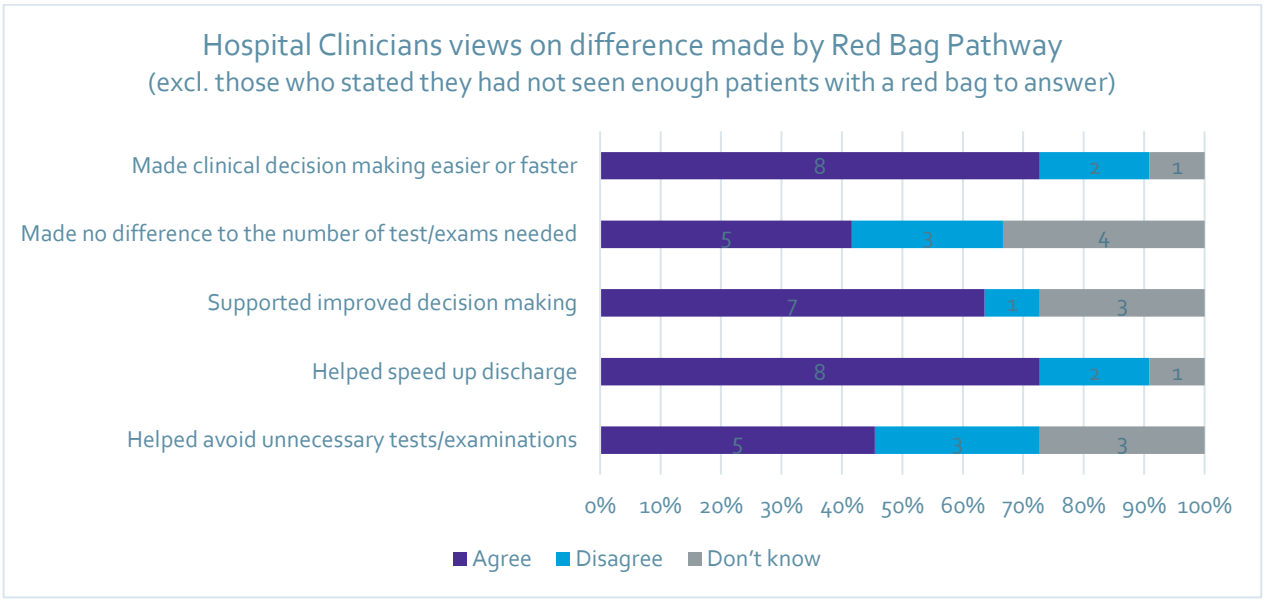


Figure 2 Hospital Clinicians views on difference made by Red Bag Pathway [N-11]

Residents' and relatives' perspectives

As stated above, the evaluation attempted to obtain the views of care home residents and relatives about the Hospital Transfer Pathway by working with Healthwatch Lambeth. Unfortunately, Healthwatch Lambeth was only able to interview two care home residents and neither resident could comment directly on the red bag. However, both felt that knowing about the red bag in advance of a hospital admission could be helpful.

To build residents' familiarity with the red bag, care home staff could, for example, present information on the red bag in the welcome/induction process for new residents and at resident and family meetings.

Average length of stay in hospital

The average length of stay (LOS) due to emergency admission from care home residents[8] for Richmond, Kingston and Lambeth are outlined in Table 2. This compares the length of stay in the three areas in the six months since the Hospital Transfer Pathway has been operating in each area (allowing for a three-month implementation period) to the same six-month period in the preceding year. This helps to control for seasonal variation in hospital admissions. In Kingston and Richmond there was a reduction in the length of stay by an average of 5.2 and 0.3 days, respectively. In Lambeth there was a slight increase in the length of stay by an average of 1.7 days.

It is important to note that the average length of stay in Lambeth was less than half that of Kingston and Richmond in the baseline period and length of stay data for Lambeth is based only on residents admitted from nursing homes in the borough and excludes admissions from residential care homes who do not provide nursing care. This may account for the some of the variation in average length of stay between Lambeth and other two areas.

Whilst average length of stay pre- and post- implementation of the Hospital Transfer Pathway is presented here, the data is not necessarily indicative of an impact from the pathway. Many factors influence length of stay and numerous initiatives are underway in hospitals to expedite discharge and reduce length of stay. In addition, it cannot be assumed that all admissions included the red bag.

Table 2 Length of stay (LOS) for Care Home Residents in the 6-month intervention period and 6 months during same period in the preceding year

Borough	Red Bag Launched	6 months Intervention period (3m after launch)	6 months baseline period (preceding year)	No. emergency admission during baseline / intervention period	Average LOS (min and max LOS) - Baseline Intervention (days)	Average LOS (min and max LOS) - Intervention Period (days)	Change in average LOS (days)
Richmond	June 2017	Sept 2017 - Feb 2018	Sept 2016 - Feb 2017	212 / 238	15.6 (9-23)	15.3 (13-18)	**-0.3**
Lambeth	Oct 2017	Jan 2018 - June 2018	Jan 2017 - June 2017	246 / 224	7.1 (5-9)	8.7 (6-13)	**1.7**
Kingston	Dec 2017	March 2018 - Aug 2018	March 2017 - Aug 2017	131 / 171	16.0 (14-25)	10.8 (7-14)	**-5.2**

[8] This is based on patients >75 years old admitted from a postcode that matches any care home in Kingston, Richmond or Lambeth (see Evaluation Approach for more details)

Learning from the implementation of the pathway

Those leading on or involved in implementing the Hospital Transfer Pathway recognised that although the pathway had led to improvements, challenges still existed at both ends of the pathway, from care homes to hospitals. There was an acknowledgement that for care homes introducing new transfer systems, particularly during the winter period has been challenging. Whilst for hospitals getting buy-in from senior leaders and keeping the initial awareness and momentum on the pathway beyond the initial implementation phase has proven difficult, especially if expected improvements are not immediate:

> *"We found with communication with the two trusts was that you need a higher level of buy in to ensure the communication is consistent and ongoing across all the departments that are involved and that didn't happen"* Joint Commissioner, CCG / Local Authority representative

> *"It is the amount of work you are asking [care homes] to do. You are asking them to put in a huge amount of time and effort into something that they do not know will be successful." Transformation Lead, Community Services Provider*

> *"When we started off [in the hospital] I was quite involved doing lots of enthusiastic work around it, only to find the bag didn't come in, or the paperwork wasn't there and then it's really hard trying to enthuse staff about something being really good if it's not."* Frailty Nurse, Hospital

The level of support to care homes from community services and established local networks with engagement from CCGs and local authorities (e.g. via the care home forums) was perceived as important factors in implementing the pathway. Also, the level of support to implement and sustain the pathway was perceived by one respondent to have varied across local areas – with some care homes needing a higher level of support:

> *"Where they had a dedicated community team…that have rolled it out from the beginning, that has worked well. Some areas just gave the bag to people, even though they had a couple of people from the CCG and committee, they weren't rolling it out from the beginning. I think the areas that worked well was if they already had an established care home forum and network."* Clinical Team Leader, *LAS*

There was a concern that where clinicians and care home managers did not see immediate improvements with the transfer process, this can lead to disillusionment with the initiative. A community provider summed up the challenge of maintaining momentum and ensuring the long-term sustainability of the Hospital Transfer Pathway, especially when the impact was not immediately apparent:

> *"The amount of energy, work and time involved is quite difficult to sustain because actually, something like this, takes a long time to imbed. I am not talking about a 6 month programme here, but a 1-2 years to work well. The danger of something like this, if you don't imbed it properly, you lose everything; it just stops being used at all."* Transformation Lead, Community Provider

Discussion

This evaluation found a clear perception that when the Hospital Transfer Pathway is adhered to as intended by care home, ambulance and hospital staff, that residents as well as health and social care professionals benefit. There is evidence from this evaluation that the Hospital Transfer Pathway is consistently used as intended by care home staff. Overall, the "red bag" does accompany residents/patients throughout their hospital stay and the Hospital Transfer Pathway has improved communication between staff across institutional boundaries and professions (i.e. between care home, ambulance and hospital staff).

However, challenges remain around embedding the Hospital Transfer Pathway into practices, systems and processes across all parts of the pathway. The evaluation shows that ongoing work is required to ensure that the correct documentation is accompanying residents into and out of hospital and the discharge information coming out is available and that this documentation is of a high quality. Specific areas for improvement are ensuring that correct and up-to-date documentation are provided on admission and discharge Concern was expressed by both care home managers and clinicians and implementation leads that if improvement to both the admission and discharge element of the pathway did not occur, there could be a loss of faith in the pathway and threaten its sustainability.

Ongoing work is required to ensure the "red bag" documentation going into hospital and the discharge information coming out is both complete and of high quality

Examples of ongoing improvements at a local level

There are examples of ongoing practice across south London to further embed and improve the Hospital Transfer Pathway following its initial implementation:

Kingston and Richmond

In both Kingston and Richmond, community care home support teams monitor all admissions and discharges to hospital using the red bag and supported care homes with on-going training, engagement with the hospital and care homes, facilitating discharges and on-going monitoring.

Kingston

Kingston Hospital, led by the Head of Nursing and with support from Capital Nurse have initiated regular engagement events with care home nursing staff – inviting care home staff to meet with hospital nurses to develop trust and build communication links.

Greenwich, Lewisham and Bromley

In Greenwich, Lewisham and Bromley, the CCGs, Lewisham and Greenwich NHS Trust and Princess Royal Hospital have held a Red Bag Awareness Week at the Hospital with stalls, balloons, badges, prizes and mini-red bags to raise red bag awareness.

Merton and Sutton

In Merton and Sutton, local authorities have introduced quality checks on the correct use of

the red bag as part of their quality assessments in care homes, this had led to positive results.

Limitations of this evaluation

The evaluation has a number of limitations. The response rate on the hospital and LAS staff surveys were relatively small. Whilst the sample size for the care home managers was small it represented 56% of the sample population (i.e. 31 out of a total 55 care home managers).

It is important to remember that whilst this evaluation looks at average length of stay pre and post the red bag pathway being implemented, it is not possible to fully understand the extent that the pathway played in changes to length of stay compared to other initiatives or changes that may have been underway at the time. Length of Stay data is therefore not necessarily indicative of impact from the pathway.

Conclusion and Recommendations

Conclusion

The evaluation showed there was real enthusiasm and passion for the aims of the "Red Bag" Hospital Transfer Pathway from care home, ambulance and hospital staff. People involved in the Hospital Transfer Pathway believe it provides a valuable opportunity to improve the care of resident. When professionals across the system (i.e. care homes, LAS and NHS acute trusts) use the pathway well, communication is improved and the transition of care into and out of hospital is smoother, which is perceived to lead to improved quality of care. However, elements of the pathway have not been fully embedded within all individual professional practice and care settings. When the pathway was not adhered to – either in the care home or hospital setting – this caused practical difficulties and could result in despondency and frustration amongst professionals. This needs to be resolved to optimise the pathway and fully realised benefits.

Key recommendations

Care Homes

- The value of Red Bag" Hospital Transfer Pathway and associated documentation needs to be promoted within care homes to staff, residents and relatives to embed it further into care home settings. Promoting the pathway with residents and relatives may foster a sense of ownership over the bag and to support practitioners' use of it.
- Completing core documentation within "Red Bag" Hospital Transfer Pathway to a high standard needs to be the responsibility of all care home staff. Specifically, all care home staff need to be able to complete the CARES escalation record, particularly nightshift and agency staff. The Older Person Assessment Form / Health Care Record Summary needs to be updated more consistently following a hospital stay and as part of the monthly care planning reviews.

Hospitals

- Further and more regular promotion and education about the "Red Bag" Hospital Transfer Pathway is required across all departments within hospitals, focusing particularly on A&E, acute medical units, older people/geriatric wards, and other acute medical wards.
- Hospitals need to ensure the Hospital Transfer Pathway and associated core documentation are fully integrated into local systems and processes so that:
    - Summary discharge information and medication are provided at the point of discharge.
    - Patients are discharged in their own clothes
    - Protocols are in place for reclaiming "red bags" for residents who have deceased in hospital or discharged to a different care home.

CCGs/Local Authorities

- Local leads should review the way the Hospital Transfer Pathway is monitored, specifically the quality and completeness of care home records of "red bag" use, non-adherence, and areas for improvement
- Following on from this, leads should facilitate better engagement and partnership working across the pathway (i.e. care home, LAS and hospital staff) to build trust and improve communication

Appendices

1.Evaluation Framework

Table 3 Evaluation framework

Evaluation Question	Outcome Measure
1. Is the Hospital Transfer Pathway being used?	Number of occasions where a red bag was sent / not sent with patient*
2. Is the Hospital Transfer Pathway being used as intended?	Number of occasions where paperwork is fully completed / not completed Number of occasions where essential items sent with bag are returned / not returned Number of occasions that a red bag is lost
3. Has the Hospital Transfer Pathway improved care?	Self-reported rating of communication between hospital, LAS and care home staff Self-reported rating of quality of information Self-reported rating of whether clinical decision making has been made easier/more enhanced, because of the red bag pathway Self-reported rating from residents' perspective of whether red bag pathway has improved transfers of care
4. Has the length of stay reduced?	Length of Stay in Hospital for Care Home Residents versus baseline

*It was not possible to collect data on the number of occasions the red bag was used as CCGs were not able to collect these data from care homes consistently. Only the survey data were used to measure red bag use

2.Interview Discussion guides

	Theme	Questions
A	**How well has the red bag been used?**	What's your view as to how the red bag scheme has been working?
		How well would you say the red bag has been working at the Care Home / Hospital end?
		Have you encountered any difficulties or challenges with getting care home/hospital staff on board?
		What's been your experience of the quality of the paperwork in the red bags?
B	**Impact of the red bag being in hospital**	Would you say communication between care homes, LAS and hospital staff improved, stayed same, or got worse – how?

		How would you say the red bag pathway and paperwork has impacted on admission, transfer between wards and Discharge
		What would you say the impact of the red bag has been on clinical decision making?
		Would you say residents' belongings have been returned, or lost less or more often?
C	**Has patient care improved?**	Would you say the red bag has made a difference to patients? How?
		Have you had any feedback from patients or clinicians on the red bag?
D	**Implementation**	How do you think the implementation of the red bag went in your area / hospital?
		What worked well, or could have been better, or different?
E	**Recommendations**	Are there any recommendations you would make to improve the red bag?
F	**Any Further comments**	Do you have any other comments you'd like to make?

3.Breakdown of survey response rates

Table 4 Care home response rates

Area	Total Homes	Total Responses
Kingston	24	11
Lambeth	13	7
Richmond	18	13
Total	**55**	**31**

Table 5 LAS response rates

Area	Responses
St Helier	6
Wimbledon	7
Other*	14
Total	**27**

*Other = ambulance areas were from stations across London

Table 6 Hospital staff response rates

Hospital / Department	Accident and Emergency	Acute Medical Unit / Assessment Unit	Geriatric Ward	Other*	Total
Guy's and St Thomas'		2			**2**
Kings College	7	2	2		**11**
Kingston		3	1	5	**9**
West Middlesex	2	2	3	3	**10**
Total	**9**	**9**	**6**	**8**	**32**

*'Other' departments were mostly unstated by respondents; however, where specified this included specialist respiratory, stroke units, and pharmacy

4.Detailed analysis of surveys

Table 1 - Care Homes: Since the red bag scheme started how often have you used the red bag and paperwork when sending residents to hospital in an emergency?

	Kingston	Lambeth	Richmond	Total
All of the time	10	4	10	**24**
Some of the time	1	3	1	**5**
Not at all / only a few times, because there is not enough time			1	**1**
Other			1	**1**

Table 2 - Care Homes: When the Ambulance Crew attend your Home, how often would you say they are aware of the Red Bag?

	Kingston	Lambeth	Richmond	Total
All of the time	2	3	3	**8**
Some of the time	9	3	8	**20**
Not at all / only a few times			2	**2**
Other		1		**1**

Table 3 - Ambulance: When attending a residential or nursing home for older people and conveying to A&E, how often would you say the red bag is given to you?

	Total
All of the times I've attended	4
Most of the time	13
Only a few times	10

Chart 1 – Ambulance Crews – Improvements Cited (Total= 27)

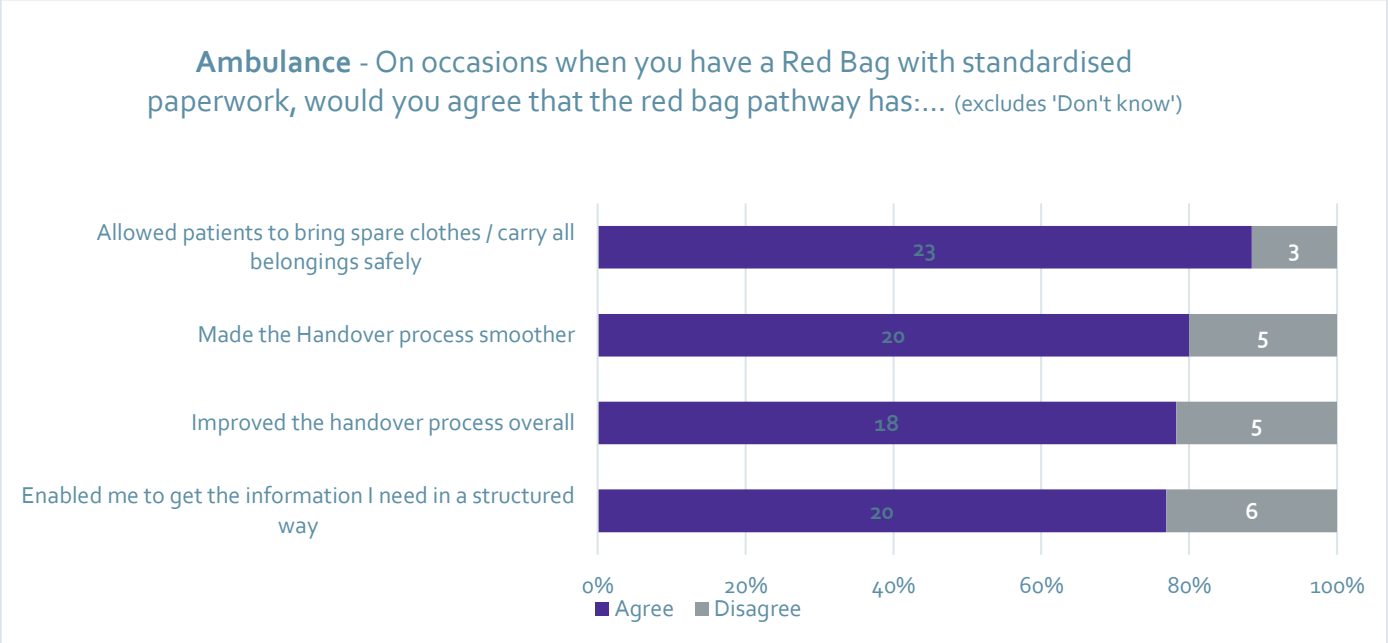


Chart 2 – Hospital Staff: Improvements Cited (Total= 32)

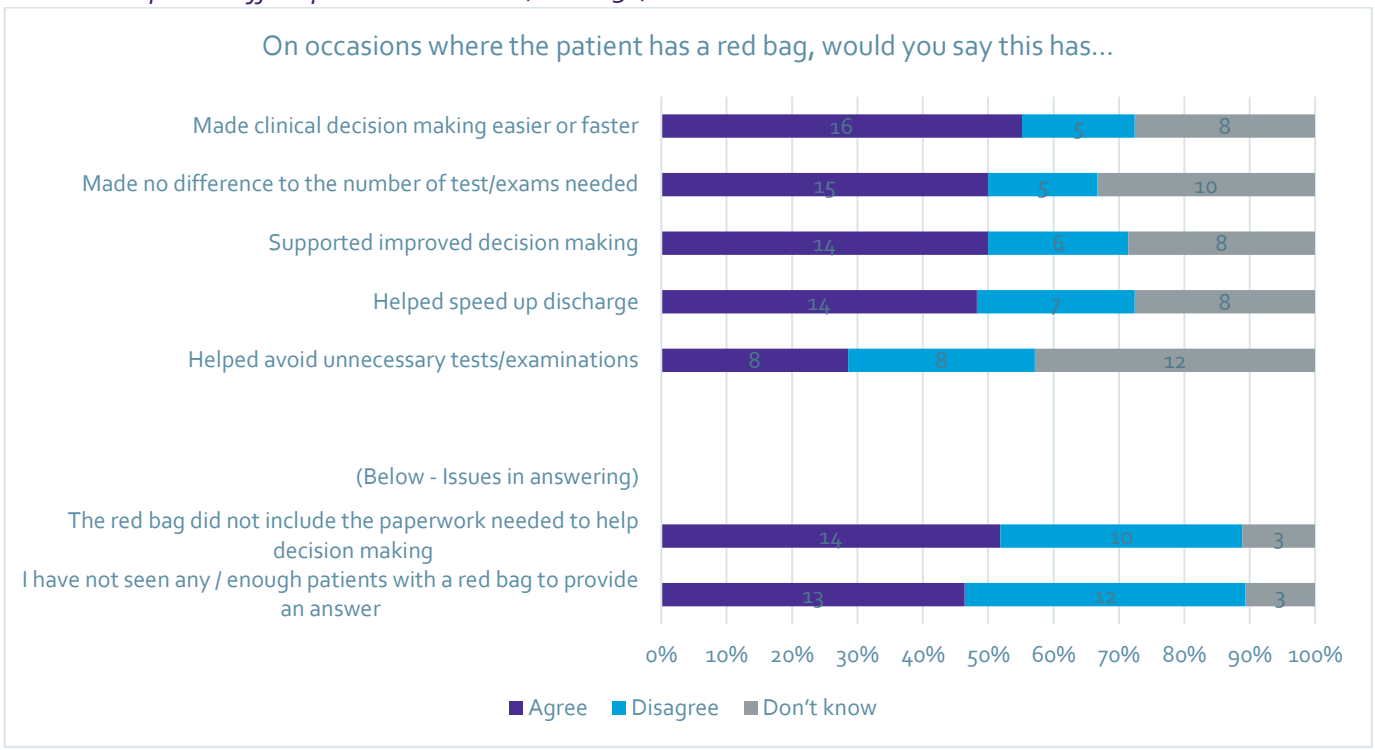


Chart 3 – Ambulance Crews and Hospital Staff: Paperwork found to be most useful (Total – 27)

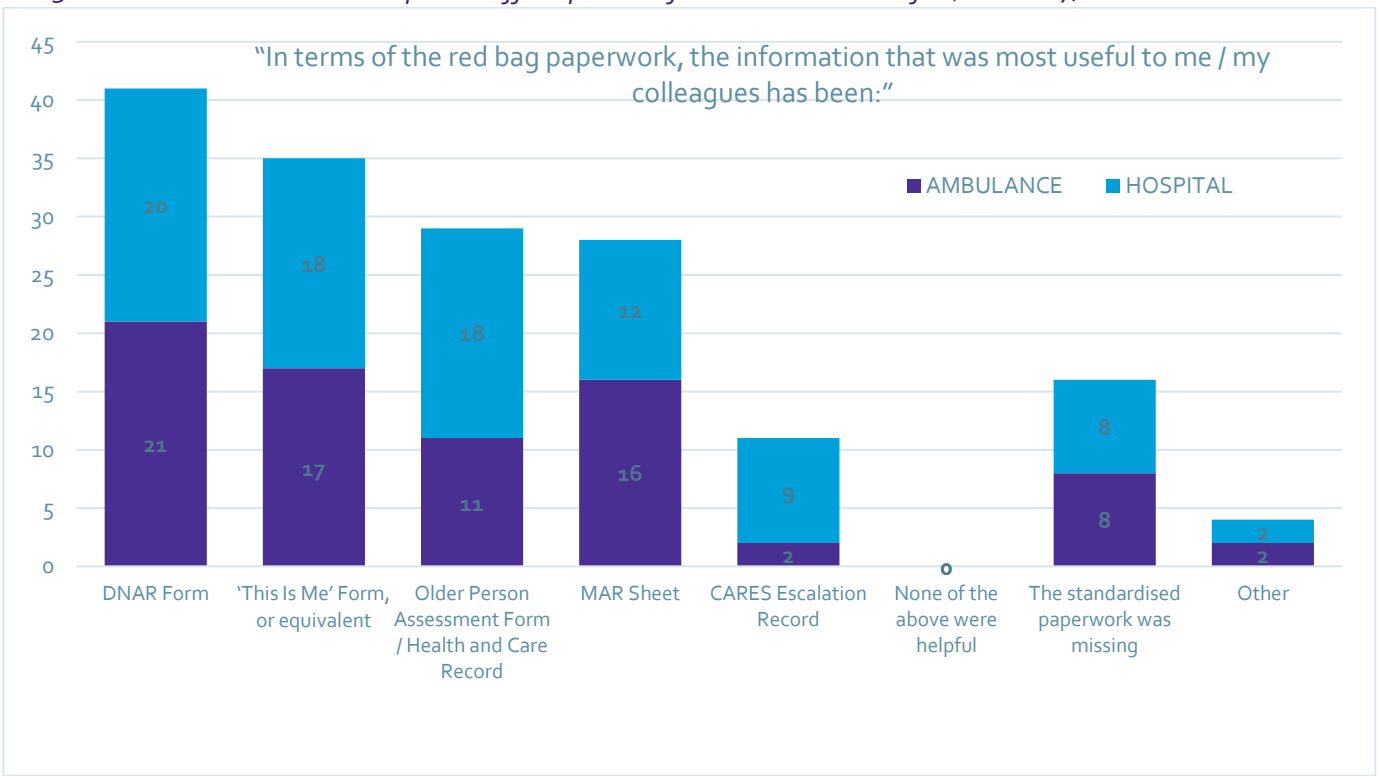


Chart 4 – Improvements Cited by Care Home Managers (Total = 31)

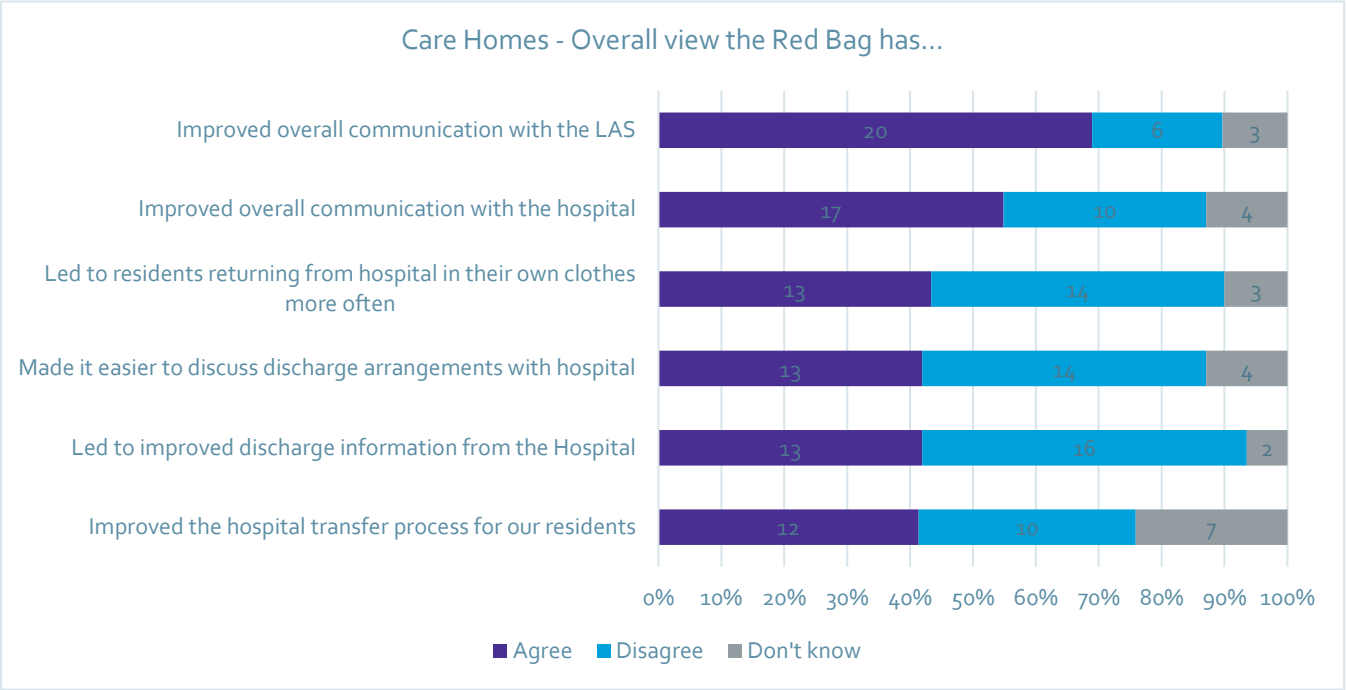


Chart 5 – Care Home Managers: On Discharge, how often is Red Bag and Residents belongings being returned? (Total= 31)

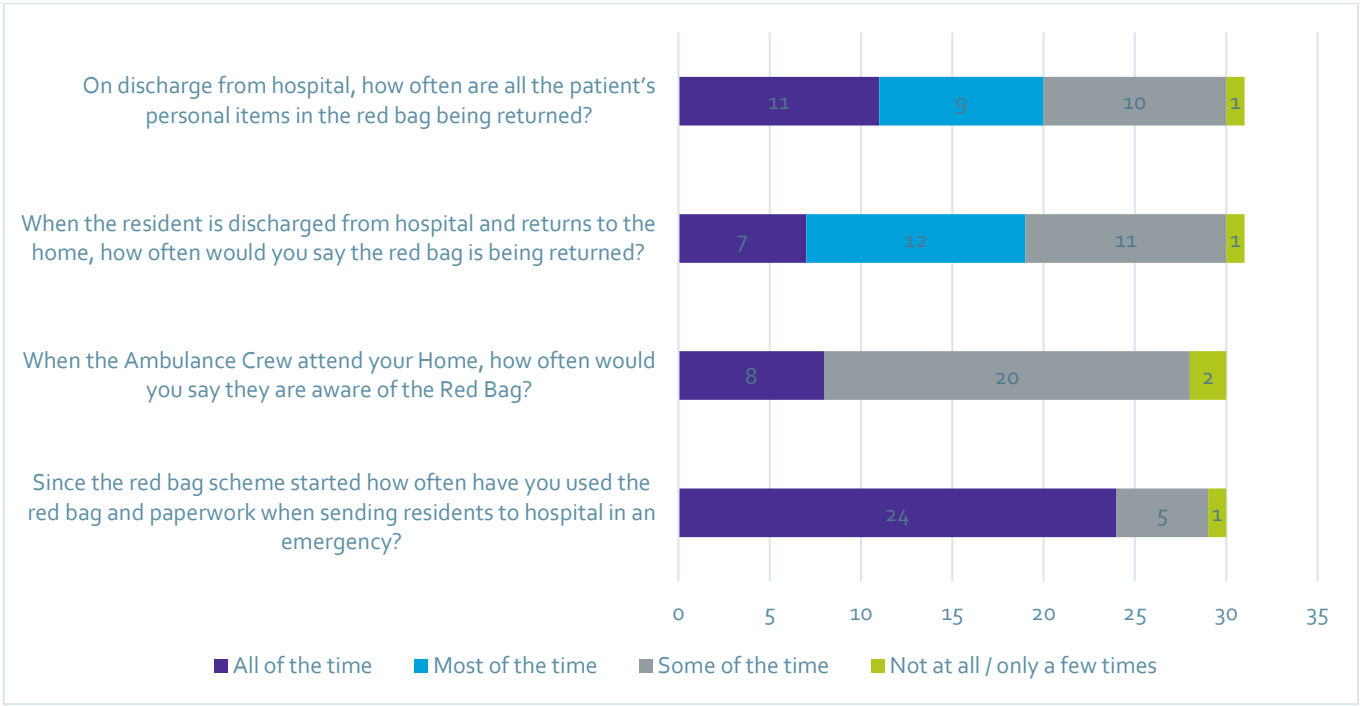


Chart 6 – Care Home Managers: On discharge, to what extent is paperwork being returned (Total= 31)

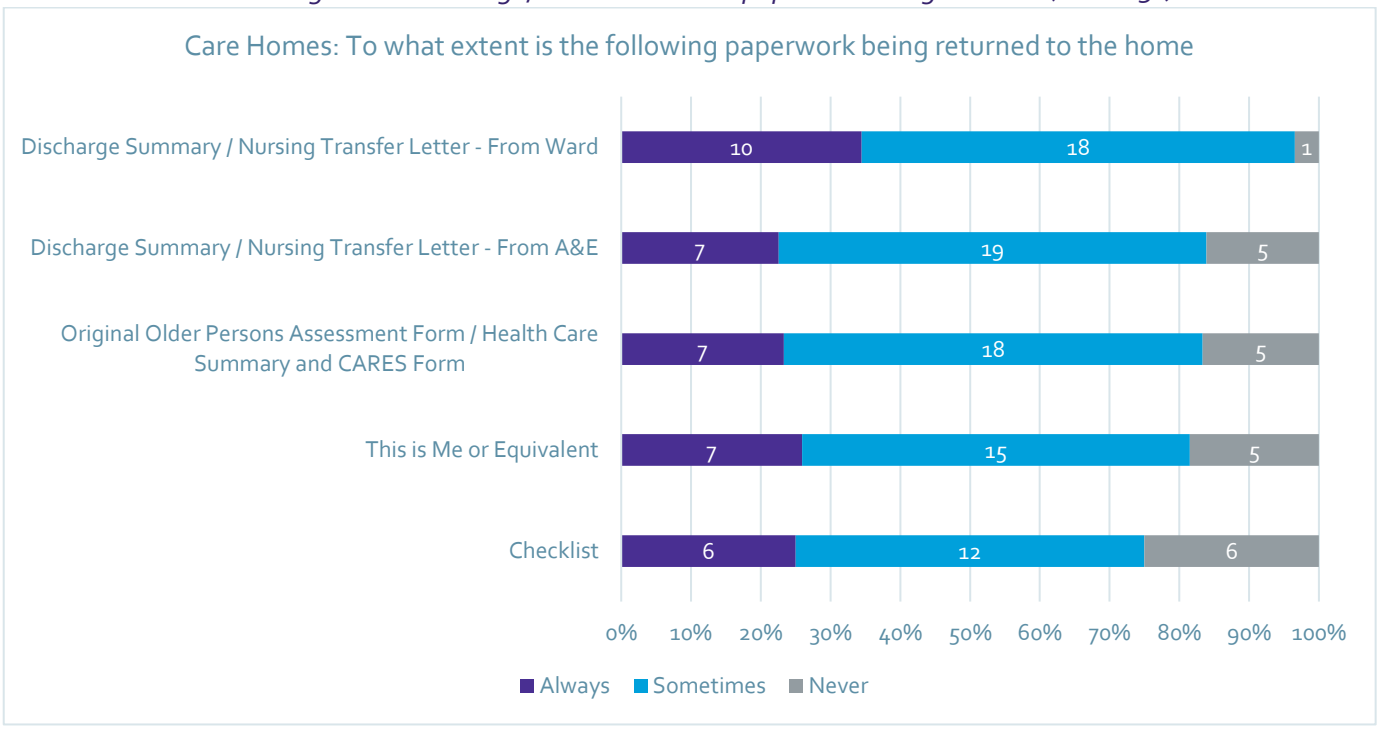


Chart 7 – Hospital Staff: Impact of the red bag in hospital (Total= 32)

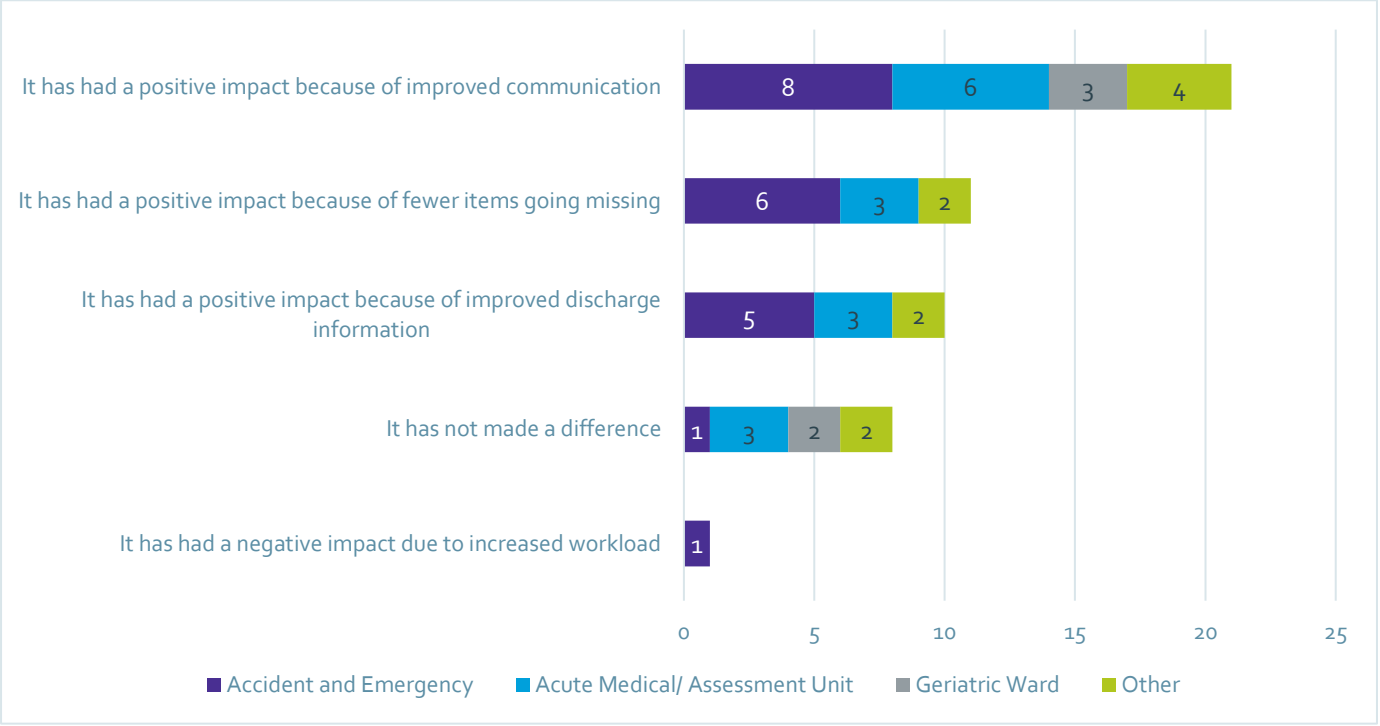
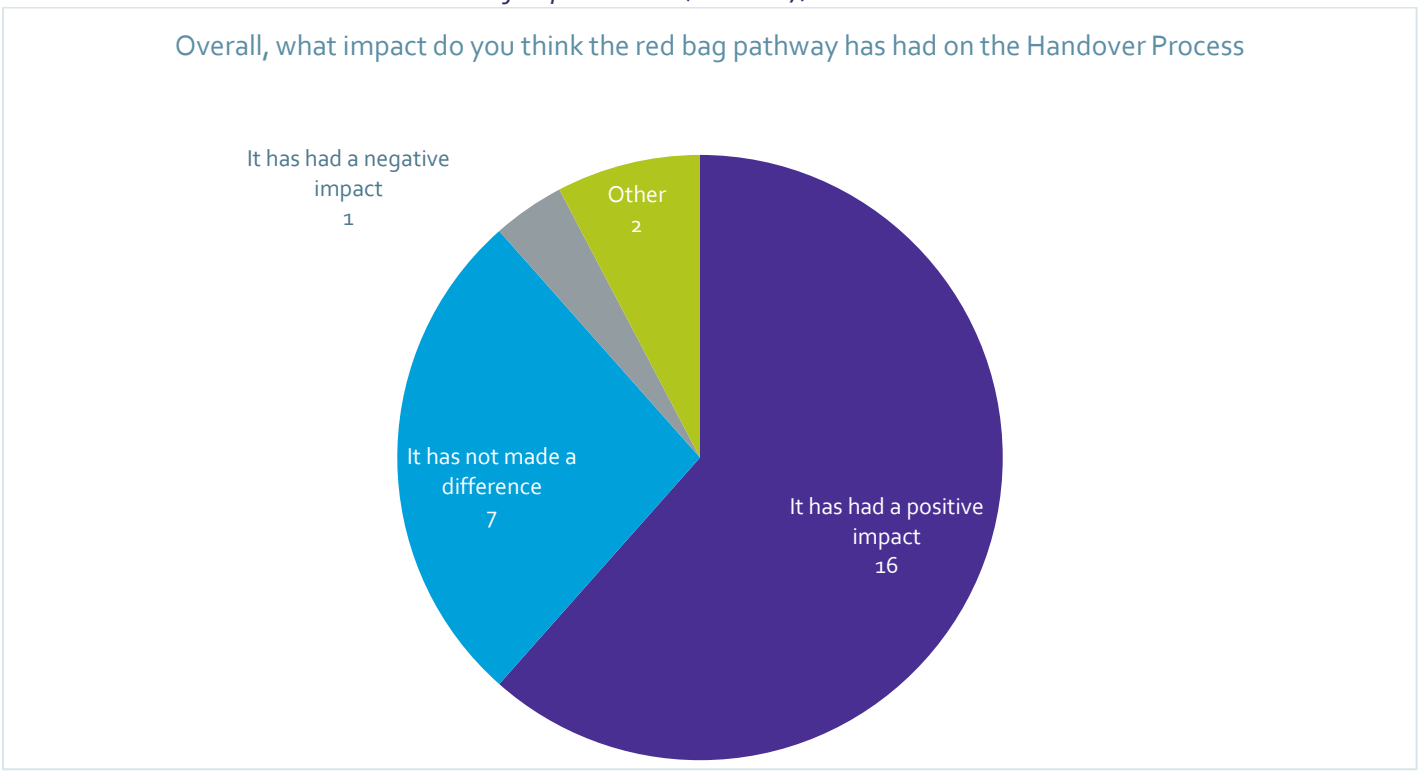


Chart 8 – Ambulance Crews: Overall view of Improvement (Total= 27)



5.Length of Stay data

Sample size – Older People or dementia care home beds

Borough	Older People or dementia care home beds
Richmond	845
Kingston	1035
Lambeth	854 - of which 682 are beds in registered nursing homes

Average Length of Stay in terms of percentage change and minimum and maximum ALOS per area

Borough	Change in ALOS (days)	% change	Min ALOS (intervention period)	Max ALOS (intervention period)	Min ALOS (baseline period)	Max ALOS (baseline period)
Richmond	-0.3	-1.9	13.0	18.0	9.0	23.0
Lambeth	1.7	23.9	6.0	13.0	5.0	9.0
Kingston	-5.2	-32.5	7.0	14.0	12.0	25.0