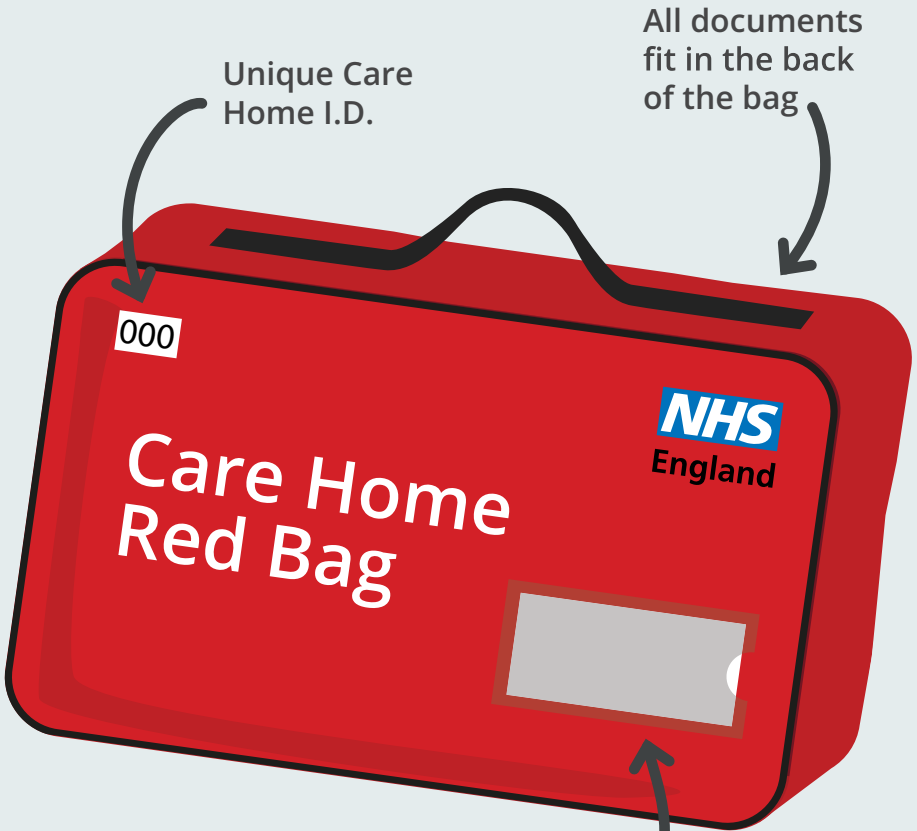
Department of Health & Social Care

NHS England and NHS Improvement

Quick Guide:
Hospital Transfer Pathway - 'Red Bag'

Transforming Urgent and Emergency Care Services in England



This is one of a series of quick, online guides providing practical tips and case studies to support health and care systems.

The Care Provider Alliance

Introduction

This quick guide aims to help local health and social care systems to develop effective and efficient arrangements for **Hospital Transfer Pathways (more commonly known as Sutton's Red Bag initiative). It is supported by a range of good practice example templates and process documents that can be accessed in Appendix A**.

This guide should also be read alongside the Enhanced Health in Care Homes (EHCH) framework which is based on the lessons learned by the 6 EHCH vanguards and highlights the components that have had the highest impact on residents' quality of care. The EHCH Framework is also one of the 8 system changes in the high impact change model which local health and care systems are using to reduce delayed discharges.

Who uses the 'Red Bag'?

- Care Home residents and staff
- Acute hospital staff
- Community hospital staff
- GPs
- Paramedics

Progress is being made to develop and improve arrangements for Hospital Transfer Pathways across the country and this guide aims to support health and social care systems to continue to enhance communication and information sharing when residents move between care homes and hospital. Where local initiatives aligned to the Red Bag are already in place or in development, there is no expectation that these should be stopped or postponed. Additionally, it should be noted that the Red Bag does not replace good communication between care staff, and is only one element of building positive and proactive working relationships between care home staff and those working in hospitals. The person should always be at the centre of decision making. Therefore, health and social care system leaders should use this guide to ensure their scheme is aligned to agreed national principles and consider learning identified from other early adopter areas.

What is the ‘Red Bag’?

- The ‘Hospital Transfer Pathway’ or ‘Red Bag’, pioneered by Sutton Homes of Care, **helps provide a prompt, safe and efficient transfer of clinical care**, when a resident moves between a care home and other clinical settings, such as; hospitals or ‘step up’ and ‘step down’ beds.
- To support reductions in hospital admissions, the Red Bag should be used where the appropriate clinical assessment has concluded that it’s not appropriate for the patient to stay in their care home. Therefore, when a resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated Red Bag that contains **standardised information** about the resident’s general health, any **existing medical conditions** they have, **medication** they are taking, as well as highlighting the **current health concern**. This means that ambulance and hospital staff can determine the treatment a resident needs more effectively.
- **The bag stays with the resident** from the time they leave the home to go to hospital, until they return to their care home. When residents are ready to go home, a copy of their **discharge summary** (which details the care they received in hospital) is placed in the Red Bag so that care home staff have access to this important information when their residents arrive back home. Alternatively, Kings College Hospital and Guy’s and St Thomas’ have also produced a **nursing transfer letter** as discharge summaries are often GP focused and therefore are not as useful for nursing handovers.
- The **bag is the most visible part of an agreed Hospital Transfer Pathway**, built on collaboration between community and hospital care, GPs, the local Ambulance Trust and care homes.
- The pathway includes an assessment of the functional level of the resident when they are well. This information allows the hospital team to understand the functional level they should be aiming for to support a safe discharge.
- The Red Bag also **clearly identifies** a patient as being a care home resident and this means that it may be possible for the patient to be discharged sooner. This is because the care home and hospitals will then engage in conversations around discharge from admission, as well as the fact that hospital staff will have a better understanding of the residents care needs.
- It is important to note here that the Red Bag scheme **is not intended to label people, take away choice or dignity**. It aims to support professional relationships between care home and hospital staff and promote a good experience for the person; to ensure **they get the right care, in the right place, at the right time**.

Local adaptation

The Red Bag can also be adapted to local needs. A number of areas in the north of England use red folders. These stay with the patients notes while they are in hospital. Their size is such that they will sit in notes trollies, identifying the patient as having come from a care home. At the point of discharge, transfer to another hospital, or transfer to another area of the hospital, the folder accompanies the resident back to their care home. This initiative was initially piloted in Leeds to improve the communication of clinical information; therefore, the bags only contain paperwork. As the smaller bags cost just £2 each, care homes can be provided with a larger number of bags. The project was well received and some care homes bought more bags on their own, as having 1 bag per room means they can be pre-populated with paperwork, making it very quick to prepare the bag when a resident needs to go to hospital. The red folders have since been rolled out to a number of areas across the north region.

What goes into the 'Red Bag'?

The Red Bag needs to fit a range of documentation, personal belongings and medication. Therefore, it is important to ensure, when procuring the bags, that they are an appropriate size.

Standardised documentation

- Transfer of care forms (including usual functional level and changes; signed consent for care home and hospital to discuss patient / resident)
- Emergency healthcare plan (including Best interest decision making)
- Medication administration record (MAR SHEET)/ MEDICATION
- Transfer bag checklist

If required

- Do not attempt cardiopulmonary resuscitation [DNACPR] (Signed and up-to-date)
- Advance decision to refuse treatment [ADRT]
- This is me / Forget me not document(s)
- Deprivation of Liberty Safeguards [DoLs]

Personal belongings

- Day of discharge clothes
- Slippers
- Medication
- Toiletries
- Dentures
- Hearing aid
- Glasses
- Ask the resident what they would like to bring (e.g. a reading book, word search etc.)

Locally reported benefits and evaluation of the Red Bag scheme

- Improvement in communication and relationships between hospital and care homes
- Fewer phone calls and follow ups made by the hospital staff to the Care Homes looking for health information about the resident and vice-versa
- Smoother admission and discharge processes
- Better person-centred care for the residents
- Having vital standardised information readily available in one eye-catching place saves time at each stage of the patient's care
- Sutton vanguard has produced an evaluation report that outlines benefits of the Hospital Transfer Pathway. In particular, length of stay is 4.4 days fewer for residents from nursing homes and 4.1 days fewer for those from residential homes. This can help reduce long and short stays in hospital and has benefits in lowering the risk of harm to patients from deconditioning associated with hospital stays.

Resources required for implementation

Local health and social care systems should plan and implement the Red Bag scheme in partnership with all stakeholders, most crucially with care homes, hospital wards, discharge nurses and managers, as well as the local ambulance service.

- Procurement of approximately one bag per 10 care home residents. The South London Health Innovation Network have produced a calculator for how many bags are required based on conveyancing rates.
- Support from community nursing services for care home staff to implement the pathway i.e. paperwork, training and refresher training, coordination of lost / replacement bag management.
- Support from leaders including care home managers to release staff to attend the meetings to develop and implement the pathway.

Who may fund these bags?

There is no one agreed way that the Red Bags should be funded. Examples of how some areas have identified funding sources include:

- Better Care Fund (BCF): The Better Care Fund provides joint funding in each locality to support greater integration of health and social care. There may be resource available within BCF schemes to contribute towards the cost of Red Bags.
- Voluntary sector sponsorship: Wakefield Clinical Commissioning Group (CCG) have received sponsorship from Age UK.
- Private sector business sponsorship: Companies have been approached in some areas and they have been supportive to sponsor.
- CCGs and Local Authorities: NHS local Clinical Commissioning Groups (CCGs) and Local Authorities may be able to identify funding either individually or collectively to support the funding of the bags.
- NHS Acute or Community Trusts: NHS Trusts may be able to identify budget that can be used to support the funding of the bags.
- Care Home pooled funding: Care Homes have collaborated in some health and social care systems and agreed to pay for the bags, as they understand the benefit of implementing the initiative and hence feel this justifies the cost.
- Sustainability Transformation Partnerships (STPs) funding: STPs could potentially play a coordinating role and provide overarching funding to implement the scheme wider than care homes (e.g. including homecare providers and housing associations) providing further potential sponsors for the bags.

Before you start...

- Ensure care home managers are part of early discussions (they are the leaders for the initiative and their complete buy-in is required). Discussions between care homes, the ambulance service, Emergency Department and Discharge teams should include what's working well and what is not in terms of hospital transfer and discharge. The pathway should be developed based on these discussions.
- All stakeholders need to be engaged at the start of discussions. This includes engagement with staff from across the system, such as; local hospital Emergency Department, ward staff, discharge teams, care homes, community nursing staff, ambulance services, social care and pharmacists.
- Ensure care homes are in agreement with the paperwork to be included in the Red Bag and are involved in its development - encourage all to use the standardised paperwork that is included in this guide.
- Resolve issues relating to infection control at early stages of conversations. NHS Trusts and care homes may raise this as an issue, but this is similar to any patient / resident taking in their own bag, where these would commonly be stored beside the patient's bed on tables, trays, or in lockers. The difference with Red Bags is that they will be used by multiple residents and move frequently in and out of hospital and care settings. Where Red Bags are shared between residents there is a risk of cross infection. It is important that advice is sought from the local infection control team and care taken to ensure that the bags are cleaned in line with agreed protocols. This may include putting personal belongings into a sealed plastic bag within the Red Bag. Example instructions for cleaning the bags are included in Appendix A.
- Consider the governance arrangements of the scheme with all partners. This should include; setting up a steering group (to co-produce the local pathway), deciding who will be the lead organisation (to take lead responsibility for implementation), deciding what will be measured and how care homes will be involved. Monitoring arrangements also need to be in place to track how well pathway is being adhered to.
- Stakeholders should also be aware of the need to comply with the General Data Protection Regulations (GDPR), that came into force in May 2018. This new data protection legislation intends to strengthen the protection of individuals' data and the role information sharing can play in improving services and creating better outcomes and experiences for people. It will not hinder transfer of information between a hospital and care home via a Red Bag or by phone, as there is a clear reason for the information sharing for direct care.

How to engage with partners?

Ensure all engagement is undertaken at the start, so partners can see that they are part of a larger system and taking an equal responsibility to its success.

- Ambulance services need to understand the benefits of this initiative on both the residents/ patients and on the actual ambulance service.
- Timescale to full implementation (including engagement) is approximately four months.
- Use meetings, workshops and events to present the initiative to colleagues from across health and social care.
- Training must be given to care home and ward staff. This training could be delivered in a variety of ways, for example; a nurse specialist could deliver a half-day training programme, a GP service aligned to the care home, or via a care home forum.
- It is important to engage and work with care home residents and family members on the development and rollout of your local Red Bag scheme. This could be done by working with local care homes, care home residents' groups and local Healthwatch organisations. Engaging with residents and their families will help to ensure successful rollout of the scheme, by ensuring that local circumstances are considered, as well as enabling concerns and suggestions of residents to be taken on board. It will also ensure that residents and families are aware of the scheme, understand the benefits and have a way to put forward ideas around improving the service. Sutton's patient and relative representatives were involved in initial discussions and during the process of development. They also developed a patient experience video of the Red Bag.
- Agree a channel for quick and easy communication and feedback once the scheme is live, this ensures that problems and issues can be dealt with, and learned from, immediately. Care home forums are well placed to fulfil this function.

Learning from the vanguards

- Ensure clinical engagement and shared responsibility for delivery is clear from the start of discussions.
- Utilise the clinical links to 'do the selling' – particularly with acute hospitals. Bring the partners round the table. Use resources you already have i.e. clinical leads from CCGs, Discharge teams, Trust nurses – colleagues who already have the relationships with the Trusts and are able to influence change via discussion and negotiation.
- Empower the 'bridge colleagues' between Primary and Secondary care.
- Relationships are a key to success of this collaborative initiative.

Common challenges and local solutions

Biggest challenges	Examples of practical documents and local solutions
Engaging with NHS Acute Trusts (and A&E departments in particular) to support implementation and on-going sustainability of the scheme	• Sutton CCG agreed a joint communications strategy with the hospital and ambulance service and engaged senior leaders across the system. For instance, a briefing from the CEO to all the workers within the trust. • Screen savers of the Red Bag, links and training videos were added to hospital computers.
Engaging with care homes	• Sutton CCG ensured that care home staff were fully involved in designing the Red Bag pathway. They also delivered awareness training to ensure care home staff understood the documentation and how to use the Red Bag.
Responsibility of the bags: 1. Overall Responsibility 2. Tracking Bags 3. Lost Bags	Allocation of an identifier number to all the care homes for easier tracking. • Yorkshire and Humber Discharge Teams (from Acute Care) are able to track all Red Bags and are comfortable taking overall responsibility to ensure their safe keeping. • Wakefield EHCH Vanguard, use their MDT to track all Red Bags and this also allows an audit process to be carried out looking at how frequently bags are being used. • Sutton CCG has a protocol for lost bags and uses the red flag on the hospital system to identify and track patients/residents with a Red Bag. There is also a protocol for when a resident dies and how the bag is returned to the care home. Links to these protocols and other good practice documentation is provided in Appendix A.
Monitoring - how will the pathway be monitored and reporting from care homes back to CCG	The South London Health Innovation Network have developed a monthly reporting tool for care homes to report to CCG on Red Bag activity.

Moving Medicines Safely - Green Bags

To support with the safe transfer of medication between care settings the Specialist Pharmacy Service has produced a toolkit on implementing a Green Bag scheme to support commissioners and service providers implementing the scheme. A 'Green Bag' is simply a clearly designated, easily identifiable bag which can be used for transporting medicines between and around care settings. The purpose is to keep all the medicines belonging to a patient together in a readily identifiable container. Where local areas already have a Green Bag scheme in place, these can be used alongside the Red Bag. If there is no Green Bag in place local agreement will need to be reached between Acute and Community Trusts, care homes and the ambulance service.

Tips for getting started

This section contains tips for success from local areas that have put a Hospital Transfer Pathway/ 'Red Bag' model in place.

1	Before implementing the Hospital Transfer Pathway, ensure all colleagues are fully engaged.
2	Speak to your stakeholders, including care homes, local hospital providers (both Acute and Community), community nursing services, the local authority and Ambulance Services.
3	Use the standard paperwork listed in this guide.
4	Try to keep consistency to using 'Red Bags' as this reduces confusion on wards and other settings where multiple colours may be in use.
5	Order enough bags per care homes (approximately one per 10 residents) and ensure that the bags are the right size to fit all the required documentation and belongings. Make sure a tracker number is in place for each bag prior to distributing them to care homes.
6	Don't overcomplicate this initiative.
7	Provide training before implementation and consider how new staff will be trained, especially where staff turnover is high.
8	Monitor and audit, once implemented, to ensure the bags are being used appropriately. Consider using Plan, Do, Study, Act (PDSA) cycles for improvements.
9	Keep the health and care system updated using newsletters, presentations, board updates etc.
10	Ensure that there is an appropriate member of staff available in the care home to receive the person when they return from hospital.
11	Roll out of 'Red Bags' have been most successful in areas that have strong CCG support as they can engage with all partners across the pathway.

Appendix A -
Material to support the Hospital Transfer Pathway

Some of the following resources marked with * are only available on the FutureNHS collaboration platform. To access these resources you will need to request access to the site by contacting england.carehomes@nhs.net

Information and briefing:

- Case study – Hospital Transfer Pathway (Sutton)
- *Red Bag initiative - briefing (Sutton)
- *Standard information (Sutton)
- *Example communications plan (Sutton)
- Poster - Betty's journey (Sutton)
- Transfers of care resources (Newcastle Gateshead)
- Red bag poster – what goes into the bag? (East and North Hertfordshire)
- Evaluation plan (South London HIN)

Training videos:

- System Engagement Video - Whole pathway in action
- Hospital Transfer Pathway - From a Residents Perspective
- Red Bag introductory Video - Betty Video

Transfer of care:

- Red Bag CARES Handover process (Sutton)
- Transfer of care form – into care home (Newcastle Gateshead)
- Transfer of care form – into hospital (Newcastle Gateshead)
- *Hospital Admission Form (Wakefield)

Personalised care:

- This is me leaflet (Sutton)
- *Forget me not scheme form (part 1/1) (Wakefield)
- *Forget me not scheme form (part 2/2) (Wakefield)
- Medication and DNAR form (East and North Hertfordshire)
- *Catheter Record Booklet (Wakefield)

Appendix A -
Material to support the Hospital Transfer Pathway
continued

Cleaning and infection control:

- Red Bag cleaning instructions (Sutton)
- Infection Prevention Protocol (Newcastle Gateshead)

Confidentiality:

- Red Bag confidential access to information note (East and North Hertfordshire)
- *Confidentiality - Work flow diagram draft (Wakefield)

Assessment:

- Older persons assessment form (Sutton)
- Care Home Resident's assessment form - example (East and North Hertfordshire)

Checklists:

- *Red Bag checklist (Sutton)
- *Transfer bag checklist (Newcastle Gateshead)
- Red Bag Checklist (East and North Hertfordshire)
- Red Bag journey (East and North Herts)
- *Red Bag Checklist (Wakefield)
- *Red Bag Checklist - Work flow diagram (Wakefield)
- *Protocol for Red Bag if a patient dies in hospital

Safety:

- CARES Red Bag Escalation record (Sutton)
- *CARES Escalation record example (East and North Hertfordshire)

Appendix B -
Supporting Red Bag scheme implementation

To support the spread of the Red Bag scheme a maturity assessment tool has been created, which is aligned to the approach used within the high impact change model to reduce delayed discharges from hospital. This tool will enable health and social care systems to assess current levels of implementation of Red Bag schemes for care home residents requiring a hospital admission.

Each Health and Wellbeing Board (HWB) in England has been asked to report on Red Bag implementation using the maturity levels outlined below as part of quarterly Better Care Fund (BCF) self-assessments from November 2017. Where areas have chosen not to implement a Red Bag scheme, quarterly BCF reporting will provide an opportunity for HWBs to provide detail on how partner agencies are using alternative mechanisms to mitigate the risks of poor communication exchange in hospital transfer from care settings.

Red Bag scheme maturity assessment tool

Not yet established	Planned	Established	Mature	Exemplary
Care home residents routinely move to and from hospital without their standardised paperwork	There are discussions underway to develop standardised paperwork to be used by all agencies involved in hospital transfer to and from care homes	Standardised paperwork is used by all staff involved in hospital transfer to and from care homes	Additional paperwork, specific to the care home resident, is routinely being shared and discussed by partner agencies during hospital transfer	Joint systems are in place to monitor, review and act where examples of variance from the hospital transfer protocol are identified
Care home residents routinely return from hospital stays without all the belongings / paperwork they took with them on admission	Conversations have taken place between partners to plan how the Red Bag scheme can be implemented (including funding sources being identified) and have agreed a launch date	The Red Bag scheme is in use, with the protocol usually being followed by the partner organisations involved. Most care home residents move to and from care homes and hospital with all the relevant paperwork and personal belongings being transferred	All care home residents travel with a Red Bag when going to/ from hospital. Training and awareness raising is in place and ongoing across all partner agencies to ensure the Red Bag is used consistently	Protocols and systems are in place to feedback issues quickly and implement rapid improvement. There are also systems in place to replace lost or damaged Red Bags

Acknowledgements

- Sutton CGG Enhanced Health in Care Homes Vanguard Programme
- Wakefield Connecting Care CCG Enhanced Health in Care Homes Vanguard
- Newcastle and Gateshead CCG Enhanced Health in Care Homes Vanguard
- East and North Hertfordshire Vanguard Programme
- South London Health Innovation Network

To share or discover more case study examples in this area please use the BetterCareExchange. Email Better Care Exchange to request an invite to join.

For further information on any of the case studies used in this Quick Guide, please contact the Hospital to Home team via england.ohuc@nhs.net

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