Hospital Transfer Pathway
Red Bag Initiative

NHS Sutton Clinical Commissioning Group

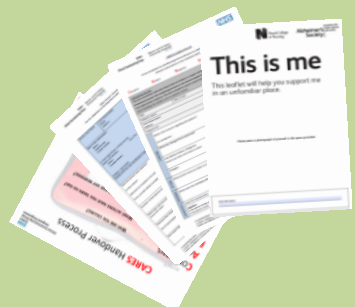
Working together to build the best affordable healthcare for Sutton

An overview of the Pathway

- An end to end integrated care pathway for Care Home residents going to hospital.
- The pathway includes a set of standardised documentation outlining the residents medical history, current acute episode, medication and social information to ensure health professionals have the necessary information to provide the appropriate treatment for the resident. The set of paperwork along with medication is sent in a Red Bag which also contains a change of clothes for discharge, toiletries and personal aids e.g. glasses, dentures, hearing aid.
- The Red Bag with the standard set of documentation go with the resident on their journey from the Care Home with the ambulance to hospital, and back to the Care Home when the resident is are well enough to return home.

Challenges being addressed

- No standardised paperwork
- No baseline information provided to assess care home resident appropriately, and no medical information on the acute episode provided
- Documentation lost
- Personal belongings lost
- No system in place to track red bag residents through the hospital
- Poor communication channel between Care Home and hospital
- Residents can remain in hospital for longer unnecessary time periods



What we hope to achieve

- More efficient admission / discharge process (NICE compliant)
- Reduced length of stay in hospital
- Better communication regarding clinical needs of patient in hospital and more inclusive discharge planning with Care Home
- Clearer co-ordination of medications/TTOs (to take out)
- Improved patient experience

Key findings and outcomes

- Developing plans to conduct an audit in hospital
- Feedback from Care Homes
- More effective, quicker handover to LAS
- Improved relationships and communications between hospital and care homes
- Improved communication across agencies regarding residents clinical needs
- Clearer coordination of medications and TTOs
- Improved communication for discharge planning
- Reduced length of stay for resident in hospital
- Improved person-centred care for residents

Contact details: sutccg.carehomevanguard@nhs.net
See our short film on https://www.youtube.com/watch?v=XoYZPXmULHE