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**Health Innovation Network**

**Hospital Transfer Pathway (HTP / Red Bag) Evaluation Plan 2017-2018**

1. **Overall aim:**
2. To measure the overall impact of the Hospital Transfer Pathway (Red Bag Scheme) in three South London boroughs (Lambeth, Kingston and Richmond), evaluating the length of stay in hospital, improvements in patient care and levels of communication between acute care teams and care homes.

1. To gain feedback from care home residents on their perspective of the impact of the red bag pathway
2. To share the evaluation techniques and tools with South London boroughs to support their own evaluation
3. **Evaluation Steering Group**

The HIN will convene and chair an Evaluation Steering Group to steer and advise on the HTP evaluation process. It is suggested that the steering group consist of representatives from the four boroughs under evaluation and two of the hospitals involved (Kings College Hospital and Kingston Hospital).

The steering group will meet / teleconference 2-3 times during 2017-18 (anticipated: October 2017, January 2018, June 2018) to steer the evaluation plan and methodology and to review data that has been received. Dr Carrie Chill, HIN Clinical Director for Healthy Ageing will be also advise the group.

1. **Sharing evaluation tools and process**

The HIN will develop and then share all evaluation tools (hospital data process, questionnaire, interview questions) with all HTP stakeholders, to support their own evaluation in their area.

1. **HTP Evaluation Questions - Outcome Measures**

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| **Evaluation Question** | **Outcome Measure** | **Data Source** |
| **Has length of stay reduced?** | Length of Stay in Hospital for Care Home Residents vs. baseline | NHSE New Models of Care Dashboard[[1]](#footnote-1) |
| **Is the red bag being used?** | Number / % of occasions where a red bag was not sent with patient, as expected | Care home reports to CCG & ward observations |
| **Is the red bag being used as intended?** | Number / % of occasions where paperwork not fully completed | Care home reports to CCG & staff feedback |
| Number / % of occasions where essential items sent with bag are not returned | Care home reports to CCG & staff feedback |
| No. of bags that are lost | CCG |
| **Has patient care improved?** | Self-reported rating of communication between hospital, LAS and care home staff (expect increase in rating)  Self-reported rating of quality of information (expect an increase in rating)  Self-reported rating of whether clinical decision making has been made easier/more enhanced, because of the red bag pathway – from LAS and Hospital perspective  Self-reported rating from residents’ perspective of whether red bag pathway has improved transfers of care | HIN Interviews/focus groups and Questionnaire |

1. **Methodology**
2. Hospital Length of Stay data - to be monitored using NHSE New Models of Care Dashboard
3. Red bag used or lost / belongings, medicines and paperwork returned - to be monitored via reporting systems between care homes and CCG, and asked as part of questionnaire, interviews and focus groups.
4. Self-reported measures to be obtained from all staff involved (care homes, LAS, hospital) via a very short self-completion questionnaire at 6 months post implementation
5. Qualitative interviews and/or focus groups to be conducted by HIN with staff in 3 areas, including care homes, hospital, community provider, local authority and CCGs to understand in more depth what has worked well/not so well/areas for improvement etc – approach to be considered and agreed with local staff.

Revised Timeline of data collection – three HIN evaluation boroughs

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| --- | --- | --- | --- | --- | --- |
| **CCG** | **Estimated Launch** | **Care Home Survey** | **Hospital Survey** | **LAS Survey** | **HIN Interviews / Questionnaire –**  **6 month point** |
| Richmond | July 17 | March 2018 | Kingston / West Midds – March 2018 | June 2018 | March / April 18 |
| Lambeth | Est. October 17 | April 2018 | GSTT – June 2018 | June 2018 | April 18 |
| Kingston | December 1st 2017 | May 2018 | Kingston – June 2018 | June 2018 | July 18 |
| **Final HIN Report** | Write up: August to September 2018  **Published: October 2018** | | | | |

Appendix i

**Approach to monitoring length of stay in hospital**

One of the key findings from the evaluation of Sutton Vanguard is that there was an observed reduced length of stay of an average of 4 days for those being admitted to hospital with a red bag compared to those being admitted without one.

In the past it has been very difficult to track hospital activity for care home residents as there has been no way of identifying which patients being admitted to hospital are from care homes. Through the New Models of Care team a new process for identifying and tracking hospital activity for care home residents has been developed[[2]](#footnote-2). This approach identifies approximately 85% of care home residents nationally. The Operational Research and Evaluation Team at NHS England have been using this data to produce a dashboard that sets out a number of key metrics around hospital activity for care home residents. These metrics include Average Emergency Admission Length of Stay in hospital.

The dashboard produced by NHS England sets out the Length of Stay metric for each CCG in England on a quarterly basis. The dashboard has been produced up until quarter 2 of 2017. This dashboard can therefore be used to produce a baseline for the red bag project to understand what the average length of stay for each CCG partaking in the implementation of the red bag pathway was prior to implementing the pathway. It can also be used to track going forward the length of stay for care home residents post implementation to see if this has reduced for those areas that have implemented the red bag.

**Caveats to using the dashboard to monitor the transfer of care pathway**

The dashboard cannot identify those care home residents that were admitted with a red bag and those that were not. It only shows whether the overall average Length of Stay has reduced each quarter.

The raw data was only able to match approximately 85% of care home residents nationally so there are some residents that are not being monitored through this dashboard, although the majority are.

The data is matched via care home address and whether there are 3 or more residents at the address that are aged 65 and over. Whilst it picks up care homes for older people it also picks up care home residents in Learning Disability or Mental Health care homes where there are 3 or more residents aged 65 and over. For this reason the cohort is not just care homes registered for older people but includes a small number of those with different types of registration.

**Where can we find this data?**

The dashboard is updated periodically and is available on the New Models of Care Kahootz platform at the following link [ADD IN LINK WHEN WE RECEIVE IT].

1. Please see Appendix i [↑](#footnote-ref-1)
2. *Enhanced Health in Care Homes - ACS, STP & CCG benchmarking Tool (version 2) - NHS England* [↑](#footnote-ref-2)