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**NATIONAL INSTITUTE FOR HEALTH AND CARE
EXCELLENCE**

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5

DRAFT GUIDELINE

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**Transition between inpatient hospital
settings and community or care home
settings for adults with social care needs**

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Draft for consultation, June 2015

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1 Introduction

2 A range of health, social care and other services are involved when adults
3 with care and support needs move into or out of hospital from community or
4 care home settings. Families and carers also play an important part.

5 Problems can occur if services and support are not integrated, resulting in
6 delayed transfers of care, re-admissions and poor care. Hospital discharge
7 problems also occur when people are kept waiting:

- 8 • for further non-acute NHS care
- 9 • for their home care package to be finalised
- 10 • for community equipment
- 11 • because their home is unsuitable
- 12 • because of disputes between statutory agencies about who is responsible
- 13 for their ongoing support.

14 Figures released by NHS England in March 2015 show that on 1 day in
15 February, 3342 people were delayed in hospital. Uncoordinated hospital
16 admissions and avoidable admissions to residential or nursing care from
17 hospital are important examples of poor transitions.

18 The Department of Health asked the National Institute for Health and Care
19 Excellence (NICE) to develop a guideline to help address these and related
20 issues (see the scope). For information on how NICE guidelines are
21 developed see [Developing NICE guidelines: the manual](#).

22 This guideline covers all adults with social care needs, including older people.
23 Social care needs are defined as where an individual requires personal care
24 and other practical assistance by reason of age, illness, disability, pregnancy,
25 childbirth, dependence on drugs, or any other similar circumstances. The
26 guideline does not cover children and young people. It covers transitions
27 between general hospital settings and community or care home settings. It
28 does not include inpatient mental health settings. A separate NICE guideline
29 on [transitions between inpatient mental health settings and the community](#) is
30 being developed.

1 This guideline considers how person-centred care and support should be
2 planned and delivered during admission to, and discharge from, hospital. It
3 addresses how services should work together and with the person, their family
4 and carers, to ensure transitions are timely, appropriate and safe.

5 The guideline is for health and social care practitioners; health and social care
6 providers; commissioners; service users and their carers (including people
7 who purchase their own care)'

8 This guideline has been developed in the context of a complex and rapidly
9 evolving landscape of guidance and legislation, most notably the [Care Act](#)
10 [2014](#). The Care Act and other legislation describe what organisations must
11 do. This guideline focuses on 'what works', how to fulfil those duties, and how
12 to deliver care and support.

13 The Care Quality Commission use NICE guidelines as evidence to inform the
14 inspection process and NICE quality standards to inform ratings of good and
15 outstanding

16

1 **Context**

2 ***Legislation, policy and guidance***

3 This guideline has been developed in the context of important legislative
4 changes which have a significant impact on people with care and support
5 needs moving between inpatient hospital settings and community or care
6 home settings. Most notably, implementation of the [Care Act 2014](#) establishes
7 new provisions as well as updating existing ones, bringing together relevant
8 policy and guidance affecting people with care and support needs. Most of the
9 Care Act took effect from April 2015, with specific financial provisions coming
10 into force from April 2016. [No Health without Mental Health strategy](#)
11 recognises that people may live with both long-term physical conditions and
12 mental ill-health. [No voice unheard no right ignored](#) (Department of Health
13 2015) sets out proposals to strengthen rights and choices of people with
14 learning disabilities and mental health problems.

15 While the Care Act and other legislation describe what organisations must do,
16 this guideline is focused on ‘what works’ in terms of how they fulfil those
17 duties. The legislation places a duty on local authorities to promote wellbeing
18 when carrying out any of their care and support functions and to focus on the
19 needs and goals of the person concerned. Recognising the important role
20 played by carers and families, the Care Act requires local authorities to
21 assess and offer support to address the needs of carers, independently of the
22 person for whom they care. They also have a duty to provide information and
23 advice for the whole population, not just those who are receiving services that
24 they fund.

25 The Act requires that local authorities carry out their care and support
26 responsibilities with the aim of promoting greater integration with NHS and
27 other health related services, for example housing. This reflects similar duties
28 placed on NHS England and Clinical Commissioning Groups (CCGs) to
29 promote integration with care and support set out in the [National Health](#)
30 [Service Act 2006](#).

1 Effective joint working, especially at the interface between hospital and
2 community, requires partners to be clear about their responsibilities. To
3 support this, [Care and Support Statutory Guidance \(Oct 2014\)](#) seeks to clarify
4 where boundaries of responsibilities lie as well as where joint working is
5 required. Updated provisions on the discharge of hospital patients with care
6 and support needs contained in [Schedule 3 to the Care Act 2014](#) and the
7 [Care and Support \(Discharge of Hospital Patients\) Regulations 2014](#), aim to
8 ensure that the NHS and local authorities work together effectively and
9 efficiently to plan the safe and timely discharge of people over 18 years with
10 social care needs from NHS acute medical care facilities.

11 The changing regulatory framework is an important driver for quality in
12 hospital, community and care home settings. [New guidance about care
13 regulations](#) was published by the Care Quality Commission (CQC) in February
14 2015, including fundamental standards which took effect from April 2015.
15 Reflecting changes in the law, recommended by an [Inquiry](#) by Sir Robert
16 Francis, they are standards everybody has a right expect. They also build
17 upon the 2013 [NHS Mandate](#) in focusing on quality of life for people and on
18 'the person as a whole, rather than on specific conditions'.

19 ***Current practice***

20 Those developing this guideline have been mindful of challenges faced by
21 social care and health practitioners to respond to public expectations and
22 manage demand at a time of increasing demographic pressures and
23 decreasing resources. Data from [NHS England](#) on Delayed Transfers of Care
24 offer a perspective on these challenges and of trends overtime. According to
25 the [Kings Fund](#), the number of transfers of care categorised as 'delayed'
26 reduced from 2007 and was relatively stable until 2014/15 but has begun to
27 increase. Analysis suggests that the proportion of delays attributable to social
28 care has fallen and delays attributable to the NHS rose between 2010/11 and
29 2014/15. King's Fund assessment is that reforms following the [Health and
30 Social Care Act 2012](#) contributed to growing pressures facing the NHS.

31 In May 2013, a national collaboration co-produced ['Integrated Care and
32 Support: Our Shared Commitment'](#), a framework document on integration.

1 This continues a policy direction towards better partnership and integrated
2 working. The document sets out how local areas can use existing structures
3 such as Health and Wellbeing Boards to make further steps towards
4 integration. National Voices, a national coalition of health and care charities,
5 developed a [person-centred 'narrative' on integration](#) with [Think Local Act](#)
6 [Personal](#).

7 Following on from the framework document the [Integrated Care and Support](#)
8 [Pioneers Programme](#) was set up in December 2013 to test new ways to join
9 up people's care around their needs. The first [annual report](#) sets out the
10 experiences of the first 14 areas to take part in the programme – many of
11 them seeking to provide integrated care and support at the interface with
12 general hospitals.

13 Whilst some localities have 'pioneer' status, all local systems are faced with
14 tackling the challenges presented through better joined up working. New
15 models of practice are emerging with the aim of enabling older people to
16 remain at home for longer. Some aim to ensure that, where care and
17 treatment in a hospital environment is really needed, people are admitted for
18 the shortest possible episodes. Anticipatory and advance care planning, used
19 particularly to ensure people at the end of life can exercise choice, may also
20 be used for people in the early stages of dementia, or who have other forms of
21 cognitive impairment or who are considered at greater risk of avoidable
22 hospital admission.

23 Focusing on admission from care homes, analysis from the [Health Foundation](#)
24 and Nuffield Trust highlights that care home residents are particularly at risk of
25 emergency hospital admissions. The report of a [Serious Case Review](#) on the
26 Orchid View care home highlights the critical importance of engagement of
27 service providers in pre-admission assessment. It states that this should
28 reflect their 'engagement as a key part of the whole systems approach of
29 health and social care, hospital, residential, primary and community care.'

30 Whilst statistics show a significant percentage of people in general hospitals
31 are older people, studies suggest that other adults with care and support

1 needs can experience disadvantage in the way they experience transition
2 between settings. Commenting on the [evaluation report of the homeless](#)
3 [discharge fund](#) published in January 2015, the [Chief Executive of Healthwatch](#)
4 [England](#) used an example from their Special Inquiry on unsafe discharge to
5 illustrate the difficulties and unequal treatment that can be faced by homeless
6 people – whether they are experiencing street homelessness, staying in
7 temporary housing accommodation, bedding down in hostels or on a friend’s
8 sofa.

9 Many people with learning disabilities live relatively straightforward lives but
10 others will have a range of intellectual disability combined with physical and
11 sensory difficulties and complex co-morbidities which mean transition from a
12 community setting to a hospital environment can be traumatic and damaging.
13 [Healthcare for All](#), the report of an independent Inquiry into access to
14 healthcare for people with learning disabilities describes this. More recently,
15 [best practice guidance from Wales](#) gives examples of emerging practice to
16 improve services.

17 ***The changing landscape – new models for providing and funding care***
18 Increasingly local systems are testing out local initiatives such as ‘discharge to
19 assess’ schemes. This approach and other emerging models are described in
20 an article by Dr Ian Philp. Following initial assessment in hospital and some
21 short term reablement, people can discuss their needs and aspirations for
22 longer term support in their home environment. Initiated to help the NHS to
23 manage ‘patient flow’, interest is growing in what positive impacts there might
24 be on people using services and their carers and in what system or
25 organisational change is required to scale up these local initiatives.

26 In October 2014 the Chief Executive set out his [Five year forward view](#) of the
27 future of the NHS. It includes proposals for greater citizen empowerment and
28 self-management of their health conditions, service redesign with new models
29 of care – including at the interface between hospital and home and with care
30 homes.

1 In January the NHS invited individual organisations and partnerships,
2 including those with the voluntary sector to apply to become 'vanguard' sites
3 for the New Care Models Programme, one of the first steps towards delivering
4 the [Five Year Forward View](#) and supporting improvement and integration of
5 services. The CQC has signaled its intention to adapt to reflect new ways of
6 working across health and social care as well as older models of care
7

1 **Person-centred care**

2 This guideline assumes that the practitioners using it will read it alongside the
3 [Care Act 2014](#). It is also written to reflect the rights and responsibilities that
4 people and practitioners have as set out in the [NHS Constitution for England](#).

5 Care and support should take into account individual needs and preferences.
6 People should have the opportunity to make informed decisions about their
7 care, in partnership with health and social care practitioners. Practitioners
8 should recognise that each person is an individual, with their own needs,
9 wishes and priorities. They should treat everyone they care for with dignity,
10 respect and sensitivity.

11 If someone does not have capacity to make decisions, health and social care
12 practitioners should follow the [code of practice that accompanies the Mental](#)
13 [Capacity Act](#) and the supplementary [code of practice on deprivation of liberty](#)
14 [safeguards](#).

15 If the person using the service agrees, families and carers should have the
16 opportunity to be involved in decisions about care and support. Families and
17 carers should also be given the information and support they need in their
18 own right. NICE has produced guidance on the components of good [patient](#)
19 [experience in adult NHS services](#).

20

1 **Recommendation wording**

2 The Guideline Committee makes recommendations based on an evaluation of
3 the evidence, taking into account the quality of the evidence and cost
4 effectiveness.

5 In general, recommendations that an action 'must' or 'must not' be taken are
6 usually included only if there is a legal duty (for example, to comply with the
7 Care Act or health and safety regulations), or if the consequences of not
8 following it could be extremely serious or life threatening.

9 Recommendations for actions that should (or should not) be taken use
10 directive language such as 'agree', 'offer' 'assess', 'record' and 'ensure'.

11 Recommendations for which the quality of the evidence is poorer, or where
12 there is a closer balance between benefits and risks, use 'consider'.

13

1 Recommendations

The wording used in the recommendations in this guideline (for example words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation). See 'recommendation wording' for details.

2

3 Person-centred care

4 1.1.1 See everyone receiving care as an individual and an equal partner
5 who can make choices about their own care. They should be
6 treated with dignity and respect throughout their transition.

7 1.1.2 Identify and support people at risk of less favourable treatment or
8 less access to services, for example people with communication
9 difficulties or who misuse drugs or alcohol.

10 1.1.3 Involve families and carers in discussions about the care being
11 given or proposed if the person gives their consent. If there is doubt
12 about the person's capacity to consent, the principles of the [Mental](#)
13 [Capacity Act](#) must be followed.

14 Communication and information sharing

15 1.1.4 Ensure that everyone involved in someone's move between
16 hospital and their home is in regular contact with each other to
17 ensure the transition is coordinated. For more information on
18 communication needs see recommendation 1.1.2 in the NICE
19 guideline on [patient experience in adult NHS services](#).

20 1.1.5 Information should be offered:

- 21 • verbally and in written format (in plain English)
- 22 • in other formats that are easy for the person to understand, such
23 as braille, [Easy Read](#) or translated material.

24

1 1.1.6 Give people information about their diagnoses and treatment when
2 they are being transferred between hospital and home. If
3 appropriate, also give this to their family and carers.

4 **1.2 Before admission to hospital**

5 1.2.1 Health and social care practitioners should develop a care plan for
6 adults with identified social care needs who are at risk of being
7 admitted to hospital. This should include contingency planning to
8 help them manage their health condition. If they are admitted to
9 hospital, health and social care practitioners should refer to this
10 plan.

11 1.2.2 Assign a member of the community multidisciplinary team to
12 coordinate support with the hospital multidisciplinary team for
13 people with a long-term condition.

14 1.2.3 Health and social care practitioners and advocates should explain
15 to the person what type of care they might receive and discuss
16 advance care plans and contingency planning (see sections 1.3
17 and 1.5 of NICE's guideline on [patient experience in adult NHS](#)
18 [services](#)). Discussions might cover:

- 19 • place of care
- 20 • religion and spirituality
- 21 • daily routines
- 22 • managing risk
- 23 • how, when and where they receive information and advice
- 24 • the use of an advocate to support them when communicating
25 their needs and preferences
- 26 • end-of-life care.

27 1.2.4 During end-of-life care, find out and record the person's wishes and
28 those of their family and carers.

1 **1.3 Admission to hospital**

2 **Communication and information sharing**

3 1.3.1 Health and social care commissioners should encourage the use of
4 communication protocols and procedures to support admissions.
5 These might include sharing of:

- 6 • lists of medicines in standard documentation
- 7 • contact details for the main carer
- 8 • contact details for next of kin
- 9 • end-of-life wishes.

10 1.3.2 The admitting team should identify and address people's
11 communication needs at the point of admission. For more
12 information on communication needs see recommendation 1.1.2 in
13 the NICE guideline on [patient experience in adult NHS services](#).

14 1.3.3 Health and social care practitioners, including out-of-hours GPs,
15 responsible for transferring people from the community into hospital
16 should ensure the admitting team is given all relevant information.
17 This may include:

- 18 • advance care plans
- 19 • behavioural issues (triggers to certain behaviours)
- 20 • communication needs
- 21 • communication passport
- 22 • current medicines
- 23 • hospital passport
- 24 • housing status
- 25 • named carers
- 26 • other profiles containing important information about the
27 person's needs and wishes
- 28 • preferred places of care.

1 1.3.4 For an emergency admission, A&E should ensure all relevant
2 information is given to the admitting team, when a person is
3 transferred for an inpatient assessment or to an admissions ward.

4 1.3.5 The admitting team should provide the person and their family with
5 an opportunity to discuss their care. They should also provide them
6 with the following information:

- 7 • reason for admission
- 8 • how long they might need to be in hospital
- 9 • care options and treatment they can expect
- 10 • when they can expect to see the doctors
- 11 • the name of the person who will be their contact
- 12 • how they might get home when they are discharged from
13 hospital
- 14 • care and treatment after discharge.

15 1.3.6 The admitting team should identify whether there is a need for
16 reasonable adjustments to be made to accommodate the person in
17 hospital. For example, the team should ensure:

- 18 • there is enough space around the bed for wheelchair users to
19 move from their bed to their chair.
- 20 • people with visual impairments know where the nurse call bell
21 and emergency buzzer are
- 22 • there are adequate facilities for carers who stay with the person
23 in hospital.

24 **Establish a hospital-based multidisciplinary team**

25 1.3.7 As soon as the person is admitted to hospital, identify staff to form
26 the hospital-based multidisciplinary team that will support them.
27 They should work with the community-based multidisciplinary team.
28 The composition of both teams should reflect the person's needs
29 and circumstances.

30 Members of a hospital-based multidisciplinary team could include:

- 1 • doctor
- 2 • nurse
- 3 • physiotherapist
- 4 • occupational therapist
- 5 • mental health practitioner
- 6 • hospital pharmacist
- 7 • dietitian
- 8 • specialists in the person's conditions
- 9 • hospital social worker.

10 1.3.8 The hospital-based multidisciplinary team should provide
11 coordinated support for older people, from hospital admission
12 through to their discharge home.

13 **Assessment and care planning**

14 1.3.9 As soon as people with complex needs are admitted to hospital,
15 intermediate care or step-up facilities, all relevant practitioners
16 should start assessing their health and social care needs. They
17 should also start discharge planning. If assessments have already
18 been conducted in the community, refer to the person's existing
19 care plan.

20 1.3.10 Start a comprehensive geriatric assessment of older people with
21 complex needs at the point of admission and preferably in a
22 specialist unit.

23 **1.4 *During hospital stay***

24 **Communication and information sharing**

25 1.4.1 Record multidisciplinary assessments, prescribed medicines and
26 individual preferences in an electronic data system. Make it
27 accessible to both the hospital- and community-based
28 multidisciplinary teams, subject to information governance
29 protocols.

1 1.4.2 At each shift handover and ward round, members of the hospital-
2 based multidisciplinary team should review and update the
3 person's progress towards hospital discharge.

4 1.4.3 Hospital-based practitioners should keep people regularly updated
5 about any changes to plans for a person's transfer from hospital.

6 **Providing care**

7 1.4.4 Provide care for older people with complex needs in a specialist,
8 geriatrician-led unit or on a specialist geriatrician-led ward.

9 1.4.5 Treat people admitted to hospital after a stroke in a stroke unit and
10 offer them early supported discharge. (See recommendations 1.1.8
11 and 1.1.9 in NICE's guideline on [stroke rehabilitation](#).)

12 1.4.6 Encourage people to follow their usual daily routines where
13 possible, during their hospital stay.

14 **1.5 Discharge from hospital**

15 **Discharge coordinator**

16 1.5.1 One health or social care practitioner should be responsible for
17 coordinating the person's discharge from hospital. Create either a
18 designated discharge coordinator post or make a member of the
19 hospital- or community-based multidisciplinary team responsible.
20 Select them according to the person's care and support needs. A
21 named replacement should always cover their absence.

22 1.5.2 The discharge coordinator should be a central point of contact for
23 health and social care practitioners, the person and their family,
24 particularly during discharge planning. They should be involved in
25 all decisions about discharge planning.

26 **Communication and information sharing**

27 1.5.3 Health and social care commissioners should agree clear
28 discharge planning protocols.

- 1 1.5.4 Health and social care managers should ensure all health and
2 social care practitioners receive regular briefings on the discharge
3 planning protocols.
- 4 1.5.5 During discharge planning, the discharge coordinator should share
5 assessments and updates on the person's health status, including
6 medicines data, with both the hospital- and community-based
7 multidisciplinary teams.
- 8 1.5.6 The hospital-based doctor responsible for the person's care should
9 ensure the discharge summary is sent to the person's GP within
10 24 hours of their discharge. They should also ensure a copy is
11 given to the person the day they are discharged.
- 12 1.5.7 Make a member of the hospital-based multidisciplinary team
13 responsible for providing carers with information and support. This
14 could include:
- 15 • printed information
 - 16 • face-to-face
 - 17 • by phone
 - 18 • hands-on training, including practical support and advice.
- 19 1.5.8 The discharge coordinator should provide people who need end-of-
20 life care and their families with details of who to contact about
21 medicine and equipment problems that occur in the 24 hours after
22 discharge.

23 **Discharge planning: key principles**

- 24 1.5.9 Ensure continuity of care for people being transferred from hospital,
25 particularly older people who may be confused or who have
26 dementia. For more information on continuity of care see the
27 recommendations in section 1.4 of NICE's guideline on [patient](#)
28 [experience in adult NHS services](#).

1 1.5.10 Commissioners and providers should ensure people do not have to
2 make decisions about long-term residential or nursing care while
3 they are in crisis.

4 1.5.11 Hospital managers should try to ensure that any perceived or real
5 pressures to make beds available do not result in unplanned and
6 uncoordinated hospital discharges.

7 **Discharge planning**

8 1.5.12 From admission, or earlier if possible, the hospital- and community-
9 based multidisciplinary teams should work together to identify and
10 address factors that could prevent a safe, timely transfer of care
11 from hospital. This could include:

- 12 • homelessness
- 13 • safeguarding issues
- 14 • suitable placement in a care home.

15 1.5.13 The discharge coordinator should work with the hospital- and
16 community-based multidisciplinary teams and the person receiving
17 care to develop and agree a discharge plan.

18 1.5.14 The discharge coordinator should ensure the discharge plan takes
19 account of the person's social and emotional wellbeing, as well as
20 the practicalities of daily living. It should include:

- 21 • details about the person's condition
- 22 • medicines management information (for more on medicines
23 management for people in transition between settings see
24 section 1.2 of NICE's guideline on [medicines optimisation](#))
- 25 • contact information after discharge
- 26 • arrangements for continuing social care support
- 27 • arrangements for continuing health support
- 28 • details of other useful community services.

- 1 1.5.15 The discharge coordinator should give the plan to the person and
2 all those involved in their ongoing care and support, including
3 families and carers (if the person agrees). The discharge
4 coordinator should also arrange follow-up care.
- 5 1.5.16 The discharge coordinator should identify practitioners (from
6 primary health, community health, social care and housing) and
7 family members who will provide support when the person is
8 discharged. Their details should be recorded in the discharge plan.
- 9 1.5.17 Once assessment for discharge is complete, the discharge
10 coordinator should agree the plan for ongoing treatment and
11 support with the community-based multidisciplinary team.
- 12 1.5.18 The discharge coordinator should discuss the need for any
13 specialist equipment and support with primary health, community
14 health, social care and housing practitioners as soon as discharge
15 planning starts. This includes housing adaptations. Any specialist
16 equipment and support should be in place at the point of discharge.
- 17 1.5.19 A relevant health or social care practitioner should discuss with the
18 person how they can manage their condition after their discharge
19 from hospital. They should provide support and education,
20 including 'coaching' if needed. Make this available for carers as
21 well as people using services.
- 22 1.5.20 Consider supportive self-management as part of a treatment
23 package for people with depression or other mental health
24 problems.

25 **Discharge planning for end-of-life care needs**

- 26 1.5.21 Commissioners should ensure both general and specialist palliative
27 care services are available for people who have end-of-life care
28 needs.

1 1.5.22 Health and social care practitioners should work together to ensure
2 people needing end-of-life care are offered both general and
3 specialist palliative services, according to their needs.

4 1.5.23 The named consultant responsible for a person's end-of-life care
5 should consider referring them to a specialist palliative care team
6 before they are transferred from hospital.

7 1.5.24 The discharge coordinator should ensure people who have end-of-
8 life care needs are assessed and support is in place so they can
9 die in their preferred place.

10 **Early supported discharge**

11 1.5.25 Commissioners should ensure older people with identified social
12 care needs are offered early supported discharge with a home care
13 and rehabilitation package.

14 1.5.26 Consider commissioning early supported discharge with a home
15 care and rehabilitation package provided by a community-based
16 multidisciplinary team for adults with identified social care needs.

17 **People at risk of hospital readmission**

18 1.5.27 The discharge coordinator should refer people at risk of hospital
19 readmission to the relevant community-based health and social
20 care practitioners before they are discharged. For example, if a
21 person is homeless, the discharge coordinator should liaise with
22 the local authority housing options team to ensure they are offered
23 advice and help.

24 1.5.28 Health, social care and housing commissioners should ensure
25 homeless people with social care needs are offered suitable
26 temporary accommodation and support.

1 **Involving carers**

2 1.5.29 The hospital- and community-based multidisciplinary teams should
3 treat the family as an important resource for understanding the
4 person's life and needs.

5 1.5.30 With the person's agreement, include the family's views and wishes
6 in discharge planning.

7 1.5.31 If the discharge plan involves support from family or carers, the
8 hospital-based multidisciplinary team should take account of their:

- 9
- 10 • willingness and ability to provide support
 - 11 • circumstances, needs and aspirations
 - 12 • relationship with the person
 - 13 • need for respite.

14 1.5.32 In line with the [Care Act 2014](#), carers must be informed about their
15 right to a carer's assessment.

16 **Support and training for carers**

17 1.5.33 Commissioners should ensure training is available to help carers
18 provide practical support.

19 1.5.34 A member of the hospital-based multidisciplinary team should
20 discuss the practical and emotional aspects of providing care with
21 potential carers.

22 1.5.35 The relevant multidisciplinary team should offer family members
23 and other carers of people who have had a stroke needs-led
24 training in how to care for them. For example, this could include
25 techniques to help someone carry out everyday tasks as
26 independently as possible. Training might take place in hospital or
27 it may be more useful at home after discharge.

28 1.5.36 The relevant multidisciplinary team should consider offering family
members and other carers needs-led training in care for people

1 with conditions other than stroke. Training might take place in
2 hospital or it may be more useful at home after discharge.

3 1.5.37 The community-based multidisciplinary team should review the
4 carer's training and support needs regularly (as a minimum at the
5 person's 6-month and annual reviews). The team should take into
6 account that their needs may change over time.

7 **After transfer from hospital**

8 1.5.38 Community-based health and social care practitioners should
9 maintain contact with the person after they are discharged. This
10 could include regular phone calls and home visits. It also involves
11 making sure the person knows how to contact them when they
12 need to.

13 1.5.39 An appropriately skilled practitioner should follow up people with
14 palliative care needs within 24 hours after their transfer from
15 hospital.

16 1.5.40 A GP or community-based nurse should phone or visit people at
17 risk of readmission 24–72 hours after their discharge.

18 **1.6 Supporting infrastructure**

19 1.6.1 Local health commissioners and local authorities should ensure a
20 range of local services is available to support people on discharge
21 from hospital. This might include:

- 22 • reablement: helping people re-learn some of the skills for daily
23 living that they may have lost
- 24 • other intermediate care services
- 25 • practical support for carers.

26 1.6.2 Local health commissioners, hospital trusts and local authorities
27 should have a multi-agency plan to address pressures on services,
28 including bed shortages.

- 1 1.6.3 Local health commissioners should ensure all care providers,
2 including GPs and out-of-hours providers, are kept up to date on
3 the availability of local health and social care services.
- 4 1.6.4 Local health commissioners should ensure local protocols are in
5 place so that out-of-hours providers have access to information
6 about the person's preferences for end-of-life care.
- 7 1.6.5 Health and social care practitioners should be aware of the local
8 community health, social care and third sector services available to
9 support people during their move from hospital.

10 **1.7 Training and development**

- 11 1.7.1 Hospital trusts and local authorities should make sure their staff are
12 trained in the hospital discharge process. Training should take
13 place as early as possible, with regular updates. It could include:
- 14 • medicines management
 - 15 • medicines adherence (for more information see NICE's guideline
16 on [medicines adherence](#))
 - 17 • medicines review in partnership with the person
 - 18 • how to get information about the person's social and home
19 situation (including who is available to support the person)
 - 20 • discharge communications
 - 21 • interdisciplinary working between the hospital- and community-
22 based multidisciplinary teams, people using services and their
23 carers
 - 24 • learning how to assess the person's home environment (home
25 visits)
 - 26 • awareness of the local community health, social care and third
27 sector services available to support people during their move
28 from hospital to the community
 - 29 • helping people to manage risks effectively so that they can still
30 do things they want to do (risk enablement).

1 1.7.2 Consider making the training recommended in 1.7.1 available to
2 community-based health and social care practitioners,
3 physiotherapists and occupational therapists.

4 **2 Research recommendations**

5 The Guideline Committee has made the following research recommendations
6 in response to gaps and uncertainties in the evidence identified from the
7 evidence reviews. The Guideline Committee selected the key research
8 recommendations that they think will have the greatest impact on people's
9 care and support.

10 **2.1 *Training for hospital and social care practitioners***

11 What is the effect of hospital discharge or transitions training for health and
12 social care practitioners on achieving successful transfers from hospital to
13 home or the community? (Including specifically the effects on formal and
14 informal carers, and on avoidable readmissions?)

15 **Why this is important**

16 There is some evidence from US studies that training improves medical
17 students' confidence in planning hospital discharge. It also shows that
18 dedicated transitions training involving home visits helps medical and
19 pharmacy students appreciate the person's home environment and how it
20 may affect discharge decisions.

21 But the studies could not determine whether this translated into improved
22 practice or outcomes for people using services. In addition, there is a lack of
23 UK-based evidence on whether training improves people's experience of
24 transitions from hospital to home or the community.

25 Comparative studies are needed on different approaches to training for social
26 care staff, and on whether training improves outcomes for people using
27 services and their carers.

28 Qualitative data are needed from home care commissioners and providers
29 (including managers and frontline practitioners) about their perceptions and

1 experiences of training. Interviews are also needed with people using services
2 and their carers to gauge their views of the skills and competence of their
3 support workers.

4 **2.2 Self-management support for people with mental** 5 **health problems**

6 Which interventions are effective in supporting self-management for people
7 with mental health problems who also have a physical condition and are
8 moving into and out of general inpatient hospital settings?

9 **Why this is important**

10 Current evidence on interventions that support self-management is
11 contradictory and is specific to people with heart conditions. It is not clear
12 whether certain types of support for people with mental health problems are
13 more effective, acceptable to them, or preferred by them. Groups with
14 different health or social care needs may need different approaches.

15 Research is needed on the effect of assessing mental health needs at
16 admission and discharge for different populations. Detailed examination is
17 needed of the components of effective interventions to discover what works,
18 as well as how and for whom.

19 Data are also needed on the effectiveness of models of multiagency working
20 and how GPs can support transitions from hospital to the community.

21 Qualitative studies gauging the views of people with mental health problems
22 and their experiences of self-management support during transition could
23 show which components of a self-management intervention are feasible and
24 acceptable.

25 **2.3 Mental health interventions to support discharge** 26 **from general inpatient hospital settings**

27 What interventions are cost effective in supporting people with mental health
28 problems on discharge from general hospital inpatient settings?

1 **Why this is important**

2 The only evidence found was 1 UK randomised controlled trial for frail older
3 people with dementia or delirium. It showed no significant differences in
4 mortality or service outcomes, and did not consider community care resources
5 or unpaid care.

6 Cost-effectiveness analyses are needed on interventions to support people
7 with mental health problems discharged from hospital. This includes the cost
8 of assessing needs while in hospital, including in specialist units.

9 This is particularly important for patients with dementia or delirium because
10 earlier identification in hospital might lead to long-term cost savings for the
11 public sector and society as a whole.

12 Research is needed on what measures are effective in preventing, managing
13 or resolving dementia or delirium when a person is transferred. And on what
14 training is most effective for hospital staff supporting people during transition.

15 Costs and outcomes for patients and carers need to be measured, including
16 changes in mental health and carers' outcomes. Costs should include health
17 and social care, unpaid care, and effects on employment and housing.

18 Studies are also needed for anxiety, depression and multimorbid mental
19 illness.

20 **2.4 Geriatric assessment and care**

21 What is the cost-effectiveness of comprehensive geriatric assessment and
22 care on specialist units compared with alternative models of care on general
23 wards?

24 **Why this is important**

25 Currently there is no UK evidence on the cost effectiveness of specialist
26 geriatric assessment and care compared with standard, non-specialist care.

27 International evidence (mainly from the US) and evidence from the economic
28 analysis carried out for this guideline suggest that care in a specialist unit is

1 likely to be cost effective. But in England most older people – including those
2 with complex needs – are treated on general wards.

3 It is important to establish the incremental cost and outcomes of provision by
4 mobile teams working on general wards compared with specialist units. Costs
5 need to reflect the use of health and social care resources (including in the
6 community and care homes) as well as unpaid care.

7 Data are needed for costs and outcomes 6 to 12 months after discharge: the
8 time horizon should be sufficient to measure the effects on mortality, hospital
9 readmissions and care home admissions.

10 **2.5 Assessment at home to improve hospital discharge** 11 **success rates**

12 How effective are home assessment interventions and approaches designed
13 to improve hospital discharge outcomes?

14 **Why this is important**

15 Little research has been conducted in this area. There is a little evidence that
16 older people find the hospital environment alienating because of the negative
17 impact on their routine. One Australian qualitative study highlighted the
18 challenge for occupational therapy if it is de-contextualised from normal life,
19 but the findings could not be extrapolated to UK practice.

20 Randomised controlled trials are needed to compare the effectiveness of
21 assessment in hospital with home assessment after discharge, from a social
22 care needs perspective, for different populations. Information on patient- and
23 cost-related outcomes is also needed.

24 Qualitative studies with people who were assessed at home could inform the
25 design of future interventions, by exploring the feasibility and acceptability of
26 home assessment compared with hospital assessment.

27

3 Evidence review and recommendations

Introduction

When this guideline was started, we used the methods and processes described in the Social Care Guidance Manual (2013). From January 2015 we used the methods and processes in Developing NICE Guidelines: The Manual (2014). The included studies were critically appraised using tools in the manuals and the results tabulated (see Appendix B for tables). Minor amendments were made to some of the checklists to reflect the range of evidence and types of study design considered in the evidence reviews. For more information on how this guideline was developed, including search strategies and review protocols, see Appendix A.

Rating the included studies was complex as the 'best available' evidence was often only of moderate quality. Studies were rated for internal and external validity using ++/+- (meaning good, moderate, and low). Where there are two ratings (for example +/-), the first rating applies to internal validity (how convincing the findings of the study are in relation to its methodology and conduct). The second rating concerns external validity (whether it is likely that the findings can be applied to similar contexts elsewhere). The internal quality rating is given in the narrative summaries and evidence statements with both the internal and external rating reported in the evidence tables in appendix B.

Economic studies have been rated according to their applicability using +/- and those rated applicable (+) have been rated according to the quality of methodology applied as economic analyses. Such studies are given (in the notation of -, + and ++) an 'economic evidence rating'. Methodological appraisal detailing the limitations of these studies, is fully described in Appendix C1.

The critical appraisal of each study takes into account methodological factors such as:

- whether the method used is suitable to the aims of the study
- whether random allocation (if used) was carried out competently

- 1 • sample size and method of recruitment
- 2 • whether samples are representative of the population we are interested in
- 3 • transparency of reporting and limitations that are acknowledged by the
- 4 research team.

5 Evidence rated as of only moderate or low quality may be included in
6 evidence statements, and taken into account in recommendations, because
7 the GDG independently and by consensus supported its conclusions and
8 thought a recommendation was needed.

9 A further table reports the details (such as aims, samples) and findings. For
10 full critical appraisal and findings tables, arranged alphabetically by author(s),
11 see appendix B.

12 Early in its discussions the guideline committee identified that a lack of clarity
13 about responsibilities is a significant impediment to good transitions between
14 hospital and home, and the importance therefore of being clear about this in
15 developing the guideline. In drafting the recommendations the committee
16 therefore has specified the audience, and who should take action, in the body
17 of the recommendation.

18 ***The presentation of evidence in this section***

19 The review questions examining effectiveness of different interventions and
20 approaches (5, 6, 7, 8(a), 8(b), 9(a), 9(b), 11(a), 11(b) and 12) are used as the
21 themes for the review areas reported below (for example, transitions for
22 people with mental health problems, transitions for people with end of life care
23 needs). For every review area, we also sought evidence on views and
24 experiences (1.1(a), 1.1(b), 1.2(a), 1.2(b), 2.1(a), 2.2(b), 2.2(a), 2.2(b), 3(a),
25 3(b), 4(a), 4(b), 10(a) and 10(b)). The result is that for each review area
26 reported in this section, evidence is presented from studies of effectiveness
27 and from studies of views and experiences as they relate to that review area.
28 Where relevant, evidence from economics studies is also reported.

29 The same views and experiences questions were applied for every review
30 area, so as to supplement the more measurable data on effects. The views

1 and experiences review questions which delivered material to supplement
2 effectiveness studies are:

3 1.1 (a) What are the views and experiences of people using services, in
4 relation to the transition from inpatient hospital settings to community or care
5 home settings?

6 1.1 (b) What are the views and experiences of people using services, in
7 relation to the hospital admission process (including admission from
8 community or care home settings)?

9 1.2 (a) What are the views and experiences of families and unpaid carers in
10 relation to the transition from inpatient hospital settings to community or care
11 home settings?

12 1.2 (b) What are the views and experiences of families and unpaid carers in
13 relation to the hospital admission process (including admission from
14 community or care homes)?

15 2.1 (a) What do people using services, think works well, what does not work
16 well, and what could improve the transition from inpatient hospital settings to
17 community or care home settings?

18 2.1 (b) What do people using services, think works well, what does not work
19 well, and what could improve the hospital admission process (including
20 admission from community or care home settings)?

21 2.2 (a) What do families and unpaid carers think works well, what does not
22 work well, and what could improve the transition from inpatient hospital
23 settings to community or care home settings?

24 2.2 (b) What do families and unpaid carers think works well, what does not
25 work well, and what could improve the hospital admission process (including
26 admission from community or care homes)?

1 3 (a) What are the views of health, social care and housing practitioners about
2 the transition from inpatient hospital settings to community or care home
3 settings?

4 3 (b) What are the views of health, social care and housing practitioners about
5 the hospital admission process (including admission from community or care
6 home settings)?

7 4 (a) What do health, social care and housing practitioners think works well,
8 what does not work well what could improve the transition from inpatient
9 hospital settings to community or care home settings?

10 4 (b) What do health, social care and housing practitioners think works well,
11 what does not work well, and what could improve the hospital admission
12 process (including admission from community or care home settings)?

13 10 (a) What helps and what makes it difficult to ensure successful transitions
14 from inpatient hospital settings to community or care home settings?

15 10 (b) What helps and what makes it difficult to ensure successful hospital
16 admissions from community or care home settings?

17 Due to the inter-relatedness of some of the review areas, evidence was found
18 to be overlapping. This was particularly so for the hospital admission process,
19 hospital discharge and reducing re-admissions review areas. As the review
20 work progressed through the development phase, the Guideline Committee
21 had an increasing body of evidence on which to develop recommendations.
22 They were able to consider findings from one review area and apply them to
23 the refinement of recommendations in other areas. Where evidence from one
24 review area was used to inform recommendations in another area, this is
25 described in section 3, including the 'Linking Evidence to Recommendations'
26 tables (3.8.2).

1 **3.1** ***Transitions between hospital and home for people***
2 ***with mental health problems***

3 **Introduction to the review questions**

4 The purpose of the review questions was to examine research about the
5 effectiveness and cost effectiveness of different ways (including specific
6 interventions) of supporting people with mental health problems during
7 transition between general inpatient hospital settings and home. This includes
8 admission to hospital and transfer of care from hospital to the community. The
9 questions also aimed to consider research which systematically collected the
10 views of people using services, and those of their carers and care and support
11 staff, in relation to those transitions. In line with the scope, transitions involving
12 inpatient mental health settings are not addressed by this review question.

13 Only a small amount of evidence was located and reviewed for this review
14 area. Data on views and experiences were particularly lacking. The one
15 included views study examined the experiences of people with dementia
16 during admission to hospital, via interviews with family carers. There were
17 three studies reporting effectiveness data, two of which were conflicting in
18 their findings about the outcomes of supportive self-management for people
19 with mental health problems following treatment for a heart condition.

20 Although the quantity of evidence was lacking in this area, the quality of
21 studies was judged to be moderate to good.

22 **Review question(s) for evidence of effectiveness**

23 8 (a) What is the impact of specific interventions to support people with mental
24 health problems during transition from general inpatient hospital settings to
25 community or care home settings?

26 8 (b) What is the impact of specific interventions to support people with mental
27 health problems during admission to general inpatient hospital settings from
28 community or care home settings?

1 **Review question(s) for evidence of views and experiences**

2 Evidence identified for review questions 1-4 and question 10, listed on pages
3 2-3, was included in the review where it applied specifically to transitions
4 between inpatient hospital settings and community or care home settings for
5 adults with mental health problems.

6 **Summary of review protocol**

7 The protocol sought to identify studies that would:

- 8 • Identify the effectiveness of the different ways (including specific
9 interventions) in which adults with mental health problems and social care
10 needs are supported through safe and timely transfers of care from general
11 inpatient hospital settings to community or care home settings.
- 12 • Identify emerging models of mental health care, assessment and discharge
13 planning and associated outcomes.
- 14 • Assess the cost effectiveness of interventions designed to improve
15 transitions between inpatient hospital settings and community or care home
16 settings, specifically for people with mental health problems and social care
17 needs.

18 For the views and experiences review questions, the protocol sought to
19 identify studies, specifically relating to mental health transitions that would:

- 20 • Describe the self-reported views and experiences of adults with social care
21 needs and mental health problems, their families and unpaid carers about
22 the care and support they receive during transition into and out of inpatient
23 hospital settings.
- 24 • Highlight aspects of care and support during transitions that work well, as
25 perceived by service users with mental health problems, their families and
26 unpaid carers and aspects of care and support during transitions, which are
27 perceived not to work well.
- 28 • Describe the views and experiences of people delivering, organising and
29 commissioning social care, health and housing services.
- 30 • Highlight aspects of transition into and out of hospital for people with
31 mental health problems, which work well, and are personalised and

1 integrated, as perceived by practitioners, managers and commissioners
2 and aspects of admission and discharge, which should be changed to
3 improve transitions.

- 4 • Contextualise the views of users, carers and practitioners by identifying
5 barriers and facilitators to improved or changed practice they suggest
6 would improve outcomes relating to transitions into and out of inpatient
7 hospital settings for people with mental health problems.

8 **Population:** Adults aged 18 years and older, with mental health problems and
9 social care needs who are transferring between (general) inpatient hospital
10 settings and community or care home settings and their families, partners and
11 carers. Self-funders and people who organise their own support and who are
12 experiencing a transfer of care between (general) inpatient hospital settings
13 and community or care home settings are included.

14 Housing practitioners, social care practitioners (providers, workers, managers,
15 social workers), and health and social care commissioners involved in
16 delivering social care to people during transition between inpatient hospital
17 settings community or care home settings or intermediate care units; personal
18 assistants engaged by people with social care needs and their families.
19 General practice and other community-based healthcare practitioners.

20 **Intervention:** Personalised and integrated assessment and admission
21 processes, discharge planning and care and support specifically for people
22 with mental health problems.

23 **Setting:** Service users' home, including sheltered housing accommodation;
24 supported housing; temporary accommodation; care (residential and nursing)
25 homes, bed-based intermediate care settings and inpatient hospital settings
26 (excluding acute mental health settings).

27 **Outcomes:** User and carer related outcomes (such as user and carer
28 satisfaction; quality and continuity of care; quality of life [measured using
29 specific mental health quality of life tool]; choice and control; involvement in
30 decision-making, suicide rates and mortality) and service outcomes such as

1 use of health and social care services, delayed transfers of care and rates of
2 hospital re-admissions within 30 days (see 4.4 in the Scope).

3 User satisfaction; quality and continuity of care; choice and control;
4 involvement in decision-making; dignity and independence; quality of life;
5 health status; safety and safeguarding

6 The study designs included for the effectiveness questions on transitions for
7 people with mental health problems were:

- 8 • Systematic reviews of studies of different models of discharge assessment,
9 admissions, discharge and care planning for people with mental health
10 problems;
- 11 • Randomised controlled trials of different approaches to discharge
12 assessment and care planning for people with mental health problems;
- 13 • Controlled studies of different approaches to discharge assessment and
14 care planning for people with mental health problems.
- 15 • Economic evaluations.

16 The study designs relevant to the views and experiences questions were
17 expected to include:

- 18 • Systematic reviews of qualitative studies on this topic;
- 19 • Qualitative studies of user and carer views of social and integrated care;
- 20 • Qualitative components of effectiveness and mixed methods studies;
- 21 • Observational and cross-sectional survey studies of user experience.

22 Full protocols can be found in Appendix A.

23 **How the literature was searched**

24 Electronic databases in the research fields of social care, health, economics
25 and social science were searched using a range of controlled indexing and
26 free-text search terms based on the facets of: the state of transition (service
27 user/patient transfer or admission or discharge), settings (inpatient hospital or
28 community or care home settings) and health and social care needs,
29 workforce or intervention.

1 The search aimed to capture both journal articles and other publications of
2 empirical research. Additional searches of websites of relevant organisations
3 were also carried out.

4 The search for material on this topic was carried out within a single broad
5 search strategy used to identify material which addressed all the agreed
6 review questions on the transition between inpatient hospital settings and
7 community or care home settings for adults with social care needs. The
8 searches were restricted to studies published from 2003 in order to
9 incorporate the Community Care (Delayed Discharges) Act 2003. Generic and
10 specially developed search filters were used to identify particular study
11 designs, such as systematic reviews, randomised controlled trials, economic
12 evaluations, cohort studies, mixed method studies and personal narratives.
13 The database searches were not restricted by country.

14 Full details of the search can be found in Appendix A.

15 **How studies were selected**

16 Search outputs (title and abstract only) were stored in EPPI Reviewer 4 - a
17 software programme developed for systematic review of large search outputs
18 - and screened against an exclusion tool informed by the parameters of the
19 scope. Formal exclusion criteria were developed and applied to each item in
20 the search output, as follows:

- 21 • Language (must be in English),
- 22 • Population (must be over 18 years of age and have a social care need)
- 23 • Transition (a transition into or out of an inpatient hospital setting must have
24 occurred within the last 30 days)
- 25 • Intervention (must be involved in supporting transitions)
- 26 • Setting (inpatient hospital setting, intermediate care setting, community
27 setting or care home)
- 28 • Country (must be UK, European Union, Denmark, Norway, Sweden,
29 Canada, USA, Australia and New Zealand)
- 30 • Date (not published before 2003)
- 31 • Type of evidence (must be research)

- 1 • Relevance to (one or more) review questions.

2 Title and abstract of all research outputs were screened against these
3 exclusion criteria. Those included at this stage were marked for relevance to
4 particular review questions and retrieved as full texts.

5 Full texts were again reviewed for relevance and research design. If still
6 included, critical appraisal (against NICE tools) and data extraction (against a
7 coding set developed to reflect the review questions) was carried out. The
8 coding was all conducted within EPPI Reviewer 4, and formed the basis of the
9 analysis and evidence tables. All processes were quality assured by double
10 coding of queries, and of a random sample of 10%.

11 In our initial screen (on title and abstract), we found 51 studies, which
12 appeared relevant to the review questions on mental health transitions. We
13 ordered full texts and reviewed 35 papers for final inclusion. For views and
14 experiences research, studies from a UK setting were prioritized.
15 Effectiveness studies were restricted to systematic reviews, randomized
16 controlled trials or controlled studies. On reviewing the full texts, we identified
17 4, which fulfilled the criteria (see included studies below), one of which
18 reported economic evidence. The included studies (see below) were critically
19 appraised using NICE tools for appraising different study types, and the
20 results tabulated. Further information on critical appraisal is given in the
21 introduction at the beginning of Section 3. Study findings were extracted into
22 findings tables. For full critical appraisal and findings tables, see Appendix B.

23 **Narrative summaries of the included evidence**

24 ***Studies reporting effectiveness data (n=3)***

25 **1. Davis K (2012) Targeted intervention improves knowledge but not self-** 26 **care or readmissions in heart failure patients with mild cognitive** 27 **impairment**

28 **Outline:** This is a randomised controlled trial of moderate quality [+] to
29 measure the impact of a targeted self-care teaching intervention on heart
30 failure knowledge, self-care and 30-day readmission rates for heart failure

1 patients with mild cognitive impairment. The study intervention was
2 administered by a case manager and was based on principles of cognitive
3 training. It focused on environmental manipulations and training compensatory
4 strategies for working with impairments in memory and executive functioning,
5 and on improving patients' self-confidence to manage their health.

6 **Results:** There were no significant differences between the control and
7 intervention groups in terms of readmission rates, days to first readmission, or
8 total hospital days within 30 days. Mean change scores in self-care of heart
9 failure index subscales showed greater improvement in self-care for the
10 intervention group; however this improvement was not statistically significant.
11 Mean scores in heart failure knowledge increased significantly in the
12 intervention group, but decreased in the control group ($p < 0.001$). Patients in
13 the intervention group had higher scores on follow-up on questions related to
14 fluid restriction, causes of worsening heart failure symptoms, and the function
15 of the heart, whereas the control group decreased on these questions.

16 **2. Goldberg, S., Bradshaw, L., Kearney, F., Russell, C., Whittamore, K.,**
17 **Foster, P., Mamza, J., Gladman, J., Jones, R., Lewis, S., Porock, D. and**
18 **Harwood, R. (2013) Care in specialist medical and mental health unit**
19 **compared with standard care for older people with cognitive impairment**
20 **admitted to general hospital: Randomised controlled trial**

21 **Outline:** This is a randomised controlled trial of moderate quality [+]. The
22 study was conducted in a large acute general hospital in the UK with the aim
23 of evaluating a best practice model of care for older people with cognitive
24 impairment. The model, a specialist unit in the hospital, featured joint staffing
25 by medical and mental health professionals, enhanced staff training in
26 delirium, dementia, and person centred dementia care and the provision of
27 organised purposeful activity. The outcome of primary interest to the
28 researchers was 'number of days spent at home over the 90 days after
29 randomisation'. Participants, aged over 65, were recruited to the study from
30 the mental health unit and from geriatric and general medical wards.

31 **Results:** Using the primary outcome measure the study found that this
32 specialist mental health unit had no significant effect on the number of days

1 patients spent at home (51 v 45 days) or in the hospital (16 days vs 16 days in
2 total). Specifically; patients in the mental health unit and patients in the
3 'standard' wards had the same length of hospital stay (11 days); mortality was
4 lower (but not significantly so) among the intervention patients (22 v 25 per
5 cent); readmission rates were lower (but not significantly so) for the
6 intervention group; patients returning home from the 'standard' ward spent an
7 average of half a day longer at home than patients from the mental health unit
8 and there were fewer new admissions to care homes (but not significantly so)
9 among patients from the mental health unit (20 v 28 per cent).

10 Secondary outcomes were also used to measure other elements of impact.
11 They showed some positive results. For example patients on the specialist
12 unit spent significantly more time with positive mood or engagement
13 (measured by direct observation) and experienced more staff interactions that
14 met psychological and emotional needs. The impact on family carers was also
15 assessed by measuring their psychological wellbeing using a general health
16 questionnaire. Health status outcomes, carer strain and carers' psychological
17 wellbeing were no different between the groups. However family carers of
18 patients in the mental health unit were significantly more satisfied with overall
19 care, nutrition, dignity and respect and with the needs of the patient being
20 met. Process measures (such as a more comprehensive mental health
21 assessment) also appeared improved in the specialist unit.

22 **3. Rollman Bruce L (2009) The Bypassing the Blues Treatment Protocol:
23 Stepped Collaborative Care for Treating Post-CABG Depression: a
24 randomized control trial**

25 **Outline:** This is a good quality effectiveness study [++] to measure the impact
26 of telephone-delivered collaborative care on patients who are suffering from
27 post-coronary artery bypass graft (CABG) depression in the U.S. At the time
28 of publication it was the first treatment trial for depression in cardiac
29 populations to use a treatment package that involves follow up from a non-
30 physician 'care manager'. The intervention was delivered by a nurse care
31 manager who offered the discharged patient support in multiple ways:

1 educating them about their illness, teaching them self-management
2 techniques, and facilitating co-management or transfer of care if necessary.

3 **Results:** The randomised group of 150 depressed patients which received the
4 collaborative care intervention, reported greater improvements (all $P \leq 0.02$) in
5 mental health related quality of life, physical functioning, and mood symptoms;
6 and were more likely to report a $\geq 50\%$ decline in their Hamilton Rating Scale
7 for Depression score from baseline than depressed patients randomised to
8 their physicians' usual care (N=152) ($P < 0.001$). Rate of re-admissions
9 appeared similar between groups.

10 ***Studies reporting views and experiences data (n=1)***

11 **1. Clissett, P. (2013) Experiences of family carers of older people with 12 mental health problems in the acute general hospital: a qualitative study**

13 **Outline:** This is a good quality study [++], which presents an analysis of
14 interviews concerning the experiences of 34 patients over the age of 70 with
15 cognitive impairment (predominantly delirium, dementia or both) admitted to
16 acute hospital in the UK. All interviewees were asked to give an account of the
17 admission process and were asked how their experience could be improved.
18 The focus of the analysis is on family carers' views and the study design is
19 informed by the philosophical approach of person-centred care.

20 **Results**

21 The key findings from the interviews were:

- 22 • Admission to acute care is a disruption from normal routine. It is a
23 distressing, disorientating time for older patients with cognitive impairment
24 and their carers.
- 25 • Carers have community support services withdrawn after a few days in
26 hospital and have to re-request support upon discharge.
- 27 • Effective communication, which is triadic, rather than dyadic, is essential in
28 order to allow family carers and healthcare professionals to work in
29 partnership with each other and deliver the best quality care for this
30 population – especially when carers are acting as advocates for patients

1 with dementia and/or delirium and supplying knowledge of patients'
2 'personhood'.

3 ***Studies reporting evidence of cost effectiveness (n=1)***

4 One UK RCT (Goldberg et al 2013, N=600, +) compared individual and
5 service level outcomes of a personalised geriatric intervention for older people
6 presenting with undifferentiated confusion and often reaching end of life with
7 standard care at acute geriatric (70%) or general medical wards (30%). This
8 study was not an economic evaluation. However, it applied the EQ-5D which
9 is a standardised measure for health utility (typically used in cost-
10 effectiveness studies in health); and it measured a wide range of relevant
11 service use outcomes. It could thus inform the economic evidence and was
12 included in the economic review. For individual level outcomes, the study did
13 not find significant changes for patients' physical health (via EQ-5D completed
14 by patients; n=251; 0.59 vs. 0.57; P=0.96; via EQ-5D completed by on behalf
15 of patients; n=263; 0.26 vs. 0.31; P=0.06) and overall mortality (n=68 vs.
16 n=71, P=0.89), and carers' psychological wellbeing (via GHQ; n=253; 12.5 vs.
17 12.0; P=0.05). There were also not significant changes in service level
18 outcomes relevant from a hospital and residential care perspective including
19 days spent at home (51 vs. 41; P=0.3), care home admission (20% vs. 28%;
20 95% CI for difference -16% to 0%), hospital readmission (32% vs. 35%, 95%
21 CI for difference -10% to 5%). Results were not different for specific groups of
22 people such as those admitted with delirium, from care home, those who
23 spent longer than five days in hospital, or whether the person using standard
24 care was in geriatric or general ward. This study did not include measures of
25 the impact on unpaid care and the intensity of community care packages. The
26 study did not find significant changes in individual or service level outcomes
27 and it was thus not indicated that this particular type of intervention was likely
28 to be cost-effective. Additional economic analysis was not considered useful.
29 This intervention was targeted at a very specific group of people and did thus
30 not allow generalisable conclusions to be developed about the likely cost-
31 effectiveness of other interventions to support people with mental health
32 problems.

1 Evidence statements (including economic evidence statement)

MH1	There is a small amount of good quality evidence from one qualitative study about the hospital admission process for older people with mental health problems. The UK study (Clissett, 2013) [++] described the emergency admission process as disorientating and distressing for patients and frustrating for carers who felt their own expertise was overlooked. The study reported that hospital admission would be improved if existing community support packages could be resumed to maintain important relationships, and if health care professionals conscientiously communicated with family carers and engaged them in genuine partnership.
MH2	The small amount of evidence about supportive self-management for people with mental health problems on discharge from inpatient heart failure treatment is conflicting. One randomised controlled trial of moderate quality (Davis, 2012) [+] found no significant difference in readmission rates and total hospital stay among discharged patients who had used a targeted self-care teaching intervention, compared with a control group. By contrast, one good quality (Rollman, 2009) [++] US effectiveness study reported significant improvements among depressed coronary bypass graft patients following a treatment package featuring education and self-management techniques, although rates of re-admissions appeared similar.
MH3	There is a small amount of evidence of moderate quality from 1 randomized controlled trial that readmissions and length of hospital stay are not significantly improved through a hospital-based intervention for older people with cognitive impairment. The UK study (Goldberg et al, 2013) [+] reported that a specialist mental health unit had no significant effect on patients' length of hospital stay or the days spent at home following discharge. On the other hand, the study found that the intervention improved patient experience and carer satisfaction.
MH4	No evidence was found from studies published since 2003 about the following interventions to support people with mental health problems during transition: reablement, telecare, housing support, occupational therapy, physiotherapy, nutrition support, befriending and transport services.
Ec5	A specialised geriatric intervention for older people presenting with undifferentiated confusion had no significant effect on cost-relevant or individual health and wellbeing outcomes. One UK RCT (Goldberg et al 2013, N=600) [+] was identified that evaluated cost-relevant service outcomes. The intervention was a specialist unit on a geriatric ward provided by a multidisciplinary team – including psychiatrists – following a personalised case management approach for frail older people with dementia compared with what could be described as good practice (i.e. care provided by staff with experience in dementia and delirium and access to a psychiatrist on request). Improvements across health and wellbeing outcomes for service users and carers measured with the EQ-5D and GHQ were not statistically significant; there were no statically significant changes in mortality and the economically relevant service outcomes including return home and days spent at home, hospital readmission and care home admission. The impact on community care resources and informal care was not evaluated.

2

1 **Included studies for the mental health review questions (full citation)**

2 Clissett, P, Porock D, Harwood R et al. (2013) Experiences of family carers
3 and older people with mental health problems in the acute general hospital: a
4 qualitative study. Journal of Advanced Nursing 69: 2707–16

5 Davis K, Mintzer M, Dennison Himmelfarb C et al. (2012) Targeted
6 intervention improves knowledge but not self-care or readmissions in heart
7 failure patients with mild cognitive impairment European Journal of Heart
8 Failure 14: 1041–9

9 Goldberg S, Bradshaw L, Kearney F et al. (2013) Care in specialist medical
10 and mental health unit compared with standard care for older people with
11 cognitive impairment admitted to general hospital: Randomised controlled trial
12 (NIHR TEAM trial). BMJ. 347, f4132

13 Rollman B, Belnap B, Lemenager M et al. (2009) The Bypassing the Blues
14 Treatment Protocol: Stepped Collaborative Care for Treating Post-CABG
15 Depression JAMA 71: 217–30

16

17 **3.2 Transitions between hospital and home for people with**
18 **end of life care needs**

19 **Introduction to the review questions**

20 The purpose of these review questions was to examine research about the
21 effectiveness and cost effectiveness of different ways (including specific
22 interventions) of supporting people with end of life care needs during transition
23 between general inpatient hospital settings and home. This includes
24 admission to hospital and transfer of care from hospital to the community,
25 including care homes and hospices. The questions also aimed to consider
26 research which systematically collected the views of people using services,
27 their carers, and care and support staff in relation to those transitions.

28 A moderate amount of evidence from studies of views and experiences was
29 located and reviewed for this review area. The studies were mainly of good

1 quality and represented the full spectrum of perspectives including people
2 using services, their carers and practitioners. One of the included views and
3 experiences was from outside the UK, because it was considered to provide
4 valuable data relating to the living-dying interval that that could be applied
5 beyond the study context (the USA). In contrast to the views and experiences
6 studies, only one controlled study of effectiveness was located and reviewed.
7 This is unsurprising given the focus of the review question. This evidence gap
8 prompted the Guideline Committee to call for an expert witness on the subject
9 of transitions for people with end of life care needs (see appendix??)

10 **Review question(s) for evidence of effectiveness**

11 9 (a) What is the impact of specific interventions to support people with end-
12 of-life care needs during transition from inpatient hospital settings to
13 community or care home settings, including hospices?

14 9 (b) What is the impact of specific interventions to support people with end-
15 of-life care needs during admission to inpatient hospital settings from
16 community settings including care homes and hospices?

17 **Review question(s) for evidence of views and experiences**

18 Review questions 1-4 and question 10, listed on pages 2-3, were applied
19 specifically in relation to transitions between inpatient hospital settings and
20 community or care home settings for people with end of life care needs.

21 **Summary of review protocol**

22 The protocol sought to identify studies that would:

- 23 • Identify the effectiveness of the different ways (including specific
24 interventions) in which adults with end of life care needs are supported
25 through safe and timely transfers of care from general inpatient hospital
26 settings to community or care home settings (including hospices).
- 27 • Identify emerging models of end of life care, assessment and discharge
28 planning and associated outcomes.

- 1 • Assess the cost effectiveness of interventions designed to improve
2 transitions between inpatient hospital settings and community or care home
3 settings, specifically for people with end of life care needs.

4 For the views and experiences review questions, the protocol sought to
5 identify studies, specifically relating to mental health transitions that would:

- 6 • Describe the self-reported views and experiences of adults with end of life
7 and social care needs, and those of their families and unpaid carers, about
8 the care and support they receive during transition into and out of inpatient
9 hospital settings.
- 10 • Highlight aspects of care and support during transitions for people with end
11 of life care needs that work well, as perceived by service users, their
12 families and unpaid carers, and aspects of care and support during
13 transitions, which are perceived not to work well.
- 14 • Describe the views and experiences of people delivering, organising and
15 commissioning social care, health and housing services.
- 16 • Highlight aspects of transition into and out of hospital for people with end of
17 life care needs which work well, and are personalised and integrated, as
18 perceived by practitioners, managers and commissioners and aspects of
19 admission and discharge, which should be changed to transitions.
- 20 • Contextualise the views of users, carers and practitioners by identifying
21 barriers and facilitators to improved or changed practice they suggest
22 would improve outcomes relating to transitions into and out of inpatient
23 hospital settings for people end of life care needs.

24 **Population:** Adults aged 18 years and older, with end of life care needs who
25 are transferring between (general) inpatient hospital settings and community
26 or care home settings including hospices and their families, partners and
27 carers. Self-funders and people who organise their own support and who are
28 experiencing a transfer of care between (general) inpatient hospital settings
29 and community or care home settings are included.

30 Housing practitioners, social care practitioners (providers, workers, managers,
31 social workers), and health and social care commissioners involved in

1 delivering social care to people during transition between inpatient hospital
2 settings, community or care home settings, hospices or intermediate care
3 units; personal assistants engaged by people with social care needs and their
4 families. General practice and other community-based healthcare
5 practitioners.

6 **Intervention:** Personalised and integrated assessment, admission and
7 discharge planning and care and support, specifically for people with end of
8 life care needs.

9 **Setting:** Service users' home, including sheltered housing accommodation;
10 supported housing; temporary accommodation; care (residential and nursing)
11 homes, hospices, bed-based intermediate care settings and inpatient hospital
12 settings.

13 **Outcomes:** User and carer related outcomes (such as user and carer
14 satisfaction; quality and continuity of care; quality of life [assessed using an
15 appropriate end of life care outcome measure] choice and control in relation to
16 place of death and involvement in planning) and service outcomes such as
17 use of health including palliative care and social care services, delayed
18 transfers of care and rates of hospital re-admissions within 30 days (see 4.4 in
19 the Scope).

20 User satisfaction; quality and continuity of care; choice and control;
21 involvement in decision-making; dignity and independence; quality of life;
22 health status; safety and safeguarding

23 The study designs included for the effectiveness questions on transitions
24 during end of life care were:

- 25 • Systematic reviews of studies of different models of discharge assessment
26 and care planning for people with end of life care needs;
- 27 • Randomised controlled trials of different approaches to discharge
28 assessment and care planning for people with end of life care needs;
- 29 • Controlled studies of different approaches to discharge assessment and
30 care planning for people with end of life care needs.

1 • Economic evaluations.

2 The study designs relevant to the views and experiences questions were
3 expected to include:

- 4 • Systematic reviews of qualitative studies on this topic;
- 5 • Qualitative studies of user and carer views of social and integrated care;
- 6 • Qualitative components of effectiveness and mixed methods studies;
- 7 • Observational and cross-sectional survey studies of user experience.

8 Full protocols can be found in Appendix A.

9 **How the literature was searched**

10 Electronic databases in the research fields of social care, health, economics
11 and social science were searched using a range of controlled indexing and
12 free-text search terms based on the facets of: the state of transition (service
13 user/patient transfer or admission or discharge), settings (inpatient hospital or
14 community or care home settings) and health and social care needs,
15 workforce or intervention.

16 The search aimed to capture both journal articles and other publications of
17 empirical research. Additional searches of websites of relevant organisations
18 were also carried out.

19 The search for material on this topic was carried out within a single broad
20 search strategy used to identify material which addressed all the agreed
21 review questions on the transition between inpatient hospital settings and
22 community or care home settings for adults with social care needs. The
23 searches were restricted to studies published from 2003 in order to
24 incorporate the Community Care (Delayed Discharges) Act 2003. Generic and
25 specially developed search filters were used to identify particular study
26 designs, such as systematic reviews, randomised controlled trials, economic
27 evaluations, cohort studies, mixed method studies and personal narratives.

28 The database searches were not restricted by country.

29 Full details of the search can be found in Appendix A.

1 **How studies were selected**

2 Search outputs (title and abstract only) were stored in EPPI Reviewer 4 - a
3 software programme developed for systematic review of large search outputs
4 - and screened against an exclusion tool informed by the parameters of the
5 scope. Formal exclusion criteria were developed and applied to each item in
6 the search output, as follows:

- 7 • Language (must be in English),
- 8 • Population (must be over 18 years of age and have a social care need)
- 9 • Transition (a transition into or out of an inpatient hospital setting must have
10 occurred within the last 30 days)
- 11 • Intervention (must be involved in supporting transitions)
- 12 • Setting (inpatient hospital setting, intermediate care setting, community
13 setting or care home)
- 14 • Country (must be UK, European Union, Denmark, Norway, Sweden,
15 Canada, USA, Australia and New Zealand)
- 16 • Date (not published before 2003)
- 17 • Type of evidence (must be research)
- 18 • Relevance to (one or more) review questions.

19 Title and abstract of all research outputs were screened against these
20 exclusion criteria. Those included at this stage were marked for relevance to
21 particular review questions and retrieved as full texts.

22 Full texts were again reviewed for relevance and research design. If still
23 included, critical appraisal (against NICE tools) and data extraction (against a
24 coding set developed to reflect the review questions) was carried out. The
25 coding was all conducted within EPPI Reviewer 4, and formed the basis of the
26 analysis and evidence tables. All processes were quality assured by double
27 coding of queries, and of a random sample of 10%.

28 In our initial screen (on title and abstract), we found 113 studies, which
29 appeared relevant to the review questions on end of life care transitions. We
30 ordered full texts and reviewed 62 papers for final inclusion. For views and
31 experiences research, studies from a UK setting were prioritized.

1 Effectiveness studies were restricted to systematic reviews, randomized
2 controlled trials or controlled studies. On reviewing the full texts, we identified
3 6, which fulfilled the criteria (see included studies below). In addition, there
4 were 2 economic studies (see below in econ para). The included studies (see
5 below) were critically appraised using NICE tools for appraising different study
6 types, and the results tabulated. Further information on critical appraisal is
7 given in the introduction at the beginning of Section 3. Study findings were
8 extracted into findings tables. For full critical appraisal and findings tables, see
9 Appendix B.

10 **Narrative summaries of the included evidence**

11 ***Studies reporting effectiveness data (n=1)***

12 **1. Brody, A., Aizer, Ciemins, E., Newman, J. and Harrington, C. (2010)** 13 **The effects of an inpatient palliative care team on discharge disposition.**

14 **Outline:** This quantitative study is of moderate quality [+]. Using hospital
15 records for two groups of patients, it compared the effect of an Inpatient
16 Palliative Care Team. Previous descriptive studies had associated the
17 Palliative Care Team with greater patient satisfaction, and decreased
18 resource use and costs. This study attempts to isolate the effect of the
19 Palliative Care Team by comparing two groups on the discharge disposition
20 and the effect of this on reducing rehospitalisation and improved resource
21 utilization. Groups were matched on key characteristics such as similar
22 diagnosis, risk of mortality, and number of previous hospital stays. Outcomes
23 were: discharged home without services, discharged home with services
24 (including Home Health Care and Advanced Illness Management Program),
25 discharged to another facility, and discharged to a hospice.

26 **Results:**

- 27 • Patients who died within 30 days of discharge were more likely to have
28 been seen by the PCT and discharged to a hospice (46.2%) compared to
29 patients receiving usual care (32.4%) ($p < 0.0001$)

30 Controlling for all other variables,

- 1 • Patients seen by the Palliative Care Team were 3.24 times more likely than
2 those receiving usual care to be discharged to a hospice ($p < 0.0001$),
- 3 • Patients seen by the Palliative Care Team were 1.52 times more likely than
4 those receiving usual care to be discharged to a skilled nursing facility
5 (SNF) ($p < 0.001$)
- 6 • Patients seen by the Palliative Care Team were 1.59 times more likely than
7 those receiving usual care to be discharged to home with homecare (p
8 < 0.0001)

9 The results suggest that the expertise of the palliative care planners was
10 effective in securing specialist care for their patients.

11

12 ***Studies reporting views and experiences data (n=5)***

13 **1. Hanratty, B., Holmes, L., Lawson, E., Grande, G., Addington-Hall, J.,
14 Payne, S. and Seymour, J (2012) Older adults' experiences of transitions
15 between care settings at the end of life in England: A qualitative
16 interview study.**

17 **Outline:** This is a good quality study [++] that attempts to fill the gap in
18 knowledge about people's own experience of end of life care in a UK context.
19 The study involved in-depth interviews with older people believed by their
20 physician to be in their last year of life and who had experienced transitions
21 between at least two care settings in the last three months. Interviews were
22 conducted at a location of the participant's choice by an experienced
23 qualitative researcher who was also a trainee health psychologist. The
24 average duration of the interview was 90 minutes, recorded with permission.
25 Participants could terminate the interview at any time.

26 **Results:** Thematic analysis of the views data revealed four groups of views,
27 or themes. They were:

- 28 • The prioritisation of the institutional processes
- 29 • Support across settings
- 30 • Being heard

- 1 • Dignity

2 More detailed findings are reported under the relevant views and experiences
3 questions:

4 **4 (a) What do service users think works well, what does not work well**
5 **what could improve the transition from inpatient hospital settings to**
6 **community or care home settings?**

7 ***The prioritisation of the institutional processes***

8 There was a feeling that the system operated to its own convenience instead
9 of the service users' with examples given of slavish following of the rules
10 taking precedence over the preferences of the individuals. One example cited
11 an elderly woman who had a bed installed at her home, against her wishes:
12 once "deposited" there, she found she was stuck, and dependent on her
13 elderly husband to help her off the bed.

14 "They lifted me onto this bed, and they had to leave me, they couldn't take me
15 off...that was the law, I suppose or something. They just said they had done
16 what they were told to do, and so I would just have to stay, so that was it"
17 (Female 80 years, lung cancer P78).

18 Praise from service users was usually directed toward individuals, and
19 criticisms towards systems and processes.

20 ***Support across settings***

21 Several examples were given of failures in communication between hospital
22 and the community, a lack of attention to non-health needs and inattention to
23 the need for a home life. Some felt unprepared for a return to home, and
24 unsure about how to access services once at home (and what services were
25 available).

26 ***Being heard***

27 No one seemed to have the time to talk, and service users and their carers
28 struggled to be heard. This was particularly acute at the time of transitions
29 from hospital to home.

1 A good understanding of the purpose of any move may help to minimise the
2 distress, yet participants often spoke about the lack of time for any meaningful
3 conversation and opportunity to voice concerns or needs.

4 ***Dignity***

5 An example was also given of where small things can mean a lot, and the loss
6 of dignity experienced by the loss of false teeth in the move from hospital to
7 home. Simple changes in practice, such as providing care with dignity, respect
8 and communication, would make significant improvements.

9 **2. Hanratty, B., Lowson, E., Grande, G., Payne, S., Addington-Hall, J.,**
10 **Valtorta, N., and Seymour, J. (2014) Transitions at the end of life for**
11 **older adults - patient, carer and professional perspectives: a mixed-**
12 **methods study.**

13 Linked to:

14 Hanratty, et al (2012) above

15 **Outline:** This is a good quality study [++], which explored the experiences of
16 transition from hospital to home for older adults in the last year of life, recently
17 bereaved family carers and practitioners. The data is supplemented with
18 hospital data and opinion surveys. This study incorporates the service user
19 views data from a previous study (Hanratty et al, 2012) and synthesises these
20 with the views of bereaved carers and practitioners. Therefore while this is a
21 separate study in that the data is combined and reveals new themes, the
22 population overlaps with the other study. Readers interested only in the views
23 of service users should refer to the 2012 paper.

24 **Results:** Thematic analysis of the synthesised views data for service users,
25 bereaved carers and practitioners revealed six themes. They were:

- 26 • An imperfect system with beacons of excellence
- 27 • Perspectives on the carer's role
- 28 • General practitioner and out-of-hours care
- 29 • Communication and expectations about death and dying
- 30 • Choice and the influence of personal finances

1 • Inter professional relationships

2 More detailed findings are reported against the relevant views and
3 experiences questions:

4 **2.1 (a) What do service users think works well, what does not work well
5 what could improve the transition from inpatient hospital settings to
6 community or care home settings? And**

7 **4 (a) What do health, social care and housing practitioners think works
8 well, what does not work well what could improve the transition from
9 inpatient hospital settings to community or care home settings?**

10 ***An imperfect system with beacons of excellence***

11 As found in the 2012 paper, older people at the end of life reserved criticisms
12 for the systems and processes and praise for individual members of staff. The
13 system that incorporated different funding streams could create tensions
14 between professionals and many expressed the preference for joint funding
15 wherever possible. Carers also suggested integrated IT systems would
16 facilitate easier transfers of information between care settings.

17 ***Perspectives on the carer's role***

18 There seems to be no shared understanding of the role of carers and their
19 expectations. Staff view carers either as patients in their own right or as a
20 resource to assist the professional in the delivery of care and/ or transition.
21 Carers themselves reported a need for more support and time allowed to
22 voice concerns, especially when moving from hospital to care home. A small
23 number of carers reported that the division between health and social care
24 was such that they could feel stranded between the two.

25 ***General practitioner and out-of-hours care***

26 Survey data from recently bereaved carers found that their experience of the
27 care they received was not well coordinated.

1 ***Communication and expectations about death and dying***

2 All groups of interviewees mentioned poor communication as being an issue.
3 When discussing transitions at the end of life, GPs reported having a good
4 relationship with service users and family carers as being essential to
5 providing appropriate care. GPs acknowledged that, while difficult to achieve,
6 being able to have honest conversations with patients and family carers was
7 the goal. However, survey data from bereaved carers reported that they
8 needed more help and support and more time to discuss their concerns.
9 Discussions about transitions between care settings often did not include
10 patients' wishes.

11 ***Choice and the influence of personal finances***

12 Financial resources could influence the nature and timing of transitions. Older
13 people in the last year of life who were living alone or without the support of
14 carers could find their choices greatly limited.

15 ***Inter professional relationships***

16 Practitioners also described a lack of sense of urgency in accessing services
17 across care settings for people at the end of their life resulting from different
18 ways of working and priorities.

19 "...time is of the essence in palliative care and so...trying to encourage
20 someone to see that actually no, next week is not good enough for this
21 particular patient, it may well be good enough for someone else, but not for
22 this person ...". (Hospice medical director, p47)

23 **3. Ingleton, C., Payne, S., Sargeant, A. and Seymour, J. (2009) Barriers to**
24 **achieving care at home at the end of life: transferring patients between**
25 **care settings using patient transport services.**

26 **Outline:** This is a highly relevant, good quality study [++] of the perceptions of
27 key stakeholders about how patient transport and local transport service
28 protocols impact upon patients' choices and place of care at the end of life.
29 The context for the research is the low proportion of people who are
30 supported to die in their preferred place. There is a concern that a lack of
31 available health and social care infrastructure limit efforts to increase the

1 numbers of deaths occurring at home. Transport services may be a
2 contributing factor. In response to this, Marie Curie launched the 'Delivering
3 Choice Programme' in three areas of the UK: Lincolnshire, Tayside and
4 Leeds. This paper reports qualitative data from a wider, 4-year evaluation
5 conducted in the three pilot areas. Data are reported from interviews with 44
6 patients, 19 carers, 20 bereaved carers and focus groups with specialist
7 nurses. The qualitative methods used in this study were judged appropriate.

8 **Results:** Findings are reported under the relevant views and experiences
9 questions.

10 **1.1 (a) What are the views and experiences of people using services, in**
11 **relation to the transition from inpatient hospital settings to community**
12 **or care home settings? (Note that data relates to transitions to and from**
13 **hospital, to and from the community and to and from hospices).**

14 Considerable distress is experienced by patients and carers by untimely or
15 inappropriate ambulance transfers (this is not primary data from a patient but
16 an observation by the authors).

17 **4 (a) What do health, social care and housing practitioners think works**
18 **well, what does not work well and what could improve the transition**
19 **from inpatient hospital settings to community or care home settings?**
20 **(Note that data relate to transitions to and from hospital, to and from the**
21 **community and to and from hospices).**

22 ***Does not work well***

23 Out of hours GPs. They were seen to be placed in difficult positions having
24 never previously met the patient and not necessarily having the full range of
25 information available about the patient. Having an out of hours GP triaging
26 life-threatening situations can often lead to inadvertent or unwanted
27 admissions to A&E.

28 There is a perceived lack of willingness of GPs and hospital consultants to
29 discuss 'do not attempt resuscitation' (DNAR) orders with patients and sign
30 them and this was observed to have distressing consequences for all

1 concerned, leading to difficulties when transporting patients. Nurse specialists
2 felt GPs and consultants did not understand the implication that without a
3 signed DNAR, ambulance crew will resuscitate patients en route from home to
4 hospice. Being told about a DNAR is not enough.

5 ***Could improve the transition***

6 The authors conclude that services should be responsive to the complexities
7 of patients' needs in this situation. Also, that interagency partnership is
8 needed to develop workable protocols that are safe and sensitive to patients
9 and end of life care provision. Finally, that education and training is required to
10 help GPs have difficult conversations about end of life decisions.

11 10 (a) What helps and what makes it difficult to ensure successful transitions
12 from inpatient hospital settings to community or care home settings? (Note
13 that data relate to transitions to and from hospital, to and from the community
14 and to and from hospices).

15 ***Makes it difficult***

16 A lack of continuity in out of hours GP provision was said to compound the
17 difficulties in facilitating patients' choice to die at home.

18 Distance and organisational boundaries were said to be a barrier to
19 transportation – often combined with poor road infrastructure in rural areas.

20 There were difficulties raised by both the presence and lack of 'do not attempt
21 resuscitation' (DNAR) orders. Without a DNAR order, some ambulance crews
22 reportedly refuse to transfer a patient from home to hospice or hospital. Even
23 if a DNAR order exists, its timing is critical. It has to be signed less than 48
24 hours before a planned or emergency ambulance is required.

25 Managing syringe drivers and other specialist medical equipment was viewed
26 as central to transferring patients between settings and home and potentially
27 problematic. Ambulance service protocols often require patients with syringe
28 drivers to be transferred using specially qualified crew – this can reduce the
29 flexibility to respond within a limited time period.

1 **What helps**

2 Nurses reported that the way round these restrictive protocols was to subvert
3 them. They described several ‘adaptive practices’, including hiding syringe
4 drivers under patients’ blankets and clothing and removing batteries from
5 syringe drivers for the ambulance journey. However the considerable
6 disadvantage of this was a delay in administration of subcutaneous
7 medication and consequently, a delay in symptom control.

8 The authors conclude that while offering people a choice about place of death
9 is laudable, appropriate service infrastructure including palliative care
10 sensitive protocols are needed to help make it a reality.

11 **4. Kusmaul, N. and Waldrop, D. (2011) The living-dying interval in**
12 **nursing home-based end-of-life care: family caregivers' experiences.**

13 **Outline:** This is a good quality study [++] of family members’ experiences with
14 a dying nursing home resident. In-depth interviews were conducted with 31
15 caregivers of residents who had died in the last 2 months. The paper includes
16 but is not limited to issues around hospitalisation from the nursing home and
17 transitions into the nursing home. The ‘living-dying interval’ is defined as the
18 period of time between the knowledge of an approaching death and the death
19 itself. This period is obviously relative but the authors describe three main
20 stages; (a) an acute crisis with peak anxiety (b) the chronic living – dying
21 phase, which can be certain or uncertain based on diagnosis and co-morbid
22 conditions and (c) the terminal phase. The living-dying interval was used in
23 this study as a framework for exploring family caregivers’ experiences around
24 a loved one’s death. Qualitative methods were used and these are judged
25 appropriate. According to the authors, this approach gave voice to
26 participants’ experiences.

27 **Results:** Findings are reported under the relevant views and experiences
28 questions.

29 **1.2 (b) What are the views and experiences of families and unpaid carers**
30 **in relation to the hospital admission process (including admission from**
31 **community or care home settings)? (Note that data relate to transitions**

1 **to and from hospital from the nursing home and initial nursing home**
2 **admission).**

3 Acute medical crises result in the need for nursing home placement, involving
4 poignant and emotional transitions. Residents and their loved ones had clearly
5 dealt with raw emotions during admission although in some cases, emotional
6 responses were delayed by uncertainty over whether or not the admission
7 would be permanent. In this context social workers can make an important
8 contribution (described below under 10a 'what helps').

9 In the time period between nursing home admission and death there were 3
10 elements with which carers were faced, one of which was hospitalisation.
11 When a resident's condition was rapidly deteriorating, family caregivers were
12 often asked whether or not they wanted a resident to return to the hospital. In
13 some cases, there was agreement not to hospitalize the resident, but in others
14 there was conflict between families and providers. Questions about
15 hospitalisation were accompanied by thoughts and feelings about how well
16 the nursing home would be able to manage the person's dying process.

17 **2.2 (b) What do families and unpaid carers think works well, what does**
18 **not work well, and what could improve the hospital admission process**
19 **(including admission from community or care home settings)?**

20 Families felt that aspects of the living-dying phase that worked well were;
21 individualized care based on continuing relationships with caregivers, effective
22 teamwork and advance care planning about prognosis, emotional preparation,
23 and appropriate use of medical treatments.

24 **10 (a) What helps and what makes it difficult to ensure successful**
25 **hospital admissions from community or care home settings? (Note that**
26 **data also relate to admissions to nursing homes from community**
27 **settings).**

28 In view of the emotion and uncertainty surrounding the admission process, it
29 was felt social workers could assist by providing important individual and
30 family interventions. Conversations with families about advance care planning,
31 hospitalization, and end-stage decision-making would help them recognise

1 that residents are approaching death. Chronicling the resident's decline may
2 also help clarify awareness.

3 **5. O'Brien, M. and Jack, B. (2010) Barriers to dying at home: the impact**
4 **of poor co-ordination of community service provision for patients with**
5 **cancer.**

6 Outline: This is a qualitative study of moderate quality [+]. It analyses data
7 from two focus groups that the authors ran with district nurses and community
8 specialist care nurses from across two primary care trusts in the UK.

9 Focusing on how problems in service provision can present barriers to
10 patients dying at home, the results show that poor discharge planning, and
11 difficulty in securing additional equipment and services together were both
12 contributing factors to hospital admissions for patients in the last few days and
13 hours of life. A qualitative approach, which enabled exploration of participants'
14 experiences and beliefs, was considered appropriate.

15 Results: Findings are reported under the relevant views and experiences
16 questions.

17 **3 (a) What are the views of health, social care and housing practitioners**
18 **about the transition from inpatient hospital settings to community or**
19 **care home settings?**

20 Merely identifying a need for end-of-life care is no guarantee that it can
21 actually be provided. Patients living alone may have needs greater than the
22 palliative care teams can accommodate.

23 It can be difficult to provide the necessary level of care; 24 hours-a-day care
24 cannot be guaranteed, especially during the daytime. Funding is often not the
25 issue because once funding is granted that does not change; rather, it is the
26 lack of suitably skilled staff within care agencies that can jeopardise the
27 situation.

28 The nurses stressed the ineffectiveness of the current system for arranging
29 discharge and criticised discharge planners who are supposed to co-ordinate
30 a patient's discharge home. Similarly, they felt that hospital staff would

1 sometimes make unrealistic promises about extensive community care
2 packages in order to fob off troublesome relatives of patients who were about
3 to be discharged.

4 **4 (a) What do health, social care and housing practitioners think works
5 well, what does not work well what could improve the transition from
6 inpatient hospital settings to community or care home settings?**

7 District nurses feel that hospital staff do not allow enough time to ensure that
8 they have organised and planned for the correct equipment, such as hospital
9 beds and pressure mattresses, to be ready when attempting to discharge a
10 patient home for the weekend. It is easier to arrange care at short notice, but it
11 is far more difficult to arrange the delivery of equipment, particularly if
12 discharge is intended on a Friday.

13 **10 (a) What helps and what makes it difficult to ensure successful
14 transitions from inpatient hospital settings to community or care home
15 settings?**

16 District nurses felt that they could address some of the difficulties experienced
17 if they were involved at an earlier stage in the discharge process. Community
18 nurses felt that if there was a bit more communication between themselves
19 and the ward staff they could overcome a lot of problems.

20 Sometimes referrals for something seemingly straightforward turn out to be a
21 palliative diagnosis, where the patient is actually dying. This lack of detail in
22 the information provided obviously exacerbates the problem.

23 ***Studies reporting evidence of cost effectiveness (n=2)***

24 Two UK RCTs examined the cost-effectiveness of multi-professional palliative
25 care teams for two sub-groups of the population covered in the scope.

26 The first (Higginson et al 2009, N=46, ++) showed that for people with
27 advanced MS a multi-professional palliative care team (similar to palliative
28 care consultation service but able to visit across settings) was likely to be
29 cost-effective because of lower costs (£1,789, 95%, -5,224 to 1,902); this was
30 largely because of reduced use of primary and acute care services; the study

1 evaluated the impact on unpaid care and found no significant difference.
2 There was no significant difference in the patient's primary outcome measured
3 via the Palliative Care Outcomes Scale (POS-8) at 12wks.; but there was a
4 significant reduction in the burden on caregivers (-2.88 and diff. to comparison
5 group of 4.47, CI 95%, 1.05-7.89) measured via the Zarit caregiver burden
6 interview (ZBI). In bootstrapping, with POS-8 as outcome, better outcomes
7 and lower costs occurred in 34% of replications and lower costs (without
8 improved outcomes) in 55% of replications. With ZBI as the outcome, lower
9 costs and better outcomes occurred in in 47% replications and higher costs
10 and better outcomes in 48% replications. According to these findings the
11 intervention was likely to be cost-effective although caution must be taken
12 because of the small sample size.

13 The second UK RCT (Higginson et al 2014, N=82) was of limited applicability
14 because the paper did not present sufficient detail on the evaluation of costs.
15 This was possibly because a paper with details on the economic evaluation
16 was still to be published. The quality of the study was expected to be high and
17 findings can inform the recommendations with some level of caution. Findings
18 of the study suggested that an integrated multi-professional palliative care
19 team for patients with advanced diseases and breathlessness achieved
20 significant improvements in breathlessness mastery (16%, mean diff. 0.58,
21 95% CI 0.01 to 1.15, $p < 0.05$, effect size 0.44), in statistically adjusted total
22 quality of life, on the Palliative care Outcomes scale (POS-8) and in survival
23 rate (50 of 53 [94%] vs 39 of 52 [75%]). None of the outcomes showed
24 deterioration. There was no significant difference in formal care costs at 6wks.
25 (£1,422, 95% CI 897–2101 vs. £1,408, 95% CI 899–2023) although the
26 authors reported that costs varied greatly between individuals. An
27 international literature review of economic studies carried out in the UK (Smith
28 et al 2014, -) showed that most types of generic palliative care compared with
29 non-palliative care were likely to achieve cost savings. Although the review
30 was assessed as insufficiently applicable in economic appraisal some of the
31 findings were still relevant and could inform recommendations on potential
32 cost savings (see the economic report for full details).

1 Evidence statements (including economic evidence statement)

ELC1	There is a moderate amount of evidence of good quality from 3 qualitative studies that a lack of health and social care infrastructure is responsible for poor quality hospital discharges for people with end of life care needs, including limiting people's choice about place of death. A UK study (Hanratty, 2012) [++] found that patient's social care needs were ignored when support packages were being established for discharge home. One UK paper (Ingleton, 2009) [++] found that ambulance service protocols sometimes prevent patients being transferred from home to hospice or hospital. Finally, one UK qualitative study (O'Brien and Jack, 2010) [+] reported that hospital staff failed to allow for essential equipment to be installed in the home before a transfer from hospital occurs.
ELC2	There is a moderate amount of good quality evidence from 1 mixed methods study and 2 qualitative studies that transitions would be improved if time were dedicated to discussions with patients and families about end of life preferences. Wishes surrounding resuscitation and place of death were seen as particularly important. One mixed methods study (Hanratty, 2014) [++] reported that carers wanted more help and support to discuss concerns and patients wishes were not accounted for in transitions planning. One UK qualitative study (Ingleton, 2009) [++] reported reluctance on the part of GPs and hospital consultants to discuss DNAR orders and training in that area is required. One US qualitative study (Kusmaul and Waldrop, 2011) [++] identified a key role for social workers to discuss advanced care planning and hospitalization with families of nursing home residents during the living-dying interval.
ELC3	There is a small amount of evidence of moderate to good quality that improved communication, between services and between services, patients and families, would facilitate more successful discharge and improve the experiences of patients and families. One UK qualitative study (O'Brien and Jack, 2010) [+] reported that community nurses would be able to ensure necessary equipment was in place to support a transfer from hospital to home if ward staff communicated with them far earlier in the discharge planning process. Another UK qualitative study (Hanratty, 2012) [++] reported communication failures between hospital and community services and a perception among carers that professionals did not respond to their questions or explain the rationale for transitions.
ELC4	There is a small amount of evidence of good quality that out of hours GP services can cause particular problems in the transition process for people with end of life care needs. One UK qualitative study (Hanratty, 2014) [++] reports that the involvement of out of hours GPs makes service provision seem uncoordinated and another (Ingleton, 2009) [++] found that when out of hours GPs made uninformed decisions about patients, this resulted in inadvertent or unnecessary transition into hospital.
ELC5	There is a small amount of evidence from one study of moderate quality that the provision of a specialist inpatient palliative care service can significantly improve outcomes for people with end of life care needs. The controlled retrospective US study of hospital data (Brody, 2010) [+] found that patients seen by the specialist service were significantly more likely to be transferred home with services or to a hospice during the end of life phase.
ELC6	No evidence was found from studies published since 2003 about the following interventions to support people with end of life care needs during transition: reablement, telecare, occupational therapy, physiotherapy,

	nutrition support and befriending services.
Ec7	Multi professional palliative care teams were found to be cost effective, albeit with some caution. Two UK RCTs found that specialist palliative interventions were found likely to be cost-effective. One small, high quality UK economic evaluation (Higginson et al 2009, ++) showed that specialist palliative care intervention provided for people with multiple sclerosis was likely to be cost effective. Another UK economic evaluation (Higginson et al 2014, +) targeted at people with uncontrolled breathlessness confirmed the likely cost-effectiveness of specialist palliative care. In both studies specialist palliative care referred to a multi-disciplinary palliative care team. Wider economic evidence confirmed the likely cost-effectiveness of palliative care teams. In addition, a wide range of non-UK studies showed that most types of generic palliative care compared with non-palliative care were likely to achieve cost savings (for details on wider economic evidence see the economic report).

1

2 ***Expert witness testimony***

3 **The need for expert testimony**

4 In light of these limitations of the evidence in this review area, the Guideline
5 Committee agreed to try and supplement the impact data through inviting an expert
6 witness. Members were looking for the witness to present evidence relating to the
7 costs and outcomes of an innovative service or intervention aimed at improving
8 transitions at the end of life for adults with social care needs.

9 In summary the Committee sought evidence on the following aspects of end of life
10 care to enable them to formulate additional recommendations or add weight to those
11 already drafted:

- 12 • The effectiveness and cost effectiveness of different approaches
13 or services for supporting or improving end of life transitions
14 (with a specific focus on social care input)
- 15 • Collaborative working
- 16 • Information sharing
- 17 • Support for carers in the context of end of life transitions
- 18 • End of life transitions involving care homes
- 19 • Reducing hospital readmissions (within 30 days)

20

21

1 **Testimony**

2 The full testimony from the expert witness can be found in appendix D. In
3 brief, the witness discussed the issues that can cause delays or problems
4 during transitions for people end of life care needs. These include: poor
5 communication, assumptions that family members will look after the person,
6 bed shortages or the person leaves against medical advice. Staff can also feel
7 under pressure, especially if bed occupancy is high, to discharge people
8 quickly as this can often be the case when people who are classed as
9 medically fit may have little notice to make arrangements or adjustments for
10 them to return home. Staff may also not fully understand referral processes
11 and time required to arrange for a person's needs to be addressed whether
12 within their own home or moving to a care home. Access to equipment is also
13 problematic. Finally, the witness presented on access to health and social
14 care services and the availability of funding.

15

16 **Included studies for the end of life care review questions (full citation)**

17 Brody A, Ciemins E, Newman J, et al. (2010) The effects of an inpatient
18 palliative care team on discharge disposition. *Journal of Palliative Medicine*
19 13: 541–8

20 Higginson IJ, McCrone P, Hart SR, et al. (2009), Is short-term palliative care
21 cost-effective in multiple sclerosis? A randomized phase II trial. *J Pain*
22 *Symptom Manage* 2009; 38: 816–826.

23 Higginson IJ, Bausewein C, Reilly CC, Gao W, Gysels M, Dzingina M,
24 McCrone P, Booth S, Jolley CJ, Moxham, J (2014), An integrated palliative
25 and respiratory care service for patients with advanced disease and refractory
26 breathlessness: a randomised controlled trial' *The Lancet. Respiratory*
27 *medicine*, 2 (12): 979-987.

28 Hanratty B, Holmes L, Lawson E (2012) Older adults' experiences of
29 transitions between care settings at the end of life in England: A qualitative
30 interview study. *Journal of Pain and Symptom Management* 44: 74–83

1 Hanratty B, Lowson E, Grande G et al. (2014) Transitions at the end of life for
2 older adults - patient, carer and professional perspectives: a mixed-methods
3 study. *Health Services and Delivery Research* 2 (17): 1–130

4 Ingleton C, Payne S, Sargeant A et al. (2009) Barriers to achieving care at
5 home at the end of life: transferring patients between care settings using
6 patient transport services. *Palliative Medicine* 23: 723–30

7 Kusmaul N and Waldrop D (2011) The Living–Dying Interval in Nursing Home-
8 Based End-of-Life Care: Family Caregivers' Experiences. *Journal of*
9 *Gerontological Social Work* 54: 768–87

10 O'Brien M and Jack B (2010) Barriers to dying at home: the impact of poor co-
11 ordination of community service provision for patients with cancer. *Health and*
12 *Social Care in the Community* 18: 337–45

13 Smith S, Brick A, O'Hara S, Normand C (2014), Evidence on the cost and
14 cost-effectiveness of palliative care: a literature review, *Palliative Medicine*
15 28:130-50.

16 **3.3 Improving the hospital admission process**

17 **Introduction to the review questions**

18 The purpose of these review questions was to examine the effectiveness and
19 cost effectiveness of different approaches to care planning and assessment
20 during admission to inpatient hospital settings from community or care home
21 settings. The questions also aimed to consider research which systematically
22 collected the views of people using services, their carers, and care and
23 support staff in relation to the hospital admission process.

24 A good amount of evidence both from studies of views and experiences and
25 studies of effectiveness, were located and reviewed for this review area. The
26 included studies of views and experiences were mainly good quality although
27 most were from outside the UK on the basis that UK studies were lacking and
28 the experiences and views described in the non-UK studies were judged to be
29 transferable. The studies of effectiveness were of mainly moderate quality.

1 Notably, all effectiveness studies related to admission processes involving
2 older people, none focussed on younger adults.

3 **Review question for evidence of effectiveness**

4 5. How do different approaches to care planning and assessment affect the
5 process of admission to inpatient hospital settings from community or care
6 home settings?

7 **Review questions for evidence of views and experiences**

8 Review questions 1-4 and question 10, listed on pages 2-3, were applied
9 specifically in relation to the hospital admission process.

10 **Summary of review protocol**

11 The protocol sought to identify studies that would:

- 12 • Identify different approaches to care planning and assessment during
13 admission to inpatient hospital settings from community or care home
14 settings and the ways in which they improve outcomes and experiences.
- 15 • Identify emerging models of coordinated assessment and care planning
16 approaches and associated outcomes.

17 For the views and experiences review questions, the protocol sought to
18 identify studies, specifically relating to mental health transitions that would:

- 19 • Describe the self-reported views and experiences of adults with social care
20 needs, their families and unpaid carers about the care and support they
21 receive during transition to inpatient hospital settings.
- 22 • Highlight aspects of care and support during the admission process that
23 work well, as perceived by service users, their families and unpaid carers
24 and aspects of care and support during admission to hospital, which are
25 perceived not to work well.
- 26 • Describe the views and experiences of people delivering, organising and
27 commissioning social care, health and housing services.
- 28 • Highlight aspects of the hospital admission process, which work well, and
29 are personalised and integrated, as perceived by practitioners, managers

1 and commissioners and aspects of admission, which should be changed to
2 improve the transition.

- 3 • Contextualise the views of users, carers and practitioners by identifying
4 barriers and facilitators to improved or changed practice they suggest
5 would improve outcomes relating to the hospital admission process.

6 **Population:** Adults aged 18 years and older, who are transferring to inpatient
7 hospital settings from community or care home settings, and their families,
8 partners and carers. Self-funders and people who organise their own support
9 and who are experiencing a hospital admission are included.

10 Housing practitioners, social care practitioners (providers, workers, managers,
11 social workers), and health and social care commissioners involved in
12 delivering social care to people during admission to hospital from community
13 or care home settings, or intermediate care units; personal assistants
14 engaged by people with social care needs and their families. General practice
15 and other community-based healthcare practitioners.

16 **Intervention:** Personalised and integrated assessment and admission
17 processes. Usual treatment compared to the effectiveness of an innovative
18 intervention.

19 **Setting:** Inpatient hospital settings, (“step up”) bed-based intermediate care
20 settings and service users’ home, including sheltered housing
21 accommodation; supported housing; temporary accommodation; care
22 (residential and nursing) homes.

23 **Outcomes:** User and carer related outcomes (such as user and carer
24 satisfaction; quality and continuity of care; choice and control; involvement in
25 decision-making about place of death) and service outcomes such as use of
26 health and social care services, delayed transfers of care, rates of hospital re-
27 admissions within 30 days and length of stay in inpatient hospital settings (see
28 4.4 in the Scope).

1 User satisfaction; quality and continuity of care; choice and control;
2 involvement in decision-making; dignity and independence; quality of life;
3 health status; safety and safeguarding

4 The study designs included for the effectiveness questions on the hospital
5 admission process were:

- 6 • Systematic reviews of studies of different approaches to hospital
7 admission, care planning and assessment;
- 8 • Randomised controlled trials of different approaches to assessment, care
9 planning and admission processes;
- 10 • Controlled studies of different approaches to assessment, care planning
11 and admission processes;
- 12 • Economic evaluations.

13 The study designs relevant to the views and experiences questions were
14 expected to include:

- 15 • Systematic reviews of qualitative studies on this topic;
- 16 • Qualitative studies of user and carer views of social and integrated care;
- 17 • Qualitative components of effectiveness and mixed methods studies;
- 18 • Observational and cross-sectional survey studies of user experience.

19 Full protocols can be found in Appendix A.

20 **How the literature was searched**

21 Electronic databases in the research fields of social care, health, economics
22 and social science were searched using a range of controlled indexing and
23 free-text search terms based on the facets of: the state of transition (service
24 user/patient transfer or admission or discharge), settings (inpatient hospital or
25 community or care home settings) and health and social care needs,
26 workforce or intervention.

27 The search aimed to capture both journal articles and other publications of
28 empirical research. Additional searches of websites of relevant organisations
29 were also carried out.

1 The search for material on this topic was carried out within a single broad
2 search strategy used to identify material which addressed all the agreed
3 review questions on the transition between inpatient hospital settings and
4 community or care home settings for adults with social care needs. The
5 searches were restricted to studies published from 2003 in order to
6 incorporate the Community Care (Delayed Discharges) Act 2003. Generic and
7 specially developed search filters were used to identify particular study
8 designs, such as systematic reviews, randomised controlled trials, economic
9 evaluations, cohort studies, mixed method studies and personal narratives.
10 The database searches were not restricted by country.

11 Full details of the search can be found in Appendix A.

12 **How studies were selected**

13 Search outputs (title and abstract only) were stored in EPPI Reviewer 4 - a
14 software programme developed for systematic review of large search outputs
15 - and screened against an exclusion tool informed by the parameters of the
16 scope. Formal exclusion criteria were developed and applied to each item in
17 the search output, as follows:

- 18 • Language (must be in English),
- 19 • Population (must be over 18 years of age and have a social care need)
- 20 • Transition (a transition into or out of an inpatient hospital setting must have
21 occurred within the last 30 days)
- 22 • Intervention (must be involved in supporting transitions)
- 23 • Setting (inpatient hospital setting, intermediate care setting, community
24 setting or care home)
- 25 • Country (must be UK, European Union, Denmark, Norway, Sweden,
26 Canada, USA, Australia and New Zealand)
- 27 • Date (not published before 2003)
- 28 • Type of evidence (must be research)
- 29 • Relevance to (one or more) review questions.

1 Title and abstract of all research outputs were screened against these
2 exclusion criteria. Those included at this stage were marked for relevance to
3 particular review questions and retrieved as full texts.

4 Full texts were again reviewed for relevance and research design. If still
5 included, critical appraisal (against NICE tools) and data extraction (against a
6 coding set developed to reflect the review questions) was carried out. The
7 coding was all conducted within EPPI Reviewer 4, and formed the basis of the
8 analysis and evidence tables. All processes were quality assured by double
9 coding of queries, and of a random sample of 10%.

10 In our initial screen (on title and abstract), we found 101 studies, which
11 appeared relevant to the review questions on the hospital admission process.
12 We ordered full texts and reviewed 51 papers for final inclusion. For views and
13 experiences research, studies from a UK setting were prioritized.
14 Effectiveness studies were restricted to systematic reviews, randomized
15 controlled trials or controlled studies. On reviewing the full texts, we identified
16 12, which fulfilled the criteria, one of which provided economic evidence. The
17 included studies (see below) were critically appraised using NICE tools for
18 appraising different study types, and the results tabulated. Further information
19 on critical appraisal is given in the introduction at the beginning of Section 3.
20 Study findings were extracted into findings tables. For full critical appraisal
21 and findings tables, see Appendix B.

22 **Narrative summaries of the included evidence**

23 ***Studies reporting effectiveness data (n=6)***

24 **1. Eklund, Kajsa; Wilhelmson, Katarina; Gustafsson, Helena;**
25 **Landahl, Sten; Dahlin-Ivanoff, Synneve; (2013) One-year outcome of**
26 **frailty indicators and activities of daily living following the randomised**
27 **controlled trial; "Continuum of care for frail older people"**

28 **Outline:** This is a moderate quality [+] randomised control trial which
29 measured the effects of the "Continuum of Care for Frail Older People"
30 intervention on functional ability in terms of activities of daily living (ADL) and
31 a composite measure of frailty. The intervention applied a person-centred

1 approach with shared decision-making throughout the care chain. Participants
2 in the intervention group (n=85) received collaborative care from a nurse with
3 geriatric competence at the emergency department, the hospital wards, and a
4 multi-professional team for care and rehabilitation of older people in the
5 municipality with a case manager as the hub. Together a continuum of care
6 was created for the older person from the emergency department, through the
7 hospital ward and on to their own homes.

8 **Results:**

- 9 • The 'Continuum of care for frail older people' intervention succeeded in
10 both improving ADL independence among its participants up to one year,
11 and in postponing dependence in ADL up to six months.
- 12 • At both three- and twelve-month follow-ups the intervention group had a
13 higher odds ratio (OR) in improved degree of ADL independence.
- 14 • Improved ADL
 - 15 • 3 months 42% OR 2.37 (95% CI; 1.20 - 4.68)
 - 16 • 6 months 36% OR 1.50 (95% CI; 0.77-2.94)
 - 17 • 12 months 39% OR 2.04 (95% CI; 1.03 - 4.06)
- 18 • At 6 months the intervention group maintained ADL independence at a
19 higher rate than the control group:
 - 20 • Maintained ADL
 - 21 • 3 months 38% OR 0.79 (95% CI; 0.42 -1.48)
 - 22 • 6 months 32% OR 1.30 (95% CI; 0.66 - 2.59)
 - 23 • 12 months 24% OR 0.76 (95% CI; 0.37 – 1.53)
 - 24 • At 6 months, the intervention group were less likely to have a decreased
25 ADL independence; however this was not maintained at 12 months:
 - 26 • Decreased ADL
 - 27 • 3 months 20% OR 0.51 (95% CI;0.25–1.04)
 - 28 • 6 months 31% OR 0.52 (95% CI;0.27–0.98)
 - 29 • 12 months 38% OR 0.67 (95% CI;0.36–1.26)
- 30 • There did not appear to be any differences between the groups with
31 regards to change in frailty as a result of the intervention.

32

1

2 **2. Ellis G, Whitehead MA, O'Neill D, Langhorne P, Robinson D.**
3 **Comprehensive geriatric assessment for older adults admitted to**
4 **hospital. Cochrane Database of Systematic Reviews 2011, Issue 7. Art.**
5 **No.: CD006211. DOI: 10.1002/14651858.CD006211.pub2.**

6 **Outline:** This was a good quality [++] highly relevant Cochrane systematic
7 review that included 22 randomized controlled trials. Participants were adults
8 aged 65 or older who were admitted to hospital care as an emergency,
9 including all unplanned, unscheduled, or acute presentations. Studies were
10 also stratified into those delivered by mobile geriatric teams in general wards
11 (teams) and those delivered by dedicated geriatric wards. Both settings of
12 geriatric assessment were compared to usual care, which mostly involved
13 admission to a general medical ward setting under the care of a non-
14 specialist. Included studies were from Australia, Canada, Germany, Norway,
15 Sweden and the US.

16 The primary outcome of interest to the review were odds ratios of living at
17 home at the end of the scheduled follow up (median 12 months) and is the
18 inverse of the measures for death or admissions to a residential care home
19 combined.

20 Secondary outcomes measured were death, living in residential care, death or
21 deterioration, cognitive status, mortality, dependence (defined from measures
22 of daily living), death or dependence, activities of daily living, readmissions,
23 length of stay in hospital and use of resources.

24 **Results:**

25 ***Primary outcome findings***

26 The review found that comprehensive geriatric assessment increased
27 patients' likelihood of being alive and in their own homes after an emergency
28 admission to hospital. A stronger effect was found for comprehensive geriatric
29 assessment delivered in geriatric wards rather than mobile teams, and this
30 became more pronounced at 6 months.

1 **Secondary outcomes findings**

- 2 • Comprehensive geriatric assessment decreased the likelihood of patients
3 living in residential care after an emergency admission to hospital, both in
4 the interim and the scheduled follow-ups. A stronger effect was found for
5 comprehensive geriatric assessment delivered in geriatric wards rather
6 than mobile teams at the scheduled follow-up but not at 6 months.
- 7 • The findings for the outcome of death or deterioration showed a significant
8 reduction for the comprehensive geriatric assessment groups compared to
9 usual care, but there was no significant difference between wards and
10 teams.
- 11 • There was a benefit of comprehensive geriatric assessment compared to
12 usual care on the measure of cognitive function, but again no significant
13 difference between groups.
- 14 • There was no significant difference in mortality between comprehensive
15 geriatric assessment and usual care and no difference between groups.
- 16 • There was no significant difference between comprehensive geriatric
17 assessment and usual care on measures of dependence or death and
18 dependence. Data was not available for teams on measures of
19 dependence so these could not be compared.
- 20 • There was no significant difference in activities of daily living or
21 readmission to hospital between comprehensive geriatric assessment and
22 usual care and no difference between groups. No comparisons were made
23 on length of stay given the high heterogeneity of the studies.
- 24 • Within ward and team based subgroups, there was no significant in-group
25 difference.
- 26 • For use of resources, please see the cost-effectiveness results below.

27 **3. Fox, M., Persaud, M., Maimets, I., O'Brien, K., Brooks, D., Tregunno, D.**
28 **and Schraa, E. (2012) Effectiveness of acute geriatric unit care using**
29 **acute care for elders' components: A systematic review and meta-**
30 **analysis**

31 **Outline:** This is a good quality [++] systematic review of moderate relevance
32 to this review area. It compares the effectiveness of acute geriatric unit care,

1 based on all or part of the Acute Care for Elders (ACE) model and introduced
2 in the acute phase of illness, with that of usual care. Dedicated geriatric units
3 provide prepared environments for older patients admitted into hospital and
4 are based on rehabilitation and function-focused model of care designed
5 specifically to prevent functional decline and related complications. Included
6 papers were from Sweden, USA, Spain, Australia, France and Peru. This
7 paper has already been presented at GDG 6 in response to the 'hospital
8 discharge' question; however, the reviewers felt that it was also relevant to the
9 'admission process' review area.

10 **Results:**

11 Individuals receiving acute geriatric unit care experienced:

- 12 • Fewer falls (risk ratio) RR = 0.51, 95% confidence interval (CI) = 0.29–0.88)
- 13 • Less delirium RR= 0.73, 95% CI = 0.61–0.88)
- 14 • Less functional decline between their baseline 2 week pre-hospital
15 admission status and discharge (RR = 0.87, 95% CI = 0.78–0.97; p= 0.01)
16 than those receiving usual care
- 17 • Shorter length of hospital stay (weighted mean difference (WMD) = -0.61,
18 95%CI = -1.16 to -0.05, with outliers removed; significant difference with
19 outliers included)
- 20 • Fewer discharges to a nursing home (RR = 0.82, 95% CI = 0.68–0.99, with
21 outliers removed; no significant difference with outliers included)
- 22 • Lower costs (WMD = -\$245.80, 95% CI = -\$446.23 to -\$45.38, with outliers
23 removed; significant difference with outliers included)
- 24 • More discharges to home (RR = 1.05, 95% CI = 1.01–1.10)
- 25 • Fewer pressure ulcers (RR = 0.49, 95% CI = 0.23 to 1.04). A non-
26 significant trend toward fewer pressure ulcers was observed.
- 27 • No differences were found in functional decline between baseline hospital
28 admission status and discharge, mortality, or hospital readmissions.

1 **4. LaMantia, M., Scheunemann, L., Viera, A., Busby-Whitehead. J. and**
2 **Hanson, L. (2010) Interventions to improve transitional care between**
3 **nursing homes and hospitals: a systematic review.**

4 **Outline:** This is a moderate quality [+] systematic review. It aimed to evaluate
5 interventions designed to improve communication of medication lists and
6 advance directives for people over 65 transferring between nursing homes
7 and hospitals. Five studies met the inclusion criteria and of these, three were
8 about admission to hospital from a nursing home and two were about the
9 transfer of care from hospital to a nursing home. Therefore only three of the
10 studies fell within the scope of this review area. All three were from the USA.
11 Two of them studied the use of a patient transfer sheet on admission to
12 hospital and the other reviewed the use of a prospective order form for life
13 sustaining treatment. The heterogeneity of the studies precluded meta-
14 analysis of the results of the review.

15 **Results:** Use of a one-page transfer document, developed by community
16 members, nursing home staff, nurses and physicians, with the aim of
17 improving the transition from nursing home to a university hospital emergency
18 department (Madden et al, 1998) is attributed to the following findings:

- 19 • Of 41 providers [nurses and physicians] surveyed, 88% said the list of
20 medications included in the transfer form made providing care to these
21 elderly patients “a lot easier” than before.
- 22 • It also saved a significant amount of time, with 56% of the staff reporting
23 needing more than 10 minutes to collect data in patients without forms and
24 93% requiring less than 5 minutes to collect data on patients with forms.
- 25 • 234 patients (55.7% of the study population) had a do not resuscitate
26 (DNR) preference recorded on their transfer form and 156 patients had
27 indications of whether they had a living will recorded on their transfer form.
28 However, "rates of provider awareness of DNR orders or living will forms
29 were not recorded before this intervention, so it is unclear whether the
30 intervention improved communication of this information." (p780)

31 Use of a physician order form for life sustaining treatment for end-of-life care
32 residents in eight nursing homes is attributed to the following findings. The

1 study population, which was followed for 12 months, had indications of 'DNR'
2 on their forms and 'to transfer only if comfort measures fail' (Tolle et al, 1998):

- 3 • "Over the course of a year, there were 26 instances in which patients who
4 had requested to be transferred only if comfort measures failed were
5 transferred to the hospital. Of these 26 cases, 22 (85%) were to pursue
6 more aggressive comfort measures, and four (15%) were to pursue life-
7 extending therapies. None of these 26 cases was admitted to an intensive
8 care unit, intubated, or received CPR."
- 9 • "Of the patients who died, 95% died in their nursing home. However rates
10 of hospitalization, intensive care unit admission, ventilator use, or CPR
11 administration were not reported for this population before the intervention."

12 Use of a one-page transfer form for nursing home patients transferring to an
13 emergency department is attributed to the following findings. Information on
14 the form included name and demographic info, the patient's usual mental and
15 physical status, reason for transfer and the patient's DNR status. The
16 presence of pieces of medical information in patients' charts was assessed for
17 three months pre and post intervention. Successful documentation was
18 defined as 'at least 9 of 11 pieces of medical information' (Terrell, 2005):

- 19 • Successful documentation increased from 58.5% to 77.8% with use of
20 the transfer form, and the rate of documentation of DNR status rose from
21 64.6% to 87.5%.

22 Overall, the review identified no intervention that clearly improved the
23 communication of accurate and appropriate medication lists between nursing
24 homes and hospitals. The review found that two unique transfer documents
25 facilitated the transfer of advance directive information from long-term care to
26 emergency departments (Terrell, 2005 and Madden, 1998), although these
27 studies did not report the accuracy of information transfer.

1 **5. Manderson et al (2012) Navigation roles support chronically ill older**
2 **adults through healthcare transitions: a systematic review of the**
3 **literature.**

4 **Outline:** This is a moderate quality [+] systematic review of randomized
5 control trials pertaining to navigator models, which support chronically ill older
6 adults undergoing healthcare transitions. Fifteen articles describing nine
7 discreet studies on navigator models relevant to chronic disease management
8 for older adults in transition were included in the review; the potential impact
9 of each model was examined and the findings were synthesized to identify
10 common elements. Included studies were from the US, Canada and Australia.
11 The mode of enquiry was exploratory. The authors reiterate that the navigator
12 role is still in its infancy and look for elements common to successful
13 interventions.

14 **Results:**

- 15 • The studies demonstrated mixed support for the effectiveness of navigation
16 roles for older adults with at least one chronic illness. Although two studies
17 showed little to no positive effect (Gagnon et al. 1999, Mayo et al. 2008),
18 the corresponding study interventions as described were more passive
19 than the other models reviewed; both initiated care at either discharge or
20 after, rather than on admission.
- 21 • Some evaluation studies have revealed an 'investment effect' (Toseland et
22 al. 1997) where benefits of the intervention are not seen in the short-term,
23 but are evident in longer term follow-up.
- 24 • Of the nine navigator programmes identified, five reported positive
25 economic outcomes, two reported higher satisfaction with care for
26 providers and patients, and five reported increased patient quality of life or
27 functionality.
- 28 • Recommended elements for navigator programmes serving chronically ill,
29 multi-morbid, older adults were found to be:
 - 30 – Qualifications for practitioners: Post-secondary healthcare training
31 (Registered Nurses or Master's degree in Social Work depending on
32 population); advanced gerontological training

- 1 – Responsibilities: Early discharge planning (if transitioning from hospital);
2 skilled home visits and/or phone support/availability; medication
3 management; care or treatment planning; service or care provider
4 access and coordination; patient advocacy to remove barriers to care;
5 patient and caregiver education; assessment and management of health
6 status; collaboration with healthcare providers; being part of a
7 multidisciplinary team.

8 **6. Mudge, A., Denaro, C. and O'Rourke, P. (2012) Improving hospital**
9 **outcomes in patients admitted from residential aged care: results from a**
10 **controlled trial.**

11 **Outline:** This is a moderate quality [+] study which compares characteristics
12 and outcomes of acute medical inpatients admitted from residential aged care
13 facilities (RACF) and the community. The aim was to measure the impact of
14 an interdisciplinary care intervention on outcomes of residential aged care
15 facility residents admitted acutely to general medical wards. Group
16 assignment was non-randomised, but participant characteristics were similar
17 between groups, and neither clinical nor research staff could influence group
18 allocation, which was a purely administrative decision.

19 The intervention tested the effectiveness of an allied health team, which made
20 an assessment and commenced discharge planning upon admission. Other
21 components of the intervention included: daily “board rounds”; mandatory
22 attendance for allied health and junior medical staff, twice weekly consultant
23 attendance; specialty discharge facilitator attended team meetings, and allied
24 health team estimated discharge date within 24 hours of admission.

25 **Results:**

- 26 • Patients from residential aged care allocated to the intervention had
27 dramatically reduced in-hospital mortality (4.1 versus 22.1%, $P < 0.001$),
28 and – importantly - this difference was sustained at 6 months (28.2 versus
29 44.2%, $P = 0.02$).
- 30 • 6-month readmissions (32.7 versus 22.4%, $P = 0.15$) and bed day use
31 (14.7 versus 12.3 days, $P = 0.24$) were non-significantly increased.

- 1 • The findings suggest that in-hospital mortality in hospitalised residential
2 aged care patients is poor partly because the usual model of medical ward
3 care does not meet their complex needs. Interdisciplinary care resulted in
4 similar in-hospital mortality rates for RAC residents as for community-
5 dwelling older people.

6 ***Studies reporting views and experiences data (n=6)***

7 **1. Cheah, S. and Presnel, S. (2011) Older people's experiences of acute**
8 **hospitalisation: An investigation of how occupations are affected**

9 **Outline:** This is a good quality [++] study of older people's experience of
10 acute hospitalization. Conducted in Australia, the methods involved face-to-
11 face, one to one interviews with 6 people plus observations of patient care.
12 The authors aimed to investigate the effect of acute hospitalisation on older
13 people's occupations, the meaning of any changes in occupation, as
14 perceived by older people and the influence of the hospital environment on
15 older people's abilities to engage in meaningful occupation. Study participants
16 had been admitted for a number of reasons including chest pain, gallbladder
17 removal and COPD. They were all admitted to hospital from the community,
18 as opposed to an 'institutionalised environment'.

19 **Results:** Findings are reported under the relevant views and experiences
20 questions.

21 **1.1 (b) What are the views and experiences of people using services, in**
22 **relation to the hospital admission process (including admission from**
23 **community or care home settings)?**

24 Respondents described hospital as an alien environment. They recalled their
25 lives pre admission as being full of meaning. This contrasted with life in
26 hospital, which lacked meaning and purpose and mainly comprised of waiting
27 for medical professionals and test results, "When you're home ... you're able
28 to do more. I go walking in a lovely environment, which [I] get a lot of
29 enjoyment from. Whereas walking here, you're just walking to get the exercise
30 and build up your fitness." (p123) People felt alienated by the impact of the
31 hospital on the individual's sense of routine. This was experienced either as a

1 lack of routine, a feeling of a forced routine or a routine dependent on the
2 availability of the staff. The authors conclude that these experiences amount
3 to a form of 'occupational deprivation', seen in the amount of non-occupation,
4 'waiting'. They believe that the lack of meaning in occupations in hospital has
5 profound implications for occupational therapy, "With occupational
6 performance de-contextualised from normal life, it is difficult to see how the
7 assessment of performance in the (further decontextualised) environment of
8 functional assessment might be regarded as a direct surrogate for actual
9 performance." (p126)

10 In spite of hospital being undesirable, respondents recognized the purpose it
11 serves, namely as a place to receive treatment for their health condition, "I'd
12 like to go home but...I know I'm in a good place. And if someone's going to try
13 and cure me, or work out what the problem is, it's in here, it's not at home."
14 (p124) The authors conclude that this "...highlights the importance of patient
15 education and collaborative treatment planning early in the individual's
16 admission."

17 **2.1 (b) What do people using services, think works well, what does not**
18 **work well, and what could improve the hospital admission process**
19 **(including admission from community or care home settings)?**

20 ***Works well***

21 The prospect of recovery and returning to life as it was pre admission was the
22 most frequently mentioned motivator. Patients readily engaged in activities
23 and exercises because they were seen as a means of becoming strong
24 enough to return home. The authors conclude that with this imagined future
25 shaping engagement in activities, "this suggests that if the therapist is to
26 understand an individual's occupational performance, a detailed consideration
27 of the individual's projected future (as well as his/her experienced past) must
28 be included in the process of assessment." (p127)

29 ***Does not work well***

30 Patients realised that relationships and cooperation with staff were
31 fundamental to re-engage with occupations and working with nursing staff

1 helped motivate patients. However, staff routines and workload often meant
2 they were unavailable to help patients and this was frustrating "I'm out and
3 about a lot, and I have my independence. And that's the big thing; here you're
4 not independent. It's ... sometimes you have to fight for it, sometimes it's just
5 the circumstances don't allow it." (p125)

6 ***Could improve admission***

7 Although professionals' opinions were highly regarded, better communication,
8 especially by doctors, could improve the hospital experience. Patients felt
9 uninformed because doctors would appear, make decisions about their health
10 and then move on: "They often sweep in with a little entourage and then they
11 – they pontificate and then they sweep out again (laughs) ... before you can
12 ask a question." (p125)

13 **2. Parke, B., Hunter, K., Strain, L., Marck, P., Waugh, E. and McClelland, 14 A. (2013) Facilitators and barriers to safe emergency department 15 transitions for community dwelling older people with dementia and their 16 caregivers: A social ecological study**

17 Outline: This high quality [++] qualitative study consisted of three iterative,
18 interrelated phases: interviews, creating a photographic narrative journal
19 (PNJ), and photo elicitation focus groups. The aim of the study was to draw on
20 the views of 10 older adult/ family caregiver dyads and 14 healthcare
21 professionals (10 emergency department registered nurses and 4 nurse
22 practitioners) to identify factors that facilitate or impede safe transitional care
23 for community dwelling older adults with dementia. The study design was
24 rigorous; however the efforts to hear the voices of the individuals with
25 dementia were hampered by the effect of the disease on the older adult's
26 stamina and their ability to participate in interview and focus groups. For
27 example, after initially agreeing to participate in the focus group, 4 older adults
28 elected not to take part, resulting in a caregiver only focus group.

29 Results: Findings are reported under the relevant views and experiences
30 questions.

1 **1.1(b) What are the views and experiences of people using services, in**
2 **relation to the hospital admission process (including admission from**
3 **community or care home settings)?**

4 An older adult with early to mid-stage Alzheimer's disease described the
5 emergency department as a rushed, chaotic place, which made him feel
6 'panicky'.

7 **2.2 (b) What do families and unpaid carers think works well, what does**
8 **not work well, and what could improve the hospital admission process**
9 **(including admission from community or care homes)?**

10 ***Does not work well***

11 For the caregivers, waiting in the emergency department presented two
12 confounding safety issues. First there was concern about the physical
13 problem that required the emergency department visit. Second there was
14 worry about worsening of the dementia related symptoms by waiting in an
15 environment that they were powerless to modify.

16 **3.(b) What are the views of health, social care and housing practitioners**
17 **about the hospital admission process (including admission from**
18 **community or care home settings)?**

19 Registered nurses in the emergency department revealed that they often
20 presumed that older patients had non-urgent complaints. As a consequence
21 older patients are left waiting. Nurses described the department as very
22 noisy, very high stress and intense. The stimulation and constant noise can
23 make older patients with dementia more anxious and agitated.

24 Nurses explained that they had to use restraints on the older patients with
25 dementia because there was little time to attend to mobilization needs and
26 they were concerned about safety. For many of the RNs, keeping older adults
27 with dementia safe in the ED meant keeping them in their beds so they would
28 not risk falling or wandering without supervision.

29

1 **4 (b) What do health, social care and housing practitioners think works**
2 **well, what does not work well, and what could improve the hospital**
3 **admission process (including admission from community or care home**
4 **settings)?**

5 ***Does not work well***

6 RNs and NPs recognized that waiting for long periods could add risk of
7 hunger, dehydration, and incontinence, setting up a cascade of decline
8 including hypoglycaemia for diabetic patients.

9 Nurses admitted there was a tendency for nutrition and hydration to be
10 neglected in this population. Because they are unable to express themselves
11 patients are left for hours at a time without urinating or without necessary
12 fluids. The nurses aren't always able to advocate for them due to time
13 pressure.

14 **10 (b) What helps and what makes it difficult to ensure successful**
15 **hospital admissions from community or care home settings?**

16 ***Makes it difficult***

17 Older adults with dementia are potentially 'under-triaged' because they have
18 difficulties communicating and explaining their symptoms. They don't often
19 have fevers so they may not always display the same symptoms as the
20 younger population.

21 **3. Randall, S., Daly, G., Thunhurst, C., Mills, N., Guest, D. and Barker, A.**
22 **(2014) Case management of individuals with long-term conditions by**
23 **community matrons: report of qualitative findings of a mixed method**
24 **evaluation.**

25 **Outline:** This paper presents the qualitative findings from a good quality [++]
26 mixed methods study. The main study was an evaluation of case
27 management of individuals with long-term conditions (LTCs) by a community
28 matron (CM) service. The qualitative study had a number of aims but the one
29 reported on in this paper was: to assess and evaluate the extent to which a
30 Community Matron service had implemented case management. The

1 qualitative methods involved interviews with community matrons (n=15),
2 patients (n=13), family carers (n=8) and secondary care staff who interface
3 with the community matrons. Data were also collected via focus groups and
4 audio diaries. The methods were judged to be appropriate but only a small
5 proportion of findings are relevant to the admissions review question.

6 **Results:** Findings are reported under the relevant views and experiences
7 questions.

8 **2.1 (b) What do people using services, think works well, what does not**
9 **work well, and what could improve the hospital admission process**
10 **(including admission from community or care home settings)?**

11 ***Works well***

12 For patients and family carers, knowing that they had a community matron
13 and knowing how and when to contact them was important (generally e.g. not
14 specifically in relation to admission).

15 For patients, trust and knowing that someone was there improved their mental
16 well-being and, in addition, community matrons also gave them an extra layer
17 of support instead of patients having to contact their GP and then dial for
18 emergency help: "I've stopped ringing the GP, who would say, ring an
19 ambulance" (p32) It was clear most people didn't want to go into hospital so
20 the fact that the community matron helped implement self-management was
21 seen as very positive.

22 **2.2 (b) What do families and unpaid carers think works well, what does**
23 **not work well, and what could improve the hospital admission process**
24 **(including admission from community or care homes)?**

25 ***Works well***

26 The role of the community matron in providing reassurance and advice was
27 invaluable to carers who felt they could now cope better and didn't need to
28 phone for help.

1 ***Could improve admission***

2 Admission – or rather, efforts to avoid admission – would be improved if the
3 community matron service operated during evenings and weekends. It was
4 during these times that patients reported a poor service. They said that if they
5 ring the 'out of hours' service they are just told to phone an ambulance so as a
6 result one person said he wouldn't bother ringing the out of hours any more.

7 **3 (b) What are the views of health, social care and housing practitioners**
8 **about the hospital admission process (including admission from**
9 **community or care home settings)?**

10 The matrons noted that their presence in an acute hospital (when a patient
11 had been admitted) was not always welcomed by staff, 'I can stand there for
12 20 minutes without anyone speaking to me...' (p32) Community matrons felt
13 their role was misunderstood by hospital staff.

14 **4 (b) What do health, social care and housing practitioners think works**
15 **well, what does not work well, and what could improve the hospital**
16 **admission process (including admission from community or care home**
17 **settings)?**

18 ***Works well***

19 Community matrons reported that even when a person is admitted to hospital,
20 case management continues; 'co-ordination without interfering'.

21 One community matron reported a success story where she had taught a
22 patient about 'rescue packs' and his hospital admissions subsequently
23 reduced.

24 Continuity (although not specifically in relation to the admission process): a
25 community matron noted the trust and rapport element and commented that
26 having the same person in the role makes a massive positive difference to
27 people and their families.

1 ***Does not work well***

2 A community matron commented on problems with systems/ professional
3 boundaries, describing a case where communication and procedures in
4 relation to an individual at the end of life were ineffectively managed. A carer
5 called an ambulance in the middle of the night and attempts were made by the
6 ambulance crew to resuscitate the patient and transfer them to hospital when
7 they shouldn't have been, "I just think if we have a more robust system in
8 place where they could stick 'not for resuscitation' on the door and 'please
9 leave at home'..." (p33)

10 ***Could improve admission***

11 One community matron supported the view that the service should be
12 extended to evenings and weekends. She suggested that admission at the
13 weekend and in the evenings may rise among her patients because the carers
14 find they can't cope and can't phone the community matron for support and
15 advice as they usually would.

16 **4. Shanley, C., Whitmore, E., Conforti, D., Masso, J., Jayasinghe, S. and**
17 **Griffiths R. (2011) Decisions about transferring nursing home residents**
18 **to hospital: Highlighting the roles of advance care planning and support**
19 **from local hospital and community health services.**

20 **Outline:** This is a good quality [++] qualitative study, which aimed to identify
21 opportunities for improving decision-making about transfer of nursing home
22 residents to hospital. Conducted in Australia, the study involved one to one
23 interviews with 41 nursing home managers. They represented mainly not for
24 profit and private homes, a mixture of different sized homes (most were <120
25 beds) and an even split in homes supporting people with low versus high care
26 needs. Factors found to affect the decision to transfer a resident to hospital
27 include acuteness of their condition; level and style of medical care available;
28 role of family members; numbers, qualifications and skills mix of staff; and
29 concern about criticism for not transferring to hospital.

30 **Results:** Findings are reported under the relevant views and experiences
31 questions.

1 **3.(b) What are the views of health, social care and housing practitioners**
2 **about the hospital admission process (including admission from**
3 **community or care home settings)?**

4 Whether a resident is admitted to hospital depends on the home's relationship
5 with the GP. If there's a good relationship, the GP takes the manager's views
6 on board. If the relationship is poor, a GP will send a resident to hospital
7 regardless of the policies and procedures in place at the home.

8 Managers reported that the way families are involved in decisions about
9 transferring to hospital is partly determined by the urgency of the situation. In
10 acute emergencies where the priority is immediate treatment, the decision will
11 be made by the staff and the family will be informed as soon as practicable. In
12 non-emergencies, the extent to which the family intervene in the decision is
13 affected by how often they visit and their faith in the nursing home. They often
14 feel guilty about the person being in the nursing home and if there is any
15 doubt will want them to go to hospital so that they know they've done all they
16 possibly could.

17 **4 (b) What do health, social care and housing practitioners think works**
18 **well, what does not work well, and what could improve the hospital**
19 **admission process (including admission from community or care home**
20 **settings)?**

21 ***Works well***

22 Having registered nurses available 24 hours a day: nursing homes with
23 registered nurses (usually the 'high care need' homes), especially if available
24 24 hours, are likely to keep the patient in the nursing home and prevent
25 hospital admission. Low need care homes have minimal access to registered
26 nurses and those managers felt it unfair to make personal care assistants take
27 on the responsibility, so the usual approach is to say "if in doubt, ship them
28 out". (p2901)

1 ***What works***

2 In one nursing home, staff email digital pictures of resident's wounds to
3 medics at the hospital so they can advise on the most appropriate treatment
4 and prevent an unnecessary transfer.

5 ***Could improve***

6 Communication between nursing homes and hospitals varies and a number of
7 innovative approaches were reported which aimed to try and improve the
8 situation e.g. collaborative and shared care (a visit by Emergency Department
9 staff to the nursing home so they would understand constraints and conditions
10 in the home), educational and professional support of nursing home staff and
11 alternatives to Emergency Department and inpatient care.

12 **10 (b) What helps and what makes it difficult to ensure successful**
13 **hospital admissions from community or care home settings?**

14 ***What helps***

15 Managers who took a more deliberate and systematic approach to advanced
16 care planning (ACP) indicated that they were less likely to have unplanned
17 transfers to hospital than other nursing homes. This happens for three
18 reasons:

- 19 • It means the resident and family have had chance to think about future
20 possible scenarios so when it comes to a decision about hospital
21 admission, the family are fully prepared. If this hasn't happened, families
22 tend to err on the side of caution and send the person to hospital.
- 23 • Having ACP in place puts the resident's views at the fore. If they've chosen
24 not to have unnecessarily invasive treatment they won't be subject to them
25 just because nobody can make a clear decision not to transfer them.
- 26 • It gives (sometimes less experienced) staff clear guidelines about how to
27 deal with a resident's deteriorating health - they're not making decisions in
28 an information vacuum.

29

1 ***What helps***

2 Managers reported that residents' admission to hospital has been prevented
3 because the Area Health Service provides a range of community services in
4 the nursing home itself. The services that go into nursing homes most
5 frequently are community aged care assessment, psychogeriatrics, palliative
6 care, wound care, continence care and community nurses. Unfortunately not
7 all nursing homes are aware that the AHS can provide these services.

8 ***Makes it difficult***

9 In low care NHs there are fewer staff per resident. A manager of one such
10 home reported that they would send a person to hospital more readily
11 because keeping them in the NH would require more staff to care for them -
12 thereby limiting the care that could be given to the other residents.

13 Fear of criticism and litigation with nursing home managers concerned that not
14 transferring someone is potentially litigious and may result in formal
15 complaints. Even if complaints are not upheld, the investigations are time
16 consuming and stressful.

17 **5. Themessl-Huber, M., Hubbard, G. and Munro, P. (2007) Frail older
18 people's experiences and use of health and social care services.**

19 **Outline:** This was a moderate quality views study [+] that aimed to highlight
20 older people's experiences and expectations of services in the context of
21 emergency admissions and extramural services. Twelve frail older women
22 and 6 men aged from 80-92 gave their views. All the interviewed older people
23 in this study used a range of formal and informal services and had
24 experienced multiple hospital admissions.

25 **Results:** Findings are reported under the relevant views and experiences
26 questions.

1 **1.1 (b) What are the views and experiences of people using services, in**
2 **relation to the hospital admission process (including admission from**
3 **community or care home settings)?**

4 The older people in this study associated older age with increasing frailty and
5 did not consider their emergency hospital admissions to be avoidable.

6 Trust or lack of trust in professionals was an issue that affected older people's
7 willingness to contact emergency services. Some mentioned that they did not
8 want to "bother people", others regarded receiving help as abandoning
9 independence, some were reluctant because they felt embarrassed or
10 humiliated and some argued that they appreciate the services but they prefer
11 the support of people with whom they are familiar, particularly in times of
12 crisis.

13 **2.1 (b) What do people using services, think works well, what does not**
14 **work well, and what could improve the hospital admission process**
15 **(including admission from community or care home settings)?**

16 ***Works well***

17 Nine of the 18 participants said that they were fully satisfied with the kind of
18 and amount of care that they had received prior to admission and the rest felt
19 their care had been adequate, "There's not much you can do, other than that
20 what they're doing, you know. And that way you can't expect any difference.
21 And well I don't expect miracles anyway" (p225).

22 Although older people do not perceive the Community Alarm (CA) as having
23 been able to prevent their emergency admissions, it was appreciated for
24 raising their confidence about being at home prior to the admission.

25 ***Could improve admission***

26 This group of older people would prefer health and social care services to
27 focus efforts on the care of their already established health issues, minimize
28 detrimental consequences and diminish age-related complications.

29 They prefer a service that supports and boosts their capacities, capabilities
30 and social networks and a service that makes them feel safe while remaining

1 inconspicuous when not needed and that ensures easily accessible help in
2 emergency situations (like the Community Alarm (CA) for example).

3 The older people said that services are not yet sufficiently flexible, do not yet
4 involve older people enough and do not adapt care provision to individual
5 circumstances and preferences, including being admitted to hospital.

6 **6. Toles, M., Abbott, K., Hirschman, K., and Naylor, M. (2012) Transitions**
7 **in care among older adults receiving long-term services and supports.**

8 Outline: This qualitative study was judged to be of good quality [++]. Its
9 purpose was to describe patient and family caregiver perceptions of
10 transitions between Long Term Services and Supports (LTSS) settings and
11 hospitals. Long Term Services and Supports settings include assisted living
12 facilities and nursing homes. The authors sought to understand a) patient and
13 family involvement in components of transitional care and b) issues related to
14 the experiences with care provided by professional staff. A total of 57
15 interviews took place including with 30 nursing home residents, 11 residents
16 of an assisted living facility (ALF), 10 PACE participants (Programme of All-
17 Inclusive Care of the Elderly) and 6 family caregivers of cognitively impaired
18 ALF and nursing home residents. The methods were judged to be appropriate
19 and reliable and the study is highly relevant to the admission process review
20 question.

21 **Results:** Findings are reported under the relevant views and experiences
22 questions.

23 **1.1 (b) What are the views and experiences of people using services, in**
24 **relation to the hospital admission process (including admission from**
25 **community or care home settings)?**

26 Respondents reported that during admission to hospital, they had limited
27 involvement in planning with professional hospital staff. Nearly 30% of LTSS
28 recipients reported having no conversation with a hospital physician regarding
29 acute medical conditions or planned treatments, “they didn’t have the time”
30 and “I would have liked the doctor to tell me about my condition, he never
31 came in to tests...he never told me what my diagnosis was”. Only 33% (19 of

1 57) of LTSS recipients or family care givers reported having discussions about
2 their medical condition with hospital nurses ignoring them and no one giving
3 them any information.

4 Only 21% of LTSS recipients reported discussions with hospital social
5 workers, One person described how they were told they would be discharged
6 from hospital but having had no information, they objected, "I aint leaving here
7 until somebody talks to me". (p44)

8 **1.2 (b) What are the views and experiences of families and unpaid carers**
9 **in relation to the hospital admission process (including admission from**
10 **community or care homes)?**

11 Carers reported uncertainty about hospital care and follow up planning. If they
12 wanted information, they (or the patient) had to initiate conversations with
13 staff. One caregiver reported, "I have to ask the questions and be on top of
14 things with my dad...they don't just come to me with information." (p45)

15 **2.1 (b) What do people using services, think works well, what does not**
16 **work well, and what could improve the hospital admission process**
17 **(including admission from community or care home settings)?**

18 ***Works well***

19 When LTSS residents did speak with their physicians (37 of 57) they
20 consistently expressed appreciation about the opportunity to be involved in
21 care,

22 ***Could improve admission***

23 When asked, LTSS patients and caregivers expressed a strong desire for
24 more information and explanations from their physicians, nurses, and social
25 workers. They wanted to learn information in the hospital about their diagnosis
26 and treatment. They also wanted to understand why they were being
27 transferred, "I'd like to find out the situation, the why, why was I brought back
28 [to this nursing home]" (p44)

1 Finally, people complained about a lack of access to support and treatment "I
2 want a physical therapist, if he just come two or three times a week that would
3 help me to walk and that's all I'm interested in, to try and stand up." (p44)

4 ***Studies reporting evidence of cost effectiveness (n=1)***

5 Findings from one Cochrane systematic review and meta-analysis (Ellis et al
6 2011, 19 trials, none from UK, ++) suggested that comprehensive geriatric
7 assessment (CGA) provided on specialist units or through specialist teams led
8 to reduced deterioration (OR=0.76, P=0.001, N=2,622) and improved
9 cognitive function (standard mean difference 0.08, P=0.02, N=3,317)
10 compared with standard non-specialist care. Whilst CGA in specialist units
11 improved service use outcomes such the probability of living at home between
12 6 weeks and 12 months (OR=1.22, P<0.001, N=6,290) and admission to
13 residential care (OR=0.73, P<0.001; N=6,252), these outcomes were less
14 positive for CGA by specialist teams (OR=0.75, P=0.06, N=772; OR=1.16,
15 P=0.39; N=485). Approaches for evaluating costs varied widely so that the
16 authors did not attempt to synthesise cost results. They found that some (but
17 not all) studies showed cost savings from the perspective of the hospital and
18 care home system; the wider cost impact (community care, unpaid care) was
19 unclear.

20 In simple threshold analysis (details in Appendix C) we showed that if figures
21 on the reduction of admission to residential care were translated to a UK
22 context and before considering the cost of community services (assumed
23 value of zero), expected cost savings linked to comprehensive geriatric
24 assessment and care in hospital cost savings

25 In threshold analysis (details in Appendix C) we showed the likely cost-
26 effectiveness of comprehensive geriatric assessment and care in a UK
27 context. We translated effects on residential care admission and length of
28 hospital stay into a UK context and explored the impact of different values for
29 costs of community based health and social care on total health and social
30 care savings. We also explored the impact of including unpaid care costs on
31 findings. We found that if the annual cost of community health and social care
32 were lower than between £30,000 and £35,000 the intervention was expected

1 to be saving costs from a health and social care perspective. This was about
 2 2.5 fold the costs that have been found in England for older people eligible for
 3 publicly funded social care. If the costs of unpaid care were included then
 4 annual cost of health and social care need to be lower than £12,000 to
 5 £16,000 in order for the intervention to be cost saving. This was about 1 to 1.3
 6 fold the costs expected for older people eligible for publicly funded social care
 7 and thus likely to at least offset costs.

8

9 **Evidence statements (including economics evidence statements)**

HA1	There is a small amount of good quality evidence that people being admitted to hospital and their carers do not receive adequate information about diagnoses and treatment plans. Also, if this were addressed, the admission and hospital experience would be improved. An Australian study (Cheah and Presnel, 2011) [++] found older people sought better communication, especially from doctors, whom they felt made treatment decisions without informing or involving them. An American study (Toles et al, 2012) [++] found approximately 30% of participants reported never having a conversation with a hospital physician about conditions or planned treatments. Nurses and social workers were also described as being absent or ignoring the patient and their carer, which was a cause of anxiety.
HA2	There is some good evidence that the reliable communication of advanced care directives can be improved, with the effect of avoiding unwanted admissions and invasive treatment, especially at the end of life. One UK study (Randall et al, 2014) [++] identified problems in communicating advanced care directives between agencies, noting instances where people have been transferred to hospital by ambulance at the end of life, when this was unnecessary and disruptive. An Australian study (Shanley et al, 2001) [++] found that when nursing home managers adopted a deliberative and systematic approach to advanced care planning, they were less likely to have unplanned transfers to hospital. Echoing this, a systematic review (La Mantia et al, 2010) [+] found that two transfer documents used in transitional care between long-term care and emergency departments facilitated the communication of advanced directive information.
HA3	There is a small amount of good and moderate evidence that older people experience hospital as an alien environment, which both deters them from seeking medical help and affects their rehabilitation as a hospital inpatient. One study (Themessl-Huber et al, 2007) [+] found that older people preferred the help of friends and relatives during a crisis rather than medical professionals and would rather be at home and surrounded by their own belongings than be admitted to hospital. An Australian study (Cheah and Presnel, 2011) [++] identified that people feel alienated by the hospital's impact on their own routine, which presents a challenge for occupational therapy if it is de-contextualised from normal life. The study also showed that the best motivator for people to engage in rehabilitation was the prospect of returning home.

HA4	<p>There is some good and moderate evidence that specialist geriatric care and geriatric assessment, which commences on admission to hospital, has a positive impact on experiences and outcomes for older people. One RCT (Eklund et al, 2013) [+] found that the provision of care by a nurse with geriatric competence which commenced on admission and continued through to hospital discharge, improved ADL independence among its participants up to one year, and postponed dependence in ADL up to six months. However, no improvements were seen for measures of frailty. A Cochrane systematic review (Ellis et al, 2011) [++] found that comprehensive geriatric assessment delivered in geriatric wards increases older people's likelihood of being alive and in their own homes following emergency admission to hospital. A systematic review (Fox et al, 2012) [++] identified positive service level and individual outcomes from care on dedicated acute geriatric units, which was based on hospital rehabilitation and the prevention of functional decline.</p>
HA5	<p>There is a small amount of good and moderate evidence that people with long term conditions benefit from having a single named professional to manage their care including transitions into and out of hospital. A systematic review (Manderson et al, 2012) [+] of navigation roles for chronically ill older adults found 5 out of 9 studies reported increased individual quality of life and functionality. For two studies where little or no positive effect was found, the care navigation was more passive and commenced on discharge rather than on admission to hospital. The qualitative findings of a mixed methods study (Randall et al, 2014) [++] showed that people with long term conditions and their carers valued knowing how and when to contact their community matron for advice about symptoms and medication. Being able to contact the community matron appeared to reduce the likelihood of people calling for emergency help and being transferred to hospital.</p>
HA6	<p>There is a small amount of moderate evidence that the involvement of a multi-disciplinary team to support older people from admission and throughout their hospital stay has some positive effects on outcomes. An Australian controlled trial (Mudge et al, 2012) [+] tested the effectiveness of an interdisciplinary care team, which made an assessment and commenced discharge planning on admission. The study detected a dramatic reduction in in-hospital mortality although 6-month readmissions and bed use were non-significantly increased. A randomized controlled trial (Eklund et al, 2013) [+] measured the effects of a multi-professional team for the care and rehabilitation of older people, which created a continuum of care for the older person from the emergency department, through the hospital ward and on to their own homes. Results showed improved ADL independence among participants up to one year, and postponed dependence in ADL up to six months.</p>
HA7	<p>No evidence was found from studies published since 2003 about the provision of step-up facilities during the hospital admission process.</p>
Ec1	<p>Evidence from one high quality systematic review and meta-analysis (Ellis et al 2011, ++) suggested that comprehensive geriatric assessment and care provided on specialist units was likely to be cost-effective compared with non-specialist care. Findings from the study showed positive health and wellbeing outcomes for individuals and cost savings from a hospital perspective. Additional analysis was carried out to test the likely impact of the intervention on health and social care and unpaid care costs in a UK context and found that comprehensive geriatric assessment and care provided on specialist units was likely to lead to cost savings from a health and social care perspective and to at least offset costs if costs of unpaid care were included.</p>

1

2 **Included studies for the hospital admission review questions (full**
3 **citation)**

4 Cheah S and Presnell S (2011) Older people's experiences of acute
5 hospitalisation: An investigation of how occupations are affected. Australian
6 Occupational Therapy Journal 58: 120–8

7 Eklund K, Wilhelmson K, Gustafsson H et al. (2013) One-year outcome of
8 frailty indicators and activities of daily living following the randomised
9 controlled trial; "Continuum of care for frail older people". BMC Geriatrics 13:
10 1–10

11 Ellis G, Whitehead M, Robinson D et al. (2011) Comprehensive geriatric
12 assessment for older adults admitted to hospital: meta-analysis of randomised
13 controlled trials. BMJ 343: d6553

14 Fox, M, Persaud M, Maimets I et al. (2012) Effectiveness of acute geriatric
15 unit care using acute care for elders components: A systematic review and
16 meta-analysis. Journal compilation, The American Geriatrics Society 60:
17 2237–45

18 LaMantia M, Scheunemann L, Viera A et al. (2010) Interventions to improve
19 transitional care between nursing homes and hospitals: a systematic review.
20 Journal of the American Geriatrics Society 58: 777–82

21 Manderson B, McMurray J, Pirainoet M et al. (2012) Navigation roles support
22 chronically ill older adults through healthcare transitions: a systematic review
23 of the literature. Health and Social Care in the Community 20: 113–27

24 Mudge A, Denaro C, O'Rourke P et al. (2012) Improving hospital outcomes in
25 patients admitted from residential aged care: results from a controlled trial.
26 Age and Ageing 41: 670–3

27 Parke B, Hunter K, Strain L et al. (2013) Facilitators and barriers to safe
28 emergency department transitions for community dwelling older people with

1 dementia and their caregivers: A social ecological study. *International Journal*
2 *of Nursing Studies* 50: 1206–18

3 Randall S, Daly G, Thunhurst C et al. (2014) Case management of individuals
4 with long-term conditions by community matrons: report of qualitative findings
5 of a mixed method evaluation. *Primary Health Care Research & Development*
6 15: 26–37

7 Shanley C, Whitmore E, Conforti D et al. (2011) Decisions about transferring
8 nursing home residents to hospital: Highlighting the roles of advance care
9 planning and support from local hospital and community health services.
10 *Journal of Clinical Nursing* 20: 2897–906

11 Themessl-Huber M, Hubbard G, Munro P et al. (2007) Frail older people's
12 experiences and use of health and social care services. *Journal of Nursing*
13 *Management* 15: 222–9

14 Toles M, Abbott K, Hirschman K et al. (2012) Transitions in care among older
15 adults receiving long-term services and supports. *Journal of Gerontological*
16 *Nursing* 38: 40–7

17 **3.4 Improving transfer of care from hospital**

18 **Introduction to the review questions**

19 The purpose of these review questions was to examine the effectiveness and
20 cost effectiveness of different approaches to supporting adults with social care
21 needs during transition from inpatient hospital settings to community or care
22 home settings. The questions also aimed to consider research, which
23 systematically collected the views of people using services, their carers, and
24 care and support staff in relation to the transfer of care from hospital.

25 Overall, a good amount of evidence was located and included for review in
26 this area. There were 12 studies reporting views and experiences and they
27 were mainly of moderate quality. The 16 studies of effectiveness were of
28 mixed (moderate and good) quality, although one low quality study was
29 included. Some of the effectiveness studies also provided cost effectiveness

1 data. A total of 21 papers reporting economic evidence were included for
2 review. It is notable that data on views and data on effectiveness and cost
3 effectiveness were sometimes conflicting, which suggests that although an
4 intervention or approach to hospital discharge may be effective or cost-
5 effective, it may not be acceptable to the person experiencing transfer from
6 hospital.

7 **Review question for evidence of effectiveness**

8 6. What is the effectiveness of interventions and approaches designed to
9 improve the transfer of care from hospital?

10 **Review questions for evidence of views and experiences**

11 Review questions 1-4 and question 10, listed on pages 2-3, were applied
12 specifically in relation to transfer of care from hospital.

13 **Summary of review protocol**

14 The protocol sought to identify studies that would:

- 15 • Identify the effectiveness of the different ways (including specific services
16 or interventions) in which adults with social care needs are supported
17 through safe and timely transfers of care from inpatient hospital settings to
18 community or care home settings.
- 19 • Identify emerging models of care, assessment and discharge planning and
20 associated outcomes.
- 21 • Assess the cost effectiveness of interventions designed to facilitate hospital
22 discharge.

23 For the views and experiences review questions, the protocol sought to
24 identify studies, specifically relating to transfer of care from hospital, which
25 would:

- 26 • Describe the self-reported views and experiences of adults with social care
27 needs, their families and unpaid carers about the care and support they
28 receive during transition from hospital to community or care home settings.

- 1 • Highlight aspects of care and support during the hospital discharge process
2 that work well, as perceived by service users, their families and unpaid
3 carers and aspects of care and support during discharge from hospital,
4 which are perceived not to work well.
- 5 • Describe the views and experiences of people delivering, organising and
6 commissioning social care, health and housing services.
- 7 • Highlight aspects of the hospital discharge process, which work well, and
8 are personalised and integrated, as perceived by practitioners, managers
9 and commissioners and aspects of hospital discharge, which should be
10 changed to improve the transition.
- 11 • Contextualise the views of users, carers and practitioners by identifying
12 barriers and facilitators to improved or changed practice they suggest
13 would improve outcomes relating to the hospital discharge process.

14 **Population:** Adults aged 18 years and older, who are transferring from
15 inpatient hospital settings to community or care home settings and their
16 families, partners and carers. Self-funders and people who organise their own
17 support and who are experiencing a hospital discharge are included.

18 Housing practitioners, social care practitioners (providers, workers, managers,
19 social workers), and health and social care commissioners involved in
20 delivering social care to people during transfer from hospital to community or
21 care home settings, or intermediate care units; personal assistants engaged
22 by people with social care needs and their families. General practice and
23 other community-based healthcare practitioners.

24 **Intervention:** Personalised and integrated assessment, discharge planning
25 and care and support. Usual treatment compared to the effectiveness of an
26 innovative intervention.

27 **Setting:** Inpatient hospital settings, (“step down”) bed-based intermediate
28 care settings and service users’ home, including sheltered housing
29 accommodation; supported housing; temporary accommodation; care
30 (residential and nursing) homes.

1 **Outcomes:** User and carer related outcomes (such as user and carer
2 satisfaction; quality and continuity of care; choice and control; involvement in
3 decision-making about place of death) and health and social care related
4 quality of life) and service outcomes such as use of health and social care
5 services, delayed transfers of care and rates of hospital re-admissions within
6 30 days (see 4.4 in the Scope).

7 User satisfaction; quality and continuity of care; choice and control;
8 involvement in decision-making; dignity and independence; quality of life;
9 health status; safety and safeguarding

10 The study designs included for the effectiveness questions on the hospital
11 admission process were:

- 12 • Systematic reviews of studies of different models of discharge assessment
13 and care planning;
- 14 • Randomised controlled trials of different approaches to discharge
15 assessment and care planning;
- 16 • Controlled studies of different approaches to discharge assessment and
17 care planning;
- 18 • Economic evaluations;

19 The study designs relevant to the views and experiences questions were
20 expected to include:

- 21 • Systematic reviews of qualitative studies on this topic;
- 22 • Qualitative studies of user and carer views of social and integrated care;
- 23 • Qualitative components of effectiveness and mixed methods studies;
- 24 • Observational and cross-sectional survey studies of user experience.

25 Full protocols can be found in Appendix A.

26 **How the literature was searched**

27 Electronic databases in the research fields of social care, health, economics
28 and social science were searched using a range of controlled indexing and
29 free-text search terms based on the facets of: the state of transition (service

1 user/patient transfer or admission or discharge), settings (inpatient hospital or
2 community or care home settings) and health and social care needs,
3 workforce or intervention.

4 The search aimed to capture both journal articles and other publications of
5 empirical research. Additional searches of websites of relevant organisations
6 were also carried out.

7 The search for material on this topic was carried out within a single broad
8 search strategy used to identify material which addressed all the agreed
9 review questions on the transition between inpatient hospital settings and
10 community or care home settings for adults with social care needs. The
11 searches were restricted to studies published from 2003 in order to
12 incorporate the Community Care (Delayed Discharges) Act 2003. Generic and
13 specially developed search filters were used to identify particular study
14 designs, such as systematic reviews, randomised controlled trials, economic
15 evaluations, cohort studies, mixed method studies and personal narratives.
16 The database searches were not restricted by country.

17 Full details of the search can be found in Appendix A.

18 **How studies were selected**

19 Search outputs (title and abstract only) were stored in EPPI Reviewer 4 - a
20 software programme developed for systematic review of large search outputs
21 - and screened against an exclusion tool informed by the parameters of the
22 scope. Formal exclusion criteria were developed and applied to each item in
23 the search output, as follows:

- 24 • Language (must be in English),
- 25 • Population (must be over 18 years of age and have a social care need)
- 26 • Transition (a transition into or out of an inpatient hospital setting must have
27 occurred within the last 30 days)
- 28 • Intervention (must be involved in supporting transitions)
- 29 • Setting (inpatient hospital setting, intermediate care setting, community
30 setting or care home)

- 1 • Country (must be UK, European Union, Denmark, Norway, Sweden,
- 2 Canada, USA, Australia and New Zealand)
- 3 • Date (not published before 2003)
- 4 • Type of evidence (must be research)
- 5 • Relevance to (one or more) review questions.

6 Title and abstract of all research outputs were screened against these
7 exclusion criteria. Those included at this stage were marked for relevance to
8 particular review questions and retrieved as full texts.

9 Full texts were again reviewed for relevance and research design. If still
10 included, critical appraisal (against NICE tools) and data extraction (against a
11 coding set developed to reflect the review questions) was carried out. The
12 coding was all conducted within EPPI Reviewer 4, and formed the basis of the
13 analysis and evidence tables. All processes were quality assured by double
14 coding of queries, and of a random sample of 10%.

15 In our initial screen (on title and abstract), we found 583 studies, which
16 appeared relevant to the review questions on improving hospital discharge
17 and reducing readmissions. We ordered full texts and reviewed 183 papers for
18 final inclusion. For views and experiences research, studies from a UK setting
19 were prioritized. Effectiveness studies were restricted to systematic reviews,
20 randomized controlled trials or controlled studies. On reviewing the full texts,
21 we identified 28, which fulfilled the criteria (see included studies below) and
22 related to improving discharge. The papers identified as relating specifically to
23 reducing readmissions were coded accordingly and included in a separate
24 review area, described in the next sub section.

25 Economic studies were identified through systematic review and additional
26 economic searches and the number included was 21. All included studies
27 (see below) were critically appraised using NICE tools for appraising different
28 study types, and the results tabulated. Further information on critical appraisal
29 is given in the introduction at the beginning of Section 3. Study findings were
30 extracted into findings tables. For full critical appraisal and findings tables, see
31 Appendix B.

1 **Narrative summaries of the included evidence**

2 ***Studies reporting effectiveness data (n=16)***

3 **1. Bahr Sarah J; Solverson Susan; Schlidt Andrea; Hack Deborah; Smith**
4 **Jeri Lynn and Ryan Polly (2004) Integrated Literature Review of Post**
5 **discharge Telephone calls**

6 **Outline:** This systematic review was judged to be of moderate quality [+] and
7 highly relevant to the 'hospital discharge' review area. The systematic review
8 aimed to assess the impact of a post discharge telephone call on patient
9 outcomes. Building on equivocal evidence from previous research, it set out to
10 answer the question: "are post discharge phone calls made by hospital staff
11 an effective way of improving patient outcomes and easing transition from
12 hospital to home?"

13 The post-discharge telephone call was defined as a telephone call to the
14 person who was discharged to determine "how they were doing". Calls
15 generally took place one to two weeks after discharge and may be intended to
16 answer patient's questions, review medications, assess coping, and check on
17 the status of equipment and supplies. The reviewers examined who placed
18 the call (nurse, pharmacist, phone service personnel). Patients were at least
19 18 years old and had experienced more than 25 hours in hospital. Included
20 studies were restricted to those with an experimental design and published
21 before 2013. Nineteen studies met the inclusion criteria. The reviewers
22 identified problems with the quality of this review, which is reflected in its
23 moderate rating.

24 **Results:**

25 **Individual outcomes:**

26 ***Acceptability of post-discharge telephone calls***

27 In the 6 studies that measured patient satisfaction, 2 studies found that
28 patients who received calls were more satisfied than those who did not and
29 four studies found no difference. Two studies found that although people
30 "liked" the telephone calls, there was no difference in satisfaction.

1 **Medicines**

2 Results were mixed for medicine related telephone calls in terms of cost-
3 benefit and adverse events. Studies conducted using pharmacist-delivered
4 interventions focusing on medication-related health behaviours had better
5 outcomes than studies where medication health behaviours were one of many
6 areas of concern. One study reported an increase in medication compliance
7 where another study concluded that no change in ED visits and readmission
8 made post discharge telephone calls a questionable strategy

9 **Follow-up**

10 Telephone calls appeared to be effective in ensuring timely follow ups and
11 attending appointments.

12 **Self-care management**

13 There were mixed results in terms of increasing patients' self-care knowledge.

14 **Quality of life**

15 Two studies found no difference in self-reported quality of life, whereas one
16 study found patients reported increased self-efficacy

17 **Health care provider outcomes:**

18 **Client feedback**

19 Post-discharge telephone calls appeared to offer a way of feeding back and
20 making changes to institutional processes.

21 **Service outcomes**

22 **Feasibility of post-discharge telephone calls**

23 Some interventions found that routine telephone calls post discharge created
24 unmanageable workloads for nurses who couldn't always meet or complete
25 targets.

1 ***Hospital readmission***

2 No change in hospital readmission was found in any of the studies (n = 7) in
3 which readmission was measured.

4 ***Emergency department visits***

5 Emergency department visits were evaluated in four studies. Mixed results
6 were reported with some showing, increased visits, some showing fewer visits
7 and others showing no difference between persons who received post
8 discharge telephone calls and those who did not.

9 ***Unscheduled (health) service use***

10 Two studies reported an increased use and two reported a decrease in
11 unscheduled service use between groups.

12 ***Costs***

13 None of the included studies reported a full economic evaluation of the
14 telephone service. Two reported the cost of the phone calls and one study
15 reported that the costs of the calls exceeded the benefits.

16 Overall, the findings from this review were inconclusive as there were positive
17 and negative findings for most outcomes.

18 **2. Burton, C, and Gibbon, B. (2005) Expanding the role of the stroke
19 nurse: A pragmatic clinical trial**

20 Outline: This is a good quality [++] pragmatic randomised controlled trial
21 conducted in the UK. It aimed to test the hypothesis that expanding the stroke
22 nurse role to provide continuity in care to stroke survivors and carers after
23 discharge from hospital would improve recovery from stroke. The stroke nurse
24 was to follow up from the place of discharge within two working days and
25 review the following:

- 26 • Physical functioning using activities of living
- 27 • Patient and carer knowledge of the consequences and implications of
28 stroke
- 29 • Patient and carer abilities to cope emotionally with the aftermath of stroke

- 1 • The potential of the home environment to support recovery
- 2 • Medication adherence, appropriateness and effectiveness
- 3 • Transfer of care arrangements
- 4 • Health promotion, including patient and carer education, stroke prevention
- 5 and the use of resources to support recovery control group received usual
- 6 care

7 The stroke nurse would employ a range of scales to measure function and
8 quality of life:

- 9 • The Barthel scale or Barthel ADL index is an ordinal scale used to measure
- 10 performance in activities of daily living (ADL)
- 11 • Frenchay Activities Index - Assesses a broad range of activities of daily
- 12 living in patients recovering from stroke
- 13 • The Nottingham Health Profile (NHP) is a general patient reported outcome
- 14 measure which seeks to measure subjective health status
- 15 • The Beck Depression Inventory
- 16 • Caregiver Strain Index - a 13-question tool that measures strain related to
- 17 care provision.

18 Results: The authors employed a Mann-Whitney U test for significance testing
19 between two mean scores of experimental and control (usual care) conditions,
20 which is appropriate for non-normal distributions.

- 21 • Between 3-12 months follow up, for which there was complete data, there
- 22 was a significant difference in mean scores in favour of the experimental
- 23 group on the Barthel Index.
- 24 • There was no significant difference found between the two groups on the
- 25 Beck depression scale.
- 26 • Whilst the Frenchay Activity Index failed to show improvement in the
- 27 performance of activities with social meaning, the Nottingham Health
- 28 Profile subsection showed statistically significant reductions in social
- 29 isolation.
- 30 • Carers of survivors in the experimental group reported less strain at the 3-
- 31 month assessment period. The data demonstrate, however, that this

1 effectiveness may be short-term, and therefore dependent on continued
2 receipt of the study intervention.

3 **3. Chhabra et al (2012) Medication reconciliation during the transition to 4 and from long-term care settings: A systematic review**

5 **Outline:** This is a moderate quality [+] systematic review. It evaluated studies
6 performing medication reconciliation interventions in patients transferred to
7 and from long-term care settings. Of the seven studies that met the inclusion
8 criteria, only one study (Delate, 2008) was not about hospital to community or
9 care home transition. The remaining six are all about transition to or from
10 hospital. The studies are from the US, Sweden, Belgium and Australia. The
11 results were not pooled or synthesised because of the heterogeneity of the
12 outcomes considered in each study, which is possibly a consequence of not
13 stating the outcomes a priori.

14 **Results:**

- 15 • A clinical pharmacist proved useful in providing medication reconciliation
16 interventions in long term care settings. In various studies, a clinical
17 pharmacist adopted specialized responsibilities such as serving as a
18 transition pharmacist coordinator or working through a call centre.
- 19 • Additional roles of pharmacists seen in the literature include: reducing the
20 medication errors, taking accurate and complete medication histories, and
21 providing effective admission and discharge education and planning.
- 22 • Despite evidence in all 7 studies demonstrating the effectiveness of having
23 a clinical pharmacist who provides medication reconciliation during the
24 transition to and from long-term care, the authors felt the results were not
25 generalisable owing to flaws in study design.

26 **4. Conroy et al (2011) A systematic review of comprehensive geriatric 27 assessment to improve outcomes for frail older people being rapidly 28 discharged from acute hospital: 'interface geriatrics'.**

29 **Outline:** This is a good quality systematic review (++) . It included a small
30 number of studies that aimed to examine the evidence for services for older
31 patients who developed a crisis, attended hospital, were assessed, treated

1 and discharged, within 72 hours from an Acute Medical Unit or Emergency
2 Department. Outcomes measured were hospital admissions within 30 days,
3 Emergency Department use over 30 days, hospitalisation, mortality, nursing
4 home transfers and falls over year. Interventions in the included studies varied
5 by setting, outcomes timing, and professionals delivering the intervention.

6 **Results:**

7 • Mortality

8 • There was no significant difference in mortality at final follow-up when
9 combining data for the five trials: n= 2,474, risk ratio 0.92 (95% CI 0.55 to
10 1.52) Readmissions

11 • All studies reported on readmission rates, but no statistically significant
12 differences were found in rates of readmission compared to the control
13 group.

14 • Functional outcomes

15 • Only one trial reported function (Close). The standardised mean difference
16 on the 20-point Barthel score was 0.41 (95% CI 0.21 to 0.61) in favour of
17 the intervention.

18 • Quality of life

19 • (Only reported in Mion) At 4 months there was a mean difference of 0.2
20 (95% CI -1.9 to 2.3) in the physical component of the SF36, and 0.6 (95%
21 CI -1.3 to 2.5) difference in the mental component of the SF36 - both in
22 favour of the intervention, although these differences are not clinically
23 meaningful.

24 • Intervention type

25 • Given the range of different interventions that came under the name of
26 'geriatric assessment' and the different outcomes measured by the
27 included studies, heterogeneity was high. However an analysis by
28 intervention type revealed that the predominantly nurse-led interventions (n
29 = 1,764) gave a risk ratio for readmission of 1.01 (95% CI 0.89 to 1.15),
30 whereas the predominantly geriatrician-led intervention trials (n = 710) gave
31 a risk ratio for readmission of 0.81 (95% CI 0.59 to 1.12).

1 The authors conclude that they did not find firm evidence that any form of
2 CGA in this setting (emergency departments) and with this group has any
3 effect on mortality, long-term institutionalisation, subsequent use of acute
4 care, physical function, quality-of-life or cognition.

5 **5. Fox, M., Persaud, M., Maimets, I., O'Brien, K., Brooks, D., Tregunno, D.**
6 **and Schraa, E (2012) Effectiveness of acute geriatric unit care using**
7 **acute care for elders components: A systematic review and meta-**
8 **analysis**

9 **Outline:** This is a good quality [++] systematic review, with moderate
10 relevance to our review area. It pools results from studies that evaluate the
11 effectiveness of one or more components of the Acute Care for Elders (ACE)
12 model (one component of which is discharge planning) and the effect on
13 hospital acquired functional decline. Included studies were from Sweden,
14 USA, UK, Spain, Australia, France and Peru. It is important to note that
15 although one component of the ACE model is discharge planning, it is not
16 possible to isolate from the results what effect discharge planning alone had
17 on the outcomes selected by this review.

18 **Results:**

- 19 • Iatrogenic complications (falls, pressure ulcers, delirium)
- 20 • ACE was associated with significantly fewer falls (RR 0.51 P=0.02)
- 21 • ACE was associated with significantly less occurrence of delirium (RR=0.73
22 P<.001)
- 23 • Functional decline
- 24 • Meta-analysis of 6 studies indicated individuals receiving ACE were 13%
25 less likely to experience functional decline compared to usual care (RR
26 0.87 P=0.01)
- 27 • Length of stay in hospital
- 28 • 11 complete studies Individuals receiving ACE care experienced
29 significantly shorter length of stay than usual care WMD=-1.28 P=0.02)
- 30 • Hospital readmissions

- 1 • Meta-analysis of 5 studies identified no significant difference within 1 or 3
- 2 months of discharge.(RR=1.05 P=.49)
- 3 • Discharge destination
- 4 • Meta-analysis of 9 studies 1.05 times more likely to be discharged home
- 5 (RR =1.05 P=0.01)
- 6 • Mortality
- 7 • No significant effect in 11 studies.

8 **6. Fox, M., Persaud, M., Maimets, I., Brooks, D., O'Brien, K. and**
9 **Tregunno, D (2013) Effectiveness of early discharge planning in acutely**
10 **ill or injured hospitalized older adults: a systematic review and meta-**
11 **analysis**

12 **Outline:** This was a good quality [++] systematic review and meta-analysis
13 that compared the effectiveness of early discharge planning to usual care.
14 The focus was on the effectiveness of interventions in reducing index length of
15 hospital stay, hospital readmissions and readmission length of stay and
16 secondarily in reducing mortality and increasing satisfaction with discharge
17 planning and quality of life for older adults admitted to hospital with an acute
18 illness or injury. This review included 7 studies in the final meta-analysis that
19 ranged in date from 1987 – 2011. Studies were from the UK, France and
20 Australia.

21 **Results:** The review found no significant difference in the effect of early
22 discharge planning on the Index length of hospital stay (days) or on mortality.
23 However it found that older adults who received early discharge planning
24 experienced significantly fewer hospital readmissions within one or twelve
25 months of index hospital discharge, and significantly fewer days in hospital
26 after readmission of almost two and a half days when compared to usual care.

27 The early discharge planning group reported higher quality of life scores at
28 two weeks and three months than the usual care group. No differences were
29 found on other domains, including physical functioning, role limitations due to
30 physical problems, bodily pain, mental health, role limitations due to emotional
31 problems, social functioning and vitality.

1 **7. Hesselink et al (2012) Improving patient handovers from hospital to**
2 **primary care: a systematic review.**

3 **Outline:** This is a good quality systematic review of randomised or controlled
4 trials [++] of interventions designed to improve the transfer of patient care
5 from hospital to primary care on discharge.

6 Medicine management was an outcome measure for interventions designed
7 to improve continuity of care, patient status and adverse events, or near
8 misses. Fourteen of the 22 studies examining an intervention with a focus on
9 improving the quality of the information exchanged at discharge showed a
10 statistically significant improvement. In these 14 studies, activities aiming to
11 improve the quality of the information exchanged involved; medication
12 reconciliation by a hospital pharmacist, study pharmacist, liaison pharmacist,
13 or community pharmacist in continuity of care.

14 **Results:** Effective interventions included

- 15 • Medication reconciliation;
- 16 • Electronic tools to facilitate quick, clear, and structured summary
17 generation;
- 18 • Discharge planning;
- 19 • Web-based access to discharge information for general practitioners.
- 20 • Use of electronic discharge notifications;
- 21 • Shared involvement in follow-up by hospital and community care providers.

22 While most interventions were multicomponent, medicine management
23 emerged as a specific component often associated with statistically significant
24 positive outcomes.

25 **8. Larsen T, Olsen TS, Sorensen J (2006) Early home-supported**
26 **discharge of stroke patients: health technology assessment.**

27 **Outline:** This is a moderate quality systematic review [+], which is also of
28 moderate relevance to our review area. It aimed to provide a comprehensive
29 and systematic assessment (HTA) of early home supported discharge by a
30 multi-disciplinary team that plans, coordinates and delivers care at home

1 (EHSD). Seven RCTs on EHSD with 1,108 patients followed 3–12 months
2 after discharge are selected for statistical meta-analysis of outcomes. Results
3 from this review are compared with that of conventional rehabilitation stroke
4 units.

5 **Results:**

- 6 • Incidents of poor outcomes (health or institution) reduced by 21.7% in the
7 conventional stroke unit to 14.5% in the EHSD group.
- 8 • Referrals to a nursing home or institution reduced by 5% from 11.3% to
9 6.3%.
- 10 • In six of the seven studies, the average length of stay at the hospital is
11 significantly reduced: the pooled effect sizes have a significantly shortened
12 length of initial stay by 10 days (CI, 2.6–18 days) to an average of 22 days,
13 including both the acute phase and the subsequent stroke unit
14 rehabilitation.
- 15 • No significant results are observed on the frequency of readmissions.

16 **9. Laugaland, K. et al (2012) Interventions to improve patient safety in**
17 **transitional care - a review of the evidence**

18 **Outline:** This is a moderate quality [+] systematic review of the effects of
19 discharge interventions on patient safety, e.g. adverse events. It focuses on
20 elderly patients, over 65 years of age, who have been discharged either home
21 or to a nursing home from tertiary care hospitals. The review identified the
22 following intervention types that aimed at the improvement of communication
23 during transitional care: profession-oriented interventions (e.g. education and
24 training), organisational/ culture interventions (e.g. transfer nurse, discharge
25 protocol, discharge planning, medication reconciliation, standardized
26 discharge letter, electronic tools), or patient and next of kin-oriented
27 interventions (e.g. patient awareness and empowerment, discharge support).

28 **Results:**

- 29 • Strong evidence of effectiveness seems to be principally limited to specific
30 diagnostic groups managed in specific settings.

- 1 • Developing a single, one-size-fits-all approach within transitional care of the
2 elderly does not appear possible because of the diversity and complexity of
3 elderly health care. Targeted interventions are more suitable.
- 4 • Successful interventions were found to:
 - 5 – Commence at an early stage and are maintained throughout
6 hospitalization and the post-discharge period.
 - 7 – Consist of a key health care worker which acts as a discharge
8 coordinator.
 - 9 – Include patient participation and /or education.
 - 10 – Involve family caregivers.
 - 11 – Undertake a multidisciplinary, multi- interventional component approach.
 - 12 – Contain curriculum teaching transitional care.
 - 13 – Contain pharmacy interventions- medication reconciliation.
 - 14 – Ensure standardized medication reports.

15 **10. Li Hong et al (2012) Randomized controlled trial of CARE: An**
16 **intervention to improve outcomes of hospitalized elders and family**
17 **caregivers**

18 **Outline:** This is a good quality [++] randomised control trial which tested the
19 efficacy of an intervention program, CARE: Creating Avenues for Relative
20 Empowerment, for improving outcomes of hospitalized older adults and their
21 family caregivers. 407 family caregiver-patient dyads were randomised into
22 two groups. The intervention group received a two-session empowerment-
23 educational programme, 1-2 days after admission and 1-3 days before
24 discharge. Those on the CARE Programme were assisted to develop a care
25 plan and received audio-taped and written materials which focused on
26 teaching family caregivers to be more effective and confident in their role.
27 Those in the comparison group received a generic information program that
28 mirrored the timeframe of the intervention.

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1 **Results:**

- 2 • There were no significant differences between CARE and control groups on
3 caregivers' emotional coping measures for depression, anxiety, and worry
4 or on functional coping measures for amount and quality of care giving.
5 • CARE family caregivers reported less role strain and better preparation to
6 participate in elders' post-hospital care than those in the control group.
7 However, there were no significant differences between CARE and control
8 groups in their ability to know what to expect and how to assist in the care
9 of hospitalized older relatives.
10 • There were no significant differences between the study groups on patient
11 outcomes at any time point.

12 **11. Lindpaintner (2013) Discharge intervention pilot improves**
13 **satisfaction for patients and professionals**

14 **Outline:** This is a single blind, randomised control pilot study of moderate
15 quality [+], which tests the feasibility of a discharge management intervention
16 for a larger, well-powered trial. The intervention was administered by nurse
17 care managers, who formulated a discharge plan for patients at high risk of
18 adverse events. Acutely ill patients fulfilled criteria such as polypharmacy,
19 therapy with anticoagulants or insulin, plus secondary criteria indicating
20 vulnerability. Nurse care managers collaborated with a physician team to
21 initiate and coordinate post-hospital care, both during the hospital stay and for
22 the first 5 days following discharge.

23 **Results:**

- 24 • The intervention group did not differ significantly from the control group
25 when measured at days 1-5 after discharge on: deaths, rehospitalisation,
26 urgent consultation or adverse medicine reaction.
27 • A secondary analysis of individual endpoints showed more
28 rehospitalisations in the intervention group, a difference which reached
29 significance in the time period between days 6 and 30 post-discharge
30 ($p=0.026$). However, this negative effect can, in part, be explained by 3

1 patients in the intervention group receiving planned chemotherapy (as
2 opposed to none in the comparison group)

- 3 • Despite the small sample size (n=60 acutely ill adults), subjective measures
4 of patient and family caregiver satisfaction with discharge were significantly
5 higher for those receiving the discharge intervention compared to the best
6 usual care.

7 **12. Newcomer (2006) Outcomes in a Nursing Home Transition Case-**
8 **Management Program Targeting New Admissions.**

9 **Outline:** This is a moderate quality [+] randomised control trial. The study
10 tests the effectiveness of Providing Assistance to Caregivers in Transition
11 (PACT), a program that offers nursing home discharge planning and case
12 management to individuals in the transitional period following a return to the
13 community. The intervention group received patient assessment, caregiver
14 assessment conducted by a social worker, and an assistive device and
15 environmental assessment, in addition to financial assistance if necessary.

16 **Results:**

- 17 • A trend suggesting a modest effect was reflected in both higher rates of
18 discharge (84% vs 76%) and shorter median stays (42 vs 55 days) in the
19 intervention group, but these differences are not statistically significant.
- 20 • The end-of-study status of each group was similar in terms of the number
21 of emergency room visits, hospital stays, nursing home readmissions,
22 losses to follow-up, and deaths.

23 **13. Olson, D., Bettger, J., Alexander, K., Kendrick, Amy., Irvine, J., Wing,**
24 **L., Coeytaux, R., Dolor, R., Duncan, P. and Graffagnino, C (2011)**

25 **Transition of care for acute stroke and myocardial infarction patients:**
26 **from hospitalization to rehabilitation, recovery, and secondary**
27 **prevention**

28 **Outline:** This is a good quality [++] systematic review. It investigated whether
29 evidence supports a beneficial role for coordinated transition of care services
30 for the post-acute care of patients hospitalized with first or recurrent stroke or
31 myocardial infarction (MI). Studies were included if they were published in

1 English from 2000 to 2011 and if they specified post-acute hospitalization
2 transition of care services as well as prevention of recurrent stroke or MI. The
3 population was adults, 18 years and over. The review included a total of 62
4 articles representing 44 studies for data abstraction. Transition of care
5 interventions were grouped into four categories: (1) Hospital-initiated support
6 for discharge to home or intermediary care units such as inpatient
7 rehabilitation or skilled nursing facilities (2a) Hospital-based patient and family
8 education interventions (2b) Community-based patient and family education
9 interventions (3) Community-based models of support interventions (most
10 common) and (4) Chronic disease management models of care (few). Studies
11 were included from Norway, Germany, Canada, Australia, Iran, UK, Italy,
12 Mexico, Denmark, Netherlands, Poland, Finland and the US.

13 **Results:**

- 14 • Quality of life and hospital readmissions:
 - 15 – Early supported discharge as a component of hospital-initiated discharge
16 planning (intervention type 1) after stroke was associated with a
17 reduction in total hospital length of stay without adverse effects on death
18 or functional recovery (moderate strength of evidence).
 - 19 – Specialty follow-up, a component of hospital-initiated support
20 (intervention type1), after MI and guideline-based practice were
21 associated with a reduction in mortality (low strength of evidence).
 - 22 – There was insufficient evidence to support a beneficial role for
23 intervention types 3 or 4 in terms of improvement in functional status;
24 quality of life; and reduction in hospital readmission, morbidity, and
25 mortality.
 - 26 – There was little consistency in the transition of care interventions from
27 one study to another.
 - 28 – There was much variability in the selection of outcome measures for
29 evaluating the success of transition of care interventions.

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- 1 • Risks and potential harms:
 - 2 There was insufficient evidence to determine if there were differential rates of
 - 3 adverse events for transition of care interventions or components of transition
 - 4 of care services because rates for adverse events were similar for intervention
 - 5 and usual-care groups.

- 6 • Service outcomes:
 - 7 – The use of emergency department services may be lessened by early
 - 8 education regarding stroke or MI symptoms (intervention type 2).
 - 9 – Disease management programs may be more effective than remote
 - 10 phone calls for patients with MI (intervention type 3).
 - 11 – Early return to work after MI may be safe and may be cost-effective from
 - 12 a societal perspective (intervention type 1). It did not seem to increase
 - 13 health care utilization, and it may save the cost of cardiac rehabilitation
 - 14 in low-risk patients.
 - 15 – Early supported discharge in low-risk stroke patients reduced hospital
 - 16 days and was thus cost-effective (intervention type 1). It did not increase
 - 17 burden on family providers (moderate level of evidence).
 - 18 – Physician appointments or home visits by physical therapists may
 - 19 reduce readmission rates for stroke patients (intervention type 3). Visits
 - 20 by nurses did not produce the same effects (intervention type 3).
 - 21 – Family support and case management services may reduce visits to
 - 22 physical therapists and specialists (intervention type 3).

23 **14. Preyde M, Macalay C, Dingwall T (2009) Discharge planning from**
24 **hospital to home for elderly patients: a meta-analysis**

25 **Outline:** This was judged to be a low [-] quality systematic review and meta-
26 analysis. It pooled the results from a diverse range of studies about discharge
27 planning including pre-discharge interventions and those that aimed at
28 bridging the transition from hospital to home. Interventions in the included
29 studies ranged in type, intensity and who delivered the discharge planning.

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1 **Results:**

2 • **Findings of effect**

- 3 – Authors found that “Augmented DP” (Discharge planning) appears to
4 have a large effect on patient satisfaction (mean ES 0.83), moderate
5 effects on QoL (.45) and readmission (.45), while only a small effect on
6 function (.31) and Length of Stay (.26).
7 – Augmented discharge planning appears to have a robust effect on
8 patient satisfaction and moderate effects on quality of life and hospital
9 resources.
10 – No strong effects were noted for any one type of DP, patient
11 characteristic, or quality assessment rating.

12 • **Findings on the evidence base**

- 13 – In terms of study quality, inadequate reporting of methods and outcome
14 data was evident in a considerable number of trials.
15 – Only one study could be located where the test intervention was social
16 work coordinated.
17 – The authors point out that an important finding was the dearth of
18 research evidence on the effect of social work coordinated discharge
19 planning.

20 **15. Preyde, M. and Brassard, K. (2011) Evidence-based risk factors for**
21 **adverse health outcomes in older patients after discharge home and**
22 **assessment tools: a systematic review.**

23 **Outline:** This is a moderate quality systematic review [+]. It aimed to profile
24 risk factors for adverse health outcomes for older patients discharged to their
25 homes from an acute care setting. A second purpose was to identify and
26 assess discharge assessment tools that could identify these risk factors a
27 priori based on the premise that the current health care system is discharging
28 elderly patients “quicker” and “sicker” from acute care facilities.

29 Consequently, hospital readmission is common; however, readmission may
30 only be one aspect of adverse outcomes of importance to social work
31 discharge planners. The early recognition of risk factors might ensure a
32 successful transition from the hospital to the home.

1 For this review 'adverse outcomes' was defined as the occurrence of one of
2 three events within 6 months post-discharge from an acute care setting:
3 mortality, readmission to an acute care setting, or clinically significant decline
4 in physical or psychosocial functioning.

5 **Results:**

- 6 • Discharge factors were significantly associated with adverse outcomes
7 post-discharge. A lack of documented family or patient education was
8 found to significantly relate to readmission.
- 9 • Evidence indicated that need for health care information, health and
10 concrete resource services, and emotional counselling were central to
11 optimal discharges from hospital to home.
- 12 • Other significant factors revealed in the present review were limited social
13 work involvement at admission, post-discharge patient distress and
14 unresolved medical problems at discharge.
- 15 • Risk factors
 - 16 – The most frequently cited risk factors associated with adverse health
17 outcomes after discharge were depression, poor cognition,
18 comorbidities, length of hospital stay, prior hospital admission, functional
19 status, patient age, multiple medications, and lack of social support.

20 The authors conclude that although more research is needed to determine the
21 effectiveness of various assessment tools, a comprehensive and efficient tool
22 may facilitate discharge practice. Effective discharge planning may enhance
23 the alignment of the patient to effective intervention, delay deterioration,
24 prevent readmission and adverse outcomes, and lead to improved quality of
25 life.

26 **16. Rennke et al (2013) Hospital-Initiated Transitional Care Interventions**
27 **as a Patient Safety Strategy**

28 **Outline:** This systematic review of randomised or controlled trials was judged
29 to be of good quality and of moderate relevance to the UK context [++/+]. It
30 aimed to review evidence in the international literature on the effect of
31 Pharmacist led interventions on post discharge clinical adverse events (AE).

1 **Results:** Three studies in the review reported statistically significant
2 reductions in post discharge AE rates:

- 3 • One study found that a pharmacist-led intervention reduced medication-
4 related readmissions within 12 months of hospital discharge. The
5 intervention targeted elderly patients and involved inpatient monitoring,
6 counselling, discharge teaching and medication reconciliation, and post
7 discharge telephone follow-up.
- 8 • A comprehensive pharmacist-led intervention reduced preventable drug
9 adverse events and reduced a composite outcome of medication-related
10 emergency department visits and hospital readmissions within 30 days of
11 hospital discharge.
- 12 • Another pharmacist-led study that included discharge medication
13 counselling without post discharge follow-up reduced adverse drug events
14 in a Saudi Arabian population.

15 Two additional studies reported reductions in post discharge AEs with
16 pharmacist- led medication safety interventions; findings were not statistically
17 significant, but both studies were underpowered to detect important
18 differences between intervention and control groups.

19 ***Studies reporting views and experiences data (n=11)***

20 **1. Baumann, M., Evans., S., Perkins, M., Curtis, L., Netten, A., Fernandez**
21 **J-L. and Huxley, P (2007) Organisation and features of hospital,**
22 **intermediate care and social services in English sites with low rates of**
23 **delayed discharge.**

24 **Outline:** This qualitative study of moderate quality [+] was designed to
25 investigate discharge practice and the organisation of services at sites with
26 consistently low rates of delay. The study was commissioned by the
27 Department of Health prior to the introduction of the Community Care
28 (Delayed Discharges etc.) Act, 2003. However, the Act was implemented
29 before completion of the study, so it was redesigned to investigate: discharge
30 planning and organisation of services prior to the Act; progress with
31 implementation, and the impact of the Act on local discharge planning and

1 organisation of services. Interviews with 42 health and social services staff
2 involved in hospital discharge were conducted in 6 English sites. The
3 proposed methodology involved service user interviews but the researchers
4 were unable to secure sufficient participation. The authors were transparent
5 about these and other problems encountered. Nevertheless, data collection
6 and analysis could have been more robust.

7 **Results:** Findings are reported under the relevant views and experiences
8 questions.

9 **4 (a) What do health, social care and housing practitioners think works**
10 **well, what does not work well what could improve the transition from**
11 **inpatient hospital settings to community or care home settings?**

12 ***Works well***

13 Prioritization of efforts to tackle delays at strategic and operational levels was
14 common to all sites. Multi and single-agency forums had been established at
15 a senior level to monitor delays and take action to reduce rates. The
16 Community Care (Delayed Discharges etc.) Act was a key driver of further
17 activity, since it required intensive joint work to develop protocols, implement
18 new systems, train staff, and commission new or expand existing services.

19 Medical assessment units (MAUs) had recently been established to provide
20 short-stay beds prior to a patient's admission to an acute ward. Here, health
21 and social care needs were assessed, and where possible, community
22 services were arranged. Intermediate care assessment staff were regular
23 visitors to A&E departments and MAUs to facilitate access to non-acute care.

24 Intermediate care services, involving a number of steps up and steps down to/
25 from acute care. In addition, a single Intermediate Care Assessment Team,
26 assessing patients for all Intermediate Care Services, whether they were in
27 A&E, in hospital or at home.

28 Having care managers attached to specific wards helps nurture the
29 development of good relationships and communication between wards and
30 social services. Where hospital based teams had their own budgets for

1 purchasing care, and dedicated 'placement officers' to identify vacancies in
2 suitable residential homes and/or domiciliary care, care managers were able
3 to focus entirely on care planning.

4 **10 (a) What helps and what makes it difficult to ensure successful**
5 **transitions from inpatient hospital settings to community or care home**
6 **settings?**

7 ***What helps***

8 Discharge coordinators/ teams. They support ward nurses in discharge
9 planning by monitoring patients from admission to discharge, identifying
10 patients who may require ongoing social or continuing care and by using
11 patient information systems to monitor nurses' progress with arranging
12 discharge.

13 ***Makes it difficult***

14 A lack of psychiatrists and community based mental health services meant
15 that older people with mental health problems were especially vulnerable to
16 delays.

17 The late specification of discharge drugs by doctors makes it difficult for
18 hospitals to achieve same-day discharges. Also, most sites experienced
19 difficulties with managing arrangements for cross-boundary service use,
20 although smaller sites, and those with coterminous boundaries, had less
21 difficulty.

22 Since the implementation of the Community Care (Delayed Discharges etc.)
23 Act, ward staff had begun to notify social services 3 days before a planned
24 discharge and sometimes even on admission. However 3 days was generally
25 felt to be insufficient especially where sensitive discussions with people and
26 their families were required.

27 **2. Benten (2008) Intermediate care: what are service users' experiences**
28 **of rehabilitation?**

29 **Outline:** This is a moderate quality [+] phenomenological study, which aimed
30 to investigate the experiences of older people on moving from hospital to an

1 alternative location providing intermediate care prior to going home. Using
2 face-to-face, semi-structured interviews the research question being explored
3 was: did the intermediate care unit provide rehabilitation that met the needs of
4 service users? Following the government's programme for improving services
5 for older people as set out in the NHS Plan (Department of Health, 2000) and
6 National Service Framework for Older People (Department of Health, 2001),
7 which introduced intermediate care as a central element, the study's findings
8 are aligned to the underlying principles of intermediate care as set out in the
9 document to support these initiatives.

10 **Results:**

- 11 • Users' experiences did not reflect the Department of Health's four principles
12 that underpin the delivery of intermediate care: person-centred care; whole
13 system working; timely access to specialist care; promoting health and an
14 active life.
- 15 • All users expressed satisfaction in respect of their stay (although caution
16 should be taken when considering reported satisfaction with this age
17 group). However, given the users' lack of understanding of the purpose of
18 the unit and the potential for their rehabilitation (as defined in the
19 operational policy and external references to key characteristics of effective
20 rehabilitation) this is perhaps unsurprising.

21 **3. Bryan, K., Gage, H. and Gilbert, K. (2006) Delayed transfers of older** 22 **people from hospital: causes and policy implications.**

23 **Outline:** This low quality [-] study used mixed methods to attempt to resolve
24 the problem of delayed hospital transfers in one English district. Researchers
25 collected cross sectional and qualitative data using hospital records and
26 interviews with key informants. Triangulating these data, the researchers
27 investigated the causes of delays. The records of 125 people aged 65 and
28 over were included in the study and six middle managers, three from each of
29 health and social services, were interviewed. Service user perspectives were
30 obtained by way of a local Age Concern officer, an approach that the
31 reviewers judge to be flawed. Although the authors do not explain their choice
32 of mixed methodology, the methods are appropriate. However the interview

1 respondents were limited in number and did not provide a good range of
2 perspectives. Reported data were not 'rich'.

3 **Results:** Findings are reported under the relevant views and experiences
4 questions.

5 **1.1 (a) What are the views and experiences of people using services, in**
6 **relation to the transition from inpatient hospital settings to community**
7 **or care home settings?**

8 The Age Concern officer felt that the main problems from the perspective of
9 older patients are problems with family carer roles and maintaining a right to
10 make decision during hospital discharge planning.

11 **10 (a) What helps and what makes it difficult to ensure successful**
12 **transitions from inpatient hospital settings to community or care home**
13 **settings?**

14 ***Makes it difficult***

15 From the delayed discharge records, the following reasons account for delays
16 (number of people delayed and mean delay):

- 17 • Awaiting decision about social service funding, 37 people (40.7 days)
- 18 • Seeking of care home placement: by social services, 14 people (37.4 days)
19 or privately, 15 people (20.1 days);
- 20 • Family delays, 14 people (27.8 days);
- 21 • Domiciliary care unavailable, 8 people (29.3 days);
- 22 • No sub-acute NHS bed, 9 people (23.7 days).

23 ***Makes it difficult***

24 According to the managers, the reasons most frequently perceived related to
25 the availability of adequately trained home care assistants. There was also
26 agreement about other major barriers:

- 27 • Shortages of health and social care professionals, including lack of
28 provision of round-the-clock professional and care worker support for
29 people returning to their own homes;

- 1 • Funding limitations, both inadequate resources at the disposal of social
2 services to provide domiciliary care, and the high cost of residential
3 placements;
- 4 • Confusion of responsibilities between health and social care agencies
5 giving rise to poor co-ordination.

6 **4. American Pharmacists Association and American Society of Health-**
7 **System. (2013) ASHP-APhA Medication Management in Care Transitions**
8 **Best Practices**

9 **Outline:** This review of best practice programmes is judged to be of low
10 quality [-] and moderately relevant to the UK context [+]. The review focuses
11 on medication management in care transitions.

12 The study was initiated by The American Society of Health-System
13 Pharmacists (ASHP) and the American Pharmacists Association (APhA) who
14 jointly issued a profession-wide call for best practice involving pharmacists in
15 the care transitions process. The purpose of the Medication Management in
16 Care Transitions (MMCT) project was to identify and profile existing best
17 practice models that are scalable for broad adoption. To evaluate the best
18 practice models, ASHP and APhA assembled expert panels composed of
19 pharmacists skilled in working with MMCT programs.

20 The assessment process focused on three main criteria:

- 21 • Impact of the care transitions model on patient care
- 22 • Pharmacy involvement in the transition process from inpatient to home
23 settings
- 24 • Potential to scale and operationalize the process for implementation by
25 other health systems.

26 Out of 80 programmes that responded to the call, 8 programs were
27 designated as 'best practice'.

28 **Results:** Findings are presented under the relevant views and experiences
29 questions.

1 **10 (a) What helps and what makes it difficult to ensure successful**
2 **transitions from inpatient hospital settings to community or care home**
3 **settings?**

4 ***Makes it difficult***

5 ***Financial Resources***

6 Resources were needed for additional staffing and advancing electronic data
7 sharing systems.

8 ***Staffing Resources***

9 Staffing was a significant challenge, particularly in providing out of hours or
10 weekend care.

11 ***Communication***

12 Barriers to communication during transition were reported between:

- 13 • Pharmacists and providers.
14 – Inpatient and outpatient partners.
15 – Inpatient and outpatient pharmacists.
16 – Pharmacists and patients/caregivers.
17 – Pharmacists and administrative leadership.

18 ***Difficulty Developing Partnerships With Inpatient or Outpatient Partners***

19 The most common barriers to developing partnerships have been listed above
20 (staffing, financial resources etc). Communicating a strong case for pharmacy
21 involvement was via data and evidence.

1 **4 (a) What do health, social care and housing practitioners think works**
2 **well, what does not work well and what could improve the transition**
3 **from inpatient hospital settings to community or care home settings?**

4 ***Works well***

5 ***Electronic Transfer of Patient Information and Data to Partner Groups***

6 Those best practice programmes that had a bi-directional ability to view and
7 augment Electronic Health Records had a distinct advantage in assisting
8 educational efforts and communication of drug therapy.

9 ***Multidisciplinary Support and Collaboration***

10 The ability for multiple health professional disciplines to collaborate and
11 communicate effectively and efficiently was evident in all successful models.
12 Programs that could foster collaborative ways of working demonstrated
13 pronounced benefits to patient care, decreased length of stay, and decreased
14 readmissions.

15 ***Effective Integration of the Pharmacy Team***

16 Educational resources and training opportunities in conjunction with colleges
17 and schools of pharmacy have played an important part in addressing the
18 needs of patients during care transitions.

19 ***Data Available to Justify Resources***

20 Solid data collection processes and the ability to systematically review and
21 share applicable metrics drove successful practice. Common metrics
22 included:

- 23 • Readmissions
- 24 • Length of stay
- 25 • Emergency department visits.
- 26 • Medication-related problems at medication reconciliation (e.g., duplication
27 of therapy)

- 1 • Omission of needed drug therapy; correct drug but dosage too high or too
- 2 low; drug interactions)
- 3 • Disease-specific metrics.
- 4 • Patient satisfaction or Hospital Consumer Assessment of Healthcare
- 5 Providers and Systems (HCAHPS)–related metrics.

6 ***Electronic Patient Information and Data Transfer Between Inpatient and***

7 ***Outpatient Partners***

8 In all these best practice programmes the ability to securely and efficiently

9 transfer patient information were beneficial.

10 ***Strong Partnership Network***

11 The alignment of resources was a keystone to providing a unified approach to

12 patient care. Pharmacy partnerships involved hospital pharmacy departments,

13 community pharmacies, regional pharmacy chains, ambulatory pharmacy

14 services and clinics, health clinic pharmacies, home infusion pharmacies, and

15 many others.

16 **5. Connolly, M., Grimshaw, J., Dodd, M., Cawthorne, J., Hulme, T.,**

17 **Everitt, S., Tierney, S. and Deaton, C. (2009) Systems and people under**

18 **pressure: The discharge process in an acute hospital.**

19 **Outline:** This is a moderate quality [+] study designed to understand the

20 perspective of hospital-based health professionals with regard to preparing

21 patients for discharge from an acute hospital in England. Three focus groups

22 were conducted and the data analysed using a framework approach. Eleven

23 nurses participated, fifteen allied health professionals, five social workers and

24 one doctor. Analysis identified two broad themes and a number of sub

25 themes:

- 26 • Conflicting pressures on staff
 - 27 – Keeping patients in hospital vs. getting them out;
 - 28 – Striving for flexibility within a system;
 - 29 – A paucity of intermediary provision.
- 30 • Casualties arising from conflicting pressures:

- 1 – Professionals losing their sense of professionalism;
- 2 – Patients being 'systematised'.

3 The study is only judged to be 'somewhat' relevant to this review area
4 because focus groups discussed preparing all patients for discharge rather
5 than having a specific focus on adults with social care needs.

6 **Results:** Findings are reported under the relevant views and experiences
7 questions.

8 **3.(a) What are the views of health, social care and housing practitioners**
9 **about the transition from inpatient hospital settings to community or**
10 **care home settings?**

11 Focus group members described feeling compelled to make discharge a swift
12 procedure by managers and consultants, who were seen as striving to
13 achieve government targets. Participants were keen for people to be allowed
14 out of hospital as soon as they were ready; otherwise they risked acquiring an
15 infection. However, they argued that this was not always possible when
16 community services were required and that speed did not necessarily equate
17 with an effective discharge: "...there's lots of pressure on us from the
18 government to get beds filled, to get the operation waiting list down etc. So the
19 consultant asks 'why is this patient here? We need to get them out as soon as
20 we can.'...(p552) and "...the focus at the moment and this is where I'm quite
21 appalled at the moment with dragging people through the system and
22 identifying who could go and I feel it's quite sad because these are human
23 beings..." Professionals don't get time to think through how to address
24 someone's range of needs and as a result patients come back again (re-
25 admitted).

26 **4 (a) What do health, social care and housing practitioners think works**
27 **well, what does not work well what could improve the transition from**
28 **inpatient hospital settings to community or care home settings?**

29 ***Works well***

30 Multi-disciplinary teams: They were seen as a way of avoiding communication
31 difficulties.

1 A discharge (stroke) coordinator who collected information for people to take
2 home with them about equipment that had been ordered, medication and its
3 side effects and a list of useful phone numbers. This individual also checked
4 on patients one week post-discharge. Discharge coordinators were seen as a
5 means of overcoming the problem of no one assuming responsibility for
6 organising discharge and no one being clear of their role in discharge
7 planning.

8 ***Does not work well***

9 Poor internal communication, which leads to confusion about arranging tests
10 or services. Key professionals are also left out of decisions about people's
11 discharge, for instance occasions where patients who are confused or who
12 lack capacity have been discharged to residential or nursing homes without
13 Social Services being informed.

14 Training in discharge procedures. Junior staff teach incoming professionals,
15 meaning competency gets weaker and weaker. Discharge is therefore not
16 something people learn about formally. There was a general sense of people
17 not taking it seriously and a lack of clarity among professionals about whose
18 responsibility it is and what role the different professionals should take.

19 ***Could improve transitions***

20 More intermediate provision - respondents felt that more facilities were
21 needed to act as a buffer between hospital and home to assist with the
22 recovery of medically stable individuals still in need of care and attention. "It's
23 between here and home isn't it. We need something in the middle." (p553)

24 Follow up care – this was felt to be really important, especially in complex
25 cases. However, who should arrange this was a point of contention - nurses
26 felt it would be an added pressure on their workload. They also expressed
27 concerned about what to do if someone said they weren't coping.

28 Treating the whole person - some of the current procedures associated with
29 discharge were depicted as dehumanising. For example, people were given
30 labels such as 'medically fit for discharge', which oversimplifies cases and

1 highlights that once the medical or 'acute' problem had been addressed, any
2 remaining difficulties that patients' experienced were not regarded as the
3 hospital's concern. An emphasis on a swift discharge was felt to overlook
4 people's unique circumstances and prevent the establishment of an individual
5 discharge path.

6 **10 (a) What helps and what makes it difficult to ensure successful**
7 **transitions from inpatient hospital settings to community or care home**
8 **settings?**

9 ***Helps***

10 Relatives can help facilitate discharge, advising on arrangements that will
11 need to be made and providing care at home themselves.

12 ***Makes it difficult***

13 Although they can help, relatives sometimes present obstacles to discharge,
14 especially where they're pre-occupied with the financial implications of the
15 discharge - or they see the hospital as providing respite care.

16 **6. Connolly (2010) Discharge preparation: do healthcare professionals**
17 **differ in their opinions?**

18 **Outline:** This qualitative study of moderate quality [+] surveyed the views of
19 455 hospital health professionals, therapists and social workers. The study,
20 conducted in a large acute UK hospital aimed to: examine discharge
21 preparation; identify factors that affect the quality of discharge preparation;
22 identify strategies and resources needed to improve discharge preparation
23 and in doing so, compare the views and experiences of practitioners from
24 different professional backgrounds. The survey method was judged to be
25 appropriate to meet the study aims although the relevance to this review area
26 is questionable because survey questions relate to all hospital patients.

27 **Results:** Findings are reported under the relevant views and experiences
28 questions.

1 **4 (a) What do health, social care and housing practitioners think works**
2 **well, what does not work well what could improve the transition from**
3 **inpatient hospital settings to community or care home settings?**

4 ***Could improve***

5 Training - 66% of respondents agreed that discharge would be improved by
6 further training of staff. Nurses and midwives seemed less content with the
7 amount of training on discharge preparation than doctors.

8 **10 (a) What helps and what makes it difficult to ensure successful**
9 **transitions from inpatient hospital settings to community or care home**
10 **settings?**

11 ***Makes it difficult***

- 12 • Aligning all parts of the discharge plan - 75% of practitioners agreed that
13 waiting for one part of the discharge plan to be completed before another
14 could commence was a problem.
- 15 • Moving patients between wards - according to 72% of respondents this
16 causes discharge delays.
- 17 • Staffing levels - 44% of respondents felt they were inadequate staff to
18 prepare patients for discharge.
- 19 • Government targets - 80% of respondents felt that performance targets
20 placed on the hospital by government (e.g., the target to limit the length of
21 time any patient spends in the emergency department to 4 hours) could
22 cause the discharge process to be hurried to accommodate new patients
23 with the frequent result that the patients return to hospital within days.
- 24 • Tension between professional and family views. 87% of participants agreed
25 that relatives could have an unrealistic expectation of services available.

26 **7. Huby, G., Stewart, J., Tierney., A and Rogers, W. (2004) Planning older**
27 **people's discharge from acute hospital care: linking risk management**
28 **and patient participation in decision-making AND**

29 **Huby, G., Holt Brook, J., Thompson., A. and Tierney., A (2007) Capturing**
30 **the concealed: inter-professional practice and older patients'**

1 **participation in decision-making about discharge after acute**
2 **hospitalization.**

3 **Outline:** Huby et al (2004) and Huby et al (2007) report findings from the
4 same study, which was judged to be of good quality [++]. It used mixed
5 methods, including semi-structured interviews with 22 patients and 11 staff
6 plus systematic observation of discharge planning over a 5-month period.
7 Patients were recruited from three wards in a district general hospital in
8 Scotland. They were purposively sampled to give variation in age (all 60 and
9 over), gender, home circumstances (living alone or with carer), severity of
10 condition (impact on daily life and prospects of recovery) and complexity of
11 care (number of services needed on discharge). A follow-up home interview
12 was conducted with 11 of the patients approximately two weeks after their
13 discharge. The methods used in this study were judged appropriate.

14 The authors state that the 2004 paper describes findings related to the
15 analysis of the patient journey in which they identified the key drivers of
16 discharge decision-making, whereas the 2007 paper relates more to decision
17 making in the hospital setting. In fact both papers describe the way that inter-
18 professional working affects older peoples' participation in decisions about
19 their discharge from hospital so the distinction between the papers is not as
20 marked as the authors describe.

21 **Results:** The findings from the two papers are synthesized below and
22 presented under the relevant views and experiences questions.

23 **1.1 (a) What are the views and experiences of people using services, in**
24 **relation to the transition from inpatient hospital settings to community**
25 **or care home settings?**

26 Both patients in the case studies described by Huby et al, 2004 were
27 withholding information and opinions from the professionals, which they
28 themselves explained by their declining physical and mental powers. They felt
29 the professionals (doctors especially) know best. They also equate making
30 their opinions known with making a criticism, which they were keen to avoid.
31 The researcher observed that this reluctance to express a view (or lack of

1 encouragement to do so) resulted in neither patient having an influence on
2 decisions around their treatment or discharge.

3 **2.1 (a) What do people using services, think works well, what does not**
4 **work well, and what could improve the transition from inpatient hospital**
5 **settings to community or care home settings?**

6 ***What could be improved***

7 (Note that this is an interpretation by the researcher from the perspective of
8 the patient). The transition would be improved if the professionals treated the
9 whole person, considering all relevant circumstances. The researcher noted
10 that the focus of decision-making narrowed to particular physical or cognitive
11 functions, interpreted out of the context of patients' management of their lives.
12 He noted that test results are shared at a meeting of professionals
13 (consultant, nurse, OT, physio, social worker) but the patient is not present to
14 provide any context to the results.

15 4 (a) What do health, social care and housing practitioners think works well,
16 what does not work well what could improve the transition from inpatient
17 hospital settings to community or care home settings?

18 ***Does not work well***

19 The researcher observed that involving the patient in decisions about
20 treatment and discharge does not work well. At key points in the patient
21 journey, there was no discussion with the patient (including around the lack of
22 home care resources). A geriatric consultant described case conferences in
23 which goals are set for the patient. The case conference is attended by a
24 multi-disciplinary team but not by the patient. The patient is later told the
25 outcome of the meeting by the consultant. The consultant explained that the
26 resource implications of conducting ward case conferences with patients
27 present are prohibitive.

1 **10 (a) What helps and what makes it difficult to ensure successful**
2 **transitions from inpatient hospital settings to community or care home**
3 **settings?**

4 ***Makes it difficult***

5 The researcher observed a ward round on a medical admission ward and
6 noted the effects of poor team working and information sharing. There was
7 confusion among the attending professionals who had clearly failed to share
8 information in advance. The consultant told the patient she could go home
9 only to be corrected by the nurse who pointed out that the OT and physio
10 assessment found the patient's poor mobility put her at risk of falling. The
11 exchange, played out in front of the patient, was described by the researcher
12 as "very tense". The researcher was also concerned about the potential
13 consequences had the OT and physio assessments been overlooked.

14 In both case studies a lack of available community services (home care)
15 meant they could not be discharged from hospital. In the case of Mrs B, she
16 had to wait "several weeks". The delay also meant she was moved from the
17 geriatric ward (where the OT and physio are based) to a general ward "where
18 long term patients are sent for 'boarding'" (Huby et al, 2004 p125)

19 Hospital bed shortages were clearly on the minds of some of the patients
20 interviewed who felt pressured into saying they felt well when they didn't. "As I
21 say they used to go round every day and say 'well, Mr. So-and-So's not bad
22 we'll get him put out today and So-and-So can go tomorrow and that'll give us
23 two beds vacant for other people to come in.'" (Huby et al, 2004 p128)

24 There were clear conflicts between the roles and responsibilities of different
25 medical staff involved in the discharge process with consultants under
26 pressure to prevent "bed blocking" and nurses and AHPs, concerned with
27 patients' functional ability and the potential risks of discharge. Nurses/ AHPs
28 were responsible for the practical discharge arrangements, which could take
29 time, and often wanted to delay discharge beyond the "clinically ready to go
30 home" date. The hospital social worker was responsible for organizing social

1 care, such as home help, meals on wheels, or a care home place and these
2 resources were poorly resourced (Huby et al, 2007).

3 **8. Mold, F; Wolfe, C and McKeivitt, C (2006) Falling through the net of**
4 **stroke care**

5 **Outline:** This moderate quality [+] qualitative study investigated stroke
6 professionals' views of whether particular kinds of patients might be more or
7 less likely to receive best quality care throughout the stroke care pathway, and
8 for what reasons. One-on-one focused interviews with 41 professionals from
9 hospital and community settings in South London were conducted in order to
10 determine the extent of inequalities in stroke service provision and how they
11 might arise. Clinical and social care professionals working in two hospital-
12 based stroke units as well as social workers and rehabilitation professionals in
13 the community answered questions which applied to three main categories:
14 'admission to a stroke unit', 'provision of hospital rehabilitation therapies', and
15 'services after discharge from hospital'.

16 An earlier analysis of a population-based stroke register identified variations in
17 provision of care; this study was carried out in order to investigate how these
18 differences might arise. Professionals highlighted deficiencies in the provision
19 of stroke services but in so doing they also described the factors that they
20 take into consideration when making decisions about referrals.

21 **Results:** Findings are reported under the relevant views and experiences
22 questions.

23 **4 (a) What do health, social care and housing practitioners think works**
24 **well, what does not work well what could improve the transition from**
25 **inpatient hospital settings to community or care home settings?**

26 ***Does not work well***

27 The needs of younger people with stroke were identified as less likely to be
28 met, particularly in relation to assistance to return to work. Local schemes to
29 facilitate return to the job market exist but have limited availability.

1 People with addictions (such as alcohol) were identified as being incompatible
2 with community services. People with milder cognitive impairment were more
3 likely to 'slip through then net' due to the way that services were organised.

4 Patients' communication problems, including those caused by stroke, pre-
5 existing limited literacy skills, and having English as a second language, were
6 all thought to constitute barriers to community service use.

7 **10 (a) What helps and what makes it difficult to ensure successful**
8 **transitions from inpatient hospital settings to community or care home**
9 **settings?**

10 ***Makes it difficult***

11 Front-line service providers reported practicing a kind of 'rationing' when it
12 comes to providing stroke care. Whilst aware that it was not socially just,
13 professionals admitted having to 'pick and choose' who received services and
14 who didn't. The decision-making process drew on three kinds of
15 consideration: notions of clinical benefit; resource management against
16 competing demands; moral evaluations of individual patients to assess their
17 suitability for care.

18 Certain categories of service user were susceptible to not receiving services
19 on account of their differences from the 'ideal' stroke care service user.
20 Professionals identified the following groups as being particularly at risk: those
21 who were cognitively impaired (especially those with mild cognitive
22 impairment); those regarded as having 'complex problems' (i.e. multiple
23 pathologies, patients with addictions, and those with problematic social
24 situations); those with communication problems: and younger people (<65
25 years)

26 **9. Nosbusch, J., Weiss, M. and Bobay, K. (2011) An integrated review of**
27 **the literature on challenges confronting the acute care staff nurse in**
28 **discharge planning.**

29 **Outline:** This is a moderate quality systematic review [+] that aimed to
30 synthesise previous research investigating practices, perceptions and

1 experiences of bedside staff nurses in relation to hospital discharge planning.
2 Reports were included if the focus of the research was discharge planning for
3 patients' transition from hospital to home and the role of the bedside nurse
4 working in adult medical–surgical, intermediate care, or critical care units.
5 Data relating to the nurse could reflect the perspectives of registered nurses,
6 other non-nursing health care professionals, patients and patients' family
7 members.

8 **Results:** Findings are reported under the relevant views and experiences
9 questions.

10 **4 (a) What do health, social care and housing practitioners think works**
11 **well, what does not work well what could improve the transition from**
12 **inpatient hospital settings to community or care home settings?**

13 ***Could improve transition***

14 Staff nurses and other direct care providers should strive to improve
15 communication and working relationships by embracing a collaborative, team-
16 based approach to patient centred discharge planning.

17 The modification of end-of-shift reports to include a discharge preparation
18 summary at each hand-off could improve verbal communication among
19 nurses.

20 A second change designed to improve communication (written and electronic)
21 is the use of critical pathways. Effective interagency communication can be
22 accomplished through timely and comprehensive completion of standardised
23 referral forms and creation of formal feedback system. Electronic decision
24 support and discharge referral systems have the potential to facilitate effective
25 communication among providers and agencies.

26 Findings revealed that bedside/ staff nurse contributions to discharge planning
27 are not highly visible in complex acute care environments dominated by
28 technology and its related practices. Staff nurses should make every effort to
29 organise patient care responsibilities, so they are able to actively participate in
30 interdisciplinary rounds and discharge planning meetings.

1 **10 (a) What helps and what makes it difficult to ensure successful**
2 **transitions from inpatient hospital settings to community or care home**
3 **settings?**

- 4 • Acute care bedside staff/ nurses encountered the following barriers when
5 preparing patients and families for transition from hospital to home:
- 6 • Absent or ineffective verbal and written communication
- 7 • Lack of integrated systems and structures
- 8 • Insufficient time
- 9 • Lack of continuity in patient care responsibilities
- 10 • Knowledge that quickly needs updating
- 11 • Role confusion.

12 **10. Taylor, B. and Donnelly, M. (2006) Professional Perspectives on**
13 **Decision Making about the Long-Term Care of Older People**

14 **Outline:** This good quality [+] qualitative study investigated the perspectives
15 of a range of health and social services staff on risk and decision making
16 regarding the long-term care of older people. The study was conducted in
17 Northern Ireland, where 4 trusts were purposively sampled to represent each
18 of the 4 Health and Social Services Board areas, at least one 'integrated'
19 Trust (i.e. providing both acute hospital and community services) and at least
20 one providing only community health and social services; and at least one
21 serving each of rural and urban areas. Participants were also purposively
22 sampled and comprised of care managers, social workers, consultant
23 geriatricians, general medical practitioners, community nurses, home care
24 managers, occupational therapists & hospital discharge support staff. They
25 participated in focus groups and in-depth interviews. The qualitative methods
26 were judged to be appropriate to the aims of the study and data collection and
27 analysis were reliable.

28 **Results:** Findings are reported under the relevant views and experiences
29 questions.

1 **4 (a) What do health, social care and housing practitioners think works**
2 **well, what does not work well what could improve the transition from**
3 **inpatient hospital settings to community or care home settings?**

4 ***Does not work well***

5 Participants described how decisions are taken to refer older people to
6 institutional care on discharge from hospital. They described how these
7 decisions are usually made in a crisis situation, for example due to 'societal
8 factors'. Examples were given of a landlady not allowing an elderly tenant to
9 return home after hospital. Other 'societal factors' include the lack of available
10 public funding with only the most urgent cases receiving a publicly funded
11 service, hence decisions were more likely to be taken in an emergency
12 situation. The crisis nature of the situation increased the chance of people
13 being admitted to residential care because there was less time to stimulate
14 family support or set up a home care package, especially in rural areas.

15 The assessment of eligibility for residential care appears to be completely
16 focussed on people's physical needs rather their anxieties or emotional
17 condition. For example, many respondents described the importance of
18 people's 'fear of burglary' as a consideration for whether to refer them to
19 residential care on discharge from hospital (as opposed to returning home).
20 Practitioners knew that fear of burglary couldn't be cited as a reason to refer
21 to institutional care but when it was an issue they'd try and accommodate the
22 person using 'social' criteria.

23 The availability and adaptability of services to meet identified needs was a key
24 factor in decisions about the need for admission to long-term care.

25 Practitioners were frustrated that home care workers were not allowed to
26 undertake certain tasks even though family members do them with very little
27 training. There was particular concern about meeting night care needs, and a
28 perception that this could be critical in deciding on long-term care. "The one
29 thing that drives them into nursing homes is because they can't be left alone
30 at night" (p817).

1 The availability of suitable staff to undertake home care work was an issue in
2 some Trusts as well as limitations in public funding, "As has happened
3 recently, the resources (public funding) have been there but the people
4 haven't been there to do the work. In that situation they will end up in an
5 institution" (GP, p819).

6 **10 (a) What helps and what makes it difficult to ensure successful**
7 **transitions from inpatient hospital settings to community or care home**
8 **settings?**

9 ***What helps***

10 Respondents highlighted the importance of seeing beyond a person's
11 condition or physical need in deciding whether to refer them for residential
12 care. The way different people respond to their physical needs can vary. For
13 instance, a fall may cause some people to become very anxious and lose
14 confidence, dramatically changing their lifestyle where as others may not be
15 affected.

16 Responses emphasized the importance of assessing people in their home
17 and not only in the hospital environment. Whereas someone might appear to
18 be at risk of falling because they are very unsteady in a ward environment
19 (and therefore a candidate for referral to residential care), when they are
20 home they can move around their house more easily, often using 'furniture
21 walking'.

22 ***What helps/ Makes it difficult***

23 The availability, ability and willingness of a family member to provide care in
24 the circumstances can both help the transition from hospital and make it
25 difficult. "You cannot assume because they are about or living in the same
26 house that they will do this [provide care]" (Social worker). Sometimes it was
27 not so much the time or physical strength of carers that was an issue.
28 Perhaps families could meet a range of care needs, but not more intimate
29 needs because of their family relationship.

1 **11. Turner, B; Ownsworth, T; Cornwell, P and Fleming, J. (2009)**
2 **Reengagement in meaningful occupations during the transition from**
3 **hospital to home for people with acquired brain injury and their family**
4 **caregivers.**

5 **Outline:** This moderate quality [+] qualitative study uses a prospective
6 longitudinal design to explore people with acquired brain injury's (ABI)
7 experiences of reengagement in meaningful occupations during the hospital-
8 to-home transitions phase. The study applied a phenomenological approach
9 to address the following research questions:

- 10 • What occupations are most important to people with ABI and their family
11 caregivers during the transition phase?
- 12 • How do people with ABI and their family caregivers perceive the process of
13 reengagement in meaningful occupations during the transition from hospital
14 to home?

15 Semi-structured, in-depth interviews with both participants with ABI and their
16 family caregivers were conducted at three time points during the transition
17 phase: pre-discharge, and at 1 and 3 months post-discharge. The thematic
18 data analysis process yielded 34 main categories, of which 8 were identified
19 as having the most relevance to reengagement in meaningful occupations.

20 **Results:** Findings are reported under the relevant views and experiences
21 questions.

22 **1.1 (a) What are the views and experiences of people using services, in**
23 **relation to the transition from inpatient hospital settings to community**
24 **or care home settings?**

25 ***Desired vs. Actual Participation***

26 Both participant groups identified that the occupations of most importance to
27 them during the transition phase were returning to driving and work or
28 education. However, for most participants with ABI, driving and work were
29 only desired occupations, as opposed to actual occupations. This incongruity
30 was a source of stress and frustration for many participants with ABI.

1 Many reported that they did not understand why they were not able to
2 participate in these occupations or why it was taking so long to return to active
3 participation in these occupations. Participants reported feeling uninformed or
4 ill informed (i.e. received conflicting information) concerning the process of
5 returning to driving and work or education.

6 ***Struggle for Independence***

7 Returning home was typically seen by participants with ABI as a newfound
8 freedom; they were excited at the prospect of discharge and were relieved
9 when the time came.

10 However, certain barriers and restrictions- including both formal and informal
11 constraints - hampered their pursuit of independence, and their perceived
12 freedom was often short-lived.

13 **2.1 (a) What do people using services, think works well, what does not 14 work well, and what could improve the transition from inpatient hospital 15 settings to community or care home settings?**

16 People with ABI and family caregivers wanted more information or education
17 on the following areas:

- 18 • The process of returning to work or education and driving
- 19 • Ways to establish routines and structure one's time
- 20 • Ways for managing stress and frustration
- 21 • Ways to cope with formal and informal restrictions

22 **10 (a) What helps and what makes it difficult to ensure successful 23 transitions from inpatient hospital settings to community or care home 24 settings?**

25 ***Occupational therapy practice***

26 OTs need to establish meaningful yet realistic client-centred goals. Therapists
27 need to ensure they do not promote false hope by ensuring the client's
28 desired occupations are validated and incorporated into the development of
29 therapy plans.

1 **Key elements which are integral to early transitions success for people**
2 **with ABI and their caregivers:**

3 facilitating recovery through participation, fostering feelings of usefulness,
4 enhancing people's use of time, and assisting people in managing perceived
5 restrictions

6 **Studies reporting evidence of cost-effectiveness (n=9)**

7 People with stroke

8 Evidence from one systematic review and meta-analysis (Fearon and
9 Langhorne 2012, 14 trials, 8 from UK, ++) showed that early supported
10 discharge with multidisciplinary community care (ESD-MCC) for people with
11 stroke led to a reduction in length of hospital stay (7 days, $p < 0.0001$,
12 $N = 1,695$) but not in the risk of hospital readmission (31% vs 28%, $N = 918$); a
13 reduction in care home admission ($OR = 0.78$, $p = 0.05$, $N = 1,758$); a reduction in
14 short-term dependency ($OR = 0.80$, $p = 0.02$, $N = 1,957$) and an increase in
15 extended activities of daily living (standard mean difference 0.15, $P = 0.02$).
16 Effects varied by severity of needs with clinical outcomes improving more for
17 people with mild and moderate needs and reductions in hospital bed days
18 being greater for people with high needs. Findings from seven studies
19 (including two UK studies) suggested that costs were reduced when direct
20 and indirect costs were included and that costs of the intervention were likely
21 to be offset by the reduction in hospital bed days.

22 This was confirmed by two systematic reviews which both were of moderate
23 quality with potentially serious limitations (Larsen et al 2006, [+]; Brady et al
24 2005 [+]); they found that ESD-MCC had lower costs or was cost neutral if it
25 was compared to conventional care including hospital rehabilitation; one of the
26 reviews suggested that reductions in costs were achieved when ESD-MCC
27 was provided in a stroke unit. Compared with stroke unit alone ESD-MCC
28 achieved reductions in total costs, linked to a significant reduction in care
29 home admissions ($OR = 0.45$, $CI 0.31-0.96$, $N = 1,108$) and hospital length of
30 stay (10 days, $CI 2.6-18$, $N = 1,108$). Studies in this area did not measure the
31 impact on health and social care services in the community so that a
32 conclusion about total costs could not be drawn.

1 Findings from one UK cost-utility decision modelling study (Saka et al 2009,
2 ++) suggest that stroke unit with early supported discharge had better
3 outcomes (health-related quality of life) and higher costs than stroke unit and
4 was altogether more cost-effective with an ICER of under £20,000 per QALY
5 (measured over 10 years).

6 A cost-utility study carried out alongside a RCT (Patel et al 2004, N=457; ++)
7 compared three strategies, stroke unit, stroke team in general ward and stroke
8 care at home, and found that stroke unit care was linked to a reduced risk of
9 care home admission (14%, 30%, 24%; $p < 0.03$) and better chance of survival
10 without disability at 1 year (85%, 66%, 71%, $p < 0.001$). Total health and social
11 care costs were highest for stroke unit care and lowest for stroke care at
12 home. Informal care costs were substantial but did not change the order of
13 cost findings. QALYs were measured via the EQ-5D and it is reported that
14 stroke care provided at home was the most cost-effective strategy. Findings
15 have to be interpreted in the context of the UK system at the time when the
16 studies were carried out (in the late 90thies) and stroke care was significantly
17 less developed.

18 Older people

19 A UK-based cost utility study (Miler et al 2005, N=272, ++) evaluated an early
20 discharge and home care and rehabilitation package provided to older people
21 living in their own home with social care and rehabilitation needs who did not
22 require 24 hours care. The intervention consisted of a maximum number of 4
23 visits per day provided over no longer than 4 weeks. QALYs measured with
24 the EQ-5D improved by 0.07 at 3 months (95% CI -0.01 to 0.14) and 0.02 at
25 12 months (95% CI -0.06 to 0.09). Wider health and wellbeing outcomes
26 including those of carers improved and there were no significant changes in
27 terms of mortality or care home admission (findings reported in Cunliffe et al
28 2004). The intervention achieved a significant reduction in health and social
29 care costs (due to reduced hospital bed use). Cost-effectiveness acceptability
30 curve showed high probabilities that the intervention was cost-effective at
31 different willingness-to-pay-thresholds; and the results were robust against
32 various assumptions tested in sensitivity analysis.

1 A cost-utility study carried out alongside an RCT in Finland (Hammar et al
2 2009, N=668, ++) compared case management organised through a nurse-
3 support worker partnership with standard care; the study found better health-
4 related quality of life outcomes in the intervention group at baseline and
5 follow-up (at t=0: 0.6 vs 0.5, p=0.002, t=2: 0.5 vs. 0.4, p=0.021) and higher
6 scores on the Nottingham Health Profile in the intervention at 6 months follow-
7 up and non- significant reduction in total health and social care costs (in
8 Euros, 2001 prices; t=0 2,831, SD 2,655 vs. 2,722, SD 2,691; t=1 6,678, SD
9 5,574, vs. 7,773, SD 6,884). Figures showed that the intervention was highly
10 likely to be cost-effective at willingness to pay thresholds of £20,000 to
11 £30,000: The ICER for EQ-5D ranged from EUR 10,951 to 12,274 (£6,899 to
12 £7,733).

13 A cost-effectiveness study carried out alongside a RCT in Australia (Lim et al
14 2004, N=598, ++) compared health professional led discharge planning and
15 case management with budget for community services with routine care.
16 Individuals in the intervention group showed greater improvements in
17 independent living (p=0.002) and quality of life (p=0.02). There were no
18 significant differences in other outcomes such as mortality, carers' stress,
19 unplanned readmission and emergency department visits. Results were not
20 presented in combined form but authors concluded that the intervention
21 appeared to be beneficial, led to an improvement in quality of life and a
22 reduction in health care costs.

23 A cost utility study carried out alongside an RCT in Hong Kong (Wong et al
24 2012, N=555; +) compared a case management organised through a nurse-
25 volunteer partnership with standard care and found significantly lower hospital
26 readmission rates at 28 and 84 days (4% vs. 10.2%, 8.1% vs. 19.4%, p-value
27 not reported) and health-related quality of life gains at 28 days (p<0.001) and
28 84 days (p<0.001). Total changes in costs were not reported; cost-
29 effectiveness acceptability curves were presented that showed that the
30 intervention had a 65% and 95% chance of savings costs at 28 and 84 days
31 and an 89% chance of being cost-effective at a willingness-to-pay threshold of
32 £20,000.

1 Evidence statements (including economic evidence statement)

<p>HD1</p>	<p>There is a moderate amount of moderate quality evidence that improved inter professional communication would ensure more successful transfers from hospital. One mixed methods qualitative study (Huby et al, 2004 and Huby et al, 2007) [++] found hospital based professionals had failed to share assessment results, leading to confusion about whether a patient was fit for discharge. A moderate quality study using focus groups (Connolly, 2009) [+] found that poor internal communication leads to confusion about arranging tests or services and means that vitally placed professionals are left out of critical discharge decisions. A moderate quality systematic review (Nosbusch et al, 2011) [+] recommended that improved communication and information sharing would help acute staff nurses in discharge planning. Within the ward, the completion of discharge preparation summaries at each shift handover was believed to improve communication between nurses. For all relevant professionals, the use of standardized referral forms and electronic decision support and referral systems was recommended. Finally, a moderate quality qualitative study (Baumann, 2007) [+] found that improved communication between wards and social services is achieved by having a care manager attached to a ward.</p>
<p>HD2</p>	<p>There is a moderate amount of moderate quality evidence that designating a discharge coordinator has a positive effect on hospital discharge processes and outcomes. A qualitative study (Baumann et al, 2007) [+] found that discharge coordinators helpfully support ward nurses in discharge planning by monitoring patients from admission to discharge and identifying patients requiring ongoing social or continuing care. A moderate quality study using focus groups with hospital based professionals (Connolly, 2009) [+] identified that having discharge coordinators was a way of overcoming the problem of people not being clear about their role in discharge planning. The discharge coordinator collected information for patients to take home and checked up on the person a week after discharge. A low quality study (Pethybridge, 2004) [-] found it was helpful to have a ward sister in charge of all decision-making, referrals and planning for discharge, although this also resulted in a lack of team working. Finally, a systematic review (Laugaland, 2012) [+] focusing on patients over 65 years found that successful transitional care interventions consisted of a key health care worker acting as discharge coordinator.</p>
<p>HD3</p>	<p>There is a moderate amount of moderate quality evidence that bed shortages and government targets create pressure to discharge patients without involving all relevant professionals, often resulting in readmissions. A moderate quality study (Connolly, 2009) [+] reported that focus group members feel compelled to make discharge a swift procedure due to pressure from managers and consultants, who were seen as striving to achieve government targets to fill beds and reduce waiting lists. Similarly, a survey of hospital based professionals (Connolly, 2010) [+] found 80% of respondents felt government targets caused the discharge process to be rushed and result in readmissions within days. A good quality mixed methods study (Huby et al, 2004 and 2007) [++] showed that pressures owing to bed shortages were clearly on the minds of patients who claimed to feel well purely so they would be discharged. Finally, a low quality study (Pethybridge, 2004) [-] showed staff felt an enormous pressure to discharge patients to avoid a 'bed crisis' and an example was given of consultants discharging patients at night when no other professionals were available to get involved in the decision.</p>

HD4	<p>There is a good amount of moderate quality evidence that support for people after they have been transferred from hospital improves experiences as well as service level and individual outcomes. Where support is unavailable, the success of hospital discharge is threatened. A good quality RCT (Burton and Gibbon, 2005) [++] found that when follow up care was provided by a stroke nurse, ADL and social isolation scores were significantly improved although there was no difference in depression scores. Focus group participants (Connolly et al, 2009) [+] cited lack of equipment in people's homes as a cause of delay, which could be improved if assessments were conducted earlier in the hospital stay. A low quality mixed methods study (Bryan et al, 2006) [-] reporting managers' views cited inadequate social services resources and shortages of health and care professionals to provide support for people returning home as major barriers to discharge. A qualitative study (Huby et al, 2004 and 2007) described how a lack of community services meant patients could not be discharged, in some cases for several weeks. Finally, two systematic reviews (Larsen et al, 2006 and Olson et al, 2011) [+] [++] reported that early home supported discharge which includes delivering care at home, caused a reduction in length of stay, nursing home referrals and poor outcomes in a stroke unit although it had no effect on readmissions.</p>
HD5	<p>There is a moderate amount of moderate to good evidence that professionals involved in discharge planning fail to treat patients as a 'whole person'. One qualitative study (Huby et al, 2004 and 2007) [++] concluded that transitions from hospital would be more successful if professionals considered all relevant circumstances surrounding a patient rather than making decisions based on a narrow understanding of physical and cognitive functions. A good quality qualitative study (Taylor and Donnelly, 2006) [++] also highlighted the importance of seeing beyond a person's condition or physical need when considering their transition from hospital to the community. A moderate quality study (Connolly et al, 2009) found hospital professionals who depicted the discharge process as de-humanising'. They felt that use of the label 'medically fit for discharge', oversimplifies cases and highlights that once the medical or 'acute' problem had been addressed, any remaining difficulties that patients' experienced were not regarded as the hospital's concern.</p>
HD6	<p>There is a good amount of mixed quality evidence that including people and families in decision-making and preparation for discharge affects the quality of transitions from hospital. A study (Benton, 2008) [+] of patients' experiences of intermediate care found they lacked understanding about the purpose of the unit and their potential for rehabilitation. Two studies (Pethybridge, 2004) [-] (Huby et al 2004 and 2007) [++] found that individual needs are ignored and patients are excluded from decision making about treatment and discharge. A systematic review (Laugaland et al, 2012) [+] showed that successful interventions involved caregivers and included patient participation and/ or education. Similarly, another systematic review (Preyde, 2011) [+] found that a lack of family or patient education during discharge was significantly related to readmission. Finally, one RCT (Li Hong et al, 2012) [++] reported mixed results. When patient-carer dyads received empowerment-educational sessions on admission and discharge, there was no significant difference on caregivers' emotional coping for depression, anxiety and worry and no reduction in the amount of care giving; the only differences were less role strain and caregiver preparedness to participate in post hospital care.</p>

HD7	There is a small amount of moderate quality evidence that certain groups of stroke patients are excluded from specialist care and support, including hospital discharge services. A qualitative study from the UK (Mold et al, 2006) found that hospital and community based professionals ration stroke services in a way that excludes younger stroke patients, people with communication difficulties and people with addictions.
HD8	There is a small amount of good quality evidence that people are more likely to be transferred to residential care from hospital when those decisions are made within the context of a crisis. A UK qualitative study (Taylor and Donnelly, 2006) [++] found that health and social care professionals are more likely to recommend someone transfers to a care home when resources to support them at home are lacking (referring to both formal and unpaid care), when other housing options are unavailable and when people are perceived to be “vulnerable”, for example, to falls.
HD9	There is a small amount of mixed quality evidence that sharing patient medication data among hospital and community based practitioners via electronic systems improves the quality of transitions between hospital and home. One low quality review of best practice (American Pharmacists Association and American Society of Health-System. (2013)) [-] found that electronic transfer of patient information between practitioners assisted in communication of drug therapy and improved transitions. One good quality systematic review (Hesselink, 2012) [++] found that interventions to improve information exchange at discharge significantly improved transitions, particularly in terms of care continuity.
HD10	There is a small amount of good quality evidence from one study that pharmacist led interventions reduce negative outcomes of hospital discharge. The systematic review (Rennke et al, 2013) [++] located evidence that pharmacist led interventions reduced medication related readmissions, post discharge emergency department visits and adverse events.
HD11	No evidence was found from studies published since 2003 about the following interventions to improve the transfer of care from hospital: nutrition support, befriending and transport services.
Ec2	There is good amount of good and moderate quality economic evidence that shows that stroke unit care provided with early supported discharge and multi-disciplinary community care is likely to be cost-effective when compared with standard care. One UK cost-utility study carried alongside a RCT compared stroke unit care with alternative options of stroke provision and found that stroke unit care was more cost-effective than care provided on a general ward (Patel et al 2004; ++); in the same study stroke care provided at home was the most cost-effective option but this was not considered an appropriate alternative in the current context of stroke service provision. A cost-utility decision modelling study carried out in the UK (Saka et al 2009, ++) suggested that stroke unit care with early supported discharge was more cost-effective than stroke unit care alone. This was supported by 2 international systematic reviews and 1 health technology assessment which looked at the cost-effectiveness of early supported discharge provided with multidisciplinary community care versus standard care (Fearon and Langhorne 2012 ++; Brady et al 2005 +; Larsen et al 2006 +).
Ec3	There is a moderate amount of good quality economic evidence that suggests that early supported discharge in combination with rehabilitation was likely to be cost-effective if compared with standard care. This finding related to four full economic evaluations carried out in different countries, including one UK study (Miller et al 2005). The studies were carried out

alongside randomised controlled trials and models of service provision included a nurse-help worker partnership in Finland (Hammer et al 2009, N=668; ++), a nurse-volunteer partnership in Hong Kong (Wong et al 2012, N=555; +), a discharge lead with budget for community services in Australia (Lim et al 2003, N=598; ++) and a multi-disciplinary team in the UK (Miller et al 2005, N=272; ++). Findings from all four studies suggested that early supported discharge in combination with rehabilitation improved physical health and reduced costs and was likely to be cost-effective.

1

2 **Included studies for hospital discharge review questions (full citation)**

3 Bahr S, Solverson S, Schlidt A et al. (2014) Integrated Literature Review of
4 Post-discharge Telephone Calls. *Western Journal of Nursing Research* 36:
5 84–104

6 Baumann M, Evans S, Perkins M et al. (2007) Organisation and features of
7 hospital, intermediate care and social services in English sites with low rates
8 of delayed discharge. *Health & Social Care in the Community* 15: 295–305

9 Benten J and Spalding N (2008) Intermediate care: what are service users'
10 experiences of rehabilitation? *Quality in Ageing - Policy, Practice and*
11 *Research* 9: 4–14

12 Brady BK, McGahan L, Skidmore B (2005), Systematic review of economic
13 evidence on stroke rehabilitation services, *International Journal of Technology*
14 *Assessment in Health Care*, 21:1: 15-21.

15 Bryan K, Gage H, Gilbert K et al. (2006) Delayed transfers of older people
16 from hospital: causes and policy implications. *Health Policy* 76: 194–201

17 Burton C and Gibbon B (2005) Expanding the role of the stroke nurse: A
18 pragmatic clinical trial. *Journal of Advanced Nursing* 52: 640–50

19 American Pharmacists Association and American Society of Health-System
20 (2013) ASHP-APhA Medication Management in Care Transitions Best
21 Practices

22 Chhabra P, Rattinger G, Dutcher S et al. (2012) Medication reconciliation
23 during the transition to and from long-term care settings: A systematic review.
24 *Research in Social and Administrative Pharmacy* 8: 60–75

- 1 Conroy S, Stevens T, Parker S et al. (2011) A systematic review of
2 comprehensive geriatric assessment to improve outcomes for frail older
3 people being rapidly discharged from acute hospital: 'interface geriatrics'. *Age*
4 and Ageing 40: 436–443
- 5 Connolly M, Deaton C, Dodd M et al. (2009) Systems and people under
6 pressure: The discharge process in an acute hospital. *Journal of Clinical*
7 *Nursing* 18: 549–58
- 8 Connolly M, Deaton C, Dodd M et al. (2010) Discharge preparation: do
9 healthcare professionals differ in their opinions? *Journal of Interprofessional*
10 *Care* 24: 633–43
- 11 Fearon P and Langhorne P (2012), Services for reducing duration of hospital
12 care for acute stroke patients. *Cochrane Database of Systematic Reviews*:
13 *Reviews* 2012; Issue 9.
- 14 Fox M, Persaud M, Maimets I et al. (2012) Effectiveness of acute geriatric unit
15 care using acute care for elders components: A systematic review and meta-
16 analysis. *Journal compilation, The American Geriatrics Society* 60: 2237–45
- 17 Fox M, Persaud M, Maimets I et al. (2013) Effectiveness of early discharge
18 planning in acutely ill or injured hospitalized older adults: a systematic review
19 and meta-analysis. *BMC Geriatrics* 13: 1–9
- 20 Hammar T, Rissanen P, Peraelae ML (2009), The cost-effectiveness of
21 integrated home care and discharge practice for home care patients, *Health*
22 *Policy* 92:10-20.
- 23 Hesselink G, Schoonhoven L, Barach P et al. (2012) Improving patient
24 handovers from hospital to primary care: a systematic review. *Annals of*
25 *Internal Medicine* 157: 417–28
- 26 Huby G, Stewart J, Tierney A et al. (2004) Planning older people's discharge
27 from acute hospital care: linking risk management and patient participation in
28 decision-making. *Health, Risk & Society* 6: 115–132

- 1 Huby G, Brook J, Thompson A et al. (2007) Capturing the concealed:
2 Interprofessional practice and older patients' participation in decision-making
3 about discharge after acute rehospitalisation. *Journal of Interprofessional*
4 *Care* 21: 55–67
- 5 Larsen T, Olsen T, Sorensen J (2006) Early home-supported discharge of
6 stroke patients: a health technology assessment. *International Journal of*
7 *Technology Assessment in Health Care* 22: 313–20
- 8 Laugaland K, Aase K, Barach P et al. (2012) Interventions to improve patient
9 safety in transitional care - a review of the evidence. *Work* 41: 2915–24
- 10 Li H, Powers B, Melnyk B al. (2012) Randomized controlled trial of CARE: An
11 intervention to improve outcomes of hospitalized elders and family caregivers.
12 *Research in Nursing & Health* 35: 533–49
- 13 Lim W K, Lambert S F, Gray L C. (2003), Effectiveness of case management
14 and post-acute services in older people after hospital discharge. *Medical*
15 *Journal of Australia*; 178(6): 262-266.
- 16 Lindpaintner L, Gasser J, Schramm M et al. (2013) Discharge intervention
17 pilot improves satisfaction for patients and professionals. *European journal of*
18 *internal medicine* 24: 756–62
- 19 Miller P, Gladman J R, Cunliffe A L, Husbands S L, Dewey M E, Harwood R
20 H. (2005), Economic analysis of an early discharge rehabilitation service for
21 older people. *Age and Ageing*; 34(3): 274-280.
- 22 Mold F, Wolfe C, McKevitt C et al. (2006) Falling through the net of stroke
23 care. *Health & Social Care in the Community* 14: 349–56
- 24 Newcomer R, Kang T, Graham C et al. (2006) Outcomes in a Nursing Home
25 Transition Case-Management Program Targeting New Admissions. *The*
26 *Gerontologist* 46: 385–90

- 1 Nosbusch J, Weiss M, Bobay K (2011) An integrated review of the literature
2 on challenges confronting the acute care staff nurse in discharge planning.
3 *Journal of Clinical Nursing* 20: 754–74
- 4 Olson DW, Bettger J, Alexander K et al. (2011) Transition of care for acute
5 stroke and myocardial infarction patients: from rehospitalisation to
6 rehabilitation, recovery, and secondary prevention. *Evidence*
7 *Report/Technology Assessment* (202) 1–197
- 8 Patel A, Knapp M, Perez I, Evans A, Kalra L (2004), Alternative strategies for
9 stroke care: cost-effectiveness and cost-utility analyses from a prospective
10 randomized controlled trial. *Stroke*; 35(1): 196-203
- 11 Preyde M, Macalay C, Dingwall T et al. (2009) Discharge planning from
12 hospital to home for elderly patients: a meta-analysis. *Journal of Evidence-*
13 *Based Social Work* 6: 198–216
- 14 Preyde M and Brassard K (2011) Evidence-based risk factors for adverse
15 health outcomes in older patients after discharge home and assessment tools:
16 a systematic review. *Journal of Evidence-Based Social Work* 8: 445–68
- 17 Rennke S, Nguyen O, Shoeb M et al. (2013) Hospital-Initiated Transitional
18 Care Interventions as a Patient Safety Strategy. *Annals of Internal Medicine*
19 158: 433–40
- 20 Saka O, Serra V, Samyshkin Y, McGuire A, Wolfe C C (2009), Cost-
21 effectiveness of stroke unit care followed by early supported discharge. *Stroke*
22 2009; 40(1): 24-29
- 23 Taylor B and Donnelly M (2006) Professional Perspectives on Decision
24 Making about the Long-Term Care of Older People. *The British Journal of*
25 *Social Work* 36: 807–26
- 26 Turner B, Ownsworth T, Cornwell P et al. (2009) Reengagement in
27 meaningful occupations during the transition from hospital to home for people
28 with acquired brain injury and their family caregivers. *American Journal of*
29 *Occupational Therapy* 63: 609–20

1 Wong FK, Chau J, So C, Tam SK, McGhee S (2012), Cost-effectiveness of a
2 health-social partnership transitional program for post-discharge medical
3 patients, BMC Health Services Research, 12:479.

4 **3.5 Reducing (30-day) readmissions to hospital**

5 **Introduction to the review questions**

6 The purpose of these review questions was to examine the effectiveness and
7 cost effectiveness of health and social care interventions designed to reduce a
8 hospital readmission within 30 days of the person being discharged from
9 hospital. The questions also aimed to consider research, which systematically
10 collected the views of people using services, their carers, and care and
11 support staff in relation to approaches and interventions designed to reduce
12 hospital readmissions within 30 days of discharge.

13 Overall, a good amount of evidence about the impact of interventions to
14 reduce hospital readmission was located and reviewed and this included
15 evidence of cost-effectiveness. The quality of the evidence was mostly good.
16 Some of the studies included in the 'improving hospital discharge' review area
17 could arguably have been used to answer the hospital readmissions question
18 and vice versa. This is because many of the evaluations of interventions for
19 improving hospital discharge use 'readmission rates' as an outcome measure.
20 A successful hospital discharge is routinely indicated by there being no
21 readmission within 30 days. For studies to be included in the reducing
22 readmissions review, 'readmissions' had to be the stated primary outcome.
23 The interrelatedness of the two review areas is demonstrated by one of the
24 hospital discharge studies (Bahr et al, 2004) informing one of the evidence
25 statements about reducing readmissions (RHR2).

26 The amount and quality of effectiveness and cost effectiveness studies was
27 contrasted by views and experiences data, which were not reported in any
28 included papers.

1 **Review question for evidence of effectiveness**

2 7. What is the effectiveness of interventions and approaches designed to
3 reduce hospital re-admissions within 30 days of hospital discharge?

4 **Review questions for evidence of views and experiences**

5 Review questions 1-4 and question 10, listed on pages 2-3, were applied
6 specifically in relation to interventions or approaches for reducing
7 readmissions.

8 **Summary of review protocol**

9 The protocol sought to identify studies that would:

- 10 • Identify the effectiveness of health and social care interventions designed
11 to reduce the likelihood of a person being readmitted within 30 days of
12 hospital discharge.
- 13 • Identify emerging models of care, assessment and discharge planning
14 which demonstrated reduction in readmissions within 30 days of hospital
15 discharge.
- 16 • Assess the cost effectiveness of interventions designed to reduce hospital
17 readmissions.

18 For the views and experiences review questions, the protocol sought to
19 identify studies, specifically relating to transfer of care from hospital that
20 would:

- 21 • Describe the self-reported views and experiences of adults with social care
22 needs, their families and unpaid carers about the care and support they
23 receive during interventions or approaches designed to reduce hospital
24 readmissions.
- 25 • Highlight aspects of care and support during the hospital admission and
26 discharge process that work well, as perceived by service users, their
27 families and unpaid carers, and aspects of care and support during
28 discharge from hospital which are perceived not to work well in terms of
29 reducing readmissions.

- 1 • Describe the views and experiences of people delivering, organising and
2 commissioning social care, health and housing services.
- 3 • Highlight aspects of the hospital admission and discharge process, which
4 work well, and are personalised and integrated, as perceived by
5 practitioners, managers and commissioners, and aspects which should be
6 changed to reduce readmissions.
- 7 • Contextualise the views of users, carers and practitioners by identifying
8 barriers and facilitators to improved or changed practice they suggest
9 would improve outcomes relating to hospital readmissions.

10 **Population:** Adults, aged 18 years and older, with social care needs who are
11 transferring from inpatient hospital settings or intermediate care to community
12 or care home settings. Self-funders and people who organise their own
13 support and who are transferring from inpatient hospital settings or
14 intermediate care to community or care home settings.

15 Housing practitioners, social care practitioners (providers, workers, managers,
16 social workers), and health and social care commissioners involved in
17 delivering social care to people during transfer from hospital to community or
18 care home settings, or intermediate care units; personal assistants engaged
19 by people with social care needs and their families. General practice and
20 other community-based healthcare practitioners.

21 **Intervention:** Personalised and integrated assessment, planning and care
22 and support. Usual treatment compared to the effectiveness of an innovative
23 intervention.

24 **Setting:** Bed-based intermediate care settings (“step down” or “step up”) and
25 service users’ home, including sheltered housing accommodation; supported
26 housing; temporary accommodation; care (residential and nursing) homes.

27 **Outcomes:** User and carer related outcomes (such as user and carer
28 satisfaction; quality and continuity of care; choice and control; involvement in
29 decision-making about place of death and health and social care related
30 quality of life) and service outcomes such as use of health and social care

1 services, unplanned or inappropriate admission, emergency hospital
2 (re)admissions (see 4.4 in the Scope).

3 User satisfaction; quality and continuity of care; choice and control;
4 involvement in decision-making; dignity and independence; quality of life;
5 health status; safety and safeguarding.

6 The study designs included for the effectiveness questions on reducing
7 hospital readmissions were:

8 Systematic reviews of studies of different models of intermediate care,
9 assessment and planning;

10 Randomised controlled trials of different approaches to bed based
11 intermediate care, assessment and care planning;

12 Controlled studies of different approaches to bed based intermediate care,
13 assessment and care planning;

14 Economic evaluations;

15 The study designs relevant to the views and experiences questions were
16 expected to include:

- 17 • Systematic reviews of qualitative studies on this topic;
- 18 • Qualitative studies of user and carer views of social and integrated care;
- 19 • Qualitative components of effectiveness and mixed methods studies;
- 20 • Observational and cross-sectional survey studies of user experience.

21 Full protocols can be found in Appendix A.

22 **How the literature was searched**

23 Electronic databases in the research fields of social care, health, economics
24 and social science were searched using a range of controlled indexing and
25 free-text search terms based on the facets of: the state of transition (service
26 user/patient transfer or admission or discharge), settings (inpatient hospital or

1 community or care home settings) and health and social care needs,
2 workforce or intervention.

3 The search aimed to capture both journal articles and other publications of
4 empirical research. Additional searches of websites of relevant organisations
5 were also carried out.

6 The search for material on this topic was carried out within a single broad
7 search strategy used to identify material which addressed all the agreed
8 review questions on the transition between inpatient hospital settings and
9 community or care home settings for adults with social care needs. The
10 searches were restricted to studies published from 2003 in order to
11 incorporate the Community Care (Delayed Discharges) Act 2003. Generic and
12 specially developed search filters were used to identify particular study
13 designs, such as systematic reviews, randomised controlled trials, economic
14 evaluations, cohort studies, mixed method studies and personal narratives.
15 The database searches were not restricted by country.

16 Full details of the search can be found in Appendix A.

17 **How studies were selected**

18 Search outputs (title and abstract only) were stored in EPPI Reviewer 4 - a
19 software programme developed for systematic review of large search outputs
20 - and screened against an exclusion tool informed by the parameters of the
21 scope. Formal exclusion criteria were developed and applied to each item in
22 the search output, as follows:

- 23 • Language (must be in English),
- 24 • Population (must be over 18 years of age and have a social care need)
- 25 • Transition (a transition into or out of an inpatient hospital setting must have
26 occurred within the last 30 days)
- 27 • Intervention (must be involved in supporting transitions)
- 28 • Setting (inpatient hospital setting, intermediate care setting, community
29 setting or care home)

- 1 • Country (must be UK, European Union, Denmark, Norway, Sweden,
- 2 Canada, USA, Australia and New Zealand)
- 3 • Date (not published before 2003)
- 4 • Type of evidence (must be research)
- 5 • Relevance to (one or more) review questions.

6 Title and abstract of all research outputs were screened against these
7 exclusion criteria. Those included at this stage were marked for relevance to
8 particular review questions and retrieved as full texts.

9 Full texts were again reviewed for relevance and research design. If still
10 included, critical appraisal (against NICE tools) and data extraction (against a
11 coding set developed to reflect the review questions) was carried out. The
12 coding was all conducted within EPPI Reviewer 4, and formed the basis of the
13 analysis and evidence tables. All processes were quality assured by double
14 coding of queries, and of a random sample of 10%.

15 In our initial screen (on title and abstract), we found 583 studies, which
16 appeared relevant to the review questions on improving hospital discharge
17 and reducing readmissions. We ordered full texts and reviewed 183 papers for
18 final inclusion. For views and experiences research, studies from a UK setting
19 were prioritized. Effectiveness studies were restricted to systematic reviews,
20 randomized controlled trials or controlled studies. On reviewing the full texts,
21 we identified 11, which fulfilled the criteria (see included studies below) and
22 related specifically to reducing hospital readmissions, plus 3 economics
23 studies. The included studies (see below) were critically appraised using NICE
24 tools for appraising different study types, and the results tabulated. Further
25 information on critical appraisal is given in the introduction at the beginning of
26 Section 3. Study findings were extracted into findings tables. For full critical
27 appraisal and findings tables, see Appendix B.

1 **Narrative summaries of the included evidence**

2 ***Studies reporting effectiveness data (n=11)***

3 **1. Allen J, et al (2014) Quality care outcomes following transitional care**
4 **interventions for older people from hospital to home: a systematic**
5 **review**

6 **Outline:** This is a good quality [++] systematic review, which is moderately
7 relevant to the review area. It aimed to synthesise RCTs examining the
8 outcomes of transitional care interventions compared with standard hospital
9 discharge for older people with chronic illnesses. It also sought to make
10 recommendations for research and practice. Included studies were published
11 in a peer reviewed journal, they reported transitional care compared with
12 standard hospital discharge, they used a randomized control design, were
13 published in English and provided an analysis of outcomes evaluating quality
14 indicators relating to older people. Twelve papers met the inclusion criteria.
15 Although they matched the scope on intervention and population, half the
16 papers were published before our 2003 cut-off date and none were UK
17 studies; they were from the US, Australia, Denmark and France.

18 **Results:** In six studies (out of 11 with re-hospitalisation as an outcome),
19 significant reductions in re-hospitalisation rates were found for people in the
20 intervention groups at up to six months following hospital discharge and at up
21 to three months following discharge in the study by Legrain et al.

22 (Findings are highlighted here from studies published 2003 onwards. Full
23 findings can be found in the evidence tables.)

- 24 • Advanced practice nurse delivered transitional care, Naylor (2004)
- 25 – At 52 weeks, intervention patients had fewer re-hospitalizations and
 - 26 lower total mean costs.
 - 27 – There were short term improvements among intervention patients in
 - 28 quality of life (physical domain) up to 12 weeks post discharge and
 - 29 satisfaction with discharge and transition care (up to 6 weeks post
 - 30 discharge).

- 1 • Brief nurse practitioner intervention for 3 months following discharge,
2 Enguidanos (2012)
 - 3 – No change in re-hospitalization rates at 6 months following enrolment in
4 the study.
 - 5 – The intervention group experienced significantly fewer visits to GPs.
 - 6 – No changes between intervention and control groups in self-efficacy or
7 satisfaction with service.
- 8 • Hospital coordinated discharge plan involving GP, Preen (2005)
 - 9 – No differences in length of stay between groups Intervention group
10 reported improved satisfaction with discharge planning, access to health
11 services, confidence with discharge, and 'mental quality of life' one week
12 following discharge.
- 13 • Self-management and transition coaching, Coleman (2006)
 - 14 – The intervention group had significantly lower re-hospitalization rates
15 than the control group at 30, 90 and 180 days post discharge.
 - 16 – The intervention group had significantly lower hospital costs than the
17 control group at 30, 90 and 180 days post discharge.
- 18 • Discharge case management, Lim (2003)
 - 19 – Over a 6-month follow-up period there were no differences in rates of
20 unplanned re-hospitalizations.
 - 21 – Intervention patients had significantly reduced length of stay (index
22 hospitalisation).
 - 23 – Costs (hospital utilisation) were lower in intervention patients over 6
24 months following discharge. No differences in costs (utilisation of
25 community services) between groups.
 - 26 – Significantly improved self-reported quality of life in intervention patients
27 at one month follow-up
 - 28 – No difference in caregiver burden at 1-month follow-up.
- 29 • Inpatient geriatric evaluation, co-management (with ward staff) and
30 transitional care, Legrain (2011)
 - 31 – Intervention group were significantly less likely to attend the emergency
32 department or be re-admitted at 3 months following discharge.

1 – No differences between groups in ED attendances or re-hospitalizations
2 at 6 months following discharge.

3 **2. Hansen, L., Young, R., Hinami, K., Leung, A. and Williams, M. (2011)**
4 **Interventions to reduce 30-day rehospitalization: a systematic review.**

5 **Outline:** This is a good quality systematic review [++] that aimed to provide an
6 inventory of interventions studies to reduce rehospitalization within 30 days
7 and describe the best-published evidence for the effectiveness of these
8 interventions. Included studies were from the USA, Israel, Canada,
9 Netherlands, Hong Kong, Ireland, Portugal, New Zealand, Denmark, Belgium,
10 Australia and Taiwan.

11 **Results:** Authors identify three types of interventions to reduce hospital
12 admissions.

- 13 • Pre-discharge Interventions, comprising of Patient education, Discharge
14 planning, Medication reconciliation, appointment scheduled before
15 discharge.
- 16 • Post discharge interventions, comprising of Timely PCP communication,
17 Timely Clinic follow up and follow up telephone calls, Post discharge
18 hotline, Home visits.
- 19 • Interventions bridging the transition including Transitional coach, patient
20 centred discharge instructions and provider continuity.

21 Few studies in the systematic review studied only one component of a
22 discharge care plan, and were a collection of different components. Ten RCTs
23 did not find significant effects of isolated or bundled interventions over all,
24 when negative effects were included.

25 There were five RCTs (out of a total of 16) that documented statistically
26 significant improvements in rehospitalisation outcomes within 30 days. One
27 study compared early discharge planning to usual care with the treatment
28 group experiencing an 11 percentage point reduction in 30-day readmissions.
29 The remainder of the studies looked at multi-component interventions.
30 Interventions common to the 4 studies were the post discharge telephone

1 calls and patient centred discharge instructions (PCDI). However two RCTs
2 that included these interventions did not report significant effects, and two
3 studies that looked at follow up calls in isolation did not find a significant
4 effect.

5 **3. Hung WW, Ross JS, Farber J et al. (2013) Evaluation of the mobile
6 acute care of the elderly (MACE) service. JAMA Intern Med. 173: 990-996**

7 **Outline:** This is a moderate quality [+] matched cohort study which evaluated
8 the impact of The Mobile Acute Care of the Elderly (MACE) service on
9 patients aged 75 years or older admitted to hospital for an acute illness. 173
10 matched-pairs were recruited. MACE is a model of care for hospitalized older
11 adults, delivering specialized care, such as early mobilization, minimization of
12 procedures, medication review, attention to geriatric syndromes, and
13 enhanced discharge planning to older adults wherever they are located within
14 the hospital. Specifically, MACE consists of a geriatric hospitalist who serves
15 as the primary hospital provider, along with a geriatrics fellow, a clinical nurse
16 specialist and a social worker.

17 The usual care team did not have a geriatrician, or a clinical nurse specialist.
18 In addition, they had a unit-based social worker rather than a team-based
19 social worker. Data were obtained on admission and at 15 and 30 days post
20 discharge by a clinician who was not blinded to the allocation groups.

21 **Results:**

22 Whilst MACE service was not associated with any significant reduction in
23 readmission rates at 30 days it was associated with better outcomes in
24 several important areas when compared with usual care. The MACE service
25 was associated with lower rates of adverse events, shorter lengths of stay,
26 and improved satisfaction on transitions of care when measured on the Care
27 Transition Measure. These findings suggest that providing inpatient care
28 through a MACE service may be associated with better outcomes for this
29 vulnerable older adult population.

30 The authors state that the MACE model may be a viable alternative to
31 dedicated units or floors for the care of older adults. It can be integrated in a

1 hospital's work flow without the requirement of a dedicated unit. The only new
2 role that requires staffing is the nurse coordinator, as the social worker and
3 geriatrics physician are obtained from reallocating existing resources.

4

5 **4. Jacob (2008) Systematic review: Predictors of successful transition to**
6 **community-based care for adults with chronic care needs**

7 **Outline:** This is a moderate quality [+] systematic review of care management
8 strategies to support transition from acute care back to the community.

9 Studies were grouped into one of two broad categories: studies of patient
10 characteristics and /or of discharge support interventions. The review meta-
11 synthesized qualitative research findings in order to identify which patients are
12 susceptible to difficult transitions, and to understand strategies to reduce risk
13 of unplanned readmission. Successful transition was defined as reduced
14 acute care readmission, reduced emergency department use, and reduced
15 mortality. Some studies attempted to use improved quality of life as an
16 outcome but this proved poorly defined and difficult to quantify.

17 **Results:**

- 18 • There is support for enhanced discharge support in preventing or delaying
19 hospital readmissions in the presence of specific discharge diagnoses,
20 specifically heart failure and stroke
- 21 • There was little evidence that enhanced discharge support is related to
22 improved physical status at home
- 23 • Lapses in discharge planning may affect patients' perceptions of readiness
24 for discharge, which may affect actual discharge success
- 25 • Those with adequate social support and confidence in self-care ability tend
26 to experience fewer readmissions than do those living alone and those who
27 perceive themselves as not ready to return home

1 **5. Leppin (2014) Preventing 30-Day Hospital Readmissions: A**
2 **Systematic Review and Meta-analysis of Randomized Trials**

3 **Outline:** This is a good quality [++] systematic review that assessed the
4 effectiveness of peri-discharge interventions versus any comparator on the
5 risk of early (i.e within 30 days of discharge) all-cause or unplanned
6 admissions and readmissions. In addition, the review sought to identify
7 intervention features - including their impact on treatment burden and on
8 patients' capacity to enact post discharge self-care –that might explain their
9 varying effects. Included studies were from US, Croatia, Hong Kong,
10 Switzerland, Denmark, Israel, Australia, Sweden, Belgium, New Zealand, the
11 Netherlands, England, Taiwan, Germany, Canada. The aims and outcomes of
12 the review are clearly stated and each trial was assessed for risk of bias using
13 a standardized form based on the Cochrane Collaboration's tool.

14 **Results:**

- 15 • The body of randomized trial evidence shows a consistent and beneficial
16 effect of tested interventions on the risk of 30-day readmissions.
17 • Interventions that used a complex and supportive strategy to assess and
18 address contextual issues and limitations in patient capacity were most
19 effective at reducing early hospital readmissions. Many of these contacted
20 the patient frequently, used home visits, and reported cost savings.
21 • Findings showed that more recently tested interventions were less
22 effective.

23 **6. Linertová, R., Garcia-Perez, L., Vazquez-Diaz, J., Lorenzo-Riera, A.,**
24 **and Sarria-Santamera, A. (2011) Interventions to reduce hospital**
25 **readmissions in the elderly: in-hospital or home care. A systematic**
26 **review.**

27 **Outline:** This is a good quality [++] systematic review to identify effective
28 interventions for reducing the risk of hospital readmissions in patients aged 75
29 years and older. The role of home follow-up was a particular focus. Eligible
30 studies were controlled trials of an intervention conducted during hospital
31 admission or follow-up. Hospital admission could be for any reason. Trials had

1 to report the outcome of unplanned readmission to hospital. The review
2 included thirty-two clinical trials, which were divided into two groups: in-
3 hospital interventions (17 studies) and interventions with home follow-up (15
4 studies). Thirteen of the 32 studies were published before our cut-off date
5 (2003) but population and interventions were within scope. The review is
6 therefore judged to have good external validity.

7 **Results:**

8 In-hospital geriatric evaluation and discharge management:

- 9 • In three (out of 17 studies) in-hospital treatment produced statistically
10 significant differences to the control group in terms of reduced
11 readmissions (the 3 interventions were: Intermediate care at a community
12 hospital; a 'targeted care bundle' and inpatient community based geriatric
13 assessment).
- 14 • A negative effect was observed in one in-patient study (geriatric evaluation
15 and management consultation services in frail hospitalised patients) and
16 the remainder did not show any effect of the interventions evaluated on the
17 risk of hospital readmission.

18 Geriatric assessment with home follow-up:

- 19 • The effectiveness of home follow-up interventions was demonstrated in
20 seven clinical trials (out of 15), two of them only partially depending on the
21 follow-up period, while in one study a negative effect on readmission rate
22 was described.
23 The remainder of the studies did not show any effect of the intervention on
24 readmissions.
- 25
26 • Among the studies reporting positive effects, a comprehensive geriatric
27 assessment followed by home care provided by a hospital-based
28 multidisciplinary outreach team was evaluated. This study showed that
29 patients in the intervention group had a lower rate of hospital readmissions
30 during the first 30 days, together with a lower rate of emergency
31 admissions and a longer time to the first emergency admission.

1 Interventions that incorporate geriatric management supported with home
2 care post discharge are more likely to reduce or prevent hospital
3 readmissions in elderly patients. The services are complex requiring a high
4 degree of collaboration and communication between patients, caregivers,
5 geriatricians, general practitioners, social community services and other
6 agents. Specific features of the interventions are patient education on
7 specific issues, close follow-up, home monitoring, adjustment of medication
8 and regular communication with clinical experts. Therapeutic success in
9 many instances rests more on effective patient targeting than on setting,
10 intensity or duration of the interventions.

11 **7. Naylor, M. (2011) The importance of transitional care in achieving**
12 **health reform**

13 **Outline:** This is a low quality [-] systematic review, which is moderately
14 generalizable. It aimed to identify and synthesize available evidence regarding
15 transitional care for adult, chronically ill populations and particularly, to
16 recommend strategies to guide the implementation of transitional care under
17 the Affordable Care Act.

18 The inclusion criteria for Transitional care was defined as "a broad range of
19 time-limited services designed to ensure health care continuity, avoid
20 preventable poor outcomes among at-risk populations, and promote the safe
21 and timely transfer of patients from one level of care to another or from one
22 type of setting to another".

23 **Results:** Studies of nine interventions demonstrated a positive effect on at
24 least one measure of readmissions; eight of the nine reduced all cause
25 readmissions through at least thirty days after discharge. Among these nine
26 interventions, the average length of the post discharge portion was six and a
27 half weeks. However, three more effective interventions, which demonstrated
28 reductions in readmissions through six or twelve months, averaged more than
29 nine weeks post discharge in length.

- 30 • All nine interventions that showed any positive impact on readmissions
31 relied on nurses as the clinical leader or manager of care.

- 1 • Six of the nine studies that demonstrated a positive effect on at least one
2 measure of readmission included in-person home visits.
- 3 • Two types of multicomponent interventions have proved more effective in
4 reducing all-cause readmissions:
 - 5 – Comprehensive discharge planning with follow-up interventions that
6 incorporate patient and caregiver goal setting, individualized care
7 planning, educational and behavioural strategies, and clinical
8 management
 - 9 – A tele-health facilitated intervention emphasizing daily home videophone
10 or telephone monitoring and transmission of physiologic measurements,
11 self-care instruction, and symptom management.
- 12 • Each of the three studies that effectively reduced readmissions through at
13 least six or twelve months after discharge included a focus on patient self-
14 management.

15 **8. Sadowski, L., Kee, R., VanderWeele, T. and Buchanan, D. (2009) Effect**
16 **of a housing and case management program on emergency department**
17 **visits and hospitalizations among chronically ill homeless adults: A**
18 **randomized trial.**

19 **Outline:** This is a moderate quality [+] randomised controlled trial of moderate
20 relevance to the UK context. The aim of this study was to assess the
21 effectiveness of a case management and housing program in reducing use of
22 urgent medical services among homeless adults with chronic medical
23 illnesses. Housing was offered as transitional housing after hospital discharge,
24 followed by placement in long-term housing.

25 The homeless population was one that was considered by the equality impact
26 assessment to be particularly vulnerable in the transition from hospital to the
27 community. This US study offers a unique perspective in attempting to
28 address the issues of having no home to transition to.

29 **Results:** Adjusted for baseline characteristics, the intervention groups had
30 statistically significantly lower rates of

- 31 • Hospitalisations

- 1 • Hospital days
- 2 • Emergency department visits

3 However, at 18 months there was no significant differences between
4 groups on health related quality of life measures.

5

6 **9. Schwarz, K., Mion, L., Hudock, D. and Litman, G (2008) Telemonitoring**
7 **of heart failure patients and their caregivers: a pilot randomized**
8 **controlled trial.**

9 **Outline:** This is a good quality [++] RCT designed to examine the effects of
10 tele monitoring by an advanced practice nurse on older heart failure patients.
11 The outcomes included impact on social support, a range of clinical outcomes,
12 subsequent hospital readmissions, emergency department visits, costs, and
13 risk of hospital readmission for patients with heart failure. Caregiver outcomes
14 were also measured with patient and caregiver dyads assigned to the
15 intervention and control. The intervention group received an electronic home
16 monitoring (EHM) system, which recorded their weight on a daily basis and
17 collected other subjective data about physical symptoms. The 'Cardiocom
18 EHM system' was installed at the first interview and removed by the nurse 90
19 days later, at the second interview. 'Usual care' was not described. The
20 methods of evaluation were judged appropriate and the study is relevant to
21 the scope.

22 **Results:**

- 23 • Hospital readmissions, emergency department visits and costs of care
24 between groups:
 - 25 – There was no difference in hospital readmission between the
26 intervention (n=12) and usual care (n=13) groups ($x^2=0.27$; $P=.60$).
 - 27 – Hospital charges alone did not differ significantly between intervention
28 and usual care groups ($\$10,996.86 \pm \$29,230.05$; $\$5,462.58 \pm \$9,825.00$,
29 respectively; $P=.26$).

- 1 – Out-of-pocket costs for medications, physician office visits, and
2 laboratory testing were similar between groups.
- 3 – There was no significant difference in emergency department visits
4 between groups.
- 5
- 6 • Depressive symptoms, days to readmission, quality of life, caregiver
7 mastery between groups:
- 8 – While differences existed between groups at baseline with regard to
9 caregiver mastery, there were no differences between groups for any
10 outcome at the 90-day follow-up visit.
- 11 – For those readmitted to hospital, the number of days to readmission did
12 not differ significantly between groups.
- 13 – There was no significant difference in quality of life scores between
14 groups at the 90-day follow-up visit.
- 15
- 16 • Caregiver mastery, informal social support and tele monitoring as
17 predictors of reduced hospital readmission:
- 18 – Cox proportional hazards regression modeling was used to identify
19 independent predictors of risk for hospital readmission in days.
20 Independent variables included caregiver mastery, informal social
21 support, and tele monitoring. None of these predicted risk of hospital
22 readmission.

23 **10. Scott (2010) Preventing the rebound: Improving care transition in**
24 **hospital discharge processes**

25 **Outline:** This is a good quality [++] systematic meta-review, which included
26 only systematic reviews and controlled studies. The aim was to determine the
27 relative efficacy of peri-discharge interventions categorised into two groups:
28 (1) single component interventions (sole or predominant) implemented either
29 before or after discharge; and (2) integrated multi-component interventions,
30 which have pre- and post-discharge elements.

31

1 **Results:**

- 2 • Intense self-management and transition coaching of patients at high risk of
3 readmission, and the use of home visits or telephone support for patients
4 with heart failure appear to be the only single-component strategies that
5 demonstrated consistent evidence of efficacy in reducing readmissions.
- 6 • Trials involving integrated multi-component strategies that span the pre-
7 discharge/ post-discharge continuum are limited in number but appear to
8 show positive outcomes in reducing readmissions.
- 9 • The evidence suggests that discharge processes are effective in reducing
10 readmissions if they include the following components:
- 11 – Early and complete assessment of discharge needs and medication
12 reconciliation;
 - 13 – Enhanced patient (and care-giver) education and counselling specifically
14 focused on gaining an understanding of the patient’s condition and its
15 self-management
 - 16 – Timely and complete communication of management plan between
17 clinicians at discharge when patient care is transferred from hospital staff
18 to primary care teams;
 - 19 – Early post-acute follow-up within 24–72 h for high-risk patients with
20 either doctor or nurse;
 - 21 – Early post discharge nurse (or pharmacist) phone calls or home visits to
22 confirm understanding of management and follow-up plans in high-risk
23 patients;
 - 24 – Appropriate referral for home care and community support services
25 when needed.

26 **11. Shepperd et al (2013) Discharge planning from hospital to home**

27 **Outline:** This is a good quality [++] systematic review, which included only
28 randomised control trials that compared an individualised discharge plan with
29 routine discharge care that was not tailored to the individual patient. The
30 review reported on a wider range of outcomes than just re-admission, but the
31 reviewers focused specifically on this outcome (which was primarily measured
32 as readmission within 3 months as opposed to within 30 days). All studies

1 were quality assessed using the Cochrane 'risk of bias' table and were
2 excluded if they had major methodological weaknesses. Sixteen out of the 24
3 included studies recruited older patients with a medical condition. The studies
4 were from the USA, UK, Canada, France, Australia, Denmark, the
5 Netherlands and Taipei.

6 **Results:**

- 7 • Unscheduled readmissions to hospital were statistically significantly
8 reduced for elderly patients admitted to hospital with a medical diagnosis
9 and who were allocated to discharge planning (readmission rates RR 0.82,
10 95% CI 0.73 to 0.92, 12 trials; 3217 participants).
- 11 • Evidence suggests that a discharge plan tailored to the individual patient
12 probably brings about reductions in hospital length of stay and readmission
13 rates for older people admitted to hospital with a medical condition.
- 14 • One trial, recruiting patients with heart failure, reported a significant
15 improvement on the total score for the Chronic Heart Failure Questionnaire
16 (mean difference 22.1 (20.8); $P < 0.01$) (Rich 1995).
- 17 • There is some evidence to suggest that patients receiving discharge
18 planning experience increased levels of satisfaction with their hospital and
19 discharge care (Moher 1992; Weinberger 1996; Laramée 2003); however,
20 overall the impact of discharge planning on mortality, health outcomes and
21 cost remains uncertain.

22 **Studies reporting evidence of cost-effectiveness (n=1)**

23 One UK cost-effectiveness study carried out alongside a RCT was identified
24 (Ellis et al 2006, N=194, ++) which compared a short-term rehabilitation unit
25 with standard community care after hospital discharge for older people. The
26 study found that total mean costs (in 1999/2000 prices) for health and social
27 care were higher in the intervention group at 12months follow up (£8,542 vs.
28 £8,511); cost of the intervention fell more heavily on social services, while the
29 cost of the comparison group fell more strongly on the NHS. There was no
30 significant difference in mean survival-at-home time at 12 months (272 days
31 vs. 285 days; unadjusted mean diff. 1.28, 85% CI 0.81 to 2.03); however,
32 people in the intervention group were significantly older ($p=0.028$). Sensitivity

1 analysis showed that standard care was in most scenarios cheaper and
 2 missing data had only a modest impact on the results.

3 No final conclusions could be derived about the cost-effectiveness of
 4 rehabilitation or reablement interventions aimed to reduce short-term hospital
 5 readmission. The only study applicable to the review question referred to a
 6 specialist rehabilitation unit and did not find that this was likely to be cost-
 7 effective if compared with standard community care.

8 **Evidence statements (including economic evidence statement)**

RHR1	There is some evidence of mixed quality that self-care and self-management reduces hospital readmissions although conflicting evidence was also located. One good quality systematic review (Allen et al, 2014) [++] found that self-management and discharge coaching significantly lowered readmission rates at 30, 90 and 180 days. A good quality systematic meta-review (Scott, 2010) [++] identified patient (and care-giver) education for promoting self-management as a vital component for reducing readmissions. Finally, a low quality systematic review (Naylor, 2011) [-] reported that 3 out of 9 effective interventions included a focus on self-management.
RHR2	There is a moderate amount of evidence of mainly good quality that post discharge communication with patients reduces hospital readmissions although conflicting evidence also exists. A good quality systematic review (Leppin, 2014) [++] identified frequent contact with the patient and home visits as common components of complex interventions, which were most effective in reducing early readmissions. A good quality systematic meta-review (Scott, 2010) [++] concluded that home visits or telephone support for patients with heart failure appear to be one of two single component strategies demonstrating consistent evidence of efficacy in reducing readmissions. A low quality systematic review (Naylor, 2011) [-] located 9 studies demonstrating a positive effect on readmissions. Six of these included in person home visits. Finally, a good quality systematic review (Hansen et al, 2011) [++] found slightly conflicting results; of 4 effective multi-component interventions, post discharge telephone calls were common to them all. However Hansen et al also located two RCTs that included post discharge telephone calls and which did not report significant effects. Similarly, two studies that examined follow up calls in isolation did not find a significant effect. Finally, a moderate quality systematic review (Bahr, 2014) [+] of post discharge telephone calls did not find any significant effect in the studies (n=7) which measured hospital readmission.
RHR3	There is some good quality evidence that in-hospital assessment of needs and planning for discharge lead to lower readmission rates. One good quality systematic review (Allen et al, 2014) [++] located a study that found an inpatient geriatric evaluation (combined with co-management with ward staff and transitional care) significantly reduced the likelihood of readmission 3 months following discharge. Another good quality systematic review (Shepperd et al, 2013) found that individually tailored discharge plans to meet older people's ongoing needs reduced readmission rates. A good quality systematic review (Scott, 2010) [++] highlighted the importance of early assessment of discharge needs, which was one of several components

	of discharge processes effective in reducing readmissions. Finally, a moderate quality systematic review (Jacob, 2008) [+] concluded that lapses in discharge planning undermine patients' perceptions of their readiness for discharge and compromise discharge success.
RHR4	There is a small amount of evidence of mixed quality that follow up care at home is vital to reducing readmissions. A good quality systematic review (Linertová et al, 2011) [++] located 15 home follow up studies, of which 7 clinical trials demonstrated effectiveness in reducing readmissions among older people. Interventions that combined geriatric management supported with home care post discharge were most likely to produce positive effects. A low quality systematic review (Naylor, 2011) [-] found that comprehensive discharge planning with follow up interventions (incorporating patient and caregiver goal setting and clinical management) was one of two most effective multi component interventions. A good quality systematic meta-review (Scott, 2010) [++] found that appropriate referral for home care and community support services was an essential component of discharge processes effective in reducing readmissions.
RHR5	There is a moderate amount of good quality evidence that communication between secondary health and primary health and community services is vital in reducing hospital readmissions. A good quality systematic meta-review (Scott, 2010) [++] found that one of the key components of effective discharge processes is timely and complete communication of management plans between clinicians when patients' care is transferred from hospital staff to primary care teams. Echoing this, another good quality systematic review (Hansen et al, 2011) identified interventions comprising of timely primary care provider communication as being effective in reducing hospital readmissions. Finally, a good quality systematic review (Linertová, 2011) [++] concluded that interventions incorporating geriatric management and home care support are more likely to reduce hospital readmissions. These services are complex requiring a high degree of collaboration between patients, caregivers, geriatricians, general practitioners, social community services and other agents.
RHR6	A limited amount of evidence of moderate quality suggests that housing support combined with case management has a positive effect on hospital readmission rates for homeless people. One randomized control trial (Sadowski, 2009) [+] found that when housing was offered on discharge from hospital, followed by placement in long-term housing, the intervention groups had statistically significantly lower readmissions (as well as hospital days and emergency department visits).
RHR7	No evidence was found from studies published since 2003 about the following interventions to reduce (30 day) hospital readmissions: nutrition support, befriending and transport services.
Ec4	Only a small amount of relevant economic evidence was identified which suggested that short-term rehabilitation for older people was not likely to be cost-effective. This referred to one UK cost-effectiveness evaluation carried out alongside a RCT (++) which compared a short-term rehabilitation unit with standard community care after hospital discharge for older people and showed that standard care was in most scenarios cheaper. No final conclusions could be derived about the cost-effectiveness of rehabilitation or reablement interventions aimed to reduce short-term hospital readmission. The only study applicable to the review question referred to a specialist rehabilitation unit and did not find that this was likely to be cost-effective if compared with standard community care.

1

2 **Included studies for reducing (30-day) readmissions review questions**
3 **(full citation)**

4 Allen J, Hutchinson A, Brown R et al. (2014) Quality care outcomes following
5 transitional care interventions for older people from hospital to home: a
6 systematic review. *BMC Health Services Research* 14:1–18

7 Ellis A, Trappes Lomax T, Fox M, Taylor R, Power M, Stead J, Bainbridge I.
8 (2006), *Buying time II: an economic evaluation of a joint NHS/Social Services*
9 *residential rehabilitation unit for older people on discharge from hospital.*
10 *Health and Social Care in the Community*; 14(2): 95-106

11 Hansen L, Young R, Hinami K et al. (2011) Interventions to reduce 30-day
12 rehospitalization: a systematic review. *Annals of Internal Medicine* 155: 520–8

13 Hung WW, Ross JS, Farber J et al. (2013) Evaluation of the mobile acute care
14 of the elderly (MACE) service. *JAMA Intern Med.* 173: 990-996

15
16 Jacob L and Poletick E (2008) Systematic review: Predictors of successful
17 transition to community-based care for adults with chronic care needs. *Care*
18 *Management Journals* 9: 154–65

19 Leppin A, Gionfriddo M, Kessler M et al. (2014) Preventing 30-Day Hospital
20 Readmissions: A Systematic Review and Meta-analysis of Randomized Trials.
21 *JAMA International Medicine* 174: 1095–107

22 Linertová R, Garcia-Perez L, Vazquez-Diaz J et al. (2011) Interventions to
23 reduce hospital readmissions in the elderly: in-hospital or home care. A
24 systematic review. *Journal of Evaluation in Clinical Practice* 17: 1167–75

25 Naylor M, Aiken L, Kurtzman E et al. (2011) The importance of transitional
26 care in achieving health reform. *Health Affairs* 30: 746–54

27 Sadowski L, Kee R, VanderWeele T et al. (2009) Effect of a housing and case
28 management program on emergency department visits and hospitalizations
29 among chronically ill homeless adults: A randomized trial. *JAMA: Journal of*
30 *the American Medical Association* 301: 1771–8

1 Schwarz K, Mion L, Hudock D et al. (2008) Telemonitoring of heart failure
2 patients and their caregivers: a pilot randomized controlled trial. *Progress in*
3 *Cardiovascular Nursing* 23: 18–26

4 Scott I (2010) Preventing the rebound: Improving care transition in hospital
5 discharge processes. *Australian Health Review* 34: 445–51

6 Shepperd S, Lannin N, Clemson L et al. (2013) Discharge planning from
7 hospital to home. *Cochrane Database of Systematic Reviews* 2013 (1) 1– 91

8

9 **3.6 Support for carers during transitions**

10 **Introduction to the review questions**

11 The purpose of these review questions was to identify approaches to
12 supporting families and carers during transitions between inpatient hospital
13 settings and community or care home settings and to identify evidence about
14 the effectiveness and cost effectiveness of those approaches. The questions
15 also aimed to consider research, which systematically collected the views of
16 people using services, their carers, and care and support staff in relation to
17 approaches and interventions designed to support carers during transitions.

18 Overall, a moderate amount of evidence about support for carers was located.
19 There was more evidence of views and experiences than there was about the
20 effectiveness of carer support. The views data were mainly of moderate
21 quality and one of the studies was from outside the UK because it was judged
22 to be transferable to the UK context and to offer valuable insight. The two
23 studies of effectiveness and two of the views and experiences studies related
24 to support for carers of stroke patients. A task for the Guideline Committee
25 was to consider the generalizability of findings to the wider population of
26 carers for adults with social care needs during transition to and from hospital

1 **Review questions for evidence of effectiveness**

2 11. (a) How should services work with families and unpaid carers of adults
3 with social care needs during admission to inpatient hospital settings from
4 community or care home settings?

5 11. (b) How should services work with families and unpaid carers of adults
6 with social care needs during transition between inpatient hospital settings to
7 community or care home settings?

8 **Review questions for evidence of views and experiences**

9 Review questions 1-4 and question 10, listed on pages 2-3, were applied
10 specifically in relation to carer support during transitions.

11 **Summary of review protocol**

12 The protocol sought to identify studies that would:

- 13 • Draw on material identified in questions 1, and 5, 6, 7, 8, 9 to identify
14 approaches in care planning and delivery which enable carers, partners
15 and families to participate in care planning and delivery during transitions
16 between inpatient hospital settings and community or care home
17 settings.
- 18 • Identify and evaluate interventions and approaches (including information
19 and education) which support carers in the tasks of caring during
20 transitions;
- 21 • Consider how providers of social care and health care should work in
22 partnership and support families and unpaid carers of adults with social
23 care needs during admission to and discharge from hospital.

24 For the views and experiences review questions, the protocol sought to
25 identify studies specifically relating to carer support that would:

- 26 • Describe the self-reported views and experiences of adults with social care
27 needs, their families and unpaid carers about the support carers receive
28 during transitions between hospital and home.

- 1 • Highlight aspects of support for carers during the hospital admission and
2 discharge process that work well, as perceived by service users, their
3 families and unpaid carers and aspects of care and support for carers,
4 which are perceived not to work well.
- 5 • Describe the views and experiences of people delivering, organising and
6 commissioning social care, health and housing services in relation to carer
7 support.
- 8 • Highlight aspects of carer support, which work well, and are personalised
9 and integrated, as perceived by practitioners, managers and
10 commissioners and aspects, which should be changed.
- 11 • Contextualise the views of users, carers and practitioners by identifying
12 barriers and facilitators to improved or changed practice they suggest
13 would improve the outcomes of carer support.

14 **Population:** Families, partners and unpaid carers of adults with social care
15 needs during a transfer of care from inpatient hospital settings to community
16 or care home settings and during admission to inpatient hospital settings from
17 community or care home settings. Families, partners and unpaid carers of
18 self-funders experiencing a transfer of care from inpatient hospital settings to
19 community or care home settings and vice versa are included.

20 Housing practitioners, social care practitioners (providers, workers, managers,
21 social workers), and health and social care commissioners involved in
22 delivering social care to people during transfer between hospital and
23 community or care home settings, or intermediate care units; personal
24 assistants engaged by people with social care needs and their families.
25 General practice and other community-based healthcare practitioners.

26 **Intervention:** ‘Support to care’ (involvement in planning and delivery, specific
27 support such as needs assessment and respite, training in skills such as
28 lifting; support to enable social participation and reduce isolation of carers).

29 **Setting:** Inpatient hospital settings, hospices, bed-based intermediate care
30 settings (“step down” and “step up”) and service users’ home, including
31 sheltered housing accommodation; supported housing; temporary
32 accommodation; care (residential and nursing) homes.

1 **Outcomes:** Carer outcomes (such as carer satisfaction; quality and continuity
2 of care; quality of life, perception of carer burden; choice and control for users
3 and carers; involvement in decision-making; dignity and independence; health
4 status of carer; safety and safeguarding. Service outcomes including hospital
5 readmissions, avoidable admissions, length of stay in hospital.

6 User and carer satisfaction; quality and continuity of care; choice and control;
7 involvement in decision-making; dignity and independence; quality of life;
8 health status; safety and safeguarding

9 The study designs included for the effectiveness questions on reducing
10 hospital readmissions were:

- 11 • Systematic reviews of qualitative studies on this topic;
- 12 • Systematic reviews utilising measures of carer burden and satisfaction;
- 13 • Randomised controlled trials (RCTs) and cluster-randomised trials of
14 interventions to support carers to care (e.g. education).
- 15 • Controlled studies of interventions to support carers to care (e.g.
16 education).
- 17 • Economic evaluations.

18 The study designs relevant to the views and experiences questions were
19 expected to include:

- 20 • Systematic reviews of qualitative studies on this topic;
- 21 • Qualitative studies of user and carer views of carer support;
- 22 • Qualitative components of effectiveness and mixed methods studies;
- 23 • Observational and cross-sectional survey studies of carer and user
24 experience.

25 Full protocols can be found in Appendix A.

26 **How the literature was searched**

27 Electronic databases in the research fields of social care, health, economics
28 and social science were searched using a range of controlled indexing and
29 free-text search terms based on the facets of: the state of transition (service

1 user/patient transfer or admission or discharge), settings (inpatient hospital or
2 community or care home settings) and health and social care needs,
3 workforce or intervention.

4 The search aimed to capture both journal articles and other publications of
5 empirical research. Additional searches of websites of relevant organisations
6 were also carried out.

7 The search for material on this topic was carried out within a single broad
8 search strategy used to identify material which addressed all the agreed
9 review questions on the transition between inpatient hospital settings and
10 community or care home settings for adults with social care needs. The
11 searches were restricted to studies published from 2003 in order to
12 incorporate the Community Care (Delayed Discharges) Act 2003. Generic and
13 specially developed search filters were used to identify particular study
14 designs, such as systematic reviews, randomised controlled trials, economic
15 evaluations, cohort studies, mixed method studies and personal narratives.
16 The database searches were not restricted by country.

17 Full details of the search can be found in Appendix A.

18 **How studies were selected**

19 Search outputs (title and abstract only) were stored in EPPI Reviewer 4 - a
20 software programme developed for systematic review of large search outputs
21 - and screened against an exclusion tool informed by the parameters of the
22 scope. Formal exclusion criteria were developed and applied to each item in
23 the search output, as follows:

- 24 • Language (must be in English),
- 25 • Population (must be over 18 years of age and have a social care need)
- 26 • Transition (a transition into or out of an inpatient hospital setting must have
27 occurred within the last 30 days)
- 28 • Intervention (must be involved in supporting transitions)
- 29 • Setting (inpatient hospital setting, intermediate care setting, community
30 setting or care home)

- 1 • Country (must be UK, European Union, Denmark, Norway, Sweden,
- 2 Canada, USA, Australia and New Zealand)
- 3 • Date (not published before 2003)
- 4 • Type of evidence (must be research)
- 5 • Relevance to (one or more) review questions.

6 Title and abstract of all research outputs were screened against these
7 exclusion criteria. Those included at this stage were marked for relevance to
8 particular review questions and retrieved as full texts.

9 Full texts were again reviewed for relevance and research design. If still
10 included, critical appraisal (against NICE tools) and data extraction (against a
11 coding set developed to reflect the review questions) was carried out. The
12 coding was all conducted within EPPI Reviewer 4, and formed the basis of the
13 analysis and evidence tables. All processes were quality assured by double
14 coding of queries, and of a random sample of 10%.

15 In our initial screen (on title and abstract), we found 51 studies, which
16 appeared relevant to the review questions on support for carers during
17 transitions. We ordered full texts and reviewed 27 papers for final inclusion.
18 For views and experiences research, studies from a UK setting were
19 prioritized. Effectiveness studies were restricted to systematic reviews,
20 randomized controlled trials or controlled studies. On reviewing the full texts,
21 we identified 7, which fulfilled the criteria (see included studies below) plus 2
22 economics studies. The included studies (see below) were critically appraised
23 using NICE tools for appraising different study types, and the results
24 tabulated. Further information on critical appraisal is given in the introduction
25 at the beginning of Section 3. Study findings were extracted into findings
26 tables. For full critical appraisal and findings tables, see Appendix B.

1 **Narrative summaries of the included evidence**

2 ***Studies reporting effectiveness data (n=3)***

3 **1. Bakas, T., Farran, C., Austin, J., Given, B., Johnson, E. and Williams L.**
4 **(2009a) Stroke Caregiver Outcomes from the Telephone Assessment**
5 **and Skill-Building Kit (TASK)**

6 **Outline:** This is a good quality [++] mixed methods study, which is highly
7 relevant to the review question. The study comprised of a literature review and
8 evaluation of the Telephone Assessment and Skill- Building Kit (TASK), which
9 is an 8-week program that addresses caregiver needs. The TASK intervention
10 comprised of written tip sheets addressing each of the 32 items in the
11 Caregiver Needs and Concerns Checklist (CNCC) in 5 areas of skill-building
12 needs

- 13 • Finding out information about stroke
- 14 • Managing survivor's emotions and behaviours
- 15 • Providing physical care
- 16 • Providing instrumental care
- 17 • Dealing with personal responses to providing care.

18 In addition, a workbook and 5 process tip sheets provided skill building
19 strategies on strengthening existing skills, screening for depressive
20 symptoms, maintaining realistic expectations, problem solving and
21 communicating with health professionals. The tip sheets and workbook were
22 developed and revised based on input from 10 experts (see Bakas 2009b
23 under views and experiences data).

24 **Results:** Based on findings from the literature review authors conclude that
25 skill building is more helpful to care givers than psycho-educational support,
26 that caregivers find managing emotions and behaviours of stroke survivors
27 amongst the most stressful part of providing care and that care givers often
28 neglect their own physical and mental health needs.

29 The evaluation found increases in measures of optimism at 4 weeks, 8 weeks
30 and 12 weeks with a medium effect size for the TASK group compared to the

1 attention control group. Significant improvements were also reported for the
2 task difficulty situational factor at 4 weeks, and threat appraisal at both 8
3 weeks and 12 weeks.

4 There were no significant differences found between groups on measures of
5 health perceptions, depressive symptoms, and caregiver life changes at 4, 8
6 or 12 weeks.

7 **2. Forster et al (2013) A cluster randomised controlled trial and**
8 **economic evaluation of a structured training programme for caregivers**
9 **of inpatients after stroke: the TRACS trial.**

10 **Outline:** The TRACS trial was a good quality, relevant, pragmatic, multi-site
11 clustered randomised controlled trial conducted in the UK [++/++]. The trial
12 collaboration team followed up the smaller randomised controlled trial (Kalra
13 et al, (2004) London Stroke Carer Training Course (LSCTC – narrative
14 summary, below), a standardized structured competencies-based training
15 programme, to test the effectiveness, acceptability and feasibility of scaling up
16 the Training Caregivers After Stroke (TRACS) programme as standard
17 practice for all caregivers of stroke survivors.

18 The London Stroke Carer Training Course (LSCTC) programme consisted of
19 14 core competencies designed to train and test the skills and knowledge
20 needed to care for a stroke patient at home. The programme was modified to
21 allow the intervention to be implemented in multiple NHS settings by Stroke
22 rehabilitation Units and Multidisciplinary teams with a range of skills and
23 expertise.

24 **Results:** Unlike the Kalra RCT, the research team did not identify significant
25 differences between the two groups on any of the following measures at 6 or
26 12 months follow up:

- 27 • Nottingham Extended Activities of Daily Living (NEADL) scale
- 28 • Activities of Daily Living (Barthel Index)
- 29 • Hospital Anxiety and Depression Scale (HADS)
- 30 • Health state (EQ-5D)

- 1 • Stroke Impact Scale (SIS) physical domain
- 2 • Caregiver Burden Scale

3 These results are at odds with the Kalra findings but the following possible
4 reasons for the different results should be considered:

- 5 • In the 9 years since the Kalra RCT London Stroke Carer Training Course
6 (LSCTC), standard care may have improved to be at least as good as that
7 offered by TRACS programme.
- 8 • The impact of the programme was beneficial for some people and
9 detrimental for others. This could lead to a no difference result. The
10 indication here would be the programme may be better targeted to some
11 groups of caregivers rather than offered as standard practice for all
12 caregivers of stroke survivors.
- 13 • There were differences in the implementation of the programme between
14 the two studies. The smaller Kalra study may have benefited from higher
15 practitioner engagement, and the same staff responsible for the delivery in
16 a single site compared to the routine delivery of the programme across
17 multiple sites. This could mean that the programme would be difficult to
18 scale up in multi sites as standard practice.

19 **3. Kalra L; Evans A; Perez I; Melbourn A; Patel A; Knapp M; Donaldson N**
20 **(2004) Training care givers of stroke patients: Randomised controlled**
21 **trial**

22 **Outline:** This is a good quality [++] single blind randomised control trial, which
23 is highly relevant to the review area. The study aimed to evaluate the
24 effectiveness of caregiver training in reducing burden of stroke in patients and
25 their caregivers. Out of 300 carer/patient dyads, 151 dyads were randomised
26 to receive caregiver training. The intervention included: instruction on
27 prevention and management of common stroke-related problems - including
28 continence, nutrition and gait facilitation; advice on benefits and local services;
29 'hands on' training in lifting and handling techniques; assistance with personal
30 activities of daily living tailored to the needs of individual patient; and a 'follow
31 through' session upon return home. Robust, well validated, and objective

1 outcomes were used to measure caregiver and patient function, depression,
2 mortality, caregiver burden and costs at three and twelve months.

3 **Results:**

- 4 • Training caregivers during patients' rehabilitation reduced costs and
5 caregiver burden while improving psychosocial outcomes in caregivers and
6 patients at one year.
- 7 • There were no significant differences in patient mortality,
8 institutionalisation, or functional abilities between the training and control
9 group.
- 10 • Patients whose caregivers had received training reported significantly
11 improved quality of life and mood outcomes, both at three and 12 months.
- 12 • Burden of care was reduced significantly and quality of life and mood in
13 care givers improved significantly at three and 12 months.
- 14 • Caregiver training was associated with significant cost reductions over one
15 year (£10,133 (SD £8676) v £13,794 (SD £10,510); P = 0.001), mainly
16 because of lower hospital costs (£8,987 (SD £7,368) v £12,383 (SD
17 £9,104)).

18 ***Studies reporting views and experiences data (n=4)***

19 **1. Addington-Hall, J. and Armes, P. (2003) Perspectives on symptom** 20 **control in patients receiving community palliative care**

21 **Outline:** This qualitative case study of moderate quality [+] was carried out in
22 a specialist palliative care service (SPCS) in South London which provides
23 both inpatient and home care services. The study aimed to explore the
24 reasons why patients required crisis management and were admitted for
25 inpatient care. The paper mainly focused on carers' ability to manage and
26 interpret their relatives' symptoms in the home, with a view to avoiding
27 admissions (which is out of scope) rather than ensuring successful
28 admissions. As the study presents findings on how service providers can
29 work in partnership with family caregivers who were caring for someone
30 admitted into inpatient care the study has been included for this review area,

1 but on account of the admission avoidance bias the external validity has been
2 graded as low [-].

3 **Results:** Findings are reported under the relevant views and experiences
4 questions.

5 **1.2 (a) What are the views and experiences of families and unpaid carers**
6 **in relation to the transition from inpatient hospital settings to community**
7 **or care home settings?**

8 Knowing what to monitor, how to interpret the signs and when to inform a
9 health professional were all issues of concern for carers as they recognized
10 that these were important for the achievement of symptom control.

11 Carers explained that they were not always kept informed in the way that they
12 wanted to be. For example, one carer, who wanted to be with their relative
13 when they were dying was not informed that their death was imminent.

14 **2.2 (b) What do families and unpaid carers think works well, what does**
15 **not work well, and what could improve the hospital admission process**
16 **(including admission from community or care homes)?**

17 ***Could improve admission***

18 More information and education (on symptom management), needs to be
19 given to carers to allow them to fulfil their roles more successfully. Monitoring
20 a symptom not only requires that carers are aware of what to report but also
21 that they are able to decide when to report it.

22 **4 (b) What do health, social care and housing practitioners think works**
23 **well, what does not work well, and what could improve the hospital**
24 **admission process (including admission from community or care home**
25 **settings)?**

26 When health professionals were not provided with accurate and reliable
27 information this often resulted in crisis management (i.e. they were admitted to
28 inpatient care).

1 A number of times health professionals felt that certain symptoms should have
2 been reported earlier so that they could intervene before the situation became
3 unmanageable.

4 **2. Bakas Tamilyn ; Farran Carol J; Austin Joan K; Given Barbara A;
5 Johnson Elizabeth A; Williams Linda S; (2009b) Content Validity and
6 Satisfaction With a Stroke Caregiver Intervention Program**

7 **Outline:** This was a mixed methods study of moderate quality [+] and high
8 relevance [++] that included both views of carers and measures of impact.
9 Stroke caregivers often express the need for information about stroke and
10 assistance with stroke-related care in the early discharge period. The
11 Telephone Assessment and Skill- Building Kit (TASK) is an 8-week program
12 that addresses caregiver needs. The underlying conceptual model was
13 derived from Lazarus's transactional theory of stress, which is outlined in the
14 narrative summary for Bakas et al, 2009a (above). This and Bakas et al,
15 2009a are linked papers.

16 The element of the evaluation reported in this paper is the development of the
17 TASK intervention tip sheet and workbook, for which experts were employed
18 to rate the TASK intervention components for accuracy, feasibility,
19 acceptability and problem relevance. A convenience sample of 40 stroke
20 caregivers also rated the intervention for usefulness, ease of use and
21 acceptability. The qualitative component is limited to selected quotes that
22 illustrate survey response findings. The survey responses and the qualitative
23 components inform the data extraction for this paper.

24 **Results:** The stroke survivor's caregiver intervention group scored higher
25 than the control group on all satisfaction domains (usefulness, acceptability
26 and overall satisfaction) with a large effect size of 0.81.

27 Most of the non-significant effects were about the usefulness, ease of use and
28 acceptability of the nurse's phone calls: "the calls from the nurse helped me",
29 "The nurse calls each week were convenient" and "I like getting calls from the
30 nurse". (p372)

1 In addition, a non-significant effect was found in the usefulness domain on the
2 statement, "The TASK/ ASA pamphlet tip sheets work well for me"

3 The non-significant effect of the "The TASK/ ASA pamphlet tip sheets work
4 well for me" subscale may be due to a lack of ability to make a comparison
5 between the two types of approaches and pick a preference, or that most (if
6 not all) caregivers would find information provided after discharge useful to
7 some degree.

8 The findings from the satisfaction survey were supported by selected quotes
9 from both the intervention and the control group that contact with nurses after
10 discharge was highly valued and may explain the non-significant differences
11 between the groups on the questions that related to the nurse contact.

12 **2.2 (a) What do families and unpaid carers think works well, what does
13 not work well, and what could improve the transition from inpatient
14 hospital settings to community or care home settings?**

15 Works well

16 Proactive support: It is likely that caregivers of stroke survivors had no
17 previous experience of this event or anything comparable to it, they did not
18 know what to expect and appreciated the pro-active approach of being invited
19 to take part in the intervention, "I'd never been in this situation before and I
20 had absolutely no clue of what to do or how to go about anything, so I think
21 the information that you provided was just what I needed" (p372)

22 **3. Cobley CS, Fisher, R J, Chouliara N, Kerr M, Walker MF. (2013) A
23 qualitative study exploring patients' and carers' experiences of Early
24 Supported Discharge**

25 **Outline:** This is a good quality [++] views study that aimed to fill the gap in
26 patient and carer perceptions of early supported discharge (for stroke
27 patients) during the early post-discharge phase in the UK. It was intended to
28 inform future Early Supported Discharge service development and provision.
29 The study employed a constant comparative method to develop themes from
30 interviews given by participants receiving Early Supported Discharge as well

1 as people who did not. Common themes across both groups were identified
2 plus themes that were only reported by individuals who received Early
3 Supported Discharge.

4 **Results:** Findings are reported under the relevant views and experiences
5 questions.

6 **2.2 (a) What do families and unpaid carers think works well, what does
7 not work well, and what could improve the transition from inpatient
8 hospital settings to community or care home settings?**

9 ***Works well***

10 Respite time for the carer emerged as a significant and recurring theme.
11 Carers reported that the therapeutic sessions between the patient and the
12 Early Supported Discharge team enabled them to engage in their own
13 activities, "I could get on with the little jobs that wanted doing, or I could just
14 put my feet up and have a rest, so it made life a darn sight easier for me."
15 (p753)

16 ***Could be improved***

17 Provision and delivery of information: "I thought it'd be good to talk about if
18 you were entitled to any benefits because I've never been on the sick ever. I
19 didn't understand any of it, we had to figure it out for ourselves". (p755)

20 "It would have been nice to have somebody sit down with me and say this is
21 what's happened, this is why it's happened, this is what you can expect. Okay,
22 so it is there in the leaflets but you just kind of flick through the leaflets" (p755)

23 Limited support in dealing with carer strain: Some carers felt that there was
24 little support or recognition of carer strain and the strain on physical and
25 mental health as well as a strain on family and social relationships. Carers
26 also described their difficulties in dealing with emotional and psychological
27 needs, both for themselves and for the person they were caring for. "His
28 depression...I just don't know what to do. I can't cope because I don't know
29 what to do to stop it." (p754)

1 **10 (a) What helps and what makes it difficult to ensure successful**
2 **transitions from inpatient hospital settings to community or care home**
3 **settings?**

4 ***What helps***

5 Satisfaction with provision and delivery of equipment: There was a general
6 consensus that the equipment provided was useful and delivered in a timely
7 manner.

8 ***What makes it difficult***

9 ***Provision and delivery of information:***

10 Some participants expressed their concerns about their limited understanding
11 of stroke and its causes, secondary preventative measures, and lifestyle
12 changes. Some caregivers felt that information wasn't provided in the right
13 format, "I wouldn't have a clue what was normal, what wasn't normal ... who to
14 ask for help and advice. I mean the internet's okay, but it only takes it so far.
15 Sometimes you need a person to put it into terms that you understand.
16 Because it's stressful when you don't know what's going on". (p754)

17 ***Disjointed transition between early supported discharge and future***
18 ***services:***

19 Some patients felt that the six-week cut off from Early Supported Discharge
20 was 'abrupt' and not 'continuous enough'.

21 ***Lack of education and training of carers:***

22 Some respondents felt that they were thrown into the caring role without
23 receiving enough support from the community stroke teams, "I don't think they
24 told me anything. I was just left out in the cold...I didn't have a clue what was
25 going on" and "I wasn't shown the best way to support him...it was all trial and
26 error". (p754)

1 **4. Pearson, P., Procter, S., Wilcockson, J. and Allgar, V. (2004) The**
2 **process of hospital discharge for medical patients: a model.**

3 **Outline:** This moderate quality [+] paper reports on the qualitative findings of
4 a study which tracks decision-making processes surrounding hospital
5 discharge. The study considers outcomes for a sample of medical patients
6 and their carers who were identified as being at risk of experiencing
7 unsuccessful discharge processes. The authors define unsuccessful
8 discharge as: 'unplanned readmission within 6 months of discharge, or
9 delayed discharge'. Evidently, the paper overlaps with the 'discharge
10 planning' and 'avoiding 30-day-readmission' review areas, and has been
11 graded as being 'somewhat relevant' to the current review area, 'support for
12 carers during transition from inpatient hospital settings to community or care
13 home settings'.

14 **Results:** Findings are reported under the relevant views and experiences
15 questions.

16 **1.1(a) What are the views and experiences of people using services, in**
17 **relation to the transition from inpatient hospital settings to community**
18 **or care home settings?**

19 Loss of identity, or fear of its loss, was an issue for 14 patients (out of 30), and
20 10 commented that their illness prevented them from fulfilling previous roles.

21 For many patients the opportunity to sustain their previous values and identity
22 while maintaining an appropriate social role was an important component of
23 their ability to manage their health problem(s) successfully.

24 **1.2 (a) What are the views and experiences of families and unpaid carers**
25 **in relation to the transition from inpatient hospital settings to community**
26 **or care home settings?**

27 Carers perceived themselves as forming a 'barrier' when healthcare
28 practitioners were assessing patients' needs: if they were 'there', then they
29 could cope. Carers were taken for granted and assumptions were made that
30 they would take on support of patients after discharge (regardless of
31 capacity).

1 Carers described the process of juggling their own needs, their family's needs
2 and those of the patient. They experienced constant pressure to prioritise,
3 with carers seeking to find a balance between different demands and drawing
4 on what resources they could find.

5 **2.2 (a) What do families and unpaid carers think works well, what does**
6 **not work well, and what could improve the transition from inpatient**
7 **hospital settings to community or care home settings?**

8 ***Could improve the transition***

9 More information and consistent behaviour from health and social care
10 professionals - carers said that a lack of information and the perceived
11 contradictory behaviour of professionals exacerbated their anxiety as
12 caregivers.

13 **3.(a) What are the views of health, social care and housing practitioners**
14 **about the transition from inpatient hospital settings to community or**
15 **care home settings?**

16 Nurses described preparation for discharge mainly in terms of ordering drugs
17 and arranging transport. GPs described 'picking up the pieces' following
18 discharge.

19 **4 (a) What do health, social care and housing practitioners think works**
20 **well, what does not work well what could improve the transition from**
21 **inpatient hospital settings to community or care home settings?**

22 ***What could be improved?***

23 Some nurses indicated that they were unable to achieve an adequate level of
24 understanding of each patient and their individual circumstances because
25 they were short staffed. Only four nurses mentioned some consideration of
26 the patient's home circumstances and seven spoke of giving information to
27 relatives.

28 GPs received inadequate discharge notes from the hospital, which led to
29 problems providing continuity of care for patients in the community.

1 **10 (a) What helps and what makes it difficult to ensure successful**
2 **transitions from inpatient hospital settings to community or care home**
3 **settings?**

4 ***What helps***

5 The findings from this study reinforce the need for active involvement of
6 patients and carers in discharge planning.

7 ***Makes it difficult***

8 Carers highlighted the inadequacy of the environment in which patients were
9 expected to recuperate after hospitalization – a setting which they saw as
10 purposeful, compared with the isolation of the environment to which they were
11 discharged.

12 **Studies reporting evidence of cost-effectiveness (n=2)**

13 One UK cost-utility study that was carried out alongside a RCT was identified
14 (Patel et al 2004, N= 300, ++). The intervention referred to 3 to 5 training
15 sessions for carers (30-40 min) on a stroke rehabilitation unit compared to
16 stroke rehabilitations unit only. There was no significant difference in carers'
17 health measured via EQ-5D at different time points with the latest follow up at
18 1 year but a significant reduction in total costs ($p<0.001$) due to shorter
19 hospital stays. There were also no significant changes in personal care,
20 domestic help or unpaid care. The intervention was dominant in cost-
21 effectiveness terms so that ICER was not calculated.

22 Findings were not confirmed in a more recent, larger pragmatic cluster RCT of
23 the same intervention (Forster et al 2013, N=928, ++) which was carried out
24 between 2008 and 2010. This study measured a wider range of outcomes for
25 patients in a stroke unit and their carers including functional independence,
26 caregiver burden and physical health (via EQ-5D). None of the outcomes
27 differed significantly between the two groups at 6 and 12 months. Carers in
28 the intervention group had higher health and social care costs at 6 months
29 (adj. mean diff £207 (95% CI 5–408, $p=0.045$) but not over 12 months.

30 Deaths, hospital readmission and institutionalisation rates did not differ either
31 at 6 or 12 months.

1 Evidence statements (including economic evidence statement)

CS1	There is a moderate amount of good quality evidence that targeted training to support carers in managing illness before and after hospitalization improves outcomes for carers and individuals. One study (Addington-Hall and Armes, 2003) [+] found carers were unsure at what stage in the development of symptoms they should call for emergency help. Another study (Cobley et al, 2013) [++] found carers lacked knowledge about stroke and were at a loss about how to manage potential consequences such as depression. Two studies (Bakas et al, 2009a and Kalra et al, 2004) [++] [++] found positive effects of caregiver training for stroke patients, which included instruction in hands on care for stroke-related problems and support in coping with emotions and behaviours.
CS2	There is a small amount of moderate and good quality evidence that carers experience strain, anxiety and stress as a result of their role and that respite is an invaluable means of dealing with this. One study Pearson et al (2004) [+] found carers felt taken for granted by the professionals involved who assumed they would provide support following discharge regardless of their capacity to do so. Another study (Cobley et al, 2013) [++] echoed this, reporting little support or recognition of carer strain (including physical, mental and on other relationships). Respite, even for short stretches of time, was invaluable to carers.
CS3	There is some evidence of moderate and good quality that caregivers of stroke patients value proactive support, which is provided directly from professionals, with leaflets and the internet playing a subsidiary role. One study (Bakas et al, 2009b) [+] presented evidence which showed that caregivers found printed information to provide much needed support, whilst repeated telephone contact from a nurse considerably improved their experience of transition from hospital to home. Another (Cobley 2013) [++] found that family caregivers of stroke patients undergoing early supported discharge felt that direct contact with a professional would have considerably improved their experience of transition. Finally, a study (Kalra et al, 2004) [++] in which caregivers received instruction directly from appropriate professionals during patients' rehabilitation reduced costs and caregiver burden while improving psychosocial outcomes in caregivers and patients at one year
Ec6	There is a small amount of good quality economic evidence for the same kind of training intervention provided to carers of stroke patients. Whilst the initial earlier study (Patel et al 2004, ++) found that the intervention was likely to be cost-effective, a larger more recent evaluation carried out by the same researchers did not confirm the findings (Forster et al 2013). Reason for the different findings might be due to improvement in standard care through time, and might mean that cost savings that were linked to a reduction in hospital stay can no longer be realised to the same extent. The differences between study findings might also be explained by differences in study design and/or differences in the implementation of the intervention.

1

2 **Included studies for the support for carers review questions (full**
3 **citation)**

4 Addington-Hall J and Armes P (2003) Perspectives on symptom control in
5 patients receiving community palliative care. *Palliative Medicine* 17: 608–15

6 Bakas T, Farran C, Austin J et al. (2009a) Stroke Caregiver Outcomes from
7 the Telephone Assessment and Skill-Building Kit (TASK). *Top Stroke*
8 *Rehabilitation* 2: 105–21

9 Bakas T, Farran C, Austin J et al. (2009b) Content Validity and Satisfaction
10 with a Stroke Caregiver Intervention Program. *Journal of Nursing Scholarship*
11 41: 368–75

12 Cobley, C., Fisher, R., Chouliara, N et al. (2012) ESD Services: Patient and
13 carer experiences and perspectives. *Clinical rehabilitation* 27: 750–7

14 Forster, A., Dickerson, J., Young, J., Patel, A., Kalra, L., Nixon, J., Smithard,
15 Knapp, M., Holloway, I., Anwar, S. and Farrin, A (2013) TRACS Trial
16 Collaboration; A cluster randomised controlled trial and economic evaluation
17 of a structured training programme for caregivers of inpatients after stroke: the
18 TRACS trial. *Health technology assessment* 17: 1-216

19 Kalra L, Evans A, Perez I et al. (2004) Training care givers of stroke patients:
20 Randomised controlled trial. *British Medical Journal* 328: 1099–101

21 Patel A, Knapp M, Evans A, Perez I, Kalra L (2004), Training care givers of
22 stroke patients: economic evaluation, *British Medical Journal*, 328:1-6.

23 Pearson P, Procter S, Wilcockson J et al. (2004) The process of hospital
24 discharge for medical patients: a model. *Journal of Advanced Nursing* 46:
25 496–505

1 **3.7 Practitioner training to support transitions**

2 **Introduction to the review questions**

3 The purpose of these review questions was to examine the impact of training
4 to support transitions between inpatient hospital settings and community or
5 care home settings. The aim was to examine the effectiveness of training in
6 terms of the impact on practitioners as well as on the outcomes of transitions
7 at the individual and service levels. The questions also aimed to consider
8 research, which systematically collected the views of care and support staff
9 and people using services and their carers in relation to training and continual
10 professional development for improving transitions between hospital and
11 home.

12 Overall, a small amount of evidence about training to support transitions was
13 located and reviewed. There was no evidence about a direct causal link
14 between training and the outcomes of transitions at the individual or service
15 level. However, studies of the impact of training on practitioners involved in
16 transitions were located and they were of moderate quality. The studies all
17 evaluated training for medical (and pharmacy) students so a task for the
18 Guideline Committee was to consider the generalizability of findings to the
19 wider population of care and support staff involved in transitions.

20 Studies of views and experiences relating to training were lacking. The only
21 one included for review, was of low quality and from outside the UK.

22 The impact studies all evaluated training for medical (and pharmacy students).
23 Consider applicability to other professional groups.

24 **Review question for evidence of effectiveness**

25 12. What is the impact of training to support transitions between inpatient
26 hospital settings and community or care home settings?

27 **Review questions for evidence of views and experiences**

28 Review questions 1-4 and question 10, listed on pages 2-3, were applied
29 specifically in relation to practitioner training to support transitions.

1 **Summary of review protocol**

2 The protocol sought to identify studies that would:

- 3 • Identify the effectiveness of approaches to existing induction, training and
4 continuing personal development delivered to social care staff,
5 (unregulated) personal assistants and hospital staff involved in admission
6 and discharge processes;
- 7 • Identify the potential for improvement in this area
- 8 • Identify possible barriers and facilitators to the implementation of training
9 and support for social care and relevant hospital staff to improve transitions
10 between health and social care;
- 11 • Consider whether and how increased integration could foster shared
12 learning with healthcare staff in relation to improving transitions between
13 inpatient hospital settings and community or care home settings.

14 For the views and experiences review questions, the protocol sought to
15 identify studies, specifically relating to practitioner training, that would:

- 16 • Describe the self-reported views and experiences of adults with social care
17 needs, their families and unpaid carers about the training that practitioners
18 receive to improve transitions between hospital and home.
- 19 • Highlight aspects of training for practitioners that work well, as perceived by
20 service users, their families and unpaid carers and aspects of training,
21 which are perceived not to work well.
- 22 • Describe the views and experiences of people delivering, organising and
23 commissioning social care, health and housing services in relation to
24 training to support transitions.
- 25 • Highlight aspects of practitioner training, which work well, as perceived by
26 practitioners, managers and commissioners and aspects, which should be
27 changed.
- 28 • Contextualise the views of users, carers and practitioners by identifying
29 barriers and facilitators to improved or changed training that they suggest
30 would improve the outcomes of transitions.

1 **Population:** Social care practitioners (providers, workers including home care
2 workers, managers, social workers), and social care commissioners involved
3 in delivering social care to people during transition between inpatient hospital
4 settings and community or care home settings or intermediate care units; (un-
5 regulated) personal assistants engaged by people with social care needs and
6 their families (including self-funders).

7 General practice and other community-based healthcare practitioners: GPs
8 and community/district nurses - nurses in residential care settings,
9 physiotherapists and other therapeutic professionals; hospital ward staff (with
10 a role in hospital admission and discharge procedures).

11 Adults aged 18 years and older, who are transferring from inpatient hospital
12 settings to community or care home settings and their families, partners and
13 carers. Self-funders and people who organise their own support and who are
14 experiencing a hospital discharge are included.

15 **Intervention:** Organisational skills support; models of integration and cross-
16 agency work and training; personalised services which respond to the needs
17 of the individual, and to identify and respond to existing or evolving problem
18 conditions. Staff support, supervision, training and assessment. Development
19 and use of protocols.

20 **Setting:** Inpatient hospital settings, bed-based intermediate care settings
21 (“step down” and “step up”) and service users’ home, including sheltered
22 housing accommodation; supported housing; temporary accommodation; care
23 (residential and nursing) homes.

24 **Outcomes:** Effectiveness studies of ‘training’ with follow up; outcomes
25 relating to safeguarding and safety, such as (e.g. falls prevention); reduction
26 in hospital bed days, reduction in hospital re-admissions: implementation of
27 CQC regulations and contract monitoring.

28 Practitioner satisfaction, knowledge and skills. User and carer satisfaction;
29 quality and continuity of care; choice and control; involvement in decision-

1 making; dignity and independence; quality of life; health status; safety and
2 safeguarding

3 The study designs included for the effectiveness questions on reducing
4 hospital readmissions were:

- 5 • Systematic reviews of quantitative studies on relevant interventions
- 6 • Standardised scales measuring satisfaction and wellbeing
- 7 • Randomised controlled trials (RCTs) and cluster RCTs on training
- 8 • Controlled studies and on training
- 9 • Pre-test, post-test evaluations
- 10 • Economic evaluations.

11 The study designs relevant to the views and experiences questions were
12 expected to include:

- 13 • Systematic reviews of qualitative studies on relevant interventions
- 14 • Qualitative studies of service user and carer views of training and
15 competencies of staff (drawing on questions 1 and 2)
- 16 • Qualitative studies of practitioner views of training and competencies of
17 staff
- 18 • Qualitative components of effectiveness and mixed methods studies
- 19 • Observational and cross-sectional survey studies of carer and user
20 experience.

21 Full protocols can be found in Appendix A.

22 **How the literature was searched**

23 Electronic databases in the research fields of social care, health, economics
24 and social science were searched using a range of controlled indexing and
25 free-text search terms based on the facets of: the state of transition (service
26 user/patient transfer or admission or discharge), settings (inpatient hospital or
27 community or care home settings) and health and social care needs,
28 workforce or intervention.

1 The search aimed to capture both journal articles and other publications of
2 empirical research. Additional searches of websites of relevant organisations
3 were also carried out.

4 The search for material on this topic was carried out within a single broad
5 search strategy used to identify material which addressed all the agreed
6 review questions on the transition between inpatient hospital settings and
7 community or care home settings for adults with social care needs. The
8 searches were restricted to studies published from 2003 in order to
9 incorporate the Community Care (Delayed Discharges) Act 2003. Generic and
10 specially developed search filters were used to identify particular study
11 designs, such as systematic reviews, randomised controlled trials, economic
12 evaluations, cohort studies, mixed method studies and personal narratives.
13 The database searches were not restricted by country.

14 Full details of the search can be found in Appendix A.

15 **How studies were selected**

16 Search outputs (title and abstract only) were stored in EPPI Reviewer 4 - a
17 software programme developed for systematic review of large search outputs
18 - and screened against an exclusion tool informed by the parameters of the
19 scope. Formal exclusion criteria were developed and applied to each item in
20 the search output, as follows:

- 21 • Language (must be in English),
- 22 • Population (must be over 18 years of age and have a social care need)
- 23 • Transition
- 24 • Intervention (must be involved in supporting transitions)
- 25 • Setting (inpatient hospital setting, intermediate care setting, community
26 setting or care home)
- 27 • Country (must be UK, European Union, Denmark, Norway, Sweden,
28 Canada, USA, Australia and New Zealand)
- 29 • Date (not published before 2003)
- 30 • Type of evidence (must be research)
- 31 • Relevance to (one or more) review questions.

1 Title and abstract of all research outputs were screened against these
2 exclusion criteria. Those included at this stage were marked for relevance to
3 particular review questions and retrieved as full texts.

4 Full texts were again reviewed for relevance and research design. If still
5 included, critical appraisal (against NICE tools) and data extraction (against a
6 coding set developed to reflect the review questions) was carried out. The
7 coding was all conducted within EPPI Reviewer 4, and formed the basis of the
8 analysis and evidence tables. All processes were quality assured by double
9 coding of queries, and of a random sample of 10%.

10 In our initial screen (on title and abstract), we found 21 studies, which
11 appeared relevant to the review questions on training for practitioners. We
12 ordered full texts of 17 papers, which appeared to apply to a UK setting (for
13 views and experiences studies) or, for effectiveness studies, met the criteria of
14 being systematic reviews, randomized controlled trials, controlled studies or
15 pre-test, post-test evaluations. On reviewing the full texts, we identified 4,
16 which fulfilled these criteria, although the views study was not from the UK
17 (see included studies below). No relevant economic studies were located.
18 The included studies (see below) were critically appraised using NICE tools
19 for appraising different study types, and the results tabulated. Further
20 information on critical appraisal is given in the introduction at the beginning of
21 Section 3. Study findings were extracted into findings tables. For full critical
22 appraisal and findings tables, see Appendix B.

23 **Narrative summaries of the included evidence**

24 ***Studies reporting effectiveness data (n=3)***

25 **1. Eskildsen, M., Chakkalakal, R. and Flacker, J. (2012) Use of a virtual** 26 **classroom in training fourth-year medical students on care transitions**

27 Outline: This is a moderate quality [+] survey, which evaluated the
28 effectiveness of a new care transitions curriculum taught to all fourth year
29 medical students at Emory University School of Medicine. The course
30 consisted of three components: a presentation on care transitions with an

1 associated case discussion, training on discharge summaries, and the
2 execution of a post-discharge phone call.

3 Questionnaires were used to measure changes in medical students' pre-test
4 to post-test confidence in performing discharge tasks, attitudes toward the
5 care transitions process, and performance on a knowledge quiz. Students'
6 satisfaction with the course was also assessed, as was the quality of the
7 students' discharge summaries and post-discharge call reports performed
8 during the module. Discharge summaries were deemed 'satisfactory' if they
9 had the 5 following components:

10 A documented discharge medication list with specific dosing schedules.

- 11 • Lists of admission medications and/or a list of medication changes during
12 hospitalization.
- 13 • A discharge plan that specifies the next setting of care, as well as the
14 planned follow-up.
- 15 • A hospital course organized by system and/or specific chronology.
- 16 • A physical exam, laboratory tests, and diagnostic studies performed on
17 admission.

18 'Satisfactory' post-discharge phone calls had to contain at least the following 2
19 elements:

- 20 • A discussion of the patient's medication list, including documentation of a
21 discussion of hazardous medications (e.g., furosemide, warfarin, digoxin,
22 insulin) if applicable.
- 23 • Documentation of a discussion on follow-up plans with a primary physician
24 or specialist.

25 The authors credit Dr Karin Ouchida of Montefiore Medical Centre for help
26 with developing questionnaire items, and reference Lai et al (2008), from
27 which the five multiple choice questions measuring students' confidence were
28 developed. Both Lai (2008) and Ouchida (2009) are reviewed as separate
29 (unlinked) studies under this review question.

30

1 **Results:**

- 2 • Students' confidence in their ability to perform discharge tasks improved
3 from 16.7 to 20.7 on a 25-point scale ($P < 0.001$).
- 4 • The change in students' attitudes regarding the importance of different
5 components of the care transitions process was not statistically significant
6 ($P=0.07$).
- 7 • Changes in total knowledge scores were statistically significant: the mean
8 percentage of correct answers out of ten rose from 68% on the pre-test to
9 82% on the post-test ($P < 0.001$)
- 10 • 90.1% (109/121) of discharge summaries and 90.1% (109/121) of post-
11 discharge call reports performed during the module met all quality criteria.

12 **2. Lai, C., Nye, H., Bookwalter, T., Kwan, A. and Hauer, K (2008) Post-**
13 **discharge follow-up visits for medical and pharmacy students on an**
14 **inpatient medicine clerkship.**

15 Outline: This is a moderate quality [+] study, which was designed to determine
16 whether a discharge curriculum would improve students' attitudes and self-
17 assessed skills in interdisciplinary collaboration and transitional care for
18 chronically ill patients. The discharge curriculum comprised of an
19 interdisciplinary workshop, follow-up visits with discharged patients, a final
20 group debriefing, and letters to patients' primary care providers. The effects of
21 the curriculum were tested via a before and after 5-point Likert-scaled survey
22 to establish the change in students' attitudes and skills in interdisciplinary
23 collaboration. Students reported their satisfaction using additional Likert-
24 scaled and open-ended questions. The survey methods were judged to be
25 appropriate to the aims of the study.

26 Results:

27 ***Student rated satisfaction with the curriculum***

28 Overall programme:

29 Mean score [scale 1-5]: 4.1: SD 1.14: 86% rated the curriculum v good or
30 excellent.

1 Most valuable components:

- 2 • The interdisciplinary collaboration on patient care (4.5: SD 1.04: 94%)
- 3 • The post discharge visit (4.3: SD 0.68: 91%)
- 4 • Followed by the debriefing session (3.9: SD 1.04: 74%)

5 Least useful components:

- 6 • The initial workshop on interdisciplinary roles (3.6: SD 1.18: 54%)
- 7 • The write-up to the primary care provider (3.4: SD 0.81: 48%)

8 ***Student assessment of impact of discharge curriculum***

- 9 • 91% of students agreed that they learned skills valuable for future patient
- 10 care (medical students 4.4, SD 0.61; pharmacy students 4.1, SD 0.62)
- 11 • Most students agreed that the program enhanced their learning about
- 12 interdisciplinary care (4.3, SD 0.72), discharge planning (4.4, SD 0.70), and
- 13 humanism (4.4 SD 0.63).
- 14 • 93% agreed that the curriculum was valuable to their education.

15 Some views and experiences data were also reported in this paper and
16 presented below under the relevant review questions:

17 **4 (a) What do health, social care and housing practitioners think works** 18 **well, what does not work well what could improve the transition from** 19 **inpatient hospital settings to community or care home settings?**

20 ***Works well***

21 Students felt the most valuable component of the curriculum was seeing
22 patients at home in their social context (30 total comments):

23 "I was unaware of the types of living conditions many patients face, especially
24 in the setting of chronic disease. In the future I will try to gain a more detailed
25 understanding of my patients' social situations in order to help identify and
26 anticipate problems in the management of their medical issues." (p23)

27 Thirteen students valued the interdisciplinary team working, which was a
28 feature of the curriculum.

1 ***Works well***

2 Eight students said they appreciated learning about transitional care and the
3 components of discharge planning. The following quote reflects on managing
4 medication during the transition process with the student describing how this
5 could be done better in future:

6 "I was a little surprised during this home visit to find how much Ms. C had
7 altered her medication regimen. She didn't like how she was feeling on the
8 higher blood pressure medications, so she halved them. She doesn't really
9 like taking pills, in general, so she stopped taking the aspirin, Senna, and
10 Colace. I suppose something that might have made this discharge more
11 successful would have been if we had really elicited her preferences regarding
12 medications while she was in the hospital, such that we could have been more
13 selective in what we prescribed and very clear with her with respect to what
14 exactly we were hoping to accomplish with each." (p23)

15 Other students described how the curriculum helped them to recognise that
16 patients lack understanding about medication regimens after transfer home. In
17 this context, they discussed the importance of communicating with patients'
18 primary care providers about the hospital course and follow-up.

19 **3. Ouchida, K., LoFaso, V., Capello, C., Ramsaroop, S. and Reid, M.**
20 **(2009) Fast forward rounds: An effective method for teaching medical**
21 **students to transition patients safely across care settings.**

22 **Outline:** This is a moderate quality [+] study with moderate relevance to the
23 review area. Authors test two hypotheses about improving knowledge and
24 practice in relation to transitions from hospital to home:

25 Hypothesis 1. That a curriculum combining an interdisciplinary team approach
26 and diverse teaching modalities would improve participants' transitional care
27 knowledge, perceived competence in managing the discharge process, and
28 frequency of transitional care behaviours such as patient education and
29 medication reconciliation. Hypothesis 2. That participants would respond
30 positively to an interactive, multimodal learning climate.

1 The authors discuss the problems associated with transitions including care
2 falling between staff responsibilities and increased numbers of care providers
3 sharing the care of a given patient. They argue that this has been
4 compounded because there has been no concurrent increase in training nor
5 incentives to collaborate across settings.

6 The development of the Fast Forward Round training curriculum formed part
7 of a mandatory component of the 12 week internal medicine clerkship. The
8 programme involved 2 x 90 minute sessions that incorporate interdisciplinary
9 lectures, and educational digital video, small group discussions and team
10 based learning exercise. The programme was attended by 103 third year
11 medical students. Increases in knowledge were assessed via a 28 item
12 assessment tool in the domains of transitional care, functional assessment,
13 interdisciplinary team, community resources, and reimbursement. The post-
14 test questionnaire also elicited feedback via open- ended questions about the
15 course, the overall effectiveness and the effect of the course on patient care.

16 **Results:** Significant positive percentage gains were observed pre-test to post
17 test on all domains, but the greater gains were seen in the domains of
18 functional assessment, interdisciplinary team and transitional care.

19 Within the transitional care domain, significant gains were observed for
20 knowledge, attitudes and behaviour:

- 21 • The proportion of students who can correctly identify medication errors as
22 being the most common source of adverse events after hospital discharge
23 increased from 14.9% to 56%, $P < .001$.
- 24 • Confidence levels in managing the discharge process for patients with a
25 chronic illness increased from 9.8% of participants feeling competent or
26 expert before the teaching to 66.3% of participants feeling competent or
27 expert afterwards, $P < .001$
- 28 • Feeling skilled in educating patients and carers about discharge
29 medications increased from 28.4% of participants to 75.8% of participants,
30 $P < .001$

- 1 • Demonstrating an increase in key transitional care behaviours, such as
2 reporting that they now reviewed discharge medications with patients and
3 caregivers: 42.3% to 50% , $P < .002$,
4 • The growth in the number of students performing medicines reconciliation
5 was not significant but showed a positive direction of effect.

6 Some views and experiences data were also reported in this paper and
7 presented below under the relevant review question:

8 **4 (a) What do health, social care and housing practitioners think works**
9 **well, what does not work well what could improve the transition from**
10 **inpatient hospital settings to community or care home settings?**

11 ***Works well***

12 Participating students described the positive change in awareness and
13 change in the level of importance attributed to discharge planning for
14 successful transition, “[The course] reminded me [of] the importance of
15 discharge summaries when so often they are considered formalities” (p915)

16 Students also became more aware of services in the community that could
17 integrate with care from hospital to home, “I am more aware of the services
18 that exist for patients once they leave the hospital.” And “I will be better able
19 to think about my patients’ post-discharge care and know what to do to help
20 them at home.” (p915)

21 Participants also reported a feeling of knowing the patient and their needs in a
22 more holistic way and how this might translate to discharge planning practice
23 in the future, “[The course] made me think about what the patient’s life is like
24 when they leave so as to make it easier and prevent re-admission.” And “[I
25 have a] desire to be more personal with the patient and really emphasize
26 patient education to improve compliance.” (p914)

27 “[The course] helped me with understanding the patient’s perspective from
28 discharge and realize how little they know. I take more time now in explaining
29 to patients what is going on, tell them test results, etc.” And “I will spend more
30 time explaining the discharge plan to patients.” (p915)

1 Participants reported that the changes in knowledge and attitudes may also
2 have enabled them challenge the prevailing culture of resistance to prioritising
3 the discharge process, described by the authors as the “hidden curriculum”.

4 ***Could be improved***

5 Feedback from the students indicated that the course was so helpful that they
6 would have preferred for the training to be made available earlier on in their
7 programme to enable them to put their new knowledge into practice.

8 ***Studies reporting views and experiences data (n=1)***

9 **1. Northrup-Snyder, K., van Son, C. and McDaniel, C. (2011) Thinking** 10 **beyond "the wheelchair to the car": RN-to-BSN student understanding of** 11 **community and public health nursing**

12 **Outline:** This was a low quality [-] study, judged to be of little relevance to the
13 UK context. Authors employed methods of retrospective content analysis of
14 online comments made by registered nurses (RNs) taking a community health
15 course as part of their bachelor of science in nursing degree programme
16 (BSN). The Authors point to a gap in training from the level of registered nurse
17 to BSN. They hypothesise that the additional training for community health
18 nursing that forms part of the training in the bachelor degree programme
19 would lead to an increase in knowledge and improvement in attitudes towards
20 community health nurse roles and practice. The authors suggest that
21 ultimately, this would enable the acute care nurse to facilitate a smoother
22 transition for patients returning home.

23 **Results:** Understanding: Home–Hospital–Home Patient Transitions.

24 ***Context of Care***

25 Nurse’s comments reflected changing attitudes towards the boundaries of
26 care extended beyond the hospital to the community:

27 “I will think beyond “from the wheelchair to the car” as I discharge patients. I
28 will...have the big picture of the client’s home environment, neighbourhood,
29 state, nation and world” (p228)

1 "While assessing, [I'm] always thinking about the community they live in and
 2 how that affects their health, [and this] will be taken into consideration.
 3 Discharge planning will be looked at dramatically different due [to] my
 4 experiences in this course". (p228)

5 Nurses' comments also suggested that they became more aware of the
 6 challenges that these necessary links across settings and staff might create:

7 "I think discharge planners are a link between the entities. But, as an acute
 8 care nurse, or as a community nurse, how could you create a line of
 9 communication with each other?" (p228)

10 ***Patient-Centred Approach.***

11 A theme that emerged from the online comments was the challenge of how to
 12 apply patient-centred care to their acute care practice, "I really envied them
 13 [the public and community health nurses] their ability to really know, see, and
 14 care for the patient." (p228)

15 **Evidence statements**

TR1	There is some evidence of moderate quality that dedicated transitions training for hospital based health professionals increases their understanding of the social context into which people are transferred from hospital. One moderate quality survey (Lai et al, 2008) [+] found that a discharge curriculum including home visits caused medical and pharmacy students to appreciate patients' own environment and the effect it may have on managing medical issues following hospital discharge. A low quality study (Northrup-Snyder et al, 2011) [-] found that training hospital-based nurses in community health made them understand the importance of considering people's home and community in discharge planning. Finally, a moderate quality study (Ouchida et al, 2009) [+] found that interactive learning about transition planning made medical students aware of the importance of discharge planning that is person focussed and takes account of options for community support.
TR2	There is a small amount of moderate evidence that specific transitions training for medical students increases their confidence in managing the hospital discharge process. One survey (Eskildsen et al, 2012) [+] found that following a multi component care transitions curriculum, which included training on discharge summaries and a post discharge phone call, medical students confidence in their ability to perform discharge tasks increased significantly. Another study (Ouchida et al, 2009) [+] found that an interdisciplinary, multi modal transitions curriculum significantly increased the number of medical students who felt 'competent to expert' in managing the discharge process.
TR3	There is some evidence of moderate quality that transitions training for hospital based health professionals improves their skills in medication management and increases their appreciation of its importance during hospital discharge.

<p>One survey (Eskildsen et al, 2012) [+] found that when medical students followed a care transitions curriculum, 90 per cent of the discharge summaries they completed met all quality criteria. This included a documented discharge medication list with specific dosing schedules and a list of any medication changes resulting from hospitalisation. Another survey (Lai et al, 2008) [+] found that medical and pharmacy students benefitted from training on the components of discharge planning including medication management. Students learned that health professionals should take care to understand the person being discharged, their preferences and lifestyles in order to plan and manage medication in a way that best suits the individual. Finally, a study (Ouchida et al, 2009) [+] of transitions training for medical students found that the proportion of students able to identify medication errors as the most common source of post discharge problems increased significantly.</p>
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1

2 **Included studies for the training review questions (full citation)**

3 Eskildsen M, Chakkalakal R, Flacker J et al. (2012) Use of a virtual classroom
4 in training fourth-year medical students on care transitions. *Journal of Hospital*
5 *Medicine* 7: 14–21

6 Lai C, Nye H, Bookwalter T et al. (2008) Post-discharge follow-up visits for
7 medical and pharmacy students on an inpatient medicine clerkship. *Journal of*
8 *hospital medicine: an official publication of the Society of Hospital Medicine* 3:
9 20–27

10 Ouchida K, LoFaso V, Capello C et al. (2009) Fast forward rounds: An
11 effective method for teaching medical students to transition patients safely
12 across care settings. *Journal of the American Geriatrics Society* 57: 910–17

13 Northrup-Snyder K, van Son C, McDaniel, C (2011) Thinking beyond "the
14 wheelchair to the car": RN-to-BSN student understanding of community and
15 public health nursing. *Journal of Nursing Education* 50: 226–9

16

1 **3.8 Evidence to recommendations**

2 This section of the guideline details the links between the guideline
 3 recommendations, the evidence reviews, expert witness testimony and the
 4 GDG discussions. Section 3.8.1 (see below) provides a summary of the
 5 evidence source(s) for each recommendation. Section 3.8.2 provides
 6 substantive detail on the evidence for each recommendation, presented in a
 7 series of linking evidence to recommendations (LETR tables).

8 **3.8.1 Summary map of recommendations to source(s) of evidence**

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GDG consensus)
1.1 Overarching principles of care and support during transition	
Person centred care	
1.1.1 See everyone receiving care as an individual and an equal partner who can make choices about their own care. They should be treated with dignity and respect throughout their transition.	HD7 and HD6
1.1.2 Identify and support people at risk of less favourable treatment or less access to services, for example people with communication difficulties or who misuse drugs or alcohol.	HD7 and HD6
1.1.3 Involve families and carers in discussions about the care being given or proposed if the person gives their consent. If there is doubt about the person's capacity to consent, the principles of the Mental Capacity Act must be followed.	HD5, HD6 and MH1.
Communication and information sharing	
1.1.4 Ensure that everyone involved in someone's move between hospital and their home is in regular contact with each other to ensure the transition is coordinated. For more information on communication needs see recommendation 1.1.2 in the NICE guideline on patient experience in adult NHS services.	ELC3
1.1.5 Information should be offered: <ul style="list-style-type: none"> • verbally and in written format (in plain English) • in other formats that are easy for the person to understand, such as braille, Easy Read or translated material. 	HA1
1.1.6 Give people information about their diagnoses and treatment when they are being transferred between hospital and home. If appropriate, also give this to their family and carers.	HA5

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GDG consensus)
1.2 Before admission to hospital	
1.2.1 Health and social care practitioners should develop a care plan for adults with identified social care needs who are at risk of being admitted to hospital. This should include contingency planning to help them manage their health condition. If they are admitted to hospital, health and social care practitioners should refer to this plan.	GC consensus
1.2.2 Assign a member of the community multidisciplinary team to coordinate support with the hospital multidisciplinary team for people with a long-term condition.	HA5
1.2.3 Health and social care practitioners and advocates should explain to the person what type of care they might receive and discuss advance care plans and contingency planning (see sections 1.3 and 1.5 of NICE's guideline on patient experience in adult NHS services). Discussions might cover: <ul style="list-style-type: none"> • place of care • religion and spirituality • daily routines • managing risk • how, when and where they receive information and advice • the use of an advocate to support them when communicating their needs and preferences • end-of-life care. 	HA3
1.2.4 During end-of-life care, find out and record the person's wishes and those of their family and carers.	ELC2
1.3 Admission to hospital	
Communication and information sharing	
1.3.1 Health and social care commissioners should encourage the use of communication protocols and procedures to support admissions. These might include sharing of: <ul style="list-style-type: none"> • lists of medicines in standard documentation • contact details for the main carer • contact details for next of kin • end-of-life wishes. 	HA2, expert witness testimony and GC consensus.

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GDG consensus)
<p>1.3.2 The admitting team should identify and address people’s communication needs at the point of admission. For more information on communication needs see recommendation 1.1.2 in the NICE guideline on patient experience in adult NHS services.</p>	HD5
<p>1.3.3 Health and social care practitioners, including out-of-hours GPs, responsible for transferring people from the community into hospital should ensure the admitting team is given all relevant information. This may include:</p> <ul style="list-style-type: none"> • advance care plans • behavioural issues (triggers to certain behaviours) • communication needs • communication passport • current medicines • hospital passport • housing status • named carers • other profiles containing important information about the person’s needs and wishes • preferred places of care. 	MH1 and HD9
<p>1.3.4 For an emergency admission, A&E should ensure all relevant information is given to the admitting team, when a person is transferred for an inpatient assessment or to an admissions ward.</p>	HA2
<p>1.3.5 The admitting team should provide the person and their family with an opportunity to discuss their care. They should also provide them with the following information:</p> <ul style="list-style-type: none"> • reason for admission • how long they might need to be in hospital • care options and treatment they can expect • when they can expect to see the doctors • the name of the person who will be their contact • how they might get home when they are discharged from hospital • care and treatment after discharge. 	HA1
<p>1.3.6 The admitting team should identify whether there is a need for reasonable adjustments to be made to accommodate the person in hospital. For example, the team should ensure:</p> <ul style="list-style-type: none"> • there is enough space around the bed for wheelchair users to move from their bed to their 	MH1

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GDG consensus)
<p>chair.</p> <ul style="list-style-type: none"> • people with visual impairments know where the nurse call bell and emergency buzzer are • there are adequate facilities for carers who stay with the person in hospital. 	
Establish a hospital based multi-disciplinary team	
<p>1.3.7 As soon as the person is admitted to hospital, identify staff to form the hospital-based multidisciplinary team that will support them. They should work with the community-based multidisciplinary team. The composition of both teams should reflect the person's needs and circumstances.</p> <p>Members of a hospital-based multidisciplinary team could include:</p> <ul style="list-style-type: none"> • doctor • nurse • physiotherapist • occupational therapist • mental health practitioner • hospital pharmacist • dietitian • specialists in the person's conditions • hospital social worker. 	HD1, ELC3 and ELC4
<p>1.3.8 The hospital-based multidisciplinary team should provide coordinated support for older people, from hospital admission through to their discharge home.</p>	HA6 and Ec3
Assessment and care planning	
<p>1.3.9 As soon as people with complex needs are admitted to hospital, intermediate care or step-up facilities, all relevant practitioners should start assessing their health and social care needs. They should also start discharge planning. If assessments have already been conducted in the community, refer to the person's existing care plan.</p>	RHR3
<p>1.3.10 Start a comprehensive geriatric assessment of older people with complex needs at the point of admission and preferably in a specialist unit.</p>	HA4 and Ec1

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GDG consensus)
1.4 During the hospital stay	
Communication and information sharing	
1.4.1 Record multidisciplinary assessments, prescribed medicines and individual preferences in an electronic data system. Make it accessible to both the hospital- and community-based multidisciplinary teams, subject to information governance protocols.	HD1 and HD9
1.4.2 At each shift handover and ward round, members of the hospital-based multidisciplinary team should review and update the person's progress towards hospital discharge.	HD1
1.4.3 Hospital-based practitioners should keep people regularly updated about any changes to plans for a person's transfer from hospital.	RHR3
Providing care	
1.4.4 Provide care for older people with complex needs in a specialist, geriatrician-led unit or on a specialist geriatrician-led ward.	HA4, Ec1 and GC consensus
1.4.5 Treat people admitted to hospital after a stroke in a stroke unit and offer them early supported discharge. (See recommendations 1.1.8 and 1.1.9 in NICE's guideline on stroke rehabilitation .)	Ec2
1.4.6 Encourage people to follow their usual daily routines where possible, during their hospital stay.	HA3
1.5 Discharge from hospital	
Discharge coordinator	
1.5.1 One health or social care practitioner should be responsible for coordinating the person's discharge from hospital. Create either a designated discharge coordinator post or make a member of the hospital- or community-based multidisciplinary team responsible. Select them according to the person's care and support needs. A named replacement should always cover their absence.	HD2
1.5.2 The discharge coordinator should be a central point of contact for health and social care practitioners, the person and their family, particularly during discharge planning. They should be involved in all decisions about discharge planning.	HD2
Communication and information sharing	
1.5.3 Health and social care commissioners should agree clear discharge planning protocols.	HD1 and GC consensus
1.5.4 Health and social care managers should ensure all health and social care practitioners receive regular briefings on the discharge planning protocols.	HD1 and GC consensus

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GDG consensus)
1.5.5 During discharge planning, the discharge coordinator should share assessments and updates on the person's health status, including medicines data, with both the hospital- and community-based multidisciplinary teams.	HD1 and RHR5
1.5.6 The hospital-based doctor responsible for the person's care should ensure the discharge summary is sent to the person's GP within 24 hours of their discharge. They should also ensure a copy is given to the person the day they are discharged.	RHR5
1.5.7 Make a member of the hospital-based multidisciplinary team responsible for providing carers with information and support. This could include: <ul style="list-style-type: none"> • printed information • face-to-face • by phone • hands-on training, including practical support and advice. 	CS3
1.5.8 The discharge coordinator should provide people who need end-of-life care and their families with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge.	Expert witness testimony and GC consensus
Key principles	
1.5.9 Ensure continuity of care for people being transferred from hospital, particularly older people who may be confused or who have dementia. For more information on continuity of care see the recommendations in section 1.4 of NICE's guideline on patient experience in adult NHS services .	MH1
1.5.10 Commissioners and providers should ensure people do not have to make decisions about long-term residential or nursing care while they are in crisis.	HD8
1.5.11 Hospital managers should try to ensure that any perceived or real pressures to make beds available do not result in unplanned and uncoordinated hospital discharges.	HD3
Discharge planning	
1.5.12 From admission, or earlier if possible, the hospital- and community-based multidisciplinary teams should work together to identify and address factors that could prevent a safe, timely transfer of care from hospital. This could include: <ul style="list-style-type: none"> • homelessness • safeguarding issues • suitable placement in a care home. 	HD4 and GC consensus

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GDG consensus)
1.5.13 The discharge coordinator should work with the hospital- and community-based multidisciplinary teams and the person receiving care to develop and agree a discharge plan.	HD2, HD6 and GC consensus
1.5.14 The discharge coordinator should ensure the discharge plan takes account of the person's social and emotional wellbeing, as well as the practicalities of daily living. It should include: <ul style="list-style-type: none"> • details about the person's condition • medicines management information (for more on medicines management for people in transition between settings see section 1.2 of NICE's guideline on medicines optimisation) • contact information after discharge • arrangements for continuing social care support • arrangements for continuing health support • details of other useful community services. 	HD5, RHR3 and HD9
1.5.15 The discharge coordinator should give the plan to the person and all those involved in their ongoing care and support, including families and carers (if the person agrees). The discharge coordinator should also arrange follow-up care.	RHR5 and GC consensus
1.5.16 The discharge coordinator should identify practitioners (from primary health, community health, social care and housing) and family members who will provide support when the person is discharged. Their details should be recorded in the discharge plan.	RHR5 and GC consensus
1.5.17 Once assessment for discharge is complete, the discharge coordinator should agree the plan for ongoing treatment and support with the community-based multidisciplinary team.	RHR5 and GC consensus
1.5.18 The discharge coordinator should discuss the need for any specialist equipment and support with primary health, community health, social care and housing practitioners as soon as discharge planning starts. This includes housing adaptations. Any specialist equipment and support should be in place at the point of discharge.	ELC3
1.5.19 A relevant health or social care practitioner should discuss with the person how they can manage their condition after their discharge from hospital. They should provide support and education, including 'coaching' if needed. Make this available for carers as well as people using services.	RHR1 and GC consensus
1.5.20 Consider supportive self-management as part of a treatment package for people with depression or	MH2

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GDG consensus)
other mental health problems.	
Discharge planning for end of life care needs	
1.5.21 Commissioners should ensure both general and specialist palliative care services are available for people who have end-of-life care needs.	Expert witness testimony and GC consensus
1.5.22 Health and social care practitioners should work together to ensure people needing end-of-life care are offered both general and specialist palliative services, according to their needs.	Ec7
1.5.23 The named consultant responsible for a person's end-of-life care should consider referring them to a specialist palliative care team before they are transferred from hospital.	ELC1
1.5.24 The discharge coordinator should ensure people who have end-of-life care needs are assessed and support is in place so they can die in their preferred place.	ELC1 and ELC5
Early supported discharge	
1.5.25 Commissioners should ensure older people with identified social care needs are offered early supported discharge with a home care and rehabilitation package.	Ec3
1.5.26 Consider commissioning early supported discharge with a home care and rehabilitation package provided by a community-based multidisciplinary team for adults with identified social care needs.	Ec3 and GC consensus
People at risk of hospital readmission	
1.5.27 The discharge coordinator should refer people at risk of hospital readmission to the relevant community-based health and social care practitioners before they are discharged. For example, if a person is homeless, the discharge coordinator should liaise with the local authority housing options team to ensure they are offered advice and help.	RHR4 and RHR6
1.5.28 Health, social care and housing commissioners should ensure homeless people with social care needs are offered suitable temporary accommodation and support.	RHR6
Involving carers	
1.5.29 The hospital- and community-based multidisciplinary teams should treat the family as an important resource for understanding the person's life and needs.	HD5 and HD6
1.5.30 With the person's agreement, include the family's views and wishes in discharge planning.	HD5 and HD6
1.5.31 If the discharge plan involves support from family or carers, the hospital-based multidisciplinary	CS2

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GDG consensus)
<p>team should take account of their:</p> <ul style="list-style-type: none"> • willingness and ability to provide support • circumstances, needs and aspirations • relationship with the person • need for respite. 	
<p>1.5.32 In line with the Care Act 2014, carers must be informed about their right to a carer's assessment.</p>	<p>CS3 and GC consensus</p>
Support and training for carers	
<p>1.5.33 Commissioners should ensure training is available to help carers provide practical support.</p>	<p>Ec6 and GC consensus</p>
<p>1.5.34 A member of the hospital-based multidisciplinary team should discuss the practical and emotional aspects of providing care with potential carers.</p>	<p>CS3</p>
<p>1.5.35 The relevant multidisciplinary team should offer family members and other carers of people who have had a stroke needs-led training in how to care for them. For example, this could include techniques to help someone carry out everyday tasks as independently as possible. Training might take place in hospital or it may be more useful at home after discharge.</p>	<p>Ec6 and GC consensus</p>
<p>1.5.36 The relevant multidisciplinary team should consider offering family members and other carers needs-led training in care for people with conditions other than stroke. Training might take place in hospital or it may be more useful at home after discharge.</p>	<p>Ec6 and GC consensus</p>
<p>1.5.37 The community-based multidisciplinary team should review the carer's training and support needs regularly (as a minimum at the person's 6-month and annual reviews). The team should take into account that their needs may change over time.</p>	<p>Ec6 and GC consensus</p>
After transfer from hospital	
<p>1.5.38 Community-based health and social care practitioners should maintain contact with the person after they are discharged. This could include regular phone calls and home visits. It also involves making sure the person knows how to contact them when they need to.</p>	<p>RHR2</p>
<p>1.5.39 An appropriately skilled practitioner should follow up people with palliative care needs within 24 hours after their transfer from hospital.</p>	<p>GC consensus</p>
<p>1.5.40 A GP or community-based nurse should phone or visit people at risk of readmission 24–72 hours after their discharge.</p>	<p>RHR4</p>

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GDG consensus)
1.6 Supporting infrastructure	
<p>1.6.1 Local health commissioners and local authorities should ensure a range of local services is available to support people on discharge from hospital. This might include:</p> <ul style="list-style-type: none"> • reablement: helping people re-learn some of the skills for daily living that they may have lost • other intermediate care services • practical support for carers. 	HD4 and GC consensus
<p>1.6.2 Local health commissioners, hospital trusts and local authorities should have a multi-agency plan to address pressures on services, including bed shortages.</p>	HD3 and GC consensus
<p>1.6.3 Local health commissioners should ensure all care providers, including GPs and out-of-hours providers, are kept up to date on the availability of local health and social care services.</p>	HD4 and ELC4
<p>1.6.4 Local health commissioners should ensure local protocols are in place so that out-of-hours providers have access to information about the person's preferences for end-of-life care.</p>	ELC2 and ELC4
<p>1.6.5 Health and social care practitioners should be aware of the local community health, social care and third sector services available to support people during their move from hospital.</p>	HD4 and GC consensus
1.7 Training and development	
<p>1.7.1 Hospital trusts and local authorities should make sure their staff are trained in the hospital discharge process. Training should take place as early as possible, with regular updates. It could include:</p> <ul style="list-style-type: none"> • medicines management • medicines adherence (for more information see NICE's guideline on medicines adherence) • medicines review in partnership with the person • how to get information about the person's social and home situation (including who is available to support the person) • discharge communications • interdisciplinary working between the hospital- and community-based multidisciplinary teams, people using services and their carers • learning how to assess the person's home environment (home visits) • awareness of the local community health, social 	TR1, TR3 and GC consensus

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony GDG consensus)
<p>care and third sector services available to support people during their move from hospital to the community</p> <ul style="list-style-type: none"> • helping people to manage risks effectively so that they can still do things they want to do (risk enablement). 	
<p>1.7.2 Consider making the training recommended in 1.7.1 available to community-based health and social care practitioners, physiotherapists and occupational therapists.</p>	<p>TR3 and GC consensus</p>

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2 3.8.2 Linking Evidence to Recommendations (LETR) tables

Topic/section heading	Overarching principles of care and support during transition
<p>Recommendations</p>	<p>Person Centred Care</p> <p>1.1.1 See everyone receiving care as an individual and an equal partner who can make choices about their own care. They should be treated with dignity and respect throughout their transition.</p> <p>1.1.2 Identify and support people at risk of less favourable treatment or less access to services, for example people with communication difficulties or who misuse drugs or alcohol.</p> <p>1.1.3 Involve families and carers in discussions about the care being given or proposed if the person gives their consent. If there is doubt about the person's capacity to consent, the principles of the Mental Capacity Act must be followed.</p> <p>Communication and information sharing</p> <p>1.1.4 Ensure that everyone involved in someone's move between hospital and their home is in regular contact with each other to ensure the transition is coordinated. For more information on communication needs see recommendation 1.1.2 in the NICE guideline on patient experience in adult NHS services.</p> <p>1.1.5 Information should be offered:</p> <ul style="list-style-type: none"> • verbally and in written format (in plain English) • in other formats that are easy for the person to understand, such as braille, Easy Read or translated material. <p>1.1.6 Give people information about their diagnoses and treatment when they are being transferred between hospital and home. If appropriate, also give this to their family and carers.</p>

Research recommendations	The Guideline Committee did not prioritise this is an area to make research recommendations on.
Review questions	<p>6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?</p> <p>5. How do different approaches to care planning and assessment affect the process of admission to inpatient hospital settings from community or care home settings?</p> <p>8 (a) What is the impact of specific interventions to support people with mental health problems during transition from general inpatient hospital settings to community or care home settings?</p> <p>8 (b) What is the impact of specific interventions to support people with mental health problems during admission to general inpatient hospital settings from community or care home settings?</p>
Quality of evidence	<p>The evidence underpinning these recommendations related to improving hospital discharge, transitions for people with mental health problems and the hospital admission process.</p> <p>In the area of hospital discharge, there were 12 views studies mainly of moderate quality. The 16 effectiveness studies were mostly of moderate and good quality.</p> <p>There was a paucity of evidence on transitions for people with mental health problems although what was included was of moderate to good quality; views data were notably lacking and effectiveness evidence was contradictory</p> <p>Recommendation 1.1.4 was based on evidence reviewed for end of life care transitions comprising good quality views data of and one moderate quality controlled study of effectiveness.</p> <p>Recommendation 1.1.6 was based on hospital admission evidence, which was mainly good quality views studies and moderate quality effectiveness studies all of which related to older people rather than younger adults.</p>
Relative value of different outcomes	<p>Most of the studies relevant to person centred care and the ones relevant to recommendation 1.1.4 were qualitative studies so it was not possible to ascertain and compare the relative value of outcomes associated with those principles.</p> <p>The research underpinning 1.1.6 demonstrated that a care navigator for chronically ill older people during transitions was associated with increased quality of life and functionality. Nevertheless, the GC reflected on the fact that this evidence was of moderate quality. In light of their experience they agreed that on balance, it would be more valuable for people to receive crucial information during transitions, by any member of the multi-disciplinary team, rather than from a specific, named individual.</p>
Trade-off between benefits and harms	These recommendations were informed by data on views and effectiveness plus the Guideline Committee's experiences. The data and the Guideline Committee's experience indicated that transitions between hospital and home should follow some overarching principles ensuring person centred care and the communication of information at every stage during home to

	hospital and hospital to home transitions.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the GC were mindful of potential costs and resource use when making the recommendations. The implementation of the recommendations will require additional staff time and thus increase costs although some long-term costs associated with poor quality of care might be avoided. To ensure safe and effective practice, person-centred care and communication and information sharing as recommended above should be implemented despite the economic rationale.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>HD 7 There is a small amount of moderate quality evidence that certain groups of stroke patients are excluded from specialist care and support, including hospital discharge services. A qualitative study from the UK (Mold et al, 2006) found that hospital and community based professionals ration stroke services in a way that excludes younger stroke patients, people with communication difficulties and people with addictions. (Rec 1.1.1 and 1.1.2)</p> <p>HD6 There is a good amount of mixed quality evidence that including people and families in decision-making and preparation for discharge affects the quality of transitions from hospital. A study (Benton, 2008) [+] of patients' experiences of intermediate care found they lacked understanding about the purpose of the unit and their potential for rehabilitation. Two studies (Pethybridge, 2004) [-] (Huby et al 2004 and 2007) [++] found that individual needs are ignored and patients are excluded from decision making about treatment and discharge. A systematic review (Laugaland et al, 2012) [+] showed that successful interventions involved caregivers and included patient participation and/ or education. Similarly, another systematic review (Preyde, 2011) [+] found that a lack of family or patient education during discharge was significantly related to readmission. Finally, one RCT (Li Hong et al, 2012) [++] reported mixed results. When patient-carer dyads received empowerment-educational sessions on admission and discharge, there was no significant difference on caregivers' emotional coping for depression, anxiety and worry and no reduction in the amount of care giving; the only differences were less role strain and caregiver preparedness to participate in post hospital care. (Rec 1.1.1, 1.1.2 and 1.1.3)</p> <p>HD5 There is a moderate amount of moderate to good evidence that professionals involved in discharge planning fail to treat patients as a 'whole person'. One qualitative study (Huby et al, 2004 and 2007) [++] concluded that transitions from hospital would be more successful if professionals considered all relevant circumstances surrounding a patient rather than making decisions based on a narrow understanding of physical and cognitive functions. A good quality qualitative study (Taylor and Donnelly, 2006) [++] also highlighted the importance of seeing beyond a person's condition or physical need when considering their transition from hospital to the community. A moderate</p>

	<p>quality study (Connolly et al, 2009) found hospital professionals who depicted the discharge process as de-humanising'. They felt that use of the label 'medically fit for discharge', oversimplifies cases and highlights that once the medical or 'acute' problem had been addressed, any remaining difficulties that patients' experienced were not regarded as the hospital's concern. (Rec 1.1.3)</p> <p>MH1 There is a small amount of good quality evidence from one qualitative study about the hospital admission process for older people with mental health problems. The UK study (Clissett, 2013) [++] described the emergency admission process as disorientating and distressing for patients and frustrating for carers who felt their own expertise was overlooked. The study reported that hospital admission would be improved if existing community support packages could be resumed to maintain important relationships, and if health care professionals conscientiously communicated with family carers and engaged them in genuine partnership. (Rec 1.1.3)</p> <p>HA5 There is a small amount of good and moderate evidence that people with long term conditions benefit from having a single named professional to manage their care including transitions into and out of hospital. A systematic review (Manderson et al, 2012) [+] of navigation roles for chronically ill older adults found 5 out of 9 studies reported increased individual quality of life and functionality. For two studies where little or no positive effect was found, the care navigation was more passive and commenced on discharge rather than on admission to hospital. The qualitative findings of a mixed methods study (Randall et al, 2014) [++] showed that people with long term conditions and their carers valued knowing how and when to contact their community matron for advice about symptoms and medication. Being able to contact the community matron appeared to reduce the likelihood of people calling for emergency help and being transferred to hospital. (Rec 1.1.6)</p> <p>ELC 3 There is a small amount of evidence of moderate to good quality that improved communication, between services and between services, patients and families, would facilitate more successful discharge and improve the experiences of patients and families. One UK qualitative study (O'Brien and Jack, 2010) [+] reported that community nurses would be able to ensure necessary equipment was in place to support a transfer from hospital to home if ward staff communicated with them far earlier in the discharge planning process. Another UK qualitative study (Hanratty, 2012) [++] reported communication failures between hospital and community services and a perception among carers that professionals did not respond to their questions or explain the rationale for transitions. (1.1.4)</p> <p>HA1 There is a small amount of good quality evidence that people being admitted to hospital and their carers do not receive</p>
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	<p>adequate information about diagnoses and treatment plans. Also, if this were addressed, the admission and hospital experience would be improved. An Australian study (Cheah and Presnel, 2011) [++] found older people sought better communication, especially from doctors, whom they felt made treatment decisions without informing or involving them. An American study (Toles et al, 2012) [++] found approximately 30% of participants reported never having a conversation with a hospital physician about conditions or planned treatments. Nurses and social workers were also described as being absent or ignoring the patient and their carer, which was a cause of anxiety. (Rec 1.1.5)</p>
<p>Other considerations</p>	<p>Recommendations 1.1.1 are 1.1.2 derived directly from evidence statements 6 and 7 on hospital discharge and supported by GC consensus. Recommendation 1.1.3 is also derived from evidence statement 6 on hospital discharge. A number of recommendations throughout the guideline refer to involving or informing family and carers and the GC wanted an over-arching principle to ensure that in all cases, this depends on the person giving consent. Where there is doubt about their capacity to provide consent, the recommendation states that the Mental Capacity Act must be followed because this is a legal requirement.</p> <p>For recommendation 1.1.4, the GC agreed that although this was based on evidence from the end of life care review area, it should be applied generally to improve transitions for all adults with social care needs.</p> <p>Recommendation 1.1.6 is derived from evidence statement 5 from the hospital admission review area. In discussing the evidence, the GC agreed that responsibility for providing information to people with long term conditions should not necessarily rest with one named individual. They felt it could lead other practitioners to neglect to provide information. The GC therefore agreed the provision of information by a member of the multi-disciplinary team should be the focus of the recommendation. Finally, the GC agreed that the recommendation should be applied broadly for adults with social care needs so specific mention of people with long-term conditions was removed. The GC agreed that for some patients written as well as verbally provided information is valued and this is emphasized in recommendation 1.1.5.</p>

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Topic/section heading	Before admission to hospital
Recommendations	<p>1.2.1 Health and social care practitioners should develop a care plan for adults with identified social care needs who are at risk of being admitted to hospital. This should include contingency planning to help them manage their health condition. If they are admitted to hospital, health and social care practitioners should refer to this plan.</p> <p>1.2.2 Assign a member of the community multidisciplinary team to coordinate support with the hospital multidisciplinary team for people with a long-term condition.</p> <p>1.2.3 Health and social care practitioners and advocates should explain to the person what type of care they might receive and discuss advance care plans and contingency planning (see sections 1.3 and 1.5 of NICE’s guideline on patient experience in adult NHS services). Discussions might cover:</p> <ul style="list-style-type: none"> • place of care • religion and spirituality • daily routines • managing risk • how, when and where they receive information and advice • the use of an advocate to support them when communicating their needs and preferences • end-of-life care. <p>1.2.4 During end-of-life care, find out and record the person’s wishes and those of their family and carers.</p>
Research recommendations	The guideline Committee did not prioritise this is an area to make research recommendations on
Review questions	<p>6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?</p> <p>5. How do different approaches to care planning and assessment affect the process of admission to inpatient hospital settings from community or care home settings?</p> <p>9 (a) What is the impact of specific interventions to support people with end-of-life care needs during transition from inpatient hospital settings to community or care home settings, including hospices?</p> <p>9 (b) What is the impact of specific interventions to support people with end-of-life care needs during admission to inpatient hospital settings from community settings including care homes and hospices?</p>
Quality of evidence	<p>The evidence underpinning these recommendations related to improving hospital discharge, the hospital admission process and transitions for people with end of life care needs.</p> <p>In the area of hospital discharge, there were 12 views studies mainly of moderate quality. The 16 effectiveness studies were</p>

	<p>mostly of moderate and good quality.</p> <p>Recommendations 1.2.2 and 1.2.3 were based on hospital admission evidence, which was mainly good quality views studies and moderate quality effectiveness studies all of which related to older people rather than younger adults.</p> <p>Recommendation 1.2.4 was based on evidence reviewed for end of life care transitions comprising good quality views data of and one moderate quality controlled study of effectiveness.</p>
Relative value of different outcomes	<p>Most of the studies relevant to the recommendations for practice before hospital admission were qualitative studies so it was not possible to ascertain and compare the relative value of associated outcomes. The exception was research underpinning 1.2.2, which demonstrated that a care navigator for chronically ill older people during transitions was associated with increased quality of life and functionality. In light of GC expertise they agreed that the positive outcomes would be likely to apply for all people with long-term conditions, not just older people.</p>
Trade-off between benefits and harms	<p>These recommendations were informed by data on views and effectiveness plus the Guideline Committee's expertise. The data and the Guideline Committee's expertise indicated that even before a person is admitted to hospital, or as early as possible on admission, health and social care practitioners (in the community or in hospital) should provide anticipatory support for people at risk of admission. There was a small amount of moderate evidence about the quantitative outcomes of having a single named professional but there was also good evidence that it improves transitions experiences for people with long-term conditions.</p>
Economic considerations	<p>Although no economic evidence was available to inform these guideline recommendations, the GC were mindful of potential costs and resource use when making the recommendations. For example, it is plausible that there are economic benefits associated with care plans for adults with social care needs at risk of hospital admission. This includes a reduction in hospital admissions and associated health and wellbeing benefits to individuals.</p>
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>HA 5 There is a small amount of good and moderate evidence that people with long term conditions benefit from having a single named professional to manage their care including transitions into and out of hospital. A systematic review (Manderson et al, 2012) [+] of navigation roles for chronically ill older adults found 5 out of 9 studies reported increased individual quality of life and functionality. For two studies where little or no positive effect was found, the care navigation was more passive and commenced on discharge rather than on admission to hospital. The qualitative findings of a mixed methods study (Randall et al, 2014) [++] showed that people with long term conditions and their carers valued knowing how and when to contact their community matron for advice about symptoms and medication. Being able to contact the community matron appeared to reduce the likelihood of people calling for emergency help and being transferred to</p>

	<p>hospital.(Rec 1.2.2)</p> <p>HA 3 There is a small amount of good and moderate evidence that older people experience hospital as an alien environment, which both deters them from seeking medical help and affects their rehabilitation as a hospital inpatient. One study (Themessl-Huber et al, 2007) [+] found that older people preferred the help of friends and relatives during a crisis rather than medical professionals and would rather be at home and surrounded by their own belongings than be admitted to hospital. An Australian study (Cheah and Presnel, 2011) [++] identified that people feel alienated by the hospital's impact on their own routine, which presents a challenge for occupational therapy if it is de-contextualised from normal life. The study also showed that the best motivator for people to engage in rehabilitation was the prospect of returning home.(Rec 1.2.3)</p> <p>ELC 2 There is a moderate amount of good quality evidence from 1 mixed methods study and 2 qualitative studies that transitions would be improved if time were dedicated to discussions with patients and families about end of life preferences. Wishes surrounding resuscitation and place of death were seen as particularly important. One mixed methods study (Hanratty, 2014) [++] reported that carers wanted more help and support to discuss concerns and patients wishes were not accounted for in transitions planning. One UK qualitative study (Ingleton, 2009) [++] reported reluctance on the part of GPs and hospital consultants to discuss DNAR orders and training in that area is required. One US qualitative study (Kusmaul and Waldrop, 2011) [++] identified a key role for social workers to discuss advanced care planning and hospitalization with families of nursing home residents during the living-dying interval. (Rec 1.2.4)</p>
<p>Other considerations</p>	<p>Recommendation 1.2.1 was derived from GC consensus, on the basis of members' expertise. The GC felt strongly that community as well as hospital practitioners should contribute to and be accountable for smooth transfers of care to hospital. The recommendation also reflects the GC's view about the importance planning in anticipation of hospital admissions, especially for people identified as being at risk.</p> <p>Recommendation 1.2.2 is derived directly from evidence statement 5 in the hospital admission review area. Although the evidence was exclusively about older people, the GC agreed that the recommendation should apply more broadly to people with long-term conditions. Recommendation 1.2.3 was based in part on evidence statement 3 from the hospital admission review area and also from GC consensus about the importance of having detailed discussions with people during admission. The aim is to ensure hospital feel a less alien environment, understand the person's wishes and preferences and let them know what to expect while in hospital. Finally, 1.2.4 is derived directly from evidence statement 2 in the end of care review area.</p>

Topic/section heading	Admission to Hospital
Recommendations	<p>Communication and information sharing</p> <p>1.3.1 Health and social care commissioners should encourage the use of communication protocols and procedures to support admissions. These might include sharing of:</p> <ul style="list-style-type: none"> • lists of medicines in standard documentation • contact details for the main carer • contact details for next of kin • end-of-life wishes. <p>1.3.2 The admitting team should identify and address people's communication needs at the point of admission. For more information on communication needs see recommendation 1.1.2 in the NICE guideline on patient experience in adult NHS services.</p> <p>1.3.3 Health and social care practitioners, including out-of-hours GPs, responsible for transferring people from the community into hospital should ensure the admitting team is given all relevant information. This may include:</p> <ul style="list-style-type: none"> • advance care plans • behavioural issues (triggers to certain behaviours) • communication needs • communication passport • current medicines • hospital passport • housing status • named carers • other profiles containing important information about the person's needs and wishes • preferred places of care. <p>1.3.4 For an emergency admission, A&E should ensure all relevant information is given to the admitting team, when a person is transferred for an inpatient assessment or to an admissions ward.</p> <p>1.3.5 The admitting team should provide the person and their family with an opportunity to discuss their care. They should also provide them with the following information:</p> <ul style="list-style-type: none"> • reason for admission • how long they might need to be in hospital • care options and treatment they can expect • when they can expect to see the doctors • the name of the person who will be their contact • how they might get home when they are discharged from hospital

	<ul style="list-style-type: none"> • care and treatment after discharge. <p>1.3.6 The admitting team should identify whether there is a need for reasonable adjustments to be made to accommodate the person in hospital. For example, the team should ensure:</p> <ul style="list-style-type: none"> • there is enough space around the bed for wheelchair users to move from their bed to their chair. • people with visual impairments know where the nurse call bell and emergency buzzer are • there are adequate facilities for carers who stay with the person in hospital.
Research recommendations	<p>The following research question is relevant to this topic:</p> <p>2.1 What is the effect of hospital discharge or transitions training for health and social care practitioners on achieving successful transfers from hospital to home or the community? (Including specifically the effects on formal and informal carers, and on avoidable readmissions?)</p>
Review questions	<p>5. How do different approaches to care planning and assessment affect the process of admission to inpatient hospital settings from community or care home settings?</p> <p>6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?</p> <p>7. What is the effectiveness of interventions and approaches designed to reduce hospital re-admissions within 30 days of hospital discharge?</p> <p>8 (a) What is the impact of specific interventions to support people with mental health problems during transition from general inpatient hospital settings to community or care home settings?</p> <p>8 (b) What is the impact of specific interventions to support people with mental health problems during admission to general inpatient hospital settings from community or care home settings?</p> <p>11 (a) How should services work with families and unpaid carers of adults with social care needs during transition from inpatient hospital settings to community or care home settings?</p> <p>11 (b) How should services work with families and unpaid carers of adults with social care needs during admission to inpatient hospital settings from community or care home settings?</p>
Quality of evidence	<p>The evidence underpinning these recommendations related to improving hospital discharge, transitions for people with mental health problems and the hospital admission process.</p> <p>Recommendation 1.3.1 was based on hospital admission evidence, which was mainly good quality views studies and moderate quality effectiveness studies all of which related to older people rather than younger adults. It also drew on testimony from an expert witness.</p> <p>Recommendations 1.3.2 and 1.3.6 were based on evidence</p>

	<p>about reducing hospital re-admissions, for which overall there was a good amount of good quality effectiveness evidence, including evidence of cost-effectiveness.</p> <p>In the area of hospital discharge, which informed 1.3.2 and 1.3.3, there were 12 views studies mainly of moderate quality. The 16 effectiveness studies were mostly of moderate and good quality.</p> <p>Finally, there was a paucity of evidence on transitions for people with mental health problems although what was included was of moderate to good quality; views data were notably lacking and effectiveness evidence was contradictory</p>
Relative value of different outcomes	<p>The studies from the mental health review and some from the hospital admission review were qualitative studies of views and experiences. It was therefore not possible to ascertain and compare the relative value of outcomes associated with those approaches to communication and information sharing.</p> <p>However there was good evidence that reliable communication of advanced care directives reduced unnecessary transfers to hospital and the associated negative outcomes. There was also evidence that interventions to improve information transfer on discharge significantly improved outcomes, including care continuity.</p>
Trade-off between benefits and harms	<p>These recommendations were informed by data on views and effectiveness and by expert testimony. Combined with Guideline Committee expertise, the data indicated that if people are admitted to hospital without information being shared about them and with them, the experience will be negative and outcomes including on discharge will be poor.</p>
Economic considerations	<p>Although no economic evidence was available to inform these guideline recommendations, the GC were mindful of potential costs and resource use when making the recommendations.</p> <p>There may be some additional costs linked to the implementation of the recommendation it is unlikely that those will be substantial.</p>
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>HA2 There is some good evidence that the reliable communication of advanced care directives can be improved, with the effect of avoiding unwanted admissions and invasive treatment, especially at the end of life. One UK study (Randall et al, 2014) [++] identified problems in communicating advanced care directives between agencies, noting instances where people have been transferred to hospital by ambulance at the end of life, when this was unnecessary and disruptive. An Australian study (Shanley et al, 2001) [++] found that when nursing home managers adopted a deliberative and systematic approach to advanced care planning, they were less likely to have unplanned transfers to hospital. Echoing this, a systematic review (La Mantia et al, 2010) [+] found that two transfer documents used in transitional care between nursing homes and hospitals facilitated the communication of advanced directive information. (Rec 1.3.1, Rec 1.3.3, Rec 1.3.4)</p> <p>Expert Witness group 3: Claire Henry and GDG Consensus (Rec 1.3.1)</p>

	<p>HD5 There is a moderate amount of moderate to good evidence that professionals involved in discharge planning fail to treat patients as a 'whole person'. One qualitative study (Huby et al, 2004 and 2007) [++] concluded that transitions from hospital would be more successful if professionals considered all relevant circumstances surrounding a patient rather than making decisions based on a narrow understanding of physical and cognitive functions. A good quality qualitative study (Taylor and Donnelly, 2006) [++] also highlighted the importance of seeing beyond a person's condition or physical need when considering their transition from hospital to the community. A moderate quality study (Connolly et al, 2009) found hospital professionals who depicted the discharge process as de-humanising'. They felt that use of the label 'medically fit for discharge', oversimplifies cases and highlights that once the medical or 'acute' problem had been addressed, any remaining difficulties that patients' experienced were not regarded as the hospital's concern. (Rec 1.3.2)</p> <p>RHR6 A limited amount of evidence of moderate quality suggests that housing support combined with case management has a positive effect on hospital readmission rates for homeless people. One randomized control trial (Sadowski, 2009) [+] found that when housing was offered on discharge from hospital, followed by placement in long-term housing, the intervention groups had statistically significantly lower readmissions (as well as hospital days and emergency department visits).</p> <p>MH1 There is a small amount of good quality evidence from one qualitative study about the hospital admission process for older people with mental health problems. The UK study (Clissett, 2013) [++] described the emergency admission process as disorientating and distressing for patients and frustrating for carers who felt their own expertise was overlooked. The study reported that hospital admission would be improved if existing community support packages could be resumed to maintain important relationships, if health care professionals conscientiously communicated with family carers and engaged them in genuine partnership. (Rec 1.3.3, Rec 1.3.6)</p> <p>HD9 There is a small amount of mixed quality evidence that sharing patient medication data among hospital and community based practitioners via electronic systems improves the quality of transitions between hospital and home. One low quality review of best practice (Cassano, 2013) [-] found that electronic transfer of patient information between practitioners assisted in communication of drug therapy and improved transitions. One good quality systematic review (Hesselink, 2012) [++] found that interventions to improve information exchange at discharge significantly improved transitions, particularly in terms of care continuity. (Rec 1.3.3)</p> <p>HA1 There is a small amount of good quality evidence that</p>
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	<p>people being admitted to hospital and their carers do not receive adequate information about diagnoses and treatment plans. Also, if this were addressed, the admission and hospital experience would be improved. An Australian study (Cheah and Presnel, 2011) [++] found older people sought better communication, especially from doctors, whom they felt made treatment decisions without informing or involving them. An American study (Toles et al, 2012) [++] found approximately 30% of participants reported never having a conversation with a hospital physician about conditions or planned treatments. Nurses and social workers were also described as being absent or ignoring the patient and their carer, which was a cause of anxiety. (Rec 1.3.5)</p>
<p>Other considerations</p>	<p>Mostly of the evidence and GC discussions relating to these recommendations was connected with information sharing and communication.</p> <p>Recommendation 1.3.1 is derived from evidence statement 2 in the hospital admission review area. This was supported by testimony from the expert witness on end of life care and GC consensus about the vital importance of establishing communication protocols to ensure certain information is shared in a consistent way during hospital admissions.</p> <p>Recommendation 1.3.2 is based on evidence from the hospital discharge review area about the importance of ensuring all relevant needs and difficulties are considered in assessment and planning. The GC agreed that communication needs are one aspect often overlooked with the result that vital information is not shared with them.</p> <p>Recommendation 1.3.3 is based on three evidence statements, which emphasize the importance of ensuring the admitting team is given a range of information about the person's needs, wishes and circumstances. The GC agreed that the community-based practitioners making the referral to hospital should take responsibility for ensuring that information is provided.</p> <p>The GC derived 1.3.4 from the evidence informing 1.3.3. The recommendation emphasizes that once the person is admitted, the admitting team in turn have responsibility for ensuring the information cited in 1.3.3 is passed on to the admissions ward.</p> <p>Recommendation 1.3.5 is derived from evidence and GC consensus that people usually have to ask for information during admission to hospital, rather than being included in discussions or given information.</p> <p>Finally, 1.3.6 is based on evidence that the hospital admission process can be disorientating and distressing and that carers often feel overlooked. Although the evidence was specifically about older people with mental health problems, the GC extrapolated it to all adults with social care needs. They also considered equalities issues and agreed the recommendation would help to improve admission to hospital, regardless of existing disabilities.</p>

Topic/section heading	Establish a hospital-based multidisciplinary team
Recommendations	<p>1.3.7 As soon as the person is admitted to hospital, identify staff to form the hospital-based multidisciplinary team that will support them. They should work with the community-based multidisciplinary team. The composition of both teams should reflect the person's needs and circumstances.</p> <p>Members of a hospital-based multidisciplinary team could include:</p> <ul style="list-style-type: none"> • doctor • nurse • physiotherapist • occupational therapist • mental health practitioner • hospital pharmacist • dietician • specialists in the person's conditions • hospital social worker. <p>1.3.8 The hospital-based multidisciplinary team should provide coordinated support for older people, from hospital admission through to their discharge home.</p>
Research recommendations	The guideline Committee did not prioritise this is an area to make research recommendations on
Review questions	<p>5. How do different approaches to care planning and assessment affect the process of admission to inpatient hospital settings from community or care home settings?</p> <p>6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?</p> <p>7. What is the effectiveness of interventions and approaches designed to reduce hospital re-admissions within 30 days of hospital discharge?</p> <p>9 (a) What is the impact of specific interventions to support people with end-of-life care needs during transition from inpatient hospital settings to community or care home settings, including hospices?</p> <p>9 (b) What is the impact of specific interventions to support people with end-of-life care needs during admission to inpatient hospital settings from community settings including care homes and hospices?</p>
Quality of evidence	<p>The recommendations in support of establishing a hospital-based multi-disciplinary team were informed by evidence from the following review areas; reducing hospital readmissions, improving hospital discharge, end of life care and the hospital admission process. Good quality economic evidence on community-based multi-disciplinary palliative care teams also informed one recommendation (1.3.7) in this section.</p> <p>For reducing readmissions, there was a good amount of good quality effectiveness evidence, including evidence of cost-</p>

	<p>effectiveness. In the area of hospital discharge, there were 12 views studies mainly of moderate quality. The 16 effectiveness studies were mostly of moderate and good quality. The hospital admission evidence comprised mainly of good quality views studies and moderate quality effectiveness studies all of which related to older people rather than younger adults. Finally, evidence reviewed for end of life care transitions comprised good quality views data of and one moderate quality controlled study of effectiveness plus two good quality economic evaluations carried out alongside RCTs.</p>
<p>Relative value of different outcomes</p>	<p>It was not possible to ascertain and compare the relative value of outcomes of inter professional communication in relation to hospital discharge because the relevant studies were qualitative. Similarly, the studies on end of life care transitions.</p> <p>However there was good quality evidence that early assessment of needs by relevant practitioners reduced readmission rates. There was further moderate quality evidence that involving a multi-disciplinary team in the assessment and care of older people reduced in hospital mortality although it (non significantly) increased readmissions and bed use. On balance, combined with the economic evidence demonstrating positive outcomes, the GC agreed to recommend early assessment and support from a multi-disciplinary team from admission to discharge home.</p>
<p>Trade-off between benefits and harms</p>	<p>These recommendations were informed by data on views and effectiveness. Combined with Guideline Committee expertise, the data indicated that if people are assigned a multi-disciplinary team of practitioners to assess and support them from admission through to discharge, experiences are improved and the outcomes on discharge will be positive.</p>
<p>Economic considerations</p>	<p>Findings on cost-effectiveness are influenced by the costs of the multi-disciplinary team which depends on the mix of professionals in the team, their salaries, contracted working week hours, relationship between direct and indirect contact time with patients. Based on the systematic review by Fearon and Langhorne (2012, ++) standardised staffing levels for a typical early supported discharge team for stroke patients sufficient to manage a notional 100 new patients per year required 3.0 WTE (ranging 2.5 to 4.6) staff. This included 0.1 medical staff, 0 to 1.2 nurses, 0.1 physiotherapy, 1.0 occupational therapy, 0.1 speech and language therapy, 0.2 assistant, 0 to 0.5 social work and secretarial support. Assumed was that staff would have a 35-hour working week with 20 hours direct contact time and 10 hours indirect contact time. For the costs of the community-based team, additional important factors to consider are travelling distances to patient and between community care settings. A community-based palliative care team described in Higginson et al 2009 [++] comprised 0.5 WTE specialist consultant and 0.5 WTE specialist nurse, 1.0 WTE administrator and 1.0 WTE psychosocial worker. Activities included visits to patients in hospital and the community, assessments, specialist welfare benefits advice, bereavement support and liaison with local services.</p>

<p>Evidence statements – numbered evidence statements from which the recommendation(s) were developed</p>	<p>HD1 There is a moderate amount of moderate quality evidence that improved inter professional communication would ensure more successful transfers from hospital. One mixed methods qualitative study (Huby et al, 2004 and Huby et al, 2007) [++] found hospital based professionals had failed to share assessment results, leading to confusion about whether a patient was fit for discharge. A moderate quality study using focus groups (Connolly, 2009) [+] found that poor internal communication leads to confusion about arranging tests or services and means that vitally placed professionals are left out of critical discharge decisions. A moderate quality systematic review (Nosbusch et al, 2011) [+] recommended that improved communication and information sharing would help acute staff nurses in discharge planning. Within the ward, the completion of discharge preparation summaries at each shift handover was believed to improve communication between nurses. For all relevant professionals, the use of standardized referral forms and electronic decision support and referral systems was recommended. Finally, a moderate quality qualitative study (Baumann, 2007) [+] found that improved communication between wards and social services is achieved by having a care manager attached to a ward. (Rec 1.3.7)</p> <p>ELC3 There is a small amount of evidence of moderate to good quality that improved communication, between services and between services, patients and families, would facilitate more successful discharge and improve the experiences of patients and families. One UK qualitative study (O'Brien and Jack, 2010) [+] reported that community nurses would be able to ensure necessary equipment was in place to support a transfer from hospital to home if ward staff communicated with them far earlier in the discharge planning process. Another UK qualitative study (Hanratty, 2012) [++] reported communication failures between hospital and community services and a perception among carers that professionals did not respond to their questions or explain the rationale for transitions. (Rec 1.3.7)</p> <p>ELC4 There is a small amount of evidence of good quality that out of hours GP services can cause particular problems in the transition process for people with end of life care needs. One UK qualitative study (Hanratty, 2014) [++] reports that the involvement of out of hours GPs makes service provision seem uncoordinated and another (Ingleton, 2009) [++] found that when out of hours GPs made uninformed decisions about patients, this resulted in inadvertent or unnecessary transition into hospital. (Rec 1.3.7)</p> <p>EC7. Multi professional palliative care teams were found to be cost effective, albeit with some caution. Two UK RCTs examined the cost-effectiveness of multi-professional palliative care teams for two sub-groups of the population covered in the scope. The first (N=46, ++) showed that for people with advanced MS a multi-professional palliative care team (similar to</p>
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palliative care consultation service but able to visit across settings) was likely to be cost-effective because of lower costs (£1,789, 95%, -5,224 to 1,902); this was largely because of reduced use of primary and acute care services; the study evaluated the impact on unpaid care and found no significant difference. There was no significant difference in the patient's primary outcome measured via the Palliative Care Outcomes Scale (POS-8) at 12wks.; but there was a significant reduction in the burden on caregivers (-2.88 and diff. to comparison group of 4.47, CI 95%, 1.05-7.89) measured via the Zarit caregiver burden interview (ZBI). In bootstrapping, with POS-8 as outcome, better outcomes and lower costs occurred in 34% of replications and lower costs (without improved outcomes) in 55% of replications. With ZBI as the outcome, lower costs and better outcomes occurred in 47% replications and higher costs and better outcomes in 48% replications. According to these findings the intervention was likely to be cost-effective although caution must be taken because of the small sample size. The second UK RCT (N=82) was published last year and was of limited applicability because the paper did not present sufficient detail on the evaluation of costs. This was possibly because a paper with details on the economic evaluation was still to be published. The quality of the study was expected to be high and findings can inform the recommendations with some level of caution. Findings of the study suggested that an integrated multi-professional palliative care team for patients with advanced diseases and breathlessness achieved significant improvements in breathlessness mastery (16%, mean diff. 0.58, 95% CI 0.01 to 1.15, p<0.05, effect size 0.44), in statistically adjusted total quality of life using the Palliative care Outcomes scale (POS-8) and in survival rate (50 of 53 [94%] vs 39 of 52 [75%]). None of the outcomes showed deterioration. There was no significant difference in formal care costs at 6wks. (£1,422, 95% CI 897–2101 vs. £1,408, 95% CI 899–2023) although the authors reported that costs varied greatly between individuals. (Rec 1.3.7)

HA6 There is a small amount of moderate evidence that the involvement of a multi-disciplinary team to support older people from admission and throughout their hospital stay has some positive effects on outcomes. An Australian controlled trial (Mudge et al, 2012) [+] tested the effectiveness of an interdisciplinary care team, which made an assessment and commenced discharge planning on admission. The study detected a dramatic reduction in in-hospital mortality although 6-month readmissions and bed use were non-significantly increased. A randomized controlled trial (Eklund et al, 2013) [+] measured the effects of a multi-professional team for the care and rehabilitation of older people, which created a continuum of care for the older person from the emergency department, through the hospital ward and on to their own homes. Results showed improved ADL independence among participants up to one year, and postponed dependence in ADL up to six months.(Rec 1.3.8)

	<p>Ec3 There is a moderate amount of good quality economic evidence that suggests that early supported discharge in combination with rehabilitation was likely to be cost-effective if compared with standard care. This finding related to four full economic evaluations carried out in different countries, including one UK study (Miller et al 2005). The studies were carried out alongside randomised controlled trials and models of service provision included a nurse-help worker partnership in Finland (Hammer et al 2009, N=668; ++), a nurse-volunteer partnership in Hong Kong (Wong et al 2012, N=555; +), a discharge lead with budget for community services in Australia (Lim et al 2003, N=598; ++) and a multi-disciplinary team in the UK (Miller et al 2005, N=272; ++). Findings from all four studies suggested that early supported discharge in combination with rehabilitation improved physical health and reduced costs and was likely to be cost-effective. (Rec 1.3.8)</p>
Other considerations	<p>Recommendation 1.3.7 is based on evidence statements; HD1, ELC3, ELC4 and Ec7. The Guideline Committee agreed that the right professionals should be involved with patients at the right time and that they should be communicating with each other. Pragmatic and practical planning was important as well as understanding each other's timescales. The importance of involving community nurses and other community practitioners led the Guideline Committee to develop the recommendation with an emphasis not only on establishing a multi-disciplinary hospital based team but ensuring those practitioners also work closely with their community based counterparts.</p> <p>Recommendation 1.3.8 is derived directly from HA6 although being only a small amount of moderate evidence, it was strengthened by Guideline Committee consensus about the importance of multi-disciplinary support for older people throughout the hospital stay. The recommendation was also based on good quality economic evidence in favour of early supported discharge and rehabilitation.</p>

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Topic/section heading	Assessment and care planning
Recommendations	<p>1.3.9 As soon as people with complex needs are admitted to hospital, intermediate care or step-up facilities, all relevant practitioners should start assessing their health and social care needs. They should also start discharge planning. If assessments have already been conducted in the community, refer to the person's existing care plan.</p> <p>1.3.10 Start a comprehensive geriatric assessment of older people with complex needs at the point of admission and preferably in a specialist unit.</p>
Research recommendations	<p>The following research question is relevant to this topic:</p> <p>2.4 What is the cost-effectiveness of comprehensive geriatric assessment and care on specialist units compared with alternative models of care on general wards?</p> <p>2.5 How effective are home assessment interventions and approaches designed to improve hospital discharge outcomes?</p>
Review questions	<p>5. How do different approaches to care planning and assessment affect the process of admission to inpatient hospital settings from community or care home settings?</p> <p>7. What is the effectiveness of interventions and approaches designed to reduce hospital re-admissions within 30 days of hospital discharge?</p>
Quality of evidence	<p>The recommendations on assessment and care planning during the hospital admission process are informed by evidence from the review areas on reducing hospital readmissions, the hospital admission process and economic evidence.</p> <p>For reducing readmissions, there was a good amount of good quality effectiveness evidence and an economic evaluation. The hospital admission evidence comprised mainly good quality views studies and moderate quality effectiveness studies all of which related to older people rather than younger adults. A high quality meta-analysis presented cost-effectiveness evidence mainly from US studies; findings of this study informed additional economic analysis.</p>
Relative value of different outcomes	<p>The strength and quality of effectiveness and cost effectiveness evidence meant the Guideline Committee could ascertain the relative value of early assessment of people's needs and specifically, geriatric assessment for older people. Evidence of positive, health, wellbeing and service level outcomes was clear and this is reflected in the two strong recommendations.</p>
Trade-off between benefits and harms	<p>These recommendations were informed predominantly by data on effectiveness and cost effectiveness. Combined, with the Guideline Committee's expertise, data demonstrated that if assessment of people with complex needs, including older people is not carried out as soon as possible, this will result in a poor transition from hospital including additional costs to health and social care services and unpaid carers.</p>

Economic considerations	Recommendations in this area were informed by cost-effectiveness evidence.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>RHR3 There is some good quality evidence that in-hospital assessment of needs and planning for discharge lead to lower readmission rates. One good quality systematic review (Allen et al, 2014) [++] located a study that found an inpatient geriatric evaluation (combined with co-management with ward staff and transitional care) significantly reduced the likelihood of readmission 3 months following discharge. Another good quality systematic review (Shepperd et al, 2013) found that individually tailored discharge plans to meet older people’s ongoing needs reduced readmission rates. A good quality systematic review (Scott, 2010) [++] highlighted the importance of early assessment of discharge needs, which was one of several components of discharge processes effective in reducing readmissions. Finally, a moderate quality systematic review (Jacob, 2008) [+] concluded that lapses in discharge planning undermine patients’ perceptions of their readiness for discharge and compromise discharge success.(Rec 1.3.9)</p> <p>HA4 There is some good and moderate evidence that specialist geriatric care and geriatric assessment, which commences on admission to hospital, has a positive impact on experiences and outcomes for older people. One RCT (Eklund et al, 2013) [+] found that the provision of care by a nurse with geriatric competence which commenced on admission and continued through to hospital discharge, improved ADL independence among its participants up to one year, and postponed dependence in ADL up to six months. A systematic review (Ellis et al, 2011) [++] found that comprehensive geriatric assessment delivered in geriatric wards increases older people’s likelihood of being alive and in their own homes following emergency admission to hospital. A systematic review (Fox et al, 2012) [++] identified positive service level and individual outcomes from care on dedicated geriatric units, which was based on hospital rehabilitation and the prevention of functional decline.(Rec 1.3.10)</p> <p>Ec1 Evidence from one high quality systematic review and meta-analysis (Ellis et al 2011, ++) suggested that comprehensive geriatric assessment and care provided on specialist units was likely to be cost-effective compared with non-specialist care. Findings from the study showed positive health and wellbeing outcomes for individuals and cost savings from a hospital perspective. Additional economic analysis was carried out to assess the likely impact of the intervention on health and social care and unpaid care costs in a UK context and found that comprehensive geriatric assessment and care provided on specialist units was likely to lead to cost savings from a health and social care perspective and to at least offset costs if the costs of unpaid care were included. (Rec 1.3.10)</p>
Other considerations	Recommendation 1.3.9 was derived directly from RHR3. The Guideline Committee agreed that the recommendation should stipulate ‘as soon as possible’, in order to be aspirational. They discussed current practice for assessment of older people in hospital and concluded that timing and coordination of all

	<p>relevant practitioners is crucial, with needs most likely to be addressed if they are assessed concurrently rather than sequentially. Finally, they agreed to extrapolate the research evidence to apply to all adults with complex needs, not just older people.</p> <p>Recommendation 1.3.10 is based on good quality economic evidence and effectiveness data synthesized in HA4, which was endorsed by the Guideline Committee.</p>
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Topic/section heading	During Hospital Stay
Recommendations	<p>Communication and information sharing</p> <p>1.4.1 Record multidisciplinary assessments, prescribed medicines and individual preferences in an electronic data system. Make it accessible to both the hospital- and community-based multidisciplinary teams, subject to information governance protocols.</p> <p>1.4.2 At each shift handover and ward round, members of the hospital-based multidisciplinary team should review and update the person's progress towards hospital discharge.</p> <p>1.4.3 Hospital-based practitioners should keep people regularly updated about any changes to plans for a person's transfer from hospital.</p>
Research recommendations	<p>The following research question is relevant to this topic:</p> <p>2.1 What is the effect of hospital discharge or transitions training for health and social care practitioners on achieving successful transfers from hospital to home or the community? (Including specifically the effects on formal and informal carers, and on avoidable readmissions?)</p>
Review questions	<p>6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?</p> <p>7. What is the effectiveness of interventions and approaches designed to reduce hospital re-admissions within 30 days of hospital discharge?</p> <p>9 (a) What is the impact of specific interventions to support people with end-of-life care needs during transition from inpatient hospital settings to community or care home settings, including hospices?</p> <p>9 (b) What is the impact of specific interventions to support people with end-of-life care needs during admission to inpatient hospital settings from community settings including care homes and hospices?</p>
Quality of evidence	<p>The recommendations about communication and information sharing during the hospital stay were informed by evidence from the linked areas of hospital discharge and reducing readmissions plus testimony from the expert witness.</p> <p>For reducing readmissions, there was a good amount of good quality effectiveness evidence but no evidence of views and experiences. In the area of hospital discharge, there were 12 views studies mainly of moderate quality. The 16 effectiveness studies were mostly of moderate and good quality.</p>
Relative value of different outcomes	<p>Most of the studies from the hospital discharge review area that informed these recommendations reported views and experiences. It was therefore difficult to ascertain and compare the relative value of outcomes associated with recording multidisciplinary assessments on shared electronic data systems. However the Guideline Committee and expert witness agreed that any negative outcomes of doing so would be greatly</p>

	<p>outweighed by the benefits.</p> <p>There was good evidence from systematic reviews that early assessment of need and discharge planning that involves the patient reduces readmissions.</p>
Trade-off between benefits and harms	<p>These recommendations were informed by data on views and experiences and some effectiveness data combined with testimony from the expert witness. Together with the Guideline Committee's expertise, this indicated that communication and information sharing via electronic systems and with practitioners and patients, would improve the experience and outcomes of discharge.</p>
Economic considerations	<p>The reviews found no cost-effectiveness evidence in relation to different approaches to keeping records up to date. Although no economic evidence was available to inform these guideline recommendations, the GC were mindful of potential costs and resource use when making the recommendations</p>
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>HD1 There is a moderate amount of moderate quality evidence that improved inter professional communication would ensure more successful transfers from hospital. One mixed methods qualitative study (Huby et al, 2004 and Huby et al, 2007) [++] found hospital based professionals had failed to share assessment results, leading to confusion about whether a patient was fit for discharge. A moderate quality study using focus groups (Connolly, 2009) [+] found that poor internal communication leads to confusion about arranging tests or services and means that vitally placed professionals are left out of critical discharge decisions. A moderate quality systematic review (Nosbusch et al, 2011) [+] recommended that improved communication and information sharing would help acute staff nurses in discharge planning. Within the ward, the completion of discharge preparation summaries at each shift handover was believed to improve communication between nurses. For all relevant professionals, the use of standardized referral forms and electronic decision support and referral systems was recommended. Finally, a moderate quality qualitative study (Baumann, 2007) [+] found that improved communication between wards and social services is achieved by having a care manager attached to a ward. (Rec 1.4.1 and 1.4.2)</p> <p>HD9 There is a small amount of mixed quality evidence that sharing patient medication data among hospital and community based practitioners via electronic systems improves the quality of transitions between hospital and home. One low quality review of best practice (Cassano, 2013) [-] found that electronic transfer of patient information between practitioners assisted in communication of drug therapy and improved transitions. One good quality systematic review (Hesselink, 2012) [++] found that interventions to improve information exchange at discharge significantly improved transitions, particularly in terms of care continuity. (Rec 1.4.1)</p>

	<p>RHR3 There is some good quality evidence that in-hospital assessment of needs and planning for discharge lead to lower readmission rates. One good quality systematic review (Allen et al, 2014) [++] located a study that found an inpatient geriatric evaluation (combined with co-management with ward staff and transitional care) significantly reduced the likelihood of readmission 3 months following discharge. Another good quality systematic review (Shepperd et al, 2013) found that individually tailored discharge plans to meet older people’s ongoing needs reduced readmission rates. A good quality systematic review (Scott, 2010) [++] highlighted the importance of early assessment of discharge needs, which was one of several components of discharge processes effective in reducing readmissions. Finally, a moderate quality systematic review (Jacob, 2008) [+] concluded that lapses in discharge planning undermine patients’ perceptions of their readiness for discharge and compromise discharge success. (Rec 1.4.3)</p>
<p>Other considerations</p>	<p>Recommendation 1.4.1 is derived directly from evidence statements HD1 and HD9, which described the negative consequences of practitioners failing to share information and suggested means of addressing this through electronic systems. Testimony from the expert witness concurred although the Guideline Committee agreed that information sharing via electronic systems should support transitions of all adults with social care needs, not just people at the end of life. The Guideline Committee agreed about the importance of health and social care information systems being compatible so that, subject to information governance protocols, all relevant practitioners can access the information. 1.4.2 is also based on HD1 and recommends that members of the multi-disciplinary team should share discharge progress on the electronic system, The Guideline Committee considered naming a responsible person (for example ward nurse or matron) but favoured giving all multi-disciplinary team members responsible. Finally, 1.4.3 partly follows from 1.4.2 in that practitioners should keep patients as well as each other informed about progress towards discharge but also RHR3, which emphasized the importance of involving patients in discharge planning.</p>

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Topic/section heading	During Hospital Stay
Recommendations	<p>Providing Care</p> <p>1.4.4 Provide care for older people with complex needs in a specialist, geriatrician-led unit or on a specialist geriatrician-led ward.</p> <p>1.4.5 Treat people admitted to hospital after a stroke in a stroke unit and offer them early supported discharge. (See recommendations 1.1.8 and 1.1.9 in NICE's guideline on stroke rehabilitation.)</p> <p>1.4.6 Encourage people to follow their usual daily routines where possible, during their hospital stay.</p>
Research recommendations	<p>The following research question is relevant to this topic:</p> <p>2.4 What is the cost-effectiveness of comprehensive geriatric assessment and care on specialist units compared with alternative models of care on general wards?</p>
Review questions	<p>5. How do different approaches to care planning and assessment affect the process of admission to inpatient hospital settings from community or care home settings?</p> <p>6. What is the effectiveness of interventions and approaches designed to improve the transfer of care from hospital?</p>
Quality of evidence	<p>The recommendations about providing care during the hospital stay are based on economic evidence and evidence from the hospital admissions review area, all of which was judged to be good or moderate quality.</p>
Relative value of different outcomes	<p>The strength of effectiveness and cost effectiveness evidence meant the Guideline Committee could ascertain the relative value of providing care for older people with complex needs in a specialist ward and treating stroke patients in a stroke unit together with offering early supported discharge. Evidence of positive individual and service level outcomes as well as cost-effectiveness was clear.</p> <p>The studies supporting 1.4.6 reported views and experiences data and it was therefore not possible to ascertain and compare the relative value of outcomes associated with encouraging people to follow daily routines in hospital. Nevertheless, the Guideline Committee agreed this would be likely to have a positive effect on individuals.</p>
Trade-off between benefits and harms	<p>These recommendations were informed predominantly by data on effectiveness and cost effectiveness. Combined, with the Guideline Committee's expertise, data demonstrated that if older people with complex needs are cared for on a specialist unit or and if stroke patients are treated in a stroke unit and offered early supported discharge, then in hospital treatment and short-term outcomes such as dependency and extended activities of daily living would be positively affected and cost reduced due to shorter hospital length of stay.</p> <p>The Guideline Committee considered whether recommending that patients should be encouraged to pursue daily routines would have an adverse effect on hospital resources but agreed</p>

	<p>that this recommendation could be followed within existing resources and would benefit individuals and ultimately health and social care services.</p>
<p>Economic considerations</p>	<p>The recommendations were derived from economic evidence. The costs and outcomes of early supported discharge teams were often evaluated in the context of stroke unit provision and stroke units with early supported discharge were more cost-effective than stroke unit provision on its own. The assumed staff mix of an early supported discharge team for stroke patients is described elsewhere (LETR table 4).</p> <p>Findings on (cost-) effectiveness only related to geriatric assessment and care through specialist unit provision and not to provision via mobile teams. For example, geriatric assessment and care provided by mobile teams could reduce the odds of older people living at home at follow up favouring non-specialist assessment and care.</p>
<p>Evidence statements – numbered evidence statements from which the recommendation(s) were developed</p>	<p>HA4 There is some good and moderate evidence that specialist geriatric care and geriatric assessment, which commences on admission to hospital, has a positive impact on experiences and outcomes for older people. One RCT (Eklund et al, 2013) [+] found that the provision of care by a nurse with geriatric competence which commenced on admission and continued through to hospital discharge, improved ADL independence among its participants up to one year, and postponed dependence in ADL up to six months. A systematic review (Ellis et al, 2011) [++] found that comprehensive geriatric assessment delivered in geriatric wards increases older people's likelihood of being alive and in their own homes following emergency admission to hospital. A systematic review (Fox et al, 2012) [++] identified positive service level and individual outcomes from care on dedicated geriatric units, which was based on hospital rehabilitation and the prevention of functional decline. (Rec 1.4.4)</p> <p>Ec1 Evidence from one high quality systematic review and meta-analysis (Ellis et al 2011, ++) suggested that comprehensive geriatric assessment and care provided on specialist units was likely to be cost-effective compared with non-specialist care. Findings from the study showed positive health and wellbeing outcomes for individuals and cost savings from a hospital perspective. Additional economic analysis was carried out to assess the likely impact of the intervention on health and social care and unpaid care costs in a UK context and found that comprehensive geriatric assessment and care provided on specialist units was likely to lead to cost savings from a health and social perspective and to at least offset costs if the costs of unpaid care were included. (Rec 1.4.4)</p> <p>Ec2 There is good amount of good and moderate quality economic evidence that shows that stroke unit care provided with early supported discharge and multi-disciplinary community care is likely to be cost-effective when compared with standard care. One UK cost-utility study carried alongside a RCT compared stroke unit care with alternative options of stroke provision and</p>

	<p>found that stroke unit care was more cost-effective than care provided on a general ward (Patel et al 2004; ++); in the same study stroke care provided at home was the most cost-effective option but this was not considered an appropriate alternative in the current context of stroke service provision. A cost-utility decision modelling study carried out in the UK (Saka et al 2009, ++) suggested that stroke unit care with early supported discharge was more cost-effective than stroke unit care alone. This was supported by 2 international systematic reviews and 1 health technology assessment which looked at the cost-effectiveness of early supported discharge provided with multidisciplinary community care versus standard care (Fearon and Langhorne 2012 ++; Brady et al 2005 +; Larsen et al 2006 +). (Rec 1.4.5)</p> <p>HA3 There is a small amount of good and moderate evidence that older people experience hospital as an alien environment, which both deters them from seeking medical help and affects their rehabilitation as a hospital inpatient. One study (Themessl-Huber et al, 2007) [+] found that older people preferred the help of friends and relatives during a crisis rather than medical professionals and would rather be at home and surrounded by their own belongings than be admitted to hospital. An Australian study (Cheah and Presnel, 2011) [++] identified that people feel alienated by the hospital's impact on their own routine, which presents a challenge for occupational therapy if it is de-contextualised from normal life. The study also showed that the best motivator for people to engage in rehabilitation was the prospect of returning home. (Rec 1.4.6)</p>
<p>Other considerations</p>	<p>Recommendation 1.4.4 is derived directly from good quality effectiveness and cost effectiveness evidence, which is synthesized in HA4 and Ec1, with which the Guideline Committee concurred. The committee discussed whether the recommendation ought to apply to all older people, which could arguably be people 55 and over. However, the consensus was that the recommendation should be specifically applied to people with complex needs, normally those over 75 or 80.</p> <p>Recommendation 1.4.5 is directly derived from economic evidence statement 2. The Guideline Committee discussed whether the findings could be extrapolated to other groups with high needs but ultimately agreed that the stroke unit setting and stroke patient population were specific to the research and findings. The Guideline Committee noted the connection with the existing NICE Guideline on stroke rehabilitation so agreed to cross refer to the relevant recommendations, which concur with 1.4.5</p> <p>Finally, recommendation 1.4.6 was derived from HA3. It was the intention of the Guideline Committee to place a responsibility on the hospital to enable people to maintain as much of their daily routine as possible, in order to stimulate motivation to recover and reduce anxiety by making hospital feel a less alien environment.</p>

Topic/section heading	Discharge from hospital
Recommendations	<p>Discharge coordinator</p> <p>1.5.1 One health or social care practitioner should be responsible for coordinating the person's discharge from hospital. Create either a designated discharge coordinator post or make a member of the hospital- or community-based multidisciplinary team responsible. Select them according to the person's care and support needs. A named replacement should always cover their absence.</p> <p>1.5.2 The discharge coordinator should be a central point of contact for health and social care practitioners, the person and their family, particularly during discharge planning. They should be involved in all decisions about discharge planning.</p>
Research recommendations	The Guideline Committee did not prioritise this is an area to make research recommendations on
Review questions	6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?
Quality of evidence	The recommendations about identifying a discharge coordinator were derived from evidence identified in the hospital discharge review area, for which there were 12 views studies mainly of moderate quality. There were also 16 effectiveness studies, mostly of moderate and good quality.
Relative value of different outcomes	Most of the studies relevant to the key principles of discharge planning reported views and experiences so it was not possible to ascertain and compare the relative value of outcomes associated with those principles. Similarly, most of the studies relevant to the role of the discharge coordinator were also qualitative except for one systematic review, which found that successful transitions for older people involved a discharge coordinator.
Trade-off between benefits and harms	These recommendations were informed mainly by data on views plus the Guideline Committee's experiences. They indicated that discharge planning should follow some key principles for all adults with social care needs, including the identification of a single discharge coordinator.
Economic considerations	'Although no economic evidence was available to inform these guideline recommendations, the GC were mindful of potential costs and resource use when making the recommendations
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	HD2 There is a moderate amount of moderate quality evidence that designating a discharge coordinator has a positive effect on hospital discharge processes and outcomes. A qualitative study (Baumann et al, 2007) [+] found that discharge coordinators helpfully support ward nurses in discharge planning by monitoring patients from admission to discharge and identifying patients requiring on-going social or continuing care. A moderate quality study using focus groups with hospital based professionals (Connolly, 2009) [+] identified that having discharge coordinators was a way of overcoming the problem of

	<p>people not being clear about their role in discharge planning. The discharge coordinator collected information for patients to take home and checked up on the person a week after discharge. Finally, a systematic review (Laugaland, 2012) [+] focusing on patients over 65 years found that successful transitional care interventions consisted of a key health care worker acting as discharge coordinator. (Rec 1.5.1 and 1.5.2)</p>
<p>Other considerations</p>	<p>Recommendations 1.5.1 and 1.5.2 are both derived from HD2, which provides evidence of the benefits of having a single individual coordinating people's discharge from hospital. The Guideline Committee were unanimous in their support for this but they decided against stipulating exactly how hospitals should allocate the role.</p>

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Topic/section heading	Discharge from hospital
<p>Recommendations</p>	<p>Communication and information sharing</p> <p>1.5.3 Health and social care commissioners should agree clear discharge planning protocols.</p> <p>1.5.4 Health and social care managers should ensure all health and social care practitioners receive regular briefings on the discharge planning protocols.</p> <p>1.5.5 During discharge planning, the discharge coordinator should share assessments and updates on the person's health status, including medicines data, with both the hospital- and community-based multidisciplinary teams.</p> <p>1.5.6 The hospital-based doctor responsible for the person's care should ensure the discharge summary is sent to the person's GP within 24 hours of their discharge. They should also ensure a copy is given to the person the day they are discharged.</p> <p>1.5.7 Make a member of the hospital-based multidisciplinary team responsible for providing carers with information and support. This could include:</p> <ul style="list-style-type: none"> • printed information • face-to-face • by phone • hands-on training, including practical support and advice. <p>1.5.8 The discharge coordinator should provide people who need end-of-life care and their families with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge.</p>
<p>Research recommendations</p>	<p>The following research questions is relevant to this topic:</p> <p>2.1 What is the effect of hospital discharge or transitions training for health and social care practitioners on achieving successful transfers from hospital to home or the community? (Including specifically the effects on formal and informal carers, and on avoidable readmissions?)</p> <p>2.5 How effective are home assessment interventions and approaches designed to improve hospital discharge outcomes?</p>
<p>Review questions</p>	<p>6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?</p> <p>7. What is the effectiveness of interventions and approaches designed to reduce hospital re-admissions within 30 days of hospital discharge?</p> <p>9 (a) What is the impact of specific interventions to support people with end-of-life care needs during transition from inpatient hospital settings to community or care home settings, including hospices?</p> <p>9 (b) What is the impact of specific interventions to support people with end-of-life care needs during admission to inpatient</p>

	<p>hospital settings from community settings including care homes and hospices?</p> <p>11(a) How should services work with families and unpaid carers of adults with social care needs during transition from inpatient hospital settings to community or care home settings?</p> <p>11 (b) How should services work with families and unpaid carers of adults with social care needs during admission to inpatient hospital settings from community or care home settings?</p>
Quality of evidence	<p>The recommendations about communication and information sharing for the hospital discharge process were informed by evidence from the linked areas of hospital discharge and reducing readmissions plus testimony from the expert witness. For reducing readmissions, there was a good amount of good quality effectiveness evidence, including evidence of cost-effectiveness. In the area of hospital discharge, there were 12 views studies mainly of moderate quality. The 16 effectiveness studies were mostly of moderate and good quality.</p> <p>Recommendation 1.5.7 was informed by evidence from the carers' support review area, for which there was a moderate amount of views and experiences evidence, judged to be of moderate quality. The two effectiveness studies in this area related specifically to support for carers of stroke patients.</p>
Relative value of different outcomes	<p>Most of the studies from the hospital discharge review area that informed these recommendations reported views and experiences. It was therefore difficult to ascertain and compare the relative value of outcomes associated with the use of discharge planning protocols.</p> <p>However, there was good evidence from systematic reviews that sharing discharge information between hospital and community based practitioners reduces readmissions. Evidence on carer support also demonstrated that training caregivers of stroke patients reduces costs and caregiver burden while improving psychosocial outcomes in caregivers and patients.</p>
Trade-off between benefits and harms	<p>These recommendations were informed by data on views and experiences and some effectiveness data combined with testimony from the expert witness. Together with the Guideline Committee's expertise, this indicated that improving communication and information between hospital and community based practitioners and with caregivers, would improve the experience and outcomes of hospital discharge including reducing readmissions within 30 days.</p>
Economic considerations	<p>Although no economic evidence was available to inform these guideline recommendations, the GC were mindful of potential costs and resource use when making the recommendations</p>
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>HD1 There is a moderate amount of moderate quality evidence that improved inter professional communication would ensure more successful transfers from hospital. One mixed methods qualitative study (Huby et al, 2004 and Huby et al, 2007) [++] found hospital based professionals had failed to share assessment results, leading to confusion about whether a patient was fit for discharge. A moderate quality study using focus</p>

	<p>groups (Connolly, 2009) [+] found that poor internal communication leads to confusion about arranging tests or services and means that vitally placed professionals are left out of critical discharge decisions. A moderate quality systematic review (Nosbusch et al, 2011) [+] recommended that improved communication and information sharing would help acute staff nurses in discharge planning. Within the ward, the completion of discharge preparation summaries at each shift handover was believed to improve communication between nurses. For all relevant professionals, the use of standardized referral forms and electronic decision support and referral systems was recommended. Finally, a moderate quality qualitative study (Baumann, 2007) [+] found that improved communication between wards and social services is achieved by having a care manager attached to a ward. (Recs 1.5.3, 1.5.42 and 1.5.5) Consensus (Recs 1.5.3 and 1.5.4)</p> <p>RHR5 There is a moderate amount of good quality evidence that communication between secondary health and primary health and community services is vital in reducing hospital readmissions. A good quality systematic meta-review (Scott, 2010) [++] found that one of the key components of effective discharge processes is timely and complete communication of management plans between clinicians when patients' care is transferred from hospital staff to primary care teams. Echoing this, another good quality systematic review (Hansen et al, 2011) identified interventions comprising of timely primary care provider communication as being effective in reducing hospital readmissions. Finally, a good quality systematic review (Linertova, 2011) [++] concluded that interventions incorporating geriatric management and home care support are more likely to reduce hospital readmissions. These services are complex requiring a high degree of collaboration between patients, caregivers, geriatricians, general practitioners, social community services and other agents. (Recs 1.5.5 and 1.5.6)</p> <p>CS3 There is some evidence of moderate and good quality that caregivers of stroke patients value proactive support, which is provided directly from professionals, with leaflets and the internet playing a subsidiary role. One study (Bakas et al, 2009b) [+] presented evidence which showed that caregivers found printed information to provide much needed support, whilst repeated telephone contact from a nurse considerably improved their experience of transition from hospital to home. Another (Cobley 2013) [++] found that family caregivers of stroke patients undergoing early supported discharge felt that direct contact with a professional would have considerably improved their experience of transition. Finally, a study (Kalra et al, 2004) [++] in which caregivers received instruction directly from appropriate professionals during patients' rehabilitation reduced costs and caregiver burden while improving psychosocial outcomes in caregivers and patients at one year. (Rec 1.5.7)</p> <p>Expert Witness group 1: Claire Henry (Rec 1.5.8)</p>
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<p>Other considerations</p>	<p>Recommendations 1.5.3 and 1.5.4 are linked and both based on evidence statement HD1 which emphasizes the importance of communication and information sharing between professionals that is supported by standardized forms and systems. The Guideline Committee felt that for this to be achieved, health and social care commissioners should take responsibility for agreeing discharge planning protocols. In turn the Guideline Committee agreed that health and social care managers should ensure relevant practitioners are trained to follow the protocols (1.5.4).</p> <p>Recommendation 1.5.5 was derived from a combination of HD1, RHR5 and Guideline Committee consensus. The evidence demonstrated the importance of communication between the hospital and community based practitioners. The Guideline Committee wanted the wording of the recommendation to reflect that this sharing of information should not be limited to shared data systems because there is a danger that practitioners cease to actually speak to each other.</p> <p>Recommendation 1.5.6 was also based on RHR5. It aims to ensure the GP receives the medically focused discharge summary containing information about the hospital admission such as diagnoses and prescribed medicines. The Guideline Committee said that in their experience, people leaving hospital often do not receive copies of the discharge summaries and that this should be rectified. Through discussion and consensus, the Guideline Committee agreed that the discharge summary should be sent to the GP within 24 hours of discharge.</p> <p>As well as ensuring the person being discharged, the GP and the community based multi-disciplinary team receive all relevant information, evidence from the carer support review area emphasized that families and carers should be given information during discharge planning. The Guideline Committee agreed that although written information could be useful to carers, face-to-face contact with practitioners was preferable. They also agreed that if the carer was supported to feel more confident this would reduce their anxiety and in turn improve outcomes for the person being discharged.</p> <p>Finally, evidence provided by the expert witness and supported by the Guideline Committee informed 1.5.8, which recommends that for people with end of life care needs, it is especially important that problems with equipment and medicines are rectified very quickly. To this end the Guideline Committee agreed there should be a named individual (whether hospital or community based) who can respond to problems occurring within 24 hours of discharge.</p>
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Topic/section heading	Discharge planning: key principles
Recommendations	<p>1.5.9 Ensure continuity of care for people being transferred from hospital, particularly older people who may be confused or who have dementia. For more information on continuity of care see the recommendations in section 1.4 of NICE's guideline on patient experience in adult NHS services.</p> <p>1.5.10 Commissioners and providers should ensure people do not have to make decisions about long-term residential or nursing care while they are in crisis.</p> <p>1.5.11 Hospital managers should try to ensure that any perceived or real pressures to make beds available do not result in unplanned and uncoordinated hospital discharges.</p>
Research recommendations	The guideline Committee did not prioritise this is an area to make research recommendations on
Review questions	<p>6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?</p> <p>8 (a) What is the impact of specific interventions to support people with mental health problems during transition from general inpatient hospital settings to community or care home settings?</p> <p>8 (b) What is the impact of specific interventions to support people with mental health problems during admission to general inpatient hospital settings from community or care home settings?</p> <p>9 (a) What is the impact of specific interventions to support people with end-of-life care needs during transition from inpatient hospital settings to community or care home settings, including hospices?</p> <p>9 (b) What is the impact of specific interventions to support people with end-of-life care needs during admission to inpatient hospital settings from community settings including care homes and hospices?</p>
Quality of evidence	<p>The recommendations on the key principles of discharge planning and the role of a discharge coordinator were based on evidence from mental health transitions and hospital discharge. There was a paucity of evidence on transitions for people with mental health problems although what was included was of moderate to good quality; views data were notably lacking and effectiveness evidence was contradictory</p> <p>In the area of hospital discharge, there were 12 views studies mainly of moderate quality. The 16 effectiveness studies were mostly of moderate and good quality.</p>
Relative value of different outcomes	Most of the studies relevant to the key principles of discharge planning reported views and experiences so it was not possible to ascertain and compare the relative value of outcomes associated with those principles. Similarly, most of the studies relevant to the role of the discharge coordinator were also qualitative except for one systematic review, which found that successful transitions for older people involved a discharge coordinator.

Trade-off between benefits and harms	These recommendations were informed mainly by data on views plus the Guideline Committee's experiences. They indicated that discharge planning should follow some key principles for all adults with social care needs, including the identification of a single discharge coordinator.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the GC were mindful of potential costs and resource use when making the recommendations
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>MH1 There is a small amount of good quality evidence from one qualitative study about the hospital admission process for older people with mental health problems. The UK study (Clissett, 2013) [++] described the emergency admission process as disorientating and distressing for patients and frustrating for carers who felt their own expertise was overlooked. The study reported that hospital admission would be improved if existing community support packages could be resumed to maintain important relationships, if health care professionals conscientiously communicated with family carers and engaged them in genuine partnership. (Rec 1.5.9)</p> <p>HD8 There is a small amount of good quality evidence that people are more likely to be transferred to residential care from hospital when those decisions are made within the context of a crisis. A UK qualitative study (Taylor and Donnelly, 2006) [++] found that health and social care professionals are more likely to recommend someone transfers to a care home when resources to support them at home are lacking (referring to both formal and unpaid care), when other housing options are unavailable and when people are perceived to be "vulnerable", for example, to falls. (Rec 1.5.10)</p> <p>HD3 There is a moderate amount of moderate quality evidence that bed shortages and government targets create pressure to discharge patients without involving all relevant professionals, often resulting in readmissions. A moderate quality study (Connolly, 2009) [+] reported that focus group members feel compelled to make discharge a swift procedure due to pressure from managers and consultants, who were seen as striving to achieve government targets to fill beds and reduce waiting lists. Similarly, a survey of hospital based professionals (Connolly, 2010) [+] found 80% of respondents felt government targets caused the discharge process to be rushed and result in readmissions within days. A good quality mixed methods study (Huby et al, 2004 and 2007) [++] showed that pressures owing to bed shortages were clearly on the minds of patients who claimed to feel well purely so they would be discharged.. (Rec 1.5.11)</p>
Other considerations	Recommendation 1.5.9 was derived directly from MH1. The Guideline Committee were in agreement about the disruption and anxiety caused when a care package is discontinued when a person is admitted to hospital. They discussed whether a local authority might keep the care package 'open' and although they accepted this would incur costs, they thought there may be savings from not having to train a new care worker following discharge and also weighed the costs against the negative

	<p>impact on wellbeing of a disrupted care package. In the end, they agreed to 'ensure continuity' rather than to specifically recommend a care package be kept 'open'. Recommendation 1.5.10 was derived from HD8. The Guideline Committee agreed to a recommendation that would avoid people making the decision to move to residential or nursing care while their options felt limited during a crisis. Recommendation 1.5.11 is derived from HD3. Acknowledging that pressures on bed occupancy are a reality, the Guideline Committee wanted to ensure that even in those circumstances transfers of care are still well coordinated and involve all relevant practitioners.</p>
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Topic/section heading	Discharge Planning
Recommendations	<p>1.5.12 From admission, or earlier if possible, the hospital- and community-based multidisciplinary teams should work together to identify and address factors that could prevent a safe, timely transfer of care from hospital. This could include:</p> <ul style="list-style-type: none"> • homelessness • safeguarding issues • suitable placement in a care home. <p>1.5.13 The discharge coordinator should work with the hospital- and community-based multidisciplinary teams and the person receiving care to develop and agree a discharge plan.</p> <p>1.5.14 The discharge coordinator should ensure the discharge plan takes account of the person's social and emotional wellbeing, as well as the practicalities of daily living. It should include:</p> <ul style="list-style-type: none"> • details about the person's condition • medicines management information (for more on medicines management for people in transition between settings see section 1.2 of NICE's guideline on Medicines optimisation) • contact information after discharge • arrangements for continuing social care support • arrangements for continuing health support • details of other useful community services.
Research recommendations	<p>The following research question is relevant to this topic:</p> <p>2.5 How effective are home assessment interventions and approaches designed to improve hospital discharge outcomes?</p>
Review questions	<p>6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?</p> <p>7. What is the effectiveness of interventions and approaches designed to reduce hospital re-admissions within 30 days of hospital discharge?</p> <p>11(a) How should services work with families and unpaid carers of adults with social care needs during transition from inpatient hospital settings to community or care home settings?</p> <p>11 (b) How should services work with families and unpaid carers of adults with social care needs during admission to inpatient hospital settings from community or care home settings?</p>
Quality of evidence	<p>These recommendations for discharge planning are based on evidence from the linked review areas of hospital discharge and reducing readmissions.</p> <p>For reducing readmissions, there was a good amount of good quality effectiveness evidence, including evidence of cost-effectiveness. In the area of hospital discharge, there were 12</p>

	views studies mainly of moderate quality. The 16 effectiveness studies were mostly of moderate and good quality.
Relative value of different outcomes	<p>It was not possible to ascertain and compare the relative value of outcomes of early assessment and planning for discharge because most of the relevant studies were qualitative. However, two systematic reviews found that early supported discharge for stroke patients reduced the length of hospital stay, although it did not reduce readmissions. Nevertheless drawing on their own expertise and data from views and experiences studies, the Guideline Committee concluded that the benefits of early assessment and planning for discharge outweighed any negative outcomes.</p> <p>The evidence about the importance of discharge plans that account for all aspects of a person's needs and circumstances was largely from qualitative studies so it was not possible to ascertain and compare the relative value of that approach to assessment and planning for discharge.</p> <p>However, the evidence in support of sharing discharge assessment and plans between hospital and primary care practitioners was mainly from quantitative studies, which demonstrate this approach improves the outcomes of hospital discharge including reducing readmissions.</p>
Trade-off between benefits and harms	It was not possible to ascertain trade-offs between benefits and harms of different models, however, views data and the committee's experience indicated that assessment and planning which does not take into account all their circumstances may result in a discharge plan which does not meet their needs and which threatens the success of the hospital discharge.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the GC were mindful of potential costs and resource use when making the recommendations
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>HD4 There is a good amount of moderate quality evidence that support for people after they have been transferred from hospital improves experiences as well as service level and individual outcomes. Where support is unavailable, the success of hospital discharge is threatened. A good quality RCT (Burton and Gibbon, 2005) [++] found that when follow up care was provided by a stroke nurse, ADL and social isolation scores were significantly improved although there was no difference in depression scores. Focus group participants (Connolly et al, 2009) [+] cited lack of equipment in people's homes as a cause of delay, which could be improved if assessments were conducted earlier in the hospital stay. A low quality mixed methods study (Bryan et al, 2006) [-] reporting managers' views cited inadequate social services resources and shortages of health and care professionals to provide support for people returning home as major barriers to discharge. A qualitative study (Huby et al, 2004 and 2007) described how a lack of community services meant patients could not be discharged, in some cases for several weeks. Finally, two systematic reviews (Larsen et al, 2006 and Olson et al, 2011) [+] [++] reported that early home supported discharge which includes delivering care at home, caused a reduction in length of stay, nursing home</p>

	<p>referrals and poor outcomes in a stroke unit although it had no effect on readmissions. (Rec 1.5.12)</p> <p>HD2 There is a moderate amount of moderate quality evidence that designating a discharge coordinator has a positive effect on hospital discharge processes and outcomes. A qualitative study (Baumann et al, 2007) [+] found that discharge coordinators helpfully support ward nurses in discharge planning by monitoring patients from admission to discharge and identifying patients requiring ongoing social or continuing care. A moderate quality study using focus groups with hospital based professionals (Connolly, 2009) [+] identified that having discharge coordinators was a way of overcoming the problem of people not being clear about their role in discharge planning. The discharge coordinator collected information for patients to take home and checked up on the person a week after discharge. Finally, a systematic review (Laugaland, 2012) [+] focusing on patients over 65 years found that successful transitional care interventions consisted of a key health care worker acting as discharge coordinator (Rec 1.5.13)</p> <p>HD6 There is a good amount of mixed quality evidence that including people and families in decision-making and preparation for discharge affects the quality of transitions from hospital. A study (Benton, 2008) [+] of patients' experiences of intermediate care found they lacked understanding about the purpose of the unit and their potential for rehabilitation. One study (Huby et al 2004 and 2007) [++] found that individual needs are ignored and patients are excluded from decision making about treatment and discharge. A systematic review (Laugaland et al, 2012) [+] showed that successful interventions involved caregivers and included patient participation and/ or education. Similarly, another systematic review (Preyde, 2011) [+] found that a lack of family or patient education during discharge was significantly related to readmission. Finally, one RCT (Li Hong et al, 2012) [++] reported mixed results. When patient-carer dyads received empowerment-educational sessions on admission and discharge, there was no significant difference on caregivers' emotional coping for depression, anxiety and worry and no reduction in the amount of care giving; the only differences were less role strain and caregiver preparedness to participate in post hospital care.(Rec 1.5.13 and 1.5.14)</p> <p>HD5 There is a moderate amount of moderate to good evidence that professionals involved in discharge planning fail to treat patients as a 'whole person'. One qualitative study (Huby et al, 2004 and 2007) [++] concluded that transitions from hospital would be more successful if professionals considered all relevant circumstances surrounding a patient rather than making decisions based on a narrow understanding of physical and cognitive functions. A good quality qualitative study (Taylor and Donnelly, 2006) [++] also highlighted the importance of seeing beyond a person's condition or physical need when considering</p>
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	<p>their transition from hospital to the community. A moderate quality study (Connolly et al, 2009) found hospital professionals who depicted the discharge process as de-humanising'. They felt that use of the label 'medically fit for discharge', oversimplifies cases and highlights that once the medical or 'acute' problem had been addressed, any remaining difficulties that patients' experienced were not regarded as the hospital's concern. (Rec 1.5.14)</p> <p>RHR3 There is some good quality evidence that in-hospital assessment of needs and planning for discharge lead to lower readmission rates. One good quality systematic review (Allen et al, 2014) [++] located a study that found an inpatient geriatric evaluation (combined with co-management with ward staff and transitional care) significantly reduced the likelihood of readmission 3 months following discharge. Another good quality systematic review (Shepperd et al, 2013) found that individually tailored discharge plans to meet older people's ongoing needs reduced readmission rates. A good quality systematic review (Scott, 2010) [++] highlighted the importance of early assessment of discharge needs, which was one of several components of discharge processes effective in reducing readmissions. Finally, a moderate quality systematic review (Jacob, 2008) [+] concluded that lapses in discharge planning undermine patients' perceptions of their readiness for discharge and compromise discharge success. (Rec 1.5.14)</p> <p>HD9 There is a small amount of mixed quality evidence that sharing patient medication data among hospital and community based practitioners via electronic systems improves the quality of transitions between hospital and home. One low quality review of best practice (Cassano, 2013) [-] found that electronic transfer of patient information between practitioners assisted in communication of drug therapy and improved transitions. One good quality systematic review (Hesselink, 2012) [++] found that interventions to improve information exchange at discharge significantly improved transitions, particularly in terms of care continuity.(Rec 1.5.14</p>
<p>Other considerations</p>	<p>Recommendation 1.5.12 is derived from evidence statement HD4 and GDG consensus about the importance of identifying potential barriers to discharge as early as possible. The Guideline Committee felt one of the ways of achieving this would be to conduct visits and assessments in people's homes before they are discharged. Recommendation 1.5.13 is based on HD2 about the importance of a discharge coordinator plus HD6 and Guideline Committee consensus about the importance of the coordinator working with hospital and community based practitioners and the person themselves to agree a suitable and acceptable discharge plan. Recommendation 1.5.14 is based on a good amount of evidence from three different evidence statements; HD5, HD6, HD9 and RHR3 about the important of early discharge planning that addresses all aspects of a person's needs, lives and circumstances. The Guideline Committee concurred with the evidence and this is reflected in a strong recommendation.</p>

Topic/section heading	Discharge planning (continued)
Recommendations	<p>1.5.15 The discharge coordinator should give the plan to the person and all those involved in their ongoing care and support, including families and carers (if the person agrees). The discharge coordinator should also arrange follow-up care.</p> <p>1.5.16 The discharge coordinator should identify practitioners (from primary health, community health, social care and housing) and family members who will provide support when the person is discharged. Their details should be recorded in the discharge plan.</p> <p>1.5.17 Once assessment for discharge is complete, the discharge coordinator should agree the plan for ongoing treatment and support with the community-based multidisciplinary team.</p> <p>1.5.18 The discharge coordinator should discuss the need for any specialist equipment and support with primary health, community health, social care and housing practitioners as soon as discharge planning starts. This includes housing adaptations. Any specialist equipment and support should be in place at the point of discharge.</p>
Research recommendations	<p>The following research question is relevant to this topic:</p> <p>2.5 How effective are home assessment interventions and approaches designed to improve hospital discharge outcomes?</p>
Review questions	<p>7. What is the effectiveness of interventions and approaches designed to reduce hospital re-admissions within 30 days of hospital discharge?</p> <p>9 (a) What is the impact of specific interventions to support people with end-of-life care needs during transition from inpatient hospital settings to community or care home settings, including hospices?</p> <p>9 (b) What is the impact of specific interventions to support people with end-of-life care needs during admission to inpatient hospital settings from community settings including care homes and hospices?</p>
Quality of evidence	<p>These recommendations were informed by evidence about reducing hospital readmissions and transitions for people with end of life care needs. For reducing readmissions, there was a good amount of good quality effectiveness evidence but no views and experiences data. Evidence reviewed for end of life care transitions comprised good quality views data and one moderate quality controlled study of effectiveness. There was no economic evidence that directly related to discharge planning for people with end-of-life needs but there were two moderate to high quality economic evaluations of multi-disciplinary palliative care teams in the community.</p>
Relative value of different	<p>The recommendations about the discharge coordinator linking with the community based multi-disciplinary team over the</p>

<p>outcomes</p>	<p>discharge plan are derived from two good quality systematic reviews and supported by Guideline Committee consensus. Therefore there is a strong indication that the recommendations will improve the success of hospital discharge, including reducing readmissions.</p> <p>The absence of effectiveness studies relevant to ensuring specialist equipment is in place meant it was not possible to ascertain and compare the benefits and harms associated with following this principle.</p>
<p>Trade-off between benefits and harms</p>	<p>These recommendations were informed predominantly by data on effectiveness as well as some views and experiences data. Combined, with the Guideline Committee's expertise, data demonstrated that if these overarching principles are followed during discharge planning, the outcomes and experiences of hospital discharge will be improved.</p>
<p>Economic considerations</p>	<p>It is likely that the referral to multidisciplinary palliative care teams for people with end of life needs is cost-effective, Generally, the economic evidence supports that end-of-life care compared to standard care is likely to achieve cost savings and this refers to many different types of provision and arrangements.</p>
<p>Evidence statements – numbered evidence statements from which the recommendation(s) were developed</p>	<p>RHR5 There is a moderate amount of good quality evidence that communication between secondary health and primary health and community services is vital in reducing hospital readmissions. A good quality systematic meta-review (Scott, 2010) [++] found that one of the key components of effective discharge processes is timely and complete communication of management plans between clinicians when patients' care is transferred from hospital staff to primary care teams. Echoing this, another good quality systematic review (Hansen et al, 2011) identified interventions comprising of timely primary care provider communication as being effective in reducing hospital readmissions. Finally, a good quality systematic review (Linertova, 2011) [++] concluded that interventions incorporating geriatric management and home care support are more likely to reduce hospital readmissions. These services are complex requiring a high degree of collaboration between patients, caregivers, geriatricians, general practitioners, social community services and other agents (Recs 1.5.15, 1.5.16 and 1.5.17).</p> <p>ELC3 There is a small amount of evidence of moderate to good quality that improved communication, between services and between services, patients and families, would facilitate more successful discharge and improve the experiences of patients and families. One UK qualitative study (O'Brien and Jack, 2010) [+] reported that community nurses would be able to ensure necessary equipment was in place to support a transfer from hospital to home if ward staff communicated with them far earlier in the discharge planning process. Another UK qualitative study (Hanratty, 2012) [++] reported communication failures between hospital and community services and a perception among carers that professionals did not respond to their questions or explain the rationale for transitions.(Rec 1.5.18)</p>

<p>Other considerations</p>	<p>Recommendation 1.5.15 is based on evidence from both the hospital discharge and reducing hospital readmissions review areas. The Guideline Committee also agreed that the person and everyone involved in their support beyond discharge should receive the discharge plan and have it explained to them. As with all recommendations that refer to informing families and carers, the Guideline Committee agreed this is subject to the person giving consent.</p> <p>Recommendations 1.5.16 and 1.5.17 were derived from RHR7 and Guideline Committee consensus about the importance of the hospital based discharge coordinator connecting and working with community based practitioners to agree and 'hand over' the discharge plan. The Guideline Committee felt it was also important that the person and their families should have a record of the names of the community based practitioners.</p> <p>Recommendation 1.5.18 was based on ELC3 about the importance of ensuring equipment is in place at home to support hospital discharge at the end of life. The Guideline Committee agreed to extrapolate the evidence to apply to all adults with social care needs.</p>
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Topic/section heading	Discharge planning (continued)
Recommendations	<p>1.5.19 A relevant health or social care practitioner should discuss with the person how they can manage their condition after their discharge from hospital. They should provide support and education, including 'coaching' if needed. Make this available for carers as well as people using services.</p> <p>1.5.20 Consider supportive self-management as part of a treatment package for people with depression or other mental health problems.</p>
Research recommendations	<p>The following research question is relevant to this topic:</p> <p>2.2 Which interventions are effective in supporting self-management for people with mental health problems who also have a physical condition and are moving into and out of general inpatient hospital settings?</p>
Review questions	<p>7. What is the effectiveness of interventions and approaches designed to reduce hospital re-admissions within 30 days of hospital discharge?</p> <p>8 (a) What is the impact of specific interventions to support people with mental health problems during transition from general inpatient hospital settings to community or care home settings?</p> <p>8 (b) What is the impact of specific interventions to support people with mental health problems during admission to general inpatient hospital settings from community or care home settings?</p>
Quality of evidence	<p>These recommendations were based on evidence about reducing hospital readmissions and transitions for people with mental health problems. For reducing readmissions, there was a good amount of good quality effectiveness evidence, including evidence of cost-effectiveness. There was a paucity of evidence on transitions for people with mental health problems although what was included was of moderate to good quality; views data were notably lacking and effectiveness evidence was contradictory.</p>
Relative value of different outcomes	<p>The evidence about self-management for adults with social care needs is taken from effectiveness studies. Although one RCT found no effect on readmissions, the Guideline Committee concurred with the evidence of positive outcomes showing reduced readmissions. The effectiveness evidence in support of self-management for people with mental health problems was not as strong but still suggested that positive outcomes could be achieved.</p>
Trade-off between benefits and harms	<p>These recommendations were informed largely by effectiveness data combined with Guideline Committee expertise. The evidence indicates that the benefits of supporting self-management during the hospital admission process are dominant and that no harm is incurred.</p>
Economic considerations	<p>Although no economic evidence was available to inform these guideline recommendations, the GC were mindful of potential costs and resource use when making the recommendations. For example, additional costs of training and additional staff time for</p>

	<p>providing care were considered economically justified because of potential positive impacts on health and wellbeing.</p>
<p>Evidence statements – numbered evidence statements from which the recommendation(s) were developed</p>	<p>RHR1 There is some evidence of mixed quality that self-care and self-management reduces hospital readmissions although conflicting evidence was also located. One good quality systematic review (Allen et al, 2014) [++] found that self-management and discharge coaching significantly lowered readmission rates at 30, 90 and 180 days. A good quality systematic meta-review (Scott, 2010) [++] identified patient (and care-giver) education for promoting self-management as a vital component for reducing readmissions. Finally, a low quality systematic review (Naylor, 2011) [-] reported that 3 out of 9 effective interventions included a focus on self-management. (Rec 1.5.19)</p> <p>MH2 The small amount of evidence about supportive self-management for people with mental health problems on discharge from inpatient heart failure treatment is conflicting. One randomised controlled trial of moderate quality (Davis, 2012) [+] found no significant difference in readmission rates and total hospital stay among discharged patients who had used a targeted self-care teaching intervention, compared with a control group. By contrast, one good quality (Rollman, 2009) [++] US effectiveness study reported significant improvements among depressed coronary bypass graft patients following a treatment package featuring education and self-management techniques, although re-admission rates appeared similar. (. (Rec 1.5.20)</p>
<p>Other considerations</p>	<p>Recommendation 1.5.19 was derived from mixed evidence about the effectiveness of self-management and self-care following discharge from hospital. Although the evidence was conflicting, it was strengthened by the expertise of the Guideline Committee who agreed about the value of self-management. The Guideline Committee also agreed that the same coaching about managing conditions should also be offered to carers. Recommendation 1.5.20 is linked to 1.5.19 but derived from MH2. Given that MH2 is based on a small amount of mixed quality evidence, the Guideline Committee agreed this should be a weaker a recommendation. The evidence was specifically focused on people with depression and the GC agreed to extend the recommendation to include other mental health problems.</p>

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Topic/section heading	Discharge planning for end-of-life care needs
Recommendations	<p>1.5.21 Commissioners should ensure both general and specialist palliative care services are available for people who have end-of-life care needs.</p> <p>1.5.22 Health and social care practitioners should work together to ensure people needing end-of-life care are offered both general and specialist palliative services, according to their needs.</p> <p>1.5.23 The named consultant responsible for a person's end-of-life care should consider referring them to a specialist palliative care team before they are transferred from hospital.</p> <p>1.5.24 The discharge coordinator should ensure people who have end-of-life care needs are assessed and support is in place so they can die in their preferred place.</p>
Research recommendations	The guideline Committee did not prioritise this is an area to make research recommendations on.
Review questions	<p>9 (a) What is the impact of specific interventions to support people with end-of-life care needs during transition from inpatient hospital settings to community or care home settings, including hospices?</p> <p>9 (b) What is the impact of specific interventions to support people with end-of-life care needs during admission to inpatient hospital settings from community settings including care homes and hospices?</p>
Quality of evidence	These recommendations were informed by evidence about transitions for people with end of life care needs including evidence of cost effectiveness. Evidence reviewed for end of life care transitions comprised good quality views data and one moderate quality controlled study of effectiveness. The economic evidence was judged to be of mixed, moderate and good, quality.
Relative value of different outcomes	The effectiveness and cost effectiveness evidence enabled the Guideline Committee to ascertain the relative value of making specialist as well general palliative care available as appropriate. Evidence of cost effectiveness plus better outcomes for caregivers and people with end of life care needs was clear. Strengthened by committee expertise they resulted in three out of four strong recommendations about discharge planning for people with end of life care needs.
Trade-off between benefits and harms	These recommendations were informed predominantly by data on effectiveness and cost effectiveness. Combined, with the Guideline Committee's expertise, data demonstrated that if, where appropriate, people with end of life care needs are offered specialist palliative care, this will be cost-effective and enable people to die in their preferred place,
Economic considerations	The recommendations were based on and informed by economic evidence. The costs during the last year of life are substantial mainly due to hospital (re-admissions) and provision of unpaid care; the provision of end-of-life care can reduce those costs substantially and this refers to different types of care.

<p>Evidence statements – numbered evidence statements from which the recommendation(s) were developed</p>	<p>Ec 7 Multi professional palliative care teams were found to be cost effective, albeit with some caution.</p> <p>Two UK RCTs examined the cost-effectiveness of multi-professional palliative care teams for two sub-groups of the population covered in the scope. The first (N=46, ++) showed that for people with advanced MS a multi-professional palliative care team (similar to palliative care consultation service but able to visit across settings) was likely to be cost-effective because of lower costs (£1,789, 95%, -5,224 to 1,902); this was largely because of reduced use of primary and acute care services; the study evaluated the impact on unpaid care and found no significant difference. There was no significant difference in the patient's primary outcome measured via the Palliative Care Outcomes Scale (POS-8) at 12wks.; but there was a significant reduction in the burden on caregivers (-2.88 and diff. to comparison group of 4.47, CI 95%, 1.05-7.89) measured via the Zarit caregiver burden interview (ZBI). In bootstrapping, with POS-8 as outcome, better outcomes and lower costs occurred in 34% of replications and lower costs (without improved outcomes) in 55% of replications. With ZBI as the outcome, lower costs and better outcomes occurred in 47% replications and higher costs and better outcomes in 48% replications. According to these findings the intervention was likely to be cost-effective although caution must be taken because of the small sample size. The second UK RCT (N=82) was published last year and was of limited applicability because the paper did not present sufficient detail on the evaluation of costs. This was possibly because a paper with details on the economic evaluation was still to be published. The quality of the study was expected to be high and findings can inform the recommendations with some level of caution. Findings of the study suggested that an integrated multi-professional palliative care team for patients with advanced diseases and breathlessness achieved significant improvements in breathlessness mastery (16%, mean diff. 0.58, 95% CI 0.01 to 1.15, p<0.05, effect size 0.44), in statistically adjusted total quality of life using the Palliative care Outcomes scale (POS-8) and in survival rate (50 of 53 [94%] vs 39 of 52 [75%]). None of the outcomes showed deterioration. There was no significant difference in formal care costs at 6wks. (£1,422, 95% CI 897–2101 vs. £1,408, 95% CI 899–2023) although the authors reported that costs varied greatly between individuals. (Recs 1.5.21 and 1.5.22)</p> <p>GDG Opinion and poss. Expert Witness (Rec 1.5.21)</p> <p>ELC1 There is a moderate amount of evidence of good quality from 3 qualitative studies that a lack of health and social care infrastructure is responsible for poor quality hospital discharges for people with end of life care needs, including limiting people's choice about place of death. A UK study (Hanratty, 2012) [++] found that patient's social care needs were ignored when support packages were being established for discharge home. One UK paper (Ingleton, 2009) [++] found that ambulance service protocols sometimes prevent patients being transferred from home to hospice or hospital. Finally, one UK qualitative study</p>
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	<p>(O'Brien and Jack, 2010) [+] reported that hospital staff failed to allow for essential equipment to be installed in the home before a transfer from hospital occurs. (Recs 1.5.23 and 1.5.24)</p> <p>ELC5 There is a small amount of evidence from one study of moderate quality that the provision of a specialist inpatient palliative care service can significantly improve outcomes for people with end of life care needs. The controlled retrospective US study of hospital data (Brody, 2010) [+] found that patients seen by the specialist service were significantly more likely to be transferred home with services or to a hospice during the end of life phase. (Recs 1.5.23 and 1.5.24)</p>
<p>Other considerations</p>	<p>Recommendations 1.5.21 and 1.5.22 and 1.5.23 are linked and based on economic evidence statement 7. Although there were some limitations in the evidence, the Guideline Committee agreed that where appropriate, specialist palliative services should be made available and provided, as well as general palliative services for all others being discharged from hospital with end of life care needs. Recommendation 1.5.24 is based on ELC1 and ELC5 and it places a responsibility on the discharge coordinator to support people with end of life care needs to die in their preferred place. The Guideline Committee agreed that this is where the discharge coordinator has a key role to play.</p>

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Topic/section heading	Early supported discharge
Recommendations	<p>1.5.25 Commissioners should ensure older people with identified social care needs are offered early supported discharge with a home care and rehabilitation package.</p> <p>1.5.26 Consider commissioning early supported discharge with a home care and rehabilitation package provided by a community-based multidisciplinary team for adults with identified social care needs.</p>
Research recommendations	<p>The following research question is relevant to this topic:</p> <p>3.5 How effective are home assessment interventions and approaches designed to improve hospital discharge outcomes?</p>
Review questions	<p>6. What is the effectiveness of interventions and approaches designed to improve the transfer of care from hospital?</p>
Quality of evidence	<p>Both evidence statements are based on good quality economic evidence located under the hospital discharge review area.</p>
Relative value of different outcomes	<p>The recommendations are derived from evidence of cost-effectiveness and supported by committee expertise. This meant the Guideline Committee could establish the value of early supported discharge and rehabilitation for older people specifically and for adults with social care needs more generally.</p>
Trade-off between benefits and harms	<p>These recommendations were informed by data on cost-effectiveness and combined with the Guideline Committee's expertise. The evidence demonstrated that if early supported discharge combined with rehabilitation is commissioned for older people this will result in better outcomes for individuals as well as being cost-effective.</p>
Economic considerations	<p>The recommendations were based on or informed by the relevant economic evidence. In addition, there was a range of wider economic evidence which was insufficiently applicable which supported the cost-effectiveness of early supported discharge for different populations.</p>
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>Ec 3 Four economic evaluations were identified of interventions with early supported discharge in combination with some form of rehabilitation provided to older people (Lim et al 2003, N=598; Miller et al 2005, N=272; Hammer et al 2009, N=668; Wong et al 2012, N=555). The studies were carried out alongside randomised controlled trials and models of service provision included a nurse-help worker partnership in Finland (N=668; ++), a nurse-volunteer partnership in Hong Kong (N=555; +), a discharge lead with budget for community services in Australia (N=598; ++) and a multi-disciplinary team in the UK (N=272; ++). Findings from all four studies suggested that early supported discharge in combination with rehabilitation improved physical health and reduced costs and was likely to be cost-effective. The UK-based study was a cost utility study which evaluated a home care and rehabilitation package provided to older people living in their own home with social care and rehabilitation needs who did not require 24 hours care. The intervention consisted of a maximum number of 4 visits per day provided over no longer than 4 weeks. QALYs measured with the EQ-5D improved by</p>

	<p>0.07 at 3 months (95% CI -0.01 to 0.14) and 0.02 at 12 months (95% CI -0.06 to 0.09). Wider health and wellbeing outcomes including those of carers improved and there were no significant changes in terms of mortality or care home admission (findings reported in Cunliffe et al 2004). The intervention achieved a significant reduction in health and social care costs (due to reduced hospital bed use). Cost-effectiveness acceptability curve showed high probabilities that the intervention was cost-effective at different willingness-to-pay-thresholds; and the results were robust against various assumptions tested in sensitivity analysis. (Recs 1.5.25 and 1.5.26)</p>
<p>Other considerations</p>	<p>Recommendation 1.5.25 was derived directly from economic evidence statement 3, which synthesizes good quality evidence in favour of the cost effectiveness of early supported discharge with a home care and rehabilitation package for older people. The Guideline Committee discussed whether they could be precise about the length of the rehabilitation package. The evidence clearly states that 4 weeks rehabilitation is cost effective although the committee knew from their experience that local authority rehabilitation is likely to last up to 6 weeks with further input provided by a physiotherapist for longer, as necessary. Because of the significant cost savings, identified by the included studies, it is likely that the intervention could still be cost-effective beyond 4 weeks. Following discussion, the Guideline Committee agreed to maintain flexibility in the recommendation by omitting a precise time period for the rehabilitation package. Finally, the committee agreed to extrapolate the findings from the research beyond the specific population of older people and this is reflected in 1.5.26, which refers to all adults with social care needs and is a weaker recommendation.</p>

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Topic/section heading	People at risk of hospital readmission
Recommendations	<p>1.5.27 The discharge coordinator should refer people at risk of hospital readmission to the relevant community-based health and social care practitioners before they are discharged. For example, if a person is homeless, the discharge coordinator should liaise with the local authority housing options team to ensure they are offered advice and help.</p> <p>1.5.28 Health, social care and housing commissioners should ensure homeless people with social care needs are offered suitable temporary accommodation and support.</p>
Research recommendations	The guideline Committee did not prioritise this as an area to make research recommendations on
Review questions	7. What is the effectiveness of interventions and approaches designed to reduce hospital re-admissions within 30 days of hospital discharge?
Quality of evidence	These recommendations are based on effectiveness evidence about reducing hospital readmissions, which was judged to be of mixed, good to moderate quality. For this review area, there was no data on views and experiences. There was also no economic evidence.
Relative value of different outcomes	The evidence for follow up and support on discharge was provided by effectiveness studies so the Guideline Committee could ascertain the relative value of this approach. Evidence that follow up support reduces readmissions was clear, albeit that it mainly referred to older people. The committee judged that the positive outcomes would be achieved for all adults at risk of readmission and they specified homeless people as an example.
Trade-off between benefits and harms	These recommendations were informed predominantly by data on effectiveness. Combined, with the Guideline Committee's expertise, data demonstrated that if people at risk of readmission are not supported at home following discharge, they are more likely to be readmitted to hospital within 30 days. Considering the equalities impact assessment as well as evidence from one randomized controlled trial, the committee agreed that homeless people in particular would benefit from follow up support and placement in suitable housing.
Economic considerations	The implementation of the recommendations is likely to have economic implications including an increase in short-term costs linked to additional time spent by professionals on coordinating care and organising temporary accommodation and support. Hospital length and associated costs might reduce, however, if patients can move from hospital into temporary accommodation sooner. It is not possible to predict long-term impact on costs across government budgets.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	RHR4 There is a small amount of evidence of mixed quality that follow up care at home is vital to reducing readmissions. A good quality systematic review (Linertova et al, 2011) [++] located 15 home follow up studies, of which 7 clinical trials demonstrated effectiveness in reducing readmissions among older people. Interventions that combined geriatric management supported with home care post discharge were most likely to produce

	<p>positive effects. A low quality systematic review (Naylor, 2011) [-] found that comprehensive discharge planning with follow up interventions (incorporating patient and caregiver goal setting and clinical management) was one of two most effective multi component interventions. A good quality systematic meta-review (Scott, 2010) [++] found that appropriate referral for home care and community support services was an essential component of discharge processes effective in reducing readmissions. (Rec 1.5.27)</p> <p>RHR6 A limited amount of evidence of moderate quality suggests that housing support combined with case management has a positive effect on hospital readmission rates for homeless people. One randomized control trial (Sadowski, 2009) [+] found that when housing was offered on discharge from hospital, followed by placement in long-term housing, the intervention groups had statistically significantly lower readmissions (as well as hospital days and emergency department visits). (Rec 1.5.27 and 1.5.28)</p>
<p>Other considerations</p>	<p>Recommendation 1.5.27 is derived directly from RHR4, which provides evidence in favour of follow up care and support after discharge from hospital. The evidence was mainly about older people but the committee wished to extrapolate to adults with social care needs judged by hospital practitioners to be at risk of readmission within 30 days. Also partly based on RHR6, the committee chose to include homeless people as an example of a population at risk of readmission and to suggest how they should be supported on discharge. Recommendation 1.5.28 follows from this and is also based on RHR6, which highlights evidence from a randomized controlled trial that a housing placement reduces readmissions. Committee members were keen to use this evidence to develop recommendations about supporting homeless people on discharge, not least because they were identified in the equalities impact assessment as being vulnerable to poor transitions.</p>

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Topic/section heading	Involving Carers
Recommendations	<p>1.5.29 The hospital- and community-based multidisciplinary teams should treat the family as an important resource for understanding the person's life and needs.</p> <p>1.5.30 With the person's agreement, include the family's views and wishes in discharge planning.</p> <p>1.5.31 If the discharge plan involves support from family or carers, the hospital-based multidisciplinary team should take account of their:</p> <ul style="list-style-type: none"> • willingness and ability to provide support • circumstances, needs and aspirations • relationship with the person • need for respite. <p>1.5.32 In line with the Care Act 2014, carers must be informed about their right to a carer's assessment.</p>
Research recommendations	The guideline Committee did not prioritise this as an area to make research recommendations on.
Review questions	<p>6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?</p> <p>11(a) How should services work with families and unpaid carers of adults with social care needs during transition from inpatient hospital settings to community or care home settings?</p> <p>11 (b) How should services work with families and unpaid carers of adults with social care needs during admission to inpatient hospital settings from community or care home settings?</p>
Quality of evidence	These recommendations are based on evidence from the hospital discharge and carer support review areas. In the area of hospital discharge, there were 12 views studies mainly of moderate quality. The 16 effectiveness studies were mostly of moderate and good quality. In the carers' support review area, there was a moderate amount of views and experiences evidence, judged to be of moderate quality. The two effectiveness studies with an RCT design for carer support related specifically to carers of stroke patients. Economic evaluations were carried out alongside those two effectiveness studies.
Relative value of different outcomes	The absence of effectiveness studies relevant meant that it was not possible to ascertain and compare the relative value of outcomes associated with involving carers in the hospital discharge process.
Trade-off between benefits and harms	The absence of effectiveness studies meant that it was not possible to ascertain and compare the benefits and harms associated with involving carers in the discharge process. However the committee drew on the qualitative evidence and their own expertise and concluded that, assuming the patient's consent, the benefits of involving carers by far outweighed any potential harm.
Economic considerations	The economic studies evaluated the cost-effectiveness of a particular training intervention provided to carers of stroke

	<p>patients at hospital discharge. The newer study did not find that this particular intervention was cost-effectiveness and that it was possible carers' support could be more cost-effective if it was provided differently, e.g. integrated into continuous support.</p>
<p>Evidence statements – numbered evidence statements from which the recommendation(s) were developed</p>	<p>HD5 There is a moderate amount of moderate to good evidence that professionals involved in discharge planning fail to treat patients as a 'whole person'. One qualitative study (Huby et al, 2004 and 2007) [++] concluded that transitions from hospital would be more successful if professionals considered all relevant circumstances surrounding a patient rather than making decisions based on a narrow understanding of physical and cognitive functions. A good quality qualitative study (Taylor and Donnelly, 2006) [++] also highlighted the importance of seeing beyond a person's condition or physical need when considering their transition from hospital to the community. A moderate quality study (Connolly et al, 2009) found hospital professionals who depicted the discharge process as de-humanising'. They felt that use of the label 'medically fit for discharge', oversimplifies cases and highlights that once the medical or 'acute' problem had been addressed, any remaining difficulties that patients experienced were not regarded as the hospital's concern. (Recs 1.5.29 and 1.5.30)</p> <p>HD6 There is a good amount of mixed quality evidence that including people and families in decision-making and preparation for discharge affects the quality of transitions from hospital. A study (Benton, 2008) [+] of patients' experiences of intermediate care found they lacked understanding about the purpose of the unit and their potential for rehabilitation. One study (Huby et al 2004 and 2007) [++] found that individual needs are ignored and patients are excluded from decision making about treatment and discharge. A systematic review (Laugaland et al, 2012) [+] showed that successful interventions involved caregivers and included patient participation and/ or education. Similarly, another systematic review (Preyde, 2011) [+] found that a lack of family or patient education during discharge was significantly related to readmission. Finally, one RCT (Li Hong et al, 2012) [++] reported mixed results. When patient-carer dyads received empowerment-educational sessions on admission and discharge, there was no significant difference on caregivers' emotional coping for depression, anxiety and worry and no reduction in the amount of care giving; the only differences were less role strain and caregiver preparedness to participate in post hospital care. (Recs 1.5.29 and 1.5.30)</p> <p>CS2 There is a small amount of moderate and good quality evidence that carers experience strain, anxiety and stress as a result of their role and that respite is an invaluable means of dealing with this. One study Pearson et al (2004) [+] found carers felt taken for granted by the professionals involved who assumed they would provide support following discharge regardless of their capacity to do so. Another study (Cobley et al, 2013) [++] echoed this, reporting little support or recognition of carer strain (including physical, mental and on other relationships). Respite, even for short stretches of time, was invaluable to carers. (Rec 1.5.31 and Rec 1.5.32)</p>

<p>Other considerations</p>	<p>Recommendations 1.5.29 and 1.5.30 are both derived from HD5 and HD6, which emphasize the importance of treating the whole person during discharge planning and including families and carers in decision-making about hospital discharge. The committee agreed that given the evidence in HD6, families and carers should be treated as a resource to provide information about the broad spectrum of the person's needs and circumstances, relevant to discharge planning. In developing recommendation 1.5.30, the committee discussed issues of confidentiality and agreed that families and carers should contribute their opinions and express their wishes, assuming the person consents to this. Recommendation 1.5.31 is based on evidence about the strain and anxiety carers experience as a result of their role supporting people after discharge. The Guideline Committee agreed that although families can make an invaluable contribution to supporting hospital discharge, their role should never be assumed and in developing discharge plans that involve families, hospital based practitioners should consider a range of issues cited in the recommendation.</p> <p>Finally, linked to all the recommendations in this section, 1.5.32 refers to a provision of the Care Act 2014, stating that carers must be informed about their right to an assessment. The fact that this is legally binding is reflected by the strength of the recommendation.</p>
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Topic/section heading	Support and training for carers
Recommendations	<p>1.5.33 Commissioners should ensure training is available to help carers provide practical support. (.34)</p> <p>1.5.34 A member of the hospital-based multidisciplinary team should discuss the practical and emotional aspects of providing care with potential carers. (.33)</p> <p>1.5.35 The relevant multidisciplinary team should offer family members and other carers of people who have had a stroke needs-led training in how to care for them. For example, this could include techniques to help someone carry out everyday tasks as independently as possible. Training might take place in hospital or it may be more useful at home after discharge.</p> <p>1.5.36 The relevant multidisciplinary team should consider offering family members and other carers needs-led training in care for people with conditions other than stroke. Training might take place in hospital or it may be more useful at home after discharge.</p> <p>1.5.37 The community-based multidisciplinary team should review the carer's training and support needs regularly (as a minimum at the person's 6-month and annual reviews). The team should take into account that their needs may change over time.</p>
Research recommendations	The guideline Committee did not prioritise this is an area to make research recommendations on.
Review questions	<p>11(a) How should services work with families and unpaid carers of adults with social care needs during transition from inpatient hospital settings to community or care home settings?</p> <p>11 (b) How should services work with families and unpaid carers of adults with social care needs during admission to inpatient hospital settings from community or care home settings?</p>
Quality of evidence	These recommendations are based on a good quality economics study and evidence from the carer support review area, where there was a moderate amount of views and experiences evidence, judged to be of moderate quality. The two effectiveness studies with RCT design for carer support related specifically to carers of stroke patients. Economic evaluations were carried out alongside those two effectiveness studies.
Relative value of different outcomes	These recommendations are largely based on effectiveness and cost effectiveness evidence, which meant the Guideline Committee could ascertain the relative value of providing information and training for carers of stroke patients on discharge from hospital. Although evidence was to some extent conflicting, in light of their expertise, the committee agreed that training for carers would reduce costs, decrease caregiver burden and increase the success of hospital discharge.
Trade-off between benefits and harms	These recommendations were informed predominantly by data on effectiveness and cost effectiveness. Combined, with the Committee's expertise and interpretation of the evidence, data demonstrated that if carers of stroke patients are provided with information and training on discharge, the individual and service level benefits would outweigh any harms or associated costs.

Economic considerations	The two economic studies evaluated the cost-effectiveness of a particular training intervention provided to carers of stroke patients at hospital discharge. The newer study did not find that this particular intervention was cost-effective and that it was possible carers' support could be more cost-effective if it was provided differently, for example integrated into continuous support.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>CS3 There is some evidence of moderate and good quality that caregivers of stroke patients value proactive support, which is provided directly from professionals, with leaflets and the internet playing a subsidiary role. One study (Bakas et al, 2009b) [+] presented evidence which showed that caregivers found printed information to provide much needed support, whilst repeated telephone contact from a nurse considerably improved their experience of transition from hospital to home. Another (Cobley 2013) [++] found that family caregivers of stroke patients undergoing early supported discharge felt that direct contact with a professional would have considerably improved their experience of transition. Finally, a study (Kalra et al, 2004) [++] in which caregivers received instruction directly from appropriate professionals during patients' rehabilitation reduced costs and caregiver burden while improving psychosocial outcomes in caregivers and patients at one year (Rec 1.5.34)</p> <p>Ec6 One UK cost-utility study that was carried out alongside a RCT was identified (N= 300, ++). The intervention referred to 3 to 5 training sessions for carers (30-40 min) on a stroke rehabilitation unit compared to stroke rehabilitations unit only. There was no significant difference in carers' health measured via EQ-5D at different time points with the latest follow up at 1 year but a significant reduction in total costs ($p < 0.001$) due to shorter hospital stays. There were also no significant changes in personal care, domestic help or unpaid care. The intervention was dominant in cost-effectiveness terms so that ICER was not calculated. Findings were not confirmed in a more recent, larger pragmatic cluster RCT of the same intervention (N=928, ++) which was carried out between 2008 and 2010. This study measured a wider range of outcomes for patients in a stroke unit and their carers including functional independence, caregiver burden and physical health (via EQ-5D). None of the outcomes differed significantly between the two groups at 6 and 12 months. Carers in the intervention group had higher health and social care costs at 6 months (adj. mean diff £207 (95% CI 5–408, $p = 0.045$) but not over 12 months. Deaths, hospital readmission and institutionalisation rates did not differ either at 6 or 12 months. (Recs 1.5.33, 1.5.36 and 1.5.37. Also 1.5.35 with cross reference to the NICE stroke rehabilitation guideline)</p>
Other considerations	Recommendation 1.5.34 is based on evidence statement CS3 about the value that caregivers of stroke patients attach to receiving information and support. In their experience, the committee agreed that a member of the multi-disciplinary team should discuss the practical and emotional aspects of providing care; rather than simply give carers an information leaflet.

	<p>Recommendations 1.5.33, 1.5.35, 1.5.36 and 1.5.37 are based on evidence about the effectiveness and cost-effectiveness of training for carers of stroke patients. Although findings from the two studies did not concur, the Guideline Committee agreed that the findings of no significant differences in costs and outcomes in the more recent study could be explained by the differences in study design and by the fact that usual care had improved by then. The committee concluded that, combined with their own expertise, the evidence for the cost effectiveness of training for carers of stroke patients was robust enough to support a strong recommendation. They also extrapolated the findings to develop a linked, weaker recommendation about providing training for carers of people with other conditions (1.5.36) and they felt commissioners has a responsibility to ensure training is available. Recommendations 1.5.35 and 1.5.37 are similar to existing NICE recommendations from the stroke rehabilitation guideline. However, for 1.5.35, the committee wished to update the reference to the type of training provided and emphasize that, in light of the evidence, it may be better to deliver the training at home, after the discharge from hospital.</p>
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Topic/section heading	After transfer from hospital
Recommendations	<p>1.5.38 Community-based health and social care practitioners should maintain contact with the person after they are discharged. This could include regular phone calls and home visits. It also involves making sure the person knows how to contact them when they need to.</p> <p>1.5.39 An appropriately skilled practitioner should follow up people with palliative care needs within 24 hours after their transfer from hospital.</p> <p>1.5.40 A GP or community-based nurse should phone or visit people at risk of readmission 24–72 hours after their discharge.</p>
Research recommendations	<p>The following research question is relevant to this topic:</p> <p>2.1 What is the effect of hospital discharge or transitions training for health and social care practitioners on achieving successful transfers from hospital to home or the community? (Including specifically the effects on formal and informal carers, and on avoidable readmissions?)</p>
Review questions	<p>7. What is the effectiveness of interventions and approaches designed to reduce hospital re-admissions within 30 days of hospital discharge?</p>
Quality of evidence	<p>These recommendations are based on evidence about reducing hospital readmissions, for which there was a good amount of good quality effectiveness evidence but no views and experiences data.</p>
Relative value of different outcomes	<p>The evidence for post discharge contact is from effectiveness studies so the Guideline Committee could ascertain there is value in that approach, although conflicting evidence meant it was not possible to establish the relative value of phone calls or home visits.</p> <p>Evidence for GP or community nurse follow up of people at risk of readmission is based on mainly good quality effectiveness evidence so the Guideline Committee could ascertain this approach would achieve positive outcomes, in terms of reducing hospital readmissions.</p>
Trade-off between benefits and harms	<p>These recommendations were informed predominantly by data on effectiveness. Combined, with the Guideline Committee's expertise, data demonstrated that if community based health and social care practitioners follow people up via a visit or phone call and if people at risk of readmission are visited within 24 hours by a GP or community nurse, then readmissions to hospital would be reduced.</p>
Economic considerations	<p>Although there was no evidence on costs, the committee felt the individual and system level benefits would outweigh additional costs incurred.</p>
Evidence statements – numbered evidence statements from which the	<p>RHR 2 There is a moderate amount of evidence of mainly good quality that post discharge communication with patients reduces hospital readmissions although conflicting evidence also exists. A good quality systematic review (Leppin, 2014) [++] identified frequent contact with the patient and home visits as common</p>

<p>recommendation(s) were developed</p>	<p>components of complex interventions, which were most effective in reducing early readmissions. A good quality systematic meta-review (Scott, 2010) [++] concluded that home visits or telephone support for patients with heart failure appear to be one of two single component strategies demonstrating consistent evidence of efficacy in reducing readmissions. A low quality systematic review (Naylor, 2011) [-] located 9 studies demonstrating a positive effect on readmissions. Six of these included in person home visits. Finally, a good quality systematic review (Hansen et al, 2011) [++] found slightly conflicting results; of 4 effective multi-component interventions, post discharge telephone calls were common to them all. However Hansen et al also located two RCTs that included post discharge telephone calls and which did not report significant effects. Similarly, two studies that examined follow up calls in isolation did not find a significant effect. Finally, a moderate quality systematic review (Bahr, 2014) [+] of post discharge telephone calls did not find any significant effect in the studies (n=7) which measured hospital readmission. (Rec 1.5.38)</p> <p>Consensus (Rec 1.5.39)</p> <p>RHR4 There is a small amount of evidence of mixed quality that follow up care at home is vital to reducing readmissions. A good quality systematic review (Linertova et al, 2011) [++] located 15 home follow up studies, of which 7 clinical trials demonstrated effectiveness in reducing readmissions among older people. Interventions that combined geriatric management supported with home care post discharge were most likely to produce positive effects. A low quality systematic review (Naylor, 2011) [-] found that comprehensive discharge planning with follow up interventions (incorporating patient and caregiver goal setting and clinical management) was one of two most effective multi component interventions. A good quality systematic meta-review (Scott, 2010) [++] found that appropriate referral for home care and community support services was an essential component of discharge processes effective in reducing readmissions. (Rec 1.5.40)</p>
<p>Other considerations</p>	<p>Recommendation 1.5.38 is derived from RHR2, which synthesizes evidence in support of post discharge contact although some evidence cast doubt on the effectiveness of post discharge telephone calls. Having discussed the evidence and reflected on their own experience, the committee agreed that people should be contacted following discharge although they chose not to stipulate whether this should be via home visits or phone calls. The committee also chose to extrapolate the findings to make a specific recommendation about following up people with palliative care needs (1.5.39) and the 24 time frame reflects the urgency often associated with supporting people at the end of life. Finally, 1.5.40 is derived directly from evidence in RHR4. The committee were unanimous in their agreement about this recommendation, including that it should be focussed on people at risk of admission, rather than just older people and that the timeframe should be 24-72 hours.</p>

Topic/section heading	Supporting infrastructure
Recommendations	<p>1.6.1 Local health commissioners and local authorities should ensure a range of local services is available to support people on discharge from hospital. This might include:</p> <ul style="list-style-type: none"> • reablement: helping people re-learn some of the skills for daily living that they may have lost • other intermediate care services • practical support for carers. <p>1.6.2 Local health commissioners, hospital trusts and local authorities should have a multi-agency plan to address pressures on services, including bed shortages.</p> <p>1.6.3 Local health commissioners should ensure all care providers, including GPs and out-of-hours providers, are kept up to date on the availability of local health and social care services.</p> <p>1.6.4 Local health commissioners should ensure local protocols are in place so that out-of-hours providers have access to information about the person's preferences for end-of-life care.</p> <p>1.6.5 Health and social care practitioners should be aware of the local community health, social care and third sector services available to support people during their move from hospital.</p>
Research recommendations	The Guideline Committee did not prioritise this is an area to make research recommendations on.
Review questions	<p>6. What is the effectiveness of interventions and approaches designed to improve hospital discharge?</p> <p>9 (a) What is the impact of specific interventions to support people with end-of-life care needs during transition from inpatient hospital settings to community or care home settings, including hospices?</p> <p>9 (b) What is the impact of specific interventions to support people with end-of-life care needs during admission to inpatient hospital settings from community settings including care homes and hospices?</p>
Quality of evidence	The recommendations about supporting infrastructure were based on evidence from the hospital discharge and end of life care review areas. For hospital discharge, there were 12 views studies mainly of moderate quality. The 16 effectiveness studies were mostly of moderate and good quality. Evidence in the end of life care review area consisted of good quality views data and one moderate quality controlled study of effectiveness.
Relative value of different outcomes	<p>Evidence supporting provision and awareness of community based health, social care and third sector services to support hospital discharge mainly comes from effectiveness evidence and committee expertise. The committee could therefore ascertain that support following discharge from hospital achieves positive outcomes including reduced length of hospital stay, nursing home referrals and social isolation.</p> <p>Evidence in favour of ensuring that out of hours providers can access a record of people's end of life care preferences was</p>

	from qualitative studies so it was not possible to ascertain and compare the relative value of associated outcomes.
Trade-off between benefits and harms	<p>The recommendations about support following hospital discharge were informed by data on effectiveness plus the Guideline Committee's expertise. The data and the Guideline Committee's expertise indicated that ensuring health and social care services are available to support people following hospital discharge achieves service level and individual benefits that outweigh any possible harms, such as having no effect on readmissions.</p> <p>It was not possible from the evidence to ascertain and compare the trade-offs between benefits and harms in respect of ensuring out of hours providers know people's end of life care preferences although the qualitative evidence and committee expertise suggest the benefits justify the recommendation.</p>
Economic considerations	Most of economic evidence on rehabilitation and intermediate (with the exception of one study) was not sufficiently applicable to the review question. The question of which type of reablement and intermediate care different groups of people will be referred to is likely to have economic implications.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>HD4 There is a good amount of moderate quality evidence that support for people after they have been transferred from hospital improves experiences as well as service level and individual outcomes. Where support is unavailable, the success of hospital discharge is threatened. A good quality RCT (Burton and Gibbon, 2005) [++] found that when follow up care was provided by a stroke nurse, ADL and social isolation scores were significantly improved although there was no difference in depression scores. Focus group participants (Connolly et al, 2009) [+] cited lack of equipment in people's homes as a cause of delay, which could be improved if assessments were conducted earlier in the hospital stay. A low quality mixed methods study (Bryan et al, 2006) [-] reporting managers' views cited inadequate social services resources and shortages of health and care professionals to provide support for people returning home as major barriers to discharge. A qualitative study (Huby et al, 2004 and 2007) described how a lack of community services meant patients could not be discharged, in some cases for several weeks. Finally, two systematic reviews (Larsen et al, 2006 and Olson et al, 2011) [+] [++] reported that early home supported discharge which includes delivering care at home, caused a reduction in length of stay, nursing home referrals and poor outcomes in a stroke unit although it had no effect on readmissions. (Recs 1.6.1; 1.6.3 and 1.6.5)</p> <p>HD3 There is a moderate amount of moderate quality evidence that bed shortages and government targets create pressure to discharge patients without involving all relevant professionals, often resulting in readmissions. A moderate quality study (Connolly, 2009) [+] reported that focus group members feel compelled to make discharge a swift procedure due to pressure from managers and consultants, who were seen as striving to achieve government targets to fill beds and reduce waiting lists. Similarly, a survey of hospital based professionals (Connolly, 2010) [+] found 80% of respondents felt government targets</p>

	<p>caused the discharge process to be rushed and result in readmissions within days. A good quality mixed methods study (Huby et al, 2004 and 2007) [++] showed that pressures owing to bed shortages were clearly on the minds of patients who claimed to feel well purely so they would be discharged. (Rec 1.6.2)</p> <p>ELC2 There is a moderate amount of good quality evidence from 1 mixed methods study and 2 qualitative studies that transitions would be improved if time were dedicated to discussions with patients and families about end of life preferences. Wishes surrounding resuscitation and place of death were seen as particularly important. One mixed methods study (Hanratty, 2014) [++] reported that carers wanted more help and support to discuss concerns and patients wishes were not accounted for in transitions planning. One UK qualitative study (Ingleton, 2009) [++] reported reluctance on the part of GPs and hospital consultants to discuss DNAR orders and training in that area is required. One US qualitative study (Kusmaul and Waldrop, 2011) [++] identified a key role for social workers to discuss advanced care planning and hospitalization with families of nursing home residents during the living-dying interval. (Rec 1.6.4)</p> <p>ELC4 There is a small amount of evidence of good quality that out of hours GP services can cause particular problems in the transition process for people with end of life care needs. One UK qualitative study (Hanratty, 2014) [++] reports that the involvement of out of hours GPs makes service provision seem uncoordinated and another (Ingleton, 2009) [++] found that when out of hours GPs made uninformed decisions about patients, this resulted in inadvertent or unnecessary transition into hospital. (Recs 1.6.3 and 1.6.4)</p>
<p>Other considerations</p>	<p>Recommendation 1.6.1 is based on HD4, which synthesizes evidence that found support from health and social care practitioners following discharge facilitated timelier, successful transfers from hospital and improved people's experiences. The committee endorsed this and from their expertise, agreed to cite specific examples of the types of support that would be effective. They also agreed that the responsibility should be on health and social care commissioners to ensure such support services are available. Recommendation 1.6.2 is derived directly from HD3 and Guideline Committee consensus that health and social care commissioners should have plans in place to respond to pressures on hospital beds to attempt to avoid the circumstances described in the evidence. Recommendation 1.6.3 is linked to 1.6.1. It is based on HD4 and also ELC4, which highlights that problems can occur when out of hours services such as GPs are not aware of the range of available services. The committee therefore agreed that having ensured the local support services are available, health and social care commissioners should ensure that all providers are aware of them.</p> <p>Recommendation 1.6.4 is based on ELC2 and ELC4 and also addresses the problems that can arise when out of hours services are involved, in this instance with people who are at the</p>

	<p>end of life. If practitioners do not know people's preferences for end of life care, they may have unnecessary, unwanted and uncomfortable transitions forced on them. Finally, the guideline committee agreed recommendation 1.6.5, partly on the basis of HD4 and partly their own experience that home based support to improve hospital discharge can be accessed not only via health and social care but also third sector services. They agreed that practitioners should ensure they are aware of the range of options.</p>
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Topic/section heading	Training and development
Recommendations	<p>1.7.1 Hospital trusts and local authorities should make sure their staff are trained in the hospital discharge process. Training should take place as early as possible, with regular updates. It could include:</p> <ul style="list-style-type: none"> • medicines management • medicines adherence (for more information see NICE's guideline on medicines adherence) • medicines review in partnership with the person • how to get information about the person's social and home situation (including who is available to support the person) • discharge communications • interdisciplinary working between the hospital- and community-based multidisciplinary teams, people using services and their carers • learning how to assess the person's home environment (home visits) • awareness of the local community health, social care and third sector services available to support people during their move from hospital to the community • helping people to manage risks effectively so that they can still do things they want to do (risk enablement). <p>1.7.2 Consider making the training recommended in 1.7.1 available to community-based health and social care practitioners, physiotherapists and occupational therapists.</p>
Research recommendations	<p>The following research question is relevant to this topic:</p> <p>2.1 What is the effect of hospital discharge or transitions training for health and social care practitioners on achieving successful transfers from hospital to home or the community? (Including specifically the effects on formal and informal carers, and on avoidable readmissions?)</p>
Review questions	<p>12. What is the impact of training to support transitions between inpatient hospital settings and community or care home settings?</p>
Quality of evidence	<p>These recommendations are based on evidence from the review area about practitioner training to support transitions between hospital and home. Overall, there was a small amount of evidence and none of it was about a direct causal link between training and the outcomes of transitions at the individual or service level. However, studies of the impact of training on practitioners involved in transitions were located and they were of moderate quality. Studies of views and experiences relating to training were lacking. The only one included for review, was of low quality and from outside the UK.</p>
Relative value of different outcomes	<p>The fact that none of the studies used a controlled design meant there were limits to the extent to which the committee could ascertain and compare the relative value of transitions training. Nevertheless, the before and after study designs, coupled with</p>

	<p>Guideline Committee expertise provided sufficient confidence that training for hospital and community based trainees would have a positive outcome on their own skills and expertise. Further research is needed to ascertain whether this will result in improved hospital discharge outcomes.</p>
Trade-off between benefits and harms	<p>From the evidence, it was not strictly possible to ascertain and compare the trade-offs between benefits and harms in respect of transitions training for health and social care trainees. However, the committee interpreted the evidence and used their expertise to conclude that the benefits of training outweighed any potential harms or costs.</p>
Economic considerations	<p>The development of the training programme will be associated with additional costs to hospital trusts and local authorities and there will be also on-going costs linked to additional staff time for implementing the training in routine practice. There is no economic evidence to predict whether this will be justified by service users' and carers' health and wellbeing benefits; or if short-term costs will be possibly offset by cost savings in the medium to long-term linked for example to, reduction in hospital length of stay, readmission or admission to residential care.</p>
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	<p>TR1 There is some evidence of moderate quality that dedicated transitions training for hospital based health professionals increases their understanding of the social context into which people are transferred from hospital. One moderate quality survey (Lai et al, 2008) [+] found that a discharge curriculum including home visits caused medical and pharmacy students to appreciate patients' own environment and the effect it may have on managing medical issues following hospital discharge. A low quality study (Northrup-Snyder et al, 2011) [-] found that training hospital-based nurses in community health made them understand the importance of considering people's home and community in discharge planning. Finally, a moderate quality study (Ouchida et al, 2009) [+] found that interactive learning about transition planning made medical students aware of the importance of discharge planning that is person focussed and takes account of options for community support. (Rec 1.7.1 and rec 1.7.2 with consensus discussion)</p> <p>TR3 There is some evidence of moderate quality that transitions training for hospital based health professionals improves their skills in medication management and increases their appreciation of its importance during hospital discharge. One survey (Eskildsen et al, 2012) [+] found that when medical students followed a care transitions curriculum, 90 per cent of the discharge summaries they completed met all quality criteria. This included a documented discharge medication list with specific dosing schedules and a list of any medication changes resulting from hospitalisation. Another survey (Lai et al, 2008) [+] found that medical and pharmacy students benefitted from training on the components of discharge planning including medication management. Students learned that health professionals should take care to understand the person being discharged, their</p>

	<p>preferences and lifestyles in order to plan and manage medication in a way that best suits the individual. Finally, a study (Ouchida et al, 2009) [+] of transitions training for medical students found that the proportion of students able to identify medication errors as the most common source of post discharge problems increased significantly. (Rec 1.7.1 and Rec 1.7.2 consensus discussion)</p>
<p>Other considerations</p>	<p>Recommendations 1.7.1 and 1.7.2 are linked and both based on TR1 and TR3 although 1.7.1 is a stronger recommendation because it is derived directly from the evidence, which found that transitions training for hospital-based trainees improves their understanding of patient's social context and their skills in medicines management. Although the evidence was about hospital-based health trainees, the committee agreed that benefits for hospital based social work trainees could reasonably be implied. They also reached a consensus to develop a weaker recommendation (1.7.2) for training community based health and social care professionals in all the aspects stated in 1.7.1.</p> <p>Finally, TR2 provides evidence that transitions training for medical students improves their competence with important aspects of managing hospital discharge, not least tasks such as completing discharge summaries and making follow up phone calls, which have been recommended elsewhere in this guideline.</p>

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2 **4 Implementation: getting started**

3 NICE has worked with the Committee to identify areas in this draft guideline
4 that may have a significant impact on practice and could be difficult to
5 implement.

6 If the draft recommendations are not changed after consultation we think there
7 will be cross-cutting challenges in 3 important areas of the guideline:

- 8 • Recognising that everyone receiving care is an individual and an equal
9 partner who can make informed choices about their own care (related to
10 recommendations 1.1.1, 1.1.2, 1.1.3 and 1.3.6).
- 11 • Developing effective communication and improving coordination of services
12 (related to recommendations 1.1.6, 1.3.3 and 1.3.5).
- 13 • Changing working practices to improve planning for transitions in and out of
14 hospital (related to recommendations 1.2.1 and 1.3.9).

1 During consultation we want stakeholders to let us know whether you agree.
2 Or do you think other areas in this guideline will have a bigger impact – or be
3 more difficult to implement?

4 We would also like you to send us your suggestions about how these
5 challenges could be met. For example, you could share examples of good
6 practice, or give us details of educational materials or other resources that you
7 have found useful. This information will be used to write an implementation
8 section for the final guideline.

9 Please use the [stakeholder comments form](#) to send us your comments and
10 suggestions.

11 ***Challenges for implementation***

12 ***4.1 Challenge 1 Recognising that everyone receiving*** 13 ***care is an individual and an equal partner who can*** 14 ***make informed choices about their own care***

15 See recommendations 1.1.1, 1.1.2, 1.1.3 and 1.3.6.

16 **Potential benefits of implementation**

17 People receiving care will benefit because they will experience care and
18 support that suits their needs rather than the needs of services.

19 **Challenges**

20 For health and social managers this will mean ensuring that:

- 21 • Significant changes in practice take place in services where the decisions
22 are made ‘about’ rather than ‘with’ people.

23 For health and social care practitioners this will mean ensuring that:

- 24 • Families and carers are involved in discussions about the person, if the
25 person has given permission.
- 26 • People who are at risk of less favourable treatment or less access to
27 services (such as people who are homeless or with mental health

1 problems) are identified and supported, and reasonable adjustments are
2 made, to ensure that they can make informed choices

3 **4.2 Challenge 2 Developing effective communications** 4 **and improve coordination of care**

5 See recommendations 1.1.6, 1.3.3, and 1.3.5.

6 **Potential benefits of implementation**

7 Good communications, both between health and social care practitioners
8 working in multidisciplinary teams and between practitioners and the person,
9 their family and carers, enable improved coordination of care and therefore a
10 better experience for the person.

11 **Challenges**

12 For health and social care service managers this will mean ensuring that:

- 13 • Effective systems are in place so that practitioners are enabled to
14 communicate successfully.

15 For health and social care practitioners this will mean ensuring that:

- 16 • The admitting team is given all relevant information and good
17 communications are maintained throughout the hospital stay, discharge
18 and after.
- 19 • There is good communication with the person and, where appropriate, their
20 family and carers.

21 **4.3 Challenge 3 Changing working practices to improve** 22 **planning for transitions into and out of hospital**

23 See recommendations 1.2.1 and 1.3.9.

24 **Potential benefits of implementation**

- 25 • Efficient admission and discharge planning enables a smooth transition that
26 meets the person's specific needs and preferences.

1 **Challenges**

2 For health and social care practitioners this will mean ensuring that:

- 3 • The assessment and discharge planning process begins as soon as the
4 person has been admitted to hospital (if this process hasn't already been
5 included in an existing care plan).
- 6 • People in the community at risk of being admitted to hospital have this
7 recorded in a care plan and the plan is referred to when a person at risk is
8 admitted to hospital.
- 9 • All planning is person-centred

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9 **6 Related NICE guidance**

10 Details of [related guidance](#) are correct at the time of consultation on the
11 guideline (June 2015).

12 **Published**

- 13 • [Excess winter deaths and morbidity and the health risks associated with](#)
14 [cold homes](#). NICE guideline NG6 (2015)
- 15 • [Managing medicines in care homes](#). NICE guideline SC1 (2014)
- 16 • [Mental well-being of people in care homes](#). NICE quality standard 50
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- 4 [social care](#). NICE guideline CG42 (2006).
- 5 • [Improving supportive and palliative care for adults with cancer](#). NICE
- 6 cancer service guideline (2004).

7 **In development**

8 NICE is [developing](#) the following guidance:

- 9 • Home Care. NICE social care guideline. Publication expected July 2015.
- 10 • Older People: independence and mental wellbeing. NICE public health
- 11 guideline. Publication expected September 2015.
- 12 • Social care of older people with multiple long-term conditions. NICE social
- 13 care guideline. Publication expected September 2015.
- 14 • Transition between inpatient mental health settings and community and
- 15 care home settings. NICE social care guideline. Publication expected
- 16 August 2016.
- 17 • Care and support of older people with learning difficulties. NICE social care
- 18 guideline. Publication expected September 2017.

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19 **Kathryn Smith** (Chair)
20 Director of Operations, Alzheimer's Society

21 **Kathleen Sutherland-Cash**
22 Person using services

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24 Professional Lead for Social Work (Adults), Sirona Care and Health

25 ***NICE Collaborating Centre for Social Care technical team***

26 A technical team at the NICE Collaborating Centre for Social Care was
27 responsible for this guideline throughout its development. It prepared

1 information for the Guideline Development Group, drafted the guideline and
2 responded to consultation comments.

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- 8 **John Mclean and Justine Karpusheff**
- 9 Guideline Programme Managers

- 10 **Anthony Gildea**
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- 12 **Rita Parkinson**
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- 14 **Peter O'Neill**
- 15 Technical Lead

- 16 **Tony Smith and Sarah Richards**
- 17 Economists

- 18 **Sue Jelly and Susie Burlace**
- 19 Editors

- 20

1 **Declarations of interests**

2 The following members of the Guideline Committee made declarations of
 3 interest. All other members of the Group stated that they had no interests to
 4 declare.

Committee member	Interest declared	Type of interest	Decision taken
Olivier Gaillemin	Interests are in improving the transition of care for frail older people.	Non-personal, non-pecuniary interest	None
Deborah Grieg	Employed full time by Gloucestershire County Council to undertake the role of Head of Adult Social Care in Gloucestershire Care Services NHS Trust (salaried post). Not a director of either organisation	Personal pecuniary interest	None
Deborah Grieg	Husband is employed full time in Gloucestershire Hospitals NHS Trust for which he receives a salary, he is not a Director	Personal family interest	None
Margaret Lally	While at the British Red Cross, contributed to documents on the need to improve transitional arrangements.	Non-personal pecuniary interest	None
Margaret Lally	A trustee of Heritage Care, a charity that provides independent living support for people with learning difficulties, people with mental health issues (through a subsidiary) and residential care for older people.	Non-personal pecuniary interest	None
Manoj Mistry	In February 2015 appointed a member of the Patient Panel at National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care, Greater Manchester.	Personal non-pecuniary interest	None
Manoj Mistry	In May 2015 appointed a member of the Study Steering Committee for the research project:	Non-personal pecuniary	None

	“Comprehensive Longitudinal Assessment of Salford Integrated Care (CLASSIC): a study of the implementation and effectiveness of a new model of care for long term conditions ”. (University of Manchester / Salford Royal NHS FT).	interest	
Sandy Marks	Chair of Disability Action Islington, London.	Non-personal pecuniary interest	None
Sandy Marks	Co-chair of Islington Making it Real board, London.	Non-personal pecuniary interest	None
Sandy Marks	Member of Integrated Care board of Islington Local Authority and Clinical Commissioning Group, London	Non-personal pecuniary interest	None
Sandy Marks	Chair of London Patient Voice.	Non-personal pecuniary interest	None
Sandy Marks	Father will benefit from the improvements the guideline aims to make.	Non-personal pecuniary interest	None
Manoj Mistry	In December 2014 appointed Public Representative Interviewer at the Medical School, Lancaster University.	Non-personal pecuniary interest	None
Manoj Mistry	In January 2015 appointed Public member of the NIHR's Research for Patient Benefit Programme Committee, Northwest Region.	Non-personal pecuniary interest	None
Manoj Mistry	Public private investment (PPI) representative for the Health Research Authority, London.	Non-personal pecuniary interest	None
Manoj Mistry	PPI representative for the Health Quality Improvement Partnership), London.	Non-personal pecuniary interest	None
Manoj Mistry	Lay member of NICE Clinical Guidelines Update Committee B.	Non-personal pecuniary interest	None

Manoj Mistry	PPI representative for the Primary Care Research in Manchester engagement Resource group at the University of Manchester.	Non-personal pecuniary interest	None
Manoj Mistry	Lay representative for the MSc in Clinical Bio Informatics at the University of Manchester.	Non-personal pecuniary interest	None
Manoj Mistry	Lay Educational Visitor at the Health and Care professions Council, London.	Non-personal pecuniary interest	None
Rebecca Pritchard	Involved in campaigning work on behalf of homeless people.	Non-personal pecuniary interest	None
Kathryn Smith	Director of Operations at the Alzheimer's Society and frequently asked to comment in the media on poor transitions between hospital and home.	Non-personal pecuniary interest	None
Kathleen Sutherland-Cash	Husband is employed regularly by an agency as a locum counselling psychologist for NHS mental health services	Personal family interest	None
Kathleen Sutherland-Cash	Work has involved challenging statutory authorities (NHS, Department for Work and Pensions and local councils) to ensure that disabled people's needs are met appropriately and policies and procedures are being correctly applied. Therefore involved in supporting disabled people to make formal complaints about appropriate health and social care practice and decisions.	Non-personal non-pecuniary interest	None
Kathleen Sutherland-Cash	Has asked MP to assist with issues relating to coordinating information and referral to local, regional and national hospitals for people with complex health conditions. Because the issues arising relate to cross referral to numerous trusts, as well as access to the specialist	Personal and non-personal pecuniary interest	None

	services of the NHS as a whole, they can only be resolved by the Department of Health.		
Kathleen Sutherland-Cash	Involved in work representing the interests of people with learning difficulties.	Non-personal pecuniary interest	None

1

2 **8 Glossary and abbreviations**

3 ***Glossary***

4 **Advance care plan**

5 An advance care plan, which may result from discussions between an
6 individual, their care providers and often those close to them could include:

- 7 • An advance statement (a statement of wishes and preferences)
- 8 • An advance decision to refuse treatment (ADRT)
- 9 • The appointment of a personal welfare Lasting Power of Attorney (LPA).

10 **Care plan**

11 An agreement between a person and a health professional (or social services)
12 to help them manage their health day to day. It can be a written document or
13 something recorded in patient notes.

14 **Communication passport**

15 A communication passport draws together information on a person with
16 communication difficulties' likes, dislikes, how they communicate, and how
17 best to communicate with them (including the person's own views, as much as
18 possible). It can be a book, video or collection of images which distils this
19 information into a clear, positive and accessible format.

20 **Community-based multidisciplinary team**

21 Members of a community-based multidisciplinary team could include:

- 22 • GP

- 1 • community nurse
- 2 • community mental health practitioner
- 3 • social worker
- 4 • housing officer
- 5 • community pharmacist.

6 **Coaching**

7 To give someone instructions to support them through hospital discharge, for
8 example in medication management or identifying possible triggers indicating
9 deterioration in their condition and what to do about them.

10 **Discharge plan**

11 Describes the coordination of care and support for discharge from hospital. It
12 is a working document for the multi-disciplinary teams.

13 **Discharge summary**

14 A summary of what happened during the admission and hospital stay from a
15 medical perspective. Information might include diagnosis, the outcomes of
16 investigations, changes to treatment and the medicines with which the person
17 was discharged.

18 **Early supported discharge service**

19 A multidisciplinary service that aims to allow patients return home from
20 hospital earlier than usual and receive more rehabilitation in the familiar
21 environment of their own home.

22 **Hospital passport**

23 A document for people who have a learning disability which helps provide
24 hospital staff with the information necessary for appropriate care planning and
25 discharge arrangements.

26 **Intermediate care**

27 Care to help people avoid going into hospital, or to help them regain their
28 independence after a hospital stay.

1 **Medicines management**

2 The safe and effective use of medicines to enable the best possible
3 outcomes.

4 **Step-up facilities**

5 Intermediate care function to receive patients from home/community settings
6 to prevent unnecessary acute hospital admissions or premature admissions to
7 long term care.

8 **Supportive self-management**

9 Supportive self-management is based on the principle that people should be
10 active partners in their own health and wellbeing, rather than passive
11 recipients of care. Health and social care practitioners teach self-management
12 techniques and help people build confidence to make informed decisions and
13 achieve their health and social care related goals.

14 Please see the [NICE glossary](#) for an explanation of terms not described
15 above.

16 ***Abbreviations - terms from included studies***

Abbreviation	Term
ABI	Acquired brain injury
ACE	Acute Care for Elders
ACP	Advanced care planning
ADL	Activities of daily living
AHS	Area Health Service
ALF	Assisted living facility
CA	Community alarm
CGA	Comprehensive Geriatric Assessment
CI	Confidence Interval
CM	Community matron
COPD	Chronic obstructive pulmonary disease
CPR	Cardio-Pulmonary Resuscitation
CQC	Care Quality Commission
DNAR	Do not attempt resuscitation
EQ-5D	EuroQol: a standard health measure that allows the calculation of quality-adjusted life years (QALYs)
ESD-MCC	Early supported discharge with

	multidisciplinary community care
GDG	Guideline Development Group
GHQ	General Health Questionnaire
GP	General practitioner
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
ICER	Incremental cost effectiveness ratio as a ratio of change in costs to change in benefits
LTC	long-term conditions
LTSS	Long Term Services and Supports
MAU	Medical assessment units
MI	Myocardial infarction
N	Number of participants
NH	Nursing home
NHS	National Health Service
NHP	Nottingham Health Profile: a general patient reported outcome measure which seeks to measure subjective health status
NICE	National Institute for Health and Care Excellence
OR	Odds ratio
OT	Occupational therapist
p	p-value: a measure that indicates whether the change in outcome was due to chance; a p-value of less than 0.05 suggests that the change was not due to chance (statistically significant)
PCT	Palliative Care Team
PNJ	Photographic narrative journal
POS	Palliative care Outcomes Scale
QALY	Quality-adjusted life year
QoL	Quality of Life
RACF	Residential Aged Care Facilities
RCT	Randomised controlled trial
RN	Registered nurse
RR	Risk ratio
SD	Standard deviation
SF-36	Short Form (36) Health Survey
WMD	Weighted mean difference
ZBI	Zarit Burden Interview

1

2 **About this guideline**

3 ***What does this guideline cover?***

4 The Department of Health (DH) asked the National Institute for Health and
5 Care Excellence (NICE) to produce this guideline on Transition between
6 inpatient hospital settings and community or care home settings for adults with
7 social care needs (see the [scope](#)).

8 The recommendations are based on the best available evidence. They were
9 developed by the Guideline Committee – for membership see section 7.

10 For more information on how NICE guidelines are developed, see Developing
11 NICE Guidelines: The Manual.

12 ***Other information***

13 We will develop a pathway and information for the public and tools to help
14 organisations put this guideline into practice. Details will be available on our
15 website after the guideline has been issued.

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